Paper ref:	TB (10/21) 021

Sandwell and West Birmingham Hospitals NHS Trust

QUALITY & SAFETY COMMITTEE - MINUTES

Venue: Meeting held via MS Teams **Date:** 27th August 2021, 11:30-13:00

Members:

Harjinder Kang	(HK)	Non-Executive Director (Chair)
Kate Thomas	(KT)	Non-Executive Director
Lesley Writtle	(LW)	Non-Executive Director
David Carruthers	(DC)	Medical Director
Kam Dhami	(KD)	Director of Governance
Liam Kennedy	(LK)	Chief Operating Officer

In Attendance:

Sarah Carr-Cave	(SCC)	Deputy Chief Nurse
Parmjit Marok	(PM)	GP Rotton Park Medical Centre
Lakshmi Thirumalaikumar	(LT)	Consultant Obstetrician
Dave Baker	(DB)	Director of Partnerships & Innovation

Minutes	Reference
1. Introductions [for the purpose of the audio recorder]	**Verbal**
Chair Harjinder Kang (HK) welcomed Committee members and attendees to the meeting.	
2. Apologies for absence	**Verbal**
Apologies were received from Mel Roberts, Helen Hurst, and Chizo Agwu.	
3. Minutes from the meeting held on 30th July, 2021	**QS (08/21) 001**
The minutes of the meeting held on 30th July 2021 were reviewed. The following amendment was noted: • DC requested that on page 3, "A 10% vaccine uptake" should be "A 10% vaccine increase". The minutes were **ACCEPTED** as a true and accurate record of the meeting, subject to the amendment.	
4. Matters and actions arising from previous meetings	**QS (08/21) 002**
Progress in the gynaecological oncology area was queried by KT. LK reported that they had effectively created a specifically dedicated PACU-type area within ICU by releasing reservists from theatres. They were in discussions to further increase capacity to reduce the backlog of patients. There were no actions arising from previous minutes.	
4.1 Feedback from the Executive Quality Committee and RMC	**Verbal**
KD reported that the Executive Quality and Risk Management Committees had discussed the following	

points:

Executive Quality Committee (EQC)

- **Safeguarding:** Levels of compliance standards were not where they should be. Tammy Davies was now leading this work. She had presented an action plan. This would also be an area of focus for the CQC.
- **Pharmacy audits:** The latest audit results of controlled drugs and the handling and storage of medicines were discussed. Direct discussions about this were planned with Group Directors of Nursing, Matrons, and Ward Managers. Some wards were below the 75% compliance standard whilst others were doing well.
- **Patient nutrition and hydration:** They discussed further work required following complaints.

Risk Management Committee (RMC)

- People & OD had reported their 'amber' and 'red' rated risks, which they had discussed.
- One of new Board metrics was around the oversight of risk mitigating actions. They had good risk identification but they had identified that overdue actions that were not being mitigated.

HK queried the themes around the reasons behind the nutrition and hydration issues. SCC reported that the Nutritional Steering Group had benchmarked themselves against the new National Food Standards document. The benchmarking showed that they were partially compliant with some elements where actions were in place to raise standards. Three sub-groups for the core areas of focus, including oral hydration, had been set up. All their policies were being reviewed and updated. They were creating a Trust strategy for nutrition and hydration, led by MR. They were taking quarterly reports to the EQC.

DISCUSSION ITEMS	
5. Gold update on COVID-19 position, including vaccine update	**QS (08/21) 003**

LK reported that the increased rate of COVID admissions had continued. He highlighted the following points from his report:

- **Community rates:** The graph showed that COVID community infection rates within Sandwell had spiked just prior to the national government easing of mask wearing and restrictions. Where the reduction was shown, this needed to be caveated by the 50% reduction in the number of tests being carried out. They had been using community infection rates as a predictor of ICU and hospital admission rates but now it was unclear whether these rates were a true reflection.
- **In-patients:** The number of in-patients had remained fairly stable but significant over the past two weeks. Around 13% of the organisation were COVID-positive. This was by far the highest proportion of COVID patients per bed in the Midlands region.
- **ICU:** For the last two or three weeks, they had been over 125% in ICU. Their influx had begun before others in the region, who had now caught up, creating significant pressure on ICUs across

the Midlands. Nottingham and Leicester had subsequently become worse than the Black Country. They were struggling with transfers out of ICU now as a result. They had deployed further reservists into ICU, in addition to those for gynae-oncology, allowing them to expand above 125% in ICU. For the best part of 18 months, there had been over 100% occupancy. The team were doing a great job but the challenges on this department had been recognised. They were providing as much support as they could.

- **Point of Care Testing:** They had been pushing for national allocation of additional analysers and kit to be able to accurately depict what patients were coming in with COVID. The analysers had been delivered three weeks after agreement from the national stock supplier.
- **Staff LAMP testing:** Weekly reports showed their rates of testing were on par with other Black Country organisations. They had been ranked the highest at one point.
- **Vaccinations:** City Hospital were taking walk-ins and bookings. Vaccination levels were at just over 81% of the organisation. They continued to push the message frequently.

HK queried the true community infection rate. LK estimated that it was plateauing, or reducing at a slower rate than the curve suggested, based on the ICU numbers regionally. Conversion from general admission into ICU was greater than before. Previously this had been 9% to 10% but they were up to 15% conversion. This was a significant change in the proportion of patients needing ICU intervention.

DC added that the fall in community infection rates appeared to be in the lower age band. He predicted that the return to schools would have an impact. 10% of those vaccinated were at risk of coming into hospital. The number of hospital admissions they had had dropped below 80 patients when he had checked this today. The changing population density and the exposure rate was affecting rates, such as in Cornwall after holiday periods and festivals.

They had agreed to take on vaccinations for extremely vulnerable 12 to 15-year-olds at the City Hub. They were waiting for a final check from the paediatric department that they were happy with the processes in place before they began. The strategy for boosters was slightly unclear at the moment. They were getting boosters and flu vaccines provisionally ready for staff and in the community at Tipton. They were considering pop-ups and ways to provide vaccinations in West Birmingham. All 12 to 15-year-olds were likely expected to be vaccinated in the schools, with processes being reviewed.

DC commented on the influx of refugees from Afghanistan into Birmingham that would put a strain on primary care and maternity services because of pregnant women, unaccompanied children, people with chronic illness, and unvaccinated people. Evacuees from terror attacks and the implications of patients coming to UHB would add pressure to ITUs. Locally, it would affect being able to move patients around. LK agreed that this would have an impact on the System and on the region. The pressure on UHB would have an impact on the neighbouring Trusts, especially City Hospital, being the closest. They needed to factor this into their planning.

LW queried whether LK thought there was anything more that needed to be done to support staff. LK reported that they spoke to staff regularly and asked for their feedback about what the organisation could do to support them. Generally, everything staff had highlighted was what they were already doing,

such as mental health support and decompression of the unit when they reached certain levels. They had pushed for regional transfers and moved patients to respiratory support units and then out into other areas of the organisation where possible. They had wellbeing offers such as water, food, ice-cream vans, generous offers, and additional days of leave as a thank you for staff's response over the last period. They tried to assure that leave was taken and that wellbeing hours were attended weekly. The sanctuaries were up and running, and reaching out internally.

They had put in a case for additional funding into the regional ICU team before COVID, when they recognised that they had a lack of critical care provision for their population. They had resubmitted two subsequent bids after COVID. It was only ever agreed in principle that this was right. They needed to increase their critical care capacity so that they staffed for a more appropriate level. He welcomed NED support in this field. LW suggested they could speak to the Board.

SCC commented on the influx of refugees coming in on flights to Birmingham. She had been on a regional Black Country West Birmingham call that morning about how to manage their health concerns. This was having an impact on Safeguarding teams.

HK queried the numbers involved. DC had been told that there were six flights a day of 200 people being quarantined in hotels before being housed. People with serious injuries and ailments were being stabilised at a stop off point in Dubai. He wasn't sure about the medical repatriation plans for people.

Item 6 was reported after item 8.

7. Safe staffing and workforce update: nursing and radiology	**QS (08/21) 005**

SCC took the report as read and summarised the following key points:

- During July and August, they had had an increased dependency on temporary staff to support the 'red' and 'amber' COVID pathway streams, combined with sickness and vacancy rates.
- They used a Quality Impact Assessment tool that RAG rated their staffing areas and articulated what actions should be taken based on the nationally recommended staff to patient ratios.
- During daily staffing meetings chaired by a senior nurse, they looked at in-patients and community beds, highlighted hotspots, and made sure they had robust plans in place for shifts.
- Over June and July, they had 95 internationally recruited nurses join the Trust. By October they should have gone through the OSCE process and have their NMC registration.
- A further 76 newly qualified nurses would join in September.
- By the end of October, they would nearly be into an over-establishment model. For Medicine and Emergency Care, they would have just under two full time RN vacancies.

LW queried what extra measures they had in place to support these recruits in order to retain them. SCC assured her that they were focused upon this. They had recruited a senior nurse post that provided pastoral support to help with induction and to meet and greet each intake. The Practice Development Nurses had also been engaged to support them. Senior Nurses were monitoring this carefully.

LW added that social support was also important and learning to live in a new environment. SCC reported that they were providing help with setting up bank accounts and finding accommodation. They built peer support by coming in as cohorts. They went through the induction process together and established links. They hoped that their approach would have the positive impact they planned.

HK queried what they were doing above and beyond to be competitive in the market, given they had 19 radiographer vacancies, or if they were relying on temporary staff. SCC reported that Imaging had put a lot of focus on recruitment, which seemed to be paying off. There was a national shortage.

HK queried whether they were adopting innovations in radiography such as remote assessments. DC reported that studies were ongoing with IBM to provide reassurance or first looks at mammography images or breast ultrasound to reduce radiographers' time and reporting. Radiologists' time could be reduced particularly in lung imaging for safety checks and missed pathologies. They were looking at new technology for certain groups of patients but this was still in the research stage.

8. Board level metrics and IQPR exceptions	**QS (08/21) 006**

DB referred Quality & Safety Committee members to the shorter paper on the new Board level metrics and described the following points:

- They had built this in line with NHSE/I's 'Making Data Count' group, using their charts, colours, and symbols. This was all in line with the regulators.
- The Making Data Count group worked with over 130 Trusts. They had taught his team the term 'spuddling'. This happened without SPC [statistical process control] charts when a metric moved and someone ran off to investigate but it wasn't significant, so it was a waste of time. Time was too precious, so it was good to get rid of spuddling.
- Page 3 showed a final set of 17 metrics they agreed on and the right way of displaying them. They could be expected to change a bit but there were some fundamentals that wouldn't change. They needed a process for adding and taking away metrics.
- Slide 4 showed what the pictures meant. They described what was statistically significant, such as having six points above or below the mean or going one point outside the massive variation.
- They were regularly passing only one metric without any special cause variation: the E-coli metric. There were a number that were hit and miss. Therefore, they hadn't created a process that was stable enough to consistently deliver. Some they were regularly failing at, even if they were in the top quartile. Some had no target and would be picked up through PMC in due course.
- Page 6 showed the HSMR [Hospital Standardised Mortality Rate]. The graph showed peaks caused by COVID. None of them looked like they were significant variations. Significant variations were done against the mean, which was running at just over 140%. HSMR didn't have significant variation but it was still running 40% above their target. In the latest section, HSMR had improved to the lowest point it had been for some time.
- SHMI [Summary Hospital-level Mortality Index] hadn't been affected as much by COVID. Throughout COVID, SHMI had stayed within common cause variation.
- The C. Difficile graph in slide 7 had significant variation outside its control limits in May 2021. This was explained below as being due to antibiotic usage, identified following a post-infection

review. They had understood the variation and the cause, put in the corrective action, and it hadn't happened again since.

- E-coli showed the target line at the top between 9 and 10. They had a period of time where they had seven points above the mean, which was significant variation. They had since got this back into its control limits

- MRSA Bacteraemia had a target of none. This probably showed the wrong graph because they had so few events. This should go into the exception report.
- Safe staffing had not yet been built.
- Page 8 showed patient safety incidents but they didn't have a target. Until July 2021, they hadn't had any significant variation.
- 'Patient safety incidents moderate harm' showed the impact of COVID wave 3. The reason why there were no peaks in the first two waves was that in November 2020 Trusts were asked to report hospital-acquired infections as safety incidences. They hadn't been recorded before that period.
- In April 2021, a spike of Serious Incidents had been reported, but this wasn't when they actually happened. Those 65 or 66 incidents would have been spread over the previous months. It would be smarter to know which months they fell in so they could be linked to things like low staffing levels. They needed to show the dates when they happened instead of when they were reported.
- The Friends and Family graph showed that they were consistently off their target. Response rates showed statistically significant variation as they dipped over nine months consecutively. They had work to do there.
- The Emergency Care 4-hour standard moved around and correlated to the graph below it. As they had less attendances, performance had gone up until recently. Whilst their performance was going down, it was also important where they stood in the country. They had data beyond March that would be in the Board report. They were 65th out of 135 in May. Over the last few months, they had moved up the country's ranking from 118th to 109th to 92nd to 81st to 65th. That team was doing well compared to others, albeit that they would like it to be better for their population.
- 62-day cancer showed in June 2021 that they had fallen dramatically. They had actually improved their performance against the rest of the Trusts in June compared to April and May. They were 118th out of 136, whereas in April and May they had been 131st and 132nd. This was a significant variation but everyone was struggling.
- With RTT, it showed that they were hitting about 92% before dipping far enough to affect the mean. Once the mean had reset itself, they achieved positive statistical significance by being above that mean for a significant number of data points. They had brought stability back to RTT, even though they weren't at the target they wanted to be at.
- Emergency readmissions peaked during COVID as well. They hadn't established a target yet but it was getting better.
- Sickness was usually talked about as a percentage rate. This graph showed it by days lost to sickness absence. It was notable at 13,000 days a month lost. Data points were within control

apart from COVID peaks.

- Their staff turnover rate had gone through a statistically significant shift from October 2020 to March 2021 with 6 points below the mean. It had subsequently moved around again.
- The risk mitigation graph showed where they were setting goals and then not hitting them. Their missed risk mitigation days were climbing.
- Better payment practice had improved. They were getting close to their target and had a number of points above the upper control limit.
- The CIP plan graph showed data points showing the difference between that month and the target for that month. From April 2020 to March 2021, they had been missing targets by about £1m per month at times. They had been carrying a target of about £25m that they had no chance of hitting when COVID hit. They did well to achieve about half of that. This year, they had been missing targets each month but then it jumped up after June to hit the CIP target within month.
- The graph on the top right showed that despite the fact that they were missing the CIP target, they were performing better than plan. There were a number of points above the upper control limit.
- SPC was not thought to be the right type of graph to show the underlying deficit and the previous two financial metrics. They were looking for alternatives.
- The last page replaced the old front-page IQPR summary of exceptions for discussion. They had talked about ED performance but they were also seeing longer waits in the department. Their median wait post DTA had gone up in comparison to others.
- The 62-day cancer had recovery plans but they hadn't factored in the backlog they had to clear.
- The mixed sex accommodation report was being worked on. It was hoped to report next month.

HK thanked DB for walking everyone through the report in its easy-to-digest format. He queried how to know if there was spuddling in the exception report. DB explained that they should explore statistically significant variations. If something jumped a huge amount, going outside the control limits, or had six data points above or below the mean, the cause should be understood. Otherwise, it should be left alone and perhaps noted when it got to four or five.

KT voiced her approval for the new presentation style and her appreciation for their perseverance. DB explained that they had looked at other people's and the part they had added was dialogue boxes. These could be changed but the graphs were aligned to the Making Data Count group.

LW observed that the report was easier to read. Anomalies like Serious Incidents (SI) were eye-catching but they needed to get cleverer at explaining the reasons why. The serious incident graph left her with questions. This report would help them to anticipate problems to become more proactive. DC explained that the peak in the Serious Incident graph was due to a reporting requirement. This was a retrospective look at hospital-acquired COVID deaths. These had already been looked at and reviewed. In the background was the process of SI review by the Group and then by DC, including the action plan. Wider learnings were followed up through EQC. SI summaries were presented to the Board every six months.

HK thanked DB and looked forward to receiving these reports on a regular basis.

6. Planned care and recovery report	**QS (08/21) 004**

LK referred Committee members to the paper and highlighted the following points:

- COVID had had an impact on their planned care and recovery timescales. They were trying to maintain as many services as possible. They already had backlogs that they didn't want to make worse. They also wanted to address time-sensitive conditions that needed surgery.
- They continued to have safety nets around patient stratification and the Harm Review documentation completed on Unity for patients that had waited longer than necessary.
- P2 was the highest stratification at 28 days agreed time allocation. There were no P1 classifications because patients went through emergency surgery as and when. With the exception of some gynae-oncology, the remaining P2 breach patients had been reduced in all other areas except for Ophthalmology. The challenge was that no limited Independent Sector Providers (ISPs) could support with any outreach due to the complexity of the cases.
- They had secured one outsource provider and three insource providers who were able to support them to clear the Ophthalmic backlog. This was modelled for the end of October. The outsourcing contractor operated outside of BMI, their elective eye clinic, as a consortium of consultants that also worked for SWBH. Modality, Medinet, and a limited company of consultants that previously worked for UHB were the three ISPs that would be insourcing.
- They had looked at all different ways to try to tackle the Ophthalmic backlog, including discussions with NHSE/I's regional team who was reviewing the complexity of their cases. They had reached out to the Medinet seven tertiary providers nationally to see if they could offer support.
- They no longer had any 104-week wait patients. They were down to a handful of patients over 90 weeks. Long wait patients were being prioritised along with P2s.
- As a System, Walsall and Dudley had also cleared their 104-week waits. There was some work to be done across the System to support Wolverhampton, who still had over 160 to clear. They could see a slight reduction in their 90-plus as they worked together as a System to ensure that patients had adequate care, regardless of which provider they were currently listed with.
- They had achieved their ERF [Elective Recovery Fund] forecast for the first quarter of the year, earning £5.2m of ERF funding. This would require careful consideration around investment in sustainable improvements. They hadn't achieved ERF in July and wouldn't in August because parameters had been changed up to 95% delivery from 85%. Most organisations were struggling to deliver against this, so ERF funding had pretty much halted.
- RTT performance had standout specialties that remained concerning. One was Oral Surgery, which hadn't been provided by UHB for some time. They were looking across the Black Country for where this could be provided.
- Dermatology had been a source of challenge for 2-week waits and RTT. This had been resolved with a mixture of in-house and external support into the Dermatology department. They had cleared 2-week wait backlogs and were back to 10 days. Their RTT position had moved from 30%

to 70% in the last six weeks. Sustainable solutions were being investigated.

- They had been asked if every patient within the Ophthalmology backlog had been risk assessed and that they could assure that no harm had come to them. They could not give 100% assurance of this. They had done what they could by stratifying surgical patients into P2, P3, and P4 categories and dating these as close as they could to these parameters. Any patient coming in for a diagnostic or out-patient had a harm review. Deteriorations of care were escalated by bringing them in for urgent appointments. There were too many Ophthalmic backlog patients to categorically say that they weren't having deterioration of sight in some way.

- There had been reviews of other Ophthalmic departments within the System where significant sight deterioration or loss had occurred. They hadn't seen any of this so far with patients that had come in.
- They had just commissioned their Friends and Family provider to support them with a widescale waiting list validation starting with Ophthalmology. All patients would be called and asked whether they had had their treatment done elsewhere, if their condition was deteriorating, and if they were happy with the wait time they were currently providing. This would provide more assurance.

PM queried progress on the 2-week waits, because the figures she had seen a couple of months ago had been stark, especially around Breast. LK acknowledged that they had had a significant backlog a couple of months ago for Breast, Dermatology, and Haematuria. Breast was booking to day 12. Dermatology was booking to day 10. Backlogs had been cleared for both of those. Haematuria was still booking to day 23. They had an outsource provider supporting them in September. They predicted that Haematuria would be back within the 14-day standard by the middle of September. They didn't predict that any of these would go off of their 14-day target going forward. Patients back in April and May had been waiting 60 days for their first two-week wait appointments, creating a backlog that then affected performance while backlogs were cleared.

9. Maternity Dashboard and Neonatal Data Report	**QS (08/21) 007**

LT took the report as read and highlighted the main points in the report as follows:

- **Activity**: July had been a busy month with 450 births. Based on the 2016 birth rate, they aimed to have 500 deliveries per month. They typically had 80 to 100 less. The team continued to monitor bookings and to work with their stakeholders to encourage more women to come to them.
- **Caesarean section rate**: Their Caesarean section rate was 28% in July compared to a 30% national average. This was 25% seven years ago and it had been gradually rising. Other units with similar births were at 30 to 35%. They were monitoring inductions very closely.
- **Perinatal mortality**: There had been two stillbirths in July. One was a lady who had not been compliant with medical advice at over 40 weeks and wanted to wait for spontaneous onset of

labour. The foetal heart rate had been normal when she agreed to induction but it then deteriorated. The other stillbirth occurred at 25 weeks. The mortality rate was 4.4/1000, which was a reduction from previous months.

- **NNAP data**: The National Neonatal Audit Programme looked at things like the use of antenatal steroids and Magnesium Sulphate, babies' temperature, and antibiotic use. Significant improvement had been made from how they had been working before.
- **ATAIN**: They had a high admission rate compared to the regional levels for Avoiding Term Admissions Into Neonatal units (ATAIN). This could be because they didn't have a TCU [transitional care unit]. They had processes in place to monitor and review all ATAIN admissions every month. They were looking for learning points with midwives and an ATAIN Lead from both the Obstetric and Neonatal sides.
- **Family and Friends feedback**: They were trying to raise response rates by providing patients with iPads when they did the postnatal discharge discussions so they could fill in the questionnaire.
- **Education**: Survey results on how aware women were about reduced foetal movements had been reviewed by the new Equality and Diversity Inclusion Lead Midwife. She was showing animation videos with more images to raise awareness about the importance of early action. This linked well with the Saving Babies' Lives initiative, for which they had a separate Lead Midwife. They were looking at smoking cessation programmes and patient education to reduce mortalities.
- **Staffing**: There had been some staffing gaps in July alongside higher activity levels. They achieved full service coverage through redeployments but this had affected antenatal clinic training opportunities. They had a full complement of consultants. They were recruiting neonatal staff and community midwives. Staffing was monitored through daily situation reports.

DC commented that he had regular weekly text reminders to do LAMP testing. He suggested that texts could be sent for foetal movement check reminders. LT added that foetal movement was the first question patients were asked at every contact.

LK raised the Caesarean rates as a measure that required more than just a national comparison for full understanding. The proportion of women needing a Caesarean, that had one, was more pertinent. The term admissions rate was a better indicator because the proportion of patients reflected what happened versus what was expected. However, there were risk-adjusted factors that weren't clearly reflected in the report. As a Committee, they needed meaningful measures that provided assurance. LT agreed and explained that the ATAIN review was focusing on what they had done wrong at various stages for babies who had been admitted. LT undertook to provide feedback requesting that reporting was clearer.

DC noted that Category 1 Caesarean sections that were not delivered within half an hour would be a useful safety measurement. For term admissions, once they had the transitional care unit (TCU) up and running, a lot less babies would go there because they needed nursing care rather than neonatal support. LK queried whether the neonatal admissions figures would appear concerning if the TCU fact wasn't known. DC clarified for LK that the figures for the neonatal term admissions ought to separate

the proportion that would have gone to the transitional care areas so they could look at the other cases. They regularly reviewed closely audited cases of prolonged rupture of membranes and meconium in labour. DC, LK, and HK agreed to look at this report on Friday morning's meeting to discuss this further.
Action: LT to provide feedback on the request to consider ways to change the Maternity reporting metrics into more meaningful measures that provided assurance.

10. Mortality dashboard	**QS (08/21) 008**

DC outlined the following key points from the Mortality dashboard:

- There was a slight increase in the number of deaths in July.
- Crude mortality rates were a bit elevated. This included patients and deaths within 30 days of discharge.
- Elective and non-elective admissions had gone up to about 8,200 in July.
- SHMI remained high but it was coming down a little bit. They needed to ensure that their palliative care coding was right, as patients from the Leasows site should not have been included.
- Weekday mortality was slightly higher than weekend at the moment but there was debate around the relevance of weekend mortality. They had work to do with primary care colleagues and patients within the working week for timely escalation and management.
- Monthly HSMR rates in May was up slightly to 110 but remained generally lower than it had been. This reflected the impact of COVID. More work continued with mortality leads to go through to the coding to ensure that it had been and was correct.
- September was Sepsis month, where a real focus on learning was planned around escalation and the Sepsis 6. There was a programme in place from CA and the Sepsis Team.

11. Safeguarding vulnerable people: Initial appraisal	**QS (08/21) 009**

This Safeguarding topic was moved to the next meeting due to time constraints.

MATTERS FOR INFORMATION/NOTING

12. Matters to raise to the Trust Board	**Verbal**

It was suggested that the following topics were raised at the Trust Board:

- Board level metrics
- Maternity report.

13. Meeting effectiveness	**Verbal**

This was not discussed.

14. Any other business	**Verbal**
There was no further business.	
Details of next meeting	
The next meeting will be held on **24th September 2021**, from **11:30 to 13:00**, remotely via MS Teams.	

Signed ……

Print ……

Date ……