TB (02/20) 023

BOARD – PUBLIC SESSION MEETING MINUTES

Venue: Training Room 2, Rowley Regis Hospital, Moor Lane, Rowley Regis, B65 8DA

Date: Thursday 2nd January 2020, 09:30 – 13:00

Members:			**In Attendance:**		
Mr R Samuda	(RS)	Chairman	Mrs R Wilkin	(RW)	Director of Communications
Mr T Lewis	(TL)	Chief Executive Officer	Mr D Baker	(DB)	Director of Partnerships and Innovation
Dr D Carruthers	(DC)	Medical Director	Mr Chris Liston	(CL)	Executive Assistant
Mrs P Gardner	(PG)	Chief Nurse			
Mrs R Goodby	(RG)	Director of People & OD	**Apologies:**		
Ms R Barlow	(RB)	Chief Operating Officer	Mrs C Rickards	(CR)	Convenor
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			

Minutes	**Reference**
1. Welcome, Apologies and Declarations of Interest	**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**

PG introduced Clare to present her patient story. PG noted that Clare's story, whilst from three years ago, was still relevant to the current position. Clare presented her story to the Board:

- For 14 years, she has had a rare medical condition, Scleredema of Buschke. She was admitted to City Hospital due to a flare up of the condition – she had intense pain and was placed on a high dosage of steroids. During that inpatient stay, she contracted numismatic corinna pneumonia.
- She had been admitted into a ward with a lot of chest infection patients. Due to concern for her compromised immune system, she had requested with the consultant on multiple occasions to be put in a side room. The request was rejected based on not meeting the criteria.
- She spent a total of seven-months in care; critical care for nine weeks, medical ward for one month, Rowley Regis for rehab for four months and readmitted once from rehab with a chest infection. The seven-month episode had caused long-term trauma and it took a long time to recover physically and mentally.
- Her critical care unit experience was extremely positive – a specialised team where she felt safe. The after care and support on discharge from the hospital was brilliant. The outreach team were also brilliant in their prompt actions.
- Communication was a problem due to the tracheostomy tube – only had the communication boards to spell words, which was exhausting. She believed that they had plans to update the

boards with expressions and parts of the body to make communication easier.

- Upon waking she was completely paralysed and could not press the nurse call button – had to find other methods to attract attention – she believed that the Trust was investigating in an alternative to a press bell.
- During a change of her tracheostomy tube, she was scared as the doctor performing the procedure hadn't explained what he was doing. She encouraged doctors to explain the procedure as they were doing it to reduce fear/reassure the patient.
- She had no idea of the time or date and had asked for something to be displayed to keep track of reality.
- She experienced sever intense hallucinations due to the drugs. It did not appear that all staff understood how intense and 'real' hallucinations could be. One nurse had threatened to call security to have her removed if she did not calm down.
- She experienced fear of being transferred from the critical care unit to the ward. A major transition in the type of care and felt extremely vulnerable and concerned for the level of attention that would be provided. In her situation, the transition was a very quick process. There was a lack of understanding by ward staff that she had been transferred from critical care – some thought she had gone home and been readmitted.
- Ward care – there were some very good nurses and OT services. There were good links with critical care for ongoing support. Basic nursing care was sometimes lacking. Nurses were busy with tasks and the Health Care Assistants were providing the nursing care. There appeared to be a gap between the qualified and non-qualified. As she did not have use of her hands, she waited long periods to be fed (not enough staff) and never had her hair combed or washed. The basics of nursing care was not always there.
- Part of the physio treatment was to sit in a chair for 'x' amount of time and then to be returned to bed. This was extremely painful and was left for longer periods waiting for staff to put her back to bed. She suggested the use of a whiteboard to display the OT's instructions/time to be put back to bed and how many persons required to manoeuvre the patient.
- She felt that the Ward Manager was detached to what was happening at the ground level – someone should be looking at the basic tasks.
- She had a good experience at rehab (four months in the Henderson Ward). The Ward was spotless and she had support visits from critical care support staff – which led to the patient forums which was valuable. Critical care nurses needed to visit more as continuation of care – they were able to explain things that others on the ward could not.
- There was no psychological support or counselling – should happen in rehab prior to returning to the community. There were no activities or services (hairdressing, nails, craft) available during her stay.

The Chairman thanked Clare for her sharing her experience and called for questions from the Board.

TL noted that they were doing work around mental health support across the organisation and questioned Clare as to what would have been helpful to her during her stay. Clare suggested a trained counsellor that understood what critical care entailed, especially in regard to the hallucinations and the traumatic impact it has on a patient – someone to express fears to and get some understanding of what is happening on a weekly basis.

MP questioned if improved communication at care transition points in regard to what was going to happen could have improved her experience. Clare agreed that improved communication would have certainly helped, particularly the transition from critical care to the ward as she felt very vulnerable. PG advised that the process now entailed the ward team introducing themselves to the patient whilst the patient is still in

critical care – the process was not perfect, but it was progress. She stated that she had advised Clare of the changes they had implemented subsequent to her hospital stay.

The Chair thanked Clare for her attendance.

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 the following:

- He congratulated Professor Elizabeth Hughes, Consultant Chemical Pathologist on receiving an MBE for services to medical education, locally, regionally and national with health Education England – a great achievement.
- He had had a session with the alcohol team – a fantastic engaged team with a lot of opportunity based on good work lead by the Board, but very much lead by Sally Bradberry. It was a real asset to support others – and we would discuss later in the agenda under vulnerable services.
- He congratulated the team on the sign-off of Midland Metropolitan Hospital with Balfour Beatty in situ, they would see hard hats back onsite. The contract for the FM Supplier had been signed with Engie, who were a key interface with how Midland Met would be serviced and operate.

UPDATES FROM THE BOARD COMMITTEES

5a Estates Major Projects Authority	**TB (01/20) 001**

a. The Chairman provided the Board with an update from the extraordinary Estates Major Projects Authority meeting, held on 10th December 2019, with the following key points discussed:

- As agreed at the December Board, they had delegated to the Estates MPA to look at the detail of the final contract.
- Had all the assurances required – had done the best deal possible with Balfour Beatty, had the right commercial arrangements and that was signed off in that committee meeting.
- TL advised that the workers were onsite. They had made the first cash payment, as per the contract signed on 11 December 2019. The MOU with NHS England was being finalised. The next 3-4 months were critical, particularly in regard to engineering design.

5b People and OD Committee	**TB (01/20) 002** **TB (01/20) 003**

b. ML provided the Board with an update from the People and OD Committee meeting held on 19th December 2019. He noted the following committee discussions:

- Still had two limited SBAF items in which the Committee hoped to move to adequate by March 2020.
- RG and the team had designed a dashboard to provide further insight into the things the Committee should be tracking – to be presented at the next committee meeting for refinement.
- Rostering discussions were occurring at every meeting to drill down on understanding how to improve performance, what the stats are really saying and how reliable the stats are. He had spent some time with the rostering team after the last People and OD Committee to get a feel for the system. He was surprised to learn that there were parts of the organisation that do not

use the electronic system as their primary rostering tool and were still using a paper-based system – compounding the issues and People and OD Committee need to review that.

c. The minutes of the People and OD Committee meeting held on 25th October 2019 were received by the Board.

MATTERS FOR APPROVAL OR DISCUSSION

6. Chief Executive's Summary on Organisation Wide Issues	**TB (01/20) 004**

TL noted:

Infection Control

- TL urged Board members to consider the paper's annex on infection control. In September / October there was an external review by a NHSI senior nursing advisor and the Trust was rated amber. The annex to the paper sought to demonstrate the route to green. He expressed concern that not every part of the organisation was monitoring against success. They had persistent infection control reports over 4-5 years that appeared to be green but when a different evaluative mechanism was applied, they do not rate green. A lot of resource is expended into cleaning and infection control which their monitoring is reporting a good rating, whereas the external review is not reflecting that same score – something was going awry. He and PG would review to ensure the right things are tracked to ensure consistency when different evaluative mechanisms are applied.
- In regard to the patient story, they did not have enough side rooms – hence why Midland Met was being built. There was an algorithm to determine which patients are allocated side rooms and why. That algorithm would need to be refreshed and publicised.
- They had had a Health and Safety Executive Report on the TB incident at Sandwell in early 2019.
- The NHSI visit was expected in February/March 2020. It was called out that in the IQPR there are issues in regard to MRSA surveillance and there was a MRSA bacteraemia in the last couple of weeks.

The Chairman questioned if the items at Annex F were quick to rectify. PG advised that some were quick fixes. The mattress issue was something to take forward into a mattress replacement programme. There were monitoring processes in place to ensure action was being taken on directives which would go to the Infection Control Steering Group to be fed up to the Executive Quality Committee.

Tertiary Gynae-Cancer Centre

- It was likely that an agreement would be made to take on the Tertiary Gynae-Cancer Centre on a long-term basis – finalising a revised long-term financial settlement with NHS England. The Centre would be accommodated within the footprint of Midland Met.
- The general election result had not resulted in any obvious health announcement – possibly more likely that legislative time would be found for an NHS-related Bill. There had been some headlines around car parking – when meaningful guidance is received, we would look to implement that in the New Year. Anticipated that it would slightly amplify the number of patient concessions on offer. The Government would require that Trusts provide free car parking for blue badge holders and night shift workers. TL proposed to have a dedicated car park for night shift workers to control the administration of that requirement. The two car parking planning applications had been submitted to the relevant councils and a commercial close was expected in March or April 2020.

Waiting Times

- Although they had missed the RTT standard again in November, the waiting list time remained a focus fix for regulators. Waiting list numbers were 4,000-5,000 patients in excess of their stated numbers. There was optimism that they would achieve close to the number they had stated by

year end. He noted that a large number of patients were not on a waiting list or a waiting time trajectory and they need to be equally interested in those people who 'don't count' on the system. £80,000-£90,000 would be spent over the next few weeks in terms on sorting that out.

Budgetary Position

- Whilst they had not finalised the budgetary position for next year, that would not prevent investments. Within the Quality Plan there was a desire to invest more in end of life care. Progression had been made with the expansion of the team with a focus on end of life care for patients that have chronic obstructive pulmonary or heart failure (who remain to be the patients that are likely to be readmitted multiple times).

ML questioned when the next CQC discussion takes place (to keep the momentum going). TL advised that the CQC would be discussed in the Private Board meeting. A new executive committee focussing on the CQC would commence a week on Tuesday.

The Chairman questioned the commentary around the GIRFT reports in the paper. TL noted that GIRFT was receiving good feedback with a lot of energy going into it. The CLE reviews would be used to ensure that the top two most impactful issues are seen to. The Commissioners' focus was on Better Care indicators (largely a population-based set of indices). We need to ensure that GIRFT and Better Care are considered side-by-side or it will result in a disjointed view. In regard to the STP, there was no process to do that. Partners were almost at the point to share their GIRFT data.

It was noted that the patient story brought up the issue of qualified nurses doing 'tasks' and HCAs performing the nursing. It was questioned if there was confidence that the gap would be filled by the Nurse Escalator Programme. TL stated that we want to create a single ward-based team amongst registered and non-registered professionals, and therefore they were being more descriptive about what the unregistered staff should do. It was possible for people to fall through the gaps and team dynamics can also hinder progress – we would need to look into the team culture between different bands. The registered nurses would be asked to mentor and support the band 4 roles. There was more work to be done in the internal comms around that.

7. Integrated Quality and Performance Report	**TB (01/20) 005**

DB reported key areas in the IQPR for the month:

- The Trust had met the diagnostic standard target significantly, 99.84%.
- Hit the cancer wait time targets in November – a return to compliance.
- The waiting list had reduced, even though the RTT position worsened.
- Various comments and actions around cancellations etc were due in the coming weeks.
- Three areas within the IQPR which cannot report data, now had dates for when they would become reportable; MSA (March Board), TIA (March Board with retrospective view at April Board) and 21-day length of stay (unsure – had started reporting to NSHI; however, had an error-rate.)

MP questioned the root cause and plan for the unplanned A&E re-attendance increase in the last five months. RB advised that:

- There was a trajectory to return to target in January.
- Post-Unity go live, there was local DQ issues.
- An audit of the patients in that group of unplanned re-attendance had been conducted.
- Had addressed user effort correction with training.

RS questioned the drop in the rate of 85% target in infection control. PG noted that the Board may recall that MRSA screening now had different criteria. It appeared that by introducing that new criteria it had

confused some staff as to the screening requirements. She advised that the Executives had discussed the matter and infection control would return to screening everybody from 1 February 2020.

MP noted that workforce measures had sickness rates close to 16% in some wards. She questioned what had been done to support those wards. RG advised that through group directors of operations or matrons, hotspot wards had action plans. Those action plans would be signed off by the business partner and group director of operations.

TL suggested to present the data in a different format:

i. Take the existing indicators and put them into; Safe, Effective, Responsive etc. which would be done over the next couple of weeks.

ii. To enter the Insight data from the CQC.

iii. The CQC's Provider Information Request would be completed by the end of February, after which consideration would be given to whether any of the PIR indicators should come into the IQPR – that process would take until April.

8. Monthly Risk Register Report	**TB (01/20) 006**

KD noted the following:

- There were no new red risks for Board consideration.
- The report covered the high-severity/low likelihood risks. The RMC had reviewed it with an action for the Committee to consider other actions, additional resources needed etc.
- The report also covers the current red-risks that need a determined position as at 31 March with the ask to move the risk out of the red, and if not, the Board would need to have a discussion if they were happy to carry that risk.
- There were two current red-risks which the Board had agreed to tolerate beyond 31 March:
    - **Risk 2784** Midland Met contingency funding – little that can be done to mitigate that before the new hospital is completed.
    - **Risk 325** work continuing, but would go into 2021.
    - **Risk 666** Lack of tier 4 beds – had set a risk review to identify any further actions that could be done.
- All other risks had various actions and timeframes to get out of the red in the near future.

TL noted that upon reflection, he and DM should address risk 2784 in the sense that if the contingency funding runs out, they would need to work out what stuff they would not do in the long-term Financial Plan to pay for the first £10m.

The Chairman questioned if others were in a similar position as described in the cyber risk (325). TL stated his optimism that all of the risk penetration testing from the 2019 review would be concluded by the end of February. A further testing regime would be commissioned. The RMC had concluded that it was not mitigatable due to the continual cyber risks unthought of. The Trust was in no worse position to others.

TL noted to review whether all of the actions to remove the risks from red to amber had had the actual desired impact/outcome. KD advised that the RMC would review those risks to determine reassurance that they were now amber. TL noted the importance of ensuring that there was no false compliance due to downward pressure.

9. BREAK

10. Serious Incident mid-year review: update on actions	**TB (01/20) 007**

KD reminded the Board that in November a paper reporting 15 SIs and three Never Events from 1 April to 31 October had been presented to the Board. Paper TB (01/20) 007 detailed subsequent actions on those SIs. She noted that there had been further serious incidents subsequent to the reporting period and had not been included in this paper; however, would be included in the end of year report with a particular focus on learnings.

1. SI Reference 204453 (from 2018/19)

Left over from 2018/19 and some actions within that had not been completed and work was ongoing.

Never Events

KD advised that the investigations had been completed and the final reports and actions plans had been presented to DC. The final signoff was with the CEO and the Chair of the Quality and Safety Committee. The CEO had cited the final reports and action plans, and had provided comment. The conclusion of the investigation resulted in a long list of actions that would not necessarily prevent that incident from reoccurring. She stated the need to tighten up the move to arriving at solutions to prevent reoccurrence – a change in process to have a more robust signoff where the SI lead and group director are called-in to meet with some Executives to ensure that the investigation had achieved its purpose and confidence that the group director was ensuring that actions are delivered.

DC provided an update on the Never Events:

3. SI Reference 2019/16341 – Retained Instrument (from 1 April 2019 to date)

Ophthalmology retained trocar, 8-9 actions. The main area of focus was around regular audits. Each ophthalmology theatre had completed audits for October, November and December of swab counting and WHO checklists. The audits were presented and discussed at the Theatre Governance Group, QIHD and staff meetings to try and stop reoccurrence. Ongoing audits of swab/instrument counting and WHO audit processes on a monthly basis.

4. SI Reference 2019/14182 – Retained Vaginal Swab (from 1 April 2019 to date)

Process issue to ensure swab counting and the recommended advice for a final examination of the vagina to ensure no swabs placed or not counted in the swab count process. That was an ongoing process awaiting final confirmation from the clinical director in obstetrics and gynaecology that that message is being instituted and followed. Would be audited in January through to February.

5. SI Reference 2019/11348 – Wrong Site Surgery (from 1 April 2019 to date)

There were multiple steps that had led to the wrong site surgery. The main issue was around the marking of the area. There were ongoing discussions with the surgical teams around the marking of all skin lesions that require surgery. Working through the process to identify surgical groups where that form of marking was not practically possible to ensure further problems are not created by making a definitive statement.

KD noted that the question for the Board was how to prevent reoccurrence and whether their approach was right. Some audits had been completed with some to be put in place for the Never Events – to be completed by the end of February with the findings reported to the March Quality and Safety Committee.

TL stated that the action plan was a 'laundry list' of things and therefore he could not sign off on it. He noted that item 4.2 in the Report was helpful if it comes from the mindset of how to make this never happen again, rather than a list of things that a reasonable person would do as a result.

RB noted that it was a training issue and getting people in the mindset of how to ensure these things do not happen again across the organisation, rather than what is detailed in section 4.2 which raises concern about; executive bandwidth and senior leaders and specialists that are unable to articulate the prevention.

DC noted the importance of the wider learning – there are specific processes in gynaecological surgery to ensure it did not reoccur, but there are wider processes and policies that can be applied elsewhere to finesse the two.

ML questioned if there was a clear standard process applied consistently after a SI and if it was an area in which the CQC investigate. KD noted that the CQC would be interested, particularly in the Never Events, and would inquire further within the area and with the exec as part of the well-led process. The SI process and policy closely mirrored the National SI Framework. The SI leads had been trained – the speciality leads (group directors and clinical directors) need to have the 'reaching a solution training and conversation', as they were not in that mindset at sign-off.

TL questioned if it would be reasonable to expect that with the new quality and safety structures for each group, they would regard SI actions as a lead indicator; therefore, it would be possible for the EQC to see that on a regular basis. KD advised that the group mentioned in section 4.2 would meet frequently and monitor the action tracker. The action tracker would be included in the Governance Scorecard that is presented monthly to the EQC.

TL noted that they would be spending more money on human factor training which should provide the tools to re-do a swab count if an interruption occurs. It was common to all three Never Events that staff were aware of the policies and procedures, but somehow was not followed perfectly – the human factor (culture).

KD noted that they need to find a better way to ensure comms reach all staff. TL advised that a face-to-face comms audit would be conducted in February.

11. Flu update: Route to 85%	**TB (01/20) 008**

RG advised that progress had been made subsequent to the paper; however, they were still behind the normal position for the time of year. Currently, 72% of patient facing staff had been vaccinated, that would increase to 75% at close of business 3 January. On 6 January, an audit would be conducted to ensure that staff had responded to whether they had had their vaccination (and where) and if they had refused the vaccination (and why) – to date, 700 responses to that comms had been received. Each group had put forward a plan to achieve 85% but had failed despite many campaigns (including explicit videos and myth busters) to encourage staff to participate. There has been a more vaccination refusals this year compared to previous years. She advised that next year's campaign would commence with the myth busters' approach.

WZ noted the religious challenge in regard to the ingredients in the children's vaccinations and questioned if that had been investigated. RG advised that there had been a lot of discussion with their Muslim liaison group:

- The adult vaccination contained no gelatine or pork-based products – this had been widely communicated. There was egg present, therefore a concern for those allergic or vegan.
- Different advice was coming from the local mosques and Imam's in regard to the childhood vaccination. They would need to work with the community leaders for next year.

PG noted that the issue was across all professionals and it was difficult to myth-bust.

TL congratulated the team on their perseverance – it was encouraging that they had achieved 75%. He requested an analysis of the protected characteristics, seniority, organisation and profession of those that had received the vaccination to indicate the balancing number in the rest of the organisation. That would assist in understanding if a large number of people didn't have the flu vaccination (who had had it in the past) or a large number of new starters had not had it – need to identify that for the campaign next year.

Action: RG to analyse the flu vaccination data (protected characteristics, seniority, organisation and profession of those that had received the vaccination).

12. Midland Metropolitan Hospital: Next steps	**TB (01/20) 009**

TL advised that more detail in regard to the clinical model and the programme for the clinical model, as

referenced in section 3 and 4 of the paper, would be provided in February. He noted the following three key items from the paper:

- Section 1.2 – The paper outlines the intent in 2020 to fix the 'what is changing'. That would provide 18 months to work through with existing and new staff on how they would change.
- Section 2.4 – recognises the balance in committing the £17m contingency between the contract need to move with accuracy when notification is received versus the organisation need to not spend the whole contingency up front. The entire contingency would be spent, but it was a question of timing. He suggested to reserve £5m of the contingency as a break point to review it together as a Board. Section 2 of the Paper sets out recommendations for the governance of the estate-side of the building contract, which places governance oversight, on behalf of the Board, with the Estate MPA.
- Effectively, it is suggested that the oversight of the clinical purpose of the development is held in common by the Board as a whole. He would expect that the Director of System Transformation (when appointed) to be regularly reporting to the Board on that programme.

He noted the mention of charitable funds at section 6, and requested that the governance model be reconfirmed or confirmed to the Board's satisfaction for implementation.

The Chairman questioned the Board if they were satisfied with the oversight of the clinical model arrangements.

WZ noted the importance of re-engaging the staff in the progress and to utilise the Midland Met site to socialise staff to the building. TL advised that there would be a two-year period where there would be no access to the building site. By February there would be alternative reality headsets to use at each of their education centre sites which would allow a virtual tour of the site.

RG advised that requests from community leaders had been received to have access to the site before building commenced to bless the site. TL undertook to accommodate the requests.

TL noted that the large scale of Midland Met would be an issue – people currently working in a small-scale environment. The augmented VR site would allow staff to voice their feedback on how make the environment workable. The desirable outcome would be to identify all of the big changes for each post.

13. Retention Plan 2020	**TB (01/20) 010**

RG thanked all those that had contributed to the paper, PG's team in particular. She noted that a retention paper was presented to the Board in February 2019 – the current position remained similar to that of February 2019. There was a trend of people leaving within the first three years of employment.

She noted the following key points:

- In the past 12 months, 818 people left the Trust (706 WTE).
- Expecting 145 people to retire within the next 12 months.
- A lot of people did not indicate the reason(s) for leaving as they want to retain good references.
- The paper details a multi-disciplinary Retention Plan in which HR would report on the data and HR business partners are held accountable to work with the various business leaders for implementing the Retention Plan.
- Improvement focus in the following areas:
    - Already improved the induction and onboarding process – January CLE would look at local induction.
    - Retention of new starters – widening the use of the Preceptorship Programme and peer support.

- Ageing workforce – to focus on flexible working and create a role that garners the skills of the individual but with less demand. To widen the comms around that.
- Leavers data is sporadic – honesty, consistency and follow up in completing the leavers survey. Follow up after the leaver had settled in new role to elicit honest answers.
- Recommunicate the employee benefits.

RG asked the Board to reflect on the Retention Plan with the ultimate outcome to reduce turnover to 10% and to delegate the monitoring of the Plan to the People and OD Committee with regular updates to the Board.

TL noted that the paper infers that the flexibility of this was not getting through to staff. He questioned how they could communicate the offers available better to staff. RG advised that a narrative around flexible working had commenced with the recruitment event based around flexible working, in particular for working parents. There was a lot more they could do to recognise the different types of flexible working people were looking for and enhancing confidence in managers to be able to successfully discuss flexible working opportunities with their staff.

TL questioned if the retirement pattern was similar to previous years. RG advised that the number of potential retirees was not above what it had been previously. TL noted that people were indicating that they would retire when they move to Midland Met – that would need consideration.

HK questioned if nurses were leaving to continue their career elsewhere or if they were leaving to switch careers. RG advised that they were leaving to continue nursing elsewhere. HK suggested to discuss with universities as to their approach to retain nurses in the profession.

HK questioned if the Nurse Escalator was working as expected. RG advised that more participation was anticipated. PG noted that the rationale behind the poor uptake was either; not the right time in their career or concern about getting the time off to complete it. The line managers were struggling to fill rosters and how to fit all staff requests within that to safely staff the wards. PG noted that discussions with the universities to ensure the training was fit for purpose would be beneficial – the training and reality in balance (especially with the awareness of dementia/mental patients).

TL stated that the induction process for nurses would be changed to grouping surgery nurses together in a simulation space to expose them to what their first three weeks would be from a clinical prospective and in terms of interacting with other professions. Skilling them up and providing a peer support group.

ML noted that he did not get a sense of the ward/group hotspots that were easier to retain staff or recruit too and vice versa – unless that was addressed, it would be a never-ending loop. RG advised that retention turnover data by clinical area/staff group at a high-level was available and could be explored in more detail. She noted that the high staff turnover wards tended to have high sickness, high vacancy and low-engagement rates. Conversations were needed with leaders that are known to be difficult and to have a structural process in place for formal flexible working requests to be looked at in an audited way. There was a need to be more innovative in flexible working arrangement.

The Chairman questioned if there were non-process-based initiatives that could be implemented (breaks/food). It was noted that over Christmas and winter, health and wellbeing trolleys were available to staff making it geographically easier to have a comfort break. Also, the offer of somewhere to sleep after a long shift – particularly beneficial for the retention of junior doctors to show that we care for their wellbeing.

TL noted that there was a divide between Board conversations with noble intentions and the reality lived by staff and suggested that the Executive reflect on what else can be done to make it easier to close that gap.

RG questioned if the Board was happy with the recommendations in the paper and to delegate responsibility to the People and OD Committee with relevant escalations to the Board. The Chairman stated that the Board would like regular updates and for the matter to be a distinctive feature of the

Board.

14. Staffing our wards in 2020/21	**TB (01/20) 011**

PG provided an update on recruitment:

- Recruitment was difficult with a significant shortage of nurses in the UK and in particular, regionally.
- Sandwell and West Birmingham take part in regional and national recruitment fairs and internationally with a successful recruitment drive in Australia with 156 converted posts. The paper suggests doing another recruitment drive in Australia.
- Nursing turnover had been reduced.
- There was an issue with staff retirement – and if retirees return to work, in what capacity.
- There are 150 students in the pipeline with 75 of those expected to convert into post.
- The 18 January recruitment event would see those student nurses looking at all offers from each organisation at the event. The biggest impact would be the Nurse Associate role and how that progresses going forward. The Nurse Associates would be an integral part of the team, but need to consider how to mentor those posts to ensure their importance is felt. The opportunity to convert into a registered band 5 role was available for the right people. There was 26 people on the training programme with 35 commencing in February, with a forward look to recruit a further 75 in June.
- The Health Care Assistant Escalator from a Band 2 to a Band 3 feeds into the Nurse Associate role to a Band 5 up to a Chief Nurse. PG questioned how they could sell that offer at recruitment fairs.

KT suggested sending 'mystery shoppers' to see what others were offering at the recruitment fair.

ML suggested that they participate in retirement recruitment fairs to pitch to people that are nearing retirement that don't want to or can't retire. He questioned how much of the CQC *requires improvement* rating featured in discussions and if the rating impeded recruitment. PG noted that the CQC rating was key – there was an element of not recommending the Trust as a place to work. They need to turn it into a positive to attract new people to get the Trust to fill vacancy gap to get to *good* and reap the benefits was beneficial for everyone.

RG advised that 306 people had definite start dates between now and the end of March. The team had done additional work as to how realistic it would be to get to the 550 FTE target, as listed in the budgetary position by the end of March. There was a number of people that they could advertise and recruit to by then with start dates. The end of March would not be realistic; however, the end of April would be with a focus on Health Care Assistant vacancies. TL noted that they would discuss the matter further in the break and continue the discussion at the Private Board.

HK questioned if the people that leave to go elsewhere were made aware that they were welcome to return to the Trust. PG noted that they need to be mindful of who they offer a 'welcome to return' to as some staff do not fit the Trust's values. RG noted that bureaucracy made it difficult for people to return – they need to be more flexible with the requirement of completing all the paperwork/induction again. She advised that all bank medical/nursing staff that were doing 30 plus hours per week were offered permanent positions with an uptake of 30 people. That process would be done monthly as an ongoing intervention.

15. Optimisation trajectories Q4	**TB (01/20) 012**

RB noted that the optimisation reporting programme was flawed and behind schedule; however, most of that data was now available. The devolvement/transition from a programme of Unity to business with

Unity, through the refocus of the digital committees was summarised in the Paper to ensure they were locally fit to take optimisation forward.

She reported that:

- Half of the optimisation areas had active ongoing work with delivery trajectories in January, including two KPIs to clear backlog data (results endorsement and discharge letters), which were being managed locally.
- Each clinical group had been requested to conduct a deep dive of PDSA cycle to prove a concept of what improvement could look like and then take the recommendations and roll that out.
- The real test would be barcode scanning which had failed to make progress. Medicine were deep diving into that and would review the findings on 6 January for learning and to implement improvement activities in January to progress that throughout the month. The improvement team were also resourced around barcoding to help roll it out.
- There were six areas of optimisation KPIs that had yet to work in earnest – time would be spent in January to benchmark data and design improvements.
- There was a data dashboard that was not 100% reliable in terms of use – need to concentrate on the information they were providing to staff. The publishing of individual data of best staff and team data would be discussed between RB, Dave Baker, Matthew Maguire and TL to accelerate that forward in January.
- There are a few areas of cross-cutting optimisation work that would be concluded over the next few weeks (Capman, patient flow).
- A few data quality issues that were being worked through – most non-ED issues had been resolved and would be in the position to close off the ED areas in the next few weeks.
- Outpatient optimisation piece would progress through phase x via speech recognition products.

HK questioned if there was a heightened drug interaction risk by half of the drug administration not being bar coded. RB advised that it was known exactly what drugs had been administered. The ability to scan the patient and their medicine to link the two improves safety and provides a tightened end-to-end process. DC advised that a review was being conducted on the last three months to identify if there had been an increase in medication errors to help understand the benefits of Unity compared to paper-based charts.

ML questioned if there was any work going on that brings the new Midland Met clinical model and Unity optimisation priorities together so that they are not done in isolation. RB noted that Unity optimisation had been designed as a set of work that would be completed by March. There would be plenty of opportunities to use Unity to make the best of Midland Met. The equipment needed in Midland Met in consideration to the scale of wards and logistics of technology had formed part of new hospital planning, which needs to be revisited. DC noted that feedback would be gathered from clinicians for suggested improvements in the use of Unity to plan ahead for Midland Met.

TL noted that the biggest and most important link between Unity optimisation and Midland Met was that the new hospital would be a team-based model of care. Some of the indicators that struggled most in Unity were the things based on being part of a pool. They would need to work that stuff through as there would be more patients held in a pool at Midland Met. There were seven medication indicators in the optimisation suite, one of them had been met (lack of free test prescribing). The other six (2 nurse-led, 2 doctor-led and 2 pharmacist-led) require amplification around medication errors. Success was dependent on achieving those six-medication metrics. He advised that barcoding was due to be delivered by end of January and the balance by end of March. Getting a directorate/clinical group to discuss medication performance on a multi-professional basis was not a habit. It's a new conversation to have in many areas – to be made a topic in the year ahead.

DC noted that it would be useful to identify which report(s) can be used at team level (to get down to ward level) and which report(s) would allow team-based focus within the ward, whether it's looking at sepsis management, VTE prevention, prescribing/dispensing.

16. Delivering the emergency care standard	**TB (01/20) 013**

RB reported a one percentage point improvement compared to the previous month, December closed at 71.93% (the best in three months), but off the target of in the 80s. She reminded the Board that at the last Board meeting, they had just had the NHSI visit – a letter had been received from the NHSI which reflected the verbal feedback. The NHSI felt that considerable progress had been made in terms of implementation and had experienced the energy and engagement of the teams. The letter had particular points of recommendation with no golden bullet, those things were helpful but would not get the Trust to 80%. They had achieved over 80% three times in the last week – she thanked the clinical teams and executive directors for their efforts.

She noted the following:

- There had been discussions about bringing the new ED leadership team into the Board space through Executives – planned for February to further discuss.
- The new specialty lead was settling in well and was focusing his efforts at City Hospital where there was no movement on indicators.
- The Smart Senior Triage was now staffed consistently from 10-6pm. Some consultants would need support – RB and DC would meet with Saurav Bhardwaj, Specialty Lead, to focus development plans and start recruiting for new leaders on the back of Midland Met. There was a need to focus on the coaching in situ to get decisions quickly.
- Minors at City Hospital had moved and separated from the main department for the paediatrics building works – minors' performance was returning to the 90s. It had been requested that the same be done at Sandwell. RB and TL were discussing the decoupling of minors from the main department to improve performance.
- The medical consultant, Chetan Varma, DC, TL and RB would meet tomorrow in regard to clerking patients in a shift.

DM questioned if the reason why performance had improved was known. RB advised that some of the attendance and bed occupancy was down, but was not always the case. Performance had a lot to do with the staff on shift – their capability and commitment.

PG stated that the efforts of the COO and the pre-Christmas preparation had been of benefit and was a credit to RB and the team.

HK questioned if the results around admittance within 2 hours was due to the lack of decision making or lack of beds. RB stated that it was both. TL noted that it would need to be discussed further with Saurav Bhardwaj to come to a solution. DC stated that there are patient groups where decisions can be made easily and other patient groups that require more information or a more experienced consultation. A consultant presence in the ED to make those decisions would free up the admitting staff to focus groups that need admitting and get clerks on shift (which would also help support the ambulatory care unit and educate and support ED staff).

MATTERS FOR INFORMATION/NOTING

17. Finance Report: Month 8 2019/20	**TB (01/20) 014**

DM advised that paper TB (01/20) 014 and TB (01/20) 015 were replicas of what would be discussed at the

Private Board and called for any comments or questions. None were received.

18. Draft 2020/21 budget paper [as per FIC]	**TB (01/20) 015**

As discussed at agenda item 17.

19. NHS Regulatory Undertakings: monthly status update on agency and four-hour standard	**TB (01/20) 016**

TL noted that they had drifted materially off track on agency and noted the annex to the paper which provided more detail. He noted the following:

- The target had been exceeded by about £125,000.
- There was work to do, particularly on the medical side, if they were going to get from £635k down to £454k. The bulk of that was contained in A&E medicine and elements of the GIM. Time would be spent with the medicine leadership group on 16 January to understand if that was a known spend.
- They were investing agency nursing staff at their bed position in order to make it safe and stable.
- The Board would need to be clear on the essential agency spending expected next year before a budget is set.

20. Application of the Seal	**TB (01/20) 017**

Noted.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS

21. Minutes of the Previous Meeting, Action Log and Attendance Register	**TB (01/20) 018** **TB (01/20) 019**

The minutes of the meeting held on 5th December 2019 were **approved** as a true/accurate record of discussions.

KD advised that most action log items were either ongoing, on the agenda or closed. Updates were provided for the following items:

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

  TL advised that further discussions were required.
- *TB (11/19) Patient Story – Complete an audit on how systemic the issue of not booking radiology in advance for procedural operations with a predicted discharge resulting in increased length of admission, and to introduce a process to avoid reoccurrence.*

  RB advised that the results from the audit had returned and some process changes had been made.
- *TB (05/19) 015 – Create single reporting template for pillar plan data supporting 2020 vision*

  TL advised that the action was third in the queue of priorities and the item should remain on the action log.

22. Any Other Business	**Verbal**

None.

23. Details of Next Meeting

The next Public Board meeting would be held on Thursday, 6th February 2020 in the Haywood Lecture Theatre, Postgraduate Education Centre at City Hospital.

Signed ……..

Print ……..

Date ……..