SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 6th February 2020

Chief Executive's Summary of Organisation Wide Issues

1. There remain real challenges in care. We have not reduced our long length of stay patient volumes to 80 or less as we had hoped, and our four hour wait position remains below our own expectations. However, we need to recognise the hard work of all involved, and also note that very often we are managing to stay safely within our acute bed base, which betters the prior two winters. Real improvements in community length of stay are starting to be visible. **Now then is precisely the time to prepare for 'winter 2020' and specifically to bring forward our final plans on Frailty and a detailed plan on the relationship between acute medicine and care home residents.** We have approached Russell's Hall to discuss how we best support their future emergency planning, and ensure that Sandwell residents who could be looked after within our place can access that care.

2. We are now at 82% flu vaccination coverage and continue to seek to reach 85%. The study of whether our unvaccinated staff are new to the Trust or are longstanding, and if so whether they have ceased vaccinated or always declined, will report in March. That will then help inform our work this spring to be ready for the next year. The resilience commenced in our last Board meeting needs to translate into focus and energy for winter 2020.

3. This report is written without the NHS operating guidance having been issued. However, the shape and intent of national policy is also already reflected in our ICS long term plan and our own 2020 Vision. **What is clear from recent national announcements is that our focus on digital optimisation and innovation, on community and third sector care alternatives, and on tackling errors and variation in care are all very much the focus of NHS attention in 2020**. We will seek to compare our current delivery and improvement plans to national policy and appraise the Board in April of our gap analysis. For example, where we say we have a plan for Single Sign On to help staff time, when will it deliver? Or whether our role-model iCares services, and the Integrated Sandwell Hub, is ahead, or behind, the national pilot sites for community care teams that were recently announced. One of the issues we need to consider in due course and make representations about within NHS Midlands, is whether the release of national monies to pilot projects risks stymieing innovation investment locally, because those who start before national funding cannot then access it, as we found with imaging, and may yet find with car parks.

4. Our patients

4.1 There is some encouragement for us in the Health-watch report released nationally into complaints handling. **The Trust is rated in the top 15% in the country** for the work we have done on learning and transparency from complaints. Equally importantly it is clear that feedback from local community interest groups with whom our teams have engaged is very positive on our efforts to ensure that no voice goes unheard. Our Annual Report for 2019-20 will very much focus on changes made in our organisation on the back of feedback and advocacy from patients, by way of ensuring that anyone fearful of complaining or wondering if it changes anything, can seek some reassurance from other's experience. However, we need to make sure that we meet

the standards set out and recommended by Health-watch in 2020-2021 and I have asked Kam Dhami to make sure that the Quality and Safety Committee assesses that in upcoming meetings. Our Patient Voice scorecard is due back to the Board in Q4 as well.

4.2 It would not be appropriate to discuss individual complaints and concerns in this report. However, I want to acknowledge our evident failure in respect of **an unremoved cannula** in a patient, whose family have raised real questions about our care and our response. This is even more disappointing given that three years ago we put in place specific discharge checklist additional arrangements on this matter arising from a prior complaint. Alongside the February audit data we are collating on our never event changes I have therefore asked us to collect positive assurance data on every discharge from our care until we are confident that this was solely an isolated mistake. The Never Event list is important, but where we find serious acts and omissions locally, we must regard those with equal seriousness.

4.3 Results acknowledgement deficits featured heavily in our Board safety discussions in the early months of 2019-20, as we moved towards Unity deployment. The expectation was that we sought to use that change to make our change. Specifically we would require lab test acknowledgement, and we would make better arrangements for pooling of results acknowledgement where patients moved through several teams. Data is now routinely available internally and performance remains short of plan. The Board discussed this in considering Optimisation last month. **There is work to do on data accuracy before we escalate our involvement with individuals or teams who are not making 'closure' at 3 days/3 weeks their standard**. I am simply reinforcing that that expectation remains the one that we have of our teams and we will consider before the end of March what support and consequences we need to put in place where we cannot meet that standard. If we re-examine SIs from 2018-19, tackling this was a key response (set out in our annual report) and 2019-20 has not yet seen this matter concluded - despite real improvements.

4.4 The Trust has made necessary arrangements to address risks from Coronavirus. If the position persists or grows we will reconsider our oversight model, but our emergency planning standards make provision for both outbreaks and containment. Staff are being supported with any knowledge requirements, and to date our principal focus has been on ensuring good triage and risk assessment. PHE and other agencies are working to ensure information flow to the Trust as the position evolves.

4.5 A focus on children remains a priority for the Board, and a follow up to our July special session has taken place. In March we will update the Board on that, as well as summarising CYP transition improvements. Board visits in February reflect recent changes made in neonates, and we are looking forward to the changed arrangements for paediatric emergencies at City from May. These changes are a "game-changer" in offering 24-7 specialist paediatric care at the Trust, as we will offer when we move into Midland Met. We have discussed before the benefits and challenges of having a near-by specialist Children's Tertiary Centre, but we need to be very clear that our scale of population, scale of local need, and residual expertise at the Trust demands that **we provide "better-than-DGH" paediatric care**. We are investing this year on CPAP/BiPAP on that basis, and reflecting a patient complaint from late 2018. Both ICPs are focused on childhood obesity and school readiness, and the Trust is working closely with the education department in

Sandwell to see how our medical students from both universities can play a part in the curriculum at primary age level.

5. Our workforce

5.1 During February we will receive the results of the National Staff Survey. Likewise in Q4 we re-start our own **we**connect survey, which we have undertaken since July 2018 as part of our programme of employee engagement. **That work has clearly improved engagement and engagement 'scores'**. Targets for further improvement have now been set for directorates for 2020-2021 which, if collectively achieved, would lead the Trust into the top few in the NHS. When we used our Speak Up Day to ask staff about their priorities they told us that IT, flexible working and communication were key. The local data suggests that fairness is important and may derive in part from the latter two items. Encouragingly our **we**connect pioneers are showing gains on issues of trust and fairness. We are working to see what from that might be scaleable. Later in 2020 we expect to undertake organisational engagement around our values and promises, against an expectation of work on a Just Culture which has been effective in some other NHS organisations, and is reflected in the NHS People Plan. We will use our pioneers to help us develop that work, whilst also putting greater emphasis on our Staff Networks in 2020 after some abeyance in 2019.

5.2 In recent Board meetings we have considered our recruitment trajectory twice, and our retention plans. Group Reviews in January sought to explore 'hard to fill' posts – those being ones with national or regional supply shortages. **Together these composite into an emerging workforce plan for the Trust in the coming year**. We are working to confirm the staffing, and therefore the pay-bill position. That work is largely complete in corporate directorates, in imaging, and in women and child health. There is work to do in both surgery and PCCT to align volumes of care with staffing. Finally, and most relevantly to both our safe staffing return, and our £329m pay-bill aspiration (pre investments and at 19-20 prices), we need to resolve future staffing in Medicine and Emergency Care. The current overspends in ED are not sustainable, and some of the vacancy positions in our wards are also not sustainable. Revised arrangements for agency governance in 2020-2021 are being finalised which will specify by post any roles which may require agency cover. This will only work if we have in place (a) coherent rostering governance and (b) transparent medical rota management. The People and OD committee will receive a report from me in March on whether those conditions have been met and I would expect both items to feature in the 19-20 Annual Governance Statement [AGS].

5.3 In September I briefed the Board on the specific challenges we were facing in delivering a different **mandatory training** model and we confirmed an intention to reach 85% compliance at the end of January and 95% at the end of March. This is 95% of our staff are 100% compliant. We are discussing with the CQC how they will compare that data to other organisations. It is apparent that that level of compliance would be outstanding. The executive recognises the implications of this improvement for our 2020-2021 performance related pay launch, and the Clinical Leadership Executive has had an initial discussion, to be reprised in March, on how we liberate more time for staff to undertake non-mandatory training and development. This is vital if we are to learn from our errors and develop more excellence. *At Annex F an update on mandatory training is provided and the Board should seek assurance on work over the coming 8 weeks.*

5.4 The Board's remuneration committee agreed in 2019 on **a long term succession plan in respect of organisational leadership**. That plan is now part way through execution, with the appointment of Rachel Barlow from March to the new role of Director System Transformation after external advertisement. This post takes responsibility for both the clinical model within Midland Met, and completion of construction. With the retirement of Paula Gardner as Chief Nurse in June 2020, we are now recruiting for a Chief Operating Officer, Chief Nurse, and the revised role of Chief Finance Officer. We will recruit to the CIO role which sits within the portfolio of the COO from April. Once appointments are made we will consider the future Group structure of the Trust, specifically whether a four group model with well-sized directorates, is the right platform to take us to 2025. In May I would expect to be discussing in some detail the development path and programme for leaders within our directorates and groups to ensure that they are equipped with the resilience and skills to drive change and to manage our workforce. These are all matters that rightly will form part of the external assessment of our governance/well-led standing that we have currently out to commission.

6. Our partners

6.1 A number of organisations local to the Trust have recently undertaken CQC inspections and there is clearly an opportunity for us to learn from those outcomes (and to better understand the local emphasis of our inspection team). **The Trust itself features in the Outstanding rating given to the Broadway Health Centre through our work on diabetes population management**. Broadway are part of the Urban Health group, with whom we co-deliver the Heath Street practice in the Summerfield Centre. BCHC/RWT are awaiting their latest CQC outcomes, but the Black Country Partnership organisation, led until this month by Lesley Writtle, has moved from RI to Good.

6.2 We have discussed AI on a number of occasions at the Board, pursuant to our work on imaging with IBM Watson. We have held constructive discussions with UoB and UHB to understand their work in that field, and **it was pleasing to hear that they are looking to us for insights in the imaging field**. Notwithstanding early results from Babylon triage tech at QEH, and the RWT/Babylon app, we continue to work within our ICP to develop a model that supports triage back to one's GP as part of our commitment to list based general practice.

6.3 Engagement work has commenced for **our strategic partnership with Engie**. Over the coming 14 months we will both work on the Midland Met contract, prepare for the transfer of all estate functions in 2021, and consider what role we might wish our partner to play in our work on environmental health. NHS England have just published ambitions in this area, and the Trust will want to be at the forefront of that work. We have dramatically stayed the growth in energy cost and consumption over the last four years, but we recognise that there is more to do, and that our large footprint new build creates both challenges and opportunities.

6.4 Linked to the Midland Met, we have held the first a series of tripartite discussions with both Sandwell Council and the City Council. These have also included the Canal and Rivers Trust, and there is **a shared desire to ensure that the waterfront connectivity between the 'revolution corridor' of the canal, and the new hospital, is an outstanding feature of the local landscape**. Both councils are currently updating master-planning work, and it is very much to be hoped that a single masterplan might be cohered to reflect the innate connectivity of the local population across formal boundaries. With the changed land use at City Hospital and the huge change in the scale and nature of the population around Midland Met, there is a real opportunity to bring

wealth into an area of predominant deprivation, and consistent with prior discussions we need to do that faithful to the local population and with though and consideration.

7. Our commissioners, ICS and ICP

7.1 **Both ICPs continue to make good progress towards formal standing**, and arrangements are now agreed for how places will be represented within the wider ICS from March. This clarity is important to creating a place-led locally relevant model, which the ICS recognises, and where the 'system' level scale of Sandwell and West Birmingham works in partnership with a sub-system across other Black Country boroughs. The Person-Shaped approach that we continue to advocate will be best delivered through collaborations at place level, which take care to ensure the sustainability of local third sector groups and primary care partnerships. It is really important that any 'purchasing' or contracting model for the Trust and the ICPs from April reflects those values. Discussions have been held with the CCG to ensure alignment on this matter.

7.2 The overall governance model for our ICPs and ICS will come to the Board in March for discussion. In the current arrangements, the Trust will be one of several NHS parties representing the ICP at the ICS Board, with both general practice and social care also represented. Encouragingly **the Birmingham Health and Wellbeing Board has asked the Ladywood and Perry Barr ICP to take a seat with them**, and partners have nominated SWB to hold that seat on their behalf. This should provide a strong window on public health led work across the city, as well as creating an opportunity for Council leaders to understand the good work being done by clinicians in west Birmingham; 'levelling up' should definitely be our ambition. Currently neither the ICPs nor ICS have formal non-executive defined arrangements. Presently at ICP level we have arranged for a CCG lay member to attend, and arrangements for the ICS are awaited from the independent chair.

7.3 Contracting arrangements are being put in hand to **confirm the long term future of gynaecology-oncology as part of the Midland Met**. NHS England have agreed to secure the necessary funding to maintain training and quality, and the Trust will look to ensure better bed availability for complex patients and reduce cancellation rates. With the security of this long term arrangement we can now invest in the development of the service, and work with UoB to ensure research excellence too.

8. Other comments

8.1 **The Chairman has asked me to ensure that going into 2020-2021 we develop a clearer plan for the future direction of the Birmingham and Midland Eye Centre (BMEC).** There is a real service, teaching and research asset within the skills of staff working in the centre, and we want to work with Birmingham University Medical School and the Health College within Aston (which trains AHPs) to ensure that we are getting the very best from those abilities. If we look at complaints within the Trust the centre continues to give rise to administrative difficulties, and we are presently working through a validation exercise on over 25,000 waiting list entries. Recruitment in 2019 was a real success story, and we plan to invest in assets in the short term to help satisfy those recruits and our patient's needs. There are estate opportunities linked to our re-development plans on the city site, and industry partnerships that may be attractive. Internationally there may be scope for collaboration. Accordingly a time limited Board level

project group will be created in Q1 to finalise a specific strategy for the centre, in cooperation with the wider ICS, and in anticipation that this regional centre may take a more overt role in collaboration across acute partners in the STP in line with the Board's Partnership Pledge. As this implies the work we need to do is not simply on defining need or role, but also developing execution capability, and a greater managerial consistency in how the centre functions. During March and April we will undertake specific study of patient's views of what works and what does work within BMEC to help to inform this longer term vision. The eye health objective within the Trust Quality Plan will be at the forefront of any future plans for the centre.

8.2 The Trust continues to engage with national arrangements in relation to Brexit. There is nothing material to report to the Board, but we will discuss with our FIC in February whether any budgetary provision is necessary for the coming year in respect of price instability.

Toby Lewis
Chief Executive
January 28th 2020

Annex A – TeamTalk slide deck for February
Annex B – January Clinical Leadership Executive summary
Annex C – 2019 imaging improvement indicators
Annex D – Vacancy dashboard
Annex E – Safe Staffing data including shift compliance summary
Annex F – Work in progress update on mandatory training compliance