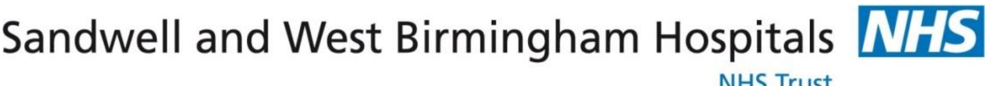
Paper ref:	TB (06/20) 027



TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by WebEx. **Date:** Thursday 7th May 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)
Cllr W Zaffar Non-Executive Director	(WZ)
Prof K Thomas Non-Executive Director	(KT)
Mr T Lewis Chief Executive	(TL)
Mrs L Writtle Associate Non-Executive Director	(LW)
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:

Mr M Hoare Non-Executive Director	(HK)

Minutes	Reference
1. Welcome, Apologies and Declarations of Interest	**Verbal**
RS welcomed Board members to the meeting. There were no declarations of interest. **Apologies:** Mike Hoare.	
2. Chair's Opening Comments	**Verbal**
RS commented that the agenda would be dominated by COVID-19 matters and reflected that the Trust had weathered the first surge as far as the hospital systems were concerned. RS acknowledged that the Trust was second in the West Midlands in terms of the numbers of deaths. The impact of the virus was in no way past its peak and social care had been under pressure. A significant change had been observed in the presentation of patients with a fall of around 40% in general admissions and a 26% reduction in ambulance conveyances. Paediatrics' 70% reduction in admissions was a particular concern. RS paid tribute to clinical teams who had been forced to reorganise at pace. RS commented that the Trust leadership had taken a lead on testing and supporting other organisations and feedback from primary care partners had been that they had been impressed by the Trust's response. The Trust had also played an important role in BAME impact analysis. RS stated that the Trust's innovation had really come to the fore throughout the organisation. RS stated that staff had felt well-supported and commended the Trust's open communications, which had been well received. RS commented that staff psychological wellbeing was an important focus. RS stated that the Board was	

very keen to support the rapid changes and transformation that had been happening in the Trust and to embed the ones that were important for the future.

RS expressed the view that the case for place-based work in communities had been made by the current experience.

MATTERS FOR APPROVAL OR DISCUSSION

3. COVID-19: Surge and super surge	TB (05/20) 001

LK referred Board members to the paper which set out some of the detail of the COVID-19 surge plan and its effectiveness. It had been acknowledged that the first peak in March had now passed.

LK reminded Board members that the hospital had been split into Red (COVID-19) and Blue (non-COVID-19) streams which was also reflected in community and GP services to help avoid cross infections. This had been done at a rapid pace, taking into account all national guidance

The surge plan was developed in four key areas and was implemented through clinical groups controlled by a project management function through regular tactical meetings. The areas were:

- Workforce
- Assets
- Supplies
- Realignment of clinical services and the estate

LK reported that not all national guidance had been implemented in the specified timeframe [to allow for due diligence on risk] and there had been some specific derogations in relation to enhanced PPE/viral filter masks which had helped achieve the current good PPE supply position. A decision to wipe down single-person face visors had been a safe way to reduce the burn rate. All were in the papers. PG clarified that a very strict cleaning regime had been put in place for multiple use masks.

LK reported that the super surge plan had focused on increasing ICU capacity beyond the initial surge, meaning the provision of an additional 52 ICU beds across the City site. This had been put in place, but as admissions were observed, some advanced modelling had indicated it would not be required. LK stated that the recommendation was to stand down the super surge plan.

LK reported that there had been a lot of changes to services and it had been recognised that it would be beneficial to retain some of these positive and successful changes that had been made through necessity.

KT queried the embedding of protective screens and the planned response to a potential second surge. LK responded that protective screens would be in areas such as the canteen and reception areas. In terms of the second surge, the separate, segregated streaming system would remain in place for the foreseeable future. The challenge would be in the resilience of staffing and the restoration and recovery of the Trust. DC commented that the redeployment of staff had required rapid retraining, which would be important to maintain as staff returned to their usual routines, so that clinical teams could respond to a new surge more easily. PG added that staff who had been moved into ITU would keep their new competencies updated which was a positive. PG commented that having fewer patients would free up time to complete mandatory training etc.

ML queried which innovations should be taken forward. LK stated that critical decision making, reviewing

cases, technology and communications, site relocations, different ways of working, one-stop appointments for patients were among the learnings.

In response to a query from WZ, TL commented that there was no plan at the present time to use the Nightingale Hospital that he was aware of other than on a second surge back-up basis. TL stated that there was a Clinical Advisory Group looking at hospital plans regionally, which was expected to suggest how the Nightingale Hospital might be used. TL reported that there was no utilisation plan presently for the equipment in the Nightingale Hospital. No Trust staff had had to be sent to the Nightingale, although a plan was still in place to respond if necessary.

LW commented that this was the time to catch up with staff and clinical teams to reflect on how they were coping and planned to cope in the future. LK reported that there were open and closed environments where supportive conversations could take place however the scale of the impact was uncertain.

HK asked whether the Nightingale Hospital could be repurposed as a half-way house for patients returning to care homes from hospital. TL commented that he would be meeting with the Council to discuss the care home agenda. The Black Country had been a hotspot for this issue, but Sandwell had been seemingly better than the rest of the Black Country. TL reported that six care homes were closed locally with approximately half of the closures COVID-19 related. TL stated that the use of the Nightingale Hospital might be considered if the numbers deteriorated but raised the real importance of maintaining a connection to family and loved ones for patients.

TL stated that the Executive team were looking at the things that could have been done better whilst recognising the superb response to the challenge. He noted the planned review of deaths.

DC commented that innovations in COVID-19 treatment were being implemented and training was now getting back on track. TL queried whether proning was happening. PG stated that she was working with senior nurses to discover if proning was taking place with patients who met the criteria. This could be recorded in a chart within Unity, but currently, the date had been suggesting that the Trust was not proning anyone.

KD reported that the month’s QIHD had offered an opportunity for staff to reflect on what had worked well and not so well. RS commented that the high number of participants was testament to how keen staff were to engage.

4. COVID-19: Restoration and recovery	**TB (05/20) 002**

TL introduced the restoration and recovery paper and stated that 712 people had returned home from Trust care having fully recovered from COVID-19.

TL commented that it was important to think of the big themes as well as the granular activity e.g. air quality was an important component of how the virus affected a community.

TL stated that it was anticipated that the number of COVID-19 patients would be at a three or four ward level in the immediate weeks. The Trust had seen a steep decline [in cases] and the situation was expected to plateau, however, there would need to be a base level of provision and staffing, being mindful and protective of wellbeing, probably by rotation.

In terms of longer-term relocation, there was a public engagement and consultation statutory obligations process which would need to be discharged. TL reported that the expectation was that all children’s surgery would continue to follow the single site model along with other services (Urology and ENT) which

would be on single site. Cancer surgery was currently being delivered offsite within private hospitals which would likely to continue until the end of June and possibly beyond.

TL stated that a piece of work was being carried out around moving some corporate functions to home working longer-term. Engagement with homeworking staff would take place.

In terms of financial recovery, TL commented that it was important to be clear about the margins of financial risk because it could not be assumed there would be a national resourcing pot to cover all eventualities and therefore, the Trust needed to be clear about the local funds available.

DMc commented that there were block income arrangements from months one to four for patient-related income from the Trust's main Commissioners. A process had been undertaken to identify all the Trust's sources of income.

On the Patient Related Income (PRI) front, there had been a shortfall of around £500k per month and there had been a COVID-19 period shortfall of £1m per month, against the 20/21 budget in the four-month period. However, this would not necessarily translate into a monthly deficit of £1.5m as there were clearly some ongoing costs that had significantly reduced. DMC reported that helpful guidance had been received in relation to how COVID-19 costs should be accounted for, using new templates and spreadsheets. It was no longer a reimbursement process. The Trust's objective was still to break even for the first four months of the financial year.

TL requested that details be set out in a table for the Finance Committee with mitigating actions identified. TL expressed the view that this presented a material risk and needed to be examined in some detail.

ML queried when the CQC would resume its inspection regime and when the Trust would have its next discussion about CQC preparedness. TL responded that further discussion would take place at the July or August Board meeting. There had been no indication of a renewed inspection regime before the end of the year. He noted the detail provided in the papers on this matter.

WZ raised the issue of inequality, ethnicities, and their relation to COVID-19 impact on communities. TL also added gender to the discussion. TL commented that the Trust had applied for all relevant studies in the PHE enquiry and had been contributing its data.

In response to a statement by LK, TL stated that poor and disadvantaged people were less likely rather than more likely to present for healthcare and expressed the view that technology could be helpful.

In response to a query from KT about 7-day acute care for medicine, TL explained that Chetan Varma had put in place rolling rotas of senior consultants and sensitivity would be required to continue the service, taking into consideration the outpatient model and delivery of care and services via technology.

TL reported that a comparison of the number of ITU beds in Sandwell and West Birmingham going back a decade had found it was lower than the West Midlands and national. A renewed investment plan on growth in critical care capability had been requested.

In response to a query from RS about the Board's role in helping message that it was safe to come into hospital in the COVID-19 environment. TL suggested that the Executive be pushed to make more effort into communicating with communities in the coming weeks. The sense that the hospital was 'too busy' had been pervasive in the general public.

5. COVID-19: Risk mitigations	**TB (05/20) 003**

Sandwell and West Birmingham Hospitals
NHS Trust

KD presented the paper identifying risks presented by COVID-19 focusing on the surge phase and the actions the Trust could take to mitigate them. Risk management was being led by the Gold Command workstream.

Risks had been categorised and risk assessed with actions identified. Target scores had been set and the aim was to get the likelihood of the risks materialising to a 1 or 2 score and quickly. KD reported that the paper identified some of the highest rated current risks.

KD stated that the risks that were of most concern were those that were rated 'red' and would remain 'red' following mitigating actions. The following risks were discussed, and the following comments made:

Workforce - Risk one was staff wellbeing and the risk of psychological trauma and harm. Risk two was about staff not taking their annual leave during the crisis and therefore, this presented a risk of multiple absences at the same time later in the year. Mitigations had been put in place in the plan to manage this.

Equipping – The Trust's PPE was currently satisfactory which was a positive, however, future supply remained uncertain and was out of the Trust's control.

Assets – KD reported that the assets had the least current 'reds' but that if other neighbouring organisations had a greater demand for assets, this might impact supply.

Clinical Care – KD reported that this area needed more work. The lead risk was that the Trust could be overwhelmed by the number of patients who had previously avoided attending hospital for care during the peak of the crisis.

Other Events – KD reported that other events covered the risk of another major event occurring and the risk of cyber-attack. There were five [NHS Midlands KLOE] tests which could be done nationally to discover the 'hygiene' of cyber risk.

KD stated that there needed to be good governance around these risk areas over the next few months. The target risk scores would be update weekly and the Board would be advised if any target score would not be reached by 1st July 2020.

ML queried whether there was an increased risk of litigation because of the pandemic. KD reported that it was already accepted that the Trust needed to be in a good position to defend an inevitable number of COVID-19 related claims. The Trust had been launching investigations into COVID-19 related complaints and had been ensuring that learnings were in place. The Trust was already labelling and marking all potential COVID-19 related litigation, including staff claims. ML commented that he was supportive of the work being done.

LK raised the issue of the balance between external, national factors and local factors. LW queried whether the Trust's fragile financial situation should be on the Risk Register. KD commented that DMc and her team had done a piece of work on the financial risks. TL stated that more work needed to be done to add quantification to DMc's work and that would feature in the recovery risks paper in June.

TL emphasised that the Board in these papers was currently therefore tolerating three 'red' residual risks including the PPE risk. He suggested the forward focused needed to be on the difference between the 3 and 2 scores, especially in the equipping issues.

LK responded that the challenge was national versus local. There were things that could be done locally to mitigate the PPE challenge e.g. the testing and swabbing cycle however, this could be impacted by factors outside the Trust's control.

DMc commented that a score of 3 represented that it remained possible to mitigate. The standard of imported equipment etc remained uncertain. DMc reported that she was confident the Trust was currently well placed. DMc requested that procurements should be done through Centre.

HK queried whether the local aid system was working transparently. TL commented that the local aid system had been working fairly well but expressed the view that the system could be better with clearer information about what supplies/stock would be available.

RS queried whether the use of the BTC was a risk. TL commented that it was possible that patients in particular disease pathways, or generally, might be sent to particular institutions and that work needed to be done at an STP level to decide what would be practical and desirable. TL further expressed the view that some communication would be required in relation to zoning and designation.

LK commented that infection control had been put in place at BTC and the bigger risks were about getting patients to come to the hospital.

6. Psychological scorecard	**TB (05/20) 004**

RG reported that the response to the pandemic in terms of protecting staff wellbeing and psychological health had been front of mind for the Trust at both a team and organisational level.

A temporary Wellbeing Team had been established to ensure staff members who called in sick, either with COVID-19 related symptom or other health problem, would get immediate support. RG stated that it would be desirable for the Trust to maintain this service once the pandemic was over or had slowed.

RG reported that activities in the ‘Prepare’ and ‘Active’ parts of three phases of response had been discussed at the People & OD Committee and included the Learning Works and Staff Sanctuary which had been offering services such as meditation sessions and psychological support etc., which had been positive.

The third phase, ‘Recovery’ was about ensuring the Trust was prepared for the longer-term responses to the pandemic and would include the following:

- A Partnership with the March on Stress organisation providing:
  - Train the Trainer – The training of 700 line-managers so they can have a psychological conversation with team members.
  - Mental Health First Aiders - A list of 60 people had been put on the list to respond to psychological stress from around 250 volunteers. These would have around two hours per week to support others.
  - TriM practitioners – An accredited 32-strong team trained to have highly detailed conversations with colleagues.

RG reported that the impact would be measured through SBAF1 which addressed wellbeing. A mental health app would be piloted and weconnect engagement scores would also be taken into consideration.

LW paid tribute to the rapid mobilisation in response to the pandemic and expressed the view that the response plan was excellent.

KD explained that the Recharge Booth programme was a new idea to give an opportunity to tell their stories in a small, safe environment and would commence shortly.

WZ queried whether the Trust was giving any specific support for Muslim staff who had been responding to the pandemic whilst fasting [Ramadan]. RG commented that the link between psychological and spiritual wellbeing was well known and the trust had been working with the Chaplains to ensure people were supported and some work had been done with the Muslim Liaison Group. Prayer rooms had been set up in every 'hot' area, prayer mats had been donated by the Muslim community and a speaking Quran had been made available. The Trust and the community had been providing plentiful food in replacement for the proscribed Iftar gatherings. Guidance had been issued on how to pray in PPE following discussions with local Imams. RG reported that colleagues had been positive in response to the measures and an evaluation would be done at the end of Ramadan.

KT queried how mental health services were being messaged to staff to counteract any misguided stoicism. RG reported that it had been suggested that the annual mandatory health risk assessment check be made online and anonymous to enable staff to be more open and honest. RG expressed the view that the Executive would need to play its part in changing the culture around accepting mental health needs.

HK queried whether there was a Trust mechanism to identify people who were psychologically at risk. RG reported that the Wellbeing Team had been active in following up on cues.

ML queried whether the volume of activity was sufficient and asked how feedback from staff would be captured. RG stated that feelings before and after interventions were being recorded. ML expressed the view that assessing outcomes would be difficult, but the Trust needed to keep working to find an answer to achieve assurance on its initiatives, in effect an impact quantification or evaluation.

TL supported the view of ML in terms of the importance of measurement. TL raised the potential problem of 'returning heroes' where people might come to a realisation that they had participated in something that was less successful than lauded. TL commented that this had the potential to become psychologically disruptive and expressed the view that the Trust needed to be prepared.

REGULAR MATTERS

7. Questions from members of the public	**Verbal**

There were no questions from members of the public, however, RS reported that comments had been received that had been universally highly supportive and full of gratitude for the Trust's teams.

TL reported that live streaming would be considered for the next Board meeting.

8. Patient Story	**Verbal**

PG reported that the patient story concerned a man admitted to hospital from a care home, who had developed perianal abscess. The story had raised concerns about communications with relatives, however, the Palliative Care team had been praised for its interventions.

DC commented that for those patients with complex histories, streamlined communications with relatives was necessary.

TL suggested that a paper on end of life/DNACPR be discussed at the next Board meeting. RS agreed. Live streaming of patients' views/stories would be investigated.

Action: A briefing paper on end of life/DNACPR to be brought to the June Board meeting for discussion.

Sandwell and West Birmingham Hospitals
NHS Trust

UPDATES FROM BOARD COMMITTEES	
9a. a) Receive the update from the **People & OD Committee** held on 24th April 2020. b) Receive the minutes from the **People & OD Committee** held on 27th March 2020.	**TB (05/20) 005** **TB (05/20) 006**
ML acknowledged the support that had been offered to staff through the COVID-19 period. ML also raised the need to refocus efforts on the importance of mandatory training which had dipped towards the end of the financial year.	
9b. a) Receive the update from the **Quality and Safety Committee** held on 24th April 2020. b) Receive the minutes from the **Quality and Safety Committee** held on 27th March 2019.	**TB (05/20) 007** **TB (05/20) 008**
HK commented that many COVID-19 issues had been previously discussed but made the point that the BAME story was becoming a key issue. In terms of the safety plan, compliance remained poor and not where the Board wanted to be. RS stated that mortality would again be discussed at the next Quality and Safety Committee meeting.	
9c. a) Receive the update from the **Estate Major Projects Authority Committee** held on 24th April 2020. b) Receive the minutes from the **Estate Major Project Authority Committee** held on 27th March 2020.	**TB (05/20) 009** **TB (05/20) 010**
RS reported that around 160 people were still working on the design phase of Midland Met. TL reported that he had received a detailed joint paper from the team and Balfour Beatty about how social distancing obligations would be maintained as the number of on-site staff continued to grow over the next six months. TL reported that it was too early to say if there would be any significant delay in opening and guessed that it would be weeks/months rather than years. Supply chains were a risk. TL drew the Board's attention to the invoice delegation agreed by the EMPA Committee to repeat the approval of the invoice delegation arrangements under PFI, which would mean invoices being checked though due process and signed off by TL and DMc. This was agreed by the Board. RS commented that Balfour Beatty had been a positive partner in terms of the wider support they had offered. Further progress had been done on the regeneration agenda and the car parks had been achieved.	
10. Chief Executive's Summary on Organisation Wide Issues	**TB (05/20) 011**
• Noted.	
10.1. Integrated Quality and Performance Report	**TB (05/20) 012**

Sandwell and West Birmingham Hospitals
NHS Trust

DB reported that the Trust had met the Q4 cancer target.

The CDiff reporting now included community cases for the whole year. This was still within the annual control target for what the Trust wanted to achieve.

10.2. Finance Report Month 12 2019/20	TB (05/20) 013

DMc expressed the view that an in-depth review of financial risks was needed particularly to cover transition and the second part of the 20/21 financial year. One of the key risks would be timing the 20/21 performance to the long-term financial model.

10.3. NHS Regulatory Undertakings: Monthly status update on agency and four-hour standard	TB (05/20) 014

TL highlighted new agency controls and stressed it was a regrettable action which would be maintained only for a short space of time. The intention was to reach an understanding of the reasons for expenditure.

11. Application of the Trust Seal	TB (05/20) 015

APPROVED.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS

12. Minutes of the previous meeting and action log	TB (05/20) 016 TB (05/20) 017

The minutes of the previous meeting held on 2nd April 2020 were reviewed and **APPROVED** as a true and accurate record of the meeting.

The action log was reviewed with no updates. Timescales of 'ongoing' actions to be determined.

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 4th June 2020 via WebEx.

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

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

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