SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 2 May 2019

Chief Executive's Summary on Organisation Wide Issues

1. Our 28-day engagement 'challenge' around Unity has now started. The Board's Digital MPA has agreed the go-live criteria for the product, and the Clinical Leadership Executive has agreed the Optimisation programme which is the essence of our benefits realisation. Over the next four weeks we need to make progress with our HIE and our plans for a patient portal, whilst completing technical readiness work which **hinges on the replacement of our N3 connection**. There is every reason to be optimistic that this summer we can deploy – replacing our old IT systems, introducing electronic prescribing, creating visually useful chronologies to save clinicians' time. In terms of our Q2 work as a Trust, this deployment will be all-consuming. The opportunities are huge but the risks are real.

2. Meanwhile, we remain on track with the Early Works Contract for Midland Met. Our bid process is **finalising a Final Contractor proposition from Balfour Beatty against our specification for quality, price, risk and time**. This will be incorporated into the Preferred Bidder Final Business Case later in May for Whitehall approval in June. The Board requested a sensitivity to take account of the west Birmingham issues raised by the CCG boundary consultation. That additional cost proposal is being finalised presently. That cost would be borne locally.

3. I am pleased to confirm on time and on budget submission of our 2019-20 annual plans. In addition, as the papers record, we ended 2018-19 having bettered our control total, and **reduced by a third our underlying deficit compared to March 2017**. A PSF bonus of £12.5m, which is cash backed, assists our forward plans.

4. Our patients

4.1 For over a year, the full Board has had an unremitting focus on the elevated mortality rate for the Trust, a position that has grown over time. We reviewed again last month with expert NHS Improvement advice, whether our plans were sufficient to address the evaluative and improvement issues we face. SHMI, HSMR and RAMI data continues to be published, and we would expect upcoming data releases to show improvement. It was clear that in addition to our work on Sepsis, and the new work on Pneumonia, we need to continue work on coding, on ambulatory care exclusions (our huge growth in this coincides with comparative mortality deterioration at the Trust), and on admission codes – in each case ensuring that what is coded is true. Next month's Quality and Safety committee and Board will review **next step plans for our Quality Plan for 2019-20** which takes us beyond simply a focus on the mortality related measures. At the same time, the

bi-monthly performance review process will include testing local operational implementation of changes relevant to mortality, including acting on sepsis screening. The Unity product will give us better and more immediate data, more directly linked to specific clinical teams and pathways.

4.2 For June's Quality and Safety committee we will set out expectations around **safe prescribing** and medicines, as a key benefit for 2020 from deploying Unity. As part of our integrated care work we continue to focus on medicines reconciliation work, especially for older and housebound patients. Tenders for commercial partners to operate elements of our pharmacy services are being finalised so that we bring the very best experts to bear on our future models of care at Rowley Regis, Sandwell and by the BTC. The pharmacy developments will also offer a retail and amenity benefit for staff and visitors.

4.3 We have been working for some months in our **imaging position**, both in terms of waits and in terms of results acknowledgement. A key part of individual clinical portfolios in 2019-20 will be the expectation of individuals acknowledging <u>all</u> test results. I report in an annex on the following wait metrics, in advance of the changes in which we have invested:

- 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

4.4 I reported four weeks ago on the **improvement in emergency waits in March**, when compared to the prior four months, and also set out the deterioration in very early April. That deterioration has continued through the month, with around 300 additional patients attending per week, and rises in admissions. At the same time our discharge profile has worsened, including some fall back in our over 21-day position. There continues to be issues of unplanned readmission as well. Our deterioration is reflected in that seen at other neighbouring Trusts. Given what appears to be 'spring pressure', we are revisiting our immediate Q1 bed plan, that for the summer, and firming up our plans for the winter, for which we have provided additional funding in our budget. The first of these three plans is in effect directly operational, but the credibility of the latter two would benefit from testing by a cross section of Board members. I would suggest we discuss how best to achieve that. Important projects like a Good Night's Sleep, due for go live in June, will lack credibility with staff without a change in the present profile of pressure on beds, especially at Sandwell.

4.5 During May we will start a new pilot project which seeks to link better our adult community services to our inpatient acute care system. Specifically, all patients discharged locally from our beds will have **contact with our community services** over the

first 48 hours after discharge. For less complex cases this contact may be simply a telephone check-up, for others direct visiting or signposting. This pilot aims to both understand the discharge experiences of our patients through their eyes, and create a chance to coordinate onward care. By including changes such as post discharge blood results in this 'interface' work we aim to save some hours of delayed discharge as part of a shift towards more morning discharges from our wards. The LACE tool that we used some years ago to tackle readmission risk will also form part of this project. Outwith this over the next four months we will look again at the volume of community contacts our patients have with both our services and those of partners to see what might be done to better coordinate, streamline or reduce that variation – our HIE should assist with that work.

4.6 New leadership joins our paediatric management team in May and June. At the same time we are finalising our reconfiguration plans for later this year, to move acute paediatric services within the City site and establish a 24-7 children's A&E function. This function is a Midland Met promise, and rather than delaying that offer we want to introduce some improvement in 2020. With that in mind, **we will focus time at the July Board meeting on children's services as a whole at the Trust**. One in six of our patients in any given year are under 18, and a significant part of the communities we serve are among the youngest populations in Europe. Part of the shift in care and in spend that we want to contribute to within the Healthy Lives Partnership is around childhood wellbeing, both psychological and physical. Our school nursing teams are now embedded for Sandwell, and the Board will hear from those teams during Q2 about their suggestions for re-design – a re-design we are looking to take forward with partners from the Black Country Partnership MH Trust and with the borough Children's Trust as well.

4.7 Finally, the Trust has contributed to the launch of the **West Birmingham and Sandwell Air Quality partnership**. This brings together the upcoming Sandwell consultation on air quality with implementation plans associated with Brum Breathes and the January 2020 Clean Air Zone (CAZ). As an employer, as a purchaser, and as a care provider we have much to contribute to this key public health initiative. Both our community respiratory teams and our hospital physicians are involved with the project, because we need to be candid that this is a life expectancy programme. Deprivation and poor air quality correlate, and the outcomes that follow from that are the outcomes we are seeking to change.

5. Our workforce

5.1 The second of four annual **we**connect surveys has now been analysed. The Board will recall that in July 2018 we committed ourselves to **a major programme of employee engagement**. We have partnered with Wigan, Wrightington and Leigh NHS Trust to do this. Over a dozen Trust employees have been trained in their approach and our first ten

Pioneer Teams (covering almost 500 employees) start their 26-week programme in June. That bottom up improvement work has been matched by corporate-wide change on management communication, IT and flexible working. The data on our pledges on the last matter comes back to the Board later in Q1. There is a very positive upswing in emphasis on these issues, and there are clear changes in both management approach and employee involvement. Our latest Speak Up day takes place on May 1st. During May our new manager's code of conduct is being consulted upon, ready for the Leadership Conference in June.

5.2 Our second survey reached our target response rate of 35%. This compares very well to peers and is nearly double what we were achieving with our Your Voice product. 36% is up from our first survey response of 28%. It includes better penetration into clinical teams, but also very strong representation from more junior staff and from ancillary functions. In both surveys we achieved **an overall engagement score of 3.86/5**. This is halfway to our very ambitious goal of 4/5, against our average engagement score of 3.7 in the annual NHS wide survey last year. Of course specific challenges around estate TUPE, smoking and car parking, as well as major projects like Unity, could sap these results. But more positively if we have built engagement alongside those disruptions we may sustain our position better. It will be really important during Q1, Q2 and Q3 to evidently deliver on the action plans published by directorates in response to each survey. These have been profiled in Heartbeat and Group Reviews will test delivery.

5.3 Elsewhere in the Board papers we discuss month one people plan delivery. The new bi-monthly Board People and OD committee will place a clear spotlight on the **quantified scale of changes being accomplished** and whether we are strategically reshaping our workforce to reflect the skills we need and the demographic profile that our population requires. This will and must include progress on diversity, and our latest Gender Pay Gap data has been published.

5.4 We have agreed to ensure that we are making material **progress to close our vacancy gaps**. By mid-May it would be extremely disappointing if every vacancy funded in our budget was not at internal or external advertisement. By the end of Q2 we will then need to assess which roles have limited prospect of being filled, and what path of workforce re-design is then necessary. We continue to collate safe staffing data for our key nurse-based services. As I described last month, overlain on that we are now tracking how many shifts each month were at or above our establishment. *Before* mitigation by our nursing leaders (which takes place on a daily basis) that position was just above 75%. Over the course of the year we need to see that figure rise sharply. It will not do so unless ward based sickness rates fall significantly.

6. Our partners and commissioners

6.1 **We have closed contract signatures for 2019-20**. We did so without arbitration at around £4m less than our submitted plans. The contracts show growth against outturn, and if we achieve our widely discussed localisation plans, will reshape the pattern of care in our local community in line with the 2015-16 Midland Met FBC. Taking pressure of neighbouring hospitals is part of the promise of the new build and we are testing those changes in advance of opening. By mid-May we will have agreed our CQuin plans with the SWBCCG, and at the end of Q2 we can assess with BSol CCG whether their QIPP plans are delivering in practice. Any move to create an ICS-wide single control total in 2020-21 within our extant STP must reflect efficiency, not deficits, or it simply locks in current practice. Our own FBC and Long Term Financial Model removes our underlying deficit by March 2021.

6.2 Educational partnerships are a key and important part of what we do as a Trust. We have historically been the highest rated University of Birmingham provider for medics, and are the founded partner for the new Aston Medical School from which clinical attachments commence in 2020. At the same time as we work through plans for Midland Met in 2022 we need to ensure the right alignment with our existing nursing schools. **A formal process of Board level partnership review with each medical school** will take place over coming months. The intended output is, in each case, a formal bilateral strategy which sets out mutual obligations. We are progressing conversations with Birmingham Health Partners in parallel with this work.

7. Our regulators

7.1 Three **engagement events with the CQC** take place in May as we look to build the right collaboration on the back of the 2018 report. Registration applications associated with patient transport services and our primary care functions are separately ongoing. By the end of Q1, as we agreed last month, we will be routinely sharing the CQC's data view of our Trust through our CLE and private Board. It is clear from the emerging CQC strategy documents that centrally collected and monitored data will play an increasingly important part in their approach, alongside on-site inspection.

7.2 Changes across **NHS England and NHS Improvement** continue to be implemented. In addition to Dale Bywater, a director team has been appointed and announced, with the current exceptions of the finance and strategy roles. Julie Grant, hitherto our NHSI portfolio link, has been reconfirmed to that role for the merged organisation. There is a clear commitment from Dale to a style of engagement consistent with a more strategic focus derived from the LTP. It will clearly be important that the Trust/place/STP/regulator interaction has a golden thread. A series of 2020 and beyond documents are expected late in the summer including the forward financial model, and our own STP five year plan. With that in mind, we are hosting an STP-wide event about

Midland Met at the end of May, and will contribute to a joint planning meeting with BSol in June.

7.3 At Annex E I summarise progress against the ten promises that we made to the regulator in October 18-19.

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

8.1 Since the Board met last, we have hosted engagement events with community leaders from Perry Barr and Ladywood at Midland Met, and co-led a Sandwell alliance event to consider whether a collaborative non procured place based partnership is possible locally. I will update the Board orally on work to align Primary Care Networks, with Care Alliances, and with **the important 2030 vision for the borough**. The independent chair for our local partnership has been extended, having evidently contributed to better working between health partners in 2018-19, when compared to the non-contracted 2016-17 period, and the requirement for the GE report into the local system.

8.2 We discussed last month the current engagement, or consultation, on **the CCG boundary**. Positions have perhaps regrettably hardened, with the Overview and Scrutiny Committee of Birmingham City Council publishing its initial view, absent discussion with either the CCG or Trust leadership. The process remains ongoing, but it is increasingly clear that there is a division of opinion between those who consider that this decision is in effective either reflexive or ideological, and those who might wish to have written options put before them and appraised. No such written options presently exist and an EIA and QIA are in draft form. If this decision is important, and we have considered that it is, then the latter approach of appraisal must have merit, and if the initial outcome of the process is divisive, then we need to consider how best to bring partners together and to undertake calm evaluation, including meaningful public involvement. That is why we have indicated publicly that we are now perplexed by both the proposal and the process. GP alignment should not be considered in isolation from other elements of the care pathway or system, and patient postcodes should not be confused with practice postcodes. Integration is about patients and about caregiver relationships, not statutory organisational borders.

Toby Lewis
Chief Executive
April 25th 2019

Annex A – TeamTalk slide deck for May
Annex B – April Clinical Leadership Executive summary
Annex C – 2019 imaging improvement indicators – April MTD
Annex D – Safe Staffing data including shift compliance summary (first draft)
Annex E – Summary of Trust/NHSI mid-year promises