

AGENDA - TRUST BOARD SESSION IN PUBLIC

Venue:

Conference Room of the Sandwell Education Centre

Date:

Wednesday 12th March 2025,
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
Mrs D Wake (DW) 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 (AAI) 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
Ms S Thomas (ST) Interim Chief Integration Officer

In attendance:

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 <i>To declare any interests members may have in connection with the agenda and any further interests acquired since the previous meeting.</i> Apologies:	Verbal	DN
10:05	2.	Story – Population	Verbal	MR
10:20	3.	Minutes of the previous meeting and action log To approve the minutes of the meeting held on January 2025 as a true/accurate record of discussions, and update on actions from previous meetings	TB (03/25) 001 TB (03/25) 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 (03/25) 003	DW
10:35	7.	Integrated Committee Chairs Report	TB (03/25) 004	LW
MMUH				
11:00	8.	MMUH Benefits Review	TB (03/25) 005	SS
11:15	9.	MMUH Closure – Programme Assurance Review (PAR)	TB (03/25) 006	RB
11:30	10.	MMUH Programme Closure Report - DRAFT	TB (03/25) 007	RB
Break (10 mins) 11:50				

Time	Item	Title	Reference Number	Lead
Our Patients				
12:00	11.	Perinatal Service Report	TB (03/25) 008	MR
12:15	12.	Finance Report	TB (03/25) 009	SS
12:25	13.	Acute and Community and Winter Plan Report	TB (03/25) 010	JN
Governance and Risk				
12:35	14.	BAF Report	TB (03/25) 011	KD
For Information				
12:45	15.	Board level metrics and IQPR exceptions	Reading Room	DB
	16.	Any other business:	Verbal	DN
	17.	Details of next meeting of the Public Trust Board: 14th May 2025 at 10:00am.		

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Venue: Conference Room of the Sandwell Education Centre
Date: Wednesday, 8th January 2025,
10:00 – 13:00

Voting Members:

Sir D Nicholson (Chair) (DN)
Mrs L Writtle, Deputy Chair (LW)
Mr M Laverty, Non-Executive Director (ML)
Mrs V Taylor, Non-Executive Director (VT)
Mrs R Hardy, Non-Executive Director (RH)
Ms D Wake, Chief Executive Officer (DW)
Mrs M Roberts, Chief Nursing Officer (MR)
Mrs J Newens, Chief Operating Officer (JN)
Mr S Sheppard, Acting Chief Finance Officer (SS)
Dr M Anderson, Chief Medical Officer (MA)

Non-Voting Members:

Mr J Sharma, Associate Non-Executive Director (JS)
Mr A Ali, Associate Non-Executive Director (AA)
Dr M Hallissey, Associate Non-Executive Director (MH)
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 (RBa)
Programme Company
Ms S Thomas, Interim Chief Integration Officer (ST)

Members of the Public, Staff and External attendees

None
Ms Rebecca Burt, Lung health check (RB)
Mr Steve Nelson, Lung health check (SN)
Mr Paul Knightly, Patient (PK)

Apologies:

Mr A Ubhi, Associate Non-Executive Director (AU)
Prof L Harper, Non-Executive Director (LH)
Mr A Argyle, Non-Executive Director (AA)

Patient Story Presenters:

Ms Rebecca Burt, Lung health check (RB)
Mr Steve Nelson, Lung health check (SN)
Mr Paul Knightly, Patient (PK)

In Attendance:

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)
Mr J Shah, Head of Charity, Your City and Metropolitan Hospitals Charity (JS)
Mr S Allen, Chairman, Your City and Metropolitan Hospitals Charity (SA)

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. Sir Nicholson welcomed Ms Wake to her first Trust Board meeting as Interim Chief Executive.	
2. Patient Story	Verbal
Mrs Roberts introduced members to the patient story on Lung health check. Ms Rebecca Burt and Mr Steve Nelson informed the members of the service the background and the process. Mr Ali and Mr Taylor joined the meeting at 10:04.	

The patient introduced himself as Mr Paul Knightly and passed on his immediate thanks to the Trust for saving his life. Mr Knightly told members of his story and advised he had written multiple thank you letters.

Sir Nicholson questioned what would have happened if the abdominal aortic aneurysm had not been picked up. Dr Anderson advised it would have been critical and would have resulted in death but Mr Knightly's life had been saved because of having the scan.

Mr Sharma questioned what areas did the project cover. Mr Nelson advised it covered the whole of Sandwell population that had ever smoked in a particular age range. The process was an initial scan and if there were no findings there would be a further scan every 24 months until the individual aged out of the programme. Mr Sharma questioned if individuals that do not take up the opportunity initially are followed up. It was confirmed and advised work was taking place around individual practices and getting out into the local communities as the National Publicity was increasing. Mrs Roberts agreed the Community work was vital and Mr Knightly had had his scan in the local Community through Mecca Bingo. Mrs Roberts added that working with partners and Place were the key.

Ms Wake advised that within the Black Country there had been a bid to pilot the Lung Health screening and it had been agreed the Trust had been best placed to start the screening but advised it have been rolled out to Dudley NHS Trust and its Community. Further work was ongoing to roll out the service across Walsall and Wolverhampton NHS Trusts.

Sir Nicholson thanked Mr Knightly and the Lung Health team for presenting and that seeing an individual that had gone through the service made the difference to members. Sir Nicholson added this services approach was the future and would look to support the reduction in emergencies coming into the Hospitals.

Mr Knightly asked if there was a potential to combine the aortic aneurysm and the lung scan together. Dr Anderson advised both tests were conducted by different machines, the aortic aneurysm scan was done by an ultra sound and the lung scan was conducted by a CT scan. Dr Anderson advised the CT scan had picked up the aortic aneurysm.

3. Minutes of the previous meeting, action log and attendance register

TB (01/25) 001 / 002

Mr Baker requested minor amendments to the minutes. These changes were agreed by the Chair. Following the changes being made, the minutes could be **APPROVED**.

4. Chairs Opening Comments

Verbal

Sir Nicholson welcomed Ms Wake, Interim Chief Executive to the Organisation. Sir Nicholson advised members the next 6 months was an important period for the Organisation and stated that MMUH was now up and running and the time given back needed to be used more valuably. It was expressed the financial plans moving forward were going to be tight and the Trust would be in a tough position. Members noted there was a need to do things differently moving forward such as working better and more closely with Dudley NHS Trust and the Black Country System. It was added the Government would be launching their 10 year plans and this needed to be monitored as it would change the expectations of our people and the population. Sir Nicholson expressed previously the Trust had a timetable to open a new hospital that drove many things but now that was complete the momentum needed to continue. Members noted this would be a challenging time for the Organisation and if new ways of working could not be thought of then it never would change.

5. Questions from members of the public

Verbal

There were no questions received from the public.

6. Chief Executive's Report

Verbal

Ms Wake advised a report had not been pulled together but she had pulled some key points that she would share with members. Ms Wake advised moving forwards she would meet with the Non-Executive Directors to understand what they require within the report.

- NHS continued to wait for the Operational Planning guidance as it had been delayed but information was being slowly being given. It was expected the full guidance would be released by the end of the week.
- Mrs Newens and her team were commended on Operational performance.
- Cancer performance was likely to be the main focus within the planning guidance. Current performance was strong but performance would need to continue to be driven.
- 62 day standard target had proved challenging for Organisations to achieve post COVID-19 so had been lowered. However, it was expecting the target would return to 85% once the guidance was released.
- For Elective care, at the end of December 24, there were 22 patients outstanding 65 weeks but there was a robust plan in place to ensure it was down to 0 by the end of January 25. The drivers for this were ENT and Oral Surgery.
- The RTT performance was 52.9%, but it was anticipated the target would be 60% with a push to try to achieve 65%.
- The Trust had done well with its robust Winter plan. It was advised winter pressures were being seen and an increase in activity and the Organisation had coped well.
- Maternity department had received a CQC visit and the team had been working hard on completing the work against the Section 29a notice that was given. All actions had been completed and the oversight would be delegated down to Group level for monitoring. Ms Wake confirmed she would be writing to the Chief Executive of the CQC to ask for an outline of getting the notice lifted.
- The Trust had been given an outlier status on hip fracture mortality in 2024 and the Trust had engaged with the British Orthopaedic Association for a peer review on the pathway and processes in February 25. Non-Executive Director input was required. It was added following the move to MMUH there had been some improvement.
- Letter of thanks had been received from the Organ donation commending the exceptional referral rate from the Trust.
- The Staff Survey embargoed had been received and an improvement had been seen on the previous years. The plan for the current year would be around staff engagement and ensuring more surveys are completed. It was reported through the staff survey that a number of staff had not received their appraisal.
- MMUH had successfully opened and was going through its first 100 days. The first 100 days report was on the agenda. Some services were still being embedded and some teething issues.
- Ms Wake expressed Trust Headquarters was in the wrong place and not at the heart of the Organisation. It was added the Trust Board meetings were also in the wrong place.

Sir Nicholson expressed conversations needed to be held and Ms Wake and the Executive team would discuss and mitigate.

Mr Laverty thanked Ms Wake for the report. It was advised the Trust faced a difficult financial settlement so a focus moving forward on things such as transformation and digital and how the Trust was going to do things differently. Ms Wake confirmed she agreed and stated when the patient earlier questioned if it was possible to combine the lung and aortic aneurysm scan together she had thought it was not possible to do together but aortic aneurysm scans were only being conducted within the Hospital and they should be held in the community. Ms Wake added the Trust needed to look into why it was not generating ERF, why

the productivity metrics were not where they needed to be and there needed to be a deep dive into the services to review how the improvements could be made.

The Trust Board **NOTED** the update.

7. Integrated Committee Chairs Report

TB (01/25) 003

Mrs Writtle presented to members and advised there had been difficulty pulling the report together due to the Christmas period so encouraged Committee Chairs to add their input.

- There were vigorous debates within the Committees generally around system implementation but members noted the implementation would take time but members needed to ensure there was robust delivery of the systems implementation. It was added the vigorous system implementation was starting to pay off. It was requested that assurance was given at the next meeting around the implementing of workforce and clinical systems to give the maximum benefit to staff and overall make the Organisation work more efficient.
- Quality Committee heard the mental health patients still attending the emergency department (ED) being faced. Mrs Roberts explained a pathway meeting would be arranged this month with the Mental Health Trust.
- The 100 day plan had been well articulated but now members needed to see the benefit realisation and Ms Barlow was leading the discussions with Committee Chairs and Executive colleagues.

Mr Sheppard advised productivity needed to be the key priority for the Trust and advised some of the planning guidance information was being given and there was a 5 to 6% increase required on productivity. A briefing paper would be taken to the Executive Group next week. Mr Sheppard stated the data was not perfect therefore the Trust would push back but also recognise the data was good enough to challenge how the Trust was going to do things differently. It was noted Productivity was a key theme for the next quarter and as the Trust moves into 25/26. Mr Sheppard added this was the key benefit for opening MMUH and was being monitored through Finance and Productivity Committee. Sir Nicholson expressed he had concerns once the planning guidance was released there were a lot of planning meeting and more returns to be completed for the Region but no time to make the transformation and members needed to be mindful of this.

Mr Baker queried the wording of the report and reminded members that KPMG were being brought in to coach the Trust to do things differently enabling the Trust to deliver and not KPMG deliver for the Trust. Mrs Hardy expressed there needed to be clarity on what the delivery model was across the Organisation and understand how KPMG would plan a role in coaching the Staff. Sir Nicholson added this was the purpose for the Integrated assurance as the improvement elements were always conducted in silos rather than how it all fit together.

Sir Nicholson questioned the mental health concerns. Mrs Roberts advised there was a pathway created for MMUH for 2 providers working together however, because they are not working together there are an increasing amount of mental health patients waiting within the Emergency department. It was added there was also an increase in violence from patients towards staff. The escalation process was confirmed to be to Ms Wake as Interim Chief Executive. Mrs Roberts added she was committed to getting this right and it was about getting the teams on the ground involved and performing was agreed. Ms Wake agreed with comments raised and added there needed to be a push on care for mental health to support the patients but also to support the frontline staff within the Emergency Department. Ms Wake agreed to take forward to the Chief Executive meeting.

Mrs Roberts advised members when the pathway was initially brought to the meeting for approval, there was a recommendation that required further funding but was declined. Mrs Roberts added she felt it should be pushed forward and agreed to share the report with Ms Wake.

The Trust Board **NOTED** the report.

Action:

- **Assurance on the Workforce and Clinical Systems Capacity implementation to be presented at the next Trust Board.**

8. Board Level Metrics

TB (01/25) 004

Mr Baker presented to members and took members through the report. It was advised there would be a meeting arranged between himself, Mr Demetri Wade and Mr Martin Chadderton to agree further metrics to be presented to Finance and Productivity Committee on Operational Performance. The Financial improvement was progressing well but there needed to be more focus on the recurrent position.

Mr Lavery expressed the deficit was still increasing as some of the CIP was non-recurrent. Mr Lavery questioned if the Trust was going out to tender for a review on the waiting lists. Mrs Newens expressed it was due to the volume of patients but also there was concerns were the data validation. It was added a new starter would commence within post on Monday to support this but the Organisation as the only one not to have a revalidation team in place. Mrs Newens advised once the review had been conducted, it would need to be discussed how it was done moving forward.

Mr Lavery questioned if there was a data quality concern. Mr Baker advised there was data quality issues in all the Organisations but the Trust had a managed process in place of a data quality log which was prioritised. It was advised data quality was down to 1 of 3 issues, data not being put into the system properly, data not being transferred between systems properly or not being reported properly. Sir Nicholson expressed he was not clear if this was a big problem or not. Mr Lavery informed members that there had also been a large issue within owed hours which had resulting in the Trust underselling itself. Mrs Writtle also added last year a member of staff had raised concerns around the waiting lists and a data access policy was created and questioned if all other actions following Internal Audits plan had been completed. Mrs Newens advised the concern and action plan purely focused on Referral Time to Treatment (RTT) but confirmed all the actions had been completed and implemented. Ms Wake added the Operational and Analytics team needed to be working together rather in silos as it resulted in inaccurate data submissions. Sir Nicholson expressed he was still unsure of how big the issue was and requested Audit Committee to look into it.

It was summarised members recognised what action was being taken around operational data and waiting list validation. Sir Nicholson expressed he looked forward for a proposal to be brought forward on Operations and the Analytics team moving forward.

The Trust Board **NOTED** the report.

Midland Metropolitan University Hospital (MMUH)

9. MMUH Update Report

TB (01/25) 005

Mrs Newens presented to members with support from Mrs Barlow and the following information was highlighted.

- Positive feedback had been received from staff on the building.
- So far everything had gone remarkably well with no incidents that were specific to MMUH.
- There would be 100 day review for all Clinical and Corporate Groups within the next few weeks including deep dives into infection control and patient experience. The findings and outputs would be presented at the next Trust Board.
- The Trust had delivered what it expected to deliver.

- The risk profile was looking positive with only 2 significant risks around bed fit and system activity.
- There was possible defects to the new building so work continued with NHP to obtain a defect budget, leaving the Trust in a strong position to mitigate.
- At the next Trust Board meeting there would be a report recommending to close the programme down and ensure assurance was ready.
- A company had been externally commissioned to review the benefits case. It would be reforecast and there was an expectation it would improve.
- A third party was to be brought into authenticate the decision to close down the programme.
- Lessons learnt would be shared with the Trust Board, NHP and the System through a closure report.
- IPA Gate 5 would be conducted next year.
- The activity impact on other Trusts following the opening of MMUH were in the ranges predicted by the Trust and the ICB. It was recognised there was an increase in activity due to winter and the closure of Sandwell but the activity was as predicted but would continue to be monitored.

Mr Lavery expressed he had read the Urgent Treatment Centre had slipped and requested an update at the next meeting. Mrs Thomas confirmed a capital case would be brought to the next meeting.

Ms Wake questioned the data used in the report. Mrs Newens confirmed it was the data from Robert Franklin. Sir Nicholson raised somewhere during the planning process there would be an ask to reallocate resources between Black Country Trusts and questioned what the Trust response would be. It was advised there should be no money reallocated and this should be confirmed within February 25. Mrs Barlow stated the case mix would need to be reviewed to ensure it was right. Ms Wake stated the bigger issue was receiving out of System activity. Mr Sheppard advised there would be a discussion during the 25/26 planning.

Sir Nicholson summarised MMUH was being delivered in the way originally planned but expressed the UTC was going to be a bigger issue moving forward and there was a need to watch carefully to ensure money moved around the System.

The Trust Board **NOTED** the report.

Action:

- **Capital case on Urgent Treatment Centre to be brought to the next meeting.**

Our Population

10. Trust Charity Annual Report and Accounts

TB (01/25) 006

Sir Nicholson welcomed Mr Shah and Mr Allen to the meeting and thanked them for the work they do.

Mr Allen introduced himself as Chairman for the “Your City and Metropolitan” Charity and passed on this thanks to Mr Shah for the good work he had put in, getting the charity up and running. The report presented required sign off but moving forward as the Charity was independent, Mr Shah and Mr Allen would only attend Trust Board twice a year.

Mr Allen took members through the report and asked for approval.

Mrs Roberts expressed she had worked closely with the Charity and thanked them for the work achieved. Sir Nicholson agreed with Mrs Roberts and advised the Charity moving to independent provided the Trust with a lot of opportunities. Members were informed of the Freedom of the Borough award received in December 24.

The Trust Board **APPROVED** the report.

Mr Shah and Mr Allen left the meeting at 11:24.

Break

Our Patients

11. Maternity and Neonates Report

TB (01/25) 007

Mrs Roberts and Mrs Hurst presented the report to members and the following was highlighted.

- The Trust had achieved 9 out of 10 on CNST as compliance was below the 90% standard for fetal monitoring and resuscitation of the newborn. It was advised plans were in place to ensure the training was completed by end the of January 25 and requested the Trust Board approval to delegate authority for Quality Committee to submit due to the cycle of the meeting not fitting in with the submission.
- It was advised a Junior Doctor system passport was looking to be implemented but should be done at System level.
- Big initiatives have happened to support the CQC survey such as moving into MMUH as the previous estate could not do what was required for the community.
- “Call the midwife” had been implemented in Community and had since had its service times extended due to being well received.

Mr Sheppard questioned if achieving 10 of 10 on CNST was possible as the financial difference between scoring 9 and 10 was £1m. Ms Wake expressed there needed to be thought into ensuring this was achieved next time. Mrs Roberts agreed and expressed the team were disappointed as last year 10 out of 10 was achieved. Mrs Roberts advised there was a “you said, we did” outcome and a review into the Friends and Family test. It was added this needed to be focused on ahead of the next CQC inspection.

The Trust Board **APPROVED** delegated authority for Quality Committee to approve the CNST and the Ockenden report was **NOTED**.

12. Finance Report

TB (01/25) 008

Mr Sheppard presented to members and the following was highlighted.

- At the end of November 24, the Trust reported a £2.8m deficit, £45k positive variance to plan.
- Financial performance had been consistent and was in a positive position.
- The Capital Programme was under spend but a detailed year end forecast had been pulled together and submitted through required templates and it was confirmed the Trust would deliver its plan.
- The Cash position was lower than expected due to a delay in receiving delay funding from MMUH. Now that has been received the Cash was in a healthy position.
- The Trust was £50k ahead in the Financial Improvement Plan and work was ongoing to look at maximising the schemes.
- The key drivers for the financial position was the elective recovery was £480k below plan but positive performance against outpatients. The main focus was on maximising theatre and outpatients.
- The workforce position remained off plan.
- The Trust forecast it would deliver the income and expenditure plan. It was noted the Trust would deliver what it could and also support the System. It was added the recurrency of the workforce remained a key focus.

Mr Fleet advised the month 9 positive had been an improvement in relation to workforce with 100 less full-time equivalents (FTE). It was noted majority of this reduction was Bank staff which was initially targeted. Work would take place with the Groups to further support reaching the agreed target by March 25. There were a number of initiatives being brought in that would also support including the new rosters

coming online next week along with the new thresholds would be commenced resulting in staff that owe a certain amount of hours would be unable to pick up bank shifts. It was also added there was a number of MMUH staff that would be filling vacant roles.

Mrs Hardy advised members to reflect on the last 12 months and added the Trust had not got where it needed to be but there had been some huge step changes. It was added there had been more focus on non-traditional CIP and further conversations on how the Trust built on this and resourced it moving forward. Members noted that Finance and productivity Committee had received a deep dive into the Theatres work which had been interesting to members. Mrs Hardy stated there needed to be a conversation on what the Trust was going to focus on, resource and keep momentum to continue to move forward.

Mr Baker advised there had been work on the Strategic Planning Framework and it would be presented to Executive Group next week. Previously, the Trust success measure was used but the A3 work had not been conducted. Mr Baker suggested the Strategy and SPF were brought to March or May 25 Board. Mrs Writtle expressed this needed to be done as soon as possible and agreed with Mrs Hady's comments. Mrs Writtle added another thing to reflect on was the amount of work done around budgets and establishments and the staff doing that was the ones that would drive the delivery. Mrs Hardy agreed and expressed it was the practical things that needed to be thought about and gave the example of the people doing the PMO work and what was the plan moving forward as it was not clear.

Mr Lavery questioned the Birmingham and Solihull share. Mr Sheppard advised the Trust's share would be £9.6m but was initially thought to be £12m. The Trust had tried to change this but there was still a gap. Sir Nicholson advised part of the money was because the footprint was bigger and what the Organisation was told was within the total allocation.

Mr Hallissey questioned if there had been sight of the CIP for the end of March 25 for 25/26. Mr Sheppard advised the Trust's position against recurrent was 76% in December 24 and during quarter 4 there would be a lot of focus on recurrent. Mr Sheppard confirmed he was optimistic knowing the work was ongoing. It was added the requirement into 25/26 was a requirement of usual from the Groups, the benefits from MMUH, System wide work and a mix of clinical and corporate transformation work. Ms Wake expressed between now and March 25 there need to be a view on the big ticket items and advised what was agreed at the Joint Provider Collaborative needed to be reviewed. It was advised some Trusts had moved away from corporate transformation but there was a workshop in a few weeks time to bring everyone back on track. Ms Wake advised there had been a lot of money spent through outsourcing and it needed to be considered bringing the Black Country work back into the Black Country.

Mrs Hardy agreed with comments raised and advised as the Trust moved into 25/26 this was year 2 of the improvement programme and the Trust had moved into a new hospital and achieved a lot but expressed members needed to see what years 2 and 3 would look like. Sir Nicholson agreed and advised there was no shortage of things to do but it needed to be pulled together and the best people deployed to do the work.

The Trust Board **NOTED** the report.

13. CQC National Urgent and Emergency Care Survey 2024

TB (01/25) 009

It was advised this report had not been presented to a Committee but would be in future. This hasn't been to committee but would go to committee in future.

Mrs Roberts presented to members.

- Overall there was 19% response rate but the Trust had no influence over this, unlike FFT.
- The position was similar to last year.

- The FFT had highlighted the access to food and hydration.
- Patients now get electronic updates in waiting areas.
- Department staff have been engaged and are involved.
- An improving picture had been seen with ED but challenges still continue within the waiting areas.

Mr Laverty questioned how the fundamentals of care were being evaluated. Mrs Roberts advised an in depth report had been presented to Quality Committee but advised there had been a lot of positives following the move into MMUH but expressed there was a need to go back to basics. It was noted there was a session arranged with the deputies next week. Mrs Roberts stated the fundamentals of care was consistent but was not where the Trust needed to be.

Mrs Writtle advised the volunteers were a powerful resource that wanted to be involved in the hospitals and were likely to get feedback immediately. Mrs Roberts advised the Trust had increased its number of volunteers and currently the service sits within the Communication team but there was a proposal for them to move to sit under soft FM.

Sir Nicholson advised this did not paint a great picture of the Organisation and stated it was not clear what the interventions were going to happen.

Ms Wake stated the Trust Board had a role to play in this and at Dudley NHS Trust there were Board to Wards visits to all areas including pressure points like ED. Ms Wake advised after Trust Board it was a good time to go out into the hospital to speak to staff and service users rather than listening to feedback from the survey. Mrs Roberts advised visits had been taking place with Non-Executive Director conducting 3 visits a year. Mrs Writtle confirmed and advised she had revamped the paperwork and it had been based around the fundamentals of care. These visits would look to commence soon but momentum had been lost due to the amount of work around MMUH.

The Trust Board **NOTED** the report.

14. Acute and Community and Winter Plan Report

TB (01/25) 010

Mrs Newens presented to members and explained the report provided an update on how the Trust was improving at the front door, the focus on MMUH right sizing and maintaining bed capacity.

- There had been an increase in ambulance attendance in November 24 and continued to increase further into December 24.
- The acuity of patients has also increased with Critical Care having to be at or over capacity.
- Section 3 highlighted the scheme for right sizing with the graphs detailing the position.
- The Medicine and Emergency Care Group continue to improve on length of stay and bed occupancy was in a better position than last year. The bed utilisation across the Region showed the Trust to be in a better position.
- PCCT beds have seen an increase in capacity.
- The Elective Access Standard (EAS) performance had deteriorated but the position at 8th January 25 displayed a 3% increase. The last few weeks have been the busiest but that was expected.
- From Monday 6th January 25 there was time limit of 45 minutes for West Midlands Ambulance to offload their patients between the hours of 8am and 8pm. The Trust had coped well with this ranking the best in the System.
- A mock census was due to take place next week for all of Medicine and Emergency Care Group but it was noted this was not as resource intensive as previous.

Mr Ali joined the meeting at 12:27.

Ms Wake stated the Trust should be commended on its robust winter plan and delivering what it said it was going to deliver. Mrs Barlow agreed and advised it would be beneficial to evaluate the 2 models of

census. It was questioned what the forward plan was like for Medical SDEC. Mrs Newens advised it was discussed at Executive Group but as a System it was being benchmarked in terms of criteria, workforce and numbers. Mrs Newens advised there had been a suggestion from the consultants around an integrated SDEC would provide 11 more beds opportunity. It was advised NHP had said the Trust might consider a surgical and medical one after the move into MMUH.

Mr Laverty advised the census worked well when the Trust needed to move into MMUH but requested to get a sense of the benefits from the resources the Trust would need to put into in. Mrs Newens advised this was a modified version of the census but it was possibly an approach to invest to save. Mr Hallissey advised the census could only be learning tool and should not be continued long term. If it was to continue long term, it would disempower the consultants.

The Trust Board **NOTED** the Report.

Our People

15. MMUH Learning Campus – Employability Update

TB (01/25) 011

Mr Fleet presented to members and the following was highlighted.

- Learning campus would open this year with practical completion date being 1st December 25.
- The employability programme was being worked through.
- The learning campus sat at the heart of MMUH benefits case.
- The Trust was filling up a lot of posts through the programme with local people.
- This was more than just a job programme, it had landed for the local community and so far 203 people have received support and 155 had been employed by the Organisation.
- The learning campus will allow the Trust to accelerate the programme.
- The retention rate for staff that had come through this programme was at 97%.
- It provided a big opportunity to bring university level education to the local population.
- Closer to the opening of the learning campus, a report would be presented to Trust Board.

Mrs Taylor requested to know the split between how many had been involved from Sandwell and West Birmingham. Mr Fleet advised currently the profile was 2/3 Sandwell and 1/3 Birmingham but that was mainly down to Sandwell College. It was also added the most interest had come from the immediate population around MMUH.

Mr Sharma advised the right partners had been engaged but highlighted long term there would need to be a discussion with schools and a career advice piece. Mr Fleet advised the stakeholder plan would be brought to People Committee. Mrs Barlow expressed she would benefit from having sight of the list.

Mr Ali advised his visit to the learning work was the highlight of his time as an Associate Non-Executive Director on the Trust Board. Mr Ali added he was 100% supportive of this work and was sure it would be making a difference and requested there was a further people story to bring to life this programme. Sir Nicholson agreed.

The Trust Board **NOTED** the MMUH Learning Campus report.

16. Workforce Systems Optimisation

TB (01/25) 012

Mr Fleet presented to members and the following was highlighted.

- A number of concerns had been raised in relation to workforce systems and plans had been put in place for them to be brought together in April 25.
- This would look to reduce the reliance on temporary staffing and provide a proactive and consistent approach to absence management.

- The full programme plan had been pulled together and the team were committed to deliver this.
- There was a lot of data issues within the Workforce systems such as rostering which following a deep dive highlighted there was a higher level of owed hours than first anticipated.
- The Trust was working toward a systematic way of ensuring there was a sustainable system that managers can use correctly moving forward.
- GoodShape had been implemented on the 11th December 24 and was working well so far. Within the next 6 to 7 weeks the Trust would be able to start to produce its own reports.
- The programme plans run until the end of March 25 and the Trust was currently on track.

Mr Laverty expressed there was good information within this report but expressed there was a need to ensure this was prioritised work. Sir Nicholson agreed and stated for a system to be in place effectively, it would need to be resourced properly and added this would create data that can be used. Sir Nicholson questioned what this would like to a manager and also what the impact was on staff. Mr Fleet advised the impact of the system was that life was easy for staff as when rostering works well, staff are able to plan in advance and provides them with clarity. Mr Fleet added staff working within Organisations with rostering systems in place tended to have better staff survey results. It was added the GoodShape platform provided a self management tool and once reported, the individual would get information and guidance on the reason on why they were off sick. Ms Wake added a system was only as good as the oversight and rostering would only be as good as what the oversight of the system was.

The Trust Board **NOTED** the report.

Governance and Risk

17. Board Skills and Experience Exercise

TB (01/25) 013

Ms Dhami presented to members and it was advised there was an 100% response rate. Ms Dhami took members through the report.

Mrs Writtle expressed the report was helpful and highlighted the Trust was not in a strong position in relation to IT. It was advertised this report would minimise risk moving forward in any potential gaps within the Trust Board. Mrs Writtle added there was a concern around Primary Care presence. Members noted there would be a possible membership review of the Committees moving forward in relation to Non-Executive membership.

Ms Wake expressed it would be beneficial to conduct this review over the 4 Black Country Organisations.

The Trust Board **NOTED** the Board Skills and Experience Exercise.

Information

18. Board level metrics and IQPR exceptions

Members noted this item was for information and was available in the reading room.

19. Any other business

Verbal

There was no other business discussed.

Details of next meeting of the Public Trust Board: 12th March 25 at 10:00am. In person meeting in the Conference Room of the Sandwell Education Centre

Meeting close

Tier 1 - Paper ref: PublicTB (01/25) 003

REPORT TITLE:	Chief Executive's Report
SPONSORING EXECUTIVE:	Diane Wake, Chief Executive
REPORT AUTHOR:	Diane Wake, Chief Executive
MEETING:	Public Trust Board
DATE	12 th March 2025

1. Suggested discussion points <i>[two or three issues you consider the PublicTB should focus on in discussion]</i>	
Assure <ul style="list-style-type: none"> • MMUH 100 +days Advise <ul style="list-style-type: none"> • Operational Performance • Productivity Pack Metrics and Key Opportunities • Care Quality Commission Engagement • Never Events • Rapid Improvement Weeks • PLACE • Black Country Finance Undertakings • 2025/26 Operational and Financial Planning Priorities and Timescales • Black Country Provider Collaborative • Visits and Events 	

2. Alignment to our Vision <i>[indicate with an 'X' which Strategic Objective[s] this paper supports]</i>		
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 <i>[at which meeting[s] has this paper/matter been previously discussed?]</i>	
Executive Group	

4. Recommendation(s)	
The Public Trust Board is asked to:	
a) DISCUSS the contents of the report	

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 13th November 2024

Chief Executive's Report

1. Operational Performance

- 1.1 Total Emergency Access Standard (EAS) performance for January 2025 was 74.4%, a 2.9% improvement on last month and 3.6% away from the 78% performance target we are expected to achieve by March 2025.
- 1.2 Ambulance turnaround within 30 minutes was reported at 62.67% in January 2025, a 9.89% improvement on the previous month. Ambulance triage time has also shown a significant improvement with 5.53% more patients being triaged within 15 minutes.

Productivity pack metrics and key opportunities

- 1.3 The key opportunities that are available to us to ensure we see more patients quicker than we are seeing them currently are:

- Increased theatre utilisation to a minimum of 85% currently we are 72%
- Reduce follow ups (Patient Initiated Follow Ups, PIFU). Our peers are reporting 4.5% uptake we are currently on 5%
- Improve booking and scheduling processes (6-4-2, whilst this is in place to varying degrees across the Trust it is not comprehensively implemented, this is a key focus going forward)
- Reduce DNAs (642). The Trust DNA rate is 8% we aim to get this to 5% with a phased further improvement target by speciality
- Validation of our total patient waiting list. The Trust has consistently delivered over 90% in all metrics measured for validation. MBI, an independent provider, is currently assigned to validate 20,000 records to remove at least 10% of the waiting list
- Improve pre-operative assessment (reduce on the day cancellations)
- Reduce outsourcing to bring activity back in house. As part of our production plan for next year each speciality will agree a trajectory to reduce the need to outsource activity. The outsourcing to date has been implemented to reduce 65-week breaches and 13-week diagnostic breaches.

- 1.4 Productivity improvement initiatives to improve the Trust's position include:

- Roll out scheduling tool.
- Improve theatre in-list utilisation.
- Utilise weekend & evening elective lists.
- Improve pre-assessment triage process using digital/technology.
- Ringfence surgical beds for planned procedures.
- Workforce optimisation.

- Digital & data-driven approaches.
- Reducing late / on the day cancellations and DNAs.

1.5 Cancer Services

	November	December	January	February
FDS	75.50%	75.90%	72.40%	85.30%
31-day	88.36%	88.81%	87.03%	87.25%
62-day	66.67%	70.45%	67.97%	69.89%

1.6 Our cancer position for February is an improvement on January's position. Our three services where we need to improve are:

- **Breast:** The Consultant job plans have been revised to support overnight stays, and these changes will take effect from February 2025.
- **Gynae:** A revised consenting process, following reviews by the anaesthetist and cardiology, will support the delivery of the 31-day standard. Implementation of electronic consent transfer for satellite clinics. A cancer tracker is now in place to monitor and track patients on the pathway, which will help in managing patients proactively.
- **Skin:** As an interim measure, clinicians within the team have agreed to cover vacancies through Bank. The job advert has been out to fill the plastic vacancy.

2. MMUH 100+ Days

2.1 One of the key aims for or bed fit was to maintain good performance in our patient length of stay (LOS) in our bed base. January's Medical and Emergency Care acute average LOS was 6.3 days, which is an improvement from December and was an improvement vs January 2024s LOS.

2.2 Other key points of note include:

- No moderate or high-risk incidents against our critical pathways
- Stroke pathway time to CT has now seen 93% compliance against the 1-hour standard, up 9%
- Discharges before midday have improved with implementation of the Rhythm of the Day
- 40% reduction in the referrals through to Medical Examiner, which has also reduced the number requiring a structured judgement review
- A reduction on average of 30 admissions per day in line with bed rightsizing impact and the equivalent 78 bed benefit

3. Care Quality Commission Engagement

- 3.1 The Care Quality Commission (CQC) has started to pilot a new approach to effective provider engagement between the CQC and NHS trusts which commenced on 16 September 2024, following learning from work they undertook with some Cheshire and Mersey NHS trusts. This pilot recognises that currently there are significant differences between networks and their local team in how engagement is managed with NHS trusts. This pilot is seen as an opportunity to reset how the CQC engage with NHS trusts and establish a baseline for future engagement, from which they can improve. Our Trust has been selected to be part of this pilot, which we welcome.
- 3.2 The approach includes a provider oversight lead who for SWB is Laura Harrison and an Operations Manager, Karen Williams, who will coordinate regular engagement meetings. There is an agreed agenda for each meeting, and the CQC will continue to develop this approach with us. Throughout this process the CQC will be clear how our feedback has influenced their decisions and what changes they make because of these meetings.
- 3.3 The Trust had its first engagement meeting with the CQC as part of this pilot on the 27th January 2025, attended by the Chief Nursing Officer, Chief Medical Officer, Chief Executive and Associate Director of Quality Governance. The agenda was broad covering Trust Performance, People and Quality & Safety. They also asked to visit ED to understand how we were operating the 45-minute ambulance offload policy. It was agreed future meetings would be split into two sections. The first part being any exceptions and updates in relation to the agenda points above and the second for the CQC to learn about the Trust so it was agreed a clinical group would attend, present their services and then the CQC would visit some of their services. These engagement meetings will occur quarterly.

4. Never Events

- 4.1 The Trust has had a good track record with no Never Events in 2023 or 2024. However, two have occurred in January 2025. The Patient Safety Incident Investigations have been logged on the national Strategic Executive Information System (STEIS) as per current processes.
- 4.2 Never Event 1: Wrong Site Surgery. A 76-year-old female had a witnessed fall at home, and experienced immediate pain. The patient was conveyed to the emergency department (ED) at Midland Metropolitan University Hospital (MMUH), and a left sided neck of femur fracture (NOF) was identified. The plan was for the patient to receive a Fascia Iliaca Block (FIB) for pain management whilst awaiting surgical intervention. A foundation house officer completed the FIB under supervision of the ED Registrar. Post procedure, whilst documenting, it was noted that the FIB had been performed on the right side rather than the left. The patient and her family were immediately informed. Unfortunately, the patient could not have a FIB on the correct (left) side due to the risk that the cumulative safe anaesthetic dosage would be exceeded, therefore the patient's pain was managed orally. The patient remained well, and her pain was managed effectively orally. The patient has since undergone surgical intervention and is recovering well.

- 4.3 Early actions included raising awareness in ED, the department tasked with creating a checklist for the FIB procedure, and a Trust wide safety alert was sent out, reminding of the importance of stopping and checking before procedures.
- 4.4 Never Event 2: Mis-selection of high strength midazolam during conscious sedation. An 89-year-old patient developed a disordered cardiac rhythm (atrial fibrillation) and the EMRT was called. The patient required cardioversion with sedation, and the attending consultant anaesthetist intended to administer 1mg midazolam. The Senior House Officer inadvertently prepared high strength midazolam (5mg/1ml) in a syringe, and no check of the vial was completed before administration. The patient became drowsy, and the medication slip was recognised, and the reversal agent (flumazenil) administered. The patient has recovered from the event.
- 4.5 Two different strengths of midazolam exist in stock and have different uses in the Trust. A rapid Trust-wide alert was sent out reminding of the need to check the drug being drawn up, with photographs of the different boxes. The Patient Safety Incident Investigation (PSII) will include review of the current usage and stock of differing available concentrations.
- 4.6 Both Never Events are being investigated by a SWB Patient Safety Investigator as a PSII to ensure actions and shared learning takes place to prevent repeat incidents.

5. **'Improving Together' Implementation**

- 5.1 With the evolving formation of an Improvement Academy and the support approved by the Board we are launching 5 Rapid Process Improvement Weeks (RPIWs) across the organisation, focussed on areas that the Executive has identified as the main areas where improvement can be made in line with our 2025/26 In-Year Objectives. Each area has identified Executive Sponsorship and delivery leads. This provides us with the opportunity to excite the organisation by implementing and testing change during the week. The areas selected for Improvement are:
- Endoscopy
 - Pre-Operative Assessment
 - Central Admissions Unit (CAU)
 - Surgical Length of stay (Orthopaedics)
 - Streaming in Emergency Department
- 5.2 These events run in parallel with a 2-week staggered start between each of them. This means that the actual Improvements event weeks will commence on 24/3/2025 and end on 26/5/2025. Intensive work is carried out in advance and after the work to prepare for the changes and to embed them
- 5.3 In addition, the Executive have identified 2 Value Stream Events (VSEs) that it will conduct. These events cover **1)** Theatres and **2)** Hospital to Community. The VSEs are more strategic in nature, aiming to align stakeholders to the current state, provide clarity about what the patient/citizen values and then identify the key changes that would be required to enhance value to the patient/citizen through change. These events will act as a catalyst to doing the right work to add value through improved alignment and flow.

6. PLACE

6.1 West Birmingham

Dr Oruj Alam has now completed his time as Chair of the West Locality Delivery Partnership (WLDP). We would like to thank him for his hard work and drive in taking the West Locality forward, the WLDP is recognised across Birmingham for its strong relationships and track record of partnership delivery.

Dr Stepanie Dawe, GP and Clinical Director from Modality Partnership, has taken over the role of Chair and is taking the opportunity to work with all partners on a review of plans for the forthcoming year ahead.

As part of the Birmingham and Solihull Fairer Futures Fund, the West Locality Delivery Partnership has been awarded over £1.2M to transform health and social care over the next five years by integrating services closer to people's homes preventing ill-health.

The LDP have selected seven projects that will improve outcomes focussed on mental health, diabetes, vaccinations and immunisations, improving maternal outcomes and reducing infant mortality.

6.2 Sandwell

Over the last three months the Partnership Board have been working with the new integration team to review the current workstreams around Integrated Primary Care, Intermediate Care, Mental Health & Wellbeing and Community Prevention looking at what has been delivered and what the barriers to success have been. This has culminated in several development workshops with the Partnership Board to refresh the Purpose, Vision and Ambitions which has then informed the scope of the partnership. This review will be finalised and signed off by the Board in March/April with the 25/26 work programmes set up to deliver the agreed outcomes.

Meanwhile work has continued around the development of the Sandwell Town Teams model with several visits to surrounding areas for shared learning. This has led to a proposed revision to the model which is being drafted with primary care leaders ready for a trial of the model in Q1 of 25/26.

Within Intermediate Care the ARCC review has identified opportunities for improvement and releasing efficiencies in the Short-Term Assessment and Reablement Service (STAR) and the Harvest View Integrated Health & Social Care Centre. The review is now looking at Home Based Intermediate Care (HBIC) and the Integrated Discharge Hub (IDH). These recommendations will culminate in a Sandwell wide proposal for our integrated model for Home First.

7. Black Country Finance Undertakings

- 7.1 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.
- 7.2 The Undertakings letter was received from NHS England, outlining the Undertakings to the Trust, and an action tracker 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.
- 7.3 The key point to bring to the Trust Board's attention is the Acting Chief Finance Officer is working with system colleagues to develop the financial element of the 2025/26 Operational and Financial Plan inclusive of the underlying position.
- 7.4 Progress against all the actions is described in **Annex 1** (in the Reading Room).

8. Operational and Financial Planning Priorities and Timescales

- 8.1 The operational planning guidance stresses that 2025/26 will be a challenging year financially. It calls on local systems to agree plans that maximise productivity and contribute towards the 'three shifts' which will be the focus of the upcoming 10-year health plan. The three shifts are:
 - a. from hospital to community
 - b. from analogue to digital
 - c. from sickness to prevention.
- 8.2 By focusing on these three shifts, NHS England hopes that it can better meet the needs of an ageing population, making the NHS sustainable into the future. Further details will be included in the 10-year health plan, which is due for release in Spring 2025.
- 8.3 The two major themes that come through the operational planning guidance are on financial challenge and increasing autonomy for local systems.
- 8.4 To meet the national priorities within the funding allocated, NHS England calculates that trusts will need to reduce their cost base by at least 1% (after inflation) and improve productivity by 4%. The challenge will be even greater in areas that are dealing with specific local pressures or are relying on non-recurrent savings in 2024/25.
- 8.5 There is much stronger messaging than in previous years about the difficult decisions that local systems will need to make about their services. Consistent with previous years, the guidance urges ICBs and providers to focus on operational performance, productivity, unwarranted variation and waste
- 8.6 NHS England stresses that '2025/26 needs to mark a financial reset'. This means that systems need to develop plans that are affordable within the allocations set. They must

continue to improve productivity and tackle waste, and once these opportunities are exhausted, should look at whether they need to reduce or stop services.

- 8.7 The operational and planning guidance includes a framework to help systems make difficult decisions about how to prioritise their resources. Specifically, ICBs and providers should consider both the in-year and medium-term quality, financial and population health impacts of the options they are considering.
- 8.8 As part of the financial reset, the operational and planning guidance lists a set of actions that ICBs and providers should take to improve procurement, contract management and prescribing. It also suggests that systems use the resources available from the Productivity and efficiency improvement hub to identify areas for local improvement.
- 8.9 To help tackle the financial challenge and achieve the best outcomes for patients, NHS England is increasing the control and flexibility that local systems must decide how they can best meet the needs of their local populations. It is doing this through two changes in the planning guidance. The first change is that it is significantly reducing the number of national priorities (see **Annex 2**). And the second is that it is reducing the national ring-fencing of funds, moving most of the service development funding (SDF) bundles into ICB core allocations.
- 8.10 This signals the start of a move towards *‘a more devolved system where ICBs and trusts can earn greater freedom and flexibility, and patients have more choice and control’*. For instance, the operational planning guidance suggests that providers may in future be able to take the lead in planning and transforming local services, using strategic frameworks set by their ICB.

9. External Visit

- 9.1 Sir Jonathan, Chair of the Independent Inquiry into the issues raised by the David Fuller case, visited the Trust with members of the Inquiry team on 12th February as part of the work to understand the measures in place to safeguard the security and dignity of deceased people in the area.
- 9.2 Sir Jonathan expressed his thanks for the arrangements put in place to support the visit and the generosity of staff with their time in answering questions.

Diane Wake
Chief Executive

4th March 2025

Annex 1: 2024/25 Undertakings Progress Report - in the Reading Room

Annex 2: 2025/26 NHS priorities and operational planning guidance: 18 headline targets

2025/26 NHS priorities and operational planning guidance

18 headline targets

Priority	Success measure	Change since 2024/25
Reduce the time people wait for elective care (page 9 of operational planning guidance)	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	New
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement	New
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	Previous target was on 65 week waits
	Improve performance against the headline 62-day cancer standard to 75% by March 2026	Previous target was 70%
	Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	Previous target was 77%
Improve A&E waiting times and ambulance response times (page 10)	Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	The 12 hours part of this target is new
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26	No change
Improve access to general practice and urgent dental care (page 12)	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey	New
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more	New
Improve mental health and learning disability care (page 12)	Reduce average length of stay in adult acute mental health beds	New
	Increase the number of children and young people (CYP) accessing services to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019	No change
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction	Previous target was <30 adults and 12-15 under 18s per million population
Live within the budget allocated, reducing waste and improving productivity (page 14)	Deliver a balanced net system financial position for 2025/26	No change
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	Previous target was <3.2% of total pay bill
	Close the activity/whole time equivalent (WTE) gap against pre-Covid levels (adjusted for case mix)	New
Maintain our collective focus on the overall quality and safety of our services (page 15)	Improve safety in maternity and neonatal services, delivering the key actions of the <i>Three year delivery plan</i>	No change
Address inequalities and shift towards prevention (page 14)	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people	No change
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded cardiovascular disease (CVD), who have their cholesterol levels managed to NICE guidance	Previous targets were 80% of hypertension patients and 65% of CVD patients

Black Country Provider Collaborative Executive

The following are the key messages from the **3rd February 2025** Black Country Provider Collaborative (BCPC) Executive meeting.

A. IMPROVEMENT

- **Clinical & Operational Productivity** – The Collaborative Executive were provided a brief update on the following key items:

- **BCPC FRP delivery update** – During Month 9 System Finance lead has worked with partner Trusts to maximise recurrent CIP delivery with efforts not having the desired impact, with an adverse underlying position (£355m forecast, compared to £235m in Financial Recovery Plan - £121m adverse to Financial Recovery Plan).

Detailed assessment to be undertaken following month 10 reporting with a refresh of the suite of I&I KPI's during February to ensure these continue to add value.

Month 9 data is showing a reduction in headcount (mainly due to bank and agency usage) overall for the first time. Cost of workforce continues to reduce, the number of vacancies is increasing, and number of vacancies going through panels is reducing.

Positive work in other areas such as Medicines Management (focus on Cardiology and Ophthalmology), with many other opportunities emerging (e.g. New to Follow Up ratios, Discharges to Patient Initiated Follow Ups, Theatre Utilisation rates) that are being targeted further.

- **'Delivery Partner'** – Steady progress is being made to procure and secure a Delivery Partner, with the procurement team now actively engaged. A presentation to the BCPC Joint Provider Committee will provide an update on the following:
 - Revisit the agreed focus areas
 - Share the potential for scale through the recent Productivity Opportunities
 - Take through JPC through a 'worked example' from a neighbouring system
 - Outline the procurement process options
 - Outline key governance issues – sign-off processes, and delivery management arrangements

Governance arrangements will require BC ICB and NHSE sign off, with the current specification currently remaining as a BCPC only approach to a 'Delivery Partner'.

B. TRANSFORMATION

- **Corporate Service Transformation (CST)** – The second and third CST Programme Engagement Workshops were held on Monday the 18th of November 2024, with over 70 delegates in attendance and Workshop 3 on Monday 27th January 2025 with 80 delegates in attendance including both CEOs and staff side / trade union representatives.

Preparations are in development for the forthcoming last Engagement Workshop together with an insight on key next steps, the development of a 'Case for Change' which will support the preparations for the development of a Full Business Case.

In parallel, work will commence shortly to firm up the legal framework for the establishment of the agreed strategic vehicle, previously agreed as a Managed Shared Service through a Joint Contractual Venture.

Key messages from the engagement workshop continue to be consistently communicated to all partners and associate partners for active dissemination to their staff, though concerns remain as to how deep this permeates through our workforce.

- **BCPC Service Transformation ‘Road-map’** – The BCPC Managing Director presented a short paper (requested by JPC) outlining a ‘Road-map’ for key clinical transformation activities over the course of 25/26.

These have been driven by the work of the BCPC Clinical Networks, aligned to some opportunities emerging through national capital resources. Some initial high-level activity, finance, and workforce implications have been provided to all partner Trusts for use in their 25-26 planning considerations.

Business cases are now being developed for all of the identified strategic developments (BC Elective Hubs, BC Breast Unit Consolidation, BC Breast Reconstruction service, BC Bariatric Centre, and some repatriation of services) in addition to a public involvement exercise commencing and positive dialogue with commissioners commenced

C. STRATEGIC & ENABLING PRIORITIES

- **Elective Hubs** – Work continues through the two leadership teams on the development of robust short form business cases for the establishment of the Black Country Elective Hubs (South & North).

Some flexibility has been identified within the recent Capital resource allocations but will still require rigorous review for approval. It is anticipated that this will be sufficient to enable the commencement of the BC Elective Hub (South) in the first instance as this proposal is closer to being operational ready.

- **Pharmacy Aseptic Service Transformation** – The Collaborative Executive received an update from the BCPC Pharmacy Lead and Pharmacy Aseptic Project Manager on the progress with the development of a tender to secure a partner to undertake a feasibility study for a Black Country wide Aseptic service.

Work remains on track to secure a preferred supplier by Q1 2025/26 able to progress the feasibility study and subsequent outline business case with appropriate tender costs.

- **Workforce workstream** – The Collaborative Executive heard from the BCPC Workforce lead on the positive range of progress being made, which includes:
 - Early discussions by the Medical Bank Rate Working Group commenced to align medical bank rates.
 - Agreement to align on Non-Medical Bank rates at the entry level by the 1st April by all partners, though there is likely to remain some ‘noise’ in the system as we transition.
 - Work progressing at pace to implement an agreed arrangement for Clinical Bands 2 & 3, with work to harmonise job descriptions for Clinical Bands 4, 5, & 6 continuing through the CNO’s.

- A scoping exercise has been undertaken to identify 'hard to fill' positions, currently identified as Elderly care, AHPs', and Pharmacy. This will be reviewed on a frequent basis to reassess the situation.
- Work on policy alignment across the four partner Trusts continues, with a request to identify and prioritise key policies to be received by CE shortly. One key policy in the final stages of review is that of "Management of Change" policy, which will be key in supporting the mobilisation of the CSTP work

Visits and Events

8 January 25	Public and Private Trust Board
10 January 25	ICB/NHSE Sandwell Oversight and Assurance
10 January 25	Birmingham and Solihull ICS Chief Executives
13 January 25	Black Country Provider Collaborative Executive
13 January 25	GIRFT Further Faster SRO Group
14 January 25	Black Country ICB System Chief Executive Officers
15 January 25	Black Country Regional Performance Tier Call
17 January 25	Deputy Chair and Non-Executive Directors
17 January 25	NHSE Operating Model Workshop – Midlands Region
17 January 25	Chief Nurse and Medical Director Deputies introductions
20 January 25	Black Country ICS Cancer Board
20 January 25	Black Country Elective and Diagnostic Strategic Board
20 January 25	Performance Management Group
22 January 25	Midlands CEOs call with Regional Director NHS Midlands
23 January 25	Agency Price Cap Compliance Oversight Group
23 January 25	Black Country ICB Financial Recovery System Oversight Group
23 January 25	West Midlands Diagnostic Collaborative
24 January 25	Black Country Provider Collaborative Clinical Council
27 January 25	Black Country Provider Collaborative Corporate Services Transformation Workshop
27 January 25	Care Quality Commission Engagement visit
28 January 25	Trust Management Committee
28 January 25	Black Country ICB System CEOs
29 January 25	Quality Committee
29 January 25	Black Country Regional Performance Tier Call
29 January 25	People Committee
30 January 25	NHSE Chair visit to MMUH
30 January 25	Black Country Integrated Care Board
31 January 25	Finance and Productivity Committee
31 January 25	MMUH Opening Committee
31 January 25	NHSE Midlands 2025/26 Priorities and Operational Planning Roadshow
3 February 25	Black Country Provider Collaborative Executive
4 February 25	KPMG Executive Improvement Module
5 February 25	Financial Improvement Group
6 February 25	ICB and Provider Performance Improvement Framework Workshop
7 February 25	Black Country Provider Collaborative Joint Provider Committee
11 February 25	Black Country ICB System CEOs
12 February 25	Black Country Quarterly System Review
12 February 25	Board Development Workshop
14 February 25	West Midlands ICB CEOs MMUH Tour
17 February 25	ICS Cancer Board
18 February 25	GIRFT Further Faster 20 SRO Group
19 February 25	Principle of Health Command Training
25 February 25	Trust Management Committee
25 February 25	Black Country ICS System Leadership Event
26 February 25	Quality Committee
26 February 25	Midlands CEO call with Regional Director NHS Midlands
26 February 25	Black Country Regional Performance Tier Call
26 February 25	Black Country Elective Diagnostic Strategic Board
27 February 25	Finance Improvement Group
28 February 25	Finance and Productivity Committee
28 February 25	Meet and Greet Staff at MMUH
28 February 25	Economist Interview re MMUH

First awake breast surgery performed at the Midland Met

A retired NHS nurse has become the first patient to undergo “awake” breast surgery at the Midland Metropolitan University Hospital.

Felicia Selvaraj, aged 63, underwent a right total mastectomy and sentinel node biopsy at the hospital, run by Sandwell and West Birmingham NHS Trust.

Surgeons successfully performed the procedure under regional anaesthesia, which “blocks” a specific area of the body, and conscious sedation. Felicia, from Solihull, was safely discharged the following day.



Clinicians from the Trust’s breast unit at Birmingham Treatment Centre, along with anaesthetic colleagues, made the decision to perform the surgery while the mum-of-two was awake as she was at a higher risk of potential complications if she were to undergo the procedure under general anaesthetic, due to her medical history.

Dr Viraj Shah, consultant anaesthetist at the Trust said: “This type of surgery is definitely an option for patients who are not keen on or are not fit for general anaesthetic and there are also other benefits such as reducing the length of time patients need to stay in hospital recovering from an operation.”

Mr Mehboob Mirza, consultant breast surgeon and clinical lead, whose team performed the surgery also added: “We intend to use this technique in the future for high-risk patients who require surgery at the Midland Met, to avoid the need for them to stay on a high dependency or intensive care unit.

“I’m happy that we are able to offer this as an alternative to patients so that they can receive the care they need.”

Felicia’s breast cancer was first detected in November 2024, after she attended a breast screening for women aged between 50 and 71. The surgery successfully removed all cancerous breast tissue, and now that she has healed from surgery, her treatment will continue with medication and preventative radiotherapy.

Richard Meddings, Chair of NHS England visits Midland Met

In January, we were delighted to host Chair of NHS England, Richard Meddings, who met staff at the Midland Metropolitan University Hospital and heard about the integrated care clinical model which means local people get high quality care in the right place, at right time and by the right people.

Commenting after the visit, Richard said: “During my visit to the new Midland Metropolitan University Hospital, I was deeply impressed by the warmth and dedication of the staff.

“The innovative community-based care model here offers valuable lessons for others across the NHS. Particularly striking was the promising improvement in managing admissions for the most frail and elderly in the community.

“It was also great to see the leadership at the Black Country ICB, where I joined a Board meeting to hear about the financial challenges it faces and its performance on key operational indicators.

“Thank you to everyone at Sandwell and West Birmingham NHS Trust and the Black Country ICB for your exceptional work and commitment to patient care.”



Partnership working with Stroke rehabilitation centre at Rowley Regis

Earlier this month the Trust opened its brand-new stroke rehabilitation centre at Rowley Regis Hospital. The specialised inpatient rehabilitation care will be delivered into the heart of the community at Rowley Regis Hospital in partnership with The Dudley Group NHS Foundation Trust.

The unit allows for those patients who have suffered with a stroke to undergo their rehabilitation away from a main acute hospital and receive one on one care from the dedicated support team.



Clair Finmore, Stroke Therapy Lead, said: “There are many benefits of moving rehabilitation to Rowley Regis Hospital.

“By centralising rehabilitation services at the hospital, we provide a larger, more resilient team of specialists, enhancing care quality and responsiveness. It will mean smoother transitions for patients from hospital back to home-based care and will allow more clinical time to care for patients, whilst also supporting our commitment to greener practices.”

The unit is currently in its trial phase with the expectation that the service will continue in years to come.

NHS Careers event

Over 140 students were invited to Smethwick to learn about the range of jobs the NHS has to offer, at the first careers event held at the Midland Metropolitan University Hospital.

The Insight into NHS Careers event was hosted by the widening participation team at Sandwell and West Birmingham NHS Trust and showcased the different clinical and non-clinical roles available within the NHS.



Students from high schools and colleges across the local area, aged between 14-18, were invited to the event and given the chance to speak to staff and find out more about the NHS role that interested them the most.

The event featured a career marketplace, with staff from a range of departments on hand to talk about their roles and to give advice on how to find a career within healthcare.

There were also stalls from two of the Trust's Learning Campus partners, Sandwell College and Wolverhampton University, offering students advice on health and social care-related courses in further and higher education.

Long serving Stephen scoops national award

Stephen Turner, who has dedicated over 50 years to Sandwell and West Birmingham NHS Trust has scooped the lifetime achievement award at a prestigious awards ceremony.

Stephen began working at City Hospital, Birmingham aged just 16, has won the National MyCleaning Award at a ceremony held in February.

Speaking afterwards, Stephen, 67, from Smethwick, said: "I'm absolutely shocked and thrilled to be given this award.



"I couldn't believe it when I was nominated and now I've won, I'm even more stunned.

"I've worked in the NHS for 50 years in the same role and I am looking forward to retiring soon. This win is the icing on the cake and a fitting end to my career. I've made so many great friends along the way."

When asked to sum up his incredible life-long service, he simply said: "There have been good days and bad days, but I have always tried to do my best to make a difference."

First coffee and cake session is a success

I recently hosted my first coffee and cake session at Midland Metropolitan University Hospital, where staff from all corners of the Trust came to join me for a drink and some nibbles.

It was wonderful to see some familiar faces but also to meet some new ones – and I certainly had some actions to take away and look at improvements we can make.

I will be hosting these on a regular basis – across all Trust sites and look forward to meeting many more staff.



Tier 1 - Paper ref: PublicTB (03/25) 004

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:	12 th March 2025

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 (see appendix 1) 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 these are appended.

The report includes key issues to advise, assure and alert the Board from January and February 2025 committees:

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

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	<i>Deliver on its ambitions as an integrated care organisation</i>
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 February and March 2025

ALERT

- Reduction of workforce numbers and workforce control : discussed in both Finance and People committee, both committees received reports that concluded reduction in workforce numbers will not be achieved by year end. This remains a risk for the organisation as we move into 25/26. Robust action and delivery will be required in 25/26
- Financial Improvement Programme: Whilst the overall target of circa £44m efficiency is likely to be achieved, the recurrent target of c 80% will not be . A revised objective is to get to circa 50% recurrent. The underlying deficit will therefore increase as a result, cash balances will reduce and the challenge for financial year 2025/26 becomes greater. A major area of focus is vacant posts, which of them are essential and which can be removed without risk, this initiative is being prioritised by the Chief Executive.
- MMUH Jump risk : a comprehensive report was discussed in Quality Committee, we heard there had been higher than anticipated incidents. A follow up risk review as agreed in the first 100 days had been completed, Committee acknowledged the higher risk rating and mitigating actions and noted that risks were being minimised immediately. Staff were praised for their diligence and care. Further information and plans will be required for committee to be fully assured.
- Infection Control and prevention: discussion over concerns of antimicrobial stewardship and rising rates of C.Difficile, there have been 63 cases between April to December 2024. Quality Committee have requested a strong QI approach for sustained improvement which will be monitored closely.
- Risk to annual Internal Audit outcome: members heard that there could be a risk to the internal audit opinion if the two outstanding re-audits, Cost Improvement Programme and 78+ week waits are not satisfactory. In particular, the clearing of actions and good communication with the internal audit team is important. This year there is no option for a split opinion.
- Importance of the internal PMO to lead on CIP / other major projects and the need to be fully staffed with an executive board level lead by the end of this financial year was discussed at Audit Committee. It is felt at this stage there is only minimal assurance in place, albeit plans are anticipated to deliver at pace. This has also been a common area of discussion in Finance & Productivity Committee.

ADVISE

- MMUH Benefits oversight and governance framework: NED Committee Chairs and lead Executive Directors have met with Rachel Barlow Managing Director MMUH programme company, to ensure an effective transition of benefits delivery into the core Committees, once MMUH Opening Committee ends its tenure. The Quality, People and Finance committees will receive a quarterly report on benefits delivery and oversee assurance in the related benefit domains of quality, people, and productivity. The committees will also schedule relevant subject matter reviews in first year of MMUH being open e.g.;

review of the benefits case related to electronic end to end medicines management, 7-day services, infection prevention and control and the OD investment. The Audit Committee will receive a biannual review of the benefits case, including an annual external review being completed.

- Data quality. The Trust needs to complete its diligence on areas of data weakness, the underlying reasons and options to improve. Careful consideration of how to best use the internal improvement resource we have and whether investment in systems is necessary. Whilst this was discussed in Audit Committee this matter cuts across all sub committee areas of work and needs a detailed plan. Audit committee will monitor monthly.
- Staff Survey: shows good progress, group triumvirate representatives, staff networks and staff side representatives were involved in presenting this year's reflections and actions for improvement to People Committee. Significant improvement in responses linked to "your manager" and "your organisation", personal development and appraisal areas for improvement.

ASSURE

- MMUH : RSM (Internal Audit) benefits review has concluded. Significant additional benefits have been identified (potential benefits have increased from c£2bn to c£3.8bn). Overall lifetime financial 'payback' for the investment is now potentially as high as 4.5 times. Also it should be noted that the NHP Programme Assurance Review (PAR) closure review report was received and was very positive.
- Workforce: Good progress being made across several initiatives: e-rostering, absence management, timeliness in recruiting, consultant job planning. Committee undertook a deep dive into progress and delivery. This will be monitored closely for efficiency and quality improvements for staff.
- Midland Metropolitan Learning Campus (MMLC), proposal was agreed to extend range of lease for Sandwell College, amend layout and increase efficiency proposal. People Committee noted that any costs link to change are met by Sandwell College and will not compromise Aston and Wolverhampton Universities.
- CQC Visit to Primary Care Your Health Partnership resulted in good feedback for the Trust.

Appendix 1

<p>Minimal Assurance Partial Assurance Reasonable Assurance Substantial Assurance</p>	<p>Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.</p>
<p>Minimal Assurance Partial Assurance Reasonable Assurance Substantial Assurance</p>	<p>There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.</p>
<p>Minimal Assurance Partial Assurance Reasonable Assurance Substantial Assurance</p>	<p>There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.</p>
<p>Minimal Assurance Partial Assurance Reasonable Assurance Substantial Assurance</p>	<p>There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)</p>

Quality Committee Chairs Report

Committee Chair: Mike Hallissey

29 th January 2025	
CQC quarterly report including queries and next steps for self-assessment	Noted
PSIRF bi-monthly update	Partial Assurance
Infection Prevention and Control quarterly report	Partial Assurance
Complaints and PALs quarterly report	Partial Assurance
Perinatal update report - CNST update (Further documents in the Reading room)	Partial Assurance
Learning from Deaths/Mortality & Morbidity incl. HSMR & SHMI	Partial Assurance
MMUH first 100-day closure report	Partial Assurance
Urgent and Planned care update	Noted
Quality metrics	Noted
CQI update	Noted

26 th February 2025	
BAF Update	Noted
Maternity Dashboard and Perinatal Update	Partial Assurance
Learning from Deaths/Mortality & Morbidity incl. HSMR & SHMI	Reasonable Assurance
Intentional Jumps Report	Noted
Pediatric Audiology Update	Reasonable Assurance
C.Diff/Antimicrobial Antibiotics	Partial Assurance
Quality metrics	Noted

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Two Never events in the January
- C diff rates above trajectory
- CPE outbreak in Neonates, a potential area for network wide action
- Concern about jump risk at MMUH, subject to action and further review
- Acute rise in peri-natal mortality in January

MAJOR ACTIONS AGREED

- See a further report on Audiology in June
- See a further report on Antimicrobial prescribing in the Summer

POSITIVE ASSURANCES TO PROVIDE

- CQC Visit to YHP resulted in good feedback
- All ICB acute providers aligned over CQC methodology
- PSIRF now embedded and working, learning to follow
- Fewer infection outbreaks following move to MMUH
- No issues have arisen following change to 45 minute offload
- Good progress on LocSIPPs
- Support form Region on BCG vaccination delivery

DECISIONS MADE

- CNST submission for maternity approved for submission

People Committee Chairs Report

Committee Chair: Lesley Writtle

29 th January 2025	
Benefits rebase line output final report	Partial Assurance
People Story – Workforce Optimisation	Reasonable Assurance
Workforce Optimisation Deep dive	Reasonable Assurance
People Committee Metrics - Workforce Financial Improvement Programme	Reasonable Assurance
Health Campus move update and agile working project closure	Partial Assurance
Learning Campus Occupation Update	Reasonable Assurance

February 2025	
MMUH Workforce Programme (closure and transition to BAU)	Substantial Assurance
People Story – Disability Network	Noted
Update on Staff Survey 2024	Reasonable Assurance
People Metrics – Workforce Financial Improvement Programme NHSE SPC Charts – All POD Metrics	Substantial Assurance
BAF Update	Noted

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Continued risk that we will not meet WTE reduction for year end
- Continued use of agency which needs to cease. Require Trust to fill substantive posts and reduce Bank staff.
- Low compliance rates for PDR 55%, must improve and must be meaningful for staff.
- Deep Dive into Training compliance , especially clinical training where there are areas of concern

MAJOR ACTIONS AGREED

- Workforce Optimisation Deep Dive : 6 month review of work stream on: e rostering, job planning, temporary staffing and Goodshape. Good progress and significant work . Committee requested focus on 3 areas Reframe of ambition for 25/26, Creation of metrics to demonstrate progress, identification of cash releasing benefits.
- Health Campus Agile working, the committee requested a situation update in 3 months as there are still residual issues on all sites . it was acknowledged that significant work has been achieved.
- Agreed the process to monitor MMUH benefits realisation, the committee will review vacancies, turnover and staff survey 3 monthly. Reviewing the overall programme 6 monthly.

POSITIVE ASSURANCES TO PROVIDE

- People committee in February discussed in detail this year’s staff survey which shows good progress, Group triumvirate representatives, staff networks and staff side representatives where involved in presenting this years reflections and actions for improvement. This will be shared with Trust Board. Significant improvement in responses linked to “your manager” and “your organisation”, personal development and appraisal areas for improvement.

DECISIONS MADE

- Midland Metropolitan Learning Campus (MMLC), proposal to extend range of lease for Sandwell College , amend layout and increase efficiency proposal agreed. Noting that any costs link to change are met by Sandwell College and will not compromise Aston and Wolverhampton universities.

Finance and Productivity Committee Chairs Report

Committee Chair: Rachel Hardy (Jan) Mick Laverty (Feb)

31 st January 2025	
Operational Performance Report	Partial Assurance
Theatre Improvement Programme	Partial Assurance
MMUH – Activity Flows	Reasonable Assurance
Contractual Activity Report	Reasonable Assurance
Productivity Report	Partial Assurance
Workforce Report	Partial Assurance
Month 9 Financial Improvement Programme Update	Partial Assurance
Month 9 Finance Report	Reasonable Assurance
Year End Forecast: 2 Year Forward Look (Incl 2025/26 Annual Plan)	Reasonable Assurance
Month 9 Cash and Capital	Reasonable Assurance
Improvement Resources	Reasonable Assurance
Undertakings	Reasonable Assurance
Urgent Treatment Centre Business Case	Reasonable Assurance
Update On Vision for Information	Partial Assurance

28 th February 2025	
2024 /25 Operational Performance	Partial Assurance
Contractual Activity Report	Partial Assurance
Workforce Update	Reasonable Assurance
Financial Position Month 10 - Capital and Cash - Income and Expenditure Financial Improvement Programme	Partial Assurance
2024 / 25 Year End Forecast	Partial Assurance
2025 / 26 Planning Slides to be presented on the day	Partial Assurance
Sandwell Elective South Hub	Noted
Board Assurance Framework	Partial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- **Financial Improvement Programme:** Whilst overall target of c£44m is likely to be achieved, the recurrent target of c80% will not be. (Underlying deficit will therefore increase as a result, cash balances will reduce and the challenge for financial year 2025/26 becomes greater).
- **Workforce:** Agreed reduction in WTE will not be achieved by year-end.
- **2025/26 Planning Guidance:** Guidance suggests a difficult year financially with System CIP requirements of c£270m. This may translate into an avg System CIP target of c7%.
- **2024/25 Forecast:** SWB likely to be able to hit (original) deficit budget, but a System-wide issue is emerging re ERF income being capped.
- **Operational Performance:** Diagnostics off track and unlikely to achieve year-end target. Primary Care targets still under-development.
- **Contractual Activity:** Performing well (largely due to coding corrections), but there is a danger that ERF funding may be capped, and we do not receive all the income expected (£12m risk for the System).

POSITIVE ASSURANCES TO PROVIDE

- **Operational Performance:** With the exception of Diagnostics (and Primary Care) all other targets currently being achieved or expected to be achieved by year-end.

MAJOR ACTIONS AGREED

- **Financial Improvement Programme:** Focus for March is to drive up recurrent portion of overall c£44m target (revised objective is to get to c50% recurrent). Major area of focus is vacant posts, which of them are essential and which can be deleted. This initiative is being prioritised by the Chief Executive.

DECISIONS MADE

- **Contractual Activity:** CFO to provide a breakdown of out-performance (coding corrections v increase in activity).

- **Workforce:** Good progress being made across a number of initiatives: e-rostering, absence management, reduction in Bank/Agency, timeliness in recruiting.

- **Workforce:** Continuing resources for e-rostering team to support ongoing roll-out and optimisation of e-rostering was supported by FPC.

MMUH Opening Committee Chairs Report

Committee Chair: Mick Laverty

31st January 2025	
MMUH Programme Closure Report Lessons Learnt and Case Study Outputs.	Reasonable Assurance
Pre Programme Closure financial Report	Reasonable Assurance
Benefits rebase line output final report	Partial Assurance
Risk Forecast and handover	Reasonable Assurance
First 100 days closure report	Partial Assurance
Logistics Project PID, Progress Report and handover of Project to Business as Usual.	Partial Assurance
Health Campus Move update and Agile working project closure.	Partial Assurance
MMUH Communications and Engagement Plan 2025	Reasonable Assurance
Programme Documentation Archiving Proposal	Partial Assurance
IPA Gate 5 self-assessment	Reasonable Assurance
Optimising Transition Report	Partial Assurance
PID	Reasonable Assurance

28th February 2025	
MMUH Benefits Review	Reasonable Assurance
MMUH Programme Closure Report	Reasonable Assurance
MMUH Programme Closure Assurance Review Output Report	Reasonable Assurance
Final draft of Programme Financial Closure Report	Reasonable Assurance
Optimising Transition Report	Substantial Assurance
BAF Risk Closure	Reasonable Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- February
- None.
- January
- Logistics: AGVs still not operational and some issues with logistics – but both are being managed.
 - MMUH building being revalued and additional Public Divided Capital (PDC) will be required as a result.

MAJOR ACTIONS AGREED

- February
- None.
- January
- None

POSITIVE ASSURANCES TO PROVIDE

- February
- RSM benefits review concluded. Significant additional benefits identified (potential benefits have increased from c£2bn to c£3.8bn). Overall lifetime financial 'payback' for the investment is now potentially as high as 4.5 times.
 - NHP PAR closure review report received – and was very positive.
- January
- Preparations in hand for NHP led Programme Assurance Review (PAR) closure review.

DECISIONS MADE

- February
- MMUH Benefits Governance. Benefits to be tracked and reported through each Board Sub-Committee (Quality, People, FPC) then summarised and report to Audit Assurance and the main Trust Board.
 - Discussions to be held with Grant Thornton to establish the process and timetable for including benefits achieved in 2024/25 in the Annual Report & Accounts.
 - A clear articulation of the cost of MMMUH (c£800m) needs agreeing with stakeholders (What was the final cost, reasons for the final cost – Carillion/BB, and what we'll get for the investment – c£3.8bn of benefits).
 - Near final closure report to be presented to the March Board for Board feedback, then final version to be signed-off at March MMUH Committee.

- RSM appointed to provide external validation of MMUH benefits. Rebased MMUH exceeding original forecast. MMUH benefits will be integrated into the overall Improvement Plan.
- Only three risks still likely to be open at the point the Programme Company closes, and will be transferred to BAU.

January

- Need to ensure MMUH programme closure reports are properly indexed and archived, and are readily available in an accessible fashion to NHP and others so that lessons can be learnt from the MMUH programme.

Audit Committee Chairs Report

Committee Chair: Andrew Argyle

5 th March 2025	
MMUH Benefits: Independent Review and Governance	Substantial Assurance
Data Quality	Partial Assurance
Internal Audit Plan 2024-25 - Progress Report	Partial Assurance
Allocate and e-Rostering	Partial Assurance
Consultant Job Planning	Partial Assurance
Draft Internal Audit Plan 2025-26	Reasonable Assurance
Counter Fraud Progress Report	Reasonable Assurance
External Audit Plan 2024-25 Update	Reasonable Assurance
Financial Improvement Plan Phase 2	Minimal Assurance
Progress on staffing the internal PMO for CIP 2025-26	Minimal Assurance
Changes to Trust Standing Financial Instructions	Substantial Assurance
Informing the Audit Risk 2024-25	Substantial Assurance
Trust Accounting Policies 2024-25	Substantial Assurance
Governance Pack	Substantial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Importance of the internal PMO to lead on CIP / other major projects being fully staffed with an executive board level lead by the end of this financial year
- The risk to the internal audit opinion if the two outstanding re-audits, CIP and 78+ week waits are not satisfactory. In particular the clearing of actions and good communication with the internal audit team is important.
- Data quality. The Trust needs to complete its diligence on areas of data weakness, the underlying reasons and options to improve. Careful consideration of how to best use the internal improvement resource we have and whether investment in systems is necessary.

MAJOR ACTIONS AGREED

- Data quality update to become a standing item on audit committee agenda
- RSM to implement data analytic solutions as part of routine internal audit work. This will enhance monitoring of payroll and job allocation systems
- Audit committee to receive and update from quality committee of major risks / outstanding actions from clinical effectiveness team work and external statutory reviews
- External audit plan to be circulated
- Internal auditors to keep committee updated on the "opinion"

POSITIVE ASSURANCES TO PROVIDE

- Well co-ordinated benefits realisation work using RSM to validate. Six monthly rolling updates and a plan for the Trust finance team and external auditors to agree inclusion / format in annual report.

DECISIONS MADE

- See above
- Benefit tracking to be revisited in six months

- Huge effort and commitment to continuing the e-rostering / allocate implementation and to resolve historic time recording issues. This remains ongoing and the transition from external support to internal team needs careful management.
- Preparation for external audit and vfm work appears to be progressing well.

- New Trust SFIs approved
- External audit risk document approved for use by Grant Thornton
- Internal audit will finalise their work on rostering in 25/6 and issue an opinion

Joint Provider Committee – Report to Trust Boards

Date: XXth March 2025

Agenda item: TBC

TITLE OF REPORT:	Report to Trust Boards from the 7 th of February 2025 JPC meeting.
PURPOSE OF REPORT:	To provide all partner Trust Boards with a summary of key messages from the 7 th of February 2025 Joint Provider Committee.
AUTHOR(S) OF REPORT:	Sohaib Khalid, <i>BCPC Managing Director</i>
MANAGEMENT LEAD/SIGNED OFF BY:	Sir David Nicholson - <i>Chair of BC JPC & Group Chair of DGFT, SWBH, RWT, & WHT</i> Diane Wake - <i>CEO Lead of the BCPC</i>
KEY POINTS:	<p>The Joint Provider Committee (JPC) was held, and was quorate with attendance by the Chair, three Deputy Chairs, and both CEO's.</p> <p>Key discussion points included:</p> <ol style="list-style-type: none"> A progress update from the BCPC CEO Lead with a particular focus on progress with Pharmacy Aseptic work, and a Clinical Services Transformation 'route map' for 25/26. Progress update on the Corporate Services Transformation work, with a range of key recommendations made and approved by the JPC. Update on the progress to secure a 'Delivery Partner' to support year 2 of the FRP work in addition to outlining key governance requirements.
RECOMMENDATION(S):	<p>The partner Trust Boards are asked to:</p> <ol style="list-style-type: none"> RECEIVE this report as a summary update of key discussions on the 7th February 2025 JPC meeting. NOTE the key messages, agreements, and actions in section 2 of the 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.
ACTION REQUIRED:	<input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Endorsement / Support <input checked="" type="checkbox"/> Approval <input checked="" type="checkbox"/> For Information

1. PURPOSE

- 1.1 To provide all partner Trust Boards with a summary of key messages from the 7th of February 2025 Joint Provider Committee.

2. SUMMARY

- 2.1 The Joint Provider Committee was held on the 7th of February 2025. The meeting was quorate with attendance by the Chair, both CEO's and three of the Deputy Chairs.
- 2.2 The minutes of the previous meeting were accepted as an accurate record and the Action Log was reviewed for progress with completed actions noted.
- 2.3 The following is a summary of discussions with agreements noted:
- a) **Items for Noting**
- **CEO Leads update report** – The JPC received an update report from the Chair of the Collaborative Executive, which highlighted:
 - Month 9 data is indicating an adverse underlying position (£355m forecast, compared to £235m in FRP - £121m adverse to FRP). Month 9 data is showing a reduction in headcount (mainly due to bank and agency usage) overall for the first time. Cost of workforce continues to reduce, the number of vacancies is increasing, and number of vacancies going through panels is reducing. Detailed assessment to be undertaken following month 10 reporting with a refresh of the suite of I&I KPI's during February to ensure these continue to add value.
 - Steady progress is being made to procure and secure a Delivery Partner, with the procurement team now actively engaged. Governance arrangements will require BC ICB and NHSE sign off, with the current specification currently remaining as a BCPC only approach to a 'Delivery Partner'.
 - Work continues on the development of short form business cases for the BC Elective Hubs (South & North), with alternative funding streams being actively sought as the system has been informed that it is unlikely to be successful in the TIF3 round.
 - Positive progress being made on the progress with the development of a tender to secure a partner to undertake a feasibility study for a Black Country wide Aseptic service. Work remains on track to secure a preferred supplier able to progress the feasibility study and subsequent outline business case with appropriate tender costs by Q1 2025/26.
- b) **Items for Discussion**
- **Service Transformation 'Route Map'** – The JPC received an update from the BCPC Managing Director outlining a 'Road-map' for key clinical transformation activities over the course of 25/26.

These have been driven by the work of the Clinical Network, and to be driven for delivery through the BCPC. They continue to reinforce the pursuit of a 'Black Country' brand in all that we do. A range of key actions were described which are already underway to mobilise for implementation.

Phase 2 ideas generation will commence through both the BCPC Clinical Council and key work to be commissioned from a 'Delivery Partner' focused initially from the 'bucket' of 'fragile services'.
 - **Corporate Services Transformation** – The JPC received an update from the CSTP SRO. Currently the programme remains on track and there has been strong engagement, which is highly valued at this early stage, from our most senior corporate leaders, Trade Union and staff side representatives. Eight recommendations were presented to enable

the progression of work at pace, and following discussion were agreed by JPC, with some finer practical details for further discussion with the two CEO's. Amongst the key actions agreed are:

- **Service Model & Design Principles** – JPC approved the proposed services model and the draft 'Design Principles' upon which work should proceed, with the recognition that these would be 'tweaked' as circumstances necessitated.
 - **Scale & Ambition** – JPC confirmed that it remained committed to pursuing opportunities at scale once.
 - **Data Validation** – JPC agreed to support the current work being progressed to better understand the range of options available for attaining efficiencies through workforce reductions.
 - **Identification of Phase 1 services** - Both CEOs agreed an initial range of services for progression and work is underway to develop approach.
 - **Exit Strategy** – JPC agreed to establishing a BCPC 'At Risk Pool' and pursuing the establishment of a MARS scheme (Mutually Agreed Resignation Scheme) across the BCPC partners to support options for exit strategy.
 - **Legal Framework** – JPC agreed to work being commissioned from a legal partner to develop and establish the legal framework, aligned with the existing Collaboration Agreement already in place and the Expression of Interest (EOI) approach.
 - **Mobilisation / Implementation** – JPC supported the exploration of options to secure additional expertise and capacity to support mobilisation and implementation.
- **Update on the 'Delivery Partner'** – The JPC received an update on the commissioning of a 'Delivery Partner' to support the four BCPC partners with their contribution of the system Financial Recovery Plan. A range of productivity and efficiency opportunities were outlined, illustrated through a 'worked example' from a neighbouring system.

Work continues with the procurement teams to identify a safe route for the speedy commissioning of a 'Delivery Partner' which it is anticipated will be in place for April 2025.

- **Key Decisions** – With no planned JPC in March and key decisions required (sign-off of the 'Delivery Partner', approval of the BC Elective Hub (South), and the Pharmacy Aseptic Feasibility work) there may be a need to 'stand up' an extra-ordinary JPC.

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 7th of February 2025 JPC meeting.
- b. **NOTE** the key messages, agreements, and actions in section 2 of the above report.

Tier 1 - Paper ref:	PublicTB (03/25) 005
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Report title:	MMUH Closure – Programme Assurance Review (PAR)
Sponsoring executive:	Rachel Barlow, Managing Director MMUH Programme Company
Report author:	Simon Sheppard, Acting Chief Finance Officer
Meeting title:	Public Trust Board
Date:	12 th March 2025

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

Following the successful opening of Midland Metropolitan University Hospital (MMUH) , the Trust performed a re-baselining of the new hospital benefits assessment in January 2025. RSM have been commissioned to undertake an independent review of this work.

The Acting Chief Finance Officer and Managing Director of the MMUH Progrmame welcomed the report, the comprehensiveness of the review and associated learning.

The rebaselining demonstrated an increase from the original PriceWaterhouse Copper benefits baseline of £2.2 billion to £3.8 billion opportunity in January 2025, which is a circa 4:1 ratio return on investment. The RSM report concluded the Trust have rebaselined the benefits comprehensively and that there was good executive engagement on the importance of tracking benefits going forward.

Forward governance is in place to mature and provide assurucne on the tracking and optimisation of the MMUH related beenefits. The Committee Chairs and Lead Executives have been engaged on the transition of benefits tracking from 2025 onwards, as MMUH Opening Committee concludes. This will include an annual independent benefits review reporting to the Audit Committee.

The MMUH Benefits Independent Review received a reasonable assurance rating at the MMUH Opening 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?]*

MMUH Opening Committee

4. Recommendation(s)

The Public Trust Board is asked to:

a) **ACKNOWLEDGE** the growth in the MMUH benefits baseline to £3.8 billion.

b) **DISCUSS** and **ACCEPT** the MMUH Benefits Independent Review.

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

PRIVATE AND CONFIDENTIAL



Midland Metropolitan University Hospital Benefits Review

Sandwell and Birmingham NHS Trust

04 March 2025

Final report v3.0



Table of Contents

01 EXECUTIVE SUMMARY	3
02 RECOMMENDATIONS	4
03 BENEFITS REVIEW	5
04 BENEFITS GOVERNANCE	16
05 ADDITIONAL BENEFIT AREAS	18
06 APPENDICES	21

This report is solely for the use of the persons to whom it is addressed.
To the fullest extent permitted by law, RSM UK Consulting LLP will accept no liability in respect of this report to any other party.

Executive Summary

In February 2023, Sandwell and West Birmingham NHS Trust ('the Trust') commissioned PwC to update the historic benefits assessment for the new Midland Metropolitan University Hospital (MMUH) and identify further benefit areas. Following the successful opening of MMUH, the Trust performed a re-baselining of the new hospital benefits assessment in January 2025. RSM have been commissioned to undertake an independent review of this work.

Scope: RSM has completed an independent quality review of the re-baselining of the benefits for MMUH, using the PwC report as a baseline. This included:

- A review of the updated models, both financial and non-financial, to ensure they align with the assumptions and have been updated accurately
- A review of the updated or new assumptions being used, that they are reasonable and have been appropriately incorporated into the models
- Interviews with key members of staff
- A review of the internal governance around benefits tracking and delivery against benefits

Conclusions: The MMUH benefits team have re-baselined the benefits comprehensively and the executive team members we spoke with are clear on the importance of tracking the benefits going forward.

Inaccuracies identified over the course of this review have been resolved, and the quantified benefits have clear, documented methodologies. We have recommended areas for further improvement on the following page.

Trust response: The Trust welcomes the independent review of the benefits assessment and the timeliness and comprehensiveness of this report. It is welcoming to see positive confirmation of the assumptions, calculations and governance. This results in an increase in the forecast benefits from £2.2bn to £3.8bn

In particular, the governance arrangements re-enforce our commitment to delivery and optimisation of the benefits. Our focus will now be to deliver the benefits and further develop the benefits around the elective hub.

Recommendations

Ref	Actions	Trust response	Date due
1	<p>Tracing of duplication across benefits</p> <p>Within the workbooks used to track benefits there are several duplicated benefits (these do not impact the overall financial totals), which are subsequently 'backed out' later in the baselining workbooks.</p> <p>To avoid risk of error, these should be recorded separately.</p>	<p>The principle is agreed – it would be helpful to have a couple of examples of duplicated benefits.</p>	31/03/2025
2	<p>Finalise core list of benefits</p> <p>MMUH must be able to compare benefits across years. This will support tracking and help everyone to see whether targets are being hit. The hospital has not yet agreed the core benefits that it is going to use going forward. We recommend:</p> <ul style="list-style-type: none"> - A final list of the benefits that will be formally tracked is agreed. - Each of the benefits on the list has a fixed, documented methodology. 	<p>The Trust will identify a core list of benefits aligned to SWB.</p>	31/03/2025
3	<p>Formal agreement of governance arrangements</p> <p>MMUH should have formal governance arrangements over benefits: who owns them, how they are reviewed, and how they are reported. To date, this has been done ad hoc.</p> <p>We reviewed the draft <i>MMUH Benefits Oversight and Governance framework</i> which will go to the executive on 18th February 2025. This will then be presented to the Audit Committee on 5th March 2025 to enable it to be live from the start of FY25/26. Once these are formalised, they should be reviewed regularly.</p>	<p>Governance arrangement have been supported by the Executive team and will be presented to Audit Committee on 5th March for ratification.</p>	05/03/2025
4	<p>Alignment across benefits and integration into communication plans</p> <p>Benefits tracking should be aligned with wider system outcomes and strategy. This makes tracking efficient, and aligns the benefits case with the wider optimisation work occurring across the Trust.</p> <p>Part of this work should include embedded communications. Staff communications should reinforce how benefits tracking connects to their roles and drives improved outcomes, with benefits forming a key part of wider communication engagement plans.</p>	<p>Post MMUH communications plan post programme closure has been agreed and aligns with the benefits case. The benefits case, non-financial and financial, will also be included in the roll out of Trust Strategy</p>	30/04/2025

Benefits Review

Our approach

At the outset of the review, benefits were grouped based on when benefits were identified i.e. in the 2023 PwC report (*initial*) or the MMUH January 2025 re-baselining (*additional*). Where possible, benefits have also been grouped by benefit type: cash releasing benefits (CRB), non-cash releasing benefits (NCRB) and societal benefits (SB).

For each of the identified benefits, the following areas were considered to ensure that benefits had been quantified both accurately and consistently (to support with ongoing benefits tracking):

- The source for each assumption was clearly identifiable
- The input assumption correct at re-baseline and could be traced to the evidence source (or closely matched)
- The calculation of benefits from the re-baseline could be replicated and was accurate based on the assumptions

Each benefit was also reviewed to determine whether there was an associated benefits owner and that governance arrangements had been established, to ensure that appropriate governance was in place.

48 Benefits reviewed

309 Assumptions reviewed

48 Calculations reviewed

Summary of benefits of reviewed and reflections

Summary of benefits reviewed

The total of all quantified benefits is £3.8bn (excluding benefits detailing metrics measured by years / hours).

All benefits that were quantified as part of the PwC 2023 baselining report have been included in our re-baselining review. A total of **48 quantified benefits** were reviewed. The table below shows the total number of benefits included in our review:

	Benefits reviewed
Initial (PwC 2023 report)	21
Additional (MMUH 2025 re-baseline)	27
Total	48

Of these 48 benefits, 35 benefits have been finalised (i.e. have been developed post a Full Business Case approval) and these generate an estimated lifetime benefit of £2.4bn. A further 13 benefits, while quantified, have not had Full Business case approval. These benefits are estimated to generate an additional £1.4bn.

The total of both these groups of benefits is £3.8bn (excluding benefits detailing metrics measured by years / hours).

Reflections

From the interviews with staff, there were discussions the level of **attribution of certain benefits** to the operationalisation of MMUH versus what may have happened regardless, through quality improvement processes. For the benefits discussed, while these have been included the benefits baseline, these have been identified with a “**Ⓜ**” in the following slides.

There is a general area of caution around how **duplication** is regarded in the benefits baseline. While duplication is accounted for in the benefits summary, this should be clearly traceable within the baseline, to support with the tracking of realised benefits over the benefits period.

Please see **action 1** in the ‘Recommendations’ section.

Exclusions

There are 30 benefits that have been identified within PwC 2023 report but have not been included in the review, as they have either not been quantified or do not have sufficient information included to review. While these have not been reviewed, these have been included for completeness in Appendix A.

In addition, some benefits were removed during the January 2025 re-baseline. A summary of these benefits including rationale for removal have been included in Appendix B.

A further eight non-quantified benefits were identified in the January 2025 re-baseline (see slide 19), but these were out of scope due to their current level of maturity at the time of this review.

Review of initial benefits (Cash releasing)

In total there were six cash releasing benefits identified in the initial benefits baseline. Following the January 2025 re-baselining and this review, the total estimate of these cash releasing benefits (over the lifetime of the hospital) is £529.5m. All initial cash releasing benefits have an identified benefits owner and established governance arrangements.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Homes England Development	£18,800	Yes	Yes	Yes	Yes
Bed Rightsizing [Ⓜ]	£450,304	Yes	Yes	Yes	Yes
Hospital Acquired Infections Cost Reduction	£2,666	Yes	Yes	Yes	Yes
Improved energy efficiency	£13,973	Yes	Yes	Yes	Yes
Reduced Agency Costs	£39,250	Yes	Yes	Yes	Yes
Recruitment Cost Savings	£4,554	Yes	Yes	Yes	Yes

Review of initial benefits (Non-cash releasing)

In total there were ten non-cash releasing benefits identified in the initial benefits baseline. Following the January 2025 re-baselining and this review, the total estimate of these non-cash releasing benefits (over the lifetime of the hospital) is £1.2bn. All initial non-cash releasing benefits have an identified benefits owner and established governance arrangements.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Homes England Development - Land Value Uplift	£9,001	Yes	Yes	Yes	Yes
Construction GVA - for Homes England Development, Urgent Treatment Centre, Learning Campus	£5,934	Yes	Yes	Yes	Yes
Construction GVA for MMUH	£150,284	Yes	Yes	Yes	Yes
Staff Satisfaction	£320,784	Yes	Yes	Yes	Yes
Backlog Maintenance	£73,141	Yes	Yes	Yes	Yes
LifeCycle Benefit	£98,746	Yes	Yes	Yes	Yes
Reduction in Staff Sickness	£56,253	Yes	Yes	Yes	Yes
Split of planned and unplanned care on the hospital site	£220,157	Yes	Yes	Yes	Yes
Reduction in DNA rates ^a	£194,236	Yes	Yes	Yes	Yes
Phase 2 Benefit - Learning Campus Salary Uplift	£46,021	Yes	Yes	Yes	Yes

Review of initial benefits (Societal)

In total there were five societal benefits that were included in the initial benefits baseline. Following the January 2025 re-baselining and this review, the total estimate of these cash releasing benefits (over the lifetime of the hospital) is £508.7m. All initial societal benefits have an identified benefits owner and established governance arrangements.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Homes England Development - Council Tax	£29,652	Yes	Yes	Yes	Yes
Employment GVA - MMUH	£281,366	Yes	Yes	Yes	Yes
Ambulance Turnaround Improvement	£1,779	Yes	Yes	Yes	Yes
Phase 2 Benefit - Learning Campus Employment GVA	£195,871	Yes	Yes	Yes	Yes

Benefit	Estimated benefit (Years)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Phase 2 Benefit - Learning Campus Life Expectancy Uplift	68,473	Yes	Yes	Yes	Yes

Review of additional benefits (Finalised)

In total there were seven additional benefits that have been finalised during the January 2025 re-baselining. The total estimate of these benefits (over the lifetime of the hospital) is £133.7m. All additional finalised benefits have an identified benefits owner and established governance arrangements.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Net Zero - Construction GVA	£4,558	Yes	Yes	Yes	Yes
MMUH Travel Demand Reduction	£606	Yes	Yes	Yes	Yes
Compass Retail Construction GVA	£260	Yes	Yes	Yes	Yes
Social Value - Compass Retail Proposal	£102,939	Yes	Yes	Yes	Yes
Patient Experience – Complaint Reduction	£2,332	Yes	Yes	Yes	Yes
Nurse in charge - on all wards support rhythm of the day: £ value	£22,976	Yes	Yes	Yes	Yes

Benefit	Estimated benefit (Hours)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Nurse in charge - on all wards support rhythm of the day: additional hours	37,260	Yes	Yes	Yes	Yes

Review of ‘Deep Dive’ Benefits – Learning Campus

In addition, two benefits outlined in the PwC report have been expanded in ‘Deep Dive’ papers: *Learning Campus* and *Logistics*. *Deep Dive - Learning campus* expands upon seven individual benefits, five of which are additional and have been reviewed below and two of which are overlapping benefits, already reviewed in previous slides. The total benefit considered by the *Deep Dive – Learning Campus* paper is £282.4m (of which £10.2m is additional). The benefits associated with the *Deep Dive – Learning Campus* all have a benefits owner and governance arrangements established.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Employment GVA	£150,679	N/A – Overlapping with Previous Benefit			Yes
Salary Uplift Benefit	£121,453	N/A – Overlapping with Previous Benefit			Yes
Decreased Spending on Welfare	£7,204	Yes	Yes	Yes	Yes
Electricity Savings	£852	Yes	Yes	Yes	Yes
Annual Travel Demand	£1,983	Yes	Yes	Yes	Yes
Carbon Emissions	£185	Yes	Yes	Yes	Yes

Benefit	Estimated benefit (Years)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Life Expectancy Uplift Benefit	148,736	Yes	Yes	Yes	Yes

Review of ‘Deep Dive’ Benefits – Logistics

Similarly, the *Deep Dive – Logistics* paper expands upon five benefits, two of which are additional and three of which overlap benefits already considered. The total benefit considered by the *Deep Dive – Logistics* paper is £35.7m (of which £2.4m is additional). The benefits associated with the Logistics ‘Deep Dive’ all have a benefits owner and governance arrangements established.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Stock Holding Reduction	£350	Yes	Yes	Yes	Yes
Reduced Obsolescence	£2,049	Yes	Yes	Yes	Yes
Clinical Time Saved	£4,380	<i>N/A – Overlapping with Previous Benefit</i>			Yes
Employment GVA	£8,302	<i>N/A – Overlapping with Previous Benefit</i>			Yes
Salary Uplift	£20,609	<i>N/A – Overlapping with Previous Benefit</i>			Yes

Review of Additional MMUH Benefits – Not-Finalised

The following 13 benefits have not yet been finalised. Therefore, whilst we have reviewed the calculations and assumptions built into the benefits, we have noted where assumptions are still to be reviewed and confirmed when finalised. The current total for these benefits is £1.4bn.

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Additional – Mortuary	£74,059	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - Economic impact on spending	£1,250	Yes	Yes	Yes	Yes
Elective Hub - Reduced spend on welfare	£1,335	Yes	Yes	Yes	Yes
Elective Hub - financial contribution - efficient process in Theatres / Outpatients	£33,608	Yes	Yes	Yes	Yes
Elective Hub – Impact to a patients’ long term quality of life as a consequence of fewer readmissions	£60,130	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - Impact to a patients’ long term quality of life as a consequence of faster access to treatment	£1,160,970	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes

Review of Additional MMUH Benefits – Not-Finalised

Benefit	Estimated benefit (000s)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Elective Hub - Reduction in patient days off sick from employment as a consequence of faster access to treatment	£2,909	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - Reduction in patients who need unemployment support and can return to economic activity as a consequence of faster access to treatment	£26,436	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - Salary Uplift	£5,390	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - Employment GVA	£71,390	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - South Hub Construction GVA	£2,252	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes
Elective Hub - Reduction in Patient Complaints	£4,407	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes

Review of Additional MMUH Benefits – Not-Finalised

Benefit	Estimated benefit (Years)	All assumption sources are clearly identifiable	All input assumptions are correct at re-baseline	Calculation of benefits is correct at re-baseline	Benefits owner and governance established
Elective Hub - Life expectancy uplift	154	Yes	<i>Not all assumptions confirmed at point of review</i>	Yes	Yes

Benefits Governance

Governance and tracking – work to date

Work to date

Benefits tracking has been embedded as part of the MMUH project from its foundation. At each stage of the project, requirements for benefits tracking have evolved, both in terms of the scope of the benefits that have been identified and tracked and the frequency with which they have been reviewed.

This process is appropriate given the different stages of the project but, as the hospital leaves 'project status' and moves into operational BAU, a regular structure for reviewing and tracking benefits is essential.

This was acknowledged across the leadership team members that we engaged with during this review and work has commenced on formalising this structure.

Documents reviewed

We were provided with the draft *MMUH Benefits Oversight and Governance framework* dated 10 February 2025. This document outlines the accountabilities and responsibilities for the project, the regular formal reporting, and the format of management information in monthly tracking dashboards.

We were also provided with the tracking spreadsheets for all benefits and noted that each benefit has a named owner.

Areas for future improvement

Whilst we acknowledge the emergence of additional benefits as the hospital becomes operational, we suggest that a core group of benefits are identified for continuous tracking to enable reports to be comparable across time periods.

These should be referenced in the *Benefits Oversight and Governance Framework* (as an appendix or reference out to a separate document), and changes made to these should be by formal agreement only. This approval pathway should be outlined within the document.

Integrating benefits tracking into governance structures will ensure ongoing visibility and accountability. Ownership should be embedded within operational and performance objectives, ensuring clear accountability for monitoring, reporting, and corrective actions

A tiered benefits review cycle should be implemented, with regular reviews for core benefits, annual evaluations for wider economic and social benefits, and long-term checkpoints to assess sustainability.

MMUH should reinforce benefits tracking as a driver of operational improvement (rather than a finance function), with a compelling change narrative that ensures all stakeholders understand the importance of benefits tracking and its impact.

Benefits should be a key element of the wider communication engagement plan for the Trust.

Please see **actions 2-4** on slide 4.

Additional benefit areas

Future identification

Review of additional benefits (not yet been quantified)

Within the MMUH re-baselining undertaken in January 2025, there were several benefits have been identified but not yet quantified. Risk of benefits duplication will need to be considered during the quantification of these benefits. Please note that these benefits are not necessarily intended to be quantified moving forward but were included, as a nil balance, in the tracking spreadsheet provided and have, therefore, been documented here for completeness.

Benefits	Benefits type	Rationale
Patient Experience - PIFU impact	CRB	Utilising the services of partner organisations such as Macmillan cancer support is expected to enhance patient involvement and control over their care decisions and thus, increased use of PIFU is expected.
Patient Experience - Optimised discharge	CRB	Partner organisations are becoming involved in the discharge process. It is anticipated that this will improve Trust length of stay and have an impact on bed utilisation.
Patient Experience - Reduced NCC	CRB	Changes in the interpreting service are intended to avoid the last-minute booking of interpreters (as failure to book an interpreter can lead to cancellation of appointments). Non-clinical cancellations have an adverse impact on Trust income and lead to high skilled staff being underutilised.
Net Zero - Energy efficiency at Sandwell site	CRB	The above allows decommissioning of a steam boiler. This enables a switch from gas to electricity.
Patient Experience - Employment benefit	NCRB	It is expected that the 'Youth Space' initiative involving 300 young people will translate into successful recruitment of local youth. This initiative will support the MMUH Employment GVA. It will also support the recruitment cost reduction benefit.
Patient Experience - Readmissions	NCRB	The crossroads initiative is aimed to support carers. Where carers are supported appropriately it is anticipated that there will be fewer readmissions.
Elective Hub - Patient Choice	NCRB	Shorter waiting lists are likely to attract out of areas resulting in a qualitative benefit for a wider cohort of patients.
Weekend Discharges	NCRB	As a result of 7-day working there should be an increase in weekend discharges. In this way, there are expected benefits on length of stay, throughput and flow.

Benefit topics to be explored

In our discussions with management, the following topic areas emerged as spaces where additional benefits may lie, but that have not yet been fully explored. This builds on the list from the previous page, gathered by the benefits team.

Some of these have elements captured in the existing benefits identified, however, they will continue to evolve as more information becomes available from the fully operationalised hospital.

As these areas are still evolving, they should be reviewed alongside the additional benefits on the previous page to identify how and when they can start to be measured.

Health Inequalities: Reflecting the significant work to be done in the Black Country and across the nation, how has the introduction of the new hospital served to minimise health inequalities.

Infection Prevention: Improved infection control from the structure of the building (e.g. ratio of open wards to side rooms) and new technologies.

Regeneration: Socio-economic regeneration impacts across the community, with the new hospital serving as an anchor institution.

Environmental sustainability: Cross referencing to net zero goals and embedding across the Trust's environmental goals.

Transport: From cycle paths to bus schedules, the hospital has had a positive impact on transport links.

Appendices

Appendix A: Initial benefits which were not reviewed

Appendix B: Initial benefits which have been removed

Appendix C: List of interviews held

Appendix A: Initial benefits which were not reviewed

The following 30 benefits in the initial PwC report were not quantified at the time - with the majority of these being considered unquantifiable benefits (UB). Some of these benefits have now been assumed into additional benefits whilst the remainder have been outlined below. In some instances, these benefits may have been implicitly included in initial or additional benefits, but we have included them to track completeness of benefits included in the PwC report.

Benefit	Type	Description
Capital Investment	CRB	Lower capital investment in the existing estate which will be replaced over period of build.
Minimal interruption to hospital services for maintenance and repairs	CRB	There will be minimal interruption to hospital services for maintenance and repairs.
Key worker accommodation	CRB	Part of the previous site turned into accommodation for staff.
Cohesion in working places	NCRB	Single teams creating cohesion in working practices and improved roster resilience.
Remote Working – Administrative	NCRB	Administrative staff have the option to work remotely hence reducing the costs incurred in this regard with the hospital focussed on facilitating only clinical administrative staff and experts requiring direct patient contact.
Improved Health	NCRB	MMUH has been designed to allow for colocation of UTC and ED, believed to have incremental benefit above and beyond UTCs elsewhere.
Future capex requirement cost avoidance	NCRB	Future capex requirement not required to same level as existing levels within Trust Capital Plan.
Car Parking – EV Spaces	NCRB	Extra spaces can be created as a result of new development.
Automated Guidance Vehicle System (AGV)	NCRB	Automated Guided Vehicle System (AGV) will be implemented, transporting various payloads including waste, linen, food, supplies, sterile instruments, endoscopes and pharmacy items. N.B. This benefit was quantified at £153k p.a. in the PwC report but no supporting evidence of the methodology has been provided so it has been omitted from our review.
Increase local staff levels	SB	Increased local staffing levels increase the GDP of the local area, and reduce the deprivation index of the local area, pushing up acuity.

Appendix A: Initial benefits which were not reviewed

Benefit	Type	Description
Rehabilitation Community Care	UB	In stroke, the rehabilitation ward is being decoupled with patients being diverted to community care instead.
Additional car parking spaces	UB	Additional car park provision will reduce wasted time from staff having to search for spaces and being late for work.
Environmental impact of new building stock	UB	The new building and reduced use of older buildings allows the Trust to better contribute to environmental strategies and policies locally and nationally, including energy budgets, sustainability goals and reduced carbon emissions.
Recruiting and retaining high quality staff	UB	Recruiting and retaining high quality staff, enables them to develop in truly interprofessional collaborative environments and learn from best practice to provide the best quality services, resulting in higher throughput.
Quality Improvement	UB	Improvement in quality of care translating to improvements in CQC rating.
Deliver Excellent Acute Services	UB	Ability to deliver excellent acute services.
Patient confidence in care	UB	Patients are confident that they have received the best possible treatment out to completion, along with smooth patient pathway being well planning from patients POV.
Ability to introduce new service developments	UB	Ability to introduce new service developments.
Better collaboration across the system	UB	The opportunity for collaboration across the system, bringing patients, the public and partners together to share best practice and professional expertise.
Integrated remote working	UB	Ability to implement integrated remote working will allow clinical experts to interact with complex cases (or any cases) even if they are not geographically proximate to the hospital.
Organisational ambition and vision	UB	Commitment to the long-term aim of the Trust to be a provider of best care for the community.
Higher community staffing	UB	7-day integrated discharge which results in lower community wards being used and higher staffing requirements.
Release land / Local Authority partnership working	UB	Ability to release land for development opportunities.

Appendix A: Initial benefits which were not reviewed

Benefit	Type	Description
Improving health of local population	SB	Improved health of the local population through better quality of care and further health gain in terms of social deprivation.
Economic cost to society	SB	Lost Economic value associated with long waiting times.
Research & Innovation (R&I)	UB	<p>Generation of additional R&I income via increased and dedicated capacity to deliver R&I activity.</p> <p>Improved patient outcomes from inclusion in clinical research. Increased staff attraction and retention resulting from increased R&I reputation, contributing to a more capable substantive staff base and the delivery of quality care.</p> <p>Improved investability as a whole resulting from greater R&I reputation and faster achievement of targets, attracting future revenue and capital funding for the wider system.</p>
Use of Big Data - Nurse Call Systems	UB	<p>Holistic Healthcare approach is on the rise. This approach provides support that looks at the whole person and recognises each patient's unique physical, mental and emotional needs. To make a holistic approach work, the medical personnel need to operate with a range of different information about the patient.</p> <p>Handling all this information can elongate the healthcare process and waste valuable time. Modern nurse call systems are well equipped and offers advanced information and communication solutions through use of big data.</p>
Increased quality of care - Elderly	UB	7-day elective services results in an increase in the quality of care people receive, as opposed to the quality of their treatment. Admitted patients are often elderly and vulnerable, making it even more important that they are cared for with compassion and respect.
Affordable Housing	UB	2021/2022 statistics show 104,545 households are on the waiting list for Social Housing in West Midlands. The Homes England development is assisting this issue by ensuring 30% of the development is affordable housing.
Strengthening local relationships	UB	Strengthening local relationships with GPs, making community services work, working to integrate them into a new system.

Appendix B: Initial benefits which have been removed

Within the MMUH re-baselining, which was undertaken in January 2025, there were several benefits included in the PwC report which have since been removed. A summary of these benefits and their impact on the expected benefits has been summarised below. The total impact to the expected benefits was £148.8m.

Benefit	Rationale for removing benefit	Impact to the expected benefits (000s)
International Nurses GVA - 300 Nurses	<p>Feedback from interviewees identified that there has been a strategic move away from the recruitment of international nurses, with an imminent focus on local recruitment to support MMUH.</p> <p>40 of the international nurses identified in the PwC report that were already recruited have since been attributed to supporting the workforce during the Covid-19 pandemic and were not related to MMUH.</p>	(£132,658)
Productivity Increase - Consultant Journey Time	<p>This benefit was removed from the re-baseline on the basis that it would not be delivered. Based on current practice, Consultants are still traveling between hospital sites.</p> <p>Productivity increases are expected to evolve into benefits, measured in relation to the Productivity Plan / Elective Hub.</p>	(£11,731)
Phase 2 Benefit - Fundamentals of Care Roles	Based on feedback during re-baselining, the impact of the logistics work has not been recognised with regards to nursing teams and thus has been removed.	(£4,380)
Phase 2 Benefit - Fundamentals of Care Hours Saved	As above	13,824 hours saved

Appendix C: List of interviews held

As part of this review, we conducted sessions to examine assumptions with benefit owners and to understand the processes used to determine methodologies and areas of scope. During our review, we held meetings with the following individuals:

Name	Role
Rachel Barlow	Managing Director MMUH and SRO
Simon Sheppard	Acting Chief Finance Officer and Benefits Workstream Lead
Warren Grigg	Director of Estates Development
Mick Laverty	Non-Executive Director and Chair of the MMUH Opening Committee
Tim Reardon	Finance Lead – Benefits
Austin Bell	Project Director
Mel Roberts	Chief Nursing Officer
Jo Newens	Chief Operating Officer
Meagan Fernandes	Director of People and OD

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Tier 1 - Paper ref: PublicTB (03/25) 006

Report title:	MMUH Closure – Programme Assurance Review (PAR)
Sponsoring executive:	Rachel Barlow, Managing Director MMUH Programme Company
Report author:	Rachel Barlow, Managing Director MMUH Programme Company
Meeting title:	Public Trust Board
Date:	12 th March 2025

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

As part of ongoing learning and assurance, the Managing Director for the MMUH Programme Company (also the Senior Responsible Officer SRO) commissioned an independent Programme Assurance Review (PAR) as part of the MMUH Programme Closure. This is in line with the Infrastructure Project Authority (IPA) independent assurance process. Different to the IPA Gate Reviews, a PAR is commissioned by the Senior Responsible Officer against a set of key lines of enquiry. The intention of this was to add an independent view to the Programme Closure activities.

The attached paper is the output report. The review commended and recognised many areas of exemplar work and best practice.

The recommendations and suggestions all have action owners with roles and accountability in the core Trust structure to ensure these are actively pursued post programme closure.

The paper was reasonably assured at the MMUH Opening 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?]*

MMUH Opening Committee

4. Recommendation(s)

The Public Trust Board is asked to:
a) **RECEIVE** and **ACKNOWLEDGE** the PAR report

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

Draft NHP Report – MMUH Post Go Live Review

Post Go Live Informal Review Midland Metropolitan University Hospital(MMUH) February 2025

Report Version:	Draft 0.1
Senior Responsible Owner (SRO):	Rachel Barlow, Managing Director, MMUH Programme Company
Programme or Project Title	Midland Metropolitan University Hospital
Does this review cover the entire Project / Programme?	No – Post Go Live review against stated Key Lines of Enquiry (KLOEs)
Programme/Project Director (or equivalent):	
Planned date of opening to patients:	Opened October 2024
Decision/approval point this report informs:	Post Go Live Project Review
Review Start Date:	10 February 2025
Review End Date:	10 February 2025
Review Team Executive	Josie Rudman, Director Transformation, NHP
Review Team Leader:	Eamonn Sullivan, Director Clinical Transformation, NHP
Review Team Members:	Michael Barker, Senior Clinical & Strategy Advisor, NHP Cheryl Riotto, Deputy Director, Clinical, NHP Elaine Turner, Deputy Director, Workforce, NHP Sue McIntosh, Assistant Director: Hospital Operations, NHP Iain Fletcher, Head of Digital Engagement, NHP Colin Mapperley, NHP Technical EFM Consultant, NHP
Previous Review:	IPA Gateway 4

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Draft NHP Report – MMUH Post Go Live Review

Contents

Contents

1. Summary of Findings	3
2. Summary Suggestions and Recommendations.....	4
3. Comments from the SRO.....	7
4. Background.....	9
5. Review Team findings.....	9
5.1. Clinical Transformation of Services and Safe Embedding.....	9
5.2 Operational and Workforce: Readiness for Service.....	11
5.3 Activation and Move.....	12
5.4 Workforce and Safe Staffing.....	13
5.5 Hard and Soft Facilities Management Readiness.....	14
5.6 Digital opportunities	16
5.7 Communications and Engagement.....	17
5.8 Programme Structure and Leadership.....	19
6. Acknowledgement.....	21
7. Next Assurance Review.....	21
ANNEX A - Terms of Reference for Review.....	22
ANNEX B - Background.....	25
ANNEX C – List of Interviewees.....	27

About this report

This report is an evidence-based snapshot of the scheme's status in terms of operational readiness at the time of the review. It reflects the views of the independent review team, based on information evaluated over the review period, and is delivered to the Senior Responsible officer (SRO) following the conclusion of the review.

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1. Summary of Findings

Current RAG Rating: no RAG rating is given as part of this Review

This Review was commissioned by the Managing Director of the Midland Metropolitan University Hospital (MMUH) Programme as the Senior Responsible Officer (SRO) for the Programme. The terms of reference (Appendix A) were focused on findings, reflections and lessons learned, in particular with reference to the immediate run up to opening and the period thereafter. It did not include build performance indicators or finance.

The Review team heard how a unitary vision and purpose were the galvanising forces that kept the belief in the project team and wider workforce over the long life of this Programme. The Programme was further anchored in the 'More than a Hospital' philosophy. This means building an enduring legacy for the local community, which has already seen the creation of jobs, and working with the Councils to improve local transport routes.

A culture of openness and mutual respect was fostered by the SRO; the positive power of which can't be underestimated.

The Review Team heard how the Programme used delays in construction to focus on extensive clinical and other transformation and to prepare meticulously for the move and early operations. The moves from 2 separate district general hospitals to a single acute site were completed successfully in 2024.

The Programme's approach to risk management was also exemplary in now only handing over 3 active risks to the Trust. The Review Team considers this a success and applauds all the Programme Company and Trust staff on this significant achievement.

The Review Team identified areas of innovation and forward-focused thinking, such as the approach to marketing and communications, work within Soft FM using Digital workers as well as the work on frailty and other clinical pathway transformation such as ensuring only patients who need to stay in hospital do so.

The report is commissioned by and drafted for the SRO and is shared at her discretion. It is the expectation it will be shared with the MMUH Opening Committee, a Trust Board Committee. NHP is happy for this report to be referenced in MMUH's Project Closure Report which will be shared with the Trust Board, ICB Boards and NHP Executive Board.

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2. Summary Suggestions and Recommendations

The report includes Reflections, Suggestions, Lessons and Recommendations. The Suggestions and Recommendations are listed here for ease of access. It is suggested the Trust consider how it might like to follow these up. Reflections are areas of good practise. Lessons are largely for learning beyond MMUH, and will be used by NHP in their work with other NHP schemes.

Ref	Finding	Reflection, suggestion or lesson	Action
1	MMUH works with NHP to explore opportunities for formal data gathering and research around clinical outcomes of the new facility.	Recommendation	The Trust is committed to design a research programme related to MMUH. There is an initial research scoping meeting scheduled in March 2024. The Trust request NHP provide a named contact who the Trust can work with on this. Action Owner: Rachel Barlow, Managing Director.
2	Clarity of the formula/ methodology used to determine safer staffing numbers for wards with single bedrooms to then establish effectiveness and impact on safer staffing numbers following teams having embedded in the new working environment.	Suggestion	The methodology for nurse staffing on wards was documented as part of the workforce planning and supporting QIAs. The Chief Nursing Officer is committed to review the establishment and workforce model in the first year of opening. Action Owner: Melanie Roberts, Chief Nursing Officer.
3	In the context of delayed implementation of AGVs, consider enhancing training and monitoring of staff deployed to do the work manually.	Suggestion	The Logistics project will continue post MMUH Programme Closure, chaired by the Chief Finance Officer and attendance by the MMUH Managing Director. The implementation plan for AGVs is part of the project. The implementation proposal

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			<p>will be considered in an early March 2025 Project meeting.</p> <p>Action Owner: Simon Sheppard, Chief Finance Officer.</p>
4	<p>Develop a plan to implement AGVs at an appropriate time so as to contain the damage to fire doors and smoke seals of using metal cages.</p>	Recommendation	<p>Response as above.</p> <p>Damage to fire door is part of the Estates snagging schedule post move. A risk assessment will be completed by the start of March 2024 following a full survey.</p> <p>Action Owner: Rachel Barlow, Managing Director.</p>
5	<p>Trust to seek additional Digital investment to link BIM and multiple other EFM-related systems together to progress towards achieving Smart Enterprise Asset Management (SEAM). This will improve the effectiveness and efficiency of managing the estate in the future. Help and advice is available from the NHP EFM and Smart Building teams.</p>	Suggestion	<p>Director of Estates Development supported by the Director of IT to work with NHP EFM to write a proposal and business case to seek additional digital investment to link BIM and other EFM IT systems.</p> <p>Action Owner: Warren Grigg, Director of Estates Development.</p>
6	<p>Focus on developing the capabilities of asset and people tracking to develop benefits relating to operational efficiency, staff and patient experience and safety and quality of care.</p>	Suggestion	<p>Director of IT to write a proposal to develop capabilities for asset and people tracking to develop the benefits case further.</p> <p>Action Owner: Mark Taylor, Director of IT.</p>
7	<p>To fully maximise the ability for MMUH to deliver its digital ambitions investment will be needed with an appropriate budget and programme of work to include further integration and optimisation of its systems and user experience.</p>	Recommendation	<p>The Trust would like to benchmark the Hospital 2.0 digital plans against MMUH to inform digital optimisation plans and cases for investment.</p>

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			Action Owner; Mark Taylor, Director of IT.
8	The Trust takes some time to consider the move from transformational change driven by a particular event (the move) to evolutionary change driven by the long term benefits of the investment and the pursuit of operational excellence.	Suggestion	The KLOE did not include longer term benefits delivery which is subject to an external specialist review. The Trust have an agreed benefits realisation delivery and oversight structure and are committed to continue to track and optimise benefits delivery. The Trust will report benefits in the annual report. Action Owner: Rachel Barlow, Managing Director.

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3. Comments from the SRO

SRO Comments

The PAR was commissioned by the Managing Director of the MMUH Programme Company as the Senior Responsible Officer (SRO). The Review was very much welcomed as part of the process to close the programme in March 2025 and the transition of on-going benefits delivery to Trust.

The Managing Director was pleased to receive the feedback, informed through the Review Team interviewing 13 Trust staff. The Key Lines of Enquiry excluded construction, finance and benefits, the latter of which is subject to a separate external specialist review commissioned by the SRO.

The Managing Director was delighted to receive the commendations and recognition of exemplar work and best practice in relation to:

- Clinical transformation inclusive of the new Frailty Service. Avoidable hospital stay has resulted in the avoidance of 78 acute beds being used.
- The pre move patient census approach which avoided unnecessary patient transfers to MMUH.
- Effective partnership working with partners including HCR, the move partner.
- How a compelling programme vision materially makes a positive difference to engaging staff.
- Recognition of developing effective relationships with the Hard FM provider which had previously been challenging and subject of a critical recommendation in the PAR October 2023.
- Excellence in water safety commissioning.
- The transformation of the new integrated Soft FM teams being universally praised.
- The use of MSP methodology and establishment of the MMUH Programme Company which enabled capacity to deliver a complex programme. This included constructive relationships working through formal governance arrangements to deliver transformation and a successful move.
- The effectiveness of the mass population campaign to support a safe opening of MMUH.

The learning from the impact of a compressed activation period has been recognised in report and it is hoped that future new hospital projects can use this learning to inform safe and realistic activation plans.

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The AGV roll out was postponed due to the impact of delayed planned completion and compressed activation. The Logistics project will continue in 2025 and will oversee a safe AGV implementation, as well as the associate benefits realisation.

MMUH opened with SMART enabling infrastructure but without active SMART technology due to a lack of investment. The Trust would like to work with NHP to benchmark the Hospital 2.0 digital plan against MMUH to inform future investment cases.

As part of learning and benefits realisation, the Trust are currently scoping research priorities related to MMUH and again would like to work in partnership with NHP to inform and potentially jointly commission research.

The Trust would like to thank the Review Team for their time and feedback.

Draft NHP Report – MMUH Post Go Live Review

4. Background

Following a long and very difficult construction Programme, patients moved into the new Midland Metropolitan University Hospital in two stages in October and November 2024. The Review Team heard how the Programme used delays in construction to focus on extensive clinical and other transformation and to prepare meticulously for the move and early operations. The moves from 2 separate district general hospitals to a single acute site were completed successfully. At time of writing, there have been no serious incidents. Operational and clinical indicators show no (statistically significant) deterioration in safety or other measures and improvements in some areas. The Review Team considers this a success and applauds the Programme Company and Trust staff on this momentous achievement.

This Review was commissioned by the SRO of the MMUH Programme. The Terms of Reference have been set by the SRO and discussed and agreed with NHP. NHP assembled a team of reviewers who are members of NHP but have not been directly involved with the project to complete it. It was based on evidence gathered from pre-reading material provided by the Trust and interviews conducted with a range of senior interviewees on Monday 10 February 2025. Estates and Facilities Management and Digital Subject Matter Experts (SMEs) completed a site tour of specifically relevant areas. All Reviewers were invited to join a short tour of the facility including visiting a ward and maternity.

The scope of the interview was shaped by the Terms of Reference (ToR) provided by the SRO. These are provided at Appendix A. The ToRs were not fully explored due to time constraints. The Review was focused on preparation for go live, the period immediately following opening and did not include consideration of construction or finance.

This report is centred around “Reflections”, “Suggestions”, “Recommendations” and “Lessons”. “Reflections” identify successes and areas of good practice, “Suggestions” identify points which the Review Team thought would be helpful to the Trust moving forward. “Recommendations” are actions NHP would advise the Trust to complete. “Lessons” are learning points which NHP will use for the benefit of other MHP schemes.

5. Review Team findings

5.1. Clinical Transformation of Services and Safe Embedding

Clinical transformation was a key workstream for MMUH as fitting the numbers of beds in the new facility depended on changes to models of care and care pathways.

The Review Team heard about the extensive work invested into clinical transformation for a period of around two years ahead of MMUH opening. The Team was able to capitalise on their status as an integrated Trust to “pump prime” Community and Primary Care services (e.g. Community Frailty service) in preparation for changes in models of care and support from Community services was key to the clinical transformation. Over all the use of 78 beds has been avoided.

Particular progress was made in the area of Frailty: MMUH now provides a 12 hour, 7/day service for frailty in partnership with Social Care to establish the right package of care for a patient up front – rather than admitting to a general medical bed. This has resulted in many avoided admissions and “created” a capacity of approximately 29 beds.

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In the period ahead of moving, particular effort was invested into ensuring only patients who had to be in hospital were moved. A series of “patient censuses” were held, comprising a daily review over 6 days of each inpatient, centred around the question of whether the patient needed to be in hospital. It was Consultant-led, with a Deputy Chief Medical Officer reviewing and challenging other Consultant led multiprofessional teams as to the reason for a patient to remain in hospital. A large multi-disciplinary team including Community and Social Care participated. As a result, the Trust planned to move 679 patients – but actually moved 327 patients. Elements of this have been carried into the new facility to ensure only patients who need to stay in hospital do so. The Review Team heard how effectively other providers across the local health system such as Social Care supported the Trust during this work.

The Trust moved into the new facility in October and November 2024 and did not need to use the additional beds which had been identified as a contingency during winter to support the post move period. The use of the increased winter bed profile played out as forecast. This is a major achievement and indicates the success in the implementation of new models of care. The Review Team heard about the significant amount of planning and preparation which contributed to this successful outcome (see Operational and Workforce: Readiness for Service below).

In the months immediately post opening, productivity dropped as was expected and planned for. It was noted that the specialist move company Health Care Relocations (HCR) had suggested MMUH’s plans for productivity to recover were optimistic and this turned out to be correct. Productivity has improved each month since opening – but at a slower rate than originally anticipated.

Interviewees reflected on the amount of change which has been successfully delivered in the period prior to opening the new facility. The drive for this appeared to be rooted in the major event of preparing to move to a new facility and supported by the “head space” provided to key Programme leaders through the vehicle of the Programme Company. The Review Team heard that successfully moving into the new facility and embedding new service models is regarded as a beginning for service transformation, not an end: there remains an opportunity and appetite to continue to transform care and deliver better outcomes for patients. Maintaining momentum poses a challenge since without the catalyst of a major event there is a risk that the push for change will decrease. It was noted that the COVID-19 pandemic also provided a real catalyst for change, in particular breaking down barriers between professions and institutions and this helped MMUH in its transformation. The importance of focusing on long term benefits was noted together with the powerful narrative which can be created by successful on-going delivery.

The Reviews Team heard there is an appetite at MMUH to gather evidence on the clinical impact of the new facility – for example anecdotally, infection rates for the winter respiratory infections appear to have reduced but interviewees were keen to be able to confirm this with more rigorous data and research. This is quite difficult to do, and some support to develop a research programme would be valued.

Reflection: cross functional and multi-disciplinary working were key to the successful clinical transformation and reducing bed usage.

Reflection: major events (positive or negative) provide a catalyst for extensive change and for engagement with change amongst staff. MMUH used them effectively to make transformational change happen.

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Reflection: there is a safety benefit in discharging as many patients as possible as this reduces the number of patients who must be moved. MMUH has demonstrated this is possible but takes wide participation and a willingness for challenge between clinical colleagues.

Lesson: productivity dips following changes related to the move period; it is important to be realistic about the length of time it takes for the change to embed and productivity to rise.

Recommendation: MMUH works with NHP to explore opportunities for formal data gathering and research around clinical outcomes of the new facility.

5.2 Operational and Workforce: Readiness for Service

The Review Team heard consistent praise of the remarkable resilience, support, positivity and practical approach of their staff. This manifested itself before, during and after the move. During a short tour of the new facility, the Review Team heard staff talk about how they had adjusted to the new facility and new ways of working and were positive about their experience and new environment.

The Review Team heard about the considerable amount of work that had been completed in preparation for the move to the new facility and interviewees emphasised the amount and importance of this work. The Leadership Team had created a vision for the new MMUH which was widely and consistently communicated and with which staff engaged positively. The importance of this positivity was acknowledged and appeared to translate into the attitudes demonstrated by staff and their willingness to react pragmatically and constructively to early (normal) challenges associated with the move.

Considerable resource and effort were invested in staff preparation. Review Team heard about cross-disciplinary desktop simulations for 41 critical clinical “flows” ahead of the move. Bringing different staff together into a single room (including Nurses, Doctors, Radiographers, Pharmacists, Soft FM and others) for an exercise centred around key pathways allowed for discussion and for “wrinkles to be ironed out”. Twelve flows were then worked through “in situ” in the new facility. This was a risk-based exercise led by the Deputy Chief Medical Officer, the Deputy Chief Nursing Officer and the Chief Safety Officer looking at whether risks had increased, decreased or changed at each step of the pathway. In the weeks following the move, the safety profile remained the same or reduced and indicators (as laid out in the 100 Day Report) show most indicators stable or improving.

Interviewees commented on the importance of Organisational Development (OD), the length of time it took and the investment of resource and time into it. This was universally regarded as an investment well made, contributing to the success of the move in the early weeks in the new facility. OD was both generic (available as a “kit”) but tailored to individual groups in terms of timing. The OD process was credited with giving staff time to come to terms with the change as well as familiarising themselves with new processes and the new facility. Review Team heard consistently that the value of OD should not be underestimated, nor the time and effort that should be invested in it.

The Review Team heard that some workforce and OD work started late due to senior staffing and resource issues shortening the work required to be done from over 12 months or more to a few months prior to the move. This created an unnecessary and avoidable “mad dash” to complete OD work in time for opening.

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Reflection: a compelling and commonly understood Programme vision can make a material difference to staff positivity which in turn influences actions.

Reflection: MMUH invested significant resource and time into preparation (both operational and people). This was a key strand of work and credited for making the move and the post move period a success.

Reflection: with delivery dates constantly being flexed, and with no suitable off-site storage planned, getting equipment into the new build was challenge.

Lesson: begin workforce and OD work as early as possible and at least 12 months prior to the planned move.

5.3 Activation and Move

The Review Team heard of the successful moves using an external move company Health Care Relocations (HCR) with the 2nd move, 1 month after initial occupation, being “almost seamless”. Staff engagement with the actual move was proactive, with a huge amount of pre-planning including with the patient census prior to each move (see 5.1. Clinical Transformation of Services and Safe Embedding). Using HCR meant that all aspects of risk as a result of the move were managed well. A subsequent value for money exercise in using HCR for the planning and move due to their extensive experience of similar hospital moves internationally since the 1990s has shown that it was a good investment which delivered exactly as promised.

The Review Team heard that the decision to move with a 6-week full activation period (post Construction Planned Contract Completion and building handover) put pressure on teams relating to preparation, inductions and ensuring that the move would happen.

The activation and move was led by a dedicated ‘commissioning team’ who led on induction, activation, equipping, and the physical move (service relocation) of patients and all items of furniture and equipment required. The elements were well-co-ordinated with learning points including the value of visiting other sites during moves led by HCR (first-hand experience), starting the move plan early (2 years before the move took place) , the importance of some of the MMUH commissioning team coming from a clinical background so that conversations with clinicians could happen in a fluent way, trial runs of patient moves with MMUH staff to identify best routes and mitigations to risks and having a dedicated commissioning team properly funded.

The Review Team heard of the value of ‘beneficial access’ so that staff, contractors and other relevant stakeholders could access the building to plan/complete specific work in a soft activation period which commenced 6 months before the move. This allowed some activation activities to take place ahead of Planned Contract Completion which enabled a short full activation period. Support from other providers during the move, in particular West Midlands Ambulance Service was noted.

It should be noted “soft” activation was a compromise used as a mitigation to protect a 2024 opening. The combination of soft activation and the 6 week full activation was the best available approach to allow for completion on site scenario testing, inductions and loading of the building in advance of patient day 1. A 6 month activation period is recommended for this scale of project.

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The Review Team heard the full activation period was too short (6 weeks) compromising staff induction, the distribution of furniture and stock, as well as delaying the implementation of an automated logistics service. Ideally the activation period would have been a minimum of 6 months due to size of the hospital and numbers of staff. In retrospect, the Trust team would not repeat the soft activation to the extent they did.

Reflection: use of an external company – Health Care Relocations – provided Value For Money (VFM) and was successful in engaging staff, managing risks, reducing numbers of patients to be moved and ensuring a safe and efficient move.

Lesson: provide 6 months between announcing the definitive move date and the move itself to reduce unnecessary pressure on teams and impact on staff.

Lesson: do not advocate soft activation as a compromise to activation. It should only be considered in extremis under a full risk assessment to understand the associated impact and consequences.

Reflection: set up of a Commissioning Team ensured clear ownership and oversight on key aspects and requirements for a safe and successful activation.

Reflection: including clinicians in the Commissioning Team supports effective communication between the Commissioning Team and clinicians which reduces clinical risks.

Reflection: beneficial access to the new building during construction enabled a variety of visits and activities could be carried out to shorten the time that would have been otherwise required for activation.

5.4 Workforce and Safe Staffing

The Review Team heard that staff were tired with the negative impact of continuous change and a balance needed for on-going progress. We heard of the health and well being impact on the MMUH project team after go-live, many had been working heroically going the extra mile 7 days a week in the lead up to the move.

Retained estate staff were considered as the move to the new building could have alienate staff remaining in older estates – communications were critical to ensuring no one felt left out. The campaign 'Get Set for Midland Met' was used to bring everyone together as well as issuing new ID badges and pin badges with 'Midland Metropolitan' on them to help with creating a single identity (see also 6.5 Communications and Engagement).

The Review Team asked for information on the staffing model around single bed rooms (wards are 32 beds with 50% side rooms) . There are 4 Registered Nurses, 4 Healthcare Assistants and 2 super-numerary Senior Nurses per shift (daytime) within ward settings. The staffing was bolstered in recognition that the supernumerary staff were not in place pre-move and is a required standard and the healthcare assistant numbers were the real area modified. It would be helpful to understand the formula/methodology behind this and to establish how this is working in terms of safer staffing numbers now that the teams are embedding working practices post occupation. The serial workforce establishment review was conducted pre-move but Review Team heard that a further planned review of the safer staffing was an area that the Chief Nurse and team were committed to.

The Review Team heard about the creation of the term 'digital worker' to describe the set of skills of a job/role which could be undertaken by Artificial Intelligence (AI). This has enabled

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conversations about skillsets in a less threatening manner in terms of staff feeling that AI will take over parts of their roles.

The Review Team heard that early engagement of trade unions would have been helpful to align on the approach and communication/engagement with staff.

Successes included an internal recruitment drive ahead of opening, leadership training for 600 leaders and team member training for over 700 staff, seen an improvement in key worker KPIs (e.g. reduction in ED staff turnover from 13.5% to 5.7% post OD intervention, and a reduction in staff turnover from an average of 14% in 2022 to 9.8% in January) and sickness rates reducing. Interviewees cited the biggest achievement as delivering management of change for over 6900 staff and improved people metrics.

Induction and move champions were identified once a move time known (even if date not identified) as they were needed to counter any staff turnover/absences. Staff were asked to nominate these so that they represented the workforce in each area and were representatives of the staff, chosen by the staff.

Lesson: the impact of the health and wellbeing of staff, attributed to working 7-day weeks in a pressured 6-week lead up to moving to the new site. Consideration for impact on workforce and increase the move window to 6 months to reduce the negative impact on the workforce.

Reflection: proactive and targeted engagement of staff who were remaining in older estates reduced alienation and discord amongst the workforce. Use of 'Get Set for Midland Met' campaign and providing new badges to all staff were good and effective tools.

Suggestion: clarity of the formula/methodology used to determine safer staffing numbers for wards with single bedrooms to then establish effectiveness and impact on safer staffing numbers following teams having embedded in the new working environment.

Reflection: use of 'digital worker' creates a positive conversation about skillset and different roles who can fulfil tasks with the required skills.

Lesson: earlier engagement of trade unions would have helped with alignment and staff engagement.

Reflection: leadership training and internal recruitment drive supported with reducing staff turnover and sickness rates.

Reflection: teams were asked to nominate induction and move champions so that they were trusted and empowered to represent their teams.

5.5 Hard and Soft Facilities Management Readiness

A Trust priority for the successful opening of the Hospital was an estates team who were trained, familiar with the building layout and the distribution of the mechanical and electrical plant (MEP) whilst still maintaining BAU on the existing hospital sites.

The Trust estates team worked hard to build a good relationship with the Hard FM provider, which enabled some robust discussions to take place to establish what resources were required. While this did come at a financial cost, the Trust were able to direct where this investment went. An example of this was to increase the presence on-site of the Building Management System (BMS) specialist from two days a week to five days. This brought benefits both in resolving problems quickly and training maintenance staff in how to

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interrogate the BMS to resolve issues in the future. Whilst looking at the BMS, the Review Team noted there were several other digital systems including fire alarm, emergency lighting, LV and HV monitoring but these were each separate systems which didn't 'talk' to each other. To achieve Smart Enterprise Asset Management (SEAM), these systems plus others and the Building Information Modeling (BIM) need linking together to optimise day-to-day running and future planning. Ideally, this data should be owned by MMUH and not with its providers. This will require additional investment but will improve the effectiveness and efficiency of managing the estate in the future.

The Trust leadership were able to showcase an integrated and robust approach to water safety and in particular both the Estates and clinical teams were very aware of the importance of water safety and focused on measures to control waterborne bacteria such as Legionella and Pseudomonas. The early appointment of the Authorising Engineer (AE) for water safety to advise and help put plans in place was felt to be beneficial. The Review Team heard that while still in the construction phase of the project, the main contractor agreed to a sampling and testing regime for the domestic hot and cold-water systems. This was implemented once systems became live in the building, not at the point of commissioning, which was later. The BMS was used to monitor temperatures with sensors giving early warning of any issues. In addition, Review Team heard about the importance of the role the Director of Infection Prevention and Control (DIPC) has had in driving water and wastewater safety during the hospital development. Review Team applauds the operational practices to maintain open dialogue and understanding of this very dynamic issue, which appears to have had a real impact on water safety. The team is proud no issues have been encountered to date.

The in-house Soft FM teams (catering, housekeeping, portering and security) had been split between various areas. These services were brought together as one team within the Hard and Soft FM support team. Review Team heard this change has delivered several benefits. The teams demonstrated a great desire to protect and look after the building and keep it in the condition as when it opened. The housekeeping team assisted with flushing of taps and reporting defects. Staff have taken opportunities to progress their career by moving to supervisory roles, perhaps in different disciplines in Soft FM. Apprenticeships have been introduced, giving staff the opportunity to develop their skills under a formal and recognised structure with a qualification. There were challenges around staffing numbers especially when preparing to open the new site and carrying on with BAU. Staff rose to challenge and worked extra hours to help. Recruitment of new staff has taken place and retention rates are high. There is a great sense of pride in the new building, and this is reflected in good scores for National Standards Cleaning Audits, and patient feedback from catering questionnaires and the improvement to service to wards was commented on.

The Reviewers asked about the Automatic Guide Vehicles (AGVs) to assist with delivery of supplies, linen and collection of waste. The vehicles were not introduced from day one as it was felt to be one too many transformational changes in the pressured 6 week full activation period. With staff, patients and visitors still getting familiar with the building layout, adding guide vehicles into the mix was a step too far and it was agreed not to go live. Plans are currently being put in place to bring them into operation. The review team received comments about some of the fire doors being damaged due to cages being pushed manually in place of the AGV's. The cages were being pushed through the doors rather than being opened first. This does need to be resolved as soon as possible as many of the doors are fire doors and the smoke seals are being damaged.

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Reflection: the close relationship established with the outsourced Estates provider was important in maintaining standards and resolving issues rapidly. This reflects the hard work from the Trust as previous reviews (e.g. PAR) identified challenges in this area

Reflection: the robust, cross discipline approach to water safety clearly paid dividends in the absence of water safety issues in the new facility.

Reflection: the transformation of the Soft FM teams was referenced by a range of interviewees and universally praised, from the increased opportunities and pride for Soft FM staff to the observed improvement in cleaning standards and service to wards

Suggestion: in the context of delayed implementation of AGVs, consider enhancing training and monitoring of staff deployed to do the work manually.

Recommendation: Develop a plan to implement AGVs at an appropriate time so as to contain the damage to fire doors and smoke seals of using metal cages.

Suggestion: Trust to seek additional Digital investment to link BIM and multiple other EFM-related systems together to progress towards achieving Smart Enterprise Asset Management (SEAM). This will improve the effectiveness and efficiency of managing the estate in the future. Help and advice is available from the NHP EFM and Smart Building teams.

5.6 Digital opportunities

The Review Team heard about benefits of a single senior IT Lead having cross-cutting role in both the IT Senior Leadership Team but also being the specific IT Lead for MMUH. This ability to lead and influence at a senior level was a key factor in ensuring the digital infrastructure was in place and did not cause any delays to go-live, a major objective for the team.

The importance of People, Processes and Technology was highlighted during the visit. For People, there was a specific IT lead for each work area, so they were involved in both planning the technology roll-out but also ensuring staff received the end user devices. For the process element there were regular IT commissioning meetings which, in addition to the multi-disciplinary teams, involved Balfour Beatty. For Technology, delivering the network infrastructure on time was key and beneficial access helped the Trust implement the system configuration. However, this focus on an effective go-live did mean that certain technologies such as the asset tracking had to be pushed back. This will be a crucial development in the future to help manage the tracking of assets and also potentially track patients and staff if required.

Unlike the legacy estate, the new building enjoys a strong technology infrastructure, meaning that Wi-Fi / 5G reaches all the clinical areas – there are no blackspots. This focused use of limited funds puts the Trust in a good position to capitalise on other technology should funding become available.

As well as focusing on the building's digital fabric, the team has also been supporting virtual working and there are now 500 community-based workers with new 5G-enabled laptops.

The MMUH IT Team should be recognised for its excellent work in ensuring the new hospital was digitally enabled from day one, in particular having to plan its digital needs 15 years

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ahead of go-live, it has not been able to benefit from the more recent development of the NHP Hospital 2.0 Digital Ambition and Intelligent Hospital Capabilities.

For MMUH to continue to build and continue its digital transformation it will need to invest further to realise the full benefits of improving outcomes for patients and staff productivity. It will need to ensure it has an appropriate budget for the scope of any further changes planned.

The Trust should look to focus on further integrating and optimising its systems and user experience. Without this it will take much longer to realise any benefits. The NHP Digital Team would be happy to help with any Intelligent Hospital Capabilities and Smart Buildings gap analysis work to identify where future improvements could be made and help the Trust develop a refreshed digital and data roadmap.

The MMUH team has consistently been keen to share its digital good practice and lessons learned with programme staff and other schemes, including presentations at Communities of Practice and developing case studies.

Suggestion: focus on developing the capabilities of asset and people tracking to develop benefits relating to operational efficiency, staff and patient experience and safety and quality of care.

Reflection: The ‘new geography, not new technology’ strapline helped reduce anxiety amongst staff about the move to a new building and using digital products there.

Reflection: Be aware of how staff utilise digital tools in successive ‘generations’ – how initial users are trained in using the technology may be quite different to how successive groups of clinical and other staff use it.

Lesson: Plan beyond the capital outlay for technology – think about licensing costs afterwards. Also check network terms in the contract and build resilience into the network.

Lesson: Don’t underestimate the systems configuration work – put in the resource up front well before any go live. Team was planning for switchover for 3 years, including mapping all the ward areas to end user devices.

Recommendation: to fully maximise the ability for MMUH to deliver its digital ambitions investment will be needed with an appropriate budget and programme of work to include further integration and optimisation of its systems and user experience.

5.7 Communications and Engagement

The Review Team heard about the highly structured approach taken to Communications. The Trust acknowledged it did not have the skills internally to deliver the extensive and complex campaign required and so engaged an external agency to help deliver the campaign to the widest possible audience. The campaign was based on professional marketing approaches such as detailed research of the target audience and subsequent segmentation resulting in multiple channels being used for maximum coverage. The success of the overall campaign is reflected in the absence of negative local headlines, a significant achievement in the context of two EDs being closed.

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The Review Team heard about approaches taken to prevent messages relating to the new MMUH and the move “getting lost” in wider Trust communications. As well as using dedicated email bulletins (weekly initially, rising to daily as the move became closer), the Communications Team also used ‘MMUH corners’ with information boards in each ward/service area, which were deployed to reach staff who are not generally desk-based. The Team also used existing forums such as Facebook and WhatsApp channels and used a line manager group to drive messaging and ensure local ownership (this included staff moving to the new site and those remaining in existing/legacy sites). A video repository was created and added to for staff to see the changes that would happen and the new building (e.g. car parks, restaurant, wards etc).

The Review Team heard about a challenging external stakeholder environment and the meticulous work that had gone into reaching into it. Engagement started early both with specific local neighbourhoods and the wider public, initially on general plans and then focusing on managing the region-wide risk of closing 2 Emergency Departments. The Communications Team used tightly targeted marketing based on language which took account of factors such as reading age and those for whom English is not a first language, geography, nearest hospital site and so on. In addition to using multiple media channels, the Communications Team also used faith groups and community leaders to ensure messages were getting to all impacted sections of the population. The Review Team heard that the efficacy of this approach could be demonstrated by metrics which were gathered by the Agency.

Communications did not stop with the opening of the new facility. Post go-live communications have now been steered towards conveying the benefits of the scheme to key audiences e.g. reduced length of stay in hospital, frailty pathway and Emergency Department performance.

One important element of the communication work which was highlighted by interviewees was that of 2-way communication. By making sure there were clear and open pathways to communication into the Programme by those impacted, the Communications Team were able to establish a “dialogue” with staff impacted by the change. This allowed staff to raise concerns which could be resolved or responded to and enabled effective myth-busting.

Reflection: the professional, “marketing style” approach to communications was effective in reaching many elements of a complex stakeholder group, in particular the detailed analysis of audience groups which enabled messages and channels to be effectively targeted.

Reflection: rooting communications in the Trust’s strategic objectives helped to reinforce a consistent vision (see also 5.1. Clinical Transformation of Services and Safe Embedding)

Reflection: use of multiple channels including videos, social medial, email and a bus helped MMUH messages to cut through other standard communications

Reflection: Communications Team were a key enabler in the engagement of line managers to prepare for the move and ensure ownership and actions across all teams.

Reflection: appropriate resourcing (staff and finances) and creative autonomy over this work led to novel ways to engage with the widest stakeholder groups required to reduce the risk of the public turning up at the wrong hospital, especially for Emergency Department visits.

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5.8 Programme Structure and Leadership

The Review Team heard that MMUH had created a separate Programme Company, the MMUH Programme Company, to steer the Programme. This was established as a separate entity within the Trust, and worked closely with the core Trust leadership and clinical teams. Formal governance underpinned the right relationship. Key senior posts in the Programme Company (including SRO, Delivery Director) were staffed by senior individuals from the Trust and it included senior nursing and medical representation. The constructive relationships between the Executives in the Programme Company and Executives in the Trust were commented upon.

Establishing a separate Programme Company allowed senior staff the space to invest wholly in the Programme (as opposed to this being an extension of the “day job”) and for them not to be distracted by the challenges of day-to-day operations. It also gave “permission” for the Programme to lead potentially contentious transformational work to change pathways or reduce the number of medical inpatients which resulted in an impressive amount of clinical change which was completed ahead of the move to the new facility.

Some concerns were voiced about the closure of the Programme Company, the potential loss of institutional memory and the loss of impetus to drive change as the organisation settles into business as usual.

MMUH used “Managing Successful Programmes” methodology. Key senior staff within the Programme Company trained themselves on the methodology and used it consistently and effectively to deliver the project. Previous reviews at MMUH including the Infrastructure Projects Authority (IPA) Gateway 4 have commented on the effectiveness of established governance and monitoring.

The Review Team also heard about the natural tension between the Programme Company and the operational workforce – this is unavoidable given the pressures on each entity and was largely well managed (as reflected in the successful opening of the new facility). Close involvement of operational staff throughout the programme is important to build ownership and confidence in the new facility, and finding effective ways to make this time available is a challenge in the context of key clinical and operational staff in an acute hospital.

More broadly, during 17-year development and build window of MMUH, the Commissioner landscape changed materially. Integrated Care Boards (ICBs) replaced Clinical Commissioning Groups (CCGs) in July 2022. The creation of a new commissioning environment in the final 36 months of the Programme was disruptive and there was some loss of institutional memory as well as more established relationships. This disrupted multiple aspects of the local healthcare system. Latterly relationships have normalised.

Suggestion: the Trust takes some time to consider the move from transformational change driven by a particular event (the move) to evolutionary change driven by the long term benefits of the investment and the pursuit of operational excellence.

Reflection: having a separate Programme Company allowed the Programme to continue to drive forward without being diverted by the day-to-day pressures of working as part of an acute Trust.

Reflection: operational and clinical staff from the Trust will be needed to complete a lot of the work for clinical transformation and operational readiness. Effective routes to giving these staff clear time to invest in the project are difficult to establish.

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Lesson: training in MSP (or similar) should be encouraged (or possibly required) for key Programme staff elsewhere

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6. Acknowledgement

Review Team Acknowledgement

The Review Team would like to thank all interviewees for their time, and MMUH colleagues who accommodated the Review Team on the site tours.

The Review Team would like to extend particular thanks to Pat Lee for her help in preparing for the 10th February 2025 and for her support on the day.

7. Next Assurance Review

Next Assurance Review

IPA Gateway 5: Spring 2025

Draft NHP Report – MMUH Post Go Live Review

ANNEX A - Terms of Reference for Review

Workstream 1: Clinical Services

Major transformation was required to deliver the 7 Day Service model, the clinical model and hospital standardisation outlined in the original business case. A reduction in bed days is attributed to circa 25% of the benefits case.

Operational Readiness was a critical success factor to a decision to move and enabling the safe embedding of services.

	Theme	Key lines of enquiry
1	Clinical Service Transformation and safe embedding of services	<p>Confirm the scale of clinical service transformation achieved which was critical to deliver and embed ahead of the move. Evaluate the impact of this work in the context of national LOS and bed capacity.</p> <p>Review the evidence of a safe transfer of services to MMUH, particularly the embedding of the 41 critical clinical pathways.</p>
2	Hospital standardisation	Confirm the Fundamentals of Care Programme impact on hospital standardisation.
3	Operational Readiness	<p>Comment and confirm the impact of the Programmes approach to operational readiness.</p> <p>Review the First 100 Days data set as impact indicators as evidence of safely embedding services.</p>
<h3>Workstream 2: Clinical Support Services</h3> <p>This workstream includes several major investments and transformations of the way clinical support services are provided, that ordinarily would be significant change as a stand alone single project. These include:</p> <ul style="list-style-type: none"> • The formation of a single Soft FM service. • Commissioning of a new technically enabled end to end medicines management service; MMUH is the first hospital to have designed in full end to end medicines management. 		
4	Soft FM readiness	<p>Confirm Soft FM is safely transitioned and embedded as a new service.</p> <ul style="list-style-type: none"> • Confirm effective single leadership plans. • Confirm workforce plans aligned with service model/ demand and capacity plans for MMUH and the Health Campus's are effective. • Explore governance and business information to ensure safe Soft FM services are in place in core organisation.
5	End to end medicines management	<p>Confirm status of implementation of end to end medicines management service.</p> <ul style="list-style-type: none"> • Confirm equipment installation and technical installation status. • Confirm future oversight of project to determine full benefits realisation.

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		<ul style="list-style-type: none"> Confirm commitment and scheduling of the benefits evaluation for this project.
<p>Workstream 3: Workforce</p> <p>Workforce readiness in a significant component of preparedness to open a new hospital and embed the intended clinical model. The workforce model to support the MMUH clinical model was subject to circa £25 million investment; which was a change from the original business case.</p> <p>The Workstream was RAG rated red up to a year before the hospital opened and was subject to investment and mitigation to support adequate workforce readiness.</p>		
6	Route to safe staffing and benefits realisation	<p>The Trust Workforce model increased by 484 staff to support the new clinical model.</p> <ul style="list-style-type: none"> Review the approach to mitigation of the red workstream and comment on the lessons learnt evidence to inform plans and effective risk management for workforce workstream in future (new hospital) projects.
<p>Workstream 4: IT</p> <p>MMUH is designed to be a paper light building. As such the line of enquiry for this workstream is about our digital and staff preparedness to work in a paper light building as well as the ongoing strategic development of SMART technology.</p>		
7	The MMUH is enabled to be developed as a SMART facility and this strategic IT development is integral to the Digital Strategy.	<p>Confirm the transition from the MMUH Programme IT workstream to the Trust Digital Strategy to continue the optimisation of SMART technology.</p> <ul style="list-style-type: none"> What are the key SMART priorities? Have we got the staff/capability and money to do the digital transformation required. What further opportunities are being explored with NHP and NHS Digital?
<p>Workstream 5: Commissioning</p> <p>The workstream included managing activation of the hospital during continued construction delay; the mitigation approach was to review agilely the activation critical path activities and through a change control process, reprofile a soft activation approach that enabled planned completion and the hospital to open in 2024.</p> <p>MMUH is one of the largest hospitals to open in the last decade in the UK. The multi-site move was supported by move partners Health Care Relocations. Logistical plans were to transfer a maximum of circa 600 patients over a 3 stage move.</p>		
8	The Trust had a 6 month activation plans. This was compromised by a delay in Construction and Planned Completion.	<p>Review the approach and risk management to managing the delayed construction and soft activation period vs delay to the hospital opening in 2025.</p>

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9	The MMUH move plans were designed over 3 phases; Sandwell, Maternity, Neonates and Gynaecology; and City.	Review the evidence of the decision to move process, effectiveness of the move day plans and the relevant quality and safety outcomes.
Workstream 6: Estates MMUH is the newest and one of the most technically advanced hospital building infrastructures in the country. The readiness of the Trust Estates Team and Outsourced FM provider to fully and effectively mobilise Hard FM was a critical readiness factor. This context of delayed construction and planned completion was a challenge to the Programme.		
10	Readiness of the Hard FM provider	<p>Confirm the Hard FM readiness and safe transition to full mobilisation of services as successful.</p> <p>Review use of Project Oversight Board and risk management approach to enable safe service mobilisation in a shortened activation period.</p>
Workstream 7: Communications and Engagement The range of internal communications to over 8000 staff and external communications and engagement to 750,000 local members of our population along with hundreds of partners and stakeholders was critical in terms of readiness to move and establishment of our new health service model.		
11	Internal Communications	Confirm the reach and impact of the internal communications during operational readiness and move.
12	External Communications	Confirm the reach and impact of the mass population campaign and provide an opinion of its effectiveness.

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ANNEX B - Background

Question	Answer
<p>Describe the aims and objectives of the scheme. This can be drawn from the Strategic Case</p>	<p>The MMUH Programme is more than a hospital move and has a purposeful programme <i>#morethanahospital</i>. The purpose of the MMUH Programme is to transform clinical services, acting as a catalyst for enhanced care and treatment, improving life chances and health outcomes for local communities.</p> <p>As well as transforming clinical pathways, the Trust is a leading anchor institution leading and influencing widening participation and sustainable employment agenda. As part of this work, they are partnering with the Department of Work and Pensions, Sandwell College, multiple university partners and Sandwell Metropolitan Borough Council to establish a new Learning Campus funded by Government Levelling Up monies. Located at the entrance to the site, this facility will create over 1200 new local learning opportunities a year.</p> <p>The Trust has an active partnership with West Midlands Combined Authority, Birmingham City Council and Sandwell Metropolitan Borough Council who have 2 masterplan frameworks to regenerate the immediate Grove Lane area and wider Smethwick to Birmingham development zone which focus on social, economic, health and being an active travel exemplar as well as creating a healthy sense of place.</p>
<p>Provide a summary of the scheme, including extend of build vs refurb and the key services to be delivered in the new/refurbished facility</p>	<p>The new MMUH brings together acute services from two hospitals across the region into one state-of-the-art site, promoting better patient safety and care while ensuring value for money. As the closest serving acute hospital to Birmingham's City centre, it has a large emergency department supported by 739 in-patient beds and 13 operating theatres, 10 storeys and a gross internal area of 86,000m². It serves a population of over 750,000 people with some of the most deprived wards in England within its catchment.</p>

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The impact if the scheme opens late/is delayed	N/A – the scheme opened as planned in October – November 2024.
Project place in NHP (cohort)	Cohort 1
Current delivery/ops readiness status:	MMUH is live
Funding:	The project is working within its FBC funding envelope
Programme/Project plan:	Does the project / programme have an appropriate plan in place? Yes / No
Current position regarding previous assurance reviews:	Gateway 3a Report completed in June 2015 (prior to FBC approval being secured) Gate 4 Report completed in June 2024

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ANNEX C – List of Interviewees

The following stakeholders were interviewed during the review:

Name	Organisation and role
Liam Kennedy	MMUH Delivery Director
Jo Newens	Chief Operating Officer
Melanie Roberts	Chief Nursing Officer
Mark Taylor	MMUH Deputy Chief Informatics Officer
Rachel Barlow	MMUH SRO and Managing Director MMUH Programme Company
Mick Lavery	Non-Executive Director
Laura Broster	Deputy Director Communications, ICB
Jayne Dunne	Director of Commissioning
Mark Anderson	Chief Medical Officer
Sarab Clare	Deputy Chief Medical Officer
Meagan Fernandes	Director People and Organisational Development
Warren Grigg	Director of Estates Development
Ian Oliver	Head of Soft Facilities Management

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Tier 1 - Paper ref:	PublicTB (03/25) 007
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Report title:	MMUH Programme Closure Report - DRAFT
Sponsoring executive:	Rachel Barlow – Managing Director MMUH Programme Company
Report author:	Rachel Barlow – Managing Director MMUH Programme Company
Meeting title:	Public Trust Board
Date:	12 th March 2025

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

The draft Midland Metropolitan University Hospital (MMUH) Programme Closure Report is attached (**in the Reading Room**) for discussion and comment by the Trust Board. A fully designed version of the report inclusive of photos which add to the narrative, will be available for the Trust Board meeting.

The purpose of the MMUH Programme Closure Report is to record the chronology and programme journey to successfully open the MMUH, which is one of the largest hospitals to open in England in the last decade. The report does not cover the programme in its entirety, focussing on the period from 2020 onwards. This includes the inception of the MMUH Programme Company in October 2022 to the formal closure in March 2025. A series of case studies and lessons learnt have informed the closure process.

In creating this report, it provided an opportunity for the MMUH Programme Team and stakeholders to reflect and feedback on their experience and learning associated with delivering a major infrastructure and transformation programme. The document sets out successful working practices, lessons learnt and is transparent in sharing reflections that can be applied to future significant Trust projects, as well as future new hospital projects.

The Trust has been privileged to learn from other organisations on their journey. It is intended that this closure report is an opportunity to share the MMUH learning with the New Hospitals Programme, other new hospital projects and other NHS stakeholders to support successful delivery of similar transformation and future major infrastructure projects.

The MMUH Opening Committee were reasonably assured with an earlier draft of this paper, and Committee discussions added to the final draft content.

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?]*

MMUH Opening Committee

4. Recommendation(s)

The Public Trust Board is asked to:

a) **COMMENT** on the MMUH Programme Closure Report content, providing any personal reflections.

b) APPROVE the MMUH Programme Closure Report, subject to inclusion of feedback.

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

Tier 1 - Paper ref:	PublicTB (03/25) 008
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Report title:	Perinatal Service Report
Sponsoring executive:	Melanie Roberts – Chief Nursing Officer Dr Mark Anderson – Chief Medical Officer
Report author:	Helen Hurst – Director of Midwifery
Meeting title:	Public Trust Board
Date:	12 th March 2025

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

There are 5 key areas to update Trust board following discussion at Quality Committee:

- The Neonatal unit have had a Carbapenemase Producing Enterobacteriaceae (CPE) outbreak, following repatriation of two babies from another organisation. This has been managed through collaboration between neonates and the infection prevention control team, with no harm coming to those affected. This has led to a wider discussion at Region regarding screening compliance with British Association of Perinatal Medicine (BAPM) guidance. CPE screening will also be discussed and agreed at the Neonatal Partnership Board
- Core competency training compliance has shown achieved 90% for all professional groups other than Consultant Obstetricians and Anaesthetists. A schedule to achieve compliance for all staff groups has been devised for next year, which includes moving to a 10-month training cycle. Impacting factors for both non-compliant groups have been the movement to cover outside of obstetrics, with a plan to resolve this issue in place.
- The service has been identified as an outlier for babies born before arrival (BBA), with a higher-than-average overall number of pre-hospital births, a 5% increase noted form 22/23. A local audit of these cases identified the majority of women and birthing people experiencing BBA did not contact the hospital prior to birth.
- Lower than the national average compliance against the National Neonatal Audit Program standard for parents’ involvement on the ward round, this is a new target with not national standard set yet. The current national average is just below 40%, in Trust this sits at 22.6%, with an improvement plan in place.
- The Directorate continue the quality improvement work across the service via the Perinatal Improvement Plan. Of the 547 individual actions, 528 are on track, completed or assured, with 19 delayed. Project management support has now commenced.
Annex 1 contains the detail of compliance for the improvement plan
Annex 2 contains the Ockenden Framework update for December 23 and January 2024.

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?]*

Quality Committee

4. Recommendation(s)
The Public Trust Board is asked to:
a) NOTE and DISCUSS the report and supporting data
b) NOTE the Ockenden Framework Update in Annex 2

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Perinatal Service Report

Report to Trust Public Board on 8th January 2025

1. Introduction

- 1.1 The paper supports Board level oversight for the perinatal service which is fundamental to quality improvement, to ensure transparency and safe delivery of services. The paper presents five areas to highlight as matters of information and escalation from Quality Committee, as well as an update on progress.

2. Escalations

2.1 Carbapenemase Producing Enterobacteriaceae (CPE) Outbreak – Neonatal Unit

A significant CPE outbreak was confirmed following repatriation from another organisation, involving four positive babies and multiple additional contacts. This had a significant impact on capacity and flow within our own Neonatal Unit and led to delayed repatriation of babies from within the network during this outbreak for safety purposes. The impact internally was further compounded by a reduction in available isolation rooms due to planned installation of pendants and a malfunction of the air pressure system within the isolation room lobbies.

Action: Enhanced Infection Prevention Control (IPC) measures are in place within the Neonatal Unit. Admission pathway under review to include amendment to the screening process to require all repatriations to be screened and isolated until a negative screen result is available.

SWB follow the British Association of Perinatal Medicine (BAPM) guidance for screening on NNU – neighboring units do not follow this guidance, this has been escalated to West Midlands Operational Delivery Network (WMODN) infection control lead and Regional IPC lead, who will work with the network to improve IPC procedures and ensure all units undertake screening in line with BAPM guidance. It will also be discussed and agreed at the Local Black Country Neonatal Partnership Board.

2.2 Born Before Arrival (BBA) Outlier Status

The Trust has been identified as an outlier for babies born before arrival at hospital, with a higher-than-average overall number of pre-hospital births, and a 5% increase in incidence from 2022/23. A local audit identified that the majority of women experiencing birth before arrival did not contact the hospital prior to birth.

Action: The Equality, Diversity and Inclusion Lead Midwife is to undertake a piece of work to explore barriers to accessing care with the local community/ groups and then develop

an associated action plan to improve this position and encourage women to receive antenatal care.

2.3 Core Competency Training

Compliance for all staff groups for Multiprofessional Obstetric Emergency (PROMPT) training, Fetal Monitoring training and Resuscitation of the Newborn training is monitored monthly. **PROMPT** compliance is being achieved for all staff groups except for Anesthetics and GP trainees. Impacting factors have been the movement to cover outside of obstetrics, as well as the short GP rotation.

Action: A recovery plan is in place with monitoring via leads. PROMPT planning meeting scheduled for 25th February 2025 to finalise training plans for the new financial year. A plan to resolve this issue is in place with a trajectory of trainee compliance by April 2025 and Consultant and GP trainee by May 2025.

Resuscitation of the Newborn training remains below the acceptable standard for Neonatal Medics and Neonatal Nursing staff, the action plan can be found in the reading room.

Action: Ward level action plan implemented to address non-compliance in all staff groups, which will attain compliance by March 2025. A training schedule to achieve compliance for all staff groups has been devised for next year, which includes moving to a 10-month training cycle. This will provide flexibility. This includes an escalation process and support for non-compliance, which includes counselling, reassigned area of work and utilising Trust policy via the line management route.

The action plan for non-achievement of MIS year 6 for this safety action has been formulated and submitted with the return. This action plan will come with funding from NHS resolution on acceptance and includes an increase in the number of resuscitation council trained instructors and generic instructor courses to enable in-house delivery of courses and increased capacity.

- 2.4.1 The Trust has lower than the national average compliance against the **National Neonatal Audit Program** standard for parents' involvement on the ward round. This is a new target with no national standard set. The current national average is just below 40%, in Trust this sits at 22.6%, with an improvement plan in place.

The main driver for low compliance is the ability for parents to be in the neonatal unit at the time of ward rounds due to multiple factors. To support this, ward rounds are conducted both in the morning and evening. The improvement that will assist us to see greater compliance will be the introduction of a virtual ward round supported by interpretation. Work has commenced on this project with an implementation date of the beginning of June, with a trajectory to reach 60% compliance by the beginning of September, which would be above the National average and an aim for 85% by January 2026.

3 Perinatal Improvement Plan

The plan comprises of 547 individual actions over 13 individual plans , of these 528 are on track, completed or assured, with 19 delayed. Project management provision has now commenced to support the Directorate to progress and deliver the actions of the plan and sustain them. The actions are split across the 4 themes:

1. Safe and Effective
2. Grow, retain and develop our workforce in line with the needs of the service
3. Work with service users, staff and community voices to shape our services, listening to and working with women and families with compassion.
4. Create a collaborative culture of safety, learning and support through effective leadership.

The detail of compliance and the specific delayed actions are included in annex 1.

Governance is in place to ensure oversight and support internally with executive oversight. External oversight is via the Local Maternity and Neonatal System as well as a monthly joint NHSE and ICB Improvement Oversight and Assurance Group (IOAG). The IOAG meeting included an assurance visit in February, with positive feedback received.

Support is in place from NHSE perinatal quality improvement team, across key areas. The main area of support over the next three months is the triage department, with a working group in place to progress this and improve compliance with the 15 minute target.

The perinatal improvement plan has been shared across the directorate and will form part of the regular updates through team meetings, as well as sharing of ideas to support improvement. The Maternity and Neonatal Voices Partnership are engaged and sighted on progress through membership of the safety champion meeting.

4 Summary

4.1 In summary this report provides key areas of focused escalations and actions from the Directorate. The Directorate are progressing the Perinatal Improvement Plan, now with project management support. There is noted engagement with the quality improvement team from NHSE and key stakeholders. Monitoring remains in place both internal and external to the Trust.

5 Recommendations

5.4 The Public Board is asked to:

- a. **DISCUSS** and **CHALLENGE** the report and supporting data
- b. **NOTE** the compliance data for the Perinatal Improvement Plan in Annex1
- c. **NOTE** the Ockenden Framework Update in Annex 2 for **APPROVAL**

Helen Hurst
Director of Midwifery

21st February 2025

Annex 1: Perinatal Improvement Plan

Annex 2: Ockenden Framework Update (December 2024 and January 2025 Data)

Perinatal Improvement Plan

Annex 1

	Delayed	On Track	Complete	Assured
Theme 1: Safe & Effective Care – Through improving standards and Structures	2.2%	32.4%	16.5%	48.9%

Delayed actions have improved overall to **2.2%** in February 2025. **178 actions** are on track, completed or assured.

4 Delayed actions relate to the following Action Plans:

MNSI- 1 delayed actions

- Exploration of a digital tool to track induction activity and delays.

NHS Resolution Thematic Review- 2 delayed actions

- An audit of the provision of analgesia is completed to assess ongoing compliance.
- The Perinatal Audit program includes audit of the Care of Women in Labour Guideline.

Neonatal Improvement Plan- 1 delayed actions

- Define governance process for high-risk fetal med cases.

	Delayed	On Track	Complete	Assured
Theme 2: Grow, retain and develop our workforce in line with the needs of the service	9.5%	17.2%	22.3%	51%

Delayed actions have improved overall to **9.5%** in February 2025. **63 actions** are on track, completed or assured.

6 Delayed actions relate to the following Action Plans:

Maternity Independent Review Action Plan- 3 delayed actions:

- Share consultant allocated roles with the wider perinatal team. Delayed due to awaiting commencement of consultant and job reallocation.
- Expansion of career MOT. To be progressed through the Perinatal People Plan.
- Review of specialist midwifery roles (including job plan review), to align with changing needs of the Perinatal service and ensure efficiency and effective use of resources.

3 yr delivery Plan- 2 delayed actions:

- Annual census of perinatal staffing groups to facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists. Delayed, will be completed in the 25/26 workforce cycle.
- Continuity of carer. Unable to deliver as per Ockenden recommendations.

Neonatal Improvement plan- 1 delayed action:

- Implement enhanced TC cot configuration. Delayed – plan to start 1st April 2025.

	Delayed	On Track	Complete	Assured
Theme 3: Work with service users, staff and community voices to shape our services, listening to and working with women and families with compassion.	6.9%	23%	37.9%	32.2%

Delayed actions have improved overall to **6.9%** in February 2025. **81 actions are on track, completed or assured.**

No delayed actions in the following action plans:

Birth trauma benchmarking

NHS Resolution Thematic Review

NHS single delivery plan

MBRACE

SDIP Action Plan

Neonatal improvement plan

6 Delayed actions relate to the following Action Plans:

CQC Patient survey action plan:

- Include birth choices on websites – trust & VSO available in formats that is accessible i.e. videos, different languages, pictures.
- To create a virtual drop-in session to support families with perinatal mental health.
- Retention lead midwife to incorporate cultural and bias awareness in training to ensure there is an understanding of how bias can impact response to expression of pain.
- MMUH will accommodate partners to stay during the latent phase of labour to enable partners to support throughout.
- Staff to attend bias awareness training to ensure that families are receiving culturally appropriate support.
- Creation of resources to support with discharge talks in a variety of formats and languages

	Delayed	On Track	Complete	Assured
Theme 4: Create a collaborative culture of safety, learning and support through effective leadership.	4.9%	13.1%	24.6%	57.4%

Delayed actions have improved overall to **4.9%** in February 2025. **58 actions are on track, completed or assured.**

3 Delayed actions relate to the following Action Plans:

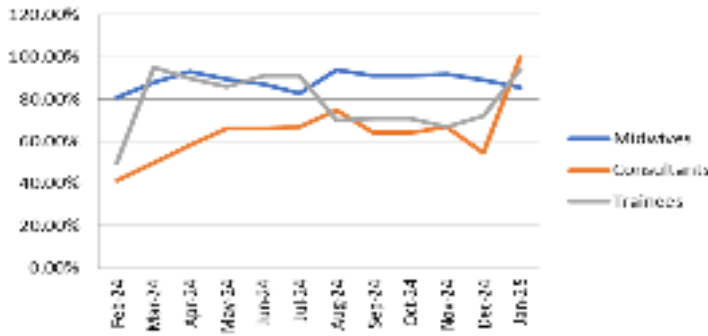
Neonatal improvement plan:

- ARC (equivalent) exposure to ANNP's/Junior's/Consultants
- Review of rosters and SPA (non-clinical roles)
- Development of Lead ANNP

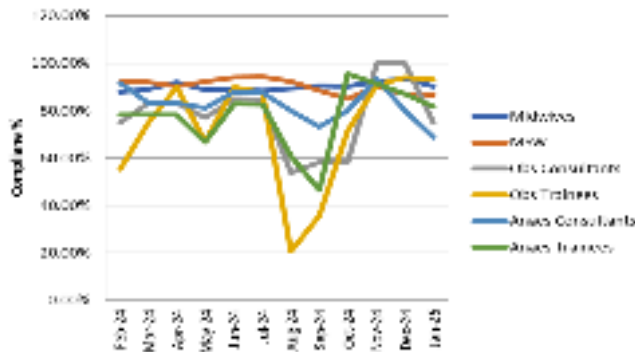
Ockenden Framework (December 2024 and January 2025)

Data Measures	Summary		Key Points															
<p>Findings of review of all perinatal deaths using the real time data monitoring tool</p> <p>Rate is per thousand births. 2/512 = 2 still births out of 512 in month births</p>	<p>Data Jan 24-Jan 25</p>		<p>Deep dive undertaken Review findings and any immediate actions required PMRT will review in depth cases Noted 3 were under the care of fetal medicine either in Trust or elsewhere, 2 with complex brain conditions. 3 were in relation to reduced fetal movements</p>															
<p>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.</p>	<table border="1"> <thead> <tr> <th colspan="2" data-bbox="336 1064 740 1099">Current ongoing MNSI</th> <th data-bbox="826 1064 1038 1099">Themes of Cases</th> </tr> </thead> <tbody> <tr> <td data-bbox="336 1099 740 1279">Open MNSI Referrals Cases from June to December</td> <td data-bbox="740 1099 826 1279"></td> <td data-bbox="826 1099 1267 1279">5 cases HIE/cooling 3 Intrapartum still birth/ 1 maternal death (SWB not the provider of any maternity care, but sadly died in our ED)</td> </tr> <tr> <th colspan="2" data-bbox="336 1279 740 1314">Draft/Completed Reports</th> <th data-bbox="826 1279 1267 1314"></th> </tr> <tr> <td data-bbox="336 1314 740 1359">Draft</td> <td data-bbox="740 1314 826 1359">2</td> <td data-bbox="826 1314 1267 1359"></td> </tr> <tr> <td data-bbox="336 1359 740 1404">Completed</td> <td data-bbox="740 1359 826 1404">0</td> <td data-bbox="826 1359 1267 1404"></td> </tr> </tbody> </table>		Current ongoing MNSI		Themes of Cases	Open MNSI Referrals Cases from June to December		5 cases HIE/cooling 3 Intrapartum still birth/ 1 maternal death (SWB not the provider of any maternity care, but sadly died in our ED)	Draft/Completed Reports			Draft	2		Completed	0		<p>3 cases referred in December all for cooling, 2 cases are still in the triage phase by MNSI and as such not yet accepted.</p>
Current ongoing MNSI		Themes of Cases																
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Draft	2																	
Completed	0																	
<p>Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training.</p>			<p>See narrative in main report.</p>															

EFM Compliance



PROMPT Compliance

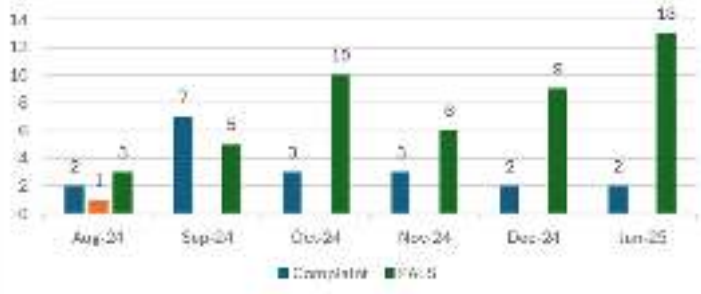


Minimum safe staffing in maternity services, to include obstetric cover on the delivery suite, gaps in rotas and minimum midwifery staffing, planned vs actual prospectively.

	Jan 25	Feb 25	March 25	April 25	May 25	June 25
Recruitment	3.53wte band 5 mw		3.31wte community 1.0 wte triage	3.84 b5 1.0 wte triage	0	1.0 wte band 5
Leavers	0	0.4 cmw	0.6wte cmw	0.71 lw	0	0
Posts held for apprenticeship completion	3wte	3wte	3wte	3wte	3wte	3wte
Vacancy (including additional 6.9wte)	23.99wte	24.39wte	20.68	16.55	16.55	15.55

Vacancies now include the funding for triage, an establishment options paper has been agreed, realigning banding to increase midwifery establishment. We continue to see positive interest in posts, including out of area contacts.

	<p>Obstetric workforce</p> <table border="1"> <tr> <td data-bbox="335 190 582 526"> <p>8 Obstetrics only consultants-</p> <p>2 vacancies</p> </td> <td data-bbox="582 190 1300 526"> <ul style="list-style-type: none"> • 1st vacancy created since January 2024. Interviews planned for June- No short listable candidates. Currently covered by locum Obstetrician; Readvertisement failed as no candidates applied. Locum cover will be extended • 2nd vacancy from Mid-October- Locum Consultant has commenced from 9th December </td> </tr> <tr> <td data-bbox="335 526 582 862"> <p>4 Obstetrics and Gynae consultants-</p> <p>3 vacancies</p> </td> <td data-bbox="582 526 1300 862"> <ul style="list-style-type: none"> • 1st Vacancy- Job shared by 2 consultants- One half of Obstetrics on calls- locum for the last 3 years due to job plan changes. The 2nd half of Obstetrics on calls- currently covered by locum due to long term sickness- Due to commence phased return as per OH advice • 3rd vacancy- maternity leave - from November- Locum consultant due to commence in March. </td> </tr> </table> <p>Neonatal Workforce</p> <p>Medics: Tier 1-3 BAPM compliant</p> <ul style="list-style-type: none"> • 2 substantive consultant posts still going through RCPCH (2 good locums in post currently) • Money from NHSE for use on more ANNP hours to support NICU experience and support shifts for new community registrars • Work ongoing to move 1 paedS SHO to neonates to support NIPE service (agreed by paedS. RCPCH tutor and foundation HoS) Current plan for this to commence 01.04.25 <p>AHPs:</p> <ul style="list-style-type: none"> • 80% BAPM compliant for physio, OT, SALT and dietician • NHSE recurring money to be used on psychology & dietician to fulfil BAPM compliance; work in progress <p>Nurses:</p> <ul style="list-style-type: none"> • Nurse establishment BAPM compliant • 11.7% sickness Jan 2025 with significant short term acute sickness plus some long term sickness supported by HR • 70% QIS (BAPM standard) • NHSE recurring money to be used to support all BAPM requirements for nurse specialist roles; work in progress 	<p>8 Obstetrics only consultants-</p> <p>2 vacancies</p>	<ul style="list-style-type: none"> • 1st vacancy created since January 2024. Interviews planned for June- No short listable candidates. Currently covered by locum Obstetrician; Readvertisement failed as no candidates applied. Locum cover will be extended • 2nd vacancy from Mid-October- Locum Consultant has commenced from 9th December 	<p>4 Obstetrics and Gynae consultants-</p> <p>3 vacancies</p>	<ul style="list-style-type: none"> • 1st Vacancy- Job shared by 2 consultants- One half of Obstetrics on calls- locum for the last 3 years due to job plan changes. The 2nd half of Obstetrics on calls- currently covered by locum due to long term sickness- Due to commence phased return as per OH advice • 3rd vacancy- maternity leave - from November- Locum consultant due to commence in March. 	<p>NNU nursing plan in place, to over recruit at band 5 to grow QIS.</p>
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<p>Service User Voice feedback</p>	<p>Number of PALS VS Complaints, by month August 24 until January 25</p>  <table border="1"> <caption>Number of PALS VS Complaints, by month August 24 until January 25</caption> <thead> <tr> <th>Month</th> <th>Complaints</th> <th>PALS</th> </tr> </thead> <tbody> <tr> <td>Aug-24</td> <td>2</td> <td>3</td> </tr> <tr> <td>Sep-24</td> <td>7</td> <td>5</td> </tr> <tr> <td>Oct-24</td> <td>3</td> <td>10</td> </tr> <tr> <td>Nov-24</td> <td>3</td> <td>6</td> </tr> <tr> <td>Dec-24</td> <td>2</td> <td>8</td> </tr> <tr> <td>Jan-25</td> <td>2</td> <td>13</td> </tr> </tbody> </table> <p>Feedback form MNVP in January has led to work to review letters to sent to bereaved families where we seek their questions to support PMRT</p>	Month	Complaints	PALS	Aug-24	2	3	Sep-24	7	5	Oct-24	3	10	Nov-24	3	6	Dec-24	2	8	Jan-25	2	13	<p>After birth listening service is working well, with positive feedback Collaboration with MNVP continues to ensure voices are heard and ensure, 'you said, we did' to transform the service to meet the needs of our population.</p>
Month	Complaints	PALS																					
Aug-24	2	3																					
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<p>Staff feedback from frontline champions and walk-about</p>	<p>The non-executive director for maternity safety, Lorraine Harper did a walkabout of the department in December 2024. The maternity safety champion, Mark Anderson carried out a department visit in January 2025. Both have reported positive feedback and sense changes are being felt by staff.</p> <p>The morale seems better, there was real pride in their work and staff felt empowered. There was more confidence that they are being heard and listened to. Some commented on better relations with leaders and leaders being visible.</p> <p>Parents that spoke were all happy with the care received and gave positive feedback about the staff.</p>																						
<p>MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust</p>	<p>None</p>																						
<p>Coroner Reg 28 made directly to Trust</p>	<p>None</p>	<p>None</p>																					
<p>Progress in achievement of CNST10</p>	<p>Papers and action plan have been submitted to NHSR following sign off both in Trust and ICB.</p>																						
<p>Proportion of midwives responding with 'Agree or Strongly</p>	<p>Reported via staff survey report.</p>																						

<p>Agree' on whether they would recommend their trust as a place to work or receive treatment</p>																																																											
<p>Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical</p>	<p style="text-align: center;">GMC National Training Survey - Obs & Gynae specialty</p> <table border="1"> <thead> <tr> <th>Indicator</th> <th>Mean score</th> <th>Outcome</th> </tr> </thead> <tbody> <tr><td>Adequate Experience</td><td>67.76</td><td>Within IQR</td></tr> <tr><td>Clinical Supervision</td><td>66.66</td><td>Within IQR</td></tr> <tr><td>Clinical Supervision out of hours</td><td>66.46</td><td>Within IQR</td></tr> <tr><td>Educational Governance</td><td>62.72</td><td>Within IQR</td></tr> <tr><td>Educational Supervision</td><td>62.24</td><td>Within IQR</td></tr> <tr><td>Fiduciary</td><td>56.77</td><td>Within IQR</td></tr> <tr><td>Feedback</td><td>59.67</td><td>Within IQR</td></tr> <tr><td>Handover</td><td>71.27</td><td>Within IQR</td></tr> <tr><td>Induction</td><td>66.84</td><td>Within IQR</td></tr> <tr><td>Local Teaching</td><td>52.40</td><td>Within IQR</td></tr> <tr><td>Overall Satisfaction</td><td>67.11</td><td>Within IQR</td></tr> <tr><td>Regional Teaching</td><td>73.14</td><td>Within IQR</td></tr> <tr><td>Reporting Systems</td><td>68.42</td><td>Within IQR</td></tr> <tr><td>Risk Design</td><td>58.62</td><td>Within IQR</td></tr> <tr><td>Study Leave</td><td>60.16</td><td>Within IQR</td></tr> <tr><td>Supportive Environment</td><td>65.79</td><td>Within IQR</td></tr> <tr><td>Teamwork</td><td>73.69</td><td>Within IQR</td></tr> <tr><td>Work Load</td><td>52.46</td><td>Within IQR</td></tr> </tbody> </table>	Indicator	Mean score	Outcome	Adequate Experience	67.76	Within IQR	Clinical Supervision	66.66	Within IQR	Clinical Supervision out of hours	66.46	Within IQR	Educational Governance	62.72	Within IQR	Educational Supervision	62.24	Within IQR	Fiduciary	56.77	Within IQR	Feedback	59.67	Within IQR	Handover	71.27	Within IQR	Induction	66.84	Within IQR	Local Teaching	52.40	Within IQR	Overall Satisfaction	67.11	Within IQR	Regional Teaching	73.14	Within IQR	Reporting Systems	68.42	Within IQR	Risk Design	58.62	Within IQR	Study Leave	60.16	Within IQR	Supportive Environment	65.79	Within IQR	Teamwork	73.69	Within IQR	Work Load	52.46	Within IQR	
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Tier 1 - Paper ref: PublicTB (03/25) 009

Report title:	Financial Position – to 31 January 2025 (Month 10)
Sponsoring executive:	Simon Sheppard, Acting Chief Finance Officer
Report author:	Simon Sheppard, Acting Chief Finance Officer
Meeting title:	Public Trust Board
Date:	Wednesday 12 th March 25

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

As of the end of January 2025, the Trust reported a deficit of £2.22 million, which is £0.04 million favourable to the plan, an over-spend of £1.51 million against the capital programme with a cash balance of almost £41 million.

Key issues to highlight include the Trust being 417 whole-time equivalents above the workforce plan and need 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 year end forecast, and the critical areas of focus, including workforce management, elective recovery 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?]*

Finance & Productivity Committee

4. Recommendation(s)

The Public Trust Board is asked to:

- NOTE** the financial position at the end of January 2025 and the year-end forecast
- DISCUSS** the key areas of focus of workforce trajectory, elective recovery 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	<i>Deliver safe, high-quality care.</i>
Board Assurance Framework Risk 02	X	<i>Make best strategic use of its resources</i>
Board Assurance Framework Risk 03	X	<i>Deliver the MMUH benefits case</i>
Board Assurance Framework Risk 04	X	<i>Recruit, retain, train, and develop an engaged and effective workforce</i>
Board Assurance Framework Risk 05	X	<i>Deliver on its ambitions as an integrated care organisation</i>
Corporate Risk Register <small>[Safeguard Risk Nos]</small>		
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 12 March 2025

Financial Position – to 31st January 2025 (Month 10)

1. Executive summary

1.1 This report updates the Trust Board on the financial position at the end of January 2025 against the income & expenditure plan, the year-end forecast, 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 As the Board is aware, the Trust submitted a plan at the beginning of May, a deficit of £43.24m. During September, NHSE released details of deficit funding, of which the Trust's share is £41.3m, moving the plan to a deficit of £1.95m.

1.3 The key performance measures are:

- At the end of January, the Trust has reported a deficit of £2.22m which is £0.04m favourable to the Income & Expenditure Plan.
- £1.51m over-spend against the capital programme.
- A cash balance of almost £41m.
- £34.02m delivered against the financial improvement (efficiency)
- £0.43m favourable position against the elective recovery/ variable activity funding exclusive of significant clinical coding and counting improvements.
- 417 whole time equivalents (WTE) above the plan trajectory reflecting the additional capacity open and the stretching nature of the trajectory.

1.4 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. Due to the deficit funding the I&E plan has now improved to a £1.95m deficit plan. The requirement to deliver £44.1m financial improvement / efficiency remains the same.
- A monthly cashflow plan that ends the year with a circa £6m balance (from £65m as at 31st March 2024). This is now £47m as a consequence of the deficit funding.
- A reduction in deployed workforce of 158wte by 31st March 2025, net of the Midland Metropolitan University Hospital agreed staffing investment.

2.2 This report updates the Trust Board on the financial position at the end of January 2025 (Month 10), 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	2.11	2.05	● (0.06)	(2.27)	(2.22)	● 0.04
	Agency Costs	0.77	1.47	● (0.69)	8.25	15.14	● (6.90)
	Financial Improvement Programme	4.46	5.26	● 0.80	34.50	34.02	● (0.48)
	Capital Expenditure (CB Allocation)	1.45	1.49	● (0.00)	15.58	17.81	● (2.23)
	Capital Expenditure (Other)	1.85	1.68	● 0.21	78.95	78.23	● 0.72
	Cash Balance	55.24	40.83	● (14.41)	55.24	40.83	● (14.41)

Income & Expenditure Performance

3.2 At the end of January the Trust has reported a deficit of £2.2m which is £0.04m favourable to the Plan.

	Plan £000s	Actual £000s	Variance £000s
Patient Related Income	(588,019)	(603,169)	15,150
Other Income	(49,672)	(44,636)	(5,036)
Pay	398,034	407,689	(9,655)
Non Pay	241,922	242,340	(418)
Total	2,265	2,224	41

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

A favourable position at month 10 of £0.041m. This is driven by:

- £7.6m+ adverse “other income” from Birmingham & Solihull Integrated Care Board for MMUH costs (the year to date balance of the annual plan assumption of £18.75m from BSOL less the contractual offer)
- Pay deficit as a consequence of being above the workforce trajectory.
- ERF performance above plan after excluding the significant coding and counting improvements
- Offset by non-recurrent benefits e.g. favourable Elective Recovery Funding settlement of £2.6m relating to 2023/24; higher interest receivable.

- 3.4 Whilst the month 10 position is broadly on plan the Trust Board should discuss this position in the context of the year end forecast.

Workforce

- 3.5 The Trust has agreed on a stretch workforce plan for the current financial year targeting a circa 5% reduction, excluding MMUH, equivalent to approximately 400 full time equivalent (FTE). With the need to recruit for MMUH (242 FTE), the net planned reduction is 158 'deployed' FTE, representing around a 2% reduction. However, by the end of January, the Trust is 417 FTE adverse to the plan. Details are provided in Annex 1.
- 3.6 Despite clear plans for a gradual reduction in deployed Full-Time Equivalents (FTE), staffing levels continue to exceed both the original and revised trajectories. Instead of aligning with the 2024/25 Plan target of 7,983 FTE, actual deployment has remained consistently high, prompting multiple revisions. However, this period has been marked by significant operational challenges, particularly the commissioning and move to MMUH during the no-fly zone (which have driven the requirement for additional temporary staffing; MMUH induction, Omnicell training and clinical and corporate service set-up).
- 2.1.3 The original plan aimed for a reduction to 7,983 FTE by year end, balancing cost efficiency with service continuity. However, evolving requirements of the MMUH transition have kept actual FTEs above this target, leading to a September 2024 revision to 8,181 FTE and a further increase to 8,227 FTE in January 2025.
- 2.1.4 The variance between planned and actual FTEs has widened throughout the year, peaking at 417 FTE above plan in Month 10. Staffing levels remain elevated, with a peak of 8,473 FTE in Month 08, reflecting the workforce demands of the MMUH transition.
- 2.1.5 As the move and operations stabilise, a reduction of approximately 190 FTE will be required to meet the revised January 2025 outturn of 8,227 FTE. Focused actions are being taken to achieve further reductions during Q4, with a focus on work with the Groups to reduce agency and bank usage during February and March 2025.

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 needed to deliver a minimum £128.2m income in 2024/25 to meet the elective recovery funding (ERF) target. This target has been increased to £142.6m as a consequence of the significant improvements in coding and counting, the increase being part of the financial improvement programme, and the impact of the pay award.
- 3.9 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.

3.10 Month 10 performance is summarised in the table below - £0.975m favourable to the plan for ERF and £0.548m adverse for other elective.

Variable Type	PodGrpCode2	Total Activity Plan	Total Activity Actual	Total Activity Diff	Total Price Plan	Total Price Actual	Total Price Diff	Activity Variance	Price Variance	Total Variance
Variable ERF	Daycase	29,844	29,918	74	£32,466,762	£31,537,869	£928,893	682,809	-(£1,009,701)	-(£326,892)
	Elective	4,575	4,265	-310	£18,761,488	£18,825,158	-(£1,995,353)	-(£1,268,818)	-(£666,512)	-(£1,836,330)
	Excess Bed Days	1,285	1,220	+65	£491,905	£413,082	£78,823	-(£28,422)	-(£50,807)	-(£78,823)
	OP New Attendances	177,394	178,208	-814	£56,993,027	£56,235,930	£757,097	£194,009	£116,983	£291,992
	OP New Virtual Attendances	38,485	20,480	2,046	£4,063,160	£4,581,514	-(£498,453)	£491,267	£47,567	£488,453
	OP Procedures	152,881	168,465	16,584	£27,136,597	£30,948,054	-(£3,811,457)	£2,943,784	£867,278	£3,811,062
	Other	0	0	0	£0	£0	£641,224	£0	-(£641,224)	-(£641,224)
Variable ERF Total		384,630	403,601	18,967	£118,877,833	£119,848,079	-(£970,246)	£2,361,218	-(£1,336,979)	£975,248
Variable Other Elective	Imaging - Direct Access	54,507	48,176	+6,331	£4,085,755	£3,381,946	£703,809	-(£394,682)	-(£309,129)	-(£653,811)
	Imaging - OP Diagnostics	56,985	57,241	-256	£6,011,615	£6,857,465	-(£845,850)	£29,127	£20,729	£255,843
	Chemotherapy	3,153	2,308	+845	£795,423	£645,064	£150,359	-(£23,137)	£62,771	-(£151,362)
Variable Other Elective Total		114,645	107,725	+6,920	£11,102,793	£10,884,475	£218,318	-(£178,692)	£30,271	-(£548,330)
Grand Total		499,275	511,326	13,051	£130,305,630	£130,732,554	-(£426,924)	£1,732,534	-(£1,306,621)	£425,913

3.11 The improved coding and counting is excellent, however we have a significant adverse position in day case and elective activity, 236 patients, £2.9m, adverse on the income plan. There are areas of over performance, particularly in the specialties under the Women & Child Health Group and Gastroenterology. The key specialties underperforming are Trauma & Orthopaedics and Ophthalmology.

3.12 The Trust Board is asked to note a potential system risk on ERF payments following the “capping” of ERF payments in 2024/25. This is as a consequence of the following process:

- Over performance on elective activity capped by Treasury
- Regional teams were notified on 15 January 2025 and then to ICBs of the total amount– allocation based on M8 forecast at ICB level
- Trusts/Systems assessed any risk of the latest forecast being above the elective allocation – opportunity to quantify the financial risk of further over performance and seek further rebasing across the NHSE (ICB, then region, then national) i.e. unders and overs. Black Country ICB submission was +£12m above the cap.
- **SWB submitted a year end forecast of £147m at month 9 which it is still on track to deliver.**
- ICB’s to be notified in early March of the finally agreed values.
- No 2024/25 year-end “cashing up” in 2025/26.

Financial Improvement Programme

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

3.14 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 £34.02m against a plan of £34.50m.

- 3.15 The risk adjusted forecast stands at c£41.545m PLUS, significant new ideas not yet valued. Pipeline opportunities must progress through a robust 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.
- 3.16 The Executive Sponsors of each workstream have “approved” the year-end financial value to ensure accountability and delivery of the 2024/25 financial plan. The details were discussed at the Finance & Productivity Committee on 31 January 2025.
- 3.17 The focus for the remaining weeks of the financial year is to maximise the recurrent full year effect of the savings particular regarding the workforce schemes.

Capital and Cash

- 3.18 The Trust is reporting a £1.51m overspend year to date against the plan of £94.53m. The respective professional leads have been tasked with ensuring the year end forecast is delivered.
- 3.19 The cash balance at the end of January of £40.83m. With receipt of the deficit funding the Trust is still forecasting not to require any borrowing during 2024/25.

4. Year End Forecast

- 4.1 The Trust undertook a bottom-up year-end forecast inclusive of activity, income and expenditure and workforce trajectories following the month 8 reported position. This forecast also incorporated the reset financial improvement programme values that must be delivered over and above the base forecast.
- 4.2 The most likely forecast has a number of key assumptions the Board is asked to note. These are:
- A baseline bottom-up forecast following M8
 - Review and validation of the base forecast i.e. remove any double counts; clarify assumptions.
 - NHSE to fund the capital charges associated with MMUH
 - Alignment with the last Financial Improvement Programme (FIP) reset at a workstream level. This follows Executive Sponsor sign off of the relevant 2024/25 values.
 - Central schemes outside of FIP i.e. Revenue to Capital transfers
 - Non recurrent improvement – i.e. 2023/24 ERF settlement; reserves; balance sheet management.
- 4.3 The forecast position was discussed in detail at the Finance & Productivity Committee on 28 February 2025 with the headline being the Trust is currently forecasting to deliver the £1.95m year-end deficit
- 4.4 Whilst there is a route to delivery of the financial plan this is predicated on 6 significant assumptions:

- Delivery of the FIP workstream reset values. The respective Executive leads must ensure the reset values are delivered.
- Proactive management of risks and ensuring mitigating actions are implemented as required.
- Non-recurrent flexibility to be released in addition to that in the year to date position. This is required, predominantly, to cover the non-recurrent shortfall in BSOL income.
- The Public Dividend Capital impact of MMUH is supported through a national solution. At this stage this remains a risk of £4.5m – the principle of funding has been agreed although the baseline position is still being discussed.
- Impact of the ERF cap on the Black Country Integrated Care System.
- Contribution to the wider Integrated Care System financial position.

5. Recommendations

5.1 The Public Trust Board is asked to:

- a. **NOTE** the financial position at the end of January 2025 and the year-end forecast.
- b. **NOTE** the key areas of focus of workforce trajectory, elective recovery, and the financial improvement programme.

Simon Sheppard
Acting Chief Finance Officer

27 February 2025

Annex 1: Workforce trajectory and performance to date

Annex 2: Elective Recovery Performance

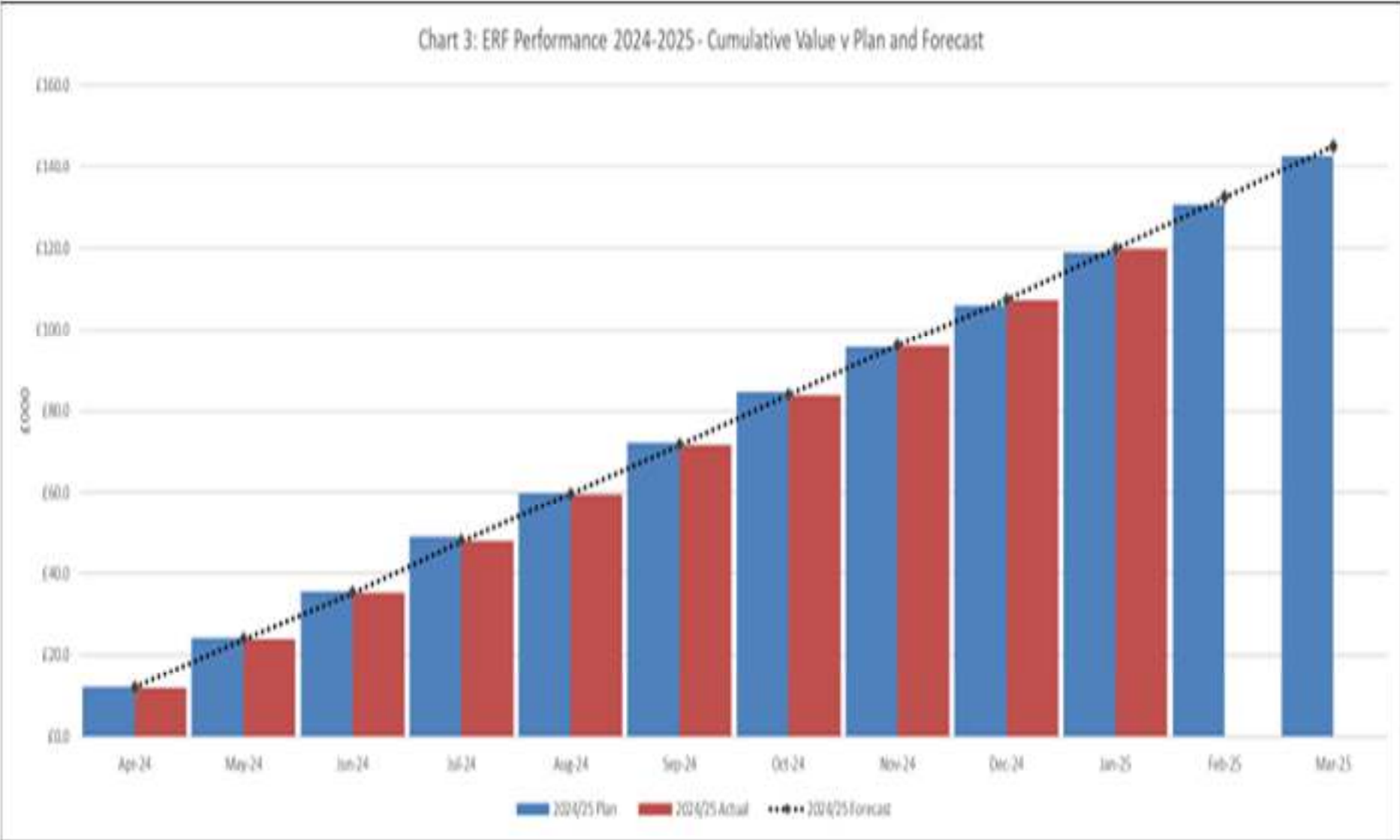
Annex 3: Capital Programme

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 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	8067.58	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	7097.26	7169.61	7170.61	7180.61	7190.61	7210.00	7212.00	7212.00	7212.00
bank	998.00	974.08	959.17	926.25	902.33	878.42	854.50	830.58	806.67	782.75	720.00	720.00	711.00
agency	102.00	88.50	86.00	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	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Substantive - Contracted	7,060.9	7,094.0	7,102.5	7,116.2	7,127.4	7,200.6	7,253.9	7,293.1	7,290.2	7,335.3	-	-
Administration and Estates	1,062.0	1,075.3	1,084.3	1,082.6	1,078.2	1,082.7	1,064.2	1,065.2	1,063.4	1,064.1	-	-
Healthcare Assistants and Support Staff	1,310.7	1,331.7	1,335.9	1,357.5	1,356.3	1,373.5	1,391.9	1,412.9	1,407.0	1,416.2	-	-
Management	304.6	307.6	310.2	310.5	306.4	301.7	305.7	307.1	308.1	305.5	-	-
Medical Staffing	923.6	924.7	921.9	904.1	930.4	946.6	959.2	959.8	960.2	952.3	-	-
Other Pay	-	-	-	-	-	-	-	-	-	-	-	-
Qualified Nursing and Midwifery	2,377.5	2,375.8	2,376.4	2,382.9	2,371.8	2,388.0	2,402.1	2,417.8	2,418.7	2,443.0	-	-
Scientific, Therapeutic and Technical	1,082.5	1,078.9	1,073.8	1,078.6	1,084.4	1,108.2	1,130.7	1,130.3	1,132.8	1,154.4	-	-
Bank	981.6	977.7	1,033.0	993.6	994.5	975.3	1,075.6	1,053.6	953.4	948.3	-	-
Administration and Estates - Bank Staff	151.9	161.5	164.0	172.8	161.4	187.8	215.1	192.3	163.7	162.2	-	-
Healthcare Assistants and Support Staff - Bank	358.6	338.0	365.0	325.6	339.8	327.8	328.5	333.3	312.2	304.6	-	-
Medical Staffing - Bank Staff	97.5	100.9	103.1	116.7	114.9	96.8	112.4	101.1	94.4	102.2	-	-
Qualified Nursing and Midwifery - Bank Staff	329.4	336.4	362.1	334.0	340.4	320.5	364.7	375.5	338.6	334.9	-	-
Scientific, Therapeutic and Technical - Bank Staff	44.2	40.9	38.8	44.5	38.1	42.4	55.0	51.4	44.6	44.4	-	-
Agency	127.2	124.3	122.2	133.3	131.0	135.7	132.3	126.0	121.5	132.8	-	-
Administration and Estates - Agency Staff	2.6	16.3	16.2	16.2	14.6	15.0	15.0	4.8	5.1	5.5	-	-
Healthcare Assistants and Support Staff - Agency	0.8	-	3.5	2.4	1.6	9.9	12.2	18.6	16.9	17.8	-	-
Medical Staffing - Agency Staff	52.2	43.8	42.8	44.1	51.6	45.2	38.4	41.3	34.4	44.1	-	-
Qualified Nursing and Midwifery - Agency Staff	51.7	40.8	40.6	43.4	32.1	31.8	37.5	38.0	41.2	43.4	-	-
Scientific, Therapeutic and Technical - Agency Staff	20.0	23.4	19.2	27.2	31.1	33.8	29.3	23.4	24.0	22.1	-	-
Grand Total	8,169.8	8,196.0	8,257.7	8,243.0	8,252.9	8,311.6	8,461.9	8,472.7	8,365.1	8,416.4	-	-

- Plan workforce trajectory at the end of January of 7,999 WTE
- Actual workforce WTE of 8,416.
- Adverse position of 417WTE, predominately due to additional capacity remaining open and the stretching trajectory.



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	7,468	7,864	8,325	-461	7,468	5,460	2,008
Mid Met Urgent Treatment Centre	6,045	1,141	1,141	0	6,045	6,045	0
IT	4,147	3,490	3,897	-407	4,147	4,147	0
Medical equipment	3,855	3,080	4,442	-1,362	3,855	5,223	-1,368
Charity	0	0	0	0	0	90	-90
Sub total	21,515	15,575	17,805	-2,230	21,515	20,965	550
External - PDC Funded							
IT - Frontline Digitisation	0	0	0	0	0	0	0
MMUH - Cost to complete	67,000	65,622	65,622	-0	67,000	67,000	0
Learning Hub / Campus	13,384	10,328	9,054	1,274	13,384	13,484	-100
Eradication by RAAC (PDC)	12,233	69	69	-0	12,233	12,233	0
Genesis Handheld Devices (PDC)	60	60	59	1	60	60	0
CT Scanner (PDC)	1,725	0	0	0	1,725	1,725	0
National Energy Efficiency Fund-LED (PDC)	45	0	0	0	45	45	0
National Energy Efficiency Fund-BMS (PDC)	134	0	0	0	134	134	0
National Energy Efficiency Fund-Solar (PDC)	322	0	0	0	322	322	0
SGH Aseptics/Pharmacy Pressures (PDC)	80	0	0	0	80	80	0
SGH Critical Infrastructure Work-Fire Safety/Emergency Lighting	500	0	0	0	500	500	0
SGH Critical Infrastructure Work-Fire Door & Aesthetics (PDC)	1,050	0	0	0	1,050	1,050	0
Sub total	96,533	76,079	74,805	1,274	96,533	96,633	-100
TOTAL INTERNAL & PDC FUNDED	118,048	91,654	92,610	-956	118,048	117,598	450
Technical-IFRIC12							
BTC & MES	1,567	1,397	1,397	-0	1,567	1,567	0
ROU Assets - IFRS16							
ROU Leased Assets (internally Funded)	1,475	1,475	2,025	-550	1,475	2,025	-550
Trust Wide Programme	121,090	94,526	96,032	-1,506	121,090	121,190	-100

The table above shows the Month 10 spend position against the agreed Trust plan for 24/25, which includes an overcommitment of £3.2m against the NHSE plan.

Tier 1 - Paper ref:	PublicTB (03/25) 010
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Report title:	Winter Plan 2024/2025 Update
Sponsoring executive:	Johanne Newens – Chief Operating Officer
Report author:	Demetri Wade – Deputy Chief Operating Officer Taj Virk-Dhugga – Assistant Director of Urgent Care
Meeting title:	Public Trust Board
Date:	12 th March 2025

1. Summary of key issues <i>two or three issues you consider the PublicTB should focus on in discussion]</i>
This paper provides an update on the winter plan for 2024-2025 for Sandwell and West Birmingham Places and Acute Services following the opening of the Midland Metropolitan University Hospital (MMUH) in October 2024. The paper focuses on progress to date against our winter and Emergency Access Standard (EAS) improvement plans, the MMUH Rightsizing schemes, quality and safety considerations and the governance arrangements for oversight and leadership of delivery against our targets.

2. Alignment to our Vision <i>[indicate with an 'X' which Strategic Objective[s] this paper supports]</i>		
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 <i>[at which meeting[s] has this paper/matter been previously discussed?]</i>
Plan delivery, mitigations, safety and quality considerations, and performance metrics in this paper have been considered at Performance Management Group, Trust Management Committee, Finance and Productivity Committee, and Quality Committee. The Winter plan was presented at Trust Board in September 2024 and an update in January 2025.

4. Recommendation(s)
The Public Trust Board is asked to:
a) DISCUSS the UEC performance update and contributing factors
b) DISCUSS progress of UEC Improvement and Rightsizing Schemes
c) DISCUSS and ACCEPT the winter plan update

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board

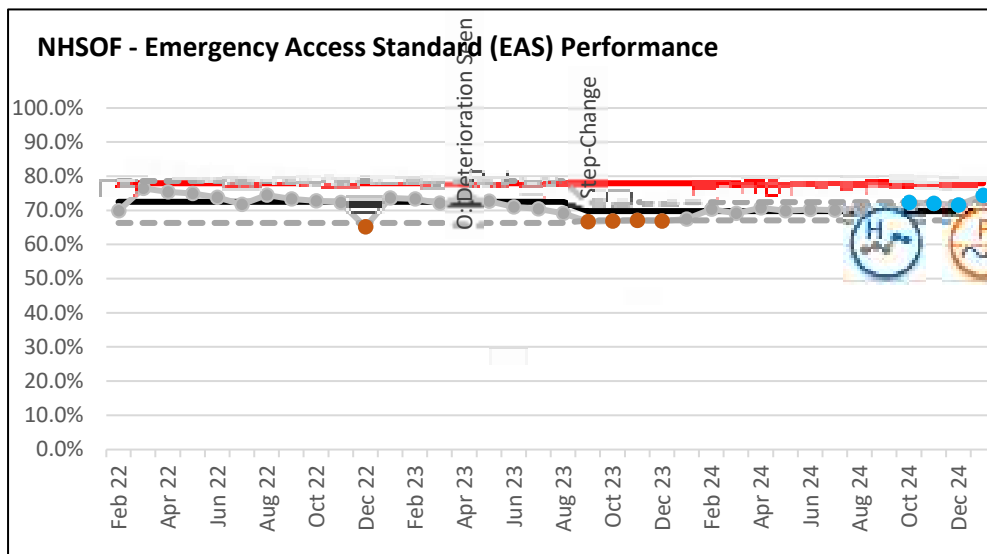
Sandwell and West Birmingham Places and Acute Hospital Winter Plan Update

1. Introduction

1.1. This report provides a summary of Urgent and Emergency Care (UEC) performance for January 2025. There will be a focus on the MMUH rightsizing programme that has concluded and is currently in monitoring, and progress thus far of the UEC Improvement programme in phase 2. There will also be an overview of the UEC Improvement programme and update on the governance and oversight framework for UEC.

2. UEC Performance Update

2.1. Total EAS performance for January 2025 was 74.4%, a 2.9% improvement on last month and 3.6% away from the 78% performance target we are expected to achieve by the end of March 2025.



2.2. The Trusts benchmark ranking for EAS performance is 5th out of 23 providers in the Midlands region for January 2025, and 30th out of 122 acute national providers.

KPI	Latest month	Measure	In-Month Target	Target (score use this)	Variation	Assess	Mean	Benchmark Latest Month	4	23	122	28/24 Outturn Performance
									Providers	Providers	Providers	
NHSDF - Emergency Access Standard (EAS) Performance	Jan 25	74.4%	76.0%	78.0%			69.8%	2025-01-31	2nd	5th	30th	69.1%

2.3. January performance shows improvement across several clinical indicators. Monthly data suggests that the number of handovers over 60 minutes have gone down from 798 in December to 447 (-351), and as a percentage, down from 23.17% to 12.25% of all conveyances. The improvements in ambulance handover are related to the implementation of the 45-minute maximum offload processes and increased flow through various initiatives as part of the EAS Improvement programme, including Medicine and Emergency Care Length of Stay and Same Day Emergency Care (SDEC) workstreams.

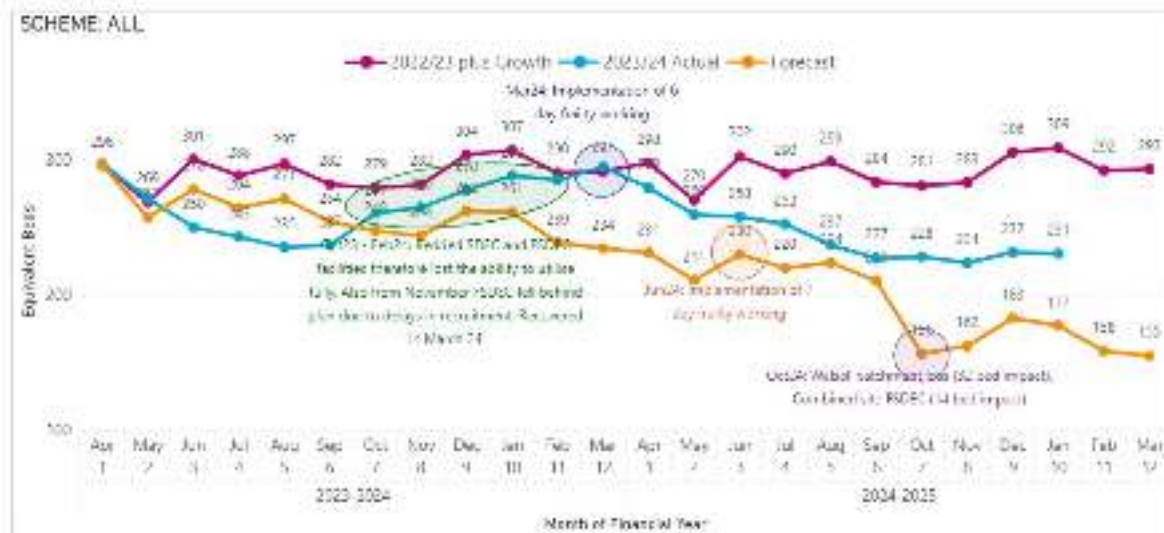
2.4. 12+ hour DTA trolley waits reported lower in January and below the average at 196 (-32). As with the improvement in ambulance handover, January’s performance is likely to be due to the improvement in outflow through the focused work as part of the Length of Stay workstream and embedding of the Quality Standards. ‘Your Next Patient’ is also being adopted across other Clinical Groups, proactively moving patients several times a day from assessment units to create assessment beds for patients in ED with decision to admit.

3. MMUH Rightsizing Schemes

3.1. The 5 transformational schemes that are supporting the overall MMUH bed rightsizing and our winter resilience include:

- Medical Same Day Emergency Care (SDEC) – Funded in current run rate
- Frailty Virtual Ward (VW) and Frailty Intervention Team (FIT) – System Development Funding and within current run rate
- Respiratory Virtual Ward (VW) – System Development Funding
- Heart Failure – System Development Funding and within current run rate
- Birmingham Care Homes – Birmingham Community Healthcare funding

3.2. These schemes have provided 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 above forecast.



Scheme	Actual bed usage	Forecast bed usage	Variance	% Variance	Baseline 2022/23	Variance to Baseline	% Variance
Frailty	66	49	17	35%	102	-36	-35%
Medical SDEC	42	29	13	45%	49	-6	-12%
Heart Failure	18	12	6	50%	16	-3	-19%
Respiratory VW	39	50	-11	-22%	54	-18	-33%
Cardiology VW	6	5	1	20%	8	-2	-25%
Bham Care Homes	19	20	-1	-5%	22	-11	-50%
Falls	17	7	10	143%	15	3	20%
Walsall/Dudley Catchment	24	6	18	300%	43	-15	-35%
Total	231	177	54	31%	309	-78	-25%

- 3.3. The patient cohorts targeted by right-sizing schemes saw a similar bed usage to recent months despite usage forecast to increase due to seasonal demand. An equivalent of 78 fewer beds were used compared with the Pre-MMUH-Program baseline. However, January bed-usage was still +54 higher than forecast.
- 3.4. 4.4% lower than expected emergency attendances in January will have aided performance, possibly over-estimating the impact of all Rightsizing Schemes.
- 3.5. The largest deficit was related to Walsall/Dudley Catchment (+18 beds), where despite close-to-planned number of ED attendances, the change from pre-MMUH ambulance conveyances has been small, and length of stay for that patient group has been above baseline, resulting in less impact on MMUH bed usage.
- 3.6. The Frailty Scheme has seen a deficit of 17 beds, which is reduced compared to the previous month, however, there is now a persistent trend of this scheme failing to pull bed-usage down to the post MMUH forecast. The Medical SDEC scheme saw larger variance (+13 beds) and the downward trend that was seen in recent months was reversed. Respiratory Virtual

Ward continued to see a sharp drop in bed usage, which correlated with increased VW volumes.

3.7. There were small variances in other schemes which represent normal variation rather than any trend. The Rightsizing programme has concluded, however, monitoring against schemes continues through the UEC Delivery and Steering Groups. Several of the schemes are also being monitored at a local level as business as usual.

3.8. To support the winter plan, Rightsizing was expected to deliver at 70% and over delivery would mitigate against any slippage. At the end of January, Rightsizing is delivering at 59%. There will be ongoing monitoring of ambulance conveyance activity and further discussion with the ICB through the UEC System meetings.

4. Medicine and Emergency Care Length of Stay Improvement Measures

4.1. Acknowledging the importance of reducing length of stay (LoS) for enhancing patient experience and EAS performance, targeted measures are being implemented, encompassing various aspects such as patient journey, bed base management, and access to support services in Medicine and Emergency Care.

4.2. The Medicine and Emergency Care acute average LoS for January was 6.3 days, which is an improvement when compared with the previous month and an improvement vs January 2024's LoS. When considering the better-than-expected LoS for October and November, in addition to a better January figure, overall winter performance for LoS has been positive.

4.3. Analysis of the data demonstrates that Cardiology, Stroke and Clinical Haematology all reached their stretch targets in January. Reviewing by pathway shows that Pathway 0 has recovered from December's lower position, but pathways 1 and 3 have been challenged.

4.4. We continue to perform well when benchmarking against other Trusts within the Midlands, including our peers.

Data are from ECIST dashboard for week ending 5/2.
Peers are marked in blue

4.5. Removal of telephone handovers from the transfer processes has resulted in no reported patient safety concerns. A volunteer organisation is in place and now supporting doorstep delivery of To Take Out (TTOs) post discharge for suitable patients. There is a continued focus on right patient right bed and flow. Patient information in various formats is in development and will inform patients of the journey and possible Primary Care, Community

and Therapies (PCCT) destination in order to improve discharge planning, communication and reduce delays on discharge.

- 4.6. The winter planning assumed that Length of stay would remain similar to December 2023 at 6.3 days. In January, length of stay was reported at 6.3 days for Medicine and Emergency Care, and 4.4 days overall non-elective length of stay. Early February data suggests that the overall Trust length of stay is 4.3 days.

5. PCCT Bed Capacity

- 5.1. In preparation for the Sandwell site move to MMUH, 12 PCCT beds were released into the Trust capacity. Preparations were made to support the release of a further 12 beds for the City move and remained open post MMUH move. These beds are open at the end of February and are consistently available to support the winter plan, however, will close at the end of March 25.

6. Bed Occupancy

- 6.1. The bed occupancy rate in January was 92.1% with 692 average beds open. The six-week average bed occupancy for the Midlands' region range is 97.41-94.59%.
- 6.2. The 2023/24 NHS operational planning guidance states that bed occupancy should be a maximum of 92%. January 25 occupancy was reported at just above 92% but not requiring expansion of the bed base.

7. Clinical Group Interventions

- 7.1. Each clinical group identified and have subsequently implemented a separate set of interventions to reduce bed occupancy pre and post MMUH move.

7.2. Primary Care, Community and Therapies

Stroke Decoupling and delivery/optimisation of ICSS for the move of rehabilitation services to Rowley Regis Hospital has been completed. To ensure that there is the appropriate use of community beds, the Therapy lead, representing therapies and Integrated Discharge Hub, continues to attend all scheduled length of stay meetings.

Several services in PCCT, continue to work to Level 4 action cards. The Integrated Discharge Hub trialled and implemented in early December new defined admin roles with the aim to ensure capacity to accommodate 'live' 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.

7.3. Medicine and Emergency Care

Medicine and Emergency Care continue to run daily Length of Stay meetings with senior leadership representation using the PFIT tool to identify wards that require additional support where discharge targets have not been met. To avoid variation in length of stay and daily discharges from ward to ward, there is also review of Consultant ward cover 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, AMU and SDEC to ensure that there is experienced substantive Consultant presence. Additional Acute Medicine shifts have been added to rotas to support admission avoidance in ED, although filling them consistently has been challenging.

7.4. Surgical Services

In preparation for the move to MMUH and reduction in bed occupancy, Surgical Services increased 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 to medical colleagues emphasised the importance of optimised discharges to support the safe transfer of patients to MMUH and post-move. The overall Trust reduction in length of stay has been driven by significant reductions in Trauma and Orthopaedics and General Surgery in January and February.

Capacity was doubled daily for trauma and NCPOD to facilitate earlier intervention, reducing overall length of stay. When required, Multi Agency Discharge Event (MADE) events are 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.

7.5. Women's and Child Health

The clinical group have continued to focus on appropriate and timely escalation where increased support is required from external partners e.g. CAMHS patients for social admissions.

Increased consultant presence on ward rounds across the groups was implemented and has facilitated timely discharges across all specialties. Support from the network for the induction of labours and utilisation of network cots translated to a reduction in patient numbers prior to the MMUH move.

In Gynae, Gynae oncology and Breast services, there continues to be specific focus on review of elective caseloads to reduce length of stay including patients on long-term total

parenteral nutrition (TPN) who could be suitable for earlier discharge into the community. Inpatients waiting for procedures such as SCP are routinely identified earlier and receive treatment facilitating timely transfer of care or discharge.

7.6. Imaging and Pathology

To support the clinical groups in reduction of bed occupancy, additional imaging hot slots have been made available alongside additional computerised tomography coronary angiography (CTCA) sessions during weekends. To support the reduction in length of stay and facilitate earlier discharges, the imaging operational lead for the day takes escalations and actively works to bring forward imaging appointments for patients awaiting diagnostics prior to discharge decision. Mutual aid for Non-Obstetric Ultrasound Scan (NOUS) and Insourcing will continue to meet diagnostic demands.

7.7. MMUH Census

In preparation for the transfer of patients to MMUH, a Mock Census was run week commencing 2nd September for Sandwell and 9th September for City. This involved 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 were completed by the ward teams to familiarise them with the documentation to 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 learning from the mock census was taken into account when planning for the official census.

The census prior to the Sandwell and City move to MMUH was successful in reducing the number of patients for transfer. Sandwell safely transferred 176 of 320 inpatients (55%) and City, 112 of 220 (51%) with the remaining discharged or transferred to PCCT beds. The census facilitated a reduction in length of stay and improved flow.

8. UEC Improvement Programme

8.1. The UEC Phase 2 Improvement Programme aims to deliver EAS performance of 78% and improve ambulance handover by the end of March 2025. Ensuring the objectives are aligned with the national priorities and success measures for 25/26, there will be the additional aim of reducing the proportion of patients admitted, discharged and transferred from ED within 12 hours.

8.2. The programme is made up of 5 key workstreams including Streaming, SDEC, ED and Acute Operational Processes, and Length of Stay underpinned by Quality Standards, Patient Safety Flow Hub and Business Intelligence. New Key Performance Indicators and project plans for the next financial year are in the process of being developed alongside rolling improvement trajectories with governance and assurance through the UEC Delivery and Steering Groups. A workstream specifically for Imaging will be added to the programme from March 2025.

8.3. With external support, clear opportunities have been identified for ED processes in line with bed occupancy and length of stay. An emergency care ICB peer review and informal visit from NHSE focused on the patient pathway post-MMUH move have taken place and areas for further development identified to support flow through the Emergency Department (ED) to achieve an improvement in EAS performance. Further visits will be scheduled for April with a plan to complete process mapping and establish further opportunities to improve efficiency. A review has also been completed by the Emergency Care Intensive Support Team Clinical Associate, who has made recommendations for how risk related to patient waits can be managed in the ED through effective workforce planning, changes in operational processes and clinical pathways. The recommendations from all these reviews are being tracked through the UEC Improvement programme but specifically the ED and Acute Medicine Operational Processes workstream.

9. Oversight and Leadership

9.1. The MMUH Rightsizing scheme delivery will continue to be monitored locally at service and group level as well as the UEC Delivery and Steering Groups. Through monthly tracking, there is an opportunity to identify areas where corrective measures may be needed.

9.2. Length of stay meetings run daily using the Patient Flow Insights Tool (PFIT) to monitor and identify wards that may need additional support to meet their discharge targets. The weekly task and finish group tracks Length of Stay and implements strategies to facilitate earlier discharge whilst improving the quality and safety of services.

9.3. Bed occupancy including the availability of additional PCCT beds is tracked daily through site meetings and formal performance reporting with immediate actions taken where required. During the winter NHSE, will require bed occupancy reporting with all organisations expected to deliver occupancy of no more than 92%.

10. Winter Plan Update Summary

10.1. This year's winter plan focuses on continuing to realise the potential of our rightsizing schemes, improving the community offer and reduction in length of stay.

10.2. The table below shows our progress against the plan that was set out.

	Expected delivery	Actual- November month end	Actual- January month end
Rightsizing schemes	70%	62%	59%
Length of Stay- Dec 2023	6.3 days	6 days	6.3 days (M&EC) 4.3 days (Trust overall)
PCCT beds available (24 beds)	24 beds	24 beds- in use with capacity available	24 beds- in use with capacity available daily
Occupancy Increase (8 beds)	1.7%	Not required. Occupancy sits below 92%	Not required. Occupancy sits at 92%
Clinical Group interventions	All actions completed	All actions completed	All actions completed

11. Recommendations

The Trust Board is asked to:

- a. **DISCUSS** the UEC performance update and contributing factors
- b. **DISCUSS** progress of UEC Improvement and Rightsizing Schemes
- c. **DISCUSS** and **ACCEPT** the winter plan update

Demetri Wade
Deputy Chief Operating Officer

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3rd March 2025

Tier 1 - Paper ref: PublicTB (03/25) 011

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 five principal risks were reviewed, with two currently scoring as high risks: 'The failure to make the best strategic use of resources' and 'The failure to deliver the MMUH benefits case'.

Discussions in the MMUH Opening Committee highlighted the 2 actions to secure capital funding and advance digital transformation, ensuring the realisation of SMART-enabled benefits. These outstanding actions will be transferred to a relevant Trust Board Committee for continued oversight and progress monitoring as this committee is closing in April 2025

An internal audit by RSM provided a "Reasonable Assurance" rating but identified areas for improvement, including better risk tracking, clearer documentation, and enhanced Board engagement. Key recommendations include updating the Risk Register and Assessment Policy, improving control gap tracking, and implementing a structured risk escalation framework by mid-2025.

In response, there is a plan to dedicate time to BAF at the April 2025 Board Workshop to ensure alignment with strategic goals and evolving governance requirements.

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. **NOTE** the current position of the BAF risks and scores.
- b. **SUPPORT** review of the BAF at the April Board Workshop

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

Board Assurance Framework Update

1. Introduction

- 1.1 The Board Assurance Framework (BAF) is informed by the Trust strategy and related principal risks that may prevent us from achieving our strategic objectives. This version represents the Quarter 4 position

2. BAF Summary

- 2.1 An effective BAF supports the understanding and discussions around delivery of the Trust's strategic objectives by identifying the principal risks that may threaten the achievement of those objectives. The BAF is presented by each of the 3 strategic objectives within the Trust Strategy.

Patients	People	Population
To be good or outstanding in everything that we do	To cultivate and sustain happy, productive and engaged staff	To work seamlessly with out partners to improve lives

- 2.2 There are five strategic risks on the BAF, each has been reviewed by the lead Executive Director and updated to ensure identified actions are appropriate and have appropriate timeframes. Two risks are currently scoring as high risk, and are summarised below:

No:	Risk	Initial	23/34 Q4	24/25 Q1	24/25 Q2	24/24 Q3	24/25 Q4	Trend	Target
001:	There is a risk that the Trust fails to deliver constant safe, high-quality care.	16	16	16	12	12	12	↔	8
002:	There is a risk that the Trust fails to make best strategic use of its resources	16	16	20	20	20	20	↔	4
003:	There is a risk that the Trust fails to recruit, retain, train, and develop an engaged and effective workforce.	16	16	16	12	12	12	↔	4
004:	There is a risk that the Trust fails to deliver on its ambitions as an integrated care organisation and therefore its ability to improve life chances and health outcomes for the population.	16	12	12	12	12	12	↔	8
005:	There is a risk that the Trust fails to deliver the MMUH benefits case	16	20	20	15	15	15	↔	8

3. Committee work of note to support the BAF Risks in Q3

3.1 Quality Committee: Risk of Failing to Deliver Consistent, High-Quality Care

- **PSIRF:** Patient safety incident reporting has increased, which is a positive trend. Inpatient falls have decreased, while hospital-acquired pressure ulcer rates remain stable. However, both areas remain a concern, and a thematic review is planned for 2025.
- **Perinatal Improvement Plan (PIP):** The Directorate has consolidated 12 action plans into the PIP, aligning them with four key priorities to strengthen perinatal care.
- **Complaints and Patient Experience:** The Trust has enhanced the Patient Experience Team, leading to measurable improvements. Key complaint themes in Q3 included clinical care (52), communication standards (15), and patient care (13).
- **Safeguarding Improvement Plan:** The Safeguarding Team has restructured its governance and revised training. Some actions remain for completion in 2025 to fully close the plan.

3.2 Finance and Productivity Committee: Risk of Failing to Optimize Resources

- **2025/26 Planning:** NHS England published operational planning guidance on 28 January 2025. The Committee will oversee the Trust's Cost Improvement Plan (CIP), acknowledging the financial challenges ahead.
- **Financial Improvement Programme (FIP):** The committee continues monthly reviews, with a focus on prioritising recurrent cost mitigations and setting out FIP planning for 2025/26.
- **Operational Performance:** The Elective Access Standard has shown month-on-month improvement but remains 2% below target. Length of Stay (LOS) metrics are above average. Urgent and Emergency Care performance (EAS) improved to 74.4% in January, a 2.9% increase from the previous month, but remains 3.6% short of the 78% target for March 2025.

3.3 People Committee: Risk of Failing to Recruit, Retain, and Develop an Effective Workforce

- **Workforce Optimisation Deep Dive:** A six-month review of e-rostering, job planning, and temporary staffing showed progress. Expansion into three additional areas, the creation of progress metrics, and identification of cost-saving benefits have been requested.
- **2024 Annual Staff Survey:** The Trust achieved a 34% response rate, with improvements across all People Promises and Domains compared to 2023. Despite gains, several areas remain below the Picker average, requiring targeted interventions. A strategic plan for improving staff experience at group and local levels was presented.

- **Bank Reduction & Agency Elimination:** plans and interventions to reduce temporary staffing usage, including eliminating agency usage were presented. There was still work to do to meet the required targets.

3.4 Integration Committee: Risk of Failing to Deliver Integrated Care and Improve Population Health

- **Development Workshop:** Led by the Interim Chief Integration Officer, a workshop reviewed the BAF risk. As the committee had been stood down for months, further discussions were agreed upon to reframe the risk. This will be addressed in a Board Workshop Session.

3.5 MMUH Opening Committee: Risk of Failing to Deliver the MMUH Benefits Case

- **Final Actions:** With the committee closing, all but two actions have been completed. The remaining actions focus on securing capital funding and advancing digital transformation to optimize MMUH’s strategic benefits.
- **Next Steps:** Outstanding actions will transfer to a relevant Trust Board Committee for continued oversight, with progress incorporated into a BAF refresh at a future Board Workshop Session.

3.6 **Risk Scores:** There have been no changes in BAF risk scores this quarter.

4. Key risks linked to the BAF

4.1 In response to an Internal Audit recommendation, collaborative work has been carried out with the executive lead and Ameer Chughtai, Head of Risk Management, to refine the risk descriptors. This ensures that supporting risks are clearly aligned with the principal risks and articulated through risk statements that adhere to the Trust's Risk Management Policy. Below is a summary of these risks.

4.2 These risks are owned by executives and will be managed and have oversight at their allotted board committee.

BAF	Risk Statement	Current Risk Score (LxS)	Target Risk Score (LxS)
001	There is a risk of significant failure to deliver the standards of quality and safety for patient care across the Trust, could result in substantial incidents of preventable harm, poor clinical outcomes, and increased litigation.	12	8
001	There is a risk of failing to implement safer practices and improve clinical conditions and outcomes following significant events, incidents and complaints, which may result in preventable harm and poor patient experience.	12	8
001	There is a risk of failing to recognise clinical deterioration in patients , which may result in delayed interventions, preventable complications (sepsis, cardiac arrest), prolonged hospital stay and patient mortality/morbidity.	12	8
001	There is a risk that the Trust lacks a systematic-wide approach to continuous improvement , which may result in reduced patient experience and missed opportunities for improvement.	12	8
002	There is a risk to income and expenditure performance , this may lead to reduced financial flexibility, and risks to the Trust's overall financial stability and long-term sustainability.	20	8

002	There is a risk of failing to optimise the Estates strategy . This could result in the inability to fund necessary upgrades or maintenance, reduced functionality, deteriorating infrastructure, and a failure to meet regulatory standards impacting service delivery and long term financial performance.	20	8
002	There is a risk of failure to ensure adequate infrastructure, capacity and governance to deliver the Cost Improvement Programme (CIP) , which may result in failure to achieve planned financial savings and deliver the financial plan	20	8
002	There is a risk that the Trust fail to deliver operational performance in line with agreed recovery trajectories	20	8
003	There is a risk that the Trust fail to effectively attract and recruit a suitably qualified, skilled, and diverse workforce resulting in compromised patient safety, increased reliance on agency staff, and financial pressures due to higher staffing costs.	12	4
003	There is a risk that if the Trust fails to embed a positive, compassionate and inclusive work environment , this may lead to negative patient experiences, low staff morale, and reputational damage	12	4
003	There is a risk of an insufficiently staffed and appropriate skilled workforce , this may result in compromised patient safety, service quality decline, operational inefficiencies and increased financial expenditure.	12	4
004	There is failure to establish an effective strategic benefits oversight and delivery framework that results in the inability to provide assurance on the delivery of the strategic benefits case	TBC	TBC
004	Failure to secure capital funding and progress digital transformation and SMART optimisation at MMUH will compromise the digital impact on the strategic benefit case.	TBC	TBC

5. BAF Internal Audit Findings & Areas for Improvement

4.1 The BAF was reviewed in January/February 2025 by RSM, the Trust's Internal Auditors, received an audit opinion of **Reasonable Assurance (the full report is available in the Reading Room)**. The audit evaluated the framework's effectiveness and the validity of controls and assurances in place.

4.2 The review identified some areas for improvement, particularly in risk tracking, documentation clarity, and Board engagement. The report notes that the Trust has initiated reforms, but further action is required to strengthen governance and assurance mechanisms.

4.3 RSM made the following recommendations:

- Update the Risk Register and Risk Assessment Policy (by July 2025).
- Ensure all assurances are clearly dated and categorised (by July 2025).
- Strengthen tracking mechanisms for actions addressing control gaps (by July 2025).
- Fully implement a risk escalation framework via Chair reports and assessments (by August 2025).
- Present the BAF to the Board quarterly to enhance governance oversight (by July 2025).

6. Next Steps

6.1 In response to the internal audit findings, and recent Trust Strategy refresh, it is proposed that time is devoted to the Board Assurance Framework (BAF) at the April 2025 Board Workshop. This session will be used to ensure the BAF remains aligned with the Trust's strategic objectives, risk appetite, and evolving governance requirements.

7. Recommendations

The Public Trust Board is asked to:

- a) **NOTE** the current position of the BAF risks and scores.
- b) **SUPPORT** review of the BAF at the April 2025 Board Workshop.