AGENDA - TRUST BOARD SESSION IN PUBLIC

Venue: Conference Room, Sandwell Education Centre, Sandwell Health Campus, Lyndon, West Bromwich. B71 4HJ

Date: Wednesday 10th September 2025, 10:00 – 13:00

Voting Members:

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

Non-Voting Members:

Mr M Hallissey	(MHa)	Associate Non-Executive Director
Mr J Sharma	(JS)	Associate Non-Executive Director
Mr A Ali	(AAl)	Associate Non-Executive Director
Mr A Ubhi	(AS)	Associate Non-Executive Director
Mr L Williams	(LW)	Associate Non-Executive Director
Mr J Fleet	(JF)	Group Chief People Officer
Mrs R Barlow	(RB)	Group Chief Development Officer
Mr A Thomas	(AT)	Group Chief Strategy and Digital Officer
Miss K Dhami	(KD)	Chief Governance Officer
Ms S Thomas	(ST)	Interim Chief Integration Officer

In attendance:

Mr D Conway	(DCo)	Associate Director of Corporate Governance/Company Secretary

Time	Item	Title	Reference Number	Lead
10:00	**1.**	**Welcome, apologies and declarations of interest** *To declare any interests' members may have in connection with the agenda and any further interests acquired since the previous meeting.* *Board members declarations available here:* https://www.swbh.nhs.uk/our-trust/trust-board/board-members-and-exec-team/ **Apologies:** Kam Dhami,	Verbal	**DN**
10:05	**2.**	**People Story**	Verbal	**JF**
10:20	**3.**	**Minutes of the previous meeting, action log and attendance register** *To approve the minutes of the meeting held on Wednesday 9th July as a true/accurate record of discussions, and update on actions from previous meetings*	TB (09/25) 001 TB (09/25) 002	**DN**
	4.	**Chair's Opening Comments**	Verbal	**DN**
	5.	**Questions from members of the public** *[as submitted]*	Verbal	**DN**
10:25	**6.**	**Chief Executive's Overview**	TB (09/25) 003	**DW**

Time	Item	Title	Reference Number	Lead
10:35	**7.**	**Integrated Board Committees Assurance Report** **Joint Provider Committee Report**	TB (09/25) 004	**LW**
10:45	**8.**	**Board Assurance Framework and Risk Appetite Statement 2025/26**	TB (09/25) 005	**DC**
Our Population To work seamlessly with our partners to improve lives				
10:55	**9.**	**Place Report**	TB (09/25) 006	**ST**
Break (10 minutes) - 11:05				
Our Patients To be good or outstanding in everything we do				
11:15	**10.**	**Chief Nursing Officer and Chief Medical Officer's Report**	TB (09/25) 007	**MR / MA**
11:25	**11.**	**Winter Plan Assurance Statements 2025/26**	TB (09/25) 008	**JN**
11:35	**12.**	**Maternity Update**	TB (09/25) 009	**MR**
11:45	**13.**	**Finance Report**	TB (09/25) 010	**SS**
11:55	**14.**	**Learning from Deaths Annual Report**	TB (09/25) 011	**MA**
12:05	**15.**	**Strategy Update**	TB (09/25) 012	**AT**
Our People To cultivate and sustain happy, productive and engaged staff				
12:15	**16.**	**Performance Against Workforce Forecast**	TB (09/25) 013	**JF**
12:25	**17.**	**Equality, Diversity and Inclusion Update**	TB (09/25) 014	**JF**
Governance, Risk & Regulatory				
12:35	**18.**	**MMUH IPA Gateway 5 Review**	TB (09/25) 015	**RB**
12:45	**19.**	**The Green Plan**	TB (09/25) 016	**RB**
12:55	**20.**	**Committee Effectiveness Review 2024/25**	TB (09/25) 017	**DC**
For Information				
12:55	**21.**	**Any other business:** - Integrated Performance Report (in the Reading Room)	Verbal	**-**
	22.	**Details of next meeting of the Public Trust Board:** 12th November 2025 at 10:00am at Conference Room, Sandwell Education Centre, Sandwell Health Campus, Lyndon, West Bromwich. B71 4HJ		
13:00	**Meeting Close**			

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Trust Board: Wednesday 10th September 2025

People/Service Story

SWB Inclusive Talent Management Programme – Participant journey and experience

Summary of the Story

SWB designed its Inclusive Talent Management Programme to support colleagues from under-represented groups to develop into senior leadership roles (from Band 8c up to Executive level). This reflected the Trust's Workforce Race Equality Scores (WRES) which highlight the need to establish greater diversity and representation at Executive and Board levels.

The pilot programme was aimed at Trust Colleagues who completed the Black Country ICB Next Generation of Leaders Programme and offers a structured career development framework over 12-18 months, which is tailored to the individual's specific needs, providing career development support alongside a range of experiential learning opportunities. The programme aims to support and enable individuals from BME backgrounds to advance their career aspirations and increase their likelihood of successfully securing senior leadership roles.

Ho Jan Sen is a Pharmacist by background and participated in the pilot programme. Ho Jan shares her experience of how the programme has helped her in achieving her career development goals and in her future career aspirations.

Ho Jan feels privileged and fortunate to have had the support and investment in her development from the Trust and has benefited immensely from the exposure she got through this programme, including board sponsorship and the opportunity to shadow board and committee meetings. Ho Jan has also engaged in reciprocal mentoring and learning from peers and colleagues on the programme. Since completing the programme Ho Jan has been appointed into a Trustee and Governor role and is now working towards obtaining a Non-Executive Director role.

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

Colleagues that have participated in the pilot have confirmed that they:

- Have developed a clear career and development plan
- Have actively sought and engaged with relevant development opportunities
- Have a clearer awareness of personal strengths and limitations
- Feel ready and confident to move to next stage of their career
- Feel the programme provided the opportunity to gain the experience and confidence to achieve career goals
- Would recommend the programme to others.
- 50% are actively seeking job opportunities for their next career move.

Areas for improvement - accessibility of a coach and the support available via the sponsor.
Next Steps

- Ambition to run a second cohort 2026/27 – Programme aimed at Band 8a+ colleagues from BME and disabled staff groups in response to WRES & WDES data.
- Timing of next cohort has been reviewed due to implications of current cost improvement programme (e.g. vacancy freezes, MOC processes, move to Group model).
- Group model – will look at how we collaborate with Dudley Group FT to benefit both Trusts.

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Venue: Lecture Suite, Education Centre, MMUH **Date:** Wednesday, 9th July 2025, 10:00 – 13:00

Voting Members:		**Non-Voting Members:**	
Sir D Nicholson (Chair)	(DN)	Dr M Hallissey, Associate Non-Executive Director	(MH)
Mrs R Hardy, Non-Executive Director	(RH)	Mr J Sharma, Associate Non-Executive Director	(JS)
Mrs L Writtle Non-Executive Director	(LWr)	Mr A Ali, Associate Non-Executive Director	(AA)
Prof L Harper, Non-Executive Director	(LH)	Mr A Ubhi, Associate Non-Executive Director	(AU)
Mrs V Taylor, Non-Executive Director	(VT)	Mr J Fleet, Group Chief People Officer	(JF)
Mrs D Wake, Group Chief Executive	(DW)	Mr A Thomas, Group Chief Strategy and Digital Officer	(AT)
Dr M Anderson, Chief Medical Officer	(MA)	Mrs S Thomas, Interim Chief Integration Officer	(ST)
Mrs J Newens, Chief Operating Officer	(JN)		
Mrs M Roberts, Chief Nursing Officer	(MR)		
Mr S Sheppard, Acting Chief Finance Officer	(SS)		

In Attendance:		**Apologies:**	
Mr W Grigg, Director of Estates Development	(WG)	Mr M Laverty, Non-Executive Director	(ML)
Mr D Conway, Associate Director of Corporate Governance/Company Secretary	(DC)	Mr A Argyle, Non-Executive Director	(AA)
		Mr L Williams, Associate Non-Executive Director	(LW)
Mrs S Harris, Senior Executive Assistant (Minute taker)	(SH)	Mrs R Barlow, Group Chief Development Officer	(RB)
		Miss K Dhami, Chief Governance Officer	(KD)

Patient / Service Story Presenters:		**Members of the Public**
Mrs J Thompson, Patient Experience Manager	(JT)	Representative from Healthwatch Sandwell
Amanda and Flash the dog		

Minutes	**Reference**
1. Welcome, apologies and declaration of interest	**Verbal**
The Chair welcomed members and attendees to the meeting. Apologies were received and noted above. The declarations of interest, which included a new declaration for Rachel Barlow who had become a Governor at Sandwell College in June, were received and approved. The Chair emphasised the benefits of this appointment for both the college and the Trust.	
2. Patient Story	**Verbal**
Mrs Roberts welcomed Mrs Thompson, Amanda and her dog Flash to the meeting and explained that they had joined to talk about the amazing difference that Flash has made to patient experience and staff morale. Mrs Thompson talked about how she had met Amanda during her husband's recent stay in hospital following surgery. It had been agreed for Flash, who was already a trained therapy dog, to come into the ward to visit his owner to assist in his recovery. Since then, Amanda and Flash had been coming into MMUH each week to visit patients, families and staff on the wards. Amanda spoke about the positive interactions Flash had had with patients and their families and shared a touching story about Flash's impact on a young	

stroke patient, describing how the patient's smile upon seeing Flash brought joy to his family and staff. Amanda discussed Flash's interactions with various patients, including those in critical care and end-of-life situations, highlighting the positive effects on patients and their families. Flash and Amanda had also spent a lot of time interacting with staff. She recognised how challenging working in the NHS can be and felt that providing a brief moment of respite could help in easing the burden. Flash's presence often opened up conversations that may not have happened and improved patient's willingness to engage in activities that would support in their recovery e.g. physiotherapy. She thanked the Board for the privilege of being able to volunteer with Flash and wanted to thank Nurse Agnes on ward A7 who had allowed her to bring Flash in to see her husband during his recovery. Amanda also thanked Julie for supporting her and Flash along this wonderful journey.

Mrs Writtle thanked Amanda for attending and recognised that animals were able to sense when a person is unwell. She asked whether Amanda was part of any groups offering animal therapy. Amanda provided some background of Flash's journey into becoming a therapy dog which started at the North Essex Trust. She explained that he had also attended secure mental health units and supported young children in school. She added that she and Flash volunteered solely at MMUH now, due to time constraints, however, would be working with the Trust to encourage more people to bring their pets to join the therapy service.

The Chair thanked Mrs Thompson and Amanda for their hard work and support. He highlighted that although this work would not feature in any Board report, it was just as important given the impact it has on staff and patient experience.

3. Minutes of the previous meeting, action log and attendance register	**TB (07/25) 001 / 002**

The minutes of the meeting held on Wednesday 14th May 2025 were reviewed and **APPROVED** as a true and accurate record of discussions. The action log was received, and there were two open actions which were not due but were being progressed.

4. Chairs Opening Comments	**Verbal**

The Chair welcomed members to the first meeting at MMUH and reminded them it had been a year since the decision had been made to open the hospital in October 2024. He took the opportunity to reflect on the achievements and contributions of the staff involved.

Furthermore, the Chair discussed the publication of the 10-year plan for the NHS, emphasizing the importance of neighbourhood teams and their role in driving changes in the healthcare system. He added that the proposals set out in the plan were welcomed by the Trust which continues to focus on building community services and creating a system approach. It was noted that a number of reports were published alongside the 10-year plan including the July 2025 review by Dr Penny Dash into patient safety across the health and care landscape in England. A briefing note had been circulated, and this would be discussed in more detail at the next Quality Committee meeting.

Finally, the Chair advised that he had officiated at the annual surgeon's vs physicians cricket match this week, which the surgeon's had won. He added that it was a nice event and showed the nature of the organisation.

5. Question from members of the public	**Verbal**

There were no questions from members of the public.

6. Chief Executive's Overview	**TB (07/25) 003**

The Chief Executive's report was received and Mrs Wake updated on three developments since the time of writing the report. She provided a high-level overview of the NHS 10-year plan which had been published during the previous week, she highlighted that the plan is called fit for the future and outlines that the NHS is in a critical condition and the need to focus on future sustainability. The plan was mainly focused on the shift from hospital to community care, digital innovation, and prevention strategies. Mrs Wake confirmed that the Trust's strategy was aligned with these three priorities.

Mrs Wake also provided an update on the publication of the NHS Oversight Framework for 2025/26, explaining the scoring system for patient safety, financing, and integrated care system collaboration. The Trust had been rated as being in segment 3 out of 5, which is the highest segment for Trust's in a financial deficit. Chief Executives had been invited to a training session to further understand the domains within each segmentation and how Trusts can regularly access the information behind this.

Mrs Wake advised the Board that following the publication of the review by Dr Penny Dash, previously mentioned by the Chair, there would need to be an emphasis on quality, safety and patient experience in relation to reducing staffing levels and the metrics relating to this would continue to be an area of focus for the Quality Committee.

The report also included an update on operational performance, and it was noted that there had been a significant improvement in the Emergency Access Standard and elective performance. There continued to be challenges in relation to the 52-week performance in four specialties and robust recovery plans had been signed off for each of these areas. Cancer targets continue to be an area of focus and support had been requested from the West Midlands Cancer Alliance to realign pathways for skin, gynaecology, head and neck and lung services. The Provider Collaborative had organised a session to review the model of care for gynaecology as this is an area of concern across the four providers.

Finally, Mrs Wake congratulated the Chief Nursing Officer on being offered a place on the National Safety Advisory Group alongside the Chief Nursing Officer at Dudley and felt that this was a real accolade and would strengthen the Trusts position in accessing information as quickly as possible, for example details of the planned review of maternity services.

Mr Sharma queried whether the new reporting arrangements in the NHS Oversight Framework would be in place immediately. This was confirmed and it was noted that the performance scorecard for each quarter would be presented to the Board. The Chief Strategy & Digital Officer is also working on aligning the Trust's metrics with those included in the framework.

Mrs Writtle queried whether the Quality Committee would be overseeing the work on improving Cancer wait times and the impact on quality. Mrs Roberts confirmed that the committee were due to receive a deep dive report into Cancer performance and outlined the process for undertaking a harm review for any patients waiting over 104 days.

Mrs Writtle acknowledged the positive relationship between the Trust and the Care Quality Commission (CQC) and suggested that it would be useful for the Board to see an update on progress. Mrs Roberts advised that the Trust's self-assessment had recently been finalised and agreed to bring this to the September Board as well as provide an update to the Quality Committee in July.

The representative from Healthwatch Sandwell requested an update on plans to tackle obesity. Mrs Wake advised that there had been some recent announcements in relation to improving access to weight loss injection within primary care, however, there was a very rigid criteria associated with this. She highlighted other ways that providers could tackle this agenda including increased promotion of nutrition and hydration and regular exercise.

The Board **NOTED** the Chief Executive's Overview.

ACTION: Trust CQC self-assessment to be presented to the September Board and an update to be provided to the Quality Committee in July.

7. Integrated Board Committees Assurance Report Joint Provider Committee Report	**TB (07/25) 004**

Mrs Writtle presented the report, highlighting that she had met with each of the committee Chairs to develop the report and this would be an evolving process over the coming months. The report would focus on areas for assurance to the board, any concerns discussed by the committees and links to the Board Assurance Framework. The following points were noted:

- The Non-Executive Directors (NEDs) had acknowledged the significant work around the financial improvement plan and feedback had been taken on board through the Finance & Performance Committee (FPC). There was a need to understand the plan to deliver at the end of quarter 1. The process for engaging with external audit had been strengthened, however, their value for money opinion on financial sustainability and CIP was a "significant weakness".
- There had been progress seen each month in reducing workforce numbers, however, challenges remained in relation to delivery of the plan and most committees had asked whether the 8.5% reduction is too great.
- The Quality Committee were alerted to a potential risk of harm as a result of process failures and a back log of follow ups in Ophthalmology. The committee is expecting some robust actions to be put in place to mitigate the risk, and the committee Chair is due to meet with the Chief Nursing Officer and Chief Medical Officer to understand whether this is a risk across any other services.
- The first meeting of the Infrastructure Committee had taken place in partnership with the Dudley Group, chaired by Mick Laverty. Mrs Writtle highlighted that the committee had potential to make a difference in light of the NHS 10-year plan and members had been keen to ensure that the meeting doesn't become estates focused.
- The People Engagement Teams continue to drive actions in relation to staff engagement and recognition which would feed into the People Committee.

It was recognised that the Long Service Awards had recently been re-established, and the team were working through a backlog, which had resulted in some queries from staff expecting to receive an award.

There was a further discussion regarding the issues in Ophthalmology, and it was noted that there had been one case in urology and one in endoscopy which had been delayed due to the backlog. Mrs Roberts advised that an update had been received at the Quality and Safety Group from the Ophthalmology team, outlining that work had commenced to review the backlog. There were issues relating to human error as well as digital systems that were also being addressed. Mrs Wake added that there is a risk stratification process for follow ups and a meeting had taken place with the service to accelerate this as well as issues with diagnostics which is also causing delays. This risk was due to be reviewed by the Risk Management Group and a further update would be received by the Quality Committee.

The Trust Board **NOTED** the report.

8. Board Assurance Framework	**TB (07/25) 005**

Mr Conway presented the Board Assurance Framework (BAF) and provided an overview of progress and current challenges with the five BAF risks which were aligned with the corporate risk register. This included the formal closure of BAF005, with residual risks transferred to the Infrastructure Committee, and the reframing of BAF004 to better align with the Trust's strategic objectives. It was noted that moving forward joint Board committees would be managing BAF risks for both Trusts and he confirmed that he would be working with the Company Secretary at Dudley to ensure both risks were picked up through the

committees. The report also summarised findings from a recent internal audit, which provided reasonable assurance on the BAF's effectiveness and outlined several recommendations for improvement.

Mr Conway updated on the roadmap to the October Board Workshop which includes preparatory sessions with NED Chairs and Executive Leads to discuss strategic risk appetite and the future governance structure of the BAF. It was recognised that there is a gap in relation to the committee oversight of the corporate risk register linked to the BAF and this would be picked up in discussions with the chairs.

The Board **NOTED** the current position with the BAF risks and **APPROVED** the revised BAF004 risk statement for the Integration Committee and the formal closure of BAF005, with its residual risks transferred to the Infrastructure Committee.

Our Population	
9. Place Report	**TB (07/25) 006**

Mrs Thomas presented the report, and the following points were noted:

- The Sandwell Health and Care Partnership (SHCP) continued to focus on the two transformation priorities in relation to Connected Communities and Home First.
- A Connected Communities workshop had been held with partners with interest in the neighbourhood health model.
- The importance of digital innovations was noted, for example the Bridget app launched by the Council, to support unpaid carers in navigating support for the person they are caring for.
- Work continued to progress the data and KPIs needed to support the partnership, as well as establishing a clear work plan for the Home First transformation priority.
- The strategic framework for the West Birmingham partnership had been developed and outlines the purpose, vision and priorities of the partnership. A delivery plan had also been developed to sit alongside this focusing on Urgent and Emergency Care and Winter.
- An update was received on the integration work being undertaken by the organisation, particularly the Primary and Secondary Care Interface.

Mrs Taylor queried how the primary care approach had been received by the primary care partners and whether the partnerships were prepared to respond to changes outlined in the 10-year plan. Mrs Thomas confirmed that in-house primary care colleagues had been involved in the development of the approach which had been well received. She and Mrs Newens had also worked together to lead the frailty work, and it was encouraging to hear discussions regarding the innovation opportunities. Furthermore, she felt that significant progress had been made in relation to becoming an integrated health organisation for the population and recognised the need to maximise opportunities to demonstrate readiness for proposals in the 10-year plan. It was noted that the Sandwell place was in a strong position to respond to these changes, particularly in relation to the maturity of relationships in place. The partnership is currently working on completing the neighbourhood health maturity assessment, however, there are elements that could not be well scored within Sandwell due to a reliance on the ICB approach.

The Chair talked about the challenges associated with the implementation of a population health and neighbourhood approach and felt there was a need to look at how the Board oversees this. Mrs Writtle recognised the progress made in relation to the neighbourhood approach and queried whether there is an opportunity to review the presence of primary care and community colleagues at the Board and subcommittees as they were integral to the work required to respond to the 10-year plan. Mr Sharma highlighted that there had also been a detailed debate through the Integration Committee about the approach and he felt that an opportunity to understand the current position and associated risks would be beneficial for the Board.

The Chair recommended that a Board development session be dedicated to understanding the neighbourhood health model and identified risks associated with the 10-year plan, including how the Board works with the relevant teams to strengthen the overall position.

The Board **NOTED** the report.

ACTION: Board development session to be dedicated to population and neighbourhood health model.

10. Sandwell UTC Procurement	**TB (07/25) 007**

Mrs Thomas presented the paper which proposed a one-year contract, with potential to extend for a further year, to be awarded to Malling Health Ltd for the provision of Urgent Treatment Centre (UTC) services at the Sandwell Health Campus. The current contract is due to expire in September. It was noted that costs to extend the current contract were included in the budget and there were clear benefits of retaining Malling Health such as the continuation of services to the current standard, with continuity of staffing, delivery, performance and patient experience. Mrs Thomas outlined that there were plans to change the current operational model of the UTC working with other partners in the near future, therefore it would not have been appropriate to undertake a competitive tender at this time as the service model is likely to change.

The Chair confirmed that the proposed arrangements were reasonable, however, recommended that the contracts in place with Malling across the Black Country be reviewed to ensure providers are getting the best possible value for money. Mrs Wake confirmed that the recent discussions had driven the teams to review wider arrangements currently in place to explore different ways of working and improve value for money.

The Board **APPROVED** the Sandwell UTC procurement.

Break

Our Patients

11. Chief Nursing Officer and Chief Medical Officer's Report	**TB (07/25) 008**

Dr Anderson and Mrs Roberts presented the report, and the following points were noted:

- The Emergency Department is significantly above the accepted standard of contaminated blood cultures. Additional training had been implemented, and a reduction had been seen.
- Progress had been made in relation to medical job planning following improvement work with Missang who were due to leave the organisation.
- The Trust had celebrated "Red for Research" day with various activities taking place to share experiences and learning from research being undertaken across the organisation
- A CQC Ionising Radiation (Medical Exposure) Regulation visit (IRMER) had taken place on 18th June as part of the routine IRMER visits to all Trusts. The Imaging team had worked hard to coordinate the day, and the formal report is due to be received imminently.
- The Medicine and Emergency Care (MEC) group had been shortlisted for a Health Service Journal award for their work on length of stay and had also been approached to present their work on the "your next patient" initiative at the Nursing Live event later in the year.
- Professor Niten Makwana had been appointed as the new Deputy Chief Medical Officer and was due to commence in the role in September.

There was a further discussion about the work to reduce blood culture contamination in ED and concerns were raised that this issue had not been addressed sooner. It was noted that the rate of contamination

had increased significantly following the move to MMUH, however, this had been raised by the MEC team through the Strategic Infection Prevention and Control Group and an action plan had been put in place to drive improvements. It was noted that there is a high turnaround of students within ED which may have contributed to the issue, however, substantive staff are now taking bloods following a refresh of training.

Mrs Writtle recognised the remarkable journey the job planning team had been on with Missang and queried whether there were plans in place to sustain the improvement once they left. Dr Anderson confirmed that a job planning unit had been implemented with a generic mailbox. Missang had also provided some training and a standard operating procedure to support the team going forward. Mr Fleet added that a monthly report on job planning is due to be presented to the People Committee from August and an external audit was planned in October to review progress in this area. The Trust were also able to benchmark against other Trusts in the Black Country as job planning metrics were built into the provider workforce returns. Mrs Newens highlighted that some of the clinical leads had attended People Committee last month to discuss their experience of the process, and she recognised the hard work from the Group Directors who had driven these improvements with the medical teams. She also commended Dr Kannan, Deputy Chief Medical Officer for his support to the clinical teams in driving this.

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

12. Winter Plan 2025/26	**TB (07/25) 009**

Mrs Newens commended the teams involved in the development of the Winter Plan which had been developed in advance this year and had not been due to be presented to the Board until September. She presented the plan firstly focusing on the lessons learned from the previous winter which had been reviewed as part of the 100 days post MMUH outlining that it was a safe winter. Modelling from last year's plan, moving into MMUH, had been used again alongside some informed assumptions in relation to length of stay, bed occupancy and activity shifts within community, to develop this year's plan. Mrs Newens provided a detailed analysis of specific plans agreed for each of the clinical groups, and these were aligned with the expectations outlined in the recently published NHS England Urgent and Emergency Care plan. She added that there was also an expectation within this plan to improve vaccination rates for frontline staff and emphasized the importance of the staff flu vaccination plan, including a stretch target of 35% more staff being vaccinated through the implementation of a peer vaccination programme. It was noted that there were no plans to open additional winter beds as part of the winter plan which is based on cost as well as predictions in the shift to community activity meaning these beds will not be required. The Board were advised that the plan reflects the need to improve the financial improvement plan, therefore there was no additional funding requirements to support the plan.

There was a further discussion about the non-elective length of stay data which had been reported differently on two occasions in the report. Mrs Newens clarified that the graph in section 1.2 related to total Trust length of stay and the graph in item 2.3 related specifically to Medicine and Emergency Care.

Mrs Writtle queried whether the sprint work being undertaken alongside the rightsizing work had been concluded. Mrs Newens confirmed that rightsizing and sprint initiatives had been embedded during the previous year, including maximising the use of virtual ward, single point of access and avoiding admissions, however, there is more work to do to embed these out of hours, 7 days a week.

Mrs Wake commended the team for the approach taken to develop the plan which had included partners in the community and felt that it provided a lot of assurance to the Board. She felt that the organisation should be proud of the wok undertaken to deliver last year's winter plan as well as moving into a new hospital. It was noted that other providers in the Black Country system could learn from the initiatives put in place. Mrs Wake recognised the need to focus on performance against the constitutional standards alongside the winter plan which had been an area of slippage during the previous year. The Board were notified that there had been an announcement that junior doctors had confirmed the decision to take

strike action from 25th – 30th July and it was agreed that the impact of these decisions should also be considered as part of the winter plan.

The Chair recognised that the plan had been built on what went well last year, however, the context this year would be very different particularly due to the need to reduce costs within the organisation and the lack of enthusiasm that would have been in place last year with the opening of the new hospital. Mrs Newens agreed that the context would be different, which is why all modelling had been based on previous years plans, embedding lessons learnt and focusing on the Community First model. She recognised that plans required additional detail in relation to identifying cost savings while still investing in community services. It was noted that not all plans had been fully embedded and there would be further opportunities related to the improvements in weekend flow and 7-day working. It was noted that there would be a reduction of 20 beds in this year's plan and discussions were ongoing to agree whether these funds would be invested into community services or would contribute to the financial improvement plan. There were also plans in the financial improvement plan to remove a further 20-25 beds in February/March, however, this was still being debated to ensure this could be done safely.

Mrs Thomas updated on some comprehensive work taking place with MEC and community, modelling specific pathways and patient cohorts where changes can be made. There would be four pilots taking place between July and September to build an evidence base to identify whether interventions would make a difference in these areas.

The Chair acknowledged the hard work to develop initiatives to support the winter plan, however, emphasised the importance of the delivery of the plan, as well as the focus on improving vaccination rates across the organisation.

The Board **DISCUSSED** and **ACCEPTED** the winter plan and mitigation proposals.

13. Finance report Month 2 (May '25) inc. Cost Improvement update	**TB (07/25) 010**

Mr Sheppard presented the month 2 Finance report, focusing on the income and expenditure plan. It was noted that at the end of May the Trust had reported a £5.95m deficit, which is £0.9m adverse to plan. The key drivers for this had been outlined in the report and included overperformance in elective recovery activity particularly in surgery. Mr Sheppard confirmed that subject to overall ICS performance on elective recovery, there is a future risk of nonpayment of overperformance in line with the agreed elective activity allocation and work continues with ICB colleagues to mitigate this risk. The Board were advised that the positive position with activity was currently being offset by workforce costs which would be picked up in more detail within the workforce report. Mr Sheppard did however point out that the Trust were overspending on pay costs due to being off trajectory with the workforce plan, despite there being a slight improvement since May. There had also been an increase in waiting list initiatives to support elective activity which is driving the current pay overspend.

The Board received an update on progress with the financial improvement programme, and it was noted that at the end of month 2, the Trust had delivered £3.7m against the plan which is off trajectory to achieve the £50.8m target by the end of the year. Mr Sheppard updated on the work ongoing with the executive and clinical groups to ensure detailed plans for all schemes had been developed by 21st July to report into FPC. The plans would need to include workforce and financial trajectories, signed off project initiation documents (PID) and quality impact assessments (QIA) to provide further assurance on the workstreams and improve the trajectory to achieve the target. Work is also ongoing to sign off clear mitigation plans to cover any risks within the workstreams to ensure delivery of the financial plan without impacting access targets and safety.

An update was also received on month 3 performance and it was noted that the adverse position had gone from £0.9 to £1.2, however, despite the improved run rate, the planned trajectory had also been expected to improve by £0.3m which reflects the future challenges with the trajectory.

The Chair challenged the areas that had contributed to non-delivery of the trajectory to date and felt that these had been predictable. Mr Sheppard advised that the reduced costs being seen as a result of workforce reductions had been lower than expected to date, however, it was expected that there would be a higher cost reduction from the corporate plans over the next few months. There was a further discussion about the challenges associated with income, particularly the discussions ongoing with the Birmingham and Solihull ICB regarding reduced activity income. Mr Sheppard advised that the MEC team had undertaken some work to validate the activity which had confirmed an increased position, therefore this was being challenged with the ICB.

Mrs Hardy recognised the need for additional focus on the financial improvement programme, however, welcome the level of detail presented to the Board which was clearly evolving. Concerns were raised in relation to pace of escalation of some of the challenges through the FPC and the plans to resolve these as well as holding the relevant people to account.

Mrs Wake highlighted the need for the executive team to evaluate the position with the financial improvement programme and the need to be open and honest with the Board on this, as well as articulating the risks to delivery and how these will be mitigated. She raised that the cost improvement programme had not been delivered for a number of years within the organisation and support had been required during the previous year to achieve a 25% recurrent saving. Mrs Wake added that the workforce reduction plan is hugely ambitious and poses a number of risks, however, meetings had taken place to review plans and drive delivery. It was noted that the Trust now had access to good data sources to allow continuous monitoring of the position and agree additional mitigations as required. There had been a slight improvement in the workforce trajectory for month 3, however, further recovery actions would need to be agreed to sustain this. It was recognised that a culture change is required to ensure leaders were aware of the expectations and accountability in relation to delivering financial improvement and this would take time. Some progress had been seen recently, and groups were now able to articulate their role within this. A further discussion would take place in the private session to articulate actions being taken to get back on track with the plan.

The Chair concluded that there had been disappointing progress with the financial improvement plan in the first few months and raised that the plan had been agreed as early as possible due to the scale of the challenge in relation to changing the culture around financial improvement.

The Board **NOTED** the month 2 Finance report and progress with the Financial Improvement Programme including key risks and mitigations to delivery of the plan.

14. Maternity Report	**TB (07/25) 011**

Mrs Roberts advised the Board that the format of the report had been revised identify what is going well and ongoing challenges. She also updated the Board on the letter received from Jim Mackey regarding an independent investigation into maternity and neonatal services across the country. It was noted that the investigation would include a review of 10 NHS organisations which were yet to be selected and the criteria for the review is also yet to be determined. Mrs Roberts highlighted that the national Maternity and Neonatal Safety Summit would be taking place next week and hopefully more information would be shared. She agreed to circulate a high-level briefing which had been shared with maternity teams at Sandwell and Dudley Trusts.

Mrs Hurst presented the report, and the following points were noted:

- The Trust had been identified as a negative outlier for Midwifery training as outlined in the National Education and Training Survey (NETS) results. The response rate had been very low, and work is ongoing with the relevant universities to agree actions to improve the position. The GMC had also undertaken an assurance visit in December and the report had outlined the need for level 2 surveillance to monitor relevant actions. Organisational development support had been put in place in delivery suite to focus improvement of the educational environment for students.
- Maternity incentive scheme for year 7 had been launched and the team were working through the requirements associated with this. Safety action 7 was particularly raised due to the increased requirement for the maternity and neonatal voices partnership, commissioned by the ICB, to form part of the quoracy of meetings. A risk of non-compliance had been highlighted by the ICB and the escalation of this through the LMNS Board meets the requirement associated with this safety action and no further action is required.
- An update was received on the progress against Ockenden letters and recommendations, one of the 20 points raised was in relation to the number of vacancies within community midwifery and it was noted that a successful recruitment event had resulted in all vacancies across the service being recruited to.
- 72% of actions had been completed within the perinatal improvement programme with 4% of actions being delayed, however, these do not present a safety concern. A supportive diagnostics visit is due to be undertaken by NHS England on 24th and 25th July and feedback will be presented to the Board.
- A perinatal workshop had been held in June to support the community first programme to support a reduction in health inequalities. The next step was the formation of a Perinatal Community Partnership Forum.
- The team wanted to formally thank the Chief Executive, Chief Nursing Officer and Chief Medical Officer for the feedback and support they were given following the announcement of the review by the Secretary of State. It was noted that this would have a significant impact on maternity services as a whole given the recent focus in this area, and in particular the Trust's service who had been working on transforming their services over the last few years.

Mrs Roberts added that a further discussion had taken place with the CQC, who were unable to confirm when the Trust can expect a re-visit of maternity services due to changes within their inspection regime going forward. It was noted that the visit from NHS England would provide feedback in relation to sustainability of the service. The feedback report would be received within 2 weeks and would be shared with the Board in September.

There was a further discussion about the national review and the risk that the Trust could be included in this due to the results of the most recent CQC inspection and concerns around perinatal mortality rates. It was recognised that the current situation within maternity services nationally was complex and there was a need for the Board to understand the Trust's current position in more detail. It was recommended that this could be an area of focus for a future development session.

Professor Harper advised the Board that she had attended all the maternity safety meetings, as NED safety champion, and had seen evidence that the trajectory is improving with perinatal mortality, and progress was also being made with the 27-week pathway and triage. She was concerned that an additional review of the service would add further pressure to the team who were already working hard to sustain improvements. It was recognised that there was still more work to be done to improve the culture within the department, however, the service had made significant progress since the initial CQC visit.

The Chair queried how the service became aware of any issues, and it was noted that concerns were picked up by the Midwifery Consultant and Equality, Diversity and Inclusion lead, through feedback from families and formal complaints. There had only been one complaint that had been escalated wider than the Trust

in the last 2 years. The Chair requested that the Board receive a brief, high-level position statement to highlight the current position against recent reviews to include how the Trust engages with mothers and families. It was recognised that there is a delay with the national data so it would be good to include the local data so that members could see the current position.

Professor Harper highlighted that the team had worked hard on pulling together the perinatal improvement plan which brings together all of the actions from various reviews that had been undertaken. Mrs Roberts added that there is a paper included in the reading room that provides an update on the current position which is shared with the ICB. She recommended that this be used to inform the statement for the Board.

Mr Sharma acknowledged that there had not been a good response rate to the education and training survey and asked whether the action plan agreed with one of the universities would address the concerns from this. Mrs Hurst highlighted that the main areas of concern had been raised by students from the University of Wolverhampton, therefore a meeting had taken place to discuss how placements could be managed differently across a number of areas, not just within delivery suite. Work is ongoing to increase responses through student forums, and targeted organisational development work also is taking place within the department.

For the purpose of the minutes, Dr Anderson clarified that it was Health Education England and the deanery who undertake the education visits, not the GMC.

The Board NOTED the report.

ACTION: Maternity services to be considered an area of focus for a future board development session.

ACTION: Board to receive a brief, high-level position statement to highlight the current position against recent reviews to include how the Trust engages with mothers and families.

15. Emergency Preparedness, Resilience and Response (EPRR) Annual Report	**TB (07/25) 012**

Mrs Newens presented the EPRR annual report which is required to be submitted to the Board prior to submission to the ICB at the end of August. A version of the report had also been received by the FPC in April; however, some actions had been updated since this time. Mrs Newens outlined the Trust's responsibilities as a category 1 responder which included the requirement for the Trust to respond to a major incident or a series of critical incidents externally. The core standards had also been included in the report and the Board were required to review compliance with these core standards prior to submission of the self-assessment.

It was noted that last year's report had declared that the Trust were non-compliant by NHS England due to the robustness of overall plans and policies. Mrs Newens updated on the EPRR recovery programme which included focused work with the ICB EPRR leads, work to improve compliance with business continuity plans across the organisation as well as implementation of training for managers and business continuity champions. An initial assessment had been undertaken by the ICB who had advised that the Trust is likely to be compliant at the time of submission, however, this feedback had been received the previous year, and the final assurance from NHS England had been non-compliant. Mrs Newens felt that following the focused work that had been done, the Trust would at least be rated partially compliant.

It was noted that none of the Trust's in the Black Country were compliant with the EPRR standards at present, however, members acknowledged the need for work to continue to achieve full compliance as soon as possible.

The Board **ACCEPTED** the annual EPRR NHSE Core Standards and recovery plan for 2025/26 and **ACCEPTED** the EPRR Policy, business continuity management system and training and exercise plan.

Our People	
16. Performance against Workforce Forecast	**TB (07/25) 012**

Mr Fleet presented the report which outlined the workforce performance exit position for 2024/25, as well as the position at month 3 for 2025/26. Figures for month 3 (June 2025) had been identified as being indicative within the paper, however, had been confirmed since the time of writing the report. The Board received a detailed update on performance against the stretching plan agreed in March 2025 to deliver a 718 FTE reduction (8.5%) in March 2026. It was noted that workforce deployment had been reduced by 171 FTE as at June 2025, compared to January 2025 which is the data used to set the plan, and 321 FTE compared to March 2025. There had been a reduction in bank and agency use between January and May 2025 and the Trust's adverse performance against plan continued to reduce.

Mr Fleet highlighted that delivery of the workforce plan exit position would require delivery of the wider components of the workforce CIP programme, in particular the delivery of the Group level plans and the corporate services workforce efficiency plans. He updated the Board on some of the risks to the plan which included a gap of a 139 FTE within the group level plans, mainly in MEC, trajectories being 'back loaded' in terms of their delivery phasing, timeframes for management of changes processes, as well as implementation of the Mutually Agreed Resignation Scheme (MARS) and the Voluntary resignation (VR) scheme which was still yet to be confirmed. It was noted that the management of change process for removal of substantive posts within the corporate reduction plan had been signed off by both SWB and Dudley executive teams to deliver the quickest results, however, the posts would not be removed until early in the new year and they had been phased into the plan from September 2025.

The Board were advised of the mitigations being put in place to reduce the risks to the plan which included an agreed vacancy freeze across the organisation, optimisation of MARS as well as rapid implementation of VR once it had been launched. Intensive work would also be taking place with the MEC group to focus on workforce reduction plans. Mr Fleet highlighted that the Trust had access to robust data to allow the position to be monitored closely and mitigations to be put in place as required.

The Chair recognised that the workforce plan had been delivered during the first quarter of 2025/26, he added that the ongoing risks to the plan would be discussed in more detail during the private session. Mrs Writtle welcomed a discussion in the private session regarding the project management and quality improvement support being provided to the groups, particularly given the challenge in MEC.

The report was **NOTED** by the Board.

Governance, Risk & Regulatory	
17. New Joint Board Committee Report	**TB (07/25) 013**

Mr Conway presented the report which included the draft terms of reference for the Infrastructure Committee. Changes discussed previously had been reflected. It was noted that options to establish other joint subcommittees were being explored.

The Board **APPROVED** the Infrastructure terms of reference noting that there may be further changes following the workshop taking place next week.

For Information	
18. Any other business	**Verbal**

The Integrated Performance Report and Annual Report, Accounts & External Audit Report had been included in the reading room. There was no other business.
Details of the next meeting of the Public Trust Board: 10th September 2025 at 10:00am in person, meeting in the Seminar Room of MMUH
Meeting close

Public Trust Board – Action Log

Meeting Date: 9 July 2025

Next Meeting: 10 September 2025

Ref	Action	Lead	Deadline	Update
1	Present Trust CQC self-assessment to September Board and provide update to July Quality Committee.	Chief Nursing Officer (MR)	September 2025 Board / July QC	**Discussed at the Quality Committee**
2	Board development session to be dedicated to population and neighbourhood health model, including risks and Board's role in the NHS 10-year plan.	Chief Integration Officer (ST)	To be scheduled (before year end)	**Detailed in the place Report this month**
3	Consider maternity services as an area of focus for a future Board development session.	Chief Nursing Officer (MR)	Date to be agreed	**On going**
4	Provide Board with a brief, high-level position statement on maternity services, highlighting current position against recent reviews and how the Trust engages with mothers and families.	Chief Nursing Officer (MR)	September 2025 Board	**On the agenda**

Paper ref:	PublicTB (09/25) 003

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Chief Executive's Report
SPONSORING EXECUTIVE:	Diane Wake, Chief Executive
REPORT AUTHOR:	Diane Wake, Chief Executive
MEETING:	Public Trust Board
DATE:	10/09/2025

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

Advise

- Operational performance
- Resident doctors' industrial action
- Independent Review of Physician Associates and Anaesthesia Associates (the Leng Review)
- Black Country Finance Undertakings
- HSJ awards shortlisted SWB entries
- NHS Oversight Framework: Provider capability
- Visits and Events

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

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

None

4. Recommendation(s)

The Public Trust Board is asked to:

a) **DISCUSS** the contents of the report

5. Impact

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board: 10th September 2025

Chief Executive's Report

1. Operational Performance

1.1 The Trust has continued the positive progress with Urgent and Emergency Care performance achieving the national target of 78% against the Emergency Access Standard (EAS). Performance for July was 78.87%, a 1.7% improvement on last month. Type 1 EAS performance was reported at 64.4% for July, ahead of trajectory by 11.3%. July's average ambulance handover was reported at 23 minutes. Ambulance conveyances were higher compared to June 25 (+265, +6.7%). Handover within 30 minutes in July reported at 84.5%. We are above trajectory for July 2025 and delivering the target we are expected to achieve by March 2026.

1.2 As of July 2025, the Trust reported a Referral to Treatment (RTT) waiting list of 63,805 patients, with 36,750 patients currently waiting within the 18-week RTT standard. This reflects a compliance rate of 57.6%, surpassing the planned trajectory of 54.68%. The Trust remains on track to achieve its target of 60% compliance by March 2026, with regular monitoring in place to ensure continued progress. Additionally, the proportion of patients receiving a first new outpatient appointment within 18 weeks stands at 61.4%, against the trajectory of 58.10%. The Trust is working towards a target of 67% compliance by March 2026, supported by comprehensive action plans. The Trust is also ahead of its Patient Initiated Follow-up (PIFU) trajectory, achieving 2.91% in July against the target of 2.20%.

1.3 We have delivered on 3 out of 4 elective metrics, leaving a recovery plan for 52 weeks. A revised trajectory was submitted to achieve 1% by the end of January 2026. We have categorised specialties based on the risk they pose due to various factors affecting the delivery of the 52-week target. High-risk specialties such as ENT, Oral Surgery, Cardiology, Gynaecology, and Dermatology have individual action and recovery plans, which are monitored weekly at the Planned Care Delivery Group. The low-risk specialties aim to ensure that no patients are waiting over 52 weeks by the end of September 2025. Variation against the original trajectory is primarily driven by unanticipated 52-week challenges in gynaecology and dermatology which were not present during trajectory phasing.

1.4 Our cancer targets performance is improving, with the Faster Diagnosis Standard at 77.53% in June against a 77.51% trajectory, the 31-day standard at 92.81% against a 96.36% trajectory**,** with the 62-day standard at 68.07% against a 72.26% trajectory. We submitted a Trust wide cancer recovery plan to the ICS and NHS England and are focused on delivering improvements. There are positive signs of progress against this with improvement in the Faster Diagnosis Standard and achievement of 31-day and 62-day targets in July pending final validation. We are on track for the implementation of a tele dermatology pathway during September this yea

2. Resident doctors' industrial action

2.1 Resident doctor members of the British Medical Association (BMA) took industrial action from 25th July to 30th July. This took place over five days and nights and included a weekend. This took the form of full strike action and members were asked not to start a shift after 06:59 on the Friday until 06:59 on the Wednesday.

2.2 The Trust response was managed with regular tactical meetings in the ten days before and then daily during the action. We maintained the same acting down rates for consultants as in previous years.

2.3 We did not request any derogations or declare any safety concerns that necessitated asking for resident doctors to return.

2.4 The % of resident doctors taking industrial action at SWB this time was 56%. This is slightly down on the % for the industrial action that took place in February 2024 (62%).

Fresh Ballot

2.5 The BMA is holding a fresh ballot for industrial action, after announcing that it was bringing the issue of insufficient training places and jobs into its existing pay dispute with the government. The ballot will be for this year's cohort of newly qualified doctors, known as FY1 or foundation year one doctors, who were not included in the previous ballot on pay earlier in the year.

2.6 The BMA argues that it has become increasingly difficult for doctors to progress in their training. After completing their two-year foundation programme, doctors can enter specialist training. The BMA is calling for both full pay restoration to 2008 levels and an increase in training places. After meeting with Health Secretary Wes Streeting on 5 August, the BMA's Resident Doctors Committee agreed to a period of negotiations without strikes. The new ballot opens on 8 September

3. Independent Review of Physician Associates and Anaesthesia Associates (the Leng Review)

Professor Gillian Leng published her review into the role of Physician Associates (PAs) which has implications for the role within the Trust. NHS England has accepted all the recommendations made and requested some immediate changes to the role.

3.1 SWBT employs 14 PAs in Primary Care and 1 in our emergency department with some additional bank PAs. The Leng review also covered Anaesthetic Associates (AAs). SWBT does not employ any AAs, and therefore these are not discussed further. Both departments have confirmed they have adopted the recommendations.

3.2 NHS England requested that the name change to Physician Assistant was made immediately and that they should not be triaging or seeing undifferentiated patients also with immediate effect. This request has been actioned. New name badges have been arranged.

3.3 Physician Assistants will not see undifferentiated patients in primary care except triaged adult patients with defined clinical presentation pending national guidance on protocols. Primary Care Networks will develop defined local clinical pathways for patients greater than 12 years old, based on current competency as an interim measure. Physician Assistants will not be involved in clinical triage.

3.4 As a response to the report our standard Physician Assistant session template in primary care has been reviewed with a focus on increased follow up and continuity, and removal of new problem slots. To counteract any other workforce changes the team are reviewing Physician Assistants work in our Extended Assessment Beds setting. Physician Assistants can still play a part in the home visiting team seeing triaged adult patients.

3.5 In the emergency department PAs are not to see undifferentiated patients. The Royal college should be issuing guidance soon on protocols for PAs in ED. In the meantime, they will work under direct and complete supervision of consultants and comply with all previous recommendations to ensure patient safety.

3.6 The Physicians assistants remain a valued part of our workforce

4. Black Country Finance Undertakings

4.1 As the Trust Board is aware NHS England Midlands concluded that, given the scale of financial challenge within the system in 2024/25 and the underlying deficit, it is important to place a common and consistent set of expectations on all key NHS partners in the ICS. The regulatory mechanism to do this via agreement of undertakings.

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

4.3 The Acting Chief Finance Officer is working with system colleagues to improve the underlying financial position of the Integrated Care System and partner organisations. This is a key performance indicator of the medium-term planning process and will be updated based on the end of August 2025 financial position.

4.4 The medium-term planning framework has now been published. Plans will be required for each statutory body linked to their specific roles and responsibilities in the context of an effective system approach to addressing key opportunities and challenges. Planning over multiple years creates the opportunity to focus on longer-term strategic changes that support population health need, through service transformation, reconfiguration and adoption of new technology. The three-year revenue and four-year capital spending review provides the opportunity to pivot to a mature, transparent and strategic approach to medium term planning.

4.5 Integrated Care Boards and providers will be asked to develop the foundational elements for their medium-term clinical and financial sustainability plans inclusive of:

- Coherent clinical strategy
- Robust understanding of productivity and efficiency opportunities and how they will be delivered
- Shared view on service reconfiguration opportunities and plans including fragile services
- Transparent articulation of underlying financial position
- Strong core demand and capacity planning approach and capability within and across organisations
- Rebasing fixed payments impact assessment

4.6 Progress against all the actions is described in **Annex 1** (in the Reading Room).

5. Health Service Journal Awards

5.1 I am delighted to inform you that SWBT has been shortlisted for three prestigious HSJ Awards. This recognition highlights the exceptional efforts and achievements of our teams in various categories.

Below is a summary of the shortlisted teams and their respective categories.

5.2 The **Communications and Engagement Team** have been shortlisted in the *Communications Initiative of the Year* category for their work in preparing 750,000 people in the local area for the successful opening of the Midland Metropolitan University Hospital, and the subsequent closures of the emergency departments at City and Sandwell Hospital.

There was a huge volume of work that went in preparing our staff, patients and the local community for the changes. Messages were tailored to mee the needs of our diverse communities as in Sandwell alone, over one-in-ten residents do not speak English as a first language.

Along with translating messages, the team also engaged trusted local voices such as faith leaders and shopkeepers to spark real, impactful conversations with a range of local communities. For a team so often behind the limelight of others – it's great to see the spotlight shining on them this time.

5.3 I was also delighted to see the **Frailty Intervention Team** on the shortlist for the *Transforming Care for Older People* category. Our work around frailty, and in particular the reduction in the number of frail patients being admitted to hospital is drawing national attention, with lots of Trusts interested in how we are achieving the results we are.

The Frailty Intervention Team consists of advanced clinical practitioners, geriatricians, therapists, and assistants who have supported the development of frailty services within the Trust, including a Frailty Virtual Ward team that enables people to receive acute-level care

at home, and a frailty-based Same Day Emergency Care Unit, where Comprehensive Geriatric Assessments can be delivered away from the busy A&E environment.

The team has reduced hospital admissions of older people by 67 per cent and delivered significantly improved outcomes for patients – and a place on the shortlist is very well deserved.

5.4 The Trust is also shortlisted in the **Advancing Patient Safety with Data and Analytics Award** in the Patient Safety Awards, the recognition of the how our *Medicines Length of Stay Programme*, has identified opportunities to use data to improve the patient transfer process.

This led to the creation of an innovative data-driven platform, the Patient Flow Insights Tool (PFIT), to help teams manage discharges and patient flow. Developed in 2024, the tool is a visual dashboard which pulls together data from different systems for all adult inpatients, which can be filtered by length of stay, patient pathway or discharge criteria.

The tool has helped pinpoint where resources should be directed, to support timely discharges. The introduction of PFIT has led to lower rates of bed occupancy, reducing delays from ED to inpatient wards and minimising the risk to patient safety.

The length of stay of patients during the 2024/25 winter period has reduced by six per cent, in comparison to the previous year. The Trust have also reduced the number of patients staying in the admissions unit over two nights from 86 per cent to 63 per cent and reduced the number of short stay patients waiting over three nights for a transfer to a specialist ward to 42 per cent.

PFIT is now widely used by discharge teams, ward managers, matrons, and patient flow co-ordinators to ensure the safe and timely discharge of patients. It has been expanded to teams within surgery and community services, and work is underway to explore its use at other neighbouring NHS trusts within Birmingham and the Black Country.

5.5 The Patient Safety Awards will take place on 15 September, followed by the HSJ awards in November. We wish all three teams the very best of luck.

6. NHS Oversight Framework: Provider capability assessment

6.1 As part of the NHS Oversight Framework (NOF), NHS England will assess NHS trusts' capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across 6 areas derived from the insightful provider board, namely:

- strategy, leadership and planning
- quality of care
- people and culture

- access and delivery of services
- productivity and value for money
- financial performance and oversight

6.2 These will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams.

6.3 Guidance issued on 26th August 2025 is designed to help boards make this self-assessment, set out the process and what organisations can expect along the way.

6.4 The Trust's self-assessment will be completed within the two-month period given and presented to the relevant Board Committees and Board prior to submission.

6.5 Regional oversight teams will review the trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the trust's capability rating and share this with it, including the rationale for the rating.

7. Recommendation

The Public Trust Board is asked to:

a. DISCUSS the contents of the report

Diane Wake
Chief Executive

29th August 2025

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

Key Messages on the Provider Collaborative – August 2025

The following are the key messages from the 4th August **2025** Black Country Provider Collaborative (BCPC) Executive meeting.

A. GENERAL

- **Updates from the BC ICB –** BC ICB Board is focused on transition arrangements to the new ICB Clusters, with programmes of work identified for progression shortly. Announcements on Chair and CEO appointments are due in late August / early September with subsequent leadership roles to follow.
- **Updates from NHS West Midlands –** publication timeline for "shared leadership governance" together with that for "Wholly Owned Subsidiaries" (WOS) are still not known. Foundation Trust Assurance Framework is being re-invigorated, and it is anticipated that existing Foundation Trusts will also need to go through any new processes. Guidance on the "Model Region" is to be published soon, with the 26/27 National Oversight Framework (NOF) being guidance in development.
- **BCPC Managing Directors Quarterly Progress Report** - Robust report presented which highlighted:
  - The three programmes continue to make positive progress in delivering against priorities
  - Overall performance is RAG rated as Amber, reflecting minor areas where performance is marginally behind trajectory
  - BCPC budget is in a positive position, currently underspending against profile trajectory
  - Governance has been strengthened with clear objectives for each system lead and a more frequent operational meeting of the programme Senior Responsible Officer's
  - Key messages from the Joint Provider Committee were shared
  - BCPC were alerted to a range of forthcoming Collaborative activities

B. IMPROVEMENT

- The Collaborative Executive were provided a brief update on the following key items:
  - **Clinical Improvement programme** – The BCPC Managing Director presented a summary report highlighting the key progress reported at the recent monthly Clinical Network meetings. Positive strides continue to be made with a more detailed timeline of actions to be presented in the BCPC Managing Directors quarterly highlight report next month.
  - **Clinical Service Transformation** – The BCPC received relevant progress updates on priorities which included:
    - **BC Elective Hub** – BCPC Executive received confirmation that the formal business case had been submitted on the 31st July 2025 and now await formal feedback on approval. Informal meeting with NHSE colleagues held to assure of intent and progress. Phase 1 transition well underway, with plans for Phase 2 being mobilised soon

- **Breast DIEP Reconstruction** – Final draft of the Business Case received and approved by the BCPC Executive. Positive feedback received and good engagement with key forums and stakeholders (e.g. ICB, Elective Care Board, Cancer Care Board)
- **Vascular services** – Work underway by Task and Finish group, with baseline data being sourced for review and further dialogue on preferred model, with a Service Plan due in the Autumn for consideration and approval.
- **System Transformation** – Breast Unit engagement workshop scheduled for October with consistent baseline positions of each partner Trust being sourced and presented as part of the socialisation and engagement activities.

  The Pharmacy Aseptic feasibility study continues to be drafted with the output report due in early autumn outlining possible options for next steps.
  Formal output reports from a Colorectal / Robotically Assisted Surgery workshop and a separate Gynae-Oncology workshop were received by the Collaborative Executive, highlighting positive engagement and focused priorities to be progressed.

C. TRANSFORMATION

- **Corporate Service Transformation (CST) –** The BCPC Senior Responsible Officer and Programme Lead provided an update on progress highlighting an urgent review of focus to be undertaken imminently and a realigned programme to be agreed.

  It was confirmed that partner Trusts are continuing to focus on the "corporate cost reduction target" established by NHSE as part of integrated Cost Improvement Plans, monitoring progress against trajectory through internal governance arrangements.
  The programme team continue to drive forward work to establish a solution on consolidating both "Collaborative Bank" and the recruitment functions, with expressions of interest being sought from the market.

D. STRATEGIC & ENABLING PRIORITIES

- **Medical Bank Rate Harmonisation –** The task group led by the BCPC Chief Medical Officer presented their output report following extensive engagement, and baseline reviews from across the country. The proposed position was well received, with some further minor work required to avoid any perverse incentives especially in relation to "Waiting list Initiatives".
- **Communications - Public Involvement Exercise** – The public involvement exercise commissioned from STAND is nearing completion. Early indications are that the engagement has been positive, with responses now being analysed and an output report highlighting key issues to be addressed due for presentation in early September. This report will be utilised within any Business cases relating to Clinical Service Transformation areas being progressed.

Visits and Events – July and August 2025

1 July	Executive Directors Sandwell & West Birmingham NHST Development Day
2 July	Black Country Regional Performance Tier Call
2 July	NHS Chief Executive 10 Year Health Plan webinar
4 July	Birmingham & Solihull Chief Executive's Development Session
4 July	Sandwell & West Birmingham NHST Long Service Staff Awards
9 July	Sandwell and West Birmingham Public and Private Board of Directors
10 July	Dudley Group NHSFT Public and Private Board of Directors
11 July	Birmingham & Solihull Chief Executive Officers
11 July	Dudley Group NHSFT Committed to Excellence Staff Awards
14 July	Black Country Provider Collaborative Senior Responsible Officers
15 July	Executive Directors Dudley Group NHSFT Development Day
16 July	Sandwell & West Birmingham NHST Long Service Staff Awards
16 July	Black Country Regional Performance Tier Call
17 July	Joint Dudley Group/Sandwell & West Birmingham Board Workshop
21 July	Black Country Integrated Care System Cancer Board
23 July	NHSE Midlands Regional Director Monthly Update Briefing
23 July	Black Country ICB Oversight & Assurance Sandwell & West Birmingham NHST
23 July	Further Faster 20 Senior Responsible Officers Group
24 July	Black Country ICB Oversight & Assurance Dudley Group NHSFT
24 July	Freedom to Speak Up Steering Group Dudley Group NHSFT
25 July	Joint Provider Committee
28 July	Black Country Provider Collaborative Senior Responsible Officers
28 July	Freedom to Speak Up Steering Group Sandwell & West Birmingham NHST
28 July	Midlands Endoscopy Board
30 July	Sandwell Together Partnership
30 July	Black Country Elective and Diagnostic Strategic Board
31 July	Finance and Productivity Committee
31 July	Finance and Productivity Committee Dudley Group NHSFT
31 July	Black Country Integrated Care Public and Private Board
1 August	Finance and Performance Committee Sandwell and West Birmingham NHST
4 August	Black Country Provider Collaborative Executive
4 August	Black Country ICS Chief Executive and Chief Finance Officers
7 August	Staff Meet & Greet Midland Met University Hospital
8 August	Birmingham & Solihull Chief Executive Officers
8 August	Sonia Kumar MP catch up meeting
11 August	Black Country Provider Collaborative Senior Responsible Officers
11 August	Staff Meet & Greet Sandwell General Hospital
12 August	Dudley Group & Sandwell & West Birmingham Joint Executive Development
13 August	Birmingham Cabinet Visit & Tour Midlands Met University Hospital
13 August	Black Country ICB Regional Performance Tie Call
14 August	Staff Meet and Greet Russells Hall Hospital
15 August	Birmingham & Solihull Financial Recovery

18 August	Black Country Integrated Care System Cancer Board
18 August	Further Faster 20 Senior Responsible Officers Group
27 August	Quality Committee Sandwell & West Birmingham NHST
27 August	Black Country Regional Performance Tier Call
28 August	Finance and Productivity Committee Dudley Group NHSFT
28 August	Finance and Productivity Committee Sandwell & West Birmingham NHST

Events

South Asian Heritage Month

South Asian Heritage Month take place from 18 July – 17 August each year and seeks to understand and celebrate the diverse heritage and cultures that continue to link the UK with South Asia.

South Asian Heritage Month is not just about acknowledging the past - it's about celebrating a living, breathing cultural tapestry that continues to enrich our communities today. The South Asian diaspora encompasses the diverse heritage of India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, Afghanistan, and the Maldives, each bringing unique traditions, languages, cuisines, arts, and philosophies that have profoundly shaped the cultural landscape of the UK and beyond.

We are hugely lucky to have such a diverse workforce, and I want to take this opportunity to recognise the contributions of our South Asian colleagues across the Trust – thank you for sharing your stories and helping us to reflect on the diversity that strengthens and enriches our organisation.

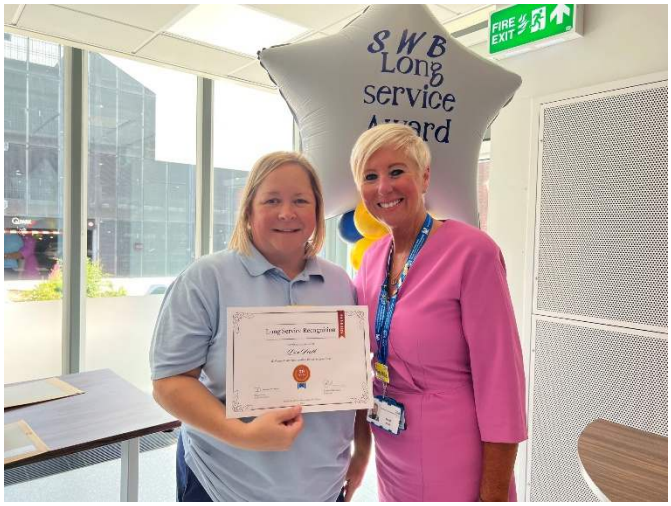
Our month of celebrations included food tasting and a Bhangra dance workshop in the Winter Garden.

Dudley Governors Visit Midland Met

It was a pleasure to welcome non-executives and governors from The Dudley Group NHS Foundation Trust to Midland Met.

Discussions revolved around transitioning from hospital-based care to community models, implementing seven-day workforce models and leveraging future capital investments for mutual benefits across both organisations.

Long Service Awards



Over 400 colleagues attended a drop-in long service awards celebration, with one session taking place at Midland Met and another at Sandwell Health Campus.

The Long Service Awards at SWB have been on pause since the COVID-19 pandemic and on arrival at the Trust, I made a promise to staff that I would re-instate them.

We have recognised thousands of years of loyal NHS service, and I have thoroughly enjoyed hearing stories from our long serving colleagues.

There will be another event in October, to catch those who have missed awards during the pause, and we will then move on to recognise those who have reached a long service milestone during 2025 at a ceremony in December.

Paper ref:	PublicTB (07/25) 004

REPORT TITLE:	Integrated Committee Chairs Report		
SPONSORING EXECUTIVE:	Diane Wake, CEO		
REPORT AUTHOR:	Lesley Writtle, Non-Executive Director, Deputy Chair		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

This report provides a consolidated summary of assurance levels and issues identified by the Trust Sub-Committee Chairs. It offers the Board an opportunity to review, triangulate, and escalate concerns where necessary, as well as to recognise examples of good practice aligned to the Trust's strategic priorities.

Sub-Committees provide regular reports to the Trust Board, offering assurance on key matters discussed and progress made in addressing identified issues. This paper combines the committee assurance reports, which were previously received as separate agenda items. The individual reports remain available in the Board Reading Room for reference.

For this reporting cycle, we have also included work linking key issues to the Board Assurance Framework (BAF) and associated strategic risks. Committee Chairs have reviewed relevant risks and their overall scores which are presented on todays agenda.

In summary, this has led to the areas highlighted being directly tracked against the five refreshed BAF risks.

The "Alert" items (finance, workforce deployment, deteriorating patients) map to the highest-scoring BAF risks (001, 002, 003), while the "Advise/Assure" issues demonstrate progress in Infrastructure (006) and Integration (004), albeit with some dependencies still in play

This report covers matters from the following Sub-Committee meetings held in July, August, and September 2025:

- **Quality Committee** – chaired by Mike Hallisey
- **People Committee** – chaired by Jatinder Sharma
- **Finance and Productivity Committee** – chaired by Rachel Hardy
- **Audit Committee** – chaired by Andy Argyle
- **Integration Committee** – chaired by Val Taylor

The report highlights key issues for the Board to **advise, assure, and alert**.

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

OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x

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

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

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**NOTE** the report and assurance provided.
b.	**PROVIDE** feedback for any identified issues shared for escalation

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

KEY ITEMS DISCUSSED AT THE BOARD COMMITTEES
ALERT
• **Delivery of the 2025/26 Financial Improvement Plan** remains a high-risk issue for the organisation, with significant work required to ensure sufficient recurrent and non-recurrent measures are achieved to deliver the financial position and protect cash. A delivery gap of £13m remains, which if unresolved will directly impact the year-end revenue and cash position. The CEO will lead focused work with clinical and operational groups in early September to drive greater productivity, strengthen clinical ownership, and secure clear commitments to delivery.
Linked BAF risk: BAF 002 – Resources **Reason:** Directly relates to financial sustainability, delivery of CIP, and risk of running out of cash. The £13m delivery gap highlights the very high current score (20) and fragility noted in BAF 002.
• Workforce control remains a key focus of committees, with significant progress in reducing bank and agency usage, owed hours, and sickness; however, the plan remains challenging, and the targeted 8.5% reduction is ambitious, relying on strong engagement from the Groups. In June, workforce deployment was 8,239.7 FTE against a plan of 8,237.1 FTE (+2.6 FTE, 100.0% utilisation), and in July deployment reduced to 8,224.6 FTE, which was 98.9 FTE above the planned 8,125.7 FTE (101.0% utilisation). Although a decrease of 15.1 FTE from June, this was insufficient to align deployment with plan. Resident Doctors' industrial action affected headcount and costs. Committees have been assured on processes and comprehensive QIAs in place but remain concerned about delivery.
Linked BAF risk: BAF 003 – Workforce **Reason:** Ongoing challenge in reducing bank/agency, managing sickness, and aligning FTE to plan reflects gaps in recruitment, retention, and optimisation. This is a central driver of BAF 003.
• The management of deteriorating patients remains a concern for the second consecutive report. Although a workplan is in place, it has yet to demonstrate measurable improvement, with persistent failures in the documentation of clinical care linked to the Fundamentals of Care dashboard, including NEWS, falls assessment, and recognition of end-of-life care. The CEO has commissioned a review of support for digital systems, which, while not a complete solution, is expected to provide some assistance. The Quality Committee continues to monitor this closely as a standing monthly agenda item.
Linked BAF risk: BAF 001 – Quality **Reason:** Failures in documentation and patient safety processes directly align with BAF 001 concerns about consistent delivery of safe, high-quality care.
ADVISE
• **The Joint Infrastructure Committee** continues to demonstrate good leadership and focus, with work now progressing on emerging 3 year plans for both Digital and Estates, aligned to the Trust's medium-term five-year plan. Key discussions this month centred on the Sandwell and Dudley Elective Hub, alongside recognition of the need for greater support

to the digital agenda, particularly the functionality and accessibility of clinical systems, which remain a barrier to improvement.

Linked BAF risk: BAF 006 – Infrastructure

Reason: Strong alignment to the risk of failing to optimise estates and digital. There is progress but also digital functionality barriers and this risk is still being developed.

- **Operational reporting** to the Finance Committee has improved significantly, with members assured on both the quality and presentation of data. This provides confidence that the committee and Groups now have reliable information to drive improvement and productivity. Notably, excellent data and improvement initiatives were presented on community performance. This strong approach in Finance and People committees needs replication across all reporting areas.

Linked BAF risk: BAF 002 – Resources

Reason: Better data quality and transparency strengthens assurance against financial/resource use, one of the noted gaps in BAF 002.

ASSURE

- **Group Contributions at subcommittee**: this has improved greatly in most committees, members benefiting greatly from strong connection to services and debate with group leaders. Committee chairs recognise that this is valuable in encouraging learning within the Trust.

Linked BAF risks: All BAF risks (001–004, 006)

Reason: Stronger Group-level debate and ownership supports all strategic risks, as effective governance and leadership is a cross-cutting enabler

- **Sandwell West Birmingham and Dudley elective Hub**: The Finance Committee reviewed the proposal, granting first-stage approval. The Committee was assured by the soundness of the plans and the strength of the strategic vision, while requesting further detail on the funding of the workforce model in future papers.

Linked BAF risks: BAF 006 – Infrastructure & BAF 002 – Resources

Reason: Assurance given on the vision and capital plan, though with a noted dependency on future workforce planning.

- **Workforce Race Equality Standard (WRES)** shows good progress with staff from Black and Minority Ethnic (BME) backgrounds now making up 45% of the workforce, fewer BME staff entering formal disciplinary processes, more reporting equal access to promotion, and an increase in ethnicity disclosure; however, challenges remain in recruitment, access to development, senior leadership representation, and experiences of harassment and discrimination, and the Trust will continue to address these through the 'With You All the Way' culture programme and EDI Plan as part of the wider 2023–2025 Workforce Journey.

Linked BAF risk: BAF 003 – Workforce

Reason: Positive progress on diversity and inclusion strengthens the People strategic objective, though gaps remain in leadership representation.

- **Integration:** Over the past 10 months since the establishment of the new integration team, significant progress has been made in implementing a clear strategic direction

supported by a structured and meaningful delivery programme. Notable achievements include strengthened relationships with partners, the establishment of a jointly owned forward plan for place-based partnerships, and strong engagement in work on health inequalities and population health. The main risk to the ongoing success of the programme lies in the capacity and, in some areas, capability of the business and financial analytics teams, which are essential for developing and improving live dashboards, risk stratification, population health analysis, and financial modelling.

Linked BAF risks: BAF 004 – Integration

Reason: Assurance given on the progress of this agenda and assurance on the BAF

Sandwell and West Birmingham NHS Trust

Finance and Productivity Committee Chairs Report

Committee Chair: Rachel Hardy

1st August 2025	
Deep Dive into Diagnostics	Reasonable Assurance
Update on Community Performance	Reasonable Assurance
Operational Performance Report	Reasonable Assurance
Month 3 Finance Report	Partial Assurance
Month 3 Cash and Capital	Partial Assurance
Medium Term Planning	Partial Assurance
Financial Improvement Programme - Summary Dashboard - Workstream Updates (Plans, PIDs, QIAs) - Performance to date and forecast - Risks and mitigations	Partial Assurance
National Cost Collection Final Submission	Reasonable Assurance
Maternity Theatres Business Case	Reasonable Assurance
Mapping Agenda items from F&P to the Infrastructure Committee	Reasonable Assurance
Undertakings	Substantial Assurance

29th August 2025	
Community Performance Report	Reasonable Assurance
Operational Performance Report	Reasonable Assurance
Month 4 Finance Report	Partial Assurance
Month 4 Cash and Capital	Partial Assurance
Financial Improvement Programme - Summary Dashboard - Workstream Updates (Plans, PIDs, QIAs) - Performance to date and forecast - Risks and mitigations	Partial Assurance
Learning Campus Business Case	Substantial Assurance
Elective South Hub Business Case	Substantial Assurance
Medium Term Planning	Reasonable Assurance
MMUH - Post Opening Additional Costs	Reasonable Assurance
Board Assurance Framework	Reasonable Assurance
Finance and Productivity Committee Annual Report to the Trust Board	Substantial Assurance
Undertakings	Substantial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- A gap still remains to be identified to deliver the FIP of £13m. This will impact on the year end revenue position and the cash position.

MAJOR ACTIONS AGREED

- Group Directors to present FIP progress and productivity on a rolling basis.
- Maternity theatres business case plus a way forward to manage safety issues in year from a financial perspective
- Learning campus business case on the basis that it is being revisited and will be revenue neutral
- Elective South Hub Business case – Supported the strategic vision , recognise the current financial gap with the expectation that it will be a financially viable model; as part of the ongoing work

POSITIVE ASSURANCES TO PROVIDE

- Proactive work is underway to close the gap of £13m on the FIP.
- Really good work and debate on operational and community performance
- Work plan under way with Groups to work through productivity opportunities and ensure that this is a key part of the agenda moving forward
- Deep Dive Diagnostics positive assurance of the processes in place to recover, with a further deep dive to look at the impacts of this in 6 months

DECISIONS MADE

- Group Directors to present FIP progress and productivity on a rolling basis.
- Maternity theatres business case plus a way forward to manage safety issues in year from a financial perspective
- Learning campus business case on the basis that it is being revisited and will be revenue neutral
- Elective South Hub Business case – Supported the strategic vision, recognise the current financial gap with the expectation that it will be a financially viable model; as part of the ongoing work
-

Infrastructure Committee Chairs Report

Committee Chair: Mick Laverty

1st August 2025	
Infrastructure Workshop 18/7/25 - Output (Assurance rating not applicable)	**NOTED**
Board Assurance Framework (More work needed before assurance rating is assigned)	**NOTED**
Governance Reporting Structure/Mapping	**Reasonable Assurance**
3 Year Digital Plan	**Reasonable Assurance**
RACC Update	**Partial Assurance**

18th July 2025	
3 Year Estates Plan (More work needed before assurance rating is assigned)	**NOTED**
IPA Gate 5 Review	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

-
-

MAJOR ACTIONS AGREED

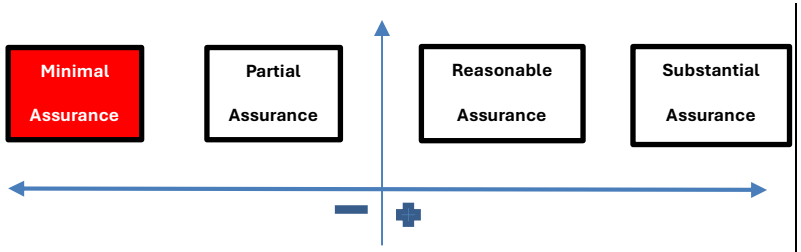
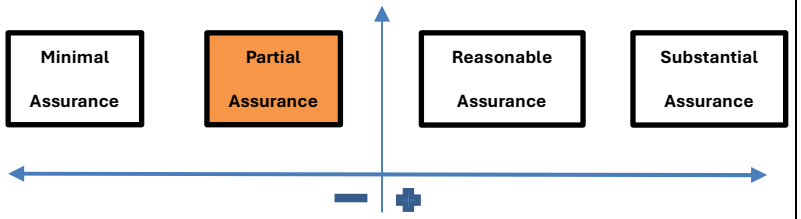
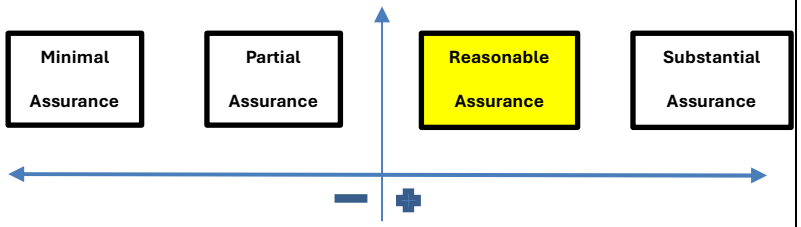
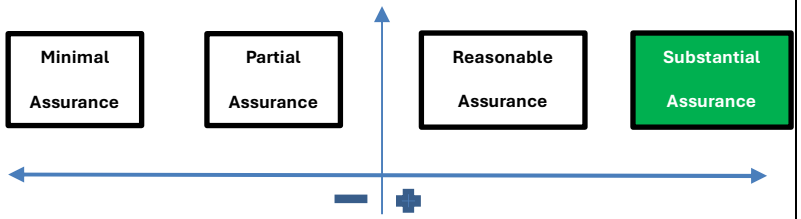
- RACC plan to be reviewed by Infrastructure Committee at the October meeting. (Proposal to bring forward a scheme that is more transformational, than a simple RACC replacement scheme, has been shared with NHS colleagues. Potential cost £150-200m.)

POSITIVE ASSURANCES TO PROVIDE

- IPA Gateway 5 Review – graded 'green' and positively commended by the Review Team.
- Workshop held on the 18/7/25 was well attended by colleagues from both Trusts and good (early) progress made re confirming 2025/26 priorities, longer term ambitions and immediate opportunities to share good practice and 'level up'.
- 3 year Digital plan well progressed – will be combined with Estates plan to create an overall Infrastructure Plan.

DECISIONS MADE

- Agreed vision statement for the work of the Infrastructure Committee (as discussed at the 18/7/25 workshop event and voted on by workshop participants).
- 3 year Estates plan being worked on and will be considered by the Committee in Q4. Estates plan will be combined with Digital plan to create an overall Infrastructure Plan.
- Infrastructure Plan will need to support the new Clinical Model as it evolves.

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

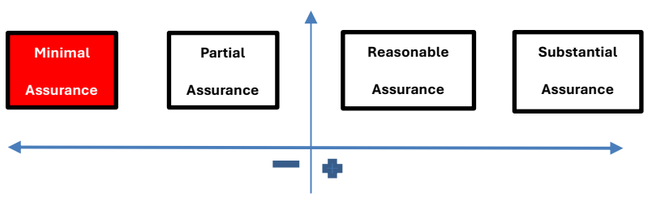
People Committee Chairs Report

Committee Chair: Jatinder

30 July 2025	
6) Logistics	Reasonable Assurance
7) People Metrics	Partial Assurance
8) CMO/CNO Report receive further update in September	Reasonable Assurance
9) Flu 5% increase to target, continued monitoring	Reasonable Assurance
10) Mars – 85 Mars Applications received, national settlement to be determined.	Partial Assurance
11) Library Business Plan	Reasonable Assurance

27 AUGUST 2025	
7. People Metrics – Workforce Financial Improvement Programme/delivery against workforce Trajectory's NHSE SPC Charts – All POD Metrics	Partial Assurance
8. EDI/WRES/WDES Report	Reasonable Assurance
9. 'With you All the Way'	Reasonable Assurance
10. ARC Culture Overview	Reasonable Assurance
11. Job Plan Update	Partial Assurance
12. MARS/MoC Update	Partial Assurance
13. Pulse Check Update	Reasonable Assurance
14. Learning Campus	Reasonable Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS AGREED
• 20% gap on financial forecast against CIP. • Awaiting clarity on MARS position.	• People Metrics-Further detailed work necessary to further cost savings within directorate. Forecast to be re-presented. • Job Plan Work Completion Table to be brought to each Committee. • Learning Campus – Refinement of cost savings to be brought back to Committee. • Board Assurance Revised Framework approved. • Annual Report approved to go to Full Board.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Excellent EDI/WRS/WDES Reports – Further work commissioned to establish Groups detail.	• The EDI/WRES Report acknowledged and approved.



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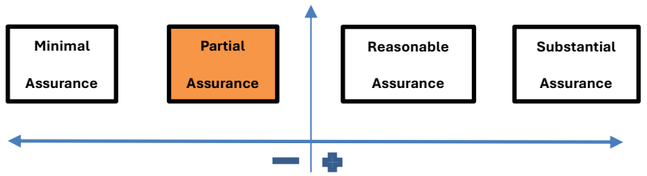
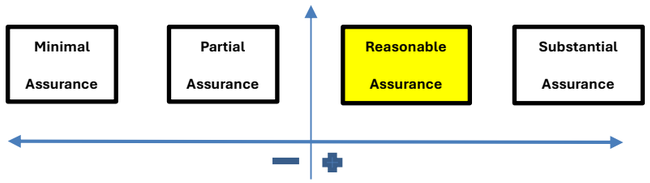
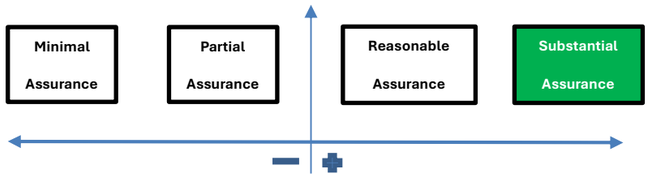
	There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.
	There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.
	There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

Sandwell and West Birmingham NHS Trust

Quality Committee Chairs Report

Committee Chair: Mike Hallissey

30th July 2025	
Fundamentals of Care Metrics	Minimal Assurance
Improving Together Update	Partial Assurance
QIA/EQIA Update	Noted
Clinical Group Feedback – Imaging	Noted
Antimicrobial Stewardship Update	Reasonable Assurance
Learning From Deaths/Mortality & Morbidity incl. HSMR & SHIMI	Partial Assurance
Maternity Dashboard incl Ockenden	Partial Assurance
PSIRF	Reasonable Assurance
Complaints, Compliments, PALS & PP	Reasonable Assurance
Clinical Effectiveness (Inc Audit plan & progress reports/GIRFT/LocSIPPs)	Partial Assurance

27th August 2025	
Care Quality Commission (CQC) Update	Noted
Fundamentals of Care Metrics	Minimal Assurance
Deteriorating Patient Update	Minimal Assurance
QIA/EQIA Update	Noted
Update on Dermatology Services	Minimal Assurance
Infection Prevention & Control Annual Report 2024-25	Noted
Clinical Group Feedback – Surgery (including Patient Story)	Noted
PSIRF and Learning Report	Partial Assurance
Safeguarding Improvement Plan	Partial Assurance
Learning From Deaths/Mortality & Morbidity incl. HSMR & SHIMI	Partial Assurance
Maternity Dashboard including Ockenden	Partial Assurance
Patient Experience Workplan Update	Reasonable Assurance
Board Assurance Framework	Noted
Quality Committee Annual Report to the Board	Noted

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The are a number of failures in documentation of clinical care: NEWS2; Falls assessment; and recognition of End of Life
- Significant issues over medications with risks to patient safety
- Delays in MRI
- Triage in maternity is performing below expected levels
- Never event in O&G

MAJOR ACTIONS AGREED

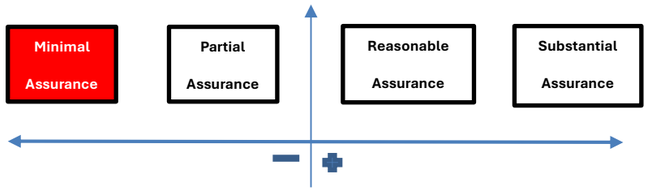
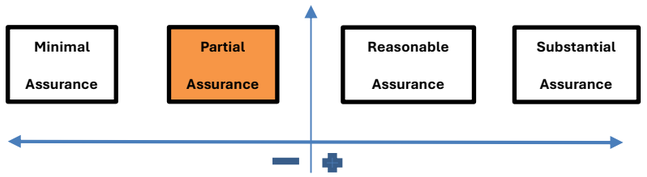
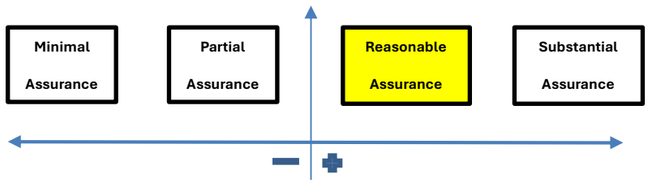
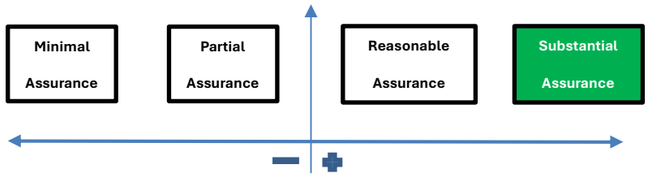
- Review of medication administration issues for November Quality Committee

POSITIVE ASSURANCES TO PROVIDE

- Improvements in antibiotic pe-packs
- Improvement in complaints response
- Sepsis Mortality low
- Overall SHMI continues to decline
- PSIRF Group is developing a robust approach

DECISIONS MADE

- Request that BAF risk appetite move to Open

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

Paper ref:	PublicTB (09/25) 00

REPORT TITLE:	Board Assurance Framework and Risk Appetite Statement 2025/26		
SPONSORING EXECUTIVE:	Kam Dhami, Chief Governance Officer		
REPORT AUTHOR:	Dan Conway, Associate Director of Corporate Governance/Company Secretary		
MEETING:	Public Trust Board	**DATE:**	10/09/2025

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

The Q2 2025/26 BAF highlights material risks across all domains, with progress evident in quality, workforce, and integration but overall assurance remaining inconclusive. Financial sustainability (BAF 002) is the most acute challenge, with risk elevated to inherent levels due to fragile recovery, reliance on non-recurrent savings, and CIP accountability.

Quality and workforce show improvements through new dashboards and optimisation programmes, though gaps persist in consistent adoption, succession planning, and senior diversity. Integration benefits from strong governance and town-level plans but faces data fragmentation and uncertain funding beyond 2025.

Infrastructure risks remain high while baselining continues, with RAAC funding, Net Zero planning, and converged governance yet to be secured.

The Corporate Risk Register is being refreshed ahead of the next Board to strengthen alignment between operational risks and the Trust's defined appetites.

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

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

None

4.	**Recommendation(s)**

The Public Trust Board is asked to:

a.	**Approve** the current position of the refreshed Board Assurance Framework (Q2 2025/26).
b.	**Approve** the updated Risk Appetite Statement for 2025/26 for publication.
c.	**Note** that the Corporate Risk Register will be refreshed with strengthened governance and alignment ahead of the next Board presentation.

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

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 10 September 2025

Board Assurance Framework and Risk Appetite Statement 2025/26

1. Purpose

1.1 This quarterly update provides the Trust Board with a summary of the current position on all refreshed Board Assurance Framework (BAF) risks for Q2 2025/26. Each risk has undergone review by its lead executive and oversight committee, ensuring alignment with the Strategy Refresh 2025 and the Trust Success Measures.

1.2 The new Committee Assurance Level descriptors (Positive, Inconclusive, Negative) are now consistently applied across all BAFs

2. Summary of Principal BAF Risk Scores

BAF Risk No	Description	Initial Score	Current Score	Target Score	Committee Assurance Level descriptors	Trend
BAF001	Safe, high-quality care (QC)	16	12	8	Inconclusive	Improving
BAF002	Strategic use of resources (F&P)	16	20	4	Inconclusive	High Concern
BAF003	Workforce (PC)	16	12	4	Inconclusive	Improving
BAF004	Integrated care delivery (IC)	16	12	4	Inconclusive	Static (to be updated)
BAF006	Infrastructure: Digital, Estates, and Facilities	20	20	16	Inconclusive	**NEW RISK** (baseling in progress)

3. Review of Principal Risks

3.1 BAF001 – Safe, High-Quality Care

- **Current Score: 12 (Target: 8)**
- **Lead Committee: Quality and Safety Committee**

3.1.1 The Quality Committee has refreshed the BAF 001 risk relating to the Trust's ability to consistently deliver safe, high-quality care. Key controls are now more firmly embedded, including the rollout of the Fundamentals of Care Dashboard, the application of PSIRF with an increased focus on learning, and strengthened safe staffing and job planning arrangements.

3.1.2 However, significant assurance gaps remain, particularly in the consistent adoption of the Fundamentals of Care across all services, the availability of real-time quality dashboards to drive frontline improvement, and the triangulation of assurance between outcomes, experience, and harm data at Board level.

3.1.3 The Committee has undertaken a review of the risk appetite and reconfirmed a ***Cautious*** position for quality, reflecting the Trust's very low tolerance for risks to patient safety. It proposes maintaining the current risk score at 12 (3x4), acknowledging progress made but recognising that assurance remains Inconclusive at this stage.

3.1.4 Committee Assurance Level descriptors, the committee discussed the assurance level and agreed it was:

Committee Assurance Level *descriptors*	
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.	

3.2 **BAF002 – Strategic Use of Resource**

- ***Current Score: 20 (Target: 4)***
- ***Lead Committee: Finance and Productivity Committee***

3.2.1 The Finance & Productivity Committee has refreshed BAF 002, which captures the risk of failing to make best strategic use of financial, workforce, and operational resources. Despite stronger financial reporting and early productivity improvements in theatres and urgent care, the Trust continues to rely heavily on non-recurrent savings, with weak CIP accountability and only partial embedding of the Strategic Planning Framework (SPF).

3.2.2 These limitations, combined with heightened national recovery pressures, mean the Trust is now exposed to risk at its inherent level.

3.2.3 The Committee has reviewed the risk appetite and reconfirmed a **Cautious** position, emphasising that value for money remains the overriding priority. It is therefore proposing to increase the risk score to **20** (5x4), reflecting the fragility of current delivery and the urgent need for sustained progress.

3.3.3 Committee Assurance Level descriptors, the committee discussed the assurance level and agreed it was:

Committee Assurance Level *descriptors*	
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.	

3.4 BAF003 – Workforce

- ***Current Score: 12 (Target: 4)***
- ***Lead Committee: People Committee***

3.4.1 The People Committee has refreshed BAF 003, which reflects the risk of being unable to recruit, retain, train, and develop an engaged and effective workforce. Progress is visible through the Workforce Optimisation Programme, improved absence management using GoodShape, the launch of the MARS scheme, and continued investment in staff engagement and leadership development.

3.4.2 Nonetheless, significant gaps remain, including succession planning, diversity at senior leadership levels, and the full adoption of ARC leadership and culture programmes. These challenges are further compounded by the impact of financial recovery requirements.

3.4.3 The Committee has refreshed its appetite and reconfirmed an **Open** position, accepting controlled workforce risks where these enable innovation and long-term sustainability.

3.4.5 The risk score remains at **12** (4x3), recognising progress but acknowledging that material risks persist

3.5.6 Committee Assurance Level descriptors, the committee discussed the assurance level and agreed it was:

Committee Assurance Level *descriptors*	
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.	

3.6 BAF004 – Integrated Care

- ***Current Score: 12 (Target: 8)***
- ***Lead Committee: Integration Committee (reconvened April 2025)***

3.6.1 The Integration Committee has refreshed BAF 004 to sharpen its focus on the Trust's strategic objective of improving care and lives through partnership working. There is clear progress, with strong ICS representation across BSOL and Black Country, the development of town-level dashboards and plans, alignment of MMUH delivery with community transformation priorities, and the establishment of Joint Partnership Boards and VCSE forums.

3.6.2 Despite this, challenges remain around fragmented data, uncertain transformation funding beyond 2025, and the underutilisation of the VCSE sector. This BAF risk is still under development with the final version expected to be presented at the November Trust Board.

3.6.3 The current score is provisionally held at **12** (3x4), with an Inconclusive assurance level proposed while work continues to strengthen delivery.

3.6.4 The Committee has reviewed its position and reconfirmed an ***Open*** risk appetite, reflecting the importance of bold innovation in integration while balancing regulatory and operational risks.

3.6.5 Committee Assurance Level descriptors, the committee discussed the assurance level and agreed it was:

Committee Assurance Level *descriptors*	
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.	

3.7 BAF006 – Infrastructure

- **Current Score: 20 (Target: 16)**
- ***Lead Committee: Group Infrastructure Committee***

3.7.1 The Joint Infrastructure Committee has refreshed BAF 006, covering the strategic risks associated with digital, estates, and facilities. The risk remains set at the inherent level of **20** (4x5) while baselining across the joint Group portfolio is completed. Early progress includes the development of group-level governance structures, progress on RAAC mitigation cases, and initial planning for a converged digital and estates strategy.

3.7.2 However, there are still significant gaps, including unsecured RAAC replacement funding, variable compliance arrangements across the Group, incomplete Net Zero plans, and a lack of converged workforce and investment strategies. The Committee has reviewed the appetite and is proposing a Seek position, reflecting the need to pursue ambitious innovation with robust governance.

3.7.3 At this stage, the assurance rating is Inconclusive, pending the outcome of detailed baselining and programme development:

Committee Assurance Level *descriptors*	
Inconclusive	Progress is being made to close gaps in controls and assurance but not all actions have been completed on time or have yet had the desired impact. It is uncertain whether the current approach to managing this strategic risk will be sufficient to reduce the level of the risk to the target score within twelve months.
This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.	

4. Overall Board View

4.1 The Trust continues to face a range of material strategic risks across all BAF domains. In quality (BAF 001), the overall position is a moderate risk, with controls strengthening but persistent gaps in assurance leading to an inconclusive rating. Resources (BAF 002) remain under the greatest pressure, with fragile financial recovery and productivity delivery resulting in high exposure, and assurance therefore rated negative. Workforce (BAF 003) shows visible improvements through optimisation programmes, although progress is constrained by national shortages and financial recovery requirements, leaving the assurance position inconclusive. Integration (BAF 004) is supported by strong governance foundations, but delivery is still challenged by fragmented data and uncertain funding, which also results in an inconclusive assessment. Infrastructure (BAF 006) remains at an early baselining stage, with residual risk high until group-wide strategies are embedded, and the assurance level has been assessed as inconclusive.

4.2 Across the framework, BAF 002 (Finance & Productivity) stands out as the most acute, with the risk score now aligned to inherent levels and assurance judged to be negative. While there has been progress in quality, workforce, and integration, assurance remains incomplete and further work is required to close gaps. Infrastructure is a critical enabler of long-term transformation but continues to carry high residual risk until investment, planning, and governance arrangements are fully established.

5. Corporate Risk Register

5.1 The There are clear linkages between the BAF and the Corporate Risk Register (CRR). Red-rated risks on the CRR underpin several of the strategic risks, including those related to workforce shortages, maternity fragility, financial sustainability, medicines governance, and digital compliance. These operational risks provide important evidence of the pressures driving the higher-level BAF risks and highlight where gaps in assurance remain.

5.2 Recognising this interdependency, the CRR is scheduled to be refreshed with strengthened governance arrangements before the next Board presentation. This refresh will ensure clearer alignment between corporate and strategic risks, stronger escalation pathways, and more consistent oversight across committees.4. Recommendations

6. Risk Appetite

6.2 Risk appetite is defined as the decision about the level of risk that an organisation is prepared to accept, after balancing the potential opportunities and threats a situation presents. It takes into account the potential benefits of innovation and the risks that change inevitably brings.

6.3 Our Trust Board has defined its appetite for each of the five main types of risk facing NHS organisations: quality, financial, regulatory, workforce, and reputational risks

6.4 This matrix provides a consistent framework to guide decision-making, ensuring that committees and the Board can balance ambition with stewardship of public resources.

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	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.	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.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	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.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritize new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	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.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	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 chan.

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6.5 In Q2, each Committee has reviewed its risk appetite as part of the BAF refresh. Following these discussions the updated risk appetite statement for the Trust (to be published on the website is proposed and is detailed in Annex 1.

6.6 This refreshed articulation of risk appetite strengthens alignment across the Trust's governance structure, enabling a clearer link between operational risks on the Corporate Risk Register and strategic risks on the BAF. The Corporate Risk Register itself is due to be refreshed before the next Board presentation, with strengthened governance and escalation arrangements to ensure more consistent oversight and alignment with these agreed appetites.

7. Recommendations

7.1 The Board is asked to:

a) **Approve** the current position of the refreshed Board Assurance Framework (Q2 2025/26).
b) **Approve** the updated Risk Appetite Statement for 2025/26 for publication.
c) **Note** that the Corporate Risk Register will be refreshed with strengthened governance and alignment ahead of the next Board presentation.

Appendix 1: Risk Appetite Statement 2025/26
Appendix 2: the full BAF risks (in the Reading Pack)

ANNEX 1

Sandwell and West Birmingham NHS Trust

Risk Appetite Statement 2025/26

Definition

The Good Governance Institute (GGI) defines risk appetite as 'the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings and therefore should be at the heart of an organisation's risk management strategy.'

Good Governance Institute: Board guidance on risk appetite, 20201

Risk appetite levels

The Board accepts there will always be an element of risk in the pursuit of its aims and objectives. It is has determined, and will continuously assess, the nature and extent of the risks that the organisation is exposed to and is willing to take (its risk appetite) to achieve its objectives and ensure that planning and decision-making reflects this assessment.

Risk tolerance reflects the boundaries within which the executive team is willing to allow the day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the agreed risk appetite, in other words the residual risk. The Board has set specific limits (risk ratings) for the levels of risk that the organisation is able to tolerate. In setting these, risk factors in both the external and internal business environments have been considered.

The appetite level informs the target or acceptable level of risk to the organisation. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk to the lowest possible level that is reasonably practicable.

The risk levels for each category of risk have been defined through the context of existing organisational risks, issues, and consequences and are as follows:

- **For Quality:** we have adopted a **Cautious** appetite, reflecting the Trust's low tolerance for patient safety risk.
- **For Finance & Productivity:** we have adopted a **Cautious** appetite has been reconfirmed, emphasising that value for money is the overriding priority.
- **For Workforce:** we have adopted an **Open** appetite, accepting managed risks where innovation is required to secure long-term sustainability.

- **For Integration:** we have adopted an **Open** appetite has been reconfirmed, recognising that bold innovation and partnership are essential to deliver system benefits.
- **For Infrastructure:** we have adopted a **Seek** appetite, reflecting the ambition to pursue innovation and transformation opportunities in estates and digital while maintaining robust governance.

Paper ref:	PublicTB (09/25) 006

REPORT TITLE:	Place, Neighbourhoods and Population Health		
SPONSORING EXECUTIVE:	Sian Thomas, interim Chief Integration Officer		
REPORT AUTHOR:	Sian Thomas, interim Chief Integration Officer		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

Both Sandwell and West Birmingham place-based partnerships continue to lead the way in their integrated working. Of particular note this month for Sandwell is the submission to the national neighbourhood programme and the partnership sessions on home first, frailty and national fitness day. In West Brimingham the submission of our locality plan has demonstrated a strong understanding of our populations' needs and how partners in the West are thinking innovatively; the Team West event on 11 September will be an exciting opportunity for frontline staff across all partners to shape our West ethos.

In the wider integration agenda, our Community First work continues to progress well across a number of transformation areas, with this month's report focussing on frailty and the exciting work underway to push our already strong model further forward. Early positive benefits are already being seen from piloting palliative care in ED and supporting care homes with readmissions.

Finally, the paper highlights the work underway to develop our approach to data, and in particular how we think about and deliver 'population health'. While much of this work is in its infancy what we have enabled is a partnership and Trust wide conversation based on real data, demonstrating what we can do now; and what our data and/or technical gaps are and how important it is to build our future way of working on a comprehensive understanding of our population and its needs.

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		To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	X

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

The matters within this paper were discussed at Integration Committee on 2 September

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**Note** the work underway in the Sandwell and West Birmingham partnerships
b.	**Note** and support the work underway for Community First Frailty
c.	**Note** and support the work underway on data and analytics to support population health

5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*							
Board Assurance Framework Risk 01		*Deliver safe, high-quality care.*						
Board Assurance Framework Risk 02		*Make best strategic use of its resources*						
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*						
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*						
Board Assurance Framework Risk 05	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 10 September 2025

Place, Neighbourhoods and Population Health

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1. Introduction or background

1.1 This month's report provides an update on the significant progress made in both the Sandwell and West Birmingham partnerships. The work and agendas in both places are moving at an ever-increasing pace, with local buy-in and external interest also growing.

1.2 The update on the wider integration work, which includes health inequalities and primary-secondary care interface, focusses on community first this month. Highlighting the great work undertaken by our clinical and operational teams in designing and testing new approaches to frailty, the approach outlined shows how we can take co-design other pathways in the future.

1.3 Finally, the paper gives the Board an early insight into the significant work underway to build our data and intelligence capabilities in order to better equip the Trust and our partnerships with the tools needed to meaningfully think about, and deliver, in a population health model.

2. Sandwell Health and Care Partnership

2.1 In July the Partnership undertook the national Neighbourhood Health Maturity Self-Assessment. Structured to follow the six core components of the Neighbourhood Health Guidance, published in January 25, it sets out the expectation for successful neighbourhood working. The assessment also included four key enablers: system architecture, workforce, digital and leadership.

2.2 While completed at the Place level, several of the components and enablers are system led, and the assessed level is therefore not a reflection of local capability or capacity. Where local leadership is integral Sandwell is particularly mature in two of the core components, integrated intermediate care and urgent neighbourhood services, with more work to do on Neighbourhood Multi-Disciplinary Teams (MDTs). The full detail of the assessment can be found in Annex 1.

Figure 1 – summary neighbourhood self-assessment

Core Component	Local/ICB driven	Self-Assessment			
		Starting	Progressing	Achieving	Excelling
Population Health Management	ICB	X			
Modern General Practice	ICB	X	X		

Standardising Community health services	ICB	X			
Neighbourhood MDTs	Local	X			
Integrated Intermediate Care	Local				X
Urgent Neighbourhood services					X
Enablers					
System Architecture	ICB	X			
Workforce	ICB/Local	X	X		
Clinical & professional leadership	*Not assessed as no criteria released nationally*				
Digital	ICB/Local	X			

2.3 In August the Partnership submitted an application for the National Neighbourhood Health Implementation Programme. Designed to accelerate areas that are already progressing their neighbourhood model through access to tailored support, shared learning opportunities and the ability to influence national neighbourhood policy; we expect to hear the outcome in September with 42 areas being selected in a first wave.

2.4 Sandwell's application was supported by all partners and co-produced across health and care. The full application can be found at Annex 2.

2.5 Regardless of our place on the programme the aspirations and work outlined in the application will continue:

- Our DRAFT neighbourhood model pilots all commence in September
- A session with the Strategy Unit on approaches to evaluation has informed how we take forward our planning and impact assessment
- The last Board development session focussed on understanding our neighbourhoods; with draft town level dashboards developed including public health profiles, Trust data, family hubs, adult social care and public feedback.
- A successful Home First redesign session with adult social care colleagues on 27 August has given us a clear medium-term plan for how we further advance our integrated intermediate care model.
- A frailty pathway mapping session between acute, community and primary care is being undertaken in September to identify out of hospital proactive care opportunities
- The partnership is hosting an all-day event at MMUH on 24 September to celebrate National Fitness Day. Co-developed with Sandwell Leisure Trust there will be a range of free activities throughout the day as well as a healthy marketplace with stands from across the partnership showcasing what is available for people to support their own health and wellbeing. We are also using the day to test our approach with the Department of Work and Pensions by advertising the day to young people who are out of work due to health-related reasons.

Figure 2 – promotional material

3. West Birmingham Locality Partnership

3.1 BSoL has co-ordinated its locality and neighbourhood model across the system, with all localities required to submit a plan for their 'local delivery' of the 'system design'. As previously highlighted at Board, the plan was required to demonstrate how it would improve Urgent and Emergency Care (UEC) pathways for winter, roll out INTs and locality hubs as well as how it would impact the system agreed locality metrics outlined in figure 3.

Figure 3 – BSoL locality metrics

Indicator	Explanation	Supporting...	Aim
No. of Hospital Occupied Bed Days (OBDs) for the Locality population	To reduce the number and LOS of 'locality' residents in hospital, regardless of acute site across BSOl	Acute care bed pressures	Reduce
No. of Primary and Community Care Amenable Conditions in ED	To reduce the number of individuals presenting to ED, for whom their care and support could be provided within a community setting	Acute care ED pressures	Reduce
Total no. of 'hours' in ED for Mental Health service users, from point of arrival	To reduce both the number of MH presentations to ED along with the time spent within ED for the locality. Will consolidate presentations and LOS.	Acute care ED pressures	Reduce
No. of 'repeat' GP Contacts	Reduction in number of contacts per high-intensity patient (frequent attenders) following MDT input. (Indicates MDT support is helping to stabilise complex patients and reduce GP time burden)	General Practice	Reduce
Number of Pathway 1 patients on caseload for >42 day LoS	To reduce the number of people on Pathway 1 for over 42 days – with a subsequent impact on the home-based domiciliary care service	Adult Social Care / Community Care	Reduce

3.2 The West Locality plan was fully endorsed by the Community Care Collaborative in its August meeting. The full plan is attached at Annex 3, with a few highlights to note:

- West Birmingham has a younger diverse population with some of the poorest outcomes for early childhood development, infant mortality, and childhood immunisation & vaccines. Suicide and drug and alcohol misuse are particularly high
- These population outcomes have informed our better mental health and prevention priorities, while the system ask of localities around UEC is being delivered through our third priority of improving access.
- The majority of people in the West attend ED at SWB (76%) followed by the QE (13%); and while most inpatient care is also delivered at SWB (67%) the proportion relative to those who are admitted to QE (15%) is lower.
- There are some notable differences in who attends which Trust (gender and ethnicity in particular) as well as some key difference in what people attend for (paediatrics).
- As a partnership we are responsible for our population regardless of where they receive their hospital care, therefore the West Locality hub must work effectively across two hospital Trusts to prevent admission and facilitate discharge. Our model will make use of the tools developed by SWB and BSoL, and builds on our successful relationships across two community care providers.

3.3 A 'Team West' event on 11th September, involving clinical and operational leaders from across the partnership, will support colleagues to get to know one another and involve frontline staff in shaping how the West delivers its plan, thereby creating a West identity and ethos.

4. Wider Integration work

4.1 Community First

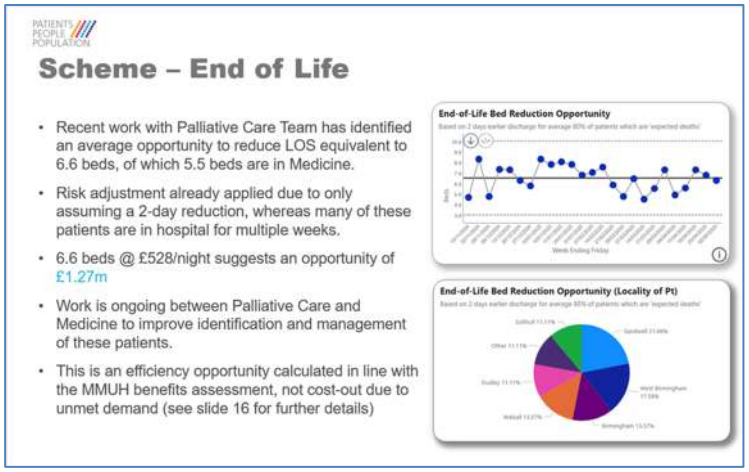
4.1.1 The community first work programme continues to progress all of its key transformation priorities however this month's Board report focuses on frailty, due to the potential for this to be a major programme of work across all partners.

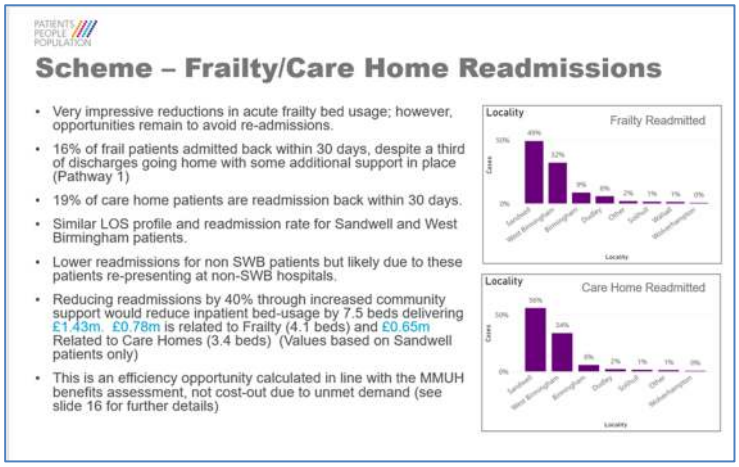
4.1.2 While the Trust is recognised regionally for its work with care homes, end of life (EoL) care and reducing the likelihood of people over the age of 65 being admitted to hospital our data shows we can go further and support more people to stay at home and receive community care.

4.1.3 Four pilots were agreed through a series of clinical MDT workshops to rapidly test new ways of working - palliative care in ED, Geriatricians & GPs in the Care Navigation Centre, care home readmission wrap and a GP led proactive frailty MDT. Palliative care and care homes have already gone live, with early positive findings. A high-level summary of the work is outlined in figure 4.

Figure 4 – Developing our frailty model to the next level

1. Taking a data driven approach to identifying and confirming opportunities





2. Clinically led redesign and identification of pilots

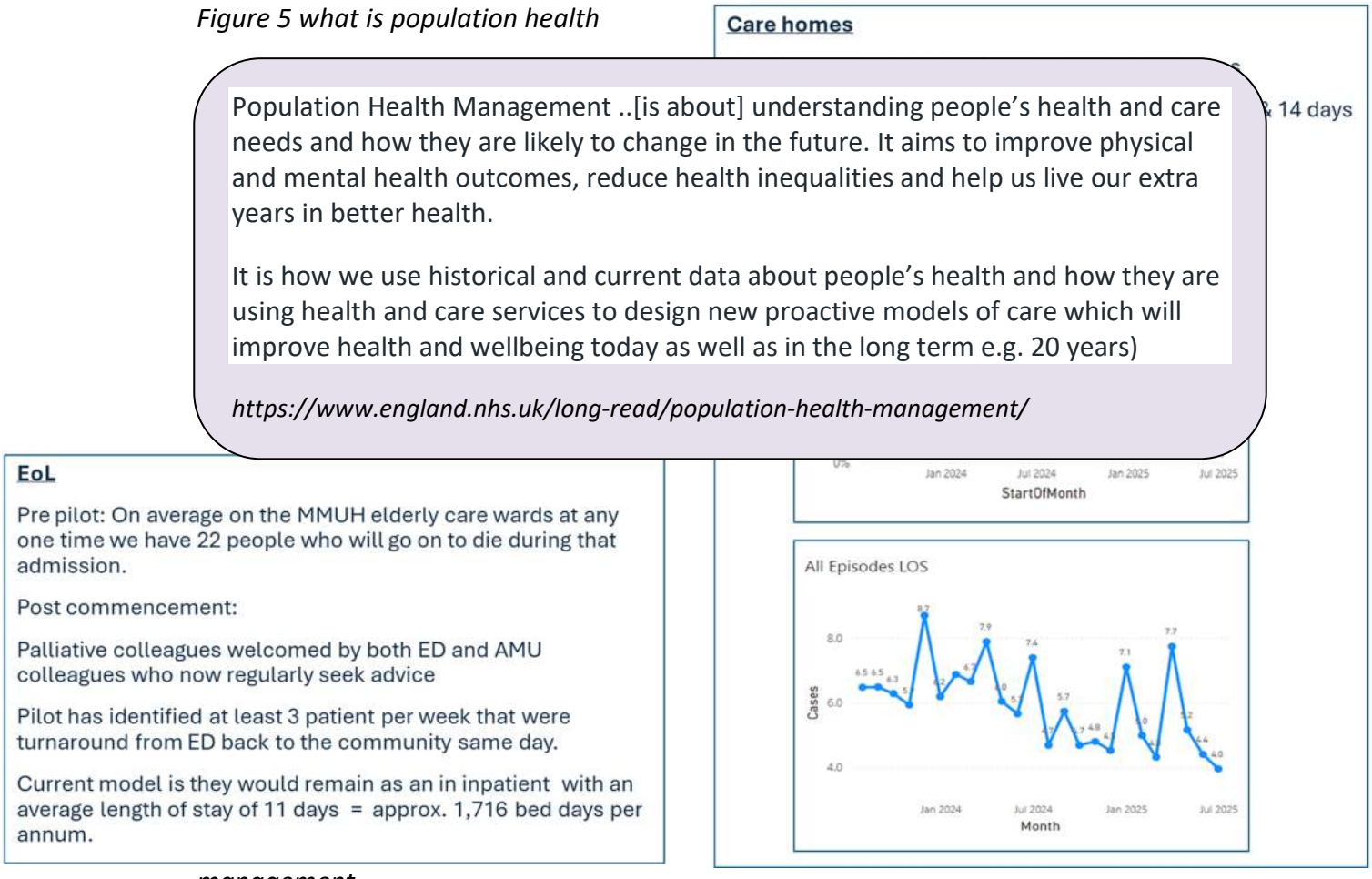
3. Early benefits identification

4.2 Integration enablers and population health

4.2.1 In order to ensure our integration work is focusing on the right areas, we are evidencing impact and making the case for how we can improve our efficiency (both savings and investment) good quality information is integral.

4.2.2 Moving towards a population health management approach, which is a core component of becoming an Integrated Health Organisation (IHO), also requires a level of information integration, analysis and routine frontline and strategic use that is currently ad-hoc or undeveloped.

Figure 5 what is population health management

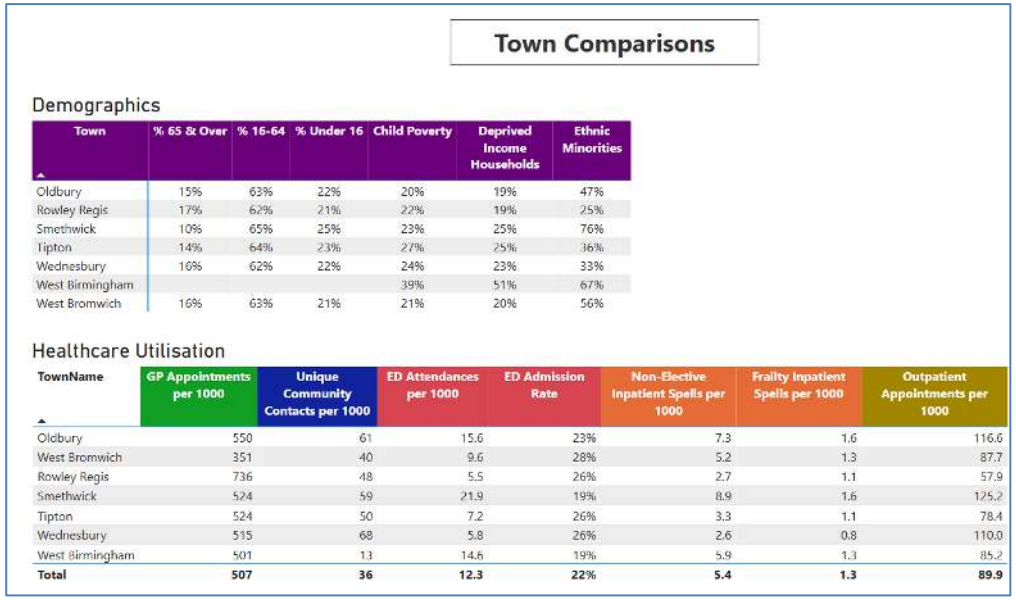


4.2.3 Significant progress has been made in the analytical and business intelligence available to improve both direct care delivery and inform pathway transformation, allowing us to start

both MDT (Trust specific) and partnership wide conversations. The figures on the next few pages demonstrate:

- how we are developing **data driven insights** at a borough and neighbourhood level to inform our strategic focus (figure 6)
- how we understand healthcare utilisation and its associated costs to both **risk stratify** people who would benefit from **proactive case management** and identify how we could 'left shift' **spend at a patient level** (figure 7)
- How we learn from our current operations as a 'mini-IHO' for the registered primary care population of our in-house GP services (figure 8)
- How we give clinicians access to the right data to support **real time decisions** about changing care pathways (figure 9)

Figure 6, Integrated neighbourhood team dashboard: combining public health, primary care and Trust data at town level, enabling us and partners to understand differences in access, use and outcome.



Town Comparisons

Demographics

Town	% 65 & Over	% 16-64	% Under 16	Child Poverty	Deprived Income Households	Ethnic Minorities
Oldbury	15%	63%	22%	20%	19%	47%
Rowley Regis	17%	62%	21%	22%	19%	25%
Smethwick	10%	65%	25%	23%	25%	76%
Tipton	14%	64%	23%	27%	25%	36%
Wednesbury	16%	62%	22%	24%	23%	33%
West Birmingham				39%	51%	67%
West Bromwich	16%	63%	21%	21%	20%	56%

Healthcare Utilisation

TownName	GP Appointments per 1000	Unique Community Contacts per 1000	ED Attendances per 1000	ED Admission Rate	Non-Elective Inpatient Spells per 1000	Frailty Inpatient Spells per 1000	Outpatient Appointments per 1000
Oldbury	550	61	15.6	23%	7.3	1.6	116.6
West Bromwich	351	40	9.6	28%	5.2	1.3	87.7
Rowley Regis	736	48	5.5	26%	2.7	1.1	57.9
Smethwick	524	59	21.9	19%	8.9	1.6	125.2
Tipton	524	50	7.2	26%	3.3	1.1	78.4
Wednesbury	515	68	5.8	26%	2.6	0.8	110.0
West Birmingham	501	13	14.6	19%	5.9	1.3	85.2
Total	**507**	**36**	**12.3**	**22%**	**5.4**	**1.3**	**89.9**

Integrated Neighborhood Teams

Sandwell and West Birmingham Hospitals NHS Trust

Data Period June 2025

Emergency Care

Oldbury | West Bromwich | Rowley Regis | Smethwick | Tipton | Wednesbury | West Birmingham

Attendances Per 1000 Of Registered Population

18

Moderate/Severe Frail Attendances per 1000 of Registered Population

2

Outcome

76.2% Home

23.1% Admitted

Age Group

80+ 10%, 65to<80 12%, 30to<65 39%, 17to... 15%, <17 24%

Frailty Score (where recorded)

1 - Very... 2%, 2 - Well 11%, 3 - Managing... 24%, 4 - Vulnera... 23%, 5 - Mildly Frail 22%, 6 - ... 12%

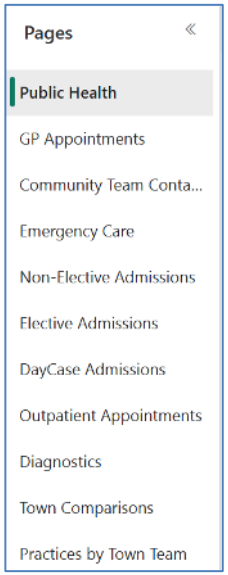
Arrival Mode

Walkin 69%

Ambulance 31%

Top 10 Chief Complaints

Chief Complaint	% Of Total
Injury of hip / leg / knee / ankle / foot	20%
Injury of shoulder / arm / elbow / wrist / hand	18%
Abdominal pain	17%
Short of breath	14%
Generalised weakness	11%
Pain in hip / leg / knee / ankle / foot	5%
Vomiting + / - nausea	4%
Backache (no recent injury)	4%
Headache	3%
Seizure (fit)	3%



Pages

- Public Health
- GP Appointments
- Community Team Conta...
- Emergency Care
- Non-Elective Admissions
- Elective Admissions
- DayCase Admissions
- Outpatient Appointments
- Diagnostics
- Town Comparisons
- Practices by Town Team

Integrated Neighborhood Teams

Sandwell and West Birmingham Hospitals NHS Trust

Public Health

Oldbury | West Bromwich | Rowley Regis | Smethwick | Tipton | Wednesbury | West Birmingham

Oldbury town facts and figures

54,929 residents — 3rd highest in Sandwell 2021

11,868 under 16s — 3rd highest in Sandwell 2021

34,751 16 to 64 — 3rd highest in Sandwell 2021

8,310 65 and over — 3rd highest in Sandwell 2021

47% Ethnic minorities — 2021 England: 27%

29% of children's first language is not English — 2019 England: 19%

79% of migrant National Insurance number registrations: India, Nigeria & Pakistan — 2021-2

19% living in income deprived households — 2019 England: 13%

20% of children in poverty — 2019 England: 17%

60.7 per 1,000 Claimant count — June 2023 England: 41.1

Figure 7 – Patient level healthcare use of SWB services, linked to cost

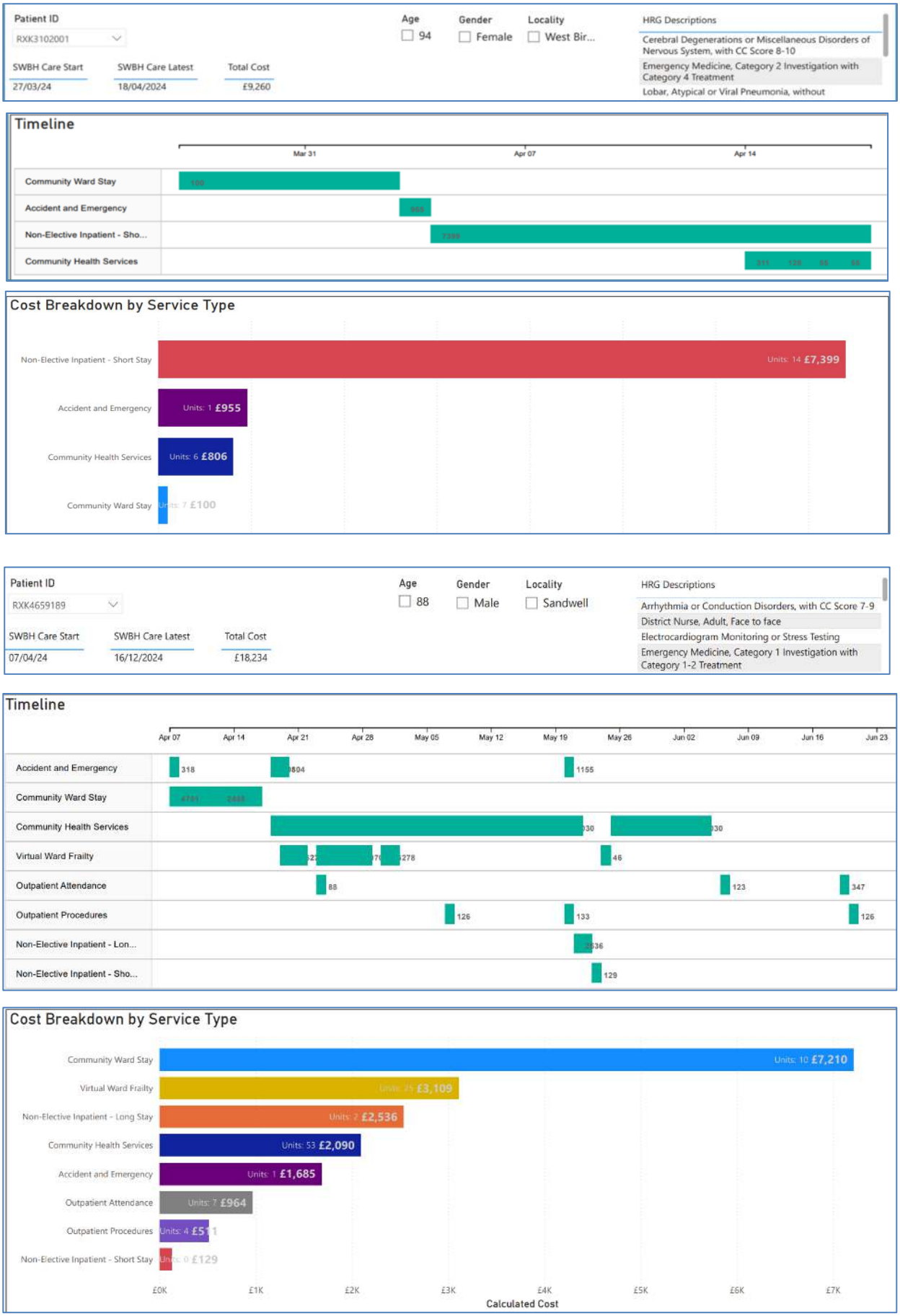
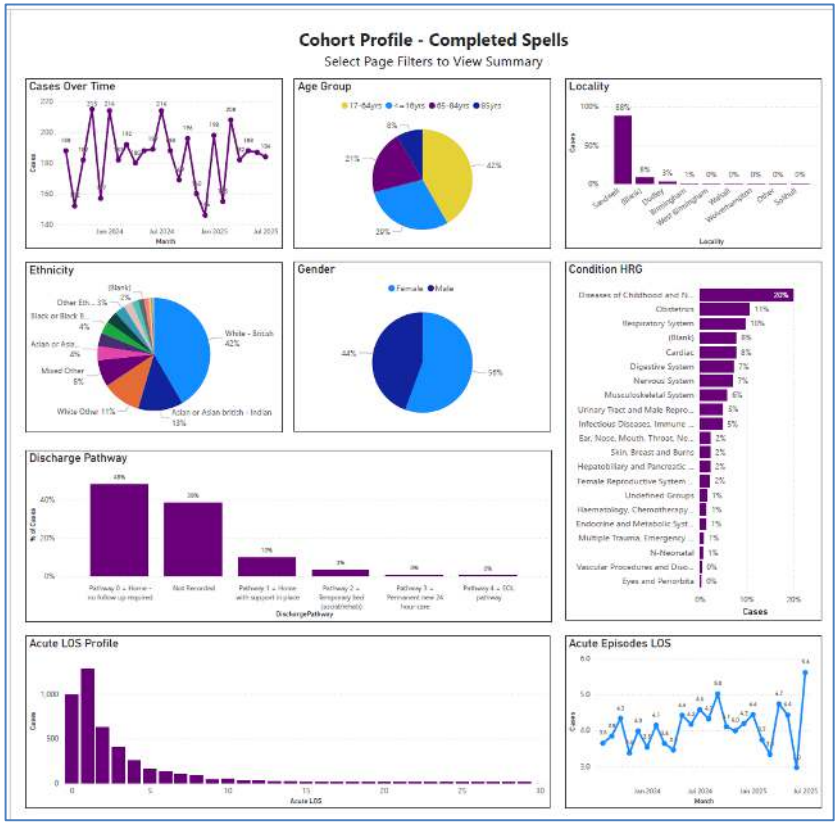


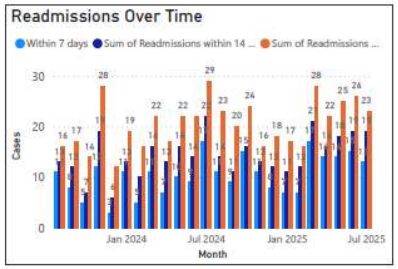
Figure 8 – how is the YHP registered population using SWB services?

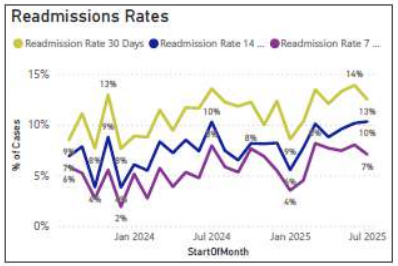


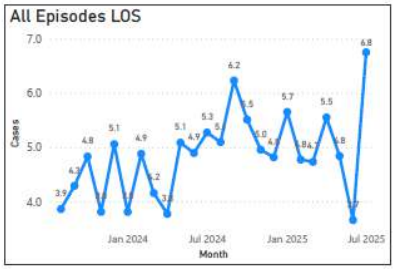
Top 20 Patients for Inpatient Overnight Bed Days - By Discharging Acute Specialty

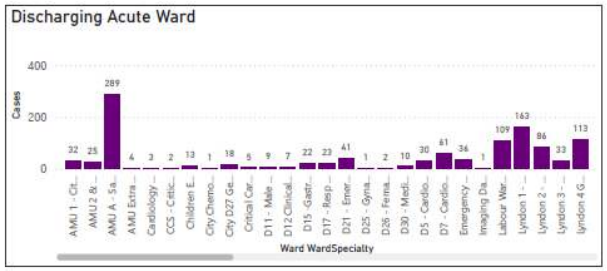
Last 24 Months, Non-Elective Only

NHSNumber	Acute Internal Medicine	Clinical Haematology	General Medicine	Geriatric Medicine	Respiratory Medicine	Stroke Medicine	Trauma & Orthopaedics	Total
[redacted]						104		104
	17		111					48
	70							70
			49					49
						85		85
							54	54
							56	56
	54							54
	63							63
					49			49
						79		79
							56	56
				77				77
						55		55
						65		65
	73							73
	20	22				148		53
		1			195			98
						98		98
				58				58
Total	45	15	111	49	63	122	91	55	65









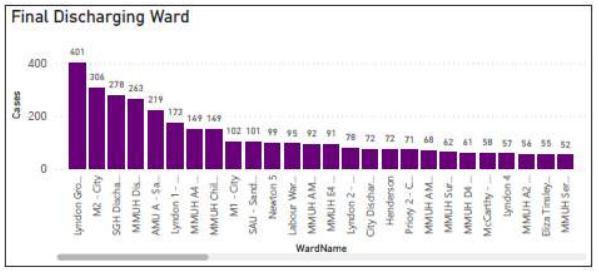
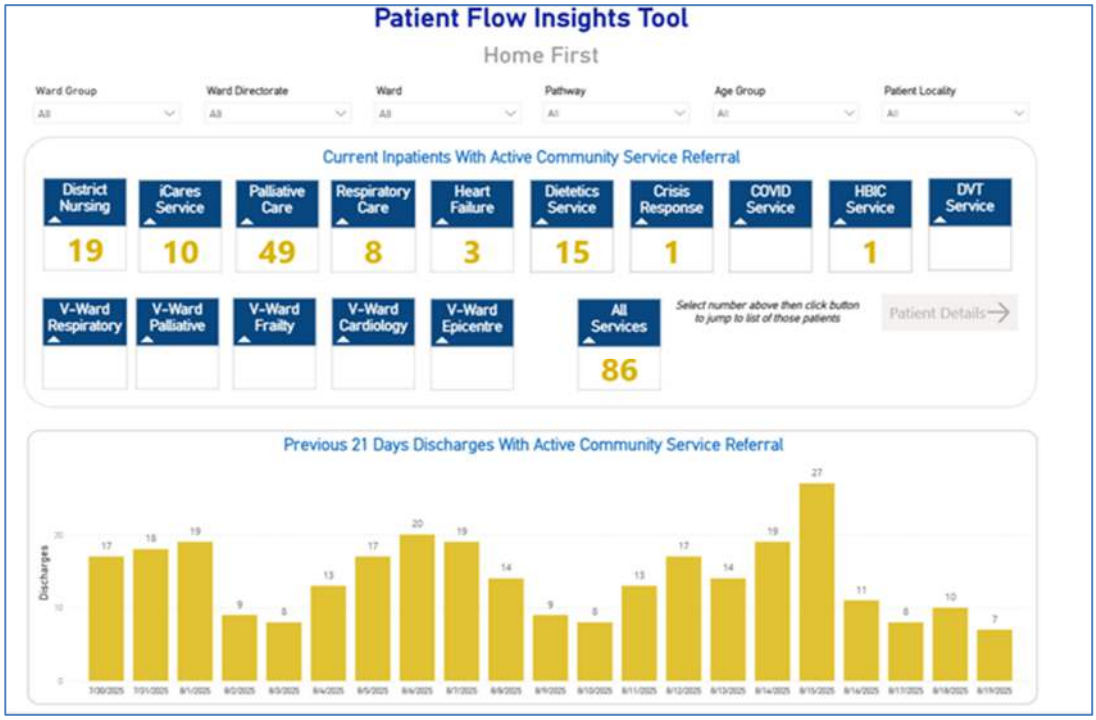


Figure 9 – Community Patient Flow Insights Tool (PFIT)

A live dashboard, traditionally used by medicine to manage bed flow, the tool has been updated to include flags for patients in beds who are from a care home, EoL, frail or known to community services. This will be displayed within the CNC enabling community teams to proactively identify patients to pull into the community.



4.2.4 Much of this work is in its infancy and these tools will be tested through partnership conversations, clinical audits and 'mock MDTs'. What the final set of key measures, both strategically and tactically, will look like may change however, what we have enabled is a conversation based on real data, demonstrating what we can do now and what our data and/or technical gaps are and how important it is to build our future way of working on a comprehensive understanding of our population and its needs.

5. Recommendations

5.1 The Public Trust Board is asked to:

a. **Note** the work underway in the Sandwell and West Birmingham partnerships
b. **Note** and support the work underway for Community First Frailty
c. **Note** and support the work underway on data and analytics to support population health

Sian Thomas
Interim Chief Integration Officer

Monday, 01 September 2025

Annex 1: Sandwell Neighbourhood Maturity Assessment
Annex 2: Sandwell application to the National Neighbourhood Health Implementation Programme
Annex 3: West Birmingham Locality Plan

Paper ref:	PublicTB (09/25) 007

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS Sandwell and West Birmingham NHS Trust

REPORT TITLE:	CNO/CMO Report		
SPONSORING EXECUTIVE:	Diane Wake – Chief Executive Officer		
REPORT AUTHOR:	Melanie Roberts, Chief Nursing Officer Mark Anderson, Chief Medical Officer		
MEETING:	Public Trust Board	**DATE:**	10/09/2025

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

The report updates Trust Board on areas within the CNO/CMO Portfolio as follows:

- Alert – CT/MRI Backlog, TRIFECTA Valves
- Advise – Penny Dash report, CQC Ionising Radiation (Medical Exposure) Regulations (IRMER) Report, CQC Self-Assessment update
- Assure – Antimicrobial Antibiotic Usage, Infection Control, Paediatric Audiology, PSIRF, Surgical award finalist.

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		To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	

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

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the report and offer any feedback on the content
b.	**DISCUSS** the two areas highlighted in the ALERT Section

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

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

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 10 September 2025

CMO/CNO Report

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1. ALERT

CT/MRI Scan Backlog

1.1 There are backlogs in both the scanning and reporting areas within Radiology both which give rise to increased risk of harm and increased administrative burden across the Trust and Primary Care, as well as reduced patient experience. The increase in backlog has been due to a number of different factors including increased demand, introduction of improved pathways and static/reduced reporting capacity not mirroring increased scanning activity.

1.2 The Group has undertaken a number of immediate actions to reduce the backlog and reduce the risk as well as implementing a harm review process.

1.3 As a result of the backlogs, there needs to be a significant scrutiny of the quality and safety risks associated with such backlogs. There have been a couple of incidents in relation to the backlog of the reporting backlog which have been raised by primary care, either through incidental findings or where delay has caused potential harm. As a result, the following actions have been taken to review potential harm and also to reduce the risk, whilst appreciating the main methodology of risk reduction will be to reduce/remove current backlogs across both domains (scanning and reporting):

1. Harm reviews undertaken on incidents where harm/potential harm has been identified
2. MRI reporting backlog – two consultants have reviewed the largest backlogs (head and spine). Review being undertaken where a finding can be seen and prioritisation for reporting and/or full reporting being undertaken where concerns raised.
3. Immediate outsourcing of all urgent patients over 4 weeks for MRI backlog.
4. Immediate outsourcing of 1000 longest waiting GP Direct Access routine (Cat 1 and Cat 3) and 1000 longest waiting Cat 5 reports
5. Review of reports where findings have been flagged and has delay caused potential harm

1.4 The harm review process has been undertaken on over 150 longest waiting MRI spines and 20 have identified where findings have been found where the report should be expedited. This has resulted in the report being either hot reported or sent out via outsourcing for urgent Turnaround reporting. To prevent further backlog and support a seamless transition to outsourcing if the reports are unable to be reported internally (job planned/insourced) an updated SOP will be written to provide clear timelines to the clinical, operational and admin teams to support the outsourcing of the reports.

Trifecta heart valves

1.5 Background:

i. Valve name: Trifecta (type 1and GT) manufactured by Abbott and approved in 2016; withdrawn in July 2023.
ii. Type of valve: Tissue valve used for replacement of stenosed (narrowed) or regurgitant (leaky) native aortic valves.
iii. Problems with the valve: Early structural valve degeneration (SVD) is noted at 3-5 years after implantation more frequently than seen with other tissue valves.
iv. Recommended follow-up: Transthoracic Echocardiogram to be performed 1-3 months after valve has been implanted, thereafter annually to assess the valve.

1.6 SWBH Patients: Valve insertions are performed at New cross but long term follow up is devolved locally. Issues with the valve started to surface in July 2020 and an email with an excel spread sheet labelling 31 patients as "SWBH" was sent to us from New Cross. We took the initiative to organise enhanced surveillance for this group of patients.

All of the 31 patients listed as SWBH were under enhanced monitoring for valve dysfunction by our specialized Valve team.

A patient with a Trifecta valve, who was not on the original "SWBH" list was admitted and sadly passed away in late February 2025 (INDEX patient). This led to further analysis of the original spread-sheet sent from New Cross resulting in 13 additional patients being identified after they did a comprehensive review of their master list of all patients.

Of these 13 patients that were not flagged to us as needing enhanced monitoring, 6 are still alive and 7 have passed away.

1.7 SWBH actions since identifying the issue.

i. *6 patients who are alive:*
These patients have undergone clinic review, urgent echocardiogram, and duty of candour.
ii. *7 patients who passed away:*
2 patients: were already on enhanced surveillance with satisfactory echo parameters
2 patients: were on routine surveillance of whom 1 passed away with valve dysfunction (INDEX patient) and 1 passed away due to non-valve related cause
1 patient passed away within a year of the valve being implanted –cause unknown
2 patients: were not on routine or enhanced surveillance of whom 1 passed away due to valve dysfunction. For this patient, our valve team are working with the patient safety team and seeking to contact the family and perform duty of candour.

Our team continues to liaise with New Cross over patient lists. The valve is no longer in use.

2. ADVISE

Penny Dash Report

2.1 As shared at the recent Joint Trust Board session, the Penny Dash review of 6 regulators has been published. The review was commissioned by the Secretary of State for Health & Social Care. It examined 6 key bodies and found several key themes such as:

- Fragmentation and overlap among oversight bodies create inefficiencies and confusion.
- Excessive recommendations often lack cost-benefit analysis and are poorly coordinated.
- A narrow focus on safety has led to underinvestment in other care quality dimensions: effectiveness, experience, equity, leadership.
- Strategic leadership is weak, the National Quality Board (NQB) lacks influence and direction.
- Patient and staff voices are undervalued or inconsistently acted upon.
- The NHS complaints system is fragmented and slow.
- Data and analytics are underused to drive improvement.
- No national strategy exists for adult social care quality.

2.2 The outcome of the report was 9 recommendations for which a quality delivery plan is being developed but this will mean enhanced governance for provider Trusts.

CQC Ionising Radiation (Medical Exposure) Regulations (IRMER) Visit

2.3 On the 18th June the Trust received a CQC IRMER Visit. We have now received the report for factual accuracy checking and the report overall was positive with 3 areas for improvement. The full report, when received, will be shared with Quality Committee. This was part of the routine IRMER Visits across Trusts which have been prioritising any new hospitals or Trusts they haven't visited for a long period of time.

CQC Internal Self Assessments

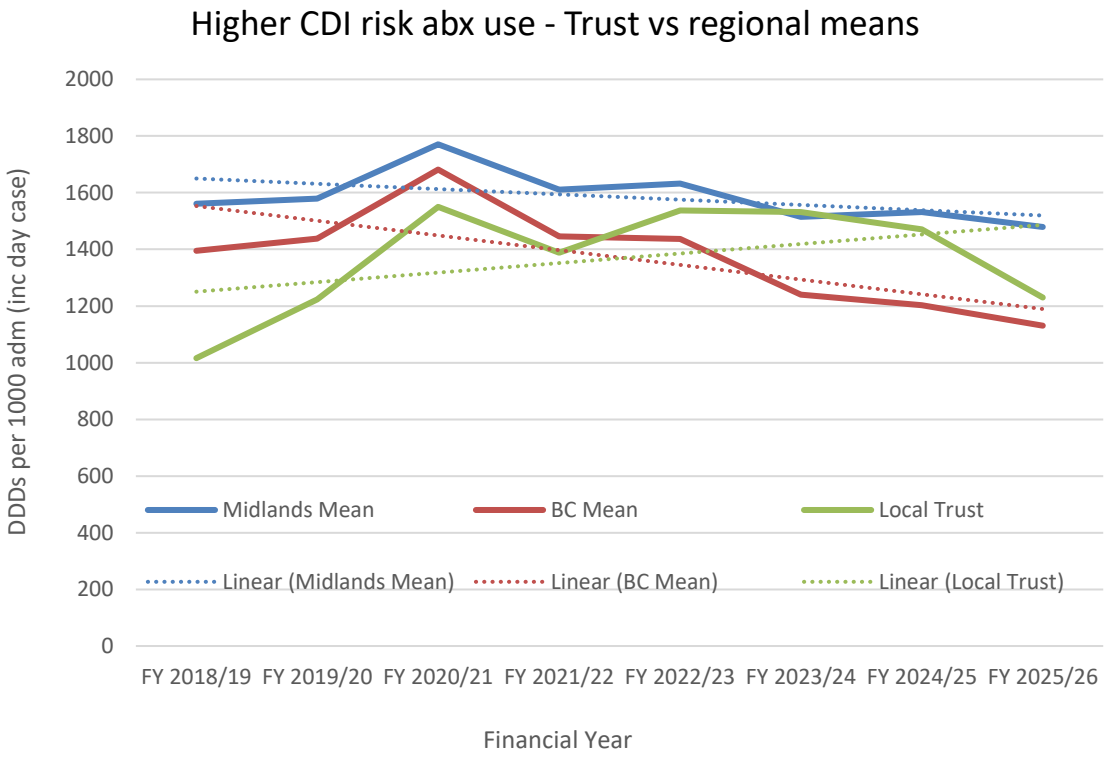
2.4 CQC Self Assessments have been completed for SWB for each Directorate and then compiled into overarching returns for each Core Service. There has been good engagement from all clinical groups. Some areas having had CQC Inspections (Maternity and ED) have been able to reflect in their self-assessments, the work undertaken subsequent to these inspection visits. The scoring methodology used at SWB for this round is more robust as it requires scoring each of the six different evidence categories, rather than providing overall scores for the quality statements. Some services have given themselves reduced ratings due to the lack of evidence they can provide. This is subject to change after validation which is ongoing amongst the executive triumvirate. Returns have been validated by Trust Leads / Subject Matter Experts and are now undergoing Executive Director Validation in readiness for presentation at September Quality Committee and October 2025 Black Country Provider Collaborative Board.

3. ASSURE

Antimicrobial work and improvement in high-risk antibiotic use

3.1 The Trust has an overall antimicrobial action plan to support the work we are doing on reducing C. Difficile which is being managed by the Quality Committee. Overuse of antibiotics can

contribute to C. Difficile. Last year the Trust was above target for the number of cases, as opposed to this year, the numbers remain on target as a result of the work that the team have been undertaking to ensure the correct antibiotics are prescribed when needed. The graph below shows our progress in reducing the risk of C. Difficile antibiotic usage across the Trust.



PSIRF

3.2 The patient safety team have been invited to present our PSIRF approach in the national PSIRF webinar in January. Planning will start in October

Paediatric Audiology

3.3 Further to previous reports to Trust Board and Quality Committee Audiology and Newborn Hearing Screening had a 2-day on-site visit as part of the United Kingdom Accreditation Service (UKAS) Improving Quality in Physiological Science (IQIPS) programme on 23rd and 24th June 2025. An assessment manager conducted a management and operational review with the Audiology Management Team and a team of six technical assessors observed appointments in Adult rehabilitation, Paediatric assessment and rehabilitation, newborn screening and vestibular assessment. The team assessed practice and facilities at multiple locations across the Trust. A lay assessor also examined the service from a patient experience perspective.

3.4 The recommendation from the assessment was for the service to maintain it's accreditation, subject to the satisfactory completion of corrective actions for 25 mandatory findings by 13th August 2025. These included issues with facilities, clinic scheduling, safeguarding alerts, document archiving, and minor documentation or technical improvements. Overall the assessment team we impressed with the services embedded quality management system,

openness to improvement and the clinical quality and caring attitude demonstrated by the staff. A full assessment report will be presented at Quality Committee on 24th September 25.

Infection Control

3.5 During 2024-25, the focus of the year for the IPC Team was the opening of the Midland Metropolitan University Hospital. The IPC Team worked closely with Estates and the site contractors to ensure effective IPC was built into the environment both during the final stages of construction and during fitting out of the building. The IPC Team also advised on IPC compliant consumables including patient chairs. Learning from the Covid-19 pandemic included the importance of effective ventilation and the installation of compliant ventilation systems and the provision of 50% single rooms in the new building, which has likely contributed to minimising outbreaks of respiratory infections such as influenza. There were very few outbreaks of respiratory infection at the new hospital site (MMUH) with just 3 small outbreaks of influenza consisting of 2 patients on each occasion during the 2024-25 winter season.

3.6 During 2024-25 there were 85 cases of Trust attributable Clostridioides difficile infections against an NHS England target of no more than 52 cases. This compares to 55 cases during 2023-24. However, a similar increased position has been reported at the other local Black Country Acute Trusts. In addition, NHS England and UKHSA have acknowledged a national increase and are taking steps to investigate and understand why this has occurred. However, for Q1 of 2025-26 Clostridioides difficile has remained on trajectory with 13 cases during April to June 2025 against a trajectory of no more than 13. There is continued focus on antimicrobial prescribing including continued challenge on consumption of broad-spectrum agents via clinical audit, prescriber feedback and prescribing guideline changes. Sustained positive changes in consumption are evident from end of 2024, including in reduction in consumption of Co-amoxiclav, an antibiotic known to trigger Clostridioides difficile infection.

3.7 During 2025-26 there will be increasing cooperation with Dudley Group with the two IPC teams increasingly sharing information on policy and practice and the teams look forward to continuing to work together.

Silver Scalpel Award finalist

3.8 Mr Diwakar Sarma, Consultant General and Colorectal Surgeon at our Trust, was shortlisted for the **2025 Silver Scalpel Award**, one of the most prestigious accolades in UK surgical education.

Now in its 26th year, the Silver Scalpel Award is run by the Association of Surgeons in Training (ASiT) and recognises surgical consultants who go above and beyond in nurturing the next generation of surgeons. This honour is particularly meaningful as it is nominated by trainees themselves, following a rigorous national selection process that evaluates leadership, professionalism, accessibility, development of trainees, and the creation of a positive and inclusive training environment.

3.9 The association wrote to us saying; 'To be shortlisted for the Silver Scalpel Award is, therefore, not only a personal achievement, but it is also a powerful reflection of your Trust's commitment to high-quality care, inclusive leadership, and professional excellence. This year's shortlist represents the very best in UK surgical training, and Diwakar Sarma was amongst only six shortlisted.'

4. Recommendations

The Public Trust Board is asked to:

a. **NOTE** the report and offer any feedback on the content
b. **DISCUSS** the areas highlighted in the ALERT Section

Mark Anderson, Chief Medical Officer,
Mel Roberts, Chief Nursing Officer
Sept 2025

Paper ref:	PublicTB (09/25) 008

REPORT TITLE:	Winter Plan Board Assurance Statement		
SPONSORING EXECUTIVE:	Johanne Newens COO		
REPORT AUTHOR:	Johanne Newens COO		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

As part of the NHS England winter planning round all boards are required to complete a Board Assurance Statement (BAS). This statement includes a requirement to ensure that winter plans have been produced with consideration to the wider system that an executive lead has been identified and that key risks to quality have been considered.

Within the BAS that is presented to board reference is made to the fact that the trust Winter pan 25/26 was approved at the Board meeting in July where the above points were covered.

The final key element that the board needs to be assured of is that the trust will take part in a winter resilience exercise. The Midlands regional winter planning stress test exercise scheduled for 17th September 2025 and all lessons learned from this will be incorporated into our winter plan refresh.

There is a requirement to submit the BAS to the national Urgent an emergency Care Team by the 30th September.

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		To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	

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

None however the winter plan has been shared with the Black Country ICB and approved and shared with the Black Country Provider Collaborative clinical leads forum

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**Approve** the Winter Planning Board Assurance Statement
b.	
c.	

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

Winter Planning 25/26

Board Assurance Statement (BAS)

Sandwell & West Birmingham NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Presented and approved at Trust Board 9th July 2025
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Included as part of the Trust Winter Plan with mechanisms for monitoring the impact on quality and safety over the winter period.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Winter Planning workshop 24th June 2025. Plan shared with the ICB for comment and feedback. This was approved by the ICB. It was also presented at Black Country clinical leads group.
The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.		Regional Winter Planning Stress Test Exercise scheduled for 17th September 2025
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Johanne Newens Chief Operating Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		Presented and approved at Trust Board 9th July 2025
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		Presented and approved at Trust Board 9th July 2025. These will be considered on a monthly basis at the trusts Quality Committee

Provider:	Double click on the template header to add details

The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.		Presented and approved at Trust Board 9th July 2025. This will be monitored monthly at the trusts Finance and Productivity Committee

Provider CEO name	**Date**	**Provider Chair name**	**Date**
Diane Wake	10/09/2025	Sir David Nicholson	10/09/2025

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Approach and delivery outlined in plan. July to September- Engagement and recruitment of vaccinators. September to December- Communication and vaccination (majority vaccinated by the end of November).
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Four scenarios based on bed occupancy and length of stay. Included modelled increases in bed occupancy applied to assessment units and direct access wards.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Review at Clinical Group level across all specialties.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Data reviewed daily. Strategies to optimise discharges over weekends included in Clinical group level interventions.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Clinical group interventions include specific actions related to planned care delivery.
Infection Prevention and Control (IPC)		

6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Engaged with during the planning phase for vaccination.
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Ongoing as new staff are recruited.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	In place and all relevant teams aware.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	In places as BAU
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	In place as BAU with clear escalation processes.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

Paper ref:	PublicTB (09/25) 009

Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Perinatal update Report to Public Board of Directors		
SPONSORING EXECUTIVE:	Melanie Roberts, Chief Nurse Mark Anderson, Chief Medical Officer		
REPORT AUTHOR:	Clare Cheatham, Head of Midwifery Lakshmi Thirumalaikumar, Obstetric Clinical Director Penny Broggio, Neonatal Clinical Director Joanne Treacy, Directorate General Manager		
MEETING:	Public Board of Directors	**DATE**	10th September 2025

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

The biannual Maternity and Neonatal staffing report can be found in the reading pack The report outlines current position with staffing levels, as well as plans for the commencement of a BIRTHRATE plus calculation. Contents of this report support compliance with Maternity Incentive scheme year (MIS) 7, and associated mitigations.

The Maternity Outcomes Signal System (MOSS) has been developed by NHS England in response to the first recommendation in the Reading the Signals East Kent report to 'identify valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers for national mandatory use'. MOSS aims to identify signals about potential critical safety issues in maternity intrapartum care that could lead to adverse outcomes and is intended to be used as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQOM). As part of the Pilot programme, the Directorate Senior Leadership Team have completed a critical safety check of Intrapartum services to identify any immediate concerns or learning from incidents, which will be shared with the Maternity Safety Champions group for oversight.

The NHS England 2-day diagnostic review was completed on the 24th and 25th July 2025. Formal feedback from the visit has now been received, and next steps will be developed and communicated to the Quality Committee and Maternity safety champions.

The directorate is on track to meet six safety actions of the **Maternity Incentive scheme year 7** as of the end of July 2025, with additional work required to meet the requirements for a further four, details are highlighted within the report.

The Perinatal team are are undertaking a number of interventions, directly focused on reducing Perinatal mortality. A summary of the interventions are included in the paper:

- Pregnancy journey and risk assessment
- Preterm birth prevention
- Intrapartum care
- Triage process
- Induction of labour processes

- Saving babies lives compliance
- Supporting those living in the most deprived areas.

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

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

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**Discuss** and challenge the report in particular noting the alert section
b.	**Note** the diagnostic review undertaken by NHS England on the 24/25th July
c.	**Discuss** the perinatal mortality interventions outlined in the report

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 10th September 2025

Maternity Report

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1. Introduction

This paper supports Board level oversight for the Perinatal service which is fundamental to quality improvement, to ensure transparency and safe delivery of services. The paper focuses on the key focus of the Perinatal Directorate to reduce perinatal mortality, highlighting work on four key priorities to achieve this.

2. Key Items for Escalation

Key Items for Escalation
ALERT - Alert to matters that require the Quality Committee's attention or action
MNSI Escalation A letter of escalation of concern was received from the Maternity and Newborn Safety Investigation programme (MNSI) on the 27th of July relating to four cases involving care in Maternity Triage dating from August 2024 to March 2025. The concerns related to the length of time between arrival and initial assessment, and delay in ongoing care. **Action:** An action plan has been developed in response to the concerns raised, including the actions already underway following recommendations from completed investigations, and completed actions resulting from the completed CQC Section 29a. A Triage Improvement Group is in place, meeting weekly to drive improvements within the service. A copy of the action plan is provided within the reading room. **Triage** BSOTS standards for timely doctors' review is not met. The current percentage of timely doctor review across all the BSOTS categories remains poor at 20% on an average across all the categories. The audits have highlighted an element of poor documentation. More than 40% of the time we are not documenting as to when the doctor was called and when the doctor attended. Where there is documentation about the time when the doctor was called, the BSOTS standards are met only in 45% on an average across all the categories. **Actions completed so far to ensure adherence to BSOTS standard:** • To improve timely documentation, additional shared laptops have been allocated for doctors. New doctors (Induction Programme) and midwives (through the Triage Improvement Group meetings) have received education and training on the importance of documentation. A Quick Reference Guide has been distributed to the team members showing correct Badger Net documentation. A snapshot audit is

planned to assess the uptake of this training.

- Posters on the Roles and Responsibilities for Triage doctors and the BSOTS standard timeframes for Triage Medical Review are displayed in the clinical areas.
- Workforce review- Additional doctors in Triage funded to cover 12 hours per day, 7 days per week, commenced 1/9/2025.

Maternity Outcomes Signal System (MOSS) Pilot

The Maternity Outcomes Signal System (MOSS) has been developed by NHS England in response to the first recommendation in the Reading the Signals East Kent report to 'identify valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers for national mandatory use'.
MOSS aims to identify signals about potential critical safety issues in maternity intrapartum care that could lead to adverse outcomes and is intended to be used as part of routine safety monitoring within the Perinatal Quality Oversight Model (PQOM).

The Trust are a pilot site for implementation of the new tool, which went live with data from January 2025 on the 1st of August 2025, followed by a formal launch event on the 7th of August 2025. Data for July 2025 shows that a Level 1 alert has been triggered, due to a higher-than-expected number of term stillbirths during the month. Three term stillbirths were reported, one of which meets the criteria for referral to the Maternity and Newborn Safety Investigation programme (MNSI). Receiving an alert does not necessarily mean that a service is unsafe – the programme requires a critical safety check to be undertaken to determine any safety concerns.

Action: As part of the Pilot programme, the Directorate Senior Leadership Team have completed a critical safety check of Intrapartum services to identify any immediate concerns or learning from incidents, which will be shared with the Maternity Safety Champions group for oversight.

ADVISE - Advise of areas of ongoing monitoring or development, or where there is negative assurance

NHS England Visit and diagnostic review: 24th & 25th July 2025.

The NHS England 2-day diagnostic review was completed on the 24th and 25th July 2025. Formal feedback from the visit has now been received, and next steps will be developed and communicated to the Quality Committee and Maternity safety champions.

PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) *see chart in annexe 3*

Two elements have poor compliance with the PERIPrem standards and remain our key focus:

1. Early Maternal Breast milk within 6 hours of birth. This increased to 38% in July.

Action: The PERIPrem quad continue to work with the infant feeding team to support this standard, with antenatal education and support for mothers seen in the preterm birth clinic. Staff education is ongoing to support mothers to express on Delivery Suite using the colostrum packs within 2 hours of birth; to enable colostrum to be brought to the neonatal unit so baby receives this within 6 hours.

2. Multistrain probiotic within 24 hours of life. This remains at 0%. We currently follow the network guideline, and babies receive probiotics once on 20mls/kg/day of milk, with good results on audit of the current guidance. The probiotic currently requires 3mls of colostrum to be administered, which is challenging within 24 hours of birth.

Action: Guideline is being amended in consultation with pharmacy, the network and other region's guidelines, to achieve PERIPrem. The amended guideline will be taken to PCEG and Directorate governance for approval in Sep meetings and will then be implemented by 30.09.25. Staff training is in progress for this date.

Use of Periprem Passports will also be relaunched 30.09.25 which will support all standards.

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme

The directorate is on track to meet six safety actions as of the end of July 2025, with additional work required to meet the requirements for a further four, detailed below.

Safety Action 5 (Midwifery Workforce): Birthrate + review requested, awaiting confirmation of commencement date. This will inform a full midwifery workforce review. The bi-annual Midwifery staffing oversight report will be submitted to the Board in September 2025.

Safety Action 7 (MNVP): Co-production of an action plan to address the themes from the 2024 CQC Patient Survey has been commenced. Commissioning for the MNVP does not meet the requirements for Safety Action 7, however the Trust will still be able to declare compliance with this standard as the required escalation pathway has been followed.

Safety Action 8 (Training): Compliance with fetal monitoring training is above the required 90% standard for all staff groups. PROMPT training compliance is below the target for maternity support workers and anaesthetic trainees in July 2025. Compliance for maternity support workers has fallen just below the required level for the first time in this training year, and all members of staff have planned training booked. Anaesthetic compliance has improved, and is now 83%, with non-compliant staff booked for upcoming training.

Compliance with resuscitation of the newborn training is reported below the required standard of 90% for neonatal medical staff, due to an identified issue with recording compliance on ESR. A move to a locally held database has been commenced, with the work expected to be completed by mid-September.

Safety Action 9 (Perinatal Quality Surveillance Model): Update required on progress against the maternity and neonatal culture programme.

Action: Bi-weekly safety action owner assurance meetings in place. Quadrumvirate assurance meeting planned for 20th August 2025.

Reduction in Trust Perinatal Mortality

SWBH Perinatal Mortality is reported to MBRRACE-UK for national reporting annually; Local perinatal mortality data are analysed using national definitions of stillbirth, neonatal death and perinatal mortality and are quoted per 1000 births.

The mortality case reviews take place within monthly multidisciplinary Perinatal Mortality Review Board using national review tools. The PMRB then decides on the grading of the care as per PMRT tool. The national standards are met in terms of time frame for the investigation and the presence of external reviewers. As per MIS- Safety action 1 there is adherence to recommended MBRRACE timelines for commencing case documentation/draft report after MDT review/publication of full case report.

MBRRACE -UK data for SWBH:

The table below shows the stabilised and adjusted rates consider local population demographics, ethnicities and delivery details and are derived from robust statistical analysis. These allow comparison with other local units and across comparable Units nationally.

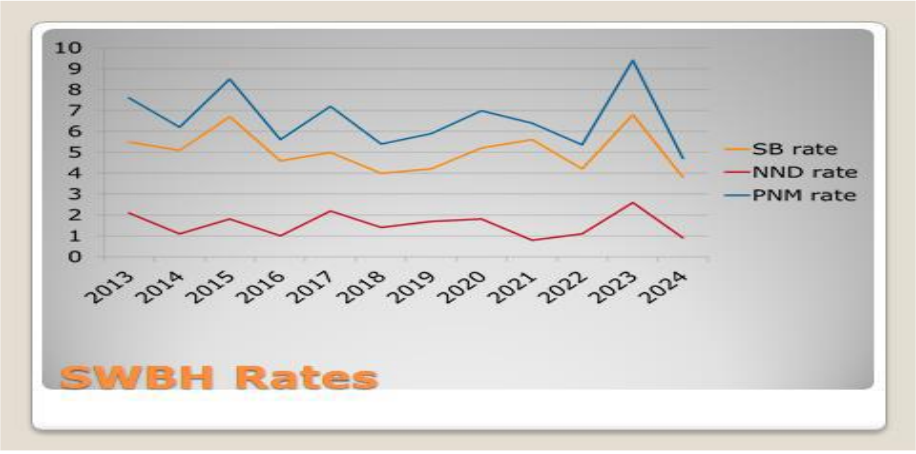
SWBH	Dels	Crude SB rate	Crude NND rate	Crude PNM rate		Adj SB rate	Adj NND rate	Adj PNM rate	3 yearly average
2013	5462	7.14	2.95	10.1		4.58	1.69	6.77	
2014	5577	6.10	2.35	8.43		3.98	1.52	5.73	
2015	5530	8.14	2.19	10.3		4.47	1.65	6.10	6.20
2016	5779	5.70	1.57	7.27		3.79	1.19	4.97	5.60
2017	5882	5.60	3.93	9.52		3.60	2.09	5.64	5.57
2018	5502	5.45	2.56	8.00		3.44	1.64	5.04	5.21
2019	5176	4.44	2.71	7.15		2.96	1.59	4.50	5.06
2020	4826	6.84	2.50	9.32		3.55	1.36	4.90	4.81
2021	4842	7.02	1.87	8.88		3.65 / 3.22*	1.24 / 0.92*	4.88 / 4.13*	4.92
2022	5117	6.45	1.38	7.82		3.27 / 2.97*	1.07 / 0.89*	4.33 / 3.86*	4.70
2023	5317	8.28	3.79	12.04		3.34 / 3.60*	1.59 / 1.12*	4.98 / 4.73*	4.73
2013-22 reductions in rates (%)						-28%	-37%	-36%	-25%

* Excl cong abn cases

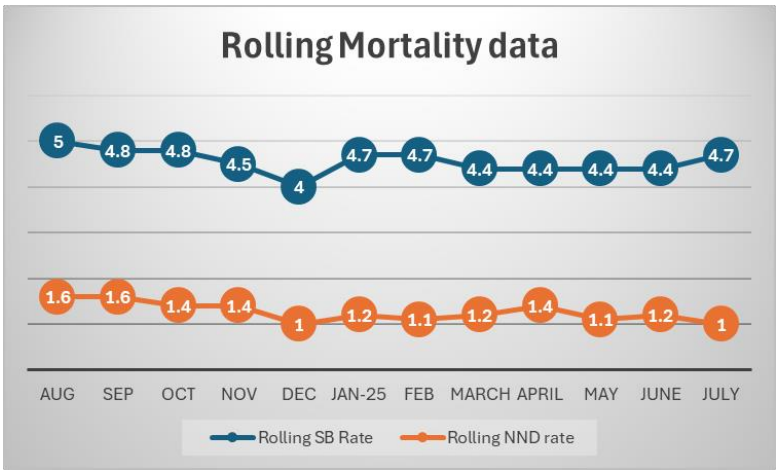
MBRRACE-UK data for SWBH

Local Data:

Local SWBH Perinatal Mortality Rate for 2024 shows a significant reduction in all rates compared to 2023 and the lowest Stillbirth and Perinatal mortality rates on record with an overall 45% fall in PNM in the last decade (2015-2024).



Rolling Perinatal Mortality Rate:



The Trust rolling annual Perinatal Mortality reported as 5.7/1000 in July 2025. This shows a overall reduction in mortality over the last 12 months from 6.6/1000 in August 2024.

Actions taken to reduce Perinatal Mortality Rate:

One of the key important drivers of care is reduction of Perinatal Mortality Rate. SWBH Maternity team is working on

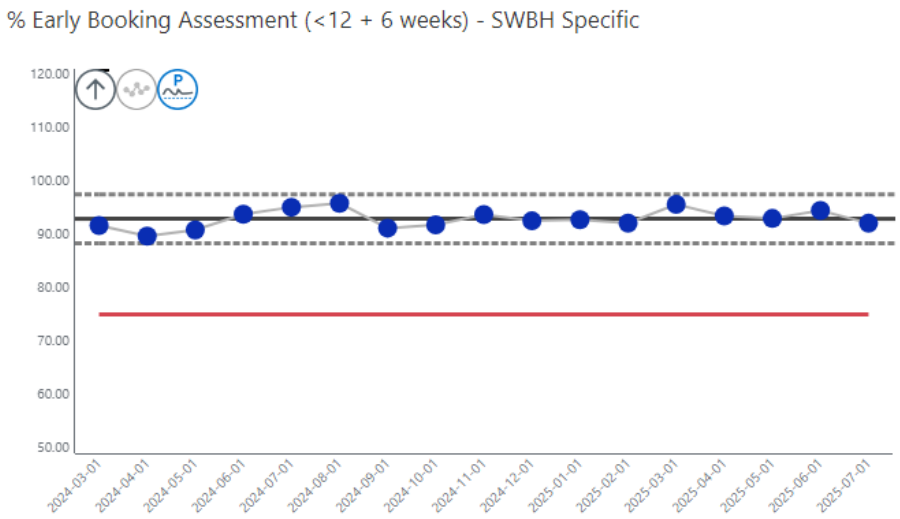
1. SWBH maternity is achieving this by making required changes in **women's pregnancy journey** (Booking, Risk assessment , antenal and Intrapartum care pathway).
2. Induction of labour- SWBH maternity has seen significat positive changes in our **IOL pathway.** We have aligned our postdates IOL to national guidance and strenghtened the IOL care pathways with senior oversight and proper escalation when there is delay.
3. We have bench marked **our guidelines** to ensure they are in line with National recommendations. These guidelines focus on reduction of Perinatal Mortality
4. SWBH Maternity is compliant with NHS E initiative- **Saving Babies Lives care Bundle v3.2** wth an aim to reduce our Perinatal Mortality rate. Adopting the 6 elements of SBLCB and continuous monitoring of it has a positive impact on perinatal Mortlaity Rate reduction.
5. SWBH EDI team also focusses on the information that must reach all women in community that are challenged by **barriers due to ethnicity and Deprivation**.

The following sections outlines the actions that have been completed and on going to address the Perinatal Mortality Rate.

Pregnancy Journey:

- **Booking Process**- There is an emphasis on early booking of women that will have a positive impact on their pregnancy. The booking process is monitored through Patient

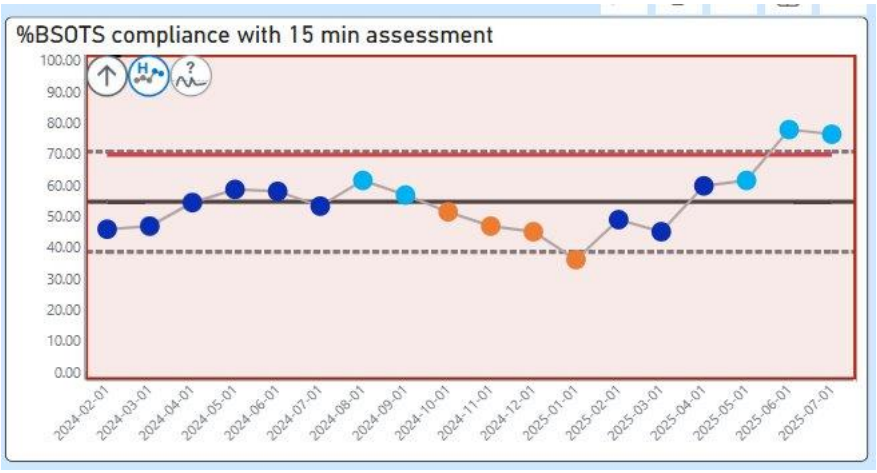
Tracker Lists to ensure women receive their dating scan and screening tests in the right time frame. The chart below explains how we maintain the early booking.



- **Risk assessment** – There is more emphasis on Risk assessment for Growth restriction at booking. Community midwives are able to initiate Aspirin Prescription through PGD.
- **Pre-term births** - Under 27 weeks pathway- Birth in the right place- The development of Periprem QUAD in ensuring adherence to under 27 pathways and optimisation of preterm births- as per SBLCB Element 5.

Intrapartum care pathway:

- **Triage assessment**- We have made consistent improvement in initial Triage review as per BSOTS standard.

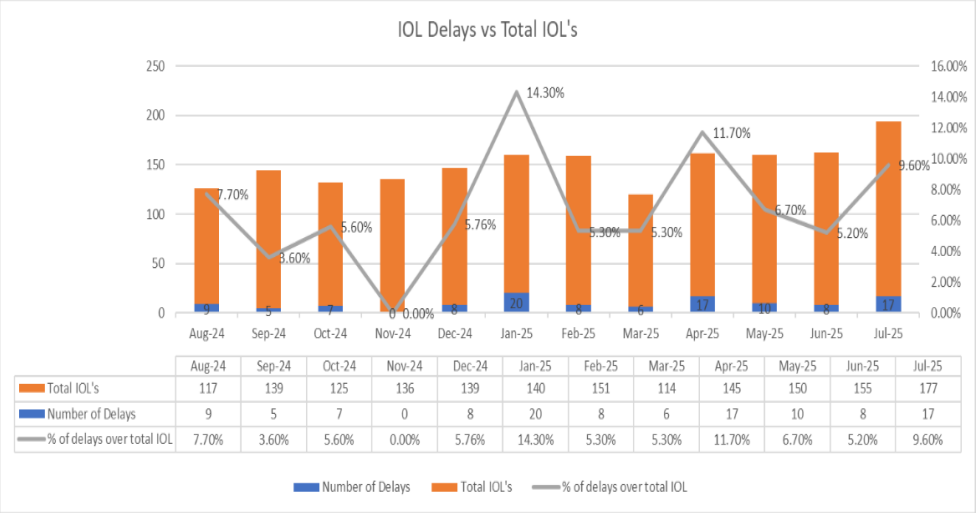


- We have focussed on Management of women with Pre-labour Rupture of membranes and ensured they are monitored and IOL occurring in Delivery Suite with prophylactic Antibiotics

- Through appropriate Badger Net documentation, we ensure women are risk assessed correctly in labour. This then adds to the benefit of safe care as per risk status.
- CTG monitoring- We are fully compliant with CTG training as per SBLCB Element 4. Women receive appropriate monitoring as per risk assessment. The regular CTG webinars and compliance with mandatory training are key in reducing the perinatal morbidity and mortality

Induction of labour:

- The Trust is now line with national guidance (NICE) and offers IOL at Term+7 to all our low risk women. This has been in place since October 2024. The team monitors IOL process closely. A separate consultant led ward rounds adds to the timely senior oversight. There is an SOP to monitor any IOL delays and approporiate escalation pathways in place. The delays in IOL are monitored and escalated.
- The chart below shows the number of IOLs and the delays associated with it.



	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Total IOL's	117	139	125	136	139	140	151	114	145	150	155	177
Number of Delays	9	5	7	0	8	20	8	6	17	10	8	17
% of delays over total IOL	7.70%	3.60%	5.60%	0.00%	5.76%	14.30%	5.30%	5.30%	11.70%	6.70%	5.20%	9.60%

1. **Amended Guidance & pathways**

We have amended the following guidelines with a view to guiding the team on reducing the perinatal mortality.

- DNA- Follow up guidance- Amended in April 2024
- Unbooked women and Late booker pathway- Amended in September 2024
- Fetal Growth Restriction detection- April 2025
- Guidance on RFM Management – January 2025

2. **Saving Babies Lives Care Bundle Compliance- Audit data for Quarter 1**
   - The compliance status is submitted to Directorate Governance and LMNS every quarter. Overall implementation 97% validated by LMNS in August 2025 with review of provided evidence.

- **Element 1 - Reducing smoking in pregnancy** - Fully Implemented. The team complete the CO monitoring at booking and at 36 weeks. We are 82.1% compliant at booking and 88.7% compliant at 36 weeks. Smoking in Maternity guideline updated to include partnership with Sandwell Council Healthy Pregnancy Team . Women are referred for smoking cessation after discussion as outlined in Care Bundle.
- **Element 2 - Fetal growth: risk assessment, surveillance and management** - Partially implemented (95%). The department is unable to implement placental growth factor testing due to capability of Black Country Pathology Service. There is a system wide solution being explored. The pathways for Uterine Artery Doppler USS was implemented from April 2025 for women at high risk of FGR- fetal growth restriction. We are monitoring our detection rate for FGR- Identification of growth restricted babies requires improvement. In q1 - 65.3% babies <3rd centile delivered later than 37+6/40.
- **Element3 -Raising awareness of reduced fetal movement (RFM)** Fully implemented. We are monitoring all the aspects includiong using of check lists and the offer of growth scans. Currently our compliance with next working day USS for RFM is 36.9%.
- **Element 4 -Effective fetal monitoring during labour -** Fully Implemented; Our EFM training compliance >90% for all staff groups.
- **Element 5 -Reducing preterm birth** Fully implemented- We have good compliance with AN steroid / MgS04/ DCC NNAP elements. Management of preterm birth identified as an issue in 6.8% of PMRT reviews in Q1. We require improvement in Temperature management and early breast milk elements.
- **Element 6** - **Management of pre-existing diabetes-** Partially implemented (85%). We need to improve compliance with HBA1c testing for women with existing diabetes which currently is 70.6%.

3. Barries due to Ethnic Minority and Deprivation:

- Access for service- EDI lead MW works closely with 3rd sector organisations and charities to early access and AN education.
- Language barriers- There is on-going work top overcome language barriers. There is widespread use of Face- face interpreters, Language line and other mobile devices including Wordski.
- Patient education- Patient receive education with easy Read leaflets in their language. There are plans for implementation of EDI Passport – with the required information for refugee women and women that are new to the country
- Significant work has been in progress where women had BBA due to language barriers
- EDI Lead MW has attended different communities to promote awareness and educate early access to maternity care
- EDI MW is working with specific Indian/Punjabi and black African community to increase awareness on early referral and AN care.

There is ongoing monitoring of the above data and processes. The lessons learnt from the reviews are shared with the team through safety Brief memos and in QIHD meetings.

Midwifery Biannual Workforce paper (see reading room)

The biannual report presented to the Board of Directors provides an overview of midwifery and neonatal staffing status and outlines the staffing requirements necessary to deliver safe, high-quality perinatal care. In addressing the maternity workforce requirements, this will be based on the Birth Rate Plus report and 'Safe midwifery staffing for maternity settings' (NICE guideline, NG4). In the provision of addressing safe quality nursing care within the Neonatal Unit, the overview will be in relation to the standards set out by The British Association of Perinatal Medicine (BAPM). The biannual report provides oversight for the Board and evidence for the NHS Resolution's Maternity and Perinatal Incentive Scheme (MPIS) with regards to safety actions 4 and 5.

A Birth Rate Plus (BR+) review was completed in 2022 and amended with the BR+ team in January 2023. This reviewed the midwifery staffing levels reflecting the acuity of birth activity within the service. The next Birth Rate plus assessment is now required and process will commence in September 2025. A further paper will be bought to the Board following publication of this staffing calculation.

ASSURE - Inform the Committee where positive assurance has been achieved

Birthing Partners:

Birthing partners of women/ birthing people who are in in the latent phase of labour, having an induction of labour or are using transitional care, are invited to stay for 24 hours per day. Staff engagement and the working group continue. No negative experiences or outcomes have been reported in July 2025. However, one incident has been reported in August 2025, which has resulted in legal advice being sought regarding the minimum age of the birthing partner who may stay overnight/unattended. Once this has been agreed the policy and patient information leaflet will be updated.

3. Recommendations

3.1 The Public Trust Board is asked to:

a. **Discuss** and challenge the report in particular noting the alert section
b. **Note** the diagnostic review undertaken by NHS England on the 24/25th July
c. **Discuss** the perinatal mortality interventions outlined in the report

Clare Cheatham, Head of Midwifery
Lakshmi Thirumalaikumar, Clinical Director for Obstetrics
Penny Broggio, Clinical Director for Neonates
Joanne Treacy, Directorate General Manager

Wednesday, 03 September 2025

Reading Room: Biannual Maternity and Neonatal staffing report.

Paper ref:	PublicTB (09/25) 010

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Finance report Month 4 (July 2025)		
SPONSORING EXECUTIVE:	Simon Sheppard, Acting Chief Finance Officer		
REPORT AUTHOR:	Simon Sheppard, Acting Chief Finance Officer		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

As of the end of July 2025, the Trust reported a deficit of £10.435 million, which is £2.054 million adverse to the plan, spend of £12.96m against the capital programme with a cash balance of £31.1m.

The Trust Board is asked to discuss the financial position at the end of July, the progress of the financial improvement programme and the risks and mitigations to ensure delivery of the 2025/26 financial plan.

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

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

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

Executive Group; Trust Management Committee; Finance & Productivity Committee

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the financial performance as at the 31 July 2025 (month 4)
b.	**NOTE** the progress of the Financial Improvement Programme and the key next steps
c.	**NOTE** the key risks and mitigations to delivery of the Income and Expenditure financial plan.

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

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

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 10 September 2025

Finance report Month 4 (July 2025)

1. Executive summary

1.1 This report updates the Trust Board on the 2025/26 financial position against the income & expenditure plan and the capital and cash programmes. It also provides an update on the financial improvement programme and the key risks / mitigations to delivery of the financial plan.

1.2 As the Board is aware, the Trust submitted a plan at the end of March of breakeven for 2025/26. This was inclusive of £14.2m of national deficit funding and a cost improvement programme of £50.8m.

1.3 The key performance measures at the end of July 2025 (month 4):

- The Trust has reported a deficit of £10.435m which is £2.054m adverse to the income & expenditure plan of £8.381m deficit. This includes £0.82m of additional pay costs relating to the resident doctor's industrial action.
- £12.96m capital spend below planned capital programme phasing, mainly against the Estates schemes.
- A cash balance of £31.13m.
- £8.9m delivered against the financial improvement (efficiency).
- £3.18m favourable position against the elective recovery/ variable activity funding
- 99 whole time equivalents (WTE) above the workforce plan trajectory.

2. Financial Overview

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

Table 1 – Financial Key Metrics

	Year to Date Plan £ms	Year to Date Actual £ms	Year to Date Variance £ms
I&E Performance	(8.38)	(10.44)	(2.06)
Agency Costs	2.13	3.75	(1.62)
Financial Improvement Programme	8.08	8.89	0.82
Capital Expenditure (ICB Allocation)	8.91	2.98	5.93
Capital Expenditure (Other)	8.70	9.98	(1.28)
Cash Balance	51.25	31.13	(20.12)

Income & Expenditure Performance

2.2 The summary position at the end of July 2025 is shown below:

Income & expenditure summary	Year to date			
	Plan £000s	Actual £000s	Variance £000s	%
Operating income	264,907	266,818	1,911	**0.7%**
Agency pay	(2,169)	(3,754)	(1,585)	**(73.1%)**
All other employee expenses	(163,721)	(166,716)	(2,995)	**(1.8%)**
Operating non pay	(100,237)	(99,400)	837	**0.8%**
Total operating surplus / (deficit)	**(1,220)**	**(3,052)**	**(1,832)**	
Non operating items	(7,161)	(7,383)	(222)	**(3.1%)**
Adjusted financial performance surplus/(deficit)	**(8,381)**	**(10,435)**	**(2,054)**	**(0.8%)**
Less Non-Recurrent Deficit Support	(4,732)	(4,732)	0	**0.0%**
Adjusted financial performance surplus/(deficit) excluding non-recurrent deficit funding	**(13,113)**	**(15,167)**	**(2,054)**	**(0.8%)**
EBITDA as a percentage of related income	**5.4%**	**4.6%**	**(0.8%)**	
I&E margin	**(3.2%)**	**(3.9%)**	**(0.8%)**	

2.3 At Month 4, the Trust reported a £10.435m deficit, against a plan deficit of £8.381m, an adverse variance of £2.054m.

2.4 The key drivers for this position are:

- A favourable position against the elective income plan of £3.4m, £3.2m over-performance and £0.2m accrual for catch up of coding.
- An adverse position against the planning assumption regarding urgent and emergency care activity of £0.67m
- An overspend against the pay budget of £4.6m. The main drivers year to date have been
  - the Resident Doctors Industrial Action £0.82m,
  - an increase in maternity leave payments,
  - an increase in waiting list payments to support elective activity,
  - being 99WTE above the workforce target for July,
  - where there has been a reduction in staff these have been at a lower band than planned
- Non pay is underspent year to date £0.8m.
- A £0.2m overspend on non operating items which is predominately lower interest receivable as a consequence of the lower cash balance.

Workforce

2.5 In March 2025, the Trust Board approved a stretching workforce plan for 25/26, which delivers a 718 FTE reduction (8.5%), i.e. an exit position of 7,693 FTEs in March 2026. Whilst markedly higher than any of the other Black Country Trust's (DGFT 5.1%, RWHT 3.4%, WHT 4.3%) SWB's planned workforce reductions reflect:

- 90% reduction in agency usage
- 75% reduction in bank usage
- 140 reduction in corporate services FTE's
- 106 net FTE increase in substantive (clinical) staff

2.6 At Month 4 (July), workforce deployment stood at 8,224.6 FTE. This represents a reduction of 186 FTE from the January baseline of 8,411 FTE and 336 FTEs from the actual starting point

of 8560.6 FTEs in April 2025, confirming that the Trust remains below baseline and is delivering net reductions. However, against the planned trajectory of 8,125.7 FTE, deployment was 98.9 FTE higher, signalling that delivery is adrift of the in-year plan.

2.7 The monthly profile shows steady progress compared with the baseline: April recorded 8,298.8 FTE, May 8,237.2 FTE, June 8,239.7 FTE, and July 8,224.6 FTE. Against plan, however, the variance has fluctuated. It narrowed significantly in the early part of the year, from 111 FTE adverse in April to only 2 FTE in June, before widening sharply again in July (99 FTEs).

2.8 By pay group, July comprised 7,388.5 FTE contracted staff (30.2 FTE below plan), 779.0 FTE bank staff (136.9 FTE above plan), and 57.2 FTE agency staff (7.8 FTE below plan). This confirms that bank utilisation is the principal driver of variance. Agency use has continued to reduce, and substantive staffing has remained within plan, this reflects the robust vacancy control arrangements that are in place which have driven a significant reduction in recruitment of new staff, effectively restricting recruitment to operationally and clinically critical posts only.

2.9 It is vital that the workforce plan and trajectory is delivered, or mitigating schemes implemented, to support achieving the financial plan.

Elective Recovery

2.10 As part of financial performance management it is vital that the Trust monitors and manages the activity levels against the 2025/26 contract and against previous trends. This will help to make informed decisions around productivity, changes to the cost base and the overall financial improvement programme, whilst balancing these decisions against the operational targets and quality / safety.

2.11 The following chart summarises the financial monthly profile for 2025/26 in terms of the plan and actuals for activity linked to elective recovery.

2.12 Month 4 financial performance can be summarised in the following tables. By point of delivery we can see a favourable position against ERF - £3,314k. (£3,181k for all variable activity).

Variable_Type	PODGrpCode2	Total Activity Plan	Total Activity Actual	Total Activity Diff	Total Price Plan	Total Price Actual	Total Price Diff
Variable ERF	Daycase	11,808	13,367	1,559	£12,875,997	£14,404,225	£1,528,228
	Elective	1,749	1,800	51	£7,359,403	£8,423,453	£1,064,050
	Excess Bed Days	490	594	103	£170,416	£215,457	£45,041
	OP New Attendances	73,667	67,881	-5,786	£15,364,066	£14,295,559	-£1,068,507
	OP New Virtual Attendances	8,842	11,320	2,478	£2,003,251	£2,655,432	£652,181
	OP Procedures	66,711	71,334	4,622	£12,538,711	£13,631,224	£1,092,512
Variable ERF Total		**163,268**	**166,295**	**3,027**	**£50,311,843**	**£53,625,350**	**£3,313,506**
Variable Other Elective	Chemotherapy	926	894	-33	£264,909	£257,415	-£7,494
	Direct Access - Imaging	19,105	20,737	1,632	£1,219,124	£1,297,752	£78,627
	Outpatient Diagnostic Imaging	23,571	22,580	-991	£2,905,481	£2,701,852	-£203,629
Variable Other Elective Total		**43,602**	**44,210**	**608**	**£4,389,515**	**£4,257,019**	**-£132,496**
Grand Total		**206,871**	**210,506**	**3,635**	**£54,701,358**	**£57,882,369**	**£3,181,011**

Capital and Cash

2.13 The Capital Position in **Annex 1** shows the current spend to July 2025. Spend on internally funded schemes is behind plan but there is a robust forecast for each workstream which will see delivery ramp up through the year. The Finance teams are working with operational leads to ensure that the Trust avoids a repeat of historical, disproportionally high spending patterns in Q4. In addition, the Capital Management Group meets monthly to monitor and manage delivery of the programme

2.14 The cash balance at the end of January of £31.13m. Cash was behind plan for July due to the settlement of invoices earlier than planned to the Trust's Facilities Management provider, Engie, and unresolved long-term debts with Sandwell Metropolitan Borough Council (SMBC). During August, at the time of writing, SMBC had made a payment of £2.7m, with the remainder being chased for a confirmed payment date.

2.15 The forecast shows a revised cash balance at 31 March 2026 of £46.7m, this has been reduced by £5m from the previously presented papers and reflects a prudent position, acknowledging the challenges in Income & Expenditure (I&E) performance and savings delivery. The achievement of 2025/26 CIP schemes, against the Trust target of £50.8m will be monitored and the impact on the Trust's I&E and cash plan amended to reflect changes. In addition, the cash forecast includes the receipt of £14m national deficit support from NHSE, which will be under review throughout the year.

3. Financial Improvement Programme

3.1 The Trust has a very stretching and ambitious financial improvement programme of £50.8m in 2025/26, 6.2% of turnover. The target is profiled approximately 31% (£16m) in the first half of the year and 69% (£35m) in the second half.

3.2 The financial improvement programme is structured across quality and productivity workstreams and efficiency workstreams, inclusive of workforce. Each workstream has an Executive sponsor, senior responsible officer and support from a multi-disciplinary team (finance, HR, analysts).

3.3 At the end of July we are reporting £8.9m delivered against the programme, which is ahead of plan. However, a simple extrapolation to year end would only achieve £27m.

3.4 The focus during September is to ensure all schemes are fully developed inclusive of quality impact assessments, detailed milestones and monthly trajectories for both 2025/26 and the recurrent full year effect. Where there are gaps to the workstream targets mitigating actions will need to be put in place.

3.5 To support delivery of the financial improvement programme the Trust is also focusing on a number of productivity opportunities identified through the NHSE Cost Driver and Disparities Dashboard, the Model Health System and the National Cost Collection (Annexes 2-3). These will help support both the cost reduction and improved productivity.

4. Risks and Mitigations

4.1 The 2025/26 financial plan is stretching yet ambitious, and risk management is vital to ensure timely mitigations.

4.2 The risks can be summarised into 3 categories:

- Contractual negotiations particularly Birmingham and Solihull (BSOL) Integrated Care system. This relates to a post planning submission change to the contractual offer - linked to proposed changes in Emergency Department and Urgent & Emergency Care activity based on interventions in BSOL and intelligent conveyancing. We are in formal contract dispute with BSOL.
- Financial Improvement Programme (as discussed above)
- Performance risks – national deficit funding and the Black Country Integrated care system risk pool.

4.3 The private board will receive a paper detailing the financial position, risks and mitigating actions.

5. Recommendations

5.1 The Public Trust Board is asked to:

a. **NOTE** the financial performance as at the 31 May July (month 4).
b. **NOTE** the progress of the Financial Improvement Programme and the key next steps.
c. **NOTE** the key risks and mitigations to delivery of the Income and Expenditure financial plan.

Simon Sheppard
Acting Chief Finance Officer
28 August 2025

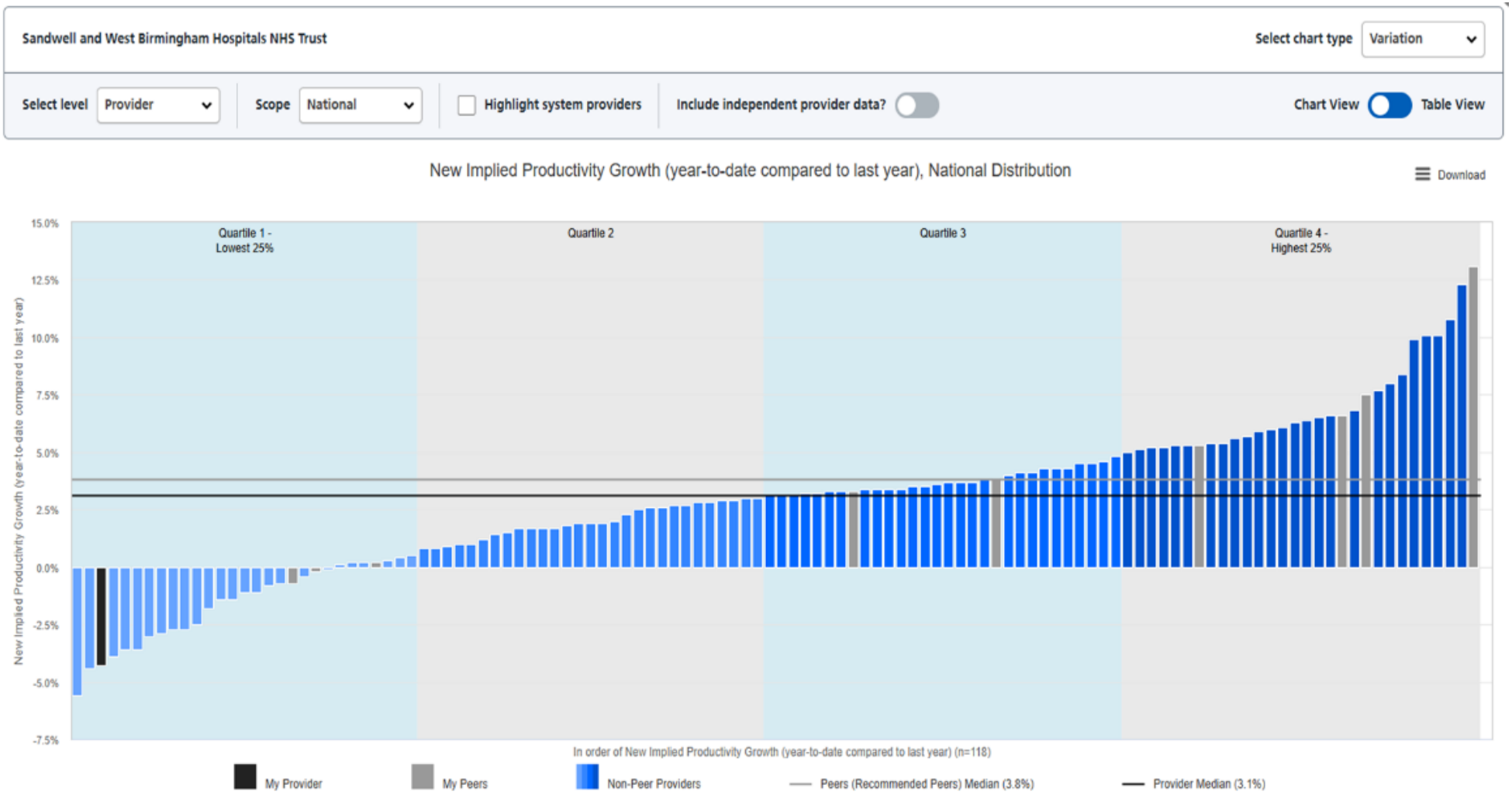
Annex 1: Capital Programme
Annex 2: Productivity Opportunities – Model Health System
Annex 3: Productivity Opportunities – National Cost Collection

Annex 1 – Capital Programme

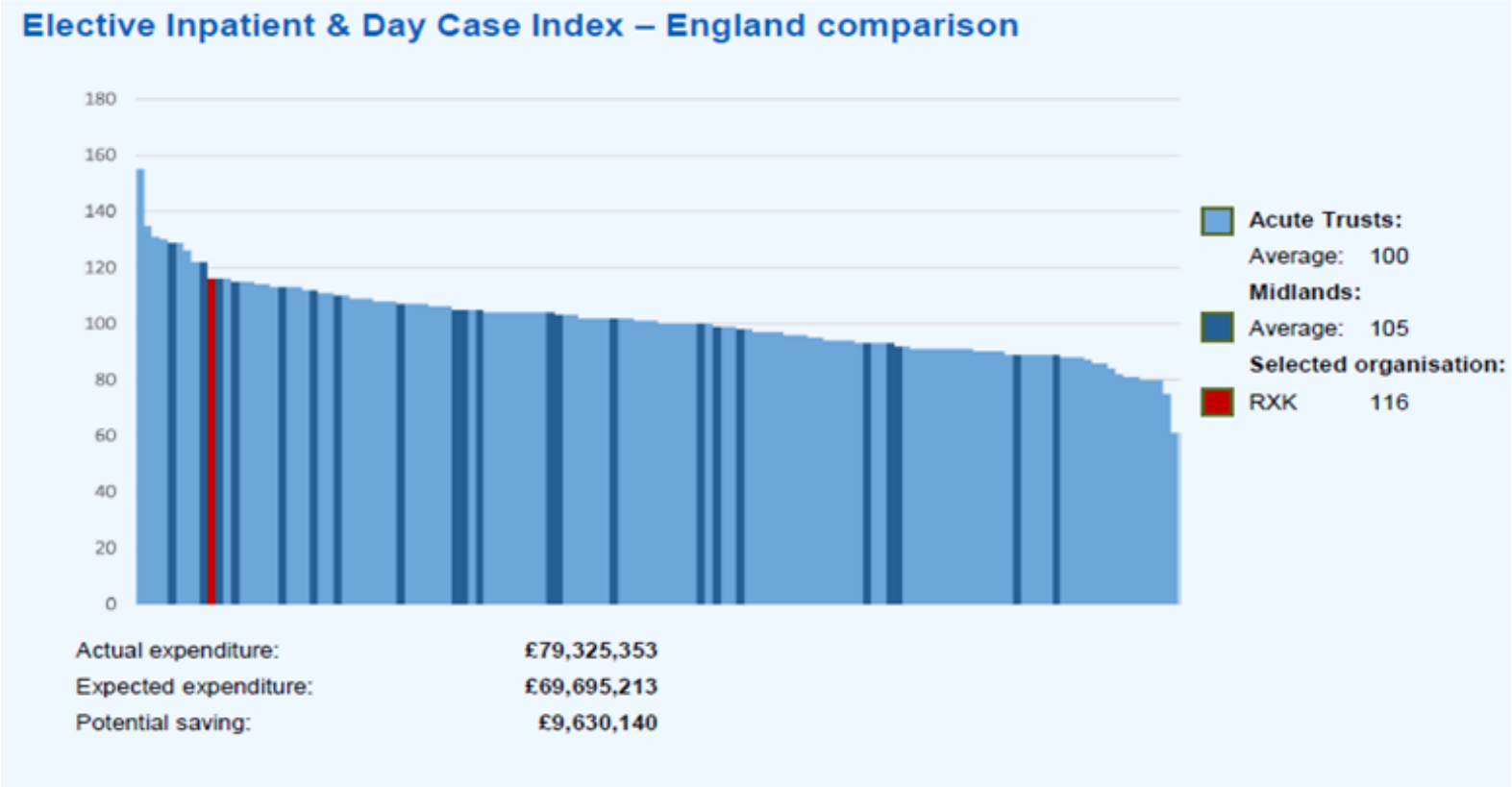
SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

Summary Capital Expenditure: FY 2025/26 to P04

	Annual	Year to Date			Year End Forecast		
	NHSE Plan £000s	NHSE Plan £000s	Actual £000s	Variance £000s	NHSE Plan £000s	Forecast £000s	Variance £000s
Internal - Self Financing							
Estates	12,651	3,485	1,099	2,386	12,651	12,651	0
Mid Met Urgent Treatment Centre	5,082	1,000	286	714	5,082	5,082	0
IT	4,825	1,468	1,104	364	4,825	4,825	0
Medical equipment	1,828	418	35	383	1,828	1,828	0
Charity	0	0	0	0	0	0	0
Sub total	**24,386**	**6,371**	**2,524**	**3,847**	**24,386**	**24,386**	**0**
External/PDC Funded							
MMUH - Cost to complete (PDC)	1,746	308	1,746	-1,438	1,746	1,746	0
Learning Hub / Campus (Grant Funded)	12,000	5,333	8,031	-2,698	12,000	12,000	0
Eradication by RAAC (PDC)	3,100	620	96	524	3,100	3,100	0
Rowley Regis Roof Replacement RAAC (PDC)	717	80	1	79	717	717	0
Elective Hub (PDC)	9,750	1,950	105	1,845	9,750	9,750	0
National Energy Efficiency Fund-Solar (PDC)	404	404	0	404	404	404	0
Sub total	**27,717**	**8,695**	**9,979**	**-1,284**	**27,717**	**27,717**	**0**
TOTAL INTERNAL & PDC FUNDED	**52,103**	**15,066**	**12,503**	**2,563**	**52,103**	**52,103**	**0**
Technical-IFRIC12							
BTC & MES	1,709	570	458	112	1,709	1,709	0
ROU Assets - IFRS16							
ROU Leased Assets (Internally Funded)	5,920	1,972	0	1,972	5,920	5,920	0
Trust Wide Programme	**59,732**	**17,608**	**12,961**	**4,647**	**59,732**	**59,732**	**0**


Sandwell and West Birmingham Hospitals NHS Trust
Select chart type
Variation
Select level
Provider
Scope
National
Highlight system providers
Include independent provider data?
Chart View
Table View
New Implied Productivity Growth (year-to-date compared to last year), National Distribution
Download
Quartile 1 - Lowest 25%
Quartile 2
Quartile 3
Quartile 4 - Highest 25%
15.0%
12.5%
10.0%
7.5%
5.0%
2.5%
0.0%
-2.5%
-5.0%
-7.5%
New Implied Productivity Growth (year-to-date compared to last year)
In order of New Implied Productivity Growth (year-to-date compared to last year) (n=118)
My Provider
My Peers
Non-Peer Providers
Peers (Recommended Peers) Median (3.8%)
Provider Median (3.1%)

Elective Inpatient and Day Case Index



Paper ref:	PublicTB (09/25) 011

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Mortality and Learning from Deaths 12 month overview		
SPONSORING EXECUTIVE:	Mark Anderson, Chief Medical Officer		
REPORT AUTHOR:	Arvind Rajasekaran, Deputy Chief Medical Officer (Quality and Safety) and Trust Mortality Lead. Sally Arnold-Jones. Associate Director of quality governance.		
MEETING:	Public Trust Board	DATE:	10th Sept 2025

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

This paper aims to provide assurance that SWB:

- Consistently completes Tier 1 scrutiny Medical Examiner Review (ME) of inpatient deaths to identify. In the last 12 months, >99% of inpatient deaths have completed Tier 1 review.
- Monitors compliance against the ME Office standards and is achieving the national standards following the community roll out of Medical Examiners services.
- Has addressed the backlog of Tier 2 (Structured Judgement Reviews) and has taken appropriate action to clear the backlog and we will build a more sustainable workforce moving forward.
- Reviews all deaths of patients with Learning Disabilities and has completed a benchmarking exercise against peer trusts in the Black Country ICB. There are no concerns with the number of LD deaths, and we continue to work to improve reporting and learning processes with LeDeR.
- Is aware of conditions that have high mortality statistics (e.g. SHMI) and investigates these appropriately to identify contributing factors and areas for learning.
- Has achieved an improvement in the SHMI index for deaths from sepsis.
- Acknowledges the overall SHMI remains high for the organisation but has followed an improving trend in the last year.
- Failure to recognise and respond to Deteriorating patient remains a significant contributor to avoidable harm. There is now a robust process to address the many factors that will put the trust in a stronger position with the establishment of Deteriorating Patient Steering Group that reports to QSG and QC.

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

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

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

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

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**Receive assurance** that the learning from deaths processes for scrutinising deaths and monitoring various data sources is robust and in alignment with national standards
b.	**Acknowledge** the issues identified (i.e. high SHMI)
c.	**Accept** the actions in place to better our position

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

REPORT TO THE Public Trust Board ON 10TH SEPTEMBER 2025

Mortality and Learning from Deaths 12-month overview

1. Introduction or background

1.1 This report is presented to the Public Trust Board to provide assurance of Learning from Deaths processes and activity at Sandwell & West Birmingham Trust in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017) ((NQB), 2017). This report describes activity from August 2024 – July 2025.

1.2 Please note the Learning from Deaths portfolio was significantly impacted by staffing challenges May 2025 – July 2025. We have a Deputy Chief Medical Officer for Quality & Safety (in role since Mar 2024) and more recently a new Learning from Deaths Facilitator. These two roles are crucial for continuing to identify learning and make sustainable change in the learning from deaths portfolio.

2. Medical Examiners Office: Tier 1 scrutiny of deaths

	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Number of inpatient deaths	74	100	109	110	114	134	97	101	91	98	87	77
Tier 1 review completed	100%	100%	100%	100%	99%	100%	100%	99%	91%	100%	100%	100%
Tier 2 referrals	8.%	20%	8%	7%	11.4%	8%	13%	8%	7%	8%	8%	7%
MCCD	84%	90%	90%	94%	82%	87%	87%	96%	97%	94%	94%	96%
Next of Kin contacted	92%	87%	87%	95%	90%	90%	93%	96%	95%	93%	93%	88%

Coroners Referral (% of total deaths)	14%	19%	15%	9%	16%	15%	13%	16%	8%	12%	12%	11%

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

2.2 During the reporting period August 2024 – July 2025, the Medical Examiners reviews (tier 1 scrutiny) have been completed for an average of 99% of all inpatient deaths within the Trust. This is an excellent achievement and provides assurance that we have independent scrutiny of inpatient deaths.

2.3 In September 2024 the Community Medical Examiner roll out became mandatory, requiring all non- coronial community deaths to have scrutiny from the Medical Examiner. The operational roll out to all the Sandwell practices has been successful. The expectation is that all deaths are registered within 5 days of the event. There are some instances when there is delay in reporting deaths in the community to the medical examiner office. Our internal audit assures that from receipt of notification of death in community, the ME scrutiny is completed within 1 day on average. There is ongoing comms with relevant practices to reduce delays in receiving referral.

2.4 The number of cases in which Medical Cause of Death discussions (MCCD) are held between the Medical Examiner and certifying clinicians has remained above 80%.

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

2.6 Over the last 12 months there is a mean average of 15.4% of deaths referred for SJR (tier 2 scrutiny) following Medical Examiner scrutiny. It is usual to see month on month variation due to the different factors involved in individual cases.

3. Structured Judgement Reviews: Tier 2 scrutiny of deaths

3.1 The previously reported backlog of SJRs has now been largely resolved with only 5 cases outstanding. These are currently undergoing review.

3.2 Themes from returned SJRs and actions taken

3.2.1 When completed SJRs are returned to the Learning From Deaths team, regular qualitative analysis is completed to pull out themes.

- **Deteriorating patient** – Many SJRs outline missed opportunities to identify signs of deterioration, interpret these signs and act appropriately. This is by far the most recurring theme resulting in avoidable harm. An EMRT (emergency Medical Response Team) power note has been implemented on the Trust EPR, which standardises the documentation by clinicians and structured handover to the parent team following a critical incident requiring the input of the emergency team. This has been rolled out to synchronise with the new intake of doctors in Aug 2025. In addition, a trust wide approach to improving the standards in recognition, escalation, response and prevention of further deterioration is the remit of the Deteriorating Patient Steering Group that will meet starting Sep 2025. This is in line the PIER framework for Deteriorating Patient recommended by NHSE. This steering group reports to the Quality Committee on a bimonthly basis.
- **Involvement of family** – The involvement of family is a crucial influencing factor in end of life experience. Multiple SJRs identified missed opportunities to involve families in care planning, however when this is done well it has a significant positive impact on the patient, the family and our staff. The Trust is rolling out Martha's rule and is on trajectory for the national target date of Mar 26 for it's full implementation.
- **Documentation** – In some SJRs it has been highlighted that clarity of the clinical record has a detrimental impact on patient care and collaborative working. As the quality of the clinical record is something that also consistently impacts national audit data, Clinical Effectiveness Team, working with clinicians and IT team, have created templates on the trust EPR for admission clerking and Post-Take ward notes . Additionally, new induction videos have been produced aimed at the new intake of doctors to highlight the importance of avoiding the overuse of copy and paste function while documenting clinical progress updates on EPR. These measures, standardise the documentation, aid effective handover between clinicians, improves safe care and will aid the coding team to identify the codable conditions effectively.

4. Specialty spotlight: Learning disability (LD) deaths

4.1 At SWB, our Learning from Death Policy mandates all deaths of patients with a learning disability require an SJR, which functions to fulfil the requirement to submit to the national LeDeR programme. A deep dive into all LeDeR deaths in the trust in the preceding 6 months was completed in Jan 2025 and presented to Quality Committee. This gave assurance that there were no safety concerns or red flags in care standards.

4.2 The table below details the number of LD deaths for the reporting period.

Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
2	3	0	2	1	0	2	1	4	0	2	3	1	1	3	1

4.3 We also noticed an increase in LeDeR requests (e.g. requesting case notes if patients were known to us) both within our ICB and from ICB in other regions in 2024, which implies this is a trend being seen nationally. We met with the Black Country ICB lead for LeDeR who confirmed that number of LD deaths reported in our area is high, likely due to our Population, but there has been an increase nationally. A contributing factor to this is likely an increased awareness of the national reporting requirement (i.e. improvements in how

LDs are recorded in notes and increase in number of cases reported to LeDeR). Activities to improve the recognition of patients with LD, flagging such admissions to the LD team on the Trust EPR system and early involvement of the LD specialist team who advise the ward clinical teams on the reasonable adjustments that can be made to improve the experience and ensure safe care are some of the Quality improvements initiated in the last year. Staff can contact the CNSs for support and add a flag on Unity to the patients record, which populates a 'referral' list for the CNSs. The two LD CNSs aim to see any patient in an inpatient or outpatient setting referred to them within 24 hours of the request. The ICB Leder lead attends the Trust Learning from Deaths committee meetings regularly. The Learning from Deaths Facilitator and Learning Disability CNSs attended ICB LeDeR stakeholders event in May 2025.

5. Specialty spotlights: End of life care

5.1 End of Life Quality Improvement Project:

5.2 The National Audit of Care at End of Life has relaunched this year. The End of Life Care team are aiming to improve compliance with NACEL standards through their Continuous Quality Improvement Project. Following the launch of their trust wide mandatory e-learning package on end of life care, one area the team are now focused on is encouraging conversations about preferred place of death, as our local data indicates significant opportunities to reduce the number of inpatient deaths by supporting patients to pass away in their preferred location outside of hospital. The team are also working to improve the number of Support Care Plans and Treatment Escalation Plans developed for patients early on in their journey, so patients have adequate support and management in the dying phase. This is likely to result in better clinical care of patients in the dying phase, as well as better patient and family experience, and positively impact our mortality statistics.

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

	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Cases discussed at CAPROM	0	4	2	1	0	1	1	1	0	1	1	0
Cases confirmed "avoidable"	0	1	0	1	0	0	1	0	0	1	1	0

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

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

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

6.3 Within the last 12 months 5 deaths have been confirmed by CAPROM as "avoidable" compared to 9 last year.

It is important to note that an avoidable death within this framework does not mean the death was caused by neglect or error, but rather that the panel of reviewers identified care that could have been improved and from which learning can be drawn. The purpose of this process is to strengthen safety and quality, not to attribute blame.

When a death is considered "avoidable" the panel agree actions to take forward to improve quality and safety, and mitigate against similar deaths occurring in future. The actions following the avoidable deaths are reported to the Quality Committee. The Clinical services own the actions and the LFD team track the progress. The Quality Committee has sought assurance that tracking, implementation and evaluation post implementation is captured to evidence timely and effective interventions. The Governance process around ensuring actions are embedded long term, is a focus area in the upcoming LFD policy review. It is expected that the Policy will be through due approval process and updated by Jan 2026.

7. Learning from Deaths Group

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

7.2 Thematic analysis of learning is discussed in this meeting. In Apr 2025, a thematic analysis of all the Tier 2 mortality reviews was completed by our LFD co-ordinator and the findings were presented to quality committee. The findings of the thematic analysis were then mapped to ongoing Quality improvement projects and the findings were used to initiate others. Notable initiatives include:

- The trust nutrition lead is working with the Deteriorating Patient Steering group to optimise the recording and monitoring of fluid and nutrition intake on EPR.
- EMRT power note has been rolled out in the Trust EPR and this will aid effective handover of critically unwell patients.
- Failure to recognise the early signs of deterioration and missing opportunities for early intervention remains a significant risk resulting in avoidable harm. A deteriorating patient steering group has now been constituted and will lead on the

implementation of the plan in alignment with the Trust Strategic planning framework.

8. National Statistics

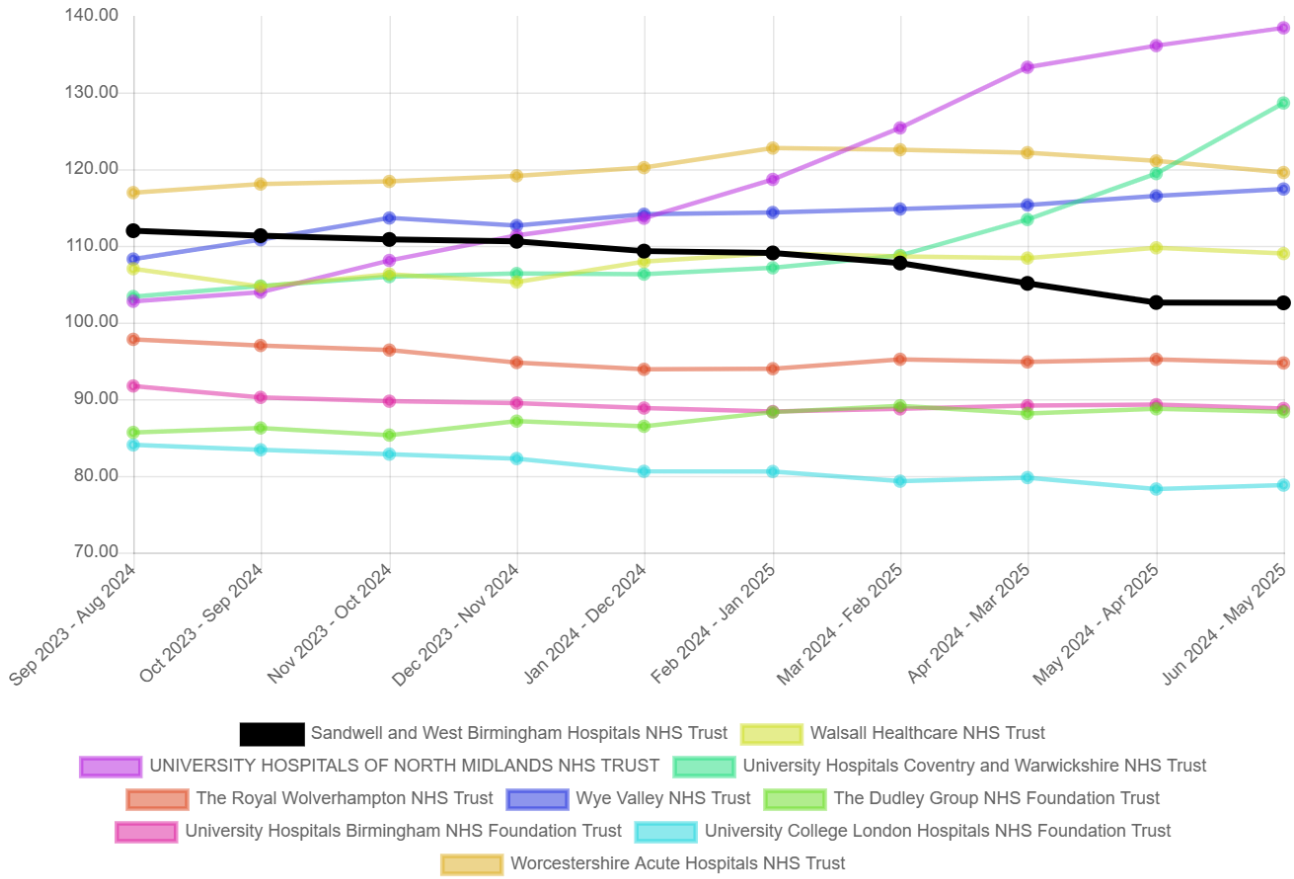
8.1 Hospital Standardised Mortality Ratio (HSMR) (from Healthcare Evaluation Data)

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

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

8.1.3 We monitor our HSMR through the Hospital Episode Statistics (accessed via HED platform). Due to data validation and analysis processes involved in HSMR calculation, there is a 3 month delay to reporting (i.e. May 25 reported in August 25).

8.1.4 The most recent monthly HSMR for May 2025 is 102.17, and our 12-month-cumulative HSMR is 102.57 ; a reduction since the last report of 15 points.



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

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

8.2.2 As described on the NHS Digital website "The SHMI is not a measure of quality of care. A higher than expected number of deaths should not be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance." (NHS England, 2024).

8.2.3 We track SHMI and carry out further analysis of the headline data and such analysis inform the areas for improvements in care processes.

8.2.4 The most recent **monthly value for SHMI** for March 2025 available is **102**. However, as our **12-month-cumulative SHMI (104.28)** demonstrates, SWB still has a higher SHMI than we should accept, which is why trust wide improvement efforts continue. These scores demonstrate a continuing improving trend in SHMI scores seen over the last 12 months. The screenshot below demonstrates that SWB currently sits within 'the expected range'.

Summary Hospital-level Mortality Indicator (SHMI), England, April 2024 - March 2025

Trust-level summary Return to contents Reset filters

NHS England

To support the interpretation of the SHMI, various contextual indicators are published alongside it. A breakdown of the data by site of treatment is also available. The SHMI, site level breakdown and contextual indicator data for a particular trust are summarised on this page (scroll down the table to see all of the indicators / sites). Further information on the contextual indicators is presented on the following pages. A SHMI value is only calculated for a subset of sites. Please see the SHMI interpretation guidance for more information on the site level breakdown.

Select or search for a trust to display a summary of thei

sandwell

Sandwell and West Birmingham Hospitals NHS Trust

Trust-level data

As expected SHMI

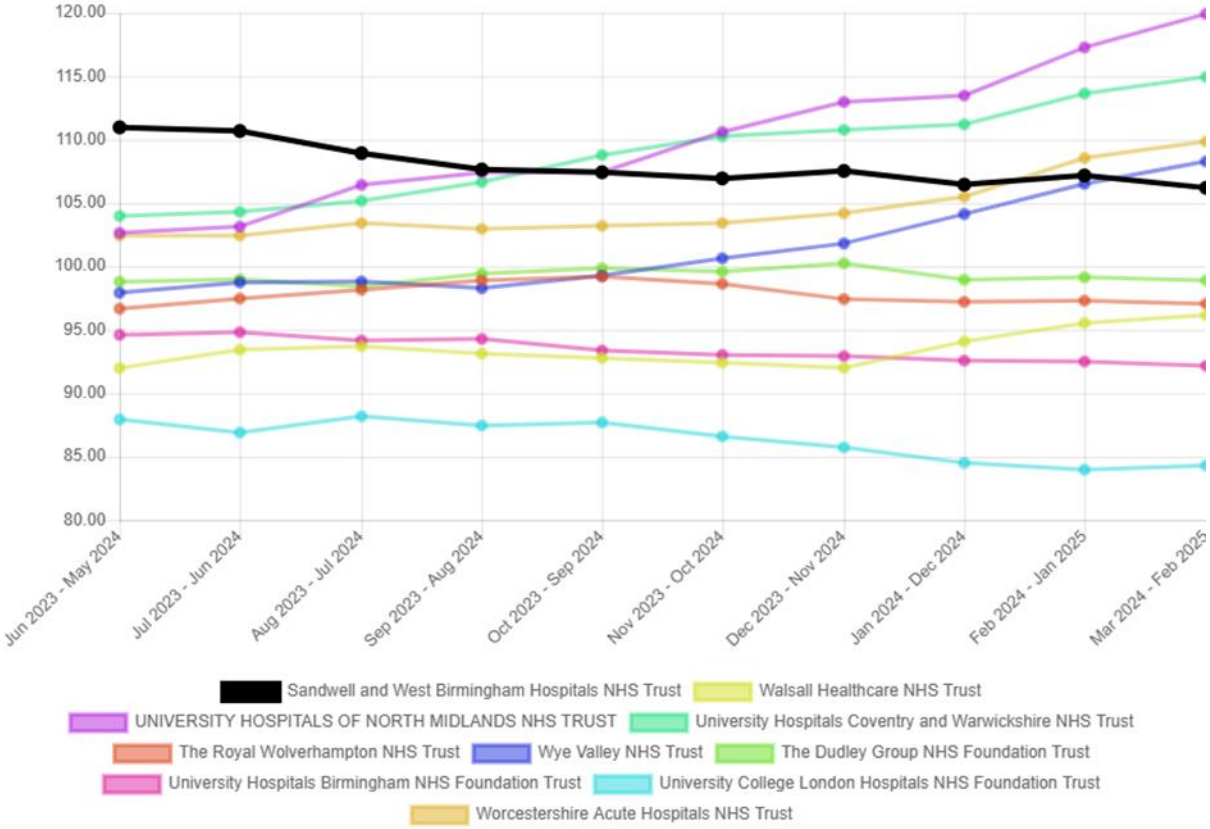
57,510	1810	1,740.00	1.04
Provider spells	Observed deaths	Expected deaths	SHMI value

SHMI contextual indicators

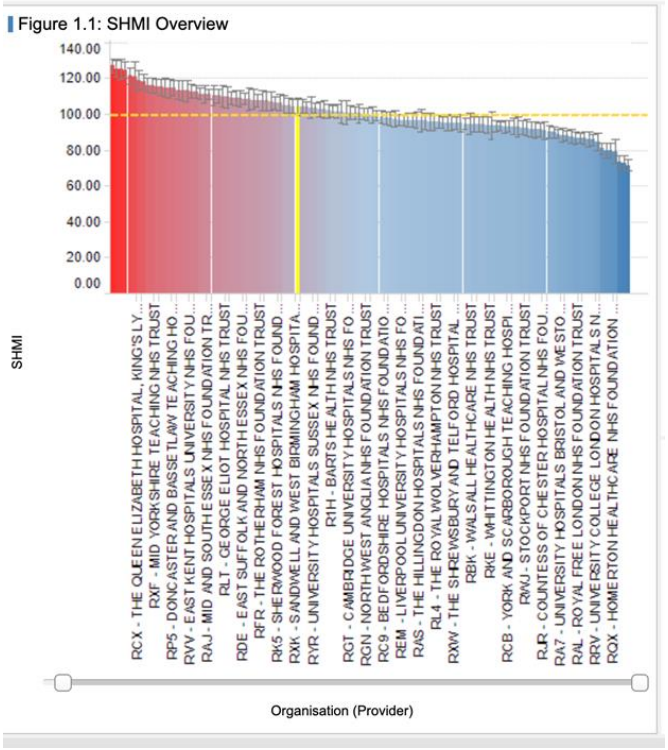
Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.2	0.1
Percentage of provider spells with palliative care diagnosis coding	1.6	2.1
Percentage of provider spells with palliative care coding	1.7	2.1
Percentage of deaths with palliative care treatment specialty coding	4.0	2.0
Percentage of deaths with palliative care diagnosis coding	34.0	45.0
Percentage of deaths with palliative care coding	35.0	45.0
Admission method		
Crude percentage mortality rate for elective admissions	0.0	1.0
Crude percentage mortality rate for non-elective admissions	3.5	3.4
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	71.0	69.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	30.0	31.0

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
I3W1A	Midland Metropolitan University Hospital	23,405	775	725.00	1.07	As expected SHMI
RXK01	Sandwell General Hospital	13,905	580	535.00	1.08	As expected SHMI
RXK02	City Hospital	19,175	445	445.00	0.99	As expected SHMI
RXK10	Rowley Regis Hospital	355		25.00		
.	Unknown		0			
L8H2I	Burcot Hall	40	0			
NVC44	The Westbourne Centre		0			
RXK27	Leasowes Intermediate Care Centre	125	10			
X9T4U	Birmingham Treatment Centre City Hospital Elective Surgical Hub	500				

12-month cumulative SHMI: comparison with peer trusts



8.2.5 On 12th Sep 2024, NHSE published an alert to include 13 trusts with 'higher than expected' number of deaths. Sandwell was 13th on that list. This latest figure represents how our trust currently benchmarks better against the other 142 acute providers in NHS England.

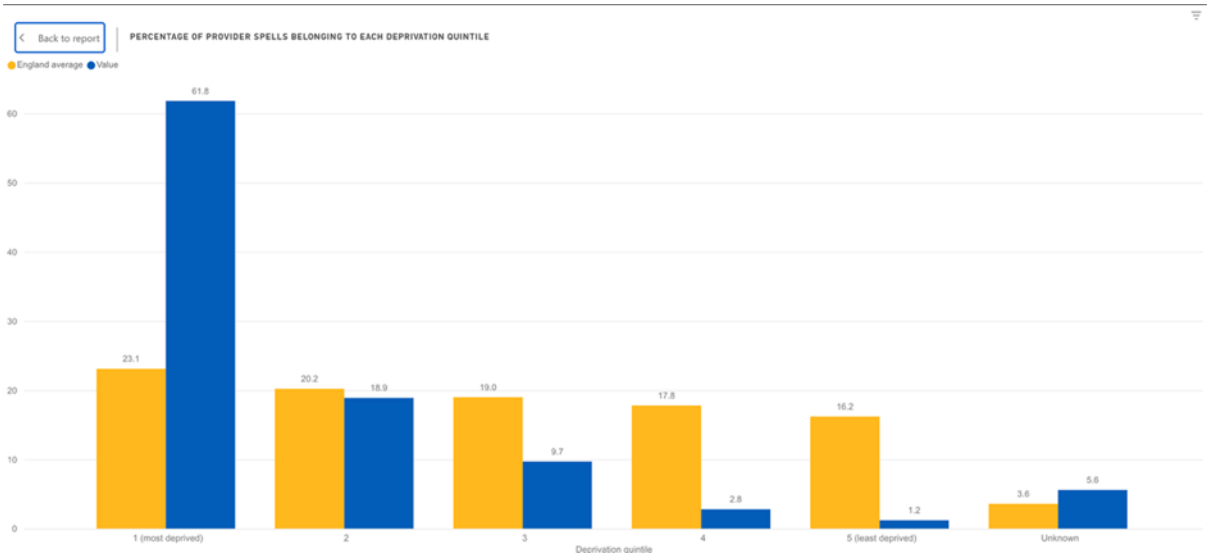


8.3 SHMI contextual data (From NHS Digital)

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

8.3.2 At SWB we have a continuing pattern of remaining above the national average for **mean depth of coding for non-elective procedures** (i.e. we are doing well with documenting all the comorbidities for our non-elective patients), however we continue to benchmark poorly for **mean depth of coding for elective admissions** (i.e. we are not doing well for documenting all comorbidities for elective patients). A piece of work has started to investigate this discrepancy and identify actions to mitigate against this. Working with the Coding department, it's been identified that similar issues were identified prior to the move to electronic records, and a piece of work was completed with Dermatology to strengthen the documentation of their high volume low acuity cases. As this was successful historically, we are aiming to relaunch this project with Dermatology in order to identify learning that can strengthen comorbidity documentation and coding across the trust. Good depth of coding is more likely to produce accurate "expected" numbers of deaths, which will then influence mortality ratios.

8.3.3 Further investigation into data quality and contributing factors to mortality statistics. The graph below indicates the level of deprivation within our local population. Yellow indicates the average for England, with blue representing the SWB value.



8.3.4 At SWB, 61.8% of patient treated as inpatient come from deprived communities. This is the highest in comparison with other provider organisations in the ICS. For comparison, the corresponding figures for Dudley, Wolverhampton and Walsall are 38.0, 39.8 and 54.2 respectively. SHMI methodology does not correct for this high level of deprivation. Deprivation is typically measured using the Index of Multiple Deprivation (IMD). It combines indicators across income, employment, education, health, housing, crime, and living environment. Populations are usually grouped into quintiles "most deprived" to "least deprived" people in the most deprived areas of England live 7–9 years fewer (men)

and 6–7 years fewer (women) than those in the least deprived areas. Published SHMI values do not correct for deprivation, but NHS England separately publish the deprivation indices of the admitted population for provider organisation as a contextual factor for consideration.

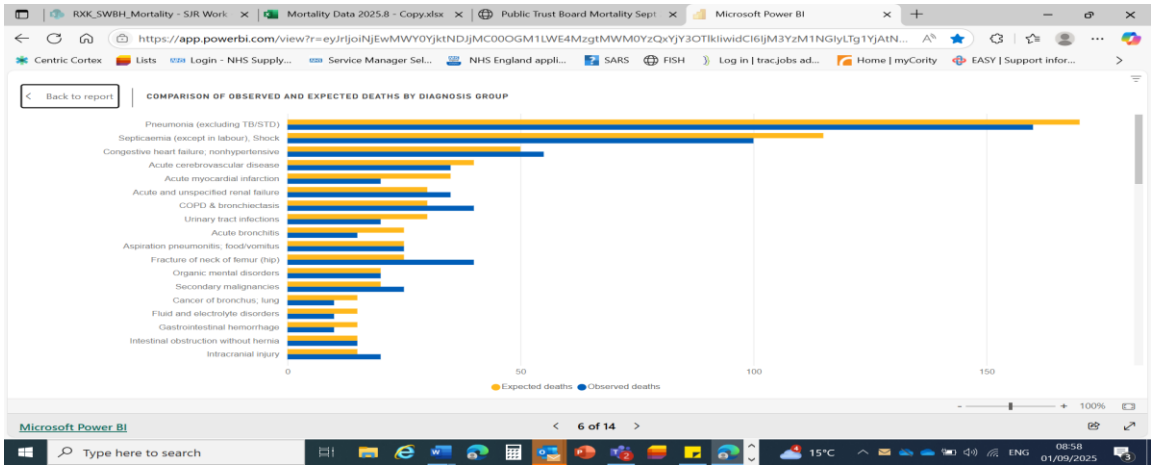
9. Observed Vs Expected Deaths (from NHS digital)

9.1 Each month NHS Digital provides a breakdown by diagnostic group of deaths that were considered “expected deaths” due to factors such as mortality risk, and “observed deaths” which captures the actual number of deaths that occurred; this reflects the 2 factors determining our SHMI.

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

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

Cumulative Observed (blue) Vs Expected (orange) deaths reported in August 2025



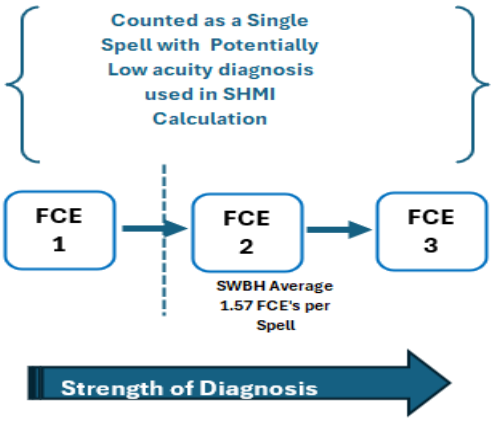
9.1.3 A Targeted audit was carried out on a cohort of Pneumonia patients with the lowest mortality risk resulting in Death, 2023-2024 which found that 9 out of 25 (36%) of the patients had significantly lower absolute score for their documented co-morbidities subsequently having a lowering effect on the ‘expected’ element of the SHMI ratio. The documentation QI work is expected to address this and the ongoing QI work to improve coding documentation will be used to evaluate the impact in the coming months.

9.1.4 We have recently reviewed and updated the community acquired pneumonia careplan after an initial pilot had found areas which required improvement. In particular, it was found that users were unable to easily navigate the careplan and so the layout has been updated and streamlined for a more efficient use. A non-functioning hyperlink to the antibiotic guidelines was fixed and the display of misleading clinical parameters was

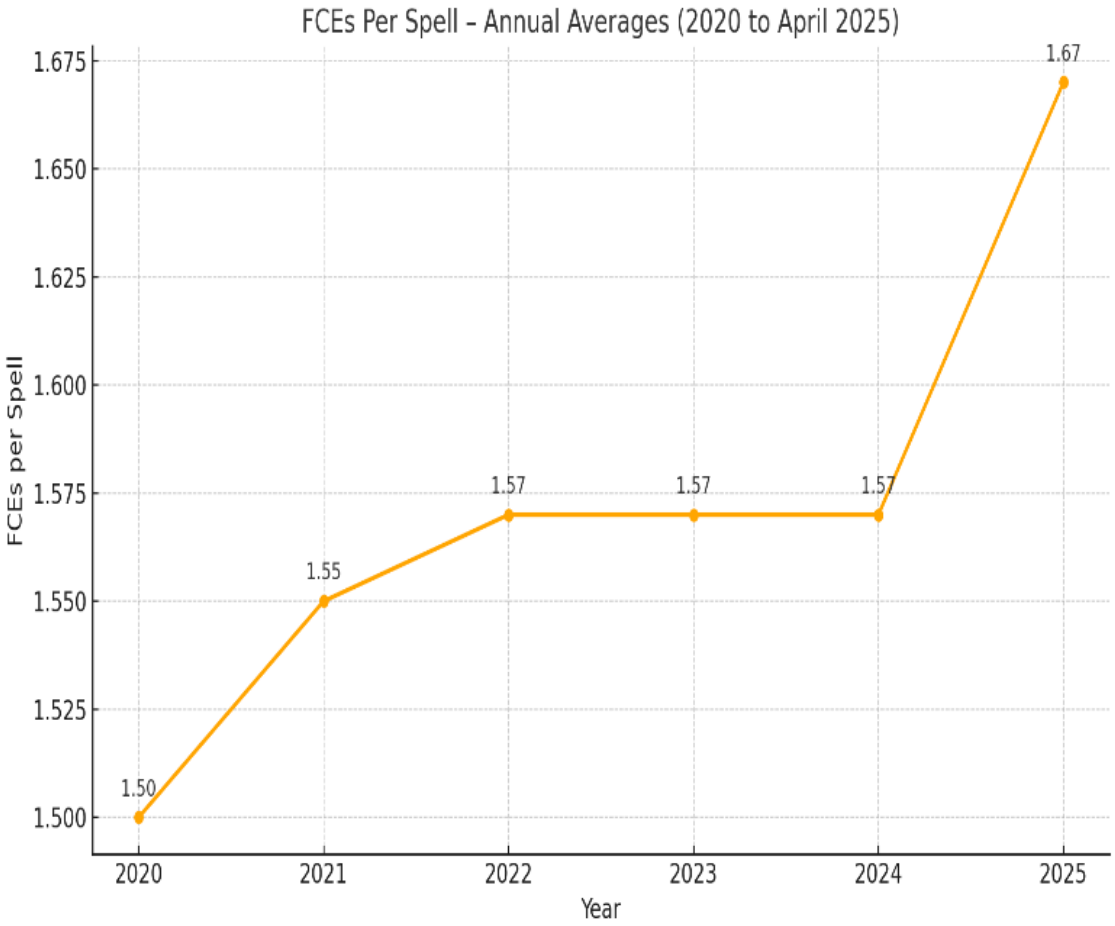
removed. The functionality has also been updated and now allows the user to initiate the oxygen careplan and prescribe oxygen directly from the pneumonia careplan where relevant. We have now included a form which requires the user to record the severity score (CURB-65) and to justify any deviation from the guidelines with regards to antibiotic prescribing. We feel this will encourage more accurate scoring of severity, more accurate antibiotic prescribing and will allow easier audit of any deviations.

10. Potential Impact of Elevated Finished Consultant Episodes (FCEs) on SHMI at SWB

10.1 At Sandwell and West Birmingham (SWB), our clinical admission and care processes often result in multiple Finished Consultant Episodes (FCEs) within a single patient spell, due to transfers between consultants during the hospital stay. While such transfers can reflect appropriate clinical pathways, they all need to be coded with a Diagnosis.



10.2 It is the final FCE that has a coded Diagnosis that benefits from knowledge obtained from all the tests and clinical work done during the spell. **SHMI Methodology Update (2024),** The updated 2024 SHMI model now selects the first coded episode with a valid diagnosis—excluding symptom-only codes. However, this diagnosis may still reflect a lower level of acuity than the condition that ultimately led to the patient's deterioration, and may therefore continue to underestimate the 'expected' mortality in some cases.
Graph 1.9, FCE-to-Spell Ratio (Annual Averages, 2020 – April 2025)



10.3 Nationally, the average FCEs per spell across acute NHS providers is stable at 1.1 to 1.2. However, SWB consistently exceeds this, with an average above 1.5, as shown below:

10.4 Result: Our elevated FCE rate may be distorting SHMI, making mortality outcomes appear worse by reducing the 'expected deaths' component.

Attempts to reduce unnecessary FCEs have been constrained by current Electronic Patient Record (EPR) limitations, which restrict visibility of diagnostic results and clinical notes across consultants — leading to avoidable transfers and fragmented documentation.

A QI approach to understanding the multiple drivers of FCE, proposed digital and clinical workflow optimisations that can result in improvements, the impact of the changes downstream will be undertaken. The LFD team is working with Performance and Insight team and the Improvement team and will report to the Quality committee.

10 Recommendations

10.5 The Public Trust Board is asked to:

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

Arvind Rajasekaran
Deputy Chief Medical Officer and Trust Mortality Lead

30/08/2025

References

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

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

Paper ref:	PublicTB (09/25) 012

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS Sandwell and West Birmingham NHS Trust

REPORT TITLE:	Strategy Update (Quarter 1) : Progress Update on Strategic Objectives and Annual Plan Delivery		
SPONSORING EXECUTIVE:	Adam Thomas Group Chief Strategy & Digital Officer		
REPORT AUTHOR:	Martin Chadderton, Associate Director of Strategy (SWBH)		
MEETING:	Public Trust Board	**DATE:**	10/09/2025

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

This report provides a quarterly update on progress against the Trust's strategic objectives and in-year annual plan priorities, covering the period April – June 2025. It summarises delivery against target, highlights key risks and mitigations, and identifies areas of improvement or concern based on performance trajectories.

- **Overall Progress**: The Trust continues to make progress against its strategic objectives and in-year priorities, with clear areas of positive assurance. Members are asked to consider whether the pace and scale of progress is sufficient to deliver the intended outcomes within the agreed timeframes.
- **Areas Requiring Focus**: While improvement activity is underway across all domains, a number of objectives remain challenged. The Board is invited to reflect on whether the mitigations in place are adequate, and where additional support or oversight may be required.
- **Delivery Confidence & Risks**: The report outlines the performance for each objective and identifies key risks. The Board should consider whether the level of risk is acceptable in the context of the Trust's wider priorities and capacity, and if not, what further actions are required.
- **Learning & Improvement**: The report highlights examples of good practice and early impact where new initiatives are already contributing to improvement. The Board is asked to consider how these can be further embedded and scaled across the organisation.
- **Future Outlook**: Given the external context (including national planning guidance, ICB requirements, and financial challenges), the Board should discuss the implications for the Trust's ability to maintain momentum and align local priorities with system-wide commitments.

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?]*

Executive Group.

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**Note** the quarterly progress update against the Trust's strategic objectives and in-year annual plan priorities for April – June 2025.
b.	**Discuss** the areas of challenge, associated risks, and whether the proposed mitigations provide sufficient confidence in delivery.
c.	**Endorse** the ongoing improvement actions and support any additional measures required to strengthen delivery confidence and alignment with system-wide priorities.

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		

Paper ref:	PublicTB (09/25) 013

REPORT TITLE:	Early Performance Against 2025/26 Workforce Plan		
SPONSORING EXECUTIVE:	James Fleet, Group Chief People Officer		
REPORT AUTHOR:	James Fleet, Group Chief People Officer Simon Sheppard, Acting Chief Finance Officer Johanne Newens, Chief Operating Officer Melanie Roberts, Chief Nurse/Deputy Chief Executive Andy Harding, Group Associate Director – Workforce Digital and Analytics		
MEETING:	Public Trust Board	**DATE:**	10/09/2025

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

2025/26 Workforce Plan:

- The Trust entered 2025/26 with an ambitious plan to reduce workforce deployment by 718 FTE (8.5%) to reset the workforce baseline following the mobilisation of MMUH.
- At Month 4, deployment has reduced by 186 FTE from the April starting point (January 25 – M10: 8411 FTE), and 336 FTE when compared to March 25 – M12: 8560 FTE), confirming progress against the 2020/26 baseline.
- The workforce reduction plan is supported by enabling programmes including GoodShape sickness absence management, rostering optimisation and owed hours clearance, roll-out of Activity Manager, and implementation of the Mutually Agreed Resignation Scheme (MARS). Oversight is maintained through strengthened governance, including weekly executive forums and monthly confirm-and-challenge sessions with each Clinical Group.

Month 4 position:

- Despite strong performance in reducing agency usage and stabilising substantive staffing, at month 4 the Trust is 99 FTE's above the 25/26 total workforce trajectory, driven primarily by sustained bank usage and reflecting the impact of industrial action.

Risks & Mitigations:

- Forecasts indicate a year-end shortfall of 217 FTE and £5.99m against plan, with the greatest delivery risks sitting in Medicine and Emergency Care and Surgical Services.
- Corporate services are expected to outperform.
- Mitigation measures include strengthened vacancy control, accelerated MARS implementation, enhanced rostering and owed hours clearance, and intensified executive oversight. In addition, a rapid piece of work is being taken forward, involving the leadership teams from all Groups and Corporate Directorates, to develop a range of wider mitigating schemes, covering workforce and non-workforce areas, with a

particular focus on improving productivity, reducing outsourcing, and maximising non-pay efficiencies.

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

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

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**ASSURANCE:** Receive the report for assurance that there is robust monitoring of performance against the 2025/26 workforce plan.
b.	**NOTE:** the M04 performance against the 25/26 workforce plan
c.	**NOTE:** the identified risks to delivering the 25/26 workforce plan
d.	**NOTE:** the actions in place to mitigate these risks and support delivery

5.	**Impact** *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*								
Board Assurance Framework Risk 01		x	*Deliver safe, high-quality care.*						
Board Assurance Framework Risk 02		x	*Make best strategic use of its resources*						
Board Assurance Framework Risk 03		x	*Deliver the MMUH benefits case*						
Board Assurance Framework Risk 04			*Recruit, retain, train, and develop an engaged and effective workforce*						
Board Assurance Framework Risk 05			*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 10 September 2025

Early Performance Against 2025/26 Workforce Plan

1. Introduction and Context

1.1 During 2024/25 the Trust's overall workforce deployment rose by 390.8 whole-time equivalent (FTE), bringing the year-end position to 8,411 FTE. This was 577 FTE above plan and 520 FTE above budget. The excess reflected both the deliberate recruitment undertaken in preparation for the opening of the Midland Metropolitan University Hospital (MMUH) and the reliance on bank staff to provide transitional capacity. These measures were necessary to sustain operational resilience, but they left the Trust carrying a higher deployed workforce than planned.

1.2 The Trust initiated a suite of workforce transformation programmes, covering rostering optimisation, electronic job planning, eLeave, Activity Manager and the GoodShape healthy attendance platform, which were sequenced to deliver tangible benefit in 2025/26.

2. The 2025/26 Workforce Plan

2.1 In March 2025, the Board approved an ambitious workforce reduction plan that aimed to reduce deployment by 718 FTE, or 8.5 per cent, by March 2026. The exit position was set at 7,693 FTE, a sharper reduction than comparable Black Country providers, reflecting both the higher baseline at SWB and the strategic requirement to reset the workforce footprint following the MMUH mobilisation.

2.2 The 2025/26 workforce plan reflects: a 90 per cent reduction in agency usage, a 75 per cent reduction in bank, as well as significant structural/substantive FTE reductions in corporate services, particularly through alignment with the April 2022 baseline. The plan also includes targeted increases in substantive frontline clinical staffing to rebalance the workforce mix.

2.3 Delivery is dependent on a series of enabling programmes. These include:

- Sustained 'grip & control' across all areas of workforce spend – substantive, bank and agency, including: vacancy control processes, enhanced confirm-and-challenge forums, and regular executive oversight
- Strengthened sickness absence management through GoodShape
- Full optimisation of rostering and the systematic clearance of owed hours
- Roll-out of Activity Manager to integrate workforce and activity planning
- Implementation of the Mutually Agreed Resignation Scheme (MARS) alongside other restructuring interventions
- Realisation of MMUH efficiencies.
- Local Group-led workforce efficiency plans, to reduce operational FTE requirements, through a combination of productivity improvement interventions (i.e. elective productivity), capacity reduction (i.e. ED) as well as transformational developments and

leveraging opportunities to operate at scale through the Group leadership arrangements.

3. Leadership and Governance

3.1 Overall accountability for the 2025/26 workforce plan sits with the Group Chief People Officer as SRO, supported by shared executive responsibility across portfolios. Designated leads are in place for Group-level delivery, corporate workforce reductions, rostering optimisation, and medical workforce efficiencies.

4. Delivery to July 2025 (Month 4 Position)

Group / Directorate	June - Plan	June - Actual	June - Variance	June - Utilisation	July - Plan	July - Actual	July Variance	July - Utilisation
Imaging	360.5	360.2	0.3	99.9%	356.6	358.4	-1.8	101%
Medicine and Emergency Care	2010.9	2044.8	-33.9	101.7%	1965.8	2042.2	-76.4	104%
Primary Care Community and Therapies	1494.8	1471.7	23.1	98.5%	1477.7	1459.2	18.6	99%
Surgical Services	1509.7	1513.8	-4.1	100.3%	1490.7	1519.2	-28.5	102%
Women and Child Health	1039.7	1031.0	8.7	99.2%	1036.1	1031.0	5.1	100%
Clinical Total	**6415.5**	**6421.5**	**-6.0**	**100.1%**	**6326.9**	**6410.0**	**-83.1**	**101.3%**
Chief Development Officer	639.5	631.5	7.9	98.8%	634.4	640.5	-6.1	101%
Chief Executive Officer	53.3	52.6	0.7	98.7%	52.2	52.4	-0.2	100%
Chief Medical Officer	280.0	269.9	10.0	96.4%	277.3	271.1	6.2	98%
Chief Nursing Officer	156.7	162.2	-5.5	103.5%	154.6	158.8	-4.2	103%
Chief Operating Officer	123.8	128.0	-4.2	103.4%	121.2	124.4	-3.2	103%
Finance	237.9	235.0	2.9	98.8%	234.6	233.1	1.5	99%
People and Organisation Development	144.2	153.3	-9.1	106.3%	141.7	146.8	-5.1	104%
Strateg and Digital	186.2	185.6	0.6	99.7%	182.9	187.5	-4.7	103%
Corporate Total	**1821.6**	**1818.2**	**3.4**	**99.8%**	**1798.8**	**1814.6**	**-15.8**	**101%**
Total	**8237.1**	**8239.7**	**-2.6**	**100.0%**	**8125.7**	**8224.6**	**-98.9**	**101%**

Pay Group	June - Plan	June - Actual	June - Variance	July - Plan	July - Actual	July Variance
Contracted	7397.9	7414.4	-16.5	7418.6	7388.5	30.2
Bank	764.2	749.7	14.5	642.1	779.0	-136.9
Agency	75.0	75.6	-0.6	65.0	57.2	7.8
Total	**8237.1**	**8239.7**	**-2.6**	**8125.7**	**8224.6**	**-98.9**

4.1 At Month 4 (July), workforce deployment stood at 8,224.6 FTE. This represents a reduction of 186 FTE from the January baseline of 8,411 FTE and 336 FTEs from the actual starting point of 8560.6 FTEs in April 2025, confirming that the Trust remains below baseline and is delivering net reductions. However, against the planned trajectory of 8,125.7 FTE, deployment was 98.9 FTE higher, reflecting the impact of industrial action, as well as the 2025/26 workforce plan itself reducing by 100+ FTE's between June and July.

4.2 The monthly profile shows steady progress compared with the baseline: April recorded 8,298.8 FTE, May 8,237.2 FTE, June 8,239.7 FTE, and July 8,224.6 FTE. Against plan, however, the variance has fluctuated. It narrowed significantly in the early part of the year, from 111 FTE adverse in April to only 2 FTE in June, before widening sharply again in July (99 FTEs).

4.3 Group-level performance reflects this pattern. Medicine and Emergency Care has consistently operated above plan and accounts for the largest variance, with deployment materially higher than expected. Surgical Services has also been above plan, though at a lower level. In contrast, Primary Care, Community and Therapies has remained below trajectory, providing some offset, while Imaging and Women and Child Health have tracked close to plan.

4.4 July comprised 7,388.5 FTE contracted staff (30.2 FTE below plan), 779.0 FTE bank staff (136.9 FTE above plan), and 57.2 FTE agency staff (7.8 FTE below plan). This confirms that bank utilisation is the principal driver of variance. Agency use has continued to reduce, and substantive staffing has remained within plan, this reflects the robust vacancy control

arrangements that are in place which have driven a significant reduction in recruitment of new staff, effectively restricting recruitment to operationally and clinically critical posts only.

4.6 Therefore, whilst the Trust has stabilised substantive staffing and reduced agency reliance, an over-reliance on bank staff has resulted in an overall adverse to plan performance for month 4.

5. Workforce Efficiencies and Optimisation

5.1 Alongside direct deployment management, targeted workforce efficiency actions are underway to support both immediate cost control and longer-term structural change.

5.2 The GoodShape absence management system has now been adopted for 76 per cent of absence episodes, demonstrating consistent month-on-month growth. While the proportion of return-to-work interviews remains below the desired level, the upward trend in system usage indicates growing operational grip on absence.

5.3 The pay back of owed hours through the e-rostering platform has reached 2,150 hours. This represents tangible progress in converting owed time into rostered activity and releasing efficiency gains. A larger pool of owed hours has been identified and remains to be processed, offering further opportunity to reduce bank usage by up to £2m through swapping bank shifts for owed hrs. The Chief Nurse and nurse leaders are leading the work to transact as much of this opportunity as possible by March 2026, with the support of digital systems, i.e. Ward Guardian.

5.4 Implementation planning for Activity Manager, to support medical workforce job planning and demand-capacity planning, has advanced, with Surgical Services confirming a phased roll-out beginning with Trauma and Orthopaedics, ENT and Ophthalmology. These specialties will act as early adopters, enabling improved oversight of theatre utilisation, activity scheduling and workforce deployment.

5.5 These initiatives have underpinned the plan delivery during Q1 and will continue to support the realisation of measurable in-year workforce efficiency benefits, whilst also strengthening operational functionality and effectiveness.

6. Forecast and Phasing Risk

Table 1: Plan												
Group / Corp. Directorate	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Chief Development Officer	5.16	5.16	5.16	12.91	13.87	15.69	23.33	30.38	31.61	25.65	24.71	32.45
Chief Executive Officer	1.75	8.36	6.46	6.46	6.46	6.46	7.46	7.46	7.46	7.46	7.46	7.46
Chief Medical Officer	4.02	4.57	4.17	6.83	7.34	8.30	12.35	16.08	16.73	14.58	14.08	17.18
Chief Nursing Officer	11.75	14.46	13.95	5.45	5.85	6.62	9.85	12.83	13.35	10.84	10.44	13.70
Chief Operating Officer	3.85	4.38	4.00	6.55	7.03	7.95	11.83	15.41	16.03	13.01	12.53	16.46
Finance	5.06	5.75	5.24	8.59	9.23	10.44	15.53	20.24	21.08	17.11	16.48	21.63
People and Organisation Development	3.74	4.26	3.88	6.36	6.83	7.72	11.47	14.93	15.53	12.60	12.14	15.94
Strategy and Digital	5.02	5.71	5.21	8.54	9.17	10.39	15.44	20.10	20.91	16.97	16.35	21.46
Corporate Total	**40.35**	**52.65**	**48.07**	**61.69**	**65.78**	**73.57**	**107.26**	**137.43**	**142.70**	**118.22**	**114.19**	**146.28**
Imaging	5.83	6.63	6.05	9.90	10.63	12.02	17.89	23.30	24.24	19.68	18.96	24.89
Medicine and Emergency Care	67.95	77.27	70.45	115.43	123.97	140.15	208.47	271.58	282.55	229.33	220.90	290.06
Primary Care Community and Therapies	25.69	29.22	26.63	43.62	46.85	52.98	78.82	102.67	106.81	86.69	83.51	109.65
Surgical Services	28.67	32.60	29.72	48.70	52.30	59.14	87.97	114.59	119.22	96.77	93.22	122.41
Women and Child Health	13.93	13.93	7.69	8.97	9.85	11.16	16.60	21.83	22.55	18.24	17.63	23.08
Clinical Total	**142.07**	**159.65**	**140.54**	**226.62**	**243.60**	**275.45**	**409.75**	**533.97**	**555.37**	**450.71**	**434.22**	**570.09**
Workforce Total	**182.42**	**212.30**	**188.61**	**288.31**	**309.38**	**349.02**	**517.01**	**671.40**	**698.07**	**568.93**	**548.41**	**716.37**

Table 2: Actuals / Forecast												
Group / Corp. Directorate	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Chief Development Officer	4.16	10.03	3.78	4.51	8.16	21.53	25.65	27.65	29.65	30.05	35.49	35.49
Chief Executive Officer	0.70	8.36	8.55	8.99	5.65	5.05	7.05	7.05	7.05	7.46	7.46	7.46
Chief Medical Officer	0.00	7.91	13.60	15.02	15.02	17.02	19.42	19.42	16.18	16.18	17.18	17.18
Chief Nursing Officer	6.56	15.43	15.71	13.49	9.75	9.75	7.26	7.26	7.26	7.26	7.26	7.26
Chief Operating Officer	1.00	0.31	0.00	2.62	1.00	6.00	12.00	12.00	15.00	15.74	15.74	15.74
Finance	7.00	7.67	8.13	12.16	7.30	7.30	7.30	7.30	6.30	9.30	9.30	9.30
People and Organisation Development	0.00	0.12	0.00	11.27	3.91	3.91	7.51	7.51	7.51	13.04	13.04	13.04
Strategy and Digital	0.00	0.07	1.86	3.35	3.35	3.35	3.35	3.35	3.35	4.35	4.35	4.35
Corporate Total	**19.42**	**49.90**	**51.63**	**71.41**	**54.14**	**73.91**	**89.54**	**91.54**	**92.30**	**103.38**	**109.82**	**109.82**
Imaging	0.00	13.81	15.61	15.03	3.46	6.26	6.26	12.67	12.67	16.67	16.67	16.67
Medicine and Emergency Care	0.05	54.43	61.51	57.69	86.84	115.36	117.36	94.60	96.60	149.60	149.60	162.11
Primary Care Community and Therapies	100.87	87.32	108.00	98.23	28.54	28.54	54.14	54.14	54.14	80.38	80.38	100.17
Surgical Services	0.00	33.80	44.08	47.90	21.39	31.39	41.13	47.13	52.13	83.27	89.27	94.27
Women and Child Health	74.17	54.71	24.09	22.89	19.12	18.12	16.15	16.15	16.15	16.15	16.15	16.15
Clinical Total	**175.09**	**244.07**	**253.29**	**241.74**	**159.35**	**199.67**	**235.04**	**224.69**	**231.69**	**346.07**	**352.07**	**389.37**
Workforce Total	**194.51**	**293.97**	**304.92**	**313.15**	**213.49**	**273.58**	**324.58**	**316.23**	**323.99**	**449.45**	**461.89**	**499.19**

Table 3: Variance to Plan												
Group / Corp. Directorate	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
Chief Development Officer	-1.00	4.87	-1.38	-8.40	-5.71	5.84	2.32	-2.73	-1.96	4.40	10.78	3.04
Chief Executive Officer	-1.05	0.00	2.09	2.53	-0.81	-1.41	-0.41	-0.41	-0.41	0.00	0.00	0.00
Chief Medical Officer	-4.02	3.34	9.43	8.19	7.68	8.72	7.07	3.34	-0.55	1.60	3.10	0.00
Chief Nursing Officer	-5.19	0.97	1.76	8.04	3.90	3.13	-2.59	-5.57	-6.09	-3.58	-3.18	-6.44
Chief Operating Officer	-2.85	-4.07	-4.00	-3.93	-6.03	-1.95	0.17	-3.41	-1.03	2.73	3.21	-0.72
Finance	1.94	1.92	2.89	3.57	-1.94	-3.15	-8.24	-12.95	-14.79	-7.82	-7.19	-12.34
People and Organisation Development	-3.74	-4.14	-3.88	4.91	-2.92	-3.81	-3.96	-7.42	-8.02	0.44	0.90	-2.90
Strategy and Digital	-5.02	-5.64	-3.35	-5.19	-5.82	-7.04	-12.09	-16.75	-17.56	-12.62	-12.00	-17.11
Corporate Total	**-20.93**	**-2.75**	**3.56**	**9.72**	**-11.65**	**0.34**	**-17.73**	**-45.90**	**-50.41**	**-14.85**	**-4.37**	**-36.47**
Imaging	-5.83	7.18	9.56	5.13	-7.17	-5.76	-11.63	-10.63	-11.57	-3.01	-2.29	-8.22
Medicine and Emergency Care	-67.90	-22.84	-8.95	-57.74	-37.13	-24.79	-91.11	-176.98	-185.95	-79.73	-71.30	-127.95
Primary Care Community and Therapies	75.18	58.10	81.37	54.61	-18.31	-24.44	-24.68	-48.53	-52.67	-6.31	-3.13	-9.48
Surgical Services	-28.67	1.20	14.36	-0.80	-30.91	-27.75	-46.84	-67.46	-67.09	-13.50	-3.95	-28.14
Women and Child Health	60.24	40.78	16.40	13.92	9.27	6.96	-0.45	-5.68	-6.40	-2.09	-1.48	-6.93
Clinical Total	**33.02**	**84.42**	**112.75**	**15.12**	**-84.25**	**-75.78**	**-174.71**	**-309.28**	**-323.68**	**-104.64**	**-82.15**	**-180.72**
Workforce Total	**12.09**	**81.67**	**116.31**	**24.84**	**-95.90**	**-75.45**	**-192.43**	**-355.17**	**-374.08**	**-119.48**	**-86.52**	**-217.18**

6.1 The latest forecast indicates that by March 2026 the Trust will have reduced its workforce deployment by 499.2 FTE (including the 100 FTE against the MAR Scheme) compared with the January baseline, therefore an FTE exit position of 7,909.8 FTE. Against the plan for a 716.4 FTE reduction, this represents a projected shortfall of 217.2 FTE (noting the risk of 100 FTE MARS included within the 499 FTE). In financial terms, this equates to £24.86m of delivery against a planned £30.85m, i.e. a 6.8% FTE reduction v the planned 8.5%, equating to a financial gap of £5.99m. The recurrent full year effect of the identified CIPs is £28.91m.

6.3 Clinical portfolios account for the majority of the forecast variance. Medicine and Emergency Care is projected to end the year 127.9 FTE under plan, equating to £3.17m adverse. Surgical Services is forecast 28.1 FTE under plan and £2.22m adverse. Primary Care, Community and Therapies and Imaging are also currently forecasting to under-deliver against their plan, while Women and Child Health is projected to remain broadly on plan.

6.4 Corporate portfolios are forecast to over-achieve, ending the year 36.5 FTE below plan but £0.64m favourable. This reflects timing differences in reductions and changes in skill mix across Strategy and Digital, Finance and other corporate areas.

7. Mutually Agreed Resignation Scheme (MARS)

7.1 The Trust has received 125 applications under the Mutually Agreed Resignation Scheme. Each is being assessed against agreed eligibility and affordability criteria to ensure consistency and compliance with national requirements. The assessment process will confirm the number of applications that can be supported within the available financial envelope, which has been modelled to ensure sustainability and to avoid adverse impact on services. Final approval of MARS applications involves an Executive decision-making panel, as well as external approval by NHS England.

8. Risks and Mitigation

8.1 The Month 4 position highlights some key risks to delivery. Elevated bank usage is the principal driver of variance. The phasing of delivery of the wider Group workforce plans and FTE reductions also represents a risk to the finance plan, with the phasing of Group plans in particular creating a greater in-year pressure.

8.2 Clinical Groups drive the highest proportion of the risk to plan delivery, particularly Medicine and Emergency Care and Surgical Services, which together account for the majority of the projected shortfall. In corporate services, while offsets are expected, there is a risk that delivery is delayed or that reductions fall short of profile.

8.3 Mitigation measures are in place. A strengthened vacancy freeze and enhanced vacancy control process are being strictly applied. Monthly confirm-and-challenge sessions are being chaired by the Chief Executive with each Group to provide targeted scrutiny, while delivery of the workforce enabling workstreams is reviewed weekly by the Group Executive Workforce SRO . Additional grip is applied through the Financial Improvement Group, which meets twice monthly, and through specific forums for rostering, job planning and nursing workforce.

8.4 Operational capacity has been bolstered to accelerate the management of change, with enhanced trade union engagement to support delivery. Group trajectories are being stress-tested and pipeline schemes are being accelerated through development, quality impact assessment and implementation. Alongside this, a wider set of non-pay mitigations are being developed.

8.5 In addition, a new weekly pay 'grip & control' reporting process has been introduced by NHS England, which will take effect from 1st September.

8.6 With a current financial gap of circa £6m (£8m excluding MARS), in addition to the actions described in the paper, a rapid piece of work is being taken forward, involving the leadership teams from all Groups and Corporate Directorates, to develop a range of wider mitigating schemes, covering workforce and non-workforce areas.

8.7 These additional mitigations were discussed at the Finance & Performance Committee meeting in August and will be covered through the finance report, both Public and Private Board. These mitigation schemes will give particular focus on improvements in productivity, reducing outsourcing, and maximising non-pay efficiencies.

9. People Metrics

9.1 Alongside the workforce reduction trajectory, People Committee reporting continues to show improving trends in several underlying workforce indicators. Retention has improved, training compliance remains strong, and sickness absence has shown a modest reduction in recent months. Recruitment and turnover indicators remain under close monitoring, as there is a risk that pressures on deployment could translate into deteriorating performance in these areas. Sustained engagement at Group level will be required to ensure recent gains are embedded and recurrent.

10. Conclusion and Recommendation

10.1 The Month 4 position confirms that deployment has reduced compared with baseline, but variance to plan has widened, principally due to sustained bank usage, against an increasingly challenging plan. The forecasts highlight a risk of missing the 2025/26 workforce plan by 217.2 FTE's/£5.99m, with the largest risks sitting in Medicine and Emergency Care and Surgical Services.

10.2 The profile of the 2025/26 workforce plan gets increasingly challenging during the remainder of the year. Whilst risks are being mitigated through strengthened grip and control, accelerated delivery of corporate programmes, and the progression of the MARS process, additional mitigating measures are being developed to address the existing gap.

The Public Board is asked to:

a) **RECEIVE** this report for assurance that there is robust monitoring of performance against the 2025/26 workforce plan
b) **NOTE:** the M04 performance against the 2025/26 workforce plan
c) **NOTE:** the identified risks to delivering the 25/26 workforce plan
d) **NOTE:** the actions in place to mitigate these risks and support delivery

James Fleet
Group Chief People Officer
26th August 2025

Paper ref:	PublicTB (09/25) 014

PATIENTS PEOPLE POPULATION

AMBITION RESPECT COMPASSION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Equality, Diversity and Inclusion (EDI) Update – 2025 WRES & WDES Updates		
SPONSORING EXECUTIVE:	James Fleet, Group Chief People Officer		
REPORT AUTHOR:	James Fleet – Group Chief People Officer Sabrina Richards, Strategic EDI Specialist (Interim support) Meagan Fernandes, Director of People and OD		
MEETING:	Public Trust Board	**DATE:**	10/09/2025

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

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

The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) provide key indicators and benchmarks for evaluating the impact and effectiveness of interventions for improving the experiences of staff across the organisation.

Sandwell and West Birmingham NHS Trust has implemented a range of actions and interventions to embed an inclusive and compassionate culture through its With you all the Way Culture Programme which promotes equality and challenges all forms of discrimination. Updates on progress and impact are reported to the People Committee regularly.

This report presents Sandwell and West Birmingham's performance against the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) metrics for 2025. Whilst improvements have been made for both WRES and WDES metrics there still remain some disparities and challenges for ethnically diverse staff and disabled staff. The report highlights key trends, as well as areas of progress and ongoing challenges. The report also sets out the Trust's strategic actions to advance equity across the organisation.

The Board are invited to consider the updated WRES and WDES metrics, as well as the plans for driving further improvements and to take assurance that this work has the support of the Trust's wider leadership team.

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		To cultivate and sustain happy, productive and engaged staff	x	To work seamlessly with our partners to improve lives	

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

None

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**Review** and consider the latest Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results, particularly the areas of improvement and those areas requiring further focus intervention, ahead of public publication and approve sign off.
b.	**Be Assured** that the Trust is fully engaged and focused on tackling and reducing inequality and discrimination for staff from Black and Minority Ethnic backgrounds and disabled staff.
c.	**Support** the ongoing interventions for driving improvement in staff experience and outcomes across Sandwell and West Birmingham (SWB) NHS Trust.
d.	**Require** regular updates on progress

5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*							
Board Assurance Framework Risk 01			*Deliver safe, high-quality care.*					
Board Assurance Framework Risk 02			*Make best strategic use of its resources*					
Board Assurance Framework Risk 03			*Deliver the MMUH benefits case*					
Board Assurance Framework Risk 04		x	*Recruit, retain, train, and develop an engaged and effective workforce*					
Board Assurance Framework Risk 05			*Deliver on its ambitions as an integrated care organisation*					
Corporate Risk Register [Safeguard Risk Nos]								
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 September 2024

Equality, Diversity and Inclusion (EDI) Update
2025 WRES & WDES Metrics

1. Introduction

1.1 Equality, Diversity and Inclusion (EDI) is a strategic and legal duty for NHS Trusts, underpinned by national legislation, regulatory standards, and growing expectations from patients, the public, and the workforce. The Equality Act 2010 and the Public Sector Equality Duty place clear statutory responsibilities on the Trust to eliminate discrimination, advance equality, and foster inclusion across the nine protected characteristics. These obligations are reinforced by the NHS Constitution, the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), and the Health and Care Act 2022, all of which embed fairness, inclusion, and the reduction of health inequalities at the core of NHS values and service delivery.

1.2 The NHS England EDI Improvement Plan (2023–2025) sets clear expectations for inclusive leadership, equitable recruitment, and the elimination of disparities in patient outcomes, requiring Boards to actively oversee delivery and monitor progress. The Care Quality Commission's Single Assessment Framework also identifies EDI as a core element of the Well-Led domain, placing a regulatory requirement on Boards to demonstrate robust governance, accountability, and impact in advancing equality and inclusion. Alongside this, the NHS People Promise and the Long-Term Workforce Plan highlight that inclusive and supportive cultures are essential for workforce wellbeing, retention, and performance, factors that directly influence the quality and safety of patient care. Furthermore, achieving the ambitious goals within the 10-Year Plan will require NHS organisations to improve staff experience, strengthen retention, and attract talent from the widest possible pool, ensuring the workforce reflects and serves the diverse communities it supports.

1.3 The Board has a fundamental responsibility to ensure that EDI commitments are embedded within
strategic priorities, operational practice, and cultural leadership. This report provides assurance on current progress, identifies areas for improvement, and outlines how the Trust will continue to deliver measurable outcomes for its people.

2. Sandwell and West Birmingham EDI Priorities

2.1 The Trust's Equality, Diversity and Inclusion (EDI) Plan is at the heart of our People Plan and an integral component of our "With you all the way" Culture Programme. The main focus of the Plan is on nurturing a culture of compassion and inclusion, addressing under representation, delivering fair access to opportunities for employment and progression, as well as maintaining a zero-tolerance approach to discrimination and harassment. The Trust is committed to fostering a workplace that is compassionate, equitable, and inclusive for everyone who works at the Trust.

2.2 Figure 2.2.11 illustrates the Trust's EDI Plan 2023-2027 :

Figure 2.1.1

2.2 Our key priorities for 25/26 are as follows:

1. Deliver and embed a robust framework for inclusive Recruitment
2. Empower, Equip and enable the Staff Networks
3. Optimise the role and function of the EDI Team within the Trust
4. Launch a Sandwell and West Birmingham Inclusive Talent Management Programme

3. Workforce Race Equality Standard (WRES) & Workforce Disability Equality Standard (WDES)

3.1 In line with the national EDI 2024 plan, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) provide critical indicators for the Board to discharge its responsibility in overseeing, scrutinising, and driving the effectiveness of interventions that improve staff experience and advance equality across the organisation.

3.2 As well as focused work to improve the experience of ethnically diverse staff and disabled staff, as reflected in the WRES and WDES metrics, the Trust is also currently in the process of undertaking the Well-Led assessment which includes a key EDI domain. The outputs of the self-assessment will further enhance the improvement work that is being undertaken and will be reported to the People Committee as well as the Board.

3.3 At its meeting in August 2025, the People Committee received, considered and discussed a detailed report and related improvement plan which focused on addressing key areas for improvement across the WRES and WDES metrics, whilst also building on the areas where improvement has been achieved and sustained.

4. Workforce Race Equality Standard (WRES)

4.1 The Workforce Race Equality Standard (WRES), implemented in 2016 is a nationally mandated standard aimed at improving workplace experiences and career progression for NHS staff from Black and Minority Ethnic backgrounds (BME). The WRES consists of nine specific metrics that allow organisations to compare the experiences of employees from BME backgrounds with those of white staff, enabling the identification of disparities and supporting targeted improvement efforts.

4.2 Metrics 5 to 8 are based on responses to the NHS Staff Survey, which in 2024 achieved a 34 % response rate, which includes 39.93 % from staff who identify as Black and Minority Ethnic.

4.3 The 2025 Workforce Race Equality Standard (WRES) data for Sandwell and West Birmingham NHS Trust reveals some encouraging progress, as well as

ongoing challenges for staff from BME backgrounds within the Trust. Specifically, whilst there have been improvements in representation and improvements within the career progression and disciplinary indicators, notable disparities persist in areas such as recruitment, access to non-mandatory training, and limited representation at senior levels.

4.4 The key highlights from the WRES report:

- **Workforce Representation**: Staff from Black and Minority Ethnic (BME) backgrounds make up 45% of the workforce, which is higher than local community representation, which is 42.7%.
- **Disciplinary Action**: BME staff are 1.09 times more likely to face formal disciplinary processes than white staff, an improvement from 1.2 times the previous year.
- **Career Progression**: Staff reporting equal access to promotion increased from 44.5% to 46.4%.
- **Ethnicity Declaration**: Slight increase in staff disclosing ethnicity, improving data accuracy

4.5 Declined and static indicators:

- **Recruitment**: White applicants are 1.54 times more likely to be appointed from shortlisting. For the previous year, this indicator was 1.06.However what is important to note is that the reason for this decline is attributed to the way in which recruitment date was previously collected (e,g ESR rather than from TRAC-this ha now been corrected for next year's report.)
- **Development Access**: Staff from a white background are 1.09 times more likely to access non-mandatory training and CPD. For the previous year, this was 0.89
- **Harassment from the Public:** Reports slightly increased among staff from BME backgrounds, from 25% to 26% (2024 staff survey) and decreased among staff from a white background.
- **Discrimination**: Rates remain unchanged, but disproportionately affect BME staff 15% vs 6.3% (white staff).
- **Board Representation**: Remains unchanged from the previous year at 25%.

5. Workforce Race Equality Standard Five-Year Overview

The table below (Table 5.1.1) presents a summary of the Trust's WRES performance

and highlights trends across all nine metrics from 2020 to 2025.

Table 5.1.1

WRES Indicator			Reporting Year						Trend
			2020	2021	2022	2023	2024	2025	
1	Workforce Representation. Percentage of staff from all other ethnic groups combined	Overall	40.4%	40.7%	40.0%	42.0%	44.0%	45.4%	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to applications from all other ethnic groups		1.01	1.26	1.69	1.15	1.06	1.54	
3	Relative likelihood of staff from other ethnic minority groups entering the formal disciplinary process compared to white staff		0.35	1.83	2.54	1.48	1.2	1.09	
4	Relative likelihood of white staff accessing non-mandatory training and Continued Professional Development (CPD) compared to staff from all other ethnic groups		1.29	1.63	1.46	1.08	0.89	1.02	
5	(Staff Survey) - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	29.6%	27.2%	29.2%	31.9%	25.0%	26.0%	
		White	28.7%	27.4%	30.7%	28.0%	20.1%	17.9%	
6	(Staff Survey) Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	28.2%	29.9%	32.2%	30.7%	27.6%	27.3%	
		White	22.3%	23.1%	26.0%	23.3%	17.9%	17.2%	
7	(Staff Survey) - Percentage believing that Trust provides equal opportunities for career progression or promotion	BME	71.5%	42.8%	41.3%	41.0%	44.5%	46.4%	
		White	85.9%	57.1%	58.6%	59.4%	60.5%	60.9%	
8	(Staff Survey) - In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	BME	13.7%	15.8%	19.5%	17.7%	15.0%	15.0%	
		White	5.2%	6.3%	7.9%	7.9%	6.8%	6.3%	
9	Board representation	Overall	16.7%	22.2%	14.3%	20.0%	25.0%	25.0%	
	Board representation - of which Voting Members	Overall					20.0%	8.3%	

Note: the WRES data is 12 months behind the reporting year, i.e. the 2025 WRES data is drawn
from the 2024 annual staff survey.

5.1 The data relating to performance against the WRES metrics over the past 5 years highlights some key areas of consistent and/or overall improvement, these are:

- Indicator 1 - Workforce representation (40.4% in 2020 to 45.% in 2025)
- Indicator 5 – BME staff experiencing harassment, bullying or abuse from patients (29.6 % in 2020 to 26% in 2025, albeit this remains notably above the level reported by white staff)
- Indicator 6 - BME staff experiencing harassment, bullying or abuse from staff (28.2 % in 2020 to 27.3% in 2025, albeit this remains notably above the level reported by white staff)
- Indicator 9 – Board representation (16.7% in 2020 to 25% in 2025). This is also significantly higher than the national position, as reported in the latest national 2024 WRES report, which identifies that 'BME board membership nationally is at 16.5%

5.2 The data relating to performance against the WRES metrics over the past 5 years also highlights the following areas of deteriorating performance:

- Indicator 8 – BME staff who have experienced discrimination at work (13.7% in 2020 to 15% in 2025, which is also markedly above the level reported by white staff)
- Indicator 7 – BME staff believing that the Trust provides equal opportunities for career progression (71.5% in 2020 to 46.4% in 2025, which is markedly below the level reported by white staff.

5.3 In summary, over the past 5 years there has been an increase in the representation of staff from Black and Minority Ethnic groups BME backgrounds, alongside a slight decline in bullying incidents affecting BME staff. Reports of discrimination from managers or colleagues have also seen a slight decrease. These changes reflect the Trust's sustained commitment to fostering an inclusive organisation.

6. National Overview - WRES

6.1 The 2024 national WRES report highlights progress with equality, diversity, and inclusion in the NHS, with an 85% increase in very senior BME managers since 2018. However, challenges remain white applicants are still favoured in 80% of trusts, and only 42.3% of Black and Minority Ethnic staff feel they have equal career opportunities. White Gypsy or Irish Traveller staff report the highest workplace abuse, while BME staff face more harassment than white colleagues.

7. The Black Country System WRES overview

7.1 Since 2020, the Black Country system has had steady improvements in workforce diversity and inclusion, with BME workforce representation rising from 24.3% to 31.4%, career progression for BME staff has improved from 34% to 48%, and board diversity has increased. However, despite positive improvements in some of the WRES indicators, both nationally and at the system level, the data highlights several areas that still require focused attention and strategic action at both the individual, team and organisational levels. Persistent disparities remain in recruitment, cultural indicators, disciplinary procedures, access to development opportunities and representation in senior leadership.

8. Driving further improvements for our staff - WRES Action Plan and Next Steps

8.1 Taking account of the latest Sandwell and West Birmingham NHS Trust WRES data, the performance data over the past 5 years, as well as feedback from the BME Staff Network, trade unions, Freedom to Speak Up (FTSU), and other staff engagement channels, the Trust reaffirms its commitment to advancing racial equality. The Trust is committed to driving further improvements, through the following actions:

- **Inclusive Recruitment and Career Development**
  Through the Inclusive Talent Management and Resourcing Group, the Trust will improve recruitment by continuing to roll out our Inclusive Recruitment Training (ARC Leadership) for hiring managers which focusses on inclusive practices and ensuring diverse interview panels. The Trust will also expand development opportunities for BME staff and work to close career progression gaps through our Inclusive Talent Management Programme.

- **Disciplinary Process Improvements**
  The Trust is embedding a just and learning culture through a reframed Conduct at work policy, a strengthened decision-making framework which enables potential cases to be triaged through a multi-disciplinary Decision Making Group (DMG) with the main aim being to reduce the disproportionate impact of HR processes on BME and Disabled staff and improve the experience of our staff going through formal processes. The Trust has also launched training in undertaking formal investigations through a just culture lens, trained additional Trust mediators to support early resolution of people management issues and included training on Just and Learning Culture principles within Part 2 ARC Restorative People Management Practice leadership training.

- **Anti-Bullying, Harassment, and Discrimination Initiatives**
  The Trust will strengthen accountability for WRES and WDES outcomes by supporting Group leadership teams to drive improvements for staff. As discussed at the People Committee in August 2025, WRES data will be provided at the Group level from October 2025 and clearer accountability for improvements incorporated into existing performance management arrangements. Additionally, Groups are encouraged to support the release of managers and staff members in attending the ARC Leadership Programme in order to embed our Trust values and behavioural framework and to nurture a culture of compassion, inclusion and safety at all levels within the organisation.

- **Leadership and Board Diversity**

The Trust remains committed to increasing ethnic diversity at leadership and board levels. Targeted development programmes, building on the learning from the Inclusive Talent Management Programme, will support BME staff in progressing to senior roles through our Inclusive Talent Management approach.

- **Additional Support for the BME Staff Network**
  Additional support will be provided to the Trust BME Network to help strengthen its impact for the Trust's BME staff. The EDI team will work closely with the BME Network to identify a focused set of supporting and enabling actions.

9. Workforce Disability Equality Standard (WDES)

9.1 Launched in 2019, the Workforce Disability Equality Standard (WDES) aims to improve workplace experiences and career opportunities for staff with disabilities across the NHS. The WDES consists of ten specific measures (metrics) that enable Trusts to compare the experiences of disabled and non-disabled staff. These comparisons inform action plans allow organisations to track progress in advancing disability equality.

9.2 Commissioned by the Equality and Diversity Council and mandated through the NHS Standard Contract, the WDES provides a framework for meaningful change. Metrics 2 and 3 are calculated using a "times more likely" formula, which assesses disparities between disabled and non-disabled staff. Metrics 5,6,7,8 and 9a are based on data from the NHS Staff Survey.

9.3 The Trust's annual report for the Workforce Disability Equality Standard (WDES) results show encouraging progress in disability declaration, access to reasonable adjustments presenteeism, and career progression. However, disparities remain in staff experience particularly around harassment, feeling valued and Board representation.

10. Key highlights from the 2024/25 WDES Report

Whilst remaining vigilant against the risks of complacency, the Trust has achieved several notable improvements in the most recent (2025) results. These outcomes demonstrate that interventions implemented over the past 12 months, in partnership with the Disability Network are delivering positive improvements for disabled staff within the Trust.

10.1 Key highlights include:

- **Workforce representation**: 4.8% of staff have declared a disability on the Electronic Staff Record (ESR), up from 4.0% in 2023 to 4.8%
- **Recruitment:** The relative likelihood of appointment for applicants with a disability improved slightly from 1.3 to 1.06.
- **Career Progression:** 52% of staff with a long-term condition believe they have equal opportunities for progression, reducing the gap with non-disabled colleagues to 3.66
- **Presenteeism:** The proportion of staff with long-term conditions who felt pressured to work while unwell dropped to 27.9% from 34.7%, indicating progress in wellbeing support.
- **Reasonable Adjustments:** 71.9% of staff with long-term conditions reported receiving reasonable adjustments, an improvement from the previous year, which was 68.9%

10.2 Declined and static indicators 2025

- **Harassment and Bullying:** Staff with long-term conditions continue to experience higher rates of bullying and abuse, particularly from patients and colleagues, than their non-disabled peers.
- **Feeling Valued:** Only 33.6% of staff with long-term conditions feel valued by the organisation, compared to 46.7% of non-disabled staff.
- **Board Representation:** 0% of board members declared a disability in 2025. This has remained static since the previous reporting year.

11. Workforce Disability Equality Standard Five-Year Overview

11.1 The chart below (Table 11.1.11), presents a summary of the Trust's WDES performance and highlights trends across all ten metrics from 2020 to 2025.

Table 11.1.1

	Indicator			Reporting Year 2020	2021	2022	2023	2024	2025	Trend
1	Workforce Representation. Percentage of Disabled staff		Overall		2.8%	3.1%	3.5%	4.0%	4.8%	
2	Relative likelihood of non-disabled applicants being appointed from shortlisting across all posts compared to Disabled staff.			1.38	1.7	0.75	1.16	1.3	1.06	
3	Relative likelihood of Disabled staff entering the formal capability process (performance management rather than ill health) compared to non-disabled staff			0	0	0	0	0	3.00	
4a	Percentage of staff experiencing harassment, bullying or abuse in the last 12 months	From Managers	Staff with a long lasting health condition or illness		23.0%	23.6%	19.5%	18.6%	15.8%	
			Staff without a long lasting health condition or illness		12.4%	12.3%	10.7%	8.9%	7.5%	
		From Other Colleagues	Staff with a long lasting health condition or illness		29.2%	35.1%	29.8%	23.7%	23.6%	
			Staff without a long lasting health condition or illness		17.4%	19.4%	20.0%	15.4%	15.5%	
		From Patients / Public	Staff with a long lasting health condition or illness		36.8%	39.3%	35.4%	27.7%	26.1%	
			Staff without a long lasting health condition or illness		25.9%	26.9%	28.0%	20.2%	19.6%	
4b	Percentage of disabled staff compared to non-disabled staff that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it		Staff with a long lasting health condition or illness		53.4%	48.3%	55.4%	56.3%	53.3%	
			Staff without a long lasting health condition or illness		48.5%	46.3%	49.8%	47.4%	53.0%	
5	Percentage of staff believing that trust provides equal opportunities for career progression or promotion		Staff with a long lasting health condition or illness		45.1%	47.6%	47.6%	51.6%	52.0%	
			Staff without a long lasting health condition or illness		52.8%	52.9%	51.9%	54.0%	55.6%	
6	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties		Staff with a long lasting health condition or illness		40.4%	38.5%	33.7%	34.7%	27.9%	
			Staff without a long lasting health condition or illness		31.7%	30.8%	25.6%	23.4%	22.4%	
7	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work		Staff with a long lasting health condition or illness		31.0%	31.1%	30.6%	36.5%	33.7%	
			Staff without a long lasting health condition or illness		47.9%	40.2%	38.8%	44.8%	46.7%	
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work		Staff with a long lasting health condition or illness				71.0%	68.9%	71.9%	
9a	Staff engagement score (a composite of nine questions		Staff with a long lasting health condition or illness		6.21	6.16	6.03	6.20	6.30	
			Staff without a long lasting health condition or illness		6.97	6.80	6.71	6.87	6.92	
9b	Percentage of Trusts that facilitate the voices of Disabled staff to be heard within the organisation			Yes	Yes	Yes	Yes	Yes	Yes	
10	Representation of disabled people among Board members		Overall	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	

11.2 The data relating to performance against the WDES metrics over the past five years highlights the following areas of consistent and/or overall improvement. These are as follows:

- **Indicator 1:** 2.8% of staff declared a disability on the Electronic Staff Record (ESR) in 2021 compared to 4.8% in 2025
- **Indicator 2**: Relative likelihood ratios comparing the likelihood of non-disabled and disabled candidates being appointed from shortlisting were close to equity (1.0) than the previous reporting year which was 1.38 times more likely to appoint a non-disabled applicant than a disabled applicant. For the 2024 WDES report this improved to 1.09 times more likely.
- **Indicator 4:** The percentage of staff experiencing harassment, bullying and abuse(HBA) from Managers has reduced from 23.05 to 15.8% although the rates are still disproportionately higher than non-disabled staff. Harassment, bullying and abuse from other colleagues has also reduced since 2021, from 29% to 23% in 2025. Similarly, harassment, bullying and abuse from patients and members of the public have also reduced since 2021, from 36.8% in 2025 to 26.1% in 2025
- **Indicator 5:** The percentage of disabled staff who believe that the Trust provides equal opportunities for career progression and promotion has improved from 45.1% in 2021 to 52.0% in 2025
- **Indicator 6:** The percentage of staff saying that they felt pressurised to attend work despite feeling unwell has reduced from 40% to 27%
- **Indicator 7:** Indicator 7: The percentage of staff who are satisfied with the extent to which the organisation values their work has improved slightly from 31% to 33%
- **Indicator 9a**: The trust's overall engagement score has increased from 6.21 to 6.30 over the past five years.

11.3 The data relating to performance against the WDES metrics over the past 5 years highlights some key areas of areas of deteriorating performance and areas which have remained static. These are :

- **Indicator 3**: The relative likelihood of disabled staff entering the capability process has declined over the previous five years from 0 to 3.00; however, it is important to note that the figure of 3.00 equates to 0.1% of disabled staff (1 member of staff).

- **Indicator 4b**: The percentage of staff reporting harassment, bullying and abuse when they have witnessed inappropriate behaviour remained unchanged at 53%.
- **Indicator 10:** There has been no change in the percentage of disabled staff members at the Board level over the past five years. It has remained static at 0%.

11.4 In summary, at Sandwell and West Birmingham NHS Trust, there has been an increase in the representation of staff with a disability or long-term condition groups, improvements in the recruitment and career progression indicators, and slight improvements in the bullying harassment and abuse indicators, as well as improvements in presenteeism and access to reasonable adjustments. However, there have been no changes in the percentage of disabled staff members at the Board level and no statistical increases in the number of staff reporting bullying and abuse when they have witnessed inappropriate behaviour.

12. National WDES overview

The 2024 report highlights several positive trends, i.e. disabled people are more likely than average, to be represented on NHS boards than in the wider workforce, disabled candidates are also more likely to be appointed from an interview, and more employers are also making reasonable adjustments that enable disabled staff to carry out their work, disabled staff remain more than twice]as likely to be performance managed compared to their non-disabled colleagues, and experienced higher levels of harassment, bullying and abuse from managers and other colleagues. The report also confirms that nearly one in four NHS Staff have disabilities or long-term conditions.

13. Black Country System WDES overview

Since 2020, there have been notable improvements in the WDES metrics at a system level. Disabled staff representation nearly doubled from 3.1% to 6.1%, and recruitment indicators improved, and board representation grew from 6.6% to 8.1%, reflecting an ongoing commitment to equity and career development in the Black Country. However, it is acknowledged that there are ongoing challenges with staff experience related to harassment, bullying and abuse from patients and discrimination from other staff and plans are in place to tackle these issues through individual provider EDI plans and the Six High Impact Actions. individual Provider EDI plans and the NHSE Six High Impact Actions.

14. Driving further improvements for our staff - Action Plan and Next Step

Based on the latest Sandwell and West Birmingham NHS WDES data and informed by feedback from the Disability Staff Network, trade unions, Freedom to Speak Up (FTSU), and other staff engagement channels, the Trust reaffirms its commitment to advancing disability equality and will accelerate actions within the Trust's EDI Plan as set out below:

- **Health Passport Implementation**
  The Health Passport supports open discussions between disabled colleagues and their managers about health needs and reasonable adjustments. Survey findings on current use and areas for improvement are currently under review. The full launch is planned for Q3 2025.

- **Reasonable Adjustments Framework Development**
  A new framework is being developed to complement the Attendance at Work policy, which doesn't cover all adjustment needs (e.g. menopause-related symptoms). This framework will offer clear guidance for managers on legal duties and inclusive practices. It's being developed with People Services, EDI, and staff networks, targeting completion in Q3 2025

- **Focus Groups on Barriers and Solutions**
  Focus groups led by the Disability & Long-term Health Conditions Network, with support from the People Engagement & Experience team will explore challenges around reasonable adjustments. Insights will guide targeted improvements and cultural change.

- **ARC Leadership Training**
  A new training module on reasonable adjustments was added to the ARC leadership programme's Wellbeing module in July 2025, helping managers understand and apply adjustment practices.

- **Briefings and Communications**
  Short, accessible briefings and targeted communications are being developed to raise awareness of disabilities and reasonable adjustments. Led by the Disability & Long-term Health Conditions Network.

- **Centralised Support and Funding**
  To address delays with Access to Work funding, alternative centralised support options are being explored to speed up access to essential adjustments and reduce funding barriers.

15. Wider EDI Reporting

15.1 The Trust continues to report on the wider EDI domains and is improving its reporting capabilities to capture information on intersectionality, which recognises that people have complex and multiple identities. It is important to note that multiple forms of inequality or disadvantage accumulate to create obstacles that cannot be addressed through the lens of a single characteristic in isolation. This report covers: age, ethnicity, disability and sexuality.

15.2 Future EDI Board reports will also incorporate information on the gender pay gap, as well as ethnicity pay gap reporting, and disability pay gaps, as these will become a mandated requirement by the UK Government.

16. Recommendations

The Public Trust Board is asked to:

a) **Review** and consider the latest Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results, particularly the areas of improvement and those areas requiring further focus intervention, ahead of public publication and approve sign off.
b) **Be Assured** that the Trust is fully engaged and focused on tackling and reducing inequality and discrimination for staff from Black and Minority Ethnic backgrounds and disabled staff.
c) **Support** the major ongoing initiatives aimed at driving continued improvement in staff experience and outcomes across Sandwell and West Birmingham (SWB) NHS Trust.
d) **Require** regular updates on progress

September 2025
James Fleet – Group Chief People Officer
Sabrina Richards – Strategic EDI Specialist (The Black Country ICB)
Meagan Fernandes, Director of People and OD

Paper ref:	PublicTB (09/25) 015

REPORT TITLE:	MMUH IPA Gateway 5 Review		
SPONSORING EXECUTIVE:	Rachel Barlow – Group Chief Development Officer		
REPORT AUTHOR:	Rachel Barlow – Group Chief Development Officer		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

The Infrastructure Project Authority (IPA) completed the final Gate Review for Midland Metropolitan University Hospital (MMUH) between 22-24th July 2025. Gate 5 assesses the Operational Delivery and Benefits Realisation for government major infrastructure investment projects.

The review achieved the highest rating of GREEN. The project was reviewed as exemplary and is another positive, significant milestone of external assurance for the programme.

30 colleagues participated in the review which included a site visit and a range of interviews. The Review Team were extremely complementary about the application of managing successful programme methodology, the approach to benefits realisation and partnership working, as well as the quality of our team.

There are 8 recommendations which will be tracked through the benefits governance framework and reported to the Infrastructure Committee at the end of Q3. As part of the recommendations, the Review Team recommended that the Senior Responsible Officer recommend to the Trust Board and the New Hospital Programme Team that Gateway Assurance training and nomination for key members of the programme delivery staff. Through the PDR process, 2 colleagues have been identified to complete this training, enabling them to participate in future IPA Gate reviews. This experience would endorse a future professional network across national major infrastructure projects and provide learning opportunities that would be of benefit to the South Black Country Group and wider provider collaborative.

This level of external assurance is a positive reference for South Black Country Group capability to deliver future major capital investments, given the robust approach to lessons learnt, operational delivery and benefits realisation, with a majority MMUH team being retained in the Trust.

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?]*

Joint Infrastructure Committee

4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**Accept** the IPA Gate 5 output report.
b.	**Endorse** the nomination of colleagues to complete Gateway Assurance training.
c.	

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

Department of Health & Social Care

[MMUH to Insert Security Classification once completed]

Midland Metropolitan University Hospital MMUH

Gate 5 – Operations Review and Benefits Realisation

Template Version	V1.0 2021
Report Version:	Issued 1.0
Senior Responsible Owner (SRO):	Rachel Barlow
Date of Osmotherley Appointment letter issued to SRO:	N/A for the MMUH Programme but this sits under New Hospitals Programme where the SRO appointment letter is publicly available.
Programme or Project Title	Midland Metropolitan University Hospital MMUH
Does this review cover the entire Project?	Yes
Department/Organisation of the programme/project	DHSC
Agency or NDPB (if applicable):	N/A
Project Director (or equivalent):	N/A
Business Case stage reached:	Full Business Case (FBC) – Delivered
Decision/approval point this report informs:	Not applicable
Review Start Date:	22 July 2025 (early interviews conducted 16 & 17 July due to availability)
Review End Date:	25 July 2025
Review Team Leader:	Ian Brown
Review Team Members:	Emily Dawes Paul Nichol
Report Distribution	Final report: AO, SRO, HMT tbc
Previous Review:	Gate 4 24-27 June 2024 Amber

Department of Health & Social Care

Contents

[Please remember to click on "update table" once the report is completed to ensure that the contents table above is accurate]

About this report
This report is an evidence-based snapshot of the programme's/project's status at the time of the review. It reflects the views of the independent review team, based on information evaluated over the review period, and is delivered to the SRO immediately at the conclusion of the review.

Department of Health & Social Care

1. Stage Gate Assessment (DCA)

Delivery Confidence Assessment
Green
The Delivery Confidence Assessment is rated **Green** because the project is closed, the hospital is operational, and the benefits have been reviewed and embedded within the BAU governance of the Trust. Risks are well understood, and mitigations have been considered. The overall challenge of revenue reduction is transparent across the trust with plans wrapped up in the Cost Improvement Plan CIP delivery target of £50m. *Successful delivery of the project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.* Most major hospital builds are often referred to as once in a generation. The design of MMUH is certainly in that category. It provides a sense of public space, light and well-being best summed up in the RIBA Journal November 2024 *There's no missing the Midland Metropolitan University Hospital, both for its imposing size and its ambition to nurture wellbeing and recovery* The building however is recognised as a facilitator for patient treatment and recovery. Its function is to enable staff to deliver this service. MMUH however has an even wider objective in its employment and regeneration plans centred in #MoreThanAHospital. We saw evidence at both the macro and micro level that MMUH was well placed to deliver this ambition. Regarding its benefits forecast, the Trust has raised this from £2.2bn to £3.8bn. This is backed up by embedded governance arrangements with clear plans for benefits realisation including senior management ownership, and a transparent annual review. This latter should ensure granularity and clear timescales against delivery. The transition from two former acute sites into MMUH was a significant achievement. The fact it was done with a compressed activation period of just 7 weeks is one that should be avoided by future schemes. The formal closure of the project has been exemplary in both its performance and documentation. We saw and heard clear evidence of its transition to BAU, with attention to both remaining risks and the continued delivery of benefits. The relationship with the New Hospital Programme NHP has been symbiotic. NHP support through commercial challenges was fundamental to the project's continuance. In turn the NHP has benefitted from a raft of lessons learned both positive and negative by the project. Whilst the lessons learned process is ongoing, it is essential that by the 12-month mark in operation these are fully documented between the bodies and made available to future schemes. The Trust is well placed to continue in its realisation of benefits and to take the project learning into the exciting opportunities presented by regional and Group reorganisations and the overall #MoreThanAHospital initiative.

Department of Health & Social Care

2. Summary of concerns, evidence and recommendations

Priority	Recommendation	Risk* and Issue Identified with Evidence	Classification Insert Reference Number	Critical, Essential, Recommended
4	**Recommendation 1: The SRO should ensure that the annual review of benefits is transparent, and performance reported in a granular manner against clear timescales.**	Failure to deliver benefits	6 Benefits Management and Realisation	Essential
1	**Recommendation 2: The SRO should continue to monitor the sensitivity in relation to the CIP to ensure that it doesn't undermine the overall delivery of benefits.**	Failure to deliver wider benefits	6 Benefits Management and Realisation	Critical
7	**Recommendation 3: The SRO should ensure that the strategy developed for continuous improvement capability is embedded into BAU**	Failure to deliver CIP and associated benefits	10 resource and skills management	Recommended
5	**Recommendation 4: The SRO reviews ongoing plans for improved communication and feedback within the A&E department to ensure the earliest implementation.**	Failure to effectively communicate with patients and associated reputational risk	2 Stakeholder Management	Recommended
6	**Recommendation 5: The SRO ensure that the review of wayfinding and signage is completed and**	Failure to effectively communicate with patients and associated reputational risk	2 Stakeholder Management	Recommended

	implemented as soon as possible			
2	**Recommendation 6: The SRO should ensure the production of a Business Case for Digital investment to compliment any plans produced by the NHP**	Failure to utilise existing infrastructure investments and realising benefits	12 Technology	Essential
3	**Recommendation 7: The SRO approach NHP to jointly agree and document a summary of lessons learned for easy access to other future hospital developments.**	Failure to learn lessons and to avoid issues on future schemes	11 Knowledge Management	Essential
8	**Recommendation 8: The SRO should recommend to the Trust Board and to NHP that Gateway Assurance training and nomination for key members of programme delivery staff.**	Failure to develop staff and embed MSP and Assurance in future projects	3 Project and programme management	Recommended

**Risk denotes risks, issues, concerns and key dependencies*

All recommendations should be categorised as Critical, Essential or Recommended:

- **Critical (Do Now)**: To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.
- **Essential (Do By)**: To increase the likelihood of a successful outcome the programme/project should take action in the near future. *[Note to review teams – whenever possible Essential risk based recommendations should be linked to programme/project milestones e.g. before contract signature and/or a specified timeframe e.g. within the next three months.]*
- **Recommended**: The programme/project should benefit from the uptake of this recommendation. *[Note to review teams – if possible Recommended risk based recommendations should be linked to programme/project milestones e.g. before contract signature and/or a specified timeframe e.g. within the next three months.]*

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3. Blockers to delivery

Ref No	Blocker	Describe specific nature of blocker	Consequence if not resolved
1	N/A		

4. Comments from the SRO

SRO Comments
The Gate 5 process was a valuable opportunity for learning and assurance. The Senior Responsible Owner (SRO) extends sincere thanks to the Panel for their time, as well as to the 30 colleagues from Sandwell and West Birmingham Hospitals NHS Trust who participated in the site visit and interview process. The identification of best practices—particularly the Trust's commitment to an annual external review of benefits and the breadth and ambition of the declared benefits—was warmly welcomed. It was also encouraging to see the #MoreThanAHospital ethos recognised at both macro and micro levels. In retrospect, the timing of the review was well judged. Operational delivery at the hospital has now stabilised, with month-on-month improvements being seen in efficiency and performance. The Panel's engagement prompted valuable reflection on how we can maintain this momentum, including drawing inspiration from other industries to further optimise our approach to realising benefits. The Trust's exemplar programme management, robust risk management, and effective collaboration with stakeholders continue to be recognised by both the Infrastructure and Projects Authority (IPA) Gate 4 and 5 reviews. These strengths should remain central to our approach, particularly as we look to optimise benefits and deliver future major projects.

5. Review Team findings and recommendations

Business Case and Benefits

The Final MMUH Business Case (FBC) was approved in 2016 articulating a clear strategic demand for the MMUH capability. On review the strategic intent defined in the FBC has clearly been delivered. There have however been substantial changes to the final cost, schedule and management of the programme. A principal factor has been the impact of the change of construction contractor (collapse of Carillion) and the subsequent remobilisation of a new capability (appointment of Balfour Beatty (BB)). Alongside this was the associated shift from a PFI contract arrangement to one that utilised public funding. This was facilitated by the National Hospitals Programme (NHP). We understand how critical this support has been at this point and subsequently to the delivery of the project.

We saw and heard that the original benefits case in the FBC was for £2.2bn over 57 years in line with Treasury Green Book guidance. In line with a recommendation from the Gate 4 Review the Trust commissioned a Benefits Review by way of an update to rebase line the benefits. Minutes from the March 2025 Public Trust Board meeting confirmed that the Board had approved this document and an uplift in benefits to £3.8bn. These benefits cover core operational benefits through to wider societal benefits. We saw robust evidence that while these benefits are ambitious in their scope, the benefits are well considered and robustly underpinned.

We saw clear evidence of best practice in benefits management. The management of residual benefits has been hard wired into Business as Usual (BAU) governance with delegated executive ownership and clear line of sight metrics. We saw and heard that Benefits governance is clear and robust through executive sub-committees alongside a strategic benefit committee and independent annual review. Performance against benefits is included in the Annual Report providing confidence that the delivery of benefits will remain a key focus for the organisation. It will be important for the annual report to break these figures down to make them granular and more accessible in line with the RSW suggestions for future improvement *"…a core group of benefits are identified for continuous tracking to enable reports to be comparable across time periods."*

> **Recommendation 1: The SRO should ensure that the annual review of benefits is transparent, and performance reported in a granular manner against clear timescales.**

Finance

The final capital cost for MMUH delivery was significantly higher than forecast. Whilst this is in part due to inflation, impact of Covid and the war in Ukraine etc, it was worsened by the financial collapse of Carillion and the subsequent delay to project delivery which conflated all these impacts.

To find and appoint a building contractor willing to 'adopt' a half-finished building, and its associated design is extremely difficult. To do this with a highly serviced hospital building of the scale of MMHU was a major feat. The time it took along with interim enabling arrangements was significant. We heard how the engagement of the NHP was crucial in supporting a resolution to the issue and the provision of additional capital funding. This

included negotiations around risk allocation and efforts to close the gap between the aspirations of the MMUH team and the risk appetite of BB. Again, NHP were instrumental in setting up funding to cover a range of risk.

The revenue implications for the scheme have been a constant challenge not least with the Public Dividend Capital rising proportionate to the capital cost. The Programme Closure Report (March 2025) recommended a greater awareness of future NHP schemes around PDC and depreciation. It was not clear to us exactly how the revenue situation would be resolved, although it was stressed that this was very much a BAU situation that the organisation understood and was used to managing.

As the programme has transferred into BAU we have seen that the MMUH faces a Cost Improvement Programme (CIP) requirement to achieve revenue savings of £50m within the current financial year. The current care model within the MMUH project is predicated on areas of investment in staff. Whilst we saw and heard that there is opportunity to tighten up the finances around this model, what is not clear to us is what the MVP is. This is the minimum viable product or input of staff in this case that sustains the model and its associated efficiencies operable. Put another way, establishing the point before the additional 'straw is placed on the camel's back!'

It is essential the Trust senior management review the sensitivity of the current care delivery model against the financial saving targets set out in the CIP to ensure that 'chasing targets' doesn't cause the system to collapse. This would compromise MMUH's ability to fully realise the benefits of revised wider system thinking and associated clinical pathways which support both core and wider benefit delivery.

Recommendation 2: The SRO should continue to monitor the sensitivity in relation to the CIP to ensure that it doesn't undermine the overall delivery of benefits.

PPM

We saw and heard that the uptake of Managing Successful Programmes (MSP) was widely regarded as critical to its successful delivery. The fact that this was not previously mandated within the NHP was a surprise to the review team. The appointment of a committed SRO with the gravitas and skills to lead, coupled with a commitment to MSP and access to external programme management core skills were also key in creating the foundations of a successful outcome.

The Trust recognised that a programme of this size should not be delivered as BAU.

We were pleased to see a recognition by the MMUH programme of the importance of investing in a whole range of specialist skills required to deliver a project of this size and scale. We note that appropriate investments were made for both internal and external skills and availability. This meant the separation of Project delivery resource from that of BAU. Internally staff where utilised were funded to ensure a separation from BAU. Externally, professional organisations were employed with Project Director, PMO skills from Archus and move expertise from HealthCare Relocations. and benefits partners. Although there were costs (sometimes significant) these paled into insignificance against the overall project cost

and the risks that these specialists covered. *As one example, the return of investment of the entire move process could be retrieved in 2 days of regaining elective work. .* We were pleased to note that this was recognised by NHP, and we understand has been incorporated in their project learning.

By the time of this review the project had been effectively closed in March 2025. Residual activities had been transferred into BAU. We understand that the development of the programme closure plan had begun two years prior to formal closure. Consequently, arrangements for transition were comprehensive and well thought through (as evidenced by the programme closure report). Of note were the governance arrangements that had been put in place to ensure the transfer of any outstanding risk as well and the metrics for ongoing benefits realisation. These arrangements provided the best opportunity to minimise the impact of the development of new capability on routine operations. There was however a wide recognition that there remained the risk of a residual impact / distraction to operational productivity. This is an important lesson for future schemes.

Risk

Risk transfer was effectively managed throughout delivery of the programme, and the significance of key risks was well understood. The importance of risk transfer from the programme into BAU was well managed and we saw clear evidence that residual programme risks have been transferred into the risk management process. We noted the inclusions in the corporate risk register which particularly recognise significant challenges that remain associated with ‘strategic use of resource’ and ‘failure to deliver benefits.’
In addition, we understand that the recommendations from the independent RSM audit of benefit delivery have been enacted by the enterprise and incorporated into risk processes.

Workforce

We saw and heard that the programme’s approach to workforce was underpinned by a strategic investment in high-quality staff and a commitment to safe, patient-centred service redesign. Impressively over 70% of the workforce was recruited locally, supported by initiatives like the #MoreThanAJob programme and the Sector Wide Academy Programme (SWAP), which helped over 200 local residents into NHS careers. This reflected a commitment to local employment and future sustainability. A complex Management of Change process involving more than 6,800 staff ensured a smooth transition into the new hospital.

The workforce transformation has been a central and complex component of the hospital programme. A 7-day workforce model was introduced to support the new clinical service design, with significant organisational development investment committed to embed cultural change and unify teams from previously separate sites. While efficiencies have already been achieved—such as a 30% reduction in bank staff and 40% in agency use—these gains have come alongside challenges. The Cost Improvement Programme (CIP) is driving a reduction in headcount. Whilst this is ongoing there remains significant work still to do, with the associated risks about sustainability and staff morale.

The ability to drive innovation and improvement at every level in the organisation will be a key enabler to the delivery of required efficiencies. While we saw evidence of the appointment of a new Group Director of Improvement, we were left unclear as to the underlying strategy to deliver operational continuous improvement and the associated skills.

Recommendation 3: The SRO should ensure that the strategy developed for continuous improvement capability is embedded into BAU

We heard that staff were supported through induction programmes, training, and leadership development. In addition, the workforce model was designed to align with the new clinical service pathways. This investment not only enabled a smoother transition during the hospital move but also contributed to improved patient care, reduced reliance on agency staff, and enhanced staff satisfaction over time. This included targeted recruitment and retention strategies, particularly in clinical and operational roles, to ensure the workforce was equipped to deliver care in a new, modern environment. Staff surveys indicate that the workforce has adapted well to the new environment, with improved feedback on ward layouts and patient flow.

We heard that a key success was the detailed mapping of patient pathways and the 300 interdependencies, which involved clinically led, bottom-up planning to transition from current to future states, identifying gaps and embedding measurable improvements or changes. This process supported the development of a new clinical service model and was crucial in ensuring continuity and safety during the hospital move and first 100 days.

Looking ahead, the development of a MMUH Learning Campus is expected to provide over 1,280 learning opportunities annually, reinforcing MMUH's role as a centre for education, retention, and workforce development. This integrated approach not only supports the delivery of high-quality care but also contributes to the wider social and economic regeneration of the local area.

Stakeholder Management and Communications

Stakeholder management and communication were central to the success of the MMUH programme, ensuring alignment, transparency, and trust throughout a complex and high-profile transformation. We heard that the Trust engaged with a wide range of stakeholder from patients and staff to local authorities, community groups, and national bodies like the New Hospital Programme . A multi-channel communications strategy supported this engagement, including campaigns, internal briefings and volunteer-led wayfinding.

The programme demonstrated strong stakeholder management and communications, particularly during critical phases such as the hospital move. Effective collaboration with partners including the ambulance service and the wider health sector ensured a smooth transition, while public engagement was supported by bold media strategies capturing the success of Day 1. These efforts helped raise awareness pre move and contributed to a well-informed public, evidenced by the absence of false turn-ups to A&E.

Communication however remains an area under review, with ongoing efforts to improve wayfinding and address patient feedback on wait times and emergency care. Despite these strengths, public perception has been negatively impacted for example, by poor Google reviews, highlighting the need for continued focus on the patient experience. We heard that the hospital welcomes the feedback and is continually reviewing processes to improve this. Whilst communication and improvement strategies are still under review, the proactive and collaborative approach to stakeholder engagement was widely recognised as a strength of the programme.

Recommendation 4: The SRO reviews ongoing plans for improved communication and feedback within the A&E department to ensure the earliest implementation.

Wider Benefits

The wider benefits of the programme extend beyond the delivery of a new hospital building, encapsulated in the initiative's ethos of #MoreThanAHospital. This vision has driven an impressive and wide-ranging focus on social value, regeneration, and long-term community impact.

MMUH was designed not only to transform healthcare delivery but also to serve as a catalyst for local regeneration and wellbeing in one of England's most deprived regions. Through recruitment, education initiatives, cultural investment, and strategic partnerships, the hospital has become a hub for employment, learning, and community pride. Its integration into the Smethwick to Birmingham regeneration corridor, alongside sustainable transport and urban renewal projects, reinforces the role in shaping healthier, more connected communities.

Key developments include the creation of a Learning Campus, in partnership with Sandwell College and local universities, aimed at improving employability and creating pathways into healthcare careers for young people. We heard that the learning campus is funded through the Sandwell Council's Government's Towns Fund with additional support from the NHS Trust and the West Midlands Combined Authority and will be operational in early 2026.

We heard that the sale of land at the previous City Hospital site to Homes England will enable the construction of around 750 new homes and expected to have a significant and positive impact on the wider area, contributing to both regeneration and long-term economic uplift. This development is closely linked to the broader #MoreThanAHospital vision, supporting local infrastructure, housing, and community growth. We heard that the relationship with Homes England has been described as strong and collaborative and is a key enabler of local regeneration, employment opportunities, and improved quality of life for the surrounding population. We heard that an upfront payment has been received for the land but in addition overage payments are expected once sale of the houses has been completed.

We heard that a new bike lane connecting Sandwell and Birmingham City Centre, has been developed in partnership with Sandwell and Birmingham City Councils. While not monetised separately in the benefits valuation, it is recognised as a meaningful contributor to the programme's wider societal impact. It supports active travel, which in turn

promotes improved life expectancy, wellbeing, and reduced carbon emissions. The lane is also linked to the Learning Campus and transport strategy, enhancing accessibility for staff and patients.

Social value has been embedded through improved accessibility, active travel infrastructure, and a commitment to community wellbeing. These benefits are seen as replicable across the NHS, offering a model for how healthcare infrastructure can catalyse broader societal improvements. However, there is recognition that continued investment and governance are needed to ensure these non-core benefits are realised and sustained.

National Hospitals Programme (NHP)

The project predates the NHP, and its multiple challenges have been well documented. As an original Business Case in its own right, it would not and could not have been approved under the requirements of the NHP. However, we saw and heard that its subsequent adoption into the programme's support has been essential to its now functioning as a working emergency hospital. The relationship however is symbiotic and the NHP has benefitted greatly through its support and by learning lessons from the project.

On the construction and commercial side, the collapse of Carillion was a major unforeseen challenge. The commercial advice and support from NHP have been integral to the publicly funded solution and resolution of additional commercial challenges that arose following the appointment of the replacement contractor. This included provision of funding to cover risks and to close the gaps to allow a viable takeover of a half-built project through to completion and commissioning.

On the other side of the relationship, various actions and arrangements by the MMUH team have proved to be an excellent 'proving ground' and one that will directly benefit the NHP future arrangements. We have touched on these elsewhere but a short summary of some of the points is worth repeating and indeed reminding future NHP projects.

- MSP adoption and regular IPA/NISTA Assurance – A single proven methodology with external assurance at regular and/or key milestones
- The appointment of experienced PPM professionals and a PMO function performing roles of Project Director
- Allocation of funding to ensure a separation of project delivery from BAU
- The appointment of specialist Hospital 'Movers' to de risk the move process and enable eary establishment of BaU
- Clinical Pathways – "Form follows function" energy and focus to get this right. Suitability for NHP use?
- Stress testing building for handover
- Activation and decision to move– – The lesson not to over compress activation commissioning and advocating the decision to move process
- Approach to operational readiness.
- 7 day workforce planning

The MMUH Facility

It was widely acknowledged that the building which was based on a PFI type contract and on clinical models well over a decade old at the time of opening. This means on the one hand that MMUH provides a unique atrium area and associated public utility with an atmosphere of space and wellbeing. On the other hand, there are areas of compromise and adaptation that are and will be required as clinical demands and associated models of care evolve. In truth, this is not unique given the nature of healthcare provision and delivery.

We understand that the design and layout was considered to maximise patient flows and reduce travel distances. Whilst this has worked in general and is understood by the hospital staff, we understand that it is providing some challenges to patients and visitors. We were pleased to note that the Trust has commissioned a review in relation to overall wayfinding and signage. This is something which will improve with time and public familiarity but that we would endorse the Trust complete as a matter of priority in the meantime.

Recommendation 5: The SRO ensure that the review of wayfinding and signage is completed and implemented as soon as possible

There are several additional lessons that have arisen from the completion of the physical building. Whilst we understand that these have been shared with NHP it is important that this is part of a formal and documented process to ensure that they are not lost. We make a recommendation on this in the section below.

One example of this is the location of the A&E Department on the second floor. Issues of access and the cohort of vulnerable attendees accentuates the risk of the location at height within the building. The increase nationally in Mental Health patients attending was not completely recognised and presents its own challenges in terms of appropriate attendance and design of A&E. This presents an increased cost pressure (and staff risk) and discussions are ongoing with other agencies to ensure such patients receive help appropriate to their individual needs.

Other issues include Safety heights both internally and externally on stairs and balcony areas. Doors, as is often the case with hospitals are proving a challenge, roof space for services. Wayfinding as already mentioned. On the positive side there are notable benefits with the derogations around single room layouts which allow for enhanced observation. We understand that these were noted by the NHP, alongside multiple case studies and other lessons learned.

We saw and heard the foresight and investment that had been committed to the building in the form of digital infrastructure. Unfortunately, at the time of this review no plan or funding for the digital delivery had been completed. We understand that this is an area being worked on by NHP and that discussions were ongoing in relation to a business case for further investment. It was not clear to us what the extent of those plans or the timeframe for implementation would be. Given the opportunities to catalyse benefits through the completion of digital investment we would endorse a prioritisation of this work. This could seek NHP funding on the basis that it provides an excellent ‘test bed’ for projects following on. The Trust is intending to benchmark with the NHP digital strategy.

Recommendation 6: The SRO should ensure the production of a Business Case for Digital investment to compliment any plans produced by the NHP

The activation phase of the facility was carefully planned and executed, with a strong emphasis on safety, coordination, and readiness. Despite the significant compression of this phase, we understand that the activation was marked by high morale and strong collaboration. Clinical business change managers lead this interface into business-as-usual operations. Lessons learned from this phase have been documented and shared, offering valuable insights for future hospital activations. Although a successful outcome was achieved the most significant lesson is to avoid compression of agreed and planned schedules.

Current Operation

We saw and heard considerable evidence that the MMUH was in full operational mode. The energy and momentum generated by the new facilities and their opportunities were palpable. As is often the case with new facilities they provide the catalyst for change, either as a reward at the end of the process or as an enabler at the beginning or as in the case of MMUH a combination of both. On the downside we understand that the capacity and quality of facilities has acted as a magnet drawing in more activity or different activity to that of which the clinical models originally intended. For example, the risk exists that day cases undertaken at MMUH do so at the expense of the more complex cases for which the facility and the model of care envisaged.

Lessons Learned

The MMUH project has combined delays and disasters with triumphs and success over its considerable life. Both the positives and negatives that have been part of the project and instrumental in shaping and driving its successful closure in March 2025. They have also been taken forward into the current operation and benefit delivery phase and have provided a rich seam of learning to both the Trust as well and the NHP.

We saw and heard how much of this learning had been jointly realised, shared and is having an impact on other projects which seek MMUH out as a reference site. Additionally, we saw and heard joint learning that wasn't captured or that might have been verbalised but remained undocumented.

As the project approaches the end of its 12-month defects liability period, this would be a good marker for NHP and MMUH to jointly review and commission a documentation of the lessons to date. This should be in a format which allows enough detail for others to assess replicability and to understand the specifics behind each lesson, as well as having a summary 'A4' to provide an overview of each benefit. It may well include the production of checklists and tools which have proven helpful in the clinical design through to the operational Go Live of MMUH.

Recommendation 7: The SRO approach NHP to jointly agree and document a summary of lessons learned for easy access to other future hospital developments.

The MMUH team have received benefits from external assurance. To assist in embedding these benefits and MSP delivery methodology further into the organisation as well as providing an excellent means of personal development, considerations should be given to providing some individuals with the Gateway training and encouragement to participate in a Gateway review either in the comfort area of health, or across any number of other government schemes.

Recommendation 8: The SRO should recommend to the Trust Board and to NHP that Gateway Assurance training and nomination for key members of programme delivery staff.

6. Areas of good practice

Commending delivery of	Describe specific details of successful delivery
6 Benefits Management and Realisation	Commitment to the annual external review of benefits. The allocation of senior responsibility for benefits embedded within the organisations BAU. Breadth and ambition of the declared benefits.
2 Stakeholder Management	Recognition for the socio-economic deprivation in the local community and the impact such a major scheme can have on employment and community regeneration. #MoreThanAHospital
13 Other Management of data	Overall ability to use data and metrics to track, manage and inform change and delivery of benefits
3 Project and Programme Management	Significant investment into the detail and contingency plans behind a successful hospital move, including the use external specialists

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7. Acknowledgement

Review Team Acknowledgement
We would like to thank the Project Team for their support and openness, which contributed to our understanding of the Programme and the outcome of this review. Lisa Wright for the excellent job in arranging all the interviews etc.

8. Next Assurance Review

Next Assurance Review
N/A

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ANNEX A – Stage Gate Assessment (SGA) Descriptions

From 1 April 2021, the IPA moved to a 3 coloured assessment (Red, Amber, Green) which the DHSC has also adopted. The SGA will be based on the following definitions:

Colour	Criteria Description
Green	Successful delivery of the programme/project to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery.
Amber	Successful delivery of the programme/project to time, cost and quality appears feasible but significant issues already exist requiring management attention. These appear resolvable at this stage and, if addressed promptly, should not present a cost/schedule overrun.
Red	Successful delivery of the programme/project to time, cost and quality appears to be unachievable. There are major issues which, at this stage, do not appear to be manageable or resolvable. The programme/project may need re-baselining and/or its overall viability re-assessed.

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ANNEX B - Terms of Reference for Hybrid Review

This is a Gate 5 Review.

The standard terms of reference for all Guidance and Workbooks can be found here and does not need to be included within the body of the report UNLESS any amendments have been made to the original Terms of Reference.

- Review and comment on the MMUH benefits case.
- Review and comment on benefits oversight and delivery framework.

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ANNEX C - Background

Question	Answer
Describe the aims of the project/ programme	The MMUH Programme is more than building and moving a hospital, it has a purposeful programme #MoreThanAHospital which is transforming clinical services, acting as a catalyst for enhanced care and treatment, improving life chances and health outcomes for local communities. MMUH offers acute and emergency care as well as maternity and paediatric services. These services are supported by a 7 day workforce model. A majority of the Trusts planned care is now delivered in treatment centres at the Sandwell and City Health Campus's. As well as transforming clinical pathways, the Trust is a leading anchor institution, influencing widening participation and the sustainable employment agenda. As part of this work, they are partnering with the Department of Work and Pensions, Sandwell College, multiple university partners and Sandwell Metropolitan Borough Council to establish a new Learning Campus funded by Government Levelling Up monies. Located at the entrance to the site, this facility will create over 1200 new local learning opportunities a year and contribute to the resilience of the local workforce. This faciality will open in January 2026. The Trust has an active partnership with West Midlands Combined Authority, Birmingham City Council and Sandwell Metropolitan Borough Council who have 2 masterplan frameworks to regenerate the immediate Grove Lane area and wide Smethwick to Birmingham development zone which focus on social, economic, health and being an active travel exemplar as well as creating a healthy sense of place.
Reasons for the project/ programme's existence, by type and description	The new MMUH brings together acute services from two hospitals across the region into one state-of-the-art site, promoting better patient safety and care while ensuring value for money. As the closest serving acute hospital to Birmingham's City centre, it has a large emergency department supported by 736 in-patient beds and 13 operating theatres, 10 storeys and a gross internal area of 86,000m2. It will serve a population of over 750,000 people with some

	of the most deprived wards in England within its catchment. MMUH has a long history. Although it pre-dates the New Hospitals Programme, it has now been folded into the NHP which is a Ministerial Initiative.
The impact if the project/programme fails to deliver e.g. any risks to or any material impact on civilians/citizens:	The hospital has successfully opened and the programme has started to deliver operational improvements and financial benefits which have been subject to an independent review. The Programme was formally closed in March 2025 and the benefits transitioned to the core business. There is a potential risk the benefits are not fully utilised, but there are processes in place to track this and governance post programme company is embedding.
Project/programme link to departmental or government strategies or policies:	MMUH is part of the New Hospitals Programme, within Cohort 1.
Projects/programme interdependencies [if applicable]:	Interdependencies are within the Trust across a range of services, the local health and social care system, community services, partner providers including acute and ambulance Trusts, local councils and the Combined Authority.
Has the SRO's Osmotherley letter (letter of appointment) been approved at the appropriate levels?	N/A Project not on GMPP in own right, sits under NHP where the SRO appointment letter publicly available.
The procurement / delivery status:	The hospital construction is complete and the defects management period ends in October 2025.
Funding / Business Case:	The project is operating in is FBC funding envelope.
Integrated Assurance and Approval Plan (IAAP):	N/A The project commenced prior to the creation of the IPA. The MMUH programme follows the governance and assurance processes of the New Hospitals Programme.
Programme/Project plan:	Does the project / programme have an appropriate plan in place? The Programme was formally closed in March 2025 by the Trust Board; the MMUH closure report documents this closure and the programme

	transitioned residual work and risks to the core organisation.
Current position regarding previous assurance reviews:	PAR – October 2023 IPA Gate 4 – June 2024 PAR – January 2025 (to provide programme closure assurance) A summary of recommendations, progress and status from the previous assurance review can be found in **Annex D**.

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ANNEX D – Progress against previous assurance review

Progress Against Previous Review			
Previous Review Date: IPA Gate 4 Jule 2024			
Priority	**Summary of risks, issues and related recommendations from the original recommendation**	**Critical/ Essential/ Recommended**	**Current status - has the risk / issue been mitigated**
	Business Case validity - Future cost audit mitigation. **The project should, at a suitable point after go live, update or issue an addendum to the 2015 business case to refresh benefits and update the financial position.**	Recommended (to be done 6 months after opening)	**Closed.** Independent benefits audit complete February 2025 and be included as part of programme closure documentation. Updated financial position for the forecast of benefits realisation for Programme Closure documentation presented to the Trust Board in March.
	Efficiencies not realised. **Modelling capacity and usage should not end when MMUH opens.**	Essential	**Completed and closed.** Ongoing monitoring and reporting of all agreed metrics will continue into BAU.
	Poor Alignment of key stakeholders **The programme team should ensure adequate resources to continue the good engagement that has now been established, including with the commissioners and with GPs/primary care, through implementation and into the longer term.**	Essential	**Completed and closed.**
	Sub optimal communications.	Essential	**Completed and closed.**

	Consideration should be given to some form of communications audit to increase the likelihood that key messages are being received by all staff and that the staff have a route for queries and concerns that is effective.		
	Decision to proceed made without verification evidence of key requirements being met. **One output from the planned Safety Case should be a set of agreed Red Line "Must Complete" Requirements.**	Recommended	**Completed and closed.**
	Patient care is impacted due to high numbers of low order 'teething troubles' across hospital. **Appropriate resources should be identified that will be able to provide support to the BaU management during the first 100 days as part of transition.**	Essential	**Completed and closed.**
	Full benefit of 'digital' patient care not met. **Opportunities should be sought for funding to enable applications to run**	Recommended	Digital plan under review. The SRO now Group Chief Development Officer and Group Director of Strategy (with the digital portfolio) are working

	on the architecture MMUH has put in place.		with the NHP team benchmark hospital 2.0 digital strategy and potentially be an investment site for hospital 2.0 digital pilots.
	Poor alignment of key stakeholders. **Consideration should be given as to how to ensure the voice of patients is heard in planning for the move.**	Recommended	**Closed and completed.**
	Hard FM contractor performance failures result in degradation of patient care (and asset). **The increased and consistent oversight of Equans more recently established should continue and Equans' accountability to achieve better performance recognised.**	Critical	Closed as an action and joint working at exec level has continued post programme.

Department of Health & Social Care

ANNEX E – List of Interviewees

The following stakeholders were interviewed during the review:

Name	Organisation and role
Sir David Nicholson	Chairman
Warren Grigg	Director of Estates Development
Tim Reardon	Benefits Lead; Senior Finance Manager
Alessandra Raja	Partner RSM
Rachel Barlow (SRO)	Group Chief Development Officer
Joanne Newens	Chief Operating Officer
Jayne Dunn	Director of Commissioning & Equipping
Melanie Roberts	Chief Nursing Officer & Deputy Chief Executive
Mick Laverty	Non-executive Director
Simon Sheppard	Acting Chief Finance Officer
Meagan Fernandes	Deputy Director of People & OD
Diane Wake	CEO
Deborah McInerney	Former Project Director
Laura Broster	Group Chief Communications Officer
Danielle Joseph	Former Associate Delivery Director for the MMUH Programme
Natalie Forrest	Chief Operating Officer for the New Hospital Programme
Mark Jaques	MEP Project Director - Balfour Beatty Kilpatrick
Aner Marcelo; Zaheer Iqbal; Ian Oliver Steven Hill; Louise Johnson; Maria Mateunas	We were able to have a group discussion with these individuals for which we were very grateful

Department of Health & Social Care

ANNEX F – Recommendation Classifications and Priority Order

There are 13 classifications in the classification set, Review Teams are asked to record the classification reference number of each recommendation as per the table below.

#	Classification	Definition
1	Governance	Recommendations related to the oversight, structure and decision making of a project/ programme. This theme also includes recommendations relating to alignment with pan-government priorities, strategies and controls.
2	Stakeholder Management	Recommendations related to relationships with all parties with an interest in the outcome of the project/programme, whether internal to the agency, internal to government or external.
3	Programme and Project Management	Recommendations related to all aspects of project, programme and portfolio management, but excludes recommendations on Risk, Issues and Dependency Management (Theme 9) and Resource Management (Theme 10)
4	Change Management & Transition	Recommendations related to the Management of Business Change – all the work required with and in the business and with the customer to make ready for the initiative, in terms of changes to business processes including: business continuity planning, changes to work processes and resourcing, changes to organisational structures and staffing to support transformational or process changes to business delivery to ensure a smooth transition to BAU It does not include Technology Readiness for Service (Theme 12).
5	Financial Planning and Management	Recommendations related to financial planning, organising, directing and controlling of financial activities.
6	Benefits Management & Realisation	Recommendations related to the identification, ownership, measurement and realisation of benefits and dis-benefits. Benefits can be either financial or non-financial.

7	Commercial Strategy & Management	Recommendations related to the end-to-end procurement process including: Procurement strategy and planning, Approaches to the market, Contract negotiation and Contract management.
8	Context, Aim & Scope	Recommendations that are aimed at the clarity of the change to be implemented. It covers alignment to vision, strategy and policy; the purpose, objectives, justification and description of the change; and the determination of success and the necessary environment to ensure success.
9	Risk, Issues & Dependency Management	Recommendations related to the identification, analysis, impact assessment, response and the on-going review and management of Risks, Issues and Dependencies (i.e. outputs that are required by a project to succeed, but which will be delivered by parties not under the direct control of the project).
10	Resource & Skills Management	Recommendations related to all aspects of the identification, supply, optimisation, prioritisation and maintenance of resources and appropriate skills.
11	Knowledge Management	Recommendations related to the process of capturing, developing, sharing, and effectively using organizational knowledge. It includes sharing knowledge and experiences or Lessons Learnt.
12	Technology	Recommendations related to all technology issues, including the alignment of the technology solution to the technology and business strategy, the integration of one or more technology solutions,the operational readiness of the solution (including testing of the solution), and all aspects of security relating to the technology solution.
13	Other	To be used only when other classifications do not apply.

Each risk-based recommendation will be recorded as Critical / Essential or Recommended:

- **Critical (Do Now):** To increase the likelihood of a successful outcome it is of the greatest importance that the programme/project should take action immediately.

- **Essential (Do By):** To increase the likelihood of a successful outcome the programme/project should take action in the near future. [Note to review teams – whenever possible Essential risk-based recommendations should be linked to programme/project milestones e.g. before contract signature and/or a specified timeframe e.g. within the next three months.]
- **Recommended:** The programme/project should benefit from the uptake of this recommendation. [Note to review teams – if possible Recommended risk-based recommendations should be linked to programme/project milestones e.g. before contract signature and/or a specified timeframe e.g. within the next three months.]

Paper ref:	PublicTB (09/25) 016

REPORT TITLE:	Green Plan		
SPONSORING EXECUTIVE:	Rachel Barlow – Group Chief Development Officer		
REPORT AUTHOR:	Fran Silcox- Head of Sustainability		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

The Trust's Green Plan sets out how the organisation will reduce its environmental impact and contribute to improved health and life chances for the local population. The Board is asked to discuss the Green Plan and act as advocates for this agenda.

The Trust's purpose is to improve the life chances and health outcomes of the local population. A key part of this is working collaboratively with partners to build healthier, fairer and more sustainable communities.

The Green Plan is central to this ambition and provides a framework for how the Trust will reduce its environmental footprint while supporting sustainable models of care.
The Green Plan outlines actions across the following domains for discussion:

- Travel and logistics
- Asset management
- Climate adaptation
- Capital projects
- Sustainable models of care
- Procurement
- Use of natural resources

The Joint Infrastructure Committee, with a remit covering digital, data, estates, facilities and sustainability, is aligned with the Government's 10-year plan. The Committee will ensure that infrastructure development supports clinical excellence, improved outcomes, and a sustainable future for the communities we serve.

The Infrastructure Committee will oversee the final submission of the Green Plan to NHS England by the end of October 2026.

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

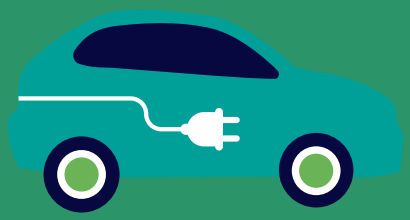
OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff	X	To work seamlessly with our partners to improve lives	X

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

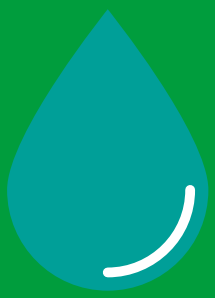
4.	**Recommendation(s)**
The Public Trust Board is asked to:	
a.	**Discuss** the Green Plan and its alignment with the Trust's purpose.
b.	**Endorse** the importance of sustainability as a driver of improved health and life chances.
c.	**Act** as advocates for the Green Plan within the Trust and with external partners.

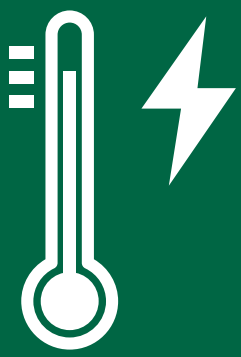
5.	**Impact** *[indicate with an **'x'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*							
Board Assurance Framework Risk 01		*Deliver safe, high-quality care.*						
Board Assurance Framework Risk 02	x	*Make best strategic use of its resources*			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

NHS
Sandwell and West Birmingham
NHS Trust



GREEN PLAN 2025 - 2028





CONTENTS

EXECUTIVE FOREWORD

As a major acute and community healthcare provider, Sandwell and West Birmingham NHS Trust recognises the significant environmental impact of delivering care to our communities. Like all large organisations, we consume substantial amounts of energy and water, generate waste, and are responsible for thousands of staff, patient, and visitor journeys every day.

Our purpose is to improve the life chances and health outcomes of the local population. A key part of achieving this is working seamlessly with our partners to create healthier, fairer, and more sustainable communities. The **Green Plan** is a central driver of this ambition. It sets out how we will reduce our environmental impact across travel and logistics, asset management, climate adaptation, capital projects, sustainable models of care, procurement, and the use of natural resources.

This plan looks beyond the walls of our hospitals and community facilities. It is designed to engage our staff, patients, and partners, enabling us all to play a role in improving environmental sustainability for future generations.

Over the past four years we have made significant progress, reducing carbon emissions and receiving national recognition as a multi-award-winning organisation. Key achievements include:

- The opening of **Midland Metropolitan University Hospital (MMUH), built with a strong focus on sustainability**. The building uses intelligent LED lighting, solar photovoltaic (PV) panels for renewable energy, and combined heat and power (CHP) systems to reduce carbon emissions. The building's management system is optimised to enhance operational efficiency. The adjacent 'Learning Campus' due to open in January 2026 is being developed to be a **net-zero carbon building** with a target of a BREEAM Outstanding rating.
- **Decommissioning of steam boilers** at City Health Campus, with the retained site now being run by modern gas boilers.
- **Securing £12 million in Public Sector Decarbonisation Scheme (PSDS) funding** for decarbonisation work at Sandwell Health Campus in 2024.
- Securing over **£800,000 of external funding** for solar panels, LED lighting, and Building Management System (BMS) upgrades in 2025.
- Installing **significant electric vehicle charging infrastructure** across our estates. This has resulted in 323,519 miles travelled in electric vehicles and an estimated 74,000 kg of CO2 emissions saved.
- Engagement of our colleagues to take sustainable actions through our **'Green Impact' environmental engagement programme**. 'Green Impact' is in its ninth year at the Trust. In 2024, teams completed 611 actions over 7 months, resulting in 142,918kg of carbon saved.
- **Wider and stronger partnerships** with our system partners and external collaborators, contributing to our successes.
- **Since 2019/20, the Trust has reduced its energy-related carbon emissions by 5.7%**. This measurement includes data up to and including the 2023/24 financial year. For us to meet the net zero target, we need to reduce emissions by a further **7.1% each year**, or 1,2430 tCO2e.

We remain committed to building on this success. As an anchor institution, we are proud to collaborate with partners such as Sandwell Council, Birmingham City Council, the West Midlands Combined Authority, Birmingham Clean Air Coalition, EQUANS, Transport for West Midlands, and others. Together, we are contributing not only to reducing carbon emissions but also to improving health, wealth, and regeneration across our region.

Looking ahead, this **Green Plan** will guide us in adopting more efficient and sustainable practices. Alongside it, we are implementing ambitious **Net Zero Carbon plans**, with a particular focus on transitioning to low-carbon energy and technology. Together, these programmes will embed sustainability into our daily operations, while inspiring and enabling our staff and patients to take part in this shared journey.

We know that public health is inseparable from the health of our planet. Without a sustainable environment, we cannot sustain a healthy population. That is why we are committed to embedding sustainability across our organisation and working with local and national partners to deliver positive, lasting change.

Through the **South Black Country Group** – a collaboration between Sandwell and West Birmingham NHS Trust and Dudley Group NHS Foundation Trust – we are further strengthening our commitment to sustainability. The Joint Infrastructure Committee, with a remit covering digital, data, estates, facilities, and sustainability, is aligned to the Government's 10-year plan and will ensure that our infrastructure supports clinical excellence, improved outcomes, and a sustainable future for the communities we serve.

This Green Plan is not just about reducing carbon – it is about building resilience, protecting public health, and securing a better future for generations to come.

Best wishes

Rachel Barlow
Group Chief Development Officer
The Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust

EXECUTIVE SUMMARY

Sandwell and West Birmingham (SWBT) NHS Trust and The Dudley Group NHS Foundation Trust (DGFT) recognise **climate change as a critical public health issue** driven by human activity and commits to mitigating its impact through partnership and collective action. This document is a refresh of our Green Strategic Plan, initially approved in January 2022, aligning with its strategic objective to empower sustainable development and public health at local and national levels. This plan outlines the Trusts updated strategies and ambitions across several critical areas to achieve its net zero and sustainability goals, driven by strong commitment from its people, strategic estate management, sustainable transport initiatives, responsible medicine practices, and a circular economy approach to procurement and food.

Significant strides have been made, particularly through new partnerships and collaborations. However, **systemic, transformational changes are still required** across the healthcare system to achieve net carbon zero and sustainable ways of working.

The Trust is dedicated to addressing climate change as a core public health responsibility through strategic planning, strong partnerships, and continuous effort towards a more sustainable future.

ABOUT US

Sandwell and West Birmingham NHS Trust is an integrated care organisation. We are dedicated to improving the lives of local people, to maintaining an outstanding reputation for teaching and education, and to embedding innovation and research.

We employ over 8,000 people and spend around £700 million of public money, largely drawn from the Integrated Care Boards (ICBs) which serve the Sandwell and West Birmingham areas. The ICBs and the Trust are responsible for the care of 530,000 local people from across North-West Birmingham and all the towns within Sandwell.

Our teams are committed to providing compassionate, high quality care from the Midland Metropolitan University Hospital (MMUH) in Smethwick, City Health Campus (formerly City Hospital) on Birmingham's Dudley Road, from Sandwell Health Campus (formerly Sandwell Hospital) in West Bromwich, and from our intermediate care hubs at Rowley Regis and Leasowes in Smethwick.

The Trust includes the Birmingham and Midland Eye Centre (a supra-regional eye hospital), as well as the Pan-Birmingham Gynae-Cancer Centre, our Sickle Cell and Thalassaemia Centre, and the regional base for the National Poisons Information Service.

Inpatient paediatrics, most general surgery, and our stroke specialist centre are located at The Midland Met. We have significant academic departments in cardiology, rheumatology, ophthalmology, and neurology.

Our community teams deliver care across Sandwell providing integrated services in GP practices and at home, and offering both general and specialist home care for adults, in nursing homes and hospice locations.

WHY DO WE NEED A GREEN PLAN?

The climate emergency is a health emergency. From poor air quality to rising heat-related morbidities and extreme weather events, climate change is already impacting the health and wellbeing of our communities, especially the most vulnerable.

The NHS is the first health system in the world to embed net zero into legislation. Under the Health and Care Act 2022, NHS England, Integrated Care Boards (ICBs) and Trusts now have a legal responsibility to contribute to statutory emissions targets. In line with this, all NHS organisations must have a Board-approved Green Plan, regularly reviewed and informed by staff, patients, and wider communities.

At the same time, the UK's Climate Change Act sets out our national carbon reduction commitments. The NHS accounts for around 4-5% of the UK's total carbon footprint, making us both part of the problem and key to the solution.

We are legally obliged to address climate change, with a reduction in carbon emissions set out in the UK's Climate Change Act (CCA). This Plan responds to these and other requirements placed on the Trust to manage and reduce our environmental impact.

We published our first Green Plan in 2022; this refresh continues that journey, building on good practice and further embedding sustainability within the Trust. We have developed our Green Plan to be inclusive and representative whilst responding to a rapidly changing world. Sustainable healthcare will help our budgets stretch further; it contributes towards the green ambitions of region and aligns with prevention to further reduce pressure on health services.

INTRODUCTION

Our key overarching aims across the Trusts are:

- To **deliver high-quality care without exhausting resources or causing environmental damage** to preserve resources for future generations,
- To **develop ambitious net carbon zero plans**, including decarbonising our estates,
- To **embed sustainability into the heart of our organisation** and lead on driving working practice towards using resources, like energy and water, more efficiently to reduce wastage, and
- To **engage and inspire our colleagues and patients** to take actions that will collectively make a big impact.

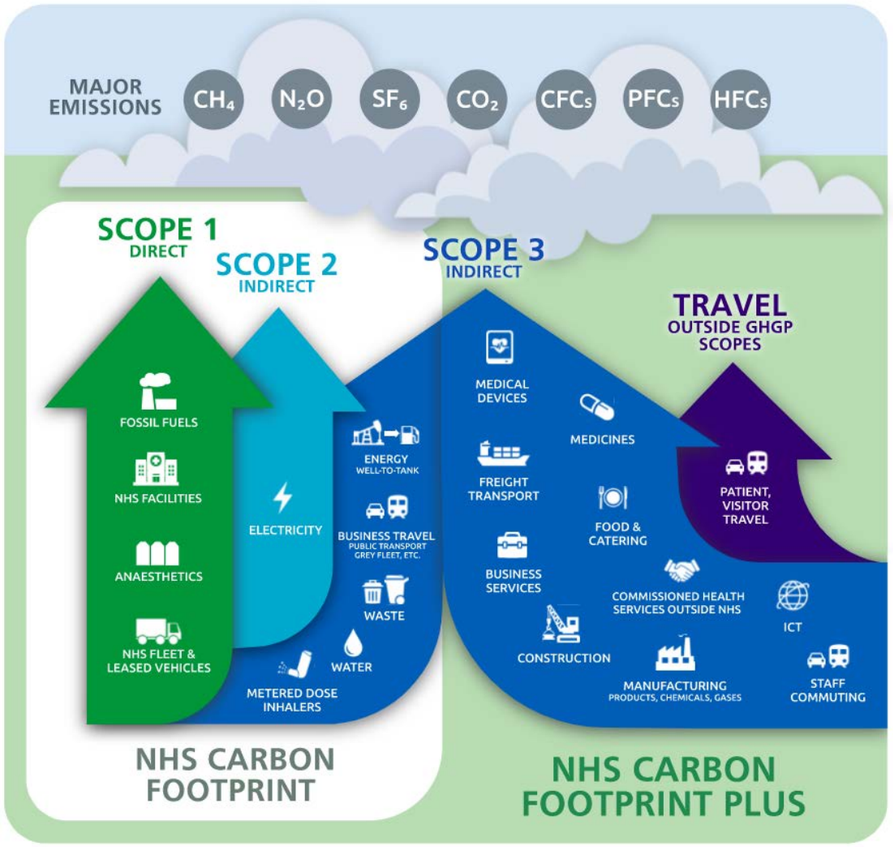
Our Green Strategic Plan was Trust Board approved in January 2022. This plan aligns to our 'population' based strategic objective, empowering others at local and national levels to positively contribute to sustainable development and public health. This is a refresh of the Green Strategic Plan (launched in 2022) and outlines our sustainability strategy for 2025. to 2028.

OUR PROGRESS SO FAR

We have aligned our targets with the NHS ambitions. As a minimum, we will:

- Reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 for the emissions we control directly (the 'NHS Carbon Footprint'),
- Reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 for the emissions we can influence (the 'NHS Carbon Footprint Plus').

Figure 1: Carbon emission scopes in the context of the NHS (NHS England, Delivering a net zero NHS, 2022).



The total scope 1, 2 and 3 emissions for the Trust are estimated to be 198,102 tCO2e (using 2022/23 data). Scope 3 emissions make up the largest proportion of the Trust emissions at approximately 92%. Figure 1 below shows the Trust total carbon emissions by scope. Figure 2 show the breakdown of emissions.

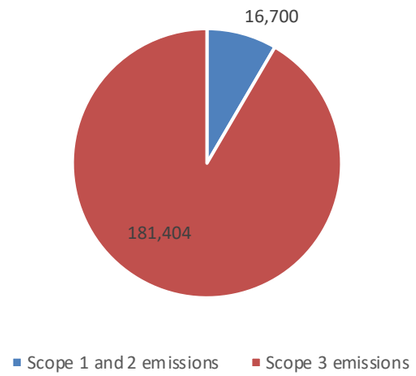


Figure 2: Trust Carbon Emissions for Scope 1 and 2, 2022-2023 (in tonnes of carbon)

Scope 1 emissions: direct emissions from owned or controlled sources.

Scope 2 emissions: indirect emissions from the generation of purchased energy.

Scope 3 emissions: all indirect emissions (not included in Scope 2) that occur in the value chain of the reporting company, including both upstream and downstream emissions.

Since 2019/20, the Trust has reduced its energy-related carbon emissions by 5.74%. This measurement includes data up to and including the 2023/24 financial year. For us to meet the net zero target, we need to reduce emissions by a further **7.1% each year**, or 1,2430 tCO2.

Momentum with our Green Plan has really grown over the last four years, with more staff becoming engaged and joining our 'Green Impact' environmental staff engagement programme.

We have received significant funding to support decarbonising our Sandwell Health Campus, and additional funding for solar panels and LED lighting upgrades.

We have also strengthened partnerships with local authorities and transport providers to offer eligible staff and patients free bus travel.

Since launching the Green Strategic Plan in 2022, we have achieved the following:

Zero desflurane (a very high carbon anaesthetic gas) purchased since 2021

Use circular economy approaches - **Reducing waste, repurposing and transitioning to re-useables** e.g. harmonic scalpels, reduced apron and glove use, re-usable tourniquets trial

Green Impact programme completed with 611 actions carried out and an **estimated 142,918kg of CO2 saved** (2023)

Public Sector Decarbonisation Funding (PSDF) for **£12m of decarbonisation works** at Sandwell Hospital (2023)

Installed electric vehicle charging infrastructure across our sites - 42 sockets, with a further 15 sockets at MMUH

2022

5 fully electric vehicles now in the Trust fleet with a view to transition other vehicles to low/ultra low emission vehicles

Partnered with National Express to offer staff **free bus passes and discounted travel** for both staff and patients (2022 onwards)

Installed outdoor gym equipment at City Hospital (2023)

Reduced the unnecessary prescription of medicine **avoiding dispensing 57,828 drugs and saving £751,764** between April and December 2023

2024

STAKEHOLDERS

Delivery of the Green Plan cannot be achieved in isolation. We will therefore continue to work closely with our system partners and proactively engage with a broad range of stakeholders. This includes seeking collaborative opportunities with local authorities, universities, transport providers, third-sector organisations, and industry partners to support the delivery of Green Plan actions. We will also explore alternative funding streams to invest in our estate, accelerate innovation, and strengthen progress towards net zero.

BLACK COUNTRY ICS

- Black Country ICB
- The Royal Wolverhampton NHS Trust
- Sandwell & West Birmingham Hospitals NHS Trust
- The Dudley Group NHS Foundation Trust
- Walsall Healthcare NHS Trust
- Black Country Healthcare NHS Foundation Trust
- West Midlands Ambulance Service
- Primary Care Services

WIDER NHS

- Birmingham and Solihull ICS
- Greener Midlands Teams
- NHS England
- Midlands Clinical Product Evaluation Group
- Midlands Nursing and Midwifery Clinical Transformation Group
- National workstream groups such as estates, waste, biodivesrity etc.

EXTERNAL

- West Midlands Combined Authority
  - Travel
  - Air Quality Monitoring
  - Climate Adaptation
- Travel Providers and Operators
- Local Authorities
- Property Services
  - PFI
  - NHS Property Services
  - CHP
- Local University and Colleges
- Suppilers

AREAS OF FOCUS

Our People, Workforce & Leadership

Encourage and inspire staff, local population and wider stakeholders to implement good environmental practices.

Estates & Facilities

Transition to low carbon technologies, ensuring our estates are as energy and utility efficient as possible.

Travel & Transport

Encourage active and sustainable modes of travel and transition to low emission vehicles.

Medicines

Enable care pathways that improve patient outcomes whilst reducing resource use and carbon emissions.

Food & Nutrition

Deliver high-quality, healthy and sustainable food and minimise waste.

Net Zero Clinical Transformation

Enable patient and clinician led service redesign and embed prevention into the development of our care models. Encourage patients and staff to make lifestyle choices that will improve their health.

Digital Transformation

Prioritise sustainability in the procurement, design and management of digital services.

Climate Change Adaptation

Plan, mitigate and build future resilience so that there is limited impact on the delivery of our patient care and to our staff.

Supply Chain & Procurement

Transition to whole lifecycle environmental, social and costings based decision making. Use evidenced based practice to challenge overuse of products and look at care pathways that deliver outcomes that also save resources..

OUR PEOPLE, WORKFORCE & LEADERSHIP

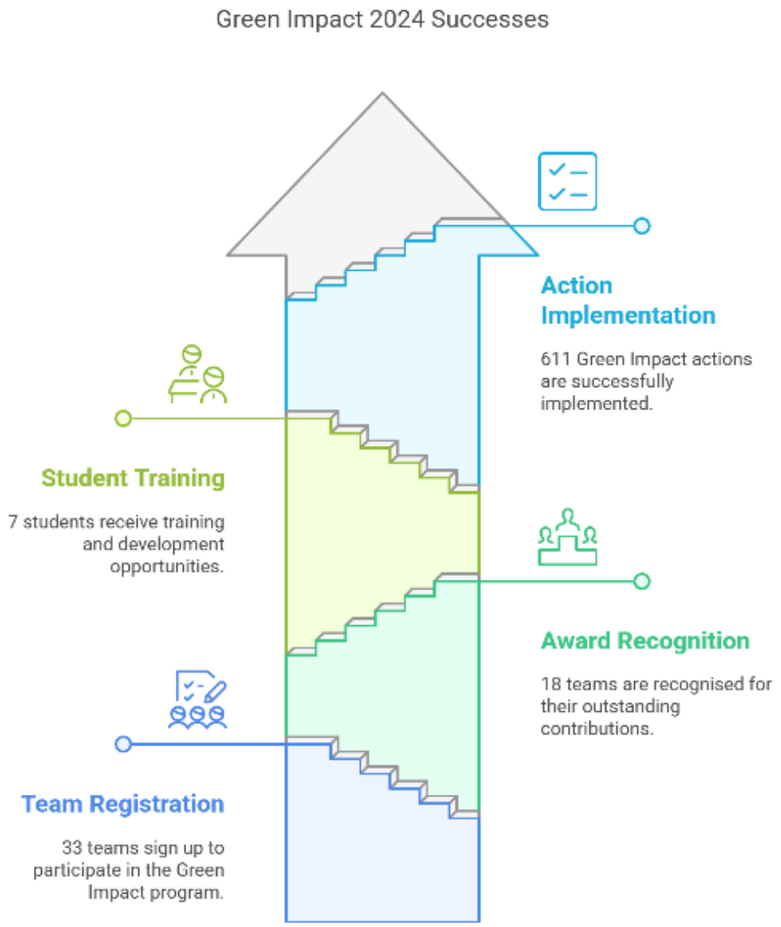
Sustainable healthcare and the transition to a net zero must be driven by people - the communities we serve and our colleagues. There is strong support from NHS colleagues to tackle climate change.

We aim to encourage and inspire staff, local population and wider stakeholders to implement good environmental practices.

We have:

- Developed plans to support sustainability from a strategic stance, allowing for further funding bid opportunities and further engagement across the Trust to ensure that the importance of sustainability is engrained and supported from Board and Executive Directors.
- 'Green Impact', our programme to engage staff in sustainable practices, is in its 5th year and has seen increasing participation and actions completed each year. See Figure 4 for a summary of the 2024 Green Impact success, including the teams completing 611 actions over 7 months. This resulted in estimated carbon savings of 142,918kg.
- Rewarded and incentives staff for participation in active and sustainable lifestyles such as healthy meal vouchers offered to incentivise walking and cycling and a free hot drink to reward new registrations to Kinto (our car sharing, walking and cycling buddy-up app).
- Worked in partnership with Transport for West Midlands (TfWM) to offer a range of discounts and free bus passes for new starters and wider colleagues.
- Between January 2023 and January 2024, 450 staff received a free 4-week bus pass, promoting a shift towards greener travel.
- Provided staff to manage sustainability activities - Head of Sustainability, Waste and Decommissioning Manager in post, and our FM provider has a Trust dedicated Energy Manager.
- Partnered with the University of Birmingham for 10 years to support a student every year on sustainability related projects.

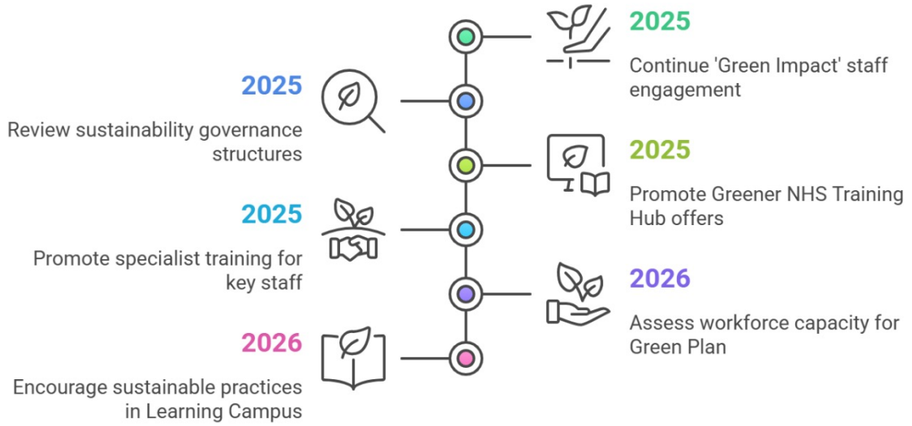
Figure 3: A summary of the 2024 Green Impact success



WE WILL

- From 2025, we will continue to deliver our 'Green Impact' staff engagement programme, offering colleagues an opportunity to work together in teams to complete environmental actions that make a difference.
- In 2025, we will add content on the importance of sustainability at the Trust in the employer description for all job descriptions. This will set a precedent that sustainability is focal to the work we do.
- In 2025, we will review existing sustainability governance structures and networks to ensure these are fit for purpose. We will ensure we have a designated board-level net zero lead to oversee the Green Plan delivery, with clearly identified operational support.
- By the end of 2025, we will promote, and consider setting uptake targets for, core training offers set out on the Greener NHS Training Hub.
- By the end of 2025, we will promote specialist training for staff groups who underpin the delivery of the Green Plan, such as board members, procurement, finance, estates and facilities staff and clinicians.
- By the end of 2026, we will have assessed our workforce capacity and skill requirements for delivering the Green Plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways.
- From 2026, we will encourage sustainable practices into our new Learning Campus (due to be completed in 2026) that will provide a major new education and skills resource, covering training from entry-level to Level 7 skills, linked to the new hospital, and focused on widening participation in education, as well as targeting hard-to-reach groups.

Figure 4: Our people, workforce and leadership key sustainability plans



Some of our Green Impact teams taking sustainable actions

Some of our Green Impact teams collecting their awards

KEY PERFORMANCE INDICATORS

- Green Impact staff engagement programme in place.
- Number of Green Impact teams registered and number of actions completed per year by the teams.
- Designated board-level lead for net zero and clinical net zero lead in place.
- Green Plan tracker developed to monitor progress.
- Number of colleagues undertaking sustainability training.

RISKS

- Resource and dedicated time for colleagues to deliver actions and projects in Green Impact.
- Time and availability of colleagues for training.
- Capacity of teams to deliver the actions in the Green Plan.

Sustainability Garden Party event to engage staff and the public on sustainability

ESTATES & FACILITIES

There are significant opportunities across the NHS estate to reduce emissions and lower costs, while improving energy resilience and patient care.

We aim to transition to low carbon technologies, ensuring our estates are as energy and utility efficient as possible.

Estates and Facilities is an important part of the Green Plan and the delivery of our carbon reductions.

Across the two Trusts, SWBT and DGFT, 88% of our NHS Carbon Footprint is from our building energy; electricity, gas, and oil. Action in this area is critical in achieving our net-zero ambition.

We will measure and report significant carbon emissions on an annual basis.

WE HAVE

- Successfully bid for £12.5m Public Sector Decabonisation Scheme (PSDS) funding for heat decarbonisation and energy efficiency measures at Sandwell Health Campus.
- Mapped our Scope 1, 2 and 3 carbon emissions for 2022-23 (covering energy, buildings, medicines, travel, supply chain, and wider).
- Worked with a consultancy to develop Excel based decarbonisation intervention tool has been developed for the estate. The tool will allow the scope 1 and 2 emissions source usage data to be entered annually to keep track of the ongoing annual emissions for the estate. It has a high-level, integral decarbonisation intervention planner focused on the buildings located on the Sandwell Health Campus, City Health Campus, Leasowes and Rowley Regis sites.
- Successfully bid for NHS Energy Efficiency Fund (NEEF) funding of over £838,000 for solar panel schemes, LED lighting upgrades and Building Management System (BMS) upgrades.
- Ensured future new build or refurbishment projects follow the guidance set out in HTM 07-07 Environment and Sustainability; planning, design, construction and refurbishment.
- Moved towards on-site renewable energy with solar PV installed at our City Health Campus, Sandwell Health Campus, and Rowley Regis Hospital sites and MMUH.

WE WILL

- In 2025, we will develop a Heat Decarbonisation Plan (HDP) that will focus on transition away from fossil-fuel as a primary heating source by 2032, with a view to remove all oil primary heating systems by 2028. This will be used as a business case to apply for funding.
- As part of our HDP, we will put in place a programme of works to roll out LED lighting to

all accessible areas across the retained estate.

- We will work in partnership with local authorities, organisations and wider to connect to a future energy from waste district heating network.
- In 2025, we will invest in on-site renewable energy to generate electricity on our sites by installing solar panels. We aim to generate over 330,000 KWH of renewable electricity per year on site before 2026.
- In 2025, we will deliver the projects specified in the Public Sector Decarbonisation Funding (PSDF) bid for energy efficiency adaptations projects at Sandwell Health Campus, reducing carbon emissions by 2,000 tonnes each year. This will include:
  - Installation of a heat pump system to provide low carbon heating and Domestic Hot Water (DHW),
  - Replacement of windows,
  - Upgrading three elevations of the Tower Block thermal envelope with a new cladding/ window system,
  - Replacement of the Tower Block failed roof insulation/coverings,
  - Replacement of 1,377 fluorescent light fittings with new energy efficient LED fittings.
- By the end of 2026, we will open our 'Learning Campus' at MMUH. This aims to be our first, purpose built Net Zero building.
- Improve the ground maintenance programme to increase biodiversity on site.
- Improve waste segregation and compliance by aiming for a 20-20-60 waste split – 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste.

Figure 5: Key actions for our estates and facilities.

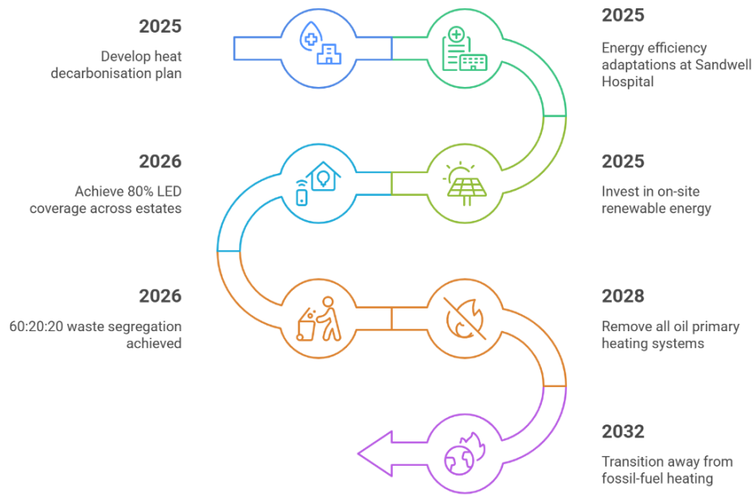
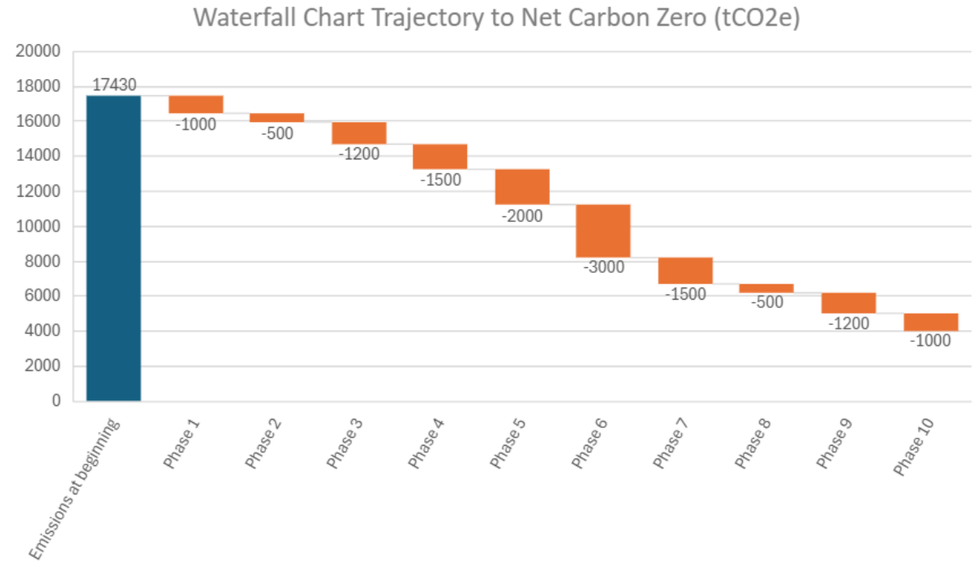


Figure 6: Waterfall chart showing some of the potential energy efficiency projects the Trust will consider to reach net carbon zero.



The waterfall chart in figure 6 shows some of the phased energy efficiency projects that have been completed, those that are in development and those that are proposed (subject to funding). These will reduce the Trusts annual energy related carbon emissions by 13,400 tonnes. The waterfall chart has been split into the following phases:

PHASE 1: Site rationalisation (2024)

PHASE 2: Site rationalisation with energy optimisation

PHASE 3: Site rationalisation with no energy optimisation (2025)

PHASE 4: Energy optimisation (2025)

PHASE 5: Energy optimisation (2025-2026)

PHASE 6: Removal of gas reliance (2026-2027)

PHASE 7: Connect to a district heating network (2028+)

PHASE 8: Hydrogen transition where feasible (2030+)

PHASE 9: Further renewable energy generation (2030+)

PHASE 10: Carbon offsetting (if required) (2035+)

KEY PERFORMANCE INDICATORS

- Heat Decarbonisation Plan (HDP) developed, with a plan to decarbonise the Trust estates.
- Partnerships are in place and cross-organisation working.
- Delivery of the Public Sector Decarbonisation Scheme (PSDS) funding for energy efficiency adaptations projects.
- Percentage area of lawn with reduced lawn mowing.
- Improved waste segregation and compliance by aiming for a 20-20-60 waste split – 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste.
- Generate over 300,000 kWh of solar PV renewable electricity per year generated on our sites by 2026.

RISKS

- No funding available through the Public Sector Decarbonisation Funding (PSDF) from 2025.
- Lack of internal resource and funding to deliver the Heat Decarbonisation Plan (HDP) and related energy efficiency schemes.
- Waste segregation reliant on engagement of colleagues.

The Commons Garden at MMUH, a wonderful additonal space on our estate.

TRAVEL & TRANSPORT

The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles. It directly contributes to harmful air pollution.

We will encourage active and sustainable modes of travel and transition to low emission vehicles. We will align our plans to the NHS Net zero travel and transport strategy, a roadmap that to decarbonising NHS travel and transport, while also providing cost-saving and health benefits.

WE HAVE

- Installed significant electric vehicle charging infrastructure across our estates. Between June 2024 and June 2025, the electric vehicle charged points have supported 589 drivers and saved 91,534 kg of carbon.
- 5 fully electric fleet vehicles, with a view to transition the other vehicles to low/ultra-low emission vehicles.
- Supported staff and patients in transitioning towards more sustainable travel. 26% of non-bus users were converted into bus users. Working in partnership with Transport for West Midlands, we now offer:
  - A free 4-week bus pass for all new starters,
  - Opportunities for eligible staff to access a 4-week free bus pass, followed by 8 weeks at 25% discount,
  - A 1-week free bus pass for eligible patients, or 25% discount on Daysaver tickets for patients
- Implemented our car sharing scheme, with Kinto, to allow colleagues to car share.
- Produced a Travel Plan in accordance with the NHS Net Zero Document, conducting annual staff travel surveys to explore how we can better support colleagues with travel to work.
- Chaired the ICS NHS Greener Sustainable Travel and Transport Group, sharing best practice, any issues and working to develop partnerships.
- Ran annual staff travel surveys and a new patient and visitor survey to capture travel habits and inform how we can better support people with travel to our sites.
- Installed air quality monitors at Sandwell Health Campus and MMUH to monitor the quality of air around our sites.

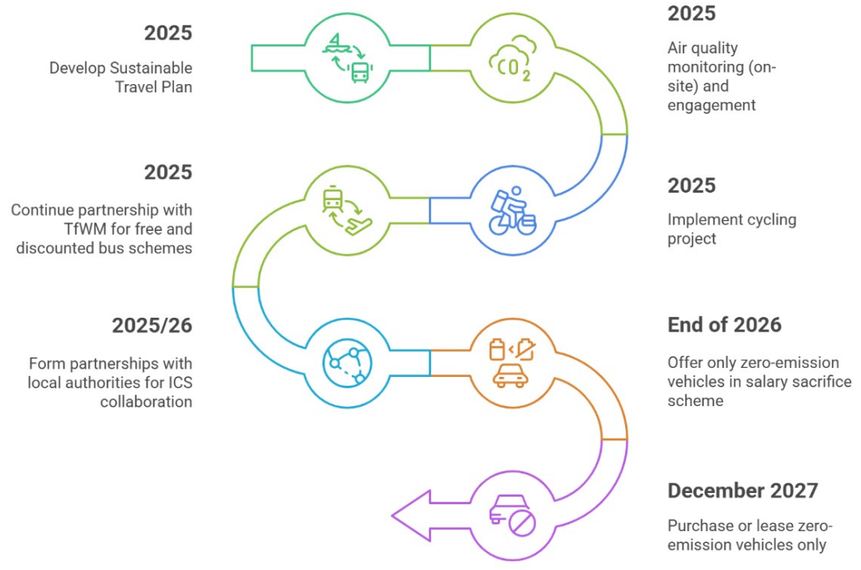
A bus pulling into MMUH.

Electric vehicle charging points at City Health Campus.

WE WILL

- In 2025, we will develop a Sustainable Travel Plan, ahead of the December 2026 NHS guidance. This Travel Plan will have a detailed action plan with potential measures focusing principally on promoting alternative forms of travel to single occupancy car drivers. This includes assisting in the development of feasible alternatives and therefore will include options for encouraging active travel, public transport and car sharing.
- From 2025, we will continue to monitor air quality and engage our stakeholders on the linkages between air quality and health.
- In 2025, we will run cycling projects aimed at supporting staff and patients in cycling activities, including:
  - A project with our cardiology team to support with patient rehabilitation,
  - An e-bike pool bike scheme allowing staff to hire out an e-bike free of charge to get to/from work.
- In 2025, we will continue to run schemes in partnership with Transport for West Midlands to provide free trial bus passes and discounted bus travel to staff and patients.
- In 2025/26, we will continue to form partnerships with local authorities, local transport authorities, and West Midlands Ambulance Service (WMAS) to ensure alignment, access to funding and collaboration, across the Integrated Care System (ICS) and other regions.
- From the end of 2026, we will only offer zero-emission vehicles through our vehicle salary sacrifice scheme for new lease arrangements. The current scheme only allows for ultra-Low Emission Vehicles (ULEVs) (i.e. vehicles that emit less than 75g CO2/km).
- From December 2027 onwards we plan to purchase, or enter new lease arrangements, for zero-emission vehicles only.

Figure 7: A summary of the travel and transport actions.



KEY PERFORMANCE INDICATORS

- Sustainable Travel Plan developed, with SMART targets.
- Cycling programmes in place to support colleagues.
- Partnership programmes in place, e.g. Transport for West Midlands free bus passes trials and discounted bus travel to staff and patients.
- Only zero-emission vehicles offered through the Trust vehicle salary sacrifice scheme for new lease arrangements.
- Purchase, or enter, new lease arrangements for zero emission vehicles only.

RISKS

- Lack of resource to deliver the actions in the Sustainable Travel Plan.
- Lack of engagement and support from partners to deliver sustainable travel schemes.
- Lack of appetite for people to transition to sustainable and active modes of travel.

MEDICINES

Medicines account for around 25% of NHS emissions, with anaesthetic gases and inhalers being 'point of use' emissions focus areas. Optimising medicine use and reducing waste will reduce emissions and improve patient care.

We will enable care pathways that improve patient outcomes whilst reducing resource use and carbon emissions.

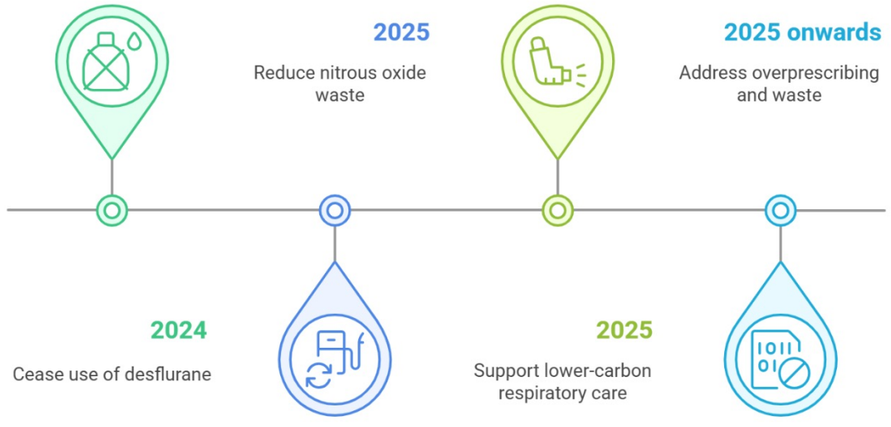
WE HAVE

- Collaborated with the ICS to support engagement to help inform clinicians and patients to make environmentally positive decisions.
- Ran in-house and ICS engagement 'lunch and learn' sessions with guest speakers to engage colleagues on the importance of assessing inhaler technique and prescribing, where clinically appropriate, Dry Power Inhalers (DPI) which have a much lower carbon impact than Meter Dose Inhalers (MDIs).
- Established a Greener Theatres Working Group with an action plan to drive moving to greener ways of working.
- Ensured zero desflurane (a very high carbon anaesthetic gas with a potent global warming potential) purchased since 2021. Sevoflurane is the primary anaesthetic gas used across the Trust. Sevoflurane is one of the lowest carbon inhalational anaesthetic agents.

WE WILL

- Continuing to cease the use of desflurane in line with **national guidance**, unless there are exceptional circumstances.
- In 2025, we will put in place actions to reduce nitrous oxide waste from medical gas pipeline systems (MGPS), adopting a phased approach based on clinical audits. We will reduce our reliance on nitrous oxide manifold systems, decommissioning these where possible. We will focus efforts on the retained estate initially where systems may be sized based on previous clinical usage and where there is greater potential to reduce waste.
- In 2025, we will support high-quality, lower-carbon respiratory care in secondary care, including supporting patients to choose the most appropriate inhaler(s) in alignment with clinical guidelines, performing inhaler technique checks with patients and promoting the appropriate disposal of inhalers.
- From 2025 onwards, we will support system-wide action to address over prescribing and oversupply.
- We will reduce pharmaceuticals waste by implementing automated control and 'Scan4Safety'. 'Scan4Safety' technology will help track the movements of patients, medicines and equipment contributing significantly to inventory management.
- We will support avoidance of stock discrepancies and excess stock held.

Figure 8: Key deliverables for medicines.



KEY PERFORMANCE INDICATORS

- Zero desflurane usage, alongside monitoring of anaesthetic gases and the carbon impacts.
- Reduced reliance on nitrous oxide manifolds to reduce wastage from the pipelines, saving costs and carbon.
- Tracking inhaler prescribing trends and engagement with staff and patients around inhaler technique and choices.
- Percentage reduction in pharmaceutical waste.

RISKS

- Medicines are heavily driven by system-wide action across primary and secondary care. It is difficult to break long-term trends and cultures of prescribing Meter Dose Inhalers (MDIs) that are high in carbon. This is also heavily driven by patient and consultant preference.
- Substantial upfront and ongoing costs for system implementation (Scan4Safety, nitrous oxide system repairs, etc.).

FOOD & NUTRITION

When food is produced, processed, distributed, served and then wasted, it creates an unnecessary carbon impact. Procuring local, seasonal and healthy food and reducing waste will significantly reduce the environmental impact of the food we procure. It will also improve the health of our population.

We will implement the National standards for healthcare food and drink, delivering high-quality, healthy and sustainable food and minimise waste.

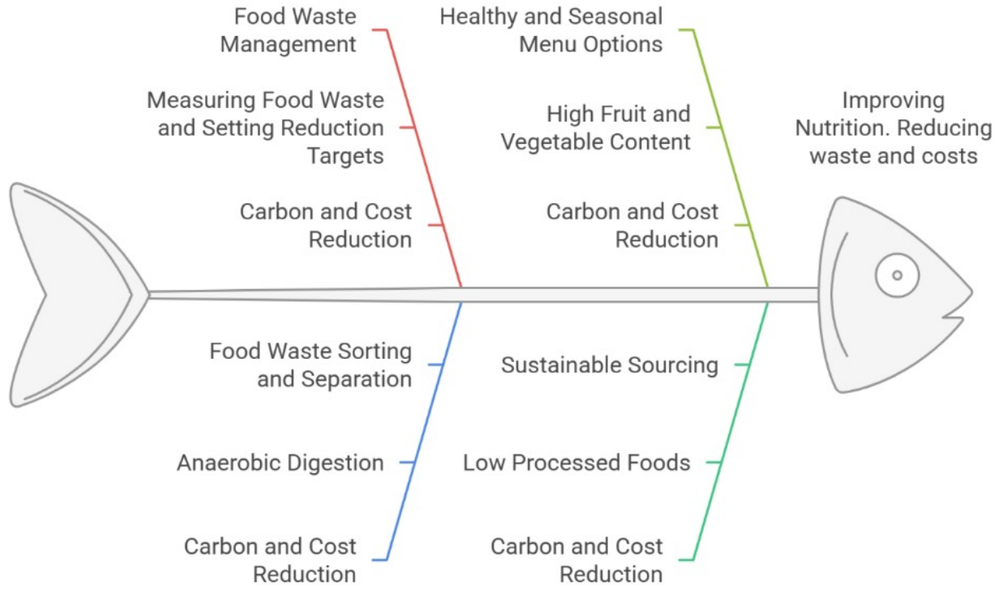
WE HAVE

- Put in place a 'Real Junk Food' project at City Health Campus where people can purchase surplus to use food from supermarkets that would normally be wasted.
- Purchase food as locally as possible (where procurement protocols allow).
- Adjusted the patients cook chill production numbers according to patient uptake to reduce waste.
- Identified areas via ward audit meals and electronic waste collection data where food waste levels are high. These wards have been engaged and are working to tackle food waste reduction.
- Taken part in a pilot study, working with NHS England, serving patients meals on a new style of crock plates and bowls at Rowley Regis Hospital to see if this reduces food waste.
- Transitioned to more environmentally friendly packaging in catering (e.g. sandwiches are now packed in environmentally friendly wrap and cardboard, and we have introduced paper-based products rather than plastic containers at our salad bar).
- Stopped purchasing single-use plastic stirrers, straws (unless clinically required), cutlery and plates.

WE WILL

- From 2025, we will measure food waste in line with the Estates Return Information Collection (ERIC) and set reduction targets.
- Move towards "Simpler Recycling", the UK government initiative focused on standardising recycling practices across England. This will include separating food waste for anaerobic digestion by the end of 2025.
- From 2025, we will consider opportunities to make our menus healthier and lower carbon by supporting the provision of seasonal menus high in fruit and vegetables and low in heavily processed foods.

Figure 9: A summary of the key deliverables for food and nutrition.



KEY PERFORMANCE INDICATORS

- Percentage reduction in food waste.
- Food waste sent for anaerobic digestion.
- Percentage of seasonal and healthy food options available.

RISKS

- **Operational and cost burdens:** Implementing new waste processes and sourcing specific foods will demand significant staff time, training, and could potentially lead to increased financial costs.
- **Supply chain and menu acceptance:** Ensuring a reliable supply of seasonal, lower-carbon foods is challenging, and changes to menus could face resistance from patients and staff.
- **Compliance and data accuracy:** Gaining consistent staff compliance for waste separation and accurately measuring waste for reporting (ERIC) can be difficult, impacting the validity of targets.

NET ZERO CLINICAL TRANSFORMATION

Delivering health care with increasing environmental, social and financial pressures is challenging but essential. For our health care system to become more efficient and future-proof, we need to embed holistic sustainable practices and take a more proactive (rather than reactive) approach.

Enabling patient and clinician led service redesign and embedding prevention into the development of our care models is crucial. We aim to encourage patients and staff to make lifestyle choices that will improve their health and reduce demand on the healthcare system.

WE HAVE

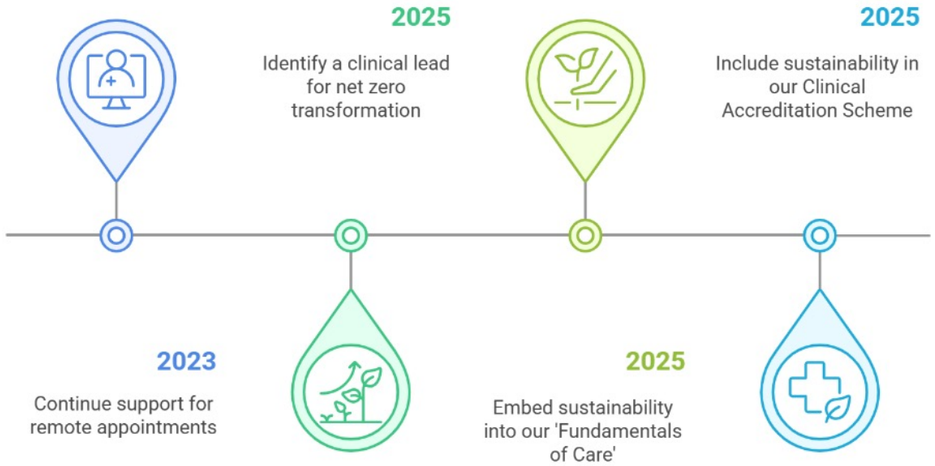
- Supported remote appointments for patients where possible to reduce the need for travel into hospital.
- Worked towards more optimised outpatient scheduling to reduce the number of visits to hospital sites for our patients.
- Engaged patients and utilise local partnerships to encourage healthy lifestyles.
- Transition to digital ways of working through reducing paper usage and delivering virtual care.
- Created an outdoor gym at City Health Campus so people can get active and enjoy outside space.

The outdoor gym at City Health Campus.

WE WILL

- From 2023, we will continue to support remote appointments for patients to reduce the need for travel into hospital.
- In 2025, we will identify a clinical lead to drive net zero clinical transformation.
- From 2025, we will embed sustainability into our **'Fundamentals of Care' programme**. This underpins our Patient Plan as part of our Trust Strategy; it sets out how the interdisciplinary team connects and builds relationships with our patients.
- From 2025, we will include sustainability as part of the **Trust Clinical Accreditation Scheme**. This will focus on reducing emissions and improving quality of care across clinical practices, starting with the ward areas. Quality improvement projects in clinical areas will focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities. Learnings will be shared across the region and nationally. Projects will include the following expectations with audits and progression:
  - Increase participation in our Green Impact staff environmental engagement programme and the number of actions taken by the teams,
  - Reduce the unnecessary use of clinical products such as gloves, gowns and aprons,
  - Ensure waste is kept to a minimum and that waste is placed into the correct waste streams. The guidelines for NHSE clinical waste separation are a 60:20:20 split - 20% incineration waste, 20% infectious and 60% offensive waste. This will be done through staff engagement.

Figure 10: The net zero clinical transformation journey.



KEY PERFORMANCE INDICATORS

- **Remote appointment rate:** Percentage of eligible patient appointments conducted remotely.
- **Net zero clinical lead:** Confirmation of an appointed and active clinical lead for net zero transformation.
- **Clinical accreditation scheme sustainability score:** Once in place, measure the sustainability performance across clinical areas.

RISKS

- Lack of willingness to transition to remove appointments (staff and patients) or unable to run appointments remotely for more complex cases.
- Sustainability not embedded into the Trust 'Fundamentals of Care' programme due to other clinical priorities taking precedence.
- Lack of time and resource for staff to drive sustainability projects.

DIGITAL TRANSFORMATION

Digital sustainability is a critical element in transforming health and social care. Recognising the environmental and cost impacts of digital technology, the Trust's Digital Strategy supports the Trust's commitment to delivering a green agenda that aligns with both local and national sustainability objectives, including the Greener by Design and the Fit for the Future ten-year health plan, which is a blueprint for transforming healthcare in England. The plan is deeply intertwined with digital sustainability, ensuring that technological innovation supports long-term health outcomes, environmental responsibility, and operational resilience.

Strong digital foundations are essential for transforming care by improving access, quality, productivity and reducing emissions. Although digital services can sometimes increase carbon output, our transition to new digital ways of working will ultimately reduce travel and other carbon emissions associated with delivering and managing healthcare.

WE HAVE

- Successfully moved towards 15% of our appointments being run virtually.
- Rolled out 'one-stop shops' to improve patient pathways.
- Started rolling out 'Health Care Communications' so that patients are sent appointment information digitally, reducing resource and paper use.
- Supported and facilitated virtual ways of working for colleagues.

WE WILL

- From 2025, we will measure the impact of Virtual Wards and assess how this has reduced travel emissions.
- From 2024, we will reduce the use of paper and transition to virtual pathways where clinically appropriate to reduce emissions and improve patient care.
- By 2026, we will complete the Digital Maturity Assessment, embedding sustainability into digital services by:
- Integrate circular economy principles into our informatics, focusing on repair and reuse to minimise waste.
- Considering low carbon hosting, promoting good data hygiene (such as, deduplication and archiving) and engaging digital suppliers.

Figure 11: Digital sustainability milestones.

KEY PERFORMANCE INDICATORS

- Patient volumes and emission reductions from running ‘virtual wards’.
- Paper consumption reduction.
- Progress towards completing the Digital Maturity Assessment.
- Percentage of refurbished/remanufactured IT equipment purchased, and average device lifetime.

RISKS

- Complicated cases may reduce the feasibility of remove appointments and Virtual Wards.
- Digital pathways may lead to increase costs initially and a need to implement more systems.

CLIMATE CHANGE ADAPTATION

Climate change poses a fundamental threat to places, species and people’s livelihoods. Due to climate change, heatwaves, storms and floods are affecting the way that care is delivered across the NHS. Scientific evidence strongly indicates that these events will only become more frequent over the next 30 years.

We will plan, mitigate and build future resilience with a changing climate to reduce the risk posed to the delivery of care.

WE HAVE

- Designed our buildings to maximise natural and mechanical ventilation to cool areas of the building if overheating is experienced.
- Developed and executed a ‘Severe Weather Plan’ as part of emergency planning. This is reviewed regularly to ensure sustainability elements are included.
- We have developed a ‘Grounds and Gardens Plan’ to ensure green space is not build upon, reducing the risk of ‘urban heating’.

WE WILL

- Actively partner with others (e.g. local authorities, transport providers and other local and regional stakeholders), and participate in, carbon reductions and sustainability meetings to drive adaptation plans. We will share findings with partners to ensure critical information is integrated into broader emergency planning and climate adaptation planning practices.
- Comply with the adaptation provisions within the **NHS Core Standards for emergency preparedness**, resilience and response (EPRR) and the **NHS Standard Contract** to support business continuity during adverse weather events.
- Set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services.
- Consider the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions.
- Ensure adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government’s **Adverse Weather and Health Plan**.
- Write a climate adaptation plan specifically for procurement and logistics activities aligning to the sustainable development goals and using the Climate Change Risk Assessment tool.

KEY PERFORMANCE INDICATORS

- Active partners and sharing of best practice.
- Compliance with all relevant standards and contracts.
- Climate change included in the Trust resilience planning and adaptation strategies.
- Put in place a climate adaptation plan.

RISKS

- **Inter-organisational dependency & influence:** Success relies heavily on the engagement, cooperation, and capacity of external partners (local authorities, transport providers, NHS Trusts, etc.).
- **Complexity of integration & measurement:** Challenging to effectively embed climate considerations into all infrastructure decisions and procurement processes, and to accurately measure the impact of these adaptation.
- **Unforeseen climate impacts & insufficient adaptation:** Climate change effects may be more severe or rapid than anticipated, rendering current plans or infrastructure adaptations insufficient, leading to service disruption or safety issues despite effort.

SUPPLY CHAIN & PROCUREMENT

The NHS is a vast consumer of goods and natural resources. Procurement of medical devices, equipment and medicines are major contributors of carbon emissions – they make up 62% of the NHS, Public Health and Social Care total carbon footprint (2020 data).

Whilst we cannot directly influence the demand for resources, we will embed environmental, sand economic values into our purchasing decisions. We will work alongside our suppliers and encourage them to adopt sustainable practices for the products and services they provide.

Within the organisation, our vision is to transition to whole lifecycle environmental, social and costings analysis decisions are made (i.e. long-term thinking). We strive to adopt the waste hierarchy (reduce, re-use, repurpose, recycle) across all activities and reduce the number of disposable items we procure, use and waste. We will use evidenced based practice to challenge overuse of products and look at care pathways that deliver outcomes that also save resources.

WE HAVE

- Changed to reusable baskets from polymer carrier bags, saving over 13,000 carrier bags per annum.
- Stopped using red drug round aprons, saving over 12,000 polythene aprons each year, reducing clinical waste and carbon emissions.
- Stopped using theatre 'warm up gowns', saving over 32,000 downs from incineration.
- Moved to re-usable tourniquets.
- Transitioned to re-manufactured devices in some departments: 25% of harmonic scalpels are repurposed saving circa £282 each time a device is purchased.
- Stopped the ordering of pulp kidney dishes and replaced these with reusable plastic trays that can be cleaned.

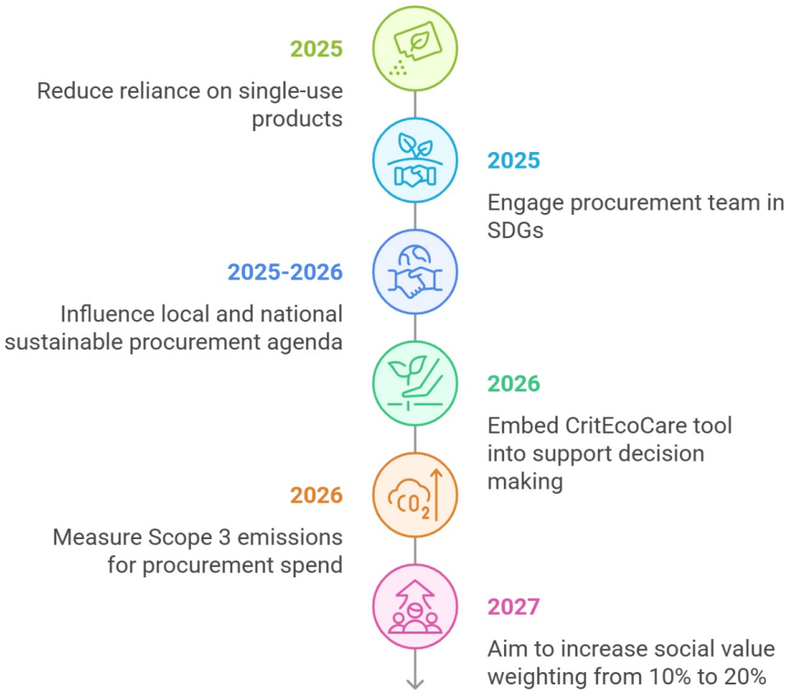
Figure 12: Achievements since 2022 towards greener supply chain and procurement

WE WILL

- Continue to reduce our reliance on single-use products, with a view to including this in our Fundamentals of Care programme and our clinical improvement projects.
- Embed NHS net zero supplier roadmap requirements into all relevant procurements and ensure they are monitored via KPIs.
- Minimise waste through circularity, opting for reusable, remanufactured or recycled solutions where feasible.
- Continue to ensure our suppliers go beyond the minimum standards and engage with the Evergreen Sustainable Supplier Assessment to support the NHS Net Zero aspirations and the Trust goals of #Morethanahospital to reduce health inequalities, including:
  - All suppliers we purchase from via frameworks will have a carbon reduction plan,
  - For all new regulated below threshold contracts above £30,000 and below the PR2024 threshold, will have a net zero commitment requirement (1 year ahead of the April 2026 mandate),
  - All tenders will continue to include a minimum of a 10% weighting for social value with a plan to increase this where proportionate.
- In 2025, we will engage the procurement team in the Sustainable Development Goals (SDGs) (United Nations, 2015) and support the senior team in completing the **Environmentally Sustainable Healthcare - elearning for healthcare** module on ESR.

- In 2025-2026, we will work with our partners (BC ICS, NHSE Midlands, NHSE, Local Authorities etc) to support and influence the national sustainability agenda pertaining to procurement, logistics and innovation.
- By 2026, we will embed the CritEcoCare tool into all significant or Trust wide procurement decision making. This unique tool allows buyers and suppliers to enter information about healthcare products to make comparisons beyond the carbon impact.
- By 2026, we will work with the clinical teams to influence and identify where carbon hotspots are, and which products will have the bigger impact on getting to Net Zero fastest.
- By 2026, we will measure the Scope 3 emissions of our procurement influenceable spend and set actions to reduce emissions.

Figure 13: Planned actions to support working towards a greener supply chain.



KEY PERFORMANCE INDICATORS

- **Single-use purchasing:** Reduction in single-use items purchased and a transition to reusables, remanufactured, or recycled products.
- **Net zero roadmap integration:** Percentage of relevant procurements embedding NHS Net Zero Supplier Roadmap requirements.
- **Evergreen assessment engagement:** Rate of supplier completion/progress on the Evergreen Sustainable Supplier Assessment.
- **Procurement team sustainability training:** Percentage of procurement team engaged with relevant sustainability training.
- **CritEcoCare tool adoption:** Percentage of significant procurement decisions using the CritEcoCare tool.
- **Clinical carbon hotspot engagement:** Number of clinical teams involved in identifying carbon hotspots.
- **Scope 3 procurement emissions:** Baseline and ongoing measurement of procurement influenceable Scope 3 emissions.

RISKS

- **Supply chain resilience and costs:** Reusable products may cost more in the first instance. Reliance on new, potentially smaller, or less established circular economy suppliers might introduce risks to supply chain reliability and lead times.
- **Supplier & market maturity:** Limited availability of genuinely sustainable products and supplier reluctance or inability to meet stringent new environmental criteria.
- **Staff resource:** Time needs to be allocated for training.
- **Measurement & compliance difficulty:** Challenges in accurately measuring Scope 3 emissions and ensuring consistent supplier data for compliance.

GOVERNANCE & ACCOUNTABILITY

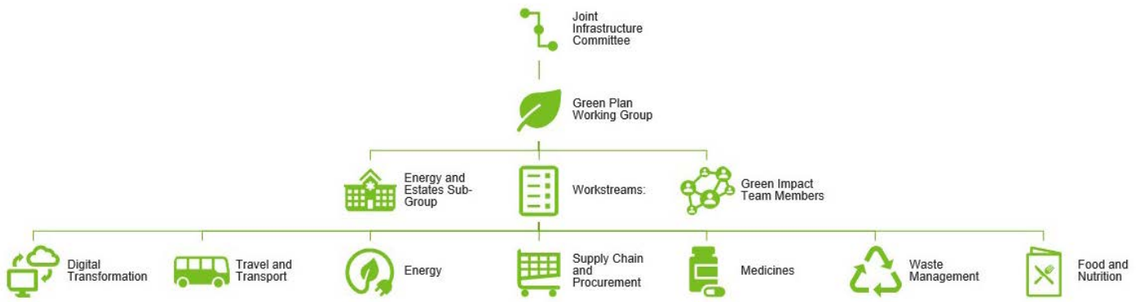
This Green Plan has been developed in alignment with the Trust objectives and agreed with the relevant working groups and committees. It is based on guidance and recommendations from NHS England.

To ensure the plan is delivered, a Green Plan Working Group will be established and will meet on a quarterly basis, reporting to the Joint Infrastructure Committee.

The Joint Infrastructure Committee will be led by the net zero board lead that overseas DGFT and SWBT progress on the Green Plan.

The Energy and Estates relevant sub-groups will meet on a bi-monthly basis to progress the pressing need to address estate emissions and to develop a heat decarbonisation plan. Elements of the carbon footprint will be monitored on an annual basis, full carbon accounting take place by NHSE to avoid double counting emissions.

The Sustainability Lead for DGFT and the Head of Sustainability for SWBT will provide regular reports to various boards and committees, alongside reporting key achievements in the Trust's Annual Reports. Joint, overarching KPIs will be set across both Trusts, and these will be monitored regularly.



LEGISLATION

Health and Care Act 2022 (legislation.gov.uk)

Environment Act 2021 (legislation.gov.uk)

RELEVANT DOCUMENTS

SWBT NHS Green Plan 2022 (internal document)

Green Plan Guidance

Greener NHS Guide (2021)

NHS Standard Contract 2025/26 Service Conditions: SC18

NHS Clinical Waste Strategy

Net Zero Travel and Transport Strategy

Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works

NHS Net Zero Building Standard

A Greener NHS

CQC – Well Led: Environmental sustainability

GREEN PLAN 2025 - 2028

M8415 Designed by Medical Illustration Design Team at Sandwell and West Birmingham NHS Trust. swbh.miprint@nhs.net

Paper ref:	PublicTB (09/25) 017

REPORT TITLE:	Committee Effectiveness Review 2024/25		
SPONSORING EXECUTIVE:	Kam Dhami, Chief Governance Officer		
REPORT AUTHOR:	Dan Conway, Associate Director of Corporate Governance/Company Secretary		
MEETING:	Public Trust Board	DATE:	10/09/2025

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

This paper provides the Trust Board with an overarching summary of the 2024/25 annual reports (in the Reading Room) from its key sub-committees. The reports confirm that committees have discharged their responsibilities in line with their Terms of Reference, providing assurance on quality, workforce, finance, integration, and the safe opening of Midland Metropolitan University Hospital (MMUH).

Key achievements included embedding PSIRF, strengthening workforce culture and EDI, overseeing £44m efficiency delivery, and supporting the safe opening of MMUH. Ongoing risks requiring continued Board attention include mortality, maternity and neonatal resilience, workforce supply and retention, recurrent CIP delivery, system integration governance, and realisation of MMUH benefits.

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

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

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

None

4. Recommendation(s)

The Public Trust Board is asked to:

a. **NOTE** the collective assurance provided by its sub-committees during 2024/25.

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

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

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 10 September 2025

Committee Effectiveness Review 2024/25

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1. Introduction or background

1.1 This paper provides the Trust Board with a consolidated overview of the work and assurance provided by its key sub-committees during 2024/25. The committees have played a critical role in ensuring oversight of quality, workforce, finance, integration, and the opening of Midland Metropolitan University Hospital (MMUH). Each has discharged its responsibilities in line with approved Terms of Reference and escalated key risks to the Board through routine reporting.

1.2 Together, the committees have ensured the Board has maintained sight of its principal strategic risks, including patient safety, workforce supply, financial sustainability, integration delivery, and safe MMUH transition.

2. Committee Summaries

2.1 **Quality Committee**

2.2 The Committee provided strong assurance on the Trust's approach to clinical governance, patient safety, and experience Key achievements included oversight of the Fundamentals of Care programme, embedding of the Patient Safety Incident Response Framework (PSIRF), and focused attention on mortality, maternity, and deteriorating patient pathways.

2.3 Ongoing risks include mortality coding accuracy, workforce resilience in maternity and neonatal services, and sustaining long-term learning from PSIRF implementation.

2.4 **People Committee**

2.5 The Committee has overseen workforce delivery and assurance, aligned to BAF003. Major areas of focus included MMUH workforce readiness (recruitment of 3,000+ roles), embedding Equality, Diversity and Inclusion (EDI), strengthening organisational culture, and targeted wellbeing initiatives.

2.6 Progress was seen in staff survey results and cultural development, though risks remain around workforce supply, retention in high-pressure areas, and sustaining improvement momentum.

2.7 **Finance and Productivity Committee**

2.8 The Committee maintained oversight of financial sustainability, productivity and resource use, aligned to BAF002. It scrutinised financial recovery, capital and cash management, efficiency programmes, and digital investment.

2.9 Challenges included delivery of recurrent savings, management of MMUH transition costs, and dependency on system-level allocations. The Committee confirmed improvements in assurance maturity but emphasised the need to focus more sharply on productivity delivery in 2025/26.

2.10 **MMUH Opening Committee**

2.11 This time-limited committee provided comprehensive assurance over the safe opening of MMUH. It oversaw programme risk, readiness assessments, and benefits realisation planning.

2.12 The hospital opened safely in October 2024, with no safety incidents during the move. The committee was formally closed in March 2025, handing residual risks and benefits delivery into core Board committees.

2.13 **Integration Committee**

2.14 The Committee has provided oversight of the Trust's role as an integrated care organisation. It monitored place-based care, provider collaboratives, discharge pathways, rightsizing planning, and GP practice acquisition.

2.15 Assurance was reasonable overall, with positive progress on community partnerships and engagement, but key risks remain around system governance clarity, rightsizing capacity, and delivery of long-term MMUH benefits.

3. Cross-Cutting Themes

3.1 Across the committees, several common themes emerge:

- MMUH Transition: All committees played a role in assuring readiness, from workforce and financial planning to clinical safety and integration.
- System Partnerships: Integration and finance committees highlighted reliance on ICB and collaborative arrangements, with risks around funding flows and decision-making clarity.
- Workforce and Culture: Sustained challenge remains around recruitment, retention, and embedding inclusive, engaged cultures.
- Productivity and Resources: Achieving recurrent savings and maximising efficiency is a shared priority, requiring closer alignment between finance, workforce, and operational transformation.
- Learning and Governance: PSIRF implementation, strengthened EDI programmes, and improved risk triangulation show progress, but evidence of long-term embedded change is still developing.

4. Conclusion

4.1 The Board can take assurance that its committees have operated effectively during 2024/25, fulfilling their Terms of Reference and escalating key issues in a timely manner. Each committee has provided focused oversight on its respective domain while contributing to cross-cutting assurance on MMUH transition, workforce, finance, and integration.

5. Recommendations

5.1 The Public Trust Board is asked to:

a. **Error! Reference source not found. NOTE** the collective assurance provided by its sub-committees during 2024/25.

Dan Conway

Associate Director of Corporate Governance / Company Secretary

2nd September 2025

Reading Room: Committee Annual Reports

Quarterly strategy and Annual plan progress report
Apr – Jun 2025

Sandwell and West Birmingham NHS Trust

The Strategic Planning Framework | Report on Progress of Strategic Objectives and IN YEAR Objectives

Purpose

To improve the life chances and health outcomes of our population

Strategic Objectives

Trust measures of success

FFT 91.15% Response Rate 20.08%	Enhance Patient experience score	EAS (4 Hour) 77.16% Target 78%	Deliver Access Standards Unplanned	Optimise Workforce Productivity
Incidents (Moderate Harm or Above) 24	Reduce Moderate and above Harm	RTT 57.97% Target 65%	Deliver Access Standards Planned	Sickness 5.64% Turnover 9.14% Sustained reduction
SHMI Rate 1.06 Target 1.00	Reduce Mortality (SHMI)			

Patients	People	Population
To be good or outstanding in everything we do	To cultivate and sustain happy, productive and engaged staff	To work seamlessly with our partners to improve lives
Achieve recurrent financial sustainability	Improve Staff Engagement Score	Improve Population Health
	Achieve Representative Leadership	Increase volume of local people employed and trained
		Right Size Acute, Community and Virtual beds

In year objectives

69% Target 76%	Improve Recognition and Management of Deteriorating patients	77.16% Target 78% (Mar 26)	Improve Productivity across Elective and Non-Elective pathways	>70% Virtual ward Occupancy	Optimise Utilisation of Community Services
18.3M Risk	Deliver Recurrent Financial Improvement	2.2FTE Ahead (Jun) 99FTE Risk (Jul)	Reduction in Temporary Staffing		Work with Partners to Improve Population Health

In Year Objectives

Improve Recognition and Management of Deteriorating Patients

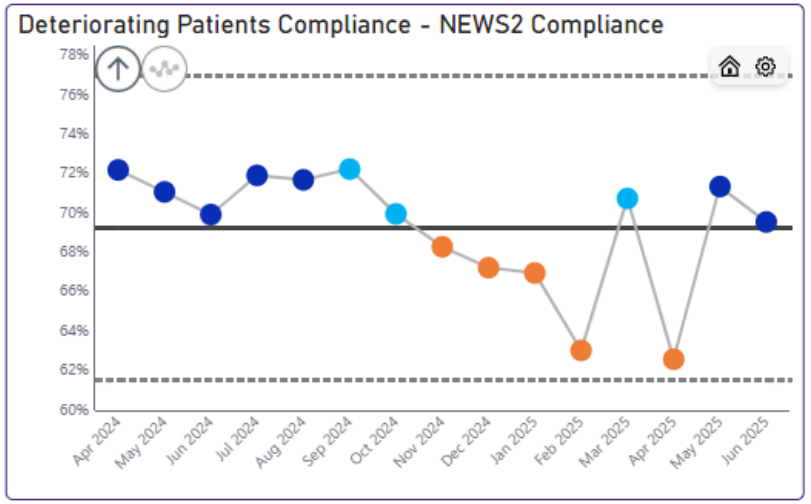
Quarter: Apr – Jun 25	Executive sponsor: Mark Anderson
	Leads: Arvind Rajasekaren, Jenni Riley

Early recognition and response to deteriorating patients is critical to reduce avoidable harm, improve patient outcomes and support staff to deliver safer, reliable care.

Objective status		Status
Summary	*Progress is being made across multiple workstreams, including stakeholder engagement, training development, and digital infrastructure. However, key gaps remain in PMO support and metric ownership, which are critical to delivery at scale. NEWS2 compliance has not yet shown sustained improvement, though upcoming staff training and Unity optimisation are expected to support progress. Overall, delivery is feasible but requires strengthened project governance and continued focus on implementation.*	**69%** Target 76%

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Strengthening Clinical Governance and Leadership	🟢	Stakeholder engagement workshop held in May. RSM audit actions assigned to clinical leads. Oxygen clinical leads identified and joined the Medical Gas Committee.	Follow up on audit actions. Ensure active participation of leads in governance structures. Establish KPIs for oxygen safety within Medical Gas Committee.
Improving Deteriorating Patient (DP) Systems and Communication	🟠	EMRT Unity proforma designed and scheduled for August rollout. Clinical lead exploring PDN-led NEWS training. Digital Nurse identified to lead PEWS/NEWS integration in Unity.	Finalise timelines for Unity integration. Deliver PDN NEWS training. Begin digital rollout of colour-coded charts. Secure PMO/Project support to enable delivery.
Resuscitation Readiness and System Ownership	🟠	Business case approved for 2 x Band 6 Resus posts. Collaboration explored with Dudley Resus team. Metric ownership and PMO support gaps identified.	Recruit Band 6s and launch workplan. Explore joint simulation options with Dudley. Establish ward-level ownership model. Propose FoC dashboard inclusion for oversight.

Key Performance Indicator



🟢 **On Track** – Delivery proceeding to plan; milestones and KPIs on track; no major risks or issues.
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⚪ **Status Undefined** – Insufficient information or no update provided to assess delivery progress.

Risks and mitigations

Risk identified: No PMO/ Project support for DPSG.
Metric ownership and ward-level challenge process not yet defined.

Progress against relevant KPIs

The performance of NEWS Compliance has been variable with peaks around 72% but dips 10% below that to 62% month to month with an average performance of c.68%.
Statistically this is is 'Common Cause variation' and hasn't yet shown a sustained improvement.
The expectation is that with Staff education, training and Unity optimisation this will improve and stabilise.

Deliver Recurrent Financial Improvement

Quarter: Apr – Jun 25	Executive sponsor: Simon Sheppard
	Lead: Amanda Geary / Tim Reardon

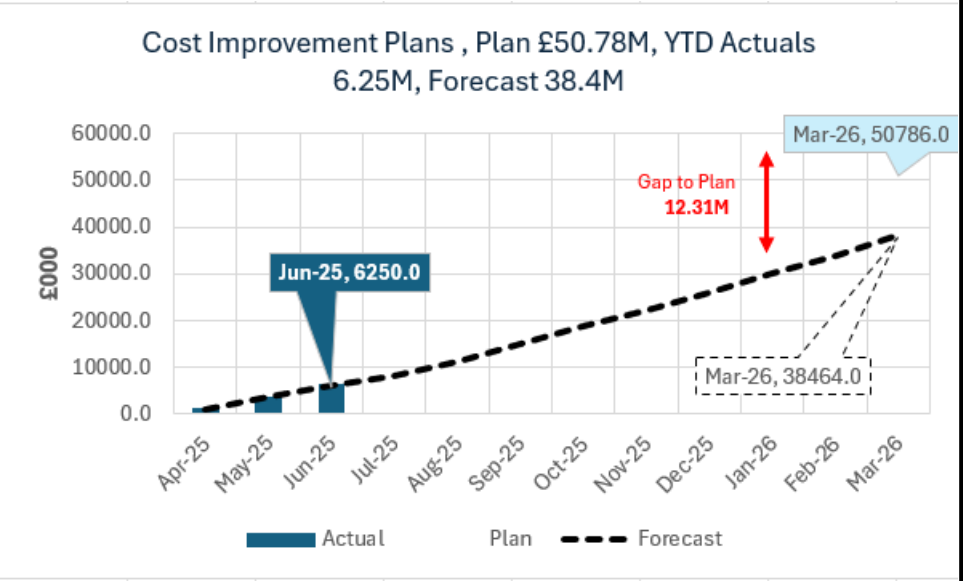
Delivering Recurrent Financial Improvement enables **long-term investment in care, infrastructure, and innovation for the benefit of our patients and staff.**

Objective status

		Status
Summary	Q1 CIP target was exceeded, but 73% was delivered non-recurrently. Key workstreams (Community 1st, Elective, Outpatients) have yet to transact savings, and income schemes are not reflected in actuals. The forecast of £38.5m remains £12.3m below the £50.8m target, with total risk of £18.3m (12.3 plus There is also significant risk of £5,091k and £918k relating to Elective and Outpatients). Urgent action is needed to identify and deliver new schemes — a pipeline workshop is scheduled for 7 August.	**18.3M** Risk

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Deliver Cost Improvement Plan and Pipeline Acceleration		Q1 CIP target exceeded, with £6.25M delivered. However, 73% was non-recurrent. No savings transacted for Community 1st, Elective or Outpatients workstreams. Elective schemes delivering income not yet reflected in actuals.	The gap to plan of 12.31M forecast needs urgent action to identify and accelerate schemes. Cost Improvement Pipeline Workshop on the 7th August 2025.
Ensure QIA Completion and Compliance		All developed Quality & Productivity schemes now have QIAs in place. However, sign-off rates vary significantly across clinical groups — e.g. Surgery 6%, CEO 20%, PCCT 50%.	Accelerate QIA sign-off across all groups via EQIA Panels. Focus on low-compliance areas (Surgery, CEO, Finance) and QIA of high-value. Target full compliance within weeks. Review of QiA against MMUH benefits.
Deliver Workforce-Linked CIP and Align to WTE Reduction		Q1 tracker shows forecast of £24.7m against a £30.8m workforce target, with a current gap of £6.2m. Risks include £2.5m shortfall in MEC, £3.1m in PCCT, and a further £2m risk in non-workforce schemes and MARS.	Close the £9.1m risk . Validate MARS assumptions. Strengthen planning across high-variance areas (MEC, PCCT, Surgery).

Key Performance Indicator



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Risks and mitigations

High reliance on non-recurrent savings in Q1 (73%) limits sustainability.Workforce delivery risk totals £9.1m, driven by forecast gaps (£6.2m), unvalidated MARS assumption (£2.0m), and shortfalls in MEC (£2.5m), PCCT (£3.1m), and Surgery (£1.5m).QIA sign-off remains low in some groups (e.g. Surgery 6%, CEO 20%).Mitigation: Accelerate pipeline (7 Aug workshop), validate MARS assumptions, strengthen planning across high-variance areas, and fast-track EQIA panel sign-offs.

Progress against relevant KPIs

Q1 delivery of £6.25m achieved — plan met but 73% non-recurrent.Forecast (as of 24 July): £38.4m — £12.3m below the £50.8m target.Workforce schemes represent the largest delivery risk, with gaps and WTE alignment issues across multiple groups.Urgent action needed from Q2 onward to close the forecast gap and shift delivery towards recurrent savings.

Figures reported at Finance and Investment Productivity committee, 1st August 2025.

Improve Productivity across Elective and Non-Elective pathways

Quarter: Apr – Jun 25	Executive sponsor: Johanne Newens
	Leads: Demetri Wade, Dani Joseph

Ensure we not only meet our targets for elective and non-elective care improving income and the timely treatment for our patients.

Objective status		Status
Summary	Elective productivity shows positive momentum with RTT performance slightly ahead of trajectory. However, urgent and emergency care performance remains fragile. EAS 4-hour performance reached 77.16% in June 2025 — just below the 78% target — driven by under-delivery in Type 2. Q2 will focus on strengthening discharge processes, reducing ED delays, and embedding pathway reforms across all EAS types.	77.16% Target 78% (Mar 26)

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Improve Capacity and Throughput		RTT 18-week performance reached 57.9%, exceeding June trajectory (54%) and on track for March 2026 target (65%). Elective procedural volumes rising, but vulnerable to Financial caps and capacity gaps.	Improved demand and capacity planning is currently underway combined with stronger validation of waiting lists and patient prioritisation. Ensure productivity managed within Elective Recovery Fund, and stabilise procedural capacity with workforce and theatre optimisation.
Strengthen Flow and Efficiency		EAS 4-hour performance reached 77.16% in June, slightly below the 78% target. Ambulance handover performance improved significantly, with a June average of 22 minutes (ahead of the 25-minute target), despite a rise in conveyances. Triage performance also improved, with 91.6% of patients triaged within 15 minutes.	Embedding of Emergency Department (ED) roles and responsibilities including SMART (Senior Management And Rapid Treatment), in and out of hours.Strengthen discharge coordination, further embed SDEC models, and implement recommendations from ED rapid improvement week, including rota and escalation improvements.
Improve Demand and Pathway Management		Variation in ED performance by type: Type 1 under pressure (62.5%), Type 2/3 slightly below trajectory. Workstreams launched to review referral and attendance pathways.	Roll out SIIFT model and ensure ED quality standards; Review eye improvement plan; use consultant escalation process to improve referrals and response times across urgent care.

Key Performance Indicator

EAS 4 Hour Standard

77.16%

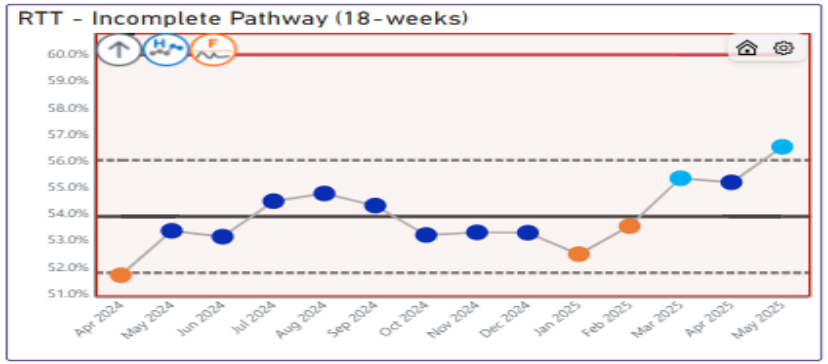
March 2026 Target 78%

Average Ambulance Handover Times (minutes)

22

March 2026 Target: 25

June 2025



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Risks and mitigations

Risk: Underperformance in Type 2 EAS due to capacity and service model challenges.
Mitigation: Deliver actions from Eye ED improvement plan, including rota, huddles, and service leadership
Risk: Delays in patient flow and discharge from ED affecting performance.
Mitigation: Strengthen discharge processes, use escalation forms for real-time resolution, and embed learning from SDEC streaming.
Risk: Workforce constraints impacting elective throughput.Mitigation: Workforce rostering, backfill for key elective roles, and consultant cover for priority procedures.

Progress against relevant KPIs

Progress during Quarter 1 shows early signs of recovery in elective performance, with RTT 18-week incomplete pathways reaching 57.9%, exceeding the June trajectory target of 54% and tracking toward the March 2026 target of 65%. Non-elective productivity remains under pressure, with EAS 4-hour performance at 77.16%, slightly below the year-end target of 78%, reflecting ongoing challenges in flow and capacity.While elective throughput and procedural volumes are improving, performance remains fragile and exposed to risk from workforce constraints, demand variation, and elective recovery fund caps. Non-elective flow and discharge delays continue to impact ED performance. Q2 priorities must focus on sustaining elective gains and addressing constraints in urgent care pathways to deliver a more balanced improvement across both streams.

Reduction in Temporary Staffing

Quarter: Apr – Jun 25	Executive sponsor: James Fleet
	Lead: Andy Harding

Overuse of temporary staff strains budgets and signals deeper issues in managing rosters, absences, and skill deployment.

Objective status

		Status
Summary	Between April and June 2025, temporary staffing saw a marked decline across both bank and agency usage. Total bank FTE fell from 808.9 in April to 749.7 in June, and agency FTE dropped significantly from 122.5 to 75.6. This reduction supports broader efficiency objectives and reflects improvements in workforce planning and deployment accuracy. The challenge ahead is maintaining these gains while aligning to tighter workforce trajectories and supporting care delivery.	**2.2FTE** Ahead (Jun) **99FTE** Risk (Jul)

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Bank usage reduction across staff groups		Bank FTE dropped from 808.9 in April to 749.7 in June. A reduction of 59.2. Reduction of Qualified Nursing and Midwifery – bank of 34.8 and HCA/Support staff of 25.6	Sustain lower bank usage through continued control measures and improved substantive rostering.
Reduction in agency staffing		Agency FTE dropped from 122.5 to 75.6 a reduction of 46.9. This includes a reduction in HCA agency from 47.7 to 22.4.	Target stable agency use through active vacancy management and recruitment.
Alignment of deployed workforce to plan (trajectory)		Deployed WTE reduced from 8,350 in April to 8,239.7 in June; variance closed from 106.6 to just 2.2 Note: July Position now 99 FTE behind plan.	Continue active vacancy and deployment management to meet tighter July WTE plan; expected reduction of ~100 more FTE needed.

Key Performance Indicator

Pay and FIMS Staff Groups	01/04/2025 Deployed	01/05/2025 Deployed	01/06/2025 Deployed
Substantive	**7,418.9**	**7,410.4**	**7,414.4**
Administration and Estates	1,073.0	1,071.0	1,074.0
Healthcare Assistants and Support Staff	1,412.4	1,412.4	1,412.4
Management	307.0	298.7	298.7
Medical Staffing	959.6	959.6	959.6
Other Pay	-	-	-
Qualified Nursing and Midwifery	2,507.0	2,508.8	2,509.8
Scientific, Therapeutic and Technical	1,159.9	1,159.9	1,159.9
Bank	**808.9**	**729.6**	**749.7**
Administration and Estates - Bank Staff	138.5	128.2	132.7
Healthcare Assistants and Support Staff - Bank Staff	264.4	229.0	248.8
Medical Staffing - Bank Staff	92.6	83.7	88.9
Qualified Nursing and Midwifery - Bank Staff	287.0	262.3	252.2
Scientific, Therapeutic and Technical - Bank Staff	26.4	26.3	27.2
Agency	**122.5**	**91.5**	**75.6**
Administration and Estates - Agency Staff	1.8	0.8	
Healthcare Assistants and Support Staff - Agency Staff	47.7	26.2	22.4
Medical Staffing - Agency Staff	29.1	35.1	35.5
Qualified Nursing and Midwifery - Agency Staff	25.0	15.1	6.2
Scientific, Therapeutic and Technical - Agency Staff	18.9	14.3	11.6
Grand Total	**8,350.3**	**8,231.5**	**8,239.7**

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Risks and mitigations

Risks:
Difficulty maintaining reduced temporary staffing levels without impacting service delivery.
Risk of rising bank and agency use in clinical groups with persistent vacancies.
Financial risk if workforce overshoots trajectory in July or later.

Mitigations:
Ongoing recruitment freeze aligned to CIP plans.
Enhanced control via rostering, absence management, and deployment.
Monitoring via ESR, triangulated with vacancy data and operational need.

Progress against relevant KPIs

Bank Staff FTE: ↓ from 808.9 to 749.7 (↓59.2)
Agency Staff FTE: ↓ from 122.5 to 75.6 (↓46.9)
Total variance from workforce trajectory: ↓ from 106.6 in April to 2.2 in June
Qualified Nursing & Midwifery (Bank + Agency) combined: ↓ 54.6 FTE

Note: July Position c.99 FTE behind plan.

Optimise Utilisation of Community Services

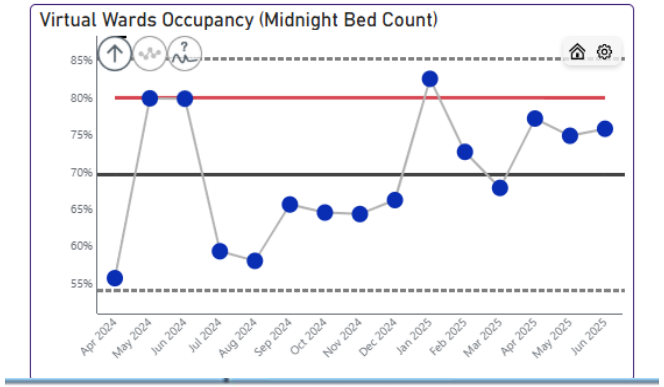
Quarter: Apr – Jun 25	Executive sponsor: Sian Thomas
	Lead: Kulwinder Johal

Shifting care from hospital to community through better use of virtual wards and local services frees acute beds and supports recovery closer to home.

Objective status	Status
Summary: *Ensure consistent and effective use of existing community services while developing further pathways to increase the number of people cared for at home*	>70% Virtual ward Occupancy

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Increase use of existing community services	On track	• VW occupancy consistently above 70% • UCR 2 hour consistently achieved • Commenced overnight CAD stacking • Scoping SWB/DGHT SPoA opportunities • Streaming RPIW completed	• Process in place for Sandwell patients in Russell's Hall to be stepped down to Sandwell VW • Commence trial(s) of SWB/DGHT SPoA opportunities • Increase GP use of SPoA for ED/SDEC
Develop new community pathways	On track	• Series of frailty workshops held with primary care, community and acute colleagues • New pathway opportunities identified, pilots scoped: palliative care in ED, Care home re-admissions 72-hour support, Geriatrician in SPoA, Reactive and Proactive GP MDT • Opportunities to reduce bed utilisation modelled	• Complete all frailty pilots and evaluate impact • Make case for service change and/or investment • Develop bed reduction case
Strengthen Community performance Visibility	On track	• Monthly community report for FPC now in place • Development of new BI dashboards commenced e.g. PFIT tool to include community indicators to support proactive pull • Demand & Capacity Workforce review completed & submitted to GMB	• PFIT tool launched in SPoA • Incorporate VW amenable into PFIT tool • Launch West Birmingham Locality Hub with live data • Develop primary care report for FPC

Key Performance Indicator



Risks and mitigations

RISK – inability to invest in community services given current financial context. MITIGATION – undertake pilots within resources to test quickly and ensure evidence-based case for investment where need is identified.

RISK – further development of community and primary care BI is limited by available resource and technical skills in primary care. MITIGATION share learning from primary care skills across black country, use of additional resource to develop in-house capability

Progress against relevant KPIs

All relevant KPIs being consistently achieved

New suite of metrics developed to support community bed reduction

New metrics developed for targeted pathways (EoL, Frailty, Care Homes) in ED and acite bed base

Work with Partners to Improve Population Health

Quarter: Apr – Jun 25	Executive sponsor: Sian Thomas
	Lead: Steve Phillips & Lisa Maxfield

Shifting focus from treatment to prevention is essential to reduce long-term conditions and improve population health

Objective status

Summary

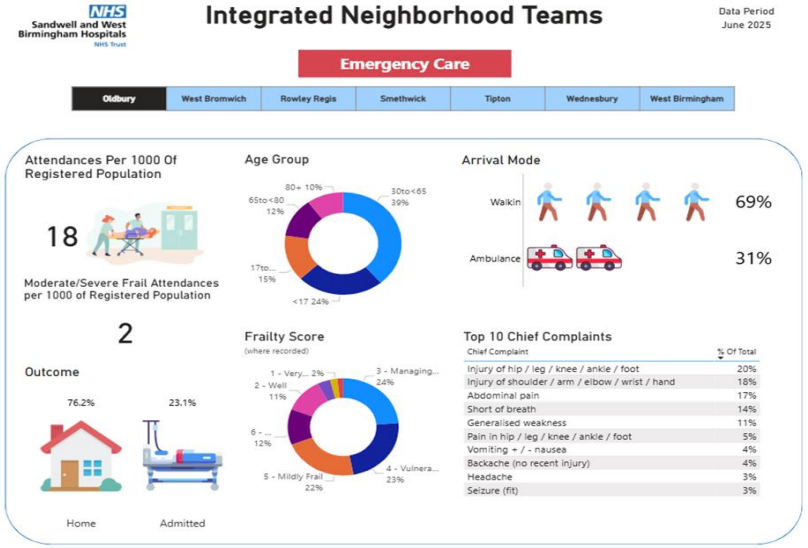
Using public health data and risk stratification to target evidenced based interventions and models to drive a long term improvement in population health

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Develop a clear set of priorities and governance for how the Trust and Place work together		• Board development workshops held in Sandwell Health & Care Partnership (SHCP) and West Birmingham Locality Partnership (WBLP) to agree strategic framework and clear priorities • Trust integration committee re-launched with cleat ToR and work plan linking to SHCP & WBLP • Health Inequalities Trust plan and dashboard completed	• Develop reporting capabilities to measure impact of priority work programme • Develop governance for ICB delegation, Multi-Neighbourhood Models and new Community tariffs
Develop the Neighbourhood health model		• Draft model agreed for Sandwell and West Birmingham • Pilots scoped and starting for Sandwell, West Birmingham starting to mobilise • SWB draft town team dashboard developed	• Complete Sandwell pilots & evaluate • Launch West Birmingham model • Develop town team dashboard with more metrics and data from partners • Submit National Neighbourhood Pioneer Programme application
Develop our prevention model		• Health & Wellbeing Board Workshop held and agreed a JSNA refresh • Public health & CSU completed population health analysis • All Flourish schemes now live	• Develop our Sandwell prevention model • Develop our West Bham Prevention workstream

Key Performance Indicator

Improving population health is a long-term development. Our current focus is on developing the KPIs to understand our population and how as a Trust we service their health needs.

- Sandwell has **higher rates** of obesity, diabetes, hypertension, coronary heart disease (CHD), and chronic kidney disease (CKD) than regional and national averages.
- **Mortality rates** are higher than England's average, especially in deprived and older populations.
- **ED attendances** are highest for COPD, CHD, hypertension, dementia, and mental illness.



Risks and mitigations

RISK – data sharing across health and social care is dependant on a S251 by the ICB which is significantly behind schedule. MITIGATION – agree local tactical cohort based data sharing a

Strategic Measures of Success

Enhance Patient experience score

Quarter: Apr – Jun 25	Executive sponsors: Mel Roberts, Mark Anderson
	Lead: Jamie Emery

Improving patient experience is essential to build trust, boost staff morale, and deliver better health outcomes.

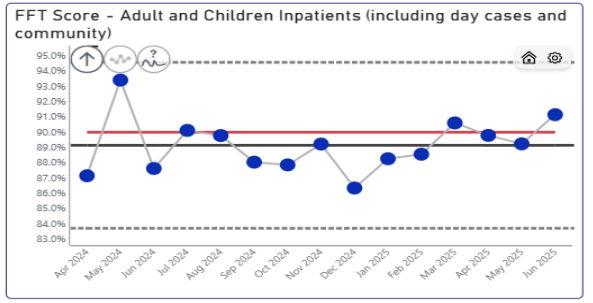
Objective status

Summary

While the Friends and Family Test (FFT) score for adult and children inpatients has exceeded the March 2026 target of 90%, reaching 91.15% in June 2025, the overall trend remains broadly steady without clear signs of sustained improvement. The FFT response rate also reached 20.08% in June, meeting its target, but performance varies between areas and month to month. Improvement activity is underway with focused training, patient feedback initiatives, and enhanced volunteer support, but consistency and wider engagement still need to improve.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Improve FFT Response Rate and Engagement		Overall response rate reached 20.08% in June (above March 2026 target). Volunteer survey support and enhanced unpaid carer engagement in place.	Sustain and grow participation across OPD and ED. Trial ED-specific Patient Experience Group to co-design improvements. FFT Response Rate (Target: 20%)
Strengthen Patient-Centred Training and Awareness		'Putting the Patient First' education days launched across May–September. AMU training delivered across 7 weeks, with follow-up planned in stroke. Wayfinding Action Group formed and live log in place.	Extend training across further clinical areas. Finalise and publicise actions to improve patient boredom and communication. FFT Score – Adult and Children Inpatients (Target: 90%)
Personalise and Tailor Patient Experience Interventions		Sensory bags piloted in ED for patients with learning/sensory needs.EDI projects launched to support inclusion and reduce anxiety in care settings.	Review and scale EDI interventions based on feedback. Target further specialties for FFT theme-based reviews.

Key Performance Indicator

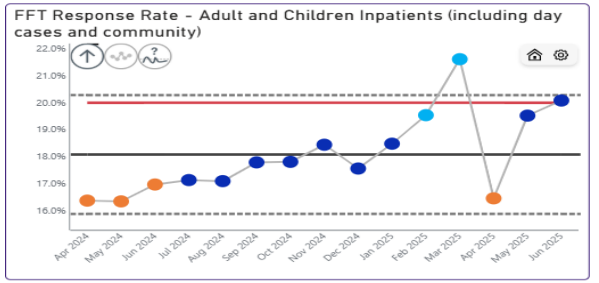


FFT Score - Adult and Children Inpatients (including day cases and community)

91.15%

March 2026 Target: 90%

June 2025



FFT Response Rate - Adult and Children Inpatients (including day cases and community)

20.08%

March 2026 Target: 20%

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Risks and mitigations

Risk: FFT response rate not consistent across departments.
Mitigations: Co-delivery of training with operational teams.Development of 'Essential Skills for Everyone' offer.Volunteers supporting feedback collection.Development of local champions and peer networks.Increased carer engagement via partnership events.

Progress against relevant KPIs

FFT Score (Inpatients): **91.15%** (above target)
FFT Response Rate (Inpatients): **20.08%** (on target)
Performance has been relatively stable, but there is fluctuation between departments and over timeED, OPD, and AN within expected range but remain below target for response rate
Birth services consistently perform above target for response rate
June 2025 shows the highest FFT score in over a year

Reduce Mortality (SHMI)

Quarter: Apr – Jun 25	Executive sponsors: Mark Anderson
	Lead: Arvind Rajasekaren

Reducing our higher than expected or desired mortality rates remains a key focus to improve patient outcomes and deliver safer, more effective care.

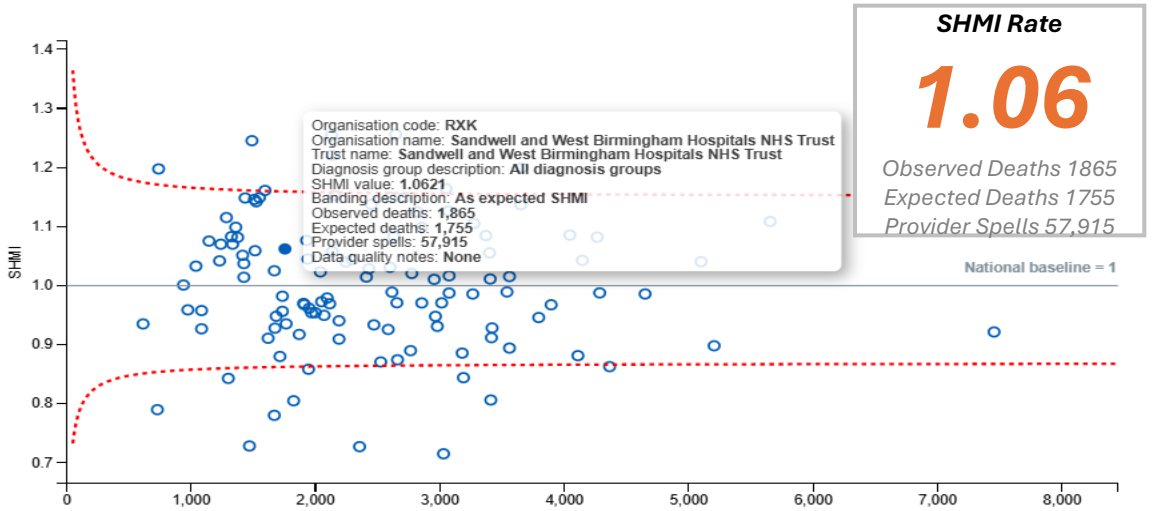
Objective status

Summary

2025-26 Baseline: Eliminating mortality is entirely unattainable; however, our hospital's mortality rates are higher than the expected levels based on national averages for England, taking into account the specific characteristics of the patients we care for.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Embedding Care Bundles into Unity (Pneumonia & Chest Drain)		IT lead identified for Pneumonia care bundle. Launch being scheduled to avoid EMRT clash. Pleural nurse working with MEC IT to scope Chest Drain Unity launch.	Finalise launch dates for both care bundles. Ensure clinical engagement and digital readiness. Monitor early implementation issues.
Strengthening Clinical Governance for Mental Capacity & LD Flagging		Mental Capacity Steering Group established. Training expected to improve performance. Safeguarding team leading improvements to LD flagging in Unity.	Deliver staff training programme. Embed revised LD flagging processes. Establish early monitoring indicators.
Reducing SHMI through Clinical Standardisation and Data Insights		Deep-dive completed with HED and DCMO. Strategic support being mobilised with execs and P&I team.	Translate insights into actionable interventions. Mobilise cross-group taskforce. Define KPIs and tracking approach for SHMI improvement.

Key Performance Indicator



Source: NHS England, Summary Hospital Mortality Rate

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Risks and mitigations

Risk flagged: Standardisation alone unlikely to shift SHMI.

Site	Spells	Observed Deaths	Expected Deaths	SHMI	Banding
Sandwell	16,455	685	630	1.09	As expected
MMUH	18,630	635	590	1.08	As expected
City	21,860	530	510	1.04	As expected

Progress against relevant KPIs

SHMi rate at 1.06 which is above national baseline of 1 but within control limits marking Sandwell and West Birmingham in the 'As expected' band. This performance is reflected at site level also.

Reduce Moderate and above Harm

Quarter: Apr – Jun 25	Executive sponsors: Mel Roberts, Mark Anderson
	Leads: Sally Arnold Jones/Stef Cormack

Reducing avoidable harm is essential to protect patients, improve care quality, and foster a culture of safety and learning.

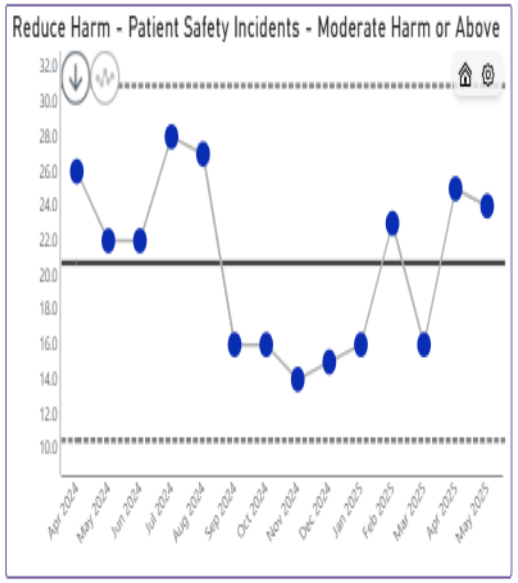
Objective status

Summary

Patient Safety Incident reporting remains within expected confidence limits, including those involving moderate or above harm. The overall level of reporting has increased, supported by targeted Trust-wide work. While no single category accounts for the increase, nutrition and hydration incidents are now monitored monthly, and additional reports related to transfers from iBEDS are being logged. Work continues to raise reporting in historically low-reporting areas.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Strengthen Incident Reporting Across All Areas		Incident volumes have increased and remain within control limits.Focused support in place for low-reporting areas and targeted nutrition/hydration reporting commenced in May.Incident rises linked to transfers from iBEDS into acute are being captured more consistently.	Sustain improved reporting levels across all clinical areas.Embed monthly reporting of nutrition/hydration incidents.Continue identifying and addressing low-reporting areas.
Improve Awareness Through Training and Communication		ARC training ongoing across governance teams. Regular incident training delivered to teams. PSIRF newsletter shared Trust-wide to promote learning.	Maintain high ARC training coverage.Continue PSIRF communications and embed incident trends into QIHD slides.Roll out learning events focused on deteriorating patient scenarios.

Key Performance Indicator



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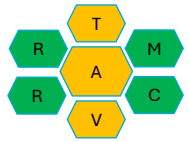
Risks and mitigations

Progress against relevant KPIs

The number of overall patient safety incidents remains within expected control limits, demonstrating stable reporting across the Trust. Moderate harm and above incidents also remain within confidence limits, with no significant variation. The May 2025 figures (1,292 total incidents; 24 moderate or above) reflect increased reporting consistency and improved staff engagement following targeted training and awareness efforts.



Achieve Recurrent financial sustainability

Quarter: Apr – Jun 25	Executive sponsors: Simon Sheppard
	Leads: Simon Sheppard

Restoring financial independence and enabling long-term investment in care, infrastructure, and innovation for the benefit of our patients and staff.

Objective status

Summary

Year to Date Position - At month three the Trust reported a £8.566m deficit, against a plan of £7.322m, an adverse variance of £1.244m. The Trust is off plan at the end of month 3, with Q2 onwards requiring a stepped improvement to ensure delivery of the financial plan.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
FIP delivery and recurrency		The Trust has reported a positive variance against the Financial Improvement Target. It must be recognised that the target ytd is low (9.8% of total), and this has largely been achieved non-recurrently. A straight-line forecast of ytd delivery would indicate a £25m outturn, significantly below the £50.788m in the plan. This highlights the importance of identification of schemes and increased pace of delivery.	Acceleration of 2025/26 schemes. Addition of new pipeline CIP schemes to rectify the CIP position. Strengthen monitoring and delivery assurance.
Contractual and System-Level Risks		ICB CFO letter confirmed elective overperformance will be offset against deficit support with no additional payment. Ongoing contract negotiations (BSOL, UEC, Specialist Services). National risk pool funding dependency highlighted.	

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Key Performance Indicator

	Plan £000s	Actual £000s	Variance £000s
Patient Related Income	179,364	183,735	4,371
Other Income	17,618	13,852	(3,766)
Pay	(123,762)	(126,508)	(2,746)
Non Pay	(80,542)	(79,645)	897
Total	(7,322)	(8,566)	(1,244)

At Month 03, the Trust reported a £8.566m deficit, against a plan deficit of £7.322m, an adverse variance of £1.244m

Key drivers for this position are:
- A favourable position against the elective income plan of £3.20m
- An adverse position against the specialist services contract of £1.47m
- An adverse position against the planning assumption regarding urgent and emergency care activity of £0.5m
- An overspend against the pay budget of £2.746m.
- Non pay is underspent year to date £0.897m

Risks and mitigations

Key Risks Identified:ICB funding policy risk: Elective overperformance now offsets deficit support — up to £7.13m at riskSystem deficit funding risk: £14.2m dependent on system delivery each quarter — Q3 and Q4 particularly vulnerableCIP trajectory risk: £18.3m current gap in FIP delivery (Annex 6)Contractual risk: Unresolved BSOL (£6.9m), UEC (£2m), and Specialist Services (£4.9m) disputesPerformance risk: Delivery of elective recovery, UEC assumptions, and workforce productivity are key dependencies

Mitigations:
- Full vacancy freeze across the Trust
- Curtailment of outsourcing and waiting list initiatives
- Suspension of all new developments
- Strengthened contract management and dispute escalation
- Monthly tracked FIP delivery plans by Group
- Non-recurrent flexibilities deployed as needed
- Workforce and capacity reviews to align demand and spend

Deliver Access Standards - Planned

Quarter: Apr – Jun 25	Executive sponsors: Johanne Newens
	Leads:Demetri Wade/Dani Joseph

Ensuring we meet our targets for elective care improving timely treatment and outcomes for our patients.

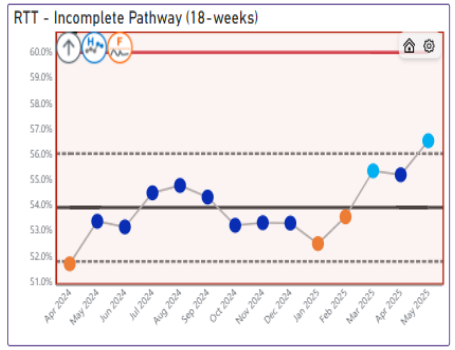
Objective status

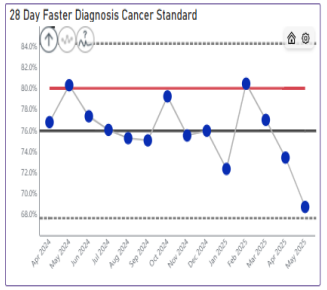
Summary

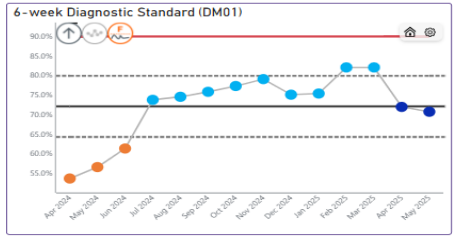
Performance against elective access standards remains challenged. RTT shows steady recovery and is tracking towards the March 2026 target. However, cancer and diagnostic standards remain below trajectory, particularly for the 62-day standard and DM01. Improvement actions are underway across pathways, with workforce resilience, productivity, and pathway redesign key to driving further progress in Q2.

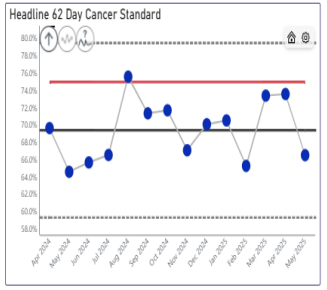
Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
RTT Access Standards		The June total RTT waiting list for the Trust currently stands at 65,540 patients, with 37,994 patients waiting within the 18-week RTT standard. This reflects a compliance rate of 57.97%, which is an increase from 56.38% in May. The Trust remains on track to achieve its target of 65% compliance by March 2026.	Implement targeted recovery actions: increase clinic sessions, extend hours, validate waiting lists, and prioritise high-risk specialties Continue use of outsourcing, improve engagement to reduce DNAs, and monitor progress through PCDG.
Cancer Access Standards		In May 2025, the Trust delivered 68.8% against the 28-day FDS, slightly below the planned trajectory of 77.78%. While validation is expected to yield some improvement, the trajectory target will not be met. May 2025: The Trust delivered 66.5% against the 62-day standard, sbelow the planned trajectory of 71.78%. The Trust delivered 93.9%, exceeding the planned trajectory of 96.65% for May 2025 for the 31-day DTT standard.	Priorities for the next quarter include continued management of dermatology waits, Endoscopy to maintain 30% ringfenced core capacity and agile escalation processes. Radiology to deliver improvements to the CT colonography pathway, reducing the timeline from 14 to 3–5 days. WMCA will review gynae oncology pathways to assess support for tertiary referrals. Workforce resilience to be strengthened.
DM01 Diagnostic Access Standards		June's provisional data is showing an improvement of 3.2% to 73.9%, largely driven by improvements in Endoscopy, NOUS, audiology and echo. The Trust went from the 17th to the 22nd largest waiting list during this period.	Neurophysiology are working with system partners to review referral patterns and demand management. NOUS will maintain improvements seen and reduce insourcing reliance. A revamped Diagnostic Improvement Group will focus on scheduling, utilisation and missed appointments

Key Performance Indicator









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Risks and mitigations

Risk: High rates of missed appointments (DNAs) affecting RTT delivery.**Mitigation:** Use of patient engagement tools, short-notice booking, and communication platform pilots.
Risk: Workforce shortages in diagnostics and cancer specialties.
Mitigation: Short-term locum contracts, recruitment to substantive posts, and support from the Improvement Academy and PMO.

Progress against relevant KPIs

While RTT performance has shown improvement, rising to 57.9% in Q1 and tracking towards the March 2026 target of 65%, both cancer and diagnostics remain significantly off trajectory. The 62-day cancer standard has remained below 60% for most of the period, while DM01 sits at 73.5% against a March target of 100%.

Deliver Access Standards - Unplanned

Quarter: Apr – Jun 25	Executive sponsors: Johanne Newens
	Leads:Demetri Wade/Dani Joseph

Ensure we meet our targets for our Urgent and Emergency care improving timely treatment and outcomes for our patients.

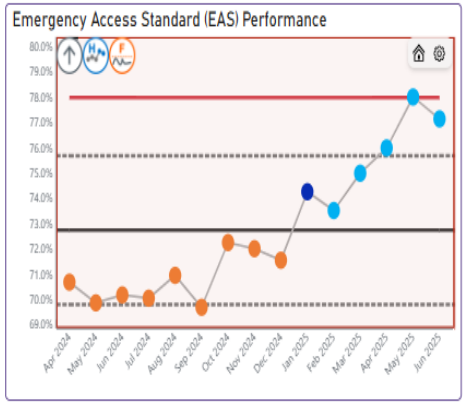
Objective status

Summary

Performance against unplanned care access standards continues to improve. The EAS 4-hour standard reached 77.16% in June 2025, just below the 78% target, with Type 1 performance holding above trajectory. Ambulance handover times also improved, averaging 22 minutes — better than the March 2026 target of 25. However, trolley waits remain high (90 in June), with 75% of 60+ minute delays occurring out of hours. Continued pressure on flow and discharge remains a key constraint on sustainable improvement.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Emergency Access Standards (Type 1–3)		Total EAS performance for June 25 was 77.16%, a slight reduction on May's performance of 78.02%. Type 1 EAS performance was reported at 62.5% for June. Type 2 and Type 3 EAS performance was reported at 94.6% for June, 2.9% below the trajectory. Type 2 performance is the greatest contributor to under-delivery The Trust is ranked 35th nationally out of 120 trusts with Type 1 departments.	Embed ED roles and responsibilities (including SMART), standardise front-loading with SIIFT, and adhere to new escalation form processes. Act on recommendations from SDEC streaming rapid improvement week, and review Eye ED Improvement plan. Focus on rota management, leadership roles, and safety huddles. Expand Straight-To-Test pathways and continue monitoring activity/attendance in urgent primary care service areas. Reduce breaches and 12-hour delays through pathway improvement and discharge planning.
Ambulance Handover Times		June's average ambulance handover was reported at 22 minutes. There was an increase in ambulance activity in June compared to May (3,958 against 3,871). Of the 126 ambulance conveyances over 60 minutes, 75% were 'out of hours' (i.e. between 5pm and 9am).	Streamlined Handover Processes will ensure smooth transitions, including enhanced communication between ambulance services and hospital staff. The escalation process will be used to prevent patients waiting on the corridor longer than 30 minutes. Increased focus on discharge planning and patient flow will create space in the ED. Communication with admitting specialties will ensure quality standards are adhered to, with a focus on active pull into SDEC and assessment units to maintain flow.

Key Performance Indicator



Emergency Access Standard (EAS) Performance
77.16%
March 2026 Target: 78%
June 2025

Emergency Care Trolley Waits >12 hours
90
March 2026 Target: 0
June 2025

Emergency Access Standard (EAS) Performance
5
Out of West Midlands Trusts: 13
June 2025

Average Ambulance Handover Times (minutes)
22
March 2026 Target: 25
June 2025

Emergency Access Standard (EAS) Performance - 12 Hours
6.88%
March 2026 Target: 10.50%
June 2025

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Risks and mitigations

Risk: High number of >12-hour trolley waits (90 in June) linked to delayed discharge and poor patient flow.

Mitigation: Embed escalation process, strengthen discharge planning, and improve use of SDEC and assessment capacity.

Progress against relevant KPIs

Despite falling short of national access standards for Emergency Access (EAS) and ambulance turnaround, performance is now on a **clear upward trajectory**. The **EAS 4-hour standard** has improved significantly over the past quarter, rising from around **71% to 75.1%**, approaching the March 2026 target of **78%**.

Progress has been supported by improvements in flow and non-admitted care pathways. However, pressures remain in **ambulance handover delays** and **timely admission**, which continue to impact overall system responsiveness and patient experience.

Improve Staff Engagement Score

Raising staff engagement to strengthen morale, productivity, and patient experience

Quarter: Apr – Jun 25	Executive sponsors: James Fleet
	Leads:Frances Jackson

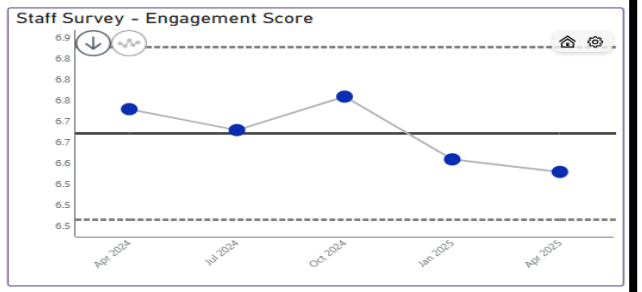
Objective status

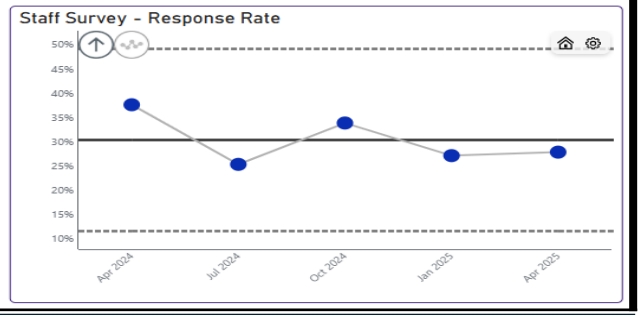
Summary

2025-26 Baseline: The Trust's staff engagement scores and survey response rates have historically been in the lower quartile compared to peer NHS trusts, reflecting challenges in motivating, involving, and retaining staff with inconsistent experience across staff groups.**Impact :** Low engagement impacts workforce productivity, staff well-being, and ultimately patient care quality.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Embed PET (People Engagement Team) Function Across Divisions		All Clinical Groups have a People Engagement Team in place. PET leads have attended People Committee to present their plans for 2025/26. A PET workshop was held in March 2025 to focus on how the PETs can be further embedded in future.	Ensure Group action plans are being progressed and communicated to teams.
Improve Survey Visibility and Accountability for Response Rates		Regular communications on team response rates during survey period. Survey results incorporated into Power BI report for easier analysis. PETs are responsible for response rates and accountability is via People Committee.	Achieve Group targets for July Pulse Survey Response rates.
Deliver Targeted Actions on Low-Scoring Themes		Each PET has developed an action plan against their lowest scoring themes. A series of corporate actions have also been developed and are in progress.	Groups to provide progress update on their actions to People Committee.

Key Performance Indicator





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Risks and mitigations

There is a risk that the current MARS scheme and CIP savings plans impacts on staff morale and engagement and distracts for pulse survey completion. Regular, ongoing communication and appropriate risk assessments (QIA,EIA) will help to ensure people are kept informed and plans consider the impact on staff wellbeing alongside service delivery considerations.

Progress against relevant KPIs

The staff engagement score declined slightly (0.45%) in April 2025 compared to the January 2025 survey due to a decline in the Advocacy and Involvement score.

Pulse survey response rate for April 2025 has improved slightly since the previous survey but remains below Trust target.

Optimise Workforce Productivity

Quarter: Apr – Jun 25	Executive sponsors: James Fleet
	Lead:Andy Harding

Improving workforce alignment to reduce inefficiencies and support sustainable staffing levels.

Objective status

Summary

Workforce productivity improvements continue to be implemented through optimised rostering, sickness absence reduction initiatives, and active workforce management. Sickness absence and turnover are both showing positive trends, and a reduction in leaver volumes supports stability. Actions remain focused on aligning staffing with demand and delivering financial efficiencies.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Implement GoodShape and drive sickness absence reduction		Full rollout of GoodShape in Q1. Sickness absence reduced from 6.72% (Dec) to 5.64% (June).	Sustain reduction below 5.5% and embed reporting compliance.
Deliver CIP through enhanced grip, bank pay controls and vacancy management		Recruitment freeze enacted. Leaver volumes reduced. Bank pay control comms prepared for Sept implementation.	Launch bank pay controls in Sept. Monitor vacancy growth. Progress workforce efficiency schemes with QIAs.
Advance rostering and voluntary redundancy (MARS) to address service alignment and deployment efficiency		Owed hours reduced. MARS planning commenced.	Launch MARS, increase rostering coverage, especially for AHPs and Clinical Scientists.

Key Performance Indicator

Component	Measure	Median	Trend
Leavers (exc. Jnr Docs) (in-Month)	FTE	50.76	
Leavers (exc. Jnr Docs) (Rolling 12 months)	FTE	721.92	
Mandatory Training Subject Compliance	%	92.87	
PDR Completed (Year to Date)	%	36.70	
Recruitment Time To Hire - Trust (with Exceptions)	Working Days	63.00	
Sickness (In-Month)	%	5.66	
Sickness (Open LT Cases)	HC	222	
Sickness (Rolling 12 months)	%	5.71	
Staff In Post (Assignment Headcount)	HC	8,302	
Staff in Post (Change From Previous Month)	%	0.40%	
Staff In Post (contracted)	FTE	7,302.45	
Starters (exc. Jnr Docs) (In-Month)	FTE	67.63	
Turnover (exc. Jnr Docs) (Rolling 12 months)	%	9.95	
Variance (Est:SIP Variance)	FTE	1024.79	
Variance (Est:SIP Variance)	%	12.31	

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Risks and mitigations

Risk: Workforce efficiency gap remains against Group trajectories. **Mitigation:** Active QIA completion, MARS acceleration, and wider optimisation interventions.
Risk: Funding risks linked to national voluntary redundancy schemes. **Mitigation:** Close coordination with finance and national programme guidance.

Progress against relevant KPIs

Staff in post (contracted) increased to 7,397.11 FTE by June 2025, despite the recruitment freeze.
Rolling turnover improved to 9.14% (from 11.52% in July 2024).
In-month sickness absence improved to 5.64%, with further reduction expected via GoodShape and local controls.

Achieve Representative Leadership

Quarter: Apr – Jun 25	Executive sponsors: James Fleet
	Lead:Catherine Griffiths

Strengthening our leadership pipeline to better reflect the diverse communities we serve.

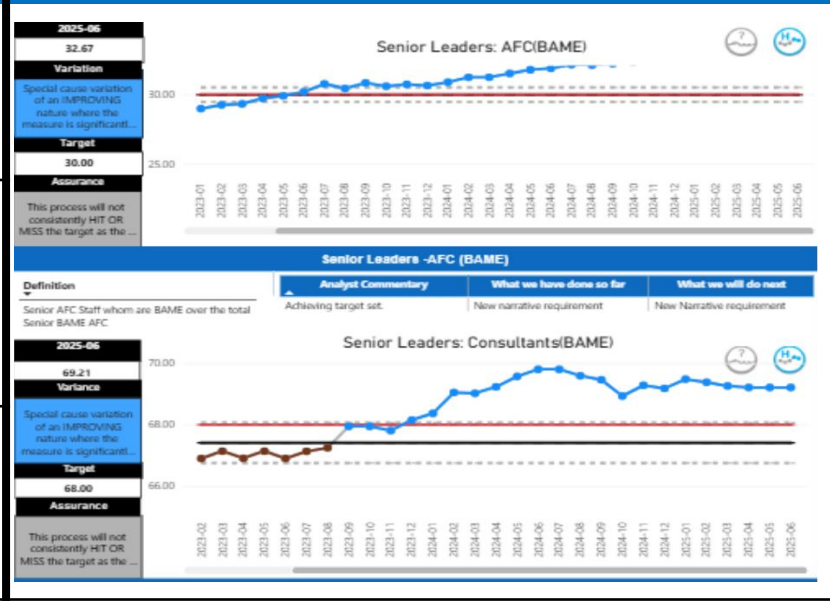
Objective status

Summary

Over the past year, we have strengthened our leadership pipeline to better reflect the diverse communities we serve. Progress has been made, particularly in BAME representation across AFC and senior consultant roles, with sustained improvement evident. Some metrics remain below target but show positive trends.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Embed Inclusive Recruitment Practices at Leadership Levels		visible improvement in BAME senior leadership, especially AFC Band 7+ (now 39.5%) but not yet at 40% target.	Targeted development of underrepresented groups; use new talent data to inform future recruitment
Track Diversity in Internal Leadership Pipelines		Pipeline metrics established and routinely monitored.	
Develop Next-Gen Diverse Talent Through Targeted Programmes		Engagement with emerging leaders has supported sustained growth; pipeline is being actively developed, particularly among consultants.	

Key Performance Indicator



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Risks and mitigations

Progress against relevant KPIs

Improving Trends:BAME Senior Leaders (overall): 38.9% → 39.5%AFC BAME: Stable above target at 69.2%Consultant BAME: Slight dip but remains above target

Right size acute, community and virtual beds

Quarter: Apr – Jun 25	Executive sponsors: Sian Thomas
	Lead:

Shifting care from hospital to community settings to improve patient outcomes and reduce pressure on acute services.

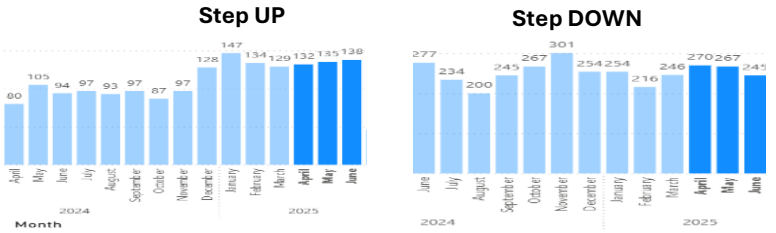
Objective status

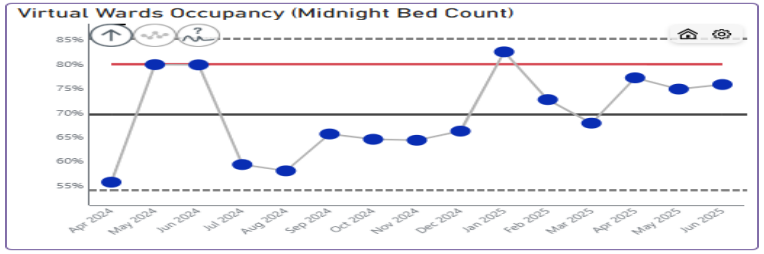
Summary	**2025-26 Baseline:** The community bed capacity (virtual & physical) is not being fully utilised resulting in unnecessary hospital stays. Having invested in capacity in virtual wards and Harvest View there are high quality services available but not fully utilised. Within our existing capacity (Rowley & Leasowes) the 'right' patients are not being identified on a daily basis resulting in available capacity that is not utilised, even when the Trust is on Level 4.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter
Improve Identification and Referral of Suitable Patients to Community and Virtual Beds		See IN YEAR OBJECTIVE "Optimise Utilisation of Community Services"	
Implement a Clear Strategy for Community Bed Use Across Localities		Bed paper written for Exe sign off based on no additional winter ward for 25/26 and a further reduction of 1 ward of 20 beds Leasowes by April 26	Commence and complete staff engagement Commence and complete the public conversation/consultation Plan to HOSCple
Strengthen Digital Health Offer and Data-Driven Decisions		Completed self-assessment for SWB VW digital requirements to be considered as part of the system's reprocurement of digital health platform	Progression of procurement of suitable digital platform for the local VW needs Review and update the VW data dashaboard to better reflect capacity & activity

Key Performance Indicator

VW Patients per month





- **On Track** – Delivery proceeding to plan; milestones and KPIs on track; no major risks or issues.
- **Off Track (with Plan)** – Issues identified, but recovery plan exists and delivery is still achievable.
- **Off Track (No Viable Plan)** – Major risks or delays with no credible recovery plan; delivery at serious ris
- **Status Undefined** – Insufficient information or no update provided to assess delivery progress.

Risks and mitigations

Progress against relevant KPIs

Virtual Ward (VW) – Q1 2025/26 Performance Summary (April–June 2025),
Step UP (Community Referrals to VW): Step UP activity demonstrated **continued growth and stability** across Q1, with patient numbers increasing month-on-month: **April**: 132. **May**: 135, **June**: 138
This represents the **highest Q1 performance to date**, with a **56% increase** compared to the same period i2024.
Step DOWN (Discharges from Hospital to VW):
Step DOWN activity remained **high and consistent** throughout Q1: **April**: 270,**May**: 267, **June**: 245
Although slightly lower in June, performance remains well above 2024 levels, with an **average year-on-year Q1 increase of 19%**.
This indicates effective utilisation of Virtual Wards as an alternative to extended hospital stay, supporting earlier discharge and flow.

Improve Population Health

Quarter: Apr – Jun 25	Executive sponsors: Sian Thomas
	Lead:

Shifting focus from treatment to prevention is essential to reduce long-term conditions and improve population health.

Objective status

Summary	We are making progress in building the infrastructure for a population health approach, with clear governance and strategic alignment now in place. However, the development of neighbourhood models and prevention initiatives is still in early stages, and data sharing challenges remain a key dependency.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter	Key Performance Indicator
Develop a clear set of priorities and governance for how the Trust and Place work together		Board development sessions held with SHCP and WBLP to agree strategic framework. Trust integration committee re-launched with refreshed ToR. Health inequalities dashboard completed.	Develop reporting to measure impact of priority programmes. Establish governance for ICB delegation and neighbourhood/community tariffs.	Improving population health is a long-term objective. Current KPIs are focused on understanding community needs and shaping Trust services accordingly: **Sandwell** has significantly higher rates of LTCs (obesity, diabetes, CHD, CKD, hypertension) than regional and national averages. **ED attendance and mortality rates** are higher, especially for COPD, CHD, and in older/deprived cohorts. Integrated neighbourhood dashboards in general show: 18 ED attendances per 1,000 population 2 frailty attendances per 1,000 76% of these patients are admitted Common complaints: falls, limb pain, abdominal pain, breathlessness
Develop the Neighbourhood Health Model		Draft model agreed for Sandwell and West Birmingham. Pilots scoped and initial mobilisation underway. Town team dashboard developed.	Complete Sandwell pilot and launch West Birmingham model. Expand town team dashboard with additional partner data. Submit national Neighbourhood Pioneer bid.	
Develop our Prevention Model		Health and Wellbeing Board workshop held. JSNA refresh agreed. Public health and CSU completed population analysis. All Flourish schemes live.	Develop Sandwell and West Birmingham prevention models aligned to population health data and community need.	

- **On Track** – Delivery proceeding to plan; milestones and KPIs on track; no major risks or issues.
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Risks and mitigations

Risk: Data sharing across health and care is dependent on a delayed S251 approval by the ICB. This is significantly behind schedule and may impact neighbourhood analytics.
Mitigation: Agree a local tactical cohort-based data sharing approach while waiting for full ICB sign-off.

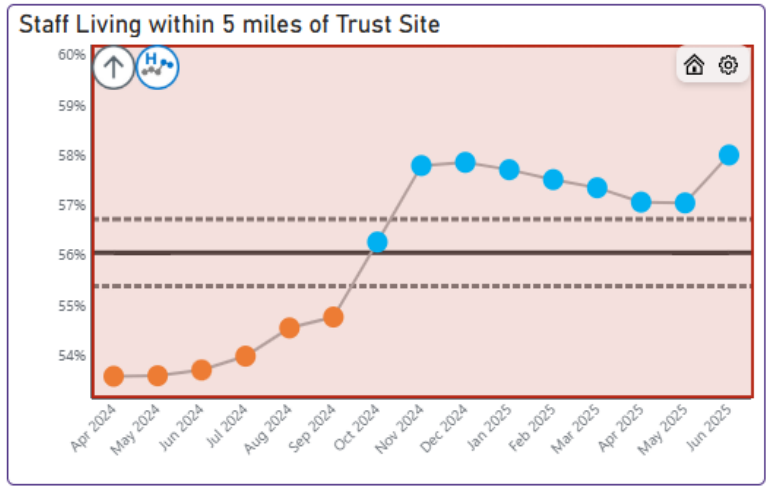
Increase volume of local people employed and trained

Quarter: Apr – Jun 25	*Executive sponsors: Sian Thomas/James Fleet*
	Lead:

Investing in local talent to strengthen our workforce and support inclusive economic growth.

Objective status

Summary	Employing and training local people helps us to connect with our community, creates jobs, and it means we can provide healthcare that's tailored to local needs.

Key Activities	RAG	Progress in the previous quarter	Priorities for the next quarter	Key Performance Indicator
Expand Employability and Apprenticeship Programmes	○		Build on the success of the externally funded programme by growing access to apprenticeships, in-post training, and entry-level roles for local people.	
Strengthen Partnerships with Local Education Providers	○		Deepen collaboration with schools, colleges, and training providers to align pathways into Trust roles and promote NHS careers.	
Targeted Local Recruitment and Retention Initiatives	○		Focus recruitment efforts on underrepresented communities and local postcodes, using data-driven approaches to attract, support, and retain local talent.	

- **On Track** – Delivery proceeding to plan; milestones and KPIs on track; no major risks or issues.
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Risks and mitigations

There is a risk that wider workforce transformation programmes (e.g. new models of care, automation, service redesign) could impact the volume of local roles in the medium term. However, current initiatives have not shown any adverse effect on local recruitment or retention. Continued monitoring is in place to ensure transformation aligns with our strategic goal of growing a sustainable, locally based workforce.

Progress against relevant KPIs

The Trust has continued to improve local recruitment, with the proportion of staff living within 5 miles of a Trust site rising from 54% in early 2024 to just under 59% by June 2025. This upward trend reflects progress in embedding community-focused employment practices. While the shift is positive, sustained effort is needed to reach and maintain 60% and beyond.

Progress against Annual Plan

Metric

RTT 18 week %

Summary

RTT 18 week performance for Quarter 1 stands at 57.9%, exceeding the June target of 54.08% and tracking towards the March 2026 target of 65%. Strong performance was seen in Gynaecology (+39.92%), Cardiothoracic Surgery (+31.63%), and Respiratory Medicine (+33.80%). However, underperformance in Oral Surgery (-24.96%), Plastic Surgery (-19.77%), and Gynaecology (-12.00%) highlights key areas requiring targeted improvement. Overall, the Trust is on an upward trajectory with steady progress against plan.

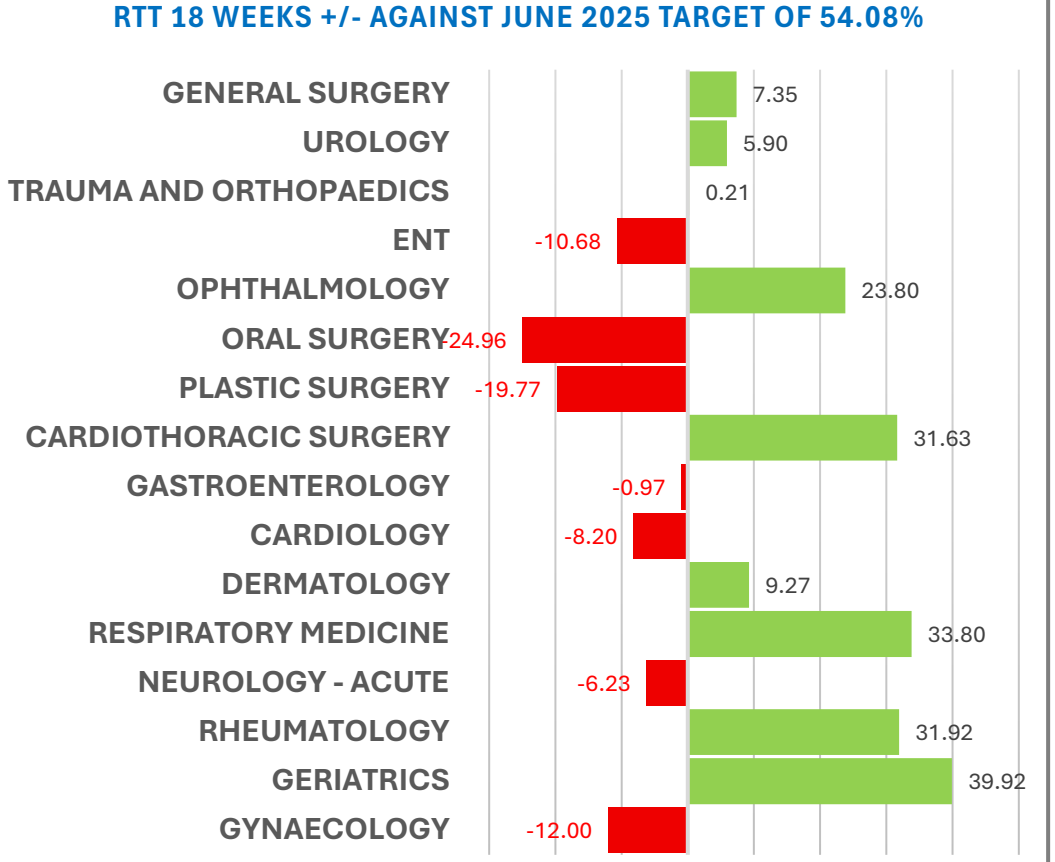
Performance at Qtr 1

Quarter 1 Target 54.08%

57.9%

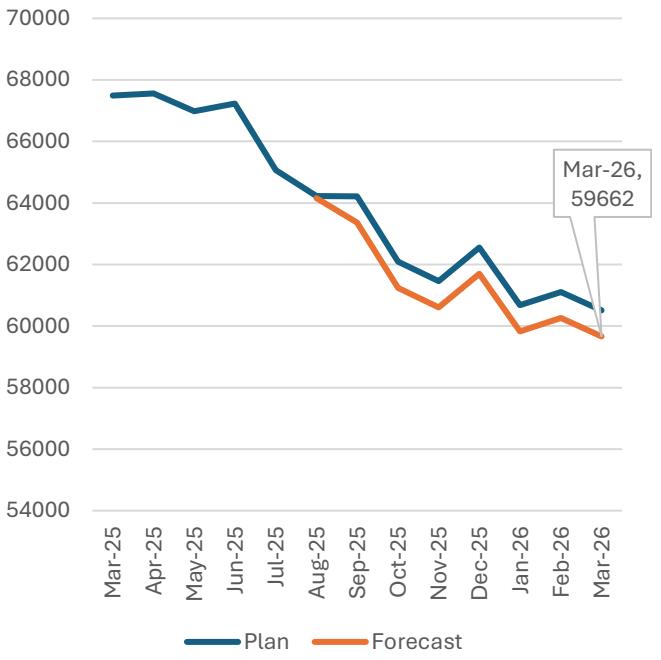
March 2026 Target 65%, Plan of 60%

Variance Against Target

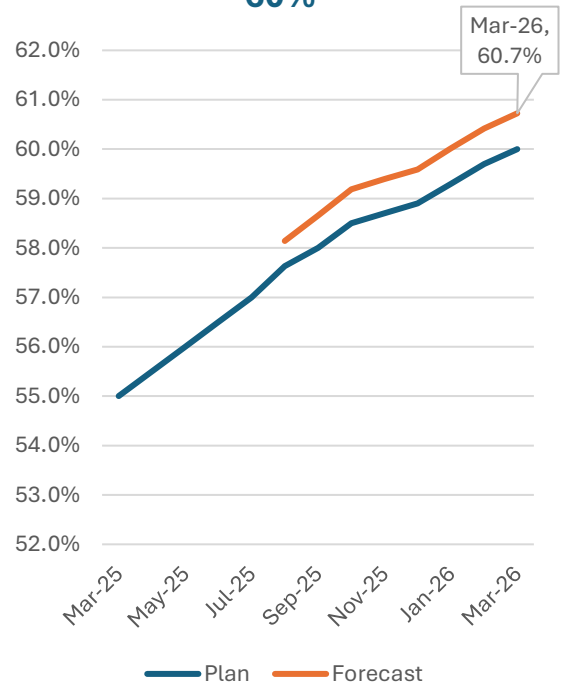


Trend

Total WL Size - Forecast 59,662 against an original plan of 60,510



RTT % - Forecast 60.7% against an original plan of 60%



Metric

DM01 – 6 weeks %

Summary

Diagnostic 6-week performance for Quarter 1 is 73.5%, just above the June target of 73%, but well below the year-end ambition of 100%. While there is good performance in DEXA scans (+30.0%), non-obstetric ultrasound (+18.2%), and gastroscopy (+14.1%), significant underperformance in areas like colonoscopy (-31.5%), flexi sigmoidoscopy (-25.2%), and neurophysiology (-15.3%) presents a substantial challenge. Given current performance and trajectory, achieving 100% compliance by March 2026 appears unlikely without further intervention.

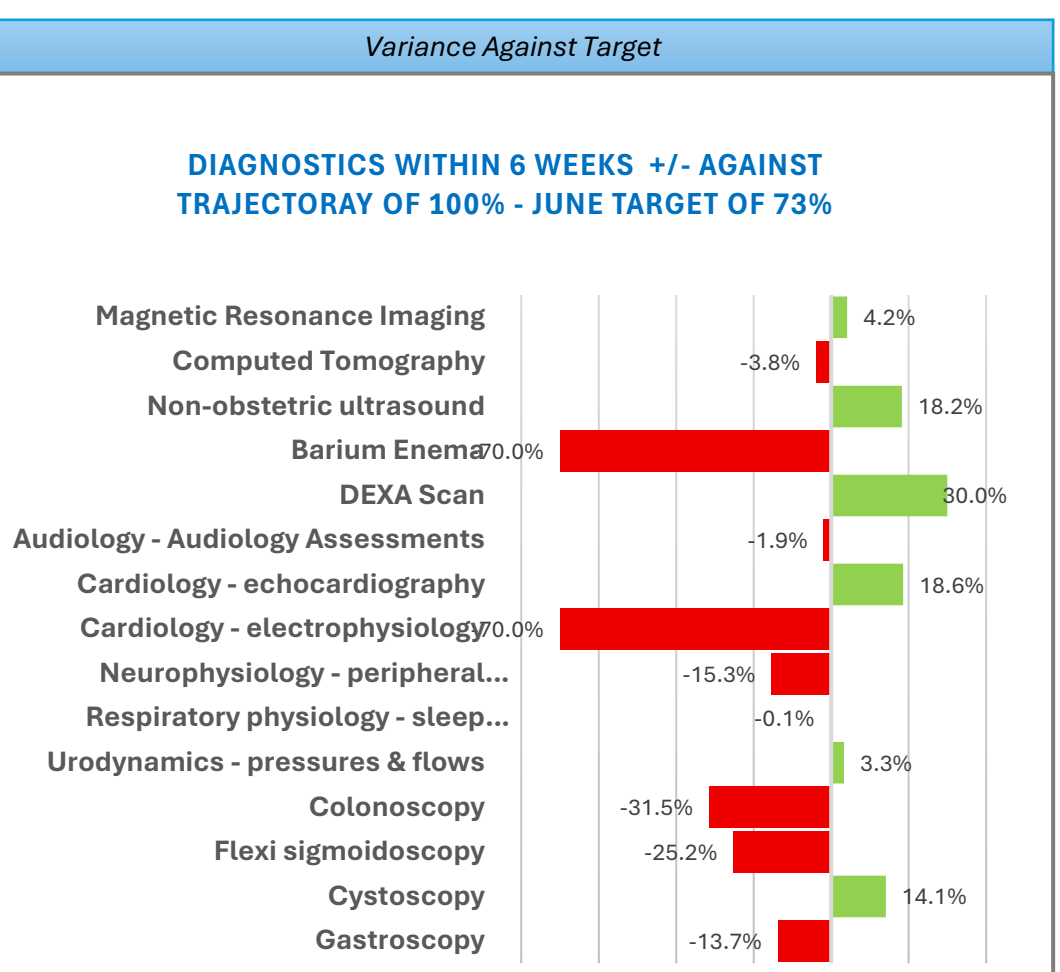
Performance at Qtr 1

Quarter 1 Target 73%

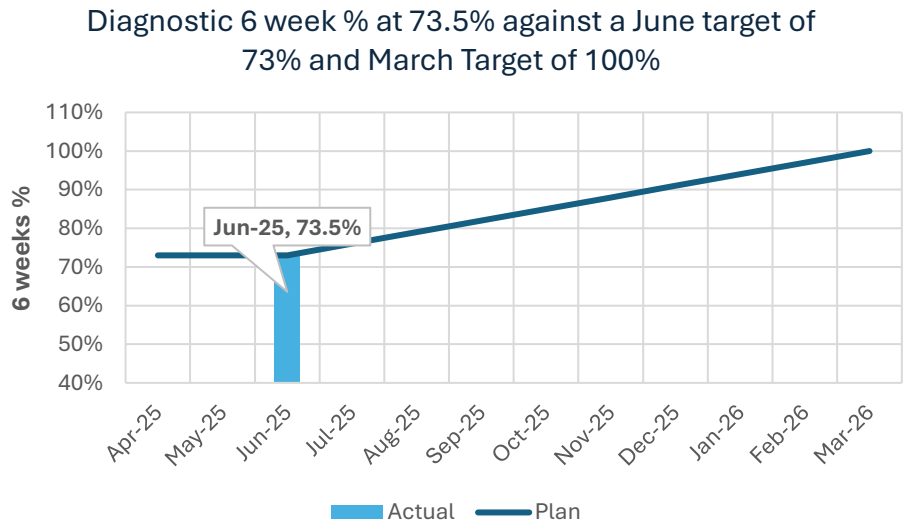
73.5%

March 2026 Target 100%

Variance Against Target



Trend



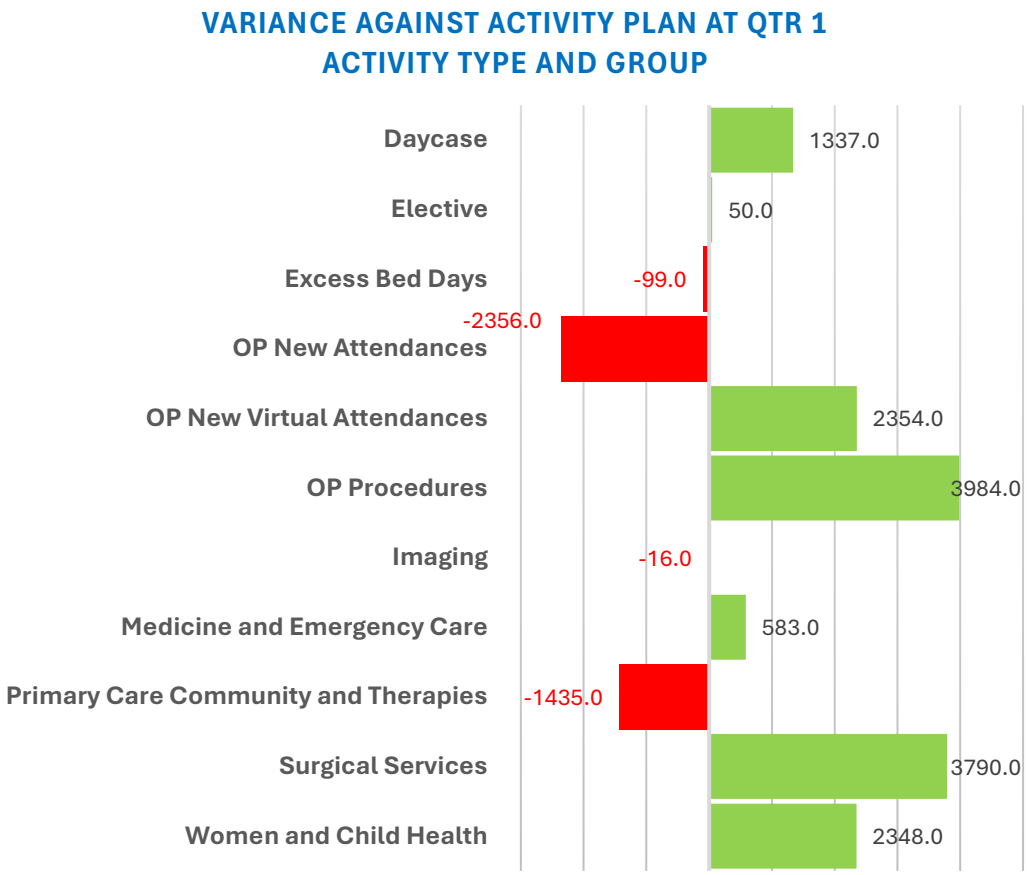
Metric

Activity Plan

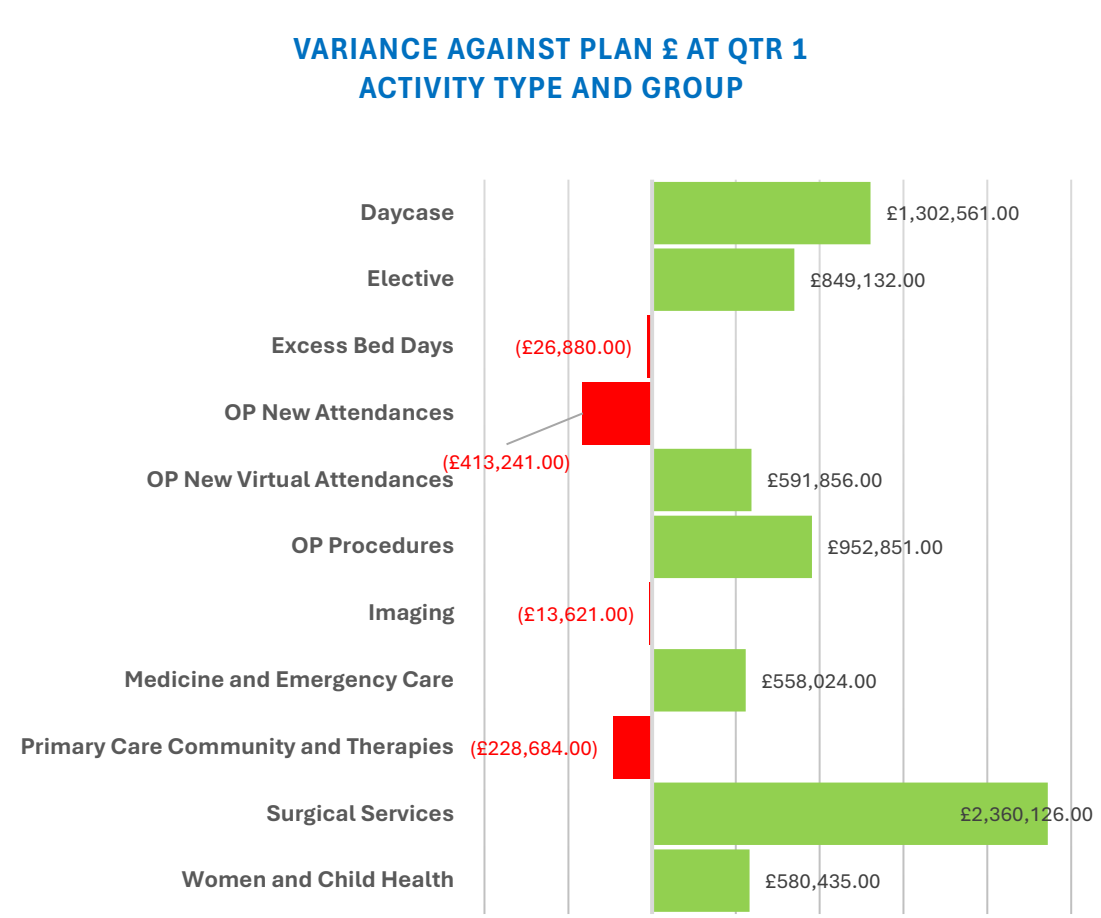
Summary

Activity delivery in Quarter 1 shows a mixed performance, with notable overperformance in daycase (+1,337), OP virtual attendances (+2,354), OP procedures (+3,984), and Surgical Services (+3,790) — all contributing to a positive financial variance of £2.36M in Surgical Services and over £1.3M in Daycases.However, there are significant under-deliveries in OP new attendances (-2,356) and Primary Care, Community & Therapies (-1,435), translating to a combined adverse financial variance of £641k. Excess bed days (-99) and Imaging (-16) also underperformed, albeit with smaller financial impacts. Despite the positive financial picture overall, there is a **material risk** linked to the **Elective Recovery Fund (ERF) cap**, which may limit the ability to realise full income benefit from overperformance. **This could affect the Trust's finances unless activity levels are carefully managed within ERF parameters.**

Variance Against Target - Activity



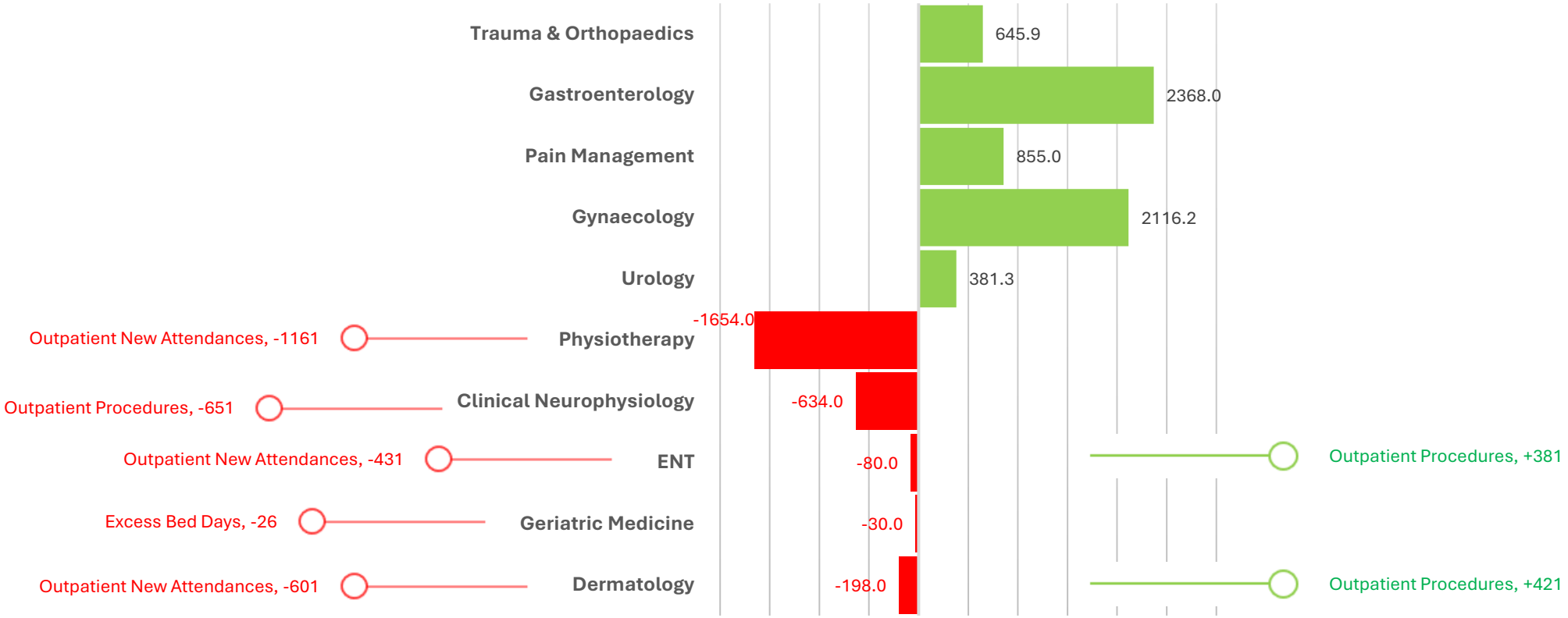
Variance Against Target - Financials



Metric
Activity Plan

Summary
At Quarter 1, activity performance varied significantly by specialty. Strong overperformance was seen in Gastroenterology (+2,368), Gynaecology (+2,116), and Pain Management (+855), supporting the overall activity position and financial outlook.In contrast, Physiotherapy (-1,654) and Outpatient New Attendances in Urology (-1,165) were the most significant underperformers, alongside notable drops in Clinical Neurophysiology (-634) and Dermatology (-198). The data highlights both capacity strength in procedure-heavy services and ongoing pressures in community-facing and diagnostic specialties, reinforcing the need for careful workforce and access planning to support balanced recovery across all specialties.

TOP 5 AND LOWEST 5 SPECIALTIES ACTIVITY VARIANCES AT QTR 1



Appendix 1 – Multi Year Commitment Metrics

NHS

MIDLAND METROPOLITAN UNIVERSITY HOSPITAL

FUNDAMENTALS OF CARE

Clinical Group: All

NHS

SAFE & SKILLED WORKFORCE | QUALITY & SAFETY - HARM FREE CARE | QUALITY & SAFETY - USER JOURNEY | COMMUNICATION

SAFE & SKILLED WORKFORCE	QUALITY & SAFETY - HARM FREE CARE			QUALITY & SAFETY - USER JOURNEY			COMMUNICATION	
Sickness Absense 5.6% Target: 6% Jun 2025	Patient Safety Incidents 1,277 Jul 2025	MRSA Bacteraemia 0 Target: 0 Jun 2025	Pressure Ulcers 149 Jul 2025	Ambulance Handover 81.9% Target: 65% Jul 2025	IP Imaging Within 24hrs 61.2% Target: 85% Jul 2025	Golden Discharges <10am 3.9% Target: 15% Jul 2025	RTT 18 Week Incomplete 58.0% Target: 60% Jun 2025	Complaints Received 115 Jul 2025
Band 5 Nurse Vacancies 51 Feb 2024	Incidents >=Moderate Harm 60 Jul 2025	C-Diff Bacteraemia 2 Target: 3 Jun 2025	Cat 4 Pressure Ulcers 1 Target: 0 Jan 2025	ED 4-Hour EAS 78.9% Target: 78% Jul 2025	MRI Weekday vs Weekend 1.1 Jul 2025	Early Discharges <Midday 10.8% Target: 40% Jul 2025	RTT Over 65 Weeks Wait 4 Target: 0% Jun 2025	Complaints Rate 4.98 Jul 2025
Staff Pulse Response Rate 28% Target: 40% Apr 2025	Inpatient Falls 76 Jul 2025	MSSA Bacteraemia 3 Jun 2025	P'Ulcer Risk Assessment 95.7% Target: 95% Jul 2025	< 2hr DTA to Admit 47.0% Jul 2025	USS Weekday vs Weekend 1.3 Jul 2025	In-Hours Discharge <5pm 46.5% Target: 60% Jul 2025	Cancer 31-Day DTT 92.8% Target: 96% Jun 2025	Complaints Response Time 87.8% Target: 80% Jul 2025
Staff Survey Recommend 55.1% Target: 70% Jul 2024	Inpatient Falls with Harm 5 Jul 2025	Medication Errors with Harm 0 Target: 0 Mar 2025	VTE Risk Assessment 95.7% Target: 95% Jul 2025	GP Appt Within 2 Weeks 87.0% Jun 2025	CT Weekday vs Weekend 0.7 Jul 2025	Length of Stay - Acute NEL 4.3 Jul 2025	Cancer 62-Day RTT 68.1% Target: 75% Jun 2025	Maternity FFT Positive 81.6% Target: 82% Jun 2025
Staff Survey Engagement 6.5 Target: 7 Apr 2025	Falls Risk Assessments 28.1% Target: 95% Jul 2025	Controlled Drug Audit 86.3% Target: 95% Feb 2025	Sepsis Treated <=1 Hour 93.4% Target: 85% Jul 2025	Urgent GP Appt 59.8% Jun 2025	EOL on SPC Pathway 42.5% Target: 70% Jul 2025	Readmissions within 30 days 6.3% Target: 7% Jul 2025	Cancer 28-Day Faster 77.5% Target: 80% Jun 2025	ED FFT Positive Response 71.9% Target: 68% Jun 2025
Temporary Staffing	Falls Rate 4.61 Jul 2025	NEWS2 Compliance 69.1% Jul 2025	Mortality Index (SHMI) 111 Feb 2025	Urgent Community Response 71.2% Target: 70% Jul 2025			6 Week Diagnostic Standard 73.7% Target: 90% Jun 2025	Inpatient FFT Positive 91.1% Target: 90% Jun 2025
							Length of Stay - Elective 2.5 Jul 2025	Outpatient FFT Positive 86.5% Target: 93% Jun 2025

Tiles with purple border display trust level stats only

Tiles in blue border are live with data changing daily as cases are validated.

NaN indicates no related data for that group

LINKS

- Ward Level FOC
- EWS Compliance
- Emergency Care Reporting
- Cancer Dashboard
- Pt Experience Dashboard
- Inpatient Flow
- Theatre Dashboard
- Staff Survey Results

Sandwell and West Birmingham NHS Trust

Appendix 2 – Kite Marks

Kitemark

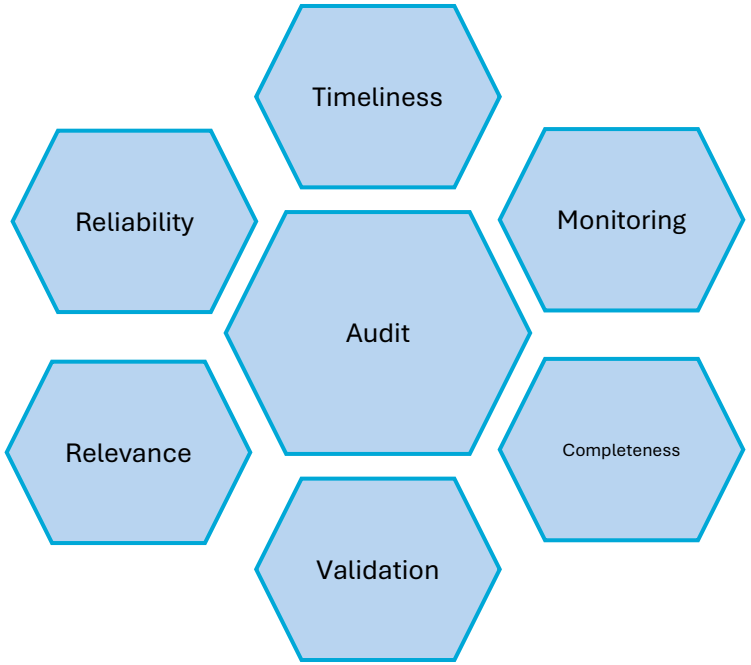
Kitemark audit completed by Performance & Insight. Kitemarks rankings based on the reported metrics.

Timeliness

- The time taken between end of the data period and when the information can be produced and reviewed
- Acceptable data lag will vary between performance indicators
- Data should be captured as soon as feasible after reporting event or activity, and available within a reasonable period
- Data must be available quickly and frequently enough to support and influence appropriate level of service or management decisions

Reliability

- The extent to which the data is generated by a computerised system, with automated IT controls or manual process.
- The degree of documentation outlining the data flow
- Data should reflect stable and consistent data collection processes across collection points and over time, both automatic and manual indicators
- Stakeholders should be confident that progress toward performance targets reflects real changes rather than variation in data collection methodology



Monitoring

- The degree to which the Trust can drill down into data to review and understand operational performance
- The level will vary between performance indicators
- Some indicators should always be available at patient level, whereas others may be sufficient at specialty or Trust level.

Relevance

- The extent to which the data is captured for the purposes for which it is used
- Periodic review of the selection of key performance indicators reflect changing needs, such as new strategic objectives
- Strategic objectives will be defined within the scoping document for proposed new measures

Completeness

- The extent to which all the expected attributes of the data are populated
- The extent to which all the records for the relevant population are provided

- Insufficient
- Insufficient, but under active review/management
- Sufficient
- Not Yet Assessed

Validation

- The extent to which data has been validation to ensure accuracy and compliance with relevant reporting requirements
- The level of validation will vary between indicators and will depend on the level of data quality risk
- Final validation is classified as sufficient where validation has been completed and the indicator has received final approval from responsible individuals

Audit

- The extent to which the integrity of data (the tiles of kitemark) has been audited by someone independent of the indicator
- The extent to which the assurance provided from the audit is positive