| Paper ref: | TB (12/21) 001 |
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Sandwell and West Birmingham Hospitals NHS Trust

# TRUST BOARD – PUBLIC SESSION MINUTES

**Venue:** Meeting by MS Teams

**Date:** Thursday 4th November 2021, 09:30-13:00

**Members:**

| Name | Initials |
|---|---|
| Sir D Nicholson (Chair) | (DN) |
| Mr H Kang, Non-Executive Director | (HK) |
| Mr M Laverty, Non-Executive Director | (ML) |
| Prof K Thomas, Non-Executive Director | (KT) |
| Mrs L Writtle, Non-Executive Director | (LW) |
| Mr R Beeken, Chief Executive Officer | (RBe) |
| Dr D Carruthers, Medical Director | (DC) |
| Mr L Kennedy, Chief Operating Officer | (LK) |
| Mrs M Roberts, Acting Chief Nurse | (MR) |
| Ms D McLannahan, Chief Finance Officer | (DM) |
| Miss K Dhami, Director of Governance | (KD) |
| Cllr W Zaffar Non-Executive Director | (WZ) |
| Mr M Hoare, Non-Executive Director | (MH) |
| Ms F Mahmood, Chief People Officer | (FM) |
| Mr D Fradgley, Executive Director of Integration | (DF) |

**In Attendance:**

| Name | Initials |
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| Mrs R Wilkin, Director of Communications | (RW) |
| Ms H Hurst, Director of Midwifery | (HH) |
| Mr D Conway, Company Secretary | (DCo) |
| Mr D Baker, Director of Partnerships & Innovation | (DB) |

**Guests:** (Patient Story)

| Name | Initials |
|---|---|
| Mr J Balega, Consultant Gynaecologist | (JB) |
| Ms T Weston, Matron | (TW) |
| Mrs L Cotterill – Patient Story | (LC) |

**Apologies:**

| Minutes | Reference |
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| **1. Welcome, apologies and declarations of interest** | **TB (11/21) 001** |

Chair Sir David Nicholson welcomed Board members to the meeting.

**Apologies:** Apologies were received from Frieza Mahmood.

**Declaration:** Declarations of interest were received from Daren Fradgley.

| **2. Patient story** | **Verbal** |
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The Chair stressed the importance of the Board grounding themselves in the services they provided by hearing direct feedback from patients and staff. They were dedicated to improving services for patients.

MR introduced the Patient Story, which centred on the Oncology pathway and some of the challenges they had faced since COVID Wave 2. She introduced Consultant, Janos Balega, and Matron, Tracy Weston. They introduced themselves before introducing Lynn, who had agreed to tell her story.

JB explained that he was the Clinical Services Lead for the Pan Birmingham Gynaecological Cancer Centre, one of the largest lead centres in England. They had the best ovarian cancer figures in the country. He described being part of providing an exemplary research-focused service.

TW introduced herself as the Matron for Gynae and Gynae-oncology. She described COVID and winter pressures on the HDU (high dependency unit). Staff who had started training to work in the HDU before COVID had been forced to stop their training. They were working hard to get the PACU up and running.

Lynn explained that she had been referred by her GP in early March, following a post-menopausal bleed. She had been seen really quickly on 17th March, when she had scans, a biopsy, and had her coil removed.

She had been seen again on 4th April in the Gynae Clinic. The results of the biopsy came back quickly and she was diagnosed with atypical hyperplasia. Because she was overweight, with Diabetes Type 2 and hypertension, she was considered a high risk for surgery. She had also had a cardiac problem called Takotsubo syndrome from stress. A hormone releasing coil was considered as the best option.

Lynn chose to go to Sandwell to have the coil put in. She had a third biopsy and a hysteroscopy. She was told that it looked like more than hyperplasia. She was referred to the Gynaecology team but she still felt quite positive because the process had been so quick. She felt reassured that the problem would be tackled. She had telephone consultations with an anaesthetist and a cardiology specialist. It was decided that she needed to have an HDU bed for recovery, just to be safe.

After an MRI and consultant visit on 5th May, they discussed the surgical options. She was put on a waiting list. In June, she decided to tell her family so they could take annual leave to help her after her imminent surgery. She was given a tentative date of 3rd August. Her daughter booked leave. She became concerned when she hadn't heard anything at the end of July and she was told that the HDU was full. She was admitted on 6th September. She was worried about the anaesthetic, the operation, and her recovery.

Lynn was prepped for theatre, and then informed that there was no HDU bed. She became emotionally distraught. Her daughter couldn't take more annual leave. The stress forced Lynn to go off sick. Not being able to work or get help from her daughter added to the general fear of cancer and surgery. She felt disappointed in the Trust, abandoned, and angry about there being no plan. She then had the surgery on 13th September and was recovering well. She thanked everyone for the care she received.

The Chair expressed the wish to be able to give her a hug. Behind every number was a Lynn.

MH commented on her mental anguish and queried the support that the Trust gave her for her mental health. Lynn explained that her line manager had gone through a similar experience. She had practical advice from McMillan. Her manager gave her emotional support and told her about counselling and wellbeing services. She didn't feel that she needed this. When she fell apart, nothing could have helped.

LK thanked Lynn for sharing her story and expressed his apologies and frustration. They had been working on solutions as urgently as possible. He assured her that they were putting plans in place to create a separate post-operative care unit to support the gynae-oncology service.

Lynn described a personal benefit knowing that there were plans in place for a PACU to support gynae-oncology patients. She felt that her story had helped to benefit others and would take this as a positive.

RBe thanked Lynn for a clear, powerful, and surprisingly objective description, given the emotional impact. He explained that what she had gone through and the clinicians trying to help her was a practical manifestation of the challenges that busy acute Trusts faced with urgent care pressures when they were trying to help people like her. She was right that in the second COVID wave, access to private sector capacity to protect services had been patchy compared to wave 1. At the weekly sessions they had to manage COVID and the delivery of services to protect people, cases like hers had been at the forefront of their minds and of their plans for some time. He hoped there would be far fewer occasions in future.

The Chair thanked Lynn again and apologised on behalf of the Board for the angst. He wished her a speedy recovery. He thanked JB and TN for their contributions. The service was one of their crown jewels as an organisation and they wanted to do what they could to sustain and improve those services.

| **Minutes of the previous meeting, action log, and attendance register** | **TB (11/21) 002**<br>**TB (11/21) 003** |
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| To approve the minutes of the meeting held on 7th October 2021 as a true/accurate record of discussions, and update on actions from previous meetings | **TB (11/21) 004** |
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The minutes of the previous meeting held on 7th October 2021 were reviewed and **APPROVED** as a true and accurate record of the meeting.

There were no matters arising or actions.

| **3. Chair's opening comments** | **Verbal** |
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DN recognised and thanked HK on behalf of the Board for everything he had done since he had started in 2012. He had been Vice-Chair of the Board and part of many committees. HK had been described by previous Chair, Richard Samuda, as his right-hand man for advice. He had been involved in Midland Metropolitan University Hospital (MMUH) business cases, championed research and development, and on a personal level, he was highly committed and thought about things differently, caring for and supporting both staff and patients. DN wished HK well in his new role in trade negotiations with India.

HK thanked everyone for their support over the last nine years. His wife had been born at City and his daughter at Sandwell, who had later trained as a medic at City. He hoped to keep in touch.

| **4. Questions from members of the public** | **Verbal** |
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None.

**Updates from Board Committee Chairs**

| **5a.** Receive the update from the **Quality and Safety Committee** held on 29th October 2021. | **TB (11/21) 005** |
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KT highlighted the following four topics to raise to the Board's attention:

1. Patient experience benchmarking against the NHSI Patient Experience Improvement Framework would be helped by a new Patient Involvement and Insight Lead, Jamie Emery.
2. The staffing position in maternity and neonates remained challenging. The team were looking at improvement options, including moving nurses into midwifery.
3. 31 of 57 first unannounced in-house inspection visits had been done, to finish in December 2021. Revisits had begun. Actions to address emerging themes would be led by Executives. Learnings would be shared widely. Ruth Spencer was commended for her work on this project.
4. Safeguarding had an increasingly large number of Looked after Children (LAC) by the Trust and also cared for adults through multi-agency partnerships. Learning was underway on the Mental Capacity Act and Liberty Protection Safeguards, previously Deprivation of Liberty Safeguards.

MR reported that the Safeguarding business case had been superseded by the Safeguarding review going to Q&S at the end of the month. DN was assured that the caseloads for LAC were on their risk register.

| **5b.** Receive the update from the **People & OD Committee** held on 29th October 2021. | **TB (11/21) 006** |
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ML reported the following key topics of discussion at the People & OD (P&OD) Committee meeting:

- The main topic of discussion had been the MMUH workforce model. The longer it took to agree the model, the less time they would have for consulting, explaining, and implementing it. Ideally, 18 months would be available, with 12 months the absolute minimum. They were over budget and over-staffed compared to the original business plan. The longer they worked on polishing that, the less time they had for implementation, which was more difficult to get right.
- Heatmap and retention hotspots showed known areas of difficulty. These now needed to be concentrated on to make progress.
- E-rostering progress was slow and the Trust would benefit from getting a system in.

The Chair queried the timetable for the MMUH workforce model and the funding. RBe reported that the timetable they were aiming for was to discuss this at the February Board. If agreed, that would give them the time they needed to start the implementation phase. They would have had the affordability work done and potential sources of funding. The ICS had been involved in the affordability work to provide full transparency. The Chair advised that they needed to avoid the risk of leaving the funding approvals too late. DM suggested that they would have a realistic multi-year view, which should put them in an advantageous position because they should have the ability to justify the value for money question.

The Chair queried when the e-Rostering system would be in place. MR reported that by 1st April 2022, they would have procured and bought a system, with a six-month plan to be implemented. It would take until April to have it implemented on site and to do the transfer of data. They would phase it across the ward areas first before going into community services so that all staff would go onto e-Roster. MR confirmed for DN that the implementation plan still had to go to P&OD.

| 6. Chief Executive's report | TB (11/21) 007 |
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RB presented a paper that had been produced by the Integrated Care System (ICS) Leadership Team for all Boards to better understand the architecture and the nomenclature of Systems and Place. He requested the following from the Board so that he could feed back their views:

- Opinions on the naming conventions proposed for the Black Country ICS
- How they might mitigate conflicts of interest that were theoretically present for Non-Executive Directors (NEDs) of the Board who took part in ICS sub-committees
- Views on consultation questions from page 10 onwards of the report
- Whether they accepted his views outlined in the following steer he provided:

1. With regard to provider collaboratives, their Boards should not yet be through a lead provider model for a provider collaborative in the Black Country. They had as a System opted for the loosest version of provider collaborative as currently defined by NHSE guidance, which was a functional service change collaboration model between partner organisations, jointly managed and governed through a Programme Board.
2. It wasn't clear how the Chair and NEDs could meaningfully engage in the Integrated Care Board sub-committees as well as their own and how that dovetailed with Trust governance.

3. The Board were asked to support the naming conventions.

ML queried whether NHSE/I in the West Midlands was part of this infrastructure and timescales for shaping the work. RBe reported that NHSE was retaining its regional footprint for the Midlands. A lot of their senior staff and Area Directors were aligned to the Black Country System. It wasn't clear how NHSE staff regionally would in effect be seconded into Systems to provide the additional bandwidth and leadership support because at the moment, the Black Country ICS had people like him trying to lead the System at the same time as trying to do their own jobs. It was unsustainable for them to also keep up their responsibilities to their own Boards. The question was when the significant numbers and talent in the Clinical Commissioning Group leadership roles would transfer into the ICS and into the Place Based Partnerships to make a difference. Until the CEO of the ICS was appointed with a clear philosophy on how it would be handled and by when, it would remain unclear. The first part of the consultation process was to get the Executive opinion from every ICS organisation. He and DM had provided this and needed Board input to do this by the final deadline for opinions on 10th November.

LW commented on the governance and workload challenge. She suggested mapping out the potential governance. RBe agreed that it was unmanageable from an Executive perspective. He chaired the Urgent Care Board for the System. This could become an SRO role, which could theoretically take up all his time.

LK suggested some time out to assess their appetite for getting involved in the System workings, with everything they had going on internally and with Place having more value. Issues needed to be worked out across four organisations rather than one. There needed to be a benefit to justify doing it.

KD commented on conflicts of interest, which could be resolved by openly declaring them. The issue was about partnerships suggesting equality. Each party would have their own loyalties. The final say, if consensus couldn't be reached, was fraught with difficulty.

The Chair commented on the need to build up from the closest level to the population as possible with power to achieve partnership working rather than delegating down. They needed to discuss the ICS in relation to their strategy in order to deploy their resources to benefit their ICS populations.

DF noted that they needed to try to actively shape the System, which was a subdivision of five Places.

| **7. Maternity Improvement Plan** | **TB (11/21) 008** |
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MR introduced the Maternity Improvement Plan and its focus on governance and their workforce challenges. HH reported the key points to note from the report:

- Good governance was fundamental to safe, effective, quality maternity services. Three national reviews and their CQC inspection in May 2021 had focused on governance. Self-assessments had led to professional training and improved structures and processes.
- Improvement platforms had been put in place to support staff and families involved in incidents.
- Their main impetus remained workforce. They had reduced their vacancies by five. They had held recruitment days and incentives. There was a petition to support the national midwifery workforce and there was a march for midwives with vigils from 21st November.
- They had been looking at introducing new workforce models. There was a 5-year plan to develop student midwives. HH was part of a strategic advisor group and the national working group that had been set up to look at nurses joining the profession to support maternity services.

- HH paid tribute to the dedicated staff who worked for them. Maternity services bookings continued to grow, putting the workforce under more pressure.

ML queried how tailoring their approach for hard-to-reach groups fit into their plan to improve services. HH reported that more voluntary services from local communities were helping the hard-to-reach groups to navigate the NHS maternity service. They were leading the way with continuity of carer with refugees.

KT queried the effectiveness of safety huddles and how they fit with governance. HH described how well the regional, three local, and daily safety huddles with the other three hospitals within LMNS in the Black Country were working and being replicated. Local ones were held three times a day and for escalations.

LW commented on the amount of work being done to move things in the right direction. She queried staff's feedback from Debbie Graham's work on culture. HH described the long-term nature of cultural change. Staff had led a communication strategy. Staff midwifery advocates had increased from 5 to 15.

RBe commented that the Board needed to stay informed about their critical responsibilities for neonatal services. He queried how frequently the Board should receive updates. HH undertook to separate the neonatal elements in future reports. She welcomed support in following the Ockenden guidelines on what needed to be reported to the Board and the regularity.

The Chair commented on the work going into processes and queried whether it was achieving the necessary outcomes and if they were learning lessons. The Board needed to focus on the outcomes. He thanked everyone for their work. The Board **NOTED** the work being done to strengthen the governance.

| **8. Winter Plan** | **TB (11/21) 009** |
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LK updated the Board on the Winter Plan and highlighted the following points:

- They had modelled schemes to safely mitigate the impact of a bed gap of between 40 and 80 beds due to winter demand for services. Modelling had been conducted by the System and for the Trust. They had incorporated NHSE/I's "Missed Opportunities Audit", NHSE's 10 Point Action Plan, and a letter on handover delays from ambulances.
- Plans to mitigate a 60-bed gap with contingencies also supported the reduction of Emergency Department (ED) wait times and the reduction of stay for people in ED.
- Annex 1 outlined the suggested schemes with an identification of the outcome and required staffing. D30 was a temporary ward with 20 beds that wasn't in the original modelling. This was suggested to be continued over winter with a decision around whether to fund this substantively.
- The residual 40-bed gap would be mitigated by 37 beds by the proposed schemes and the reduced admittance they needed to see. Further mitigation contingency plans were shown.
- The costs of the schemes and the identified external and internal resilience funding streams resulted in £1.52m required from the Trust in order to implement the schemes effectively. This had been built into their second half of the financial year (H2) planning submission.
- This had been a Place discussion. Both ICBs had been involved to ensure a joint effort over winter.

The Chair queried which committees had seen this report. LK reported that it had been scrutinised by the Clinical Leadership Executive (CLE) Committee who had requested joint oversight and ownership of the Winter Plan. Most of the schemes were community-based. Their Primary Care, Community and Therapies

Group was leading the way on their admission avoidance and frailty intervention work.

LW queried their confidence in getting staff. LK reported that this was their biggest risk. They had worked with the Groups on provisional implementation and discussed extensions to third-party contracts and additional contracts. They would be doing some staffing ratio risks and assessments for the Quality and Safety Committee. They had done some market testing and feasibility assessments. They would be making changes in how they operated at the front door to further mitigate burdens on staff.

ML queried the Care Homes wrap around support scheme intervention to save 10 of the 37 beds. LK reported that during COVID, they had supported 20 care home with the highest emergency admissions. The Community Urgent Response Team had made daily preventative care visits. They had an acute medical registrar working with all of these care homes doing point of care testing like ultrasounds to ascertain diagnostics at the care home. This avoided hospital-acquired frailty stays of up to four days. The scheme was to increase support to 40 care homes. ML suggested that this was done all year round.

DF commented on how well thought through the schemes were. Next year, he suggested that they looked at the material flows through Primary Care and the community to create a System plan with Place designing the solutions.

DB noted LW's comment about competing with the System for staff. Standardised policies and staffing to create safe hospitals and population could result with greater ICS collaboration.

RBe commented on the detailed modelling work the ICS had done over the autumn. Each Place in the Black Country had added to a genuine team effort. There was a risk of not having a true Place-based Winter Plan in each area of the Black Country. Acute and community Trusts' winter plans were being critiqued by local authorities and GPs instead of these partners contributing to plans.

RBe warned that this winter would be exceptionally difficult even if their schemes were fully successful. This winter would see significant front door pressures and patient safety challenges. NHSE correspondence last week had made it clear that any ambulance handover times beyond 15 minutes were unacceptable because it stopped them from being able to respond to the most acute patients. The Board would be receiving regular reports on urgent care winter pressures set against the schemes to provide assurance of success. They would also report on an assessment of ambulance performance.

The Chair commented on the scale and nature of the healthcare challenges they would face that winter. It was a testament to their people how they continued to do remarkable things to make sure that patients were safe and well treated, including proven innovative schemes and their reach into the community. He queried whether they were well enough equipped in terms of everything they needed to do operationally to ensure that they ran things as smoothly as possible. RBe assured him that they were. They had weekly assurance of this by MR, who provided plans on COVID, winter, and urgent care. The Board would receive monthly reports.

DM confirmed that the H2 report included the Winter Plan. The Board **NOTED** the contents of the report, supported the schemes set out, and in principle, the Board **AGREED** to allocate £1.5m to the Winter Plan.

**BREAK**

| **9. COVID-19: Overview, including vaccination update** | **TB (11/21) 010** |
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LK reported the following key points to note from the COVID-19 update:

- The number of inpatient COVID patients remained steady over the past three months at around 60 patients or 9% of their bed occupancy. This was higher than national or Midlands proportions.
- Community infection rates also remained stable. Sandwell rates were shown. These were no longer good indicators of hospital admissions because of the variations in vaccination rates.
- They had decreased their COVID bed areas, primarily at the D17 respiratory unit, to give staff a chance to rotate to get a break from the extra PPE regulations over the last 18 months.
- Infection Prevention and Control guidelines were in place. They had updated their elective swabbing pathway to reflect national changes and to ensure that patients were receiving their PCR and were double vaccinated before elective procedures. Community and care home discharges were being swabbed upon transfer.
- About 85% of staff had been doubly vaccinated. Personal conversations had been held with 15%.
- They were driving COVID vaccinations/boosters and flu at the same time. The 12 to 15-year-old school programme had completed 9 of 17 schools so far.

KT queried whether the rumour was true that staff who hadn't been double vaccinated were no longer allowed to work in theatres. LK stated that this was a myth.

MR reported that they were at 34% across the region with the flu vaccination and at 49% with the COVID booster. The booster programme had begun 5 weeks ago. They were seeing 400 students a day at Tipton.

The Board **NOTED** the report. The Chair suggested that they aimed to keep up the ambition.

**Our people: To cultivate and sustain happy, productive, and engaged staff**

| **10. Pulse Check** | **TB (11/21) 011** |
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RW introduced the new report from the quarterly Pulse survey. This was the first time that the Trust had carried out the new survey, which was a national mandate. The next ones would be in January and April 2022. Nine questions had been taken from the national staff survey, which was out now. The paper was taken as read and the following key points were noted:

- The themes were fairly similar to what had been seen with the annual survey. They were tracking slightly lower on staff engagement and involvement, such as feeling able to make improvements in their area of work.
- Some Directorates had areas that stood out. These areas were not a surprise. Emergency Care, Maternity, and two of their Surgical Directorates had tracked lower. Work was ongoing within these Directorates to improve how staff were feeling about their work and being involved.
- The results would be a good indicator of how well they were embedding their People Plan locally.
- Results would go to the P&OD Committee. Frequencies of reports to the Board were queried.

The Chair queried the survey response rate, which was 23%. He noted that the report was based on 21% and that generally speaking, the lower the percentage was, the worse the results were.

RBe proposed that going forward, the Board sought assurance through the P&OD Committee on whether the People Plan was working. This measurement showed whether people felt safe, valued, and like they

belonged. If they better triangulated Pulse Check survey results on staff engagement with heatmap indicators and the heatmap of freedom to speak up concerns, they could take a more positive approach in Directorates or departments where there had been particular leadership, cultural, or engagement challenges, or issues like bullying and discrimination. He proposed to take this triangulation idea away with FM to propose a new approach for P&OD. Then the Board would receive things by exception from the P&OD Committee or where the Board sponsored development action.

LK agreed with the need for triangulation, which would also feed into a longitudinal review of impact. They needed to act on survey results. He recommended that the Board looked at comparative snapshots. He warned about survey fatigue and suggested easier approaches like via SMS or quick interviews.

DM advised targeted responses. They needed to encourage their leaders to thank their teams more.

MF reported that the heatmap provided some high-level triangulation, which confirmed where they needed to focus their attention. They wanted to introduce a deep dive methodology.

ML queried how they could engage and involve the clinical leaders to make improvements on things like this and retention. LK explained that the Clinical Group had a triumvirate chaired by the Group Director, who was a clinician. Directorate structures also had a triumvirate headed by a clinical director. The ownership was on the Directorates to resolve the situation, and feed back plans to Group. They had regular Group discussions, either at Executive triumvirate, through CLE, or through Group Reviews.

ML queried the accountability where clinical leadership issues were evident. The same areas had been problematic since he joined the Board. MF reported that their professional leads had been working on retention issues. Their Deputy Medical Directors led a task and finish group to look at retention issues. They had begun work for SAS doctors and JSTs on wellbeing, transforming the employment experience, and career development and training. The Deputy Chief Nurse also led a nurse retention programme.

RBe noted that accountability was discharged through the CLE forum and Group performance reviews. If the Executives weren't assuring the Board about shifting problems, and triangulation continued to show hotspots, the P&OD Committee could request more in depth discussions with clinical Groups.

The Chair noted that it was disappointing that barely 50% of people would recommend the organisation as a place to work and felt able to make improvements happen in their area of work. They needed a whole organisation response to change the way they led and managed their organisation to engage and empower front-line people to do things. They were working on a proper strategy to do that. They also needed to give people tools. The way a person's direct supervisor managed them had the biggest impact. It was possible to move the numbers. This would help to retain staff and improve patient care. He requested that RW thought about a common operating model. They would have P&OD oversee this and the Board would review this as part of their assurance process around P&OD.

| **11. Retaining our staff (an update on retention activity)** | **TB (11/21) 012** |
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MF referred Board members to the retention paper and highlighted the following three areas:

1. The Trust-wide retention plan had begun to be implemented with a range of programmes, including a review of their recruitment processes and onboarding experience. They were working with the NHSE/I on "Flex for the Future" to embed a flexible working culture. They were piloting a "Just & Learning" approach. Their turnover rate had improved since April 2021. They were looking into whether this was sustainable or if there was further work to be done.

2. The heatmap was confirming where further retention and staff experience work was required. A task and finish group had been set up. They would propose to the next P&OD a monthly disciplinary QR deep dive framework at team and Group level, with action plans.
3. Exit interview surveys had been refreshed. They now had a 25% response rate. The outcomes would be addressed at a Trust level through their retention programme and at a team level.

The Board **NOTED** the paper.

| **12. Well-led Self-Assessment** | **TB (11/21) 013** |
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KD reported that the CQC had wanted to conduct a well-led review in June 2021, which they agreed to put on hold due to other independent reviews the Trust had commissioned. The report was about preparing themselves for a well-led review next year with a self-assessment over the next six weeks.

Executive leads had been assigned to each of eight Key Lines of Enquiry (KLOE) about strategy, culture, and risk. They would make their statement about where they thought they were, collect evidence, and create a plan to address the gaps. That would be reported to the Board to create a shared narrative. In 2017, the Trust had been rated “good” as a well-led provider. In 2018, they dropped to “requires improvement” due to not having a consistent narrative, with conclusions shown in Annex 1. Core services would also be rated. Their critical care service had been rated “outstanding” at being well-led. The proposal was to discuss the self-assessment at the February 2022 Board with some Board development time to explore selected KLOEs. The Board agenda should be focused on the KLOEs. They may need external support or advice.

RBe outlined next steps. Their new strategy would be presented at the January 2022 Board, including clear delivery vehicles for achieving strategic objectives and accelerating work on the organisation’s understanding and contributions. Changes to their Executive operating model and following their corporate governance review would need to be built into the self-assessment. They would need time to scrutinise their view on the Executive self-assessment. He recommended Board development time.

LK described the need to improve the areas identified in 2018 and to answer the KLOE questions in a way that everyone agreed with, backed with evidence.

ML supported dedicating time to focus on this. He queried the meaning of “leaders” in Annex 1. KD explained that leaders were Board members, including Non-Executive Directors. The CQC would interview the Board and other key leaders like Groups and Directorates to test consistency of the narratives.

LW agreed that consistency needed work. She suggested that Non-Executive Directors were partnered into each KLOE and that they began to develop the work well before February.

KD suggested that Non-Executive Directors could be seen as better placed to challenge if they weren’t part of the KLOEs. She undertook to take views on this and the timings.

KT commented on the invisibility of the Non-Executive Directors and suggested more on-site visits.

LK agreed with LW’s partnering idea, as NEDs could still challenge each other along with the rest of the Board. That scrutiny and cross-challenge would be a good idea.

The Chair queried the infection control rules for Non-Executive Director visits on site. MR confirmed that

they needed to wear masks or PPE depending on the area of the hospital or community services.

The Chair requested that DCo arranged useful site visits. He suggested that Non-Executive Directors should be questioned along with Executive leads for KLOEs if KD and RBe decided to partner them up. He agreed with setting aside Board development time and to reserve the idea of an external review.

**Action:** DCo to arrange hospital site visits for Non-Executive Directors. KD and RBe to decide whether to partner NEDs up with Executive KLOE leads for the well-led self-assessment. KD to arrange Board development time.

**Our population: To work seamlessly with our partners to improve lives**

| 13. Place-Based Partnerships Update | TB (11/21) 014 |
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DF referred Board members to the paper, making the following key points:

- The paper reviewed the first 4 weeks and key next steps for the next 5 ½ months and to put a structure in place for the Sandwell Place, excluding Ladywood and Perry Barr.
- Their high-quality services weren't connected together so they didn't reap potential rewards.
- Good work had been started on the case for change, the work on the wider metrics and strategic alignment by DB, and the Place financial metrics work led by DM.
- The roadmap for the next few months and the six core themes outlined in the paper were critical to host the collaborative thinking, including key governance and lines of assurance.
- The first theme was the establishment of a collaborative senior leadership team formed from each of the partners at an executive level to drive the partnership.
- The Board needed to pull its weight on the oversight of the strategy and the delivery outcomes. Separate meetings needed to report into and then out of the Partnership Board, into the Trust's governance structure. The committee structures and connections were critical.
- The transformation plan would be emerging. Good work had begun on Discharge to Assess. The primary care wing of PCCT was the best he had seen and should be built on.
- On workforce development, it was important to start thinking as a Place instead of an organisation to attract and retain more people. They needed to work together.
- Everything they did was data driven. The Board level metrics and a common view of the partnership data was important. All of the above needed to be done by April 2022.

RBe queried where they were with political understanding and support for what a Place-Based Partnership (PBP) in Sandwell could achieve. He queried where the Local Authority was at when it came to delegated authority to the PBP and how close they were to defining Board-level metrics for their population strategy. DF described the political support as mixed. They had a meeting pencilled in with the Health and Wellbeing Board in December. They needed to work on their cultural development to encourage delegated authority. Population metrics were being drafted. The inputs would move before the outputs and outcomes. The sub-metrics needed to be developed to keep people connected.

ML suggested that communications should be a 7th priority. He queried how the transformation plan

would deliver. DF explained that the communication plan was part of the senior leadership ownership. The PMO or Place governance team would enable them to deliver the transformation with senior leadership. Governable decision making would have gateways and measurables to make it happen.

MR agreed that communications warranted a separate section. Workforce and leadership development needed to stress the importance of an organisational development element across all the organisations involved. DF agreed that getting all leaders to cascade information to their teams could be a challenge.

The Board **NOTED** the report contents. DN supported the priorities identified and the Board's feedback.

| **14. Acute Care Collaboration Programme** | **TB (11/21) 015** |
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DB reported the following key points to note:

- The Acute Care Collaboration had run three clinical summits for 16 different specialties.
- They were about to start seven "back office" service reviews. They had commissioned an Ernst & Young review of clinical configuration.
- There was a recognition at the last Board that the Acute Collaborative was becoming like a provider collaborative and would be part of the future infrastructure. A six-month review would be an opportunity to set out the vision. Alignment sessions could then help to set the pace.
- Fragile Services should be on everyone's risk registers. If this risk could be mitigated as a Collaborative, this would connect process to outcomes, as the Chair had noted earlier.

LK suggested that they limited focus to where there were key risks. A focused alignment with evidence in standardising practice to make Ophthalmology and Urology work would be a place to start.

DC explained that they had chosen topics across the ICS where it was felt that there was most clinical opportunity to get collaboration for everyone's benefit. He agreed that they needed to decide priorities.

RBe suggested that it was powerful to get clinicians in the same specialty together from across four organisations who could share best practice. DB's vision needed to take into consideration the Case for Change. They wanted functional service change that was clinically led. He recommended to the Board that they reaffirmed their position that they wished to openly participate in the Acute Care Collaboration where they thought it would benefit the delivery of their patients' strategic objectives and to not align themselves to agree proposals regarding organisational form change or shared leadership. They wished to prioritise delivery of MMUH and its associated service redesign and workforce change around that.

DB queried whether they wanted to get involved in the "back office" workstreams or the clinical configuration design and whether the Board wanted monthly updates. RBe stated that if any of the "back office" work meaningfully released time for their staff to care for patients, they should participate. The frequency of papers to the Board should be reduced to focus on the deliverables they committed to.

The Chair advised that any shared governance work or cross-Black Country issues should be post-MMUH opening. They should be pragmatic based on their strategic direction and adopt exception reporting.

## Governance / Assurance

| **15. Finance Report Month 6** | **TB (11/21) 016** |
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DM presented the following highlights from the Month 6 Finance Report:

- They had achieved a break-even position to the end of H1.
- During Month 6, they had seen an increase in costs, mainly related to back pay for the pay rise, costs incurred around elective recovery, and pressure on pay rates, which was one of their biggest risks, linked to retention. They did not expect to earn any ERF [Elective Recovery Fund] in H2.
- They did currently have enough money for costs attributed to COVID but it was likely that that these budgets would be reduced in 2022/23. They had spent £9m on COVID in H1.
- Another risk was ENGIE cost increases in Month 6. Costs may have peaked in September 2021.
- They were forecasting a £1m underspend attributable to the shared care record. They had been given £985k as a System last year to implement a shared care record across the Black Country and West Birmingham. Everything else was expected to be on plan, with the exception of MMUH.
- The cash balance remained strong.
- Better payments practice performance to pay suppliers on time included a list of actions that had resulted in meeting the 95% target in every month except September.

MH commended DM on the work over the past 6 to 8 weeks to get to this position.

ML queried the danger of anyone else in the System claiming capital resource they were underspending. DM reported that there was little risk of this. LK reported an increase in the replacement items under order in the capital equipment spend.

The Chair congratulated DM on the payment arrangements and the good results. He noted that they were taking forward a series of risk around staffing, inability to recruit, the cost of the pay award, and energy prices. It was good to be acknowledging risks and to have done what they said they would do in H1.

| **16. Draft H2 Submission** | **TB (11/21) 017** |
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DM outlined the Draft H2 plan for approval and raised the following key points:

- The final submission dates were in mid-November. They weren't expecting any major changes before submission. They were requesting delegated authority to the CEO and CFO to sign off and submit the final templates subject to there being no significant changes to the items in the pack.
- The activity plan was essentially unchanged from the full year plan, based on 2019/20 outturn.
- ERF rules had changed to be based on clock stops. They didn't expect the System to receive ERF. They were working with COO colleagues to ensure that they were committing costs in a proper way to maximise ERF for the System and to improve elective recovery waiting times.
- They expected to increase their substantive staff up to 6,876 and to see an increase in bank and agency over winter. This would be adjusted due to the recruitment of 200 overseas nurses.
- The ICS block proposal of £1.4b broken down by organisation showed a base starting point of the H1 allocations. This was £197.2m for the Trust. Adjustments (including £2.4m for winter capacity, and UTC, Ageing Well, and Long-COVID funding) took this to an envelope of £204.6m for H2.

- The ICB needed to demonstrate equitable and fair share of resources. The System was getting more money for growth and to deal with demand, acuity, and pandemic pressures.
- All of the £4.8m Winter Plans were shown in the numbers. This year had been the best joint working between Finance and Operational colleagues around the Winter Plan.
- Against the £12.4m deficit, they had been quite prudent by reflecting all cost pressures they could foresee including a £4m increase in pay costs, £1m for developments, £1.8m of additional cost around Surgery and Imaging to support activity and insourcing plans, and £4m energy pressure.
- To submit a balanced plan, they would need to use their remaining ERF flexibility, balance sheet flexibility of £1.5m, H1 non-pay flexibility of £1.8m and the ICS risk reserve of around £5.5m.
- They needed to do some work on the recurrent position as a System and as a Trust.

LK queried what other parts of the System were doing with ERF and the impact on ICS risk reserve.

The Chair queried what would happen to the ERF funding for the second half of the financial year if it was meant to be an incentive that few Trusts could achieve. LK and DM explained how this worked. There was no incentive to spend money trying to earn ERF if the rest of the System didn't deliver.

The Board **APPROVED** the submission of planning templates to the ICS and the provider submission to NHSE/I. The Board **APPROVED** delegated authority to sign off and submit the final provider plan subject to there being no significant changes. Approving this included the amount for the Winter Plan.

| **17. Board level metrics and IQPR exceptions** | **TB (11/21) 018** |
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DB referred Board members to the Board level metrics. The following points were highlighted:

- New targets had been agreed and Sepsis treatment within 1 hour had been added to the metrics.
- They planned to track variations against the metrics by their population's ethnicity and social deprivation. They were speaking to the ICS Academy about this.
- The E-coli graph issues and Mixed Sex Accommodation reporting were being investigated.
- They were improving on being Safe. They were very good on infection control. SHMI had improved by 20 spots in April 2021, although they were still in the bottom quartile. Safe staffing would go in next month as a graph. Safety incidents were up but there were less severe incidents.
- Caring was brought down by Friends and Family and they needed data for the Perfect Ward.
- They were battling Responsive well. Two-week waits for cancer had improved. RTT was still in the top half. ED was in the third quartile but attendances had increased significantly.
- For Effective, they had significant positive variation in readmissions, which they had pulled down below their average for six consecutive points.
- For Well-led, their sickness and turnover continued to rise. The staff survey wasn't great and the overdue risk mitigations continued to rise.
- Use of resources showed that they were missing their CIP target by about £600k per month.

RBe commented that the word 'targets' should not be applied to mortality rates. There would be some

| changes made to the Executive-led mitigation descriptions to provide more assurance. | |
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| **18. Any other business** | **Verbal** |
| None discussed. | |
| **19. Details of next meeting of the Public Trust Board** | **Verbal** |
| The next meeting will be held on Thursday, 2nd December 2021 via MS Teams. | |

Signed ……………………………………………………………………………………………….

Print ……………………………………………………………………………………………….

Date ……………………………………………………………………………………………….