AGENDA - TRUST BOARD SESSION IN PUBLIC

Venue: Conference Room of the Sandwell Education Centre

Date: Wednesday 11th September 2024, 10:00 – 13:00

Voting Members:

Sir D Nicholson	(DN)	Chair
Mr M Laverty	(ML)	Non-Executive Director
Mrs R Hardy	(RH)	Non-Executive Director
Mrs L Writtle	(LW)	Non-Executive Director
Prof L Harper	(LH)	Non-Executive Director
Mr A Argyle	(AA)	Non-Executive Director
Mrs V Taylor	(VT)	Non-Executive Director
Mr R Beeken	(RBe)	Chief Executive
Dr M Anderson	(MA)	Chief Medical Officer
Mrs J Newens	(JN)	Chief Operating Officer
Ms M Roberts	(MR)	Chief Nursing Officer
Mr S Sheppard	(SS)	Acting Chief Finance Officer

Non-Voting Members:

Mr M Hallissey	(MHa)	Associate Non-Executive Director
Mr J Sharma	(JS)	Associate Non-Executive Director
Mr A Ali	(AAl)	Associate Non-Executive Director
Mr A Ubhi	(AS)	Associate Non-Executive Director
Miss K Dhami	(KD)	Chief Governance Officer
Mr D Baker	(DB)	Chief Strategy Officer
Mr J Fleet	(JF)	Interim Chief People Officer
Mrs R Barlow	(RB)	Managing Director MMUH Programme

In attendance:

Ms L Abbiss	(LA)	Comms Lead
Mr M Sadler	(MS)	Executive Director of IT & Digital
Ms H Hurst	(HH)	Director of Midwifery
Mr D Conway	(DCo)	Associate Director of Corporate Governance/Company Secretary

Time	Item	Title	Reference Number	Lead
10:00	1.	**Welcome, apologies and declarations of interest** *To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.* **Apologies:**	Verbal	DN
10:05	2.	**Story –**	Verbal	MR
10:20	3.	**Minutes of the previous meeting and action log** To approve the minutes of the meeting held on Wednesday 10th July 2024 as a true/accurate record of discussions, and update on actions from previous meetings	TB (09/24) 001 TB (09/24) 002	DN
	4.	**Chair's opening comments**	Verbal	DN
	5.	**Questions from members of the public**	Verbal	DN
10:25	6.	**Chief Executive's Report**	TB (09/24) 003	RBe
10:35	7.	**Integrated Committee Chairs Report** • **Joint Provider Committee – Report to Trust Boards**	TB (09/24) 004 TB (09/24) 004a	LW
10:45	8.	**Board Metrics Exception Report**	TB (09/24) 005	DB
MMUH				
10:55	9.	**MMUH Update Report**	TB (09/24) 006	RBa

Time	Item	Title	Reference Number	Lead
Break (10 mins) 11:05				
Our Population				
11:15	**10.**	**Place Based Partnership Update**	TB (09/24) 007	**RBe**
Our Patients				
11:25	**11.**	**Maternity and Neonates Report**	TB (09/24) 008	**MR**
11:35	**12.**	**Finance Report**	TB (09/24) 009	**SS**
11:45	**13.**	**Mortality and Learning from Deaths**	TB (09/24) 010	**MA**
11:55	**14.**	**Length of Stay Reduction Including Winter Plan Update**	TB (09/24) 011	**JN**
Our People				
12:05	**15.**	**Freedom to Speak Up 6 monthly Report**	TB (09/24) 012	**MS**
12:15	**16.**	**Equality, Diversity and Inclusion Update**	TB (09/24) 013	**JF**
Governance and Risk				
12:25	**17.**	**Core standards for EPRR**	TB (09/24) 014	**JN**
12:35	**18.**	**BAF Report**	TB (09/24) 015	**KD**
12:45	**19.**	**Annual Board and Committee Effectiveness Report**	TB (09/24) 016	**KD**
12:55	**20.**	**Annual Fit and Proper Persons Report**	TB (09/24) 017	**KD**
For Information				
	21.	**Board level metrics and IQPR exceptions**	**Reading Room**	**DB**
12:55	**22.**	**Any other business:**	**Verbal**	**DN**
	23.	**Details of next meeting of the Public Trust Board: 13th November 2024 at 10:00am. In person meeting in the Conference Room of the Sandwell Education Centre**		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Quality and Safety Committee: Wednesday 28th August 2024

Trust Board: Wednesday 11th September 2024

Patient / Staff Story

Patient and Staff Engagement – End of Life and Bereavement

Summary of the Story:-

A working group to improve how we communicate and support patients, their essential companions, their relatives and SWB people was established in March 2023.

Two engagement events around death, dying and bereavement were held to gain understanding of people's perceptions of end-of-life care and their experience as families, and staff surrounding end of life within our organisation.

The first event was held in September 2023 at a community venue with the aim of engaging with our community. The second event was held during "dying matters week" in May 2024 with the aim of engaging with our staff across the organisation. Both events had keynote speakers inclusive of patient and carer stories. Each event had Executive sponsorship being opened by a member of the Executive team and attendance across both session was strong.

What are the key lessons / themes to emerge from this story?

The main themes to emerge from the events were very similar from both staff and the public. Communication was the strongest theme. Active listening was not always thought to have taken place to allow for patients' and families' wishes and wants for end-of-life.

Inconsistent communication also featured as receiving different messages from different members of staff, which left families unsure of what the reality was. Effective and honest communication before death was overwhelmingly important to all as this impacted on grief in the time to come.

Staff felt that they needed more education in relation to difficult communication, especially being honest in relation to death, which correlated with what the public had said.

Personalised care featured strongly. Meeting individual needs and wishes at such a crucial time was thought paramount. This included the inclusion and consideration of

cultural differences and traditions that take place at end of life. It was thought that staff who did not recognise these needs or assumed cultural practices were the same as theirs' impacted on end-of-life experience in a negative way. Staff highlighted that they did not have knowledge about all cultures and religions and therefore could not always meet the needs of patients.

Empathy and compassion were not considered to be consistent from all staff and at times sadly lacking; examples given were around staff talking about their social lives in ear-shot of family and a dying person, not checking behind the curtains to see how the family are, not offering drinks or hospitality to families on bed vigils for long periods of times, amongst others.

Staff felt that they needed increased awareness around behaviours at end-of-life. They also highlighted they felt that they needed "permission" to sit with the dying person as it was not considered a good use of their time.

Actions have been created from the two-day events; some are already in place or in progress. This is being monitored via the working group referred to above.

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Venue: Conference Room of the Sandwell Education Centre

Date: Wednesday, 10th July 2024, 10:00 – 13:00

Voting Members:

Sir D Nicholson (Chair)	(DN)
Mrs L Writtle, Deputy Chair	(LW)
Mr M Laverty, Non-Executive Director	(ML)
Prof L Harper, Non-Executive Director	(LH)
Mrs R Hardy, Non-Executive Director	(RH)
Mr A Argyle, Non-Executive Director	(AA)
Mrs V Taylor, Non-Executive Director	(VT)
Mr R Beeken, Chief Executive Officer	(RBe)
Mrs M Roberts, Chief Nursing Officer	(MR)
Mrs J Newens, Chief Operating Officer	(JN)
Mr S Sheppard, Acting Chief Finance Officer	(SS)

Non-Voting Members:

Mr J Sharma, Associate Non-Executive Director	(JS)
Dr M Hallissey, Associate Non-Executive Director	(MH)
Mr A Ubhi, Associate Non-Executive Director	(AU)
Miss K Dhami, Chief Governance Officer	(KD)
Mr J Fleet, Interim Chief People Officer	(JF)
Mr D Baker, Chief Strategy Officer	(DB)
Mrs R Barlow, Managing Director, MMUH Programme Company	(RBa)

Patient / Service Story Presenters:

Members of the Public, Staff and External attendees

None

Apologies:

Dr M Anderson, Chief Medical Officer	(MA)
Ms L Abbiss, Communications Lead	(LA)
Mr A Ali, Associate Non-Executive Director	(Al)

In Attendance:

Mr M Sadler, Executive Director of IT & Digital	(MS)
Mr D Conway, Associate Director of Corporate Governance/Company Secretary	(DC)
Miss B Edwards, Senior Executive Assistant (Minute taker)	(BE)
Mrs H Hurst, Director of Midwifery	(HH)

Minutes	Reference
1. Welcome, apologies and declaration of interest	**Verbal**
The Chair welcomed members and attendees to the meeting. Apologies were received and noted above.	
2. Story – Youth Forum	**Verbal**
Sir Nicholson welcomed the Youth forum to the meeting. Mrs Roberts introduced members to the Youth Forum and advised this had been set up with the work of Ms Salter-Scott for the past 2 years and currently had 210 members. The Youth Forum was made up a broad range of ages between 13 and 21 years old with a broad range of backgrounds and each session was to engage with senior Trust colleagues. Members were informed the Youth Forum had been engaged with to participate in a survey for the Children's Ward and Paediatric assessment unit and completed insight reports for departments. It was added there had been a visit to the MMUH site to allow members of the Youth Forum to propose ideas on how to make the MMUH site friendly towards young people.	

Mrs Writtle questioned how the Forum felt it would get involved with the Trust Board and what members ambitions were. The Trust Board was advised the ambition was to inspire children's departments with designs and with the Board support, would support towards achieving the best healthcare.

Mr Ubhi questioned what message was being taken back to community and networks to support the Trust in spreading the message to tackle heath inequalities. It was noted the sessions allowed for different staff members to speak to the forum and the messages were taken back into the community through schools to engage and encourage other pupils to join the Forum. It was added the messages and increase in attendance of the form would support in spreading the NHS values and support young people in understanding the healthcare system.

Ms Dhami queried what the Youth Forum would spend £1m on if the money was allocated. It was advised some funding would be utilised in marketing to encourage young people to join the Forum but also to support young people as they transition from a children's ward to an adult ward.

The Forum queried what the biggest restriction on the NHS was and how the Forum could help. Mr Sheppard advised most would allude to Finances being the largest restriction and confirmed it was challenging. However, it was advised the Trust had roughly £700m to spend a year, equating to £2m a day. Mr Sheppard expressed he felt the biggest restriction was workforce and ensuring the Trust had a future workforce as the Trust's turnover rate remained high. Mr Beeken agreed and advised he felt the biggest restriction was how the Nation saw the NHS Service and explained during the election period there were several discussions in relation to waiting times for elective and A&E but there was no discussions around public health, chronic disease and the future of the health service to prevent ill health.

The Forum questioned what plans were in place to reduce patient waiting times. Mrs Newens advised there were a number of plans in place with some quick resolutions but stated some would take a longer time to work. Members were advised that prior to COVID-19, waiting lists were down to 18 weeks but this is now not the case with a deadline to achieve 0, 65 weeks by September 24. The Black Country was on track to achieve this and the Trust had 700 patients waiting but plans were in place to address this. Members noted there was some restrictions due to the financial position and the limiting factor was workforce but work was ongoing to support the Trust in becoming more efficient through a number of Subject Matter Experts being brought in. Mrs Newens advised it was anticipated the new Government could have the expectation for the NHS to achieve 18 weeks waiting, quicker than originally thought. It was acknowledged that MMUH would offer that opportunity to achieve but was not the full resolution. Mrs Newens offered to attend a Youth Forum to provide an update on the waiting list for children and young people.

The Forum questioned how it was ensured there was opportunities within the hospital for young people. Mr Fleet expressed the work was being focused on and opportunities would increase in the opening of MMUH. It was advised there was already work placement opportunities within the Organisation and proved to be a brilliant opportunity to young people with the programme looking to be extended across departments. The widening participation scheme was being looked at adding into the workforce plan.

The Forum queried how the Trust prioritised the money spent on patient care. Mr Beeken advised it was complicated to do but not impossible. Protecting the safety of care was a top priority for the Trust Board and services were either required further or continual investment. After that, the decision in investment was more difficult but the projects were reviewed against the biggest impact, reduction of length of stay and improving productivity.

Sir Nicholson thanked for Forum, Ms Salter-Scott and Mrs Roberts. Sir Nicholson advised the NHS had wide support from the population, but each generation needed to support it and acknowledged the importance of engagement with young people. Sir Nicholson requested a progress report at a future meeting.

3. Minutes of the previous meeting, action log and attendance register	TB (07/24) 001 / 002

The minutes of the meeting held on Wednesday 8th May 2024 were reviewed and Mr Fradgley requested he was added to the attendance list. With this one exception, the minutes were **APPROVED** as a true and accurate record of discussions. The action log was received, and there were two pending actions that were not due this month.

4. Chairs Opening Comments	Verbal

Sir Nicholson advised there was hope there was a meeting with junior doctors and the new government would bring a resolution to the Industrial Action. It was acknowledged there was 2 large issues in relation to waiting times and an extra 40,000 appointments. Members noted there would be a lot more emphasis on winter planning moving forward.

Members noted there would possibly be an audit of the NHS to review to baseline and a 10 year plan for the NHS with a spending review. It was acknowledged the 1st term would be tight but materially there would not be an impact on the general strategy of the Organisation.

Mr Beeken advised that Keir Starmer had been interested in visiting the MMUH site but since the announcement of the new government, members were not sure if the visit would still be taking place. It was advised that Sir Nicholson and Mr Beeken had previously tried to engage with the politicians and had failed but an improvement had already been noticed. Mr Sharma expressed there needed to be a positive communication piece completed. Members noted the ICB had pulled together a drafted briefing note that detailed the roles of each ICB and MMUH information had been appended to Sandwell and West Brimingham (SWB).

Sir Nicholson advised he had given out awards at the internal SWB cricket match and expressed members were keen for a Black Country tournament to take place. It was noted there was an overwhelming positive view from the Physicians and Surgeons in relation to MMUH.

5. Questions from members of the public	Verbal

There were no questions received from the public.

6. Chief Executive's Report	TB (07/24) 003

Mr Beeken presented to members and the following information was highlighted.

- Quality Committee was working through the paediatric audiology expert review. An action plan had been developed and would be tracked through Quality Committee.
- It had been reported the highest number of patients receiving transplants in the last 10 years.
- Formal monitoring of the Undertakings letter would be completed through Finance and Productivity Committee.
- Strategic agreement had been signed with Sandwell Council in relation to the learning campus. Formal signing would be conducted on Wednesday 17th July 24 with various Trust Board members attending.
- 5 Staff Networks are in the process of being developed with 31 applications for the Network Chair.
- New Staff Side Convenor and Deputy was in place from 1st July 24. The Trust Board noted their thanks to the work conducted by Simon Morley during the management of change process for MMUH.

Mr Fleet expressed so far 157 votes had been received for the Network Chairs and the voting would close by the end of the week. Sir Nicholson queried when the Trust Board would be meeting with the newly

appointed Chairs. The elected Chairs would be invited to the People Committee at the end of July 24 before coming to attend a Trust Board in Autum to present the plans for the networks.

Mr Ubhi questioned if there was a breakdown of data for Organisation and how the message was going out to the community. Mr Beeken advised the data could be shared outside of the meeting as it was not available in the meeting. It was advised engagement with maternity services was done differently and that there was a greater focus on staff feeling comfortable to ask the question around organ donation. Members discussed that people carry the organ donation card but occasionally the family decline the request. Mrs Barlow advised as the Trust moved to the end of the MMUH programme, the Trust had a duty to evaluate the programme and the community engagement utilised around organ donation. Mr Ubhi agreed and stated it would be a lost opportunity if it was not explored and encouraged members to hold open days to strengthen community attendance.

Mr Argyle queried the staff networks and if there were some based in the Community setting. Mr Fleet confirmed there currently was not but the work was ongoing and would look to spread into the Community setting with internal and external engagement. It was explained the staff network groups were small and mainly were focused around the 2 main sites with no further engagement. Mr Fradgley expressed the importance of engaging Community colleagues and advised conversations needed to be held on equal ground. Mr Fleet expressed the agendas for the networks was not influenced by anyone and added the networks previously had not had support or infrastructure in place which was part of the work ongoing currently to empower the networks.

Sir Nicholson requested a paper to be brought back to the Trust Board on the engagement and moving towards the end of the MMUH programme, to include what worked well and what could have been done differently.

It was **AGREED** the plans from the Staff Networks would be brought back to a future meeting.

7. Integrated Committee Chairs Report	**TB (07/24) 004**

Mrs Writtle presented to members and advised the Committee Chair assurance reports were located within the reading room. Mrs Writtle expressed it was clear through each Committee the key risks were surfacing with several conversations around operational readiness of MMUH but expressed more work needed to be undertaken and each Committee Chair needed to focus on the key emerging risks.

Mrs Writtle took members through the report including what members needed to be aware of that had taken place in the Committees across May and June 24.

Mr Laverty informed members in relation to the operational readiness for MMUH, KPMG had been brought in to support the Trust in working towards its reduction in length of stay.

The Board **NOTED** the content of the report.

8. Board Metrics Exception Report	**TB (07/24) 005**

Mr Baker presented to members and advised the report was in a new layout and requested members' feedback. Members were advised the full Board Level Metrics were available in the reading room.

Mr Beeken stated he thought there was a trajectory in place for the 65 week wait. Mrs Newens advised there was a draft trajectory in place but still required sign off at the Black Country planned care steering group and confirmed there was a route to 0.

Sir Nicholson stated there needed to be a change in what was required and expressed the end point was to achieve pre-COVID-19 measures, 18 week waits. Members noted majority of the waits were outpatients and this would not be achieved if the sole focus remained on inpatients. Mrs Newens advised there was

not singular focus on inpatients, but a mix of long and shorter waiters and added that a lot of specialities were already achieving 18 week waits. Finance and Productivity Committee had been shown the specialities on track but expressed there was concerns around the 4 higher volume specialities. Mrs Newens confirmed with the work around productivity and efficiently the waiting lists were reducing. Mr Argyle queried if weekend work was being utilised to support the reduction in waiters. Members noted that some specialities did work through the weekend but WLIs were paid for extra sessions. Mrs Newens confirmed that job plans were also being validated by Missang.

The Board **NOTED** the content of the report.

Break	
Midland Metropolitan University Hospital (MMUH)	
9. MMUH Update Report	**TB (07/24) 006**

Mrs Barlow presented to members and advised there 63 working days until the opening of MMUH and advised there was a lot of positive work going on but there needed to be a focus upon the risk profile.

Members were informed that planned completion had slipped but work was ongoing with Balfour Beaty to have the building formally handed over at the end of July 24. Mrs Barlow advised the positive work undertaken by the team to manage the slip in the programme.

Mrs Barlow advised she believe the July 24 date for the planned completion could be achieved but expressed that this had not yet been confirmed yet. The critical success factors were outlined with Hard FM procurement being mitigated in June 24 and the largest risk being on bed fit, in which there was a sperate paper available for.

Members were informed there had been a loss of grip and control actions for operational readiness but it was advised it could be recovered. Mrs Newens and Mr Kennedy, MMUH Delivery Director, were holding regular meeting to look to improve the grip and control. Mrs Barlow advised the National Team had confirmed Tony Wilding from NHP had been made available to provide additional capacity and would be a welcome resource.

Members noted a mock move had been undertaken with a live transfer from a bed at the Sandwell site to a bed at MMUH. It was confirmed the management of change that involved 3000 staff had been completed. Mrs Barlow advised the main focus from next week would be induction.

The risks were outlined in section 5 and members noted the UTC and EQUANs risk had been downgraded.

Members were advised the IPA Gate 4 review had been performed and the report had been accepted. The outcome report would be shared with the MMUH Opening Committee and Trust Board once it has been accepted.

Mr Hallissey stated there was to be an onsite inspection on the 16th September 24 and questioned how the risk would managed. Ms Dhami expressed the CQC would be onsite at MMUH in the 3rd week of September 24 to do an assessment without patients present to cover items such as fire, water safety, emergency department and discussions with staff. Mr Hallissey expressed concern the CQC would be talking to staff without operational delivery plans in place. Mrs Barlow confirmed most delivery plans were in place but in draft form that had been created by the relevant teams. It was added the induction process will start on the 1st August 24 with the SOP signed off and scenario testing to commence in September 24. It was confirmed the CQC would be made aware that all staff would not be inducted at the time of the inspection.

Mrs Writtle expressed concern on the capacity of staff and advised the conversations had been held in Quality and People Committees on the factor that nothing could be dropped. Mrs Barlow stated there was work ongoing to review but confirmed there was opportunities for some that could be dropped. Mrs Barlow emphasised the importance of MMUH and there was a goal to free up at least 2 days a week. Mr Fleet echoed comments raised around capacity and expressed work was ongoing between now and the opening of MMUH of reducing meeting and having exception reports to allow the Executive team to support the leaders and create the space required. Members acknowledged the importance of visibility.

Mr Laverty expressed there was less than 63 working days to go until opening but there needed to be confidence around the go ahead decision and it had taken too long to decide extra support was needed through KPMG and Tony Wilde. Mr Laverty questioned if this would be sufficient. Mrs Barlow stated there should not be too many people brought onboard as it could cause further disruption. Mr Beeken agreed with Mrs Barlow's comments and expressed the core minimum was tried to be obtained with the reduction of projects.

Sir Nicholson expressed he could not fault the work that had been ongoing and was glad members were confident it could still be delivered.

The Board **NOTED** the content of the report.

Our Population	
10. Place Based Partnership Update	**TB (07/24) 007**

Mr Fradgley presented to members and advised the report was longer due to Integration Committee not taking place. The following points were highlighted.

- Urgent Community Response continued to be exceptional.
- Continual improvement had been seen in WMAS referrals.
- A significant risk in Intermediate care continues to be mitigated.
- Further risk identified in the difficulty to discharge to pathway 2 setting with Sandwell performance increasing but Birmingham not. This had been escalated to Chief Executive level.
- There had not been positive experience on the digital access portal but there was to be a move to System 1.

Mrs Taylor questioned how close the Trust was to closing the HBIC therapy staff 12.5WTE, if it would be sufficient to mitigate the risk and if there was any long term damage to patients. Mr Fradgley advised there was a plan for each with the expectation of achieving between 6 and 8 WTE. It was advised the route out of this was starting to do services with the combined authority and that conversations were still ongoing. It was noted the change in dosage would not have an impact but Fradgley advised he would look to assure the Quality Committee.

Mr Argyle questioned if the Trust needed to be tougher in turning away ambulances with the increasing pressures of MMUH. Mr Fradgley expressed with the pathway performance, patients are known about prior to coming into hospital due to the success in Town Teams being aware of the population and having a discharge plan in place prior to getting admitted. It was stated this process had not yet being replicated in Birmingham.

Mr Beeken questioned with everything that had been achieved, what the net recurrent financial investment was. Mr Fradgley advised the recurrent investment came from the closure of the Sheldon wards where the budget and care had been moved. There had been a redesign of all rapid response and community teams with the hard recurrent investment being virtual wards and the integrated front door.

Sir Nicholson commended the remarkable work.

The Board **NOTED** the content of the report.

Our Patients	
11. MMUH Bed Fit and 2024/25 Winter Plan Contingencies	**TB (07/24) 008**

Mr Beeken presented the report to members and advised the current projections show the Trust would be able to fit into MMUH at an unplanned suboptimal occupancy level but confirmed that work was still ongoing on the length of stay reduction and reducing the bed occupancy to the target outlined. It was advised KPMG had been brought in to support the reduction in length of stay to enable a lower occupancy level before the move into MMUH. Members were advised that during winter this year there was to be caution and a prudent approach. It was advised 30 beds additional capacity had been identified at Rowley to house Dudley patients, that had already been identified.

Members attention was drawn to section 5 that outlined the risk. It was advised the biggest risk to project completion was operational readiness and the bed fit. This would be discussed at the session held in private on 21st August 24.

Sir Nicholson queried the Trust needed to reduce its length of stay in deep medical bed base to live within the new hospital and there was a plan to achieve this but if this was not achieved there would be patient moves to Walsall and Dudley Trusts resulting in the Trust being able to fit but at a less than desirable occupancy. Sir Nicholson advised the length of stay issue needed to be addressed and questioned the Executive confidence level in achieving this now when previous plans have failed. It was advised the financial risk had not yet been calculated and Mr Beeken agreed a figure needed to be confirmed. Mr Beeken confirmed it was not absolute but advised in December 23 the Trust was achieving what was required to ensure a safe move into MMUH. It was advised the vast majority of senior medical staff that was hugely enthusiastic about MMUH that have accepted their ways of working needed to change. Mrs Newens added clinical and operational engagement was important as well as having the right behaviour. It was advised since KPMG had been brought in it had been demonstrated and following the noise from the last risk summit, the move to MMUH had become more real to staff members.

Mrs Newens expressed previous plans had been implemented and forgotten about as there was no quality improvement approach. Members were informed in the past 3 months, Medicine and Emergency Care leadership teams had demonstrated the change. Mrs Newens added that plans previously had not been externally validated where as the new plan had been

Mrs Roberts stated to members that patient flow and streaming was key and ensuring patients were in the right place. Mr Fradgley agreed and stated streaming had worked elsewhere. It was advised there was a risk in pathway 2 beds within Birmingham but would be contained with mitigations.

Mrs Writtle stated to members she acknowledged the amount of work going on but expressed that she was still anxious and questioned if there was ownership at clinical leadership level. Mr Beeken advised the Medicine and Emergency Care team had taken a step up in relation to the oversight of flow but no fundamental changes. It was noted the lead clinician for Elderly Care had agreed to be the lead in engaging colleagues.

Mrs Writtle expressed she remained worried and that 5 weeks was not long enough to change the minds of staff. Mr Laverty shared the same concern and advised it was an uncomfortable position to be in in 12 weeks before opening and questioned what progress needed to be made for the position to be comfortable. Mr Beeken confirmed there needed to be a reduction in the length of stay trajectory and advised there was weekly data set against 5 or 6 of the key drivers for length of stay but could not confirm if December 23 level could be achieved by when they needed to be. Mr Laverty expressed his concern and

the loss of the catchment. Mr Beeken advised an assumption had not been made but if there was catchment loss the Trust could still fit into MMUH at a higher occupancy.

Mr Fradgley advised when the modelling was done in relation to the flow and the site, it was consistent between pathway 0 and pathway 1 sitting between 38% and 41%. It was advised Rowley had both pathways together and Mr Fradgley advised it was known there was not enough capacity to fully utilise Rowley with a singular pathway so it was used as flex bed to temporary hold pathway 1 patients. Mr Hallissey requested these numbers were included moving forward.

Mrs Barlow stated to members that she was not yet confident but advised KMPG would provide a skill set to allow a different way of working but advised they would not solve the whole problem on their own.

Sir Nicholson questioned if expectations could be set out within the plan and to provide clarity around the progress required before a "go or no go" decision was made. It was requested if an assumption was made on Walsall and Dudley Trust having the Trust patients, then the financial implications would need to be understood.

Sir Nicholson advised there was a lot of anxiety around the plan but the mechanisms were very clear and he hoped that when the final decision needed to be made, the confidence was there to make it.

The Board **NOTED** the content of the report.

12. Maternity and Neonates Report	**TB (07/24) 009**

Mrs Roberts presented to members and advised there had been 4 visits from the CQC during June 24 which were very targeted inspections. An independent review had been conducted and had brought up similar concerns to the CQC including culture and leadership. It was confirmed following the independent review, a single action plan was deemed to be required. Mrs Roberts advised the work on Culture that had been led by Debbie Graham had not been sustained within the department. The independent review report would be available in 10 days and would be presented to the Quality Committee at the end of July 24.

Mrs Hurst took members through the report and advised across the Black Country there had been a spike in still births. A deep dive would be conducted through Quality Committee to review the spike. Mrs Hurst advised 70% of the population sits within the first decile of deprivation and women at high risk can now be prescribed aspirin as it has been found to improve chances. Ratification and safe storage was required before it could be rolled out to community sites.

The Board **NOTED** the content of the report.

13. Finance Report	**TB (07/24) 010**

Mr Sheppard presented to members.

- The Trust reported a £10.7m, a variance to plan of £0.9m.
- Positive work had been completed through the Performance and Insight team on Coding and Counting which had been able to gain £500k recurrently and better information for the quality metrics.
- £12m had been secured from BSOL for MMUH leaving a shortfall of £6.8m.
- A further review of MMUH cost and profiles had been agreed to and would be complete by the end of July 24.
- At the end of May 24 the Trust was 111 posts overplan against the workforce trajectory. The Executives would be working with the Groups in separate sessions through out July 24 to support the Trust in getting back on track.
- The Elective Activity Production Plan was positive but with coding activity pulled out, it displayed an under activity.

- The Financial Improvement Plan was progressing and at the end of June 24, £50m had been allocated in the hopper. It was assured there was the opportunity there but there would be challenge around delivery.

Mr Laverty requested that recurrent and non-recurrent was routinely spilt down and if the underlying deficit was being monitored. Mr Sheppard agreed with the spilt of recurrent and non-recurrent and would be brought to Finance and Productivity Committee. It was added the underlying deficit would be included within the Board level metrics and would be pulled out for the next meeting.

Sir Nicholson expressed his concern in relation to the workforce and if it was not under control it would be seen as the Trust not taking the matter seriously. Sir Nicholson stated if the proposed measures were not working then alternative measures need to be sought. Mr Beeken advised applying the standard measures did not save money, but defer expenditure.

Mr Fleet expressed all the work and effort in recruiting to substantive roles was starting to pay off with the Trust having the lowest turn over rate in the last 3 years but expressed the challenge was then reducing bank and agency. It was advised the vacancy control process was in place and started to work. Mr Fleet further advised what was missing was a detailed plan from each group to remove bank and agency and therefore 5, 2 hours sessions had been identified to meet with the Group to develop a plan. It was added the Group leaders had also been invited to the Workforce Oversight meeting.

Members acknowledged that Emergency Department nurses had been removed off the hard to recruit list following appointments made. It was noted huge progress had been made but Group input was still required.

Sir Nicholson advised a reason why the Trust was facing what it was, was done to there not being a medium term strategy in place for finance and already projects were looking at being deferred into the next financial year. Sir Nicholson questioned when a 3 to 5 year strategy for finance would be in place. Mr Beeken advised it would need to be dovetailed with the System Collaboration and to include what the PA Consulting work did and did not identify.

Mrs Hardy expressed this was not just about having a standalone finance strategy and needed to be apart of wider improvement scheme and a Trust and System Strategy. Mr Sheppard agreed and advised the System Directors of Finance had said the medium term plan would be looked into.

The Board **NOTED** the content of the report.

Our People	
14. Staff Survey/Pulse Survey Engagement Scores	**TB (07/24) 011**

Mr Fleet presented to members and the following information was highlighted.

- The overall response rate to the staff survey was below average but minor improvements had been made.
- A list of actions had been set out and a difference approach had been taken. The approach has started to see the benefits of the work be delivered and a further detailed report was discussed at People Committee.
- Pulse survey was currently ongoing and would close at the end of the month.
- Concern was raised as the Trust moved into the “No fly zone” for MMUH, the amount of work around survey engagement would be dialled back.
- People Engagement Teams (PET) had been created and had stated to get a grip.

Mr Laverty quired the engagement score. Mr Fleet advised he was happy to discuss the engagement score outside of the meeting but a score of 7 was consistently achieved the Trust would be in the top quarter

quartile. Mr Ubhi expressed the work was good to hear and the importance of getting the message out to staff. The Board **NOTED** the content of the report.	
For Information	
15. Annual Report & External Audit Report	**Reading Room**
Members noted the information available in the reading room.	
16. Any other business	**Verbal**
There was no other business discussed.	
Details of next meeting of the Public Trust Board: 11th September 2024 at 10:00am. In person meeting in the Conference Room of the Sandwell Education Centre	
Meeting close	

Tier 1 - Paper ref:	PublicTB (09/24) 003

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Chief Executive's Report
SPONSORING EXECUTIVE:	Richard Beeken, Chief Executive
REPORT AUTHOR:	Richard Beeken, Chief Executive
MEETING:	Public Trust Board
DATE	11th September 2024

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

This month's report focuses on the following subjects:

1. Paediatric Audiology Services: Part 2 response
2. Black Country Finance Undertakings: monthly update
3. CQC Adult inpatient survey 2023
4. Five-year SWB Trust Strategy review
5. NHS England Healthcare Leaders' Update
6. SWB receiving the Veterans Covenant Healthcare Alliance (VCHA) Veterans Accreditation

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	- To be good or outstanding in everything that we do	**x**
OUR PEOPLE	- To cultivate and sustain happy, productive and engaged staff	**x**
OUR POPULATION	- To work seamlessly with our partners to improve lives	**x**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **RECEIVE** assurance on the safety, quality, and accessibility of the Trust's children's hearing services from on-going external accreditation.

b) **NOTE** performance against the Undertakings actions.

c) **DISCUSS** the results of the published CQC Adult Inpatient Survey results and Trust response

d) **NOTE** the work commenced by the Executive on a proposed Trust Strategy refresh.

e) **RECEIVE** assurance that action is taken by the Executive following receipt of guidance from NHS England

f) **NOTE** the good news about the Trust receiving the VCHA Veterans Accreditation

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

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 11th September 2024

Chief Executive's Report

1. Paediatric Audiology Services: Part 2 Response

1.1 The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. A letter that all NHS Trusts have received from the CQC requests that Boards consider the assurance they have about the safety, quality, and accessibility of their children's hearing services. The questions posed for us to consider are:

- Whether we have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.
- Whether we are working towards IQIPS accreditation.
- What stage that work has reached and the assurance we have as Trust board about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.

1.3 SWB Audiology services have been accredited for Paediatric Audiology with UKAS, through the IQIPS scheme, since 2013. The team have implemented and maintained a quality monitoring system as per the IQIPS standards, which has supported our development of departmental audit plans, competency assessments, peer review, document control and equipment monitoring. They are in the third year of the current 4-year IQIPS cycle.

1.4 The last surveillance visit was held in June 2024 and went well. The department had 12 mandatory findings for which actions were completed, and evidence submitted to UKAS on 23rd July 2024. The Trust response was accepted, and ongoing accreditation approved. The next surveillance visit will be in June 2025

At the surveillance visit in June 2024, UKAS raised concerns about the department's waiting times which required ongoing quarterly monitoring. The waiting time performance (DM01) for June 2024 was 69.67%. A 'Demand and Capacity' exercise to help understand the staffing required to manage the demand and any other associated factors has commenced and is in the very early stages. The findings and response will be presented to the Quality Committee in the New Year. Two papers have been submitted and discussed at the Quality Committee and received reasonable assurance

2. Black Country Finance Undertakings: monthly update

2.1 As the Trust Board is aware NHS England Midlands concluded that, given the scale of financial challenge within the system, it is important to place a common and consistent set of expectations on all key NHS partners in the ICS. The regulatory mechanism to do this via agreement of undertakings.

2.2 The Undertakings letter was received from NHS England, outlining the Undertakings to the Trust and an action tracker (Annex 1) developed to monitor the Trust's performance throughout the year. Performance is monitored through the Performance Management Group and the Finance & Productivity Committee prior to the Trust Board.

2.3 The key points to bring to the Trust Board's attention are:

- The Chief Finance Officer is working with system colleagues to develop the next iteration of the system financial recovery plan. The final report from the first phase of the Investigation and Intervention review is expected by the 30 August 2024.

- Draft underlying position presented to Performance Management Group on 19 August 2024, with recurrent financial improvement being a key part of the Strategic Planning Framework.

- Progress against all the actions as described in Annex 1.

3. CQC Adult Inpatient Survey 2023

3.1 The CQC Adult Inpatient Survey looked at the experiences of 63,573 people, across 131 NHS trusts, who stayed at least one night in hospital as an inpatient during November 2023. Questions included in the survey follow people's journeys from admission to hospital, treatment and discharge.

3.2 Between January and April 2024, 1,250 SWB patients were invited to take part in the survey and 332 responses were received. The Trust's national benchmark results were received in August 2024 and can be found in the Reading Room.

3.3 SWB's benchmark performance nationally was the same as other Trust's nationally for the majority of questions (41). There were eight questions in which the Trust was either 'worse' (6) or 'somewhat worse' (2) compared with Trusts nationally. The subject matter of these questions and the feedback will be discussed at the Patient Experience Group, triangulated with other intelligence such as complaints, incidents etc and addressed through the existing workstreams in place managing these issues.

3.4 Some of the subject matter will be resolved by our move to the Midland Metropolitan University Hospital (MMUH) - the obvious likely improvement being cleanliness: often the 'tiredness' of our estates is seen by patients and carers as unclean. The addition of ward level kitchens and planned improvements to out of hours food is expected to lead to improvements. We will be moving to Year 2 of our Fundamentals of Care (FOC) framework in 2025. Elements of our intended focus in FOC this year have been deferred until MMUH is open, although focus on deteriorating patients and communication has been maintained. This survey will be used as the baseline to improve our inpatient survey response rate which is one of the annual plan priority objectives in 2024/25.

4. Five-year SWB Trust Strategy review

4.1 By the end of January 2025, we will have completed our first 100 days at MMUH. Understandably, the intensive focus on operational readiness, service transformation and staff culture and engagement for MMUH, has meant that the new hospital, its care model and benefits case have dominated our strategic focus for some time.

4.2 We agreed our Trust Strategy in the summer of 2022. A major, declared focus for the early stages of that strategy was a relentless focus on MMUH care model adoption, with associated organisational development and management of change for thousands of our staff. We must now set ourselves up for success, through declaring our Trust's strategic ambition in the post-MMUH era. That will involve taking into account what we might term strategic "anchors" for the Trust in the future, such as accelerating our community first approach, tackling areas of the Trust where the

fundamentals of care are not being delivered, maximising opportunities to become the elective care provider of choice through the unique opportunity of the Sandwell and City Health Campus sites and underpinning all our work through a continuous quality improvement system and philosophy. The strategy revision should also of course, consider the anticipated direction of the Labour government's 10-year NHS Plan (expected in April 2025) and alignment to the Black Country and Birmingham systems' existing strategies.

4.3 The executive team has started to consider how such a review and possible refresh of our strategy should be conducted, and we will engage all Board members in this methodology, before bringing something more fulsome and definitive to the Board in November 2024.

5. NHS England Healthcare Leaders' Update

5.1 This bulletin is sent every Monday to ICB and NHS provider senior leaders including chief executives, chairs, chief operating officers, finance, medical and nursing directors and includes guidance and instructions.

5.2 In the Trust the bulletin is issued weekly to the Executive Group with a lead Director identified to act, where required. Annex A includes the 'headline' items included over the past two months.

5.3 In future this report will include feedback on items included in the Update which required the Trust to take some action.

6. SWB receiving Veterans Accreditation

6.1 VCHA National Steering Group has approved Sandwell and West Birmingham Hospitals NHS Trust application for Veteran Aware accreditation, which was the 200th application and marks a significant milestone in the national programme. In the Reading Room is a copy of the formal letter of notification from our Patron and Co-chair and certificate of accreditation.

6.2 NHS Veteran Aware is an accreditation programme designed to support NHS trusts in understanding and meeting the needs of the Armed Forces community. Accreditation is administered by the Veterans Covenant Healthcare Alliance (VCHA), an NHS England funded programme of work hosted by the Royal National Orthopaedic Hospital NHS Trust.

6.3 Veteran Aware accreditation seeks to deliver:

- better health and wellbeing for the whole of the Armed Forces community,
- a more joined-up experience of care for serving personnel and their families as they move around the country and transition from service to civilian life,
- faster and more local access to high quality, personalised care for the Armed Forces community and
- greater value for money.

6.4 Veteran Aware accreditation supports NHS, and other healthcare organisations, to meet the commitments of Armed Forces Act, 2021. The Armed Forces Act brought the Armed Forces Covenant into law and states that members of the Armed Forces Community, should not be disadvantaged when accessing or receiving healthcare.

6.5 I would like to thank our Armed Forces Champions for their hard work in attaining the accreditation:

- James Fleet - Armed Forces Executive Sponsor
- Mark Anderson - Armed Forces Clinical Champion
- Simon Mitchell - Armed Forces Clinical Champion
- Meagan Fernandes - Armed Forces Management Champion
- Nick Bellis - Armed Forces Management Champion
- Cathy Rooney - Armed Forces Therapies Champion
- James Pollitt - Armed Forces Champion and Network Chair
- Michael Jequier - Armed Forces Champion

7. Recommendations

7.1 The Public Trust Board is asked to:

a. **RECEIVE** assurance on the safety, quality, and accessibility of the Trust's children's hearing services from on-going external accreditation.
b. **NOTE** performance against the Undertakings actions.
c. **DISCUSS** the results of the published CQC Adult Inpatient Survey results and Trust response.
d. **NOTE** the work commenced by the Executive on a proposed Trust Strategy refresh.
e. **RECEIVE** assurance that action is taken by the Executive following receipt of guidance from NHS England
f. **NOTE** the good news around the Trust receiving the VCHA Veterans Accreditation

Richard Beeken
Chief Executive

4th September 2024

Annex 1: 2024/25 Undertakings: Progress report as at the end of August 2024
Annex 2: NHS England Healthcare Leaders' Update: July and August items

READING ROOM: CQC Adult Inpatient Survey 2023 – benchmark results
READING ROOM: formal letter of notification from the VVHA Patron and Co-chair and certificate of accreditation.

Annex 2

NHS England Healthcare Leaders' Update

Monday 1st July

• Safeguarding accountability and assurance framework	CNO
• Respiratory Syncytial Virus (RSV) vaccinations	CNO / MDO
• Allied Health Professional (AHP) learning disability videos	CNO
• New medical certificate of cause of death (MCCD)	MDO
• Public sector management practices survey - extended deadline	CSO
• Cyber Assessment Framework	ED-IT/CGO
• NHS IMPACT: Investing in People and Culture	CSO / CPO

Monday 8th July

• GP Connect: update record	CMO / ED-IT
• Community pharmacy inactivated influenza vaccine Patient Group Direction	CMO / CNO
• Discontinuation of Hologic fetal fibronectin testing	CMO / CNO
• Programmes and support for leadership	CPO
• Apprenticeship pay guidance and FAQs	CPO / CFO
• Event: Managing handover delays	COO
• Event: Model Health System	CSO

Monday 15th July

• Guidance for trusts on the use of insourcing	COO / CMO / CNO
• Children and young people diabetes toolkit	CMO / CNO
• Managing the NHS performers lists	COO / CMO
• General ophthalmic services	COO / CFO
• COVID-19 vaccination –	CNO / CFO
• Improving the management of physical deterioration	CMO / CNO
• Artificial Intelligence (AI) learning resources	CMO / CPO / CSO
• Community water fluoridation north east – consultation	CNO
• Artificial Intelligence: fraud and security risks in recruitment	CPO / CFP
• NHS and care volunteer responders – Mel Roberts	CNO
• Cultural transformation: Moving from the 'what' to the 'how'	CPO / CSO

Monday 22nd July

• Medical Certificates of Cause of Death	CMO
• ICB annual assessments	CSO
• Primary medical care policy and guidance manual	CIO
• National Quarterly Pulse Survey (NQPS): Data submission	CPO
• Emergency preparedness, resilience and response (EPRR)	COO
• Framework for managing the response to pandemic diseases	COO
• Shape your future workforce	CPO
• Hospital appointments in the NHS App	COO
• New legal duty to prevent sexual harassment	CPO
• Developing preceptors and retaining newly qualified colleagues	CPO
• Legacy mentoring: supporting newly qualified health registrants	CNO

Tuesday 30th July

• Planning for potential 'collective action' by general practice	CMO / CPO
• Amber alert for O type blood	CMO / CNO
• ICB constitution guidance and template	CGO
• NHS IMPACT resources	CSO
• Guidance on intensive and assertive community mental health treatment	SNO / CMO / CIO
• Applying PSIRF outside of NHS trusts	CNO
• Pharmacy incident reporting	CMO
• National Cancer Patient Experience Survey (NCPES)	CNO / COO
• Tackling health inequalities in dental care in Suffolk and north east Essex	CPO
• Principles of better patient safety consultation	CMO / CNO
• Legacy mentoring: supporting newly qualified health registrants	CMO / CNO
• The Model Health System – Dave Baker	CSO

Monday 12th August

• Work to transform gender identity services	CPO
• Respiratory syncytial virus (RSV) vaccination programme	CNO
• COVID-19 vaccination	CNO / CPO
• Primary care capital grants	CFO
• Federated Data Platform (FDP) - information governance framework	CGO
• Dialysis transport support offer	CNO / CMO
• 2024 NHS Staff Survey	CPO
• Population health and prevention in curricula	CPO / CIO

Monday 19th August

• Flu and COVID-19 autumn/winter vaccination programme	CNO / CPO
• Medicines procurement and supply chain frameworks	CFO
• Emergency preparedness, resilience and response	COO
• Learning Disability Register	CNO / CMO

Wednesday 28th August

• Maximising uptake of antenatal vaccinations	CNO / CMO
• Provider contracts, guidance and variations	CNO / CMO / CPO
• RightCare dementia scenario	CNO / CMO
• Exploring the future – artificial intelligence (AI) and dermatology	ED-IT / CMO
• Consultant pay, terms and conditions	CPO / CMO
• Intermediate pay point for bands 8a and above	CPO / CFO
• Medical certificates of cause of death communications survey	CMO

Tier 1 - Paper ref:	PublicTB (09/24) 004

Sandwell and West Birmingham NHS Trust

Report title:	Integrated Committee Chairs Report
Sponsoring executive:	Kam Dhami, Chief Governance Officer
Report author:	Lesley Writtle , Non executive Director, Deputy Chair
Meeting title:	Public Trust Board
Date:	11th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

This report provides a summary of assurance levels and issues identified by the Trust Sub-Committee Chair's, offering an opportunity to review, triangulate, and escalate concerns, as well as identify good practices aligned with the strategic priorities.

Sub Committees provide regular reports to the Trust Board providing assurance on key items discussed and progress made to resolve identified issues. This report combines the committee assurance report's, which were previously separate agenda items (they are still produced and available in the Board Reading Room).

The report includes key issues to advise, assure and alert the Board from July and August 2024 committees:

Quality Committee: Chaired by Mike Hallisey
People Committee: Chaired by Lesley Writtle
Finance and Productivity Committee: Chaired by Rachel Hardy
MMUH opening Committee: Chaired by Mick Laverty/ Rachel Hardy
Audit Committee: Chaired by Andy Argyle

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
OUR PATIENTS	- To be good or outstanding in everything that we do	
OUR PEOPLE	- To cultivate and sustain happy, productive and engaged staff	
OUR POPULATION	- To work seamlessly with our partners to improve lives	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **NOTE** the report and assurance provided.

b) **PROVIDE** feedback for any identified issues shared for escalation

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*
Board Assurance Framework Risk 03	x	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*

Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

KEY ITEMS DISCUSSED AT THE BOARD COMMITTEES IN MAY & JUNE 2024
ALERT
• Maternity services remain a concern; significant work has been underway over the last few months with help and guidance from several sources. There is recognition of the issues within the service which now has external support to tackle deeply embedded cultural and operational issues. • Reduction of workforce numbers and workforce control : was discussed in both Finance and People committee, there remains a significant challenge in seeing a fall in workforce numbers on a recurrent basis. Currently we are 155 posts adrift of the trajectory. That said comprehensive work has taken place with clinical groups to agree their work force plans and reduced workforce. All Sub Committees are sighted on this and working closely together. • MMUH induction and operational readiness was discussed in all sub committees with particular feedback from MMUHOC and Quality Committee. Whilst progress can be seen there is considerable concern over demonstrating operational readiness with day to day demands upon staff.
ADVISE
• Delivery of the Financial Improvement Programme: Finance & Productivity Committee raised concerns around the overall pace and capacity to see tangible results from the programme. Also in August Internal Audit identified areas of low assurance which led to a split opinion from significant parts of the Cost saving programme assumptions in the Financial Improvement programme. The FPC committee will receive a revised financial plan and workforce plan in September with mitigations for delivery for the second half of the year, this will include specific plans to address the productivity and improvement plan. • Completion of the Trusts annual report : Audit committee held an extra ordinary meeting during August. There had been no overall co-ordination or project management around finalising the submission of the annual report and accounts, this led to a delayed submission to NHSE, this needs improvement for next year. • Infection Control and prevention : concerns over antimicrobial stewardship and rising rates of C.Diff, Quality Committee have requested true QI approach for sustained improvement. • Training and development of junior middle managers: Deep Dive in people committee with the Surgery group together with triangulation in other committees demonstrates a significant Training need on key management skills. Some of this will be addressed by stage 2 ARC programme.
ASSURE

- EDI : people committee participated in an extended discussion about all matters EDI this is showing slow but confident progress: launch of staff networks, work on gender pay gap and a co-ordinated action plan that Trust Board will receive.
- MMUH : good practice reported as part of the IPA Gate 4 output report.
- Finance and Productivity committee approved the Resource model proposed for programme resources alongside CQI investment
- Learning Campus partnership agreement and overarching governance arrangements agreed.

Joint Provider Committee – Report to Trust Boards

Date: 19th July 2024

Agenda item: TBC

TITLE OF REPORT:	Report to Trust Boards from the 19th of July 2024 JPC meeting.
PURPOSE OF REPORT:	To provide all partner Trust Boards with a summary of key messages from the 19th of July 2024 Joint Provider Committee.
AUTHOR(S) OF REPORT:	Sohaib Khalid, *BCPC Managing Director*
MANAGEMENT LEAD/SIGNED OFF BY:	Sir David Nicholson - *Chair of BC JPC & Group Chair of DGFT, SWBH, RWT, & WHT* Diane Wake - *CEO Lead of the BCPC*
KEY POINTS:	The Joint Provider Committee (JPC) was held, and was quorate with attendance by the Chair, two Deputy Chairs, and all three CEO's. Key discussion points included: a. A progress update from the BCPC CEO Lead with a particular focus on key agreements at its recent meeting. b. An update on the progress being made to deliver the CIP schemes across the four BCPC partners. c. An update on plans to address the increased UEC activity within the Black country, and the underlying financial gap. d. An update on the establishment and progression of the Corporate Services Transformation work. e. An update on the development of the programme for the forthcoming Joint Board Development Workshop on the 23rd August 2024.
RECOMMENDATION(S):	The partner Trust Boards are asked to: a) **RECEIVE** this report as a summary update of key discussions at the 19th of July 2024 JPC meeting. b) **NOTE** the key messages, agreements, and actions in section 2 of the above report.
CONFLICTS OF INTEREST:	There were no declarations of interest.
DELIVERY OF WHICH BCPC WORK PLAN PRIORITY:	The Joint Provider Committee oversees and assures progress against the agreed BCPC annual Work Plan, as outlined in schedule 3 of the Collaboration Agreement, and any other delegations.
ACTION REQUIRED:	☒ Assurance ☐ Endorsement / Support ☒ Approval ☐ For Information
Possible implications identified in the paper:	

Financial	The following agenda items have a potential risk implication: ▪ Urgent & Emergency Care has a c£8m risk to the system and potentially to the four partners of the BCPC. ▪ The non delivery of the BCPC CIP schemes as part of the system FRP ('Clinical & Operational Productivity') ▪ The non-delivery of cash efficiency savings from the Corporate Services Transformation work
Risk Assurance Framework	The following agenda items have a potential risk implication: ▪ Corporate Services Transformation – require a clear plan of planned efficiency savings, productivity improvement, and resilience.
Policy and Legal Obligations	▪ N/A
Health Inequalities	▪ N/A
Workforce Inequalities	The following agenda items have a workforce inequalities implication: ▪ The BCPC CIP schemes as part of the system FRP ('Clinical & Operational Productivity'), and in particular the configuration of the agreed 4% workforce reduction. ▪ Corporate Services Transformation work – if not specified correctly could have workforce inequalities implications
Governance	▪ N/A
Other Implications (e.g. HR, Estates, IT, Quality)	The following agenda item has a potential implications: ▪ BCPC CIP schemes – may have positive/ negative implications for quality depending on the focus of the CIP scheme. ▪ Corporate Services Transformation work – if not specified correctly could have workforce inequalities implications

Black Country Provider Collaborative

NHS

1. PURPOSE

1.1 To provide all partner Trust Boards with a summary of key messages from the 19th of July 2024 Joint Provider Committee.

2. SUMMARY

2.1 The Joint Provider Committee was held on the 19th of July 2024. The meeting was quorate with attendance by the Chair, three CEO's and two of the four Deputy Chairs.

2.2 The minutes of the previous meeting were accepted as an accurate record. The Action Log was reviewed with progress discussed and accepted.

2.3 The following is a summary of discussions with agreements noted:

a) **Items for Approval / Noting**

- **CEO Leads update report** – The JPC received an update report from the Chair of the Collaborative Executive, which focused on a smaller range of important topics, highlighting the following:
  - The positive progress being reported (based on month 2 data) in delivering to plan across the four BCPC partners on the programme of CIPs. It was noted that there remain some challenges ahead, but positive progress is being made to close the unidentified year 1 'gap' from £45m to c.£39m.
  - A focused discussion on the corporate transformation programme which updated on the formation of governance and leadership arrangements, in addition to some key principles and communication messages to come.
  - The confirmation of a consolidated clinical contracting function to be established on behalf of the four partners, and to be hosted by RWT, following due processes.
  - A review of the proposed changes to the Collaboration Agreement, with all partners supporting and approving the updates and revisions. A Board paper will follow shortly to confirm changes and seek delegations which will require adjustments to all partner Trusts 'Scheme of Reservation or Delegations' (S.O.R.D).

b) **Items for Discussion**

- **Clinical & Operational Productivity** – The JPC received a detailed and up to date position (based on out-turn month 3 data). It was noted that efficiency delivery remains on track, but non-recurrent delivery is ahead of plan compensating for under-delivery on recurrent schemes.

  Workforce plans are off-track, which may be due to the recent Industrial Action, but will require a focused effort moving forward.

  There remains a significant challenge ahead, due to the profiling of efficiency savings incrementally growing monthly from Q3 onwards, in addition to the need to convert non-recurrent efficiency savings to recurrent savings.

  Given its tier 4 status, the Black Country ICS has been informed by NHSE that it will be undergoing some focused 'Investigation & Intervention' work, with the system selecting PA Consulting as its partner for this work. Phase 1 will

commence immediately, lasting for about 4-6 weeks, and resulting in an assurance assessment of the governance arrangements in place for planned delivery, alongside the identification of 4-6 further interventions which may support delivery of efficiencies.

- **Plan for Urgent & Emergency Care Flows** – The JPC received an updated system paper outlining the range of issues driving a financial gap for Urgent & Emergency Care (UEC) activity. It was noted that the Black Country system is a net importer of UEC activity from surrounding systems which is a significant cause of operational and financial pressures across most of the Black Country Acute sites.

  Currently there is a projected c£8m revenue gap for which options were presented and discussed. The JPC provided firm guidance on managing this risk, which will be conveyed by the UEC Chair (and SWBT CEO) to the BC ICB imminently.

- **Corporate Services Transformation** – The JPC received an update from the SRO confirming agreements at the 1st of July 24 Collaborative Executive. Governance and leadership arrangements are being established, and the first meeting of the Corporate Services Transformation programme – Delivery Group (CSTP-DG) will take place shortly.

  Our external partners, BC Integrated Care Board and Black Country Healthcare NHS trust have confirmed their participation in the Corporate Services Transformation work.

  A communications and engagement plan is being developed and will be shared as soon as possible, together with a 'detailed benefits schedule' and other key supporting processes.

- **Joint Board Development Workshop** – The JPC reviewed the draft programme for the forthcoming Joint Board Development Workshop. It was noted that acceptance to attend was high, and all logistics were in hand. A slight adjustment to the programme was requested to include a short slot on the progress for opening the MMUH.

c) Any Other Business

- There was no A.O.B.

3. REQUIRED ACTIONS

3.1 The partner Trust Boards are asked to:

a. **RECEIVE** this report as a summary update of key discussions at the 19th of July 2024 JPC meeting.

b. **NOTE** the key messages, agreements, and actions in section 2 of the above report.

Tier 1 - Paper ref:	PublicTB (09/24) 005

Sandwell and West Birmingham NHS Trust

Report title:	Board Metrics Exception Report
Sponsoring executive:	David Baker: Chief Strategy Officer
Report author:	Martin Chadderton, Head of Improvement Analytics Executive Lead provided commentary for each indicator
Meeting title:	Public Trust Board
Date:	11th September 2024

1. Summary of key issues two or three issues you consider the Public Trust Board should focus on in discussion

This report highlights key metrics that are integral to our strategic portfolio, focusing on three areas for assurance. Each area is accompanied by executive commentary to provide the Board with a comprehensive understanding of how these metrics are being effectively managed.

- **Improve Workforce Oversight: Staff Turnover**
- **NHSOF – Outpatient Attendances Attracting a Procedure Tariff**
- **NHSOF – 28-Day Faster Cancer Diagnosis Standard**

Additionally, the report flags three areas as **Alerts** that require discussion. Each alert includes executive commentary, detailing the associated risks and the mitigation strategies in place:

- **Mortality**
- **Increase Activity In-Session and Deliver Production Plan**
- **Improve Workforce Oversight: Sickness Percentage and Agency Spend**

These areas are important components of the Trust's strategic portfolio. Active discussion on these matters is deemed necessary to our ongoing performance and strategic objectives.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	- To be good or outstanding in everything that we do	**x**
OUR PEOPLE	- To cultivate and sustain happy, productive and engaged staff	**x**
OUR POPULATION	- To work seamlessly with our partners to improve lives	**x**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **REVIEW** and **DISCUSS** the metrics under the assure heading

b) **REVIEW** and **DISCUSS** the metrics under the alert heading, raising any gaps in the risks and mitigations.

c) COMMENT on the revised approach to reporting the metrics

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

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*
Board Assurance Framework Risk 03	x	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date: N		
Is Equality Impact Assessment required if so, add date: N		

Sandwell & West Birmingham NHS Trust

Report to the Public Trust Board on 10th September 2024

Board Metrics Exception Report

1. Executive summary

The Board Metrics Exception Report highlights key performance areas under Assure and Alert. All performance data is sourced from the Board Metrics Report, available in the reading room aligned with the 2024/25 Strategic Planning Framework and the NHS Operational Framework. Additional charts referenced in this report are included in Annex A. Each metric is accompanied by commentary from the respective executive lead, with an overall summary provided by the Performance & Insight (P&I) team.

2. Assure

2.1 **Staff Turnover, Strategic Objective : People (Improve Workforce Oversight)**

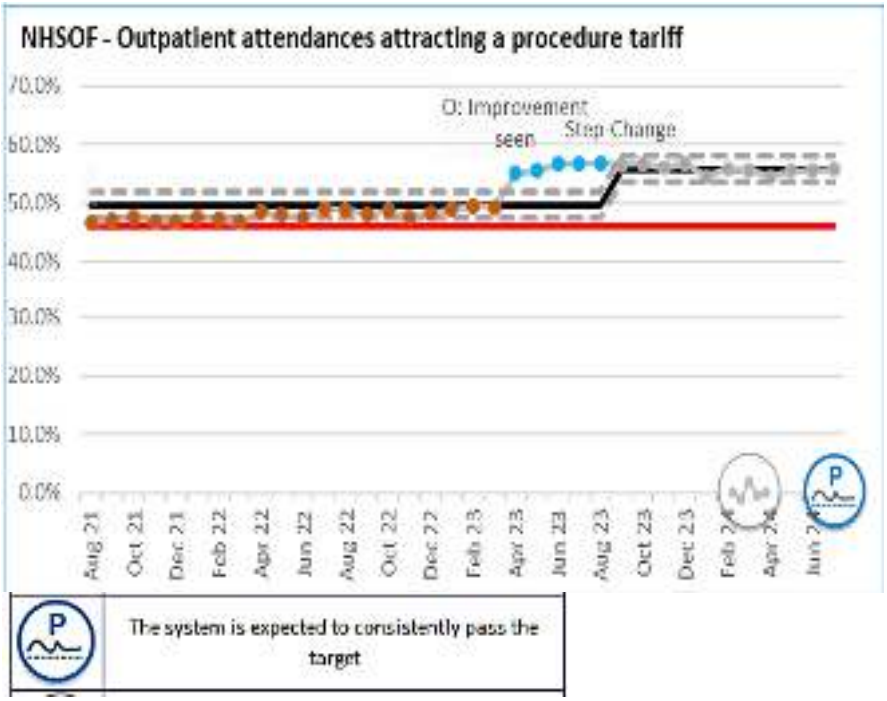
2.1.1 *Strategy and Governance Team*: Turnover has significantly improved to 11.5% ahead of the Target of 13.0%. While the turnover trend is positive and downwards, there is some variability in the process across months, suggesting a need for ongoing attention to ensure long-term stability and consistency. The graph shows a significant improvement, particularly since mid-2022, reflecting successful strategies in reducing turnover.

2.1.2 *Executive Commentary – James Fleet, Chief People Officer*: Turnover has significantly improved, now reduced to 11.5%, which is a positive step towards better staff retention, reduced recruitment costs, and enhanced organisational stability. To sustain and build upon these gains, maintaining a strong focus on employee engagement and satisfaction remains essential.

2.2 **Assure: NHSOF – Outpatient Attendances attracting a Procedure Tariff, Strategic Objective: Patients (Achieve Financial Surplus).**

2.2.1 *Performance & Insight Team*: Starting around February 2023, there's a noticeable upward trend (marked by “Improvement seen”- on graph) suggesting an improvement in the percentage and associated income. This improvement leads to a "step-change" where the control limits shift to a new, higher level (around 55%-60%).

2.2.2 Stabilisation: Post-June 2023, the graph suggests that the data has stabilised at this higher level.

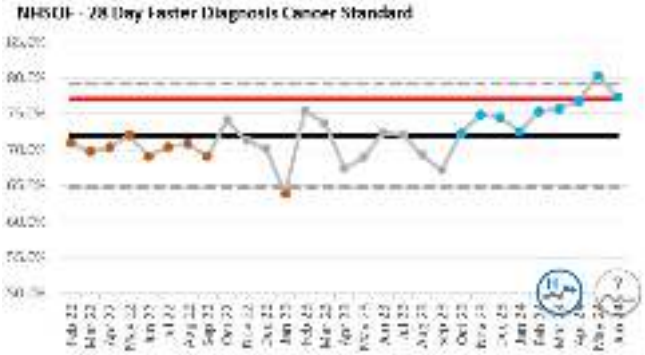


2.2.3 *Performance & Insight Team Actions*:

- Further Improvements: We will conduct further assessments of recording and coding quality. Based on the findings, these initiatives could potentially be extended to other outpatient procedures to enhance overall system performance and accuracy.

2.3 **Assure: NHSOF–28 day Faster Diagnosis Cancer Standard, Strategic Objective: Patients (100% Access Standards).**

2.3.1 *Performance & Insight Team*: The graph demonstrates a clear upward trend in performance starting from February 2023, indicating that initiatives to enhance the 28-day Faster Diagnosis Standard (FDS) are yielding results. Overall performance has remained stable, consistently falling within the 70-75% range, which provides a solid foundation for further improvements.



	Special cause variation - improvement (indicator where high is good)

2.3.2 *Executive Commentary – Johanne Newens, Chief Operating Officer*: Actions to Sustain: Weekly Patient Tracking List (PTL) and action log which has a positive impact on the management of pathways, improving FDS as well as reducing the 62-day backlog. The cancer team are working closely with the Clinical Groups to ensure the Cancer Access Policy is utilised and best practice is adopted.

2.3.3 Clinic Changes and Capacity: Roll out of one-stop clinics with Ultrasound for ENT will mitigate the major challenge with waits for diagnosis in the pathway. Demand and Capacity work has been carried out with specialities that have seen an increase in demand, with plans for additional capacity being implemented where required.

2.3.4 Engagement: Proactive patient pathway validation is being undertaken with particular focus on tertiary referrals, where we are reliant on other providers to achieve pathway compliance.

3. Alert

3.1 Mortality, Strategic Objective : Deteriorating Patients (In Year Objective),Annex A.3.1

3.1.1 *Performance & Insight team*: High Mortality Risk; The risk-adjusted mortality score places the trust in the worst 20% of all trusts in England. This indicates that more patients are dying than would be expected based on Hospital Episode Statistics (HES) data.

3.1.2 Unusual Deaths in Low-Risk Groups: There were 22 deaths reported in low-risk diagnosis groups. These deaths are uncommon and should be investigated for potential issues in the quality of care and coding accuracy.

3.1.3 Decline in Mortality Performance: The trust's performance in key mortality metrics, including RAMI (Risk-Adjusted Mortality Index), SHMI (Summary Hospital-level Mortality Indicator), and HSMR (Hospital Standardized Mortality Ratio), has declined compared to the previous year (2022/23). Specific areas where performance has significantly declined include:

- Urinary Tract Infections: Performance declined by 11%.
- Intestinal Obstruction without Hernia: Performance declined by 4%.
- Other Infections: Performance declined by 22%

3.1.4 A paper is submitted to quality committee this month concerning mortality.

3.1.5 *Executive Commentary – Mark Anderson, Chief Medical Officer*: Failure to recognise the deteriorating patient is a common and consistent theme from qualitative review of the Trust mortality. Our SHMI and HSMR indices have been roving around a high mean of 107. We regularly have monthly alerts for sepsis and pneumonia. We are one of the Midlands pilot sites for implementation of Martha's rule. NHSE recommends a PIER (Prevent, Identify, Escalate and Respond) to managing acute physical deterioration.

3.1.6 *Mitigations*:

- Relaunch Deteriorating Patient Group to cover the full scope of deteriorating patients including Martha's rule and supported by a suitably resourced governance structure- Jan 25
- Socialize Standard Operation Procedure (SOP), use of Situation, Background, Assessment and Recommendation (SBAR), escalation and reporting- In-Year Objective (IYO)
- Workforce development- Business case in progress
- Digital infrastructure –optimisation and innovative solutions (Workstreams and Business case and procurement plans to be developed)
- Education and Training- Needs and resources – to be defined within the In Year Objective
- Evaluation metrics, local and national audits- Identify, report and track- within the In Year Objective

3.1.7 *Risks*:

- Recruitment delays- Organisational Development (OD) intervention support
- Capacity for change management- MMUH No fly zone

3.2 **ALERT: Increase Activity In-Session and Deliver Production Plan, Strategic Objective: Patients (Achieve Financial Surplus)**

3.2.1 *Performance & Insight Team*: In July 2024, in-session utilisation in Trauma & Orthopaedics was only 64.3%, with early finishes (Under run) resulting in 23% of available time being lost, and this trend is not improving.

3.2.2 Booking ahead is not being optimised, with significant drops in booking rates from week 0 (95.5%) to week 2 (50%).

3.2.3 Executive Commentary – Simon Sheppard, Chief Finance Officer:

How are we performing?

- **Income & Expenditure** - An adverse position at month 4 of £3,596k. This is driven by £2.7m income assumption from Birmingham & Solihull (BSOL) ICB for MMUH costs (the year-to-date balance of the annual plan assumption of £18.75m from BSOL less the contractual offer) and the impact of industrial action, £1.1m.
- **Capital –** Actual spend of £14.8m against a Plan of £19.9m – underspends against all the categories of Estates, IT and Equipment
- **Cash –** cash balance of approximately £36.8m

Actions:

- Deliver the Financial Improvement Programme
- Deliver the production plan, **with particular focus on Trauma & Orthopaedics**
- Safely close the additional bed capacity

- Progress the orders aligned to the capital programme

Risks:

- Birmingham & Solihull Income for MMUH (I&E/Cash)
- Delivery of the Financial Improvement Programme inclusive of the deployed Whole-Time Equivalent reduction (I&E/Cash)
- Additional capacity to support Emergency Access Standard (EAS) target and emergency activity (I&E/Cash)
- Capacity and capability (All)
- Unforeseen costs of the move into MMUH

3.3 **ALERT: Sickness, Strategic Objective: People (Improve Workforce Oversight).**

3.3.1 *Performance & Insight Team:* The sickness percentage is improving but consistently exceeds the target, indicating that while there has been some improvement, the process remains unreliable in achieving the target. Over the past 12 months, the rate has remained 0.5-1.0 percentage points above the desired level. A significant portion of this sickness is due to long-term cases. This issue should be considered in the context of the Trust's 2024/25 workforce plan, which aims to reduce reliance on agency staff while addressing the recruitment needs of MMUH and includes an element of reduction.

3.3.2 *Executive Commentary – James Fleet, Chief People Officer* Rolling 12-month sickness remains static and, more importantly, at too high a rate at this stage of the financial year. The current rate has remained the same for the last two months at 5.86%/5.85%. Based on previous years/seasonal trends, the current rate (assuming no further intervention) can be expected to rise.

3.3.3 Actions:

- Goodshape: The stand still period ended midnight 19th August with no challenges to the procurement process. The award letter and contract are due out by the close of w/c 19th August.
- Initial implementation discussions to be held with GoodShape by the close of w/c 26th August.
- Review of the Attendance at Work policy has started. In summary, there's ongoing work which will be completed within the timeline – there's been some initial group discussions and research; task and finish groups will be organised with relevant stakeholders; stakeholder views/feedback from use of policy/input from Goodshape will be taken into consideration.

- Check and Challenge meetings continue to be done along with focussed monitoring of sickness and action plans per individual.

4. Recommendations

4.1 The Public Trust Board is asked to:

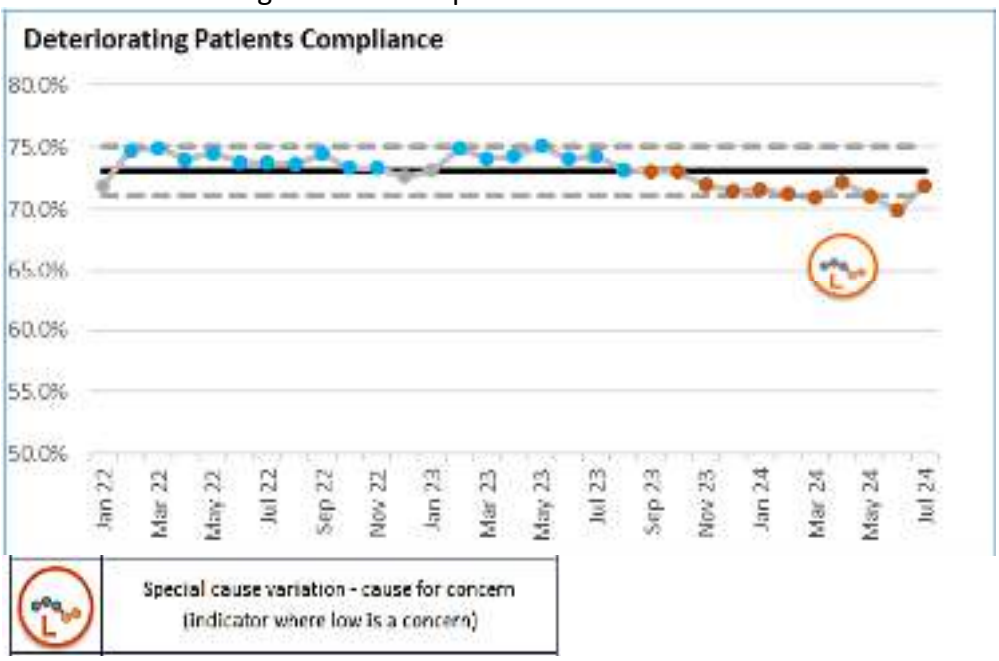
a. **REVIEW** and **DISCUSS** the metrics under the assure heading
b. **REVIEW** and **DISCUSS** the metrics under the alert heading, raising any gaps in the risks and mitigations.
c. **COMMENT** on the revised approach to reporting the metrics

Martin Chadderton
Head of Improvement Analytics

23rd Aug 2024

Annex A: Supporting Performance Charts

A 3.1 Deteriorating Patients Compliance chart



Tier 1 - Paper ref:	PublicTB (09/24) 006

Sandwell and West Birmingham NHS Trust

Report title:	Midland Metropolitan University Hospital update (MMUH)
Sponsoring executive:	Rachel Barlow – Managing Director MMUH Programme
Report author:	Rachel Barlow – Managing Director MMUH Programme
Meeting title:	Public Trust Board
Date:	11th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

After achieving 2 major milestones in August 2024; planned completion resulting in handover of the building asset from Balfour Beatty to the Trust and the Trust Board giving the green light to prepare to open MMUH to Patient Services on 6th October 2024, this paper provides oversight on the remaining programme activities, risk profile and state of operational readiness.

The commitment, confidence and energy of the Trust staff as they get ready and complete their site and local inductions is testament to their determination to make MMUH a success for our patients, people and local population.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	**X**
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	**x**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

TMC

4. Recommendation(s)

The Public Trust Board is asked to:

a) **ACCEPT** the update of the MMUH Programme

b) NOTE that Patient Day 1 is scheduled for the 6th October 2024.

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

Board Assurance Framework Risk 01		*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03	x	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Sandwell & West Birmingham NHS Trust

Report to the Public Trust Board on 11th September 2024

Midland Metropolitan University Hospital update

1. Introduction

1.1 The Midland Metropolitan University Hospital (MMUH) is due to open to patient services on the 6th October 2024.

1.2 The Trust achieved 2 major milestones at the end of August 2024. We received handover of the building from Balfour Beatty the Construction partner on the 19th August 2024. Following this on the 21st August 2024, the private Trust Board considered a Safety Case of readiness to move which included assurance on the design of patient pathways, service interdependencies to ensure patient pathways are resourced and work in the new hospital, bed fit, operational readiness, the programme risk register and the plan for embedding services into the new hospital in the first 100 days. The Trust Board were assured on the Programme readiness status and gave the green light to work to Patient Day 1 on the 6th October 2024.

1.3 This paper provides an overview of the move plans and an update on the remaining critical path activities and state of organisational readiness to move.

2. The Move Plan to MMUH and retained services at Sandwell and City Health Campus's

2.1 On the 6th of October 2024, Sandwell Hospital Emergency Department (ED) and In Patient services will relocate to MMUH. The ED cutover will begin at 5am and patients still requiring hospital based care will be transferred to MMUH to continue their treatment during the day.

Sandwell ED will be permanently closed. Sandwell Health Campus will retain an Urgent Treatment Centre (UTC) service, Sandwell Treatment Centre which will continue to provide outpatients, diagnostic and day case treatments as well as Lyndon Primary Care Centre.

2.2 Between the 6th of October until the 6th of November City Hospital site will remain open to local residents to access the Emergency Department, Inpatient Care and Maternity Service.

2.3 On the 6th November 2024, Maternity and Neonatal services will relocate from City Hospital to MMUH.

2.4 On the 10th November 2024, City ED and adult In Patient services will relocate to MMUH. The ED cutover will begin at 5am and patients still requiring hospital based care will be transferred to MMUH to continue their treatment during the day.

City ED will be permanently closed. City Health Campus will retain the Birmingham Treatment Centre which will continue to provide outpatients, diagnostic tests and day case treatments, and the Birmingham and Midland Eye Centre. Summerfield Primary Care / UTC remains open nearby to the City Health Campus.

2.5 A population communications campaign is in train to increase awareness about MMUH and nearer the time of the moves, to communicate precise information about accessing local health care and the service move plans. The campaign includes a mix of advertising including out of home and digital radio, leaflet drops and targeted community engagement, digital social media campaign, existing estate and partner channels and media relations.

3. Critical Path activities

3.1 There is still a lot of activities to complete before MMUH opens to patient services; key operational readiness and activation activities include:

- Soft FM service and Pharmacy Hub established.
- Automated Guided Vehicle (AGVs) fully operational.
- End to end Pharmacy equipment in place and commissioned.
- IT equipment in place and infrastructure final checks complete.
- Stocking the building of equipment, furniture and supplies.
- Completing on site scenario testing.
- CQC registration.
- Final operational readiness conditions are met inclusive of Induction
- Reduce planned activity and Patient Census completed.
- Staff Induction completion.

3.2 The activation plan is intensive and compromised from its original form due to the delayed in planned completion and in itself is related to a significant Programme Risk. At the time of writing planned activities are managed to be on track and will be conditional to complete before the final decision to move is made.

4. Programme Information

4.1 In order to ensure we can safely open MMUH in 2024, the MMUH Programme has set criteria under the banner of '**Ready, Set, Go'** that must be delivered to demonstrate preparedness and readiness for service. Readiness will be demonstrated by the aggregated position in relation to Programme Critical Success Factors (CSFs), Operational Readiness, Programme Risk and Clinical Safety/Hazard management.

4.2 At the time of writing the measures are rated as follows:

Measure	Current RAG rating
Programme Critical Success Factors	**Amber**
Operational Readiness	**Green**
Programme Risk	**Amber**
Clinical Safety/Hazard management	**Green**

The amber ratings are related to the CSF and risk profiles of bed fit, activation and induction, all of which have adequate forecasts or mitigations to meet acceptable tolerance for Patient Day 1 on 6th October 2024. The subsequent sections in the paper provide oversight and assurance on these Ready, Set, Go criteria.

5. Critical Success Factors

5.1 **The 31 Critical Success Factors (CSFs) are the key measures at Programme level which are critical for safe opening at Patient Day 1**. The Trust Board were informed that the CSFs profile for Patient Day 1, is that all CSFs are met it mitigated to an acceptable tolerance.

5.2 There are 5 CSFs off track form their trajectory with acceptable tolerance or mitigation plans.

5.3 **Right sizing and bed fit**

i) Deliver the right sizing bed reduction plan for cohorts targeted as part of the 6 right sizing schemes.

This CSF is on track to deliver by Patient Day 1 at 95% compliance or more. This transformation work related to the Rightsizing schemes delivered over the last 18 months is demonstrating success with current rightsizing schemes showing 93% of the projected benefits of 130 beds saved.

ii) Total bed usage at planned MMUH occupancy rates within plan to Fit, with focus on length of stay improvements.

Length of stay (LOS) assumptions are higher than planned with continued variability and circa > 1 day above the 2022-23 LOS, which is aligned to the 'best case bed fit scenario'**.**

The 'likely bed fit scenario' enables fit into the MMUH bed base with a derogated bed occupancy of 89.2% from the original business case bed occupancy of 80 % for admitting areas and 90% of the inpatient bed base. This is an improvement from the current occupancy of over 95%. Winter 2024 will be supported by a winter ward at Rowley Regis, which is available from 29.09.2024. This scenario is an acceptable tolerance and would enable improved Urgent and Emergency Care Flow through the hospital.

These CSFs are mitigated with a plan forecast to meet target for Patient Day 1, with a derogated bed occupancy from the original business case through the Likely Bed Scenario.

6.1.2 **Logistics**

iii) Logistics team readiness; testing of the Automated Guided Vehicle (AGV) process (comprised of the completion of commissioning, staff training, handover, familiarisation & operationalisation).

The testing of AGV capacity has fallen short by circa 30% against plan. This was thought due to the way the provider has commissioned the AGV's and was only discovered when we were able to access the building and complete our run through. However, it has since been identified that this function is available but was an issue with transfer of knowledge from Balfour Beatty to the trust staff. Additional training sessions directly from MLR have been established for the week commencing the 9th Sept.

In the scenario that MLR fail to deliver on time for Patient Day 1, we already had a 20% buffer in our capacity planning to successfully deliver the logistics service when we move to MMUH. If the reprogramming cannot be completed, we have enough existing capacity to run for the 6th October 2024 the logistics demand associated with the Sandwell service move. In extremis, if the capacity is not rightsized for the City service moves in November, business continuity plans would be enacted and we can switch one of the logistics services eg; waste collection to manual collection until resolved.

The Logistics service will be able to run once we move to MMUH. There is a risk there might be a requirement to run a small amount of the service manually for a limited period to mitigate the CSF. The MMUH Programme Change Control panel will consider this plan if need be in September 2024.

iv) Logistics team readiness; training of staff. To be measured as planned vs actual training completion rates.

Due to delayed Planned Completion and the impact of delayed access to train on staff site, the training of staff is behind plan. There is a revised schedule to complete training for active services on Patient Day 1.

This CSF is mitigated and forecast to meet target for Patient Day 1.

6.1.3 **Induction**

v) Site and department tours of MMUH post-handover offered and taken up; completion in line with planned trajectory.

Site tours were postponed in July 2024 to support Balfour Beatty completing commissioning activities uninterrupted. The induction capacity has been rescheduled to meet demand, prioritising Sandwell teams first for Patient Day 1 and City team induction will be scheduled to complete before the 6th November 2024.

This CSF is mitigated and forecast to meet target for Patient Day 1.

The Critical Success Factors to inform a decision for Patient Day 1 on 6th October 2024 are on trajectory, or forecast with mitigations within acceptable tolerances.

6. Operational Readiness

6.1 **At the time of writing operational readiness has 67.4% completed activities which is in line with the operational readiness trajectory within an acceptable tolerance and**

forecasts complete readiness for Patient Day 1 on the 6th October 2024. The work to date includes over 83 operational policies, resolution of over 300 service interdependencies and tracking and delivery of over 5000 actions.

6.2 Actions behind track will all be mitigated and completed by the end of September include; 2 operational policies, finalisation of communication of a few external contracts and alignment of some of the telephone numbers for departments.

6.3 The delivery of operational readiness has been behind plan earlier this year, with delayed engagement of clinical and operational teams over a challenging winter. With support from the New Hospitals Programme and increased oversight, all Clinical Groups have confirmed their commitment to being fully operationally ready for Patient Day 1 on the 6th October 2024. There is now reasonable assurance in the MMUH Programme of meeting the operational readiness conditions for Patient Day 1.

6.4 As we get nearer to Patient Day 1, fortnightly **departmental operational readiness visits** take place to enable conversations and validation at the most local level, that our staff are prepared to move and operate services safely in MMUH. The visits attended by the Executive Directors, Business Change Managers and Directorate leaders have been extremely positive. There is a palpable energy and belief toward Patient Day 1 on the 6th October 2024. There have been no new significant risks identified.

6.5 In September 2024, as part of the final readiness checks we will be able to test on site at MMUH 7 high risk patient pathways and business continuity plans prior to opening.

6.6 **The workload to ensure all staff and services are ready for Patient Day 1 cannot be underestimated. However, the commitment, want and determination of staff to deliver Patient Day 1 on 6th October is unmistakable**. This loyalty and excitement of staff is worth a lot in terms of resilience and going the extra mile. The following few months will be intensive. We need and have the staff to want to go on this journey with us.

The current operational readiness status is within acceptable tolerance and forecasts complete readiness for Patient Day 1 on 6th October 2024.

7. Programme Risk and Hazards

7.1 There remains a robust, effective and healthy culture to risk management in the Programme, which has been acknowledged by 3rd parties, most recently in the Infrastructure Project Authority Gate 4 Readiness for Service Review.

7.2 At the time of writing there are 14 Programme level risks, 10 of which are significant scoring over 15**. Annex 1 Programme Risk Register.**

7.3 Of the 8 programme risks to be mitigated before Patient Day 1, they are on track to be mitigated to score below 15. In month the risk profile is ahead of plan for 3 risks. **Annex 2 Programme Risk Profile.**

7.4 Of those risks, the risk related to activation is **Risk 5974 which is a risk of a late change to move dates will be required as a result of the activation critical path running until 1 week prior to Patient Day 1** is anticipated to remain a significant risk and a step down in score is expected to this risk until 27th September 2024, in line with the critical path.

7.5 **There are just 2 significant Programme risks scoring 15 or above forecast for Patient Day 1**. These are **Risk 5157 related to Bed Fit** and **Risk 5941 System Urgent Emergency Care Activity Modelling**. Both these risks were reviewed at the Trust Board Safety Case workshop, also attended by the Black Country and Birmingham and Solihull Integrated Care System Chief Executive Officers, and accepted as tolerable risks with mitigation in place. Both will be reviewed in the first 100 day period.

The Programme Risk Register is well managed. The forecast risk status is considered an acceptable risk profile for Patient Day 1 on 6th October 2024.

8 Significant risks have satisfactory mitigation actions to reduce the score < 15 before Patient Day 1 on 6th October 2024. Activation risks remain significant in line with the critical path of 27th September 2024.

It is accepted that 2 risks related to Bed Fit and System activity are tolerated with existing mitigating actions at Patient Day 1 and reviewed in the first 100 day period.

8. Clinical Hazards

8.1 The **Clinical Hazard process** enables staff to log a hazard they are concerned about and the Hazards Group review this to identify if it is a programme issue, risk or if departments need support. Examples of hazards raised to date are mainly related to the patient pathway interdependency work in train, medical gas storage, phones for medical examiners, provisions of Medical Infusion Suite service, movement of mothers to neonatal unit, space for doctor wellbeing and maternity staff.

9.2 The Hazards process is well advertised across the organisation and uses a web based link for submission. All hazards are reviewed weekly in Clinical Safety Group. This Group work closely with the Clinical Change forum, interdependency and workstream groups. There have been 44 submissions to date. The level of hazard reporting is increasing as anticipated with more staff now attending site for induction, which is a positive aspect of openness, observation and hazard reporting as staff better get to know the building. None of these reported hazards impact negatively on Patient Day 1 trajectory. Hazard reporting will be integral to the first 100 day oversight.

The current Hazards status is within acceptable tolerance and status for Patient Day 1 on 6th October 2024.

9. External Stakeholders

9.1 Following the Board approval of the move date, we have had another critical provider session with all providers giving reassurance of their preparedness for the 6th of October move date. Activity plans were discussed, and an agreement was made through the ICB to support the monitoring of post move flow of patients across the system.

9.2 There are 2 major stakeholder events before MMUH opens to patient services. On the 20th September key stakeholders will be invited to an onsite event in advance of opening. This marks an opportunity to celebrate partners long standing contributions to the Programme and creates a positive media opportunity as part of the Programmes media campaign.

On the 23rd September the Trust have invited their Near Neighbour population to register for a neighbourhood event which is an opportunity to invite our neighbours to see their new local hospital and to thank them for their support during the elongated construction and readiness phases of the Programme.

10. Next steps

10.1 The Trust continues to work in collaboration with partners to achieve the activities on the critical path to Patient Day 1.

10.2 The main operational readiness focus is now on induction, the activity of which is tracked daily.

10.3 The first 100 day plan was presented to the Trust Board workshop in August 2024; work continues to finalise the detail of this important governance and oversight arrangements which will over see a safe transition to embedding new ways of working. Both the first 100 day and Move Plans will be presented to the MMUH Opening Committee in advance of the final Trust Board assurance being provided on the 4th October 2024.

11. Recommendations

11.1 The Public Trust Board is asked to:

a. **ACCEPT** the update of the MMUH Programme
b. **NOTE** that Patient Day 1 is scheduled for the 6th October 2024.

Rachel Barlow
Managing Director

September 2024

Annex 1: Programme Risk Register
Annex 2: Programme Risk Profile

Tier 1 - Paper ref:	PublicTB (09/24) 007

Sandwell and West Birmingham NHS Trust

Report title:	Integrated Place Performance Report
Sponsoring executive:	Richard Beeken, Chief Executive
Report author:	Kulwinder Johal, Group Director Operations, PCCT Lisa Maxfield, Associate Chief Integration Officer
Meeting title:	Public Trust Board
Date:	11th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

The performance of Integrated Place services across Sandwell and within Ladywood and Perry Barr are fundamental to reducing urgent and emergency care demand. As key contributors to the annual plan and the Midland Metropolitan University Hospital (MMUH) rightsizing transformation, driving improvements in the following areas is vital:

- Emergency Department (ED) attendance reduction
- Admission avoidance
- Length of stay reduction

The report provides an overview of continued performance linked to the annual plan and community driven MMUH rightsizing for Primary Care, Community & Therapies (PCCT) and includes the narrative for Paediatric Virtual Wards (VW) and Paediatric Community Waiting Times.

The board should note that this report is longer than usual as the Integration Committee has not sat to provide the oversight and assurance.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	**X**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

This report has been considered at Performance Management Group August 2024

4. Recommendation(s)

The Public Trust Board is asked to:

a) **NOTE** the contents of the report in the absence of the Integration Committee

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Board Assurance Framework Risk 01		*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Sandwell & West Birmingham NHS Trust

Report to the Public Trust Board on 11th September 2024

Integrated Place Performance Report

1. Executive summary

1.1 Integrated Place performance directly impacts both urgent and emergency care demand and the ability to deliver the MMUH rightsizing plan. Appropriate oversight of delivery and improvement trajectories should therefore be a key area of focus.

1.2 It should be noted that the data relating to Sandwell is more accessible and easier to influence. However, the impact of work in Ladywood and Perry Barr will also be fundamental to success. It has not been possible to ascertain data for West Birmingham at present, and it is expected that the reporting of data from this area will improve in future months, as the engagement develops with the Birmingham and Solihull Community Care Collaborative.

1.3 The board is asked to note that there is a current recruitment process in progress to lead and support the delivery of integration at place level. There will be a new Chief Integration Officer and two deputy roles have been recruited to, one focusing on Sandwell locality and the other role focussing on the West Birmingham place. Further details of progress will be provided in the next report, with a more defined place-based update. The Integration Committee is expected to recommence in late October 2024.

2. Attendance Reduction

2.1 The **Urgent Community Response (UCR)** pathways provide an alternative route to ED attendance. Within Sandwell, we are delivering the 9 urgent community response (UCR) pathways outlined in the national planning guidance.

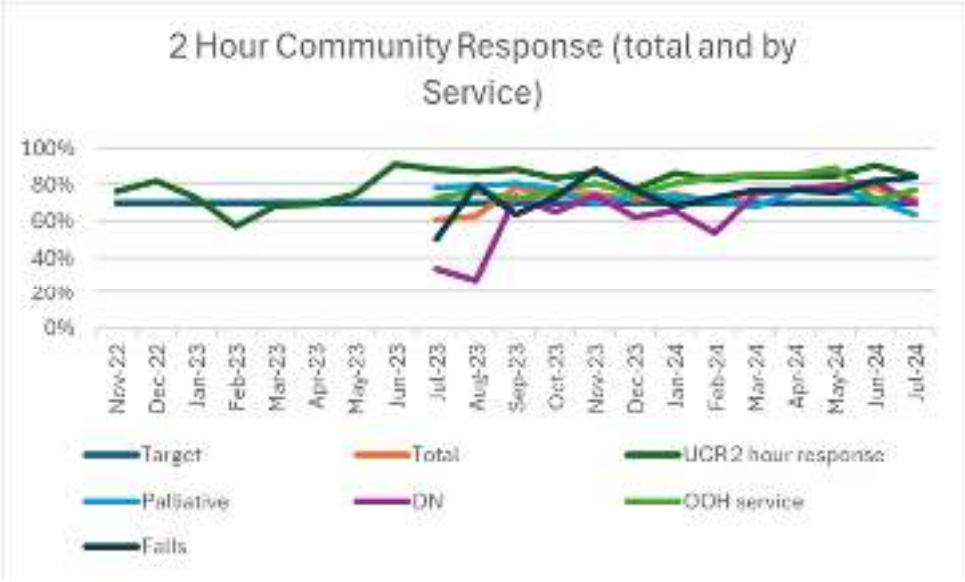
2.2 The **Trust annual plan** sets out a target to increase total UCR contacts to 1500 per month.

Chart 1: UCR contacts vs target

2.3 UCR activity continues to sustain 1500 above contract linked to the ongoing optimisation of utilisation of existing and flexible capacity through strengthening links with primary care, West Midlands Ambulance Servic (WMAS) and community services. UCR is overseen within the PCCT Group and the Sandwell Place workstreams.

2.4 There were 9 rejected referrals in month, as inappropriate referrals were diverted to other community services or non-ED pathways.

Chart 2: UCR2 performance against 70% target



2.5 In addition to the total contacts for UCR, performance is monitored against the national target which requires 70% of all patients meeting the criteria to be reviewed within 2 hours. Changes in data reporting, now captures all services providing 2-hour community response and overall the 70% target has been achieved.

3.0 Falls and Frailty

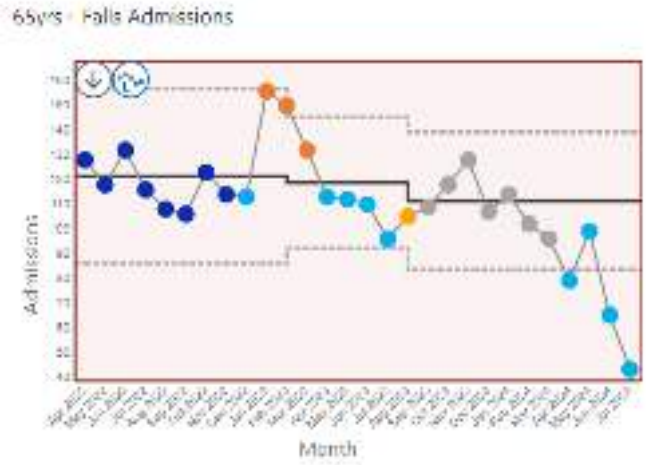
3.1 The Sandell Joint Partnership Board (JPB) meeting in June 2024, agreed to continue to fund A&A services for the falls pick up services until November 2024. This is whilst the SMBC

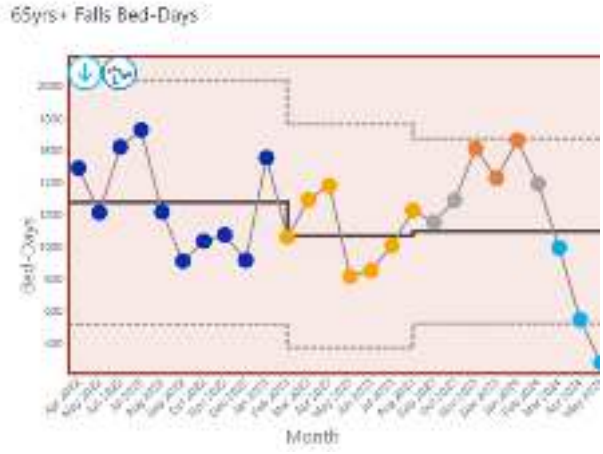
Community Alarms Service is undergoing recruitment, which will enable this service to provide the falls pick up services to all of Sandwell.

3.2 The falls pick up service not only provides support for patients on the floor, but those patients that are stuck in a seated position. The UCR falls service can now manage minor injuries and suturing following a fall.

3.3 The forecasted annual activity for the service 23/24 was 1660 responses. The actual 23/24 A&A activity was 2131 falls (128% of the predicted activity).

3.4 In July, the number of incidences responded to by A & A falls pick up service was 285 which continues to see a month on month increase in activity with 10 incidences (3%) resulting in WMAS calls.





4.0 Care Homes

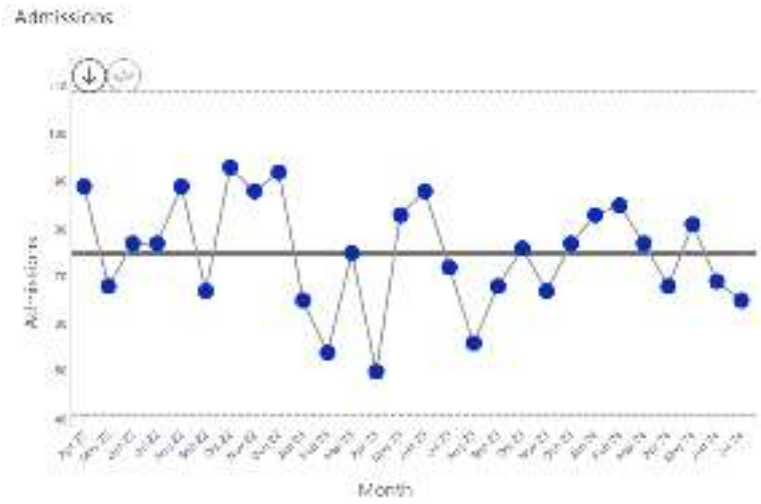
4.1. The **enhanced care homes model** in Sandwell has delivered improvements with those homes receiving intensive, targeted care thereby seeing significantly fewer ED attendances and admissions. The dedicated care home team has had funding agreed for the 0-20 top care homes, the 20-40 care homes funding has not been agreed for Better Care Fund (BCF) funding (previously funded by Sandwell and West Birmingham NHS Trust (SWB) winter funding). Despite this, clinical contacts for 0-40 care homes across Sandwell

has been maintained as part of the core contract and the current workforce and admission avoidance low improvement trend is sustained. Close monitoring of care home admissions continues.

4.2 The continued activity into the 0-20 care homes is showing a direct correlation to the ongoing downward trend in care homes admissions for this cohort of homes.

Chart 4: Care homes admissions Sandwell

Chart 5: Care homes admissions Birmingham



4.3 Birmingham care home admissions remain stable, Birmingham Community Healthcare are currently increasing wrap around and proactive support to the top 4 admitting care homes from Birmingham. Bed days used by Birmingham Care Home Citizens remains significantly lower than last winter, due to both admission avoidance and the integrated discharge hub benefits with the exception of Dec 23 and March spikes.

4.4 Through clinical triage the **Care Navigation Centre (CNC) and Single Point of Access (SPA**) assess and provide interventions for patients avoiding acute admission where appropriate.

4.5 The SPA consistently avoids attendances in > 70% of cases.

Table 2: Single Point of Access (SPA) activity

Call Disposition	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Total No of Calls to SPA	1342	1769	2186	2137	2044	1514	1989	1782	2204	2076	1811	2422	2021	1812	2731	2214	2210	2664	2136	2355	2696
Total ED Divert	909	1248	1747	1502	1483	1192	1597	1429	1748	1688	1326	1805	1551	1368	2000	1718	1691	1820	1596	1669	1997
% ED attendance avoidance	68%	71%	80%	70%	73%	79%	80%	80%	79%	81%	73%	75%	77%	75%	73%	78%	77%	68%	75%	71%	74%

4.6 Total referrals with a failed divert due to capacity in destination pathway was 240 in July 2024 of which 160 (66%) were related to medical pathways.

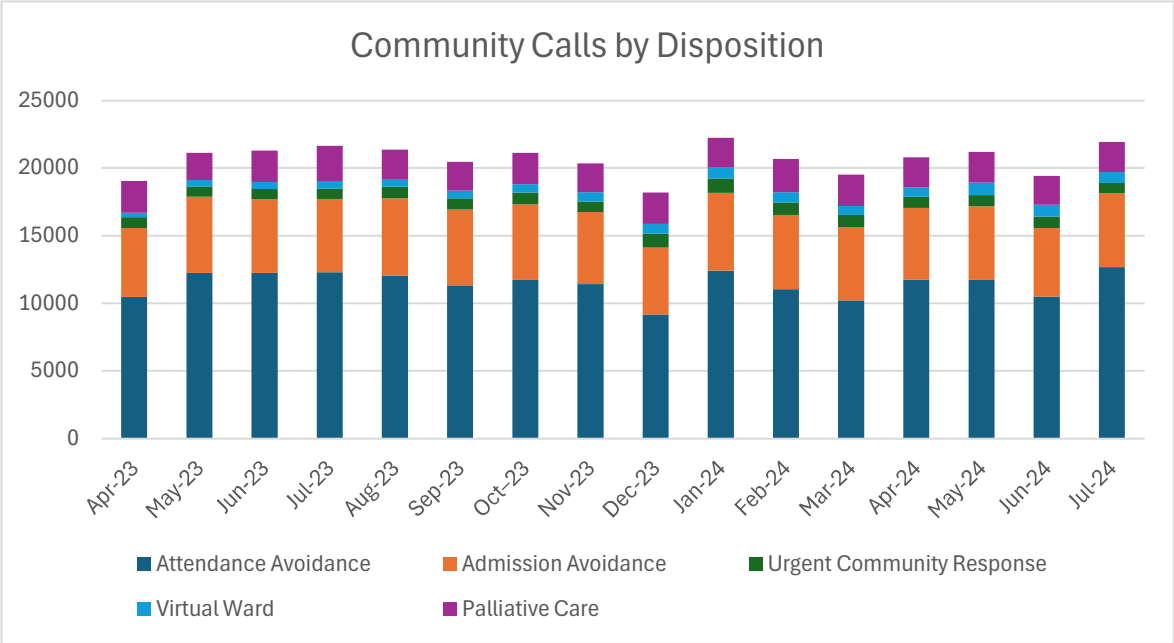
a. The average call waiting time for June 2024 remains below two minutes, at 1minuite and 49 seconds, however this position will potentially deteriorate due to vacancies within the team.

b. Call handling compliance was 84% at 2.5 minutes.

c. The number of calls that were directed to General Practice (GP) was a total of 80 (0.4%) for the month, which remains consistent with previous months and in line with less than 5 % of calls going to GPs.

d. 291 (1.3%) calls were directed to external services such as home loans and Age Concern which is consistent with previous months. A process has been set up with Social Care to transfer calls.

Chart 7: CNC calls by disposition



5. Admission Avoidance

5.1 Admission avoidance is delivered in 2 main ways: Frailty Same Day Emergency Care (including Frailty Intervention) and Integrated Front Door.

5.2 Streaming at the front door commenced at Sandwell on 1st July 2024 with the streamers empowered to direct patients to the correct destination to provide their care without the need to ask for permission.

5.3 Clinical reviews have taken place and concluded that this new way of working has caused no harm.

5.4 Medical Same Day Emergency Care (SDEC) as a disposition for streamers is now live

5.5 The key metrics that are being used for the schemes are shown below: (EAS performance has now improved to over 71%):

Measure	Current performance	Predicted outcome
Registration to streaming	New metric	Monitor as part of PDSA
% triage (15 mins)	47.93% (SGH)	Increase
% triage (30 mins)	72.02% (SGH)	Increase
% door to dr (<60min)	31.24%	Increase
Overall time in ED	339.07 mins	decrease
EAS performance	69.88%	increase

6. Length of stay reduction

6.1 The **Integrated Discharge Hub** have continued to focus on reducing the total number of patients in acute beds with No Criteria To Reside (NCTR) and to increase the number of discharges within 48 hours.

6.2 All pathways demonstrate improvement in discharges within 48 hours in Sandwell. Delay reasons informing broader action planning to improve pathway performance as part of the Discharge To Assess (D2A) task and finish group is being overseen be the Sandwell Place Intermediate Care Board. In addition, on-going work continues with the Birmingham teams to ensure consistency is in place.

6.2.1 Performance in Pathway 1, discharge within 48 hours had seen a deterioration over winter months linked to volume, trend of NCTR decision making through the week, creating a Thurs/Fri bottleneck, McCarthy beds opening and some team sickness and vacancies. There was an improvement in the performance during March and April linked to progress in the action plan below and targeted workstreams across group and place. Pathway 2 continues to fluctuate in performance which is driven by the difficulties in access to enhanced assessment bed (EAB) beds in Birmingham, family choice and best interest decision. Escalation has been undertaken in August, with Birmingham Community Health Care, through the Community Care Collaborative is relation to pathway 2 beds.

6.2.2 Implementation of P1 safety checklist for Sandwell residents - Transfer Of Care (TOC) process changed to a safety checklist which supports wards to provide handover for discharge to STAR directly. Initial data for August shows that 25% are discharged with 24 hours of NCTR and 55% within 48 hours.

6.5 There is a clear process for the homeless pathway for Sandwell residents, implemented to support IDH to support discharge .

1. People with no care needs on pathway 0
2. People with care needs on pathways 1-4
3. People who are asylum seekers as they tend to be labelled as homeless when in fact they are not.

6.6 The impact of **Home-Based Intermediate Care (HBIC)** to support Pathway 1, is critical to ensure prompt discharges. The demand through this pathway continues to be above the staffed capacity. Demand for this pathway is tracked to inform predicted demand and potential increases in capacity for winter. Time to treat delay has improved gradually over the last 3 months but remains persistently above the 2-day target. Due to fluctuation, we have now capped tolerance for first assess to 5 days and continue to monitor readmission within this window and throughout the episode. There were 16 admissions to acute in July 24 . The staffing for HBIC is improving, 84% of the workforce have been recruited with 11.64 WTE posts remain in active recruitment.

6.7 HBIC provision continues to be a risk due to vacancies which are current being mitigated by locality teams and reduction in dosage provided increasing overall LOS.

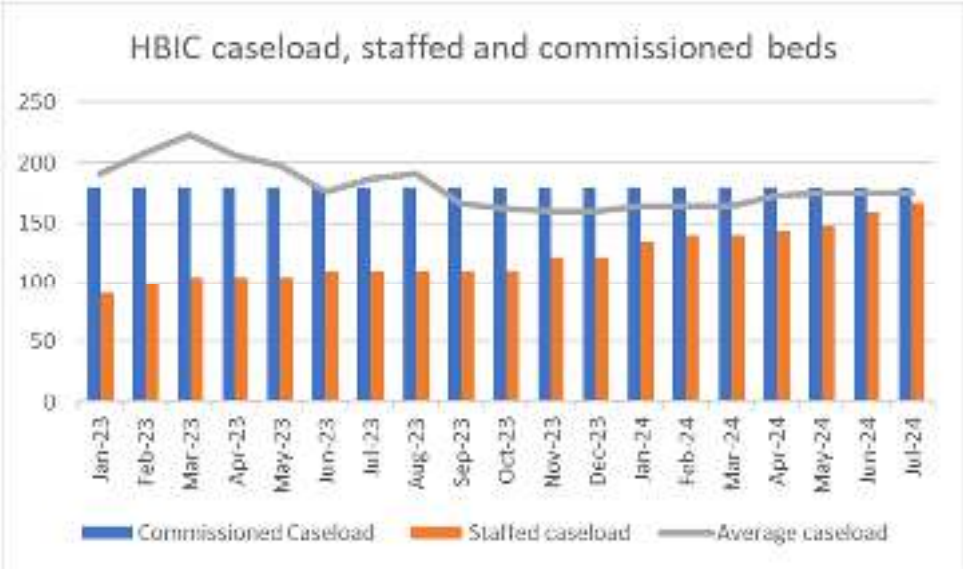
Risks: The National KPI's for home based immediate care have not been met since the service expanded including time to assess and time to treat, and reduced dosage resulting in increased length of stay beyond the anticipated 4-6 weeks.

6.8 Recruitment to these BCF funding posts is tracked and reported through place governance with partners.

6.9 **Current Mitigation:** Due to recruitment challenges, the service is now staffed to 175 beds but below the commissioned 180 beds. The service hasn't closed to referrals but implements a series of mitigations to maintain safe provision and met demand these include:

- Increased time to assess – safety netting in place
- Increased time to rehab commencement.
- Reduced intensity/dosage of rehab resulting in increased length of stay
- Ongoing active recruitment to 11.64 WTE in 24/25
- Bank and agency usage to mitigate 'hotspots'
- Suboptimal job plans (high ratio of Direct Clinical Care (DCC))

Chart 10: Actual vs commissioned and staffed HBIC beds.



6.10 We continue to have **75 Virtual Wards (VW)** beds open. Following the increase in occupancy during May and June 24 which saw the occupancy increase to above 90% which is above the national target of 80% occupancy. Occupancy for July saw a fall to 71% occupancy -which was driven by the fall in occupancy in Cardiology and respiratory. Occupancy for the individual wards are as follows: Cardiology (58%), Paeds (109%), frailty (92%), epicentre (82%), palliative (69%) and respiratory 34% from a previous high in May of 81%.

6.10.1 Further work is being undertaken to support the transfer of endocarditis patients for intravenous (IV) fluid provision within Cardiology VW. A review of diagnosis of patients stepping down into the Respiratory VW suggests the team are largely moving the intended

types of patients to the VW. However, the lack of impact on LOS and bed-days may suggest patients are leaving too late in their pathway; therefore, saving bed-hours rather than bed-days.

7.0 Type 3 Activity (UTC and GP Streaming)

7.1 Type 3 Activity contract performance for Malling provision is managed by the PCCT group, the contract KPIs include 4 hour target of 95%.

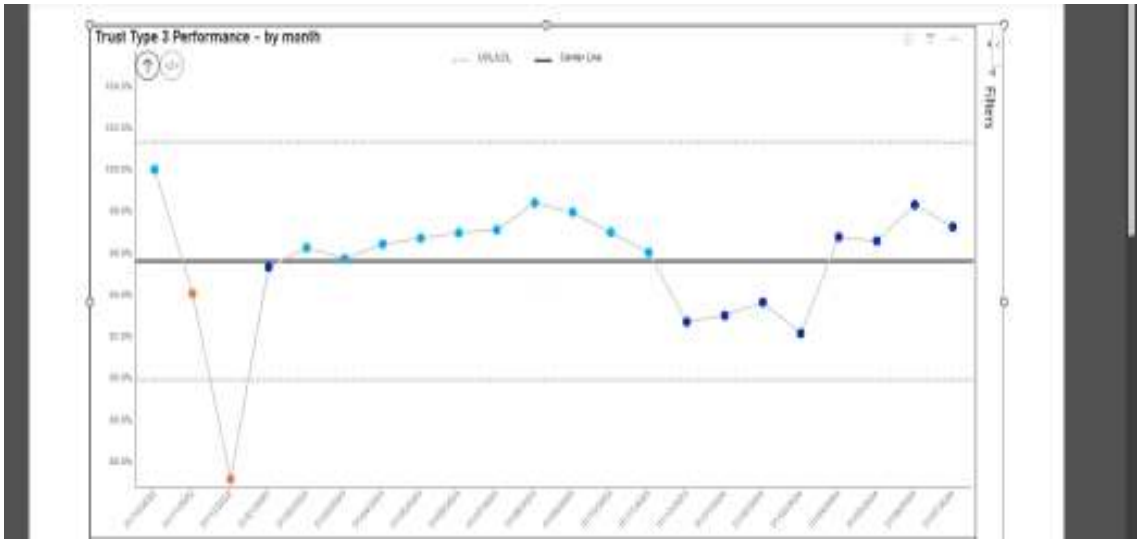
7.2 Combined Sandwell and City Malling performance demonstrates a recovery in April 24 and May 24 following the new process of Adastra data exaction and validation (Chart 14).

7.3 Additional Advanced Nurse Practitioner resource has been added to City provision to support with increased demand and hotspot volume of referrals.

7.4 Winter extended hours provision ceased at the start of April 24 as per the winter plan. However, it is now recommenced that from June 2024, that the extended hours continue to support the number of redirect referrals back to ED and this is due to referrals being received close to the closing time.

Chart 14: Type 3 Malling performance

Overall Trust Type 3 Performance



8.0 Operation Guidance 24/25 metrics

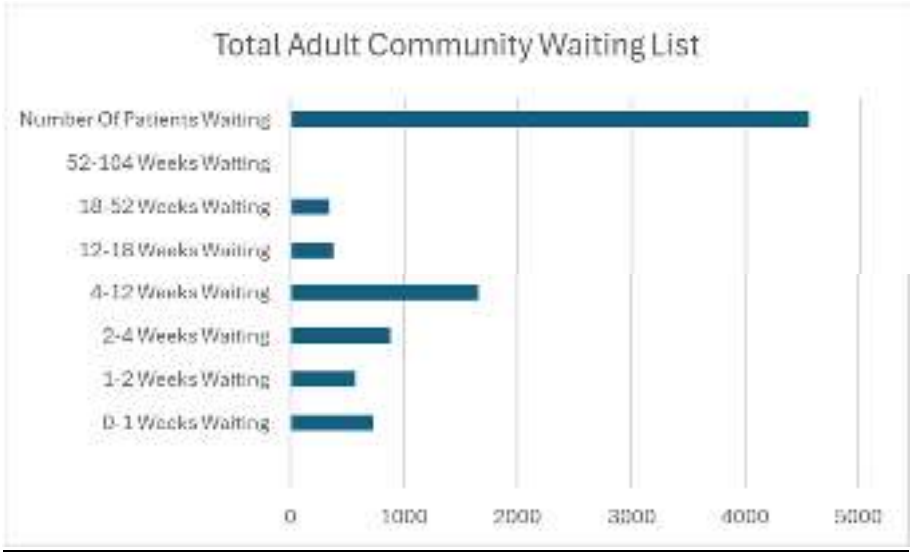
8.1 As per 24/25 planning guidance new metrics include:-

- Improve community services waiting times, with a focus on reducing long waits

- Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need

8.2 Adult Community waiting times by service are represented below in Chart 15.

Chart 15: Adult Community Waits by total and by service

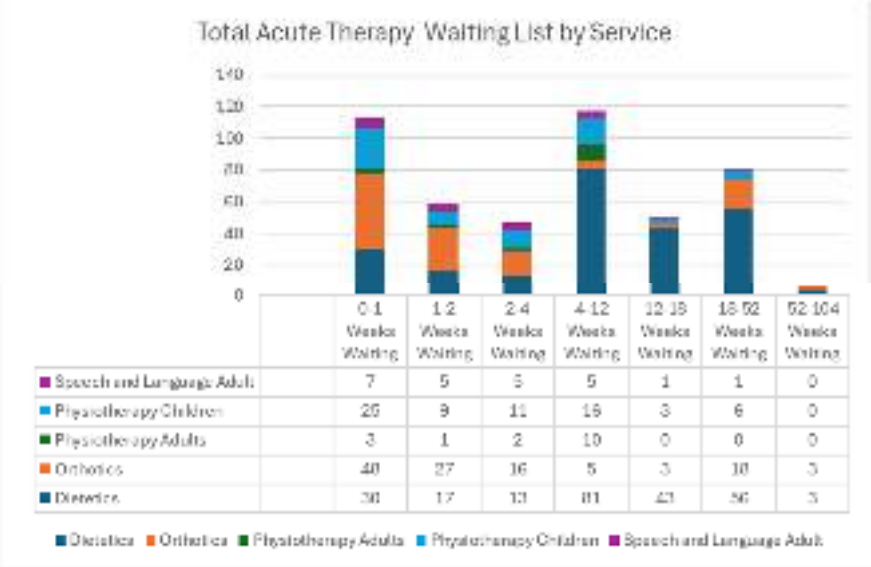


NB: Adult Community Services inclusive of Foot Health, Heart Failure, rehabilitation, Musculoskeletal, Continence, Community Respiratory, Community Nursing, Orthotic and Dietetics.

	All Adult services total	0-1 week wait	1-2 week wait	2-4 week wait	4-12 week wait	12-18 week wait	18-52 week wait	52-104 weeks wait	104+
Total	4560	733	573	884	1658	372	340	0	0

8.3 There are 0 community patients waiting over 52 weeks and all have a plan in place. There has been an overall increase in the waiting list by 3% rising from 4443 to 4560 with the biggest increase falling in the new referrals received into the services. There has been an overall reduction in the numbers waiting over 1 week by approximately 3% with the exception of 1- 2 weeks which has seen an increase from 500 patients to 573.

8.4 The data below shows the current waiting times for the acute therapy services



There are 6 patients that are over 52 weeks which have a plan in place to action.

8.5 The data for the community paediatric waiting list shows there are a total of 567 patients waiting with the longest non-TCI patient at 51 weeks. Ten (10) Additional clinics have been organised for September which will provide an additional capacity which will bring the waiting list down to 44 weeks with the proviso that the patients do not cancel their appointments.

8.6 The data below shows the data per 1000 registered population, however the low percentage of patients seen by a GP does not mean that the patient wasn't seen by the appropriate member of staff as Your Health Partnership (YHP) has a wider multidisciplinary team to meet the needs of the patients. If we use the Sandwell Place data as the comparator, YHP is 1.6% below the number seen by GP. However, there is more work to be done in terms of the number of appointments available to see patients on the same day or next day, which should improve with the implementation of the new triage / access system via Systm1

8.7 <u>Table 5:GP metrics for Integrated Practices</u>

		Month 6
		27th May - 30th June (5 weeks)

Practice	Summary	Total	Monthly Total Per 1,000	Weekly Ave / Per 1.000
YHP	Registered Patients	**50181**		
	Total Appts	**28432**	**567**	**113**
	DNA Appts	**2101**	**42**	**8**
	F2F Appts	**17885**	**356**	**71**
	Appts Booked to GP	**12724**	**254**	**51**
	Appts to Same Day	**11720**	**234**	**47**
Heath Street	Registered Patients	**6999**		
	Total Appts	**2407**	**344**	**69**
	DNA Appts	**200**	**29**	**6**
	F2F Appts	**1312**	**187**	**37**
	Appts Booked to GP	**1654**	**236**	**47**
	Appts to Same Day	**1003**	**143**	**29**
Summerfield	Registered Patients	**8802**		
	Total Appts	**2880**	**327**	**65**
	DNA Appts	**245**	**28**	**6**
	F2F Appts	**2277**	**259**	**52**
	Appts Booked to GP	**2069**	**235**	**47**
	Appts to Same Day	**1667**	**189**	**38**

		Total		
		Jan 2024 - June 2024 (6 Months / 26 Weeks)		
Practice	**Summary**	**Total**	**Monthly Total Per 1,000**	**Weekly Ave / Per 1,000**
YHP	Registered Patients	**304284**	**50714**	
	Total Appts	**142241**	**467**	**108**
	DNA Appts	**10385**	**34**	**8**
	F2F Appts	**88622**	**291**	**67**
	Appts Booked to GP	**64335**	**211**	**49**
	Appts to Same Day	**52583**	**173**	**40**
Heath Street	Registered Patients	**41994**	**6999**	
	Total Appts	**12538**	**299**	**69**
	DNA Appts	**925**	**22**	**5**
	F2F Appts	**6028**	**144**	**33**
	Appts Booked to GP	**8542**	**203**	**47**

	Appts to Same Day	**5505**	**131**	**30**
Summerfield	Registered Patients	**52812**	**8802**	
	Total Appts	**15083**	**286**	**66**
	DNA Appts	**1251**	**24**	**5**
	F2F Appts	**12212**	**231**	**53**
	Appts Booked to GP	**10737**	**203**	**47**
	Appts to Same Day	**8737**	**165**	**38**

GP Appointment Indicators	**YHP**	**Heath Street**	**Summerfield**	**Sandwell Place**
Appt Rate per 1000 population	**467**	**299**	**286**	**454.06**
% GP appointment	**45**	**68**	**71**	**46.8**
% F2F Appointments	**62**	**48**	**81**	**66.3**
% Same/Next Day Appointments	**37**	**44**	**58**	**53.3**

9.0 The Public Trust Board is asked to:

a) **NOTE** the contents of the report in the absence of the Integration Committee

Kulwinder Johal
Group Director of Operations

Lisa Maxfield
Associate Chief Integration Officer

August 2024

Tier 1 - Paper ref:	PublicTB (09/24) 008

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Maternity and Neonatal Service Update to Board		
SPONSORING EXECUTIVE:	Melanie Roberts – Chief Nursing Officer Dr Mark Anderson – Chief Medical Officer		
REPORT AUTHOR:	Helen Hurst – Director of Midwifery		
MEETING:	Public Board	**DATE:**	11th September 2024

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

- The Trust received a section 29A this is a warning notice where significant improvement is required, following the unannounced visit on 4-5th June 2024 from the Care Quality Commission (CQC), highlighting 6 areas of concern. The Trust were asked to make significant improvements to 5 of the 6 concerns by the 31st of July with the remaining area by 16th of September. The required response and evidence were submitted on the 31st July 2024. The CQC acknowledged the in-depth response.

- An independent review was commissioned earlier in the year by the Chief Nursing and Medical Officers due to several concerns raised through varying arenas. The review took place during June and July, coincidentally at the same point as the CQC visit. The high-level findings are within the report, with the full report and recommendations found in the reading room.

- Annex 1 contains Ockenden framework update.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff	X	To work seamlessly with our partners to improve lives	X

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Board is asked to:

a.	**NOTE** the report
b.	**DISCUSS** the content

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

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		

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 Board on 11th September 2024

Maternity and Neonatal Service Update to Board

1. Introduction

1.1 The paper supports Board level oversight for Maternity and Neonatal Services which is fundamental to quality improvement, to ensure transparency and safe delivery of services.

2. Update of Progress Following the CQC Section 29A

2.1 The Trust received a Section 29A following the unannounced visit on 4th – 5th June 2024, this is a warning notice where significant improvement is required, highlighting 6 areas of concern which were as follows:

1. The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards and national guidelines. We were not assured that daily checks of emergency and lifesaving equipment were effectively carried out, and there was no process in place for the checking of enhanced care emergency equipment. There was no resuscitaire in triage, and the triage environment did not promote the privacy and dignity of service users.
2. There were not enough midwifery and nursing staff to provide safe care and treatment, and skill mix did not always follow national guidance. There was not always appropriate medical oversight of the triage unit.
3. The Trust's induction of labour guidelines did not meet national guidance. There were delays to the induction of labour, which led to poor outcomes for women, birthing people and babies.
4. Routine enquiries around domestic abuse were frequently not completed, with rationale often omitted. Recording of other safeguarding concerns, such as female genital mutilation (FGM), was not always accurate.
5. The Trust did not adhere to guidance around the Birmingham Symptom Specific Obstetric Triage System (BSOTS) in triage.
6. Service users did not always receive interpreting services as appropriate.

2.2 <u>Response:</u>

2.2.1 The developed action plan was approved via the executive and non-executive led weekly oversight meeting set up to monitor and support the progress required to address the section 29A notice. The ongoing governance was via monitoring the weekly oversight meeting, with attendance from the non-executive safety champion, relevant perinatal team and corporate governance team members. This included an upward report, containing updated evidence.

2.2.2 The plan consists of 22 separate actions and all evidence submitted against on the 31st July has been through a 2 step scrutiny process: 1st level scrutiny by the Associate Director of Quality Assurance with final scrutiny by the Chief Medical Officer, this included an update

on progress made against the submission for the 16th September. Feedback from the CQC has been that the action plan and actions were comprehensive.

2.2.3 Weekly oversight and upward reporting continue, with good progress being made against all actions and progress to meet the submission for the 16th September. There are no actions off target, however the ability to support an independent telephone triage for maternity is compromised based solely on workforce, with a plan in place to mitigate this, looking at an alternative workforce model across the system with the formation of a centralised telephone triage collocated with West Midlands Ambulance Service, a working group is in place and progressing, trajectory for introduction in Quarter 4. Weekly updates are shared with the CQC.

2.2.4 Workforce trajectory is in place with a current trajectory to fill 22 whole time equitant (wte) vacancies at midwife practitioner (B5&6). Expected new starts commence from 16th September, these are newly qualified midwives, given the high number and effect on skill mix, the team have developed a plan to ensure safe staffing and bespoke additional package has been designed to ensure support across the service.

2.2.5 Specific funding has been identified via the allocated monies from NHSE to support establishments to achieve birth rate plus requirements to further support maternity triage, with an additional 6.6 wte posts.

2.2.6 The full action plan and letter of response can be found in the Trust Board meeting reading room on iBabs.

3. Independent Review – Key Themes

3.1 An independent review of the Trust's Maternity services was commissioned following staff concerns about staffing levels, culture and behaviours, whistle blowing concerns raised with CQC, the departure of a senior postholder, concerns detailed within the Neonatal Review (2023) and patient feedback within complaints.

3.1.1 The review took place during June and July 2024. A draft report was shared with Group, Directorate and Executive commissioners for factual accuracy check prior to submission. During the review period, an unannounced CQC inspection of the maternity service took place.

3.1.2 The Directorate team are facing a unique set of circumstances: newly appointed Head of Midwifery, impending relocation of services and expected CQC report.

3.2 *<u>High Level Findings</u>*

3.2.1 Staff within maternity are displaying "victim mentality" behaviours and silo working practices which are hampering innovation and transformation. There is an urgent requirement for development of the matron and Band 7 teams to enable consistent and robust clinical leadership. The directorate needs to move from silo working and victim mentally to learning and innovation, with challenge and professionalism.

3.2.2 Staff and family voices have not always been heard. They need to be heard and responded to in a professional, structured and consistent manner.

3.2.3 The directorate structure, roles and responsibilities of senior and specialist staff are not understood nor valued by several clinically based staff which is contributing to the negative feelings within the workforce.

3.2.4 Adherence to Trust policy relating to Infection Prevention and Control is urgently required.

3.2.5 Multi-disciplinary daily leadership and coordination of shifts is needed to ensure safety and effective team working.

3.2.6 There is a need to adopt national National Institute for Health and Care Excellence (NICE) guidance relating to Induction of Labour. Transitional Care for vulnerable babies should be established to reduce unnecessary separation of mothers and their babies.

3.2.7 Senior, Perinatal representation is required within the Women & Children Group leadership team. The interim matron structure currently in place should be maintained. Assigned Consultant roles need to be widely shared and understood.

3.2.8 The Perinatal team require support and development to navigate the challenging and unique set of circumstances they face.

3.2.9 A full action plan is yet to be established. The Board are asked to note that the following actions already taken:

- The Director of Midwifery will be working as part of the Women & Children Group team.
- Substantive appointment of a Head of Midwifery has been made and the appointee has already started in post.
- Development of a People Plan for Directorate staff groups is underway and in draft, developed by members of the Directorate teams.
- Handling and responding to complaints training has been undertaken.
- A phased plan is in progress to achieve NICE guidance relating Induction of Labour.
- External support from an external Midwife and Obstetric Consultant is being explored.
- An independent Improvement Director has been brought in to support the actions from this review, as well as the CQC and other actions, developing an intended single improvement plan for the service.
- The report will be shared across the service, ensuring support and listening events for the staff.

3.3 The full report can be found in the reading room.

4. Recommendations

4.1 The Public Board is asked to:

a. **NOTE** the report
b. **DISCUSS** the content

Helen Hurst
Director of Midwifery

29TH August 2024

Annex 1: Ockenden Framework Update for September (June and July Data) 2024

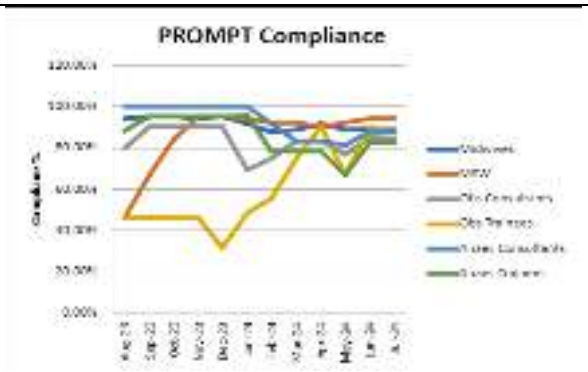
Annex 1

Ockenden Framework Update for September (June and July Data) 2024

<table>
<tr><th>Data Measures</th><th>Summary</th><th>Key Points</th></tr>
<tr><td>Findings of review of all perinatal deaths using the real time data monitoring tool

Rate is per thousand births. 2/512 = 2 still births out of 512 in month births</td><td>
<table>
<tr><th>2024</th><th>Jan</th><th>Feb</th><th>March</th><th>April</th><th>May</th><th>June</th><th>July</th></tr>
<tr><td>Corrected Stillbirth rate</td><td>3.9
2/512</td><td>3.95
2/506</td><td>6.09
3/493</td><td>2.0
1/487</td><td>4.2
2/474</td><td>2.2
1/447</td><td>4.02
2/497</td></tr>
<tr><td>Neonatal Mortality Rate</td><td>0
(0)</td><td>2
(1)</td><td>0</td><td>0</td><td>4.2
(2)</td><td>2.2
(1)</td><td>2.05
(1)</td></tr>
<tr><td>Perinatal Mortality Rate</td><td>3.9</td><td>5.9</td><td>6.09</td><td>2.0</td><td>8.4</td><td>4.5</td><td>6.1</td></tr>
<tr><td>Rolling PNMR from January</td><td>2/512
3.9</td><td>6/1018
5.9</td><td>9/1511
5.9</td><td>10/1998
5.0</td><td>14/2472
5.7</td><td>16/2919
5.5</td><td>19/3416
5.6</td></tr>
</table>
</td><td>Still Birth occurred between 28 and 36 weeks.
The 2 NND, 1 case occurred at 9 days of age at home.

Cases will be reviewed using the perinatal mortality review tool and graded according to the findings. The quarterly report on cases will be presented to quality committee next month.</td></tr>
<tr><td>Findings of review all cases eligible for referral to Maternity and neonatal safety investigation MNSI)
The number of incidents logged graded as moderate or above and what action being taken.</td><td>
<table>
<tr><th colspan="2">Current ongoing MNSI / moderate harm MDT review/ SWARM or After-Action Review</th><th>Themes of Cases</th></tr>
<tr><td>Open MNSI Referrals</td><td>3</td><td>HIE/cooling
Intrapartum still birth</td></tr>
<tr><td>MDT Review</td><td>8</td><td>Haemorrhage
Sequential instruments at birth
Born outside of the < 27 week pathway
Birth injury</td></tr>
<tr><td>SWARM Huddles/after action reviews</td><td>3
1</td><td>Undiagnosed cardiac anomaly
Still birth</td></tr>
<tr><td>Concise Reviews Commissioned</td><td>0</td><td></td></tr>
<tr><td colspan="2">Completed Reports</td><td></td></tr>
<tr><td>MNSI</td><td>4</td><td></td></tr>
</table>
</td><td>There were 4 completed reports, all with action plans being developed, shared learning and family debriefs scheduled.
Shared learning and actions from all reviews in place.</td></tr>
</table>

<table>
<tr>
<td>Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.</td>
<td> 
</td>
<td>All training above 85% against target of 90%, on track to achieve. Plan to move towards a 10-month rolling year.</td>
</tr>
<tr>
<td>Minimum safe staffing in maternity services, to include obstetric cover on the delivery suite, gaps in rotas and minimum midwifery staffing, planned vs actual prospectively.</td>
<td>Midwifery vacancy 26.7 wte(B5&6)
8.8 (B7 including specialist mw and manager roles))

Obstetric workforce
<table>
<tr><td>Consultant</td><td>1 vacancy (locum in place)</td></tr>
<tr><td>Middle Grade</td><td>3 Vacancies</td></tr>
</table>
NNU Nursing vacancy at QIS at 14.94 wte

Neonatal Clinicians
<table>
<tr><td>Tier 1</td><td>0 vacancies</td></tr>
<tr><td>Tier 2</td><td>0 vacancies</td></tr>
<tr><td>Tier3</td><td>10 in post (includes 2 locums)</td></tr>
</table>
Both nursing and clinical establishment funding is British Association of Perinatal Medicine complaint.</td>
<td>23 midwifery job offers made, this however will impact skill mix again and will require planning and support. The service is impacted further by the current international midwives progressing through competency to work autonomously. The workforce gap does impact on the morale of our workforce, with support for health and wellbeing in place. Work continues to improve safety culture which is impacted.
NNU nursing plan in place, to over recruit at band 5 to grow QIS.</td>
</tr>
<tr>
<td>Service User Voice feedback</td>
<td>Complaints received related to communication, care and information sharing.</td>
<td></td>
</tr>
<tr>
<td>Staff feedback from frontline</td>
<td>feedback from Executive and Non-Executive safety champion focus on morale and staffing, however staff have started to see a more supportive environment. Freedom to speak up walkabouts and work</td>
<td>People plan developed in</td>
</tr>
</table>

champions and walk-abouts	undertaken by the recruitment and retention lead, as well as feedback via the Improvewell App form staff have also been taking place regularly to support the culture of staff being able to raise concerns has been positive overall. Concerns and issues raised are actioned by the Head of Midwifery and team.	collaboration with the teams in draft.
MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	CQC section 29A NHSR review of cases referred from 2017-to date MNSI action plan	See above Themed report taken to QC 28.8.24 Monitored via QC
Coroner Reg 28 made directly to Trust	None	None
Progress in achievement of CNST10	The team are working through MIS year 6, with governance in place to ensure oversight and provide update via the Group. Currently on track with 8 out of 10, actions in place to support compliance.	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Reported via staff survey report.	
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical	GMC National Training Survey - Obs & Gynae specialty Indicator / Mean score / Outcome Adequate Experience / 87.76 / Within IQR Clinical Supervision / 90.66 / Within IQR Clinical Supervision out of hours / 86.46 / Within IQR Educational Governance / 82.72 / Within IQR Educational Supervision / 82.24 / Within IQR Facilities / 58.77 / Within IQR Feedback / 59.67 / Within IQR Handover / 71.27 / Within IQR Induction / 86.84 / Within IQR Local Teaching / 82.40 / Within IQR Overall Satisfaction / 87.11 / Within IQR Regional Teaching / 73.74 / Within IQR Reporting Systems / 68.42 / Within IQR Rota Design / 78.82 / Within IQR Study Leave / 83.16 / Within IQR Supportive Environment / 85.79 / Within IQR Teamwork / 73.69 / Within IQR Work Load / 82.46 / Within IQR	

Tier 1 - Paper ref:	PublicTB (09/24) 009

Sandwell and West Birmingham NHS Trust

Report title:	Financial Position – to 31 July 2024 (Month 4)
Sponsoring executive:	Simon Sheppard, Acting Chief Finance Officer
Report author:	Simon Sheppard, Acting Chief Finance Officer
Meeting title:	Public Trust Board
Date:	11 September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

As of the end of July 2024, the Trust reported a deficit of £20.007 million, which is £3.596m worse than planned, an underspend of £5.094 million in the capital programme with a cash balance of over £38 million.

Key issues include being 155 whole-time equivalents above the workforce plan and needing to address a significant shortfall in elective recovery activity, despite improvements in clinical coding and counting. The Trust Board is asked to note the financial position and the critical areas of focus, including workforce management, elective recovery and productivity, and the financial improvement programme.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	**X**
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	**X**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

Performance Management Group; Trust Management Committee; Finance & Productivity Committee

4. Recommendation(s)

The Public Trust Board is asked to:

a) **NOTE** the financial position at the end of July 2024.

b) **DISCUSS** the key areas of focus of workforce trajectory, elective recovery and productivity and the financial improvement programme.

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

Board Assurance Framework Risk 01	X	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	X	*Make best strategic use of its resources*
Board Assurance Framework Risk 03	X	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	X	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	X	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Sandwell & West Birmingham NHS Trust

Report to the Public Trust Board on 11th September 2024

Financial Position – to 31 July 2024 (Month 4)

1. Executive summary

1.1 This report updates the Trust Board on the financial position at the end of July 2024 against the Income & Expenditure plan and the capital and cash programmes. It also provides an update on the key drivers of the financial plan, these being, workforce, elective recovery and the financial improvement programme.

.

1.2 The key performance measures are:

- At the end of July the Trust has reported a deficit of £20.007m which is £3.596m adverse to the Income & Expenditure Plan.
- £5.094m under spend against the capital programme.
- A cash balance of almost £37m.
- £1.436m favourable position against the elective recovery funding inclusive of significant clinical coding and counting improvements.
- 155 whole time equivalents above the plan trajectory reflecting the additional capacity open.

1.3 The Trust Board is asked to note the financial position, the key areas of focus and the mitigating actions to manage the risks.

2. Introduction

2.1 The Trust Board on 8 May 2024 approved the Operational Plan for 2024/25. From a financial perspective this included:

- The Income & Expenditure (I&E) Plan of £43.2m deficit plan inclusive of a £44.1m (5.7%) efficiency plan.
- A capital plan of £62.5m.
- A monthly cashflow plan that ends the year with a circa £6m balance (from £65m as at 31 March 2024).
- A reduction in deployed workforce of 158wte by 31 March 2025.

2.2 All providers were asked to resubmit plans on the 12 June 2024. From a financial perspective there were no changes.

2.3 This report updates the Trust Board on the financial position at the end of July 2024 (Month 4), and the key elements of this position including performance against the workforce plan and the elective activity plan.

3. Financial Overview

3.1 Table 1 provides a summary of the key financial metrics.

Table 1 – Financial Key Metrics

	In Month Plan £ms	In Month Actual £ms	In Month Variance £ms	Year to Date Plan £ms	Year to Date Actual £ms	Year to Date Variance £ms
I&E Performance	(1.24)	(4.84)	(3.61)	(16.41)	(20.01)	(3.60)
Agency Costs	0.83	1.43	(0.60)	3.52	5.95	(2.43)
Financial Improvement Programme	3.19	2.63	(0.56)	9.76	9.21	(0.54)
Capital Expenditure (ICB Allocation)	2.48	1.23	1.25	6.16	3.32	2.83
Capital Expenditure (Other)	3.59	2.29	1.30	13.76	11.50	2.26
Cash Balance	39.16	36.83	(2.32)	39.16	36.83	(2.32)

Income & Expenditure Performance

3.2 At the end of July the Trust has reported a deficit of £20,007k which is £3,596k adverse to the Plan.

	Plan £000s	Actual £000s	Variance £000s
Patient Related Income	(216,583)	(215,275)	(1,308)
Other Income	(19,588)	(18,005)	(1,583)
Pay	154,955	157,641	(2,686)
Non Pay	97,627	95,646	1,981
Total	**16,411**	**20,007**	**(3,596)**

3.3 The key points for the Trust Board to note are:

An adverse position at month 4 of £3,596k. This is driven by:

- £2m+ adverse "other income" from Birmingham & Solihull Integrated Care Board (BSOL) for Midland Metropolitan University Hospital (MMUH) costs (the year to date balance of the annual plan assumption of £18.75m from BSOL less the contractual offer)
- The impact of industrial action, £1.1m, across patient related income and pay costs.
- Pay overspend as a result of industrial action and being adverse to the workforce trajectory.

3.4 The month 4 position, with the exclusion of the MMUH income assumption and the impact of industrial action (funding expected for the end of August position) would be on plan. However, the Trust Board should note the trajectory of the plan becomes ever stretching

and the mitigating actions described later in the paper need to be enhanced from an action and delivery perspective.

Workforce

3.5 The Trust has agreed on a stretch workforce plan for the current financial year targeting a 5% reduction, excluding MMUH, equivalent to approximately 400 whole time equivalent (WTE). With the need to recruit for MMUH (242 FWE), the net planned reduction is 158 'deployed' WTE, representing around a 2% reduction. However, by the end of July, the Trust is 155 FTE adverse to the plan. Details are provided in Annex 1.

3.6 Key actions to support getting back on track with the trajectory include:

- Formal sign off of the Group / Corporate Directorate Establishment reviews and recurrent disestablishment of posts where safe to do so. This includes Quality Impact Assessments.

- Whilst we have seen an increase of substantive recruitment over plan the challenge is ensuring that bank and agency are significantly reduced to offset this. A detailed review of agency, interim and fixed-term posts has commenced and will be finalised in September.

- The [safe] closure of additional capacity in Medicine (86 FTE) directly linked to the MMUH bed fit challenge.

- Implementation and delivery of the workforce related Financial Improvement Programme (FIP) schemes. Three workforce workstreams have been mobilised as part of the FIP, focusing on Rostering, Medical Workforce, and Temporary Staffing.

- Consideration of further actions to ensure the monthly trajectory is achieved.

Elective Recovery

3.7 As part of the 2024/25 Operational Plan the Trust Board approved the activity and elective recovery trajectory. This included a submission of 103.4% relating to the value weighted activity. This SWB submission supported the Black Country ICB in submitting in excess of the national target of 107%.

3.8 In total the Trust needs to deliver a minimum £128.2m income in 2024/25 to meet the elective recovery funding (ERF) target. The monthly values reflect a realistic profile taking account of working days and the opening of MMUH. Annex 2 graphically shows performance to date and the monthly trajectory.

3.9 Month 4 performance is summarised in the table below and clearly shows a positive start to the 2024/25 financial year against ERF - £1,436k favourable.

Variable_Type	PodGrpCode2	Total Activity Plan	Total Activity Actual	Total Activity Diff	Total Price Plan	Total Price Actual	Total Price Diff
Variable ERF	Daycase	12,346	11,863	482	£13,006,126	£12,247,249	-£758,877
	Elective	1,902	1,798	-104	£7,567,071	£6,537,407	-£1,029,664
	Excess Bed Days	527	488	-39	£193,977	£154,172	-£39,804
	OP New Attendances	73,337	75,866	2,529	£34,200,759	£34,731,194	£530,434
	OP New Virtual Attendances	7,512	6,771	741	£1,616,728	£1,479,462	-£137,265
	OP Procedures	44,363	62,533	18,181	£8,302,607	£11,173,699	£2,871,091
Variable ERF Total		139,977	159,449	19,472	£44,947,268	£46,383,183	£1,435,915
Variable Other Elective	Imaging - Direct Access	22,155	19,292	-2,863	£1,595,088	£1,339,081	-£256,008
	Imaging - OP Diagnostics	21,250	23,783	2,533	£2,472,924	£2,808,936	£336,012
	Chemotherapy	1,282	811	-471	£313,636	£221,632	-£92,004
Variable Other Elective Total		44,687	43,885	-802	£4,381,648	£4,369,649	-£12,000
Grand Total		184,664	203,334	18,670	£49,328,916	£50,752,832	£1,423,916

3.10 It is important for the Trust Board to be aware of the significant improvement in the coding and counting and the impact on the ERF numbers – both activity and £'s. This is estimated to be in excess of £6m in 2024/25.

3.11 The improved counting is an excellent start, however if we exclude the in year improvement from this, it does highlight the significant adverse position in day case and elective activity. -8.7%, £1.8m, adverse on the income plan. The Theatres workstream needs to ensure the identified improvements are implemented to recover this position and support over-performance against the Plan.

Financial Improvement Programme

3.12 The Trust has a very stretching and ambitious financial improvement programme of £44.1m in 2024/25.

3.13 The target is profiled approximately 40% (£17m) in the first half of the year and 60% (£27m) in the second half. The year to date position is an actual performance of £9.213m against a plan of £9.758m.

3.14 The risk adjusted forecast stands at c£40.4m PLUS, significant hopper ideas not yet valued. Pipeline opportunities must progress through the gateway process before they can be reflected on the tracker for profiled reporting. Workstreams have been mobilised to progress this in addition to further ideas generation.

3.15 Each workstream has an accountable Executive with support from a responsible officer and the project management office. The workstreams can be grouped into 2 categories – those of a desk top nature / corporate driven such as contract review, clinical coding and counting and procurement and those requiring operational support and capacity such as workforce, theatres and outpatients.

3.16 The Trust Board should also note the external review by PA Consulting regarding the "Investigation and Intervention" phase of the system recovery plan has been concluded. The report will be considered in the private board.

Capital and Cash

3.17 The Trust is reporting a £5,094k underspend year to date against the plan of £19,914k. This underspend is across all the categories. The respective professional leads have been tasked with ensuring this underspend is recovered during quarters 2 and 3.

3.18 The cash balance at the end of July is £36.8m and the Trust is still forecasting not to require any borrowing during 2024/25.

4. Productivity

4.1 There is national focus on improving the levels of NHS productivity both this year and into the future to help deliver balanced system finances and improvements in operational standards. Some of the background and context to this work is set out in the May 2024 NHS England Board paper.

4.2 Over the last few months NHS England have been working to develop a number of tools and products to help support organisations diagnose and improve their own productivity performance. There are 4 tools and products which are now available to support organisations. These tools come with an analysis of the implied productivity position of your trust in 2023/24 vs 2019/20, with an explanation of what may be driving the productivity gap.

- Each trust's position and drivers will be unique, and the national analysis won't be able to reflect all local nuances but is a useful starting point for local discussions on how to drive productivity gains in 2024/25 and beyond.
- Service changes and coding changes could distort the productivity position, in particular when comparing to 2019/20. Where such issues are known to the national team, adjustments have been made to illustrate the impact.
- The waterfall workbook includes underlying data and detailed calculation methodology has been provided that allows providers to make adjustment to input to reflect, for example, service changes.

4.3 Based on our submitted activity levels and costs SWB has 12% productivity lag when compared to 2019/20. Further details are provided in Annex 5.

4.4 The Finance & Productivity Committee had a comprehensive discussion regarding how the productivity analysis can support the 2024/25 Financial Improvement Programme and our underlying financial position and medium term financial plan. The action plan will be presented to the Committee at the September meeting. This also supports the key in year objective of our Strategic Planning Framework – Recurrent Financial Improvement.

5. Risks & Mitigation

5.1 Overall, across all of the Operational Plan metrics the plan can be described as stretching, ambitious and realistic. That said, it is not without risks, which are actively being managed and mitigated.

5.2 The risks can be summarised into 4 categories and are shown in Annex 4.

5.3 The risks within the plan are well understood by the Executive team and will be reflected in the 2024/25 risks register and Board Assurance Framework (inclusive of actions and controls). Oversight of the management of these risks at Board level will be via the relevant Board committee.

6. Recommendations

6.1 The Public Trust Board is asked to:

a. **NOTE** the financial position at the end of July 2024.
b. **NOTE** the key areas of focus of workforce trajectory, elective recovery and productivity, and the financial improvement programme.

Simon Sheppard
Acting Chief Finance Officer

29 August 2024

Annex 1: Workforce trajectory and performance to date
Annex 2: Elective Recovery Performance
Annex 3: Capital Programme
Annex 4: Risks & Mitigations
Annex 5: Productivity

Annex 1 - Workforce trajectory and performance to date

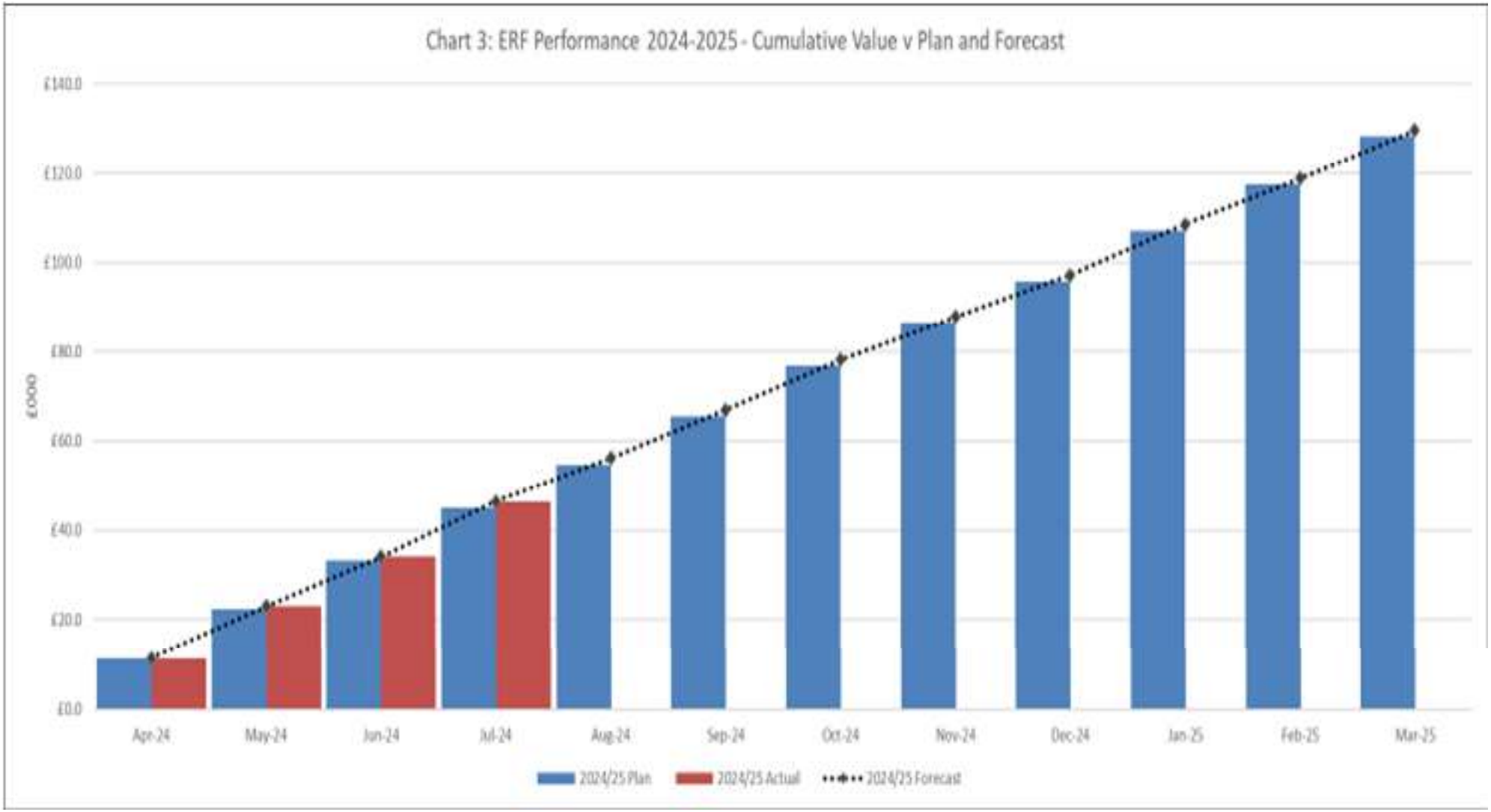
Date	01/03/2024	01/04/2024	01/05/2024	01/06/2024	01/07/2024	01/08/2024	01/09/2024	01/10/2024	01/11/2024	01/12/2024	01/01/2025	01/02/2025	01/03/2025
	Baseline	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Staff in post outturn Year End (31 Mar-24)	As at the end of Apr-24	As at the end of May-24	As at the end of Jun-24	As at the end of Jul-24	As at the end of Aug-24	As at the end of Sep-24	As at the end of Oct-24	As at the end of Nov-24	As at the end of Dec-24	As at the end of Jan-25	As at the end of Feb-25	As at the end of Mar-25
	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE	Total WTE
Total	8141.03	8109.50	8085.11	8080.48	8087.58	8122.53	8106.11	8088.69	8071.28	8063.25	7999.00	7995.50	7983.00
Contracted FTE	7041.03	7036.92	7039.94	7062.73	7097.25	7169.61	7170.61	7180.61	7190.61	7210.00	7212.00	7212.00	7212.00
bank	998.00	974.08	950.17	926.25	902.33	878.42	854.50	830.58	806.67	782.75	720.00	720.00	711.00
agency	102.00	98.50	95.00	91.50	88.00	84.50	81.00	77.50	74.00	70.50	67.00	63.50	60.00

In-Month Actuals / Contracted

	Apr-24	May-24	Jun-24	Jul-24
Substantive - Contracted	**7,060.9**	**7,094.0**	**7,102.5**	**7,116.2**
Administration and Estates	1,062.0	1,075.3	1,084.3	1,082.6
Healthcare Assistants and Support Staff	1,310.7	1,331.7	1,335.9	1,357.5
Management	304.6	307.6	310.2	310.5
Medical Staffing	923.6	924.7	921.9	904.1
Other Pay	-	-	-	-
Qualified Nursing and Midwifery	2,377.5	2,375.8	2,376.4	2,382.9
Scientific, Therapeutic and Technical	1,082.5	1,078.9	1,073.8	1,078.6
Bank	**981.6**	**977.7**	**1,033.0**	**993.6**
Administration and Estates - Bank Staff	151.9	161.5	164.0	172.8
Healthcare Assistants and Support Staff - Bank	358.6	338.0	365.0	325.6
Medical Staffing - Bank Staff	97.5	100.9	103.1	116.7
Qualified Nursing and Midwifery - Bank Staff	329.4	336.4	362.1	334.0
Scientific, Therapeutic and Technical - Bank Sta	44.2	40.9	38.8	44.5
Agency	**127.2**	**124.3**	**122.2**	**133.3**
Administration and Estates - Agency Staff	2.6	16.3	16.2	16.2
Healthcare Assistants and Support Staff - Agenc	0.8	-	3.5	2.4
Medical Staffing - Agency Staff	52.2	43.8	42.8	44.1
Qualified Nursing and Midwifery - Agency Staff	51.7	40.8	40.6	43.4
Scientific, Therapeutic and Technical - Agency St	20.0	23.4	19.2	27.2
Grand Total	**8,169.8**	**8,196.0**	**8,257.7**	**8,243.0**

- Plan workforce trajectory at the end of July of 8,088 WTE
- Actual workforce WTE of 8,243.
- Adverse position of 155WTE, predominately due to additional capacity remaining open.

Annex 2 - Elective Recovery Performance



Annex 3: Capital Programme

	Annual	Year to Date			Year End Forecast		
	NHSE Plan £000s	NHSE Plan £000s	Actual £000s	Variance £000s	NHSE Plan £000s	Forecast £000s	Variance £000s
Internal - Self Financing							
Estates	7,458	3,419	2,010	1,409	7,458	8,530	-1,072
Mid Met Urgent Treatment Centre	11,127	15	30	-15	11,127	11,127	0
IT	4,147	1,951	1,024	927	4,147	4,147	0
Medical equipment	3,855	770	260	510	3,855	5,223	-1,368
Charity	0	0	0	0	0	90	-90
Sub total	**26,587**	**6,155**	**3,324**	**2,831**	**26,587**	**29,117**	**-2,530**
External - PDC Funded							
IT - Frontline Digitisation	4,200	868	10	858	4,200	4,200	0
MMUH - Cost to complete	15,739	9,527	8,726	801	15,739	15,739	0
Learning Hub / Campus	13,384	1,516	367	1,149	13,384	13,484	-100
Sub total	**33,323**	**11,911**	**9,103**	**2,808**	**33,323**	**33,423**	**-100**
TOTAL INTERNAL & PDC FUNDED	**59,910**	**18,066**	**12,427**	**5,639**	**59,910**	**62,540**	**-2,630**
Technical-IFRIC12							
BTC & MES	1,190	373	339	34	1,190	1,190	0
ROU Assets - IFRS16							
ROU Leased Assets (internally Funded)	1,475	1,475	2,053	-578	1,475	2,053	-578
Trust Wide Programme	**62,575**	**19,914**	**14,820**	**5,094**	**62,575**	**65,783**	**-3,208**

The table above shows the Month 4 spend position against the agreed Trust plan for 24/25, which includes an overcommitment of £3.2m against the NHSE plan.

The Capital workstream leads are producing a rephased plan for the remainder of 24/25 to ensure progress can be monitored.

A revised MOU for MMUH will be released, the Trust's Finance teams are liaising with NHP Finance to agree a timescale and an agreed forecast for 2024/25.

Annex 4: Risks & Mitigations

Theme	Risk	Board Committee Oversight	Update
MMUH	Operational readiness Bed Fit Unforeseen costs	MMUH Opening Committee	12 week sprint supported the discussion at the Board on 21 August 2024. There is no contingency in the plan for additional beds
Financial	Efficiency at 5.7% Cash Excess inflation BSOL income assumption No contingency in the plan	Finance & Productivity Committee	Financial Improvement Programme requires the opportunities moved to delivery particularly around reducing pay costs and increasing income. Focus on productivity metrics and key lines of enquiry
Workforce	Recruitment Retention Sickness levels Temporary staffing reduction Industrial Action	People Committee	We are 155 adverse to our agreed trajectory. This requires immediate action. Additional capacity needs to safely be closed to support us getting on track. Granular review of temporary staffing needed for M5 reporting
Capacity	Winter Plan Additional beds required People to support MMUH opening and core business	Finance & Productivity Committee	

Annex 5: Productivity

NHS Black Country Integrated Care Board	Integrated provider[††]	Substantive Workforce			Workforce growth comparison		CW Activity	Productivity 2019/20-2023/24	Productivity - Model Health System 2019/20-2023/24
Provider Name		2019/20	2022/23	2023/24	Growth (#)	Growth (%)	Growth (%)	((1+CWA%)/(1+WTE Growth%))-1	Includes temp staff
Sandwell and West Birmingham Hospitals NHS Trust	Yes	6,255	6,714	6,818	563	9.0%	-4.4%	-12.3%	-17.3%
The Dudley Group NHS Foundation Trust		4,418	5,328	5,459	1,041	23.6%	19.5%	-3.0%	-0.1%
The Royal Wolverhampton NHS Trust	Yes	8,236	9,661	10,067	1,831	22.2%	33.7%	9.4%	6.5%
Walsall Healthcare NHS Trust	Yes	3,575	4,333	4,507	931	26.0%	28.5%	2.0%	-3.3%

Sandwell and West Birmingham Hospitals NHS Trust	Activity*			Growth	
Activity Type	2019/20	2022/23	2023/24	Growth (#)	Growth (%)
Cost Weighted Activity Growth					-4.4%
1st Outpatients	206,822	176,878	194,761	-12,061	-0.6%
Follow Up Outpatients	270,251	253,072	248,933	-21,318	-0.9%
Total Outpatients	477,073	427,948	443,694	-33,379	-1.4%
Total Elective Admissions	42,901	40,587	41,059	-1,842	-0.6%
A&E Attendances	216,238	331,889	283,169	66,931	4.7%
Non Elective Admissions	46,628	41,569	39,070	-7,558	-7.0%

	Substantive Workforce			Growth	
Staff Group	2019/20	2022/23	2023/24	Growth (#)	Growth (%)
Substantive Workforce	6,255	6,714	6,818	563	9.0%
HCHS Doctors	816	826	865	49	6.0%
Registered Nurses	1,763	2,024	1,957	194	11.0%
Other Staff	3,676	3,863	3,996	320	8.7%
HCHS Doctors	816	826	865	49	6.0%
of which, Consultants	295	314	324	29	9.8%
Nurses & Health Visitors	1,763	2,024	1,957	194	11.0%
Midwives	191	181	184	-7	-3.8%
Ambulance staff	2	0	0	-2	-100.0%
Scientific, therapeutic & technical staff	681	776	817	136	20.0%
Support to clinical staff	1,647	1,649	1,740	93	5.7%
of which Support to doctors, nurses & midwives	1,335	1,356	1,412	77	5.7%
of which Support to ambulance staff	53	0	16	-37	-70.1%
of which Support to STAT staff	259	293	313	54	20.9%
NHS Infrastructure Support	1,155	1,257	1,255	101	8.7%

Tier 1 - Paper ref:	PublicTB (09/24) 010

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Mortality and Learning from Deaths : 12 month overview		
SPONSORING EXECUTIVE:	Mark Anderson, Chief Medical Officer		
REPORT AUTHOR:	Rebecca Kershaw, Head of Clinical Effectiveness		
MEETING:	Public Trust Board	**DATE:**	11th September 2024

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

This paper aims to provide assurance that the Trust:

- Consistently completes Tier 1 scrutiny (Medical Examiner Review) of inpatient deaths to identify. Since January 2024 100% of inpatient deaths have completed Tier 1 review.
- Monitors compliance against the ME Office standards and is ready for the community roll out of Medical Examiners services.
- Has addressed the backlog of Tier 2 (Structured Judgement Reviews) and has taken appropriate action to build a more sustainable approach.
- Reviews all deaths of patients with Learning Disabilities and has completed a benchmarking exercise against peer trusts in the Black Country ICB. There are no concerns with the number of LD deaths and we continue to work to improve learning processes with LeDeR.
- Has monitored our number of Emergency Department deaths and the number that have identified concerns requiring further review. The number of deaths and proportion of SJRs has not risen within the last year.
- Is aware of conditions that have high mortality statistics (e.g. SHMI) and investigate these appropriately to identify contributing factors and areas for learning;
- Has achieved an improvement in the SHMI index for deaths from sepsis.
- Acknowledges the overall SHMI remains high for the organisation.
- Has identified a common theme of poor recognition of deteriorating patients. Is working with the deteriorating patient working group to address this as part of our Trust priorities for 2024/25.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	X

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

Monthly reporting through Learning from Deaths Group and Quality Committee
Quarterly reporting through Executive Quality Group

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**RECEIVE ASSURANCE** that the learning from deaths processes for scrutinising deaths and monitoring various data sources are robust and in alignment with national standards
b.	**ACKNOWLEDGE** the issues identified (i.e. high SHMI)
c.	**ACCEPT** the actions in place to better our position

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

Board Assurance Framework Risk 01	X	*Deliver safe, high-quality care.*						
Board Assurance Framework Risk 02	X	*Make best strategic use of its resources*						
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*						
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*						
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*						
Corporate Risk Register [Safeguard Risk Nos]								
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 on 11th September 2024

Mortality and Learning from Deaths 12 month overview

1. Introduction or background

1.1 This report is presented to the Public Trust Board to provide assurance of Learning from Deaths processes (see Reading room: appendix 1) and activity at Sandwell & West Birmingham Trust in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017) ((NQB), 2017). This report describes activity from August 2023 – July 2024.

1.2 Please note the Learning from Deaths portfolio was significantly impacted by staffing challenges December 2022 – June 2024. We now have a new Deputy Chief Medical Officer for Quality & Safety (in role since April 2024) and a new Learning from Deaths Facilitator (in role since June 2024). These two roles are crucial for continuing to identify learning and make sustainable change in the learning from deaths portfolio.

2. Medical Examiner's (ME) Office: Tier 1 scrutiny of deaths

	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024	July 2024
Number of deaths	93	112	109	115	140	140	138	137	117	112	87	98
Tier 1 review completed	98%	97%	98%	96%	99%	100%	100%	100%	100%	100%	100%	100%
Tier 2 referrals	12%	12%	7%	11%	5%	6%	9%	11%	15%	9%	11%	8%
% coroners referral	17%	22%	15%	22%	18%	21%	20%	21%	16%	16%	22%	11%
MCCD	73%	70%	72%	68%	74%	67%	71%	70%	80%	89%	85%	87%
Next of Kin contacted	89%	90%	94%	89%	92%	94%	93%	84%	89%	91%	89%	89%

2.1 It is an expected trend to see a slightly smaller number of deaths in summer months. This is due to multiple factors such as increase in flu prevalence in winter months.

2.2 Since January 2024 the Medical Examiners reviews (tier 1 scrutiny) have been completed for 100% of all inpatient deaths within the trust. This is an excellent achievement and provides assurance that we have independent scrutiny of all inpatient deaths.

2.3 In September 2024 the Community Medical Examiner roll out becomes mandatory. At the time of writing this paper acknowledgement has been received from 91% of GP services:

15 of the 47 practices within SWB trust have already started the process of sending referrals. 9 practices have tested the referral process ready for September.

2.4 The number of cases in which Medical Cause of Death discussions (MCCD) are held between the Medical Examiner and certifying clinicians have largely remained above 70%. In January 2024 the dip in compliance is believed to be due to Junior Doctor industrial action and the Christmas/New Year bank holiday, therefore the ME carried out Tier 1 scrutiny without the MCCD.

2.5 The Medical Examiner's Office are required to have a conversation with the next of kin (NOK) to share condolences and ask if they had any concerns about care. Our compliance with this standard is usually very high. On months where compliance has dropped below 90%, it is due to deceased people having no next of kin to contact, and the number of cases referred to coroner for inquest where there is not a legal requirement for MEs to talk to the family.

2.6 Over the last 12 months there is a mean average of 9.6% of deaths referred for Structured Judgement Review (SJR tier 2 scrutiny) following Medical Examiner scrutiny.

3. Structured Judgement Reviews: Tier 2 scrutiny of deaths

3.1 The current completion rate of SJRs has resulted in backlog of SJRs (reading room: appendix 2). We are working to alleviate this backlog by doing the following:

- A scoping exercise was completed with mortality leads and a theme emerged around insufficient allocation of resources. We now encourage specialties with higher numbers of deaths to seek additional colleagues to be trained in SJR, and to apply the SWB Job Planning policy to support resource allocation.
- Local SJR training has been made available within Sharepoint for colleagues to sign up to.
- We now have a Lead Structured Judgement Reviewer who continues to meet with Mortality Leads to discuss the processes for learning within their specialties and identify barriers to completion of SJRs. They also complete peer review of SJRs to promote standardisation and quality of SJRs being completed.
- A 6 week deadline has been issued so that learning is captured in a timely manner.

3.2 Themes from returned SJRs

3.2.1 When completed SJRs are returned to the Learning From Deaths team, regular qualitative analysis is completed to pull out themes. These are presented as part of the integrated governance scorecard report every month in the Group Governance forums.

- **Deteriorating patient** – Many SJRs outline missed opportunities to identify signs of deterioration, interpret these signs and act appropriately. Learning from deaths has been identified as a key stakeholder in the trust wide project tackling deteriorating patients as part of the Strategic Planning Framework, see point 8.2.5.
- **Involvement of family** – The involvement of family is a crucial influencing factor in end of life experience. Multiple SJRs identified missed opportunities to involve families in care planning, however when this is done well it has a significant positive impact on the patient, the family and our staff.

- **End of life care planning** – Many SJRs identified missed opportunities to agree Treatment Escalation Plans and Shared Care Plans in a timely manner. As outlined in point 7.2.1, the End of Life Care team continue to engage with the National Audit for Care At End of Life as well as a local Quality Improvement Project.
- **Mental capacity assessment and Deprivations of Liberty Status:** All deaths involving patients with a learning disability must undergo SJR. We regularly spot opportunities for learning regarding capacity assessment and utilisation of the mental health act. This year the Vulnerable adults team created a shared learning topic for a Quality Improvement Half Day (QIHD), focused on understanding and applying the mental capacity act. This coincided with the national requirement to complete the Oliver McGowan mandatory training to help healthcare organisations tackle healthcare inequalities resulting from learning disabilities.

4. Specialty spotlight: Learning disability deaths

4.1 Our process is that any deaths of patients in which the Medical Examiners (Tier 1) note the patient has a Learning Disability are referred for structured judgement review (Tier 2). We also cross reference with Unity and the Vulnerable Adults case load to ensure all relevant cases are identified for SJR. These SJR's are primarily completed by the Safeguarding Vulnerable Adults team, unless there were wider concerns with process or care, for which the review is completed by the relevant specialty.

4.2 At the point of identifying a relevant case, a notification is made by the Clinical Effectiveness Team to the Learning Disability Mortality Review (LeDER) programme and provide case notes to inform the review. When completed, individual reviews are shared with the Vulnerable Adults Team for learning.

4.3 Table of numbers of deaths of inpatients with learning disabilities each month, compared with the same time frame for last year:

	Jan 23	Feb 23	March 23	April 23	May 23	June 23	July 23
LD deaths 2023	3	2	2	2	0	0	0
	Jan 24	Feb 24	March 24	April 24	May 24	June 24	July 24
LD deaths 2024	2	3	0	2	1	0	2 (TBC)

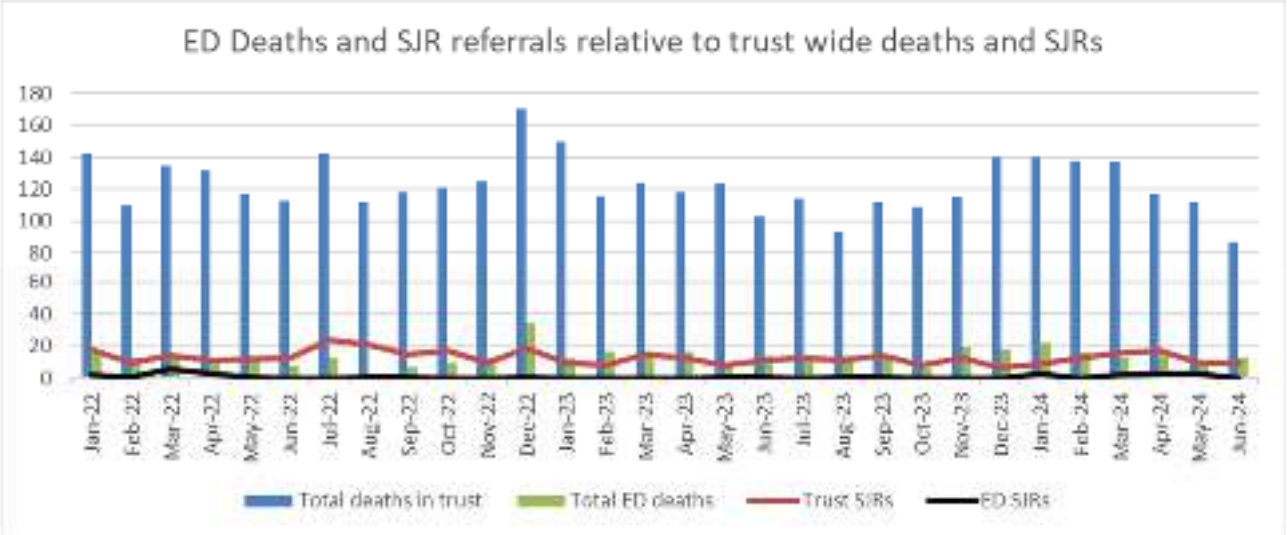
4.4 A benchmarking exercise against peer trusts within the Black Country ICB has shown that we are in the middle of our peers for number of deaths and different types of LeDeR reviews of these deaths (e.g. initial and focused reviews) (reading room: appendix 3)

5. Specialty spotlights: Emergency Department deaths

5.1 All deaths that occur within SWB Emergency departments undergo tier 1 security. Any deaths identifying concerns with care are referred for an SJR.

5.2 When comparing the total number of deaths seen each month across the Trust and how many of these were referred for SJR, to the total number of ED deaths and how many of

these were referred for SJR, the pattern does not indicate current concerns around quality and safety are resulting in increased patient deaths.



6. Clinical And Professional Review of Mortality (CAPROM): Tier 3 Scrutiny of deaths

	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Cases discussed at CAPROM	2	2	3	4	0	4	3	2	1	4	3	3
Cases confirmed "avoidable"	0	2	0	1	0	1	0	1	0	2	2	0

6.1 The criteria for a case to be discussed at CAPROM are any of the following;

- any death for which the SJR grades the death as "avoidable" or "potentially avoidable (greater than 50:50 chance of avoidability)"
- any death for which the SJR grades the deaths as "potentially unavoidable (less than 50:50 chance of avoidability)" and overall care poor care
- Any death on the SWB "preventables" report (e.g. death following elective procedure)

6.2 CAPROM is a multi-disciplinary discussion of factors influencing the outcome of each case. Mortality leads and other experts attend to share insight into decision making and process. Following discussion of the case the panel vote as to the avoidability of the death.

6.3 Within the last 12 months 9 deaths have been scored by CAPROM as "avoidable".

6.4 When a death is considered "avoidable" the panel agree actions to take forward to improve quality and safety, and mitigate against similar deaths occurring in future (reading room: appendix 4)

7. Learning from Deaths Group

7.1 Learning from Deaths Group is a multidisciplinary meeting in which information from across the learning from deaths portfolio is presented for discussion and identification of improvement opportunities. Specialties present their themes, learning and actions following deaths within their specialty. Quality Improvement Projects and national clinical audits are also presented here to identify learning.

7.2 National Audit for Care at End of Life (NACEL)

7.2.1 The National Audit for Care at End of Life measures against standards of care provided to dying patients and their families. Our results showed slight improvement on the previous year and no variation in quality of care between SWB sites. The service described various changes implemented as part of quality improvement; a "saturation week" by palliative care staff who increased presence on wards to build staff confidence; a data dashboard built for teams to use; electronic training implemented trust wide for clinical and non-clinical staff; and engagement sessions carried out with clinicians.

7.3 MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK and Perinatal Deaths

7.3.1 In November 2023, data on maternal and baby deaths was presented to Learning from Deaths (as published in the 2019-21 "MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK" report). The focus of this national audit is improving the delivery of safe, equitable, high quality, patient-centred maternal, newborn, and infant health services. The SWB team have taken actions to address support for women from black and ethnic minority backgrounds who are at higher risk of maternal deaths, and for mental health patients with concealed pregnancies.

7.3.2 The national and local SWB perinatal mortality figures were also discussed. The service has created clearer clinical guidelines and have focused on strengthening communication between trusts. It identified key areas that would benefit from improvement, and these are being taken forward by the team: more training in cardiotocography to ensure appropriate cardiac monitoring and action; more thorough risk assessment and management plans; following-up with patients who did not attend to prevent stillbirths.

7.4 Sentinel Stroke National Audit Programme (SSNAP)

7.4.1 This national clinical audit programme captures data on performance of Stroke teams within the NHS, presented at the January 2024 Learning from Deaths Group. The most recent data showed that 64.5% SWB patients achieved the standard of admission to a stroke ward within 4 hours. We also had a high compliance with the standard of administering thrombolysis within 60 minutes. Overall, our SSNAP score has improved a grade (from C to B) which reflects the increased involvement of therapy services, and clear documentation in patient records. Improvement work continues: changes to IT have been made to reduce issues out of hours, an extensive education package is now in place. The Stroke MDT have agreed to utilize daily whiteboard huddles to improve MDT discussion.

7.5 **Trauma and Audit Research Network (TARN, now known as the National Major Trauma Registry)**

7.5.1 In April 2024, the findings from the recent Trauma Peer Review were presented alongside learning from the Trauma and Audit Research Network (TARN). In response to these findings, the team have improved the electronic capture of documentation from major trauma cases, and plan to utilise areas of the Emergency Department electronic platform to more effectively record information that allows for patient identification.

7.6 **National Hip Fracture Database (NHFD)**

7.7 In 2024 we received a notification from the National Hip Fracture Database alerting us that we are an outlier for our 30-day case-mix-adjusted mortality rates, meaning we are seeing more deaths within 30-days than we should expect. The Frailty Fracture Group have agreed an action plan to improve data quality, and care for patients. A deep dive of case records identified an issue with ASA grade defaulting to a low value. The team have implemented a process to ensure data accuracy. They have also reviewed the pathways to ensure best practice is applied when we move to MMUH. Going forward the team are investigating how to ring fence theatre list and recovery beds, to ensure the 36 hour target for surgery is met. An external review is planned for early 2025 by the British Orthopaedic Association.

8. National Statistics

8.1 **Hospital Standardised Mortality Ratio (HSMR) (from Healthcare Evaluation Data)**

8.1.1 The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell compared to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups only.

8.1.2 There are many factors that influence HSMR: The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, co-morbidities, month of admission, admission method , the presence of palliative care, and number of previous emergency admissions.

8.1.3 Due to data validation and analysis processes involved in HSMR calculation, there is a 3 month delay to reporting (i.e. May 24 reported in August 24).

8.1.4 The most recent **monthly HSMR** for May 2024 is **126.81,** and our **12-month-cumulative HSMR** is **117.22.** These values remain higher than most of our peer trusts (reading room: Appendix 5)

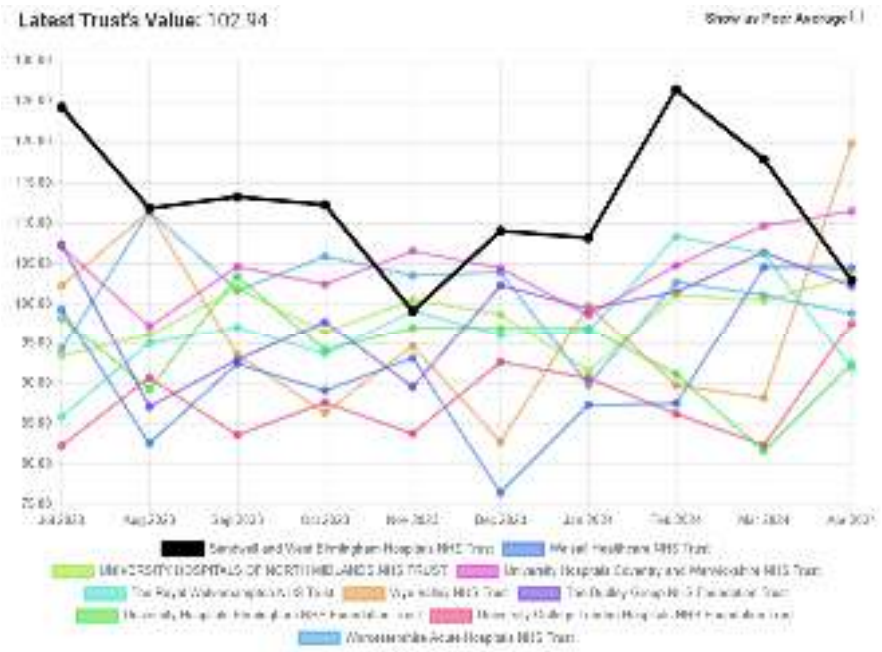
8.2 **Summary Hospital-level Mortality Indicator (SHMI) (from Healthcare Evaluation Data)**

8.2.1 The **SHMI** is the ratio between the actual number of patients who die after hospitalisation at SWB and the number that would be expected to die based on average England figures, given the characteristics of the patients treated at SWB. It includes death up to 30 days post discharge and does not adjust for palliative care. SHMI above 100 is higher than benchmark.

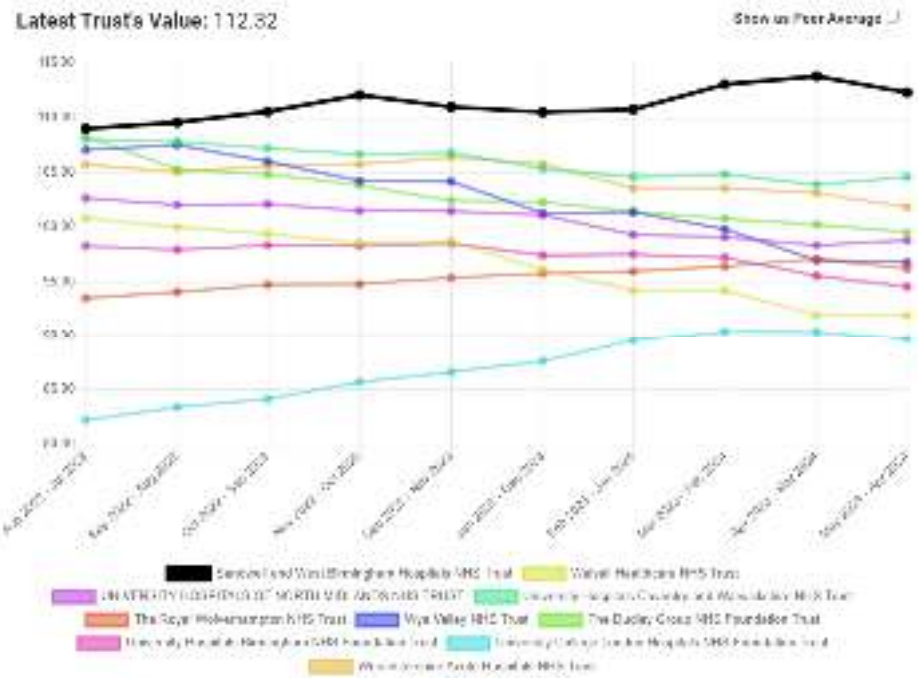
8.2.2 As described on the NHS Digital website "*The SHMI is not a measure of quality of care. A higher than expected number of deaths should not be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance*." (NHS England, 2024). We track SHMI and carry out further analysis of the headline data to inform the areas for improvements in care processes.

8.2.3 The most recent **monthly value for SHMI** for April 2024 available is **102.94**, which is the lowest it has been since December 2023. However, as our **12-month-cumulative SHMI (112.32)** demonstrates, SWB still has a higher SHMI than we should accept, which is why trust wide improvement efforts continue.

Monthly SHMI: comparison with peer trusts



12-month cumulative SHMI: comparison with peer trusts



8.2.4 **Trust wide approach to Deteriorating patients:** Delay or failure to recognise a deteriorating patient is a common theme and a contributing factor identified from Learning from deaths and other governance sources. Learning from deaths will feed into the deteriorating patient working group to ensure progress against the strategic planning framework. As part of the working group there is a focus on strengthening EMRT/resus processes and ensuring a sufficiently resourced workforce to improve patient outcomes. Also, IT provisions are being reviewed to support early identification, escalation and action of deteriorating patients, therefore enabling effective treatment and better patient outcomes. This year will also see the implementation of Call4Concern and Martha's law, therefore providing additional opportunities to recognise and act on deterioration. As stated in 7.2 there is work ongoing to improve end of life care and acknowledge deterioration as part of effective end of life planning. We acknowledge that recognition of deteriorating patients is an area we need to significantly improve on.

8.3 SHMI contextual data (From NHS Digital)

8.3.1 NHS Digital provide updates on contextual factors, such as provider coding and demographics. These don't influence SHMI directly, but may suggest wider issues impacting mortality reporting.

8.3.2 At SWB we have a pattern of remaining above the national average for mean depth of coding for non-elective procedures (i.e. we are doing well at documenting all the comorbidities for our non-elective patients), however we continue to benchmark poorly for mean depth of coding for elective admissions (i.e. we are not doing well at documenting all comorbidities for elective patients). A piece of work has started to investigate this discrepancy with the coding department. Good depth of coding is more likely to produce accurate "expected" numbers of deaths, which will then influence mortality ratios.

9. SHMI Alerts

9.1 Each month we receive "alerts" for any condition groups that have a high SHMI. Alerts themselves do not indicate poor performance, but they do provide valuable steer for investigation and targeted improvement efforts. At SWB we review the data behind these monthly alerts to identify contributory factors and take mitigating action where needed.

9.2 Intestinal obstruction without hernia

9.2.1 In October 2023 we became aware of a SHMI alert for "Intestinal Obstruction without hernia" (reading room: appendix 6). Initial analysis of the cases indicated the high SHMI in October was largely due to two deaths within the Emergency Department of patients presenting with intestinal obstruction. Following discussion at CAPROM, the pathway has been changed; there is now direct referral to surgical registrar rather than SAU nurse. There is ongoing monitoring of our performance as part of the National Emergency Laparotomy Audit (NELA). The teams have also reviewed the local guideline on acute abdomen and have implemented digital screens to disseminate learning, particularly around early recognition of acute abdomen.

9.3 Skin and subcutaneous tissue infections

9.3.1 Throughout 2023 there were several SHMI alerts for "skin and sub-cutaneous infections" (reading room: appendix 7). The Group Director of Nursing for Primary Care, Community and Therapies completed a deep dive into the cases that were known to SWB GPs and found only 3 cases where skin and subcutaneous tissue infections directly contributed to death. Learning was identified for across the ICB: care homes, primary care and secondary care providers need to strengthen communication and planning with regards to moving patients onto end of life pathways effectively. There needs to be focus on advanced planning and robust processes for patients who are clearly deteriorating and at end of life.

9.4 Hepatitis, viral infection, other infections, sexually transmitted infections (not HIV or hepatitis), immunisations"

9.4.1 We have had alerts for the group "Hepatitis, viral infection, other infections, sexually transmitted infections (not HIV or hepatitis), immunisations" (reading room: appendix 8). In August we met with coding to discuss 3 deaths that had a code linked to this alert. Two of these cases fell into the 'immunisation and screening for infectious disease' sub-category, which may just indicate good practice, as we are completing and documenting more screening of our patients. However, on analysis of all cases triggering the historic alerts, a high number of deaths had the "other and unspecified infectious diseases" coding. This code has a low mortality risk which likely contributes to the high SHMI. This finding has been escalated to Coding, and work will continue to identify opportunities for clearer documentation, therefore more specific coding, which is likely to reduce the SHMI.

9.5 Urinary tract infections (appendix 14)

9.6 We have alerted for 3 consecutive months for Urinary Tract Infections. Analysis of HED data (reading room: appendix 19) clarifies there has been an overall increase in SHMI since

December 2023. When comparing the dominant ICD10 codes on admission with those at death, we see that most cases continue to be coded in a manner that triggers the alert for "Urinary tract infections". Therefore, we plan to complete a further analysis of individual cases to identify any specific trends, learning points or opportunities for improvement. Clinical Effectiveness will work with key stakeholders to move forward with this.

10. Observed Vs Expected Deaths (from NHS digital)

10.1 NHS Digital provides a monthly breakdown by diagnostic group of deaths that were considered "expected deaths" due to factors such as mortality risk, and "observed deaths" which captures the actual number of deaths that occurred; 2 factors effecting our SHMI.

10.1.1 These values are cumulative and work on a 5 month delay due to additional data validation and analysis processes (i.e. March 24 reported in August 24).

10.1.2 Observed Vs Expected deaths is another useful source of information that identifies conditions to focus on. SWB consistently see higher observed than expected deaths for the Pneumonia and Sepsis categories.

Cumulative Observed (blue) Vs Expected (orange) deaths reported in August 2024

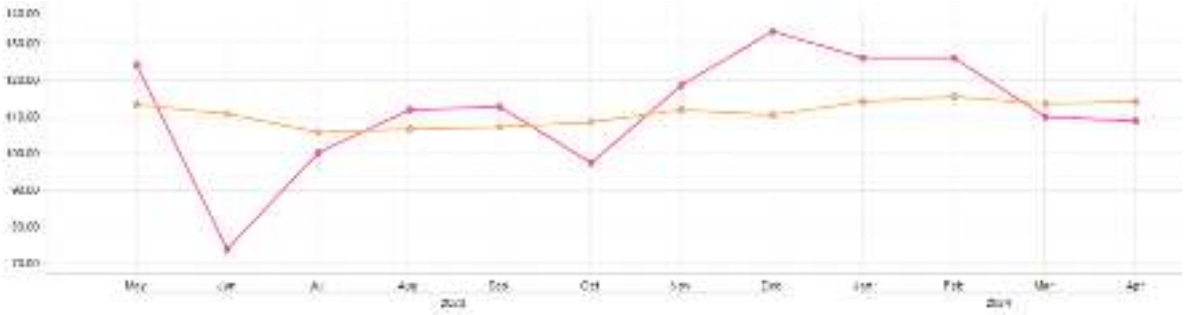
11. Priority conditions for monitoring and improvement:

Pneumonia and sepsis are highlihgted at SWB, and we monitor SHMI for these conditions closely and continue to seek opportunities for improvement.

11.1 **Pneumonia**

11.1.1 Monthly SHMI for April is 108.95, the 12 month cumulative is 114.14. Our monthly value fluctuates in and out of "alert" status. This pattern indicates there are still improvements to be made in pneumonia care at SWB.

Pneumonia SHMI: Monthly (pink) and 12-month cumulative (orange) values

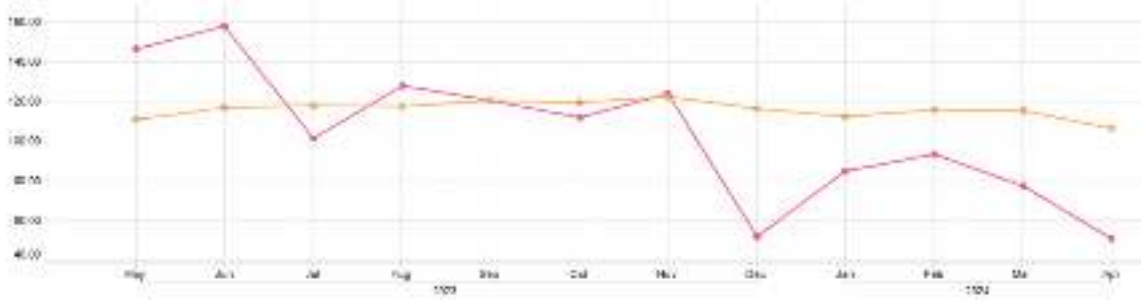


11.1.2 In 2024 the Pneumonia Task force was reestablished to tackle barriers and increase understanding of pneumonia care best practice, with the aim of reducing number of deaths from pneumonia. Following local audits, it became apparent that an electronic solution was needed to increase awareness and reduce human error. Microguide has been updated to ensure alignment to correct antibiotic practice for pneumonia patients, and a larger piece of work was completed to create a "pneumonia care bundle" within Unity. This is now in the testing phase and reporting parameters are being established. Following this, a trust wide comms piece will be launched to promote use.

11.2 **Sepsis**

11.3 Monthly SHMI for April is 50.88, the 12 month cumulative SHMI is 106.48, which reflects an overall improvement in sepsis SHMI over the last 12 months.

Sepsis SHMI: Monthly (pink) and 12-month cumulative (orange) values



11.4 Our monthly SHMI for April is the lowest value we have seen since December 2023. The April dip coincides with the new Sepsis standards published by NICE in March 2024. There is a plan to work with the new Chief Registrar to complete a gap analysis to benchmark us fully against those new NICE standards and identify further areas for improvement.

11.5 Clinical Effectiveness met with the Improvement team to discuss the closure report for the trust wide improvement project on Sepsis, and alignment of this workstream with the strategic planning framework going forward. It's been identified that Sepsis is often linked with deteriorating patients, which is a trust priority. Currently a governance framework is being developed for the Deteriorating Patient element of the strategic planning framework, which any future work on sepsis will be able to link in to.

12. Recommendations

12.1 The Public Trust Board is asked to:

a. **RECEIVE ASSURANCE** that the learning from deaths processes for scrutinising deaths and monitoring various data sources is robust and in alignment with national standards
b. **ACKNOWLEDGE** the issues identified (i.e. high SHMI)
c. **ACCEPT** the actions in place to better our position

Mark Anderson, Chief Medical Officer
Rebecca Kershaw, Head of Clinical Effectiveness
30/08/2024

References

(NQB), N. Q. (2017). *A Framework for NHS trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.* NHS England. Retrieved from NHS England.

NHS England. (2024, February 8th). *Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation*. Retrieved from NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2024-02

Tier 1 - Paper ref:	PublicTB (09/24) 011

Sandwell and West Birmingham NHS Trust

Report title:	Length of Stay Reduction Including Winter Plan Update
Sponsoring executive:	Johanne Newens – Chief Operating Officer
Report authors:	Demetri Wade – Deputy Chief Operating Officer
	Taj Virk-Dhugga – Assistant Director of Urgent Care
Meeting title:	Public Trust Board
Date:	11th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

This paper describes the winter plan for 2024-2025 for Sandwell and West Birmingham Places and Acute Hospital with the opening of Midland Metropolitan University Hospital (MMUH) on 6th October 2024. The paper focuses on lessons learnt and reflections from last winter, modelling assumptions for activity and beds, national expectations on performance, and proposed mitigations for anticipated pressure on acute beds.

Modelling and analysis of the forecast demand, established rightsizing scheme delivery, further proposed mitigation as Clinical Group interventions, and capacity contingency activities in preparation for the move to MMUH will be presented. An overview of recent performance against Urgent and Emergency Care metrics are also included to demonstrate current challenges and to measure the impact of delivery against the interventions included in the plan.

The requirement for joint working and responsibilities across the health and care system is recognised, and to support the system alongside population resilience, work with partners in local place has continued. The winter plan will be reviewed by the Black Country Urgent and Emergency Care Board alongside plans for the other 3 Places/Trusts with an appropriate governance structure to monitor progress and escalation.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	**X**
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	**X**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

Plan delivery, mitigations, safety and quality considerations, and modelling included in this paper have been considered at the Non-Elective Steering Group and MMUH Opening Committee.

4. Recommendation(s)

The Public Trust Board is asked to:

a) **REVIEW** and **DISCUSS** the local and national context for this winter including the MMUH move period.

b) **CONSIDER** the winter modelling and activity assumptions and confidence of interventions.

c) **DISCUSS and ACCEPT** the winter plan inclusive of mitigation proposals.

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

Board Assurance Framework Risk 01	X	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	X	*Make best strategic use of its resources*

Board Assurance Framework Risk 03	X	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	X	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 11th September 2024

Sandwell and West Birmingham Places and Acute Hospital Winter Plan

1. Background

1.1. As anticipated through national and local intelligence and modelling, last year's winter was challenging with significant pressure on Urgent and Emergency Care (UEC) services. October to December 2023 was a particularly difficult period for service resilience with the system struggling to de-escalate from sustained demands for admission and discharge on the acute sites requiring further resilience beyond the scope of the plan. With Board approval, the Emergency Access Standard (EAS) Recovery Plan, focused on delivering sustainable improvement, was implemented with associated financial implications.

1.2. Average length of stay last winter, particularly in December 2023 and January 2024 was high and hit a new peak compared to previous years. The chart below demonstrates the comparison with winter 22/23.

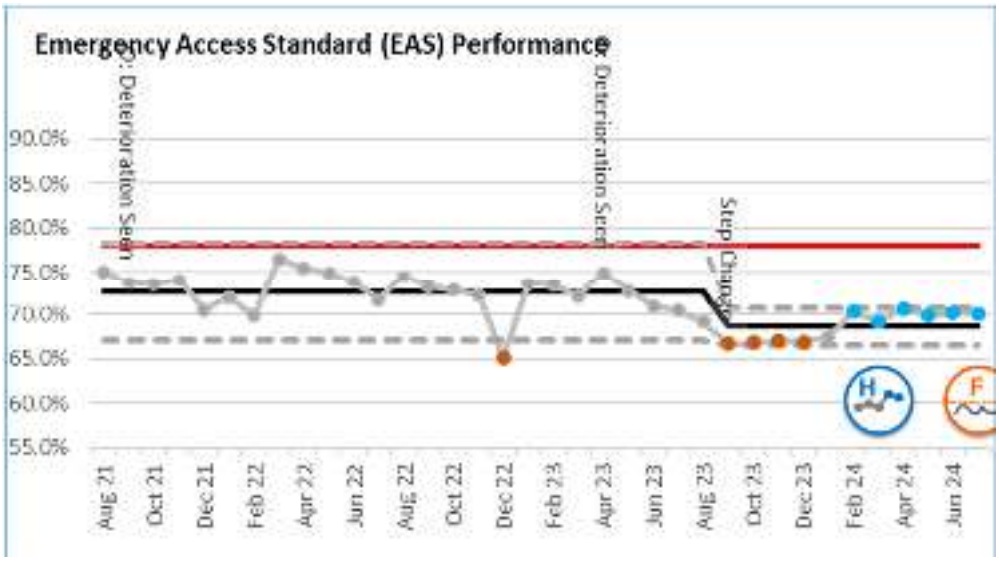
1.3. Adverse UEC performance indicates increased risk of patient harm. The purpose of the Winter Plan and subsequent EAS Recovery Plan was to minimise and where possible avoid any harm. Consistent overcrowding in Emergency Departments (ED) with long waits to be seen, and to be admitted to the appropriate location, posed the risk of increased mortality and morbidity, and reduced the ability to provide critical interventions in a timely manner. Therefore, the episodes of pressure required urgent and sustainable actions.

1.4. The Trust's ability to respond to the pressures were supported by the rightsizing schemes, unfunded interventions and the addition of the EAS Recovery Plan, delivering on improvements in EAS performance, ambulance handover times, and maintaining the safety of services. Although a reasonable target improvement in EAS performance of 4.3% by March 2024 was set, performance at the end of the winter period was 1.77% short of the trajectory.

1.5. Workforce resilience was a significant challenge within the EDs, with vacancies in nursing, Emergency Medicine consultant and registrar posts, and a heavy reliance on additional bank, agency and locum, approved through EAS recovery funding. While there has been significant progress in recruitment into these posts and those funded for the move to MMUH, it is unlikely that all posts will be filled this winter.

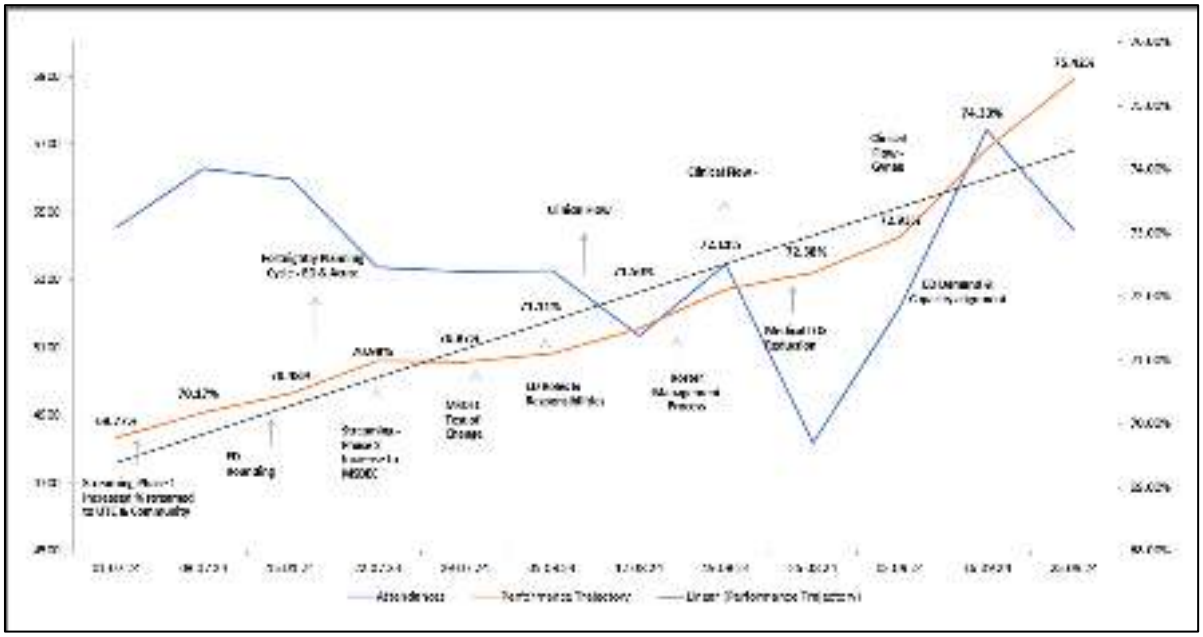
1.6. Planned interventions for winter were focussed on our MMUH rightsizing schemes, and additional acute and community beds to support our admission capacity based on the winter activity profile and bed deficit projection. The rightsizing schemes have continued to deliver collectively since March 2024 and in June, delivered close to forecast.

1.7. The UEC improvement plan was presented to March Trust Board and outlined the trajectory from April 2024 to return EAS to the upper quartile nationally prior to the opening of the Midland Metropolitan University Hospital. With these interventions and those included in the sprint programme, EAS performance is consistently reported at around 70% and over the month of August we saw further improvement with a peak daily achievement of 78.8%.



1.8. The national priorities for winter 24/25 continue to focus on the Urgent and Emergency Care Recovery Plan. This principally looks at increasing capacity, workforce resilience, timeliness of discharge, expansion of community services, care in the right place at the right time, and reducing variation. This aligns with our rightsizing interventions, non-elective improvement plan, sprint activity (LoS, Streaming, Medical SDEC) and workforce plans.

1.9. The 12-week sprint commenced in June 2024 to accelerate delivery of elements of UEC improvement, with support of external resource from KPMG to implement Continuous Improvement (CI) methodology. Workstreams include Streaming, Medical Same Day Emergency Care (SDEC), Length of Stay (LoS), Operational Processes, Demand and Capacity, and Clinical Flow. This has enabled the bed closure plan in advance of move to be delivered and target medicine length of stay (LoS) for pathway 0 to be achieved.



1.10. The winter plan for 24/25 will focus on continued delivery our rightsizing schemes, alongside reducing LoS back to our 22/23 baseline to support timely and safe care. This will be supported by further interventions across clinical services to improve care navigation, access to services and timeliness of discharge.

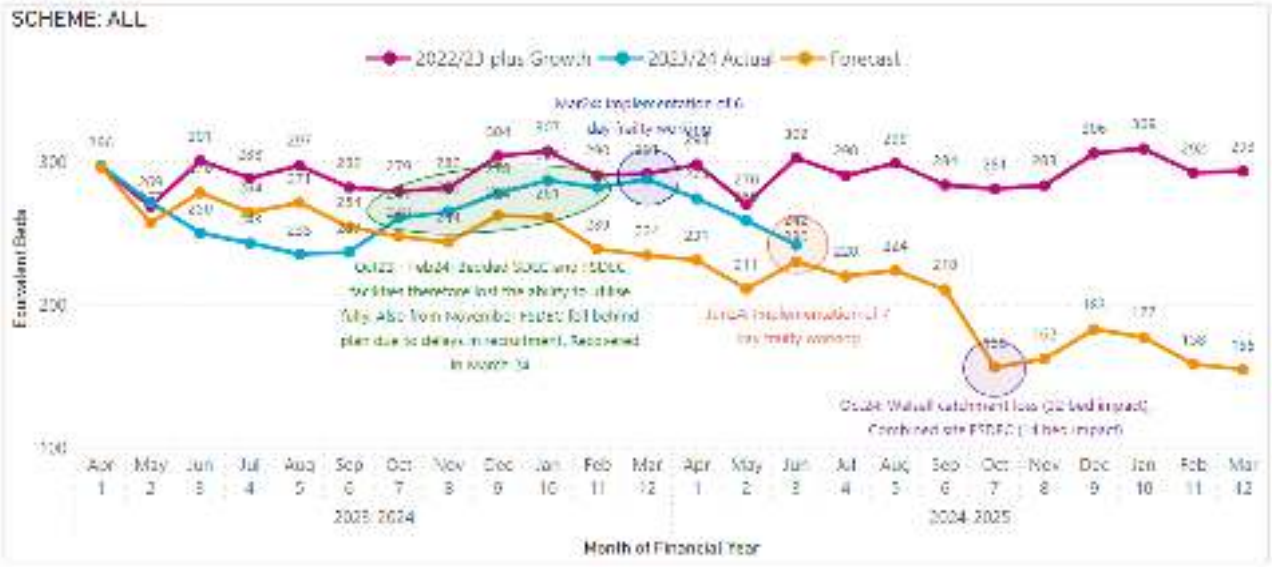
2. Rightsizing Schemes

2.1. There are 7 transformational schemes that support the overall MMUH bed right sizing and our winter resilience:

- Medical Same Day Emergency Care (SDEC)
- Frailty Virtual Ward (VW) and Frailty Intervention Team (FIT)
- Respiratory Virtual Ward (VW)
- Cardiology Virtual Ward (VW)
- Heart Failure
- Birmingham Care Homes
- Falls Admission Avoidance

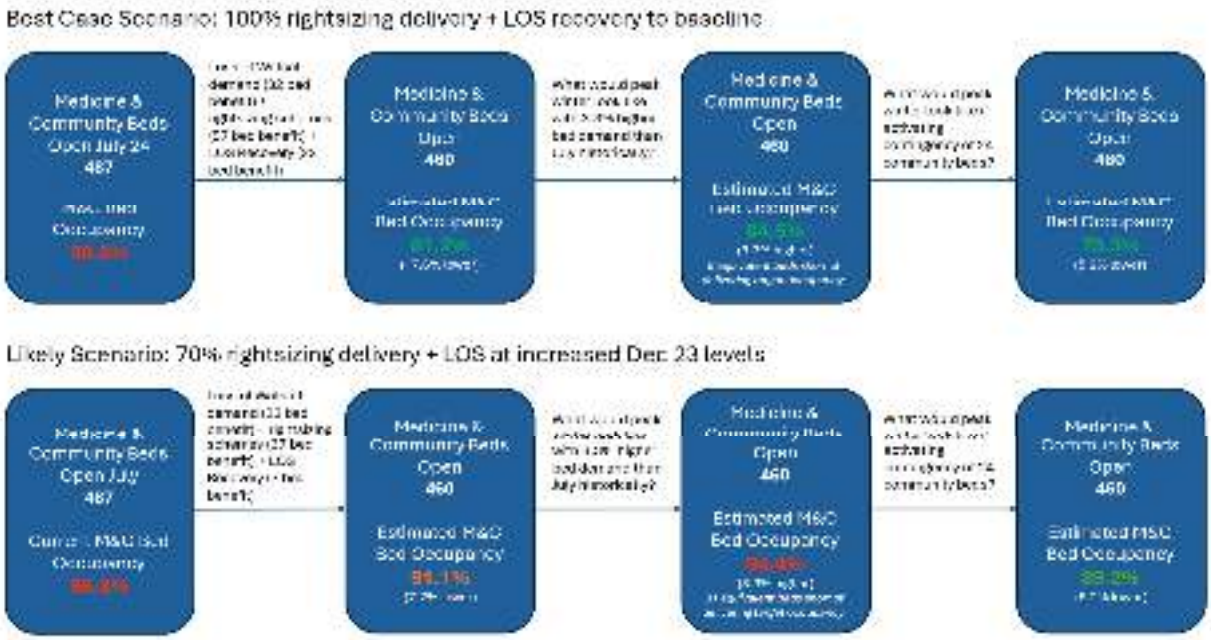
These schemes provide significant benefit to the reduction of attendances, admissions, and length of stay. The graph below illustrates delivery against these schemes collectively and shows bed usage slightly above forecast. Schemes such as Frailty Intervention Team are

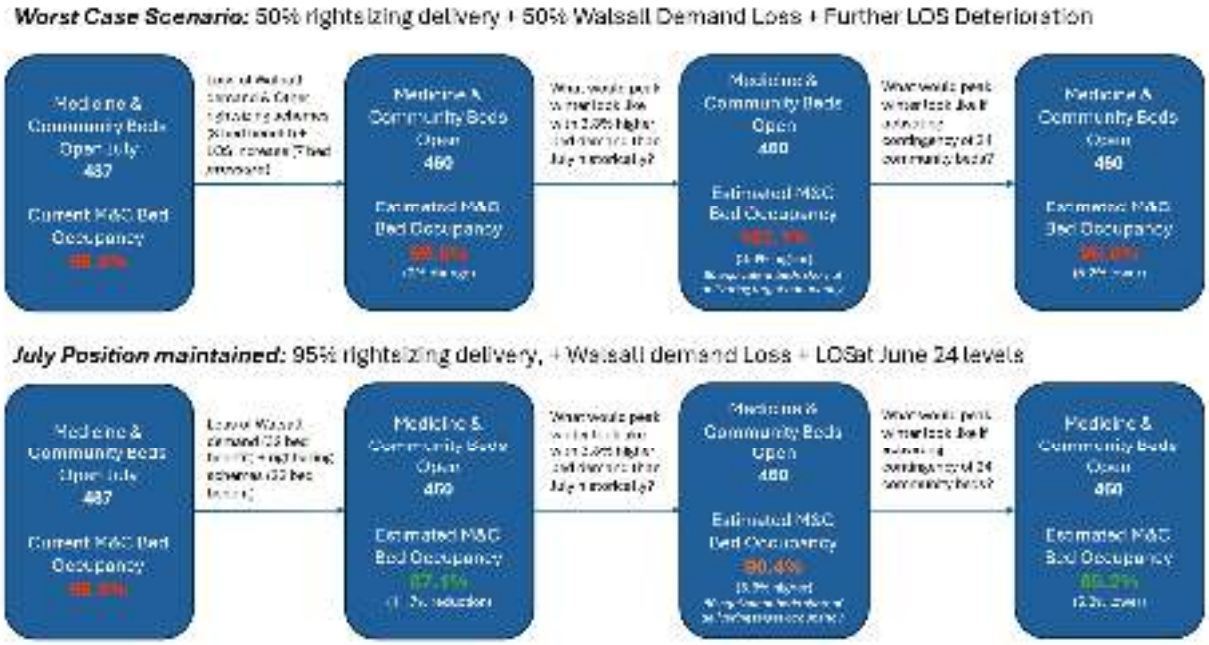
expected to deliver additional benefit following the move to MMUH due to improved service access for Birmingham patients, and services such as Medical SDEC will combine two separate clinical teams giving greater flexibility to meet changing demands.



3. Winter Scheme Delivery

3.1. The charts below show a range of scenarios for transition to MMUH and winter resilience based on the delivery of Rightsizing schemes and overall Length of stay position.





3.2. Currently the rightsizing schemes are delivering at 90%. A 70% delivery with a length of stay at increased levels similar to those in December 2023 would result in a -31 bed deficit. Mitigation includes 24 PCCT beds released into the Trust capacity bringing the deficit to -7 beds (outlined in annex 1). There will be further closure of the gap with 8 beds from allowing a 1.7% bed occupancy increase, resulting in an overall position of +1.

3.3. We continue to deliver positive admission avoidance and attendance reduction and outperform our neighbouring Black Country places. This delivery directly supports the realisation of likely case scenario. As we have experienced during previous winters, the other providers in the system are continuing to work on mitigations to close forecast winter bed deficits, while with our plans for this winter we are predicting a small surplus that can be improved further as we work to progress towards our best-case scenario.

4. Clinical Group Level Interventions

4.1. Each clinical group has a separate set of interventions that will be implemented to reduce bed occupancy prior to the move to MMUH and into winter.

4.2. Primary Care, Community and Therapies (PCCT)

Work on Stroke Decoupling and delivery/optimisation of ICSS is in progress and on track for the move of rehabilitation services to Rowley Regis Hospital. To ensure that there is the appropriate use of community beds, the Therapy lead, representing therapies and Integrated Discharge Hub, attends all scheduled length of stay meetings.

Following engagement with system partners, from 26th August, several services in PCCT, started working to Level 4 action cards. The Integrated Discharge Hub are currently trialling new defined admin roles with the aim to ensure capacity to accommodate 'live' Transfer of Care (TOCs) throughout the entire shift to prevent delays. To maintain flow and discharge to Town Teams, there are routine reviews of Home-Based Intermediate Care (HBIC) caseloads for additional confirm and challenge.

Annex 1 outlines the specific actions to reduce delays to discharge from community beds and release a further 12 beds into the Trust capacity in the days before Sandwell site move to MMUH. Following the move from Sandwell to MMUH, preparations will be made to support the release of a further 12 beds into the Trust capacity when City move to MMUH.

4.3. Medicine and Emergency Care

Medicine and Emergency Care have daily Length of Stay meetings which will continue to run with senior leadership representation. Variation in length of stay and daily discharges from ward to ward can be dependent on the Medical Leadership. Review of Consultant ward cover is routinely undertaken to ensure that discharge numbers remain as expected and that there is Clinical Director led review of the ward areas/referee rounds where appropriate.

The clinical group review rotas for the medical wards, Acute Medical Unit (AMU) and SDEC to ensure that there is experienced substantive Consultant presence. Additional Acute Medicine shifts will be added to rotas to support admission avoidance.

4.4. Surgical Services

In preparation for the move to MMUH and reduction in bed occupancy, Surgical Services will be focusing on increasing Consultant presence on the wards by introducing 7-day Consultant rounds for every specialty with the presence of the senior leadership team at huddles to provide confirm and challenge. Communication from the senior leadership team emphasising the importance of optimised discharges to support the safe transfer of patients to MMUH and post-move has gone to all medical colleagues.

Capacity has been doubled daily for trauma and emergency National Confidential Enquiry into Perioperative Deaths (NCPOD) to facilitate earlier intervention, reducing overall length of stay. Multi-Agency Discharge Events (MADE) will be held with the purpose of supporting improved patient flow, identifying and unblocking delays, and challenging the complex discharge processes with the support of Trust services and system partners.

4.5. Women's and Child Health

Paediatric services will continue to utilise the Respiratory Syncytial Virus (RSV) pathway for this winter with the addition of the paediatric virtual ward providing in reach into ED. Appropriate and timely escalation is a focus for paediatrics where increased support is required from external partners for child and adolescent mental health services (CAMHS) patients for social admissions.

Social admission support is also a priority for Perinatal services.

There is a planned roll out of the RSV vaccine for pregnant women commencing in September with a social media campaign and counselling to support uptake.

Increased consultant presence on ward rounds will facilitate timely discharges across all specialties. Support from the network for the induction of labours and utilisation of network cots will translate to a reduction in patient numbers.

In Gynae, Gynae oncology and Breast services, there will be specific focus on review of elective caseloads to reduce length of stay including patients on long-term total parenteral nutrition (TPN) who may be suitable for earlier discharge into the community. Inpatients waiting for procedures such as Sacrocolpopexy (SCP) will be identified earlier and receive treatment facilitating timely transfer of care or discharge.

4.6. Imaging and Pathology

To support the clinical groups in reduction of bed occupancy, additional imaging hot slots have been made available alongside additional CT Coronary Angiography (CTCA) sessions during weekends. To support the MMUH Mock Census, the imaging booking team will be available to pull forward imaging appointments for patients awaiting diagnostics prior to discharge decision with the aim of assisting earlier discharges and reducing length of stay. Mutual aid for Non-Obstetric Ultrasound Diagnostic Service (NOUS) and Insourcing will continue to meet diagnostic demands.

4.7. MMUH Mock Census

In preparation for the transfer of patients to MMUH, a mock patient census will be run week commencing 2nd September for Sandwell and 9th September for City. This involves attendance to a daily meeting by the Ward Manager/Nursing Lead, Consultant and Operational lead for the ward.

Identical proformas to those planned for use during the move period will be completed by the ward teams to familiarise them with the documentation which will be presented to a panel made up of an MDT from clinical support services (Imaging, Pharmacy, IDU, Therapies, Virtual Wards) and clinical leaders for confirm and challenge.

The aim is to review every inpatient across Medicine, Surgery and Gynaecology to assess specific needs and requirements for transfer and to facilitate earlier discharge in order to support transfer of lower patient numbers. The mock census for the remaining services in Women's and Child Health will be scheduled later following the census at City site.

5. Leadership and Oversight

5.1. Appropriate oversight of all winter interventions is vital to ensure we continue to drive forward performance and deliver the target trajectory for improvement.

5.2. Delivery of the winter plan is managed at Trust and Place level daily through site safety calls and service level safety huddles.

5.3. The Trust escalation process is utilised to mobilise Tactical and Strategic command as required in addition to daily Executive oversight.

5.4. The MMUH rightsizing and Urgent Care Scorecard dashboards will be used alongside daily urgent and emergency care (UEC) data to inform decision making and progress against our plans, ensuring that corrective measures are implemented when required.

5.5. Regular reports will be submitted to Quality Committee, Finance and Performance Committee and Trust Board to ensure that the plan continues to deliver against our strategic objectives.

6. Summary

6.1. This year's winter plan focusses on continuing to realise the potential of our rightsizing schemes and improving the community care offer. Modelling and scenario testing suggest that with a delivery of rightsizing schemes at 70%, with a length of stay at increased levels as in December 2023, is the most likely outcome and will leave a deficit of -31 beds. Mitigation includes 24 PCCT beds released into the Trust capacity bringing the deficit to -7 beds. There will be further closure of the gap with 8 beds from 1.7% occupancy increase, resulting in an overall position of +1. Clinical group interventions are expected to support the plan alongside higher than 70% delivery of rightsizing schemes, which currently sits at 90%. All interventions including those proposed as mitigation will impact positively on patient journey, experience and outcomes.

7. Recommendations

7.1. The Public Trust Board is asked to:

a. **REVIEW and DISCUSS** the local and national context for this winter including the MMUH move period.
b. **CONSIDER** the winter modelling and activity assumptions and confidence of interventions.
c. **DISCUSS and ACCEPT** the winter plan and mitigation proposals.

Demetri Wade
Deputy Chief Operating Officer

Taj Virk-Dhugga
Assistant Director of Urgent Care

30th August 2024

Annex 1: Pre-MMUH Activities Gantt chart.

		Activity	Plan	26/08/2024	02/09/2024	09/09/2024	16/09/2024	23/09/2024	30/09/2024	07/10/2024	14/10/2024	21/10/2024	28/10/2024	04/11/2024	11/11/2024	
MMUH Mock Census	1	Planning for MMUH Mock census-including communication to clinical groups, identifying panel members from support services and clinicians to provide challenge, production of rota, data collection.	Opportunity for clinical teams to understand and test the census process planned. The mock census process will be documented and recommendations/lessons learned shared prior to move period.													
	2	Mock Census- Sandwell (Medical and Surgical wards)														
	3	Mock Census- City (Medical and Gynae wards)														
	4	Data collection to demonstrate impact														
	5	Observation and process mapping using Finlay tracker to document process and potential issues.														
	6	Debrief and recommendations for census prior to MMUH move.														
PCCT	1	Availability of partner services to support increase in discharge activity e.g. discharges into Bham & Sandwell Local Authority services.	iBeds teams work against Level 4 action cards – includes PCCT Community Beds, Harvest View, Inpatient Therapies & Integrated Discharge Hub teams. Includes senior presence on daily D2A calls and weekly confirm & challenge for all NCTR patients with LOS > 5 days in PCCT Beds													
	2	Preparation work to ensure BAU activities completed ahead of July (to accommodate MMUH inductions) and then August to accommodate the subsequent pressure on patient flow.														
	3	Step down all non-essential/non DCC work releasing capacity into clinical support/decision making.														
	4	Weekly confirm & challenge calls with senior support from system partners in Bham and Sandwell local authorities.														
	5	Pump-prime activity through AA, UCR, Palliative care, PCCT ACP, PCCT Therapy Provision and IDH services.														
	6	Proactive optimisation of current community pathways – Virtual Ward, AA, Hospice, Home from Home, Connected Palliative Care Hub.														
	7	Identification of suitable patients on N4 for transfer to Eliza Tinsley from 3/9/24	Move 12 patients from Eliza Tinsley to McCarthy Ward, maintaining closure of 12 beds													
	8	Release of N4 staff to transfer to Eliza Tinsley team by this date at the latest.														
	9	12 Stroke Rehabilitation Beds open on Eliza Tinsley 3/9/24														
	10	Proactive palliative care in-reach to optimise senior decision making, SCP and EOL care planning and identification of Preferred Place of Death 25/09/24	Protect 10 Leasowes beds to accommodate EOL demand ahead of Sandwell site move on 6th October													
	11	Continue to pump-prime activity through AA, UCR, Palliative care, PCCT ACP, PCCT Therapy Provision and IDH services.														
	12	2 Palliative Care Nurses on Sandwell site 8am – 6pm daily to identify EOL who should not be in hospital and support a move home, Hospice, Nursing Home or Leasowes.	Transfer EOL patients into Leasowes as directed by Palliative Care Team													
	13	Support Leasowes team with increase in EOL patients.														
	14	Additional OT and CNS support to identify EOL admissions that could be diverted with the use of VW, Leasowes.														
	15	Additional OT at Leasowes to support discharges from Leasowes.														
	16	Transport to transfer additional 12 patients (on top of BAU) to Rowley site.	Release an additional 12 PCCT Beds (McCarthy ward opens to capacity of 24)													
	17	PCCT staffing to manage higher than usual admissions demand (admissions process, clerking, new assessments).														
	18	Pressure to keep these beds open throughout the MMUH stabilisation phase minimises the impact of being able to release 12 beds in the days leading up to the City site which is likely to facilitate immediate release in bed pressures to support the 2nd acute site move	Temporary closure of 12 beds on McCarthy (risk assessed at the point of closure)													
	19	Proactive palliative care in-reach to optimise senior decision making, SCP and EOL care planning and identification of Preferred Place of Death	Protect 10 Leasowes beds to accommodate EOL demand ahead of City site move on 10th November													
	20	Continue to pump-prime activity through AA, UCR, Palliative care, PCCT ACP, PCCT Therapy Provision and IDH services.														
	21	2 Palliative Care Nurses on City site 8am – 6pm daily to identify EOL who should not be in hospital and support a move home, Hospice, Nursing Home or Leasowes														
	22	Support Leasowes team with increase in EOL patients														
	23	Additional OT and CNS support to identify EOL admissions that could be diverted with the use of VW, Leasowes														
	24	Additional OT at Leasowes to support discharges from Leasowes														
	25	Transport to transfer additional 12 patients (on top of BAU) to Rowley site	Reopen McCarthy ward fully (releasing an additional 12 PCCT Beds)													
	26	PCCT staffing to manage higher then usual admissions demand (admissions process, clerking, new assessments)														
Medicine & Emergency Care	1	Daily Multidisciplinary Length of Stay (LoS) review meetings held to review pathways 0 and 1, with support of PCCT colleagues to assess 2 – 4.	Focus on increasing admission avoidance and discharge numbers, while reducing bed occupancy													
	2	Clinical Director led reviews of ward areas/referee rounds based on daily discharge forecasts conducted from 26th August on a rolling basis through the move period.														
	3	Management of ward, AMU and SDEC rotas overseen by the Clinical Directors to ensure experienced substantive consultant presence to promote higher risk tolerance for discharge.														
	4	Additional Acute Medicine shifts will commence from 9th September to provide support for the Emergency Departments in addition to 3 x consultants being on shift for the Acute Medical Units to support admission avoidance and discharge timeliness.														
	5	Daily huddles inclusive of PCCT to assess discharge progress and escalate for support where required.														
	6	Transfer teams established to improve handover and transfer times between ED, AMU and the Medical Wards.														
	7	Mental Health provider provision to have an increased capacity offer for SWB to prevent delays in access to specialist beds for ED attenders, and consideration for other providers being primary places of safety.														
Surgical Services	1	Multidisciplinary Agency Discharge Event (MADE) held week commencing 16th September and 23rd September.	Focus on Surgical flow and bed occupancy prior to move to support ward transfers for surgical services by reducing patient numbers as far as practicable. Lower bed occupancy and increased consultant presence will also improve transfer times from ED for surgical referrals and help to reduce cubicle demand and increase ED clinical availability.													
	2	Group leadership attendance at the daily surgery flow huddles for senior challenge and escalation of interventions or support required.														
	3	Increase to 2 trauma lists each day from 16th September.														
	4	Increase to 2 NCPOD lists each day from 16th September.														
	5	7-day consultant rounds for every speciality from 16th September.														
	6	Senior communications planned for all consultants along with a Group discussion emphasising the need to optimise discharges.														
	7	Clinical Director led reviews of ward areas/referee rounds based on daily discharge forecasts conducted from 26th August on a rolling basis through the move period.														
Women's and Child Health	1	Increased consultant ward rounds to facilitate increased and timely discharges will commence on a rolling basis from 16th September.	Paediatric bed flow, occupancy and discharge rates will be the priority in the weeks prior to move.													
	2	Clinical Director led reviews of ward areas/referee rounds based on daily discharge forecasts conducted from 26th August on a rolling basis through the move period.														
	3	Increased support required from external partners regarding CAMHS and social admission patients.														
	4	Increased support in Neonates and Maternity for social admissions.	Perinatal Services will focus on reducing maternity and neonatal activity with support of additional medical cover and wider network support.													
	5	Support from Local Maternity and Neonatal Network (LMNS) for induction of labours and utilisation of network cots to reduce numbers on site prior to move.														
	6	Clinical Director led reviews of ward areas/referee rounds based on daily discharge forecasts will be conducted from 26th August on a rolling basis through the move period.														
	7	Increased consultant ward rounds to facilitate timely discharges implemented from 16th September.	Gynae, Gynae Oncology and Breast to focus on reducing inpatient numbers and enhance timely review of referrals in ED.													
	8	Focus on inpatient on SCP – to facilitate timely transfers of care or discharges.														
	9	Review of elective caseloads in the weeks before as some patients have longer LoS than others.														
	10	Review of patients on long term Total parenteral nutrition (TPN) for earlier transfer into community.														
	11	Close D25 on Monday prior to move and merge all patients onto D21, giving opportunity to move an empty ward before the patient move.														
	12	Clinical Director led reviews of ward areas/referee rounds based on daily discharge forecasts from 26th August on a rolling basis through the move period.														
Imaging, Pathology and Support Services	1	Additional Hot Slots for scanning and reporting will be mobilised in line with previous Industrial Action response.	Timely and improved access to Imaging and Pathology are critical enablers to support clinical services in expediting discharge. Therefore, these services are increasing reporting capacity for inpatients and scanning capacity over the weekend to reduce turnaround times to target performance.													
	2	Confirmed rotas with additional cover to respond to escalations and earlier demand from increased intensity of ward reviews.														
	3	Additional WLIs at the weekend will support CTCA turnaround times and management of Cardiology demand.														
	4	Insourcing to continue other than the move weekend.														
	5	Mutual aid to continue for NOUS to enable a focus on inpatient demand.														
	6	Additional Pharmacy provision for the wards to support prescribing and TTO accuracy, as well as dispensary cover to reduce turnaround times for access to medication.	There is a requirement for support services to increase provision prior to move to facilitate services improving discharge and transfer timeliness.													
	7	Hotel Services increased cover to ensure IPC related cleaning to access side rooms and bays on wards happens rapidly once identified.														

Tier 1 - Paper ref:	PublicTB (09/24) 012

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Freedom to Speak Up annual report
SPONSORING EXECUTIVE:	Martin Sadler- Executive director Information Technology and Digital
REPORT AUTHOR:	Jamil Johnson- Interim lead for Freedom to Speak Up
MEETING:	Public Trust Board
DATE	11th September 2024

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

The paper will provide the public trust board with assurances the Freedom to Speak Up team with the wider organisational learning being undertaken as a result of concerns raised via Freedom to Speak Up.

The activity of the Freedom to Speak Up team to support organisational culture change and partnership working with our partner organisations.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	**X**
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **RECEIVE** the contents of the report

b) **DISCUSS** the themes and actions

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

Board Assurance Framework Risk 01	X	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 11th September 2024

Freedom to Speak Up update Report.

1. Introduction or background

1.1 Following on from Sir Francis review of the speaking culture within the NHS, which was published in 2015, Freedom to Speak Up remains a business-critical component to support the provision of safe effective care for our patients. Freedom to Speak Up remains on a transformational journey at Sandwell and West Birmingham trust, to ensure all concerns are heard and appropriate and meaningful actions are taken as appropriate.

1.2 The report will provide the public board with an overview of the national picture of speaking up and collate this with the local speaking up culture.

1.3 The report will provide the Public Trust Board with a thematical overview of the concerns raised with a breakdown of the top three. The board will be advised of the action being taken or taken to address these top three concern areas and the collaborative work being undertaken for wider organisational learning.

2. National picture on speaking up- Listening to the silence: Freedom to Speak Up in the NHS staff survey 2023 and the local speak up picture

2.1 The Listening to the Silence report was published in 2024 by the National Guardians office and provides and provides insight into colleague's perception of speaking up within the NHS nationally with the sub-scores remaining unchanged from the previous year (6.44 2022 to 6.46 in 2023), suggesting the perception of speak up remaining relatively unchanged.

2.2 The sub score is made up of four questions, two related to clinical practice concerns and latter to concerns relating to any other matters (**Annex 1**). There has been no change in the perception of colleagues feeling safe to raise concerns relating to unsafe clinical practice, however, there has been a slight decrease in colleagues feeling the organisation would address such concerns. This is in line with the national picture. Colleague perception of feeling safe to raise concerns regarding matters not related to unsafe clinical practice and being confident the organisation will address the concerns have both increased and we are closing the gap on the national average.

2.3 Listening to the silence, is crucial to truly understanding what is occurring beyond the intelligence data provides. The FTSU team remain increasingly visible in areas where 'silence' is noted in relation to colleague engagement to listen to the barriers to engagement, which has influenced the managers guide to dealing with concerns being published and finalising the operating procedure of escalating concerns of disadvantageous and demeaning treatment.

3. Concerns raised via FTSU

3.1 The FTSU team had a total of 50 concerns raised during the reporting period of **April 24-June 24** (**Annex 2, Figure 1**). The top 3 themes reported were worker safety or wellbeing (40), Inappropriate behaviours or attitudes (28) and patient safety or quality (13). There has been a good uptake on the use of the FTSU portal, with colleagues feeling reassured this is managed by the FTSU team and comparison to previous reporting mechanisms.

3.2 There is an increase in concerns in relating to worker safety and wellbeing and this commonly relates to the impact of inappropriate behaviours or attitudes on colleagues in addition to perceived inappropriate application on HR processes, in addition to this the team continue to receive concerns of incivility from various staff groups. The team have had some concerns in relation to safe provision of patient services, with the actions noted in Annex 3.

3.3 Recruitment practices, remain a reoccurring HR process which colleagues have raised as not being equitable. The FTSU team continue to raise such concern at the Inclusive resourcing and talent management group, with the focus on ensuring accountability when the prescribed processes are not followed.

4. FTSU activity

4.1 The FTSU team remain proactive in supporting colleagues with obtaining meaningful feedback and assurance regarding their concerns, with 3 monthly follow ups to ensure there has been meaningful action.

4.2 The FTSU team, continue to ensure targeted increase visibility to area's where the FTSU suggests there is a fear of reprisals for raising concerns. The team have also finalised the Disadvantageous and Demeaning Treatment escalation procedure to further support colleagues and ensure such concerns are centrally captured.

4.3 The FTSU team continue to be key stakeholders in the ARC compassionate inclusive people management group and the Inclusive Talent Management and resourcing group, to support triangulation and wider organisational learning from FTSU concerns.

4.4 The FTSU team have started to publish on quarterly themes and actions taken to the wider staff group to provide assurance concerns are heard and actioned.

4.5 The FTSU team are working collaboratively with FTSU guardians within the Blackcountry system to promote FTSU during the speak up month via an online conference which the trust is leading on.

5. Recommendations

5.1 The Public Trust Board is asked to:

a. **RECEIVE** the contents of the report
b. **DISCUSS** the themes and Actions

Martin Sadler
Executive director Information and Technology and Digital.
Jamil Johnson
Interim Lead for Freedom to Speak Up

23/08/24
Annex 1: NHS staff survey speak up culture indicators
Annex 2: FTSU concerns Quarter 1
Annex 3: Summary of concerns and Actions taken

Annex 1

Q20a I would feel secure raising concerns about unsafe clinical practice.

	2021	2022	2023
SWB	73.4%	69.9%	69.15%
Best	83.2%	79.4%	77.96%
Average	74.1%	70.8%	70.24%
Worst	66.4%	61.8%	63.19%
Responses	**2871**	**2825**	**2288**

Q20b I am confident that my organisation would address my (clinical practice) concern

	2021	2022	2023
SWB	55.5%	55.1%	53.85%
Best	75.5%	73.6%	69.29%
Average	60.7%	60.3%	55.90%
Worst	47.6%	49.0%	43.62%
Responses	**2682**	**2727**	**2283**

Q25e I feel safe to speak up about anything that concerns me in this organisation.

	2021	2022	2023
SWB	55.0%	53.7%	57.90%
Best	76.2%	69.1%	73.98%
Average	57.7%	55.7%	60.89%
Worst	44.1%	42.2%	50.32%
Responses	**2862**	**2817**	**2276**

Q25f If I spoke up about something that concerned me, I am confident my organisation would address my concern.

	2021	2022	2023
SWB	43.9%	42.8%	46.26%
Best	67.4%	63.9%	66.13%
Average	48.0%	55.7%	48.65%
Worst	32.0%	33.7%	35.26%
Responses	**2681**	**2721**	**2280**

Annex 2

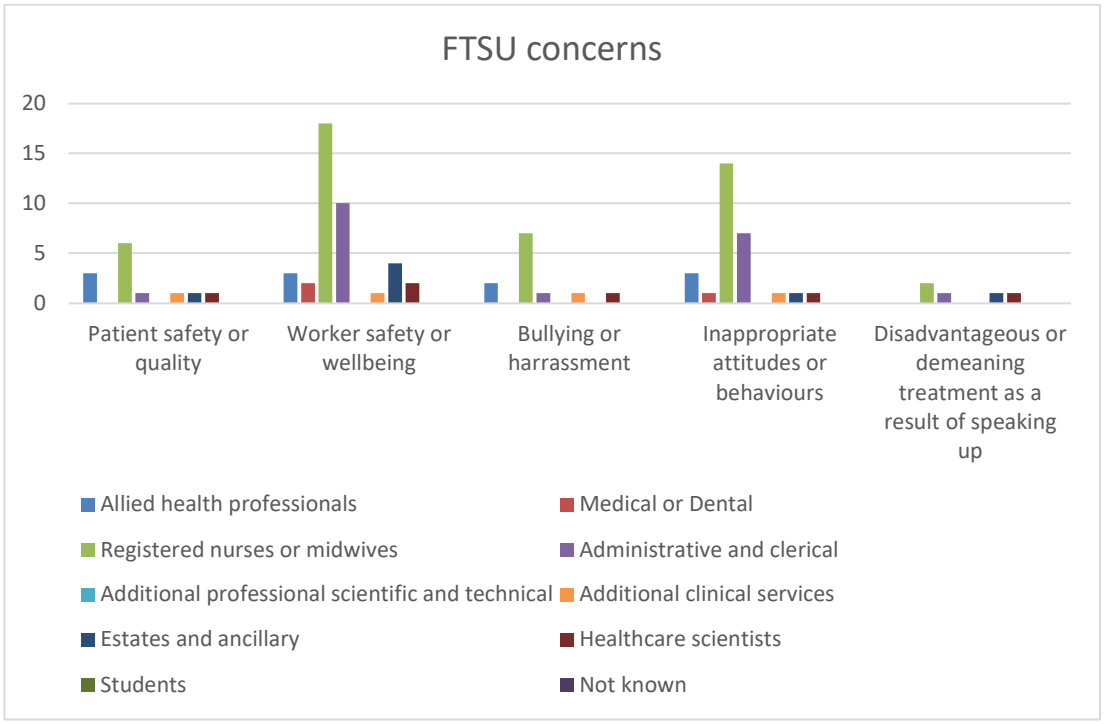


Figure 1 Quarter 1

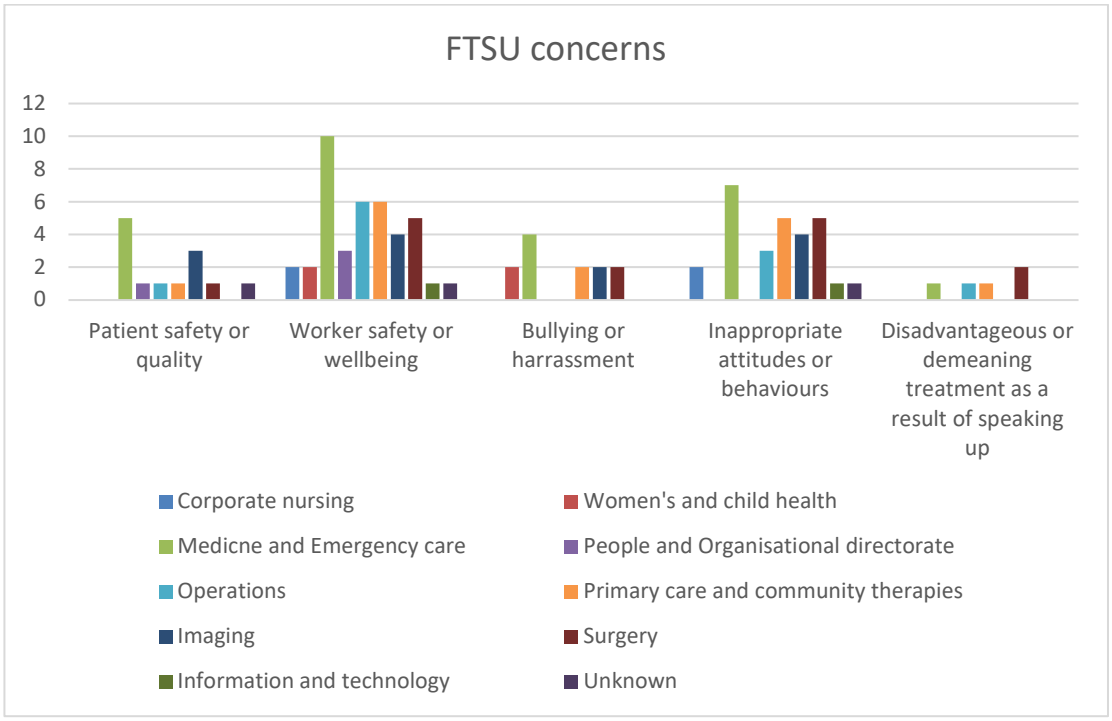


Figure 2 Quarter 1 directorate breakdown

Themes	Action/s taken
Patient safety or Quality • Inequitable treatment provided to patients due to their race. • Staffing shortages within specialist area, is increasing the workloads of the healthcare professionals increasing risk of clinical errors. • Inconsistency in documentation for patient care.	• Ward meeting facilitated with Equality, Inclusion and Diversity input to reinforce the organisations expectations and provide education. • Meeting undertaken to understand concerns and a plan formulated with key stakeholders. • Local team have implemented guidance on documentation expectations.
Worker safety or Wellbeing • Refusal of flexible working request, without a substantiated reason. • Nonadherence to trust policies in regard to security. • Managing three services as a newly appointed band 7 with a lack of support.	• Facilitated meeting to support colleague to escalate concerns, to support the management team to have a better understanding of the colleagues needs. • Local procedures updated and trust policy being reviewed. • Raised with directorate team resulting in regular 1-1s with colleague.
Bullying or harassment • Passive-aggressive emails received from a line manager, and this being noticed by other colleagues. • Colleague felt harassed by manager after an incident had occurred. • Colleagues perceiving behaviours experienced by manager from senior leader aligned to bullying.	• Facilitated meeting to support a plan of moving forward. • Reflection of incident and understanding of perceived behaviours.

Inappropriate attitudes or behaviours • Incivility experienced from a colleague when asking for clarification. • Inappropriate language used in front of junior colleagues • Acting manger enforcing changes to practices without consulting colleagues affected.	• Reflection undertaken by individual with learning. • Support offered by line manager to colleague to support transition to management role. • Raised with group and acknowledgment on the importance of engagement of colleagues.
Disadvantageous or demeaning treatment (DDT) as a result of speaking up. • Inappropriate behaviours experienced after raising concerns.	• Standard operating principle for DDT circulated. • Reinforcing the organisations expectations and values.

Tier 1 - Paper ref:	PublicTB (09/24) 013

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Equality, Diversity and Inclusion (EDI) Update
SPONSORING EXECUTIVE:	James Fleet, Interim Chief People Officer
REPORT AUTHOR:	James Fleet, Interim Chief People Officer Meagan Fernandes Director of People and OD
MEETING:	Public Trust Board
DATE	11th September 2024

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

NHS Boards play a hugely important role in championing an organisational culture of equality, diversity and inclusion, as highlighted in NHS England's first equality, diversity and inclusion (EDI) improvement plan, published on 8 June 2023.

The People Committee undertook a focused EDI deep-dive session at its July 2024 meeting. The July deep-dive covered progress against the Trust's 4 key 2024/25 EDI priorities, which are captured within the annual plan and strategic planning framework (SPF). The deep dive also reviewed and challenged the Trust's performance across the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap measures and the key improvement actions for 2024/25, in advance of publication on SWB's website. The Committee noted the positive engagement of the Networks in developing the WRES/WDES and Gender Pay improvement plan. This Board briefing paper was commissioned by the People Committee, following the July EDI deep-dive and implements the Sandwell and West Birmingham NHS Trust (SWB) Trust Board's responsibilities to review, discuss, challenge and support the work so far and the further actions required over the next 12 months, particularly for the WRES, WDES and Gender Pay Gap.

SWB is committed to embedding a culture of compassionate and inclusive leadership, in which equality, diversity and inclusion is core to everything that we do. The Trust Equality Diversity and Inclusion (EDI) Plan 2023-2027 was approved in January 2023 at the Trust People Committee and reflects the emphasis within the SWB People Plan, which highlights EDI as a Trust priority within the People strategic objective of our Trust Strategy.

More recently in February 2024, following a review of the effectiveness of the multiple EDI programmes that were in place, the People Committee supported a proposal to streamline and focus the Trust's EDI work programme to deliver 4 key priorities during 2024/25. These were reflected in our prioritised annual plan and strategic planning framework (SPF). These are:

1. Empower, equip & enable the Staff Networks
2. Optimise the role and function of the EDI Team within the Trust
3. Deliver and embed a robust framework for inclusive Recruitment
4. Launch a SWB inclusive Talent Management programme

The Board are invited to **review** the progress to date across the 4 EDI (re-set) priority areas, to **note** the positive developments and areas of progress, as well as **support** the major initiatives that are underway which will enhance the lives of SWB staff and ultimately patients. Board members

are also prompted to seek further regular updates on progress across the EDI agenda and to support the call to formally appoint a Board level EDI Guardian.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	**X**
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	**X**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*
None

4. Recommendation(s)
The Private Trust Board is asked to:
a) REVIEW the progress made in delivering the 2024/25 EDI priorities and People Plan programmes linked to EDI.
b) NOTE the positive EDI developments, interventions and key achievements during the past 12 months.
c) CONSIDER the latest WRES, WDES and Gender Pay Gap results, particularly the areas of improvement and those areas requiring further focus, ahead of public publication.
d) SUPPORT the major initiatives that are underway to drive further improvement for the staff of SWB.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Board Assurance Framework Risk 01	X	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	X	*Make best strategic use of its resources*
Board Assurance Framework Risk 03	X	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	X	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	X	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		**See Programme Risk Register**
Is Quality Impact Assessment required if so, add date: multiple QIAs completed in the MMUH Programme.		
Is Equality Impact Assessment required if so, add date: As above.		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 11th September 2024

Equality, Diversity and Inclusion Update

1. Introduction – National EDI Context

1.1 In a recent (2024) survey of NHS senior leaders by the NHS Confederation there was a strong consensus that tackling the issues that cause disparities in health and staff experience improves productivity, efficiency and outcomes. Furthermore, that this helps healthcare systems to achieve financial and operational goals and to improve performance.

1.2 Despite the NHS having a legal responsibility to tackle workforce and health inequalities under the Equality Act 2010 and Health and Care Act 2022, reinforced in the NHS Long Term Plan and annual planning guidance, disparities still exist. Indeed, reporting on 2019 data, the NHS Confederation reports that the annual cost to the NHS of bullying, harassment and discrimination was estimated at £2.281 billion. Most recently, the 2023 WRES results highlighted that 27.5% of MBE staff reported experiencing harassment, bullying or abuse from other staff in the last 12 months, compared to 21.7% of white staff. "This shows that there is still a long way to go for NHS organisations to facilitate true workplace equality for BME staff" (NHS Employers, 2024).

1.3 In 2023 NHS England (NHSE) published its first equality, diversity and inclusion (EDI) improvement plan, which was developed in consultation with diverse staff, staff networks and stakeholders. This plan introduced six high impact actions (HIAs) for improving equality, diversity and inclusion in the NHS, underpinned by a combination of success metrics.

2. SWB EDI Priorities

2.1 The Trust Equality Diversity and Inclusion (EDI) Plan 2023-2027 was approved by the People Committee at its meeting in January 2023. The Plan incorporates a range of key EDI work programmes which were developed as part of the SWB People Plan, including action to strengthen workforce representation and therefore develop a more diverse and inclusive organisation.

2.3 The Plan is split into four quadrants as set out within Figure 1 below:

2.4 During January 2024 a full review of the effectiveness of the EDI programmes was undertaken, involving Staff Networks, trade unions, executive colleagues the People Committee. This work highlighted the need to focus efforts, resources and capacity on a smaller number of priorities in order to make progress in key areas, such as establishing Staff Inclusion Networks and across the key measures captured through the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

2.5 In February 2024 the People Committee supported a proposal to streamline and focus the Trust's EDI work programme to deliver 4 key priorities during 2024/25, included in our annual plan and SPF. These are:

1. Empower, equip & enable the Staff Networks
2. Optimise the role and function of the EDI Team within the Trust
3. Deliver and embed a robust framework for inclusive Recruitment
4. Launch a SWB inclusive Talent Management programme

2.6 These improvement priorities will have the greatest immediate benefit in delivering the Trust's commitment to embedding a workplace culture which embraces EDI at all levels and in all parts of the organisation. These actions respond to the previous 2023 WRES, WDES and Gender Pay Gap reports, as well as wider analysis of the staff survey results through different inclusion lenses and forums. Furthermore, there was strong support from the existing Networks that these actions represent tangible interventions for addressing inequalities, as well as stamping out discrimination and tackling underrepresentation within our workforce.

2.7 The People Committee undertook a focused EDI deep-dive session at its July 2024 meeting. The July deep-dive covered progress against the Trust's 4 key 2024/25 EDI priorities, which are captured within the annual plan and strategic planning framework (SPF). The deep dive also reviewed and challenged the Trust's performance across the WRES, WDES and Gender Pay Gap measures and the key improvement actions for 2024/25 in advance of publication on the Trust's website. The Committee noted the positive engagement of the Networks in developing the WRES/WDES and Gender Pay improvement plan. This Board briefing paper

was commissioned by the People Committee, following the July EDI deep-dive and implements the SWB Trust Board's responsibilities to review, discuss, challenge and support the work so far and the further actions required over the next 12 months, particularly for the WRES, WDES and Gender Pay Gap.

2.8 The Board is also advised that the work to deliver the 2024/25 EDI priorities is being led by the core EDI team, working closely with the Staff Networks, during the 'no fly zone' for MMUH, to safeguard the capacity of the Group leadership teams for opening MMUH. The Networks will increasingly take the lead role for driving the improvement plans across the diversity areas, as they grow and mature, with support from the core EDI team.

3 Update on progress made in delivering the EDI priorities for 24/25

3.1 Empower, equip and enable the Staff Networks

3.1.1 Following a half day workshop session with all of the existing Staff Network Chairs and Deputy Chairs, Lesley Writtle (Vice Chair), Val Taylor (Non-Executive Director), James Fleet (Interim Chief People Officer) and Meagan Fernandes (Director of People and OD) a programme of work was launched to re-launch the Staff Networks within the Trust.

3.1.2 A number of the Networks no longer had current Chairs, Vice Chairs, Executive and/or Non-Executive Sponsors. Few of the Networks had workplans, objectives and in some cases regular meetings had ceased. There was a strong commitment to re-launch the Networks and champion them support SWB to better embed and promote a culture of inclusion. As NHS England have highlighted, 'Staff networks play an important role in helping NHS organisations deliver high-quality care, and equality through their ability to: share the lived experience of people to inform decision-making and improvements. support equality, diversity, and inclusion'. With over 700 staff networks operating across the NHS in England, they provide protected spaces where people can be open and inclusive, nurturing a culture of belonging and trust. (2023).

3.1.3 Work has been undertaken to reset of the terms of reference for Staff Inclusion Networks, re-define the role of the Networks, enhance the supporting infrastructure for the Networks, identify new Executive and Non-Executive Sponsors for the Networks, re-define the facilities time commitment and develop a clear profile and role description for Network Chairs and Deputy-Chairs.

3.1.4 In June 2024 a Trust wide election process was launched to appoint Chairs and Deputy Chairs for the 7 Networks. There was an overwhelming response and interest into these roles. Based on over 130 votes from staff form across the Trust, Chairs and Vice Chairs have now been confirmed for 6 of the 7 Networks.

3.1.5 The Network Chairs will be invited to attend the People Committee meetings on a quarterly basis. Formal updates on the work programmes for each of the Networks will be presented to the People Committee and with annual updates also to the Trust Board.

3.2 Optimise the role and function of the EDI Team within the Trust

3.2.1 There has been significant work undertaken over the last 12 months to support and develop the remit and scope of the EDI team to optimise their role and impact in championing EDI. This includes a series of OD team effectiveness sessions, EDI team coaching, and focussed work to develop the EDI Team vision, and objectives aligned to our Trust EDI Plan.

3.2.2 A lead EDI representative has also now been allocated to each Clinical Group to support and facilitate targeted support at a local level. The team are currently planning a series of education and awareness programmes to raise the profile of EDI across the organisation including focussed EDI comms.

3.2.3 The Director of People and OD is the joint SRO for the ICS Inclusive Culture Group, and the EDI Team represent the Trust in a number of key ICS EDI workstreams and programmes of work.

3.3 Deliver and embed a robust framework for inclusive Recruitment

3.3.1 An Inclusive Resourcing programme has been developed through the Inclusive Talent Management and Resourcing Group which and was launched in April 2024. The Group is chaired by Val Taylor (Non-Executive Director). The programme consists of six key work streams:

- Implementation of values based interviews and assessment processes.
- Making processes fairer for all by sharing interview questions/themes in advance of interview.
- Evaluation of the role of the Black, Minority & Ethnic (BME) advisor in the recruitment process.
- Review of recruitment documentation to support a fully inclusive approach.
- Embed our new employer brand and values within the Trust recruitment documentation.
- Specific measures intended to target underrepresented groups (BME and Disability) at Band 7 and above.
- Supporting local people through employability programmes.
- Pastoral service for new starters who have gained employment through an employability programme.

3.4 Launch a SWB inclusive Talent Management programme

3.4.1 An SWB Inclusive Talent Management programme has been launched to focus on addressing the under-representation of specific demographics within senior leadership roles, Band 8c – VSM. This is one of our EDI high-impact actions, alongside the Inclusive Recruitment action plan and responds directly to poor representation of BME staff at the most senior levels within the Trust, which has been a consistent challenge in the Trust's annual WRES results.

3.4.2 The aim of this intervention is to create a career development framework, which is tailored to the specific needs of the individual participant, providing bespoke career development support alongside a range of experiential learning opportunities. It aims to support and enable staff from diverse backgrounds to work towards their career goals and increase their likelihood of successfully securing senior leadership roles. Phase 1 is a pilot which is focused on Black, Asian and Ethnic Minority (BME) staff based on our most recent WRES results. The first cohort of staff to join this programme are the 6 SWB staff that participated in the Black Country ICS 'Next Generation of Senior Leadership Programme' (NGSL), which concluded in May 2024.

3.4.3 Following the evaluation of Phase 1 the programme will be rolled out to other diverse staff groups. This work will firmly establish a diverse talent pipeline of senior leaders that can apply for executive-level roles in the future. We believe that focusing on improved representation within senior leadership will in turn influence the diversity of the wider workforce.

4 Embedding EDI through our SWB People Plan

4.1 In addition to the work underway to deliver the four 2024/25 EDI priorities, a number of the existing People Plan initiatives are also helping to embed and nurture a culture of compassion and inclusion within SWB, including:

- Compassionate and Inclusive Leadership for all line managers - ARC leadership programme.
- Creating a positive culture of compassion and inclusion - Restorative People Management Programme, deploying a 'Just and Learning' approach to people management.
- Cultural Ambassador (CA) Programme.

5. Some Key Achievements

5.1 During the past 12 months the Trust has secured a number of noteworthy achievements and recognition for its progress and delivery in EDI, these include:

5.1.1 SWB has signed up to the Race Code and successfully achieved the Race Code quality mark in May 2024.

5.1.2 SWB has taken part in phase two of the Rainbow Badge Scheme. The Rainbow Badge Scheme was created to be a way for NHS staff to demonstrate that they are aware of the issues that LGBT+ people can face when accessing healthcare. Phase two is an assessment and accreditation model and allows Trusts to demonstrate their commitment to reducing barriers to healthcare for LGBT+ people, whilst evidencing the good work they have already undertaken. Following our assessment, we have achieved bronze status.

5.1.3 SWB has signed up to the Sexual Safety in Healthcare Charter and the EDI team are working with a number of key stakeholders to develop a communication campaign to socialise the ten principles and actions associated with the charter.

5.1.4 SWB is a member of the Employers Network for Equality & Inclusion (ENEI) and has undertaken the TIDE (Talent Inclusion & Diversity Evaluation) and was awarded Gold status which is the highest level.

5.1.5 SWB has successfully achieved Disability Confident Employer Level 2 Status in July 2024

5.1.6 SWB has completed the NHS Employers Diversity in Health and Care Partners 2023/2024 programme.

6. Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap Data

6.1 As part of the re-launch of the Staff Networks the EDI team have worked collectively with the Networks to review the outcome of the latest (2024) WRES, WDES and Gender Pay Gap data and to develop a set of meaningful actions which will drive further improvements for diverse staff.

6.2 For reference the WRES aims to address inequalities and help improve the experiences of employees from BME backgrounds. The WRES data covers the period from 1st April 2023 to 31st March 2024.

6.3 For reference the WDES aims to help improve the experiences of Disabled colleagues and covers the period from 1st April 2023 to 31st March 2024.

6.4 For reference under the Equality Act 2010, as a public body with more than 250 employees, the Trust is required to publish its Gender Pay Gap information each year. The Gender Pay Gap shows the difference in the average pay between all men and women in our workforce and utilises the snapshot date of 31st March 2024.

6.5 In July 2024, the People Committee undertook a deep-dive session on EDI to assess progress against the 4 priorities that were set by the Committee in February 2024. A paper and power BI dashboard were presented to summarise the WRES, WDES and Gender Pay Gap data and a DRAFT improvement plan was presented, which was supported by the attendance of the existing Staff Network Chairs and Vice-Chairs. The People Committee approved the plan and the supporting delivery arrangements, through the Networks supported by the EDI team, working closely with the Clinical Group Leadership Teams.

6.6 An update on progress in delivering improvements across the WRES and WDES indicators has now also been included as a core part of the People Committee Care Group deep-dive metrics.

6.7 Whilst avoiding the risks of complacency and whilst fully recognising that there are significant areas for improvement in the Trust's WRES, WDES and Gener Pay Gap results, the most recent (2024) results to highlight are some early signs that the work highlighted above is starting to have a positive impact for the workforce. These are highlighted below:

- **WRES** - there has been improvement in representation of BME staff across most Agenda for Change Bands , including at Band 8D and Band 9 as well as across Medical roles, which is positive for the Trust and reflects improved diversity in representation.

- **WRES** – there has been an improvement in the staff engagement score for BME staff across the most recent Quarterly Pulse Survey, as reported to the People Committee in July 2024.
- **WRES** - The Trust has shown a marked improvement in parity for BME staff with their white colleagues in appointment from shortlisting and there has been a decline in the number of BME staff going through disciplinaries.
- **WDES** - There is an increase in the number of disabled colleagues we employ, and the Trust has shown a marked improvement in the number of disabled staff shortlisted and appointed into roles in 2024.
- **WDES** - There is an increase in the number of disabled colleagues we employ, and the Trust has shown a marked improvement in the number of disabled staff shortlisted and appointed into roles in 2024.
- **WDES -** There has been progress made in relation to the percentage of disabled staff who believe their organisation provides equal opportunities for career progression or promotion has increased.
- **Gender Pay Gap** - The mean pay gap has decreased by **0.75%** when comparing 2022/2023 to 2023/2024.
- **Gender Pay Gap** - The median pay gap has closed by **0.74%** when comparing 2022/2023 to 2023/2024.

6.8 Key areas for improvement include:

- **WRES** -There has been little demonstrable progress in securing an increase in representation of BME staff in pay Band's 8C. There has also been a decline in BME representation in Very Senior Manager (VSM) roles where BME staff are significantly under-represented relative to the number of BME employees in the Trust and within the wider population that we serve.
- **WDES –** There is currently no representation of disabled staff at Band 9 or VSM level.
- **WDES -** The percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months with a long term condition or illness is above the average and the percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties is also above the average.
- **Gender Pay Gap -** The current data shows on-going gender pay disparities, with some progress in specific staff groups like AfC. However, gaps remain, particularly in the Medical & Dental staff group.

7. Wider EDI Reporting

7.1 The Trust continues to report on the wider EDI domains and is increasingly developing reporting on an intersectionality basis, which recognises that people have complex and multiple identities, and that multiple forms of inequality or disadvantage sometimes combine to create obstacles that cannot be addressed through the lens of a single characteristic in isolation. This reporting covers; age, ethnicity, disability and sexuality.

8. Board EDI Champion/Guardian

8.1 At the July meeting of the People Committee there was significant support for identifying a Board level EDI Champion/Guardian (separate to the Interim Chief People Officer and the Executive/NED Network Sponsors). The proposal was that this should be a Non-Executive Director.

9. Recommendations

9.1 The Public Trust Board is asked to:

A. **REVIEW** the progress made in delivering the 2024/25 EDI priorities and People Plan programmes linked to EDI.

B. **NOTE** the positive EDI developments, interventions and key achievements during the past 12 months.

C. **CONSIDER** the latest WRES, WDES and Gender Pay Gap results, particularly the areas of improvement and those areas requiring further focus.

D. **SUPPORT** the major initiatives that are underway to drive further improvement for the staff of SWB.

James Fleet, Interim Chief People Officer
Meagan Fernandes – Director of People and OD

August 2024

Tier 1 - Paper ref:	PublicTB (09/24) 014

Sandwell and West Birmingham NHS Trust

Report title:	Emergency Preparedness, Resilience and Response for Sandwell and West Birmingham NHS Trust
Sponsoring executive:	Johanne Newens – Chief Operating Officer
Report authors:	Caroline Rennalls – Assistant Director of Operations and Resilience Management
Meeting title:	Public Trust Board
Date:	11th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

The Trust is required to undertake the duties of a category 1 responder in the Civil Contingencies Act 2004 and all subsequent legislative guidance. In 2023/24 the Trust declared itself partially compliant against the NHSE self-assessment core standards and this was supported by the ICB.

There is a statutory requirement to ensure the Board have an overview of the following:

1. Training and exercises undertaken by the organisation in 2024/5.
2. Business Continuity Management Systems (BCMS) and that the BCMS is monitored, measured and evaluated against established KIPs.
3. Compliance with the NHS England EPRR Assurance process.
4. There is a mechanism in place to ensure all staff are aware of their roles in an incident and that they know where to locate plans relating to their areas of work.

For the 24/25 year we are on course to submit a rating of substantially complaint with the NHSE EPRR Core standards. This is an improvement on last year's position. The main reasons for our improvement are outlined in the main body of the report and our work plan to further improve our resilience.

Our self-assessment will be assessed by the Regional EPRR team and feedback will reported to the Trust Audit and Risk Committee.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	**X**
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	**X**
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	**X**

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **DISCUSS** the NHSE Core Standard self-assessment submission for 2024/25

b) **UNDERSTAND** and **TAKE** assurance from our annual EPRR NHSE Core standards submission.

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

Board Assurance Framework Risk 01	X	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	X	*Make best strategic use of its resources*
Board Assurance Framework Risk 03	X	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	X	*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 11th September 2024

Emergency Preparedness Resilience and Response for Sandwell and West Birmingham NHS Trust

1. Introduction or background

1.1 The Trust is required to undertake the duties of a category 1 responder under the Civil Contingencies Act 2004 and all subsequent legislative guidance. In 2023/24 The Trust achieved partially compliant against the NHSE self-assessment core standards. The Black Country Integrated Care Board (BCICB) Emergency Preparedness Resilience and Response (EPRR) forum requested and obtained the newly produced 2024 NHS England (NHSE) Core Standards Evidence based criteria on which organisations are measured. The 777 subsections provide a transparent framework on how the evidence offered is assessed.

1.2 The Trust is submitting a self-assessment rating of substantially compliant with the NHSE EPRR Core standards. This is an improvement on last year's position. There are 3 amber rated but no red rated returns within the submission. These are:

- "Standard 37 LHRP engagement". (local health resilience partnership) Executive Director responsibility for emergency planning Accountable Emergency Officer (AEO) will attend all regional EPRR meetings are attended by them or a nominated deputy.
- "Standard 38 LRF engagement". (local health resilience forum) Our EPRR lead will attend all future meetings.
- "DD10 Deep Dive Cyber Security. Business Continuity plans do cover IT, but we are working on including a greater cyber response and recovery section to be incorporated. Each area has an identified action plan and progress, and timeframes will be presented at the Trust EPRR Group in October 2024.

1.3 In November 2023 under the new Business Continuity Management System (BCMS) the new BCM template was launched. This allowed groups and services to capture Business Continuity Plans (BCP) for a) services in MMUH, b) specific BCP needed by each service on the days of the move c), the retained estate (City and Sandwell campus, Rowley Regis and Leasowes). We have had greater than 95% of all BCPs. The Accountable Executive Officer quality checked several of the acute services such as theatres and the Emergency Departments from which BCPs have been added to and the inter relationships with other key services crossed refenced.

1.4 The portfolio of training and exercises ensures our Executive Directors and Senior Managers on-call are trained to the National Occupational Standards required by NHSE and legislative guidance. EPRR training for all staff are not part of the Trust Mandatory programme or induction days. Discussion to have this added are ongoing. Recruiting

managers are asked to ensure EPRR awareness including navigating new staff the designated EPRR site on the home page in their local induction.

1.5 The introduction of BCP champions in clinical areas support business continuity being part of the local induction programme for new starters and for local learning to be captured and shared within the team. Lessons learnt inform the changes needed to local BCP and keeps them current.

1.6 The requirements to deliver a comprehensive emergency planning agenda is based on collaborative working with health and social care partners across the ICBs, blue light responders and local authorities. The Black Country Integrated Care Board (BCICB) have developed a system wide strategy underpinned by the Joint Emergency Services Interoperable Principles (JESIP).

1.7 Greater engagement from the BCICB, NHSE training and the joint review and sharing of polices will support polices, plans and processes that adhere to what is considered good practice and offer the staff detailed information and structures that will improve their ability to plan for, respond to, and recover from, an incident.

2. Exercise and Training

2.1 Testing Command and Control processes. The series of consultant and junior doctors' Industrial Action (JDIA) declared Critical and Business Continuity incidents as successfully tested and demonstrated the Trust ability to manage both planned and unplanned events. Hot and cold debriefs with senior clinical and managerial colleagues, promotes the sharing of learning and actions plans ensure measurable outcomes are achieved. The Command-and-Control function at MMUH will be tested on the 15th of September as part of a multiagency evacuation exercise.

2.2 All executive directors and senior on-call managers undergo a training before taking up their responsibilities and are provided with detailed set of documents to ensure they can undertake their Strategic or Tactical commander roles should the need arise.

2.3 Loggist training ensures the Trust records the decisions made in an incident, in line with national requirements. We plan to have a minimum of 100 trained loggist by March 2025

2.4 The Trust has met the annual requirements to carry out 2 communication test per year. The on-call Executive Director/Senior Managers and the Ward-to-Ward cascade tests has been completed once and will be repeated in MMUH in December 2024.

3. MMUH

3.1 The BCP template has been specifically designed to assist groups and services consider the BCPs that are required in MMUH, moving to MMUH and their services on the retained estate. Greater emphasis has been given to the BCPs of 3rd party contractors, here their ability to respond 24/7 is pivotal to the successful recovery of any unplanned incident.

3.2 Within the first 100 days all BCPs will be revisited to ensure any new learning or greater understanding of how the service works and its relationship to other key player is reflected in the BCPs, Table top exercises, unannounced business continuity audits are scheduled for MMUH, and the retained estate and the 2-communication test mentioned in 2.4.

3.3 Black Country Integrated Care Board have agreed to support our EPRR team with audits and exercises recognising the additional work needed with MMUH opening.

4. Recommendations

4.1 The Public Trust Board is asked to:

a) **DISCUSS** the NHSE Core Standard self-assessment submission for 2024/25
b) **UNDERSTAND** and **TAKE** assurance from our annual EPRR NHSE Core standards submission.

Caroline Rennalls
Assistant Director of Operations and Resilience Management

30th August 2024

Tier 1 - Paper ref:	PublicTB (09/24) 015

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Board Assurance Framework Report		
SPONSORING EXECUTIVE:	Kam Dhami, Chief Governance Officer		
REPORT AUTHOR:	Dan Conway, Associate Director of Corporate Governance / Company Secretary		
MEETING:	Public Trust Board	**DATE:**	

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

The Board Assurance Framework (BAF) update for Quarter 2 outlines the principal risks to the Trust's strategic objectives, with no changes recommended to risk scores across the BAF.

Key risks include challenges in maintaining high-quality care, strategic resource utilisation, workforce recruitment and retention, and achieving integrated care goals, all of which remain significant concerns.

As the Trust faces ongoing financial and workforce pressures, deep dives into these risks will be conducted, and a refreshed Trust Strategy will guide future risk management discussions.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	x	To cultivate and sustain happy, productive and engaged staff	x	To work seamlessly with our partners to improve lives	x

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

At all Board Committees in August 2024

4. Recommendation(s)

The Public Trust Board is asked to:

a. **APPROVE** the current position of the BAF risks and scores.

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

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*
Board Assurance Framework Risk 03	x	*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05	x	*Deliver on its ambitions as an integrated care organisation*

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to Public Trust Board on 11th September 2024

Board Assurance Framework Update

1. Introduction

1.1 The Board Assurance Framework (BAF) sets out the principal risks to the delivery of the Trust's strategic objectives. This version represents the Quarter 2 position and details updates made since the BAF presented at the Trust Board in May 2024.

2. BAF Ratings Dashboard and Updates

2.1 The BAF table below comprises of a Ratings Table supported by commentary for each Strategic Risk with includes updates from the executive lead, the committee chair assurance rating and a summary of the discussion in the committee meeting.

PATIENTS: **001: There is a risk that the Trust fails to deliver constant safe, high-quality care**.	Current Risk Score: **4 X 3 = 12**	Target Risk Score: **4 X 3 = 12**	Committee Assurance Rating for August 2024: **Reasonable Assurance**
Commentry: The Quality Committee agreed that the risk score should remain at 4X3=12 as there have been no, never events for over 18 months. Additionally, the quality governance processes are strong and is supporting the management of the Patient Safety Incident Response Framework (PSIRF). Moderate harm and above incidents, remain the same level as previously reported. It was noted that given the challenges of the financial improvement plans, there would be a need to have a deeper review of the BAF in the next quarter to ensure that any actions agreed for the Trust and the system, that could have a potential effect on quality and safety are understand and any risks are articulated within the BAF. The Chief Nursing Officer also stated that following the opening of the new hospital, the Fundamentals of Care Framework would also be refreshed, and this would lead to some additional actions to this risk.			
PATIENTS: **002: There is a risk that the Trust fails to make best strategic use of its resources**	Current Risk Score: **4 X 5 = 20**	Target Risk Score: **4 X 1 = 4**	Committee Assurance Rating for August 2024: **Reasonable Assurance**
Commentry: The Finance and Productivity agreed to the score remaining at 4x5 =20, due to very challenging external financial environment, and a 2024/25 efficiency target of in excess of 6% of turnover. The priority for 2024/25, aligned to our Strategic Planning Framework (SPF), is to deliver the financial plan and ensure recurrent financial improvement.			

It was noted that there was a potential gap on this risk around the improvement agenda and this will be added before the next presentation, this may be an element that would require oversight in the Quality Committee.

The estates and performance elements lacked several updates, and this will need to be resolved for the next presentation.

PEOPLE:	Current Risk Score:	Target Risk Score:	Committee Assurance Rating for August 2024:
003: There is a risk that the Trust fails to recruit, retain, train, and develop an engaged and effective workforce.	**4 X 3 = 12**	**4 X 1 = 4**	**Reasonable Assurance**

Commentry:

The People Committee were satisfied with the current score of 4x3=12. The Interim Chief People officer identified the 3 key issues to be addressed before the be reduced, the first was to have a better grip and understanding of the establishment requirements. Additionally, workforce optimisation and system improvements achieve, along with a reduction in the adverse position.

The People BAF is well set into the forward planning process for agenda setting of the committee. There will be a need to review the BAF and make some additions round the workforce reduction agenda before the next presentation.

POPULATION:	Current Risk Score:	Target Risk Score:	Committee Assurance Rating for August 2024:
004: There is a risk that the Trust fails to deliver on its ambitions as an integrated care organisation	**4 X 3 = 12**	**4 X 2 = 8**	**N/A**

Commentry:

The Integration Committee has been stood down since May 2024 due to a gap in executive leadership. From October 2024 the Committee will reconvene and the BAF will be reviewed, refreshed and presented at the first meeting.

POPULATION:	Current Risk Score:	Target Risk Score:	Committee Assurance Rating for August 2024:
004: There is a risk that the Trust fails to deliver on its ambitions as an integrated care organisation	**5 X 4 = 20**	**5 X 3 = 15**	**Reasonable Assurance**

Commentry:

The MMUH Opening Committee were informed that the risk score is being driven by planned completion and EQUANS readiness of service, and bed fit. As the planned completion has now completed, it is expected that the risk score would have a recommended reduction at the next presentation.

The next step as the Committee comes to the end of its lifecycle there needs to be an exercise to agree how the risks within this BAF are closed or are move to another committee as business as usual.

2.2 Tables of controls and assurances and action plans supporting the BAF are available separately in the September 2024 Trust Board *Reading Room* on iBabs. Changes / additions from the May 2024 version are noted in **blue**.

3. Overview

3.1 Following the quarter 2 reviews, there have been no recommended changes to the risk scores across the BAF. A lack of recommended changes could indicate complacency or failure to recognise evolving risks. This could result in the Board and its committee's not adequately addressing new or emerging risks, leading to vulnerabilities in the risk management approach.

3.2 It's important for the BAF to be a living document that adapts to the evolving risk landscape. There is a need as we go into quarter 3 to have several deep dives into specific areas of the BAF, focusing on significant risks and emerging risks. Risks that sit across the attention of several committees requires attention

3.3 The BAF has been low down on the committee agendas when presented in Quarter 2 and this has due to time pressures in the meeting meant that the required discussion was not always possible.

4. Actions

4.1 All the BAF Risks to have a deep dive given the current financial and workforce challenges. A joint chairs meeting to be convened lead by the Deputy Chair to have a round table review following the deep dive.

4.2 The Trust Strategy is being reviewed and refreshed, once this is completed a Board Workshop will take place to enable a Board discussion on the risks to deliver future objectives and agreeing an updated risk appetite statement.

5. Recommendations

The Public Trust Board is asked to:

Tier 1 - Paper ref:	PublicTB (09/24) 016

Sandwell and West Birmingham NHS Trust

Report title:	Committee Effectiveness Review 2023/24
Sponsoring executive:	Kam Dhami, Chief Governance Officer
Report author:	Dan Conway, Associate Director of Corporate Governance/Company Secretary
Meeting title:	Public Trust Board
Date:	10th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

The 2023/24 Committee Effectiveness Review involved surveys and individual meetings to assess committee performance, with feedback highlighting strong leadership, good relationships between executive leads and chairs, and some areas for improvement, such as paper quality and brevity.

All committees met their terms of reference and delivered comprehensive work programs, with positive feedback on the new effectiveness review process, although the Integration Committee's review was delayed due to a leadership gap.

The survey results will inform revisions to committee terms of reference, work plans, and the BAF, with good practice from the MMUH Opening Committee to be applied across all committee structures.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]

OUR PATIENTS	**-** To be good or outstanding in everything that we do	
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

All the Board Committees in August 2024

4. Recommendation(s)

The Public Trust Board is asked to:

a) **CONSIDER** the effectiveness reviews of the Board committees

b) **ACCEPT** that the reports provide assurance that the Committees have operated effectively during 2023/24

c) **SUPPORT** the areas for improvement proposed in the paper

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

Board Assurance Framework Risk 01		*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 11th September 2024

Committee Effectiveness Review 2023/24

1. Introduction or background

1.1 In line with best practice each year the Trust completes Board committee effectiveness reviews during quarter four. A survey was undertaken for each committee in May 2024.

1.2 The format this year has included individual meetings with the Lesley Writtle (Deputy Chair) during August 2024 with each of the non-executive committee chairs and executive lead to discuss and review committee performance, workplans and terms of reference. The People Committee review meeting was held with Sir David Nicholson, as Lesley is the Chair of this committee.

1.3 The Audit Committee review was undertaken using the Healthcare Financial Management Association (HFMA) NHS Audit Committee handbook. This review included a self-assessment of committee administration by the Chief Governance Officer and the Committee Chair, a self-assessment of committee effectiveness by members, and a review of the terms of reference and work plan against best practices.

1.4 The Audit Committee's effectiveness was positively noted, with members highlighting effective challenges to executive and the proactive engagement of the Chair. Additions were made to the committee's processes, such as increased liaison with external and internal auditors.

1.5 Due to a gap in executive leadership for the Integration Committee the effectiveness process was not undertaken, this will be addressed for 2024/25.

2. Board Committee Effectiveness

2.1 Board Committee performance has considered the following themes: support and infrastructure, leadership, effectiveness and behaviours.

2.2 Each Board committee received an individual effectiveness report encapsulating all the above and these are available in the Reading Room.

2.3 The Board Committee effectiveness survey was sent to all committee members and regular attendees and the response rate for each committee is below (**all committee surveys are available in the Reading Room)**:

Committee	Response Rate (sent/Received)
Quality Committee	14/8 (57%)
People Committee	15/6 (40%)
Finance & Performance Committee	14/8 (57%)
MMUH Opening Committee	16/10 (63%)
Audit Committee	12/6 (50%)

2.4 The response rate to the surveys is an area of improvement for the process in 2025. To support this a request will be made to have a slot on the agenda in the May 2025 committee meetings to allow members to complete the survey in the meeting.

3. Board Effectiveness Survey 2024 Summary of Themes [some direct quotes used]

Support and Infrastructure
• Clarity to those writing the papers about the role of the committee as seeking assurance • Further work on quality and brevity of papers • Frequency of meetings is correct currently • Agendas can be large but once MMUH is open this should improve • Membership of Committee's is correct
Leadership
• BAF still needs work to keep as live document and reflect changing picture / agenda • All committee chairs were seen as responsive, supportive and manage their committee's well.
Effectiveness
• Some of the committees have had the length of the meetings extended to support the large remit they need to cover; this was seen as a positive step. • A refocus on what the priorities are for the Trust was needed.
Behaviours
• Effective leadership of the committee chairs. • Good relationships between the Executive leads and the Chairs.

4. Overall evaluation

4.1 This was a new effectiveness review process, when presented at the individual committee meetings the feedback was that this was a positive step for the organisation.

4.2 The committees of the Board have completed an annual review and self-assessment of performance using a standardised approach. Each committee produced an Annual Report and has reviewed their Terms of Reference as appropriate as well as an annual cycle of business.

4.3 Attendance has been generally good during 2023/24 and all committee meetings have been quorate allowing committee business to be appropriately transacted.

4.4 No committee has needed to co-opt membership to facilitate its understanding of the business to be transacted.

4.5 Each Committee has continued to meet its Terms of Reference and has delivered a comprehensive programme of work on behalf of the Board, providing timely reporting of issues via interim reporting arrangements following each meeting and Minutes once these have been approved. Changes in Executive Director portfolios and to Non-Executive membership of the Board of Directors did not adversely affect the operation of Committees.

4.6 The Deputy Chair felt that by holding the review meetings with each committee Chair and Executive Lead, she was able to better understand how some of the committee's interlink and where improvements would be needed in the next 12 months. She will use the reports when undertaking each committee chairs annual review.

5. Next Steps

5.1 The survey results and feedback from the deputy chair will be used to support a review of the terms of reference and to reset the forward planner for each committee. They will also be used when the BAF has a Board Workshop session following the planned Trust Strategy refresh.

5.2 As the MMUH Opening Committee comes to the end of its lifecycle there are areas of good practice that could benefit all the committee structures, and the Deputy Chair was clear that this should be considered when each committee carries out its work plan reviews.

6. Recommendations

6.1 The Public Trust Board is asked to:

a. **CONSIDER** the effectiveness reviews of all Board committees.
b. **ACCEPT** that the reports provide assurance that the Committees have operated effectively during 2023/24
c. **SUPPORT** the areas for improvement proposed in the paper.

Dan Conway

Associate Director of Corporate Governance / Company Secretary

2nd September 2024

Reading Room: Committee Annual Reports and Surveys

Tier 1 - Paper ref:	PublicTB (09/24) 017

Sandwell and West Birmingham NHS Trust

Report title:	Fit and Proper Persons Annual Assurance 2023/24
Sponsoring executive:	Kam Dhami, Chief Governance Officer
Report author:	Dan Conway, Associate Director of Corporate Governance/Company Secretary
Meeting title:	Public Trust Board
Date:	10th September 2024

1. Summary of key issues *two or three issues you consider the* PublicTB *should focus on in discussion]*

The Trust has successfully conducted the Fit and Proper Persons Test (FPPT) for 2023/24, ensuring that all Board members meet the requirements outlined in the Health and Social Care Act 2008 regulations. The process included new appointment checks and annual assurance measures, such as DBS checks, searches of relevant registers, and self-declarations, with outcomes recorded in personal files and the Electronic Staff Record (ESR). NHS England reviewed and signed off the submission in July 2024, confirming that all Board directors continue to meet the statutory requirements.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
OUR PATIENTS	**-** To be good or outstanding in everything that we do	
OUR PEOPLE	**-** To cultivate and sustain happy, productive and engaged staff	
OUR POPULATION	**-** To work seamlessly with our partners to improve lives	

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **NOTE** the content of this paper

b) **RECORD** that the FPPT has been conducted for the period 2023/2024 and that all Board members satisfy the requirements

c) **ACCEPT** the Trust Board 6 monthly declarations of interest

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*
Corporate Risk Register [Safeguard Risk Nos]		
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Sandwell & West Birmingham NHS Trust

Report to the Public Trust Board on 10th September 2024

Fit and Proper Persons Annual Assurance 2023/24

1. Introduction or background

1.1 As a health provider, the Trust has an obligation to ensure that only individuals fit for their role are employed. Following the regulatory standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Trust must ensure that all Board directors meet the 'Fit and Proper Persons Test'.

1.2 In 2019, a government-commissioned review (the Kark Review) of the scope, operation, and purpose of the Fit and Proper Person Test (FPPT) was undertaken. In response to the recommendations in the Kark Review, NHS England developed a FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. This FPPT framework came into effect from 30 September 2023.

1.3 The Trust's Fit and Proper Persons framework specifies the scope of the staff who are included as:

"All executive and non-executive directors of the Board, including permanent, interim, and associate positions, irrespective of their voting rights. It also applies to individuals who are acting up into Board level positions. The FPPT Framework only applies to deputies who are required to act up for a period of six weeks or more. To ensure deputies are able to act up to Board level positions at short notice, the Trust's position is that all deputy executive directors are within scope of this procedure".

1.4 The framework requires a full FPPT to be completed on appointment. It also requires ongoing assurance as follows:

1.5 The annual self-declaration process will normally be undertaken at the start of each new financial year. Additionally, DBS checks are required to be conducted at least every three years. Where practicable, these checks will be aligned to the annual self-declaration.

1.6 The Associate Director of Corporate Governance/Company Secretary will ensure that the results of the annual self- declaration are recorded on the Electronic Staff Record (ESR) and will draft an assurance report to the Board on behalf of the Chair.

2. Fit and Proper Person: New Appointment and Annual Assurance Checks

2.1 All new appointments are subject to a full FPPT that includes:

- Standard employment checks as per the Trusts Recruitment and Selection Procedure,

- References, using the board member reference template that cover a six-year continuous employment history,
- An enhanced DBS for a person who will be acting in a role that falls within the definition of a 'regulated activity',
- Search of insolvency and bankruptcy register,
- Search of Companies House register to ensure that no board member is disqualified as a Director,
- Search of the Charity Commission's Register of Removed Trustees,
- Web/social media search,
- Satisfactory completion of the self-declaration.

2.2 For annual assurance, the FPPT includes:

- Search of insolvency and bankruptcy register,
- Search of Companies House register to ensure that no board member is disqualified as a Director,
- Search of the Charity Commission's Register of Removed Trustees,
- Web/social media search,
- Satisfactory completion of the self-declaration.

3. Outcome of the Annual Fit and Proper Persons Checks

3.1 In February 2024, the Board of Directors completed the Fit and Proper Persons Test Self Declaration Form.

3.2 The Associate Director of Corporate Governance/Company Secretary reviewed the signed declarations with the Chair and determined that the Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

3.3 In addition, during the year 2023/24, the Associate Director of Corporate Governance/Company Secretary has overseen the completion of pre-employment checks for new appointments and confirms that all checks meet the FPPT Framework.

3.4 The outcome of the FPPT's have been saved on each personal file and uploaded onto ESR.

3.5 Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of the Associate Director of Corporate Governance/Company Secretary or the Trust Chair.

3.6 The submission was sent to NHS England in June 2024 for review. The submission was signed off by Dale Bywater - Midlands Regional Director for NHS England on the 18th July 2024 (see appendix 1)

4. Declarations of Interest

4.1 Members of the Board are required to make an annual declaration of any interests which they have.

4.2 In addition, Board members are required to provide an update during the year should a new interest arise, or an interest cease. Where the interest ceases, the information will be held on the record for a period of at least six months.

4.3 The full Trust Board declarations of interest are attached in **appendix 2**.

5. Conclusion

5.1 All Directors of the Trust Board satisfy the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.

6. Recommendations

6.1 The Public Trust Board is asked to:

a. **NOTE** the content of this paper.
b. **RECORD** that the FPPT has been conducted for the period 2023/2024 and that all Board members satisfy the requirements.
c. **ACCEPT** the Trust Board 6 monthly declarations of interest

Dan Conway, Associate Director of Corporate Governance/Company Secretary

August 2024

Annex 1: FFPT submission template
Annex 2: Trust Board Declarations of Interest

NHS England

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
Sandwell and West Birmingham NHS Trust	Sir David Nicholson	2023/2024

Part 1: FPPT outcome for board members including starters and leavers in period

Role	Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	11	11		None	0	
Executive board members	11	11		None	0	
Partner members (ICBs)						
Total						

** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.*

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

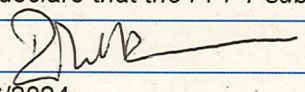
Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Internal Review Reported to Trust Board in May 2023	10/05/2023	All existing Board directors, Board members and individuals who perform the functions equivalent to the functions of a Board director and member meet the requirements of the Fit and Proper Persons Test.	None	May 2023
Internal Review of all new starters in 2023/24	Throughout the year	All new staters undertook the FPPT test and passed.	None	N/a
NHSE NED appointments	April 2023	Andrew Argyle was appointed through NHSE and passed the FPPT	None	N/a

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Deputy Chair	Lesley Writtle	26/6/2024	Yes

For the chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	No	

As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.	
Chair signature:	
Date signed:	26/6/2024
For the regional director to complete:	
Name:	
Signature:	
Date:	

For the regional director to complete:	
Name:	Dale Bywater
Signature:	
Date:	18th July 2024

Declarations of Interest

Members of the Board are required to make an annual declaration of any interests which they have.

In addition, Board members are required to provide an update during the year should a new interest arise, or an interest cease. Where the interest ceases, the information will be held on the record for a period of at least six months.

Name	Role	Description of declared interest	Comment / reasoning for acceptance of material interest (where required)
Sir David Nicholson	Trust Chair	• Chair – Dudley Group NHS Foundation Trust • Chair – The Royal Wolverhampton NHS Trust • Chair - Walsall Healthcare NHS Trust • Sole Director – David Nicholson Healthcare Solutions • Member - Institute for Public Policy Research (IPPR) Health Advisory Committee • Senior Operating Partner for Healfund (Investor in healthcare in Africa) • Non-Executive Director – Lifecycle • Visiting Professor – Global Healthcare Solutions • Advisor to KMPG Global • Spouse Chief Executive to Birmingham Women's and Children's NHS Foundation Trust **(ended 31/12/2022)** • Spouse appointed National Director of Urgent and Emergency Care and Deputy Chief Operating Officer of the NHS	Will withdraw from any business discussions that could have any potential conflict of interest
Mick Laverty	Non-Executive Director	• CEO: ExtraCare Charitable Trust • Council Member & Audit Committee Chair: University of Birmingham	Will withdraw from any business discussions that could have any potential conflict of interest
Lesley Writtle	Non-Executive Director	• Nil declared	n/a
Rachel Hardy	Non-Executive Director	• Sole Director - Doodle Health Limited • Consultancy work with Doodle Health Limited primarily in the NHS.	Will withdraw from any business discussions that could have any potential conflict of interest

Name	Role	Description of declared interest	Comment / reasoning for acceptance of material interest (where required)
		• Teaching and coaching through the HFMA • Trustee of WE Dunne Charitable Trust	
Mike Hallissey	Associate Non-Executive Director	• Director of Assure Dialysis, wholly owned subsidiary of UHB	Will withdraw from any business discussions that could have any potential conflict of interest
Val Taylor	Associate Non-Executive Director	• Trustee of Servol Community Trust	Will withdraw from any business discussions that could have any potential conflict of interest
Lorraine Harper	Non-Executive Director	• Ad hoc lectured fees	Will withdraw from any business discussions that could have any potential conflict of interest
Andrew Argyle	Non-Executive Director	• Director Sal Germany Ltd • Sole Director German Desk Ltd • Consultant to Folkes Worton LLP • Employee Coventry University • CORE Education Trust	Will withdraw from any business discussions that could have any potential conflict of interest
Jatinder Sharma CBE	Associate Non-Executive Director	• AoC F&GP Committee Member • AOC Sports Board Chair • AoC Board member • Black Country Chamber of Commerce Director • Black Country Colleges Ltd. • (change of name from Black Country Partnership for Learning – 11 June 2016) Director • Broadway Training Director (Dormant) • Collab Group Education Trustee/Treasurer • Principals' Reference Group (PRG) Member • Walsall Economic Board Member • Walsall Proud Partnership • (previously called Walsall Borough Management Team) Member	Will withdraw from any business discussions that could have any potential conflict of interest
Richard Beeken	Chief Executive	• Director and Company Secretary of Watery Bank Barns Ltd • Spouse is a senior lecturer in midwifery at Wolverhampton University • Son works for the Trust Communications department via Trust Bank contract	Will withdraw from any business discussions that could have any potential conflict of interest

Name	Role	Description of declared interest	Comment / reasoning for acceptance of material interest (where required)
Mel Roberts	Chief Nursing Officer	• Company Secretary – Star leather (husband's company)	Will withdraw from any business discussions that could have any potential conflict of interest
Mark Anderson	Chief Medical Officer	• Company secretary for Woodland Gardens Management Company	Will withdraw from any business discussions that could have any potential conflict of interest
Jo Newens	Chief Operating Officer	• Nil declared	n/a
Kam Dhami	Chief Governance Officer	• Nil declared	n/a
David Baker	Chief Strategy Officer	• Director of PB Health Ltd since June 2020 • Trustee of the Liaison Group Workforce Charity	Will withdraw from any business discussions that could have any potential conflict of interest
Simon Sheppard	Acting Chief Finance Officer	• Nil	N/a
James Fleet	Interim Chief People Officer	• Nil	N/a
Amrick Singh Ubhi	Associate Non-Executive Director	• Director, Civic Employment & Partnerships – Nishkam Group of Organisations • Non-Exec Director, Acorns Children's Hospice • Non-Exec Director, Birmingham Children's Trust • Non-Exec Director, Soho Road Business Improvement District • Chair of WMCA Faith Strategic Partnership Group • Chair of Council of Sikh Gurudwaras Birmingham • Chair of Birmingham Faith Leaders Group • Vice Chair National Spirituality & Mental Health Forum • Inclusion Advisory Board member at Warwickshire County Cricket Club • Council of Governors, University Hospitals Birmingham NHS Foundation Trust (Stakeholder Governor) • Former Vice Chair of Birmingham Voluntary Sector Council • 12. Deputy Lieutenant with West Midland Lieutenancy	Will withdraw from any business discussions that could have any potential conflict of interest
Afif Ali	Associate Non-Executive Director	• Project Manager – NHS England	Will withdraw from any business discussions that could have any potential conflict of interest

Name	Role	Description of declared interest	Comment / reasoning for acceptance of material interest (where required)
		• Birmingham Repertory Theatre – Non-Executive Director and Trustee • Birmingham Race Impact Group – Board Member • The Lunar Society – Trustee and Executive Team Member • Bournville Village Trust – Housing and Community Services Committee Co-opted Independent Member • Director at Vibrant Voices CIC	