Sandwell and West Birmingham Hospitals NHS

NHS Trust

TRUST BOARD PUBLIC MEETING MINUTES

Venue: Anne Gibson Boardroom, City Hospital **Date:** 4th October 2018, 0930h – 1300h

Members Present:

Mr R Samuda, Chair	(RS)
Mr M Hoare, Non-Executive Director	(MH)
Prof K Thomas, Non-Executive Director	(KT)
Mr H Kang, Non-Executive Director	(HK)
Cllr W Zaffar, Non-Executive Director	(WZ)
Mrs M Perry, Non-Executive Director	(MP)
Mr T Lewis, Chief Executive	(TL)
Ms D McLannahan, Acting Director of Finance	(DMc)
Prof D Carruthers, Medical Director	(DC)
Mrs R Goodby, Director of People & OD	(RG)
Mrs P Gardner, Chief Nurse	(PG)
Miss K Dhami, Director of Governance	(KD)

In Attendance:

Mrs C Rickards, Trust Convenor	(CR)
Mrs R Wilkin, Director of Communications	(RW)
Mr D Baker, Director of Partnership & Innovation	(DB)
Ms C Dooley, Head of Corporate Governance	(CD)
Mr L Kennedy, Deputy Chief Operating Officer	(LK)

Minutes	Reference
1. Welcome, apologies and declaration of interests	**Verbal**
Mr Samuda welcomed everyone to the meeting. Apologies were received from Ms Barlow and Ms Dutton.	
2. Patient Story	**Presentation**

Mrs Gardner introduced Jenny Clark the mother of an 8 year old boy with autism. Jenny described that her son is often given a general anaesthetic or heavily sedated for procedures to be undertaken due to his anxiety/distress and she explains to staff that he needs a ward side room. Staff may not fully understand her son's distress and he sometimes self harms and has now commenced anti-depressants. Jenny's son has a twin sister and often the distress impacts on her, with the family housebound for some periods due to his condition. Jenny advised on some positive progress with her son now slowly starting back to school for a few hours each week.

Mr Samuda thanked Jenny for her story and asked for questions from Board members.

Mr Lewis asked when family come in into the Trust do staff listen to them as expert carers and Jenny replied that as her son has no voice so it is really important that staff listen to her mainly as she knows him so well and provided an example of advising not to insert a cannula as he will rip it out. Mr Lewis asked again do staff pay attention to her and she confirmed they do once she explains fully, in a lot of detail.

Professor Carruthers asked about the difference between same/routine appointments and those in a different/acute environment. Jenny felt if staff were prepared for him the experience is better.

Mr Kennedy asked about appointments that are not adequately lined up and Jenny replied that there are times her son waits for appointments, for example dental appointments or to manage constipation problems, that could have been managed at different appointments already scheduled.

Miss Dhami agreed that she felt when staff talk to the patients by their name and are pre-prepared for individual patient needs this eases the experience. Jenny agreed with this and commented that if she shows her son pictures of what might take place, in advance, this helps to prepare him is better. Miss Dhami felt that the staff being prepared for the patient is really helpful.

Mrs Gardner talked about simple strategies that can be put into place to aid patient experience and she will liaise with the paediatric team about Jenny's son in particular.

Mr Samuda advised Jenny's son can receive good care by knowing of his specific needs, along with other patients that we know about. Mr Samuda commented that this information is very powerful and useful for us to improve care and we will respond on progress directly to Jenny for her son. Jenny thanked the Board for listening to her story and noted she had come today not just to talk about her own son but for other children's experiences.

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

A visitor, on behalf of Healthwatch, asked about transport to the day hospice, a system that has been in operation for 19 years old and is letting people down. Mr Lewis apologised for this and committed to ensure an improvement over the next 4 months (by end of January 2019). Healthwatch also felt GPs should provide better communication about the day hospice and Mr Lewis felt this is primarily in fact an issue for the Trust as it is essential information to provide to patients, families and carers.

The Board was asked to confirm the funding arrangements for Midland Met and adopt a mandate that no cuts should arise locally from its construction. In replying Mr Lewis noted that the final costs involved will not be known until commercial close in 2019, but that in line with our practice, both the Outline Business Case and Final Business Case will be public documents. There was a clear Ministerial and Trust commitment to no costs above the prior unitary payment. He noted that future NHS efficiency requirements are set nationally and the Trust would meet those, unless it would unsafe to do so locally. He did not foresee that arising.

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

Mr Samuda thanked those involved in the Windrush event on Monday 1st October in the Education Centre at Sandwell commenting on the fantastic photo gallery on display.

Mr Samuda noted some non-executive directors had attended the GIRFT programme event and this provided clinical engagement on best practice which is a powerful tool/information for future integrated care. Mrs Perry asked for dates for future meetings/events for scheduling into diaries.

ACTION: Provide GIRFT event dates to Non-Executive Directors.

5a. Update from the Charitable Funds Committee – 13 September 2018	TB (10/18) 001

Cllr Zaffar highlighted the following from the Charitable Funds Committee:

- A review of confirmed fund-raising targets was received.
- A discussion took place on external resource campaigns which had not been successful.
- Duplication of funding is often a challenge.
- The committee approved 5 new projects.
- Generally progress is moving on well projects, particularly the alcohol project.

5b. Update from the Public Health, Community Development and Equality Committee - 13 September 2018	TB (10/18) 003

Prof Thomas drew attention to key points from the Public Health, Community Development and Equality Committee:

- The smoke-free sites messages have commenced (posters were seen at Rowley Regis Hospital on last Trust Board meeting day).
- The Mental health strategy wemind has been launched and she will be filmed about this today for staff communications (available on the Trust intranet site).
- Data on bullying in the workplace was discussed noting the Trust is not out of step on this issue as there are concerns across the health service on this issue and as a board this needs to be taken very seriously.
- Pet therapy progress – Mrs Gardner advised ponies have been used and now robotic seals are being trialled.

Mr Lewis asked for confirmation of the source of the cited figure of 17-23% of staff report that there is bullying and harassment in the workplace and Mrs Goodby advised this is from national staff survey which asks “have you experienced bullying or harassment at work”, noting this could be personally or seen in others. In terms of aggression in the workplace our results are “average” as a Trust but we are taking any report very seriously, at the highest level through detailed committee discussions, on actions that we can take to improve working experiences/conditions and supporting staff. Mr Lewis drew the Board’s attention to a distinction in that work between security related issues and de-escalation projects within clinical care environments.

5c. Update from the Estate Major Project Authority – 21 September 2018	TB (10/18) 005

Mr Samuda reported that the focus of the EMPA meeting was on Midland Met construction oversight and members reviewed the resources required to complete the build, options for facilities management (including key life cycle of replacements) noting this work is in progress and will be scrutinised closely over the next month. Detailed summaries on all projects will be reviewed closely through the committee and reported to the Trust Board.

Mr Lewis referred to the August MPA minutes about the expected decision on Cerner (Unity) go-live, advising that no decision on January was yet possible and he will work with Communications Team on providing briefings to staff on go-live, which is now expected to be during the first half of 2019.

5d. Update from the Quality and Safety Committee - 28 September 2018	TB (10/18) 007

Mrs Perry highlighted the following from the Quality and Safety Committee meeting:

- Strategic Board Assurance Framework – risks reviewed and discussed:
  - Missed safety checks risk - internal audit will undertake a review on this.
  - Quality plan mortality is a detailed item for the next Q&S meeting.
  - Paediatric eye care – a written update from the group has been requested for review.
- IQPR – there is a lack of clarity on quality standards responsibilities (doctor or nurse) and Q&S have asked to see a plan on this to confirm how this is addressed.
- 4 hour targets on admission to stroke wards – improvements need to be explored and this will be a focus in detail next meeting.
- Mandatory training is improving but still needs to reach 95%, noting a lot of groups are already at 100% and Mrs Goodby advised on programmes that are planned to improve this (increasing basic life skills training by writing to individual staff).
- Approach to persistent reds – any quality standards for 2-3 months will be reviewed closely.
- Good news on T&O quality standards (following summit) and a dashboard was presented, which will now go back to group for management rather than through Q&S.
- Unannounced visits (4am by Chief Nurse) - feedback will be provided at next Q&S committee meeting.

Mr Kang referred to Mandatory Training and stressed this also discussed at P&OD committee to focus on ensuring 100% compliance.

Mr Lewis felt a single report on mortality should be prepared to be shared across different meetings as one lean report in a standard format would be beneficial to stop several assurance reports being produced and he would work with Dr Carruthers on this.

Mr Kennedy referred to the T&O safety dashboard and asked if there was a measure in place that led to its de-escalation. Miss Dhami replied that gone back to group as it had been green for several months.

5e. Update from the Finance and Investment Committee – 28 September 2018	**TB (10/18) 009**

Mr Samuda highlighted the following from the Finance and Investment Committee meeting:

- High level forecast to end of year control total, with risk, including £28M CIP, with a structured programme on resources and investment in place in improve position, including income.
- Procurement – there is good procurement team in place and data but there is more to do to turn this into information clinicians can use on how gains can be made without affecting clinical outcomes.
- At October FIC there will be a capital and cash plan, in particular in relation to any impacts on Midland Met delay (which will then come to November Trust Board).

5f. Update from the People and OD Committee – 2 October 2018	**TB (10/18) 023**

Mr Kang presented headlines from the People and OD committee:

- There is strengthening of the rostering process taking place.
- Performance of PDR process and moderation is taking place and normalising the process going forward (as this is the first year of the new system) and guidance/support is being provided to managers on moderation conversations with staff.
- There has been good development of the internal nurse cadre/escalation process and we now have a bank of individuals in place that have been developed.
- Progress on the KPIs used in IQPR will take place in relation to fine tuning/finessing of visibility.

6. Chief Executive's Summary on Organisation Wide Issues	TB (10/18) 11

Mr Lewis highlighted the following from his report:

- We will sign the contract later today with Balfour Beatty for the Early and Enabling Works Contract for Midland Met.
- Staff in pathology have now changed their employer to Black County Pathology as reported several times to the Trust Board, with specialist pathology being provided on a separate arrangement. A lot of people have worked very hard on this (e.g. location, payroll, TUPE etc) and we now should move forward with pathology as an out-sourced service.
- The top quality focus for the Trust is sepsis. There is still work to do on the wards and by December we expect to see significant improvement.
- IT resilience – this item is to be discussed in detail later on agenda.
- Recruitment – there are hot spot areas of focus over next 4 weeks and Executive Directors will spend more time on this across different staffing groups and will use generic improvements which have worked with specialist focus on a small number that need a targeted approach/pitch (e.g. stenographers). If over next 6 weeks do not see significant progress by April/May 2019 this will be more serious issue. There is no lack of enthusiasm we just need targeted approach on the goals we have set to reach them.

7. Integrated Quality and Performance Report	TB (10/18) 012

Mr Baker reported on the following keys areas:

- Emergency care and mortality progress will be provided to future board meetings.
- There will be a focus on VTE focus and a paper on this will be provide to the next Quality and Safety Committee.
- There is a focus on improvement for diagnostic performance and to improve sickness absence rates.

Mr Lewis asked for assurance on the improvement work for diagnostics and Mr Kennedy responded that there are significant staffing issues (in imaging and parts of medicine groups) and the focus is on longer term plans by mitigating the gaps and clearing the backlog due to broken scanner. There is a significant focus on recruitment and data collection (real-time information is required and this should be fixed fairly quickly). The return of staff off sick trajectory is being progressed but there is not clear picture yet on the improvement deadline date. Improvements in undertaking scanning is taking place by using a different skill mix within the imaging group, repairing equipment and tackling actual demand is the focus for improvement and by November Trust Board we need a coherent plan (general and specialist) to show this improvement trajectory with timescales and confidence.

Mr Hoare asked about admittance to stroke wards (25 breaches) by querying if this was a specialist capacity issue or lack of beds. Mr Baker replied that the bulk of this was capacity issues on stroke wards. Mr Kennedy also replied this is dual issue on capacity and making sure the right patients are on right wards as we need to ensure we utilise the stroke wards for stroke patients. Mr Lewis challenged whether we were certain of the Root Cause Analysis. This data will be reviewed and provided to Quality and Safety Committee and the Performance Management Committee.

7.1 Financial Performance: Month 5	TB (10/18) 013

Ms McLannahan described the key elements of her report, which shows the Trust maintaining plan with some support from reserves. It remains possible to achieve the control total, but this will require improved delivery in Q3-4 of our production plan. The proportion of expenditure reduction delivery achieved non recurrently is growing and there is an acknowledgement that this will need to be addressed in month 12 to exit the year in recurrently a strong position.

Prof Thomas asked about creditors and whether or not we can identify make or break issues and deal with them. Ms McLannahan replied there is not a systematised approach to dealing to prioritisation (other than threats from supplier to put us on stop) but prioritisation of local suppliers does take place.

Mr Samuda asked about non-procurement savings targets into groups. Ms McLannahan replied that there is a large/granular workplan by group and various assumptions were made aligned to groups and how savings can be achieved. Mike Hanson, the new Black Country Procurement Director is leading a substantial piece of consistency work on this, with Group Directors keen to have this detail to realise the benefits to each Group. Group Directors of Operations and Finance Managers are working closely with the procurement team to focus on the savings that can be made, which requires work on data validation/consistency across the 3 Black Country Trusts.

Mrs Perry asked about consistency across the clinical groups and Ms McLannahan replied the groups meet together to review consistency at a meeting which is chaired by Debbie Talbot, Associate Director of Nursing and here is an extensive amount of clinical engagement work which takes place by finance team.

Mr Kang asked about £18M QIPP/health economy savings and Mr Lewis noted that of our triangle approach this remained the least developed area. Six bundles of change were planned and the recent Avastin decision creates a real opportunity for the system to realise shared savings for reinvestment.

Mr Lewis asked about delayed payments and the clear indication on the 60 day target for non-NHS payments asking that the report for next month is separated and tracked, which Ms McLannahan agreed to provide.

ACTION: Delayed payments – 60 target for non-NHS payments to be separated and tracked in the next Financial Performance Report to the Trust Board.

8. Monthly Risk Register	TB (10/18) 014

Miss Dhami advised the monthly risk register report provides an overview of risks and those with a high impact/low likelihood, along with highlighting risks not addressed over the previous 12 months. There have been no new risks have been added to the Trust Risk Register. There are 4 risks on IT infrastructure and the new CIO will review these mitigation plans, which will be discussed at the Digital MPA and Trust Board. The Midland Met risks will be updated in advance of the next Trust Board meeting.

In relation to the high severity/low likelihood risks, these focus on the potential number of staff or patients affected, penalties/fines, or a large number of potential patient harm. There are 42 high severity/low likelihood risks and half of these relate to the estate, which is highly unlikely but could be catastrophic if they occur. Those that are clinical are unlikely but also noted as severe if they materialise. Treatment plans are now in place for 10 out of the 18 clinical risks with assurance on mitigation and Groups will provide reports on the remaining 8 at the next Risk Management Committee.

Mr Lewis referred to 2.6.3 about asbestos and commented that the Estate Major Projects Authority will take a review of all 24 estate risks in detail at the December committee meeting.

Mr Lewis referred to Tier 4 CAMHS bed position which has been on the Trust Risk Register for 4 years, a position which is not likely to improve. We have ligature light space but that is not a substitute for the provision patients need from others. He agreed to again approach commissioners and providers for a trajectory on improvement.

Ms Dhami outlined the risks where we could not evidence change or review over a 12 month period. If they have been resolved this should be reported to ensure the risks that are still live and being managed can be addressed. The Risk Management Committee will focus on this issue and then report the findings to Group Directors at the Clinical Leadership Executive.

ACTION: STP discussion required on CAMHS Tier 4 bed provision across the local health economy.

ACTION: Risks not managed for previous 12 months to be reviewed by Risk Management Committee and findings reported to Groups at the Clinical Leadership Executive.

ACTION: Estate risks to be reviewed at Estate MPA in December 2018.

9. CQC Well Led Self Review	**TB (10/18) 015**

Miss Dhami noted the CQC well led self review took place at the Board development session in August 2018 and the Trust received a "good" rating for well-led in 2017. Group triumvirates are doing same and see this at November self review assessment reports. The Board were asked to review the self review information from the board development session to check against deliverables and discussion took place on these as follows:

- Mr Lewis asked why we scored green/yellow on engagement and Miss Dhami replied that there is staff, patient and partner scores, which were at different levels and the aggregated score was agreed at green/yellow.

- Mrs Goodby referred to coaching and mentoring and noted the work on accredited manager training and from our 93% compliance on complete PDRs there is a strong theme on mentoring and coaching. Mr Kang felt the benchmarking of the PDRs and mentoring, which could be external sources was a powerful message. Mr Kennedy referred to mentees he has in the organisation, and the recognition of other mentors who are accredited (e.g. from Leadership Academy) across the organisation.

- A focus on all the individual plans and strategies that underpin the 2020 vision will need to be provided in detail.

- We are well sighted on the IT issues and can provide extensive narrative on our improvement plan and trajectory.

- Detail on the considerable ICS mobilisation plans can be reported in detail from the weekly Chair/Chief Executive meetings with the CCG. The increasing traction/gains on integration, with the ICS independent chair in place, and links to STP/place based system, including Mental Health and public health plan, can be articulated, with common methodologies on education.

- Mrs Goodby referred to "high potential" which is tracked from PDRs/development plans, aligned to protected training spend and our success with the apprenticeship levy. It is essential to invest in the right areas to ensure our staff are supported and tracked closely, linked to talent/aspiration score. Mr

Kang commented staff in the high potential band receive a lot of attention and those in the middle category still need the same amount of focus/traction.

- Ms Perry referred to supplier management and felt that managing suppliers needs more support. Mr Lewis felt over next 12 months more confidence can be assured on this. Ms McLannahan replied there is a suppliers list in place but Mr Lewis felt this was not accurate/robust and needs further work.

- There will be a data quality improvement plan presented to the next Audit and Risk Management Committee from which Mr Baker will then set out the revised and updated kite marks detail/improvements.

The Board affirmed both the self-assessment and the improvement plan.

ACTION: Progress well-led deliverables:
W1 - Finalised succession plan for each director role – Feb 19
W2 - Continued delivery of quality, education and public health plans– Mar 19
W2 - Full delivery of Board's IT turnaround plan – Jan 19
W2 - ICS mobilisation plan delivered – Mar 19
W3 - Tracking high potential individual's PDP execution - Mar 19
W3 - Delivery of weconnect programme - Feb 19
W3 - Improvements in mental wellbeing of workforce – Mar 19
W4 - Comprehensive third party supplier management introduced – Feb 19
W5 - Refresh approach to PMO and improvement teams – Feb 19
W5 - Significant improvement in risk mitigation delivery – Mar 19
W6 - Data quality plan to be finalised and executed – Mar 19
W6 - Visible data at frontline level for safety and quality plans – Mar 19
W7 - Friends and family data volumes increased to West Midlands mean – Feb 19
W8 - Full QIHD accreditation achieved – Jan 18
W8 - welearn programme agreed at Board level – Jan 18

10. IT Infrastructure	**TB (10/18) 016**

Mr Lewis introduced this subject as the number one safety risk across the Trust and the paper setting out the improvements/actions required from the Chief Informatics Officer, highlighting:

- N3 capacity issue – the lead time for improvement is measured in weeks not months.
- WIFI – we expect to fully roll out the required works by end of October (currently 2/3 days behind plan).
- Further work with the external support company, Logicalis continues over the next 2 weeks with scope to expand this further if required.
- A new Chief Informatics Officer (Mr Martin Sadler) and small leadership team are now in place to focus on essential works and the Digital MPA at end of October will consider the skills platform as well as technical platform/stability.

Mr Samuda asked for more detail on N3 and Mr Lewis replied that works commenced and then faltered as the work undertaken was not accurately assessed, which Mr Sadler is now addressing as a priority.

Prof Thomas asked if we are not asking the right questions and Mr Lewis replied we have had a limited use of system performance data and with the Logicalis work undertaken we now have a better understanding of the issues to focus remedial actions and improve stability. Mr Kennedy also commented that the change management process in place shows the business impact and the check and balance of this was the element of work which was missing.

Prof Thomas then asked if changes are made and move onto the next work, or was it a rigour issues, and Mr Kennedy replied it is both issues as there is a continual need to improve the system (as the priority) but tracking work is successful if equally as important and had not been taking place.

Mr Kang asked if this is partly from not capturing corporate memory. Mr Lewis felt the people to people handover is ok (including at the most senior level) and the element missing was to report the system in action, which Mr Sadler will now progress/report clearly and conclude (with oversight from Logicalis).

Mr Hoare noted the evolution of IT over last 4-5 years is from traditional paper based written models to IT solutions, so that staff can use a live/dynamic system that works with the organisation (more intelligent in real time) and reports immediately and accurately.

11. Weconnect	**TB (10/18) 017**

Mr Lewis advised there are Executive Director and Clinical Leadership Executive taskforces focussed on engagement, he referred to the table on page 2 for the 4 key workstreams.

From feedback the engagement focus for most staff is on IT, internal communication (line manger to team) and flexible working opportunities. These 3 areas will be the prime focus for the taskforces and then the other 7 workstreams set out in the paper to ensure the focus is right with staff. Lots of time has been spent on people interventions and there have been lots of People and OD initiatives previously, we are trying a new approach to go from ok to good.

The proposed programme will support pioneer teams, through phased approaches, and will empower local team leaders into making things happen. It will be important to also have a corporate change element/taskforce to ensure local leaders in these areas are energised and empowered.

We undertake a substantial staff polling system, one of the largest known across the NHS, and in October we go out with new survey. At the next Clinical Leadership Executive taskforce there will be a programme of how the survey will commence and be carried on.

Mr Samuda referred to the importance of corporate services as well as clinical and Mr Lewis referred to the corporate team reviews that he Chairs and the metrics that are scrutinised closely at each meeting, and as part of this meeting the cultural and engagement work will progress.

Mr Kang asked how much freedom groups have to focus their programme locally and Mr Lewis felt responses are anticipated to the similar, which is ok as they will have had the opportunity to do things differently if they want to. He anticipates PCCT will request be a different approach and the other groups will be similar to programmes already in place. There will be an important component to focus on those staff working at night/out of hours.

Mrs Wilkin will provide a face to face communication plan on this and there will be a big focus for managers on enabling change.

Mr Samuda asked about the Non-Executive role on “you said / we did” and discussion focused on how visits and other communication could more overtly reference our listening and acting approach.

ACTION: Briefing on Non-Executive support role on new engagement approach.

12. Winter Readiness and Plan	TB (10/18) 018

Mr Kennedy advised the report covers two areas:

- The specific winter period of 22/9/18 to 2/1/19
- Winter preparedness in totality

NHS Improvement visit the Trust at the end of October to review our winter preparedness through a series of key lines of enquiry.

Winter attendances against summer attendances have been reviewed and we have changed the bed base and monitoring length of stay mitigations required. We need a robust/followed system from "red" to "green" to ensure stability via a SMART review of ED front door, AMU unit usage and 2 registrars on night shifts on both sites to support decision making and flow. Elective care reduction over winter period will take place, which has already been modelled and additional emergency/trauma cover is in place. The staff flu vaccination campaign is underway. In terms of adverse weather (which we had 2 periods of last year), the lessons learned will be reviewed and improvement actions undertaken. 7 day services over the Christmas period will be robust by ensuring we know who and how we call for additional staff on duty, additional cath labs, additional trauma and theatre provision, additional transport and additional pharmacy and admission avoidance work (e.g. focussed on respiratory and frailty). There is a risk management workshop with CCG and NHS Improvement planned to understand the rating levels and escalation processes.

Mrs Perry commented the planning was comprehensive but she asked about the lessons learned communication from last yet. Mr Kennedy replied that Ms Barlow and he will share the information from last year (strategies), including where these did not work well, how they were RAG rated and the improvements we will put in place this year (e.g. transport impact and winter tyres purchased for this year).

Mrs Gardner asked about the care home nursing assessor role and how this will work and Mr Lewis noted he has asked for a plan/assurance on this from local authority colleagues (compliance and leverage).

Mr Lewis reported that today we have the right number of beds open (within our bed base) and by end of October we need a plan B if neighbouring Trusts are affected how this could negatively impact our provision. Our winter plan works well but there may be factors outside of our control. This will be important to have in place and discuss with NHS Improvement at the workshop at end of October.

Professor Thomas noted lots of GPs have started 7 day working and asked if this is the case for Sandwell GPs and if this will improve or worsen the position. Mr Kennedy felt it should largely improve (noting peaks of ED activity on Mondays), but this is yet to be fully tested. Prof Thomas felt GPs see patients sooner and can prevent admissions/reduce pressure on system. Mr Kennedy noted that our new 7 day GP point of access will also ease pressures.

Mr Lewis felt proactive care home wrap around has been sporadic and this challenge needs to be improved.

Mr Samuda asked about Ambulance Service support and Mr Lewis noted there is a workshop planned with the Ambulance Trust leaders and other NHS system leaders in October about changes all can make to improve performance such as focussing on conveyance boundaries and conveyance to non-traditional bases.

This item will be discussed further (plan B) at the next Trust Board meeting.

ACTION: Winter Plan B report for November Trust Board meeting.

13. Acute Care Sustainability	TB (10/18) 019

Mr Lewis noted this paper narrows down the options on ensuring sustainability across 2 sites in advance of Midland Met opening. We are working through the plan on staffing, sustaining 2 critical care units, there is work to do on paediatric configuration particularly paediatric A&E and co-location issues.

Supporting acute medicine admissions into 2 AMUs over 7 days within target. The staffing need to support this standard will be brought back to Board, along with Ambulatory Care staffing/model by lead physicians and using other physicians into the acute medicine space with the options on respiratory/cardiac location and focussed physician time at City and at Sandwell will be similar based on older people's medicine.

There is a clinical workshop taking place on 16th October to agree the proposals which will come back to the Trust Board, to CCG and then through OSC prior to engagement/consultation.

Mr Samuda asked about support from Primary Care and Mr Lewis referred to options in the paper led by senior primary care colleagues, including to advise on the GP capability base that informs the impact to the Trust.

Mr Kang asked about demand patterns for City and Sandwell and Mr Lewis replied both are fairly similar in terms of patient age of demand.

Mr Kennedy commented on evidence based work on best yields/outcomes based on similar demographics and research that could be undertaken to provide good practice to support our reconfiguration improvement results.

Miss Dhami asked about the clinical risk scoring (at 15) and commented she anticipated this may have been higher. Mr Lewis replied we already compare well on this (7 day services) to other Trusts but there is no obvious route to 7 day robustness.

ACTION: Next iteration of the sustainability report to the November Trust Board.

14. 2019/20 Investment Decisions	TB (10/18) 20

Ms McLannahan referred to the tariff uplift and efficiency (4% cost reduction on 2018/19 plans). In terms of 2019/20, there are plans to advance income in-line with commissioning intentions and closer working, with shared system delivery plan/strategy approach (£300M contract with CCG). The report provides information on existing markets, which could be increased further (£18M of new activity and significant productivity improvements).

This paper focusses on surgery income, and also particular focus on recruitment in PCCT, ED and diagnostics, which will be considered at the October Finance and Investment Committee.

Mr Samuda asked about the recruitment focus and Mr Kennedy advised there is an income working group on the recruitment programme for hard to fill roles with workstreams and strategies to target specific action.

Mr Lewis noted the risk profile has changed but as the NHS planning round now commences there is an intrinsic risk, and if elective work is undertaken we will be paid for this activity. Mr Baker referred to the GP input into this work including the collaborative recognition/approach across the ICS footprint to ensure care is localised and the shift required/to be influenced to move care to the right place, underpinned by robust activity data.

Ms McLannahan advised the next iteration of this report will be provided and discussed at the October Finance and Investment Committee.

ACTION: The Board noted the intention to make a substantial investment to develop enlarged elective capacity for local residents in 2019-20.

15. Minutes of the previous meeting and action log	TB (10/18) 021 TB (10/18) 022

With the following amendment, the minutes of previous meeting were approved as an accurate record:

- Mrs Perry had attended.

Actions Log

- Living wage updated drafting note on minutes and more robust plan to future meeting
- Patient handover – Mr Kennedy advised that SOP is now in place for any clinician leaving for both handover of clinical care and results acknowledgement (taken through planned care board) and the follow letters. The final issue will be to ensure the IT system will also dovetail with this process (not prepopulate to leavers). This should be kept on board action log until it is concluded.

16. Any other business	Verbal

No other items of business were discussed.

17. Date and time of next meeting	Verbal

Details of next meeting: The next Public Trust Board meeting will be held on Thursday 1st November 2018 in the Main Room at Aston Business School, Aston University.

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