# TRUST BOARD – PUBLIC SESSION MINUTES

**Venue:** Meeting held via MS Teams.

**Date:** Wednesday, 6th July 2022, 09:30-13:00

**Voting Members:**

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| Sir D Nicholson (Chair) | (DN) |
| Mr M Laverty, Non-Executive Director | (ML) |
| Mr M Hoare, Non-Executive Director | (MH) |
| Cllr W Zaffar, Non-Executive Director | (WZ) |
| Prof K Thomas, Non-Executive Director | (KT) |
| Mrs R Hardy, Non-Executive Director | (RH) |
| Mrs L Writtle, Non-Executive Director | (LW) |
| Mr R Beeken, Chief Executive | (RBe) |
| Dr D Carruthers, Chief Medical Officer | (DC) |
| Mr L Kennedy, Chief Operating Officer | (LK) |
| Ms M Roberts, Chief Nursing Officer | (MR) |
| Ms D McLannahan, Chief Finance Officer | (DM) |
| Mrs J Wass, Associate Non-Executive Director | (JW) |

**Guest:**

Helen, presenting the Patient Story

**Non-Voting Members:**

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| Ms F Mahmood, Chief People Officer | (FM) |
| Miss K Dhami, Chief Governance Officer | (KD) |
| Mr D Baker, Chief Strategy Officer | (DB) |
| Dr M Hallissey, Assoc. Non-Executive Director | (MHa) |
| Mrs R Barlow, Chief Development Officer | (RBa) |
| Mr D Fradgley, Chief Integration Officer | (DF) |
| Mrs V Taylor, Assoc. Non-Executive Director | (VT) |

**In Attendance:**

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| Mrs R Wilkin, Director of Communications | (RW) |
| Ms H Hurst, Director of Midwifery | (HH) |
| Mr D Conway, Associate Director of Corporate Governance/Company Secretary | (DCo) |
| Mr J Emery, Head of Patient Experience | (JE) |
| Ms L Wilde, Head of Midwifery | (LW) |
| Mr M Sadler, Executive Director for IT and Digital | (MS) |
| Mr R Guttridge | |

| Minutes | Reference |
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| **1. Welcome, Apologies and Declarations of Interest** | **Verbal** |
| The Chair, DN, welcomed Board members and attendees to the meeting.<br>Attendees introduced themselves for the purposes of the voice recording. No apologies were received. There were no declarations of interest. | |
| **2. Staff/Patient Story** | **Verbal** |
| MR introduced Helen, who would be relating the story of her and her father, Bill. Their stories linked well with their draft Patient Strategy: Fundamentals of Care (FoC). There were two themes from the story. One was about barriers to open communication with Helen and the other was about a lack of compassion and understanding from some staff and Helen's lack of confidence in her father's care when she was not there.<br>JE supported Helen by describing the car accident on 8th January 2022 that led to Bill being admitted to the Queen Elizabeth Hospital (QE) in a comatose state, with a Glasgow Coma Score of 8. The CT had revealed bilateral frontal contusions and a fractured base of his skull. It was decided that surgery was not appropriate. He was intubated and then extubated when he was placed on a palliative pathway and transferred to the neurosurgery ward at the QE before being transferred to Sandwell Hospital.<br>Helen apologised for not being well with a cold and having just found out a few days ago that her mother had cancer. Helen related the story of when her father arrived at Sandwell Hospital on 18th February 2022. The first time she visited him, he had no clothes on. His bed was dirty and he had not been changed. They | |

gave her a meal to feed him at the wrong level and they didn't reposition him even though Helen asked. He didn't eat because he was sedated and the staff promised to change him after Helen left.

Helen went home to a message asking her to call the hospital for an update on her father. It took over 3 hours and at least 170 telephone calls to get through. Helen was rudely told on the telephone that she had called at tea time, and then at drugs time. When Helen arrived back at the hospital less than 24 hours after her father had been transferred there, his eye was cut and his face was smashed. He looked worse than after the accident. After another brain scan, Bill was told that he hadn't made the damage any worse.

The next day, the doctor dismissed the incident. Bill was still covered in crusted blood and the bed was still dirty. The gauze on his eye was stuck in his hair and Helen had to cut out chunks down to his scalp. The next day, she had to wait 15 minutes to see her father. He was alone and trying to get out of bed. The crash mat hadn't been put down. It was stood up against the wall.

During the days before Bill was moved to the proper bay, Helen was given excuses that he was on the wrong ward, they were short staffed, and it was during COVID. Bill was put opposite an aggressive patient with a brain injury. Helen felt forced to stay there to defend her father, who could not shout out. After being there for 13 hours one day, Helen waited 3 hours after demanding a one-to-one for her dad, who hadn't had one in the 6 days since he arrived at the new ward. To get attention, Helen took the brake off the bed and started pushing Bill's bed. Security arrived within seconds. Within 10 minutes, security had listened to Helen's story, comforted her, and managed to get Bill a one-to-one.

Helen received a phone call to say her father had banged his nose on the side of the bed but it was nothing to worry about. She found Bill the next day with eyes swollen and a large cut that bent his nose out of shape. A subsequent letter said that he had fallen rather than having hit his nose. A few days later, Helen received a call to ask if the fire brigade could cut her father's watch off because the cannular had been put in and after an aggressive evening, his skin had gone through his watch.

A doctor had ignored Helen's questions when he found she had photos on her phone of her dad's injuries and turned to the doctor next to him to ask him to seek legal advice about it. Bill was born named Albert but had always been called Bill. His name had been written in two places as Albert. He often went without drinks. A lady named Jeanette was the only person who kept Helen informed.

Helen described how her father was 77 and he loved football and music. He had been married for 55 years with a son and three grand-daughters. After being in her job for 20 years, Helen had felt unable to go to work ever since because she had been afraid to leave her dad at the hospital. A continual lack of respect and basic care for her father had made Helen feel guilty that she could not protect him.

The Chair thanked Helen for the powerful lessons about how the hospital functioned that required reflection and assured her that MR would follow up on this. The Chair apologised on behalf of the Board and the Hospital to Helen and her father for their experiences. He acknowledged that this was shocking.

RBe introduced himself and apologised for letting Helen and her father down. RBe posed questions to DC and MR because everything they had heard exemplified the challenges in delivering consistent personal and clinical care and the communication of this care to family and carers. RBe signed off every complaint letter and seeing the inability at times to deliver a clear diagnosis, prognosis, plan, and point of contact was a frustration to everyone. RBe queried how to give staff a clear framework that would drive consistency of two-way communication to avoid Helen's and Bill's experience from happening to others.

MR described the internal communications that needed to be fixed first to get everyone to work as an interdisciplinary team because nurses in one bay should be able to help in others as a complete ward team approach. During a Fundamentals of Care (FoC) session, one of the medics had raised the way that clinical

care had too great a focus when holistic care was needed to be given as a team. Staff were defensive rather than delivering open communication. A lot of work needed to be done that Helen's story would help with. MR had apologised to Helen and assured her that the work had been started to address this.

DC thanked Helen for sharing her story and remembered it from what she had shared with her MP. DC hoped that her father was doing well in his new placement and apologised about Helen's mother's diagnosis. DC queried whether Helen felt that anyone amongst the medical staff took overall responsibility or if there were inconsistencies in communication. Helen agreed that this was one of the main problems because messages were not passed on amongst the staff. When Bill stopped eating, Helen was called into a meeting about fitting a Percutaneous Endoscopic Gastrostomy (PEG). When a discharge person asked Helen to find her dad a care home, Helen was informed that the consultants had decided against a PEG but she had never been informed. Helen started feeding him frozen smoothies to get him to eat again.

LW apologised about what had happened and acknowledged the time and emotional commitment Helen had invested to help her father. LW queried what measures could be put in place for patients without families like Helen. MR explained that this was why they were putting the Patient Strategy together with FoC and doing engagement with staff to set clear expectations about respect and value for everybody who cared for patients, from porters to doctors, introducing a charter between patients and staff.

Helen's final message was to get the basics right regarding manners, empathy, communication, and compassion. The Chair acknowledged the lack of consistent care and thanked Helen for turning a horrible experience into a positive tool to work with. Helen thanked everyone for accepting that there was a problem and apologising. The Chair assured Helen that DC and MR were focused on getting this right.

| **3. Minutes of the previous meeting, action log and attendance register** | **TB (07/22) 001**<br>**TB (07/22) 002**<br>**TB (07/22) 003** |
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The minutes of the previous meeting held on 8th June 2022 were reviewed and **ACCEPTED** as a true and accurate record of discussions.

The action log was reviewed. DCo informed the Board that the first action was in progress, with an update to conclude later in the year. All other actions had been completed.

The attendance register was noted.

| **4. Chair's opening comments** | **Verbal** |
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The Chair observed that the Patient's Story adequately framed the next discussions.

There had been good news about plans to open the Midland Metropolitan University Hospital (MMUH).

There had been a meeting of the newly formed Black Country Provider Collaborative that DN chaired. Papers from this meeting would be shared to prompt consideration about how to work more closely together with Dudley, Walsall, and Wolverhampton, particularly in relation to the Clinical Strategy being developed across the Black Country. A Clinical Summit was planned next week, involving hundreds of clinicians from across the Black Country to work through the practical details of how to improve clinical services going forward.

| **5. Chief Executive's Report** | **Verbal** |
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RBe reported on the publication of clarity between the Trust and the Department of Health and Social Care regarding the opening period of the Midland Metropolitan University Hospital (MMUH) in Spring of 2024.

Clarity about the opening period would allow a clear platform from which the Trust could reverse engineer their plans for recruitment, care model change, and overdue consultation with staff and stakeholders.

RBe thanked the Trust team led by RBa, Balfour Beatty for their contribution to the detailed programme review, and the Department of Health's New Hospitals Programme (NHP) team. The NHP review's intensity and clarity of output for all three parties had been instrumental.

RBe noted that the Trust had all their daily challenges in addition to a once in a generation opportunity that they had to get right. RBe acknowledged that collective assurance was still required regarding the workforce and recruitment plans, change and consultation planning, and that the revenue implications yet to be agreed with the two Integrated Care Boards (ICBs) who would commission the majority of the services in the hospitals and in the new revised care model. Internal expectations needed to be managed because the change control process would be extremely tightly managed regarding any changes to the layout or technical capability of the new hospital. The Acute Care Model redesign had involved a significant amount of impressive work by clinical leaders and general managers in both acute and community services. Clear delivery milestones on what needed to be done by when to deliver this had only begun. The contract with Balfour Beatty would need to be carefully managed with NHP's input.

The Chair queried whether this report was consistent with the Sub-Committee that oversaw this work. ML agreed that this resonated with what RBe had reported.

The Chair noted that there was a lot of work to be done and that some progress had already been made in all the areas described. It was an exciting time to be investing in the Trust and the local community, which would make a massive impact for the local economy and local people and in the delivery of high-quality healthcare, revolutionising the way the hospitals would work and the wider health community.

| **6. Questions from members of the public** | **Verbal** |
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There were no questions forwarded from members of the public.

**Governance, Risk & Regulatory**

| **7. Standing Financial Instructions / Standing Orders Update** | **TB (07/22) 004** |
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The Chair noted that this work had been reviewed by the Audit and Risk Management Committee.

DM advised that it was a requirement that the Standing Financial Instructions (SFIs) and Standing Orders were signed off by the Board as the financial rules that governed NHS Trusts. DM assured the Board that she had personally reviewed these and they had been updated for the new Committee Structure and to address internal audit actions on SFIs. There were plans to increase awareness about the key rules around tendering, raising orders, and for compliance with budgets and ensuring effective reporting of conformance through the Audit and Risk Committee. DB had made a few amendments to incorporate.

RBa queried whether the SFIs for the MMUH programme needed to be updated following changes to the contract. DM agreed that specific governance and delegation of authority rules compared with the original Balfour Beatty contract needed to be reviewed for larger values than the SFIs currently allowed.

The Chair thanked DM and her team for the significant amount of detailed work involved.

The Board **APPROVED** the Standing Financial Instructions and Standing Orders, subject to amendments and review of SFIs as they affected MMUH. The Board **APPROVED** the need for the implementation plan to communicate this for budget holders.

**Action:** DM to review and amend the Standing Financial Instructions against the new MMUH contract. Communicate changes to budget holders.

## OUR PATIENTS

| **8. Our Patients: Dashboard** | **TB (07/22) 005** |
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DM noted that the Hospital Standardised Mortality Rate (HSMR) and Summary Hospital-level Mortality Index (SHMI) monthly and annualised data showed stability and improvement. The detailed reports shown at the Quality and Safety (Q&S) Committee showed that improvements in depth of coding, removal of symptoms as a diagnosis, palliative care recording, and COVID-related reporting may be reflected. Clinical areas where there were alerts on care provided were being worked on. The Sepsis work was still positive.

LK noted that the ambulance handover numbers over 30 minutes had been added to the Board Level Metrics. A stark increase since 2021 had been shown, which aligned with the introduction of Intelligent Conveyancing from West Midlands Ambulance Service (WMAS). More context would be provided by reporting on the overall conveyancing and a regional position. The report in item 15 had a typo that should say that 90% had been seen 'within' 30 minutes at City Hospital. A very good standard of handovers was being delivered compared to regional colleagues.

RH queried the Perfect Ward (Tendable) report and the meaning of the Trust level combined score for May 2022 being 93%. MR offered to explain Perfect Ward offline. All wards had questions on standards that had to be completed every month. There were 9 sections, such as Infection Prevention Control (IPC) and pain management. Each ward's answers were then peer checked for accuracy. These were being combined with the Fundamentals of Care (FoC), the weAssure process, and the Chief Nurse Quality and Safety Review Process like what was being applied following issues being raised, such as during the Patient Story.

RH queried whether funding from the CCG would be forthcoming to help with the Emergency Care 4-hour waits. LK confirmed that funding was likely available to correct the inequality. The Black Country System position was that two providers had 24/7 Urgent Treatment Centres (UTCs) and the Trust and Walsall did not even have one open until midnight. The Trust had asked for funding of the UTC up until midnight due to the rise in attendances that the Trust were trying to stream appropriately. The missed opportunity audit had shown that there was an opportunity during these hours to help patients to be seen appropriately.

The Chair queried whether Perfect Ward would pick up if the sort of care described by Helen in the Patient Story was systemic. MR reported that this would be triangulated with weAssure and other FoC dashboard elements. Perfect Ward would be a warning sign but other metrics would be examined first.

KT noted that the Safe Staffing metric showing that the Trust had -4.57 Whole Time Equivalent (WTE) Registered Nursing vacancies, followed by mention of recruiting an additional 144 nurses. KT queried whether the 144 were over establishment. MR advised that there was a 10% turnover in nursing that needed to be taken into account when planning recruitment over 12 months. There were also hotspot areas like health visitors and surgical-gynae nurses. The over-establishment was in Band 5. District nursing had been a success story, where vacancies had been reduced to less than 6.

The Board **NOTED** the Board Level Metrics report for assurance on the Patient strategic objective.

| **9.** Receive the update from the **Quality and Safety Committee** held on 29th June 2022 | **TB (07/22) 006** |
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KT referred Board members to her report and highlighted the following points:

- Midwifery Continuity of Carer had been an ambition by the NHS but the latest Ockenden report suggested that this should only be pursued if safe and sufficient staffing was in place. The Trust had a five-year Local Maternity and Neonatal (LMN) System plan to move towards Continuity of Carer that would prioritise women from minority ethnic groups and those living in socio-economic deprivation, which was the majority of the Trust's women.
- DC had provided a summary of serious incidents. There were 13 investigations outstanding. It was a concern that trained investigators did not have sufficient time to devote to the task. Alternative ways of managing this were being pursued.
- The maternity dashboard highlighted low neonatal staffing that was judged to be safe based on consultants acting down and cross covering for colleagues not in post. The Women's and Child Health Directorate was meeting weekly to monitor this. Locums had been secured to improve the situation. The 5 international midwives had settled well and were progressing well.
- The COVID report showed that the number of inpatients had risen but without requiring ICU admission. Infection Prevention Control (IPC) guidance was noted to have changed to reduce mandatory mask wearing. Staff were still testing twice a week.
- For the second month running, the Trust was no longer an outlier for sepsis.
- Board Level Metrics for DM01 were a concern regarding people waiting for non-obstetric ultrasounds, MRI, and CT scans. Demand had risen and the MRI scanner at City had broken down. There was a short-term plan to improve the situation.
- A never event was discussed that would be reported to the Board in due course.

The Chair raised the Continuity of Carer Policy that had a strong evidence base, particularly for people from ethnic minorities and deprived socio-economic backgrounds. KT confirmed that the Trust was not happy with the status quo but there was a plan in place and the LMN System would put the plan in action. 45% of women who booked with the Trust did not deliver within the Trust. Continuity of antenatal and post-natal care would need to be aimed for unless this could be resolved.

JW queried how long the 13 serious incidents had been outstanding and how the business case was being prioritised. DC agreed that the 13 cases needed to be addressed from the 2021/22 financial year. Immediate duty of candour feedback to families had been provided and changes advised after the 72-hour review. The business case was going through the Business Investment Group for additional time or staff. It was not just those people who were leading investigations but also those who provided information.

JW queried whether timescales had been set nationally or by the Trust and how far they had been exceeded by. DC advised that the Trust's timescales were shorter than the national ones. The cases were from a spectrum of times, with extensions granted on some. KD reported that the national timescale was 60 days from end to end. The local target was 50 days. Some had gone over by months. The priority was the duty of candour to make the family aware. The National Patient Safety Strategy suggested that longer should be taken to do it properly and to look for trends and themes. A balance was required that would be proposed at Q&S and signed off by DC and MR.

The Chair took assurance from DC's description that these were being actively managed and the patients' relatives were being kept informed. The Q&S Committee had been asked to scrutinise improvements.

The Board Committee Chair's Report on Q&S was **NOTED** for assurance by the Board.

| **10.** Receive the update from the **Finance, Investments and Performance Committee** held on 1st July 2022 | **TB (07/22) 007** |
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MH highlighted the following points from the Finance, Investments and Performance Committee (FIPC):

- The Month 2 finance report was tracking well but there were underlying issues that needed to be addressed in order to recoup the £3m variance.
- The 2022/23 plan had been discussed regarding the Integrated Care System (ICS) plan with a £48.1m deficit and the Trust's £12.2m deficit. All providers had been asked by the ICS to resubmit their plans. There was a risk that the additional income required to break even had not been secured from the ICS. Communications were required across the System.
- The MMUH lifetime model bridge showed strong links to the original business case but there were three areas of significant variation, including the increase in workforce needed to deliver the services of over 1,000 Full Time Equivalents (FTEs) at a value of £62m.
- MMUH affordability had involved significant work but the Committee was not convinced that these plans were affordable, so additional income would need to be secured.
- The Committee were not criticising what was being done but had highlighted the complexity of the environment and items to clarify with the ICS to enable mitigating actions to be put into place.

The Chair suggested that Month 2 and planned care positions would be discussed in item 12.

RBe noted that a collective agreement had been reached at the MMUH Committee and at FIPC regarding a simple pictorial depiction of the Trust's start point deficit as a result of MMUH's opening and plans to mitigate this deficit partially or wholly. Clarity on the product that DM had to produce was queried. MH confirmed that the objective of what was trying to be achieved and how to depict it was clear. Full visibility of the unknowns that would potentially impact this were the issue.

ML agreed that the gap was large. Some of the things being planned to close it may not be sufficient and some fundamental action may be needed. Securing additional income was the plan but the only other way of closing it would be to reduce expenditure.

FM reported that she would support Simon Sheppard to update the waterfall diagram to track the journey with activity planning assumptions in changing Whole Time Equivalents and predicted growth for MMUH.

DM agreed with ML that the current actions were to close the gap in 2022/23 recurrently, and to secure regional and national support for capital charges, and additional income against the cost profile currently seen. The other options were to plan for a deficit or to adjust the cost profile.

RH queried how clearly this had been articulated to the people the Trust was expecting to receive the additional income from because the two new ICSs would be setting a new strategy.

RBe suggested that the formal start point of educating the Strategic Commissioners about the care model, workforce assumptions, and the revenue requests and implications would be tomorrow afternoon at MMUH, where the Birmingham and Solihull (BSOL) team would be taken on a tour.

ML suggested that asking System colleagues for additional resources should be accompanied by benefits realisation work, which required time and effort to package.

The Chair queried whether the Trust was being paid for the ED performance for BSOL. LK reported that there was an agreement from the System to provide £1m to support them but the overall impact and activity trends needed to be worked out regarding additional wards and staff to be requested from the

two ICSs. MH added that the continual effect of the knock-on impact within the Trust was more destabilising than the actual funding of the particular items being covered.

The Chair queried whether a process was in place that would come to a conclusion. LK confirmed that he was hopeful that RBe was taking this forward with the two ICSs and DM was taking it forward with the Directors of Finance. RBe stated that he was expectant.

The Board **NOTED** the Board Committee Chair's report on FIPC.

| **11.** Receive the update from the **Audit and Risk Management Committee** held on 21st June 2022 | **TB (07/22) 008** |
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RH referred Board members to her report and highlighted the following main focus of the meeting:

- The Committee discussed the 2021/22 Financial Statements and audit findings from Grant Thornton (GT). The accounts had not been ready to be signed off or submitted for two reasons:
    1. The value of Impairment for MMUH had been raised by GT. DM reported that this was expected to be resolved today and a formal reconvening of the Committee would likely take place on Friday, 8th July 2022. An asset under construction like MMUH would not normally be revalued. There was no market for a partially completed asset to apply a value. GT argued that the trigger for impairment was signing the new contract. The best estimate of the value had been agreed. GT took this through an internal panel after the Committee meeting and the approach and impairment value were challenged. This had been revised and DM would create a briefing paper for RH and decide whether to sign off or reconvene.
    2. Assets of £90m at Net Nil book value that had been fully written down had been queried by GT. A full review in 2022/23 had been planned but GT wanted an earlier review. It was agreed that assets worth £40m that were over 30 years old or where a third party couldn't confirm that they existed could be removed from the books.

DM reported that the national team had been kept fully briefed and GT would have qualified the accounts if their advice had not been followed. The change would mean a smaller impairment amount when MMUH was finished. DM confirmed for the Chair that the forms had been submitted but the accounts could not be formally submitted without an auditor's report. The deadline had been 22nd June 2022.

The Chair queried whether being late was unusual. DM confirmed that this was no longer unusual and only 88 of GT's 105 clients had had their accounts signed off by the deadline. The rationale was that this was an extraordinary issue. This would be something they would try to avoid next year.

DB queried whether the two major adjustments affected the income and expenditure or the underlying position. DM advised that these were only technical adjustments. There was no net impact from the Net Nil book value. The impairment went against their historic reserves at the bottom of the balance sheet.

The Board Committee Chair's Report on the Audit and Risk Committee was **NOTED** by the Board.

| **12. Finance Report Month 2** | **TB (07/22) 009** |
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*DM requested to report on item 13 before item 12.*

DM highlighted the following key points about Month 2 performance:

- The adverse variance of £1.1m was against the internal deficit plan of £17.2m. Any larger System variance was as a result of not being able to reflect the required extra income.

- The main driver of the variance was non-pay, due to an energy contract issue. FIPC had received a 12-month proposal for the Trust's energy contract in February 2022. Process failures resolved at the end of April on behalf of the Trust, the energy brokers, and Scottish Power had caused the Trust to fall into a charge bracket for energy that drove a £1.1m cost pressure above the plan in April. Negotiations were underway to settle on something fair that would be reflected in Month 3.
- Elective Recovery Fund (ERF) income underperformance was not reflected in Month 2. It was assumed that this money would not be clawed back even though the rules said it would be.
- The risks being carried in the financial plan were considerable. The plan to close some unfunded beds had not been possible, which could be due to the additional activity from BSOL and other Black Country partners. A case for additional resources from BSOL was being prepared.
- Plans to reduce bank rates had not yet been possible. Free car parking had been assumed to end at the end of Q1 but this was being continued.
- Group risks identified through budget setting had been funded in part on the basis that Groups would manage other risks in the overall position. A lot of risk was being carried at the moment.
- Plans to use reserves for things like wellbeing and overseas recruitment, a ward nursing business case, and provisions for Royal College of Emergency Medicine standards, MMUH recruitment, and changes to ward relief would be reviewed in Month 3 to make risk-based reprioritisations.

RH noted that this had been debated at FIPC and a lot of the risks were highly likely. A plan had been agreed at FIPC that looked at each risk with a lead against it, a timeline, and a set of actions. RH suggested that this and the CIP needed to be seen as a Board to ensure that the £17.2m deficit could be delivered.

ML queried where they were on capital, given that they were 20% behind and there were supply chain delays. DM reported that the Capital Management Group was monitoring this monthly and it was the intention to fully deliver the capital programme. More detail could be provided next month.

The Chair noted that the £17m plan was slightly riskier than expected and supported RH's suggestion.

The Board **NOTED** the assurance from the Month 2 Finance report.

**Action:** DM to report back on the capital programme spend.

**Action:** DM to report on the financial risks presented to FIPC and on CIP progress.

| **13. 2022/23 Financial Plan Update** | **TB (07/22) 010** |
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DM highlighted the following main points about the prolonged planning process for 2022/23:

- The Trust originally had an internal deficit plan of £31m. The Trust had a share of £12.2m in the tactical System deficit plan of £48m.
- The difference between these figures was additional income. The cost plan was clear and the only route to break even was by accessing the System's risk reserve.
- The whole NHS system had been expected to do better. Additional money for inflation and specific issues had been issued to help with Trusts' bottom lines. The £31m deficit was reduced to £17m.
- The range of measures to take the System from the initial £124m deficit down to £48.1m was shown in the paper. The Trust's cost position had remained the same throughout and the £12.2m deficit plan had also become break even.

- The final 2022/23 plan would have no impact on activity plans, workforce plans, or budgets for the Groups or their delivery or risks. Access to more System income would drive a bottom-line change.
- The risks included the lack of System-wide financial reporting. Assumptions included a low level of COVID, which was increasing. A report was planned in Q1 and development work was establishing System-wide financial frameworks and shared objectives. This should result in assumption consistency and equity of resource allocation that would become clearer in future years.

ML queried which of the two goals the Non-Executive Directors and the Trust Board were being held to account to deliver, either a deficit of £17.2m or break even. DM clarified that it was both of these goals. The uncertainty around breakeven was beyond their control. There were activity plans and cost budgets that remained consistent across both totals.

RBe assured ML that there was a strong audit trail that their cost improvement programme (CIP) was challenging yet realistic. There was a collective mutual accountability of the host System to the region but as a Board, the goal was to achieve a £17.2m deficit. DM and RBe had been consistent in articulating that they were not comfortable with the baseline starting positions for the constituent organisations within the System. There was a highly varied approach to what constituted a challenging CIP amongst organisations.

RBe queried the deployment of a senior facilitator that was expected to be brought in to provide clarity. DM reported that this independent, senior person had been unavailable at the first development session to create a secure long-term model but was expected to help going forward. The Trust's capital plans for investing in MMUH and the residual Estate were no longer in their control. A single version of facts for comparison of efficiency assumptions and plans for each organisation was necessary.

RH sympathised with the challenges caused by the vagaries of how to operate within the System that the Board had to deal with. The collective strategy for breakeven was needed by influencing the ICB.

DB raised the Elective Recovery Fund (ERF) upside and its ownership. DM confirmed that the System had to earn ERF to get it into the System to be able to receive it.

JW suggested that the System needed to learn quickly to work in a better way. The correspondence trail with the System was queried. DM advised that the System had recognised that the Trust could not be clearer. Nobody knew yet whether risk reserve would be available. Someone objective needed to ensure that each organisation was consistent, particularly around commitments for new service developments. An internal and System process was needed to prioritise risks versus the available resources.

LW queried the cost improvement risks. DM reported that £10m of recurrent CIP and £7.5m non-recurrent CIP was in the plan. The £7.5m may need to be increased to £10m if absolutely necessary. The £10m was attached to a detailed list of schemes that added up to £9.9m. A further £2m to £3m of opportunities had been identified. There would be a report on how CIP was being achieved in Month 3.

DF suggested that in future years, non-NHS partners needed to be looked at. DM agreed that the ICB gave them this opportunity with the growth into primary care and mental health. The impact and benefits from this were unknown. The integration agenda was hoped to link up primary care and the Better Care Fund.

The Chair queried the list of items in the table that took the deficit from £17.2m to break even. DM advised that this was the System's list, not what was in the Trust's plan. The Chair queried the 3% minimum efficiency in the list. DM reported that this was a standard amount applied to everybody that didn't change the CIP plans. The 3% was the System's mathematical expectation of what would be delivered.

LK suggested that the 3% that equated to £7.8m was on top of the current CIP saving plan. DM advised that this was in addition to another £5m of non-recurrent CIP that the Trust had not agreed to.

RH suggested that the Board should write to the ICB on behalf of all the organisations requesting a strategic System route back to break even along with actions to enable this to be achieved collectively.

ML agreed that a letter should be written now but regardless of what the list constituted, the Trust had accepted this when they signed up to a break-even position.

The Chair agreed that they were in a transitional state of dealing with NHS Finance. The implications and consequences of this were being seen. The Executive were being held to account by the Board to deliver a deficit of £17.2m and to work across the System to get the balanced position right. Clarity for the whole System was needed through engaging with them. A formal communication from the Board to the System was agreed by the Chair.

The Board **NOTED** the 2022/23 Financial Plan report.

**Action:** RBe/DM to write a letter to the System on behalf of the Board requesting greater clarity on the strategic route to break even.

| **14. Maternity Improvement Plan** | **TB (07/22) 011** |
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MR and HH highlighted three key areas and the following points from the Maternity Improvement Plan:

1. Six external investigations by the Healthcare Safety Investigation Branch (HSIB) had been reported on for the first time and would be reported on quarterly. The outcomes, themes, and trends would build as this was shared over the next year. HSIB had conducted 760 investigations in England in 2020/21. Top 5 improvement themes had been useful. The Trust was part of the quality improvement theme for fetal monitoring. HSIB provided families with reports and involved them from the very first point. A just culture for staff focused on learning from events and lessons.
2. How Midwifery Continuity of Carer (MCoC) linked to Ockenden 2 was described. MCoC would be the default model of care by the end of March 2024. Only 4 of the 11 provider Trusts across the West Midlands had some degree of MCoC. It had been decided to join together to progress and learn lessons. 56% of women could only be supported by MCoC through antenatal, intrapartum, and post-natal care. The System's four providers had decided to use 20 teams to base the model of care on choice of place of birth. This would support communication, reduction in health inequalities, and fluidity of staffing. The workforce was planned to be at establishment by March 2023. This plan had gone to the People Board within the System. The vision had been sent to NHSE/I and working groups had been started with appetite for change.
3. The monthly update from safety champions had focused on Ockenden and staffing risks around neonatal. Approval was requested for the Ockenden framework for May 2022.

VT queried how the six HSIB reports compared to the numbers the year before and whether there was an ethnic breakdown on the women to track ethnicity patterns. HH reported that the backlog in HSIB reporting made it difficult to compare to the previous year. Less cases had been referred to HSIB due to lessons learnt. HSIB had reviewed their reporting criteria from all babies that had cooling to support their brains to only babies that had changes on scan. The Trust had been applauded for the number they sent through to HSIB. The majority of these had a higher proportion of ladies from a BAME background. This data was included in the stillbirths and neonatal deaths. HH confirmed for VT that this was broken down

into ethnic groups on the monthly Quality and Safety reports that she offered to go through with VT offline. HH confirmed for VT that the midwife and maternity support worker was part of a five-year plan.

DF queried how long it would take to link MCoC with the two Place offerings because there was a risk with it not being in West Birmingham. HH reported that this offer had been looked at for every lady served and a meeting with the BSOL counterparts was needed next. DF suggested that a conversation offline would be helpful to ensure that documentation was in place to join the two. HH assured DF that both Places were represented on the workstream that was leading MCoC.

RBe queried what the framework looked like for redistribution of human and financial resources between the two Systems to meet the different patterns of service delivery. HH acknowledged that the financial support within the System was proving difficult through the pelvic health System approach, where the West Birmingham money had gone to BSOL. The two Systems needed to come together. MR had spoken to Sally and Lisa on how to align resources and LMNSs. Making this work within the Black Country System could potentially be rolled out elsewhere. The Chief Midwifery Officer for England was excited about this.

FM confirmed that following HH's presentation at the People Board, a joint bid for NHSE/I money had been agreed in scope for the end of July. This would only provide 50% of the funding needed to prioritise key areas of recruitment like Maternity. The retention programme was surveying existing staff to find out how to incorporate learning about being more attractive. HH's thinking was well regarded by the System.

DB queried whether more focus on mothers who would give birth in the System would deflect demand for those who had not traditionally given birth there into BSOL and how they would cope. The provider collaborative's 9 services didn't include Maternity but would need to link with developing a clinical strategy. HH suggested that more births would come back. 1,800 ladies were currently giving birth at Birmingham Women's Hospital but the Trust was providing antenatal and post-natal care. The rest were within the Black Country. The ICB Chief Nurse recognised the need to be part of the collaborative work.

DF queried whether the People Directive could include local jobs for local people, as employment was part of improving health. FM agreed and reassured DF that one of the areas was looking at learnings from their Supporting Career Opportunities, Recruitment & Employment (SCORE) Programme as part of their wider participation approach and developing the pipeline from those apprentices and young people. Reaching some of the more difficult areas required more work. FM had been collaborating with Tapiwa (Taps) Mtemachani at the CCG, who had suggested some pilot approaches to speak to DF about offline.

HH asserted that within each Place, third sector providers were also being reached out to, to support continuity of support workers on pathways to get the communities involved. The assurance framework had one HSIB request made to the Trust relating to a case discussed at Q&S at the previous meeting. HSIB were happy with the response. The Clinical Negligence Scheme for Trusts (CNST) had commenced pace and there were some alterations to the Board submission on 5th January 2023 that would require the Head of Midwifery and the Clinical Director to provide their own assurances to the Board on the 10 points.

The Chair noted that the MCoC was a big change management exercise that needed careful thought around resourcing and support because it affected every single person's working practices.

The Board **NOTED** the report's assurance and **APPROVED** the oversight framework for Ockenden.

| **15. Ambulance Handover Performance Report** | **TB (07/22) 012** |
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LK highlighted the following key points from the Ambulance Handover Performance report:

- The graph showed the percentages of West Midlands Ambulance Service (WMAS) ambulances that were offloaded within 30 minutes, with City maintaining around 92% and Sandwell just above 72%.
- There had been an increase in conveyances in May. A longer-term view was being looked at to show the significant difference in the pattern from different areas since Intelligent Conveyancing had been introduced by WMAS in April 2021.
- Intelligent Conveyancing into City and Sandwell showed that the Trust remained a major net importer to support System pressures. The timing of the arrivals was often a glut over a short period, making it difficult to offload and maintain standards.
- Four proposals were being worked through ahead of the Winter Plan, that would come to Board in September. These included (1) workforce improvements, (2) outflow within the Sandwell Department that lacked cubicle capacity, (3) re-direction streaming into Same Day Emergency Care (SDEC) facilities into Medicine, Surgery, Paediatrics, and Gynae with triage at the front door via individual assessment units to allow ED to create cubicle capacity more quickly, and (4) increasing physical capacity by rearranging departments or additional structure to provide a cohorting area for ambulances, depending on staffing if WMAS could provide a paramedic-led unit.

VT queried evaluation of the model used in Wales. LK reported that he only had anecdotal evidence about the additional areas. The shift in volume of activity had coincided with implementation, so cause and effect were difficult to determine. The physical capacity to allow cohorting would help, but staffing was the issue.

RBa noted that bed days associated with this cohort were significant. There were three risk assessments that needed to be conducted regarding now, winter, and MMUH. Staffing and costs of the extra beds were significant. The question of whether improvements would drive greater demand by virtue of empty beds being filled needed to be considered with scenarios. MMUH Opening Committee had agreed to look at reviewing the scenario testing that would be included in the paper coming back to the Board.

LK agreed with RBa's point about the three risk assessments and the risk to MMUH metrics about occupancy and flow improvements when others were struggling, which would mean that the pressures would need to be shared across the System. This could affect the modelling.

MR noted that a patient safety paper would go to Executive Quality Committee on the quality metrics to consider patients. The way to capture this would be discussed in detail for incorporation within LK's report. This would then go to Q&S. LK agreed that patient safety in busy departments and more complex patients required wider analysis to triangulate the elements together, which was being analysed by DB's team.

RBa noted that the paper's proposals were internal and didn't include System consideration of risk and multiple partners and providers that were involved in the Urgent Care System.

RBe advised that in the Black Country System, there were one or two partner organisations that struggled more with patient flow and delayed discharges than the others. On patient safety grounds and ED crowding, a System and regionally assisted deep dive for those organisations and their supporting Place Based Partnerships was imminent. The BSOL System's support for Heartlands Hospital was unknown.

The Chair observed that the relative performance of the Trust was extraordinary and he credited the people on the front line. The risk assessments to mitigate the risks now, in Winter, and for MMUH were agreed. Parts of all 4 proposals would likely be necessary. Having the paper come to Board in September would help with thorough planning. The Trust depended on the whole System working and only part of this was under the Trust's control.

LK noted a question about flow between the two sites and the difference between them. Sandwell patients stayed longer than BSOL patients but the BSOL shift in length of stay was greater, while Sandwell was seeing a reduction. Admission avoidance could be having an impact on the patients being seen, which may be impacting on the original modelling. This would be reported back on next time.

The Board **NOTED** the report and the ambulance handover performance.

**Action:** LK to do risk assessments regarding the impact of ambulance conveyancing now, during Winter, and for MMUH.

| **16. Digital Strategy** | **TB (07/22) 013** |
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LK highlighted the following key points from the Digital Strategy:

- The Digital Strategy had been presented to the Digital Committee, the Clinical Leadership Executive (CLE), and FIPC, where recommendations had been suggested.
- The Digital Strategy aligned with the overall Trust Strategy of Patients, People, and Population and underpinned the objectives. The visions for Patients, staff, and Population were outlined.
- The outcomes hoped to be achieved through the Digital Strategy would change along with technology but premises of ease of access and use would stay the same. Priority projects needed review on when to be phased through.
- Financial considerations were raised at CLE and FIPC to understand the costs. An outline of where the Trust was currently and where the Trust needed to go to to deliver the strategic objectives and elements that would be useful for MMUH, and included a search for external funding sources.
- Inequalities in the System would be addressed. There had been patient user group engagement, feedback from clinical Groups, and review by the senior leadership team.

JW observed that the Strategy was thorough and well-structured. JW suggested the use of an external advisory group and a link with the Research and Innovation Strategy around the use of patient data for research and engaging with patients and local community about how data might be used. A widening of inequalities was a risk for people without access or skills. Links with the lack of organisational development and change capacity support would be needed. External sources of funding could be missing that could be helped by an advisory group, such as Innovate UK. Industry often had better access to funding.

RBe suggested an explicit gap analysis between a SMART MMUH and what the business case would deliver, with plans to bridge this gap. The priority projects list regarding staff and Population may be too wide to make it clear what to decide upon. This required input from everyone in the planning transition.

ML praised the work and suggested that the Trust's ambition should not be moderated by funding. ML noted that the Trust was in the lowest quartile regarding FTEs whilst being about to move into a world-class hospital. ML suggested that IT & Digital spend was considered as an investment, not a cost, because there was a wide scope to make improvements with the MMUH opportunity, so as not to have regrets.

LK agreed with the difficulty in deciding priorities and risk appetite in the digital sphere. Stabilising the digital platform had brought benefits to patients and staff and better feedback. The financial and quality benefits offered by investment needed more detail. LK agreed to JW's offer to discuss her ideas offline.

The Chair agreed that this was a good piece of work that took them forward and that the level of their ambition required consideration and further work. An external advisory group including industry looking at

alternative financing methods was agreed to help them to put into place what they wanted to deliver. The opening of MMUH was a good opportunity to outline the plan about what would be done.

The Board **ADOPTED** the Digital Strategy.

**Action:** LK/MS to engage an external advisory group. Add a gap analysis between digital ambition for a SMART hospital versus what the business case would deliver and plans to bridge this gap.

## OUR POPULATION

| **17. Our Population: Dashboard** | **TB (07/22) 0014** |
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DF advised that a set of metrics that was better aligned to what was being done in Place was being developed. The urgent community response (UCR2) was seeing average volume but really good performance with the patients being seen. The UCR2 best performing area in Walsall was seeing 280 per month, which would mean about 400 a month when it was triangulated with the Trust's population. There was a good plan for virtual wards, with an aim of 110 virtual beds in Sandwell and 54 in West Birmingham that would be phased over the rest of the year. The only virtual ward that was currently live and compliant with the national protocol was COVID at home. Respiratory, Frailty, Paediatric, Palliative Care, and Heart would go online over the next three months. Work on avoided admissions was looking at how to push forward the acute services into the community arenas. Further work on both Epicentre and a piece of work on an integrated front door to put the teams together would be added to the metrics.

The Population dashboard report was **NOTED** by the Board for assurance.

| **18.** Receive the update from the **Integration Committee** held on 28th June 2022 | **TB (07/22) 015** |
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WZ referred Board members to the paper and highlighted the following four points:

1. The Sandwell workstreams had been established. Work was going on with the Primary Care Networks to recruit more staff.
2. Early inequalities data had shown some positives and some challenges. West Bromwich was a particular area with challenges. Work with partners and local communities to codesign interventions there had been helped by this early data to design better services.
3. The terms of reference for the Locality Board had been approved for another 12 months for Ladywood & Perry Barr. The Committee remained concerned about whether West Birmingham was in the same place regarding Place-based approach workarounds, which was being monitored.
4. Good work had been done on the narrative on how the Trust, as an acute provider, needed to work closer with Primary Care. Partners were increasing the footprint within Primary Care. An updated Primary Care Strategy was hoped to be brought to the Board for discussion and approval.

The Chair queried the partial assurance reported regarding the Provider Collaborative update. WZ reported that more work needed to be done around the operating model that was work in progress. DB agreed that the original case for change and 9 clinical areas had been selected but without a model yet.

DF reported for the Chair that of the three points raised for Ladywood & Perry Barr, two had been resolved, leaving the continuity of the chair and the sharing with Sandwell. The BSOL team were listening.

The Integration Committee Chair's report was **NOTED** for assurance by the Board.

| **19. Place Based Partnership Update** | **TB (07/22) 016** |
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DF highlighted the following points from the Place Based Partnership (PBP) update:

- The communication and engagement strategy work had begun. RW was taking the lead in coordinating this. A lot of third sector organisations would be part of the future.
- The workstreams were starting to build delivery plans. Work being done with Primary Care had been raised. The new Fuller Report talked about building neighbourhood teams for localised care.
- Intermediate care work in the graph showed a consistent reduction in being below 72 hours in the pathway. Work would be done with DB and LK's teams to look at complex discharges.
- Smethwick and Tipton had younger populations but had presented with some of the highest numbers of long-term conditions in urgent care, such as cardiac and gastro issues that were normally associated with over 65s.
- The partnership position with the Local Authority in Sandwell had led to the idea of using Town Halls to set up health and wellbeing centres.

RBe noted that the MMUH business case made assumptions about community services like Primary Care and mental health that would support the care model and activity assumptions. Work to ensure that this happened and to engage the people at PBPs to deliver this needed to be shown to the Board.

DF reported that conversations at the Performance Management Committee (PMC) and with RBa and DB had looked at the logical flow and how that interacted with MMUH sustainability. There was a link between admission attendances, bed occupancy, and length of stay reduction that made MMUH sustainable in the longer term. The new Board Level Metrics would point in that direction to show the work that Place was doing, changes or opportunities that presented for MMUH, and any gaps.

The Chair requested that this was shown in DF's reports. DB reported that the revised Board Level Metrics would go through the next PMC, CLE, and Board meetings. These were ready to be reviewed. More Population and MMUH metrics were included, which linked to the 8 priorities in the Strategy.

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

## OUR PEOPLE

| **20. Our People: Dashboard** | **TB (07/22) 017** |
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FM stated that sickness absence performance had improved but weekly tracking showed that the focus needed to be maintained. Further deep dives in PCCT and Medicine had been done due to rates being significantly above the monthly targets. Deterioration had been seen in turnover but focused work in the areas where it was tracking above target had started to show improvements.

RW confirmed that the positive Pulse check was based on April 2022 data.

JW suggested better continuity in units of measurement. Targets that were percentages were being reported in number of days lost and should be in percentages as an industry standard. FM agreed.

The Our People: Dashboard paper was **NOTED** by the Board for assurance.

| **21.** Receive the update from the **People and Operational Development Committee** held on 29th June 2022 | **TB (07/22) 018** |
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LW highlighted the following points from the People and OD (POD) Committee Chair's report:

- Staff survey debates had led to an improvement plan focused on fairness, equality, and leaders' roles in working with staff. Key areas of service and staff requiring intensive support in the Trust had been identified through quality health report deep dives. A Quality Improvement (QI) methodology would be looked at to drive steady improvement. The approach to the next survey would be refreshed with a range of incentives. The HR and OD team were working with three well-performing Trusts to select good areas of practice that POD would monitor regularly.
- MMUH recruitment and delivery plans had been approved. Monitoring of recruitment and expenditure had been discussed. POD supported the request for extra capacity to support the MMUH recruitment delivery support and raised the lack of capacity and skill to deliver as a risk.
- A deep dive into recruitment challenges had been requested for the July POD meeting.
- Detailed HR performance metrics on sickness and turnover had been discussed. A wider range of metrics on training compliance and HR performance would be examined in July 2022.
- The staff survey work was positive and would be a long-term piece of work.

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

**FOR INFORMATION**

| **22. Board Level Metrics and IQPR exceptions** | **TB (07/22) 019** |
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DB noted the improvement in SHMI and issues with bed usage and DM01 performance, already discussed.

The report was **NOTED.**

| **23. Any Other Business** | **Verbal** |
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The Chair thanked the following three people for their support of the Trust and wished them well:

1. Mike Hoare had been a stalwart Non-Executive Director for eight years and had made major contributions to the digital work and finance and performance.
2. Kate Thomas had made major contributions to improving quality and community public health.
3. David Carruthers had provided service over many years and was well loved and highly regarded.

Details of next meeting of the Public Trust Board: **Wednesday, 7th September 2022** at 9:30am.

**Meeting Close**