TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting held via MS Teams.

Date: Wednesday 8th June 2022, 09:30-13:00

Voting Members:

Sir D Nicholson (Chair)	(DN)
Mr M Laverty, Non-Executive Director	(ML)
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)
Mr M Hoare, Non-Executive Director	(MH)

Non-Voting Members:

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

In Attendance:

Mrs R Wilkin, Director of Communications	(RW)
Mr D Conway, Associate Director of Corporate Governance/Company Secretary	(DCo)
Mr M Taylor, Informatics Associate	(MT)
Ms L Wilde, Head of Midwifery	(LW)
Ms D Tipton, Primary Care Liaison Manager	(DT)
Ms C Newton, Group Director of Nursing	(CN)

Guests:

Ms A Barker, CEO of Newbigin Community Trust	(AB)
Rachel, colleague of Ms A Barker	
Mr A Smith	
Ms J Haynes, Birmingham Mail - *joined at 11:51*	

Apologies:

Dr M Hallissey, Assoc. Non-Executive Director	(MHa)
Mrs J Wass, Associate Non-Executive Director	(JW)
Ms H Hurst, Director of Midwifery	(HH)

Minutes	Reference
1. Welcome, Apologies and Declarations of Interest	**Verbal**
The Chair, DN, welcomed Board members and attendees to the meeting. Attendees introduced themselves for the purposes of the voice recording. Apologies were received from Mike Hallissey, Jo-Anne Wass, and Helen Hurst. There were no declarations of interest.	
2. Staff/Patient Story	**Verbal**
DN welcomed Anji Barker (AB) and her colleague Rachel, who had together formed the West Birmingham Health Group around GP Access. They had joined to provide a Trust Board Place/Population story. MR introduced AB, the CEO of Newbigin Community Trust, which supported the community of Winston Green and Handsworth areas. There were opportunities to work together to improve healthcare access. AB described families of high need who had been moved from London since 2015 that were mainly single mothers with children, asylum seekers, and refugees. Council services were being reduced at the same time. In 2018, the housing shifted to shared accommodation, creating an influx of single adults aged 40 to 60. There had been 89 beds for single chaotic adults within the 13 streets around Newbigin Trust at the	

time and there were now 317 beds for people with multiple complex needs. Single homeless people from across the country were being housed immediately and 5,174 families were living in B&Bs and hostels.

AB related stories to illustrate the challenges of accessing healthcare. They helped by sending advocates along to accompany families who struggled to present their problems well and to support single people with mental health and addiction issues. GPs and A&E were dealing with more pressures as the early help services were being shut down. GPs were being asked to provide proof of address letters and things that could be handled through the voluntary and charity sector.

AB shared an idea about setting up a team of volunteers to look after Emergency Department (ED) patients to fill out their forms and support them while they waited. Frequent fliers could be diverted to charities.

DN thanked AB for bringing the descriptions of moving populations and this community to life.

LK noted that access to repeat prescriptions and GPs were issues and suggested that working together to provide the Trust's predictive analysis tools for when people would run out of prescriptions would be helpful. The idea around the volunteer ED team from 11pm to 3am was commended. LK offered to work with AB after the meeting to make this happen.

WZ thanked AB for the descriptions that resonated with him and for everything they were doing. WZ suggested that he visited AB's organisation to discuss things further and queried how the NHS system could work better with school communities to tackle cohesion issues. AB explained how they ran a hub and were building a new high school in Sandwell where another hub would be put in. AB suggested co-housing GPs in schools to centralise services like vaccines.

DF welcomed the opportunity to meet with AB and suggested that they joined up their work on resilience.

RBa described how Learning Works reached out to vulnerable parts of the population to support sustainable employment. The Trust was building a Learning Campus and partnering with the Department of Work to provide better health outcomes. RBa suggested that they discussed this further.

AB reported that deregulated and exempt housing and HMOs were shutting down. There was only about a 40% occupancy. Their goal was to get families out of hostels into re-established family homes. There was hope that a more mixed community would be created over the next two years.

DN commended AB for her contributions and ways of working that the Trust could learn from. DN committed that the Board would follow up through DF to work with AB. DN thanked AB for everything that AB's charity did and the inspiration to do more. The Board committed to work together to find practical ways of collaborating to improve the lives and health outcomes of the population.

Action: DF to follow up with Anji Barker, CEO of Newbigin Community Trust, to introduce an ED volunteer team and to work together to improve the lives of the population.

3. Minutes of the previous meeting, action log and attendance register	**TB (06/22) 001** **TB (06/22) 002** **TB (06/22) 003**

The minutes of the previous meeting held on 4th May 2022 were reviewed. The following amendment was made:

- Item 2 – The STORK figures for infant mortality stated as 3% and 9% should be 3 per 1000 and 9 per 1000 population.

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

DB informed the Board that the retrospective review of the provider collaborative would not be going ahead. DB was working instead with the Strategy Director and Programme Director to write papers on a stocktake and governance to try to achieve a similar outcome.

The action log was reviewed. DCo informed the Board that of the two outstanding actions, one was underway and the other had been completed. There was nothing to update around the public enquiry.

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

The Chair made no opening comments.

5. Chief Executive's Report	**TB (06/22) 004**

RBe presented his report which focused on the undertakings document that the Trust had been sent by NHS England and NHS Improvement (NHSE/I). RBe made the following points to note:

- Undertakings documents had historically been issued from NHSE/I to NHS Trusts regarding performance issues against constitutional standards, or about quality and safety matters. This now took place at a System level at Integrated Care Boards (ICBs). This left undertakings documents to be sent when there were concerns about an organisation's delivery on issues like quality or corporate governance, leadership churn, or culture and staff satisfaction ratings.
- Previous undertakings for the Trust had been formally closed. A new undertakings notice related principally to five matters:
    1. The relatively high churn in leadership at Executive and Non-Executive level
    2. The Trust's Well-led rating
    3. The staff survey results
    4. The governance review findings and associated actions
    5. Ongoing concerns regarding culture of staff engagement and engagement of hard-to-reach communities regarding maternity services. The Care Quality Commission (CQC) had rated the Trust's maternity service as good, which was the only maternity service in the Black Country to have achieved this rating.
- The proposed response for Board agreement was to sign the undertakings, to send the latest version of the governance review action plan by 30th June 2022, and to undertake to continue to update NHSE/I quarterly on this plan. The People Plan response on staff satisfaction would be provided quarterly once the People and OD Committee and the Board had signed this off.

LW requested an update on the CQC's last visit and progress within the Sub-committees and the Boards because the Trust's ambition to be good required improvements in key areas to be driven forward. RBe advised that MR and KD were cross-referencing the previous 2018 CQC inspection findings to current activity to present to the Board to provide assurance with the Well-led quarterly self-assessment update.

RBe clarified for MH that this superseded the previous undertakings. NHSE/I was turning their attention to Systems for regulatory activities like 4-hour waits and Referral to Treatment (RTT) waiting times, and to individual Trusts for leadership, culture, staff satisfaction, and governance concerns. MH requested that the work to address the original undertakings was incorporated. RBe suggested a discussion on how the work of the System and the Trust's contribution provided assurance.

DM commented that the governance review action plan should be fully owned and that quarterly reviews would be welcome. There also needed to be continuous monitoring to show that the Trust felt the impact of the improvements and that changes were being embedded, such as the freedom to speak up. RBe agreed that the Sub-committees needed to reflect on this as well as Executives.

The Board **NOTED** the Chief Executive's report and the closure of prior undertakings. The Board **ACCEPTED** the update on the governance review action plan and **APPROVED** quarterly Board updates on this plan and

the Well-led self-assessment and action plan. The Board **APPROVED** that the CEO would sign the undertakings before the end of June 2022 and would send the People Plan when it had been signed off.

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

There were no questions forwarded from members of the public.

Governance, Risk & Regulatory

7. Draft Annual Report	**TB (06/22) 005**

RW presented the draft Integrated Annual Report and Accounts 2021/22 for input from the Board. The accounts were currently being audited. RW requested authority for the Audit and Risk Management Committee to receive the final document and audited accounts in time for the national submission.

DB noted that the reference to C-section rates should be taken out because this wasn't measured on the back of Ockenden, but was based on what the baby and mother needed. MR agreed that it was either the mother's choice or a clinical requirement. MR agreed to discuss this amendment with RW offline.

The Board **NOTED** the draft Annual Report and **DELEGATED** authority to the Audit and Risk Management Committee for approval. The Chair thanked RW and everyone who had created the Annual Report.

Action: MR to work with RW to amend the C-section description and any further feedback on the draft Annual Report.

BREAK

OUR PEOPLE

8. Our People: Dashboard	**TB (06/22) 006**

The Chair referred Board members to the dashboard in relation to People.

FM advised that the sickness plan targeted reduction to 6% had not been achieved and focused work was going on with the Groups. Positive developments had been achieved in reducing turnover and in improvements to the Pulse survey responses.

RH queried the benchmarks and how to assess the results in the dashboard. The improved response rate of 22% for the Pulse survey and turnover improvement did not show what the Trust was striving for and how this compared to other Trusts. FM reported that the turnover target was 11%. Although an improvement had been made, turnover was still at 13.5% overall and as high as 18% in key qualified nursing groups. A retention Quality Improvement Methodology was focused on targeting areas who required the most interventional support and monitoring.

FM reported that the previous Pulse survey response rate had been 17%. Although this had improved to 22%, previous results had been as high as 34%. The best Trusts had achieved a 45% response rate. RW added that the Pulse survey had started nationally in the first quarter of 2021. Data for other organisations was not available yet but should soon allow benchmarking, like for the national staff survey.

DN agreed that what the Trust was aspiring to needed to be clarified in the graphs. As benchmark data was available, this was important to be built in.

DB noted that the red target line was shown just below 1% per month for turnover and at 80% for the Pulse survey, where the Trust was just below 63%. DN commented that showing the target percentage changes for the Trust turnover of 1% together with the calculation of 14.45% to 13.61% was confusing.

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

Action: DB to clarify the Board level metrics' aspirations and incorporate available benchmarking data.

9. Receive the update from the **People and Operational Development Committee** held on 27th May 2022	**TB (06/22) 007**

LW referred Board members to the Chair's report and highlighted the following:

- There was a busy forward plan of work and the People Plan objectives were being updated to outline priority areas. The People and Operational Development (POD) Committee would then be able to monitor clear measures of success, such as the staff survey responses.
- POD had received an update on a wide range of Equality, Diversity, and Inclusion (EDI) issues from the Head of EDI. The Trust EDI plan would be presented to POD in July 2022 and then to the Board.
- The Midland Metropolitan University Hospital (MMUH) recruitment plan was expected at the June POD meeting, including how to closely monitor delivery and avoid double employment.
- The capability and capacity for the organisation to undertake this recruitment would be discussed.
- A second draft of the OD and Change Management Plan was expected at POD in July 2022.
- eRostering was progressing well. POD had noted the huge cultural shift for the staff, which was the biggest challenge. A quarterly update would be received on progress towards full implementation.
- There had been a healthy discussion about performance. Benchmarking and performance metrics were tracking good governance within HR and the improved delivery that was expected.

ML highlighted that the workforce stream of MMUH was behind schedule. ML stressed the importance of completing this so that recruitment and organisational change work could begin.

DN suggested that the EDI plan should be presented to the Board. LW assured the Board that this was also her recommendation. POD had seen a general overview of the EDI work being done.

DN stressed the importance of tracking the outcomes and benefits from eRostering. LW advised that there were benefit realisations outlined in the implementation plan that POD would be monitoring quarterly.

In answer to DN's question about the Trust having sufficient capacity, RBe acknowledged that the MMUH workforce challenge had a recruitment team that were struggling to meet expectations. As part of the June paper, there would be recommendations on how this was resourced through insourcing or outsourcing. From a change management and OD perspective, further resource was needed and proposals would be put forward to POD and the MMUH Committee in July 2022 to allow enough time to secure this resource on a non-recurrent basis in order to deliver. A comprehensive review of FM's corporate function had shown strengths and weaknesses that needed to be addressed. The Executive Team were working on risk mitigation around capacity.

DN queried when this would be resolved. RBe advised that he hoped to assure the Board that they had comprehensively addressed this by the end of July 2022. DN emphasised the importance of this.

The Board Committee Chair's Report on POD was **NOTED** by the Board.

10. People Plan Update	**TB (06/22) 008**

FM highlighted the following key points from the People Plan update:

- A five-year journey identified key priorities for 2022/23, including equality and leadership culture, to improve the staff experience. Personal and collective responsibilities in this process were noted.
- A multidisciplinary approach was required to provide people with the right tools and environment.

- The delivery plan would be presented to POD in July 2022. Workshops were planned to unite everyone's efforts towards the same aims and outcomes.

ML suggested that performance management was a missing priority. FM advised that this would be addressed in the values work and underpinning behaviours. The technical competencies would be part of the leadership framework. People experienced the organisation through their line managers and colleagues, so this was a fundamental part of the work they were planning to do.

ML advised that this went beyond behaviour and was simply what people were expected to do. DN agreed that the strategic plan and objectives needed to be translated into what that meant for each person regarding the organisation's expectations and what support could be expected from the Trust.

LK acknowledged that there was a lack of understanding of what was available for staff on their development journey and the core standards they had to deliver in each role. A prospectus had been suggested regarding opportunities and core skills at each level, talent management, skill enhancement, and educational development. LK advised that the structure needed to make the Groups integral to the workforce and steering groups. FM assured LK that the Groups had been an integral part of developing the governance structure to streamline their input through less meetings through a series of workshops.

LW suggested that a timescale and prioritisation to deliver the product of this work was important, with what needed to be seen to recognise that achievements had been made.

RBe acknowledged that there were a range of opinions on what was important in the People Plan. The Executive Team would propose priorities. The debate over what was the most urgent was inevitable.

RH asked FM to expand on the section about staff experiencing the Trust predominantly through interactions with line managers and survey results showing that this was lacking. FM observed that the national staff survey and Pulse check showed that good meaningful dialogue and communication with line managers and support around wellbeing was lacking. More of an anticipatory response in relation to the management of risks affecting staff and being treated with empathy and compassion was needed. Line managers should be engaging with staff regularly through Performance and Development Reviews, appraisals, regular dialogue, and ongoing support. Managers needed to focus on less things and have simpler messages and to see how Fundamentals of Care, the People Plan, and MMUH were linked.

KD noted that one of the Well-led lines of enquiry was around the Trust's culture being centred around the needs and experiences of people who used their services. This aligned with the Fundamentals of Care. The interactions patients were having with staff could be improved and should be aligned with the People Plan.

FM agreed and reported that historical incidents had been reviewed thematically. Themes like poor EDI experience and communication were being woven into the competencies of the Fundamentals of Management and the broader leadership framework to underpin the values. Restorative people practice delivered the just culture principles. More engagement should result from Jamie Emery's patient experience work, which should link into the work on patient EDI and staff EDI that needed to be tackled holistically. KD added that staff feeling proud to work in the organisation came across with patients.

RBa commented that the priorities of working from home and agile working required staff to work efficiently, safely, and well supervised. MMUH would address the clinical facilities for acute but 50% of patient contacts were in the community. The physical working environment was other people's homes and properties. Staff safety outside of the hospital needed to focus on cameras and the ability to call for help if needed. DN added that people's cars were another issue.

FM acknowledged the Board's active investment in People. The Board was asked to receive assurance on the plan. FM asserted that constant reinforcement of the messages would be key going forward.

The Board **NOTED** the report and welcomed the clarity of thought. DN suggested that the final plan would be more of a description of how a list of a few key things would be achieved to make a big impact.

OUR POPULATION	
11. Our Population: Dashboard	**TB (06/22) 009**

DF acknowledged that the metrics in the Population dashboard were new and still filling with activity and that DB was helping to coordinate new metrics as the Place model developed.

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

12. Receive the update from the **Integration Committee** held on 25th May 2022	**TB (06/22) 010**

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

1. The strong partnership work in Sandwell Place was starting to come through. It was important to bring colleagues and stakeholders across the Trust and Sandwell on the journey of change.
2. The approach to Ladywood & Perry Barr remained a concern. The West Birmingham Locality Board Chair had a three-month extension. There was a concern about whether Birmingham and Solihull (BSOL) understood the importance of synergy between Sandwell and West Birmingham Place.
3. The first tranche of health inequalities data for Sandwell had been presented. This would be further developed and data for West Birmingham would also be made available to share with the Board.
4. The draft Primary Care Strategy needed more work on the narrative of the importance to ensure that there was a strong base within primary care. Work with West Birmingham primary care partners was creating some exciting developments.

DN queried the draft Primary Care Strategy. WZ explained that this document described the Trust's relationship with primary care. DF acknowledged that this was more of a plan than a strategy. There were exciting opportunities with practices and primary care networks, particularly in West Birmingham.

DN requested an update on the relationship with BSOL and the West Birmingham community following RBe's letters to a series of people about how they could work together more closely on regeneration.

RBe described the desire for local assessment of needs and local determination regarding allocation of resources and/or changing service provision to meet that need was strong in Ladywood & Perry Barr. This was at risk by the view of Birmingham as being one Place. There was a lack of assurance that they were able to receive the delegation of people resources from the CCG as it transitioned and local governance on a local Place-based board with an independent chair to develop the work. The letter had invited attendance at an idea generation workshop on how work like that around MMUH could create regeneration, better employment, and life chance opportunities to improve public health.

They were aiming to demonstrate a clear developing understanding of what Ladywood & Perry Barr needed to senior leaders of the Council and ICB to show that there was no risk attached in letting the collective partnership act on these needs by trying to change services in a way that reflected need.

DN asserted that the change needed to be built from the community upwards and this was more about giving power to local people to develop their own resilience and ways to improve their life chances.

WZ reinforced the need to work together and suggested the importance of showcasing the dynamic, localised approach in Sandwell and the six towns across in West Birmingham and beyond. All the partners were working together in Sandwell, being led by the needs of the community and their residents.

DF identified the material risk of the continuity of the Locality Board and local decision making, which was being actively worked on within West Birmingham. The best Places were about the coming together and taking decisions collectively and managing risk, not about creating new infrastructures.

LW queried how the talent from primary care could be co-opted into more of the Trust's management and Sub-committee decision making. DF advised that there were two pieces of work that were going on:

1. A single workforce would be recruited across primary care and the Place Based partnership. This partnership was being coordinated in Sandwell.
2. Portfolio career options were being looked at. The enhanced access roles that were part of primary care network funding showed that the opportunity existed such as to spend a day a week on an ambulance, at a GP practice, and at a community site. The Trust was one of two organisations in the country that was going to launch this portfolio career to enhance workforce sustainability.

DM added that BSOL was an associate to the Black Country contract. Direct contract opportunities could be explored with the BSOL ICB for 2023/24 to ensure that some of this could happen with more contractual leverage to be able to mitigate some of these risks.

RH commended the good work going on and queried what success looked like over the next three years linked to integration and Population metrics. DF advised that they didn't want to prescribe the collective view of success until people were settled into the partnership and it was clear what direction to take.

DF reflected on his journey in developing Place in Walsall that had started in 2014. Walsall were a success in providing more timely access to urgent care and patient experience outputs but this could not yet be measured in health inequality outcomes. There was a Board development session in September to do a deep dive into what success looked like for the Trust.

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

13. Place Based Partnership Update	**TB (06/22) 011**

DF highlighted the following Place Based Partnership (PBP) update focused on Sandwell:

- It was becoming recognised that this was an operational redesign rather than a piece of work.
- The gradual reduction of complex discharges (no criteria to reside) was significant in absolute numbers and length of stay for two reasons:
    1. The patient experience was better because they were getting to the preferred place of their care more quickly.
    2. There weren't areas open adding additional risk and burden to the organisation. The pathway 1 length of stay had reduced from an average of 10.1 days to 5.4 days. This equated to two full wards of occupancy that had been closed as a result of this work.
- The Urgent Community Response had resulted in 87% of patients interacting with the community teams who were avoiding some form of acute admission. Most other organisations were achieving around 70%. The volumes were still low. The ambition was to reach over 1,000 patients per month.
- Activity benchmarks for the six towns of Sandwell showed significant usage of acute and urgent care services dependant on the practices of the populations that used the services. Urgent care was six times more likely to be accessed from West Bromwich than from other areas of the borough. Urgent care could be disrupted in a really positive way.
- The case study described an actual patient who was on an end-of-life journey. There had been three bedded interactions with the Trust and multiple failed attempts at interventional care at home. He then died in the emergency department (ED), which was not ideal for his family. The Place-based model's interventions were shown that could have changed this patient's journey.

MR advised that sharing this case study would help to change culture. This provided amazing opportunities to improve the patient experience, illustrating the crossover of People, Patients, and Population.

LK commended the paper and the move from acute to community. LK queried what they would do to progress the ED data by progressing preventative care through PBPs. LK reiterated that they were an integrated organisation so the acute feature was a component of integrated care.

DF advised that the town teams, including the GPs, would analyse this data to understand why the activity numbers were so high so that interventions could be put into place. This diagnostic would drive the actions whose effects could then be measured. Diabetes, cardiovascular disease, and dementia were specialities that could be managed better at home through acute Place outreach.

DB queried whether the two wards were community wards or acute. DB suggested that the reds and the blues in the paper's metrics should be reversed because the goal was to drive ED attendances down.

LK commended how the care navigation and the saving of ward and bed days were brought together in the paper. A reduction of admissions of over 65s, using Same Day Emergency Care (SDEC), integration and reductions in pathways 1 to 4, a significant increase in Intermediate Care, and activity coming from BSOL and other Systems needed to be worked through to understand the impact on the overall position. The Trust being a net importer made it impossible to understand the answer to DB's question on the impact on acute or community beds, although the latter had been reduced.

DN suggested that this lens could be applied to elective care as well, as a future step.

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

14. Public View Board Report – Verification against Internal Reporting	**TB (06/22) 012**

DB referred Board members to the paper and highlighted the following key points:

- The Public View Report had been looked at for assurance as to why the Overall Hospital Combined score had fallen, as well as 19 other data points that had been explored in more depth.
- 6 of these metrics mapped directly. The 'new to follow up ratio' had highlighted a data quality problem. This affected capacity planning and posed a risk to the income because more clinics had been marked as 'new' that were actually follow ups than vice versa.
- Hospital Onset was reported based on 48 hours but Public Health England (PHE) collected this based on days. Someone in hospital for 25 hours would be looked at as two days but not by the Trust's calculation. This would be taken up with PHE to agree a way forward. Reporting by day would slightly worsen infection rates.
- There were 4 metrics that related to the emergency care or maternity services data set. When a supplier put a system in, they were mandated to create a report in XML. Data tables would need to be written to turn this into something that could be read in order to make improvements.
- The Clinical Effectiveness Team needed to access the NHS Digital data on Summary Hospital Mortality Indicator (SHMI) rather than Healthcare Evaluation Data (HED).
- There were three other data points to look into. The priority was to provide the right information to the Board. The finalised work was proposed to go to Performance Management Committee instead of to the Board.

ML queried whether the intention was still to have a quarterly look at Public View data to track the direction of travel as a proxy for how the CQC would assess a rating of good. DB agreed that this was possible. ML suggested that a periodic look would be helpful. DB suggested that the Hospital Combined Score chart could also be integrated into the Board level metrics to show the component parts.

LK provided context on the small proportion of the New to Follow Up ratio, which had about 1,000 activities, representing about 1.3% of overall outpatient activity out of approximately 65k per month. The Patient Administration System's upgrade in April should enable changes to be made to clinic templates.

RBe agreed to ML's request for quarterly CQC action planning and assurance and a Well-led update that would allow a view to be taken on whether progress was being made in the event of a full inspection. DN agreed that a timetable would be created to action this together with the Public View data.

The Board **NOTED** the findings and thanked DB for the work.

OUR PATIENTS

15. Our Patients: Dashboard	**TB (06/22) 013**

The Chair referred Board members to the paper which was **NOTED** and taken as read.

DC observed that the Hospital Standardised Mortality Rate (HSMR) and SHMI monthly figures showed continual improvement with an overall fall in the 12-monthly cumulative score. Significant improvement had been made to Sepsis SHMI since January 2022. Work continued on documentation issues and there was a specific focus on sepsis, pneumonia, and other infections like urinary tract infection.

LK highlighted the subsequent month of increased emergency attendance, the change in the RTT graph's continual decline, although the return to 92% was predicted to be over a year away, and a small improvement to SDEC utilisation. SDEC would be further improved by increased senior cover, a larger estate footprint, and the change in philosophy to a pull process. An operational and clinical lead had been appointed to oversee SDEC across the organisation.

MR highlighted the increase in Serious Incidents (SIs) due to hospital-acquired COVID being reported in the same month instead of over a three-month period. A new process was in place to correct this. Areas where there was no or low reporting of SIs would be investigated, monitored by the Q&S Committee. Infection prevention control targets had reduced for the year except for C. difficile, which had increased. The Trust would retain the more difficult target of 33. Band 5 staffing had greatly improved over the past 12 months. There were 42 HCA vacancies but the graph needed to be corrected, as it also showed trainee roles.

MR confirmed for DN that the Perfect Ward would be replaced by a Fundamentals of Care dashboard.

The Board **NOTED** the HSMR and SHMI and RTT improvements.

16. Receive the update from the **Quality and Safety Committee** held on 25th May 2022	**TB (06/22) 014**

KT highlighted the following points from the Quality and Safety (Q&S) Committee Chair's report:

- Two still births and one neonatal death had taken place. Learnings had been reported from the 72-hour review to HSIB, who had sent a letter of urgent concerns. HSIB were pleased that the Trust had done this so rapidly. Maternity services had put the learning into place immediately.
- Recruitment of midwives should lead to a slight over-establishment by March 2023 but there were still problems with staffing in Neonatology and in the community.
- There were fewer deaths than expected for both heart failure and stroke.
- MR had given an excellent presentation on Fundamentals of Care, which was everybody's work.
- The Trust was a high reporter of incidents. Staff had reported low confidence that incident reporting would lead to change. The WeLearn programme needed to be reinstated following COVID to shift the culture. The Trust would appoint a patient safety specialist who was hoped to help with identifying where culture needed to change, including areas of low reporting.

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

17. Receive the update from the **Finance, Investments and Performance Committee** held on 27th May 2022	**TB (06/22) 015**

MH highlighted the following points from the Finance, Investments and Performance Committee (FIPC):

- Month 1 was on forecast associated with targets but there were risks around the System that could affect future performance.
- The 2022/23 plan had been reviewed and there was assurance that this was reasonable. Another review would take place following the meeting on 29th June prior to a request for Board approval.
- The Committee thanked the Procurement team for their hard work, key performances, and turnarounds over the last 12 to 18 months.
- The capital plan was in a good position to adapt if required to the outcomes of the Systems' planning and MMUH discussions.

RBe noted that the Procurement team was achieving decent results for its size. DM agreed that the results were good. Their Procurement team had a clear focus on clinical engagement. Clare Nash was commended for her sustainability work. A local supplier day would be run on 14th July, inviting local suppliers, NHS partners, and Councils. Being relatively small allowed a focus on this as much as the bulk purchasing opportunities. Proper systematic governance around the collaboration the Centre wanted was important. There were joint work plans with the University Hospitals of North Midlands (UHNM) Stoke collaboration that ran procurement for Wolverhampton and Walsall Trusts to maximise joint purchasing opportunities, as well as through links with Black Country Healthcare and local Councils and with the Midlands Health Alliance. There were plans to formalise this through the new ICB governance structure through the Finance Committee. There was no push to merge teams as long as the best possible value was demonstrated.

The Board **NOTED** the report, the performance of the Procurement team, and the capital plan's flexibility.

18. Finance Report Month 1	**TB (06/22) 016**

DM highlighted the following headlines on Month 1 performance:

- The Trust was on plan overall regarding their internal deficit of £31m. The Trust had a share of £12.2m in the draft System deficit plan of £48m.
- The cost plan of £643m was expected to stay stable.
- There was a final 2022/23 plan submission due on 20th June 2022.
- Due to the late timescales in setting the plan and not transacting all the budgets at Month 1, there were changes to income targets and reserve allocations that would improve the Group position.
- Risks to the income and expenditure position delivery were set out in the paper. The set of metrics that would track delivery and mitigation of these risks would be part of Month 2 reporting. A new set of Board level metrics for 2022/23 would also be proposed, linked to the Board Assurance Framework and improvement work on the use of resources.
- The capital programme had been set and a prioritisation with the Executive and Estates teams would be reported back through the FIPC.
- At the end of Month 1, there was £69.8m of cash in the bank.

ML queried the underlying deficit change. DM advised that there was no relationship between the £24m in the 2021/22 budgeted deficit position and the £31m deficit because this had been a reset to reflect some of the run rate pressures in the recurrent budgets coming out of the pandemic. There was a recurrent income plan of £612m and expenditures of £643m, giving the Trust a £31m deficit. £7.5m of non-recurrent

CIP was expected to be put into this position and an additional £7m of income. This needed to be dovetailed with the long-term recovery trajectory for the System's underlying deficit position. Everyone needed to be calculating this in the same way with consistent assumptions that would be discussed at a meeting on Wednesday, 15th June 2022 to start this work.

ML queried whether it mattered that the Trust had an underlying deficit. DM reported that it was not unusual in the acute Trust sector, given the ongoing pressures. This drained the cash that could otherwise be put into the capital programme and cash may need to be borrowed from the System. There were operational and strategic downsides to this. The Centre expected this position to be recovered. The Trust needed to be realistic about the pace and the trajectory. System collaboration should help with this goal.

The Board **NOTED** the assurance from the Month 1 Finance report.

19. Maternity Improvement Plan	**TB (06/22) 017**

MR highlighted three key areas and the following main points from the Maternity Improvement Plan:

1. Afrah Mulfihi had been doing work around the Trust's Equality, Diversity, and Inclusion (EDI) agenda to listen to mothers, women, families, and third sector partners to ensure that they booked as early as possible and to reduce health inequalities. This EDI role had been extended for another 12 months with a review of funding planned.
2. Workforce remained the focus. At a recruitment event in May 2022, 7 midwives and 4 maternity support workers had been recruited. There were 37 vacancies, including the Ockenden establishment. 21 students from September 2022 and 20 internationally educated midwives had been appointed, 5 of whom had started. The biggest risk was the students changing their minds. Otherwise, the vacancies would be filled by the end of March 2023. Work had started on retention.
3. The monthly update from safety champions had focused on Ockenden and staffing risks around neonatal consultant roles and using locum consultants.
4. Less than 1% of the Trust's births were home births. Since April, the lack of staff in the community had meant that support had been through other partners. This was reviewed monthly.
5. A paper for the Q&S Committee was planned on continuity of carer in relation to Ockenden. This needed to be provided properly as a System. Approval was requested for the Ockenden framework.

DN queried the vacancy position. MR explained that students often accepted more than one job so a third were expected not to take the appointed roles. FM assured the Board that the dropout rate was 17%. FM gave recognition to Helen Hurst for her work.

The Board **ACCEPTED** and **SUPPORTED** the important EDI update, **ACCEPTED** the safety champion update, and **APPROVED** the oversight framework for Ockenden.

20. Ambulance Handover Performance Report	**TB (06/22) 018**

LK highlighted the following key points from the Ambulance Handover Performance report:

- There was the highest possible risk score of 25 across the System for ambulance availability handover. West Midlands Ambulance Service (WMAS) had seen the highest number of calls ever and the amount of level 2s left unattended was unprecedented. A lot of the problem stemmed from ambulances being held at hospitals so they could not be released to go back out to answer calls. The Trust was working towards a 15-minute handover to release the ambulance crews.
- 30-minute handovers were featured in the Board metrics. Nearly 65% of 30-minute handovers were being achieved at City and this was lower from a Sandwell perspective.

- 60-minute handovers were achieved 90% of the time at Sandwell and 95% to 100% for City. This equated to less than 200 at Sandwell in April 2022 after a spike in March and just over 50 at City.
- There were about 830 conveyances across the West Midlands in April, of which 41% or 350 came into City or Sandwell. The Trust had become a net importer to minimise the risk across the Birmingham and Solihull (BSOL) System and within the Black Country. This had a material impact on attendances at ED departments and in occupancy.
- Early modelling suggested that about 2 ½ wards' worth of patients were currently being housed from other Systems. Most of the conveyancing away was between the two sites. City and Walsall were performing best across the Black Country and Sandwell was next best. Compared to the West Midlands region, this was also true if Birmingham Women's and Children's Hospital was taken out of the equation. George Eliot Hospital were up there but the rest were far behind in terms of ambulance handover times, which was why conveyancing was coming to the Trust.
- Safety to patients was addressed through action cards and ambulance offloading standard operating procedures and protocols in line with best practice. A report on the actions to ensure patient safety would be presented to Q&S Committee.
- Early intervention in the pathway to work in a preventative manner through Place Based Partnerships needed to be looked at. SDEC was critical for freeing up assessment areas. An extension to the Urgent Treatment Centre (UTC) had been agreed for another two months. This had a huge impact in outflow from the ED, which freed up the ED and allowed offloading.

RBe observed that his role as the Urgent Care Senior Responsible Officer for the Black Country had highlighted the reality of the problem for category 2 patients on the WMAS call stack who waited for hours without being responded to. The Q&S Committee should consider a harm review or study for ambulances who had delayed handovers at the front door. In the West Midlands area and in the Black Country System, the Trust had the lowest ambulance conveyance rates to hospital in the country. There had been a 1% increase in 999 call activity to the ambulance service overall and not a significant increase in emergency department attendances or admissions on average. Regional and local performance continued to deteriorate on average. As the only major net importer of intelligently conveyed ambulances that were not originally destined for the Trust, this was having a significant impact on beds and flow and yet other organisations were having difficulty in responding quickly even without this additional pressure.

DN queried why a small increase in 999 and no appreciable increase in attendance had caused so many problems. RBe advised that in general terms there had been an exit block from hospitals on complex discharge pathways and post-pandemic increased patient acuity and dependency, increasing the length of stay on medical wards. This was being mitigated by delivering SDEC and best practice at the front door and by improving the outflow through Place Based Partnership work with social care. The residual problem could be an urgent care system that was less resilient than before.

LK confirmed for DN that the average length of stay had increased. There was analysis being done on the increase in out of area ambulances arriving, which became admissions that were difficult to discharge through pathways 1 to 4. This then backed up the ED at other hospitals, who diverted ambulances to the Trust, that blocked discharges at the Trust and compounded the problem. Across the West Midlands, there were less ambulance conveyances and attendances. Demand and capacity were being looked into.

DN agreed with LK that the performance of the Trust was remarkable in the circumstances.

DF commented on the agonising wait with 999. This was the case for disrupting flow and getting Places to work together differently. The whole pathway issue was not designed to straddle geography. Given that this was a System challenge, DF queried what other Trusts were doing to try to address this issue and how to change the profile of concern and pressure on the City site in particular with BSOL partners.

LK advised that there was an acknowledgement of the pressure and the risk around ambulances, particularly in the Black Country. There was development around outflow elsewhere that needed work. BSOL and West Birmingham had acknowledged the Trust's work with some funding but further discussions were needed with further resources and changes to pathways to address the root causes.

RBe suggested that the Urgent Care Board in the Black Country was trying to get assurance around delivery and best practice in urgent care. The Trust did relatively well around reducing risk around exit block and complex discharges but SDEC, UTC provision, pathways 1 to 4 exit, and streaming at the front door of ED could still be improved.

MR reported a long conversation at Operational Management Committee about long waits that would result in a paper to Executive Quality Committee and to Q&S Committee. Some of the patients coming through ED needed to be audited for harm. Patients diverted on alerts were not always known about properly. Other patient safety issues and wider breach aspects needed to be included in the paper.

In response to DN's request to expand on the improvement plan for the 30-minute handover, LK reported that cohorting bays would be expanded. City struggled with cohorting due to its location within ED but a 3 or 4-way move was being investigated. The care navigation centre that was being imminently set up would look at supporting WMAS and 111 with ambulances going direct to SDEC or other assessment areas or providing an urgent community response instead, with a full triage of patients to all services. This would be a preventative measure. Only 65% to 70% of SDEC utilisation was being used to free up cubicles in ED. The caveat was that if ambulances were turned around more quickly, more would be sent.

In response to a question from DN on resources from Birmingham, DM advised that £1m had been agreed in principle that would be at best a direct allocation and at worst, first call on a risk reserve.

DN credited the front-line staff and LK and his team for managing this so well and dealing with the issues. DN credited the Executive and the Trust as a whole for putting the population's interest and sick patients' needs before any internal organisational benefits.

The Board **APPROVED** the report and the improvement plan for dealing with 30-minute handovers.

FOR INFORMATION	
21. Board Level Metrics and IQPR exceptions	**TB (06/22) 019**
The report was **NOTED.**	
22. Any Other Business	**Verbal**
There was no other business.	
Details of next meeting of the Public Trust Board: **Wednesday 6th July 2022.**	
Meeting Close	