SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 3 January 2018

Chief Executive's Summary on Organisation Wide Issues

1. In 2019, as in 2018, we enter the year needing to achieve several major structural changes to how we provide care in order to improve outcomes for local residents. In particular we need to deliver our Unity electronic patient record, originally due for installation in November 2017, and the opening of Midland Met, originally due to open in October 2018. Whilst the combined impact of these severe delays is being mitigated it remains a difficulty which impacts considerably on management 'bandwidth' and on our ability to provide the most modern co-ordinated clinical care. We expect to deploy Unity during the first six months of 2019, and to move to Midland Met by 2022, with some alternations to acute care models later in 2019. Procurement for the new build is one month behind schedule as we await some necessary approvals to proceed.

During January we will receive the initial draft of the CQC's 2018 report into selected services at the Trust. As reported since October, that is expected to point to more work yet to do to achieve a good rating, especially in acute care for both adults and children. In responding to the report, we will need to be more precise and more insistent than ever that changes are made and new operating policies adhered to. The Board will discuss our second Never Event in the last four months, after over a year with no such. Our learning culture, so admirably showcased with the **we**learn QIHD poster work in December, will return to the public Board meeting next month with a commitment to make sure we create space, time and energy to make sure we anticipate and respond to risk and error.

2. Our patients

2.1 Last month the Board agreed an overwhelming focus on, and investment in, radiology in 2019-20. This will provide a guaranteed referral-report wait time, supported by outsourcing of some reporting to strategic partners. This project will help GP colleagues to manage expectations, and will assist hospital based clinicians with rapid diagnosis in clinic or within our bed base. As a first step to this work we delivered at the start of December the removal of our complex diagnostic reporting backlog. In January we aim to be again compliant with the DM01 scanning standard. And prior to going live with Unity we need to address the results acknowledgement administration arrangements which feature on our risk register.

2.2 We have had our second never event of 2018-19. The patient concerned is not harmed. Siten Roy, the accountable Group Director, will attend the Board meeting to discuss the initial findings into this guidewire event within critical care. The critical care board is looking more generally at the best practice within the trust for line insertion. After over one year with no never events, we will redouble our efforts to learn from errors in our

own Trust and elsewhere, and the private Board will receive a presentation on our welearn model as it is finalised.

2.3 Despite huge collective effort, concerted Board leadership and an external review highlighting the good practice seen across the Trust we continue to fail to deliver either the emergency care standard or an improvement in our four hour performance. The exception to this is the eye hospital, where we meet the standard, albeit there remains work to do on the patient environment we are using. The focus of the next month is in three areas:

(a) Ensuring that 28 patients in any hour can be treated by each of our EDs, given available staffing
(b) Improving the initial assessment and onward management in our acute medical units, consistent with the 14 hour standard that we aim to deliver later in 2019
(c) Making sure that we sustain and develop improvements in discharge practice, both across seven days, and into our community wards

A revised governance and leadership structure is being implemented from mid-January.

2.4 The Board has raised repeated concerns about cancelled operations, and a prevalence of short notice appointments both for surgery and clinic. The IQPR provides the latest update data and does suggest that we have made progress with reducing cancellations. This is an important marker of patient experience and one we will continue to focus on the first six months of 2019. At the same time, we will use February's quality and safety committee to conduct a review of long wait clinic follow ups, to make sure that we are sighted on any delays to follow up which might compromise care, and have familiarity with how these delays are tracked to the CLE Planned Care Board. Patients not covered by the national RTT standard nonetheless merit focus and pace in their care and in areas like glaucoma, there are obvious and important implications should there be delay.

3. Our workforce

3.1 We remain determined to improve engagement among our workforce during 2019-20. Groundwork, with this in mind, has taken place throughout 2018. The first **we**connect survey was issued in Q3 and the results are now being analysed. Relevant directorates will complete action plans, which will be publicised through Heartbeat in February, and followed through at CLE. Pioneer teams are about to be selected and 12 will be supported in 2019-20. These teams will fast-track improvements and be encouraged to develop their own plans for advocacy and involvement, linked to the Trust-wide aim to raise engagement scores organisation wide.

3.2 Recruitment activities continue. Annexed to my report is our April 2017 recruitment targets and delivery to date. We recognised mid-year that a number of these targets

were significantly off-track, and the latest data from the People and OD team reflect a commitment to achieve the vast majority over the next ten weeks. This detailed work will continue with work to rationalise the establishments, and vacancy position, from April. The pay-bill paper presented to the Board last month set out how we would achieve this, at a high level, and teams now have until mid-January to complete the detailed reconciliation work. Until that is done it will not be possible to be confident that the agency estimate is deliverable.

3.3 The Board agreed at its November meeting to re-focus mandatory training data and organisational effort at year-end. Absent employees were to be removed from the headline percentage and we wanted to track the number of full compliant, and therefore the number of non-compliant individuals. Countdown work is now gearing up to achieve full compliance during Q1 2019-20, with Basic Life Support and Information Governance the present focus. BLS was due for delivery by Christmas but will slightly slip into January. After a number of years of focusing on appraisal and PDR, it is right that we now have a complimentary focus on mandatory training standards, especially as the majority of most employees' training can now be completed on-line.

3.4 The People and Organisation Development committee has now considered the slow start made with the nurse escalator project, which the Board agreed in April 2018. A relaunch of this work will take place early in 2019, focused on high-PDR scoring nurses. At the same time a long waited project to create a single career escalator between bands 2/3 HCA will come into operation. The bridge between both will be the band 4 role, which is being developed NHS wide in coming months. Changes to the approach we take to HCAs has long been advocated by the trade union group within JCNC, and it is important that we deliver in 2019-20 on our commitment to change. We want to be an organisation in which individuals can develop their careers, not simply take a job, and the escalator programme recognises that commitment.

3.5 During Q4 we will be refreshing the approach that we take to health and safety governance within the organisation. Several attempts to this end have taken place in 2018, and I have agreed to sponsor a piece of improvement work, which looks to ensure that we take very seriously both risks and external standards, and secure measurable improvements in consistent delivery. This "mission and aims" work will then give rise to consideration of the governance and personnel needed to deliver the plan. I would expect change in early 2019-20 in this area, not least as we look to tackle themes from our incident reporting systems, and staff welfare claims which the audit and risk management committee has identified are comparatively high.

4. Our partners and commissioners

4.1 Last month, both through the CCG Governing Body, and the NHSI stocktake, we discussed waiting list size. This was somewhat disingenuously reported in local media as a potential

deterioration in wait times. There is a useful paper contained within the Board's papers which sets out improvement action, consistent with our aim to see more referrals for local people managed inside the local system.

4.2 Finance and Investment committee has been briefed on the progress of contract negotiations for 2019-20. These are now a month behind schedule, and there remains concern that planning assumptions may differ between the parties. The HLP executive meetings will be used to reach a conclusion on these matters during January. If not concluded by the time the Board meets in February this would clearly become both an annual plan red risk, and a Midland Met red risk.

5. Our regulators

5.1 The Board considers elsewhere the latest response plan to the informal feedback we have received during Q3 from the Care Quality Commission. It would be surprising, and rather disappointing, if the final draft report, due with us in early January, contained any enforcement action given the passage of time. On the other hand, we would expect the report to identify areas for improvement during 2019. It will be important to work with the new local CQC team to be sure that we have a shared view of what good looks like, for example, around the Mental Capacity Act, before altering established practices based on individual inspectors' perceptions.

5.2 The reorganisation of NHS Improvement and NHS England continues to take place. We understand that local tiers and teams are probably due for confirmation in autumn 2019. However, it is worth advising the Board that Dale Bywater has been appointed to the Midlands-wide leadership role. This provides continuity with improvement and transformation work done over the last five years.

6. Healthy Lives Partnership ICS and the Black Country and WB STP

6.1 I reported last month on productive discussions around the development of the STP. A draft Memorandum of Understanding is ready for signing which commits local partners to collaboration. In 18-19 this continues to be on a per-organisation basis, but we continue to advocate for a 19-20 move, perhaps from mid-year, to a 'patch' or locality based representation model, which reflects the SWB-wide work we doing within HLP. Similar work is being done in other parts of the STP and the opportunity to study, compare, and evaluate models must be seized over coming months.

6.2 The BSol STP footprint continues to develop its own model of joint working. This is less population and more pathway based than in the wider Black Country, with arguably a more traditional view of commissioner/provider relationships. Productive discussions have taken place with Birmingham City Council, which confirm Local Authority support for the work being done in Perry Barr and Ladywood, and a desire for structured learning between the districts of the city. It is clear that local councillors understand, as do

provider partners, the central role that the future Midland Met will play in Birmingham as a whole, alongside other hospitals, and that it would be folly to start introducing hard borders into the landscape, which would destabilise the underlying business case for this desperately needed development. The approval letter, issued earlier in 2018 by DHSC, for the scheme, is of course explicit that local planners and partners are being invited to deliver the scheme not re-imagine it in flight. Until the "west birmingham question" is framed as a question, it would be premature for any party or regulator to begin to propose solution options. Strong relationships are developing within the provider alliance locally on which the statutory and third sector should seek to build.

7. Other items for attention

7.1 Last month I drew the Board's attention to the ward fill dataset which is annexed. This is the national template, which uses a monthly average. Via Performance Management Committee, the executive has examined a wider dataset, which will be completed over the next three weeks, which looks in parallel at:

- Our Barnacle roster data
- Our fill rate per shift vs. establishment (those agreed by the Board in April 2018)
- Our fill rate vs. in situ acuity assessment

We will want from April 2019 to be sharing each month by ward how many times a ward fell short by shift of either its establishment or its acuity assessment. The former will reflect vacancies and sickness, the latter may reflect variation in demand. The work we have done on amber/red/purple ratings for care complexity will also inform our establishments for 2019-20 and the model we use for focused care. In medicine, as we discussed at the Board's workforce committee, it is patently clear that roster discipline is insufficient, and the incoming Group management team will address this over the next four weeks. Meanwhile, directors of nursing continue to scrutinise a range of data about ward care which gives rise to a performance ranking, including any wards where there is a pattern of concern. That list is subject to escalated support with the involvement of the Chief Nurse and we are advised that by the end of February the current red-rated areas will have improved.

7.2 In November, we agreed the governance approach that we would take to NHS preparation to Brexit. From February I will report that work in my monthly report.

Toby Lewis, Chief Executive
December 28th 2018

Annex A – Team Talk slide deck
Annex B – Clinical Leadership Executive Summary
Annex C – Recruitment scorecard
Annex D – Safe staffing summary