TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by WebEx. **Date:** Thursday 4th February 2021, 09:30-13:00

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

Minutes	**Reference**
1. Welcome, Apologies and Declarations of Interest	**Verbal**
The Chair welcomed Board members to the meeting. There were no new declarations of interest. **Apologies:** Toby Lewis and Cllr Waseem Zaffar.	
2. Patient Story	**Verbal**
MR introduced patient John Phillip, who had attended the Emergency Department following a work accident and had faced some confused communications and poor aftercare following surgery. Mr Phillip explained that on 15th October 2020, he had amputated the tip of a finger during a ladder accident whilst painting a house. Arriving at hospital, he was triaged quickly and forwarded for X-Ray. He was also swabbed for COVID-19 and MRSA before being seen by a surgeon. He had been given painkillers and antibiotics and sent home until the results of his infection control tests were known. He contacted PALS the next morning because he had not been contacted with the results and then contacted the laboratory directly. However, the hospital called him in the interim to organise surgery, without the tests being known, which he was subsequently told was an error. A temporary dressing was put on his wound over the weekend and he was told not to eat or drink for several hours before his Monday surgery because he would be given a general anaesthetic. The surgery was however, performed under local anaesthetic. Mr Phillip reported that his aftercare had been poor. He claimed he was left with inadequate relief for excruciating pain, which was witnessed by nurses and reported that some were unsympathetic when he called out in pain.	

He was also uncomfortably hungry because he had not eaten all day.

Whilst Mr Phillip was denied his request to be given morphine, he appreciated the time taken by a doctor to explain why prescribing more was a risk.

Visiting the GP surgery to have the stitches removed, he was prescribed more antibiotics instead, because of concerns about the wound's integrity, and was referred to the hospital. Here there was further communication confusion over dressing changes, which had been concerning although he was very happy with the service from the surgical nurse.

RS apologised for Mr Phillip's mixed experience.

DC queried the communication aspects of the story. Mr Phillip reported that he had appreciated the doctor's candid approach concerning the morphine issue. In terms of the surgery confusion (general v local anaesthesia) Mr Phillip commented there appeared to be a lack of understanding of the procedure by the staff communicating with him.

LK summarised that Mr Phillip had not had his expectation of the experience managed clearly enough. He commented that this was a common theme in feedback and that the Trust needed to get better at imparting accurate information regarding treatment pathways to patients. Mr Phillip commented that being given contact information on discharge would have been useful.

DC commented that anticipatory pain relief was another theme of the story and would be discussed with the wider surgery team. MR assured Mr Phillip that she would be considering the approach by nursing staff. RS thanked Mr Phillip for his contribution.

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

The Chair, RS, expressed the Trust's appreciation for Captain Tom Moore's extraordinary fundraising efforts for the NHS before his recent death.

The hospital was still busy dealing with a high community [COVID-19] infection rate, although numbers had recently fallen. There had been a successful visit from NHSE/I (to be discussed later in the agenda) which had been a boost to the team dealing with relentless pressure from the infection surge.

More positively, there had been significant progress and excellent collaboration to deliver the vaccination programme.

An interim Chief Executive appointment had been announced. Richard Beeken would shortly join the Trust (Monday 8th February 2021). RS expressed sincere thanks on behalf of the Trust to Dr David Carruthers for stepping up to the role and for his leadership of the Trust alongside his Medical Director role.

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

The following questions were received from members of the public:

Q. Can Dr Carruthers say what the impact of the UK COVID-19 variant has been on the Trust? What percentage of patients have tested positive for that variant, and has the Trust had any cases of the South African variant?

A. DC commented that variant infection figures were uncertain. He reported that in Wave 3 of infections, the total number of patients in the organisation had been double the number in the previous wave. The community instance rate had been higher than in Wave 1. Laboratories had not been routinely testing for variants on every patient, but the assumption was that a high percentage would be one of the new

variants because of their increased transmissibility. Outcomes of admissions to the hospital and ITU were being monitored, but there was no evidence to support the idea that there would be poorer outcomes for patients being admitted to hospital, compared to Wave 1.

Q. *What arrangements are in place for patients on the cancer pathway? What cancer services have been stepped down?*

LK reported that the Trust was still operating all of its cancer services, but they had been reduced because of access to theatres and doctors.

All ITUs were operating at full capacity dealing with COVID-19 patients, and it had been difficult to deliver the higher level of aftercare following cancer surgery. Instead, a regional, shared prioritisation group had been established to offer this care.

UPDATES FROM BOARD COMMITTEES	
5a. a) Receive the update from the **Finance and Investment Committee** held on 29th January 2021. b) Receive the minutes from the **Finance and Investment Committee** held on 27th November 2020.	**TB (02/21) 001** **TB (02/21) 002**

MH referred Board members to the paper, which was taken as read. The following points were highlighted:

The car parking works had been progressing well and on time. Tariffs had been discussed and had been presented to the Board for approval.

A significant amount of work had been devoted to the planning of the 21/22 financial budgets, ensuring they were aligned and on the trajectory to the opening of MMUH. More work would be required to get to a refined summary and this would be done by April 2021.

The COVID-19 'Exit' strategy had also been discussed in terms of aligning to the infection control rules.

RS commented that the residual costs of COVID-19 remained an emerging picture. DMc commented that the finance team had done a lot of planning work and conversations had been taking place with NHSE/I about funding settlement and the financial impact of the pandemic.

5b. a) Receive the update from the **Quality and Safety Committee** held on 29th January 2021. b) Receive the minutes from the **Quality and Safety Committees** held on 27th November 2020 and 8th January 2021.	**TB (02/21) 003** **TB (02/21) 004**

HK reported that many of the key points from the sub-committee would be discussed on the agenda. He made the following additional points to note:

The COVID-19 situation had been the dominant discussion in terms of dealing with the pressures and the impact of the surge on the current workings of the Trust, the numbers of cancellations and routine services.

The impact of infections on staff had also been discussed. However, it was positive that 5,000 staff had been vaccinated against the virus with a few thousand to go.

The planned recovery and improvement of patients' waiting times and CQC inspection preparation had

been discussed.

Governance around Maternity Services in the wake of the Ockenden Report had been put in place with HK volunteering to be the Board representative in support.

5c. a) Receive the update from the **Digital Major Projects Authority** held on 29th January 2021. b) Receive the minutes from the **Digital Major Projects Authority** held on 27th November 2020.	**TB (02/21) 005** **TB (02/21) 006**

MH reported that the meeting had focused on the future plans of the Digital Roadmap, ensuring there was an alignment to improve Clinical Care across the Trust ahead of the move to MMUH.

Migration of services from data centres in Sandwell and City into the cloud consumption model had been discussed. The PACS system provided by IBM would be involved in the move and images were a focus, ensuring that the systems were fit for purpose.

Cyber security had also been discussed with all associated patches rolled out in the estate. There would be additional improvements from NHS Digital and from the in-house team.

5d. a) Receive the update from the **Public Health, Community Development and Equality Committee** held on 29th January 2021. b) Receive the minutes from the **Public Health, Community Development and Equality Committee** held on 27th November 2020.	**TB (02/21) 007** **TB (02/21) 008**

KT reported that the committee had received the Equality and Inclusion report, which had been excellent and required promotion both internally and externally.

A mathematical presentation had looked at the gender pay gap and the reasons why this might exist. Some of the variants between men and women appeared to be linked to length of service.

Staff wellbeing and activities to support it had been a focus. It had been noted that Dr Makwana's dance sessions had been popular and there had been a lot of interest in the E-bike scheme.

Austin Bell had delivered an exciting presentation on the wider regeneration plan [around MMUH].

FM added that the Trust was proactively recruiting two new positions, the Head of Equality, Diversity and Inclusion and a Manager of Equality, Diversity and Inclusion. There had been a significant amount of interest from high calibre, diverse candidates.

5e. a) Receive the update from the **Estates Major Projects Authority** held on 8th January 2021. b) Receive the minutes of the **Estates Major Projects Authority** held on 27th November 2020.	**TB (02/21) 009** **TB (02/21) 010**

RS reported that the future of the old Hallam hospital site had been debated, with consideration of what planning consents might be required.

An update had been received about a bid for funds from Salix [green/environment-related projects] with the support of Engie, who had extensive experience in this area.

A MMUH progress update had been received. It would be important to acquire more detail of the next

stage of development so as to have clear forward sight. Work of the Clinical Groups in getting the acute care model would be important. More work was still to be done with the results of clinical discussions to be brought back to a future Board meeting.

hMATTERS FOR APPROVAL OR DISCUSSION

6. COVID-19: Overview	**TB (02/21) 011**

DC referred Board member to the paper, but cautioned that the COVID-19 situation was very dynamic and that many of the numbers had changed.

In under a month, community cases had risen from around 200 to just under 1,000 cases per 100,000 per week, before falling back to 485 cases – a reduction of 50%.

The total number of in-patients with COVID-19 had been represented in the paper at a peak of almost 430 and this had reduced to 340. Around 50% of bed space was now occupied by COVID-19 patients rather than 60%.

ITU was currently running at around 160%, although Sandwell was now more pressured than the City site. Expansion of ITU into other areas had been welcome. Reservist staff had been successfully supporting ITU.

A continual risk assessment was taking place daily to ensure appropriate staffing was in place. Additional support had been received from medical, nursing and paramedic student volunteers, along with non-medical military personnel who were helping with logistics and processes. This help had been well-received.

Separate respiratory rotas had been helping with patient flow and new pathways had been introduced for swabbing and patient movements between wards and during discharge.

Positive swabs had fallen from around 50 to 30 per day.

Lateral flow COVID-19 testing of staff would be replaced with the LAMP, saliva-based test, which was more sensitive.

The Trust's PPE position had been reassessed and enhanced a few weeks previously because of the high number of admissions and an increase in the staff infection rate, exacerbated by poor ventilation and crowded wards. This was being continually risk assessed but had been considered an appropriate deviation from National guidance in response to the pressures.

LK commented that the Wave 3 had been more difficult than the others because of the speed and volume of the surge. It was noted that staff had been coping with COVID-19 for a year and were now very tired. He commented that the Trust ought to be mindful not to push the staff too hard in the Restoration and Recovery phase.

HK queried the enhanced testing capability and the timing. DC reported that staff LAMP testing was ready to be rolled out. Lateral flow testing was already taking place. Testing within hospital (2-hour turnaround). Black Country Pathology had extended processing hours. Point of Care testing would be possible overnight within the ED department and the Trust was awaiting final decisions on availability of equipment.

ML supported comments about the high performance of staff in challenging circumstances. He queried staff vaccination numbers. DC reported that details would be discussed during the Private Board session (following this meeting).

MR reported that staffing had been very challenged during COVID-19 and had coped with daily deployment changes for which the Trust was very thankful. A Quality Impact Assessment on staffing paper

would be going to EQC in March 2021.

KT also paid tribute to the heroism of staff. She expressed concern at the Department of Health and Social Care's desire to get things back to normal quickly because it might be asking too much from exhausted staff. LK reported that the Trust had been one of the hardest hit by the pandemic. He confirmed that pressure was being applied to try to secure more time for the recovery, balancing this with patient care.

LW commented that the impact on staff would be felt for a long time. Nationally, there was an aim to place a 'Wellbeing Guardian' in all Trusts which the Board could consider, to ensure staff were looked after over the coming year.

FM expressed the view that there was a responsibility for the Board to consider work and activities to support resilience longer-term. She raised the risk that the pandemic experience might be the trigger for older frontline workers to accelerate their retirement plans, leaving the Trust with big gaps to fill. She also suggested that COVID-19 and non-COVID-19 achievements be better recognised.

6.1 COVID-19: Vaccination Hub	**TB (01/21) 012**

MR reported that a hospital Vaccination Hub had been provided at Sandwell Education Centre since 29th December 2020.

Vaccination had started at a rate of 215 vaccines per day and capacity had grown to up to 400 jabs per day (as of 21st January 2021). The hours of operation had been 8am-8pm.

The Hub had been providing vaccines for the first two cohorts (care home staff, frontline health workers and patients over the age of 80). The service had also been supporting the Primary Care Networks (PCNs) with the vaccination of housebound patients, those residing in care homes and over 80-year-olds.

The Hub also had clinical responsibility for the Tipton Hub which would go live in the next couple of weeks.

Staffing for the hub had been mainly redeployed staff and some non-qualified healthcare staff who had been trained to deliver the vaccine.

MR reported that the Trust had been guided by the STP and region about the cohorts of patients treated. The third and fourth cohorts were the over 75s and the over 70s. The special Vaccination Centres had dealt with the over 70s.

MR stated that the vaccination programme had commenced with the administration of the first dose and the timing of the administration of the second dose had been changed to 11-12 weeks. These jabs were now being booked.

Initially, staff had been offered a vaccine at Walsall and via a number of PCNs. Currently, the Trust's own hospital Hub had vaccinated 6,889 individuals (mix of patients and staff). Data systems were enabling staff vaccine rates to be monitored.

There had been STP discussions about vaccine flow. From 11th February 2021, Walsall would be the only hospital vaccine hub to continue. The Trust's own hub would temporarily suspend activity until 15th March when second doses would commence.

In response to a query from RS, MR reported that the STP had discussed take up among ethnic groups. Take-up amongst black and Afro-Caribbean groups was a concern and targeted work would be required. RW added that key influencers in those communities had been helping with the messaging. YHP was taking part in a pilot with Sandwell Local Authority, taking an individual approach.

HK queried whether the Trust had a good understanding of the nature of community concerns about the

vaccination programme. RW commented that Q&A panels/forums had been taking place in the community. Intelligence was being shared across the Midlands region and also nationally.

RS queried whether administration of the second doses would pose any problems. MR commented that checks were being made to ensure staff would receive their second dose within the recommended 77 to 84-day window.

FM advised that information in communities was usually transmitted through places of worship, community gatherings and interaction with family members and friends. She suggested that younger people and children could play a part in communicating messages and helping to educate families about the vaccine.

7. Planned Care and Recovery Report	**TB (02/21) 013**

LK reported that in December 2020, the Trust had been tracking reasonably well against RTT and DM01, but the position had now changed.

Diagnostics for all urgent cancers and routine (where possible) were still continuing along with cancer and emergency work. There had been a large impact on the non-cancer and non-urgent work because staff had been redeployed to ITU and extended ward areas. This would have an impact on activity levels and waiting lists.

In response, the Trust had standardised a Harm Review document and this was in the process of being uploaded onto Unity, so that it could be linked to the patient record.

Clinical prioritisation continued with most patients on the in-patient waiting list having been prioritised into categories. However, 1,744 had yet to be allocated. Those patients who fell outside of the indicated length of wait were being monitored. More and more patients were waiting a long time. This was an issue across the NHS. Referrals were being tracked to ensure there was a safety net and that the Trust was aware that care was required.

The risk was that the longer the pandemic went on, the longer the waiting list and risk of harm.

LK reported that the Trust would be working collaboratively on its Restoration and Recovery journey to utilise possible extra capacity elsewhere. Cancer patients needing high dependency beds were already being pooled across the region, utilising independent sector capacity.

LW queried communication with patients on waiting lists. LK reported that all patients had been contacted by phone during the categorisation process. High priority cases were being encouraged to come into hospital when capacity was available. More patient feedback would be sought about the process.

MH queried the catch-up time. LK reported that this would be difficult to predict. The position in relation to Ophthalmology had got worse from Wave 1 and was of most concern. Even in other areas, it would take a minimum of six months to get back to normal levels of care. All capacity would need to be used to its fullest to ensure timely treatment for patients.

DMc reported that the STP had undertaken some modelling around 21/22 cost base. There was an expectation of funding to assist the Recovery, but the limitation would be physical capacity in the workforce.

BREAK	
8. Maternity Services Report	**TB (02/21) 014**

Since the publication of the Ockenden Report 2020 which had exposed serious failings in Maternity Services, Trusts had been required to strengthen and optimise Board-level oversight of quality and safety.

HH presented a paper setting out the Trust's proposed governance framework of its Maternity Services from Directorate to Trust Board. It was proposed that a Highlight Report, inclusive of the Maternity and Neonatal dashboards would be presented at the Quality and Safety Committee, the Quality Committee, and the CLE, before being presented to the Trust Board on a monthly basis.

RS queried whether the plan was a settled position. HH confirmed it was aligned with the Ockenden findings.

ML queried whether it would be more efficient to use the same report for each governance/reporting stage, rather than create a bespoke piece of work each time. HH explained that many of the members sat across all Committees and therefore, differently written reports would be more helpful to provide the level of scrutiny required. There were also some very necessary national requirements for reporting.

The dashboard had already been built by the Trust's Business Intelligence Support unit which would identify highlights and exceptions.

DMc commented that culture was often the cause of problems and queried the measurement of data. HH reported that culture was a key focus of the current transformation work in Maternity Services. Staff were now raising concerns and felt better listened to, which was a positive.

KT queried how the issue would appear on the Trust's Risk Register. HH reported there was a robust governance procedure in place and a good Risk Register but that it would be formalised into one clear reporting mechanism set down by national requirements. All Maternity Services in all Trusts were now reporting in the same way.

RS queried the interface with LMNS and whether comparability with partner Trusts was visible. HH reported that the Ockenden Report and assurance tool went to the Exceptions Committee and were approved.

9. CQC Improvement Plan Report	**TB (02/21) 015**

KD reported that there would likely be changes in the wake of a CQC's consultation which would end on the 23rd March 2021. The CQC had been operating an inspection regime since 2014. However, this was considered no longer fit for purpose given the new lockdown restrictions and the introduction of digital channels.

The CQC had indicated that it was keen to update providers' ratings without having on-site inspections, instead, utilising other sources such as data and feedback from the public.

KD reported that, currently, the CQC could not change a rating unless there had been an inspection, which had caused some anxiety for providers. The Trust for example, currently had an 'inadequate' rating for Children and Young People's services at City Hospital, but since the rating was given a few years ago, services had vastly improved and urgently required updating.

Some organisations would still be visited going forward - those where there was significant risk to people's safety and to the rights of vulnerable people.

KD reported that the expected change to the CQC's approach would mean that the Trust's current rating would be assessed quicker which was a positive. The CQC would also take into account the timing of

previous inspections of Trust services. The less the concern, the less frequent the attention from the CQC.

The CQC planned to publish a simplified overall rating for the Trust, moving away from its five question areas (listed below) which would only apply to individual hospitals and services going forward:

- Safe
- Effective
- Responsive
- Well-led
- Caring

In terms of GP practices, the CQC would stop providing rating for individual population groups because their current approach had been too complex.

KD reported that the changes were expected to be made 'as soon as the pandemic allowed' (April/May 2021). KD expressed the view that the Trust should continue with its continuous quality improvement and stay close to the CQC inspectors. Public perceptions of the Trust would be increasingly important going forward and more work would be required to better engage with patients.

LW commented that the CQC information often lagged and it would be useful for the Trust to collect its own information. She suggested undertaking an internal review of Trust services with a clinical panel. She expressed the view that the Trust did not get enough feedback from patients and it would be useful for the Board to see this. KD agreed and commented that the Trust should be more proactive in capturing feedback.

LK queried how the waiting lists caused by the pandemic pressures might be viewed by the CQC. KD commented that being able to give a good explanation of the situation to the CQC, evidenced with relevant data would be essential.

HK queried whether the CQC was moving from a quantitative to a qualitative approach. KD commented that the existing inspection regime had become an outdated model during a period when many services were being delivered differently, but there were a number of factors involved.

ML commented that getting a 'good' or better rating was important in terms of attracting staff and to have a credible voice in the STP. Prioritisation would be required to identify areas of improvement for the Trust. He queried the self-assessment process. KD reported that in terms of self-assessment, there was a deadline at the end of February 2021. Scrutiny by some professional panels was being considered so that teams could present their achievements.

DMc suggested getting a perspective on SWBH from the leadership of a Trust that had been achieving 'outstanding' ratings. KD acknowledged that this would be a good idea.

LW reported that, when she had been leading a previous organisation, its rating had moved to 'good' because of an improvement in culture. She suggested that collecting and sharing patient stories and staff perspectives and achievements would help boost morale amongst staff.

10. Fulfilling our Equality, Diversity & Inclusion commitments - update	**TB (02/21) 016**

FM referred Board members to the paper which updated the position in relation to Equality, Diversity and Inclusion initially presented to the Trust Board in December 2020.

Progress had been made on resourcing and FM expressed thanks to the Board for the recommendation to

focus on a smaller number of objectives.

There were now four key areas of focus:

- The efficacy of the Trust's recruitment and employee relations practices
- Equitability of access to career progression and employment development opportunities within the organisation
- Fairness in relation to the allocation of pay and related benefits.
- Relevance and timeliness of support for those with additional needs and requirements

Dashboards would assist in monitoring progress and achievements in relation to these objectives. Local and national targets would be considered. The paper also provided an update on progressive work in relation to Black Lives Matter.

RS stated that it was important for the topic to remain visible at Trust Board level. FM reported that a further update would be presented to Board at the end of Q1 following the publication of a response to national requirements.

HK queried whether the Black Lives Matter movement had morphed into a political movement rather than a network focused on the equality and diversity agenda. FM reported that this question had been discussed at the STP meeting. It was not considered a political movement because it was aligned with the key lines of enquiry within the WRES and was part of inclusion for BAME colleagues.

DMc expressed the view that the Trust needed to ensure it was tackling institutional problems. It would also be important for the EDI roles to have real influencing power and impact. FM agreed and made the point that tackling systemic racism was very difficult but could be addressed with education.

KT commented that there used to be a staff side representative who observed the Board and Committees. She suggested this might be re-instated. FM stated this idea was being considered and would be taken away as an action.

Action: FM to seek update in relation to the re-instatement of a staff representative Trust Board observer to the next Board meeting.

REGULAR MATTERS

11. Chief Executive's Summary on Organisation Wide Issues	**TB (02/21) 017**

DC reported that COVID-19 was still the focus of Trust activity. He acknowledged the quality of the services being provided under extreme pressure. UCL's ITU Service had visited to support the organisation.

DC read an extract from a letter received by the Trust's ITU team from the Deputy National Strategic Incident Director which acknowledged the leadership and dedication of staff at SWBH in maintaining high standards during the surge.

There had been no enforced cancellation of annual leave for staff, although some had voluntarily postponed it. Leave could now be carried forward up to a maximum of 20 days.

Deployment of staff was being constantly assessed to be responsive to the changing situation.

DC highlighted the following other points:

Patient Care

Improvements were ongoing in relation to patient flow and care. It was likely that Lateral Flow and LAMP testing would be introduced earlier than expected into Maternity Services, so that paternal visits into scanning appointments could be re-introduced.

In terms of discharges, clinician understanding of pathways that were available for supported discharge had been a recent focus so that home oxygen monitoring, community service availability and referral to the Discharge to Assess hub had been promoted.

The NHS Staff Survey had been completed by 38% of staff (similar to the previous year). The initial results had been received.

QIHD poster competition

DC reported that the competition had attracted high quality submissions, with Ophthalmology, Gynaecology and Breast Screening making the top four.

However, the winner had been Speech and Language Therapy (Children's Community Service) who had taken an evidence-based approach to their work with children with speech and language difficulties in education.

Building progress

Building work was continuing on the new multi-storey carparks and the GP practice on the Sandwell site which was almost complete.

Leadership

Richard Beeken would be joining the Trust as Interim CEO from Monday 8th February 2021. DC expressed gratitude for the support from the Board and the broader team during his period in the role.

LK raised the issue of circulating rumours around West Birmingham and BSOL. RS stated that MMUH was the Trust's key priority and assured Board members that it had support at the highest level accompanied by major investment.

RS queried the improvements in care/alternative treatments for COVID-19. DC commented that treatments continued to be developed, refined and modified.

ML queried the learnings that DC would take away from his experience as the Trust's interim CEO. DC commented that he had benefited from being able to take a more overarching, longer-term, strategic view of the organisation which he could now take forward to his Medical Director role.

DB commented that the Trust had developed its growth mindset during the pandemic and there was now a shift from performance metrics to a people-focused culture. RS acknowledged his point and the importance of staff wellbeing.

11.1 Integrated Quality & Performance Report	**TB (02/21) 018**

DB reported that the Trust had hit targets for delivery of the seasonal flu vaccination which was a positive.

Whilst A&E performance had gone down, it had climbed up national rankings, having performed better than other Trusts despite being busier than many other parts of the country, which was another positive.

In relation to two maternal deaths, the first case had occurred post-delivery with acute fatty liver being a key factor. There had been no failings in care found during the deep dive and had now been referred to the healthcare safety investigation branch. A second death related to complications from a termination of

an early pregnancy. The case had now been referred to the Coroner.

The Never Event had been discussed at the last Board meeting and was being investigated through the SI Never Event pathway.

ML queried the changing CQC regime and the importance of data. DB reported that the Trust had recently committed to purchasing an intuitive benchmarking tool utilising Artificial Intelligence to report on a range of metrics relevant to the CQC. It would also enable the Trust to identify areas where improvements would have the most impact.

Action: DB to organise a demonstration of the new benchmarking tool utilising AI to report on a range of metrics to Non-Executive Board members before a presentation to the Trust Board in April 2021.

11.2 Improving Hospital Standardised Mortality Ratio (HSMR)	**TB (02/21) 019**

DB reported that the Trust's HSMR [a measure of deaths against expected numbers] was very high at 139 rather than 100 or below (note a reporting lag to IQPR of 3-4 months). Before the pandemic, it had been 112.

A task and finish group had been established, Chaired by Deputy Medical Director, Chizo Agwu to align efforts to improve the HSMR score. The group included the Clinical Head of Coding who would provide a useful link.

Further assurance was provided to the Trust Board by the fact that care notes relating to 85% of deaths, were already being scrutinised by Medical Examiners as a matter of course.

DB reported that it appeared that the coding process was one of the reasons for the high HSMR number. Referring Board members to several graphs in the paper, DB pointed out that cases had started to gradually rise after Unity was introduced in September 2019 and had sharply risen from March 2020 when the pandemic hit.

Issues included an excess of consultant episodes. DB explained that in terms of primary diagnosis for example, choice of words could affect the coding. There were thought to be 79 COVID-19 related deaths which had not been picked up because they were not first or second episodes which were the focus of the HSMR coding process.

DB reported that the Quality and Safety Committee had requested to see the paper every two months to track the lead measures. The work to address the issue would likely be completed by February 2021 and the results should be seen in June 2021. The hope was that lower figures would be observed.

LK commented that, as well as the introduction of Unity, there was also a Trust-wide project to reduce the allocation of the admitting consultant which might have had an impact.

DMc queried whether there was any other information to give assurance that coding was the issue. DC reminded the Board that another layer of assurance was provided by the role of the Medical Examiners and their scrutiny of cases.

11.3 Finance Report: Month 9 2020/21	**TB (02/21) 020**

DMc reported that the Trust was ahead of its deficit plan at Month 9 and was on track to achieve its £2.3m year end deficit (subject to confirmation of the £2m taper relief and excluding any provision for Annual Leave accrual).

DMc reported that she was working with HR and informatics to get an accurate financial assessment of the

implications of carrying leave forward for those colleagues who had not been able to take advantage of their entitlement because of COVID-19 pressures.

DMc reported that NHS leaders had made it clear that because of current pressures, there was no insistence of an improvement on the Trust's deficit position. DMc further reported that the forecast would be reviewed at Month 10, when risks and the overall STP position were understood in more detail, given the risk-sharing situation. She commented that if risks were mitigated or avoided then the Trust might be able to improve on its forecast.

It had been confirmed that current block payment arrangements would be rolled over into at least Q1 of 21,22, although the values have not yet been confirmed. The advance cash payment was expected to stop because the Trust's cash balances had been very strong.

DMc reported that internally funded capital was on plan and if all COVID-19 capital was not funded, then the Trust would be able to absorb the expenditure from its own funds, although this would mean the amount of slippage offered to the BCWB STP capital CRL would be reduced.

This month's capital forecast also included a more accurate assessment of MMUH cashflows against plan, reflecting some slippage due to COVID-19, and an estimate of spend at the beginning of the year in the absence of Balfour Beatty cashflow at that time.

11.4 Trust Risk Register Report	**TB (02/21) 021**

KD reported that the list of risks for which the Board had oversight would be returning to RMC and there was nothing to escalate to the Board.

The previous RMC had considered the 'Red' risks at its previous meeting and these had been sent back to the Groups for further work - particularly around the risk statements - before returning to the Trust Board at the March meeting.

The COVID-19 risks would also be reviewed and presented to the Board at the next meeting.

LW commented that staff often struggled to understand risk assessment and documenting it. She queried whether the Groups understood what was being asked of them. KD commented that the Trust was trying to empower people in this area and a cascade system was being used in support.

11.5 NHS Regulatory Undertakings: Monthly status update on agency and four-hour standard	**TB (02/21) 022**

DC reported that ED attendances were lower than corresponding months last year.

Acuity of patients remained high as well as the number of ambulance conveyances with longer waits in ED. There had been some 12-hour breaches and longer ambulance waits than would normally be acceptable. A joint review would be undertaken across the STP about flow of patients.

There had been increased expenditure on agency work which was linked to the rise in COVID-19 community cases and a rise in admissions to hospital.

DMc added that, despite the pressures described, the agency rate was lower than the previous year.

LK reported that in January there had been 23 x 24-hour breaches at a time when the Trust was responding to a rapid COVID-19 surge. A report would be presented to the Board at the next meeting.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS

12. Minutes of the previous meeting and action log To approve the minutes of the meeting held on 7th January 2021 as a true/accurate record of discussions, and update on actions from previous meetings	**TB (02/21) 023** **TB (02/21) 024**
The minutes of the previous meeting held on 7th January 2021 were reviewed. The minutes were **APPROVED** as a true and accurate record of the meeting. There were no updates to the action log.	
MATTERS FOR INFORMATION	
13. Any other business	**Verbal**
• None discussed.	
14. Details of next meeting of the Public Trust Board:	**Verbal**
• The next meeting will be held on Thursday 4th March 2021 via WebEx meetings.	

Signed ……

Print ……

Date ……

Sandwell and West Birmingham Hospitals NHS

NHS Trust