TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting held via MS Teams.

Date: Wednesday, 02 November 2022, 09:30

Voting Members:		**Non-Voting Members:**	
Sir D Nicholson (Chair)	(DN)	Mrs J Wass, Assoc. Non-Executive Director	(JW)
Mr M Laverty, Non-Executive Director (*joined at 10:00)*	(ML)	Mrs V Taylor, Assoc. Non-Executive Director	(VT)
Mrs L Writtle Non-Executive Director	(LW)	Dr M Hallissey, Assoc. Non-Executive Director	(MH)
Mrs R Hardy, Non-Executive Director	(RH)	Ms F Mahmood, Chief People Officer	(FM)
Cllr W Zaffar, Non-Executive Director	(WZ)	Mr D Fradgley, Chief Integration Officer	(DF)
Mr R Beeken, Chief Executive	(RBe)	Mr D Baker, Chief Strategy Officer	(DB)
Mr M Anderson, Chief Medical Officer	(MA)	Miss K Dhami, Chief Governance Officer	(KD)
Ms M Roberts, Chief Nursing Officer	(MR)	Mrs R Barlow, Chief Development Officer	(RB)
Ms J Newens, Acting Chief Operating Officer	(JN)	Ms D McLannahan, Chief Finance Officer	(DM)
		In Attendance:	
Patient Story Presenter:		Mrs R Wilkin, Director of Communication	(RW)
Mr M McGuire, Assoc Director of Performance and Strategic Insight	MMc	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)

Apologies: Nil

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

The Chair opened the meeting at 9.30am and welcomed Board members and attendees to the meeting.

No apologies had been received. Mr M Laverty was noted as being delayed.

The Chair welcomed Ms C Agwu who had been invited to attend the Public and Private Board for career development purposes and Mr Matthew McGuire who was delivering the patient story.

2. Staff/Patient Story	**Verbal**

MR introduced Matthew McGuire who was a staff member that had been admitted as a patient. Matthew had experienced a range of services during his stay and was presenting on the positivity of his journey, the variations in types of patients in care and how challenging that would be for staff but also some communication issues.

MMc advised that he was returning to work after a holiday abroad. He woke with chest pains and was feeling unwell but thought it was asthma due to a change in temperature. It took an hour for him to walk from the carpark to Trinity house, a distance of 500 yards when normally it would have taken 5-10 minutes as he needed to stop or sit down to catch his breathe. When at his office, members of staff told him his lips were blue, his face was grey and he was sweating profusely. One of the team went downstairs to the single point of access (SPA) service and two members came up to attend. They said he was either having a heart attack or a pulmonary embolism (PE). The emergency response team

(EMRT) were called and arrived swiftly. The consultant in charge said he was having either a heart attack or PE and needed to go to A&E. The West Midlands ambulance service were contacted however could not give a time for arrival, so the EMRT team got a trolley and took him to A&E.

MMc's comments on his treatment included the following:

- An A&E consultant did tests and arranged for an Echo/ECG, CT scans etc. The CT scan showed it looked like a PE.
- The respiratory team came and informed him they had also seen something in his lung which needed further investigation however the focus was the PE.
- When the respiratory team left, the A&E consultant came to confirm MMc understood what his conditions was, what was happening and also that he had a 1.6cm malignant tumour on his lung. He was moved to majors waiting for an AMU admission bed.
- His wife, who had worked at Sandwell in oncology and now worked at Russell Hall in histology, arrived and questioned how a diagnosis of cancer and a tumour could be made without a biopsy or histology report. She asked to see the chief nurse and the consultant how they had come to that conclusion.
- The consultant apologised for the comment and advised that it needed to be managed by the respiratory team.
- After 9 hours in A&E, 6 hours in Resuscitation he was admitted onto AMU into a monitored bed. MMc stated the care he received in Resus was great, the staff were very caring and compassionate.
- MMc was being monitored as he was having difficulty breathing. His alarms went off regularly around every 20 minutes. It was an intensive time for the nurses and for him. His oxygen levels were being increased so he knew we was not doing well. The nursing staff were marvellous each time they came. One of the nurses tried it make it almost a game for me holding the table and breathing slowly and calming myself back down until my monitor stopped beeping.
- MMc was regularly checked by the respiratory and the cardiology team. The consultant cardiologist, Derek Connolly visited every day and told him how close he was to death. His wife was present. She appreciated that he told things straight.
- MMc was moved to the non-monitored bay after 3 days. He had the opportunity to observe some of the staff. He commended the actions of a staff member, Stuart Roberts, who he was truly inspirational to watch. Mr Roberts started making hand puppets and interacting with the grandchildren of a man who had just received a terminal diagnosis. He took the children away so that the man had an opportunity to talk to his son.
- The variety of patients on AMU was incredible. There were patients waiting three days for cardiology beds or waiting for stroke beds. There were patients who were drug users who were complaining they wanted their methadone. There were alcoholics who were pulling out their cannulas requiring the nursing and medical staff to redo work. The staff never complained or moaned at the patients and continually gave the same level of care to those patients. It was humbling to see people continuing to do their job while working in such difficult conditions.

- MMc was eventually told by the respiratory team that he could go home if he learned how to self-inject his Enoxaparin. He watched someone deliver it at midnight and then self-injected for the first time the next morning so had done everything he needed to go home.
- His TTO drugs were ordered at 0900 but did not arrive for 1100. By 1400 MMc felt he was taking a bed that someone else could use so he contacted the Chief Pharmacist who he knew to ask when his drugs would be ready. The Chief Pharmacist advised the drugs were ready at 1100 however there was no one available to deliver to the ward. Arrangements were made so MMc received his TTO drugs
- Since leaving, MMc had seen the outpatient service for an anti-coagulation follow up and would go back for an Echo in January 2023 and a CT of his lung on 16 November.
- He returned to work a week after discharge, two weeks from the incident and had been working on site and from home with the support of his line manager.

The Chair thanked Matthew for his amazing story which showed the services in a good and a poor light.

Comments and questions:

RBe stated the story indicated that the fundamentals of care were being delivered on the acute medical unit however the cancer diagnosis without evidence was a key learning. MMc responded that the communication received when his father in law was in ED with a PE was concise, precise and what needed to be heard and was the best thing in the situation. He believed the consultant in his case potentially was trying to get across the gravity of the situation but made a bad choice of words, and as MMc worked in the health service certain words stuck more than others.

MR stated that communication was one of the key priorities for fundamental care for the year. She asked MMc if it was possible to capture his story in a video to assist the clinical staff. MMc indicated he would be happy to participate.

DB commented on a visit to see MMc where MMc had been working through what he was required to do to get home. MMc advised he did like working with task lists and appreciated that he had been told what he needed to do. The Chair commented that it seemed to have worked, he was clear of the tasks so was able to focus his attention to completing them.

RB questioned whether the issue with the TTOs could be resolved by using prepacks. JN stated the issue was the whole process and recommended that a separate session be held to take a deeper dive into TTOs.

MA commented that he had seen incidences where doctors were hesitant about giving people a diagnosis and had delayed too long however in MMc's situation they had jumped the gun and spoke too soon. He asked whether MMc felt he had been treated differently because he was known or whether he received exactly the same kind of care as others around him. MMc stated there were two other patients in Resus who were seeing the same doctors as they worked through the patients. He believed the same level of care was provided by the nurses and the doctors. In relation to the malignant tumour news, he believed that the respiratory team should have advised the A&E consultant that they had informed MMc of the lump in the chest.

The Chair said there was a whole series of issues that had come from the story. The first was that taking an hour to walk from the car to Trinity house should have indicated to MMc that he was not well however people often put off accessing treatment. He agreed that providing the detail of the

story for staff training purposes would be very powerful. There was also a whole set of issues about streamlining the flow of care and TTOs and how to engage patients in their treatment.

The Chair thanked MMc for providing his story and was glad to see he was better and had returned to work.

3. Minutes of the previous meeting, action log and attendance register	**TB (11/22) 001 TB (11/22) 002 TB (11/22) 003**

The Board reviewed the minutes. An amendment was noted.

The Board **accepted** the minutes of the 5 October 2022 meeting as an accurate record of the meeting.

ML Joined the meeting at 10.05

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

The Chair commented on a visit to the Austin Pride Centre with RBe and MR for the formal opening of the midwife's community hub in West Birmingham. It was evident that the community were amongst the most challenged in the country and the types of day-to-day issues that the midwives dealt with were remarkable. He noted his thanks to the team of midwives for what they do.

Prof Lorraine Harper, Professor of Nephrology at the University of Birmingham was to be the university nominated NED. Prof Harper was particularly interested in developing the research portfolio and would make a massive contribution to the Trust. Prof Harper would come to the next meeting.

5. Chief Executive's Report	**TB (11/22) 004**

RBe highlighted three main topics from his report:

<u>New NHS Operating Framework</u>

A summary of the 47-page operating framework had been prepared for the Board. The three main points were:

1. The dual accountability to the host Integrated Care Boards (ICB) and in parallel to the regional tier of NHS England due to the outcomes framework rating of 3. The other trusts in the Black Country host system were all outcomes framework 3 trusts and also had dual accountability except for Black Country Health Care.

2. It was an NHS England document about the NHS. There was little or no mention of Place, Place based partnerships, the integration white paper and the role of integrated care partnerships at system level missing an opportunity define the NHS's role in Place hosting Place, influencing public health and population health for the better. NHS England expenditure is at or near OECD median and yet the health outcomes as a nation are relatively poor.

3. The continued definition of what was meant by commissioning, "NHS commissioning of services" and the overt separation of commissioning and the provision of health care which is another missed opportunity to demonstrate that planning of health care for the medium and longer term should be a joint endeavour between the allocators of the resource – the ICBs and the ICB

executive, and those that know how to best spend it i.e. general practice, mental health or acute and community trusts.

Trust Strategy

The information on the work being done to drive the Trust's strategic objectives had been added for information and noting and was presented in a format to demonstrate the work that has been done or is yet to be done with regards to the pre-Midland Metropolitan University hospital priorities and post Midland Met priorities.

Birmingham Health Partners (BHP)

The Trust were now an equal partner of Birmingham Health Partners Research and Development network. BHP had formed a clinical trials working group. The BHP Board had requested each member Trust Board agree to certain commitments. As a result, the Board were required to approve the following:

1. To formally minute its commitment seeking to reduce delays in clinical trials and R&D bureaucracy at any point that it could.
2. To formally nominate the CE's recommendation of the Chief Medical Officer, Dr Anderson to be the executive lead for R&D and in particular clinical trials bureaucracy reduction.
3. To commit, through BHP membership, the co-founding of a joint research office that has the sole intention of accelerating and streamlining ethics approval and clinical trials approvals both locally and within the partnership.

Comments and questions:

There were no questions regarding the operating framework or the Trust Strategy.

JW indicated she was happy to support the BHP Board proposals and advised that the University of Leeds where she worked, hosted a National Institute for Health and Care Research (NIHR). The NIHR had launched a program called Research Reset in an attempt to increase the level of clinical trials to pre-COVID levels. JW stated the lessons learned through COVID with regards streamlining of processes to and get things done quickly should be applied to business as usual now.

JW questioned the status of the research and development strategy and whether it included data about on the Trust's performance in clinical trial activity. MA advised the strategy document was almost complete. A director's report was available which included KPIs on performance such as recruitment targets and time taken to initiate research. The Trust's average time to initiate and deliver trials in 2021 was 101 days against the national average of 79 days. While both were high some quick wins could be achieved to reduce the process bureaucracy.

JW added that league tables for recruitment to trials compared to other Trust's would be useful to see and that many local Trusts locally had put a lot of effort into recruitment and been rewarded by seeing themselves going up those league tables.

RBe advised that the Research and Development Manager had extensive university teaching hospital experience and what he believed was the perfect balance of competitiveness and realism about what can be achieved which should produce positive results.

JW stated that as it was a public meeting it was worthwhile explicitly stating that the focus on clinical trials was because of the evidence between research and clinical trial activity and patient outcomes, whereby better patient outcomes were achieved in Trusts that did a lot of research.

The Chair stated the repetition of work between individual Trusts resulted in delays. He agreed that the research strategy should come to the Board for discussion, in particular the measurable outcome and the benchmarking.

The Board **agreed** with the three recommendations from the BHP Board.

The Board **noted** the report.

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

No questions had been raised.

Our Patients

7. Board Level Metrics for Patients	**TB (11/22) 005**

MR presented the following key points from the Board Level Metrics for Patients:

- Medicines Management had been taken to Q&S because of concerns. It would be an area of focus for the next twelve months. Medicines management was included on the December Q&S agenda for more in depth discussion
- Nurse staffing levels were positive for Band 5s and 87 more Band 5s would join over the next 3-4 months. There were close to 100 Band 6 vacancies. Strategies being discussed to address this included a talent program from existing experienced Band 5 and to grow from within to fill the specialised Band 6 roles. District nursing has used this strategy effectively done that over the last year. A plan was also being developed to fill the gaps for healthcare assistants.

KD highlighted two points in relation to complaints:

- The backlog from the 2021 complaints had been caught up. There were 3 C21 2021 complaints to finalise and approximately 17 related to quality assurance. The focus on clearing the 2021 backlog had slowed processing of the 2022 complaints however overall things were in a much better position.
- A pilot to fact track complaints was underway. Complaints about a single issue were receiving a simple investigation and were expected to be resolved in one telephone call if the complainant accepted the treatment process. This allowed more time to be devoted to complaints requiring a full formal investigation. A report on the process would be submitted to the Quality and Safety committee as part of the Qtr. 3 report.

DB provided details of a process of Status Sheets used by ThedaCare in Wisconsin. The sheets had questions such as which patient on the ward was most likely to make a complaint today and why; which patient on the ward was most likely to fall today and why. This process focused on risks for the day and building plans rather than reviewing what had happened the previous day. The status sheets could be part of the improvement system.

RBe stated that the metrics showed some positive “green shoots” on lead measures and that a greater understanding of the root causes of mortality in terms of patient safety and quality had been achieved.

DB said that the metrics highlighted improvements in certain operational areas compared to others rather than against national targets. The cause of the high complaint levels was understood and was

as much about patient satisfaction. The RTT was starting to be a concern because of the volume of patients which had already breached. The patient experience metric was probably a key metric to monitor. Overall, the metrics indicated that "dials" were being moved however it takes times to move them all.

DM reported the recognition of a gap in the Board level metrics for patients around relative productivity and efficiency. Work was being done to determine what the metric needed to look like to be useful and informative.

There were no further questions.

8. Quality and Safety Committee Assurance Report	**TB (11/22) 006**

MH presented the following key points from the Quality and Safety Committee Assurance Report.

- It was reassuring that COVID was no impacting on activity.
- As stated by RBe the problem in terms of mortality was understand. The issues were known but not all had been addressed yet. There was work to be done to be below the target of 100 however progress was positive.
- Medicines management was the biggest concern from the Q&S meeting. A commitment was made to a 12-18 month project to embed a culture change and ensure staff did not lapse back into old practices. A walk around had identified lapses such as not locking drugs trolleys, making sure they are chained to the wall and making sure patients were taking their drugs.

MR advised that an investigation of 7 incidences had led to a deeper investigation of medicines administration which identified the absence of a robust training approach for medicines management ensuring regular assessment against competencies. Medicine management would be highlighted under fundamentals of care and harm free care. A training plan would be presented to the December Q&S next month.

The Chair requested MH report back when further information was available.

9. Maternity Services Update	**TB (11/22) 007a** **TB (11/22) 007b**

MR presented the following three main points regarding Maternity Services

- The Insights report outlined details of the September regional midwifery visit. The visit went very well but lack of audit was the main theme nationally. Other matters discussed included job planning and additional roles for medics.
- A quality assurance visit for antenatal and postnatal screening occurred in October. There were no immediate safety concerns. A full report and learnings would be presented to the Board in January.
- The recently released East Kent maternity report of an investigation of the East Kent hospitals, the Queen Mother hospital and the William Harvey hospital between 2009 and 2020 identified that the Trust provided sub optimal clinical care over a period of time leading to significant harm. There were similar themes as the Ockenden report. The action areas would be added to the Ockenden action plan and brought to the Q&S and Board in the coming months. A three-

page summary of the East Kent report had been produced and made available in the reading room.

MR requested that the Board approve the Ockenden Framework update for October included as Annex 2.

MR responded to a question from RBe saying that the Insights team said a learning from Sandwell for other Trusts was the culture change and staff feedback; the recruitment plan was good and Sandwell were the first to employ registered general nurses. An area for improvement was maternity support and LM&S. Several Trusts were named where it would be beneficial to share and learn from each other.

LW advised that the Trust had gone through a successful recruitment campaign however there had been a high attrition rate due to cost-of-living pressures and an inability to afford to live locally or move from home.

There was discussion on how or whether the Ockenden and East Kent findings applied to Sandwell. MR suggested a Board Development Day be scheduled to review the main points from the reports, any areas of concern or potential improvements across all services.

FM advised that actions were in place to mitigate the retention risks which included an arrangement with local accommodation providers to give staff preferential rates. Another opportunity was to review how the accommodation within the Trust estate was being utilised.

The Chair agreed with the decision not to maintain a separate action plan for East Kent. He suggested that if a development session was being considered the first thing to do was to look at the commonality in the reports which was there was a group of mothers or families who felt that what they considered as important matters had not been responded to, and whether Sandwell would be seen in a similar way. Secondly, the distance between the maternity leadership and the unit members; were Sandwell's maternity leadership teams engaged, recognised by the staff, and did staff believe they are listened too. Thirdly, was whether there was a common purpose between midwives' obstetricians and paediatricians as often there were different objectives

The Board **approved** the Oversight framework and **noted** the East Kent maternity report and the initial feedback from the QA Screening Visit

10. Finance, Investment and Performance Committee Assurance Report	**TB (11/22) 008**

RH advised the three points discussed by the Committee were the 2033/23 forecast; the MMUH Affordability Update which was the medium-term financial model and the NHSE paper from Julian Kenny.

The Committee wanted to see a more clearly triangulated financial strategy and plan developed for better financial management and BAU efficiency over the next 3 years, required in the context of opening a new hospital. The Committee wanted to review how performance was presented and discussed.

RBe indicated that the executive team had been discussing the medium-term financial strategy and timing at length. The aim was to present the strategy to the December FIPC for a first run through and to the January board. A number of questions initially needed to be addressed including why there were 1000 more FTE delivering a similar level of activity.

RH indicated an internal workshop with Executives would be held in November where the focus would be on triangulating history, current and future state and re-establishing pre-pandemic links between capacity, workforce, activity and money. Some costing benchmarking across the Black Country system was underway and there were plans to recruit to a senior lead focusing on operational efficiency, productivity, and benchmarking.

Comment was made on the potential to look at contribution by speciality or EBITDA pre versus post COVID to determine how things have changed and the possibility of a return to payment by results which based on the current activity vs block income would give an additional risk.

The Chair stated that a broad understanding of what was happening was all that was required rather than attempting to develop a perfect plan. He noted the escalation and the Board looked forward to receiving the final report coming in January 2023.

11. Finance Report Month 6 and Forecast	**TB (11/22) 009**

DM presented the following key points from the Finance Report:

- A slightly lower deficit had been seen in month 6 (£1.1m) compared to an average of £2.8m in months 1-5 primarily due to the funding received from the pay award versus the cost.
- There had been a serious risk that the £17.1m deficit plan would not be achieved and a recovery plan was developed (Annex 4) which showed an unmitigated deficit of £43m requiring recovery actions of £26m. The risk of £24.5m of the £26m recovery was green and amber; beds in medicine and emergency care had a red status. Several back pocket schemes were underway and additional income was expected to be realised. However, a considerable proportion of the recovery plan was nonrecurrent and worsening the underlying position.
- The capital and cash position were positive. The program was overcommitted by £5.2m initially. There had been slippage and new schemes included. The forecasting was for a £4m overspend. The system was expected to be able to cover the overspend.
- The forecast was a cash position of £37m by the end of the year which assumed the deficit of £17.1m and the fully committed capital program. This would be a successful outcome. The figures were being doubled checked to ensure everything had been considered.

There were no questions.

BREAK	

12. Winter Plan	**TB (11/22) 010**

JN presented the following key points with regards the Winter Plan:

- Workforce was one of the biggest risks to delivering the plan. The gaps were detailed in the report. The Director of Delivery would be tracking winter posts as part of a broader piece of work on recruitment. A recruitment tracker would be presented with the January Board paper.
- Funding was primarily place based with contributions from posts as part of Midland Met Investments. There was not a lot of costs to the Trust associated with the winter plan which was positive.

- February was forecast to biggest pressure month which allowed time to implement recruitment solutions.
- The ability to flex any more acute beds had not been considered.
- Elective activity would continue as long as possible because of the rising non-elective surgical admissions with 20% of those patients having been on the waiting list.

DF referred to table 3.1 of the paper which highlighted the residual recruitment risk for virtual wards however noted that the respiratory ward was already up and running and the frailty ward had 14 patients. The biggest risk was cardiology which was yet to start but had the lowest load for winter. Further comments included:

- The integrated front door model was fully funded, and members of the frailty team were being moved to the front door as part of an admission avoidance service.
- A deep dive of pathway 1 & 2 would be presented to the November Integration Committee. The biggest risk was Pathway 1, the availability of therapists to enable virtual beds to be increased from 90 to 180. The risk on Pathway 2 had been mitigated.
- The risks were considered to be evenly spread and the schemes were starting to deliver.

RBe questioned whether the virtual ward recruitment trajectory was realistic. DF said that as virtual wards were the "new kid on the block" everyone was recruiting to these roles, however, this was more of a system risk than a Trust risk. Sandwell were doing reasonably well with virtual ward recruitment through movement of internal staff and new staff whereas other places were not. A clear risk on virtual wards was paediatrics as it had the highest recruitment number however also had the lowest bed deficit so was not expected to be a significant problem.

DF suggested the selling proposition for virtual recruitment needed to be strong due to the strong demand. FM responded saying she was pleased with the Trust's offer and the support provided however the turnover in virtual at 19.4%, substantially above the Trust average, was the risk. More investment in local support resources should increase the likelihood of being able to hold on to some staff.

FM responded to a question saying the main drivers for the turnover were work/life balance, work pressure and development opportunities offered elsewhere and some of the marketability of packages. Work had been done to make the Trust more attractive however the legacy effect of the last 12-month period was still being dealt with.

The impact of the new Walsall emergency department, the catchment area changes to ambulance journeys and therefore admissions was discussed. JN stated that the ED opening had been delayed to mid Feb; there may be an initial impact for a few days, but it was not expected to impact conveyancing rates or admissions. The exception may be walk ins where people choose to attend a new "sparkling" ED.

The Chair questioned the correctness of his reassurance of the post mitigation deficit in table 2.4, excluding January. JN responded that the metrics based on the modelling were sound. The key was the ability to recruit to the numbers required, induct them and make those staff productive quickly. The required clinical models had been identified through modelling; the risk was around staff mobilisation. There were several back stops position including reopening the extra beds that were being closed or reducing elective work and moving the urgent care into the elective beds. The focus however was the proactive schemes rather than the "planning to fail type" schemes.

DF stated there was also an option to load share between the two parts of the system. He was confident this provided a reasonable level of mitigation. Work was being done across borders in areas with less robustness in their plans e.g. the alternate use of some of the Rowley beds. The Winter plan this year was as much about a system response as it is about a place response.

There was discussion on the earlier comment re 20% of people admitted already being on a waiting list. JN confirmed it was 20% of urgent surgical admissions which was identified via an audit triggered because of a gradual rise in urgent surgical admissions (approx. 11-12%). The teams were undertaking a second level audit to answer some of the questions such as how long they had been on a waiting list, are we admitting them for the same or a related issue etc. The aim was to anticipate whether certain conditions, demographics, profiles etc were more likely to present non-electively and therefore who were the next cohort of patients. As the matter was around patient safety, the outcomes of the audit would be taken down the quality and safety route.

The Board **noted** the paper and looked forward to seeing the risk assessment of recruitment at the next meeting.

The Chair thanked Darren for his missionary work in Dudley.

ACTION: Winter Plan Recruitment Tracker and Risk Assessment to come to the January Meeting. JN

Our People	
13. Board Level Metrics for People	**TB (11/22) 011**

FM highlighted the following key points from the Board Level Metrics for People report:

- Previous comments on turnover were noted. The most common reason provided in a survey of staff was the impact of workload pressure and work life balance. Local targeted plans for retention were in place to reduce turnover.
- The staff survey was live, and plans were being implemented to increase the response rate.
- There were positive improvements in sickness absence rates, reducing from 6.8% in July to 5.97% in August, with a further reduction expected in September. The improvement for the quarter of 1.3% indicated that the rectification plans implemented 4-5 months previously were starting to take effect.

FM responded to a question saying the “stress and anxiety” measure was predominantly work related but included personal stressed whereas workload was related to exhaustion as a result of work-related presses.

RBe indicated that the executive team were working to persuade staff to complete the staff opinion. An identified reason for non-completion of surveys was cynicism whereby staff believed their responses were not anonymous and could be tracked and viewed by transactional line managers also the culture in some parts of the organisation prevented staff from speaking up which was why cultural change and leadership development would be emphasised in the People Plan being presented to the Board in January.

The Chair questioned whether any analysis had answered why with 1000 more staff than two years previous, less work was being done yet everyone complained about workload.

FM advised that some detailed analysis existed from the retention QI work which could be presented to the Board to provide insights. Factors impacting performance levels included the length of time to

support the new people until they reached the maximum contribution of their roles; that people were tired as they had not been able to take their annual leave etc. and that people have gotten used to working differently.

RBe provided his interpretation of the results as they applied to the strategic objectives for People indicating that the Board may need to measure progress in relative terms initially rather than absolute terms because of the wider context of the NHS total care.

JW suggested that several hypotheses could be taken into the triangulation of finance productivity and service previously discussed, such as has the intensity of the work changed or has the acuity of patients made a difference.

RBe stated that the executive were putting a focus on answering the critical "exam" question regarding more staff and less activity due to the flow on effect to finance, activity and people objectives. Considerations such as service acquisitions or business case investment to meet new national standards such as same day emergency care need to be factored in.

14. People and Organisational Development Committee Assurance Report	**TB (11/22) 012**

LW highlighted the following key points from the POD Committee Report:

- The final People Plan was expected to be progressed to the Trust Board in January. A simplified version for staff needed to be produced first to outline what they needed to do and what was being prioritised.
- The response to the staff survey was disappointing. The current completion rate was 22% against a 39% final completion rate last year. The strong message from discussions was that good leaders who were consistently connecting with staff were getting better completion rates by their staff. A longer-term piece of work was required to get leaders working alongside their staff to improve the opinion towards the survey and improve completion rates.
- The implementation of eRostering was on target. As this was a significant cultural change support for staff needed to continue.
- A final version of a report on an operating model for the HR and workforce team was expected in December. The model was expected to drive and focus the workforce team in supporting the strategic objectives around the people plan.

The staff survey results were discussed. LW advised the results had been escalated to indicate that further action was required to improve the response rate by the end date of 25 November. POD had discussed the need for face-to-face conversations with conversations. RBe confirmed that staff had received a paper copy of the survey from managers. He spoke of targeted feedback from the executive team to directorates on their own response rates and the expectation each team leader, directorate manager, and divisional Director of Nursing was required to deliver on them. JW suggested the conversations with staff may be similar to those in relation to COVID vaccinations.

The Board **noted** the report

The Chair questioned the timeline until the Board received the People Plan. LW advised that a version had been presented to the July Board which was not too far off the final iteration. FM confirmed that it should be possible to have the Plan presented at the Development day in December.

ACTION: The People Plan to come to the January Board. FM

Our Population	
15. Board Level Metrics for Population and MMUH	**TB (11/22) 013**

DF and RH highlighted the following key points:

- The Community 2a response was going in the right direction. Attempts were being made to move activity from admission avoidance into 2 hr response as this had the biggest impact on disrupting urgent care activity. A pilot would commence with WOMASS to respond to and pick up patients who had fallen at home and had no injuries.
- The length of stay on the discharge except for pathway 1 was largely stable and going in the right direction for us. Pathway 1 had been discussed earlier.
- Target discharge dates were discussed by the Integration Committee where it was said that you could land potentially 80% of the variable and still not move the target. A review of measures would occur and a proposal brought to the November Integration Committee to reconfigure the calculations.
- The concern around fit into Midland Met had been mentioned in the winter plan and the summary assurance report. It had been reported at the Integration Committee that the Delivery Director would commence work to look for the lead and lag indicators and evidence of transformational impact. Early analysis showed some positive impact of transformation through the frailty pathway. A more granular view would be provided over two steps in November and December with a report back to the Q&S integration committee and midland met with forecast

The Chair responded to the comments on the target discharge date stating that a line of defence about flow was that the target date was set on the day of admission, and everything organised to deliver it which indicated that its execution was variable. Regardless for the need for a smaller set of numbers to make conclusions on the discharge date, he questioned whether, operationally, staff did not take any notice of the target date, it was just something that was done and therefore there was no improvement mechanism underpinning it.

DB stated the target discharge date being measured for the “last” one i.e. the date was set and reset. The aim was to identify the most frequent factor stopping a patient getting out on time. With clarity over the bottle necks investment could be made in the things that would make the difference.

DF agreed stating the target date was not fixed but updated dependent on the pathways. The aim was to look at the whole pathway and work out what the measures on the pathway were that provided a solid point to analyse against.

JN stated the work described was ongoing. A ward dashboard would be rolled out to all wards to show performance against various metrics. The wards were aware of how they were doing but against local measure. The length of stay for various specialities would be benchmarked against national average length of stays to inform the target discharge date and to allow the wards to determine whether they sat against the national performance.

The Chair remarked that it was likely an investment in improvement was required underneath this work. He would wait for the report from the integration committee.

16. Integration Committee Assurance Report	**TB (11/22) 014**

WZ spoke of a place story which was a good example of integration, collaboration, and partnership work in practice. A patient had received a package of support which included contributions from the occupational therapist and GP within 24 hours of raising concerns. An example of a less successful place story would be obtained to assist in identifying areas for improvement.

WZ highlighted the following points from the Assurance Report:

- The executive team were working very closely with partners to calm things down following a pitch by Dudley Integrated Health Care partnership to be the system voice. There were huge issues with this in Ladywood and Perry Barr and resetting of relationships with the local authority in the Trust with Belle Vue health care community health care. Five Ancor institutions were being looked at to lead place within Birmingham.
- Discussions were held with RB about the opportunity for the work at Midland Met university hospital to be a catalyst for creating a healthy neighbourhood around the hospital. The hope would be that other partners would also join.
- The Committee heard about the draft Frailty Strategy and supported bringing together all the pieces of work around frailty support. The Trust had greater challenges with life expectancy due to the makeup of the population.

RBe indicated the Dudley Health Care matter was being watched and influenced by DF and Tammy. The risk was that Dudley would approach and be approached by GPs who did not want to be hosted or integrated with NHS trusts. The Trust would need to accept this for a considerable time until a point was reached where such a venture cut across and/or undermined what a functional and functioning place-based partnership was doing.

RBe stated that the situation with Ladywood and Perry Barr was confidential and had not been concluded. A more definitive position would be presented to the January Board.

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

ACTION: An update on the Ladywood and Perry Barr to come to the January Board. DF

17. Place-Based Partnership Report	**TB (11/22) 015**

DF highlighted the following key points from the report:

- The Primary Care Strategy signed by the Board would mitigate some of the risks addressed in the assurance item.
- The report called out the fact that the Trust were looking at the primary care access model largely through the lens of YHP whereas other PCNs were looking at this in a positive manner. It was known that access for winter was going to be an issue.
- The joint respiratory hub in RSP hub hosted by place last year would be repeated due to its success..
- The community team were investigating an innovative home visiting service in conjunction with PCN to pick up the patients whose home visiting appointments were missed. These patients often ended in urgent care.

- The STAR domiciliary care agency run by the local authority and therapists would be co-located and work as a single team. This was expected to reduce the pathway 1 risk moving forward. Therapy would continue to be hosted by the Trust and STAR hosted by the local authority.
- Delivery of an operational model in Sandwell through Birmingham community was being marketed as focusing on dissemination of best practice rather than who leads the organisation or who leads place. Positive feedback was being received however it was too early to determine if the correct levers had been received.
- The GPs in Ladywood and Perry Barr had reconfigured the underspend of their primary care budget and made an approach to Sandwell to do part of the access delivery over winter as well as protection of the front door of city ED. A full update would be provided in January.

DF responded to a question from LW regarding Dudley Integrated Healthcare and Sandwell's position as the voice of the clinical GP. He advised of discussions with several GPs for more direct involvement with the Trust either through the committees or by playing an active role in the redesign. Additionally, due diligence was being done on additional reimbursement schemes such as hosting of roles. Thirdly, conversations with GPs were occurring on the provision of back-office services as a different model to assist primary care delivery. Regardless, it was likely the two places would need to commit to having a formal GP lead in the structure somewhere.

There was further discussion on DF's remarks. Comments included:

- The Board were reminded it had already signed off on the Primary Care strategy.
- Detailed due diligence on financial risk was required as part of the business case for any potential acquisition, collaboration or working relationship with primary care, as well as clarity on the bandwidth of corporate services required to support the venture. This would occur on a case-by-case basis.
- The due diligence for one of the proposals would be brought to committees in November and then to the Private Board in January. The speed to engage was driven by the Trusts commitment to its existing plan for the year and the financial resources required.

The Chair spoke of his inability to respond to organisations claims as the voice of GPs as he was unsure what Sandwell's position was with primary care.

DF commented on the Trust's current position stating that the place budget funded two sessions a week for a GP to sit on the Place senior management team and represent the whole of the GP community on that team. Two sessions a week were funded for Tamina Ryan, a GP, to represent Sandwell and Sandwell place on the ICB board. The next step was a GP leader in a decision making position inside of the trust, or inside the primary care community and therapies group.

The Chair stated the complexity with having GPs on the Trust Board was that only GP's who worked outside of the area could be appointed which was of limited value.

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

18. MMUH Report	**TB (11/22) 016**

RB highlighted the following points from the report:

- The critical path for the programme would be presented to the January Board via the November committee structure.

- There has been discussions on the significant transformation through the winter plan the same day emergency plan and the frailty pathway as they related to patient objectives. Assurance of the triangulation to the workforce plans and the forward trajectory would be brought back in November.
- A suggestion was made to "pull out" and further discuss the outcome of the day case surgery pathways.
- The Midland Met Programme company were recognised as having reasonable assurance in terms of implementation and pace.
- Teams were going up to Midland Met every week to look at the building and plan how to work and to think about the standard operating procedures (SOPs).
- A suggestion to be taken to the Integration Committee was to outsource development of the community locations to the local community.

VT questioned whether the Frailty Strategy was about the over 65s as in the report or non-age bound as stated in the Integration Committee. RB confirmed that the Frailty Strategy was not age bound however a strategy for Midland Met was transforming the over 65 current occupied bed days into community-based care; the over 65s were a subgroup for Midland Met.

There was discussion on various aspects of the learning campus.

The Chair remarked that the report brought to life the awe of a new building but also the challenges that would be faced going forward such as are the cupboards big enough, where is the oxygen and should we create an "anaesthetic hub."

The Board noted the report for assurance purposes.

For information	
19. Board level metrics and IQPR exceptions	**TB (11/22) 017a** **TB (11/22) 017b**

The report was **noted.**

DB suggested that the Number of Sitrep Declared Late Cancellations should be discussed in OMC. CLE had indicated this was due to absences in neurology and general surgery and complications in women and children however the size of the variation from target and the doubling over the five months suggested further investigation. that we need to look into a bit more. JW stated that learnings would be developed from the measurements and analysis done during Perfect Theatre weeks however agreed that the continual rise in numbers should be addressed. The Chair suggested the review should be recorded as a matter arising.

20. 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: **11th January 2023 at 9:30am**

Sandwell and West Birmingham NHS Trust

PATIENTS PEOPLE POPULATION

Public Trust Board Action Log: 2 November 2022

	Action		Assigned To	Due Date	Status/Response
1.	TB (11/22) 010	Winter Plan Recruitment Tracker and Risk Assessment to come to the January Meeting	JN	Jan 2023	On the Agenda - Close
2.	TB (11/22) 012	The People Plan to come to the January Board.	FM	Jan 2023	On the Agenda - Close
3.	TB (11/22) 012	An update on the Ladywood and Perry Barr to come to the January Board.	DF	Jan 2023	In the Place Based Partnership Update – Close