TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by WebEx. **Date:** Thursday 1st April 2021, 09:30-13:00

Members:		**In Attendance:**	
Mr R Samuda (Chair, Trust Chairman)	(RS)	Mrs R Wilkin, Director of Communications	(RW)
Mr M Laverty, Non-Executive Director	(ML)	Mr D Baker, Director of Partnerships & Innov	(DB)
Mr M Hoare, Non-Executive Director	(MH)	Ms S Rudd, Assoc. Director of Corp Governance	(SR)
Mr H Kang, Non-Executive Director	(HK)		
Cllr W Zaffar Non-Executive Director	(WZ)		
Prof K Thomas, Non-Executive Director	(KT)		
Mrs L Writtle, Non-Executive Director	(LW)		
Mr R Beeken, Interim Chief Executive	(RB)		
Dr D Carruthers, Medical Director	(DC)		
Mr L Kennedy, Chief Operating Officer	(LK)		
Ms M Roberts, Acting Chief Nurse	(MR)	**Apologies:**	
Ms D McLannahan, Chief Fin. Officer	(DMc)	Mr T Lewis, Chief Executive	(TL)
Ms F Mahmood, Chief People Officer	(FM)	Ms H Hurst, Director of Midwifery	(HH)
Ms K Dhami, Director of Governance	(KD)		

Minutes	**Reference**
1. Welcome, Apologies and Declarations of Interest	**Verbal**
RS welcomed Board members to the meeting. **Apologies:** Toby Lewis, Helen Hurst.	
2. Patient Story	**Verbal**
MR introduced 'Deborah,' a female former in-patient who had been admitted to City Hospital earlier in 2021. She had been suffering from COVID-19 and treated on the NIV Unit. Her story would cover themes such as dignity, lack of communication, DNAR, mixed wards, end of life, food and nutrition and environmental noise. Deborah explained and she and her husband had tested positive for COVID-19 about a week before she was admitted to hospital at the beginning of January 2021. They had both become very ill quickly, but Deborah's condition had continued to get worse with high fever and feelings of suffocation. Deborah acknowledged she should have sought help sooner but explained that she had been afraid for her life. By the time she arrived at A&E, she was critically ill with Type 1 respiratory failure caused by COVID-19 pneumonia. Admitted to the hub ward, she was treated by doctors from both the High Dependency and Intensive Therapy units. She had been fitted with a high-flow, nasal oxygen device which she found very noisy as a user. The ward itself also had extremely loud noise levels from a system designed to reduce oxygen to safe levels. Deborah commented that she struggled to think and to hear the voices of nurses and doctors who were also wearing PPE which muffled speech. She expressed sadness that some patients had died in this noisy environment.	

Deborah had been moved to a small, five-bed, mixed (male and female) ward where she was the only female. This situation had been communicated to her but she had still found this uncomfortable. Noise from her oxygen flow equipment was improved by the wearing of noise-cancelling headphones but there was a lack of space on the ward and a loss of dignity and privacy as a result.

Deborah detailed that she frequently saw naked male bodies and, due to gastric problems and overall weakness caused by the virus, had been forced to use a commode in the ward area where the curtain around her bed station was too short, making her visible to the other male patients. This had been highly embarrassing and humiliating.

Deborah further commented that she had received confusing and frightening messages about her treatment from doctors. She had been asked daily questions about her end-of-life plan - she is 52 years old. Her husband (now at home) did not get any updates from the team looking after her. She reported that he had tried to call the ward, but was told no-one was available. Deborah expressed the view that because of the restrictions around COVID-19, it was essential that channels of communication with families were put in place.

She commended the Trust for the quality and choice of food but commented that little thought had been given to patients with medical, nutritional needs. This had severely restricted her choice of foods and her choices had still sometimes contained gluten and lactose which she had been advised to avoid.

Despite her experience, Deborah thanked the hospital for saving her life and for the compassion and expertise shown by staff.

DC queried post COVID-19 care. Deborah advised that she was on the post COVID-19 pathway and had been visited by nurses. She had been offered a conversation with a psychologist. She commented that having COVID-19 had been terrifying because of the numbers of fellow patients who had died around her. She suggested that psychological therapy sessions by zoom or on the ward might be helpful.

RB raised the issue of consistency of communication and queried whether improvement was possible. DC commented that communication would be a key learning and expressed disappointment that calls had not been made to Deborah's husband and apologised for this experience.

WZ queried whether the Trust could do any more to encourage patients to come into hospital at an earlier stage. Deborah reported that a self-bought oximeter had revealed her falling oxygen levels and credits it with saving her life. She suggested that more coverage of cases where people were ill but had avoided ventilation and had recovered would be helpful in terms of building confidence.

LK acknowledged the nutrition point as being very valid.

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

RS commented that further progress was being made on the Acute Collaboration discussions which would now be clinically led. The focus would now be on governance and resource arrangements to support and accelerate the process.

The pressure to bring back services where the volumes have had to fall away because of the COVID-19 response would need to be carefully monitored. There were now penalties if Trusts did not meet recovery targets, but RS commented that the Trust should not lose sight of the importance of staff taking their annual leave so as to recover from some of the trauma they had been close to long-term, during the pandemic.

RS further commented that great work was being done in many other areas of the Trust, despite the focus

on COVID-19.

HK acknowledged the fact that this meeting would be the last for RS as Chair of the Trust and paid tribute to an incredible contribution (three terms of office). Speaking on behalf of the Board members, he expressed the view that RS had led the Board with great integrity. He further highlighted the deep relationships which RS had fostered across the organisation and with staff over the years and with external communities.

HK also commented that the high performance of the Trust had been partly due to his leadership. HK suggested that RS's lasting legacy would be the oversight of the development of MMUH from its inception to a maturing project.

HK also thanked RS for the support he had given to himself and fellow Board members during his tenure.

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

There were no questions from members of the public.

UPDATES FROM BOARD COMMITTEES

5a. a) Receive the update from the **Finance and Investment Committee** held on 26th March 2021. b) Receive the minutes from the **Finance and Investment Committee** held on 29th January 2021.	**TB (04/21) 001** **TB (04/21) 002**

MH referred Board members to the papers which were taken as read. The following highlights were made:

The Month 11 position and the forecast for the year was most likely to be break even, however, there were several influencing items which were still to be finalised. One of these was the risk share agreement with related Trusts.

In terms of planning for 2021/22, the block payments would continue into the new financial year and this would have an effect, along with the reinstatement of services and re-establishment of the associated treatment pathways.

Planning for MMUH had been discussed with respect to activity plans and affordability. This would be reported into the Finance and Investment Committee (FIC).

MH reported there were several SBAF items which currently had only 'limited' assurance status. These would be closely monitored.

It was noted that the Acute Care Collaboration programme would have an effect on Ophthalmology in particular and this would need to be considered in terms of financial planning.

Positively, the balance sheet had strengthened throughout the 2020/21 period and the Trust's cash position remained strong.

5b. a) Receive the update from the **Quality & Safety Committee** held on 26th March 2021. b) Receive the minutes from the **Quality & Safety Committee** held on 26th February 2021.	**TB (04/21) 003** **TB (04/21) 004**

HK reported that the Committee had discussed the latest COVID-19 position. It was pleasing to note that

infection rates in the community had been falling, reflecting the national picture. Infections in the community were now being increasingly seen in the younger age group, which was another indicator of the impact of the vaccination campaign.

The HSMR had also been discussed because it remained significantly high.

Infection Prevention and Control (IPC) and plans around this topic had also been a focus for the Committee. In terms of IQPR, it had been noted that around 3,000 patients had missed their dates for prioritisation.

HK further highlighted the clinical agreement the Trust had with other organisations for some specialist services which created a reliance in terms of delivery. This was a risk to the Trust if these providers were dealing with their own halts and backlogs.

A piece of technology called the 'Perfect Board' had been discussed. This was an app which would feed real time data into the system and assist with achieving and tracking some of the Trust's KPIs.

RB queried the assurance offered by the current approach to mortality. RS acknowledged there was concern that indicators had been in decline. MR reported that a piece of work would shortly commence to identify focus areas for improvement.

ML queried how often the Committee reviewed the Trust's CQC preparations. HK responded that activities had been updated at most Committee meetings. However, KD confirmed there had been no full report at the last meeting as this had been deferred a month because of the ongoing self-assessment process.

KD also reported that there had been an announcement that the CQC would be stepping up its inspections of organisations deemed either 'inadequate' or as in the case of the Trust had a 'required improvement' status. In the meantime, conversations had taken place with local CQC representatives to gain insight into potential areas of interest and to offer assurance of safe care.

5c. a) Receive the update from the **Estates Major Projects Authority** held on 26th March 2021. b) Receive the minutes from the **Estates Major Projects Authority** held on 26th February 2020.	**TB (04/21) 005** **TB (04/21) 006**

RS reported that progress on the ground [MMUH construction site] had slipped back further by five days. This reflected a combination of pressure on the programme (because of COVID-19 management) and the project reaching the most critical stage. The Trust was working closely with Balfour Beatty to attempt to recover some time, however, this continued to be a risk to the organisation.

A further concern was that the contingency also continued to come under pressure. Two weekly briefings of NHSI had been taking place to keep it ahead of progress and aware of the COVID-19 costs incurred, in terms of managing infection control on-site.

The workforce implications of the new model of care would be a key workstream and focus. FM commented that additional project management resource and specialist analytical modelling support would be required to cope with the scale of work over the next few months, in terms of assisting clinical modelling workshops and to ensure workforce plans were robust leading into the change management process.

FM also reported that some external options were being considered, which could be enacted quickly.

RS congratulated the Regeneration Team for reaching the next stage of funding from the Smethwick

Towns Fund worth £13m for the Learning Campus which was positive news and part of the Trust's ambition to ensure skills were resourced from the local community.

It was reported that the ENGIE FM project would go live in April.

The revised terms of reference had been signed off for the Estates MPA.

MATTERS FOR APPROVAL OR DISCUSSION

6. COVID-19: Overview including vaccination update	**TB (04/21) 007**

RB referred Board members to his report and highlighted the following points:

The community COVID-19 infection incidence rates in the Black Country had been falling – rapidly so in Sandwell borough which had suffered stubbornly high rates for a long period of time. However, there had been an increase in infections amongst school-age people.

In terms of hospital-based services, the only 'red' areas remaining on the Sandwell site were in Acute Medicine. The City site was now the main receiving area for COVID-19 positive patients. De-escalation plans were being refined on a weekly basis.

The hospital [vaccination] hub was being reopened for second doses. RB informed the Board that staff vaccination rates were being collated and data broken down by staff grouping and protected characteristics. This information would shortly be available for Board assurance and action.

RB highlighted the concern around Critical Care occupancy (which at the time of writing his report), was still at over 100% of the normal, staffed, funded baseline. It had only very recently dipped below 100% for the first time since February/March 2020. RB commented that this was an indicator of what the new baseline was likely to be for the autumn and winter which would require reflection in winter planning.

ML queried the vaccine rollout amongst staff (numbers and BAME take up). RB reported these figures were currently being validated but would be shared as soon as they were available. HK further commented that this issue had been discussed by the Q&S Committee and it had been noted that extra effort would be required to connect with the BAME community. He queried whether the Trust had been doing enough.

MR advised that a lot of activity would be taking place across the Black Country throughout April to address both the BAME community, and populations with learning difficulties and autism through special clinics.

WZ queried communication of hospital safety progress, commenting that he knew of constituents in Lozelles who still did not want to go to hospital for treatment for non-COVID-19 related health problems because of safety concerns. RW commented that a lot had been done to message communities throughout the pandemic and this would be re-visited. She also pointed to the work of Community Champions who had been promoting vaccination.

LK confirmed that the referral rate had recovered to around 75% and whilst not up to pre-COVD-19 levels had been improving steadily. Cancer and urgent work had remained the same or above previous levels and there were no concerns about these pathways. MR suggested that a piece of work carried out with the West Midlands Ambulance Service (WMAS) to encourage patients to return to the hospital following the first Wave of the virus, could be utilised again by Community Champions.

7. Planned Care and Recovery Report	TB (04/21) 008

LK reported that the Trust was now on its recovery trajectory and there had been a step up of the Restoration and Recovery Programme.

LK noted that his paper had been written before the release of the National Planning Guidance, however, the Trust's Restoration and Recovery Programme had been found to already be aligned with the guidance and required no change to its focus.

Zero tolerance had been adopted with respect to 104 week waits – there were eight current cases, with seven having a plan of action in place. The eighth case concerned an oral surgery patient who would require a resolution forged between the Trust and UHB which was responsible for the service delivery.

LK advised that the wider recovery timeframe was likely to be six to twelve months because of the large numbers of backlogs affecting both outpatients and inpatients. He advised that the issue would be addressed by the system, utilising a collaborative, prioritisation approach across the Black Country.

Staff wellbeing and recovery continued to be paramount.

The key figures were as follows:

- Production Plan – 75% of activity, 63% of value. National planning guidance was 65% of value.
- RTT – There was an improving position to around 76%. Difficult areas were Oral (no provision), Dermatology and Plastics (staff shortages).
- The DM01 position had been improving and the Trust was in a good position which was currently around 88/89%. The Trust had continued to deliver its diagnostics throughout the pandemic which had assisted recovery. However, there were a few key areas around Cystoscopy which required extra work. Extra sessions were being arranged aimed at reducing the backlog. LK advised that the DM01 standard was expected to be delivered by the end of June 2021 or even by the end of May 2021, which was a positive.
- Clinical prioritisation continued, with the Trust aware of its standing in the system. The Trust and Wolverhampton [NHS Trust] had the largest numbers of P2 patients, but most areas had plans in place for their reduction. It was noted that the Trust had 3,254 patients had been prioritised outside of their prioritisation timeframe. LK commented this had been inevitable given the numbers of patients in each category.

Theatre activity would be stepped up shortly and staff gradually redeployed away from ICU to allow substantive staff time for leave and reflection.

KT queried the arrangements with respect to Endoscopy. LK responded that an insourced company was currently helping clear the backlog, combined with the gradual redeployment of staff.

LW queried whether the Trust was getting the response required in relation to services. LK acknowledged that it was difficult for hospitals delivering oral and vascular services who might only beginning to get back on track. Conversations were ongoing regarding definitive dates which were expected in the next week. However, he commented that any plan would not deal entirely with the backlog. This issue might require further consideration.

HK queried whether there was system visibility of the issue. LK confirmed this was visible from a Black Country STP perspective.

In response to a query from RS in relation to collaboration, LK confirmed that the level of engagement

across the system was high and represented a culture shift.

8. Infection Prevention and Control (IPC) **a) NHSE/I visit action plan update** **b) IPC Board Assurance Framework update**	**TB (04/21) 009** **TB (04/21) 010**

MR referred Board members to the papers and made the following points as follows:

There had been two visits [by NHSE/I] in September and November 2020. Both plans emanating from these visits had been linked and were currently being managed by the Infection Control Committee.

MR had recently met with the Associate Director of Infection Control for NHSE/I to give some verbal assurance on Trust progress and MR had agreed to share the action plan following this meeting. Arrangements had been made to meet on a more regular basis to build the relationship. A further visit would be expected in Q1 or Q2. MR reported that the Associate Director was happy with the verbal update of progress made since November 2020.

Infection prevention would be assisted by the 'Perfect Ward', which would deliver some real time data to focus attention on wards requiring improvement.

In terms of current progress, there were no immediate actions the Trust needed to take as the three original ones had been addressed. MR commented that the Ward Managers and Matrons would be key to implementing the actions and a meeting had taken place with Matrons to discuss a number of issues. A programme for all staff would be launched alongside the Perfect Ward app which would be piloted across four wards from 6th April 2021.

The 'I am Green' tagging initiative had been implemented in relation to cleaned equipment. There was a daily Matron checklist, an ongoing review of the Trust position at IPC Board level and the action plans were in place.

Next steps would include:

- Ensuring all teams were aware of their infection prevention and control responsibilities so that it would become business as usual.
- The first draft of an IPC dashboard had been produced. The dashboard would be presented to the Q&S Committee and Board once it was in operation (within 2-3 months).
- A self-assessment exercise against the Code of Practice for Hygiene was planned.
- A development bid had been submitted to extend the control of the Infection Team from a base of 6.1 FTEs.
- There would be a review of Infection prevention and Control BAF in Q2.

ML queried MR's view of the Trust's current position. MR reported that this was probably currently 'amber'.

KT queried whether the Trust had taken up the offer of a Masterclass from NHSE/I. MR confirmed this would be delivered in a rolling programme over the next few months, along with other leadership material. KT further queried whether there were too many initiatives ongoing. MR accepted this point as valid.

LK queried how an IPC culture could be embedded within working practices. MR commented this would be

reliant on ownership of IPC responsibility on wards and acknowledged there was still work to do.

LW suggested that a targeted, Trust-wide briefing or training session might be useful in terms of setting expectations. MR commented that the focus had been on five key messages for ward teams which would include, but not be restricted to, IPC.

BREAK

9. 2020 Staff Survey: Summary findings	**TB (04/21) 011**

RW introduced the paper and explained that it contained the summary report of the full Staff Survey results which compared the Trust against all Acute and Community Trusts. This served as a better benchmark than initial self-assessment results discussed at a previous Board meeting.

The Trust had fallen slightly below other organisations in almost all areas. Trends over time had demonstrated a broad consistency of scores – being either on average or slightly below average over the last five years with the exception of Equality, Diversity and Inclusion which appeared to have deteriorated over the past two years.

Additional surveys had been undertaken in relation to COVID-19. When ethnicity and disability had been analysed staff, who were BAME or with a long-term condition, had reported generally less positively.

It was interesting to note that staff who had been shielding [from COVID-19] had reported less positively on most measures on average across the staff survey.

RW reminded the Board that when the initial results had been discussed at the February 2021 meeting, the Board had been content to approve three areas:

- Equality, Diversity and Inclusion,
- Health and Wellbeing
- Communication

A fourth had been added around line management development which reflected some of the results around immediate managers and support provided which was not always positive.

The Board had already received Trust plans in relation to the first three priority areas.

In terms of Health and Wellbeing, some actions were already in place, however, RW expressed the view it would be important to further engage with staff to gather views and suggestions. A summary of results had been included in TeamTalk and teams had been asked to consider response and suggestions around the Survey results.

FM reminded the Board that the strategy in relation to Equality, Diversity and Inclusion had previously been presented and aligned resources had been significantly increased. Engagement with key stakeholders regarding priorities over the next six months was currently ongoing. One of the key themes was bullying and harassment in which certain protected characteristics had been over-represented. Significant improvements had been made in this area.

It was acknowledged that extensive work on Health and Wellbeing had been award winning and there was a new focus on health surveillance of the workplace, physical health and healthy lifestyles. An important part of staff recovery would be creating time and space to recover and receive support.

Wider ambitions around talent and leadership development would also be a future focus. There were a significant number of new leaders/managers in the organisations requiring training and support. This would also be an important part of staff retention strategy.

ML expressed disappointment that the [Staff Survey] results had not got better in five years and in some cases had got worse. He queried how the response could be different to make a greater impact and also queried links into the CQC process.

RB queried how managers were being given the expectation that they must generate two-way conversations with team members, including the communication of strategic and corporate messages and the capture of questions in return.

MH queried how the response rate of 38% compared and where it had come from. RW responded that the response rate this year had compared to 39% in 2020, however, in the three years before 2020, the Trust had struggled to get more than 29%. One of the reasons was that previously, only a sample of staff had been involved.

In terms of other organisations, the Trust was lower in terms of response rates. Corporate and desk-based staff members were more likely to respond, with frontline clinicians less likely to respond.

RW agreed that team communication was important and should be linked to the line manager development conversation. There was a need for line managers to understand their responsibilities and for the Trust to make it easier for them to do this through simplification of messaging.

LW agreed that the process needed to be made very simple. She commented that at her previous organisation, a strong connection between staff feedback and action had been successful.

FM commented that the Trust had been braver this time around in focusing on a smaller number of things and in focusing on co-design of the process with staff. She expressed the view that the infrastructure in the Trust was not in place to effectively support staff engagement and therefore, staff saw the survey as a mere add on to their jobs. FM commented that it had been evidentially proven that middle management could be a barrier because managers were bombarded with so many requests.

KD flagged that the Staff Survey information would feature in the CQC's Insight Report, where the Trust would be compared to others and ranked. Along with other issues, this might flag to the CQC that the Trust required scrutiny. KD raised the question as to why staff were not speaking up and reminded the Board that internal surveys used to be done more regularly.

ML commented that the issue needed focus and resource and supported LW's comment that communications with staff would be critical to improvement.

RW reported that it was important for the Board to note that it was a requirement for organisations to do a quarterly survey as part of the People Plan. This would give the Trust an early indication of how things were changing (or not) throughout the year.

FM commented there had been a high level of turnover in middle management and many new managers would require support and development, creating open channels of communication for issues and problems to be expressed.

DC commented there were fewer opportunities to connect with consultant staff because of different ways of working and changing environments. New ways to connect would be required.

RS agreed that a summary of the discussion about the Staff Survey and a planned approach for future improvement be brought to the People and OD Committee.

Action: RW to prepare a summary of the discussion about the Staff Survey and a planned approach for future improvement for discussion and monitoring through the People & OD Committee.

10. Maternity Services Report	TB (04/21) 012

MR introduced the Maternity Services report and highlighted the following:

Maternity Dashboard and Maternity Quality Improvement Plan

MR reported that a downward trend had been observed with respect to the birth data which was not unusual for the Trust. The predicted COVID-19 baby boom had not materialised.

A piece of work had been undertaken to try to ensure that the Trust would become the first choice for pregnant women, utilising the opening of MMUH as an incentive.

The Trust's Caesarean section rate continued to be at the national average level. All cases were reviewed on a regular basis. There had been two stillbirths in February 2021 and perinatal mortality remained slightly higher due to the low number of births. The 72-hour reviews had not identified any new trends, themes or gaps in care.

The neonatal data had been added to advise on identified bed days and term admissions.

There were a number of vacancies in community midwifery compounded by staff maternity leave which had been causing staffing issues and a backlog in ante-natal booking. A business continuity plan had been put in place to map out activity over the next four weeks. Matrons and Senior Managers would be completing a triage process on a daily basis to ensure high risk women were seen appropriately.

MR had attended a Listening and Action session for Maternity Services where these issues were discussed further along with feedback surveys that had been undertaken with staff in November and December 2020.

Over the coming three months, an outside company would complete further surveys with teams and with patients. Further training would be undertaken under different themes. The Trust had agreed to be the second Trust to have LMNS reviews.

Discussions were ongoing with NHSE/I in relation to acquiring an improvement midwife for further support. Funding had been secured to appoint a Diversity and Inclusion Midwifery lead in a pilot scheme.

DC reported that many improvements were already in place before the Ockenden Report had been published. He expressed the view that the key point was in culture and dispelling or mistrust between departments.

MR and HH would shortly meet with the Regional Midwifery Officer to talk about progress in relation to the Ockenden Report.

HK queried whether the Trust had undertaken any work to understand why women were choosing to give birth elsewhere. He also queried why the Trust was losing midwifery staff. MR reported that work on birth choices had been done but would be continued by Debbie Graham on 19th April 2021 to capture what women wanted. MR explained that many women received ante-natal care with the Trust but chose to give birth at the specialist Birmingham Women's Hospital and the focus would be to retain these patients.

There were issues around staff retention fairness, listening and culture with the biggest topic being a perceived failure of leadership. 21 student nurses would join the Trust shortly.

RB queried why admissions to neonatal had been falling towards the regional mean. DC commented that national policies and processes had helped and the changing use of antibiotic treatments had led to lower numbers of patients/babies requiring respiratory support.

LW queried whether the Trust had a recruitment initiative given the number of vacancies. She also

commented that some feedback was that the service was too hierarchical and was unfair to highly trained staff that wanted to work part-time. MR agreed this point had been reflected through staff discussion sessions and pointed to leadership as being part of the problem. In terms of recruitment, FM reported that there were a number of approaches in place. Pleasingly, a flexible working agreement had recently been signed within the STP to ensure that vacancies would be advertised on a fully flexible basis with the primary aim being that this would be governed by a centralised rostering system.

RS commented this was an area of national concern. He requested that a report be presented to Q&S Committee.

The NHSE/I response to the HSJ report was noted.

Action: MR to report to the Q&S Committee on the Maternity Services recruitment, culture and flexible working arrangements.

11. Finance **a) 2021/22 Financial planning round** **b) 2020/21: Month 11**	**TB (04/21) 013** **TB (04/21) 014**

DMc reported that confirmation and planning guidance had been received of block income for the first half of the financial year (through to the end of September 2021).

The planning guidance had been clear on its objectives, focusing on the health and wellbeing of staff, the vaccination programme, ongoing COVID-19 pressures, restoration of elective and cancer care, managing health demand with very strong focus on local health outcomes, transforming community and emergency care and working collaboratively.

The financial value of the block for the system was known and it was expected there would be enough money in the system for the Trust to achieve a breakeven position. However, this would be reliant on the Trust's ability to reduce some of the more extreme COVID-19 costs which had been seen in Q4, i.e. enhanced pay rates.

A route to exit some of the enhanced pay rates had been determined and the extensive food support package would be phased out.

There was additional funding (over and above the block) for the Ockenden Report response, however, how this would be delivered was currently uncertain. The Elective Recovery Fund was also available (over and above the block). The Trust could start to earn 85% of its 19/20 values in terms of activity month on month.

DMc reported that specific items for the Trust would be:

- The H1 block was expected to be what was reported for Q3 20/21 in terms of actuals (around £148m per quarter of income). DMc suggested this would be enough and would give the Trust headroom providing Q4 costs could be reduced.
- The Maternity rebate might now be assumed. However, whether there would be relaxation of the criteria to enable this was uncertain because of COVID-19.
- Funding would need to be created for ENGIE
- A funding for the step up on taper relief would need to be found.

There was a risk over the uncertainty of funding beyond the block which would emphasise the importance of CIP delivery.

Controls on agency spend and the funded bed position continued to be important.

A list of cost pressures, risks and developments had been drawn up with input from Directorates and Groups which had been socialised with CLE. The list of £24m of planned developments was still very much desired and, in some cases, badly needed.

The plan was to work with each Directorate and Group to mitigate and manage the spending plan and manage the costs pressures and risks. This would involve risk assessment of the likely income position and identification of reserves in the current plan which were not committed, thereby maintaining a route to breakeven and creating a value pot for investment. It was hoped this could be considered by the CLE in April 2021.

The local STP had put forward a plan rejecting internal local investment. DMc expressed the view that investment would reasonably be required in quality and safety. She suggested the Trust undertake a careful, risk-assessed process. Discussions would continue with STP and CCG colleagues about how to create a route to investment.

RB observed that the Trust wanted to become the best Integrated care organisation in the country, but this would require investment beyond what was already in existence. He queried how extra headroom could be found. DMc expressed the view that the opportunities through the BCF in Sandwell were encouraging.

In terms of Taper Relief, NHSE/I was very sighted on the Trust's Taper Relief plans

Capital

DMc reported that the draft Capital Programme had been reviewed by the Finance and Investment Committee (FIC) at its previous meeting. Submission of the Capital Programme was expected on 12th April 2021.

An STP/ICS Control Total had been confirmed but discussions were currently ongoing as to the amount due to an agreement with NHSE/I. its status was unclear which would impact on the system's ability to submit a balanced plan. DMc informed the board that the draft Capital Plan for the Trust was c£23m.

LW queried the impact on services for next year given the cost pressures and risks. DMC reported that in the first six months there would be a CIP efficiency requirement of 0.28% which was negligible. DMC commented that it was not expected this would need to be passed onto teams. DMC further expressed the view that this was deliberately low to enable restoration and recovery.

REGULAR MATTERS	
12. Chief Executive's Summary on Organisation Wide Issues	**TB (04/21) 015**

RB referred Board members to the report which was taken as read. The following was highlighted:

Staff opinion concerns and recovery (discussed earlier in the agenda).

RB commented that as the organisation's strategy was refreshed in the coming months, the wellbeing of staff would be the key priority with some differential action taken.

He suggested that a refreshed, simpler set of organisational values might be part of this process.

In terms of the Acute Collaboration project, the first Programme Board had now met and had set out and agreed a process of clinical engagement to determine initial priorities. The Trust had committed to being a committed and open-minded partner in this process and the case for change was much more clinically focused

The Health Service General Awards had been a huge success for the Trust with wins in the Sustainability Award category and the Alcohol Team and Dr Sarb Clare receiving 'highly commended' nominations in other categories, which in difficult times was a fillip for the organisation.

The Integrated Care System Accreditation was going live as of 1st April 2021. The Board would need to consider how it could delegate authority and also be accountable to the State. He suggested this would require careful consideration.

12.1 Integrated Quality & Performance Report	**TB (04/21) 016**

DB referred Board members to the paper and highlighted the issue of re-admissions.

DB explained that the figure of 11.3% was the January 2021 figure and tallied with a COVID-19 peak. A figure of 9.6% would be reported for February and the Trust was tracking around 9.8% for March.

In terms of the PCCT wards, there had been no increase in the 'amber' areas but an increase in 'red' areas. There had been some slight worsening in Surgical Services around general and specialist surgery and Ophthalmology. Tammy Davies had indicated that one of the reasons could be the redeployment of staff to support the COVID-19 peaks, but some root cause analysis had been undertaken.

DB clarified there had been two Never Events which had been discussed at Q&S Committee but had been reported in the papers of different months. This would be amended.

In response to a query from RS, DB reported that the readmissions figure had been tracking at around 8.4% pre-COVID-19 with an ambition to reduce the figure to 7.57%. However, some progress had been made.

HK commented that it appeared that numbers would be on track if COVID-19 could be taken out of the equation. DB responded that this would be a reasonable assumption if the increase could be attributed to the 'red' wards.

LK reported that the Trust was working towards the national average of 7.5%.

12.2 Trust Risk Register Report	**TB (04/21) 017**

KD reported there were three items of focus in the monthly risk report as follows:

Risk 534 - The lack of UHB oncologists attending MDT meetings.

- KD reported this had been resolved through the use of WebEx and recommended its removal from Board oversight. The situation would be monitored locally.

The Board **APPROVED** the risk's removal from Board oversight.

KD further reported that the groups had identified their own 'red' risks. However, following review by the Risk Management Committee (RMC) it was felt that the risk statements required more work. These would be brought back to CLE and the Board.

The MMUH work on risks had been presented and would be received by RMC for regular review.

DMc highlighted that a 'red' risk in relation to MMUH affordability related to construction and not the MMUH business model. The Trust was planning to report against it through the MMUH Strategy Board and through FIC.

13. Never Events	**TB (04/21) 018**

DC reported that two Never Events had occurred in quick succession, both relating to the same issue – the use of air when oxygen was intended to be used for patients. One had happened on ITU and the other on the Acute Medical Unit.

For context, DC explained that there had been previous national safety alerts in relation to this issue because of the risk of patients not getting the oxygen required. DC reported that no harm had come to either of the patients concerned because the issue had been identified early and rectified.

All air outlets were meant to have a removeable flap as an additional safety mechanism to indicate to the user that air was being connected for nebulised therapy. This had not happened on the two occasions. In one of the episodes, the flap was in place, but the tubing was incorrectly connected and in the other case the warning flap had been removed from the air outlet meter.

DC reported that an immediate check had been made on all the wards containing flow meters, to ensure the safety flaps were in place. Where they were not in place, the flow meter had been removed and the outlet plugged. The flow meters would be kept in a separate place in the ward to be fetched when required to reduce the risk of error.

Full reports into the incidents were awaited.

HK reported that it had been commented at Q&S Committee that the two outlets were the same colour (both black) and suggested the easiest solution might be to make them different colours. MR confirmed that they were manufactured in the same colour but that different coloured caps were available. These were being sourced and also for MMUH. MR commented that it was an easy mistake to confuse the two flows if the caps were not affixed.

RS queried the role of hospital engineers. MR reported that the team conducted an annual inspection which was reported to the Medical Gases Committee. However, MR commented there had not been enough medical representation on the Committee and reports were not being shared further.

FOR INFORMATION/NOTING

14. Application of the Trust Seal	**TB (04/21) 019**

The Board **APPROVED** the items listed on the Trust Seal

15. 2020/21 Declarations **a) Register of interests** **b) Fit and Proper Person**	**TB (04/21) 020** **TB (04/21) 021**

SR confirmed that the Register of Interests had been fully updated and had been published on the website.

Checks for fit and proper person had included general internet searches, bankruptcy, insolvency searches etc., according to Company Secretarial practice.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS	
16. Minutes of the previous meeting and action log To approve the minutes of the meeting held on 4th March 2021 as a true/accurate record of discussions, and update on actions from previous meetings	**TB (04/21) 022** **TB (04/21) 023**

The minutes of the previous meeting held on 4th March 2021 were reviewed and **APPROVED** as a true and accurate record of the meeting.

The action log was reviewed with the following updates made:

- *TB (08/20) 010 - Reach out to CCGs to investigate whether GPs are carrying out separate patient stratification work.*
  - LK reported that GPs conducted general stratification work and had not done anything different under COVID-19. It was agreed to take the issue to the ICP. **Completed.**
- *TB (12/20) 001 - Provide an update to Board on Freedom to Speak Up resource enhancement (administration support and additional Guardians)*
  - KD reported that the Guardian post had been signed off, but the funding was still to be found. RS requested this be accelerated. KD reported that funding should be signed off in April.
  - KD to confirm sign off to the Q&S Committee.
- *TB (12/20) 001 - Prioritise the Equality, Diversity and Inclusion action plan to identify key projects on which to focus and any scope to achieve quick wins. Articulate short-, medium- and longer-term expectations.*
  - **Completed.**

Action: KD to confirm funding sign off for the Guardian post to the Q&S Committee.

MATTERS FOR INFORMATION	
17. Any other business	**Verbal**

None discussed.

20. Details of next meeting of the Public Trust Board:	**Verbal**

- The next meeting will be held on Thursday, 6th May 2021 via WebEx meetings.

Signed …….

Print …….

Date …….