PUBLIC SESSION

The Royal Wolverhampton NHS Trust (RWT) & Walsall Healthcare NHS Trust (WHT) Group Trust Board Meeting– to be held in Public
Tuesday 16 September @ 12:00 – 3:00 pm
Meeting Room 9, MLCC, 3rd Floor, Walsall Healthcare NHS Trust

AGENDA

Agenda No.	ITEM	PAPER REF	LEAD	PURPOSE	TIME
1	Chair's Welcome, Apologies and Confirmation of Quorum	Verbal	Sir David	To inform & assure	12:00
2	Patient Story WHT – Child Bereavement	Verbal	A Godson	To inform	12:02
3	Register of Declarations of Interest	Verbal	Sir David	To inform & assure	12:17
4	Minutes of the RWT/WHT Group Trust Board Meeting held in Public On 15 July 2025	Enclosure 4	Sir David	To approve	12:19
4.1	Group Board Action Log and Matters Arising	Enclosure 4.1	Sir David	To update, inform & assure	12:22
5	Chair's Report - Verbal	Verbal	Sir David	To inform	12:27
6	Group Chief Executive's Update	Enclosure 6	J Chadwick-Bell	To inform	12:35
7	Group Assurance Report– Quality, Finance & Productivity, Transformation and Partnerships, People and Audit	Enclosure 7	J Dunn/ L Toner/ D Brathwaite/ L Cowley	To inform, assure and Approve	12:43
7.1	RWT and WHT Audit Committee Chair Verbal Updates	Verbal	J Jones M Martin	To inform & assure	12:55
7.2	RWT & WHT Charitable Funds Committee – Chair's Verbal update to Trustees	Verbal	M Levermore	To discuss & assure	13:03
8	Trust IQPR's				
8.1	Integrated Performance Report –The Royal Wolverhampton NHS Trust	Enclosure 8.1	G Nuttall/ D Hickman/ B McKaig/ A Duffell/ K Stringer	To inform & assure	13:08
8.2	Integrated Performance Report – Walsall Healthcare NHS Trust	Enclosure 8.2	A Godson/ Zia Din/ A Duffell K Stringer	To inform & assure	13:18
8.3	COMFORT BREAK (10 MINS) 13:28				

Agenda No.	ITEM	PAPER REF	LEAD	PURPOSE	TIME
8.4	**Group Chief Community and Partnerships Officer Report by Exception /for RWT & WHT**	Enclosure 8.4	S Cartwright	To discuss, inform & assure	13:38
8.5	**Proposed Model for Stroke Rehabilitation across Walsall and Wolverhampton**	Enclosure 8.5	S Cartwright	<mark>To approve</mark>	13:46
8.6	**Winter Plans 2025/26 for RWT & WHT**	Enclosure 8.6	G Nuttall & A Godson	<mark>To approve</mark>	13:54
9	**RWT & WHT Freedom to Speak Up Report**	Enclosure 9	A Duffell/ Freedom to Speak up Guardians G Padmore-Payne/Shabina Raza	To inform	14:04
10	**2026-30 Green Plan for RWT and WHT**	Enclosure 10	K Stringer	<mark>To approve</mark>	14:14
11	**Our Improvement Strategy – Embedding Quality Improvement**	Enclosure 11	S Evans	<mark>To approve</mark>	14:22
12	**Questions Received from the Public**	Verbal	Sir David	To inform	14:30
13	**Any Other Business**	Verbal	Sir David	To inform	14:40
14	**Resolution**	Verbal	Sir David	<mark>To approve</mark>	14:45
15	**Date and Time of Next Meeting : Tuesday 18 November 2025 – venue to be confirmed**	Verbal	Sir David	To note	14:47
16	**Reading Room (these items will not be presented)– to view documents in the reading room follow instructions below:** *On the ibabs system click on the following tab:* *Documents* – shared folder – Group Public Board Meetings 2025 – September 2025 (Reports uploaded to reading room): - RWT Winter Plan 2025-26 attachments - WHT Winter Plan 2025-26 - Our Improvement Strategy 2025 - 2028 - WHT Biannual Skills Mix - RWT Biannual Skills Mix - RWT & WHT Winter Plan 2025/26 inc. Board Assurance Statements - Workforce Race Equality Standard and Workforce Disability Equality Standard - Appendices for Green Plan 2026-30 for RWT and WHT - RWT & WHT Freedom to Speak Up attachment				
MEETING CLOSE					

MEETING OF THE PUBLIC GROUP TRUST BOARD MEETING
TUESDAY 15th July 2025 AT 12:30pm
held at Brownhills Community Association, Chester Road North, Brownhills, Walsall, WS8 7JS

PRESENT
Members *(Abbreviations: WHT: Walsall Healthcare NHS Trust; RWT: The Royal Wolverhampton NHS Trust)*

Sir D Nicholson	Group Chair
Ms J Chadwick-Bell	Group Chief Executive Officer
Ms R Barber	Joint Associate Non-Executive Director, RWT and WHT
Ms D Hickman	Chief Nursing Officer, RWT
Ms L Carroll	Chief Nursing Officer, WHT
Ms S Cartwright	Group Chief Community and Partnerships Officer
Ms L Cowley	Joint Non-Executive Director, RWT and WHT
Mr A Duffell	Group Chief People Officer
Mr J Dunn	Deputy Chair/Non-Executive Director, RWT
Mr S Evans	Deputy Group Chief Executive Officer & Chief Strategy Officer
Ms A Heseltine	Joint Associate Non-Executive Director, RWT and WHT
Ms J Jones	Non-Executive Director, RWT
Dr B McKaig	Chief Medical Officer, RWT
Dr Z Din	Chief Medical Officer, WHT
Ms G Nuttall	Managing Director, RWT
Mr K Stringer	Group Chief Financial Officer
Prof L Toner	Joint Non-Executive Director, RWT and WHT
Ms M Martin	Non-Executive Director, WHT
Lord Carter	Specialist Advisor to the Board, RWT
Mr W Roberts	Chief Operating Officer, WHT
Dr U Daraz	Joint Associate Non-Executive Director, RWT and WHT

In Attendance

Mr K Wilshere	Group Company Secretary
Ms E Stokes	Senior Administrator, WHT
Ms J Toor	Senior Operational Coordinator, WHT
Ms J Wright	Director of Midwifery, WHT
Mr R Purewal	Senior Healthcare Director – C2-Ai.com – Precision Healthcare
Dr J Tinsa	Member of the Public
Ms A Downward	Communications Lead RWT/WHT
Mr R Edwards	Commercial Director, Surgical Consortium
Dr K Warren	Consultant in Public Health for RWT (In Attendance for Item 091/25)
Ms J Weeks	Consultant Radiographer, RWT (In Attendance for Item 076/25)

Apologies

Ms D Brathwaite	Joint Non-Executive Director, RWT and WHT
Mr P Assinder	Deputy Chair/Non-Executive Director, WHT
Prof M Levermore	Joint Non-Executive Director, RWT and WHT

075/25	**Chair's Welcome, Apologies and Confirmation of Quorum**
	Sir David welcomed everyone to the meeting and apologies were received and noted. Sir David confirmed the meeting as quorate. **Resolved: that the Group Trust Board Meeting held in public be confirmed as quorate.**
076/25	**Patient Voice (Royal Wolverhampton NHS Trust) – Prostate Cancer Patient Story**
	Ms Hickman introduced the story of Alan Lewis, a 62-year-old afro Caribbean gentlemen who had suddenly developed symptoms in March 2020 which when investigated by his GP had been confirmed as a positive diagnosis for prostate cancer. Ms Hickman reported that Mr Lewis had experienced sensitivity to chemotherapy and had been required to alter his treatment plan and referred for Radium therapy. She said Mr Lewis had been extremely positive and grateful for the care he had received at The Royal Wolverhampton NHS Trust (RWT).

Ms Hickman welcomed Ms Weeks, Consultant Radiographer who had provided care and support to Mr Lewis during his treatment. Ms Weeks reported that the molecular radiotherapy service, which was the treatment Mr Lewis had received, was a small part of the medical physics department at RWT. She said the British Nuclear Medicine Society had launched a YouTube channel and had asked Mr Lewis to share his story.

Ms Weeks advised that Mr Lewis had finished his 6 cycles of radiotherapy that had allowed for a better quality of life and his confidence had increased and he had felt well enough to return to the gym. She reported on her role within the molecular radiotherapy department which she had taken on from oncologists due to their increased workload. She said this role enabled a more personalised service with her as the point of contact for patients in treatment.

Sir David and Ms Chadwick-Bell said that Mr Lewis had received extraordinary care and thanked Ms Weeks for her dedication to patients at RWT. Ms Chadwick-Bell referred to the video and some of the points raised by Mr Lewis in the video and asked how RWT and WHT could further inform patients of signs and symptoms to be aware of and if the reasoning behind missed appointments could be further explored. Dr Din suggested that they should further review the inequalities agenda through the Joint Health Inequalities Steering Group. Ms Cartwright reported that a requirement of the Neighbourhood Health Agenda was to understand the population at a local neighbourhood level to further raise awareness of treatments and identify people of highest risk.

Dr McKaig advised that 1 of the 10 key priorities of the Health Scrutiny Committee within Wolverhampton was to raise awareness on low prevalence diseases such as prostate cancer and to advise that cancer screening programmes were active. He said access to harder to reach communities and ethnic minorities had been recognised as an inequality.

Ms Cowley said she had seen some really good cancer screening work being undertaken in the West Midlands and advised on some work currently being undertaken with the Cancer Network in relation to the lack of referrals for the right groups. Ms Weeks said she attended regional meetings and that she also looked after patients from Shropshire and Telford. She said that Radium therapy is funded, so the Trust gets these funds back for these patients and said there were however other funds they could also draw on the NHS Tariff which were not currently being claimed. Prof Toner asked why the Trust was unable to expand the RWT clinical trials portfolio further. Ms Weeks reported that RWT did not have the available funding or staffing to proceed with clinical trials currently. Prof Toner said that it would be good to have these discussions with the Research and Development Department.

Sir David advised that Mr Lewis story was a great example of early diagnostics, health inequalities and pressures on people despite which tailored care was still being delivered. He thanked Ms Weeks for attending to present this patient story.

Resolved: that the Patient Voice (Royal Wolverhampton NHS Trust) –Prostate Cancer Patient Story be received for information and assurance.

Ms Weeks left the meeting.

077/25	**Register of Declarations of Interest**
	Sir David confirmed that no further declarations of interest had been received that were not already included within the register of interests. **Resolved: that the Register of Declarations of Interest be received and noted that there were no further declarations of interest declared that were not already included within the Register of Interests.**
078/25	**Minutes of the Previous RWT/WHT Group Trust Board Meeting held in Public on 20 May 2025**
	Sir David approved the minutes of the Group Trust Board Meeting held on 20 May 25 as an accurate record. **Resolved: that the minutes of the previous meeting held 2o May 25 be received and APPROVED.**
079/25	**Group Board Action Log and Matters Arising**
	Sir David confirmed that there were no outstanding matters arising or actions. **Resolved: that any updates to the Group Action Log and Matters Arising be received and noted.**
080/25	**Chair's Report – Verbal**
	Sir David advised that the NHS 10 Year Health Plan had been published on 3 July 25 with an emphasis on community services and the development of neighbourhood teams and enhanced system-wide working across the primary, community, hospital, social care and voluntary sector. He said Trusts would need to think about long term sustainability and how they approach the Plan with the 3-year funding allocation. **Resolved: that the Chair's report be received for information and assurance.**

081/25	**Group Chief Executive's Report**
	Ms Chadwick-Bell thanked colleagues across RWT and WHT for their continued hard work and dedication to delivering excellent patient care. She said it had been a privilege to present the Long Service Awards to staff across RWT and WHT who had completed 20, 25, 30, 40 and 50 years of continuous service and this had showcased staff commitment to the NHS and individual Trusts. She said it was important for the Trusts to retain and motivate experienced staff whilst allowing for new colleagues to join teams to refresh and maintain skills.
	Ms Chadwick-Bell reported that RWT and WHT were part of the Defence Employer Recognition Scheme (ERS) which encouraged employers to support the Armed Forces Community. She said RWT had been awarded Gold Status and WHT had been awarded Bronze. Ms Chadwick-Bell advised that work would continue to allow WHT to achieve gold status.
	Ms Chadwick-Bell advised that NHS England (NHSE) had launched the final version of the NHS Oversight Framework 2025/26 which would encompass the shift from a target driven accountability model to a focused set of national priorities.
	Ms Chadwick-Bell reported that RWT and WHT would be applying for the Neighbourhood Health Pioneers model to build on the excellent work and partnerships with health and care and voluntary sector colleagues.
	Ms Chadwick-Bell advised that the Urgent and Emergency Care plans for 2025/26 had been published and would be reviewed as to how RWT and WHT would recover nationally to deliver the constitutional standards for urgent care access. She said there needed to be increased focus on out of hospital care becoming the front door of access for patients.
	Ms Chadwick-Bell reported that the Black Country Integrated Care Board (ICB) and Birmingham and Solihull ICB had announced the development of a new Operating Model with the focus on strategic commissioning functions and position of provider collaboratives and partnerships across the cluster.
	Ms Chadwick-Bell advised that Ms Amelia Godson had been appointed as Managing Director at WHT and would commence in post 2 September 25. She reported that Mr Duffell would be retiring from his role as Group Chief People Officer on 16 December 25 and recruitment was underway to find a replacement.
	Ms Chadwick-Bell advised that culture conversations with staff and the Executive Team would be taking place across RWT and WHT. Ms Chadwick-Bell's report advised that the RWT had gained the RACE Code re-accreditation, with WHT going through the same accreditation process at present. **Resolved: that the Group Chief Executive's Report be received for information and assurance.**
082/25	**Integrated Committee Chairs Report - Quality, Finance & Productivity, Transformation and Partnerships, People and Audit**
	Mr Dunn thanked his Non-Executive Director colleagues for their support in preparing the first Integrated Committee Chairs report comprising of a joint summary of the 4 Group Board Committees Group Quality Committee (QC), Group Finance and Productivity (GFPC), Partnerships & Transformation Committee (PATC) and the Group People Committee (GPC).
	Mr Dunn highlighted the common areas of alert across GQC, PATC, GFPC, GPC with the first being the Use of Resources – Cost Improvement Planning (CIP). Mr Stringer advised that the challenge of the Use of Resources report was the underpinning of the CIP and the nature and size of risk involved. He reported that the Executive Team would present a mitigated plan to the Group Trust Board in September 25 and GFPC to ensure oversight of options.
	Mr Dunn advised that the workforce plan and the communications plan were also a common area of alert. He said that the unaffected workforce required clearer communication and reassurance. Ms Chadwick-Bell advised that communications had been sent out to colleagues who would not be affected by changes. She said RWT and WHT needed to work together to engage the workforce during the restructure process.
	Mr Dunn said plans for the move into Community was raised as a common theme across the Committees of the Board with concerns regarding transition plans which were still in the development stage and requested more visibility of detailed plans as hospital savings were underpinned by investment into community-based care. Ms Cartwright advised that PATC had asked for a detailed report on the services that would be invested

into at the next PATC meeting. Ms Nuttall reported that an investment case had been approved through the new structures allowing for transfer of additional resource into the community.

Mr Dunn advised that RWT remained in Tier 1 intervention for Referral to Treat (RTT) performance. He said that resource optimisation was also discussed at all Sub Committees of the Board and that both Trusts needed to ensure greater cross group working. Ms Nuttall advised that there was mutual aid already underway across RWT and WHT to resolve the challenges within surgical specialities.

Mr Dunn referred to the ICB Risk Share Agreement and said that RWT and WHT needed to develop mitigation strategies if the ICB Risk Share Agreement was enacted. Mr Stringer reported that the Group Trust Board held in Private had approved the signing of the ICB Risk Share Agreement and would closely monitor that the proposed mitigation actions were taking place.

Mr Dunn confirmed that each of the common area of alert discussed as above had been linked with the relevant Board Assurance Framework (BAF) risk.

Prof Toner reported for record that GQC had noted how RWT and WHT were working towards achieving the required funded establishment for Clinical Negligence Scheme for Trusts (CNST) Safety Action 5 safe staffing.
Resolved: that the Integrated Committee Chairs Report - Quality, Finance & Productivity, Transformation and Partnerships and People be received for information and assurance.

083/25	**RWT and WHT Audit Committee Chair Reports**
	Ms Jones reported on RWT's internal audit for 2024/25, and advised that this had concluded with auditors issuing a positive audit opinion. She advised that the RWT Internal Audit Grip and Control Action Plan had indicated that improvements were required on how grip and control actions were documented and evidenced. She said assurances had been received and new procedures were in place. She that the RWT Cyber Risk Assessment internal audit had offered minimal assurance and that following completion of the report assurances had been received that recommendations were to be addressed in a timely manner and significant risks had been mitigated.

Ms Martin reported on WHT's Audit Committee and advised that the External Auditors had reported a clean opinion on the WHT 2024/25 financial statements. She reported that the WHT Audit Committee would continue to ask Executive Leads for all high or medium internal audit recommendations to attend Audit Committee meetings to set out implementation plans, revised timelines and risk mitigations.
Resolved: that the RWT and WHT Audit Committee Chair Reports be received for information and assurance.

084/25	**WHT Audit Committee Terms of Reference (ToR)**
	Ms Martin reported that the WHT Audit Committee (AC) ToR had been reviewed by the Audit Committee and comments and changes had been received and approved at their May 25 Committee. She said the ToR had been reviewed against the new Code of Governance for NHS Providers.
Resolved: that the WHT Audit Committee Terms of Reference be received and APPROVED.

085/25	**Group Finance & Productivity Committee Terms of Reference (ToR)**
	Mr Dunn requested approval of the Group Finance & Productivity Committee (GFPC) Terms of Reference (ToR) that had been revised to include 3 BAF Risks.

Ms Chadwick-Bell advised that the word 'Productivity' had been omitted from the TOR. Mr Dunn advised he would get that corrected. She reported that the use of resources and cost efficiency programme had been implied but not noted specifically within the ToR. Mr Dunn confirmed that he would take forward the required amendments to the ToR.

Sir David advised that the Group Trust Board approved the GFPC ToR subject to the amendments being made.
Resolved: that the Group Finance & Productivity Committee Terms of Reference be received and APPROVED subject to further amendment. |

086/25	**Group Board Assurance Framework**
	Mr Wilshere reported that following an internal review the Board Assurance Framework (BAF) for the Group Trust Board and individual Trusts RWT and WHT had been redesigned and refreshed as per internal audit management actions. He said risk appetites had been debated and agreed at a previous Group Board Development Session with pictorial summary of the Group BAF risks at the end of Q1 2025/26 alongside a

		summary of the risk appetite statements and risk tolerance levels at the Group Trust Board. **Resolved: that the Group Board Assurance Framework be received for information and assurance.**
087/25	**NHSE Maternity and Neonatal Care**	
	Ms Hickman reported that all Trusts had been formally advised in June 25 that an independent task force would be undertaking a targeted review of up to 10 Trusts where specific issues had been identified within maternity and neonatal services. She said no further information had been received since receipt of the letter or which 10 Trusts would be included within the review. She said that a System-wide call had been held which confirmed that the review would be a targeted approach with focus on leadership, experience, behaviour and listening to women. Ms Hickman reported that detailed reports for maternity and neonatal care were received and discussed at the monthly Goup Quality Committee meetings and that these captured any maternity and neonatal service updates and escalations. She reported that the Maternity and Neonatal Voice Partnership was commissioned at system level and had experienced reduced commissioning. She said RWT and WHT were reviewing the potential impacts of the reduction. **Resolved: that the NHSE Maternity and Neonatal Care report be received for information and assurance.**	
Strategy (Section Heading)		
088/25	**Summary of 10 Year Plan and Implications on Group**	
	Mr Evans reported that the 3 radical shifts to reform the NHS within the Government's NHS 10-year Plan were Hospital to Community, Analogue to Digital and Sickness to Prevention. He advised that the development of Neighbourhood Health Services to support Hospital to Community, was the solution to providing single coordinated patient-oriented services. He said plans were being developed to transform the NHS App to allow patients to book appointments, communicate with professionals, receive advice and view their care plan. Mr Evans reported that for Analogue to Digital, the NHS would look to establish single patient records to enable coordinated, personalised and predictive care. He said the Plan would look to introduce a single sign on for staff to alleviate numerous logins to different systems. Mr Evans said that the West Midlands was amongst the poorest regions nationally and that the Government's ambition for Sickness to Prevention was to allocate increased resources to the areas of greatest deprivation to make a committed difference to healthy life expectancy and change healthcare provision for those most in need. Mr Evans reported that the 5 enabling measures underpinning the Plan were a new Operating Model, a new transparency of quality of care, an NHS workforce fit for the future, powering transformation and productivity and a new financial foundation. He advised that as part of the new Operating Model, the Integrated Care Boards (ICB) would be merged and Commissiong Support Units (CSU) would be abolished. He reported that the NHS Foundation Trust (FT) model would also be revised with the ambition that every NHS provider would become a FT with freedom to retain surpluses and reinvest. He advised that RWT and WHT would continue to further explore opportunities and potential benefits surrounding Foundation Trust status. Mr Evans reported that the Government planned to make the NHS the most transparent healthcare system in the world and would introduce the publication of easy-to-understand league tables that would rank providers against key quality indicators. He said this would allow the public to view how healthcare was being delivered locally. He said the NHS would be moving away from the aspirations that had been set out in the 2023 Long Term Workforce Plan, to a goal of fewer staff who are better treated, more motivated and have better training. He said NHS recruitment would move away from its dependency on international recruitment and focus on local recruitment. Mr Evans reported that five transformative technologies had been identified to personalise care, improve outcomes, increase productivity and boost economic growth. He noted these as data, AI, genomics, wearables and robotics. Mr Evans advised that the Plan outlined the intention to restore financial discipline for a new financial foundation and deliver reform. He said action would be taken to deconstruct block contracts and distribute NHS funding more equally locally. Mr Evans reported that the digital work would underpin the whole of the 10-year Plan and its enablers and that the Group would need to make sure they had a clear digital roadmap that outlined the future direction	

required and why. He said that more effort was required behind understanding their priorities with a clear governance structure to enable improvements to begin.

Mr Evans advised that RWT and WHT were continuing the movement to shift from hospital into community care, the right services within the community and educating patients on this shift. He said that the Trusts need to ensure they have a strategic approach for digital transformation so that they were not trialling several different pieces of equipment for robotics and AI and that this approach should be aligned across the Black Country. He said partnership working with a digital partner would be beneficial for the Trusts.

Sir David asked what order the changes would be expected to be implemented and queried any confirmation on the tariffs. Mr Evans reported that the Operating Plan had been committed to being implemented from October 25 with a view to identifying the first lines of the 3-year financial settlement which would allow RWT and WHT to enable planning. He advised that confirmation on the tariffs had not yet been received.

Ms Martin said she welcomed the focus on digital within the 10-year Plan and asked how the NHS would help Trusts to achieve digital transformation within the current financial constraints.

Mr Evans reported that the NHS app and single log in would be undertaken as a national piece of work. He said the Dudley Group Foundation Trust had led a piece of work on ambient voice technology and were supporting the centre on creating the standards and benchmarks for suppliers for ambient voice technology.

Ms Barber asked for further assurance regarding RWT and WHT approaches to leading the digital transformation and sickness to prevention work. She said the 2 elements required more in-depth conversations at future Group Trust Board meetings. Mr Evans advised that a new Oversight Committee was being formed which would oversee the transformation work from analogue to digital which would also incorporate transformation around estate and using the technology that is already in place and that this Committee would report to the Board for assurance. He reported that a new Electronic Patient Record (EPR) system had been implemented that would allow further opportunity without requiring new technology.

Ms Chadwick-Bell said that the Board needed to agree which Committees would be required to be Sub Committees of the Board. She said the digital transformation would need to be aligned with their own Group transformation plan too and that the Information Officers across the Trusts were meeting to pull this together. She said the Group Board would require a clear road map for the future that would allow delivery tracking of the actions required.

Dr Din said that RWT and WHT's unique selling point was the system being integrated into community as not all Trusts had this benefit.

Dr Mckaig advised that RWT and WHT needed to be aligned on how health and population data was interpreted to allow identification of where resources were required.
Resolved: that Summary of 10 Year Plan and Implications on Group be received for information and assurance.

<center>**The Board Convened for a 10-minute break at 14:00PM**</center>

089/25	**Black Country Provider Collaborative System Transformation Update and Formal Report from the Joint Provider Committee**
	Mr Dunn reported that the Black Country Provider Collaborative (BCPC) had met on 16 May 25 to discuss a progress update from the BCPC Chief Executive Officer (CEO) lead highlighting the progress within the key clinical networks, the National visit from the Getting It Right First Time (GiRFT) team and a detailed trajectory of the deliverables for the agreed clinical services transformation work. Mr Dunn advised that the external capacity support for partner Trusts to enable faster productivity had been stood down pending review by the CEOs on possible next steps. Mr Dunn reported that there had been a progress update received on the corporate services transformation work that had highlighted the repositioned programme of work that had considered the recent national corporate services cost reduction targets for each partner Trust. Ms Chadwick-Bell said it was helpful for the Board to receive this update and to understand clinical

	improvement so that they could align these back to their own clinical pathways. **Resolved: that the Black Country Provider Collaborative System Transformation Update and Formal Report from the Joint Provider Committee be received for discussion, information and assurance.**
090/25	**Group Chief Community and Partnerships Officer Report on Place Development for One Wolverhampton and Walsall Together**
	Ms Cartwright reported that OneWolverhampton and Walsall Together were 2 well established place partnerships with ambition and infrastructure already existing that would help enable delivery of the 10-year plan and maximise intended benefits. Ms Cartwright advised that it was essential that place-based health and care partners worked to develop appropriate governance structures to prepare for potential additional responsibilities. Ms Cartwright advised that Walsall Together had a longstanding governance arrangement in place and was a subcommittee of the Group Trust Board and explained Walsall's ambition to be successful through the pioneer application programme. She said that Walsall Together was the right organisation to host accountable arrangements moving forward. Ms Cartwright reported that OneWolverhampton had developed excellent services and had won awards for joint and integrated working on the winter plan. She said OneWolverhampton also had a strong will to be successful in the pioneer application programme. Sir David asked if the Group Trust Board would review the submission applications and identify which would be successful or if it would be delegated to the ICB. Ms Cartwright explained that it is not the sole decision of the Trust as to whether to submit an application, it is the decision of the place based partnership of which the Trusts are one partner. Mrs Cartwright advised that the ICB would review applications and would make the decisions on which the ICB would put forward for submission. Ms Cartwright advised that the Trust CEO is one of the signatures to the application form. Ms Chadwick-Bell asked that the Group Trust Board review Walsall Together and OneWolverhampton applications and provide a recommendation on which would be the strongest application to succeed. **ACTION: Group Trust Board to review Walsall Together and OneWolverhampton Pioneer Applications and recommend which is the strongest and likely to succeed** Sir David said that an upcoming test of the effectiveness of collaborative working would be RWT and WHT Winter Plans. Ms Chadwick-Bell advised that the Winter Plans would need to be submitted by October 25. She said it had been clear that Trusts needed to develop their own elements of the plans and ICBs were required to pull together the system plan. Sir David asked which Sub Committee of the Board would oversee the plan and provide assurance through to Group Trust Board. Mr Dunn advised that the winter plan had been reviewed through the Group Finance & Productivity Committee in the past. Ms Nuttall reported that the timetable for submission would allow for the winter plan to proceed through OneWolverhampton and Walsall Together before final submission. **ACTION: Sir David asked that Executive Directors confirm which Sub-committee the winter plan would be delegated to for final sign off.** **Resolved: that the Group Chief Community and Partnerships Officer Report on Place Development for One Wolverhampton and Walsall Together be received for discussion, information and assurance.**
091/25	**Health Inequalities Report – Dr Warren in attendance**
	Ms Cartwright welcomed Dr Warren, Consultant in Public Health for RWT and the City of Wolverhampton Council and reported that following approval of the Joint Health Inequalities Strategy 2024-27, a Joint Health Inequalities Steering Group had been established to provide oversight for RWT and WHT. She said there would be 5 themed meetings per year that aligned to the key domains within the delivery plan and that the report would be presented to Group Trust Board three times per year. Ms Cartwright advised that RWT and WHT needed to review metrics that were used to identify health inequalities that were happening across RWT and WHT. Dr Warren advised that the concept of disseminated leadership would be a priority topic for the Joint Health Inequalities Steering Group and ensuring that any

	items that were signed off by Group Trust Board or Group Committees inequalities and potential impacts were considered across all areas of inequality within RWT and WHT.

Dr Warren asked that the Group Trust Board complete the NHS Providers Board self-assessment tool for health inequalities. She said this would allow better assurance of how RWT and WHT were tackling any inequalities through work streams and making this business as usual across all directorates and workstreams.

Dr Warren asked that Group Trust Board members consider which future reports they would like to see inequalities information reflected in.

Ms Chadwick-Bell said the report would need to be broken down into various categories including ethnicity and a whole range of other categories but also considering safety, outcomes, experience, better access and prevention. She said that the Board would not be looking towards an action plan but key performance indicators and asking how they would have the assurance that improvement was being made. She said she would be happy to work with Dr Warren to identify reports that were missing inequalities data and that further discussions around the governance could be discussed outside of the meeting.

Ms Cowley asked how systems were not further creating systemic inequalities. Dr Warren reported that deprivation and socially excluded groups needed to be considered alongside Equality Act characteristics that aligned with Equality Impact Assessments.

Prof Toner reported that Health Inequalities reports were presented at Group Quality Committee for assurance across RWT and WHT and they could see where change was already happening. She said however they need more people to analyse the data. Dr Warren agreed and said this was dependent on having the right infrastructures in place.

Sir David advised that Health Inequalities would be an area of continued focus for the Group Board. He said staff needed to feel enabled to tackle different areas of health inequalities throughout their daily practice and not be presented with overcomplicated action plans that would not inspire them to make changes. He asked if maternity services are included within the Health Inequalities priorities. Dr Warren confirmed that maternity services was one of the high impact areas that had been identified.

Dr Warren advised of the Equity Assessment Tool that could be used as a framework to help people think through decisions.

Sir David thanked Dr Warren for her report.
Dr Warren left the meeting.
Resolved: that the Health Inequalities Report be received for information and assurance. |
| | **Trust Integrated Quality & Performance Reports (Section Heading)** |
| 092/25 | **Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity** |
| | Ms Chadwick-Bell advised that the Integrated Performance Reports for WHT and RWT were the result of feedback to ensure reports sent through to Committees of the Board were presented to Group Trust Board in an integrated way.

Mr Roberts reported that WHT had delivered a financial position ahead of plan at Month 2 and would continue to focus on the 2025/26 budget and use of resources plan. He said WHT had successfully closed 51 beds with the ambition to close 21 further beds and there had been no significant risks identified because of the closures.

Mr Roberts reported on the formal outcome of the Care Quality Commission (CQC) inspection of critical care services at WHT. He said WHT had received an overall rating of requires improvement and an improvement plan was in place to address the areas identified.

Mr Roberts reported that WHT performance against constitutional standards remained strong with WHT ranking within the national upper quartile for Urgent and Emergency Care, Elective Care and Cancer. He said focus would be given to making improvements in diagnostic access with a focus on Ultrasound, Cardiac Physiology and Audiology with the Audiology waiting list being reduced completely by the end of 2025. |

Ms Carroll advised that the Falls rate had increased to 3.64 per 1,000 bed days in May 25 but remained within the expected variation. She reported that there had been 2 severe harm incidents reported in May 25 and these were under Patient Safety Incident Response Framework (PSIRF) investigation and the findings would be presented to Group Quality Committee.

Ms Carroll advised that there were 2 Coroner's cases under review which related to a misdiagnosed post-surgical wound and one rapid deterioration from red skin to necrotic ulcer post fall.

Ms Carroll reported that WHT *C-Difficile* threshold for cases reported for 2025 was 65 and this had reduced from the 2024/25 financial year. She said 5 *C-Difficile* cases had been reported for May 25 and this brought the total for 2025/26 to 9 cases. She advised that there would be a system wide peer review initiative led by the regional Infection Prevention and Control (IPC) lead to identify and address contributing factors that led to all 4 Acute Trusts within the Black Country being identified as outliers for *C-Difficile* cases in 2024/25. She said WHT had been working through plans across the system and had seen reduction in rates.

Ms Carroll reported that the perinatal mortality rate was 3.42 per 1,000 births and this had shown sustained improvement throughout 2025.

Ms Carroll advised that Maternity Leave had reduced to 14 whole time equivalents from 19. She said WHT would continue to monitor compliance and staffing impact through Local Maternity and Neonatal System (LMNS) reporting.

Ms Carroll reported that the current midwife-to-birth ratio was 25.5:1 which was below the national benchmark set by Birthrate Plus at 28:1.

Ms Carroll advised that 35 patients spent over 24 hours in the Emergency Department in May 25. She said there was a notable deterioration in performance that had indicated system-level strain in completing timely mental health assessments. Ms Carroll reported that WHT mental health team were working in collaboration with external providers to improve care pathways and share themes and incidents. She said access to mental health provision was on the Corporate Risk Register and a report was being prepared for Ms Chadwick-Bell to escalate.

Ms Martin queried the Trust's agreement for Responsible Clinician (RC) support within the Trust. Ms Carroll reported that RC support was in place and would enhance WHT legal capacity to detain under the Mental Health Act (MHA).

Dr Din advised that Venous Thromboembolism (VTE) compliance had decreased to just over 88% in May 25 but remained below the national target. He reported that WHT had consistently achieved 100% on elective pathways and focus remained on non-elective areas.

Dr Din reported that the Summary Hospital-level Mortality Indicator (SHMI) data for January 25 had been recorded at 0.95 and was a continued improvement from 0.96 in October 24. He said the Learning from Deaths process continued to be embedded with the Mortality Surveillance Group reviewing structured judgement reviews. Dr Din advised that focus remained on thematic learning and reducing avoidable deaths.

Mr Duffell advised that the workforce reduction achieved in Month 2 compared to Month 1 was -22.8 whole time equivalents (WTE) and was better than NHS England (NHSE) plan.

Mr Duffell reported that updated nursing and midwifery job profiles had been released and would ensure profiles aligned with current practice. He said the Chief Nursing Officer (CNO) team were reviewing band 4 and 5 roles following the changes.

Ms Martin asked if WHT or RWT had anticipated any financial pressures following review of band 4 and 5 roles. Ms Hickman reported that initial analysis had not identified any pressures but work was continuing and no guarantee could be offered.

Mr Duffell advised that a system-wide Mutually Agreed Resignation Scheme (MARS) had been agreed by the Group Trust Board and made available to other system providers. He reported that the healthcare support worker band 2 and band 3 job descriptions and banding review process had been completed and accepted by staff. He said assimilation and back pay for those affected would take place in July 25.

	Mr Duffell advised that Group People Committee continued to review sickness absence and appraisal rates to ensure alignment to the agreed targets. Mr Stringer reported that WHT was £2.4M ahead of plan year-to-date. He said Elective Recovery Fund (ERF) was down by £169K but the month 3 position had pulled this back. He advised that the cost improvement plan (CIP) was £8M ahead of plan. **Resolved: that the Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity be received for information and assurance.**
093/25	**Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality, People, Access Standards, Finance and Productivity**
	Ms Nuttall advised that Referral to Treat (RTT) remained a key area of focus for 2025/26 due to RWT being in tier 1 for recovery. She said this had impacted segmentation but assured the Board that progress had been made against the trajectory that had been set, and this had been signed off nationally and regionally. Ms Nuttall reported that RWT were 2.1% ahead of the improvement plan for RTT. Ms Nuttall reported that waiting lists had seen significant reductions following a validation process by an external team who had been employed and funded externally nationally for validation. She said that RWT waiting lists were below 80,000 but challenge remained within the surgical specialities. Ms Nuttall advised that there had been an increase in the number of patients waiting over 52 weeks within surgical specialities and actions plans were in place to address the increase. Ms Nuttall advised that a business case for insourcing had been approved, and significant improvements were expected to be identified across surgical specialities as a result. Ms Hickman reported that Group Quality Committee continued to discuss and explore all activity and actions regarding quality issues and nurse sensitive indicators. She said RWT continued to work collaboratively with WHT. She advised that RWT had seen a reduction in the excessive wait times in the Emergency Department (ED) with patients waiting less than 12 hours. Ms Hickman reported that a multimodal piece of work was underway titled Eat, Drink, Dress Move to Improve (EDDMI) and covered a wide range of activity and a reduction in pressure ulcers had been identified as result. Ms Hickman advised that there had been reduction in *C-Difficile* cases reported for the 3rd consecutive month. She said cleaning through the patient equipment cleaning centre and of ward environments had seen high levels of activity maintained. Ms Hickman reported that RWT and WHT had completed the pilot for the 27-week pathway peer review through the Maternity and Neonatal Partnership Board. Dr Mckaig advised that RWT's Summary Hospital Level Mortality Indicator (SHMI) was 0.98 and was within the expected range. He said stroke SHMI was no longer an outlier. He said RWT were proactively managing the Learning from Deaths agenda overseen by the Mortality Review Group with action plans in place regarding pneumonia and acute myocardial infarction. Dr Mckaig reported that sepsis inpatient pick up had deteriorated and there had been a change in reporting methodology following the introduction of Sepsis Inpatient Dashboard in February 25. He said the dashboard incorporated a daily report to ward managers detailing all sepsis triggers and missed opportunities. Dr McKaig advised that action plans were in place to manage planned industrial action across RWT. Mr Duffell reported that RWT were showing better than NHSE plan at Month 2. He said there needed to be greater focus on sickness absence across RWT. Mr Duffell advised that there would continue to be fluctuation throughout 2025/26 with regard to vacancy rates as staff left RWT leaving a gap within budget establishment. Mr Stringer reported that RWT remained on plan for May 25. He said income was lower than plan relating to Service Level Agreements (SLA) and was offset by expenditure underspends and efficiency overachievement. He advised that ERF performance was £157K above initial plan year to date.

	Mr Stringer reported that in Month 2 RWT had overachieved against the CIP target of £2.87M by £0.7M. **Resolved: that Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality, People, Access Standards, Finance and Productivity be received for information and assurance.**
094/25	**WHT Skill Mix Reviews - Medical Day Case, Theatres and Emergency Department**
	Ms Carroll advised on 3 skill mix reviews for Board approval which included Nursing Workforce Review, Theatre Establishment Review and Medical Day Case Unit. She said all 3 skill mix reviews had been reviewed by Group Quality Committee. She reported that the skill mix and establishment reviews incorporated the Safe Nursing Care Tool (SNCT) data from Marchs and May 25 and that the reviews assessed current staffing against patient demand and acuity using national and local benchmarks. Ms Carroll reported that no change was necessary to staffing in theatres following the review. **Resolved: that the WHT Skill Mix Reviews - Medical Day Case, Theatres and Emergency Department be received and APPROVED.**
095/25	**RWT & WHT Charitable Funds Committee - Chair's Report**
	Resolved: that the RWT & WHT Charitable Funds Committee - Chair's Report be received for information and assurance.
096/25	**Questions Received from the Public**
	Sir David advised that the Group Trust Board had received questions from Dr Tinsa, Member of the Public. Dr McKaig advised that the first question raised had been how many excessive deaths there had been in the Stroke Unit in June 2025, May 2025, April 2025, March 2025, February 2025, January 2025. He reported that excess death data was derived from the SHMI for diagnostic group acute cerebrovascular disease and not the stoke unit. He said the numbers were published nationally and retrospectively over a 12-month period (November 23 – June 25). Dr Mckaig advised that RWT had identified a reducing trend in excess deaths from March 24 to February 25. He said expected deaths for March 24-February 25 had been 189 and observed number of deaths had been 196. Dr McKaig replied to the 2nd question "When is the RCP report on the excessive deaths in the stroke unit likely to be released" and advised that it was due to be delivered in January / February 2025 and then in April / May 2025. What is the reason for the delay? In reference to the Royal College of Physicians (RCP) report, Dr McKaig advised that this had been received in draft and comments regarding factual accuracy had been returned on 10 July 25. He said RWT were awaiting the final report to publish to the public. Dr McKaig responded to the question "When is the RCP and National Stroke Team going to meet the Group Quality Committee? It is stated that they will be meeting in July, do you have the date yet?" and advised that the RWT stroke team were attending Group Quality Committee on 30 July 25 to present an action plan and progress following the initial RCP visit and receipt of the letter following the RCP visit in November 24. He said the RCP team and National Stroke Team would not attend Group Quality Committee as this would not be the way an external body would interact with RWT. **Resolved: that Questions from the public be received for information.**
097/25	**Any Other Business**
	Sir David advised that Mr Roberts would be leaving the Trust in August and congratulated him on his new role in the United States of America. He thanked him for all his hard work and dedication during his role as Chief Operating Officer at WHT. Sir David advised that Mr Wilshere would be leaving RWT and WHT and thanked him for his long service as Group Company Secretary and for his commitment to the Group Board. **Resolved: that Any Other Business be received for information.**
098/25	**Date and Time of Next Meeting – Tuesday 16th September 2025 @10AM – Venue to be confirmed**
	Sir David confirmed the date and time of the next meeting as Tuesday 16 September 2025, 10:00AM.

Enc 4.1 Public/Sept/25 Group Board Action List

Agenda item		Assigned to	Deadline	Status
RWT/WHT Group Trust Board Meeting - to be held in Public 15/07/2025 8.3 Group Chief Community and Partnerships Officer Report on Place Development for One Wolverhampton and Walsall Together				
2838.	ACTION: Group Trust Board to review Walsall Together and OneWolverhampton Pioneer Applications and recommend which is the strongest and likely to succeed.	● Cartwright, Stephanie ● Chadwick-Bell , Joe	16/09/2025	🟩 Completed
	Explanation action item Sir David asked if the Group Trust Board would review the submission applications and identify which would be successful or if it would be delegated to the ICB. Ms Cartwright explained that it is not the sole decision of the Trust as to whether to submit an application, it is the decision of the place based partnership of which the Trusts are one partner. Mrs Cartwright advised that the ICB would review applications and would make the decisions on which the ICB would put forward for submission. Ms Cartwright advised that the Trust CEO is one of the signatures to the application form. Ms Chadwick-Bell asked that the Group Trust Board review Walsall Together and OneWolverhampton applications and provide a recommendation on which would be the strongest application to succeed. UPDATE: 03/09/25 Ms Cartwright advised all Place partnerships in the Black Country submitted an application that was supported by NHS Trust CEOs, Local Authority CEOs, the ICB CEO, the Combined Authority Mayor, PCN Clinical Directors and voluntary sector representation.			

2837.	ACTION: Sir David asked that Executive Directors confirm which Sub-committee the winter plan would be delegated to for final sign off.	🟡 Carroll, Lisa 🟡 Din, Zia Dr 🟡 Hickman, Debra 🟢 McKaig, Brian Dr 🟡 Nuttall, Gwen 🟡 Stringer, Kevin	16/09/2025	🟩 Completed
	Explanation action item Sir David said that an upcoming test of the effectiveness of collaborative working would be RWT and WHT Winter Plans. Ms Chadwick-Bell advised that the Winter Plans would need to be submitted by October 25. She said it had been clear that Trusts needed to develop their own elements of the plans and ICBs were required to pull together the system plan. Sir David asked which Sub Committee of the Board would oversee the plan and provide assurance through to Group Trust Board. Mr Dunn advised that the winter plan had been reviewed through the Group Finance & Productivity Committee in the past. Ms Nuttall reported that the timetable for submission would allow for the winter plan to proceed through OneWolverhampton and Walsall Together before final submission.			
	Explanation McKaig, Brian Dr Agree that this would be signed off through Group P&F			

![NHS]

Tier 1 - Paper ref:	PublicTB (09/25) Enclosure 6

Report title:	Group Chief Executive's Report
Sponsoring executive:	Joe Chadwick-Bell, Group Chief Executive
Report author:	Gayle Nightingale, Business Manager to the Group Chief Executive
Meeting title:	Group Trust Board
Date:	16 September 2025

1. Summary of key issue - Assure, Advise, Alert

Firstly, I would like to thank all pf our colleagues across Walsall and Wolverhampton in their continued commitment to the success of both trusts and their contributions to patient care and the health of our populations.

Staff culture engagement sessions
I wanted to reflect locally on the staff culture engagement sessions that took place during July and August 2025 and to say thank you to Board members who joined me on these insightful events. As part of the NHS People Promise which includes commitments to ensuring that staff have a voice that counts and to foster staff engagement, I decided to hold staff culture engagement sessions across both RWT and WHT and in an attempt to reach all groups of staff we also visited various community venues and other hospital sites

Now these sessions are concluded the feedback is being considered and themes identified so that we can agree some key themes which will help to take our organisations forward and ensure the culture supports the evolving strategy for the group. We will be planning to share the outputs with colleagues across the trusts in October and consider how we work with the key staff groups to put this into action.

Increasing staff involvement will be key to the success of both RWT and WHT. Staff need to feel included in decision-making so that they feel they have a sense of ownership. Visible senior leadership is a key element of sustained engagement and with the planned Non-executive Directors (NEDs), Executives, Group Chair and my own walkabouts allowing for regular open question and answer sessions I feel staff will feel listened to and with them sharing their suggestions for improvement of service provision planned changes can be worked on as a whole organisation. Another area of key focus will be the partnership working with staff-side, by building strong relationships with bodies such as trade unions and staff networks, we can identify where issues and concerns are with an overall aim of improving staffs working conditions, which leads to improved patient care.
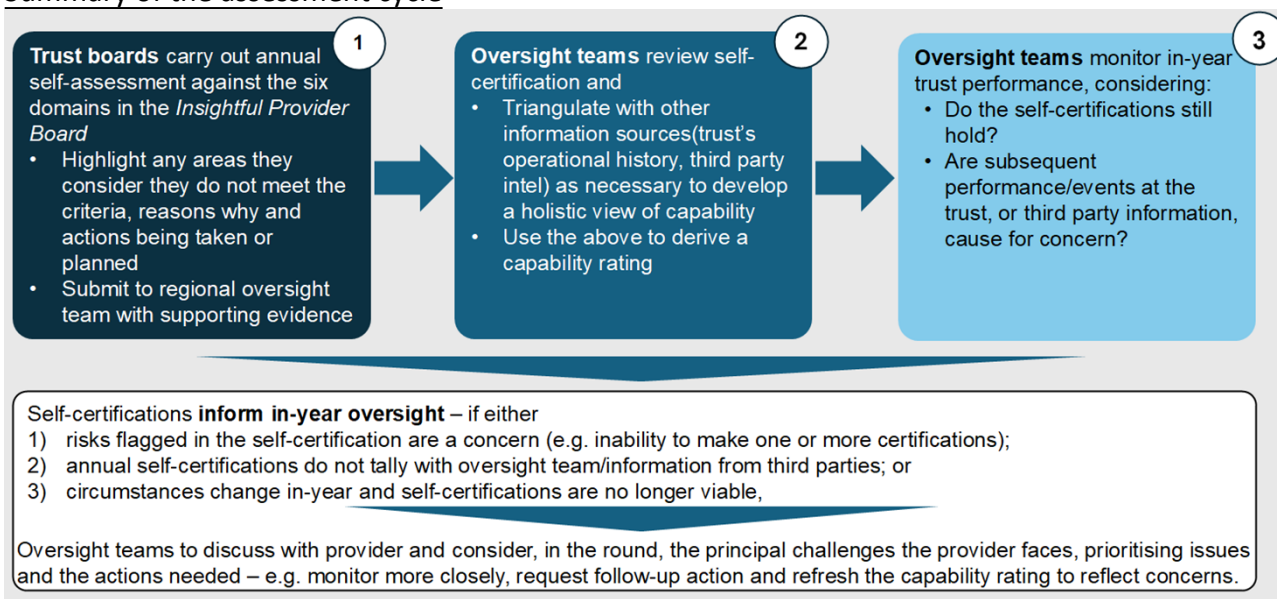
National updates
NHS England - Provider Capability approach
As part of the NHS Oversight and Assessment Framework (NOF), NHS England will assess NHS trusts capability, using this alongside providers' NOF segments to judge what actions or support are appropriate at each trust. As a key element of this, NHS boards will be asked to assess their organisation's capability against a range of expectations across six 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

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. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.

The purpose is to promote self-awareness and transparency at NHS trust boards regarding their organisation's capabilities, strengths, weaknesses and the challenges they face. It also provides a consistent framework for regional oversight teams to engage with NHS trusts, identify key risks and, over time, assess management's track record in delivering performance and/or identifying and addressing issues to ensure strong, sustainable organisations able to deal with challenges as they emerge. Trusts will have 8 weeks to carry out this self-assessment.

Summary of the assessment cycle

1 **Trust boards** carry out annual self-assessment against the six domains in the *Insightful Provider Board*
- Highlight any areas they consider they do not meet the criteria, reasons why and actions being taken or planned
- Submit to regional oversight team with supporting evidence

2 **Oversight teams** review self-certification and
- Triangulate with other information sources(trust's operational history, third party intel) as necessary to develop a holistic view of capability
- Use the above to derive a capability rating

3 **Oversight teams** monitor in-year trust performance, considering:
- Do the self-certifications still hold?
- Are subsequent performance/events at the trust, or third party information, cause for concern?

Self-certifications **inform in-year oversight** – if either
1) risks flagged in the self-certification are a concern (e.g. inability to make one or more certifications);
2) annual self-certifications do not tally with oversight team/information from third parties; or
3) circumstances change in-year and self-certifications are no longer viable,

Oversight teams to discuss with provider and consider, in the round, the principal challenges the provider faces, prioritising issues and the actions needed – e.g. monitor more closely, request follow-up action and refresh the capability rating to reflect concerns.

The above sets out the self-assessment process which will take a number of stages across the year.

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 including the rationale for the rating.

As stated at the Trust Board Development workshop on 2 September 2025 we plan to coordinate the process, with executives allocated to specific domains aligned to their portfolios. This will ensure the evidence presented is accurate and up to date, identifies any areas where assurance is weak or incomplete. The Group Management Committee will review the draft before presenting it to the Board Development session on 21 October. An engagement exercise will be conducted by the Board to test and shape the final self-assessment. The self-assessment must be submitted by 22nd October 2025.

National neighbourhood health implementation programme
The first wave of the national neighbourhood health implementation programme, which focuses on deprived areas to tackle health inequalities opened for applications from one or more of the Places in their geographical area. The programme aims to accelerate the work we are doing, or planning to do, by learning together, sharing solutions, tackling challenges, delivering improvement and adapting solutions. I am pleased to advise that we submitted a partnership application for both Walsall and Wolverhampton geographical Place areas, the announcement of who has been successful is still awaited.

Community Diagnostic Centres (CDCs)
As part of the national initiative to increase the number of diagnostic centres with extended opening hours, that are within convenient settings closer to people's homes, making care more accessible, I am pleased to advise that the Trust has approached NHS England (NHSE) for support to establish a Community Diagnostic Centre (CDC) serving Wolverhampton and Walsall populations. This follows extensive consultation with Walsall and Wolverhampton Councils.

Should this be successful, a comprehensive business case is likely to be needed by the end of the year in readiness for a capital bid in 2026/27. This development will support the existing CDCs in Cannock and Corbett (Dudley)

BMA Resident Doctor industrial action
Sir Jim Mackay wrote to the NHS leadership community to thank everyone for their hard work during the BMA resident doctor industrial action of 25 – 30 July 2025. He requested systems and Trusts try to maintain normal levels of booked activity and consider what is cancelled over the entirety of the cumulative period of disruption (both on days of action and days either side). I can advise the Board at RWT the Trust cancelled a total of 236 patient appointments - 109-day case/ inpatients and 127 outpatient appointments and at WHT 269 routine operations were cancelled, to note there had been no harm or serious patient events identified during this period.

Independent Review of Physician Associates (PAs) and Anaesthesia Associates (AAs) - the Leng Review
In autumn of 2024, in the light of an increasingly intense debate focused on PAs and AAs, Wes Streeting, the Secretary of State for Health and Social Care (DHSC) established an independent review to help inform a refreshed workforce plan. Perhaps most importantly, the review aimed to provide a period of engagement and reflection, and an opportunity to reset the debate and to enable all staff groups to accept the recommendations and work collaboratively.

The Leng Review, published on 16 July 2025, is an independent review of the physician associate (PA) and anaesthesia associate (AA) professions. Led by Professor Gillian Leng, the review responds to concerns raised around patient safety, role clarity and the expanding presence of these professionals in healthcare settings.

Following the publication of the Leung review I wanted to update the Board on its implementation at both WHT and RWT. The Leng review recommendations are far reaching and require cross-system partnership working to consider, plan and deliver these effectively. As a group we are aligning our approach to the guidance forthcoming from the Department of Health and Social Care, Royal Colleges, unions and other relevant organisations to implement the recommendations. NHS England's (NHSE) response letter of 16th July 2025, sought to provide guidance to employers on what implementing some of the key recommendations from the Leng Review would mean to ensure safe and effective management of PAs and AAs as part of multi-disciplinary teams. RWT and WHT are reviewing these in line with clinical guidance and protocols and our organisational policies, and consulting with local trade unions on how any changes can be applied, taking into account employment law and in line with clinical governance processes.

Newly qualified nurses and midwives
Further to Wes Streeting, Secretary of State for Health and Social Care's, announcement on 11 August 2025, that thousands of new jobs will be unlocked across the healthcare sector to make sure there are enough jobs for every newly qualified nurses and midwives in England. I wanted to reassure the Board that both Lisa Carroll and Debra Hickman – Chief Nursing Officers are and on a continued basis working with the local universities and Sally Roberts, Chief Nurse – Black Country Integrated Care Board (BCICB) in ensuring recruitment plans include newly qualified staff. Our focus has always been to include staff from within the local community for all levels of vacancies, with a view to both supporting our local communities and providing services to patients that meet their needs from locally qualified professionals.

Elective Care Capital Incentive Scheme: Returning to the RTT Standard
A new elective care capital incentive scheme has been launched by NHSE and aims to incentivise and reward providers who make significant improvements to their referral-to-treatment (RTT) position, while also ensuring continued progress is made towards reducing the waiting list, including long waits. The £40 million capital departmental expenditure limit (CDEL) uplift is being divided into 2 rounds of £20 million with the first round being allocated to providers in Q1J (April – June 2026/27) based on performance from April to September 2025. In the first funding round the scheme will reward the 10 most improved providers who make the greatest improvements towards meeting the RTT standards. To qualify, these providers must also be on track to deliver the waiting list reductions they committed to in their planning submissions, including specifically meeting their targets for reducing the number of patients waiting over 52 weeks for treatment.

Timeline and milestone

Phase	Activity	Date
Performance review	RTT performance is tracked monthly	April to September 2025

Launch	Scheme is announced	June 2025
Scheme design	Details confirmed on how the scheme will run and how the capital funding will be allocated	August 2025
First funding round	10 most improved providers identified	Quarter 3 2025/26
Funding allocated	Capital funds allocated to successful providers	April 2026 (unless agreed otherwise)
Evaluation and refinement	Early impact insights and scheme refined prior to H2 funding	Quarter 2 2026/27

NHS England will assess whether the capital allocated has successfully contributed to a national improvement in 18-week RTT performance. It will also explore the wider impact of the capital funding on elective reform. The impact of the scheme will be reviewed to allow further refinements of the criteria ahead of future funding rounds. I will provide an update of the outcome for RWT and WHT once the funding is allocated.

10 point plan to improve Resident Doctors working lives

As part of the 10 year plan for the NHS, the government set out a 10 point plan to improve the resident doctors working lives. The plan consists of the following 10 points:

1. Trusts should take action to improve the working environment and wellbeing of resident doctors
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating
7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours
8. Resident doctors should receive reimbursement of course related expenses as soon as possible
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate

Both the Chief Medical Officer and Chief People Officer are working through the plan to ensure practices are altered where necessary to meet and exceed these requirements which we currently are within areas. However, there is always room for improvement.

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

The reason for focussing on resident doctors is because they are different from other staff because they provide care whilst training in different parts of the NHS, which means they move employer regularly for several years. As NHS England note within this plan all NHS staff are important, and we will continue to support improvements in working conditions, retention, health and wellbeing and facilities through the 10 Year Health Plan and the forthcoming NHS Workforce Plan for all staff whichever area they work in.

However, the principles as laid out above should apply to all staff and linking to our culture conversations, getting the basics right is important no matter your role, seniority or professional background.

Actions to tackle sexual misconduct in the NHS
The Sexual Safety Charter was published by NHS England in September 2023 with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace. We as a Group Trust support NHS England in its commitment to supporting and challenging the system to ensure a sexually safe environment for our staff and patients. The Trusts along with all NHS Trusts received a letter from NHSE on 20 August 2025 which provides a refreshed sexual safety assurance framework. I would like to assure the board that policies and procedures for staff and patients will be reviewed and updated in line with the revised framework.

Regional update

NHS Birmingham, the Black Country and Solihull Integrated Care System (ICS)
I wanted to advise you that the Integrated Care System clusters have been agreed by NHS England's Executive team and Government Ministers with implementation scheduled during the NHS quarter 3 of 2025/26, the Black Country will now form the NHS Birmingham, the Black Country and Solihull Integrated Care System (ICS). While clustering ICBs will work together through shared leadership and combined teams, they will remain separate legal entities. CEO announcements are still awaited but I can advise that Danielle Oum, has been appointed as the Chair of the newly formed NHS Birmingham, the Black Country and Solihull Integrated Care Board (ICB) as from 1 September 2025. Danielle was the Chair for Walsall Healthcare NHS Trust from 2016 to 2021

Site visits across Walsall and Wolverhampton

Sureena Brackenridge MP – Wolverhampton North East
Myself and Sir David Nicholson KCB CBE had the pleasure of welcoming Sureena Brackenridge MP to visit RWT on 11 July 2025 following a briefing on initiatives being undertaken at the Trust we undertook a general walk around the site.

Valerie Vaz MP – Walsall South
Again myself and Sir David Nicholson KCB CBE had the pleasure of welcoming Valerie Vaz MP to Walsall Manor Hospital on 11 July 2025, on this occasion we shared an update on emergency pressures and the work underway on waiting lists to expedite patient operations and outpatient appointments.

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Mortuary visit – RWT

I undertook a site visit of the mortuary at RWT on 28 July 2025 as part of my yearly assurance exercise to ensure service provision for this group of patients meets well established guidelines.

I am pleased to report it does and it was such a pleasure to meet staff who care for this important group of patients, my sincerest of thanks. I plan to undertake the same exercise at Walsall on 6 November 2025.

Peter Kyle, Secretary of State - Digital and Richard Parker, West Midlands Mayor visit to RWT

I had the opportunity to welcome Peter Kyle, Secretary of State for Digital and Richard Parker – West Midland Mayor to RWT on 15 August 2025, to look at elements of our digital programme, this included a demonstration of the robot within theatres. Both Peter and Richard went away noting all the innovative work the Trusts were working on.

Local updates

Urgent and Emergency Care – Winter Plans 2025/26

To note these are an agenda item of the Board. However, I wanted to thank all departments for their support and hard work in producing both RWT and WHT winter plans to deliver services at what is an exceptional busy period for the NHS, both plans have received rigours testing and are both affordable and reflect service changes based on previous demand.

Undergraduate clinical teaching programme at RWT

As part of RWTs undergraduate teaching each year the Clinical Teaching Fellows (CTFs) from 10 academies submit work for the Dean's prize - the best four are shortlisted of which this year two were from New Cross and I am pleased to advise that they won 1st and 2nd prize - they showcased their work on Inter-professional Education (IPE) with the Clinical Team Physician Associates (CTPA), nursing and medical students.

Employer Recognition Scheme (Armed forces) reaccreditation gold award

I am delighted to report that on 14 July 2025 myself and Alan Duffell, Group Chief People Officer, signed the renewal covenant as our declaration to support the Armed Forces community with workforce opportunities upon leaving their employment with the Armed Forces. As part of our on-going commitment we have been awarded Gold status, which is the highest award possible in recognition of our efforts to support the Armed Forces. The Armed Forces Covenant is a commitment from the nation that those who serve or have served, and their families, are treated fairly and not disadvantaged in their day-to-day lives as a result of their military service. The government and indeed ourselves are committed to supporting the Armed Forces and by making this public pledge it shows how much we value the Armed Forces.

Work Experience Quality Standard Gold Award

I am very pleased to advise you that RWT has been awarded the Gold standard for work experience provision from NHS England (NHSE).   The award demonstrates how the work experience placements we offer are planned, delivered and evaluated by NHSE and following the evaluation stage an award is then granted as either bronze, silver or gold.

HSJ award

I am pleased to announce that OneWolverhampton Board (OneWolverhampton place-based partnership is a collaboration of health, social care, voluntary and community organisations, working together to improve the health and wellbeing of the people of Wolverhampton) which RWT is a member of has been shortlisted for an HSJ award in the 'Driving Efficiency through Technology category' for the Better Lives, Better Value: Wolverhampton's Technology Enabled Care Transformation programme.

The National Black and Minority Ethnic (B.A.M.E) Health and Care Awards 2025

I am delighted to announce that Chris Innerarity, Pharmacy Manager – RWT, has been shortlisted for a national BAME Health and Care award within the category 'Lifetime Achievement' the shortlisting panel stated 'your achievements have shone through a sea of outstanding entries, and we are excited to welcome you to our prestigious alumni community', the awards are due to be presented on 25 September 2025, my sincerest best wishes to Chris on a successful entry.

Physician Associate Quality Management visit to The Royal Wolverhampton NHS Trust

Further to the Leng review I referred to under national updates; locally we had a Physician Associate (PA) Quality Management visit at The Royal Wolverhampton NHS Trust on 30 July 2025, which was undertaken by Keele University. This visit reviewed the quality of the training programme for PAs ensuring it was fit for purpose with clear standards of training. A report has been received from Keele University and notes the Trust has a culture of supportive learning and teaching, they commended all the support provision as provided by the educational team along with the Head of the Undergraduate Academy. Importantly reflecting on the Leng review they stated the internal governance framework and Standard Operating Policies (SOPs) were excellent and the student feedback was that of feeling welcomed and supported.

RWT – reaccreditation of RACE Code

At both RWT and WHT we are committed to creating a workplace that is fair and inclusive. The aim of the Workforce Race Equality Standard (WRES) is to improve the experience of Black, Asian and minority ethnic (BAME) staff in the workplace. This can be achieved by taking positive action to eliminate discrimination, harassment and unfair treatment of BAME staff in the workplace; we the Trusts are fully committed to delivering on this important objective. I am pleased to advise that following a further national assessment RWT has been reaccredited for its work on promoting a positive culture for all current and future staff members, we know there's more work to be done and we will continue to strive to uphold and improve all recruitment processes and staff working practices to provide an inclusive working place for all members of staff.

Board matters

I am pleased to announce the appointment of Demetri Wade, Chief Operating Officer– WHT, due to commence in post during November 2025 and Kate Shaw, Chief Operating Officer – RWT who commenced in post 1 September 2025.

I would also like to note that Will Roberts, Chief Operating Officer – WHT left the Trust on 31 August 2025, wish him well in his new endeavour at Harvard University.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
Care	- Excel in the delivery Care	☒
Colleagues	- Support our Colleagues	☒
Collaboration	- Effective Collaboration	☒
Communities	- Improve the health and wellbeing of our Communities	☒

3. Previous consideration [at which meeting[s] has this paper/matter been previously discussed?]
Not applicable.

4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a)   Note the contents of the report.

5. Impact [indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]		
Group Assurance Framework Risk GBR01	☒	*Break even*
Group Assurance Framework Risk GBR02	☒	*Performance standards*
Group Assurance Framework Risk GBR03	☒	*Corporate transformation*
Group Assurance Framework Risk GBR04	☒	*Workforce transformation*
Group Assurance Framework Risk GBR05	☒	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

S

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

NHS

Tier 1 - Paper ref:	Enclosure 7 Public/Sept 25

Report title:	Group Assurance Report
Sponsoring executive:	Kevin Bostock on behalf of Joe Chadwick-Bell
Report author:	John Dunn, Paul Assinder – Deputy Chairs
Meeting title:	Group Trust Board - in Public
Date:	16/09/2025

1. Summary of key issues/Assure, Advise, Alert

The Board Committee Chairs Report comprises a joint summary of the 4 Board Committees
- Finance and Productivity Committee (F&PC)
- Quality Committee (QC)
- People Committee (PC)
- Partnerships & Transformation Committee (PaTC)

In addition, the Audit Committee Chairs' Reports and the Charities Chairs' Reports will continue to be provided separately. Where there are linkages in themes and issues (e.g. Internal Audit work impacting on the work of a Committee) then those linkages will be highlighted in the Report.

The attention of the Group Board is required to the Alert themes in Part 1 of the summary regarding
i. The Finance Plan, Efficiency Review and Recovery Plan
ii. Workforce Plan
iii. Regulation 28 Notice from Coroner's Office
iv. Enforcement under The Regulatory Reform (Fire Safety) Order 2005 – Kevin to give correct wording
v. Shortage of Turberculosis (TB) Medication
- Under Section 2.3, the Quality Committee, the Group Board is asked to note by minute, both RWT and WHT are on track to meet the requirements for achieving Clinical Negligence Scheme for Trusts (CNST) year 7 required by the Action.
- Approval of the RWT and WHT Biannual Skill Mix Review (SNCT data), under 2.3.

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

Care	- Excel in the delivery Care	☒
Colleagues	- Support our Colleagues	☒
Collaboration	- Effective Collaboration	☒
Communities	- Improve the health and wellbeing of our Communities	☒

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

All Board Committees.

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Walsall Healthcare NHS Trust

4. Recommendation(s)/Action(s)
The Group Board is asked to review, consider and discuss
a) The themes identified in the Alert Section 1.
b) The summary Board Committee reports in Sections 2.1-2.3
c) Seek any necessary action and/or evidence for assurance required.
d) Under Section 2.3, Quality Committee, the Group Board is asked to note by minute, both RWT and WHT are on track to meet the requirements for achieving CNST year 7 required by the Action.
e) The Board is asked to approve RWT and WHT Biannual Skill Mix Review (SNCT data), under Section 2.3

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Group Assurance Framework Risk GBR01	☒	*Break even*
Group Assurance Framework Risk GBR02	☒	*Performance standards*
Group Assurance Framework Risk GBR03	☒	*Corporate transformation*
Group Assurance Framework Risk GBR04	☒	*Workforce transformation*
Group Assurance Framework Risk GBR05	☒	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Joint Group Board Committee Chairs Report

Meetings in July and August 2025

Summary

The Board Committee Chairs Report will comprise a joint summary of the 4 Board Committees

- Finance and Productivity Committee (F&PC)
- Quality Committee (QC)
- People Committee (PC)
- Partnerships & Transformation Committee (PaTC)

In addition, the Audit Committee Chairs' Reports and the Charities Chairs' Reports will continue to be provided separately. Where there are linkages in themes and issues (e.g. Internal Audit work impacting on the work of a Committee) then those linkages will be highlighted in the Report.

Structure

The Report is structured as follows.

- Summary
- Part 1 – Summary of common themes under Assure, Advise and Alert.
- Part 1 – Alignment of themes with Board Assurance Framework (BAF) Risks
- Part 2 – 1. Assure, 2. Advise, 3. Alert by Committee, 2 months combined where appropriate.

1. Common themes under Assure, Advise and Alert

Assure – no matters for the Board's consideration at this time, other than to note 2.2 below.

Advise – no matters for the Board's consideration at this time, other than to note 2.3 below.

Alert			
Theme/Issue	Board Lead	Notes	BAF Reference
i. **Use of Resources – CIP Underpinning**	**John Dunn**	**Whilst the efficiency target is underpinned is still contains significant risk. This is receiving heavy engagement and further action is underway. The latest position was presented to an Extra-Ordinary F&P meeting on the 9 September 2025 whilst further work – a revised Plan to reach end of year financials was presented and further work is taking place on the delivery element**	**GBAF1**
ii. **Workforce Plan & Communications**	**Dawn Brathwaite**	**The Workforce Plan is an integral part of the use of resources and Annual Operating Plan. There are ongoing concerns about the communications of the plan and the wider communications to the full workforce.**	**GBAF3, GBAF4**
iii. **Plans for the move into Community & Timing**	**Lisa Cowley**	**Hospital savings are underpinned by investment in a greater reliance on community-based care. We are concerned that plans for transitions are still in development.**	**GBAF4, GBAF5**
iv. **Enforcement under The Regulatory Reform (Fire Safety) Order 2005 at The Royal Wolverhampton**	**Louise Toner**	**The Royal Wolverhampton is improving fire safety to comply with enforcement at Cannock Chase Hospital and New Cross Hospital Maternity and Neonates Block and Nucleus Theatres.**	**Not currently linked to a BAF risk**

2.1 Alert - matters of concern for escalation

Finance & Productivity Committee	Quality Committee

Finance & Productivity Committee

Performance
- WHT Type 1 ED attendances 3.89% up YTD on last year.
- WHT DM01 performance was 73.42%. Challenged modalities:
  - Audiology
  - NOUS
  - Cardiac Physiology.

Digital Update
- Trusts will have to replace all computers running window 10 by 14th October so that they can accommodate Windows 11. WHT is on track to meet the deadline for 98% completion. RWT have 1,500 devices to replace to achieve 93% completion. PCs that have software compatibility issues will require an extended Windows 10 support for each device, the costs will be passed back to those services and they will be asked to provide a replacement timeframe to be compliant.

Workforce
- WHT substantive figures are off plan. The Recruitment Team have been informed and are monitoring this to bring the Trust in line with plan.
- RWT bank and agency figures are off plan. Areas impacting on temporary staffing are staff sickness, increased acuity and ED.

Quality Committee

- There are enforcement notices in place at RWT under The Regulatory Reform (Fire Safety) Order 2005 in relation to Cannock Chase Hospital Theatres, New Cross Maternity and Neonatal Block Theatres and Nucleus Theatres. The dates for closure of the recommendations from these has been exceeded, regular dialogue with both Staffordshire and West Midlands Fire Services has taken place to keep them up to date on delayed progress.

- RWT received a Regulation 28 Prevention of Future Death Notice from the Coroner's Office following a patient death in December 2024 – this was related to a drug given to the patient when the patient was allergic, an action plan is under development and CQC has been informed.

- An unannounced visit by the Health and Safety Executive to the delivery suite at WHT took place. in relation to Entonox exposure levels to staff. No immediate actions were identified, and the Trust is awaiting the visit report. Entonox exposure level safety is in focus across both RWT and WHT maternity services and actions are in place to minimize the risk as far as reasonably practicable.

- A national patient safety alert was received by the trust regarding a shortage of TB medications. This is being explored further across both Trusts to enable any actions that can be put in place to preserve as much medication as possible.

2. Alert - matters of concern for escalation

People Committee	Partnerships & Transformation Committee
BMA conducting a ballot of FY1 Doctors re strike action. Outcome to be known in late September.	Community services digital infrastructure and systems remains an area of concern. The committee have proposed this is reviewed to assign committee oversight responsibilities.

2.2 Assure

Finance & Productivity Committee	Quality Committee
Performance - Continuing high level of performance across the board, slight deteriorations due to additional volumes at WHT - Continuing good performance in Ambulance handover, despite slight deterioration - WHT -good performance on cancer metrics and in first quartile nationally for 18-week performance - Cancer performance diagnostics have slightly declined at WHT in four modalities - RTT referral to treatment - WHT continues high level of performance RWT on track on recovery plan performance deescalated to Tier 2 - The BAF was received, and assurance received. **Finance** Month 4 Finance performance is strong and slightly ahead of plan full details in Group Finance Directors Report	15 births per month to be redirected from RWT to WHT which commenced 1 August 2025. Women from Walsall who chose to book at RWT would be triaged to determine appropriate place of birth. - Positive feedback had been received from Insight Visits which took place by Local Maternity and Neonatal System (LMNS) and Regional Chief Nurse at RWT and WHT. - The Urgent Community Response and Virtual Ward uptake was now achieving the required standard. - Following the successful roll out of Martha's Rule, a NHSE visit is scheduled to both RWT and WHT in early September. - A number of staff/teams have been shortlisted for awards, the Nurse Education Team with the Nursing Times and Sepsis, Quality and Digital with the Health Service Journal.

People Committee	Partnerships and Transformation Committee
Workforce metrics: Sickness absence and appraisal continue to be challenging at both Trusts. GPC took assurance from the following: - plans to improve appraisals on track - sickness absence reduction plan to come back to GPC - final 'notice of concerns' meetings planned for September - Joint sickness absence policy to be implemented by September Month 4 figures are off plan. WHT: substantive figures are behind target and RWT bank and agency are off plan. Both Trusts are not on track for the stretched target.	- Detailed discussions at both committee meetings regarding Community First Plan B proposals. Recommendations made to include detail on proposal development to provide assurance of effective committee governance and oversight. - BAF risk reviewed and scoring revised based on consistency assessment. - Paper provided documenting transition from Ward 14 closure to community services. This provided assurance of the model and viability of transition.

Partial assurance only. Assured that controls around bank and agency approvals are still in place. Request for assurance of the trajectories for the people targets and that the shift in people numbers were delivering the expected impact and within the projected timescale. Concern that timescales for financial year are getting away from us due to the implementation date for initiatives such as MARS & MoC.

BAF reviewed and assurance received.

2.3 Advise

Finance & Productivity Committee	Quality Committee
Major Actions Commissioned • WHT Draft Winter Plan to be reviewed at the Extra-ordinary Group Meeting on 2nd September. – check with Claire was this reviewed Decisions Made • Contract Award RWT: Downstream Access for 2nd Class Post (ETB) REAF 5009 Renewal: New Contract – Endorsed to Trust Board (following review of cover report). • Contract Award RWT: AHP/HSS Master Vendor Contract (ETB) REAF 5151 Renewal: New Contract – Endorsed to Trust Board (following review of cover report). • Contract Award RWT: Vehicle Hire (ETB) REAF 5179 Contract Start Date: 1/9/25 – Endorsed to Trust Board. • Business Case: Insourcing and Outsourcing in Challenged Surgical Specialties – Endorsed to Trust Board (following review of cover report). • BAF – GBR 1, 2 and 3 were reviewed and risk tolerances were reduced. • RWT Draft Winter Plan – Endorsed to Trust Board. • Community First proposal was supported by the Committee	• RWT is no longer in the Tiering system relating to meeting national cancer targets. Challenging pathways remain in terms of Urology, Renal, Prostate and Gynecological Cancers. Some mutual aid is available for Prostate Cancer. • RWT is in Tier 2 screening for its Referral to Treatment activity. However, the Trust is achieving the performance agreed to improve this situation. • WHT is meeting all the required cancer and RTT targets. • Both RWT and WHT are on track to meet the requirements for achieving Clinical Negligence Scheme for Trust (CNST) year 7. • The final report from CQC, following their visit to the Critical Care Unit was published in June. • There was a Human Tissue Authority reportable incident in July in relation to a post mortem sample unable to be processed by pathology services at RWT that has been dealt with as required and the associated learning shared with staff. • Both Trusts have completed their Biannual Skill Mix Review (SNCT data), these require Trust Board approval. There are no changes proposed to establishments, rather, staff movement across wards and departments as appropriate. A further review will be conducted in January 2026 for inpatient areas. The areas covered were: • RWT – all adult inpatient wards, three Acute Assessment Wards/Units, One Paediatric Inpatient ward/one paediatric Assessment Unit, Surgical theatres, ICCU, NNU and Children's Community. • WHT – Adult Inpatients, Acute Assessment Units, and Paediatric inpatients • The incidence of C Difficile is much improved on last years figures with cleaning regimes in place across both Trusts.

- It was confirmed that the decision by the ICB to no longer commission the Urgent Treatment Centre overnight remains. Provisions have been made within A&E.

- There was a sharp increase in Perinatal Mortality in July at WHT, having been in a stable position for the previous few months. Work is being undertaken to determine the reasons for this increase

People Committee	Partnerships & Transformation Committee
The Trusts are compliant with their obligations under the Equality Act 2010 and the Public Sector Equality Duty and the Workplace Race Equality Standards by publication of the following: - EDI Annual Report - PSED report - WRES & WDES reports - Gender Pay Gap Report WHT has been re-accredited under the Race Code. GPC noted the areas for further work and were assured by the planning sessions to be conducted in September to build on the action plans. An overview of the overarching plan will be presented to GPC in November.	Funding allocations for Place are still not resolved, the committee will monitor any impacts of partnership delivery and/or financial impact for the Group.

How to Interpret SPC (Statistical Process Control) charts

Variation			Assurance				
Common Cause	Concern	Improvement	Inconsistent	Achieving	Not Met	No Target	Not Enough Points
Common cause - no significant change	Special cause of concerning nature or higher pressure due to Higher or Lower values	Special cause of improving nature or higher pressure due to Higher or Lower values	Variation indicates inconsistently hitting passing and failing short of the target	Variation indicates consistently Passing the target	Variation indicates consistently Falling short of the target	No target has been set for this metric	There are not enough points to generate the Variation & Assurance information

The position of a target line in relation to the process limits will inform you if your indicator can hit a target or threshold consistently, by random chance, or not at all.

If your target line is in between the process limits be cautious about reacting to success (green) and failure (red) when natural variation may be causing the target to be passed or failed. Remember that approximately 99% of data points should fall within the process limits. These graphs will help guide your action:

Target (to be greater than)

System redesign required to hit target

Target (to be greater than)

Capable system should reliably hit target

Target (to be greater than)

System will not reliably hit target

Care Colleagues Collaboration Communities

Managing Director Summary

- The Trust has been de-escalated from Tier 1 (poorest performing) for achievement of referral to treatment (RTT) performance. The Trust remains in tier 2, regional escalation. The Trust is not in tiering for its cancer performance.

- As a result of improvements to performance during the last 12 months, the Trust has been placed in segment 3 (along with all other Black Country Trust) ranking 79 out of 134 providers.

- The go-live date for the replacement of the Trust patient administration system (PAS) to a new Electronic Patient Record (EPR) is scheduled for Mondy 29th September. The Trust, PAS, Theatre(s), Emergency Department and Community systems will all be replaced with System C Care Connect programme. This will align RWT core systems with WHT. This is a significant Trust IT update and it's phase 1 of a programme to update clinical IT systems across the Trust.

- The Trust Endoscopy Department has retained its Joint Advisory Accreditation (JAG)

- The Trust has been chosen as one of Seven Trusts to be involved in the National Frailty Collaborative. The programme will help RWT develop it's frailty programme, linked to NHS plan and Community First Programmes of work. There was a national visit on the 10th September.

- The clinical senate visited West Park Hospital as part of the Stroke Rehabilitation work across the Group. Verbal Update to be provided in the meeting.

- The Trust Nursing Workforce establishment reviews have been completed for Inpatient areas, Theatres, ICCU and Neonatal Unit and discussed at the Quality Committee. Children's Community service review agreed to design transformation of the service and reviews are ongoing for Clinical Nurse Specialists, ACPs, ED and Adult Community.

Authors

Gwen Nuttall
(Managing Director)

**Care Colleagues
Collaboration Communities**

Balanced Scorecard

Quality, Safety & Patient Experience	Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	19/20 Same Period	Variation	Assurance
Patient falls - rate per 1,000 occupied bed days	4.50	3.22	3.15	Jul-25	-	Common Cause	Inconsistent
Pressure ulcers per 1,000 occupied bed days	1.50	1.42	1.11	Jul-25	1.36	Common Cause	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.49	0.53	Jul-25	-	Concern	Achieving
Observations on time (Trust wide)	90.00%	89.12%	89.04%	Jul-25	-	Improvement	Not Met
VTE risk assessment - % within 14 hours	95.00%	90.60%	89.90%	Jul-25	-	Concern	Not Met
Sepsis screening - ED	90.00%	100.00%	98.00%	Jun-25	-	Common Cause	Inconsistent
Sepsis screening - Inpatients	90.00%	82.30%	84.50%	Jul-25	-	Concern	Inconsistent
Clostridioides difficile	5	4	4	Jul-25	4	Common Cause	Inconsistent
MRSA Bacteraemia	0	2	0	Jul-25	-	Common Cause	Inconsistent
Number of complaints as a % of admissions	0.50%	0.41%	0.44%	Jul-25	-	Concern	Inconsistent
FFT recommendation rates - Trust wide	92.00%	89.00%	88.00%	Jul-25	92.00%	Improvement	Not Met
Care hours per patient - total nursing & midwifery staff actu	7.6	7.6	7.5	Jul-25	7.5		No Target Set
Care hours per patient - registered nursing & midwifery staf	4.5	5.0	4.9	Jul-25	-	Common Cause	No Target Set
SHMI	1.00	0.97	0.97	Jul-25	-	Concern	Achieving
Never events	0	0	0	Jul-25	-	Improvement	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	10193.62	10175.61	10147.37	Jul-25	-	Improvement	Inconsistent
Agency (WTE) Trust	21.80	23.06	33.20	Jul-25	-	Improvement	Inconsistent
Bank (WTE) Trust	506.00	517.92	631.98	Jul-25	-	Improvement	Not Met
Vacancy Rate	6.00%	4.62%	4.95%	Jul-25	-	Common Cause	Inconsistent
Turnover Rate (12 Months)	10.00%	8.96%	8.84%	Jul-25	-	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	91.06%	91.06%	Jul-25	-	Improvement	Inconsistent
Sickness Absence (Rolling 12 Months)	5.00%	5.39%	5.39%	Jun-25	-	Concern	Not Met
Appraisals	90.00%	81.51%	80.90%	Jul-25	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	97.02%	96.76%	Jul-25	-	Improvement	Achieving

Operational Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
18 Weeks RTT - % Within 18 Weeks - Incomplete	60.00%	55.46%	55.17%	Jul-25	82.13%	Concern	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	0.99%	2.97%	2.80%	Jul-25	-	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	75489	79970	78673	Jul-25	39142	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	79.98%	78.43%	Jul-25	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	96.00%	93.58%	89.82%	Jul-25	89.05%	Improvement	Not Met
Cancer - 62 Day Referral to Treatment	75.00%	72.25%	49.17%	Jul-25	56.85%	Improvement	Not Met
No. of patients no longer meeting the Criteria to Reside	89	73	79	Jul-25	-	Common Cause	Inconsistent
Diagnostics - % within 6 weeks from referral	95.00%	95.85%	96.60%	Jul-25	84.70%	Improvement	Not Met
Total Time Spent in ED - % over 12 Hours	-	7.81%	9.81%	Jul-25	-	Common Cause	No Target Set
Total Time Spent in ED - % within 4 Hours	78.00%	82.75%	81.90%	Jul-25	81.83%	Improvement	Inconsistent

Finance	Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£000) - in month	-1802	1743	843	Jul-25	-	Common Cause	Inconsistent
Surplus/(Deficit) (£000) - YTD	-3379	5113	5956	Jul-25	-	Improvement	Inconsistent
Surplus/(Deficit) (£000) - FOT	-	0	0	Jul-25	-	Improvement	No Target Set
Elective Variable (£000) - in month	14631	15932	16696	Jul-25	-	Concern	Inconsistent
Elective Variable (£000) - YTD	28905	45732	62428	Jul-25	-	Common Cause	Inconsistent
Elective Variable (£000) - FOT	180585	186238	186238	Jul-25	-	Improvement	Inconsistent
Efficiency (£000) - in month	2907	4322	4029	Jul-25	-	Common Cause	Inconsistent
Efficiency (£000) - YTD	5707	10756	14785	Jul-25	-	Common Cause	Inconsistent
Efficiency (£000) - FOT	57240	57240	57240	Jul-25	-	Improvement	Not Met
Capital (£000) - YTD	1636	1397	3102	Jul-25	-	Concern	Inconsistent
Capital (£000) - FOT	29350	29350	29350	Jul-25	-	Not Enough Points	Not Enough Points
Cash (£000) - in month	48124	57311	52374	Jul-25	-	Common Cause	Inconsistent
Cash (£000) - FOT	26081	26081	26081	Jul-25	-	Not Enough Points	Not Enough Points

Care Colleagues
Collaboration Communities

Quality, Safety and Patient Experience

Quality, Safety & Patient Experience | Executive Summary

- *Clostridioides difficile (C.diff)* continues on the improved trajectory for the last quarter and furthermore was below target in month reporting 4 cases, Quality improvement approach continues to underpin activity underway alongside emphasis on adherence to practice standards where it falls short.

- Community Pressure Ulcer themes are associated with patient choice in declining equipment or altered activities of daily living, a focussed shared decision-making Council for community pressure ulcer prevention has been developed.

- Since the launch of the Sepsis dashboard the Trust have observed a 10% increase in compliance with sepsis screening.

- Nursing Teams have been shortlisted for Nursing Times- Nurse Education Team of the year, and HSJ Awards for Sepsis, Quality and Digital alongside colleagues in the Digital & Information teams.

- The Trust received a regulation 28 notice following a patient death in December 2024. The Coroner identified gaps in relation to identification and checking of a patient's allergy status prior to prescribing. A multi-disciplinary working group is meeting to co-ordinate actions within the required time frame.

Mortality

- SHMI: The Standardised Hospital Mortality Indicator is 0.96; within the expected range. Individual diagnostic groups with higher than expected SHMI values (acute MI, pneumonia, epilepsy & thyroid disease) are reviewed via clinical pathway meeting and the Trust is proactively managing the Learning from Deaths agenda overseen by the Mortality Review Group.

- With coding changes related to SDEC being implemented from October 2025, there will be an adverse impact on SHMI.

Authors

Debra Hickman
(Chief Nursing Officer)

Brian McKaig
(Chief Medical Officer)

Care Colleagues
Collaboration Communities

Perinatal Quality Oversight Model (PQOM) Dashboard

Latest CQC Summary

17 September 2024 assessment Overall Good

Safe-Good, Effective-Requires improvement, Caring-Outstanding, Responsive-Good, Well-led-Good

Elements of the PQOM are items in the monthly Group Quality Committee reports presented in detail by Directors of Midwifery

	April	May	June	July
PMRT Reviews (including babies >28 days old or not born at RWT)	5	4	7	5
Grades Maternity/neonatal	A = 1	A = 1	A = 0	A = 2
	B = 3	B = 3	B = 5	B = 3
	C = 1	C = 0	C = 2	C = 0
	D = 0	D = 0	D = 0	D = 0
Final MNSI Reports Received	0	1	2	0
Incidents Moderate & Above (all new MNSI cases and those assigned PMRT C and D, and those assigned moderate harm on datix)	2	5	4	2
Service user & Staff Feedback to Board Level Safety Champions	Delivery Suite	Neonatal Unit	Ante/Postnatal ward	Antenatal Clinic
Coroner Reg 28	0	0	0	0
Obstetrics/Gynaecology Trainees Quality of Clinical Supervision reported annually	Quality of Supervision 91% *GMC national trainee survey*			

*Themes are detailed on page 2

CNST & Training Position 31.07.2026

Safety Action	Red	Amber	Green	Blue	Total requirements
1	1	6	0	0	7
2	0	2	0	0	2
3	0	4	0	2	6
4					20
5	4	7	2	0	13
6	2	2	5	0	9
7	0	2	3	0	5
8	0	22	0	0	22
9	4	3	1	1	9
10	0		8	0	9
Total					102

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated actions will not be included in this table

Staff Group	PROMPT	Fetal monitoring	NLS
Obstetricians	87%	95%	87%
Midwives	85%	88%	85%
Support Staff	80%	NA	NA
Anaesthetists	85%	NA	NA
Neonatal Doctors	NA	NA	100%
Neonatal Nurses	NA	NA	79%

Perinatal Staffing									Actions
Staff Group	April		May		June		July		
Midwives Birth to midwifery ratio Planned/Actual	21	27	21	27	21	27	21	27	Midwife to Birth ratio based on Feb 2022 BR+ report as awaiting our most recent BR+ report for 2025. Staffing monitored daily at the huddles and by the duty manager, manager on call
Obstetrics RCOG Compliant on delivery suite	yes		yes		yes		yes		
Neonatal Nurses BAPM Compliant	45%		45%		90%		58%		Based on actual acuity and staffing numbers, rather than QIS
Neonatal Doctors BAPM Compliant	yes		yes		yes		yes		

Perinatal Service

Following the MNSI recommendations;

- Daily Staffing Huddles are embedded to ensure there is greater oversight of flow and capacity. The Duty and Manager on Call are available 24/7 to support escalation to ensure we have the flow and capacity throughout the maternity unit to enable prompt transfer from the maternity triage unit .

- Maternity Triage have a specific escalation process with a defined escalation response in place. This is to support timely triage assessment, and an expectation of what escalation actions will follow

- Maternity Triage Standard Operation Procedure implemented April 2025 which outlines the thresholds for escalation.

- Oversight is maintained through auditing transfer of patients from maternity triage to identify and recognise challenges in delayed transfers in accordance with local amber and red alerts.

Consultant staffing concerns were discussed at the safety champions meeting and Medical recruitment plans are to be shared with the safety champions.

Birthrate+ is currently in progress for 2025.

Authors

Debra Hickman
(Chief Nursing Officer)

Brian McKaig
(Chief Medical Officer)

Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

Patient falls - rate per 1,000 occupied bed days

Inconsistent	Common Cause	3.15
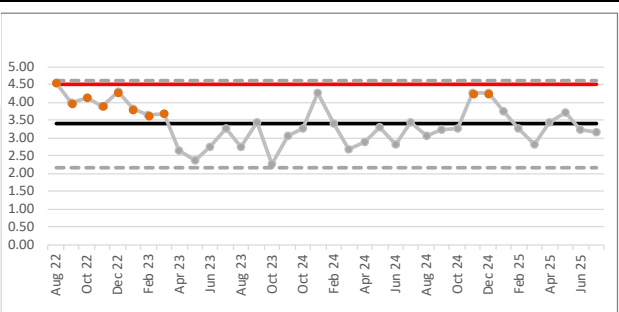
Pressure ulcers per 1,000 occupied bed days

Inconsistent	Common Cause	1.11
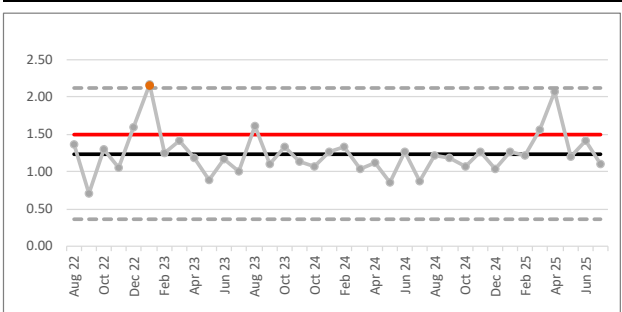
Community acquired pressure ulcers per 10,000 population

Achieving	Concern	0.53
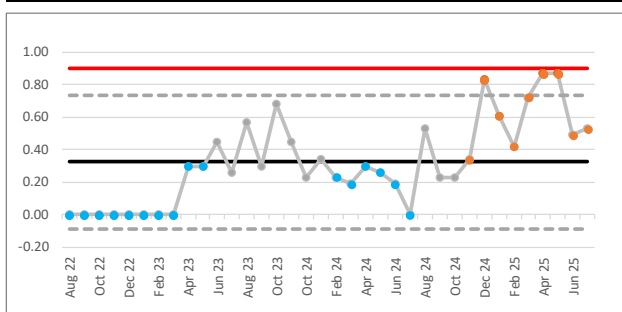
Clostridioides difficile

Inconsistent	Common Cause	4
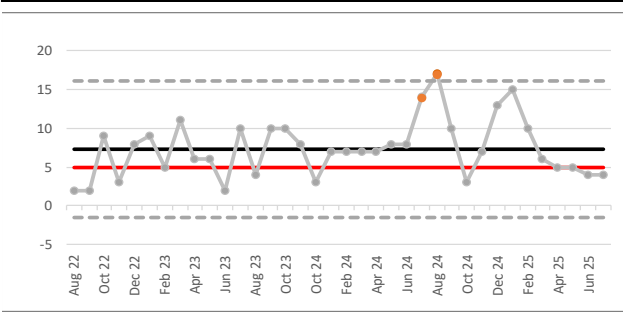
Observations on time (Trust wide)

Not Met	Improvement	89.04%
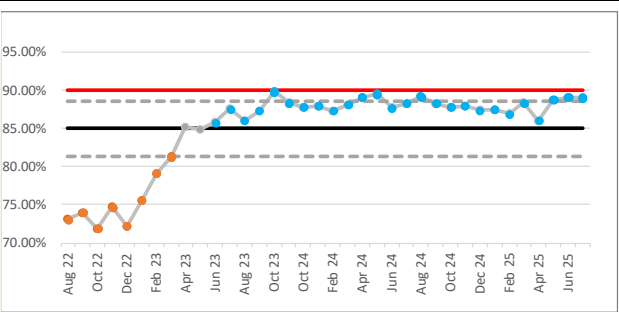
VTE risk assessment - % within 14 hours

Not Met	Concern	89.90%
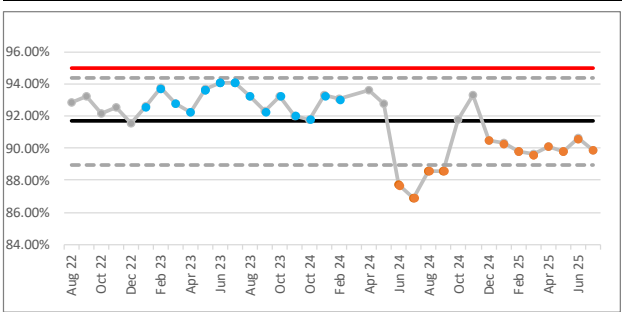
Sepsis screening - ED

Inconsistent	Common Cause	98.00%
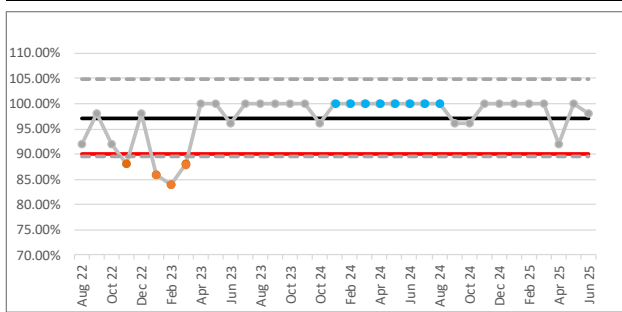
MRSA Bacteraemia

Inconsistent	Common Cause	0
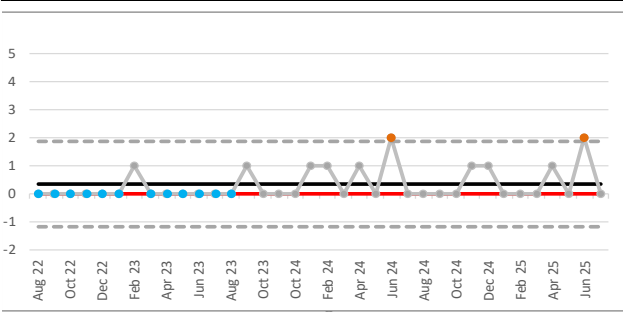
Sepsis screening - Inpatients

Inconsistent	Concern	84.50%
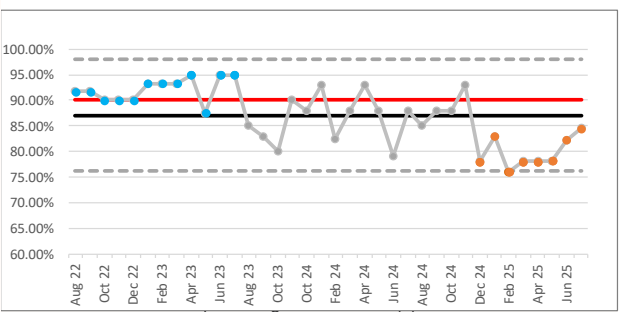
Medication error - incidents causing serious harm

No Target Set	Improvement	0
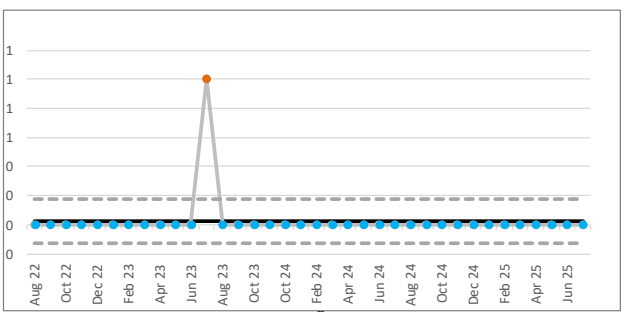
Mental health patients spending over 12 hours in A&E

No Target Set	Common Cause	110
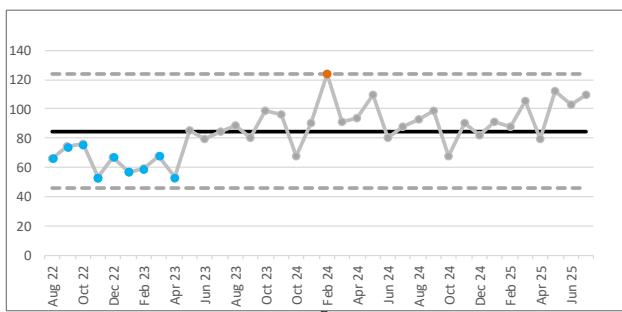
Number of complaints as a % of admissions

Inconsistent	Concern	0.44%
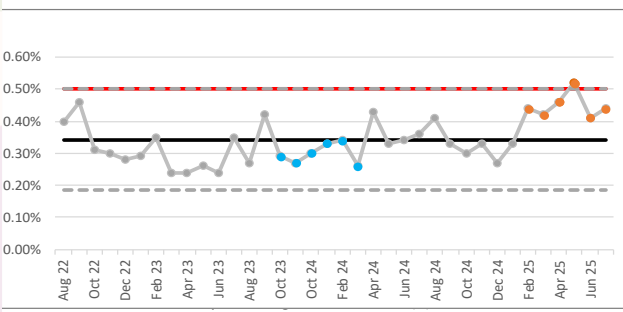
Quality, Safety & Patient Experience | Core Metrics
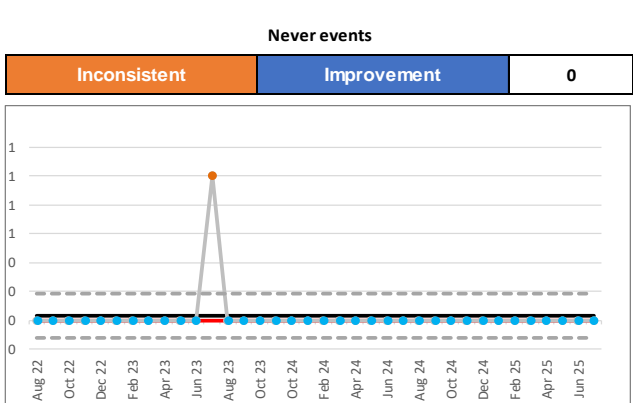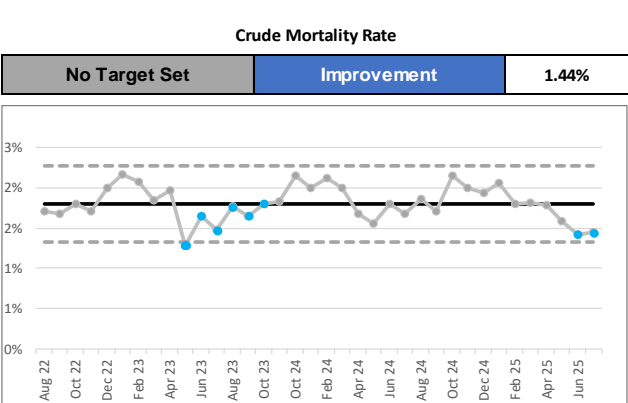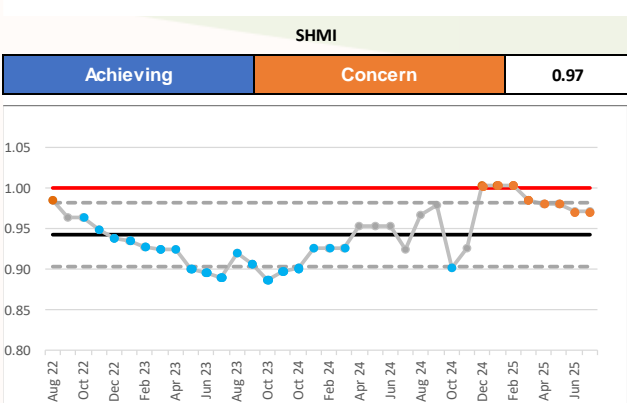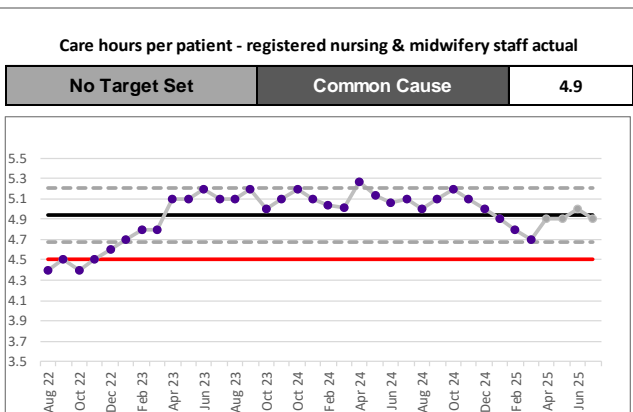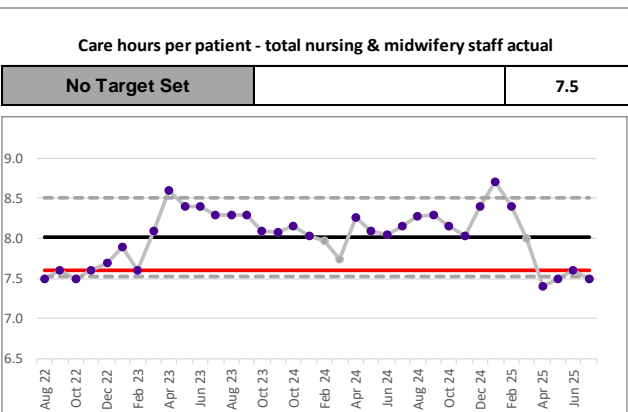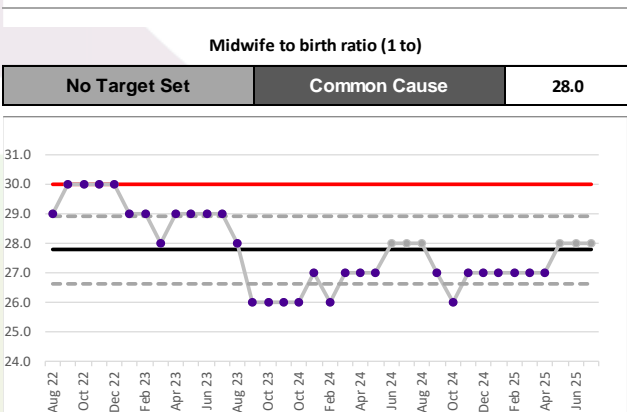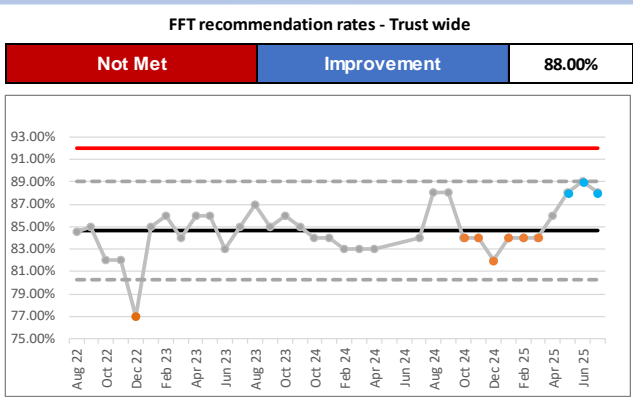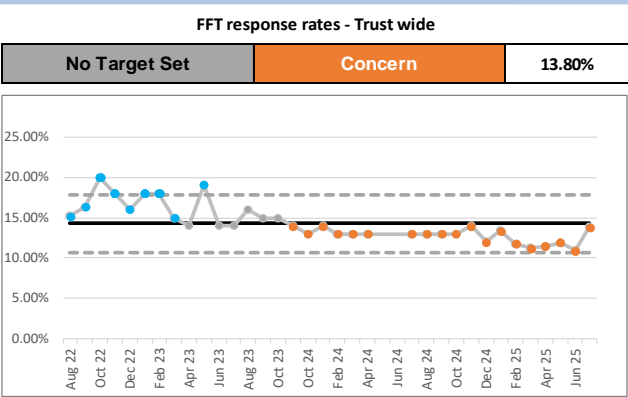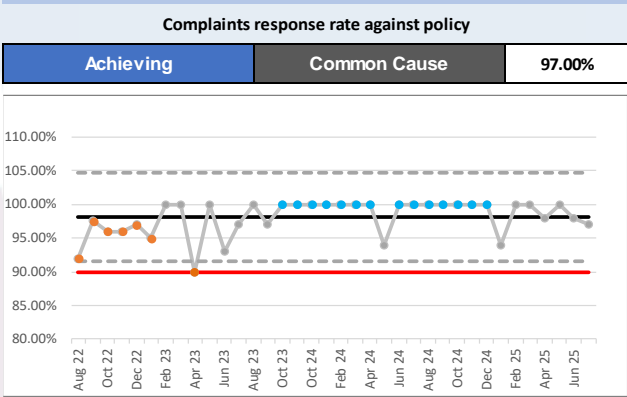
People

People | Executive Summary

For M4 there was an increase in the total workforce compared to M3 by 111.70 WTE which was driven by temporary workforce. The M4 position is therefore worse than plan comprising of a reduction in month of -28.24 WTE for substantive, an in-month increase of +129.81 WTE for bank and an agency increase of +10.14 WTE. M12 compared to M4: Total WTE reduction of -106.22 WTE, comprising -176.41 WTE substantive staff, +65.32 WTE bank, and +4.87 WTE agency.

A comparison of M4 WTEs was undertaken as this is the first increase seen since the beginning of 2025/26, however following analysis there is no single causing factor. This review has shown that recorded in month 4 are approximately 15 WTEs (bank) relating to month 3 which exacerbates the position. The corrected position means M3 bank position was 517 WTE and therefore M4 would be 617 WTE so a revised in-month bank increase of +100 WTE.

Further analysis of the temporary staffing expenditure has identified a range of factors; these are summarised in the table.

Forecast for the M5 substantive stretch target remains on track however the variance is expected to smaller than the variances seen in previous months. To meet the stretch target for the end of Q2 a further 16.01 WTE reductions are required from the substantive M4 position.

Analysis of cause	WTE increase M4 vs M3
Industrial Action - specifically identified	4.14
Increased sickness — Nursing	24.55
Increased sickness — Medics	5.95
Observed Acuity driving bank use	28.64
Increased operating list pressures	1.78
Resident doctor rotation impact	1.64
Observed general increase in shift uptake (particularly ED)	21.82
Increased Mental Health agency staff (non-medic)	9.29
Other factors - balance	12.19
Analysed total	110.00

	Reported at M3	Adjustment - reported in M4	Restated M3 WTEs
Substantive	10,176		10,176
Bank	502	15	517
Agency	23		23
	10,701	15	10,716

M4 reported position	Adjustment - reported in M4	Restated M4 WTEs	Restated M4 to M3 movement
10,147		10,147	(28)
632	(15)	617	100
33		33	10
10,813	(15)	10,798	82

Sickness absence remains an area of challenge and in-month sickness increased to 5.17% from 5.31%. Measured over a rolling 12-month period, the sickness rate has remained at 5.39%.

Appraisal compliance performance decreased to 80.90 during July 2025, indicating a lack of assurance that the 90% target can be met within a 24-month trend. Appraisal alignment work across the group continues.

Mutually Agreed Resignation Scheme (MARS) remains open for application until 15th September 2025 and the process to review the applications has commenced across the trust with formal panels taking place in September.
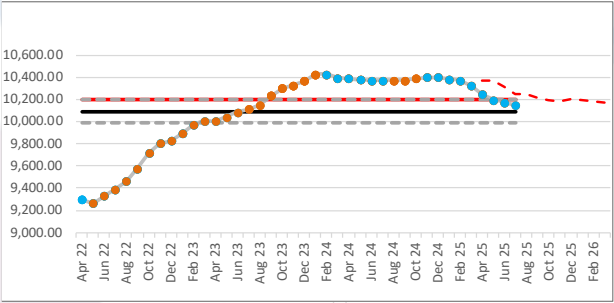
Authors

Alan Duffell
(Group Chief People Officer)

Care Colleagues
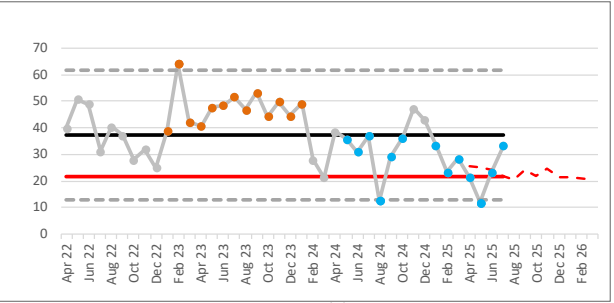Collaboration Communities

People | Core Metrics

Substantive (WTE) Trust — Inconsistent | Improvement | 10147.37

Agency (WTE) Trust — Inconsistent | Improvement | 33.20

Bank (WTE) Trust — Not Met | Improvement | 631.98
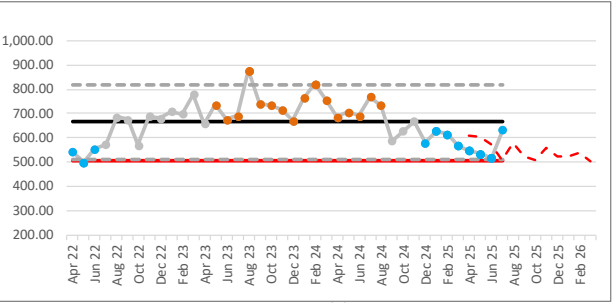
Short-Term Sickness Absence (In Month) — Achieving | Improvement | 1.81%
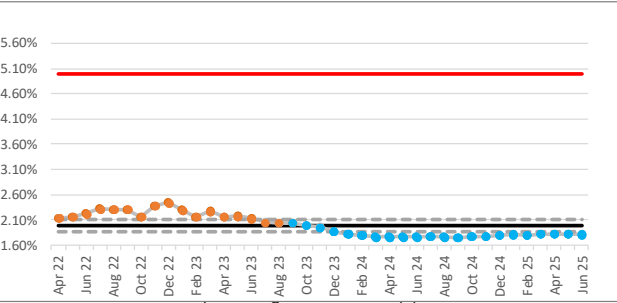
Vacancy Rate — Inconsistent | Common Cause | 4.95%
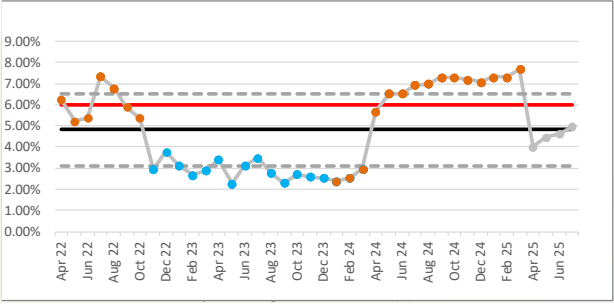
Turnover Rate (12 Months) — Inconsistent | Improvement | 8.84%
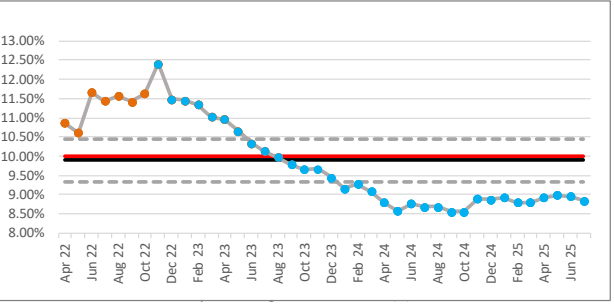
Retention Rate (12 Months) — Inconsistent | Improvement | 91.06%
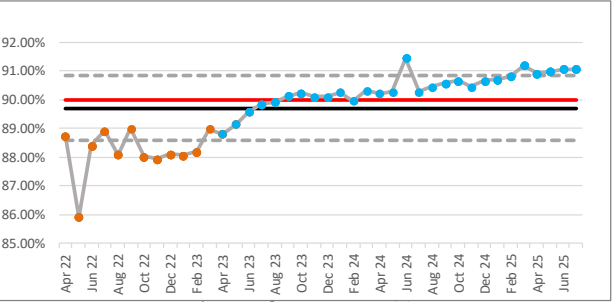
Long-Term Sickness Absence (In Month) — Achieving | Concern | 3.57%
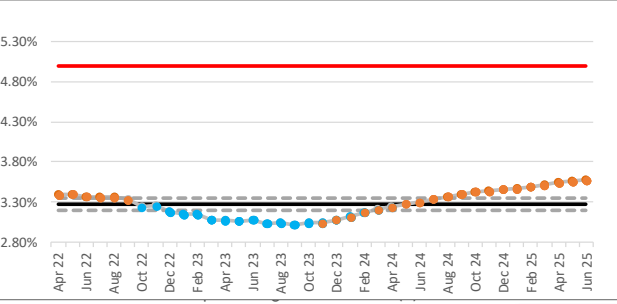
Sickness Absence (Rolling 12 Months) — Not Met | Concern | 5.39%
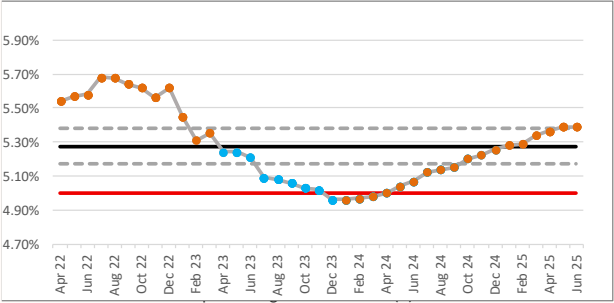
Appraisals — Not Met | Concern | 80.90%
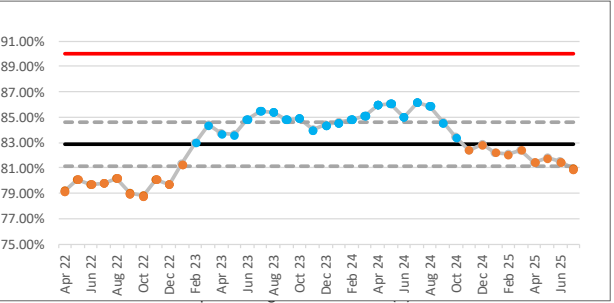
Statutory & Mandatory Training — Achieving | Improvement | 96.76%
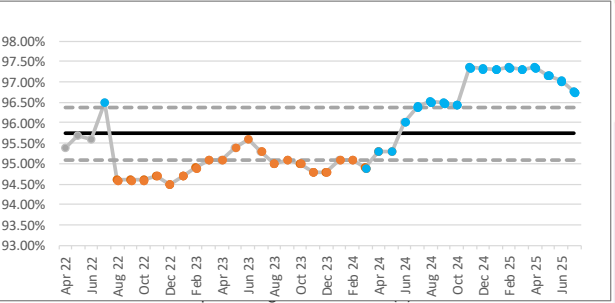
Sickness Absence (In Month) — Inconsistent | Common Cause | 5.31%
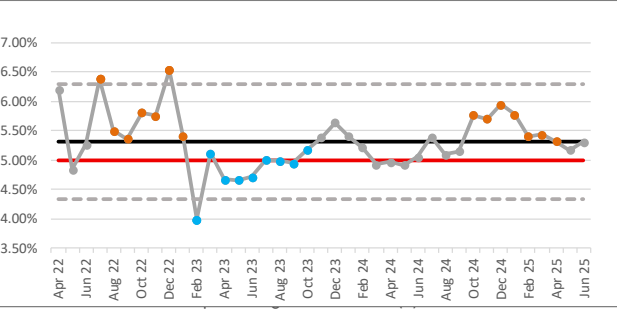
Operational Performance

Operational Performance | Executive Summary

We continue to make good progress in reducing the size of our waiting list and have now re-commenced external validation of our waiting list in line with the commencement of the second validation sprint. Our 18-week performance remains ahead of trajectory which increases more significantly next month in line with the commencement of insourcing in focused specialties. The number of 52-week breaches continues to reduce from previous months but remains above trajectory – this is likely to be the case until September 25 at the earliest. This is driven by performance in Gynaecology, Urology and Ear, Nose & Throat in the main.

From an unplanned care perspective, performance remains comparatively strong. The Trust is achieving the UEC 4 hr performance metric at 80%. Ambulance handover performance is within trajectory, with 15 min handover the best within the Black Country, however 10% of patients can wait over 1 hr, which is the main focus of recovery and improvement.

From a cancer perspective, we continue to meet the 28-day faster diagnosis standard of 80%, however, our 62-day performance at 70.2% fell below our planned trajectory. The Trust has moved from being in the bottom decile in 2024, to the 2 (best) quartile in 2025. Urology remains the area of biggest challenge, particularly the diagnostic stage of the pathway, although there has been a reduction in patients waiting in August for their diagnostic.

Diagnostic performance across all the 9 domains, remains amongst the best in the Midlands region.
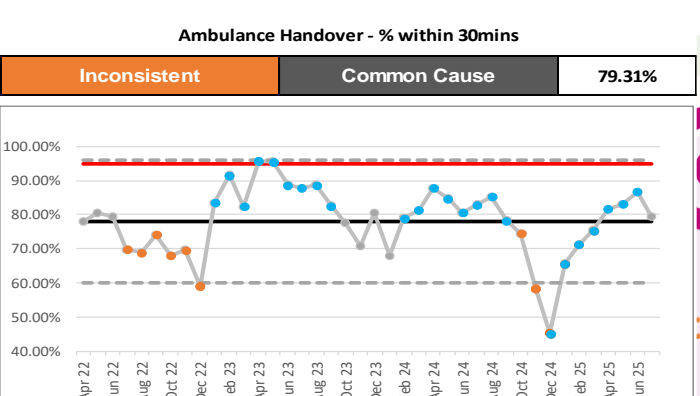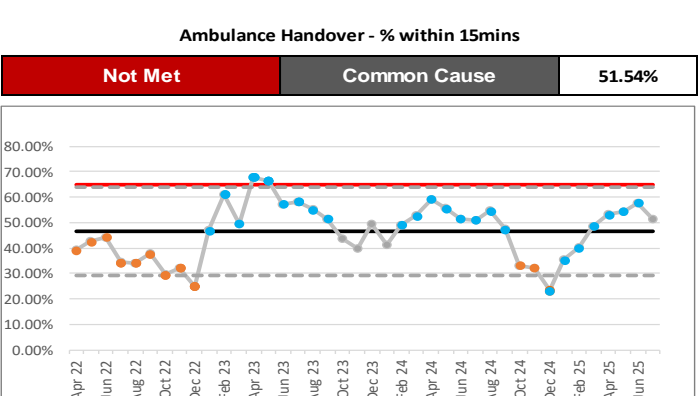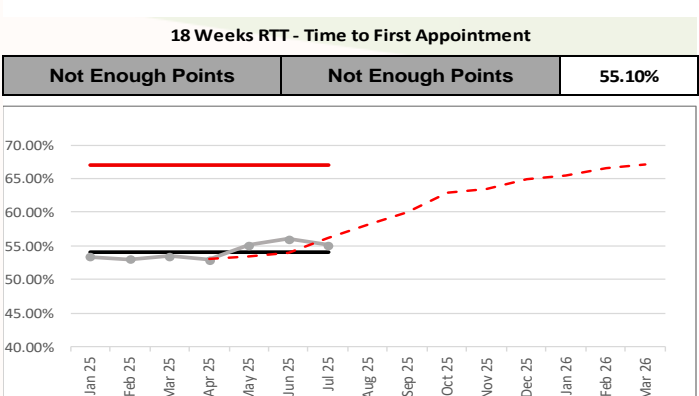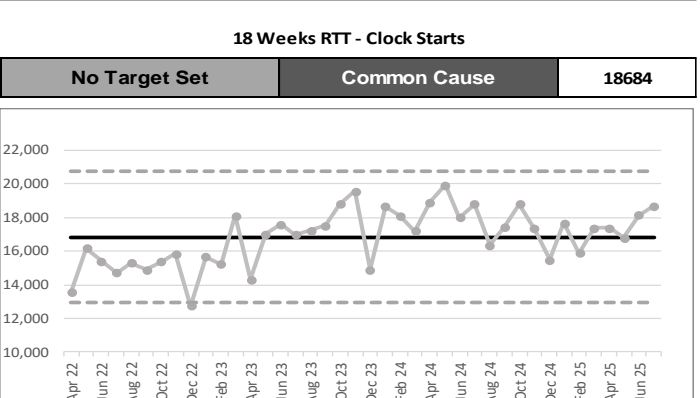
Authors

Gwen Nuttall
(Managing Director)

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics
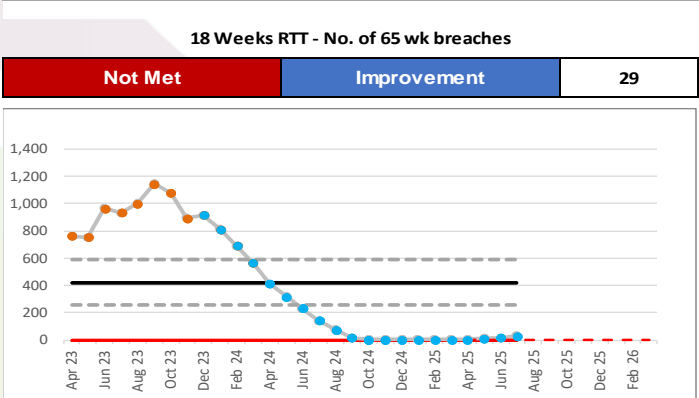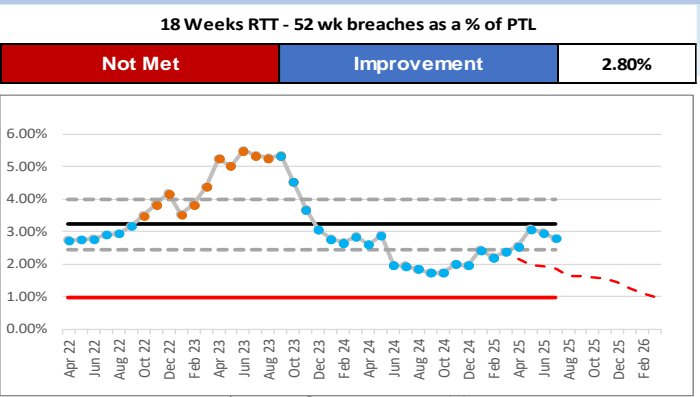
18 Weeks RTT - % Within 18 Weeks - Incomplete

Not Met	Concern	55.17%

18 Weeks RTT - No. of 52 wk breaches

No Target Set	Improvement	2202

18 Weeks RTT - 52 wk breaches as a % of PTL

Not Met	Improvement	2.80%

18 Weeks RTT - No. of 65 wk breaches

Not Met	Improvement	29

18 Weeks RTT - Total Incomplete PTL

Not Met	Improvement	78673

18 Weeks RTT - Clock Starts

No Target Set	Common Cause	18684

18 Weeks RTT - Time to First Appointment

Not Enough Points	Not Enough Points	55.10%

Ambulance Handover - % within 15mins

Not Met	Common Cause	51.54%

Ambulance Handover - % within 30mins

Inconsistent	Common Cause	79.31%

Colleagues
Communities

Operational Performance | Core Metrics

Ambulance Handover - % within 60mins

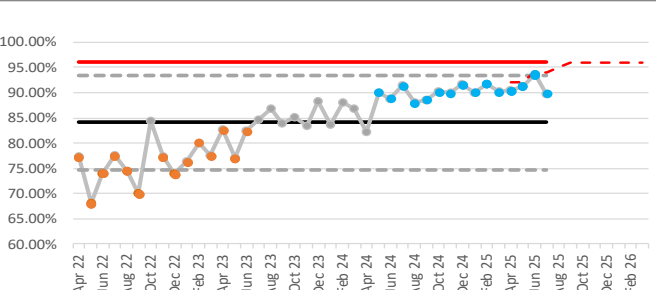| Inconsistent | Common Cause | 10.49% |
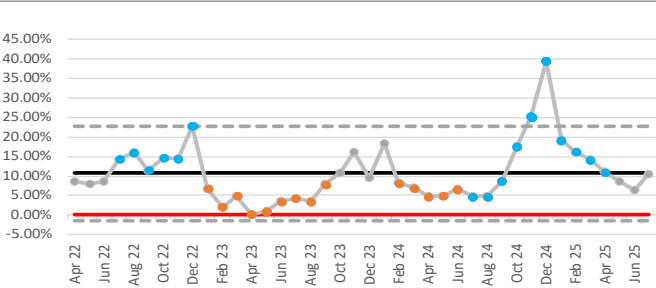
Cancer - 2 Week Wait

| Inconsistent | Common Cause | 84.00% |
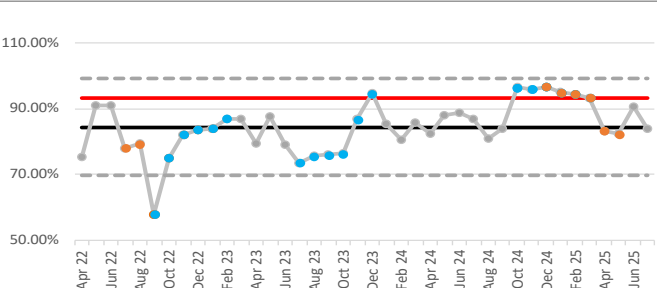
Cancer - 28 Day Faster Diagnosis

| Inconsistent | Improvement | 80.00% |
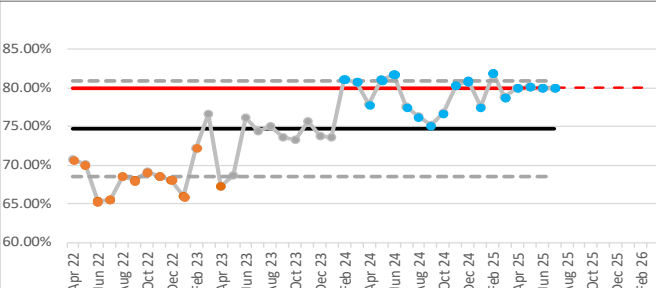
Cancer - 31 Day Treatment

| Not Met | Improvement | 89.82% |

Cancer - 62 Day Referral to Treatment

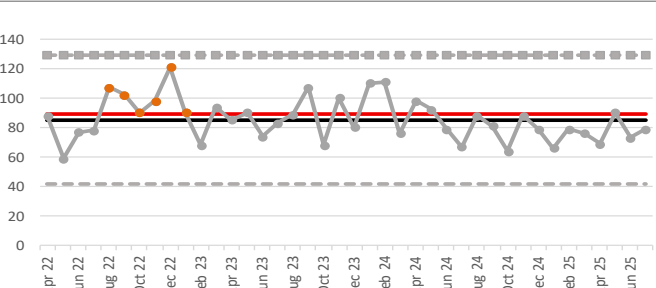| Not Met | Improvement | 70.20% |
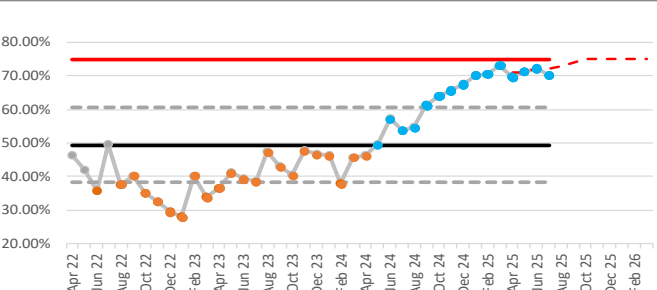
Cancer - No. of patients waiting 63+ Days for treatment

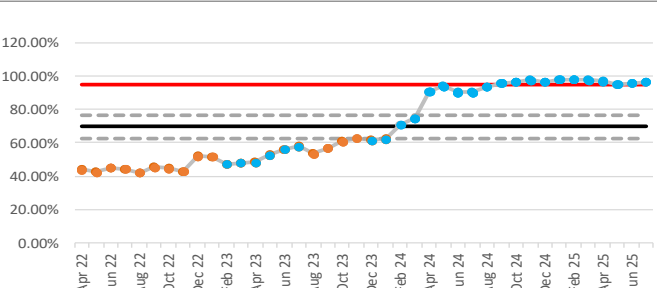| No Target Set | Improvement | 151 |
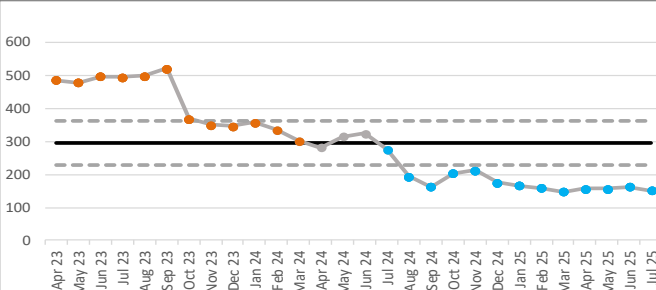
No. of patients no longer meeting the Criteria to Reside

| Inconsistent | Common Cause | 79 |

Diagnostics - % within 6 weeks from referral

| Not Met | Improvement | 96.60% |

Total Time Spent in ED - % over 12 Hours

| No Target Set | Common Cause | 9.81% |

Operational Performance | Core Metrics

Total Time Spent in ED - % within 4 Hours

Inconsistent	Improvement	81.90%

Type 1 ED Attendances

No Target Set	Common Cause	13276

Variable Contract Delivery

Not Enough Points	Not Enough Points	97%

Theatres - Touch Time Utilisation (MH)

Achieving	Improvement	91.84%

Community - Virtual Ward % Occupancy

Inconsistent	Concern	76.00%

Community - Urgent Care Response (UCR) 2 Hour Response

Inconsistent	Common Cause	69.40%

Community - Waiting List - Total

No Target Set	Improvement	2436

Operational Performance | Benchmarking

Referral to Treatment

A&E 4 Hour

Cancer 62 Day

Diagnostic Waiting Times

Finance

Finance | Executive Summary

Key Headlines – Month 4 2025/26

- In month deficit of £0.8m, which is in line with the plan.

- Patient care income has underperformed by £0.1m in month. There has been a reduction in activity from Wales in month. Variable activity is £0.1m ahead of plan in month.

- Education and Training income is under-plan due to a shortfall against the LDA income target in month due to the timing of income, however YTD it is in line with plan.

- Pay is overspent by £0.1m in month, due to additional bank and agency usage in month, a proportion of which will be as a result of Industrial Action.

- Non-pay is underspent in month due to one off benefits being released in the month following detailed reviews of all outstanding orders and accruals.

- CIP is overachieved by £0.1m in month, mainly due to non-recurrent savings associated with the review of previous years orders.

Authors

Kevin Stringer
(Group Chief Finance Officer)

Care Colleagues
Collaboration Communities

Finance | I&E Summary

In-Month Income & Expenditure		RWT		
	Plan M4 £m	Actual M4 £m		Surplus/ (Deficit) £m
Income	85.8	85.4		(0.4)
Expenditure				
Pay	55.7	55.8		(0.1)
Non Pay	19.6	19.2		0.4
Drugs	7.2	7.3		(0.1)
Other*	4.1	3.8		0.3
Total Expenditure	86.6	86.2		0.4
Net reported surplus/(Deficit)	(0.8)	(0.8)		0.0

Year-to-date Income & Expenditure		RWT		
	Plan YTD £m	Actual YTD £m		Surplus/ (Deficit) £m
Income	335.9	334.2		(1.7)
Expenditure				
Pay	217.0	217.3		(0.3)
Non Pay	80.5	79.7		0.8
Drugs	27.7	27.7		(0.0)
Other (incl. depreciation)	16.7	15.5		1.3
Total Expenditure	342.0	340.2		1.8
Net reported surplus/(Deficit)	(6.1)	(6.0)		0.1

The Trust's financial position remains on plan for July and year to date with an in-month deficit of £0.8m and YTD deficit of £6.0m.

Income is lower than plan relating to SLAs and is offset by expenditure underspends and efficiency overachievement.

Pay is overspent by £0.3 YTD for reasons including industrial action, activity related overspends, absence cover and medical vacancy cover. Non pay is underspent by £0.8m YTD relating to hosted services and partially offset by activity related overspends in Division 1, in addition to prior year accrual releases. 'Other' CIP has overachieved by £2.0m YTD, due to one off benefits relating to 24/25 being identified and other non-recurrent benefits being bought forward.

The RWT annual plan is breakeven following national deficit support of £31.4m and local support funding of £14.5m, totalling £45.9m. The plan requires £57.2m of efficiencies for the year.

The profile of the plan for the remainder of the year requires an improvement each month, with a surplus from month 7 onwards.

Care Colleagues Collaboration Communities

Finance | ERF Performance

Point of Delivery	RWT		
	Plan	**Actual**	**Variance**
	Activity	**Activity**	**Activity**
Elective	2,528	2,470	(58)
Palnned Same Day	17,742	17,595	(147)
Outpatient Procedures	53,939	56,198	2,258
Procedures Total	**74,209**	**76,263**	**2,054**
Outpatient 1st	69,679	72,410	2,731
Diagnostic Imaging	30,084	28,685	(1,399)
Chemotherapy	4,737	4,851	114
Grand Total	**173,972**	**177,358**	**3,500**

	£'000	**£'000**	**£'000**
Elective	16,097	15,782	(315)
Planned Same Day	18,797	18,376	(422)
Outpatient Procedures	9,313	9,582	348
Procedures Total	**44,185**	**43,796**	**(389)**
Outpatient 1st	13,238	14,011	649
Diagnostic Imaging	4,835	4,801	(112)
Chemotherapy	1,591	1,669	787
Grand Total	**60,611**	**60,759**	**226**

This table shows the variable activity performance against the Trust activity plan. This includes elective recovery activity as well as diagnostic imaging and chemotherapy. The planned initiatives to achieve the RTT improvement are profiled into the plan from August.

Total activity is £226k above plan YTD with overperformance mainly in Respiratory, Cardiology and Oncology. This is partially offset by underperformance in Neurology and Gynaecology, who are developing plans to bring activity back on plan.

It is the current assumption the Trust will receive full payment for all activity. There are ongoing discussions with commissioners as to the activity levels to be purchased to achieve RTT standards and escalation/arbitration is being prepared for.

Care Colleagues Collaboration Communities

Finance | Cost Improvement Plans

Efficiencies 2024/25	Plan approved by Board £m	YTD recurrent achievement Month 4 £m	YTD non-rec achievement Month 4 £m	YTD achievement Month 4 £m	YTD plan Month 4	YTD Variance Month 4 £m	FOT assuming all plans achieved £m
Affordable Urgent Care	4.5	0.2	0.0	0.2	0.3	(0.1)	4.5
Cessation of Unfunded Schemes	1.0	0.0	0.0	0.0	0.1	(0.1)	1.0
Counting and Coding	2.1	0.0	0.0	0.0	0.3	(0.3)	2.1
Estates Utilisation	1.0	0.0	0.0	0.0	0.2	(0.1)	1.0
Non-Pay and Procurement	14.6	4.0	7.2	11.2	4.3	6.9	14.6
Operational Productivity	11.9	0.0	0.0	0.0	2.3	(2.3)	11.9
Workforce	22.1	0.2	3.1	3.3	5.3	(2.0)	22.1
Sub Total - internal plans	**57.2**	**4.5**	**10.3**	**14.8**	**12.8**	**2.0**	**57.2**
Total efficiency plan	**57.2**	**4.5**	**10.3**	**14.8**	**12.8**	**2.0**	**57.2**

In Month Four, the Trust overachieved against its CIP target of £3.9m by £0.1m. The over-achievement is due to one off benefits relating to 24/25 being identified and reported as non-recurrent CIP.

Of the in-month achievement, £1.0m has been achieved recurrently (21%). A significant proportion of the in-month savings are driven by a review of GRN's that have been released and achieved as CIP (£1.1m). This achievement is propping up the in-month and YTD achievement of CIP.

30% of the YTD achievement is recurrent(£4.5m).

None of the workstreams, with the exception of Non-pay and Procurement are achieving their planned level of YTD savings. The most significant schemes that aren't currently delivering their plans relate to workforce reductions and reductions in bank and agency. There are a number of other schemes that aren't delivering their plans, which can be seen in the detailed UoR reports as well as the Divisional Performance Review packs.

Delivery risks in future months are contained within targets for; Clinical Best Practice, Operational Productivity, Workforce reductions.

National Oversight Framework Dashboard

National Oversight Framework Dashboard

Oversight Framework	Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	Variation	Assurance
18 Weeks RTT - % Within 18 Weeks - Incomplete	60.00%	55.46%	55.17%	Jul-25	Common Cause	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	0.99%	2.97%	2.80%	Jul-25	Improvement	Not Met
Difference between actual and planned 18 week elective pe	-	3.48%	2.23%	Jul-25	Not Enough Points	Not Enough Points
Percentage of patients waiting over 52 weeks for community	-	1.47%	1.41%	Jul-25	Common Cause	No Target Set
Cancer - 28 Day Faster Diagnosis (Rolling 12 Months)	80.00%	78.65%	78.73%	Jul-25	Improvement	Not Met
Cancer - 62 Day Referral to Treatment (Rolling 12 Months)	75.00%	65.57%	65.10%	Jul-25	Improvement	Not Met
Total Time Spent in ED - % within 4 Hours (Rolling 3 Months)	78.00%	82.29%	82.05%	Jul-25	Improvement	Inconsistent
Total Time Spent in ED - % over 12 Hours	-	7.81%	9.81%	Jul-25	Common Cause	No Target Set
Planned Surplus / Deficit	-	4	4	Jul-25	Common Cause	No Target Set
Year to date variation from plan	-	1	1	Jul-25	Not Enough Points	Not Enough Points
Implied level of productivity	-	-	-0.2	Jun-25	Not Enough Points	Not Enough Points
CQC inpatient survey satisfaction rate	-	-	7.1	Jun-25	Not Enough Points	Not Enough Points
Staff survey - raising concerns sub-score	-	6.26	-	Dec-24	Not Enough Points	Not Enough Points
CQC safe inspection score	-	-	2	Sep-24	Not Enough Points	Not Enough Points
Rate of C-Difficle infections (Rolling 12 Months)	-	145.68%	133.33%	Jul-25	Improvement	No Target Set
Number of MRSA infections (Rolling 12 Months)	0	4	4	Jul-25	Concern	Not Met
Rate of E-Coli infections (Rolling 12 Months)	-	296.26%	288.79%	Jul-25	Concern	No Target Set
Average number of days between planned and actual discha	-	5.10	5.40	Jun-25	Common Cause	No Target Set
Summary Hospital Level Mortality Indicator (Rolling 12 Mont	-	0.97	0.97	Jul-25	Concern	No Target Set
Community - Urgent Care Response (UCR) 2 Hour Response	-	72.50%	69.40%	Jul-25	Common Cause	No Target Set
Staff survey engagement theme score	-	6.73	-	Dec-24	Not Enough Points	Not Enough Points
Staff Sickness Rate (Rolling 12 Months)	5.00%	5.39%	5.39%	Jun-25	Concern	Not Met

Headlines	Data period	Provider value	Peer average (i)	National value	National value method	Chart
Adjusted segment			Q1 2025/26	3 NOF Score	Provider value	
Average metric score			Q1 2025/26	2.45 NOF Score	Provider value	
Unadjusted segment			Q1 2025/26	3 NOF Score	Provider value	
Financial override	Q1 2025/26	■ Yes	Yes	Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	■ No	No	No	Provider median	

Care Colleagues
Collaboration Communities

Productivity Dashboard

RWT - Productivity Dashboard

Ref no.	Theme and KPI	Definition	2025/26											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	Implied Productivty Growth (year to date compared to last year)	Output growth (cost-weighted activity) divded by input growth (workforce) compared to the same in last years period.	To follow, on release of methodology. Expected next month											
Operational and Clinical Productivity / Best Practice														
2	Average LOS for elective admissions (excluding daycases)	Average length of stay for all elective patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	3.82	3.55	3.58	3.90								
3	Average LOS for non-elective admissions	Average length of stay for all patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	6.08	5.96	5.89	5.79								
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	94.3%	95.1%	94.3%	93.9%								
5	Bed Occupancy classed as clinically ready for discharge (% of acute)	The average number of patients across the month who do not meet the criteria to reside (Question 2), divded by the total number of patients in hospital or discharged by 23:59 each day (sum of Question 3a and 3b).	17.5%	17.7%	18.8%	17.7%								
Theatre Utilisation														
6	Capped elective theatre utilisation	Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration	85%	83%	84%	83%								
7	Average number of cases completed per theatre list	Total number of cases completed divided by total number of sessions utilised	2.15	2.18	2.13	2.18								
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	84%	86%	87%	79%								
9	CT, MRI & ultrasound utilisation		To follow next month											
Outpatients														
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	Currently unable to report until introduction of new PAS system											
11	DNA Rate	Number of outpatient missed outpatient appointments divded by total outpatient appointments	8.4%	8.7%	9.0%	8.6%								
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	3.1%	2.8%	3.0%	2.8%								
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referra) divded by total number of outpatient first attendances	5.8%	6.3%	6.5%	7.3%								
14	Number of FUs taking place unfunded (by virtue of exceeding cap)	Number of follow ups taking place over and above 2019/20 amount	887	0	2490	233								

Productivity Dashboard

Coding/ Income

15	Mean price per spell charged	Total income for elective inpatient, daycase and non-elective patients divided by total volume of elective inpatient, daycase and non-elective activity.	2657	2642	2579	2598
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes	£0	£0	£0	£0
17	Number of unfunded services being delivered	Number of services being delivered that do not have any form of funding arrangement in place	6	6	4	4

Non Pay

18	Procurement CIP	Value of procurement cost improvement savings delivered	£2,531k	£2,997k	£2,425k	£3,247k

Workforce Productivity

19	Non-elective admissions per clinical WTE	The number of non-elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	1.94	1.98	1.99	2.00
20	Elective admissions per clinical WTE	The number of elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	1.40	1.43	1.49	1.55
21	Outpatient attendances per consultant WTE	The number of outpatient admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	119.35	121.80	122.00	123.28
22	A&E attendances (Type & 2) per Emergency Medicine Consultant	The number of A&E attendances (Type 1 & 2) in month, divded by the number of Emergency Medicine Consultants (WTEs) including substantive, bank and agency staff.	473.89	498.78	493.52	436.79
23	Corporate services cost per £100m income (£m)	The total cost of corporate services divided by £100m.	0.25	0.27	0.28	0.26

Workforce Drivers

24	Temporary Staff Spend as a % of Total Spend	Proportion of financial year-to-date total staff spend that is on temporary staffing (a combination of agency and bank staff	5.85%	5.99%	6.14%	6.82%
25	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	5.32%	5.17%	5.31%	5.38%
26	Turnover Rate	The percentage of all staff that left the organisation to join another NHS organisation, or left NHS over the previous 12 months.	8.92%	8.99%	8.96%	8.84%
27	Care hours per Patient Day	Total care hours worked by registered nurses & midwives divided by total patient bed days	7.40	7.50	7.60	7.50

Support Services

28	Estates and Facilities Cost per m2	Total estates and facilities running costs divided by total occupied floor area	£25.36/m2	£25.22/m2	£26.23/m2	£26.09/m2
29	Pathology cost per test	The average cost of undertaking one test across all disciplines, taking into account all pay and non-pay cost items	To follow next month			

Integrated Performance Report

Walsall Healthcare NHS Trust

July 2025 (Month 4)

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

| Variation			Assurance				
Common Cause	Concern	Improvement	Inconsistent	Achieving	Not Met	No Target	Not Enough Points
Common cause - no significant change	Special cause of concerning nature or higher pressure due to Higher or Lower values	Special cause of improving nature or higher pressure due to Higher or Lower values	Variation indicates inconsistently hitting passing and failing short of the target	Variation indicates consistently Passing the target	Variation indicates consistently Falling short of the target	No target has been set for this metric	There are not enough points to generate the Variation & Assurance information

The position of a target line in relation to the process limits will inform you if your indicator can hit a target or threshold consistently, by random chance, or not at all.

If your target line is in between the process limits be cautious about reacting to success (green) and failure (red) when natural variation may be causing the target to be passed or failed. Remember that approximately 99% of data points should fall within the process limits. These graphs will help guide your action:

Target (to be greater than)

System redesign required to hit target

Target (to be greater than)

Capable system should reliably hit target

Target (to be greater than)

System will not reliably hit target

SPC Key

— ◆ — Performance —— Mean ----- LCL ----- UCL
◆ Point of Concern ◆ Point of Improvement —— Target ---- Trajectory
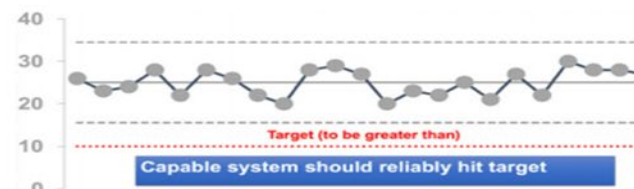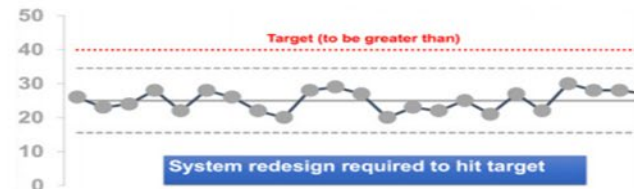
Care Colleagues
Collaboration Communities

Managing Director Summary

August saw the Trust receive confirmation of NHS England's National Oversight Framework (NOF) Q1 segmentation. The Trust received an overall score of 2.03. The Trust has been placed in segment 3. Trusts with an in-year planned deficit cannot be scored any better than segment 3. The Trusts league position is 39 out of 134 Trusts.

Walsall Healthcare NHS Trust delivered a financial position ahead of plan as at Month 4. This is £4.3m ahead YTD. Increased CIP performance has been the driver for this improvement. 51 beds remains closed since April 2025. Work is underway to finalise the Trust's Winter Plan for 2025/26, to maintain the delivery of safe and effective urgent and emergency care services, in the context of growing demand.

Quality and safety continue to be at the forefront of what we do. There was a slight increase in falls and pressure ulcer rates, with 3 falls with moderate or severe harm reported in month. CHPPD and fill rates for RNs and CSWs remained static in M4. Mental Health presentations continue to reflect the national trend with patients spending longer in the Emergency Department awaiting assessment and placement. Work continues with system partners to improve pathways.

The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for nine consecutive months. Cancer performance remains strong and the Trust is meeting all three constitutional standards for access to treatment for cancer.
There has been a reduction in performance against the 4-hour Emergency Access Standard from 78.7% to 77.03% in July, ranking 42nd nationally. The Trust has seen deterioration in access to diagnostics within 6 weeks. Focus is on recovery in audiology, non-obstetric ultrasound and cardiac physiology.

Balanced Scorecard

Quality and Patient Safety	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Patient falls - rate per 1,000 occupied bed days	4.50	3.17	4.51	Jul-25	5.01	Common Cause	Inconsistent
Pressure ulcers per 1,000 occupied bed days	1.50	1.79	2.25	Jul-25	-	Concern	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.83	0.76	Jul-25	-	Concern	Inconsistent
Observations on time (Trust wide)	90.00%	88.19%	87.51%	Jul-25	-	Improvement	Inconsistent
VTE risk assessment - % within 14 hours	95.00%	87.93%	88.71%	Jul-25	-	Common Cause	Not Met
Sepsis screening - ED	90.00%	-	-	-	-	Not Enough Points	Not Enough Points
Sepsis screening - Inpatients	90.00%	-	-	-	-	Not Enough Points	Not Enough Points
Mental health patients spending over 24 hours in A&E	0	11	29	Jul-25	0	Common Cause	Not Met
Clostridioides difficile	4	6	7	Jul-25	2	Common Cause	Inconsistent
MRSA Bacteraemia	0	1	0	Jul-25	0	Common Cause	Inconsistent
Number of complaints as a % of admissions	0.50%	0.48%	0.47%	Jul-25	-	Common Cause	Inconsistent
FFT recommendation rates - Trust wide	92.00%	89.00%	90.00%	Jul-25	-	Common Cause	Inconsistent
Care hours per patient - total nursing & midwifery staff actual	-	7.7	7.7	Jul-25	-	Common Cause	No Target Set
Care hours per patient - registered nursing & midwifery staff actual	-	4.5	4.5	Jul-25	-	Common Cause	No Target Set
SHMI	1.00	0.96	0.94	Mar-25	1.08	Improvement	Achieving
Never events	0	0	0	Jul-25	0	Common Cause	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	4525.28	4546.61	4551.43	Jul-25	-	Concern	Inconsistent
Agency (WTE) Trust	13.91	11.98	12.55	Jul-25	-	Improvement	Not Met
Bank (WTE) Trust	442.50	452.34	426.48	Jul-25	-	Common Cause	Inconsistent
Vacancy Rate	6.00%	10.83%	10.26%	Jul-25	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	8.61%	8.38%	Jul-25	-	Improvement	Not Met
Retention Rate (12 Months)	90.00%	93.11%	94.08%	Jul-25	-	Improvement	Inconsistent
Sickness Absence (Rolling 12 Months)	5.00%	6.72%	6.71%	Jul-25	-	Concern	Not Met
Appraisals	90.00%	72.90%	74.93%	Jul-25	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	90.90%	91.08%	Jul-25	-	Improvement	Inconsistent

Operational Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
18 Weeks RTT - % Within 18 Weeks - Incomplete	73.04%	71.46%	71.11%	Jul-25	83.93%	Improvement	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	1.00%	0.16%	0.16%	Jul-25	0.00%	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	26155	28040	28313	Jul-25	14852	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	84.13%	85.62%	Jun-25	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	96.00%	98.10%	96.15%	Jun-25	100.00%	Common Cause	Inconsistent
Cancer - 62 Day Referral to Treatment	75.00%	83.07%	80.34%	Jun-25	82.72%	Improvement	Inconsistent
No. of patients no longer meeting the Criteria to Reside	68	33	44	Jul-25	-	Common Cause	Achieving
Diagnostics - % within 6 weeks from referral	95.00%	73.51%	73.42%	Jul-25	97.57%	Concern	Not Met
Total Time Spent in ED - % over 12 Hours	2.00%	3.84%	4.59%	Jul-25	2.69%	Common Cause	Inconsistent
Total Time Spent in ED - % within 4 Hours	78.00%	78.70%	77.03%	Jul-25	77.49%	Common Cause	Inconsistent

Finance	Target	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£'000) - in month	-800	-892	283	52	Improvement	Achieving
Surplus/(Deficit) (£'000) - YTD	-6,898	-2,841	-2,558	181	Improvement	Achieving
Surplus/(Deficit) (£'000) - FOT	0	0	0	50	-	Achieving
ERF (£'000) - in month	6,369	6,603	6,716	N/A	Improvement	Achieving
ERF (£'000) - YTD	23,859	17,844	24,560	N/A	Improvement	Achieving
ERF (£'000) - FOT				N/A		
Efficiency (£'000) - in month	831	1,633	2,191	623	Improvement	Achieving
Efficiency (£'000) - YTD	2,356	5,035	7,226	2,789	Improvement	Achieving
Efficiency (£'000) - FOT	30,076	30,076	30,076	8,515	-	Achieving
Capital (£'000) - YTD	4,515	1,149	2,189	0	Concern	Not Met
Capital (£'000) - FOT	15,055	14,055	14,405	11,704	Concern	Not Met
Cash (£'000) - in month	7,329	33,591	33,075	2,623	Deterioration	Achieving
Cash (£'000) - FOT	6,652	6,652	6,652	9,056	-	Achieving

Care Colleagues
Collaboration Communities

Quality, Safety and Patient Experience

Quality, Safety & Patient Experience | Executive Summary

Falls per 1,000 Bed Days

- July 2025 rate: 4.51 (↑ from 3.17 in June 2025), below the national mean of 6.1 (Royal College of Physicians).

- 3 severe harm falls reported, all under review via PSIRF processes.

- Improvement Actions: Shared Learning Forum reviewing 1:1 nursing policy and national alignment of 'Enhanced Therapeutic Observations'.

Pressure Ulcers per 1,000 Bed Days

- Overall small increase in incidents (hospital and community).

- The community division is experiencing a cluster of patients with extensive pressure ulceration. On review it is evident that surveillance and documentation have improved.

- A hospital mattress task group has developed a resolution plan to ensure repairs and maintenance of pressure relieving devices.

Observations on Time

- July 2025 compliance:
    - 87.51% including ED (↓ from 88.19%)
    - 90.76% excluding ED (↓ from 91.93%)

- ED performance (65.50%) continues to impact MLTC.

- Improvement Actions: Ongoing review of observation frequency led by the Head of Nursing for Quality.

VTE Risk Assessment

- July 2025 compliance: 88.71% (↑ from 87.93% in June 2025), still below the national target.

- Improvement Actions: Divisional performance reviewed monthly. Reporting at 14-hour threshold continues. Benchmarking data pending.

SHMI (Summary Hospital-level Mortality Indicator)

- Latest data available: February 2025 – SHMI recorded at 0.96, a minor reduction in performance from 0.95 in January 2025.

- Improvement actions: Learning from the deaths process continues to be embedded, with the Mortality Surveillance Group reviewing structured judgment reviews. Focus remains on thematic learning and reducing avoidable deaths.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Quality, Safety & Patient Experience | Executive Summary Cont.

Sepsis Screening

- Adult Inpatients: 72.58% compliance (↓ from 84.61%)

- ED Patients: 87.83% compliance (↑ from 87.69%)

- Paediatrics: Ward 21 – 90%;

- Improvement Actions: Reinforced bundle completion and accuracy of documentation. Inpatient screening remains a focus within the deteriorating patient agenda.

Clostridioides difficile Infection (CDI)

- 7 HOHA and 0 COHA. difficile cases reported in July 2025; national target for 2025/26 set at 65.

- Improvement actions: Focus on timely sampling and antibiotic use

Care Hours Per Patient Day (CHPPD)

- Remained static at 7.7 in July 2025 (7.7 in June 2025).

- Overall combined (RN + CSW): July 2025 95.95% (June 96.05%)

- Improvement actions: CHPPD is stabilising following reductions due to agency control measures; quality trends are being monitored alongside red flag incidents and safe staffing oversight.

FFT Recommendation Rate – Trust Wide

- Current position: 90% in July 2025, below the Trust's target of 92% (previous month: 89%).

- Improvement actions: Divisional patient experience leads continue to monitor FFT returns and address thematic concerns. Work is underway to enhance the use of digital collection tools and increase response rates from underrepresented groups.

Complaints as a Percentage of Admissions

- Current position: 0.47% in June 2025, an improvement from 0.48% in June and lower than the internal threshold of 0.50%.

- Improvement actions: A revised complaints training programme has been implemented, and lessons learned from upheld complaints are disseminated through Quality & Safety Huddles. The Patient Experience Group tracks Complaint response timeliness and quality.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Care Colleagues Collaboration Communities

Midwife-to-birth ratio

- Current position: The current midwife-to-birth ratio at Walsall Healthcare NHS Trust is 26:1 (a very slight decrease in the month), which is below the national benchmark set by Birthrate Plus (28:1).

- Improvement Actions: Continue to engage with regional maternity networks to address workforce recruitment and retention issues. Monitor compliance and staffing impact through Local Maternity and Neonatal System (LMNS) reporting.

Medication Errors - % causing harm

- Current position: 6.4% of errors result in harm; majority of harm is categorised as low harm. In July 2025, and there were no moderate harm or above incidents. Improvement Actions: Themes are identified and actions developed and supported under the Safe Medication Pillar of the Quality Framework 2025-28.

Mental Health Patients Spending Over 24 Hours in ED

- Current position: 29 patients spent over 24 hours in the Emergency Department in July 2025, (11 in June 2025 & 35 in May 2025) There remains system-level strain in the timely provision of mental health assessments and placements posing operational risk to patient care and ED flow.

- Challenges: Ongoing difficulties in securing timely assessments by the Mental Health Liaison Team (MHLT) for adults.

  Reports of Child and Adolescent Mental Health Services (CAMHS) staff not providing face-to-face assessments, opting for telephone triage only.

  Extended out-of-hours delays in consultant or middle-grade psychiatric assessments across the Trust.

  Limited availability of appropriate inpatient mental health beds contributes to prolonged stays.

- Improvement Actions: There has been CEO To CEO escalation of concerns, and we are now awaiting a response.

  The Trust Mental Health Team is working in collaboration with external providers, including Black Country Healthcare NHS Foundation Trust, to improve care pathways and share themes and incidents.
  Pan-Trust training in mental health is delivered to key areas, such as Paediatrics, AMU, and ED, to improve staff confidence and early intervention capability.
  Escalation of concerns via the Patient Safety Group and Safeguarding Committee, with oversight from the Executive Nursing and Medical Leads.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Care Colleagues Collaboration Communities

Outlier status in the National Neonatal Audit Programme

We have received negative outlier status for two of the National Neonatal

Audit Programme 2024 measures

- 1) Breast milk by 2 days: Out of 71 eligible babies 28 that is 40% received breast milk by day 2.

- 2) Deferred cord clamping: Out of the eligible 71 babies 34 that is 47.9% were deferred 60 secs or more.

Improvement Actions:

- Continuous and consistent education across the MDT (neonates and maternity).

- Looking to implement life start trolley with few modification in the accessories.

- Local PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) quad team monitoring on monthly basis for a consistent improvement.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

Patient falls - rate per 1,000 occupied bed days

| Inconsistent | Common Cause | 4.51 |
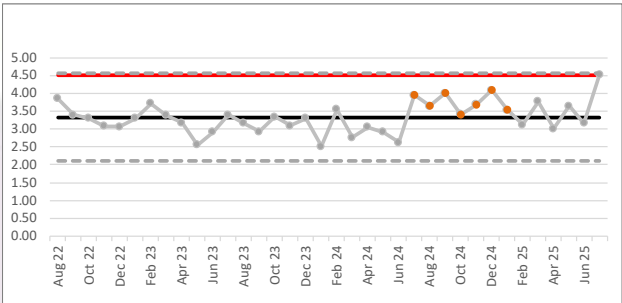
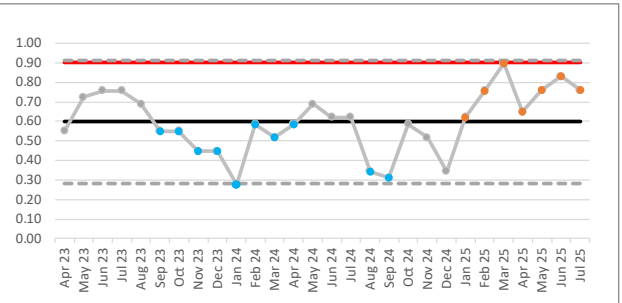## Pressure ulcers per 1,000 occupied bed days

| Inconsistent | Concern | 2.25 |
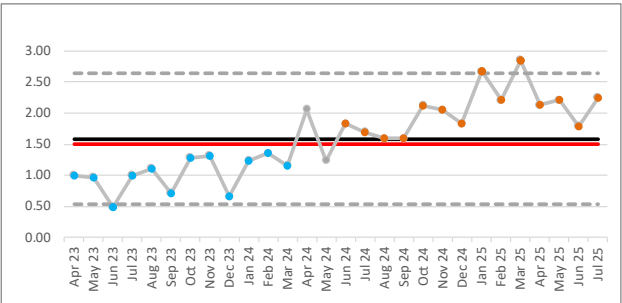
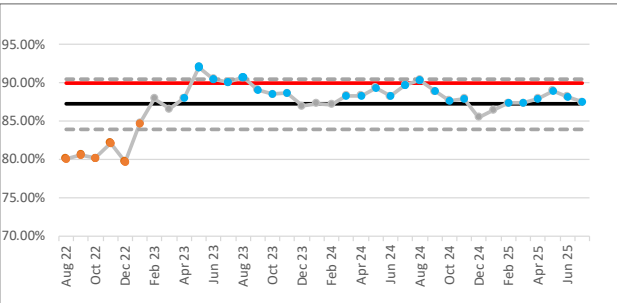## Community acquired pressure ulcers per 10,000 population

| Inconsistent | Concern | 0.76 |

Observations on time (Trust wide)

| Inconsistent | Improvement | 87.51% |

VTE risk assessment - % within 14 hours

| Not Met | Common Cause | 88.71% |
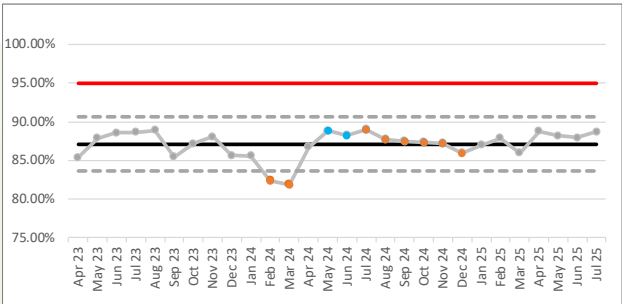
Sepsis screening - ED

| Not Enough Points | Not Enough Points | - |

In Development
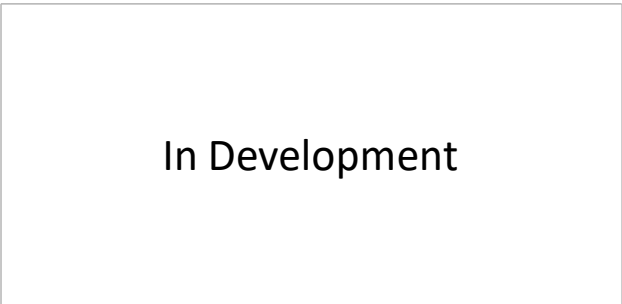
Sepsis screening - Inpatients

| Not Enough Points | Not Enough Points | - |

In Development
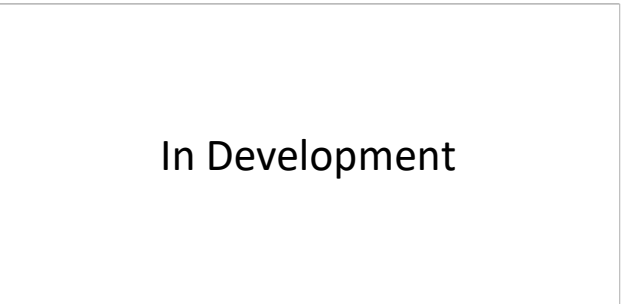
Medication Errors - % causing harm

| Inconsistent | Common Cause | 6.41% |
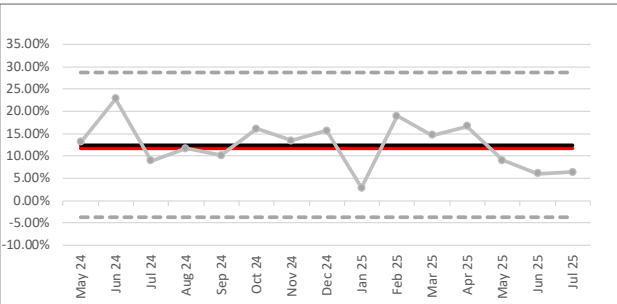
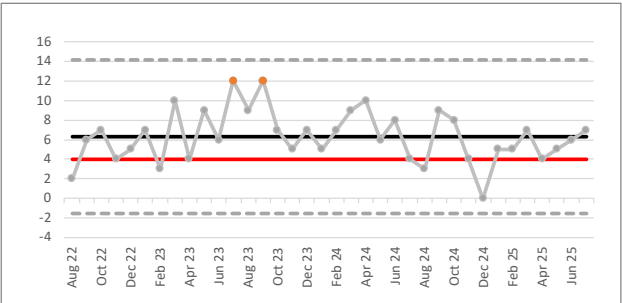## Mental health patients spending over 24 hours in A&E

| Not Met | Common Cause | 29 |
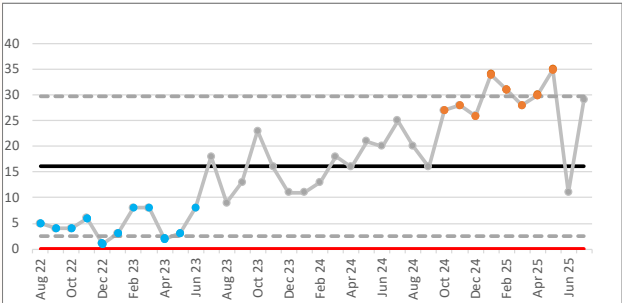
Clostridioides difficile

| Inconsistent | Common Cause | 7 |

MRSA Bacteraemia

| Inconsistent | Common Cause | 0 |
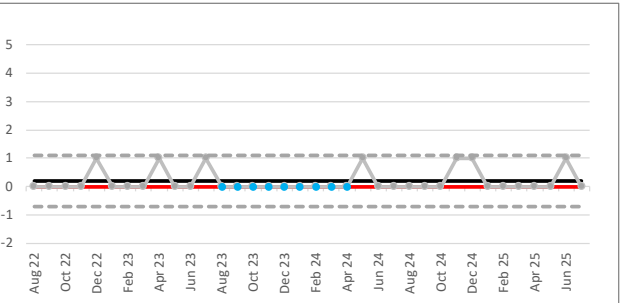
Number of complaints as a % of admissions

| Inconsistent | Common Cause | 0.47% |

Quality, Safety & Patient Experience | Core Metrics

Complaints response rate against policy

Inconsistent	Common Cause	76.67%

FFT recommendation rates - Trust wide

Inconsistent	Common Cause	90.00%

Midwife to birth ratio (1 to)

Inconsistent	Improvement	26.00

Care hours per patient - total nursing & midwifery staff actual

No Target Set	Common Cause	7.7

Care hours per patient - registered nursing & midwifery staff actual

No Target Set	Common Cause	4.5

SHMI

Achieving	Improvement	0.94

Crude Mortality Score

No Target Set	Common Cause	3.06

Never events

Inconsistent	Common Cause	0

Care Colleagues
Collaboration Communities

Perinatal Quality Oversight Model (PQSM) Dashboard 2025/26 Walsall Healthcare NHS Trust

CQC Maternity Inspection 2021	Safe	Effective	Caring	Well-Led	Responsive
	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
CNST Year Six	Full compliance with all 10 safety actions				

Elements of the PQSM are items in the monthly Group Quality Committee reports presented in detail by Directors of Midwifery

	April	May	June	July
PMRT Reviews	0	1	2	5
Grade	A 0 B 0 C 0 D 0	A 0 B 1 C 0 D 0	A 2 B 0 C 0 D 0	PMRT review process still ongoing X1 grade D (MNSI Case as per below)
MNSI	0	0	0	1 Stillbirth 39/40**
Incidents Moderate & Above	3	10	6	5
Service feedback FFT recommendation	94%	93%	88%	89%
Service user & Staff Feedback to Board Level Safety Champions	Delivery Suite	Neonatal Unit	Ante/Postnatal ward	Antenatal Clinic
Coroner Reg 28	0	0	0	0
Midwives Agree/ Strongly agree place to work/ receive treatment reported annually	Recommend as a place to work 60.6% Recommend to family & friends 64.4% *NHS Staff Survey*			
Obstetrics/ Gynaecology Trainees Quality of Clinical Supervision reported annually	Quality of Supervision 90% *GMC national trainee survey*			

*Themes are detailed on page 2

CNST & Training Position 31.07.2026

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	1	6	0	0	7
2	0	2	0	0	2
3	0	2	1	3	6
4	1	8	6	4	19
5	4	7	1	0	12
6	2	6	0	1	9
7	0	1	1	2	4
8	0	20	1	0	21
9	0	7	1	1	9
10	0	9	0	0	9
Total	8	68	11	11	98

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated actions will not be included in this table.

Requirement	NLS	PROMPT	Fetal Monitoring
Neonatal Nurses	87%	NA	NA
Neonatal Doctors	91%	NA	NA
Anaesthetists	79%	79%	NA
Midwives	94%	94%	93%
Obstetric Doctors	89%	89%	95%
MSW's	NA	91%	NA

Perinatal staffing									Actions
Staff Group	April		May		June		July		
Midwives Birth to midwifery ratio Planned/ Actual	22.32	24.08	22.32	24.08	23.68	26.19	22.20	26.00	Ratios based on 2020 not 2024 Birthrate plus recommendations therefor partially compliant. Staffing monitored on a daily basis to maintain safety. Birthrate plus business case in progress. Safe staffing maintained via daily mitigations. Staffing is monitored and escalated via Division, Group Quality Committee, the Neonatal Operational Delivery Network and Local Maternity and Neonatal system
Obstetrics RCOG Compliant on delivery suite	YES		YES		YES		YES		No actions required
Neonatal Nurses BAPM Compliant	Yes		Yes		Yes		Partial		There is an overarching neonatal staffing action plan which is taken through Division, Group Quality Committee, the Neonatal Operational Delivery Network and Local Maternity and Neonatal system
Neonatal Doctors BAPM compliant	Partial		Partial		Partial		Partial		

People

People | Executive Summary

Performance against Trust 2025/26 Workforce Plan

The total workforce WTE deployed in M4 was -20.48 WTE less than M3 and remained ahead of (better than) the NHSE plan. This comprised of a reduction of bank WTEs which offset slight reductions in substantive and agency. M12 compared to M4: total reduction of -94.54 WTE, comprising -33.88 WTE substantive staff, -48.72 WTE bank, and -11.94 WTE agency.

The 2025/26 workforce plan, submitted to NHSE in March set out a total workforce reduction trajectory of 222 WTE including 92 WTE substantive posts based on schemes identified at the time. To bridge an internal cost improvement gap, a further 89 WTE substantive reductions are required and reflected in the Trusts 25/26 financial plan.

Actual performance was a positive variance of -20.48 WTE (better than) plan meaning both the NHSE target and the internal stretch target were achieved.

Authors

Alan Duffell
(Group Chief
People Officer)

Performance against Key Workforce Metrics

- Three of the six workforce indicators are within target KPI range:
  - The 12-month turnover rate (8.4%) reflects stabilised performance, now achieving the 10% target.
  - Due to an increase month on month, assurance can be provided that the 12-month retention rate, currently 94.1%, will meet the 90% target following continued performance trend improvement.
  - The mandatory training compliance rate has further improved at 91.1% providing limited assurance, in the context of a 24-month trend, that the 90% target will be consistently met, with the performance trend currently improving.
- The following three workforce indicators are outside the target KPI range:
  - The vacancy rate remains above the 6% target and is reflective of the workforce plan.
  - There is no current assurance that the rolling 12-month sickness absence rate will meet the target of 5% remaining consistent at 6.7%. In month SA has increased from 5.8% to 6.1% driven by 66.27% of long term sickness absence.
  - There is no assurance that appraisal compliance, currently at 74.9%, will consistently achieve the 90% target, although the short-term performance trend is improving having increased from 72.9% in June. Validation of data to support the transition of recording from ESR to my academy continues at local level during July and August with an intention to achieve an increased trust compliance level of 80% by the end of September.

Care Colleagues
Collaboration Communities

People | Core Metrics

Substantive (WTE) Trust
| Inconsistent | Concern | 4551.43 |
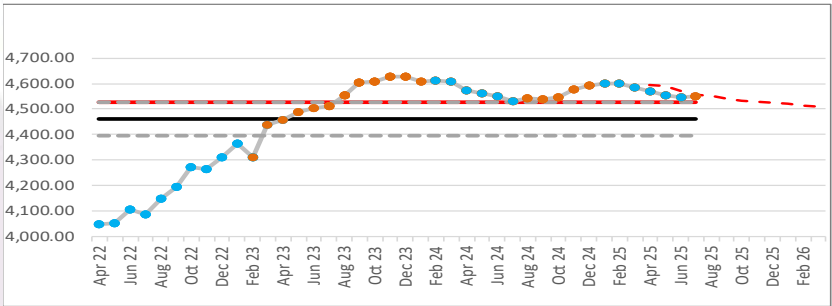
Agency (WTE) Trust
| Not Met | Improvement | 12.55 |
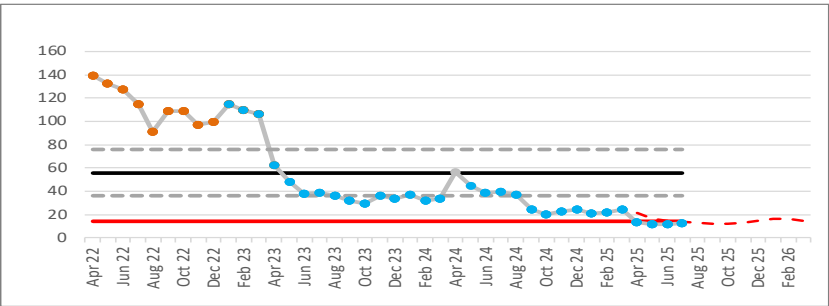
Bank (WTE) Trust
| Inconsistent | Common Cause | 426.48 |
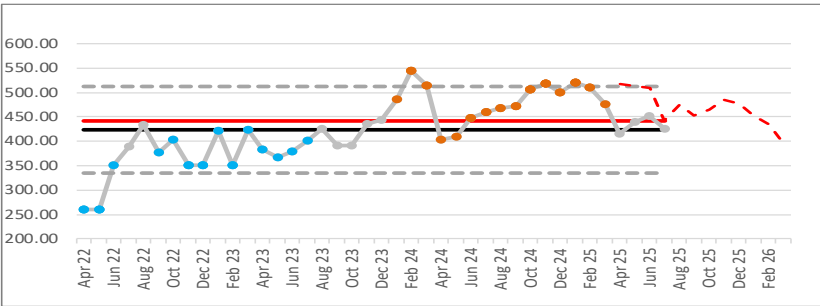
Vacancy Rate
| Inconsistent | Concern | 10.26% |
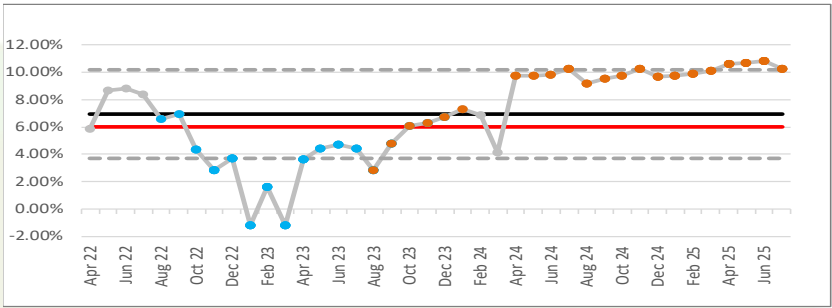
Turnover Rate (12 Months)
| Not Met | Improvement | 8.38% |
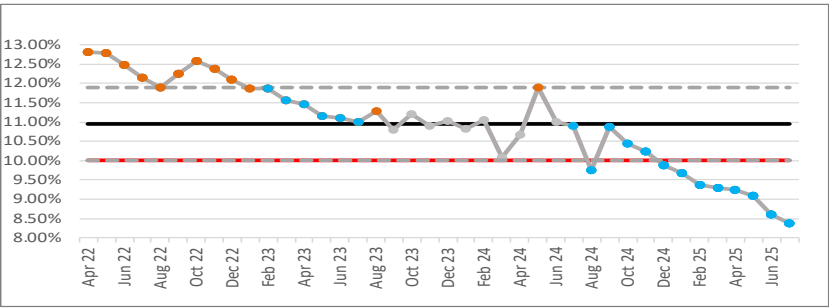
Retention Rate (12 Months)
| Inconsistent | Improvement | 94.08% |
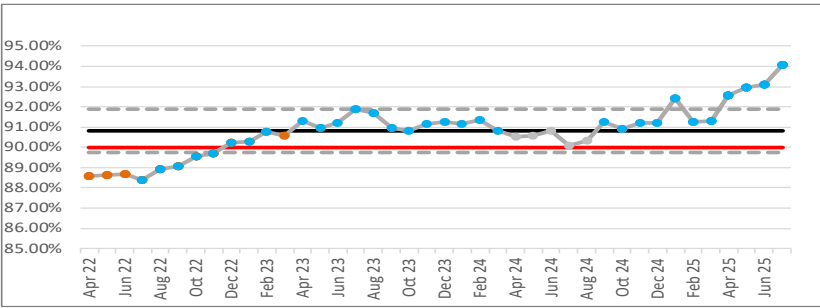
Sickness Absence (Rolling 12 Months)
| Not Met | Concern | 6.71% |
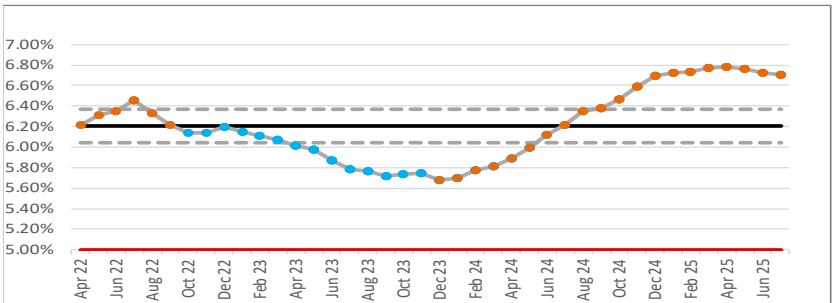
Appraisals
| Not Met | Concern | 74.93% |
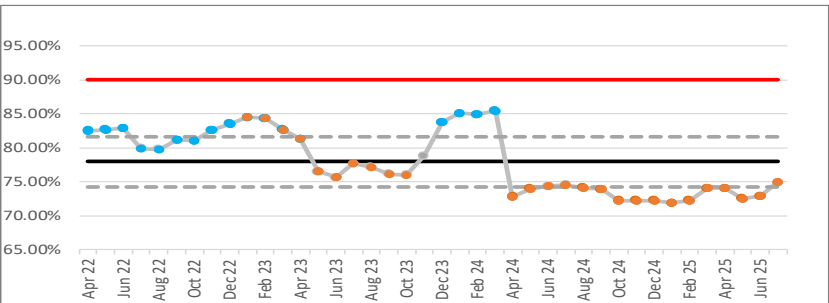
Statutory & Mandatory Training
| Inconsistent | Improvement | 91.08% |
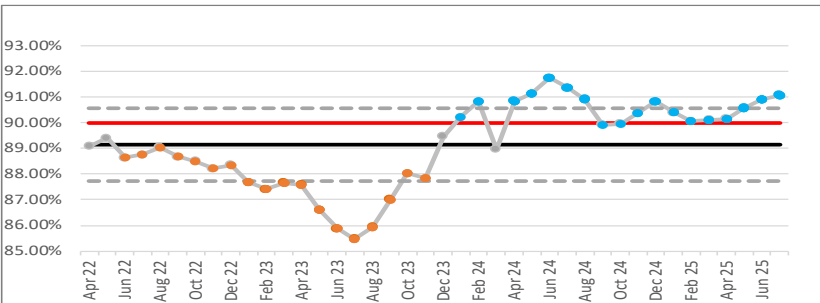
Operational Performance

Operational Performance | Executive Summary

Authors

Will Roberts
(Chief Operating Officer)

Urgent & Emergency Care
The Trust has seen a reduction in performance against the 4-hour Emergency Access Standard, taking performance from 78.7% to 77.03% in July, ranking 42nd nationally. This is still in line with the Trust's submitted trajectory. Performance in August is recovering as is on track to reach 79%. Type 1 attendances are also up 3.7% YTD compared with 2024/25.

Cancer Care
Performance remains strong and the Trust is meeting all three constitutional standards for access to treatment for cancer. Statistically significant improvement remains both for access to treatment within 62 days and access to diagnosis within 28 days. Against the 62-day standard, the Trust ranks 13th nationally.

Elective Care
The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for nine consecutive months, and remains slightly ahead of the 5% point improvement trajectory expected in 2025/26. The Trust also has the fewest patients waiting more than 52 weeks for treatment.

Diagnostics
The Trust has seen deterioration in access to diagnostics within 6 weeks, ranking in the 3rd quartile nationally.. This is being driven through access to audiology, non-obstetric ultrasound and cardiac physiology. Audiology will recover to meet the standard by February 2026. Recovery trajectories in the remaining two areas have now commenced, with improvement expected to be seen in September's performance.

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

18 Weeks RTT - % Within 18 Weeks - Incomplete

| Not Met | Improvement | 71.11% |

18 Weeks RTT - No. of 52 wk breaches

| Not Met | Improvement | 46 |

18 Weeks RTT - 52 wk breaches as a % of PTL

| Not Met | Improvement | 0.16% |

18 Weeks RTT - No. of 65 wk breaches

| Not Met | Improvement | 2 |

18 Weeks RTT - Total Incomplete PTL

| Not Met | Improvement | 28313 |

18 Weeks RTT - Clock Starts

| No Target Set | Concern | 9457 |

18 Weeks RTT - Time to First Appointment

| Not Enough Points | Not Enough Points | 76.92% |

Ambulance Handover - % within 15mins

| Not Met | Concern | 35.63% |

Ambulance Handover - % within 30mins

| Inconsistent | Common Cause | 87.94% |

Operational Performance | Core Metrics

Ambulance Handover - % within 60mins

| Inconsistent | Common Cause | 97.11% |

Cancer - 2 Week Wait

| Inconsistent | Common Cause | 89.63% |
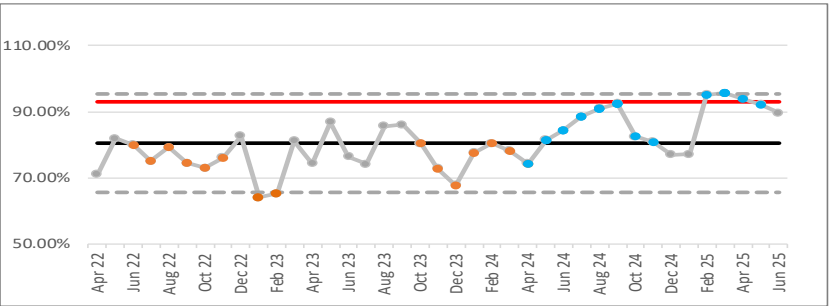
Cancer - 28 Day Faster Diagnosis

| Inconsistent | Improvement | 85.62% |
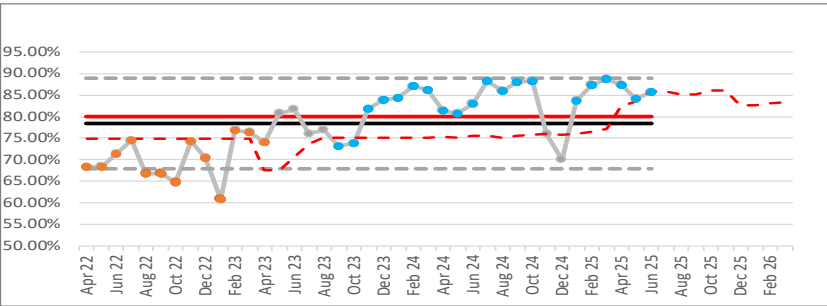
Cancer - 31 Day Treatment

| Inconsistent | Common Cause | 96.15% |
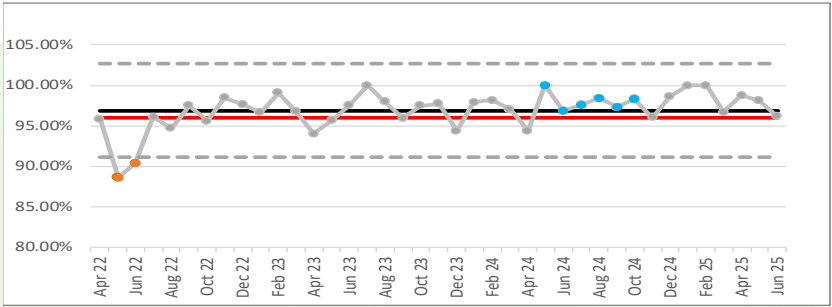
Cancer - 62 Day Referral to Treatment

| Inconsistent | Improvement | 80.34% |
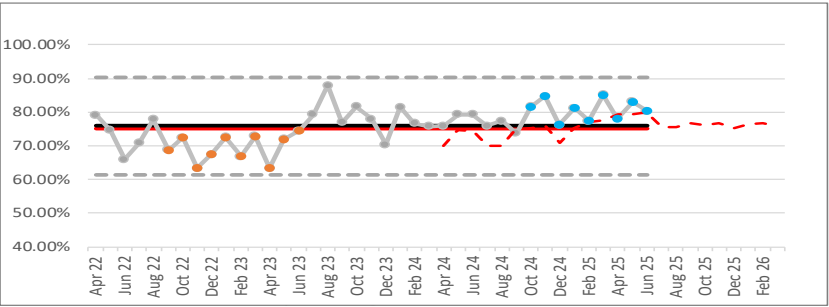
Cancer - No. of patients waiting 63+ Days for treatment

| No Target Set | Improvement | 50 |
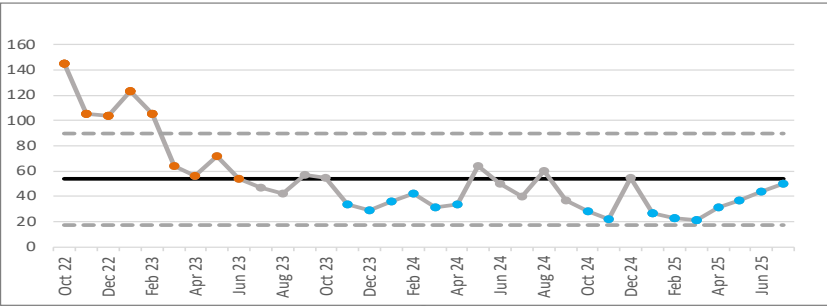
No. of patients no longer meeting the Criteria to Reside

| Achieving | Common Cause | 44 |
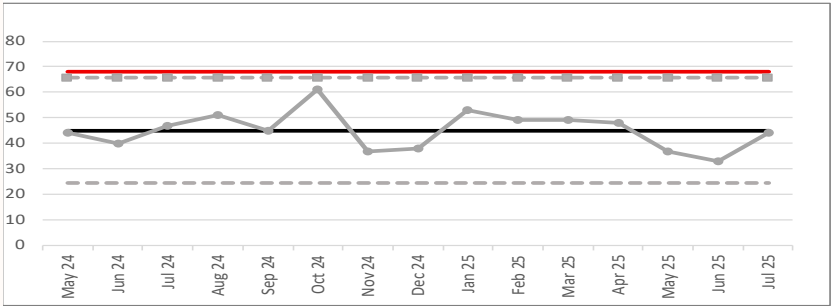
Diagnostics - % within 6 weeks from referral

| Not Met | Concern | 73.42% |
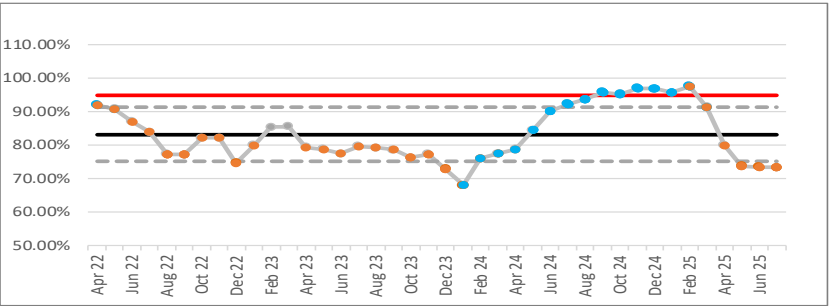
Total Time Spent in ED - % over 12 Hours

| Inconsistent | Common Cause | 4.59% |
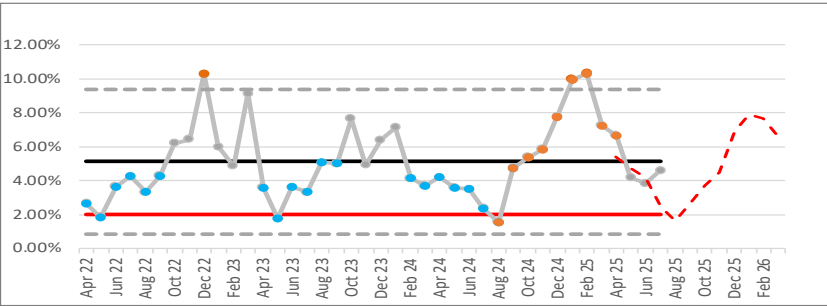
Operational Performance | Core Metrics

Total Time Spent in ED - % within 4 Hours

| Inconsistent | Common Cause | 77.03% |
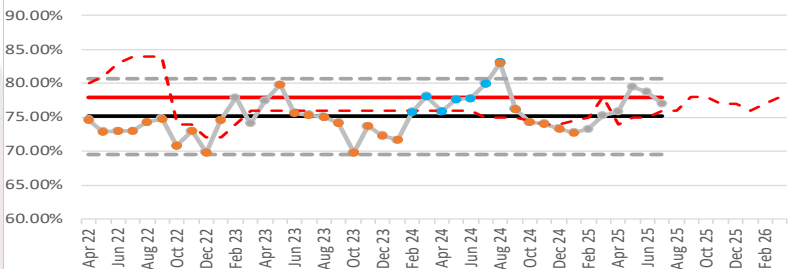
Type 1 ED Attendances

| No Target Set | Concern | 9865 |
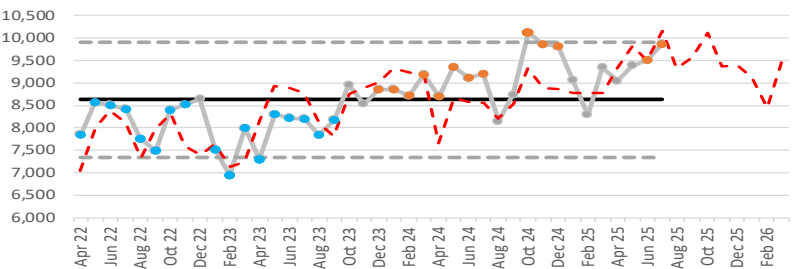
Deliver % of Activity Delivered in 2019/20 (Variable Contract Delivery)

| Inconsistent | Common Cause | 116% |
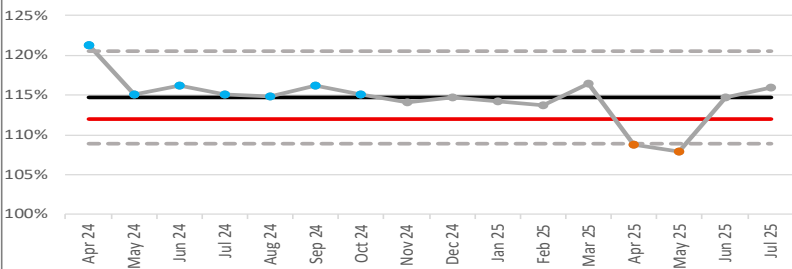
Theatres - Touch Time Utilisation (MH)

| Inconsistent | Common Cause | 84.30% |
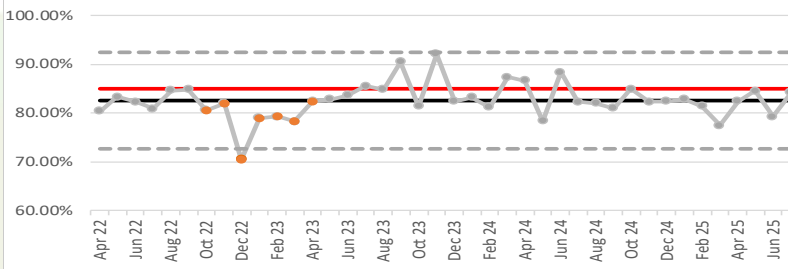
Community - Virtual Ward % Occupancy

| Not Met | Improvement | 78.41% |
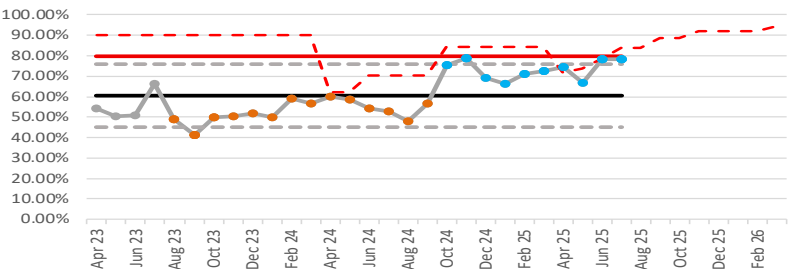
Community - Urgent Care Response (UCR) 2 Hour Response

| Inconsistent | Common Cause | 65.90% |
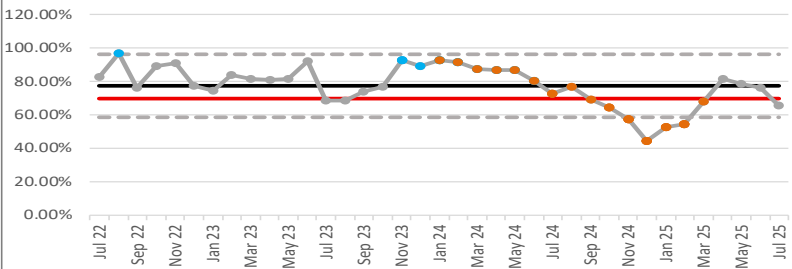
Community - Waiting List - Total

| No Target Set | Concern | 5516 |
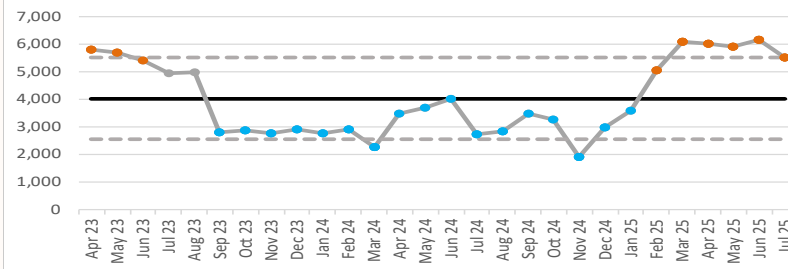
Operational Performance | Benchmarking
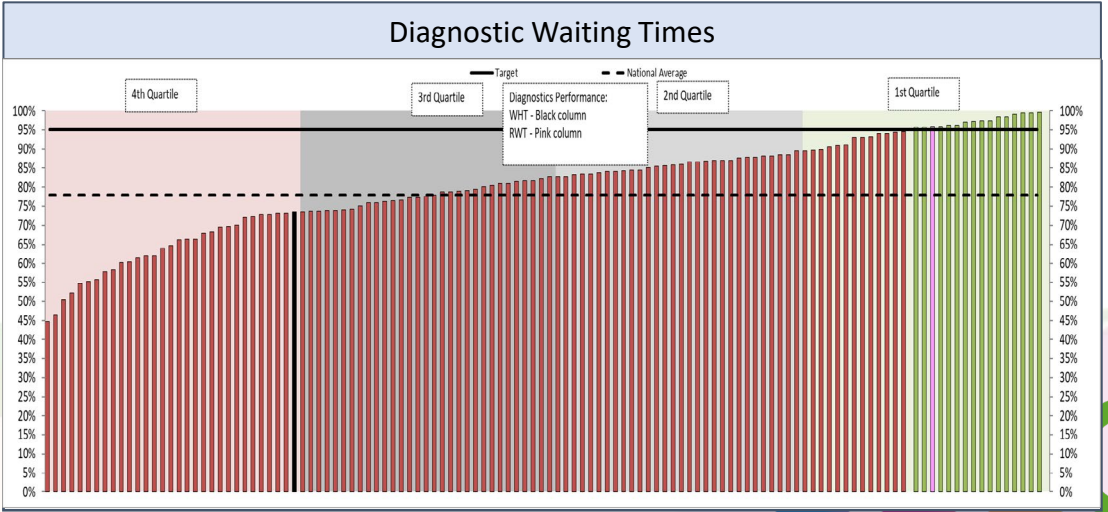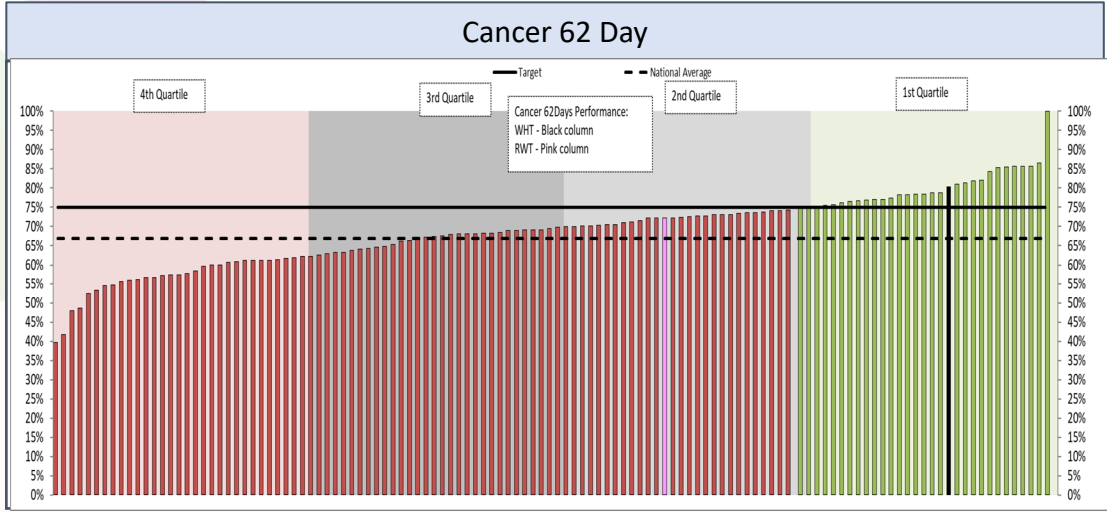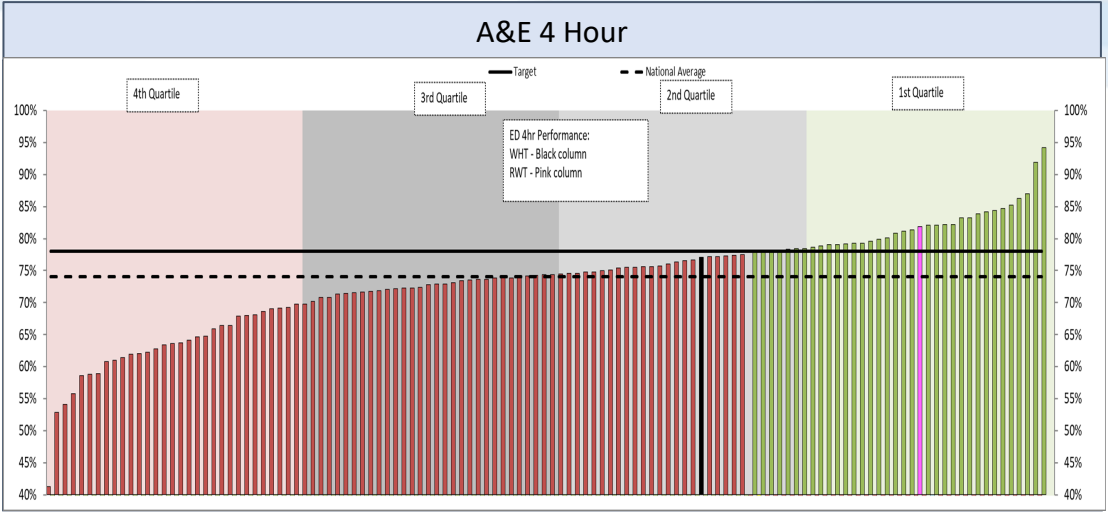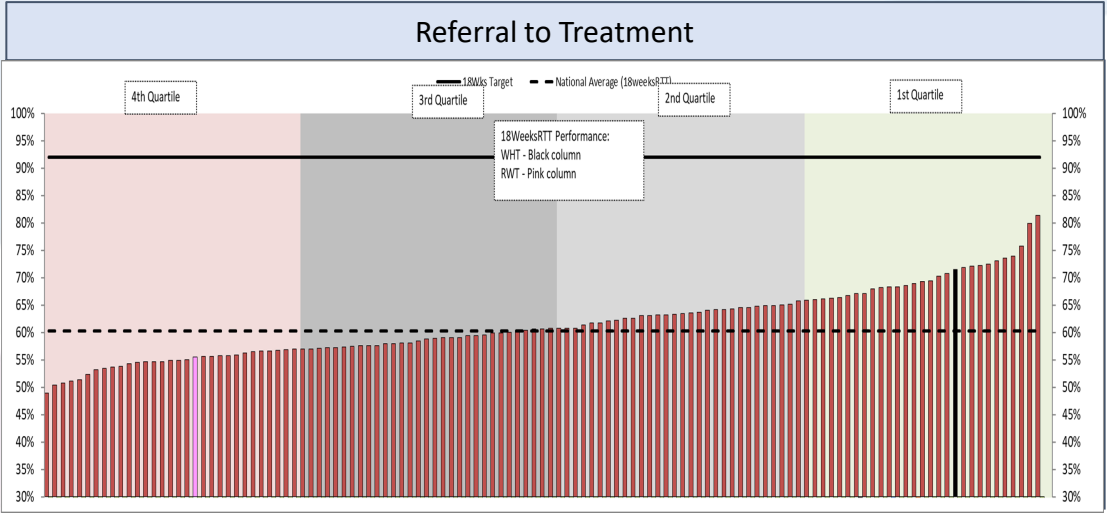
Finance

Finance | Executive Summary

Revenue

WHT is ahead of plan by £4.3m at month 4. Increased CIP performance has been the driver for this improvement.

The WHT plan assumed that unidentified CIP at the start of the financial year would be achieved in the 2nd half of the financial year. As a result the plan has a deficit of c£8.9m in the first half of the financial year and then a surplus of c£8.9m in the second half of the year. With performance being better than plan at month 4 that will 'smooth' the improvement trajectory, the I&E performance chart on the following slide demonstrates this.

This month includes c£0.7m of ERF performance over contract. There is currently no pathway for this to be funded but discussions are taking place with the ICB. If no income route can be identified then the Trust will need to reduce elective activity later in the financial year. The Trust has allowed funding for WLIs within the financial plan. At current run rate that funding will be exhausted in Month 5. Noting that some WLIs are used for non-elective activity.

Stike costs are currently forecast at £0.406m for the July industrial action. However, this is based on rotas and acting down forms from consultants are still awaited

CIP is £7.2m versus a plan of c£2.4m, so a YTD positive variance of c£4.87m

Capital

Year to date capital expenditure at month 4 is £2.189m, £0.821m on PSDS.

The Theatres refurbishment and reconfiguration project remains the main part of the 25/26 capital programme. The project has suffered numerous delays and is now expected to complete in quarter 4 of 25/26. However, there remains risk to completion. Discussions with contractors imply there may be increased cost pressure, however discussions are ongoing.

The Trust has received notification of increased capital allowances for 25/26, (c£0.6m). Further discussion on the allocation of this allowance is in progress with a number of areas of pressure (Theatres, IT. Medical equipment).

Cash

The Trust cash position at end of month 4 is £33.1m. The CIP programme will see more benefits in half 2 which will see the Trust make deficits in half 1 and the cash position reduce. Current forecasts indicate the Trust will not need cash support.

Authors

Kevin Stringer
(Group Chief
Finance Officer)

Finance | I&E Summary

	Plan £000s	Actual £000s	Variance £000s
Income			
Patient Care Income	149,175	149,188	13
Education and Training Income	4,307	4,272	(34)
Other Income	2,949	3,250	301
Interest Receivable	601	601	0
Subtotal Income	**157,032**	**157,311**	**280**
Pay Expenditure			
Substantive Salaries	(100,562)	(91,998)	8,565
Temporary Nursing	(612)	(4,398)	(3,786)
Temporary Medical	(262)	(3,049)	(2,787)
Temporary Other Clinical	(26)	(907)	(881)
Temporary Non Clinical	(119)	(1,863)	(1,744)
Subtotal Pay Expenditure	**(101,582)**	**(102,215)**	**(633)**
Non Pay Expenditure			
Drugs	(9,871)	(10,068)	(197)
Clinical Supplies and Services	(8,307)	(8,421)	(114)
Non-Clinical Supplies and Services	(12,489)	(13,175)	(686)
Other Non Pay	(16,231)	(15,468)	763
Depreciation	(5,054)	(4,799)	255
Subtotal Non Pay Expenditure	**(51,951)**	**(51,930)**	**21**
Subtotal CIP	**(4,823)**	**0**	**4,823**
Interest Payable and PDC	(5,026)	(5,030)	(4)
Subtotal Finance Costs	**(5,026)**	**(5,030)**	**(4)**
Adjust PFI revenue costs to UK GAAP basis	(548)	(694)	(146)
Total Surplus / (Deficit)	**(6,898)**	**(2,558)**	**4,340**

Patient Care Income is behind plan due to planned additional variable income CIP which is restricted due to commissioner affordability. This is offset by reduced expenditure.

Education & Training income is within £34k of plan and is based on a detailed funding schedule received this month.

Other Income is ahead of plan due to Staff Benefits and R&D income being ahead of plan.

Pay is overspent by £0.633m. Lower than planned headcount (4990 v 5011 plan) and reduced temporary expenditure have allowed greater CIP delivery than planned. However, pressures within Medical Staffing (Including Industrial Action) are driving an overall overspend.

Non-Pay overall is on plan with pressures in Drug, Consumables and Services offset by underspends in Premises costs and Depreciation

Finance | Variable Contract Performance

Variable Contract Delivery vs Funding Limit, Internal Plan and Historical – 2025/26
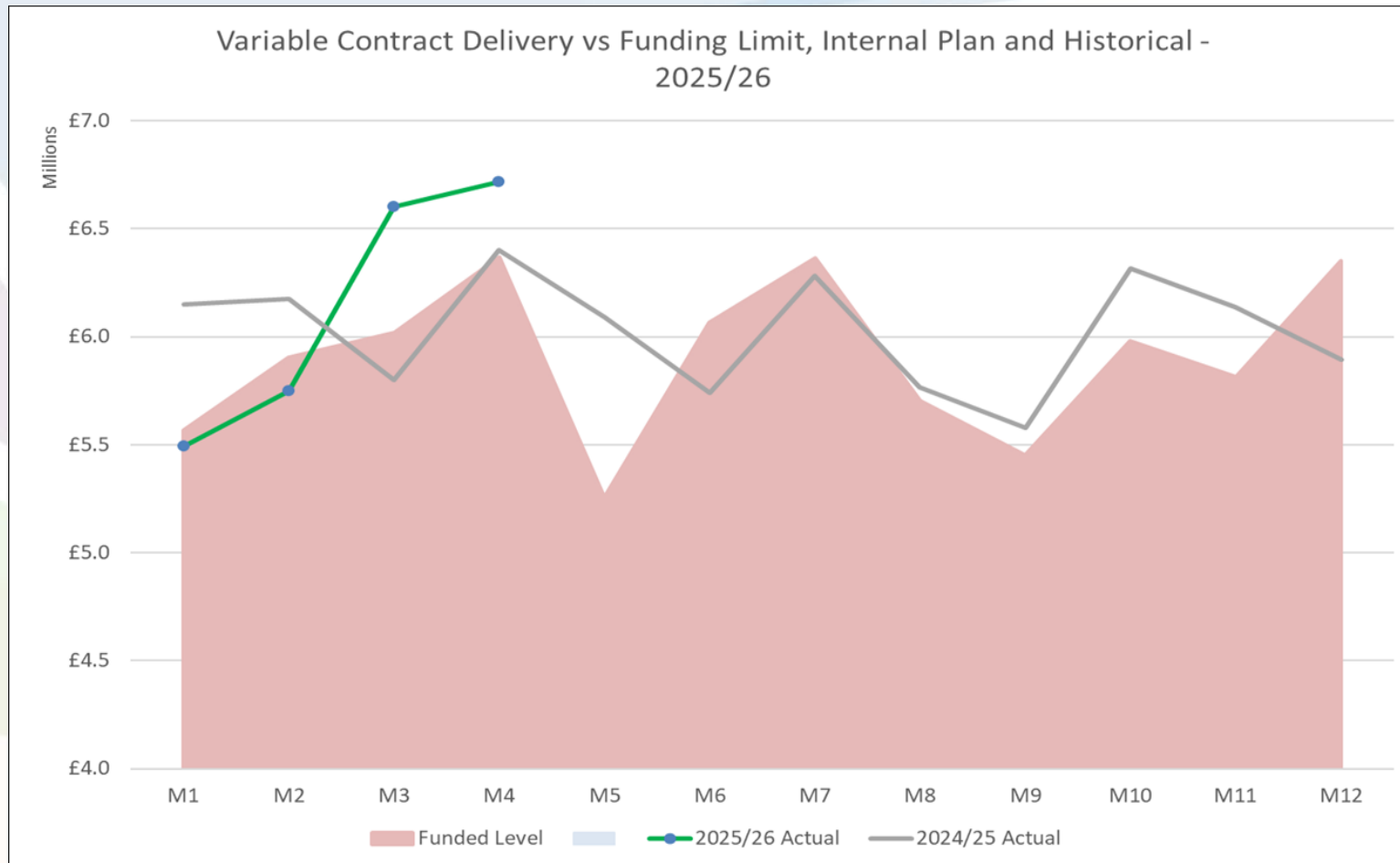
Performance

The Trust is delivering:

- 116% of 2019/20 at month 4
- £701k above the contracted funding limit.
- YTD performance is driven by elective inpatient and daycase activity within T&O (£661K).

Assumptions & Basis

Formal indicative activity plans have been agreed with the commissioners.

- The funding limit is based on a fixed commissioner affordability level within the contract.
- Funding limits and divisional targets may change depending on variation in performance across the systems and commissioner funding becoming available.
- Variable performance includes chemotherapy and diagnostic imaging.

Finance | Cost Improvement Plans

Plan vs Target

The Trust CIP target of £30.1m includes £9.8m of headcount reduction plans. A significant proportion of the forecasted schemes £17.4m (58%) are largely rated **Amber**, **Red** including the GAP (**Blue**) as Divisions work through plans to deliver.

The summarised table highlights the risk at the Plan stage.

Pie chart:
- 7,229,180, 24%
- 12,697,742, 42%
- 4,244,908, 14%
- 5,904,171, 20%

2025/26 - Target vs Forecast vs Actual

Legend:
- ActualRec
- ActualNRec
- Target
- ProfiledForecast
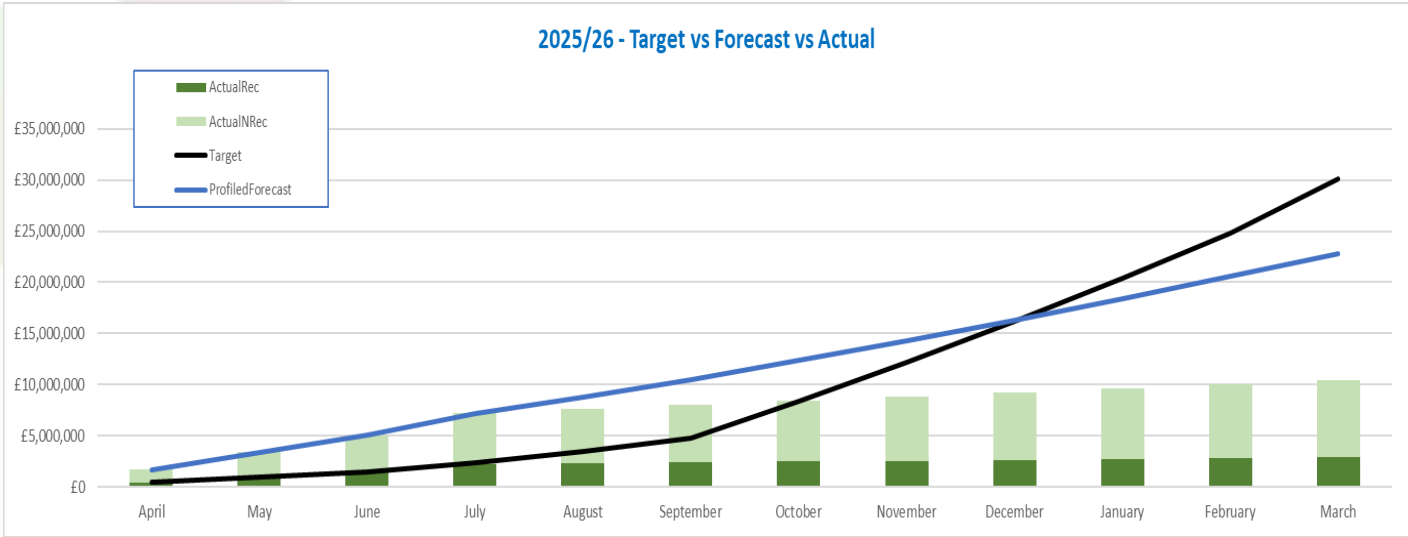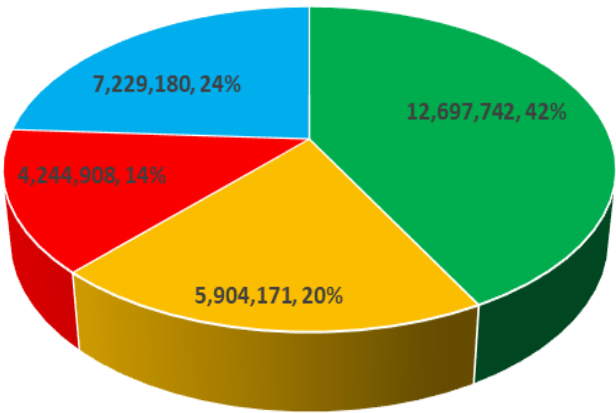
Plan Risk	Target
Green	£5,989,742
Amber	£2,799,371
Red	£21,286,887
Grand Total	£30,076,000

Care Colleagues
Collaboration Communities

National Oversight Assurance Framework Dashboard

National Oversight Assurance Framework Dashboard

Oversight Framework	Target / Limit	Previous Month	Current Month	Latest Time Period	Variation	Assurance
18 Weeks RTT - % Within 18 Weeks - Incomplete	73.04%	71.46%	71.11%	Jul-25	Improvement	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	1.00%	0.16%	0.16%	Jul-25	Improvement	Not Met
Difference between actual and planned 18 week elective performance	-	2.42%	1.43%	Jul-25	Not Enough Points	Not Enough Points
Percentage of patients waiting over 52 weeks for community services	0.00%	4.36%	4.89%	Jul-25	Concern	Inconsistent
Cancer - 28 Day Faster Diagnosis (Rolling 12 Months)	80.00%	84.43%	84.67%	Jun-25	Improvement	Not Met
Cancer - 62 Day Referral to Treatment (Rolling 12 Months)	75.00%	79.27%	79.36%	Jun-25	Improvement	Inconsistent
Total Time Spent in ED - % within 4 Hours (Rolling 3 Months)	78.00%	78.03%	78.40%	Jul-25	Improvement	Not Met
Total Time Spent in ED - % over 12 Hours	2.00%	3.84%	4.59%	Jul-25	Common Cause	Inconsistent
Planned Surplus / Deficit	-	-892	283	Jul-25	Not Enough Points	Not Enough Points
Year to date variation from plan	-	-2841	-2558	Jul-25	Not Enough Points	Not Enough Points
Implied level of productivity	-	-	4.35	Jun-25	Not Enough Points	Not Enough Points
CQC inpatient survey satisfaction rate	-	7.7	7.8	Dec-23	Not Enough Points	Not Enough Points
Staff survey - raising concerns sub-score	-	6.29	6.34	Dec-24	Not Enough Points	Not Enough Points
CQC safe inspection score	-	-	3	Dec-22	Not Enough Points	Not Enough Points
Rate of C-Diffcile infections (Rolling 12 Months)	100.00%	92.31%	96.92%	Jul-25	Improvement	Not Met
Number of MRSA infections (Rolling 12 Months)	0	3	3	Jul-25	Concern	Not Met
Rate of E-Coli infections (Rolling 12 Months)	100.00%	189.58%	193.75%	Jul-25	Concern	Not Met
Average number of days between planned and actual discharge date	-	5.36	5.33	Jul-25	Improvement	No Target Set
Summary Hospital Level Mortality Indicator (Rolling 12 Months)	1.00	0.96	0.94	Mar-25	Improvement	Achieving
Community - Urgent Care Response (UCR) 2 Hour Response	70.00%	76.19%	65.90%	Jul-25	Common Cause	Inconsistent
Staff survey engagement theme score	-	6.84	6.80	Dec-24	Not Enough Points	Not Enough Points
Staff Sickness Rate (Rolling 12 Months)	5.00%	6.72%	6.71%	Jul-25	Concern	Not Met

Model Health System

NHS Oversight Framework Summary

Overall Domain and Segment Scores	Latest Published Data
	Q1 2025/26
Headlines	NOF Score
Oversight Framework Segment latest Distribution	3
Average Metrics Score	2.03
Pre-Adjusted Segment	2
Is this segment down graded due to financial deficit	Yes
Is the Organisation in the Provider Improvement Programme	No

The Performance Assurance Framework has now been confirmed with the indicators above applicable to the Trust. The Trust has been placed into Segment 3 for Quarter 1 of 2025/26.

The dashboard will be reported routinely going forward.

Care Colleagues
Collaboration Communities

Productivity Dashboard

WHT - Productivity Dashboard

Ref no.	Theme and KPI	Definition	2025/26											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	Implied Productivty Growth (year to date compared to last year)	Output growth (cost-weighted activity) divded by input growth (workforce) compared to the same in last years period.	To follow, on release of methodology. Expected next month											
Operational and Clinical Productivity / Best Practice														
2	Average LOS for elective admissions (excluding daycases)	Average length of stay for all elective patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	2.70	3.40	2.90	2.80								
3	Average LOS for non-elective admissions	Average length of stay for all patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	8.70	8.00	8.10	7.70								
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	94.0%	94.4%	93.0%	93.3%								
5	Bed Occupancy classed as clinically ready for discharge (% of acute)	The average number of patients across the month who do not meet the criteria to reside (Question 2), divded by the total number of patients in hospital or discharged by 23:59 each day (sum of Question 3a and 3b).	23.5%	22.2%	21.5%	21.9%								
Theatre Utilisation														
6	Capped elective theatre utilisation	Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration	88%	84%	93%	85%								
7	Average number of cases completed per theatre list	Total number of cases completed divided by total number of sessions utilised	1.78	1.89	1.83	1.96								
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	93%	90%	96%	91%								
9	CT, MRI & ultrasound utilisation		To follow next month											
Outpatients														
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	78%	79%	80%	79%								
11	DNA Rate	Number of outpatient missed outpatient appointments divded by total outpatient appointments	8%	8%	8%	9%								
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	4%	5%	5%	5%								
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referra) divded by total number of outpatient first attendances	9%	9%	9%	6%								
14	Number of FUs taking place unfunded (by virtue of exceeding cap)	Number of follow ups taking place over and above 2019/20 amount	0	0	963	0								

Productivity Dashboard

Ref no.	Theme and KPI	Definition	2025/26											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Coding/ Income														
15	Mean price per spell charged	Total income for elective inpatient, daycase and non-elective patients divided by total volume of elective inpatient, daycase and non-elective activity.	£1,798	£1,849	£1,813	£1,380								
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes	£145 k	£96 k	£182 k	£270 k								
17	Number of unfunded services being delivered	Number of services being delivered that do not have any form of funding arrangement in place	9	9	5	5								
Non Pay														
18	Procurement CIP	Value of procurement cost improvement savings delivered	£149 k	£269 k	£172 k	£205 k								
Workforce Productivity														
19	Non-elective admissions per clinical WTE	The number of non-elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	3.03	3.07	3.02	3.20								
20	Elective admissions per clinical WTE	The number of elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	1.55	1.59	1.76	1.85								
21	Outpatient attendances per consultant WTE	The number of outpatient admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	130.88	131.46	137.71	139.92								
22	A&E attendances (Type & 2) per Emergency Medicine Consultant	The number of A&E attendances (Type 1 & 2) in month, divded by the number of Emergency Medicine Consultants (WTEs) including substantive, bank and agency staff.	529.90	492.32	475.18	492.55								
23	Corporate services cost per £100m income (£m)	The total cost of corporate services divided by £100m.	0.55	0.54	0.51	0.50								
Workforce Drivers														
24	Temporary Staff Spend as a % of Total Spend	Proportion of financial year-to-date total staff spend that is on temporary staffing (a combination of agency and bank staff	9.7%	10.2%	10.3%	9.7%								
25	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	5.64%	5.64%	5.76%	6.05%								
26	Turnover Rate	The percentage of all staff that left the organisation to join another NHS organisation, or left NHS over the previous 12 months.	9.24%	9.09%	8.61%	8.38%								
27	Care hours per Patient Day	Total care hours worked by registered nurses & midwives divided by total patient bed days	9.00	8.70	7.70	7.70								
Support Services														
28	Estates and Facilities Cost per m2	Total estates and facilities running costs divided by total occupied floor area	To follow next month											
29	Pathology cost per test	The average cost of undertaking one test across all disciplines, taking into account all pay and non-pay cost items	To follow next month											

Tier 1 - Paper ref:	Enclosure 8.4 Public/Sept/25

Report title:	Group Chief Community and Partnerships Officer Report
Sponsoring executive:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Report authors:	Stephanie Cartwright, Group Chief Community and Partnerships Officer Michelle McManus, Director Place & Transformation, Walsall Together Matthew Wood, Head of the Programme and Transformation Office, OneWolverhampton
Meeting title:	Group Trust Board
Date:	16th September 2025

1. Summary of key issues/Assure, Advise, Alert

This report provides an overview of developments within the Walsall Together and OneWolverhampton partnerships.

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

Care	- Excel in the delivery Care	☒
Colleagues	- Support our Colleagues	☒
Collaboration	- Effective Collaboration	☒
Communities	- Improve the health and wellbeing of our Communities	☒

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

OneWolverhampton Board – July 2025
Walsall Together Partnership Board – July (development session) and August 2025

4. Recommendation(s)/Action(s)

The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:

a) Acknowledge the progress being made towards the delivery of integrated care

b) Take assurance on the progress being made by the place partnerships in improving the health and wellbeing of our communities.

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

Group Assurance Framework Risk GBR01	☐	*Break even*

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Group Assurance Framework Risk GBR02	☐	*Performance standards*
Group Assurance Framework Risk GBR03	☐	*Corporate transformation*
Group Assurance Framework Risk GBR04	☐	*Workforce transformation*
Group Assurance Framework Risk GBR05	☒	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date: not required		
Is Equality Impact Assessment required if so, add date: not required		

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Group Chief Community and Partnerships Officer Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 16th September 2025

1. Executive summary

This report provides an overview of progress, performance and assurance across the Walsall Together and OneWolverhampton partnerships.

We have 2 well-established place partnerships; OneWolverhampton and Walsall Together. The partnership, ambition and infrastructure already exist that will enable delivery of this agenda and maximise the intended benefits. Under the Communities strategic objective, the place partnerships drive integrated care, address health inequalities and deliver care closer to home.

Our place partnerships are embracing the opportunities that the recently published NHS Plan offers including the development of neighbourhood health and further integrated care. Discussions are also taking place across the partnerships in relation to the development of integrated health organisations and the opportunities afforded from delegation in the future.

Both place partnerships have recently submitted applications to be part of the national Neighbourhood Health Pioneer Programme. Walsall place based partnership was successful and will commence the programme in September 2025. All successful places will become an accelerator site, with support from a national team to develop neighbourhood working at pace.

2. OneWolverhampton Update

2.1 From Acute to Community: National Neighbourhood Pioneers application

Wolverhampton applied to take part in the National Neighbourhood Pioneers Programme but was unfortunately unsuccessful. It was a competitive process, with 42 Places being selected as part of the first wave.

The application was based on our strong foundation of integrated, place-based working, with the focus now on accelerating the rollout of the four-neighbourhood model—North, East, South, and West—aligned with established Family Hubs. This will enable more localised, joined-up, and preventative care across the life course.

The application focused on the partnership's ability to:

- Shift from reactive to proactive care, using tools like PRADA to drive early identification and intervention, reducing reliance on acute services.
- Integrate wider services—including education, housing, employment and VCSE partners—to tackle the broader determinants of health.
- Support smoother transitions between children's and adult services by aligning neighbourhood delivery with Family Hubs.
- Deepen resident involvement, using a joined-up insight model that reduces duplication and maximises community voice.

The partnership working is already delivering measurable impact:

- PRADA-driven end-of-life planning increased register size by 20% and enabled 97% of patients to avoid hospital admission
- A wellbeing programme across the North Network PCN supported 115 residents to lose 226kg collectively, improving health and confidence.
- Uptake of physical health checks for people with Serious Mental Illness rose from 58% to 67%, exceeding national targets
- Falls prevention work in care homes cut falls by 30% and reduced ambulance callouts by 33%

The partnership are in a strong position to develop neighbourhood working locally, given ring-fenced funding from the Better Care Fund (BCF) to support the delivery of this work. The partnership will work closely with Walsall Together colleagues who will share the learning from the programme across all of the places in the Black Country.

2.2   **From Analogue to Digital: Health Service Journal (HSJ) Award Nomination**

Our Technology Enabled Care (TEC) programme has been nationally recognised and shortlisted for a prestigious HSJ Award. We are taking strides in the realisation of the key shift from analogue to digital and are demonstrating how digital-first, co-produced solutions can transform health and care.

The pilot programme has moved the city from reactive, analogue models to preventative, personalised digital care. Over 170 residents have already benefitted, with 78% reporting greater independence and 66% an improved quality of life. Alongside these outcomes, £616,000 in gross annual savings have been achieved. Residents describe the technology as providing safety, reassurance, and reduced isolation.

Delivery has been underpinned by strong collaboration with residents, carers, social workers, and partners including Alcove, Rethink Partners, Care City, and the Department for Science, Innovation and Technology. The introduction of Digital Care Navigators, embedded

within the partnership, has been key to driving cultural change, training staff, and ensuring digital tools are tailored to individual needs.

By sharing learning across regional networks and through business case evaluations, OneWolverhampton is positioning itself as a leader in digital-first integrated care. This work not only demonstrates compliance with national priorities but also sets a blueprint for wider regional and national adoption.

2.3 **From Sickness to Prevention: National Frailty Collaborative**

Wolverhampton is one of seven areas selected nationally for the National Frailty Collaborative, giving us a leading role in shaping best practice and testing 'bundles' of care prior to national roll-out. We are particularly keen to trial a proactive and preventative approach, building on our ambitions to develop a proactive frailty clinical model based on the success of the Jean Bishop Centre in Hull.

This work has been trialled on a limited basis in the city and we are looking to use the support from the national team to scale up this approach. Local pilots have demonstrated considerable impact: 67% of patients were found to have unmet needs, 80% required medication changes and 56% were referred for further support, with highly positive patient feedback. The Bradley Resource Centre has been identified as the preferred site for a Frailty Assessment Hub, building on its role in intermediate care and its strong NHS–Local Authority partnership.

The new partnership led model will focus initially on those at highest risk of crisis, delivering multidisciplinary comprehensive geriatric assessments and individualised care plans shared across the system. Future phases will expand through neighbourhood outreach, virtual delivery and targeted specialist pathways. Given the multi-disciplinary approach required, this work will be aligned with the development of our Integrated Neighbourhood Teams to ensure joined-up care, in line with the ambitions of the 10 Year Plan.

3. **Walsall Together Update**

3.1 **Neighbourhood Health Pioneer Programme**

The Walsall Together Partnership has been successful in being selected as one of 42 places across the country to participate in a neighbourhood health pioneer programme. The programme will commence in September 2025, and will include:

- A national coach to work with the Place and neighbourhood teams
- Access to subject experts
- 3 face-to-face regional learning workshops
- Online support (practical tools, case studies and real-time learning)

- A knowledge hub with themed areas for peer-to-peer learning (currently in development)
- Data and evaluation workshops to support baseline development and outcome tracking
- A knowledge management centre to share and access insights from across the country
- Capability-building training for your local coach and team members
- Opportunity to help shape enablers (such as funding flows)

3.2   **Future Partnership Arrangements**

Following on from the previous update to Trust Board, the Walsall Together partnership has discussed the potential implications of the NHS 10-year plan on the future organisation and partnership arrangements in Walsall and the Black Country. It has also approved an alignment of the neighbourhood health agenda to the partnership and wider health and wellbeing work in Walsall.

In the Black Country, the ICB and providers, including General Practice, have started to think about how best to organise partnerships, contracts and future commissioning to support the ambitions of the 10-year plan. Two Community First Collaboratives (CFC) are being proposed by the ICB in the North and South of the Black Country respectively, aligned with NHS Trust Group structures. Subject to contractual and financial readiness, the Community Collaborative would support the transition to a future Integrated Health Organisation (IHO), in line with national guidance and approval processes. This would enable the ICB to delegate further responsibilities and budgets for integrated community health and care services through the CFC to a Walsall IHO. The delegation process could be aligned with the development of neighbourhood teams, positioning it as a key enabler for the delivery of integrated services across Walsall alongside single or multi-neighbourhood providers.

The establishment of a lead organisation for integrated services must enable and enhance the existing partnership arrangements in Walsall, delivering further improvements to population outcomes. This can only be achieved through strong relationships and trust between partners. It is clear from the national guidance that IHO contracts will only be awarded to those organisations that can demonstrate long-standing partnership working with improved outcomes. Walsall Together has all of the foundations to support this approach, and recent discussions have identified some clear priorities for strengthening these arrangements:

- Financial governance and transparency
- Shared decision-making in relation to service planning and design, investment and disinvestment
- Commissioning and funding flows to support a transfer of resources from acute to community and enhance financial sustainability

The NHS Neighbourhood Health Guidelines describe a broad offer of support, connecting planned and unplanned needs, integrating across key partners and inclusive of all ages, complex physical disabilities, and multiple LTCs. There is explicit reference to aligning with other offers such as mental health centres, women's hubs and family hubs. The national model reflects the core elements of the Walsall Together model of health, care and wellbeing (see pictures below) and includes an initial 6 core components, which all feature in our integrated commissioning and transformation plan.

The following diagram overlays the national neighbourhood model to the Walsall Together model of health, care and wellbeing:

- Intermediate, unplanned and crisis care is delivered at borough level
- Integrated neighbourhood teams and family hubs operate at neighbourhood (7 PCN-aligned areas) and locality level (north, east, south and west)
- Neighbourhood and locality teams are fully aligned to local care networks, our communities offering of holistic wellbeing and wider determinants support
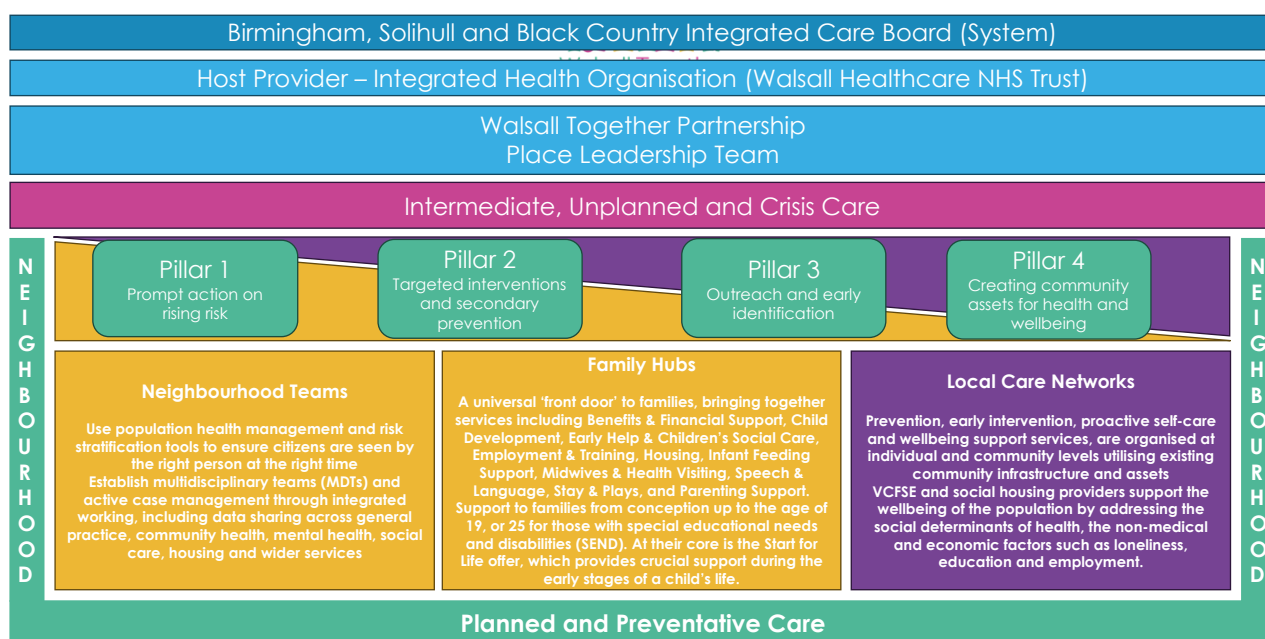
3.3 Walsall Together Programme Highlights

Work in progressing in Walsall to develop a new communication approach that will better convey the current work programme and associated impact. The approach, based on the '4Ps of Communicating Change' was approved in August and the programme office is implementing the approach between September and December. This approach will be utilised in this section of reporting to Trust Board from the next reporting period.

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Walsall Healthcare NHS Trust

Neighbourhood Teams (NT): In parallel to the application to the national implementation programme, work continues to develop NTs in Walsall. Collaborative conversations across 7 teams are building on ideas developed during the recent workshop. A delivery framework is being developed to support the design of the teams, ensuring alignment and a consistent approach aligned to local and national objectives. Plans are underway to roll out the risk management tool to further support and enhance this work.

Live Well at Home and in Your Community: This pilot project forms part of our neighbourhood teams approach and aims to "grow and shape services that meet a range of needs in people's own homes and communities to help maintain independence, improve outcomes and to prevent and delay the need for long-term care and support for as long as possible". The focus is on developing outcomes-based homecare services by increasing awareness and use of community resources, integrating technology and AI to promote self-care, investing in flexible and person-centred multidisciplinary teams (aligned to the MDTs in NTs), empowering providers with more autonomy, addressing social and environmental impacts, and expanding direct payments to enable individuals to manage their own care.

Intermediate Care Service Development: A business case, looking at ways to mitigate the forecast overspend within the intermediate care service, has been approved in principle by the Place Integrated Commissioning Committee. The focus is on building on the skills and capacity of the workforce to cope with a significant growth of 65% increase in activity since the establishment of the service in 2017. Limited staffing has impacted service performance with delays to therapy assessments leading to longer lengths of stay in the intermediate care service. The aim is to prioritise investment in the workforce which will enable the implementation of a dedicated bed-based rehabilitation unit to support people in the community.

Acute Respiratory Infection Evaluation: Delays in agreeing on a provider and securing funding meant the service started slightly later than planned, impacting on delivery and uptake. Overall, the ARI Hub was effective, with good patient flow and low emergency admissions. 78% of service users stated they would have otherwise attended the Urgent Treatment Centre or ED, suggesting a significant diversion of activity whilst maintaining safe care in the community for circa 1,783 patients. Additionally, Walsall has a backlog of around 3,000 children awaiting respiratory assessments. The service included asthma diagnosis through FeNO testing for a 6-week period. Of those tested, 20–25% were diagnosed with asthma and placed on annual care plans with ongoing monitoring and clinical review. Going forward, it is recommended reviewing the spirometry pathway and shifting towards a broader respiratory testing model that includes FeNO, which could be more cost-effective and scalable if practices deliver testing locally.

Session Date	Total Appointments offered	Total Appointments booked	DNA's	Usage Utilisation	DNA (%)	Number of children presenting with ARI symptoms	Total number of PAU Admissions	Virtual ward escalation	Social Prescribing referral (WHG)	ED Referral	111 Referral	Community Pharmacy	Given steroids/ nebulised	Distribution of age			Follow up at Hub
														Under 1	1 - 5 years	5 - 12 years	
Oct-24	120	61	0	51%	0%	61	0	0	0	0	3	0	0	10	34	17	0
Nov-24	630	477	52	76%	11%	430	3	0	0	10	4	0	18	87	209	134	0
Dec-24	585	505	50	86%	10%	455	2	0	0	8	13	0	16	65	218	172	0
Jan-25	675	400	44	59%	11%	357	3	0	0	5	13	0	17	68	178	111	0
Feb-25	601	501	53	83%	11%	448	0	0	0	6	18	0	13	65	267	116	1
Mar-25	630	583	47	93%	8%	536	0	0	0	4	4	0	29	87	309	139	1
Total	3241	2527	246	78%	8%	2287	8	0	0	33	55	0	93	382	1215	689	2
														16.7%	53.1%	30.1%	

ARI - Patient Satisfaction Questionnaire Results

Please rate your clinical consultation with our clinician?
- 2%, Average
- 19%, Good
- 79%, Excellent

Do you feel OurNet Health Services has helped you with the current medical issue you were facing today?
- 1%, No
- 99%, Yes

Where would you have gone if this service was not available?
- 1%, Pharmacy
- 21%, GP Practice
- 15%, Accident and Emergency
- 63%, Urgent Care Centre
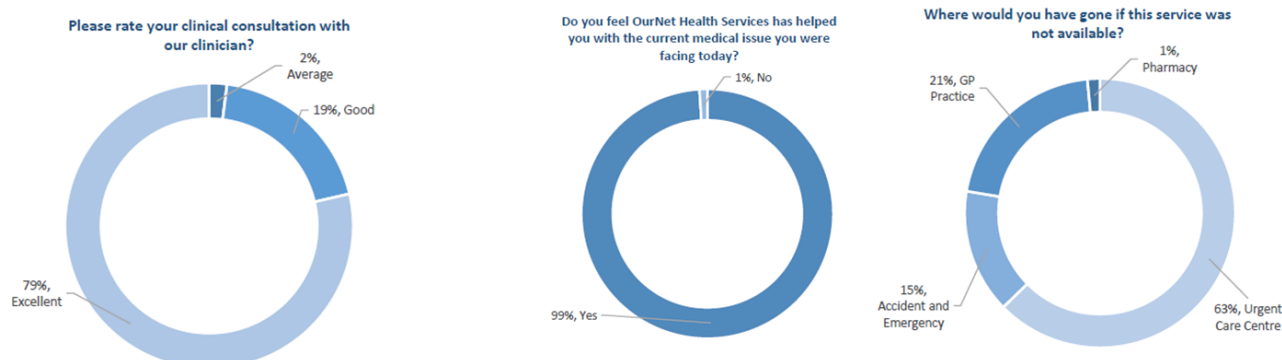
Creative Health: National evidence shows creative activities (art, dance, music, drama, writing, etc.) can lower anxiety and depression, increase wellbeing, support management of chronic health conditions, and reduce social isolation. In 2023, Walsall Council secured £3.7 million to develop the Creative Industries Enterprise Centre (CIEC), supporting creatives and linking culture with regeneration. This is being used to restore and transform Walsall's Grade II* listed Guildhall building into a creative hub. The centre is expected to support up to 50 companies across five floors, fostering business growth in the creative industries sector. It will provide workspace, specialist equipment, skills training, and facilities such as a café, gallery space, and conference rooms for local creatives and small businesses. More recently Walsall has been awarded nearly £1 million in funding from Natural England's Nature Towns and Cities programme to support a range of green infrastructure projects across the borough over the next three years — helping us create healthier, greener, and more connected communities.

4. Recommendations

4.1 The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:

a. Be assured on the development of the place based partnerships in Wolverhampton and Walsall and the alignment with the ambitions outline in the NHS 10 Year Plan.

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Walsall Healthcare NHS Trust

Report title:	**Proposed Model for Stroke Rehabilitation across Walsall and Wolverhampton**
Sponsoring executive:	**Stephanie Cartwright, Group Chief Communities and Partnerships Officer**
Report author:	**Stephanie Cartwright, Group Chief Community and Partnerships Officer** **Stephen Jackson, Director of Operations, Division of Community Services**
Meeting title:	**RWT/WHT Group Trust Board Meeting**
Date:	**16th September 2025**

1. Summary of key issues/Assure, Advise, Alert

The proposed move of the Walsall Stroke Rehabilitation service from Hollybank House to West Park Hospital presents an opportunity to invest in the community first model, thus augmenting the service in Walsall and transforming the services in Wolverhampton, removing the variation that currently exists across the Group. By investing in the community offer more patients will be discharged home or to alternative community setting (e.g. care home), regardless of their disability, as soon as their ongoing needs can be safely met in the community setting supported by the Integrated Community Stroke Service (ICSS). The ICSS model ensures that all discharged stroke patients are seen in a timely way by an integrated multidisciplinary team (MDT) which is inclusive of all key professions in stroke care and accessible 7 days a week. The ICSS model is a national model which is evidence-based and is considered to be best-practice for patient outcomes. It also supports the national agenda of the hospital to community model described within the NHS Ten Year Plan.

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

Care	- Excel in the delivery **Care**	☒
Colleagues	- Support our **Colleagues**	☒
Collaboration	- Effective **Collaboration**	☒
Communities	- Improve the health and wellbeing of our **Communities**	☒

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

A paper was taken to Board on 17th April 2024 setting out the options that were considered for an interim location of the Walsall Stroke Rehabilitation service and opportunities to explore to enable a more sustainable solution, as a result of Holly Bank House in Walsall being no longer fit for purpose as a healthcare facility. The proposed solution was to launch a project with the intention of relocating the Walsall Stroke Rehabilitation Unit to West Park Rehabilitation Hospital in Wolverhampton. The summation of this work is to consolidate the bed-based rehabilitation services for Walsall and Wolverhampton on Ward 1 at West Park and to increase the level of rehabilitation for patients in their own home setting.

The proposed model has been approved by the Community First Programme Board and the Partnerships and Transformation Committee.

The review of the model by the West Midlands Clinical Senate is taking place on Friday 12th September and therefore the outcome of this review will be shared at the Board meeting.

4. Recommendation(s)/Action(s)

The Group Trust Board is asked to support the proposed model for Stroke rehabilitation subject to a review by the Clinical Senate on 12th September, review by Health Overview and Scrutiny Committee on 25th September, alongside a public conversation and staff consultation on the proposed changes.

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

Group Assurance Framework Risk GBR01	☒	*Break even*
Group Assurance Framework Risk GBR02	☒	*Performance standards*
Group Assurance Framework Risk GBR03	☐	*Corporate transformation*
Group Assurance Framework Risk GBR04	☒	*Workforce transformation*
Group Assurance Framework Risk GBR05	☒	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

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Walsall Healthcare NHS Trust

Report to the Group Trust Board

Proposed Model for Stroke Rehabilitation Across Walsall and Wolverhampton

1.   Executive summary

The proposed move of the Walsall Stroke Rehabilitation service from Hollybank House to West Park Rehabilitation Hospital presents an opportunity to invest in the community services, thus augmenting the service in Walsall and transforming the services in Wolverhampton, removing the variation that currently exists across the Group. By investing in the community offer patients will be discharged home or to alternative community setting (e.g. care home), regardless of their disability, as soon as their ongoing needs can be safely met in the community setting supported by the Integrated Community Stroke Service (ICSS). The ICSS model ensures that all discharged stroke patients are seen in a timely way by an integrated multidisciplinary team (MDT) which is inclusive of all key professions in stroke care and accessible 7 days a week. The ICSS model is a national model which is evidence-based and is considered to be best-practice for patient outcomes. It also supports the national agenda of the home and community first model.

In order to implement the model, an investment into the expansion of roles and capacity within the multi disciplinary teams in both Walsall and Wolverhampton Community Stroke Teams would need to be made.   An analysis of the funding currently deployed has indicated that there is sufficient funding to provide the investment required in the community teams.

The creation of an ICSS, would bring the following benefits:

- A significant reduction in the number of rehab beds needed (from 20 to 12 in Wolverhampton and 12 to 8 for Walsall) due to an increase in service users being able to access the required level of rehabilitation in the community (a predicted increase from 46% of referrals to 73%).
- A reduction in the number of rehab beds needed due to being able to support discharge at weekends (Walsall).
- A reduction in the length of stay improving flow through the rehabilitation beds (Walsall & Wolverhampton).
- Patients can be discharged from the hyper acute and rehab bedded unit 7 days a week which will support flow and timely discharges (Walsall).
- Access to a complete interdisciplinary team with all relevant professions in the community, thus optimising outcomes and an MDT approach to rehab (Walsall & Wolverhampton).
- Access rehab beds more quickly due to interventions delivered at West Park which currently aren't offered at Hollybank i.e. IVs, oxygen therapy (Walsall).
- Increased intensity/frequency of sessions in the community environment resulting in improved quality of life, reduced burden on family and carers, reduction in care needs/packages of care and optimising outcomes (Walsall & Wolverhampton).

- Reduction in delayed discharges due to integration of a social worker in the team thus reducing length of stay and improving flow through the beds (Walsall & Wolverhampton).
- Improvement in psychological well-being of patient and their family unit due to being discharged home more quickly (Wolverhampton & Walsall).
- Improved access to the community service, particularly for those who have returned to work, due to 7-day working (Walsall & Wolverhampton).
- Reduction in spend for the wider health economy. For example, we would anticipate a reduction in GP appointments for the service user and their carer due to enhanced support and a reduction in the length of time a package of care is needed for due to optimising physical outcomes and independence.

Recommendation:

The Group Trust Board is asked to support the proposed model in Appendix One for Stroke rehabilitation subject to consideration by the West Midlands Clinical Senate, the Walsall Health Overview and Scrutiny Community, a public conversation exercise and a staff consultation.

Appendix One - Proposed New ICSS Model

Access from hospital: ICSS working with inpatient colleagues, the patient and their family and support services to ensure a timely and safe transfer of care.

Access from community: Triage by the ICSS and contract made within 48 hours of referral.

Core stroke/neuro specialist ICSS team:
- Occupational therapy
- Physiotherapy
- Speech & language therapy
- Nursing
- Social worker
- Rehabilitation assistant
- Assistant practioner
- Physician
- Cinical psychology

Appropriate access to services including:
- Return to work services and vocational rehabilitation services
- Additional psychological and neuropsychological services
- Dietetics, orthoptics, orthotics, spasticity clinic
- Specialist seating/wheelchair support
- Consultant review (e.g. 6 week review)
- Life after stroke and voluntary services
- Carer support services

Need-based, responsive and intensive stroke rehabilitation

- ESD assessment and treatment within 24 hours, same intensity as stroke unit (typically daily sessions) based on clinical need and goals
- All other patients assessed within 72 hours and provided treatment no later than 7 days later. Rehabilitation intensity typically less (e.g. approx three sessions per week), basedd on clinical need and goals
- 7 day service, up to 6 months

Pathway 1:	Pathway 2:	Pathway 3:
Discharged home with ICSS support. Patients able to manage independently or with a carer	Discharged home with ICSS and daily social care support.	Discharged to residential or nursing home with ICSS support.

Longer term support:
Six-month reviews using an evidence based tool.

Promotion of wellbeing, including stroke education and secondary prevention, community leisure activities and exercise classes, peer-led support groups and social prescribing.

Re-referral back in at any time after discharge if patient has defined rehabilitation needs and goals.

End of life care planning using gold standard framework.

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Tier 1 - Paper ref:	Enc 8.6 Public/September

Report title:	RWT Winter Plan 2025/26
Sponsoring executive:	Gwen Nuttall, Managing Director – RWT
Report author:	Kate Shaw, Deputy Chief Operating Officer, Division 2
	Gwyneth Kidd, Service Improvement Programme Manager, Division 2
Meeting title:	RWT/WHT Group Trust Board Meeting to be held in Public
Date:	16 September 2025

1. Summary of key issues/Assure, Advise, Alert

- The Winter Plan is aligned to the Walsall Healthcare NHS Trust Winter Plan and is a subsection of the OneWolverhampton Winter Plan. The plan is overseen by the Home First Strategic Working Group.

- Learning from previous winters, the plan has been built on the strength of our partnership working. This has included a full evaluation of schemes that were implemented in the previous winter to inform decision-making. Schemes that proved successful in the previous year have been prioritised for implementation for 2025/26 through the City of Wolverhampton Council and Black Country ICB's (Wolverhampton Place) Discharge Fund.

- The official ICB bed modelling has been received. The Winter Bed Model for 2025/26 projects a peak requirement of 835 beds on 8 January 2026. This plan aims to mitigate the impact of that bed gap.

- A Trust wide Winter Planning Workshop was held on 21 July 2025 to understand further actions that can be taken and to thoroughly test the plans so far to ensure that the overall Winter Plan is a shared responsibility across all directorates and services within both Trusts.

- There is approximately £6.5m allocated to Wolverhampton place which is comprised of:

  - £2,585,025 of discharge funding allocated via ICB (£1.14m allocated to Home First and Integrated Neighbourhood Teams)
  - £3,449,153 of discharge funding allocated via CWC (fully committed)
  - £427,000 Community Transformation and Ageing Well funding (£117k unallocated)

- A full breakdown of committed funding by scheme (subject to approval at the Integrated Commissioning Committee) can be found in the OneWolverhampton winter plan. As with previous years, this will follow the governance route of the Home First Strategic Working Group with final sign off at the Place Integrated Commissioning Committee. Indicative costs for each of the RWT schemes are set out in Section 19 of the plan.

- The NHSE Board Assurance Statement is attached, along with the OneWolverhampton draft Winter Plan. A prioritisation exercise has been undertaken for the unfunded schemes, should monies become available.

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

Care	- Excel in the delivery **Care**	☒
Colleagues	- Support our **Colleagues**	☒
Collaboration	- Effective **Collaboration**	☒
Communities	- Improve the health and wellbeing of our **Communities**	☒

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

Draft plan approved at:
- TMC - 27 June 2025
- Executive Directors - 23 July 2025
- F&P - 26 August 2025.

4. Recommendation(s)/Action(s)

The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:

a) Approve this year's winter plan.

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

Group Assurance Framework Risk GBR01	☐	*Break even*
Group Assurance Framework Risk GBR02	☐	*Performance standards*
Group Assurance Framework Risk GBR03	☐	*Corporate transformation*
Group Assurance Framework Risk GBR04	☐	*Workforce transformation*
Group Assurance Framework Risk GBR05	☐	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

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Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 16 September 2025

RWT Winter Plan 2025/26

1.   Executive summary

This paper sets out the Trust's 2025/26 Winter Plan. It focuses on the priority areas within NHS England's Urgent and Emergency Care Plan published in June 2025. The plan is aligned to the Walsall Healthcare NHS Trust Winter Plan and is a subsection of the OneWolverhampton Winter Plan in recognition of the required joint working and responsibilities that continue to be taken across the Health and Care System. The plan is overseen by the Home First Strategic Working Group. Structures remain in place to maintain involvement and engagement with partners at executive, clinical and operational levels.

Learning from previous winters, the plan has been built on the strength of our partnership working. This has included a full evaluation of schemes that were implemented in the previous winter to inform decision-making. Schemes that proved successful in the previous year have been prioritised for implementation for 2025/26 through the City of Wolverhampton Council and Black Country ICB's (Wolverhampton Place) Discharge Fund.

During the previous winter, the opening of the Midland Metropolitan University Hospital (MMUH) created an extra layer of complexity across the Black Country. RWT ED attendances however were not significantly impacted as a result of the boundary changes.

A Trust wide Winter Planning Workshop was held on 21 July 2025 to understand further actions that can be taken and to thoroughly test the plans so far to ensure that the overall Winter Plan is a shared responsibility across all directorates and services within both Trusts. Outputs from the workshop that have an internal to RWT focus, (e.g. ward huddles, TTO efficiencies, etc.) continue to be worked up throughout August. Place and system wide outputs will be worked up through the OneWolverhampton and UEC Black Country Ops Group.

2.   Introduction or background

The Urgent and Emergency Care Plan for 2025/26 outlines three key areas of focus:

1. Focus as a whole system on achieving improvements that will have the biggest impact on urgent and emergency care services this winter;
2. Develop and test winter plans, making sure they achieve a significant increase in urgent care services provided outside hospital compared to last winter;
3. National improvement resource and additional capital investment is simplified and aligned to supporting systems where it can make the biggest difference.

The Urgent and Emergency Care Plan states that there must be whole system focus on the 7 priorities that will have the biggest impact on UEC improvement this coming winter. As a minimum, these are:

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1. Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes;
2. Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes;
3. A minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours;
4. Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time;
5. Reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month;
6. Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date;
7. Seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25.

The combined pressure of improving cancer waiting times and delivering elective recovery whilst simultaneously managing increasingly complex non-elective demand, is putting significant strain on the Trust and the wider system. These challenges are only expected to increase during the winter months when emergency care services face greater pressure because of patients being more acutely unwell with a longer stay in hospital longer. These usual pressures are expected to be exacerbated this winter, because of:

- Noroviruses, influenza, rotavirus, norovirus, astrovirus and sapvirus
- Surges in Respiratory Syncytial Virus (RSV) in children
- Challenges in the social care market to assist with discharges
- Potential increase in staff absence due to seasonal illness and burnout.

All the above give rise to the need for a Winter Plan demonstrating increased resilience to support these pressures whilst at the same time recognising some of the constraints currently faced including vacancies in the workforce, current levels of sickness and staff fatigue.

3.   Modelling and assumptions

The official ICB bed modelling has been received. The Winter Bed Model for 2025/26 projects a peak requirement of 835 beds on 8 January 2026 which forecasts a 29 bed shortfall. This plan aims to mitigate the impact of that bed gap.
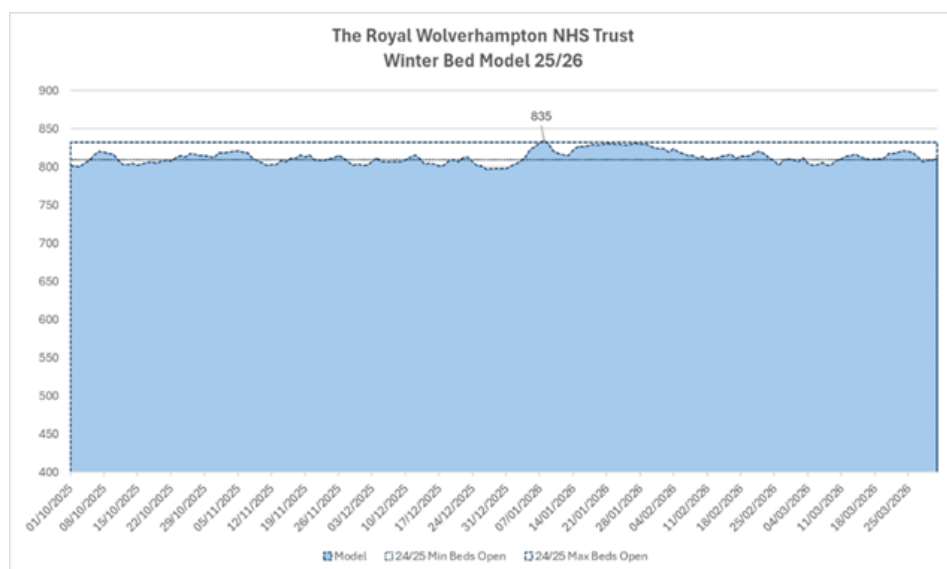
The impact on the bed base is currently being forecasted based on the mitigating schemes detailed below. Several schemes and initiatives are being worked up via discussions with commissioners and through the learning from previous years to mitigate the bed capacity gap which is detailed in the table below.

A number of these are extensions and further developments of existing services and schemes whilst some are new. Discharge Funds and Service Development Funds (SDF) have been utilised to support schemes targeted at reducing the bed deficit. Worst and best-case scenarios have been based upon best judgement and are indicative rather than definitive.

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Initiative	Worst case	Best case	Detail	RAG rating
Enhanced Pharmacy provision	2	4	• Expanding the ED Pharmacy service • Roaming discharge team • Additional support for the dispensary • Pharmacy provision in SDDC • Discharge Medication (TTO) delivery	
Virtual wards	10	20	Ongoing delivery of 98 Virtual Ward beds for Wolverhampton and South Staffordshire patients	
Community Neuro Therapy	1	2	Additional neuro rehab capacity	
Hydration in Care Homes	2	4	Reducing the number of admissions from care homes due to falls and UTIs	
Urgent Community Response	4	10	Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission. To also include speech and language therapy input	
Acute Medicine cover in Care Co.	4	10	To widen the breadth of patients that can be managed in the community	
Community based Frailty model	5	10	A community-based model at Bradley Resource Centre	
Intermediate Care (To incorporate RASC and Home first)	3	8	Enhancing RWT Intermediate Care services. BCHT additional step-down beds mobilised. Reviewing opportunities for integrated intermediate care	
Same Day Discharge Centre (SDDC)	0.5	1	Enhanced discharge service (adults) to remain on C41 throughout winter. 4 no. reclining chairs to be purchased to support flexibility of space, if funding allows	
Total	**31.5**	**69**		

Additional detail regarding funded schemes can be found in the OneWolverhampton plan, which will be updated regularly throughout the winter period. The Trust has undertaken a prioritisation exercise for the unfunded schemes, should monies become available. These have been reviewed against the 7 key priorities in the UEC plan.

4.   Risks

There are risks associated with the winter initiatives. These are listed below along with their mitigations.

Risk	Mitigation	RAG rating
IC's above current levels	• Continuous monitoring and escalation	
Potential for ongoing industrial action	• Ongoing strike planning and impact monitoring	
Staff sickness	• Trust processes in place • Annual winter vaccination programme to be launched - both Covid booster and flu • Divisional and Trust staff allocation meetings • Prioritising the wellbeing of our staff	
Transport failure	• Escalation and utilisation of alternative provider as now	
Covid, Flu, Norovirus, etc. impacting on inpatient flow and nursing home closures	• IP processes and guidelines in place • Joint work with Capacity • IP input to Nursing Homes • Community infection and vaccination rates are routinely monitored by the system and within the Trust	
45-minute offload mandate creates heightened pressure in Emergency Services	• Physical space identified in UEC • Ongoing engagement with teams to ensure specialty reviews are undertaken promptly • Ongoing monitoring	
Lack of inpatient capacity due to reduction in bed base	• Continue to be managed within current community services with additional resource • Ongoing monitoring	

5.   Summary

- All services will continue to work on winter plan delivery over the coming weeks and months
- The plan is aligned to the WHT Winter Plan and is a subsection of the OneWolverhampton Winter Plan.
- Current bed capacity gap forecasting suggests a 29 bed shortfall – mitigations are planned and included in the plans.
- A Trust wide Winter Planning Workshop was held on 21 July 2025 to understand further actions that can be taken and to thoroughly test the plans so far to ensure that the overall Winter Plan is a shared responsibility across all directorates and services within both Trusts. Outputs from the workshop that have an internal to RWT focus, (e.g. ward huddles, TTO efficiencies, etc.) continue to be worked up throughout August. Place and system wide outputs will be worked up through the OneWolverhampton and UEC Black Country Ops Group.
- Confirmation is awaited to understand the allocation of any funding. However, based on the review of previously funded schemes, and highlighted pressure points a number of schemes have been earmarked for funding as and when this is known. A prioritisation exercise has been undertaken for the unfunded schemes, should monies become available.

- 45-minute offload implemented on 6 January 2025 which is being managed well. Ongoing monitoring will continue.
- The intention is to retain elective operating throughout the winter period by utilising the ring-fenced capacity at New Cross and Cannock Chase.
- The closing of C39 in May 2025 has a mitigation plan; however this is deemed amber risk, due to the number of risks that will likely exist in the winter period, be those levels of flu or covid or staff sickness or ambulance conveyances from other regions.
- Actions will be monitored daily, weekly and all reviewed at the end of the winter period to assess success and impact in preparation for the following winter. Trust-wide winter wash up to be held 16 March 2026.

6.   Recommendations

6.1   The RWT/WHT Group Trust Board Meeting to be held in Private is asked to:

   a. Approve this year's winter plan.

28 August 2025

Annex 1: RWT Winter Plan (paper)
Annex 2: OneWolverhampton draft Winter Plan
Annex 3: IP measures
Annex 4: Board Assurance Statement

Tier 1 - Paper ref:	Enc 8.6 Public/September

Report title:	WHT winter Plan 2025/26
Sponsoring executive:	Amelia Godson, Managing Director - WHT
Report author:	William Roberts, Chief Operating Officer
	Stephen Jackson, Deputy Chief Operating Officer
Meeting title:	RWT/WHT Group Trust Board Meeting to be held in Public
Date:	16 September 2025

1. Summary of key issues/Assure, Advise, Alert

- The Trust has a demonstrable record of improved urgent and emergency care (UEC) performance in recent years, now placing the Trust in the upper quintile nationally across both the 4-hour constitutional standard and the GIRFT Emergency Medicine Index of patient flow (GEMI).

- Forecasting by the Black Country ICB utilising the same approach adopted to prepare for Winter in previous years, indicates an expected 46 bed shortfall relating to additional local Walsall winter demand. Plans are in place to mitigate this shortfall to 16 beds.

- Options for our Winter Plan are considered, all of which carry risk. Board should be sighted on research from the GIRFT Emergency Medicine programme, and endorsed by the Royal College of Emergency Medicine, which evidences that there will be one additional death associated with every 72 patients that experience an 8–12-hour wait in ED prior to their admission[1] and thus that delays in the UEC pathway are directly associated with harm.

- Winter Plan initiatives will prioritise admission avoidance, expediting hospital discharge and a focus on prevention to minimise this risk of harm. The plan presented provides mitigations to ensure the Trust does not enter the winter period with an unacceptable and unsafe risk across the urgent and emergency care pathway. Assurance is provided in this document to meet NHS England's Winter Plan checklist.

- In light of the current financial pressures, the plan proposes a reduced resource of £892,629 from the £1,400,000 of allocated funding for Winter within the Trust's 2025/26 financial plan to mitigate the anticipated urgent and emergency care demand this Winter. This includes £211,341 of available Service Development Funding to support Community Service initiatives.

- The plan recognises the interdependency with the Trust's plan to close a further 21 overnight beds, taking the Trust total to 72 beds in 2025/26. The 51 beds already closed means that only three other NHS Trusts have closed a greater proportion of overnight beds than the Trust in 2025/26. This is in the context of year-on-year growth in demand (2.2% type 1 attendances and 10.0% type 3 attendances). It should be noted that the closure of further beds does include plans for reinvestment in appropriate Community Services.

[1] [Almost 300 deaths a week in 2023 associated with long A&E waits despite UEC Recovery Plan | RCEM](#)

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2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
Care	- Excel in the delivery **Care**	☒
Colleagues	- Support our **Colleagues**	☒
Collaboration	- Effective **Collaboration**	☒
Communities	- Improve the health and wellbeing of our **Communities**	☒

3. Previous consideration [at which meeting[s] has this paper/matter been previously discussed?]
Trust Group Executive - 16th July 2025, 20th August 2025
Trust Group Performance and Finance Committee - 29th July 2025, 9th September 2025
Black Country ICB Urgent & Emergency Care Board – 1st August 2025

4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a)   Approve this year's winter plan

5. Impact [indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]		
Group Assurance Framework Risk GBR01	☐	*Break even*
Group Assurance Framework Risk GBR02	☐	*Performance standards*
Group Assurance Framework Risk GBR03	☐	*Corporate transformation*
Group Assurance Framework Risk GBR04	☐	*Workforce transformation*
Group Assurance Framework Risk GBR05	☐	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

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NHS

Tier 1 - Paper ref:	Enc 9 Public/Sept/25

Report title:	Joint WHT RWT Freedom to Speak Up Report
Sponsoring executive:	Alan Duffell Group Chief People Officer, Joe Chadwick-Bell Group CEO
Report author:	Miss Shabina Raza Lead Trust Guardian, Lead Clinician WHT Ms Giselle Padmore-Payne Lead Guardian, RWT
Meeting title:	Group Public Trust Board Meeting
Date:	16th September 2025

1. Summary of key issues/Assure, Advise, Alert

WHT: Q1 - Q4 2024/25 with elements of Q1 2025/26

Assure:
- There is a continually increase in the demand of the service; 362 concerns raised in 2024/25 (**+66.8%** vs 217 in 2023/24), showing increased engagement, confidence, and engagement in the service.
- **For Q1 2025/6, there has been a 3% increase in the number of concerns in comparison to the same period last year.**
- Regular attendance and engagement from various staff throughout the organisation during drop- in sessions, departmental visits, ward walks, professional forums with support of executive/non-executive walkabouts etc.
- Outstanding feedback recently from Information Governance inspection
- Collaborative working on key workstreams with RWT
- Hosted a remarkably successful leadership event in collaboration with RWT with the national guardian and keynote speakers attending WHT.
- Recognised nationally for being in the 10 most improved trusts for speaking up.

Advise:
- A consistently high number of cases are reported due to inappropriate attitudes and behaviours, which aligns with national data.
- A marked increase in concerns relating to staff wellbeing and safety was seen in Q4.
- Active engagement from all staff is required to increase uptake of FTSU training which currently sits at 75.41% for speak up training. Making this mandatory is a potential option to ensure a target of 90% is achieved.
- There are currently 15 FTSU champions recruited within Walsall, developing, and maturing this network is a current focus. Ring fenced time is required to undertake this role effectively.

Alert:
- High percentage of concerns have undisclosed professional groups, suggesting potential fear of detriment. Improvement in disclosure in the month of June in Q1 for 2025/6.
- Effective feedback is required to monitor progress of reporting concerns and giving assurance that concerns are responded to appropriately.
- Inappropriate attitudes and behaviours remain a consistent concern, requiring collaborative and proactive work from the leadership teams to address these utilising current systems.

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RWT: Q1 - Q4 2024/25 with elements of Q1 2025/26

Assure – Increased Engagement & Reporting

- A 10% increase in FTSU cases (247 vs 225 in 2023/24) reflects improved staff confidence and visibility of the service.
- 34 drop-ins and 26 presentations delivered, reaching 899 staff, with a clear rise in staff accessing support.
- Cross-Trust Collaboration & Awareness Activities
- Continue to participate in CQC fact finding interviews when requested.
- Joint initiatives with Walsall HCT, launched promotional video, use of social media, and October's Speak Up Month activities show strong commitment to cultural change.
- Working on a new Feedback Mechanisms with HR colleague.
- Staff feedback tool introduced via QR code survey following board concerns about lack of service evaluation in 2023/24.

Advise – Attitudes & Behaviours Remain a Prominent Concern

- This theme remains the highest reported category (99 cases), indicating a continued need for culture improvement and leadership focus this aligns with nationwide data.
- Bullying & Harassment Decline.
- Encouraging reduction in reported bullying and harassment cases compared to previous year, possibly due to increased visibility, training, and preventative action.

Alert – Q4 Spike in Staffing Level Concerns

- A notable increase in concerns related to staffing safety in Q4 (23 cases), requiring executive review and potential workforce planning action.
- Sustained High Levels of Behavioural Concerns Demand Systemic Action
- Despite progress, prominent levels of inappropriate behaviour signal a need for further leadership development, restorative culture training, and deeper engagement with teams.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
Care	- Excel in the delivery Care	☒
Colleagues	- Support our Colleagues	☒
Collaboration	- Effective Collaboration	☒
Communities	- Improve the health and wellbeing of our communities	☒

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

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4. Recommendation(s)/Action(s)	
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:	
a) **Note** this Joint WHT and RWT report and performance trends.	
b) **Support** FTSU independence and visibility across both Trusts.	
c) **Endorse** the cultural shift toward transparency, learning, and psychological safety. d) **Support** with closing the loop and feeding back to staff and stakeholders.	

5. Impact *[indicate with an '**X**' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*			
Group Assurance Framework Risk GBR01	☐	*Break even*	
Group Assurance Framework Risk GBR02	☐	*Performance standards*	
Group Assurance Framework Risk GBR03	☐	*Corporate transformation*	
Group Assurance Framework Risk GBR04	☐	*Workforce transformation*	
Group Assurance Framework Risk GBR05	☐	*Service transformation*	
Corporate Risk Register [Datix Risk Nos]	☐		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

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Tier 1 - Paper ref:	Enclosure 10. Public/Sept 25

Report title:	2026-30 Green Plan for RWT and WHT
Sponsoring executive:	Simon Evans, Group Deputy Chief Executive & Chief Strategy Officer
Report author:	Janet Smith, Head of Sustainability
Meeting title:	RWT/WHT Group Trust Board Meeting
Date:	16 September 2025

1. Summary of key issues/Assure, Advise, Alert

1. **Assure:** The Green Plans for both Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust are comprehensive, evidence-based, and fully aligned with NHS Net Zero objectives and statutory requirements, including the Health and Care Act 2022, Green Plan Guidance (February 2025), and the NHS Net Zero Building Standard. The Plans are explicitly aligned with the 10 Year Health Plan for England: Fit for the Future (July 2025), ensuring the Trusts deliver against the latest national vision for a sustainable, digitally enabled, and population-focused NHS.

   Notable progress has been made in carbon reduction, the elimination of high-impact anaesthetic gases, increased use of renewable energy, digital transformation, waste minimisation, and staff engagement. Scope 1 and 2 emissions (including energy and anaesthetic gases), as well as Scope 3 emissions (procurement, supply chain, medicines, waste, food, and travel), are comprehensively measured, monitored, and reported with robust Board-level oversight. Supplier engagement, data quality, and regular progress reporting are fully established and comply with the NHS Net Zero Supplier Roadmap and Greener NHS frameworks.

2. **Advise:** Continued capital and revenue investment is essential to maintain and accelerate delivery, particularly for heat decarbonisation, digital infrastructure, workforce training, and clinical transformation, with a particular focus on medicines management and inhaler use. Sustaining momentum with suppliers and addressing outstanding emissions from pharmaceuticals and energy remain key to achieving full compliance with the NHS Net Zero Supplier Roadmap by 2030.

   Further cross-Trust collaboration in procurement, workforce sustainability, digital innovation, and supply chain decarbonisation is expected to yield greater efficiency and impact. Proactive management is required in areas where emissions are rising or plateauing (such as pharmaceuticals and energy demand), and to ensure all new estate developments are fully compliant with the NHS Net Zero Building Standard.

3. **Alert:** Any delay or shortfall in funding could impede critical infrastructure delivery and slow progress towards net zero, with the risk of non-compliance with NHS requirements. Rapid expansion of the estate and increased clinical demand may offset emissions reductions if not matched by operational controls and sustainable design. Pharmaceuticals and the supply chain remain the most significant contributors to residual emissions and require further focus on decarbonisation, improved supplier engagement (especially with SMEs and indirect suppliers), and ongoing innovation.

Achieving and maintaining full supplier compliance, alongside further reductions in emissions from pharmaceuticals and energy, are critical to meeting NHS Net Zero targets and mitigating reputational or regulatory risk.

2. Alignment to our Vision [indicate with an 'X' which Strategic Objective[s] this paper supports]		
Care	- Excel in the delivery Care	☒
Colleagues	- Support our Colleagues	☒
Collaboration	- Effective Collaboration	☒
Communities	- Improve the health and wellbeing of our Communities	☒

3. Previous consideration [at which meeting[s] has this paper/matter been previously discussed?]
This paper was discussed and signed off at the Sustainability Group and the Group Finance and Productivity Committee meeting on 29 July 2025. The version control of each document shows the updates as result of reviews at each stage.

4. Recommendation(s)/Action(s)
The Group Finance & Productivity Committee is asked to:
a) Approve the Green Plans for Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.
b) Endorse the investment priorities and operational targets required for delivery.
c) Support ongoing cross-Trust collaboration in procurement, workforce training, supply chain management, and digital innovation.
d) Mandate quarterly reporting against all key metrics and operational risks.

5. Impact [indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]		
Group Assurance Framework Risk GBR01	☐	Break even
Group Assurance Framework Risk GBR02	☒	Performance standards
Group Assurance Framework Risk GBR03	☒	Corporate transformation
Group Assurance Framework Risk GBR04	☒	Workforce transformation
Group Assurance Framework Risk GBR05	☒	Service transformation
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date: No		
Is Equality Impact Assessment required if so, add date: No		

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Report to the RWT/WHT Group Trust Board Meeting to be held in Public

2026-30 Green Plan for RWT and WHT

1.   **Executive summary**

The 2026–2030 Green Plans for Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust set out ambitious, evidence-based strategies for achieving NHS Net Zero, building climate resilience, and delivering measurable improvements in operational and population health. Both Trusts have demonstrated national leadership in energy reduction, elimination of high-impact anaesthetic gases, supply chain engagement, digital innovation, and workforce involvement.

The Plans are fully aligned with the 10 Year Health Plan for England: Fit for the Future (July 2025), the Health and Care Act 2022, Green Plan Guidance (February 2025), and the NHS Net Zero Building Standard. Collectively, these frameworks support national priorities on prevention, tackling health inequalities, digital transformation, sustainable care models, and climate resilience.

Approval and implementation of the Green Plans, along with endorsement of investment and operational priorities, will support ongoing compliance, financial sustainability, and environmental leadership. Quarterly progress reporting and sustained cross-Trust collaboration are recommended to ensure successful delivery.

2.   **Introduction and Background**

Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust are required to deliver Green Plans aligned to NHS Net Zero and climate adaptation policies. These Plans detail progress to date, strategic objectives for 2026–2030, and define operational and investment priorities, principal risks, and governance arrangements. The Plans have been developed in consultation with staff, system partners, and stakeholders, and meet requirements stipulated by NHS England, Integrated Care Systems (ICS), and the Care Quality Commission (CQC).

Both Green Plans are explicitly aligned with the Health and Care Act 2022, the most recent Green Plan Guidance (February 2025), and the 10 Year Health Plan for England: Fit for the Future (July 2025). The Trusts are committed to full compliance with the NHS Net Zero Building Standard for all new construction and major refurbishments, thereby ensuring that future estates development supports long-term decarbonisation and climate resilience.

These Plans operationalise national priorities in prevention, population health, health inequalities, and embedding environmental sustainability within clinical transformation, digital innovation, and community partnership. This alignment guarantees that both Trusts meet statutory obligations while actively contributing to the delivery of a sustainable and future-ready NHS.

3. 2020-25 Green Plan - Key Achievements and Combined Metrics

Scope 1 and 2 Carbon Emissions (2019/20–2024/25)

Between 2019/20 and 2024/25, Royal Wolverhampton NHS Trust reduced its Scope 1 and 2 (energy only) carbon emissions from 19,646 tCO_2e to 15,294 tCO_2e, a reduction of 22.2%. While RWT includes anaesthetic gases in its aggregate reporting, it has fully eliminated desflurane and achieved significant reductions in nitrous oxide, both of which have materially contributed to its carbon reduction. Walsall Healthcare NHS Trust reduced its Scope 1 and 2 emissions (including energy and gases) from 12,239 tCO_2e (comprising 11,122 tCO_2e energy, 688 tCO_2e nitrous oxide, and 429 tCO_2e desflurane) in 2019/20 to 11,495 tCO_2e in 2024/25. This represents an overall 6% reduction, achieved despite a 1.9% increase in energy emissions (from 11,122 tCO_2e to 11,336 tCO_2e), as substantial cuts were achieved in anaesthetic gases: nitrous oxide emissions fell by 79% (from 688 tCO_2e to 146 tCO_2e, as reported in line with NHS methodology; Entonox figures are tracked separately and only the nitrous oxide component contributes to the carbon footprint) and desflurane by 97% (from 429 tCO_2e to approximately 13 tCO_2e, saving 416 tCO_2e). These outcomes demonstrate the positive impact of targeted clinical and operational interventions, even amidst increasing service demands.

Scope 3 Carbon Emissions (Procurement, Supply Chain, Medicines, Waste, Food, Travel)

Royal Wolverhampton NHS Trust reduced its Scope 3 carbon emissions from 103,956 tCO_2e in 2019/20 to 89,385 tCO_2e in 2024/25, a 14% reduction. This demonstrates significant progress towards the Trust's target of net zero by 2045 and a 30% reduction in procurement emissions by 2030. By contrast, Walsall Healthcare NHS Trust's Scope 3 emissions increased from 21,535 tCO_2e to 24,362 tCO_2e (a 13.1% rise), mainly due to growth in clinical activity and service expansion. In response, WHT has developed targeted plans for supply chain decarbonisation, greener procurement, and product switching, with the objective of achieving a 10% reduction in Scope 3 emissions by 2028 and net zero by 2045.

4. Strategic Priorities for 2026–2030 (RWT & WHT)

- **Deliver Net Zero Trajectory:** Achieve Net Zero Scope 1 & 2 by 2040 and Scope 3 by 2045, with annual milestones. Establish and monitor measurable carbon reduction targets across all domains.

- **Estates and Infrastructure Decarbonisation:** Update both Estate Strategies. Implement full Heat Decarbonisation Plans, replace oil, and gas heating, introduce low-carbon and renewable energy solutions, and ensure all new builds and refurbishments meet the NHS Net Zero Building Standard. Complete upgrades to ventilation, insulation, and fire/smoke dampers.

- **Clinical Transformation:** Eliminate desflurane (WHT) and significantly reduce nitrous oxide use. Expand low-carbon clinical pathways across perioperative, respiratory, and emergency care. Deliver medicines optimisation, inhaler switching, medicines reuse and take-back schemes, and equipment and walking aid reuse initiatives.

- **Digital Innovation and Transformation:** Digitise health records (targeting at least 90% coverage), expand virtual outpatient care, and reduce paper-based workflows. Complete legacy IT rationalisation and embed green procurement. Deploy digital tools to support smarter working and emissions reporting.

- **Procurement and Supply Chain:** Achieve full compliance with the NHS Net Zero Supplier Roadmap by 2030. Rationalise high-carbon products, switch to lower-emission alternatives, and implement circular procurement and robust sustainability criteria across all contracts.

- **Travel and Transport:** Transition Trust fleets to at least 60% zero or ultra-low emission vehicles (RWT) and 100% for new vehicles (WHT). Promote active and public transport options for staff and patients and reduce travel emissions through virtual care and transport planning.

- **Waste, Food, and Resources:** Maintain zero landfill, increase recycling, and reduce clinical waste by 10%. Reduce food waste by 20–25% and increase plant-based menu options to at least 60–75%. Eliminate single-use plastics from food services.

- **Workforce and Culture:** Deliver sustainability training for all staff by 2027 (RWT) and 2030 (WHT). Appoint Green/Sustainability Champions and embed sustainability objectives in leadership and appraisals.

- **Community, Prevention, and Health Inequalities**: Embed sustainable models of care prioritising prevention and early intervention. Partner with local authorities and communities to address health inequalities and climate vulnerabilities.

- **Climate Adaptation and Resilience:** Complete climate risk assessments for all sites. Integrate adaptation measures into all capital projects, reviewing these annually considering new guidance and events.

- **Governance, Reporting, and Assurance:** Continue quarterly Board and Committee reporting, maintain transparent public reporting and NHS Greener Data compliance, and share best practice across the Group.

5. Investment Priorities 2026–2030 (RWT & WHT)

To enable delivery of the Green Plans and the transition to Net Zero, both RWT and WHT needs to prioritise the following areas for capital and revenue investment over the next five years:

- **Heat Decarbonisation and Estates Upgrades:** Delivery of Heat Decarbonisation Plans, including the replacement of oil and gas boilers with heat pumps and low-carbon technologies, and major upgrades to insulation, ventilation, and energy controls. Compliance with the NHS Net Zero Building Standard in all new builds and refurbishments. Continued investment in renewable energy solutions (e.g., solar PV, LED lighting, BMS optimisation).

- **Digital Transformation and Data Infrastructure**: Investment in digitising health records, expanding virtual outpatient care, and supporting digital access for patients and staff. Modernisation of IT infrastructure, including legacy system decommissioning, cloud-based services, and energy-efficient hardware.

- **Sustainable Clinical Transformation**: Expansion of low-carbon clinical pathways, medicines optimisation programmes, and switching to low-carbon inhalers and devices. Upgrading gas scavenging and abatement systems to eliminate desflurane and further reduce nitrous oxide emissions.

- **Sustainable Procurement and Supply Chain**: Implementation of sustainable procurement systems and tools to support the NHS Net Zero Supplier Roadmap, including supplier engagement, data management, and contract management platforms. Investment in circular economy pilots and sustainable product switching (e.g., walking aids (WHT), equipment reuse, switch to refurbished equipment).

- **Fleet and Active Travel Infrastructure**: Electrification of vehicle fleets, expansion of EV charging facilities, and transition to low or zero-emission vehicles. Improved facilities for cycling, walking, and sustainable travel.

- **Waste, Food, and Resources**: Upgrading waste segregation and recycling infrastructure to maintain zero landfill and increase recycling. Investment in sustainable catering, food waste reduction technology, and elimination of single-use plastics.

- **Workforce Development and Culture Change:** Delivery of sustainability training and education for all staff, including recruitment and training of Green Champions. Integration of sustainability objectives into performance management and leadership development.

- **Climate Adaptation and Resilience:** Capital works to address identified climate risks (flood, heat, severe weather) and to enhance site resilience. Implementation of green infrastructure and natural capital improvements.

The Green Plans set out indicative investment requirements for priority areas, with further detailed costings and business cases to be developed as part of the Trusts' annual capital planning and Estates Strategies. All investment decisions will be aligned to statutory compliance, NHS national and ICS funding frameworks, and the Trusts' financial planning processes. The Trusts will also continue to actively pursue external funding opportunities, including the NEEF (NHS Energy Efficiency Fund), NHS Estates Safety Fund, and other relevant grants or sources, to support delivery of these Green Plan ambitions.

6.   Conclusion and Recommendations

In conclusion, both Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust have produced Green Plans that reflect strong leadership and a clear commitment to meeting national and statutory expectations for sustainability, Net Zero, and climate resilience. The identified priorities and investment areas offer a credible pathway to deliver measurable improvements in environmental performance, operational effectiveness, and population health, while also supporting broader NHS transformation and future preparedness. With sustained commitment, appropriate investment, and continued collaboration across both Trusts, the organisations are well placed to achieve their Green Plan objectives. The Committee is therefore asked to consider and approve the following recommendations:

a. Approve the Green Plans for both Trusts.
b. Support the investment and operational priorities required for effective delivery.
c. Mandate quarterly reporting against delivery of targets and escalation of risks.
d. Endorse further cross-Trust collaboration to maximise efficiency and impact.

Annex 1: Royal Wolverhampton NHS Trust 2026-30 Green Plan
Annex 2: Walsall Healthcare NHS Trust 2026-30 Green Plan

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NHS

Tier 1 - Paper ref:	Public/Sept Enclosure 11

Report title:	Our Improvement Strategy – embedding Quality Improvement
Sponsoring executive:	Simon Evans, Group Deputy CEO & Chief Strategy Officer
Report author:	Kate Salmon, Deputy Chief Strategy Officer
Meeting title:	Trust Board
Date:	16th September 2025

1. Summary of key issues/Assure, Advise, Alert

RWT and WHT face unprecedented challenges: financial pressures whilst maintaining ambitious care standards. Despite performing well against peers on key metrics, we are falling short of our aspirations. It is acknowledged that quality improvement (QI) must now move from the margins to mainstream - becoming our default approach to solving clinical, operational, and financial challenges.

After six years of building QI foundations, we are not positioned as an organisation where improvement culture drives exceptional care delivery and high colleague satisfaction. This represents our pathway to achieving our ambitions of top quartile performance, financial sustainability, employer of choice status, and CQC outstanding rating.

Our NHS IMPACT maturity assessment reveals strong foundations but significant opportunities across all five domains. We have trained over 10% of staff in QI methodology and established improvement hotspots yet have not reached the tipping point where QI becomes business as usual.

Our Improvement leaders have developed 'Our Improvement Strategy 2025-28' (Annex 1 – reading room) with options as to how we deliver this transformation where QI becomes the default approach to solve clinical, operational and financial challenges.

This paper seeks Board approval to agree an overall Direction of travel that enables us to implement a Quality management System and further embed QI principles and methodology.

A number of options have been considered and presented, option 5 is the recommended option.

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

Care	- Excel in the delivery Care	☒
Colleagues	- Support our Colleagues	☒
Collaboration	- Effective Collaboration	☒
Communities	- Improve the health and wellbeing of our Communities	☒

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

Board Development Session June 2025

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4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a) Note 'Our Improvement Strategy 2025-28' Annex 1
b) Discuss the options for delivering improvement transformation
c) Agree the preferred option

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Group Assurance Framework Risk GBR01	☒	*Break even*
Group Assurance Framework Risk GBR02	☒	*Performance standards*
Group Assurance Framework Risk GBR03	☐	*Corporate transformation*
Group Assurance Framework Risk GBR04	☒	*Workforce transformation*
Group Assurance Framework Risk GBR05	☒	*Service transformation*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 16 September 2025

Our Improvement Strategy – embedding Quality Improvement

1.   Executive summary

RWT and WHT have committed to quality improvement (QI) as a fundamental enabler for achieving financial stability whilst delivering exceptional care. Despite six years of investment in QI methodology and staff training, the organisation has not yet realised the full potential of this approach. We now need to complete the transformation into an organisation where QI becomes the default methodology for solving clinical, operational, and financial challenges.

2. Background

Our organisations currently face significant challenges: falling short of ambitious care aspirations whilst confronting the largest financial challenge in our history. Despite performing relatively well against peers on key metrics, we have not reached the tipping point where improvement approaches are the norm. Outstanding NHS organisations demonstrate that effective QI implementation delivers:

- Top quartile clinical and operational performance
- Improved staff satisfaction and reduced turnover
- Financial sustainability
- CQC outstanding ratings

3. Strategic Vision

The QI team envisions "an organisation that embraces an improvement culture, where our people are proud to demonstrate the impact on patient care and colleagues' experience." This transformation will create a quality management system where organisational priorities are planned, prioritised, and promoted; where our QI approach becomes widely understood as the default change methodology; and where quality control enables real-time performance monitoring.

4. Strategic Framework for QI transformation

Our vision encompasses creating an integrated improvement system where staff operate within three foundational elements:

1. **Quality Management System**

   - Organisational priorities are systematically planned, prioritised and promoted
   - Quality improvement becomes the widely understood default change methodology
   - Real-time quality control enables immediate performance monitoring and response

2. **Empowered Workforce**

   - Staff understand their role and feel purposeful in delivering visible, tangible, relevant, desirable, and achievable organisational goals
   - Psychological safety enables innovation and learning from failure
   - Leaders consistently role-model improvement behaviours
   - Staff are empowered and supported to develop and implement change ideas

3. **Collaborative Culture**

   - Active engagement between colleagues and patient stakeholders
   - Cross-silo agreements deliver sustainable patient care improvements
   - Reporting structures reinforce trust priorities and improvement methodology
   - Shared accountability drives collective commitment to transformation

Expected outcomes

This vision creates a self-reinforcing cycle where improvement becomes embedded in daily practice, staff engagement increases through meaningful participation, and sustainable change delivery becomes standard operating procedure across all organisational levels.

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5. Options for delivery – How can we achieve this?

Option 1: Status Quo (3-5 years) (est. cost £)	
Continue current implementation with existing small team and implement 'Our QI Strategy 2025-28' (Appendix 1).	
Advantages:	No additional resources required, steady progress with respected teams.
Disadvantages:	Limited pace, potential credibility loss if unable to meet required transformation speed.

Option 2: External Partner (est. cost £££££)	
Engage an external company for board training and quality management system implementation (£1-1.5m over 12-24 months).	
Advantages:	Additional resources, fresh ideas, established credibility, speed of implementation.
Disadvantages:	High costs during financial constraints, reduced staff engagement, sustainability concerns when partner leaves, potential duplication with NHS Board Impact Programme.

Option 3: Enhanced Internal QI Team (est. cost ££)	
Strengthen existing QI team to accelerate transformation whilst maintaining current supportive approach. Team has established relationships, trained 10% of staff in QSIR methodology, and built trusted brand. Includes participation in NHS Board Impact Programme with Black Country partners.	
Advantages:	Lower costs, ready to launch, higher sustainability, leverages existing expertise.
Disadvantages:	Requires recurrent investment for additional QI expertise and training capacity. Ability to attract the right people in the correct timeframe.

Option 4: Hybrid Model (est. cost ££££)	
Combines Option 3 with limited external partner input for the development of a Quality Management System whilst focusing internally on leadership behaviours and national programme participation.	
Advantages:	Reduced costs compared to full external model, potential board engagement benefits. Existing team get to work alongside external experts and benefit from knowledge transfer. Quicker to implement and benefits realised sooner.
Disadvantages:	Costs still incurred by using external support. May not be as quick to implement as wholly external approach.

Option 5: Secure external Advisor and appoint to Director of Improvement and expand Team (est. cost £££)	
Securing the support of an external advisor who will work with the Board and senior leadership team with an explicit aim of re-framing the board approach and culture. The advisor will be a nationally recognised expert who has experience at Board level and will have implemented QMS systems previously. The Director of Improvement will have sole responsibility for the QI team and their sole focus will be leading on improvement for the organisations, overseeing the cultural transformation, establishing a quality management system, and embedding QI at all levels of the organisation.	
Advantages:	The advisor post will have experience of and will be able to introduce the concepts and cultures required for effective board working and relationships and challenge behaviours where necessary. Dedicated leadership post appointed to drive a culture of quality improvement and provide leadership and management support for improvement initiatives, fostering a collaborative environment through promoting engagement with our own teams. Creates a supportive culture that fosters sustainable improvement and develops the leadership behaviours necessary for this cultural change, embedding a quality management system approach.
Disadvantages:	Ability to recruit to specialist advisor post. Initial Investment required plus a smaller recurrent investment required. Possible issues of perception in the current financial climate.

4.   Recommendations

4.1   The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:

   a. Note 'Our Improvement Strategy 2025-28' Annex 1
   b. Discuss the options for delivering improvement transformation
   c. Agree the preferred option

Annex 1: 'Our Improvement Strategy 2025-28'

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