SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 1 August 2019

Chief Executive's Summary of Organisation Wide Issues

1. The countdown to **our new electronic patient record**, Unity, continues. Staffing rosters on the basis of the change are being finalised this week. The criteria set by the Board continue to be scrutinised at local and organisational level, and there remains work to do on both technical readiness and especially people and operational readiness. It is crucial that the Board maintains an overwhelming emphasis on Optimisation of the product in the weeks after go live. It is through that smart use of the new product on a 'herd' basis that we will deliver the benefits of improved systems, with better prescribing and medicines data being the single biggest gain we will see. Our Patient Portal will go live in March or April 2020 and is a huge opportunity to fulfil the spirit of our wider 2020 Vision to put control in the hands of patients and their carers.

2. As the Board discussed last time we met, our work to deliver the public health improvements that our communities need remains a focus across the organisation. Our Smoke Free launch on July 5th was largely successful and that success has been sustained since. In coming weeks we will work to ensure that momentum is maintained. In late September we expect to have finalised **our wider Obesity strategy** (best you?), working with others over the short and longer term to address this critical issue, especially for children and young people. Unity Go Live brings with it the re-launch in earnest of our Making Every Contact Count brand. That re-launch will, of course, illuminate again real differences in the preventative health offer between Sandwell and western Birmingham, and discussions with local authority partners continue to try and find a levelling up approach common to both.

3. Our patients

3.1 Whilst our IQPR shows some renewed red indicators on re-attendance rates, and a one off dip in theatre cancellations, it also illustrates a broad pattern of comparative success. **Wait times** for operations and for clinics, for diagnostic tests and for cancer care, are at the forefront of the region's healthcare. There is no room for complacency and there is work to do on the experience of clinical administration (my wait was short but felt long). However, as we both see and seek rising referral demand, and look to localise services into the Integrated Care Place (ICP) this is a positive platform with which to end quarter 1. Our Achilles Heel against NHS constitution standards remains the four hour standard, where per site monthly data still averages only just above 80% YTD. NHS Midlands have reviewed our plans and our deployment and more clinical expertise will be made available to support our frontline teams in adopting best practice in the management of clinical risk and flow.

3.2 In support of our **sepsis** priority we are now providing daily data to clinical teams on sepsis screening compliance, on treatment times, and on the proportion of their patients receiving treatment inside sixty minutes. There is real momentum behind this work and we as we move to electronic prescribing we will see further pathway gains. Expedited work on PGD guidance to support nurse prescribing will go into place over coming weeks, with the Trust benefitting from what appears to be one of the largest cohorts of nurse prescribers anywhere in the region. At our October Board meeting we will review Sepsis progress and will work before then with external subject matter experts to test our improvements against the very best in the NHS.

3.3 Our maternal deaths **learning enquiry** will report to the Board next month, having been discussed with the quality and safety committee last week. We want to complete work to assess each reviewer's forward recommendations, match those with the ideas of our staff, and confirm how we will track implementation. The enquiry is clear that quality is good and that integrity in our review and investigative processes is without question. We wanted, and have received, some ideas on how we improve further, notably for patients with co-morbidities or conditions that elevate the risks from pregnancy.

3.4 I annex our current position in terms of **referral to report for imaging**. We are sustained extant, good waiting times, but are behind trajectory with improvement. Our external partners come on line now, and during Q2 we expect to see even better turnaround times for quality reports within days or weeks of initial referral. In early September we will have a sustained awareness campaign among GP colleagues and begin to visibly report to patients what they should expect of this Midlands-leading position for imaging.

3.5 Part of the cycle of diagnostic care is issuing reports to referring clinicians and having those **reports acknowledged**, and acted upon. Our Risk Register records historic weaknesses in those processes, over many years, arising in part from our outdated IT systems. Very considerable work has taken place over the last twelve months to address this, and the move to Unity will help further. Group Directors are presenting in the Board's later session the specific countdown work to be done in August to address un-validated reports. At the same time we need to ensure that the administration of every clinical 'pathway' is robust, and address our repeated open referrals issues. The 2019 validation exercise is almost completed, and the Board will want to seek assurance on the look forward.

3.6 We continue to develop ideas and specific technology options around our Population Health offer. The aim of this work is to make sure that patients registered with local practices are receiving targeted proactive help and that the work of varied Trust based specialties is better coordinated for those with multiple conditions. Finally we want to ensure medicines management practices are strengthened. This work will lie at the heart of our **Response Plan** work due in September and November which will form the basis for service development, commissioning and long term plan implementation in 2020-21.

4. Our workforce

4.1 I annex the latest data on our **recruitment work**. Almost every vacancy within the Trust is now advertised and we are working hard to turn offers into new starters. The class of 2019 are not only vital to providing care in coming months but also represent a shift in the workforce of the Trust, and a body of employees who we can learn from, and work with through projects like **we**learn, our quality plan, and our **we**connect activities. We know that our retention challenge is greatest in new starters at the Trust and so we need to act now to make sure that 2020 does not see a surfeit of exiting staff who have not found a place in our organisation. During Q4 we will undertake targeted survey work with our new starters to understand their experience of the Trust they have chosen to come and work for.

4.2 **PDR implementation** remains behind schedule. August 2nd sees lock-down on our data ready for moderation, the process of which is covered in later papers. The big effort of 2018 was to make sure that anyone working within our Trust had objectives that they had agreed with their line manager, and that Q1 19-20 has been spent assessing progress. We would expect to use 2019-20 performance data this time next year to make our first pay awards linked directly to performance across the organisation.

4.3 Our new Manager's **Code of Conduct** goes live on August 9th. This is designed to empower colleagues to challenges behaviours that are unacceptable and to accentuate the work that line managers do to try and deliver results. The Code will operate in concert with longstanding employee charters, and is a precursor to wider work on our values and behaviours as we refresh our arrangements conscious of the NHS wide People Plan. Our Freedom to Speak Up Guardians have been vocal in raising areas of concern that give rise to this Code and we want to ensure that we use rapid feedback models where that is possible in preference to formal processes. At the same time, in line with our discussions at the Board last month, greater attention is being paid to the CIU and the time being taken to undertake disciplinary and dignity processes. By the time we review data in December 2019 and February 2020 through our People and OD committee we would expect to see a material improvement from the 2018-19 position.

4.4 The system-wide **Stepping Up** programme that the Trust pioneered to support BME leaders into more senior roles has seen its latest graduation ceremony. Our People Plan data shows that more of our senior roles are drawn from colleagues from black and minority ethnic backgrounds, but there is more to do. Coaching and mentoring programmes are being rolled out to provide peer and other support to those who have participated. Our public health committee has taken an overview of efforts to tackle gender, disability and ethnicity gaps in our workforce. This focus was also a feature of the clinical leadership executive's deliberations on our clinical audit priorities as we work

towards our 2019 equality act duty report. The government equalities office has set out minimum expectations of organisations, which we will look to exceed.

4.5 The Board considers today a draft **Speak Up scorecard** which would support the approved strategy that we agreed some months ago. The scorecard aims to view in one place a data that might indicate both the richness of culture and the experience of staff in given departments. We should be most concerned by low levels of reporting. Of course we also need to take steps to build skills and confidence in raising and framing concerns and mitigating risks. That is why we have placed such emphasis on issues like 'having difficult conversations' within our Accredited Managers programme. Our next Speak Up day is scheduled for September.

5. Our partners and commissioners

5.1 The CCG has begun to consider proposals from the Trust for **an emergency reconfiguration** of a small number of services linked to our winter plan. These proposals also help to address our acute medicine staffing model as we both move towards Midland Met and look to consistently implement 7-day standard 2, which requires within 14 hour acute assessment for all emergency admissions. The Joint Overview and Scrutiny Committee of Sandwell and Birmingham Councils has received on outline briefing on these plans which will help us to sustain both A&E departments through to the opening of Midland Met.

5.2 The Trust has received indicative advice about **the future of specialised commissioning** across the region, which we will consider within the STP. The Board may recall that the 2017 GE review of the SWB system highlighted future commissioning models for specialised commissioning as a key local risk, as nationally there is a move to tertiary centre led purchasing. We sit between two tertiary systems and so need to make sense of a move from provider-led funding to population-led funding. We have received investment from these same commissioners for services like neonatology, and we will work with partners to secure extant commitments. Our interim contract for specialist gynae-cancer surgery expires in March 2020, and 3 years after giving due notice on this service, we have made clear that any extension is wholly conditional on a contracted and agreed transfer date for the service to a new location and provider within Birmingham.

6. Our regulators

6.1 From late August NHS Midlands will undertake typical performance monitoring and regulation at ICS (STP) level. However, in the case of our STP place based reviews will also be held. We would expect ours to focus heavily on four hour waits, as well as measures of dementia identification among primary care partners.

6.2 We continue to work closely with **Health Education England** in respect of JEST and other feedback. Some concerns in general surgery and emergency medicine continue to be

addressed. A mid-year review of all trainee feedback will come to the Board in October or November, albeit presently the Hours Guardian is explicit that there are no matters for corporate escalation.

6.3 We are imminently anticipating approval of **the Midland Met Final Business Case** by NHS Midlands and the national NHSI/E process. This had been due in late June. DHSC have indicated that they have concluded their analysis of the case that we issued in mid-May and their support for the scheme to proceed to Treasury officials is awaited. The cost, timetable and contractual form to finish Midland Met is wholly consistent with the approved Outline Business Case. There is, of course, considerable urgency to finalise a contract with our preferred bidder, in order to secure the offered price and achieve the programme that will deliver the hospital open before the Commonwealth Games.

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

7.1 We would expect to bring the draft STP Five Year Plan for the Black Country and West Birmingham STP to the **September Board** meeting as part of the wider approval cycle. The document will need to be consistent with the Long Term Financial Model for the Midland Metropolitan Hospital approved by the Board in June 2019.

7.2 Constructive dialogue continues to frame **the two ICP Alliances** within our patch, one for western Birmingham and one for Sandwell. The revised STP governance proposal being developed for October is anticipated to take better account of place based leadership, and I would hope will migrate our system towards maturity and replace organisational 'seats' with place based 'seats' at the system table.

7.3 Both programmes continue to benefit from work to hear **the voices of patients**, carers and communities. Healthwatch have undertaken some valuable work in that regard and in October we kick off our work on coordinated care. Initial feedback to the STP Partnership Board in July underscored again the vital importance of poverty as a source of exclusion and poor outcomes.

Toby Lewis
Chief Executive

July 26th 2019

Annex A – TeamTalk slide deck for August
Annex B – July Clinical Leadership Executive summary
Annex C – 2019 imaging improvement indicators – July MTD – **to follow**
Annex D – Vacancy dashboard – **to follow**
Annex E – Safe Staffing data including shift compliance summary
Annex F – Strategic Board Assurance Framework