Sandwell and West Birmingham NHS Trust

TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by MS Teams **Date:** Wednesday, 5th January 2022, 09:30-13:00

Members:

Sir D Nicholson (Chair)	(DN)	Ms V Taylor, Associate Non-Executive Director	(VT)
Mr M Laverty, Non-Executive Director	(ML)	Mrs R Hardy, Non-Executive Director	(RH)
Mr M Hoare, Non-Executive Director	(MH)	*(joined at 10:00)*	
Cllr W Zaffar Non-Executive Director	(WZ)	Mr L Kennedy, Chief Operating Officer	(LK)
Prof K Thomas, Non-Executive Director	(KT)	*(joined at 10:45)*	
Mrs L Writtle Non-Executive Director	(LW)		
Mr R Beeken, Chief Executive Officer	(RBe)	**In Attendance:**	
Dr D Carruthers, Medical Director	(DC)	Mrs R Wilkin, Director of Communications	(RW)
Ms M Roberts, Chief Nurse	(MR)	Ms H Hurst, Director of Midwifery	(HH)
Ms D McLannahan, Chief Finance Officer	(DM)	Mr D Conway, Company Secretary	(DCo)
Ms F Mahmood, Chief People Officer	(FM)	Mr D Baker, Director of Partnerships & Innovation	(DB)
Miss K Dhami, Director of Governance	(KD)	Ms R Barlow, Director of System Transformation	(RB)
Mr D Fradgley, Interim Executive Director of Integration	(DF)	Ms F Silcocks, Head of Sustainability	(FS)

Minutes	**Reference**
1. Welcome, Apologies and Declarations of Interest	**TB (01/22) 001**
Chair DN welcomed Board Members to the meeting, including newly appointed Associate Non-Executive Director, Val Taylor. Apologies were received from two of the other new Associate Non-Executive Directors, and for the late arrival of Liam Kennedy, who would join at 10:45, and Rachel Hardy, who would join the meeting at 10:00. The Declarations of Interests register was reviewed. Declarations were received from DN, who declared that he was Chair of Worcestershire Acute Hospitals NHS Trust and no longer Chair of Worcestershire and Herefordshire ICS, nor Governor of Nottingham Trent University, nor Trustee of Invictus Academy. LW declared a conflict of interest regarding agenda item 20: the appointment of Vice Chair. KT declared that she worked for the University of Birmingham. WZ declared that he had joined the Co-operative Party.	
2. Patient Story	**Verbal**
The Chair expressed the importance of the patient story to build a greater understanding of the consequences of their decisions on people's lives. A variety of patient stories had been prearranged for the next few months.	
3. Minutes of the previous meeting, action log and attendance	**TB (01/22) 002** **TB (01/22) 003** **TB (01/22) 004**
The minutes of the meeting held on 2nd December 2021 were reviewed and **APPROVED**, subject to the following amendments:	

- Item 2 – The spelling of *'Lyndon 3'* to be corrected.
- Item 13: Winter Plan – The ambulance conveyances statement should read: City Hospital had an additional 256 ambulance conveyances received under intelligent conveyance protocols, placing a significant additional demand.
- Item 15: The middle statement should read: The Acute Collaboration Programme Board had agreed to change the governance model aligned to new national guidance on Provider Collaboratives.

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

DN reported that they had had a successful recruitment process for the roles of a Non-Executive Director and Associate Non-Executive Directors. Val Taylor had been appointed as Associate Non-Executive Director and Rachel Hardy had been appointed as Non-Executive Director. RH would chair the Audit Committee. The other two Associate Non-Executive Directors who had been appointed were Jo-Anne Wass and Mike Hallissey. The new Directors would bring a whole range of experience, knowledge, and standards to add to the Board's strength.

Outside of central London, the SWBH had been in the top ten in the country as the most greatly affected by the pressures and proportion of work around COVID-19. They were a hospital in the lower end of the vaccinated population. The Chair thanked their staff for the efforts and work they had put in to protect their patients. He especially extended his thanks to the CEO and the Executive team for doing an extraordinary job under unprecedented circumstances.

5. Chief Executive's Report	**TB (01/22) 005**

The CEO reported the imminent announcement of written proposals for emergency temporary governance arrangements over the next two months, prior to a review. These reflected their interpretation of the new national guidance in reducing the burden of Trust governance during these unprecedented times. This would affect the intensity and the volume of the work being managed but not the frequency or regularity of the Board and Committee meetings.

RBe summarised the Chief Executive Report. The following two key points were highlighted:

1. There had been an IT incident that was disrupting one key Trust system. Some of their servers that were not Cloud-based had required an operating system upgrade and a security patch issued by an international software provider. Over 20 of their IT systems across the organisation had been affected by instructions to uninstall the security patch. 19 of these were now running again with no apparent major issues. Their electronic patient record service for Ophthalmology had lost historic data, putting a burden on the clinical staff to assess the risk for each patient and to rescan where necessary, prior to planned procedures. There was a risk that the data recovery may not be complete.
2. The COVID-19 public enquiry national response required the collection of evidence. A 'stop notice' would be issued that week and overseen by KD, instructing all staff to retain records and documentation of all actions and decisions taken during the pandemic, since February 2020.

MH reported that the IT incident had been a global issue. He had checked and updated the terms of reference for their review process. Learnings from the remediation process were hoped to ensure that their data was protected at all times.

WZ queried whether they would make a written submission to the public enquiry regarding the long-term

challenges of the Trust's demographics leading to a lack of resilience in some of their communities to fight off COVID. RBe agreed that this was a good suggestion that he would take as an action to report back to the Board. The Chair acknowledged that they had a distinctive view on how their population had suffered and the importance of putting in place measures to support them in case anything like this happened again.

ML queried whether they could get compensation from the supplier or insurance for the IT incident. DM undertook to investigate whether they had any contractual mechanism to get compensation from the supplier. They planned to present a paper to the Audit Committee in February 2022 about lessons learnt, including procurement and identification of the remedial supplier, as there was only one in the world who could do this. They had estimated the cost at £300k. Their ICS had offered to cover the cost of the recovery.

The Chair summarised that IT lessons learnt would come back to the Board in due course.

Action: RBe to 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.

Action: DM to investigate contractual compensation from the IT supplier.

6. Questions from members of the public	**TB (01/22) 006**

None had been submitted. The Chair reported that a member of public had raised a series of questions during the 2nd December 2021 Board meeting. Their responses had been circulated in a paper.

Well Led

7. Board level metrics and IQPR exceptions	**TB (01/22) 007**

DB highlighted PREMs (Patient Related Experience Metrics), which they had reviewed and decided against including as Board level metrics. Next month, the addition of eight new metrics had been agreed to help lead them into MMUH (Midland Metropolitan University Hospital). These would also be used by the MMUH Programme Board.

The hospital combined score was a tool created by a company called Public View, who had been providing them with benchmarking data since April 2021. Public View had reviewed the metrics that outstanding Trusts were performing particularly well on. A list of 13 metrics made up this score, plus a combined performance score, to show how well the Trust benchmarked against the others in areas that indicated how they would do in a CQC visit. This allowed them to measure themselves against everyone else, rather than just national targets, especially during difficult periods with greater pressure, like during the pandemic. There were three metrics highlighted that had taken their score down since June 2019:

1. Complaints had moved from the 22nd percentile to the 4th.
2. SHMI (Summary Hospital Mortality Indicator) had moved from the 35th percentile to the 12th.
3. Cancer 62 Day had moved from 88th to the 30th percentile.

Also of note was that while their staff recommending care had fallen, the Trust had moved up the league table, even though they were still in the bottom quartile. Sickness absence had gone up but they remained stable in their position in the country. They had moved their A&E performance from just above the bottom quartile to being in the top half, even though performance had dropped.

In the Board level metrics paper, they had removed the Executive overview because this was covered in the Board papers within the strategic objectives. Where they had a benchmark for metrics, they had used the CQC definitions to show how they were performing. Where their metric was in the top quartile, it was shown as outstanding. In the top half, performance was shown as good.

Responsive metrics showed that the Trust was good in Emergency Care (ED) and for volume of attendances, they were classed as outstanding because they had such a high volume. RTT was good, in the top half. Their 62-day cancer metric required improvement.

LW queried what they were doing with the information and whether they were targeting support to help with improvement in certain areas. DB explained that this was the intention of the strategy using the Board level metrics. The Safe, Caring, Responsive, and Effective metrics fed into the Quality & Safety Committee. Use of Resources fed into the Finance Committees. Aligning metrics to committees allowed committees to work with the delivery vehicles in place to move the metrics.

RBe responded to LW's question by describing that as part of being placed in segment 3 of NHS England's System Oversight Framework, they had been asked whether there was targeted support that the regional NHS team could help them to make progress with. They had asked for support regarding the Friends and Family Test. As an Executive Team, they had requested best practice examples for fundamentals of care. He suggested that they could share NHS England's response with Board colleagues offline. In addition, they had commissioned external support, such as from the Urgent and Emergency Care Improvement team.

ML queried what proportion of the deterioration in overall hospital combined score metrics since June 2019 had been due to their population being hit during the pandemic and what was not due to COVID-19. He further queried what they planned to do to focus on improving a select number of things rather than generally targeting too many things to see progress. RBe suggested that two of the main reasons for the change had been cancer waiting time performance and complaints. COVID had impacted on cancer waiting times. As waiting times were being caught up on, the way things were reported showed a deterioration in cancer wait performance. Complaints were also indirectly affected by COVID. There had been an increase in complaints about waiting times in being able to use the service or contacting loved ones on wards and Emergency Department performance. Prioritisation should be done to target areas that would improve their perception with the public, themselves, and their regulators. Priorities for next year needed to be refined operationally and strategically they needed to be refined over the next 18 months to 2 years.

KD reported that the complaints data was converted against full time equivalents, which was unusual. It was old data from March 2021. They were looking into whether they had more complaints and why, to identify themes. GP complaints had increased their numbers. They were investigating how new formal complaints were being recorded, whether there were opportunities to address informal complaints to stop them from becoming formal complaints, and what neighbouring Trusts were doing differently. There were plans in place to make improvements where they identified problems.

The Chair suggested that as they had voluntarily bought into the Public View benchmarking, they needed to take it seriously. He requested an analysis as to why there had been a deterioration to identify if there were any specific issues around how they ran the organisation. Priorities needed to be identified in addition to the three that had been highlighted in order to have a Board discussion next month.

Action: RBe to identify priorities for a Board discussion and to analyse the overall deterioration in Public View metrics to name any underlying issues.

Our patients

8. Our Patients: Dashboard	TB (01/22) 008

MR highlighted the following points from the report on Board level metrics for Patients:

- A plan for e-rostering for nurse staffing would go to the P&OD Committee at the end of January 2022.
- Nursing Band 5 staff vacancies were down to 33.
- Perfect Ward, rebranded as Tendable, was being rolled out in January 2022 to all community paediatrics. Information would form part of the Board level metrics from 1st February 2022.

DC added the following points:

- Ongoing work on finished consultant episodes, coding, palliative care, and R code documentation continued on Hospital Standardised Mortality Rate (HSMR). HSMR for September was 89, with a cumulative score of 127. These were both reductions. SHMI had stayed stable at 116. Individual groups of cases were explored to ensure high standards of care. COVID recording of hospital acquired COVID or COVID documented later in patients' stays had an additional person helping on this project.
- Sepsis treated with all core care standards applied within 1 hour, particularly around fluid administration, would have an additional focus in February 2022. Over the last few weeks, they had had good recording of data in treating sepsis in ED, with 100% being treated within an hour.

LW queried whether staff were struggling to meet expected standards and how safely wards were being staffed. MR reported that the extra beds they had open had impacted on staffing. Without the 85 extra beds, staff would be doing well, with international nurses having been recruited. Today's sickness level had been 13%. Twice a day, senior staff were manually dealing with safe staffing. They were trying to develop a dashboard to tide them over until they got the Allocate or Liaison e-rostering system. An example of safe staff in an acute ward was 1:8, but they were currently at 1:11. There had been instances in the last two weeks of going down to 2 nurses per ward, which was the absolute minimum. Everything possible was being done to keep the wards safe. The hotspots were ED, AMU, theatres, PCCT, Rowley, and the district nursing teams. They had quality impact assessments and a good plan in place. How they were managing on a daily basis was in line with everyone else.

DN queried whether the 85 extra beds were in the Winter Plan. MR reported that the numbers varied between 55 and 85. Lyndon 1 and D30 were open.

ML queried where they were with the e-rostering system to be able to better target the problem. MR reported that they had agreed at CLE to go out to tender in January 2022 with Allocate and Liaison. Liaison's new system wouldn't be ready until September. They hoped to have procured a system by April, with a six-month implementation plan to get the system in place.

FM assured the Board that they had done a full market assessment exercise. There were only two who provided a full rostering solution for all staff in the organisation, which was what they needed for MMUH.

DN acknowledged the work to keep patients as safe as they could be in the circumstances. He encouraged DC and the team to continue the important sepsis 6 work and overseeing the mortality improvements.

RBe presented the following Responsiveness and Effectiveness highlights on LK's behalf:

- The best proxy indicator of patient safety and experience in urgent care was the 4-hour emergency care wait. Performance had deteriorated in November and December 2021, but they continued to

perform in the top half of the country. The impact of COVID on the ED was outside of their control, as they were essentially running two EDs for each ED in order to treat COVID and suspected COVID patients separately. Due to the layout of the departments, they were dealing with issues to keep everyone safe. Particularly on the Sandwell site, they remained an organisation that was able to deliver the right number of discharges across 24 hours to match admissions. The timing of those discharges occasionally put downwards pressure on the ED and AMU during daylight hours. This process warranted scrutiny.

- Good progress had been made on the RTT prioritising of P2 patients and 104-week patients. The impact of 13% sickness rates was having an impact on operating theatre capacity.
- Subject to a further increase in COVID and/or urgent care pressures, they had been urged to step up contingency plans for 'super surge' capacity in terms of beds. This could include a reduction in bed capacity for elective orthopaedics on the Sandwell site, which would affect waiting lists.
- They continued to struggle to find the right physical location for Same Day Emergency Care (SDEC), particularly on the Sandwell site. More critically, it was a challenge to find robust medical staffing for SDEC to deliver best practice. They were increasingly optimistic about finding this for the rest of the winter, and then permanently recruiting thereafter. This would allow them to deliver best practice SDEC well in advance of the opening of MMUH.

DM highlighted the following Use of Resources points:

- Better payment practice performance had significantly improved against the target to pay 95% of undisputed invoices within 30 days of receipt. In 2019/20, they had been at around 45% to 50% but they were now consistently achieving their target. Cash balances were strong. Next steps were to increase their local supplier base from 10.26% of their current controllable spend in Birmingham and the Black Country, as part of being an Anchor Institution.
- The Trust had set a stretch efficiency target of £13.2m for 2021/22, which was roughly double national efficiency expectations. They had maximised transactional efficiencies and had managed to exceed national but not internal targets. The Trust had significantly outperformed other acute providers in the Black Country. For 2022/23, the focus would be on delivering recurrent efficiency savings and transformational and specialties-specific opportunities.
- I&E performance for 2021/22 was on plan. The key piece of work was to understand the recurrent position. There was a relationship between the budget and current run rate and funded bed establishment, with reconciliation required for the costs of the additional beds coming through. There had been an increase in COVID costs, enhanced rates of pay for bank and agency, and elective activity recovery costs. There had been no Elective Recovery Fund (ERF) income assumed in H2, but in Month 8, they had seen an improvement in performance that led to anticipated ERF for the System and the organisation.
- The underlying deficit position was £24m. Being behind where they expected to be from an activity point of view had driven this position. Work was underway to improve this and to create a sustainable break-even position. This included collaborative opportunities and work to oversee a System-wide governance efficiency group, expected to go live in Q4.

MH queried what further impact COVID was expected to have on their production plan and their ability to deliver over the year. DM reported that there was work going on to do a detailed analysis of what they were spending on COVID. An understanding of what was recurrent in their baseline costs versus what could be released after the COVID wave was critical to inform the reset of their budgets.

LK joined the meeting at 10:45. On the income front, LK reported that they expected to get back to their 2019/20 income and activity position. They would need to reconcile the areas where social distancing and PPE made it more challenging to have the same efficiency. They were looking at national best practice to change ways that they worked in addition to having moved from day case to outpatient procedures.

ML queried whether the fact that they had an underlying deficit meant that they would score badly on the Public View financial surplus/deficit metric. DM confirmed that the Public View metric was a headline position that ignored the underlying deficit. The methodology for estimating the underlying deficit position varied across organisations, so these amounts couldn't be consistently compared.

The Chair commended the good work in getting their suppliers paid on time, particularly local businesses who relied on this. He agreed with DM's emphasis on controlling costs.

9. Maternity Improvement Plan	**TB (01/22) 009**

MR introduced the paper by summarising its contents for Board members regarding recruitment risks, staff plans and challenges due to COVID, patient experience work, especially from their BAME communities, an update from safety champions, and the cultural work and next steps in relation to changes.

HH took the report as read and provided the following update from two of the paper's main subjects:

1. Attrition and recruitment:
    - Vacancies for community and inpatients remained static. Neonatal had 7.89 Qualified in Service (QIS) vacancies but they were one of the few to have over-recruited at the band 5 line. The QIS shortage was a national issue. They had a good pipeline succession, with 9 nurses in training for QIS, and 2 qualifying in May 2022.
    - One of the main midwifery attrition reasons included retirement. Less staff were coming back nationally after retirement, due to exhaustion from COVID. They were pleased to be starting to see midwives with specialist skills who wanted to come back.
    - Shift fill rates had remained static from June through most of December 2021. Since Boxing Day, sickness rates had increased. They had 45 members of staff off with COVID-related illness last week, which had subsequently reduced. Business continuity plans based on equality impact assessments had been put into place ready for the Christmas period. This would be part of their surge plan going forward. They had maintained 1:1 care during labour, which was their most high-risk area.
    - They had 4 advertisements out for maternity recruitment, including for Ockenden actions.
    - International nurse recruitment was filtering into their inpatient areas, with good feedback. Morgan McKinley were supporting them in finding international midwives.
    - They were working with third sector organisations to support women for care outside of their clinical needs, particularly with the low-risk midwifery-led units.
    - The community team leaders had identified 3 top priorities that they would deliver by April 2022.
    - 8 external staff were being recruited to bolster bank capacity, which they had historically done themselves.
2. Culture workshops in June and September 2021:

- Initial feedback from culture workshops run by Kinder Life was shown in the paper. 139 people had attended the first session and 127 attended session 2. Staff felt that the workshops were useful and motivating and that they provided tools to assist them to address things in the future.
- Teamwork was essential to create a good day at work. Colleagues' poor behaviour towards each other created the top bad day at work. The 3 key principles from the workshops would help them to move forward with greater kindness, respect, and teamwork.
- The improvement plan had been implemented and would be refreshed.
- All new starters had online learning on themes from the cultural workshops.
- Improved communication methods had been agreed to better suit staff preferences.

ML queried whether they had apprentice healthcare worker conversions to support the midwifery plans and recruitment process. HH reported that this had been in last month's paper. One apprentice midwife had started in September. Support workers were doing degree-level work. They had just accepted 5 seconded midwives into the organisation as well.

WZ queried what they did to proactively encourage staff and patients to communicate in their community languages. HH reported that the top 6 languages were used in addition to others. They had stopped using mainly white British midwives to run classes. Rather than trying to continuously translate, they had started to offer English classes to empower women not to be reliant on translation.

FM reported that using second languages had been looked at as divisive rather than being embraced. She had seen staff who had been taken through a formal management concerns process. She offered to look at providing education from an inclusion perspective.

MR added that with DB, they were reviewing their interpretation strategy across the organisation. Using a language line and bank staff didn't cover their demographic needs. Having just met with their interpreters, there was more work to do. They would be taking this through Quality and Safety over the coming months.

RBe queried how HH's pragmatic plans of introducing nurses had been accepted by staff, where it could potentially be a challenge to ensure understanding to unite nurses and midwives. HH reported the work being done with managers and teams to introduce nurses into the inpatient ward. They had been blessed by outstanding nurses who wanted to support them. Previous issues with midwives not accepting nurses as qualified members of staff had improved but there was still work to do with some staff members. The majority of maternity staff on the wards had responded well to the nurses.

ML queried whether lack of transport to access services was an issue for patients. HH reported that this hadn't been a concern. They had had good attendance at the hubs.

WZ commented that having a diverse workforce of staff with multiple languages was an asset that should be encouraged. It was disappointing to hear about disciplinary reactions that would discourage the use of different languages. He supported work to look at how they could use community languages.

The Chair thanked HH and her staff for the work they were doing to keep the service running and the work being done to change culture. Using staff as an asset as part of their striving to be an inclusive organisation was important. When MR and FM had done more work on proposals, he welcomed a Board discussion.

BREAK	
10. Winter Planning	**TB (01/22) 010**

LK introduced the Winter Plan, highlighting the following points to note:

The three main assumptions in the Winter Plan had been around (1) infection control, including the management of COVID, (2) the utilisation of SDEC facilities, and (3) continuation of management of patients being medically fit for discharge into care homes and domiciliary care, which was working well. They were assessing the impact of an increased outbreak of COVID in care homes recently.

They had seen a significant increase from the Omicron variant in staffing and in wards. They now had 182 COVID-positive inpatients. These were mostly secondary cases who had been admitted for other reasons. Having to separate patients who were contacts, COVID-positive, or negative, was having an impact.

Small incremental improvements in patients going through SDEC facilities were being made. They had only moved the percentage of patients going through SDEC by 5% to 10%, where they had anticipated trying to move this to closer to 15% to 20%. The main contribution was trying to find senior consultant cover at both sites. With the extra wards open, less medical cover was available. They had to utilise Newton 1 as a bedded area due to COVID instead of as the area identified to be a discharge lounge.

Throughout December 2021, they had tracked well against their best-case scenarios for occupied beds. This suggested that they had implemented most of the schemes. Early indicators in January tracking showed a movement towards worst-case scenarios. This was hoped to get back on track following the holiday period.

11. COVID-19: Overview, including vaccination update	**TB (01/22) 011**

LK reported that the COVID-19 situation had jumped at the end of December 2021 from the mid-70s to 180 inpatient numbers. This was less to do with COVID admissions and more as a result of outbreaks in contacts across the organisation. Omicron was more infectious. They were separating three streams of patients. The staff sickness rates of 6% or 7% had doubled. Safe staffing had been maintained.

MR reported that they had suspended visiting from Boxing Day for all general wards. Last week, they had suspended birthing partners in the maternity ward for 24 hours, which had been a miscommunication within the department. This had been in the national press. Paediatrics and maternity had normal visiting hours. End of life or vulnerable patients were allowed extra support.

There had been several Infection Prevention and Control (IPC) changes in the last four weeks. Staff who had been in household contact who had been doubly vaccinated could return to work after a negative PCR test and 10 days of lateral flow tests. Exceptions for the double vaccination rule had been risk assessed and documented. Staff who were positive had to do a lateral flow test on day 6 and 7 before returning to work with negative results and a lack of symptoms. A workforce hub was being implemented to help staff off with COVID to get access to lateral flow tests.

On top of 180 COVID-positive patients, they had over 50 contact patients on site to keep separated. There were 7 wards currently in an outbreak situation. This could be the whole ward or just a bay within it.

The vaccination programme had been increased prior to Christmas. They had three sites open at City, Tipton, and Sandwell. They were doing drop ins to encourage vaccines in the ward areas. All matrons were being trained to vaccinate. They had 80% of staff double vaccinated. There was a task and finish group in place to look at next steps for the 20%.

FM reported that they were taking a System approach that would be signed off that evening regarding a joint policy on how to manage this and definitions for the central priorities for vaccinations. They had developed an action plan to take forward locally. This would target the 1,080 staff that they had no

confirmed vaccination status for. The impact of potentially not being able to utilise professionally registered workforce was being looked at.

KT queried the definition of patient facing staff. RBe reported that the Chief Executives in the Black Country System were taking the initial view that they would like to pursue an approach that included all staff that were not working from home 100% of the time. An effective plan B was needed and was being looked at by their Occupational Health lead physician to define a Black Country approach in more detail.

ML queried the percentages of vaccinated staff. MR confirmed that 85% had the first vaccine. 80% had both vaccines. 38% had the COVID booster. The 20% undefined could include vaccinated people.

LK reported that they would be writing to the 20% of staff. They had to assume that these staff were unvaccinated unless they could prove that they had been.

The Chair commented that the next two weeks would be difficult as the virus got worse. He queried what the next steps were to assure themselves that they had capacity to treat their patients safely and what their current views were on staff that didn't have their first mandatory vaccine in early February 2022.

LK described the capacity they had in their surge plan for expansion. Staffing was the limiting factor. This week, they had to tackle the staffing crisis across the country. They were looking at increasing PPE to reduce the numbers of staff going off sick. They were looking at data on vaccinated and non-vaccinated staff with household contacts. Becoming more regimented about what date staff were due back following their lateral flow tests would enable them to forecast staff numbers and their ability to open expansion areas. The Winter Plan schemes were still improving, including more staff for the FIT rollout at City Hospital and increasing the opening hours of UTCs to push demand away from the front door.

RBe reported that like all Trusts, they had been approached by the regional team to confirm when they could open 'super surge' capacity and whether they had the equipment and beds necessary to do so. They had identified Sheldon Block at City Hospital but this would be difficult to staff. The next step in terms of contingency for additional capacity was to first consider elective work that used inpatient beds on the Sandwell site. Next would be not needing to swab patients who were discharged to their own homes for palliative care, which could release between 10 to 20 patients.

MR stated that the 20% of staff would be offered the vaccine and advise if classed as patient facing.

LK described the limit to the number of staff that could be redeployed or given notice. Once they had identified the number of staff who would not be vaccinated, they would do a risk assessment and put forward suggestions on what to do about them.

DF reported that they were talking to all the Place providers to quantify the size of the risk. There were 700 care sector workers providing domiciliary care at Sandwell who were unvaccinated and were unlikely to be vaccinated before the 4th February 2022 deadline. They had set up daily calls with partners to try to mitigate the risk ahead of this date, as well as in the care homes. They were investigating additional efficiencies by fine tuning the System and Place providers to remove excessive demand activity.

RBe reiterated the Winter Plan's improvements that could help to mitigate the worst-case scenario.

The Chair thanked everyone for what they were doing on a planning and day-to-day basis to keep the service running. They would need more capacity over the upcoming weeks. The Board were prepared to do whatever was necessary to support the Executives in looking after the best interests of their patients.

12. Acute Collaboration Programme	**TB (01/22) 012**

The paper was noted. DB reported that they would call this the Provider Collaborative from now on.

National guidance was suggesting that they moved to a tighter fit across the System. They may need to look at group structure more formally. The workshop on 7th January 2022 would take place in early February. The Workforce and OD workstream had highlighted three areas of staffing risk but this had missed out Maternity.

MR agreed about getting the Committee to consider Maternity staffing as well. The LMNS were leading this piece of work. They needed to look at how this linked in with Provider Collaboratives to be seen as a whole.

RBe commented that shared governance in difficult times to ensure standardisation of clinical care and optimisation of service and workforce configuration was seen as a benefit. They would not get involved with this until they had opened their new hospital and bedded it in. A case for change would need to be agreed. Should the local Integration Care Board (ICB) decide that this should be initiated, an early paper on their interim stance should be taken to the Board to refresh their position on this.

The Chair agreed that Maternity needed to be on the list. He asked that RBe brought a paper to the Board relatively quickly on their position if the ICB move to take forward shared governance, whilst maintaining their focus on opening the new hospital.

13. Finance Report: Month 8	**TB (01/22) 013**

DM reported the following highlights from the Month 8 Finance Report:

- They had reported a break even at Month 8 and a forecast for the year at break even. This assumed access to the Integrated Care System (ICS) risk reserve of £11.9m, which looked achievable.
- Funding for elective stretch and energy cost pressure was expected. The plan didn't assume any ERF in H2 but it was likely that the Trust would be entitled to £180k to the end of November and a similar sum for the rest of the year.
- From a capital point of view, they were forecasting to achieve their plan. The System had confirmed that they were working to a £21.6m share, excluding MMUH expenditure. Lack of access to some clinical areas could cause a potential for slippage with Estates works.
- The cash balance was £58.8m at the end of November 2021.

The Board noted the results in the report.

14. Draft Finance 2022/23 Planning	**TB (01/22) 014**

DM reported that the headline NHS planning guidance for 2022/23 had been published on 24th December 2021. The following main points were outlined from the paper:

- Plans were based on a fundamental assumption that they returned to summer 2021 levels of COVID, which would be kept under regular review. Timescales and planning parameters could change.
- Key messages were around improving services and access, money available for digital innovation, investing in workforce, and stretching elective care expectations of returning to pre-pandemic plus 10% levels, as well as responding to the longer-term COVID requirements.
- The legal establishment of ICSs and ICBs would be delayed to 1st July 2022 but the alignment of ICSs with local authorities would go ahead from 1st April 2022. There was uncertainty around this delay leaving them without the legal framework to transfer the resources from West Birmingham

and the Black Country into the Birmingham and Solihull ICS. The CCGs may need to vote on this.

- There were considerable growth and efficiency assumptions. There were opportunities for service development funding, cancer diagnostics, mental health, and elective performance funding.
- Assumed within growth opportunities was a big cut in COVID funding. The efficiency expectation was 1.1%, which was around £6m. Their plans were in line with this. If they could deliver more than this, money could be put aside for development and investment in service improvement.
- There was £450m available to establish virtual wards over two years.
- A 3-year capital framework had been published, with 2022/23 amounts for community diagnostic hubs and digital. The System would need to create a 3-year plan, with the financial infrastructure and System governance structure being set up in Q4. The Trust had a 5-year rolling plan. Pre-MMUH in 2022/23, they had the greatest capital requirements, which then dropped significantly.
- An internal organisational planning process was set out in Annex 1.
- The System needed to work together over the next quarter to create a meaningful System-wide plan to share resources and financial benefits and a collective approach to managing and mitigating risks.

ML queried the impact on the underlying deficit. DM suggested joining up their organisational work to understand drivers of recurrent and non-recurrent cost drivers and collaborative efforts to improve the position across the System. The System had declared an overall underlying deficit but the Black Country had been breaking even. A collective understanding of how to calculate the underlying position was required. She advised that they focused on improving their recurrent position so they could invest more.

RBe commented on the number of priorities in the planning guidance. He highlighted to the Board that they needed to look at these through the lens of their strategic objectives, particularly their people, population, and transforming community services agenda. Investment was required for improving recruitment and retention through professional development opportunities and a behaviours framework to maintain a better way of doing things. They needed to invest in chronic disease management and admission avoidance.

The Chair observed that this was a rare financial reset that gave them a fresh start to rethink how they did things. They needed to grasp the opportunity to reshape their services in the way that their strategy dictated. The Board noted that the stewardship of their finances had put them in a good position to take this forward.

15. Risk Register Report	**TB (01/22) 015**

KD presented operational risks for the Board's attention twice a year. These differed from strategic risks, which would be discussed at next week's Board development session. The escalation route for these risks were shown. They were currently in the process of reviewing their risk management policy and approach as part of the governance review. There were 935 risks identified. The following points were highlighted:

- There were a large number of System Transformation (254) and Corporate Operations risks related to MMUH. They would be investigating whether these were risks or issues.
- The Board had previously had oversight of risks identified as no longer being red because they had been mitigated down. It was recommended that these were removed from the list for Board oversight. These included risks 214, 4333, 4467, 4469, and 2693. Given recent circumstances, LK

recommended that the hospital acquired COVID-19 risk 4459 remained under oversight.

- Three risks currently rated as red continued to have a red target rating because there was a high probability that they would occur and they would have a high impact on the Trust. The first two were related to MMUH, which were outside of their control, and the third was their staffing plan for safeguarding, which was reliant on the CCG.

MR acknowledged that it would take a couple of months to put a plan in place for the safeguarding. It was confirmed for DN that this risk had been discussed at the Quality and Safety Committee.

The Board **APPROVED** the recommendation to remove risks 214, 4333, 4467, 4469, and 2693 from its oversight and **NOTED** the three risks: 4521, 3053, and 4408, that had been raised to their attention.

Our people

16. Our People: Dashboard	**TB (01/22) 016**

FM highlighted that the current staff sickness rate had risen since the report, based on 6 weeks ago, to 13%, with 953 staff currently being away from work. Half of this was COVID-related. The critical staffing point was deemed to be 13.5%. Sickness was expected to continue to rise and the Board was asked to support any decisions required over the next week. Mitigation plans had been put in place.

Turnover figures had been improved by over 1.5% over recent months. Based on a worst-case scenario, this could increase to between 18% to 22% on sites if they were unable to influence staff to be vaccinated.

There would be no new Pulse Check results for the Board for the next 6 to 8 weeks.

The Chair queried the decisions the Board was being asked to support regarding sickness absence. FM explained that safer staffing ratios could be impacted if sickness increased beyond 13.5%. MR reported that she was working with DC, LK, and FM on mitigations that might deviate from national guidance.

The Chair acknowledged that the CEO had already proposed to share some revised governance arrangements which would enable them to make decisions rapidly. The Board noted the paper.

ML queried whether 13.5% represented all staff or frontline staff. FM clarified that they had set the tolerances for all staff registered to have frontline impact who were implementing COVID surge support.

Our population

17. Our Population: Dashboard	**TB (01/22) 017**

DF reported challenges in getting the population metrics developed because some of them took 2 to 3 years to move, so getting the right ones to show the Board progress was critically important. Long-term strategic objectives would take another 2 to 3 months to work through. NHSE/I were working on health inequalities metrics with white papers that they needed to align with.

The substantial work they had done on outcome measures related to the transformation should show moves on a monthly basis. This was where the role of the Integration Committee would become pivotal.

They were also working on getting alignment across the other Places in the Black Country and influencing West Birmingham in order to measure the same things. Individuality would be expected to add up to a 30% metric difference. The timeline for this was within the next 6 to 8 weeks, before presenting to the Board.

LK requested an example of the transformation output. DF explained that this would include length of stay reduction on Discharge to Assess, like the amount of pressure and demand within each of the 10 teams and some of the transformational measures such as what condition-specific areas they were looking at in virtual wards and what outcomes they were looking for in length of care impact in care pathways.

18. The Green Plan	**TB (01/22) 018**

RB introduced Fran Silcocks as the author and programme lead for the Green Strategic Plan work. The following main points were presented to the Board in a request for approval:

- The Trust had already been active for years and had won the HSJ Sustainability Award in 2021.
- The extensive engagement and contribution of clinicians, procurement, and operational colleagues, and Estates into this work remained high, despite recent pressures.
- Strategic stakeholders and partners included the Councils on district heating schemes and transport strategies, the Combined Authority, and Canal and River Trust. The STP was becoming more active.
- Each workstream had an annual plan. This would fit with integration and healthy outcomes they were looking to achieve. Sustainability measures were being created as Board level metrics.

WZ reiterated his interest and thanked RB. He praised the document and what they hoped to achieve. Getting every section of the Trust to buy into this and holding everyone to account on delivery was crucial.

RBe queried whether he could assume that commitments would be built into their annual plans and in governance terms, that the new Integration Committee would oversee the work and the impact on the population. RB confirmed that this had been agreed along with developing tools to track progress.

DF commended FS's document and recommended that they publicised this and became thought leaders.

DM supported the idea of raising their profile around their ambitions and capitalising on the financial opportunities. RB agreed that becoming leaders of strategic partners would help them welcome funding for commercial opportunities and to keep abreast of innovation. A communications plan would follow approval.

FS thanked everyone for their feedback. Raising their profile would achieve more through collaboration.

The Chair described the document as a strategy and a lens for subcommittees to look at things through. The opportunity to make a difference in the sustainability of the planet was important to staff and for the communications strategy. They were uniquely placed to provide leadership for their population. The Board **APPROVED** the document with acclamation. The Board supported making it real. DN thanked RB and FS.

19. Place-Based Partnerships Report	**TB (01/22) 019**

The report was taken as read. DF highlighted the following points to note:

- Progress was being made in bringing the scope of the partners together.
- Work on oversight and assurance of domiciliary care and care homes connected to the Winter Plan.
- DM had begun work on social value, looking at best public use of their 'taxpayer pound'.
- The Integration Committee had Terms of Reference available for input before approval next month.
- The Trust now had a place on the Senior Management Team of Birmingham Community Healthcare. Meetings had been held with the Primary Care Networks in the West. There was an

ambition to set up a Provider Collaborative to bring together primary and secondary care.

- The Birmingham and Solihull and Black Country views of Place were different. This risk would be reduced by making progress in the next few months before the ICSs were formally constituted.

ML thanked DF for adding the communication and engagement work strand. He queried when progress would be seen, given the lack of resource allocation. Work could be started with their own internal staff. DF agreed that they had committed to make progress but the establishment of the Place Development Team would prompt real action. In the interim, they had been working with each internal communications team to get the brand going and to put out messages of success around what they had been doing. This would start to move in the next few weeks. It would need to be aligned with the MMUH work as well.

The Chair commented on the critical population in West Birmingham they had been supporting over the years. He queried where the City Council sat in relation to the Provider Collaborative. DF reported that the City Council were less present with Place conversations. They were working with the Chair of the Health and Wellbeing Board to connect with their local strategy. There was more opportunity to work with the local Social Care teams on this, who currently saw Place as Birmingham. They recognised that they needed to line up with current players to make progress without creating tension.

The Chair queried whether they were engaged properly with the Social Care teams. DF reported that they were committed to getting Birmingham Community Healthcare into the partnership alliance to establish a connectivity, which would create a connection with the local Social Care teams.

RBe agreed that the emerging risk was the depiction of Birmingham itself as a Place and the lack of clarity about the true subsidiarity that West Birmingham and Ladywood and Perry Barr could achieve in terms of local determination. With Birmingham Community Healthcare and the local GPs, they would paint a compelling narrative about how local determination could be handled safely so that an element of accountability, authority, and resource allocation could be devolved safely from the System in Birmingham and Solihull to Ladywood and Perry Barr.

The Chair encouraged comments back to DF on the Terms of Reference of the Integration Committee.

Governance	
20. Appointment of Vice Chair	**TB (01/22) 020**
The Board **APPROVED** the appointment of Mrs L Writtle as Vice Chair.	
21. Any other business	**Verbal**
DC described five Never Events that had taken place over the past few weeks. Two related to medicines being provided by the wrong route. One had the wrong incision made for surgery on the right limb so that a second incision had to be made, and a nasogastric tube had been misplaced due to the wrong reading of an x-ray. A few days ago, a further air flow meter incident had occurred. Air had been provided instead of oxygen for a short period of time because the meter had not been removed as it should have been. A detailed report would go to the Quality & Safety Committee, looking for trends and common themes.	
22. Details of next meeting of the Public Trust Board:	**Verbal**

- The next meeting would be held on Wednesday, 2nd February 2022.

Meeting Close

Signed ……

Print ……

Date