The Royal Wolverhampton NHS Trust (RWT)
& Walsall Healthcare NHS Trust (WHT)
Tuesday 18 November 2025 @ 12:30-15:30
Meeting Room 9, 3rd Floor, MLCC, Walsall Manor Hospital

Group Board of Directors Meeting - to be held in PUBLIC

ITEM NO	DESCRIPTION	PAPER REF	LEAD	PURPOSE	TIME
1	Chair's Welcome, Apologies and Confirmation of Quorum	Verbal	Sir David	To inform & assure	12:30
2	Patient Story - (RWT) – R&D Pauline Boyle in attendance	Verbal	B McKaig	To inform	12:32
3	Register of Declarations of Interest	Verbal	Sir David	To inform & assure	12:47
4	Minutes of the Previous RWT/WHT Group Board of Directors Meeting held in Public on 16 September 2025	Enclosure 4	Sir David	To approve	12:49
4.1	Group Board Action Log and Matters Arising	Enclosure 4.1	Sir David	To inform & assure	12:52
5	Chair's Report – Verbal	Verbal	Sir David	To inform & assure	12:57
6	Group Chief Executive's Report	Enclosure 6	J Chadwick-Bell	To inform & assure	13:02
7	Integrated Committee Chairs Report - Quality, Finance & Productivity, Transformation and Partnerships and People	Enclosure 7	J Dunn/ P Assinder/ L Toner/ D Brathwaite/ L Cowley	To inform & assure	13:12
7.1	RWT Charitable Funds Committee Chair's Report	Verbal	M Levermore	To inform & assure	13:32
8	Group Finance Plan and Workforce Report	Enclosure 8	K Stringer	To inform & assure	13:37
9	Governance (Section Heading)				
9.1	Annual Research & Development Report	Enclosure 9.1	B McKaig Z Din	To inform & assure	13:45
9.2	Group Board Assurance Framework (GBAF)	Enclosure 9.2	K Bostock	To inform & assure	13:55
10	**COMFORT BREAK (10 MINS)**				**14:03**
11	**Strategy (Section Heading)**				
11.1	Group Chief Community and Partnerships Officer Report Work Programme for One Wolverhampton and Walsall Together	Enclosure 11.1	S Cartwright	To inform & assure	14:13
11.2	Outline Planning Framework	Enclosure 11.2	J Chadwick-Bell S Evans	To approve	14:21

ITEM NO	DESCRIPTION	PAPER REF	LEAD	PURPOSE	TIME
12	Trust Integrated Quality & Performance Reports (Section Heading)				
12.1	Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity	Enclosure 12.1	A Godson	To inform & assure	14:29
12.2	Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality, People, Access Standards, Finance and Productivity	Enclosure 12.2	G Nuttall	To discuss, inform & assure	14:39
12.3	Resident Doctor 10 Point Plan	Enclosure 12.3	B McKaig Z Din	To inform & assure	14:49
12.4	Health Inequalities	Enclosure 12.4	S Cartwright	To inform & assure	14:54
12.5	WHT Birthrate Plus – Business Case	Enclosure 12.5	L Carroll	To approve	15:02
12.6	EPR Implementation Update	Enclosure 12.6	G Nuttall	To inform & assure	15:07
12.7	RWT Charitable Funds Annual Accounts 2024/25 and Representation Letter	Enclosure 12.7	K Stringer	To approve	15:12
12.8	Use of WHT and RWT Trust Seals	Enclosure 12.8	K Bostock	To assure	15:17
13	Questions Received from the Public	Verbal	Sir David	To inform	15:21
14	Any Other Business	Verbal	Sir David	To inform	15:26
15	Resolution to close meeting	Verbal	Sir David	To inform	15:31
16	Date of Next Meeting: Tuesday 20th January 2026 – Venue to be confirmed	Verbal	Sir David	To inform	15:33
MEETING CLOSE					

MEETING OF THE PUBLIC GROUP TRUST BOARD MEETING
TUESDAY 16 SEPTEMBER 2025 AT 12:30pm
held at Meeting Room 9, MLCC, 3rd Floor, Walsall Healthcare NHS Trust

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 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 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
Dr U Daraz	Joint Associate Non-Executive Director, RWT and WHT
Ms D Brathwaite	Joint Non-Executive Director, RWT and WHT
Prof M Levermore	Joint Non-Executive Director, RWT and WHT
Ms A Godson	Managing Director, WHT

In Attendance

Ms O Powell	Senior Administrator, RWT
Ms S Banga	Senior Operational Coordinator, RWT
Ms J Wright	Director of Midwifery, WHT
Dr J Tinsa	Member of the Public
Ms G Padmore-Payne	Lead FTSU, RWT
Ms S Raza	Lead FTSU, WHT
Ms V Manuh	Member of the Public, Health Visitor Team Lead, RWT
Mr S Vetharaj	Member of the Public, SAS Doctor in Anaothoins, RWT
Ms K Cheshire	Head of Midwifery and Neonatal Services
Ms C Whyte	Deputy Chief Nursing Officer
Ms Amy Downward	Member of the Public, Communications Lead Press and Media
Ms L Atkinson	Bereavement Midwife, WHT
Ms S Kalang	Bereavement Midwife, WHT

Apologies

Ms L Carroll	Chief Nursing Officer, WHT
Ms A Heseltine	Joint Associate Non-Executive Director, RWT and WHT
Mr P Assinder	Deputy Chair/Non-Executive Director, 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 Story (Walsall Healthcare NHS Trust) - Child Bereavement**
	Ms Godson introduced Laura Atkinson and Joselle Wright. Ms Atkinson said the patient story was of a couple who had lost their baby, an abnormality was found during the preliminary stages of the pregnancy, but the couple wished to continue with the pregnancy. She said the team considered ways to support the parents during and after the baby's birth. She advised the Bereavement

	Services supported parents who wished to continue with their pregnancy after an abnormality had been identified. She said this also included parents who went through unexpected loss like still birth or a neonatal death and parents who went home with their babies who then later had passed away. She said at the beginning of the bereavement process there was support on choosing a model of delivery. She mentioned after the baby was born various matters were considered, such as the length of time they wanted to spend with the baby along with what family members they wanted to bring for support, together with their cultural and spiritual needs. She said memory boxes had also been introduced for all cultural needs. Prof. Toner commended the team for their outstanding work and thanked the patients for sharing their story. Ms Hickman echoed Prof. Toner's comments and stated there was opportunity for collaboration and working across both RWT and WHT for support. Sir David asked how the services compared to services at RWT. Ms Atkinson advised structures and models were similar and both teams worked well together. She also said communication also took place with midwives in the area where sharing was undertaken. Ms Wright commended Ms Atkinson and the team. She advised the team had a pivotal role in bringing varied factors together. She said discussions had taken with Ms Cheshire about potential opportunities for collaboration across the two Trusts to maintain the 7 day a week service. She highlighted the success of the Calm Connections Clinic, which was the only clinic of its type in the Country. She said the Trust had received a national award for the clinic which was positive news. She finally assured the Board that external reviews were undertaken to ensure a thorough review was completed when the death of a baby occurred in the organisation. **Resolved: that the Patient Story (Walsall Healthcare NHS Trust) - Child Bereavement be received for information and assurance.**
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 15 July 2025**
	Sir David approved the minutes of the Group Trust Board Meeting held on 15th July 2025 as an accurate record. **Resolved: that the minutes of the previous meeting held on 15th July 2025 be received and APPROVED.**
079/25	**Group Board Action Log and Matters Arising**
	16 July 2025/090/25 **Group Chief Community and Partnerships Officer Report on Place Development for One Wolverhampton and Walsall Together** **Action: Group Trust Board to review Walsall Together and OneWolverhampton Pioneer Applications and recommend which is the strongest and likely to succeed**. 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 Integrated Care Board (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 Chief Executive Officer (CEO) was one of the signatures to the application form. Ms Chadwick-Bell asked that the Group Trust Board review Walsall Together and One Wolverhampton applications and provide a recommendation on which would be the strongest application to succeed.* *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.* **Resolved: It was agreed the action be closed** 16 July 2025/090/25 **Action: Sir David asked that Executive Directors confirm which Sub-committee the winter plan would be delegated to for final sign off.** *Dr McKaig confirmed it had been agreed the Winter Plan would be signed off through Group Finance and*

	Performance Committee **Resolved: it was agreed the action be closed**
080/25	**Chair's Report – Verbal**
	Sir David congratulated the team in WHT being the only Trust in the Black Country who had been selected to participate in the development activity with the Department of Health for 43 areas. He also mentioned Trust league tables had been released, with WHT and Dudley both performing at a high level and RWT and Sandwell performing at a lower level. He said resolving financial issues together with access to services could assist with positive assurance for RWT.
081/25	**Group Chief Executive's Report**
	Ms Chadwick- Bell thanked colleagues across both Trust's for their continued hard work. She mentioned Executive Colleagues had attended several successful positive staff engagement sessions. She advised a summary of those discussions would be presented to the public forum, highlighting four or five actions that the Board could take which would make a difference to people working across the organisations. Ms Chadwick-Bell advised a self-assessment was to be undertaken on capability of the Board, and as an Organisation. She said this would be led by Mr Bostock and presented at the next Public Board Meeting. She noted both Trusts had received several awards which was positive. She finally mentioned a visit took had taken place from the Minister from India bringing together the University of Wolverhampton and colleagues from India to look at medical education together with research. She highlighted the independent review of Physician Associates (PA) and asked Dr McKaig to comment. Dr McKaig reported the PA review was produced following public criticism of PA which was contributed to by the British Medical Association (BMA) significantly linked to the junior Doctor's strike. He advised recommendations were dependent upon what each Organisation deemed were appropriate to implement. He said there were considerable legal matters, judicial reviews and Union matters which needed to be considered. He advised an initial review was undertaken of potential safety measures, the largest one identifying whether any of the PA were seeing patients that undifferentiated predominately from an Acute perspective in the Emergency Department. He reported various immediate adjustments were made to ensure the environment was safe. He finally mentioned other changes were being reviewed in an appropriate way across both Organisations. He said he had met with the 25 PAs at both Trusts who said they felt well supported and had provided assurance to them that they would be provided with the opportunity for career development in a safe framework. Sir David said the Board fully supported the PAs and their work was recognised as an asset for the organisation and its patients. **Resolved: that the Group Chief Executive's Report be received for information and assurance.** **Action: Mr Bostock to prepare a self-assessment on the capability of the Board and as an organisation.**
082/25	**Group Assurance Report – Group Quality Committee (GQC), Group Finance & Productivity Committee (GFPC), Transformation and Partnerships Committee (TPC) and Group People Committee (GPC)**
	Mr Dunn advised the report brought together critical issues which had been reported and discussed at each Committee meeting. He highlighted it was important that the Annual Operating Plan was achieved, there were a number of initiatives, but it was known there was a gap that would prevent the plan from being delivered unless changes were made. He said this was escalated to the Board and a discussion had taken place earlier today at Private Board. He said in addition to looking at the Hospital to Community movement, there were also Workforce Plans to ensure that everyone was informed of what was going on. Ms Chadwick-Bell felt that she needed to take the action regarding communication of the Workforce Plan, and she would do so, in order to understand what the expectations were and provide assurance. She felt it may be the concerns that the plans were still in development for the fundamental shift. She mentioned the Corporate Transformation Plan was currently being developed and Board discussions had taken place for it. Mr Dunn said continuing high performance was being delivered across the Organisations and complemented the Emergency Department (ED) and Referral to Treatment Plan teams. He finally mentioned there had been a deterioration on diagnostics at WHT and plans were in place. Ms Toner mentioned both WHT and RWT Biannual Skills Mix required approval and the Clinical Negligence

	Scheme for Trusts (CNST) be noted for the Board minutes. **Resolved: that the Group Assurance Report- Group Quality Committee, Group Finance & Productivity Committee, Transformation and Partnerships and Group People Committee be received for information and assurance. Both WHT and RWT Biannual Skills Mix be approved and the Clinical Negligence Scheme for Trusts (CNST) be noted.** **Action: Ms Chadwick-Bell to identify what the expectations were and provide assurance on the communications of the Workforce Plan.**
083/25	**RWT and WHT Audit Committee Chair Verbal updates**
	Ms Jones reported the RWT Audit committee met on 9 September 2025, which was a positive meeting, concluding last year's internal audit programme. She said the new process for tracking the closure of internal audit recommendations, which required individuals to provide evidence that the action had been resolved, the actions were not being closed in a timely manner. She reported benefits were seen by the hospital from the recommendations raised from the internal audit which was positive. Ms Martin reported that WHT Audit Committee also convened last week. She said the Trust was slightly behind with the internal audit programme and the commission had been provided an additional month to complete two important pieces of work, one pertaining to medical staffing and the other compliance and pay rates. She mentioned policies and procedures were being examined as part of the review process to identify whether there were any recommendations from internal auditors. She said whilst the Trust was trying to improve efficiency it was felt it was important to obtain those reports for any recommendations She finally mentioned the Cyber team had received a positive report stating that a plan was now in place to enhance the Trust's Cyber Assurance Framework as last year only partial assurance had been received. **Resolved: that the RWT and WHT Audit Committee Chair verbal updates be received for information and assurance.**
084/25	**RWT & WHT Charitable Funds Committee – Chair's Verbal Update to Trustees**
	Mr Levermore reported both RWT and WHT charities were impeccable. He encouraged members of the Board whilst on Walkabouts to visit the memorial garden at WHT and the paediatric garden, he said the response had been encouraging and positive. He noted positive feedback had been received from local communities of the work being undertaking by the Charities as the Charity was an anchor institution. Sir David said the Charity was open to listen to suggestions on how to use the funds for the benefit of the patients. **Resolved: that the RWT and WHT Charitable Funds Committee verbal updates be received for information and assurance.**
Trust IQPR's (Section Heading)	
086/25	**Integrated Performance Report –The Royal Wolverhampton NHS Trust**
	Ms Nuttall reported the Trust had been placed in Tier 2 after being de-escalated from Tier 1, which was the lowest performing escalation for achieving Referral to Treatment Times (RTT). She advised biweekly meetings were being held with the regional team to review the action plan to ensure they were within the trajectory. She highlighted the Trust was no longer in any tiering for its cancer performance and in the performance metric RWT was now within the top quartile for 62 days. She said this was a positive achievement for the Organisation. Ms Nuttall mentioned the go live date for the Electronic Patient Record (EPR) documentation system was 29 September, which was a most major IT upgrade for RWT. Ms Nuttall mentioned as part of the system-wide approach to how the Trust would be addressing frailty, RWT had been selected as one of the seven Trusts to participate in a National Frailty Collaborative Accelerator Programme. She said would be a crucial component of offering metrics to monitor progress. She reported Urgent and Emergency care together with Cancer diagnostics were within the first quartile. She finally reported improvement in operational performance and treatment times for the patients. Dr McKaig highlighted the Summary Hospital-level Mortality Indicator (SHMI) at RWT was stable at 0.96. He asked the Board to note from April 2026 Same Day Emergency Care (SDEC) coding would be changed nationwide to type 5 activity. He said this would result in a decrease in the inpatient denominator and the removal of SDEC activity which would lower the SHMI ratio. He said modelling had been received and would be presented to the Board to determine what mortality expectations may arise from the coding changes. Dr

	McKaig reported that RWT had received a prevention of future deaths exception notice from the Coroner which was due to the death of a patient relating to drug prescription allergies. He advised a detailed action plan was being prepared and a response would be submitted to the Coroner within the appropriate time frame. He highlighted this was recognised as a significant issue and not an isolated event. He said any learning received would be shared widely. Ms Hickman reported there has been improvement in several quality and nurse sensitive indicators. She said there had been a reduction in C. difficile and it had been maintained for six months. She said although there was improvement it should be recognised that ongoing work was required to address longer waits, 12 hour waits in the ED department and the effects of that. She mentioned teams had been short listed for several Health Service Journal (HSJ) awards, which was positive. She said including within the report was the first iteration of the minimum maternity data set which had been discussed thoroughly at GQC and a revised version had been created since presenting the report to the Board. Mr Duffell reported the Workforce Reduction Plan as of month 4 RWT was adverse to the plan. He said this was driven by temporary staffing, linked into five key areas, the first being an increase in nursing sickness absence, high acuity and increased ED demands, also the move from band two to band three which fed through the cost of temporary staffing and the final impact was switching of systems which resulted in double counting. He said both temporary and substantive staffing for month 5 were on target against the plan. He finally mentioned the Mutually Agreed Resignation Scheme (MARS) ended at midnight last night for both Trusts and applications would be reviewed. Ms Martin made reference to page 8 of the report Perinatal Service mentioned concerns with Consultant staff. She said that the Nursing Skills Mix had been signed off today, but Consultants were a different group. She asked how Consultant staff were monitored to ensure correct levels of Consultant staffing were available. Dr McKaig said the concerns were not around the establishment but rather about temporary combinations of gaps due to vacancies and difficult to recruit. He said there were challenges in both obstetrics and genecology. He reported there were no metrics for the established workforce unlike in nursing, but the route of those challenges had been established in that they were reliant upon temporary workforce to try and support that issue. Ms Hickman clarified there were certain establishments that were signed off but did not include maternity as the Birth Rate Plus report was still awaited. Ms Barber asked if it would be beneficial to include patient feedback and complaints within the report for information purposes as it was not reported into the Board Meeting, she was aware it was reported by GQC. Ms Nuttall said it was the first time the productivity dashboard was incorporated within the report. She advised it was work in progress after having been reviewed with the Executives. She said it needed to indicate where there were opportunities where performance was positive or negative. She encouraged the Board to provide input on the contents of the dashboard. Ms Hickman questioned whether a narrative was required and mentioned that the report contained charts that included complaints. Ms Barber advised it was the actions linked to the trends. Sir David said the report was work in progress and key was to simplify it and to be able to benchmark the organisations against other Trusts. **Resolved: that the Integrated Performance Report for RWT be received for information and assurance.** **Action: Ms Hickman to provide more detail within the next report on actions linked to trends for patient feedback and complaints**
087/25	**Integrated Performance Report –Walsall Healthcare NHS Trust**
	Ms Godson highlighted that WHT was ranked first in the Midlands for RTT for the last 9 consecutive months, second in the region, and positive performance for Cancer and for Ambulance 30 min offloads. She also mentioned challenges with diagnostics and work was being undertaken with RWT to provide mutual aid. She said in Month 4 there had been an increase in falls and pressure ulcers and action plans were in place. Ms Godson reported the GCEO had written to the Chief Executive of the Mental Health Trust regarding the rise of of Mental Health presentations in ED. She said a response had been received and colleagues from the Mental

	Health Trust, WHT and RWT would be attending a workshop to look at how to improve patient experience. Dr Din reported an increase in falls but remained within the national standards. He said harm level continued to be submitted through Patient Safety Incident Response Framework (PSIRF). He said there had been an increase in pressure ulcers which was being monitored and actions were in place. He advised there had been improvements in Ventricular Tachycardia (VT) but remined below the national ask. Dr Din reported focus on acute portals for the Acute Medical Unit (AMU) and the surgical units ensuring first reviews and VT assessments were documented. He mentioned sepsis remained strong in terms of screening in paediatrics and had improved in ED. He reported there had been 7 C-Difficile cases at the Trust and a key intervention was timing of sampling. He said the SHIMI remained within the standard. He reported improvement with friends and family tests to 90% and complaints remained lower than the threshold. Dr Din mentioned there were no moderate or serious harm for medication errors. He highlighted the outlier status which was received with the national neonatal audit programme which was from the audit standards from the 24 data, one which was relating to breast milk by 2 days and out of the 71 eligible patients only 28 received breast milk by day two. He reported the second was deferred cord clamping for which the expected standard was 60 seconds and below. He said the Trust achieved 47.9%, an action plan had been prepared which would be reported to the Committee and work had already commenced showing some improvement to 50% - 55%. Mr Duffell said the Workforce Reduction Plan for WHT, temporary staffing was better than plan and substantive staffing was ahead and adverse to plan. He reported there was an error in month 5 which was due to a counting issue where doctors who had relocated were still counted. He mentioned concerns around sickness absence and GPC had asked for plan as to how this could be addressed. He finally mentioned detailed discussions had taken place at GPC as to the issues with appraisals and actions were in place to try and resolve them. **Resolved: that the Integrated Performance Report for WHT be received for information and assurance**
088/25	**Group Financial Performance Update - verbal**
	Mr Stringer reported the budget was set at £1.5 billion across the Group which was challenging. He said in addition a 6.2% cost improvement programme had been agreed which was £87 million across the Group which was also a challenge. He also mentioned due to changes with the Integrated Care Board (ICB), across the two Trusts approximately £60 million of deficit support funding nationally had been put into the Group. He said there was an intention that that would be removed from organisations on a national level over time. Mr Stringer said the Month 4 position showed a total surplus of £4.3 million across the Group against the plan. He mentioned the figure had improved at the end of August to a collective of £6.1 million surplus which was driven by £6 million being WHT's proportion and £0.1 million for RWT. He mentioned the figures were driven by the phasing of Cost Improvement Plan (CIP) in particular at WHT. He said WHT took the view that there was an unidentified CIP programme in March which they put towards the end of the year and they had taken a view that some of the capacity issues and reductions were difficult to achieve. He said together with workforce it would take time to come through the system and learning lessons from 24/25. He advised therefore WHT had overperformed against the CIP phase. Mr Stringer said it was believed there would be a £20 million gap and a delivery plan was being finalised outlining options which were to be presented to GFPC by the end of September, early October and would be presented to the next Board meeting in November. He said the financial position of WHT in Month 5 had assisted the ICB significantly in offsetting other areas within the ICB to enable a collective breakeven position. He mentioned this was important as the ICB was judged on whether they received the deficit funding on a quarterly basis. Mr Dunn said it was a false positive with it being £6 million due to the significant challenges moving forward. Sir David mentioned the phasing brought time and there needed to be assurance that the time was used to the positive effect. Sir David said the financial position for the Group was challenging but was it important that both Trusts delivered the Plan that was agreed. He said this would take both Trusts closer to their objective in the next two to three years as to being financially stable. He also mentioned the significant sanctions that would be applied to organisations if they did not deliver. **Resolved: that the Group Financial Performance be received for information and assurance**

089/25	**Group Chief Community and Partnerships Officer Report by Exception for RWT & WHT**
	Ms Cartwright highlighted WHT was successful in its application for the Neighbourhood Health Programme and would join 42 other areas across the Country. She said both Place Based Partnerships had completed the application, and feedback was expected which would be shared with Board members. Ms Cartwright reported the Better Care for OneWolverhampton had assigned money this year to support the Neighbourhood Health Programme and other initiatives around the Home First. She highlighted OneWolverhampton had received a HSJ award nomination for the Technology Enabled Care Programme. She mentioned this was a specific programme working with Social Care colleagues that looked at putting remote monitoring within patient's homes for the ability of people to be able to live independently. She said Wolverhampton Place had been selected in the National Frailty Collaborative and the first was session was positive. She also mentioned work being undertaken in Wolverhampton on the Complex Geriatric Assessments which was one of the reasons why Wolverhampton had been selected for an award. She said another area identified for development was a Frailty Hub and would be reported through PCTC. Ms Cartwright advised the welcome pack had been received for the Programme and a national coach had been assigned. She reported a regional launch event was to take place on the 23 October where a team of people would attend from across the Partnership. She said it may have been seen through media coverage where areas that were successful were announced they did except the areas to lead the way on implementation of NHS Plan. She said regular updates would be provided to PCTC and the Board. Ms Cartwright reported discussions continued around the opportunity for the next stage of developments for Partnership Arrangements and conversations had taken place with the ICB as they considered options for commissioning for neighbourhood and out of Hospital Care. She mentioned included in the paper was the Neighbourhood Team Plan that was recently approved by the Walsall Together Board which would be used as the basis for developing those teams as part of the national programme. Sir David said it would be difficult to layer the work together with the work being undertaken with a partner organisation for Community First and the Winter Plan. He felt thought was required to this. Ms Cartwright said both plans were complimentary to each other, and part of the Transformation Plan included the development of the neighbourhood teams and the ability to manage more people through a coordinated care approach. Mr Dunn asked about the position with Partnerships in Primary Healthcare. Ms Cartwright said both Places, the Primary Care Collaborative and the Primary Care collaborative also had membership within the Walsall together and OneWolverhampton Place Boards. She said in addition both organisations had the primary and secondary care interface groups. She noted that the Black Country Primary Care Collaborative was undertaking a significant amount of work with regards to its future and it would be able to support the system in regards to Primary Care transformation. Ms Chadwick-Bell said to be able to develop the Neighbourhoods the money needed to be shifted to be able to build those Community Teams as they were all linked. She said the neighbourhoods would not be able evolve to optimise both models without shifting the resource from its hospital-based services into community. She felt that was why an internal programme of work was important. **Resolved: that the Group Chief Community and Partnerships Officer Report by Exception for RWT & WHT be received for information and assurance**
090/25	**Proposed Model for Stroke Rehabilitation across Walsall and Wolverhampton**
	Ms Cartwright advised a report was presented last year to the Board about the development of Community Stroke Services across the Group due to the current location at WHT for the Inpatient Stroke Rehabilitation Service not being fit for purpose. She said a piece of work was initiated with Board approval to look at what alternatives there were with regards to the provision of that service. She advised the report summarised the position to date with regards to a transformational piece of work on how the Trust cared for patients recovering from Stroke. She mentioned the proposal was to move from Hospital to Community and increasing the number of patients that were going to be looked after within their own homes by either returning to their home quicker following discharge or by transferring home earlier from their Stroke Rehabilitation Inpatient support. She advised that would be undertaken by investing in both Community Services across Walsall and Wolverhampton and reduce the bed base and co locate the bed base over to West Park in Wolverhampton which was a Specialist Rehabilitation Hospital. She said Board support was required today to proceed to the

	transitional phase. She highlighted that the Clinical Senate attended the Trust to review the model and had spoked to staff at both WHT and RWT who were applauded for their passion and commitment for Stroke care. She said the Senate was positive that the work being proposed would be better for patients. Ms Cartwright advised feedback was awaited from the Senate setting out recommendations around increased staff engagement with regards to how to co-locate the services and to increase the workforce from a community perspective. She mentioned a Public Engagement exercise would be undertaken to engage with the Public so they understood what the changes would mean for them. She advised a report was to be presented at the Health and Care Overviews Scrutiny Committee on the 10 September. She finally thanked staff who had worked on the model for their extensive work. **Resolved: that the proposed Model for Stroke Rehabilitation across Walsall and Wolverhampton be approved**
091/25	**RWT & WHT Winter Plan 2025/26 inc. Board Assurance Statements**
	Ms Nuttall reported the Board Assurance Framework required approval today from the Board and highlighted RWT Winter Plan was aligned with WHT and aligned in style, content and approach across the Black Country. She advised the RWT Winter Plan was a sub section on the OneWolverhampton Plan. She explained that the approach for the Plan was based on lessons learnt from previous winters and finance had been a key part of the discussion. She reported that funding that had been identified to support discharge plans and winter planning. She said £6.5 million had been allocated to Wolverhampton Place and it was allocated across some specifically to the Organisation and some to other partners. She mentioned the gap in the bed modelling for RWT was 29 beds and the mitigations were identified at 31.5 beds. She said the Red-Amber-Green (RAG) rating for the risk was amber and it was not a plan without risk, only two of the schemes were acute focused and the rest linked into the partners. She advised focus was on community working and engagement of Community teams. She said staff sickness was a key element on how it would be managed going forward. She asked for Board Assurance Framework (BAF) would be shared for approval and had also been presented to GFPC. Mr Dunn said the plan reflected experience from last year including the possible risk for industrial action and staff sickness. He asked what the process was this year for flu and covid vaccinations. Ms Hickman advised a decision had been taking that only Flu vaccinations would be offered to staff. She said there was a focus on hearts and minds and discussions were taking place on learning from previous plans. She said she would ensure the Flu Plan was presented at GPC. Mr Dunn asked whether sickness was still a key risk and whether it had been mitigated. Ms Hickman advised a plan was in place but remained a significant risk. She said it was noted that the uptake for Flu vaccinations was significantly lower than previous years as it was linked into Covid vaccines. Mr Dunn asked about demand management and if it was going through the OneWolverhampton team. Ms Nuttall said yes, and it was also done in conjunction with West Midlands Ambulance Service. She said all the actions linked in with all of the key stakeholders. Sir David asked Mr Dunn whether it was recommended that the Board Assurance Framework be accepted. Mr Dunn confirmed agreement. Dr Din asked if there had been sight of the system for the Winter Plan. Ms Nuttall confirmed they could obtain sight of the Plan and there were specific West Midlands Plans available as an ambulance service. Sir David asked about the issue of external assurance. Ms Nuttall said a Black Country event was held yesterday and tomorrow was the Winter Planning sign off event where the ICB would be assured and tested. She said using external partners were scenario testing and testing the response. She mentioned a document was released nationally yesterday through the centre about monthly escalation monitoring and reporting, to ensure that organisations had the appropriate escalation mechanisms in place. Sir David asked how the Trust performed in scenario testing. Ms Nuttall said some risks had been identified with regards to ambulance handovers during the first test which took place last week and the main test was to take place tomorrow. Ms Godson highlighted the ICB digitalization approach and for WHT there was a shortfall of 46 beds, and the plan mitigated it down to 16. She said there was a mix of Walsall schemes and Walsall Together Partner

	schemes. She reported these were phased and the plan had been reported to GPFC due to costs and it was reduced from £1.4 million to £193K as they were looking to reduce it further. She mentioned it recognised that 51 beds had already closed and the further 21 beds that plan to close together with the investment into Community Services. She said an internal event took place last week and were to be tested at a regional event tomorrow. **Resolved: that RWT & WHT Winter Plans 2025/26 and Board Assurance Frameworks be approved**
092/25	**RWT & WHT Freedom to Speak Up Report**
	Mr Duffell highlighted in recognising the importance to Freedom to Speak Up key highlights were reported to the Board. He introduced Ms Padmore-Payne and Ms Raza. Ms Padmore-Payne reported there had been an increase of complaints for RWT by 10% and reports had indicated improved confidence and psychological safety from staff members. She mentioned reports had also been received around attitudes and behaviours, policies and procedures in terms of management of change and MARS together with some discrimination cases. She said this was being reviewed collaboratively and they were in line with some the National Guardian Officers reports published nationally. She reported Nursing and Midwifery continued to be at the top of the reporting boards and there was more engagement from Medical, Dental and Allied Health Professional (AHP). She said a high proportion of staff were not stipulating what areas they were working, and that issue was being addressed. She advised training and induction programmes were available through inductions to ensure staff were aware of whom the team was and how they could access the service. She said joint presentations with WHT took place for Nursing inductions, Clinical Fellows, Consultants, Health Care Assistant (HCAs) and all the other groups. She mentioned training compliance was positive and remained above 90. She reported the first magazine had been launched in July with Freedom to Speak up Updates. She said services were also being aligned to triangulate more information with the Assurance Groups, Well-Being Groups and other Senior Member Groups. She finally said the team and staff felt more walkarounds should be arranged with Senior Leaders. Ms Raza thanked Board members for their support with Freedom to Speak up. She reported there had been an increase in the number of concerns raised at WHT. She mentioned that training was lower in comparison to RWT, and work was being with undertaken in addressing the issue. She advised staff supported the roll out of staff culture conversations and positive feedback had been received. She also mentioned the work being undertaken by Dr Zin in the shift in culture for Consultants as there had been an increase in medical colleagues raising concerns. Mr Duffell reported there would be a significant reduction in the National Guardian's Office and he was unaware of what that impact would be for supporting organisational guardians as he felt they were a key support. He said staff were keen for feedback after raising issues, and how this was reported was difficult as most staff wished to remain anonymous, and was an ongoing issue when identifying feedback which had been received. Ms Cowley said in the report for WHT there was mention of an increase in Quarter 4 in staff wellbeing and an increase in Quarter 1 around policies procedures and processes. She asked if there was anything specific that required actioning. Ms Raza advised it varied, some related to policies and procedures and changes in terms of staffing and ways of working. She said there were not specific actions that needed to be taken but it was being reviewed at staff wellbeing. She mentioned one of the biggest concerns was the multi faith prayer room where staff had limited access to the Chaplaincy to meet all faith groups. She said the team were looking at how the issue could be addressed. Ms Cartwright said Senior leaders would be very supportive to join the Freedom to Speak Up Guardians on walkabouts. Mr Levermore asked if staff knew the difference from Freedom to Speak Up compared to whistleblowing. Ms Padmore-Payne said this was a question that had been raised quite frequently by staff and managers. She felt that staff did see the Freedom to Speak Up services as the whistleblowing service. She said a few years prior the policy was changed across the Non-Governmental Organisation (NGO) that the Freedom to Speak Up would now also act as the Whistleblowing Service and it was changed in line across national policies. She said staff would come to the team and the team would help them to approach the challenges, which they would

	try and resolve initially internally prior to escalating further. Mr Levermore asked their thoughts on their personal mentors. Ms Padmore-Payne said RWT and WHT Guardians had a few mentors, one directly from the NGO service, and different mentors across the service and ICB who were contactable and approachable. She also mentioned mentors were also available at the Trust who were very supportive if there were any concerns. Ms Shah echoed the comments made and said they had different mentors depending on what the challenge was. Finally, they both thanked the Board for their support. Sir David thanked the team as the team were forefront to concerns of staff and commended them for their work and said it was important for the Board to ensure the team were supported to enable them to be able to do their work. **Resolved: that the RWT & WHT Freedom to Speak Up Report be received for information and assurance**
093/25	**Green Plan 2026-30 for RWT and WHT**
	Mr Evans mentioned positive work was already in place for the Green Plan across both Trusts. He reported the updated plan was based on guidance that was published early in the year and committed the organisations to achieve net zero for Scope 1 and Scope 2 by 2040 and Scope 3 by 2045. He said for Scope 1 at RWT there had been a 22% reduction and at WHT there had been a 6% reduction. He advised at RWT there was a reduction of 14% for Scope 3 but WHT had increased by 13%. He said this was due to medical devices, IT devices together with growth in activity. He said since the baseline assessment at WHT it had been recognised that the Estate had increased by 24% in Scope 3. He advised the report identified the 9 strategic priorities and the investment priorities, which both aligned to Estate's Decarbonisation Plan and the Digitalisation of Health Care. He mentioned finally investment was required in fleet which needed to be moved over a period of time to electric vehicles. He said the report was reported routinely through the GFPC and was a positive piece of work. Ms Cowley said there was significant shift towards Artificial Intelligence (AI) and AI was a significant driver of energy usage in terms of a supplier route but there was no mention within the NHS assessments around net zero as a driver. She asked what implications there were for organisations in terms of what needed to be measured. Mr Evans advised there was a report on this issue. He said the NHS were looking at the wider contributions and they were looking at how to extend Scope 3 as there were some obvious benefits that were discovered in early research when face to face appointments were stopped and the number of people who had stopped traveling to appointments. He said a benefit was seen, but the Trust would not see the carbon benefit. He felt there could be a revision on guidelines and how organisations were measured. Ms Toner asked why there was a three-year gap in the training of staff at RWT and WHT . Mr Evans said this was due to the fact RWT had commenced the process significantly earlier. **Resolved: that the Green Plan 2026-30 for RWT and WHT be approved**
094/25	**Our Improvement Strategy – Embedding Quality Improvement**
	Mr Evans reported a presentation took place at a Board Development Session on potential Quality Management System (QMS). He also mentioned previously the NHS England Improvement team had attended to present about making data count and the Board reports now reflected this in terms of Statistical Process Control (SPC) charts. He said most of the Board members had attended many of the Quality Improvement (QI) award and QI ceremonies. He said the QMS had 4 component parts which were ensuring planning was aligned, linked and focused on key important areas, control measures were in place, understanding what was being undertaken and why, together with routinely monitoring and having assurances about the process and finally adopting and implementing a quality improvement methodology. He reported extensive work, and training had been undertaken at both organisations on QI methodology. Mr Evans felt the Trusts were not yet in a position of bringing this together in one combined way. He said the paper discussed the options that were available. He reported the first option was to continue with the current implementation which would take multiple years to achieve the outcome required. He advised there was an option go externally with a provider which would achieve a quicker outcome but was expensive. He said the recommended option number 5, was to evolve and work with a nationally recognised eternal adviser who had implemented these types of programmes elsewhere and to work exclusively with the Board. He advised to

	implement this there was a need to recruit a Director of Improvement, and their sole role would be to focus on the Quality Management System (QMS) approach and work with the Quality Improvement (QI) team to implement this. Ms Chadwick-Bell reported this was an Organisational Development (OD) programme and linked within the Corporate Transformation Programme. She said this would assist in ensuring staff that worked within the organisations were an improvement partner and they felt able to make their own changes within parameters. She highlighted this would essentially alter the way the organisation operated. Mr Dunn questioned whether it was too soon and if the Board needed to do more research to figure out how to move forward. He also asked about the practical implications and whether it should be discussed at a Board Development Session. Ms Chadwick-Bell felt it was not premature and felt this was how the Board worked and that it needed to commence with the Board, so that the Board were clear in what they were trying to achieve. She said it was acknowledged that some work would be undertaken across the Black Country, as a pilot. She felt if an advisor was not brought in to lead the programme of work and assist in embedding that through the organisation at the beginning, they would then be picking it up halfway and needed to be part of the ownership. Ms Cowley said there needed to be clarify on how it worked with any partners around Community First and the ability to discern between the work being done by the internal team and that of any partner or advisers. She felt there was a risk of conflicting discussions and confusion if things went to different Committees. As she said they were expected to work together and equally as a Board to which the various things were reported through the Committees. Ms Chadwick-Bell said it was about how the Organisation worked rather than a programme of work. She believed the work programme would not have a Governance Group. She said this would assist in achieving the benefit of being held to account together with changing behaviours. She felt this would support the various programmes where working with partners, but those partners would need to understand that the organisations would be altering the way they worked. Mr Levermore said a significant amount of QI work had been completed over time which had been beneficial. He asked how the information would be preserved as some QI programmes had already been embedded into the QMS. Mr Evans said over 100 initiatives were currently being run and any associated resource which was left behind were priorities. He said this did not mean that staff would stop undertaking improvement initiatives but that they would already have resources to address any issue with QI. Sir David felt this was genuinely transformational, and at its core, it was about giving all staff the confidence to not only perform their jobs but also to enhance their work, their surroundings, their coworkers, and the services they provided. He said it was important that staff were provided with the resources to help them accomplish that, both in terms of the training that would be expanded and the authority to make decisions at a local level, which was crucial for our partners. He said it was a significant transformation and that was why it was important to have a Board advisor to ensure the programme was being delivered. **Resolved: that the Our Improvement Strategy – Embedding Quality Improvement be received for information and assurance and the recommendation of option 5, to secure external Advisor and appointment a Director of Improvement be approved**
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 Question 1. I was told by Mr Kevin Bostock that a summary of the RCP Report will be provided sometime in October 2025. The final RCP Report was received by RWT on 25 July 2025. There was then a meeting between the stroke team and internal governance on 30 July 2025. i) Why is only a summary of the report being provided? Are the people of Wolverhampton and the surrounding areas incapable of reading and understanding the report in question. This is a public interest document, and I am sure the authors of this report will be well aware and would have used language

	accordingly whilst being mindful of the nature of the report. I certainly cannot accept a summary, especially with a history of RWT falsifying mortality data and then sacking a senior whistleblower when she brought this matter to the attention of senior management. This sorry saga is displayed by the Verita Report of 2016 which was commissioned by the Trust Development Authority. ii) Why is RWT sitting on this report for 53 days and possibly for much longer when patients are dying unnecessarily due to poor stroke care! Dr McKaig said the Royal College had clear rules with how the report was shared and the legal obligations were being met. He said Trust would comply with its legal obligations regarding publication, there was a requirement under the Data Protection Act 2018 and UK General Data Protection Regulation to protect the rights and freedoms of data subjects who may be identified, therefore the Trust would achieve compliance through redaction, a summary of the report or other lawful method of disclosure, either way the duty of transparency and accountability obligation for public bodies will be followed. Dr McKaig said the current SHMI for Acute Cerebrovascular Disease is 1.00 (ie expected and observed deaths over the last 12-month period were matched with no excess deaths observed). Question 2. I recently visited our neighbouring Russell Hall Hospital in Dudley and was pleasantly surprised to find that Martha's Rule is being fully implemented whilst RWT seem to have kicked this matter into the long grass! I also witnessed volunteers helping patients to their destinations with a fully staffed reception. Why don't we have this at RWT anymore? RWT used to have a buggy which transferred patients across the hospital and were operated by trained volunteers with little cost to RWT. Dr McKaig reported Martha's Rule component 1 had been successfully introduced at both RWT and WHT as part of the National pilot. He said the National team visited WHT last week regarding the pilot work in both Trusts, which was extremely complimentary about how both organisations had embraced this important initiative, speaking to both staff and patients as to their experiences. Question 3. The Chief Executive's Report is woefully inadequate and again is focussing on the welfare of staff rather than concentrating on patient issues. I notice that there no longer appear any reports from Chief Medical and Nursing Officers, and there seems to be no discussion about the level of patient complaints and whether these complaints are being dealt with within statutory time periods. I feel that the Chief Executive should at least list all the meetings that she has attended in the previous two months. Ms Chadwick-Bell said report covered a range of areas of focus which affect staff and patients alike, the Managing Director's reports cover the specifics relating to each trust, which includes quality and patient safety, access to services, workforce and finance. She said this allowed each domain to be considered in a more integrated way and identify themes and impact as opposed to individual reports. Ms Chadwick-Bell said she had considered the suggestion to list all the meetings she attended, but as this was quite extensive over a 2 month period she did not feel it added to the relevant content of the report. She advised any significant outcomes from the meetings were covered either through the CEO report or through the remaining board agenda. 4. Newsflash for RWT. The Covid Pandemic ended in 2022 and the Board Meetings held in public should revert to monthly meetings, Additionally, most staff should return to their desks and stop working remotely. I have often phoned Hollybush House and cannot reach many people and their phones just ring out. It appears that staff working from home are not even bothering to divert their calls from their offices!!! Ms Chadwick-Bell said since 2022 the Group model had progressively matured and most staff that were based in Hollybush House prior to that were now mobile across two trusts. She advised a team of executive assistants were always available that could be contacted through switchboard to locate and get messages to Executives.
097/25	**Any Other Business**
	Ms Nuttall said that RWT would be going live with the EPR programme on 29 September 2025. She mentioned that this was phase 1 of a 3 year programme of a £24million scheme that would be implemented. She said

	there would be a new patient administration system and replacing that with care flow PAS, a new ED system and a new theatre management system. She advised company was system C and it aligned with the system that was at WHT.
098/25	**Date and Time of Next Meeting – Tuesday 18 November 2025 at 12:30PM – Venue to be confirmed**
	Sir David confirmed the date and time of the next meeting as Tuesday 18 November 2025 at 12:30 pm

Tier 1 - Paper ref:	Enc 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:	18 November 2025

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

I'd like to thank and recognise all the hard work colleagues have done to contribute to our patient experience and delivery of services. Their commitment to patients every day, whether that be front line or in supporting services makes a difference and there are many examples which are shared in various formats celebrating the work they do.

We celebrated some of the achievements at the Caring for All Award 2025 last week, and I'd like to recognise everyone who nominated and was nominated, they should be proud of the work they do. There were 17 award categories with winners across WHT and RWT. It was a great evening, and the HR, Communications and clinical illustration teams put on a fantastic event.

Executive Team Updates

As you will be aware we have made a number of changes across the wider Executive Teams in Walsall and Wolverhampton over the last few months, which includes a reduction in posts and change of portfolios, plus Alan Duffell, Group Chief People Officer, will be retiring in December.

I'd like to take this opportunity to thank Alan for all of his hard work and dedication and wish him well in his retirement.

We are now developing a Group plan – alongside a new clinical strategy – which will outline what we need to do over the next five years. These documents will be aligned to the NHS 10 Year Health Plan, and here we will consider how we work across our two Trusts, with staff at all levels, to continually seek to improve our services and the way we work.

Our ultimate aim is to ensure our people feel proud of the work they do and feel involved with changes in their areas.

I am pleased to announce the appointment of Dr Claire Radley, she has been appointed as Group Chief of People, Engagement and Improvement across The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust and will be starting with us on 30 March 2026.

Claire will be joining us in the Black Country from Gloucestershire Hospitals NHS Foundation Trust where she is the current Director for People and Organisational Development (OD).

Claire has experience in leading large-scale culture change work that has improved both staff and patient experience.

Changing Role of NHSE and ICBs

The model NHSE Region and model ICB guidance has recently been published and this will change how we interact with both NHSE and the ICBs moving forwards.

Following the requirement from NHS England in April 2025 for ICBs to reduce running costs significantly, including through the delivery of functions at greater scale and to shift toward delivery of a strategic

commissioning function aligned to the shifts outlined in the Government's national 10-year Health Plan this resulted in Birmingham and Solihull ICB and Black Country ICB forming one integrated care system with a clear focus on strategic commissioning and the development of neighbourhood health services for the population across Birmingham, Solihull and the Black Country.

David Melbourne has been appointed as the Cluster ICB CEO (Black Country ICB and Briming and Solihull ICB), he will be working through his new structures and reduction in running costs over the coming weeks and months and we recognise this will be a significant period of change and potential disruption as people and different ways of working are introduced. It will be important to minimise impact through close working as we start the planning cycle and ensure safety over the winter months.

Of specific note, we will have a closer arrangement with NHSE and the regional team as oversight moves away from ICB to NHSE with the ICBs focusing on strategic commissioning and contract management.

Medium Term Planning Framework and Trust Strategy Refresh
The Medium-Term Planning Framework for 2026/27 to 2028/29 was published on 24 October and signals the beginning of a new way of working in the NHS, thus ending the continued programme of short-term planning. The framework provides for a more streamlined approach between the centre and NHS service provision so as to enable a more local focus for Boards to work with the local communities to drive change to meet their local population needs. Thereby resetting the foundations to enable the deliver neighbourhood health services, which will see a transformative approach to quality, and finally embrace the opportunities of digital health to drive improvements in every aspect of its work.

As the RWT/WHT Group we have started our business planning with the first submission due before Christmas, which will include the 3-year numerical plans covering workforce, finance and performance trajectories, as well as the board assurance statements. The second and final submission due February 2026 will go one step further in providing a narrative to outline as a Group with the support of the system how we plan to deliver our 5-year plan. During March 2026 plans will be assured by NHS England regional teams who will provide specific support to those organisations who face the biggest challenges in meeting their collective ambitions. NHS England's national programme teams will also provide support where required to ensure that transformation expertise is targeted and aligned to support the delivery of all plans.

Fire Enforcement Block 32 New Cross Hospital
I met with the Deputy Chief Fire Officer for West Midlands Fire Service (WMFS) at the end of September and agreed to respond in full to the Enforcement Notice. I apologised for the failure to resolve the issues or request extension of the timeframes. Significant focus has been given to this matter and the progress evidence has been provided to WMFS, supplemented by a site visit and review on 14 October 2025.

Tackling antisemitism and other racism in the NHS
As part of the Government's commitment to tackle antisemitism and racism within the NHS following recent incidents as notified by Government we will be looking at strengthening our mandatory antisemitism and antiracism training and will work with NHS England to review the uniform guidance so patients and staff always feel respected in NHS settings. I am personally committed to supporting staff irrespective of their background or disability thus building an organisation that reflects the communities we serve and allowing staff to feel valued and able to work without feeling threatened by the potential actions of members of the public or fellow staff as I would always ensure such allegations are dealt with both quickly and in a fair manner.

Care Quality Commission (CQC) regulation 5 – Fit and Proper Persons' Directors
The Annual NHS Fit and Proper Person Test submission for 2024/25 to NHSE for Wolverhampton and Walsall Trusts was made in June 2025, in compliance with reporting requirements and both Trusts have subsequently had their submissions signed off by the Regional Director. The submission requires Trusts to confirm numbers of starters and leavers in the period (board members), confirm that all board members have been tested and

concluded as being fit and proper and also to confirm and record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc. I can confirm the sign-off of the exercise to check all Executives met the national CQC regulation 5 – For and Proper Persons Directors test, with no issues or concerns raised following the completion of all the national testing.

Provider Assurance

As part of the NHS 10-year plan, the new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, to ensure public accountability for performance and providing a foundation for how NHS England will work with systems and providers to support improvement. The framework outlines the circumstances in which providers can obtain increased freedoms. It also describes how NHSE will determine whether a provider's performance falls below an acceptable standard and/or has governance concerns that may lead NHS England to use its regulatory powers to step in and secure improvement. Both Trusts have completed the data quality testing phase for the new NHS Oversight Framework, and the metrics have now been updated for Quarter 1 (April – June 2025), and the segmentation, average metric score and league table position have been finalised.

The data was released publicly post the September board meeting and shared in different forums. Both trusts have been rated in segment 3. This rating is tiered from 1 – high performing to 4 – low performing and this is achieved using a range of performance indicators which are scored within one of three broad groups of similar providers (ambulance, acute, and mental health/community trusts). Segment 5 is applied where trust needs specific and enhanced intervention and oversight.

The Royal Wolverhampton NHS Trust		
Average Metric Score	Segment	League table position (*out of 134*)
2.53	3	90

Walsall Healthcare NHS Trust		
Average Metric Score	Segment	League table position (*out of 134*)
2.03	3	39

NHS Oversight Framework - Provider Capability Self-Assessment

The board approved the first self-assessment of provider capability required to be submitted to NHS England under the NHS Oversight Framework for both Trusts on the 22 October 2025. NHS England have confirmed that feedback is expected to be provided to Trusts early to mid-December.

Site visits across Walsall and Wolverhampton

Mortuary visit – WHT

I undertook a site visit of the mortuary at WHT on 6 November 2025 as part of my yearly assurance exercise to ensure service provision for this group of patients meets well established guidelines.

Urgent Care Pathway – WHT

It was great to walk the patient pathways with the urgent care teams; it gave me an opportunity to understand some the challenges and opportunities in how we work.

Clinical Teams

I have also met with a number of clinical teams, including Gynaecology and Obstetrics (RWT), Cardiology (RWT) and the clinical leads at WHT.

Black Country Provider Collaborative (BCPC) System Transformation

BCPC - Clinical Improvement & Service Transformation programmes

- The BCPC had been working on the following clinical transformation projects as follows:
  - **Breast** – Improved engagement from all Breast Units ahead of a workshop scheduled for mid-October, where we will consider if the previously identified need for consolidation still exists or whether improvement through collaboration is the optimal way forward.
  - **Breast DIEP Reconstruction** – The ICB Delivery Committee received a presentation from the BCPC Managing Director and Executive Finance Lead, which was well received and supported. Attention is now turning to mobilisation and operationalisation.
  - **Gynaecology** – work progressing to better understand and establish appropriate and robust service model arrangements across three key gynaecology areas – benign cancer, gynae-oncology, and endometriosis.
  - **Ophthalmology** – positive GiRFT visit by Prof Tim Briggs at DGFT which highlighted the improvements made, but also the opportunities for further and consistent improvements, specifically in the area of Cataract surgery. A visit to an exemplar site is being planned.
  - **Pharmacy Aseptics** – The work on the draft Strategic Outline Case (SOC) is drawing to a close, with all partner Trusts asked to review its findings and recommendations ahead of a robust discussion at the next Collaborative Executive meeting in November.
  - **Urology** – Two papers (Aquablation, and Galeous Bladder testing) were received as possible innovations that the system should consider, with potential benefits for both are considerable. Whilst supportive the Collaborative Executive is keen to await national guidance on the Galeous Bladder testing (due shortly) and understand the merits of a collective approach to Aquablation against the context of possible capital availability this financial year.
  - **BC Professional Engagement Workshop** - A system wide professional engagement workshop was held in mid-September, which was well attended, with representation from Primary, Secondary, Community and Mental Health care segments. Its core purpose was to provide a forum through which clinical and medical staff could actively engage with one another, fostering & developing relationships that can lead to improvements in patient care. Feedback has been positive, with further events planned which may evolve to focus on 'solving' current interface challenges.

Corporate Services Transformation

The Trusts across the Black Country are working together on developing a new model for corporate services where it is appropriate seeking to digitise and improve the offer to our staff ensuring we have optimised the resources we have available to us.

Team Recognition

Nursing Times Awards

I am delighted to announce that we, as a Group, were finalists within the following categories at the Nursing Times Awards held on Wednesday 22 October 2025:

Walsall:

- Ann Shuttleworth Rising Star Award - Harmony Owhotake Senior IPC Practitioner
- Infection Prevention and Control (IPC) – two projects by the IPC team were finalists: C. diffcille reduction initiative and Mouthcare in healthcare. A pneumonia prevention strategy
- Clinical Research within Nursing – The FORCE team were finalists for: Nursing Associates working within clinical research

RWT:

- The Kings Award for Integrated Approaches to Care – maintaining kidney health in ileostomy patients. A nurse-led approach to reducing acute kidney injury
- Theatre and Surgical Nursing - joint school: Pre-operative preparation for hip and knee arthroplasty patients

Joint WHT and RWT

- Team of the year – The FORCE team were finalists for - Thrive together: A collaborative framework for lifelong learning

I wanted to recognise this amazing achievement as this is not remotely possible without the hard work and dedication of staff taking the extra mile for each other, our patients and the communities we serve, my sincerest of thanks to you all.

Flu vaccinations

The 1st October 2025 saw the start of the flu vaccination programme with many of the Executives followed shortly thereafter Board members receiving their vaccines. At the end of September 2025, the uptake of the flu vaccine had increased compared to the previous year and I would note the data held nationally recognised that both flu and COVID-19 activity had increased in recent weeks. I would like to thank those staff who have already had their flu vaccine and encourage all other staff to take up the offer of the free flu vaccine for NHS staff, to both protect yourselves, patients and the community we serve because as we all know vaccination is the best defence against respiratory illnesses such as flu and COVID-19.

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:		

Tier 1 - Paper ref:	Enc 7
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 Board of Directors Meeting - in Public
Date:	18 November 2025

Key:
RWT= The Royal Wolverhampton NHS Trust; WHT = Walsall Healthcare NHS Trust

1. Summary of Key Issues/Assure, Advise, Alert

The Committees of the Board Chairs' Report comprises a joint summary of the 4 Group Committees of the Board:

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

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

The attention of the Board is required to the key themes and areas of discussion.

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 Committees of the Board

4. Recommendation(s)/Action(s)

The Board is asked to review, consider and discuss:

a) The common themes and key areas of discussion
b) The summary Committee of the Board reports in Sections 2.1-2.3
c) Seek any necessary action and/or evidence for assurance required

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 Committees of the Board Chairs' Assurance Report
Meetings held in September and October 2025

Summary

The Committees of the Board Chairs' Report will comprise a joint summary of the four Group Committees of the Board:

- Group Finance & Productivity Committee (F&PC)
- Group Quality Committee (QC)
- Group People Committee (PC)
- Group 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 (eg. 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 and areas of discussion
- Part 2 – 1. Assure, 2. Advise, 3. Alert by Committee, 2 months combined where appropriate

1. Common themes and areas of discussion

Theme/Issue	Board Lead	Notes
1. Finance The Group is currently forecasting a £15.5m variance from plan. Mitigations are being worked through	**CFO**	Boards are required to reforecast, if necessary, at the end of Q3 following a protocol that includes ICB and NHSE discussion
2. Emergency & Urgent Care Both trusts are seeing increased pressures with increasing numbers waiting over 12 hours at RWT	**CNOs**	Assurance requested on the quality of care provided to long
3. Fire Precautions Fire Safety Notices in relation to i) Maternity at New Cross; ii) Block 55 New cross; iii) Cannock Chase	**CEO**	Actions being agreed with Fire Service authorities but a theme of estates compliance and utilisation is emerging across Committees
4. Safety Notices Safety notices relating to Boston Scientific Pacemakers & Entonox exposure are being actively addressed by our trusts.	CEO	
5. Workforce The Group remains off plan (106.6 adverse at Month 6). Staff sickness rates are increasing and are higher than peers (average 25 days WHT & 22 at RWT). Management of change Plans remain unfunded in part.	CPO	Within financial limits the Mutually Agreed Resignation Scheme (MARS) has now been implemented and tight vacancy control measures remain in place, as well as authorization for temporary staffing. A sickness absence recovery plan has been developed and is currently being

Theme/Issue	Board Lead	Notes
		implemented.
6. Communications to Staff & Stakeholders Clinical senate on Stroke care were critical of comms.	CEO	Effective communication is essential to support management of change plans
7. Automation of paper records etc Our trusts remain reliant upon paper- based records in some areas and effective electronic communications remains an aspiration.	CFO	Lack of automation results in significant inefficiencies.

2.1 Alert – matters of concern for escalation

Finance & Productivity Committee	Quality Committee
Performance Performance across the Group remains high. The matters of concern whilst receiving attention are: RWT (The Royal Wolverhampton Trust): • The percentage of patients seen under 18 weeks remains below trajectory, a plan to increase capacity is in place. • Of concern is the number of patients who remain in the emergency department over 12 hours this has increased to 11%. This is receiving urgent attention. WHT (Walsall Healthcare Trust): • Emergency Department demand is above plan and is being monitored. **Finance** Forecast Year End: • A detailed review has been undertaken and is currently forecasting a deviation from plan of £15.5m. Work is continuing to reduce and eliminate this and a full update will be provided separately.	• The Trust has received a Field Safety Notice from Boston Scientific related to the battery life of Pacemakers. This has risk implications for approximately 1000 RWT patients who will require to be assessed by the Trust, have a remapping exercise carried out and ultimately a replacement pacemaker. This is deemed to be a national concern and has been escalated accordingly. • The report by the H&SE following their unannounced visit to the maternity services at WHT is awaited. The visit was in relation to Entonox exposure levels, and no immediate actions were identified. However, Entonox exposure levels is an issue across both RWT and WHT maternity services and actions are in place to manage as far as possible, given the nature of the building housing maternity services, particularly at RWT. • In September 2025, RWT received a Fire Safety Enforcement Notice for failing to meet the stated deadline for fire safety works needed in Block 32 – Maternity Services at New Cross Hospital. Following a meeting with the West Midlands Fire Service (WMFS), a series of actions were agreed and a range of work has been undertaken. A further review by WMFS is scheduled for the 3rd of November after which time the Trust will be clear on the way forward with the associated timeframes. • A WMFS Fire Safety Enforcement Notice remains in place relating to the Nucleus Theatres in Block 55 at New Cross Hospital. A range of work is underway to meet the stated deadline date of the 27th of May 2026. • A Fire Safety Enforcement Notice by Staffordshire Fire and Rescue Service is in place regarding Cannock Chase Hospital. Whilst a range of actions have been taken, not all the required work has been

2.1 Alert – matters of concern for escalation	
Finance & Productivity Committee	**Quality Committee**
	completed by the stated deadline. Work is continuing to achieve compliance with the notice.

2.1 Alert – matters of concern for escalation	
People Committee	**Partnerships & Transformation Committee**
• The workforce position as at M6 is an area of concern as the group is above plan. Group total WTE across month 6 was 106.64 adverse to stretch plan. There is currently no assurance of meeting the stretched target. • MARS is progressing and nearing conclusion, the impact of the scheme on structures will be reviewed. • Management of Change (MoC) is dependent on funding (currently unidentified) for enabling costs. • Sickness absence remains a challenge for both trusts and could deteriorate during 25/26 with a challenging year predicted. The Committee considered the high impact recovery plan which will be progressed between now and the end of the financial year. A further update against actions will be brought in Jan 2026. For now there is no assurance as to long term achievement of plan. • For board awareness it is an NHS England requirement to participate in a data collection in relation to Nursing and Midwifery job evaluation. This commenced in October and will be completed quarterly.	• Significant concerns regarding patient and staff communications and engagement strategy and capability. These have been raised formally previously, but the results from the Stroke Transformation Programme have resulted in escalation to PC and Board in relation to staff engagement. The Committee held detailed discussions, but further work is required to identify root causes and to develop appropriate plans.

2.2 Assure	
Finance & Productivity Committee	**Quality Committee**
<u>Performance</u> • Performance across the Group continues to remain in a good position both Regionally and Nationally and the focus and energy of the teams involved needs to be congratulated. • RWT remains upper quartile for 4-hour Urgent & Emergency Care performance, WHT is 2nd quartile, both Trusts remain above the national average. National ranking 13th (RWT) and 44th (WHT) for September's performance. • Ambulance handover within 30mins, out of 14 Trusts in the West Midlands the Trusts are ranked 3rd (WHT) and 7th (RWT). • RWT remains upper quartile for Diagnostic Waiting	• A Screening Quality Assurance Service visit took place with the Cervical Cytology Service. The feedback was very positive with no immediate concerns identified (a very rare occurrence). • It was confirmed that the Provider Capability Self-Assessment required by NHSE has been submitted with feedback expected in early November. • The annual Maternity and Neonatal Voices Partnership 15 steps review for RWT was undertaken in September. The format changed this year to try and engage with women and families from multiethnic groups who have been underrepresented in previous reviews. The feedback was very positive from both the staff

2.2 Assure

Finance & Productivity Committee	Quality Committee
Times and Activity Data Collection (DM01). • RWT – Referral to Treatment (RTT) 52 weeks was below the new revised trajectory for September 25. • WHT achieved all 3 national cancer metrics in August and remains 1st quartile for 2 standards and 2nd quartile for 1 standard. • WHT remains 1st quartile for RTT 18 weeks, above national and regional average. 1st in the region 11 consecutive months and the percentage of 52-week breaches was 0.05% well below national threshold of 1% **Finance** • Overall the Group position is ahead of plan by £5.3m year-to-date (September).	involved and the women and families who attended. Both Trusts are working towards achieving UNICEF's Baby Friendly Initiative Accreditation with plans in place to achieve full accreditation – 3 stages are involved – using a phased approach.

2.2 Assure

People Committee	Partnerships & Transformation Committee
The Committee received update reports on: • Leng Review/Physician Associate Report • Medical Appraisal and Revalidation • Flu Plan • Staff Engagement and Surveys • Sickness Absence Reduction Report • Board Assurance Framework • Resident Doctor 10 Point Plan • Sexual Safety Charter	• Neighbourhood Health Implementation programme updates provided • Community based digital infrastructure concerns have been fed into Digital and Estates Committee workplan. • Community First consultancy support plan updates provided and development relating to funding and support models. • Frailty pilot programme in Wolverhampton reports provided demonstrating progress • Outpatient transformation technology pilots demonstrating significant potential for improved efficiency. • Discussion regarding palliative care models and potential at a place and group level. • A CDC bid has been submitted by the group for the preferred location in Bilston, previous public engagement work has been undertaken by Wolverhampton City Council regarding the provision of health and social care facilities. Should the scheme by supported at a national level further specific public engagement will be undertaken across Wolverhampton and Walsall.

2.3 Advise

Finance & Productivity Committee	Quality Committee
Board Assurance Framework	• RWT's Cancer performance for 28 and 31 days is

2.3 Advise

Finance & Productivity Committee

The following risks were reviewed and agreed:

- GBR 1 (Executive Lead: K Stringer) – If the Trusts in the Group are individually and collectively unable to achieve financial break-even by year end 2027/28. Review undertaken on 7th October, no change to scores, risk appetite or risk tolerance. **Risk tolerance 20.**
- GBR 2 (Executive Lead: G Nuttall) – If the Trusts are individually and collectively unable to recover and meet future access (constitutional) standards over the next 3 – 5 years. Review undertaken on 20th October, no changes to scores, risk appetite or risk tolerance. **Risk tolerance 9.**
- GBR 3 (Executive Lead: S Evans) – If the Group Trusts are unable to optimise the Group Structure (from the Corporate Services Review) (including potential use of a Subsidiary vehicle) including the scale of efficiencies and cost-reduction required whilst maintaining or improving standards and performance. Review undertaken on 15th October. **Risk tolerance 12.**

Contract Awards and Business Cases

- WHPC1016 Foodbuy Multi-temp Food NHSSC (Retrospective Contract Renewal 29/9/25) CA – Retrospective noted.
- WHPC 275 Diabetes (Contract Renewal: 06/01/26) ETB – Endorsed to Trust Board
- WHPC 860 Outsourcing Imaging Reporting (Contract Renewal: 28/01/26) CA – Committee Approved.
- Modernisation of Histopathology Laboratory Automation Business Case – Committee Approved.
- Birthrate Plus Business Case (WHT) – Supported in principle, the Trust is looking to mitigate costs.

Performance

- Blueprint Electronic Patient Records Programme – A full review was taken at the Committee of the implementation of the new PAS system – A successful implementation - the committee thanked the team and a full report will be taken to Trust board.

Finance

The September results: The group is £0.9 m off plan (partly due to the request of the system) in month but cumulatively £5.3m ahead of plan. The Group Finance Director will provide a full report.

Quality Committee

achieving the required metrics with 62 day waits at 71.07% and is on trajectory to achieve the 75% national target.

- RWT's Referral to Treatment activity is below trajectory at 55%. Work is being undertaken within the divisions to enable an improved performance, to at least 60% , by year end, which includes insourcing for challenged specialties.
- WHT is meeting all the required cancer and RTT targets. Diagnostics performance remains below target but is improving with the appointment of the required staff. Both Trusts have seen a slight decrease in 4 hour drop off performance due to increased attendances and flow through the hospitals.
- The Temporary Escalation Space at WHT has been used almost daily during October with harm reviews conducted on all patients in accordance with the SOP.
- Work is starting to align reports across the RWT and WHT group with January being the likely date for implementation.
- The Committee received the Review of Stroke Services at RWT undertaken by the Royal College of Physicians and agreed that a summary of the report should be made available on the Trust website.
- It was reported that there are challenges with the Venous Thromboembolism (VTE) system that is required to complete the VTE assessment documentation. Champions are in place, and some areas are improving but emergency areas are proving more difficult. The issue will continue to be monitored by the VTE group with a report back to the Group Quality Committee in December.
- The implementation of the Electronic Patient Record went live on the 29th of September and is progressing well after some initial challenges. It was noted that these will very likely Impact on the quality metrics.
- Both Trusts continue to see improvements in some of the Nurses sensitive indicators, however, Falls and Pressure ulcers remain challenging, and work is continuing to improve these and better understand possible reasons e.g., 12 hour waits in ED.
- The incidence of C Difficile has increased at RWT

2.3 Advise

Finance & Productivity Committee	Quality Committee
	to 10 in month. A desktop review of C Diff, E Coli and MRSA is taking place with NHSE and the ICS in the next week. Cleaning regimes remain in place. • The introduction of the Sepsis Dashboard is showing significant improvement in compliance at RWT. • RWT has submitted the required Annual Emergency Preparedness, Resilience and Response (EPRR) submission to NHSE as being substantially compliant. • Following the escalation of the agreed input from Black Country Mental Health Services to both RWT and WHT, there has been more engagement and some improvements. However, the timeliness of securing support for patients in both RWT and WHT remains and further work is being undertaken across both Trusts with Mental Health Services. • The CQC Medicine Assessment Report following the visit on the 8th and 9th March 2025 is still awaited. • There has been a reduction in Perinatal Mortality at WHT this month. A review is being conducted to determine the reasons for the previous increase. WHT remains an outlier for its stillbirth rate. A Perinatal Working Group has been set up. • The Birthrate Plus review of Staffing within Maternity and Neonatal Services at WHT has been completed and the resultant detailed business case was discussed by the committee, who approved in principle Option 3. The report will go to Trust Board for a decision in November. • RWT Birth rate Plus (BR+) full assessment full assessment has been completed as per the standards for a Midwifery workforce review in line with NICE (2015) Safer Staffing Guidance and The Maternity Incentive Scheme (MIS) CNST for Perinatal services Year 7 safety action 5. • Both Trusts remain on Track to achieve CNST Year 7, however, the overall compliance will not be confirmed until the end of the reporting period. A report will be presented to the Group Quality Committee in January 2026. • NHSE has produced a Report on the findings from their Maternity and Neonatal Infrastructure Review. Where the standard is not being met, the Trust is required to identify what mitigations are

2.3 Advise	
Finance & Productivity Committee	**Quality Committee**
	in place. • RWT and WHT has received correspondence from NHSE outlining the findings from their Rapid Independent Review into Maternity and Neonatal Services. • Radiography are now managing all obstetric scanning within the WHICH Trust with improvements in service provision noted.

2.3 Advise	
People Committee	**Partnerships & Transformation Committee**
• The committee discussed the workforce position of the group and have requested workforce trajectories to be discussed at future meetings. • Overarching group Equality, Diversity and Inclusion (EDI) action plan and strategy. • RWT appraisal review report. Following the National Job Evaluation Initiative several key requirements have been identified and addressed by the PC on behalf of the Board: • the PC considered the Ministerial NHSE system letter at the Sept & Oct meetings; • A board sponsor has been appointed and this will be the Group Chief People Officer • The PC was made aware of the new nursing profiles, with both the band 2/3 and the band 4/5/6 raised and discussed. The board will be updated on progress against the job evaluation outcomes via the PC	• Funding allocations for Place are still not confirmed, the committee will monitor any impacts of partnership delivery and/or financial impact for the Group. • Referral and partnership pathways with community and primary care providers require further refinement and engagement of processes and relationships. • Clarity required regarding investment in posts to drive transformation within the context of overall workforce reduction plan. • Assurance regarding transfer of activity and funding from hospital to community provided in the last report has reduced due to delays in transition. The committee are assured that the executive are reviewing and learning from the test case to inform future programmes.

Tier 1 - Paper ref:	Enc 8

Report title:	Group Finance Report
Sponsoring executive:	Kevin Stringer, Group Chief Finance Officer
Report author:	James Green, Operational Director of Finance RWT Dan Mortiboys, Operational Director of Finance WHT
Meeting title:	Group Trust Board in Public
Date:	18 November 2025

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

This report presents the financial performance of the Group for the period April 2025 to September 2025, with the notable points being:

- Overall, the Group position is ahead of plan by £5.3m year-to-date, £5.2m of which is at WHT, and £0.1m at RWT. This has deteriorated by £0.9m in month relating to the removal of £1.4m variable activity overperformance income at WHT due to BCICB affordability.
- Variable elective activity is £0.6m behind plan, with WHT being £1.6m ahead of plan and RWT £2.2m behind of Trust plan. No variance to the contract values is assumed for this performance.
- The total efficiency challenge in 2025/26 for the group is £87m; RWT £57m, WHT £30m. The in-month plan was £6.1m.
- In month 6 WHT overperformed by £0.9m against a plan of £1.3m, RWT underperformed by £0.2m against a plan of £4.8m.
- Capital expenditure is £12.2m YTD, being £8.5m below plan.
- The cash position for both Trusts is positive at £28m for RWT, and £25m for WHT.

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?]*

Finance & Performance Committee 28th October 2025

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

b) Receive the report for assurance

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*

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

Group Financial Performance

for the month of September 2025

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

Care Colleagues
Collaboration Communities

I&E Summary

In-Month Income & Expenditure	RWT Plan M6 £m	RWT Actual M6 £m	RWT Surplus/ (Deficit) £m	WHT Plan M6 £m	WHT Actual M6 £m	WHT Surplus/ (Deficit) £m	Group position Plan M6 £m	Group position Actual M6 £m	Group position Surplus/ (Deficit) £m
Income	**84.9**	**84.9**	**0.0**	**40.5**	**39.1**	**(1.4)**	**125.4**	**124.0**	**(1.4)**
Expenditure									
Pay	54.4	54.8	(0.4)	25.4	25.6	(0.2)	79.8	80.4	(0.6)
Non Pay	20.0	18.9	1.1	9.7	9.8	(0.0)	29.7	28.7	1.1
Drugs	6.8	7.0	(0.2)	2.4	2.6	(0.1)	9.2	9.6	(0.3)
Other*	3.7	4.2	(0.5)	3.6	2.7	1.0	7.3	6.9	0.5
Total Expenditure	**84.9**	**84.9**	**0.0**	**41.2**	**40.6**	**0.6**	**126.1**	**125.5**	**0.6**
Net reported surplus/(Deficit)	**0.0**	**0.0**	**0.0**	**(0.6)**	**(1.5)**	**(0.9)**	**(0.6)**	**(1.5)**	**(0.9)**

Year-to-date Income & Expenditure	Plan YTD £m	Actual YTD £m	Surplus/ (Deficit) £m	WHT Plan YTD £m	WHT Actual YTD £m	WHT Surplus/ (Deficit) £m	Group position Plan YTD £m	Group position Actual YTD £m	Group position Surplus/ (Deficit) £m
Income	**504.6**	**503.9**	**(0.7)**	**235.9**	**237.1**	**1.2**	**740.5**	**741.0**	**0.5**
Expenditure									
Pay	325.5	326.2	(0.7)	154.3	153.2	1.0	479.8	479.4	0.3
Non Pay	120.8	118.6	2.2	58.7	55.9	2.8	179.5	174.5	5.0
Drugs	41.4	41.6	(0.2)	15.1	14.9	0.2	56.5	56.5	(0.0)
Other(incl. depreciation)	23.2	23.7	(0.5)	16.8	16.8	(0.0)	40.0	40.5	(0.5)
Total Expenditure	**510.9**	**510.1**	**0.8**	**244.8**	**240.8**	**4.0**	**755.7**	**750.9**	**4.8**
Net reported surplus/(Deficit)	**(6.3)**	**(6.2)**	**0.1**	**(8.9)**	**(3.7)**	**5.2**	**(15.2)**	**(9.9)**	**5.3**

Other* Includes depreciation, other non operating expenditure and adjustments to NHSE Reported Performance

Key Headlines:

- Total YTD deficit of £9.9m,
- Performance in month 6 is £0.9m worse than plan; RWT on plan and WHT £0.9m behind. WHT deteriorated in month due to removal of YTD variable overperformance (£1.5m) at the request of the system.
- Year to date performance is £5.3m better than plan YTD; RWT £0.1m and WHT £5.2m,
- CIP overachieved in month by £0.7m, bringing the YTD overperformance to £8.5m; RWT £0.9m and WHT £7.6m,
- Variable elective activity is behind the Group plan by £0.6m YTD, with WHT above plan by £1.6m and RWT below plan by £2.2m due to delays in RTT improvement. Neither Trust are recognising any variance to the BCICB contract value associated with this.

Capital

- Capital expenditure year to date is £12.2m (£6.3m RWT and £5.9m WHT), an underspend of £8.5m (£4.9m RWT and £3.6m WHT). Within the spend, £2.4m related to PSDS grant funded schemes and donated assets of which £1.8 was at WHT and £0.6m at RWT.
- The capital plan is being closely monitored and revised where necessary to account to changes to timescales, risks and priorities, notably the theatres refurbishment and IT at WHT and Fire Service inspection works at RWT.
- The group has received an additional capital allowance for the year of £2.3m, £1.7m RWT and £0.6m WHT. RWT has also received an additional £1.6m from NHS England to support the BCPS Histopathology Automation project (PDC); and £0.2m for CDC Pathways (PDC).

Cash

- Following the receipt of YTD cash backed deficit support to enable a breakeven plan, both organisations have a good cash balance and do not foresee the need for any cash support for the year. Any under achievement against the efficiency plan will deteriorate the cash balance.

Better Payment Practice Code

- The Trust has a national target to reach 95% of invoices, in value and volume, to be paid within 30 days of receipt. Both organisations have been impacted by working capital management and are below the target YTD.

BPPC Performance	RWT		WHT	
	In-Month	YTD	In-Month	YTD
Value	94%	94%	89%	88%
Volume	92%	92%	84%	89%

Care Colleagues Collaboration Communities

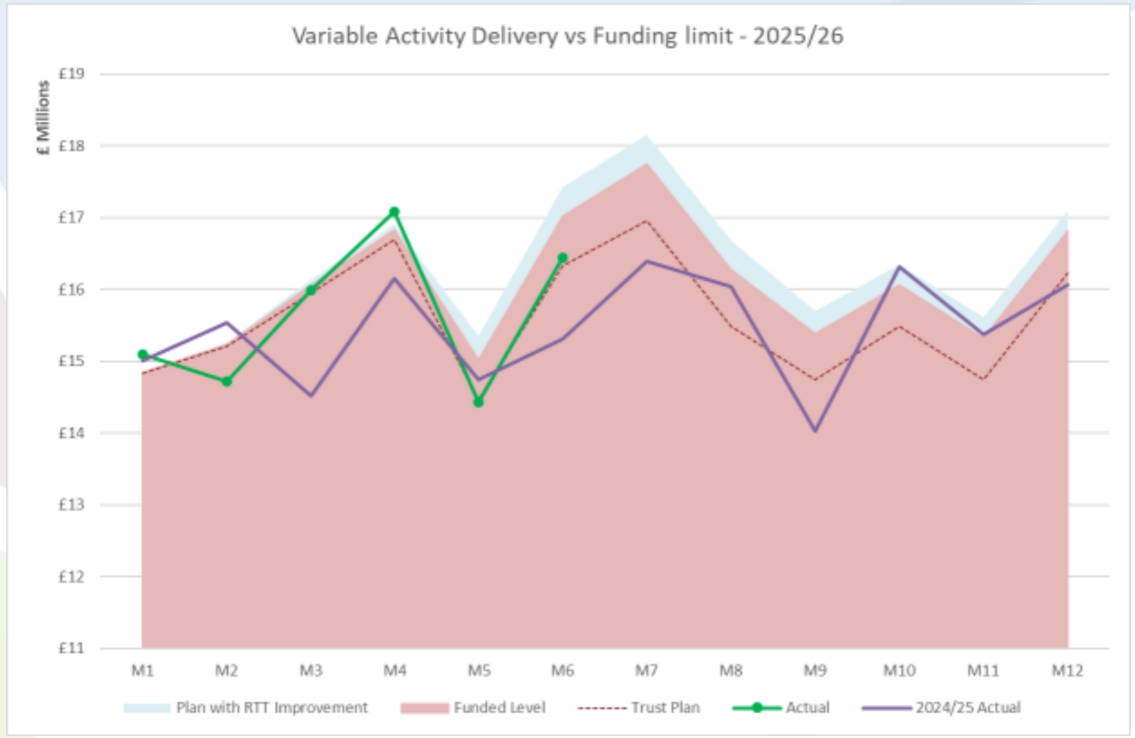
Key Month Items Within the Position

These include:

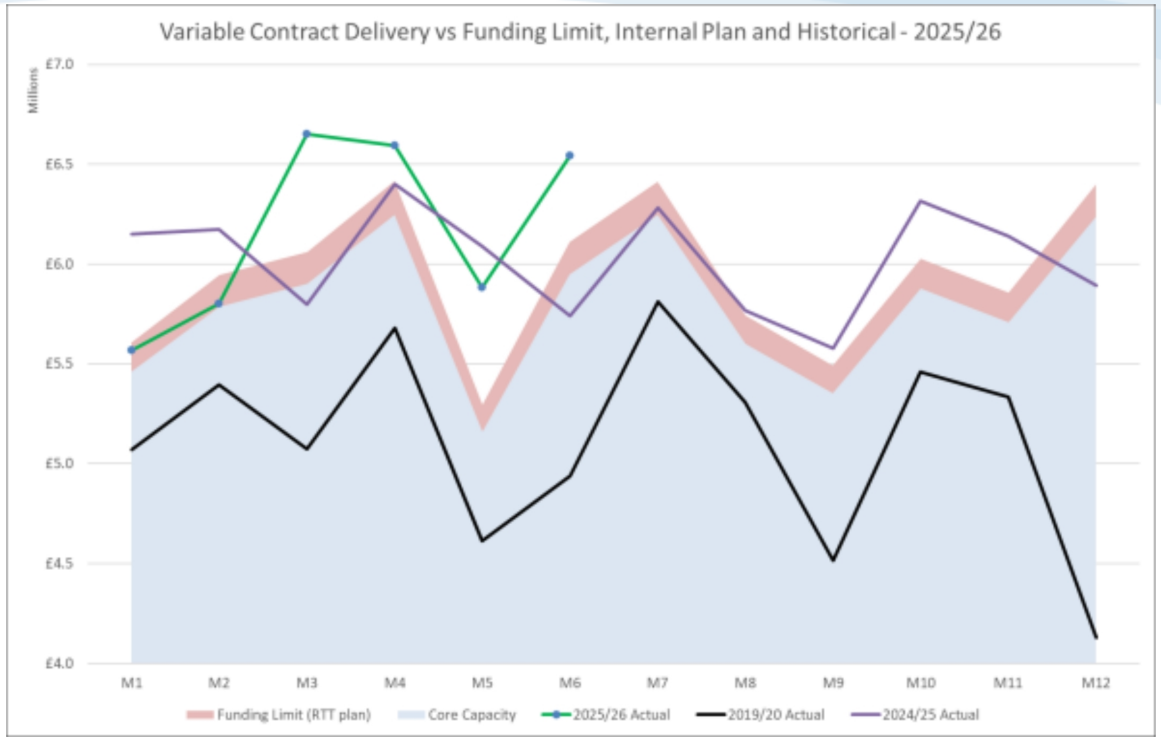
- **Income** underperformed against plan by £1.4m in month, RWT being on plan and WHT £1.4m under plan due to removal of YTD variable activity overperformance at the request of BCICB due to affordability. Year to date there is overperformance on income of £0.5m. RWT is £0.7m below plan YTD mainly due to hosted and SLA income and Education income which is offset be expenditure. WHT is £1.2m ahead of plan YTD due to PSDS income.
- **Pay** is £0.6m worse than plan in month and £0.3m favourable YTD. YTD RWT is £0.7m worse than plan, mainly due to WLI's in Division 1 and some over establishment in Division 3. WHT is £1.0m better than plan, the main driver for this is lower than planned headcount and reduced temporary expenditure.
- **Non-Pay** is underspent by £1.1m in month and underspent by £5.0m YTD, with a RWT being £2.2m better than plan - mainly relating to hosted services which offsets income, release of prior year accruals and capitalisation. WHT is £2.8m better than plan due to lower non-clinical costs.
- **Drugs** spend is £0.3m overspent in month but is on plan YTD.
- **Efficiency** performance is £0.7m favourable to plan in month and £8.5m favourable YTD, £0.9m at RWT and £7.6m at WHT. WHT overperformed mainly due to headcount reducing faster than planned. The RWT overperformance relates to non-recurrent balance sheet items and benefits being brought forward.

Variable Activity Performance – 2025/26 M6

RWT



WHT



RWT is funded at £2.9m less for the year than the plan required to meet the RTT performance target. The RTT improvement plan is profiled in from July, delays in RTT improvement initiative roll out are contributing to a variance to total plan of £2.2m. Performance is expected to be recovered for year end.

WHT's RTT plan is in line with the contract funding level. WLIs required to bridge between the core divisional capacity (internal plan) and Funding Limit. WHT’s are currently overperforming against plan by £1.6m.

Variable Performance YTD – 2025/26 M6

Point of Delivery	RWT			WHT			Group		
	Plan Activity	Actual Activity	Variance Activity	Plan Activity	Actual Activity	Variance Activity	Plan Activity	Actual Activity	Variance Activity
Elective	3,858	3,710	(148)	1,197	1,310	113	5,055	5,020	(35)
Planned Same Day	27,391	26,426	(965)	18,333	14,927	(3,406)	45,724	41,353	(4,371)
Outpatient Procedures	81,740	85,947	4,207	20,080	20,847	767	101,820	106,794	4,974
Procedures Total	**112,989**	**116,083**	**3,094**	**39,610**	**37,084**	**(2,526)**	**152,599**	**153,167**	**568**
Outpatient 1st	110,011	107,806	(2,206)	51,296	54,884	3,588	161,307	162,690	1,383
Diagnostic Imaging	44,637	42,343	(2,294)	50,875	50,468	(407)	95,512	92,811	(2,701)
Chemotherapy	7,049	7,498	449	3,007	3,240	232			
Grand Total	**267,638**	**266,232**	**(957)**	**144,789**	**145,676**	**887**	**412,427**	**411,908**	**(519)**

	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	24,647	23,834	(813)	5,236	5,743	507	29,883	29,577	(306)
Planned Same Day	29,286	27,437	(1,849)	12,293	12,044	(249)	41,579	39,481	(2,098)
Outpatient Procedures	13,930	14,687	757	3,835	4,075	240	17,765	18,762	997
Procedures Total	**67,862**	**65,958**	**(1,905)**	**21,364**	**21,862**	**498**	**89,226**	**87,820**	**(1,406)**
Outpatient 1st	20,895	20,558	(337)	8,991	9,884	893	29,886	30,442	556
Diagnostic Imaging	4,817	4,655	(162)	4,103	4,229	125	8,920	8,884	(37)
Chemotherapy	2,366	2,589	223	984	1,068	84	3,350	3,657	307
Grand Total	**95,941**	**93,760**	**(2,181)**	**35,442**	**37,042**	**1,600**	**131,383**	**130,802**	**(581)**

The group is £0.6m behind the commissioned activity plan YTD; with RWT underperforming by £2.2m and WHT overperforming by at £1.6m. The underperformance at RWT is due to £1.1m for delays in the RTT improvement plan and a further £1.1m for underperformance against base plan activity in Neurology, Urology and Children's Services.

At WHT WLI's in T&O Elective Inpatients and WLIs in general are the key drivers of performance above contract.

Both Trusts are not recognising any variance against the BCICB contract values related to variable elective activity performance, it is assumed Trusts will meet their full year activity plan and any overperformance will not result in additional income.

CIP Performance YTD

	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
WHT	1.3	2.2	0.9	4.8	12.4	7.6
RWT	4.8	4.5	(0.2)	21.8	22.7	0.9
Group	**6.1**	**6.7**	**0.7**	**26.6**	**35.1**	**8.5**

The total efficiency challenge in 2025/26 for the group is £87m; RWT £57m, WHT £30m. The in-month plan was £6.1m.

In month 6 WHT overperformed by £0.9m against a plan of £1.3m, mainly due to beds closing earlier than planned, vacancies being held and non-pay schemes performing strongly.

RWT underperformed by £0.2m in month against a plan of £4.8m, the in-month target increase of £0.5m was not fully achieved. YTD delivery is above plan.

Year to date the total overperformance against plan is £8.5m; £7.6m at WHT and £0.9m at RWT.

Statement of Financial Position

STATEMENT OF FINANCIAL POSITION Statement of Financial Position for the month ending September 2025	RWT Mar 2025 Actual	RWT September 2025 Actual	RWT Movement YTD	WHT Mar 2025 Actual	WHT September 2025 Actual	WHT Movement YTD
NON CURRENT ASSETS	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Property,Plant and Equipment - Tangible Assets	539,624	528,011	(11,613)	250,913	250,061	(852)
Intangible Assets	9,351	10,386	1,035	8,021	7,309	(712)
Other Investments/Financial Assets	16	15	(1)	0	0	0
Trade and Other Receivables Non Current	1,138	1,138	0	1,164	1,407	243
PFI Deferred Non Current Asset	1,935	1,938	3	0	0	0
TOTAL NON CURRENT ASSETS	**552,064**	**541,488**	**(10,576)**	**260,098**	**258,777**	**(1,321)**
CURRENT ASSETS						
Inventories	9,766	9,127	(639)	3,182	3,030	(152)
Trade and Other Receivables	38,389	45,335	6,946	20,665	38,367	17,702
Cash and cash equivalents	50,886	28,339	(22,547)	36,745	24,843	(11,902)
TOTAL CURRENT ASSETS	**99,041**	**82,801**	**(16,240)**	**60,592**	**66,240**	**5,648**
TOTAL ASSETS	**651,106**	**624,289**	**(26,817)**	**320,690**	**325,017**	**4,327**
CURRENT LIABLILITES						
Trade & Other Payables	(104,725)	(89,589)	15,136	(54,359)	(61,452)	(7,093)
Liabilities arising from PFIs / Finance Leases	(8,731)	(8,731)	0	(10,047)	(11,931)	(1,884)
Provisions for Liabilities and Charges	(8,072)	(4,803)	3,269	(135)	(135)	0
Other Financial Liabilities	(12,138)	(13,844)	(1,706)	(2,610)	(3,239)	(629)
TOTAL CURRENT LIABILITIES	**(133,666)**	**(116,967)**	**16,699**	**(67,151)**	**(76,757)**	**(9,606)**
NET CURRENT ASSETS / (LIABILITIES)	**(34,625)**	**(34,166)**	**459**	**(6,559)**	**(10,517)**	**(3,958)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**517,439**	**507,322**	**(10,118)**	**253,539**	**248,260**	**(5,279)**
NON CURRENT LIABILITIES						
Trade & Other Payables	0	0	0	0	0	0
Other Liabilities	(31,567)	(27,269)	4,298	(178,875)	(174,577)	4,298
Provision for Liabilities and Charges	(1,980)	(1,981)	(1)	(271)	(271)	0
TOTAL NON CURRENT LIABILITIES	**(33,547)**	**(29,250)**	**4,297**	**(179,146)**	**(174,848)**	**4,298**
TOTAL ASSETS EMPLOYED	**483,892**	**478,072**	**(5,821)**	**74,393**	**73,412**	**(981)**
FINANCED BY TAXPAYERS EQUITY						
Public Dividend Capital	337,782	337,783	1	276,052	276,052	0
Retained Earnings	26,691	20,872	(5,819)	(272,120)	(273,101)	(981)
Revaluation Reserve	120,643	120,641	(2)	70,461	70,461	0
Financial assets at FV through OCI reserve	(1,414)	(1,415)	(1)	0	0	0
Other Reserves	190	190	0	0	0	0
TOTAL TAXPAYERS EQUITY	**483,892**	**478,072**	**(5,820)**	**74,393**	**73,412**	**(981)**

Key Items for each Trust are as follows with details of cash in cashflow and other further detail in Trust appendices:

- RWT – Trade & Other Receivables: £6.9m increase with balances including prepayments, and accrued income. Trade & Other Payables: £15.1m decrease with the balance representing other Managed Service Contracts; Pharmacy Stocks, and Electricity Credits to be re-invoiced. Most of the movement in Other Financial Liabilities relates to deferred income non recurrent projects such as PASEMR. Other Liabilities of £4.3m decrease due to movement in PFI/IFRS 16.

- WHT - Trade receivables are high YTD due to LA, ERF, SDF and variable diagnostics performance. Trade payables/accruals have increased from March 25 relating to the payment of invoices and release of balance sheet provisions within the plan. This is also reflective of the current cash balance movements.

Cashflow as at 30st September

	RWT	WHT	Combined
	Sep-25	Sep-25	Sep-25
OPERATING ACTIVITIES	**Actual £'000**	**Actual £'000**	**Actual £'000**
Total Operating Surplus/(Deficit) (gross of control total adjustments)	**607**	**7,132**	**7,739**
Depreciation	16,922	7,437	24,359
Fixed Asset Impairments	0	0	0
Transfer from Donated Asset Reserve	0	0	0
Capital Donation Income	0	(1,847)	(1,847)
Interest Paid	(946)	(3,950)	(4,896)
Dividends Paid	(6,470)	(662)	(7,132)
Release of PFI /Deferred Credit	0	0	0
(Increase)/Decrease in Inventories	639	150	789
(Increase)/Decrease in Trade Receivables	(7,126)	(19,445)	(26,571)
Increase/(Decrease) in Trade Payables	148	8,504	8,652
Increase/(Decrease) in Other liabilities	1,706	629	2,335
Increase/(Decrease) in Provisions	(3,269)	(1,411)	(4,680)
Increase/(Decrease) in Provisions Unwind Discount	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**2,211**	**(3,463)**	**(1,252)**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	1,463	872	2,335
Payment for Property, Plant and Equipment	(19,940)	(6,695)	(26,635)
Payment for Intangible Assets	(1,690)	0	(1,690)
Receipt of cash donations to purchase capital assets	0	1,847	1,847
Proceeds from sales of Tangible Assets	0	0	0
Proceeds from Disposals	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(20,167)**	**(3,976)**	**(24,143)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(17,956)**	**(7,439)**	**(25,395)**
FINANCING			
New Public Dividend Capital Received	0	0	0
Capital Element of Finance Lease and PFI	(4,592)	(4,463)	(9,055)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(4,592)**	**(4,463)**	**(9,055)**
INCREASE/(DECREASE) IN CASH	**(22,548)**	**(11,902)**	**(34,450)**
CASH BALANCES			
Opening Balance at 1st April 2025	50,886	36,745	87,631
Closing Balance at 30th September 2025	**28,339**	**24,843**	**53,182**

Summary:

The cash balance is £53.2m, £28.3m at RWT and £24.8m at WHT. This is a decrease from last month of £31.1m (of which £25.0m is RWT, however this is only £9.0m behind Plan due to an additional payment run due to new finance system, otherwise would be in line with plan).

Following the receipt of YTD cash backed deficit support to enable a breakeven plan, both organisations have a good cash balance and do not foresee the need for any cash support for the year. However, any under achievement against the efficiency plan will deteriorate the cash balance and this will be monitored closely.

Care Colleagues
Collaboration Communities

Capital RWT

The Trust has spent £6.3m of Capital YTD to 30th September 2025, which is an underspend of £4.9m against planned YTD capital of £11.2m. The Trust is forecasting to meet its CRL and CDEL target for the financial year.

- CRL recorded a spend of £2.5m for the financial year to date which was £3.3m lower than plan. The Trust identified its original capital plan to support investment in backlog maintenance and medical equipment purchases. Following recent Fire Service inspections, the Trust has revised the capital plan in order to prioritise necessary rectification works resulting from the inspection. Therefore, expenditure against the original plan is lower than profiled but in line with the reforecast.

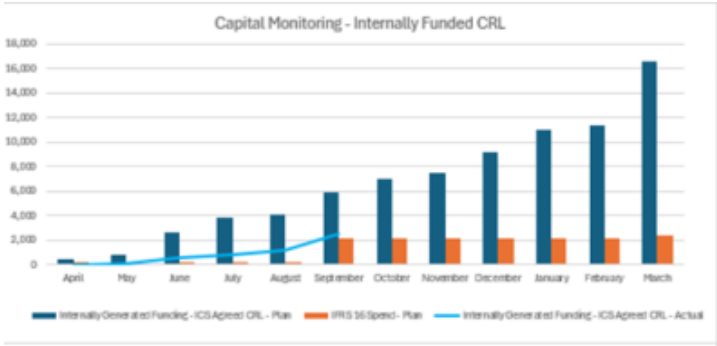
- PDC expenditure with a spend of £3.2m was in line with plan.

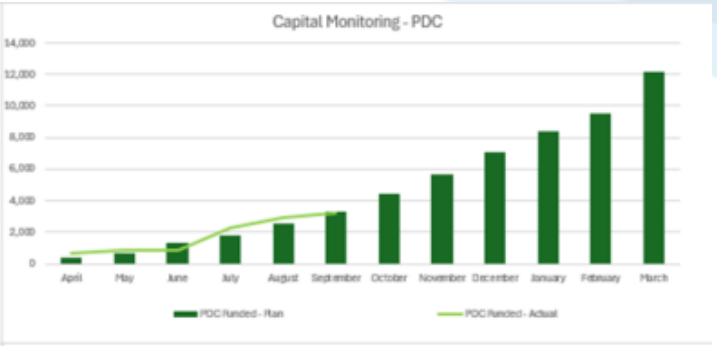
- IFRS 16 (or renewed leases) CRL with a YTD spend of £0.0m was underspent by £2.1m due to ongoing commercial negotiations. However, the Trust is forecasting to spend it's IFRS 16 allocation.

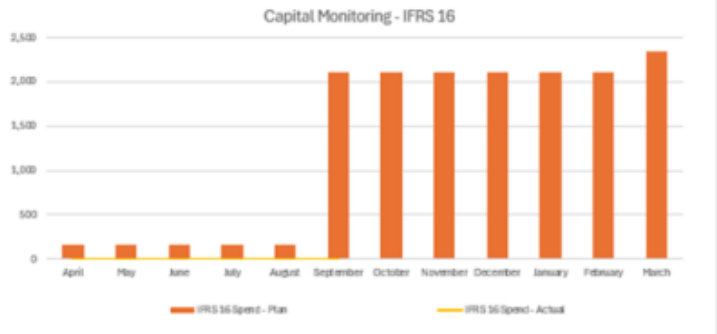
- IFRIC 12 related capital spend is £0.0m YTD which is in line with plan.

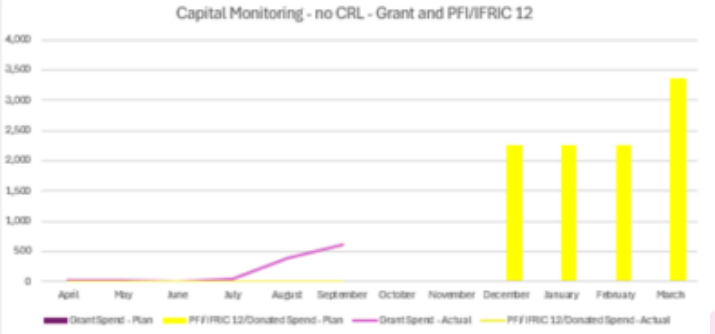
In addition to the items above monitored by NHSE, the Trust also receives grant funding:

- Grant Funding for the PSDS programme was ahead of plan YTD, with spend of £0.6m.









Care Colleagues
Collaboration Communities

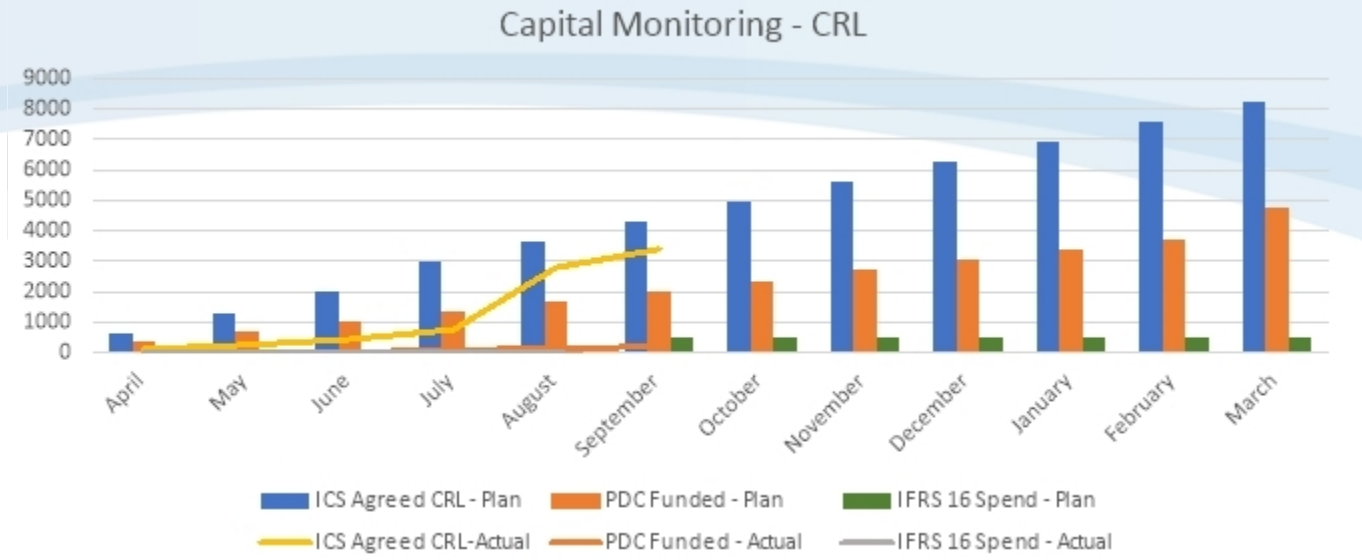
Capital WHT

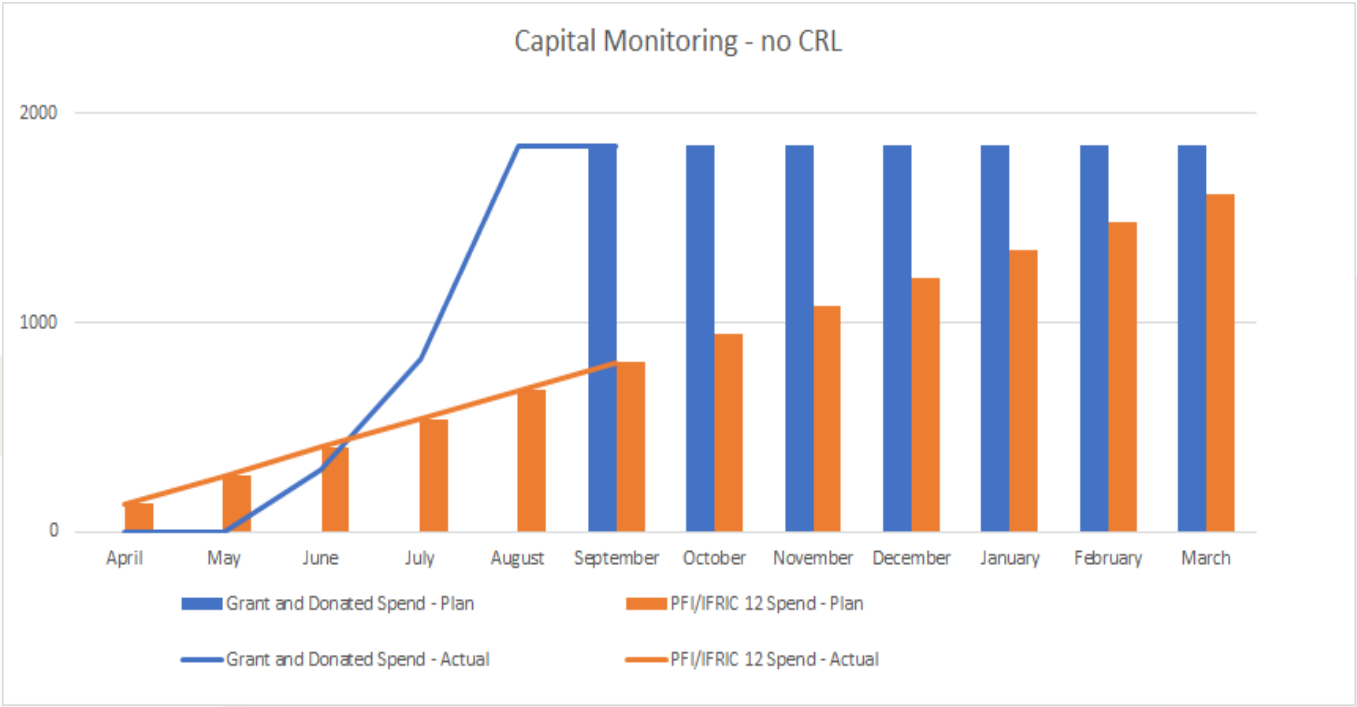
The trust has spent £5.9m of Capital & IFRS16 YTD to 30th September 2025 against planned YTD Capital of £9.5m. Of the £5.9m YTD Spend:

•£3.0m YTD Capital spend relates to CRL the trust is measured against vs YTD budget of £4.8m with a variance of £1.8m vs budget; and £0.2m YTD spend on PDC as the orders are in progress, with a variance of £1.8m vs budget. The trust has received additional PDC allocation for GB Energy NHS Solar project of £0.75m. The trust plans to achieve the CRL of £13.5m at the end of the year.

•The balance of the YTD Capital spend of £2.7m relates to PFI/IFRIC 12 capital of £0.8m on plan and PSDS grant spend of £1.8m.

Scheme	M6 YTD Budget	M6 YTD Spend
	£'000s	£'000s
Estates:		
PFI Lifecycle:	809	808
Theatres 1-4 Refurb	2,214	739
Estates Lifecycle	515	470
MMUH (UECC works)	600	1,093
Aseptic Suite	450	10
Backlog maintenance to support PSDS	400	1,085
New Build-Non Clinical (PSDS Match Funding)	1,847	1,847
Estates Total	**6,835**	**6,052**
Medical Equipment:		
Medical Equipment	114	-
Donated Medical Equipment		
Medical Equipment Total	**114**	**-**
Information Management & Technology:		
IT Equipment	-	-
Information Management & Technology Total	**-**	**-**
PDC Funding		
IM&T PDC Funding	1,434	193
PDC Funding Total	**1,434**	**193**
Estates Safety 2526		
Theatres 1-4	586	-
Estates Safety Total	**586**	**-**
IFRS16	510	- 375
Total IFRS16	**510**	**- 375**
Grand Total	**9,479**	**5,869**





Tier 1 - Paper ref:	Enc 9.1

Report title:	Group Research Report
Sponsoring executive:	Dr Brian McKaig and Dr Zia Din
Report author:	Pauline Boyle
Meeting title:	Group Public Trust Board
Date:	18 November 2025

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

Assure

- The Group has delivered a strong and financially sustainable year in research, with both RWT and WHT achieving record recruitment figures and national "firsts" in clinical trials.
- Strategic partnerships, including the University of Wolverhampton and international collaborations, have strengthened academic leadership and visibility.
- Infrastructure investments (e.g., RSA lab at WHT, patient-facing research centre at RWT) are secured and progressing well, supporting long-term research capacity.
- Governance, sponsorship, and workforce development frameworks are robust and aligned with NIHR and NHS priorities.

Advise

- Continued focus is needed on diversifying the research portfolio to reduce reliance on high-volume studies and broaden specialty engagement.
- The proposed Joint Research Office and Black Country Collaborative offer opportunities to streamline operations and attract further commercial studies.
- Recruitment equity and representation remain areas for improvement, particularly in underserved communities and wider care settings.

Alert

- The West Midlands RRDN saw a decline in recruitment in the final quarter of 2024/25, particularly in Primary and Wider Care settings.

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?]*

N/A

4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a) Note the report and consider implications for future strategic planning b) Receive the RRDN West Midlands 2024/25 performance report c) Receive performance reports on a 6-month basis (Medium Term Planning Framework 2026/27 to 2028/29)

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 18 November 2025
Group Research & Development Report

1. Executive Summary

The Group has delivered a strong and impactful year in research, marked by strategic growth, collaboration, and innovation across multiple domains. These developments directly support the ambitions of the NHS 10-Year Plan to create financially sustainable, research-active organisations that improve care through innovation. Exceptional commercial performance has also empowered both Trusts to proactively implement the Lord O'Shaughnessy recommendations, significantly enhancing recruitment into commercial clinical trials.

1.1 Strategic Collaborations and Research Capacity Building

Collaborative efforts have thrived, marked by a strengthened academic partnership with the University of Wolverhampton (UoW), which has made a notable contribution to the university's Research Excellence Framework (REF) outcomes, enhancing the visibility and impact of joint research initiatives. International engagement has expanded through a formal Memorandum of Understanding with leading Indian institutions, fostering global knowledge exchange and cross border research opportunities. Regionally, the Trusts have taken a leadership role in data-driven innovation through the West Midlands Research Collaborative, positioning themselves at the forefront of integrated research strategy.

Flagship initiatives such as the "That's Me!" project and the Research ABC programme have significantly broadened access to postgraduate research, while also building research capacity among Allied Health Professionals across the Black Country, empowering a more diverse and skilled research workforce.

1.2 Research Recruitment Performance

Research recruitment performance has been exceptional. RWT led the West Midlands in academic recruitment, while WHT achieved its highest ever commercial recruitment. Both Trusts demonstrated strong delivery in industry trials, with national "firsts" in recruitment and increased visibility through public engagement.

1.3 Financial Sustainability and Infrastructure

Research activity across both Trusts has now reached a position of financial independence, underpinned by a diversified and resilient portfolio of income streams. Strategic external capital investment has catalysed infrastructure expansion, with funding to develop a patient facing research centre at RWT and a purpose-built RSA laboratory at WHT. The financial backing provided by the Trusts in previous years has been pivotal and is sincerely appreciated, having laid the

groundwork for this transformation and enabled the R&D departments to flourish into self-sustaining entities. Notably, RWT is ahead of schedule on its three year financial recovery plan, marking a significant milestone on its journey toward full financial autonomy.

1.4 Patient and Public Engagement (PPIE)

Patient and Public Engagement remains central to the Group's research culture. The launch of the Patient and Lived Experiences Advisory Team (PLEAT), participation in NHS DigiTrials, and demographic analysis of research participants reflect a commitment to inclusive, transparent, and community-informed research. These initiatives reflect the NHS 10-Year Plan's commitment to inclusive research and improving health outcomes through patient-centred innovation.

1.5 Research Sponsorship and Governance

Research Sponsorship has grown significantly, with eight new studies, major grant submissions, and over £4.1 million in awarded funding with an estimated £5,766,258.97 pending. Governance has been strengthened through new SOPs, digital enablement, and enhanced public involvement.

1.6 Workforce Development

Workforce development has been a key focus, with the appointment of a junior doctor at RWT and Research Nursing Associates at WHT. A comprehensive training programme, delivered in collaboration with all four NHS Trusts in the Black Country, has supported staff development and regional research capability. The Group also aims to support PhD students to build long-term research leadership. This approach aligns with the NHS 10-Year Plan's emphasis on building a research-capable workforce and embedding research into everyday clinical practice.

1.7 Black Country Collaboration

Black Country Collaboration is a strategic priority for the Group. A proposed Joint Research Office and Black Country Research Collaborative would streamline operations, reduce duplication, and attract more commercial studies. This initiative would leverage existing expertise across the four Trusts and reinvest efficiencies into priority research areas. The region's stable and diverse population offers a unique opportunity for long-term follow-up and inclusive research delivery, positioning the Black Country as a national leader in collaborative, patient-centred research.

1.8 RWT Hosting the West Midlands Research Delivery Network

RWT successfully secured the competitive contract to host the West Midlands Regional Research Delivery Network (RRDN) until 2030, an important recognition of its leadership in research delivery. The RRDN forms part of the national Research Delivery Network (RDN), funded by the Department of Health and Social Care, and replaces the former Clinical Research Network. As one of 12 regional networks working under joint national leadership, the RRDN plays a key role in enabling high-quality research across the NHS.

1.9 Areas of Strength

Both RWT and WHT demonstrate distinct areas of clinical research excellence. RWT consistently performs at a high level across a broad range of specialties, including Gastroenterology, Cardiology, Rheumatology, Haematology, Obstetrics and Gynaecology, Emergency Medicine, and Laboratory Medicine, reflecting a mature and diverse research portfolio. WHT shows strength in Dermatology, Cardiology, and Orthopaedics, with focused expertise and growing research capacity in these domains. Together, these strengths underpin their contributions to regional and national research priorities.

2 Alignment with NHS 10-Year Plan

All the above developments directly support the ambitions of the NHS 10-Year Plan to create financially sustainable, research-active organisations that improve care through innovation.

3 Recommendations

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

a. Note the report and consider implications for future strategic planning
b. Receive the RRDN West Midlands 2024/25 performance report

04 November 2025

Annex 1: Regional Research Delivery West Midlands 2024/25 performance report

STRATEGIC COLLABORATIONS AND RESEARCH CAPACITY BUILDING:

RWT Collaboration with the University of Wolverhampton

RWT continues to foster a close and dynamic partnership with the University of Wolverhampton (UoW), grounded in a shared commitment to advancing clinical research, education, and innovation across the region. This collaboration has not only strengthened academic and translational research links but has also made a significant contribution to the University's Research Excellence Framework (REF) outcomes, demonstrating the real-world impact of NHS-led research. Together, RWT and UoW are shaping a research ecosystem that drives regional growth, enhances patient care, and builds future research capacity.

Current Academic Infrastructure and Achievements

- Joint Academic Leadership: Eight Clinical Academic Professors are jointly funded by RWT and UoW, providing strategic leadership across key clinical disciplines.

Clinical Academics

Professor Rousseau Gama
Professor of Chemical Pathology;
Consultant Chemical Pathologist
Black Country Pathology Services (supporting RWT); University of Wolverhampton
Focus areas and contributions:
Leads research and service innovation in laboratory medicine with emphasis on endocrine and metabolic disorders.
Bridges BCPS and RWT to deliver safer, data driven diagnostics and quality improvement in lab pathways.
Supports academic/clinical training and supervision in chemical pathology and translational diagnostics.

Professor James Cotton
Professor of Cardiology; Consultant Interventional Cardiologist
Focus areas and contributions:
Interventional cardiology research and service innovation at the Heart & Lung Centre.
Mentorship and training for cardiology trainees and research fellows.
Contributes to multi centre trials and procedural outcomes research.

Professor Thillagavathie ("Tilly") Pillay
Professor of Neonatology; Honorary Consultant in Neonatal Medicine
Focus areas and contributions:
Neonatal medicine and perinatal outcomes research.
Education and mentorship across neonatal teams; service quality improvement.
Collaborations on maternal-neonatal pathways and early life interventions.

Professor Supratik Basu
Professor/Consultant Haematologist
Focus areas and contributions:
Leads and contributes to the NIHR portfolio studies in haematology.
Creator of the West Midlands Research Collaborative
Conference presentations and public engagement to widen research participation

Professor David Churchill
Professor of Obstetrics & Fetal Medicine; Consultant Obstetrician
Focus areas and contributions:
Research leadership in anaemia in pregnancy and maternal-fetal medicine
Chief/Principle Investigator roles in national studies and first-patient-in achievements.

Professor Matthew (Matt) Brookes
Professor of Gastroenterology; Consultant Clinical Gastroenterologist
Focus areas and contributions:
Gastroenterology research and regional academic leadership.
Director of NIHR RRDN West Midlands to strengthen research delivery across the region.
Mentorship and development of early-career investigators.

Professor Tonny Veenith
Professor of Anaesthesia & Critical Care; Medical Lead / Clinical Director for Research
Focus areas and contributions:
Leads Trust wide research strategy and governance in perioperative and critical care.
Portfolio growth across commercial and non-commercial trials.
System partnerships and external representation for RWT research.

Dr/Professor Helen Steed
Consultant Gastroenterologist; Clinical Academic
Focus areas and contributions:
Research interests in IBD, nutrition and medical education.
Supervision of student projects and service evaluations to build research capacity.
Contributes to translational studies and quality improvement initiatives.

University status

It is the intention of RWT and WHT to apply for University status with University of Wolverhampton. The Group is in an excellent position to be awarded University status due to:

- Research Excellence: Active participation in NIHR portfolio studies and translational research supports improvements in patient care and health outcomes.
- Education and Training: The Group hosts undergraduate placements in medicine, nursing, and allied health professions, ensuring students gain high-quality, real-world clinical experience.
- Postgraduate Development: RWT clinicians contribute to postgraduate supervision, mentorship, and academic leadership, nurturing the next generation of clinical researchers.
- Innovation in Learning: Simulation-based training and continuing professional development (CPD) programmes enhance workforce skills and promote safe, evidence-based care.
- Research Impact: RWT staff play a significant role in the University's Research Excellence Framework (REF) submission, demonstrating high-impact, clinically relevant research.
- Infrastructure for Discovery: The jointly managed Clinical Research Support Unit and the developing AI ecosystem are strengthening the local capacity for research, innovation, and data-driven healthcare.

Together, this partnership continues to drive improvements in patient outcomes, workforce capability, and the regional research ecosystem. This ensures Wolverhampton and Walsall remains at the forefront of clinical and academic excellence.

Strengthening International Research and Education Partnerships

In 2025, RWT formalised a landmark international partnership through a Memorandum of Understanding (MoU) with the University of Wolverhampton, Rajiv Gandhi University of Health Sciences (RGUHS), and the Karnataka State Higher Education Council (KSHEC) in India. This collaboration builds upon the long-standing relationship between the Group and the University of Wolverhampton, extending its reach globally through engagement with leading academic and healthcare institutions in India.

The partnership emerged following a successful visit from an Indian delegation to the Group, during which shared priorities around education, innovation, and healthcare sustainability were identified. The agreement provides a strategic framework for joint research, education, and innovation across healthcare disciplines, reflecting a shared ambition to improve patient outcomes and address global health challenges collaboratively.

Scope and Areas of Collaboration

The MoU outlines a comprehensive programme of cooperation encompassing:

- Joint research grants with international funding bodies such as NIHR, UKRI, ICMR, and DBT.
- Collaborative clinical trials and co-development of innovative medical devices and health technologies.
- Standardisation of clinical guidelines, aligning best practices between the UK and Indian healthcare systems.
- Establishment of a Centre of Excellence (CoE) focused on the decarbonisation of healthcare which is an area of growing strategic importance globally.
- Joint supervision of PhD programmes, research publications, and the exchange of staff and students to promote cross-cultural learning.
- Seminars, workshops, and summer schools to strengthen faculty and student engagement.
- Continuing professional development programmes for medical and nursing and AHP staff, and exploration of start-up incubator initiatives supporting health innovation.

Platform for Shared Innovation

This partnership represents a shared commitment to innovation, sustainability, and excellence in healthcare delivery. It positions the Group and its partners at the forefront of global collaboration in medical research and education, bridging expertise between the UK and India. The initiative supports the Groups broader strategic goals of fostering research led improvement in clinical practice, supporting staff development, and contributing to the health and wellbeing of local and international communities.

The collaboration is underpinned by principles of equality, ethical conduct, and transparency, ensuring all activities adhere to data protection, anti-bribery, and modern slavery legislation. This MoU strengthens the Groups role as a research active organisation, enhancing its international profile and deepening its connections with global academic partners.

Clinical trials unit in Black Country, a joint effort by the University of Wolverhampton and RWH

The University of Wolverhampton and RWH is proposing the establishment of a Clinical Trials Unit (CTU) to address significant health disparities in the Black Country and contribute to the UK's national clinical research landscape. This initiative aligns with the UK Government's 10-

year Health Plan and the United Nations Sustainable Development Goals, aiming to deliver high-quality, patient-centred research, develop a skilled clinical research workforce, and translate evidence into improved patient care and public health. The CTU will focus on sustainable, socially responsible practices and robust knowledge management to ensure long-term impact and resilience.

The CTU is designed to directly tackle the region's entrenched health inequalities, such as lower healthy life expectancy, higher rates of chronic diseases, and pronounced ethnic disparities. By focusing research on these local health challenges, the CTU will not only improve health outcomes for the Black Country but also position itself as a competitive candidate for national and international funding. The unit will offer comprehensive clinical trial services, including trial design, management, regulatory compliance, and patient and public involvement, while also serving as a training hub for future clinical researchers.

Strategically, the CTU will integrate with the university's academic and research ecosystem, collaborate closely with local NHS trusts (notably the new Midland Metropolitan University Hospital), and align its research agenda with national priorities set by bodies like the NIHR. Its organisational structure will ensure efficient operation, with shared funding and resources between the university and NHS partners. The CTU's unique value lies in its commitment to regional health equity, diversity in clinical trials, and workforce development, distinguishing it from other research centres.

We have created a business plan, going through the feasibility by appointment with Professor Hayley Hutchings, who is working with Professor Tonny Veenith. The business plan outlines a phased implementation roadmap, starting with securing initial funding and provisional UKCRC registration, followed by team expansion, increased trial activity, and full registration. The anticipated benefits include job creation, economic growth, improved patient access to novel treatments, and enhanced academic standing for the university. Conversely, failure to establish the CTU risks perpetuating health inequalities, missing economic opportunities, and diminishing the university's research profile. The proposal concludes that investing in the CTU is a strategic imperative for both regional health and the university's future.

Advancing Palliative Care Research through Strategic Collaboration

WHT has demonstrated a strong commitment to enhancing palliative care research by funding a pioneering joint post in collaboration with a local hospice. This strategic initiative aims to strengthen research capacity in palliative and end-of-life care, ensuring that patients and families benefit from evidence based approaches tailored to their needs.

The jointly funded role will focus on developing and delivering a sustainable research programme that addresses key challenges in palliative care, including symptom management, patient experience, and integrated care pathways. By embedding research expertise within both WHT and the hospice setting, this partnership fosters a culture of innovation and shared learning across clinical and community environments.

“That’s Me!” Project: Widening Access to Postgraduate Research

RWT, in collaboration with the University of Wolverhampton and Birmingham City University, proudly contributes to the “That’s Me!” project, a groundbreaking initiative aimed at eliminating barriers for UK-domiciled students from Global Majority backgrounds in accessing postgraduate research opportunities.

The project takes a comprehensive approach, supporting students at every stage of their research journey, from entry and induction, through supervision and academic development, to career pathways beyond academia. By fostering inclusive practices, enhancing support networks, and connecting researchers with regional employers, the project ensures that postgraduate research is accessible, supportive, and aligned with workforce needs.

The initiative also emphasizes regional collaboration and employer engagement, partnering with over 30 organisations, including the NHS, West Midlands Combined Authority, and the Greater Birmingham Chamber of Commerce. Through events such as the Talent XChange, postgraduate researchers gain invaluable networking and career development opportunities, strengthening the regional research ecosystem.

The project is guided by the Group Director of Research, who chairs the Employee Board. In this role, they provide strategic oversight and ensure that employee perspectives are central to the project’s design and delivery, helping to create a more inclusive and equitable research environment for all participants.

Through this partnership, the Group continues to demonstrate its commitment to research excellence, diversity, and workforce development, ensuring that postgraduate research opportunities are accessible to all, while also enhancing the region’s capacity for innovation and impact.

WHT Robotic Surgery Innovation and Research Leadership

Walsall Healthcare NHS Trust has become the first district general hospital in the UK to implement robot arm-assisted surgery for hip and knee replacements, representing a significant advancement in orthopaedic care and innovation.

Led by Mr. Fahad Hossain, Consultant Orthopaedic Surgeon and Director of Research and Development, the Trust has adopted Mako SmartRobotics™ technology to improve precision in joint replacement procedures. This technology enables personalised surgical planning through 3D CT imaging, which contributes to reduced soft tissue damage, enhanced bone preservation, and accelerated recovery times.

In parallel with clinical implementation, the department has secured NHS Health Research Authority approval for participation in the RACER trial (Robotic Arthroplasty: a Clinical and

cost Effectiveness Randomised controlled trial). This positions Walsall as a key national site for evaluating the clinical and economic impact of robotic surgery.

Furthermore, the Trust has received £183,000 in NIHR funding to establish a Radiostereometric Analysis (RSA) laboratory, which will support high-precision monitoring of joint implants and expand the Trust's research capacity in orthopaedic innovation.

West Midlands Research Collaborative (WMRC)

The West Midlands Research Collaborative Health Informatics Haematology Database (WMRC Database) is a flagship regional initiative hosted and sponsored RWT. It represents a major step forward in advancing research into rare and complex haematological conditions across the West Midlands and beyond.

The WMRC Database brings together routinely collected clinical data from haematology services across multiple NHS Trusts. By aggregating real world information from diverse patient populations, it provides a powerful platform for research into rare blood disorders and conditions that require large-scale datasets to detect meaningful patterns in diagnosis, outcomes, and treatment response.

The overarching aim of the initiative is to improve patient care and treatment options through the generation of real-world evidence (RWE) to inform clinical practice, policy, and innovation across the region.

The WMRC Database operates under a robust information governance framework and is structured in two complementary parts:

1. Hospital Level Data Collection

Participating hospitals extract identifiable data (such as NHS number, date of birth, and postcode) to enable pseudonymisation.
This step allows secure linkage of datasets, validation of opt-outs, and derivation of variables such as age and deprivation indices.

2. WMRC-Level Research Database

Once processed, data is fully anonymised and stored under a unique research code.
The dataset includes variables such as gender, ethnicity, clinical diagnosis and treatment details, health outcomes and co-morbidities, and relevant physical and mental health information.
All data is stored on secure, encrypted systems, with full ethical approval (REC reference: 23/SC/0174, IRAS ID: 306020) and oversight from the RWT Caldicott Guardian.

The success of the WMRC Database is underpinned by strong regional and national collaboration. More than 20 NHS Trusts and hospitals contribute to this shared resource. This growing network ensures that the database continues to expand in scope, diversity, and research potential.

The WMRC Database supports a wide range of retrospective and observational studies, using high-quality real-world data to generate insights into:

- Disease presentation and diagnostic pathways
- Treatment effectiveness and patient outcomes
- Survival trends and co-morbid conditions

By enabling collaboration between clinicians, data scientists, and academic researchers, the WMRC Database strengthens the region's position as a leader in data-driven haematology research.

The Groups Contribution to the Midlands and North Commercial Research Delivery Centre (CRDC)

The Group has played an instrumental role in shaping and supporting the Midlands and North Commercial Research Delivery Centre (CRDC), a new national initiative designed to expand access to commercial clinical trials across the NHS. RWT contributed directly to the establishment of the Central and North West Midlands CRDC, a regional hub created through a successful £7 million NIHR-funded bid. This centre forms part of the wider national CRDC network aimed at improving access to world-class commercial research, particularly for patients in underserved areas.

Strategic Partnership and Regional Leadership.

As a key partner in the Central and North West Midlands CRDC, RWT supported the bid and development of the regional delivery infrastructure. The formal host site is Birmingham Women's and Children's NHS Foundation Trust, RWT's Research Directorate has been an active strategic collaborator, helping to shape governance, patient access, and delivery models for the network.

Delivering Inclusive, Decentralised Research.

Through its collaboration with the CRDC, the Group is contributing to the development of decentralised and digitally enabled research models, allowing patients to take part in trials without needing to travel to major teaching hospitals.

This includes:

- Community based trial locations, expanding research access into local clinics and primary care settings.
- Use of mobile and virtual research technologies to increase flexibility and reach.
- Active involvement in shaping frameworks for governance, contracting, and feasibility review, helping streamline the setup of commercial studies.

By aligning its local infrastructure with CRDC priorities, the Group is ensuring that commercial clinical research becomes more accessible, inclusive, and representative of the populations it serves.

The CRDC programme represents a major step in transforming how the NHS collaborates with industry to deliver cutting-edge studies efficiently and equitably. The Groups contribution ensures that the Midlands and North region which serves approximately 4.2 million people, have better opportunities to participate in and benefit from high-value research programmes.

RWT and the NIHR West Midlands Health & Care Professional Internship Programme

The Group played a crucial role is supporting Midlands Partnership Foundation Trust (MPFT) in being awarded the NIHR West Midlands Health & Care Professional Internship Programme. The scheme aims to place 23 interns annually across the region, with the goal of strengthening research capacity and embedding research experience among health and care professionals.

With the Groups established research infrastructure, governance frameworks, and trusted reputation, the Group helped to signal to NIHR and MPFT that the programme would have capable delivery partners in the region.

The Group has positioned itself as an intern placement hub being able to offer clinical, laboratory, and research settings capable of supporting interns under various pathways (e.g. research delivery, clinician-academic shadowing).

The internship aligns with the Groups ambitions to develop a wider research-active workforce. By engaging early-career professionals, the programme complements the Groups existing training, research education, and career development strategies.

Participation in the internship programme will enable the Group to further embed research into everyday clinical practice across professional disciplines. It would help cultivate a sustainable pipeline of clinically engaged researchers, promote research as a standard part of care, and reinforce the ethos that “research is just what we do around here.”

AHPs Building Capacity Across the Black Country: Research ABC

The Research ABC project funded through a Clinical Research Network West Midlands (CRN WM), led by Dr Ali Aries, Allied Health Professional (AHP) Research Lead at RWT aimed to strengthen research engagement and leadership among Allied Health Professionals across the Black Country Integrated Care System (ICS).

The project directly supported implementation of the Health Education England AHP Research and Innovation Strategy, structured around four key domains:

- Capacity – increasing the number of AHPs engaging in and leading research;
- Capability – developing research skills through structured training and mentorship;
- Context – creating supportive organisational systems for AHP-led research;

- Culture – embedding research as a core component of AHP practice and professional identity.

The ABC Project achieved significant measurable outcomes across the Black Country ICS, positioning RWT as a regional leader in AHP research development:

- 93 AHP Research Champions were recruited across six NHS Trusts.
- 23 bespoke training sessions were delivered, engaging 169 AHPs.
- A digital networking platform was established, now connecting 285 AHPs region-wide.
- Multiple Communities of Research Practice (CoRPs) and journal clubs were launched to sustain ongoing engagement.
- Participants gained opportunities for protected research time, presentation at national conferences, and mentorship from senior research leaders.

These achievements reflect a sustainable model for building research capability and community among Allied Health Professionals.

The initiative was delivered collaboratively across the Black Country ICS, with engagement from:
The Royal Wolverhampton NHS Trust (Lead)
Walsall Healthcare NHS Trust
The Dudley Group NHS Foundation Trust
Sandwell & West Birmingham Hospitals NHS Trust
Black Country Healthcare NHS Foundation Trust
Dudley Integrated Health and Care Trust

RWT provided project leadership, coordination, and evaluation oversight, ensuring alignment with both regional ICS objectives and NIHR priorities for research inclusion.

The project's success was recognised regionally when Dr Ali Aries received the Best Poster Award at the Black Country Research Celebration Event for the presentation of the ABC Project.
Beyond its defined timeframe, the project has left a tangible legacy: a networked community of empowered AHPs with stronger research identity, infrastructure, and inter-Trust collaboration. Its model has since informed ongoing work to embed AHP research pathways across the Group and the wider Black Country.

Novartis Collaboration

Strategic partnerships with pharmaceutical companies are essential to ensuring our population has access to innovative treatments. In 2024/25, recruitment into commercial clinical trials across both Trusts reached its highest level to date. This outstanding performance led to the establishment of a formal collaboration with Novartis, positioning the Group as a preferred site for future Novartis-sponsored studies and leveraging its strengths in research delivery.

RESEARCH RECRUITMENT PERFORMANCE ACADEMIC AND COMMERCIAL 2024/25

Recruitment into Academic studies

RWT demonstrated strong academic performance in FY24/25, leading the West Midlands in overall research recruitment and evidencing the Trust's capacity to set up, deliver and close studies at scale. While we recognise that a substantial proportion of this year's recruitment is concentrated in a single high-volume study, the result still reflects mature research governance, effective principal investigator (PI) leadership, and robust patient-identification pathways across services.

What this means

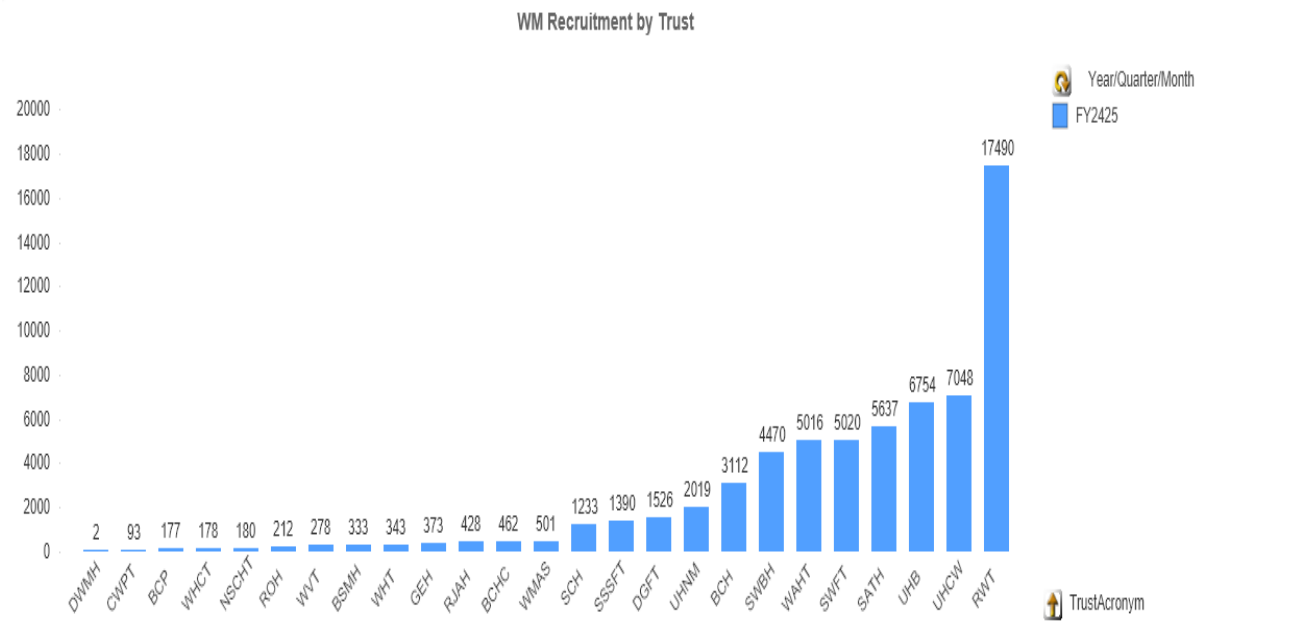
- **Capability at scale:** The ability to recruit rapidly and safely to a large multicentre study indicates resilient processes (feasibility, contracting, information governance and data quality) and strong operational alignment between clinical teams and R&D.
- **Academic credibility:** High throughput supports publications, presentations and future funding bids, strengthening RWT's standing with NIHR and industry sponsors.
- **Platform for diversification:** The current momentum provides a springboard to broaden the portfolio, balancing high-volume delivery studies with early-phase, device, and investigator-initiated research to distribute activity and impact across specialties.

WHT strategically prioritised commercial research delivery to enhance income generation and broaden patient access to innovative treatments. This focus, while resulting in lower academic recruitment figures, reflects a deliberate shift to support financially sustainable research growth and maximise clinical impact.

Next steps (2025/26)

- Convert sponsor interest into new commercial and non-commercial studies across under-represented specialties.
- Support new Chief Investigators and clinician-academic pathways to widen leadership.
- Maintain delivery excellence while reducing single study concentration risk through targeted feasibility and rapid start-up in additional trials.

Recruitment into Academic studies across the West Midlands FY24/25



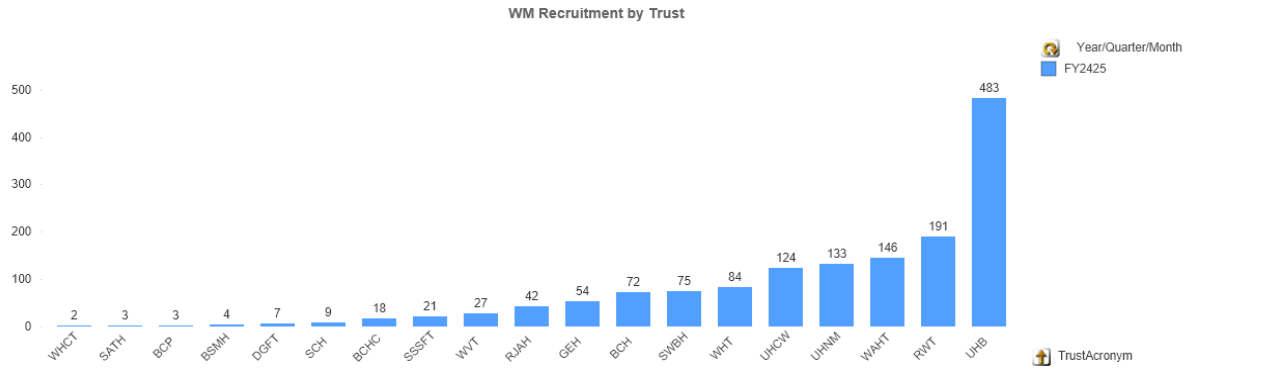
Recruitment into Commercial Portfolio Studies

Both Trusts demonstrated strong performance in commercial study recruitment, reinforcing their commitment to advancing clinical research. RWT recruited 191 participants into commercial trials, ranking second only to University Hospitals Birmingham among West Midlands providers. This achievement highlights RWT's capacity for rapid study set-up and consistent delivery of high-quality industry trials. Meanwhile, WHT secured 84 commercial recruits, positioning it in the upper mid-tier regionally and outperforming several larger organisations. This success reflects targeted Principal Investigator (PI) engagement and streamlined patient identification pathways. Collectively, these efforts directly support the Lord O'Shaughnessy recommendations to expand commercial clinical trial activity across the NHS.

Why this matters

- **Patient access to innovation:** More patients at RWT and WHT accessed cutting-edge therapies through industry trials.
- **Attractive to sponsors:** Consistent delivery signals dependable feasibility, governance and recruitment, strengthening both Trusts' position for future commercial opportunities.
- **Growth platform:** With proven commercial performance, both Trusts are well-placed to win additional phase II/III and device studies in FY25/26.

Recruitment into Commercial Portfolio Studies FY24/25



Exemplary Performance

WHT continues to make significant progress in expanding its research profile, demonstrating measurable growth in study recruitment, national recognition for innovation, and strengthened infrastructure to support clinical research across multiple specialties.

In FY24/25, the Trust achieved its highest ever level of participation, recruiting 343 patients across 19 studies, including 84 participants in commercial clinical trials. This is a record milestone for WHT. Research activity now spans a wide range of disciplines including critical care, oncology, dermatology, cardiology, neonatal and maternity care, emergency medicine, and endocrinology.

FINANCIAL POSITION AND INVESTMENT IN RESEARCH INFRASTRUCTURE:

Research activity across both Trusts is now financially self-sustaining, supported by a balanced and diversified income profile comprising NIHR funding, commercial trial revenue, and competitive grant awards. No additional financial subsidy from either Trust is required to maintain or grow research operations, reflecting a mature and resilient research delivery model.

Financial data is consistently captured within the Local Portfolio Management System (LPMS), enabling improved forecasting, streamlined invoicing, and timely recovery of income. This digital infrastructure supports robust financial governance and ensures transparency across the Group.

Capital Investment in Research Infrastructure

Both Trusts have successfully secured external capital investment to enhance research infrastructure:

- WHT was awarded £183,000 to establish a Radiostereometric Analysis (RSA) research facility, expanding capability in orthopaedic and device trials.
- RWT has secured funding to develop a bespoke, patient-facing research facility, designed to improve access, experience, and outcomes for participants while supporting delivery of a broader, higher-quality study portfolio.

These investments, secured without reliance on core Trust budgets, demonstrate the strategic value and external confidence in the research programmes at both organisations. They reflect a shift from dependency to financial autonomy, with research increasingly recognised as a contributor to institutional reputation, workforce development, and system-wide innovation.

PATIENT AND PUBLIC ENGAGEMENT:

Patient involvement remains central to WHT research culture. The Trust hosted a "Thank You" event for research participants, celebrating their vital contribution to advancing care and fostering a strong sense of community ownership in clinical research. The event was attended by the CEO and CMO and vital feedback was obtained from research participants.

Research Participants demographics:
At WHT, we undertook an analysis of the demographics of patients recruited into research studies, specifically age, sex, ethnicity, and postcode, and compared this against locally available population data. The findings showed that, in most cases, our recruitment reflects the communities we serve. However, we recognise there is more to do. In FY25/26, we will work closely with the Patient Experience Team to identify a trial that disproportionately affects a minority group and proactively take the research to those participants, ensuring greater equity and representation in research delivery.

NHS DigiTrials – NHS Number Data Collection
In line with NHS England's efforts to improve the reach and impact of clinical research, NHS DigiTrials offers an optional opt-in service for NHS Trusts to securely share NHS numbers of participants recruited into clinical trials. This initiative supports better data linkage, long-term follow-up, and improved trial outcomes while ensuring compliance with data protection regulations.

The Group has opted into this service, enabling authorised access to NHS numbers for approved studies. This participation reflects our commitment to enhancing research quality, transparency, and inclusivity, while supporting national efforts to streamline trial processes and improve patient care.

Patient and Lived Experiences Advisory Team (PLEAT)
The Group is launching the Patient and Lived Experiences Advisory Team (PLEAT), a new initiative designed to embed meaningful patient and public involvement (PPI) across all stages of clinical research.

PLEAT will serve as a dedicated advisory group, ensuring that research is shaped by diverse lived experiences and reflects the needs of the local population. The group will contribute to early-stage research design, peer review, and governance, while also acting as research

champions within the community. By involving patients and the public more systematically, PLEAT aims to improve the relevance, quality, and delivery of research studies.

Embedding PPIE in Research Culture

- Both Trusts have embedded PPIE as a core principle in their research governance and delivery frameworks. PPIE input is routinely sought during study design, ethics submissions, and peer review processes.
- Research teams across RWT and WHT actively involve patients and public contributors as co-applicants on grant submissions and as members of study steering groups, ensuring lived experience informs decision-making.
- The launch of PLEAT further formalises this commitment, creating a structured mechanism for ongoing PPIE input across all stages of research.
- The Trusts also support training and development opportunities for both staff and public contributors to build confidence and capability in meaningful involvement.
- Feedback from research participants is regularly collected and used to improve study delivery and participant experience, as demonstrated by the "Thank You" event hosted by WHT.
- Participation in national initiatives such as NHS DigiTrials reflects a broader commitment to transparency, inclusivity, and data-driven improvements in research.

RESEARCH SPONSORSHIP AND COLLABORATION:

The Group R&D sponsorship team continues to play a leading role in research sponsorship and collaboration, demonstrating strong governance, growing engagement from Chief Investigators (CIs), and increasing success in attracting external funding.

The Research Sponsorship team, within R&D, oversees all Trust-sponsored and hosted research, assuring compliance with national frameworks and supporting investigators through study design, costings, contracts, and grant submissions.

In FY24/25, sponsorship activity and collaborative research grew substantially, reflecting the Groups commitment to research excellence, partnership, and translating innovation into clinical practice.

Performance and Progress

- **New and active portfolio:** Eight new studies progressed through sponsorship (two at peer-review stage).
- **Study closures:** Fourteen studies closed following completion or recruitment.
- **Investigator capacity:** Several new CIs joined the Groups research community, strengthening internal leadership.
- **Peer review:** Three studies underwent peer review this quarter, with two additional CIs identified for future projects.

- **Major submissions supported:** RfPB applications (cardiology, IBD, prisoner health) and a large NIHR PGfR bid (Neonatology and Decarbonisation).

Grant income:

- **Awarded (hosted & sponsored): £4,122,822.41**
- **Awarded collaborations (RWT partner but not host/sponsor): ~£195,718.78** *(a small number of awards pending cost confirmation)*
- **Pending submissions where RWT is host (decision awaited): £5,766,258.97**
-

Figures are based on the latest internal R&D returns and may be subject to reconciliation.

Governance and Quality

Research sponsorship remains central to ensuring quality, safety, and ethics. The team provides end-to-end oversight of study set-up, data management, and ongoing compliance. Key developments include:

- New SOPs for data management and grant hosting.
- Review of updated medical device regulations for clinical investigations.
- Strengthened information governance (DPIA submission; Information Asset Register maintenance).
- Digital enablement with REDCap and online forms; expanded secure access for external researchers in partnership with IT.
- Ongoing engagement with the Caldicott Guardian and Information Governance team.
- Enhanced PPIE, including collaboration with Community Connexions and public members in peer review.

Collaborations and Funded Projects

RWT continues to build partnerships with universities, clinical research groups, and national bodies. Active and recently completed studies include:

- **BENCH** (Haematology) – Recruitment ongoing.
- **GFAP Laboratory Study** (Clinical Chemistry) – Recruitment ongoing.
- **Xenia Lenticule Study** (Ophthalmology) – Amendment pending; recruitment active.
- **OPTIPREM, BAM, KIDNEY** – Closed following completion and funder reporting.
- **PICOC** (Cardiology) – Recruitment completed; close out pending.

Collectively, these projects evidence strong real-world research delivery and the Groups active contribution to national and international studies.

Challenges and Opportunities

- **Capacity Pressure**: The expanding research portfolio and increased Chief Investigator (CI) engagement have significantly raised operational demands. However, this has been partially offset by increased grant income, which has facilitated the recruitment of an additional Project Coordinator to support delivery.
- **Process Modernisation**: Efforts are underway to digitise sponsorship request workflows, streamline costings, and embed grant-management tools within existing IT

systems. These initiatives aim to reduce administrative burden and accelerate study set-up timelines.

Looking Ahead (2025/26 priorities)

- Continued onboarding and development of new CIs across specialties.
- Strengthen grant-development pathways to improve success rates and diversify funders.
- Advance digital governance and workflow automation to speed study set-up.
- Deepen collaborations with academic and clinical partners regionally and nationally.

Through these actions, the Group will continue to deliver high-quality, patient-focused research that improves care and outcomes for the communities we serve.

Support for audits, service evaluations and student research

Beyond clinical trials, the Group maintains a high level of support for "other research activities" that strengthen quality, safety and workforce development. The chart shows steady month-on-month throughput across service evaluations, audits, service development projects and university-sponsored/student studies throughout FY24/25, with clear surges during peak academic periods.

Key messages from the year

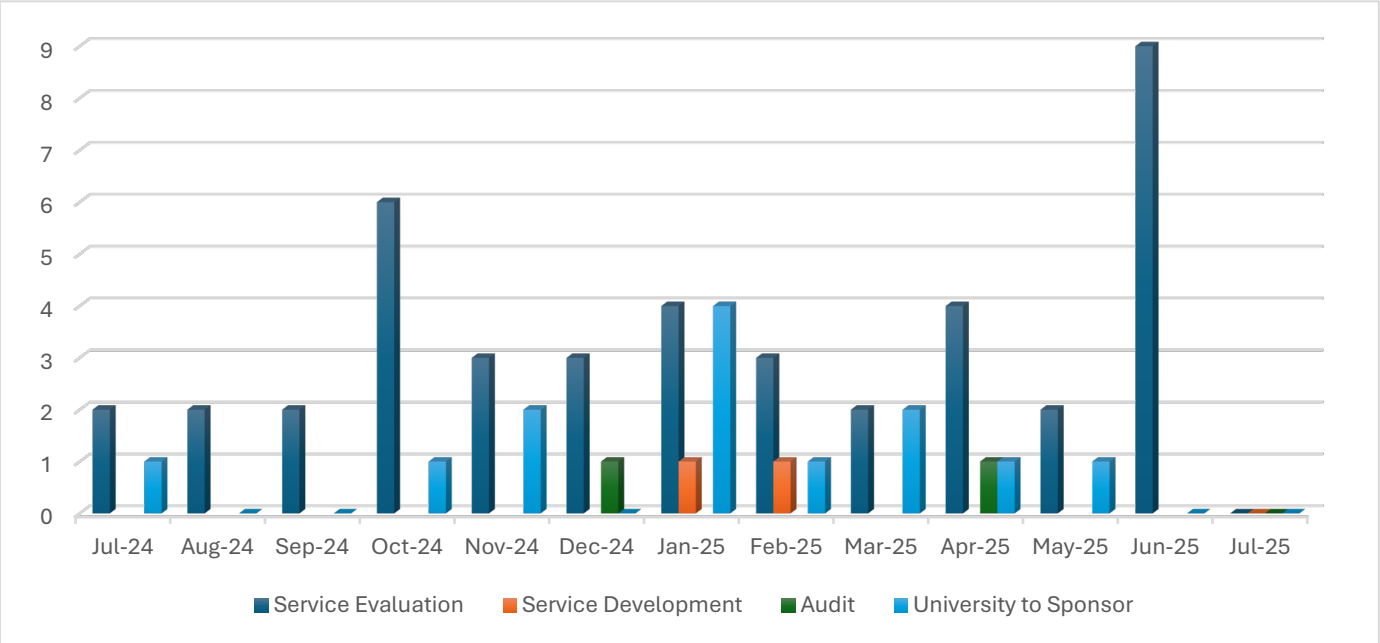
- Consistent baseline activity: Every month features multiple service evaluations, our largest category, demonstrating how research methods are embedded in routine improvement work across services. Notable step-ups occur in Oct-24, Jan-25, Apr-25 and Jun-25, aligning with clinical audit cycles and academic timetables.
- Targeted clinical audits: Regular audit activity appears across winter and spring (e.g., Dec-24 and Apr-25), supporting guideline adherence, safety monitoring and service optimisation.
- Student and academic pipeline: Peaks in university-sponsored/student projects in Nov-24–Feb-25 reflect structured placement windows and assessment deadlines. This provides supervised research experience, strengthens links with local universities and feeds the Trusts' future CI pipeline.
- Service development projects: Smaller but material volumes of service development indicate purposeful, protocolised change, often preceding or complementing formal research.

Why this matters

- Quality & safety: Audit and evaluation projects close the loop on clinical standards and generate actionable improvements at pace.
- Workforce development: Structured supervision of student projects and early-career clinicians builds research confidence and capability across professions.
- Readiness for trials: Routine governance (registration, proportionate review, data capture) in these projects keeps teams "trial-ready," shortening start-up times when external studies are offered.

- System value: Partnering with universities ensures alignment of academic effort to local priorities, spreading good practice across the region.

Both Trusts deliver a sustained programme of audit, evaluation and student research alongside their clinical trials portfolio. Throughout FY24/25 we maintained a consistent flow of service evaluations each month, complemented by targeted clinical audits and peaks in university-sponsored projects during academic terms. This activity underpins quality improvement, develops the next generation of researchers and keeps our services trial-ready, ensuring that research benefits are felt widely across patients, staff and the wider system.



WORKFORCE DEVELOPMENT:

To strengthen research delivery and expand our capacity to host commercial studies, we have introduced new roles that support clinical research across both Trusts.

At RWT, a junior doctor has been appointed with dedicated research duties. This role was created in response to the challenge of progressing commercial studies due to the lack of medical oversight for confirming eligibility and obtaining consent. The junior doctor is now embedded within the research team and is proving invaluable in enabling studies to open and recruit efficiently. This initiative not only supports the delivery of research but also provides a valuable development opportunity for early-career clinicians to gain experience in research leadership and trial management.
At WHT, the introduction of Research Nursing Associates has significantly enhanced research capacity. These team members have brought fresh energy and capability to the delivery of studies, particularly in areas where nursing resource has been stretched. Their contribution

has been recognised nationally, with the team shortlisted for the Nursing Times Awards, reflecting the innovation and impact of this initiative.

In addition, WHT has demonstrated a strong commitment to developing its research workforce by supporting staff from non-traditional research backgrounds to take on research delivery roles. This inclusive approach is helping to build a more diverse and sustainable research team, while also offering career development opportunities for existing staff. Looking ahead, the Group is committed to further developing its research workforce by supporting the appointment of PhD students to contribute to research delivery. This initiative will not only strengthen academic collaboration but also build long-term research capability within the Trusts, ensuring a pipeline of skilled researchers equipped to address future healthcare challenges.

Training and Workforce Development
The Group continues to invest in the development of its research workforce through a robust internal training programme. In FY24/25, circa 40 sessions were delivered covering key topics such as protocol understanding, safety reporting, MHRA inspection readiness, and study allocation. Training is now managed via My Academy, streamlining access, feedback collection, and certification.

The Group has 110 sessions scheduled for FY25/26. Importantly, research training is delivered in collaboration with the four NHS Trusts across the Black Country, and sessions are open to staff from any of the organisations. This shared approach promotes consistency, maximises resources, and strengthens regional research capability.

These efforts reflect a strong commitment to building capability, ensuring safe and effective research delivery, and supporting career progression across the region.

BLACKCOUNTRY COLLABORATION:

Strategic Opportunity

The potential for research collaboration across the Black Country is extensive. We collectively recognise the benefits of research in improving patient outcomes, generating income, reducing drug costs, and supporting workforce recruitment and retention. These benefits are well-documented in the Darzi Report, and the need to increase commercial recruitment is emphasised in the Lord O'Shaughnessy Report.

System-Wide Collaboration. These benefits could be significantly enhanced through a system-wide approach. Establishing a Joint Research Office (JRO) would allow us to:

- Leverage expertise across the four Trusts
- Reduce duplication

- Release resources to support research aligned with population health priorities, particularly in prevention

Commercial Research Growth. A collaborative model, Black Country Research Collaborative (BCRC) could attract greater commercial investment. While individual contracts would still be required, a single point of contact for pharmaceutical companies would streamline processes and increase appeal. This would:

- Improve access to research for our population
- Enhance outcomes
- Generate income and system-wide savings (e.g., drug and activity cost reductions)

Unique Regional Advantage. The Black Country's large, diverse, and stable population offers a unique opportunity for long-term follow-up in research studies, enhancing the quality and reliability of findings.

Potential Collaborative Roles:

- Quality Assurance
- Local Portfolio Management System (EDGE)
- Contracting
- Finance
- Study Setup
- Workforce Development
- Primary Care and Out-of-Hospital Research

Resource Reallocation. Efficiencies gained through collaboration should be reinvested into:

- Business development (commercial opportunities)
- Development of locally-led research

HOST WEST MIDLANDS REGIONAL RESEARCH DELIVERY NETWORK:

The RDN is funded by the Department of Health and Social Care (DHSC) to enable the health and care system to attract, optimise, and deliver research across England. It replaced the Clinical Research Network (CRN) on 1 October 2024. The RDN consists of 12 Regional Research Delivery Networks (RRDNs) and a Coordinating Centre (RDNCC), working together as one organisation with joint leadership. RWT has been awarded the contract to host the West Midlands RRDN until 2030.
The RDN contributes to NIHR's mission to improve the health and wealth of the nation through research. The RRDN Host Organisation is the legal entity that contracts with DHSC to provide all RRDN services and activities. Each RRDN Host Organisation will have an internal governance arrangement for the RRDN contract, commensurate with the contract value, in

accordance with that organisation's scheme of delegation and contract management arrangements.

The West Midlands Regional Research Delivery Network (RRDN) concluded the 2024–25 year with recruitment figures just 0.3% below the previous year, despite an ambitious target to increase recruitment by 10%. While this target was met during the first nine months, performance declined in the final quarter.

Key Highlights:

- Recruitment Performance:
  - 27 out of 29 specialties recruited participants; Imaging and Palliative Care did not recruit, both being new additions.
  - Acute settings exceeded last year's recruitment by 37–59%, while Primary Care and Wider Care Settings saw significant declines of 77–98% and 41–100%, respectively.
  - Interventional studies accounted for 56% of recruitment—second highest nationally by percentage and fourth highest by volume.
- Geographic and Organisational Insights:
  - Birmingham and Solihull ICB outperformed others when adjusted for population, with 20% higher recruitment.
  - The West Midlands ranked third lowest in recruitment per 100k population nationally, but had strong performance in interventional studies.
  - Royal Wolverhampton NHS Trust (RWT) led recruitment with 17,495 participants, followed by University Hospitals Birmingham (UHB) and University Hospitals Coventry and Warwickshire (UHCW).
- Specialty Trends:
  - Notable increases in Reproductive Health (+119%), Trauma & Emergency Care (+112%), and Ophthalmology (+144%).
  - Declines observed in Children (-40%), Musculoskeletal (-45%), and Primary Care (-25%).
- Study Delivery and Compliance:
  - Of 317 lead studies, 74 were flagged for assessment. Common issues included low recruitment rates and missed planned opening dates.
  - No studies were removed from the NIHR portfolio due to breaches.
- Participant Experience:
  - The region achieved its best-ever PRES results, exceeding the target by over 50%. The target of 1,533 responses has remained unchanged for three years.
- Commercial vs Non-commercial Studies:
  - Commercial recruitment in the West Midlands was 2.2%, significantly below the national average of 7.4%.

This report reflects both the strengths and challenges faced by the West Midlands RRDN in 2024–25, highlighting areas for strategic focus in the coming year, particularly in Primary and Wider Care settings, and in improving regional recruitment equity.

FROM VISION TO IMPACT: WHT's RESEARCH SUCCESS STORIES:

Celebrating Research in the Community: Walsall Showcases Innovation at Pride
WHT proudly showcased its research achievements at Walsall Pride, engaging the public in conversations about life changing clinical studies. The Trust highlighted its role as the first site in Europe to deliver the DELTA Teen study for adolescent hand eczema, alongside its highest-ever commercial recruitment figures with 84 participants recruited, driven by Cardiology and Dermatology. With over 340 participants recruited across 19 studies spanning specialties such as Oncology, Neonatal, and Emergency Care, the Trust demonstrated its commitment to inclusive, impactful research. Catherine Dexter, Research and Development Manager, emphasized the importance of reaching younger people and diverse communities to ensure everyone has the opportunity to "be part of research."

Research-Driven Respiratory Care: Extending the Life-Changing Severe Asthma Clinic
The Severe Asthma Clinic at Walsall Manor Hospital has been extended following a successful trial involving over 50 patients. The clinic offers biological injections that replace steroids, significantly improving patients' quality of life. The Trust aims to double the number of patients to 100 and enable home administration of injections to reduce clinical burden.

Pioneering Orthopaedic Research: Walsall Leads Innovation in Joint Replacement Technology Radiostereometric Analysis (RSA) Research Facility at Walsall Healthcare NHS Trust
Funding Awarded:
Walsall Healthcare NHS Trust received £183,000 from the National Institute for Health and Care Research (NIHR) as part of a national £30 million investment across 36 NHS organisations. This funding supports the development of cutting-edge medical equipment and technology to enhance clinical research capabilities.
Purpose of the RSA Lab:
The funding will establish a state-of-the-art Radiostereometric Analysis (RSA) laboratory within the Trust's Trauma and Orthopaedics department. RSA is a highly precise imaging technique used to monitor and assess the performance of orthopaedic implants, particularly in joint replacement technology.
Key Features of the Facility:

- Complex 3D mapping software for detailed implant tracking.
- Calibration equipment to ensure measurement accuracy.
- A mobile X-ray unit to facilitate flexible and efficient imaging.

Impact and Significance:

- The RSA lab will significantly expand Walsall's capacity to conduct clinical trials in orthopaedics, particularly in joint replacement research.
- Until now, such facilities have only existed in approximately 15 large research units across the UK, making Walsall one of the few district general hospitals with this capability.

- The lab will support commercial clinical trials, bringing innovative surgical techniques, implants, and medicines to patients earlier.

Leadership and Vision:
The successful funding bid was led by Mr Fahad Hossain, Consultant Orthopaedic Surgeon and Director of Research and Development at Walsall Healthcare NHS Trust.

National and International Firsts
WHT researchers achieved several national and regional "firsts" that highlight the organisation's growing influence in UK research:

- The Trust became the first site in the UK to recruit a patient into a dermatology drug trial, marking a major achievement for a district general hospital setting.
- Walsall also led participation in first-in-Europe studies such as the *DELTA Teen Trial*, which investigates new treatments for young patients with severe hand eczema.
- The Trust was again first in the UK to contribute to the HEALS2 Trial, a wound-healing study for patients undergoing lower-limb skin cancer excision.
-

These achievements demonstrate the capability and ambition of Walsall's research teams to deliver high-impact, patient-focused studies at both national and international levels.

Leadership and Collaboration
For the first time since the COVID-19 pandemic, a Walsall clinician held a Chief Investigator (CI) role on a national study, the HEALS2 dermatology trial, showcasing the Trusts growing leadership in initiating and managing research locally.

The Trust's R&D team has been shortlisted for regional awards, including recognition for collaboration in research and industry engagement, highlighting its success in strengthening partnerships with the NIHR and neighbouring Trusts such as the Royal Wolverhampton NHS Trust.
Joint initiatives, such as the "Celebration of Research" event co-hosted with Royal Wolverhampton, have fostered a shared culture of research, innovation, and learning across the region.

FROM VISION TO IMPACT: RWT's RESEARCH SUCCESS STORIES:

COBALT Trial: Leading National Research to Transform Treatment for Bile Acid Diarrhoea
RWT is proud to host the COBALT trial, its first major HTA-funded research study and the largest research grant ever awarded to the Trust.

This landmark trial aims to identify the most effective treatment for bile acid diarrhoea (BAD), a condition affecting over 1% of the population and frequently misdiagnosed as IBS. With 519 participants recruited across the UK, including approximately 50 from RWT, the study will assess symptom relief, quality of life, work productivity, and health economic impact.

Led by Professor Matt Brookes, the trial compares three licensed treatments—Colestyramine, Colesevelam, and Loperamide, ensuring all participants receive therapeutic benefit. The COBALT trial is expected to influence future NICE guidelines and improve care quality, staff retention, and patient outcomes across the NHS.

"It's a privilege and an honour to lead this study in an under-researched area," said Professor Matt Brookes. *"The funding reflects years of dedication from our research teams, and we hope to improve care and outcomes for patients with BAD."*

Cardiovascular Leadership: Professor James Cotton Drives Innovation at RWT
Professor James Cotton, Consultant Interventional Cardiologist and Professor of Cardiology, has played a pivotal role in establishing and advancing cardiovascular research at New Cross Hospital's Heart and Lung Centre. As one of the first appointed Interventionalists, he has led national and international trials focused on ischaemic heart disease, novel physiology techniques, and advanced interventions for aortic stenosis. His leadership has helped position the Centre as a nationally recognised hub for cardiac innovation.
"These appointments mark a huge step forward for clinical research in the Black Country," said Professor Cotton. "This commitment will allow us to develop first-class research projects targeting local health challenges."

National First: RWT Leads Groundbreaking Trial to Prevent Anaemia in Pregnancy
RWT has recruited the UK's first participant into the PANDA Prevention trial, a major national study investigating whether low-dose iron supplements can prevent anaemia in pregnancy and reduce risks such as preterm birth, low birth weight, and stillbirth. The trial aims to recruit over 11,000 women across the UK and is the largest of its kind in maternity care in recent years. Led by Professor David Churchill, Consultant Obstetrician and National Obstetrics Lead, and supported by Research Midwife Ellmina McKenzie, the study builds on a successful pilot conducted at New Cross Hospital.
"This is a major trial of simple intervention that, if it works, will change practice across the whole country," said Professor Churchill

RWT Patient-Facing Research Facility
Improving Patient Access and Experience
The new facility offers a single, welcoming "front door" for research, with dedicated reception, accessible clinic rooms, and co-located phlebotomy, ECG, and imaging services. This design reduces anxiety and non-attendance, streamlines visit flow, and enables evening/weekend clinics. Participants can complete screening, baseline assessments, and protocol visits on one site, shortening time to treatment and improving retention.
Enhancing Clinical Quality and Safety
A research-grade environment with calibrated equipment, IMP/pharmacy workflows, and monitored sample handling supports protocol fidelity and data integrity. Separating research

visits from routine service pressures protects protocol windows, reduces deviations, and enhances adverse-event monitoring, all within standardised SOP-driven practice.
Supporting Workforce Development
Co-location of research nurses, AHPs, investigators, data teams, and pharmacy staff creates an inter-professional hub for supervision, competency sign-off, and Chief Investigator development. The purpose-built facility also signals the Group's commitment to research, aiding attraction and retention of research-active staff.
Strengthening Sponsor Confidence and Portfolio Growth
The dedicated, high-throughput space with on-site and remote monitoring capability improves site selection for commercial trials. Increased capacity and capability support a wider study mix, including early to late phase, device, observational, and complex follow-up trials, alongside high-volume delivery studies. The facility also enables hybrid and decentralised models aligned to CRDC priorities.
Driving Operational Efficiency and Financial Performance
One-stop pathways reduce cycle times, cancellations, and re-bookings, improving recruitment, retention, and cost recovery. Clear scheduling and asset utilisation (e.g., shared imaging, point-of-care testing, -80°C storage) minimise duplication and integrate seamlessly with LPMS, EDGE, and REDCap workflows for prompt invoicing.
Enhancing System Value and Reputation
The facility positions RWT as a regional anchor within the Midlands & North CRDC network, enhancing visibility to sponsors and partners. It provides a recognisable "research front door" that strengthens PPIE and community participation.
Measuring Impact (12–24 Months)
To evidence benefits and ensure continued value, the following metrics will be tracked:
- Recruitment and retention (including screen-fail and withdrawal rates)
- Timeliness from referral to first visit and adherence to protocol windows
- Quality indicators (protocol deviations; monitor findings resolved on time)
- Equity of access (participation from underserved groups)
- Sponsor metrics (feasibility win rate; repeat selection)
- Financial and operational metrics (cost-recovery rate, average invoice age, facility utilisation)
These measures will demonstrate how capital investment translates into better patient outcomes, stronger sponsor confidence, and sustained financial resilience.

Advancing Cardiac Care Through AI Innovation
RWT is proud to celebrate the pioneering work of Dr Sandeep Hothi, Consultant Cardiologist at New Cross Hospital, whose leadership and collaboration with AI companies is advancing the use of artificial intelligence (AI) to transform cardiac imaging and improve outcomes for patients with cardiovascular disease.

Dr Hothi has led the successful implementation of EchoGo, an AI-powered echocardiography platform developed by Ultromics, into clinical practice at the Trust. This cutting-edge technology enables the rapid and highly accurate interpretation of heart scans, improving the

precision of diagnosis and monitoring for patients with a wide range of cardiac conditions, including those receiving cancer therapies that may affect heart function.

The integration of AI-driven imaging represents a major step forward in the personalisation and efficiency of cardiac care, reducing diagnostic variability and ensuring patients receive timely, evidence-based treatment.

The EchoGo project reflects the Groups commitment to embracing emerging technologies that enhance diagnostic accuracy, streamline workflows, and improve patient outcomes. As the Group continues to explore the potential of AI in healthcare, initiatives like this demonstrate the value of research-active leadership in driving forward clinical transformation.

Tier 1 - Paper ref:	Enc 9.2

Report title:	Board Assurance Framework
Sponsoring executive:	Chief Executive Officer
Report author:	Kevin Bostock, Group Director of Assurance
Meeting title:	Group Board of Directors Meeting held in Public
Date:	18.11.2025

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

Assure

The Executive Directors have reviewed and assessed the Group Board Assurance Framework in October 2025. The Committees of the Board have subsequently received and approved any changes to the BAF.

Advise

Following the review by the Executive, the Committees of the Board confirm that the following risk scores remain unchanged for the following BAFS:

- **GBR1** – 4 likelihood x 4 consequence = 16
  - **If** the Trusts in the Group are individually and collectively unable to achieve financial break-even by year end 2027/28
  - **then** the Trusts and the system will be non-compliant with NHSE/DH+ NHS Provider License requirements
  - **resulting in** special measures regime imposition and reputational damage and vulnerability as non-financially viable organisations.
- **GBR2 –** 3 likelihood x 4 consequence =12
  - **If** the Trusts in the Group are individually and collectively unable to recover and meet future access (constitutional) standards over the next 3-5 years (e.g. RTT)
  - **then** the Trusts individually and/or collectively will be non-compliant with future contract requirements
  - **resulting in** special measures regime imposition and reputational damage and vulnerability as non-financially viable organisations.
- **GBR3** – 3 likelihood x 4 consequence = 12
  - **If** the Group Trusts are unable to optimise the Group Structure (from the Corporate Services Review) (including potential use of a Subsidiary vehicle) including the scale of efficiencies and cost-reduction required whilst maintaining or improving standards and performance
  - **then** the Trusts/Group would be unable to meet its future Corporate governance needs, financial and staff reduction requirements
  - **resulting in** inability to achieve financial recovery, special measures regime imposition, reputational damage and vulnerability as non-financially viable organisations.
- **GBR4 –** 4 likelihood x 4 consequence = 16
  - **If** the Trusts/Group workforce transformation plan (reduced staffing, use of new technology, culture & behaviour) is not achieved
  - **then** there may be a disconnect between the corporate aspirations, targets and requirements
  - **resulting in** an increasingly disengaged and disenfranchised workforce (staff survey) (and regulatory expectations/requirements e.g. CQC safe staffing) that slows, halts or reverses the transformation programme including greater efficiencies and service change.

The Committees of the Board confirm the following risk score was reduced from a risk score of **16** to a reduced score of **12**:

- **BAF GBR5 -** 3 likelihood x 4 consequence = 12
  - **If** the Trusts/Group clinical service transformation plan is unable to achieve its aims and objectives &/or maintain or improve quality & safety
  - **then** quality and safety standards may fall and/or become compromised
  - **resulting in** increased claims, low staff morale (staff survey), declining reputation (F&FT) and increased scrutiny/inspection and/or declining ratings (CQC et al).

Alert

The Group BAF is being reviewed with the intention to provide a new framework for reporting to Committees and Board to be in effect from April 2026.

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?]*
Review and discussions undertaken in October 2025 by Executive and subsequently approved by Committees of the Board.

4. Recommendation(s)/Action(s)
Each responsible Board Committee and Executive has been asked to
a) Review the evidence received to date relating to any BAF Group Risks for which they are the leading Board Committee.
b) Note any Corporate Risk Register Risks associated with the BAF Risk.
c) Recommend and confirm the Quarter end Risk Score assessment.
d) Escalate to the responsible Executive and the Group Board anywhere the current risk level matches or exceeds the Risk Tolerance score.
e) Consider any emerging potential risks included on or for inclusion on the summary 'Watch List' (see Annex 1).
f) Match future reports to the appropriate BAF Risk as either evidence (of control and/or assurance) or indicative of Negative Assurances and/or Gaps in Control.

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 Group Board of Directors Meeting held 18 November 2025

Board Assurance Framework (Reviewed by Committees of the Board in October 2025)

1. Executive summary

Following internal review and Internal Audit recommendations, the Board Assurance Framework (BAF) for the Group and Individual Trusts (RWT & WHT) has been re-designed, reviewed and refreshed as per the Internal Audit Management Actions.

This report provides an overview of the Group Risks Appetite, Risk Tolerance in each case, the initial 5 Group Risks, the tracking of these in pictorial form, the revised section for the Risk Management Policy and summary documents.

It provides a quarterly update from the responsible Executives and Board Committees, including any potential emerging risks on a new Watch List.

Contents

2. Future Considerations – Horizon Scanning and Watch List

2.1 An initial example of the Horizon Scanning information was made available as part of the initial preparation of the new BAF (see Annex 1). However, the Trust lacks the resource to maintain this centrally so each Committee will be charged with its own Horizon Scanning supported by executives.

2.2 The 'Summary Watch List' has been established (see later in this document). It is important that this is maintained as a forward-looking list, focussing only on significant future potential risks to the Trusts and/or Group strategic objectives over the next 3-5 years. Short-term or immediate Risks must be placed on the Corporate Risk register, unless they are an Issue, in which case they must be differentiated from Risks.

3. Recommendations

3.1 Each Committee of the Board is asked to

a. Review the evidence received to date relating to any BAF Group Risks for which they are the leading Board Committee.
b. Note any Corporate Risk Register Risks associated with the BAF Risk.
c. Recommend and confirm the Quarter end Risk Score assessment.

d. Escalate to the responsible Executive and the Group Board anywhere the current risk level matches or exceeds the Risk Tolerance score.
e. Consider any emerging potential risks included on or for inclusion on the summary 'Watch List' (see Annex 1).
f. Match future reports to the appropriate BAF Risk as either evidence (of control and/or assurance) or indicative of Negative Assurances and/or Gaps in Control.

Annex 1: Summary Watch List June 2025

ANZ Risk Scoring Matrix

What is the likelihood of occurrence?

Use the table below to ascertain how likely or how often the hazard is to occur.

LEVEL	DESCRIPTOR	DESCRIPTION
5	Almost certain	Likely to occur on many occasions; a persistent risk (daily).
4	Likely	Will probably occur, however not a persistent risk (weekly).
3	Possible	May occur occasionally (monthly).
2	Unlikely	Not expected to occur, however could given the right circumstances (annually).
1	Rare	Not expected to occur (yearly / years).

Assign a grade

Multiplying the consequence (1 to 5) with the likelihood of occurrence (1 to 5) will give you the grade, e.g. Consequence : Minor (2) x Likelihood : almost certain (5) = 10 Amber.

Assign severity

Use the colour-coded table below to plot the severity, e.g., 5x5 = Red, 3x3 = Amber, 1x1 = Green.

Impact	No injury. Unsatisfactory experience, not directly related to patient care. omplaint findings had potential to cause harm but was evented/not realised in this case. Complaint fully and easily resolved locally.	Unsatisfactory experience readily resolvable. ubstantiated complaint peripheral to clinical care eg. Minor staff attitude. Substantiated findings required extra observation, minor treatment, caused minimal harm. omplaint fully and easily resolved locally.	Substantiated complaint, lack of appropriate care/serious staff attitude problems Mismanagement of patient care, short term consequences ie a moderate increase in treatment which caused significant but not permanent harm. Refer matrix for moderate harm definition. Complaint readily resolved with additional actions.	bstantiated complaint. Mis- management of patient care – long term/permanent consequences. Single or multiple substantiated complaints with long term/permanent consequences. Loss of body part; long term disability etc refer to matrix harm efinitions. Complaint findings meets/ potential meets the serious incident criteria.	bstantiated complaint. Mis- management of patient care leading to or potentially leading to death refer to matrix harm efinitions. Complaint findings meets/ potential meets the serious incident criteria
Likelihood	1 - Insignificant	2 - Minor	3 - Moderate	4 – Major	5 - Catastrophic
5 -Almost Certain	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

Annex 1

Watch List - Summary potential new BAF risks June 2025

Headings/Issues/themes	Specifically?	Examples?
CAF/DPST – unable to meet requirements over 3 years	Revised CAF standards not currently met by either Trust	3-year plan to meet standards Potential issues with delivering to plans
Culture and behavioural changes	Identified requirements not met or achieved	Poor morale, unclear staff, poor leadership
Estates future utilisation and fitness for future purposes	Limited Capital access over next 2-3 years	RWT Maternity WHT Backlog maintenance
Equalities progress	Staff survey and other sources still indicating lack of equality	
Future National/regional Leadership & direction	10 year Plan Changes in Government	Changes to ICB's, NHSe and DH+.
Future Cyber threats	As yet unknown new methods/actors	Attacks on retail sector in 2025.
Future threats from development of AI	Potential threats if use is not carefully assessed and managed	Access to Co-pilot as part of NHS Microsoft contract.
Population needs	Diversity of deprivation as yet un-met	Potential mis-match with Community First
Public Health future	Role, function and resource subject to change	Potential future pandemics.
Technology resources and access – IT and other	Access to new technologies including clinical for patients Lack of exploitation of existing 'big data. opportunities	e.g. Clinical advances (incl robotics, stem-cell, wearable, nano, Genomics)
Senior leadership changes	Unexpected changes in senior leadership team	e.g. Chief People Officer
Transactional change plans – non-delivery	Planned changes are not achieved in timescales	e.g. increase in Community provided services
Transformational change plans – non-delivery	Planned changes are not achieved in timescales	e.g. non-delivery of unified/inter-communicating records systems
Unintended consequences	Planned changes have undesirable consequences not anticipated.	
Unknown unknowns and known unknowns	Future world and economic situation	
Wider structural changes	Changes to ICB's, NHSe and DH subject to delay/challenge	
Workforce instability	Key staff depart and cannot be replaced	e.g. impact on standards of services, corporate memory and continuity.

Key	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	
Risk Score 5x5 ANZ Matrix (including Risk Tolerance)	25													5	Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)
	25													5	
	20													5	
	20													5	
	16													4	
	16													4	
	15													4	
	15													4	
	12													3	
	12													3	
	10													3	
	10													3	
	9													2	
	9													2	
	8													2	
	8													2	
	6													1	
	5													1	
	4													1	
	<3													1	
	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	

Risk Tolerance level – maximum score (in this case [illegible]) tolerated. Above this, urgent action required.

Highest Risk Appetite rating by Board members (in this case 5 – seek)

Previous Risk score level at each Quarter end as assessed and agreed based on evidence & assurance at lead Board Committee

Current Risk Trajectory from initial untreated (in this case 5x5=25) to 2x5=10 by end Q12

Previous Risk Trajectory from initial untreated (in this case 5x5=25) to 2x5=10 by end Q12

Current Risk score level at each Quarter end as assessed and agreed based on evidence & assurance at lead Board Committee

Risk Appetite Statement Level (in this case 3 – Cautious)

Lowest Risk Appetite rating by Board members (in this case 2 – Minimal)

3-year timescale, Quarter by Quarter

GBR 1	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	F&P
Risk Score 5x5 ANZ Matrix (including Risk Tolerance)	25													5	Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)
	25													5	
	20													5	
	20													5	
	16													4	
	16													4	
	15													4	
	15													4	
	12													3	
	12													3	
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	9													2	
	9													2	
	8													2	
	8													2	
	6													1	
	5													1	
	4													1	
	<3													1	
	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	

GBR 2	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	F&P
Risk Score 5x5 ANZ Matrix (including Risk Tolerance)	25													5	Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)
	25													5	
	20													5	
	20													5	
	16													4	
	16													4	
	15													4	
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	9													2	
	8													2	
	8													2	
	6													1	
	5													1	
	4													1	
	<3													1	
	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	

GBR 3	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	F&P
Risk Score 5x5 ANZ Matrix (including Risk Tolerance)	25													5	Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)
	25													5	
	20													5	
	20													5	
	16													4	
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	6													1	
	5													1	
	4													1	
	<3													1	
	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	

GBR 4	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	PC
Risk Score 5x5 ANZ Matrix (including Risk Tolerance)	25													5	Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)
	25													5	
	20													5	
	20													5	
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	6													1	
	5													1	
	4													1	
	<3													1	
	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	

GBR 5	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	PTC
Risk Score 5x5 ANZ Matrix (including Risk Tolerance)	25													5	Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)
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	20													5	
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	4													1	
	<3													1	
	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	

Risk Appetite Matrix (Adapted GGI risk appetite matrix) to establish initial Risk Appetite Statements refinement RWT/WHT Group June 2025

Number	Risk Types	Risk Appetite Level	1 None / Averse *Avoidance of risk is a key organisational objective.*	2 Minimal *Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.*	3 Cautious *Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.*	4 Open *Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.*	5 Seek *Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).*	Risk Tolerance Score (L)x(C)=RT
0	**Strategy** Risks in pursuing current strategy/strategic direction **(Q2, Q14)**		Avoidance of risk is a key organisational objective.	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward. **GBR2**	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).	**3x5=15**
1	**Financial** How will we use our resources **(Q8)**		We have no appetite for decisions or actions that may result in financial loss.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor. **GBR1**	We will invest for the best possible return and accept the possibility of increased financial risk.	We will prioritise investment within the Trust at the priority of delegated budgetary Responsibility and will embrace the enhanced regulatory oversight that this will invariably bring (demonstrating VFM)	**4x5=20**
2	**Statutory Compliance and Regulation** How will we be perceived by our regulator? **(Q3, Q6)**		We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	**3x3=9**
3	**Quality – Safety** How will we deliver safe services? **(Q3, Q4, Q6)**		We have no appetite for decisions that may have an uncertain impact on safety.	We will avoid anything that may impact on safety unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on safety where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on safety with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on safety where there may be higher inherent risks but the potential for significant longer-term gains.	**3x4=12**
4	**Quality - Patient Experience** How we will ensure good patient experience **(Q3-Q6)**		We have no appetite for decisions that may have an uncertain impact on patient experience	We will avoid anything that may impact on patient experience unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on patient experience where there is a degree of inherent risk and the possibility of improved patient experience, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on patient experience with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on patient experience where there may be higher inherent risks but the potential for significant longer-term gains.	**4x4=16**
5	**Quality - Clinical Effectiveness** How we will ensure good clinical effectiveness **(Q4)**		We have no appetite for decisions that may have an uncertain impact on clinical effectiveness	We will avoid anything that may impact on clinical effectiveness unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on clinical effectiveness where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on clinical effectiveness with potential for longer-term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on clinical effectiveness where there may be higher inherent risks but the potential for significant longer-term gains.	**4x4=16**
6	**Reputational** How will we be perceived by the public and our partners? **(Q15)**		We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	**5x3=15**
7	**People** How will we be perceived by our staff? **(Q10)**		We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff. **GBR4**	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	**5x4=20**
8	**Infrastructure** **(Q7)**		We have a preference for avoidance of risk and uncertainty	We have a preference for ultra-safe delivery options that have a low degree of inherent risk and only have potential for limited reward	We have a preference for safe delivery options that have a moderate degree of inherent risk and may have limited potential for reward	We are willing to consider all potential delivery options and choose the ones most likely to result in successful delivery while also providing an acceptable level of reward. **GBR3**	We are eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk.	**3x4=12**
9	**Systems and Partnership working** **(including Commercial)** **(Q9, Q16)**		We have a preference for avoidance of risk and uncertainty	We have a preference for ultra-safe delivery options that have a low degree of inherent risk and only have potential for limited reward	We have a preference for safe delivery options that have a moderate degree of inherent risk and may have limited potential for reward	Willing to consider all potential delivery options and choose the ones most likely to result in successful delivery while also providing an acceptable level of reward	We are eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk. **GBR5**	**4x5=20**
10	**Technology, Information and Data & Security** **(Q11, Q12, Q13)**		We have a preference for avoidance of risk and uncertainty	We have a preference for ultra-safe delivery options that have a low degree of inherent risk and only have potential for limited reward	We have a preference for safe delivery options that have a moderate degree of inherent risk and may have limited potential for reward	We are willing to consider all potential delivery options and choose the ones most likely to result in successful delivery while also providing an acceptable level of reward	We are eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk.	**2x5=10**

‘New’ Board Assurance Frameworks (BAFs) – Review by Executive October 2025

Group BAF Risks

Group BAF Risk Number	If	then	Resulting in	Draft Scores, Risk Appetite, Risk Tolerance	Lead Executive	Lead Committee Associated Committee(s)	Controls	Assurances	Negative Assurances	Gaps In control
GBR 1	**If** the Trusts in the Group are individually and collectively unable to achieve financial break-even by year end 2027/28	**then** the Trusts and the system will be non-compliant with NHSE/DH+ NHS Provider License requirements	**resulting in** special measures regime imposition and reputational damage and vulnerability as non-financially viable organisations.	Review undertaken 7 October 25 No change to scores, risk appetite or risk tolerance Initial – 5 likelihood x 4 consequence =20 Current – 4 likelihood x 4 consequence =16 Target – 2 likelihood x 4 consequence = 8 Risk Tolerance 4x5=20 Risk Appetite 2-4 (0, 1, 2, 6, 9) Primary RA Statement 1 – 3	GCFO (KS)	F&PC October 2025	Reporting on Plan at each meeting. Control measures remain in place for temporary manpower, vacancy review panels. Non-pay/discretionary spend controls continue in place. Training in budget management – adherence to Monthly budget @ both. New financial system implemented. Step-up in CiP from UoR Plan WiP esp Clinical productivity. Awaiting Workforce Plan for CEO to approve to initiate MoC.* Turnaround director to support delivery of financial plan but too early to tell yet. Delivery actions for the FRP– submission to November 25 board.	Draft Head of IA and EA opinions give significant assurances. Increase in Theatre productivity in IQPR. CFS Prosecutions – follow-through on Fraud – culture change. New financial system approved now live. Increased controls now part of BAU. Adherence to Month 6 budget @ both BCPC – Specified Bank, Recruitment, R&D, Communications – services improvements – not necessarily headcount or CiP. JPC report to Board.	Strike action and pay awards Termination costs funding Severance costs ICS - not paying for ERF over activity plan.	Not a fully identified CIP plan. Questions re phasing of CIP & Workforce reduction A proportion of the CIP plan relies non-recurring projects.

Group BAF Risk Number	If	then	Resulting in	Draft Scores, Risk Appetite, Risk Tolerance	Lead Executive	Lead Committee Associated Committee(s)	Controls	Assurances	Negative Assurances	Gaps In control
GBR 2	**If** the Trusts in the Group are individually and collectively unable to recover and meet future access (constitutional) standards over the next 3-5 years (e.g. RTT)	**then** the Trusts individually and/or collectively will be non-compliant with future contract requirements	**resulting in** special measures regime imposition and reputational damage and vulnerability as non-financially viable organisations.	Reviewed AG 20/10/2025 Confirmed no changes. Consequence = 4 Initial – 5 likelihood x 4 consequence Current – 3 likelihood x 4 consequence: 12 Target – 1 likelihood x 4 consequence = 4	MD's (GN, AG)	F&PC October 2025	IQPR pack to F&PC monthly. RTT trajectories (IQPR) went to Board, monitoring through Performance pack & at Board. Additional metrics regularly reported to the Recovery Meeting. Internal Audit resulting follow-up appointments, reduction in DNA rates evidenced (WHT). Use of resources aims for maintenance of 8% DNA across 'group'. Validation sprint exercise for Outpatients to reduce waiting times at RWT. ERF activity reported to F&P and Board. RTT fortnightly national reporting with figures improving.	Level 3 external: Moved from tier 1 to tier 2 for RTT performance. IQPR pack to F&P and Trust Board. Both trusts in segment 3.	Growth in back-log for follow up not covered by RTT standard e.g. monitoring as part of condition, or treatment as follow up to known or suspected cancer - WHT. Community waits lists not subject to RTT monitoring. Potential impact resulting in reduced activity related to EPR implementation (RWT).	Group Level of funded activity to meet required national RTT standards is insufficient. – Achieving RTT requires confirmation of sufficient ERF. (CRR) Changes in referral practices from Sandwell for emergency care increasing at WHT.

Group BAF Risk Number	If	then	Resulting in	Draft Scores, Risk Appetite, Risk Tolerance	Lead Executive	Lead Committee Associated Committee(s)	Controls	Assurances	Negative Assurances	Gaps In control
GBR 3	**If** the Group Trusts are unable to optimise the Group Structure (from the Corporate Services Review) (including potential use of a Subsidiary vehicle) including the scale of efficiencies and cost-reduction required whilst maintaining or improving standards and performance	**then** the Trusts/Group would be unable to meet its future Corporate governance needs, financial and staff reduction requirements	**resulting in** inability to achieve financial recovery, special measures regime imposition, reputational damage and vulnerability as non-financially viable organisations.	Review 15/10/25 Initial – 4 likelihood x 4 consequence = 16 Current – 3 likelihood x 4 consequence = 12 Target – 1 likelihood x 4 consequence = 4 Risk Tolerance 3x4=12 Risk Appetite 2-5 (0, 1, 7, 8, 10) Primary RA Statement 8 – 4	GCSO (Si E)	F&PC October 25	Deloitte work with individual executives in May/June. Outputs of Deloitte to PC (Headcount) and Use of resources (at F&PC) based on Workforce figures. ToR for Use of Resources Group - formal reporting to GMC Regular meetings with GCEO occur. Monthly BCPC CSTP board discussions. Plan in place for delivering the corporate services ‘to be’ structure.	Use of resources update report includes CIP Programme and position. Minutes from April 25 – Deloitte Impact update including Corporate Services review work. Use of resources/CIP Update (KS) – includes elements of CIP programme. Progress of UoResources at function level. Reported to F&P committee. Corporate Service programme progress covered by GCPO at Board BCPC – Specified Bank, Recruitment, R&D, Communications – services improvements – not necessarily headcount or CiP. CEO met SRO for BCPC, agreed to progress collaborative bank and recruitment team across the system. JPC report to Board Commissioned Bain to complete a diagnostic assessment of the options across all 4 trusts. All corporate services have completed their proposed structures based on group model.		Funding still to be identified to deliver final ‘to be’ structure across corporate services.

Group BAF Risk Number	If	then	Resulting in	Draft Scores, Risk Appetite, Risk Tolerance	Lead Executive	Lead Committee Associated Committee(s)	Controls	Assurances	Negative Assurances	Gaps In control
GBR 4	**If** the Trusts/Group workforce transformation plan (reduced staffing, use of new technology, culture & behaviour) is not achieved	**then** there may be a disconnect between the corporate aspirations, targets and requirements	**resulting in** an increasingly disengaged and disenfranchised workforce (staff survey) (and regulatory expectations/requirements e.g. CQC safe staffing) that slows, halts or reverses the transformation programme including greater efficiencies and service change. ? financial impact? To be discussed at the next People Committee.	Review undertaken 6/10/25 Initial – 5 likelihood x 4 consequence = 20 Current – 4 likelihood x 4 consequence = 16 Target – 2 likelihood x 4 consequence = 8	GCPO (AD)	PC October 2025	Sickness Absence Reduction Plan Yr 2 People Strategy evidence Freedom to Speak up Service Equality Impact Assessment Process in Place Vacancy / Recruitment review panels. Workforce trajectory plan to PC on a monthly basis.	Sickness absence measurement Measurement of performance against Strategy Freedom to Speak Up Annual Report provided to Board and People Committee Cultural conversations taking place with staff and Chief Officers. Performance against plan Staff Survey feedback	Divisional workstreams to support the workforce plan are not fully developed – unidentified workforce CIP Workforce reduction plan – linked to the financial recovery plan, outputs currently unknown.	E-rostering implementation. Clear-note/Heidi systems – O.P. transformation group Stroke plan for shift from Hospital to Community Not at a Group level, but some at service/directorate Awaiting clinical service strategy and Digital Programme strategy defining the future workforce requirements. Equality Impact Assessment for workforce transformation in progress Cultural conversations to be formalised – mechanism to be agreed.

Group BAF Risk Number	If	then	Resulting in	Draft Scores, Risk Appetite, Risk Tolerance	Lead Executive	Lead Committee Associated Committee(s)	Controls	Assurances	Negative Assurances	Gaps In control
GBR 5	**If** the Trusts/Group clinical service transformation plan is unable to achieve its aims and objectives &/or maintain or improve quality & safety	**then** quality and safety standards may fall and/or become compromised	**resulting in** increased claims, low staff morale (staff survey), declining reputation (F&FT) and increased scrutiny/inspection and/or declining ratings (CQC et al).	Review 25/1025 Initial – 5 likelihood x 4 consequence = 20 Current – 3 likelihood x 4 consequence = 12 Target – 2 likelihood x 4 consequence Risk Tolerance 4x5=20 Risk Appetite 3-5 (0, 2, 3, 4, 5, 7, 10)	GCSO (Si E)	P&TC October 2025	Plan to Board. Monthly updates to P&TC. New Clinical Strategy. Agreement reched at on Exec awayday in August 25 on community first programme. Presentation delivered at the Board development session in September 25. Commissioned external support through PA consulting to deliver the community first transformation plan 26/27. Business case approval from ICB and NHSE to proceed with PA Consultancy (community first programme).	Deloitte contract – increased controls impact. Routine reporting to partnerships committee on the community first proposal. PA Consulting commenced work on 1/10/2025, workshops held at WHT 12/10/25 and RWT 16/10/25. Detailed project proposals developed for all themes within the transformation plan.	10-year Plan impact. Changing NHS Operating Model post-ICB and ACO.	

Tier 1 - Paper ref:	Enc 11.1

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 of Place Development & Transformation, Walsall Together; Matthew Wood, Head of the Programme and Transformation Office, OneWolverhampton
Meeting title:	Group Trust Board
Date:	18th November 2025

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

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

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 – September and October 2025
Walsall Together Partnership Board – September and October 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 or equivalent models

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*
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		

Group Chief Community and Partnerships Officer Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 18th November 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 neighbourhood health plans and responding to the recently published Medium Term Planning Guidance.

Walsall Together is one of sites leading neighbourhood health development as part of the National Neighbourhood Health Implementation Programme (NNHIP). OneWolverhampton is part of the National Frailty Collaborative.

2. National Guidance and Policy

2.1.1 Additional national policy and guidance around neighbourhoods is starting to be published with more expected in the coming weeks.

2.2 Medium term planning guidance

2.2.1 Planning guidance has been released, which includes a section on neighbourhood health. There is a clear focus on improving GP access, avoiding non elective admissions and remodelling outpatients. The guidance is driving scale and pace, asserting the need for transformation to include all neighbourhoods, deconstructing the block contract for UEC to allow ICBs to invest into neighbourhood health. It is essential that we can prove neighbourhood effectiveness in the hospital to community shift.

2.2.2 As part of this, the Birmingham, Black Country & Solihull ICB is part of the financial flows national workstream, starting with high priority segments where there will be the biggest impacts on hospital activity.

2.3 Model Neighbourhood Framework

2.3.1 A model neighbourhood framework will be published in the coming weeks and is expected to provide guidance on the foundations that need to be in place to enable neighbourhood

health (including but not limited to neighbourhood footprint, good access to high quality general practice, implement recommendations from Right To Choose, out-of-hospital UEC plan/capacities, put neighbourhood teams on a contractual footing, agree specialities for OPD remodelling) before supporting the broader ambition. It is clear that there will not be additional investment and systems will need to find seed funding from within their allocations through freeing up resources from non-elective admissions to grow neighbourhood teams.

2.4 **Contracts**

2.4.1 The government have confirmed their commitment to GMS and the independent contractor model. Discussions are starting with the GPC for April 26 onwards, with a commitment to longer term reform of contracts. Reform of the funding formula will take a couple of years and needs to align with neighbourhoods. Single and Multi-Neighbourhood Provider contracts may be an alternative to the existing Primary Care Networks, with work progressing to identify what activity would fall outside of core general practice (GMS).

2.4.2 An Integrated Health Organisation will be a contract mechanism to drive co-ordination of care and resource allocation, delivering on outcomes set by ICBs. IHOs will work with MNPs and SNPs as well as wider system partners, ensuring resources are distributed and supporting collaboration in service delivery. A draft Foundation Trust framework will be published in November; model system architype will be published in the next few weeks followed by more technical guidance by the end of the year.

2.5 **Neighbourhood Health Plans (NHPs)**

2.5.1 Neighbourhood Health Plans should be produced under the authority of Health & Well Being Boards in advance of April 2026. The content will mirror the national model neighbourhood, reflecting the wider partnership perspective. It will encompass NHS, local government and wider partnerships including VCSE. The structure should be in two parts: a strategic element led by the HWBB; and an operational element led by providers. Until there is a reform bill to enact the formal requirement for NHPs to be part of the HWBB remit, systems are advised to use existing JSNAs and Health & Well Being strategies with the NHP added as an addendum.

3. OneWolverhampton Update

3.1 Integrated Neighbourhood Teams (INTs): Development and October Workshop

3.1.1 In October, a workshop brought together partners from the North, East, South and West neighbourhoods including all GP practices. This marks a key shift in shaping care delivery around the agreed neighbourhood geographies and away from the existing, non-co-terminus PCN footprints. The session focused on applying a population health management (PHM) approach—using local data to identify risk cohorts, understand neighbourhood needs, and begin shaping each area's vision for integrated delivery. The OneWolverhampton partnership should be commended on the four neighbourhood team model that has been created in Wolverhampton when PCNs are not on geographical footprints.

3.1.2 Extensive public engagement has been undertaken to ensure residents' views are central to the developing neighbourhoods. Initial feedback has highlighted challenges around social isolation, access to services (including digital and language barriers), mental health, and fear of rising inequalities.

3.1.3 To support the development of the four neighbourhoods, one INT Clinical Lead (GP) will be appointed for each neighbourhood for a period of 12 months whilst the model is embedded, with these roles currently being advertised through expressions of interest. The Clinical Leads will help develop the neighbourhood health team model including defining local MDT processes, ensure clinical governance, and link neighbourhood priorities with wider system objectives.

3.1.4 The Wolverhampton mobilisation team continues to work closely with Walsall Together, ensuring that learning from the National Neighbourhood Health Implementation Programme is shared across the Group.

3.2 **Frailty: National Collaborative and Local Strategy**

3.2.1 There is a significant proportion of the city's residents living with frailty - approximately 44,000 individuals. Of these, 5,280 experience moderate frailty and 1,320 experience severe frailty. Frailty remains a significant driver of hospital use. The estimated annual cost of hospital interactions for residents living with frailty is £46.5 million, with the average cost per patient ranging from £5,200 to £9,800. These programmes of work will seek to shift frailty activity away from the acute setting, focusing on reducing length of stay through the frailty collaborative, and embedding a prevent, reduce, delay approach in the community to reduce escalating need.

3.2.2 In line with national expectations, Wolverhampton is trialling two elements of the National Frailty Collaborative:

- **Bundle 3 – Hospital Discharge (Home First)**
  - Focuses on ensuring that individuals who need or may need support receive assessment at home where possible and that discharge planning defaults to home-based care.
- **Bundle 6 – Acute Hospital (Front Door Frailty)**
  - Strengthens early identification of frailty at the hospital front door, supports the use of Comprehensive Geriatric Assessment (CGA), and aims to reduce hospital-acquired complications and unnecessary admissions.

3.2.3 Metrics for the national programme are currently being agreed. These will then be baselined and shared in this report on an ongoing basis.

3.2.4 While the national programme focuses largely on acute pathways, OneWolverhampton's strategy seeks to shift activity further upstream. We are developing a city-wide frailty strategy that will support an approach grounded in prevent, reduce, and delay principles. This includes exploration of a frailty hub (based on the Jean Bishop model) and expansion of

the existing proactive frailty clinics to include wider partners. 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.

3.3 Home First and Community First

3.3.1 Work continues with the delivery partner for the Trust Community First programme. A joint workplan has been agreed with the Place-Based Home First Working Group, ensuring coordinated activity across local partners.

3.3.2 Home First will focus on areas requiring place-level partnership and collaboration, while Community First supports changes more closely linked to internal operational delivery. This ensures that Home First operates in a complementary capacity to the Community First programmes and minimises the risk of duplication.

Home First	Community First (next 6 months)
Redeveloping Transfer of Care (TOC) paperwork to focus on 'describe not prescribe' Expected impact: Reduction in LoS; reduction in the over-prescription of ongoing care; reduction in delayed discharges; improved system flow; reduced costs associated with ongoing post-hospital care	Strengthening Same Day Emergency Care (SDEC) utilisation
Assessing compliance with national discharge pathways and developing a local framework Expected impact: Reduction in LoS; improved system flow	Expanding Virtual Wards (VW) to support admission avoidance and early discharge
Reviewing intermediate care pathways to reduce the duplication of services and ensure these are commissioned sustainably using the Better Care Fund to support innovation Expected impact: Reduction in LoS; reduction in admissions	Hospital-based frailty initiatives
Delivering the national frailty collaborative Expected impact: Reduction in LoS for those living with frailty; increase in community-based care; reduction in unplanned hospital attendance and admissions for those living with frailty	
Trialling an enhanced community nursing offer at Bradley Resource Centre to support a community-based offer and reduce risk of conveyancing or readmission. Expected Impact: Reduction in unplanned hospital attendances or admissions	

4. Walsall Together Update

4.1 Walsall Together Partnership Board

4.1.1 The Walsall Together Partnership Board is a sub-committee of Walsall Healthcare Trust Board. The following items were discussed in the committee meetings during September and October.

4.1.2 Each meeting begins with a user or staff story to allow Board members to: actively listen to the real experiences of Walsall citizens; to learn how problems in care provision affect and impact upon people; and to maintain a focus on continually improving safety and experience. These stories have focussed on creative health and social prescribing during September and October respectively.

4.1.3 Monthly integrated commissioning and transformation highlights have focussed on

- priorities for Neighbourhood Teams
- investment and future proofing across Intermediate Care
- establishing a pilot for complex geriatric assessment clinics in the North neighbourhood team
- scoping work to improve outcomes for people with complex care needs, initially focussing on people with learning difficulties or autism
- agreement to develop a VCFSE Brokerage Framework across the ICB, Black Country Healthcare and Walsall Council
- initiation of co-design of Local Care Networks with Team Walsall, the local membership group for VCFSE organisations
- continued participation in NHS Confederation's national project on weight management, with the local team starting to develop a vision for integrated services in Walsall, brining together the current provision across tiers 1, 2 and 3, aligned to a neighbourhood model

4.1.4 Partners received an overview of the Walsall Financial Inclusion Strategy, developed by the We Are Walsall 2040 partnership. Partners were invited to comment and also support the action planning process.

4.1.5 Partners were informed of the appointment of Dimitri Wade to the NHS Trust Chief Operating Officer. The role will be a member of the committee.

4.1.6 Around 26,000 people of all ages in Walsall identify as carers and a lot more people provide informal care to friends and relatives. A group has been established to work on 3 areas where the partnership could add value: recognition of carers; communicating across organisations; and maximising support around health and wellbeing.

4.1.7 The Board receives a monthly assurance report on the partnership risk register, which is hosted within the Trust's risk management system. Financial constraints, sustainability and the impact of national reforms are themes across the risk register.

4.1.8 The Board has approved monthly communications briefs for sharing across partner organisations.

4.1.9 In October, partners welcomed Dannielle Oum to the committee, following her appointment to the role of Chair of the Birmingham, Black Country and Solihull ICB cluster. Ms Oum referenced 3 key areas of ICB focus for the transition period which are to deliver against this year's financial and operational objectives, work towards a safe transition of various

functions from ICB to providers and to lay the foundations to becoming a strategic commissioner.

4.2 **Walsall Together Programme Highlights**

4.2.1 **Neighbourhood Teams**: Walsall Together is one of 43 places to form part of the National Neighbourhood Health Implementation Programme (NNHIP). The programme has outlined 9 "primary drivers" for neighbourhood health including multi-organisational leadership, co-design with communities and practitioners, devolving and pooling budgets, empowering teams, and a relentless focus on outcomes. Key outcomes expected are:

- Increase in patient-reported outcomes (PROMs) and patient-reported measures (PREMs)
- Increase in people's activation (confidence, skills, knowledge) to manage their long-term conditions
- Improvement in staff experience
- Reduction in outpatient activity
- Reduction in unplanned hospital admissions and length of stay

Walsall has 7 Neighbourhood Teams, aligned to Primary Care Networks and geographically aligned to community services, primary care mental health, social care and VCSE infrastructure organisations. All 7 teams are meeting monthly, including representatives from key partner organisations and are prioritising the identification of a target cohort based on population health data and insights. The target cohort will support a shift in activity from hospital to community, establishing formal multi-disciplinary team meetings in the first instance, whilst contributing to the design of wider integrated working in line with the national models and guidance. The high-level cohorts will include frailty and adults and children with complex needs.

A team of 18 people representing the partnership and neighbourhood delivery attended a regional workshop alongside other participants within the Midlands and East of England regions. The day was a good opportunity to hear from other areas leading on different elements of implementing neighbourhood health (Walsall were asked to present on leadership) and the different models that are developing. The day included presentations to other areas in their Cohort (Coventry and North East Essex) and receive feedback. It was also an opportunity to the Walsall team to spend some time reflecting on what they had heard from across the country. Two more regional workshops will be delivered alongside a national community of practice that meets virtually on a regular basis.

4.2.2 Intermediate Care: following approval of the in-year investment case from commissioners for the intermediate care service (ICS), recruitment is in progress. The additional staffing will reduce the current wait time for therapy assessment from 21 days to 72 hours, also reducing the overall length of stay within the service from an average of 35 days to 27 days. The invest-to-save initiative is expected to reduce the forecast overspend on the Better Care Fund budget for 2025/26 from £892k to £558k. Additional savings are anticipated from reductions in length of stay, including lower care package costs and long-term care expenses within Adult Social Care. Also, the implementation of a falls service should help to reduce demand

into ICS. However, these savings cannot be reliably quantified at this stage. A steering group has been established to identify further financial mitigations including the development of a dedicated bedded rehabilitation unit. The Place Integrated Commissioning Committee is also expected to make a decision in November on the permanent recruitment of ICS staff, ready for April 2026.

4.2.3 **Feel Good Fridays**: Feel Good Friday Clinics commenced on 17th October, providing multidisciplinary support for older adults living with severe frailty, those at risk of falls, and individuals managing long-term conditions. The service provides complex geriatric assessment, using a multi-disciplinary team, as a pilot on behalf of the North Neighbourhood Team. A total of 11 people have been supported, each meeting with a GP, Pharmacist, Occupational Therapist, and Social Prescribers during their visit. Each participant leaves with a comprehensive care plan and a 'Golden Ticket' – direct contact details for the Care Navigation Centre and guidance on what to do if they have future concerns. Early feedback has been overwhelmingly positive, with service users and carers reporting that they feel valued, listened to, and more confident in managing their care. Many have also appreciated having an alternative to GP or ED visits, as well as the opportunity for social interaction and community activities at the Stan Ball Centre where the clinics are held. A full evaluation to assess outcomes and impact is in progress, with data being collected alongside the provision of the pilot service. Recruitment is currently underway for a Physiotherapist to join the multidisciplinary team and provide additional provision for falls prevention and mobility support.

4.2.4 **Neighbourhood Population Health Workshop:** In October, a face to face workshop brought together partners from across all of the neighbourhood teams including all GP practices. The session focused on applying a population health management (PHM) approach—using local data to identify risk cohorts, understand neighbourhood needs, and begin shaping each area's vision for integrated delivery. The workshop was attended by the Walsall coach from the National Neighbourhood Health Implementation Programme.

5. Recommendations

5.1 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.

Tier 1 - Paper ref:	Enc 11.2

Report title:	Outline Planning Framework - Group Planning Approach
Sponsoring executive:	Simon Evans, Group Deputy Chief Executive & Chief Strategy Officer
Report author:	Tim Shayes, Deputy Chief Strategy Officer
Meeting title:	Group Trust Board held in Public
Date:	18th November 2025

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

The attached paper sets out the proposed approach of the Group to the development and submission of our plan for the next three years. The recently published Planning Framework from NHS England sets out a requirement for three-year numerical plans (covering activity, performance, workforce and finance), in addition to a five-year narrative plan detailing our longer-term strategy. A first draft of the numerical submissions is due on 17th December 25, followed by the narrative submission (and updated numerical submissions) in early February 26 (date to be confirmed).

The planning process has already commenced within the group with Divisions developing their operational plans for presentation plans back to the executive team in late November. Simultaneously, the Planning Oversight Group are modelling the impact of our transformation plan to overlay to these operational plans. It is envisaged that the annual 2% productivity improvement will be delivered through operational productivity in the short term before transformation initiatives such as digital, community first etc. deliver the requirement in the mid-longer term.

The Board Development Session of 16th December and Board meeting of 20th January provide the opportunity for sign off of the submissions, in addition to regular updates through the Committee structure.

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 and approve the planning approach proposed

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: N/A		
Is Equality Impact Assessment required if so, add date: N/A		

Group Planning Approach – 2026/27 and beyond

Introduction

The Medium-Term Planning Framework (Delivering Change Together 2026/27-2028/29) was published on Friday 24th October. As expected, the framework focuses on a move away from shorter term, operational planning to longer term, strategic planning. To this end, Providers are required to submit:

- Three-year, numerical plans covering finance (both revenue and capital, activity, performance and workforce) – due 17th December 2025
- Five-year narrative plans alongside updated numerical plans – due February 2026 (exact date TBC).

This paper outlines a summary of the guidance alongside the planning approach being adopted by the Group.

Overview of Guidance

A very high-level summary of the framework is as follows:

Area	Key Points
Finance	• 3 per cent real terms increase in revenue and 3.2 per cent in capital funding • ICB and providers to deliver financial balance in each year by 2029 • New UEC payment model and best practice tariffs • Zero bank and agency spend by 2029/30
New Operating Model	• Regions oversee performance and responsible for grip and support for systems • ICBs act as strategic commissioners, focusing on prevention and value • Provider responsible for delivery with embedded collaboration, quality and productivity with earned freedoms
Workforce and Leadership	• Renewed commitment to staff wellbeing and anti-discrimination • Establishment of a Colleague of Executive and Clinical Leadership (2026/27) • Leadership and Management Framework with standards, training and 360-degree feedback
Productivity	• Boost productivity by cutting inpatient stays, improving theatre usage and returning to pre-covid activity levels (2019/20) • Go digital – move to digital by default approach across all services • Track performance – publish trust level productivity metrics to reduce variation
Key Targets	• 92% of patients to be treated within 19 weeks by 2028/29 – 7% improvement in 2026/27 • UEC – 82% 4-hour A&E performance by March 2027 and national 85% by 2028/29 • Primary/Community – 90% of urgent patients seen same day
Transformation	• Neighbourhood health – reducing hospital admissions and improving access • Prevention – tackling obesity, CVD, smoking and antibiotic misuse a priority • Digital – 95% digital appointments (2028/29), NHS Online Hospital in 2027 • Quality – modern service frameworks for CVD, mental illness, sepsis, dementia and frailty

Appendix 1 details the specific requirements of the Planning Framework which the Groups planning submission will need to address.

Planning Approach

Both planning submissions made by the group will encompass both the shorter-term operational plans and the longer-term strategic plans of the group. Mirroring the national expectation, the Groups plan is anticipated to deliver the annual 2% productivity requirement in the early years through operational productivity before longer term strategic initiatives such as community first, deliver this requirement in later years.

This plan will be developed in three phases, the first two running alongside each other:

- Phase 1 – Development of divisional operational plans, led by the Divisional Management Teams with support from the Group Planning Oversight Group. Unlike in previous years, these plans will cover a three-year period as opposed to one.
- Phase 2 – Modelling of longer-term strategic initiatives such as Community First, CDC etc, led by the Group Planning Oversight Group, to overlay to divisional operational plans.
- Phase 3 – Collation of the above into a plan that demonstrates delivery of the planning ambitions.

A similar approach to last year is being followed for the development of plans in Phase 1. Divisions have been allocated an overall budget but with the discretion to utilise this as they see fit, albeit within given parameters. Key operational requirements, for example CIP, RTT achievement etc. have been prescribed with delivery of all key national ambitions assumed. In addition, Divisions have been asked to identify digital initiatives to further support the productivity ask and these will prioritised corporately and modelled within the first planning submission.

Individual directorate planning meetings are taking place in early November to develop plans at specialty level. Divisional sign off meetings with the executive team are then scheduled for late November where each Division will present their financial (including CIP), workforce, activity and performance plans. Between now and the end of November, the Group Planning Oversight Group will support the Divisions in ensuring that plans produced are credible and triangulate across finance, workforce and activity/performance.

In tandem to the above, the Group Planning Oversight Group will lead on Phase 2. This will involve working with the relevant stakeholders to confirm the impact of the transformation plan, e.g. Community First, Digital Transformation etc. on all the aspects of the plan, e.g. workforce, finance and activity/performance. The expected outputs of this phase, are:

- Scenario modelling for different levels of funding
- Community First modelling
- CDC Assumptions
- Agreement over Elective Hub use and projected demand
- Outpatient transformation modelling and impact
- Digital transformation opportunities – financial and workforce impact

This impact will then be overlaid to the Divisional Operational Plans in Phase 1 which won't be expected to include this impact.

On completion of Phases 1 and 2, the Group Oversight Planning Group will then complete final due diligence of the plan prior to submission. Progress against the development of the plan will be reported to the Finance and Productivity Committee on 25th November ahead of sign off of the first submission at the Board Development Session taking place on the 16th of December.

A second Divisional sign off meeting round is proposed for January, prior to the updated submission to NHS England in February. This will provide an opportunity for Divisions to develop plans further from the meeting in late November and for any outstanding issues to be resolved.

The Board meeting of 20th January provides the opportunity for final sign off of the plan.
The timeline in Appendix 2 the end of the paper summaries the process above.

Enabling Actions

To support the process above, several enabling actions need to be taken. These include:

- Setting of budgets and agreement of principles

It is suggested that the Group reverts to roll over budgets as opposed to budgeting on FOT. The benefits of this include not rewarding current overspending and historic areas of underfunding are resolved. This would include rolling over any unidentified CIP from 2025/26, however. Divisions would continue to have an 'envelope' which they can allocate within albeit with parameters such as no overall WTE increase as an example. In addition to the rolled over CIP from 2025/26, the budget would also include the additional CIP target for 2026/27.
If the principles above are agreed, actual budgets can be developed for executive sign off prior to circulation to Divisions.

- Modelling of performance improvement impact

Although is it is acknowledged that each Trust will each have different performance issues, a consistent approach will be used to model the impact of the RTT improvement standard and the translation of this into activity and finance.

Risks and Assumptions

NHS England have advised that there is still further information to follow to support the plan submissions. Given the Group cannot afford to wait for this information, several assumptions are having to be made. Some of the most significant are as follows:

- Funding – the Group is having to make an assumption regarding the level of funding it will receive throughout the planning horizon. Whilst NHS England have advised that the National Deficit Support Funding will be reduced throughout the planning horizon, the detail of this has not been confirmed.
- It is unlikely that plans will be developed by the December submission to fully address all elements of the plan, e.g. a fully developed CIP scheme, and therefore it is anticipated that some assumptions will need to be made around delivery.

Governance

A Group Planning Oversight Group has been established to lead on the development of plans and oversee progress. The group comprises the Deputy Chief Strategy Officer – Planning (Chair), Directors of Finance, Chief Operating Officers and People Directors and meets weekly. The group will report to the executive meetings weekly who in turn report to Trust Boards via Group Management Committee.

Whilst this paper focuses on the governance ahead of the plan submission, the key performance indicators within the plan will be embedded within day-to-day reporting and delivery will be monitored through DPRs and committee papers.

Recommendations

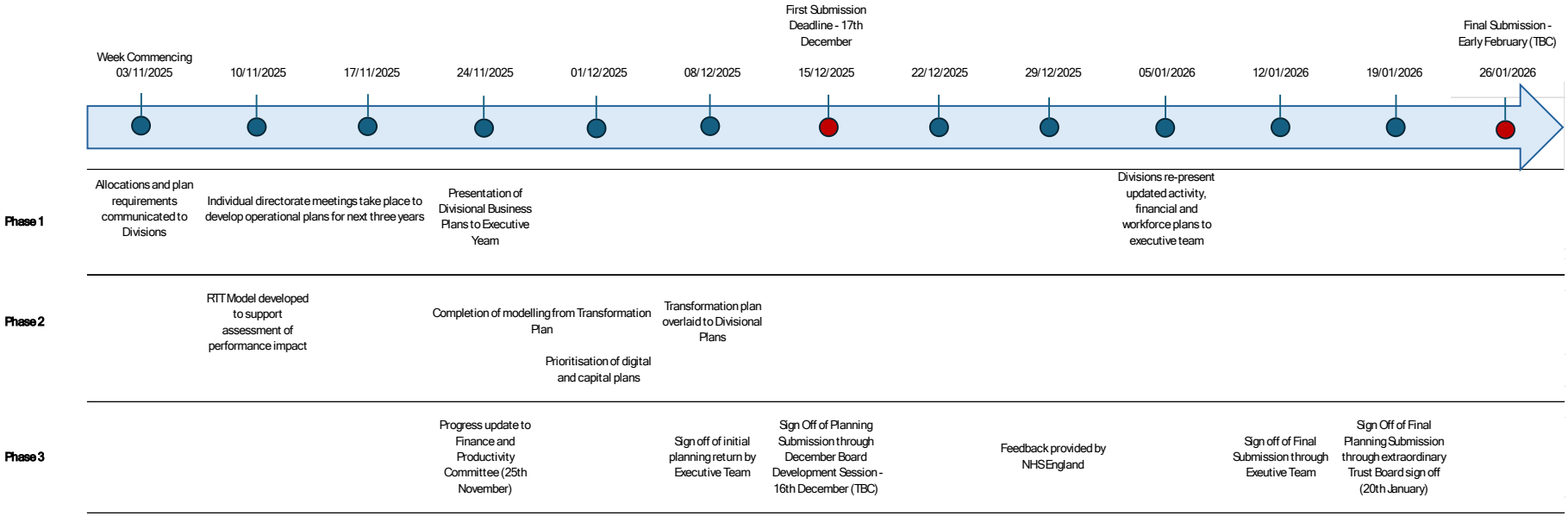
Note and approve the planning approach proposed.

Appendices - Appendix 1 - Checklist of planning requirements

Planning Submission Checklist			
		RWT	WHT
KPI Achievement	Achieve minimum 7% improvement or 65% RTT 18 week by 2026/27 with trajectory to at least 92% of patients are waiting no more than 18 weeks for treatment by 2028/29		
	Year-on year increase in ED patients admitted, discharged or transferred within 12 hours		
	Maintain or improve 4-hour ED performance to 82% by 2026/27. Rise to national average 85% target by 2028/29.		
	Utilise paediatric assessment units to improve ED paediatric performance to 95% seen within four hours.		
	Demonstrate prioritisation of diagnostics (including CDC) and treatment capacity for urgent suspected cancer pathways.		
	Maintain 28-day Faster diagnosis standard of 80%		
	Increase 31 -day standard performance to 94% by March 2027 and 96% by 2028/29		
	Increase 62-day standard performance to 80% by 2026/27 and 85% by 2028/29		
	Every system to deliver a minimum 3% improvement in performance or performance of 20% or better, whichever level is better (to achieve national performance of max 14% patients waiting over 6 weeks by 2026/27. Shifting to no more than 1% of patients waiting over 6 weeks for a test by 2028/29.		
	There should be a move to all referrals going via advice and guidance for 10 specialities at provider level - supported through strategic commissioning for 2026/27.		
	All trusts are expected to achieve reductions in waiting list sizes during 2026/27		
Outpatient Transformation	Reduce the number of routine procedures of low clinical value follow-up appointments		
	Standardise clinic templates in line with GIRFT's specialty-level good practice and job planning guides		
	Expand "straight to test" pathways and one-stop clinics where clinically appropriate, starting with the 10 largest specialties by volume and expanding to all clinically appropriate specialties by March 2029.		
	Give patients greater access to PIFU, remote consultations and digital monitoring, leading to a sustained reduction in unnecessary OPFU activity		
	Providers must model the level of OPFU opportunity v reduction required locally to accelerate delivery of RTT and long-wait recover objectives and develop plans aligned to the scale of change required		
Primary Care and Community Services	Achieve 78% of community health service activity within 18 weeks by 2026/27. Target increases to 80% by 2029 plus the elimination 52 week waits		
	Improve productivity using digital tools, point-of-care testing,- standardise core service provision, and expand use of digital therapeutics such as for MSK treament.		
	Increase community health service capacity to match expected demand growth of 3% each year		
	Ensure 90% of clinically urgent patients are seen on the same day.		
Children and Young People	Systems and providers should have targeted actions to increase activity and improve performance for CYP, including ringfenced CYP capacity using existing NHS estate; Running regular dedicated paediatric surgery days ineither a day surgery or hub setting.		
Neighbourhood Health	Neighbourhood Health Teams should improve GP access and reduce unwarranted variation, reducing unnecessary non-elective admissions and bed days from priority cohorts and shifting planned specialised care closer to home. High-functioning systems can go further, setting up integrated teams for other cohorts. From April 2026, ICBs and relevant NHS providers should: • identify GP practices where demand is above capacity and create a plan to help decompress or support to improve access and reduce unwarranted variation • ensure an understanding of current and projected total service utilisation and costs for high priority cohorts of frail and elderly • create an overall plan to more effectively manage the needs of these high priority cohorts and significantly reduce avoidable unplanned admissions • plans should be consisted with national standards for urgent community response service • plans should also include establishing integrated neighbourhood teams, working with local authorities and starting in areas of highest need.		
Financial and Capital Plans	All ICBs and trusts are expected to deliver a balanced or surplus financial position in all years of the planning period.		
	Plans should include details of: • Delivery of 2% annual productivity ambition • Break-even financial position without deficit support funding by end of planning timeline. • Where DSF is in place, non -DSF financial positions should be reported transparently to boards		

Planning Submission Checklist			
		RWT	WHT
Digital and Innovation	Services should demonstrate shift to digital-first - including expanding A&G, remote consultations and digital monitoring.		
	Trusts must submit their digital strategy, outlining how they will meet national requirements: • confirm that the trust is/will be "onboarded" to the Federated Data Platform 2028/29. • provide updates on EPR procurement and implementation • show how the trusts will use the NHS App and NHS Notify for patient communications.		
	From April 2026 the NHS must: • make 95% of appointments available via the NHS app and triage and implement digital PIFU by 2029 • move all direct-to-patient communication to NHS Notify by end of 2029 and exploit NHS App push notifications as preferred method of contact. Migration to be completed by 2028/29 • move to a unified access model, using AI assisted triage, delivered via the NHS App but with an integrated telephony and in-person offering • comply with standards in Digital Capability Framework as soon as possible including 100% coverage of electronic patient record systems • implement services in forthcoming national productivity adoption dashboard by March 2028 • providers should deploy ambient voice technology at pace		
Patient Experience	Submit stakeholder and patient engagement demonstrating evidence of meaningful co-production		
	Quality improvement and health inequalities actions - demonstrate equal access and outcomes improvement		
	By the end of 2025/26, complete at least one full survey cycle to capture the experience of people waiting for care. Also capture near patient experiences with a renewed focus on ensuring effective discharges processes. Trusts should triangulate inpatient survey results, relevant F&F test feedback and PALS complaints data to identify areas where improvement is needed.		
Genomics, life sciences and research	All providers must meet the site-specific timefreams of the governemnt's 150 day clinical trial set-up target. To support embedding research as part of everyday care, research activity and income should be reported to boards on a six monthly basis.		
	From April 2026 providers are expected to deliver services in line with the NHS Genomic Medicine Service Specification.		
Workforce	Boards must use staff survey insights and other feedback to inform workforce plans		
	Identify at least three areas with the greatest staff dissatisfaction and plan actions to resolve those issues within a year wherever possible		
	Continue to tackle discrimination, racism and sexual misconduct, including regularly assessing progress on the Sexual Safety Charter		
	Submit detailed plans on how they will meet workforce targets and implement new initiatives, including figures and a narrative for 30% reduction in agency spending and a minimum 10% reduction in bank spending during 2026/27, working towards zero agency spend by 2029/30		
	Explain how the "People Promise" will be implemented to improve staff retention		
	Report on plans to reduce sickness absence rates to 4.1%		
	Ensure 95% of medical job plans are signed off - underpinned by service level demand and capacity and that job-planned activity is tracked		
	By end of 2026/28 ensure a system for monitoring and assurance is in place for tracking job planned activity		
	By end of 2027/28 achieve tracking of job planned activity for the full year		
	By end of 2028/29 ensure multi-professional service level activity and job planning are in place		
	Fully implement the 10 Point Plan to improve resident doctors' working lives		
	Implement the reformed statutory/mandatory training framework due for publication in March 2026		
	Demonstrate alignment between financial and workforce plans		
Assurance	Board level agreement (Dec 2025)/formal board level approval of planning submissions (Feb 2026). Submit Board Assurance statement		

Appendix 2 – Planning Timetable



Appendix 2: Plan Sign Off Timeline

Enclosure 12.1

Integrated Performance Report

Walsall Healthcare NHS Trust

September 2025 (Month 6)

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

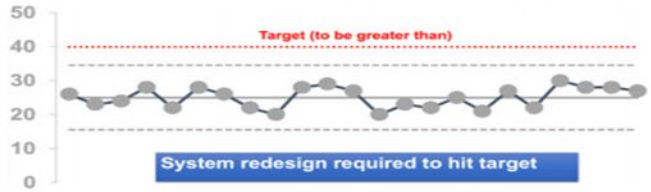
Care Colleagues
Collaboration Communities

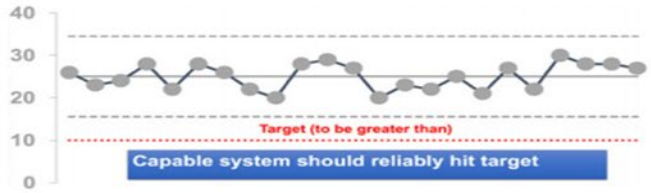
How to Interpret SPC (Statistical Process Control) charts

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:





Care Colleagues Collaboration Communities

Managing Director Summary

Walsall Healthcare NHS Trust is ahead of plan by £5.2m at month 6. Earlier than planned 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. The Trust is increasing WLI controls as it has achieved £1.6m of variable elective performance over contract YTD.

Quality and safety continue to be at the forefront of what we do. There was a slight decrease in falls pressure ulcer rates. There were one fall with severe harm reported in September. The patient has since made an uneventful recovery. CHPPD and fill rates for RNs and CSWs have reduced in M6. Quality performance are closely monitored. Complaints as a percentage of admissions were 0.46% in September (threshold 0.50%). Learning from cases is shared through quality and safety huddles.

The midwife to birth ratio increased in September to 29.66 above the national benchmark of 28.1. Newly Qualified Midwives have been recruited and the ratio is expected to improve in M7 and 8. The Trust received a next steps letter from NHSE on actions to improve care for women, babies and families. Actions the Trust is taking are detailed in the pack.
Staffing shortages in speech and language therapy and dietetics are affecting the Trusts ability to meet the 48-hour response standard. A triage process is in place and the division are actively recruiting.

The Trust is ranked 1st in the Midlands for Referral to Treatment performance for eleven consecutive months. There has been a 9% increase in elective referrals YTD. Cancer performance remains strong and the Trust is meeting all three constitutional standards for access to treatment for cancer. The Trust has seen a slight decrease in performance against the 4-hour Emergency Access Standard, taking performance from 78.04% to 75.03% in September, ranking 44th nationally The Trust has seen an improvement in DM01 performance to 76.41%. Focus continues on recovery in audiology, non-obstetric ultrasound and cardiac physiology.

Author

Amelia Godson (Managing Director)

Care Colleagues Collaboration Communities

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	3.40	3.38	Sep-25	4.47	Common Cause	Inconsistent
Pressure ulcers per 1,000 occupied bed days	1.50	2.36	2.48	Sep-25	-	Concern	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.76	0.48	Sep-25	-	Common Cause	Inconsistent
Observations on time (Trust wide)	90.00%	87.59%	86.59%	Sep-25	-	Common Cause	Inconsistent
VTE risk assessment - % within 14 hours	95.00%	89.22%	88.89%	Sep-25	-	Improvement	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	14	16	Sep-25	0	Common Cause	Not Met
Clostridioides difficile	4	6	5	Sep-25	2	Common Cause	Inconsistent
MRSA Bacteraemia	0	1	0	Sep-25	1	Common Cause	Inconsistent
Number of complaints as a % of admissions	0.50%	0.49%	0.46%	Sep-25	-	Common Cause	Inconsistent
FFT recommendation rates - Trust wide	92.00%	91.00%	91.00%	Sep-25	-	Common Cause	Inconsistent
Care hours per patient - total nursing & midwifery staff actual	-	7.8	7.4	Sep-25	-	Common Cause	No Target Set
Care hours per patient - registered nursing & midwifery staff actual	-	4.5	4.2	Sep-25	-	Common Cause	No Target Set
SHMI	1.00	0.94	0.93	May-25	1.09	Improvement	Achieving
Never events	0	0	0	Sep-25	0	Improvement	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	4495.24	4580.54	4571.05	Sep-25	-	Concern	Inconsistent
Agency (WTE) Trust	12.00	13.43	12.02	Sep-25	-	Improvement	Not Met
Bank (WTE) Trust	453.43	490.93	441.87	Sep-25	-	Common Cause	Inconsistent
Vacancy Rate	6.00%	10.17%	9.92%	Sep-25	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	7.12%	7.09%	Sep-25	-	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	94.45%	93.67%	Sep-25	-	Improvement	Inconsistent
Sickness Absence (Rolling 12 Months)	5.00%	6.69%	6.67%	Sep-25	-	Improvement	Not Met
Appraisals	90.00%	74.38%	72.44%	Sep-25	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	91.17%	91.38%	Sep-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%	70.54%	71.93%	Sep-25	83.93%	Improvement	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	1.00%	0.04%	0.05%	Sep-25	0.00%	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	26155	28355	29434	Sep-25	14852	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	87.20%	87.31%	Aug-25	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	96.00%	97.06%	97.44%	Aug-25	100.00%	Common Cause	Inconsistent
Cancer - 62 Day Referral to Treatment	75.00%	79.31%	81.42%	Aug-25	82.72%	Improvement	Inconsistent
No. of patients no longer meeting the Criteria to Reside	68	25	44	Sep-25	-	Common Cause	Inconsistent
Diagnostics - % within 6 weeks from referral	95.00%	71.90%	76.41%	Sep-25	97.57%	Concern	Not Met
Total Time Spent in ED - % over 12 Hours	2.00%	5.37%	6.33%	Sep-25	2.69%	Common Cause	Inconsistent
Total Time Spent in ED - % within 4 Hours	78.00%	78.04%	75.03%	Sep-25	77.49%	Common Cause	Inconsistent

Finance	Target	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£'000) - in month	-626	329	-1,494	15	Concern	Not Met
Surplus/(Deficit) (£'000) - YTD	-8,909	-2,229	-3,723	257	Deterioration	Achieving
Surplus/(Deficit) (£'000) - FOT	0	0	0	50	-	Achieving
ERF (£'000) - in month	6,112	5,588	6,545	N/A	Improvement	Achieving
ERF (£'000) - YTD	35,442	30,059	37,042	N/A	Improvement	Achieving
ERF (£'000) - FOT				N/A		
Efficiency (£'000) - in month	831	1,633	2,191	485	Improvement	Achieving
Efficiency (£'000) - YTD	2,356	5,035	7,226	3,770	Improvement	Achieving
Efficiency (£'000) - FOT	30,076	30,076	30,076	8,515	-	Achieving
Capital (£'000) - YTD	9,479	5,443	5,870	2,525	Concern	Not Met
Capital (£'000) - FOT	15,055	16,252	17,002	11,704	Improvement	Achieving
Cash (£'000) - in month	6,587	31,010	24,843	1,664	Deterioration	Achieving
Cash (£'000) - FOT	6,652	6,652	6,652	9,056	-	Achieving

Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

Falls per 1,000 Bed Days

- September 2025 rate: 3.38 (↓ from 3.40 in August 2025), below the national mean of 6.1 (Royal College of Physicians).
- One severe harm has been reported (a fractured neck of the femur); the patient has since made an uneventful recovery.
- Improvement Actions: Shared Learning Forum noted that the patient was assessed as independent, with rehabilitation and independence balanced in the assessment.

Pressure Ulcers per 1,000 Bed Days

- Overall, a small decrease in incidents (hospital and community), but a small increase in the 1000-bed-day ratio to 2.48
- Prolonged Emergency Department waits (average 7 hours) are increasing the risk of skin damage; an observational audit is planned to identify support measures during winter pressures.
- End-of-life skin failure and MASD remain key concerns, highlighting the need for clearer differentiation from pressure ulcers and enhanced staff training through My Academy and link nurse sessions.

Observations on Time

- September 2025 compliance:
  - 86.59% including ED (↓from 87.59%)
  - 90.90% excluding ED (↑from 90.76%)
- ED performance (58.60%) continues to impact MLTC.
- Improvement Actions: Ongoing review of observation frequency led by the Head of Nursing for Quality, Digital Nursing and ED teams.

VTE Risk Assessment

- September 2025 compliance remains static: 88.89% (↓ 89.29% in August 2025), still below the national target. Focus on UEC pathway
- Consistency in improvement achieved in elective pathway

Date	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Arrivals Lounge	81.8	76.07	76.01	97.22	97.68	94.33	95.55	97.54	98.14

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

SHMI (Summary Hospital-level Mortality Indicator)

- Latest data available: April 2025 – SHMI recorded 0.93, an improvement from 0.94 in March 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: 85.53% compliance (↑ from 85.14%)
- ED Patients: 83.76% compliance (↓ from 86.74%)
- Paediatrics: 94.4%;
- Improvement Actions: Reinforced bundle completion and accuracy of documentation. Inpatient screening remains a focus within the deteriorating patient agenda.

Infection Control

- 4 HOHA and 1 COHA. C. difficile cases reported in August 2025; national target for 2025/26 set at 65.
- Improvement actions: Focus on timely sampling and antibiotic use

Care Hours Per Patient Day (CHPPD)

- 7.4 in September 2025 (7.8 in August 2025).
- Overall combined (RN + CSW): September 2025 96.15% (August 96.83%)
- Improvement actions: CHPPD levels were stabilising after earlier reductions linked to agency workforce controls, but this month saw a significant decline; quality performance is being closely tracked alongside red-flag incidents and ongoing safe staffing reviews.

FFT Recommendation Rate – Trust Wide

- Current position: 91% in September 2025 (no change from August 2025), below the Trust's target of 92%
- Improvement actions: Divisional patient experience leads continue to monitor FFT returns, address thematic concerns, and report to the Patient Experience Group.

Complaints as a Percentage of Admissions

- Current position**:** 0.46% in September 2025, a slight improvement from 0.49% in August, and lower than the internal threshold of 0.50%.
- Improvement actions: An updated complaints training programme is now in place, with learning from upheld cases shared through Quality & Safety Huddles. The Patient Experience Group continues to monitor response timeliness and quality, noting a recent decline in performance within the Surgery Division.

Authors

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Quality, Safety & Patient Experience | Executive Summary Cont.

Midwife-to-birth ratio

- Current position: The midwife-to-birth ratio at Walsall Healthcare NHS Trust has risen to 29.66 in September, compared with 21.4 in August. This is slightly above the Birthrate Plus national benchmark of 28:1, reflecting ongoing workforce pressures in maternity services due to maternity leave and vacancies. The service still achieved 1:1 care in 100% of deliveries. Work continues to monitor staffing levels and align resources to maintain safe and effective care. We also expect the ratio to improve as Newly Qualified Midwives are onboarded over the next few months.
- Improvement Actions: Continue collaboration with regional maternity networks to tackle recruitment and retention challenges, while monitoring staffing levels and compliance through Local Maternity and Neonatal System (LMNS) reporting.

Medication Errors - % causing harm

- Current position: 8.84% of errors result in harm; the majority of harm is categorised as low harm. In September 2025, there was one moderate harm incident.
- 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: In September 2025, 16 patients spent over 24 hours in the Emergency Department, compared with 14 in August, 29 in July, and 11 in June. System-level pressures persist, particularly around the timely completion of mental health assessments and securing appropriate placements, which continue to present operational risks to patient care and Emergency Department flow.
- Challenges: There continue to be challenges in achieving timely mental health assessments, with delays noted across both adult and CAMHS services. CAMHS staff are frequently relying on telephone triage rather than face-to-face reviews, and out-of-hours psychiatric assessments by consultants or middle-grade doctors remain limited. In addition, the shortage of suitable inpatient mental health beds continues to prolong patient stays and impact overall patient flow.
- Improvement Actions: CEO-to-CEO discussions have taken place to address ongoing concerns, with plans for joint team workshops to develop solutions. The Trust's Mental Health Team continues to work closely with external partners, including Black Country Healthcare NHS Foundation Trust, to strengthen care pathways and share learning from incidents. Pan-Trust mental health training is being delivered across key areas, including Paediatrics, AMU, and ED, to build staff confidence and promote early intervention. At the same time, oversight and escalation continue through the Patient Safety Group and Safeguarding Committee, supported by Executive Nursing and Medical Leads.

Authors

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Quality, Safety & Patient Experience | Executive Summary Cont.

Speech and Language Therapy and Dietetics Staffing

- Significant staffing shortages within both Speech and Language Therapy (SLT) and Dietetics are currently affecting the Trust's ability to maintain safe and timely nutritional care across general wards, the Neonatal Unit (NNU), and the Intensive Care Unit (ICU).
- Due to current capacity constraints, SLT is unable to meet the 48-hour response standard for new adult patient assessments. This delay has direct clinical implications, including:
- Patients are remaining nil by mouth (NBM) for extended periods pending assessment.
- Delayed progression to oral or modified diets increases the risk of malnutrition, dehydration, and reduced patient experience.
- On average, 45 patients identified by Wards as being at risk of malnutrition (MUST score of 4) are unable to be seen by dietetics each month.

Actions:

- A harm review process will commence to assess any adverse outcomes associated with delayed or omitted nutritional interventions.
- Review vacancy position and recruitment actions in this difficult-to-recruit-to staffing area.
- The issue will be escalated through the Quality and Safety Committee and monitored through the Trust Risk Register until sustainable service resilience is achieved.

Temporary Escalation Space (TES) Usage

- The Temporary Escalation Space (TES) continues to be utilised to support patient flow during periods of increased operational pressure. Data from September indicates increased use, but controlled use aligned with policy and operational needs.
- The TES was in use for a total of 280.2 hours across five operational days during September 2025.
- Across other activation periods, TES usage averaged 2 hours per occasion, reflecting short-term surge management.
- All activations adhered fully to the operational policy criteria, including appropriate staffing, patient selection, and escalation governance. No incidents or patient safety concerns were reported during the period.

Actions:

- The TES remains under continuous oversight from the Site Management Team to ensure safe admission and discharge processes.
- Ongoing monthly monitoring of TES usage will continue to ensure it remains a short-term mitigation measure rather than a sustained capacity extension.

Authors

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

Actions to improve care for women, babies and families next steps

Letter sent to all Trusts 16 October 2025 – follow up from announcement of rapid independent investigation in June

Outlines next steps in 4 areas to support Trusts to go further and faster to improve maternity and neonatal care

Perinatal Equity and Anti-Discrimination Programme:

- The programme aims to give perinatal teams the skills and tools they need to improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and to improve the working lives of staff from these groups.

Actions: We will release leadership teams to attend; Strong EDI culture already exists with EDI Midwives supporting some of the most vulnerable families; Cultural development programme in place for staff; Board maternity and neonatal safety champions have strong relationship with perinatal leadership team and visible in areas.

Submit a Perinatal Event Notification service

- a web-based portal designed to streamline the notifications of qualifying perinatal safety events to MBRRACE, MNSI and NHSR EN

Actions: On-boarding commences 3rd November; Nominated users already identified from divisional team. Training provided by CSU

Maternity and Neonatal Performance Dashboard:

- First iteration of the national set of metrics and definitions that make up the performance dashboard issued with the letter
- All Trusts must report regularly to their boards on maternity and neonatal safety. A model board report will be published shortly

Actions: Directors of Midwifery to review the metrics against what is reported to Quality Committee and in the IQPR. Future reports will reflect the national dataset

Maternity and Neonatal Improvement Support Team:

- This replaces the Maternity Safety Support Programme. Its role is to support trusts to more quickly identify and resolve concerns and allow for time limited national interventions

Authors

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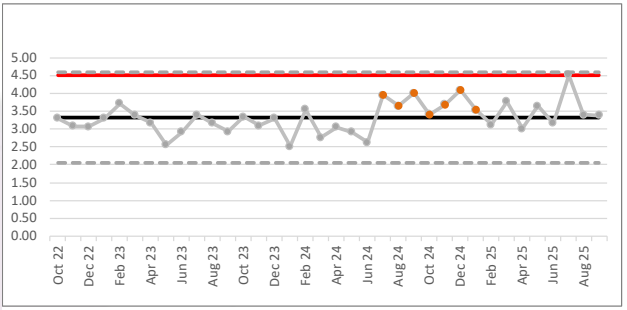
Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

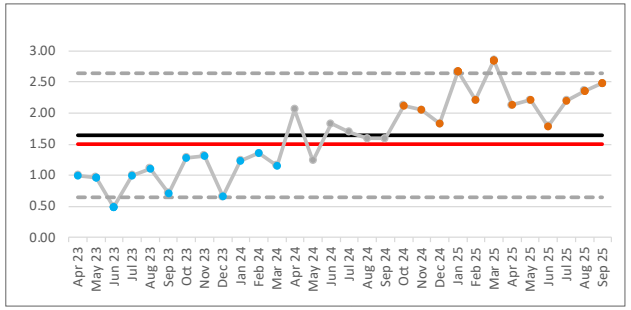
Patient falls - rate per 1,000 occupied bed days

Inconsistent	Common Cause	3.38



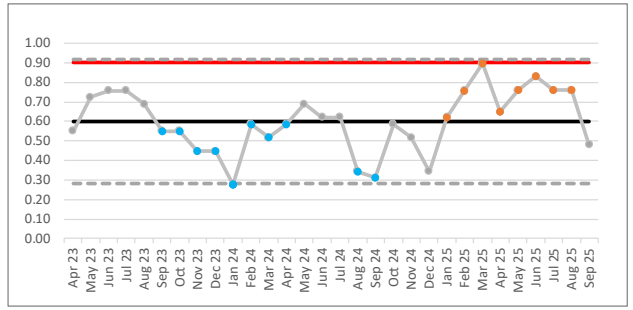
Pressure ulcers per 1,000 occupied bed days

Inconsistent	Concern	2.48



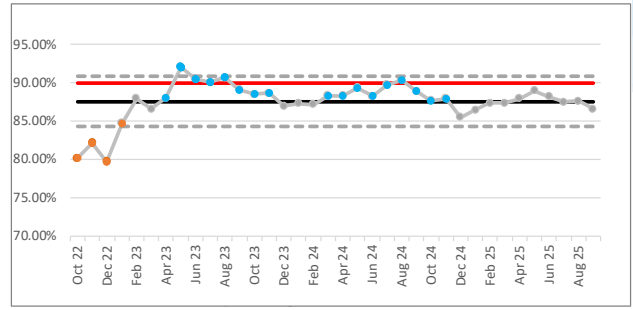
Community acquired pressure ulcers per 10,000 population

Inconsistent	Common Cause	0.48



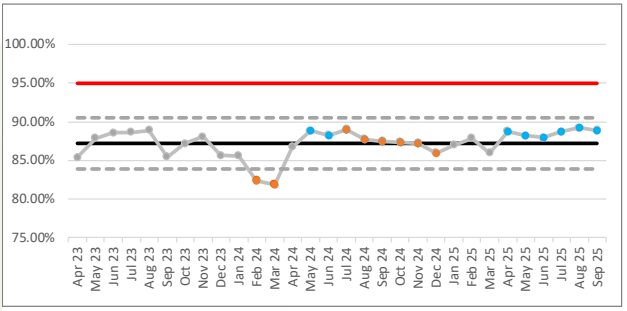
Observations on time (Trust wide)

Inconsistent	Common Cause	86.59%



VTE risk assessment - % within 14 hours

Not Met	Improvement	88.89%



Sepsis screening - ED

Not Enough Points	Not Enough Points	-

In Development

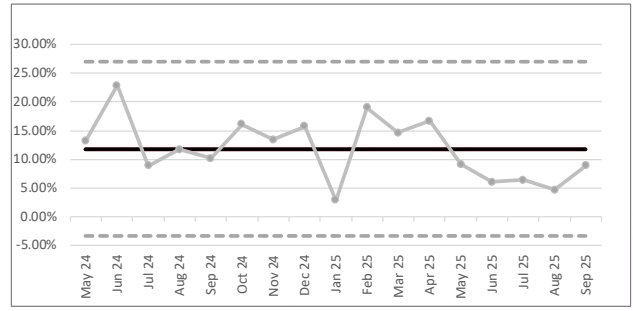
Sepsis screening - Inpatients

Not Enough Points	Not Enough Points	-

In Development

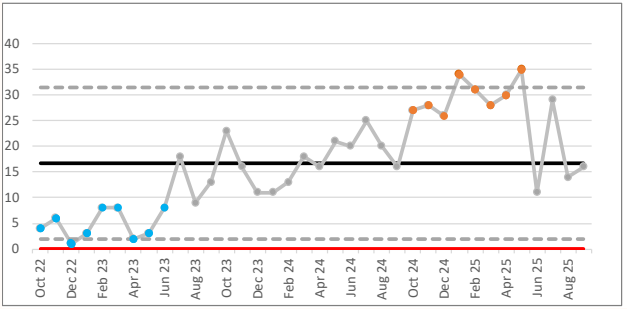
Medication Errors - % causing harm

Inconsistent	Common Cause	8.84%



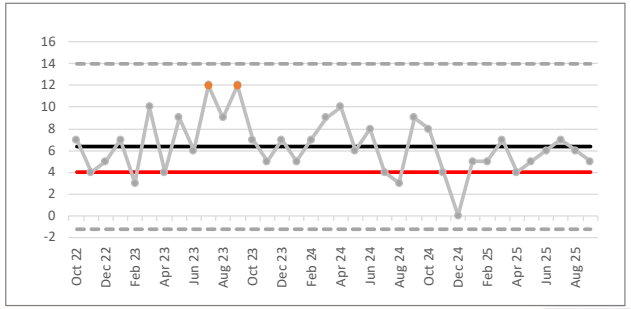
Mental health patients spending over 24 hours in A&E

Not Met	Common Cause	16



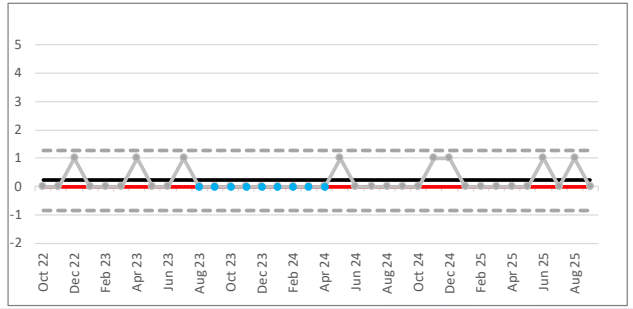
Clostridioides difficile

Inconsistent	Common Cause	5



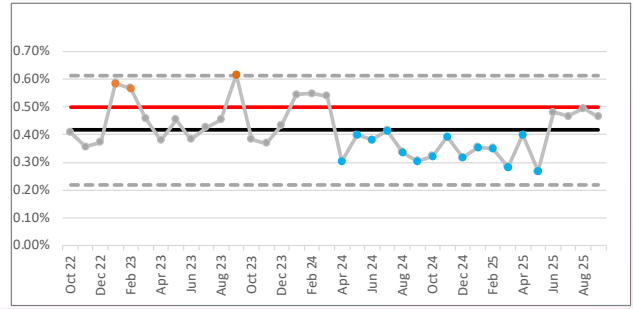
MRSA Bacteraemia

Inconsistent	Common Cause	0



Number of complaints as a % of admissions

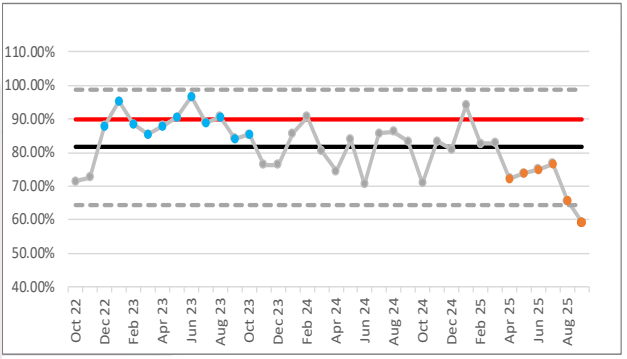
Inconsistent	Common Cause	0.46%



Quality, Safety & Patient Experience | Core Metrics

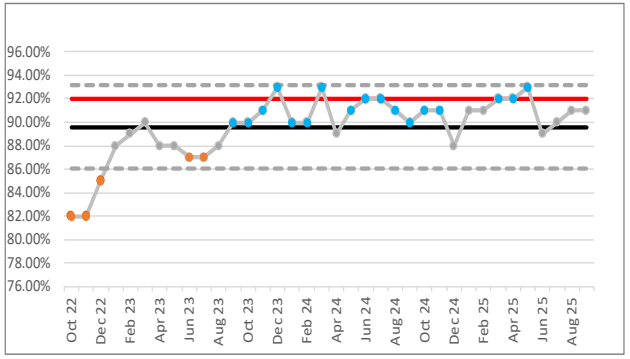
Complaints response rate against policy

Inconsistent	Concern	59.26%



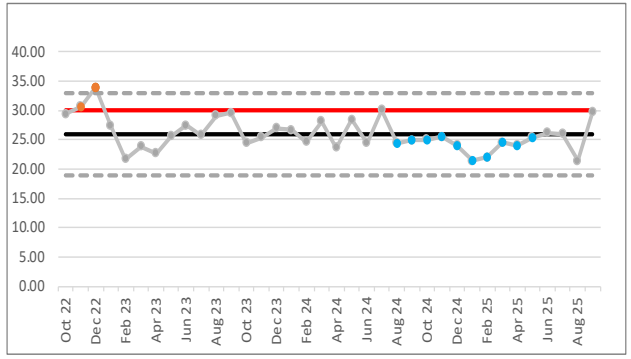
FFT recommendation rates - Trust wide

Inconsistent	Common Cause	91.00%



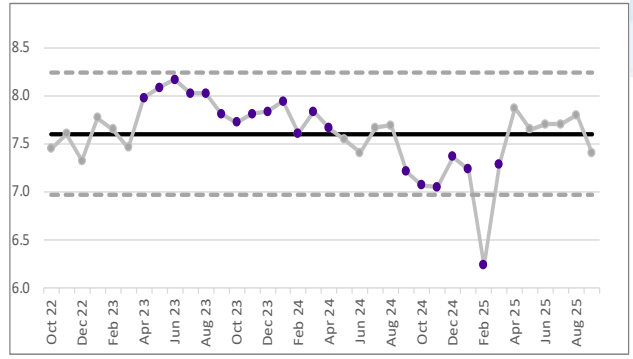
Midwife to birth ratio (1 to)

Inconsistent	Common Cause	29.66



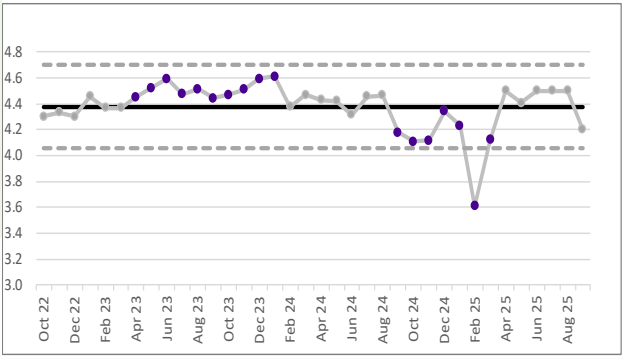
Care hours per patient - total nursing & midwifery staff actual

No Target Set	Common Cause	7.4



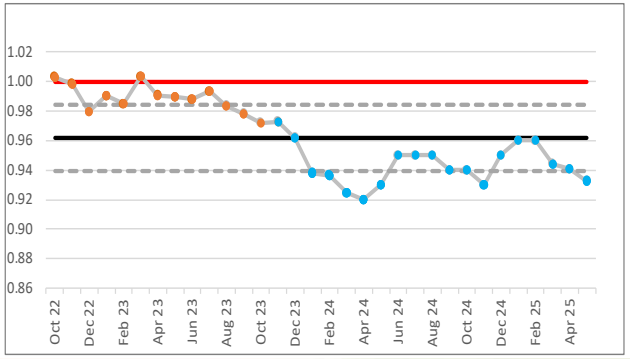
Care hours per patient - registered nursing & midwifery staff actual

No Target Set	Common Cause	4.2



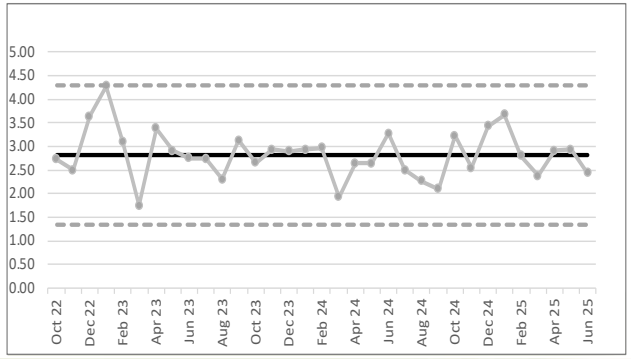
SHMI

Achieving	Improvement	0.93



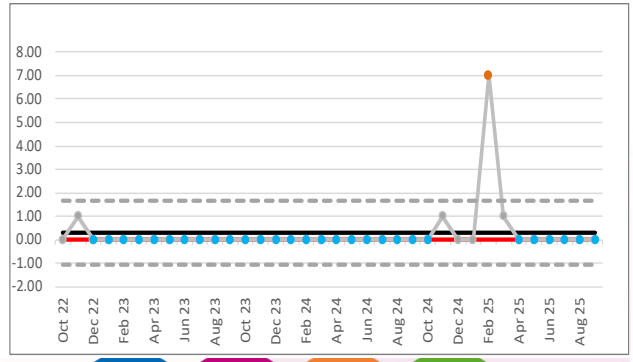
Crude Mortality Score

No Target Set	Common Cause	2.44



Never events

Inconsistent	Improvement	0



Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Maternity (update provided bi-monthly for Trust Board)

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 Director of Midwifery

	April	May	June	July	August	September
PMRT Reviews	0	1	2	5	2 (x1 awaiting review)	2 (x1 awaiting review)
Grade N = neonatal M = Maternal	N M A 0 A B 0 B C 0 C D 0 D	N M A 0 A B 1 B C 0 C D 0 D	N M A 2 A B 0 B C 0 C D 0 D	N M A 0 A 0 B 0 B 1 C 0 C 0 D 1 D 0	N M A 0 A 1 B 1 B 0 C 0 C 0 D 0 D 0	N M A 0 A 1 B 1 B 0 C 0 C 0 D 0 D 0
MNSI	0	0	0	1 Stillbirth 39/40	0	0
Incidents Moderate & Above	3	10	6	5	6	3
Service feedback FFT recommendation	94%	93%	88%	89%	91%	93%
Service user & Staff Feedback to Board Level Safety Champions Walk & Bi-Monthly meeting	Delivery Suite Bi-Monthly	Neonatal Unit	Ante/Postnatal ward Bi-Monthly	Antenatal Clinic	Community Bi-Monthly	Delivery Suite
Coroner Reg 28	0	0	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

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	3	1	2	6
4	0	12	6	1	19
5	1	9	1	1	12
6	2	6	0	1	9
7	0	0	0	4	4
8	3	17	1	0	21
9	0	4	3	2	9
10	0	9	0	0	9
Total	7	68	12	11	98

Professional Group	NLS	PROMPT	FETAL MONITORING
Neonatal Consultants	68%	NA	NA
Neonatal Residents	100%	NA	NA
Neonatal Nurses	100%	NA	NA
Anaesthetists	55%	55%	NA
Midwives	82%	82%	90%
Obstetric consultants	100%	100%	100%
Obstetric residents	100%	100%	100%
MSWs	86%	86%	NA

CNST actions that remain red include breach of MBRRACE 7-day notification of x1 neonatal death, midwifery staffing plan agreement in accordance with Birthrate Plus® 2024 recommendations, 2nd Saving Babies Lives Care Bundle Ver 3 meeting with the LMNS, anaesthetics compliance with PROMPT training which has been escalated to Divisional teams and Trust Executive team. Amber actions are on target to be completed by the end of the reporting period.

Quality, Safety & Patient Experience | Maternity (update provided bi-monthly for Trust Board)

Perinatal staffing												
Staff Group	April		May		June		July		August		September	
Midwives Birth to midwifery ratio Planned/ Actual	22.32	24.08	22.32	24.08	23.68	26.19	22.20	26.00	20.47	21.40	24.54	29.66
Obstetrics RCOG Compliant on delivery suite	YES		YES		YES		YES		Yes		Yes	
Neonatal Nurses BAPM Compliant	Yes		Yes		Yes		Partial		No		No	
Neonatal Doctors BAPM compliant	Partial		Partial		Partial		Partial		Yes		Yes	

Midwives Birth to midwifery ratio planned/ actual	Ratios based on 2020 not 2024 Birthrate Plus® recommendations therefore partially compliant. Birthrate Plus® safe staffing level in September 6% on ward and 65% Delivery suite against a target of 85%. Staffing monitored daily to maintain safety. Birthrate plus business case completed and with Trust executive team. Safe staffing maintained via daily management and clinical mitigations. Staffing monitored and escalated via Division, Group Quality Committee and Local Maternity and Neonatal system. Twelve student midwives which includes six fixed term posts have been recruited to support 19.10 WTE maternity leave. Enhanced bank rate 8th October – 8th December has been authorised by the Trust executive team to support safe staffing. No Adverse incidents have been reported
Obstetrics RCOG Compliant on delivery suite	No actions required
Neonatal Nurses BAPM Compliant	Neonatal nurse staffing did not meet BAPM standards no adverse safety incidents were identified. Medical Staffing BAPM compliant. 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	

Item	Themes	Action
PMRT	• Education regarding referral pathway of woman with history of mental health • The fetal heart monitoring in the latent phase of labour • Identification of Pre-eclampsia **Good practice** • Use of the MBRRACE PMRT parent engagement forms • Increased uptake of clinicians using, accessing and booking interpreting services • Increase in staff providing the Peri-Perm passport for women requiring intrauterine transfer	• Community midwife manager to disseminate learning and ensure all clinicians are reminded of the referral criteria for consultant-led care • Mental health midwife to review the guidance • For case to be presented at the monthly maternity clinical audit meeting • A guideline for the management of the latent phase of labour to be developed by the consultant midwife • Monitor and ensure staff compliance with attendance at the PROMPT study day • Q1 and Q2 PMRT report which details cases and compliance presented at Trust Group Quality Committee
MNSI	• Nil cases in August and September	• Awaiting reports from February and July referrals. • Action plan from LMNS Thematic Stillbirth review presented at Group Quality Committee
Incident &/or PSIRF themes	• Perinatal mortality • Postpartum Haemorrhage • Neonatal fracture	• Missed opportunity in antenatal period to optimise Hb levels • Neonatal death of a Twin at 34/40 who developed Necrotising enterocolitis • Baby born via Elective caesarean section, fracture noted ?congenital on review.
Service user feedback	• Treated with respect and dignity and had interpreter at antenatal appointment • Offered breast feeding support and adequate pain relief • Call bell not always answered in a timely manner staff could be more polite	• Service user feedback shared with staff in team meetings and 1:1s. • Conversations around call buzzers had with staff on the postnatal antenatal ward. • Continued civility and respect training
Safety Champions feedback	• Staffing challenges remain a concern • Entonox exposure levels on delivery suite	• Continued supportive discussions with staff regarding staffing concerns with Board Level Safety Champions. Support from Board level Maternity Safety Champions for fixed term staff 6.55 WTE to support service, supported with short tern enhanced bank rate. • Staff experiencing stress and anxiety due to Entonox concerns, conversations regarding Entonox exposure levels, additional workload to staff due to other staff exemptions, what the Trust is doing to keep staff safe, invitation to have face to face conversation with Board Level Champion

People | Executive Summary

Performance against Trust 2025/26 Workforce Plan

The total workforce WTE deployed in M6 was overall 59.90 WTE less than in M5. Total reductions YTD were 60.07 WTE less than M12 24/25 and 119.07 WTE less than M10 24/25. YTD reductions remained adverse to M6 stretch plan by 64.26 WTE. Within month there were reductions across substantive WTE with 5471.05 WTE employed, a reduction of 9.39 WTE from M5. Bank deployment has decreased in month by 49.10 WTE together with decreased agency WTE by 1.42 WTE. WHT agency use is currently in line with the stretch plan.

The Trust has achieved an overall reduction of 5% from M12 comprised of 4% substantive, 16% bank against a 10% national requirement and 38% agency against a 30% national requirement . There were more external leavers (57.16 WTE) than external starters (50.23 WTE).
The WHT 2025/26 Financial Plan was based on a start point of Month 10 headcount which was **5144 WTE**. Therefore the reduction to total WTE of 5024.93 at the end of M6 has generated savings.

Performance against Key Workforce Metrics

- Three of the six workforce indicators are outside the target KPI
  - The vacancy rate of 9.3% remains above the 6% target and is reflective of the workforce plan.
  - In month SA has decreased from 6.45% to 6.08% driven by a reduction in long term sickness absence. Short term sickness has increased from 26.49% to 32.57%. Rolling 12 month SA has reduced slightly from 6.69% to 6.67%
  - Appraisal compliance has decreased slightly to 72.44% from 74.48%. Validation of data to support the transition of recording from ESR to My Academy concluded in August. The intended improvement target of 80% compliance by the end of September 2025 has not been achieved at Trust level. Senior leaders have been contacted to ensure they are aware of each directorates position and to develop improvement plans and trajectories.

NHS Staff Survey

- As of the 3rd November 2025 the Trusts response rate was 37.9%. The survey closes at the end of November and whilst the Trust's target is to match last years response rate of 54%, this may be challenging as looking back at the same time last year, the trust had achieved a 46% response rate.

Authors

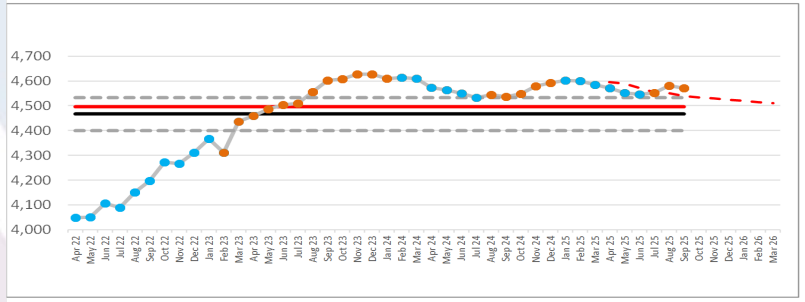
Alan Duffell (Group Chief People Officer)

Care Colleagues Collaboration Communities

People | Core Metrics

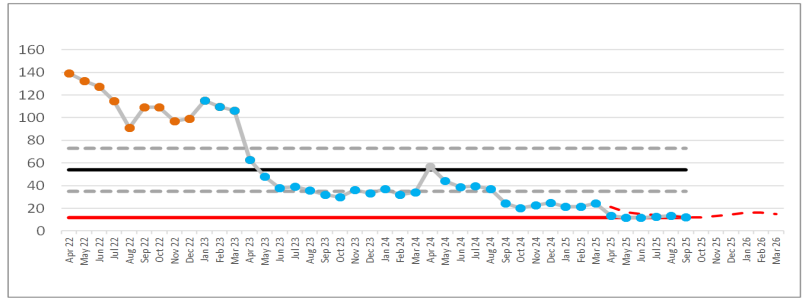
Substantive (WTE) Trust

Inconsistent	Concern	4571.05



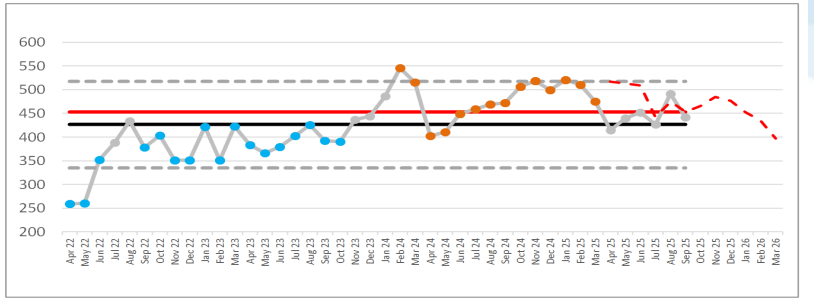
Agency (WTE) Trust

Not Met	Improvement	12.02



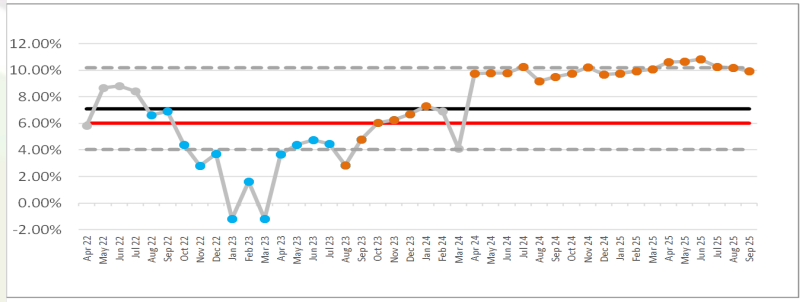
Bank (WTE) Trust

Inconsistent	Common Cause	441.87



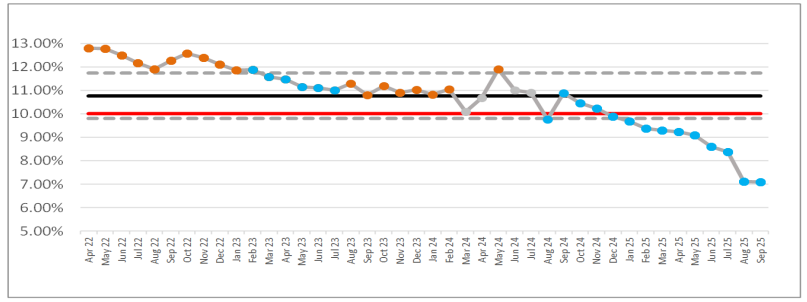
Vacancy Rate

Inconsistent	Concern	9.92%



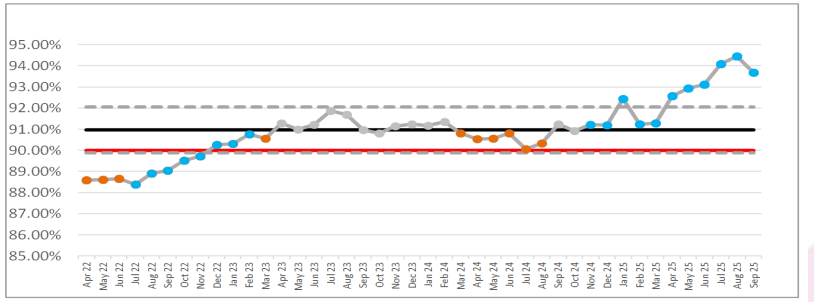
Turnover Rate (12 Months)

Inconsistent	Improvement	7.09%



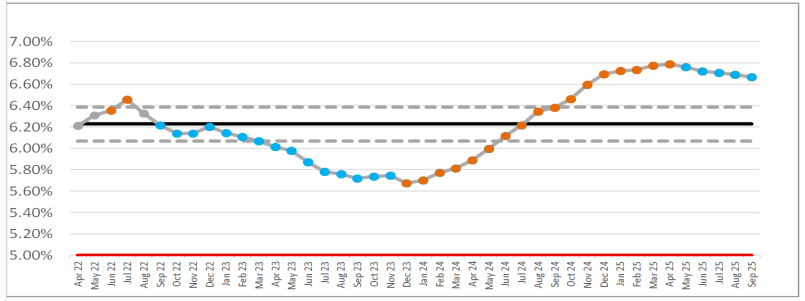
Retention Rate (12 Months)

Inconsistent	Improvement	93.67%



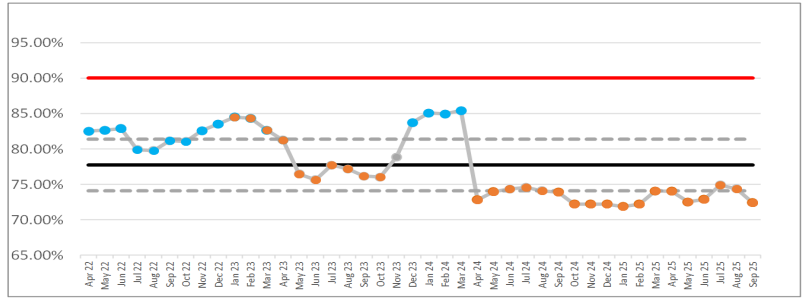
Sickness Absence (Rolling 12 Months)

Not Met	Improvement	6.67%



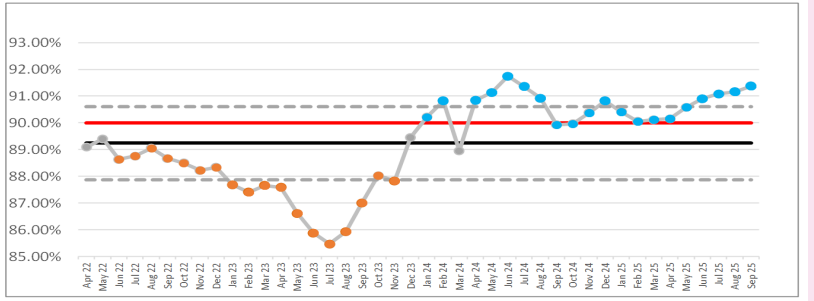
Appraisals

Not Met	Concern	72.44%



Statutory & Mandatory Training

Inconsistent	Improvement	91.38%



Operational Performance | Executive Summary

Urgent & Emergency Care

The Trust has seen a slight decrease in performance against the 4-hour Emergency Access Standard, taking performance from 78.04% in August to 75.03% in September, slightly below trajectory ranking 44th nationally and 8th in the region. Type 1 attendances continue to increase from 4.98% YTD in August to 5.46% YTD in September 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 17th nationally. The breast service has experienced reduced capacity in September with 2 week wait patient booking at 20 days. RWT have provided some mutual aid

Elective Care

The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for eleven consecutive months. Unfortunately, there was one dermatology 78 week breach in September due to a pop-on data issue. The patient was appointed in October. The community waiting list increase is due to the impact of the improvement plan for data capture and the total waiting list over 52 weeks stands at 6.95%

Diagnostics

DM01 performance improved to 76.41% Challenged modalities are: audiology, non-obstetric ultrasound and cardiac physiology. Recruitment to fixed term and substantive posts has been undertaken and improvement trajectories set

Authors

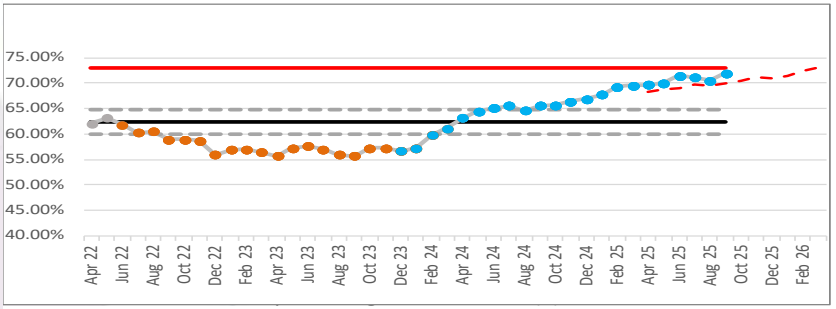
Lisa Carroll
(Interim Chief Operating Officer)

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

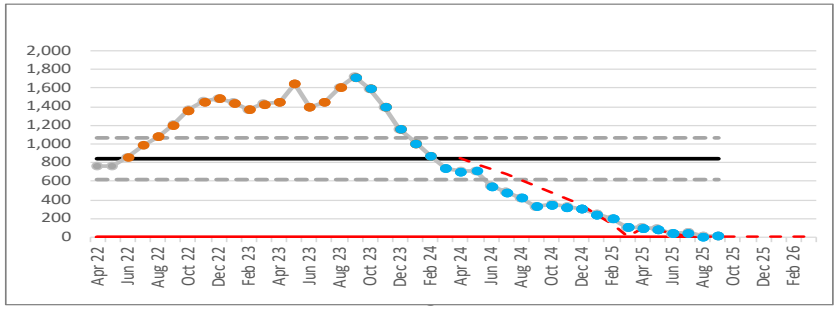
18 Weeks RTT - % Within 18 Weeks - Incomplete

Not Met	Improvement	71.93%



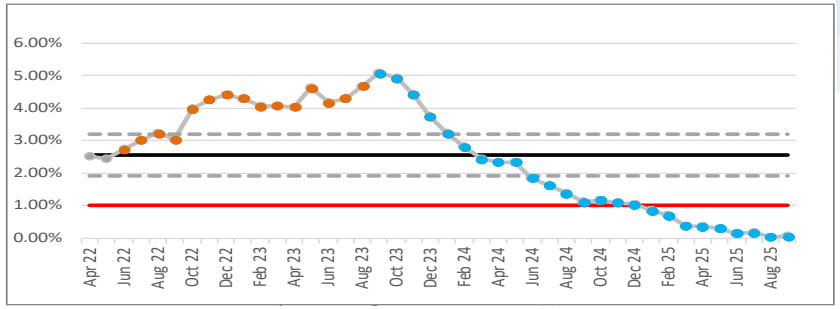
18 Weeks RTT - No. of 52 wk breaches

Not Met	Improvement	16



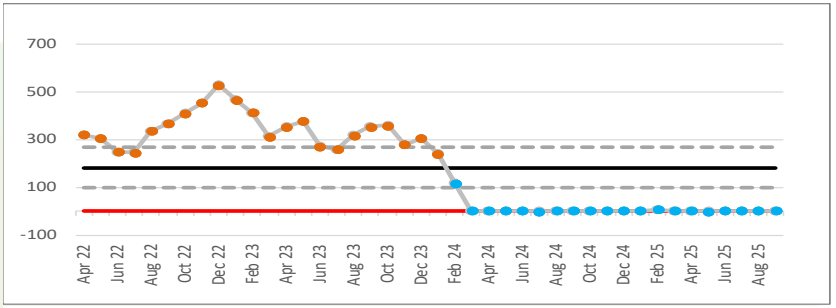
18 Weeks RTT - 52 wk breaches as a % of PTL

Not Met	Improvement	0.05%



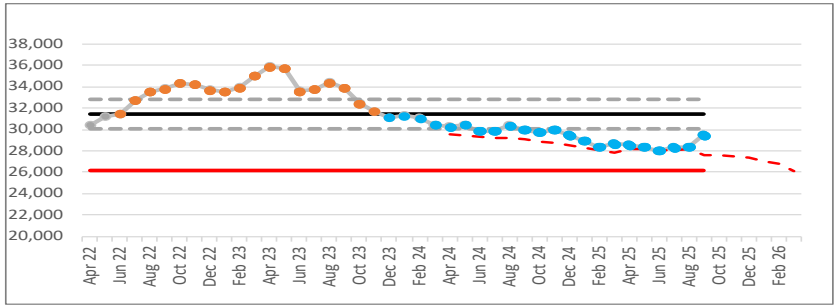
18 Weeks RTT - No. of 65 wk breaches

Not Met	Improvement	1



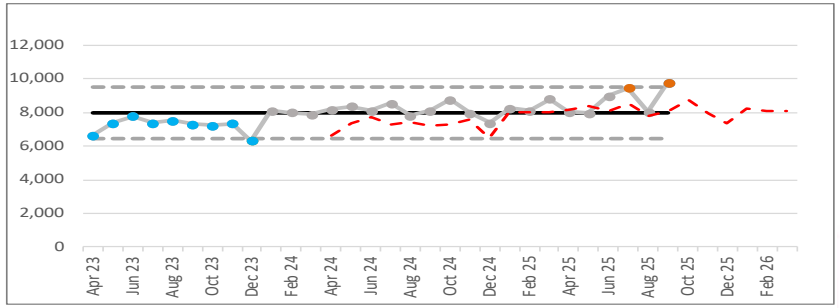
18 Weeks RTT - Total Incomplete PTL

Not Met	Improvement	29434



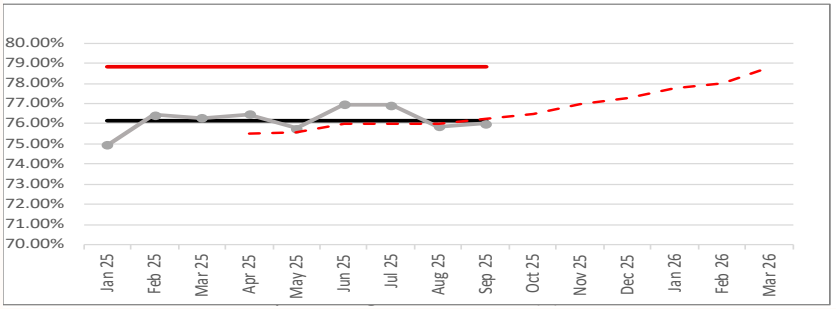
18 Weeks RTT - Clock Starts

No Target Set	Concern	9796



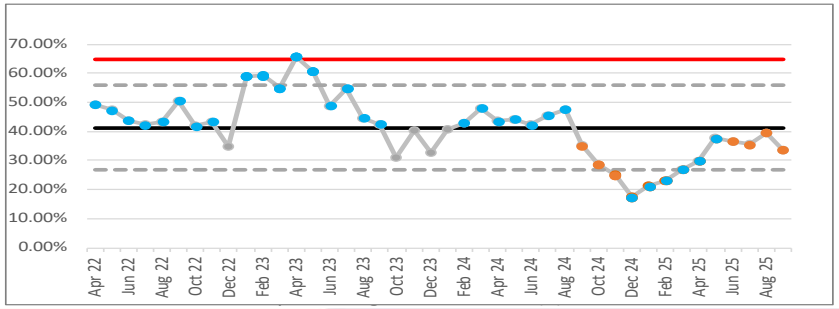
18 Weeks RTT - Time to First Appointment

Not Enough Points	Not Enough Points	76.00%



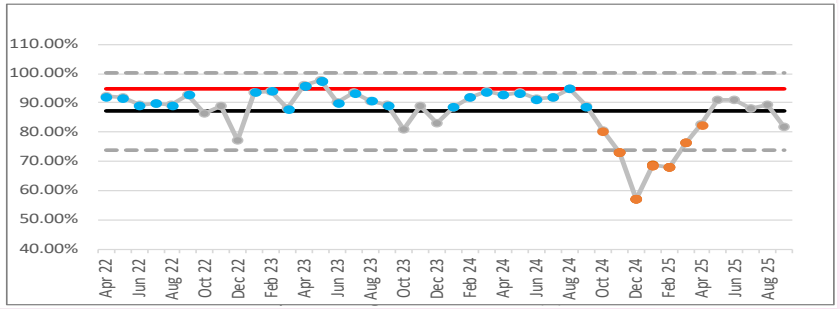
Ambulance Handover - % within 15mins

Not Met	Concern	33.69%



Ambulance Handover - % within 30mins

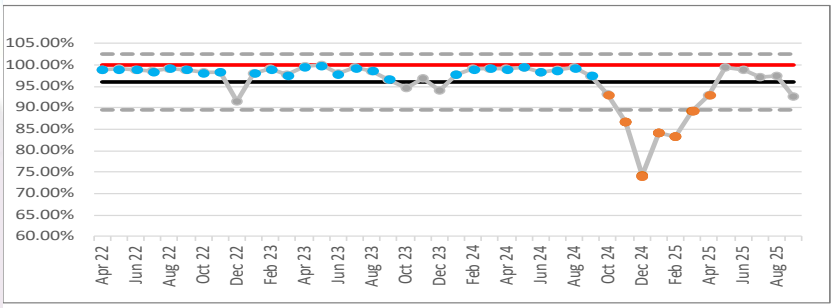
Inconsistent	Common Cause	81.80%



Operational Performance | Core Metrics

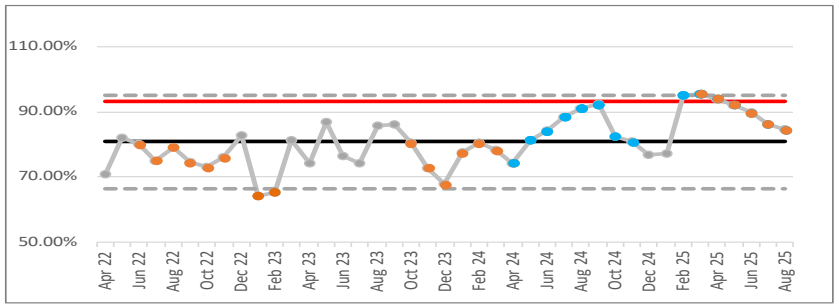
Ambulance Handover - % within 60mins

Inconsistent	Common Cause	92.75%



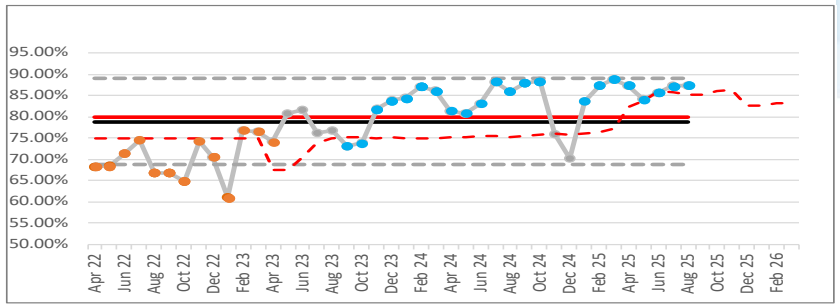
Cancer - 2 Week Wait

Inconsistent	Improvement	84.45%



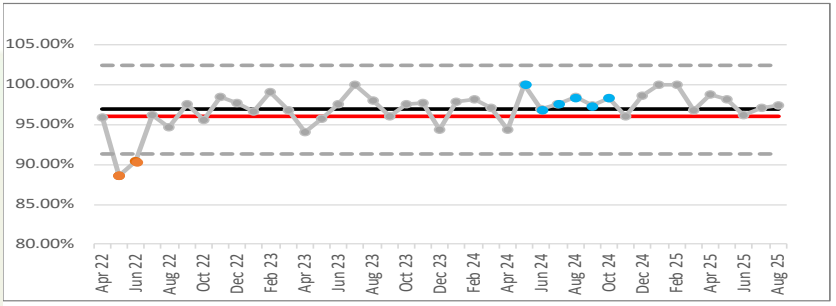
Cancer - 28 Day Faster Diagnosis

Inconsistent	Improvement	87.31%



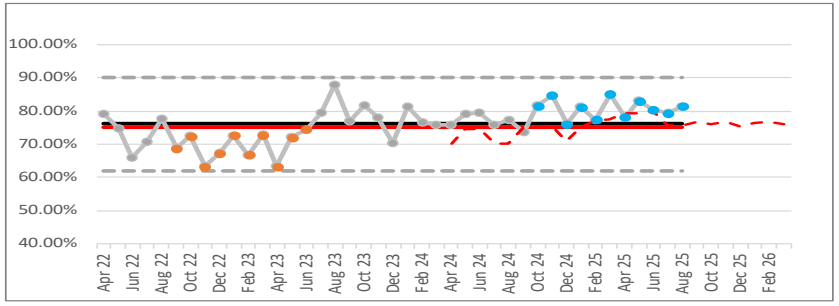
Cancer - 31 Day Treatment

Inconsistent	Common Cause	97.44%



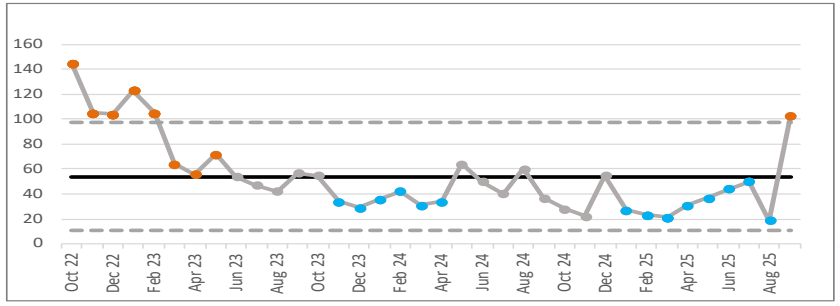
Cancer - 62 Day Referral to Treatment

Inconsistent	Improvement	81.42%



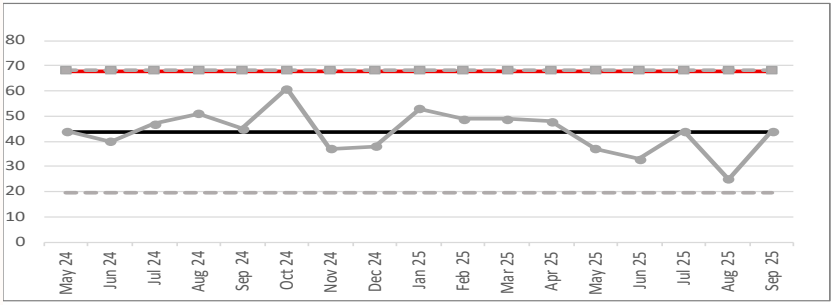
Cancer - No. of patients waiting 63+ Days for treatment

No Target Set	Concern	103



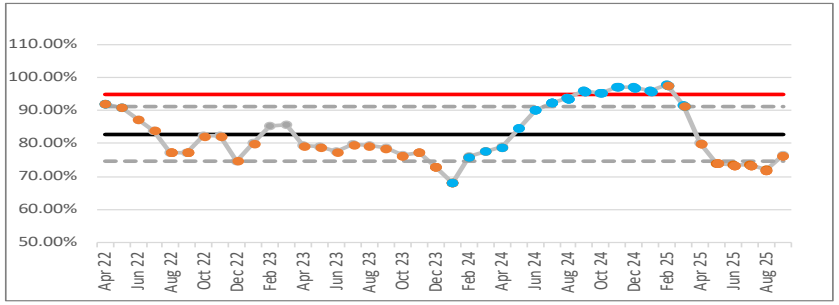
No. of patients no longer meeting the Criteria to Reside

Inconsistent	Common Cause	44



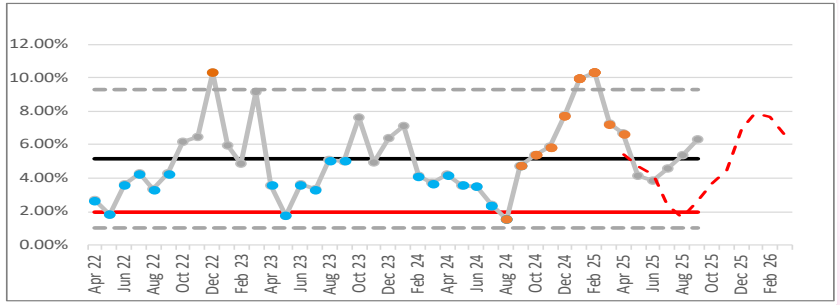
Diagnostics - % within 6 weeks from referral

Not Met	Concern	76.41%



Total Time Spent in ED - % over 12 Hours

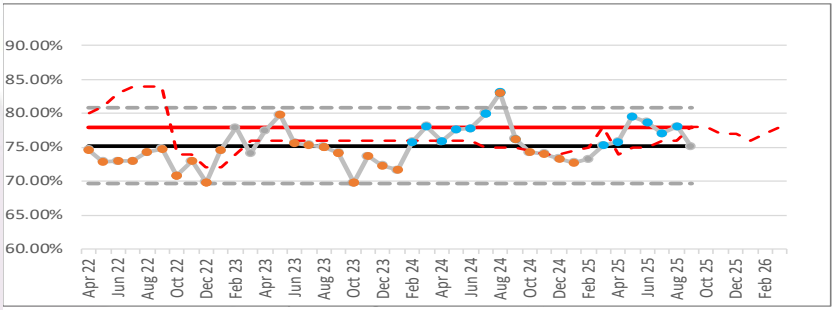
Inconsistent	Common Cause	6.33%



Operational Performance | Core Metrics

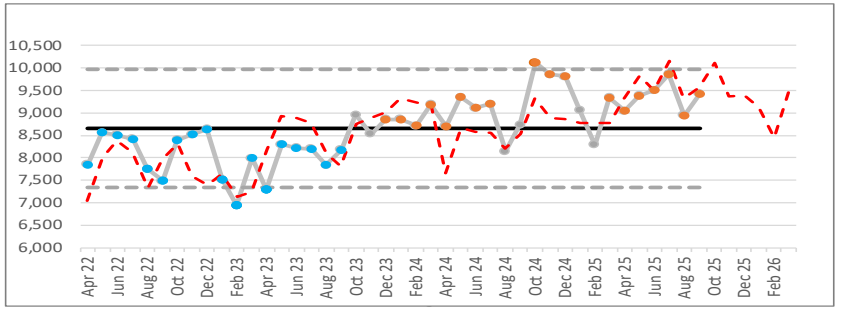
Total Time Spent in ED - % within 4 Hours

Inconsistent	Common Cause	75.03%



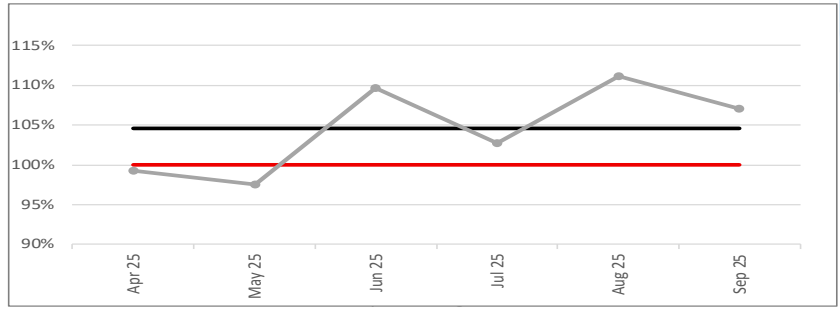
Type 1 ED Attendances

No Target Set	Concern	9429



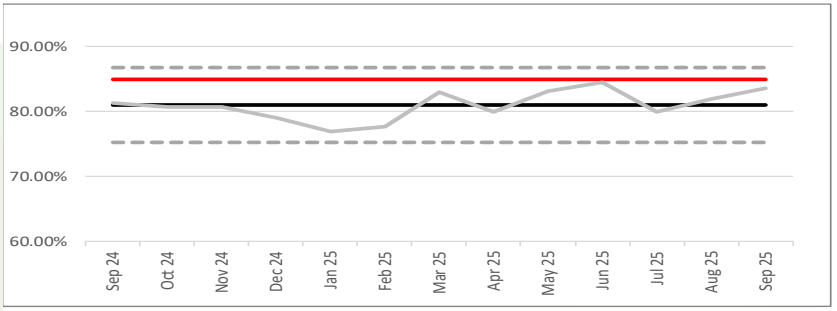
Deliver % of Activity Delivered in 2019/20 (Variable Contract Delivery)

Not Enough Points	Not Enough Points	107%



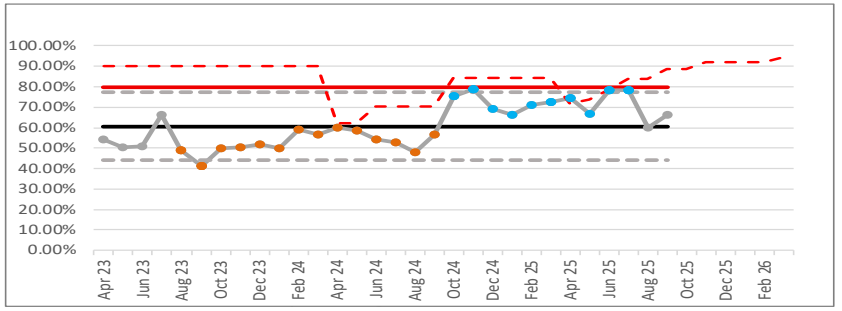
Theatres - Touch Time Utilisation (MH)

Inconsistent	Common Cause	83.60%



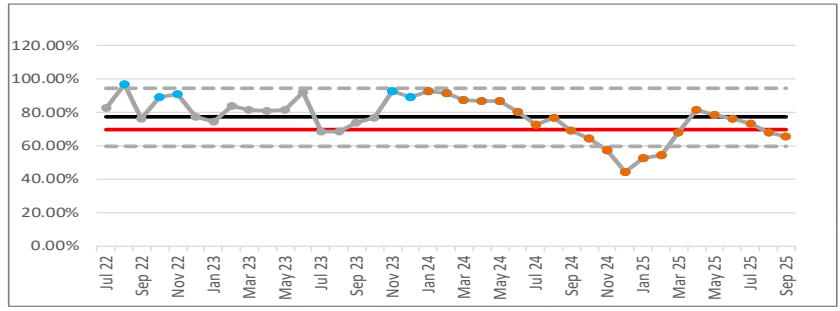
Community - Virtual Ward % Occupancy

Not Met	Common Cause	66.48%



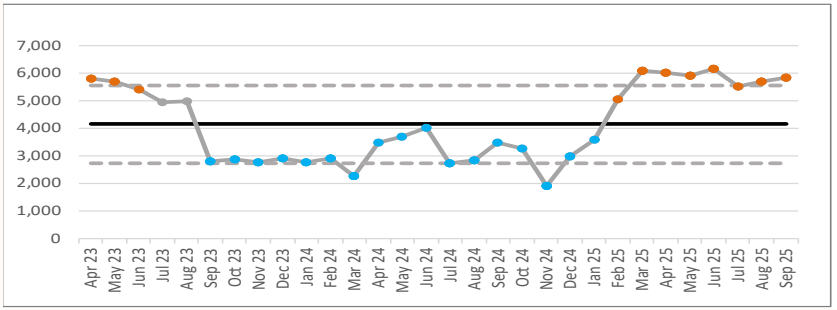
Community - Urgent Care Response (UCR) 2 Hour Response

Inconsistent	Concern	65.82%



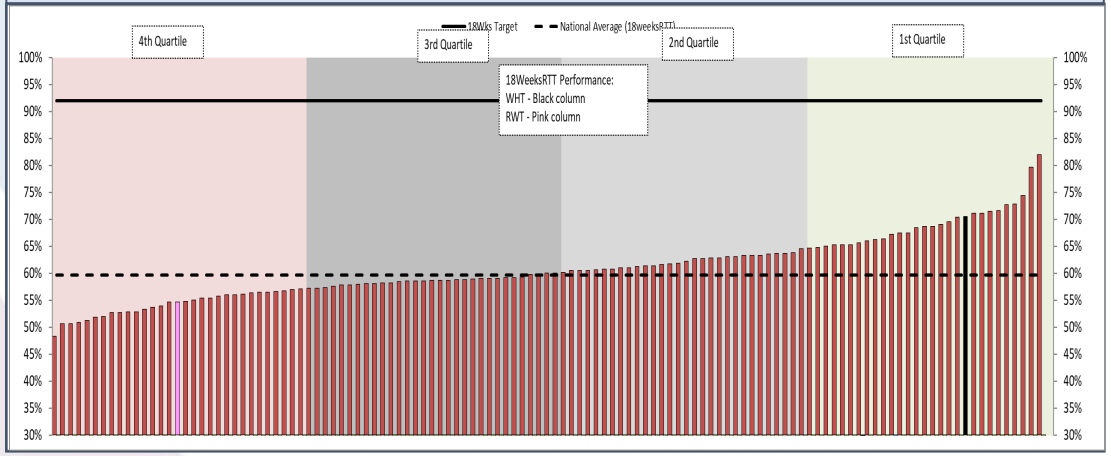
Community - Waiting List - Total

No Target Set	Concern	5829

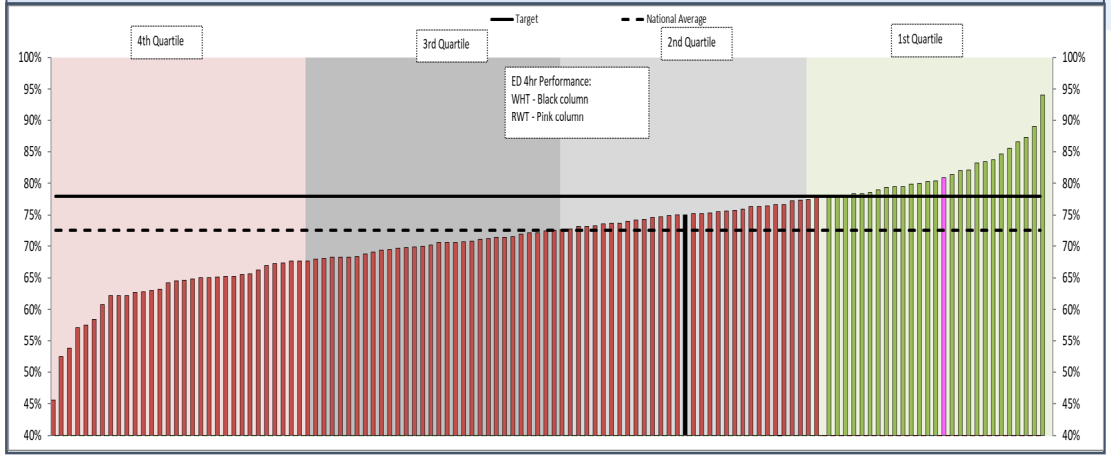


Operational Performance | Benchmarking

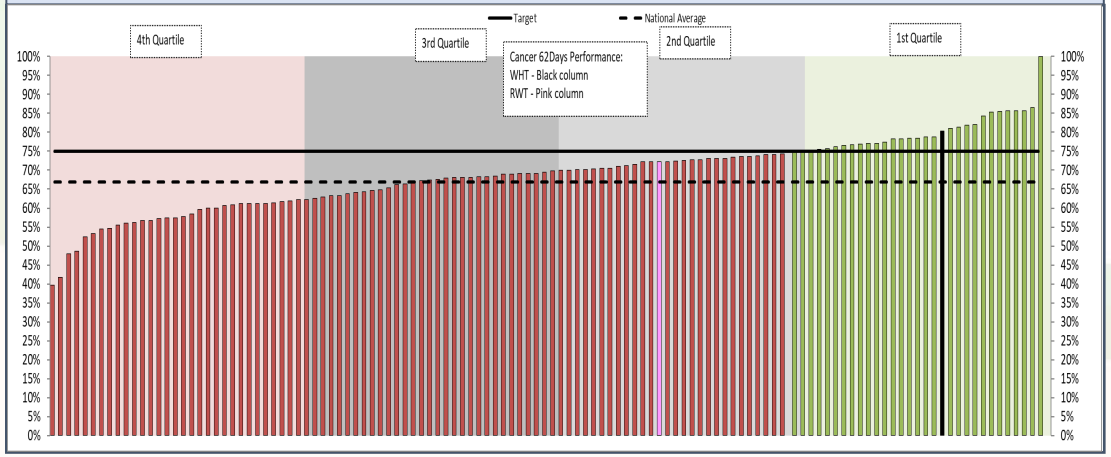
Referral to Treatment



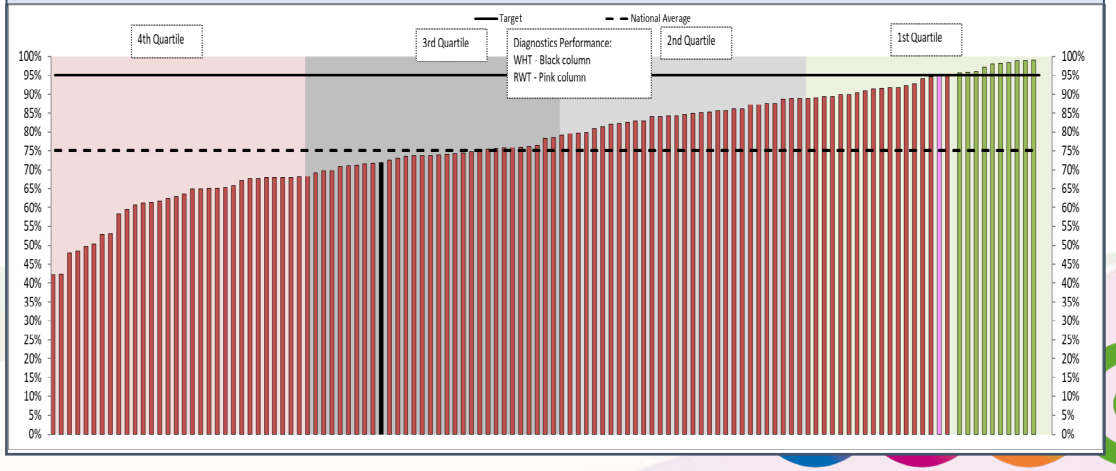
A&E 4 Hour



Cancer 62 Day



Diagnostic Waiting Times



Care Colleagues
Collaboration Communities

Finance | Executive Summary

Revenue

WHT is ahead of plan by £5.2m at month 6. Earlier than planned 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 early in the year this will 'smooth' the improvement trajectory, the I&E performance chart on the following slide demonstrates this.

YTD the Trust has achieved c£1.6m of variable elective performance over contract. There is currently no pathway for this to be funded and at Month 6 this income has not been included in the position. The Trust has allowed a limited amount of funding for WLIs within the financial plan. The Trust is increasing WLI controls immediately.

CIP is £12.4m versus a plan of c£4.8m, so a YTD positive variance of £7.6m

Capital

Year to date capital expenditure at Month 6 is £5.869m, £1.847m 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 6 is £24.8m. 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)

Care Colleagues Collaboration Communities

Finance | I&E Summary

	Plan £000s	Actual £000s	Variance £000s
Income			
Patient Care Income	225,209	224,051	(1,158)
Education and Training Income	6,471	6,375	(96)
Other Income	4,361	4,824	463
Interest Receivable	872	872	(0)
Subtotal Income	**236,914**	**236,122**	(792)
Pay Expenditure			
Substantive Salaries	(150,795)	(137,624)	13,171
Temporary Nursing	(852)	(6,795)	(5,943)
Temporary Medical	(403)	(4,666)	(4,263)
Temporary Other Clinical	(39)	(1,347)	(1,308)
Temporary Non Clinical	(168)	(2,808)	(2,640)
Subtotal Pay Expenditure	**(152,257)**	**(153,239)**	(982)
Non Pay Expenditure			
Drugs	(14,982)	(14,903)	80
Clinical Supplies and Services	(12,404)	(12,446)	(42)
Non-Clinical Supplies and Services	(18,721)	(19,942)	(1,221)
Other Non Pay	(23,903)	(23,498)	405
Depreciation	(7,581)	(7,300)	281
Subtotal Non Pay Expenditure	**(77,592)**	**(78,089)**	(497)
Subtotal CIP	**(7,614)**	**0**	7,614
Interest Payable, PDC, Disposals	(7,540)	(7,487)	52
Subtotal Finance Costs	**(7,540)**	**(7,487)**	52
Adjust PFI revenue costs to UK GAAP basis	(820)	(1,030)	(210)
Total Surplus / (Deficit)	**(8,909)**	**(3,723)**	5,186

Patient Care Income is behind plan at Month 6 despite variable elective performance being ahead of plan by £1.6m. This is restricted due to commissioner affordability so has been removed from the position at Month 6.

Education & Training income is slightly behind plan following the receipt of the updated LDA schedule.

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

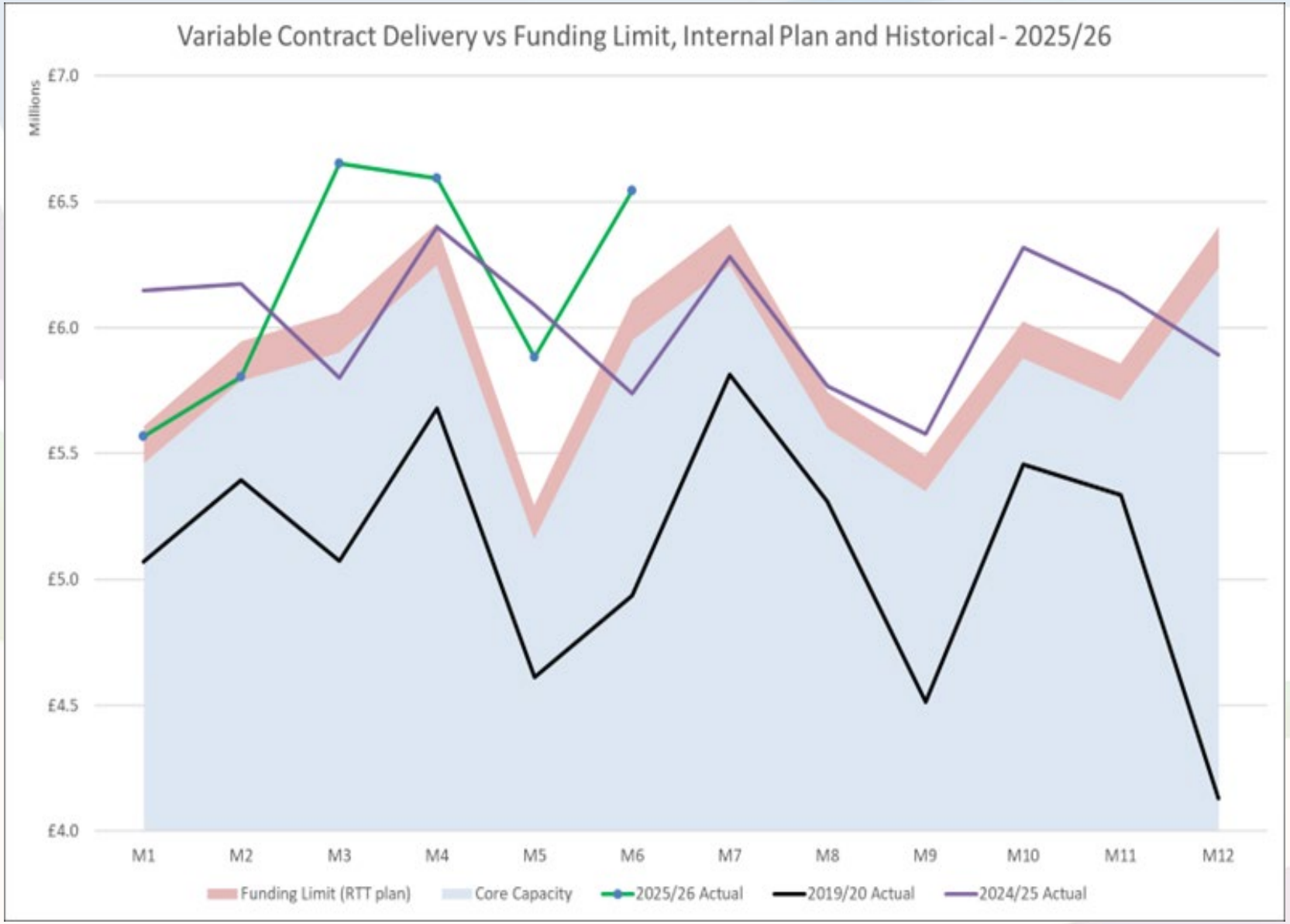
Pay is overspent by £0.98m. Overall headcount has reduced from 5,085 in Month 5 to 5025 in Month 6, 20 WTE more than planned. In addition to this key pressures within Medical Staffing (Including Industrial Action) are driving an overall overspend.

Non-Pay overall is over plan with pressures in Clinical Consumables, due to increased activity, and Services and Recharges from Other Trusts.

CIP is ahead of plan by £7.6m – further detail in later slides

Care Colleagues Collaboration Communities

Finance | Variable Contract Performance



Performance

- At Month 6 WHT are £1.6m above contract/funding limit
- Continuing WLIs at the current level will result in FOT overperformance of **£3.7m**
- The internal plan is delivered with core divisional budgets
- The gap between internal plan and funding limit is planned to be delivered with WLIs, count/code and productivity

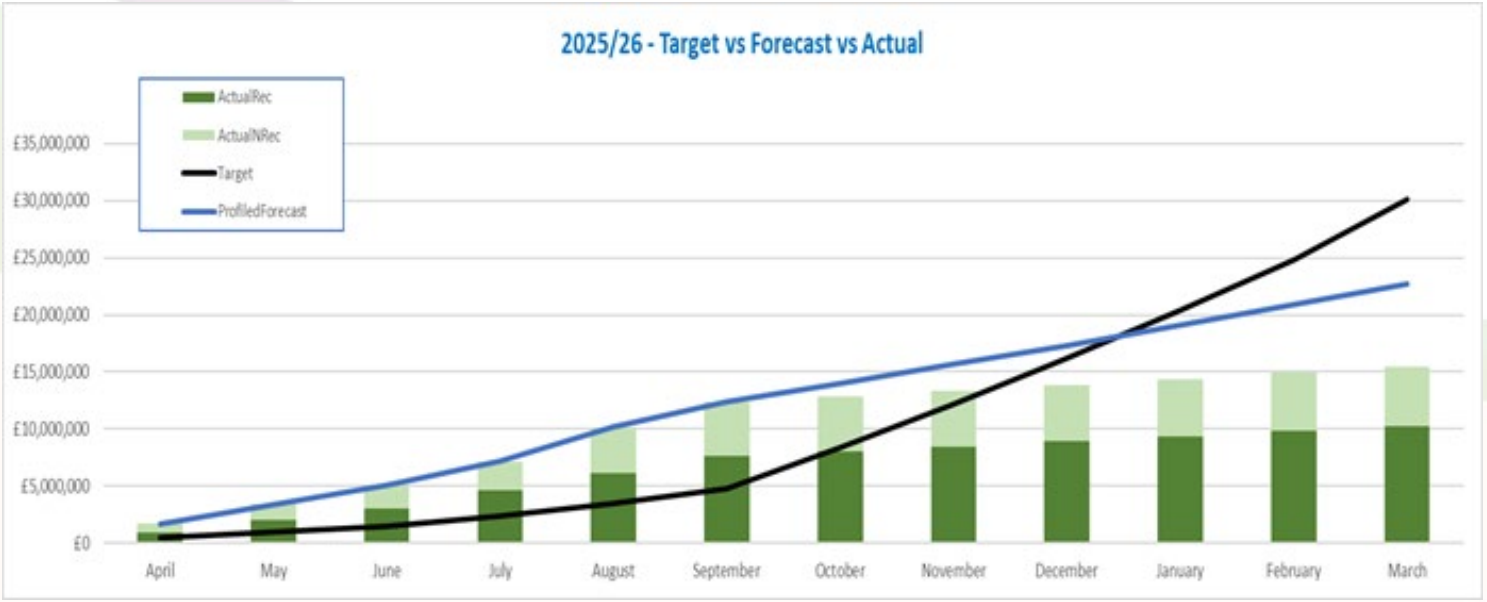
Care Colleagues Collaboration Communities

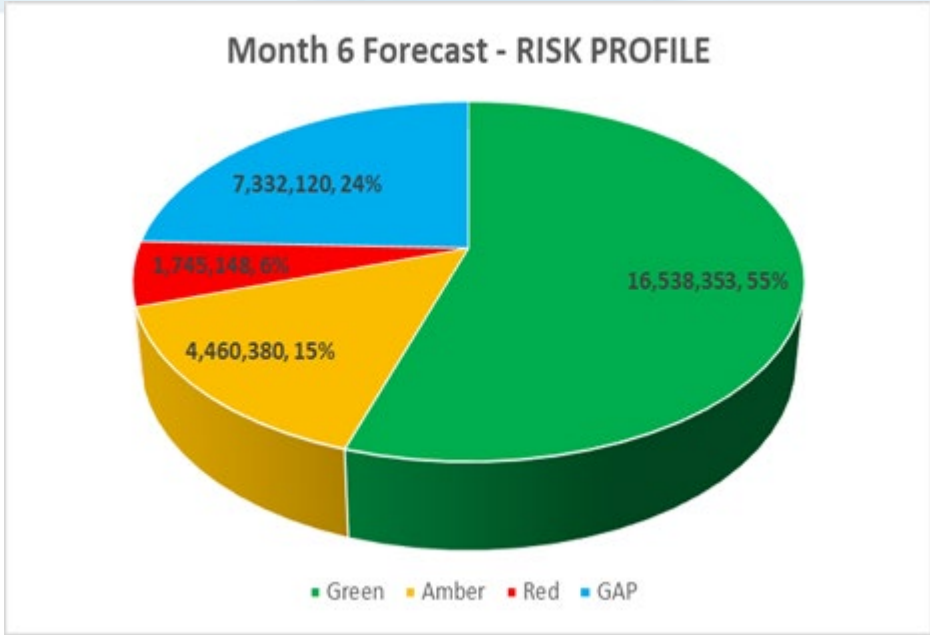
Finance | Cost Improvement Plans

Plan vs Target

The Trust CIP target of £30.1m includes £9.8m of headcount reduction plans. A significant proportion of the forecasted schemes £13.5m (45%) 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.





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 Framework - WHT

				Q1 25/26					
				Published			Internal	Internal	Internal
Code	Metric	Time Period Reported	Target	Perf	Score	Rank	Jul-25	Aug-25	Sep-25
OF0023	18 Weeks RTT - % Within 18 Weeks - Incomplete	Latest month in the period		71.46%	1.28	13/131	71.11%	70.54%	71.93%
OF0003	18 Weeks RTT - 52 wk breaches as a % of PTL	Latest month in the period	1%	0.16%	1.00	11/131	0.16%	0.04%	0.05%
OF0106	Difference between actual and planned 18 week elective performance	Latest month in the period	0%	2.42%	1.00	40/131	1.43%	1.11%	2.04%
OF0005	Percentage of patients waiting over 52 weeks for community services	End of period		4.36%	3.05	55/80	4.89%	6.57%	6.95%
OF0010	Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80%	85.74%	1.00	4/118	87.20%	87.31%	
OF0011	Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75%	80.81%	1.00	11/118	79.31%	81.42%	
OF0013	Total Time Spent in ED - % within 4 Hours	Aggregated quarterly position	78%	78.00%	1.00	37/123	77.03%	78.04%	75.03%
OF0014	Total Time Spent in ED - % over 12 Hours	Aggregated quarterly position		4.92%	1.86	36/123	4.59%	5.37%	6.33%
OF0079	Planned Surplus / Deficit	Annual plan	0	-6.31	4.00	116/134	283	329	1494
OF0081	Year to date variation from plan	Year to date		2.82	1.00	2/134	-2558	-2229	-3723
OF0085	Implied level of productivity	In-year figure to latest month vs same period in previous year		4.17	1.95	43/134			
OF1069	CQC inpatient survey satisfaction rate	Annual			2.00				
OF0061	Staff survey - raising concerns sub-score	Annual		6.34	2.85				
OF1067	CQC safe inspection score	Periodic inspection							
OF0088	Rate of C-Difficle infections (Rolling 12 Months)	12-month rolling	1	0.92	1.00	1/134	0.97	1.02	0.95
OF0020	Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	3.00	2.63	55/134	3	4	4
OF0048	Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.83	3.96	132/134	1.94	1.90	1.83
OF0025	Average number of days between planned and actual discharge date	Latest month in the period		0.40	1.50	22/126	0.3	0.3	
OF1046	Summary Hospital Level Mortality Indicator (Rolling 12 Months)	12 month rolling			2.00				
OF0057	Community - Urgent Care Response (UCR) 2 Hour Response	Quarterly aggregated figure	70%	75.17%	2.82	42/51	73.53%	68.25%	65.82%
OF0084	Staff survey engagement theme score	Annual		6.80	2.89	85/134			
OF0082	Staff Sickness Rate	Quarterly – aggregated monthly figures		6.78%	3.78	131/134	6.05%	6.45%	6.08%

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	1.97
Pre-Adjusted Segment	1
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 applicable to the Trust. The Trust has been placed into Segment 3 for Quarter 1 of 2025/26.

Care Colleagues Collaboration Communities

Productivity

The productivity dashboard overleaf shows the Trust's performance against the metrics used by NHS England to define a providers productivity. The single overriding measure of a Trusts productivity is its Implied Productivity Growth – a calculation that essentially compares inputs to outputs, compared to last year. A 4.3% increase in productivity (compared to last year) puts the Trust in the top quartile of Trusts nationally..

There are a range of underpinning metrics covering operational and productivity (that focus on the utilisation of assets in the main) as well as workforce productivity. The Trust benchmarks well (i.e. within the top quartile) for the proportion of procedures completed as a day case or outpatient procedure and also for its in session theatre utilisation. Whilst the number of cases completed per list is lower than Wolverhampton, the utilisation of lists is considerably higher.

Outpatient services offer an opportunity for productivity improvements with the DNA, PIFU utilisation rate and Specialist Advice rates all performing worse than the national average. An amount of follow up is also still taking place without being remunerated – this is by virtue of follow up income being fixed at 2019/20 levels.

Workforce productivity has improved by 5.3% in the year with non-elective and elective admissions per clinical WTE in line with the national average. There are generally less outpatient attendances taking place per consultant WTE than in other Trusts however more A&E attendances per emergency medicine consultant. Temporary staff spend as a proportion of total spend is considerably higher than the national value and this does not include waiting list initiative expenditure.

NHS England have advised that productivity packs are soon to be circulated to Trusts to assist with the planning submission – details will be incorporated into this productivity dashboard once received.

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Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target			2025/26					
			Source	Baseline	Target	Apr	May	Jun	Jul	Aug	Sep
1	Implied Productivty Growth (year to date compared to last year)	Output growth (cost-weighted activity) divided by input growth (workforce) compared to the same in last years period.	Model Health System	Top quartile	4.30%	Awaiting methodology from NHS England in order to calculate internally - expected by 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	Model Health System	N/A	N/A	2.70	3.40	2.90	2.80	3.20	3.80
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	Model Health System	N/A	N/A	8.70	8.00	8.10	7.70	7.90	8.30
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	National planning	annual	92.00%	94.00%	94.44%	93.03%	93.33%	93.05%	94.31%
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).	Model Health System	Quartile 1 (lowest provider)	22.20%	23.49%	22.22%	21.52%	21.85%	19.66%	21.32%
Theatre Utilisation											
6	Capped elective theatre utilisation	Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration	Model Health System	NHSE	85.00%	80.00%	83.20%	84.50%	80.00%	82.00%	83.60%
7	Average number of cases completed per theatre list	Total number of cases completed divided by total number of sessions utilised	Model Health System	Quartile 3 (lowest provider)	2.3	1.78	1.89	1.83	1.96	1.93	1.97
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	Model Health System		93%	93.27%	90.45%	95.83%	90.93%	93.19%	95.89%
9	CT, MRI & ultrasound utilisation		National planning	annual	**95%**	To follow next month					
Outpatients											
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	Careflow	Trust Internal	95.00%	78.40%	78.50%	79.91%	79.11%	77.98%	79.99%
11	DNA Rate	Number of outpatient missed outpatient appointments divded by total outpatient appointments	Careflow	Trust Internal	8.00%	7.99%	8.02%	8.34%	8.91%	8.18%	8.05%
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	National planning	annual	5.00%	4.42%	5.13%	5.41%	4.77%	4.42%	5.02%
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referra) divded by total number of outpatient first attendances	National planning	NHSE	13.00%	8.76%	8.55%	9.08%	6.44%	6.31%	11.07%
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	0	963	0	0	850

Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target			2025/26					
			Source	Baseline	Target	Apr	May	Jun	Jul	Aug	Sep
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.	Model Health System	N/A	N/A	£1,798	£1,849	£1,732	£1,793	£1,793	£1,820
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes		Trust Internal	tbc	£145 k	£96 k	£182 k	£270 k	£195 k	£121 k
17	Number of unfunded services being delivered	Number of services being delivered that do not have any form of funding arrangement in place			0	9	9	5	5	5	4
Non Pay											
19	Procurement CIP	Value of procurement cost improvement savings delivered		Trust Internal	tbc	£149 k	£269 k	£172 k	£205 k	£139 k	£173 k
Workforce Productivity											
20	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.	Model Health System	Quartile 1 (lowest provider)	1.90	3.03	3.07	3.02	3.20	3.08	3.28
21	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.	Model Health System	Quartile 1 (lowest provider)	2.00	1.55	1.59	1.76	1.85	1.51	1.76
22	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.			N/A	130.88	131.46	137.71	139.92	143.90	157.96
23	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.	Model Health System	Quartile 1 (lowest provider)	613	529.90	492.32	475.18	492.55	450.60	527.32
24	Corporate services cost per £100m income (£m)	The total cost of corporate services divided by £100m.	Trust	20% reduction on March 2025	0.41	0.55	0.54	0.51	0.50	0.56	0.43
Workforce Drivers											
25	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	Model Health System	August 2025 Upper benchmark top 3rd	8.50%	9.71%	10.22%	10.33%	9.72%	11.55%	9.61%
26	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	Trust	Internal	5%	5.64%	5.64%	5.76%	6.05%	6.45%	6.08%
27	Turnover Rate	The percentage of all staff that left the organisation to join another NHS organisation, or left NHS over the previous 12 months.	Trust	Internal	10%	9.24%	9.09%	8.61%	8.38%	7.12%	7.09%
28	Care hours per Patient Day	Total care hours worked by registered nurses & midwives divided by total patient bed days	Model Health System	August 2025	4.70	4.50	4.40	4.50	4.50	4.50	4.20
Support Services											
29	Estates and Facilities Cost per m2	Total estates and facilities running costs divided by total occupied floor area	Model Health System	2023/24 quartile 2 (2nd best)	£495.67						
30	Pathology cost per test	The average cost of undertaking one test across all disciplines, taking into account all pay and non-pay cost items			N/A	To follow next month					

Enclosure 12.2

Integrated Performance Report

The Royal Wolverhampton NHS Trust

September 2025 (Month 6)

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

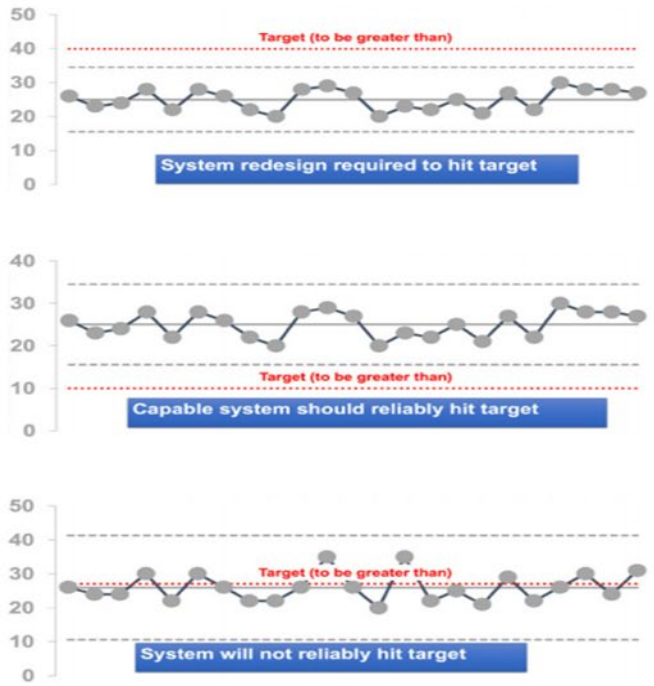
Care Colleagues
Collaboration Communities

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:



Care Colleagues Collaboration Communities

Managing Director Summary

- The Trust went live with the BluePrint EPR Programme over the weekend of 27/28th September 25 and a full launch on Monday 29th September 25. There is a summary paper included in the Board Papers. It should be noted that the Trust replaced its patient administration systems, covering inpatients, outpatients and community, it's ED system and other emergency portals and same day emergency centres and finally it's theatres information system. This was a huge programme of work in the planning and execution. There were some (expected) teething problems, however, the Trust is using the system as business as usual and is able to execute all expected internal and external reports.

- There is a forecast reduction in activity for 2 weeks whilst the programme went live and embedded into the organisation, this is expected to have an impact on activity / performance and income. There are plans in place to ensure the full recovery of all to achieve RTT and ERF trajectories over the financial year. Note, that Industrial action is planned by resident doctors 14-19th Nove

- There has also been an increase in ambulance handover times and waiting times in ED. The winter plan actions have been initiated across the Trust for adults and children to reduce waits for patients.

- The Trust has seen an increase in admissions for flu and is focussed on ensuring that as many staff as possible access the flu vaccination.

- Discussion with West Midlands Fire Service about the fire enforcement notices across the New Cross Hospital site and in particular the Maternity Building have continued, and a further update will be presented to the Private Section of the Board.

- Progress continues to be made with regard to the works required at Cannock Chase Hospital (under Staffordshire Fire Service remit).

- The Trust submitted the self assessment with regard to achievement of the core standards for Emergency Preparedness, Resilience and Response (EPPR) in August 25. The Trust has improved it's rating from last year (partial) to substantially compliant following external review and assessment. 62 Standards, 56 substantial and 6 partial.

- During September and October 25 we have celebrated AHP day, led by Chief Allied Health Professional, Black History Month and the festival of Diwali.

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	3.34	3.56	Sep-25	-	Common Cause	Inconsistent
Pressure ulcers per 1,000 occupied bed days	1.50	2.21	1.64	Sep-25	1.26	Common Cause	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.45	0.49	Sep-25	-	Concern	Achieving
Observations on time (Trust wide)	90.00%	88.90%	87.90%	Sep-25	-	Improvement	Not Met
VTE risk assessment - % within 14 hours	95.00%	89.90%	90.50%	Aug-25	-	Concern	Not Met
Sepsis screening - ED	90.00%	100.00%	100.00%	Sep-25	-	Common Cause	Achieving
Sepsis screening - Inpatients	90.00%	86.00%	82.50%	Sep-25	-	Concern	Inconsistent
Clostridioides difficile	5	9	10	Sep-25	5	Common Cause	Inconsistent
MRSA Bacteraemia	0	0	0	Sep-25	-	Common Cause	Inconsistent
Number of complaints as a % of admissions	0.50%	0.41%	0.51%	Sep-25	-	Concern	Achieving
FFT recommendation rates - Trust wide	92.00%	88.00%	82.00%	Sep-25	92.00%	Common Cause	Not Met
Care hours per patient - total nursing & midwifery staff actu	7.6	7.6	7.4	Sep-25	7.7		No Target Set
Care hours per patient - registered nursing & midwifery staf	4.5	5.0	4.9	Sep-25	-	Common Cause	No Target Set
SHMI	1.00	0.96	0.96	Sep-25	-	Concern	Achieving
Never events	0	0	0	Sep-25	-	Improvement	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	10131.36	10109.61	10102.80	Sep-25	-	Improvement	Inconsistent
Agency (WTE) Trust	24.01	25.88	38.65	Sep-25	-	Common Cause	Inconsistent
Bank (WTE) Trust	522.30	573.75	576.61	Sep-25	-	Improvement	Inconsistent
Vacancy Rate	6.00%	5.34%	5.65%	Sep-25	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	9.04%	8.77%	Sep-25	-	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	91.11%	91.42%	Sep-25	-	Improvement	Inconsistent
Sickness Absence (Rolling 12 Months)	5.00%	5.37%	5.41%	Aug-25	-	Concern	Not Met
Appraisals	90.00%	80.85%	81.57%	Sep-25	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	94.58%	94.70%	Sep-25	-	Concern	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%	54.69%	54.99%	Sep-25	82.13%	Concern	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	0.99%	2.43%	2.44%	Sep-25	-	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	75489	77368	75270	Sep-25	39142	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	80.19%	76.69%	Sep-25	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	96.00%	93.92%	88.69%	Sep-25	89.05%	Improvement	Not Met
Cancer - 62 Day Referral to Treatment	75.00%	71.07%	55.10%	Sep-25	56.85%	Improvement	Not Met
No. of patients no longer meeting the Criteria to Reside	89	92	77	Sep-25	-	Common Cause	Inconsistent
Diagnostics - % within 6 weeks from referral	95.00%	94.86%	95.53%	Sep-25	84.70%	Improvement	Not Met
Total Time Spent in ED - % over 12 Hours	-	10.63%	11.11%	Sep-25	-	Common Cause	No Target Set
Total Time Spent in ED - % within 4 Hours	78.00%	80.63%	80.51%	Sep-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	-247	-12	Sep-25	-	Common Cause	Inconsistent
Surplus/(Deficit) (£000) - YTD	-3379	6204	-6126	Sep-25	-	Improvement	Inconsistent
Surplus/(Deficit) (£000) - FOT	-	0	0	Sep-25	-	Improvement	No Target Set
Elective Variable (£000) - in month	14631	14860	16472	Sep-25	-	Concern	Inconsistent
Elective Variable (£000) - YTD	28905	77288	93760	Sep-25	-	Concern	Inconsistent
Elective Variable (£000) - FOT	180585	186238	186238	Sep-25	-	Improvement	Inconsistent
Efficiency (£000) - in month	2907	3441	4539	Sep-25	-	Common Cause	Inconsistent
Efficiency (£000) - YTD	5707	18226	22765	Sep-25	-	Concern	Inconsistent
Efficiency (£000) - FOT	57240	57240	57240	Sep-25	-	Improvement	Not Met
Capital (£000) - YTD	1636	4467	6349	Sep-25	-	Improvement	Inconsistent
Capital (£000) - FOT	29350	34773	35005	Sep-25	-	Not Enough Points	Not Enough Points
Cash (£000) - in month	48124	53256	28339	Sep-25	-	Common Cause	Inconsistent
Cash (£000) - FOT	26081	40022	31729	Sep-25	-	Not Enough Points	Not Enough Points

Quality, Safety & Patient Experience | Executive Summary

- To support improvements in quality metrics and performance associated with Emergency Department (ED) long waits, Division 2 have set up a Task Group with interventions including process mapping front triage, improved utilisation of the Same Day Discharge Centre and medication processes. Work with PA consulting to develop Community First schemes has commenced

- Pressure ulcers demonstrate an improved position in month whilst falls incidents remain static, with evidenced actions aligning to Embedding Eat, Drink, Dress, Move (EDDM) in the Quality Framework. Senior Nursing, Midwifery and AHP Leaders will have oversight of locally led improvement projects that will commence following the successful conference and workshop held across the Collaborative.

- Since the introduction of the Sepsis Dashboard, overall Trust performance has shown a 20-30% reduction in high scoring (Early Warning Score) patients, demonstrating a wider impact on the management of the deteriorating patient.

- Nursing and Midwifery vacancies have increased from 120.02 wte in August to 141.98wte, an increase of 21.96 wte. Nurse Education are currently working with resourcing to recruit the newly qualified Nurses and Midwives. 116 potential candidates have applied to be part of the “talent pool”. 12 candidates have been offered a position, 13 to interview and 26 candidates are currently in the talent pool.

- A total of 10 *C.difficile* cases have been reported in month, demonstrating an increasing trend following improved performance previously seen during this financial year. Analysis of current cases of health care associated infections and interventions are underway, which will be presented during a scheduled NHSE and ICS Infection Prevention review in November 2025.

- The Standardised Hospital Mortality Indicator is 0.96; within the expected range. Individual diagnostic groups with higher-than-expected SHMI values are reviewed via clinical pathway meetings and the Trust is proactively managing the Learning from Deaths agenda overseen by the Mortality Review Group. Currently there are 5 diagnosis groups that are managed as outliers, and they include Pneumonia, AMI, COVID-19, Short Gestation, Digestive, Anal and Rectal Conditions.

Authors

Debra Hickman (Chief Nursing Officer)

Brian McKaig (Chief Medical Officer)

Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

- The Trust continues to experience an upward trajectory in the volume of complaints received, representing an increase of 15 cases compared with the previous month. Key themes within formal complaints relate to clinical treatment, delays, and patient discharge processes.

- The Patient Experience Enabling Strategy will be a central feature of the upcoming Patient Experience Summit in November, under the theme Hear. Learn. Change., supporting the Trust's commitment to continuous improvement in patient experience.

- Two Complaint Investigation Training Modules are now available on My Academy as e-learning courses. Uptake will be monitored by the Patient Relations Team, with progress reported through the Patient Experience Group to ensure learning is embedded across services.

Authors

Debra Hickman (Chief Nursing Officer)

Brian McKaig (Chief Medical Officer)

Care Colleagues Collaboration Communities

Perinatal Service | Executive Summary

- Birth Rate + report final version received. The report is being presented through local governance and to CNO.
- MNVP 15 steps event attended by NED BSC – high level feedback has been given and awaiting report from MNVP. Themes in feedback were related to interpreting services not being accessible. Positive feedback was also received about the maternity service specifically related to care / caring.
- Training for Emergency skill drill PROMPT has dropped in compliance due to the rotation of Obstetric Medical workforce.

Actions to improve care for women, babies, and families: next steps.

Trusts received a letter in October 2025 outlining the outcome of the rapid independent review into maternity and neonatal services following the Secretary of State for Health and Social Care announcement in June 2025. The letter outlines the next steps for Trust Boards and Perinatal leaders and focuses on 4 areas for improvement:

1. Giving Perinatal teams the skills and tools to improve the experiences and outcomes of ethnic minority groups and deprived communities. Supporting leaders through a Perinatal Equity and Anti-Discrimination Programme. This programme follows on from the Perinatal Culture and Leadership Programme (PCLP).
ACTION: RWT Perinatal leadership team were in the first tranche of the national programme. Cultural development programmes continue with teams. Embedded EDI lead Midwife working with ethnic minority groups and the most vulnerable birthing people. Board maternity and neonatal safety champions have strong links with perinatal leadership teams and visible in all areas.

2. NHS England has created a portal to reduce administration time for front line staff. Submit a Perinatal Event Notification (SPEN) streamlines data input into MBRRACE-UK (Mother and babies: Reducing Risk through Audits and Confidential Enquires), Maternity and Newborn Safety Investigations (MNSI) and NHSR Early Resolution Scheme (ERS).
ACTION: On boarding commences 3rd November, nominated users already identified form within the Perinatal leadership teams. Training has commenced.

3. Monitoring performance through a Maternity and Neonatal Performance Dashboard.
The national dashboard will represent a balanced scorecard of operational; outcome and patient experience measures.
ACTION: National set of metrics have been set. RWT will continue to report bimonthly to Trust Board on Maternity and Neonatal safety.
A national standardised Board report will be produced and released shortly.

4. Maternity and Neonatal Improvement Support team will replace the current Maternity Safety support Programme to add an additional focus on maternity and neonatal expertise.
ACTION: Trusts awaiting further information on this programme.

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

	June	July	August	September
PMRT Reviews (including babies >28 days old or not born at RWT)	7	5	5	6
Grades Maternity/neonatal	A = 0	A = 2	A = 1	A = 1
	B = 5	B = 3	B = 3	B = 3
	C = 2	C = 0	C = 1	C = 2
	D = 0	D = 0	D = 0	D = 0
Final MNSI Reports Received	2	0	0	1
Incidents Moderate & Above (all new MNSI cases and those assigned PMRT C and D, and those assigned moderate harm on datix)	4	2	0	2
Service user & Staff Feedback to Board Level Safety Champions	Ante/Postnatal ward	Antenatal Clinic	Triage and induction unit	15 Steps event attended by NED BSC
Coroner Reg 28	0	0	0	0
Obstetrics/Gynaecology Trainees Quality of Clinical Supervision reported annually				

*Themes are detailed on page 2

CNST & Training Position 30.09.2026

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	1	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%

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	81%	68%	81%
Midwives	89%	85%	89%
Support Staff	68%	NA	NA
Anaesthetists	80%	NA	NA
Neonatal Doctors	NA	NA	100%
Neonatal Nurses	NA	NA	79%

Perinatal Staffing

Staff Group	May		June		July		August	September
Midwives Birth to midwifery ratio Planned/Actual	21	27	21	21	27	27	27	27
Obstetrics RCOG Compliant on delivery suite	yes		yes		yes		yes	yes
Neonatal Nurses BAPM Compliant	45%		90%		58%		76%	61%
Neonatal Doctors BAPM Compliant	yes		yes		yes		yes	yes

Care Colleagues

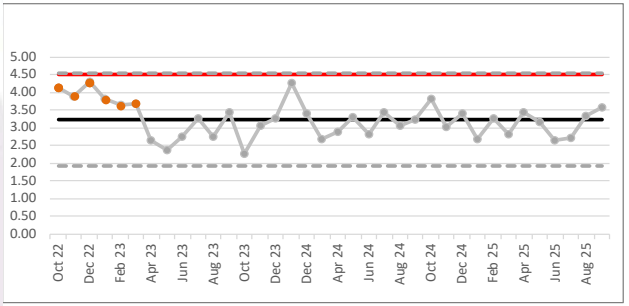
Collaboration Communities

Based on actual acuity and staffing numbers, rather than QIS

Quality, Safety & Patient Experience | Core Metrics

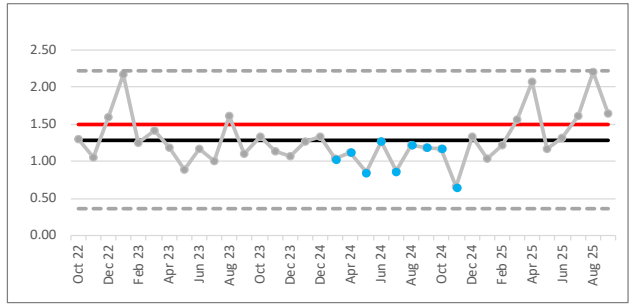
Patient falls - rate per 1,000 occupied bed days

Inconsistent	Common Cause	3.56



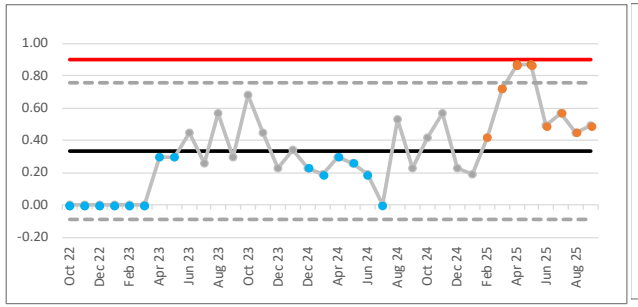
Pressure ulcers per 1,000 occupied bed days

Inconsistent	Common Cause	1.64



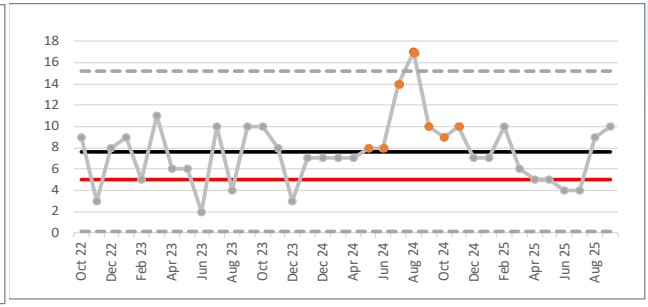
Community acquired pressure ulcers per 10,000 population

Achieving	Concern	0.49



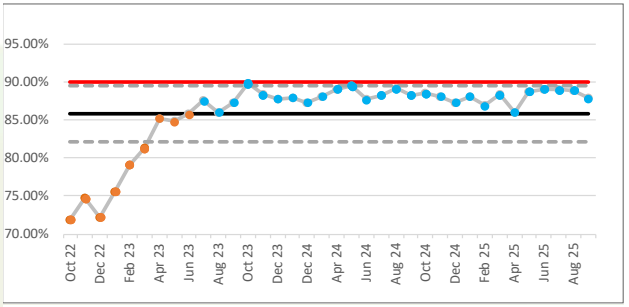
Clostridioides difficile

Inconsistent	Common Cause	10



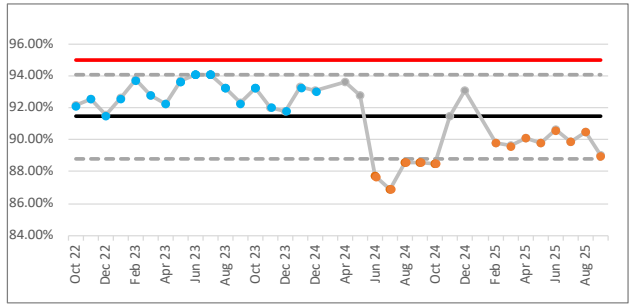
Observations on time (Trust wide)

Not Met	Improvement	87.90%



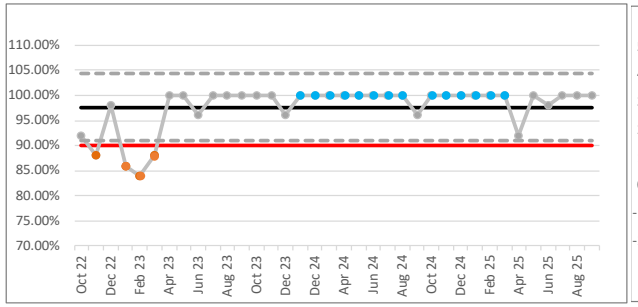
VTE risk assessment - % within 14 hours

Not Met	Concern	89.00%



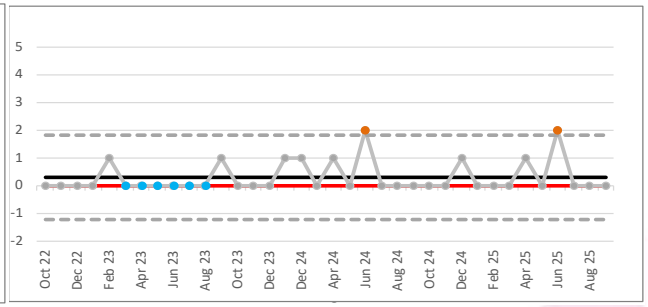
Sepsis screening - ED

Achieving	Common Cause	100.00%



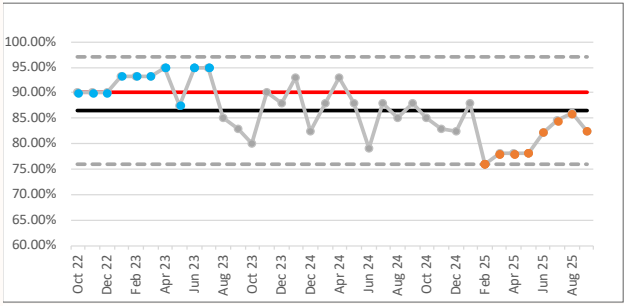
MRSA Bacteraemia

Inconsistent	Common Cause	0



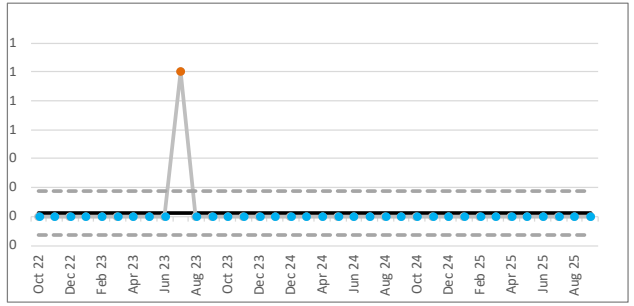
Sepsis screening - Inpatients

Inconsistent	Concern	82.50%



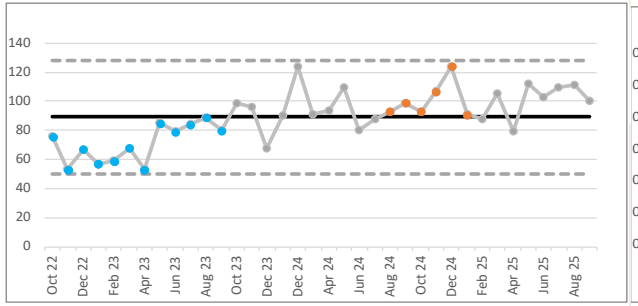
Medication error - incidents causing serious harm

No Target Set	Improvement	0



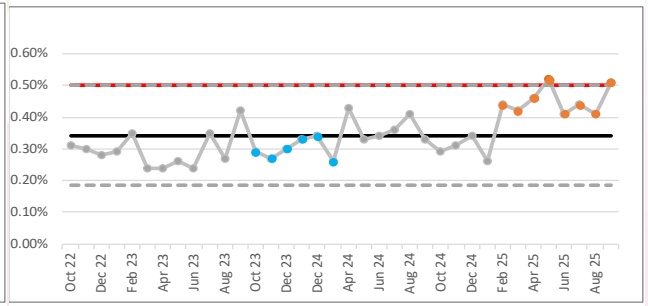
Mental health patients spending over 12 hours in A&E

No Target Set	Common Cause	100



Number of complaints as a % of admissions

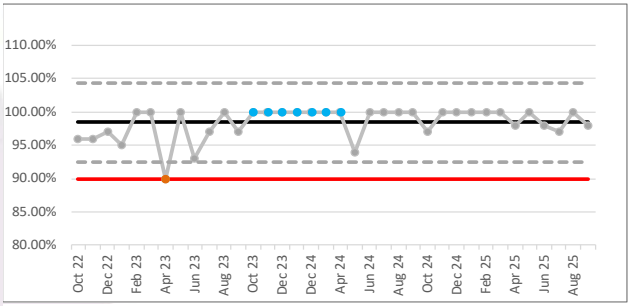
Achieving	Concern	0.51%



Quality, Safety & Patient Experience | Core Metrics

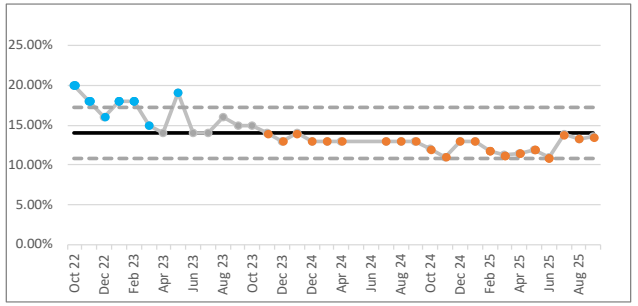
Complaints response rate against policy

Achieving	Common Cause	98.00%



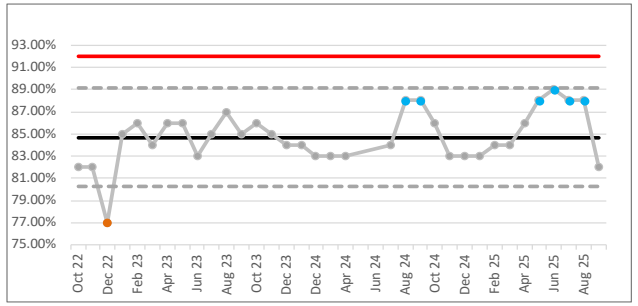
FFT response rates - Trust wide

No Target Set	Concern	13.50%



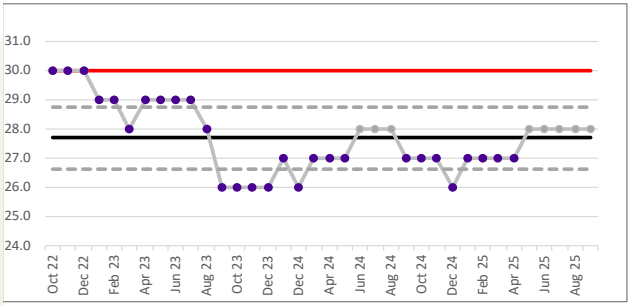
FFT recommendation rates - Trust wide

Not Met	Common Cause	82.00%



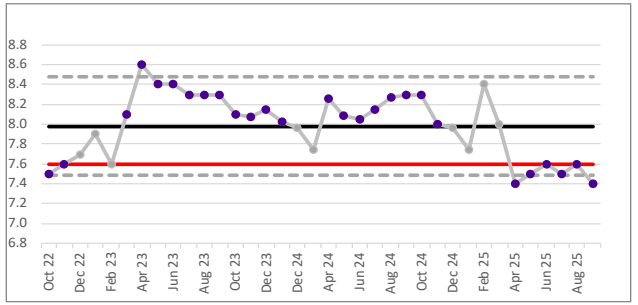
Midwife to birth ratio (1 to)

No Target Set	Common Cause	28.0



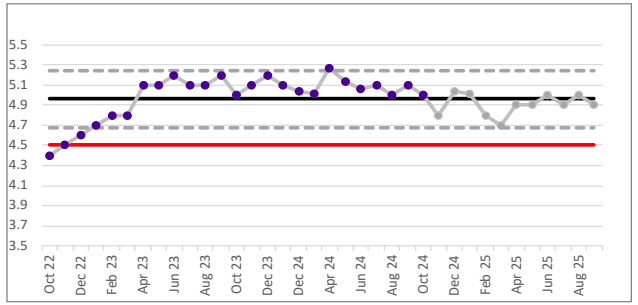
Care hours per patient - total nursing & midwifery staff actual

No Target Set		7.4



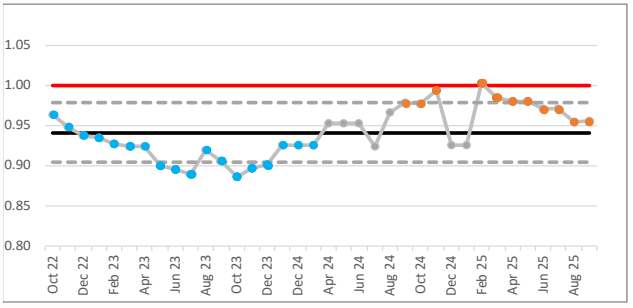
Care hours per patient - registered nursing & midwifery staff actual

No Target Set	Common Cause	4.9



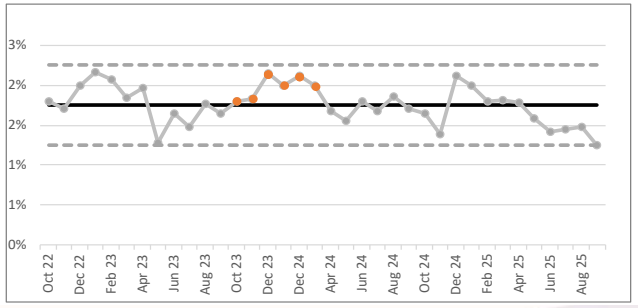
SHMI

Achieving	Concern	0.96



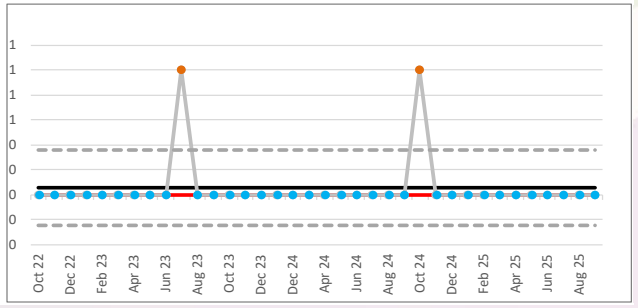
Crude Mortality Rate

No Target Set	Common Cause	1.25%



Never events

Inconsistent	Improvement	0



Care Colleagues Collaboration Communities

People | Executive Summary

RWT M6 overall workforce is 40.38 WTE above target, substantive is -28.56 WTE below plan with the in-month position driven by temporary workforce; bank is above plan by +54.31 WTE and agency +14.64 WTE. An overall increase in workforce in M6 compared to M5 by 8.81 WTE. YTD performance from M12 to M6 is an overall reduction of -200.72 WTE. Comprising of -220.99 WTE substantive staff, +9.95 WTE bank, and +10.32 WTE agency.

Movement from M5 to M6 has been minimal, for substantive there was an in-month reduction of -6.82 WTE and +2.86 WTE for bank, agency has increased in month by +12.77 WTE. Mental Health agency nursing spend was up from M5 by £43K, there was also an increase in medical agency in month for oncology, respiratory and stroke, an overall increase in medical agency spend from M5 of £180K.

Two of the six workforce indicators are not meeting the targets, appraisals and sickness; however, appraisal compliance increased slightly in month and remains amber. Sickness has continued to increase, long term sickness has remained stable in month, but short-term absence has increased from 3.57% to 3.61%.

Staff survey engagement remains challenged, as of 3rd November, overall trust response rate is 24.51%, just above the lowest Acute Trust rate (21.64%). Engagement remains low, requiring continued focus on improving participation.

Compared to 2024 survey levels:
BCPS: ↓18%, **Corporate Services:** ↓11%, **Division 1:** ↓2%, **Division 2:** ↑1%, **Division 3:** ↓6%
Estates & Facilities: ↑7%

Authors

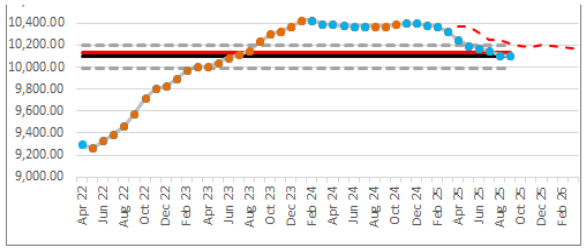
Alan Duffell (Group Chief People Officer)

Care Colleagues Collaboration Communities

People | Core Metrics

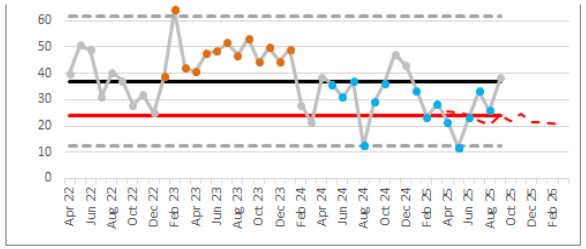
Substantive (WTE) Trust

Inconsistent	Improvement	10102.80



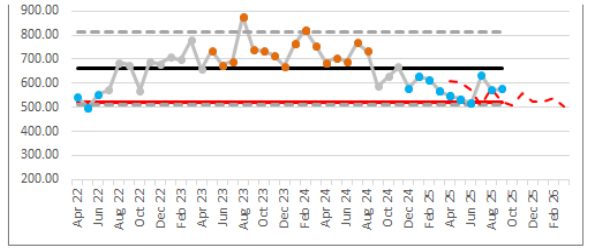
Agency (WTE) Trust

Inconsistent	Common Cause	38.65



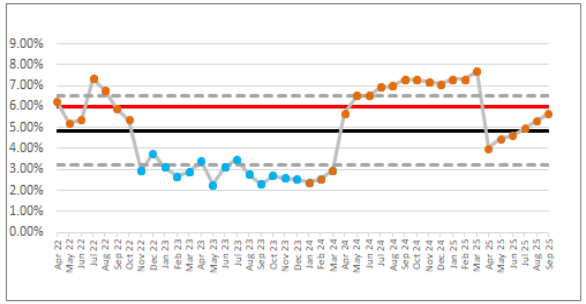
Bank (WTE) Trust

Inconsistent	Improvement	576.61



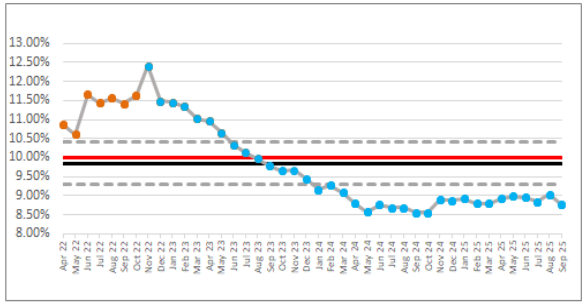
Vacancy Rate

Inconsistent	Concern	5.65%



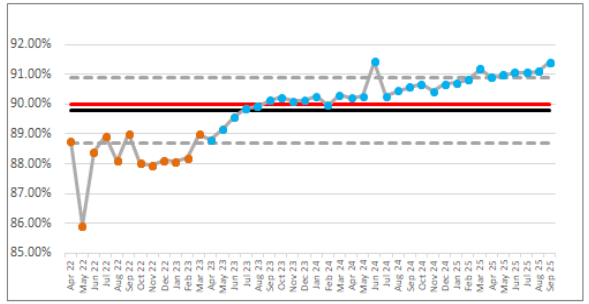
Turnover Rate (12 Months)

Inconsistent	Improvement	8.77%



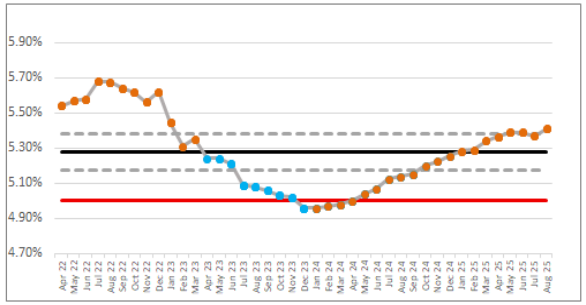
Retention Rate (12 Months)

Inconsistent	Improvement	91.42%



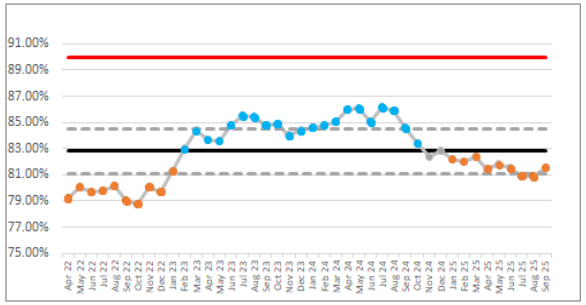
Sickness Absence (Rolling 12 Months)

Not Met	Concern	5.41%



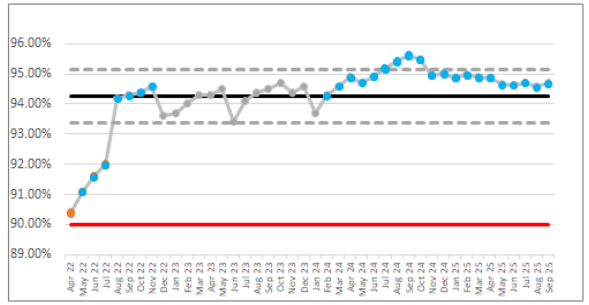
Appraisals

Not Met	Concern	81.57%



Mandatory Training

Achieving	Improvement	94.70%



Care Colleagues Collaboration Communities

Operational Performance | Executive Summary

Performance against the constitutional standards has been variable throughout September 25. The impact of implementing the new EPR system has affected all operational teams pre and post go-live and has been a particular challenge in ED and Outpatient Services.

RTT – The Trust continues to make steady progress in the reduction of the total waiting list with 75,270 patients on an incomplete pathway, an improvement from 77,368 in August 25. Improvement action plans are in place to meet the Trust's trajectory in December 25 and achieve 60% by the end of March 26. Nevertheless, improvement in our 18-week RTT position only improved marginally to 54.99% and will drop temporarily in October 25 as a result of the EPR challenges referenced above. Gynaecology, Urology and Head & Neck Services continue to be the specialities with the greatest challenge to recover. Insourcing support is in place for Gynaecology and Urology. Weekly monitoring is in place in addition to that undertaken at Directorate and Divisional level.

UEC – the 4hr performance standard was achieved in September 25 with 80.51% of patients seen and discharged/transferred from ED within this time frame. 12hr performance continues to be the area of most concern and this standard deteriorated further in September 25 with 11.11% of patients of waiting over 12hrs. In the main, this is result of poor operational flow and bed capacity. A recovery action plan is in place and includes actions to support earlier in the day discharges and increased use of the Same Day Discharge Centre as well increasing the use of schemes to avoid admission – Call Before Convery, Virtual Ward and SDECs (same Day Emergency Care).

Cancer – following final validation and upload the Trust delivered the 28-day faster diagnosis standard at 80.3%. 31day performance was 93.2% and 62day was 71.1%. Directorates continue to work on site specific pathways using Improvement Sprint methodology to target areas for improvement.

DM01 – diagnostic performance remains some of the highest in the Midlands at 95.53% with no areas of concern.

Authors

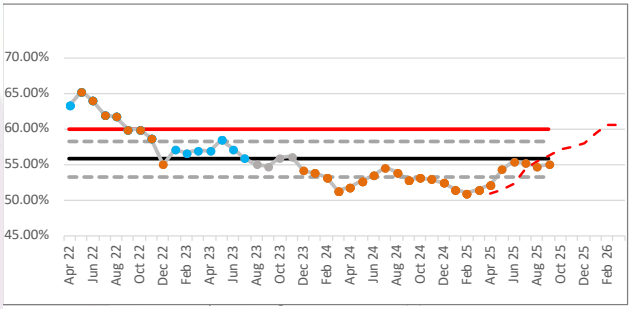
Kate Shaw
(Chief Operating Officer)

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

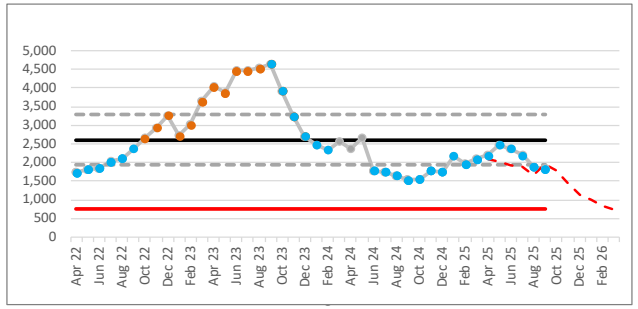
18 Weeks RTT - % Within 18 Weeks - Incomplete

Not Met	Concern	54.99%



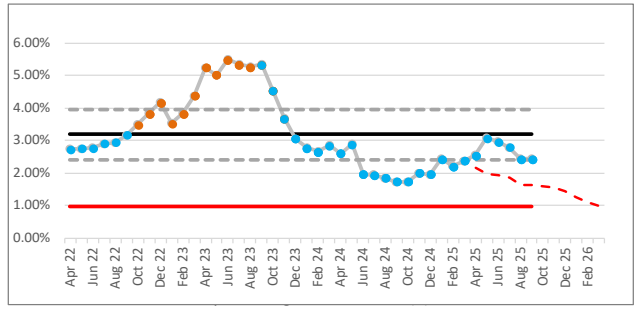
18 Weeks RTT - No. of 52 wk breaches

Not Met	Improvement	1838



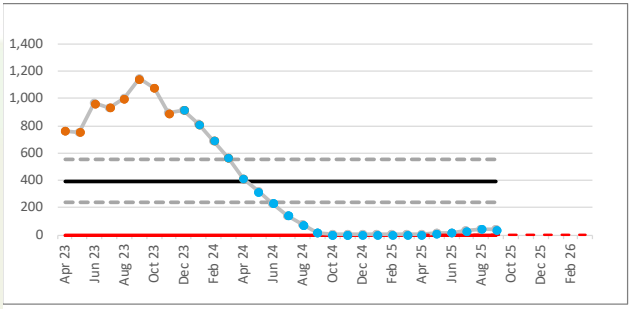
18 Weeks RTT - 52 wk breaches as a % of PTL

Not Met	Improvement	2.44%



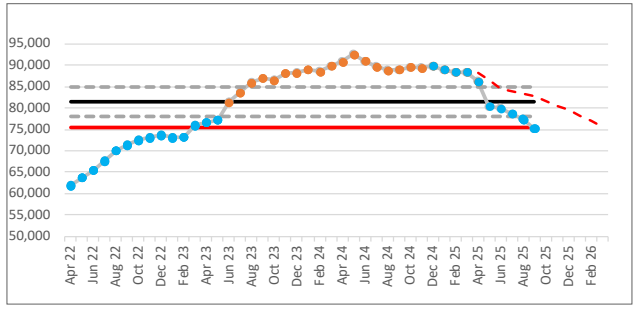
18 Weeks RTT - No. of 65 wk breaches

Not Met	Improvement	39



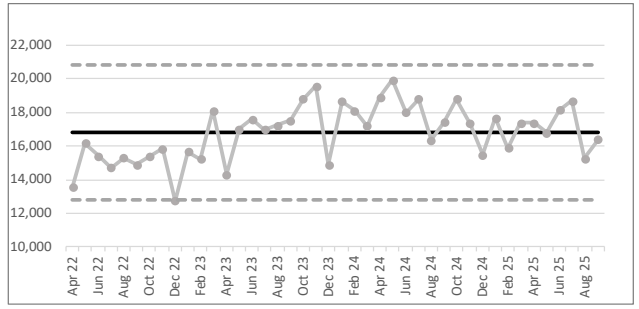
18 Weeks RTT - Total Incomplete PTL

Not Met	Improvement	75270



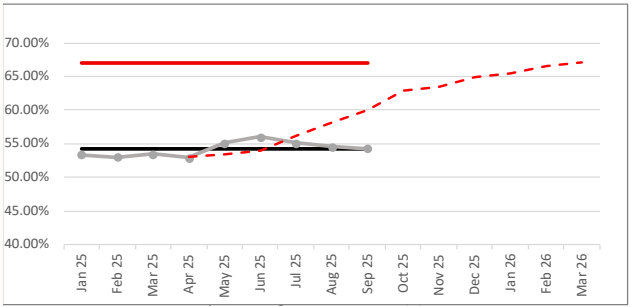
18 Weeks RTT - Clock Starts

No Target Set	Common Cause	16410



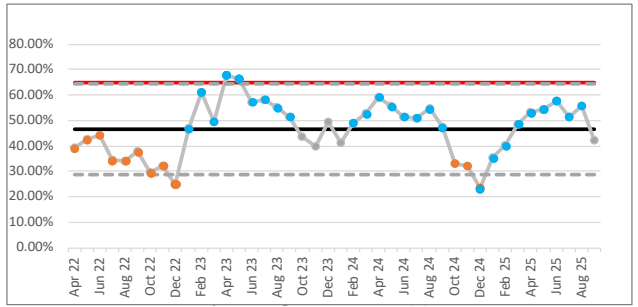
18 Weeks RTT - Time to First Appointment

Not Enough Points	Not Enough Points	54.30%



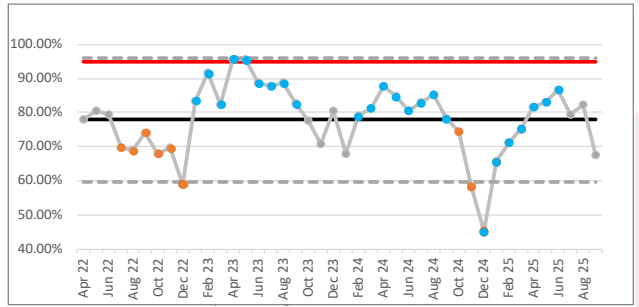
Ambulance Handover - % within 15mins

Not Met	Common Cause	42.43%



Ambulance Handover - % within 30mins

Inconsistent	Common Cause	67.38%

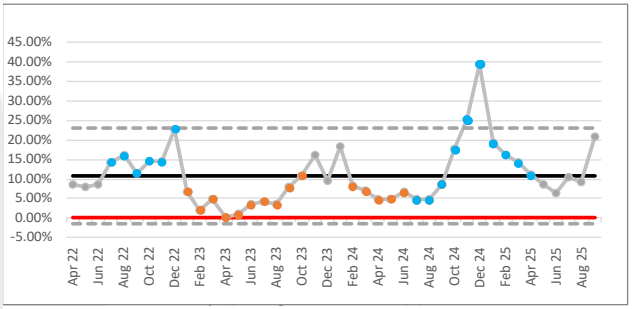


Care Colleagues Collaboration Communities

Operational Performance | Core Metrics

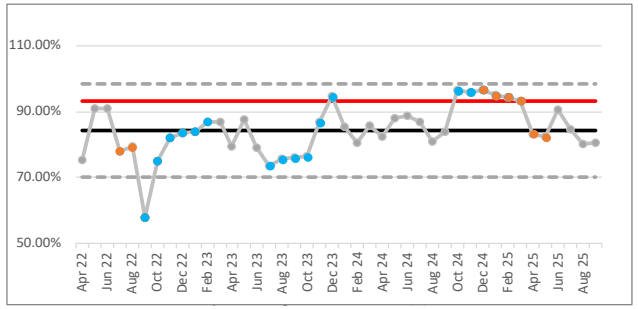
Ambulance Handover - % within 60mins

Inconsistent	Common Cause	20.89%



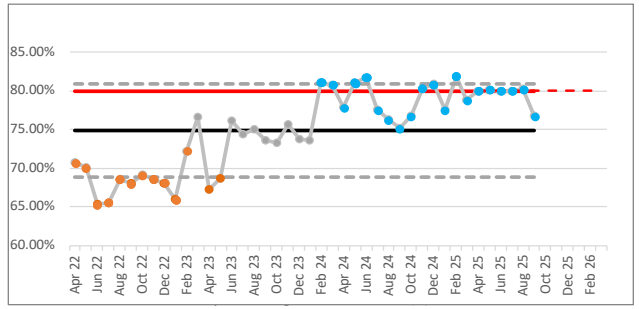
Cancer - 2 Week Wait

Inconsistent	Common Cause	80.54%



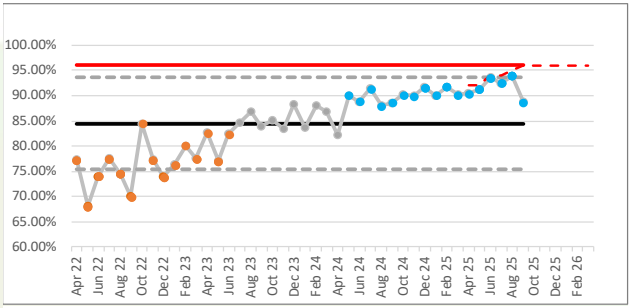
Cancer - 28 Day Faster Diagnosis

Inconsistent	Improvement	76.69%



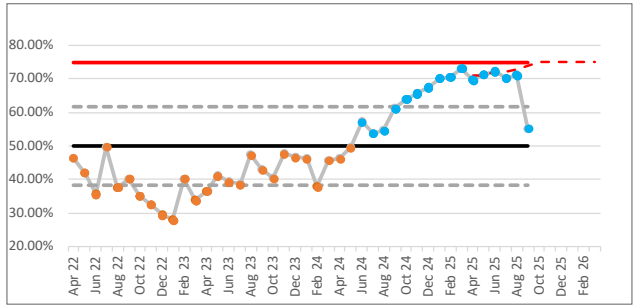
Cancer - 31 Day Treatment

Not Met	Improvement	88.69%



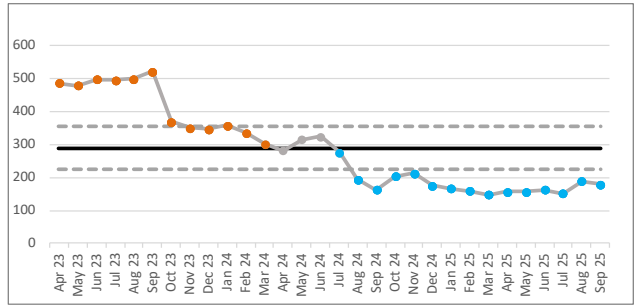
Cancer - 62 Day Referral to Treatment

Not Met	Improvement	55.10%



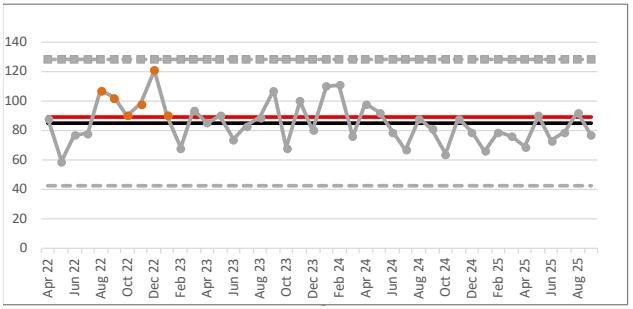
Cancer - No. of patients waiting 63+ Days for treatment

No Target Set	Improvement	179



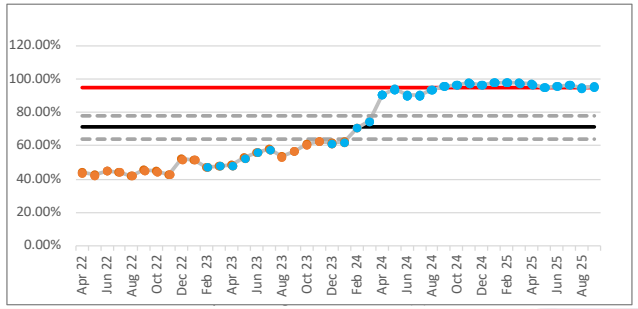
No. of patients no longer meeting the Criteria to Reside

Inconsistent	Common Cause	77



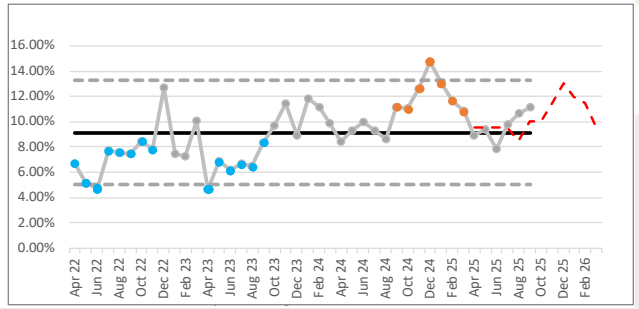
Diagnostics - % within 6 weeks from referral

Not Met	Improvement	95.53%



Total Time Spent in ED - % over 12 Hours

No Target Set	Common Cause	11.11%



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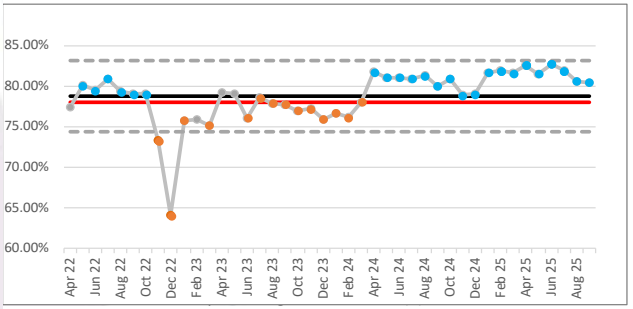
Operational Performance | Core Metrics

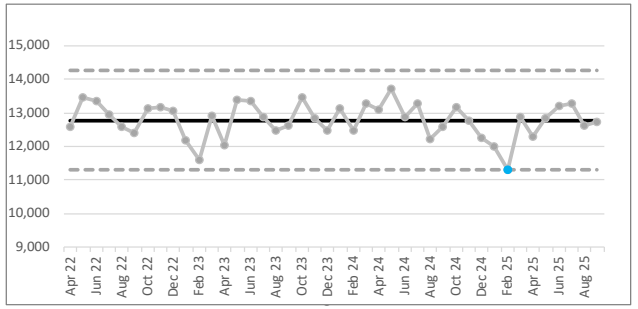
Total Time Spent in ED - % within 4 Hours

Inconsistent	Improvement	80.51%



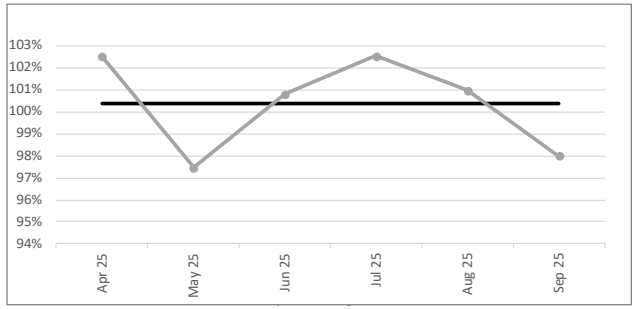
Type 1 ED Attendances

No Target Set	Common Cause	12731



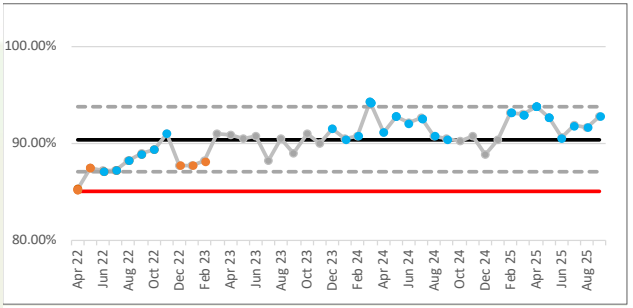
Variable Contract Delivery

Not Enough Points	Not Enough Points	103%



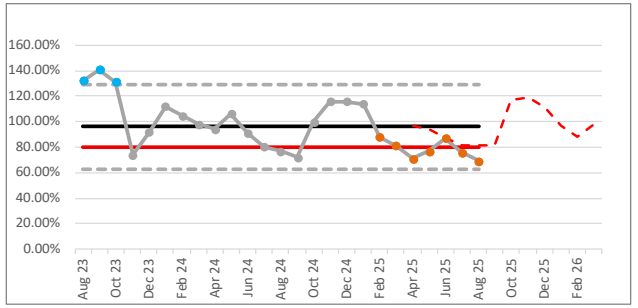
Theatres - Touch Time Utilisation (MH)

Achieving	Improvement	92.80%



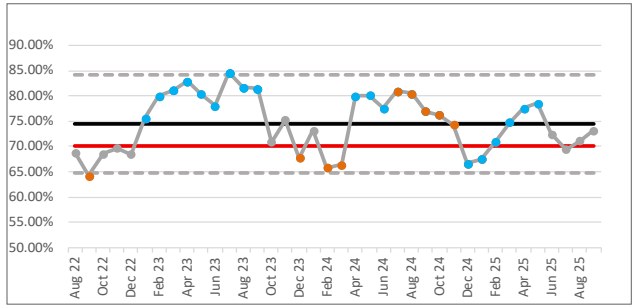
Community - Virtual Ward % Occupancy

Inconsistent	Concern	69.00%



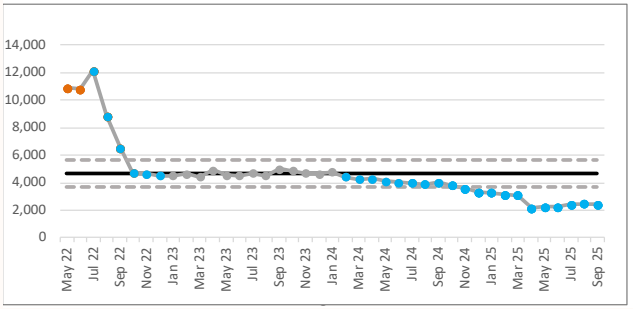
Community - Urgent Care Response (UCR) 2 Hour Response

Inconsistent	Common Cause	73.20%



Community - Waiting List - Total

No Target Set	Improvement	2401



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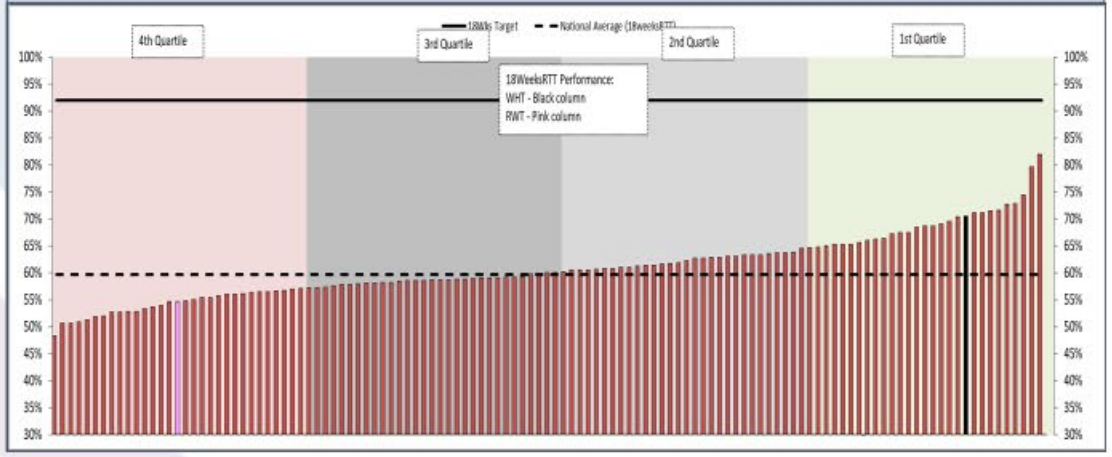
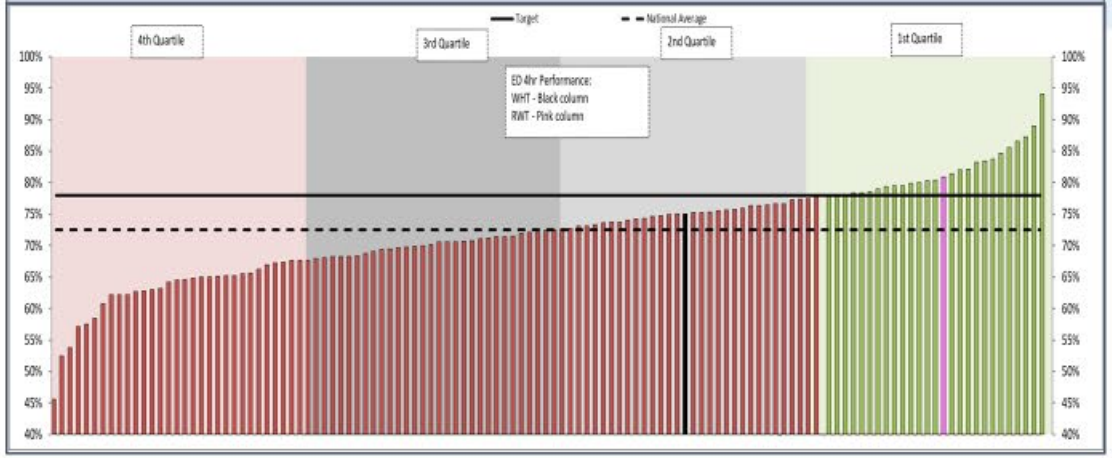
Operational Performance | Benchmarking

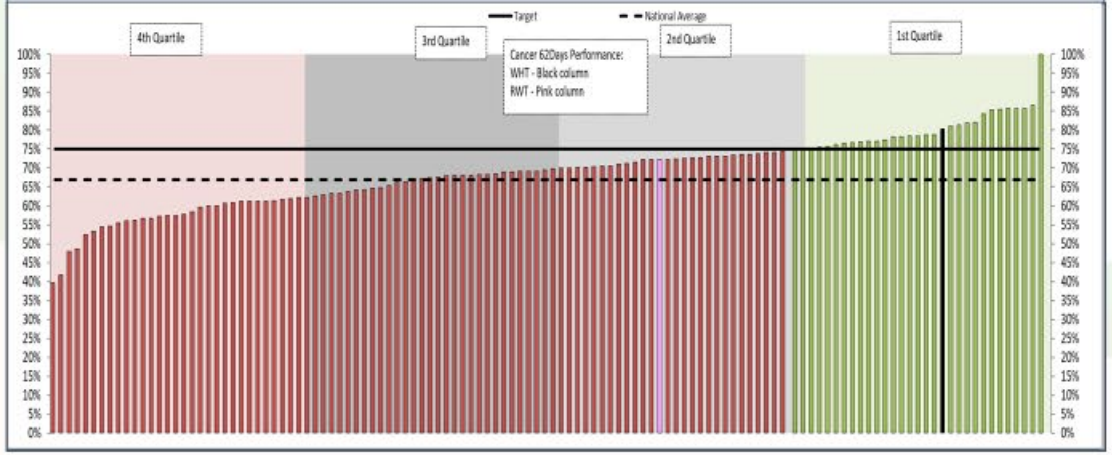
Referral to Treatment



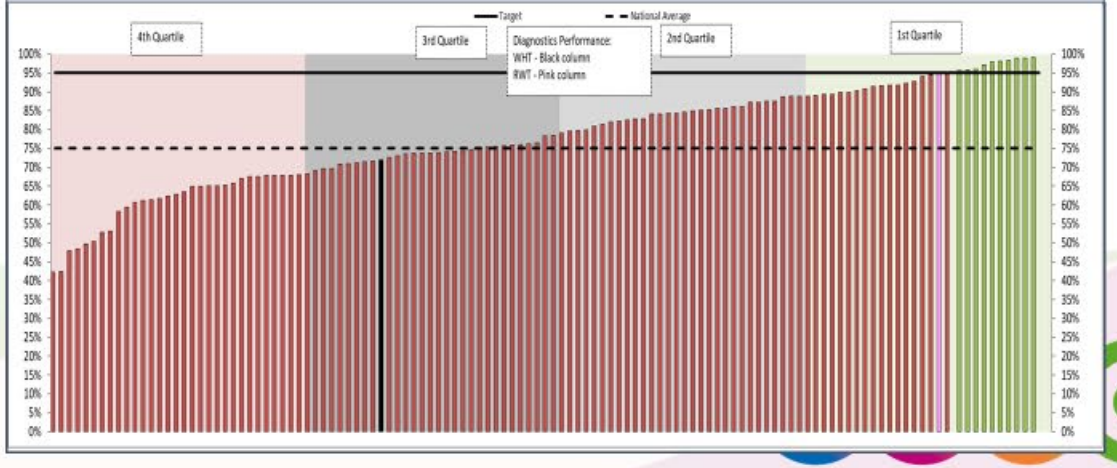
A&E 4 Hour



Cancer 62 Day



Diagnostic Waiting Times



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Finance | Executive Summary

Key Headlines – Month 6 2025/26

In month deficit of £12k, which is £3k below the plan of a £9k deficit. Year to date there is a positive variance of £93k.

- Patient care income has underperformed by £0.07m in month. This is mainly due to reduced activity from Wales and Shropshire.
- Education and Training Income is £0.3m lower than plan in month due to higher expected levels of workforce development income than has been received.
- Pay is £0.4m overspent in month due to pay arrears in month and backdated CIP £0.9m of non-recurrent CIP has been achieved in month.
- Non-pay is underspent in month due to the capitalisation of IT and Estates expenditure and underspends against ERF related reserves, which is offsetting overspends in Division One.
- CIP is under-achieved by £0.2m in month due to delays against identified schemes and targets which do not have plans in place.

Authors

Kevin Stringer (Group Chief Finance Officer)

Care Colleagues Collaboration Communities

Finance | I&E Summary

In-Month Income & Expenditure	RWT Plan M6 £m	RWT Actual M6 £m	RWT Surplus/ (Deficit) £m
Income	**84.9**	**84.9**	**0.0**
Expenditure			
Pay	54.4	54.8	(0.4)
Non Pay	20	18.9	1.1
Drugs	6.8	7	(0.2)
Other*	3.7	4.2	(0.5)
Total Expenditure	**84.9**	**84.9**	**0.0**
Net reported surplus/(Deficit)	**0.0**	**0.0**	**0.0**

Year-to-date Income & Expenditure	RWT Plan YTD £m	RWT Actual YTD £m	RWT Surplus/ (Deficit) £m
Income	**504.6**	**503.9**	**(0.7)**
Expenditure			
Pay	325.5	326.2	(0.7)
Non Pay	120.8	118.6	2.2
Drugs	41.4	41.6	(0.2)
Other (incl. depreciation)	23.2	23.7	(0.5)
Total Expenditure	**510.9**	**510.1**	**0.8**
Net reported surplus/(Deficit)	**(6.3)**	**(6.2)**	**0.1**

Other* Includes depreciation, other non operating expenditure and adjustments to NHSE Reported Performance

The Trust's financial position remains on plan for September and year to date with an in-month breakeven position and YTD deficit of £6.2m.

Income is lower than plan relating mainly related to SLAs and hosted services which is offset by expenditure underspends. In additional education and training income is lower than expected.

Pay is overspent by £0.7m YTD for reasons including industrial action, activity related overspends, absence cover and medical vacancy cover.

Non pay is underspent by £2.2m YTD relating to hosted services, underspends on ERF reserves, capitalisation of some IT and estates costs and prior year accrual releases.

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.

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Finance | ERF Performance

Point of Delivery	RWT		
	Plan Activity	Actual Activity	Variance Activity
Elective	3,858	3,710	(148)
Planned Same Day	27,391	26,426	(965)
Outpatient Procedures	81,740	85,947	4,207
Procedures Total	**112,989**	**116,083**	**3,094**
Outpatient 1st	110,011	107,806	(2,206)
Diagnostic Imaging	44,637	42,343	(2,294)
Chemotherapy	7,049	7,498	449
Grand Total	**267,638**	**266,232**	**(957)**

	£'000	£'000	£'000
Elective	24,647	23,834	(813)
Planned Same Day	29,286	27,437	(1,849)
Outpatient Procedures	13,930	14,687	757
Procedures Total	**67,862**	**65,958**	**(1,905)**
Outpatient 1st	20,895	20,558	(337)
Diagnostic Imaging	4,817	4,655	(162)
Chemotherapy	2,366	2,589	223
Grand Total	**95,941**	**93,760**	**(2,181)**

This table shows the variable activity performance against the Trust activity plan including the additional activity to meet the required RTT improvement, which represent £8.0m full year.

- Total activity is £2.2m below the plan, predominantly in planned same day and elective.
- Year to date, the RTT improvement activity represents £2.6mof the plan. Several RTT improvement initiatives are delayed in roll-out and this is driving £1.1m of the variance.
- In addition, base activity is £1.1m below plan. The highest underperforming specialities are Neurology, Urology and Children's Services.

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Finance | Cost Improvement Plans

Efficiencies 2025/26	Plan approved by Board £m	YTD recurrent achievement Month 6 £m	YTD non-rec achievement Month 6 £m	YTD achievement Month 6 £m	YTD Plan Month 6	YTD Variance Month 6 £m	FOT assuming all plans achieved £m
Affordable Urgent Care	4.5	0.4	0.0	0.4	1.0	(0.5)	4.5
Cessation of Unfunded Schemes	1.0	0.0	0.0	0.0	0.2	(0.2)	1.0
Counting and Coding	2.1	0.2	0.1	0.3	0.7	(0.3)	2.1
Estates Utilisation	1.0	0.2	0.5	0.7	0.3	0.4	1.0
Non-Pay and Procurement	14.6	5.1	9.2	14.2	6.8	7.4	14.6
Operational Productivity	11.9	0.3	0.7	1.1	4.0	(3.0)	11.9
Workforce	22.1	0.5	5.5	6.0	8.9	(2.9)	22.1
Sub Total - internal plans	**57.2**	**6.8**	**15.9**	**22.7**	**21.8**	**0.9**	**57.2**
Total efficiency plan	**57.2**	**6.8**	**15.9**	**22.7**	**21.8**	**0.9**	**57.2**

Note: there has been a change to the workstreams, where Bed Reduction has been added into the Affordable Urgent Care workstream and Clinical Best Practice has been added into the Operational Productivity workstream. The targets for the ceased workstreams have been added into the additional workstreams.

In Month Six, the Trust under-achieved against its target of £4.54m by £0.2m.

The main areas of under-achievement are against the Operational Productivity and Workforce schemes. There are several schemes that were included within the plan as placeholders, that do not have detailed plans and therefore need some further development to ensure that savings are being achieved in line with their plans.

29% of the in-month achievement is recurrent, whilst 30% of the year-to-date achievement is recurrent.

The in-month non-recurrent savings from vacancies are £0.6m. A proportion of these savings will be converted into recurrent savings once structures are formally approved, however a significant number of vacancies will need further scrutiny to identify if they can be converted to recurrent savings.

There is also £0.3m of non-recurrent non-pay and drugs savings in month that will also need a review to identify whether they can be converted to recurrent savings.

National Oversight Framework Dashboard

National Oversight Framework - RWT

				Q1 25/26			Internal	Internal	Internal	Internal	Internal	Internal
				Published								
Code	Metric	Time Period Reported	Target	Perf	Score	Rank	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
OF0023	18 Weeks RTT - % Within 18 Weeks - Incomplete	Latest month in the period		55.46	3.54	111/131	52.41	54.30	55.46	55.17	54.69	54.99
OF0003	18 Weeks RTT - 52 wk breaches as a % of PTL	Latest month in the period	1	2.98	3.21	91/131	2.54	3.07	2.97	2.80	2.43	2.44
OF0106	Difference between actual and planned 18 week elective performance	Latest month in the period	0	3.16	1.00	32/131	0.91	2.74	3.37	1.93	2.74	3.90
OF0005	Percentage of patients waiting over 52 weeks for community services	End of period		1.41	2.68	45/80	0.30	2.36	1.47	1.41	1.18	1.21
OF0010	Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80	80.03	1.00	27/118	79.97	80.06	80.03	79.98	80.07	78.96
OF0011	Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75	71.02	2.64	60/118	69.55	70.43	71.01	70.20	70.55	65.66
OF0013	Total Time Spent in ED - % within 4 Hours	Aggregated quarterly position	78	82.30	1.00	16/123	82.26	81.91	82.29	81.90	81.78	80.99
OF0014	Total Time Spent in ED - % over 12 Hours	Aggregated quarterly position		8.34	2.48	61/123	8.93	9.15	8.69	8.99	9.40	10.51
OF0079	Planned Surplus / Deficit	Annual plan	0	-3.26	4.00	92/134						
OF0081	Year to date variation from plan	Year to date		0.02	1.00	29/134						
OF0085	Implied level of productivity	In-year figure to latest month vs same period in previous		-0.58	3.53	113/134						
OF1069	CQC inpatient survey satisfaction rate	Annual			2.00							
OF0061	Staff survey - raising concerns sub-score	Annual		6.26	3.19	98/134						
OF1067	CQC safe inspection score	Periodic inspection										
OF0088	Rate of C-Difficle infections (Rolling 12 Months)	12-month rolling	1	1.46	3.57	108/134	153..09	149.38	145.68	133.33	123.46	123.46
OF0020	Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	4.00	3.01	77/134	4	4	4	4	4	4
OF0048	Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.36	3.60	112/134	293.46	288.79	296.26	288.79	287.85	284.11
OF0025	Average number of days between planned and actual discharge date	Latest month in the period		0.50	1.74	32/126	4.5	5.1	5.4	5.5	6.1	
OF1046	Summary Hospital Level Mortality Indicator (Rolling 12 Months)	12 month rolling			2.00		0.9807	0.9807	0.9707	0.9707	0.955	0.9559
OF0057	Community - Urgent Care Response (UCR) 2 Hour Response	Quarterly aggregated figure	70	76.50	2.77	40/51	77.73	78.18	76.35	73.41	70.94	70.87
OF0084	Staff survey engagement theme score	Annual		6.73	3.21	99/134						
OF0082	Staff Sickness Rate	Quarterly – aggregated monthly figures		5.49	2.71	88/134	5.36	5.39	5.39	5.37	5.41	

Green
Amber/Green
Amber/Red
Red

Care Colleagues Collaboration Communities

Productivity Dashboard

The productivity dashboard overleaf shows the Trust's performance against the metrics used by NHS England to define a providers productivity. The single overriding measure of a Trusts productivity is its Implied Productivity Growth – a calculation that essentially compares inputs to outputs, compared to last year. A 2.1% increase in productivity (compared to last year) puts the Trust within the second quartile of Trusts nationally, 0.1% below the median point.

There are a range of underpinning metrics covering operational and productivity (that focus on the utilisation of assets in the main) as well as workforce productivity. The Trust benchmarks well (i.e. within the top quartile) for the proportion of procedures completed as a day case or outpatient procedure and also for its in-session theatre utilisation. Whilst the number of cases completed per list is higher than Walsall, the utilisation of lists is considerably lower.

Outpatient services offer an opportunity for significant productivity improvements with the DNA, PIFU utilisation rate and Specialist Advice rates all performing worse than the national average. Equally, a significant amount of follow up is still taking place without being remunerated – this is by virtue of follow up income being fixed at 2019/20 levels.

Workforce productivity has improved by 2.4% in the year with non-elective and elective admissions per clinical WTE in line with the national average. There are generally less outpatient attendances taking place per consultant WTE than in order Trusts. Temporary staff spend as a proportion of total spend is lower than the national value although this does not include waiting list initiative expenditure which remains considerable.

NHS England have advised that productivity packs are soon to be circulated to Trusts to assist with the planning submission – details will be incorporated into this productivity dashboard once received.

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Collaboration Communities

Productivity Dashboard

RWT - Productivity Dashboard

Sep-25

Ref no.	Theme and KPI	Definition	Target	2025/26 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Comments
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.		**Awaiting methodology from NHS England in order to be able to calculate internally**												
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	3.80	3.50							
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	5.60	5.70							
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	92%	94.3%	95.1%	94.3%	93.9%	91.9%	94.7%							
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).	22.2%	17.5%	17.7%	18.8%	17.7%	18.3%	18.2%							
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%	85%	83%	84%	83%	81%	72%							
7	Average number of cases completed per theatre list	Total number of cases completed divided by total number of sessions utilised	2.3	2.15	2.18	2.13	2.18	2.15	2.16							
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	93%	84%	86%	87%	79%	77%	77%							
9	CT, MRI & ultrasound utilisation		95%	To follow next month												
Outpatients																
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	95%	Currently unable to report until introduction of new PAS system												
11	DNA Rate	Number of outpatient missed outpatient appointments divded by total outpatient appointments	6%	8.4%	8.7%	9.0%	8.6%	8.7%	8.8%							
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	5%	3.1%	2.8%	3.0%	2.8%	2.5%	3.9%							
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referra) divded by total number of outpatient first attendances	13%	5.8%	6.3%	6.5%	7.3%	7.8%	11.0%							
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	1185	0	3153	1213	0	1922							

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.		2,207	2,182	2,129	2,176	2,132	2,100				
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes		£0	£0	£0	£0	£12,093	£273,446				
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	4	3				
18	Cost of unfunded services being delivered	Cost of services being delivered that do not have any form of funding arrangement in place											
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.	1.9%	1.94	1.98	1.99	2.00	1.98	1.89				
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.	2.3%	1.43	1.46	1.52	1.58	1.42	1.61				
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.		119.84	122.37	123.66	125.91	120.11	136.68				
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.	613	473.89	498.78	493.52	436.79	498.23	453.56				
23	Corporate services cost per £100m income (£m)	The total cost of corporate services divided by £100m.	20%	0.25	0.27	0.28	0.26	0.25	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%	6.75%	6.41%				
25	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	6%	5.32%	5.17%	5.31%	5.38%	5.54%	5.34%				
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.	10%	8.92%	8.99%	8.96%	8.84%	9.04%	8.77%				
27	Care hours per Patient Day	Total care hours worked by registered nurses & midwives divided by total patient bed days	7.6	7.40	7.50	7.60	7.50	7.60	7.40				
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	£25.54/m2	£23.42/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									

Tier 1 - Paper ref:	Enc 12.3

Report title:	Executive Update – Resident Doctor 10-Point Plan
Sponsoring executive:	Dr Brian McKaig/Dr Zia Din/Clair Bond
Report author:	Claire Young, Group Deputy Director of Education & Training
Meeting title:	Group Trust Board Meeting – in Public
Date:	18 November 2025

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

The 10-Point plan was issued by NHSE in late August 2025 to improve Resident Doctors' working lives, intended to improve local facilities and processes, addressing on-going issues and set out actions on national initiatives. Resident doctors face unique challenges due to their rotational roles, making targeted action essential.

The purpose of this report is to provide an update on the 10 Point Plan and share the actions associated with improvements (see Appendix 1). From next month the Trusts will be required to provide an update to NHSE on progress against our 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?]*

None.

4. Recommendation(s)

This report is an update position for the Executive Team

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
RWT Board Assurance Framework Risk SR15	☐	*Financial sustainability and funding flows.*
RWT Board Assurance Framework Risk SR16	☐	*Activity levels, performance and potential delays in treatment.*
RWT Board Assurance Framework Risk SR17	☐	*Addressing health inequalities and equality, diversity and inclusion.*
RWT Board Assurance Framework Risk SR18	☐	*Potential cyber vulnerabilities and data breaches.*
WHT Board Assurance Framework Risk NSR101	☐	*Data and systems Security (Cyber-attack)*
WHT Board Assurance Framework Risk NSR102	☐	*Culture and behaviour change (incorporating Population Health)*
WHT Board Assurance Framework Risk NSR103	☐	*Attracting, recruiting, and retaining staff*
WHT Board Assurance Framework Risk NSR104	☐	*Consistent compliance with safety and quality of care standards*
WHT Board Assurance Framework Risk NSR105	☐	*Resource availability (funding)*
WHT Board Assurance Framework Risk NSR106	☐	*Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health)*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Group Trust Board – held in Public

18 November 2025
Update Position of NHSE Resident Doctor 10-point Plan

1. Executive summary

The following report provides an update following the initial self-assessment in August. There has been some progress against all 10 points of the plan which is summarised in the report and attachments. The Trusts will be required to undergo a further assessment in November and report back to NHSE on progress and further monitoring.

2. Introduction

2.1 In August 2025, NHSE asked all Trusts to participate in a national survey to provide a benchmark position of trust-level facilities, policies and processes for Resident Doctors.

2.2 Each Trust has been provided a baseline score from this data, and it is intended that each Trust will undergo reassessment at the 12-week window, and again at 12 months.

2.3 The initial assessment scores were reported as 54% for RWT and 63% for WHT, identifying both Trusts in the lower performing category.

2.4 At the 12-week reassessment window, NSHE require an update against each of the goals set for, which forms the 10-Point Plan (see Appendix 1 for detailed plan).

3. 10-Point Plan

3.1 Each of the 10 points is summarised below, RAG rated, and a brief update provided. For detailed progress to date please refer to Appendix 1.

1	Trusts should take action to improve the working environment and wellbeing of resident doctors (designated on call parking spaces- where possible, autonomy to complete portfolio and SDL from an appropriate location, access to mess facilities/rest areas/lockers in all hospitals, 24/7 out of hours menu offering hot meals and cold snacks. **Update**: Areas of priority include dedicated car parking for oncall, availability of hot food 24/7. All other items complete or work in progress.
2	Resident doctors must receive work schedules and rota information in line with the Code of Practice **Update**: Regularly reviewed and audited across both Trusts, reported through PGME Committee. 90% of work schedules received within timescale and 86% of rotas – non-compliance related to late notifications from Deanery of arrival of doctors/LTFT trainees.
3	Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing. **Update**: Annual Leave policy requires review for adequacy at RWT. Updated at WHT and in sign-off stage

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. **Update**: Both CMO's are confirmed as the named Executive leads. Peer representative appointed at RWT, recruitment in progress at WHT.
5	Resident doctors should never experience payroll errors due to rotations **Update**: Payroll reporting capabilities are limited to over/under payments only. Governance of payroll enquiries is not fully auditable currently, framework and IT solution would provide improved dataset and capability
6	No resident doctor will unnecessarily repeat statutory and mandatory training when rotating **Update**: Both Trusts compliant with 11 CSTF subjects. Locally agreed mandated subjects specific to role will be required, this will differ Trust to Trust
7	Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours **Update**: Exception reporting is under review by NHS Employers and we will update our procedures in line with the new guidance and software updates.
8	Resident doctors should receive reimbursement of course related expenses as soon as possible **Update**: Payroll not reimbursing the expense, insisting a certificate of attendance required. Study Leave policy updated to reflect new way of working, currently at LNC for review.
9	We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery **Update**: Awaiting guidance from NHSE
10	We will minimise the practical impact upon resident doctors of having to move employers when they rotate **Update**: Awaiting guidance from NSHE

4. Recommendations

4.1 The Executive Team is asked to review the Terms of Reference for the working groups associated with the 10 Point Plan and support the workstreams to ensure improvement in the baseline assessment (appendices 1,2 & 3).

Claire Young
Group Deputy Director of Education & Training
17th October 2025

The attached appendices can be located in the Reading Room on iBabs.

Appendix 1: 10-Point Plan detail

Copy of JOINT 10 point plan CY updatec

IWL Governance.odt

Appendix 2: Terms of Reference 10-Point Plan Task & Finish Group

IWL Task & Finish Group TOR.docx

Appendix 3: Terms of Reference 10 point plan Oversight Group

IWL Strategic Group TOR.docx

Tier 1 - Paper ref:	Enc 12.4

Report title:	Health Inequalities Report
Sponsoring executive:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Report author:	Stephanie Cartwright, Group Chief Community and Partnerships Officer and Dr Kate Warren, Consultant in Public Health
Meeting title:	Group Trust Board
Date:	18 November 2025

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

This report aims to provide an overview of progress against the Delivery Plan of the Joint Health Inequalities Strategy 2024-27 during the period June to October 2025. We are holding five themed Steering Group meetings per year, aligned with key domains in the plan, which remains a live document that is updated at each meeting. The steering group has broad representation. There is currently no dedicated resource for the delivery of the programme, although leadership and coordination are provided by RWT Public Health and Chief Medical Office.

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?]*

Quality and Safety Committee

4. Recommendation(s)/Action(s)

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

a) Note the progress made against the Delivery 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:		

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 18 November 2025

Health Inequalities Report

1. Executive summary

Following the approval of the Joint Health Inequalities Strategy 2024-27, a Joint Health Inequalities Steering Group has been established to provide oversight for both Trusts. This report aims to provide an overview of progress against the Strategy's Delivery Plan during the period June to October 2025, during which we held meetings on the themes of Inclusive Services and Information. We are holding 5 themed meetings per year, aligned with key domains in the Delivery Plan, which remains a live document that is updated following each meeting. The steering group has broad representation. There is currently no dedicated resource for the delivery of the programme, although leadership and coordination are provided by RWT Public Health and Chief Medical Office.

2. Background

2.1 Inclusive Services (June): The group reviewed the contributions of the EDI midwives to reducing perinatal mortality. They shared best practice around outreach and engagement of people new to the country, LGBTQ+ people, and those with language barriers or social barriers to access (including mobile data access and transport). The Walsall Together team highlighted findings from engagement with women in the community; self-care training and resources are in development for Women's Health and funding has been secured for provision of period products in food banks. Interpreting audits have been set up in maternity services and areas for improvement have been identified, including changes to the Badgernet system to record requirement for interpreters; it was agreed that a Quality Improvement project could be set up to facilitate and track progress. The group agreed to establish a peer support network of frontline staff with public health &/or inequalities responsibilities, to disseminate information on training and examples of best practice such as the interpreting audit. Staff from Sexual Health services presented work carried out to make clerking systems inclusive of trans patients, which had improved patient experience, staff confidence, and appropriate care.

2.2 Information (September): The group discussed the concept of Information as a two-way process and heard from the Walsall Together team about their approach to including citizens' voices in priority setting. Themes that were highlighted included communication, dynamics in the family, stress and anxiety, accessibility of services, stigma, language, community-based health incentives, relationships, sexual health, health advice, and autonomy. The group considered how this could be taken forward in the Patient Experience Strategy, and in Quality Improvement approaches.

2.2.1 Following national work by Nuffield Trust highlighting inequalities in Emergency Care, the Population Health Unit conducted a local equity audit of Emergency Department attendances. We used data from 2022-25 to look at the demographics of those attending our Trusts, and how long people spend in the department, from arrival in the department to either hospital admission, transfer or discharge. In times of increased pressure across the NHS, it is important to consider whether patients are attending the most appropriate site and whether there are inequalities in access and outcomes. This analysis is a starting point and will support further work to shift care from hospitals to the community.

Figure 1: ED attendance rate per 1000 population, by age

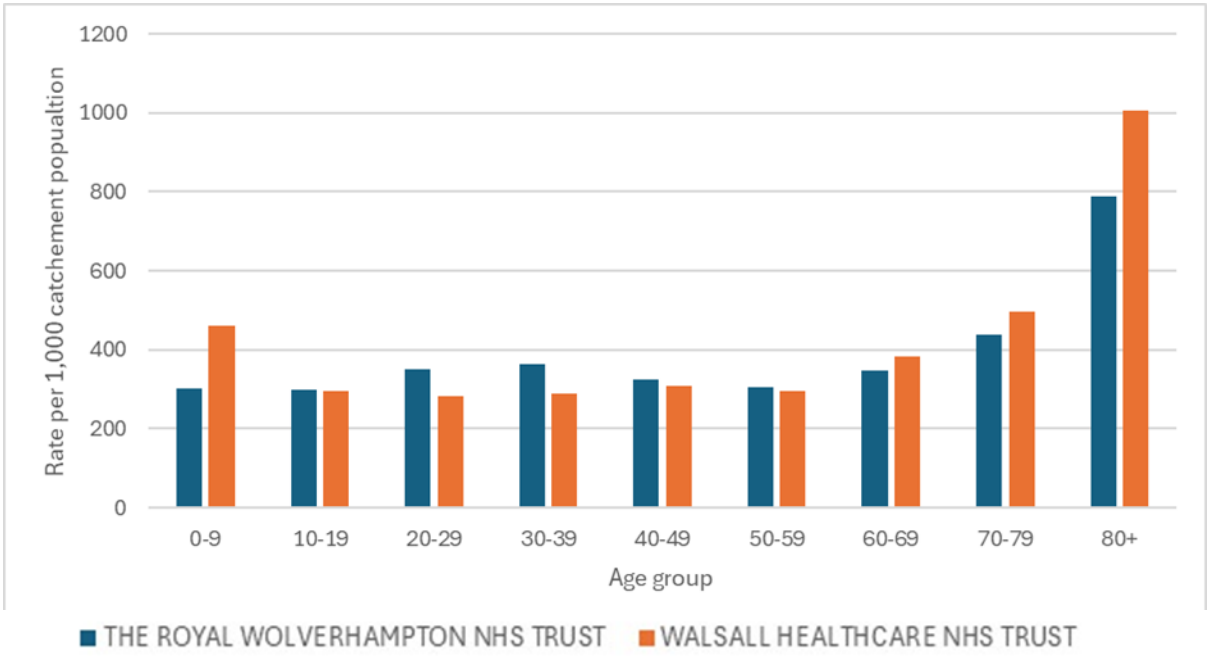


Figure 2: ED attendance by deprivation, compared with catchment population

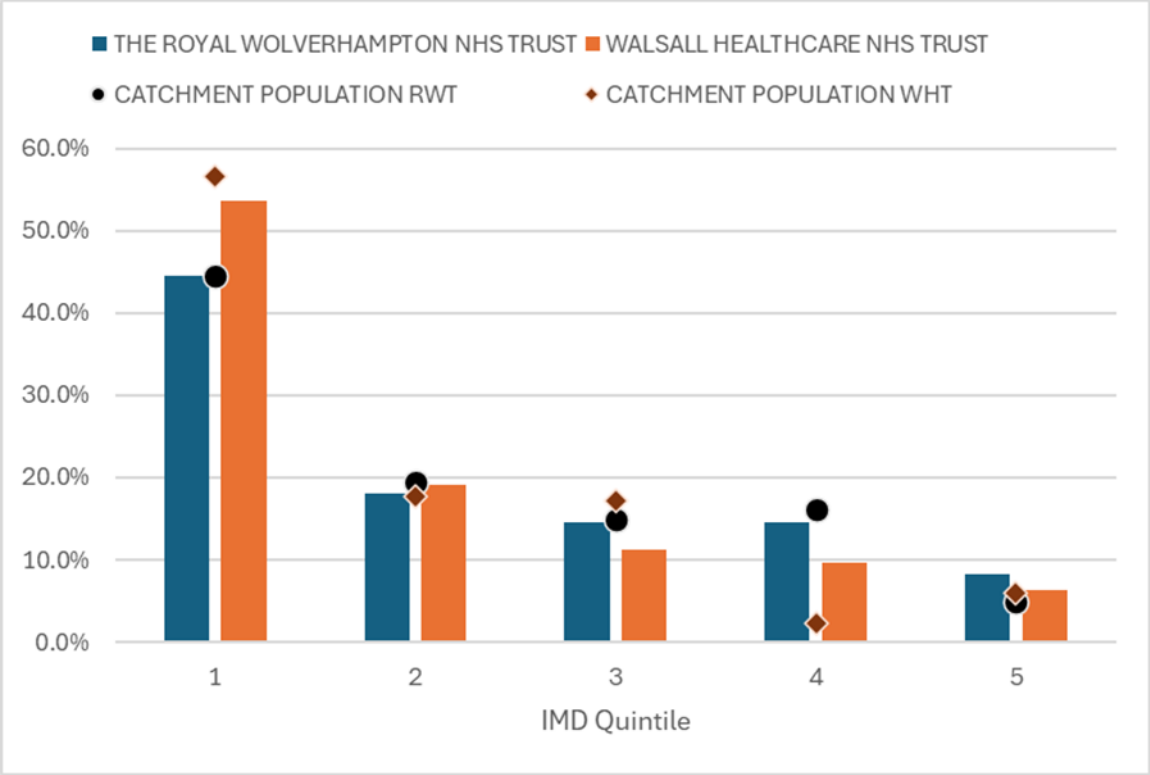
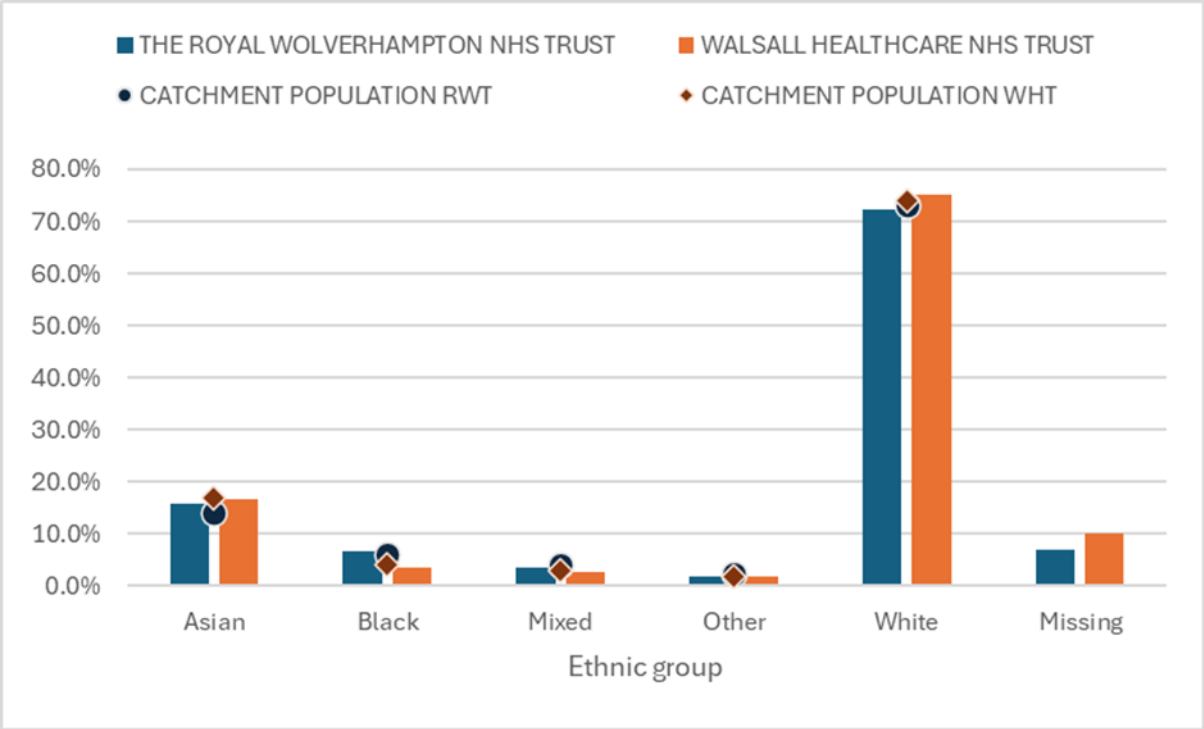


Figure 3: ED attendance by ethnicity, compared with catchment population



Our analysis showed that the groups of people who spend longer in the department are

- People who are subsequently admitted to the hospital
- People presenting with drug and alcohol issues, psychosocial or behavioural change
- Older people – time spent increases with age
- People from the White ethnic group spend slightly longer in ED but this is not significant after correcting for age (higher % older people are White)
- The most deprived groups in Walsall spent slightly less time in the department but this is no longer significant after correcting for age (more children and young people live in deprived areas)

People who attend are broadly representative of the catchment populations. There is no apparent disparity in average waiting times by ethnic group or deprivation. Although children in Walsall have a higher attendance rate, they spend less time in the department; differences in provision or case mix may explain this. Alcohol/substance misuse and psychosocial issues, although they make up a small proportion of attendances, spend a long time in the department. The emergency department may not be the most suitable place to deal with various issues, and this is an area that we are keen to explore in our Place-based Partnerships as part of the shift in services from hospital to community, and which would address some of the inequalities in waiting times.

2.3 **Forward plan**

- The development of promoting disseminated leadership, and completing the NHS Providers self-assessment tool for health inequalities, which will provide areas of focus for 2026.
- Trust Annual Report inequalities supplement – as required by NHS England for sign off by Board in January 2026
- Review with Chief Nursing Officer colleagues across the Group to maximise opportunities and drive the agenda in relation to the self-assessment tool for example in relation to management of Health Inequalities reporting and active management of waiting lists using health inequalities data.

3. Recommendations

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

a. Note the progress made against the Joint Health Inequalities Strategy Delivery Plan

Dr Kate Warren
Consultant in Public Health

Stephanie Cartwright
Group Chief Community and Partnerships Officer

18 November 2025

Walsall Healthcare NHS Trust

Enc 12.5

Report title:	Birthrate Plus® Staffing Business Case
Sponsoring executive:	Lisa Carroll – Chief Nursing Officer
Report author:	Jo Wright – Director of Midwifery, Gynaecology and Sexual Health Julie Newton – Care Group Manager, Obstetrics, Gynaecology and Sexual Health
Date:	Public Board 18th November 2025

1. Summary:

Background

- The Birthrate Plus® maternity staffing assessment was completed in 2024
- The assessment shows a requirement for an additional 11.90WTE midwives for the current 3581 births per annum
- When births rise to 3800 per annum this requirement rises by a further 5.47 WTE to a total requirement of 17.37 WTE midwives.
- There has been a 10% increase in demand for caesarean sections since 2021 with a shortfall in capacity available for 100 elective caesarean sections per year. This has resulted in an increased number of waiting list initiatives or cancellation of gynaecology activity to accommodate this demand.
- Non-compliance with Birthrate Plus® recommendations presents a patient safety issue as there is insufficient staff to deliver care requirements. In order to maintain safety the division is currently utilising specialist nurses to fill gaps in rotas, reducing their ability to deliver on the requirements of their specialist roles and non-compliance with the recommendations of Ockenden, the Three Year Delivery Plan and regulatory standards. This position is not sustainable.
- The divisional maternity staffing challenges and the mitigations currently in place to maintain safety are detailed in the monthly Director of Midwifery report to Quality Committee
- CNST Safety Action 5 requires an agreed plan approved by Trust Board by 30th November 2025 in order to achieve CNST requirements.

The Trust Board CNST requirements are:

- To receive a paper detailing a clear breakdown of Birthrate Plus® or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of Birthrate Plus® or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on Birthrate Plus® or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

Request for approval and cost

Four options have been considered:

Option 1: Do Nothing - Remain non-compliant with BirthRate Plus

Option 2: Collaboration/Integration - A Black Country Midwife model and a system triage model have been discussed by the LMNS. Whilst there may be some potential with these models moving forward this is a long term solution.

Option 3: (preferred) - Invest in midwifery workforce to implement Birthrate Plus® recommendations as a phased approach

Option 4: Invest in all workforce recommendations, to fully implement Birthrate Plus® recommendations in 2025/2026.

The Trust board are asked to approve Option 3:

- The request is to approve recruitment of 6.0 WTE newly qualified midwives,1.00 WTE backfill to support midwifery sonography training, 2.0 WTE Band 4 and 1.73 Band 3 MSWs to stabilise the service supporting the antenatal postnatal ward, maternity triage service and antenatal outpatient services in April 2026. A total of 10.73 WTE. The full year cost including overheads = £669,000.00
- In April 2027 a review of the number of births will be undertaken and if as expected they exceed 3800, recruit the remaining 5.7 WTE band 6 clinical midwives and uplift x 2 trainee community midwifery sonographers from band 6 to band 7 on completion of training. The year 2 recurrent costs including overheads = £1,072.00
- CNST income for year 6 was £488,000.00. The financial benefit of the CNST premium is already included in the 2025/26 financial position
- The improvements from BR+ enable a CNST saving of £0.5m per annum. The annualised costs resulting from an increase in staffing for BR+ equate to £0.211m (£0.448m - £0.669m year one and £0.584m (£1.072m - £0.448m) in years 2 – 3 recurrently.
- The net position (BR+ costs – CNST savings) are therefore +£0.3m saving in year 1, but a -£0.1m cost pressure recurrently from year two.
- As the CNST premium has already been accrued for 2025/26 the cost pressure for year 1 and years 2 & 3, recurrently will be the full value of the investment (£0.669m and £1.072m respectively

Mitigation

- A review of how the costs of this can be mitigated is currently being reviewed by the executive team.

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?]*
N/A

4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a) Support Option 3 of this business case which details a phased approach to meeting Birthrate plus staffing recommendations.

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: 19 September 2025		
Is Equality Impact Assessment required if so, add date: 19 September 2025		

Business Case Title: Birthrate Plus® Staffing Business Case
Business Case Prepared by: Jo Wright – Director of Midwifery, Gynaecology and Sexual Health,
Julie Newton – Care Group Manager, Obstetrics, Gynaecology and Sexual Health

This business case addresses (tick as appropriate)
Patient Safety Risk ☒ Mandatory Requirement ☒ Quality Improvement ☐
Health Inequalities ☒ Other ☐ The case has an identified route to funding ☐

Version	Amended By	Date	Key amendments
1.0	Jo Wright and Julie Newton	6th November 2024	Completion of Business Case ready for finance team.
2.0	Jo Wright and Julie Newton	July 2025	Updated the recommendation paper for full business case
3.0	Jo Wright and Julie Newton	6th August 2025	Updated business case with additional narrative and submitted to finance
4.0	Jo Wright and Julie Newton	8th August 2025	Updated business case with additional graphs including demand and capacity

5.0	Jo Wright	30th August 2025	Updated business case with MSW Triage element and submitted to finance
5.1	Jo Wright/Josh Creighton	15th September 2025	Updated business case with finance element.
5.2	Julie Newton/Jo Wright	19th September 2025	Updated demand and Quality Impact Assessment Completion and Equality Impact Assessment Completion – finalisation to be sent to Finance.
5.3	Lisa Carroll	15th October	Comments and amendments to be considered
5.3	Jo Wright/ Sunita Chhokar	15th October 2025	Updated Option 3, Phase 2 of delivery of plan.
5.4	Laura Graham	15th October 2025	Comments and amendments to be considered
5.5	Jo Wright/Julie Newton/ Sunita Chhokar	15th October	Amended and updated.

NHS
Walsall Healthcare
NHS Trust

SUBMITTED BY:

Name Jo Wright Title Director of Midwifery Gynaecology and Sexual Health

Date 26th September 2025

APPROVED BY:

Divisional Director ..... *(Name)* ..... *(Sign)* ..... *(Date)*

Divisional Manager ..... *(Name)* ..... *(Sign)* ..... *(Date)*

Divisional Accountant ..... *(Name)* ..... *(Sign)* ..... *(Date)*

Head of Nursing ..... *(Name)* ..... *(Sign)* ..... *(Date)*

FOR CAPITAL INVESTMENT ONLY

Director of Estates Development (On behalf of Capital Review Group)

..... *(Name)* .....*(Sign)* ..... *(Date_*

The Royal Wolverhampton NHS Trust

Tier 1 - Paper ref:	Enc 12.6

Report title:	Blueprint Electronic Patient Records Update
Sponsoring executive:	Gwen Nuttall, Managing Director
Report author:	Keely Evans (EPR Operational Lead) / Kevin D'Arcy (Head of EPR Delivery)
Meeting title:	Group Trust Board in Public
Date:	18th November 2025

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

The Blueprint EPR Programme has had a successful Go Live of Phase 1, with the following modules launched as planned on Monday 29th September 2025:

- Careflow PAS (including inpatients, outpatients and community modules)
- Careflow ED (to be used by ED, Ophthalmology, ERU, Medical SDEC and Frailty SDEC)
- Integrated BlueSpier Theatres information system.

During the weekend of 27/28th September over 70million items of data were successfully transferred from existing systems to the new Careflow systems.

Whilst there have been challenges post implementation, no patient safety concerns have been raised.

Staff from across the group and specifically RWT have worked incredibly hard to ensure that go-live and subsequent embedding of the system has gone well, team work and responsiveness from system partners, staff in technical IT and operational teams have pulled together to ensure that there have been no critical incidents or significant impact for patients.

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?]*

Verbal update Trust Board Sept 25. Discussion at Finance and Performance Oct 25.

4. Recommendation(s)

The Public Trust Board is asked to:

a) To note the update.

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*

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

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 18th November 2025.

Blueprint Electronic Patient Record Update

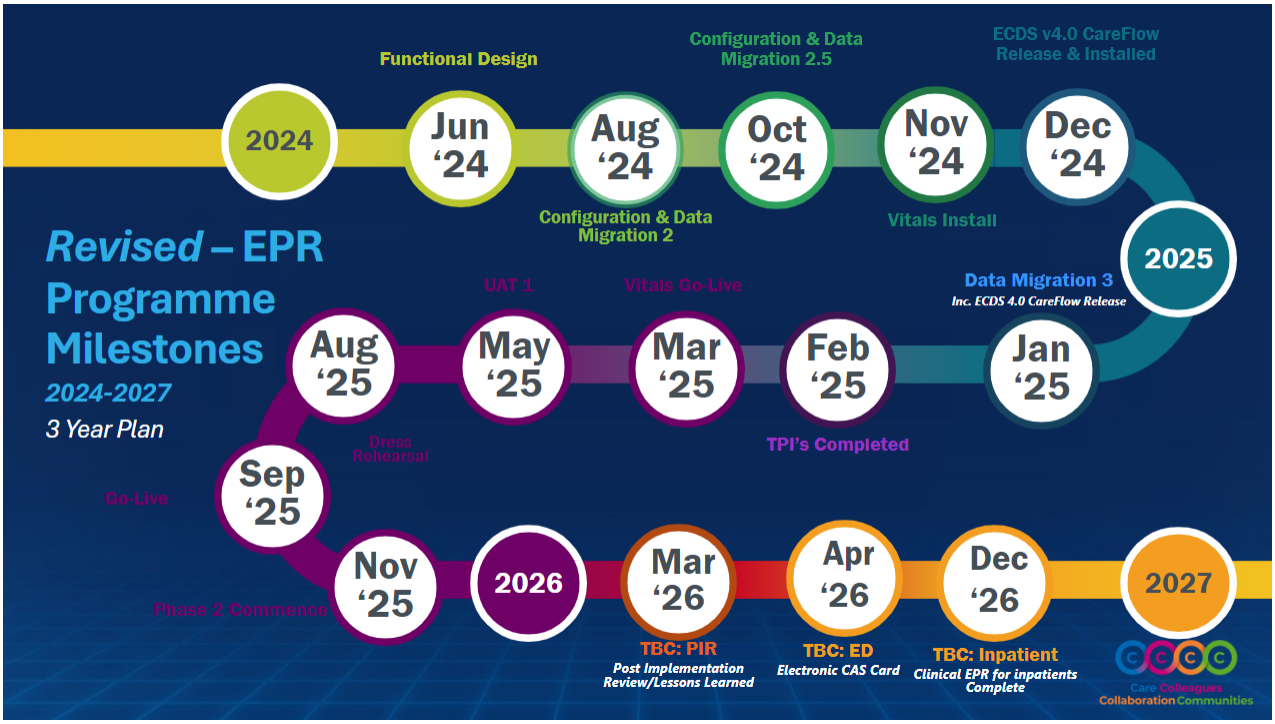
1. Background

The Blueprint EPR Programme will deliver a Trustwide Electronic Patient Record in two phases: This paper provides a brief update on the task and outcome(s) on the go-live of this significant IT replacement system from the weekend of 27th/28th September.

- **Phase 1 – Go Live 29th September 2025:** Replacement of the Trust's current **Silverlink Patient Administration System (PAS)** for both acute and community services, replacement of the **Emergency Department** current Patient First System, and replacement of the current Silverlink **Theatre Management** System.

- **Phase 2 – 2026 onwards:** Phased role out of the Trust's full **Electronic Patient Record**.

2. High Level Programme Plan



3. Cutover Weekend Summary – Friday 26th to Sunday 28th September 2025

Over the Cutover Weekend, the trust transitioned from its legacy system, Silverlink PAS, to the new Careflow platform. From the evening of Friday 26th September, Silverlink PAS was set to 'view

only' mode, and all PAS-related processes were temporarily managed on paper. Services using MSS Patient First (Emergency Department module) continued operating as usual.

During this time, the programme team carried out the complex data migration process: extracting data from Silverlink Patient 1st, transforming it, and loading it into Careflow. This represented 70 million rows of data. Once uploaded, Careflow was tested to ensure it was fit for purpose. Following this, data generated over the weekend via paper records and MSS Patient First was also rekeyed into Careflow.

While Cutover was largely delivered on time and met expectations, rekeying Emergency Department (ED) data proved challenging due to the complexity and interpretation required. As a result, the ED rekeying was not completed in time for the initial Go Live target of midnight (Saturday into Sunday). ED initially went live at 7:30am on Sunday 28th September.

However, early system usage revealed that the rekeyed data—particularly for in-flight (patients on the old system) patients—did not include the required clinical information. To maintain patient safety, a decision was made at 8:30am to pause the go-live and relaunch the system with a 'clean slate' at mid-day. This allowed for a live, incremental transition: new patients were added to Careflow, while in-flight patients continued to be managed on MSS Patient First until discharge. Careflow ED officially went live at midday on Sunday 28th September, marking a 12-hour delay.
This delay had a knock-on effect on inpatient rekeying, with support from the Patient Flow Team, all wards were rekeyed and went live as planned by Monday 29th September. Outpatients, Community, and Theatre (BlueSpier) modules also went live as scheduled on Monday.

Over this weekend, the Blueprint Programme Team, along with other digital teams, Information Department, and operational colleagues worked extended hours to meet delivery of the programme.

4. Initial issues

As expected during any major system transition, several issues have emerged following the Cutover Weekend. Importantly, there is no evidence these issues have compromised the safety of either staff or patients. Operationally, processes did move at a slower pace, largely due to staff familiarising themselves with the new system. However, aside from the planned reduction in activity to support the go-live, no patient activity has been lost.

Several specific issues were immediately identified and have been worked through by the Programme Team such as printer configuration issues, access to trust e-discharge system, general access to the system via Windows log ins, and some integration issues with downstream systems.

Despite these challenges, the Command-and-Control structure between Operational and IT teams was stood up and functioned effectively.

5. Ongoing issues

Operational and Process Issues

Many of the issues raised related to staff familiarisation with the system and new processes. In response, additional training sessions, guides, and standard operating procedures (SOPs) have been developed and shared in response. A particular area of focus is outpatients, and the Programme team are activity working with the Information Team to develop operational reports (such as the PTL) to allow patients to be booked. Equally, support for cashing up (clinics) is required in order to maintain the patient flow and also for activity to be recorded and charged for. Subject Matter Experts (SMEs) remain integral and engaged with teams across the trust, however, inevitably the requirement for SME support is high and whilst progress is being made, the Blueprint Programme currently have in excess of 150 support tickets that they are working through at pace.

Technical Issues Impacting Operational Delivery

There are some technical issues affecting operational workflows. A system bug is causing users to be locked out on occasion after a single failed login attempt or session timeout. System C is working on a permanent fix to be delivered by a new release, in the interim, timeout settings have been extended to reduce disruption.

An issue with e-discharge letters in ED, caused by a configuration error, was quickly resolved and the c.1,700 letters effected dispatched.

Residual integration issues remain with the Software Development Team working alongside the Blueprint Programme to resolve. This includes the requirement for circa 800k additional patients required to be loaded into Careflow after issues with both Somerset (Cancer Services) and Soliton (Radiology) have been identified due to not having a specific patient cohort present in the system. These records were not included in migration as they had never had any activity recorded in Silverlink PAS, nor was data quality high. These records have been uploaded and tested on 6th November 2025. This has resolved and manual workarounds in place with radiology and Cancer Services has ceased.

Issues Requiring External Supplier Support

A few issues require configuration changes from external suppliers. Temporary hospital numbers are not currently filtering through to the ICE pathology system, resulting in a manual workaround. While the volume is manageable, this introduces a risk of human error. This issue is being addressed via Clinisys. Additional fixes were required from Woodward's for Simple Code (clinical coding) and from BigHand for the Dragon Medical Workflow Manager software. Simple Code has now been resolved.

Issues Requiring Internal development of integration Support.

The Clinical Web Portal also experienced challenges with the display of next of kin details and allergy information, which required targeted fixes to be applied within the portal. Additionally, consultants were not displaying accurately in the Mosaic system, necessitating an update to interface messaging by the Trust integration team.

Reporting

We are pleased to report that through the enormous effort from the Information Team, the trust can provide an output for all the reports that were presented in the go/no go assessment report. There is variability in the expected of some of the reports, and this is being worked through in a priority order. The following status report is correct as at 14/10/2025.

Pls note the Shrewd indicators below are now completed.

REF NO.	Name	Progress	Submission status	Status
184	Daily Summary/UEC Sitrep	Completed	18/18	All daily submissions completed, including cutover weekend.
507	etl.usp_Shrewd_Indicators	In Progress	0/18	Requirement to model the frequent feeds from Careflow - in progress and hope to complete this by end of Oct.
508	dbo.usp_Shrewd_Indicators_BI	In Progress	0/18	Requirement to model the frequent feeds from Careflow - in progress and hope to complete this by end of Oct.
36	AcuteDischargeSitrep2	Completed	3/3	All weekly submissions have been completed.
34	CommunityDischargeSitrep2	Completed	3/3	All weekly submissions have been completed.
414	MSitAE - Monthly A&E Sitrep	Completed	1/1	Monthly submission completed.
403	Waiting List MDS - Clock Starts	Completed	3/3	All weekly submissions have been completed.
404	Waiting List MDS - Closed Clocks	Completed	3/3	All weekly submissions have been completed.
406	Waiting List MDS - Diagnostics	Completed	3/3	All weekly submissions have been completed.
405	Waiting List MDS - Open Pathways	Completed	3/3	All weekly submissions have been completed.
306	Paediatric Surgery Waiting List Return	Completed	2/2	All weekly submissions have been completed. Next sub due on 17th.
428	Virtual Ward Sitrep	Completed	2/2	Fortnightly submissions completed - submitting as planned.
324	Physiological Sciences Data Return	Completed	1/1	Monthly submission completed.
455	PIFU Monthly Submission	Completed	1/1	Monthly submission completed.
453	Advice & Guidance Additional Submission	Requires clarification	-	Completed by the ICB?
407	Community Health Services Sitrep	Completed	1/1	Monthly submission completed by service.
446	Qtrly VTE report (Vitalpac)	Due on 31st	-	Data being validated in readiness for submission.
402	Theatre Productivity NHSI submission	Completed	1/1	Fortnightly submission completed.
451	DM01	Completed	1/1	Monthly submission completed.
418	18 Weeks RTT Monthly	Due on 17th	-	Prepped and ready to submit on 15th Oct.
450	KH03 Bed Availability & Occupancy	Due on 30th	-	Data being validated in readiness for submission.
DATASETS				
-	Inpatient CDS	In Progress	0/18	The 3 inpatient CDS submissions are proving problematic. The carespell ID has changed and we are working through linking critical care and maternity data. Also require a SUS deletions process to be completed so we can replace old SUS records which had the old Silverlink Carespell, with the new Careflow Carespell ID and prevent duplicates in SUS. Should be completed before the end of Oct and will backdate submissions.
-	Outpatient CDS	Completed	14/18	Has been submitted Mon-Fri since 1st October. Cutover weekend to be submitted by end of Oct. Automation of dataset submissions still to be completed and will then move to 7 day submissions.
-	ECDS	Completed	14/18	Has been submitted Mon-Fri since 1st October. Cutover weekend to be submitted by end of Oct. Automation of dataset submissions still to be completed and will then move to 7 day submissions.

6. Data Validation

There are a number of areas, particularly around waiting lists, RTT and diagnostics that require validation. This is due to some cohorts of patients being reported differently in Careflow to Silverlink. These changes are due to decisions within the Data Migration process that are being reviewed.

7. Next Steps

- Publishing of full ongoing training/support offer, with specific cohorts of staff receiving targeted support.
- Continuation of ticket/incident management by Application Support Team and the Blueprint Programme Team through to final resolution.
- Validation of data and rectification if required.
- Step back of formal command and Control/Ops and Exec EPR meetings when appropriate.
- Lessons Learnt to be reviewed and full debrief to be undertaken – end of November
- Delivery / realisation of benefits identified in phase 1 as per the business case
- Strategic review of Phase 2 scope and delivery schedule in line with resource requirements and capacity.

8. Recommendations

The Public Trust Board is asked to:

a. Note the successful implementation of the new Careflow Platforms and the content of this report.

The Royal Wolverhampton NHS Trust

Tier 1 - Paper ref:	Enc 12.7

Report title:	The Royal Wolverhampton NHS Trust Charity 2024/25 Annual Report and Accounts
Sponsoring executive:	Professor Martin Levermore MBE
Report author:	Katy Ball, Charity Finance & Assurance Manager
Meeting title:	Trust Board Meeting to be held in Public
Date:	18 November 2025

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

The Board is asked to approve the 2024/25 Annual Report and Accounts for the Royal Wolverhampton NHS Trust Charity, which have been audited by WR Partners.

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?]*

The 2024/25 Charity Report and Annual Accounts were presented and discussed at the Charity Committee Meeting on October 10th. WR Partners, the auditors of the Charity were in attendance and presented their findings. The Accounts and Annual Report were approved by the Committee.

4. Recommendation(s)

The Public Trust Board is asked to:

a) Approve the 2024/25 Annual Report and Accounts for the Royal Wolverhampton NHS Trust Charity.

b) Note the Audit findings from WR Partners, which support the 2024/25 Accounts process.

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

RWT Board Assurance Framework Risk SR15	☒	*Financial sustainability and funding flows.*
RWT Board Assurance Framework Risk SR16	☐	*Activity levels, performance and potential delays in treatment.*
RWT Board Assurance Framework Risk SR17	☐	*Addressing health inequalities and equality, diversity and inclusion.*
RWT Board Assurance Framework Risk SR18	☐	*Potential cyber vulnerabilities and data breaches.*
WHT Board Assurance Framework Risk NSR101	☐	*Data and systems Security (Cyber-attack)*
WHT Board Assurance Framework Risk NSR102	☐	*Culture and behaviour change (incorporating Population Health)*
WHT Board Assurance Framework Risk NSR103	☐	*Attracting, recruiting, and retaining staff*
WHT Board Assurance Framework Risk NSR104	☐	*Consistent compliance with safety and quality of care standards*
WHT Board Assurance Framework Risk NSR105	☐	*Resource availability (funding)*

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
WHT Board Assurance Framework Risk NSR106	☐	*Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health)*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Your RWTC
going above and beyond
Registered Charity No. 1059467

The Royal Wolverhampton NHS Trust

New Cross Hospital
Wolverhampton
WV10 0QP

External Dial Tel: 01902 695566
Internal Dial Tel: 85566

WR Partners
Chartered Accountants
Belmont House
Shrewsbury Business Park
Shrewsbury
SY2 6LG

Dear Sirs

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your audit of the charity's financial statements for the year ended 31 March 2025. These enquiries have included inspection of supporting documentation where appropriate. All representations are made to the best of our knowledge and belief.

General

1. We have fulfilled our responsibilities as trustees, as set out in the terms of your engagement letter dated 09 May 2025, under the Charities Act 2011, for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (UK Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view and for making accurate representations to you.
2. All the transactions undertaken by the charity have been properly reflected and recorded in the accounting records.
3. All the accounting records have been made available to you for the purpose of your audit. We have provided you with unrestricted access to all appropriate persons within the charity, and with all other records and related information requested, including minutes of all management and trustee meetings and correspondence with The Charity Commission.
4. The financial statements including the agreed adjustments in the sum of £20,578 (as set out in the appendix to this letter) are free of material misstatements, including omissions.
5. The effects of uncorrected misstatements in the sum of £Nil are immaterial both individually and in total.

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Internal Control and fraud

6. We acknowledge our responsibility for the design, implementation and maintenance of internal control systems to prevent and detect fraud and error. We have disclosed to you the results of our risk assessment that the financial statements may be misstated as a result of fraud.
7. We have disclosed to you all instances of known or suspected fraud affecting the entity involving management, employees who have a significant role in internal control or others that could have a material effect on the financial statements.
8. We have also disclosed to you all information in relation to allegations of fraud or suspected fraud affecting the entity's financial statements communicated by current or former employees, analysts, regulators or others.

Assets and Liabilities

9. The charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets, except for those that are disclosed in the notes to the financial statements.
10. All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as appropriate.
11. We have no plans or intentions that may materially alter the carrying value and, where relevant, the fair value measurements or classification of assets and liabilities reflected in the financial statements.
12. We can confirm that the balance owed to the Royal Wolverhampton NHS Trust at the year-end was £274,423.

Funds

13. We confirm that the split of funds between restricted, unrestricted and endowed, and treatment of funds in the statement of funds in the Statement of Financial Activity are appropriate.

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Accounting estimates

14. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Loans and arrangements

15. The charitable company has not granted any advances or credits to, or made guarantees on behalf of, directors other than those disclosed in the financial statements.

Legal claims

16. We have disclosed to you all claims in connection with litigation that have been, or are expected to be, received and such matters, as appropriate, have been properly accounted for and disclosed in the financial statements.

Laws and regulations

17. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

Matters of Material Significance

18. We can confirm that there have not been any Matter of Material Significance which require reporting.

Related parties

19. Related party relationships and transactions have been appropriately accounted for and disclosed in the financial statements. We have disclosed to you all relevant information concerning such relationships and transactions and are not aware of any other matters which require disclosure in order to comply with legislative and accounting standards requirements.

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Subsequent events

20. All events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed.

Going concern

21. We believe that the charity's financial statements should be prepared on a going concern basis on the grounds that current and future sources of funding or support will be more than adequate for the company's needs. We also confirm our plans for future action(s) required to enable the company to continue as a going concern are feasible. We have considered a period of twelve months from the date of approval of the financial statements. We believe that no further disclosures relating to the charity's ability to continue as a going concern need to be made in the financial statements.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware.

Each trustee has taken all the steps that they ought to have taken as a trustee in order to make themself aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully

K. Storey
.....
Signed on behalf of the board of directors

Date: 3.11.25

Tier 1 – Paper Ref	Enc 12.8
Report title:	Use of the Trust Seal – Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust
Sponsoring executive:	Kevin Bostock, Group Director of Assurance
Report author:	Kevin Bostock, Group Director of Assurance
Meeting title:	Group Board of Directors Meeting to be held in Public
Date:	18 November 2025

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

Assure

In accordance with the Trust's Standing Orders, the Seal of the Trust is affixed to a document that has been authorised by a resolution of the Board or of a Committee of the Board or where the Board has delegated powers. The data below is to provide the Board of Directors with an annual view of the use of the official seal for each Trust. It is for information only.

Walsall Healthcare NHS Trust - Trust Seal Usage 2024/25

See table below for detail of seal usage for the period July 2024-October 2025.

Reference	Date	Witness/es	Document
170	24/7/2024	Caroline Walker (Interim CEO) & Kevin Stringer, Chief Financial Officer	Lease for consenting to allow rights over land for tv cable and maintenance
171	13/12/2024	Kevin Stringer & Alan Duffell	Skanska

The Royal Wolverhampton NHS Trust - Trust Seal Usage 2024/25

See table below for detail of seal usage for the period February 2024-October 2025.

Reference	Date	Witness/es	Document
n/a	23/2/2024	David Loughton, Kevin Stringer	Partnership Agreement RWT and Wolverhampton City Council- For the Delivery of the Family Hubs and Start for Life Programme.
n/a	07/8/2024	David Loughton, Kevin Stringer	Lease Agreement Relating to Retail Units at Event Kiosk, West Entrance and Maternity Entrance New Cross Hospital, Wednesfield Rd, Wolverhampton, WV10 0RP
n/a	16/4/2025	Caroline Walker, Kevin Stringer	Lease Renewal for RWT Space at Phoenix HC
n/a	16/4/2025	Joe Chadwick-Bell, Kevin Stringer	Lease for Greggs Retail Unit at New Cross Hospital
n/a	16/4/2025	Joe Chadwick-Bell, Kevin Stringer	Project Agreement for Molecular Managed Equipment Service
n/a	17/9/2025	Kevin Stringer	Legal Agreement for the Lease of the Yard & Car Park for Unit 1E Bently Bridge Business Park
n/a	17/9/2025	Kevin Stringer	1. Lease Renewal for RWT Space at the GEM Centre 2. License to Underlet Consent of Lift provided to grant the lease between Community Health Partnerships Ltd and RWT

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?]*
n/a

4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a) Receive the WHT and RWT report for information and assurance

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:		