Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION MEETING MINUTES

Venue: Birmingham Chamber of Commerce, 75 Harborne Rd, Edgbaston, Birmingham B15 3DH

Date: Thursday 7th November 2019, 09:30 – 13:00

Members:

Mr R Samuda	(RS)	Chairman
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
Ms M Perry	(MP)	Non-Executive Director
Mr M Hoare	(MH)	Non-Executive Director
Miss K Dhami	(KD)	Director of Governance
Mr M Laverty	(ML)	Non-Executive Director
Mr H Kang	(HK)	Non-Executive Director
Ms D McLannahan	(DM)	Acting Director of Finance
Cllr W Zaffar	(WZ)	Non-Executive Director

In Attendance:

Mrs R Wilkin	(RW)	Director of Communications
Miss C Dooley	(CD)	Head of Corporate Governance

Apologies:

Mrs C Rickards	(CR)	Trust Convenor

Minutes	Reference
1. Welcome and Introductions	**Verbal**

The Chairman welcomed the members and those in attendance to the meeting. The attendees provided an introduction for the purpose of the recording.

An apology was noted from Mrs C Rickards.

2. Patient Story	**Presentation**

Mrs Gardner introduced Justine who would share her patient story in regard to elective hip surgery linked to her SLE and Sjogren's Syndrome. Mrs Gardner advised that Justine was accompanied by her sister, Amber, a matron in critical care. Justine provided a summary of her story:

- For three years she had experienced pain originating from her groin down her leg. Her doctor had advised that it was fine and so she continued with the discomfort. She had had an appointment at Rheumatology, City Hospital where upon asking how she was, she complained about her leg. After further examination, an x-Ray and MRI found necrosis in her hip and she was put forward for a hip replacement. She saw Mr Sikand at Sandwell Hospital and had the operation on 25 June – with positive outcomes.
- Her journey from operation to discharge:
    - Hip and Knee Clinic were fabulous – after an hour they had organised all the equipment she would need post-surgery.
    - Theatre staff were fantastic – put her at ease, the anaesthetist informed her of what to expect after the operation and explained all the equipment they would use.

- Post-op she was admitted to Lyndon 3 where the nurses were amazing.

- On the Tuesday at 4.30pm, she was informed that if the x-ray had been done on the Wednesday morning, she could have been discharged, but was not until Friday.
- She praised the nurses in their proactivity in pushing hydration.

Prof Thomas queried what equipment she was allocated and where it came from. Justine advised that the equipment was from Bromsgrove and consisted of; crutches, two perching stools and a high toilet seat. Mrs Gardner noted that the benefit of the raised toilet seat *after* the recovery period was something that required further consideration as she found that it was a reoccurring theme in feedback.

Dr Carruthers queried to what extent Mr Sikand and the team discuss post-operative mobility and function. Justine noted that she was advised that by six months she wouldn't know the surgery had been done and that she would not be able to kneel or crouch until Christmas. She was provided with leaflets, booklets, conversations and a follow up at six weeks post-op.

Mr Lewis queried to what extent she was woken during the night. Justine advised that she was woken to complete observations and to encourage hydration – the method of waking was gentle. Mrs Gardner clarified if the staff woke her the first night post-op. Justine advised they woke her every night, and throughout the night, during her admission. Mrs Gardner noted that this appeared excessive.

Ms Barlow noted that the Trust was trying to make improvements in the length of admission and Justine's length of stay was avoidable. It was an operation with a predicted discharge and the radiology should have been booked in advance. She would complete an audit to see how systematic that was and to introduce a process to avoid that in future.

2.1 Evaluation of the performance of the Paro seals	**TB (11/19) 001**

Mrs Gardner noted that the Trust had purchased four Paro seals to reduce patient stress, anxiety, depression and aggressive behaviour. The Board had requested an evaluation of the Paro seals; a qualitative evaluation had been completed with a quantitative evaluation pending.

Mr Laverty questioned the return of investment in the Paro seals and how that was measured. Mrs Gardner advised that they had put an additional person in the DDD team as referrals had gone up and hadn't seen a reduction in their aggressive self-harm patients. Where they thought they would reduce one-to-one supervised care, they had not yet done that.

Mr Lewis noted that if they saved 80 bed days, the seals would pay for themselves. He suggested we look at the focused care impact. The Paro seals need to get to the point where it was part of routine work for a nurse or health care assistant. He noted that he would like to see the palpable progress in April.

The Chairman noted that the Board would review the Paro seals in April.

Action: PG to return with a further evaluation to the quality and safety committee in April 2020

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

There were no questions from members of the public.

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

The Chairman noted:

- In October we had had a fantastic awards dinner. He thanked Ruth Wilkin and her team. He reflected that everyone seemed both enthused and engaged.
- School nurses were working with schools around programs on healthy eating and exercise. It was an insight for him as to the level of engagement of the school nurses and the schools.

- On 6 November he attended a conference on learning disabilities and autism. He noted that it was a brilliant event and would need to build on that for future conferences. Mr Lewis noted that approximately 18 months ago they had worked on an accreditation programme for departments to self-accredit around learning disabilities. The Learning Disability Team were enthusiastic about the programme. He suggested to return the development of that programme to action tracker.

Action: KD to return the learning disabilities accreditation programme to the action tracker.

UPDATES FROM THE BOARD COMMITTEES

5a Audit and Risk Management Committee	**TB (11/19) 002** **TB (11/19) 003**

a) Ms Perry provided the Board with an update from the Audit and Risk Management Committee meeting held on 3rd October 2019, with the following key points discussed:

- More work to be done on the Data Quality Improvement Plan.
- Financial Systems Improvement Plan was going well – been acknowledged by the external audit team.
- Reviewed the Board SBAF – levels of assurance against those items and requested committees to try and get to an adequate assurance score by the end of 2019.

Mr Lewis noted that his understanding was the Trust was the highest billing overseas visitor institution outside of London. Unfortunately, they were not the highest fund recoverer. He requested that the relevant directors set an expectation on when that improved work would be delivered – to issue those invoices and recover those payments in a timely manner. Miss Dhami advised that one month was required to clear the backlog. Ms McLannahan noted that there were many factors feeding into the issue. Working jointly with the governance team, they had identified additional resource to deal with the receiving perspective. Mr Lewis stated that they would revisit the matter in January.

Mr Kang queried at what point did it become insensible to chase debt. Ms McLannahan advised that they follow the NHS guidance, if not paid within 45 days it can be written off. However, the Trust allows a little longer to chase that debt. She was investigating handing those outstanding debts to an external legal agency. Mr Lewis requested that that be decided on by the time of the next Audit and Risk Management Committee as a process needed to be implemented ASAP.

b) The minutes of the Audit and Risk Management Committee meeting held on 4th July 2019 were received by the Board.

Action: To revisit the recovery of overseas visitor funds in January.

5b People and OD Committee	**TB (11/19) 004** **TB (11/19) 005**

a) Mr Laverty provided the Board with an update from the People and OD Committee meeting held on 25th October 2019. He noted the following committee discussions:

- An annual work plan was discussed to ensure that all work was done over the course of a cycle to deliver the People Plan. The big-ticket items in the People Plan would be the focus at the next meeting.
- Had two *Limited* SBAF items and one *Adequate* item. The Committee was not confident that the two limited would be adequate by the 2020 deadline due to matters beyond their control, although steps were being taken to improve the position.

- Discussed rostering and noted that the matter had escalated to the CLE. Had a better understanding of the problem, but no solution.
- Fully staffed: He reflected a need to present that in a clear way for ease of understanding.

b) The minutes of the People and OD Committee meeting held on 30th August 2019 were received by the Board.

5c Quality and Safety Committee	**TB (11/19) 006** **TB (11/19) 007**

a) The Chairman provided the Board with an update from the Quality and Safety Committee meeting held on 25th October 2019. He noted the following discussion points:

- Respiratory reconfiguration – reviewed and approved the quality indicators with some requested amendments.
- Hospital Acquired Frailty Deterioration (HAFD) – NHSI Midlands had conducted interesting work in deterioration that happens as a function of frailty in terms of time spent in hospital. It was a key strand of work for understanding the flows of patients through their beds.
- Review of control and infection– had mostly good practise with a couple of areas needing attention.
- Level of speed of admission to stroke wards and late cancellations of operations looked off on their traditional position.

Mr Lewis noted that his understanding was that historically the Trust had been rated as red (CQC reports). The impact of the review was that they were now rated as amber. He stated that it would be very important for the Quality and Safety Committee to be clear about what would indicate green by the end of 2019.

Miss Dhami advised that the CQC preparations would be a standing agenda item for the Quality and Safety Committee. Mr Lewis noted that the intention was to use the Board planning day in December to work through what was required for the CQC, both outside and inside the boardroom.

b) The minutes from the Quality and Safety Committee meeting held on 30th August 2019 were received by the Board.

ACTION: Mrs Gardner to detail the route to a green IC rating at the next Quality and Safety Committee	

5d Digital Major Projects Authority	**TB (11/19) 008** **TB (11/19) 009**

a) Ms Perry provided the Board with an update from the Digital Major Projects Authority meeting held 25th October 2019, and noted that they discussed:

- Management of risks and the segregation of risk of those managed solely by the informatics team and those that are owned by other departments (and being managed jointly through the business relationship managers). Expected to see good traction.
- Received a proposal report on the insourcing and outsourcing of different services, which was agreed in principal subject to a discussion with Mike Hoare and further detail around the costs and benefits.

Mr Kang noted the IBM artificial intelligence and queried when that piece of work was due. Mr Lewis noted that it was due to launch at a radiological conference in mid-December. The project was currently paused whilst IBM and the Trust agree the price of the PACs project. The expectation was that it would be a UK first – and would start to publicise that at the end of the month. Mr Laverty noted that the University of Birmingham had an AI expertise and Dr Sara Yusuf would visit the University to learn more and establish local connections.

b) The minutes from the Digital Major Projects Authority meeting held on 30th August 2019 were received by the Board.

5e Estate Major Projects Authority	**TB (11/19) 010** **TB (11/19) 011** **TB (11/19) 012**

a) The Chairman provided the Board with an update from the Estate Major Projects Authority meeting held on 25th October 2019. The following key points were noted:
   - Welcomed the HMT approval of the final business case. Mr Lewis had briefed the Committee on the continued conditionality challenges.
   - On track with the Estate programme 2019/2020; fracture, neonates, paediatric and respiratory.
   - Confirmed the decision of Hard FM supplier.
   - Settled the extended lease on the City site.

b) The minutes from the Estate Major Projects Authority meeting held on 28th June 2019 were received by the Board and those from October 3rd were agreed..

MATTERS FOR APPROVAL OR DISCUSSION

6. Chief Executive's Summary on Organisation Wide Issues	**TB (11/19) 013**

Mr Lewis questioned if they were emphasising (publicity wise) of all the work they had done on wider regeneration estate engagement as a collective body of work.

He noted that there had been very productive meetings with the Birmingham Council around the Dudley Road site, Dudley Road itself, and regeneration through to the MMH site. The City Council Plan did not show Dudley Road as a dedicated development area. The discussions with Sandwell were somewhat more protracted. Both councils needed to be involved in that geography – they were close in putting something positive together.

He noted that over the last couple of years, work across medical inpatients had reduced length of stay by one, which was quite an achievement. The Consultants of the Week was a distinctive and unusual model that they had invested a lot in, and it was worth considering the evaluation of that model going forward – to celebrate and make decisions on next steps.

- Invitation to the Board to confirm contract signature on MMH Hard FM next week subject to conditions agreed by the Committee and moderation panel.
- Invite the Board to consider the concept and the wording of the Partnership Pledge (7.3 of the Paper). He recalled the Board debated last time the work going on around organisational form, mergers, acquisitions and partnerships. The agreed position of the Board was that they would sit to one side of that – it was important to make a small forward step in explicitly reiterating to neighbours the intention to work as a partner.

Mr Laverty asked a proposal had come forward from some clinicians in the Trust to proceed with the name Midland Met University Hospital. Mr Lewis noted it was philosophical question for discussion later and confirmed that that name could be changed at no cost in the future. He advised that *university* was not specific to Aston or Birmingham universities. Mr Kang noted that it was an important philosophical question and the inclusion of the word *university* in the title would be a powerful thing. Ms Perry noted that it would attract people interested in academic research. Dr Carruthers advised clarity in the criteria around the word *university*. He stated that it was a positive move and would push the R&D focus. Ms Barlow expressed that she was broadly supportive and noted the benefits of spreading to the portfolio of community services.

Mr Lewis noted that his plan would be to have the necessary conversations with Aston and Birmingham universities and the QE Hospital. From the discussion he concluded that the Board felt it was a neutral or positive move.

Contract signature on MMH Hard FM

Mr Lewis noted the following process:

- The procurement – there was one credible bidder above the line. The moderation panel set a series on contract conclusions and the bidder was almost there. He expected that they would be in the position to close that contract shortly. He sought the Board's endorsement to close that contract. It would not be closed until the Balfour Beatty contract had been closed.

Partnership Pledge

Mr Lewis note that in advance of a more aggregated discussion about M&A activity in the sector, they should be proactively approaching chairs with a clear public statement of partnership – or they will be positioned as unduly recalcitrant. The Chairman agreed that a pre-emptive and very clear statement that reflects the partnership reality would enable them to be on the front foot and clear in their partnership position. The Board discussed and agreed the wording as submitted.

Miss Dhami queried what made this process different to the attempts they made with the BCA. Mr Lewis noted that they were establishing how they will work with partners. The Trust's geography requires them to sit in two different settings and they need to find a positive way to narrate that in an NHS environment.

The Chairman noted that the Board **approved** the appointment of the preferred Hard FM supplier.

7. Integrated Quality and Performance Report – July 2019	**TB (11/19) 014**

Mr Lewis noted:

1. A revised At a Glance Report would be presented in January. The data contained in the Report would be unchanged – rather it would a clear indicator of the major concerns.
2. There were some exceptions highlighted in the Report that were picked up at the Quality and Safety Committee in respect to cancellations and stroke beds – worth further discussion.
3. The Board had chosen repeatedly to focus on persistent reds. The persistent reds have a recovery plan (except for patient bed moves and re-attendances that would be discussed at PMC). The intention was to enter the new calendar year with all persistent reds with a recovery plan. Conversations from January would be around the recovery plans.

Prof Thomas requested that the new format include an explanation as to why something was thought to be a problem. Ms Barlow agreed and noted that she would work on that.

Ms Barlow noted that the stroke team had a GIRFT visit that day. There were two lines of enquiry:

1. The first few weeks of Unity impacting on clerking times. Chetan Varma was looking at single clerking processes with Hereford and would report back. Teams were looking at quantitative data to determine if that was a root cause.

2. The change to the distribution of beds to meet the mixed sex accommodation requirement. In the Hyperacute Stroke Unit (where it was a gender blend), they were asked to change that to male and female bays, they hadn't had any delays getting them into beds but the specialty leads were convinced that was the case. She advised that she was looking into that data and it was expected to make a rapid improvement in stroke admissions.

Ms Barlow apologised for returning inadequate results on late cancellations. Mr Baker had discussed in length at the executive PMC that the position was not improving and was critical for patient experience and the Production Plan. A lot of avoidable cancellations were preceded by late starts in theatres and surgery could not demonstrate the grip and control on the process that was written to authorise those.

Mr Lewis clarified that 52-weeks was the long-term standard of the maximum length of elective wait. The Trust did not typically let patients wait more than 52-weeks. Linked to their long-standing data quality issues, they had historically been reporting data quality originating 52-week breaches. He had agreed with NHSI that they would pause doing that whilst they work through a piece of guidance about the national process for reporting historical data quality originating 52-breaches. At the moment the Board was reviewing reports that do not show 52-weeks breaches (now and going forward), where the retrospective data had. He advised that historic breaches had not stopped happening – the reporting was paused.

Mr Kang noted that engagement was significantly better than it had been and the turnover rate for nursing had dropped by a 1%. Mr Lewis noted that it had marginally improved. The Board would be presented with a Retention Plan in its January meeting

Action: DB to consider the inclusion of an explanation as to why something was thought to be a problem in the IQPR At a Glance Report.

8. Monthly Risk Register Report	**TB (11/19) 015**

Miss Dhami noted the following:

- Appendix A was the red rated risks:
    - Requested the removal of Risk 221 (delay in EPR with Unity go live) from the risk register. The Board **agreed** to remove risk 221.
    - The SBAF red risks were:
        - SBAF 14 amenable mortality – Quality and Safety Committee scored it adequate, and the mitigation plan was rated red.
        - SBAF 17 optimisation

  It was requested that SBAF 14 and 17 be entered into the Risk Register.
- Appendix B – list of risks that hadn't been worked up by the relevant group/director:
    - Risk 1762 (Ophthalmology OPD capacity) and 3588 (Neonatal consultant cover) – now on appendix A as they were currently red rated, been through RMC and they requested that the Board needs oversight on the risk.
    - Risk 3160 – to remain and revisit at the DMPA.
    - Risks 2784 (MMH/capital programme) and 3212 (BMEC visual function) – DMPA to revisit.
    - Risk 3689 (contracting and payment) – Ms McLannahan noted that as they progress through the financial year, receive more guidance, a clearer indication of a way forward and develop relationships with the Black Country and West Birmingham CCG AO, they can feed more into the mitigations and actions of the risk.

Miss Dhami advised that all current red risks need a clear mitigation plan by the end of the financial year, if not, they would have a conversation as to whether that would be acceptable.

Mr Lewis noted that section 3.2 of the Paper should be deleted as some were risks and some were issues. As an executive, they would need to establish a shared risk language approach for clarity in conversations – to progress further with Allison Binns.

9. BREAK

10. Speak up scorecard	**TB (11/19) 016**

Miss Dhami advised that it was the first time that the Speak Up scorecard had been presented and welcomed feedback for improvement. She noted the following:

- The scorecard would be presented quarterly at the CLE, Executive and the Quality and Safety Committee.
- The only directorates with ostensibly low incident reporting rates were ambulatory therapies and community medicine.
- Mrs Wilkin, Miss Dhami and Mr Lewis meet with the six Speak Up Guardians regularly. She noted that she had asked for the Speak Up Guardians' detailed data. There was some discomfort providing the number of cases by directorate as they felt the data may be identifiable. The standard guardian data was reported quarterly.
- External staff exits – to investigate the reasons why staff leave.

Mrs Goodby noted that they need to pick up through the Speak Up Guardians where there is 'stuff' going on informally creating an issue and how the Trust would deal with that – there was an inconsistency in how leaders deal with conflict. She advised that she was keen to work with Miss Dhami on the Dignity at Work Policy as it would pick up some of those informal elements and would align with the scorecard to strengthen it.

Prof Thomas suggested that in low count areas to use the terminology *less than 5*, rather than indicate the number to provide more confidence in the staff that they won't be identified. This was agreed.

Mr Lewis noted that there was work to do with encouraging staff to Shout Out the good work they do in their own areas and make it acceptable to celebrate good practice.

Mr Laverty noted that if they were to look at complaints to also look at compliments from the public. Mr Lewis stated that the scorecard was a focus on staff, and not services – there was a separate scorecard for services. The Chairman noted that if a service had a reduction in complaints, they would want to know about that. Miss Dhami advised that they review the complaints quarterly, and queried if it should become the IQPR or a focus on staff welfare. The Chairman noted that if there was a struggling service, one would expect that staff was not far from that.

11. STP five-year plan: Noting the submission	**TB (11/19) 017**

The Chairman noted that the Paper was a current position statement. The Board received the Paper.

12. 2020/21 finances: Trust and wider system	**TB (11/19) 018**

Ms McLannahan took the Paper as read and provided a brief introduction:

- The organisation has a five-year financial strategy around the MMH full business case and the LTFM, within that they had a plan for 20/21 based on various available assumptions (from spring 2019).

- There were two issues with the Trust's FIT, issued after the FBC:

- The start point for the 20/21 financial target was a surplus of over £600k, which had been taken from their LTFM (the end point of the 20/21 Trust Plan, which had assumptions around national growth that would flow to the Trust in which they could not see a route to now). That was at odds with how all other financial trajectories for other providers had been calculated – that was an active conversation with NHS Midlands.
- There was a double jeopardy issue with the funding that had previously been agreed for the costs of construction for MMH; the PDC dividend cost that they were going to incur as a result of drawing down the PDC to finish the build and also the double running and commissioning taper relief costs. NHS Midlands had indicated financial recovery funding for those amounts. For next year it was £14.7m specifically for both. NHS had attached that to the national regime around FRF – if other providers in the Black Country and West Birmingham STP go off their financial plan, Sandwell might not get the full FRF of which would be a red line for the organisation and not what had been previously agreed with the centre around funding for completion of MMH. The Trust did think they could navigate a way around that.

The Chairman noted that the Paper makes a clear recommendation and there were two routes to remedy the situation. One of the routes, both of them or a blend of the two, need to be applied. Absent that, the Trust won't proceed with the MMH contract, cannot accept its FIT and nor could the STP. As an STP they have to find an organising model where they were all using transparent assumptions that they think are credible. That point had been forcefully made.

Mr Lewis noted that the challenge was the route to exit the year on a run rate basis of where they need to be, their ability to recover the income by a million pounds or so a month and then compensating the pay position. Of the £18m, they had identified about 40-45% so far. The £11m was the margin that they had the greatest headache in achieving. He anticipated by the time of the next Board meeting, that the position would be rather straight forward – either they had reached an agreement or would be in a duelling situation. He advised that no financial plans required amendment at that point.

13. Winter readiness and beyond	**TB (11/19) 019**

Ms Barlow noted the following key points:

- The Paper linked to the acute care and winter preparedness discussion paper presented in August. The Winter Plan remained the same as previously noted. A number of schemes around admissions avoidance and length of stay reduction had been presented (the delivery process as outlined in the annex).
- A number of service reconfigurations; relocation of respiratory medicine to City. She noted the estates work in the urgent and emergency care space that was planned – that would be risk assessed through winter.
- The Quality and Safety Committee was presented with a piece on frailty from Mr Lewis. The frailty design and the Trust's approach going forward may also involve; caring for the elderly, linking to the Trust's sustainability of acute medicine on the Sandwell site before MMH opens.
- Winter preparedness was about improvement in A&E, a bed plan, length of stay, demand-side focus and the bandwidth to deliver the reconfiguration and improvements over winter.

Mr Laverty queried the percentage of discharges that consume the care package, rather than return back to their home as normal. Ms Barlow advised that the adult inpatient bed base had about 85 patients that required some sort of social care support (including community beds). Packages of care had a rapid turnover rate and was an important part of their care in the community.

Mr Lewis suggested that the issue was three-fold:

- demand measured by admissions was measured above where they said it would be,
- discharges by volume was below where they need it to be, and
- even though he had stated earlier in the meeting that the length of stay had improved, the vast majority of length of stay initiatives were not yet succeeding.

The obvious thing to do was assume that that was the base case, i.e. admissions would be above bed base and it would be worse than you hope. The reason that they can no longer do that is the psychical space and the ability to find staff. They need to be very candid about risk-based discharge. They may need to agree to an overall model for clinical decisions – moving into the position where that type of formality would be required.

Mr Laverty queried the contingency plan. Ms Barlow noted that out of the stretch beds:

- 18 beds were the residual beds left on the ward at Sandwell from the respiratory move – they would look to open more beds requiring two nurses (affecting the vacancy rate).
- The remaining beds were not impacted by nurse to bed ratios.

Prof Thomas queried how they would communicate the Plan to GPs and how would they ensure that patients were not being discharged into a vacuum. Dr Carruthers noted that communication would be key. GPs would have to do follow ups in regard to discharge, but also there would be work that the PCCT do in following up with patients 48 hours after discharge. There was support that comes around the care home and other work had been done for additional outreach support into care homes. Prof Thomas suggested that if the Plan didn't work very well to enlist a GP (from the Trust affiliated GP practice) – they had a different dynamic to a hospital doctor and maybe more tolerable to risk.

The Chairman advised that a representation of the Paper would be presented to the Quality and Safety Committee and a communication strategy to GPs and staff.

14. Mid-year review of serious clinical incidents	**TB (11/19) 020**

Miss Dhami noted that the Paper detailed the incident case summaries, contributing factors and solutions. An inquiry into the maternal deaths was also completed. Two trends had been identified; head injuries and metastatic spinal cord compressions (trend not continued on MSCC). The learnings were:

- Unity would prevent reoccurrence in two cases.
- WeLearn had not progressed as quickly as anticipated. A progress update would be provided in January.
- Successes with continuing QIHD accreditation and QIHD posters – there were examples of 'doing' in the WeLearn program.
- They could be speedier in concluding the investigations, and in terms of the solutions they still need the expertise in the getting the solution (Unity can be the solution in some cases).

Mr Lewis felt that there were two cases in Annex A and B where the investigation was complete and actions that are needed to be taken. He stated that in January he expected to be crystal clear that those actions had been completed and then they can discuss if those actions had had the desired impact.

Prof Thomas noted the additional maternal death and queried the wellbeing of the midwives and department staff. Mrs Gardner advised that there was now a staff counselling service onsite. She noted that they were okay. The case was still with the Coroner and there was still no absolute recording of cause of death.

Mr Lewis noted that they would move to a cycle of we learn, we change and we review toward the end of the year.

Action: To complete the outstanding actions in Annex A and B of paper *TB (11/19) 020 Serious Incident Investigations: mid-year report* by January 2020 for analysis of the impacts of the actions.

15. Quality Plan: Action plans	**TB (11/19) 021**

Dr Carruthers noted that the Quality Plan had been amended into three groupings:

1. Well-developed projects
2. Partial developed projects
3. Projects where proposal needs more support

Prof Thomas questioned what support was needed to improve 1.2.7 (take-up of health screening services). Dr Carruthers noted that there were multiple areas of ongoing work but had not been collated into one document. He advised that he had a meeting scheduled to discuss screening to get an improved handle on it – that will be one that would move up a category.

Mr Kang queried if there was data indicating late presentations and diagnosis for screening in their location compared to other parts of the UK, whether that translated into people not presenting for screening and how that important message could be penetrated through other means. Dr Carruthers noted that it linked into the cancer outcomes. He had reviewed the number of patients that had been referred on a two-week pathway (increasing rapidly), however the number of malignant diagnosis cases was not increasing at the same rate. It was a multi-layered process in which was being investigated.

The Chairman requested clarity around 4.6(4) of the Paper (non-cancer diagnosis deaths). Dr Carruthers noted that not all end of life care was around malignancy, that other patients had similar presentations and they need to focus on them too. Mr Lewis noted that the intention was to focus end of life care support at the respiratory and heart failure wards. The Chairman questioned if palliative care staff numbers would be increased. Dr Carruthers advised that that investment would probably be needed; however, they wanted to be in the position where the service wasn't dependant on one or two people, and there was education across all wards to have the conversations at multiple points over multiple admissions, rather than on the last admission.

16. Local induction assessment	**TB (11/19) 022**

Mrs Goodby noted that the Board and the People and OD Committee had talked about the improvements in the corporate induction. The focus had now shifted to local induction.

The quality of that induction was reflected in their staff retention – 50% of colleagues leave within the first two years of commencement – suggesting that there are issues with the local induction. HR can structure a lot of interventions and audits to ensure that data collation is done in the right way, but whether a new starter has an amazing local induction and feels welcomed to the team needs to be led by the local team.

An audit at 100 days (to link into the Retention Plan) and an audit to ensure people are equipped with what they need at day one to have a good local induction would be implemented.

MATTERS FOR INFORMATION/NOTING	
17. Finance Report: Month 6 2019/2020	**TB (11/19) 023**

Ms McLannahan drew attention to the additional slide that details:

- providing assurance in reaching the 19/20 control total, which remained achievable despite the income underperformance.
- What they need to do to keep out of trouble into 20/21 which represents a £1m per month recovery on the run rate in the backend of the year.

She confirmed that they were expecting to realise the £4m in commercial income in the current financial year. The Chairman requested that the FIC discuss the matters detailed in the slides to then feed back to the Board on their position.

Action: FIC to discuss the control total and recovery plan to feed back their position to the Board.

18. NHS Regulatory Undertakings – monthly status update on agency and four-hour standard	**TB (11/19) 024**

Noted.

19. Leavers audit	**TB (11/19) 025**

Ms Barlow noted that there had been a significant improvement; however, the review indicated gaps:

- Consultant attribution of diagnostic clinics – did not impact clinical care, had now rectified.
- Strengthening the end-to-end data set that goes through a monthly assurance process through the Planned Care Board.

20. Ratified ICS and STP Minutes	**TB (11/19) 026**

Noted.

21. Application of Trust Seal	**TB (11/19) 027**

Noted.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS	
22. Minutes of the Previous Meeting, Action Log and Attendance Register	**TB (11/19) 028** **TB (11/19) 029**

The minutes of the meeting held on 3rd October 2019 were approved as a true/accurate record of discussions.

Updates on the action log were received:

- *#4, TB (10/19) 008 – Reflect on the STP/SBAF issue and a draft document produced for wider consideration of the Board.*

  Mr Lewis advised that he would present a paper at the January Board.

- *#5, TB (10/19) 009 – Assist positive messaging to managers around the placement of long-term sick employees into other jobs.*

Mrs Goodby advised that would be done during November. They had launched a 'if you're too sick to do your job, here are other jobs you can do' and had very little uptake of that – need to consider a relaunch and look at that in November.

- *#10, TB (09/19) 001 – Discuss and consider how patient stories could be embedded into the WeLearn process.*

  Miss Dhami and Mrs Wilkin had discussed and would need to develop a paper. Mrs Gardner would do a gap analysis of the patient story that would link into that.

- *#15, TB (08/19) 017 – Prepare a paediatrics equivalent analysis of the demonstrated analysis in paper TB (08/19) 017.*

  Mr Lewis advised the item was delayed until November – looking at an alternative approach that had utility – not as straight forward as the adult version. Realistically he would deliver the item in February.

- *#17, TB (07/19) 020 – Mr Lewis to work with WCH Group to agree a basis for long term investment*

  Ongoing.

- *#20, TB (11/18) 006 – Future R&D Board development session proposed with primary care colleagues (led by Prof Lasserson).*

  Mr Lewis advised that they were meeting to try and progress the acute medicine care home project and would bring that back to the Board.

23. Any Other Business	**Verbal**

The Chairman thanked Clare Dooley for her support as this was her last meeting.

24. Details of Next Meeting

The next Public Trust Board meeting would be held on Thursday, 5th December 2019 in the Conference Room, Education Centre at Sandwell General Hospital.

Signed ……

Print ……

Date ……