

## TRUST BOARD – PUBLIC SESSION MINUTES

**Venue:** Meeting held via MS Teams

**Date:** Wednesday, 11<sup>th</sup> January 2023, 10:00 – 13:30

### 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, Chief Operating Officer (JN)  
Ms D McLannahan, Chief Finance Officer (DM)  
Prof L Harper, Non-Executive Director (LH)

### Staff/Patient Story Presenters:

Ms S Clarke (SC)  
Ms C Finnemore (CF)

### Apologies:

Mrs J Wass, Assoc. Non-Executive Director (JW)  
Dr M Hallissey, Assoc. Non-Executive Director (MH)

### Non-Voting Members:

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

### In Attendance:

Ms H Hurst, Director of Midwifery (HH)  
Mrs R Wilkin, Executive Director of Communications (RW)  
Mr M Sadler, Executive Director of IT & Digital (MS)  
Mr D Conway, Assoc. Director of Corporate Governance/Company Secretary (DCo)  
Ms C Agwu, Deputy Chief Medical Officer (CA)  
Mr T Parkes, Express and Star Reporter (TP)

Minutes	Reference
<b>1. Welcome, Apologies and Declarations of Interest</b>	<b>TB (01/23) 001</b>
<p>The Chair opened the meeting at 10:00am and welcomed Board members and attendees to the meeting, particularly Sarah Clarke and Claire Finnemore, who would be presenting on patients and staff, and Lorraine Harper, who would be providing research insights to the Board.</p> <p>Apologies had been received from Mike Hallissey and Jo Wass.</p> <p>The Chair declared that his wife, Sarah-Jane Marsh, had changed roles from Chief Executive of Birmingham Women's and Children's Hospital to National Director of Urgent and Emergency Care.</p>	
<b>2. Staff/Patient/Service Story</b>	<b>Verbal</b>
<p>The Chair emphasised the importance of the Staff/Patient Story to provide insights for the Board into the realities of the staff's and patients' experiences.</p> <p>MR introduced SC and CF, who would be presenting the stroke journey following a staff 'away day' to start an improvement journey from a review of stroke service issues reported by patients and staff.</p> <p>CF reported on the review of their stroke service care provision following complaints and incidents. Issues included ineffective communication, lack of opportunity to practice rehab skills outside of</p>	

therapy sessions, a high number of falls, and inconsistent documentation of essential care. The stroke away day led to actions to focus on achieving stroke care together as a multidisciplinary team (MDT) based around Fundamentals of Care and a 24-hour approach to rehabilitation.

Communication was improved by introducing therapy early starts, changing the time and focus of safety huddles, engaging patients in two workshops, and keeping the MDT informed to allow them to provide feedback on patients' progress to relatives. Information to patients was improved by co-designing packs with patient representatives. The Meal Time Matters initiative reviewed meal times and increased choice.

The vision was to focus on altering their approach to the daily routine through the MDT to maximise patient safety, integrate Fundamentals of Care, improve opportunity for skill practice throughout the day, improve efficiency through joint working, and make every contact meaningful for rehabilitation.

A 55-year-old lady was chosen to demonstrate how this was working. The MDT team worked together to achieve goals that included making sure what mattered to the patients, using HCAs with therapists to facilitate washing and dressing and to transfer practice at mealtimes, Psychology with SLT to address anxiety, Physiotherapy, OT, patient, and family working together on discharge planning, and Physiotherapy and Orthotics working together with the patient to maximise function.

The learnings had been about getting the Fundamentals of Care right for each patient through care and assessment co-production and co-design with the patient and the MDT, improving compassionate care, team morale, joint learning to allow change to happen at the right time, and reduced risk to patients through wider team thinking. Use of the third sector and communication with and about the people and services available was key in preventing patients from feeling abandoned once their treatment journey had ended with the Trust.

The future would include looking at the following:

- Integrated care/therapy assistant roles would facilitate 24-hour rehab.
- Get up, get dressed, get moving would reduce length of stay and avoidable falls.
- Continued development of the integrated approach would ensure consistency of care.
- Ongoing review of the patient journey and MDT members would ensure appropriate changes.
- A patient carer expert panel for stroke services had been started.
- Research would allow patients to access new treatments. Learnings would be shared.

**Comments and questions:**

RBe stated that he liked this story because it was about the Fundamentals of Care, self-acknowledgement about providing better care, and quality improvement. RBe queried the role of quality improvement going forward. SC reported that they used the Plan, Do, Study, Act (PDSA) method. They were improving communication by increasing audits to provide data weekly instead of monthly. Some of the HCAs had asked to do a questionnaire and had been empowered to do so.

MR advised that Midland Metropolitan University Hospital (MMUH) and the stroke pathway was part of their future and the '12 transformations' work. MR queried how the work they were doing would contribute to MMUH. CF reported that creating practices to transfer to MMUH had been the focus

during the away day. Communications had been focused across the entire pathway. Staff engagement and ownership of the pathway would ensure that changes would work.

WZ provided feedback on two stroke cases over Christmas. One was a relative who spoke no English and had a hearing impairment, whose next of kin had been complimentary about the communications regarding his health journey. A community activist had also been highly complimentary about the services and communications throughout his journey. This showed that the changes were working.

MA congratulated the stroke service team on their approach towards turning complaints into a positive story. The Mealtime Matters and importance of observing mealtime behaviour was something that could be shared with other wards. The integration of MDT working was an excellent approach. Therapists completing their documentation in the bay instead of in their offices would improve understanding of patients through observation and the ability for patients to ask more questions. CF confirmed that this change could be applied to every member of the MDT but currently only nurses and therapists were completing their documentation in the bay, not medics.

DF offered to discuss offline help in the domiciliary care area through working with the Local Authority to speed up the work. The journey with rehab and Primary Care, Community and Therapies would also help.

The Chair thanked for CF and SC for the work they did and for providing an inspiring example of empowerment through this improvement story. Everyone should learn from what was not going well.

**3. Minutes of the previous meeting, action log and attendance register**

**TB (01/23) 002**

The Board reviewed the minutes from 2<sup>nd</sup> November 2022. An amendment to item 4 was noted by MR, where Austin Pride should be spelt Aston Pride Community Health Centre.

The Board **accepted** the minutes of the 2<sup>nd</sup> November 2022 meeting as a true and accurate record of the meeting, subject to this amendment.

**4. Chair's opening comments**

**Verbal**

The Chair commented on the People Plan being at the heart of the agenda because getting this part of their responsibilities right would help to unlock the rest.

The Chair extended his thanks on behalf of the Board to the staff for their heroic work over the last few months and to the Executive team for dealing with all the pressures and improvements towards the opening of MMUH. The Trust had worked with the Ambulance Services to put into place mitigating circumstances to minimise the direct effect of industrial action on patients. The Chair wished the Government and Staff Side the power they needed to solve the disputes.

Discharge was at the heart of many of the front door NHS issues. Sandwell was creating a Same Day Emergency Care unit. All support and help were appreciated.

**5. Chief Executive's Report**

**TB (01/23) 003**

RBe highlighted the following main topics from his report:

1. NHS England's Planning Guidance

- NHS England had published their annual Planning Guidance before Christmas. The key elements were in the paper, including an emphasis on recovery of services and productivity. The Trust's Finance Strategy would have an emphasis on productivity and ambitious, yet realistic cost-improvement challenges focused through this lens.
- There was an expectation for the emergency access standard to recover to a minimum of 76%. The Trust had done relatively well on this but had now slipped to an average of 73% performance. The Board was assured that the patient journey was being prioritised as one of the three breakthrough areas being planned to have an impact.
- The Trust was on track to meet the 78-week wait expectations, with the exception of ENT, to deliver by the end of March. The Black Country System had some challenges in the 78-week wait area.
- The Trust's production plan for elective care would be scrutinised by the Board over the coming months and would be critical to the productivity targets in the planning guidance and the elective recovery.

2. Care Quality Commission's (CQC's) Inspection

- The Trust hosted Your Health Partnership (YHP) GP and Primary Care services. The CQC's inspection of YHP in October 2022 had resulted in a 'requires improvement' rating.
- Actions were being taken to address the immediate CQC requirements, which included better infection control practices and proper safety net procedures for patients on long-term medication or treatment.

**Comments and questions:**

ML challenged that the Trust did not appear to be taking the movement from 'requires improvement' to 'good' seriously.

RBe acknowledged that the Trust Board was accountable for every service in the organisation and it did not find this acceptable. The Trust had a comprehensive, evidence-backed self-assessment process regarding the new CQC domains and questions that would be coming through the Quality Committee to the Board over the next six weeks. They needed to assure themselves that the Fundamentals of Care framework and emerging evidence coming through this work would be sufficient to move the Trust to 'good' or 'outstanding' over the course of time.

MR assured ML that the Fundamentals of Care work launched in the last four months was ongoing and needed to be embedded, as demonstrated in the Patient Story. The self-assessment work was directly related to Fundamentals of Care standards. This would help to ensure that changes became 'business as usual' instead of only for the CQC. The evidence vault was building up to prove the changes being made to get the care right for each patient. Everyone was passionate about working through the Fundamentals of Care plan.

DF reported that the model for Primary Care was known to be working and 'good' was their target. Their Heath Street Health Centre had achieved 'good' in the last 12 months. When the Trust took

over Your Health Partnership, they had been at 'requires improvement' and the progress they had intended to make had not yet been made due to COVID. The inspection had been six months too early.

The Chair agreed with ML's point and emphasised that the Board's strategic objectives were to ensure that changes were made. The visibility in advance had not been high on this inspection. The Fundamentals of Care work would make the CQC requirements part of business as usual, which should lead to improvements. As the Board potentially increased its connections with Primary Care, this needed to become more important on their radar.

### 3. Black Country Provider Collaborative update

- A prioritisation session was planned with the four component Trusts in February 2023. The work of the Provider Collaborative had been focused on nine clinical services and pathway changes in the adoption of best practice standardisation of care, particularly through the lens of cancer services or high-volume, low-cost procedures. Attention needed to be focused on services with workforce challenges, critical mass concerns, ongoing clinical safety concerns, or services that contributed towards Board Assurance Framework risks that were consistent across all four organisations. This session should influence the annual two-year operational plans for each organisation.
- Capital money had been secured from the centre for the surgical robot at Sandwell and West Birmingham Trust. This was a Collaborative Provider success story because of how decisions had been taken in collaboration with other Trusts on where it was required and how they used it.
- A joint ENT service was likely to be developed with Walsall Healthcare NHS Trust. This would mirror the robustness of in-hours and out-of-hours care for emergency and electives that Wolverhampton and Dudley had shared for some years.

#### **Comments and questions:**

RH commented that the Provider Collaborative was taking shape and queried how the results would sit alongside the 2 or 3-year plan as the new hospital was opened and afterwards, and how this would fit with the People Plan and the Finance Strategy. RH emphasised the need for the Provider Collaborative work to integrate with what the Trust was doing and for the key outputs to help the Trust with the next few challenging years.

RBe concurred and explained that this was why DB was working hard with his opposite numbers to focus the Executive body of the Provider Collaborative on fewer priorities that would address risks that each Trust would be tackling in their annual or 2-year plans. This could be workforce risks, the introduction of new clinical roles, or a lack of resilience or critical mass in particular services. There was just about time after the prioritisation session to influence annual plans as a result of the session.

### 4. Executive Operating Structure

- The governance review had led to the outlined Executive Operating Structure for the senior leadership.

- This built in a new Executive and senior leadership between the core organisation and the Midland Metropolitan University Hospital (MMUH) Programme Company.
- Clear governance tiers had been built in, in line with best practice.
- The number of meetings had been reduced, including those that the CEO was expected to chair or lead.
- The Terms of Reference for the Trust Management Committee (TMC) were included for approval. TMC had previously been named the Clinical Leadership Executive (CLE). TMC would be the main Executive decision-making body in the organisation to discharge the Trust Board’s strategy and decisions.
- A clear accountability framework for clinical Groups and corporate Directorates was nearly complete, aligned to the Trust Strategy and breakthrough work for the next 12 months.

DB requested that there was reference made in the Terms of Reference for TMC to see in the Quality Improvement System as a key responsibility. RBe agreed to adopt this change.

The Chair noted that there was still a lot of work to make the changes work in practice. RBe confirmed for the Chair that the Executive Team had weekly meetings that were split into strategic and long-term matters every other week, two sessions per month for the core organisation to focus on business as usual, and one session per month devoted to the MMUH Programme team to align changes in a consistent way with core organisation work. The formal decision-making body was the TMC.

The Board **approved** the Terms of Reference for the Trust Management Committee, subject to the addition of oversight of introducing a CQI system.

#### 5. Continuous Quality Improvement (CQI)

- DB had created a paper on CQI to remind colleagues of the understanding of CQI systems and their benefits. A choice and investment would be made in CQI.
- This should lead to a stepped change in staff empowerment, improved local determination for QI, improved productivity, and improved staff satisfaction. CQI should be the ultimate organisational development (OD) tool.
- Board colleagues would be asked to complete the maturity questionnaire in advance of the February workshop on making data count and CQI systems.

The Board **noted** the report and supported the important work proposed.

**Action:** RBe and KD to add the oversight of the introduction of the Continuous Quality Improvement system to the TMC Terms of Reference.

#### 6. Questions from members of the public

Verbal

No questions had been raised by members of the public.



**7.1 Board Assurance Framework**

**TB (01/23) 004**

KD highlighted the following key points from the Board Assurance Framework (BAF):

- Details of the BAF were in the annex. The cover sheet summarised the conversations that had taken place by the Board and Executive Committees about BAF and the assurance levels assigned.
- Headlines within the paper were set out against each BAF risk, focusing on the gaps in control and assurance. Mitigating actions to reduce the risks being focused on included long-term changes like embedding Fundamentals of Care or introducing CQI or putting the right staff in place. The assurances for the Board were highlighted in the metrics that were being monitored.
- Risks had stayed the same since April 2022, with the exception of the use of finance resources risk, which had a higher likelihood of materialising. Each of the Board-level Committees were tackling the strategic risks. It would take time for target scores to be met.

ML commented that PwC had been appointed as a benefits partner, which was the most significant step that had been taken to mitigate the financial risk.

The Chair suggested that the purpose of the BAF was to be helpful and useful as a good guide.

The Board **noted** the report.

**Our People**

**8.1 Board Level Metrics for People**

**TB (01/23) 005**

The Chair observed that staff sickness was the main problem and queried whether the actions identified by FM were likely to change this metric. FM assured the Board that the figures in the report were up to October 2022, whereas detailed rectification plans at local level were shown to be delivering in November 2022. An increase in short-term sickness just prior to Christmas had led to a re-evaluation of risk plans to look at further wellbeing support. Significant improvements had been seen in long-term sickness. There were some chronic health issues and short-term sickness that was making an impact. This was regularly monitored by the People and Organisational Development Committee (PODC).

The Chair suggested that the same results would be seen unless they started doing something differently. FM reported that long-term sickness was being managed as robustly as possible and the difference was in how they were reviewing their approach to short-term sickness.

DB suggested that the SPC chart was shown as a 12-month graph instead of a rolling 12-month graph because 12 months of improvement were needed before substantial movements would be seen. Benchmarking was 6 months behind due to the data availability. The Executive Team could consider whether a month-by-month report would reflect changes more clearly. The Chair agreed.

LH queried the Trust perspective on home working for managing acute sickness rates like coughs and colds. FM reported that a Remote Working Policy to support hybrid working and home working arrangements had been put in place. This gave clear guidance and support for managers in assisting employees with the requisite flexibility. This had not improved sickness absence levels. The Trust was

working in collaboration with NHSE/I as part of the national pioneering Flex for the Future Work Programme. A formal update would be presented to PODC at the end of January. This showed more avenues to explore that FM offered to discuss with LH outside of the meeting.

FM directed the Board's attention to the positive improvement in turnover that had continued to get better over the past seven months. This showed that the QI approach to the Retention Programme was working. A proposal would go to PODC at the end of January 2023 to share the pilot site findings and to recommend adoption across the Trust.

The Chair noted that the initial results of the staff survey were available. FM reported that some high-level themes had been shared but the results had been embargoed for public discussion until they had been reviewed. LW reported that she had seen the initial results and she would be discussing these with CD on Monday and with PODC at the end of January. There were areas of significant improvement regarding managers' and leaders' approaches and relationships with staff.

**Action: DB to discuss with the Executive Team the adoption of month-by-month reporting for Board Level Metrics to replace rolling 12-month SPC charts.**

**Action: FM to discuss the Remote Working Policy and Flex for the Future with LH regarding absence.**

## 8.2 People and Organisational Development Committee Assurance Report

TB (01/23) 006

LW agreed that the staff survey should be acted upon swiftly and she would be selecting three key points to report back to staff regarding where improvements would be made. LW presented the following key points from the PODC Assurance Report:

- PODC had received the EDI Plan that had been worked on for the last six months. More granularity had been requested, with clear deliverables for the forthcoming year. This was anticipated to be presented again in two weeks and would likely be signed off.
- An area of concern was around Freedom to Speak Up. This was not delivering what it should be and strong leadership from a Lead Guardian was lacking. LW had met with DM and the current Guardians. A six-month secondment advertisement was planned for the Lead Guardian role. There should be 10 Guardians in place but there were only 3. There would be advertisements for further Guardians. LW had advised DM that this should be added to the BAF for PODC oversight. This risk could be turned around quickly once a Lead Guardian was in place.
- POD had been focused on 3 key areas of work. There were 7 or 8 hotspots with different reasons for sickness absence. Managers were being encouraged to adopt a management approach that suited their area. More work was being done with managers and leaders on ways to support staff back into work. LH's suggestion about flexible work was a good one. Another focus was the low uptake for flu vaccinations and COVID.
- Liam Kennedy (LK) was now a core member of PODC, which would help to drive the MMUH agenda. LW, FM, RB, and LK had met regarding how to work more jointly to focus on four quadrants of work:

1. Resource and recruitment



2. Approach to OD
3. Approach to Management of Change
4. Monitoring of workforce information.

The Chair queried whether LW was satisfied with the Executives' response in putting the right actions in place regarding Freedom to Speak Up. LW advised that she was satisfied with the response that week. Learnings were that a braver route earlier on could have been taken sooner. Staff were currently being let down as shown by the fact that the three excellent Guardians were very busy.

RBe acknowledged that LW's report captured the issue that good work had started but evidence was forthcoming, leading to partial assurance. Good progress had been made on the 'time to recruit'.

FM reported that demonstrable improvement had been made through new working arrangements to support performance turnarounds from 1<sup>st</sup> October 2022. The previous 'time to hire' target had been 101 days, which had not been met for a year. They were now consistently tracking an average of 80 days, which had recently been reduced to 73 days. More improvements were expected to be seen in weekly monitoring.

### 8.3 The People Plan

TB (01/23) 007

RBe noted that there were key messages regarding the People Plan from FM and RBe to the Board. This Plan was targeted at the most stubborn concern, which was staff satisfaction and staff engagement. The Plan targeted the culture, leadership and line management, and the way that colleagues would be supported through the employee life cycle. This was not a workforce plan that tackled the numbers of staff needed or workforce innovations and roles required. This would come from the MMUH Workforce Plan. This medium-term plan would drive the 2-year plan that would triangulate workforce activity and cost. A lot of refinement and input had been received on the People Plan, which provided a framework for action to tackle the biggest risks and the operational delivery framework for the next two years.

FM presented the following main points regarding the People Plan:

1. The scope would help to achieve Patient and Population-related objectives. It helped to deliver against the breakthrough objective of leadership, which was a significant area of focus to prioritise. It supported the delivery of the Fundamentals of Care framework under the Patient Equality Improvement Strategy.
2. It delivered commitments for MMUH workforce requirements to ensure a safe workforce transition. The medium-term plan aligned to that had been independently assessed and assurance had been provided through validation. Most notably, it delivered against the Population objective to widen participation and access to opportunities for work and education to improve life chances for local communities.
3. The focus on staff satisfaction would also lead to improvements in turnover, sickness, productivity, and EDI performance that had been tracking below expectations for a number of years.

4. A detailed action plan was under regular review by PODC. This was on track for delivery for all objectives for the rest of the year. A formal review would be presented to the Board at the end of 2023/24.
5. This Plan required a change in approach by all leaders. The approach within the People and OD Directorate had been reviewed independently to ensure that the necessary realignment, prioritisation, capacity, and resources were in place. Specialist support had been insourced as a result and a new operating model would be adopted by 1<sup>st</sup> April 2023 to introduce new service groupings. This aligned the structure and service offer, with skills development for the team to ensure that they could lead on the People Plan. The final iteration of the new model would be presented to PODC at the end of January 2023.

ML noted that performance management was not mentioned in the People Plan, as he had previously raised. It was important that people understood what was expected of them and how this led to the overall Trust Strategy, how they would manage whether or not people were delivering, and how poor performance would be tackled.

FM recalled that ML had previously provided this feedback and stated that it was in the People Plan in the 'How we will deliver this' section. The values would be a lever for demonstrating behaviours that fed into the leadership and behavioural framework that linked into the development offer for managers and the accountability framework. This was one of the 5 key areas of focus within leadership. This also encompassed talent management. The last 10 years of focusing on performance had not achieved staff satisfaction. The right way to focus on this was through the lens of the values.

RBe acknowledged that the organisation had relied on transaction as opposed to culture and tone, which was why there was now a focus on organisational values, inclusive leadership, just culture, and the leadership framework. A clear safety net was needed via HR policies that would be referenced in the accountability framework. Relationships with Staff Side were improving. Pockets of transactional leadership needed to be tackled through a positive lens first and if necessary, through the safety net.

LW advised that a refreshed approach to appraisal had been discussed to clarify what was expected of each member of staff. Ownership of quality improvement needed to be encouraged by providing leaders and teams with those skills. The POD metrics had been revised and the approach to performance management would lead to a culture shift of owning these key areas.

LH queried the plans for external support to work with local experts in training and development, such as at Aston and UOB, which was needed to change culture.

FM reported that they were working with Professor Michael West from the King's Fund and they had adopted his approach to compassionate leadership. They were also working with a not-for-profit organisation called Common Purpose regarding diverse thinking around leadership and experiential learning. They were working with Aston University, using their AOD dimensions profile that FM was involved with creating as an undergraduate. It was equally important that their own professional leads had a voice in the development of the curriculum.

DF suggested that a multidisciplinary approach was needed, to be monitored for assurance. The plan for local jobs for local people needed to have a stronger projection. Ownership was needed by everybody, not just the People Directorate.

FM advised that the Executive were leading different programmes and the People Board in the System had been engaged. Widening participation, the approach, and the role of everyone in the organisation in relation to the Population objective would be presented to the Integration Committee at the end of January 2023.

The Chair summarised that this was a good plan that had evolved over time to provide a good sense of direction. The 'how' to do it was important so that it moved people's hearts and minds instead of becoming bureaucracy. The accountability framework that defined leadership responsibilities needed to satisfy ML's questions. Together with the CQI, the right implementation would have an overarching impact over everything that was done, putting people at the centre. Staff in each area needed to work with the plan to make it happen. The Board **approved** the People Plan and its publication.

**BREAK**

**Our Population**

**10.1. Board Level Metrics for Population and MMUH**

**TB (01/23) 008**

DF highlighted the following key points about Population and MMUH metrics:

- There were three levels of intervention:
  1. Residents and patients were being managed better in their own homes.
  2. Work around attendance avoidance was followed by admission avoidance where it was safe to do so.
  3. Patients who had been admitted were being supported to reduce their length of stay. This was about improving discharge processes to get people home more quickly in a safe fashion, or through the use of the new virtual wards.
- Ongoing work with Public Health included interventions around health inequalities and rehabilitation back to normal living, looking at the model's outputs over 12 months.
- The Trust was running Harvest View with the Local Authority. 47 of the 80 beds were occupied. Harvest View had been closed due to a COVID outbreak between the two weeks before Christmas until 29<sup>th</sup> December 2022. The learning was to close parts of the unit for infection control, rather than the entire unit.
- The numbers and length of stay had increased due to an increased acuity over the last two months for pathway 3 (people discharged with long-term complex care needs, mainly into nursing homes) and pathway 4 (end of life capacity). This was only 2% of total discharges.
- There were 622 responses managed per month instead of 130 six months ago by the Urgent Community Response Teams, who responded within 2 hours.
- Palliative care response in people's homes had increased from 180 to 249 per month.
- Board Level Metrics would be put into a performance dashboard for the Integration Committee to scrutinise.

MR provided positive feedback on virtual wards that had risen to 100% at the end of last year. More work was needed on education. Palliative care would have a Patient Story presented to the Board in March regarding a patient that was able to be returned home for the last couple of hours during a critical incident last week. This portrayed how palliative care colleagues had worked well with acute care colleagues and the family to support the patient's wishes.

ML requested a more explicit overview of bed reduction target tracking towards MMUH, defined across the three sources. DF agreed and reported that the patient stroke user journey had pinpointed the bed reduction numbers. These were scrutinised twice a week to create actions to address issues. This was discussed with RB to relate this to the MMUH model. A set of infographics was being created.

RB noted that the MMUH work was closely aligned with the Place-based work as part of the clinical workstream. The opportunities, dependencies, and risk profile were being outlined for presentation with RW to Programme and Place. A set of deep dive workshops would be held over the next six weeks regarding the fit of the bed base into MMUH to address assurance and the risk rating.

The Chair noted that the 93% occupancies and 76% A&E targets would need to be hit at the same time.

RBe reported that all Places had received a significant sum of money towards the Hospital Discharge Fund. The Health Secretary had just announced a further £250m would be provided nationally for the provision of care home beds as a pragmatic alternative to pathway 1 domiciliary care. RBe queried whether this money would help or hinder the clear model agreed by the partners in Sandwell.

DF reported that £3.2m would be provided to Sandwell. They were working with Birmingham and Solihull partners for a breakdown that would be made available in the reading room. The majority would go to Birmingham community for their discharge pathways. Funding was quite broad and provided some substantial wins. This supported the working of health and social care partners through the Better Care Fund (BCF). Money that came too late had led to last-minute fixes rather than using the money in the most effective way. The same amount would be bid for through the BCF for next year. The money was expected to come recurrently. More benefit would be received thanks to next year's planning.

They would need to be more creative to create benefits from the second amount of money announced because these levers had already been pulled within local Place-based integration.

**Action:** DF to present progress tracking of the MMUH bed reduction target defined across reductions in attendances, admissions, and length of stays.

## 10.2 Integration Committee Assurance Report

TB (01/23) 009

WZ reported the following points from the Committee meeting on 30<sup>th</sup> November 2022:

- The Place Story had been about a 52-year-old suffering from dementia and learning difficulties. A simple discussion with the GP could have addressed some of the concerns regarding the care being provided by the supported living provider, where there was a deficit of service. An eye needed to be kept out on the impact this lack of care was creating in the community.

- The Dudley Integrated Health and Care Partnership concerns had led to work by RBe and colleagues with the Integrated Care Board (ICB). This had led to action that had reassured the Primary Care partners in Sandwell.
- A good initial community engagement session had been held in West Bromwich. The health inequalities there had been identified compared to the five other Sandwell towns.
- Winter planning needed to be looked at year-round going forward.
- Ladywood and Perry Barr work was lagging compared to Sandwell. Conversations continued about the Trust becoming the Anchor Institution in Ladywood and Perry Barr. GP engagement there was still patchy but was improving through GP support.
- The Provider Collaborative event in February would be important.
- Bed level plans had been scrutinised in the move towards MMUH.
- The Committee were meeting in person in the community. Dates and venues would be circulated with an open invitation to colleagues to join community takeovers and meetings.

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

### 10.3 Place-Based Partnership Update

TB (01/23) 010

The Chair noted the good work that had been done in Sandwell and the divergence between the population of Sandwell and of West Birmingham.

DF highlighted the following key points from the report:

- Home-Based Intermediate Care had a shift to virtual beds from 90 beds in homes to 190 virtual beds. This meant that more therapists were allowing people to be enabled at home through their services. This had been helpful over winter and social care had been supportive. This work was material in delivering preparedness for MMUH that DF was working on with RB and LK.
- Sandwell Metropolitan Borough Council had marked performance every day of the week and had matched the Trust's levers in relation to pressures, escalation status, and changes to their operating models. The Trust had been able to discharge people within 24 hours two days before Christmas. This discharge performance had never been seen and had been largely due to the Council doing everything they could. They deserved recognition for this.
- Regarding Ladywood and Perry Barr, admission and attendance avoidance that had manifested into bed days was being looked at with LK and RB to avoid differential offers for the two populations or within the MMUH model. More influence would be expected to result from pressure being placed on the Birmingham and Solihull System but no structural changes had resulted. The Plan B was to encourage GPs to join forces. An alliance agreement and looking at MMUH pathways would help the Trust to affect some health inequalities in West Birmingham. The relationship with GPs was expected to deliver at least 80% of the necessary change.

RBe undertook to write to Sandwell Council on the Board's behalf to thank them for their immediate responsiveness while the Trust had considerable front door pressure.



Regarding Ladywood and Perry Barr and their interactions with the Birmingham System, RBe stated that they were now present in all of the Birmingham and Solihull ICS discussions, including Birmingham City Council. RBe had a further opportunity to encourage the Birmingham and Solihull ICB to decide more rapidly about the Community Integrator contract and whether Sandwell and West Birmingham would be the Anchor Institution in Ladywood and Perry Barr. The plan B formal agreement with GPs in Ladywood and Perry Barr was hoped to be progressed in meeting with GP leaders next week. This would be a significant step towards mitigating the risk of a post code lottery in care pathways and referrals in daily working with City Hospital and with MMUH.

The Chair suggested that he wrote to the leader of Sandwell Council instead, to also request a meeting. The Chair advised that he and RBe should meet with the ICS Chair and CEO to discuss MMUH and the issues around West Birmingham.

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

**Action: DN to write to Sandwell Council to thank them for their supportive responsiveness.**

**Action: RBe to arrange a meeting with the Chair and the ICS Chair and CEO.**

#### 10.4 MMUH Report

TB (01/23) 011

RB highlighted the following points of emphasis from the report:

- The Programme Company and its formation had led to the creation of a Programme Vision by about 45 people. It had been presented to MMUH Programme Board and Opening Committee. This was presented for the Board's consideration as a significant enabler of the Trust's Vision, Values, and Objectives.
- The critical path for the programme was presented in the annex to the paper. Work to get the building ready like switching on utilities had been displayed differently to getting the workforce ready, transforming care, and transforming some non-clinical services.
- An update on significant activities planned in the current period would be shared across various platforms with the public and a staff-facing version would keep staff informed.
- Benefits were coming to the front of the project with a prominent role in demonstrating their delivery. Part of this was a Staff Story related to Frailty and stakeholder work.
- Implementation phase updates to the company on the People front were provided.

VT queried the main reasons for the inequalities described between Birmingham and Sandwell communities and requested an update on how close they were to the plan to recruit 88 of the 484 MMUH posts. RB reported that the inequalities were shown from analysis on Frailty and Same Day Emergency Care (SDEC) input. The pathways needed to be transformed and the outcomes on the success to date showed attendance and admission and length of stay reductions in Sandwell, while they were increasing in Birmingham by a significant margin. The link to the work with GPs, the strategic conversations with ICBs, and commissioning of community services would be essential to reduce inequalities. MMUH would not do this by itself because community pathway transformation was required. The Intelligent Conveyancing was also the cause of increased admissions from West Midlands Ambulance Services. Work was needed on the community element and with



commissioners to create more sustainable urgent care services across the Birmingham and Solihull System.

RB reported that recruitment was slightly behind plan for MMUH. 82 of the original 99 roles had been filled and an intelligent tracking of recruitment was in place for the whole Trust. The next 140+ staff were in the budget to start recruiting in the next financial year. The CEO of Remedium was confident about their input and support, particularly regarding the harder to recruit staff.

The Chair commended the roadmap design and thanked everyone for the papers.

The Board **noted** the report and **accepted** the MMUH Programme Vision.

## Our Patients

### 11.1 Board Level Metrics for Patients

TB (01/23) 012

MR highlighted the metric for patient safety (moderate harm or above) that reported 26 incidents during the month, whereas there had been 21. The Patient Safety team and the Performance team would be validating the figures. There was no evident trend from the incidents.

JN highlighted the metric for Referral for Treatment Time (RTT) that showed patients who had been waiting for over 18 weeks for care as the national standard. During and since COVID, elective care had stopped and a subsequent surge of referrals had resulted. This was true across the country. All Trusts had been charged with reducing all patients to below this national 78+ weeks wait time by the end of March 2023. The new NHS Planning Guidance expected Trusts to be down to 65 weeks by March 2024. The elective care had been delivering and was on track to meet the trajectory while the focus had been on longer waiters and meeting national expectations.

The Chair noted the danger of identifying one individual target, which left a curve behind it that was critical. JN assured the Board that some specialities were hitting their 18-week targets. The volume of new referrals was causing issues. A 2 to 3-year production plan would be the next step to stop the focus on patients waiting a long time from impacting on the shorter waits.

The Chair queried what was being done inside the hospital to provide assurance that patients are as safe as possible despite the press about excess deaths and theories on how to calculate these. MA advised that there had been no mortality incident alerts. ED issues had been focused on, including the surgical abdominal pathway and deteriorating patients in ED. The right steps had been taken to ensure that appropriate patients were taken out of ED by boarding them on the wards more quickly during critical incidents to get clinicians to ED and cancelling clinical activity to support this. A meeting on Monday with all the other Chief Medical Officers across the Black Country had assured MA that no other steps had been taken that the Trust had not tackled.

The Chair requested a clear assessment of what MA had explained and the impact because everyone was bound to be asked for this information at some stage.

**Action: RW/MA to write and circulate a clear explanation to provide assurance that ED patients had been kept safe, including the impact from the steps taken.**

### 11.3 Quality and Safety Committee Assurance Report

TB (01/23) 013

MR advised that there were three key points, apart from a constructive discussion about research:

1. The Quality and Safety (Q&S) Committee had discussed the strategy, what they wanted to achieve, and what they hadn't achieved. MA had done further work and MA and MR would meet the team to agree the plan.
2. The Training Plan for Medicines Management had been signed off and would be reported on a quarterly basis to Q&S. Incidents would be closely monitored through Executive Quality Group to ensure that an improvement was seen.
3. The draft Fundamentals of Care metrics were signed off after a second draft was presented. Groups would set their metrics over the next four weeks.

MA reported that the first draft of an R&D strategy had been presented and it had been agreed to increase the focus beyond Medics to Nursing, Midwifery, and Allied Health Professionals involved in research in addition to working with health partnership organisations, including Birmingham Health Partnership. Their focus on Primary Care was part of being an integrated organisation. Joint academic posts were being investigated as a way forward along with restoring research facilities. The R&D Clinic had been reclaimed after being used for other purposes during COVID. Admin and study set up had been reduced from above average at 166 days down to 86 days. A one-page infographic would encapsulate the strategy to aid understanding. This would be presented to EQG and Q&S.

The Board **noted** the Assurance Report.

### 11.3 Finance, Investment and Performance Committee Assurance Report

TB (01/23) 014

RH summarised the two Finance, Investment and Performance Committee (FIPC) meeting key points:

- Substantial assurance had been received about delivering the Financial Recovery Plan for 2022/23 against the Financial Plan targets. There would be a £17m deficit and a break-even position that would depend on the position of the System/ICB. This was at the expense of a deteriorating underlying position due to non-recurrent means.
- The long-term Financial Strategy had been discussed at length and more detail about its triangulation with workforce capacity and activity performance would be added. This would be a rolling three-year process to include the years before, during, and after opening MMUH. This needed to flow into operational planning discussions. Clear timelines and detail would be added on how to change the culture, which may include CQI.
- A rolling productivity programme would be an evolving 3-year operational plan with a strategy framework around it.
- 6 business cases were approved over both FIPC meetings. One had been retrospective, which was understandable under the circumstances but it had been made clear to avoid this.
- Further business case submissions and iterations of the 3-year Financial Plan were expected.

LW queried whether the risk with the Trust and ICS being adverse to plan was worsening or stable. RH suggested that they were fairly confident about this year but going into next year and the year after, there would be a deteriorating underlying position.

LW queried the non-recurrent status of cost improvement plans and confidence about looking into recurrent plans in future. RH advised that DM had reported at a productivity workshop across the Trust on looking at efficiency and how this would become a more iterative approach.

The Chair suggested that this was discussed as part of the 3-year Plan.

The Board **noted** the Assurance Report.

#### 11.4 Audit & Risk Management Assurance Report

TB (01/23) 015

RH advised that the key points from the Audit & Risk Management Committee were as follows:

- The Internal Audit Progress Report had highlighted the Freedom to Speak Up Audit issues that required resolution. Resource was needed.
- External Auditor Andrew Smith would replace Mark Stocks after his 5-year tenure.
- The External Health and Safety Provision Audit had highlighted fire safety recommendations. An action plan with timelines had been requested for the next meeting.

The Board **noted** the Assurance Report.

#### 11.5 Finance Report Month 8

TB (01/23) 016

DM presented the following key points from the Finance Report:

- The key messages around 2022/23 financial performance remained unchanged. The risks had been updated and opportunities were being tracked.
- Month 9 was also on track for year-to-date performance. A £16.8m deficit was expected, so there was internal confidence in the plan to achieve a deficit of £17m.
- There had been significant work over the past two months as part of a System to try to reach break-even. The System had decided to try to continue to reach this goal. This meant that at least £10m of the original risk reserve should be accessed by the Trust. A £7m (£17m less £10m) worst-case scenario had been outlined and a best-case scenario would be to break even as long as the rest of the System did not deteriorate significantly.
- The aim was to spend the capital budget, which did not roll forward. It was expected that the System would accommodate the slight capital overspend budget for 2022/23. Receiving large sums of PDC quite late had been a challenge to spend in the past due to supply chain demands.
- The money received for IT had been welcomed and planned for by MS.
- The cash position was stable at £55.78m at the end of Month 8.

DB observed that the underlying deficit position was growing every year. The Board should be working with the ICS to move some of the non-recurrent into recurrent to try to reduce the gap between the bottom-line reporting position and the underlying deficit position.

The Chair suggested that this was discussed further as part of the 3-year Plan. The report was **noted**. The Chair congratulated DM on delivering what had been stated.

## 11.6 Maternity Improvement Plan

TB (01/23) 017

MR advised that the results were still awaited from their Antenatal and Postnatal Screening visit in November 2022. The full report would be presented to the Board in March 2023. This report covered the following main points:

- Birth-rate Plus Maternity Workforce Review data still needed to be ratified with the Finance Team and the activity split between Black Country and Birmingham. There was an increase in Whole-Time Equivalents (WTE) required for Maternity Services based on Safeguarding, complexity of cases, and activity increase in the Birmingham area.
- The Neonatal workforce was discussed heavily at monthly meetings. Questions could be asked.

HH reported that Birth-rate Plus had found that the Trust had a workforce deficit based on 2021 data. Birth rates had fallen but tended to fluctuate. They had recruited well against the deficit and would take a phased approach to further recruitment on a collaborative basis across the Black Country.

HH suggested that the Neonatal team should be commended for their work in filling their qualified in speciality (QIS) roles and their developmental work to secure that pipeline through to the Advanced Neonatal Nurse Practitioners. There was a national deficit in QIS roles. The Trust would be slightly over-recruited in QIS, allowing more time for development towards becoming Advanced Neonatal Nurse Practitioners (AANPs). Medical workforce within the Neonatal Unit remained an issue. The Group were supporting with business cases to meet the gap against national recommendations.

RBe queried the last statement. The financial latitude was limited to create the resources that a small unit like Neonatal needed to meet this gap. Senior leaders in the Trust needed to scrutinise the business case but ultimately, there needed to be a discussion with specialised commissioning via the Neonatal Network. RBe requested assurance that this journey would be taken regarding medics. HH assured RBe that a position statement could be requested from the Group on their progress on this.

The Chair suggested that MR and HH were employed to advise on staffing needs and requested assurance that proper challenge had been applied to staffing recommendations from external sources.

HH advised that Birth-rate Plus was the only workforce tool for Maternity Services and this was scrutinised by the national team. Other elements of the workforce could also provide support. Birth-rate Plus's refresh was due halfway through the next financial year, which could result in changes.

LW suggested that as Maternity Champions, she and MA needed to take some time to look at the detail in the report and what it meant for the Trust and other Trusts in the Black Country. LW thanked RBe for his helpful query about external medical support intervention because a long time had been spent trying to deal with this internally when they should be going external for help right away.

MR suggested that time was spent validating the work done to date first. The tools were guidelines to take into account along with the environment, activity levels, and professional judgement.

The Board **noted** the report.

<b>11.7 Your Trust Charity Annual Report and Accounts</b>	<b>TB (01/23) 019</b>
<p>RW advised that Charitable Funds Committee had recommended the audited Annual Accounts and Annual Report for the Board’s approval prior to submission to the Charities Commission.</p> <p>WZ expressed confidence in these documents, following extensive discussions at the Committee meeting and with the auditors.</p> <p>The Chair noted that the Report was interesting to read. The Board <b>approved</b> and adopted the Annual Report and Accounts and commended the work of everyone involved.</p>	
<b>11.8 Your Trust Charity Independence</b>	<b>TB (01/23) 020</b>
<p>RW advised that the Charity had been considering an independent status for some time. This would mean that it would become a separate entity from the Trust. Advice and experience had been sought by a working group from other NHS Charities across the UK who had made this choice. The Audit and Risk Management Committee had reviewed the risk assessment. The Charitable Funds Committee had agreed in November 2022 to proceed with a recommendation to the Board to pursue independence.</p> <p>WZ thanked everyone who had worked on this, including the risk analysis work. Relationships had grown across the community and Children and Women’s NHS Charities’ independence allowed them the opportunity to fundraise and to operate at a far greater level and to access external resources in a better way. WZ advised that the staff should be taken on this journey through reassurance.</p> <p>DM reported that long discussions had taken place and this was a clear decision from a commercial and business perspective. There were opportunities around assets and property as well as possible VAT opportunities. The risk mitigation and achieving income targets had taken a long time but had provided assurance. The 5-year profile for the Charity would be refreshed subject to the Board’s decision to update the new expenditure profile and income opportunities aligned to MMUH.</p> <p>The Chair suggested that this would create more work that would provide greater challenge and it was important that people understood the reasons and plans.</p> <p>The Board <b>approved</b> the recommendation that Your Trust Charity became independent of the Trust.</p>	
<p><b>Action:</b> RW to create a reassuring comms plan for staff around the Charity’s independent status.</p>	
<p><b>For information</b></p>	
<b>12.1 Board level metrics and IQPR exceptions</b>	<b>TB (01/23) 021</b>
<p>The report was <b>noted</b>.</p>	
<b>12.2 Winter Plan Recruitment Tracker and Risk Assessment</b>	<b>Reading Room</b>
<p>The Board <b>noted</b> the Winter Plan Recruitment Tracker and Risk Assessment that was available in the Reading Room.</p>	

12.3 Any Other Business	Verbal
There being no other business, the Chair thanked everyone and closed the meeting at 13:00pm.	
Details of next meeting of the Public Trust Board: <b>1<sup>st</sup> March 2023 at 10:00am</b>	