Paper ref:	TB (07/20)021

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by WebEx.

Date: Thursday 4th June 2020, 09:30-12:00

Members:

Mr R Samuda (Chair)	(RS)
Mr M Laverty Non-Executive Director	(ML)
Mr H Kang Non-Executive Director	(HK)
Ms M Perry Non-Executive Director	(MP)
Mr M Hoare Non-Executive Director	(MH)
Prof K Thomas Non-Executive Director	(KT)
Mrs L Writtle Non-Executive Director	(LW)
Mr T Lewis Chief Executive	(TL)
Dr D Carruthers Medical Director	(DC)
Mrs P Gardner Chief Nurse	(PG)
Mr L Kennedy Chief Operating Officer	(LK)
Ms D McLannahan Acting Director of Finance	(DM)
Mrs R Goodby Director of People & OD	(RG)
Miss K Dhami Director of Governance	(KD)

In Attendance:

Mrs R Wilkin Director of Communications	(RW)
Ms R Biran Associate Director of Governance	(RBi)
Mr D Baker (Item 5 onwards)	(DB)

Apologies:

Cllr W Zaffar Non-Executive Director	(WZ)

Minutes	Reference
1. Welcome, Apologies and Declarations of Interest	**Verbal**
RS welcomed Board members to the meeting. There were no declarations of interest. **Apologies:** Cllr W Zaffar	
2. Chair's Opening Comments	**Verbal**
RS noted the full agenda, with COVID-19 featuring significantly. RS stated that the recovery and restoration period would be a marathon and not a sprint. At issue would be society's reaction to post- lockdown life, the Trust's capacity to meet a potential second surge and bringing services back. The wellbeing of Trust staff would continue to be a focus through the continuing impact of COVID-19 and the restoration process. RS stated that the Trust had financial questions to answer. Whilst the Trust was currently in special financial arrangements, there would be longer-term issues around COVID-19/non-COVID-19 costs in terms of how they would be covered and to what extent the Trust would need to revisit the cost improvement plan. RS reported that there had been some very important work carried out, on mortality and quality of life, that included the experience related to COVID-19 and in the handling of the death process for patients. It was reported that the wider questions implied by the NHS reset from 1st April 2020, would be discussed by the Private Board.	

RS stated that the Trust was very keen - along with rest of the Black Country - to keep a focus on place to deliver services efficiently, particularly the COVID-19 response place. RS expressed the view that the Trust demonstrated real strength in its relationships with GPs, care homes and other organisations.

RS acknowledged that it was the final Board meeting for Chief Nurse, Paula Gardner (PG). On behalf of the Board, RS thanked PG for the energy and passion she had brought to the nursing cadre and for her championing of nurses and patients generally.

RS also acknowledged the contribution of Non-Executive Director Marie Perry (MP) who would be stepping down at the end of June. On behalf of the Board, RS extended thanks for her leadership of the Audit Committee, particularly in relation to the IT transformation.

3. Draft 2019-20 Annual Report including Quality and Financial Accounts	**TB (06/20) 001**

RS referred Board members to the draft paper. RW reported that the deadline for changes was 10th June 2020 (comments to be sent directly to RW). The accounts were currently being audited and the final version of the report was expected to be ready by the end of June.

TL reported that the AGM, originally scheduled for the 18th June 2020, was now expected to run on the early evening of the July Trust Board meeting.

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

KD introduced questions submitted from members of the public:

Q1. Given the Government has started to relax the lockdown rules, including the opening of schools and allowing people to meet with others outside of their households, is the Trust preparing for an increase in infections of COVID-19 and subsequent hospitalisations. If so, by how much?

TL reported that the school nursing service had been working very closely with local schools and the Trust would continue to support staff who were parents. TL acknowledged that not going to school led to a fall in general child diseases requiring hospital attendance.

Q2. Given the Trust serves an area with a high proportion of people from BAME communities, many of whom live in multi-generational households, from small children to elderly family members, does the Trust expect those communities to be disproportionately affected by the relaxation of lockdown rules?

TL acknowledged that there were higher risk factors for men, older people, and people from black and minority ethnicities (BAME) however, TL maintained that the hygiene and social distancing messaging remained the same for people of all backgrounds.

Q3. There has been criticism that national test and trace systems are not efficient enough at this time to prevent and increase in the 'R' rate. What is the present 'R' rate for the area the Trust serves and does the Trust feel that the present test and trace is adequate enough, or, would the Trust prefer that the lockdown rules remain in place until it was satisfied that the test and trace system was robust and effective?

TL reported that the test and trace system was a work in progress. Good antibody testing was in place and the Trust's antibody testing capability would be extended to local social care, care homes and general practice staff in the coming weeks.

Generally, the 'R' rate was average for the West Midlands of between 0.5 and 1.

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UPDATES FROM BOARD COMMITTEES	
5a. a) Receive the update from the **Charitable Funds Committee** held on 14th May 2020. b) Receive the minutes from the **Charitable Funds Committee** held on 13th February 2020.	**TB (06/20) 002** **TB (06/20) 003**

DM highlighted the following points to note:

There had been significant progress made on fundraising campaign pledges. The risk to donations received by the Charity during the COVID-19 pandemic had been discussed.

The 4/5-year Income and Expenditure (I&E) projection had been reviewed along with the cash consequences of the investment into the Midland Met fundraising campaign. DM stated that the Trust's remediation plans to repair the cash shortfall in the year before the Midland Met pledges were received has also been discussed.

More work would be required on confirmation of the 20/21 detailed I&E Plan.

The grant pipeline and the asset base review of the Charity in comparison to the quality account peer group. DM commented that it was interesting to note that, except for the London charities which had huge asset bases, the Charity was relatively large in comparison to local Trust charities. DM advised that the right balance needed to be found in relation to assets and the ability to apply for grants i.e. the Trust Charity should not get too big. DM reported that the Trust Charity should be spending donated money, whilst also remaining successful

The Committee had discussed the Annual Report and accounts production timeline. DM reported that a meeting would shortly take place with the new investments funds manager to discuss the investments policy, including their ethical commitment to the Trust and the Trust's appetite for risk.

5b. a) Receive the update from the **Finance and Investment Committee** held on 29th May 2020. b) Receive the minutes from the **Finance and Investment Committee** held on 28th February 2020.	**TB (06/20) 004** **TB (06/20) 005**

MH highlighted the following points to note:

The net effect of COVID-19 in the first months of running and how the additional costs had been separated and covered from the normal run rate has been discussed.

MH advised that there would be more scrutiny of COVID-19 expenditure going forward. In relation to the recovery plans, at issue would be the effect of income and expenditure, the ability to recover the wait lists and other activities and the net effect of the Trust's clinical support due to changes in some of the standard operating procedures and the costs of the COVID-19 cleaning required in order to maintain safety.

The Committee had discussed the cash position in relation to COVID-19 options. MH reported that DM had presented a complex position regarding potential outcomes and performance of invoice payments with

Balfour Beatty.

MH paid tribute to the finance teams for meeting prompt payments obligations with suppliers and accounts payable.

MH stated that some of the financial plans and cash positions would be discussed later in the agenda along with the importance of the run rate with the CIP.

DM reported on the governance around COVID-19 costs. The Trust had created a system to monitor and accurately record costs specifically in relation to COVID-19 and the strength of the reporting and governance around this issue would support the Trust's reimbursement of the costs.

TL queried how close the Trust was to achieving seven-day payments standards. DM reported that the Trust had paid 89 invoices within seven days (not many relatively). DM acknowledged that the Centre had set out an expectation that organisations would pay within seven days if possible. However, there had been no formal amendment of supplier terms and generally, the system was still processing against the 30-day Better Payment Practice Code for suppliers. DM expressed the view that an override of the system would not be doable within a month.

TL stated that there was an absolute requirement to move to prompt payment and strongly expressed the view that the Trust needed to work out a plan as to how this could be achieved. TL made the point that the money would be critical to the survival of local businesses heading into a recession.

DM acknowledged that guidance had been issued advising that where suppliers could demonstrate they had a going concern risk and cashflow problems in the context of COVID-19, the Trust should consider payments on account and payments upfront.

DM reported that there had been no specific requests for fast payment from suppliers recently, but when this happened, the Trust had always responded quickly.

RS stated that the Board shared the concern to get payment up to the seven-day target and requested an update on progress by the end of June 2020.

5c. a) Receive the update from the **Quality and Safety Committee** held on 29th May 2020. b) Receive the minutes from the **Quality and Safety Committee** held on 28th April 2020.	**TB (06/20) 006** **TB (06/20) 007**

HK highlighted the following points to note:

Antibody testing was being rolled out across the country as a way to address the risk of a secondary spike.

The release of BAME data had been enlightening, but the reasons why this section of society had been disproportionately affected by COVID-19 were still uncertain and there were questions around risk mitigation for patients and staff.

In relation to the Mortality review, data from the analysis of Trust deaths had been presented, along with plans for developing improvement work from this analysis. Risk mitigation on the quality of care had been discussed.
Positively, 98% of all complaints were responded to within the timeframe. Positive feedback had been received from the Regional FTSUG's Network which had recognised the Trust going above and beyond in

supporting local care homes.
HK extended thanks to PG for being a key member of the Committee.

5d. a) Receive the update from the **Digital Major Projects Authority** held on 29th May 2020. b) Receive the minutes from the **Digital Major Projects Authority** held on 27th March 2020.	**TB (06/20) 008** **TB (06/20) 009**

MP highlighted the following points to note:

The Committee had discussed the performance monitoring of the Trust's networks and connectivity and had made sure the systems had been flagging up early warning signs so that the team had been able to intervene with responses. MP reported that this had positively impacted the general stability of the networks.

A shift had been observed in people moving away from complaining about connectivity issues to asking questions about how to develop and get the best out of systems instead.

5e. a) Receive the update from the **Public Health, Community Development and Equality Committee** held on 29th May 2020. b) Receive the minutes from the **Public Health, Community Development and Equality Committee** held on 28th February 2020.	**TB (06/20) 010** **TB (06/20) 011**

KT highlighted the following points to note:

The Stress Risk Assessment Plan had been rolled out after being delayed from earlier in the year. The plan had been reformulated with some beneficial wellbeing work. KT explained that completed assessments would be received by the wellbeing hub for decision-making on interventions, rather than line managers.

KT expressed the view that the Trust could be confident that learnings from COVID-19 had helped cement the Plan.

The Obesity campaign would be launched to tackle obesity in both staff and patients. Again, COVID-19 had assisted in placing the issue as a risk to health rather than it being about appearance. KT reported that the Plan would be in place shortly.

KT reminded Board members that It had been almost a year since the implementation of the smoking plan.

RS commented that obesity was a sensitive issue but was critical to public health.

TL raised the issue of national guidance on BAME employee representation in senior decision-making structures. TL reported that, by July, there would be 29% BAME representation, which was slightly short of population proportion, so improvement would be required. TL reported that the Trust was on track to beat a target set three years ago for BAME representation at Band 8 and above.

BAME representation within the COVID-19 incident room had been analysed and a consultation meeting had taken place with a large group of BAME staff (clinical and professional) to discuss how the Trust had responded to the pandemic. Views had been overwhelmingly positive. RS expressed the view that the consultation meeting had been a positive move and appeared to have been well received.

DB suggested that assumption testing be carried out with people affected to get a granular understanding

of why BAME people had been disproportionately affected by COVID-19. TL agreed that causation was not currently understood but made the point that this was distinct from the NHS drive to ensure leadership was reflective of the population. TL reported that the Good Governance Institute (GGI) would be helping with the governance model.

RS reported that he was hopeful of being able to make an announcement of an Assoc. Non-Executive Director candidate shortly which would be accompanied by an explanation of the appointment process.

6. Patient Story: Reflections on a good death	**TB (06/20) 012**

TL advised that instead of a single patient story, the theme of the discussion 'Reflections on a good death' would focus on achieving good practice and had encapsulated several patient experiences.

PG referred Board members to the paper and commented that the four stories collated from patients had not been favourable. Defining a good death had been problematic because people had different requirements. PG commented that clinical staff across health and social care needed to identify those at risk, communicate compassionately and then assess individual needs to plan appropriately.

PG reported that there had been a difference between those patients under the palliative care team and those that were not, and the inequity experienced by certain groups had been exposed.

PG reported that the main theme had been communication and expressed the view that honesty was required in relation to talking about death, preferred environments for passing, and treatment options.

PG commented that there had been an unfortunate increase in non-beneficial interventions when they were not the best options and decision making around these needed strong conversations to take place. PG further commented that open discussion of prognoses was affected by fear of litigation if they were wrong.

Out of hours decisions made about DNACPR by teams that did not know patients, or the families involved was one of the biggest issues.

Lessons from COVID-19 had included using the Palliative Care team as a 'pull' model to identify patients rather than wait for referrals. This had enabled earlier, specialist intervention and decision making.

PG reported that the use of Leasowes intermediate care centre for end-of-life care had worked well with Palliative Care and Your Health Partnership (YHP) GPs working successfully together.

The following recommendations had been identified:

- A workforce that is competent and confident in delivering end-of-life care
- The Trust had invested in two palliative care consultants with a focus on improving access to the service
- The mindset of clinicians needed to be altered so that unnecessary interventions were not carried out.
- The effective utilisation of treatment escalation plans. Patients decisions about where they wanted to die was paramount but there needed to be system wide enforcement about how the Trust used its Primary Care and Social Care to ensure the right decisions were made to honour patients' wishes.

- The wearing of purple wristbands in ITUs to identify patients with altered treatment escalation plans needed refining as they sometimes created assumptions about treatment.

LK thanked TD for a well-written paper on a difficult subject. He queried what might be holding the Trust back from documenting information that would help with advanced care planning. TD commented that improvements to the documentation would only happen when the right conversations took place. TD further expressed the view that it was important to ensure documentation was shared across the system, was acceptable to all and informed by the right decisions taken at the right time.

Short interactions in communication times would be important to improvement because people could only take in so much information at any one time. It was noted that people needed to be in the right frame of mind and be accompanied by the right people when discussing timeframes and treatments. Conversations needed to be tailored to individual patient needs and wishes.

DC commented that many of these conversations in lockdown had taken place remotely and the experience had heightened awareness of the issues.

RG queried whether the paper and learnings would help the Trust deliver the Quality Plan. TD commented that one of the key issues was that it better enabled teams to work together.

ML queried the Trust's capacity to work with GPs and care homes to educate them on the process because he observed that it often the family and GP that needed persuading. TD acknowledged that it was often families that were the barrier. She expressed the view that it was important to provide all of the information in advance. GPs needed to feel confident and have the resources and information required to be able to have conversations with patients and families. TD reported that the Trust had been working across GP surgeries and care homes in education.

TL commented that the Q&S Committee had agreed to review the Supported Care pathway for COVID-19 patients whose FCP had been initiated in hospital, to better understand missed opportunities. This was expected to be ready by the end of the month.

TL expressed the view that one of the challenges of COVID-19 had been the Trust's ability to work with large families in the decision-making process.

TL queried whether the Gold Standard Framework had helped or hindered. PG expressed the view that the Gold Standard Framework would help but commented that it was only one element. TL stated that restrictions on visitors had led to families being cut off from decision-making. PG commented that virtual meetings, iPads and physical meetings supported by PPE had been used to ensure families were consulted. PG reported these had been appreciated.

RG queried the involvement of the community in choosing people's place of death. TD stated that there were strong links with many community groups but acknowledged there were gaps and more work would be required to develop wider relationships.

DC commented that it would be important to join up hospital and primary care pathways. RS agreed.

BREAK

MATTERS FOR APPROVAL OR DISCUSSION

7. COVID-19: Restoration and recovery plan	**TB (06/20) 013**

TL advised that there were three papers covering item 7 (see below):

On the restoration plan, TL referred Board members to the paper which set out arrangements for services including Primary Care, diagnostics, screening etc. TL reported that service scale would escalate through June/July/August including being able to operate the BTC on a seven day per week basis.

TL advised that there would be some areas which would not return to full volume, mainly because of the need for cleaning between patients and cases during certain procedures.

The use of technology in outpatients had identified a need to bridge a digital poverty gap which impacted accessibility.

Although underlying demand for the trust's services had dropped sharply in March/April/May, TL reported that there would be a time pressure on some services e.g. endoscopy, to recover quickly.

TL advised that, if GP referrals stayed at 50% below normal at the fully operational point (end of August), the waiting list would be the same as it was at the start of the calendar year. If referrals recovered however, the waiting list would be higher.

TL expressed confidence that a return to full operation was in hand.

TL reported that the psychological wellness score card for June would be presented at the next Board meeting along with the closing of the surge risks, an update on the recovery risks and a data set covering the rest.

In response to a query from HK, TL reported that the Trust was doing what it could in terms of infection control and a detailed analysis had shown that rates of spread in the hospital were lower than other places.

ML queried what positive, changed ways of working - developed in the lockdown - should be preserved. TL expressed the view these would be the pace of change, widespread adoption of digital and video technologies and the breaking down of boundaries in patient care.

TL commented that, across the papers for this month (June) and the previous month, there were certain risks that were being tolerated.

In response to a query from RS about communication with communities who might feel unsafe to seek services, TL agreed that this issue needed further consideration with a period of reflection on the learnings so far.

7.1. COVID-19: Risks and mitigations	**TB (06/20) 014**

KD stated that the Trust had not lost sight of the 30 risks that had been identified in the Surge Plan. KD reported that risks had been mitigated to targets and the only risk that was likely to remain 'red' related to psychological harm.

The highest volume of risks related to workforce. However, both IT capability and finance had high ratings of concern.

KD advised that the longer the period of the pandemic, the more additional issues would come into play with a top, current risk being Winter and 'flu – dealing with the two demands at the same time would impact recovery.

7.1.2 COVID-19: Psychological wellness scorecard	TB (06/20) 015

RG reminded Board members of the Trust's plan for the longer-term wellbeing of the workforce. RG reported that the Stress Risk Assessment had been discussed extensively by the PHCE Committee. This would be a workplace stress assessment based on the Health and Safety Executive talking toolkit.

Feedback from the Board members and the Committee had been that more qualitative analysis was required. The Wellbeing Factory had been set up and RG referred Board members to the feedback in the annexe to the papers. RG reported that 91 people had enjoyed an improved experience after visiting the sanctuary.

RG also reported that the numerical analysis had been confirmed. RG advised that it was a big piece of work that would take around 12-18 months. Phase 1 was currently training people in high-priority areas. RG advised that 250 people had volunteered to be Mental Health First Aiders and therefore, there would be an ongoing programme of learning and training to ensure every Trust area had a Mental Health First Aider. RG reported that regular updates would be provided through the scorecard.

RS commented that he had found the sanctuary team and the facilities impressive when he paid a visit.

In response to a query from MH, RG reported that daily data reporting had shown an increase in sickness absence, other than for isolation or COVID-19 symptoms. RG reported that people were already physically and mentally exhausted which would make responding to a second surge more difficult.

8. Financial Plan 2020/21	TB (06/20) 016

DM referred Board members to the paper and explained that COVID-19 had hugely impacted the NHS including its financial regime. The paper, therefore, was an attempt to set out the reconciliation of the Trust's current COVID-19 arrangements with the Board approved plan.

DM reported that it was difficult to arrive at any firm conclusions without knowledge of the new financial regime.

There had been a focus on the following questions:

- Expenditure risks created by COVID-19
- Digital income risks arising from the new regime
- Work to ensure the Trust could stay within the post-CIP budget.

DM pointed out that the Trust had a Board-approved breakeven term that had created reserves both to invest and to manage risks. The draft Plan submission to NHSI on the 5th March 2020 had reflected this Plan and in addition, a point in time income agreement which had reflected the current position on contract negotiations with Commissioners.

DM reported that it was important to note the Trust had not submitted a final plan for 20/21 because of the COVID-19 emergency. DM expressed the view that it was important for the Board to confirm its intent to breakeven in 20/21, which maintained the Trust's cash balances of just over £20m for 20/21.

DM reported that, under COVID-19, there was no requirement for CIP, although the Trust was recommending continuing plans to reduce the cost base. The COVID-19 regime had given the Trust more time to put plans in place. Promising progress had been made and DM reported that the biggest gap would

be the new vacancy factor for 20/21 - there was more work to be done to firm up confidence in this area. This would be done by permanently removing posts or maintaining a constant vacancy factor through the year.

Procurement colleagues had drawn up a detailed plan in the context of COVID-19. DM reported that the Trust had speaking regularly with pharmacy colleagues to ensure the pharmacy target could be met.

DM reported that there had been no formal announcement on the financial regime post-COVID-19, although there had been strong indications that it [the regime] would be extended to the end of October 2020. Soft intelligence had suggested there would be a route to breakeven in 20/21, although there would be a likely phase out of the retrospective top-up arrangements. This situation would be carefully monitored.

In response to a query from RS about the top-up. DM stated that under the COVID-19 arrangements, the Centre worked out a block of income for the Trust that would be expected to cover the expenditure run. Top-up was the amount required to fill any gaps. Retrospective top-ups represented variance and it was assumed most of the variance could be explained by COVID-19.

DM expressed the view that it would take a lot of work for the Centre to be able to compare one organisation with another. The Trust had reasonable assurance, in comparing its absolute COVID-19 cost percentages, that it had been performing as expected. Other factors driving the variance differed from one organisation to another.

LK queried whether the full £18.5m CIP could be delivered. DM stated that the Trust had not lost sight of the figure and the pay plans had been set locally within the groups, directorate and corporate directorate budgets. Savings targets had also been allocated.

TL insisted there would be no pause in the CIP plan.

9. Learning from complaints: 2019/20 Annual report	**TB (06/20) 017**

KD highlighted the following points from the annual report:

KD stated that the Trust was making good progress in leading the complaints process. She commented that it was important for actions arising to be implemented in the wake of investigating complaints and for the learnings to be shared. The Trust had performed much better in terms of ensuring actions were recorded and safeguarded and in generating automated reminders.

In terms of improving the quality of the complaints process the Trust was working to collect feedback from complainants but had not had much success so far. Efforts were ongoing in this area.

KD reported that last year, 102 complaints were returned to the Trust because the complainants were unhappy with the response. This year 66 complaints had come back. KD spelled out various challenges in the enquiry process but commented that the trust was getting better at collecting initial details from complainants and making regular checks back with complainants during the process.

Prior to the COVID-19 pandemic the Trust was achieving 99% against the SWB target of 97% for responding to complaints within the agreed date (within 30 working days), a significant improvement on 2018/19 position of 77%. As a result of the pandemic focus, as at the date of the report, the Trust is at 97.6%; still an achievement on the previous 12 months.

Work to engage with communities to make people aware of the complaints process was being carried out and as a result, complaints had risen, however this had been viewed as a positive.

KD reported that it had been a positive year overall. RS commented that the initiative of going into the communities would be very valuable.

10. Learning disabilities priorities	**TB (06/20) 018**

PG reported that the latter part of 2019 had been utilised as learning disabilities awareness time. She commented that NHSI had been very pleased with the way the Trust had been operating in relation to this issue.

PG reported that the Trust had initiated a Learning Disability awareness month in October 2019, under the strapline *See Me: Know Me for My Ability Not My Disability,* with a series of roadshows and culminating in a conference and other events.

The Trust CEO, TL, had made five promises to Sandwell's People's Parliament as a commitment to driving forward quality care for patients with a Learning Disability.

- Flagging
- Reasonable adjustments
- Handheld records (hospital passports)
- Staff awareness and competence
- Employment of staff with learning disabilities

PG further commented that Trust considerations included providing an appropriate environment, individualised medications, and collection of feedback. PG reported that Purple Star was like a Kitemark standards.

There were four overarching standards in this area:

- Respecting and Protecting the rights of the individual
- Inclusion and Engagement
- Workforce Awareness and Competency
- Specialist Learning Disability services

PG expressed confidence that the Trust was on the right track, with respect to these standards, but there was still work to be done. A number of initiatives were in development:

- A Learning Disability Masterplan
- Roust patient and carer feedback for greater inclusivity and engagement
- Tier two training (part knowledge skills and attitudes)
- An eLearning package

LW observed that the Trust's plan was very ambitious and queried how the action plan had been received and if it had included people with a learning disability and whether there was an opportunity for people with learning disabilities to be more in control of the ambition of the Trust.

PG reported that there had been some involvement with two representatives of the People's Parliament who had learning disabilities, but PG acknowledged that people with learning disabilities, or their carers, were not regularly involved in action planning but there was now an opportunity for change.

TL expressed the view that achieving the Purple Star emblem (kitemark-style recognition) would be an important next step in demonstrating the Trust's commitment, despite the fact that it wasn't nationally known.

In response to a request from RS, PG stated that a date for the forthcoming conference would be released as soon as it had been decided.

11. COVID-19 mortality: March and April review	TB (06/20) 019

DC referred Board members to the paper and reported that three main areas had been investigated:

- How care pathways had compared to best practice?
- How outcomes compared to neighbouring providers and why?
- How well all populations served by the Trust had been treated with Covid-19 to date, and anything that needed to change in June and July?

DC reported that processes had been undertaken to realign the pathways of care to accommodate COVID-19 patients. Some pathways for specialties were created, a review of nationally published guidance from NHSe/I or from NICE was carried out and a rapid review of any published research literature helped learning and influenced treatment choices.

In terms of the Trust mortality data, DC commented that it was important to note the number of elective and non-elective inpatient spells for March and April, which showed how activity reduced throughout the organisation overall. Typically, there would be around 9,000 spells per month, but this had been reduced by around 50% leading to a relatively high, crude mortality rate.

The number of inpatient COVID-19 positive deaths for March numbered 64 and figures for April showed there had been 220 deaths and 59 for May.

Overall mortality for COVID-19 patients admitted to the organisation was 32% which compared favourably to national data of 33%.

Median age of patients was 80 with complex medical histories with hypertension and diabetes being the most common co-morbidities. Most were male, which fitted with the national picture.

In terms of ethnicity, DC reported that the Trust's data reflected the move of the pandemic from West Birmingham in March (where Black African Caribbean/African patients made up 38% of all deaths in March) towards Sandwell in April (where Black African Caribbean/African patients made up 19% of deaths in April).

Mortality by site had been predominantly at City. There were now fewer patients dying in ITU or the acute medical unit.

The Trust's ITU data was comparable with national data as was NIV data.

In response to a query from HK about the extent of on-COVID-19 related deaths, DC reported that community deaths data was not currently available to determine changes.

In response to a query from MH, DC reported that different conditions would have different consequences and it might take some time for the effects to manifest in mortality data.

KT commended the paper and queried the practice of proning as a treatment and whether it had made a difference. DC reported that all patients who had required proning or oxygen escalation had been managed in one area to ensure quality of treatment. As a result, the mortality of deaths in that area had increased month on month.

DC reported that there had been an attempt on Unity to enable staff to record the proning of patients and outcomes, but the level of data required to answer the question [on efficacy] was not available.

PG reported that patients had been proned but that unwieldy forms to record this practice had not been filled in, but this was in the process of being changed to deliver an auditable process.

TL observed that, taking the data as a whole, there appeared to be a markedly less elevated pattern in BAME figures when compared to population, when others maintained the opposite.

In response to a further TL observation around hospital acquired infections, DC acknowledged that there had a location specific focus on nosocomial infections, particularly relating to the logistics of the site at Sandwell and there had been related outbreaks. A daily report on hospital acquired infections was being produced rather than weekly.

TL clarified that the Trust had been collecting and analysing data in relation to BAME and nosocomial infections from day one, but the central collection of the data had been more recent.

TL pointed out that the paper identified 20 patients who had died whose ethnicities were unknown. TL expressed the view that this was unacceptable and warranted an answer.

Action: DC to find out the ethnicities of 20 patients who had died of COVID-19 with ethnicity unknown.

12. Chief Executive's Summary on Organisation Wide Issues	**TB (06/20) 020**

TL referred Board members to the paper and highlighted the following points:

TL reported that (a week on Monday) the Children's Emergency Care unit would open on the City site. TL reminded the Board that it represented a direct response to concerns from the Care Quality Commission about an isolated assessment unit. TL reported that the new service would operate 24/7. Paediatric ED would continue at Sandwell.

TL further reported that the terms of reference to the ICP were a work in progress.

The Star Awards for 2020 had been launched and would recognise the COVID-19 aspects of the nominations.TL reported that nominations closed on 3rd July 2020. An awards ceremony would take place in October at Aston Villa Football Ground.

In response to ML's request for an update on Midland Met, TL reported that the hospital was progressing well with around 160 people currently working on site which was expected to rise to 900 by Christmas.

TL reported that some additional funds had been released to facilitate Balfour Beatty working on a more socially distant basis. TL stated that the risk analysis of Balfour Beatty's supply chain was ongoing, but no material delays had been flagged so far.

The test centre in the car park continued but TL reported that it would probably be relocated elsewhere

over the course of the Summer.

It was expected that Midland Met's clinical model would be reviewed at the June EMPA Committee.

REGULAR MATTERS

13. Freedom to speak up scorecard	**TB (06/20) 021**

KD reported that the Trust was in a very good position in relation to the weconnect engagement scores. The scores had been above the NHS average of 3.7.

Ambulatory Therapies and General, Breast, Urology and Vascular Surgery received the highest engagement scores out of 5 - 3.98 and 3.94 respectively, with Corporate Operations achieving the highest score of all at 4.01.
The main local area of focus had been the Maternity, Health Visiting and Perinatal Medicine directorate which had high relative rates of long-term sickness, and relatively weak weconnect results.
KD confirmed that Maternity performance would be followed up. It was confirmed that the Freedom to Speak Up guardian and capacity was on track.

14. Patient voice scorecard	**TB (06/20) 022**

KD reported that General Surgery and Ophthalmology remained areas for general attention. Regarding complaints to management, there was some work to be done by the management team, particularly in relation to re-bookings/appointments.

15. NHS Regulatory Undertakings: monthly status update on agency and four-hour standard	**TB (06/20) 023**

TL reported that agency controls had been introduced for June to try to avoid last minute decision making or habitual use of agency staff.
TL reported that there was still work to be done to establish improved A&E performance. Splitting of departments in response to COVID-19 had introduced some constraints.

16. Integrated Quality and Performance Report	**TB (06/20) 024**

DB reported that the treatment of positively diagnosed Sepsis within one hour continued to be below or at 60% for the fifth consecutive month. Work was ongoing to understand why this had been happening. It was reported this would be further discussed at the next Q&S Committee.

17. Monthly risk register report	**TB (06/20) 025**

KD reported that two Informatics risks (3109 and 3110) had been mitigated so that the likelihood ratings had been reduced.
UHB Oncologists' participation in MDT had improved following the use of WebEx and this had mitigated the risk to its target rating. It was suggested that the risk be archived following discussion at the June Risk Management Committee (RMC).
TL suggested that the IT infrastructure risk might be slightly premature. Further, TL expressed a strong view that Unity Optimisation had not been mitigated to the extent that it should be removed from the risk register. LK explained that the implementation of Unity and people's ability to use Unity was the only element suggested for removal. The utilisation of metrics would remain, making the risk more specific in definition.

18. Finance Report: Month 01 2020/21	TB (06/20) 026

DM referred Board members to the report for noting.

In response to a query from RS about capital, DM reported that the capital regime within NHS I&E had been changing frequently, specifically around COVID-19. NHS I&E had acknowledged that it had not confirmed reimbursements of £680k of 19/20 COVID-19 capital.

DM reported that there had been some feedback on 20/21 capital and another submission had been made including the Midland Met welfare and carparking changes and some further information on IT.

TL expressed confidence that money owed would be received. DM confirmed that, with reference to the depreciation budget, the Trust had submitted a capital plan that was slightly less than was available depreciation budget for this year, therefore, it was fully funded by depreciation.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS

19. Minutes of the previous meeting and action log	TB (06/20) 027

The minutes of the meeting held on 7th May 2020 were reviewed and **APPROVED** as a true and accurate record of the meeting.

The action log was reviewed with the following updates:

- *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.*

  TL commented that this would be followed up as part of the Recovery Plan.

- *TB (11/19) 001 - Return with a further Paro Seal evaluation to the Quality and Safety Committee in April 2020.*

  KD reported that this had been done.

- *TB (02/20) 010 - The stroke team to be invited to the Board to discuss performance indicators in June or July.*

To be delayed until later in the year.

MATTERS FOR INFORMATION

19. Any other business	Verbal

- None.

20. Date of next meeting of the Public Trust Board:	Verbal

- The next meeting will be held on Thursday 2nd July 2020 at the Black Country Living Museum, Dudley.

Signed ……………………………………………………………………………………………….

Print ……………………………………………………………………………………………….

Date ……………………………………………………………………………………………….