SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 7 March 2019

Chief Executive's Summary on Organisation Wide Issues

1. Coming weeks will see the Trust face a series of changes and challenges. We would expect to manage the EU Exit process successfully, and have a strong grip now on how we can implement national policy locally, with more details emerging weekly on what has been planned centrally. At the same time, we are looking to commence the procurement of the FM provider to support the Midland Met opening. This comes with TUPE transfer for some employees in 2021. Recognising these 'big picture changes' our focus remains on key deliverables that the Board has prioritised including meeting cancer, planned care and diagnostic wait time standards in Q4, and **ensuring that all employees complete mandatory training by the end of the fiscal year** – a year in which we will again meet our financial obligations and receive additional investment for that success.

2. It is encouraging to report the **Full Dress Rehearsal outcome for our Unity Electronic Patient Record**, which we undertook during February, was broadly successful, and certainly produced relevant learning. The Digital MPA, and executive digital committee, have considered initial feedback and during April will finalise the criteria for Unity go live later in the year. It is very clear now how much of a safety benefit and quality gain can come from the standardisation of the data about patient's care, notably the introduction of electronic prescribing. Making key steps, like VTE assessment, a fixed point in admission or care, will help us to accelerate execution of our 2020 Safety and Quality Plans. The wider paper on IT infrastructure within the Board's papers will be relevant in ascertaining the timing of implementation, and in particular we have work to do to be ready for our April HSCN implementation, which will transform our N3 connection.

3. Our patients

3.1 **Sepsis** remains our quality focus, above all else. National and local data shows that better identification of this cause is leading to rising reported rates of sepsis, and this is visible within our mortality information. We continue to track screening performance and have driven a four-fold improvement over the course of 2018-19. In advance of implementation of Unity, and the migration to NEWS2, we will continue this work, addressing each missed screening as a potential alert to poor care. This approach is largely showing that data is mis-entered but good care given, but in a digital organisation we want to close that gap.

3.2 It is clear from the work done this year on **amenable mortality** that we should continue to pay considerable attention to:

- Our individual mortality reviews, which we stepped back from as we introduced the medical examiner process;
- The quality of our data and our coding, which matters, and in particular distinguishing accurately expected and unexpected deaths in our care; and
- Incremental quality improvement work in specific services, not only where we are outliers, but also where we have excellence

In April 2018 we began work to develop a clear and quantified route to better than peer mortality across our Trust, and in due course by site as well (as key reporting requirement after Gosport). The diagram within David Carruther's paper provides that, and will form a standard report which the Executive Quality Committee, the Quality and Safety committee, and the Board can examine as we move through 2019-20. The potential inclusion later in the year of ambulatory admitted patients back into the numerator will address a material factor in our relative deterioration over the last eighteen months.

3.3 The data for **emergency care waits** shows improvement in our overall performance, with City meeting an 85% minimum standard on 23 of the last 30 days. The equivalent figure for Sandwell is 5. Interrogation of the latter shows that daytime results have improved markedly on the site, and that that is typically above 85%, and so the focus of overwhelming attention is now the flow of patients and pattern of staffing after 5pm each night, and for a longer period at weekends. Work focuses in particular on how the acute medical unit is staffed and managed, and on decision making capacity and capability within ED itself. A final plan to achieve a consistent 85% (as a first step to improvement) will come to the Board next time. There remains tremendous engagement from clinical and managerial employees, and there is recognition that this constitutional standard remains the only one that the Trust does not meet, and that must change in the year ahead.

3.4 Stroke services continue, in the last SINAP data, to show progress towards **the top 5% of units in the UK**, and we have retained our place in the top 10%. The forthcoming symposium needs to ensure that we can offer outstanding access to diagnostics and specialist expertise, regardless of location of onset. In supporting that, and also in developing our place in the thrombectomy pathway for the area, we have stood back our stroke physicians from the general internal medicine rota, to provide more capacity to focus on stroke care.

3.5 The Trust remains a major provider of emergency surgery care, especially in general surgery and in orthopaedics. The organisation will contribute to the region wide Laparotomy Collaborative which is working to compare and improve service provision. During Q1 2019-20 our Theatre Management Board will look at **the overall quality of our emergency surgery services**, and provide a briefing for Quality and Safety as we look to

establish quantitatively what outstanding looks like by 2020. Notwithstanding indicators of good practice like the welearn winner, our orthopaedic anaesthestic team winning awards, the SAU from 2015 and SEAU from 2018, and the creation of the monitored space on Priory 2, the organisation does not yet have an organising ambition or plan to which all emergency surgery services are part. That mindset is something we want to inculcate as we build towards the clinical models we would wish to migrate into Midland Met in 2022.

3.6 The update report from this month's Quality and Safety committee notes receipt of key reports on **the future of cancer care** at the Trust. In addition to the planned return to site of the solid tumour oncology service over the coming year, the committee considered plans to meet national cancer targets as they change later in 2019-20, our own Board's ask to achieve tumour site target compliance, and the development of cancer services more broadly including screening services. Both breast screening and bowel screening services remain under pressure for staffing and with rightly raised expectations. Meanwhile our own expansion of diagnostic capability, notably imaging, should give us some scope to meet rising demand from patients and GPs for rapid access.

4. Our workforce

4.1 Our second **we**connect staff survey has now been issued, and Heartbeat at the end of February showed details of local plans to respond to the first survey, undertaken in December. The national staff survey has been published as well, and the Trust remains a low respondent, in part because of the velocity of our local polling. The use of the method, shared with Wigan, is providing better data on the detail of local concerns, and in particular is highlighting a focus on Fairness and Just behaviours as a condition for colleagues feeling that they have influence. This renewed emphasis is important and drives work such as local behavioural charters, our Management Code of Conduct, and changed governance around selection panels.

4.2 The Board has agreed a new approach to **vacancy management** in 2019-20, linked to our self-assessment of the Workforce Standards expectation from NHSI. We will track vacancies by team against our 2% standard. Clearly this is a very low measure but it sets an ambition consistent with our Fully Staffed agenda. Linked to this, and once we have signed off our 2019-20 budgets on March 22nd, we will alter our VAF approval process for replacement posts. Only new or amended roles will require corporate re-scrutiny for appropriateness. Roles unadvertised by local teams within rapid time will be considered for disestablishment as we do want to 'bank' paybill to manage budgets – the funds are provided to support local service delivery.

4.3 We have completed internal consultation on our approach to **Flexible Working** in the Trust. The five standards below represent our pledge in this area and Raffaela Goodby

will bring a quarterly compliance report to the full Board, commencing at our July meeting, outlining delivery statistics for Q1.

a) Offer part-time working for all jobs unless essential business reasons mean this is not possible
b) Ensure fair allocation of flexible working opportunities among teams including reviewing long-term practices to enable others to benefit
c) Invite teams to consider seven day working, working from home and annualised hours contracts
d) Explore help for staff during school holidays including provision of holiday clubs
e) Collect information in one place on reasonable adjustments that are made to accommodate staff needs.

4.4 Annexed to this report is a summary of our achievement in relation to flu **vaccination**. Nationally planning has commenced for winter 2019, considering the responses of NHS employees where, for the first time, standard data is being collated on reasons for staff declining the vaccine. Meanwhile, locally this spring the Trust will, on clinical advice, make MMR vaccine status, in certain service areas, a condition of recruitment. We very much hope other NHS providers will join this endeavour as we continue to face the issues created by Wakefield and others' misplaced analysis over a decade ago.

4.5 I highlighted mandatory training in introducing this report. At the time of writing over 4,000 employees are 100% compliant with local and national obligations, aided by a major move to e-training during 2018. Our push to ensure **Basic Life Support** training is in place has been successful, and we are taking final steps to replicate prior year compliance with Information Governance standards. We do have work to do in coming months around Safeguarding training, with raised expectations about level 2/3 coverage. The combined impact of our own local PDR policy (non-compliant employees cannot rate above 2/4) and local excellence awards for doctors are contingent on compliance, together with national agenda for change rules which make gateway progression dependent on compliance are heightening colleagues' focus on compliance.

4.6 Invitations have now been issued for the first of our three **Health and Safety** summits at the end of March. This looks to re-imagine how we approach workplace safety for colleagues, including students and volunteers. Without prejudging the work to be done, we want to ensure that we are evidently capturing and addressing the issues arising from RIDDOR, lower grade incidents, and risk assessment. By the time we get to the summer, we need to be clear what metrics and indicators we will use at local departmental level to assure the Board that health and safety is prioritised in how we work, and how the Trust is led.

5. Our partners and commissioners

5.1 We are making good progress readying the Trust to accommodate the teams providing **school nursing services** in Sandwell. The service has a strong history of delivery within BCH, and we need to take the opportunity of a new collaboration with local schools to support delivery of our Public Health Plan and the wider Sandwell 2030 Vision.

5.2 19-20 contracts are not yet agreed. However, there is every reason to expect signature before year end with NHS England, BSOL CCG, and Sandwell and West Birmingham CCG. **The Annual Plan shows a material increase in expected income** in the coming year based on more accurate coding but particularly on treating more patients. In particular we are looking to offer a fast first outpatient appointment timescale, and betterment on the 18-wek wait time standard. NHS England remain committed to meeting the cost of specialist gynae-cancer care and the stranded costs of the solid tumour oncology service which moves to UHB, notwithstanding its planned return to site over the next fifteen months.

5.3 As the FIC report indicates, it has not yet proved possible to reach system wide agreement locally on **antenatal charges**, where care is shared between organisations, either for 2018-19 or 2019-20. Encouragingly settlement has been reached with Black Country colleagues in Walsall and Dudley, and work is concluding in coming days with BCWH and UHB. If we cannot reach agreement prior to the forthcoming FIC, then formal dispute will need to be lodged such that a conclusion can be reached before the accounts fall due.

6. Our regulators

6.1 We continue to work through with the **Care Quality Commission** last year's report into some of our services. Notwithstanding clarifications on the draft report and other discussions, we continue to implement the Improvement Plan that the Board agreed in November. Since we last met we have taken delivery of the new Resuscitation trolleys. The IQPR records changed arrangements around Mixed Sex Accommodation and work continues to certify Mental Health Act compliance and FPPT documentation.

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

7.1 The Board will be aware that the CCG is analysing and consulting on its future configuration. Notwithstanding national policy changes around the future of commissioning, GP members are being invited to consider the best way to ensure that firstly primary care and other services are integrated, and then secondly how the population that looks to the future Midland Metropolitan Hospital are best supported. The Trust's stated and public position remains that **only a wrap of organisation across Ladywood, Sandwell and Perry Barr can make sense** of those two obligations, and any move away from those arrangements before 2025 would have an evident and material impact on the Final Business case for the new hospital. When the Board considers that

Final Business Case at our public meeting in May, we can evaluate the risk to future delivery arising from these developments.

7.2 If we are to move forward as an integrated system without the need for a formal and long-winded procurement, the HLP Board has endorsed proposals to create Care Alliances by May 2019. That agreement is conditional on a series of agreements being reached between providers, notably Primary Care Networks, over coming weeks. The Trust has been asked to take forward a coordinating role in that work, and **resource transfer for 2019-20 equivalent to £650,000** is in place to support the delivery of improvements on a maturity matrix for both PCNs and the Care Alliances. What is important is that the how-model can evidently and credibly deliver the what-outcomes that the CCG and Local Authorities have proposed. It remains to be seen whether those outcomes are long-term objectives, and whether we can break free of a cycle of plan and re-plan that militates against innovation in tackling crises like childhood obesity or alcohol misuse in our community.

8. Other annexed items for attention

8.1 Safe staffing features as usual in our monthly Board report, in line with national guidance. We have completed analytical work on our agreed establishments (which exceed NICE guidance), our acuity analysis against the Shelford tool, and our assessment of wider needs including focused care. From April, we will integrate our approach to the latter two measures and ensure any red (1c) or purple (1d) assessed patient receives extra help and support. The advice from our Chief Nurse and wider nursing leadership is very clear: Our establishments are sufficient to meet a ward of amber (1b) patients, and tools like our seals, and expert support like our DDD team reinforces that. At the end of Q1 2019-20 we will review the experience of the first twelve weeks of the new year to test this belief. Prior to that our focus is on ensuring that those establishments are met shift by shift, and ***from April I will report very simply on how many shifts each month meet and how many miss the target establishment***. The changes that we are making to how we manage recruitment, sickness and temporary spend authorisation are all focused on ensuring that we meet our assessed staffing needs routinely.

Toby Lewis, Chief Executive
February 28th 2019

Annex A – Team Talk slide deck
Annex B – Clinical Leadership Executive Summary
Annex C – Recruitment scorecard
Annex D – Safe staffing summary
Annex E – ICS Board Minutes – January 2019
Annex F – Flu compliance statistics 2018-19