Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by WebEx. **Date:** Thursday 6th May 2021, 09:30-13:00

Members:

Sir David Nicholson (Chair)	(DN)
Mr M Laverty, Non-Executive Director	(ML)
Mr M Hoare, Non-Executive Director	(MH)
Prof K Thomas, Non-Executive Director	(KT)
Mrs L Writtle, Non-Executive Director	(LW)
Mr R Beeken, Interim Chief Executive	(RB)
Mr L Kennedy, Chief Operating Officer	(LK)
Ms M Roberts, Acting Chief Nurse	(MR)
Ms D McLannahan, Chief Fin. Officer	(DMc)
Ms F Mahmood, Chief People Officer	(FM)
Ms K Dhami, Director of Governance	(KD)
Dr D Carruthers, Medical Director	(DC)
Mr H Kang, Non-Executive Director	(HK)
Cllr W Zaffar Non-Executive Director	(WZ)

In Attendance:

Mrs R Wilkin, Director of Communications	(RW)
Ms H Hurst, Director of Midwifery	(HH)
Ms S Rudd, Assoc. Director of Corp Governance	(SR)
Mr D Baker, Director of Partnerships & Innovation	(DB)

Apologies:

Mr T Lewis, Chief Executive	(TL)

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

The Chair, Sir David Nicholson (DN), welcomed Board members to the meeting. A declaration of interest was received from DN.

Apologies: Toby Lewis.

2. Patient Story	**Verbal**

DN described the importance of hearing directly from the experiences of patients and staff what it was like to be cared for and treated, to ground everyone and to set the tone at the beginning of the Board meeting.

MR introduced the story of a male patient whose care had been managed primarily in the community by the pulse oximeter service. He developed COVID and was originally managed at home with a pulse oximeter from a support team. He had become further unwell when his oxygen saturation levels fell, and he was admitted to Sandwell.

MR introduced Tim Hebbert, to explain the pulse oximetry service. Tim Hebbert his role as Head of Intermediate Care and Community within Your Health Partnership, a large Primary Care Network for a range of GP Surgeries, supporting 56,000 patients. They had formally integrated with Sandwell and West Birmingham NHS Trust in April 2020. They were the interface between Primary Care, Community Services, and Midland Metropolitan University Hospital.

His team supported the oximetry at home service. This was a national scheme to support COVID-19 patients at risk of silent hypoxia: when the body had low levels of oxygen but lacked outward symptoms of respiratory distress. It was discovered last year that this was a risk for COVID patients.

To be referred to his team, patients had to be COVID-19 positive, over 65 or shielding, or considered at risk. The pulse oximeter was fitted on the finger, with instructions to take readings three times a day, to call the team if the reading fell between 93 to 94%, or if below that, to attend the nearest A&E or dial 999.

The patient described his symptoms the night before he had been tested, on 1st February. He had received COVID positive results the following day. He was called by the Surgery, who offered him the oximeter service and he began monitoring his oxygen levels. When his oxygen readings dropped below a certain level, his wife phoned the ambulance, as advised. They put him on oxygen and took him to the hospital. His vision began to blur and he collapsed. They gave him steroids and antibiotics.

After three days, they took him off oxygen but kept him on antibiotics. He was able to go home again and he returned to work on 21st February.

If it hadn't been for the Surgery asking him to try the oximeter, he wouldn't be there today. He described it as a brilliant service. They had phoned to check up on him afterwards. He was continuing to monitor his oxygen levels. He was experiencing some long-term effects such as struggling with his breathing. He couldn't thank the Surgery and the NHS enough for what they had done to save his life.

RB commented that this story had been a good example of why their part of the country had been hit slightly harder, as many people were unable to work from home. He queried what impact the long COVID effects such as those experienced by this patient had had on the Partnership Services and whether the wider NHS were adequately recognising resourcing needs. Tim Hebbert explained that they were still trying to define what long COVID was and what the symptoms were. This patient was still struggling with his breathing and receiving out-patient treatment for effects following COVID. NICE guidance advised that further research was needed to define the long-term effects. Nobody knew the answer to this yet.

It was asked if there was a degree of clinical judgement around people like this gentleman being offered the oximeter or if it was strictly protocolised. Tim Hebbert reported that they had built into their model that there should be an element of clinical judgement to stop people from being missed. The national protocol was that Tim Hebbert's team was informed about patients with positive tests for COVID-19. They were put on a waiting list to be contacted by an ACP. This gentleman had met the national criteria.

HK commented on the media attention about people getting their own oximeter devices. He asked whether people were self-diagnosing and using this as an early warning signal and whether the protocol should be relaxed, or national campaign should encourage use. Tim Hebbert explained that this national scheme had begun in January 2021, but they had begun to offer it last November, not just for COVID but for COPD and asthma. He hadn't seen people buying their own, but they were available for £5. He recommended that everyone had a pulse oximeter, a thermometer, and a blood pressure machine to would give clinicians who were assessing patients remotely more information to determine whether people were safe to stay at home, should be seen at a GP Surgery, or sent to A&E. The CCG had provided them with a stock of oximeters in case of another wave.

MR commented that for reasons like COPD, her district nursing team had been using these for two years.

LK noted that part of their strategic objectives was to use mechanisms like pulse oximeters and testing Hba1c for diabetics to improve population health. By using population health data in combination with remote technology, they could see what indicators were changing to allow early intervention. This positive example could be used as a platform to go forward.

MR added that supporting patients to take more ownership of their conditions and become more independent was a key objective of the long-term plan.

DC commented on three types of potential long COVID patients who they needed to be ready to support by working across the ICS: patients who had been through Intensive Therapy Units, those who had been under the respiratory team in hospital and were receiving longer-term follow up care, and patients who had not been in hospital, who were accessing community-based services that had been set up.

DN expressed his thanks to everyone. He made the following three points illustrated by the patient story:

1. It was always important to see the individual, with their own particular needs and requirements, amongst the tens of thousands.
2. It showed the importance of moving towards integration and population health, where primary care, the patient themselves, the ambulance, and hospital services were all working together.
3. This gentleman had spoken of the power he was given. He felt that he played a key role himself.

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

DN expressed his excitement about getting involved with the organisation, at the forefront of change, and doing work of national importance. He remarked on the warm welcome he had received. He expressed his thanks and paid tribute to Richard Samuda, who had been a remarkable chairman over many years. He had steered the organisation through difficulties, engaged fully with both staff and patients, and provided great chairmanship. Richard Samuda would be missed by everyone.

DN described three things that were particularly significant in making the organisation unique to cherish, support, and develop even further:

1. **Involvement in the wider health community**, whether in primary care, community care, social care within the sector, and with regeneration. This organisation had played a leading role nationally in terms of what a hospital-based service could do to regenerate and develop integration across the system, something important to hold onto as go through the next period.
2. **The new university hospital** had to be completed and opened as a service for the population that we serve. That population needed and deserved public investment over the next few years and the hospital was a key part of that.
3. **Culture and advocating the hospital as a great place to work,** thinking carefully about how it was led and managed, how people were engaged, giving them power over their working lives and their services would be increasingly important going forward, whether it was the Freedom to Speak Up Guardians or giving front line leaders, clinicians, and managers the power and responsibility to get on and do the things that they knew they needed to do.

DN will be focusing initially on:

1. **Refreshing the strategy** of the organisation – the building blocks are in place and radical changes in direction are not needed. The most important thing about strategy was how patients, the public, and the staff were engaged in creating that strategy. Conversations with staff about the direction would make sure to build a strong basis to create a vibrant strategy for the organisation and the services they were responsible for.
2. Review the organisation's governance – as in many organisations, processes have grown over time and worked well. The governance arrangements will help to build on success.

DN aspires to live up to what RS had accomplished during his tenure by focusing on the population, regeneration, engagement, MMUH, and looking carefully at how to change to a more outward-looking, engaged culture while refreshing on strategy and reviewing governance.

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

The following three questions were asked by members of the public:

Q1. How is the hospital preparing for life after COVID?

A1. RB explained three things to note about their approach to living with COVID over the coming months:

i. Restoration of time-critical services, in particular, but not exclusively, cancer services and both initial access under the under two week waiting arrangements and also cancer and cancer surgery – plans were being made to develop, adopt, and maintain new ways of working, either home working or encouraging and legislating internally to rotate people's presence inside and outside of work, rather than expecting to be in at all times. There would be appropriate risk assessing of staff, the new health and wellbeing offering for colleagues, and different service offerings for patients that were more personalised, needs-led, and home-based than before.

ii. Being clear with ourselves as a Board and the public about the recovery trajectory – how long it would take for recovery of routine diagnostic and surgical waiting times to their pre-pandemic levels, not forgetting that pre-pandemic times, those waiting list times were starting to deteriorate.

iii. Preparing for more COVID, based on periodic peaks and troughs that could be seen across the globe with respect to different variants and the effects of changing lockdown arrangements on incidence rates in the population. The unique employment profile and sociodemographic in the Black Country and West Birmingham system meant it being harder hit than other areas. Contingency planning for a late summer or early autumn spike and rolling that forward into winter planning to provide a safe acute hospital service, whether or not there was a peak of COVID to manage this coming winter.

Q2. In response to a Freedom of Information request about cancelled cancer operations, they had cancelled fewer operations during the pandemic than during the previous year and how did they account for that?

A2. LK explained the following rationales as to why cancer operations had been cancelled:

i. The number of patients who were booked for surgery over the last year had been reduced due to the COVID pandemic; and therefore, fewer cancellations would be expected.

ii. The oncology service moved out some of their cancer waiting list to the Priory as part of an Independent Sector Partnership that had worked well. There had been a high number of cancellations last winter because of pressures on ICU beds, so there was a benefit received through partnership working.

iii. There had been flooding at the BTC operating theatre in January and February, causing a number of patients to be rescheduled.

Q3. How is the Trust dealing with the backlog of patients who were cancelled during the pandemic? What does their recovery plan look like?

A3. LK asserted that patient care and timely care was absolutely critical. Everything was being done to restore services as quickly as possible, whilst bearing in mind the wellbeing of hospital staff who had been on a significant journey over the past year and under a lot of pressure. His recovery paper on how backlogs were being progressed and dealt with would be described further in his report in item 7.

UPDATES FROM BOARD COMMITTEES	
5a. a) Receive the update from the **People and OD Committee** held on 30th April 2021.	**TB (05/21) 002**

b) Receive the minutes from the **People and OD Committee** held on 26th February 2021.	**TB (05/21) 003**

ML reported that at last week's People and OD Committee meeting, they had discussed staff survey results, recruitment performance, mental health for the workforce, and the sickness improvement plan.

- The results of the staff survey had been disappointing over the past four or five years, at best moving sideways or in some instances drifting down. Interventions were discussed to move into a more positive trajectory. They also discussed the impact of this on the CQC results.
- On a more positive note, the time to recruit had improved significantly, down from 81 to 74 days, as had sickness absence performance. It was hoped that these trends would be sustainable.
- Sickness absence had been reviewed in detail. The sickness absence targets were agreed to move from 3% to 4%, which would still be a stretching target beyond what had been recently achieved.
- The Committee wanted to triangulate the various information they received to better identify where the hot spots were in order to be able to make more interventions.

DN queried the kinds of interventions that were being considered around the staff survey. FM described that there were a number of indicators showing a need for improvement. Despite all their best efforts on health and wellbeing, Equity, Diversity and Inclusion (EDI) had continued to stagnate along with scores on morale, motivation, and the extent to which individuals felt supported by line managers and by the organisation in being empowered to perform their roles. Interventions were focused around developing a robust EDI strategy. They had created a more detailed action plan in collaboration with the staff networks. This included shared accountability and responsibility to connect more closely with people's needs, rather than actions being owned within HR. The impact would be tracked and reported on regularly.

From a health and wellbeing perspective, they were moving towards a health surveillance model responsive to current specific needs within COVID and beyond.

Another planned improvement was to tell the staff what they were doing differently as a result of the survey. They would begin to check in more regularly with staff.

The chair emphasised the need to deeply understand the results to be able to target interventions by the executives responsible to collectively make improvements.

5b. a) Receive the update from the **Quality & Safety Committee** held on 30th April 2021.	**TB (05/21) 004**
b) Receive the minutes from the **Quality & Safety Committee** held on 26th March 2021.	**TB (05/21) 005**

HK reported three key points from the Quality & Safety Committee:

1. The highlights of the **Gold update on COVID-19** were that the rate of infection around the community had significantly reduced and stabilised in line with what was happening nationally. The number of COVID in-patients had fallen to 14. Around 70% of staff had been vaccinated and this should increase as records were reconciled.
2. **HSMR** was on the Board's agenda because the Trust's mortality rates were higher than would have been predicted. Two strategies were being deployed to (1) focus on clinical care, and (2) to improve coding and documentation. An improvement programme was in development with dedicated

resource. Close monitoring was in place.

3. **CQC inspection preparedness** was also on the Board's agenda. The programme of assurance was discussed, including ward self-assessments, in-house inspections, staff engagement, and data interrogation. The KPIs that consistently good organisations achieved were being investigated to focus the Trust's efforts on the relevant KPIs needed to move their trajectory.

The following positive result was highlighted:

- The maternity units had been opened to partners to be able to accompany women at their appointments and to be present at birth from 12th April.

The maternity report was discussed and would be presented under agenda item 8.

DN commented that the important quality issues that had been identified were on the Trust Board agenda.

5c. a) Receive the update from the **Estates Major Projects Authority** held on 30th April 2021.	**TB (05/21) 006**

MH outlined discussions on the Midland Metropolitan University Hospital (MMUH) construction programme, how the integrated care programme would evolve in MMUH, the regeneration programme, and the logistics strategy. He highlighted the following key points:

- Implications for the construction programme were being looked at in terms of COVID conditions and continuation of those conditions and mitigations. A revised programme plan would be presented to the Committees for review in May. Further work and activities would subsequently be presented to the Private Board.
- Good engagement was reported on the integrated care programme with clinical model workshops, where the teams worked through the design and the care models for MMUH. The Private Board was considering the development of those clinical models that afternoon.
- Communication of the departmental changes had commenced last week, clarifying future work locations for those associated teams. The administration space would have further clarifications.
- Recruitment was in progress for a role to support engagement and investment in the community around leadership and resources. The next EMPA update on this would be in July.
- Regarding regeneration, the Learning Campus governance model with associated partners was presented to the EMPA. A co-creation workshop in early May would be supported by Igloo, who would inform the design of the Learning Campus, which was about widening the participation and the learning within the local community, where a more sustainable employment model and careers would be introduced. Igloo were a regeneration development specialist. The key partners included Sandwell Council, Wolverhampton and Aston Universities, Sandwell College, and Learning Works.
- The work by DHL to create a logistics strategy was considered to be robust, based on stakeholder interviews with staff and data analysis. The EMPA had accepted the proposal strategy.

5d. a) Receive the update from the **Digital Major Projects Authority** held on 30th April 2021.	**TB (05/21) 007**
b) Receive the minutes from the **Digital Major Projects Authority** held on 26th February 2020.	**TB (05/21) 008**

MH reported on the DMPA meeting on 30th April. He highlighted the following summary of discussions:

- The impact of the adoption of Microsoft 365's on the Trust going forward was considered to be not only a technical but a cultural adoption programme by staff, with engagement work being planned.
- The DMPA looked at a more detailed plan of Informatic activities planned for the next 12 months and how these would link to enabling the Trust's vision and strategy to provide integrated care.
- Cyber Security risks were being well managed. Plans for the year were discussed to improve monitoring of the Trust's position, using NHS Digital and the support services they provided.
- Delegated authority was requested for RB to sign the renewal of the CRIS radiology contract to cost £776,000 over five years.

DN requested further description of the Trust's Digital Strategy. MH outlined the following activities that would be performed over the next 12 months, which were being discussed with clinical leaders and some of the executives. These included the following elements which needed to have a level of maturity in place to support the clinical pathways in the move towards MMUH:

- Forward-thinking maintenance activities
- Software and application updates
- Features and functionalities that were coming online within Unity in preparation for MMUH.

The focus had moved from sustaining the core IT infrastructure and capabilities to advancing the position of IT within the Trust to enable the development of further clinical improvements and operational efficiencies going forward.

DMc queried whether the CRIS system worked operationally, which had had problems in the past. MH undertook to ensure that the knowledge spread was not just reliant on one key person.

The Board **APPROVED** the delegated authority to RB for the CRIS radiology contract renewal.

MATTERS FOR APPROVAL OR DISCUSSION

6. COVID-19: Overview including vaccination update	**TB (05/21) 009**

LK referred Board members to his report and highlighted the following points to note regarding the organisation's current position on COVID:

- The community COVID-19 infection incidence rates had fallen significantly. Prevalence in the community was one of the markers used with IPC regulations.
- Fewer COVID patients were in the respiratory hub, and down to less than 50% in Intensive Care.
- New IPC guidance had removed the requirement for a contact ward.
- Point-of-care testing was in place at both EDs for all admissions, helping to determine where to place patients and to know their COVID status within 30 minutes.
- The Red bed COVID-positive capacity had been reduced at the Sandwell site. Most of it had been moved to the City site where the respiratory hub was based and one of the AMUs dedicated to COVID-positive patients. Community prevalence and admissions into the acute hospital were being monitored for the consideration of further changes.
- Debrief meetings and lessons learnt in research from last time were being documented and

finalised to know what needed to be done, including to step up services if any increases were seen.

- Modelling was being done based on effectiveness of the vaccine and the proportions of people who had been vaccinated, to help with future planning.

MR provided the **vaccination and PPE updates**.

- The vaccination hospital hub opened in January had closed last week. MR expressed her thanks to everyone involved. It would reopen at the end of June for a second set of vaccines for 500 staff and patients.
- Over 70% of staff had been vaccinated. Of these, 39% were BAME colleagues, 48% were white British, and the rest were of unknown ethnicity. HR were helping them with data analysis. About 200 staff were yet to be contacted to find out their vaccination status by early next week.
- The Tipton vaccine centre had vaccinated over 25,000 patients and staff. Huge variations of appointments occurred per day, ranging between 200 and 1500, depending on when cohorts were released. They were working with the system to offer the Pfizer vaccine to under 30s at Tipton, as AstraZeneca was only for age 30 and above. The system was currently looking to keep Pfizer at only the Saddler's site, but this would depend on demand.
- Extra PPE was now considered safe by risk management to be provided within national guidelines. High risk staff continued to wear FFP3 masks throughout the organisation.

DN remarked on the huge amount of work being done. He expressed his thanks to the executive team for their role in addition to the staff on the ground for making everything happen.

HK added his thanks to everyone for their performance. He commented on the percentage of BAME staff that were unvaccinated and evidence that the younger community were hesitant due to misinformation, such as the ability to have children. He queried whether work was being done to analyse age and professions, to understand and address concerns about vaccinations, and to counter misinformation.

MR described the system's dashboard showing what was being done, what the position was at each centre, including amongst the BAME community and across age groups. Over the last months, Tipton and West Birmingham particularly had been doing pop-up clinics targeting specific groups of patients, such as women only. They were doing multi-family visits to vaccinate all ages, which were going well in West Birmingham. Sandwell had started a week ago. Tipton were supporting them around resources. They had done Q&A sessions to talk about issues, especially around fertility and pregnancy, resulting in 561 patients and staff coming forward for the vaccine following one of the March sessions. Meetings were planned next week to decide what to do to address those who were still unvaccinated.

WZ added his thanks to everyone for their efforts. He agreed with RB's answer to the public questions regarding the need to prepare for a potential surge. He queried what was being done to restore confidence to come back to hospital services that were re-opening, and to deal with 'no shows' by patients. He queried whether visitors and family to accompany patients would be allowed back to hospital soon within non-COVID areas of the hospital, and what was being done to reassure people and to allay fears, especially from communities with communication challenges.

RB explained that this was being handled through the strategic command meetings. There would be an incremental increase in hospital visit times, starting with half hour slots. This would begin in line with the national relaxation level of lockdown on 17th May. The Trust had committed themselves with all the other acute and mental health providers in the Black Country and West Birmingham system to have a joint stance on visiting rules. DN cautioned that this shouldn't mean going at the slowest level.

LK described the process of classifying patients who chose not to attend because of apprehension and anxiety under COVID. When this process started in March and April, they represented 100 patients, who were now down to 45. Individual plans were being made for them. They were seeing a significant reduction in the numbers of patients unwilling to come in for elective procedures and diagnostics. Virtual out-patient appointments were another option. 90% of activity had been restored.

LW added her thanks and commented that often staff began to feel vulnerable as things settled down after being through difficult times. She questioned what was being observed with staff.

RB reported that from what he had witnessed in his conversations with Sandwell supervisory staff, the majority of people who were prepared and keen pre-pandemic to offer additional discretionary efforts to improve or maintain waiting times had stopped coming forward due to these reasons:

- General exhaustion, such as theatre staff being redeployed
- Finding that spending more time with family and friends was good for their mental health.

The NHS, as a whole, had not yet calculated the impact of this in its ability to recover routine elective services at pace. This needed to be reflected in the restoration and recovery trajectories.

7. Planned Care and Recovery Report	**TB (05/21) 010**

LK welcomed challenges, suggestions and exploration about the approach. He noted the following key points about their current position from the Planned Care and Recovery report:

Production Plan, RTT, and DM01:

- Production Plan – 68% of the delivery of the financial production activity plan for 2020/21 has been achieved, reassuringly close to the 70% requested by the national planning guidance for April. Early predictions for April showed the Trust performing closer to 80% of the value.
- RTT – This was at 71% and recovering since elective work had resumed. Areas of particular concern included Dermatology and Oral, and a pre-pandemic issue continuing for Ophthalmology.
- DM01 – 89% of diagnostics had been achieved by the end of the year. This was now up to 94% to 95%, hoping to fully recover diagnostic standards by the end of June. Urgent diagnostics such as cancer had continued during COVID in order to clinically diagnose patients. The Trust would be looking to support other areas of the system to help them improve diagnostic standards.

Long waits and Clinical prioritisation:

- Clinical prioritisation had been completed throughout to understand when patients should be treated, in order to prioritise waiting lists and theatre allocations. New patients being added onto the waiting list were prioritised weekly using a robust process.
- P2 patients required treatment within 28 days. P3 patients required care within a three-month window. Trajectories for P2 and P3 clearance showed that the Trust hoped to clear P2 backlogs by the end of June and P3 by the end of August.
- For P4 routine-type work, the Trust did not expect to achieve clearance this calendar year without significant ISP colleagues' support or mutual aid across the system.

BCWB System update:

- Restoration and recovery work was being done as a system according to planning guidance. The cultural shift in the system supported collaboration. The delivery models were being changed

across various Boards set up to address long-term issues and ways of working within specialties.

- The 467 Ophthalmology P2 patients were 90% situated in Sandwell, as they had the Birmingham and Midland Eye Centre (BMEC). Work was ongoing to address this through a regional response.

Independent Sector Providers (ISP) update:

- By the end of March, the ISP contracts had been handed from a national contract to local organisation discussions. Significant issues arose because the national contract had mandated support for NHS organisations, whereas under local agreement it was much more negotiable. Patient-type and practicing privileges in a lot of the ISPs had caused difficulties.
- Planning and discussions were underway with ISPs to consider moving cohorts of patients where they were willing, in an effort to help the Trust with their recovery.
- There was a risk in the Trust's position with over 50% of patients being outside of the timeframe in which they should have been treated. Harm reviews were being done for all of these patients, with each one on the surgical in-patient waiting list being contacted for a documented discussion to try to manage expectations.

RB queried the causes of the Trust's two-week wait access times being relatively worse than others in the system, particularly for suspected skin or breast cancer, and by what time he could reassure the Board of a clear plan of recovery of those waits to pre-pandemic acceptable levels.

LK reported that pre-COVID, they had succeeded in getting waiting times for first appointments down to 10 days. He described three specialties that had not been achieving the 14-day goals: Dermatology, Breast, and Haematology. Backlogs had been caused by a post-COVID increase in referrals from the Birmingham Solihull catchment area and a decrease in their full capacity within Dermatology. Whilst he was unable to provide the Board with a date on full certainty to resolve this, there was work underway with system partners and with outsourced providers to increase their activity. This, coupled with their core capacity, should mean getting back to a manageable position within the next two to three months.

KT queried whether the Trust could make use of their whole team to reduce the Ophthalmology waiting list. LK reported that this was being done for all possible diagnostic, out-patient, and non-consultant led in-patient work, but because of the complex nature of in-patient surgery requirements, they were unable to tap into their own specialists or even some ISPs because they didn't deal with the complexity of cases the Trust managed. Most of the backlog required specific consultant input.

HK requested clarification on the modelling of the impact of a third COVID wave on the restoration and recovery plans. LK outlined the position of the system, which was to produce the elective recovery model withstanding future waves. Internally they had also modelled what they thought could happen and its impact on critical care and a comparative reduction in elective theatre activity. This was where discussions with ISPs and strategic reliance on them would come into play. The Trust would need to estimate now what that reduction needed to be to maintain a minimum recovery trajectory to contract with the independent sector to safeguard themselves from reducing elective activity.

ML queried what needed to be done now to engage with ISPs to work out what they could deliver for the Trust and where they could get started. LK explained that without a mandate on ISPs to support NHS organisations, as commercial entities, ISPs preferred private sector work. Many of them didn't offer the type of services the Trust required, or they didn't do complex or elective overnight work. Practicing privileges were another issue. Anaesthetists or consultants had to be registered in that ISP to be able to operate there, which hadn't been required under the national contracting framework. This limited the Trust's professionals from being able to practice there to tackle patient backlogs.

MH asked if guidance had been received from the authorities on how to handle the efficiencies of certain clinical procedures and safety guidelines based on the impacts of COVID, such as cleaning or changing rooms, which impacted on the production plan, causing financial implications. He queried what assumptions were being put in place to achieve production plan goals.

LK reported that there was no national guidance on this. Activity had to be returned to previous levels, knowing the impact of Infection Prevention and Control (IPC) requirements. The change to goals had been to try to get to 105% of previous efficiency in some areas. There were ways that the Trust could change how they delivered certain services, but their cost element had not been considered longer term.

MH queried how the Trust was assured to have enough staff to achieve their plans, given the impact on the staff's health and wellbeing from the added pressure to achieve these goals. LK felt that the impact of coming out of a pandemic together with the Ophthalmology restoration and recovery plans was further compounded by work on the move to MMUH next year, stretching staff resilience and their ability to deliver. They were trying to control the pace of their recovery plan with a guiding principle of sustainability in mind to avoid longer-term effects on the staff and the culture. They were trying not to push staff too hard or too quickly. For example, with the redeployment of the ICU staff in mid-April, they hadn't planned to return to 100% of theatre activity until this week or next week.

The Chair commented on the conflict between trying to do the most they could for both the staff and the patients. He felt reassured that the P2s would be treated by the end of June. He suggested that skin and breast cancer trajectories were addressed and that whilst 80% sounded good, it still meant a backlog was building up. It would be tricky for the executives to manage the balance of looking after staff and treating the maximum number of patients. He suggested using more benchmarking data to compare the Trust to other organisations to create a framework for knowing how hard to push. The Trust needed to explore ways to enhance their ability to use the independent sector better.

BREAK

8. Maternity Services Report	**TB (05/21) 011**

MR introduced the main points for the Board's consideration, which were Community Midwifery, the Ockenden bid, and the Maternity Quality Improvement Plan.

HH highlighted the following key areas:

Community Midwifery:

- The efforts that had been made to create a more proactive model to deliver the necessary care in a holistic, personalised way, with greater continuity of care around post-natal care to also improve job satisfaction for midwives serving a diverse, complex population, had had an impact over many years on both retention and recruitment.
- In 2019, the community midwives came up with their own new model, in line with Better Births, to formulate themselves into 'families.' This had been launched in 2020, just as COVID hit.
- Leadership changes had been made, two matrons were employed, and 16 areas were identified to support the transformational agenda across the community of midwifery. These areas were embedded into their overall improvement plan, with key milestones.
- They were currently at Phase 1, where the team was introducing new ways of working through a totally digital platform, managing diaries electronically. A duty midwife had been introduced. The

team felt more engaged, receiving good feedback at the beginning of their long-term plan.

Ockenden Report:

- This report came out on 10th December 2020. The NHSEI invested £95.9 million for 2021/22 to support the whole system to address seven essential criteria. The bid was specific around the (1) midwifery and (2) obstetric workforces, and (3) multidisciplinary midwifery training.
- When they took their bid to LMNS on 4th May, there was consensus that they needed to increase their uplift from 23% to 24% to ensure mandatory training. This increased the investment from £700,000 to £728,672, which was approved by the LMNS. They were praised for the amount of detail put into their bid on maintaining continuity of the carer.

Maternity Quality Improvement Plan:

- Last summer an improvement plan was implemented that was recently reviewed in line with Ockenden, bringing this plan together with five action plans into one overall improvement plan.
- On 25 March a learning in-action event shared the findings of local staff surveys, to discuss the improved safety culture and to co-design strategies for change. Over 60 members of staff attended.
- Debbie Graham was conducting an independent review on culture, to be taken forward in June and July.

LW queried whether there were plans to work in co-production with service users. HH reported that they would begin by understanding how their staff felt, including independent midwives, and working with their hard-to-reach community. Last year they had improved their MVP work with the CCG thanks to a new MVP Chair. An EDI lead midwife had been appointed last week with money from the LMNS as a pilot to communicate better with the local population and staff to improve knowledge and outcomes.

KT queried how learnings about practices, such as daily reviews following emergency Caesarean sections, were disseminated amongst the whole team and how fertile a field it was for multidisciplinary learning. HH reported that every morning there was a handover that included a full review process between the incoming and outgoing teams. They often did 'trolley dashes' with teaching boards taken to all staff where they found any issues or there were things that could be improved. RB had witnessed a trolley dash yesterday when he came to celebrate international day for midwives. All shared learnings could also be found using share point on Connect, on boards in the learning room or by word of mouth.

RB queried last month's safe staffing situation and how the Board could gain assurance that safe staffing standards were in place. HH reported that the Maternity team had daily staffing huddles to look at hot spots and staffing return assurance checks throughout the day. Their fill rate was between 80 to 100% with an average of 90%. They had rotation and fluidity in staffing that made it easier to move staff around.

HK questioned how confident they were, with an 8% vacancy rate, in being able to get the right levels of recruitment. HH reported that they had submitted an incentives paper to compete against other employers. They attracted staff by the quality of their development program, offering a range of courses including a critical care course that only four other organisations offered nationally. They'd offered 21 places to third year students, with 17 accepted. Certain work did not always require midwives.

DN suggested consideration about how Non-Executive Directors could liaise more closely with Maternity. He remarked on the need to not underestimate the transformational change to how midwives worked that resulted from the adoption of Better Births. This required proper management and sufficient resource.

9. HSMR review: Approach to improving Trust mortality rates	

DC introduced the paper and explained that it contained Trust mortality data and the processes in place to monitor and effect change where it was needed. He made the following key points:

- Adverse data was shown with HSMR at 149 and SHMI at 114.
- Processes were in place to monitor the clinical care provided, including the Learning from Death Committee, mortality leads, medical examiners conducting a first-tier review of over 90% of deaths. 15% to 20% had a more detailed Systematic Judgement Review by specialists to identify if there were systematic areas in the levels of care to address.
- An ongoing review process acted on data alerts within specialty or diagnostic areas.
- Clinical assurance work had been undertaken to regulate process issues that could have contributed to issues with the mortality data. Efforts were being made to improve coding and documentation, the recording of palliative care, and to use diagnoses instead of symptoms.
- Clinical teams and acute admission units needed to work more closely with coding to achieve real time correction within the Unity system.
- The impact of COVID and COVID documentation on mortality rates required investigation.

The Chair asked HK for the view of the Committee on the mortality rates. HK stated that the Trust needed to keep a close eye on this. They had approved extra resource required to execute change. He commented that better understanding could be had by removing the COVID effects to see the underlying causes of any issues. DN noted that the COVID impact was also in the national data.

DC stated that the NHSE had confirmed the Trust's COVID data was not an outlier. Recording of finished consultant episodes and when COVID was suspected within the records linked to hospital acquired COVID mortality accounted for up to 70% of excess deaths. COVID data would be presented to Q&S next month.

ML queried the magnitude of the coding errors on the scale of the problem. DC noted the importance of understanding the impact of COVID, while still focusing on the clinical care aspects. He was unable to quantify the contribution of coding and documentation errors but stated that it was fairly significant.

It was noted that the difference in HSMR and SHMI showed the impact of COVID. The impact of documentation issues that drove some of the coding that affected figures could be seen by the auto-coding work done two years ago that had reduced HSMR by 6 points.

DN stated his expectations that the strategies in place to address clinical and coding changes would improve the mortality rates over the next months. DC noted that the HSMR data was from October, November, so changes would not manifest themselves for another eight months on that basis. DN expressed the need to therefore actively focus on the clinical care so that the effects could be seen more immediately with patients, rather than through HSMR. An external look should be considered longer term.

HK queried whether evidence, case studies and expertise from the NHS as to the cause and effect of these areas were being applied. DC reiterated that the focus was on being proactive around the clinical component through focus on areas like sepsis and pneumonia being monitored at ward-based safety huddles and new practices for audit and data collection on the wards. Work had been done to understand the way things were documented and recorded in Unity. Some external data analysis was done through HED, who provided the HSMR and SHMI data.

DN requested that DC considered two things:

1. Help from external sources
2. Outlining an appropriate timetable for an improved trajectory.

He noted the report and thanked DC for the work being done.

Action: DC to consider help from external sources and to outline an appropriate timetable for an improved trajectory.

10. Finance	
a) H1 2021/22 Financial Plan	**TB (05/21) 013**
b) 2020/21 Capital Plan	**TB (05/21) 014**
c) Finance Report Month 12	**TB (05/21) 015**

DMc presented three reports and highlighted the following key points:

a) <u>H1 2021/22 Financial Plan:</u>

- Budget setting for 2021/2022 was based on supporting 2020/21 activity levels. A stage 2 planning process would look at required developments against available funding for CLE approval in June.
- Activity plans would be based on 2019/20 actuals, which was in line with national expectations.
- The system plan submission reflected the need for £303.8 million for H1.
- Efforts would be made to safely reduce COVID costs and to maximise Elective Recovery Fund (ERF) earnings, by hitting targets of 70% in April, rising in 5% intervals to 85% in July.

LK queried the Trust's risk appetite towards achieving greater ERF, which was conditional upon the system's delivery, not individual organisations, in order to underpin some of the sustainable work in areas such as MMUH and the restoration and recovery plans.

MK asked what the Trust's assumptions were around being fully staffed versus the use of agency. DMc reported spending of just over £17 million on agency for 2020/21. They needed to reduce their temporary staffing spend considerably. This was their biggest risk in terms of an MMUH affordable workforce model.

HK queried whether the Trust was in a position to put in top-down spending pressure, given their recovery plans, and what level of comfort they had around the use of rostering. DMc explained that a business case was being prepared to spend capital funding to replace their e-rostering system around the end of Q1.

MH queried the confidence in achieving a sustainable run rate and whether the planned savings and efficiencies would come in early enough in the financial period to make an impact. DMc reported that these efficiencies did not need to come in during H1. The efficiency requirements planned for H1 were manageable enough to not require a run rate reduction. The working assumption was that the Trust would reduce its exit run rate by just over £1 million per month to achieve the £13 million in the LTFM.

DN asked how much the Trust had towards the £13 million. DMc reported that £9.8 million was the indicative full year effect identified against the £13 million. A lot of this was reliant upon temporary staff reduction and bank rates. DN asked for assurance that the work was underway, which DMc confirmed was the case. She explained that the Trust had good resource around improvement and innovation.

DN thanked DMc. The Board unanimously **APPROVED** the SWBH Financial Plan submission for H1. The next steps to be taken were noted.

b) <u>2020/21 Capital Plan</u>

DMc took the report as read. She outlined that the following key points:

- The 2021/22 capital programme had been set on a refreshed five-year plan in the 2019 FBC.
- This was a self-funded plan.
- Through their Capital Management Group, the Trust had a very good link pre-COVID with statutory standards backlog maintenance plans to their risk register and red risks from the estate's point of view, which was being updated for ENGIE and the life cycle plan. They needed to confirm that this investment into staff standards was reducing their backlog maintenance liability as a result.
- FIC had approved the Trust's share of £22.8 million of the Black Country WB capital control total.
- The Trust was asked to reduce their programme by £2.6 million due to a changed expectation.
- This provided internal funding of £20.2 million with assumed slippage of £1.6 million, £1.3 million for the BMEC's Vanguard, and 670,000 for BMEC diagnostics.
- The total programme was £189.4 million, of which £167 million would be for MMUH.

ML queried the proportion of the non-MMUH programme used to save and make efficiencies and what proportion was for necessary replacements. DMc undertook to report on the invest to save ratio.

MH queried whether there was sufficient capital to proactively invest in IT to support taking MMUH to the next level, and if a high enough percentage of revenue was invested in IT. DMc reported the close involvement of IT, Estates, and MMUH in planning. She was not aware of any gaps or risks. LK concurred.

The Board unanimously **APPROVED** the Capital Programme. DN expressed two caveats:

1. The spend to save element should be considered, to be thought about in future capital planning.
2. The way that Digital could transform the services should be considered if capital became available.

c) <u>Finance Report Month 12:</u>

DMc reported that 2021 had been a momentous year for finance, transforming how money was earned and managed across the system instead of within organisations. The following key points were noted:

- The Trust had a retrospective top up in the first half of the year, with a deficit plan of £4.3 million.
- A **surplus of £383,000** was achieved by the end of the year, subject to audit.
- Less than planned was spent on MMUH. The cash balance was high due to wages paid in April.

DN congratulated DMc and her team for the work they had done in managing resources over the years.

REGULAR MATTERS	
11. Chief Executive's Summary on Organisation Wide Issues	**TB (05/21) 016**

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

1. The Trust's leadership capacity was under strain post-COVID, illustrated by being key partners and hosts of two Integrated Care Partnership arrangements, a key partner in the ICS delivery agenda, which included the Acute Hospital Collaboration Programme and a huge amount of clinical integration and patient service improvements. They were managing developments of the Midland Metropolitan University Hospital and radical changes to clinical care models, as well as the internal restoration and recovery plan to improve the fundamentals of care. A prioritisation framework would be required to support front line colleagues and leaders.

2. The Sandwell integrated Care Partnership (ICP) business case was under development. Significant funding was received thanks to the efforts of the local authority and CCG to fund a leadership team for the ICP. The question was posed whether the Trust repurposed the public health sub-committee of their Board, to make that the ICP Board that they hosted as an organisation.
3. They needed to set out the key implications and high-level responses in regards to the new national planning guidance. The Trust needed to invest in primary and community services, in the wider sense of the word, to have an impact on population health and to make the Midland Met business case fly by finding creative routes for investing new and recurrent levels of revenue money in those services and requesting that their partner organisations did the same.

DN expressed his support of prioritisation in order to become geared and organised for success.

11.1 Integrated Quality & Performance Report	**TB (05/21) 017**

DB referred Board members to the paper and highlighted the following key points:

- He described a fall with severe harm. A palliative care patient using a Zimmer frame fell, fracturing their hip. They had a hip operation on 14th March and were discharged on 27th March with care.
- Progress was being made on improvements to dashboard data, which would be important for using to describe population health for tackling inequalities, to help with Midland Met.
- The cancer target was the biggest access challenge.

RB queried which committees received assurance about meeting the four-hour emergency access standards. LK reported that these went through the Urgent Care Board, which reported into the Operational Management Committee. Escalations went to the CLE and could come to the Public Trust Board. Good inroads were being made to performance over the last few months. DN asked who oversaw operational performance. HK added that performance measure outliers were also discussed at Q&S.

The Board noted the report.

11.2 Trust Risk Register Report	**TB (05/21) 018**

KD referred members to the Trust Risk Register Report and highlighted the following items of focus:

Risk 3110 – The IT technical infrastructure risk

- KD reported that a lot of work had been done to mitigate this risk. It was monitored by the Digital Committee and Digital MPA. She recommended its removal from Board oversight.

Twelve of 40 red-rated risks were listed in Appendix B, for which she recommended Board oversight.

The Risk Management Committee (RMC) had reviewed high severity, low impact yellow and green risks. When the risk statements were robust enough, these were proposed to be reported on monthly to the Board along with further red risks that were being finalised.

DN queried the management at RMC and whether the 12 risks had been referred to the Board by CLE. KD reported that she was the RMC Chair and that CLE had referred the red risks.

DN queried Non-Executive Directorship involvement with the risks. HK reported that risks were reviewed in the committees they were involved with, for example those being highlighted to Finance or Q&S.

LW commented that she had set up a meeting with KD to discuss the risk review process.

RB commented that the number of risks being escalated was significant. He agreed that they were compelled to accept the recommendations, but he wanted assurance that some of those risks could be mitigated at a level that did not involve the Trust Board. He undertook to discuss this with LW and KD.

LK reported that they were linking data sets to risks, to show proof of mitigation. For example, with Risk 3110, they changed its rating because 99% availability was shown on all the systems within their infrastructure. He recommended that supporting evidence was used to manage risk ratings.

The Board **APPROVED** removal of risk 3110 from Board's oversight and the addition of 12 new risks.

12. CQC Inspection preparedness report	**TB (05/21) 019**

KD reported that from discussions with the new CQC Inspection Manager, an announcement was imminent about commencing their programme of work. He was doing visits and focused work with staff. He had offered to meet with the Board and to do focus groups with staff about their new inspection approach.

KD referred to the processes listed in the paper that were being used to prepare for inspections. Q&S had requested more evidence of high-quality care to back up these processes.

ML queried whether there would be time to put the processes in place prior to inspections and what would be prioritised. KD reported plans to oversee self-assessment work. Targeted work was beginning next week, prioritising areas they were expecting to be a focus from the Insight Report, such as medical wards and assessment units. ML queried whether enough resources were in place. KD reported that 70 people had volunteered to help. Executives, Deputies, Group Triumvirates and directorates were focused on the work. ML expressed concerns that the necessary resource to move areas of 'requires improvement' to 'good' were lacking. LW reinforced the need for assurance.

RB noted that the Q&S Committee had a clear ask of the executive, which was to 'develop and show the evidence repository set against each domain and each key line of enquiry that would be used by the CQC to back up their assertions' for different ratings. This task remained to be completed, which was where resource needed to be focused as a priority.

DN requested a plan from the executive about how this repository was going to be resourced and what the overall approach was going to be, as opposed to a list of activities. This would also help to inform the staff themselves about what had improved. He asked RB to present to the next Board meeting a resourced plan based on if an inspection were to happen within one or six months. Resource from the region and others could help. He suggested that KD invite the Inspector to a Board meeting to understand his approach.

Action: RB to present a resourced plan and overall approach for the Q&S action to create the CQC evidence repository, based on an inspection within one or six months.

Action: KD to invite the inspector to a future Board meeting.

13. Staff sickness improvement plan	**TB (05/21) 020**

FM noted that the Trust's sickness absence levels had put them above targeted expectations in the IQPR over the past 18 months and amongst the bottom three Trusts within the region for the past three years. She took the Staff sickness improvement plan as read. The People and OD Committee had approved the change to a more realistic sickness absence target.

DM agreed with the need to set a realistic target but suggested aspiring to the national target of 3%. She reported that ward budgets were modelled on 3% being reached. FM noted that 4% was a stretch target

for the Trust, having had a two-year rolling average of 5.7%. The new target would require an intensive focus from managers to achieve in the circumstances, by the end of the financial year.

DN commented that he saw 4% as a staging post on the way to greater improvement.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS	
14. Minutes of the previous meeting, action log, and attendance register To approve the minutes of the meeting held on 1st April 2021 as a true/accurate record of discussions, and update on actions from previous meetings	**TB (05/21) 021** **TB (05/21) 022** **TB (05/21) 023**

The minutes of the previous meeting held on 1st April 2021 were reviewed and **APPROVED** as a true and accurate record of the meeting.

The action log was reviewed with the following update made:

- *TB (12/20) 001 - Provide an update to Board on Freedom to Speak Up resource enhancement (administration support and additional Guardians)*
  - RB reported that it had been approved in principle by the Board some time ago but they had been awaiting absolute certainty on the financials. Work was underway to advertise a virtually full-time Lead Guardian role to complement an existing cohort of Guardians.

DN commented that it was important to get the right person into this important post.

MATTERS FOR INFORMATION	
15. Any other business	**Verbal**
None discussed.	
16. Details of next meeting of the Public Trust Board:	**Verbal**

- The next meeting will be held on Thursday, **3rd June** 2021 via WebEx meetings.

Signed …….

Print …….

Date …….