SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 6 June 2019

Chief Executive's Summary on Organisation Wide Issues

1. In September 2019 we aim to go live with our Unity electronic patient record. At the same time our HIE connection will create visibility of patient details and information between our teams and local GPs in Sandwell and the west of Birmingham. Within nine months we will open our Patient Portal, offering access to your data to you, and those who you choose to share your details with, for example your family. The project is a huge opportunity and it is evident that we are increasingly well prepared. Over the next 100+ days there are hurdles to cross in terms of readiness but with almost all employees trained and the majority of our technical dependencies in place or imminent I used our June 4 Leadership Conference to confirm our intention now to proceed.

2. In less than one month's time we go live with our 71st birthday Smoke Free sites. Visitors, staff and patients will not be able to smoke anywhere on our sites. Vaping will be supported in our grounds and nicotine replacement patches will be suitably but widely available. Implementation will be supported by dedicated wardens, our security teams, video cameras and leaders across our Trust. We are absolutely clear that healthy lungs and the wealth that comes from quitting cigarettes are both worth having. With 12 months' notice and very high awareness of our plans we have been fair with everyone. July 5th 2019 marks a huge moment in the public health of our communities.

3. Our patients

3.1 The IQPR shows progress with reducing our elevated mortality rates. This reflects the focus on this subject shown by the Board and clinical leaders for twelve months. That focus continues, both with our work on end of life care, and the taskforce examined deaths from pneumonia. Last week for the first time we achieved a Sepsis Screening rate of 95%, and all deviations are now investigated as Incidents of potential harm. Sepsis was, and remains, our number 1 Quality priority. The implementation of Unity referenced above gives us access to NEWS2, which is a more appropriate and sensitised tool with which to manage risk.

3.2 As last month I annex the current position with end to end waits for imaging in the Trust. By late July we expect to achieve 90% compliance with region leading turnaround times. As NHS Improvement gets ready to launch the idea of Imaging Networks, we need to ensure that any future collaboration levels up standards for our patients and partners. At the same time, our progress tackling results acknowledgement omissions is too slow. David Carruthers has set out at the Clinical Leadership Executive as very clear expectation of individual clinicians and teams. These expectations also feature in the Unity

Optimisation criteria agreed with the Board. From July formal approaches will be taken to any individuals operating in the lower quartile of non-compliance.

3.3 I reported last month on the launch of our innovation project to 'bridge' the potential gap between hospital and community care – by undertaking telephone triage follow up with all discharged patients from adult inpatient services. The work so far shows around 40% of discharged patients will benefit from additional community support. From Q4 we will work with other local community providers to aim to expand this service offer to any SWB patient discharged from our care. This will become the common standard for local residents and an expectation around anyone treated within Midland Met.

3.4 May has seen some improvement in our emergency care waiting times at the Trust, close now to the STP-wide norm, but short of either our trajectory for improvement or the standard. Key to that has been some stabilisation of arrival numbers back to plan. Within our private board meeting, in order to benefit from all clinical leaders' input we discuss the balance of improvement and investment needed for this coming winter. That will be made against core commitments that the Board has led such as a Good Night's Sleep and our revised Mixed Sex Accommodation policy. Moving into autumn must see a reduction in 'overnight bed moves'.

3.5 At our Board in August we agreed to focus time on Infection Prevention and Control. The Trust is the leading performer in the Midlands for c-diff reduction, and remains strong on a number of nationally reported indicators including MRSA. Equally last year's CQC report identifies observed hand hygiene weaknesses, and we have agreed that NHS Improvement will visit us later in Q2 to examine our plans and improvements. Having invested in better cleaning equipment for our ward service officers late last year, we are now examining how we can use technology to both prompt and test visitor and staff compliance with our bedside infection prevention expectations. We would want Midland Met to be a beacon for infection prevention practice.

4. Our workforce

4.1 The major priority that we have set for 2019-20 is to move decisively towards our Fully Staffed ambitions. In setting local plans with each team we identified a vacancy rate that was considered tolerable and affordable. Movement to that requires over 1,000 hires to be made. I annex the latest advertisement position, which shows around 400 offers extant, and a reducing number of unadvertised roles. There is a palpable change in the drumbeat of our organisation around recruitment, and that beat will intensify in the weeks ahead. By the time of October's Board People and OD committee we would expect to have assessed the success of our efforts and identified those roles where ongoing recruitment shows a low prospect of success. Those roles will then be subject to role re-design with the input of expert advisors including HEE and our partners within the

LWAB. With rapidly improving employee morale and engagement, and strong educational partnerships we are well placed to outperform others in retention and recruitment. That said, we want to bring new hires to the area, not simply compete with neighbours. As such we have supported the pooling of some educational funding across our STP designed to level up across our care system.

4.2 Having undertaken our new-style Group Reviews in May it was very clear that we have more work to do to embed the changes in approach to sickness management that the Board debated and agreed in late 2018. Raffaela Goodby will lead a 'turnaround style' project to seek to remedy this over coming weeks, such that we can make progress in 2019 towards our aims to reducing long term sickness absence below 140 individuals a month. We have agreed to introduce pre-emptive stress assessments, to approach psychological ill-health absence differently, and to target temporary redeployment options for MSK absentees. The grip of those three changes needs to become evident at frontline level, alongside focused efforts to reduce ward nursing sickness and ED non-consultant medical absences.

4.3 PDR implementation continues at pace against an aim to complete over 95% of reviews by June 30th. The remuneration committee will consider both our 2020-21 approach to performance related pay and recommendations in respect of EBAC awards for doctors, following the committee for 2018-19 that I chaired ten days ago. We have agreed to ensure that our elite performers rated at 4a are clearly supported to develop and improve further, and CLE as discussed how that will operate.

4.4 There has been considerable concern raised nationally and locally about the impact of pension payment changes on retention among senior medics, and other better paid staff. National guidance is awaited and our remuneration committee will consider proposals already in operation with Royal Wolverhampton and University Hospitals Birmingham.

4.5 The Board is familiar with our escalator programme, which is active both in our band 5/6 transition, and in taster programmes in areas like critical care. After very longstanding discussions with Staff side colleagues and others, we will reaffirm our commitment, not later than October 1 2019 to have in place a clear skills/banding escalator for band 2 and 3 HCAs. This will remove the anomaly of band 2 staff trained to band 3 level being denied the opportunity to then exercise their skills locally. As a Trust explicitly committed to nursing associate roles this development makes sense, because it develops a single route for personal development that allows people to grow in situ rather than constantly needing to seek to move team.

4.6 In October we will host our annual Star Awards ceremony. Nominations for our awards close at the end of June. Alongside our new Star of the Week Award these are key moments of recognition in the Trust. Beyond that we do have local schemes, and the

welcome publicity of the Sandwell Chronicles' Hero of the Week, which we began in 2014. I would also draw attention to our increasingly active 'Shout Out' project on connect which allows peers to celebrate small acts of kindness or excellence. Within the welearn programme, we will implement later in 2019 Learning From Excellence designed to help our organisation to take on board lessons from our own best practice, as well as the learning from error which is the more routine NHS wide model.

5. Our partners and commissioners

5.1 A very productive set of discussions have taken place since the last Board with UHB colleagues in respect of oncology services. The shared aim remains to return local clinics and chemotherapy to SWB sites in 2020, and sooner if we can. A joint proposal nears finalisation, which will see us begin to return services to the Sandwell site first. Accommodation plans for the city site are being developed presently. Once Midland Met opens our main haemato-oncology ward will be separated from our chemotherapy services, and for that and many other reasons we remain focused on the Acute Oncology Service locally. The nursing service is larger than in many peer Trusts because of our own investment decisions, and we continue to benefit from NHS England funding for medical time. We would expect to make near final proposals for the future to the Board's quality and safety committee in late July.

5.2 The Board is well versed in current discussions over the future shape of commissioning. By April 2020 we would expect to see a single CCG operating across our STP, with some of the functions of CCGs moved into place based alliances. There is an STP-level recognition that changes like capitated budgets have implications for how commissioning develops, as do long term contract expectations. On June 18th local GPs will be voting on the options associated with the SWB CCG boundary. The Trust has, in line with our public debates, put forward a strong preference for Option 1, which retains all local services within a single STP footprint. This position is also supported by partners within the Black Country and West Birmingham STP. The potential risks and costs of CCG disintegration are set out in the Midland Met FBC that the Board is invited to approve in its meeting.

5.3 The CCG has now approved a future configuration of Primary Care Networks for both Sandwell (10) and West Birmingham (5). All PCN leaders are working closely with the Trust, and the Healthy Lives Partnership is seeking to develop a joined up approach to PCN and Alliance development. Of course the Trust will work differently with different PCNs, and our approach to most GP conversations remains to ground our shared ambitions in population health analysis. The Trust is supporting some Primary Care Network Accelerator funding bids.

5.4 The Trust continues to work with NHS Blood and Transplant colleagues on our Organ Donation offer. New team members have joined that programme, and Sarindar Sahota

continues to chair our committee overseeing that work. A presentation of progress at mid-year will be coordinated with the Quality and Safety Committee chair.

6. Our regulators

6.1 Since the last meeting of the Board we have received CQC confirmation of registration approval for our GP practices and other changes associated with patient transport provision. We have also held good engagement discussions with the new CQC team, who, among other activities are likely to attend our August Board meeting and some of our October Board committees.

6.2 The quality surveillance group of regulators continues to place the Trust on routine monitoring (not elevated), and our engagement with NHS Improvement is also consistent with good performance. The framework to be used for Trust assessment in the new NHSI/NHSE world remains in development, and as such our focus remains on extant metrics alongside those in our undertakings. We are likely to undertake a Developmental Well-Led self-review in Q3, which will examine our position against the CQC well-led KLOEs and take a view on our delivery trajectory for the formal undertakings.

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

7.1 Feedback is awaited from regulators on the collective 2019-20 plans submitted through our STP. The wider Midlands region faces financial pressure in some other health economies and subsidy has been sought from other economies, including our own, to manage that distress. As an in year position, my own view is that that is manageable, but through the STP we will seek clarity on the longer term solution. The STP partnership is working closely with colleagues in Birmingham and Solihull on issues of mutual interest, and a similar collaboration into Staffordshire will also be needed.

8. Other matters of operational grip

8.1 We have discussed the need to ensure that we are tracking accurately our ward staffing and our community team staffing. Paula Gardner outlines in annex D the process for that, and work to be done in June to micro-study the red shift gaps that can be seen on e-roster. Within the constraints of the IT product, we want to prospectively and retrospectively accurately record the staffing we have in place. We have worked hard to set establishments that are reflective of acuity, and are above in most cases NICE guidance. We have gaps because of sickness, gaps because of vacancies, and gaps because of poor roster practice: Collectively these amount to a 25% red rate prospectively, which actions mitigates to below 5%. The poor roster practice can be immediately eliminated and this would then reduce the reallocation workload. Work on sickness rates and vacancies is known to the Board.

8.2 The finance report shows that we met our planned obligations in month 1 – with underspends on expenditure offsetting income deficits (sometimes because of pass through, but not typically). The Board is aware that whilst we have stepped up volumes of activity we are behind with the production plan with a plan to catch up. Having reconciled information used within the Board in May, it is important to clarify some mistakes made:

a) The *planned* activity phasing shows a Q1 discrepancy of about £974,978 between our budget book and our operational plan. We expect to end Q1 £316,978 below our operational plan, albeit in June above both budget book and operational plan.

b) There is a £978, 055 net *adverse movement* between the overall income figures briefed on May 2nd and our current expected month 1 outturn. Adverse movements were £358,217 from a difference on pass-through costs. There is, as above, £423,978 of planned care movements, and £660,784 of emergency and other contract shifts. The first two figures should not raise a concern – the last reflects low acuity emergency admissions and a calculation of full year risk is being made.

c) The agency hours briefing did not accurately capture a full month's data and as such understated usage. April showed some, but far less, improvement on March of c1000 booked hours, and May shows a deterioration which may reflect holiday rostering. Before unlocking it shows 30, 432 hours at a cost of £1,378m. Current expenditure trend is not consistent with the Agency Cap for 2019-20. A revised H2 operational plan is being finalised to reflect recruitment plans and to understand how we will operate with below £600k of monthly agency spend from October. This will be grounded in a weekly People PMO analysis.

We will provide an oral update on both May actuals and June expected data.

Toby Lewis
Chief Executive

May 29th 2019

Annex A – TeamTalk slide deck for June
Annex B – May Clinical Leadership Executive summary
Annex C – 2019 imaging improvement indicators – May MTD
Annex D – Safe Staffing data including shift compliance summary