Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION MINUTES

Venue: Meeting by WebEx. **Date:** Thursday 1st July 2021, 09:30-13:00

Members:

Sir David Nicholson (Chair)	(DN)	Mr R Beeken, Interim Chief Executive	(RBe)
Mr M Laverty, Non-Executive Director	(ML)	Ms D McLannahan, Chief Financial Officer	(DM)
Mr M Hoare, Non-Executive Director	(MH)		
Mr H Kang, Non-Executive Director	(HK)	**In Attendance:**	
Cllr W Zaffar Non-Executive Director	(WZ)	Mrs R Wilkin, Director of Communications	(RW)
Prof K Thomas, Non-Executive Director	(KT)	Ms H Hurst, Director of Midwifery	(HH)
Dr D Carruthers, Medical Director	(DC)	Ms J Newens, Deputy Chief Operating Officer	(JN)
Ms M Roberts, Acting Chief Nurse	(MR)	Ms S Rudd, Assoc. Director of Corp Governance	(SR)
Ms F Mahmood, Chief People Officer	(FM)		
Ms K Dhami, Director of Governance	(KD)	**Apologies:**	
Mrs L Writtle, Non-Executive Director	(LW)	Mr L Kennedy, Chief Operating Officer	(LK)

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

The Chair, Sir David Nicholson (DN), welcomed Board members and attendees to the meeting.

Apologies were received from Liam Kennedy. DN welcomed JN, who stood in for LK.

No declarations of interest were made.

2. Patient Story	**Verbal**

DN welcomed Janice Barrett and Donna Mighty. He described the practice of beginning the meeting with either a patient or a staff story. It was important to be grounded in the reality of how it felt to be employed or treated by the organisation before the Board's other discussions about big projects, strategies, and transformations. This helped members to focus their attention on what was really important to their staff and patients.

MR introduced Janice Barrett (JB), their Matron at the Single Point of Access Team. Donna Mighty had come to support JB. JB was a leader in the organisation who had taken part in the Stepping Up Programme in 2018. She had been awarded new leader at the Star Awards in 2019.

JB described one of her early experiences when she joined, to provide background context to her staff story. In the middle of the ED nursing station, she had been told by a senior colleague to do something about her hair. She was told that she could probably put her hair on the ironing board and iron it. Instead of the outrage she expected from other colleagues, they all laughed. She was then criticised for responding negatively for being too sensitive because it didn't mean anything.

After being nominated new leader, she was in a big group meeting where she was ignored by a senior colleague standing next to her, who acknowledged and complimented another colleague from a different site. Lots of eyes turned to JB and she looked outside. Again, the behaviour wasn't challenged. She felt that this gave a message to the room that her winning that award was not going to be acknowledged because her winning the award meant nothing to the organisation.

She felt it was better to talk about how things could be done differently and how that could benefit the organisation, rather than conveying more 'mosquito bites.' She suggested the following points:

- People needed to consider the cost of openly telling people they weren't wanted because based on her experience, the average person was constantly looking at what the next job opportunity was. People would look outside if they were constantly given that message.
- People needed to think about how they could make their environment different and what the economic cost was of losing people and what had been invested in them and having to recruit.
- It didn't work to tell people to do right or to respect people's values. When someone made themselves vulnerable by going through an interview process, their growth should be supported instead of telling them that they weren't good enough in a broad and non-specific way.
- Programmes like Stepping Up were taken for granted as being a good thing. Whilst she had benefitted from this, it told her and her colleagues that she was broken and she needed further investment to become good enough, to become equal to her colleagues. It had been uncomfortable to have to defend to colleagues why she was on the programme and to justify why she was getting treated differently, when she was using the process just to be treated fairly.
- People needed to think about how they implemented big policies and programmes fairly and across the board for everyone, and about the impact they had and what message they sent.
- Nobody wanted affirmative action; they wanted equality in order to gain respect.
- The diverse workforce should be used for overseas recruitment panels, and to work out what would make the organisation special to attract staff and to develop them equally.
- MMUH being a new building wouldn't be a selling point for anybody because it would have the same struggles that people were experiencing. It needed a workforce who could provide care for their diverse community. How they moved that forward would be critical.

DN thanked JB and commented on how much they appreciated the time and courage it took to deliver her hard hitting comments. He asked if Donna Mighty wanted to add anything. She thanked JB for being honest and for providing an idea of what she had suffered amongst a longer list. There was a lot to unpick and she asked the Board to consider how to make the organisation become a truly inclusive place that fostered a sense of belonging for everyone. DN thanked her and invited questions and comments.

FM queried what would have made a difference in her journey. JB stated that leadership needed to be responsible for looking after people compassionately and fairly. They needed to consider how people got to tribunals and the part their managers played. People feeling uncomfortable and fearful couldn't provide the best quality care because they became defensive and irrational.

WZ queried whether the black minority ethnic (BME) staff worker's network was taken seriously and given the right support. JB stated that it was undermined by people looking at anyone joining it as a negative. Leaders openly made comments to that effect, with managers looking down on people who joined the Committee. Groups like this that separated BME staff were well-intended but divisive.

WZ commented that they had brought in someone at each level of the hiring process. JB commented that this was just a tick-box exercise that was setting up minority people as isolated targets. The Board wasn't hearing the challenges they faced, which were being hidden with data that wasn't honest.

RBe commented on the need to put embracing diversity at the centre of their People Plan and strategic objectives. He reassured her that views were coming to the Board not just via the staff surveys but by

seeking people to be heard so they could tackle issues at their source. They needed to stop responding to a lack of opportunity by targeting minorities to make them better. The Board couldn't change culture but they could change the environment and the conditions for success. The staff and leaders then needed to respond, which changed the culture over time. They needed to recruit to new organisational values with this at the heart, and to manage and appraise their leaders to ensure those values.

Within their comments, each Executive thanked JB and asserted how important equality was. DN invited JB to provide final comments. She commented that the way that everyone responded to the fear shown by the BME community in how they responded to the COVID vaccination was testament to how people had a long way to go. Members of the BME community had never been valued but now they were expected to trust that efforts were being made in their best interest because it was in society's best interest. Historically, they had never engaged in healthcare in a healthy manner because it had always been a negative process. It had even been suggested to test the vaccine in Africa. Until everyone was outraged by unfair treatment, they would not move forward.

DN thanked her for her message, which they took as a wake-up call to improving fairness and inclusion faster and with more depth. Individual initiatives wouldn't shift the culture. A comprehensive approach was needed to turn things around and plans would be driven forward to address this. People needed to see practical things being done to provide confidence that the Board was determined to make it happen.

3. Chair's Opening Comments	**Verbal**

DN reflected on the need to make progress from top and throughout the Trust to have compassion in order to treat patients well and to make it a good place to work. He considered the long list of things in the in tray for the new Secretary of State for Health, the first from a BAME background, including COVID, recovery, ICS legislation, a new NHS CEO, reforming social care, and staffing issues.

He reported attending an excellent 'standing with me' session run by Sarb Clare, one of their clinical leaders, about what it meant to be an ally in these circumstances. They needed to think going forward like Jeremy Vanes, from the Black Country Trust, about the work they were doing in that area and their stress on cultural education and training for Board members.

He had enjoyed attending the launch of the appeal for funds for the Midland Metropolitan University Hospital (MMUH). Lots of people were supporting their artistic and research ambitions. He suggested the zip wire challenge as an unusual way of raising money for the appeal. 'Dr Phil' Hammond had done one of his national BBC Radio 4 programmes at Birmingham City Hospital. He had interviewed lots of staff and then invited them to his comedy show last night. The Chair commented that they would be enormously proud of their staff and what they said.

DN announced that it would be SRs final meeting before going to the University Coventry & Warwickshire. He thanked her on behalf of the Board and personally for all her help and support.

4. Questions from Members of the Public	**Verbal**

There had been no questions submitted by members of the public.

UPDATES FROM BOARD COMMITTEES	
5. a) Receive the update from the **Audit & Risk Management Committee** held on 24th June 2021.	**TB (07/21) 001**

LW reported that last week's meeting had focused on two fundamental areas of work:

1. **Annual submission of Data Security Protection**: They had seen marked improvement in this year's submission. Just two areas had not been met:
    I. Annual mandatory training
    II. Testing the resilience of their approach, which would be the same as for other Trusts.
2. **External audit by Grant Thornton** (GT) for 2020/21: They had been taken through the detail by GT. There were outstanding testing areas that had been worked on over the weekend before the Audit Committee reconvened to sign them off that afternoon. The audit included a Value for Money finance and governance review for a report at the end of summer, to be submitted in September. Early findings included the following three areas of challenge:
    I. Focusing on improvement of both patient and staff experience
    II. Work around mortality
    III. Wanting to see a clearer CQC action plan.

5. b) Receive the update from the **People & OD Committee** held on 25th June 2021.	**TB (07/21) 002**

ML raised three areas to the Board's attention from the People & OD Committee's meeting:

1. **Workforce planning** for Midland Met was behind and becoming urgent. More resource and focus were needed. It was a red issue on the EMPA programme scorecard as well.
2. The **HR dashboard** was under development. It was starting to highlight Directorates with multiple issues. This would become an important tool for drilling down to find areas to support.
3. The national **pay progression** changes had been agreed with modest amends.

RBe commented that he shared ML's concerns regarding the workforce workstream at Midland Met. The red rag rating was appropriate but he didn't fully agree about there being insufficient resources diverted to it. They had increased leadership coordination time. He planned to meet with FM and Rachel Barlow to ensure that prioritisation was correct before they could draw conclusions about resources. He had agreed with Rachel Barlow about how the Executive Team would be tackling concerns very quickly.

MR reported that no senior nursing leadership resource had been put in. She and Di Eltringham had been the main ones involved. They had agreed the process for the next three gateways but it was and would be challenging to meet because they couldn't finalise the workforce work until new clinical models were completed, such as ED, SDEC, and AMU. Matching the timescales was the challenge.

FM commented that what had been highlighted wasn't about capacity within the People & OD Directorate that needed resource. It was about clinical and operational capacity being released to support MMUH modelling at a time when the Trust was also delivering restoration and still managing the pandemic.

DN commented that it had been identified as an issue and a risk that they were facing going forward. They had the time to catch up where they were behind and to get it right. They couldn't have a situation where they didn't put enough capacity and effort in early enough in the system to make it happen. He looked forward to RBe's comprehensive view on how they would take this forward.

Action: RBe to address concerns about the workforce workstream's resources with FM and Rachel Barlow.

5. c) Receive the update from the **Quality & Safety Committee** held on 25th June 2021.	**TB (07/21) 003**

HK reported the following key points of discussion from the Quality & Safety Committee (Q&S) in addition to items already on the Board's agenda for COVID-19 and planned care and recovery:

1. **Mortality**: The dashboard had been presented. The March HSMR and the SHMI from February had dramatic declines in numbers, which was expected as the COVID-19 situation worked its way through. There were four levers affecting mortality rates: documentation, coding, multiple consultant episodes, and COVID-19 itself, which were all discussed. These would be looked at in more detail and presented on again in the very near future.
2. **Infection Control:** A gap analysis had been done in terms of the Code of Practice and how the Trust fared with respect to that. They were partially compliant with 9 out of 10 criteria and fully compliant with one. Many tactical, operational things could be fixed quite easily. This was being focused on more closely. A return visit by NHSE/I was planned in August.
3. **Vaccinations at Tipton:** On a positive note, they had done 50,000 vaccinations at Tipton and they were the lead for the PCNs in the city area.
4. **Maternity:** They had reviewed the CNST incentive scheme for Maternity and found they were non-compliant for two of the standards. It was decided that it was best to be open and honest.

DC commented that it was reassuring to see the eight-month fall in SHMI and HSMR mortality rates which supported the view about the impact of COVID and the coding-related issues they had. They had a plan to present to Q&S at the end of the month and some elements of that were already in place to address the coding related to Unity optimisation, links between the mortality rates and the coding team, and coding support within the admitting areas. They were looking carefully to ensure that any issues from coding were dealt with so that any clinical issues could be investigated, including by safety huddles on the wards. DN congratulated him for being correct about some of the reasons that had caused scepticism. He commented on how impressive the Learning from Deaths process was.

HK added that CQC preparation was also discussed at Q&S and that the Committee would take oversight of the process to review this on an ongoing basis.

DN queried the poor results of the Infection, Prevention and Control analysis. MR reported that the NHSE/I action plan was red and a huge amount of work had been done over the past six months. The concern was how to get it embedded better within the workforce. The senior nurses had met yesterday to discuss the number of things in place to address this over the next few weeks. She had had a frank conversation with NHSE/I about their position. She had also organised a peer review to get a better view of where they actually were. DN reiterated the need for embedding this focus.

5. d) Receive the update from the **Estates Major Projects Authority** held on 25th June 2021.	**TB (07/21) 004**

DN reported the following highlights from the Estates Major Projects Authority meeting:

- The new **Lyndon Primary Care Centre** was now open on the Sandwell site and looked impressive.
- The full business case for the **Hallam Hospital** development was discussed, and whether the Trust should be doing developments or whether it was somebody else's responsibility. It was consistent with their approach to regeneration and widening participation in working with

partners to do this but they had to be careful that they had both the capacity to do it and that it didn't give them an undue financial risk. They had agreed to develop the full business case.

- The **commercial retail and catering strategy** was discussed. Whilst they didn't want to turn their world class building into a market stall, they did want to work with the local community, small businesses, and the supply chain to get real local buy-in and avoid having a series of national chains. Their staff and patients were the customers and would be the final arbiters. They agreed to create an advisory board to ensure balance and to engage locals to enable them to do that.
- The Trust had previously driven a **masterplan** for development in the area. A joint plan had been put forward by Birmingham City and Sandwell Councils, supported by the Trust. They were considering the Trust's contribution to the consultation, to be discussed at Private Board.

ML added that they had had a good discussion about how building a world class hospital wasn't an end in itself. They needed to make sure that all the other activity including workforce planning was done in parallel to avoid the natural tendency to focus just on the building. Appropriate staff with proper workflows that made full benefit of that environment was important, which was why they'd literally moved workforce up on their agenda to give it the prominence it needed.

5. e) Receive the update from the **Digital Major Projects Authority** held on 25th June 2021.	**TB (07/21) 005**

MH reported on three topics that he wanted to bring to the Board's attention:

1. **Digital plan:** The activities planned over the next 12 to 18 months addressed efficiencies to meet workforce and activity plans and supported clinical care. Newer services and capabilities were combined with improving the services and capabilities of their digital environment.
2. **Cyber security:** Improvement activities were in place to take cyber security to the next level. A lot of work had already been done to meet challenges. This was being driven forward to protect clinical services and the patients in their communities.
3. **Audit Committee observations:** The auditors' questions and observations were being addressed over the next two to three weeks.

MATTERS FOR APPROVAL OR DISCUSSION

6. COVID-19: Overview, including vaccination update	**TB (07/21) 006**

DC described two points regarding the COVID community infections rates and staff testing:

- **COVID update:** Community infection rates had been increasing. In Sandwell, there were 133 new cases per 100,000 people, which was just above the England average of 110. Rates were over 200 in Birmingham. Hospital and ITU admissions were greater than in other organisations across the Black Country. Patients had not just been coming in due to COVID, but due to other reasons, and then were identified as also having had COVID. A younger age group was being admitted. Pressure on the ITU's capacity and staffing numbers had meant that some patients were being moved out to neighbouring organisations for their ongoing care so that clinical activity could continue normally. Those that were sequenced commonly had the Delta variant. Most patients were at the D17 respiratory ward at the City site or in the ITU or at Sandwell.

- **LAMP saliva testing:** As many staff as possible were being encouraged to have regular testing as part of a three-pronged approach including infection control and vaccination. MR reported that yesterday had been day 1 of the two-week awareness raising and registering at the main entrance at Sandwell. An additional 54 members of staff had been registered.

MR provided the rest of the highlights of the report as follows:

- **Vaccinations:** 80% of staff had been vaccinated. More staff had been vaccinated at Sandwell over the weekend event and at City. The surgical teams had requested to take vaccines to the wards, which could be done for Astra Zeneca for over 40s. For Pfizer, staff were asked to go to the City hub. They had continued to support Sandwell and West Birmingham and the PCNs at City and Sandwell. They had run a number of pop-up clinics in Birmingham and particularly at Sandwell over the last two weeks.
- **Updated Infection Control and swabbing guidelines:** For endoscopy, guidelines had been updated regarding the amount of time between each patient and to the new guidelines with aerosol generating procedures (AGP). They had also updated their ITU AGP guidelines in line with the latest Infection Control guidelines that had come out at the beginning of June.
- **Surge plan:** The surge plan had been agreed and shared with all the services and Groups and on call staff so that everyone was aware in the event that community incidence rates kept rising.

RBe commented on the need for transparency around the difficulties they were facing with vaccine hesitancy bordering on vaccine resistance. CCG colleagues and public health colleagues were also encountering this, particularly in Ladywood & Perry Barr. This was particularly true for under 50s, which represented a significant proportion of those in the city. He requested that MR shared her concerns and the limitations around what could be done to tackle the challenge.

MR reported that they had all been working together with daily vaccine meetings to target the under-50 population across the whole of the Black Country. West Birmingham and Birmingham in general had the lowest take-up rates, ranging between 30% to 60% across that age group. They had seen lots of adverse publicity. Last weekend they had had anti-vaccination protesters appearing at various sites including at their pop-up clinics. Although they were doing plenty of positive articles supported by their own and regional communications team around this, they were still not seeing the uptake they wanted to see. There was still a fear around fertility and the speed vaccines came in. The staff take-up mirrored the STP in age, gender, and ethnicity.

HK queried whether they were using the right methods to challenge misinformation and mistrust amongst key groups about how the vaccines were developed and their effects. He suggested there might be other more effective Trust models people might appreciate being used. MR described a family of four that were devastated by the impact of COVID. She planned to approach them to see if they were willing to work with them. Two of the family had been in ITU and two in D17 before one had to be transferred out to go onto ECMO and one had been discharged.

Some of the concerns she had seen involved what reactions would happen as a result of taking the vaccine. She had seen a member of staff who had previously had several anaphylactic responses to other vaccines, and she was perfectly fine after her COVID vaccination. It was a question of how to overcome the fear and encourage people.

WZ fed back his gratitude for all their efforts and their approach to providing vaccinations. He requested that they advertised the pop-up work being done more widely and more in advance so that the message could be spread more effectively. He suggested that restrictions around what people could and couldn't

do based on whether they were vaccinated or not, particularly around flying and holidays, would encourage more people to vaccinate. The plans for Muslim pilgrimages to Saudi Arabia would be impacted. MR reported that efforts were being made to avoid last minute planning for pop-ups and to spread the word more in advance for well-planned events.

DN queried what the modelling looked like for hospital activity for the next month. RBe assured the Board that their surge plan incorporated local vaccination rates and incidence rates. JN reported that they had begun modelling three weeks ago. What they were seeing confirmed their assumptions. Worst case scenarios of 70% of the last wave were the basis for the surge plans, which covered optimisation of ED staff and rotas and streaming into different zones and led into bed and critical care capacity. This included 70% of red COVID area occupancy, which should come down as vaccination levels went up.

KT queried whether the ICU utilisation was predicted to be the same if more younger people were affected. JN explained that only a small proportion of younger people were presenting with COVID as their primary diagnosis but they had planned for the worst. DC described younger people as having more physiological reserve, so they were less likely to need intensive care. They didn't know what the effect of the Delta variant would be and if that would have an influence. A clear Midlands System response was needed for ITUs to work together and for better bed use to avoid having to bring in reservists or turn off any of the routine activity everyone had worked so hard to get back up and running.

DN queried at what stage this would impinge upon their ability to restart and recover the work they were doing. RBe reported that it could have more of an impact on current recovery trajectories.

DN stated that he would like to see the modelling data. He suggested that more could be done on the vaccination supply side and with the Primary Care Networks. He suggested having one-to-one conversations with the staff who weren't vaccinated. They should keep up the good work with the LAMP saliva testing. He agreed that they should plan for the worst and hope for the best.

Action: RBe to show DN the COVID surge modelling plans.

7. Planned Care and Recovery Report	**TB (07/21) 007**

JN explained the main parts of the planned care and recovery report as follows:

- **Production Plan:** Monthly activity planning was done, and they monitored actual activity against it. They had only delivered 89% of what they said they would deliver for June, on an in-patient basis. They had achieved 100% of plans for out-patients. Work was being carried out to increase theatre use and staffing, and to improve booking notice times.
- **DM01:** The diagnostics indicator was a statutory target showing whether patients were receiving the elements of their diagnostics care pathway within six weeks of referral. The Trust was one of the leaders within the Birmingham and Black Country for achieving that standard.
- **Clinical Prioritisation:** Patients on all waiting lists would be prioritised on a clinical risk basis by the end of July. Patients were classified as P1 for the most urgent, followed by P2, or P3.

ML queried the conflict between being in line with national planning asks whilst being less than 100%. JN explained that they were behind for the month, but moving forward, they would be back on plan. RBe clarified the confusion. The Trust was short of meeting their ambitious internal production plan but they were meeting the national Elective Recovery Fund (ERF) activity expectation. Both the Trust and the System were meeting or exceeding ERF requirements of 80% of 2019/20 activity levels.

ML queried where they were on the independent sector provider (ISP) negotiations. JN explained that LK was the Chair of the Operational STP Recovery Programme and he had articulated their needs for help from ISPs and mutual aid from other NHS providers in key pathways including Ophthalmology. They had two or three options from the independent sector where the Trust could send their patients out or they would send staff in to help. A final paper on this was going to the Executive Team next week. Within the next two weeks, they would have a definitive plan on how things could work with ISPs.

8. Maternity Services Report	**TB (07/21) 008**

MR introduced the paper, which described where they were with the maternity improvement plan to work with staff and stakeholders to improve maternity services over the next few years. The plan was set out across five domains. They were waiting for the stakeholder element of the Debbie Graham work finalising part 2 and for the final report from the CQC before updating their plan.

HH explained the work they had done to organise the paper into three main categories with detailed actions shown in month. She highlighted the following key areas for the Board's consideration:

Culture workshops: The report showed details and positive feedback from staff. Workshops had been well delivered. E-learning packages followed the workshops.

Communication Strategy, Vision and Strategy: These had been created in conjunction with staff following their LiAs and circulated.

CNST: The two action plan sections where they couldn't meet the standard were around transitional care (TC) and safety champions. These were thought to be simple enough to fix for next year.

- They had 4 TC cots commissioned but they saw on average between 10 and 12 babies requiring TC. They needed to work out how to address this to meet their ATAIN action plan standards.
- They had monthly meetings with their safety champions at Executive level but due to COVID, they hadn't met all their required walk about and staff engagement sessions.

Focus ahead:

- They planned to reframe the improvement plan and to start leadership courses for Band 7s and above, which would be finalised by September.
- Their Lead Obstetrician started today, the first time the Trust has had one that wasn't also a clinical director (CD). This was to bolster the quality and safety agenda within the service.
- They were still waiting their Ockenden financial bid response and the CQC report.
- A monthly staffing update was included in the paper to provide assurance on staffing numbers.

KT queried whether the Lead Obstetrician was a new post or someone from within the organisation. HH reported that the Senior Obstetrician came from within the organisation but they had created a separate post in addition to the CD so the CD could have the helicopter overview and it would release capacity support to their Midland Metropolitan University Hospital (MMUH) project and LMNS work. The Lead could then focus more on quality and safety.

KT requested that HH fed the staff story back into their team's leadership discussions. HH undertook to do so and reported that with their EDI Lead Midwife in place, these conversations were being rolled out across to the patients that they served and to their staff.

DN commented on how positive the report was. He queried whether the midwives were still unhappy. HH reported that there had been a few positive comments back from midwives but that there was still shared learning to be done and low morale. They had been out with the Executives to the Hawthorns, MR had been to Aston Villa, and they had had coffee and chats with RBe and FM. MR agreed that there was still a lot of work to be done. The staff had started to see the work they had been doing.

DN queried whether the culture workshops had been both well delivered and received. HH explained that both applied. She recommended the workshops for the whole organisation.

LW queried how they were going to make sure they didn't have any loss of new people starting. HH reported that the matrons and managers for those areas had been tasked with keeping in touch via telephone conversations with staff who accepted new roles. Weekly sessions were being held for new staff to get them together for induction training and discussions about their development support.

DN thanked HH for the important change management work in both process and culture change.

BREAK

9. weAssure Programme Update (CQC inspection preparedness)	**TB (07/21) 009**

KD took the paper as read. She explained that the paper didn't consider the Well Led review. She suggested that this could be discussed as part of the governance review during the Board time out next week. They had gone from being rated as 'good' in Well Led in 2017 to 'needs improvement' in 2018.

The paper sought to set out how they linked their in-house inspection regime with their self-assessments that were done by front-line teams. The evidence that backed that up was the topic of the paper along with visibility of progress being made in the form of a dashboard. She voiced concerns that the Clinical Leadership Executive Team didn't have the time to do the work or had competing projects with colleagues or had work to do on the Midland Met. She requested that the Board discussed the priority for this work in quarters 2 and 3. Their core strategic objective was to be good or outstanding in everything they did and this was a way of visibly showing that. The reformed monthly Strategic Executive Group would also be tasked with reporting whether they had sufficient Executive and clinical Group time to focus on this and make it happen.

RBe provided further context. He and KD had sought the view of Maggie Boyd from The Value Circle on their approach to assure the Board. Maggie Boyd had formerly been the Quality Director at NHS Improvement Midlands. He summarised her feedback as follows:

- They should add additional evidence of learning instead of just inspection readiness.
- The evidence vault was a good approach but it would need regular policing to ensure relevance.
- The triangulation Executive Group should ensure that the scoring system didn't become over-engineered.
- The Chief Nurse and Medical Director needed to be fully supportive of the plan and to actively sponsoring the quality assurance and improvement processes and evidence gathering across the organisation. They needed to assure the Executive Team, the Quality Committee, and the Board of the evidence to support self-assessments.
- It was for the Governance Director to move the focus.

ML voiced concerns about no longer being on an upward trajectory and queried the importance and therefore the priority this was given to ensure that events didn't overtake their aims to become good.

LW agreed with everything that had been said by Maggie Boyd. She voiced concerns about clinicians not having time to do things that should be done every day as part of safety and quality. The culture needed to support this as one of the top things to achieve.

HK commented on the need to change the cultural way they worked to create a high quality, safe environment to treat patients rather than just to comply. He argued that it had always been a priority but that things came in to move people away from their focus. The Board needed ongoing focus.

KT agreed that this should be everyday practice by all rather than preparation for inspection.

RBe responded that creating evidence was different to making improvements. The paper outlined the way to collect the evidence. The Board needed to convince themselves about the improvement work and its prioritisation. Their first strategic objective needed to be to change the culture to be good or outstanding in everything that they did in looking after patients and resources. The fundamentals of care work being led by DC and MR was crucial to that. He suggested that the Board do the following:

1. Ask themselves whether they were assured that the Executive Team were starting to move in the right direction regarding the evidence of where they thought they were at and whether the paper came close to addressing that once Maggie Boyd's comments were taken into account.
2. Prioritise this strategic objective and determine whether they were resourcing this properly and making the right progress. The Quality Committee and Board needed to test this separately.

MH queried how they would measure the sustainability of the improvements once they got to the necessary level to maintain the momentum and ensure that it was fully embedded.

RBe suggested that the new approach to measuring success or failure from DB's development sessions would answer this through longitudinal analysis and statistical process control that determined whether they were truly making progress along the key lines of enquiry and backing that up with evidence or not. NHS England and the Trust felt that they needed to adopt this discipline to ensure that changes being made were truly embedded and proper trajectories maintained. Some difficult decisions would need to be made around what they considered statistically significant as an outcome and as progress.

DN responded that the Board had agreed that they had three priorities, one of which was being good or outstanding in everything that they did. They needed to organise themselves and resource that as such. Organisations that tried to make big quality improvements tended to do badly with CQC and vice versa. The trick was to do them together, linking what was happening with CQC to the improvement work they were doing. Connecting the move to the new hospital to the measurements would be a powerful driver for change. He agreed with Maggie Boyd's points and that this took them closer to where they wanted to be. The entire Executive Leadership Team needed to own this and it needed to be seen to be led by the Chief Nurse and Doctor as this went forward, overseen by the Quality & Safety Committee.

10. Chief Executive's Summary on Organisation Wide Issues	**TB (07/21) 010**

RBe highlighted three things from his report:

1. **Urgent care pressures:** As Chair of the Black Country and West Birmingham (BCWB) System Urgent Care Board, he and colleagues had become increasingly concerned about urgent care pressures on primary and secondary care. GPs had been approaching them to communicate the intolerable pressure they were under with the post-pandemic rush of patients who had deferred

their issues and wanted to be seen specifically by a doctor. This had in turn caused emergency department and urgent treatment centre figures to rise as well. Local Trusts around them were breaking attendance records on a daily basis. It was critical that whilst the national narrative focused on restoration and recovery like cancer care and diagnostics, they mustn't ignore the acute care pressures. As an Urgent Care System Board, they were asking commissioners for better clinical mitigation via the 111 service, who were pushing too many patients automatically towards primary and secondary care. As far as winter plans, the BCWB Board and all Trust Boards should be able to provide a coherent and detailed week-by-week demand capacity plan for secondary care, primary care, and social care from the beginning of September 2021.

2. **Director of Integration:** RBe was the Senior Responsible Officer (SRO) of the Sandwell Integrated Care Partnership (ICP) that the Trust Board hoped to host. The ICP Board had agreed to recruit a Director of Integration role to lead the virtual ICP organisation, involving its adult social care, public health, voluntary sector, mental health, and community and primary care services and that of the Trust. He planned to continue discussions with KT and to conclude them with the Chair about this person, who would become one of the Trust Board's members.
3. **ICS implementation guidance**: He apologised for the admin error that didn't append the ICS implementation guidance summary, which he undertook to send to members via email. With the new Secretary of State for Health and Social Care, the passage of legislation and implementation time could slow and become less immediate. They continued to take full part in ICS discussions.

ML queried their capacity to take these additional things on, given their other top three priorities and MMUH. RBe stated that the ICP formed part of their third objective to improve the life chances and health outcomes of their population. With his Walsall experience, which was more advanced with its formal partnership and programme of work, he was convinced that by hosting that partnership and being accountable as an organisation for integrating better public health and care response for people in the community, the Trust could achieve that objective and marginally reduce the pressures they saw in their own primary and secondary care services. It was currently causing time pressure for him and colleagues to get the ICP team resources in place but the Director of Integration role, resourced by the ICP Better Care Board, and the programme team that would be appointed thereafter, would create greater capacity that should help them.

HK commented on RB's point about seeing the pressures normally seen in winter already arriving ahead of a potential COVID wave. He queried the System's view on what winter would entail and how they would cope with it. RBe reported that the BCWB Board was worried. He was concerned that nationally there was not enough clarity with regard to how Systems should be prioritising the provision of safe urgent care in primary and secondary care venues well in advance of anticipated winter pressures. The focus was understandably on mental health and elective waiting time and recovery with less clinical risk than could emerge if the rest of the urgent care system became overwhelmed, exacerbating existing issues. The robustness of the methodology they were using to draw up the winter plan would expose where significant differential action and response would be required. Some inconvenient truths could emerge from that which could lead to having to adjust the trajectories for things like routine elective waiting time recovery to ensure that they had a safe urgent care response for the 2021/22 winter. This was his personal view that was an increasingly accepted view across the System.

DN commented that the System getting a winter plan in place for September would be good. They had learnt a lot from COVID about generic solutions needing to be adapted for their patients. The 111 was an important part and the ambulance service would have to step up and do some important work to make it a reality. If the Trust couldn't influence the right changes with its outreach, few people could.

11. Finance • **Finance Report Month 2**	TB (07/21) 011

DM introduced the paper and highlighted the following key points:

- The Trust was at a breakeven position at Month 2 and was forecasting to break even for the first half of the financial year (H1).
- They continued their focus and good progress on reducing COVID costs, which came down to £1.3 million in month 2 from £1.9 million in month 1. They had a detailed forecast trajectory to reduce COVID costs to £600,000 per month by the end of the first half of the financial year.
- £1.7 million of Elective Recovery Fund (ERF) income had been booked for months 1 and 2 based on the activity that the Trust had delivered. The risk that this would not be received was low, as they were on track for delivering the gateway requirements as a System for month 2. If they achieved their activity plan, they should expect to receive £6.7 million of ERF by the end of the first half of the year if the System delivered its overall goals to earn £16,665,000.
- They had increased their focus on agency spend, reducing it by £300,000. It was still too high.
- Their cash balance had been low at the end of month 2 but it was back up again.
- For the second half of the year (H2), they were expecting a higher efficiency requirement. They were still planning a £13 million in-year efficiency target.
- NHSE/I were proposing a standard and consistent methodology for calculation of their underlying financial position using Monitor Plus. This was due out soon and consistent assumptions it provided would inform their planning and actions.

MH queried whether they had any more information about the System's funding visibility. DM explained that the allocation of the envelope to each organisation for the first half of the year was clear. The System had been given £64 million of new money on top of last year's block but how much of that had been spent or committed or used to balance the System's books was unknown. The System had been given £8 million specifically for cancer but she didn't have full clarity about how much of that money was available for investment or how it was being spent and committed.

MH queried what could be done to help. DM reported that they were doing work as a group of Directors of Finance to put in more System-wide governance around meeting infrastructure and action recording. Escalation could be helpful as financial questions hadn't been answered sufficiently yet.

RBe reported that DM had taken the lead by having her deputy reporting into her to the ICS Finance Directors on the recommended and standardised prioritisation of financial planning methodology.

DN queried the risks with a longer-term consequence in Annex 3 that "staffing levels [were] not within the funded establishment" and "delivery of the 2021/22 Cost Improvement Programme (CIP)." DM reported that from a substantive point of view, the Trust was well within their funded establishment. Once the agency side of things had been managed, they planned to extend that to bank as well. The whole time equivalent spending levels had come down. From a CIP point of view, their requirement for the first half of the year was £1.6 million built into their envelope. There was an indication that this could be higher for the second half of the year but that would be from a higher base. They expected to see COVID and ERF built into the baseline. They had identified a total in-year value of CIP schemes of £6 million, which had been written up and was in the QIA process. The Clinical Groups and Corporate Directorates had agreed to bring back plans to close the gap to reach the overall £13 million CIP target in

the July Group Review process. They had 21 schemes being worked through. They had identified an additional £2 million that was to be written up and £6.8 million indicatively around the impact of the collaborative bank arrangement across the Black Country. They wouldn't expect to deliver all of these things, but they were making good progress.

FM confirmed that the People Board had had an agreement in principle that they wanted to proceed with the collaborative bank. They had a shared understanding about the potential savings and an agreement in principle about the impact for each Trust within that process.

DN queried the recurring consequence of the CIP in case they asked for another £13 million next year. He requested that DM added more around this in her next report because it was important to keep within the cost reduction plan. He thanked DM. The Board **NOTED** the financial position, the financial risks and mitigating actions, the approach to planning for H2, and the ICS financial position for H1.

Action: DM to add a section describing CIP in next month's finance report.

12. Integrated Quality and Performance Report	**TB (07/21) 012**

DB highlighted the following key points from the Integrated Quality and Performance Report:

- There had been a CAS alert around the air oxygen because that issue had been happening nationally. Medical air flowmeters have been removed from terminal units (wall outlets) and stored in an allocated locked place when not in use, to avoid any similar Never events.
- The HSMR dropped to 105 in March and the SHMI dropped to 106 in February. This was a significant drop, which had been predicted to fall after COVID. SHMI had been 97 in December but it would take a while for COVID effects to work their way out of the rolling 12 months.
- Ward sickness had reduced again, down to 5.9%.
- They had achieved their nursing turnover target of 10.5%, the lowest since a very long time.
- The Oversight Framework metrics were out so they could be cross-tallied to the Board metrics.
- Having looked at Public View data in relation to KD's paper, the hospitals' combined scores had been suggested as a proxy for CQC. They had improved since April from 95th to 86th out of 123 in the country. If that was put against mandated support, which was tier 3 in the Oversight Framework, they were just below that. This could be improved by working on the areas where they knew they needed to make a big impact, like SHMI, cancer 62-day and two-week, friends and family patient, staff recommending care, complaints, and sickness.

RBe posed a direct question to MR and DC about whether the Board could be assured that the medical air flow meters had been capped off and that this would no longer be a risk for their organisation. MR reported that she had done a walk around both sites and in the majority of places they had been removed. They had been left in places where they had a high use of air, where they were being replaced by nebuliser boxes. Actions were being overseen by a task force over the next couple of weeks. DC reported that the items blocking off the air flow meters would be changed from a removable to a non-removable outlet in those areas that still needed to be run from air. Those would be connected safely without the air flow meters in place, which was doable. RBe summarised that immediate action had been taken and could be evidenced but their future approach was yet to be fully determined. MR further reported that they would ensure that this was carried through to Midland Met.

LW queried what mitigation was in place for the underperformance in two-week waits for breast symptomatic cancer, which was down to 21%. RBe reported that mutual aid was the answer and that because cancer reporting was two months in arrears, it had considerably improved since the report. JN undertook to find out what they were doing to look after individual people affected to answer LW's question by email. DN requested that she send all Board members this response. He queried the fundamental issue. She explained that they had been trying to tackle that issue since before COVID. They had a lack of consultant specialists, especially across the Black Country. Nearly every Trust had vacancies. The imaging wasn't an issue for them but there were shortages in other Trusts. She clarified for DN that there was a national shortage and that as a System, they were looking for a solution.

HK commented that there was a lot of work going on with AI and how to automate a lot of this. People were also going abroad for analysis to find resources elsewhere.

DC reported that as part of the acute care provider collaboration proposals, they were looking for a clinical lead to take this breast cancer work forward across the ICS. DN commented that one of the benefits of having a System-wide approach was to do things more effectively. Individual Boards shouldn't be defensive or holding up decisions about the disposition of clinical services. He queried if there was a degree of urgency and whether their Board was putting up barriers. DC reported that the collaboration plan was to reconvene at the end of July with clinical leads within the identified specialty areas having had conversations together to identify ways they could work together based on things like the GIRFT data on hospitals. They were taking on extra clinical sessions to try to meet the need of the service at the moment. There were also pressures coming from referrals being sent their way.

FM reassured the Board that SROs were meeting with the HRDs for the Black Country region who had agreed on the need for a consolidated approach. Some alternative roles were available for them as well as working with the private sector to fill vacancies.

The Chair requested a considered report to be presented to the next meeting both about care and support being provided to the people affected and what the medium-term solution was going to be.

Action: JN to circulate an email to Board members regarding the individual care plans for patients on the two-week waiting list for breast cancer.

Action: RBe/DC/DB/FM to present a report on the medium-term solution for tackling the two-week wait backlog for breast symptomatic cancer and for supporting and caring for the patients affected.

12.1 Retaining our staff	**TB (07/21) 013**

FM reported that this paper followed on from the Board's request in December to better understand the Trust's retention challenges and to be assured that a bespoke piece of work had been done to address what had been a significant issue. She took the report as read and invited questions.

DN queried whether there was a need for the Board to do anything. FM responded that the Board needed to recognise that they continued to have some issues despite having made improvements in turnover. The new processes that they had embedded regarding exit management identified that there were still cultural issues that were impacting people's reasons to leave, particularly within their first two years of service. They were trying to do detailed work to embed the principles of a just and compassionate culture and implementing a new Leadership Development Framework alongside the refreshed values. They were developing tools to track this process.

HK queried the chart showing an unknown reason for half of the people resigning. FM explained that this was part of the reason they had introduced a new survey, because people were reluctant to say why

when information was recorded and sent centrally to the HR department. They had made the new survey and follow-up process anonymous and the hope was that that gap would close.

DM queried what the aim was on the change to the final establishment figures in terms of whether they had a minimum possible and achievable turnover rate and how this was offset by forecasted recruitment. FM reported that last year their turnover rate had been 11.5%. Their work had been effective in reducing this rate down to 9.57%, recognising that turnover had also reduced nationally because of the impact of uncertainty due to COVID. To close the gap between leavers and starters, they still had a gap of 34 whole time equivalents with bespoke plans for recruiting for each vacancy. They continued to over-recruit for the core staff, particularly for Band 5 nurses, to stay ahead of the curve.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS	
13. Minutes of the previous meeting, action log, and attendance register To approve the minutes of the meeting held on 9th June 2021 as a true/accurate record of discussions, and update on actions from previous meetings	**TB (07/21) 014** **TB (07/21) 015** **TB (07/21) 016**

The minutes of the previous meeting held on 9th June 2021 were reviewed and **APPROVED** as a true and accurate record of the meeting.

The action log was reviewed with the following updates made:

- *TB (05/21) 019 - Present a resourced plan and overall approach for the Q&S action to create the CQC evidence repository, based on an inspection within one or six months.*
  - This was presented in the weAssure Programme Update (CQC Inspection Preparedness) report (see Item 13). **Closed.**
- *TB (06/21) 006 - Raise West Birmingham's General Practice vaccination approach with the System.*
  - The first dose responsibility for Cohort 10 on Wards was now SWBH with MR leading. **Closed.**
- *TB (06/21) 006 - Ensure that communications reassured the community that non-COVID patients could continue to get safe standard hospital care in the event of another wave.*
  - They were continuing with their communication plans using the media, social media and community networks to advise people of the safety measures in place in hospitals and to urge them not to delay seeking medical care. **Closed.**
- *TB (06/21) 008 - Present a succinct summary of the Maternity transformation plan, setting out what they were aiming to achieve and how, with what resources, and what the expected outcomes would be.*
  - This was presented in the Maternity Services Report (see item 8). **Closed.**

MATTERS FOR INFORMATION	
14. Receive the minutes from the **Audit & Risk Management Committee** held on 6th May 2021.	**TB (07/21) 017**

Noted.

15. Receive the minutes from the **People & OD Committee** held on 30th April 2021.	**TB (07/21) 018**
Noted.	
16. Receive the minutes from the **Quality & Safety Committee** held on 28th May 2021.	**TB (07/21) 019**
Noted.	
17. Receive the minutes from the **Digital Major Projects Authority Committee** held on 30th April 2021.	**TB (07/21) 020**
Noted.	
19. Any other business	**Verbal**
None discussed.	
20. Details of next meeting of the Public Trust Board:	
• The next meeting will be held on Thursday, **2nd September** 2021 via WebEx meetings.	

Signed ……

Print ……

Date ……