SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 7 February 2019

Chief Executive's Summary on Organisation Wide Issues

1. Since the start of 2019, we have placed the OJEU advertisement for the final contractor to complete the construction of Midland Met. This summer we would expect to finalise that contract, with a preferred bidder appointed and a confirmatory business case at contract close. In parallel the project management contract required under the NEC4 arrangements is currently due to be appointed to, and we will shortly issue the PQQ for the Facilities Management contract. By winter 2019 our focus needs to be principally on the clinical model required to maximise the opportunity of the new assets, which represent a different therapeutic model to our current offer, with a much greater emphasis on patient privacy and dignity through single rooms, on mobilisation and de-conditioning through patient kitchens and therapy space, and on admission avoidance through ambulatory emergency care. At the same time we continue to work with partners on the regeneration mandate that the build symbolises, whether that is through existing ground-breaking projects like the Health Overseas Professionals programme recently visited by John Spellar MP, or through opportunities like the hotel proposition or our work to ensure that we create a traffic and commercial corridor up the Dudley Road between our sites.

2. Next week we start our dress rehearsal exercise to implement the Unity Electronic Patient Record later this year. Most staff have now completed basic training and from mid-March much deeper and denser acclimatisation work commences. Unity means that we will have electronic prescribing, shared data visibility with primary care, and a chance to end duplicate data entry on and after admission. These are real care gains, and whilst putting in a new system represents a huge organisational effort, we need to remain focused on the benefits that success can bring. A key step is to ensure that Virgin and BT deliver our new N3 connection in April, as we work to make sure that our IT infrastructure is sufficiently resilient to both support the new product and carry employee confidence.

3. Our patients

3.1 During December only three-quarters of our emergency care patients attending A&E were seen, admitted or discharged inside four hours. Since mid-January we have improved that position, and are focused in February to improve further. At the same time around 200 patients a week (5% of demand) are being seen by our Single Point of Access (SPA) service which bypasses A&E itself (this new service is equivalent to the in-month worsening in A&E wait percentages). Over some of the last eight weeks we have struggled to identify either critical care or general beds in a timely manner. However,

waits inside A&E have exceeded our aims, on occasion even when beds were in good supply. Looking forward over the coming four weeks, we have to ensure that our discharge timeliness is achieved each day, and that senior decision makers are available in A&E to identify those patients needing admissions, those able to be cared for elsewhere, and most crucially for safety those whose diagnosis is most unclear at presentation. Our handover times for ambulances remain among the best locally, and we are achieving our Consistency of Care safety standards in almost all cases. With new trainee doctors joining us in March, and with improved nursing mentorship in the departments since the turn of the year, we need to see that translate into shorter waits. The Trust continues to benefit from support through ECIST and NHS Improvement, and we need to turn overwhelming effort by clinicians and managers into the better patient experience we are all working to achieve.

3.2 Next month the Board will receive our latest update on amenable mortality. This will include feedback on elevated mortality analysis in stroke, myocardial infarction, and fractured hips. We will also be explicit about the following 12 weeks improvement cycle for sepsis and other infections as well as VTE. The significance of that timescale is the countdown to a possible Unity deployment, which will alter some of our data and perhaps pause some improvement work. Over the next two months we will also complete exploratory investigative work into five maternal deaths over the past eighteen months. This work will frame any external advice we commission to help to understand what we can learn from these tragedies, of which two have occurred over the last four months. Both the families effected, and our own employees, are being provided with support. We continue to work with NHS Improvement to understand how best we might approach the impact of ambulatory care on our comparative mortality rates, because treating these patients in non-inpatient settings alters our numerator for that calculation, although it represents better care.

3.3 Latest data shows some improvement in the number of falls within our care, whilst the change in national data collection means a rise in pressure ulcer reporting. The Chief Nurse is undertaking a series of summit meetings with clinical teams to work through local best practice and consider how best to approach these issues Trust wide. This work will report to the Executive Quality Committee and March's Board quality and safety committee will be asked to agree improvement trajectories for 2019-20.

2.5 February's quality and safety committee of the Board will receive two important reports which we have debated a number of times. Firstly, I asked for a summary to be prepared for the committee of how patient wait times are performing for those patients not reported within a national maximum wait time standard. This in particular applies to 'watchful wait' patients whose clocks have stopped under the RTT standard, and patients being following up within our services on either an SOS or routine basis. We need to be confident that such patients have equitable access and are not at risk of falling between

'systems' or processes. We can also review our progress with cancellations and notice periods. Secondly, the report on our approach to cancer care will be ready, to cover both tumour specific wait time compliance (we typically meet the standard in aggregate monthly and quarterly, albeit Q4 is expected to be potentially below standard) and how we will meet the new national cancer standards due for implementation later in 2019-20. At the same time we can discuss progress with returning solid tumour oncology care to Sandwell in 2019 and to the city site in 2020. By April 2019 we hope to have confirmation of long term revenue funding from NHS England, and a source for the additional capital needed to create a facility on Dudley Road for these teams. There is good collaboration with partners at UHB, as there has been latterly over head and neck cancer.

4. Our workforce

4.1 During February, we will publish our Response Plans to the November **we**connect survey, launch the next 'batch' of surveys, and see the comparative results of the national staff survey. Our latest data shows a big jump in employee engagement from 3.7 to 3.87/5, on our journey to 4/5, which would put us in the top few Trusts in the NHS. In reality, we want to achieve a commonly high level of advocacy, motivation and involvement across our teams, and with that in mind by March 31st we will have agreed aim-for standards with each directorate for December 2019. The Pioneer project, undertaken in collaboration with Wigan, gets underway in February, with our first 12 teams taking part. This 26-week work looks at how we can support teams to improve where they work. The Board asked for a programme that combined 'bottom-up and top-down'. The latter is supported through our work on internal communications, IT resilience and the Flexible Working project which is reflected in this month's appended TeamTalk.

4.2 The Board considers later progress in joining up our recruitment work with our safety and funding plans for 2019-20. My usual annex considers progress with our 2017 hot spot areas. The next People and OD committee of the Board has asked for a full reconciliation of our plans, and we have established a 2% vacancy target for the coming year. Setting that out differently we wish to undertake specific assurance of workplace safety in any area where by July 2019 we are not confidence of achieving this standard. That assurance could examine mitigations or re-distribution of staff on a temporary basis.

4.3 With payslips in January all employees were issued with up to date data on mandatory training compliance. From April new national contracts mean that agenda for change staff will not pass through increments unless they are up to date with mandatory training. We have indicated that CEA points will not be available to non-compliant medical staff. We continue to make good progress to address non-compliance, which for most employees is one, or at most two, elements. Basic Life Support remains our focus and over 300 employees have missed the end of 2018 deadline. This is being addressed now through line management and HR processes with an expectation of full compliance

by the end of February. At the same time, we have signed off revised, and more onerous, expectations of paediatric life support training in both children's specialties, BMEC, anaesthesia and A&E. This reflects learning from the last two CQC inspections.

4.4 Since the Board met last, we have re-launched our Nurse Escalator project, shortly to be joined by schemes in midwifery and among our HCAs. The focus on being Fully Staffed in 2019-20 will help us, alongside our PDR programme, to be much more overt about talent management and career progression for individuals. To tackle our vacancy issues, we know that we need to address retention and that includes supporting nurses to progress as clinical experts rather than solely following a route into management. This step is perhaps especially important as we introduce new band 4 roles into some teams over the next two years, as our band 6 nursing roles will play a pivotal role in mentorship and coaching for this new cadre of colleagues.

4.5 I indicated last month that before the end of March we would be substantively refreshing the organisation's approach to Health and Safety. Invitations to contribute to the workshops in that process will be issued shortly. The intention is to move by Q2 2019-20 to a position where it is very clear for each service and geography of the Trust where and how health and safety issues are collated, and the resolution or mitigation timetable for each raised issue. This process will support the work of statutory committees, and the Risk Management Committee of the Trust. By Q4 2019-20 we will see material improvement in the timeliness of issue resolution and be better able to tell this 'story' as part of our Speak Up culture. This is an important thing to do, but it is imperative we develop this culture well in advance of moving to new and unfamiliar facilities, which inevitably will see teething issues which need rapid resolution.

5. Our partners and commissioners

5.1 Since the Board last met, we have had formal confirmation of the awarding of two major GP contracts to the Trust, working in collaboration with Your Health Partnership, and with Urban Health (Broadway). Learning from those clinicians, and mindful of other local projects like that in Wolverhampton, we will take over responsibility for three practices from April (Summerfield, Parsonage Street, and Great Bridge). These represent real opportunities to improve services further and to learn how best to coalesce hospital, community and primary care services around a risk stratified population. By October 2019, we will want to be explicit what additional achievements we are seeking from these new contracts, whilst hearing from the patients in those practices what they value and need.

5.2 Over the last three years, we have developed health visiting services in Sandwell considerably. We are committed to working with the Sandwell Children's Trust to support social care excellence for the most vulnerable families locally. In coming days we

will have confirmation of the outcome of the borough's recent School Nursing tender. If our submission is successful, then we will work in close collaboration with local head-teachers, governing bodies and young people, to make sure that the new service sustains the best of prior provision, but is developed to ensure that both physical and psychological wellbeing are the heart of our support package. Our maternity service means we are involved from birth, health visiting sustains key early years work, and school nursing is a further step in supporting local families. Given our public health promises since 2014, we should view schools, alongside care homes and general practice, as vital components in a whole health offer to Sandwell, as part of Vision 2030.

6. Our regulators

6.1 The Trust has submitted our initial Factual Accuracy response to the 2018 CQC inspection of a minority of Trust services. We might anticipate that the report will be issued before Easter, and we recognise that there is more to do to improve services further. Within the draft report, it is hugely positive that no service is now rated as having safety inadequacies, and whilst we did not agree with that 2017 rating, it is a tribute to efforts across the organisation that that judgment is now shared by the CQC. Our key and real challenges remain in acute care, both for adults and children, and whilst we continue to operate across two hospitals, we need to remain adaptive in tackling those challenges. We have set ourselves the challenge of ensuring admitted patients see a consultant inside 14 hours to confirm their care plan, whilst maintaining our focus on reducing unplanned readmission rates. That work alongside linked programmes like our No1 quality priority, tackling sepsis, is the real aim behind our improvement work in 2019.

6.2 National planning guidance for 2019-20 continues to be shared, with control total offers being due for response in coming weeks. The two year financial plan we are half way through operationalising, and which reflects our ten year financial model, sees important income, productivity and margin changes planned from April. This localisation work has been part of the Midland Met story since 2015 and has been repeatedly re-agreed. Recognising the era of collaboration that the Long Term Plan sets out, we need to re-state a focus on patient choice and GP preference, and ensure local finances respond to that and create care continuity as a benefit – we know that more distantly treated patients receive good care initially, but their long term needs suffer from fragmentation of providers. **I would suggest that the Board delegates agreement of the Control Total offer to the Chairman and myself, contingent on foreseeable agreement of the CCG 2019-20 contract with SWB**. £27m of revenue investment excluding inflation is under negotiation, with the involvement of NHS Improvement and NHS England. If that is secured then the Trust should re-certify the control total as issued.

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

7.1 In line with my report last month, a draft Memorandum of Understanding has been signed which commits local partners to collaboration. National planning guidance is clear that much of the 2019-20 submission process for planning will flow via the STP, albeit still demand per organisation returns. The Trust continues to engage very actively in those processes, recognising that the four 'parts' of the STP have much to learn from each other, both prospectively and by studying the impact of care integration flavours approached differently in different boroughs.

7.2 At the same time, the Trust sits at the boundary of two STP footprints, and positive bilateral discussions have commenced with BSol about the patient flows, policy implications and funding model to be adopted in some practice geographies in Ladywood and Perry Barr. The Joint Overview and Scrutiny Committee of the two councils recognises the significant and material risk that would arise to the functioning of the new single acute hospital, if hard borders are introduced between Sandwell and Birmingham, or if frontline clinicians are faced with divergent pathways or paperwork based on postcode. In 2020 the Trust's audit programme will complete and publish an analysis of all paperwork differences between the two boroughs so that the scale and justification for differences of approach is open to challenge. This should be a key gateway in the road to Midland Met.

7.3 Limited progress has been made since last month with the Healthy Lives Partnership. Discussions continue with Primary Care Networks, and other partners, and productive engagement has taken place with the third sector. The Trust is working with the CCG to ensure that the resourcing of new ways of working is in place, before embarking on real or governance changes to approach for 2019-20. It remains our ambition that we move at pace to a capitated budgeting model, which enables partners to divert resources between into prevention, primary care, and mental wellbeing locally. This cannot rely on a commissioner/provider model, and must involve active and repeated experimentation until we understand how best to deliver improved outcomes for local communities. Any regression to a 'planning' model or a programme approach risks impermanence and cosmetic compliance. The scale of the outcome and inequality challenge demands bravery.

8. Other items for attention

8.1 The Board considers this month an initial report on the Workforce Safeguards guidance issued in late 2018 by NHS England. Whilst that document is nursing focused in detail, if not in intention, our aim must be to examine care hours across all disciplines as we look to ensure we deliver inter-disciplinary and multi professional care. We have had several stalled attempts at workforce transformation planning, and will address these matters again this spring in the countdown towards Midland Met. In the much shorter term our focus is twofold: (a) Ensuring congruence in our ward nursing datasets between lived

experience, acuity, and budget and (b) Positively assuring the safety of any department for 2019-20 where vacancy levels will be, or are planned to be, above 2%. At the February People and OD committee of the Board, the Chief Nurse and I will present a final reconciliation of (i) ward establishments (ii) ward acuity and (iii) focused care thresholds, whilst also illustrating the impact of work done in January on February and March rosters. Only after that work is confirmed can the Board move beyond extant safety assurances from professionals into more detailed confidence in our staffing data week by week.

8.2 We continue to work to meet national data and compliance requests relating to Brexit, and a separate note on this important issue is before the Board in public today.

Toby Lewis, Chief Executive
January 31st 2019

Annex A – Team Talk slide deck
Annex B – Clinical Leadership Executive Summary
Annex C – Recruitment scorecard
Annex D – Safe staffing summary
Annex E - Long term sickness reduction
Annex F - ICS Board Minutes – December 2018