SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 6th February 2020

Annual Governance Statement - update

Overview

1.1 The Annual Governance Statement follows a format that is very largely centrally prescribed. There are now a series of key 'statements of assurance' that I am expected to consider making. As the Board has discussed before these are challenging in that the benchmark is often unclear. Typically Trusts do declare compliance, but we have adopted our own standard as a Board that expects some positive assurance in order to confirm compliance.

1.2 Formal guidance for 2019-20 is not yet issued. On that basis I am drafting this briefing paper in anticipation of what will be included, but with a particular focus on 2019-20 outcomes.

1.3 I note the intention to separately report the Black Country Pathology Service financial position in our annual accounts by comparison to plan and to the business case. I do not intend to highlight governance concerns in respect of this service but will expect to review in 2020-2021 how the model is working and how we are contributing within it.

Risks from 2018-19

2.1 I highlighted four areas of ongoing risk which could not be fully mitigated at the time of AGS issue. In each we have made progress and two perhaps do not merit repetition in the coming AGS document.

a) **Safety risk**: Attention was drawn to both results acknowledgement and to patients not on an RTT pathway, who could become becalmed in our appointment system. The Quality and Safety Committee had explored tracking of the latter group, and data on the former was routinely visible in the Trust. The issue was highlighted because the pace of improvement was poor. Since the AGS was issued we have completed another "open referrals" data cleansing exercise. A plan for long term remedy has come to the Board. At PMC in February we will consider progress with that plan. A similar pattern applied to results acknowledgement. The final major issue is Ophthalmology appointments and work to tackle that is ongoing. I will again review the Planned Care Board's dataset to establish that the issues at hand are sufficiently visible to Groups managing them.

b) **Data risk:** The specific point raised was that greater use of IT systems to store confidential information raised new risks of large scale data theft, as well as individual errors. We have done work on guidance for staff about encryption and password protection, as well as what is held on which drives. We would expect those changes to be live by year end.

c) **Asset failure:** 2019-20 began with continued work on our IT infrastructure, including external connections, and with some uncertainty about our physical estate. We end the year with both in a much improved position. Outwith telecoms our IT infrastructure is now largely suitable, albeit some old servers remain but with back up tracked. The risk register for our estate is very much up to date and will become more so with the Lot 1 activity required to transfer asset management to Engie in 2021.

d) **Vulnerable services:** The Board discussed this matter at its last meeting, and over the year we have been deeply involved in work on specific services like ENT. That we would enter 2020-2021 with the position duly mapped in a manner recognisable to clinical leaders

moves forward our situation. We need to ensure that the resultant red rated services feature clearly on our risk register, and track that the work to address acute medicine deficits is concluded with respiratory medicine providing more sessions into assessment.

2.2 Until we have completed the IG data mapping exercise required by the revised toolkit it would seem premature to consider that the data risks raised are entirely obviated. The other three items now have a clearer shape and description and it is work to do in the balance of Q4 to establish our current state fully. My belief is that (c) and (d) now fall below a threshold for AGS inclusion looking into the year ahead.

Considerations and risks 2019-20

3.1 I do not have material financial control risks arising from the year. The improvement in functioning of the Oracle system is notable, from a low base, and it will be important in Q1 to compare what is now being achieved against best in class within that supplier family. Our income recognition work has improved coding and whilst there are specific departmental issues to discuss there is no significant risk to the Trust's oversight of patient or non-patient income.

3.2 National workforce assurance standards were introduced towards the end of 2018-19 and we did not make a statement of full compliance. I do not consider that we are in a stronger position a year on, and will discuss with the People and OD committee the work that needs to be done in 2020-2021 to improve our oversight. The emphasis of these standards is on connecting staffing with safety, and we need to consider how that is best done such that we are not simply reacting to immediate events.

3.3 We are working through our compliance with the Information Governance standards. Two in particular cause me concern in that our data mapping is not fully complete. This means that whilst we have strong systems and oversight generally we are not best able to identify specific risks associated with specific data flows. This does feature in Group Reviews and will be something we address before the end of Q1.

3.4 The exercise of preparing for Brexit has been useful in examining supply chains for goods and medications. This does not give rise to new risks or reveal particular failure points. Write offs continue to be low in scale. We recognise the challenges of an ageing aseptic system and this will be reflected in future capital planning. We now have a single supplier list in place across our purchasing functions which should allow us to be more thoughtful about management of relationships and driving common standards.

3.5 It is clear that whilst we procure staff through our own bank and contracted agencies, we are not currently wholly assured about induction arrangements for those staff. This was clear with the introduction of Unity and the fall down on the agreed induction forms for new doctors. It means we do not have an agreed quality reporting system in place for temporary staff used by the Trust and this gap needs to be remedied over coming months. In essence we need a scoring system for every agency hire, not simply a commitment to escalate concerns.

3.6 I would invite members to discuss these five domains and highlight any others that appear material from your work.

Toby Lewis
Chief Executive

February 3rd 2020