Paper ref:	PublicTB (01/24) Reading Room

REPORT TITLE:	Board Level Metrics		
SPONSORING EXECUTIVE:	David Baker (Chief Strategy Officer)		
REPORT AUTHOR:	Matthew Maguire (Associate Director of Performance and Strategic Insight)		
MEETING:	Public Trust Board	**DATE:**	10th January 2024

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

This paper provides performance against the 2023/24 annual plan and supporting assurance metrics for the sub-committees. 0% of objectives are hitting the target consistently, 47% hit and miss their targets, and 53% are failing the target. 2 Please see the summary matrix on page 3.

Public Trust Board is asked to note the combination of reducing volumes of inpatients along with the increasing average length of stay and increasing bed occupancy rates and its consequences on patient flow.

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?]*

Board Committees

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** performance against annual plan objectives
b.	**NOTE** relevant escalations

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

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

Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

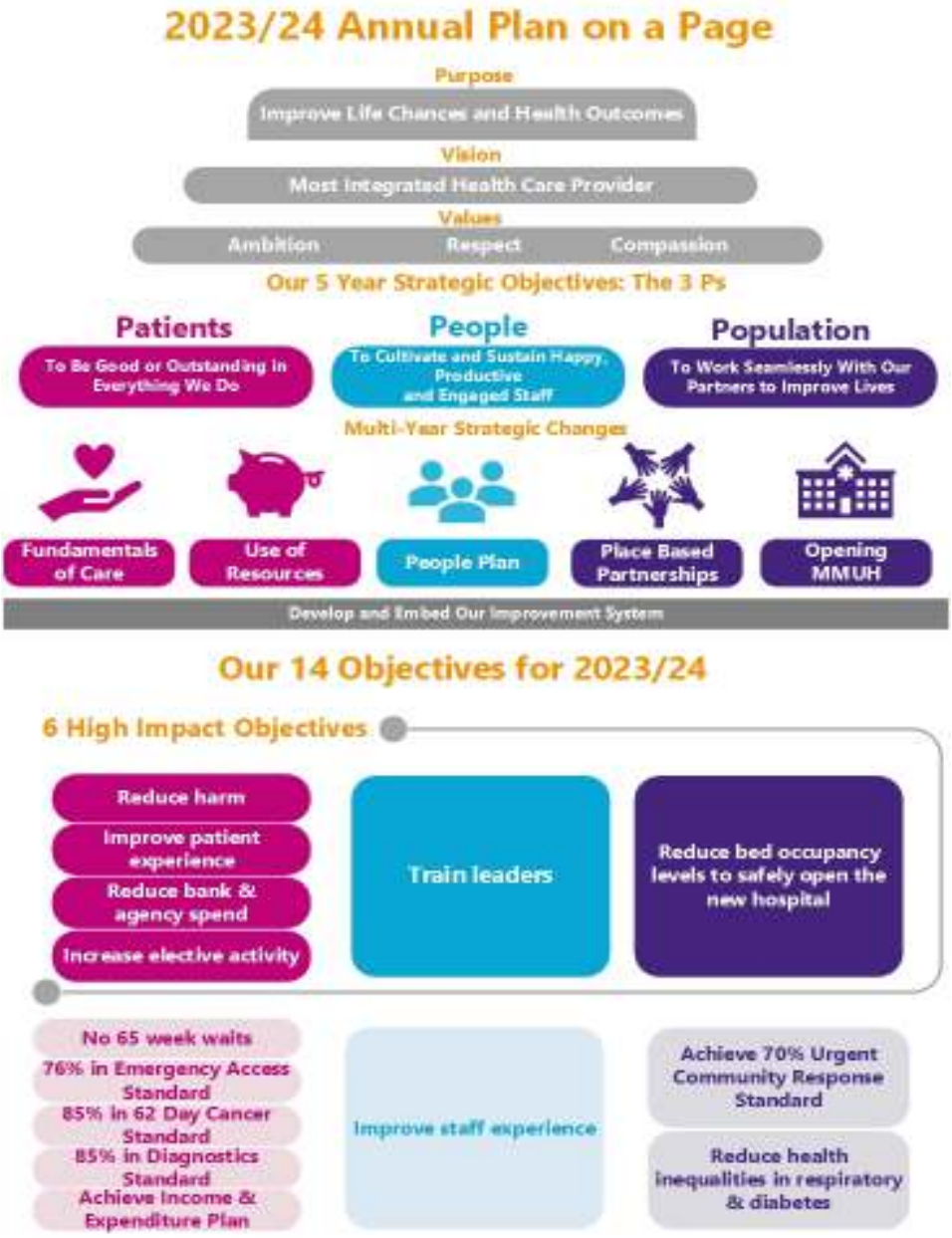
SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 10th January 2024

Board Metrics Update

1. Background

1.1 'Board Level Metrics' are a rationalised set of priority metrics for the Board to focus on. The metrics are shown below, aligned against our three strategic objectives (Patients, People, Population) and our 2023/24 annual plan. Whilst this is a rationalised set of metrics to generate higher quality discussions and assurance, we also monitor our existing Integrated Quality and Performance Report (IQPR) which tracks over 200 metrics. Any performance exceptions from the IQPR are included in this report. This report shows data in Statistical Process Control (SPC) charts using the NHS 'Make Data Count' house style of reporting. Further detail on how to interpret SPC charts including the plain English descriptions of performance icons is shown in annex 1.



2. Performance Overview: Annual Plan Objectives

(+) indicates improvement from last month, (-) indicates worsening from last month.

		Assurance		
		Passing the Target / Plan 	**Hit & Miss the Target** 	**Failing the Target / Plan** 
Variation	**Special Cause Improvement** 	**Good and getting better**	**Ok but getting better**	**Poor but getting better**
	Common Cause Variation 	**Predictably good**	**Ok** Friends & Family Test Urgent Community Response Contacts Urgent Community Response – 2 Hour Performance	**Predictably poor** DM01 62 Day (urgent GP referral to treatment) Excluding Rare Cancers Staff survey
	Special Cause Concern 	**Good but getting worse**	**Ok but getting worse** Emergency Access Standard (EAS) Performance (-)	**Poor and getting worse** RTT-Incomplete Pathway Pts waiting >65 weeks
	Not an SPC Chart	**Good**	**Ok** Patient Safety Incidents: Moderate Harm or Above Patient Safety Incidents Train leaders	**Poor** Income & Expenditure Bank & Agency Spend Elective Activity Occupancy & Bed Closure Plan
	Annual plan objectives delivery to date	**0%**	**47%**	**53%**

3. Escalations

3.1 ***Bed Days, Occupancy and Length of Stay:*** We are reporting an increased occupancy rate in the past few weeks (Figure 1). In Figure 2 we can see an increase in Average LOS in the past calendar year, because we have added a step-change in December 2022 which increased the mean LOS from 4.53 to 4.72. This metric is failing its target and cannot be expected to reach it under current process. In conjunction with an increased Average LOS, we have seen a decrease in the number of emergency admissions over the past calendar year (Figure 3 and Figure 4). The number of elective admissions is also within common cause variation (Figure 5). However, anecdotally we have seen emergency medical outliers in surgical beds, which may have influenced our elective performance. As a result, these changes have cancelled out any schemes implemented aiming to reduce the number of bed days used (Figure 6).

Figure 1. Occupancy of SWB Trust by week.

Figure 2.
*Note: this calculation uses MMUH principles and does not include Healthy Babies.

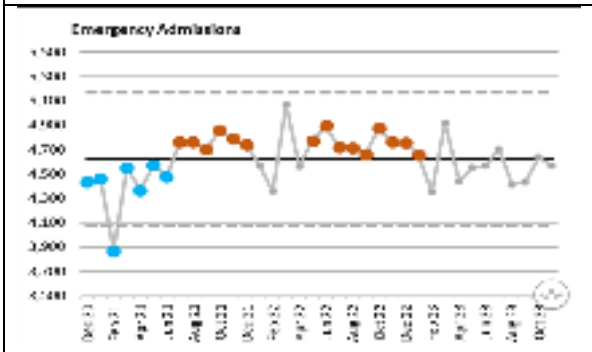


Figure 3.

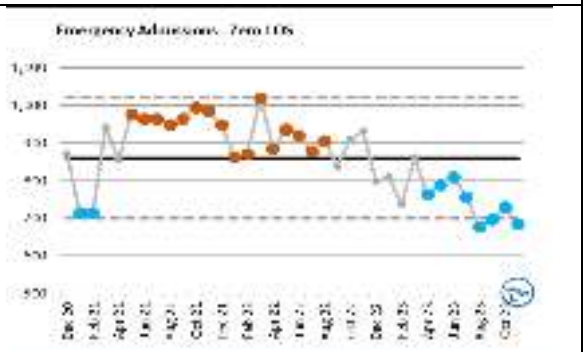


Figure 4.

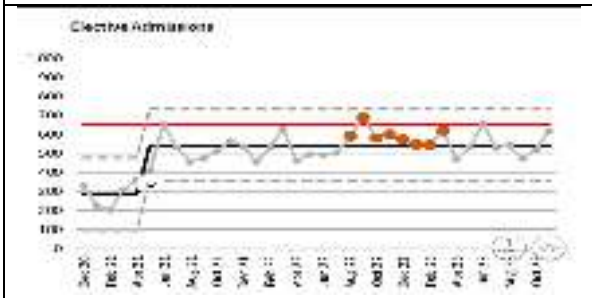


Figure 5.

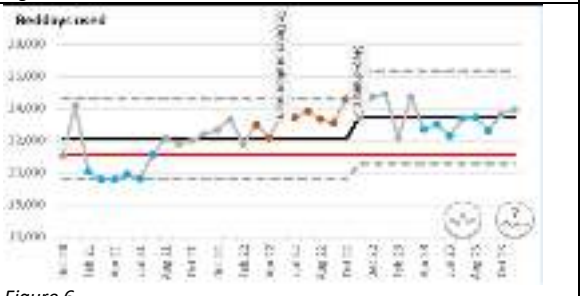


Figure 6.

3.2 ***65-Week waiters Referral to Treatment:*** Currently we have an issue with our performance of 65-week waiters for Referral to Treatment (RTT). The ICB has two key measures that they are now managing the organisation by and so we have included the operational graphs for these metrics. The first graph shows the total cohort of patients that could become 65-week waiters and shows our reduction of this cohort completely by stopping the RTT clock (Figure 7). The second graph shows the same cohort but removes the patient once the first outpatient appointment has been given (Figure 8).

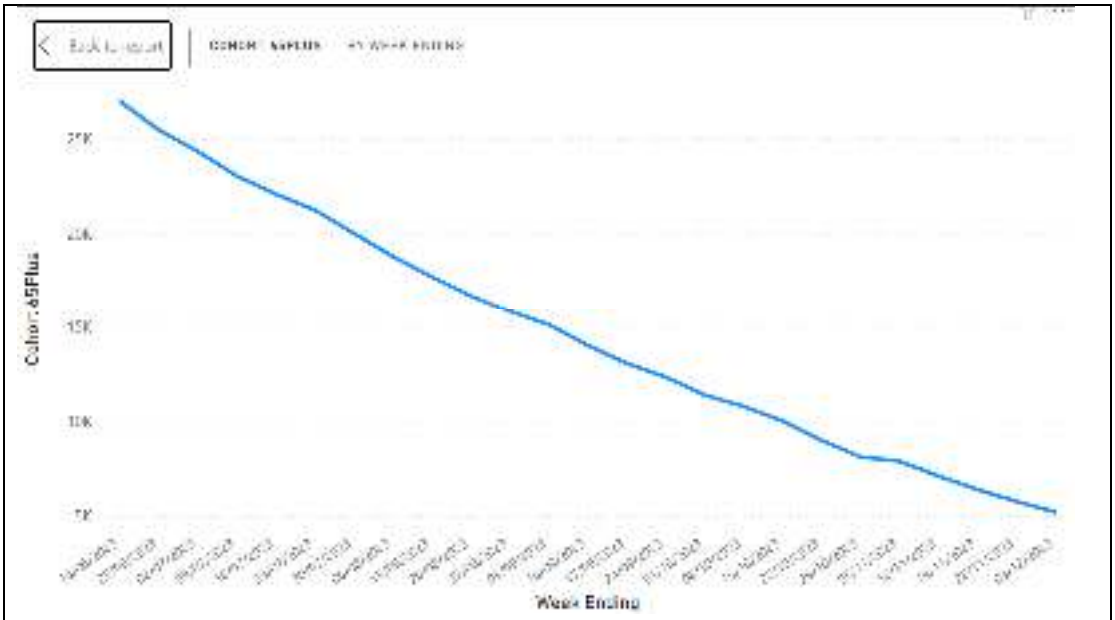


Figure 7.

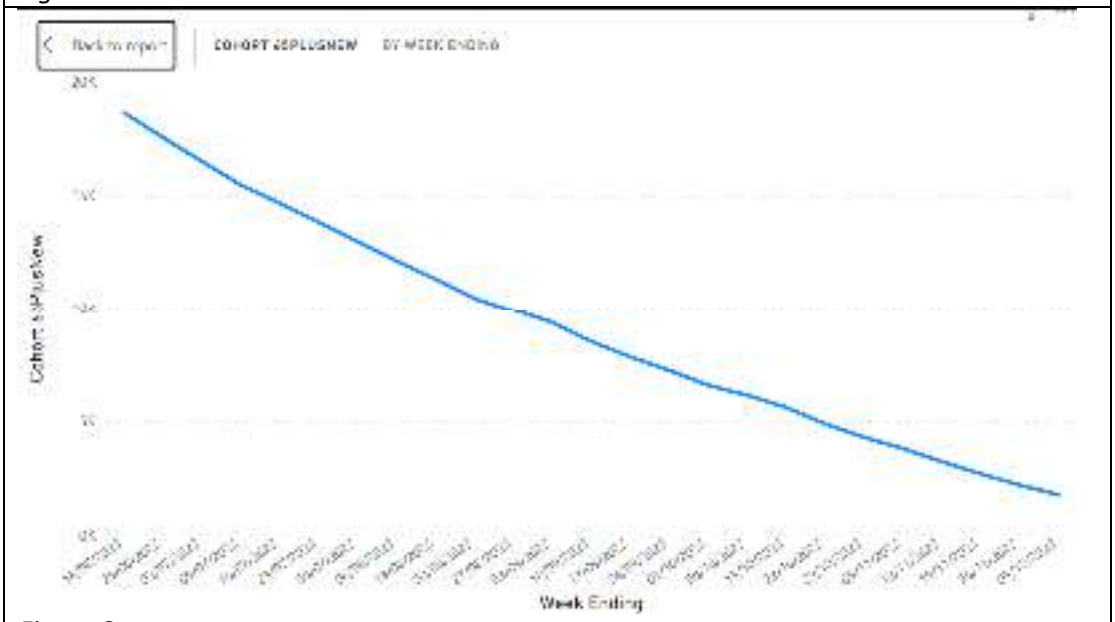
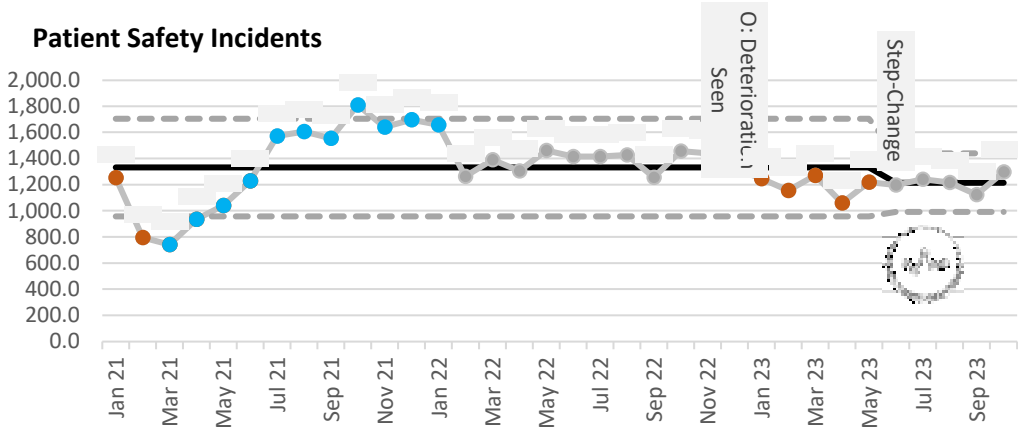


Figure 8.

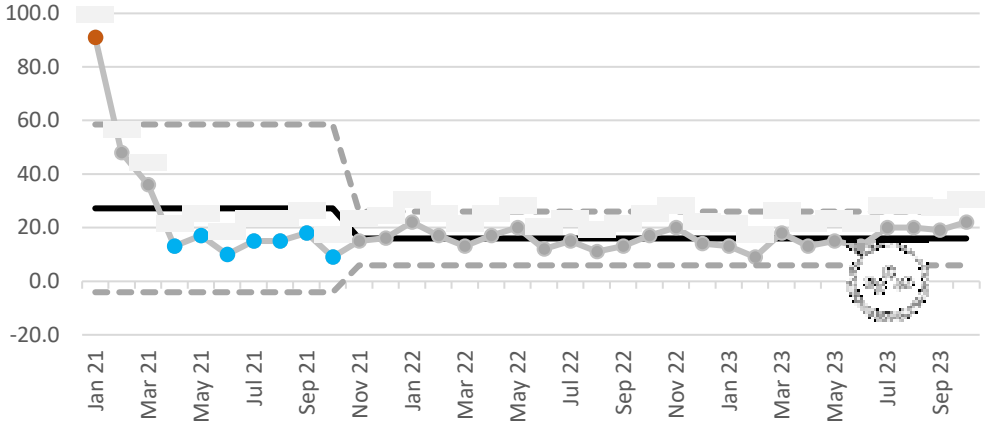
Patients

Increase patient safety incidents with no or low harm incidents and decrease patient safety incidents with moderate harm or above – Top 6 objective

Patient Safety Incidents



Patient Safety Incidents - moderate or above



Analyst Commentary – Patient safety incidents:

A step change has been added in June '23 to adjust the mean based on a consistent period of lower level of reporting. This process is in common cause variation.

Analyst Commentary – Moderate or above harm:

This process is in common cause variation.

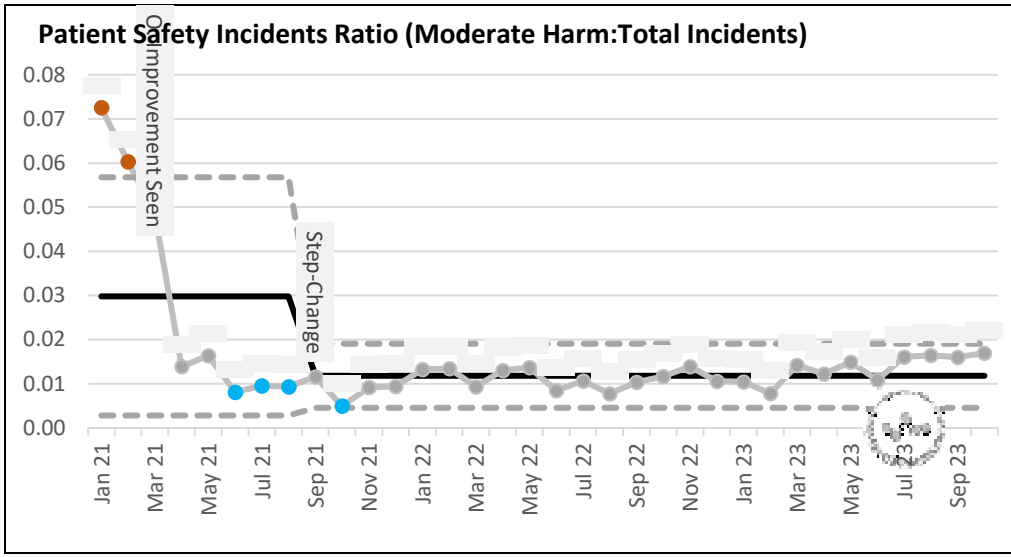
Analyst Commentary – Patient Safety Incidents Ratio:

A step-change has been added in September 2021 to reflect improvement in performance. This process is in common cause variation.

Executive Commentary:

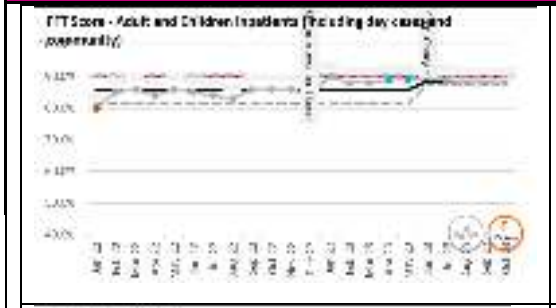
Learning from Patient Safety Events (LFPSE) was successfully launched on 1st December. In the preceding months there has been additional resources available to support staff to understand how to submit incident reports in a timely and effective manner. This appears to have positively impacted the increase in numbers of incidents reported.
Moderate harm incidents remain relatively static, with only a small increase in the number recorded in October. Medicine and Emergency Care and Maternity remain the highest reporters of moderate harm or above cases. This is due to the nature and acuity of patients within these groups. There are no real trends identified within these incidents at this stage. All incidents are reviewed as per standard governance processes.
It has been agreed by the Executive team that Patient Safety Incident Response Framework will commence on 1st April 2024, with planned activities being agreed to ensure successful launch. Fundamentals of care is gaining traction with workflow leads providing assurance at the Fundamentals of Care Delivery group on a regular basis.

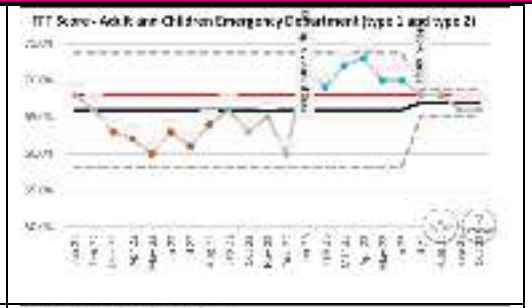
Action	*By who*	*By when*
Continue to provide robust review of moderate harm and above incidents	Chief Medical Officer Chief Nursing Officer Deputy Director of Governance	Ongoing
Re-launch of incident reporting (LFPSE)	Chief Medical Officer Chief Nursing Officer Deputy Director of Governance	Completed 1st December 2023
Fundamentals of Care rollout	Chief Medical Officer Chief Nursing Officer	Ongoing

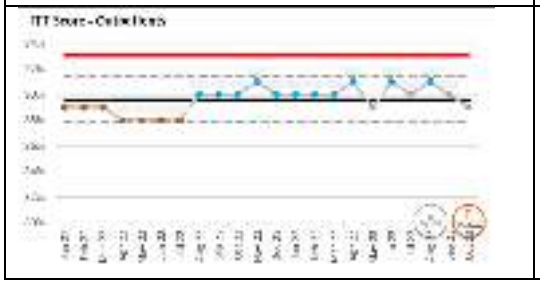

Patient Safety Incidents Ratio (Moderate Harm:Total Incidents)
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0.00
Improvement Seen
Step-Change
Jan 21
Mar 21
May 21
Jul 21
Sep 21
Nov 21
Jan 22
Mar 22
May 22
Jul 22
Sep 22
Nov 22
Jan 23
Mar 23
May 23
Jul 23
Sep 23

Patients

Increase patients rating their experience as good or very good for all touchpoints including Friends & Family Test (FFT) by area - Top 6 objective







Analyst Commentary:

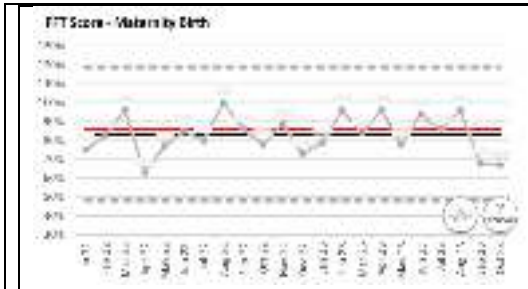
We have added step changes to FFT Score – Adult and Children Inpatients and Adult and Children Emergency Department following 6 months of special cause improvement variation. Our Friends and Family scores for Outpatient, Antenatal and Birth are in common cause variation.

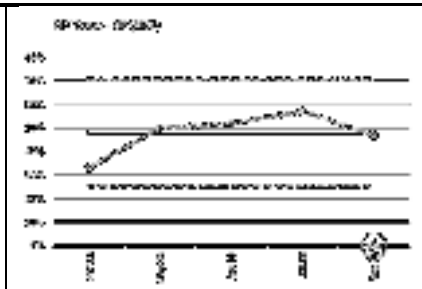
Birth scores are volatile due to their low response numbers. GP Scores have only been recorded since April 2023.

Target Source: Local Targets (median value from Public View).

Executive Commentary:

- Patient Experience Ambassadors increasing; Ambassador forum and Steering Group in place to support embedment and influence.
- A further Personalisation / Vulnerabilities study day being planned (March 2024) following successful delivery in October.
- Further stories captured regarding vulnerabilities (IVD use) and end of life.
- Further training provided via Preceptorship programme, Nursing Associate programme and the Safeguarding Team.
- Conclusion of a previous Trust Board story (re mental health care and provision) concluded with multi-agency participation and learning
- Environmental priorities around mobility and diverse needs support agreed, specific tasks to be defined (for year one, FoC Patient Friendly Environment).
- Communication boxes delivered; content and SOP to be disseminated.
- Discussion with the Patient Partner Food and Nutrition Panel about widening group's scope to cover wider needs of the organisation with group interest not restricted to food and nutrition alone.





Area	National Target	Local Target	Actual
Emergency Department	75%	68%	65%
Birth	93%	86%	76%
Antenatal	86%	82%	82%
Outpatient	94%	93%	89%
Inpatient (with day case incorporated)	95%	90%	88%
GP (Your Health Partnership)		In discussion	

Action	*By who*	*By when*
Personalisation of care measurement – broadened across project initial trial areas	Patient Insight and involvement lead	September - December 2023
Personalisation and experience training development – additional study days	Patient Insight and involvement lead / Patient Experience Manager	October 2023– March 2024
Interpreting quality standards development and implementation. Business case development to support virtual interpreting	Patient Insight and Involvement Lead	October 2023 – March 2024
Implementation of guidelines, measures and on-site support for carers (trial).	Patient Insight and Involvement Lead	April – December 2023
Patient Experience Ambassadors programme	Patient Insight and Involvement Lead / Patient Experience Manager	September 2023 – March 2024

Patients: Summary Table	Quality Committee

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Index (SHMI) (monthly)	Jun 23	99	100			111	77	145
Sepsis - Treated in 1 Hour (as % Of Treated)	Nov 23	88.2%	85.0%			87.5%	83.1%	91.9%
Pressure Ulcer SWB Hospital Acquired - Total	Oct 23	22	23			27	18	37
Pressure Ulcer DN Caseload Acquired - Total	Oct 23	25	30			30	12	47
Falls with Harm	Oct 23	37	0			38	12	64
Doctor - Safe Staffing (FTE)	Nov 23	84.4%	93.0%			85.2%	82.3%	88.1%
Nurse Band 5 Vacancies	Nov 23	34	0			-28	-73	18
Pathway 1 % patients seen within target timescales	Nov 23	40.6%	55.0%			46.7%	35.2%	58.2%
No. of Complaints Received (formal and link)	Nov 23	67	8			89	42	136
Staff Survey - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	Jul 23	54.0%	70.0%			55.3%	#N/A	#N/A
Readmission with 30 days for patients aged 65 and over	Nov 23	10.9%	7.0%			16.5%	10.7%	22.2%
Bed moves per patients	Nov 23	1.6	1.4			1.6	1.5	1.8
Bed Days with no criteria to reside	Nov 23	2215	1313			2002	1248	2755
Patient Safety Incidents	Nov 23	1170				1208	960	1455
Patient Safety Incidents - moderate or above	Nov 23	19	-			16	6	26
Discharges after 8am and before 5pm	Nov 23	47.2%	60.0%			45.8%	42.2%	49.3%
Of those people who died in hospital % with a supportive care plan	Nov 23	35.8%	79.0%			31.0%	21.8%	40.3%
Emergency Care Mean Time (minutes)	Nov 23	273.0	192.0			245.0	201.9	288.0
Cancer - 62 Day Referral to Treatment (Urgent GP Referral)	Oct 23	56.3%	85.0%			59.0%	43.8%	74.2%
RTT - Incomplete Pathway (18-weeks)	Oct 23	51.4%	92.0%			56.4%	53.5%	59.3%
E Coli Bacteraemia (Post 48 Hours) - rate per 100,000 bed days	Nov 23	0.0	94.9			0.0	0.0	0.0
C. Difficile (Post 48 hours)	Nov 23	0	3			3	-4	9
MRSA Bacteraemia (Post 48 hours)	Nov 23	0	0			0	0	1
MSSA Bacteraemia (Post 48 Hours) - rate per 100,000 bed days	Nov 23	0.0	9.4			0.0	0.0	0.0
Urgent Community Response - 2 hour performance	Nov 23	75.2%	70.0%			66.3%	49.7%	82.9%

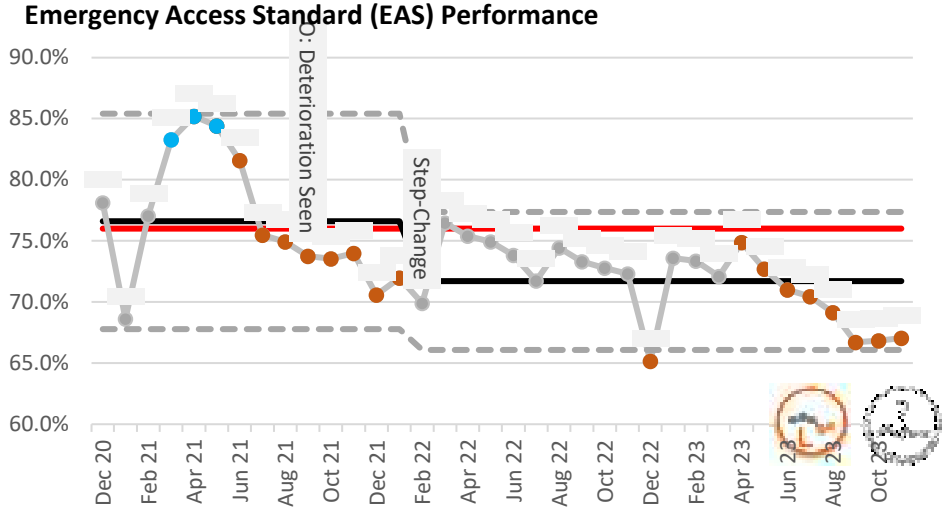
Patients: Summary Table	Quality Committee

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance handover time within 30 mins	Nov 23	68.6%	65.0%			78.7%	67.7%	89.7%
Length of stay (acute) for Virtual Ward Patients	Nov 23	4.4	4.1			3.8	2.5	5.1
No. of Sitrep Declared Late Cancellations - Total	Oct 23	48	20			49	20	79
RTT - Incomplete Pathway (18-Weeks) Patients Waiting > 65 Weeks	Oct 23	952	0			721	434	1008
Medication Errors causing serious harm	Nov 23	2	0			0	0	1
Complaints – Responses exceeding agreed response date	Nov 23	25.0%	20.0%			53.8%	26.7%	80.8%
Health Surveillance Rate - Cervical Cancer Screening	Jun 22	66.3%	-			66.3%	#N/A	#N/A
Sandwell Place - GP Ratio per 10,000 population	Aug 23	6.9	-			7.0	6.8	7.2
Sandwell Place - Learning Disability Reviews	Jul 23	261	-			441	-72	955
End of Life training	Nov 23	79.5%	95.0%			68.1%	61.0%	75.2%
Median number of days taken to setup a study at the Trust	Oct 23	45	40			59	#N/A	#N/A
Median number of days taken to recruit the first participant into a study at site	Oct 23	101	70			147	#N/A	#N/A

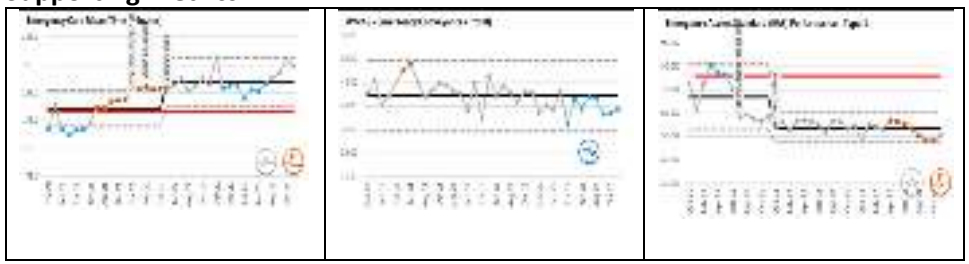
Patients

To increase patients who are seen and treated within the 4 hour emergency access standard from 73% to 76%

Emergency Access Standard (EAS) Performance



Supporting Metrics:



Analyst Commentary – Emergency Access Standard (EAS) Performance:
A step change has been added from February 2022 to adjust the mean based on a persistent period of lower percentage reporting following COVID. We are 58th out of 119 Trusts in the most recent Public View rankings [October 2023]. This process is in special cause concern. Target Source: National – updated for 23/24 operational guidance.

Analyst Commentary – Emergency Care Mean Time: A step change has been added from May 2022 to adjust the mean based on a persistent period of deteriorated performance beginning December 2021. This process is in common cause variation. If the target is below the lower process limit, the target cannot be expected to be achieved.

Analyst Commentary – WMAS – Emergency Conveyances (total): This process is in special cause improvement variation.

Analyst Commentary – Emergency Access Standard (EAS) Performance Type 1 ED: A step change has been added from December 2021 to adjust the mean based on a persistent period of lower percentage reporting beginning July 2021. This process is in common cause variation. If the target is above the upper process limit, the target cannot be expected to be achieved. We are 98th out of 119 Trusts in the most recent Public View rankings [October 2023].

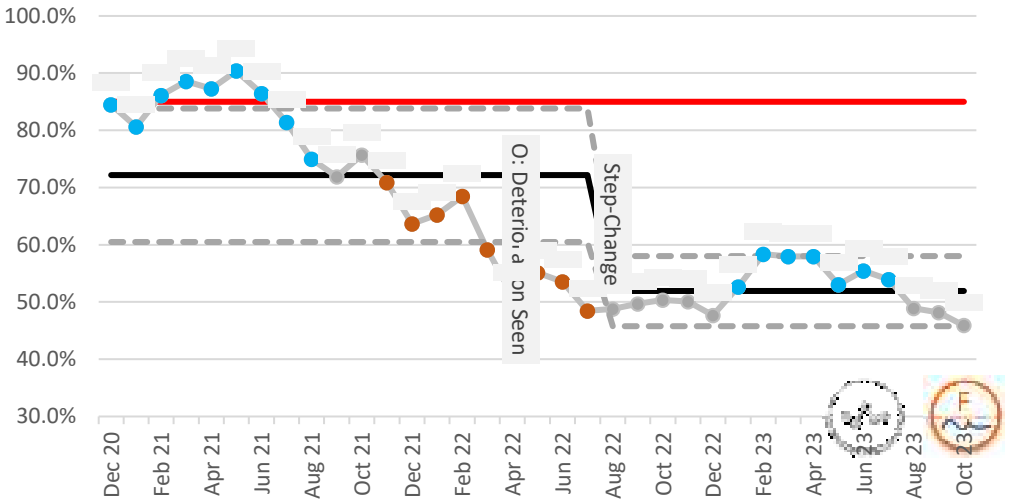
Executive Commentary: November performance showed a stabilisation and improvement in real terms EAS performance- although not yet statistically significant utilise SPC principle. All key metrics improved from October to November. Significant work continues in relation to the Winter Ambition and the EAS improvement plan.

Action	*By who*	*By when*
Improve diversion of patients away from Emergency Department to community and Same Day Emergency Care services through implementation of trust streaming model and Integrated front-door.	Rachel Clarke (Deputy GDOP)/Demetri Wade (Deputy COO)	November 23 - Recruitment ongoing, funding now agreed.
First Net roll-out for all Same Day Emergency Care areas – on hold until full review by UCAG of frailty pilot – review now complete.	Demetri Wade (Deputy COO)	Apr-Sep 2023 - report submitted for consideration of next steps.
Implementation of Urgent care bed rightsizing schemes	Rachel Clarke (Deputy GDOP)	On-going
Full action plan in place to improve EAS performance- with particular focus on Non-admitted performance	Rachel Clarke (Deputy GDOP)	On-going implementation

Patients

To increase patients who have their diagnostic completed within 6 weeks of referral from 50% to 85% (DM01)

DM01 Diagnostics 6 Weeks Target



Outstanding Tests (October 2023)		
Modality	No.OfTests	>13Weeks
Non-obstetric ultrasound	19027	6370
Computed Tomography	2023	770
Colonoscopy	841	261
Flexi sigmoidoscopy	462	194
Gastroscopy	556	144

Analyst Commentary – DM01 Diagnostics 6 weeks target:

Percentage of patients waiting less than 6 weeks for a diagnostic examination. A step change has been added from August 2022 to adjust the mean based on a persistent period of deteriorated performance. This process is in common cause variation. If the target is above the upper process limit, the target cannot be expected to be achieved. We are 116th out of 119 Trusts in the most recent Public View rankings [September 2023]. Target Source: National

Analyst Commentary – DM01 Number of Tests Outstanding > 13 Weeks:

Number of tests that are still outstanding after 13 weeks. This process is in special cause concerning variation. A step change has been added from September 2022 to adjust the mean based on a persistent period of deteriorated performance. If the target is below the lower process limit, the target cannot be expected to be achieved. Target Source: National

Executive Commentary:

The position for 13+ weeks and deterioration of DM01 is largely driven by the Non-Obstetric UltraSound (NOUS) position with contribution from CTCA, Endoscopy Neurophysiology and Echo. Deterioration of DM01 and 13+ week position has resulted in 13+ weeks added as an agenda item on tiering meeting with particular focus on NOUS.

Integrated Care System (ICS) are to complete a deep dive into NOUS with NHSE/I regional team to complete deep dive into other diagnostics/physiological services (CT, Endoscopy, Neurophysiology, Echo)

The provisional data for November shows 1.5% increase in DM01 performance but further deterioration in 13+ weeks again largely driven to the NOUS tip over from 6-12 weeks.

The NOUS position was largely contributed due to the delay in the funding decision regarding unbundling of tariff which added 4000 to the backlog due to the loss of insourcing capacity. A further 1800 was added to the backlog due to further loss of insourcing capacity when Trust aligned sonographers not to work for insourcing companies within own Trust. Increased insourcing and increased bank rates have been utilised to slow down the increase of 13+ weeks and reduce the waiting list. Increased mutual aid as well as insourcing is due to be delivered from January 2024, with additional funding sought from NHSE/I for Q4 23/24 and 24/25. A sustainability business case will be written supporting delivery of both NOUS and Obstetric Ultrasound and will go through Governance processes in February following deep dive.

CTCA has seen improved position from that reported in November with continued support of Waiting List Initiatives (WLIs) to reduce the backlog as well as template changes. A CTCA working Group chaired by the Deputy Chief Operating Officer (DCOO) and Chief Medical Officer (CMO) is looking at sustainability of the CTCA services and transformations that required to support future service delivery.

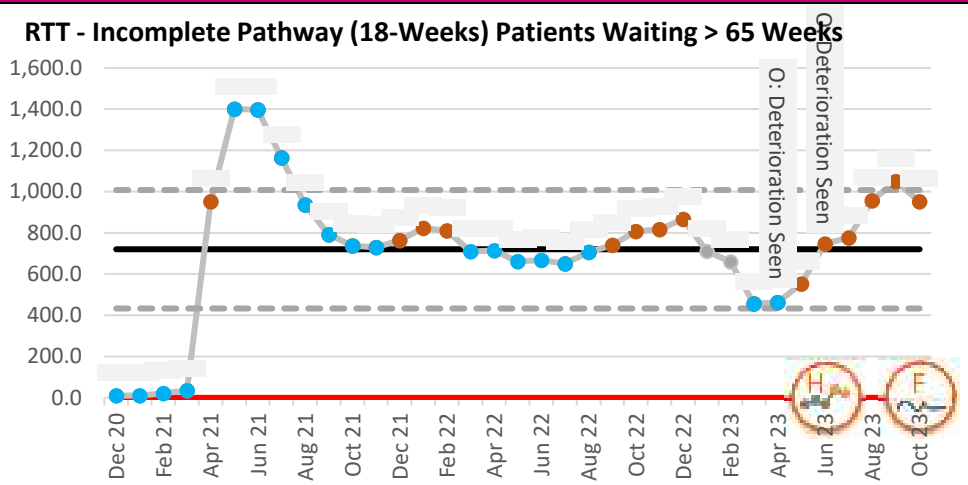
Endoscopy position being supported by insourcing provision and recruitment of locum consultants. However, significant increase in 2ww and also supporting RTT recovery is having an impact on recovery.

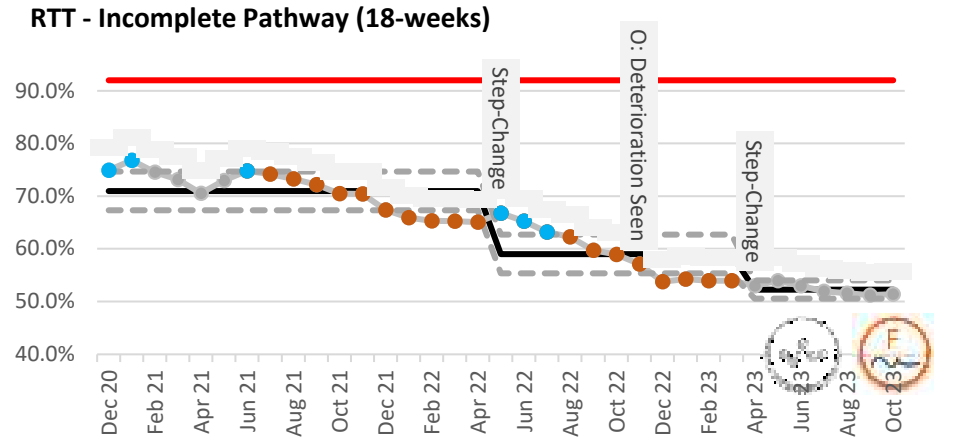
There has been significant improvement in the Echo position near eradication of 13+ weeks which is expected to be sustained. Neurophysiology has seen a deterioration in position due to workforce challenges but is mitigated with extension of insourcing been agreed. MRI and Audiology achieving 85% DM01 but MRI still to eradicate 100 13+ weeks

Action	*By who*	*By when*
Additional funding sought from NHSE/I to support insourcing for NOUS	Darren Smith (Group Director of Operations) Johanne Newens (Chief Operating Officer)	December 2023
Extension of Neurophysiology Contract	David Byrne (Group Director of Operations)	December 2023
Bank rate Paper to be submitted and reviewed to Workforce Committee	Ciara Browne (Group Director of HCP)	January 2024

Patients

To reduce the maximum length of our waiting list in all specialities from 100 weeks to 65 weeks for Referral to Treatment standard





Analyst Commentary:

RTT – Incomplete Pathway (18-Weeks) Patients Waiting > 65 Weeks:

A step change has been added in August 2021 to reflect the COVID implications beginning April 2021. This process is in special cause concern variation. If the target is below the lower process limit, the target cannot be expected to be achieved. We are 85th out of 119 in the latest Public View rankings [September 2023]. Target Source: National

This chart is reporting the total number of patients waiting over 65 weeks on an incomplete RTT pathway as at the reporting month. The Operations team and the national targets are focused on all patients who will be waiting >65 weeks on March 31st 2024, if their pathway is not completed.

RTT – Incomplete Pathway (18-Weeks):

A step change has been added in March 22 to reflect declining performance. A second step-change has been added to reflect further deteriorating performance. This process is in common cause concern variation. We are 95th out of 119 Trusts in the latest Public View rankings [September 2023]. Target Source: National

Executive Commentary:

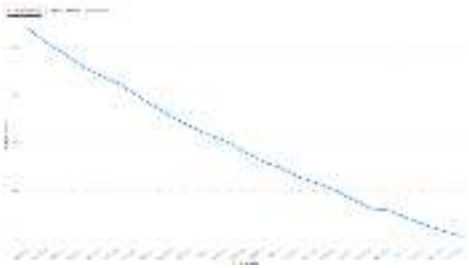
Trust is ahead of 65+ weeks cohort internal trajectory (that is being monitored by the Trust and Black Country Elective Care Board) by 3,217 patients and have seen reduction in patient waiting for 1st OPD in high-risk specialities (ENT and Dermatology) due to additional outsource capacity. Clinical Groups review and monitor both inhouse and outsource capacity and with further plans been developed to support the delivery of 65+ weeks by March 31, 2024 except ENT where System to provide mutual aid.

Junior Dr strike scheduled in December and January pose a high risk on delivering zero patients wait over 78+ weeks, 65+ weeks 1st OPD and some of the specialities may slip from performance gained past few weeks on these metrics. Clinical Groups are working through plans to mitigate and ring fence long waiters and avoid being cancelled.

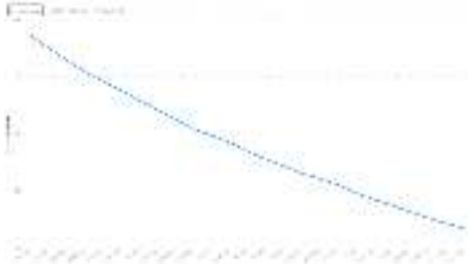
Theatre improvement program commenced and have identified number of opportunities as well as been focussing on quick wins looking at both prospective / forecast as well as learning from retrospective data to improve further and a review is scheduled in December 2023. Booking efficiency program involving all stakeholders has started and have seen improvements in specialities with high demand.

As part of outpatient transformation there are number of efficiencies identified to improve as well as best use of resources. “Further Faster” program is a good benchmark to assess the scale of improvement based on the initiatives put in place, since July 2023, Trust has made good progress in follow up reduction, and 12+ weeks validation and still have improvement work to do in Specialist Advice, missed appointments and PIFU. Action plans / working groups are in place for specialties with high cancellation rate. A new process has been rolled for Remote consultation where staff must choose type of consultation and remote consultation is one on top of the list.

Volume of patient that would breach 65 Week Waiters as at 31/03/2024.



Volume of patient that would breach 65 Week Waiters as at 31/03/2024. – does not include patients who have a new appointment booked



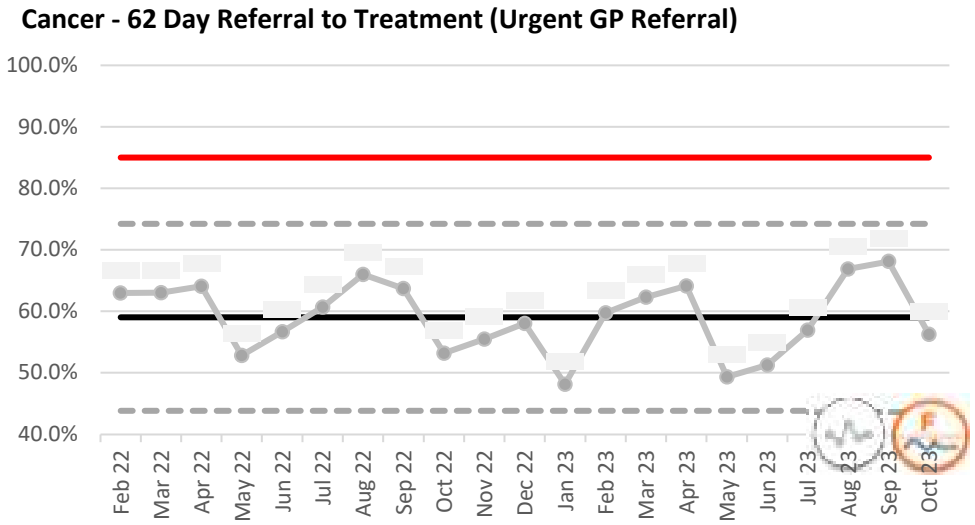
INPATIENTS WAITING > 65 WEEKS	
SPECIALTY	QTY
ENT	195
TRAUMA AND ORTHOPAEDICS	95
OPHTHALMOLOGY	22
GYNAECOLOGY	13
ORAL MAXILLOFACIAL SURGERY	7

OUTPATIENTS WAITING > 65 WEEKS	
SPECIALTY	QTY
ENT	382
GENERAL SURGERY	56
DERMATOLOGY	37
TRAUMA AND ORTHOPAEDICS	31
UROLOGY	27

Action	*By who*	*By when*
Weekly review of month to date and month end performance projection	Alwin Luke, Asst. Director of Planned Care	Emphasis at weekly Planned Care Delivery Group
Specialty level recovery and trajectory plans using demand & capacity	All Clinical Groups – GDOPs	On-going / review
Streamlining referral processes and introduction of one stop clinics	All Clinical Groups – GDOPs	On-going / review
Follow up capacity release schemes e.g., Supported Discharge, virtual clinics.	All Clinical Groups – GDOPs	On-going / review
Maximise use of Outpatient capacity and Theatre utilisation	All Clinical Groups – GDOPs	On-going / review
Train & assess knowledge of 18-week pathway management in all relevant staff groups.	Alwin Luke, Asst. Director of Planned Care Mark Whitehouse, Head of Patient Access	Commenced and ongoing

Patients

To increase cancer patients who are seen and treated within 62 days from 68% to 85%



PATIENTS WHO WAITED > 62 DAYS FOR TREATMENT	
CANCER SITE	QTY
Urological (ExcludingTesticular)	10
Gynaecological	5
Skin	4
Lower Gastrointestinal	4
Breast	4
Lung	3.5
Haematological	3
Head and Neck	1
Other (not listed)	1
Sarcoma	1
Upper Gastrointestinal	0.5

NB '-.5' patients refer to shared breaches where patients are referred between providers.

Analyst Commentary:

This process is in common cause variation. If the target is above the upper process limit, the target cannot be expected to be achieved. We are 35th out of 119 in the latest Public View rankings [September 2023].
Patients who waited >62 Days for Treatment: Breaches that are shared with an external provider are marked 0.5.

Executive Commentary:

The Trust recovered TWW (Two Week Wait) position in November achieving 93%. Capacity issues in Dermatology has improved to 80% with additional capacity via outsourcing delivered for routine patients and Colorectal pathway continues to improve achieving 90%. Non-compliance in Haematology due to consultant vacancy and long-term sickness. The 31-day performance is static at 90% against 96% target.

The trust 62-day performance has declined, 56% for October against 85% target. However, with the introduction of the combined 62-day target from 1st October 2023, trust is above the 70% target set on implementation.

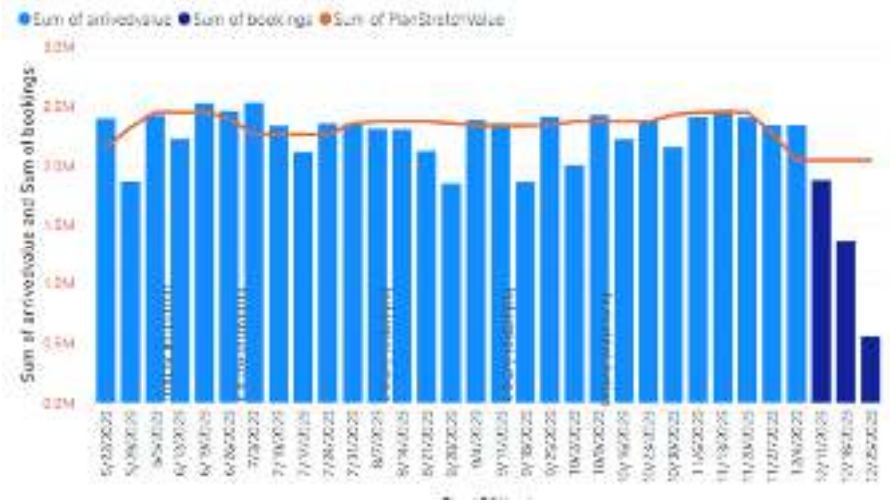
28-day FDS (Faster Diagnosis Standard) has improved achieving the 70% target for October and on track to achieve the expectation from ICB that all providers to achieve 72.5% by December 2023. USS Head&Neck capacity remains a challenge, along with the need for repeat scopes and patient-initiated delays impacting the colorectal FDS.

The backlog continued to remain ahead of trajectory through October but there are now concerns whether the March 2024 trajectory will be achieved. The backlog has continued to rise throughout November and December, areas of concern are Lower GI, Gynaecology, Haematology and Dermatology. The plans for industrial action will have an impact on performance even though cancer is a priority. Cancer Services are meeting with each specialty to develop a recovery plan which will need to micromanaged weekly.

Action	*By who*	*By when*
Review Cancer escalation & breaches guidance to ensure fit for purposes with changes.	Alwin Luke, Asst. Director of Planned Care Jennifer Donovan, Cancer Services Manager	On-going review
Comprehensive and robust Patient Treatment List (PTL) management – separate session for each speciality	Alwin Luke, Asst. Director of Planned Care Jennifer Donovan, Cancer Services Manager	On-going review
Ensure all waiting lists, appointments and diagnostic requests have a 2WW priority.	Jennifer Donovan, Cancer Services Manager All Clinical Groups – GDOPs	On-going review
Black Country Pathology Service (BCPS) turnaround time – diagnostic tests.	Black Country Pathology Service	Action plan completed
Imaging turnaround time – diagnostic tests. Review of STT pathway	Darren Smith, Group Director of Ops. Imaging Jenny Donovan - Cancer Services Manager	December 23

Patients

To increase elective activity from 94% to 104% of 2019/20 activity levels as per our production plan - Top 6 objective



Analyst Commentary:

Despite a plan amendment relating to the national financial settlement year to date the performance against the ERF target is £1,419k adverse. The ERF performance is offset by an overperformance on other variable activity of £2,567k.

The bottom graph shows production plan against predicted income per week based on delivered activity. November has seen improved arrival numbers in relation to the Plan. However, December bookings are significantly below Plan.

Executive Commentary:

The current forecast moving from £437k shortfall to £442k (against a target of £123,279k outturn) between November and December shortfall is based on a number of adjustments.

Narrative	
ERF Forecast Outturn as at Nov-23 FPC	£122,842,467
Forecast Movement: Update to Nov-23 YTD Actuals	£531,769
Winter Pressures Impact	£1,697
Coding & Counting	£929
Burcott Hall Coding	£199,425
BCHC Dental Activity	£417
SDEC Winter Surge	-£58,062
Improvement Scheme: Surgery (Optimised Care)	-£58,928
Improvement Scheme: Knee Joint Lists	-£21,515
Improvement Scheme: Endoscopy Locums	-£99,153
Junior Doctors Industrial Action	-£502,542

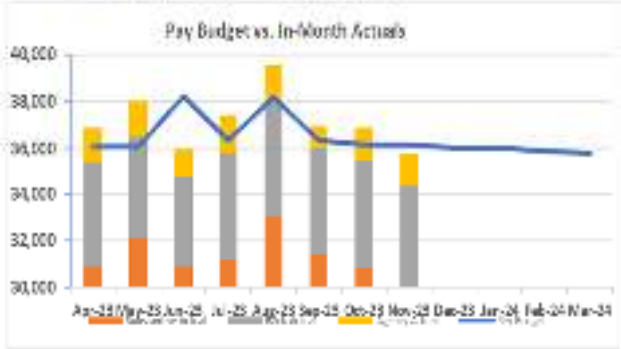
The significant adjustments are the forecast negative impact in December and January of the Junior Doctors Industrial action based on the impact of previous strikes, and the positive improvement in forecast based on the increase in activity in November compared to previous months. These largely net each other out but if increases continue as new scheduling processes

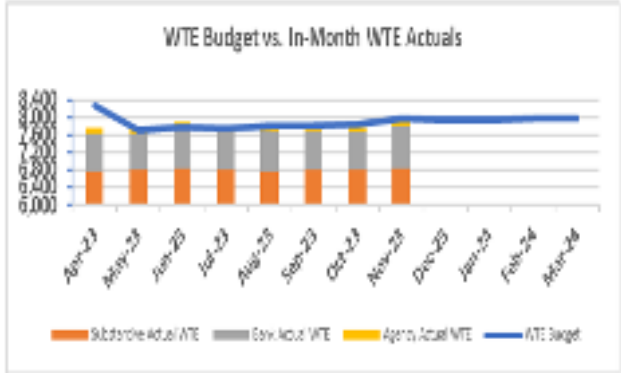
are embedded and better mitigation than previous strikes are realised then the situation will improve further.

Action	By who	By when
Improve outpatient clinic utilisation – workforce, room	Clinical Groups	Ongoing
Reducing follow-up patients by 25% and replace with new patients	Clinical Groups	Ongoing March 2024
Streamline patient pathway to include virtual clinics, Patient Initiated Follow-Up (PIFU) outcome	Clinical Groups	August 2024
Reduce patient DNAs – review patient letters, text	Clinical Groups Mark Whitehouse, Head of Patient Access	July 2024
Rota published six weeks in advance – to avoid short notice sessions	Clinical Groups	September 2024
Improve theatre efficiency – list and in-session utilisation	Clinical Groups	Ongoing
Reduce on the day surgery cancellation	Clinical Groups	September 2024
Improve OPD and theatre booking efficiency to 100%	Mark Whitehouse, Head of Patient Access Alwin Luke, Asst. Director of Operations	August 2024

Patients

To deliver our income and expenditure plan and improve our underlying deficit position from £46.9m to £40m





Analyst Commentary:

Trust reported position deficit of £17.499m. This is a significant movement from last month and reflects the system wide review of financial positions in light of announcements from NHSE around Industrial action funding and other additional non-recurrent funding releases. The Trust as part of this review has agreed, (through FPC) a forecast outturn of £27.196m. At month 8, the position is tracking in line with this, although with some significant risks to this in the next 4 months.

Executive Commentary:

The Trust has agreed to an outturn deficit position of £27.196m. At month 8, the position was in line with this trajectory. The main risk elements within the plan were:

1) Significant coding and counting improvements
2) Significant Increase in Financial Improvement Plan delivery

Since the sign off, of the plan further risks have emerged:

1) Winter Plan. Additional beds have had to be opened in advance of planned opening and significantly above the planned number.
2) Industrial Action. As part of the H2 system re-forecast, Trusts were asked to take out and forecast of further costs related to this. Since the sign off of the plan, Junior doctors have announced further strikes. From a financial perspective, this will impact both cost and income delivery, and the Trust will have to await and decisions on the funding of this
3) ERF. This may be affected by point 1 and will be affected by Point 2. Current forecasts do not meet the required delivery within the H2 system forecast.

Mitigations

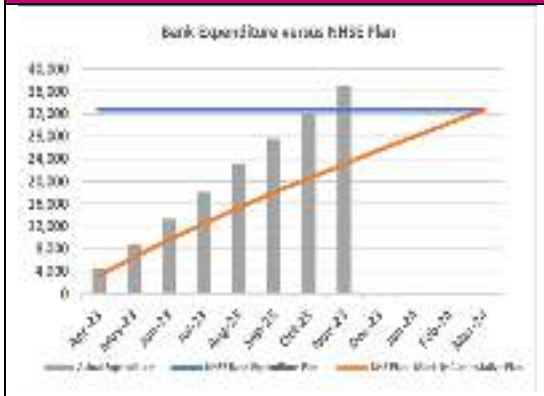
The trust is working through mitigations to the risks identified above. These include.

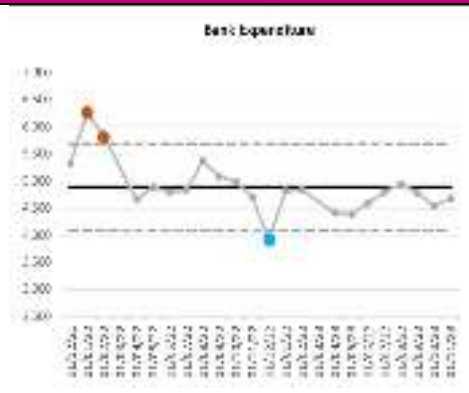
1) Possible further non-recurrent flexibility
2) Revenue to capital transfers, based on any slippage within the financial plan.
3) Financial Recovery improvements, through the CIP lead, and the Elective Recovery resource brought in by the Trust.

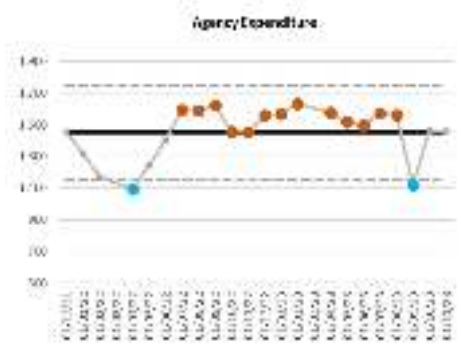
Action	*By who*	*By when*
Group and Corporate Directorate CIP/Pay Stretch – Delivery of £27m of identified schemes	Groups/Corporate Directorates	Identification Complete; Delivery on-going
Group and Corporate Directorate CIP – Identification and delivery of schemes to close gap - £10m	Groups Corporate Directorates/Executive Group	Paper to FPC 1/9/2023
Executive Led Schemes £16.2m. £2m with clear plan	Executive Group	Paper to FPC 1/9/2023
MMUH Income - £14.6m. Requirement likely to be lower in 23-24	Chief Finance Officer	Ongoing
Non-recurrent measures - £9.6m	Chief Finance Officer	On plan to deliver
Excess Inflation - £7m	Chief Development Officer	Ongoing
Elective Plan	Chief Operating Officer	Ongoing

Patients

To reduce our bank and agency spend from £64.4 million to £45.6 million - Top 6 objective







Analyst Commentary:

Bank is running nearly £1.7m a month above the NHSE plan. Agency £0.37m a month above plan. Financially bank expenditure is roughly equivalent of substantive staff, there are some areas that have agreed enhanced rates, and medical staff bank rates can vary dependent on availability. This level of spend is offset by underspends against substantive workforce lines. If our current trajectory of spending on Bank and Agency continues, we will finish the financial year with a spend on Bank and Agency staff of £73m.

Executive Commentary:

The headline pay position of the Trust is an adverse variance of £3.74 to the NHSE plan Against the System H2 forecast, pay is £1.74m ahead of the forecast, largely due to the release of reserves protection to offset slippage on income improvements. The main risks to bank and agency expenditure and improvements relate to the following:

1) Winter Plan (current Board Agreed). Have opened additional capacity in advance of the plan and opened significantly more.

2) Winter Plan (revised) opened the additional capacity in this earlier than the plan stated.

3) No scope in the revised forecast outturn of £27.196m for further winter schemes unless mitigations are identified.

Action	*By who*	*By when*
Actions to reduce Medical Bank and agency	Chief Operating Officer, Chief Nursing Officer and Chief Medical Officer	31 August 2023 (complete)
Group and Directorate workforce plans to deliver 2023/24 budgets inclusive of Cost Improvement Programme.	Group and Corporate Directorate Management Teams	31 August 2023 (complete)
CMO to authorise any request for Agency Locum Consultants	Chief Medical Officer	On-going
Plans to reduce need for Agency Locum Consultants developed by Groups	Group Directorate Management Teams	On-going
Work to analyse current medical rota oversight, initially in MEC to develop 'golden rules' being used and process for rate negotiation	Improvement Team	On-going
Engagement in Health Trust Europe (HTE) meetings with view to re-establishing clusters to assist with rate reduction	Trust-wide	On-going

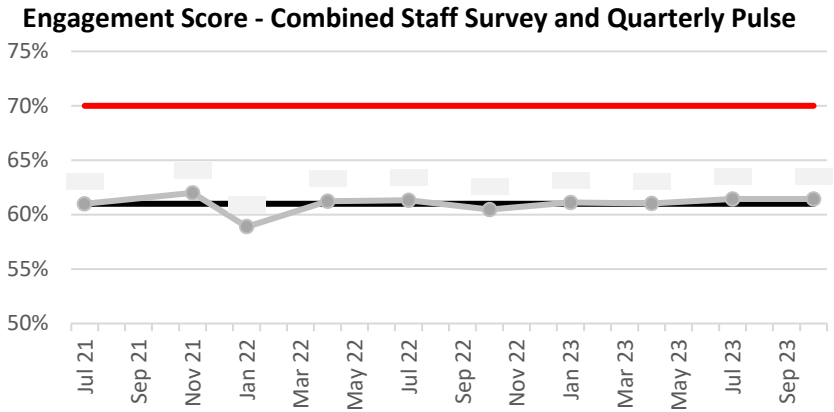
Patients: Summary Table	Finance & Productivity Committee

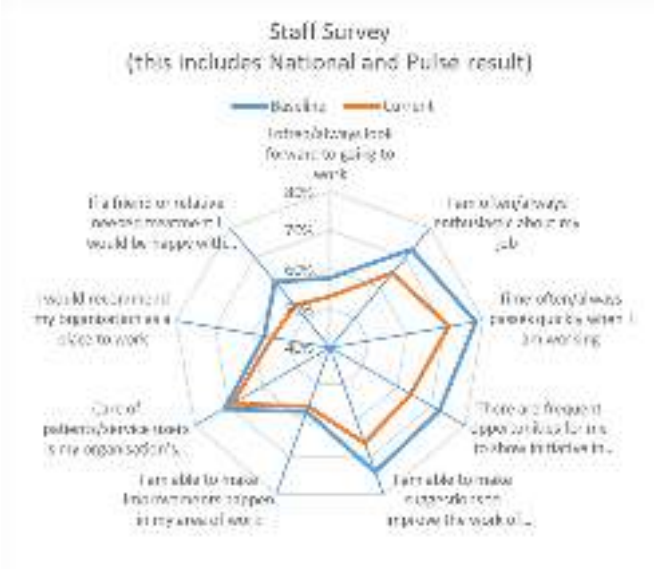
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Sickness Absence (Monthly)	Nov 23	6.1%	5.5%			5.9%	4.7%	7.2%
No. of Sitrep Declared Late Cancellations - Total	Oct 23	48	20			49	20	79
New:Follow up appointments ratio	Nov 23	1.5	2.5			1.5	1.5	1.6
DNA Rate - Exc Radiology (SWB)	Nov 23	13.2%	8.5%			12.3%	10.4%	14.2%
RTT - Incomplete Pathway (18-weeks)	Oct 23	51.4%	92.0%			56.4%	53.5%	59.3%
78+ 18 wks Referral to Treatment	Oct 23	48	0			51	27	75
Cancer - 2 Week Waits	Oct 23	91.5%	93.0%			94.9%	89.8%	100.1%
Ambulance handover time within 30 mins	Nov 23	68.6%	65.0%			78.7%	67.7%	89.7%
Theatre session utilisation	Nov 23	75.4%	84.0%			99.0%	-27.3%	225.4%
Theatre in session utilisation	Nov 23	70.8%	84.0%			71.8%	69.0%	74.6%
DM01 Diagnostics 13 Weeks target	Oct 23	7970	0			5233	3100	7367
DM01 Diagnostics 6 Weeks Target	Oct 23	45.9%	85.0%			51.9%	45.8%	58.1%
RTT - Incomplete Pathway (18-Weeks) Patients Waiting	Oct 23	952	0			721	434	1008
Urgent Community Response - 2 hour performance	Nov 23	75.2%	70.0%			66.3%	49.7%	82.9%
Emergency Access Standard (EAS) Performance	Nov 23	67.0%	76.0%			71.7%	66.1%	77.4%

KPI	Latest month	Measure	Target	...ration	...surance	Mean	Lower process limit	Upper process limit
DNA Rate - Exc Radiology (SWB)	Nov 23	13.3%	8.5%			12.0%	10.5%	13.6%
Outpatient - Clinic Throughput	Nov 23	11.1	-			10.9	10.3	11.5
Outpatient - Procedures	Nov 23	25.3%	-			25.4%	23.4%	27.4%
Inpatients - Daycase Rate	Nov 23	0.8	-			0.9	0.8	0.9
Theatre - Elective Patient Rate	Nov 23	3.2	-			3.2	2.9	3.5
Theatre - Elective Minute Rate	Nov 23	233.6	-			227.3	211.8	242.7
Theatre - Emergency Patient Rate	Nov 23	2.5	-			2.4	2.0	2.7
Theatre - Emergency Minute Rate	Nov 23	123.5	-			130.6	82.2	178.9
Outpatients per FTE	Sep 23	11.0	-			10.5	8.1	12.9
Outpatient Procedures per FTE	Sep 23	2.9	-			1.6	1.1	2.2
Inpatient Spells per FTE	Sep 23	0.7	-			0.7	0.6	0.8
Daycases per FTE	Sep 23	0.4	-			0.4	0.3	0.5

People

To improve staff experience from 60% to 70% (combined engagement score)





Analyst Commentary:

SPC Chart The engagement score is a quarterly measure tracking 9 consistent questions through the pulse / staff survey. It is measured 4 times per year, 3 via quarterly pulse and 1 via annual staff survey.

The SPC chart is in common cause variation and there are not enough data points to calculate control limits.

We are 94th out of 120 on Public View [Quarter 3 22/23]. The median target from Public View is 66.91%.

Target Source: Local

Radar Diagram The baseline (November 2019) is taken as a pre-COVID position.

Executive Commentary:

- The annual staff survey and pulse surveys are mandated for all NHS providers. These surveys currently provide the best way of measuring staff experience against the NHS People Promises, which align strongly with SWB's People Plan.
- Staff engagement and satisfaction is one of the priority people metrics for the Strategic Planning Framework (SPF) in development for 2024/25.
- Based on the feedback from the Q2 pulse survey, a range of 'high impact actions' have been developed by each of the Clinical Groups to deliver improvements to the working lives of staff locally.
- From January 2024 ownership for progress in delivering these improvement plans will sit with the Clinical Group leadership teams who will be required to attend POD Committee regularly to provide updates on the delivery and impact of these plans.
- Annual framework for improving the Trust's response rates, engagement score and staff satisfaction rates more broadly has been supported by the Trusts Management Committee and the POD Committee in November.
- The 2023/24 Staff Survey closed on 24th November, and we had a response rate of 29 %. The results will be published in Jan/Feb 2024 (under embargo).
- The next Pulse Survey will take place in January 2024.

Action	*By who*	*By when*
Clinical Group to attend POD to present updates on Staff Survey actions	Chief People Officer	January 2024
Annual Framework for improving Trust's response rates and engagement scores	Chief People Officer	November 2024

People

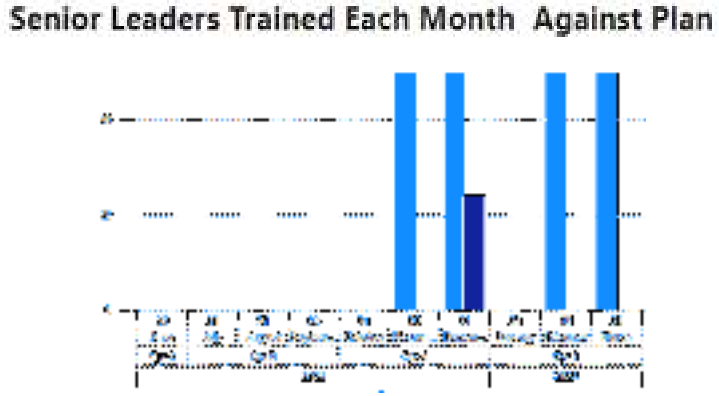
To develop 200 leaders in compassionate and inclusive leadership, restorative people management, and in safety and service innovation - Top 6 objective

Analyst Commentary:

The charts show the planned training figures for senior leaders by their planned course completion dates. People trained will show on the bar chart as a run rate against the bar chart. This data shows those leaders that have completed Day 2 of their Compassionate and Inclusive Leadership course (indicating completion of the training). Data correct as at 08/12/2023.

Executive Commentary:

- The Trust annual plan requires us to train 200 leaders in module 1 of the ARC Leadership Training (Compassionate and Inclusive Leadership) by the end of March 2024.
- 300 leaders have confirmed their attendance on the cohorts scheduled to take place between September to March 24. 171 have attended the introductory session and 95 staff have completed day 1 training. 22 have completed Day 2 training. Current operational capacity is impacting on attendance and is being closely monitored to consider if additional sessions need to be scheduled to ensure we meet our target of training 200 leaders.
- 277 staff have attended the Compassionate Caregiver Team Member Training with an additional 48 delegates booked to attend session.
- A board session on Compassionate and Inclusive Leadership led by Prof Michael West is scheduled to take place on 13th December.



Action	By who	By when
Launch leadership training programme for the first 200 leaders	Director of People and OD	May 2023 –launched
200 leaders to complete module 1 of the ARC programme	Director of People and OD	March 2024
Board and senior leader session on module 1 scheduled to take place on 13th December	Director of People and OD	December 2023
Module 2 and 3 design and roll out to be agreed	Director of People and OD	April 2024

People: Summary Table (indicators & data provided by ESR team)	People Committee

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Turnover %	Nov 23	12.8%	13.0%			13.1%	12.2%	14.0%
Sickness R12m %	Nov 23	6.0%	5.5%			5.8%	5.5%	6.0%
Vacancies %	Nov 23	13.3%	9.0%			9.9%	8.3%	11.4%
Time To Hire (Days)	Nov 23	81	67			83	56	111
ER Open Casework - Count	Nov 23	47	20			36	22	49
ER Casework - Avg Days over Target Date	Nov 23	132	50			125	78	172
Engie - SLA % of Calls Rectified	Dec 22	79.0%	0.0%			81.5%	73.6%	89.4%
Employee Relations: BAME as % of total	Nov 23	31.3%				36.7%	27.9%	45.4%
Employee Relations: Disability as % of total	Nov 23	8.6%				6.2%	3.5%	8.9%

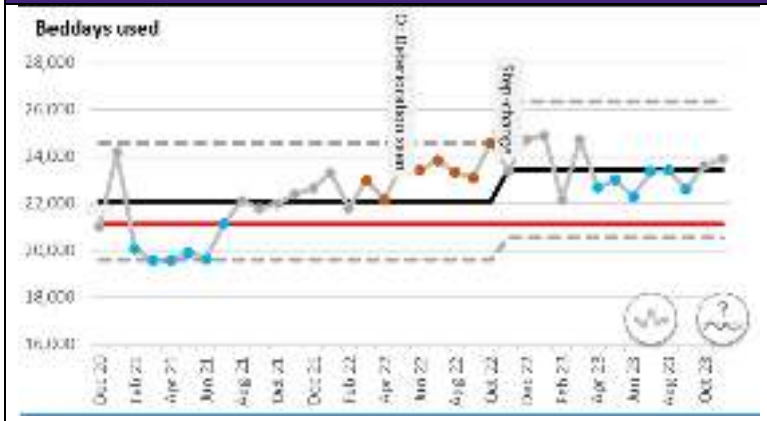
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Senior Leaders: Female	Nov 23	70.2%	74.0%			68.5%	68.0%	69.0%
Senior Leaders: BAME	Nov 23	37.6%	40.0%			35.6%	35.1%	36.1%
Senior Leaders: Disability	Nov 23	4.0%	5.0%			3.0%	2.8%	3.2%
Senior Leaders: LGBT	Nov 23	2.7%	4.0%			2.3%	2.2%	2.5%

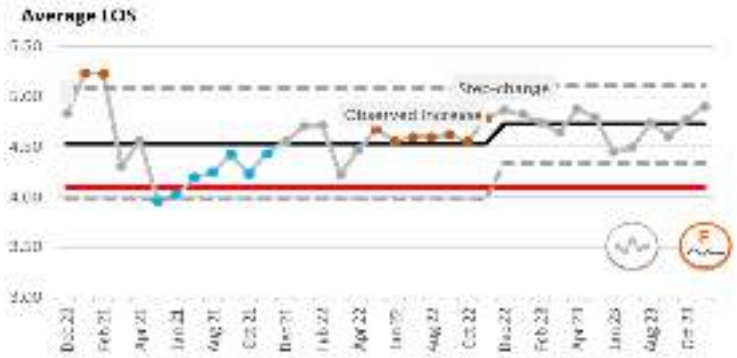
Senior Leaders Calculation: Senior Leaders (AFC Band 7+, Medical Consultants, Very Senior Management) of each individual indicator e.g. Female divided by the full cohort of Senior Leaders.

Note: The 100 Club has been removed and will be replaced with the Subject Compliance Figures, which are being collated. As of November 2023, this is 94.66%.

Population

To reduce the acute care occupied beds by 86 in line with our plans to fit into the new Midland Metropolitan University Hospital (MMUH) - Top 6 objective





Analyst Commentary – Total Bed Days used (occupancy):
A step change has been added in November 2022 after observation of 6 months increased reporting. This process is in common cause variation.

Executive Commentary:
As at 14/12/2023 we have not yet received commentary, however the graphs have been updated. We have left in the action plan from last month.

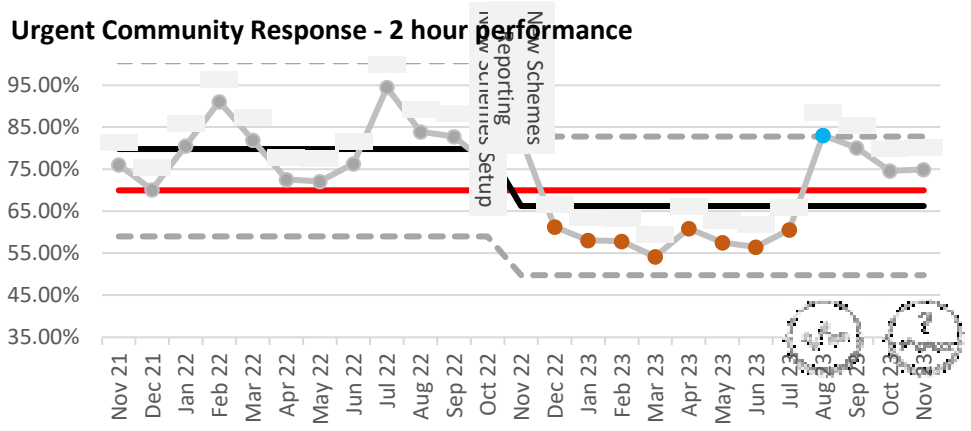
Action	*By who*	*By when*
Close a total of 62 unfunded/ additional acute beds – with an additional 24 to be identified from appropriate base wards	Deputy Chief Operating Officer	October 2023
Increase total number of frailty Virtual Ward Beds to 30 with an 85% occupancy	Deputy Chief Integration Officer	June 2023 – delayed due to uncertainty regarding SDF allocation. SDF income is now agreed but the delay hindered the ability for timely recruitment.
Commence Urgent Care steering group to include internal and external stakeholders to provide programme assurance	Deputy Chief Operating Officer / Deputy Chief Integration Officer	June 2023 - completed
Identify the causes of the increased bed usage through diagnostic work to confirm root cause and operational focus points	Deputy Chief Operating Officer / Deputy Chief Integration Officer	December 2023 - underway

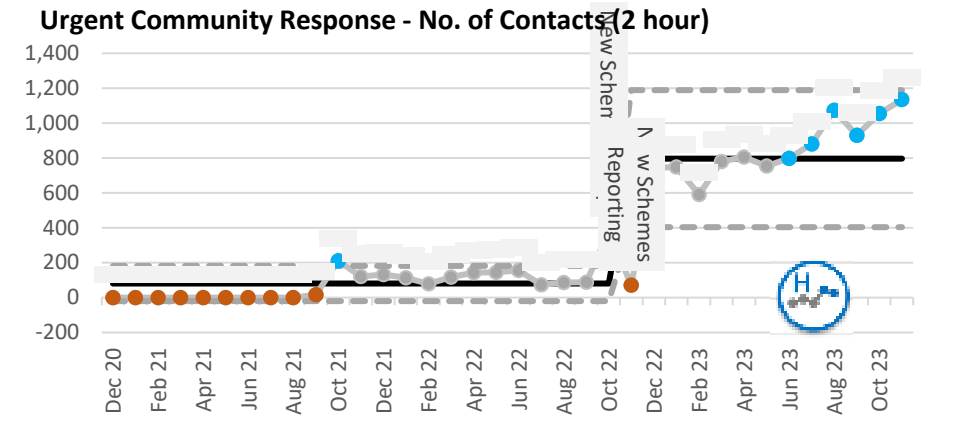
Equivalent Beds @ Planned Occupancy Rates

SCHEME: ALL

Population

To maintain that over 70% of patients are seen within the 2-hour urgent community response target, whilst increasing all urgent community response contacts per month from 1200 to 1500 per month.





Analyst Commentary – Urgent Community Response – 2 hour performance:
A step change has been introduced in November 2022 after the introduction of new schemes and their respective reporting. This process is in common cause variation. Target Source: National.

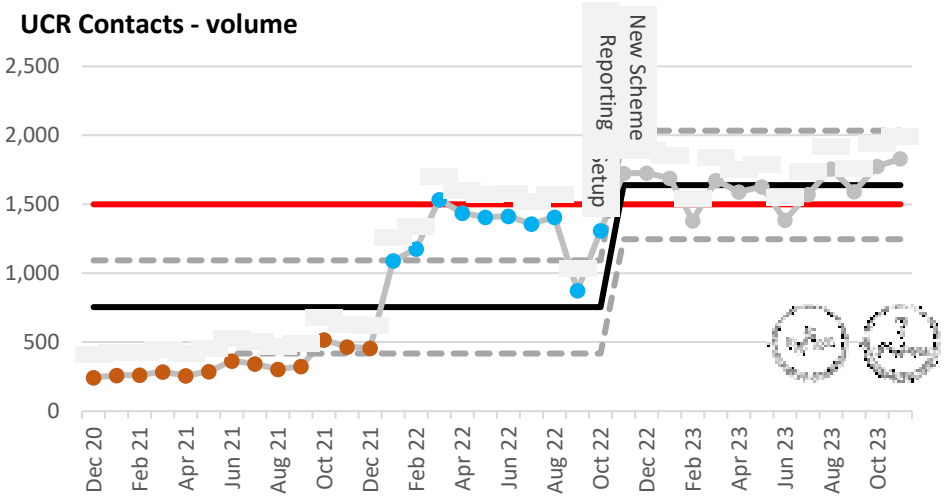
Analyst Commentary – Urgent Community Response – No. Of Contacts (2 hour):
Increase in reporting November 2022 due to implementation of new UCR services. A step change has been introduced in November 2022. This process is in special cause improvement.

Analyst Commentary – Urgent Community Response – No. Of Contacts (All UCR Schemes):
Increase in reporting November 2022 due to implementation of new UCR services. A step change has been introduced in November 2022 due to these changes. This process is in common cause variation.

Executive Commentary:
November performance sees increase in UCR contacts overall and overall the 70% target has been achieved. All services providing 2hr UCR are now reporting and all services have achieved the national target of 70% compliance

Considerable work continues within care homes to default to call UCR prior contact to WMAS. Implementation of WMAS Clinical Conversation within the Black Country UCR teams before you conveying to access alternative community pathways

Action	*By who*	*By when*
Monitoring demand and capacity trends across the service to inform need to extend operating hours given SDF envelope reduction.	Group Director of Operations – PCCT	On-going
Complete pathway alignment with West Midland Ambulance Service to increase calls to community admission avoidance	Deputy Chief Integration Officer	September 2023 – phase 1 completed
Undertake PDSA cycle as part of the Black Country with other local Places to develop a 'call before you convey' process with West Midlands Ambulance Service (WMAS)	Deputy Chief Integration Officer	January 2024


UCR Contacts - volume
2,500
2,000
1,500
1,000
500
0
New Scheme Reporting
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Apr 22
Jun 22
Aug 22
Oct 22
Dec 22
Feb 23
Apr 23
Jun 23
Aug 23
Oct 23

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Occupied Bed Days	Nov 23	23972	21110			23422	20693	26151
Older People Bed Days	Oct 23	4163	2628			4122	2787	5457
Emergency Admissions - Medical Over 65	Nov 23	1056	820			1179	1003	1355
SDEC - Delivered in the Correct Location	Nov 23	63.6%	95.0%			59.2%	53.4%	64.9%
Community Contacts	Nov 23	86846				89380	79896	98864
Inpatient RTT Incompelete Pathways	Oct 23	7950	4300			7847	7206	8489
Cardiology Bed Days	Oct 23	1548	778			1641	1108	2174
Imaging - Scanned within performance targets (A&e 30	Nov 23	77.7%	95.0%			79.7%	77.0%	82.4%
Theatre InSession Utilisation	Nov 23	70.8%	85.0%			71.5%	62.4%	80.6%

Population: Summary Table	Integration Committee

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pathway 0 - Simple Discharge [AvLOS]	Nov 23	2.4	4.1			2.5	2.0	3.0
Pathway 1 - Home with Support AvLOS. post NCTR	Nov 23	4.1	2.0			4.4	2.4	6.5
Pathway 2 - Community Bed with support AvLOS. post NCTR	Nov 23	10.9	5.0			9.8	4.9	14.6
Pathway 3 - Continuing Care AvLOS. post NCTR	Nov 23	5.8	7.0			9.0	-0.2	18.1
Pathway 4 - End of life AvLOS. post NCTR	Nov 23	5.0	2.0			5.3	2.5	8.2
Emergency Readmissions (within 30 days) - Overall (exc. Deaths and Stillbirths) month	Nov 23	6.4%	7.0%			7.0%	6.2%	7.9%
Beddays used	Nov 23	23850	21110			23441	20562	26319
Primary Care Appointments	Nov 23	9617	-			8910	6713	11108
Of those people who died in hospital % with a supportive care plan	Nov 23	35.8%	79.0%			31.0%	21.8%	40.3%
Virtual Wards - average length of stay	Nov 23	3.7	-			4.4	2.1	6.6
Admission Avoidance Schemes	Nov 23	2005	-			1791	1463	2119
Emergency Admissions aged 65 or over	Nov 23	1056	-			1165	988	1342
Frailty Intervention Team (FIT) Activity	Nov 23	31	-			56	-13	124
End of Life training	Nov 23	79.5%	95.0%			68.1%	61.0%	75.2%
Virtual Wards Patients	Nov 23	318	-			180	9	351
Urgent Community Response - 2 hour performance	Nov 23	75.2%	70.0%			66.3%	49.7%	82.9%
Average LOS	Nov 23	4.9	4.1			4.7	4.3	5.1

4. Recommendations

4.1 The Public Trust Board is asked to:

a. **NOTE** performance against annual plan objectives.
b. **NOTE** relevant escalations.

Name: Matthew Maguire, Associate Director – Strategic Performance & Insight
Date: 15th December 2023

Annex 1: How to Interpret SPC Charts

Annex 1

How to Interpret Statistical Process Control Charts

		Assurance		
		Passing the Target / Plan 	**Hit & Miss the Target** 	**Failing the Target / Plan** 
Variation	**Special Cause Improvement** 	**Good and getting better** We consistently pass the target, and performance is improving	**Ok but getting better** We hit the target sometimes and performance is improving	**Poor but getting better** We consistently fail the target, but performance is improving
	Common Cause Variation 	**Predictably good** We consistently pass the target and performance stays within a reliable range	**Ok** We hit the target sometimes but performance stays within a reliable range	**Predictably poor** We consistently fail the target and performance stays within a reliable range
	Special Cause Concern 	**Good but getting worse** We consistently pass the target but performance is worsening	**Ok but getting worse** We hit the target sometimes but performance is worsening	**Poor and getting worse** We consistently fail the target and performance is worsening
	Not an SPC Chart	**Good** We don't track this using an SPC chart, but it is hitting the target or plan	**Ok** We don't track this using an SPC chart, but it is occasionally passing the target or plan – but not consistently	**Poor** We don't track this using an SPC chart, but it is consistently failing the target or plan

A Statistical Process Control (SPC) chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation **(common cause)** in performance and unusual patterns **(special cause)** in data which are unlikely to have occurred due to chance and require investigation.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

• Trend: 6 or more consecutive points trending upwards or downwards

• Shift: 7 or more consecutive points above or below the mean

• Outside control limits: One or more data points are beyond the upper or lower control limits

Orange indicates a decline in performance; **Blue indicates an improvement in performance**.

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - improvement.nhs.uk/resources/making-data-count

Strategic Objective: Patients - To be good or outstanding in everything we do

Executive Lead(s): Chief Nurse & Chief Medical Officer

Risk ref:	BAF 001
Principle risk:	There is a risk that the Trust fails to deliver constant safe, high-quality care.
Date added to BAF:	April 2022
Oversight Committee:	Quality Committee
Date of review:	November 2023
Date of next review:	March 2024

Risk Rating:	Consequence	Likelihood	Score
Initial Risk Score	4	4	16
Current Risk Score	4	4	16
Target Risk Score	4	3	12

Q1	Q2	Q3	Q4
16	16	16	16

Existing Risk Appetite (Cautious): Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.

Aspirational Risk Appetite (Seek): We will pursue innovation where appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains**.**

Rationale for current risk score: Although there has been good progress (fundamentals of care momentum, no never events in last 12 months, no Sis in medicines management), there have been more concerns around quality and safety of patient flow and urgent and emergency care. There is increased governance around FOC program and greater assurance around CQC preparedness.

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
1a: **Significant Failure to deliver the standards of quality and safety for patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes**	• Corporate, Directorate and Service structures, accountability & quality governance arrangements at Trust • Risk Management Policy and Corporate Risk review at Risk Management Group • Fundamentals of Care Framework • The People Plan • Clinical policies, procedures, guidelines, pathways • Clinical audit programme & monitoring arrangements • Clinical staff recruitment, induction, mandatory training, registration & re-validation • Defined safe nurse staffing levels for all wards & departments • CQC Fundamental Standards, legislation and statutory duties setting out the regulatory compliance requirements • Delivery plans for MMUH – Transformation of clinical pathways of services for the delivery of care and Patient Flow to the support the patient journey • Safety Huddles in clinical areas • Relevant mandatory training modules to ensure clinical quality and safety • Infection prevention & control programme, policies, procedures, staff training and audits • Safeguarding policies and procedures • Meeting structures • FOC delivery group and separate assurance group • RCP/RCEM standard	**Management:** Quality and Governance Reporting Pathway; Clinical Group Quality Governenace meetings - Executive Quality Group → QC, Board Metrics, Fundamentals of Care Metrics, Safeguarding reports, Maternity dashboard that includes all relevant KPIs, Chair of POD sits on the committee, We learn Progress Report Reports, Incident Assessment Meeting, FFT reports, Tendable Audits. Fundamentals of Care Quality Reviews, Maternity Monthly data Reports,Maternity safety meeting **Risk and compliance:** CQC Assurance & Compliance Report, Quality & Safety (Fundamentals of Care) metrics, Quailty Account, escalations from Executive Quality Group, HSMR and SHMI indices, Safe Staffing Reports, We Assure Reports, Never Events Reports **Independent assurance:**, Internal and External Audit, CQC Action Plan reporting. Healthwatch Enter & View, ICB and Network Peer reviews. Requested Independent Reviews. GIRFT **Performance indicators:** Harm free care, medications dashboard, detiorating patinet dashboard, safety dashboards, CQC self assessments	• Momentum in fundamentals of care programme not being sustained resulting in a failure to to deliver better care to our patients **(001/1) & (001/5)** • CQC process and validationof self assesment and traingulation of data timescales **(001/2)** • Reporting on the progress of the Fundimentals of Care Framework **(001/3)** • Out of date policies and procedures and timecales for completion **(001/6)** • Improved reporting from specialty areas **(001/3)** • Buy in and engagement from staff on the the Fundimentals of Care Framework **(001/5)** • Lack of assurance of embedding learning and complaince with action plans **(see 001/09)** • Medical staffing assurance reporting strenghtened. **(001/7)** • Nursing & AHP staffing Assurance reporting to committee. **(001/7)** • Acuity assurance reporting agreed. **(NEEDS AGREED ACTION)** • Full assurance on the Delivery plans for MMUH ahead of the opening. **(001/08)** • Q&S dashboard Urgent care • Safety huddles organisation wode	**Amber**

	Gap Ref	Required Action	Lead	Monitoring	Status	
	001/1	A Fundamentals of Care Delivery Group to be established to support the management of the workstreams and drive assurance through the organisation	• Chief Nursing Officer	➢ QC	**COMPLETE**	
	001/2	The new CQC Self-Assessment Framework to be implemented. This will help with the triangulation of governance and clinical reporting into a central system	• Chief Governance Officer	➢ QC	**COMPLETE**	
	001/3	Reporting dashboard development for specialty areas in relation to Fundamentals of Care to be agreed and implimented.	• Chief Nursing Officer	➢ QC ➢ Trust Board	**COMPLETE**	
	001/4	Fundamentals of Care Dashboard and Mortality dashboard to be developed and reported on through the governance system. This will improve our patient experience and clinical outcomes.	• Chief Nurse Officer • Chief Medical Officer	➢ QC ➢ Trust Board	**COMPLETE**	
	001/5	Ensure that the Fundamentals of Care are implemented, understood through an engagement plan which includes, patient and stakeholder engagement sessions and Staff engagement sessions. This will support the Trust to gather a frontline view of where services are not meeting expectations.	• Chief Nurse Officer	➢ QC ➢ Trust Board	**DUE: March 2024**	
	001/6	Ensure all out of date policies are reviewed and updated in a timely manner	• Chief Governance officer	➢ QC ➢ Trust Board	**DUE: October 2024**	
	001/7	Staffing Assurance reports to the committee to ensure safe and effective staffing is in place, that reflects patients care needs and promotes a safe environment for service users and staff.	• Chief Nurse Officer • Chief Medical Officer	➢ QC	**DUE: February 2024**	
	001/8	ED & Bed Modelling tool to be developed and measured, that will accurately monitor both bed reduction and, performance and activity against current and proposed pathway improvements plus the development of the BI dashboards for the bed saving transformational schemes to monitor lead measures.	• MMUH Delivery Director	➢ QC ➢ MMUHOC ➢ TMC	**DUE: December 2023**	

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
1b: **Insufficent understanding and embedding of learning following significant events/incidents/complaints and evidencing improved practice and clinical outcomes.**	• Incident reporting and investigation policies and procedures. • Mandatory training in relation to safety and risk • HR policies in relation to issues relating to professional and personal responsibility • Action plans following significant events/ incidents and complaints • Clinical Policies and Procedures • SI Process	**Management:** Quaterly learning report to QC, Learning from Deaths and Mortality report to QC, Monthly Maternity Report to QC. Quality and Governance Reporting Pathway; Executive Quality Group → QC. PSIRF Executive Oversight Group Tendable metrics **Risk and compliance:** CQC Assurance & Compliance Report, Quality & Safety (Fundamentals of Care) metrics, Quailty Account **Independent assurance:** Internal and External Audit, CQC Action Plan reporting. Healthwatch Enter & View, ICB and Network Peer reviews. Requested Independent Reviews, GIRFT **Performance indicators:** PSIRF data reports, QC level metrics	• Patient safety incident response plan and framework to be implimented. **(001/9)** • Patient safety incident response policy need to be updated and staff training implimented **(001/10)** • Lack of assurance of embedding learning and compliance with action plans. **(001/9)** • Out of dates policies and procedures. **(see 001/6)** • Human Factors training to be implimented and monitored. **(001/11)** • Complaints process to be reviewed and improved reporting to be in place. **(001/12)** • Improved reporting of outstanding actions form SI's related to patient saftey incidents. **(001/13)**	**Amber**

Gap Ref	Required Action	Lead	Monitoring	Status
001/9	Patient Safety Incident Response Framework (PSIRF) to be implimented across the Trust.	• Chief Governance Officer	➢ QC	**DUE: April 2024**
001/10	Patient safety incident response policy need to be updated and staff training implimented.	• Chief Governance Officer	➢ QC	**DUE: April 2024**
001/11	Human factors thinking training to be rolled out initially to high risk area's.	• Chief Governance Officer • Chief People Officer	➢ QC	**DUE: December 2023**
001/12	A review of the compliants process to be undertaken and improvements to reporting to be established.	• Chief Governance Officer	➢ QC	**DUE: April 2024**

	001/13	A review of how patient safety inclidents actions are reported and lessons learnt are shared to be undertaken	• Chief Governance Officer	➢ QC	**DUE: April 2024**	

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
1c: **Safe & skilled workforce not achieving adequate numbers & skill mix impacts on the ability to deliver safe care, effective outcomes and organisational objectives.**	• The People Plan • Fundamentals of Care Framework • People and OD Committee • Vacancy management and recruitment systems • and processes • TRAC system for recruitment; e-Rostering system and procedures used to plan staff utilisation • Defined safe medical & nurse staffing levels for all wards and departments • Temporary staffing approval processand recruitment • processes with defined authorisation levels • Bi-annual safe staffing reports- all staff • MMUH Reports • Workforce oversight group inplace • Weekly workforce operational group	**Management:** Safe staffing reports to QC, Quality and Governance Reporting Pathway; Clinical Group Quality Governenace meetings - Executive Quality Group → QC, Board Metrics, Fundaimentals of Care Metrics, Safeguarding reports, Maternity dashboard that includes all relevant KPIs, Chair of POD sits on the committee, We learn Progress Report Reports, Incident Assessment Meeting, FFT reports, Tendable Audits. Fundamentals of Care Quality Reviews, Maternity Monthly data Reports, leadership training **Risk and compliance:** Quality & Safety (Fundamentals of Care) metrics, Quailty Account. Recruitment Dashboard **Independent assurance:** Internal and External Audit, CQC Action Plan reporting. Healthwatch Enter & View, ICB and Network Peer reviews. Requested Independent Reviews. GIRFT **Performance indicators:**	• Recruitment/retention an ongoing issue **(001/14)** • leadership and preceptorship needs to be addressed to support career pathways **(001/15)** • No system implemented to manage safe staffing effectvely **(001/16)** • Pastoral support to include Training needs ananlysis **(001/17)** • Simulation training across MDT required to develop our staff, improving clinical practice and patient safety. **(01/18)**	**Amber**

Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**
001/14	Recruitment/retention and induction process to be refined for senior medical staff, Nursing staff, Midwifery and NHPs to be established. This will feature within the People Plan which aims to remedy to our long-standing recruitment challenges and retention issues.	• Chief People Officer • Chief Nursing officer	➢ PC ➢ QC ➢ Trust Board	**COMPLETE**
001/15	Education Programme for career pathways for staff to be established which includes leadership and preceptorship. This falls under the People Plan	• Chief People Officer	➢ PC ➢ QC ➢ Trust Board	**DUE: December 2023**
001/16	Allocate to be imbedded and utilised in the Trust	• Chief Nurse Officer • Chief Medical Officer	➢ QC	**DUE: October 2024**
001/17	Pastoral support offer to be devloped and implimented, this should be holistic and focus on wellbeing needs, as well as training and development needs.	• Chief People Officer • Chief Nursing officer	➢ QC ➢ PC	**DUE: April 2024**
001/18	Options for a Simulation training programme to explored.	• Chief Nurse Officer • Chief Medical Officer	➢ QC ➢ PC	**DUE: April 2024**

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
1d: **A lack of a trust-wide systematic approach that is understood and owned by the organisation resulting in reduced patient experience and missed opportunities**	• At the heart of the improvement system is the patient/citizen and what they "value". This fits with Fundamental of care language around driving experience whilst always prioritising safety. The improvement system then eliminates waste i.e. those things not valued by the patient/citizen unless they are necessary. • Gateway Process agreed at Board that goes through 4 stages: Mandate (complete and approved); Options appraisal (complete and approved); Business Case/Partner Selection through procurement (complete and going through groups and committees in June/July as planned); Implementation Planning and delivery (subject to approval to proceed).	**Management:** Board Away Days, Gateway process to appoint partner and kick off the implementation of an imrpovement/managemet system. Financial commitment of the Board to the required support. Shift of historic "project management" Improvement team model to academy through the TMC approved Target Operating Model for the Improvement team. Delivery of implementation plan once developed with partner and set in the context of MMUH. **Risk and compliance:** access to funds originally budgeted for due to trust and system financial constraints; mindset and behavioural shift of senior leaders towards the	• Agreeing the approach and the partner **(001/19)** • Funding for the CQI not clear **(001/20)** • Board, Executive, TMC commitment and development to work in the new improvement system as the SWBT Way and to skill up and re-purpose the Improvement team into an academy. **(001/21)** • Capacity for the whole organisation to be developed in the improvement system so that it becomes the SWBT Way. **(001/22)** • Executive team focus and alignment to tackling the priorties together in a joined up and team based way **(001/23)**	**Amber**

	• Establishment of the Improvement Team academy that will own the system and develop others in its use. • Enhanced discipline around priortisation, focus (room 3 for Execs and alignment to clinical and corporate groups through aligned measures.	improvement system culture; capability and focus of Improvement team. **Independent assurance:** Considering external evaluations provided by organisations such as Universities but would require funding. May be able to harness NHS Impact as it evolves. **Performance indicators:** The Board Level Metrics and more specifically the annual plan priorities in particular patient experience and staff satisfaction.			
	Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**
	001/19	The Trust is currently deciding on the support required to implement the system, and the partner that will provide it.	• Chief Strategy Officer • CEO	➢ F&P ➢ QC ➢ PC ➢ Trust Board	**COMPLETE**
	001/20	The funding for the CQI needs to be agreed so that an implementation plan (timeline/sequence) can be developed with the partner.	• Chief Strategy Officer • CEO	➢ FIPC ➢ Trust Board	**DUE: September 2023**
	001/21	Board, Executive, TMC commitment and development to work in the new improvement system as the SWBT Way and to skill up and re-purpose the Improvement team into an academy.	• Chief Strategy Officer • CEO	➢ QC ➢ PC ➢ Trust Board	**DUE: December 2024**
	001/22	Capacity for the whole organisation to be developed in the improvement system so that it becomes the SWBT Way i.e. Implement the plan (timeline/sequence)	• Chief Strategy Officer • CEO	➢ QC ➢ PC	**DUE: December 2025**
	001/23	Executive team focus and alignment to tackling the priorties together in a joined up and team based way	• CEO	➢ QC ➢ PC ➢ Trust Board	**DUE: May 2025**

Strategic Objective: Patients - To be good or outstanding in everything we do	**Executive Lead(s): Chief Finance Officer**

Risk ref:	BAF 002
Principle risk:	There is a risk that the Trust fails to make best strategic use of its resources
Date added to BAF:	April 2022
Oversight Committee:	Finance, Investment & Performance Committee
Date of review:	November 2023
Date of next review:	February 2024

Risk Rating:	**Consequence**	**Likelihood**	**Score**
Initial Risk Score	4	4	16
Current Risk Score	4	5	20
Target Risk Score	4	1	4

Existing Risk Appetite (Cautious): We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.

Aspirational Risk Appetite (Seek): We will invest for the best possible return and accept the possibility of increased financial risk.

Rationale for current risk score: to remain at 20 due to very challenging external financial environment, leading a focus on short term non-recurring measures being implemented and a shortage of time to address recurrent improvement. In addition, the systemwide approach to planning is placing extra pressure on the trust.

Impact Description (ID) (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
2a: failure to ensure adequate infrastructure, capacity and governance to deliver CIP with insufficient prioritisation of CIP delivery to ensure success	• FIPC reporting • Board reporting • Executive Group oversight • New governance structure to support financial recovery • Additional resource secured • Re-prioritisation of 23/24 objectives to focus on financial recovery	**Management:** Executive reporting pathway to Board, FIPC forward planner linked to CIP delivery workstreams, FIPC agenda refocused on financial recovery and workforce plans including governance and resourcing, specific reporting to ICB on CIP delivery, relevant KPI's. **Risk and compliance:** Risk register linked to BAF. Compliance assurance via FIPC, FIPC metrics, Internal Audit review of CIP arrangements and associated actions. **Independent assurance:** Internal Audit, External Audit, HFMA sustainability review, PA consulting system wide work. **Performance indicators:** Benchmarking, FIPC metrics, I&E performance, recurrent versus non-recurrent CIP delivery.	• Being able to show the connection between actions underway and impact on numbers **(002/1)** • Non-compliant workforce trajectory **(002/2)** • Lack of substantive lead role for CIP delivery **(002/3)** • Lack of connection of CIP delivery and financial impact between BCPC, System wide financial recovery, MMUH benefits, Productivity opportunities, financial grip and control, and CQI and how that all comes together to deliver an efficiency programme with sufficient capacity to secure CIP delivery **(002/4)** • No dedicated resouce for CIP delivery in groups **(002/5)** • Failure to embed performance reporting framework (review of process as opposed to performance on metrics) **(002/6)** • Absence of an accountability framework with clear escalation framework which also could miss the opportunity to provide bespoke support where appropriate **(002/7)** • clarity and consistency of message **(002/35)**	**AMBER**

Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**
002/1	Demonstrate connection between narrative describing CIP improvement, current performance year to date, future run rate from existing plans, and further improvement opportunities currently not underway	• Cost Improvement Lead	➢ PMG, ➢ TMC ➢ F&P	**COMPLETE**
002/2	Determine recurrent and compliant workforce trajectories for 23/24	• Deputy CEO – Core Organisation	➢ PMG ➢ TMC ➢ F&P	**COMPLETE**
002/3	Agree to establish lead role for CIP delivery	• Chief Finance Officer	➢ F&P	**DUE: September 2023**
002/4	Describe connection between the various elements that will feed in to financial recovery and ensure resourcing plan is established to support delivery	• Chief Finance Officer	➢ F&P	**DUE: January 2024**
002/5	Ensure resourcing in the groups is sufficient and appropriate to support financial improvement	• Deputy CEO – Core Organisation	➢ F&P	**DUE: December 2023**
002/6	Ensure discussion on performance outputs at committee	• Relevant exec leads	➢ F&P	**COMPLETE**
002/7	Complete Accountability Framework – new governance framework applies	• Chief Governance Officer and exec leads	➢ F&P	**DUE: April 2024**

	002/35	ensure that messaging from exec group and committees is clear and consistent and cascaded to the organisation.	• Chief Finance Officer	➢ F&P	**TBC**	

Impact Description (ID) (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
2B: Estates strategy needs to ensure rationalisation and utilisation are maximised. There is also a risk that there are insufficient capital resources to progress required investments	• FIPC reporting of Board approved capital programme and cash impact • Standing Financial Instructions and Financial Policies; • Board reporting as above • Capital Management Group • Estates Strategy • System wide capital discussions	**Management:** Capital management group, PMG and TMC, FIPC and Board reporting framework **Risk and compliance:** backlog maintenance and statutory standards requirements funded **Independent assurance:** 6 facet survey, new estates strategy, external audit **Performance indicators:** Spend against plan	• Updated confirmation of statutory standards and backlog risks and ensure funded (**002/8)** • Consider internal audit work **(002/9)** • Consider expansion of performance indicators in relation to estates and capital programme **(002/10)** • Confirmation of estates strategy requirements already in capital 5 year plans **(002/11)** • Review of most recent 5 year capital programme internally and then with the ICS partners **(002/12)** • Confirm must do funding gap aligned to estates strategy **(002/13)** • Explore external opportunities to secure funding **(002/14)** • Ensure utilisation and rationalisation plan are part of the action plan coming out of the estates strategy **(002/36)**	**AMBER**

Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**
002/8	Confirm up to date statutory standards and backlog maintenance programme and ensure funding available under a worst case scenario	• Warren Grigg	➢ EQC ➢ F&P	**DUE: December 2023**
002/9	Discuss value of internal audit work to inform risk in relation to lack of capital funding	• Warren Grigg • Chief Finance Officer	➢ ARMC ➢ F&P	**DUE: December 2023**
002/10	Discuss potential expansion of performance indicators to measure effectiveness of available capital funding investment	• Warren Grigg • Chief Finance Officer	➢ CMG ➢ F&P	**DUE: December 2023**
002/11	Confirm alignment of the estates strategy to current capital plans	• Warren Grigg	➢ CMG ➢ TMC ➢ F&P	**DUE: December 2023**
002/12	Review current operational and strategic capital plans aligned to estates strategy and assess against likely funding and then go through with ICS partners	• Chief Finance Officer	➢ CMG ➢ TMC ➢ F&P	**DUE: December 2023**
002/13	Confirm minimum capital expenditure required against likely funding	• Chief Finance Officer • Warren Grigg	➢ CMG ➢ TMC ➢ F&P	**DUE: December 2023**
002/14	Report to FIPC current external secured funding and potential opportunities to pursue	• Chief Finance Officer • Director of IT • Director of Estates Development • Assistant Director of Strategic Development	➢ CMG ➢ TMC ➢ F&P	**DUE: December 2023**
002/36	Estates colleagues to review utilisation and rationalisation opportunities	• Warren Grigg	➢ F&P	**TBC**

Impact Description (ID) (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
2c: Income and Expenditure performance resulting in cashflow challenge to operations and capital investments	• FIPC reporting • Annual Financial Plan • Standing Financial Instructions and Financial Policies. • Board reporting • ICS oversight of cashflows across the Trust	**Management:** Monthly cashflow forecasting **Risk and compliance:** Becoming insolvent and the risks to operation of not having cash to function and having to borrow **Independent assurance:** External audit, internal audit, ICS review of cashflow forecasting, HFMA sustainability review **Performance indicators:** Cash balances, Cashflow forecast, recurrent versus non-recurrent achievement of plan	• Scenario planning on potential cash balances and impact on operations and capital investment, proposed cash mitigation plans **(02/15)** • Lack of understanding of processes to obtain additional borrowing and impact of potential delays **(02/16)** • Consider widening the suite of cash flow metrics **(02/17)** • Lack of route to achieve plan recurrently, trust still using non-recurrent means, recurrent viability exposed **(02/18)** • ICS wide cashflow monitoring and consistency of forecasting **(02/19)**	**AMBER**

Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**
002/15	Cashflow forecasting of scenarios and potential mitigations	• AD Finance Accounting	➢ F&P	**COMPLETE**

	002/16	Scope potential impact and mitigations of severe cash shortages	• AD Finance Accounting	➢ F&P	**DUE: December 2023**	
	002/17	Review scope of cash metrics across the ICS and seek advice of NHSE	• AD Finance Accounting	➢ F&P	**DUE: December 2023**	
	002/18	Ensure there is a plan to mitigate non-recurrent means of achieving plan and ensure link to underlying position understood. Ensure this is adopted consistently across the ICS	• Chief Finance Officer	➢ F&P ➢ PMG	**DUE: December 2023**	
	002/19	Work with the ICS to confirm system wide approach to cash management and mitigations	• Chief Finance Officer • AD Finance Accounting	➢ F&P	**DUE: December 2023**	
	002/37	take paper to F&P no later than Jan 24 setting out implications of cash forecast based on current I&E forecasts	• AD Finance Accounting	➢ F&P	**DUE: January 2023**	

Impact Description (ID) (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
2d: **Lack of capacity to effectively plan to address strategic risk**	• PMG reporting • FIPC reporting • Board reporting and approval of plan • ICS meetings and submissions and review / triangulation • NHSE submissions and review	**Management:** Triangulation of activity, workforce and finance at a high level **Risk and compliance:** Failure to address effective mitigation of the best use of resources **Independent assurance:** ICS review and triangulation, NHSE review and triangulation and feedback **Performance indicators:** Performance against plan, some operational benchmarks	• Lack of detailed demand and capacity plan linked to workforce capacity and workforce plans and consequent financial forecast **(002/20)** • Lack of performance indicators to robustly assess effectiveness and triangulation of the plan **(002/21)** • Inconsistencies in relation to planning assumptions and approaches in the BCPC **(002/22)** • Lack of an obvious connection between plan and operational productivity **(002/23)** • Lack of current capacity to address gaps in assurance **(002/24)**	**AMBER**

Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**	
002/21	Scope out in detail gaps in demand and capacity plans	• Chief Finance Officer	➢ PMG ➢ TMC ➢ F&P	**DUE: December 2023**	
002/22	Confer with ICS colleagues on performance indicators used to assess the effectiveness of the plan in relation to triangulation and mitigating the strategic objective	• Chief Finance Officer • Chief Strategy Officer	➢ PMG ➢ TMC ➢ F&P	**DUE: March 2024**	
002/23	Ensure a joined up and consistent approach to planning across the BCPC	• Chief Finance Officer • Chief Strategy Officer	➢ PMG ➢ TMC ➢ F&P ➢ BCPC	**DUE: March 2024**	
002/24	As for 002 above and review internal productivity benchmarks to inform planning objectives	• Chief Finance Officer • Chief Strategy Officer	➢ PMG ➢ TMC ➢ F&P	**DUE: March 2024**	
002/25	Review capacity to deliver above and take necessary action	• Chief Finance Officer • Exec team	➢ PMG ➢ TMC ➢ F&P	**DUE: March 2024**	

Impact Description (ID) (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
2e: **Failure to meet operational performance targets**	• PMG reporting • FIPC reporting • Reports to Board • Urgent Care Steering Group oversight • Planned Care Steering Group oversight • Provider collaboratvie elective care group (which includes cancer targets) • SOPs/processes in place	**Management:** PMG and TMC, FIPC and Board reporting framework **Risk and compliance:** Weekly room 3 oversight, **Independent assurance:** Exception reports to Cancer collaboartive group, Exception reports to the Black Country elective care group **Performance indicators:** RTT reduction to zero 65 week waits by march 24, Total number of 62 day wait reduction to below 100 by march 24, Reduction in diagnostic waits to <13 weeks, Delivery of 102%+ production plan	• Service improvement support **(002/26)** • Elective Care Delivery plan mapped **(002/27)** • Lack of visability of a real time production plan **(002/28)**	**AMBER**

Gap Reference	**Required Action**	**Lead**	**Monitoring**	**Status**	
002/26	Real time production plan visibility to be agrred and implimented.	• Chief Operating Officer	➢ PMG	**DUE: December 2023**	

				➢ F&P	
	002/27	Elective Care Delivery plan mapped to production and efficiency opportuntites support increase activity / cost reduction	• Chief Operating Officer	➢ PMG ➢ F&P	**DUE: October 2023**
	002/28	Service improvement support being sourced to delivery the necarry actions	• Chief Operating Officer	➢ PMG	**DUE: September 2023**

Impact Description (ID) (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
2f: **Failure to adopt and exploit digital solutions that can enhance patient care and improve efficiency.** **Digital needs to seen as a true enabler.**	• There is an established and effective IT management team. • A strategy has been agreed and approved at board. • £9.6m of national Frontline Digitisation funding has been awarded to the Trust. • A dedicated team is in place to provide digital infrastructure to open MMUH. • Structure and processes for a high achieving IT department are in place. • The digital infrastructure is in place to embrace new technologies.	**Management:** Team is in place to identify and manage external search for funding, Weekly and monthly reviews are made, Digital reports to FIPC, monthly DSPT meetings **Risk and compliance:** A full risk register is active and reviewed monthly, DSPT accreditation. **Independent assurance:** Digital spend is regulated by NHS (Digital) **Performance indicators:** Incidents are reduced in frequency and severity. Calls per user per year are falling. Combined Wasted time is reduced by service. Training measures not yet established.	• Staffing shortages in the Informatics team **(002/26)** • There is no dedicated Training team for Digital Skills **(002/27)** • Equipment coming to the end of its cycle **(002/28)** • Developing our core systems **(002/29)** • Digital engagement is not baked in to the CQI journey **(002/30)** • Lack of a Trust Digital NED, Digital Board, Digital Clinical Safety Officer **(002/31)**	**AMBER**

Gap Reference	**Required Action**	**Lead**	**Monitoring**	**Status**
002/29	The informatics staffing are too few to support the requirements of the Trust to innovate.	• Executive Director of IT	➢ Monthly IT SMT	**DUE: April 2024**
002/30	The trust needs to invest in digital skills training and create a training team.	• Executive Director of IT	➢ Digital Group ➢ F&P	**DUE: December 2023**
002/31	Better equipment will be required to replace the technology that was introduced with the EPR and is now 3 years old	• Digital Leadership Team • Executive Director of IT	➢ MMUH Programme Board	**DUE: August 2024**
002/32	Integration resources need to be built to reduce the frustration and time wasted by not developing our core systems.	• Executive Director of IT	➢ Monthly IT SMT	**DUE: March 2026**
002/33	A review of how Digital engagement can be more incorporated in the CQI journey	• Executive Director of IT • Chief Strategy Officer	➢ F&P	**DUE: December 2023**
002/34	Governance around digital to be reviewed and streghtened	• Executive Director of IT	➢ F&P	**DUE: April 2024**

Strategic Objective: People - To cultivate and sustain happy, productive, and engaged staff	**Executive Lead(s): Chief People Officer**

Risk ref:	BAF 003
Principle risk:	There is a risk that the Trust fails to recruit, retain, train, and develop an engaged and effective workforce.
Date added to BAF:	April 2022
Oversight Committee:	People & OD Committee
Date of review:	November 2023
Date of next review:	March 2024

Risk Rating:	**Consequence**	**Likelihood**	**Score**
Initial Risk Score	4	4	16
Current Risk Score	4	4	16
Target Risk Score	4	1	4

Existing Risk Appetite (Open): We are prepared to accept the possibility of some workforce risk, as a direct result from innovation, as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.

Aspirational Risk Appetite (Significant): We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

Rationale for current risk score: due to the continued work required around supporting the opening of MMUH, worsening performance in key metrics i.e. sickness absence. There are also challenges in meeting workforce planned trajectories for MMUH plus the requirement to improve staff engagement.

Description (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
3a: **Plan, attract, recruit, and develop (workforce planning and safe staffing).** -If the Trust doesn't efectively **plan for, attract , recruit and develop** a suitably qualified, skilled and diverse workforce it will be unable to deliver the strategic priorities set out within its People Plan and Trust Strategy and deliver its safe staffing requirements.	• The People Plan • The Trust EDI Plan • Trust values and behavioural framework • ARC Leadership programme • Employer Branding Programme linked to Trust People Plan ambitions, ARC values , MMUH and Widening participation. • Recruitment Plan (inclusive of MMUH) • Hard to recruit strategy and feasibility assessment to support routes to recruitment • Community engagement plan and employability programmes linked to Widening Participation agenda • Learning Campus Education and Employability Programme • Fundamentals of Care • TRAC system for recruitment • NHS Employement check standards • Recruitment stabilisation programme • Six NHS Employment Check Standards • People and OD policies , procedures and guidelines • Recruitment Training • CQC compliance • People & OD Committee • Workforce Oversight Group • Establishment Control Group • Workforce Transformation and Development Group • Temporary staffing approval and recruitment processes with authorisation levels clearly defined linked to Vacancy Control Process • Safe staffing levels monitored and reported. • Bank and agency management and oversight in place • Education partnerships	**Management: People and OD Reporting Pathway; Establishment Control group, Workforce Oversight Group/ Workforce Development and Transformation Group, People and OD Committee** →POD metrics, POD forward planner linked to People Plan Delivery workstreams, compliance reports,weekly flashreports on workforce, Recruitment Dashboard linked to demand and supply tool, bank and agency tracker, and relevant KPI's. **Risk and compliance:** Compliance reports e..g policy compliance, NHS Employment Check STandanrds , 16 core POD metrics, staffing risks, EDI compliance and monitoring. We Assure Programme , Safe Satffing Data **Independent assurance:** Annual Staff Survey Outcomes, quarterly pulse checks and outcomes of independent reveiws where appropriate including audits , benchmarking exercises, Freedom to Speak Up data, WRES, WDES and Gender Pay Gap reporting **Metrics received:** People and OD Core metrics on vacancies, Turnover, sickness, EDI representation, PDR, Mandatory Training, Time to Hire, pulse checks, staff survey, Flu and COVID vaccination complaince levels.	• Delivery of the MMUH recruitment & selection plan **(003/1)** • Exec and VSM pay review overdue and needs ratification at the Remuneration Committee. **(003/2)** • 23/24 refreshed Financial and workforce plan to take acount of CIP and workforce reprofiling ensuring triangulation of workforce, financial and activity assumptions **(003/3)** • Workforce Optimisation Plan to be developed linked to financial recovery, safe staffing, and workforce planning requirements. (**003/3)** • Erostering implementation programme in place led by the Chief Nurse Officer and oversight via POD. Training delivery plan to upskill managers in e rostering needs to be in place and completed prior to the move to MMUH. (**003/4)** • Presentation of the Safe Staffing data to provide Committee with information and assurance regarding the provision of safe nurse staffing, identifying areas of risk for escalation and outlines the quality impact that has occurred due to reduced staffing. **(003/5)** • Vaccination roll out plan required to support worforce planning into the winter. **(003/6)** • Plan C service derogation for "hard to fill " MMUH roles (that cannot be recruited via plan a and plan b) needs to be developed by the MMUH Clinical Services workstream to ensure a robust externally peer reviewed clinical model/pathway and associated workforce plan is in place to support safe staffing requirements. **(003/7)** • Requirement for a clear structered talent management programme for the organisation linked to credible career development pathways **(003/8)** • Integrated multiprofessional workforce education and transformation plan to include, upskilling , education and development. **(003/9)** • There is a lack of a robust plan on long term arrangements for recruitment delivery **(003/10)**	**AMBER**

	• Inclusive Resourcing and Talent Management and Resourcing Task and Finish Group • Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) • Influenza vaccination programme • COVID-19 vaccination programme • E rostering and Job Planning Roll out				

Gap Ref	Required Action	Lead	Monitoring	Status
003/1	A recruitment & selection plan to deliver the recruitment requirements for MMUH and Core , ensuring prompt and efficient recruitment takes place for all roles.	▪ Chief People Officer	➢ PC	**DUE: April 2024**
003/2	Pay Review Plan to cover – Exec and VSM pay, National living Wage review, alignment of pay rates for the system and premium payments for hard to fill posts	▪ Chief People Officer	➢ PC ➢ Rem Com	**COMPLETE**
003/3	Updated Financial and workforce plan to take acount of CIP and workforce reprofiling to be shared at PC and F&P	▪ Chief Finance Officer	➢ PC ➢ F&P	**COMPLETE**
003/4	e-rostering implementation plan inclusive of training delivery plan and associated golden rules linked to financial recovery to be developed	▪ Chief Nursing Officer	➢ PC	**COMPLETE**
003/5	Safe Staffing data to be presented at POD	▪ Chief Nurse Officer	➢ PC	**DUE: February 2024**
003/6	Vaccination roll out plan to be developed including comms plan and shared at committee	▪ Chief People Officer ▪ Chief Nurse Officer	➢ PC	**COMPLETE**
003/7	Plan C service derogation for "hard to fill " MMUH roles (that cannot be recruited via plan a and plan b) to be developed by the MMUH Clinical Services workstream to ensure a robust externally peer reviewed clinical model/pathway and associated workforce plan is in place to support safe staffing requirements	▪ MMUH Delivery Director	➢ PC ➢ MMUH OC	**COMPETE**
003/8	Development of a talent management framework for the organisation	▪ Chief People Officer	➢ PC	**DUE: March 2025**
003/9	Integrated multiprofessional workforce education and transformation plan to include supply, retention, upskilling , education and development.	▪ Chief People Officer ▪ Chief Nusing Officer ▪ Chief Medical Officer	➢ PC	**DUE June 2024**
003/10	Robust plan on long term arrangements for recruitment delivery (post october 2024) needs to be developed	▪ Chief People Officer	➢ PC	**DUE: January 2024**

Description (What might cause this to happen)	**Controls** (What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on is effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
3b: **Staff experience and retention (culture and climate).** - If the Trust fails to develop, transform and sustain a positive, compassionate , inclusive and psychologically safe culture, this will adversely impact on **staff experience** resulting in an **inability retain staff** and poor patient experience not aligned with our Trust values and fundamentals of care.	• The People Plan • The Trust EDI Plan • ARC values and behavioural framework • ARC Culture and Leadership Programme (includes Trust Retention Plan) • Employer Branding Programme linked to Trust People Plan ambitions, ARC values , MMUH and Widening participation and • Fundamentals of Care • People and OD policies , procedures and guidelines • CQC compliance • People & OD Committee • Workforce Oversight Group • Compassionate Communities Group • Inclusive Resourcing and Talent Management Task and Finish Group • Just and Learning Culture Programme • Wellbeing Programme and sickness improvement	**Management:** Staff Survey Action Plan , Staff Survey Annual Report to Board, Equality and Diversity Annual Report WRES and WDES report, Assurance reports on People Plan. Culture Heat Map, Retention Deep Dive Tool. **Risk and compliance:** Freedom to Speak Up Guardian report, WRES, WDES, Gender Pay Gap **Independent assurance:** National Staff Survey, Pulse surveys, Freedom to Speak Up Guardian report, WRES, WDES, Gender Pay Gap **Metrics received:** People and OD Core metrics on vacancies, Turnover, Sickness , EDI representation, PDR, Mandatory Training, Time to Hire, pulse checks, staff survey.	• Staff Networks require a complete review and overhaul to ensure networks can function more effectively and have the right Executive sponsorship and support in addressing inclusion and diversity issues including deep routed issues related to race, gender, disability and other protected characteristics. **(003/12)** • Visibility and ownership of the EDI agenda is required at all levels of the organisation more specifically at senior leadership, executive and board level. **(003/13)** • Behaviour Farmework needs to be agreed and aligned through the Trust and into recruiment. **(003/14)** • Lack of a QI approach to support improved culture within the HR teams. **(003/15)** • Requirement for a clear structurd talent management programme for the organisation linked to credible career development pathways. **(003/16** • Improve sickness and enhance wellbeing of staff **(003/17)** • Just and Learning Culture implementation is resulting in managers having to review their own leadership style in the context of creating a compassionate, psychologically safe and inclusive work environment. This may result in resistance from those managers who see this as less authoritative and more of a soft or weak approach and therefore maybe unwilling to enagage resulting in potentially disproportionate outcomes for staff and inhibit our ability to transform our culture and fully embed our values. **(003/18)**	**AMBER**

				• Staff side and trade union interrelationship issues require addressing to avoid destabilising MMUH and Trust People Plan priorities **(003/19)** • Leadership Development Framework to be agreed and implemented **(003/20)** • New People and OD Target Operating Model(TOM) in place however additional resource requirements linked to TOM havent been approved as yet. Some gaps in operational capability and capacity to deliver the whole of the People Plan have been identified e.g. EDI , People Services and OD resource and will need to be addressed via the implementation of the revised TOM. **(003/21)** • Improved visibility of the Freedom to Speak Up agenda and routes to speak up for substnative and bank staff. **(003/22)**	

Gap Reference	Required Action	Lead	Monitoring	Status
003/11	New Trust wide Staff Values to be agreed and in place. These will act as the core principles that the Trust and its people should live by. Once our values and behaviours are finalised, we need to ensure that these are embedded across the Trust, running through everything we do at work including decision-making, how we recruit and our PDR processes.	▪ Chief People Officer	➢ PC	**DUE: June 2024**
003/12	Staff Networks review to be undertaken	▪ Chief People Officer	➢ PC	**DUE: February 2024**
003/13	EDI Strategy to be agreed and implemented. To set out our vision, aims and objectives for equality across the Trust and is intrinsic to the People Plan	▪ Chief People Officer	➢ PC	**DUE: March 2024**
003/14	Behaviour Farmework linked to Values to be agreed and implemented.	▪ Chief People Officer	➢ PC	**COMPLETE**
003/15	Quality Improvement Approach for Staff Retention/Team Culture to be established	▪ Chief People Officer	➢ PC	**DUE: April 2024**
003/16	Talent management programme to be agreed, implimented and robustly measured	▪ Chief People Officer	➢ PC	**COMPLETE**
003/17	Recovery based approach to improve sickness and enhance wellbeing of staff to be agreed and rolled out.	▪ Chief People Officer	➢ PC	**DUE: May 2024**
003/18	Just and Learning Culture programme to be fully implemented to support a shift in staff experience , to reduce the number of formal cases and address the disproprotionate impact on certain staff groups	▪ Chief People Officer	➢ PC	**DUE: March 2024**
003/19	Effective partnership working between staff side and trade union colleagues needs to be in place to support delivery of MMUH workforce and People Plan priorities	▪ Chief People Officer	➢ PC	**DUE: January 2024**
003/20	Leadership Development Framework to be agreed and implemented. The Leadership Framework provides a consistent approach to leadership development for staff in the Trust irrespective of discipline, role, or function, and represents the foundation of leadership behaviour.	▪ Chief People Officer	PC	**DUE: September 2024**
003/21	People and OD Target Operating Model to be developed and resource requirements considered through a full business case	▪ Chief People Officer	PC	**DUE: September 2024**
003/22	Freedom to Speak Up strategy to be developed and launched	▪ Chief People Officer	PC	**DUE: March 2024**

Strategic Objective: Population – To work seamlessly with our partners to improve lives.

Risk ref:	BAF 005
Principle risk:	There is a risk that the Trust fails to deliver the MMUH benefits case
Date added to BAF:	April 2022
Oversight Committee:	MMUH Opening Committee
Date of review:	October 2023
Date of next review:	November 2023

Existing Risk Appetite (Seek): We will pursue innovation where appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains**.**

Aspirational Risk Appetite (Seek): We will pursue innovation where appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains**.**

Executive Lead(s): Managing Director Midland Metropolitan Programme Company

Risk Rating:	Consequence	Likelihood	Score
Initial Risk Score	4	4	16
Current Risk Score	5	4	20
Target Risk Score	5	3	15

Q1	Q2	Q3	Q4(forecast)
16	16	20	20

Rationale for current risk score:.

Impact Description (what might cause this to happen)	Controls (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Sources of assurance (Evidence that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance and controls (All identified gaps **must** result in an action being identified to rectify or manage the risk)	Committee Assurance Rating
5a: **There is significant failure to deliver sustained clinical transformation and related benefits case resulting in inability to fit into MMUH and non delivery of improved health outcomes and patient experience.**	• Establishing the Managing Successful Programme (MSP) methodology through the implementation of the MMUH Programme Company. The Project Initiation Document (PID) records Programme set up and governance. • Dedicated PMO that reviews, challenges and reports progress against the ten workstreams (each of which have a workstream lead and worstream plan). • Integrated Programme masterplan working towards building handover and first patient move dates is underpinned by robust workstream plans and the operational readiness framework. • Delivery of an effective Communication and Engagement Plan. • Benefits Case supported by 3rd Party partnership with Price Waterhouse Coopers (PWC). • Evidence based clinical model with 3rd party assurance as documented in Trust Board approved clinical model proposal in April 2022. • Plan B schemes to fit into MMUH agreed in September 2023 goverance cycle.	**Management:** MMUH Programme Oversight Group , MMUH Risk Management Group , MMUH Programme Group, Trust Management Committee, Risk Manangement Committee, MMUH Opening Committee and reports to relevent Tier 1 Committees and Trust Board. **Risk and compliance:** Programme and Workstream risk register. Critical Success Factors forecast plan and actual performance tracked. Project Management Office (PMO) monthly performance report. **Independent assurance:** 3rd party assurance of clinical model documented in Trust Board proposal April 2022. Subsequently reviewed and supported by Black Country (BC) and Birmingham and Sollihull (BSol) Integrated Care Board Executives. PWC Benefits partner commissioned to provide the accepted baseline Benefits Case in 2023. National New Hospital Programme Team. Joint Health Overview and Scrutiny Committee. Programme Assurance Review. **Performance indicators:** Critical Success Factors. Project Management Office (PMO) report.	• Benefits dashboard to track delivery of the clinical transformation and the related impact to the benefits case. **(005/1)** • Plans to reduce bed days to assure fit into MMUH. **(005/2, 005/3 and 005/4)** • Capacity of clinical and operational teams to deliver sustained clinical transformation. **(005/5, 005/6 and 005/7)** • Full stakeholder alignment to implement clinical model. **(005/8)** • Inequalities in patient pathways still exist and therefore equitable benefits at patient level are not achieved **(005/9 and 005/10)**	**AMBER**

Gap Ref	Required Action	Lead	Monitoring	Status
005/1	Establish a Benefits handbook and dashboard to track delivery of the clinical transformation and impact related to the benefits case.	• Simon Sheppard	➢ MMUH OC ➢ F&P ➢ Audit	**DUE: December 2023**

	005/2	Identify opportuntity and evidence based clinical transformation plans to reduce bed days to assure fit into MMUH aligned with a 2024 opening.	• Daren Fradgley • Jo Newens • Liam Kennedy	➢ MMUHOC	**DUE: December 2023**	
	005/3	Deliver clinical transformation at scale and pace to fit into MMUH based on a 2024 opening.	• Daren Fradgley • Jo Newens • Liam Kennedy	➢ MMUHOC	**DUE: December 2023**	
	005/4	Activate plan B schemes at specified trigger points as mitigation to fit into MMUH if required.	• Daren Fradgley • Jo Newens • Liam Kennedy	➢ MMUHOC	**DUE: December 2023**	
	005/5	Review annual plan delivery priorities through the Executive Team and Tier 1 Committees to mitigate overwhelming workload.	• Richard Beeken	➢ Trust Board	**DUE: December 2023**	
	005/6	Complete risk assessment for the impact of the ongoing industrial action and impact on operational and clinical delivery capacity.	• Mark Anderson • David Carruthers	➢ MMUHOC ➢ RMC	**DUE: November 2023**	
	005/7	Managing Director to escalate further mitigations to the Chief Executive, given Programme Risk 5143 related to delivery capacity for the Core Organisation remains at 25 with inadequate mitigation proposals.	• Rachel Barlow	➢ MMUHOC	**DUE: November 2023**	
	005/8	Provide assurance of readiness of critical provider stakeholders to implement clinical model.	• Liam Kennedy	➢ MMUHOC	**DUE: December 2023**	
	005/9	Define equitable goals to be achieved in the 'must do' clinical pathways to fit into MMUH and of care; these should include rightsizing and essential providers where there is more than 1 provider eg mental health and social care.	• Daren Fradgley • Liam Kennedy	➢ MMUHOC ➢ IC	**DUE: December 2023**	
	005/10	Ensure equality work aligns to the Integration Committee BAF and is documented as necessary in the MMUH Programme Exit Strategy and Closure Plan.	• Daren Fradgley • Rachel Barlow	➢ MMUH OC ➢ IC	**DUE: March 2025**	

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
5b: **Failure to secure revenue funding for the workforce model needed to deliver the approved and transformed clinical model, which will impact on the ability to deliver the strategic benefits related to both the clinical and workforce models.**	• Establishing the Managing Successful Programme (MSP) methodology through the implementation of the MMUH Programme Company. The Project Initiation Document (PID) records Programme set up and governance. • Dedicated PMO that reviews, challenges and reports progress against the ten workstreams (each of which have a workstream lead and worstream plan). • Integrated Programme masterplan working towards building handover and first patient move dates is underpinned by robust workstream plans and the operational readiness framework. • Delivery of an effective Communication and Engagement Plan. • Benefits Case supported by 3rd Party partnership with Price Waterhouse Coopers (PWC). • Evidence based clinical model with 3rd party assurance. • Medium Term Finance Plan agreed and inclusive of MMUH costs. • Revised business case with updated clinical and workforce model approved by Trust Board in April 2022.	**Management:** MMUH Programme Oversight Group , MMUH Risk Management Group , MMUH Programme Group, Trust Management Committee, Risk Manangement Committee, MMUH Opening Committee and reports to relevent Tier 1 Committees, FIPC and Trust Board. ICB and NHSE joint working and stakeholder engagement. Provider collaborative engagement. Escalation to regional and national NHSE team. **Risk and compliance:** Programme and Workstream risk register. Critical Success Factors forecast plan and actual performance tracked. Project Management Office (PMO) monthly performance report. **Independent assurance:** 3rd party assurance of clinical and workforce models documented in Trust Board proposal April 2022. Subsequently reviewed and supported by Black Country (BC) and Birmingham and Sollihull (BSol) Integrated Care Board Executives and Black Country Provider Collaboartive executive and Joint Provider Collaborative (JPC). PWC Benefits partner commissioned to provide the accepted baseline Benefits Case in 2023. Programme Assurance Review.	• No national, regional or local system commitment or agreement to resolve the revenue gap depsite support for the clinical and workforce models, acknowledgement of the benefits case by ICBs, BCPC and NHSE. **(005/11, 005/12. 005/13 and 005/14)**	**AMBER**

		Performance indicators: Critical Success Factors. Project Management Office (PMO) report. Finance report.			

Gap Ref	Required Action	Lead	Monitoring	Status
005/11	Finance sprint work over 3 weeks in October 2023 designed with regional NHSE to work through a 21 point action plan to inform mitigation to revenue gap.	• Simon Sheppard	➢ MMUH OC ➢ F&P	**DUE: November 2023**
005/12	BC ICB finance meeting with Julian Kelly 6th October 2023.	• Richard Beeken	➢ MMUH OC ➢ F&P	**DUE: October 2023**
005/13	Follow up from Provider Collborative meeting regarding the use of ICB growth monies to support MMUH – risk based QIA assessment to be completed.	• Simon Sheppard	➢ MMUH OC ➢ F&P	**DUE: October 2023**
005/14	Programme Assurance Review (PAR) to review financial gap and mitigation approach as a key line of enquiry.	• Rachel Barlow	➢ MMUH OC ➢ Audit	**DUE: November 2023**

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**
5c: **Failure to secure capital funding and progress build for the on-site Urgent Treatment Centre which will result in increased and overwhelming demand in the Emergency Department, compromising Urgent Emergency Care standards associated with the business and benefits case.**	• Establishing the Managing Successful Programme (MSP) methodology through the implementation of the MMUH Programme Company. The Project Initiation Document (PID) records Programme set up and governance. • Dedicated PMO that reviews, challenges and reports progress against the ten workstreams (each of which have a workstream lead and worstream plan). • Integrated Programme masterplan working towards building handover and first patient move dates is underpinned by robust workstream plans and the operational readiness framework. • Delivery of an effective Communication and Engagement Plan. • Benefits Case supported by 3rd Party partnership with Price Waterhouse Coopers (PWC). • Evidence based clinical model with 3rd party assurance. • Medium Term Finance Plan agreed and inclusive of MMUH costs. • Revised business case with updated clinical and workforce model approved by Trust Board in April 2022. • Urgent Treatment Centre Business Case. • Trust capital identified to continue project as RIBA stage 2 (until October 2023).	**Management:** MMUH Programme Oversight Group , MMUH Risk Management Group , MMUH Programme Group, Trust Management Committee, Risk Manangement Committee, MMUH Opening Committee and reports to relevent Tier 1 Committees, FIPC and Trust Board. ICB and NHSE joint working and stakeholder engagement. Provider collaborative engagement. Escalation to regional and national NHSE team. **Risk and compliance:** Programme and Workstream risk register. Critical Success Factors forecast plan and actual performance tracked. Project Management Office (PMO) monthly performance report. Project level assurance reports. **Independent assurance:** Evidence based clinical model aligns with national UTC stnadards. Clinical model and revenue case supported by Birmingham and Sollihull (BSol) Integrated Care Board. Programme Assurance Review. **Performance indicators:** Critical Success Factors. Project Management Office (PMO) report. Finance report.	• Capital for UTC remains unidentifed. **(005/15)**	**AMBER**

Gap Ref	Required Action	Lead	Monitoring	Status
000/15	Options for funding and potential mitigation need full work up and conclusion. This is in collboration with ICBs and NHSE.	• Simon Sheppard	➢ MMUH OC ➢ F&P	**DUE: December 2023**

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage the risk)	**Committee Assurance Rating**

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<td>5d:

A significant failure to prepare our workforce to move and work in MMUH and adopt new ways of working, that results in suboptimal delivery of clinical transformation and delivery of the people objectives and associated benefits case.</td>
<td>

Establishing the Managing Successful Programme (MSP) methodology through the implementation of the MMUH Programme Company. The Project Initiation Document (PID) records Programme set up and governance.
Dedicated PMO that reviews, challenges and reports progress against the ten workstreams (each of which have a workstream lead and worstream plan).
Integrated Programme masterplan working towards building handover and first patient move dates is underpinned by robust workstream plans and the operational readiness framework.
Delivery of an effective Communication and Engagement Plan.
Benefits Case supported by 3rd Party partnership with Price Waterhouse Coopers (PWC).
3rd party assurance by Health Education England (HEE) on the Workforce model.
Approved Management of Change and Organisational Development proposals and delivery plans.
Increased capacity in subject matter expertise including a 3rd party partner for Organisational Development Affina.
Operational readiness defined and compliance measures approved to inform a move decision.

</td>
<td>Management: MMUH Programme Oversight Group , MMUH Risk Management Group , MMUH Programme Group, Trust Management Committee, Risk Manangement Committee, MMUH Opening Committee, People Committee and reports to relevent Tier 1 Committees and Trust Board.

Risk and compliance: Programme and Workstream risk register. Critical Success Factors forecast plan and actual performance tracked. Workforce recruitment trajectories agreed. Management of Change delivery plan with critical milestones and success measures.
OD plan with agreed success measures.
Project Management Office (PMO) monthly performance report.

Independent assurance: 3rd party assurance of workforce model by HEE documented in Trust Board proposal April 2022. Subsequently reviewed and supported by Black Country (BC) and Birmingham and Sollihull (BSol) Integrated Care Board Executives.
PWC Benefits partner commissioned to provide the accepted baseline Benefits Case in 2023.
National New Hospital Programme Team.
3rd party partners include Camburg – reviewed MOC delivery plans, Athena to deliver Organisational Development.
Programme Assurance Review.

Performance indicators: Critical Success Factors. Project Management Office (PMO) report. Staff Survey Results.</td>
<td>

Management of service interdependencies. (005/16 and 005/17)
Board agreement to Stage 3 recruitment. (005/18)
Understand impact of total Trust workforce recruitment trajectory on the benefits case. (005/19)
Organisatioanl Development (OD) interventions not yet started at scale. (005/20)
Staff side and trade union interrelationship issues risk destabilising MMUH and Trust People Plan priorities. (005/21)
Assurance on ability to recruit the right skills/disciplines in the right numbers (incl. hard to fill posts) ie safe staffing (005/22)

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<tr><th>Gap Ref</th><th>Required Action</th><th>Lead</th><th>Monitoring</th><th>Status</th></tr>
<tr><td>005/16</td><td>Complete the identification of service interdependencies.</td><td>• Liam Kennedy</td><td>➢ MMUHOC
➢ PC</td><td>DUE: November 2023</td></tr>
<tr><td>005/17</td><td>Provide assurance on resolution of gaps in interdependencies and synergy is achieved prior to move.</td><td>• Liam Kennedy</td><td>➢ MMUHOC
➢ PC</td><td>DUE: March 2024</td></tr>
<tr><td>005/18</td><td>Assess Stage 3 recruitment within the overall Trust Workforce recruitment trajecory and quality assure the ability to deliver the intended clinical model and associated benefits case.</td><td>• Liam Kennedy</td><td>➢ MMUHOC
➢ PC</td><td>DUE: October 2023</td></tr>
<tr><td>005/19</td><td>Assess the impact of total Trust workforce recruitment trajectory on the people related benefits case and trajectory of delivery.</td><td>• Liam Kennedy
• Simon Sheppard</td><td>➢ MMUHOC
➢ PC</td><td>DUE: November 2023</td></tr>
<tr><td>005/20</td><td>Commence OD interventions in November and measure impact.</td><td>• Meagan Fernandes</td><td>➢ MMUHOC
➢ PC</td><td>DUE: March 2024</td></tr>
<tr><td>005/21</td><td>Effective partnership working between staff side and trade union colleagues needs to be in place to support delivery of MMUH workforce and People Plan priorities.</td><td>• James Fleet
• Meagan Fernandes</td><td>➢ MMUHOC
➢ PC</td><td>DUE: March 2023</td></tr>
<tr><td>005/22</td><td>Track safe staffing posts and critical recruitment to enabl ethe clinical model.</td><td>• Meagan Fernandes</td><td>➢ MMUHOC
➢ PC</td><td>DUE: December 2023</td></tr>
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<td>Impact Description
(what might cause this to happen)</td>
<td colspan="2">Controls
(what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</td>
<td>Sources of assurance
(Evidence that the controls/ systems which we are placing reliance on are effective)</td>
<td>Gaps in assurance and controls
(All identified gaps <u>must</u> result in an action being identified to rectify or manage (005/22the risk)</td>
<td>Committee Assurance Rating</td>
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<td>5e:

There is failure to establish an effective strategic benefits oversight and delivery framework</td>
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Establishing the Managing Successful Programme (MSP) methodology through the implementation of the MMUH Programme Company. The Project Initiation Document (PID) records Programme set up and governance.

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<td>Management: MMUH Programme Oversight Group , MMUH Risk Management Group , MMUH Programme Group, Trust Management Committee, Risk Manangement Committee, MMUH Opening Committee, and reports to relevent Tier 1 Committees and Trust Board.</td>
<td>

Exit strategy and benefits oversight and assurance infrastructure post MMUH Programme Closure unknown. (005/23 and 24)
Moderate term benefits for Logisitcs and Learning Campus to be identifed. (005/25)

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<td>that results in the inablity to provide assurance on the delivery of the strategic benefits case.</td>
<td>

Dedicated PMO that reviews, challenges and reports progress against the ten workstreams (each of which have a workstream lead and worstream plan).
Integrated Programme masterplan working towards building handover and first patient move dates is underpinned by robust workstream plans and the operational readiness framework.
Benefits Case supported by 3rd Party partnership with Price Waterhouse Coopers (PWC).
Stakeholders mapped to benefits case.

</td>
<td>Risk and compliance: Programme and Workstream risk register. Critical Success Project Management Office (PMO) monthly performance report.

Independent assurance:
PWC Benefits partner commissioned to provide the accpeted baseline Benefits Case in 2023.
National New Hospital Programme Team.
Included in Programme Assurance Review (October 2023) and forthcoming Infrastructure Projet Authority Gateways. Programme Assurance Review.

Performance indicators: Critical Success Factors. Project Management Office (PMO) report.</td>
<td>

Strategic Regeneration benefits are underpinned by the Grove Lane and Smethwick to Birmingham masterplan but neither have a detailed delivery plan yet. (005/26)
Strategic benefits group not yet established. (005/27)
Benefits oversight framework and dashboard not yet established. (005/28)

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Gap Ref	Required Action	Lead	Monitoring	Status
005/23	Exit strategy proposal to be presented in October 2023 governance cycle.	• Deborach McInerney	➢ MMUH OC	**DUE: November 2023**
005/24	MMUH Programme Company Exit completed leaving a legacy infrastructure for benefits assurance and oversight in place.	• Rachel Barlow	➢ MMUH OC	**DUE: March 2025**
005/25	Moderate term benefits for Logisitcs and Learning Campus to be identifed by PWC.	• Simon Sheppard	➢ MMUH OC	**DUE: February 2024**
005/26	Continune Strategic Regeneration benefits development with key partner organisations (West Midlands Combined Authority, Birmingham City Council, Sandwell Metropolitan Borough Council) and add to the strategic benefits case.	• Rachel Barlow	➢ MMUH OC	**DUE: March 2025**
005/27	Establish the Strategic Benefits Group to over see delivery and further development of the Benefits Case during and after the lifetime fo the MMUH Programme Company.	• Simon Sheppard	➢ MMUH OC ➢ F&P ➢ Audit	**DUE: December 2023**
005/28	Establish a Benefits handbook and dashboard to track delivery of the strategic benefits case.	• Simon Sheppard	➢ MMUH OC ➢ F&P ➢ Audit	**DUE: December 2023**

Impact Description (what might cause this to happen)	**Controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Sources of assurance** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance and controls** (All identified gaps **must** result in an action being identified to rectify or manage (005/22the risk)	**Committee Assurance Rating**
5f: **Failure to secure capital funding and progress digital transformation and SMART optimisation at MMUH will compromise the digital impact on the strategic benefit case.**	• Establishing the Managing Successful Programme (MSP) methodology through the implementation of the MMUH Programme Company. The Project Initiation Document (PID) records Programme set up and governance. • Dedicated PMO that reviews, challenges and reports progress against the ten workstreams (each of which have a workstream lead and worstream plan). • Integrated Programme masterplan working towards building handover and first patient move dates is underpinned by robust workstream plans and the operational readiness framework. • Benefits Case supported by 3rd Party partnership with Price Waterhouse Coopers (PWC). • Medium Term Finance Plan agreed and inclusive of MMUH costs. • Digital Strategy 2022 – 25.	**Management:** MMUH Programme Oversight Group , MMUH Risk Management Group , MMUH Programme Group, Trust Management Committee, Risk Manangement Committee, MMUH Opening Committee and reports to relevent Tier 1 Committees, FIPC and Trust Board. Provider collaborative engagement. **Risk and compliance:** Programme and Workstream risk register. Critical Success Factors forecast plan and actual performance tracked. Project Management Office (PMO) monthly performance report. Project level assurance reports. **Independent assurance:** Programme Assurance Review.	• Digital SMART infrastructure in MMUH – but no enabling infrastructure prioritised or funded such as asset tracking **(005/29 and 30)** • First net solution for Same Day Emergency Care. **(005/31)**	**AMBER**

	• SMART digital infrastructure in MMUH. • Service Change Request on Cerner Unity system critical to support the clinical model identified wiith supporting work programme.	**Performance indicators:** Critical Success Factors. Project Management Office (PMO) report.			
	Gap Ref	**Required Action**	**Lead**	**Monitoring**	**Status**
	005/29	Continue to source external funding to progress SMART technology.	• Mark Taylor	➢ MMUH OC	**DUE: December 2025**
	005/30	MMUH Exit strategy to recommend SMART prioirities to Digital Strategy SRO ie Executive Direcotr of Digital and IT.	• Mark Taylor	➢ MMUH OC	**DUE: December 2024**
	005/31	First Net SDEC business case to be considered in October 2023 governance cycle.	• Jo Newens	➢ MMUH OC	**DUE: March 2024**

Strategic Objective: Patients - Population- To work seamlessly with our partners to improve lives.	**Executive Lead(s):** Manageing Director Core Organisation / Chief Integration Officer

Risk ref:	BAF 004
Principle risk:	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.
Date added to BAF:	April 2022
Oversight Committee:	Integration Committee
Date of review:	Dec 2023
Date of next review:	April 2024

Risk Rating:	**Consequence**	**Likelihood**	**Score**
Initial Risk Score	4	4	16
Current Risk Score	4	3	12
Target Risk Score	4	2	8

Existing Risk Appetite (Open): We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident, we would be able to challenge this successfully.

Aspirational Risk Appetite (Seek): We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.

Rationale for current risk score:
Whilst there has been substantial progress by the Trust in the development of the Place Based Partnership in Sandwell, significantly less progress has been made in Ladywood and Perry Barr on both the coordination of services and the appropriate match of capacity to demand due to lack of clarity about the BSOL operating model Additionally, the work on addressing the health inequalities through the lens of Core 20 plus 5 is in its infancy and our plans for 24/25 is to focus on a town size footprint to be effective over a number of years. Finally, to have any effect on the wider determinates of social health, the Trust needs to use its role of an Anchor institution to build on our collective influence on the socio-economic factors.

Strategic Risk	**Controls**	**Sources of assurance**	**Gaps in assurance**	**Committee Assurance Rating**
4a: Failure of the Trust to engage in shared planning and decision-making at System and Place partnership level.	• An approved operating model at a system level in the Black Country that covers the role of place based partnerships • The development of the provider collaborative which will retain the focus of place based partnerships at a local footprint retaining the focus through the Trust Boards • The Host provider of the Sandwell Place Partnership • The Anchor Organisation for Ladywood and PerryBarr Locality (west Birmingham) • An approved governace structure in Sandwell Place that has been signed off by all the partners and taken through each organsation • An Alliance Agreement signed by all the Sandwell Place partners that sets out the intent, behaviours and outcomes for delivery. • An agreed terms of reference and Alliance Agreement from the Place that have been supported by the Black Country system • Participation in the system level boards in both Black Country and BSOL in all elements of delivery and coordination on Urgent Care, Planned Care, Out of Hospital and Intermediate Care. • A member as the host of the Sandwell place of the Joint Partnership Board (commissioning) in Sandwell Place • A member of the Out of Hospital Programme Board in Black Country and the lead Place for the Operational group reporting into that Board	**Management:** SHCP Place Board, LWPB Locality Partnership Board, BSOL system boards. BC system boards, Black Country Provder Collaborative. BSOL community care collaborative. Sandwell Joint Partnership Board **Risk and compliance:** CQC performance metrics. System performance metrics and benchmarking. Model hospital. **Independent assurance:** CQC, Association of Director of Adult Social Care and LGA reports. Safeguarding reviews and reports. Health Watch reports. **Metrics received:** System performance metrics. Place Performance metrics. Adult Social Care performance metrics	• Lack of a publish plan and scope for the locality partnerships in BSOL **(004/1 & 004/2)** • Poor clarity of the role of the Primary Care collaborative vs the Place Based partnerships in Black Country **(004/3)** • Lack of system data that can be disagregated to a place level **(004/4)** • Long term funding plan for the system development fund **(004/5)** • Long term funding plan for community services growth **(004/6)**	**Amber**

Gap Reference	**Required Action**	**Lead**	**Monitoring**	**Status**

	004/1	In the new role as the anchor organisation for LWPB coordinate the publication of a delivery plan for 24/25	Chief Integration Officer	Integration Committee	**DUE : MARCH 24**	
	004/2	Work with the Sandwell Primary Care Collaborative to agree a scope of work for them to lead on	Chief Integration Officer	Integration Committee	**DUE : FEB 24**	
	004/3	Work with the West Birmingham Primary Care Collaboratve to agree a scope of work to dovetail into the LWPB delivery plan	Chief Integration Officer	Integration Committee	**DUE : FEB 24**	
	004/4	Coordinate with Out of Hospital Board and also Joint Partnership Board to establish local funding opportunities and decisions for 24/25	Chief Integration Officer	Integration Committee	**DUE : MARCH 24**	
	004/5	Produce a clear benefits and oppotunites plan for the schemes funded by System Development Fund to demonstrate a credible return on investment	Chief Integration Officer	Integration Committee	**DUE : MARCH 24**	
	004/6	Establish an evidence based case for continued growth in Out of Hospital Services linked to the rightsizing work for MMUH	Chief Integration Officer	Integration Committee	**DUE : MARCH 24**	

Strategic Risk	Controls	Sources of assurance	Gaps in assurance	Committee Assurance Rating
4b: Failure to redesign the model of care to build on attendance avoidance, Admission avoidance and Length of stay reduction resulting in a growth for acute hospital services	• An agreed operating model in Sandwell Place that focuses the work around, Prevention, Planned, and Urgent and Intermediate Care with these risks as an operational outcome • Alignement with the Trusts strategy and annual planning process • Plan agreed with system development funding that transform services and build in growth for capacity in these areas • A right sizing plan for MMUH that directly addresses the need to both right size community services but also focuses on shortening acute LOS • A recruitement programme through MMUH and SDF that builds future capcity and capability in these services • Alignement of funding and capability of the place partners through the resources in the better care fund	**Management:** Sandwell Place Senior Management Team LWPB Senior Management Team Sandwell Operations and quality group PCCT Group Board **Risk and compliance:** CQC performance metrics. System performance metrics and benchmarking. Model hospital. **Independent assurance:** CQC, Association of Director of Adult Social Care and LGA reports. Safeguarding reviews and reports. Health Watch reports. Operational Peer Reviews **Metrics received:** System performance metrics. Place Performance metrics. Adult Social Care performance metrics Trust Board and committee metrics. Group metrics	• Lack if alignment between the system funding in Black Country and the role of the Better Care Fund **(004/7)** • No clear route to transformation funding in future years net of current budgets • Inability to attract the required workforce in the current climate. Therapists being the hot spot • Limited ambition from partners to bring different services together into a shared leadership model • Potential reduction plan in adult social care funding due to the financial challenge on public sector financing	**Amber**

Gap Reference	Required Action	Lead	Monitoring	Status
004/7	Work with the Sandwell Joint Partnership Board so that the Better Care Fund and delegated budgets are used on services that promote the greatest benefits	Chief Integration Officer	Integration Committee	**Due : Ongoing**
004/8	Create a plan for transformation for Trust services that builds on the benefits planned for already delivered ready for investment when it made available.	Chief Integration Officer	Integration Committee	**Due : April 24**
004/9	Have a clear recruitment strategy that targets the areas of greatest risk as a priority	Chief People Officer	Integration Committee	**Due : Ongoing**
004/10	Work initially with social care to explore opportunities for a shared leadership and delivery model on aligned services such as therapy workforce	Chief Integration Officer	Integration Committee	**Due June 24**
004/11	Have a clear understand on the budget pressures and services risks in the LGA budgets and work through potential mitigations	Chief Integration Officer	Integration Committee	**Due March 24**

Strategic Risk	Controls	Sources of assurance	Gaps in assurance	Committee Assurance Rating

Strategic Risk	Controls	Sources of assurance	Gaps in assurance	Committee Assurance Rating
4c: Failure to address directly the health inequalities of each town footprint by using the core 20 plus 5 model resulting in deteriorating population health.	• A joint strategic needs assessment co produced with public health down to a town sized level • Coordination of town teams across intially, community services, social care and primary care to focus on local health inequalities • Mapping of the core inequalities at a town level to avoid a one size fits all approach • A delivery plan that places the needs of the residents first with the delivery of specilist care and advice close to their homes • A monitoring framework that shows the patient journey before and after interventions	**Management:** Planned care Delivery group Urgent and Intermediate Care Delivery Group LWPB delivery Group Targeted Lung Health Check Delivery Group **Risk and compliance:** CQC performance metrics. System performance metrics and benchmarking. Model hospital. **Independent assurance:** CQC, Association of Director of Adult Social Care and LGA reports. Safeguarding reviews and reports. Health Watch reports. Operational Peer Reviews **Metrics received:** Health Inequalities Metric JSNA metrics Population Health Metrics Operational performance metrics	• Poor coordination on health inequalities funding at a system level which builds strategic capacity • Lack of aligned data on population metrics and delivery metrics • Poor alignment of the roles across providers • Gaps in recruitement mainly associated with primary care workforce • Lack of understanding of the volentary sectors capability in this area.	**Amber**

Gap Reference	Required Action	Lead	Monitoring	Status
004/11	Coordinate the available funding to the highest need patient areas through both the OOH Board and the Joint Partnership Board within Place	Chief Integration Officer	Integration Committee	**Due : May 24**
004/12	Make available the population health record to the town team MDT's so they can align their operational approach	Chief Integration Officer	Integration Committee	**Due : June 24**
004/13	Work with the primary care collaborative to intially recruit then coordinate the ARRS roles	Chief Integration Officer	Integration Committee	**Due : Ongoing**
004/14	Coordinate condition specific plans with the volntary sector based on schemes avilable locally	Chief Integration Officer	Integration Committee	**Due : June 24**

Strategic Risk	Controls	Sources of assurance	Gaps in assurance	Committee Assurance Rating
4d: Failure to work with partners in our role as an anchor insitution to collectively address the wider determinates of health within our population resulting in poorer life chances	• Both place based partnerships now starting to look at the wider determinates of health • Annual planning to focus on employment and the economic factors of sociual health • Education being addressed with a longer term strategy on the deployment of the learning campus • Provising local jobs for local people through the learning works progress • A plan to make the best use of local investment through mater planning on the City and MMUH sites drawing • Coordinated plans to employ local people where possible • Clear commitment from the community and volentary organisation demonstrated through the communti take over sessions in Integration Committee	**Management:** SHCP Place Board, LWPB Locality Partnership Board, Sandwell Place Senior Management Team, LWPB Locality Senior Management Team **Risk and compliance:** Joint Strategic Needs Assessment Population health metrics **Independent assurance:** CQC, Association of Director of Adult Social Care and LGA reports. Safeguarding reviews and reports. Health Watch reports. Operational Peer Reviews **Metrics received:** Health Inequalities Metric JSNA metrics Population Health Metrics Operational performance metrics	• Lack of a coordinated plan of work across providers on local employment • Clear route to benefits management not only through MMUH but also through all regeneration and employment • A link to measure local determinates and tracking the public health benefits • Understanding of the benefits of investing in the volentary secotor with a proposed future funding strategy	**Amber**

Gap Reference	Required Action	Lead	Monitoring	Status

	004/15	Coordinated employment plan between the participating partners for the areas covered by the Trust	Chief Integration Officer	Integration Committee	**Due : Sept 24**	
	004/16	A plan with a precited route to benefits mapped against the wider determinates of health	Chief Integration Officer	Integration Committee	**Due : Sept 24**	
	004/17	A data plan that delivers mapping against progress of the coorinated work	Chief Integration Officer	Integration Committee	**Due : Sept 24**	
	004/18	An agreed plan for a proportion of the collective budget of the place parts to route into the voluntary sector based on deliverable benefits. Initially mapped to 1% and tested	Chief Integration Officer	Integration Committee	**Due : Sept 24**	

Sandwell and West Birmingham NHS Trust

3 January 2024 09:33

List of action items

Agenda item		Assigned to	Deadline	Status
BAF Risk Actions 15/11/2023 1.a Significant Failure to deliver the standards of quality and safety for patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes				
478.	001/1: A Fundamentals of Care Delivery Group to be established to support the management of the workstreams and drive assurance through the organisation	Roberts, Mel	30/09/2023	Completed
	Explanation action item May 2023: First meeting due in June. TOR in place. August 23: Meetings commenced in July 23, TOR in place, FOC workstreams & MMUH hospital standardisation merged together resulting in 18 FOC projects, YR 1- Yr 3 draft delivery plan in place			
	Explanation Roberts, Mel in place with an assurance group			
479.	001/2: The new CQC Self-Assessment Framework to be implemented. This will help with the triangulation of governance and clinical reporting into a central system	Dhami, Kam	31/01/2024	Completed
	Explanation action item May 23: - CQC board development day in June (cancelled due to IA) - Self-assessments being undertaken by groups. - Triangulation dashboard being developed.			

	August 23 - Self assessments completed, Specialist roles validation, Exec validation ongoing			
480.	001/3: Reporting dashboard development for specialty areas in relation to Fundamentals of Care to be agreed and implimented.	● Roberts, Mel	01/01/2024	Completed
	Explanation action item Sept 22: - Work is underway to agree what metrics the dashboard will be reporting on so we can monitor progress. This work will be presented back to Q&S committee October/November 2022 Feb 23: - Plan in place for the development of the Harm Free Care dashboard and Group metrics for fundamentals of care based on this year's priorities. May 2023: - Medicines management dashboard in place. Harm free care in development. August 23 - Triangulation dashboard FOC/CQC draft			
	Explanation Roberts, Mel as above BI team are working to finalize and this will become part of the FOC paper update			
481.	001/4: Fundamentals of Care Dashboard and Mortality dashboard to be developed and reported on through the governance system. This will improve our patient experience and clinical outcomes.	● Anderson, Mark ● Roberts, Mel	30/09/2023	Completed
	Explanation action item Sept 22: - The draft strategy was presented at Q&S and POD in May 2022. The framework was approved by Trust Board in September 2022 - The launch our fundamentals of care approach across the organisation happened in September 2022 and the attendance was over 265 staff. Follow up events are happening throughout October/November 2022			

	Feb 23: - Q&S metrics have been signed off and will come monthly to Q&S committee August 23: - Q&S Metrics reviewed & updated			
482.	001/5: Ensure that the Fundamentals of Care are implemented, understood through an engagement plan which includes, patient and stakeholder engagement sessions and Staff engagement sessions. This will support the Trust to gather a frontline view of where services are not meeting expectations.	Roberts, Mel	31/03/2024	Pending
	Explanation action item Sept 22: - Over 1500 staff attended the engagement events and contributed to the framework. Further sessions are being held over the next two months. The implementation plan will be presented to Q&S in October 2022 Feb 23: - Communication of the delivery plan for the Fundamentals of Care to be agreed and implemented. August 23: - Engagement sessions continue, celebration events planned for later in the year			
	Explanation Roberts, Mel all Actions above completed Year one deliverable plan in place for FOC which incorporates MMUH Hospital Standardisation and planning year 2 and 3 FOC delivery group in place which reports to an assurance group - quality committee			
483.	001/6: Ensure all out of date policies are reviewed and updated in a timely manner	Dhami, Kam	31/10/2024	Pending

484.	001/7: Staffing Assurance reports to the committee to ensure safe and effective staffing is in place, that reflects patients care needs and promotes a safe environment for service users and staff.	Anderson, Mark Roberts, Mel	31/03/2024	Pending
	Explanation Anderson, Mark This will be picked up as part of roll out of Allocate, e-rostering and the allocate leave system in year 2024/25.			
	Explanation Roberts, Mel These will commence for nursing and Midwifery February 2024 following the roll out of safecare			
485.	001/8: ED & Bed Modelling tool to be developed and measured, that will accurately monitor both bed reduction and, performance and activity against current and proposed pathway improvements plus the development of the BI dashboards for the bed saving transformational schemes to monitor lead measures.	Kennedy, Liam	31/12/2023	Overdue
	Explanation action item August 2023 - The MMUH and Place Based Rightsizing Report now coming regularly through the governance cycle			
BAF Risk Actions 15/11/2023 1.b Insufficent understanding and embedding of learning following significant events/incidents/complaints and evidencing improved practice and clinical outcomes.				
486.	001/9: Patient Safety Incident Response Framework (PSIRF) to be implemented across the Trust.	Dhami, Kam	30/04/2024	Pending
	Explanation action item June 23: - PSIRF Implementation plan presented and agreed at the May Q&S Meeting. This set out the milestones to September 2023 August 23: - PSIRF reporting governance established: PSIRF Executive Group, PSIRF Stakeholder Engagement Group and Implementation Group - PSIRF plan signed off at July Q&S committee			
487.	001/10: Patient safety incident response policy need to be updated and staff training implemented.	Dhami, Kam	30/04/2024	Pending

488.	001/11: Human factors thinking training to be rolled out initially to high risk area's.	Dhami, Kam Fleet, James	31/12/2023	Overdue
	Explanation action item August 2023 - 1st training session taken place in Theatres.			
489.	001/12: A review of the complaints process to be undertaken and improvements to reporting to be established.	Dhami, Kam	30/04/2024	Pending
490.	001/13: A review of how patient safety incidents actions are reported and lessons learnt are shared to be undertaken.	Dhami, Kam	30/04/2024	Pending
BAF Risk Actions 15/11/2023 1.c Safe & skilled workforce not achieving adequate numbers & skill mix impacts on the ability to deliver safe care, effective outcomes and organisational objectives.				
491.	001/14: Recruitment/retention and induction process to be refined for senior medical staff, Nursing staff, Midwifery and NHPs to be established. This will feature within the People Plan which aims to remedy to our long-standing recruitment challenges and retention issues.	Fleet, James Roberts, Mel	31/03/2023	Completed
	Explanation action item Sept 22: - The People Plan is being developed and managed through POD and is being led in partnership with the Chief Nursing officer and Chief medical Officer. There is a retention plan that was submitted to NHSE in September 2022 in place 1for nursing and midwifery. May 2023: - People plan agree and Induction process updated.			
492.	001/15: Education Programme for career pathways for staff to be established which includes leadership and preceptorship. This falls under the People Plan	Fleet, James	30/12/2023	Overdue

	Explanation action item May 2023: - Draft education strategy developed. - Leadership programme pilot completed, and programme commenced August 23: - L&D workshop to be held			
493.	001/16: Allocate to be imbedded and utilised in the Trust	Anderson, Mark Roberts, Mel	31/10/2024	Pending
	Explanation Anderson, Mark Alllocate roll out for medics, including e-rostering is due to commence April 2024. Not expected to complete until end of Q2 2024.			
	Explanation Roberts, Mel Allocate is now in place for nursing staff as of August 2023- Safecare is being rolled out across nursing and will be completed by December 2023. Project plan in place for roll out to AHPs next and Medics from April 1st. this project will not complete until at least September 2024 for full roll out			
494.	001/17: Pastoral support offer to be developed and implemented, this should be holistic and focus on wellbeing needs, as well as training and development needs.	Fleet, James Roberts, Mel	30/04/2024	Pending
	Explanation Roberts, Mel PNA /PMAis the key to pastoral support and training Roll out across the organization is underway for PNAs and will be rolled out over the next 2 years as the training is available . PMAs are fully recruited to within midwifery For AHPs/HCA both have councils in place to discuss both of these aspects as there is not a mirrored role for these professions			
495.	001/18: Options for a Simulation training programme to explored.	Anderson, Mark Roberts, Mel	30/11/2023	Overdue
	Explanation Anderson, Mark First meeting has taken place to discuss an integrated approach to training. This ongoing plan will then incorporate simulation training and opportunities for multi-disciplinary roles.			

	Explanation Roberts, Mel The first meeting of learning and education has happened to scope what is required moving forward. this will become part of that work			
BAF Risk Actions 15/11/2023 1.d A lack of a trust-wide systematic approach that is understood and owned by the organisation resulting in reduced patient experience and missed opportunities.				
496.	001/19: The Trust is currently deciding on the support required to implement the system, and the partner that will provide it	Baker, Dave	30/09/2023	Completed
	Explanation action item August 2023: - Delivering Continuous Quality Improvement: Final Business case with preferred provider recommendation to be presented in June/July committees round. Then to Trust Board for a decision.			
497.	001/20: The funding for the CQI needs to be agreed so that an implementation plan (timeline/sequence) can be developed with the partner.	Baker, Dave	30/09/2023	Overdue
	Explanation action item August 2023: - Delivering Continuous Quality Improvement: Final Business case with preferred provider recommendation to be presented in June/July committees round. Then to Trust Board for a decision. Plan can be developed once money and partner in place.			
	Explanation Baker, Dave Board has approved the spend. Have funded first £49.5k. Seeking support for next £250k whilst applying to ICB/NHSE for permission to spend Trust money on the rest of the contract ~£1.4m s per the procurement. CFO making provision in planned spend. We have agreed a plan with our Partner, KPMG/Catalysis that is set in the context of MMUH to avoid overloading the organisation any further. Whilst our Board have approved the funding and a CFO has made a provision In the H2 plans for 2023/24 we are seeking permission from the System Investment Committee to spend it (5/1). We also need to take it through NHSE Midlands (via the ICB) as it is deemed as being Consultancy spend. Katrina Boffey is the link here and we are speaking to her. We also have the NHSE template to complete (different to the ICB one) and establishing whether we subsequently need to go to NHSE Midlands or not.			

	Post STaCC approval in December 2023 we are taking the Improvement team through a restructure. We launched the consultation on 18/12/23 so that we can form an academy in April 2024 and develop the team. We can then develop that team with a view to them commence a developmental roll out more broadly into the organisation once we have opened MMUH. We are carrying further risks to the plan around getting the Improvement team resource out of current responsibilities into the academy and not having them diverted into a financial recovery programme. Either risk could cause them to remain as project managers rather than multipliers who create the systematic approach desired.			
498.	001/21: Board, Executive, TMC commitment and development to work in the new improvement system as the SWBT Way and to skill up and re-purpose the Improvement team into an academy.	Baker, Dave	31/12/2024	Pending
	Explanation action item August 2023: - Board, Executive and TMC development prioritised alongside the development of the academy and the review of our metrics planning as part of the proposed initial phase of the plan of we are given the go ahead.			
	Explanation Baker, Dave We have agreed a plan with our Partner, KPMG/Catalysis that is set in the context of MMUH to avoid overloading the organisation any further. Whilst our Board have approved the funding we are seeking permission from the System Investment Committee to spend it (5/1) and establishing whether we subsequently need to go to NHSE Midlands or not. We are taking the Improvement team through a restructure via STaCC (December 2023) so that we can form an academy in April 2024 and develop the team. We can then develop that team with a view to them commence a developmental roll out more broadly into the organisation once we have opened MMUH. We are carrying further risks to the plan around getting the Improvement team resource out of current responsibilities into the academy and not having them diverted into a financial recovery programme. Either risk could cause them to remain as project managers rather than multipliers who create the systematic approach desired.			
499.	001/22: Capacity for the whole organisation to be developed in the improvement system so that it becomes the SWBT Way i.e. Implement the plan (timeline/sequence)	Baker, Dave	31/12/2025	Pending
	Explanation action item August 2023: - Dependent on commitment made by TMC/Board in light of other MMUH and other financial challenges			
	Explanation Baker, Dave We have agreed a plan with our Partner, KPMG/Catalysis that is set in the context of MMUH to avoid overloading the organisation any further. Whilst our Board			

	have approved the funding we are seeking permission from the System Investment Committee to spend it (5/1) and establishing whether we subsequently need to go to NHSE Midlands or not. We are taking the Improvement team through a restructure via STaCC (December 2023) so that we can form an academy in April 2024 and develop the team. We can then develop that team with a view to them commence a developmental roll out more broadly into the organisation once we have opened MMUH. We are carrying further risks to the plan around getting the Improvement team resource out of current responsibilities into the academy and not having them diverted into a financial recovery programme. Either risk could cause them to remain as project managers rather than multipliers who create the systematic approach desired.			
500.	001/23: Executive team focus and alignment to tackling the priorities together in a joined up and team based way	Beeken, Richard	31/05/2025	Pending
	Explanation action item August 2023: - Room 3 introduced in May which is run by CEO. Annual plan introduced as focus of TMC in May 2023. Both now focussed on 6 and 14 objectives in the annual plan.			
BAF Risk Actions 15/11/2023 3.a Plan, attract, recruit, and develop (workforce planning and safe staffing).				
502.	003/1: A recruitment & selection plan to deliver the recruitment requirements for MMUH and Core, ensuring prompt and efficient recruitment takes place for all roles.	Fleet, James	30/04/2024	Pending
	Explanation action item June 23 - Existing contract with Remedium extended until October 2024. - Recruitment Team stabilisation programme completed following external review. - Sustainability Plan and long term options for Recruitment Service Delivery to be scoped and taken through People and OD Committee for assurance - Vacancy management and oversight in place through Establishment Control Group and Workforce Oversight Group - Inclusive Resourcing and Talent Management Group set up to improve representation and ensure recruitment processes are inclusive and reflective of our Trust values November 2023 - Recruitment Plan in Place for all MMUH roles with recruitment activity ongoing - Recruitment Tracker in place to track and monitor all roles			

503.	003/2: Pay Review Plan to cover – Exec and VSM pay, National living Wage review, alignment of pay rates for the system and premium payments for hard to fill posts	Fleet, James	31/10/2023	Completed
	Explanation action item June 23 - 23/24 review completed following external evaluation and mechanisms built into Remuneration Committee to enable periodic reviews which will take account of national guidance August 23 - Recommendations agreed at Remuneration Committee and need to be implemented, supported by the CEO November 23 - VSM pay review completed and implemented - Reviews due annually to take account of national recommendations for pay increases			
504.	003/3: Updated Financial and workforce plan to take account of CIP and workforce reprofiling to be shared at PC and F&P	McLannahan, Dinah	31/07/2023	Completed
	Explanation action item August 23 - Workforce Plan linked to finance and activity developed as part of annual plan submission. - Plan is being updated to take account of CIP's and workforce reprofiling - workforce optimisation plan is being developed to support implementation of financial recovery measures and workforce planning requirements			
505.	003/4: e-rostering implementation plan inclusive of training delivery plan and associated golden rules linked to financial recovery to be developed	Roberts, Mel	30/09/2023	Completed
	Explanation action item August 2023 - Erostering programme updates now on POD Forward Planner - Golden rules developed to support safe staffing and grip and control			

	Explanation Roberts, Mel in place bi monthly to committee			
506.	003/5: Safe Staffing data to be presented at POD	Roberts, Mel	29/02/2024	Pending
	Explanation action item August 2023 - On PC Forward Planner but data to be agreed with the CNF.			
	Explanation Roberts, Mel Once safecare is rolled out twice yearly safe staffing data will be presented to POD Committee - this should commence at February 2024 POD			
507.	003/6: Vaccination roll out plan to be developed including comms plan and shared at committee	Fernandes, Meagan Fleet, James	31/10/2023	Completed
	Explanation action item August 2023 - Plan being developed and on forward planner for POD November 23 - Plan developed and shared at People Committee in october 23. - Implementation of flu programme has commenced			
508.	003/7: Plan C service derogation for “hard to fill “ MMUH roles (that cannot be recruited via plan a and plan b) to be developed by the MMUH Clinical Services workstream to ensure a robust externally peer reviewed clinical model/pathway and associated workforce plan is in place to support safe staffing requirements	Kennedy, Liam	30/09/2023	Completed
	Explanation action item June 23 - Being followed up via MMUH Governance Structures, programme reset sprint and via POD and Executive Group. [this action can be taken closed as it has been replaced with 005/18 and 005/19 within the MMUH BAF]			

509.	003/8: Development of a talent management framework for the organisation	Fleet, James	31/03/2025	Pending
	Explanation action item June 23 - Currently identified as a priority on the People Plan for delivery in 24/25 August 23 - Inclusive Resourcing and Talent Management Task and Finish Group to set up to scope approach November 23 - Inclusive Resourcing and Talent Management Task and Finish Group met in September and agreed key areas of focus - Talent Management Strategy not due until 24/25 however essential actions being put in place to track career development opportunities for BME staff			
510.	003/9: Integrated multiprofessional workforce education and transformation plan to include supply, retention, upskilling , education and development.	Anderson, Mark Fleet, James Roberts, Mel	30/09/2024	Pending
	Explanation action item June 23 - Safe and Skilled Workforce and Education Development Workstreams set up as delivery vehicles to support development of the plan. - Stakeholder workshop set up in October to support scoping exercise and agreement of areas of focus November 23 - Education Strategy scoping stakeholder workshop took place in October 23 - Satkeholder workshop linked to Learning Campus being planned for 24/25 - Focus of Workforce Transformation and Development Committee reviewed to support oversight for delivery of integrated workforce transformation and education programme - Deadline extended to September 2024			
	Explanation Anderson, Mark Workshop took place; now will need development of a strategy and delivery plan.			
	Explanation Roberts, Mel meeting held in October to scope			

	plan now to be put into place			
511.	003/10: Robust plan on long term arrangements for recruitment delivery (post October 2024) needs to be developed.	Fleet, James	31/01/2024	Pending
	Explanation action item November 23 - Options appraisal currently being scoped for completiong by Janaury 24 - Provider Collaborative opportunities being considered to feed into options appraisal - Market testing exercise being undertaken			
BAF Risk Actions 15/11/2023 3.b Staff experience and retention (culture and climate).				
512.	003/11: New Trust wide Staff Values to be agreed and in place. These will act as the core principles that the Trust and its people should live by. Once our values and behaviours are finalised, we need to ensure that these are embedded across the Trust, running through everything we do at work including decision-making, how we recruit and our PDR processes.	Fleet, James	30/06/2024	Pending
	Explanation action item September 22: • Considerable engagement internally has already taken place through workshops, interviews and Q&A sessions. During February and March we carried out an employee voice campaign to allow colleagues across the Trust to share their views to contribute to our new values. Two leadership sessions has also been carried out with the Trust Board. Further engagement work has happened across the Trust following which we will launch at the Annual leaders conference in September. • Values localisation work to begin from October 2022 to December 2022. Board Development Session on 7th December with update to PODC in January 2023 February 22: - Need to agree how we get assurance that we ensure that these are embedded across the Trust August 23 - Values now embedded within PDR process - Employee Value Proposition and branding work has commenced to support embedding our new values - Local translation of values training embedded within ARC Leadership Programme November 23			

	-New Employer Branding Proposition developed -Values embedded within PDR process Values and behaviours training embedded as part of ARC Leadership Programme Values to be embedded as part of recruitment process Q1 2024 onwards DEADLINE EXTENDED TO JUNE 2024			
513.	003/12: Staff Networks review to be undertaken	Fleet, James	29/02/2024	Pending
	Explanation action item November 23 - Staff Network Development Programme commissioned and being delivered via external Partner - Meetings taking place currently with each Chair and vice chair, EDI Team and Executive Sponsors - Revised TOR drafted for staff networks - Recruitment process for Chairs to commence shortly			
514.	003/13: EDI Strategy to be agreed and implemented. To set out our vision, aims and objectives for equality across the Trust and is intrinsic to the People Plan	Fleet, James	31/03/2024	Pending
	Explanation action item June 23 • EDI Plan setting out priorities for two years agreed at POD Committee in January 2023. • Plan being mobilised with updates shared at the Committee in July 23 • WRES, WDES and Gender Pay Gap reports due to be shared at Committee in August 23 - Development programme commissioned for EDI Team to include coaching - Staff network development programme commissioned to support the review and overhaul of staff networks this includes supporting the network chairs and executive sponsors. August 23 - Board Development programme in place. Race Code training delivered to the board in 22. Compassionate and Inclusive Leadership programme in place for December 2023. November 23 - Year 1 priorities now complete and shared at People Committee in July 23 - Yes 2 priorities currently ongoing and on track to complete in March 24.			

	DEADLINE EXTENDED TO MARCH 2024			
515.	003/14: Behaviour Farmework linked to Values to be agreed and implemented.	Fleet, James	26/10/2023	Completed
	Explanation action item June 23 - New behavioural framework linked to Trust ARC values now in place and being rolled out as part of the ARC Leadership Programme - Full embedding of values within recruitment, PDR and policies to commence in 24/25 November 23 This action is now complete			
516.	003/15: Quality Improvement Approach for Staff Retention/Team Culture to be established	Fleet, James	30/04/2024	Pending
	Explanation action item June 23 - QI Programme piloted in two areas -Pharmary and Health Visiting - Programme evaluated and outcome shared at Executive Group and POD Committee in June 23 - Programmes extended to cover high volume sickness areas in line with our sickness and wellbeing plans November 23 - Programme pilot complete and rolled out to further 5 teams with a focus on sickness - Appreciative Inquiry training completed for identified teams - Implementation now being undertaken			
517.	003/16: Talent management programme to be agreed, implimented and robustly measured	Fleet, James	29/02/2024	Completed
	Explanation action item [This item needs to be removed as its the same as action 003/8]			

518.	003/17: Recovery based approach to improve sickness and enhance wellbeing of staff to be agreed and rolled out.	Fleet, James	31/05/2024	Completed
	Explanation action item [This action can be removed as it is linked to action 003/15]			
519.	003/18: Just and Learning Culture programme to be fully implemented to support a shift in staff experience , to reduce the number of formal cases and address the disproprotionate impact on certain staff groups	Fleet, James	31/03/2024	Pending
	Explanation action item Aug 2023 - Programme update shared at POD in June 2023 - Revised policies in place by Q4 for disciplinaries, grievances and dignity at work matters - ARC Leadership programme (Module 1: Compassionate and Inclusive Leadership) to be rolled out to 200 managers in 23/24 and to over 510 team members (over 100 completed training since June 23) November 23 - Revised policies being drafted currently with a view To take through approval in Q4 - Wellbeing framework currently being developed - Casework experience and scrutiny panel being established (January 24) - Review into BME cases and experience of staff as well as triangulation with FTSU matters to be undertaken by Jan 24.			
520.	003/19: Effective partnership working between staff side and trade union colleagues needs to be in place to support delivery of MMUH workforce and People Plan priorities	Fleet, James	31/01/2024	Pending
	Explanation action item Aug 23 - ACAS enagged to support independent resolution - Trust engaging with all parties through structured meeting arrangements with escalation routes in place November 23 1. ACAS intervention due to take place on 4th December			

	2. CPO Led meeting with TU's being arranged (initial meeting scheduled in November had to be reorganised on TU request) 3. Immidiete actions taken by Director of People and OD to strengthen arrangements around MOC process and communicated with TU's 4. MOC Away Session schedueld for HR on 5th December to support MOC delivery for MMUH. 5. Deep dive into MOC programme led by CPO taking place on Monday 13th November			
521.	003/20: Leadership Development Framework to be agreed and implemented. The Leadership Framework provides a consistent approach to leadership development for staff in the Trust irrespective of discipline, role, or function, and represents the foundation of leadership behaviour.	Fleet, James	31/03/2025	Pending
	Explanation action item June 23 - ARC Leadership Development Framework developed - The Compassionate and Inclusive Leadership module is one of the three modules and was launched as a pilot in November 22 and concluded in March 2023. The pilot evaluated positively. Feedback from the pilot has been reviewed and the programme has been updated . - The revised programme has now been launched and will be delivered initially to 200 middle and senior managers from September 2023 onwards in line with the objectives set out within the Trust Annual Plan. In addition we will also train over 500 staff with no direct line management responsibilities (Band 6 and below). November 23 - ARC Leadership Programme in place and currently being implemented (on track to deliver training to 200 leaders by end March 24) - Module 2 and 3 being designed with a view to roll out in 2024. DEADLINE EXTENDED TO MARCH 2025			
522.	003/21: People and OD Target Operating Model to be developed and resource requirements considered through a full business case	Fleet, James	30/09/2024	Pending
	Explanation action item June 23 - TOM, vision and staffing structures developed - Stabilisation programme for underperforming areas in place and being monitored and reported via POD C - Business case currently being developed to support request for additional investment into POD. - Business case to be considered at Executive Group and then Business Invesment Group and F&P			

	November 23 - TOM currently in place and being operationalised - Staffing structures being implemented through skill mix associated with existing vacancies and MMUH funding. Additional business case for investment will be presented in 2024. DEDALINE EXTENDED TO SEPTEMBER 2024			
523.	003/22: Freedom to Speak Up strategy to be developed and launched	● McLannahan, Dinah	31/12/2023	Overdue
BAF Risk Actions 15/11/2023 2.a Failure to ensure adequate infrastructure, capacity and governance to deliver CIP				
529.	002/1: Demonstrate connection between narrative describing CIP improvement, current performance year to date, future run rate from existing plans, and further improvement opportunities currently not underway	● Dingwall, Dave ● McLannahan, Dinah	30/09/2023	Completed
	Explanation action item August 23 Year to date position to be reported to August FIPC (1.9). September FIPC will receive this analysis (29.9) November 2023 Now in place and reported monthly			
530.	002/2: Determine recurrent and compliant workforce trajectories for 23/24	● Fradgley, Daren	30/09/2023	Completed
	Explanation action item August 23 Second draft of trajectories received and summary produced. Requires analysis and agreement of next steps at September FIPC November 2023			

	COMPLETE: now measuring targets			
531.	002/3: Agree to establish lead role for CIP delivery	● McLannahan, Dinah	01/01/2024	Overdue
	Explanation action item August 23 No funding available. Trust would have to adopt invest to save approach November 2023 document in draft. meetings being held to determine role and relationships			
532.	002/4: Describe connection between the various elements that will feed in to financial recovery and ensure resourcing plan is established to support delivery	● McLannahan, Dinah	30/12/2023	Overdue
	Explanation action item August 23: Initial description of the relationship to be reviewed by FIPC at August meeting (1.9). To be further developed in Q3 2324			
533.	002/5: Ensure resourcing in the groups is sufficient and appropriate to support financial improvement	● Fradgley, Daren	31/12/2023	Overdue
	Explanation action item August 23: Linked to 002/4 piece of work (key aspect CQI)			
534.	002/6: Ensure discussion on performance outputs at committee	● McLannahan, Dinah ● Newens, Johanne	30/09/2023	Completed
	Explanation action item August 23:			

	In progress November 2023 COMPLETE and in place			
535.	002/7: Complete Accountability Framework – new governance framework applies	Dhami, Kam McLannahan, Dinah	30/04/2024	Pending
	Explanation action item August 23 To confirm timescales and work to new financial governance framework (to be reviewed at FIPC 1.9) November 2023 still waiting for framework to be detailed			
BAF Risk Actions 15/11/2023 2.b Insufficient capital resources to progress required investments				
536.	002/8: Confirm up to date statutory standards and backlog maintenance programme and ensure funding available under a worst case scenario	Grigg, Warren	31/12/2023	Overdue
	Explanation action item August 23 To agree with estates colleagues			
537.	002/9: Discuss value of internal audit work to inform risk in relation to lack of capital funding	Grigg, Warren McLannahan, Dinah	31/12/2023	Overdue
	Explanation action item August 23 To agree with estates colleagues and internal audit colleagues			

538.	002/10: Discuss potential expansion of performance indicators to measure effectiveness of available capital funding investment	● Grigg, Warren ● McLannahan, Dinah	31/12/2023	Overdue
	Explanation action item August 23 To discuss and agree with estates colleagues			
539.	002/11: Confirm alignment of the estates strategy to current capital plans	● Grigg, Warren	31/12/2023	Overdue
	Explanation action item August 23 To agree timescale with colleagues November 2023 23/24 complete and 24/25 planning session in traction			
540.	002/12: Review current operational and strategic capital plans aligned to estates strategy and assess against likely funding and then go through with ICS partners	● McLannahan, Dinah	31/12/2023	Overdue
	Explanation action item August 23 To review 5 year plan during September, internally, and then align with estates strategy, and ICS partners			
541.	002/13: Confirm minimum capital expenditure required against likely funding	● Grigg, Warren	31/12/2023	Overdue
	Explanation action item August 23 To discuss and agree with colleagues			

542.	002/14: Report to FIPC current external secured funding and potential opportunities to pursue	● Barlow, Rachel ● McLannahan, Dinah ● Sadler, Martin	31/12/2023	Overdue
	Explanation action item August 23: To agree with colleagues and plan report to FIPC November 2023: 23/24 complete and 24/25 planning session in traction			
BAF Risk Actions 15/11/2023 2.c Income and Expenditure performance resulting in cashflow challenge to operations and capital investments				
543.	002/15: Cashflow forecasting of scenarios and potential mitigations	● Higgins, Craig	31/12/2023	Completed
	Explanation action item August 23 To agree scope of work and timescales with the lead November 2023 FIPC Paper for Capital and Cash now includes a 2-year cashflow forecast based on most likely financial position, explained in the narrative of the papers. On this basis, the committee is clear that any move, both detrimentally or favourably from the I&E forecast will move the forecast cash position by equal amounts. In addition, the ICS Cash Protocol was shared with the committee in October, which covers the process of reporting cash forecasts and an approach to fund from within the system. Outside of ICS support being available, there is an established NHSE Revenue Support process to request additional PDC, updates and timetables for which, are sent out by NHSE each month/quarter.			
544.	002/16: Scope potential impact and mitigations of severe cash shortages	● Higgins, Craig	31/12/2023	Overdue
	Explanation action item August 23			

	To agree scope of work and timescales with the lead November 2023 The borrowing regime is set to avoid such instances, ensuring maintenance of Supplier Invoice payment performance and the cash to maintain liquidity for 5 days of operation (based on month end balance)			
545.	002/17: Review scope of cash metrics across the ICS and seek advice of NHSE	● Higgins, Craig	31/12/2023	Overdue
	Explanation action item August 23 To agree scope of work and gap closure November 2023 covered within ICS Cash Protocol and existing arrangements			
546.	002/18: Ensure there is a plan to mitigate non-recurrent means of achieving plan and ensure link to underlying position understood. Ensure this is adopted consistently across the ICS	● McLannahan, Dinah	31/12/2023	Overdue
	Explanation action item August 23 To agree scope of work and gap closure			
547.	002/19: Work with the ICS to confirm system wide approach to cash management and mitigations	● Higgins, Craig ● McLannahan, Dinah	31/12/2023	Overdue
	Explanation action item August 23 To agree scope of work and timescales with the lead			

	November 2023 covered within ICS Cash Protocol and existing arrangements			
BAF Risk Actions 15/11/2023 2.d Lack of capacity to effectively plan to address strategic risk				
548.	002/21: Scope out in detail gaps in demand and capacity plans	McLannahan, Dinah	31/01/2024	Pending
	Explanation action item August 23 To discuss and agree internally with operational and POD colleagues November 2023: 23/24 complete and 24/25 planning session in traction			
549.	002/22: Confer with ICS colleagues on performance indicators used to assess the effectiveness of the plan in relation to triangulation and mitigating the strategic objective	Baker, Dave McLannahan, Dinah	31/03/2024	Pending
	Explanation action item August 23 To discuss and agree with planning leads across the system			
	Explanation Baker, Dave The system, in particular the Trusts are working on their Strategic Planning Frameworks (SPFs). The ICB have committed to doing this is well. As these evolve we will then cross reference to the National Oversight Framework and to NHS Black Country Joint Forward Plan. This will help to create system alignment. Conversations at ICB level going well with SWBT strategy team working more closely with the COO, Strategy Lead and Performance lead of the ICB. This will evolve as we move towards finalising annual plans before March.			
550.	002/23: Ensure a joined up and consistent approach to planning across the BCPC	Baker, Dave McLannahan, Dinah	31/03/2024	Pending

	Explanation action item August 23 To agree approach with BCPC partners			
	Explanation Baker, Dave We have agreed and approach using the Strategic Planning Framework approach. This is underway. It will evolve each year but has been agreed at BCPC level and with the Mental Health Trust and ICB.			
551.	002/24: As for 002/23 and review internal productivity benchmarks to inform planning objectives	Baker, Dave McLannahan, Dinah	31/03/2024	Pending
	Explanation action item August 23 To agree approach with colleagues internally			
	Explanation Baker, Dave PA Consulting have looked at benchmarks to identify opportunities. These are all being validated before prioritising opportunities going forwards. Separately there may be working engaging clinicians in SLR and PLICS (Costing team) to engage /encourage clinically driven waste reduction.			
552.	002/25: Review capacity to deliver above and take necessary action. Session needed to agree	Baker, Dave McLannahan, Dinah	31/03/2024	Pending
	Explanation action item August 23 To agree approach with colleagues internally			
	Explanation Baker, Dave Not sure of question here - could be about link between strategic annual planning, operational annual planning and impact on performance metrics. If so we need session to agree plan.			
BAF Risk Actions 15/11/2023 2.e Failure to meet operational performance targets				
553.	002/26: Real time production plan visibility to be agrred and implimented.	Baker, Dave	31/01/2024	Pending

	Explanation action item August 23 In progress			
554.	002/27: Elective Care Delivery plan mapped to production and efficiency opportuntites support increase activity / cost reduction	Newens, Johanne	31/01/2024	Pending
	Explanation action item August 23 In progress activity opportunity mapped values being calculated			
	Explanation Newens, Johanne Report to Dec F&P			
555.	002/28: Service improvement support being sourced to delivery the necarry actions	Newens, Johanne	30/09/2023	Completed
	Explanation action item August 23 Candidates interviewed and term of engagement to be agreed			
	Explanation Newens, Johanne candidates secured and in post			
BAF Risk Actions 15/11/2023 2.f Failure to adopt and exploit digital solutions that can enhance patient care and improve efficiency.				
556.	002/29: The informatics staffing are too few to support the requirements of the Trust to innovate.	Sadler, Martin	30/04/2024	Pending
	Explanation action item August 23 Funding is still being applied for.			

	CXIP plans to reduce contractor spend and increase permanent headcount now that 4 years of controlled financial management have been proven			
557.	002/30: The trust needs to invest in digital skills training and create a training team.	Sadler, Martin	31/12/2023	Overdue
	Explanation action item August 23 A vacancy for team leader / co-ordinator is live Funding for 2 years is available Curriculum is being developed by CCIOs and digital clinicians			
	Explanation Sadler, Martin Lead nurses recruited to develop training.			
558.	002/31: Better equipment will be required to replace the technology that was introduced with the EPR and is now 3 years old	Sadler, Martin	31/08/2024	Pending
	Explanation action item August 23 Some funding for MMUH has been applied for Work is ongoing to understand why IT capital is being asked to reduce by £2m			
	Explanation Sadler, Martin IT budget falls short of requirements			
559.	002/32: Integration resources need to be built to reduce the frustration and time wasted by not developing our core systems.	Sadler, Martin	31/07/2024	Pending

	Explanation action item August 23 Some work is going on within the ICS to understand integration opportunities. Shared Care record is partly implemented. Suppliers with stand-alone systems have been advised of our technical integration strategy.			
	Explanation Sadler, Martin IT are building a case to increase the size of the development team to meet demand.			
560.	002/33: A review of how Digital engagement can be more incorporated in the CQI journey	Baker, Dave Sadler, Martin	31/12/2023	Overdue
	Explanation action item August 23 None			
	Explanation Baker, Dave Discussed with MS. Digital can support the Strategic Planning Framework through two means. 1) Countermeasures to support the in year objective delivery; 2) Prioritised actions linked to the multi year commitments.			
561.	002/34: Governance around digital to be reviewed and streghtened	Sadler, Martin	30/04/2024	Pending
	Explanation action item August 23 Discussions underway around the governance of Digital under the Black Country Joint Provider.			
	Explanation Sadler, Martin Adam Thomas, Deputy CEO and CIO at Dudley has been selected to represent Digital at the collaboration board.			
BAF Risk Actions 15/11/2023 5.a There is significant failure to deliver sustained clinical transformation and related benefits case resulting in inability to fit into MMUH and non delivery of improved health outcomes and patient experience.				

562.	005/1: Establish a Benefits handbook and dashboard to track delivery of the clinical transformation and impact related to the benefits case.	Sheppard, Simon	31/12/2023	Overdue
	Explanation action item October 2023 PWC have provided draft Benefits Handbook – which will be presented for acceptance and implementation via the October 2023 governance cycle. Benefits reporting dashboard in development and scheduled for implementation in November 2023.			
	Explanation Sheppard, Simon Update (21 Dec 2023) - Handbook be reviewed by MMUH team and the initial dashboards for Beds and Workforce benefits presented to the MMUH Programme Group on 20 December 2023.			
563.	005/2: Identify opportuntity and evidence based clinical transformation plans to reduce bed days to assure fit into MMUH aligned with a 2024 opening.	Fradgley, Daren Kennedy, Liam Newens, Johanne	31/12/2023	Overdue
	Explanation action item October 2023 Analysis to be completed to inform a proposal to mitigate current bed day useage which is higher than planned. The mitigation proposal will be considered via October 2023 governance cycle. November Work is still ongoing to monitor bed fit into MMUH and other schemes have been generated as further mitigation. Paper to come through November governance cycle 20/11. December 2023 rightsizing paper presented to MMUH Opening Committee in December 2023. Pending acceptance this action could be closed.			

	Explanation Newens, Johanne rightsizing paper presented to mmuh opening cttee in DEc			
564.	005/3: Deliver clinical transformation at scale and pace to fit into MMUH based on a 2024 opening.	Fradgley, Daren Kennedy, Liam Newens, Johanne	31/03/2024	Pending
	Explanation action item October 2023 Establish delivery capacity and framework for additional clinical transformation project(s) in Q3 2023/24. November 2023 Establish delivery capacity and framework for additional clinical transformation project(s) in Q3 2023/24. December 2023 Date revised to align with plan B trigger decision points on the critical path.			
565.	005/4: Activate plan B schemes at specified trigger points as mitigation to fit into MMUH if required.	Fradgley, Daren Kennedy, Liam Newens, Johanne	31/12/2023	Overdue
	Explanation action item October 2023 Plan B proposal accepted in September MMUH governance cycle. Programme plan to identify critical path for latest implantation date for each plan B scheme. November 2023			

	Programme plan to identify critical path for latest implantation date for each plan B scheme. Only plan B scheme with a lead time at the moment is the elderly care ward at Rowley, latest decision date would be marched to activate in time for MMUH. Will monitor bed fit and review in February. This will be added as a milestone to the programme critical path.			
566.	005/5: Review annual plan delivery priorities through the Executive Team and Tier 1 Committees to mitigate overwhelming workload.	Beeken, Richard	31/12/2023	Overdue
	Explanation action item October 2023 Awaiting outputs and feedback from September and October Tier 1 Committees. November 2023 • Insufficient outputs from the prioritisation work have been presented to mitigate the core clinical and operational team capacity. • This gap is having increased impact with delays to MOC, operational readiness timelines and delayed decisions making on the critical path in November. There is a now a 4-10 week risk on the overall critical path to the Programme form a non-construction perspective. • The Managing Director is reviewing the Programme Critical path risk of a circa hypothetical 8 week delay which will inform a risk impact analysis and actions with a view to protecting the critical path to open MMUH in 2024. The CEO and Managing Directors are considering alternative prioritising decisions and capacity mitigations. December 2023 Critical path review completed and represented on agenda for MMUH opening Committee in January 2024. This will be reviewed regularly to protect the critical path to open MMUH in 2024. Additional support in place to work with Clinical Groups to support MOC and operational readiness work alongside business change and clinical change mangers. MMUH now mainstreamed into all Executive meetings, reinforcing this is no longer a strategic project but one of delivery and transition to handover and closure of Programme Company by March 2025.			
567.	005/6: Complete risk assessment for the impact of the ongoing industrial action and impact on operational and clinical delivery capacity.	Anderson, Mark	31/01/2024	Pending

	Explanation action item October 2023 Preparatory work is considering this risk assessment through 3 timelines; current programme delivery, activation period post building handover and the move into MMUH. Anticipate adding a risk to the risk register in November 2023. November 2023 Risk Register not formally updated.			
	Explanation Anderson, Mark We await the outcome of ongoing BMA negotiations. As of Nov 10th no new dates of industrial action have been set. Once the position changes we will review how scenario testing can be delivered in the context of maintaining service delivery (backlog and BAU) and any future periods of industrial action. Consideration will be given to how we engage with unions over strike action that may be planned immediately before or during the move period itself to allow derogation of industrial action during the physical move period.			
568.	005/7: Managing Director to escalate further mitigations to the Chief Executive, given Programme Risk 5143 related to delivery capacity for the Core Organisation remains at 25 with inadequate mitigation proposals.	Barlow, Rachel	31/01/2024	Pending
	Explanation action item October 2023 Additional UEC change capacity in core organisation is being procured/arranged. Additional Elective Care change capacity in core organisation already secured. December 2023 Additonal delivery resource placed into clinical groups for MOC and operatioanl readiness.			

	Additional resource request to NHP for deputy / Tier 2 capacity to the Managing Director to be confirmed in January 2024. Once confirmed this action could be reviewed and potentially closed.			
569.	005/8: Provide assurance of readiness of critical provider stakeholders to implement clinical model.	● Kennedy, Liam	31/12/2023	Overdue
	Explanation action item October 2023 Scoping current critical provider stakeholder assessment with the Executive Team. Assurance to be mapped into operational readiness framework. November 2023 Assurance to be mapped into operational readiness framework. Leadership and governance with external providers to be agreed in December 2023 from establishment in January 2024. The Managing Director to meet with critical providers CEOS and leaders as a pre-engagement activity. December 2023 Paper on agenda for critical provider and commissioner readiness for MMUH to open. Managing Director networking and managing stakeholders at an Executive / Accountable Officer level. Governance to be established in January 2024 with critical providers and commissioners. MMUH Project Director needs to identify resource to support oversight and assurance along with completed scope of work and reporting process in early January – this is behind plan and needs rectification in month. Managing Director awaiting confirmation of additional resource from NHP which will strengthen deputy / Tier 2 capacity to ensure oversight of the delivery of critical providers to inform decision to move.			
570.	005/9: Define equitable goals to be achieved in the 'must do' clinical pathways to fit into MMUH and of care; these should include rightsizing	● Fradgley, Daren ● Kennedy, Liam	31/12/2023	Overdue

	and essential providers where there is more than 1 provider eg mental health and social care.			
	Explanation action item October 2023 Work in train to prioritise inequality goals for the MMUH Programme November 2023 Work in train to prioritise inequality goals for the MMUH Programme			
571.	005/10: Ensure equality work aligns to the Integration Committee BAF and is documented as necessary in the MMUH Programme Exit Strategy and Closure Plan.	Barlow, Rachel Fradgley, Daren	31/03/2025	Pending
	Explanation action item October 2023 Both MMUHOC and IC BAFs revised in October 2023. Exit Strategy drafted. Both Managing Directors will align both pieces of work by December 2023 and review regularly through to Programme Closure. November 2023 Integration BAF workshop completed to inform IC BAF. December 2023 Integration work on the 2 BAFs continues to progress.			
BAF Risk Actions 15/11/2023 5.b Failure to secure revenue funding for the workforce model needed to deliver the approved and transformed clinical model, which will impact on the ability to deliver the strategic benefits related to both the clinical and workforce models.				

572.	005/11: Finance sprint work over 3 weeks in October 2023 designed with regional NHSE to work through a 21 point action plan to inform mitigation to revenue gap.	Sheppard, Simon	31/01/2024	Pending
	Explanation action item October 2023 Work plan agreed and good peer engagement and collaboration towards this work.			
	Explanation Sheppard, Simon Update (21 Dec 2023) - NHSE due diligence to now be completed by early January. Main areas of focus are Board approvals of the 484 workforce, review of the business cases supporting the 484wte and the 1,000+wte increase of workforce over the last 3-4 years.			
573.	005/12: BC ICB finance meeting with Julian Kelly 6th October 2023.	Beeken, Richard	31/01/2024	Pending
	Explanation action item October 2023 MMUH agreed to be a separate item within in year and planning discussions. Question from NHS CFO regarding the MMUH workforce increase and bed reductions. (information provided within 005/9 submission.). Further meeting to be held mid November following the release of the end of October financial numbers. November 2023: The Chief Executive Officer (CEO) and Chief Finance Officer have agreed with NHS England that a letter confirming the NHS England national and regional position will be in receipt of the Black Country ICB and Trust by 15/12/23. The CEO will then consider the impact of that as a critical success factor to opening MMUH in the January 2024 private Trust Board. December 2023 The timeline for NHS England to clarify and respond to the revenue requirements for MMUH is now pushed out to January 2024. Regional NHSE have reneged on commitment to provide a conclusive letter on the funding and affordability position by 15th December 2023 and continue to make information requests and have not reached a conclusion which is a risk to the Programme Critical Success factors. Focus appears to be mainly on workforce costs which is circa 30% of the total			

	affordability issue, despite emphasis and clarification on capital charges and inflation. SWBH to consider revised affordability risk assessment January 2024 and consider next steps via Private Trust Board.			
574.	005/13: Follow up from Provider Collborative meeting regarding the use of ICB growth monies to support MMUH – risk based QIA assessment to be completed.	● Sheppard, Simon	31/10/2023	Completed
	Explanation action item October 2023 Black Country Provider Collaborative met on 13/10 /23 and supported the revenue implications but has unanimously determined that this cannot solely be found from within the BCPC alone. ICB Board in BC will now meet to consider agreement to funding the revenue implications from financial envelopes across the whole system. Meeting confirmed the potential funding source for MMUH would be total ICB growth monies NOT just provider collaborative organisation growth.			
	Explanation Sheppard, Simon Update (10 Nov 2023) - feedback from the Provider Collaborative meeting and further actions confirmed to the Black Country ICB			
575.	005/14: Programme Assurance Review (PAR) to review financial gap and mitigation approach as a key line of enquiry.	● Barlow, Rachel	30/11/2023	Completed
	Explanation action item October 2023 PAR review scheduled for 20th October 2023. Outcome report and recommendations expected in November 2023. November 2024 • Draft report received. Anticipate final report for November 2024 MMUH OC. • Richard Beeken CEO has had a follow up advisory conversation with the PAR finance lead. December 2023			

	PAR review received and reposne paper on MMUH OC agenda.			
BAF Risk Actions 15/11/2023 5.c Failure to secure capital funding and progress build for the on-site Urgent Treatment Centre which will result in increased and overwhelming demand in the Emergency Department, compromising Urgent Emergency Care standards associated with the business and benefits case.				
576.	005/15: Options for funding and potential mitigation need full work up and conclusion. This is in collaboration with ICBs and NHSE.	Sheppard, Simon	31/12/2023	Overdue
	Explanation action item October 2023 Currently working with a number of potential options to fund capital with NHSE; likely option is a capital loan to the ICBs over 3 years. Additional questions from the NHSE team to support the repayment option; - Can it be confirmed from a system perspective that the bridging proposal above would be workable? (ICB) - Is there a SWB operational/BAU indicative capital plan by major scheme for 24/25 (SWB) - Is there system-wide operational/BAU indicative capital plan by trust/major scheme for 24/25? (ICB) - If no, what can you give me to articulate the 24/25 position and substantiate the argument that the UTC cannot be funded locally and so a Public Dividend Capital (PDC) bridging arrangement is the only viable option?			
	Explanation Sheppard, Simon Update (21 Dec 2023) - The proposal for the capital "loan" in 2024/25 to repaid over the following 2-3 years was presented to the NHP Investment Committee on 5 December 2023 and again 19 December 2023. This proposal was approved with one further action to confirm the repayment period. To be confirmed to NHP / NHSE by 31 January 2024			
BAF Risk Actions 15/11/2023 5.d A significant failure to prepare our workforce to move and work in MMUH and adopt new ways of working, that results in suboptimal delivery of clinical transformation and delivery of the people objectives and associated benefits case.				
577.	005/16: Complete the identification of service interdependencies.	Kennedy, Liam	30/11/2023	Completed
	Explanation action item October 2023 3 areas outstanding to complete interdependency assessment.			

	November 2023 3 areas outstanding to complete interdependency assessment. Business cases are progressing through Performance Managment Committee for outstanding areas (NIV alert team, Cardiology mini c-arm and endoscopy equipment) once decision has been made can be communicated with programme team and action closed.			
578.	005/17: Provide assurance on resolution of gaps in interdependencies and synergy is achieved prior to move.	Kennedy, Liam	31/03/2024	Pending
	Explanation action item October 2023 Track assurance via operational readiness measures November 2023 Track assurance via operational readiness measures			
579.	005/18: Assess Stage 3 recruitment within the overall Trust Workforce recruitment trajecory and quality assure the ability to deliver the intended clinical model and associated benefits case.	Kennedy, Liam	30/11/2023	Completed
	Explanation action item October 2023 Complete assessment in October 2023. November 2023 Complete assessment in October 2023. First 64 WTE for stage 3 approved at private trust board, QIA being conducted for the remaining posts, will be brought through in December governance cycle. 20/11 December 2023			

	Assurance received at MMUH Programme Group on workforce trajectory and clinical alignment with QIA process completed.			
580.	005/19: Assess the impact of total Trust workforce recruitment trajectory on the people related benefits case and trajectory of delivery.	● Fleet, James ● Sheppard, Simon	31/01/2024	Pending
	Explanation action item December 2023 Work in train to align benefits and workforce trajectory to be completed in January 2024.			
581.	005/20: Commence OD interventions in November and measure impact.	● Fernandes, Meagan ● Fleet, James	31/03/2024	Pending
	Explanation action item October 2023 Affina commissioned as a 3rd party partner. On track to commence OD interventions in November 2023. November 2023 1. Affina OD commisisoned to work with the Trust OD Team to support delivery of the Programme 2. 6 individuals trained in the Affina Diagnostic assessment in October 3. Scoping of High medium low priority teams with Groups currently ongoing 4. High priority teams (4-6) will be allocated with a view to commence diagnostics in December 5. Plan to allocate Medium and low priority teams in development December 2023 Interim Chief People Officer has reviewed OD programme and is scheduled to provide a view to the MMUH Opening Committee in January 2024.			

582.	005/21: Effective partnership working between staff side and trade union colleagues needs to be in place to support delivery of MMUH workforce and People Plan priorities.	Fernandes, Meagan Fleet, James	31/01/2024	Pending
	Explanation action item October 2023 ACAS engaged to support independent resolution. Trust engaging with all parties through structured meeting arrangements with escalation arrangements. November 2023 1. ACAS intervention due to take place on 4th December 2. CPO Led meeting with TU's being arranged (initial meeting scheduled in November had to be reorganised on TU request) 3. Immidiete actions taken by Director of People and OD to strengthen arrangements around MOC process and communicated with TU's.This incldues streamlining STACC meetings, documentation, communication and escalation arrangements 4. MOC Away Session led by Director of People and OD and MMUH quadrant lead scheduled for HR and MOC on 5th December to support MOC delivery and enable stronger integrated working. 5. Deep dive into MOC programme with TU's and MOC leads led by CPO and COO took place on Monday 13th November and actions communicated. December 2023 Good progress made in month via workshops with unions and clinical groups. MOC process revised, additional STACC meetings scheduled. Pahse 3 MOC to be launched in January 2024 and this action will be reviewed and potentialy closed.			
583.	005/22: Track safe staffing posts and critical recruitment to enable ethe clinical model.	Fernandes, Meagan Fleet, James	31/12/2023	Overdue
	Explanation action item October 2023 Review staffing trajectory, with stage 3 recruitment decision and completion if a QIA due by November 2023.			

	November 23 1. Recruitment tracker has been developed and currently being trialled. 2. Safe staffing assessment and QIA for stage 3 posts undertaken via Chief Nurse, Chief Medical Officer and Chief Operating Officer			
	Explanation Fernandes, Meagan December 2023 1.Recruitment tracker has been developed 2. Safe staffing assessment and QIA for critical posts as well as stage 3 posts being undertaken via Chief Nurse, Chief Medical Officer and Chief Operating Officer			
BAF Risk Actions 15/11/2023 5.e 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.				
584.	005/23: Exit strategy proposal to be presented in October 2023 governance cycle.	McInerney, Deborah	30/11/2023	Completed
	Explanation action item October 2023 On October 2023 MMUH OC agenda November 2023 Action now closed			
	Explanation McInerney, Deborah Exit Strategy know as the Programme Closure Strategy was accepted at Opening Committee in October 23			
585.	005/24: MMUH Programme Company Exit completed leaving a legacy infrastructure for benefits assurance and oversight in place.	Barlow, Rachel	31/03/2025	Pending
586.	005/25: Moderate term benefits for Logisitcs and Learning Campus to be identified by PWC.	Sheppard, Simon	29/02/2024	Pending
	Explanation action item October 2023			

	Work Commissioned to be completed by end January 2024. November 2023 work is progressing on plan with the final outputs to be presented through the governance cycle in February 2024			
	Explanation Sheppard, Simon Update (21 Dec 23) = work is progressing on plan with the final outputs to be presented through the governance cycle in February 2023			
587.	005/26: Continune Strategic Regeneration benefits development with key partner organisations (West Midlands Combined Authority, Birmingham City Council, Sandwell Metropolitan Borough Council) and add to the strategic benefits case.	Barlow, Rachel	31/03/2025	Pending
	Explanation action item October 2023 Stakeholder visits with Birmingham City Council, Sandwell Metropolitan Borough Council Accountable Officers scheduled this calendar year. Establish membership of the Strategic Benefits Group to include strategic partners. November 2023 • Successful meeting with SMBC Council leaders. Follow up session planned with CEO and executive leadership team and Cabinet. • BCC cancelled visit. CEO escalation contact to ensure commitment to readiness and benefits delivery. Levelling up monies circa £18 million awarded to SMBC for Grove Lane masterplan investment will be a further contribution to the strategic benefits realisation76 December 2023 Meetings with Sandwell and Birmingham Councial leaders to be confirmed for Janaury 2024. Andy Street visit to MMUH scheduled for January 2024 to discuss strategic regernation delivery.			

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588.	005/27: Establish the Strategic Benefits Group to over see delivery and further development of the Benefits Case during and after the lifetime fo the MMUH Programme Company.	Sheppard, Simon	31/12/2023	Overdue
	Explanation action item October 2023 First meeting due December 2023. Post MMUH Programme Company Benefits infrastructure to be documented in Exit Strategy.			
	Explanation Sheppard, Simon Update (21 Dec 2023) - Strategic Benefits Group established with the first meeting on 29 January 2024.			
589.	005/28: Establish a Benefits handbook and dashboard to track delivery of the strategic benefits case.	Sheppard, Simon	31/12/2023	Overdue
	Explanation action item October 2023 PWC have provided draft Benefits Handbook – which will be presented for acceptance and implementation via the October 2023 governance cycle. Benefits reporting dashboard in development and scheduled for implementation in November 2023.			
	Explanation Sheppard, Simon Update (Dec 2023) - Handbook circulated to MMUH Programme Group members for comments and amendments. The final document will be presented to the January 2024 Programme Group for approval.			
BAF Risk Actions 15/11/2023 5.f Failure to secure capital funding and progress digital transformation and SMART optimisation at MMUH will compromise the digital impact on the strategic benefit case.				

590.	005/29: Continue to source external funding to progress SMART technology.	Taylor, Mark	31/12/2024	Pending
591.	005/30: MMUH Exit strategy to recommend SMART priorities to Digital Strategy SRO ie Executive Director of Digital and IT.	Taylor, Mark	31/12/2024	Pending
	Explanation action item October 2023 Digital strategy includes SMART technology.			
592.	005/31: First Net SDEC business case to be considered in October 2023 governance cycle.	Newens, Johanne	30/04/2024	Completed
	Explanation action item October 2023 Business Case for First Net SDEC solution on MMUH OC Committee agenda. December 2023 Explanation Newens, Johanne December 2023 Funding route agreed action handed over to Mark Taylor to progress contract with cerner; procurement in progress.			
	Explanation Newens, Johanne Funding route agreed action handed over to Mark Taylor to progress contract with cerner			
BAF Risk Actions 03/01/2024 4.a Failure of the Trust to engage in shared planning and decision-making at System and Place partnership level.				
725.	004/1: In the new role as the anchor organisation for LWPB coordinate the publication of a delivery plan for 24/25	Fradgley, Daren	31/03/2024	Pending
726.	004/2: Work with the Sandwell Primary Care Collaborative to agree a scope of work for them to lead on	Fradgley, Daren	29/02/2024	Pending

727.	004/3: Work with the West Birmingham Primary Care Collaboratve to agree a scope of work to dovetail into the LWPB delivery plan	Fradgley, Daren	31/01/2024	Pending
728.	004/4: Coordinate with Out of Hospital Board and also Joint Partnership Board to establish local funding opportunities and decisions for 24/25	Fradgley, Daren	31/03/2024	Pending
729.	004/5: Produce a clear benefits and opportunities plan for the schemes funded by System Development Fund to demonstrate a credible return on investment	Fradgley, Daren	31/03/2024	Pending
730.	004/6: Establish an evidence based case for continued growth in Out of Hospital Services linked to the rightsizing work for MMUH	Fradgley, Daren	31/03/2024	Pending
BAF Risk Actions 03/01/2024 4.b Failure to redesign the model of care to build on attendance avoidance, Admission avoidance and Length of stay reduction resulting in a growth for acute hospital services				
731.	004/7: Work with the Sandwell Joint Partnership Board so that the Better Care Fund and delegated budgets are used on services that promote the greatest benefits	Fradgley, Daren	03/01/2024	Completed
732.	004/8: Create a plan for transformation for Trust services that builds on the benefits planned for already delivered ready for investment when it made available.	Fradgley, Daren	30/04/2024	Pending
733.	004/9: Have a clear recruitment strategy that targets the areas of greatest risk as a priority	Fleet, James	31/01/2024	Completed
	Explanation action item On Going			
734.	004/10: Work initially with social care to explore opportunities for a shared leadership and delivery model on aligned services such as therapy workforce	Fradgley, Daren	30/06/2024	Pending
735.	004/11: Have a clear understand on the budget pressures and services risks in the LGA budgets and work through potential mitigations	Fradgley, Daren	31/03/2024	Pending

BAF Risk Actions 03/01/2024 4.c Failure to address directly the health inequalities of each town footprint by using the core 20 plus 5 model resulting in deteriorating population health.				
736.	004/11: Coordinate the available funding to the highest need patient areas through both the OOH Board and the Joint Partnership Board within Place	Fradgley, Daren	31/05/2024	Pending
737.	004/12: Make available the population health record to the town team MDT's so they can align their operational approach	Fradgley, Daren	30/06/2024	Pending
738.	004/13: Work with the primary care collaborative to intially recruit then coordinate the ARRS roles	Fradgley, Daren	31/01/2024	Completed
	Explanation action item Work is on going			
739.	004/14: Coordinate condition specific plans with the voluntary sector based on schemes available locally	Fradgley, Daren	30/06/2024	Pending
BAF Risk Actions 03/01/2024 4.b Failure to work with partners in our role as an anchor insitution to collectively address the wider determinates of health within our population resulting in poorer life chances				
740.	004/15: Coordinated employment plan between the participating partners for the areas covered by the Trust	Fradgley, Daren	30/09/2024	Pending
741.	004/16: A plan with a precited route to benefits mapped against the wider determinates of health	Fradgley, Daren	30/09/2024	Pending
742.	004/17: A data plan that delivers mapping against progress of the coordinated work	Fradgley, Daren	30/09/2024	Pending
743.	004/18: An agreed plan for a proportion of the collective budget of the place parts to route into the voluntary sector based on deliverable benefits. Initially mapped to 1% and tested	Fradgley, Daren	30/09/2024	Pending