TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting held via MS Teams. **Date:** Wednesday 4th May 2022, 09:30-13:00

Voting Members:		**In Attendance:**	
Sir D Nicholson (Chair)	(DN)	Mrs R Wilkin, Director of Communications	(RW)
Mr M Laverty, Non-Executive Director	(ML)	Ms H Hurst, Director of Midwifery	(HH)
Mrs R Hardy, Non-Executive Director	(RH)	Mr D Conway, Assoc. Director of Corporate Governance/Company Secretary	(DCo)
Cllr W Zaffar, Non-Executive Director	(WZ)	Ms S Carr-Cave, Deputy Chief Nurse	(SCC)
Mr R Beeken, Chief Executive	(RBe)	Mr M Maguire, Assoc. Director of Performance & Insights	(MM)
Dr D Carruthers, Chief Medical Officer	(DC)	Ms C Newton, Group Director of Nursing (WCH)	(CN)
Mr L Kennedy, Chief Operating Officer	(LK)	Mr M Sadler, Chief Informatics Officer	(MS)
Ms M Roberts, Chief Nurse	(MR)		
Ms D McLannahan, Chief Finance Officer	(DMc)	**Guest:**	
Mr M Hoare, Non-Executive Director	(MH)	Ms C Nuttall, NCOT	(CN)
Non-Voting Members:		**Apologies:**	
Mr D Fradgley, Chief Integration Officer	(DF)	Mrs L Writtle, Non-Executive Director	(LW)
Ms K Dhami, Chief Governance Officer	(KD)	Prof. K Thomas, Non-Executive Director	(KT)
Ms F Mahmood, Chief People Officer	(FM)	Mr D Baker, Director of Partnerships & Innovation	(DB)
Dr M Hallissey, Assoc. Non-Executive Director	(MHa)	Ms R Barlow, Director of System Transformation	(RBa)
Mrs J Wass, Assoc. Non-Executive Director	(JW)		
Mrs V Taylor, Assoc. Non-Executive Director	(VT)		

Minutes	Reference
1. Welcome, Apologies and Declarations of Interest	**Verbal**
The Chair, DN, welcomed Board Members to the meeting. **Apologies:** Apologies were received from Lesley Writtle, Kate Thomas, Dave Baker and Rachel Barlow.	
2. Patient Story	**Verbal**
MR introduced Carmen Nuttall (CN) from the new Neonatal Community Outreach Team (NCOT) who shared a slide presentation with the Board containing background information and context for the service which had commenced work in January 2022. CN reported that it had been a struggle to recruit into the team with safety concerns about working in the community being a factor.	

Provisions had been put in place to address this issue, including risk assessments, working in pairs and restriction of home visiting times to avoid working in the dark.

In terms of governance, CN reported that the Service's policies and guidelines had been ratified in April 2022.

The team's remit was to deliver Neonatal care at home, by families, with support from the team until full discharge. The aim was to reduce Neonatal cot capacity and enable intensive care patients to be cared for effectively and safely as per BAPM guidance.

It was advised that babies would automatically be referred to NCOT providing they met the [inclusion] criteria, but families had the option to opt out if they preferred.

The STORK programme had also been very successfully introduced through NCOT. This was a mobile phone information platform for parents aimed at reducing non-accidental injuries. CN reported that the national average for infant mortality involving children under the age of one in the UK was 3%, however, this figure was nearly 9% in Sandwell.

CN summarised that outcomes tended to be better for babies when their parents were able to take an active role in their Neonatal care. It improved neurodevelopment and contributed to the success of breastfeeding.

Since launch, NCOT had taken home 28 babies from 41 referrals. The NCOT database showed that 71% of the babies had been male and 29% female. Eleven parents had refused to go home with nasogastric intubation for their babies. CN reported that an audit had revealed that patients did not feel confident enough. Training for parents was being carried out by the team.

In relation to the home phototherapy element of the service, CN reported there had been three readmissions.

The Trust's cost saving as a result of the introduction of the service was £16,644 approx. (based on cot days saved).

A feedback survey from parents had returned many positive comments. An audit of views from the Neonatal staff would be conducted in June 2022.

Currently, NCOT was operating a 7-day service.

Going forward, CN would attend a course in June 2022 on how to deliver home intravenous antibiotics. A Neonatal Abstinence Syndrome (NAS) guideline was also currently being developed.

In response to a query from RBe, CN advised that the NCOT team had all been recruited internally.

DN commended CN for her work on setting up the service from scratch.

3. Minutes of the previous meeting, action log and attendance	**TB (05/22) 001** **TB (05/22) 002** **TB (05/22) 003**

The minutes of the previous meeting held on 2nd May 2022 were reviewed. The following amendments were made:

- Typo change - References to JV to be changed to JW.

- Item 26 – The words *'…relative scores [for other Trusts] in relation to Staff Survey areas could be included.'* to be changed to, 'The Trust should have benchmarking information included in a similar way to the Staff Survey results.'
- Item 13 – '*…aware of the risk of overspend'* – the word *'overspend'* to be changed to 'underspend'.

The minutes were **ACCEPTED** as a true and accurate record of discussions (subject to the amendments.

The action log was not discussed.

4. Chair's opening comments	**Verbal**

The Chair made no opening comments.

5. Chief Executive's Report	**TB (05/22) 004**

RBe presented his report which focused on a further update on the development of the provider collaborative in the Trust's host ICS (Black Country).

He made the following points to note:

Sir David Nicholson would Chair the Provider Collaborative Board on an ongoing basis.

A governance change had been agreed in the Collaborative which meant that the Chairs and Chief Executives would form a regular, but not frequent Board.

The work of the Collaborative, particularly with respect to the Acute Collaboration Programme element, would be steered by executives (mostly strategy and medical directors) who would then report to the Board.

There were essentially two priorities for the Black Country Provider Collaborative:

- To get service integration agreed where it would benefit patients or their families and accelerate it through the right engagement with stakeholders and communities.
- Refresh the case for change document to ensure that change was being sought for the right reasons and explore whether it would be appropriate to seek closer alignment between the organisations - the statutory providers in the Black Country – and to consider potential joint-leadership arrangements in the longer-term.

There would be a review of the Acute Care Collaboration programme which had been running for around 18 months. This would be led by the Trust's Director of Partnerships & Innovation, Dave Baker, with input from other strategy officers across the system, with the aim of ensuring resources were being harnessed appropriately.

RBe advised however, that the Collective remained frustrated by the lack of clarity around the transfer of resources from the CCG to the Provider Collaborative, which would help lead and run the programme and essentially provide General Management support to the clinical leadership within the programme. RBe commented that this needed rapid clarification.

JW queried the staffing resource/arrangements of the Collaborative. RBe advised that if the Provider Collaborative was asked to take on significant extra responsibilities from the ICB from 1st July 2022, then the resource would need to be transferred too, otherwise, there would be additional leadership and/or management costs at a time when there was not enough investment into clinical services.

The Board **NOTED** the Chief Executive's report

6. Questions from members of the public	**Verbal**

There were no questions forwarded from members of the public.

OUR POPULATION

7. Our Population: Dashboard	**TB (05/22) 005**

The Chair referred Board members to the papers in relation to population:

Board Level Metrics

DF highlighted that the new metric - Urgent Community Response 2 Hour (UCR2) – had been realigned to population. It was reported that it had been performing well, but volumes had been low.

The metrics – 'Avoided Admissions By Intervention Type' and 'Virtual Ward Activity' - had also been added.

UCR2 and Virtual Ward Activity were new metrics for the year.

Operational metrics had been added in for one time only and had been debated by the Integration Committee. This Committee would monitor progress of the operational workstream going forward. DF reported that these metrics had also been aligned to the CQC framework.

RBe queried how the Trust could increase the scope of the 'Epicentre Hospital at Home' service in terms of whether there was money and staff for its further development. DF responded there was around 30%-40% of capacity left but streaming of activity remained a challenge. Care Navigation would assist in streamlining by providing a much more credible route to referral.

LK acknowledged that the Epicentre service offered the best approach but cautioned that it would be dependent on what the Trust could do internally [i.e. the release of appropriate level staff] in providing acute medical intervention. LK expressed the view that it was currently relying on the goodwill of a few people and needed more structure for its sustainability.

The Board **NOTED** the Board Level Metrics report.

8. Receive the update from the **Integration Committee** held on 27th April 2022	**TB (05/22) 006**

WZ referred Board members to the paper and highlighted the following:

In relation to the Place-Based Partnership in Sandwell, there had been some dynamic and creative work taking place with partners across the Borough. Work was being conducted by six teams representing the six towns of Sandwell.

A goal was to get the CCG to take a stronger leadership role and provide a greater level of support in this area.

However, there were some concerns with respect to the Place-Based work in West Birmingham. WZ raised that there was a leadership/management issue there and the Trust was continuing to work with partners and to develop stronger relationships in the coming months.

Birmingham and Sandwell Councils had both adopted the regeneration plans that had been initiated by the Trust, which was a positive. Further conversations would be held with the West Midlands Combined Authority. A workshop had been planned with leaders, including the West Midlands Mayor, to encourage lifting the work to a higher level.

The Chair queried the nature of the 'step up' required in terms of the regeneration work. WZ stated that the Combined Authority needed to deliver in terms of house building and transport to support regeneration.

RBe commented that he would shortly be writing to all of the agencies mentioned to invite them to a session facilitated by strategic advisors to help refine and define the regeneration vision. RBe agreed that the Trust could not afford to continue to resource the generation of ideas and professional advice which increasingly required to come from the agencies.

WZ expressed the view that the Trust's strength was its relationship with Primary Care. Unity with GPs would ensure a stronger voice in West Birmingham.

DF confirmed there wasn't the same level of clarity with other partners in the West as there was in Sandwell. The Trust had been working with the partners to try to get more focus 'on the ground'.

The Chair queried whether escalation was required, beyond working with local partners. DF reported that the matter was being escalated with BCHC. He had met with the Director of Public Health and the Director of Adult Social Care to raise concerns.

The assurance levels detailed in the paper were **NOTED** by the Board.

9. Place Based Partnership Paper	**TB (05/22) 007**

DF referred Board members to the paper and highlighted the following areas:

Action Learning

DF had commenced Chairing the Action Learning set for the system. Learnings from work were being shared amongst all the places which hopefully, would enable the goal of reaching 70% of commonality to be achieved much faster.

DF commented that governance between system and place would be important going forward and would need to be common across all the places. Work to this end was ongoing.

The Trust was closely aligned with Walsall and West Birmingham. Where possible, the Trust would share ideas and carry out initiatives together and this approach would be shared with other places as they matured.

GPs

DF reported that in Sandwell, the Trust would be working with GPs on their development plan as a supportive partner to help out with recruitment, development and pathway management etc.

Similarly, there was now a single voice for the four PCNs in West Birmingham. The Trust had assisted with their partnership agreement and some substantial work was being undertaken on disease-specific pathways.

Care Navigation Centre

DF stated that it was critical that Urgent Care started in the community.

The Trust had commenced building a Care Navigation Centre for Sandwell place which would become the single referral point for GPs and would be a link to the emergency numbers (999/111). It would also be a point of contact for all of the Trust's complex patients in the community and additionally, would act as the Trust's Digital and Virtual Ward for all known patients.

DF commented that this would change the way that urgent flow pressures would present from the 'front door'. The model had been deployed in other parts of the country in part, but never in full and therefore, the Trust would be a significant first.

Once Social Care, Mental Health and Primary Care were linked, the Trust had the opportunity to materially change the way that Urgent Care worked.

Admin

DF referred Board members to a ser of graphs in the paper. He explained these aligned all of the providers planning for 2022/23 into a single plan.

Secondly, it represented the start of the virtual place organisation which was significant in both scope and ambition. It also referenced the fact that it was an all-age programme (including children).

DF highlighted that safeguarding as a place had never been done before as one team. MR and the Director of Social Care had committed to co-ordinate safeguarding as one team under the new Liberty Protection Standards.

New Outcomes Framework

DF reported that the framework had been approved as a draft by the Partnership Board. Once new metrics had been added, it would return to both the Partnership and Trust Boards for full approval, before being shared at six-monthly intervals by the Director of Public Health.

RBe questioned the link to 111 in the Care Navigation approach and queried how the algorithm could be influenced to ensure there were no inappropriate hospital admissions.

DF responded that in comparison to some other parts of the country, the Trust's 111 services were exceptional in terms of standards. He also advised that the Trust would intervene in the algorithm very early on in the process by a direct link with 111 through the Care Navigation service. Local clinicians and practitioners would tailor the response to the individual's needs to ensure local oversight and control. He further commented there was a high confidence level that it would be hugely effective.

LK observed there was a lot of extra work in train with respect to place and stressed the importance of clarifying the resource from the CCG and ensure the metrics were identified to enable successful delivery.

The Chair observed that the work appeared to be exciting but complex. He suggested that the Trust Board spend more time discussing the topic in a development session. He also stressed the importance of business case type discipline along with the innovation that was evident in the leading-edge work.

The Board **AGREED** to support the direction of travel and recognised the progress that had been made.

ACTION: A development session to be arranged for the Board to further discuss and explore the Place-Based Partnership work.

OUR PATIENTS

10. Our Patients: Dashboard	**TB (05/22) 008**

The Chair referred Board members to the papers which were taken as read.

DC reported there had been steady progress in the work programme focused on improving mortality and sepsis.

LK reported that the Emergency Care Performance Standard had shifted upwards to 76.1% which was in the top quartile.

The SDEC in terms of correct delivery and correct location had been a focus. RBe queried whether there were signs that the pressure was easing. LK commented that Emergency Care pressures appeared to be flattening out nationally, however, the Trust had to be mindful of the knock-on impact from its two neighbouring ICS entities that were under pressure. Conveyancing continued to be extremely high into the system and the Trust itself.

JW queried the references to a positive reporting culture in the paper and asked how it could be evidenced. DC mentioned the Moderate Harm Incident Review meetings, which identified any necessary escalations to Serious Incident (SI) status and further investigation. It was reported that SI reports would be brought to the Q&S Committee shortly.

MHa observed that the rate of moderate harm in relation to the number of incidents had been rising significantly. This was acknowledged by DC however, it was noted there had been a reduction in the total number of incidents reported but he accepted that further consideration might be needed with respect to the interaction between data points.

RBe acknowledged that the Trust had a healthy incident reporting rate when measured by number of admissions however, he noted the upward trend of moderate harm incidents.

KD advised there was a national reporting system to which the Trust submitted all its reporting incidents. She advised that both currently and historically, the Trust had a positive reporting culture which was evidenced by the Trust's profile. She suggested it be taken to Q&S Committee for greater visibility. The Chair commented that the Q&S Committee would be tasked with examining this issue further.

RBe reminded the Board there was a national expectation that it would discuss ambulance handover performance and actions. LK reported that the ambulance handover performance for the Trust remained good relative to others. City site had been identified as a regional exemplar for its ability to offload and handover ambulances in a timely fashion.

Cohorting had already commenced in the ED, however, additional space was being sought to help support cohorting. Sandwell was slightly more challenged because of flow issues in the bed base.

LK further commented that intelligent conveyancing did sometimes have an impact in the Trust's ability to turnaround ambulances. However, the Trust maintained good performance and performance metrics would be included in the Board Level Metrics going forward.

LK further clarified that the Trust continued to reverse offload when required and to assess in the back of ambulances to make sure from a safety perspective that patients were being triaged appropriately.

11. Receive the update from the **Quality and Safety Committee** held on 27th April 2022	**TB (05/22) 009**

MHa reported that in terms of the Ockenden response, the Committee felt there was reasonable assurance along with a similar assurance level for the Maternity and Neonatal dashboards.

Overall mortality appeared to be heading in a positive direction. COVID [rates and management] would be critical to improvement and there were a number of areas whether the Committee had sought specific feedback. However, there were no immediate concerns presently. There had been some changes prompted by COVID which the Committee had been happy with.

The QIAs and EQIAs for the new hospital had been presented and appeared to be in a good position.

The Board **NOTED** the assurance levels in the paper.

12. Receive the update from the **Finance, Investments and Performance Committee** held on 29th April 2021	**TB (05/22) 010**

ML reported that Committee members had discussed the full year position for 2021/22 and had been pleased at the level of performance.

An update had been delivered with respect to the MMUH financial position. The Committee had pre-approved some expenditure which had been likely to fall due in the month.

The 2022/23 plan had also been discussed and it had been noted there was additional work to be done. Whilst the internal position had been a £31m deficit, the system position needed to be considered in terms of closing the gap.

Progress of discussions with the National New Hospitals Team had also been discussed in terms of the Balfour Beatty contract and also the additional funds the Trust might need to pay for the delays experienced as a result of the negotiations.

The Committee had been substantially assured on Planned Care and Pharmacy drug spend items, however, there had been a couple of items where there was only partial assurance.

The Chair highlighted there had been two items of concern to escalate to the board:

- The system impacts for the Trust 22/23 (to be discussed later in the agenda).
- Continued sickness levels and ability to recruit to key roles.

RBe reported that the Finance Committee would be able to easily track whether the targeted reduction in bank and agency expenditure that was often driven by sickness levels, was declining as planned. Early indications suggested this was the case, but this would be verified in the Month 2 Finance Report.

ML added that there had also been a presentation on the Trust's digital strategy which had identified potential to make some positive changes across the Trust, but it had been acknowledged that the work would need to be prioritised and resourced. The topic would be discussed further at a later date and would be presented to the Trust Board's July 2022 meeting.

The Board **NOTED** the report.

13. MMUH Update	Verbal

RBe updated the Board on progress towards securing an opening date for MMUH and progression on recruitment to MMUH key roles.

The Trust was working with the New Hospitals Programme team nationally to help formally review the production of a new programme from Balfour Beatty for completion of the new hospital.

The Director of the New Hospitals Team had informed the Trust that it would almost certainly know the handover date, the commissioning timeframe and hospital opening date by the end of May 2022.

RBe stated that he should be able to report to the Board and the wider stakeholder group, the opening date of the new hospital by the beginning of June 2022. The Trust had been asked to lead on communications nationally, regionally and locally.

The Board had approved the pre-recruitment of up to 100 WTEs (whole time equivalent) posts – all associated with the new Acute Care Model that would drive MMUH.

RBe reported that pre-recruitment work was underway to be able to secure as many posts as possible in Q4 of the current financial year, to have the care model in operation well in advance of the opening.

14. Finance Report: Month 12	TB (05/22) 011

DMc confirmed that the Trust had closed its books on a surplus of £5.18m which was very close (£26k) to the forecast submitted to the Integrated Care system and £5.2m favourable to the H2 Plan which had been breakeven, driven mainly by additional funding to underwrite and support elective recovery and non-recurrent allocations to the system which had emerged too late for the Trust to be able to spend effectively.

The year has closed with a healthy £54.9m closing cash balance, which had included £18.2m of Public Dividend Capital being held for MMUH.

DMc reported that the Trust was currently being audited. She was not aware of any risks.

The Capital Programme had delivered with a relatively small underspend against Capital Resource Limit (CRL). Overall, DMc reported this was a positive position.

She highlighted that the balance sheet had increased by around £185m year on year, which was a strong position despite the significant challenges that would be expected going into 2022/23.

The Chair commended the position, commenting that it had been well forecasted.

15. 22/23 Planning	TB (05/22) 012

DMc reported that a recent meeting of the Trust Board (private session) had approved a £30.9m deficit plan. The Board had also agreed in principle, the tactical deficit approach that had been adopted by the Trust's system.

Because the tactical deficit was smaller than £30.9m, the Board had agreed that if the Trust deficit was to reduce to achieve its share of a tactical deficit position, that this balance could be held in the CCG.

However, the proposal had not been accepted by the CCG and therefore, DMc advised that the only feasible way for the Trust to align with the system position would be for it to reduce its deficit to a share of the tactical position.

DMc stated that the only way to achieve this was to reflect additional income. This was done and the Trust submitted a £12.2m deficit for the income and expenditure position, which was a reasonable share of an overall, system-wide deficit.

In terms of next steps, DMc advised that the Trust needed to write to the system setting out the work ahead to increase chances of identifying more income. DMc reported that this letter would be sent within the next 24 hours.

DMc also stated that work would be conducted to better understand the underlying deficit of the Trust's system using a consistent methodology across all organisations.

There was likely to be another planning submission however, because the level of deficit across the system was not considered to be at an acceptable level. There was an expectation that the Trust should not be seeing any COVID costs after the end of June 2022. DMc expressed the view that this was probably not realistic currently (without IPC guidance) but stated that the Trust was very clear on its cost position in relation to the Plan and its assumptions.

The Trust would also need to track a group of triangulated metrics through the FIPC (mainly relating to activity, cost to earn ERF, elective recovery funding etc). Workforce assumptions would also require tracking. Energy, utilities and drugs expenditure assumptions would also need to be tracked from a non-pay perspective.

Other tracking of assumptions would be done by FIPC.

Finally, the Trust would need to hold itself to account through a bi-monthly group review process and bi-monthly corporate review process for delivery of the Plan.

RH commented that she would like to see more about how the new workforce and financial plans would work together and to get a sense of how they would change over the next couple of years.

RBe queried whether Board Level Metrics (finance and activity) might need to be tweaked to better align them with the annual plan. DMc acknowledged the point and reported that work would focus on triangulation of workforce, activity and finance. She further reported that the internal audit team would be looking at the Trust's financial reporting this year.

The Chair queried the assumptions of other organisations in the system. DMc stated that a lot of work had been done to better understand the level of consistency of assumptions across the organisations. Meetings had been scheduled between the system's finance leads to aid deeper understanding.

16. Ockenden Briefing	**TB (05/22) 013**

MR introduced the paper stating that a huge amount of work had been undertaken by the Trust in recent years. Next steps were as follows:

Serious Incidents (SIs)

MR advised that the report taken to the Q&S Committee would contain more detail on SIs going forward (including themes, outcomes and triangulation etc). It would be included in a Maternity Improvement Report to the Trust Board on a quarterly basis.

Recruitment and Retention

MR advised that recruitment and retention remained a huge challenge. A plan was in place for the next 6-9 months which if successful, would mean the Trust would have fewer than 6 WTE Maternity vacancies (midwifery and maternity support workers). Thirteen new recruits were currently in the pipeline along with 15 international midwives, in addition to five international recruits who had already started in post.

With respect to work undertaken on culture and communication and engagement, a recently launched newsletter had been well received by staff.

MR reported that a huge amount of work had been conducted with respect to governance and safety and she expressed the view that a piece of work promoting the 'Freedom to Speak Up' initiative would be helpful in the short-term to ensure staff understood they had a voice.

MR further expressed the view that the Trust was doing well, but acknowledged that the improvement journey continued.

HH advised that the second and final Ockenden Report had identified a further 15 'essential and immediate' actions. However, these could be broken up into 88 sub-parts which represented a large piece of work.

The paper included the initial self-assessment undertaken by a full MDT team against all the 88 sub-parts. There were around 19 with significant work to do.

HH stated that the impact of the Report could not be underestimated nationally, regionally and locally. There had been requests regionally from families for investigations to be reopened, but none had yet been directed at the Trust.

HH commented that it would be important to support the workforce during this difficult period for the profession and continue to work on recruitment and retention plans.

MR commented that there was a lot of learning for the wider organisation out of the Report.

RBe raised in particular the identified challenges of safe induction and introduction of newly qualified midwives and leadership and clinical skills training.

In terms of newly qualified staff, HH commented that services across the country could not continue to function without them, but they required support.

HH further stated that it had been long recognised that there was a lack of training in relation to leadership within the NHS, especially around Maternity Services. In the next 2-3 months, an education plan supported by NHSE/I would be received which would have a focus on supporting labour ward co-ordinators and encouraging leaders of the future.

The Chair stated that safety had to be the top priority around birth, followed by appropriate staffing, a motivated and engaged workforce and listening to mothers and families. On a visit to Maternity Services, the Chair commented that he had been impressed by the motivation of front-line staff to make improvements and had been heartened that the Trust was making progress.

The Board **NOTED** the report.

17. Maternity Improvement Plan	**TB (05/22) 014**

MR stated that a piece of work had been done with the Community Midwifery team. She wished the Trust's midwives a happy International Midwifery Day (5th May).

HH explained that the Community Midwifery workforce had been mostly based around births. The Trust cared for around 9,000 mothers – 5,000 would deliver all three episodes of care, whilst 4,000 would be treated in ante and post-natal care.

National benchmarking had been set at 1:92 midwives per episode of care or caseloading.

Analysis of the Trust's Community Midwifery Workforce review had shown a deficit of 11%, with the current establishment at 64.08 whole time equivalent (WTE) against a requirement of 71.94 WTE (excluding the MSW 80/20 split) with a gap of 7.86 WTE midwives. This had not included maternity support workers.

However, HH reported that the redistribution of budget left an unfinanced gap of 2.22 WTE which was a positive.

A second piece of work would focus on the actual episodes of care which would be used to challenge the national benchmarking which the Trust did not support. However, HH reported that the national objective would be to introduce continuity of carer which would require being fully established, which would be a challenge for all Trusts (ratio of 1:30).

In response to a query from RBe, HH stated that the trusts maternity support worker worked no differently from those of other organisations in terms of development and education. Touchpoint with maternity support workers were being conducted on a bi-monthly basis at their request to help address any concerns.

The Chair highlighted the complexity of work in Maternity Services. He commented that the Trust needed to train and keep more midwives, develop the maternity support workers and in the short-term, recruit people from overseas. Apprenticeships should be developed in the longer-term.

The Chair queried numbers. HH reported that the first five international midwives had given very positive feedback about working at the Trust.

JW emphasised the importance of a strong relationship with higher-education providers/universities to encourage innovation in terms of course development. She commented that universities could take more students if there were more clinical placements available.

HH stated that the introduction of a Black Country midwife who could rotate around all four Trusts would be useful, flexible and help with retention. The ICS had been very supportive of the idea and it was hoped this could be achieved.

OUR PEOPLE

18. Our People: Dashboard	**TB (05/22) 015**

Board Level Metrics

FM reported that the overall position in terms of sickness levels had been improving substantially across the Trust over the last three months (median, 12 month and one-month figures).

She highlighted Surgery Directorate figures which had been recently reported on an exception basis. Some surgery had been cancelled at very late notice because of a spike in sickness for general surgery, specialist

surgery and theatres. This issue had been discussed by the People & OD (POD) Committee and CLE and was a significant challenge which was being addressed by a multi-disciplinary team.

ML queried the response to the Trust's poor showing with respect to the Staff Survey results. FM reported this had been discussed at the POD Committee, where it had been decided that more focused work was required in the areas of Equality, Diversity & Inclusion (EDI) and leadership culture. Collaboration with other providers had been considered. The approach would be to prioritise a smaller number of things.

RW reported that there had been an agreement to progress work in three main areas:

- Fairness and inclusion
- Learning from others
- Group-level action (top three local actions to be identified)

RW commented that the Staff Survey and the Pulse survey would be the metrics by which the Trust would be able to measure the efficacy of its People Plan.

The Chair queried what the Trust's narrative would be. RBe stated that the Trust was languishing in the bottom quartile nationally in terms of staff satisfaction. The Survey and Pulse results had identified issues such as how line managers interact with staff and how staff felt included, which needed tackling. He also stated that the three pillars of the Trust's People Plan needed to be scrutinised and prioritised.

The Chair queried why the Pulse Survey results had been getting worse. RW reported that the data in the paper dated back to January 2022 which had been particularly challenging for staff because of the impact of Omicron. Staff had expressed feelings of being overwhelmed and tired in group listening events.

RW confirmed that the measures were morale, motivation and recommendation of the Trust as a good place to work. The nine engagement questions asked had been aligned with those in the National Staff Survey.

RBe stated that the Trust had been engaging people more corporately, but he expressed the view that no-one could be assured about consistent local engagement and inclusion of staff in decision-making locally by line-managers. Leadership development would be critical.

FM reported that a series of workshops had been conducted with staff, acknowledging that the Trust had not made the progress it wanted in this area. Staff had demonstrated that they wanted better engagement with their local manager.

JW queried the source of the sickness absence targets. FM responded that data had been analysed over the last eight years through ESR combined with looking at Model Hospital comparators. The target had been adjusted for the more struggling areas.

The Board **NOTED** the report.

19. Receive the update from the **People and Operational Development Committee** held on 27th April 2022	**TB (05/22) 016**

Trust values

JW reported that the Committee had discussed work to develop the Trust values which appeared to be progressing well and to timescale.

The Committee's steer had been to ensure high levels of staff engagement. However, only 600 staff approx. had engaged with the Woodreed online exercise which had been disappointing.

The Committee was keen for the Trust Board to be involved in the sign-off. JW stated that the Committee had decided this item had reasonable assurance.

Review of the People Plan

The People Plan had been reviewed to try to prioritise essential areas of focus to address some of the issues the Trust was grappling with in the wake of the recent Staff Survey.

It had been agreed that leadership development and relationships with line managers was very important. The leadership development should also have a slant on EDI. The Committee decided it also had reasonable assurance on this piece of work.

MMUH

The Committee had discussed two highly detailed and complex papers relating to Phase 2 OD work and the management of change with respect to MMUH.

The Committee had felt the content had been good but had been rather too complicated. Several different approaches to line management had been set out which the Committee was concerned could be overwhelming. Therefore, simplification had been requested before it was presented to the MMUH Committee. Therefore, this piece of work was deemed to offer partial assurance.

The MMUH recruitment paper had also been discussed (as per earlier discussion in this meeting).

People Metrics

JW stated there was a lot of work to do with respect to people metrics and what the Committee needed to see in order to align with the Board Assurance Framework (BAF). Strategic links would be required and triangulation back to finance. Therefore, this piece of work also offered partial assurance.

There were no items to escalate in the month.

The Board **NOTED** the report.

FOR INFORMATION	
20. Board Level Metrics and IQPR exceptions	**TB (05/22) 017**
The report was **NOTED.**	
27. Any Other Business	**TB (05/22) 018**
None discussed.	
Details of next meeting of the Public Trust Board: **Wednesday 8th June 2022.**	
Close	

Signed …….

Print …….

Sandwell and West Birmingham NHS Trust

PATIENTS PEOPLE POPULATION

Date ……

Sandwell and West Birmingham NHS Trust

PATIENTS PEOPLE POPULATION

Public Trust Board Action Log: 4th May 2022

Action			Assigned To	Due Date	Status/Response
1.	TB (01/22) 005	Propose a voluntary submission to the COVID-19 public enquiry regarding support measures for some of their communities with a long-term lack of resilience.	RBe		(04/22) – In progress (05/22) – No update
2.	TB (01/22) 007	Identify priorities for a Board discussion and analyse the overall deterioration in Public View metrics to name any underlying issues	DB	Jun 2022	(04/22) – DB reviewing Public View. Report to be presented to the Trust Board meeting of June 2022 (05/22) – Not yet due
3.	TB (03/22) Patient Story	All non-executives to make arrangements to go and see Loren Wood in Mortuary over the next year.	DCo		(04/22) - In progress. To be included in the Board visit plan being constructed
4.	TB (03/22) 004	Provide further information to the Board in the coming months on how DIHC as a statutory constituted organisation could provide a system wide role.	RBe	May 2022	(04/22) – Not yet due. (05/22) – No update
5.	TB (03/22) 004	Provide further information to the Board on how accountable officer representation around the BSOL provider is to be handled.	RBe		(04/22) – In progress (05/22) – No update

6.	TB (04/22) 004	Include actions taken to improve ambulance handover performance on the Sandwell site to be included in the May 2022 Patient Dashboard report to Board for tracking.	LK		(05/22) – Performance metrics to be included in the Board Level Metrics going forward. **Completed (Item 10) and closed.**
7.	TB (05/22) 007	A development session to be arranged for the Board to further discuss and explore the Place-Based Partnership work.	DCo	TBC	