SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 4 April 2019

Chief Executive's Summary on Organisation Wide Issues

1. In January we had 12 P1 IT incidents and we had 14 in February. The actual downtime for IT systems is however transformed from this time last year, or indeed from six months ago. During April we will alter our N3 connection, albeit the Virgin link for which we contracted is delayed. At the same time we have made, and continue to make, server changes to improve our resilience and our capacity. I make no apology for commencing my first report of the new public sector year with detailed focus on IT. It is after all, the number one safety issue faced by the organisation in 2018-19, and the key risk to our ability to execute a very ambitious growth plan for care volumes and service productivity in the next twelve months. The replacement of the senior team in the IT function late in 2018 has brought renewed capacity and energy and that process will complete with final hires in the weeks ahead. Over £100,000 is being spent on IT skills training in our core function, and we have grown the turnover of the function by £2m+ for the year ahead. There can be doubt, nor let-up, in our commitment to succeed.

2. The underpinning work outlined is then the basis for putting in our Unity product (our electronic patient record), and the HIE connection to primary care that that permits. Some months after Go Live we will put in our Patient Portal giving local people access to their care records. We have almost completed basic training for our workforce now, and the Full Dress Rehearsal concluded in March. A 28-day QIHD "challenge" will kick off after Easter to further test and develop understanding within teams about what Unity will mean. We know that electronic prescribing brings immediate safety benefits, and the ability of the system to store and display historic information will make it easier for clinicians to work across teams and deliver good multi professional care.

3. Our patients

3.1 Our annual report in June will illustrate the work that we have done to learn from serious incidents in our care. As last year we will present that learning in the Board in May as we aim to make sure that we have taken each case seriously, and taken steps to address failings found. Locally, our CCG insists that pressure ulcers and falls with harm are considered under the SI protocol, and our recent summit meeting on those topics has sought to reinvigorate efforts to correctly assess and act on triggers for each admitted patient. Whilst the Trust compares well to peers and neighbours, we have more to do to consistently apply our own best practice. The Board discussed the culture of safety that we want to build in the year ahead, and agreed to focus time on how we learn from, and celebrate the reporting of, Near Misses. We will look first to the work that has been

done in Theatres on that culture since 2017, and bring back proposals to the quality and safety committee during Q1 on how we best build on that success.

3.2 Pleasingly, the CQC report, published later this month, will show that the Trust has eliminated all red ratings associated with safety. Nationally the safety domain shows a markedly lower set of ratings from the CQC than the other four domains, and in 2014 and 2017 we not only rated as requires improvement, but had red ratings associated with medicine and community wards. Whilst that analysis was not one we shared, the hard work of staff and local leaders now shows no such red ratings. We now need to migrate our acute care ratings for adults and children from RI to Good. We had hoped that projects in 2018 would show that gain, which is visible too in our safety plan data, but we were not able to convince inspectors of that, and so we need to re-double efforts to make progress, whilst recognising that outstanding acute care is contingent on the Midland Met.

3.3 It is over a year since we introduced Purple Point. This is our open access service to let anyone raise compliments or concerns directly with a seven day response team. The Quality and Safety Committee has reviewed progress, and the CQC and Healthwatch have also offered their view. Like any innovation it has taken time to build the brand and yet the data shows encouraging examples of problems solved for patients and for relatives. Changes for 2019-20 to our wider Complaints service will build on that success, as we shift our focus by Q2 from the speed of response to the evidence of long term impact. In 2018-19 we saw the number of disputed complaint responses fall sharply. However, unless we can address complaints about emergency care and about BMEC we will continue to see average response times above our very ambitious time target (which is faster than national policy dictates). The Trust's approach to the Friends and Family test has also changed in the last six months, and response numbers are climbing. By the end of May we expect to see the impact of those changes not only in our wards, but in maternity services and in outpatients.

3.4 At the end of April, a month later than we aimed for, we will go live with our changed reporting model for Imaging. This more than doubles our off site reporting capacity and is part of a concerted attempt to change Request-to-Report timelines in our Trust to become the fastest in the West Midlands NHS. I will report progress in my monthly report in an annex on the following metrics:

- Percentage of urgent A&E tests reported in less than one hour
- Percentage of inpatient tests reported in less than one day
- Percentage of urgent other tests reported in less than five days
- Percentage of all imaging work reported in less than four weeks

The Board decided in November 2018 to invest over £1m of new funds in this programme. Last week the Clinical Leadership Executive heard from Sarah Yusuf, our Group Director for Imaging, about the positive impact that decision was having on the whole department, when allied to successful recruitment in ultrasound, and in the new equipment which will arrive in summer 2019. Of course, the IT impact on imaging remains a major factor, and home reporting is an essential component of our sustainability plan. It is ironic that professionals outside the UK will have speedier access to our systems for reporting than staff living locally.

3.5 Against our 95% ambition for four hour emergency care, it would be wrong to view 86% as a success. However, it is clear that our 'February focus', and dedicated work since, is paying dividends. As a generalisation waits at City Hospital are now stable and daytime waits at Sandwell are too. We are operating as at April 1st with 15 too many beds and these will need to close before Easter. We have sustained improved discharge volumes at weekends, even as we have seen some fall back in 'stranded' patients above 100 days. In addition to good work on specific patient pathways, and the Council's important investment in 80 new beds at Knowle, we are bringing partners together in coming weeks to discuss No Recourse to Public Funds patients. Whilst modest in number the numbers are rising, and the effort required to provide safe onward care for these patients is significant.

4. Our workforce

4.1 The Trust has long been distinctive in achieving 100% PDR coverage. But in 2018-19 we changed our PDR model to create a more overt focus on objective setting, and a Trust-wide rating system for both performance and potential. In April, May and June 2019 we implement the second year of that system, and the post moderated data in July will show whether we have supported more colleagues to achieve the best possible ratings. The People and OD committee remains focused on whether we are fulfilling our implied promise to individuals with a potential rating of A. There is an interplay between this system and mandatory training, in that that establishes a ceiling level of 2 for non-compliant employees. Likewise, performance related pay systems such as the consultant discretionary awards system, will rarely look to invest in individuals rated below a 3.

4.2 In February we agreed, and reported to the Board, our renewed approach to flexible working. A formal routine data submission will be in place through Raffaela Goodby by the end of Q1. This is a first step towards wider work on a Just culture within the Trust. This programme has taken shape in a number of leading Trusts, most obviously Mersey Care, and is part of work we will undertake later in 2019 on our values and promises. It was also a first commitment within our **we**connect and Speak Up programmes. Our next Speak Up day is on May 1st. We had promised to make progress on IT, internal

communications and flexible working. The results of our dedicated staff survey on It will be available shortly.

4.3 Of course, valent factors in staff opinion will vary. Hygiene factors like car parking are very important to some staff. And of course to patients. We continue to hold our prices steady and have latterly published our staff tariff expectations all the way through to 2021. By then we will have had five years of freeze and with the new car parks opening are able to justify a better offer and a changed price. After considerable internal debate the pricing structure will drop prices for our lowest paid staff and raise rates for others. But in the meantime, we introduce Pay-As-You-Go tickets to support people transferring to public transport. The build of the new multi-storeys does mean that we can end the risk to local residents of on street overspill. On the other hand it means eighteen months of non-voluntary relocation of some staff car parking from Sandwell to New Square.

4.4 We have made continued progress into the high 90s for mandatory training. Work continues to simplify the system and to make it easier for staff to complete their training. Our focus on basic life support has helped, and likewise on information governance. We note that nationally there are renewed moves to introduce more mandatory training, and we will continue to monitor the time-load required to deliver the overall programme. Linked to this we are currently undertaking an analysis for ward nursing of the "off roster" time that we allow. Establishments are set with a 22% gearing, we want to track quite precisely all commitments against this allowance beyond annual leave. This will support ward leaders in making sure that the collective training, communication and development ask of our shift based nurses is actually achievable in paid time. We will then look to ensure that that time is indeed rostered, so that we are confident frontline staff do have the allowance they need to keep up to date.

4.5 The Trust now includes school nursing. This symbolic transfer for Sandwell brings together all nurses looking after children into one team. We will work closely with both the Sandwell Children's Trust and the local mental health Trust to make sure that together we make best use of our collective resource. There is all-party recognition of the public health needs of children and young people in the borough, especially the psychological wellbeing issues that they face, and we want to ensure we work together to make discernible and measurable progress as part of Vision 2030. At the end Q1 we will organise an event for the Board to meet with our new school nurses to hear from them what the transfer and joining experience has been like, and their ambitions for the future.

5. Our partners and commissioners

5.1 £423m of contracts for 19-20 form nine-tenths of our service income for the year ahead. Signature has been achieved on the local contract with Sandwell and West Birmingham

CCG. The contract seeks to balance risk and reward and move us closer to "one system" within our ICP. In particular the contract provides for the Trust and GP partners to work to find patient suitable alternatives to review outpatient attendances. This is in line with our long term strategy, contained within the Midland Met business cases in 2015-16, to alter the shape and scope of outpatient work locally, not least to release medical workforce into acute care. The key contractual matter needing resolution is proposed price changes which would necessitate the closure of neonatal cots, but we expect that, as last year, that dire step can be avoided. The Trust is investing in our neonatal unit, with a major capital refurbishment, and additional staff to confirm BAPM compliance.

5.2 In common with partners we continue to publicise and share the WB&BC STP clinical strategy. Following the Long Term Plan this sets out a series of areas of focus based on key public health outcomes or key disease areas where the next decade needs to see changed results. In some cases this necessitates implementation of consistent best practice. In other cases better targeting of care to vulnerable or excluded communities. In common with the Board's wider discussion at its last meeting, it will be useful to be quite direct about where the evidence if implemented can confidently drive improvement, and those areas where there is a risk that efforts do not, even if delivered, offer a clear prospect of treating the underlying difficulty. The same point, writ small, applies to our own amenable mortality efforts. The best resolution to these complexities remains risk stratification of populations, typically at the scale of 30-50k. This is why we have long been focused on our primary care partnerships, and with the HIE coming into place, we can develop a credible offering in this space which offers a real prospect of matching need to service.

6. Our regulators

6.1 We kick off from April 11th engagement with the incoming CQC team for the area, pursuant to publication of last year's inspection report into Trust services. The outcome of that inspection will be published on April 5th and sees modest progress since 2017. With the evolution of the CQC framework, we will invest to make sure that during 2019-20 we are reporting routinely against their data-set, and that we have built a good mutual understanding of the strategy and systems of the Trust to facilitate re-inspection in 2020. No enforcement notices are issued although the language of legal breaches and minor breaches may convey a different impression. The headline remains as before, which is that our Trust is rated as Outstanding for Caring. We have room for improvement in other domains, with acute care for both adults and children needing the most continued attention.

6.2 The Trust has reported over 90% IG Toolkit compliance in the last two years. Post GDPR the arrangements for reporting have changed, and we are working through the distinction between mandatory and developmental standards. We are unlikely to report

full compliance in that context and will use Q1 to agree an improvement action plan with NHS Digital.

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

7.1 The completion of Midland Met is a key shared objective of the STP. The ICS supported our interim capital bid, and the founding documents for the STP establish the proposition as one of the key changes to be made locally over the next five years. Indeed the BC&WB STP is distinctive in having an agreed plan to reduce the number of A&E departments within its footprint, in our case from five to four. At the same time, the approval of Outline Business Case by DHSC and HMT in autumn 2018 made it very clear that the expectation of national policy bodies and regulators was that the local system worked together to deliver the new hospital, and shaped emerging policies and approaches with the purpose of the single acute centre as a fixed point. The Trust has consistently reinforced this instruction since.

7.2 At the same time, Midland Met is a key jigsaw piece in the local integrated care partnership for 700,000 people within the SWB system, most of who live within the SWB CCG. By defining acute care onto a hot site, we liberate inter-dependent care capacity in Sandwell and in western Birmingham. The sites are indivisible in how they work, and will then work in partnership in general practice and community pharmacy, as well as with mental health and local authority teams. There will be examples where services need to be shaped directly around Midland Met, like liaison psychiatry, and examples where services will diverge to local need but will need a 'postcode blind' model where they interact at the bedside in the new build. These changes are deliverable but are massive. Typically NHS hospital moves and builds over-invest time in business case planning, and under-invest time and effort in this operational alignment, trial, error and development. Yet it is this which will mark success on day one.

7.3 Against this back-drop the Trust has taken important internal finalisation steps in recent weeks. Work is intensifying around changes to hospital paediatric services so that by 2020 we open an integrated paediatric assessment and A&E facility 24/7 for children at City Hospital. In parallel we are supporting acute medicine through the planned reconfiguration of inpatient respiratory medicine. Finally we are developing final proposals around haematology, and linked to that solid tumour oncology including the return in 2019-20 of the outpatient and chemotherapy functions that relocated to UHB-QE. Each of these changes, and others to follow, are about bringing together the teams who will be co-located and working differently in Midland Met. This is consistent with our determination to not have new ways of working starting fresh on day one, but to have formed the habits of change before we relocate into Birmingham's newest hospital for over a decade.

7.4 We discussed at the Board in our last two meetings changes proposed in commissioning models across the area. SWB CCG has commenced their formal process of future configuration deliberation. That process will shortly include consultation with statutory partners. The Trust is also involved as a GP provider and accordingly a member of the CCG itself. There are, we understand, three options, two of which maintain the cohesion of the population of Sandwell, Ladywood and Perry Barr. The third option, divides western Birmingham from Sandwell.

It remains our strong view that any such hard border proposal is a red rated risk to the coherence of the Midland Metropolitan Hospital business case. This is because such a division of responsibility will necessarily drive divergent clinical pathways for the same population using the site (indeed that must be the point of the proposal). This risk could be mitigated by the creation of a vertically integrated capitated budget for the western locality, as envisaged from 2021 in the Healthy Lives Partnership model, but this is not yet supported by other partners. We understand that general practice opinion is to be tested, with initial indications suggesting that the extant configuration makes best clinical sense. That is welcome.

It remains unclear what problem or issue the reconfiguration of commissioning boundaries would be designed to solve, and the Trust reserves the right to commission external analysis of any future change proposals. The timing of this debate is problematic, with the Midland Met Final Business Case due back for approval at the May Board, which is the latest possible date on which the extant build programme can be maintained. As such the Trust will write now to GP colleagues and statutory partners setting out our grave concerns, which are widely known, and the risks created by the continued uncertainty. The position is clearly a very disappointing one, given the ostensive commitment of partners to the delayed completion of the site. Paulette Hamilton, chair of the Health and Wellbeing Board in Birmingham has given both public and private commitments to ensure that no changes are made that would harm to development of the Midland Met, and that position was re-stated and re-affirmed at recent Council Cabinet meetings.

7.5 The Board discussed last time we met progress with our collaborative Pathology vehicle. Black Country Pathology has made progress with recruitment, notably in Histopathology. During the first six months of 2019-20 there will be a significantly increased expectation from the Trust, and presumably other partners, around test turnaround times, as well as work to develop specialised pathology services, the income from which is the basis for any capital investment in a laboratory at Sandwell after the move to Midland Met. Before the end of April, we will communicate formally expectations for the partnership for October 1 and March 31, such that we move from the initiating phase to a maturing commercial and operational relationship of expectation and delivery.

8. Other annexed items for attention

8.1 As outlined in my last report, from April we will report compliant and non-compliant shifts to ease an understanding of our safe staffing picture – at the same time putting in place the wider workforce scorecard covered in the Board's papers. The latter will replace the recruitment scorecard previously appended to this report.

8.2 Since the Board last met we have joined NHS Improvement to review our implementation of changed single sex dignity oversight. We removed the agreed NHSI and CCG assessment unit exemption from the end of 2018, after discussion with the CQC, and so have been reported more breaches of the standard than before in Q4. We expect to enter April fully compliant with policy and the review commended leaders and employees for their passion in ensuring that the dignity of our patients was the focus.

Toby Lewis
Chief Executive

March 30th 2019

Annex A – TeamTalk slide deck
Annex B – Clinical Leadership Executive Summary
Annex C – Safe staffing summary (18/19 format)
Annex D – ICP/HLP Board Minutes – March 2019