SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 2nd January 2020

Chief Executive's Summary of Organisation Wide Issues

1. Since the Board last met we have **signed contracts to construct the Midland Metropolitan Hospital and to undertake estate maintenance once it is open**. These are welcome indications of progress towards 2022, with the creation of the respiratory hub and opening of the neonatal unit illustrating that we are not waiting for the build to improve our estate or our care models. In a few weeks we will open a dedicated combined paediatric emergency unit at City which combines our assessment and emergency care functions on a 24-7 basis. The leadership roles to oversee the transformation of our acute care model as we move towards the new hospital are advertised and interviewed for during January. We need now to move at pace to be ready for the changes we intend in less than 1000 days' time.

2. The Board considers today a range of areas of work which are central to both this winter and to 2020-2021: Flu vaccination and four hour waits, workforce retention and nurse staffing, next year's budget and our current work to tackle red rated risks. **Progress diverges between our groups and directorates, suggesting again that we have work to do to make sure our most challenged teams are able to improve at the pace of the majority of our organisation**. The Trust is one where over 70% of services are rated good or outstanding and our aim for 2020 is to reach Good across the board – we know that has to be achieved team by team and shift by shift. It is clear from the recent reports on wards D26 and D11 that we can succeed.

3. Our patients

3.1 Waiting times for emergency care continue to be too long. Regardless of the relative position of the Trust against nationwide and region wide pressures, we are not meeting the standards we set for ourselves and want by way of care. We have worked closely with ECIST and NHS Improvement to achieve improvement and their review (2.12.19) suggests **we are taking all of the right steps and working with the right spirit**. It remains the case that we are rapid in undertaking ambulance assessments and returning vehicles to the road for the next patient. However, we know that we are yet improving times to be seen by a senior clinician in ED nor times to decision. Most days of the prior month we have also had major bed deficits. In the report on four hour waits, this position is considered further.

3.2 As reported last month, we ended November having delivered improvements in surgical care volumes. We are about half way to the plan we set at the start of the year. **The surgical group review on January 16th will focus on the credibility of plans to complete the journey to reach plan in March 2020 and to sustain that position through 2020-2021**. Currently we are planning on the basis of success in that work. The Deputy Chief Operating Officer is preparing a report on the waiting list position and whether we will

end the year at the planned figures we hoped for, or above that number. I would suggest that is best considered by the Quality and Safety committee alongside current referral patterns. Meanwhile Dave Baker is supporting an improvement plan for theatre cancellations, both those on the day, and in prior days, and we will consider that in PMC in February and then in Q&S.

3.3 Last month we considered in detail the patients' voice in our system, creating the new scorecard that will come forward during Q4 and throughout 2020-21, and noting the creation of our Unity Patient Portal. It is encouraging that we continue to meet our complaint response time standards and see returns fall. The Board's desire to see greater uptake of Purple Point is being considered. **Serious incidents are a different indication of quality defects** and a report is represented today on that topic. The mid-year review was challenged for impact and evidence of real change and that challenge remains. In 2018-19 our annual report highlighted changes made from incidents reported and anticipated that Unity would help us to tackle medication errors and to better track care pathways to ensure compliance. We need to consider in the next few months whether that promise is being delivered.

3.4 Our first **GIRFT reports** have now completed a 'cycle of review' into the Clinical Leadership Executive, with obstetrics and ophthalmology reporting at six months. By summer 2020 we expect to have completed the cycle for all extant reports issued in or before 2019. We understand from the national team that we are relatively unusual in having in place a worked through process for these reports and will provide a summary into Quality and Safety committee of real changes arising as a result. There is considerable time and effort required to undertake the process and so it must be judged by impact not by activity. The link between GIRFT findings and the Better Care indicators for commissioners is one that we are seeking to make.

3.5 We considered at our last meeting proposals to improve community midwifery services. This should be seen in the context of our broader Local Maternity System plan, which is highly regarded nationally. The West Midlands as a whole has comparatively troubling outcomes from maternity care and we have a part to play in improvement. **We have asked, across the LMS, but at Trust level too, for more data on late presentation cases (families who book after 12 or 18 weeks) into maternity services.** Tackling that appears correlative and potentially causative to poor outcomes and so it is a metric on which we need to focus. Subject to that analysis the hypothesis remains that many pregnancies are known within three months and contact with services is either delayed or displaced. If we can close that gap we will make a difference to outcomes. The attention of the Board of course is drawn to the success we have had under our Quality Plan with reducing still birth numbers and the success reported within QIHD on births with Cerebral Palsy by better application of PreCept standards. We now need to focus on this most challenging metric, potentially working with a PCN or two to see what truly works.

4. **Our workforce**

4.1 In October, the Board was advised that we would end the year having roughly halved our vacancy position as a Trust, and with the majority of remaining vacancies being capable of local recruitment. A proportion of hard-to-fill posts are subject to specific review, and that reports back to our Group Reviews in January. Those together - with today's retention plans - will form the **new Workforce Plan for 2020-2021. Implementation of that plan will be overseen by a Chief Executive led fortnightly meeting.** A standard reporting format will support the CLE workforce committee, Board People and OD committee, and other governance meetings. This exceptional arrangement reflects the centrality of improvement to our route to Good in 2020.

4.2 Team Talk produced a really encouraged staff-led contribution to our work on induction. Raffaela Goodby is working with teams to bring directorate specific plans to January's Clinical Leadership Executive. Corporate induction proceeds weekly, and now is the access route to all IT and other 'first day' arrangements. Clearly **work on induction is central to our retention approach**, as we wish to cut sharply the number of employees who leave within the first two years of employment here.

4.3 **Flu vaccination** take-up remains behind the trajectory of the last three years. We had hoped to reach 85% by the end of 2019, but fell short of that by around 700 vaccinations. A report is provided to the Board on how the position will be improved over the coming fortnight. We will review in February the lessons learned from this year's programme, which comes after five years of reaching 85% by Christmas in each year. There is no doubt that there are particular challenges UK-wide this year with the programme and we will listen to why with peers and advisors as well.

4.4 We have implemented our long intended changes to **ward-based band 2 and 3 roles**. This is testimony to determined advocacy by trade union colleagues and, necessarily, to a listening mind-set by our leadership team. The changes, in effect, create a skills based escalator across these two bands that reward at band 3 those people undertaking a specific set of skills that we need. It is important to put this in place before we go live with our band 4 nurse associate roles at scale, and alongside the relaunch of the band 5-6 escalator programme. The Trust, having tackled poverty pay with the living wage, and whilst working to create a performance related pay model for all employees in 2020, is reshaping the psychological contract to support individual's development of extended practice. We will develop during January a much clearer communication plan for that end to end strategy as part of explaining what it means to be part of our organisation.

4.5 In March the Board will want to review progress in the last year, and the look ahead, with medical education. This is timely as we get ready for clinical placements from August from **Aston Medical School**. Our existing Director of Medical Education, Julian Chilvers, leaves in February, and arrangements are in hand to ensure that we have the bandwidth to lead a challenging agenda in the year ahead. We have a small number of hotspots for training experience that we want to address, learning from improvements

made in paediatrics and surgery in the last year, which were previously areas of challenge.

4.6 It is nine months now since **three GP practices joined the organisation**. We would expect that number to grow in 2020. There is encouraging feedback from staff in those teams about how our governance function, volunteers, and aspects of HR, have worked to support them in the first few months. Equally we want to ensure that they are benefitting from the wider organisation and feel a full part of it. In May we will ask our GP leaders to present their vision for the practices to the Board and to reflect on the cultural integration, or otherwise, that we are achieving so far. The Board agreed a series of primary care priorities for the year ahead, which have also been adopted by the Clinical Leadership Executive, and it will be important that we track progress with that work, which includes, but is not limited to our ICP agenda.

5 Our partners

5.1 We continue to work with **a number of educational partners in supporting care**. The Trust remains at the forefront of apprentice delivery and would expect that work to grow as we incorporate recruitment for Balfour on Midland Met. Our medical school partnerships are strengthening consistent with our 'university hospital' brand. Collaborations with BCU/Wolverhampton for nursing and other professions continue, and we will consider during 2020-21 the arrangements needed for Midland Met to ensure that we have a curriculum in place that reflects a digitally enabled, whole system nursing workforce across primary care, care homes, community and hospital services. In April at the Board we will consider the extant relationships that we have and how those could be strategically strengthened. Just as we have rethought provision with more medical students joining us and need to consider how to support 150 nursing associates, we need to examine how best to mentor and train more and more nursing students in the coming 3 years.

5.2 During Q4 we want to secure **our tertiary collaborations for sickle cell and thalassemia services,** alongside Birmingham W&C Hospital. The Trust is more general focused on transitional care and a report on progress in 2019-20 will come to the Quality and Safety Committee from the CLE before the end of year. The intention is to meet transitional care standards in all of our 'in house' handovers before focusing greater attention on how best to achieve this outside-in. Presently transitional care is not per se a CQC standard for review, albeit we might expect that it will become so over coming months.

5.3 Delivery of our Outstanding End of Life Care services is, of course, a partnership model, alongside among others Crossroads, John Taylor and St. Mary's. Through our Quality Plan **we are investing in additional end of life care capacity at the Trust**, and our ICP response plans focus attention on the last 1000 days of life, and better Advanced Care Planning across our system. It will be important in the opening months of the year to renew and refresh this partnership and make sure that it continues to have the vigour and energy that it did in 2018.

6 Our Integrated Care System, Integrated Care Places and our commissioners

6.1 We have agreed with NHS England that by February 13th we will have final and agreed plans in place for both **gynae-cancer surgery** and for solid tumour oncology. We have proposed now that, almost three years on from service transfer proposals for the former, the Trust will *accept* a revised offer to retain and develop the service within our organisation and base it within Midland Met. I am optimistic that a contracted conclusion to that effect will be put in place in January. The recognition that Midland Met is a tertiary centre for key specialties is welcome and consistent with our vision of university-calibre medicine, supported by research expertise.

6.2 I reported last month that we are having **encouraging discussions about a long term funding settlement for both Sandwell and for West Birmingham,** which would allow financial risk to be held locally within a wider ICS control total regime. It should become clear in January if those agreements will lead to a PBR or other form of contract for 2020-2021 and we will look to manage that position consistent with our long term financial plan. An STP level funding agreement is in place which brings additional funds into our local system in 2021-2022 and we have in outline a balance financial plan within the NHS for 2023-24. Clearly we need to work to ensure that such a plan sustains local general practice, supports third sector partners and is consistent with a funding and operating settlement for long term care for adults. CHC costs continue to run at double digit annual growth.

6.3 The STP/ICS is currently working with several different Operating Models implicit in its agenda: A handover performance management model from NHSE/I, a multiplicity of ICS work-streams (40+) through which it is trying to make a difference, and an emerging model of ICS maturity designed to achieve accreditation by April 2021. During Q4, consistent with changes in our ICS governance and the creation of a clear link between ICPs and the ICS, it looks likely we will rationalise this position. I am hopeful that we will enter 2020-2021 with a cohered understanding of what is being done at local level, and the small number of ICS-wide programmes and priorities that we need. **We circulated the SWB Partnership Pledge that the Board approved in November to neighbours as part of that work, committing the Trust to work with others to both tackle inequality and to address variation**. The paper on service vulnerability that will be discussed in our private Board session reflects that latter agenda.

6.4 The Trust remains committed to better understanding and **working alongside the BSol STP**, which is extremely financially challenged but which has some exciting programmes of service improvement envisaged. Positive discussions continue to take place with the relevant CCG, from whom we receive about £75m of per annum funding. Birmingham City Council, the community Trust, and mental health partners have all actively engaged with the Ladywood and Perry Barr ICP and it is to be hoped that common ground continues to be found in tackling inequality in these wards. The ostensive funding

discrepancy across the city per head will doubtless need to be addressed as we build population based budgets for the longer term.

7. Conclusion

7.1 **In starting 2020 I have issued a short film to all of our employees outlining what I believe lies ahead**. We need to balance the long term creation of our ambitions, values and strategy to 2025, with the work to be done in the remaining 12 months to execute our 2020 vision and to secure improvements – in particular by delivering our Quality Plan and having our standards assured by the CQC at a Good rating.

7.2 The scale of the agenda we are tackling is significant, which is why we are looking again at our governance with external expertise in February. A 'mock' Well-Led review will take place with NHS Improvement in May. By then we will have concluded the Executive realignment exercise that I confirmed in December, which creates a revised role leading our Midland Met related transformation, whilst also honing the work of our Operations function to make sure that constitutional standards are sustainably implemented in the year ahead. 2020 will see a number of Board level personnel changes, and it is important that we have a clear narrative about front-line services and the shape of the Trust even as personalities change. On the back of 2019 progress with Midland Met, delivery of the control total for 2019-20, primary care expansion past and future, and the largely successful implementation of Unity, there is every reason to be positive about the future.

Toby Lewis
Chief Executive
December 27th 2019

Annex A – TeamTalk slide deck for January 2020
Annex B – December Clinical Leadership Executive summary
Annex C – Imaging improvement indicators
Annex D – Safe Staffing data including shift compliance summary
Annex E – Vacancy data
Annex F – Amber to green on infection control