PATIENTS PEOPLE POPULATION

NHS Sandwell and West Birmingham NHS Trust

TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting held via MS Teams. **Date:** Wednesday 5th October 2022, 09:30-13:00

Voting Members:

Sir D Nicholson (Chair)	(DN)
Mr M Laverty, Non-Executive Director	(ML)
Mrs L Writtle Non-Executive Director	(LW)
Mrs R Hardy, Non-Executive Director	(RH)
Cllr W Zaffar, Non-Executive Director	(WZ)
Mr R Beeken, Chief Executive	(RBe)
Mr M Anderson, Chief Medical Officer	(MA)
Ms M Roberts, Chief Nursing Officer	(MR)
Ms J Newens, Acting Chief Operating Officer	(JN)

Patient Story Presenters:

Ms S Oley, Directorate Lead for iBeds	(SO)
Ms A Crumpton, Clinical Lead for the Integrated Discharge Hub	(AC)

Apologies:

Ms D McLannahan, Chief Finance Officer	(DM)

Non-Voting Members:

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

In Attendance:

Mrs R Wilkin, Director of Communication	(RW)
Mr M Sadler, Executive Director of IT & Digital	(MS)
Ms H Hurst, Director of Midwifery	(HH)
Mr S Sheppard, Director of Operational Finance	(SS)
Mr D Conway, Assoc. Director of Corporate Governance/Company Secretary	(DCo)

Minutes	Reference
1. Welcome, Apologies and Declarations of Interest	**Verbal**
Chair DN welcomed Board members and attendees to the meeting. The Chair welcomed the Patient Story presenters and Simon Sheppard, who was standing in for DM. Apologies were received from Ms Dinah McLannahan (DM). There were no declarations of interest from Board members in relation to the agenda. Attendees provided an introduction for the purpose of the meeting recording.	
2. Staff/Patient Story	**Verbal**
The Chair highlighted the importance of beginning with a patient story to create a grounding in the reality of the services being provided through direct information from patients and staff. MR advised that this month's patient story would demonstrate the work being done to embed the Discharge to Assess (D2A) Model through the Integrated Discharge Hub and working with partners. MR introduced Sarah Oley, Directorate Lead for iBeds and Amy Crumpton, Clinical Lead for the Hub. SO described the D2A Model, developed 7 years ago in Warwickshire and mandated for use across England in 2020. D2A moved from the traditional assessment of a patient's needs in an acute hospital environment to follow up after the patient's discharge with an assessment in their home environment of their ongoing health and social care needs. Same day arrangements were made for carer support or	

equipment needs. Evidence had shown that care needs were overestimated in the acute hospital setting by about 50%.

The D2A Model promoted independence, privacy, and dignity and made the best use of social care resource. D2A sometimes allowed patients to return home sooner and reduced risks of a prolonged stay.

This was coordinated at the Trust through the Integrated Discharge Hub that had been established in 2020. This was a partnership of clinicians, social care workers from both Sandwell and Birmingham Local Authorities, third-sector agencies, and wider System partners through the Integrated Care System (ICS). The team worked towards patient-centred discharge based on a home-first principle.

AC introduced the story of the first lady to be discharged home as part of a D2A trial on AMU. This lady was 91 years old, had been independently active, and had experienced her first fall. Her dominant hand's wrist had been fractured. Her son had visited her house and assumed that her standard of cleanliness had deteriorated. There had been statements that the property was unsafe and the patient could not return home. The discharge plan considered a pathway to an enhanced assessment bed in an institution.

The lady was assessed on the ward as part of the D2A process. It was established that her hearing aid had been left at home. There were no concerns about her property and the lady wished to return home. Consent to speak to her son was given, who was able to confirm an objective view of the property's safety. He met with the D2A team at the patient's home. Concerns were addressed and a plan was agreed with the lady and her son. Instead of going to a home, the lady required two care calls per day to support her with personal care while her arm was in a cast. Low-level equipment was provided.

As part of the D2A process, the lady was checked on in her home 24 hours later, a week later, and 28 days later. The lady was then re-established as completely independent in her own home. The person-first experience had been quite positive and allowed the lady to have a better quality of life at home before suffering a fatal stroke a few months later. Good feedback had been received from the lady and her son.

SO reiterated the need to focus on the patient, to avoid assumptions, and to be objective. People were happier in their own homes, with better outcomes. Dedicated transport had been established for D2A.

Comments and questions:

DF commented on the need to manage expectations of both the patient and their relatives and carers. DF queried the fall-back plan for this lady. SO reported that a clear safety plan was established with everyone before leaving patients in their homes, with the next steps clearly outlined for their journey.

MH commented that this highlighted the need to communicate properly with patients. The patient's capacity issues had not been tested by simply writing something on paper, which fell into the Fundamentals of Care approach. The D2A story demonstrated how to do this properly.

WZ reported that they had discussed at the Integration Committee how this was a good example of how the Integrated Discharge Hub was working. Muslim and Jewish communities needed a different process at home if someone passed away because of the religious requirement for a swift burial. WZ queried how families could be reassured that a rapid release policy would apply at home rather than just in hospital.

MR reported that the rapid release policy should work in both cases but the policy required renewal. MR requested discussions with the Muslim and Jewish communities for input. WZ agreed to help with this.

RBe observed that Sandwell had a lot of NHS-funded community hospital beds and queried the challenge towards the home-first D2A Model. SO confirmed that in times of pressure, beds were the quickest solution. As part of Primary Care, Community and Therapies (PCCT), there was a collective responsibility to make it just as easy to send people home. AC agreed that the bed option was the model of least resistance because of the potential for difficult conversations with relatives around the home-first approach.

RBe reported that there were more beds open than had been planned but the Midland Metropolitan University Hospital (MMUH) was based on a bed occupancy of 85%, not the current 95%. The maximisation of D2A and admission avoidance would help in this transition. Between 100 and 120 beds needed to be reduced in order to safely occupy MMUH.

The Chair queried why everyone did not have the D2A option. SO reported that the capacity of social care and other factors that were tracked on a monthly basis that limited the ability to apply this to everyone. There was a national requirement to discharge those who no longer needed acute care within 24 hours. There was an average wait of 5 days because of capacity issues and supply chain issues with equipment.

The Chair observed that the way people were assessed on AMU should be tackled, which would be helped by the focus on communication in the Fundamentals of Care work. The ability to increase capacity to do D2A should be a focus. The Chair requested that DF reported on how to improve D2A capacity.

Action: WZ to help MR to arrange for input from the Muslim and Jewish communities to renew the Rapid Release Policy for D2A patients and those discharged home.

Action: DF to report on how to improve Discharge to Assess capacity.

3. Minutes of the previous meeting, action log and attendance register	**TB (10/22) 001** **TB (10/22) 002** **TB (10/22) 003**

The minutes of the previous meeting held on 7th September 2022 were reviewed and **accepted** as a true and accurate record of the meeting, subject to the following amendments to be discussed offline with DCo:

- Naming conventions and attendees needed to reflect those present at the meeting.
- Page 8 required the conclusion by the Board on CQC preparation and assurance.
- The date on the People Dashboard should be September rather than October.

The action log was reviewed. It was noted that one action had been completed and that an update would be provided on actions in progress by the next meeting.

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

The Chair commented that the Board needed to focus more of its attention on issues that mattered most.

Public Board meetings were planned to be held every two months following the November 2022 meeting in order to use the other month for Board development and strategy work. DCo had been asked to create a plan to make the public meetings more accessible and attractive and to engage more people.

5. Chief Executive's Report	**TB (10/22) 004**

RBe presented the following main points from his report:

Integrated Care Board (ICB) Operating Model

The delegated responsibility, authority, and people resource allocation that the ICB gave to both the provider collaboratives and the Place Based Partnerships required clarity around their intentions in the operating model. RBe and DF were working with Birmingham Community Trust colleagues to ensure that explicit intentions in the MMUH business case about postcode-blind services for MMUH users would mean that Ladywood and Perry Barr residents would be treated similarly to Sandwell residents. RBe and DF hoped to provide the Board with clearer assurances about the risk of transferring West Birmingham as a Place from the Black Country to Birmingham at the next meeting.

System Outcomes Framework

The Oversight Framework by NHE England (NHSE) to determine which segment NHS Trusts should be in based on financial performance, Care Quality Commission (CQC) ratings, and performance standards had been delegated from NHSE's regional team to the ICBs. The Trust's host Black Country ICB had to decide assessments based on the updated performance assessment by NHSE and would be providing Trusts with the opportunity to participate in a peer-to-peer assessment of each other's proposed segmentation.

'Mini-budget' and the new Secretary for Health's plan for patients

The Trust were well advanced with the plan for patients. The Secretary of State had announced an extra £500m nationally for winter. This was expected to be allocated by Better Care Fund arrangements in place at Place level. Approximately £500k was expected to be received for winter. The 'mini-budget' announcement regarding regional investment zones should be an opportunity for the Trust with its regeneration aspirations to address health inequalities. The work that had been started with the Combined Authorities should provide an opportunity to influence the investment zone decision for the Black Country.

JW queried the importance of the System Outcomes Framework categorisation. RBe advised that this would show how the Trust was viewed by regulators, and on an aggregate basis, how the System was viewed. This was important regarding how intensive and mandated external help would be. It was uncertain how this was being governed. RBe confirmed that he was not aware of details about how much intervention would apply for segment 3, although segment 4 was very prescribed.

ML queried the ICB partners' ratings and implications for the CQC rating. RBe advised that the CQC rating contributed to the segmentation. All Trusts except Black Country Mental Health Trust were in segment 3.

WZ raised the uncertainty around the Ladywood and Perry Barr Chair and the lack of engagement with GPs compared to in Sandwell. WZ observed that it was unfortunate that the regeneration workshop that evening had been cancelled due to a lack of attendance, as regional investment zones were real opportunities to address mass inequalities. It was encouraging that both Local Authorities had adopted

the regeneration frameworks and the masterplan initiated by the Trust. WZ suggested that the two Local Authorities and the Combined Authority were encouraged to drive forward the agenda.

RBe assured WZ that this was important to the Trust and work would continue in this area. RBe had advocated a diplomatic approach regarding the West Birmingham question and risks. There had been assurance on the three key tests but local determination and local leadership was not being honoured.

DB commented that the ICB were effectively performance managing the Trust, which aligned the Trust's and ICB's areas of importance. The Trust needed to clarify what it was focusing on to align the focus so that improvements in these areas would be recognised and approved.

DF reported that the difference between the approaches to the two Places were creating a gap. More assurance about interventions would be provided to the Integration Committee and to the Board in November 2022. A different offer was beginning to be seen based on postcode.

The Chair supported the regeneration plans and suggested that an inclusive approach was adopted.

The Board **noted** the report.

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

No questions had been raised.

Our Population

7. Our Population/MMUH: Dashboard	**TB (10/22) 005**

The Chair suggested that DF focus on the ability to be able to open the Hospital in his reporting.

DF presented the following key points from the Board Level Metrics for Population/MMUH:

- Attendance avoidance, admission avoidance, and length of stay reduction were the three key areas of focus to gain a future fit for MMUH and for right sizing the community services going forward.
- Timely response for patients was demonstrated in the 2-hour Urgent Community Response metrics for over 1,000 patients per month.
- The correct admission avoidance graph was shown in figure 2 of the Place Based Partnership update. Admission avoidance was being provided to 1,400 patients per month.
- D2A Pathway 1 length of stay had started to increase over the last two months due to capacity having been diverted to the community teams and social care teams to follow discharges. 90 virtual beds were provided for a maximum of 6 weeks. This would be increased to 180 beds as a priority. Social care capacity was suffering from workforce sustainability challenges. The multidisciplinary team working with locally based teams needed to treat individuals as residents instead of patients and with a needs-based assessment rather than prescribing care. Domiciliary care was becoming an increasing concern due to a lack of funding and workforce vacancies. A joint workforce approach with Local Authorities was gathering pace. A Joint Director of Therapies advertisement would bring together the Trust's and Local Authorities' therapy services to address resource gaps.

- The occupied bed days target would require a better elderly care offer through partners in Place. The plan was to reduce this metric to 100 bed days through interventions.

JW raised the concern that adverse consequences could result from early discharge of elderly patients. DF advised that readmissions were the ultimate quality metric for getting this right. The patient experience metrics from the Fundamentals of Care programme would also demonstrate this. The plan B would be repurposing the empty half of the 100 beds at Rowley Regis Hospitals. JW warned that hard targets could drive behaviour that required an eye to be kept on patient experience.

RBe commended the admission avoidance activity that had been incrementally rising from September 2021 and a marginal reduction in members' stay for Pathway 1 and 2 patients despite the social care staffing challenges. Older patients' bed days were rising significantly. RBe queried whether this was also happening in the rest of the West Midlands and nationally. Understanding the reasons was important.

DF reported that there was a variety of reasons driving flow and demand. GPs were saturated with activity, making it had to get appointments. Individuals that waited longer had greater care needs and stayed in hospital longer. The interventions were having a positive effect and were largely focused on the elderly. The best-case scenario to be hoped for would be to neutralise demand rather than reversing activity.

DB suggested that emergency ambulance conveyances for elderly people could be a useful metric. The new operating model didn't include a focus on older people, which would affect half the population.

RB commented that the activity demand could not be seen from the metrics. An analysis of activity assumptions to get into MMUH, workforce forecasts showing capacity, and risks and mitigations around future right-sizing of community services would be reported to Committees and the next Board meeting.

ML queried what was being done with GPs, clinicians, and families around encouraging end-of-life care at home. GPs, families, and hospitals were often reluctant to support this. DF reported that the Gold Standard Framework was present at GP practices at Sandwell and West Birmingham. End-of-life planning for death was encouraged but access to the service was important to avoid people being sent to ED.

The Chair emphasised the need to plan and organise towards MMUH being the right size and for it to be resourced properly in conjunction with the Fundamentals of Care approach.

The Board **noted** the report for assurance.

8. Receive the update from the Integration Committee held on 28th September 2022	**TB (10/22) 006**

WZ presented the following main points regarding the Integration Committee meeting:

- The joint Sandwell strategy had been approved by the Sandwell Health and Wellbeing Board. This would be enhanced over time as a live document that partners felt a stake in.
- The Place Based teams were embedding their work in the six towns in Sandwell, particularly in West Bromwich, where key inequalities were being tackled through interventions.
- The Ladywood and Perry Barr service inequalities were hoped to be reduced.
- Quarterly reports from YHP and reports from Primary Care services were being received, including how interventions were addressing YHP issues.

- The Committee had decided to meet in person in community settings, rotating across the six towns in Sandwell and the neighbourhoods around West Bromwich. The first half hour would be dedicated to discussions about local concerns, challenges, and work to address inequalities.

The Chair requested that the times and dates of these meeting were circulated in case other Board members wished to attend to connect with the local community.

RBe challenged the accuracy of the comment in the paper about being the most efficient, given that Sandwell General Hospital's ambulance handover performance was the third best in the Black Country and the Trust's handovers as a whole were second best in performance.

The Chair raised concerns about the money being allocated to tackle Ladywood and Perry Barr's (LWPB) health inequalities, given that Birmingham and Solihull ICS had stated the focus to be on the East of Birmingham. RBe agreed that this was a risk if less money would be available for LWPB, which he would investigate. The Chair suggested that the Trust should be an advocate for LWPB.

The Board **noted** the report for assurance.

Action: WZ to circulate the Integration Committee meeting dates and places to the Board.

Action: RBe to investigate whether Ladywood and Perry Barr are being allocated less funding for health inequalities and to advocate for them.

9. Place Based Partnership Report	**TB (10/22) 007**

DF presented the following main points from his report:

- The Care Navigation Centre service was managing 52k calls per month to transfer care. Ways of influencing this activity were being investigated as part of live navigation of services.
- A meeting was planned with West Midlands Ambulance Service (WMAS) next week to start to respond to delayed activity on their behalf. Falls patients would be dealt with more quickly.
- Urgent Community Response activity had increased and would be reflected in Board Level Metrics.
- Integrated Front Door work as part of the Winter Plan was progressing based on models from other Trusts. Just over 200 patients were expected to be redirected at the front door or at AMU in December 2022, increasing to 465 by April 2023. Care would then be provided in citizens' homes. This should have a significant impact on admissions and bed utilisation.
- Virtual wards were approached differently in West Birmingham compared to the Black Country approach. This alignment posed a risk regarding how different patients were treated.
- The opening of the Harvest View Intermediate Care Facility should be celebrated. There were 96 beds in total, with 80 beds to be opened first. These were not traditional care beds, but independent living beds with enhanced assessments for a maximum of six week stays. There would be therapists, carers, and social workers based in the building to help people to return home more quickly. This was being run jointly with the Local Authority. Substantial benefits were expected.

RBe queried whether WMAS had provided feedback on the impact of the Care Navigation Centre. DF reported that only about six calls a week out of 20 per day were being sent to the Trust. A summit with

their directors next week was planned. The Trust's proposal was to place clinicians into the control room.

DF clarified for the Chair that 150 Care Navigation Centre desks were situated over various sites that were planned to move into two sites. DF confirmed that the Chair would be welcome to visit this in action.

The Chair suggested that the Board should visit Harvest View. DF suggested a development session or a Board walk there. The Chair supported this idea and suggested that December's Board meeting could potentially be held there. The Chair commented that it had been helpful to cover this earlier in the agenda.

BREAK

10. MMUH Report	**TB (10/22) 008**

RB tabled the report. This would be adapted regarding the change to bimonthly Board meetings, of which there would only be nine before the move to MMUH. The paper described the workstream content and the areas of the integrated programme that needed to be delivered on to successfully move into MMUH. There was just under a year before practical completion, when the keys would be handed over. A report on readiness to move would be presented at every Board meeting. The critical path for key activities and measures of success would be published next month. RB committed to transparent reporting and risk assessments. The benefits would be a key emphasis as a workstream that would be tracked past opening.

RW advised that the planned MMUH stories would demonstrate benefits that patients and the population could expect. This may include potential staff challenges and descriptions of working in different ways.

The Chair advised that MMUH was closer to the centre of Birmingham than University Hospital Birmingham (UHB). The communications needed to highlight this to raise understanding.

KD raised the need for communication about the changes at Sandwell for patients and staff. RB emphasised that MMUH was a building and the transformation of care and workforce at all locations were included in the critical path. The retained estate and Place activities would be part of the communications plan, including regeneration and local employment opportunities.

RBe confirmed that MMUH saturation coverage plans were being agreed regarding the care model, the workforce model, the building, and its proximity to Birmingham city centre.

RB reported that stakeholder maps would be reviewed as part of relationship management. Liam Kennedy would be heading up clinical services. RW agreed with the need to remap stakeholder relationships.

The Chair suggested that Birmingham Health Partners were invited to a meeting at the new Hospital.

RW reported that the risk in System relationships had been highlighted in their deep dive to support changing urgent care pathways and mitigations would be put into place. Regular staff engagement regarding the transformation areas would be measured quarterly as part KPIs. Best practice was being investigated for ongoing public and patient engagement. Consultations needed to be completed by March 2024. The day case surgery engagement activity had been completed. Black Country

Commissioners would be spoken with soon. Patients needed to know where to go for urgent and emergency care.

The Chair acknowledged the excitement and daunting nature of the countdown towards MMUH opening.

Our Patients	
11. Our Patients: Dashboard	**TB (10/22) 009**

DB highlighted that the Trust had moved into the top 100 for the first time since April 2021 for Public View's Hospital Combined Score, which was used as a proxy for the Care Quality Commission (CQC). Public View was carrying a metric for the Trust's financial position from 2019/20, when the Trust had been 27th centile in ranking. Removing this metric would move the Trust down to 111th. The Trust's Combined Score had just gone up from 99th to 98th.

RBe advised that the financial recovery plan or its intended profile of achievement had not been addressed in the Board Level Metrics. It would be reported on at the next Board meeting.

RBe observed that the Trust was struggling alongside other Trusts to meaningfully reduce Referral to Treatment (RTT) waiting times that had emerged during the pandemic. A needs-led approach to the reduction of waiting times was not in place in the ICS to tackle the longest waits in a more equitable fashion across the Trusts. The Board needed to request this if they were in support of this approach.

JW challenged that clear evidence was required to avoid the statement looking like an excuse about the number of complaints appearing inflated because of entering enquiries and concerns into the formal complaint stream. KD reported that conversations with the Black Country Trusts had confirmed that they triaged complaints differently down the PALS route. Written confirmation was being requested, which would be taken to the Quality and Safety Committee and the Board as part of the complaints report.

DB confirmed that Public View had noted that people reported complaints differently and the Trust wanted to find a consistent approach.

The Chair queried the ICB's RTT plan. RBe reported that mutual aid efforts and excess capacity was provided between Trusts as opposed to taking a System waiting list approach to treat those waiting longest first. The regional team were asking this and the Board should be playing its part in delivering it. The RTT plan was being created in stages because there was not a clear route to a meaningful and sustained waiting list reduction time.

JN reported that there was an aspiration to create a combined list but other Systems were more advanced in their approach to shared patient waiting lists. There would be an expectation to do this but it should have been done by the Black Country already because it was the right thing to do. The Trust was on track to hit the national target three months ahead of expectations but there were some specialities that would not recover during this financial year. The next stage would be to gain commitment from the four Trusts to create a shared patient waiting list. Managing this could be done based on speciality or overall waits.

The Chair agreed that this sounded attractive but challenging. Having Northern and Southern Orthopaedic hubs made policing of waiting lists make less sense. The Chair supported doing what was best for patients and gave the Board's support to RBe to encourage a joint waiting list System approach as soon as possible.

MH queried whether there were 62-day target hotspots to worry about. JN reported that the two-week wait targets were being achieved successfully, sometimes at the detriment of the 62 days. There were hotspots that were impacting on performance, such as in Gynae-oncology. There was a rectification plan in place following deep dives over the last two weeks. There was slight underperformance in other specialities. The performance in 62 days was expected to recover very quickly.

MA raised the doctor vacancies metric, which did not reflect the successful recruitment of posts that had been difficult to fill, such as had been achieved in ENT specialities and other areas.

The report was **noted** for assurance**.**

12. Receive the update from the Audit and Risk Committee held on 13th September 2022	**TB (10/22) 010**

RH presented the following main points regarding the Audit and Risk Committee meeting:

- The external auditor's 2021/22 report had raised financial sustainability, governance, efficiency, and effectiveness issues. It was suggested that the auditors presented this at a future Board meeting to discuss the action plans. Issue tracking would be part of the Committee's agenda.
- A good discussion had been held around Charity independence with a way forward agreed.

The Chair reported that he had read the External Auditor's Annual Report and the overwhelming issue was that the organisation was not very responsive. The Chair requested that this was reflected upon.

LW agreed with the responsiveness observation. The Trust was not always willing to change the way that it presented or developed plans because it preferred its own way of doing things. Half a dozen suggested changes had consistently not been delivered and it was also about how things were done.

ML provided the example of auditor's criticism regarding preparing to deliver against CQC expectations, which had taken three years before KD had recently presented a plan providing assurance on an approach.

RH suggested that in addition to responsiveness, there was also a forward-looking theme to reflect on, such as regarding financial sustainability and governance for MMUH.

The Chair requested that when the Audit Report was presented, in addition to a report on what actions were in place for each element, a response was presented on the issue of responsiveness.

The Board **noted** the report and looked forward to receiving the full Auditor's Report.

Action: Present a report on responsiveness as well as actions in response to the 2021/22 Audit Report.

13. Receive the update from the **Quality and Safety Committee** held on 28th September 2022	**TB (10/22) 011**

MH presented the following main points regarding the Quality and Safety Committee meeting:

- Mortality figures were stable and much lower than they had been.
- Structured Judgement Reviews (SJRs) were behind and those coming back were going to Clinical and Professional Review of Mortality (CAPROM) and resulting in incident reviews.
- The Mental Health update highlighted the issue of support needed for patients in ED and care of patients in an emergency setting. This required greater focus.

- There had been more problems with medicines management and significant errors in managing medication safely that MR and MA were focused on addressing.

MR reported that a robust programme would be presented to Quality and Safety Committee on medicines management at the end of October. There had been 5 Never Events in similar areas involving mainly the wrong route of medication. The Safety Pharmacist was helping to create a training plan. The Trust needed an annual competency plan for staff. Work would be started where the issues had occurred. There was also a focus on communication between clinical colleagues as part of Fundamentals of Care.

MA reported that the SJR backlog was planned to be cleared by January 2023. Every speciality had at least one SJR-trained individual. Having only one person who could train others was being addressed.

RH queried the target on complaints in the Board Level Metrics. MR advised that the Metric was not yet right for Patients but there was a session to discuss this with KD. The metrics did not currently show the true journey. There was work being done to address this. KD advised that the number of complaints was shown as the metric and the key was to learn from these to avoid repetition. Another set of metrics was being created as part of Fundamentals of Care on how many came back and how many were upheld.

RBe reported that the Black Country had seen a 500% increase in Mental Health presentations to EDs waiting another 12 hours for admission or discharge since the start of the pandemic. This was getting higher. Mental Health Trust colleagues had received money for winter pressures. The Urgent Care Board had advised that advisory support for Mental Health professionals for EDs was needed. The new Mental Health Lead Nurse had the view that the police wrongly used EDs for individuals in crisis. Work would be done with the police to reduce the number of patients with only mental health conditions coming to EDs.

The Chair noted that the Board Level Metrics would be looked at in the light of the Fundamentals of Care.

The Board **noted** the report for assurance.

14. Receive the update from the **Finance, Investments and Performance Committee** held on 30th September 2022	**TB (10/22) 012**

RH presented the following key points on the Finance, Investments and Performance Committee meeting:

- The Month 5 report was significantly away from plan. The mitigating plans to adjust this with clear actions to be taken for Month 6 included a detailed refresh of the year-end forecast position, review of the RAG-rating of the delivery plan, a monthly trajectory showing impacts of the forecast and mitigations, and clarification around recurrent and non-recurrent mitigations.
- The Board needed to understand the impact on the future financial position of the MMUH affordability gap. The next meetings would focus on this in a more granular fashion.

The Chair noted that this would be discussed in more detail at the Private Board meeting.

The Board **noted** the report for assurance.

15. Maternity Improvement Plan	**TB (10/22) 013**

MR reported on three key areas:

1. There had been a visit from the regional insights midwifery team on 14th September to assess progress against Ockenden.
2. The Maternity Voices Partnership had undertaken a 15-steps audit to look at the service user's experience with accessing local maternity care.
3. MA and LW had become the new Executive and Non-Executive Maternity Safety Champions at a first meeting chaired by MR in September 2022.

HH highlighted the following points from the paper:

- Regional insight assurance – All 7 actions had been implemented and would be audited to ensure that they were embedded. Out of 22 organisations visited, the Trust was the first to have taken service users to a session, which had been positive. Real changes in the culture had been fed back from staff. These visits would move to the ICB and Local Maternity and Neonatal Systems (LMNS) as part of the Perinatal Surveillance Model to shift from transformation to quality oversight.
- Continuity of carer – A letter on continuity of carer had been received. This removed the target and all timeframes to achieve this as a default model of care. Recruitment and retention should be built on and plans should be developed to work locally, taking into account local population's needs, the workforce, and specialised models of care required to work to the Maternity Service's strengths.
- Choice of place of birth – This would support the 5-year System proposal to move to the choice of place of birth. All women of the Black Country and communities and staff would be surveyed to develop the right model of care.

DB suggested that a tipping point had been reached in Maternity. HH reported that it had been 2.5 years since they began to try to change culture following freedom to speak up feedback and to begin a CQC improvement plan. The staff's feedback to external reviewers about the improvements had been key.

DB queried the lessons learnt to be applied to other large changes. HH advised that the key was listening to colleagues and the people served and working with them to make the difference.

The Chair agreed that improvements had been demonstrated. The local and national focus on Maternity had shown the importance of visible, clear leadership. The most senior and middle-ranking staff were out explaining why they were doing what they were doing. It had been externally scrutinised to a larger extent.

The Chair queried the ICB supervisory responsibility. HH reported that the Perinatal Surveillance Model had come out at the end of 2021, with four principles. The first was the line of sight to Board and into the service. The oversight and assurance of this had moved to the ICB level. The LMNS had been developed to transform Maternity services following Better Births and was now assuring the System of the quality and safety of the services. The transformation journey had not finished. EDI work had been a key part of this.

The Chair suggested that LMNS was meant to encourage and develop, not to supervise. That was the Board's job. The LMNS was there to help the Board to ensure the quality of Maternity services.

MR agreed that the LMNS were aware that this was the Board's role. The work being done in Maternity had a huge input from both Executives and non-Executives to make this happen. There was still a lot more work to do to keep momentum up by reassessing and looking at what to do next.

JW suggested that what was done with Maternity was codified to be applied elsewhere and queried whether the staff survey results were better in Maternity. HH confirmed that they were not better. JW suggested that she spoke with DB offline about how to translate learnings into reportable staff experience.

RBe suggested that as well as pursuing a strategic partner on continuous quality improvement, more localised quality improvement work could be applied where it was most needed. Engaging the users of the service in this journey as the lever could be applied to areas like Ophthalmology and People services.

RBe queried whether MA and LW knew what their Maternity Safety Champion roles were. LW and MA advised that there were nationally prescribed job roles regarding assurance on the work being done. People needed to feel able to raise concerns, so MA planned to be available for personal discussions.

The Chair observed that Maternity Services had been given more visibility at Board level. Part of the Safety Champions' roles were to ensure the connection with the Board and to keep it on the agenda. The Chair thanked HH and her team for their good leadership and management, noting that it needed to continue.

The Chair requested that DB captured the positive approach taken by Maternity that could be applicable to other areas so that this could be built into general quality improvements.

LW reflected that the freedom to speak out was in evidence by staff who felt able to talk about what it was like to work in Maternity Services. The Maternity teams had mobilised quickly to listen to staff and to bring in external people to address culture and listening. The staff had valued that. Visibility was important and Non-Executive and Executive Directors needed to do more to be available for people to talk to.

The Board **noted** the report and recognised the work HH and her team were doing to improve things. The Chair observed that evidence-based Continuity of Carer needed to continue to support the vulnerable.

Action: DB to consider how to capture the positive approach taken by Maternity that could be applied to other areas to be built into general quality improvements.

16. Finance Report Month 5	**TB (10/22) 015**

SS raised three key points from the Finance Report Month 5 paper:

1. There was a £14.3m deficit at the end of August 2022. This was £8.8m adverse to plan. The key drivers were additional capacity and workforce to support the extra activity around emergency and income discussions with ICB partners. The key was the delivery of the £17.1m forecasted deficit. There was a recovery plan detailed in Appendix 9. This was driven through weekly and fortnightly meetings with Executive colleagues. Assurance for meeting the plan would continue to be reported back to the Finance, Investment and Performance Committee (FIPC).
2. Non-MMUH capital spending was behind plan. Reforecasts for all the schemes had led to assurance that the capital programme would deliver. Overcommitment last year had been a

lesson. A 5-year plan allowed schemes to be brought forward if there was any capital slippage with the ICB.

3. There was a healthy cash balance of £65m. Local providers and invoices were being paid quickly.

ML commented that Appendix 9 included uncertain and unpalatable recovery plans that were not all realistic. RBe advised that balance sheet flexibility expectations were being made of all Trusts in the host ICB. The provider collaborative and the ICB were beholden to have a financial planning and delivery process for next year that tackled underlying causes.

SS reported that the Elective Recovery Fund (ERF) had now been contractually signed off. A refreshed forecast at the end of Month 6 and focus on delivery of the actions with an understanding of the impact of the consequences of these decisions would be part of the detailed discussion at the next FIPC meeting.

LW queried the current cost pressure drivers and the level of confidence in getting the wanted results. LW suggested that unpalatable options also needed to be considered.

SS advised that if the actions in the plan were carried out, the £17m forecast would be delivered. Mitigating actions were required as part of the plan. There was agreement for the ERF and Maternity pathway changes. The discussions with ICB partners on insourcing and outsourcing were at the highest risk but letters had been sent out. The potential energy reduction had been in excess of what was in the recovery plan.

MR reported that Quality Impact Assessments would be done on the financial recovery plan and would be reported at Quality and Safety Committee.

DF reported that closing beds as the Trust was heading into winter was being looked at in the winter capacity for surge beds that could be handled differently to offset this risk. The vacancy control triangulation was based on the knowledge that the therapists would keep the pathways moving. There was a collective Executive approach to fixing this problem rather than a purely financial approach.

The Chair acknowledged all the pressures and the expectations to deliver the £17.2m deficit. The exit run rate needed to be right to provide assurance that problems would not be stored up for future.

The Board **noted** the report for assurance.

17. Autumn COVID Booster Vaccination Plan	**TB (10/22) 016**

The Chair queried the number of COVID patients in the Hospital. MR reported that there were about 67 patients. An increase had been seen that was just starting to decrease in the last 24 hours. MR confirmed for the Chair that only symptomatic patients were being tested. There had been a couple of outbreaks in the last two weeks.

MR reported the following key points from the paper:

- The Autumn COVID booster programme had begun on 5th September 2022 for all adults aged 50 and above. Those aged 5 to 49 like pregnant women, immunocompromised patients, carers for people who were unwell, care home residents and staff, and all front-line healthcare support workers were also eligible. Cohorts were being released one by one.
- Tipton Vaccination Centre could vaccinate 350 patients per day and were doing 2,000 per week. The target was 250 per day. 5 to 11-year-olds, 11 to 16-year-olds, and any staff or members of the public needing their first or second vaccination were also included in the programme.

- The staff vaccinations had been moved to occupational health, who had vaccinated 350 staff since last Tuesday 27th September 2022. The flu jab could be offered at the same time or separately. There was a local and national campaign for the flu jab.
- The programme would run until Christmas, when the programme would be re-evaluated.
- A November increase in flu and COVID was predicted. This programme was aimed to mitigate this.

VT queried the numbers in section 1 of the report as a percentage of the eligible population and the overall targets for the programme. MR reported that percentages for cohorts varied across the Black Country and the most challenged area was West Birmingham. The communications campaign was focused on going to ethnic minority and deprived areas across the System.

MR confirmed for the Chair that the same approaches were being used from the lessons previously learnt.

The Chair queried the targets for staff flu jabs. MR reported that the target was 75% of staff as a minimum.

The Board noted the **report** and the assurance it provided.

Our People

18. Our People Dashboard	TB (10/22) 017

FM highlighted the following points from the People dashboard metrics:

- The rolling 12-month sickness rate was 6.35% for July 2022. A detailed rectification plan had been presented with actions to create more realistic targets for Groups like Surgery that was tracking at 7.1%. The best performance in the System was the Dudley Group at 5%. Royal Wolverhampton Trust was at 6.1%. Walsall Trust was the highest at 7.4% and UHB was next at 6.8%.
- There had been recent assurance about improving the mental health psychological support.
- There had been a 0.7% deterioration in turnover since the same time last year. More people were choosing early retirement or were leaving for work life balance reasons.
- Deep dive activities would be focused on the five key areas that needed the most support.

The Chair noted that the Leadership Conference last week had focused on People. Almost 200 leaders had enjoyed a good day. FM reported that the feedback had been positive about it improving the staff experience. There was a series of engagement sessions planned by RW over the next 6 to 8 weeks. A Board development session would focus on how to role model values of respect and compassion.

RBe reported excellent feedback from the Conference. The Trust's values and behaviours framework should be used to recruit and appraise people and to hold people to account when necessary. Staff needed to believe that the Board and leadership would support them in living these values.

LW agreed that it was a tremendous day. The staff had the answers to a lot of the hardest problems.

The Chair agreed and thanked RW and FM and everyone who organised such a positive day.

The Board **noted** the dashboard report for assurance.

19. Receive the update from the **People and Operational Development Committee** held on 28th September 2022	**TB (10/22) 018**

LW presented the following from the People and Operational Development Committee (POD) meeting:

- Partial assurance ratings were due to a lot of interesting new work that required follow up.
- The cultural heatmap work was focusing on workforce challenges. More work was planned.
- Sickness was the biggest challenge for POD. Each of the Groups had different challenges. The Trust needed to take on a recovery-based approach with support for staff.
- The Occupational Health Lead's work was hoped to shift sickness absence. A couple of the Executives would work with him. Another report would be received at the end of the year.
- A lengthy discussion about appraisals and mandatory training would result on a new style of appraisal leading to a good experience. An update was planned in November 2022.
- An update on recruitment stabilisation showed small improvements on time to hire at 91 days, with a target of 67 days, to be monitored by HR, Finance, and Operations, with a monthly report.
- MMUH recruitment would begin with Remedium's commencement last week. Several MMUH Operational Development team appointments had been made and reports would follow.

The Chair queried assurance on detailed plans being in place to improve sickness absence. LW reported that each of the Groups had different a plan to tackle this. Some Groups would be unable to realistically improve their rates to the Trust's target. New methodologies from Occupational Health may help.

FM reported that active engagement from the Groups had led to the plans that HR had oversight on. The Groups had felt further away from sickness absence management and a realignment was needed.

RBe queried the POD discussion on the influence of Occupational Health, whose reputation was growing across the System. FM reported that they had been approached several times to act as lead provider for the System and they had led the way on the wellbeing programme response to the national People Plan.

LW reported that there were quick wins by creating a better website and maximising use of that team.

DF suggested that the focus should be on improving staff health and wellbeing, which would result in lower sickness. Bigger blocks of work to deliver more from Occupational Health needed to be coordinated.

JW suggested a dual approach of managing sickness absence alongside the health and wellbeing offering.

The Board **noted** the Chair's report for assurance.

For information	
20. Board Level Metrics and IQPR exceptions	**TB (10/22) 019**
The report was **noted.**	
21. Any Other Business	**Verbal**
There being no other business, the Chair thanked everyone and closed the meeting.	
Details of next meeting of the Public Trust Board: **2nd November 2022 at 9:30am.**	

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

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

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