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Sandwell and West Birmingham Hospitals NHS
NHS Trust

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Report Title	Chief Executive's Summary on Organisation Wide Issues		
Sponsoring Executive	Richard Beeken, Interim Chief Executive		
Report Author	Richard Beeken, Interim Chief Executive		
Meeting	Trust Board (Public)	Date	4th March 2021

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on]*

This month's report is very much written as the observations and initial conclusions made in my first two weeks as Interim Chief Executive (CEO). For continuity reasons, the report follows the basic format of previous CEO Board papers but is necessarily quite high level and observational at this stage.

The key points of discussion I wish to highlight are:

- The need to sponsor, as a Board, a systematic approach to the recovery of our staff as well as the recovery of services, in a post-COVID world
- The need to maximise the number of our staff who receive a COVID vaccination, so as to play our part collectively in tackling misinformation and scepticism about the vaccine in some of our local communities
- To take views from Board members about how we can put more resource, leadership and plan implementation into both of our Integrated Care Partnerships
- To take views from Board members about the implications of the new White Paper for our communities, our system and our organisation

2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

Safety Plan	X	Public Health Plan	X	People Plan & Education Plan	X
Quality Plan	X	Research and Development	X	Estates Plan	X
Financial Plan	X	Digital Plan	X	Other *[specify in the paper]*	

3. Previous consideration *[where has this paper been previously discussed?]*

n/a

4. Recommendation(s)

The Trust Board is asked to:

a.	**NOTE** the Interim Chief Executive's initial reflections and recommendations about future organisational intent, making suggestions about a change in focus or direction on the key issues

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register		n/a						
Board Assurance Framework	X	Where possible, all our agendas should be aligned to the BAF and mitigations to the delivery of our strategic objectives						
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 4th march 2021

Chief Executive's Summary of Organisation Wide Issues

1. Our patients

1.1 COVID-19 related pressures and associated knock-on effects, continue to dominate much of our focus when it comes to the health of our populations and our patients. The community COVID incidence rates, so much higher in the borough of Sandwell than most of the rest of the country and higher than all of the rest of the Black Country & West Birmingham (BCWB) system, has an inevitable impact on the pressures our acute and community teams are facing. That pressure is seen through differential emergency access performance between our two main hospital sites, bed occupancy with a COVID diagnosis and critical care occupancy. As part of my induction I had a very informative conversation with the Director of Public Health for Sandwell, who is very clear that whilst incidence rates are coming down in the borough, they will do so necessarily at a slower rate than most, by virtue of the nature of employment in Sandwell, which placed people of a working age at more risk of infection and they have, in general terms, less opportunity to "stay at home and save lives". This is a stark reminder, not just of the particular health status demands of our population but also evidence for informed discussions about the pressures at our Trust and why we struggle to de-escalate our COVID status as quickly as some others.

1.2 Related to the point above, there is increasing concern from both national and regional teams about COVID vaccination rates in the Black, Asian and Minority Ethnic (BAME) populations of the BCWB system. A specific and differential response has been asked of the health and public health components of our system to tackle this. The executive team at the Trust are clear in their view that the key to achieving higher vaccination rates in the BAME population, is to tackle the misperceptions and misinformation about vaccination, through assuring ourselves that all our high risk and BAME staff are offered a vaccine and the majority take it. We will be doing some specific assurance work on this which both People & OD and Public Health Committees will be interested in.

1.3 We are now turning our attention to the post-third wave period and our service response to this, not just through the previous uni-focused approach of elective service restoration and recovery. Our COVID experience has taught us many things which will drive a changed approach to how we deliver our services and how we do that in partnership at both a place and system based level. These include, not exclusively:

- Planning for winter 2021/22 which will assure the Board that our planned acute and critical care bed capacity as a baseline, is as much as 125%-150% higher than previous winters, to allow for managing COVID related pressures effectively in the future

- Delivering urgent and emergency care best practice both as a BCWB system, assured via the system urgent care Board, but also, critically, on each of our two main acute sites

- Dedicating sufficient time now, and no later than now, to planning internally and with partners, the radical changes to our care models and referral pathways to enable the Midlands Metropolitan Hospital to be the success our populations deserve it to be. A tired and jaded clinical leadership team will need to rapidly turn their attention to this work, albeit I am cheered by the COVID experience having "shown the way" with regard to radical changes in practice that we are all collectively and individually capable of implementing in a very short space of time

2. Our colleagues

2.1 After effectively three waves of managing COVID and its devastating impacts, both in their professional lives and at home, many of our staff are exhausted. We must commit as a Board to support the work of the executive in ensuring a meaningful period of recovery and reflection for our colleagues on a person centred basis, prior to or as a planned part of, responding to any imminent national expectations regarding elective and diagnostic service recovery. Our staff have served populations in Sandwell & West Birmingham which have been evidentially disproportionately impacted by COVID. Our staff have a greater post-COVID inheritance to manage and, uniquely, our staff will have to oversee radical changes to practice and pathways associated with the new hospital development.

2.2 The current executive team commitment to the above agenda includes the following approaches, some of which are already in train:

- Changing the PDR process this year to one which combines personalised recovery plans with the setting of objectives for a unique and different, post-COVID era

- Building on and expanding, the psychological support offer for teams and individuals through the lens this time of recovery, as opposed to "coping"

- Maximising staff COVID vaccination and seek assurance for the Board on achieving a high percentage of vaccination in our higher risk staff groups

- Agree to recovery trajectories for services, which are reflective of the necessary reduction in baseline capacity likely, as a result of reduced extra-contractual effort and built in/timetables recovery and reflection time for staff in particularly hard hit services. I am pushing for this to be consistently agreed at system level by all Trusts and their commissioners

3. Our partners

3.1 I have had the pleasure of attending the Integrated Care Partnership Boards (ICP) for both Sandwell and West Birmingham (Ladywood & Perry Barr) in my first two weeks in post. My observations would be that there is excellent attendance from across the multi-agency spectrum, a real understanding of the unique needs of the populations in both "places" and a genuine commitment to partnership action on population health and inequalities, particularly given the likely exacerbations of these issues which both COVID and Brexit will bring. I am not yet assured, however, that the following is in place and as a result, I feel we cannot be fully assured about progressing radical changes to care model and the wider determinants of health, which are the key to mitigating the issues we have and to ensuring a successful transition to the MMUH:

- A continuity to the response plans and delivery of these, that were originally drawn up at the inception of these ICPs

- A clear commitment to investing in a discrete, separately resourced leadership and programme team which will deliver on the plans

- An established leadership team which runs the virtual organisation that is each ICP, on a day to day basis and drives the change via a programme plan

- Clear measures of success and/or progress via a programme management approach to get assurance on the change

- Clear accountability and hosting arrangements from a governance perspective, for each ICP

3.2 At the time of writing this report, The Trust Chair and I are preparing to attend a meeting of acute Trust Chairs and CEOs, to start to progress the acute collaboration agenda across the BCWB system. Board colleagues will recall that each Trust in the system took a subtly different stance, via their Boards, on the future of such collaboration and whether or not it could or should involve organisational form or shared leadership changes in the future. I am very clear that our Trust should quite overtly be prepared to engage in planning for clinical service integration across the BCWB system, where doing so would benefit our population and our service provision outcomes. Moreover, we should offer to lead key elements of this work. Two natural, but by no means exhaustive, starting points are elective surgical recovery and imaging services. We should retain the stance that any form of shared/joint leadership arrangements or changes to organisational governance are, for our Trust at this juncture, a distraction. We should keep our minds open about the prospect, for the longer term.

4. Our commissioners and ICS/STP

4.1 Since the Board last met, the government has published its legislative proposals for the NHS in England to be placed before Parliament with an expected date of spring 2021, with a view to it receiving royal assent in early 2022 and an expectation of implementation from April 2022.

4.2 The White Paper sets out the case for joining up and integrating care around people rather than around institutional silos – care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours and prevention. At the heart of the changes being taken forward by the NHS and its partners, and at the heart of the legislative proposals, is the goal of joined up care for everyone in England. The NHS and local authorities will be given a formal duty to collaborate with each other, underpinned by the inclusion of local authorities on the boards of ICSs. A key responsibility for these systems will be to support place based joint working between the NHS, Local Government and other partners such as the voluntary and community sector. The white paper sets the framework for integrated working, as well as identifying a number of areas where powers will be given to the Secretary of State to effect decision making.

4.3 I enclose a summary of the key elements of the White Paper, written by the office of the STP SRO. Board colleagues will have already noted that there is much to clarify in terms of ICS governance and authority, for example:

- How the “repurposing” of CCGs into ICSs will work and whether the key leadership roles at ICS level will be anointed or appointed
- How the dual accountability of Trust Boards to both the Secretary of State, via NHSE and to the ICS on mutual accountability grounds, will work
- Linked to the above, what the role of non-executive directors will and should be, around the ICS Board table

- What NHSE long term thinking will be around their definition of "provider collaboratives" and whether that must go further than successful functional integration of services
- There is little mention of ICPs in the current legislative draft, leaving much open to interpretation about how such partnerships form, how statutory organisations host them, how their resources are allocated and via which routes they account for their actions and decisions
- Whether NHSE will mandate systems to be co-terminus with local authority boundaries. For us, this goes to the heart of the "West Birmingham question" and in response to the resurrection of this debate, as a Trust we are starting to pull together a set of key tests or criteria, which we feel local ICP partners would wish to be fully assured about, before any boundary changes occurred. The Board will be asked to sign off this statement, along with West Birmingham ICP partners, very soon.

4.4 I have already, with the Director of Partnerships & Innovation, taken part in some facilitated workshops led by the STP SRO which have been established to explore how these dynamics and formalities might work. Moreover, given there is an opportunity for an acute hospital system representative to become a member of the regional tier sub-group on provider collaboration, I will be expressing an interest in discharging that role, on behalf of the BCWB system

4.5 I am keen to start to gather Board member's views on their expectations of radically changed new accountability and governance arrangements at system level, both via the Board meeting but also some off-line discussions

Richard Beeken
Interim Chief Executive

March 4th 2021

Annex A – TeamTalk slide deck for June
Annex B – May Clinical Leadership Executive summary
Annex C – STP Board summary of Health & Care White Paper