TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting held via MS Teams. **Date:** Wednesday 7th September 2022, 09:30-13:00

Members:		**In attendance:**	
Sir D Nicholson (Chair)	(DN)	Mrs R Wilkin, Director of Communication	(RW)
Mrs L Writtle Non-Executive Director	(LW)	Mr D Conway, Assoc. Director of Corporate Governance/Company Secretary	(DCo)
Mrs R Hardy, Non-Executive Director	(RH)	Mr D Fradgley, Interim Director of Integration	(DF)
Ms V Taylor, Assoc. Non-Executive Director	(VT)	Ms H Hurst Director of Midwifery	(HH)
Mrs J Wass, Assoc. Non-Executive Director	(JW)	Mr D Baker, Chief Strategy Officer	(DB)
Dr M Hallissey, Assoc. Non-Executive Director	(MH)		
Mr R Beeken, Chief Executive	(RBe)		
Ms F Mahmood, Chief People Officer	(FM)	**Apologies:**	
Mr M Laverty, Non-Executive Director	(ML)	Cllr W Zaffar, Non-Executive Director	(WZ)

Minutes	**Reference**
1. Welcome, Apologies and Declarations of Interest	**Verbal**

Chair DN welcomed Board Members to the meeting - particularly NW and JE. He also welcomed Dr Mark Anderson, the Trust's new Chief Medical Officer.

Apologies: Apologies were received from Cllr W Zaffar.

There were no declarations of interest from Board members in relation to the agenda.

2. Staff/Patient Story	**Verbal**

MR advised that the story this month was focused on the work the Trust had been doing with respect to hydration, which had been led by Natalie Whitton (NW) (Matron/Lead for Nutrition and Hydration) with Jamie Emery (JE) (Patient Involvement and Insight Lead) in support. MR highlighted that the issue was very important to the recovery of patients.

NW shared a slide presentation, with the following key points to note:

- Patients can often become quickly malnourished whilst in hospital, which can be detrimental to health.
- Work to evaluate risks in relation to nutrition and hydration had commenced in 2021. In relation to several measures, the Trust was found to be falling significantly behind in care and it was necessary to improve performance for the benefit of patients.
- One major task focused on dentistry (i.e. how it could be incorporated into Unity) and how patient mouth care could be supported to enable easier eating and drinking whilst they were in hospital.

- Mealtime observation, in terms of how meals were being delivered to patients, was being conducted in several ward areas.
- Height and weight measuring equipment on wards was also reviewed, as these factors impacted nutrition and hydration.
- Monitoring methods of fluid intake were also being investigated.
- The Trust had been working with its patients and population groups to incorporate nutrition and hydration.
- JE reported that a food tasting session had been organised with the Oral Nutrition and Hydration Group (a diverse membership drawn from patients' groups) which would continue to inform decisions. A video interview with one of the individuals – a blind, male patient who was a member of the Group - was shared with the Board.
- NW commented that the approach and responsibility for ensuring good nutrition and hydration was multi-disciplinary.

Comments and questions:

MA queried whether every patient ought to have a 'MUST' (malnutrition) assessment score when they arrived at the hospital.

DF stated that through the Place-based Partnership, there were some evolving links with dentists who operated on the NHSE contract and offered to assist open doors in further conversations. This suggestion was welcomed by NW.

RBe commented that it was pleasing to see patient involvement rather than engagement. He also stated that patient flow would be the area that would have the greatest impact this year in relation to achieving the Trust's strategic objectives.

NW commented that in ED there was no current nutrition and hydration assessment of patients when they arrived in the department and further work on how this could be safely incorporated into the ED needed to be done. Discussions with the catering team and volunteers had taken place to plan an improved response.

LW queried whether there were any 'quick wins' available, highlighting the measuring equipment issue previously mentioned. NW advised there had been an audit of equipment and confirmation was awaited about what was needed and in addition, enquiries had been made about what provision would be available at MMUH.

JE also raised the issue of access to healthy food, stating that a few patients had given feedback about the appropriateness of traditional 'snack-style' vending machine goods in a hospital. He suggested that food interventions could be made in waiting areas.

The Chair commended NW and JE for their work in this area and thanked them for their presentation.

3. Minutes of the previous meeting, action log and attendance	**TB (09/22) 001** **TB (09/22) 002** **TB (09/22) 003**

The minutes of the previous meeting held on 6 July 2022 were reviewed and **accepted** as a true and accurate record of the meeting.

The action log was reviewed. It was noted that some actions related to items to be discussed on the agenda, whilst others had been completed.

Updates on others in progress would be followed up by JN and would be reported at the next Board meeting.

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

The Chair commented that there was a new PM and a new Secretary of State for Health. Whilst there was an environment of change, he stressed that the Trust (Board and organisation) would need to continue its focus on improvements.

He commented that this year would be critical for the organisation in terms of tackling the operational challenges. Work in 2022 would determine whether MMUH would successfully open as planned in 2023.

5. Chief Executive's Report	**TB (09/22) 004**

Reports

RBe presented his report which he commented was made up of two papers. The first was a report which would be going to every Trust Board in the Black Country Provider Collaborative (SWBH, the Dudley Group, Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust).

This paper set out the consensus opinion on strengthening collaboration between the four organisations and confirmed that the Board Chair of SWBH would also be Chair at the Dudley Group. It also set out the ambition for a single Chair for all four organisations in the medium term.

Currently, there was no proposed change to Board or organisational sovereignty, but if this did come, then it would be accompanied by a detailed plan for change.

The provider collaborative focused on exception reporting and driving forward the work of the first nine clinical specialties. The second strand of work was the development of the case for change.

The second report was a formal list of the final, rationalised Board Level Metrics. It was noted that patient flow and leadership development had been a focus because they would have the biggest impact on strategic objectives. Patient flow affected staff and patient experience and patient safety.

The Board was being asked to sign off on the list and comment on the Black Country Collaborative statement.

ML queried if something similar was happening in Birmingham. RBe commented that the process in Birmingham was far less mature than the Black Country's but was following a similar direction.

DN noted that the Trust's priority was to ensure that any plans did not destabilise the progress of MMUH.

Board Level Metrics

JW raised the importance of inclusion of EDI and visibility of the Board to the issue. RBe commented there was visibility through the sub-committees and sub-metrics. FM reported that the People & OD Committee (POD) metrics were also tracking disparity concerns. In addition, there would be a Board development session on EDI in November 2022.

RH queried how leadership development would be embedded. RBe stated that work was ongoing to make patient flow one of the Fundamentals of Care this year. Winter resilience was also focused on patient flow.

MH expressed anxiety that sepsis treatment within an hour had been dropped as a metric because it was the only metric that informed the Trust about the quality of the process of care being delivered. MR

commented that performance in relation to sepsis would be measured/included in the sub-board metrics under Harm-Free Care utilising a dashboard.

DB commented that it was the Trust's intent to chart patient flow. The Improvement team would start work on creating this shortly.

ML suggested that looking at the vacancy rate would be better than looking at turnover in terms of people. RBe agreed this could be reported back through POD.

The paper was **noted** and the Board **agreed** support for next steps.

Areas for improvement with respect to the Board Level Metrics were identified as follows:

- EDI
- Sepsis
- Vacancy rates

DN stated that these could be refined by the sub-Committees.

DN requested that RBe explain how leadership and flow worked together at a future meeting.

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

None.

Governance, Risk & Regulatory

7. Board Assurance Framework (BAF) Report	**TB (09/22) 005**

KD reminded the Board that the BAF framework collated all the risks to the Trust's strategic objectives and was also a key tool for the Board to utilise when it sought assurance or reassurance.

The BAF had featured on the Board sub-committee agendas since it was approved in April 2022, but KD suggested there was more to do in terms of discussions about the Trust's risk appetite and agreeing on what might be sufficient with respect to controls and whether they were operating effectively.

She referred board members to the paper which highlighted the five top risks. A meeting would be taking place shortly to discuss the quality risk. The BAF would be re-presented in November 2022 for the Board to assess progress that had been made since April.

LW requested that some work be facilitated with the Committee Chairs about how to work with the BAF as some of the challenges were not being reflected in the framework. KD agreed and the point was supported by the Chair who commented that how to use the BAF to best effect was important.

The Board **noted** the report.

Action: KD to facilitate sessions for Board Committee Chairs on how to work with the BAF.

8. CQC Report	**TB (09/22) 006**

KD stated that the CQC report had been brought to the Board after having being considered by the Q&S Committee where it had deemed to offer a reasonable level of assurance.

It was expected that 2023 would be tested against the 'I' and 'We' statements stated in the paper, the definition of which KD further explained to the Board.

There were 43 'We' statements that the Trust would focus on. It was suggested that Board development time be utilised to consider the new model more fully. The experiences of some early adopters would be considered. It appeared that the ratings would be less dependent on things such as site visits and more reliant on the CQC's assessment of the Trust's evidence submission.

KD reported that the paper outlined eight workstreams intended to prepare the organisation, partners and others for the process. These workstreams – particularly in relation to data and weAssure – would help to build a self-assessment of the Trust's own view of compliance.

It was expected that the Trust would have a view of its position by the end of January 2023.

KD expressed the view that experience had shown that staff opinion tended to dominate the ratings and therefore, delivery of the People Plan (due to launch in November 2022 following sign off by the Board) would be critical.

Emergency Care and Adult Medical wards had been the Trust's stumbling block so far and were the areas which had attracted the most recommendations. Driving the Fundamentals of Care would be key to improving the ratings.

The balance of oversight between the Q&S Committee and the whole Board would be important in terms of capturing a range of perspectives. Q&S had set a three-monthly oversight schedule. KD suggested that the Board also regularly assess data.

JW commented that there were several initiatives running and a strategic narrative should be a priority to clarify purpose.

DN suggested that how the different initiatives fitted together would be important and agreed that an overarching narrative was required.

Our Patients	
9. Our Patients: Dashboard	**TB (09/22) 007**
The Chair referred the Board to the dashboard. MR reported the positive news that the Trust only had four Band 5 vacancies across the Trust in D21 and there was a plan to fill those gaps over the next few months. The Chair agreed this progress was very pleasing. The report was **noted.**	
10. Receive the update from the **Quality and Safety Committee** held on 27th July & 31st August 2022	**TB (09/22) 008**
MH reported that at the July Committee meeting, a number of processes had been reviewed around the nurses' Q&S approach towards Fundamentals of Care and had been reasonably assured. A patient experience update had been presented as part of a complex piece of patient engagement work, which was gelt to be moving in a positive direction. COVID was still being monitored and 'flu levels were also being monitored. The monthly mortality rate continued to improve but some areas required further work including in relation to unexpectedly higher levels of mortality in some areas. Some work was being done to address this issue.	

The impact of recording and coding had been discussed. Whilst some work was still to be done in relation to changing the process, the Committee decided it had partial assurance.

The impact of intelligent conveyancing on length of stay was discussed and the maternity dashboard continued to show reasonably good levels of care, although there were concerns around the levels of medical staffing.

RBe expressed the view that the Trust's narrative around intelligent conveyancing was overdone as a driver. He confirmed that money from Birmingham was being pursued. DMc reported that a helpful meeting had been held with the CFO in the BSOL system and the trust would be putting together a case for submission to BSOL.

The Board **noted** the report.

11. Receive the update from the **Finance, Investments and Performance Committee** held on 29th July & 2nd September 2021	**TB (09/22) 009**

RH highlighted the financial forecast position as an organisation which had some significant issues to recalibrate.

The Committee suggested that an urgent discussion take place on the way forward overall.

The Committee decided there was only partial assurance in relation to MMUH which still did not have a plan to close the affordability gap.

He Board **noted** the report.

12. Receive the update from the **Charitable Funds Committee** held on 3rd August 2022	**TB (09/22) 010**

RW reported that there was partial assurance on the MMUH campaign, mainly due to the previous uncertainty of the opening date.

The Charity's audit was currently taking place and would come back to the Board for sign-off with the completed accounts.

The A&RM Committee would be considering later in September the latest risk assessment over the Charity becoming an independent entity.

The Board **noted** the report.

13. Fundamentals of Care Report	**TB (09/22) 011**

MR reported that a framework had been developed with respect to the Fundamentals of Care. She stated that it was focused on the Trust delivering inter-disciplinary, consistent standards of care which would help the Trust emerge from the COVID-19 experience.

The simple framework had seven standards (including Nutrition and Hydration) and six components/workstreams – three sitting in the People Plan and three others relating to Patients (Q&S and patient experience).

MR reported that the framework had been pulled together with engagement and involvement from patients, staff and partners. It would enable clinical groups and corporate services deliver high quality care and meet the Trust's patient strategy.

Harm-free care and good, effective communications at every level were at the heart of the framework. MR stated that it had been based on both international evidence and also local evidence and need.

The framework was a work in progress and engagement sessions were continuing. The launch of the framework had been set for 22nd September 2022 and would include sessions on CQI which was the driver for Fundamentals of Care. Unity would be an enabler from a documentation and patient perspective.

MR referred board members to the slide pack in the paper. She re-iterated that the Trust had committed to producing a set of metrics at sub-board level that would reflect this work.

A further aim was to amplify the staff voice in relation to strategy and to develop a structured programme to support an inter-disciplinary approach to ways of working.

MA acknowledged that it was a multi-disciplinary and not just a nursing project.

ML queried why six workstreams were required outside of the seven fundamentals. MR reported that the workstreams would support the frontline actions in relation to the standards of care.

JW raised the issue of EDI and the importance of raising awareness of the benefits of having a diverse workforce to connect with the population. She also raised the importance of research and making the evidence base for the strategy to be more visible to staff.

DF commented that this work was aligned with work being done with the Place partners to raise awareness that the fundamentals of care extended beyond the hospital and into the community, care in the home and adult social care.

RBe commended the work which had involved more than 1,000 people. He expressed the view that the branding was right and resonated well with staff and patients. It was noted that whilst the Trust had a strong track record in caring, the work showed an ambition to reach the next level.

The Board **agreed** the frameworks.

14. Winter Planning	**TB (09/22) 012**

The paper was taken as read. JN highlighted that the Plan had been very closely aligned to the Place objectives. The areas of focus would be as follows:

- Reduction of admissions
- Reduction in length-of-stay
- To maintain elective services as far as possible

JN reported there was now a lot of evidence that the Trust's patients were deteriorating because of long waits for elective care.

JN further stated that everything in the Plan was sustainable and either funded through the investment into the ICM model for MMUH, or through the Place Initiatives (external).

JN stated that the peak of need in terms of bed demand would occur in the January/February period, however in terms of preparation, extra beds would not be put into the system, instead, the focus would be on the patient flow improvement plan.

RBe commented that at a system level, all four Places in the Black Country were being asked to pull together a Place Winter Plan, incorporating Primary Care, Social Care, Community Services and Acute Services. He expressed confidence that SWBH could produce a coherent plan for scrutiny by the Urgent

Care Board (UCB). He assured Board members therefore, there would be a further level of assurance at system level there was a system response to Winter.

VT queried the impact of the cost-of-living crisis. It was recognised that staff and the Trust's population would be impacted. JN reported that FM and DMc were conducting a piece of work with respect to staff welfare. Key patient conditions i.e. respiratory and frailty were also being considered.

DF added there was a cost-of-living consideration in relation to domiciliary care which was being looked at.

MH queried how much resource had been allowed to respond to 'flu. JN responded that the Trust was conducting daily 'flu monitoring, but numbers were currently flat. She commented that the Trust had not made any plans to create extra inpatient capacity for 'flu and stressed that the focus would be on treating them in the home environment.

MH further queried the chances that the Trust could fill essential vacant posts in the timescale available. JN reported that some of the posts were already being advertised, whilst others were earlier in the recruitment stage, however, JN commented that these were community-based roles which had not historically proven difficult to fill.

DF commented that a system that had been purchased for the Black Country to make sure that virtual ward was inter-operable across all four Places. It was still being tested and there were other options available.

DN suggested that risk modelling would be required to ensure some of the issues that had emerged could be handled. JN stated that the plan would be further nuanced and evaluated in terms of its effectiveness. A report would go the Finance and Investment Committee.

The Board **approved** the plan, subject to the risk assessment being carried out.

15. Maternity Improvement Plan	**TB (09/22) 013**

DN referred Board members to the report which was taken as read.

RBe queried progress against the Ockenden Report actions. HH responded that in terms of the 'red' risks, there had been movement against one. Not rotating qualified midwives into the community had been mitigated. The proposal was to bring the report back to Board quarterly for review.

She reported that the LMNS and ICB would be giving support and assurance in the form of a new Q&S framework.

The Board **approved** the report.

16. Ambulance Handover Performance Report	**TB (09/22) 014**

JN reported that whilst the board was still required to review ambulance handover performance and it was a key safety metric. The Trust's performance had been variable, however.

She reported that the key issue that needed to be addressed to improve performance was patient flow out of the ED. A raft of work was being conducted looking at the safety of patients who were being held on ambulances.

Going forward the performance report would be coupled with the patient flow improvement plan. In July 2022, the Trust's 30-minute position deteriorated but there were fewer over the hour delays which was a positive because this was a key metric.

JW queried the experience of mental health patients waiting on trolleys and suggested that the board look deeper into the issue. JN reported that several pieces of work were in train addressing this issue.

RBe reported there had been a 500% increase in mental health, 12-hour waits in the Black Country since February 2020.

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

17. Finance Report: Month 4	**TB (09/22) 015**

DMc reminded the Board that the Trust had set an internal planned deficit of £17.2m for the financial year, which had translated at Month 4 to a planned deficit of £4.73m. However, the deficit was in fact around £10m (£5.6m adverse to the YTD plan).

The main driver of the variance had been the setting of assumptions relating to outsourcing of activity to the independent sector. The Trust had assumed funding would be received for this which had not yet materialised, excess energy costs above the plan and some issues recovering issues on high-cost drugs and excess capacity.

DMc reported that some of the costs had been offset by underspends with respect to vacancies in Primary Care, Community and Therapies (PCCT).

The focus for the Trust from an income and expenditure perspective was how to recover the position to be closer to the plan.

In terms of capital and cash, the trust had deliberately over committed against the capital funding available and despite relatively low levels of expenditure, the Trust was continuing to receive assurance on delivery of those plans. The plan had included some MMUH equipment which now needed to move into the 2023/24 plans in line with the revised opening date. This would be replaced with some capital expenditure in relation to same day emergency care later in the year.

The cash balance had held up well at £55m at Month 4. DM mentioned the significant CIP under delivery.

The Board noted the **report** and accepted that it would consider the implication of the position at a future date.

18. Mobile Coverage Business Case	**TB (09/22) 016**

MS referred Board members to the business case in the paper and reminded them that the potential solution to MMUH's connectivity challenge was a Distributed Antennae Service (DAS).

He stated that the solution would allow virtually everyone to access a mobile phone signal. Installation would involve a capital expenditure and a seven-year lease would be put in place equating to a spend of £1.7m (over 7 years).

Regional and national had been approached for the capital funding element of the expenditure. The worse-case scenario would involve the Trust having to find £190,000 per year to service the lease.

MH queried why the wi-fi option had been dismissed. MS explained that wi-fi calling required everyone to actively attach their phone to the signal (staff, patients, visitors) which was unreliable, awkward and delivered a poor user experience.

ML (Chair of the MMUH Opening Committee) reported that the Committee was supportive of the expenditure on the service. DMc stated that the financial implications of the business case would be built

into future plans. She acknowledged that it was money that the Trust did not have currently but commented that relatively speaking, it was not such a significant amount that could not be included into plans.

RBe stated that the Trust was trying to secure external funding.

The Board **approved** the plan by the board.

Our Population

16. Our Population/MMUH Dashboard	**TB (09/22) 014**

DF reported that Board Level Metrics were being aligned. He highlighted the following:

- Operational interventions which would impact the Metrics
- Targets for occupied bed days

Positive movement had been observed on the interventions made so far, e.g. length of stay metrics and discharge to assess had all been moving in the right direction.

RBe observed that the Trust's admission avoidance activity by community teams seemed to be deteriorating and older people's occupied bed days seemed to be increasing. DF commented that it would take around 12 months to shift the big targets such as these because it involved long-term condition management by community teams.

In response to a query from JW, DF stated that the first phase to address these issues was in hand and pointed to the community right sizing work which had commenced. The more targeted work (long term condition management) would take longer and would require careful monitoring.

JN reported that a critical path had been identified along with a governance process had been introduced into the oversight Committees of MMUH.

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

17. Receive the update from the **Integration Committee** held on 27th July & 31st August 2022	**TB (09/22) 015**

DF reported that the assurance levels were generally good however, there were continued concerns about Ladywood and Perry Barr.

DF flagged that the GPs were becoming disengaged in the area following transition to the new system and attendance to the locality Partnership had waned. Discussions were currently ongoing between Birmingham ICB and Birmingham Community Healthcare about the sustainability of the leadership in that locality.

A plan had been activated to stabilise the situation, taking an alliance approach with strengthen relationships with Primary Care.

RBe expressed the view there was still an opportunity to influence the Birmingham and Solihull (BSOL) system's operating model and further reports on progress would be made to the Board.

18. Place Based Partnership Report	**TB (09/22) 016**

DF observed that many of the points made in the report had been discussed as part of the Winter Plan or other areas. He reminded the Board that the focus was as follows:

- Attendance
- Admission avoidance
- Length of stay reduction

DF reported that engagement in Sandwell had been substantial and movement and collective decision-making had been progressing and also some consideration of joint leadership roles. The Trust and the Committee had been working on a Primary Care Plan with some significant progress with YHP in Sandwell and there was an opportunity to achieve the same in West Birmingham.

DF stated that approval was sought from the Board for the Primary Care Delivery Plan.

LW commented that there was not a lot of Primary Care experience represented at Committee level when this could bring a new dimension to discussions. DF reported that this issue had been recognised and was being addressed.

The report was **noted** for assurance.

Our People	
21. Our People: Dashboard	**Verbal**

The report was taken as read.

RH expressed the view that greater links ought to be made with some of the issues around people such as sickness absence for example, and the dashboard. DN accepted the point made.

FM reported there would be a major item on sickness improvement which would be discussed by the POD Committee in October 2022.

The report was **noted** for assurance

22. Receive the update from the **People and Operational Development (POD) Committee** held on 27th July & 31st August 2022	**TB (09/22) 020**

LW update the Board as follows:

<u>July</u>

The POD Committee had received two significant business cases for approval prior to decision by MMUH Opening Committee. The first was focused on the challenge of recruitment and a second was centred on managing OD and the management of change.

LW expressed the view that there was a significant risk around the Trust's ability to recruit. The recruitment case had been supported by the Committee, but it had been highlighted that the recruitment team was under pressure and had been working with the HR team to establish a stabilisation and improvement plan.

LW assured the Board that POD had been looking at CQC-related issues including ensuring compliance around policies linked to HR, many of which were either missing or out of date.

<u>August</u>

LW reported there had been a presentation focused on the race code had been delivered by Karl George who would be working with the Board on the same subject in November 2022.

Three further reports on the gender pay gap, WRES and WDES which were statistically interesting but required more analysis and would return to the Committee for further discussion.

A draft of the final EDI plan was expected in September 2022, which would be presented later to Board.

LW reported that the Committee's Terms of Reference had been amended to include the Deputy Director of Finance to ensure performance was being monitored against MMUH recruitment and workforce issues.

In response to a query from DN with respect to a possible resolution to the recruitment challenge, LW reported that a recommendation to partner with external agency Remedium for a nine-month period had gone to the MMUH Opening Committee. This outsourcing would target staff for MMUH.

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

23. CQI Mandate Report	**TB (04/22) 021**

DB reported that getting ready to implement CQI was one of the priorities of the Strategy Report ahead of the opening of MMUH. A four-stage gateway programme had been established as a result.

An exercise had been run with the Board, Clinical Groups and senior Corporate Services people. The Report had been twice presented to the CLE and had been approved.

DB highlighted that the Board would need to change as well as the frontline. The only costs involved currently were those associated with travel and no major cash investment was required.

Discussions had taken place with Dudley and DB reported that its Head of Improvement would probably be invited onto the Steering Group. However DB stated this did not necessarily mean that the methodology would be aligned with that of Dudley's.

DB stated that approval from the Board would be a trigger for work to start on the next gateway.

DMc commented that the Trust needed to work on the economic case to be assured on the value for money.

The Board **approved** the CQI Mandate Report.

For information only	
26. Board Level Metrics and IQPR exceptions	**TB (09/22) 024**

The report was **noted.**

27. Any Other Business	**Verbal**

None discussed.

Details of next meeting of the Public Trust Board: **Wednesday 5th October 2022.**

Close