**The Royal Wolverhampton NHS Trust (RWT)
& Walsall Healthcare NHS Trust (WHT)
Tuesday 17 March 2026 @ 12:30-15:45
Meeting Room 12 & 13, MLCC, Walsall Healthcare NHS Trust**

Group Board of Directors Meeting - to be held in PUBLIC

Agenda Item No	DESCRIPTION	REPORT REF	LEAD	PURPOSE	TIME
1	Chair's Welcome, Apologies and Confirmation of Quorum	Verbal	Sir David	To inform & assure	12:30
2	Register of Declarations of Interest	Verbal	Sir David	To inform & assure	12:32
3	Minutes of the Previous RWT/WHT Group Board of Directors Meeting held in Public on 20 January 2026	Enclosure 3	Sir David	To approve	12:34
3.1	Group Board Action Log and Matters Arising	Enclosure 3.1	Sir David	To inform & assure	12:37
4	Chair's Report – Verbal	Verbal	Sir David	To inform & assure	12:42
5	Group Chief Executive's Report	Enclosure 5	J Chadwick-Bell	To inform & assure	12:47
5.1	Freedom to Speak Up Guardians Report Q1 & Q2	Enclosure 5.1	J Chadwick-Bell	To inform & assure	12:55
6	Group Finance Plan and Workforce Report	Enclosure 6	K Stringer	To inform & assure	13:05
7	Integrated Committee Chairs Report – Quality Committee, Finance & Productivity Committee, People Committee and Transformation and Partnerships Committee	Enclosure 7	P Assinder L Toner D Brathwaite L Sadler-Todd	To inform & assure	13:13
8	**Strategy (Section Heading)**				
8.1	Neighbourhood Health Plans and Walsall Together Partnership Board Update	Enclosure 8.1	S Cartwright	To inform & assure	13:28
8.2	RWT & WHT Report on Supporting National Ambitions for Life Sciences Research and the 150-day Target on Set-up of Clinical Trials	Enclosure 8.2	B McKaig	To inform & assure	13:33
8.3	Transforming Care Together (TCT)	Enclosure 8.3	J Chadwick-Bell/ S Evans	To approve	13:38
9	**Integrated Quality and Performance Reports (Section Heading)**				
9.1	Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity	Enclosure 9.1	A Godson	To inform & assure	13:48

Agenda Item No	DESCRIPTION	REPORT REF	LEAD	PURPOSE	TIME
9.2	Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality, People, Access Standards, Finance and Productivity	Enclosure 9.2	G Nuttall	To inform & assure	14:08
9.2.1	RWT & WHT Guardians of Safe Working Report (Guardians in attendance)	Enclosure 9.2.1	Z Din	To inform	14:28
10	COMFORT BREAK (10 MINS)				14:43
11	Patient Story – Debbie's Story	Verbal	Z Din	To inform	14:53
12	Governance (Section Heading)				
12.1	RWT & WHT Audit Committee Chair Reports	Enclosure 12.1	J Jones M Martin	To inform & assure	15:08
12.2	RWT Charitable Funds Committee Chair's Report	Enclosure 12.2	M Levermore	To inform & assure	15:16
12.3	Group Board Assurance Framework Report	Enclosure 12.3	K Bostock	To inform & assure	15:24
13	Questions Received from the Public	Verbal	Sir David	To inform	15:29
14	Any Other Business	Verbal	Sir David	To inform	15:34
15	Resolution to close meeting	Verbal	Sir David	To inform	15:39
16	Date of Next Meeting: Tuesday 19 May 2026 – VENUE TBC	Verbal	Sir David	To inform	15:40
CLOSE					

MEETING OF THE RWT/WHT GROUP BOARD OF DIRECTORS MEETING held in Public
TUESDAY 20TH JANUARY 2026
MLCC, Room 12 and 13 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
Mr S Evans	Deputy Group Chief Executive Officer & Chief Strategy Officer
Ms D Hickman	Chief Nursing Officer, RWT
Ms L Carroll	Chief Nursing Officer, WHT
Ms S Cartwright	Group Chief Community and Partnerships Officer
Ms L Sadler-Todd	Group Non-Executive Director
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	Group Non-Executive Director
Ms M Martin	Non-Executive Director, WHT
Lord P Carter	Specialist Advisor to the Board, RWT
Mr P Assinder	Deputy Chair/Non-Executive Director, WHT
Prof M Levermore	Group Non-Executive Director
Mr K Bostock	Group Chief
Dr U Daraz	Group Associate Non-Executive Director
Ms A Heseltine	Group Non-Executive Director

In Attendance

Ms J Toor	Group Trust Board Secretary
Ms A Cooper	Clinical Nurse Specialist for Lipid, RWT (for Agenda Item 125/25)

Members of Staff and Public in attendance

Ms A Downward	Communications Lead RWT/WHT
Ms D Bettridge	Clinical Support Worker, WHT
Ms R O'Sullivan	Professional Lead for AHPs, WHT

Apologies

Ms D Brathwaite	Group Non-Executive Director
Mr J Dunn	Deputy Chair/Non-Executive Director, RWT

124/25	**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 RWT/WHT Group Board of Directors Meeting held in public be confirmed as quorate.**
125/25	**Patient Story of Amie Burden - Familial Hypercholesterolaemia**
	Sir David opened the meeting by reiterating the Board's practice of commencing each meeting with either a patient or staff story. He said this approach ensured the Board remained committed to patient experience and focused on the purpose of improving outcomes for patients and the wider population. Sir David confirmed that the story being presented today related to a patient with Familial Hypercholesterolaemia (FH) and he welcomed Ms Amie Cooper, Clinical Nurse Specialist at RWT to present the patient story.
	Ms Cooper advised that the video with the story of patient Amie Burden had initially been created for a lipid management education event. She provided an overview and advised that in May 25 a lipid education event at New Cross Hospital had been organised to bring together staff from across the West Midlands and The Royal Wolverhampton NHS Trust (RWT). She said as part of the programme, she had identified the importance of including a patient story to highlight and demonstrate the lived experience of FH and the impact it has on patients' lives, as well as to support reflection on how the lipid service might improve.
	Ms Cooper said the patient had also joined the Lipid Network event virtually to answer questions and attendees at the event had included lipid nurses from across the ICS, cardiology and stroke nurses,

pharmacists, and other relevant professionals. She said the session enabled staff to reflect on service delivery and consider areas for improvement.

Ms Cooper advised that the patient featured in the story had long-standing FH and had been under the care of RWT, which had included Professor Gama, for many years and spoke highly of the service. She said when her role as Clinical Nurse Specialist role had been introduced 2.5 years ago, some patients had been concerned it represented a replacement for Professor Gama, however it had been clarified that this role had been designed to support and enhance the services already provided and to work alongside each other.

Ms Cooper reported that the service reviewed FH patients at least annually to ensure adherence to treatment, achievement of lipid targets, monitoring of blood results, and provision of ongoing support and said that early intervention remained essential due to the significantly increased risk of premature cardiovascular disease in this patient group. She advised that the patient's story highlighted the familial nature of FH. Her father, who also had FH, experienced a heart attack and subsequently required bypass surgery at a young age which had led to the patient's own diagnosis. Ms Cooper advised that the patient's young son had also been tested and his results were fortunately negative. She said the patient had been active in national awareness work with the British Heart Foundation and HEART UK, contributing to fundraising and advocacy and had become a recognised ambassador for FH.

Dr Din asked how Professor Gama's compassionate relationship with patients had affected compliance. Ms Cooper reported that patients within the service were more engaging and compliant with medications.

Ms Chadwick-Bell noted the importance of ensuring that clinical communications—particularly discharge letters and follow-up correspondence—used language appropriate for patients while still providing the necessary level of clinical and technical detail for GPs and other professionals. She said that this was especially important as RWT moved increasingly towards digital communication, and that these letters often form the first of many interactions with patients following an episode of care.

Ms Cooper reported that this issue had already been discussed with the consultant and the team were exploring how communication could be improved, recognising that letters serve multiple audiences: patients, GPs, cardiologists, and for internal clinical record-keeping. She said it had been acknowledged that clinical content must be sufficiently detailed for healthcare professionals and legally robust, but that patients may find some terminology unclear or anxiety-inducing.

Ms Chadwick-Bell suggested that patients be informed that they can contact the service directly if they have questions about the clinical content of their letters. Providing a named contact or telephone number could support patients who may need clarification.

Sir David thanked Ms Cooper for presenting an excellent patient story and highlighted two key reflections. He noted that while patient interactions were sometimes viewed as episodic—such as single outpatient or inpatient encounters—certain patient groups require long-term, continuous relationships with clinical teams. He said this represented a fundamentally different type of engagement which he acknowledged was a significant part of the Clinical Nurse Specialist's role and that the development and maintenance of these long-term therapeutic relationships, had been clearly demonstrated in the story presented.

Sir David said that he observed that the patient's reflections focused very little on the clinical interventions themselves and instead her experience was shaped by how staff communicated with her, the way she was spoken to, and her ability (or inability) to understand letters and other information provided. He said this emphasised that patient experience was driven heavily by communication and interpersonal contact, rather than solely by clinical care. He said it was recognised that supporting and improving this aspect of patient experience formed a major component of the Clinical Nurse Specialist's role.

Ms Cooper thanked the Board for inviting her to present the patient's story.
Resolved: that the Patient Story of Amie Burden - Familial Hypercholesterolaemia be received for information.
Ms Cooper Left the meeting.

126/25	**Register of Declarations of Interest**
	Sir David confirmed that no further declarations of interest had been received pertaining to any items on the agenda 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.
127/25	**Minutes of the Previous RWT/WHT Group Trust Board Meeting held in Public on 16 September 2025**
	Sir David approved the minutes of the Group Trust Board Meeting held on 16 September 25 as an accurate record. **Resolved: that the minutes of the previous meeting held 16 September 25 be received and APPROVED pending the amendments noted.**
128/25	**Group Board Action Log and Matters Arising**
	Sir David received the Group Board Action Log and updates were received as below… **Action 3319: Ms Cartwright asked that the results of the self-assessment for Health Inequalities be shared at a future Group Trust Board Development Session and Dr Warren be invited to provide further information and assurance.** Ms Cartwright reported that Health Inequalities has been programmed for a future Group Board Development Session. It was agreed that this action be closed. Sir David confirmed that there were no outstanding matters arising. **Resolved: that any updates to the Group Action Log and Matters Arising be received and noted.**
129/25	**Chair's Report – Verbal**
	Sir David emphasised the opportunity to develop an ambitious three-year plan with a level of ambition and strategic direction that has not been available previously. He said the Board needed to consider how it would maximise the opportunities arising from this work. Sir David advised that Ms Chadwick-Bell and Mr Evans would continue work to identify opportunities for the Board to collectively shape and take forward the programme so that all members could contribute meaningfully. **Resolved: that the Chair's report be received for information and assurance.**
130/25	**Group Chief Executive's Report**
	Ms Chadwick-Bell noted that it had been 12 months since she had commenced in post and the one-year milestone had provided an opportunity for reflection and reset. She confirmed absolute confidence in her decision to join RWT and WHT and expressed pride in the work of staff. Ms Chadwick-Bell reported that the Executive Team had discussed the need for a reset with the focus to avoid normalising standards that fall short of what RWT and WHT expected irrespective of comparisons with other Trusts. She emphasised that the priority was to define and deliver the standards of care that both RWT and WHT aspired to provide and to make best use of available resources and maintain an engaged and proud workforce. Ms Chadwick-Bell advised that the updated Group Strategy would return to the Group Trust Board Meeting in March 26 to create the right environment for staff to excel and be able to provide safe, effective care to patients. Ms Chadwick-Bell reported that recent staff meetings and engagement sessions had demonstrated strong passion and commitment to continued improvement and emphasised that staff were motivated to be the best they could be. Ms Chadwick-Bell reported that while financial pressures remained, resources needed to be used wisely and align to organisational priorities as part of the reset. Ms Chadwick-Bell clarified that the priority areas going forward were patient safety and clinical effectiveness; reduction of waiting times; focus on clinical best practice and clinical standards of care; ensuring timely access to outpatient, surgical, and urgent care services to support better patient outcomes; supporting colleagues to demonstrate autonomy within their clinical skills and reduce unnecessary barriers to decision-making; the need for a clear digital strategy and improved utilisation of technology, with further proposals to be brought by Mr Evans; maximising resources, including workforce, funding, and estates. Ms Chadwick-Bell advised that improvements had been made in governance structures that included the establishment of the new Group Management Committee (GMC), Transforming Care Together Programme and its oversight committee, and a more structured Executive Team meeting format to support updates and strategic discussion. Ms Chadwick-Bell highlighted changes within the Executive Team, including the revised role of Mr Bostock

	who would now be a core member of the Executive Team as the Group Chief Safety and Assurance Officer. She said this reflected RWT and WHT's ongoing commitment to patient and staff safety. Ms Chadwick-Bell acknowledged the sustained operational pressures of winter, noting the significant hard work of staff over recent weeks, and expressed appreciation for their continued dedication. She said this had taken place alongside industrial action during November and December, which had required considerable planning and support from senior teams. Ms Chadwick-Bell also highlighted work on the prevention of sexual misconduct in the NHS. She said that while originating from an HR perspective, this work was about ensuring the safety of patients and colleagues. She said reports had been submitted to the Group Management Committee and Group People Committee and further updates would be brought to the Board for assurance in due course. **Resolved: that the Group Chief Executive's Report be received for information and assurance.**
131/25	**Integrated Committee Chairs Report - Quality, Finance & Productivity, Transformation and Partnerships and People**
	Mr Assinder reported on the key areas of concern that had been highlighted through the Committees of the Board across RWT and WHT. **Group Finance & Productivity Committee** Mr Assinder advised that the Committee anticipated delivering £78m efficiency this year, with a negotiated £8m year-end settlement with the ICB and focus on the two-year plans and the three-to-five-year strategy refresh. He said winter capacity and industrial action pressures had been flagged for Q4. **Group Quality Committee** Mr Assinder reported that an unannounced CQC visit to RWT (24–26 Nov) was pending final report and may include enforcement; action plans are already underway. He noted that fire enforcement notices had been issued for RWT Block 55 (theatres) and Block 32 (maternity), and for Cannock Chase Hospital; actions were being completed and NHS England financial support had been sought. Mr Assinder reported that mental health presentations and pressures across RWT and WHT had been escalated with a new role Head of Mental Health, Safeguarding, LD and complex vulnerable adults being recruited to, bringing together the previous Head of Safeguarding and a Head of Mental Health post. Prof Toner advised that Group Quality Committee had received 2 skill mix reviews, and the reports had since been confirmed. She said there would be changes with the tool used for skill mix reviews in ED moving forward. Prof Toner reported that the skill mix review for WHT had related to community and there would be a 3rd iteration produced before it was presented to the Group Trust Board for assurance. **Group People Committee** Mr Assinder reported that focused work continued against RWT sickness absence which was higher than WHT. He said improvement plans were in place and being monitored. **Resolved: that the Integrated Committee Chairs Report - Quality, Finance & Productivity, Transformation and Partnerships and People be received for information and assurance.**
132/25	**RWT and WHT Charitable Funds Committee – Chair's Report – Verbal Update**
	Prof Levermore advised that long and short-term investment portfolios remained stable with c.3% returns. He said cashflow was the principal risk but remained sound. He advised that Charity managers were considering a fixed charity hub at RWT and that RWT had received a clean bill of health from Auditors. Prof Levermore advised that the Walsall Charity were also in a good position however more timely recharges to the Trust were urged. He said WHT Mortuary refurbishment project costs were to be obtained and would be brought back to the committee for approval. Prof Levermore praised the activity over Christmas and the time spent with Charity Managers and said that feedback, including patient and staff feedback and stakeholder involvement had been very positive. Sir David clarified that WHT charity payments over Christmas had been for services received, and not NHS-funded items. Prof Levermore confirmed this was accurate.

	Resolved: that the RWT Charitable Funds Committee – Chair's Report be received for information and assurance.
133/25	**RWT & WHT Audit Committee Chair's Report**
	Ms Martin (WHT Audit Committee) advised that WHT Internal audit on pay enhancements and waiting list initiatives had received "minimal assurance," with numerous recommendations with RSM to re-review near year-end. She said Counter-fraud services had achieved a successful prosecution, to be used as a case study to reinforce policy adherence. Ms Martin reinforced the need to clear overdue actions from prior audits. Ms Jones (RWT Audit Committee) noted ongoing concerns regarding the need to reinforce the importance of maintaining strong internal controls during the period of organisational change that had taken place. she said the RWT Audit Committee had been pleased to observe that recent reports had reflected and echoed this priority. Ms Jones emphasised the need for continued vigilance, recognising that it was easy for controls to weaken or for issues to slip during times of transition. **Resolved:** that the RWT & WHT Audit Committee Chair's Report be received for assurance, with explicit follow-up of audit actions by year-end.
134/25	**Group Finance Plan and Workforce Report**
	Mr Stringer reported on the financial performance of the Group for the period April 2025 to November2025. He said the Group position was ahead of plan by £2.4m year-to-date, WHT were £3.2m ahead of plan, and RWT were £0.8m behind plan, which was a deterioration by £2.0m in month mainly relating to industrial action. Mr Stringer advised that Industrial action costs for November 25 had been funded, though RWT were seeking recovery of an underpayment of c.£1.2m from NHSE. He said that capital spend was behind plan by c.£7.8m at end-November 25 and urgent Q4 catch-up was required. He reported that cash support for Q4 was confirmed, with no cash concerns. Mr Stringer advised that prompt payment performance had dipped after the new ledger implementations and that actions were underway with Managing Directors and Procurement to protect local suppliers. Mr Stringer reported that the forecast had indicated the year-end WTE reduction would be off-trajectory, with increased bank and locum usage offsetting substantive reductions in Month 9, and detailed recovery plans were in development through the Group People Committee. Ms Chadwick-Bell reported that future reports would ensure clear separation of "pay spend reduction" and "headcount/WTE reduction". Ms Nuttall advised that RWT had reduced workforce by 141 WTE and was off the agreed trajectory by 59 WTE. Ms Godson reported that WHT had reduced workforce by 26.1 WTE year to date. Prof Levermore requested assurance on spend with local companies to evidence anchor-institution impact and for Procurement to provide Group and trust-level analyses, including national contracts with local branches and local employment. **ACTION: Mr Stringer to speak with the procurement team to report local supplier spend and employment impact in February 2026.** **Resolved:** that the Group Finance Plan and Workforce Report be received for information and assurance.
	Strategy (Section Heading)
135/25	**Group Chief Community and Partnerships Officer Report Work Programme for One Wolverhampton and Walsall Together**
	Ms Cartwright reported that forthcoming national guidance was expected imminently on the model neighbourhood framework, neighbourhood health plans, neighbourhood health centres, and system architecture/contracting for future models. She said local plans must be signed off by Health & Wellbeing Boards in March 2026; for 2026/27 they would be added to Health & Wellbeing strategies and become the main strategy from 2027/28. Ms Cartwright reported on One Wolverhampton and advised that 4 fixed-term integrated neighbourhood team (INT) clinical leads had been appointed: Dr Sam Marianna (South), Dr Cam Ahmed (Central), Dr Shahid

Rafiq (North), and Dr Chika (East). She said that Wolverhampton joined a national INT community of practice with NHS Providers and Newton.

Ms Cartwright reported on Walsall Together and advised that 'Feel Good Friday' frailty clinics had shown impact and that evaluation and a recurrent funding plan for these would follow. She reported that national measurement cohorts had been established to track outcomes such as A&E attendance and admissions and that intermediate care funding had been stabilised via Better Care Fund and place commissioning to sustain therapy-led discharge support following a positive pilot.

Ms Cartwright advised of the National Programme Director's visit to WHT on 23 January 26 to observe the model, including Hamilton Health Centre. She reported that the Walsall Together Board would transition from an independent chair to a partner-chaired model by end-March 26 and asked that formal thanks to Prof Patrick Vernon be recorded which would be conveyed.

ACTION: Neighbourhood health plans for One Wolverhampton and Walsall Together to return to March 2026 RWT/WHT Group Trust Board – to be held in Public for approval.

Sir David noted the leadership transition at Walsall Together and placed on record his formal thanks to the outgoing chair, Prof Vernon.

Resolved: that the Group Chief Community and Partnerships Officer Report Work Programme for One Wolverhampton and Walsall Together be received for Discussion, Information and Assurance.

136/25	**Proposed Transformation Model for Stroke Rehabilitation across Walsall and Wolverhampton**

Ms Cartwright provided an update on the proposed move to an Integrated Community Stroke Service (ICSS) model with strengthened seven-day home-based rehabilitation, supported by inpatient rehabilitation at West Park (Wolverhampton) and improved ambulatory stroke rehab facilities in Walsall (Short Heath Clinic adjacent to Holly Bank). She said the proposal followed Clinical Senate review, two Walsall Scrutiny Committee sessions (25 Sept and 4 Dec), and ICB service-change approvals.

Ms Cartwright acknowledged that staff engagement could and should have been better and committed to a learning review across leadership and Human Resources. She said staff visits to West Park were underway and that public and patient engagement had found strong preference for home-based rehab, with concerns about travel, and a clear expectation that the model be delivered as described. She advised that transport support, communications, and entitlement awareness would be improved by the Associate Director of Patient Experience.

Ms Cartwright advised that 2 alternative Walsall sites (Saddlers Centre and the former Walk-in Centre) had been assessed and found unsuitable for inpatient rehabilitation and that the Council Executive had been informed.

Sir David advised that The Group Trust Board approved the transformation to the ICSS model across Walsall and Wolverhampton and endorsed implementation planning, with a six-month update to the Scrutiny Committee and ongoing staff engagement.

Ms Bettridge, a member of staff who attended the Board in public asked to raise a question in respect of the agenda item. Sir David advised that whilst the Board was held in public it was not a public Board, however, he would on this occasion allow the question. Miss Betteridge asked that the c.£100,000 raised for Holly Bank remain for WHT use and not be transferred to RWT. Sir David reported that charitable funds raised for Holly Bank should remain within Walsall well-wishers for local benefit, with spending governed by charity rules. Ms Cartwright and Prof Levermore agreed to speak to Miss Betteridge outside of the meeting regarding her concerns.

The Board convened for a 10-minute break @14:00-14:10PM

Resolved: that the Proposed Transformation Model for Stroke Rehabilitation across Walsall and Wolverhampton be received for Discussion, Information, Assurance and Approval.

	RWT & WHT Trust Integrated Quality & Performance Reports (Section Heading)
137/25	**Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity**

Ms Godson reported that Referral to Treat (RTT) performance remained the best in the West Midlands, though referrals were 9% higher year-to-date; an elective "sprint" with NHSE funding would run in Q4 to reduce the total waiting list.

Ms Godson advised that WHT had achieved 2 of the 3 constitutional standards for cancer, 62-day performance was 71.3% versus 75% target due to oncology workforce capacity, with short-term mitigations in place.

Ms Godson reported that Urgent & Emergency Care (UEC) 4-hour performance dipped from 74% to 72.08% in November 25; to manage system pressures, Black Country trusts had agreed from 12 January 26 to cease "intelligent conveyances" except for formal diverts, following a joint quality impact assessment. Diagnostics performance improved to 81.75% in Month 9.

Ms Carroll advised that 1 fall with severe harm had been reported in November 25 and the patient had recovered and returned home mobile.

Ms Carroll reported that pressure ulcer reporting had increased; cases were under review via the global harm review process and linked to crowding/corridor care impacts. She reported that updated NHSE corridor-care guidance had been adopted; defined spaces were staffed and equipped, and use remained a last resort.

Ms Carroll advised that following a sexual health incident review it had been identified that all positive results had been managed accordingly and patients treated. She said there would be further focused learning system use and staff training provided.

Ms Carroll reported that CNST Year 7 declaration submitted with compliance in 9 of 10 safety actions; one element of Safety Action 1 was late (EMBRACE notification within 7 working days) due to staffing pressures, with limited financial risk anticipated.

Ms Carroll advised that occupational reassessment of Entonox showed 3 rooms were still above workforce exposure limits; 6 destruction units were purchased and went live on 8 January 26 alongside existing controls.

Dr Din reported that Joint Advisory Group (JAG) accreditation for endoscopy at WHT had been received in December 25.

Dr Din advised that Summary Hospital Mortality Indicator (SHMI) remained within expected range at 0.92 with no HSMR alerts.

Mr Assinder asked that it be noted that Walsall Healthcare NHS Trust were now compliant with their Emergency Preparedness Response (EPRR).

Sir David said he was concerned that 'corridor' care would become the normal for the Trust. Ms Carroll agreed and confirmed that that corridor case had been used in exceptional circumstances due to pressures at front door and overcrowding in ED. She advised that they were looking at discharge lounge and lots of action were being undertaken.
ACTION: Ms Godson and Ms Carroll to bring a corridor-care reduction plan with metrics to the February 2026 Quality Committee alongside an Elective variability analysis and plan to the Group Finance & Productivity Committee in February 2026.

Ms Chadwick-Bell advised that the Executive had discussed how the Trusts manage capacity and demand analysis better than they currently do and were reviewing Consultant job plans to ensure optimal activity and understand where there was variability and if it was planned variability or accidental. Dr McKaig said this would also link back to how the Clinical Strategy is developed.

Ms Sadler-Todd said that the productivity dashboard did not appear to have calculated estates and facilities and the corporate services cost had increased. Ms Chadwick-Bell said that she had asked for a clear narrative of the productivity dashboard with a level of intelligence behind the variation and needed to understand fully the metrics behind the numbers.

Mr Evans provided an update on the corporate position over the last two years. He said the overall headcount across the Group had reduced by 265 staff and the reduction had been achieved and aligned to the requirements of individual services. He advised that a second element had focused on how the Group functions could operate 20% more efficiently. He said the two-year figures reported reflected the initiatives that had delivered a significant amount of value and were driving the efficiencies.

Mr Evans reported that as planning began for the 2026/27 Cost Improvement Programme (CIP), additional

	opportunities for efficiencies had been identified but had not been progressed in the current year (2025/26) due to operational constraints. He said as services continued to become more efficient, further opportunities would be pursued. **Resolved: that the Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity be received for information and assurance.**
138/25	**Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality, People, Access Standards, Finance and Productivity**
	Ms Nuttall reported that the Care Quality Commission (CQC) had conducted an unannounced inspection (24–26 November 25) across the Emergency Department (ED) and Same Day Emergency Care (SDEC), including mental health and paediatrics. She said post-visit letters had requested assurance on waiting-room clinical oversight, SDEC flows, mental health waits, and assessment/triage times. Ms Nuttall advised that an action plan with an evidence log was in place and overseen daily/weekly with discussions at the Group Quality Committee. She advised that the final CQC report was pending. Ms Nuttall advised that the revised enforcement notice received (17 December 2025) for the Maternity block at RWT required significant capital and probable decant and advised that many short-term actions were complete. She said funding discussions with NHSE were active and the overall enforcement period was 2 years. Ms Nuttall reported that post a successful Electronic Patient Record (EPR) go-live, some outpatient outcome recording gaps had created financial and RTT risks and plans were in place to clear by end-March 2026. Ms Nuttall advised that the Trust had recorded 66 breaches of 65-week waits at end-December 25. She said all patients had treatment plans for January 26 and daily/weekly oversight was in place to prevent further breaches in Q4. She said a Q4 elective sprint would focus on clock-stops and long waiters and expected to deliver c.3% RTT improvement for >3,000 patients, with funding confirmed in principle pending letter. Ms Nuttall reported that 4-hour performance remained high but was deteriorating alongside ambulance handovers and 12-hour waits. She advised that a reset plan was being progressed, aligned with PA Consulting support on Urgent and Emergency Care (UEC) pathways, frailty and SDEC. She said the national UEC team would visit on Thursday 22 January 26 to support the plan. Ms Hickman advised that *C. Dififcile* cases had been reduced substantively following the return of high use commode cleaning activity in the Patient Equipment Cleaning Centre (PECC) after a dip in inactivity due to PECC capacity which had since been resolved. She said the Trust was on trajectory (59/81 Year to Date) though rolling segmentation would lag. Ms Hickman reported that Board accreditation quality assurance visits were being relaunched, including a new Emergency Department framework. Ms Hickman advised that enhanced oversight of maternity students' outcomes had been stepped down and this had been a positive outcome. She said Maternity Services had submitted its Clinical Negligence Scheme for Trusts (CNST) declaration and this had been validated through the Group Quality Committee. Ms Hickman advised that Maternity leave had risen by c.55 Whole Time Equivalents (WTE), impacting coverage. Ms Hickman reported that Staff survey response rates were low and a full report and engagement reset would return when national results were released. Ms Hickman noted the reference to corridor care raised by Ms Carroll and said that while it was acknowledged that RWT did not routinely deliver care in corridors there were defined spaces in use and the term also extended to areas where additional capacity had been created. She said some of the additional capacity related to models and pathways that were already established within RWT and that were utilised when services were operating in extremis. Ms Hickman reported that these arrangements were subject to review and welcomed the support being offered to reduce the need for such capacity and to ensure that patients continue to receive high-quality care. **Resolved: that the Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality,**

		People, Access Standards, Finance and Productivity be received for information and assurance.
139/25		**Antimicrobial Resistance Report**
		Dr Din presented the letter RWT and WHT had received in November 25 which had been a call to action to work with prescribers and clinical leads to implement changes required by the National Action Plan for Antimicrobial Resistance (AMR). Dr Din advised that The National Action Plan, titled *Act Now, Protect Our Present, Secure Our Future*, had been issued by NHS England in response to AMR being placed on the National Risk Register and the letter set out three required actions. He said the purpose of the report was to provide a Board-level review and assessment of the current position, the key challenges, and any immediate actions required, including completion of the risk and capability assessment and agreement of three priorities for improving AMR. Dr Din reported that the required work would be completed by April 2026. Dr Din reported that a wider session had been held with key stakeholders from the Antimicrobial and Infection Prevention teams to review the current position, the content of the letter, and progress against the required actions. He said existing structures were in place across RWT and WHT to meet the obligations set out, ensuring robust antimicrobial stewardship arrangements. Dr Din assured the Group Trust Board that both WHT and RWT were performing better than the national average on all reported Antimicrobial Stewardship (AMS) metrics as reported by the UKHSA, and in some cases were among the best performers nationally. He said this was notable given the system-wide challenges created by high antimicrobial resistance rates, which reflected the area's deprivation and complex population. Dr Din reported that concerns had been raised regarding optimisation of blood culture sampling, an area in which performance was currently suboptimal. He said an action plan was in place in RWT and a plan was being developed for WHT where performance is currently worse due to differences in phlebotomy services. Dr Din advised that RWT and WHT would work collaboratively, sharing good practice and identifying the three key priorities, which may differ slightly between Trusts due to variations in performance across the metrics. Dr Din reported that an oversight group would be established to ensure completion of the capability and risk assessment. He said existing structures would continue to provide reporting through to the Board, including via the Infection Prevention Committees and Group Quality Committee, with an annual report to be presented to the Board in 2027. **Resolved: that the Antimicrobial Resistance Report be received for information and assurance.**
140/25		**Questions Received from the Public**
		Sir David said that the Board had received six questions that had been submitted by a member of the public. He advised that only 1 question would be addressed during the meeting, with written responses to be provided for all questions received and that this had been communicated to the member of public who had raised the questions. He advised that all responses to the questions raised would however be recorded within the minutes of the Board meeting. Sir David advised that the question that would be discussed at the Board was: **"What are the current mortality rates for stroke over the last three months?".** He asked Dr McKaig to respond. Dr McKaig advised that the question asked related to Royal Wolverhampton NHS Trust (RWT), which provided acute stroke services for both RWT and WHT. He said monthly updates were received regarding the Standardised Hospital Mortality Index (SHMI) and the current SHMI for stroke was 0.97 and this was below the expected number of deaths. Dr McKaig reported that during the period in which mortality alerts had been issued, the SHMI for stroke had been 1.2, a level that was sustained for several months. A significant reduction in SHMI had now been observed. He said this reduction was considered an indication of progress; however, it was emphasised that it is essential to review the supporting quality metrics. Dr McKaig advised that the metrics were primarily derived from the Stroke Sentinel National Audit Programme (SSNAP), which assessed a range of indicators demonstrating the quality of care delivered to individual patients. Every patient is included in this audit. Improvements had been identified in SSNAP scores, which

provided assurance that the observed reduction in mortality was linked to the actions undertaken and reflects an improvement in the quality of care provided.

Dr McKaig reported that the SHMI for stroke had remained below 1 for a prolonged period, indicating that the improvement was not an isolated occurrence but is instead sustained and showing a downward trend. He said monitoring would continue, and the stroke team was progressing through a substantial action plan. The team was highly engaged, and external reviews undertaken with the Royal College of Physicians visit had been positive.

Dr McKaig advised that the national Stroke Lead commented that, based on staff engagement and the progress made, he would have no concerns if he were to visit RWT stroke services at present. Staff have demonstrated a clear understanding of their responsibilities and a strong commitment to service improvement. Significant assurance was taken from this feedback.

The following questions were responded to outside of the meeting, via email:
Q - Will the RCP be carrying out a review? Is the RWT going to provide a further update on the progress of the remediation?
A: We expect the RCP to request an update on the actions taken by the trust to address the report's recommendations this month.
The Trust has made significant improvements in workforce stability, SSNAP (Sentinel Stroke National Audit Programme) performance, and clinical processes.
The SSNAP score for July–September 2025 improved to Level D (score 58.8)—up from Level E earlier in the year—reflecting better hyperacute assessment, specialist pathway flow, and MDT engagement. Active remediation work such as daily multidisciplinary huddles, enhanced clinical communication, revised pathways, improved nutritional and swallow assessment processes, and governance driven monitoring have also been implemented.

Q - I have noticed that TIA clinics have not been taking place at weekends for a considerable period. Will these weekend clinics reopen in the immediate future? Is there a remediation plan?
A: December 2025 activity data shows that weekend clinics continued to operate, with patient numbers recorded for every Saturday and Sunday except Christmas Day. The TIA Clinic operates a 7-day service with 8 slots on weekdays and 3 on weekends.

Q - Are you using a RAG rating and if so, will this be published on the website?
A: We do not use a RAG rating for this metric

Q - Has the Police been informed concerning the excess deaths over the last 3 years?
The police have not been informed concerning the excess deaths relating to the previous Stroke SHMI at RWT. It is important to note that excess death does not mean avoidable death.

Q - What are the current staffing levels in the stroke unit?
A: Medical staffing within Stroke has strengthened with eight consultants (including locums) and improved 24/7 senior support, alongside safer staffing nursing levels that, while slightly below the planned establishment on long days, remain stable. The current staffing information confirms a broadly resilient team, including CNS, therapy, and consultant coverage.

Q: The public still deserves to have access to the original full RCP Report with essential redactions as necessary. Producing a summary 3 months after obtaining the original report is misleading. The public needs to know the starting point of the failings of the stroke services rather than a summary following 3 months or remediation. To say that the failing has been corrected is not sufficient without providing the actual evidence, otherwise it looks like a cover up!
A: Please see response re updates above regarding the invited RCP review into stroke services at RWT. As per invited review process, we do not intend to publish the entire report. RWT have summarised the reasons for the invited review, provided the terms of reference, conclusions and recommendations, and provided regular a updates regarding the actions taken by the Trust to address the issues identified by the review and the recommendations made.

Resolved: that Questions from the public be received for information.

| 141/25 | **Any Other Business** |

	Sir David advised that Mr Assinder would serve as Deputy Vice Chair for the Group Trust Board from 1 February 26. Sir David recorded thanks to Mr Dunn on behalf of the Board for his 12 years of service across RWT and WHT and wished him well in his retirement. Sir David reported that Professor Liz Hughes had been appointed as a new Group Associate Non-Executive Director with her start date to be confirmed. Sir David thanked all staff and executive team for their exceptional commitment amid significant pressures. **Resolved: that Any Other Business be received for information.**
142/25	**Date and Time of Next Meeting – Tuesday 17th March 2026**
	Sir David confirmed the date and time of the next meeting as Tuesday 17th March 2026 and resolved that the Group Board of Directors meeting held in public as closed.

List of action items

Agenda item		Assigned to	Deadline	Status
RWT/WHT Group Trust Board Meeting - to be held in Public 20/01/2026 8 Group Finance Plan and Workforce Report				
3361.	ACTION: Mr Stringer to speak with the procurement team to report local supplier spend and employment impact in February 2026.	● Stringer, Kevin	17/03/2026	🟨 Pending
	Explanation action item Prof Levermore requested assurance on spend with local companies to evidence anchor institution impact and for Procurement to provide Group and trust level analyses, including national contracts with local branches and local employment.			
RWT/WHT Group Trust Board Meeting - to be held in Public 20/01/2026 11.1 Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity				
3363.	ACTION: Ms Godson and Ms Carroll to bring a corridor care reduction plan with metrics to the February 2026 Quality Committee alongside an Elective variability analysis and plan to the Group Finance & Productivity Committee in February 2026.	● Carroll, Lisa ● Godson, Amelia	17/03/2026	🟨 Pending

Agenda item		Assigned to	Deadline	Status
RWT/WHT Group Trust Board Meeting - to be held in Public 18/11/2025 9.2 Group Board Assurance Framework (GBAF)				
3310.	ACTION: Ms Nuttall and Ms Godson to ensure the statement for GBR2 be revised to include the full scope of risk if the Group wider than the requirements of the constitutional standards.	● Godson, Amelia ● Nuttall, Gwen	17/03/2026	■ Completed
	Explanation action item Ms Nuttall and Ms Godson have revised the statement for GBR2. This has been shared with Committees of the Board prior to BAF submission to Board in March 2026.			
RWT/WHT Group Trust Board Meeting - to be held in Public 20/01/2026 10.1 Group Chief Community and Partnerships Officer Report Work Programme for One Wolverhampton and Walsall Together				
3362.	ACTION: Neighbourhood health plans for One Wolverhampton and Walsall Together to return to March 2026 RWT/WHT Group Trust Board – to be held in Public for approval.	● Cartwright, Stephanie	17/03/2026	■ Completed
	Explanation Cartwright, Stephanie NHPs will be taken to Trust Board on 17th March 2026			

NHS

Tier 1 - Paper ref:	Enclosure 5

Report title:	Group Chief Executive's Report
To embed the 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:	17 March 2026

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

I would like to express my thanks to all staff for your exceptional dedication and hard work throughout the recent busy months. Your commitment to ensuring that our services were delivered not only safely but also to the highest standard—whether within our hospital, across our community, or through our GP services—has been truly outstanding.

Despite this significant challenge, everyone rose to the occasion, demonstrating remarkable resilience and professionalism. I am both immensely grateful and proud of what we have accomplished together, particularly in managing increased workloads within GP services and through the emergency pathway that ultimately affects every part of the organisation. The unwavering commitment has ensured that our patients continue to receive the best possible care during a demanding time.

Executive Team Updates
Dr Claire Radley, Group Chief of People, Engagement and Improvement Officer will be starting with us on 30 March 2026.

As we come towards the end of the planning and financial year the executive team have been working on readying ourselves to ensure we are able to take our organisations forward on the next step of our journey. As part of this exercise, we have also been reflecting on some of the conversations we have had over the past months, through the culture conversations, whilst we have been out and about and also through our various feedback channels. I will provide the plans for the next steps of our staff engagement as part of the Staff survey results update.

Staff survey results
The staff survey results for both trusts have been received and are due to be published on the 11 March. These findings provide valuable insight into the experiences and perspectives of our colleagues across the trusts and build on our existing feedback mechanisms. A report detailing these results will be presented at the next Trust Board meeting.

We do recognise that delivering great care depends on enabling our colleagues to feel engaged, valued, and empowered in their roles. Our aim is to create an environment where every member of staff can come to work, feel supported, and be the best they can be.

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

As an executive team we have briefly reviewed the data and have heard that staff do not feel listened to, so we have decided we will be looking to engage with staff through:

- Face-to-Face Engagement: The executive team and senior leaders will be meeting directly with staff, both in person and virtually, to discuss the survey findings and explore ideas for improvement.
- Virtual Team Brief: We will share the findings at team brief, ensuring all staff have the opportunity to hear about the results, ask questions, and share their views.
- Leaders Briefing: A dedicated leaders briefing has been established. This forum will enable open and frank conversations about our priorities for the coming year and provide a space to discuss how we can deliver on our plans while maintaining outstanding care.

As we move forward with the findings of the staff survey, the executive team is committed to fostering open dialogue and ensuring everyone has a voice in shaping our future direction. We want all staff to get involved, share their perspectives, and work with us to deliver excellent care and a positive working environment for all.

Undertakings – RWT and WHT

I am pleased to advise you that following a review by NHS England Midlands Regional Support Group (RSG) on 19 February 2026 both trusts' progress against the requirements of the Enforcement Undertakings accepted by NHS England in July 2024. The RSG reviewed the supporting evidence presented and agreed that the Undertakings have been addressed and for a compliance certificate to be issued. To note: we hold a licence to provide services that NHSE via the regional team assess the trusts against, the Undertakings the trusts were subject to refer to the financial deficit projection of 2024/25, this was a whole system deficit therefore the whole system were also given Undertakings.

NHS Excellence Awards

On 19 January 2026 saw the launch of the national NHS Excellence Awards – created to celebrate local teams already driving the changes envisioned in the 10 Year Plan and inspire others to adopt and adapt proven ways of improving access, quality and patient experience. Entries were sought in ten award categories that reflect the range of innovation happening across the health and care system. Entries closed at 5pm on Friday 6 March 2026 following which regional champions will be named in Spring ahead of the national winners being announced on 10 June 2026.

We submitted 18 entries across the various categories. I would like to wish all staff who have submitted an entry across the Group my sincere best wishes on a successful win, you very much inspire me when I come and visit and see the dedication you all show both providing direct patient care, but also colleagues who support our clinical colleagues as the finance team and estates and facilities to name but a few.

Business Planning and Submission of the operational plans for 2026/27

As part of the on-going development of both trusts a 5-year strategy has been developed, which will be covered under a separate agenda item. The draft plan was submitted to NHSE, the contents of which have been discussed at a number of board development sessions, along with wider stakeholder engagement.

At an extra ordinary meeting of the board in private on 12 February 2026, the trust also approved the submission of the operational plan to NHS England (NHSE), covering 3 years, outlining what will achieve in terms of access to care, workforce numbers and the financial plan. The plan demonstrates a break-even position for the 3 years but still includes national deficit support funding. All other areas of the plan are compliant with the national planning requirements, with the exception of community waits, for which the plan is being reviewed.

Site visits across Walsall and Wolverhampton

Sexual health service visit – RWT

I undertook a site visit to the sexual health service at RWT on 10 February 2026, a truly all-encompassing service with patients at the heart of everything they do.

Feel Good Friday Clinic– WHT

Both myself and Sir David Nicholson KCB CBE, Chair had the opportunity to visit this clinic on 13 February 2026. It was great to see how a model currently in place at the Jean Bishop Centre in Hull can be adapted and utilised in a setting in Walsall. Currently a pilot initiative which is based on a clinic which consists of a multi-disciplinary team of people who are assessing people who are at risk of frailty and falls. The multi-disciplinary team (GP, Associate Clinical Practitioner (ACP), Social Worker, Physiotherapist, Occupation Therapist (OT), Pharmacist and Social Prescriber) undertake a holistic assessment of their patient and also look at the impact on their carer if applicable.

Gynaecology theatres – RWT

I had the pleasure to spend a morning within gynaecology theatres on 16 February 2026. To see the whole holistic approach towards the welfare of the patient was exceedingly reassuring.

Newly opened outpatient's department – RWT

Following the removal of Reinforced Autoclaved Aerated Concrete (RAAC) from our outpatients building it was a pleasure to meet staff following their move back into the building. Staff were clearly pleased to be back in the building and said how pleased they are with the renovations. My sincere thanks go to them whilst they worked in temporary accommodation and also the Estates and Facilities team who worked at pace to ensure everything was completed to standard and on time for the planned opening.

Departmental visits

I visited a number of clinical and departmental areas over the Christmas and New Year period. I want to thank you all for the dedication you showed to the provision of services for our patients and also for the warm welcome I received from each and everyone of you.

Flu vaccinations

As at the end of February 2026 uptake of the flu vaccine for WHT was 38.2%, compared to last year's uptake of 21.6%. For RWT the flu uptake vaccine was 5,046, when compared to last year's uptake of 3,654 which is an increase of 38.10%. Both trusts have seen a significant increase this year for which I would like to thank those staff who had the flu vaccine to both protect themselves, our patients and the community we serve.

Black Country Provider Collaborative (BCPC) update

- The BCPC Executive approved the priorities for 2026/27, aligned to a reduced budget of £1m. It agreed that two of the four existing programmes of work are to be 'stood down' with key priorities predominantly falling within a Clinical Service Transformation programme of work.
- The Joint Provider Committee (JPC) went on to agree the following clinical priorities, as well as any further opportunities to collaborate corporate services at scale:

  - **Clinical Transformation work** - Breast reconstruction, Endometriosis, Ear, Nose and Throat (ENT) transformation, Gynae-Oncology, Pharmacy aseptics, Urology-renal and bladder cancer
  - **Clinical work at scale** - Colorectal (new service models), and Surgical Robotic strategy
  - **Fragile services** - Breast Unit review, Future of Black Country oncology services, Community paediatrics – all subject to paper or outline proposal(s) being approved
  - **Clinical Productivity** - consider a proposal from Chief Medical Officers (CMO's) in due course

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.		

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

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:		

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

Tier 1 - Paper ref:	Enclosure 5.1

Report title:	Joint WHT & RWT Freedom to Speak Up Report Q1- Q3 2025/2026
Sponsoring executive:	Joe Chadwick-Bell Group CEO
Report author:	Miss Shabina Raza, Lead Trust Guardian, Lead Clinician WHT Ms Giselle Padmore-Payne, Lead Guardian, RWT
Meeting title:	Group Trust Board Meeting – in Public
Date:	17 March, 2026

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

This report provides an overview of FTSU activity across Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) for Q1–Q3 2025/26 detailing key updates for each organisation.

The Board can be assured that the detailed report has been received by both Group Management Committee (GMC) and Group People Committee (GPC) with both Lead F2SU Guardians in attendance at GPC. Both GMC and GPC accepted the recommendations set with acknowledgement and assurance of continued support across both teams as laid out in the next steps.

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?]*

Group Management Committee on the 11th February and Group People Committee on the 23rd February 2026.

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 and the continued commitment of both Trusts to support colleagues to speak up.

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:		

WHT & RWT Freedom to Speak Up (FTSU) Report Q1 - Q3 2025/26

Executive Summary

This report provides an overview of FTSU activity across Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) for Q1–Q3 2025/26. The Report has been to Group Management Committee and Group People Committee with both Lead F2SU Guardians in attendance at GPC. Both GMC and GPC accepted the recommendations laid out in the joint report with acknowledgement and assurance of continued support across both teams as laid out in the next steps.

<u>**Walsall Healthcare NHS Trust Update: April – December 2025**</u>

Assurance has been received by the committees in relation to:

- Increased utilisation of the FTSU service: 280 concerns were raised between Q1–Q3 2025/26, representing a 19.15% increase compared with 235 concerns in 2024/25. This upward trend reflects growing staff engagement, confidence, and visibility of the service.
- Strong organisational reach: Staff across a wide range of clinical and non-clinical areas continue to engage with the FTSU service through drop-in sessions, departmental visits, ward walkarounds, and professional forums, supported by Executive and Non-Executive walkabouts.
- Positive user feedback: Feedback from staff using the service remains consistently positive. However, users report variable levels of follow-up and engagement from middle managers, highlighting the need for strengthened feedback loops to support sustainable learning and improvement.
- Collaborative cross-Trust working: Joint workstreams with RWT continue to support consistency, shared learning, and improved service delivery such as joint training and induction, presentations, and engagement events.
- Broader professional engagement: Notable increases in engagement have been observed among groups that traditionally engage less frequently with FTSU, such as medical staff. Speak Up Month was highly successful, supported by divisional events and local Champion activity.

Committees were advised of the following:

- Attitudes and behaviours: Concerns relating to inappropriate attitudes and behaviours remain a prominent theme and align with national FTSU patterns. However, a decline was observed in Q3, possibly due to increased activity throughout the organisation which could have meant less staff reported incidents.
- The cultural engagement sessions led by the chief executive team, alongside focused executive listening to understand and address barriers to speaking up, has had a positive impact. Ongoing work to strengthen psychological safety, together with the delivery of civility and respect training by the organisational development team and continued reinforcement of the Trust's behavioural framework, remain key drivers in addressing these issues and supporting sustained cultural improvement.
- Cultural Objectives: The programme of cultural engagement sessions led by the chief executive team across both WHT and RWT, alongside focused executive listening to understand and address barriers to speaking up, has had a positive impact. Ongoing work to strengthen psychological safety, together with the delivery of civility and respect training by the organisational development team and continued reinforcement of the Trust's behavioural framework, remain key drivers in addressing these issues and supporting sustained cultural improvement.

- Quality and Safety: Quality and Safety concerns increased significantly in Q3 from a previously low baseline, becoming a more prominent theme. This shift appears to be influenced by staffing pressures, service changes, and increased operational demand. Concerns were predominantly reported from WCCSS, MLTC and Surgical Divisions. FTSU regularly meet with senior leaders to sight them on concerns received.
- FTSU training: Uptake of FTSU training has risen to 82.09%, up from 75.41% in the previous financial year. Achieving the aspirational 90% compliance target will require sustained organisational focus; introducing mandatory training, as implemented at RWT, may support this.
- FTSU Champion network: WHT currently has 11 Champions. Further development and maturation of this network is required, supported by dedicated, ring-fenced time to carry out the role effectively.

The Committees were alerted to the following: -

- Undisclosed reporting: A high proportion of concerns were raised by staff who did not disclose their professional group, indicating potential fear of detriment. Some improvement was noted in June in Q1 for 2025/6, but further work is needed to strengthen psychological safety and reassurance.
- Feedback mechanisms: Improved mechanisms are required to ensure timely and effective feedback to staff, demonstrating that concerns are listened to and acted upon appropriately.
- Persistent behaviour-related themes: Concerns relating to inappropriate behaviours continue to be raised and require ongoing, proactive intervention by leadership teams through established management and cultural improvement processes.
- Reduced number of guardians: Dedicated F2SU Guardian time has been significantly reduced (from 3 to 1) due to planned reductions and sickness absence.

The Royal Wolverhampton NHS Trust Update: April – December 2025

Assurance has been received by the committees in relation to:

- Ring-fenced time: The Trust has 2 WTE Freedom to Speak Up Guardians with ring-fenced time, providing a stable, accessible and sustainable service.
- 181 concerns Between Q1-Q3 2025/2026 vs 179 last year Q1-Q3 which shows a 1.1% YOY increase.
- Improved Psychological safety: The majority of concerns are raised as identified across Q1-Q3, with an overall identified-to-anonymous ratio of 2:1, demonstrating staff confidence in speaking up.
- Consistent levels of activity: throughout the year indicate sustained engagement and trust in the FTSU service.
- Cross division interaction: Concerns are raised across all divisions, departments and professional groups, confirming Trust-wide accessibility and awareness.
- Patient safety concerns: although lower in volume, are appropriately escalated and managed through established governance arrangements.
- Stability in levels of reporting: Month-by-month trends show increased reporting during periods of operational pressure, particularly in August and December, reinforcing the ongoing need and value of the FTSU service within the organisation.

Committees were advised of the following:

- Continue to prioritise compassionate and visible leadership, particularly in areas with repeat behaviour-related concerns.

- Cultural Objectives: Make Culture measurable, continue to share data via Monthly Divisional Data set and Quarterly Heat Maps, with outcome of reported themes to senior and divisional leaders. The FTSU service aims to continue to work collaboratively to reduce behaviour-related concerns and strengthen psychological safety through visible leadership, early intervention, and improved feedback mechanisms, ensuring a compassionate and respectful working environment. The FTSU team was a part of the cultural summit planning group with our CEO and stakeholders in (August 2025), we continue to target areas with raised concerns and utilise the My Academy training in civility and allyship to reach all staff, with reminders around the Joint Behavioural Framework.
- Strengthen early intervention and restorative approaches: to alleged bullying and behavioural issues in partnership with HR and OD and Education teams.
- Triangulation of data: Maintain close monitoring of staffing-related safety concerns, triangulating FTSU data with workforce, quality and assurance intelligence.
- Improve data completeness with WHT colleagues: to enhance standardised reporting.
- Continue regular Board reporting: to monitor progress and provide ongoing assurance.
- Trust wide Compliance and Training: Trust wide FTSU training remains elevated with this reflected in compliance reports month on month in line with our 90% target.
- FTSU Champion network: RWT currently has 16 Champions who are based across different specialities, they continue to be supported by the guardians.
- FTSU Training: RWT (Q1-Q3) Speak Up (All): 98.3%, Listen Up (Managers): 95.3% Follow Up (Senior Leaders): 87.12%. Consistent high compliance across FTSU training modules in 2024/25 and 2025/26.

The Committees were alerted to the following: -

- Persistent concerns: relating to staff attitudes, behaviours and bullying continue to be the most prominent themes, indicating an ongoing cultural risk.
- Staffing-related safety concerns: have increased during periods of operational pressure, requiring continued executive oversight.
- Fluctuations in anonymous reporting: particularly in September and December, may signal heightened sensitivity or reduced psychological safety in specific periods or areas.
- Continued executive oversight and support: reports provide evidence that there is a need for continued executive oversight and support to address consistent reports around attitudes and behaviour related complaints.
- Joint database for data collection: There needs to be standardisation across both Trust we require support with getting the database in place. In order to improve reporting and feedback mechanisms and data reporting.
- Timely feedback mechanisms: Improved and timely feedback mechanisms are required to ensure timely and effective feedback to staff, demonstrating that their concerns are being listened to and acted upon appropriately.

Next Steps

The Freedom to Speak Up teams of both Trusts will be focusing on the following actions throughout 2026/26.

- Maintaining visibility (walkabouts, comms, drop-ins) and leadership involvement to make FTSU business as usual.
- Grow and mature the Champion network with departmental/professional representation focusing on under-represented staff groups and explore potential to provide protected time.

- Strengthen feedback mechanisms to demonstrate action and build confidence.
- Deepen triangulation with OD, Quality and Assurance teams (e.g., exit interviews, retention, policy feedback).
- Develop a robust joint IT/reporting system for FTSU data.
- Aligning policies and systems with WHT and strengthen cross-site collaboration.

Recommendations

The Board are asked to note that both Group Management Committee and Group People Committee have received and accepted the following recommendations: -

- Accepted the full report and discussed in detail.
- Were assured that the report provided detailed information regarding Freedom to Speak Up activity and emerging themes received between Q1–Q3, acknowledging sustained staff engagement with the service.
- A continued executive focus on addressing persistent concerns relating to staff behaviours, bullying, and workplace culture and FTSU independence and visibility across both Trusts,
- Endorsement of targeted action to address staffing-related safety concerns, including triangulation with workforce and quality data assisting with the cultural shift toward transparency, learning, and psychological safety.

NHS

Tier 1 - Paper ref:	Enclosure 6

Report title:	Group Finance Report
Sponsoring executive:	Kevin Stringer, Group Chief Finance Officer
Report author:	James Green, Director of Operational Finance
	Dan Mortiboys, Director of Operational Finance
Meeting title:	Group Trust Board - in Public
Date:	17 March 2026

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

This report presents the financial performance of the Group for the period April 2025 to January 2026, with the notable points being:

- Overall, the Group position is behind plan by £2.4m year-to-date, with WHT £2.1m ahead of plan, and RWT £4.6m behind plan. This has deteriorated by £1.7m in month.
- Variable elective activity is behind the Group plan by £5.8m YTD, with WHT above plan by £2.9m and RWT below plan by £8.7m. For RWT £3.3m of this is estimated to be due to counting and coding backlogs and £5.4m due to delays against the original 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 £10.3m. In month 10 WHT underperformed by £2.1m against a plan of £4.2m, YTD performance remains ahead of plan. RWT underperformed by £1.7m in month against a plan of £6.1m
- Capital expenditure year to date is £28.1m (£16.3m RWT and £11.77m WHT), an underspend of £7.6m (£5.4m RWT and £2.2m WHT).
- The cash position for both Trusts is positive at £30.2m for RWT, and £26.9m for WHT.
- Workforce has increased overall for the group in month, decreasing by 10 WTE at RWT and increasing by 35 WTE at WHT. Both Trusts workforce are above the financial sustainability stretch target trajectory.

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 Finance & Performance Committee meeting on 24th February 2026 scrutinised the detailed report which is available on request.

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

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

4. Recommendation(s)/Action(s)		
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*
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:		

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

I&E Summary

In-Month Income & Expenditure	RWT			WHT			Group position		
	Plan M10 £m	Actual M10 £m	Surplus/ (Deficit) £m	Plan M10 £m	Actual M10 £m	Surplus/ (Deficit) £m	Plan M10 £m	Actual M10 £m	Surplus/ (Deficit) £m
Income	85.7	87.1	1.4	42.2	41.1	(1.2)	127.9	128.1	0.3
Expenditure									
Pay	51.7	54.2	(2.5)	26.2	25.9	0.3	78.0	80.1	(2.2)
Non Pay	21.5	21.1	0.4	9.7	10.5	(0.8)	31.2	31.6	(0.4)
Drugs	7.5	6.8	0.7	2.5	2.7	(0.2)	10.0	9.5	0.5
Other*	4.1	3.9	0.2	2.5	2.6	(0.1)	6.6	6.5	0.1
Total Expenditure	84.9	86.0	(1.2)	40.9	41.7	(0.8)	125.8	127.7	(2.0)
Net reported surplus/(Deficit)	0.8	1.1	0.3	1.3	(0.7)	(2.0)	2.1	0.4	(1.7)

Year-to-date Income & Expenditure	RWT			WHT			Group position		
	Plan YTD £m	Actual YTD £m	Surplus/ (Deficit) £m	Plan YTD £m	Actual YTD £m	Surplus/ (Deficit) £m	Plan YTD £m	Actual YTD £m	Surplus/ (Deficit) £m
Income	844.8	847.2	2.4	398.5	401.7	3.2	1,243.3	1,248.8	5.6
Expenditure									
Pay	527.4	542.6	(15.3)	259.9	256.0	4.0	787.3	798.6	(11.3)
Non Pay	211.4	205.4	6.1	92.2	96.0	(3.9)	303.6	301.4	2.2
Drugs	70.7	69.1	1.6	24.5	24.8	(0.3)	95.2	93.9	1.3
Other(incl. depreciation)	39.2	38.6	0.6	26.2	27.1	(0.9)	65.4	65.6	(0.3)
Total Expenditure	848.7	855.6	(6.9)	402.8	403.9	(1.1)	1,251.5	1,259.5	(8.0)
Net reported surplus/(Deficit)	(3.9)	(8.5)	(4.6)	(4.3)	(2.2)	2.1	(8.2)	(10.7)	(2.4)

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

Key Headlines:

- Total YTD deficit of £10.7m,

- Performance in month 10 is £1.7m behind of plan; RWT £0.3m ahead, WHT is £2.0m behind plan, mainly due to CIP.

- Year to date performance is £2.4m behind plan; RWT £4.6m behind plan and WHT £2.1m better than plan.

- CIP underachieved in month by £3.8m, bringing the YTD underperformance to £1.4m; with RWT underperformance of £2.7m and WHT overperformance of £1.3m.

- Variable elective activity is behind the Group plan by £5.8m YTD, with WHT above plan by £2.9m and RWT below plan by £8.7m. For RWT £3.3m of this is estimated to be due to counting and coding backlogs and £5.4m due to delays against the original plan. Both are still expected to deliver against plan at year end.

Capital

- Capital expenditure year to date is £28.1m (£16.3m RWT and £11.77m WHT), an underspend of £7.6m (£5.4m RWT and £2.2m WHT). Within the spend, £2.5m related to PSDS grant funded schemes and donated assets of which £1.9m 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 expectation is that both Trusts will achieve their Capital Resource Limit. RWT has transferred £2.0m to WHT which has been agreed by ICS. This will be repaid back in £1.0m instalments in 26/27 and 27/28.

- RWT received £0.5m of additional PDC for CDC Pathways and Physiological Science in M10.

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; the move to SBS and a new finance ledger and are below the target YTD.

BPPC Performance	RWT In-Month	RWT YTD	WHT In-Month	WHT YTD
Value	87%	91%	47%	71%
Volume	74%	85%	93%	86%

Key Month Items Within the Position

These include:

- **Income** overperformed against plan by £0.3m in month. Year to date there is overperformance on income of £5.6m, RWT is £2.4m ahead of plan due to additional System support and industrial action funding, WHT is £3.2m ahead of plan YTD due to PSDS income, industrial action funding, E&T and recharges.

- **Pay** is £2.2m worse than plan in month and £11.3m worse than plan YTD. The in-month overspend is due to unachieved CIP target at RWT (£2.5m). YTD RWT is £15.3m worse than plan, of which £12.7m is due to unmet CIP. WHT is £4.0m better than plan, the main driver for this is lower than planned headcount and reduced temporary expenditure.

- **Non-Pay** is £0.4m worse than plan in month and £2.2m better than plan YTD, with a RWT being £6.1m better than plan related to non-recurrent CIP overperformance of £7.8m. WHT is £3.9m worse than plan due SLA costs offset by income, increased purchases of healthcare, IT costs and clinical consumables.

- **Drugs** spend is £0.5m better than plan in month and £1.3m better than plan YTD.

- **Efficiency** performance is £3.8m adverse to plan in month and £1.4m adverse YTD - £1.3m favourable at WHT and £2.7m adverse at RWT. WHT overperformance is mainly due to the headcount reducing faster than planned M1-6.

Variable Activity Performance – 2025/26 M10

RWT

WHT
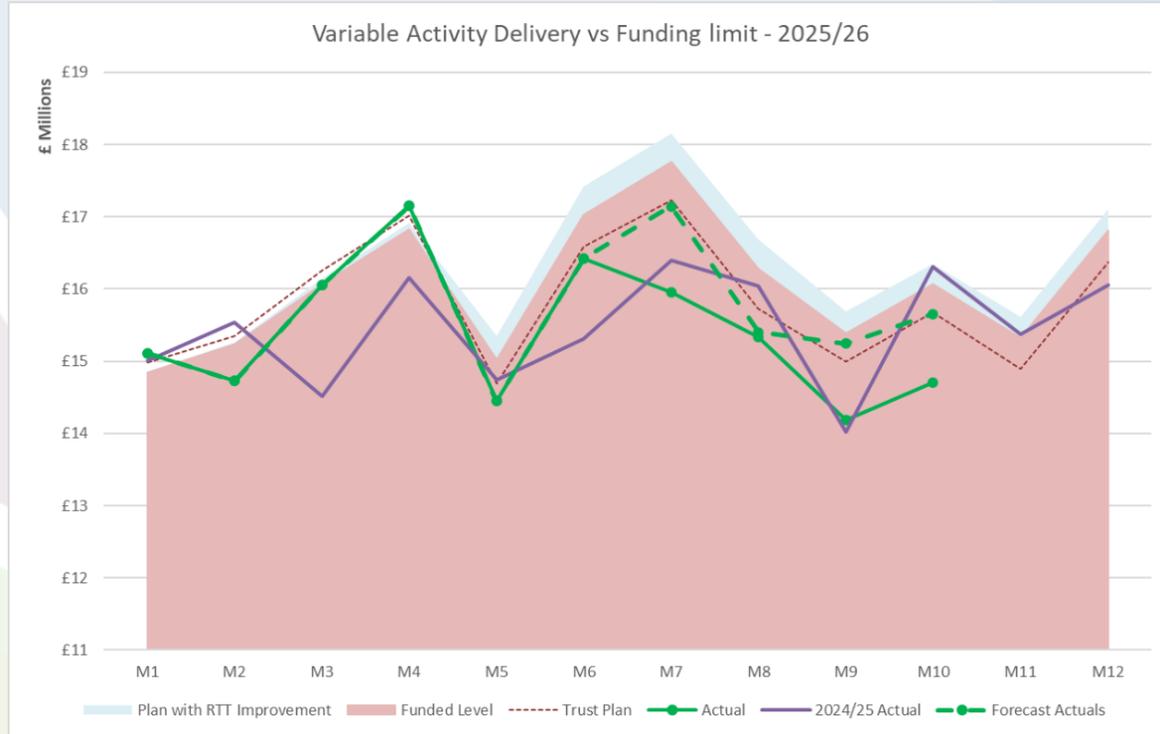
RWT

Year to date the variable elective income is £8.7m below the agreed plan with commissioners to meet 60% RTT. Issues relating to activity counting and coding due to EPR implementation are estimated to account for approximately £3.3m of this variance, giving an estimated underlying variance of £5.4m which is related to lower than plan RTT performance of 55%. The Trust is aiming for a year end RTT position of 60.6% with the aid of the Q4 sprint.

The Trust is not funded for all this required activity and therefore the estimated underlying variance, adjusting for uncoded and uncashed, against the funded plan is £3.25m.
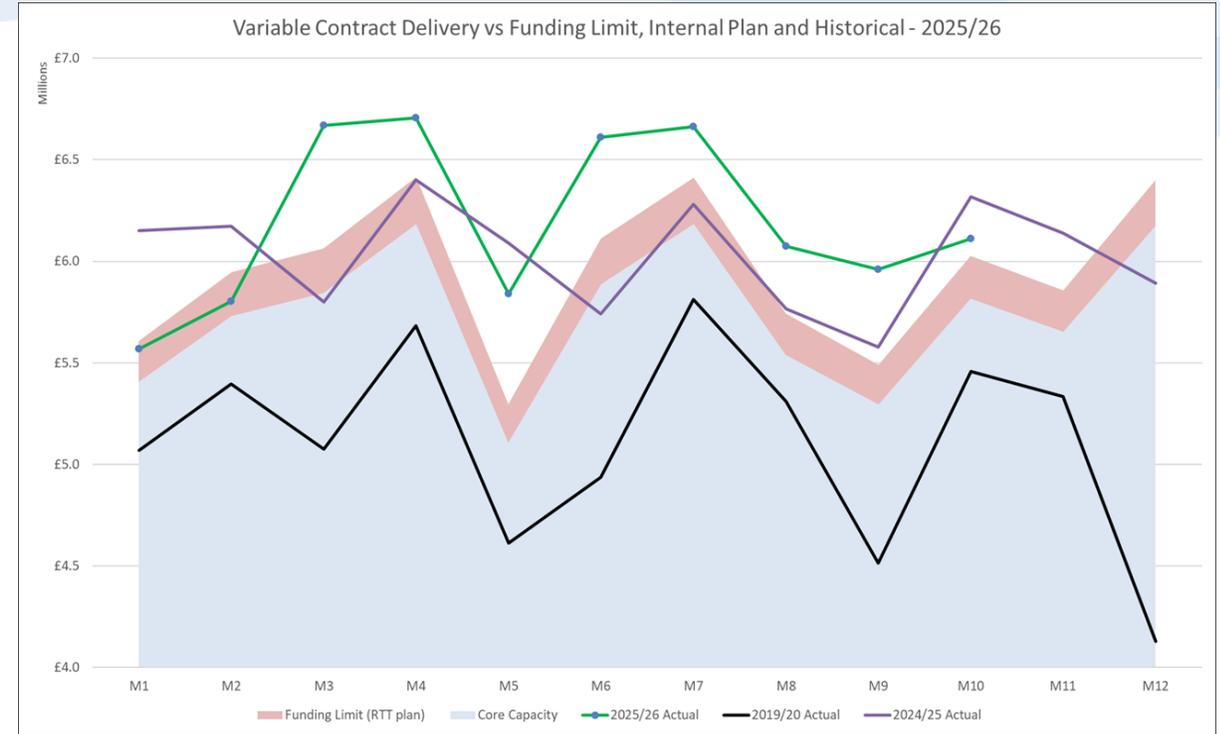
WHT

RTT plan is in line with the contract funding level. WLIs required to bridge between the core divisional capacity (internal plan) and Funding Limit. Although WLIs have been reduced to 25% to support delivery of the FRP the Trust continues to overperform the contract and receives no additional funding.

Referral growth is impacting the Trust ability to reduce the overall waiting list.

Variable Performance YTD – 2025/26 M10

Point of Delivery	RWT			WHT			Group		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	Activity	Activity	Activity	Activity	Activity	Activity	Activity	Activity	Activity
Elective	6,534	6,423	(111)	1,879	2,162	283	8,412	8,585	173
Planned Same Day	46,166	43,423	(2,744)	26,047	25,005	(1,042)	72,213	68,428	(3,786)
Outpatient Procedures	135,519	136,480	960	34,260	44,182	9,922	169,779	180,662	10,882
Procedures Total	188,219	186,325	(1,894)	62,186	71,349	9,163	250,405	257,674	7,269
Outpatient 1st	189,231	174,219	(15,012)	85,544	106,922	21,378	274,775	281,141	6,366
Diagnostic Imaging	74,750	69,480	(5,270)	85,208	85,788	580	159,958	155,268	(4,690)
Chemotherapy	11,804	12,546	742	5,086	5,493	407	16,890	18,039	1,149
Grand Total	452,200	430,024	(21,433)	238,025	269,552	31,527	690,225	699,576	9,352

Point of Delivery	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	41,753	39,486	(2,267)	8,248	9,534	1,286	50,001	49,021	(980)
Planned Same Day	49,734	45,963	(3,771)	20,792	19,752	(1,040)	70,526	65,714	(4,811)
Outpatient Procedures	23,320	23,332	12	6,543	6,912	369	29,863	30,243	381
Procedures Total	114,807	108,781	(6,026)	35,583	36,198	615	150,389	144,979	(5,411)
Outpatient 1st	35,978	33,487	(2,491)	14,994	16,891	1,897	50,971	50,378	(593)
Diagnostic Imaging	8,067	7,565	(502)	6,875	7,119	243	14,942	14,683	(258)
Chemotherapy	3,963	4,273	310	1,665	1,797	132	5,627	6,070	443
Grand Total	162,813	154,106	(8,708)	59,117	62,005	2,888	221,930	216,110	(5,820)

The group is £5.8m behind the commissioned activity plan YTD; with RWT underperforming by £8.7m and WHT over performing by £2.9m.

At RWT £3.3m of the variance is estimated to be because of uncoded and uncashed activity, the majority of which is within outpatients.
At WHT WLI's in T&O Elective Inpatients and WLIs in general are the key drivers of performance above contract YTD.

Collaboration Communities

CIP Performance YTD

	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
WHT	4.2	2.1	(2.1)	20.4	21.7	1.3
RWT	6.1	4.3	(1.7)	44.2	41.5	(2.7)
Group	10.3	6.4	(3.8)	64.6	63.2	(1.4)

The total efficiency challenge in 2025/26 for the group is £87m; RWT £57m, WHT £30m. The in-month plan was £10.3m.

In month 10 WHT underperformed by £2.1m against a plan of £4.2m. RWT underperformed by £1.7m in month against a plan of £6.1m.

Year to date the total overperformance against plan is £1.4m; £1.3m above plan at WHT and £2.7m below plan at RWT.

Statement of Financial Position

STATEMENT OF FINANCIAL POSITION Statement of Financial Position for the month ending January 2926	RWT			WHT		
	Mar 2025	January 2026	Movement	Mar 2025	January 2026	Movement
	Actual	Actual	YTD	Actual	Actual	YTD
	£000	£000	£000	£000	£000	£000
NON CURRENT ASSETS						
Property, Plant and Equipment - Tangible Assets	539,624	525,621	(14,003)	250,913	250,438	(475)
Intangible Assets	9,351	11,523	2,172	8,021	7,626	(395)
Other Investments/Financial Assets	16	15	(1)	0	0	0
Trade and Other Receivables Non Current	1,138	1,156	18	1,164	1,827	663
PFI Deferred Non Current Asset	1,935	1,920	(15)	0	0	0
TOTAL NON CURRENT ASSETS	552,064	540,235	(11,829)	260,098	259,891	(207)
CURRENT ASSETS						
Inventories	9,766	10,930	1,164	3,182	3,017	(165)
Trade and Other Receivables	38,389	54,885	16,496	20,665	28,186	7,521
Cash and cash equivalents	50,886	30,242	(20,644)	36,745	26,853	(9,892)
TOTAL CURRENT ASSETS	99,041	96,058	(2,984)	60,592	58,056	(2,536)
TOTAL ASSETS	651,106	636,293	(14,813)	320,690	317,947	(2,743)
CURRENT LIABLILITES						
Trade & Other Payables	(104,725)	(108,640)	(3,915)	(54,359)	(53,837)	522
Liabilities arising from PFIs / Finance Leases	(8,731)	(9,120)	(389)	(10,047)	(14,905)	(4,858)
Provisions for Liabilities and Charges	(8,072)	(1,778)	6,294	(135)	(135)	0
Other Financial Liabilities	(12,138)	(15,233)	(3,095)	(2,610)	(2,901)	(291)
TOTAL CURRENT LIABILITIES	(133,666)	(134,771)	(1,105)	(67,151)	(71,778)	(4,627)
NET CURRENT ASSETS / (LIABILITIES)	(34,625)	(38,713)	(4,088)	(6,559)	(13,722)	(7,163)
TOTAL ASSETS LESS CURRENT LIABILITIES	517,439	501,522	(15,918)	253,539	246,169	(7,370)
NON CURRENT LIABILITIES						
Trade & Other Payables	0	0	0	0	0	0
Other Liabilities	(31,567)	(24,008)	7,560	(178,875)	(170,466)	8,409
Provision for Liabilities and Charges	(1,980)	(1,981)	(1)	(271)	(271)	0
TOTAL NON CURRENT LIABILITIES	(33,547)	(25,988)	7,559	(179,146)	(170,737)	8,409
TOTAL ASSETS EMPLOYED	483,892	475,534	(8,359)	74,393	75,432	1,039
FINANCED BY TAXPAYERS EQUITY						
Public Dividend Capital	337,782	337,783	1	276,052	276,052	0
Retained Earnings	26,691	18,334	(8,357)	(272,120)	(271,081)	1,039
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	475,534	(8,358)	74,393	75,432	1,039

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: £16.5m increase with balances including prepayments, and accrued income. Trade & Other Payables: £3.9m increase with the increase due to bank accruals (£2.9m). Most of the movement in Other Financial Liabilities relates to deferred income on non-recurrent projects such as PASEMR. Other Liabilities of £7.6m decrease due to movement in PFI/IFRS 16.

- WHT - Trade receivables are high YTD due to LA, ERF, SDF and variable diagnostics performance. Current Liabilities increase of £4.9m and non-current other liabilities decrease of £8.4m is due to PFI and IFRS16 movements.

Care Colleagues
Collaboration Communities

Cashflow as at 31ˢᵗ January

	RWT	WHT	Combined
	Jan-26	Jan-26	Jan-26
	Actual £'000	Actual £'000	Actual £'000
OPERATING ACTIVITIES			
Total Operating Surplus/(Deficit) (gross of control total adjustments)	**2,561**	**12,255**	**14,816**
Depreciation	28,140	12,641	40,781
Fixed Asset Impairments	0	0	0
Transfer from Donated Asset Reserve	0	0	0
Capital Donation Income	(609)	(1,847)	(2,456)
Interest Paid	(1,562)	(6,577)	(8,139)
Dividends Paid	(6,470)	(1,103)	(7,573)
Release of PFI /Deferred Credit	0	0	0
(Increase)/Decrease in Inventories	(1,164)	165	(999)
(Increase)/Decrease in Trade Receivables	(16,676)	(8,183)	(24,859)
Increase/(Decrease) in Trade Payables	12,150	873	13,023
Increase/(Decrease) in Other liabilities	3,057	291	3,348
Increase/(Decrease) in Provisions	(6,293)	(1,411)	(7,704)
Increase/(Decrease) in Provisions Unwind Discount	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**13,134**	**7,104**	**20,238**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	2,227	1,384	3,611
Payment for Property, Plant and Equipment	(25,700)	(12,590)	(38,290)
Payment for Intangible Assets	(3,252)	0	(3,252)
Receipt of cash donations to purchase capital assets	609	1,847	2,456
Proceeds from sales of Tangible Assets	2	0	2
Proceeds from Disposals	0	34	34
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(26,115)**	**(9,325)**	**(35,440)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(12,981)**	**(2,221)**	**(15,202)**
FINANCING			
New Public Dividend Capital Received	0	0	0
Capital Element of Finance Lease and PFI	(7,663)	(7,671)	(15,334)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(7,663)**	**(7,671)**	**(15,334)**
INCREASE/(DECREASE) IN CASH	**(20,644)**	**(9,892)**	**(30,536)**
CASH BALANCES			
Opening Balance at 1st April 2025	50,886	36,745	87,631
Closing Balance at 31st December 2025	**30,242**	**26,853**	**57,095**

Summary:
The cash balance is £57.1m, £30.2m at RWT and £26.9m at WHT. This is a decrease from last month of £6.7m (of which £4.0m is RWT, however this is £5.6m ahead of Plan due to a reduction of capital payments due to the capital plan being behind. The decrease from last month is catch-up of payment runs and delay in invoicing).

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 £16.3m of Capital YTD to 31st January 2026, which is an underspend of £5.4m against planned YTD capital of £21.7m. The Trust is forecasting to meet its CRL and CDEL target for the financial year and has submitted a rephasing of the capital programme to the ICS.

- CRL recorded a spend of £8.1m for the financial year to date which was £2.9m lower than plan (this is an improvement from M8). The Trust identified its original capital plan to support investment in backlog maintenance and medical equipment purchases. Expenditure against the original plan is lower than profiled and Q4 has resulted in a significant increase in spend.
- PDC expenditure with a spend of £6.2m was £0.9m behind plan, but in line with the forecast profile. The Trust received £0.5m of additional PDC for CDC Pathways and Physiological Science in M10. Additional £0.1m received in M11 for Imaging Equipment.
- IFRS 16 (or renewed leases) CRL with a YTD spend of £0.0m was underspent by £2.1m due to ongoing commercial negotiations. The Trust has reforecast it's IFRS 16 obligations and due to items being brought outright by capital programme and a change in how NHS Property Services leases are accounted for, this has reduced the IFRS 16 requirement, instead this CRL has been added to CRL pot.
- IFRIC 12 related capital spend is £0.0m YTD which is behind 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.
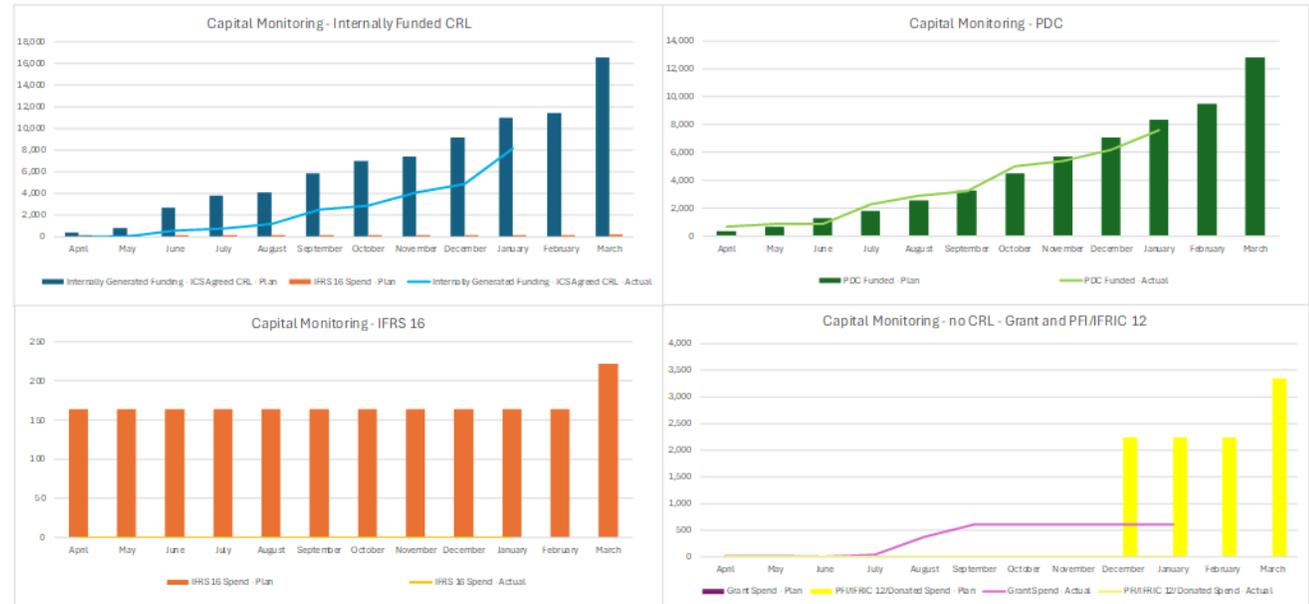
Capital WHT

•The trust has spent £11.77m of Capital & IFRS16 YTD to 31st January 2026 against planned YTD Capital of £13.99m. Of the £11.77m YTD Spend.

•£7.56m YTD Capital spend including IFRS16 relates to CRL the trust is measured against vs YTD budget of £7.43m with a variance of -£0.12m vs budget; and £1.0m YTD spend on PDC as the orders are in progress, with a variance of £2.3m vs budget. The trust has received additional PDC allocation £3.23m. The trust plans to achieve the CRL of £18.018m at the end of the year

•The balance of the YTD Capital spend of £3.19m relates to PFI/IFRIC 12 capital of £1.35m on plan and PSDS grant spend of £1.85m.

Capital Monitoring - CRL

Capital Monitoring - no CRL

Scheme	M10 YTD Budget £'000s	M10 YTD Spend £'000s
Estates:		
PFI Lifecycle:	1,348	1,346
Theatres 1-4 Refurb	3,458	3,808
Estates Lifecycle	858	1,242
MMUH (UECC works)	1,000	1,104
Aseptic Suite	750	6
Backlog maintenance to support PSDS	666	1,063
New Build-Non Clinical (PSDS Match Funding)	1,847	1,847
Estates Total	**9,927**	**10,417**
Medical Equipment:		
Medical Equipment	190	154
Donated Medical Equipment		
Medical Equipment Total	**190**	**154**
Information Management & Technology:		
IT Equipment	-	540
Information Management & Technology Total	**-**	**540**
PDC Funding		
IM&T PDC Funding	2,391	1,019
Theatres 1-4 Estates Safety PDC Funding	976	-
PDC Funding Total	**3,367**	**1,019**
IFRS16	510	- 362
Total IFRS16	**510**	**- 362**
Grand Total	**13,994**	**11,768**
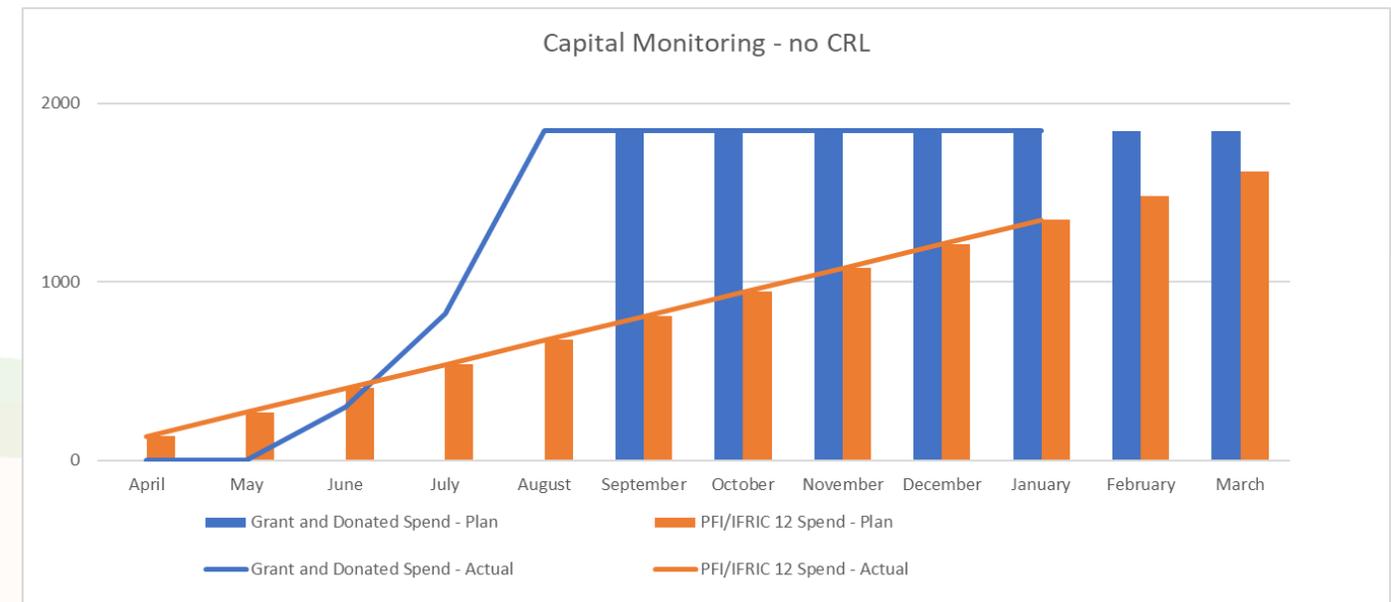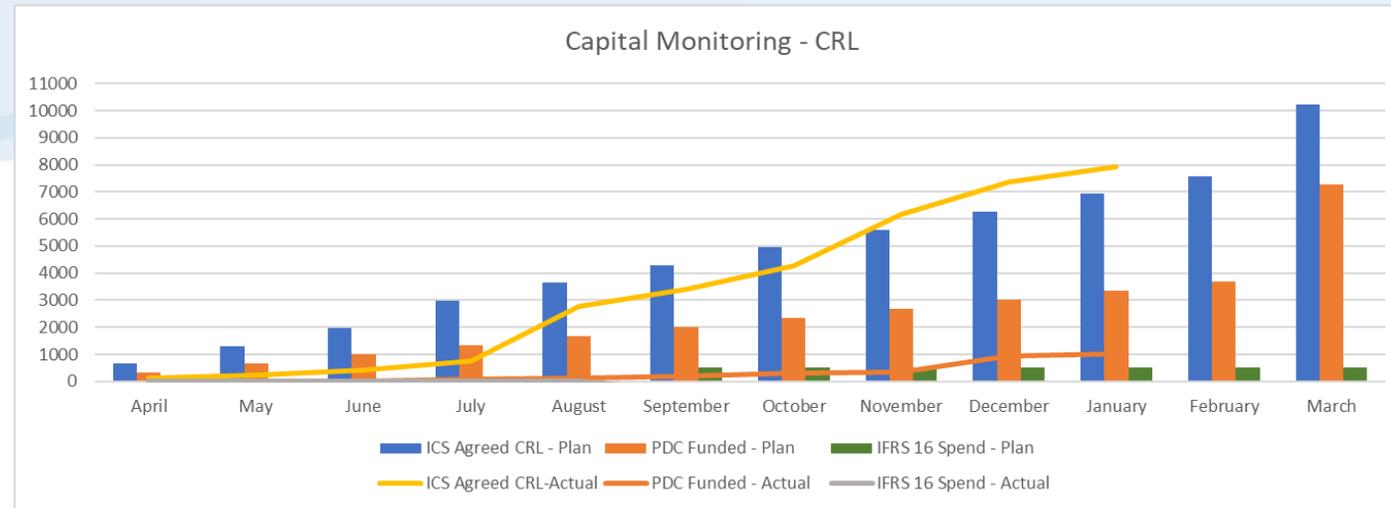
Workforce WTE Trends - RWT

RWT's overall workforce decreased during 10, reflecting a 10 WTE (30.6%) rise in agency usage, offset by a 15 WTE (0.2%) decrease in substantive staff, and a 44 WTE (7.1%) fall in bank reliance. The RWT overall workforce is 123 WTE (1.2%) above the financial sustainability (stretch) target trajectory.

Actual WTE (Nov 25 – Jan 26)

	Nov-25	Dec-25	Jan-26
ACTUAL TOTAL WORKFORCE BY STAFF GROUP (WTE)	**10777.77**	**10773.58**	**10724.59**
Registered Nursing, Midwifery and Health Visiting Staff	3083.79	3057.33	3049.28
Allied Health Professionals	621.34	619.58	613.02
Registered Scientific, Therapeutic and Technical Staff	239.41	242.25	241.07
Healthcare Scientists	511.48	509.13	508.04
Support to Clinical Staff	2143.09	2157.68	2150.33
NHS Infrastructure Support	2867.62	2854.10	2847.62
Medical and Dental	1311.05	1333.52	1315.24
ACTUAL SUBSTANTIVE STAFF BY STAFF GROUP (WTE)	**10140.74**	**10125.61**	**10110.41**
Registered Nursing, Midwifery and Health Visiting Staff	2938.83	2927.42	2928.11
Allied Health Professionals	619.77	616.32	609.77
Registered Scientific, Therapeutic and Technical Staff	234.46	236.17	238.22
Healthcare Scientists	510.64	507.28	505.72
Support to Clinical Staff	1987.24	1989.53	1980.89
NHS Infrastructure Support	2622.70	2622.82	2625.67
Medical and Dental	1227.11	1226.08	1222.04
ACTUAL BANK STAFF BY STAFF GROUP (WTE)	**601.45**	**616.10**	**572.56**
Registered Nursing, Midwifery and Health Visiting Staff	144.96	129.91	121.17
Allied Health Professionals	1.57	3.26	3.25
Registered Scientific, Therapeutic and Technical Staff	3.29	4.86	2.03
Healthcare Scientists	0.18	0.17	0.13
Support to Clinical Staff	134.92	158.00	144.82
NHS Infrastructure Support	244.92	231.28	221.95
Medical and Dental	71.61	88.62	79.21
ACTUAL AGENCY STAFF BY STAFF GROUP (WTE)	**35.58**	**31.87**	**41.62**
Registered Nursing, Midwifery and Health Visiting Staff	0.00	0.00	0.00
Allied Health Professionals	0.00	0.00	0.00
Registered Scientific, Therapeutic and Technical Staff	1.66	1.22	0.82
Healthcare Scientists	0.66	1.68	2.19
Support to Clinical Staff	20.93	10.15	24.62
NHS Infrastructure Support	0.00	0.00	0.00
Medical and Dental	12.33	18.82	13.99

2025/26 Actuals vs Planned
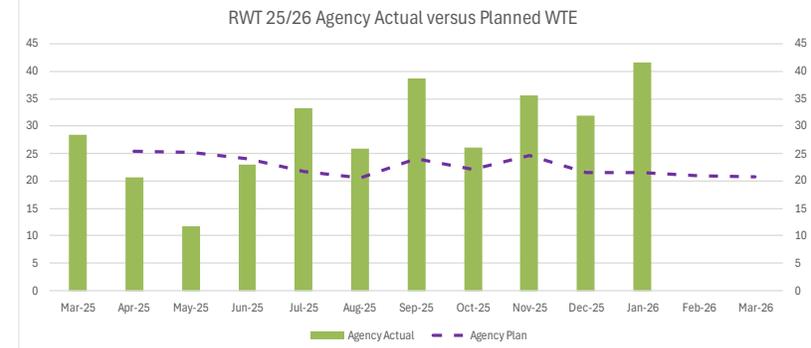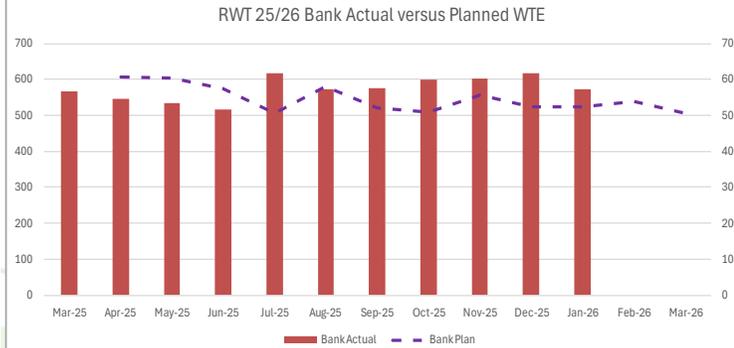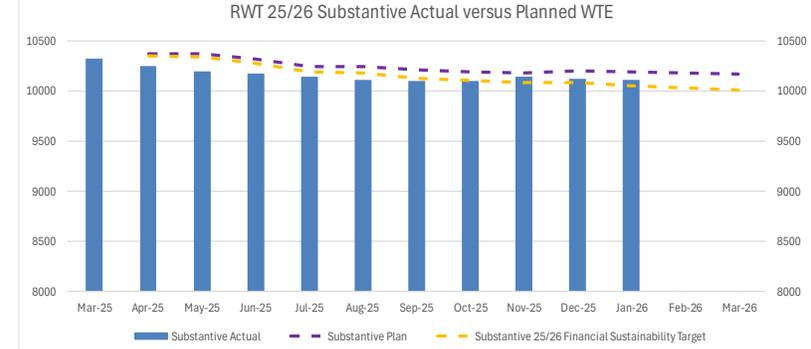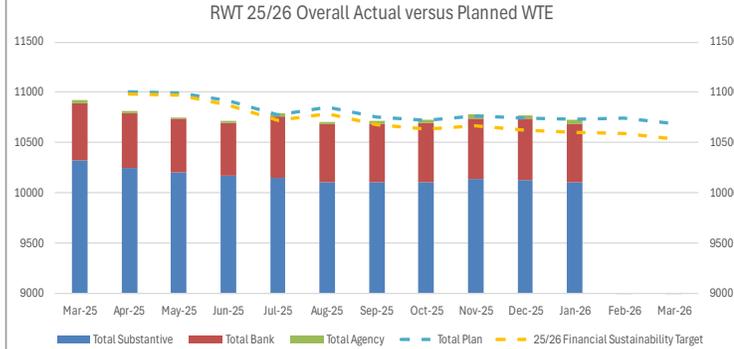
During M10 25/26, external substantive leavers (74 WTE) exceeded external substantive starters (56 WTE). Triangulated against assignment changes, such as adjusted contracted hours, this contributed to a 15 WTE decrease in the substantive workforce. While bank usage declined in January 2026 following reduced reliance on nursing and medical staff, a twofold increase in agency usage among the clinical support workforce contributed to a month-on-month increase. High Acuity remains the dominant booking reason for non-medical agency usage, and a leading driver of non-medical bank reliance. All medical agency usage during January 2026 was driven by vacancy cover.

Workforce WTE Trends - WHT

WHT's overall workforce increased by 35 WTE during M10, reflecting a decrease of 11 WTE substantive WTE, offset by an increase in bank deployment by 41 WTE, and a rise in agency usage by 5 WTE. The WHT overall workforce is 141 WTE (2.9%) above the financial sustainability (stretch) target trajectory.

Actual WTE (Nov 25 – Jan 26)

	Nov-25	Dec-25	Jan-26
ACTUAL TOTAL WORKFORCE BY STAFF GROUP	**5082.02**	**5020.89**	**5055.92**
Registered Nursing, Midwifery and Health Visiting Staff	1797.39	1769.78	1790.25
Allied Health Professionals	318.02	330.16	327.08
Registered Scientific, Therapeutic and Technical Staff	114.12	125.50	127.72
Healthcare Scientists	44.45	44.45	47.80
Support to Clinical Staff	1002.19	971.99	978.40
NHS Infrastructure Support	1165.65	1152.50	1161.59
Medical and Dental	640.20	626.50	623.08
ACTUAL SUBSTANTIVE STAFF BY STAFF GROUP	**4594.26**	**4573.54**	**4562.79**
Registered Nursing, Midwifery and Health Visiting Staff	1652.06	1653.46	1646.10
Allied Health Professionals	318.02	316.67	313.94
Registered Scientific, Therapeutic and Technical Staff	114.12	114.12	117.92
Healthcare Scientists	44.45	44.45	47.80
Support to Clinical Staff	833.87	832.62	824.48
NHS Infrastructure Support	1042.52	1031.91	1029.68
Medical and Dental	589.22	580.30	582.86
ACTUAL BANK STAFF BY STAFF GROUP	**471.74**	**430.15**	**471.24**
Registered Nursing, Midwifery and Health Visiting Staff	133.28	105.50	129.80
Allied Health Professionals	0.00	11.30	10.51
Registered Scientific, Therapeutic and Technical Staff	0.00	11.38	9.38
Healthcare Scientists	0.00	0.00	0.00
Support to Clinical Staff	168.10	139.37	153.92
NHS Infrastructure Support	119.53	116.99	128.31
Medical and Dental	50.83	45.62	39.31
ACTUAL AGENCY STAFF BY STAFF GROUP	**16.03**	**17.20**	**21.90**
Registered Nursing, Midwifery and Health Visiting Staff	12.06	10.82	14.34
Allied Health Professionals	0.00	2.19	2.63
Registered Scientific, Therapeutic and Technical Staff	0.00	0.00	0.42
Healthcare Scientists	0.00	0.00	0.00
Support to Clinical Staff	0.22	0.00	0.00
NHS Infrastructure Support	3.60	3.60	3.60
Medical and Dental	0.15	0.58	0.91

2025/26 Actuals vs Planned

WHT 25/26 Overall Actual versus Planned WTE

WHT 25/26 Substantive Actual versus Planned WTE

WHT 25/26 Bank Actual versus Planned WTE

WHT 25/26 Agency Actual versus Planned WTE

During M10 25/26, external substantive leavers (53 WTE) exceeded external substantive starters (45 WTE). Triangulated against assignment changes, such as adjusted contracted hours, this contributed to an 11 WTE decrease in the substantive workforce. While medical locum usage declined in January 2026, a rise in bank reliance among the nursing and infrastructure support workforce contributed to a month-on-month increase. Vacancy cover and high acuity accounted for two-thirds of agency bookings during January 2026, contributing to a month-on-month rise, driven by increased registered nursing reliance on temporary staffing.

Tier 1 - Paper ref: | Enclosure 7

Report title:	Report of Escalation from Tier 1 Committee Chairs
Sponsoring executive:	Non-Executive Directors
Report author:	Paul Assinder – Deputy Chair, WHT
Meeting title:	Group Board of Directors Meeting - in Public
Date of Meeting:	17 March 2026

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

The Committees of the Board Chairs' Report comprises a joint summary of the 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.

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 themes identified in the Alert Section 1
b) The summary Committee of the Board reports in Sections 2.1, 2.2 and 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 January and February 2026

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 under Assure, Advise and Alert
- Part 1 – Alignment of themes with the Group Board Assurance Framework (BAF) Risks
- 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 / Mitigations
1. CQC The draft report from CQC has been received following their unannounced visit to Emergency Department (ED) at New Cross Hospital, including SDEC (Same Day Emergency Care) in November 2025.	**MD (RWT)**	A detailed action plan is in place with a range of activities underway to address the immediate CQC feedback.
2. Workforce Sickness absence and appraisal compliance	**CPO**	Use of Resources workforce workstream is closely monitoring sickness.
3. Fire Safety Precautions Fire Safety Notices in relation to i) Maternity at	**CEO**	Actions being progressed and agreed with the Fire Service Authorities with a theme of estates compliance and utilization emerging

New Cross; ii) Block 55 New cross; iii) Cannock Chase		across communities
4. Digital and Estate A Digital Partner is being sourced	**CFO**	Specification has been prepared and procurement to source a Digital Partner has commenced
5. Community Waiting List - Community waiting list over 52 weeks has increased and ranks in the worst quartile nationally.	**CC&PO**	This is being reviewed and oversight by various Committees

2.1 Alert – matters of concern for escalation

Finance & Productivity Committee	Quality Committee
Financial Planning – The Group CEO and CFO discussed the forecast financial position with the Cluster ICB CEO on a number of occasions, which led to an offer of £8m to the Group in order to deliver a break-even position for 2025/26. Having reviewed the impact of this on the forecast deficit, the offer was accepted, however a range of further stretch mitigations are required in order to achieve a balanced position against the plan. The Group and both Trusts maintain a position that they can deliver the year-end financial targets. There are however a number of financial risks that will make this very challenging. K Stringer stated that he would brief Group F&P Committee on any issues in achieving break-even. Performance – • WHT - Community waiting list over 52 weeks has increased and ranks in the worst quartile nationally. • RWT - The percentage of patients waiting under 18 weeks saw some deterioration, this is a seasonal trend due to reduced activity and leave over the holiday period. 18 weeks RTT ranking remains lower quartile. • RWT - Ambulance handover times for <30 minutes has shown some deterioration during December 25 and remains below target. • WHT Type 1 ED attendances 3.74% up YTD on last year and the Trust remains the highest net importer of IC ambulances. • WHT DM01 performance declined to 76.74% (improved rank to 63rd (from 64th) out 121 trust November performance). There is a significant risk to continued improvement in performance due to	• The draft report from CQC has been received following their unannounced visit to the Emergency Department at New Cross Hospital, including SDEC, in November 2025. In addition, the Trust has been issued with a Section 29a Warning Notice. At the time of the meeting the report was being checked for factual accuracy, alongside the warning notice. A detailed Action Plan is in place with a range of activities underway to address the immediate CQC feedback. A GIRFT visit has been undertaken that was felt to be helpful in providing suggestions to the team for improvement and identifying some positives within ED. The report of the visit is awaited. • A Preventing Future Deaths Notice by the coroner has been issued to WHT following the death of a child. Further information is awaited. • The further Fire Safety Enforcement Notice issued by West Midlands Fire Service (WMFS) re safety works needed in Block 32 – Maternity Services at New Cross Hospital remains in force to cover the 5 remaining works that are needed with a 2 year timeframe for completion. Discussions are continuing between the Trust and the WMFS • A Fire Safety Enforcement Notice by Staffordshire Fire and Rescue Service remains in place regarding Cannock Chase Hospital. Whilst a range of actions have been taken, not all of the required work will have been completed by the stated deadline. Work is continuing to achieve compliance and Staffordshire Fire and Rescue Service has been contacted with the aim of securing additional time to complete the required work; a response to this request is still awaited.

2.1 Alert – matters of concern for escalation

Finance & Productivity Committee	Quality Committee
the seasonal capacity gap within MRI which will result in a worsening DM01 position if not resolved. • WHT RTT had 17 Patients > 52 weeks at the end of December. No patients waited > 65 weeks. Whilst the Trust is above the planning trajectory for total PTL, January is reporting a reducing PTL (so far mid-month). There is a risk to achieving zero 52-week waiters at 31st March 2026. • WHT – Community waiting list over 52 weeks increased to 17.96% (as a percentage of total waiting list) and ranks in the worst quartile nationally. Additional data for community paediatrics has been included from Decembers return. Focused actions for Adults Dietetics and S&LT. Pathway review for community Paediatrics. • RWT – Ambulance handover times for all targets saw some deterioration during January 26 and remain below target. • WHT – Type 1 ED attendances were 6.33% increase, with January showing special cause for concern. • WHT – DM01 was 72.81%, ranked 64th nationally. This is predominantly driven by a deterioration in MRI , NOUS and Echo. 13 week+ breaches in January 2026 totalled to 478. There is a significant risk to improvement in performance due to the capacity gap within MRI which will result in a worsening DM01 position if not resolved. Audiology is progressing with the recovery plan. Neurophysiology interim recovery actions are being progressed with agency support being scoped. Finance • In M10 there has been a shift of £1m from non-recurrent to recurrent delivery. This comprises 52% of FYE position. When added to the shortall in savings plans there is a total non-recurrent gap of £51m or 58%. J Creighton alerted to the Committee that if this isn't addressed in year it will have a significant impact on the 26/27 efficiency plan. Workforce	• A WMFS Fire Safety Enforcement Notice remains in place relating to the Nucleus Theatres in Block 55 at New Cross Hospital. The required work is underway and it is expected that the Trust will meet the stated deadline date of the 27th of May 2026. • Following visits by the H&SE, in relation to Entonox exposure levels, in the Delivery Suites at both RWT and WHT, monitoring of staff levels of exposure is continuing. Mobile destruction units are now in use at WHT. • The report following the visit by the Human Tissue Authority License Inspection that took place in December 2025 at both to RWT and WHT – the license holder has been received. The required Corrective and Preventative Action plan has been completed and accepted by the HTA. • The report of the visit by CQC and Ofsted re the Assessment of Services for Children and Young People with Special Educational Needs and/or Disabilities (SEND) in December 2025 with WHT with Walsall Partners is awaited.

2.1 Alert – matters of concern for escalation

Finance & Productivity Committee	Quality Committee
• Both Trusts are adverse to the internal stretch plan by 264 WTEs overall.	

2.1 Alert – matters of concern for escalation

People Committee	Partnerships & Transformation Committee
• The workforce position at M10 showed an improvement in month for RWT of -49 WTE (decreases in substantive and bank but an increase in agency). WHT saw an in-month increase of +35 WTE (decrease in substantive but increases in bank and agency). Both trusts remained above plan and there is minimal assurance of meeting the stretched target. • Early indications suggest that the M11 Group substantive position represents a reduction from the M10 position. The temporary position is still being finalised. • Sickness absence and appraisal compliance across both trusts remain challenged. Use of Resources workforce workstream is closely monitoring sickness.	

2.2 Assure

Finance & Productivity Committee	Quality Committee
Finance • The forecast year-end position is holding and a Group break-even position has been submitted for both Trusts, supported by the £8m non-recurring ICB support which has enabled both Trusts to reach year-end.	• The Birthrate Plus review of Staffing within Maternity and Neonatal Services at RWT was approved by Trust Board in January. • WHT have continued to achieve 90% compliance for level 3 Safeguarding Adults and Children. • RWT have been selected to be part of the 2nd pilot of the MNSI's Compass Tool – Culture of Organizations and its Impact on Patients' Safety, which commenced on the 9th of February to run over 4-6 months. • The Committee received the Health Inequalities Report for information which will be included as a supplement of the Annual Report. This is a comprehensive report that clearly demonstrated the significant work that is taking place across Walsall and Wolverhampton to tackle health

2.2 Assure

Finance & Productivity Committee	Quality Committee
	inequalities.
	• The Committee received and endorsed by Chair's Action, the report and recommendations for the 150 day national target for clinical trials.

2.2 Assure

People Committee	Partnerships & Transformation Committee
The Committee received update reports on: • Workforce Planning 2026-2029 • B2/3 Closure Report & B4/5/6 Update • Use of Resources Workforce Workstream • Workforce Data Triangulation at a divisional level. • E-Roster Expansion Update • Board Assurance Framework • Employment Rights Act 2025 • FTSU – WHT & RWT	• Integrated front door pre-committee walkabout provided reassurance regarding left shift mobilization and impact for patients, workforce and operations. • Review of the Community First Delivery Partner proposal and recommendation to support with caveats submitted to Finance & Performance to support business case review. • Transforming Care Together governance update provided Neighborhood Health PID presented and effective committee discussion regarding impact monitoring • Outpatient transformation updated provided and discussion regarding transformation and performance oversight committee responsibilities. • Cycle of business reviewed and agreed

2.3 Advise

Finance & Productivity Committee	Quality Committee
• 25/26 Data Security & Protection Toolkit (DSPT) Baseline Report RWT/WHT Submission Decision – 16 unmet standards (RWT) and 25 unmet standards of 47 (WHT). Targeted remediation plans are in place across both WHT and RWT with progress underway to close all gaps by June 2026. Both RWT and WHT are being externally audited in February which will provide aligned, independent assurance across both Trusts against the requirements. To return and brief GFPC following the audit. • SLR Update – The Committee requested a future deep dive into 2 of the bottom 15 reporting areas (due April).	• Members from the Stroke Team attended the meeting to update the committee on the progress the team have made and their plans for further improvements. The SHMI and SNNAP data have both shown improvements with the SHMI dropping over the last 12 episodes with no alerting diagnosis over the last 5 episodes. There have been improvements in patient pathways, workforce, leadership, culture and multidisciplinary working across the service. The team were to be commended on their achievements to date and for their future vision for the service.

2.3 Advise

Finance & Productivity Committee	Quality Committee
• Group Planning Update – Final pack to be presented to Extra-ordinary Trust Board in February. Contract Awards • REAF 5599 CCN 73 Amendments to T-SPOT Testing Solution - Lot 1 Managed Service Contract for Clinical Chemistry (Renewal Date 1/4/26) – Committee Approved. • REAF 5546 Teleradiology Reporting (Renewal Date 1/3/26) – Committee Approved. • REAF 5493 Managed Print Service (Renewal 1/4/26) – Committee Approved • REAF 5315 Children's Services-Paediatric Diabetes Insulin Pumps (Renewal Date 1/2/26) – Committee Approved. • REAF 5778 Peritoneal Dialysis – Home Delivery Service (Renewal 31/3/26) – Committee Approved. • REAF 5600 MIS2 Medtronic (Renewal 01/01/26) Retrospective – Retrospective (noted) • REAF 5671 CCN for Enhanced Liver Fibrosis (ELF) Test (Renewal 1/3/26) – Committee Approved. • REAF 5770 CCN for Clinical Flow Cytometry Service (Renewal 1/4/26) – Committee Approved. • REAF 5763 Pharmacy System (Renewal 1/4/25) Retrospective – Not approved (to be re-submitted to GFPC March as questions asked why this contract award is retrospective). • WHP00066 ICD'S & Pacemakers (Renewal 3/4/26) – Endorsed to Trust Board Business Cases • Group Proposal for Procuring Ambient Voice Technology (AVT) – Committee Approved. • Business Case to Support Replacement of RWT Non-Specialised Hospital Beds – Endorsed Chairs Action.	• The Committee received the Health Records Improvement Plan. This clearly highlighted the ongoing challenges being faced and included a number of recommendations for the Health Records Project Group. • 2 week cancer waits are monitored internally. At RWT 80.51% of patients were seen within 2 weeks. At WHT 68.27% of patients were seen within 2 weeks, mainly due to reduced capacity within the breast service – additional capacity has been secured. • Both Trusts exceeded the 80% target in respect of the 28 day Faster Diagnosis Cancer Standard. • For 31 days RWT's performance is static and an action plan is in place to improve this. WHT very narrowly missed the target achieving 95.96% against the threshold of 96% • RWT's 62 day waits are below trajectory at 73% against the 75% national target by the end of March 2026. Gynae, Renal and urology remain the most challenged areas. Patients from Walsall and Sandwell and West Birmingham are accessing service at RWT as a result of the workforce issue within Urology at University Hospitals Birmingham. WHT narrowly missed the national standard of 75% achieving 74.15%. • Diagnostics performance (DM01) at RWT is exceeding the 95% national standard. WHT remains below target at 72.81% due to challenges within MRI, Echocardiography and Non Obstetric Ultrasound. Audiology has improved and measures are being put in place to recover Neurophysiology, possibly with agency support. • Ambulance handover times across both Trusts for 15, 30 and 60 mins did not meet required targets. However, RWT marginally missed 4 hour target of 78% achieving 77.13 with WHT achieving 69.97% • Corridor Care in ED at WHT was used for 22 out of 31 days in January with patients staying for an average of 5.6 hours, an increase from 2.8 December. The SOP remains in place and harm reviews are undertaken together with peer audits. There were no harms identified.

2.3 Advise

Finance & Productivity Committee	Quality Committee
	• At RWT 18.19% of patients exceeded a 12 hour wait in ED up from 15.83% in December. At WHT 13.72 patients exceeded a 12 hour wait in ED up from11.01% in December.
	• Whilst WHT remains non-compliant with the required Systemic Anti-Cancer Therapy dataset ; an experienced Haematology Clinical Nurse Specialist has been appointed which will resolve the situation and facilitate compliance.
	• At WHT there were 3 category 4 pressure ulcers with 1 in hospital and 2 in Community and a range of actions are in place to reduce the incidence. A recent 'mattress' audit identified that a large number of mattresses were damaged and required repair.
	• At RWT there has been a continued increase in pressure ulcers, but within agreed tolerance levels. A wide range of actions are in place to try and reduce the incidence. 450 new beds have been purchased with the remaining bed replacement to be achieved within 2026-27.
	• At WHT the number of falls fell from 70 to 62 in January, within tolerance levels. However, there were 4 severe harms in December with 2 moderate and 3 severe harms in January. At RWT the number of falls increased from 91 to 101, within agreed tolerance levels. A range of actions are in progress across both Trusts to reduce falls whilst still encouraging patients to Eat, Drink, Dress and Move to Improve. Bathroom first improvement program continues with a reduction in month seen at RWT regards to falls in bathrooms. The use of sensor alarms in bathrooms is being piloted at WHT.
	• Patient falls where a patient has/may have hit their head, requires neurological observations on the patient for 12 hours. Compliance at RWT with this was 35% in January and actions have been taken to improve compliance.
	• Challenges remain in securing the required timely clinical support for the volume of patients with Mental Health issues attending ED in both Trusts. Meetings have taken place with the Mental Health Services with a view to securing more timely support.

2.3 Advise

Finance & Productivity Committee	Quality Committee
	• Perinatal mortality and stillbirths have seen a slight rise at WHT with ongoing work continuing to understand the reasons why and take appropriate actions where/if possible. • There were no Maternity Outcomes Signal System Alerts (MOSS) at either Trust • The CQC Maternity Survey showed a similar pattern to the last report in both Trusts. • RWT received the Neonatal Peer Review Report from February 2025. Three immediate actions were identified and actioned on the day. Other recommendations have been actioned and deemed compliant. The Action Plan was signed off during February by the Perinatal Leadership Team. • The CQC in its State of the Nation Report has identified concerns nationally regarding triage effectiveness in maternity services. RWT are performing well with triage times achieving 82% in 15 minutes and 93% within 30 mins. Triage times at WHT are more challenging given staffing and environmental resources. • Cultural oversight, which will be embedded into the requirements for CNST year 8 has identified some improvements following staff cultural feedback at RWT but with more work to do. • The ongoing challenges in respect of decontamination within Endoscopy could impact on the forthcoming JAG accreditation • There were no changes to the BAF and no additional issues added to the watchlist. However, there were 3 new risks added to the RWT Corporate risk register, which related to: capacity available in Cath Labs as 1 of 3 labs undergoing refurbishment and a need for a 4th lab to expand the capacity available to meet service needs; the Boston Scientific pacemaker field safety notice and the impact for a large number of RWT patients. The replacements of this device will take a number of years to complete; however, patients are being monitored to identify any adverse effects. The 3rd new risk relates to bedside suction, oxygen flowmeters and regulators. • PAS integration has proved challenging in some areas and within Ophthalmology there have been a

2.3 Advise

Finance & Productivity Committee	Quality Committee
	number of issues that have led to patients being cancelled and backlogs created which could give rise to patient harm. This is being monitored.
	• An Unused Hours paper had been approved by the Executive Group to zero unused hours prior to the 1st April 2025, majority of these were historic and linked to COVID staff deployment at RWT. Revisions are being put in place regards HR systems to enable timely update and escalations / restrictions within the Nurse staffing policy regards additional hours limits.

2.3 Advise

People Committee	Partnerships & Transformation Committee
• Guardian of safe working paper to be received quarterly at Group People Committee. The committee felt that assurance was required regarding the welfare implications of the exception reporting. • Review of targets and thresholds for 26/27 financial year, to include methodology. • 26/27 detailed sickness targets are in development at a trust and divisional level and will be monitored regularly by the committee. • Workforce performance report to include pay spend targets going forward.	• Terms of Reference (TOR) reviewed and will be tabled to Board for approval in May 2026, alongside all other Committee TORs • Funding allocations for Place are still not confirmed, the committee will monitor any impacts of partnership delivery and/or financial impact for the Group.

Report title:	Neighbourhood Health Plans and Walsall Together Partnership Board Update
Sponsoring executive:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Report authors:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Meeting title:	Group Trust Board
Date:	17th March 2026

1. Summary of Key Issues to Advise

This report includes:

1. Neighbourhood Health Plans

The draft Neighbourhood Health Plans that have been produced for OneWolverhampton and Walsall Together place based partnerships, in preparation for their presentation to the Walsall and Wolverhampton Health and Wellbeing Boards in March 2026.

2. Chair of Walsall Together Partnership Board

Patrick Vernon OBE will be stepping down as the Chair of Walsall Together Partnership Board at the end of March 2026 after a 4-year tenure. The partnership made the decision to not appoint a replacement Independent Chair, and to instead undertake a nomination process from with the partnership for the role of Chair and Vice Chair of the Partnership Board.

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?]

Neighbourhood Health Plans have been discussed at and supported by the OneWolverhampton and Walsall Together Partnership Boards. The role of Chair of Walsall Together Partnership Board and the proposed process for replacement was discussed at the Trust Board meeting in January 2026.

4. Recommendation(s)/Action(s)

The RWT/WHT Group Trust Board Meeting to be held in Public is asked to support the Neighbourhood Health Plans and endorse Greg Bloom and Stephanie Cartwright as the Chair and Vice Chair respectively of the Walsall Together Partnership Board.

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		

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

Neighbourhood Health Plans and
Update on Walsall Together Partnership Board

1. Executive Summary

Neighbourhood Health Plans

The draft Neighbourhood Health Plans have been produced for OneWolverhampton and Walsall Together place based partnerships, in preparation for their presentation to the Walsall and Wolverhampton Health and Wellbeing Boards in March 2026.

National Neighbourhood Health guidance, expected imminently, will require Health & Wellbeing Boards to approve a Neighbourhood Health Plan for their local place. In Walsall and Wolverhampton (and to align with the refresh of the Health & Well Being Strategy in Walsall) we are sharing draft Neighbourhood Health Plans with Health and Wellbeing Boards in March 2026 to prepare the Boards for their roles in assuring and monitoring implementation of Neighbourhood Health Plans. There are 2 distinct sections of the plans:

- a strategic plan, aligned to the existing Joint Health & Wellbeing Strategies and anticipated national guidance on Neighbourhood Health, setting the vision and objectives for places and neighbourhoods

- an operational plan, aligned to the NHS Medium Term Planning Guidance, and the National Neighbourhood Health Implementation Programme, detailing arrangements to deliver the vision, including how the objectives will be achieved

A longer-term Neighbourhood Health Plan will be developed alongside the Health & Well Being Strategies, for approval in advance of April 2027 (likely to be September/October 2026).

The plans have been produced by partners through the partnership teams in both places, and have both received support from the OneWolverhampton and Walsall Together Partnership Boards, and in Walsall from the national coach as part of the National Neighbourhood Implementation Programme. The plans are now being shared with each partner organisation as part of the wider governance ahead of presentation to the Health and Wellbeing Boards. The plans will become addendums to the Health & Wellbeing Strategies and are for approval by the Health & Well Being Boards in March 2026. Engagement on the plans will taken place after the local elections in May 2026. The draft plans are publicly available through local Health and Wellbeing Boards or can be made available upon request from the organisation.

Chair of Walsall Together Partnership Board
Patrick Vernon OBE will be stepping down as the Chair of Walsall Together Partnership Board at the end of March 2026 after a 4-year tenure. The partnership made the decision to not appoint a replacement Independent Chair, and to instead undertake a nomination process from with the partnership for the role of Chair and Vice Chair of the Partnership Board. This process has now been undertaken and the role of Chair will be taken on by Greg Bloom, Managing Partner of Umbrella Medical in Walsall, and the role of Vice Chair will be taken forward by Stephanie Cartwright, Chief

Community and Partnerships Officer for Walsall Healthcare NHS Trust. Both of the roles are an interim measure whilst the governance arrangements for place are reviewed over the coming months alongside potential delegation arrangements.

Recommendations:

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

- support the Neighbourhood Health Plans and

- endorse Greg Bloom and Stephanie Cartwright as the Chair and Vice Chair respectively of the Walsall Together Partnership Board.

Stephanie Cartwright
Group Chief Community and Partnerships Officer
6 March 2026

Walsall Neighbourhood Health and Care Plan 2026/27

Introduction/Context

National guidance, expected in early spring, will require Health & Wellbeing Boards to approve a Neighbourhood Health Plan for their local place. In Walsall, to align to the refresh of the Health & Well Being Strategy, we are sharing a draft ahead of national guidance, in March 2026, covering the period from April 2026 to March 2027 inclusive. There are 2 distinct sections:

Section1   a strategic plan, aligned to the existing Joint Health & Wellbeing Strategy and national guidance on Neighbourhood Health, setting the vision and objectives for places and neighbourhoods

Section 2   an operational plan, aligned to the NHS Medium Term Planning Guidance, and the National Neighbourhood Health Implementation Programme, detailing arrangements to deliver the vision, including how the objectives will be achieved

A longer-term Neighbourhood Health Plan will be developed alongside the Health & Well Being Strategy, for approval in advance of April 2027 (likely to be September/October). In Walsall, we recognise that delivery of improved health and wellbeing requires commitment and resource from a broad range of partners and as such, this document is named the Walsall Neighbourhood Health & Care Plan.

The Walsall Neighbourhood Health and Care Plan aligns with several government initiatives, including Best Start local plans for early child development (including Family Hubs), Pride in Place initiatives, employment programmes, and housing reforms. These interdependencies highlight the importance of integrated approaches addressing the social determinants of health alongside health and wellbeing services, which is also outlined in the Black Country Integrated Care Outline Strategy 2025-2028, which has a focus on prosperity, prevention and population health.

This document will become an addendum to the draft Health & Wellbeing Strategy, for approval by the Health & Well Being Board in March 2026, with the full Walsall Neighbourhood Health & Care Plan being part of the finalised Health & Well Being Strategy going to Health & Well Being Board in September 2026. We intend to consult following elections in May on the Health & Well Being Strategy and Walsall Neighbourhood Health & Care Plan together. The following diagram shows the alignment with the Health and Well Being Strategy.

Legend: Strategic alignment / Life course approach / Walsall borough plan
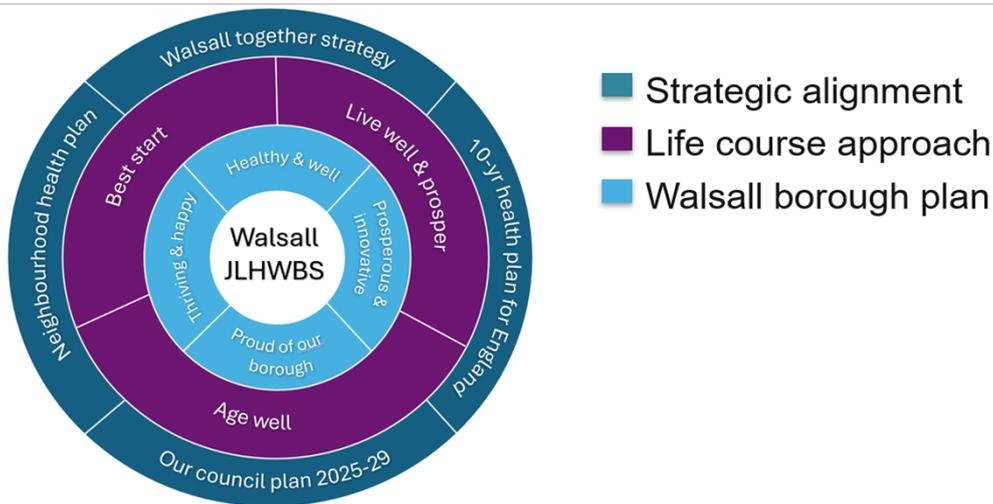
Section 1: Strategic Plan

Vision for Neighbourhood Health & Care

NHS England guidelines (2025) for neighbourhood health describe six core components, which aim to connect clinical care with wider community support, addressing social determinants of health like housing and employment for a healthier population. The guidelines recognise that there is an urgent need to transform the health and care system. We need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery. More people are living with multiple and more complex problems, and as highlighted by Lord Darzi, the absolute and relative proportion of our lives spent in ill-health has increased.

Addressing these issues requires an integrated response from all parts of the health and care system. Currently, too many people experience fragmentation, poor communication and siloed working, resulting in delays, duplication, waste and suboptimal care. It is also frustrating for people working in health and social care. Neighbourhood health and care reinforces a new way of working for the NHS, local government, social care and their partners, where integrated working and co-ordinated care is the norm and not the exception. Neighbourhood health and care aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care.

In Walsall, we will bring professionals from across the health and care system together to work hand-in-hand, supporting people of all ages and their households—including families and carers. Using shared digital systems and care planning tools, our teams coordinate care closer to home, prevent avoidable hospital visits, and improve

outcomes. This approach keeps older people safer, promotes independence, and creates a more sustainable system that works for patients, families, carers, and the community.

Neighbourhoods

Walsall has defined neighbourhoods that are coterminous with 7 Primary Care Network footprints across 4 geographical localities (see the diagram below).
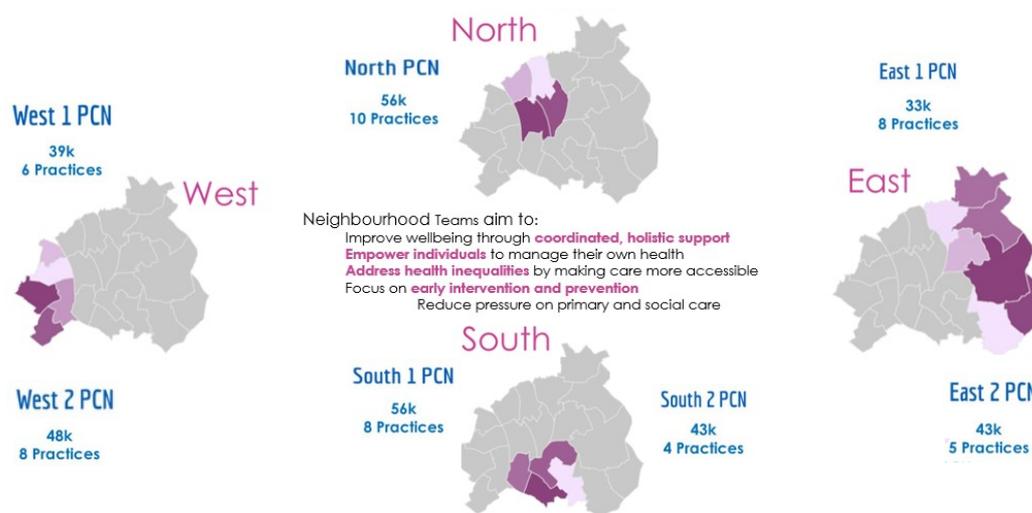
These localities align with community health, social care and voluntary sector services. Health data sets are aligned to GP registered populations, and wider data sets are aligned to resident populations in the recognised ward boundaries. More information can be found using the following links:

- Locality Profiles - Walsall Insight
- JSNA - Walsall Insight

The refresh of the Health & Well Being Strategy will incorporate neighbourhood health and care as a key theme. Mapping of current Health & Well Being Strategy priorities is in progress to think about how they relate to our neighbourhoods and potential delivery in neighbourhood teams.

Governance and Accountability

We are expecting future local accountability to ask that Health & Well Being Boards ensure neighbourhood health plans are reflected in commissioning decisions and public engagement mechanisms are effective. In Walsall, strategic governance will be led by Walsall Health & Well Being Board, responsible for developing and overseeing neighbourhood health and care plans. Plans will outlines how providers will clarify roles, responsibilities, and collaboration mechanisms such as shared culture,

workforce development, data sharing, population health management, pooled budgets, and estate use.

Alongside the local authority, the Integrated Care Board is a strategic commissioner of neighbourhood health. The Neighbourhood Health & Care Plan will support and influence the Integrated Care Board's strategic planning as well as any agreed joint commissioning arrangements.

Currently, the Black Country ICB's five-year Joint Forward Plan has a focus on improving services, preventing illness, and tackling health inequalities through collaboration and integration. Key priorities include community-based care, giving people the best start in life, and improving access to services like diagnostics and elective care, with plans to implement a shared care record and open new facilities (e.g. Community Diagnostic Centres and Neighbourhood Hubs). The strategy also emphasises collaboration between health, social care, and community services and looks to improve specific areas like cancer screening, mental health, and child health.

Statutory joint commissioning between the Council and the Integrated Care Board is undertaken through the Place Integrated Commissioning Committee. The Place Integrated Commissioning Committee sits within the Council governance and is also accountable to the Integrated Care Board's Strategic Commissioning Committee. It provides formal governance for integrated commissioning and retains statutory responsibility.
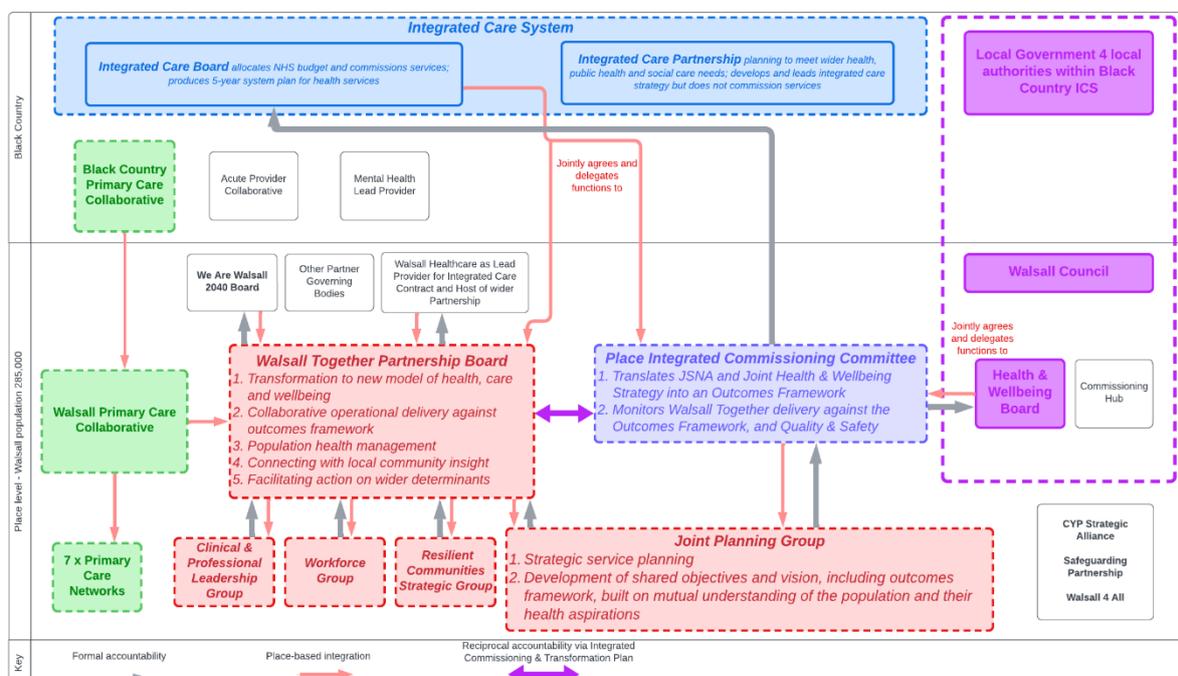
Over time, commissioning responsibilities are increasingly being delegated into the Place governance structures. Whilst the Place Integrated Commissioning Committee

retains statutory authority, the operational commissioning functions, including service model design, delivery oversight and redistribution of system-allocated resources, are being undertaken jointly with the Walsall Together Partnership. This supports the integration of planning, commissioning and delivery in line with the Health and Care Act 2022.

The Better Care Fund is reviewed and aligned through Place Integrated Commissioning Committee as part of these joint commissioning arrangements. Better Care Fund planning and resource allocation are integrated into the wider Integrated Commissioning and Transformation Plan, supporting neighbourhood health, prevention, discharge pathways and admission avoidance. We expect funding flows for neighbourhood health to increasingly come via Place. The strategic direction, set by the Health and Wellbeing Board, will be translated by the Place Integrated Commissioning Committee into joint commissioning decisions, and the Walsall Together Partnership Board will oversee delivery through integrated provider arrangements.

Oversight is shared across governance layers. The Health & Well Being Board sets the long-term ambition. The Place Integrated Commissioning Committee provides formal joint commissioning governance and statutory assurance. The Partnership Board oversees delivery and performance under the Host Provider model. Supporting groups, including clinical leadership, workforce and community resilience forums, strengthen quality, workforce sustainability and neighbourhood integration. Overall, the model shifts from a traditional commissioner–provider split to a collaborative, Place-led approach where planning, commissioning, funding and delivery for neighbourhood health are increasingly aligned and managed at Place, with clear oversight through Place Integrated Commissioning Committee and Health & Well Being Board.

The Better Care Fund vision is to help people stay independent and healthy at home for longer, support people to live healthy, independent and dignified lives and aims to provide the right care in the right place at the right time. Integration is prioritised as a key driver, through joint approaches between health and social care, which requires Integrated Care Boards and local authorities to agree joint plans and pool budgets to support personalised care and the integration of services. Plans are approved by Health and Well Being Boards and assured by NHS England and regional social care and local government leads, with oversight from the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government. The objectives of the Better Care Fund reflect the government's commitment to shifting from sickness to prevention, and from hospital to community, supporting people to live independently for longer.

There are two core Better Care Fund objectives for 2025/26 to 2026/27:

- Reform to support the **shift from sickness to prevention** by helping people remain independent for longer and prevent escalation of health and care needs, including:
    - timely, proactive and joined-up support for people with more complex health and care needs
    - use of home adaptations and technology
    - support for unpaid carers.

- Reform to support people living independently and the **shift from hospital to home**
    - help prevent avoidable hospital admissions
    - achieve more timely and effective discharge from acute, community and mental health hospital settings, supporting people to recover in their own homes (or other usual place of residence)
    - reduce the proportion of people who need long-term residential or nursing home care.

The Better Care Fund's goal is to reform and strengthen neighbourhood services across health and social care with emphasis on providing care closer to home, with a strong focus on prevention. This shift moves away from treating sickness and promotes well-being and independence. The Better Care Fund aims to improve the lives of those with complex health and care needs by ensuring health and social care services collaborate with services being joined-up and person-centred.

The Better Care Fund will be reformed into an Integrated Care Fund, with a focus on ensuring consistent joint NHS and local authority funding for those services that are essential for integrated health and social care, such as hospital discharge, intermediate care, rehabilitation and reablement.

The reform will see the Better Care Fund align to Neighbourhood Health Plans, focussed on supporting local areas to achieve better outcomes in line with the priorities of the 10 Year Health Plan. It will emphasise review of Intermediate Care Services with the aim of improving quality, efficiency and outcomes with assurance of capacity being able to meet demand and developing referral processes to improve hospital discharge and reduce avoidable admissions.

The metrics that are confirmed as being measured by the Better Care Fund 2026/27 include:

- Non elective hospital admissions for people aged 65 and over per 100,000 population
- Average length of discharge delay for all acute adult patients, derived from a combination of:

- proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)
- for those adults patients not discharged on their Discharge Ready Date, average number of days from the Discharge Ready Date to discharge
- Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population.

A review of the schemes under the Better Care Fund will ensure they are fully aligned to the objectives aligned to the reformed Better Care Fund. They will also demonstrate an outcomes-based approach supported by strong service delivery with a focus is on responsive, preventative, and coordinated care in people's homes and the community.

Objectives

The 10-Year Health Plan for England aims to shift care from hospitals to communities, analogue to digital and treatment to prevention. It is supported by a set of Neighbourhood Health Guidelines which were published in February 2025 that outline the six components of Neighbourhood Health as follows:

Component	Description
1.Population Health Management	Data-driven risk stratification using integrated datasets.
2. Modern General Practice	Enhanced access, continuity, personalised care.
3. Standardised Community Health Services	Consistent, locally tailored community services, especially bringing physical and mental health together, and reducing inequalities
4. Neighbourhood Multidisciplinary Teams (MDTs) / Integrated Neighbourhood Teams (INTs)	Collaborative teams across health, social care, voluntary sectors.
5. Integrated Intermediate Care ("Home First")	Short-term, community-based recovery support to avoid hospital admissions.
6. Urgent Neighbourhood Services	Rapid local response to urgent health needs.

The following sections describe the initial objectives against each of these components for 2026/27.

Population Health Management & Risk Stratification

Embed a prevention-led Population Health Management approach across all neighbourhoods, starting with a shared understanding of local population health needs and aligning delivery to the Joint Health & Wellbeing Strategy:

- agree Population Health Management approach, aligned to refreshed Health & Well Being Strategy
- identify tools that support identification of individuals that would benefit from additional support

This approach will begin with comprehensive analysis of neighbourhood-level data, including the wider determinants of health and the nine fundamentals of wellbeing set out in the Walsall Wellbeing Outcomes Framework. By identifying holistic needs — spanning physical health, mental wellbeing, housing, employment, social connection and financial stability — we will establish clear neighbourhood priorities that drive proactive and preventative models of care.

Neighbourhood Teams will operationalise this approach by utilising agreed risk stratification and predictive tools to identify individuals and cohorts at risk of deterioration, avoidable hospital use or widening inequalities. Through coordinated, multi-disciplinary support, Neighbourhood Teams will deliver early interventions, personalised care planning and strengths-based support that prevent escalation of need.

Success will be measured through improvements in Health and Wellbeing (HWB) outcomes across population, system, service and individual levels, as defined within the Walsall Wellbeing Outcomes Framework, ensuring prevention is measurable, equitable and outcome-focused

Primary Care Transformation & Modern General Practice

All practices meet Modern General Practice contractual criteria, are actively involved in population health management and recognising/acting on digital inequalities. A sustainable model is required for Walsall Connected.

The Black Country Integrated Care Board 's Primary Care Transformation Strategy is a five-year plan that strongly aligns with the Walsall Neighbourhood Health and Care Plan to improve services including general practice, community pharmacy, dentistry, and optometry. The strategy aims to create a more sustainable and integrated model by focusing on increasing access and appointments, expanding workforce support, improving premises, and using technology to improve patient experience and reduce pressures. Key goals include better unplanned and planned care, improved patient

satisfaction, and increased digital functionality ([Future of Primary Care in the Black Country :: Black Country ICB](#)). The Integrated Care Board is responsible for implementing Modern General Practice.

Neighbourhood health cannot succeed without tackling digital exclusion. Access to digital tools, connectivity and skills is now fundamental to accessing healthcare, employment, education and wider determinants of wellbeing. Walsall Connected is the borough's digital inclusion and connectivity programme. It supports residents, particularly those at risk of exclusion, to:

- Access affordable broadband and devices
- Develop digital skills and confidence
- Safely use online public services
- Engage with NHS digital tools such as the NHS App
- Access employment and benefits support
- Connect to community and wellbeing services

This programme directly supports the neighbourhood health ambition to:

- Shift from analogue to digital
- Reduce inequalities in service access

Standardising Community Health Services

Finalise commissioning and contracting arrangements for neighbourhood health including:
- joint commissioning arrangements between the Integrated Care Board and Walsall Council
- amendments to 2026/27 provider contracts to support the transition towards outcomes for neighbourhood health

This component is focussed on developing commissioning and funding flows to support the transition from current contracts and service models towards alternatives that increase the focus on outcomes and encourage integrated delivery of more holistic care and support to individuals and households. The following key deliverables are in progress:
- Agreeing an approach to defining measurable outcomes for each of the 9 fundamentals of wellbeing in the Walsall Wellbeing Outcomes Framework. These will be categorised into outcomes at population level Joint Strategic needs Assessment, system level (statutory targets), service level (neighbourhood teams), and individual level (self-reported wellbeing).
- Agreeing key outcomes for inclusion in 2026/27 contracts

- Development of a future joint commissioning approach between the Council and Integrated Care Board, as described above

Neighbourhood Multi-Disciplinary Teams

Neighbourhood Teams are multi-disciplinary teams that bring together professionals from adult social care, primary care, community health, mental health, housing, and the voluntary sector to deliver coordinated, person-centred support within local communities:

- all age approach thinking about Children & Young People as well as adults
- connection to prevention, starting with existing offers and thinking about physical activity opportunities
- integration across core teams (e.g. community, mental health, general practice, adult social care, social prescribing)
- data-driven definition of priority cohorts

We have 7 Neighbourhood Teams in Walsall that are coterminous with Primary Care Networks and geographically aligned with existing health and care services as well as the Volunteer, Community, Faith and Social Enterprise infrastructure organisations.

Many GP appointments today are taken up by non-medical issues such as loneliness, housing concerns, or financial stress. By creating simpler, more direct connections between health services and other local support systems, neighbourhood health can improve outcomes, reduce pressure on frontline services, and boost the overall productivity of the public sector. It is an opportunity to strengthen partnerships between councils, job centres, community organisations, and the NHS, and to design clearer, more effective pathways for non-clinical support.

Integrated Intermediate Care with "Home First" Approach

Refresh the delivery and financial models for intermediate care to provide timely, person-centred care that supports people to regain independence quickly, reduces avoidable hospital admissions, and delivers the best possible outcomes for every individual:

- Implement the agreed new workforce model for the Intermediate Care Service
- Agree a new bed-based rehab model and identify a suitable provider
- Implement technology enabled care opportunities

Walsall has a fully integrated health and social care offer to deliver intermediate care in the Borough, supporting people to remain independent for as long as possible, particularly following a stay in hospital. The model is nationally recognised and

continually delivers excellent performance as well as supporting Walsall Manor Hospital to maintain good flow. Despite continued high performance, the service has experienced unprecedented rise in demand, which poses a risk to future sustainability. Work is already in progress to meet the objectives outlined about. This will be achieved through the efficient use of resources and skilled multidisciplinary teams who will deliver high-impact care within a financially sustainable framework.

Urgent Neighbourhood Services

> Review the demand and capacity for our urgent care pathways, ensuring that individual care plans are visible across our urgent care portals, and aligning care pathways to enable future Neighbourhood Teams to support with admissions avoidance.

We have implemented a range of successful services in recent years across community health services, general practice and social care, that support people in crisis and those requiring urgent access to care and support. The demand and capacity review will inform future planning and design, ensure urgent care pathways for target cohort are well defined and data sharing enables support to those people at point of crisis.

Distributive Leadership Driving Transformational Change

Leadership from across all sectors and partners plays a crucial role in inspiring a collective movement that showcases the tangible benefits to both citizens and the workforce.

Walsall Together is long-standing and nationally recognised, with formal awards and a strong external profile. More importantly, there is a deeply embedded culture of collaboration that is evident to those who work in and visit the borough. This culture, built on trust, relationships, shared accountability and a commitment to improving outcomes. It reflects the place-based development principles set out in our vision: working with communities, not just for them, and shaping services around the strengths of Walsall.

The vision for the Place Integrated Commissioning Committee is to provide strategic leadership through joint commissioning to improve outcomes, drive integration and deliver value for money in Walsall. Central to this is a model of distributive leadership, as outlined in our strategy and supporting development papers, where leadership is not held by a single organisation but shared across partners. Through shared leadership and distributed decision-making, the Committee will leverage pooled resources, collective expertise and system insight to meet national policy requirements while delivering on the borough's ambitions.

This approach transcends traditional commissioning boundaries, shifting power more evenly to partners in the NHS, local authority, social housing and Volunteer, Community, Faith and Social Enterprise organisations.

Through our governance model, shared leadership and collaboration across all partners enable integrated decision-making, joint commissioning, and the collective action needed to improve outcomes and deliver value for Walsall's communities.

Empowering staff to deliver care in new and flexible ways allows services to be tailored to individual needs, facilitating a shift from treatment-focused approaches toward prevention.

To support meaningful engagement and ensure community voices are central to the development of neighbourhood health and care, we have recruited an individual with lived experience and experiencing in bringing insight from some of our most vulnerable citizens and those furthest away from services. We have included the following outcomes into a service level agreement for the individual to work to:

- Planning for the health priorities in the neighbourhoods of Walsall will be improved with a consideration of diverse communities, leading to increased trust and improved health and wellbeing outcomes for those communities
- The wider population health approach will meaningfully include citizen voice elements which are recent and integrated with wider data

Measuring Meaningful Outcomes

To ensure the effectiveness of care delivery and system-wide improvements, it is essential to measure outcomes that genuinely reflect the needs and experiences of the population. By focusing on outcomes that are meaningful, organisations can better assess the impact of their initiatives and identify areas for further enhancement.

The **Walsall Wellbeing Outcomes Framework (WWOF)** is fundamental to how we commission, deliver and evaluate neighbourhood health and care in Walsall. It ensures that services are designed around the holistic needs of individuals rather than organisational boundaries or single-issue interventions. By defining nine interconnected fundamentals of wellbeing, the Walsall Wellbeing Outcomes Framework recognises that health outcomes are shaped not only by clinical care, but also by housing, employment, social connection, mental wellbeing, safety and financial stability.

Embedding the Walsall Wellbeing Outcomes Framework into commissioning means that contracts are increasingly framed around outcomes that matter to people, rather than activity alone. Providers are expected to demonstrate how their services contribute to improvements across multiple wellbeing domains, encouraging

integrated working and reducing siloed delivery. For frontline teams, the framework supports strengths-based, person-centred practice, enabling professionals to consider the full context of an individual's life when developing care and support plans.

In evaluation, the Walsall Wellbeing Outcomes Framework allows outcomes to be measured at four levels: population, system, service and individual. This creates a clear line of sight from strategic priorities in the Joint Health and Wellbeing Strategy through to the lived experience of residents. Ultimately, the Walsall Wellbeing Outcomes Framework provides the shared language and accountability framework that underpins prevention, integration and meaningful impact across Walsall's neighbourhood health model.

The following table shows the types of drivers and therefore measures that could be included against a Health & Well Being Strategy or Walsall Neighbourhood Health & Care Plan that goes beyond what Walsall Together would deliver.

Fundamental	I-Statement (adults)	Key Drivers (from WWOF)	
1. Health	"I feel good and well."	• Healthy behaviours (physical activity, diet, sleep) • Prevention (vaccination, screening)	• Long-term condition management • Resilience & self-care
2. Meaningful Connections	"I have people in my life who make me feel happy and safe."	• Social contact opportunities • Community belonging • Trust and social capital	• Inclusion • Quality of relationships
3. Meaningful Activity	"I have a sense of identity and purpose."	• Access to meaningful work • Participation in leisure, cultural and social activity • Motivation, confidence, skills	• Community involvement • Cultural/faith-based participation
4. Digital	"I have the knowledge and skills to get online."	• Digital infrastructure (signal, fibre) • Access to devices • Digital security	• Cost and affordability • Digital skills, confidence & capability
5. Where We Live	"I live in a safe, secure and comfortable place."	• Housing quality & affordability • Neighbourhood safety • Cleanliness & green spaces	• Local amenities • Community cohesion
6. Education & Training	"I am confident in applying my knowledge, skills and abilities."	• Access to education & training • Foundational and vocational skills • Digital literacy	• Confidence & self-efficacy • Connection to employment pathways
7. Access to Transport	"I can get to the places and people that matter to me."	• Transport availability • Affordability • Accessibility (physical and digital)	• Reliability and safety of services • Active travel opportunities
8. Co-creation	"I am able to influence what is important to me."	• Ability to influence • Political participation (voting/contacting representatives) • Engagement in funding, policy & service design	• Beliefs, values & expectations • Opportunities for meaningful engagement
9. Money	"I have enough money to live comfortably."	• Employment & secure income • Financial literacy & budgeting skills • Affordability of essentials	• Access to benefits/support • Ability to save & plan for future

The following table shows some initial identified measures that would apply to Walsall Together, if it was commissioned to deliver neighbourhood health and care services. The population level outcomes are described in the Joint Strategic Needs Assessment and Health & Well Being Strategy. System level outcomes are those that we are accountable for as individual organisations and expected to deliver against. Service level outcomes describe potential outcomes for neighbourhood health. Individual outcomes are self-reported, often qualitatively, by our residents.

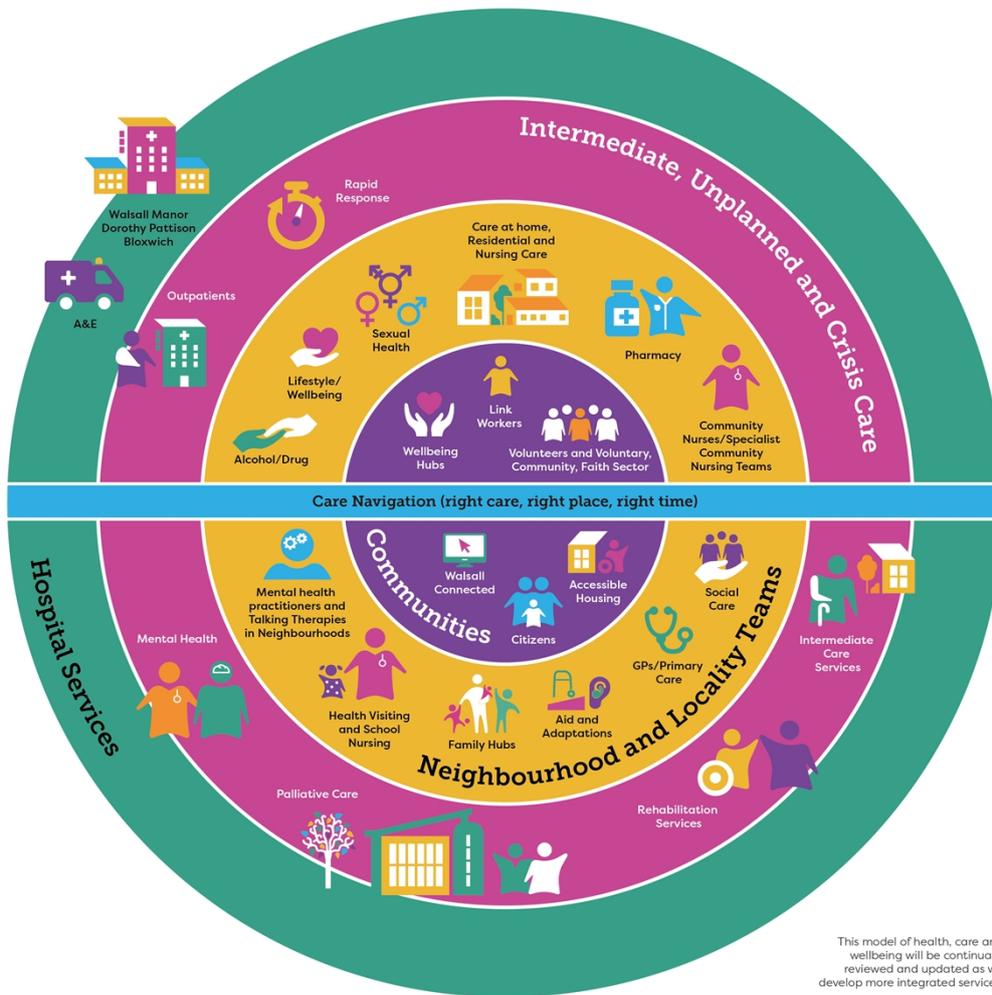| Fundamental	Population level outcomes JSNA, JHWBS	System level outcomes NHS, PHOF, ASCOF	Service level outcomes Neighbourhood Health & Care	Individual outcomes Self Reported
Health	• Healthy Life expectancy • Long term conditions prevalence • Healthy behaviours • Screening and immunisations • Inequalities	• Emergency hospital admissions • Outpatients • GP Access • Community waiting times	• Long term conditions control • Personalised care and support plans • Medicines optimisation • Long-term care packages	• Wellbeing (WEMWBS, ONS4) • Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)
Money	• Economic inactivity due to poor health • Households in relative low income	• Recruitment and retention rates • Sickness due to MSK • Uptake of support e.g. household support fund, Holiday Activity & Food programme	• Work 4 Health and Work Well • Signposting to advice about financial matters • Safeguarding escalations in relation to financial matters	• Knowing where to go for help with financial matters or benefits
Meaningful Activity	• Participation in cultural/sport activities • Adults reporting good work–life balance	• Volunteering • Availability of community activities, groups	• Referrals/connections to community groups and support	• Participation in new activities that have helped you feel more socially connected
Transport	• Public transport accessibility: travel time to key services (DfT) • Household car access (%)	• DNAs due to lack of transport • Uptake of concessionary bus passes	• Transport assistance (bus passes, referrals to ring & ride)	• Ease of getting around the local area or travel to appointments
Where we Live	• Housing stability • Perceived neighbourhood safety • Local environment satisfaction	• Respiratory illness related to housing or environment conditions • Hospital discharges impacted by living conditions	• Home hazard assessments • Referrals for housing, repairs, aids and adaptations	• Feeling safe and comfortable at home and happy with the people who come in to support you
Co-creation	• % feeling able to influence local decisions (LG Inform) • Citizen voice themes e.g. WAW2040	• Co-production and co-design in neighbourhood health and care	• Involvement in care planning, what matters to me? conversations	• Choice and control in care plan • Feeling more independent or confident in managing your life
Education & Training	• Aspiration • Adult qualification levels	• Workforce development and upskilling	• Signposting to training and education opportunities	• Knowledge and confidence to get involved with activities and services
Meaningful Connections	• Loneliness and isolation	• Contacts with services due to loneliness or isolation	• Engagement of family, friends, neighbours and carers to support needs and outcomes • Signposting to social activities	• Reduced burden or stress on family and carers • Meaningful relationships with family, friends, neighbours, carers
Digital	• Digital poverty • Safe digital spaces	• NHS App usage • Online consultations	• Self referrals and self-help • Wellbeing directory of services • Electronic prescribing • Remote monitoring and Technology Enabled Care (TEC)	• Confidence in using the internet or digital tools to get information or support

Section 2: Operational Plan

Walsall Together Partnership: Foundations for Neighbourhood Health Improvement

Walsall already has strong partnership working through the Walsall Together Partnership. The overarching aim and ambition for the partnership is to improve the health and wellbeing outcomes of Walsall residents through integration in line with our agreed model of health, care and wellbeing. Walsall Together is long standing and successful with formal recognition in the form of awards as well as a high profile nationally. There is a strong culture of collaboration that is clear to those that visit us and is a source of pride across our workforce from board members through to our frontline teams. We want to continue to stand out from the crowd and be bold in our approach whilst not losing sight of why we work together in this way.

Walsall Healthcare NHS Trust acts as the host organisation. All partners operate under an Alliance Agreement, enabling shared decision-making and collective accountability for improving health and wellbeing outcomes.

The Health & Well Being Board will hold Walsall Together to account for its share of delivery of the Neighbourhood Health & Care Plan. The Place Integrated Commissioning Committee will commission the Walsall Together partnership to deliver health, care and wellbeing services. Walsall Together will deliver the 6 components of neighbourhood health, aligning delivery of health, care and wellbeing services. It will support joint planning, including contributions to the Walsall Neighbourhood Health & Care Plan and Joint Health & Well Being Strategy.

The Walsall Together Strategy, which sits alongside Walsall's Health and Well Being Strategy, is a three-year plan to improve physical and mental health, promote wellbeing, and reduce health inequalities in Walsall. It paves the way for the neighbourhood health model. The strategy focuses on working collaboratively, supporting residents to manage their own health, and taking a strengths-based approach. Key priorities include improving mental wellbeing, supporting children and young people, and helping older people remain independent.

This model of health, care and wellbeing will be continually reviewed and updated as we develop more integrated services.

Following publication of the NHS 10-year plan, the Department of Health & Social Care released an open invitation for Places to apply to participate in a National Neighbourhood Health Implementation Programme (NNHIP). In September, Walsall was confirmed as one of 43 places that would form part of the first wave of the programme.

The national neighbourhood health guidelines were published in February 2025, 2 months after the publication of the Walsall Together strategy. The NHS Neighbourhood Health Guidelines describe a broad offer of support, connecting planned and unplanned needs, integrating across key partners and inclusive of all ages, complex physical disabilities, and multiple LTCs. There is explicit reference to aligning with other offers such as mental health centres, women's hubs and family hubs. Helpfully, the national model reflects the core elements of the existing Walsall Together model of health, care and wellbeing and is fully aligned with the ambition of the partnership.

To demonstrate this alignment, and to ensure we are focussed on how we deliver our model across our neighbourhoods, we have translated the core components of our model into the following neighbourhood approach:

- Intermediate, unplanned and crisis care is delivered at borough level (shown in pink)
- Integrated neighbourhood teams and family hubs operate at neighbourhood (7 PCN-aligned areas) and locality level (north, east, south and west) (shown in yellow)
- Neighbourhood and locality teams are fully aligned to wellbeing networks, our communities offering of holistic wellbeing and wider determinants support (shown in purple)
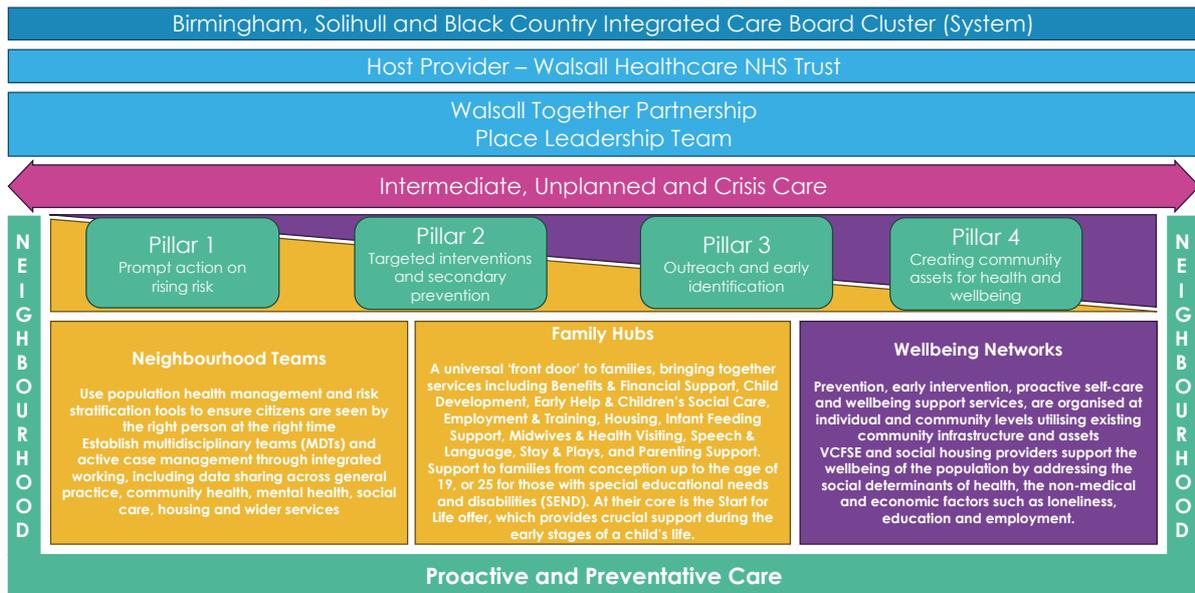
More recently, the DHSC has published six steps to follow to ensure that neighbourhood healthcare is developed across England during 2026/27. These are as follows:

Step 1:   Agree neighbourhood footprints around natural communities of approximately 50,000 people (that the public can recognise, and GPs, trusts, local authority partners and VCSE services can see their teams working together in).

Step 2:   Agreeing a plan for tackling unwarranted variation in access to high quality general practice

Step 3:   Continuing to improve relationships and performance across the primary and secondary care interface by implementing the recommendations of the Red Tape Challenge

Step 4:   Agreeing plans to establish integrated neighbourhood teams (INTs) focused on high priority cohorts (people who have moderate to severe

frailty, people living in a care home, people who are housebound or people at the end of life) at a single neighbourhood level.

Step 5:   Agreeing an initial plan with partners to reduce non-elective admissions and bed days by increasing capacity for urgent, rehabilitation and reablement services across multiple neighbourhoods

Step 6:   Starting to plan for a new neighbourhood approach for elective pathways

The following table shows Walsall's current maturity assessment against these 6 steps.

Six Steps

Walsall Together

1 = Just started
2 = More Planning Needed
3 = High Confidence Completed by March 2026
4 = Complete

Component	Maturity Score (1-4)	Update
Agree neighbourhood footprint	4	7 Neighbourhoods linked to co-terminus with the 7 PCNs (Population between 30-50k) - North - East 1 - East 2 - South 1 - South 2 - West 1 - West 2 across 4 localities. Family Hubs aligned
Ensure good access to high quality general practice	4	49/49 practices are now compliant with the same day online consultation responses, so 0% are **not** compliant. 47/49 practice are now compliant with maintaining all three access routes throughout core hours, so 4% **not** compliant. One practice will be compliant next week and the other mid-March.
Implement recommendations from Red Tape Challenge and Bridging the Gap	3	High level system plan in place with supporting Oversight and Assurance Group. A Joint Clinical Forum is in place between primary and secondary care that includes community services and will be expanded to include mental health. A Clinical and Professional Leadership Group is also in place to progress strategic and transformation development, and a Partnership Operational Group is also being established.
Agree out of hospital UEC plan/capacities (UCR, hospital at home, SPOA)	3	There are a number of commissioned services in place to provide UCR response and an established Single Point of Access/Care Navigation. We have reflected but require further understanding of contract changes and model. We have an Intermediate and Crisis Care Group in place in the partnership.
Agree plans for INTs – put on a contractual footing	3	Each NT is utilising population health data and risk stratification tools to identify sub-sets of these, including: 1. Dementia and Polypharmacy, 2. Early Palliative recognition 3. Diabetes and obesity 4. High frequency Service Use
Agree specialties for OPD remodelling and plan how to implement	3	Outpatient's transformation planning commenced November 2025

Integrated Commissioning & Transformation Plan

Walsall Together has an Integrated Commissioning & Transformation Plan, with several key workstreams aligned to delivery of the 6 components of neighbourhood health and care.

Component	WT Programme Alignment
Population Health Management	Neighbourhood Teams Project
Modern General Practice	Integrated Care Board and Primary Care led within Neighbourhood & Locality Teams workstream
Standardising Community Health Services	Neighbourhood Teams Project

Neighbourhood Multidisciplinary Teams	Neighbourhood Teams Project
Integrated Intermediate Care with Home First Approach	Intermediate, Unplanned & Crisis Care workstream
Urgent Neighbourhood Services	Neighbourhood Teams Project

Progress and Priorities for 2026/27

1.Population Health Management

We have and are evaluating a range of risk stratification tools that support direct patient care within general practices. This includes EARLY risk stratification, Integrated Care Board -developed modelling using Graphnet with the John Hopkins, and PRADA for complex care cases at end of life. To incentive practices to engage with the new tools and concept of proactive identification of at-risk individuals, the Integrated Care Board have aligned payments with the Primary Care Network Directed Enhanced Service (DES) and the local Primary Care Offer incentive scheme. All practices are signed up to the schemes, which incentivise proactive care planning, targeted interventions, and digital and data infrastructure.

- Expanding the use of a Shared Care Record that links data from GPs, hospitals, community, mental health, and social care services, with exploration of extending this to housing and Voluntary, Community, Faith, and Social Enterprise sectors. Although, this is currently being reviewed in line with the revised Integrated Care Board Digital Strategy and priorities given the NHS 10 Year-Plan
- Developing an analytics platform to enable segmentation, risk stratification, and predictive modelling, supported by real-time dashboards for multidisciplinary teams (MDTs) and neighbourhoods displaying patient and population data.
- Ensuring robust data governance and Information Governance (IG) compliance throughout the system.

2. Modern General Practice

This component sits outside of the responsibilities of the Walsall Together partnership and is implemented by the Integrated Care Board and general practices. We have agreed reporting lines into the partnership for visibility and to ensure a rounded reporting pictures inclusive of all components. As of the end of November, 43 out of 48 practices have achieved level 4 (the highest level) MGP status, with some challenge on core hours in 16 practices; 5 are outstanding and there is an action plans in place to support them in attaining level 4 status.

  - Implementing a unified digital front door for booking, triage, and self-care tools, delivered in line with contractual requirements for general practice.

- Promoting the integration of AI-assisted triage with the NHS App to enhance patient experience and access.

3. Standardising Community Health Services

This component is focussed on developing commissioning and funding flows to support the transition from current contracts and service models towards alternatives that increase the focus on outcomes and encourage integrated delivery of more holistic care and support to individuals and households. There needs to be a specific focus on ensuring care is planned to meet all health and social care needs and that service boundaries do not prevent seamless, joined-up care. The following key deliverables are in progress:

- Agreeing an approach to defining measurable outcomes for each of the 9 fundamentals of wellbeing in the Walsall Wellbeing Outcomes Framework. These will be categorised into outcomes at population level (Joint Strategic needs Assessment), system level (statutory targets), service level (neighbourhood teams), and individual level (self-reported wellbeing).
- Agreeing key outcomes for inclusion in 2026/27 contracts
- Agree place joint commissioning arrangements between Integrated Care Board and Walsall Council

4. Neighbourhood Multi-disciplinary Teams (MDTs)
- Supporting integrated neighbourhood working with multi-disciplinary team meetings to address complex care management and proactive population health.
- Whole system care utilisation and asset mapping to drive the shift in capacity from hospital to community and neighbourhoods
- Creating an operational implementation plan for weekly MDTs in each neighbourhood team, including the necessary workforce for each meeting and ensuring safe disposition of service users with appropriate care plans.
- Embedding MDT and neighbourhood collaboration to foster integrated working, developing models to remove duplication and encourage efficiency, ultimately releasing capacity for community-based care.
- Focusing on defined cohorts and using a population health approach to develop and test innovative models of care delivery.
- Developing a model for a Community Electronic Patient Record (EPR) shared across nursing, therapies, and social care, including mobile solutions for real-time data entry.
- Strengthening links through social prescribing and collaboration with the voluntary sector, social housing, PH commissioned services, employment.

5. Integrated Intermediate Care with a 'Home First' Approach
- Developing a 'Home First' dashboard that connects hospital, community, and social care data. – due for delivery in 26/27.

- Exploring digital opportunities such as home monitoring with Technology Enabled Care (TEC) devices (in NHS and social care), virtual wards for remote management, digital triage for step-up/step-down care pathways, and integrated discharge dashboards to monitor patient flow from acute to community settings.
- Bed based rehab unit
- Staffing model for Intermediate Care Services

6. *Urgent Neighbourhood Services*

We need care plans available to urgent care portals, we might have opportunity to align Urgent Treatment Centre and GP Out Of Hours

- Expanding the Single Point of Access digital hub to link NHS 111, Urgent Community Response (UCR), and primary care services.
- Exploring further digital opportunities, including real-time capacity maps of services and teams, mobile access to clinical records for rapid response, and decision support tools for clinicians.
- Integrating NHS 111, ambulance triage, and urgent community teams through a unified digital platform to streamline urgent care response.
- A case is being explored for delivery in 26/27.

Building our Neighbourhood Health Service Together

Setting the direction of travel
March 2026 position statement

OneWolverhampton - working in partnership: Black Country Healthcare NHS Foundation Trust; City of Wolverhampton Council; Compton Care; Healthwatch Wolverhampton; NHS Black Country Integrated Care Board; Primary Care Networks; The Royal Wolverhampton NHS Trust; West Midlands Ambulance Service; Wolverhampton Homes; Wolverhampton Voluntary and Community Action.

What is neighbourhood health?[1]

JOINED-UP CARE

bringing together services across the NHS, social care, and community organisations to work together rather than in isolation

PREVENTION

helping people stay well and preventing illnesses from developing or getting worse

PERSONALISED CARE

giving people more choice and control over their care

CARE CLOSER TO HOME

providing more services within the communities where people live

COMMUNITY LED APPROACHES TO CARE

making the voices of people and communities central to how health and care services are designed, delivered and evaluated

PLACE-BASED CARE

devolving budgets, service planning and decision-making to a local level

[1] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-neighbourhood-health

Contents

Neighbourhood Health is about bringing care closer to home, helping people stay well for longer, and reducing unnecessary time spent in hospital or care homes.

Foreword

I am proud to be the Chair of Health and Wellbeing Together[2]. This is a statutory board where leaders from the health, care and wider system come together to work collectively to reduce health inequalities, support the development of improved and joined up health and social care services and set the strategic direction to improve the health and wellbeing of local people.

Our aim is to build a healthier city and neighbourhoods, where local people feel good and can live longer, more active lives, and where every child in the city has the best start to life.

This will be achieved by better connecting and maximising health and care resource through the three key shifts at the core of the government's health mission[3]:

- from *hospital to community* – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
- from *treatment to prevention* – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health.
- from *analogue to digital* – greater use of digital infrastructure and solutions to improve care.

Over the next few months, we will be building our **Neighbourhood Health Plan together**, including through on-going public and stakeholder engagement sessions. At the heart of our approach is a commitment for health, social care, and wider partners, such as the voluntary, community, faith, and social enterprise sector, to embed integrated working as the norm, and not the exception.

To be successful will mean working in new and different ways and embracing the opportunities set out in the NHS Ten Year Health Plan to build and deliver a new Neighbourhood Health Service for the city.

In Wolverhampton, this work is being driven through our OneWolverhampton partnership, with Health and Wellbeing Together playing a key strategic leadership role.

This document sets out our direction of travel, our immediate areas of focus and longer-term ambitions as we develop our local Neighbourhood Health Plan together.

Councillor Obaida Ahmed

Chair, Health and Wellbeing Together

Cabinet Member for Health, Wellbeing and Community

[2] https://wellbeingwolves.co.uk/
[3] https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

Our Approach – setting the direction for travel

NATIONAL GUIDANCE

Neighbourhood health seeks to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care.

This diagram shows the aims for all neighbourhoods over the next 5 to 10 years:

NHS and social care working together to prevent people spending unnecessary time in hospital or care homes

Strengthening primary and community based care to enable more people to be supported closer to home or work

Connecting people accessing health and care to wider public services and third sector support, including social care, public health and other local government services

It sets the national direction of travel for Neighbourhood Health - starting with a focus on the innermost circle to prevent people spending unnecessary time in hospital and care homes, and as core relationships between local partners continue to grow stronger, increasing focus on the outer circles.

In the immediate term Neighbourhood Health is expected to focus on six core components and six related steps, as outlined in the Priorities section of this document.

WOLVERHAMPTON'S APPROACH

Our approach to Neighbourhood Health is being developed through the OneWolverhampton Partnership.

Work has already taken place to identify the relevant neighbourhood geography for the city, informed by our Family Hub footprints, and four Integrated Neighbourhood Team clinical leads have subsequently been appointed.

Public and stakeholder engagement is actively taking place to shape and co-design local priorities and appropriate delivery infrastructure for each neighbourhood.

This document sets out our immediate direction of travel as we co-produce our vision for Neighbourhood Health in the city together.

Our Principles

Our principles set out how we will work together to develop and implement the vision for Neighbourhood Health in Wolverhampton.

WE COMMIT TO	THIS MEANS WE WILL
Working together to prioritise and address the complex health and care issues faced by the city	• Identify priorities collaboratively and focus on a genuinely shared agenda aimed at improving outcomes for citizens. • Share data openly (where legal and appropriate) to build a holistic view of population needs, experiences and preferences. • Coordinate engagement with communities and cohorts across partners.
Collaboratively (re-)design the services that respond to population need so they better align to our shared outcomes	• Redesign services based on population health intelligence and evidence, not historic configuration. • Identify opportunities to embed prevention, focusing on maintaining health and preventing illness from developing or worsening, and working in partnership to address the wider determinants of health. • Integrate teams where this improves outcomes, with clear roles, funding and operational arrangements. • Use each other's insights to improve and innovate in-scope services.
Working together with local people to ensure they remain at the heart of decision making	• Communicate early, openly and accessibly; seek regular feedback and demonstrate impact. • Ensure involvement is meaningful and inclusive, and support partners to develop participation skills. • Adopt a strength based and trauma informed approach, focused on capabilities, protective factors and assets.
An all-age approach, built on Families First principles	• Design, deliver and commission services that work across the whole life course. • Recognise that health, wellbeing and care needs are interconnected across ages, and that what happens at one stage of life affects outcomes later on. • Ensure that support is centred on families as a whole, intervenes early, and prevents escalation of need

Section 1

OUR PRIORITIES FOR 2026-2027, LONGER TERM VISION AND STRATEGIC DIRECTION, ALIGNED TO OUR JOINT LOCAL HEALTH AND WELLBEING STRATEGY.

Priorities for 2026-2027

The national ambition is to support neighbourhoods in evolving over the next five to ten years. For 2026, the priority is to strengthen the core foundations of neighbourhood health by **scaling and standardising six core components of neighbourhood health** outlined in the NHS England Guidance[4]. This will help reduce unnecessary time spent in hospitals or care homes by supporting people earlier and closer to home.

Component	Description
Population Health Management	Data-driven risk stratification using integrated datasets
Modern General Practice	Enhanced access, continuity, personalised care
Standardised Community Health Services	Consistent, locally tailored community services
Neighbourhood Multidisciplinary Teams (MDTs) / Integrated Neighbourhood Teams (INTs)	Collaborative teams across health, social care, voluntary sectors
Integrated Intermediate Care ("Home First")	Short-term, community-based recovery support to avoid hospital admissions
Urgent Neighbourhood Services	Rapid local response to urgent health needs

[4] https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/

These are to be accompanied by six key steps:

1 Agree neighbourhood footprint

2 Ensure good access to high quality General Practice

3 Implement recommendations from Red Tape Challenge and Bridging the Gap (Primary Secondary Care Interface)

4 Agree out of Hospital Urgent and Emergency Care Plan/capacities (e.g. Urgent Community Response, hospital at home, Single Point of Access)

5 Agree plans for Integrated Neighbourhood Teams and put on a contractual footing

6 Agree specialities for Outpatients Department remodelling and plan how to implement

Section 2 sets out our approach to developing an operational plan for delivering against these.

Strengthening the foundations of neighbourhood health.

Our Neighbourhoods

The first of the six steps to successful implementation of Neighbourhood Health is agreeing neighbourhood footprints for the city.

We understand that the term 'neighbourhood' can mean different things in different contexts, therefore we have been working with local people and partners to identify neighbourhood geographies that makes sense to local people and work best for Wolverhampton.

In our city we recognise the importance of Families First principles and a life-course approach, meaning looking at a person's life as a whole journey – from before birth, through childhood, adulthood and into old age – and understanding how experiences at one stage affect health and wellbeing later on.

For this reason, we have identified four neighbourhood footprints informed by the location of our existing Family Hubs – to ensure a shared geography and improved transitions between children's and adult services. These geographies are: North, South, East, and West.

NORTH population size 59,212

EAST population size 66,502

WEST population size 97,231

SOUTH population size 68,167

WHAT ARE INTEGRATED NEIGHBOURHOOD TEAMS?

Having agreed our neighbourhood geographies we are now in the process of establishing the operational workforce that will deliver components of our Neighbourhood Health vision on a day-to-day basis.

These Integrated Neighbourhood Teams (INTs) will be local, multidisciplinary teams that bring together, health, social care, voluntary sector and community services. They will provide proactive, joined up and coordinated care – particularly for people with complex needs, improving patient outcomes by avoiding fragmented care. Each INT has appointed a GP clinical lead to represent primary care to support this work. INTs will necessarily start small as we work together to grow the approach based on local priorities and needs.

Understanding these local priorities and needs is therefore key. To support meaningful engagement and ensure community voices are central to the development of the INT model, a comprehensive involvement strategy has been taking place. This includes quarterly INT engagement sessions designed to maintain a continuous feedback loop with local residents.

Our first step in this process is building a deep, shared picture of the needs of each neighbourhood, working with professionals and our communities, to focus on:

The top health challenges
in local areas

Which groups are falling through
the cracks

Where demand and service pressures
are most acute

This will help us ensure we build our INTs around real population needs and not organisational structures.

This feedback is also being triangulated with data from Wolverhampton's Joint Strategic Needs Assessments (JSNAs) and Population Health Management intelligence.

NEIGHBOURHOOD
COHORT

Population Health Management
- risk stratification

Joint Strategic
Needs Assesment

Involvement
Data
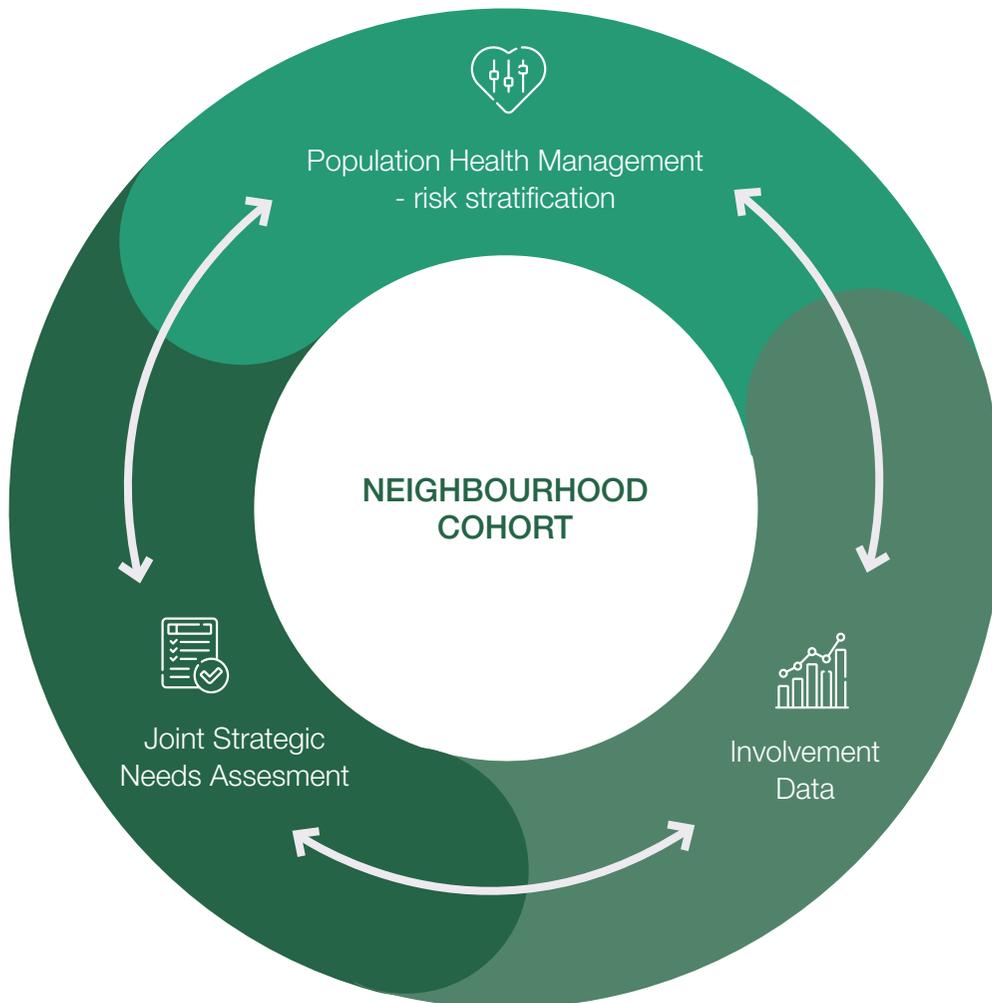
OUR AMBITION FOR INTS

Through this work our ambitions for INTs over the next 12 months are to operationalise each INT based on an agreed set of local priorities and develop an outcomes framework using local intelligence to provide a strategic tool for INT leadership, aligning neighbourhood development around shared wellbeing priorities and outcomes.

Alignment with Health and Wellbeing Together Priorities

In 2023 Health and Wellbeing Together published its Joint Local Health and Wellbeing strategy for the city[5]. This was informed by the city's Joint Strategic Needs Assessment (JSNA), the views of local people, other community feedback and local data.

The strategy outlines the board's role in coordinating and maintaining strategic oversight of activity to improve quality and access of care and promote mental health and wellbeing, alongside a collective commitment to address health inequalities.

It also details how the board will progress its three key priority areas:

1 starting and growing well

2 reducing addiction harm

3 getting Wolverhampton moving

Health and Wellbeing Together also has a statutory role in signing off the local Better Care Fund plan and providing governance oversight of the pooled fund arrangements.

Over the course of 2027 work will commence to refresh the current Joint Local Health and Wellbeing Strategy in conjunction with the new Neighbourhood Health Plan and ensure alignment with the Better Care Fund reform objectives, so there is a single joined-up strategic vision for the city.

During this period the governance of Health and Wellbeing Together and the OneWolverhampton partnership will be kept under review to ensure it remains fit for purpose and takes into account the changing role of the ICB as strategic commissioner, increasingly devolving decision making to Wolverhampton's Place Integrated Commissioning Committee.

2023
Joint Local Health and Wellbeing Strategy published

2025-2027
NHS Ten Year Plan, Neighbourhood Health Guidelines and Better Care Framework

2027
Strategy refresh and alignment

[5] https://wellbeingwolves.co.uk/pdf/Wolverhampton-Joint-Local-Health-and-Wellbeing-Strategy-2023-2028-Final.pdf

JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2023-2028

Priorities on a Page

Mental health and wellbeing – Creating the conditions for every resident in the city to have the best mental health and wellbeing that they can at every stage of their life.

Smoking

Alcohol harm

Drug misuse

Gambling harm

Reducing addiction harm

First 1001 days

Good level of development and school readiness

Emotional health and wellbeing

Home environment

Starting and growing well

Quality and access of care

Closing the health inequalities gap

Getting Wolverhampton moving

Active city

Active spaces and places

Active Wulfrunians

Active system

Workforce

Digital

Community empowerment

Alignment with the Better Care Fund Priorities

The Better Care Fund (BCF) programme supports local systems to deliver integrated health, housing and social care in a way that promotes person-centred care, sustainability, and improved outcomes for people and carers.

The programme represents a unique collaboration between:

These four partners work closely together to support local areas to plan and implement integrated health and social care services across England, in line with the vision set out in the NHS Long Term Plan. At a local level, the programme spans both the NHS and Local Government, enabling greater alignment of health and care services so that people are supported to manage their own health and wellbeing and to live independently within their communities for as long as possible.

BETTER CARE FUND FRAMEWORK 2026-2027

Looking ahead, the BCF will evolve in response to national policy changes. In particular, the 2026/27 framework emphasises linking assurance to neighbourhood health plans and measurable local goals, rather than solely national conditions. This will have implications for funding structures, programme categories and delivery approaches at place level.

As a result, 2026/27 will be treated as a transitional year, with a requirement for a one-year plan. It is recognised that for this first year of BCF reform, it will not be possible to comprehensively integrate BCF planning and neighbourhood health planning. However, Health and Wellbeing Boards, ICBs and Local Authorities are expected to take a pragmatic approach to linking BCF plans with local priorities for more integrated health and social care.

The 2026/27 Framework Guidance places particular emphasis on strengthening intermediate care; reducing non-elective admissions for people aged 65 and over; minimising delayed discharges; improving reablement outcomes; delivering integrated home adaptations; and reducing demand for long-term residential and nursing care. It also highlights the importance of enhanced support for unpaid carers and deeper integration with the VCSE sector in delivering the overall objectives of the BCF.

From 2027/28 onwards, systems will be expected to develop longer-term plans that incorporate the substantive ambitions and long-term elements of this reform.

OUR OPERATIONAL PLAN, ALIGNED TO THE NHS MEDIUM TERM PLANNING GUIDANCE.

Operational Plan

This Operational Plan sets out how Wolverhampton will deliver its Neighbourhood Health Plan in 2026/27. It aligns to the NHS Medium Term Planning Framework (2026/27-2028/29) and NHS England's Neighbourhood Health Guidelines (2025/26).

OBJECTIVES, SCOPE AND PLANNING ASSUMPTIONS

Primary objective (2026/27): Stand-up and embed neighbourhood delivery focused on people with complex needs; reduce avoidable hospital use and time in care homes by enabling care closer to home through Population Health Management led Multidisciplinary Teams (MDTs), Urgent Community Response and Home First pathways.

Scope: Deliver the six components:

Population Health Management

Modern General Practice

Standardised Community Services

INTs/MDTs

Integrated Intermediate Care (Home First)

Urgent Neighbourhood Services

Life-course / "Think Family" approach with INT footprints mapped to Family Hubs to support transitions.

Medium-term planning trajectories apply; quarterly reporting to Place/Health and Wellbeing Board with annual refresh for 2027/28.

Delivering neighbourhood health in 2026–27

Delivery Workstreams

HIGH-LEVEL SUMMARY (ONGOING DEVELOPMENT)

Workstream 1:
Population Health Management and Intelligence

We continue to develop shared data arrangements, a common data dictionary and cohort definitions across all neighbourhood teams. Work is ongoing to refine dashboards, risk-stratified lists and routine reporting to support improvement and equity reviews.

In development:

- Shared data agreements and data standards
- Priority cohort definitions with equality considerations
- Neighbourhood dashboards and risk-based workflows
- Routine improvement and reporting processes

Workstream 2
Modern General Practice Adoption and Interface

Practices are continuing to embed Modern General Practice capabilities and strengthen access models. Work remains underway to align general practice activity with neighborhood multidisciplinary teams and develop continuity approaches for residents with complex needs.

In development:

- Consistent Modern General Practice adoption
- Blended access and structured information capture
- Single workflow into multidisciplinary team referral
- Continuity lists for residents with complex or long-term conditions

Workstream 3
Standardised Community Health Services

Partners are working toward a consistent community service offer across all neighbourhoods. Development includes shared referral standards, common documentation, minimum datasets and focused equity assessments.

In development:

- Standardised service menu and referral criteria
- Shared assessment and care-planning documentation
- Common datasets
- Equity reviews and targeted outreach

Workstream 4

Integrated Neighbourhood Teams and Multidisciplinary Team Operations

Neighbourhood teams continue to embed leadership structures, membership and operating models. Weekly multidisciplinary team processes, escalation pathways, shared care planning and all-age approaches linked to Family Hubs are being developed and refined.

In development:

- Neighbourhood team leadership and operating structure
- Weekly multidisciplinary team processes
- Escalation and step-up/step-down pathways
- All-age huddles and professional development sessions
- Consistent shared care-planning

Workstream 5

Integrated Intermediate Care (Home First)

Work is ongoing to align investment with community-based recovery, redesign transfer of care processes and expand technology-enabled care to support independence and flow.

In development:

- Intermediate care funding alignment
- Redesigned transfer of care pathways
- Technology-enabled support for step-up and step-down
- Improvements in flow and reablement outcomes

Workstream 6

Urgent Neighbourhood Services (Urgent Community Response and Crisis)

The urgent community model continues to strengthen through clearer operating standards, visibility on national directories and rapid multidisciplinary follow-up. Interfaces between primary care, urgent community response and Home First are being formalised.

In development:

- Two-hour urgent community response operating model
- Directory of Services and online access visibility
- Rapid multidisciplinary team follow-up
- Shared interface standards across services

ENABLERS (ONGOING DEVELOPMENT)

Workforce and Organisational Development

Clarifying roles, cross-skilling across neighbourhood and urgent community services, and strengthening leadership and improvement capability.

Digital and Data

Modern General Practice digital access, shared documentation, population health management dashboards and improved interoperability.

Commissioning and Better Care Fund

Aligning investment with neighbourhood priorities and national requirements.

Estates

Developing co-located neighbourhood spaces linked with Family Hub access points.

High-level Governance Map

Our governance process sets out where responsibility for development, delivery and oversight of our Neighbourhood Health Plan sits in our local health system. Over the coming year we will strengthen the integration of the Better Care Fund with neighbourhood-level priorities, particularly for intermediate care, admission avoidance, discharge pathways, and community-based support.

Health and Wellbeing Together – Wolverhampton's Health and Wellbeing Board

Strategic oversight and leadership of the Neighbourhood Health Plan and Joint Local Health and Wellbeing Strategy

Black Country, Birmingham and Solihull Integrated Care Board Cluster

Strategic commissioners of local health care services informed by the population health improvement plan

OneWolverhampton Place Based Partnership

Development, delivery and accountability for the Neighbourhood Health Plan

Wolverhampton Place Integrated Care Committee

Devolved commissioning responsibilities based on population health need, including commissioning Neighbourhood Health

Integrated Neighbourhood Teams: North, South, East and West

Neighbourhood Health Plan delivery based on local need

Better Care Fund

You can get this information in large print, braille,
audio or in another language by calling 01902 551155
or emailing translations@wolverhampton.gov.uk

wolverhampton.gov.uk **01902 551155**

Tier 1 - Paper ref:	Enclosure 8.2

Report title:	Group Research Performance against the 150-day Standard
Sponsoring executive:	Dr Brian McKaig and Dr Zia Din
Report author:	Pauline Boyle
Meeting title:	Group Trust Board held in Public
Date:	17 March 2026

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

The introduction of the national 150-day target for study set-up and first patient recruitment has provided a renewed focus on operational efficiency across both Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). Performance during the reporting period demonstrates clear areas of strength, particularly in commercial research, where both Trusts continue to attract high-value studies and deliver rapid activation timelines.

Across both organisations, several studies have achieved notable early-recruitment success, with commercial studies consistently outperforming non-commercial timelines. This reflects the strong relationships built with industry partners and the capability of local research teams to mobilise quickly.

While some delays remain in specific pathways, primarily linked to external approvals and capacity constraints, mitigations are in place and are already showing positive impact. The overall trajectory is improving, and both Trusts are well-positioned to meet the national ambition with continued focus.

The Board can be assured that actions taken to streamline governance, strengthen feasibility processes, and enhance cross-Trust collaboration are delivering measurable benefits. Further optimisation is planned to ensure sustained compliance with the 150-day standard.

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 Quality Committee Chair, acting via Chair's Action, has endorsed this paper for Trust Board's information and assurance.

4. Recommendation(s)/Action(s)

The Group Trust Board -held in public, is asked to:

- Note the Group's performance against the national 150-day setup standard across commercial and non-commercial studies.
- Receive the proposed actions, endorsed by the Quality Committee, via Chair's Action, to maintain and strengthen commercial study setup performance, protecting rapid activation timelines and the introduction of AI-enabled tools to support efficient study setup within existing resources

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:		

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

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

Group Research Performance Against the 150 day Standard

1. Executive summary

The introduction of the national 150-day target for study set-up and first patient recruitment has driven significant operational focus across RWT and WHT. Both Trusts have demonstrated strong performance in commercial research, with several studies activated and recruiting within the target window. Commercial studies continue to represent a major strength, with timelines consistently shorter than non-commercial equivalents.

Key achievements include:

- High proportion of commercial studies meeting the 150-day target, reflecting efficient feasibility, contracting, and site-activation processes.
- One Group study set up team, enabling shared learning and streamlined governance.
- Early recruitment success in multiple studies, demonstrating strong engagement from clinical teams.
- Strengthened relationships with industry sponsors, resulting in increased commercial interest and pipeline growth.
- Challenges remain in areas such as capacity constraints and external approval delays, but targeted actions are underway and showing early impact. Overall, the Trusts are progressing positively toward full compliance with the national standard.

2. Introduction or background

The government's new 150-day target requires all NHS organisations to complete study set-up and recruit the first participant within 150 days of receiving a valid research application. This forms part of the national strategy to enhance the UK's competitiveness in clinical research and improve patient access to innovative treatments.

RWT and WHT have responded proactively by:
- Reviewing and streamlining internal governance processes
- Strengthening feasibility assessments
- Enhancing communication between R&D, clinical teams, and external sponsors
- Set up a single study set up team across both Trusts to reduce duplication and variation
- Commercial research has been a particular area of success, with both Trusts demonstrating the ability to activate studies rapidly and deliver early recruitment.

2.1 Performance Overview

The national 150-day standard was formally introduced through the DHSC policy statement on 2 October 2025, with NIHR issuing operational instructions to delivery organisations on 17 December 2025. In line with NIHR reporting rules, the dataset included in this paper covers studies entering the setup pathway from 1 January 2025 to 2 March 2026.

Royal Wolverhampton NHS Trust (RWT) – Performance Breakdown
Commercial Studies (150-day metrics)
17 commercial studies selected since 1 Jan 2025.
65% were confirmed within 60 days.
Median confirmation time: 34 days (faster than regional 55 days).
Median time to first recruit: 31 days.
35% of commercial studies exceeded 60 days for confirmation, and 35% exceeded 30 days for first recruit.

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

Strengths:
Strong early-phase delivery with confirmation timelines above regional performance.
High commercial volume which is indicative of strong sponsor confidence.

Challenges:
Variation across pathways, with 35% not meeting the confirmation or first-recruit thresholds.

Non-Commercial Studies (150-day metrics)
9 non-commercial studies selected since 1 Jan 2025.
78% were confirmed within 60 days.
Median confirmation time: 48 days (slower than regional 36 days).
Median time to first recruit: 26 days.
50% of non-commercial studies achieved first recruit within 30 days; the rest exceeded the target.

Strengths:
Good early recruitment timelines where delivery happens quickly.

Challenges:
Slower governance throughput compared with regional non-commercial timelines.

Walsall Healthcare NHS Trust (WHT) – Performance Breakdown
Commercial Studies (150-day metrics)
3 commercial studies selected since 1 Jan 2025.
100% confirmed within 60 days.
Median confirmation time: 40 days.
100% achieved first recruit within 30 days.
Median time to first recruit: 5 days (exceptionally strong).

Strengths:
Outstanding operational delivery, 100% compliance.
Extremely fast mobilisation, with industry-leading first-recruit timelines.

Challenges:
Smaller commercial portfolio limits the strategic impact compared to RWT.

Non-Commercial Studies (150-day metrics)
3 non-commercial studies selected since 1 Jan 2025.
100% confirmed within 60 days.
Median confirmation time: 14 days.
100% achieved first recruit within 30 days.
Median time to first recruit: 15 days.

Strengths:
Excellent compliance across all 150-day measures.

Challenges:
Very low volume of non-commercial studies reduces Trust-wide research breadth, however, WHT has been selected for seven new commercial studies starting between April and July 2026
2.2 Combined Group Summary

Commercial Performance (RWT & WHT)
Both Trusts demonstrate strong commercial delivery.

WHT achieves 100% compliance for both 60- and 30-day metrics.

RWT delivers substantial commercial volume with 65% compliance on 60-day setup and strong median times.

Commercial mobilisation is consistently faster and more predictable than non-commercial at both Trusts.

Overall:
The Group's commercial offer is high-performing, sponsor-friendly, and competitive regionally.

Non-Commercial Performance (RWT & WHT)
WHT performs strongly but with very small numbers.

RWT has lower compliance and slower confirmation timelines than both WHT and the regional average.
Non-commercial first-recruit performance is less consistent across both Trusts.

Overall:
Non-commercial performance is weaker than commercial and shows more pathway variation.
This is a clear Group-wide development area.

3. Recommended Actions

We will protect the dedicated commercial setup pathway to avoid delays caused by competing priorities, ensuring commercial studies retain a fast-track route through feasibility, governance and site activation.

We will introduce a weekly 15-minute commercial rapid-review touchpoint to ensure no avoidable delays occur in the confirmation-to-first-recruit phase.

We will explore the use of AI-enabled document automation and workflow tools to accelerate commercial study setup, with a focus on reducing administrative delays, improving document accuracy, and streamlining feasibility and contracting processes. This approach does not require additional staffing and will reinforce the rapid commercial timelines already achieved across both Trusts.

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

a. Note the Group's performance against the national 150-day setup standard across commercial and non-commercial studies.
b. **Endorse** the proposed actions to maintain and strengthen commercial study setup performance, protecting rapid activation timelines.
c. **Agree** the introduction of AI-enabled tools to support efficient study setup within existing resources

Date paper written: 2 March 2026
The annexes below for further detail can be provided on request:

Annex1: DHSC 150-Day Policy Statement (2 October 2025)
Annex2: NIHR Operational Guidance (17 December 2025)

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

Tier 1 - Paper ref:	Enclosure 8.3

Report title:	Transforming Care Together Strategy – 2026-2031
Sponsoring executive:	Joe Chadwick-Bell, Group Chief Executive
Report author:	Joe Chadwick-Bell, Group Chief Executive
Meeting title:	Group Trust Board
Date:	17th March 2026

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

This paper presents the *Transforming Care Together Strategy* for Board approval, developed over six months through extensive engagement with our staff, colleagues and system partners. The Strategy was shaped by staff feedback seeking clarity on organisational direction and is aligned to the NHS Long Term Plan.

It sets out a five-year vision for delivering high-quality, sustainable care through changing the ways we work with partners and communities, and it will continue to evolve as implementation progresses. Delivery will be monitored through agreed metrics with regular Board Committee oversight.

The Board is asked to formally adopt the Strategy as the organisation's guiding vision and direction for the next five years.

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

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

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

- Trust Board
- Transforming Care Together Group
- Group Partnerships & Transformation Committee

4. Recommendation(s)/Action(s)

The Public Trust Board is asked to:

a. Formally adopt the Strategy as the organisation's guiding vision and direction for the next five years.

b. Support the reporting arrangements across Board Committees and endorse the monitoring approach

c. Note this is an iterative document

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

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 Private on 17th March 2026

Transforming Care Together – 2026-2031

1. Executive summary

During the summer of 2025 we held conversations with colleagues across the organisations and listened; one of their key messages was they wanted to understand where the organisations were going and what we could share that described our vision. In parallel, the publication of the NHS Long Term Plan was published, and part of our key role as a Trust Board is to set direction for the organisations, aligned to the national direction.

As a result, we took time to consider where we wanted to go, what needed to be in place and how we would get there. The Strategy has been shaped through extensive engagement with our staff, colleagues and system partners over the past six months.

The Strategy describes where we want to be in five years, the changes required to deliver high-quality, sustainable care, and how we will work differently with partners and communities. It has been iteratively developed based on detailed feedback and will continue to evolve as we embed the approach.

Delivery will be tracked through a set of agreed metrics, with regular oversight through Board Committees to provide assurance that we are progressing as intended. The Board will receive updates to evidence we are achieving what we said we would do.

2. Recommendations

2.1 The Public Trust Board is asked to:

 a. To formally adopt the Strategy as the organisation's guiding vision and direction for the next five years
 b. Support the reporting arrangements across Board Committees and endorse the monitoring approach
 c. Note this is an iterative document

Joe Chadwick-Bell
Chief Executive
05-03-26

Annex 1: Transforming Care Together Strategy 2026-2026

Transforming Care Together

NHS

Our Strategy 2026/31

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

CCCC
**Care Colleagues
Collaboration Communities**

Contents

Introduction

I am delighted to introduce Transforming Care Together, our ambitious five year strategy to reshape how healthcare is delivered across Walsall Healthcare NHS Trust and the Royal Wolverhampton NHS Trust. This strategy belongs to all of us - whether you work at the bedside, in theatres, laboratories, community settings, administration, estates, digital services or any one of the many roles that keep our organisations running. Every colleague, in every team, has a part to play in transforming care together, and in return this strategy commits to investing in your development, improving your working environment and ensuring you feel valued and supported. Through a strategic work programme, we will strengthen community services, develop neighbourhood teams, expand elective capacity, modernise outpatient care and improve access to diagnostics, ensuring patients receive timely, co-ordinated and convenient care.

This strategy will ensure that by 2031 patients experience faster access to care in their communities, staff will work in a digitally enabled and supportive environment, and our organisations are fit for the future and patients will benefit from improved way of communicating with our clinical teams. Thank you for your dedication to striving to be the best and delivering excellent care for the communities we serve, I look forward to working with each of you as we transform care together.

Joe Chadwick-Bell
Group Chief Executive The Royal Wolverhampton NHS Trust & Walsall Healthcare NHS Trust

As Chair of our Group, I am proud to present Transforming Care Together, our shared five year strategy that sets a clear and ambitious direction for how we will work as one to better serve our communities. This strategy applies to all age groups, including children and young people and reflects our commitment to care that is compassionate, accessible and delivered in the right place, at the right time. It strengthens our partnership, builds on the dedication of our colleagues, and sets out the changes needed to deliver more integrated, digitally enabled, community focused services. Together, we are creating the foundation for a healthier future - one that ensures our hospitals can focus on those who need them most, whilst empowering people to live well in their communities.

Sir David Nicholson KCB CBE
Group Chair The Royal Wolverhampton NHS Trust & Walsall Healthcare NHS Trust
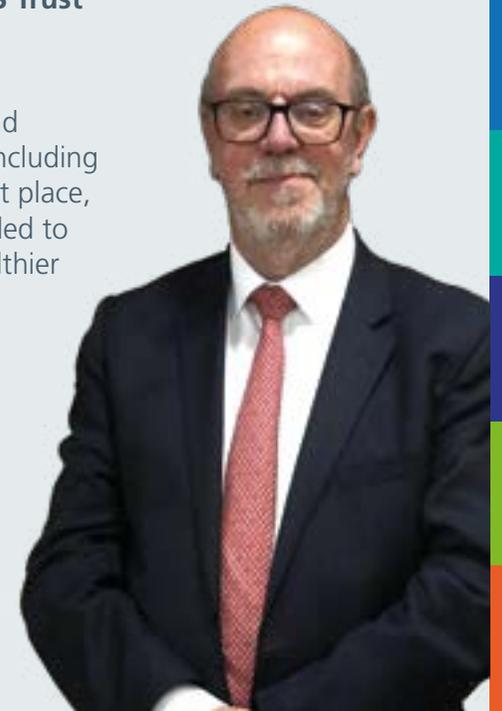
Executive Summary

Our Vision for 2031

By 2031, we will have transformed into a digitally-enabled, community-focused organisations that deliver exceptional quality of care closer to home, where clinically appropriate. We will operate within our means, and empower our staff to innovate and excel.

We will have transformed our services so care is delivered in communities, hospitals focus on emergency and complex care, and digital innovation empowers both patients and staff to achieve better outcomes.

We will work effectively with primary care and our partners across integrated neighbourhood health teams to provide co-ordinated, person-centred care that keeps people healthy and independent in their communities. We will be guided by the principles embedded in the four Cs which are Care, Colleagues, Collaboration and Communities.

The case for change is clear:

- Quality of care is impacted because patients wait too long for access to clinical services
- Hospital Emergency Departments are overwhelmed with patients who could be better served differently or in community settings
- We need to reduce the time patients wait for decisions and access to care for diagnostics, treatment, and specialist appointments
- Digital technology offers great potential which we have yet to fully harness
- The NHS 10-year Health Plan requires fundamental shifts towards neighbourhood health and prevention
- There is an ongoing financial challenge, but we have opportunities through changing clinical practice and improving how we use our resources to become financially sustainable
- Our workforce needs new skills and ways of working to deliver care in a changing environment

C Care
Excellence in clinical outcomes, closer to home.

C Colleagues
Engaged, empowered staff driving improvement.

C Collaboration
Integrated teams, shared goals, better outcomes.

C Communities
Care designed around local population needs

How healthcare will look in 2031

- ✓ Integrated neighbourhood teams caring for patients in their communities
- ✓ Emergency Departments focused on true emergencies
- ✓ Digital first approach with patients managing their own care and appointments
- ✓ Protected elective capacity delivering elective standards
- ✓ An engaged workforce with improvement methodology embedded in daily practice

- ✓ Financially sustainable services
- ✓ Good progress being made on Integrated Health Organisation status
- ✓ Organisationally aligned with the NHS 10-year Health Plan
- ✓ Integrated digital and automated systems to reduce the administrative burden for our staff and services more accessible for patients
- ✓ Using population health data, we will provide person-centred care that keeps people healthy and independent in their communities

Priorities and Enabling Plans

Our vision:
To deliver exceptional care together to improve the health and wellbeing of our communities

- Staff Involvement, Culture and Improvement
- Community First
- Neighbourhood Health Service
- Clinical Services Roadmap
- Outpatients
- Planned Care Redesign
- Digital Transformation
- Estates Optimisation
- Productivity and Financial Sustainability
- Workforce

Staff Involvement, Culture and Improvement

Every person working across our organisations matter, and your contributions are key to achieving the priorities outlined in this strategy.

What this will look like:

Everyone feels psychologically safe, respected, and able to speak openly without fear.

We learn from experiences together – especially when things do not go as planned.

Your voice will shape how services are designed, delivered, and improved.

Leaders prioritise wellbeing at work, actively listening with regular communication and responding to what matters to you.

We will have a Quality Management System which is the way we make sure we do things consistently, spot problems early, and improve care every day. Improvement is something we all participate in, using simple and accessible methods.

What we will measure:

- Ambition for staff survey results to be in the top quartile nationally
- Year-on-year improvements on NHS staff survey engagement score
- Improve staff retention rates, reduce sickness absence, grievances, bullying and harassment cases
- Number of colleagues trained in Improvement methodology
- Evidence of action and learning from Freedom to Speak Up and staff feedback routes

What we will do:

- Review current engagement and improvement practices to understand how they can be improved to optimise accessibility and application
- Provide additional forums for you to give honest feedback, where you will be actively heard and your views contribute to changes that matter
- Take a people focused approach to improving organisational culture promoting inclusion, belonging and wellbeing
- Embed a quality management system, which allows everybody to understand their role in delivering the organisational priorities, enabling people to feel engaged in identifying and solving the opportunities for improvement, as locally as possible
- Focus leadership development on compassionate leadership, quality improvement, and staff wellbeing
- Provide opportunities for growth, development, and learning, tailored to your needs and aspirations

Milestones:

2026/27

- Establish colleague listening and engagement forums at organisational and divisional level
- Review Joint People Enabling Framework against local, system, regional and national priorities
- Develop Improvement and Quality Management System plans
- Review management and leadership development offer across the Trusts connecting with regional and national opportunities
- Review and implement colleague appraisal process aligning with national approach

2027/28

- Embed Engagement and Improvement plans at organisation and divisional level
- Embed the Quality Management System

2028/29

- Continued implementation of Engagement and Improvement plans
- Review and evaluate the impact of people and improvement initiatives
- Review the effectiveness of our Quality Management System

Community First
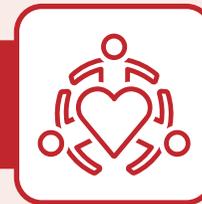
Our aim is to keep people healthy, happy and independent for as long as possible. We will provide as many services as possible to people within their own homes and community settings to avoid the need to go to hospital.

What this will look like:

Patient care will be provided in the community where possible and in hospital only when necessary.

Co-ordination between hospital and community services will work well.

A Community First Transformation Plan that will be delivered in collaboration with our partners over the next three years.

Build on what we already do well, providing specific and targeted care in a person's home or community settings.

Neighbourhood Teams will be operational across Walsall and Wolverhampton.

New community pathways will provide alternatives to hospital attendance and admission.

What we will do:

- Move the focus of care from hospitals to communities and home settings by ensuring patients have better access to services in the community for all ages
- Work with our partners in our OneWolverhampton and Walsall Together place based partnerships to deliver more services within a community setting including neighbourhood health centres with co-located services and access to urgent care
- Continue to develop care and services in the community with primary care and further improve the interface between primary and secondary care with a focus on improved pathways of care
- Create neighbourhood teams with our partners to co-ordinate care for our most complex patients
- Implement a three-year Community First Transformation Plan to move appropriate care from our hospitals into our communities
- Pro-actively identify high priority groups of patients living with moderate to severe frailty, living in care homes, housebound and end of life to help them avoid hospital admissions
- Optimise the use of short-term reablement and rehabilitation capacity
- A specific focus on prevention and long term wellbeing in early years of life
- Co-design solutions with our population and empower people to manage their care and wellbeing

What we will measure:

- A reduction in Emergency Department (ED) attendances and unnecessary emergency admissions
- Reduction in repeated or avoidable attendances by better coordinating care for patients who use our services regularly
- Improved outcomes for frailty, falls prevention, and reduction in ED attendances from care homes
- Percentage of community services provided within 18 weeks from referral
- Percentage of capacity available in our community health services

Milestones:

2026/27

- Redesigned frailty pathways
- Improved use of Virtual Wards
- Increased capacity of community health services by 3%
- Neighbourhood Health Plans
- Community services working in Neighbourhood Teams
- 78% of community health services provided within 18 weeks

2027/28

- Development of Neighbourhood Health Hubs
- Increased investment in prevention
- Frailty Hubs fully operational

2028/29

- All appropriate patient pathways converted to community where possible
- Further integration of services across NHS and other partners

Neighbourhood Health Services

We will work with our partners in Walsall Together and OneWolverhampton place based partnerships to create healthier communities, helping people of all ages to live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and empowering people in managing their own care. We will do this through our defined neighbourhoods across Wolverhampton and Walsall.

What this will look like:

Co-located, multi-disciplinary neighbourhood health and care services that are person-centred, co-ordinated and delivered in our communities. These will be supported by digital systems and community-based neighbourhood hubs and diagnostic centres.

Integrated neighbourhood teams, will through holistic care, improve prevention and population health reducing the need for unnecessary hospital attendances.

With our partners, we will be responsible for delivery of neighbourhood-based care and wellbeing that meets the needs of all, and delivers improved health outcomes for those people who currently have the worst outcomes.

What we will measure:

- Creation of multi-disciplinary integrated teams in each neighbourhood
- Access to strong population health data to develop services and to identify those at risk of hospital attendance or admission
- The neighbourhood teams will use population health data to identify those people that need proactive and co-ordinated care
- Implement neighbourhood health and care teams that ensure care is co-ordinated around the person
- Monitor outcomes by age, sex, ethnic group and socioeconomic deprivation, to ensure that care provision is fair and inclusive

What we will do:

- Work with our partners to continually strengthen and evolve the Walsall Together and OneWolverhampton place based partnerships
- Develop integrated models to improve pathways and ensure our primary care services are working in partnership to deliver integrated care
- Operationalise Integrated Neighbourhood Teams providing a patient centred and co-ordinated approach
- Create a "permissive framework" that allows and empowers staff teams to be solution focused and to work with partners to design their own teams
- Develop our workforce to have diverse skillsets working in multi-disciplinary teams tailored to meet the needs of our local populations, particularly with groups that currently face access barriers
- Implement digital improvements to community services to drive better communication, improved efficiency and co-ordinated care (including remote monitoring and technology-enabled care)
- Receive delegated accountability to deliver neighbourhood care for our local population via the place partnerships

Milestones:

2026/27

- Core community services will be organised and operating in neighbourhood teams
- Neighbourhood Health Plans to include transformation plans for non-elective admissions and modernised outpatients
- Delegation of commissioning of community based services to place based partnerships

2027/28

- Every community team will be aligned in a "team of teams" to deliver the Community First agenda
- Neighbourhood Teams to provide in-reach services
- Creation of Neighbourhood Health Hub with co-location of integrated teams
- Improved digital infrastructure for community services

2028/29

- Neighbourhood Health Teams using data to identify those who need help (population health management)
- Neighbourhood health and care is fully embedded with a shift of any agreed resources to the most appropriate provider of care
- A Neighbourhood level inequalities assessment matrix

Clinical Services Roadmap

Our Clinical Services Roadmap will use digital technology and evidence-based practices to deliver patient-centred care that is more innovative, accessible, and sustainable for all.

What this will look like:

We will enhance patient-centred care by using digital tools that make healthcare more accessible, efficient and personalised. This will give patients more control over their healthcare, and freeing up the administrative burden of our clinical staff.

We will commit to providing Urgent Care, Maternity Services, Paediatric Care and Cancer Services at both Trusts.

We will increase our research capability, number of clinical trials, and develop innovative treatment and technologies as a consequence of gaining University Hospital Trust status.

What we will do:

Develop a Clinical Services Roadmap aligned to the NHS 10-Year Health Plan that will:

- Minimise unnecessary duplication of clinical services
- Provide optimal care for patients in the right environment
- Improve our Model Health / Getting It Right First Time (GIRFT) metrics, which focuses on improving patient outcomes and reducing unwarranted variation in care.
- Reduce health inequalities
- Adopt a digital-first mindset and incorporate digital technology into the delivery of our services to improve outcomes and productivity
- We will increase opportunities for patients to take part in clinical trials and new innovation projects, so patients benefit from the latest advances in treatment and technology
- Staff will be supported to develop research skills, to work with academic partners and use evidence to improve care

What we will measure:

- Model Health and Getting It Right First Time (GIRFT) improvement metrics
- Waiting time standards
- Reduction in overall cost of delivery of services whilst improving quality
- Continued improvement of Friends and Family test scores
- Health inequality measures: outcomes by age, sex, ethnic group and socioeconomic deprivation
- Patient recommendation score will be in the top 25% in the country

Milestones:

2026/27
- High level Roadmap – March 2026
- Wider stakeholder meetings to further develop the plan – Q1
- Engagement and Roadmap Implementation plan (Phase 2)

2027/28
- Roadmap Implementation plan (Phase 3)
- Evaluate requirements and application process for University Hospital status
- Joint academic posts to support University Hospital application

2028/29
- Continued implementation of Roadmap
- Finalise submission of application for University Hospital Trust Status

Outpatients

We will transform our Outpatient Services to change how and where these are delivered from. Using well communicated and redesigned pathways ensuring right patient, first time in the right place. We will maximise our capacity and use digital technologies, providing the best experience for our patients and staff.

What this will look like:

Patients will experience faster, more convenient access to care through streamlined pathways, first-appointment diagnosis and treatment where appropriate through one-stop clinics, and the ability to request follow-up only when they need it.

The service will be redesigned to give patients more control and greater choice in accessing care, interacting with our services through digital technology in a way that suits them.

Our services will offer personalised and flexible care with virtual and closer-to-home options, where appropriate, in line with the new national approach.

What we will measure:

- Digital first and a patient-led model with virtual triage for all new referrals
- All services will fully utilise the Electronic Referral Service through a Single Point of Access
- Patient Initiated Follow-Up (PIFU) rates: 7% for all services at Walsall Healthcare NHS Trust and 8% at The Royal Wolverhampton NHS Trust (2026/27)
- Year-on-year increase in virtual consultations and remote care
- GIRFT metrics in the top quartile nationally
- Continued improvement of Friends and Family test scores
- Patient recommendation score will be in the top 25% in the country

What we will do:

- Improve access to care, reduce waiting times, make appointments closer to, or at, home, including virtual appointments, and avoid unnecessary follow-up appointments
- We will work with primary care to strengthen and streamline our clinical pathways, helping patients receive the right support in the community and reducing the number of referrals that need to come into hospital-based outpatient services
- Increase the number of patients who receive a diagnosis and start treatment on their first appointment
- Use digital solutions that will support patients to manage their conditions where appropriate, while also freeing up the administrative burden on our staff to spend more time with patients
- Patients can choose when to request a follow-up if needed through 'Patient Initiated Follow-Up' (PIFU), remote consultation and monitoring
- Have straight to test pathways and one-stop clinics in all specialties where clinically appropriate
- Ensure all patients have the support and guidance to confidently use digital options, while always providing non-digital alternatives for anyone who prefers or requires them

Milestones:

2026/27

- Increase virtual consultations and remote care
- Achieve national waiting time standards and PIFU rates of up to 8%
- Rollout of Ambient Voice Technology (AVT) in Outpatients
- All services will use the Electronic Referral Service
- Straight to test and one-stop clinics in 10 specialties

2027/28

- Delivery of the patient engagement portal and functionality of NHS App
- 100% of all new referrals will be digitally triaged through a Single Point of Access
- Top 10 specialties will have agreed pathways with primary care
- All specialties will provide virtual consultations and remote care
- 95% of all of appointments will be bookable via NHS App

2028/29

- Achieve 92% Referral To Treatment (RTT) waiting times
- All clinically appropriate specialties will have straight to test pathways and one-stop clinics

Planned Care Redesign

We will cut waiting times by working together and consolidating services where it improves quality and equity. Patients will get tests and diagnostics closer to home, faster answers, and quicker treatment—all without needing to come into hospital unless clinically necessary.

What this will look like:

There will be dedicated hospital theatre slots that are protected from emergency pressures, meaning less chance of patients' surgeries being cancelled.

We will provide vital tests closer to our patients' homes, and in doing so, reduce waiting times, and speed up diagnoses so people get answers and treatment sooner.

Patients will receive support before surgery to optimise their health and improve recovery across their care pathway.

Our clinical pathways align with recommendations from the national 'Getting It Right First Time' (GIRFT) programme, which focuses on improving patient outcomes and reducing unwarranted variation in care.

What we will do:

- Expand Cannock Hospital elective hub which will provide vital additional capacity to reduce waiting times and improve patient outcomes through standardisation of treatments
- Develop a new community diagnostic centre (CDC), a local site between Walsall and Wolverhampton, for tests such as x-rays and blood checks, closer to home
- Have a co-ordinated diagnostic centre which is digitally connected and integrated with all systems needed to ensure a full picture of patients' health needs
- Better protect theatre lists by creating more slots for patients and avoiding cancellations
- Develop staff to be highly specialised in specific procedures, leading to faster turnaround times, reduced complications and better outcomes for our patients
- Where possible outpatient, day case and post operative care will be delivered closer to home where clinically appropriate
- Pathology and healthcare sciences will be central to delivering faster, high-quality diagnostics through our new hubs

What we will measure:

- Reduction in cancellations and 90% consistent utilisation of theatres and procedure rooms
- Higher percentage of patients treated within national targets (e.g., 18 weeks standards)
- Fewer unplanned readmission rates within 30 days
- Percentage of patients seen within target timeframes for diagnostics
- GIRFT metrics in the top quartile nationally
- Continued improvement of Friends and Family test scores
- Patient recommendation score will be in the top 25% in the country

Milestones:

2026/27

- Development of the elective hub expansion at Cannock to be completed
- Development of the CDC business case to be completed
- Building works to commence
- Rollout of pre-habilitation, to optimise patients before surgery

2027/28

- Continued development of highly specialised elective surgical teams
- Expansion of pathways that move care out of hospital into community settings
- Increased use of remote and local options for pre-operative and post-operative care

2028/29

- Completion and opening of expanded elective hub
- Completion and opening of expanded CDC

Digital Transformation

We will embrace digital technologies and release time for our clinical staff to focus on patient care, while also empowering our patients with the digital tools needed for self-management, appointment scheduling and direct communication.

What this will look like:

Patients will be digitally empowered to access our services and actively participate in their care, using the NHS App. We will have a single, secure record for personalised care, supporting both patients and clinicians. Paper processes will be eliminated as data is captured digitally at the point of care.

Digital solutions will streamline our booking processes, making full use of our technology to optimise the scheduling of outpatient appointments and theatre services

What we will do:

- Patients can communicate, book and manage their appointments digitally via the NHS App and patient portal, with digital correspondence
- Reduce the administrative burden of delivering healthcare and introduce Ambient Voice Technology (AVT) and automation across all our healthcare services
- Implement all aspects of Electronic Patient Record, including community solutions, so all clinicians are working in a noteless way
- Implement a secure and resilient IT infrastructure across all digital systems, ensuring modern, reliable equipment is available to every member of staff to support high-quality patient care
- We will make sure patients including children and young people have the support they need to use digital services confidently, while always offering alternatives for those who need them
- Provide proactive care through the use of risk stratification tools to identify patients who need more support

What we will measure:

- Patient portal fully operational across all services and increased information to Regional Shared Care Record
- Full deployment of Electronic Patient Record (EPR) across the Group, along with noteless working for our clinicians
- All services will offer patients the opportunity to book appointments through the patient portal
- By 2027 our Federated Data Platform (the secure system that connects separate data sources) will be fully integrated
- Our 'Digital Healthcheck' score will improve, reflecting our digital capability and effectiveness
- By 2028, the NHS App will become the platform for patient Digital Front Door

Milestones:

2026/27

- Procurement of an AVT supplier and funding route established
- Start AVT adoption across all specialties
- Full implementation of the patient portal
- Infrastructure IT systems aligned across the group
- Implementation of year one Digital Enabling Plan

2027/28

- AVT successfully rolled out across all specialties
- Implementation of all functionalities of the NHS App
- Deployment of EPR across the group with noteless working.
- Federated Data Platform (FDP) is integrated with Trust data sources
- Digital Prescribing capability deployed across the Group

2028/29

- FDP enabling up-to-date analytics for operational decisions, and patient care
- Eliminate paper-based processes for clinical documentation, referrals, discharge summaries
- Full managed print solutions deployed across Group
- Fully functioning single patient record accessible across all care settings

Estates Optimisation

We will ensure our estate has the right amount of well-designed space to meet patient demand, enabling care to be delivered in the most appropriate setting and aligned to our clinical services roadmap. We will create an environment where staff can deliver safe care, having the space to work, learn and support their wellbeing

What this will look like:

We will have an estate that provides enough of the right space to see patients safely and efficiently. For staff, this will mean working in safe, well-designed spaces that support good teamwork, provide room to learn and develop, and promote wellbeing while helping them deliver the highest quality care.

Our premises will be optimised to ensure we provide clean and safe care to support the prevention of infection.

What we will measure:

NHS Staff Survey results, improvement in:

- Staff satisfaction with their working environment
- Staff reporting they have the space, tools and equipment to do their job well
- Staff perception of health & safety climate
- Staff engagement scores
- Staff wellbeing scores

What we will do:

- Develop an Estate Optimisation plan to repurpose our buildings to ensure space is used effectively, while providing staff with a supportive environment that enables learning, wellbeing and high-quality care
- Strengthen partnerships and co-locations through cross-Trust collaboration and continued work with our strategic local partners and aim to develop more multi-service community health hubs
- Enable digital transformation and optimise hybrid and agile working where possible to create greater flexibility of space

Milestones:

2026/27

- Publication of a new Estates Plan
- Identify key estate changes driven by Clinical Services Roadmap

2027/28

- Introduce Estates Optimisation Plan
- Develop digital building data platform
- Implement estate changes to deliver Community First workstream

2028/29

- Continued implementation of changes informed by Clinical Services Roadmap and Community First workstreams

Productivity and Financial Sustainability

We will use our resources wisely and work more efficiently so we can protect frontline care, invest in our services and ensure long-term stability for our patients and staff.

What this will look like:

We will become more productive, achieving lasting financial balance aligned with the NHS 10-year Health Plan.

Service provision will be efficient and effective delivering high quality care for our patients.

We will have delivered a financial balance without deficit support funding by the end of 2027/28.

What we will do:

- Enhance productivity, reduce duplication and eliminate waste across the Group
- Deliver efficiency gains by maximising opportunities identified in Model Health and Getting It Right First Time (GIRFT) initiatives which focuses on improving patient outcomes and reducing unwarranted variation in care
- Ensure financial resources support clinical service redesign and innovation for quality care
- Eliminate any unnecessary or unsuitable spending, managing our budgets more effectively to meet recurring costs so that services are sustainable in the future

What we will measure:

- Through delivery of our financial plan including the productivity plan, our services will be financially sustainable
- Major project and capital plan to ensure sufficient funds to address the service redesign work
- Delivery of our year-on-year efficiency and productivity programmes
- Delivered financial balance without deficit support funding by the end of 2027/28

Milestones:

2026/27

- Agree four-year capital plan
- Draft multi-year productivity plan (three-year plan)
- Sign off detailed 2026/27 productivity plan and outline 2027/28 plan
- Develop detailed delivery plans for income, activity, productivity
- Outline 2027/28 delivery plans

2027/28

- Adjust and agree year two detailed revenue financial Plan to agreed forecast
- Adjust and agree year two of capital investment plan
- Sign off detailed 2027/28 productivity plan and outline 2028/29 productivity plan
- Deliver in year financial plans

2028/29

- Adjust and agree year three detailed revenue financial Plan to agreed forecast
- Adjust and agree year three of capital investment plan
- Sign off detailed 2028/29 productivity plan and outline 2029/30 productivity plan
- Deliver in year financial plans

Workforce

We will work with our staff to co-design a future workforce that strengthens skills, expands career opportunities and provides security and support to meet new ways of working.

What this will look like:

We will build a workforce that has the right number of people with the right skills in the right places, while actively addressing unfair gaps - for example where some staff groups, roles or communities are under-represented or face barriers to progression.

Our staff will have the capabilities to flex and adapt to better support the communities we serve.

Staff will describe being supported to develop their potential and have clarity of their role in workforce transformation.

What we will do:

- Establish a framework to re-design and plan the workforce
- Develop a long-term high level workforce plan that includes identifying skills, roles and numbers of staff needed to meet future service delivery requirements
- We will deliver an operational workforce plan to meet specific service delivery changes alongside the development of a strategic long-term workforce plan aligned to the new Clinical Services Roadmap
- Work with universities and colleges to deliver the future workforce requirements
- Embed the Health and Safety Work-Related Stress Risk Assessment Framework within Workforce plans to identify, prevent and manage work-related stressors
- Develop clear career pathways and expand apprenticeships, T-Levels and emerging talent programmes to grow our own workforce, fill skills gaps and attract younger generations into the NHS

What we will measure:

- Improvement in Staff Survey results for subsection 'We are always learning'
- Patient productivity data
- Reduced temporary staffing spend
- Reduced sickness absence
- Increased number of staff working effectively in out-of-hospital or community bases

Milestones:

2026/27

- Establish clear interfaces with other workstreams
- Finalise and communicate the Operational and Strategic Workforce plans
- Development of recruitment plan
- Develop skills portfolios

2027/28

- Evaluate and adjust development of new or amended roles aligned to the Clinical Services Roadmap
- Training skills analysis aligned to workforce plans – Q1
- Staff skills development plan in place – Q2

2028/29

- Evaluate and adjust development of new or amended roles aligned to the Clinical Services Roadmap
- Reassess plans against digital progression
- Review traditional career ladders and redesign
- Aligned expansion of training places for all professions

Our wider commitments

Health Inequalities

The communities we serve across Wolverhampton and Walsall experience some of the greatest health inequalities in England, with significant gaps in healthy life expectancy linked to deprivation, ethnicity and social circumstance. Addressing these inequalities is not an add-on to our strategy - it is central to everything we do.

We will use population health data to identify the communities and groups most at risk, prioritising them in the design and delivery of our neighbourhood health services, community pathways and prevention activity. We will ensure that our shift of care closer to home benefits those who need it most first, and we will measure our success not just by average outcomes but by whether we are closing the gap for our most disadvantaged residents.

Sustainability and Net Zero

We have a responsibility to protect the health of our planet as well as the health of our communities. Both Trusts have published Green Plans setting out clear pathways to reach NHS Net Zero targets, reducing our direct emissions by 2040 and our wider supply chain emissions by 2045. We will embed sustainability into everything we do - from how we design clinical pathways and manage our buildings, to how our staff travel and how we buy goods and services.

We will de-carbonise our estates through renewable energy and modern building upgrades, introduce low-carbon clinical pathways and ensure every pound we spend considers its environmental impact. We will track and report our progress publicly, ensuring our ambition to be a greener, more sustainable organisation is matched by real and measurable action.

Prevention and Population Health

Good health begins long before a person needs a hospital, and prevention must start in early life. We are committed to shifting the focus of care from treatment to prevention, working with partners across local government, primary care and the voluntary sector, we will support people to make healthier choices, identify risks earlier and intervene before conditions become serious. This includes recognising the importance of early years and school-age prevention, with school nursing contributing to safeguarding, health education and immunisation uptake as part of a wider preventative approach.

Ensuring that children and young people are included in our prevention ambition will help build healthier communities from the start. Through our neighbourhood health teams, we will continue to proactively reach people living with frailty, long-term conditions and complex social needs, supporting independence and wellbeing within their communities. We will invest in prevention as our services develop, with a particular focus on reducing the burden of avoidable disease and supporting the national ambition to raise the healthiest generation of children ever seen.

Collaboration and Integration

By working as a Group, we will deliver more joined-up, efficient services for our communities than either organisation could achieve alone. We will simplify governance and decision-making, reduce duplicated processes and align our corporate services so that resources are directed where they matter most - to the front line.

We will work closely with partners across the Black Country to develop specialised centres of excellence, ensuring our communities have access to the very best care without having to travel far. We will deepen our relationships with local government, primary care and the voluntary sector to design services that truly reflect the needs of our local populations.

We will pursue Foundation Trust status within five years, giving us greater freedoms to invest, retain surpluses and innovate in how we deliver care. Building on this, we will develop our research capability and expand our involvement in clinical trials through University Hospital Trust status - bringing the benefits of cutting-edge treatments, technologies and academic partnerships directly to the patients and communities we are privileged to serve.

Summary

By 2031 our patients will experience:

♥ Care closer to home:

✓ Services delivered in their neighbourhood where possible

✓ Co-ordinated care from teams who know them

✓ Tests and diagnostics nearer to where they live

✓ Reduced travel time and environmental impact

Better access and control:

✓ Book and manage appointments online 24/7

✓ Access to records through the NHS App

✓ Virtual consultations when appropriate

✓ Clear communication at every stage of their care

Faster, Better Treatment:

✓ Shorter waiting times for appointments and procedures

✓ Quicker diagnosis with earlier tests

✓ Treatment started at first appointment when possible

✓ Protected operating capacity reducing cancellations

Seamless care:

✓ One co-ordinated team managing their care

✓ Right place, first time, hospital only when necessary

✓ Smooth transitions between services

✓ Support to stay well and independent at home

By 2031 our staff will experience:

♥ A better place to work:

✓ Modern, well-maintained facilities and a cleaner, safer working environment for everyone

✓ Reliable equipment and resources available to all staff, in every role and location

✓ Digital tools that reduce unnecessary paperwork across all departments

✓ Whether you work on a ward, in an office, in a kitchen or in a corridor, your day-to-day working conditions will get better year on year

🤝 The right tools to do your job:

✓ Up-to-date technology and streamlined systems that make your role easier

✓ Joined-up ways of working that cut through frustrating processes

✓ With less administrative burden, staff can focus on meaningful work, supported by the tools, spaces and resources they need

✓ Equipment and systems that work the same way whether you're at your base site or working across different locations

★ Your development and career growth

✓ Clear pathways to develop your skills and progress your career, whatever your role

✓ Apprenticeships, T-Levels and training programmes open to all staff groups

✓ Quality improvement learning embedded in everyday practice across all teams

✓ We will help staff to develop the digital skills they need, ensuring nobody is left behind or disadvantaged

✓ Your health, wellbeing and voice:

✓ Wellbeing actively supported with a real focus on reducing work-related stress

✓ A culture of psychological safety where everyone feels respected and valued

✓ Agile and hybrid working options where appropriate will give you greater flexibility

✓ Genuine opportunities to speak up and see your ideas make a real difference

Governance

Our governance process sets out how we will monitor the delivery of our Transformation Plan. This shows the flow of our internal assurance mechanisms such as Board and sub-committees through to the key working groups of each of the transformation and enabling programmes.

It will be the role of the various Group Committees to routinely monitor the achievement of the plan's aims and objectives, reporting into the Group Trust Board. The individual programme workstreams are responsible for implementing the aims and objectives, ensuring progress to timelines. We will continue to maintain strong organisational resilience and emergency preparedness to ensure our services remains safe as we introduce new models of care, digital tools and community-based pathways.

Internal Assurance	**Group Trust Board**

Group Committees	Digital & Estates Strategy Committee	Finance & Productivity Committee	People Committee	Quality Committee	Partnerships & Transformation Committee

Executive Group	**Transforming Care Together Group**

Workstreams (examples)	Clinical Services Roadmap	Outpatient Transformation	Digital Transformation	Community First	Workforce

Click the icons for more detail
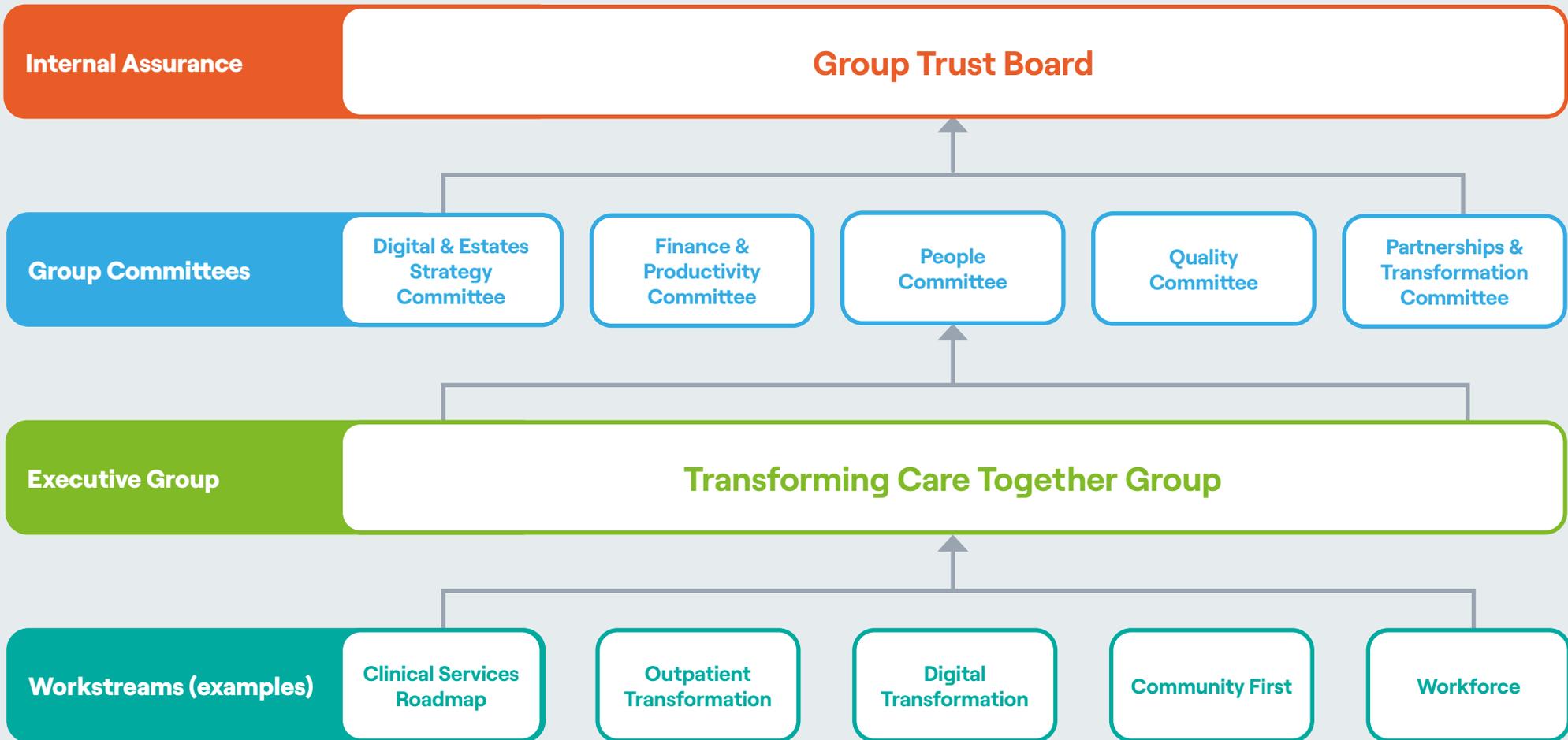
Integrated Performance Report

Walsall Healthcare NHS Trust

February 2026 (Month 10)

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:

Target (to be greater than)

System redesign required to hit target

Target (to be greater than)

Capable system should reliably hit target

Target (to be greater than)

System will not reliably hit target

SPC Key

Performance — Mean ----- LCL ----- UCL

Point of Concern — Point of Improvement — Target ----- Trajectory

Care Colleagues
Collaboration Communities

Managing Director Summary

Walsall Healthcare NHS Trust is ahead of plan by £2.1m at month 10, which is an improvement from £2m the previous month. The plan assumed 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. YTD the Trust has achieved c£2.9m of variable elective performance over contract which is currently unfunded and therefore has not been included in the position. The Trust has allowed a limited amount of funding for WLIs within the financial plan, however the Q4 Outpatient Sprint Plan provides additional funding direct from NHSE to increase capacity Q4. CIP is £21.7m versus a plan of c20.4m, so a YTD positive variance of £1.3m.

Quality and safety continues to be our priority. There were 4 falls in January resulting in severe harm, an increase from 1 in December. There was an overall increase in pressure ulcer rates with appropriate actions being taken. CHPPD hours remain stable, however safe staffing levels remain a challenge during the peak winter periods. The maternity service continues to show positive improvement on safe and effective care metrics and maintained 1:1 care in 100% of deliveries. The number of mental health patients spending >12 hours in the emergency department increased to 12 in December compared to 24 the previous month, and this work is ongoing with the mental health trust.

The ED Corridor was used in January 2026 to manage patient flow and support ambulance offload, with an average stay of 5.6 hours per patient cared for in the area. And the corridor was in use 22 out of 31 days (25 days in December 2025) in the month. All activations fully adhered to the operational policy criteria, including appropriate staffing, patient selection, and escalation governance. No incidents or patient safety concerns were reported during this period.

The Human Tissue Authority completed a full inspection on the Walsall licensable activities at WHT and RWT in October 2025. HTA reports escalate critical, major and minor shortfalls. WHT licensable activities resulted in 5 major and 7 minor shortfalls against expectations; all shortfalls are expected to be closed by the end of March 2026.The Trust received the outcome letter from Ofsted and the CQC following the joint inspection of SEND services across the Walsall system. An action plan is being developed with a system approach

WHT's overall workforce increased by 35 WTE during M10, reflecting a decrease of 11 substantive WTE, offset by an increase in bank deployment by 41 WTE, and a rise in agency usage by 5 WTE. The WHT overall workforce is 141 WTE (2.9%) above the financial sustainability (stretch) target trajectory. During January, three of the six workforce indicators — mandatory training, 12-month turnover, and 12-month retention were on target. Rolling 12-month sickness absence, vacancy rates and appraisal compliance are rated red with improvement actions in place.

Author

Amelia Godson
(Managing Director)

Care Colleagues
Collaboration Communities

Managing Director Summary

The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for fifteen consecutive months, ranking 13th nationally. There has been a reduction in the Patient Tracking List (PTL) size to 29,574 in January. This remains above the plan of 27,050 for M10. Interventions are in place with services to increase capacity and are demonstrating an impact on reducing the waiting list and increasing RTT. Performance has seen some challenges with one of the three constitutional standards for access to treatment for cancer being met. Improvement continues for access to diagnosis within 28 days, with the Trust ranking 15th nationally. Performance against the 62-day standard has been impacted by a reduction in capacity in oncology, however, there has been improvement with the Trust achieving 74.15% performance against the 75% national target.

The Trust has seen a decrease in performance against the 4-hour Emergency Access Standard (EAS), moving from 71.44% in December to 69.97% in January, which is below our trajectory in January of 76%. EAS is ranking 55th nationally and 8th in the region. Type 1 ED attendances were 6.33% higher when compared to January 25. Additional staffing and surge capacity has been utilised to manage peak periods of demand. The ED Observation Unit development has been implemented to improve our ability to treat and discharge patients safely and efficiently.

DM01 performance was 72.81% in January with a national ranking of 64th and 10th in the region. Challenged modalities are Magnetic Resonance Imaging (MRI), Audiology, Cardiac Physiology and Neurophysiology. Capacity is being increased for MRI through the national Sprint opportunity and a longer-term plan is being developed.

The Trust continues to demonstrate strong productivity performance, with the latest Model Health System data placing overall Implied Productivity Growth in the top quartile nationally. Key operational metrics show sustained strengths in day-case rates, outpatient procedures and theatre utilisation, reflecting effective use of clinical capacity. Opportunities for improvement include DNA rates, PIFU utilisation and Specialist Advice activity. Workforce productivity remains a major asset for the Trust, with Implied Workforce Productivity ranked in the best quartile, supported by high levels of non-elective activity per clinical WTE and strong emergency consultant utilisation. Elective activity per WTE, outpatient attendances per consultant and temporary staffing expenditure have been identified opportunities.

Overall, while the Trust's productivity position remains strong, targeted improvements in outpatient efficiency, elective throughput, and workforce sustainability will be key to improving future performance.

Author

Amelia Godson
(Managing Director)

**Care Colleagues
Collaboration Communities**

Productivity

The Trust continues to demonstrate strong productivity performance, with the latest Model Health System data placing overall Implied Productivity Growth in the **top quartile nationally** (a calculation that essentially compares inputs to outputs, compared to last year)

Key operational metrics show sustained strengths in day-case rates, outpatient procedures (proportion of outpatient's attendances that are for 1st or follow up appointments attracting a procedure tariff), and theatre utilisation, reflecting effective use of clinical capacity.

Despite these positives, outpatient services present notable opportunities for improvement.
DNA rates remain in the **worst quartile**, and both PIFU utilisation and Specialist Advice activity are below national average performance. Additionally, a proportion of follow-up activity continues to be delivered without corresponding income due to the 2019/20 fixed-income baseline.

Workforce productivity remains a major asset for the Trust, with Implied Workforce Productivity ranked in the **best quartile**, supported by high levels of non-elective activity per clinical WTE and strong emergency consultant utilisation.
However, elective activity per WTE and outpatient attendances per consultant lag behind national comparators, and temporary staffing expenditure continues to exceed the national benchmark.

Overall, while the Trust's productivity position remains strong, targeted improvements in outpatient efficiency, elective throughput, and workforce sustainability will be key to improving future performance.

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	4.03	3.58	Jan-26	4.67	Common Cause	Inconsistent
Pressure ulcers per 1,000 occupied bed days	1.50	2.59	3.12	Jan-26	-	Concern	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.65	0.83	Jan-26	-	Common Cause	Inconsistent
Observations on time (Trust wide)	90.00%	84.86%	84.10%	Jan-26	-	Concern	Inconsistent
VTE risk assessment - % within 14 hours	95.00%	87.43%	86.55%	Jan-26	-	Common Cause	Not Met
Sepsis screening - ED	90.00%	-	-	-	-	Not Enough Points	Not Enough Points
Sepsis screening - Inpatients	90.00%	-	-	-	-	Not Enough Points	Not Enough Points
Mental health patients spending over 24 hours in A&E	0	24	12	Jan-26	1	Common Cause	Not Met
Clostridioides difficile	4	3	3	Jan-26	2	Improvement	Inconsistent
MRSA Bacteraemia	0	0	0	Jan-26	2	Common Cause	Inconsistent
Number of complaints as a % of admissions	0.50%	0.60%	0.60%	Jan-26	-	Concern	Inconsistent
FFT recommendation rates - Trust wide	92.00%	92.00%	92.00%	Jan-26	-	Common Cause	Inconsistent
Care hours per patient - total nursing & midwifery staff actual	-	7.6	7.8	Jan-26	-	Common Cause	No Target Set
Care hours per patient - registered nursing & midwifery staff actual	-	4.4	4.5	Jan-26	-	Common Cause	No Target Set
SHMI	1.00	0.93	0.96	Sep-25	1.09	Common Cause	Achieving
Never events	0	0	0	Jan-26	1	Improvement	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	4445.30	4573.54	4562.79	Jan-26	-	Concern	Inconsistent
Agency (WTE) Trust	16.33	17.20	21.90	Jan-26	-	Improvement	Not Met
Bank (WTE) Trust	452.94	430.15	471.24	Jan-26	-	Concern	Inconsistent
Vacancy Rate	6.00%	10.22%	10.23%	Jan-26	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	7.47%	7.42%	Jan-26	-	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	94.25%	93.12%	Jan-26	-	Improvement	Achieving
Sickness Absence (Rolling 12 Months)	5.00%	6.45%	6.48%	Jan-26	-	Concern	Not Met
Appraisals	90.00%	74.46%	73.73%	Jan-26	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	91.86%	91.47%	Jan-26	-	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%	69.66%	69.29%	Jan-26	83.93%	Improvement	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	1.00%	0.06%	0.05%	Jan-26	0.00%	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	26155	30299	29574	Jan-26	14852	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	83.49%	83.87%	Dec-25	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	96.00%	96.67%	95.96%	Dec-25	100.00%	Common Cause	Inconsistent
Cancer - 62 Day Referral to Treatment	75.00%	72.30%	74.15%	Dec-25	82.72%	Common Cause	Inconsistent
No. of patients no longer meeting the Criteria to Reside	68	24	36	Jan-26	-	Common Cause	Achieving
Diagnostics - % within 6 weeks from referral	95.00%	76.74%	72.81%	Jan-26	97.57%	Concern	Not Met
Total Time Spent in ED - % over 12 Hours	2.00%	11.01%	13.72%	Jan-26	2.69%	Concern	Inconsistent
Total Time Spent in ED - % within 4 Hours	78.00%	71.44%	69.97%	Jan-26	77.49%	Concern	Inconsistent
Community - % Within 18 Weeks - Incomplete	-	63.63%	64.91%	Jan-26	-	Concern	No Target Set

Finance	Target	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£'000) - in month	1,298	1,712	(655)	(3,151)	Concern	Not Met
Surplus/(Deficit) (£'000) - YTD	(4,318)	(1,531)	(2,186)	(3,146)	Deterioration	Achieving
Surplus/(Deficit) (£'000) - FOT	0	0	0	50	-	Achieving
ERF (£'000) - in month	6,027	5,926	6,111	N/A	Improvement	Achieving
ERF (£'000) - YTD	59,117	55,864	62,005	N/A	Improvement	Achieving
ERF (£'000) - FOT				N/A		
Efficiency (£'000) - in month	4,194	2,119	2,108	1,099	Concern	Not Met
Efficiency (£'000) - YTD	20,409	19,543	21,651	6,486	Improvement	Achieving
Efficiency (£'000) - FOT	30,076	27,098	27,874	8,515	Concern	Not Met
Capital (£'000) - YTD	13,994	11,014	11,768	5,955	Concern	Not Met
Capital (£'000) - FOT	15,055	19,002	21,482	8,274	Improvement	Achieving
Cash (£'000) - in month	7,504	29,617	26,853	2,803	Deterioration	Achieving
Cash (£'000) - FOT	6,652	28,152	28,152	1,067	-	Achieving

Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

Falls per 1,000 Bed Days

- January 2026 rate: 3.58 (↓ from 4.03 in December 2025), below the national mean of 6.1 (Royal College of Physicians).

- Four severe harm inpatient falls resulted in fractured NOF (Ward 1, AMU, Ward 10, Ward 12), with early reviews pointing to supervision not being in place/maintained at the time of risk and incomplete risk assessment/documentation. Two of these patients underwent surgery but subsequently died.

- Actions underway target these causes through revising the falls prevention care plan/risk assessment to make supervision requirements explicit (including integrating the Enhanced Supervision Risk Assessment Tool), improving completion of lying and standing BP and delirium screening (4AT), and reinforcing safe mobilisation practice via Moving & Handling/Therapies-led training and practical supervision supports (including recruitment to extend our temporary workforce to cover 1:1 requirements).

- ### Pressure Ulcers per 1,000 Bed Days

- Overall, there has been an increase in incidents (both hospital and community); 3 category 4 incidents were reported in January 2026 (1 hospital and 2 community).

- Actions to enhance care metrics are detailed in the CNO report presented to the Group Quality Committee, including both global initiatives and specific departmental efforts.

Observations on Time

- January 2026 compliance: 84.10% including ED (↓from 84.86%) and 90.33% excluding ED (↓ from 91.04%). The ED compliance of 54.60% almost entirely drives the drop in overall performance.

- Improvement Actions: Ongoing review of observation frequency led by the Head of Nursing for Quality, Digital Nursing, and ED teams.

VTE Risk Assessment

- January 2026 compliance was lower at 86.55 % (↓ 87.43% in December 2025), still below the national target.

- Elective pathway maintains consistency in the VTE assessment improvement.

- Improvement Actions: Divisional performance is reviewed every month. Sharing of selected VTE cases at the Thrombosis Group meeting for learning.

SHMI (Summary Hospital-level Mortality Indicator)

- Latest data available: In September 2025, the SHMI recorded a value of 0.96, which is an increase from August 2025 (0.92). However, no alerts have been received. This will be monitored closely.

- Improvement actions: Learning from Deaths Group regularly review structured judgment reviews for specialties. Focus remains on thematic learning and reducing avoidable deaths. All Mortality Leads are being contacted to ensure they have undergone Datix Mortality training.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Quality, Safety & Patient Experience | Executive Summary Cont.

Infection Control

- 3 HOHA C. difficile cases reported in January 2026; national target for 2025/26 set at 65.

- Improvement actions: Ensure prompt sampling and appropriate use of antibiotics

Sepsis Screening

- Adult Inpatients: 72.04% compliance (↓ from 72.26%); ED Patients: 85.50% compliance (↑ from 67.23%); Paediatrics: 89%; Clinical assessment and de-escalation of patients remain a positive trend.

- Sepsis team working clinically in ICU to support demand in January 2026 meant that the tracking of the closure of sepsis bundles was not always completed. Pressures within the ED also affected the timely closure of sepsis bundles. The sepsis team liaises daily with the nurse in charge in ED to close episodes as required. No patient harms were identified

Safe Staffing

- Twice daily staffing meetings – senior nurse led. Re-deployment where required following risk assessment to maintain safety. Escalation process in place with CNO/Deputy CNO sign off for all agency requests against completed risk assessment

- Roster reviews embedded with forward review and mitigation of potential risk.

- Overall fill rate for January 2026 96.79%

- CHPPD - 7.8 in January 2026 (7.6 in December 2025). Overall fill rate combined (RN + CSW): January 2026 96.79% (December 2025 92.15%)

- Biannual skill mix reviews – all wards/departments have budgeted establishment in accordance with Board approved recommendations of SNCT

FFT Recommendation Rate – Trust Wide

- Current position: 92% in January 2026 (static from December 2025), and at Trust target.

- Improvement actions: Divisional leads for patient experience continuously monitor FFT returns, address thematic concerns, and report to the Patient Experience Group.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

Complaints as a Percentage of Admissions

- Current position: 0.60% in January 2026, static from December 2025, but higher than the internal threshold of 0.50%.

- Complaint response within timeframe increased from 71% in December 2025 to 89% in January 2026. All complaints are quality assured by the CNO and Deputy CNOs.

- Improvement actions: An updated training program for handling complaints is now in place, with insights from upheld cases shared during Quality & Safety Huddles. The Patient Relations Team continues to monitor both response timeliness and quality

Medication Errors - % causing harm

- 84 medication incidents were reported in December 2025 (latest data), a decrease from the previous month (125 in November 2025). All incidents were classified as near misses or low harm.

- Improvement Actions: The themes have been identified, and actions have been 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 January 2026, 12 patients spent more than 24 hours in the Emergency Department, compared to 24 patients in December 2025. System-level pressures continue to pose challenges, particularly in completing mental health assessments promptly and securing suitable placements. These issues pose ongoing operational risks to patient care and the flow of the Emergency Department.

- Challenges: Timely mental health assessments continue to be a challenge, with delays occurring in both adult and Child and Adolescent Mental Health Services (CAMHS). Additionally, there is limited availability of consultant or middle-grade psychiatric cover outside of regular hours and no 24-hour assessment service.

- Improvement Actions: The Trust's Mental Health Team is actively collaborating with external partners, including Black Country Healthcare NHS Foundation Trust, to enhance pathways and share insights from incidents. We are implementing pan-Trust mental health training across key areas, including Paediatrics, the Acute Medical Unit (AMU), and the Emergency Department (ED), to boost staff confidence and promote early intervention. Oversight and escalation is managed through the Patient Safety Group and the Safeguarding Committee, with support from Executive Nursing and Medical Leads.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

ED Corridor Care

- The ED Corridor continues to be utilised to support patient flow during periods of increased operational pressure. Data from January 2026 indicates an increased usage per patient time spent on the corridor but a reduction in the overall number of days the corridor was utilised.

- The ED Corridor was used in January 2026 to manage patient flow and support ambulance offload, with an average stay of 5.6 hours per patient cared for in the area. And the corridor was in use 22 out of 31 days (25 days in December 2025) in the month. One patient spent 17 hours receiving care on the corridor. All activations fully adhered to the operational policy criteria, including appropriate staffing, patient selection, and escalation governance. No incidents or patient safety concerns were reported during this period.

- Improvement Actions: The ED Corridor is continuously monitored by the Site Management Team to ensure that the admission and discharge processes are safe. Additionally, we will continue our monthly monitoring of the usage of non-clinical areas to ensure that these measures remain a temporary solution rather than a long-term capacity extension.

Human Tissue Authority

- The Human Tissue Authority completed a full 72-point inspection on the Walsall licensable activities at WHT and RWT in October 2025. HTA reports escalate critical, major and minor shortfalls. WHT licensable activities resulted in 5 major and 7 minor shortfalls against expectations; all shortfalls are expected to be closed by the end of March 2026.

SEND

The Trust received the outcome letter from Ofsted and the CQC following the joint inspection of SEND services across the Walsall system. An action plan is being developed with a system approach

Letter from DHSC re band 5 nurses

- All CNOs and CPOs received a letter on the 12th February from NHSE Director of People and CNO following a press release 'Nurses to benefit from boost to graduate pay and job progression'. We are required to review all band 5 job descriptions. The Black Country Workforce alignment group will agree an approach and work together on this.

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

<u>**Maternity**</u>

- Perinatal staffing is stable, midwifery vacancy 2.74 WTE, maternity leave reduced to 10.28 WTE and currently long-term sickness is 10.08 WTE , recruitment to commence to meet Birthrate Plus 2024 recommendations. One to one care in labour and supernumerary coordinator compliance 100%

- WHT is below the national average for perinatal mortality with a rate of 4.16:1000 but slightly above in comparison for stillbirths 3.89: 1000. Work is ongoing to address <24/40 pregnancy loss as this is the area of highest pregnancy loss.

- Obstetric staffing compliant with RCOG guidance of compliant with consultant attendance. BAPM neonatal staffing nurses and medical staff intermittently compliant, a business case is awaiting approval to address this.

- CQC Maternity Survey showed that WHT patient experience was on par with the national picture; a co-produced action plan has been completed and is ongoing to address areas for improvement. This will be monitored via patient experience group and reported via QSOG.

- Saving Babies Lives Care Bundle V3, ATAIN and PMRT are meeting national requirements set out by NHSE.

- The service had two MNSI cases reported in 2025 involving a neonatal death and stillbirth, action plans are in place to address recommendations identified within the investigation reports and are monitored at Divisional and Group Quality Committee

- The service is a positive outlier on review of the Regional Sitrep and Regional Heatmap, there have been no alerts on the Maternity Outcome Signal System.

- The Trust has not been successful in securing £300,000 maternity funding from the NHSE to support environmental and resource initiatives, the Division is exploring avenues to fund these projects and require support from the Trust.

- WHT FFT recommendation scores demonstrate that service users are having a good experience within maternity services.

- The interim report into maternal and neonatal services being conducted by Baroness Amos was published on 26th February 2026 and is currently being reviewed by the service

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Chief Medical Officer)

**Care Colleagues
Collaboration Communities**

Quality, Safety & Patient Experience | Core Metrics

Patient falls - rate per 1,000 occupied bed days

| Inconsistent | Common Cause | 3.58 |
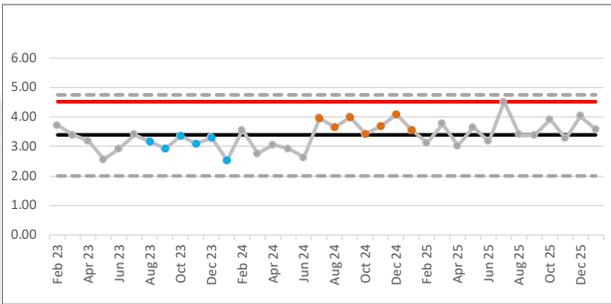
Pressure ulcers per 1,000 occupied bed days

| Inconsistent | Concern | 3.12 |
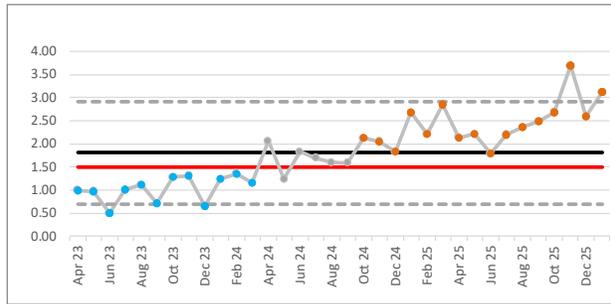
Community acquired pressure ulcers per 10,000 population

| Inconsistent | Common Cause | 0.83 |
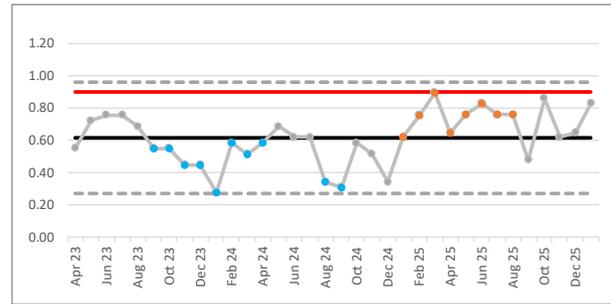
Observations on time (Trust wide)

| Inconsistent | Concern | 84.10% |
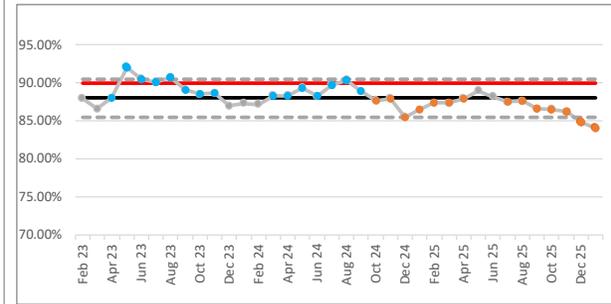
VTE risk assessment - % within 14 hours

| Not Met | Common Cause | 86.55% |
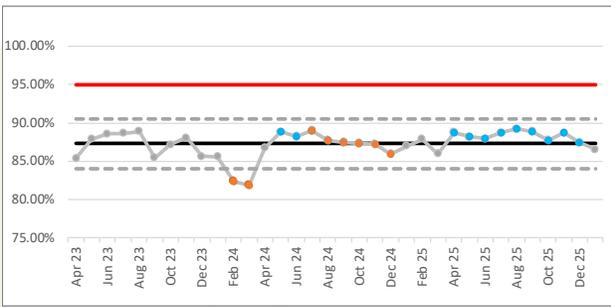
Sepsis screening - ED

| Not Enough Points | Not Enough Points | - |

In Development
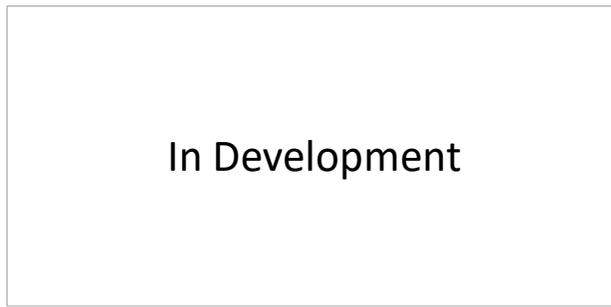
Sepsis screening - Inpatients

| Not Enough Points | Not Enough Points | - |

In Development
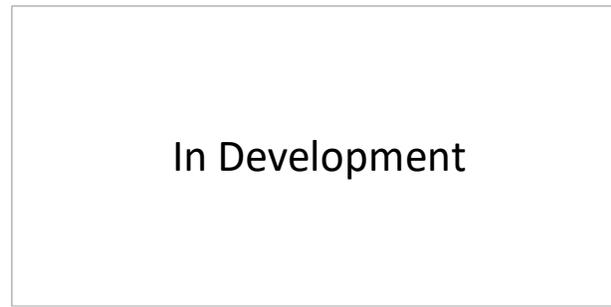
Medication Errors - % causing harm

| Inconsistent | Common Cause | 10.92% |
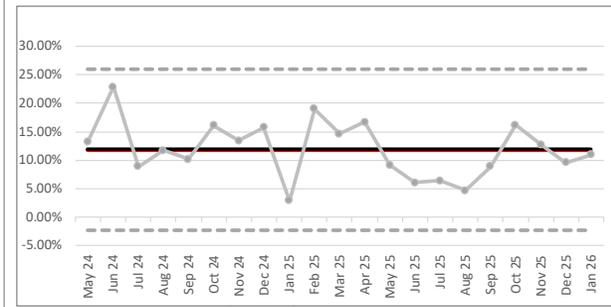
Mental health patients spending over 24 hours in A&E

| Not Met | Common Cause | 12 |
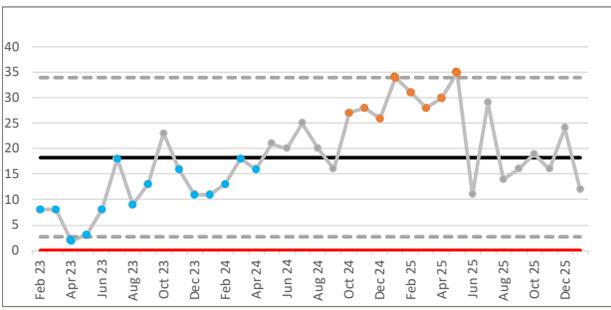
Clostridioides difficile

| Inconsistent | Improvement | 3 |
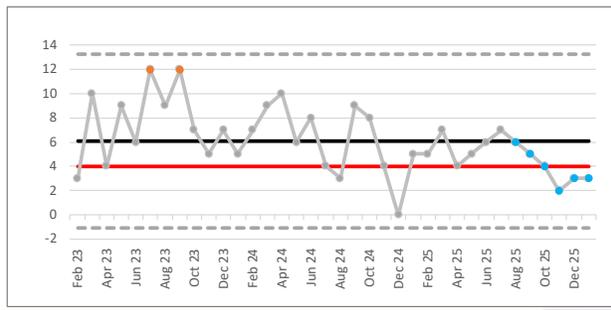
MRSA Bacteraemia

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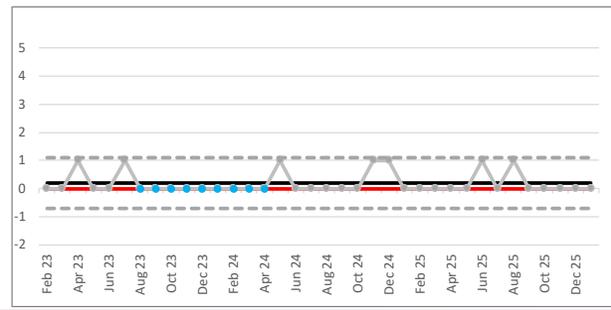
Number of complaints as a % of admissions

| Inconsistent | Concern | 0.60% |
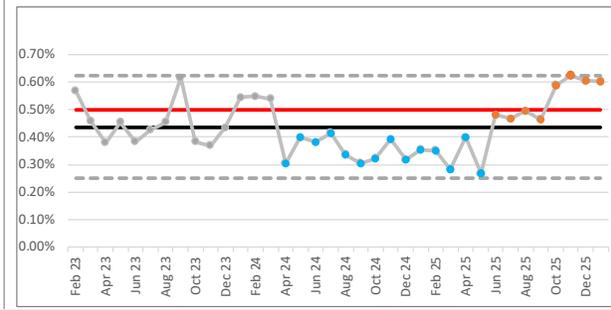
Quality, Safety & Patient Experience | Core Metrics

Complaints response rate against policy

| Inconsistent | Common Cause | 81.82% |
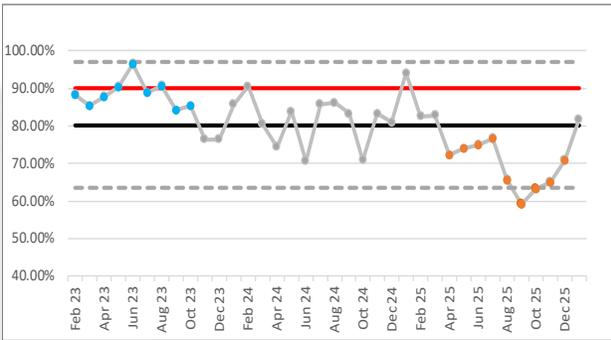
FFT recommendation rates - Trust wide

| Inconsistent | Common Cause | 92.00% |
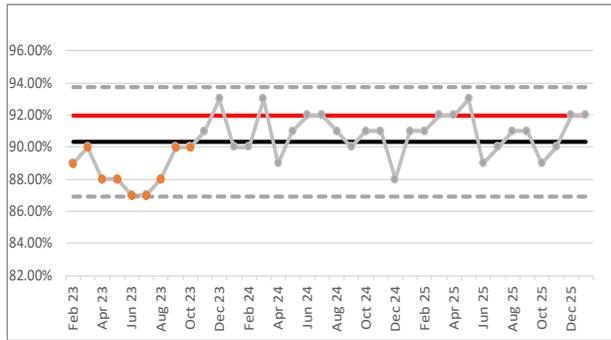
Midwife to birth ratio (1 to)

| Inconsistent | Common Cause | 26.53 |
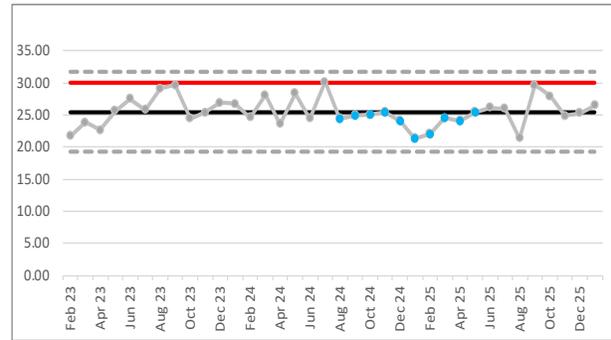
Care hours per patient - total nursing & midwifery staff actual

| No Target Set | Common Cause | 7.8 |
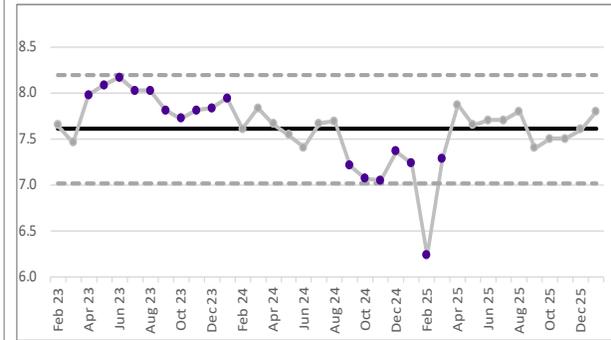
Care hours per patient - registered nursing & midwifery staff actual

| No Target Set | Common Cause | 4.5 |
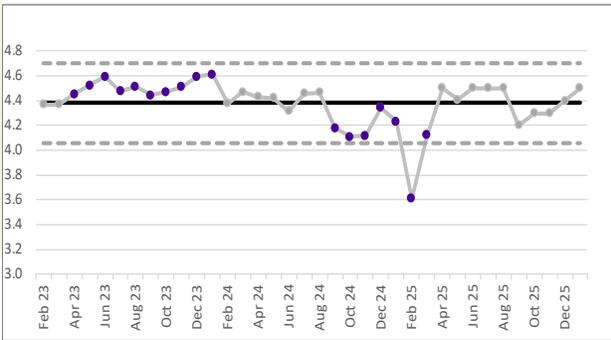
SHMI

| Achieving | Common Cause | 0.96 |
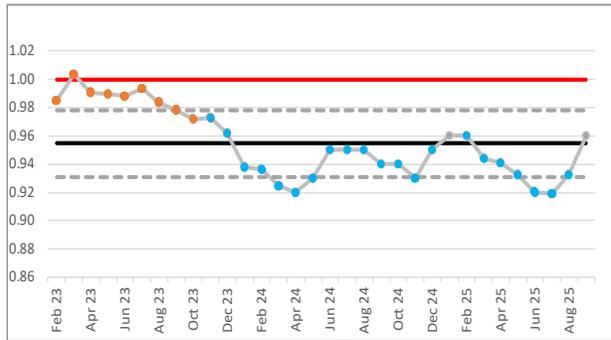
Crude Mortality Score

| No Target Set | Common Cause | 2.69 |

Never events

| Inconsistent | Improvement | 0 |

Care Colleagues
Collaboration Communities
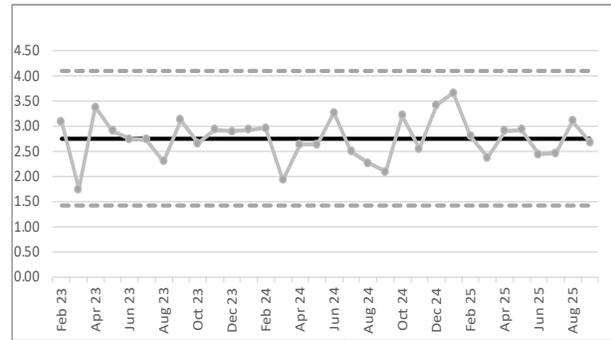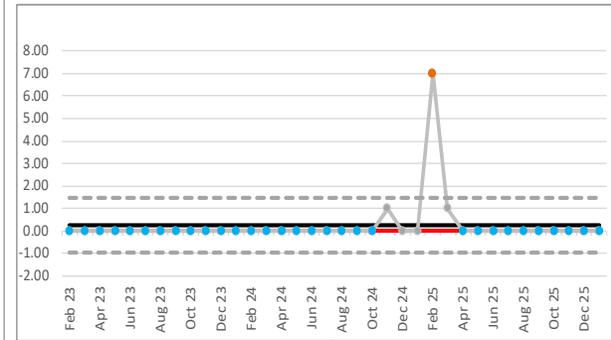
Quality, Safety & Patient Experience | Maternity

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

	August		September		October		November		December		January	
PMRT Reviews	3		3		3		3		4		1	
Grade N = neonatal M = Maternal	N	M	N	M	N	M	N	M	N	M	N	M
	A 0	A 1	A 0	A 1	A 0	A 1	A 0	A 1	A 1	A 3	A 0	A 1
	B 1	B 0	B 1	B 0	B 1	B 0	B 1	B 0	B 3	B 1	B	B 0
	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0
	D 0	D 0	D 0	D 0	D 0	D 0	D 0	D 0	D 0	D 0	D 0	D 0
MNSI new cases	0		0		0		0		0		0	
Incidents Moderate & Above	6		3		3		3		3		10 (Change to incident grading process)	
Service feedback FFT recommendation	91%		93%		88.5%		92%		89%		93%	
Service user & Staff Feedback to Board Level Safety Champions Walk & Bi-Monthly meeting	Community Bi-Monthly		Delivery Suite Bi-monthly		Neonatal Unit		Antenatal / Postnatal Ward		Antenatal Clinic & Fetal Assessment Unit Bi-monthly		Community Service	
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

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	1	1	5	7
2	0	0	0	2	2
3	0	0	1	3	4
4	0	0	1	12	13
5	0	2	0	10	12
6	0	0	0	8	8
7	0	0	0	1	1
8	0	0	0	20	20
9	0	0	1	7	8
10	0	0	0	6	6
Total	0	3	4	74	81

CNST: 9 out of 10 Safety Actions are fully compliant

There are three amber items partially achieved. SA 1, two MBRRACE cases not reported within 7 days. Reported to MIS, action plan in place will undergo MIS verification process to ascertain if this action can be declared compliant. SA 5, two items partially compliant this does not affect compliance with CNST as Birthrate Plus staffing recommendations accepted by the board. There are four green items which are awaiting evidence in the form of safety champion minutes

	NLS	PROMPT	Fetal surveillance
MW	82%	82%	97%
Obstetric Consultant	79%	79%	90%
Obstetric Residents	70%	70%	70%
Maternity support workers	69%	69%	NA
Anaesthetics	97%	97%	NA
Neonatal Nurses	90.54%	NA	NA
Neonatal Consultants	94%	NA	NA
Neonatal Residents	88.7%	NA	NA

Quality, Safety & Patient Experience | Maternity

Item	Themes	Action
PMRT	• Fetus not identified as IUGR on USS • Missed opportunity to complete MSU • Woman attended EPAU so did not see midwife screening bloods delayed **Good practice** • Parent engagement with all cases • Cases reviewed in line with national guidance within required time frame and with external reviewer present	• Case to be presented at the LMNS Perinatal Quality Surveillance Group • Feedback to sonography team regarding discrepancies and audit to be completed. • Outpatient matron to meet with EPAU staff to discuss correct MSU process • Outpatient matron to meet with EPAU staff to discuss booking bloods for screening
MNSI	• Nil cases reported to MNSI in December or January • MNSI Report received in December for Stillbirth which occurred in July 2025	• Booking risk assessment to align with maternity guidance • Audit perinatal mental health screening • Embed structured communication across the service • Explore the barriers and contributing factors to completing the CTG review prior to a CTG being stopped • Explore the barriers to commencing CTG when clinical picture changes • Mental health service works with staff to review the documentation of the multidisciplinary clinical review meetings • Perinatal mental health services review their operational guidance
Incident &/or PSIRF themes	• Perinatal mortality • Perinatal Morbidity • Service completing thematic review regarding increase in third degree tears and readmissions	• Perinatal Mortality 4.16:1000 (national MBRRACE rate 4.84:1000). • Stillbirth 3.89: 1000 (national MBRRACE rate 3.22:1000). • Avoidable term babies to the neonatal unit rate 0.7% (national target <5%)
Service user feedback		• Service users recommend WHT as a good place to receive maternity care • Area for improvement, environment, answering call bells promptly and prompt analgesia when requested.
Safety Champions feedback	• Fetal assessment unit and antenatal clinic (December) • Community (January 2026)	• Positive feedback from staff, request for more beds in unit as area can get busy • Increase in referrals across the region • You said We Did service users asked for new seating and this was provided • Staff feeling benefit of improved staffing • No concerns raised
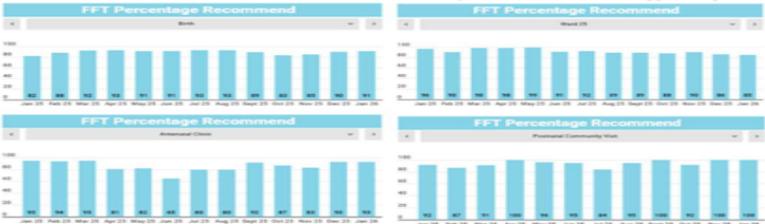
Perinatal staffing

Staff Group	August		September		October		November		December		January		
Midwives Birth to midwifery ratio Planned/ Actual	23.75	27.94	23.75	27.94	20.47	21.40	24.54	29.66	22.91	24.91	23.02	26.53	
Obstetrics RCOG Compliant on delivery suite	Yes		Yes		Yes		Yes		Yes		Yes		
Neonatal Nurses BAPM Compliant	No		No		No		Yes		Yes		Yes		
Neonatal Doctors BAPM compliant	Yes		Yes		Yes		Yes		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 January 15% on ward and 82% Delivery suite against a target of 85%. To commence recruitment to Birthrate Plus® safe staffing recommendations 2024. Safe staffing maintained via daily management and clinical mitigations. Staffing monitored and escalated via Division, Group Quality Committee and Local Maternity and Neonatal system. Maternity leave currently 10.28 WTE												
Obstetrics RCOG Compliant on delivery suite	No actions required												
Neonatal Nurses BAPM Compliant Neonatal Doctors BAPM compliant	Neonatal nursing and medical staffing met BAPM standards. The overarching neonatal staffing action plan continues and neonatal staffing business case awaiting completion to support neonatal nurse staffing for transitional care on the postnatal ward.												

People

People | Executive Summary

Performance against Trust 2025/26 Workforce Plan

WHT's overall workforce increased by 35 WTE during M10, reflecting a decrease of 11 substantive WTE, offset by an increase in bank deployment by 41 WTE, and a rise in agency usage by 5 WTE. The WHT overall workforce is 141 WTE (2.9%) above the financial sustainability (stretch) target trajectory.

During M10 25/26, external substantive leavers (53 WTE) exceeded external substantive starters (45 WTE). Triangulated against assignment changes, such as adjusted contracted hours, this contributed to an 11 WTE decrease in the substantive workforce. While medical locum usage declined in January 2026, a rise in bank reliance among the nursing and infrastructure support workforce contributed to a month-on-month increase. Vacancy cover and high acuity accounted for two-thirds of agency bookings during January 2026, contributing to a month-on-month rise, driven by increased registered nursing reliance on temporary staffing.

Performance against Key Workforce Metrics

- In January 2026, three of the six workforce indicators—mandatory training, 12-month turnover, and 12-month retention—met the agreed-upon targets/ thresholds. Rolling 12-month sickness absence, vacancy rates and appraisal compliance are rated red.
- The 12-month turnover rate (8.1%) continues to reflect a long-term improvement trajectory, with performance maintained below the 10% target.
- Despite a month-on-month decline in performance, a 24-month trend indicates that the 12-month retention rate, currently at 94.2%, will meet the 90% target if the long-term improvement trend is sustained.

- The 10.2% vacancy rate provides limited assurance, over a 24-month trend, that the 6% target will be consistently met, with performance continuing to worsen amid strategic workforce reduction initiatives.
- There is no assurance that the rolling 12-month sickness absence rate, at 6.5% in December 2025, will meet the long-term target of 5%, as a month-on-month increase ended the previous improvement trend.
- The mandatory training compliance rate of 91.5% provides limited assurance, over a 24-month trend, that the 90% target will be consistently met and that the long-term improvement trend will be maintained.
- Following a month-on-month reduction, there is no assurance that appraisal compliance, currently at 73.7%, will consistently achieve the 90% target, given a long-term trend of worsening performance.

Authors

Clair Bond
(People Director)

Care Colleagues Collaboration Communities

People | Core Metrics

Substantive (WTE) Trust

Inconsistent	Concern	4562.79
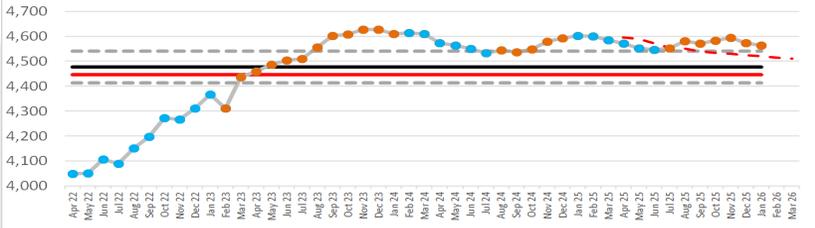
Agency (WTE) Trust

Not Met	Improvement	21.90
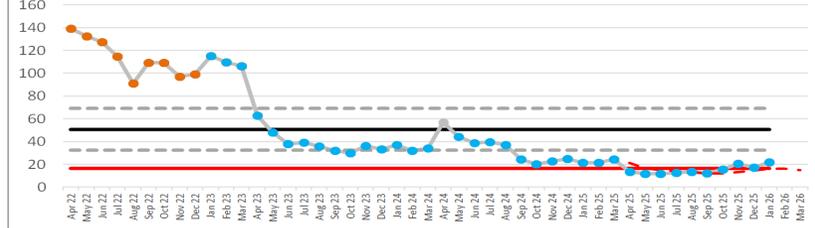
Bank (WTE) Trust

Inconsistent	Concern	471.24
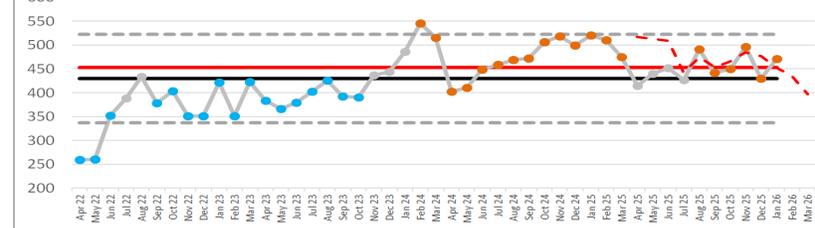
Vacancy Rate

Inconsistent	Concern	10.23%
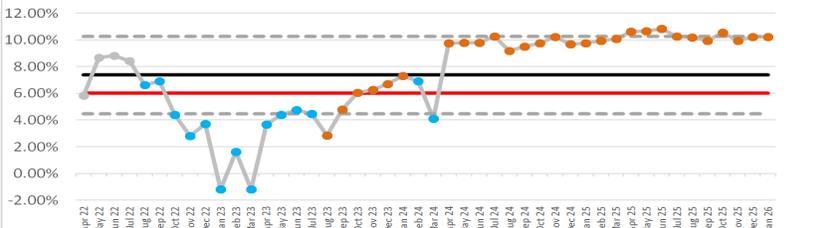
Turnover Rate (12 Months)

Inconsistent	Improvement	7.42%
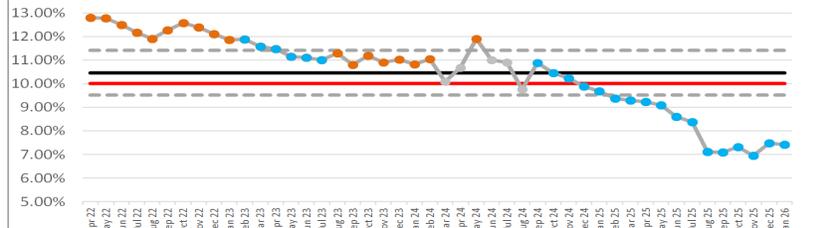
Retention Rate (12 Months)

Achieving	Improvement	93.12%
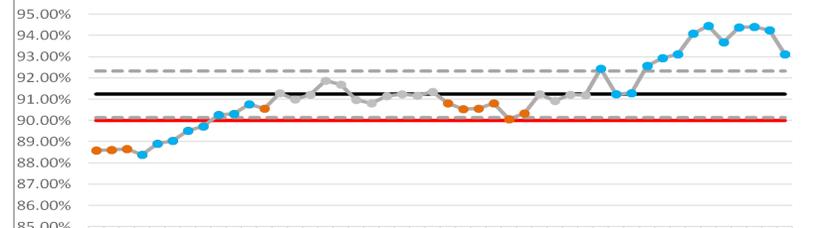
Sickness Absence (Rolling 12 Months)

Not Met	Concern	6.48%
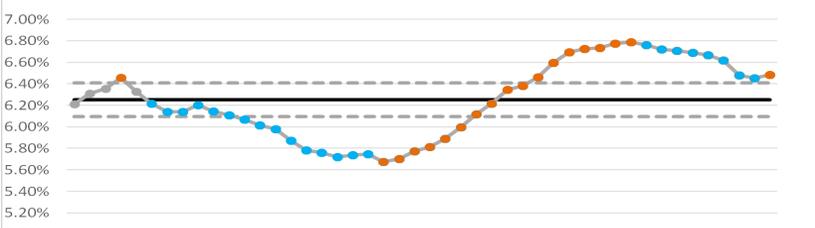
Appraisals

Not Met	Concern	73.73%
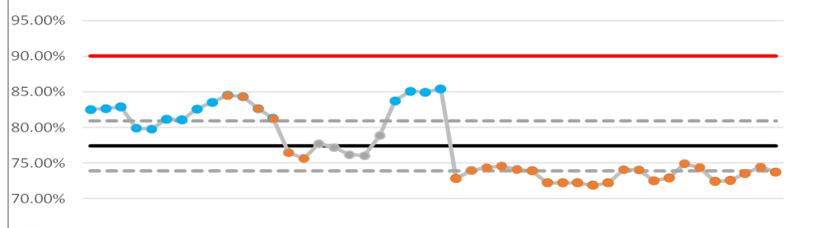
Statutory & Mandatory Training

Inconsistent	Improvement	91.47%

Operational Performance

Operational Performance | Executive Summary

Urgent & Emergency Care
The Trust has seen a decrease in performance against the 4-hour Emergency Access Standard (EAS), moving from 71.44% in December to 69.97% in January, which is below our trajectory in January of 76%. EAS is ranking 55th nationally and 8th in the region. Type 1 ED attendances were 6.33% higher when compared to January 25. Additional staffing and surge capacity has been utilised to manage peak periods of demand. The ED Observation Unit development has been implemented to improve our ability to treat and discharge patients safely and efficiently.

Cancer Care
Performance has seen some challenges with one of the three constitutional standards for access to treatment for cancer being met. Improvement continues for access to diagnosis within 28 days, with the Trust ranking 15th nationally. Performance against the 62-day standard has been impacted by a reduction in capacity in oncology, however, there has been improvement with the Trust achieving 74.15% performance against the 75% national target. The Oncology capacity due to workforce changes which are being addressed through a service development plan with short term locum recruitment and support from RWT.

Elective Care
The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for fifteen consecutive months, ranking 13th nationally. There has been a reduction in the Patient Tracking List (PTL) size to 29,574 in January. This remains above the plan of 27,050 for M10. Interventions are in place with services to increase capacity and are demonstrating an impact on reducing the waiting list and increasing RTT. In addition, we are utilising the national Sprint funding for independent sector activity to improve the position further.

Diagnostics
DM01 performance was 72.81% in January with a national ranking of 64th and 10th in the region. Challenged modalities are Magnetic Resonance Imaging (MRI), Audiology, Cardiac Physiology and Neurophysiology. Capacity is being increased for MRI through the national Sprint opportunity and a longer-term plan is being developed.

Authors

Demetri Wade
(Chief Operating Officer)

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

18 Weeks RTT - % Within 18 Weeks - Incomplete

| Not Met | Improvement | 69.29% |
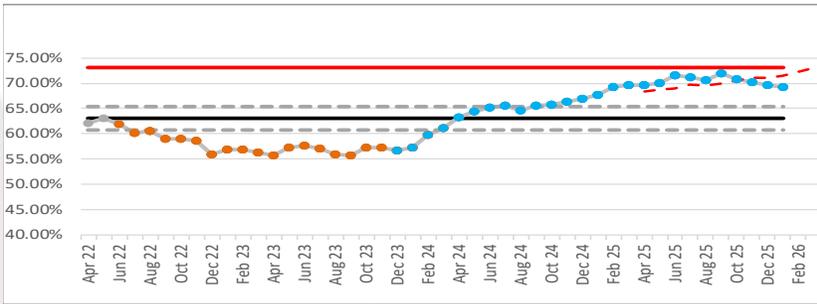
18 Weeks RTT - No. of 52 wk breaches

| Not Met | Improvement | 16 |
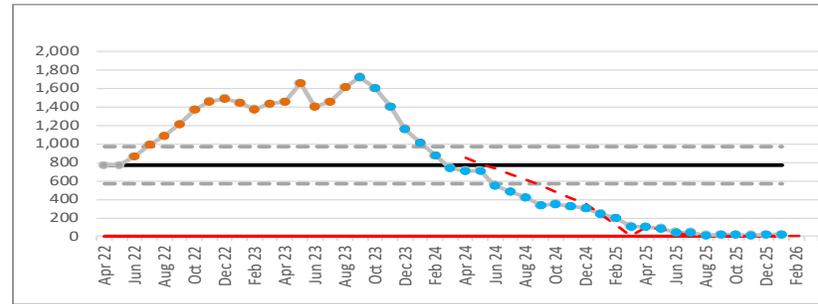
18 Weeks RTT - 52 wk breaches as a % of PTL

| Not Met | Improvement | 0.05% |
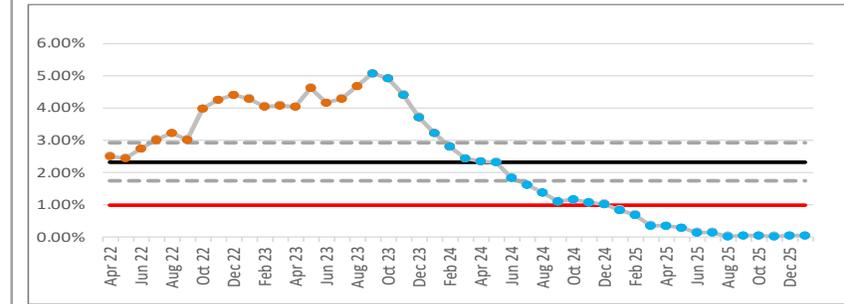
18 Weeks RTT - No. of 65 wk breaches

| Not Met | Improvement | 0 |
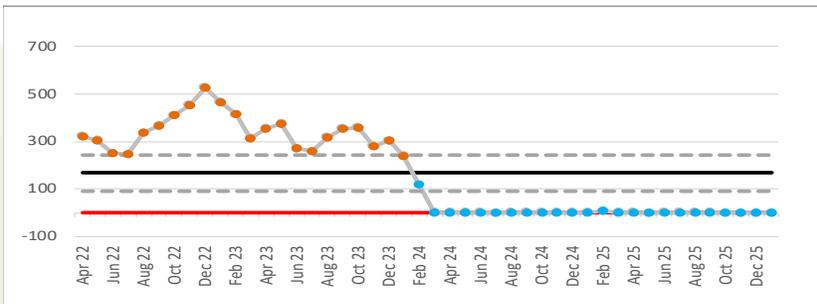
18 Weeks RTT - Total Incomplete PTL

| Not Met | Improvement | 29574 |
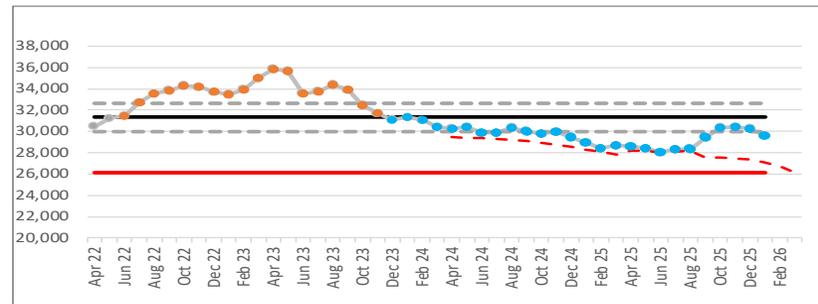
18 Weeks RTT - Clock Starts

| No Target Set | Common Cause | 8695 |
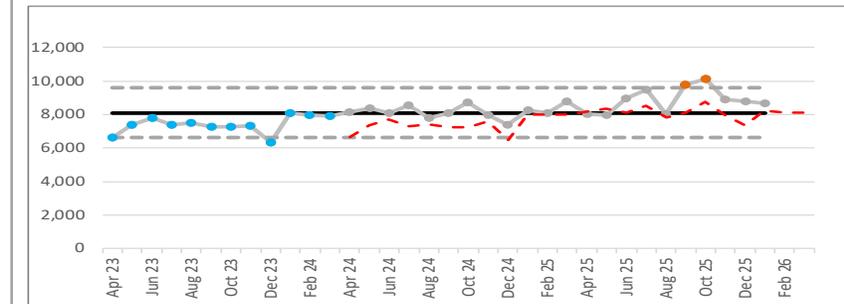
18 Weeks RTT - Time to First Appointment

| Not Met | Common Cause | 74.05% |
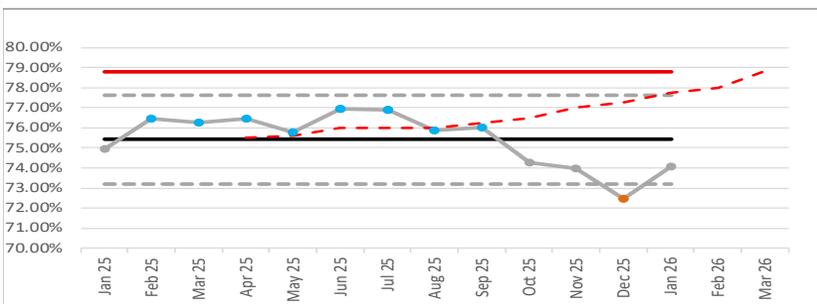
Ambulance Handover - % within 15mins

| Not Met | Concern | 22.25% |
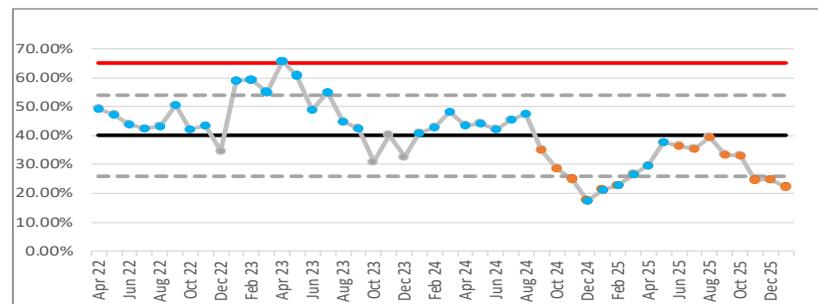
Ambulance Handover - % within 30mins

| Inconsistent | Concern | 63.25% |
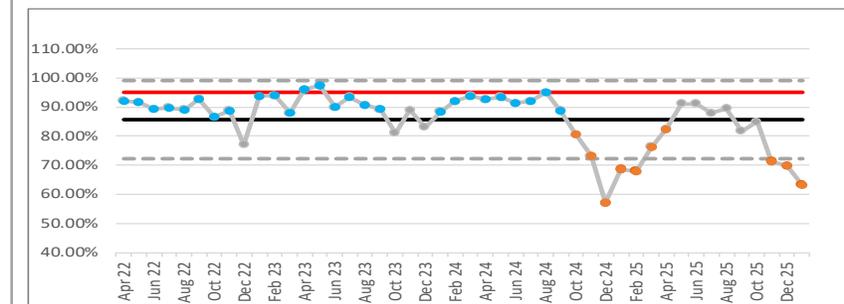
Operational Performance | Core Metrics

Ambulance Handover - % within 60mins

| Inconsistent | Concern | 77.39% |
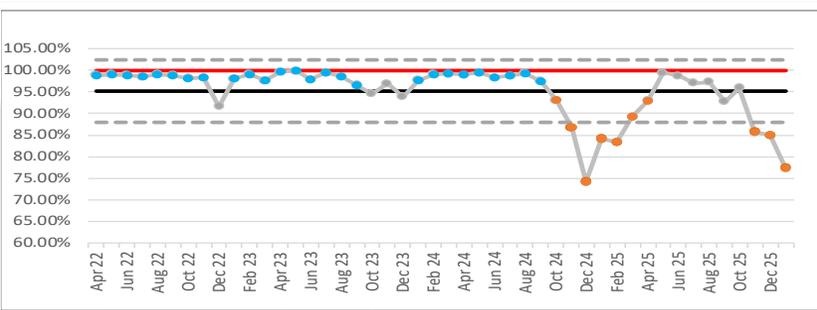
Cancer - 2 Week Wait

| Inconsistent | Concern | 68.27% |
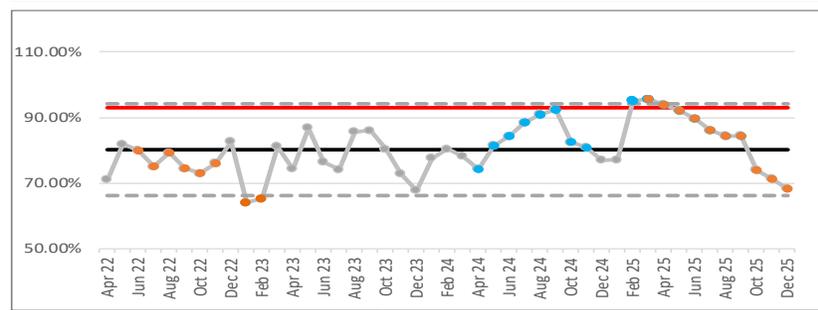
Cancer - 28 Day Faster Diagnosis

| Inconsistent | Improvement | 83.87% |
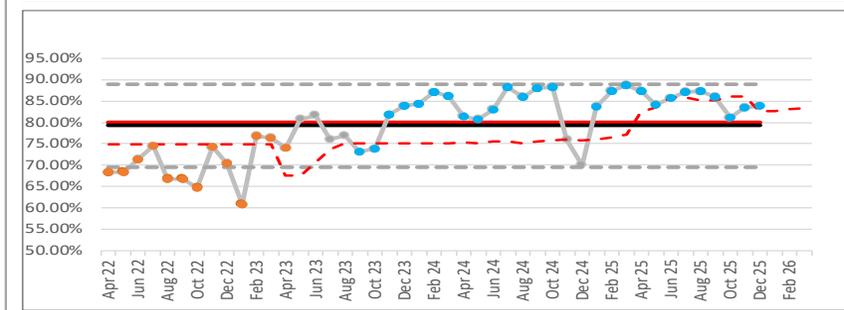
Cancer - 31 Day Treatment

| Inconsistent | Common Cause | 95.96% |
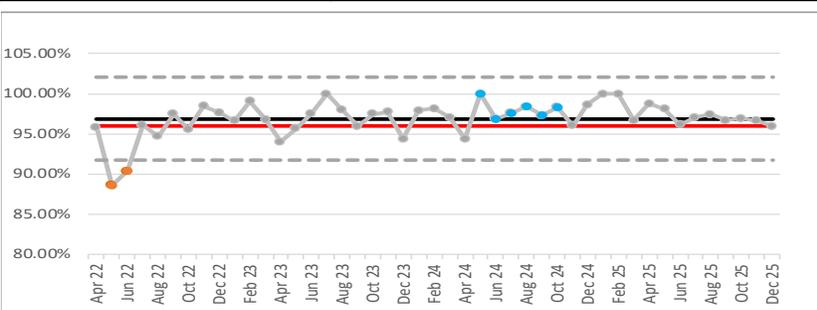
Cancer - 62 Day Referral to Treatment

| Inconsistent | Common Cause | 74.15% |
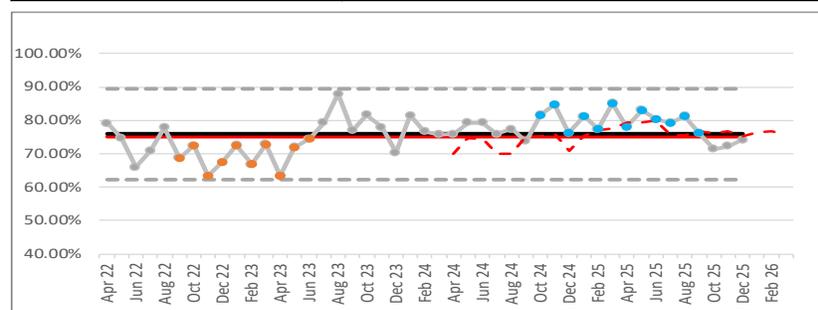
Cancer - No. of patients waiting 63+ Days for treatment

| No Target Set | Concern | 99 |
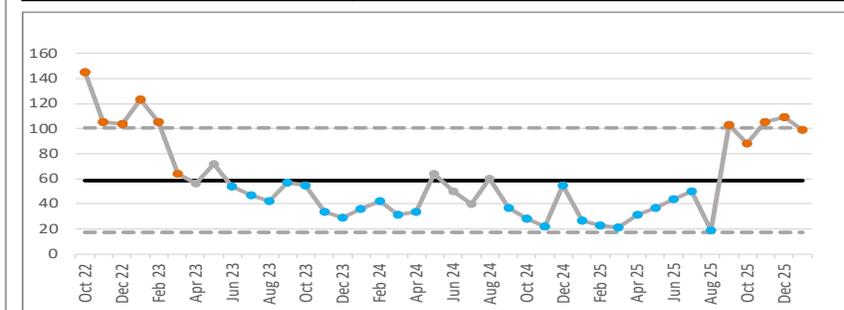
No. of patients no longer meeting the Criteria to Reside

| Achieving | Common Cause | 36 |
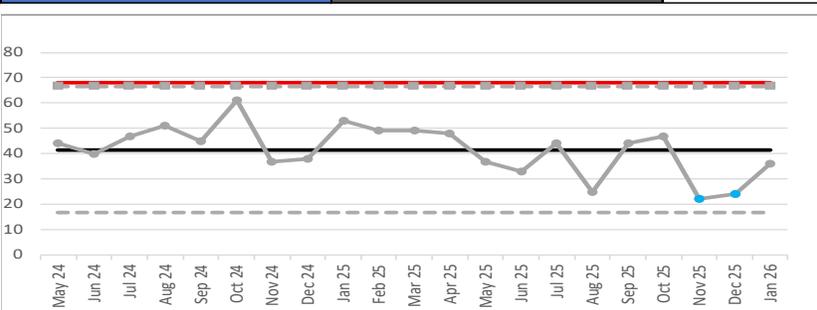
Diagnostics - % within 6 weeks from referral

| Not Met | Concern | 72.81% |
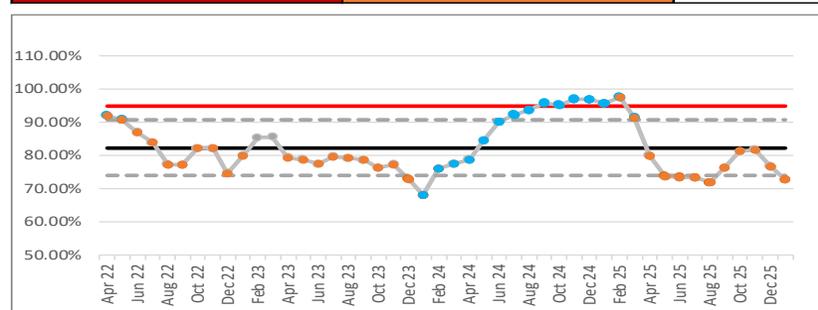
Total Time Spent in ED - % over 12 Hours

| Inconsistent | Concern | 13.72% |
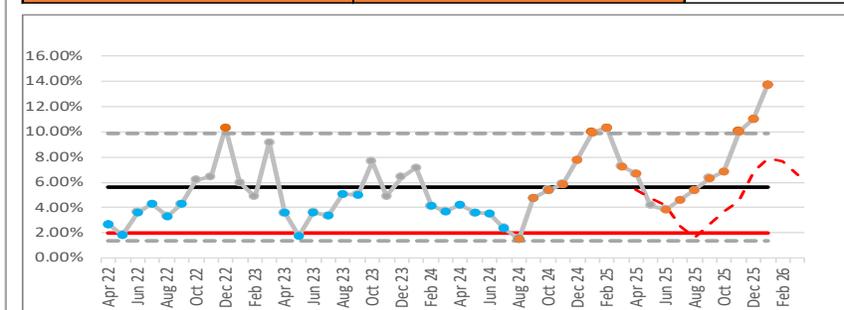
Operational Performance | Core Metrics

Total Time Spent in ED - % within 4 Hours

| Inconsistent | Concern | 69.97% |
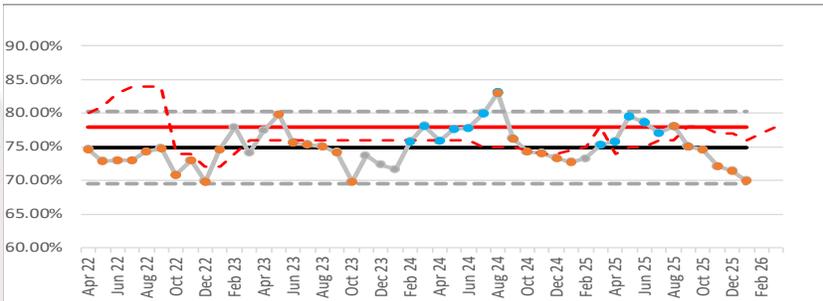
Type 1 ED Attendances

| No Target Set | Concern | 9646 |
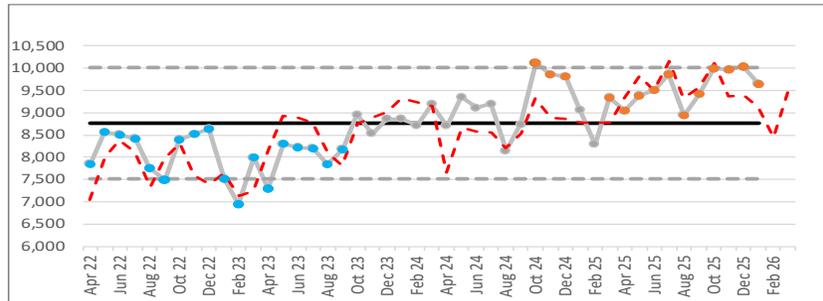
Deliver % of Activity Delivered in 2019/20 (Variable Contract Delivery)

| Not Enough Points | Not Enough Points | 101% |
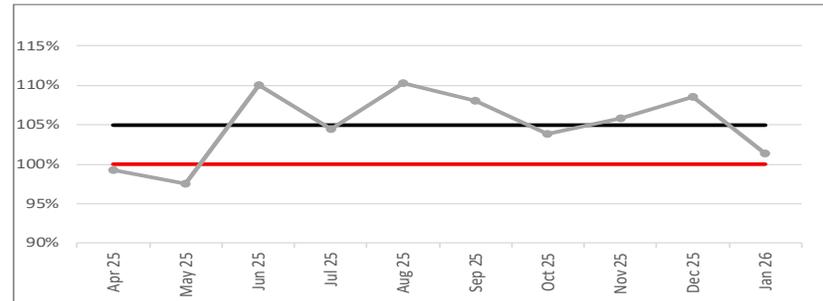
Theatres - Touch Time Utilisation (MH)

| Inconsistent | Common Cause | 83.10% |
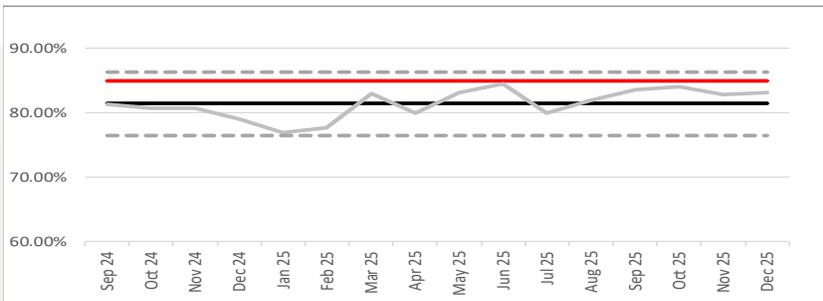
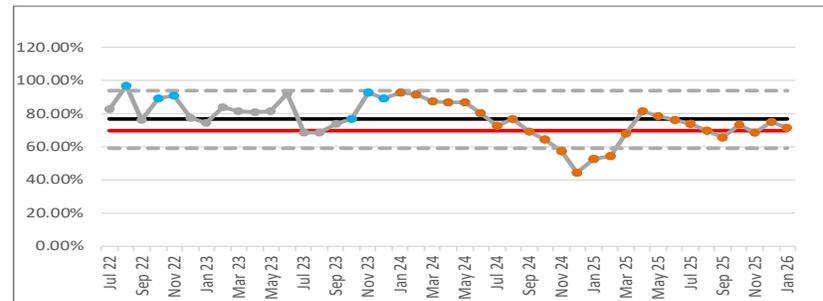### Community - Virtual Ward % Occupancy

| Not Met | Improvement | 74.44% |
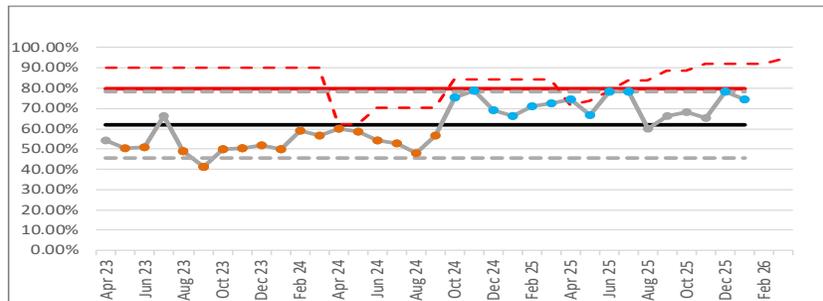
Community - Urgent Care Response (UCR) 2 Hour Response

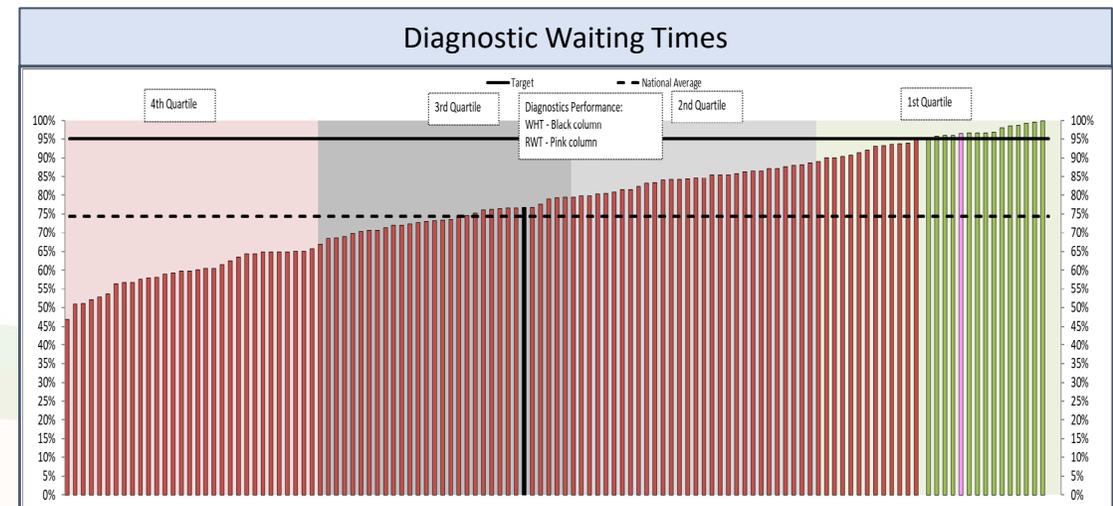| Inconsistent | Concern | 71.71% |

Community - Waiting List - Total

| No Target Set | Concern | 8996 |
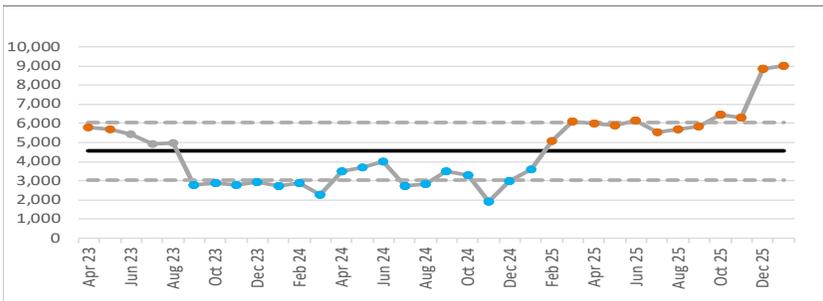
Community - % Within 18 Weeks - Incomplete

| No Target Set | Concern | 64.91% |
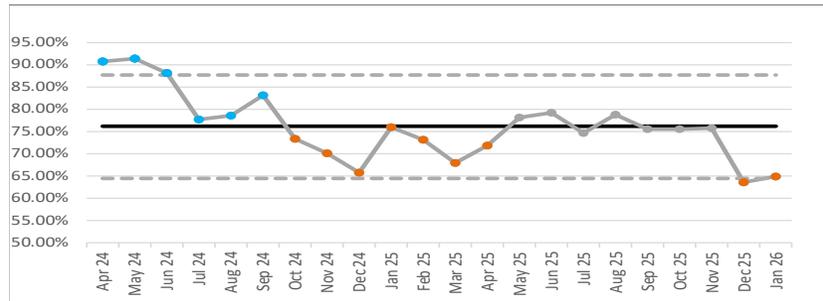
Operational Performance | Benchmarking
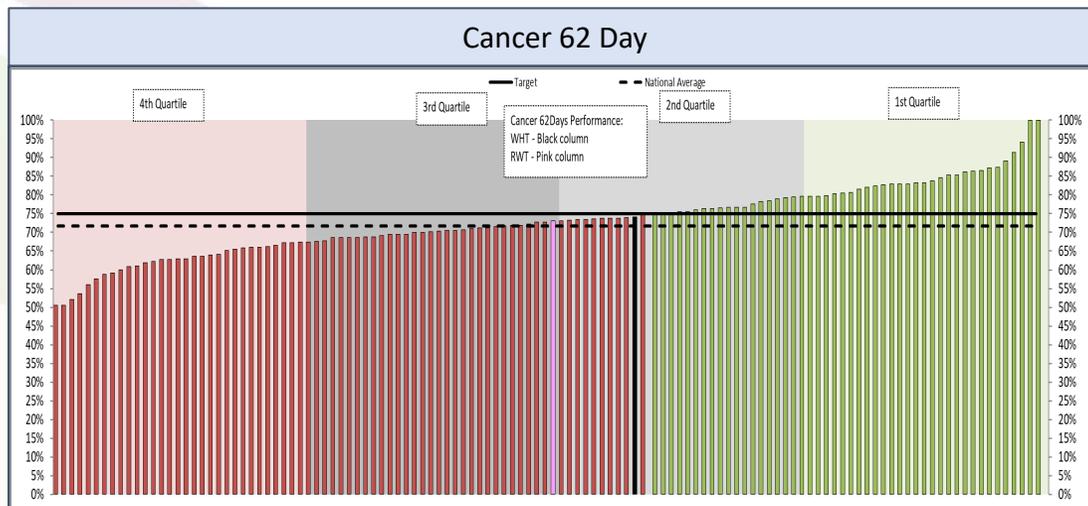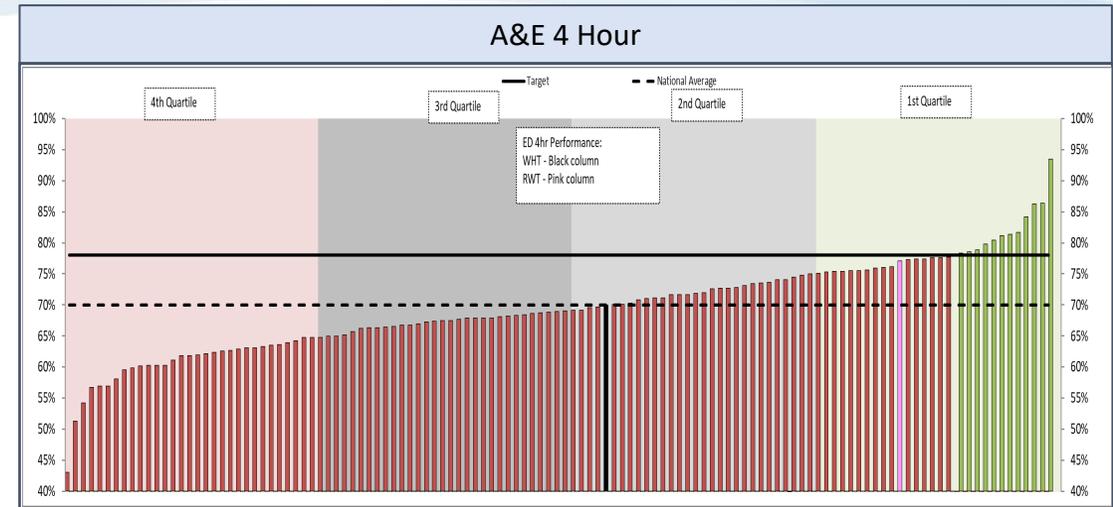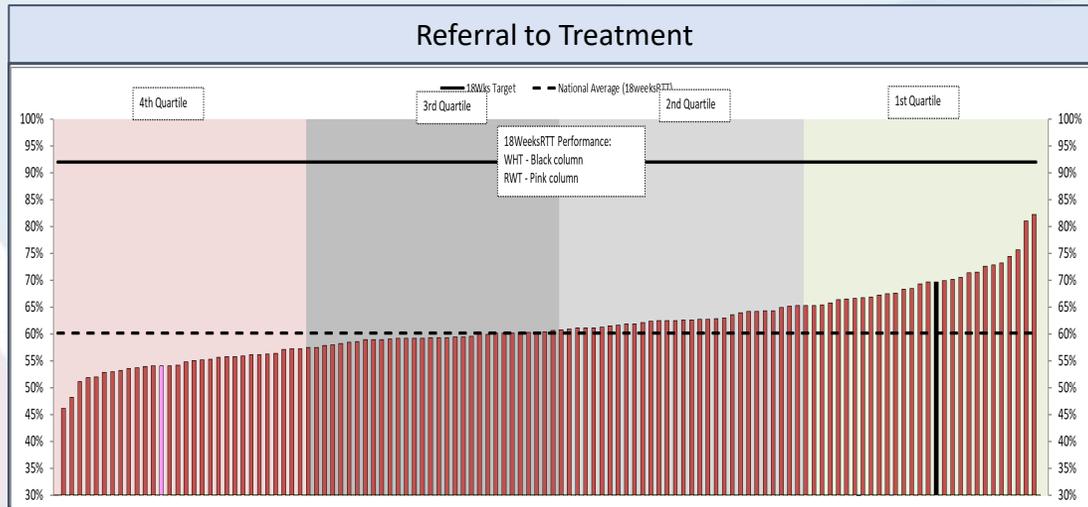
Finance

Finance | Executive Summary

Revenue

- WHT is ahead of plan by £2.1m at month 10. 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 has 'smoothed' the improvement trajectory, the I&E performance chart on the following slide demonstrates this.

- YTD the Trust has achieved c£2.9m of variable elective performance over contract. There is currently no pathway for this to be funded and at Month 10 this performance has not been included in the position. The Trust has allowed a limited amount of funding for WLIs within the financial plan. The Trust has increased WLI controls. The Q4 Outpatient Sprint Plan may provide additional funding direct from NHSE to increase capacity at the year end.

- CIP is £21.7m versus a plan of c£20.4m, so a YTD positive variance of £1.3m

Capital

- Year to date capital expenditure at Month 10 is £11.768m, including £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, further discussion on the allocation of this allowance is in progress with a number of areas of pressure (Theatres, IT, Medical equipment). The Trust is the beneficiary of circa £0.7m of solar panel funding and a further £1.9m for critical estates infrastructure.

Cash

- The Trust cash position at end of Month 10 is £26.9m. Cash is currently higher than plan due to reduced payments in October and November following the movement to SBS. This is forecasted to reduce throughout the rest of the year with movements in working balances and Capital Expenditure. The 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

In-Month Income & Expenditure	Plan M10 £m	WHT Actual M10 £m	Surplus/ (Deficit) £m
Income	42.2	41.1	(1.2)
Expenditure			
Pay	26.2	25.9	0.3
Non Pay	9.7	10.5	(0.8)
Drugs	2.5	2.7	(0.2)
Other*	2.5	2.6	(0.1)
Total Expenditure	40.9	41.7	(0.8)
Net reported surplus/(Deficit)	1.3	(0.7)	(2.0)

Year-to-date Income & Expenditure	Plan YTD £m	WHT Actual YTD £m	Surplus/ (Deficit) £m
Income	398.5	401.7	3.2
Expenditure			
Pay	259.9	256.0	4.0
Non Pay	92.2	96.0	(3.9)
Drugs	24.5	24.8	(0.3)
Other(incl. depreciation)	26.2	27.1	(0.9)
Total Expenditure	402.8	403.9	(1.1)
Net reported surplus/(Deficit)	(4.3)	(2.2)	2.1

Key headlines

- Performance in month 10 is £2.0m adverse to plan, but £2.1m better than plan YTD

- Total YTD deficit £2.2m

- ERF is above the contract by £2.9m however this income is not recognised in the position due to a performance cap. This is restricted due to commissioner affordability so has been removed from the position.

- Education & Training income is ahead of plan following the receipt of the updated LDA schedule and Other Income is ahead of plan due to non recurrent income to cover in year non pay pressures.

- Staffing Expenditure is underspent by £2.7m with a significant swing in month 10 due to the allocation of funding to cover the year to date cost of Industrial Action. There are remaining pressures, particularly in Medical Staffing, these are detailed on a further slide.

- Non-Pay is overspent due to pressures in Services and Recharges from Other Trusts, some of this is offset by vacancies within the pay position (e.g. recharges for staff from RWT). There are also overspends in the premises budget related largely to software and licences.

- The in-month underperformance on CIP is £2.1m bringing the YTD overperformance to £1.2m – further detail in later slides

Variable Elective Contract Performance – 2025/26 YTD M10

Variable Contract Delivery vs Funding Limit, Internal Plan and Historical - 2025/26
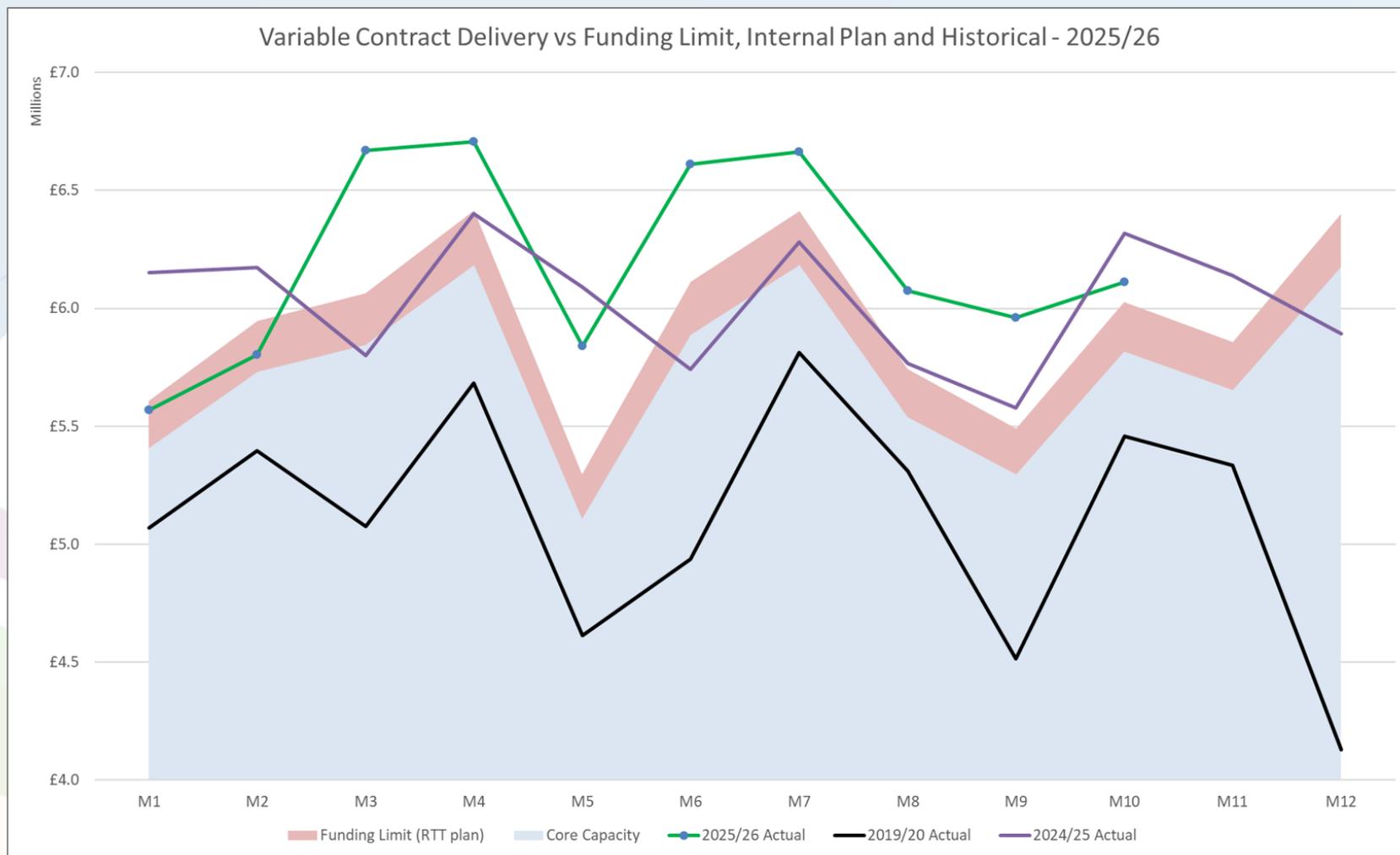
Performance
- At Month 10 WHT are £2.9m above contract/funding limit and 122% of 19/20
- The internal plan is delivered with core divisional budgets
- The gap between internal plan and funding limit is planned to be delivered with WLIs, count/code and productivity

CIP Performance YTD

	In Month				YTD		
	Plan	Actual	Variance		Plan	Actual	Variance
	4.2	2.1	(2.1)		20.4	21.7	1.3

The total efficiency challenge in 2025/26 for WHT is £30m. The in-month plan was £4.2m an increase of £0.2m from last month's target.

In month 10 the Trust underperformed against the CIP plan by £2.1m, savings run rate remained static.

Year to date the total overperformance against plan is £1.3m.

WHT: CIP Performance Overview

Executive Summary

- As of M10, **WHT has delivered CIP of £21.65M against a target of £20.41M** (a positive variance of £1.2M). For M10, the Trust delivered £2.1M vs a target of £4.2M (negative variance of £2.1M).
- WHT has a FOT of **£27.9M** against a full year target of **£30.1M a negative position of £2.2M.**
- Delivery Status of Schemes has stayed consistent at all levels with no movement within month.
- Note that some Divisions are **not forecasting to meet their targets.** There is **current underperformance against YTD Target** in all clinical divisions at M10.

Headline Figures (£M)

|	WHT						
	Community	**Corporate**	**DoS**	**Estates**	**MLTC**	**WCCSS**	**Total**
Total CIP Target	4.04	3.68	6.06	2.14	6.97	7.18	30.08
Plan (baselined May)	3.73	6.59	5.13	1.25	7.73	5.65	30.08
Forecast Outturn (FOT)	2.04	8.12	4.53	1.80	5.44	5.92	27.85
Variance (Target to FOT)	2.00	-4.43	1.53	0.34	1.53	1.26	2.23
YTD CIP Target	2.74	2.50	4.11	1.45	4.73	4.87	20.41
YTD Actuals	1.76	5.22	3.85	1.62	4.63	4.56	21.65
YTD Variance (Target to Actuals)	0.98	-2.72	0.26	-0.17	0.10	0.31	-1.24

Actual and Forecast Outturn Delivery Against Plan and Target (£M)
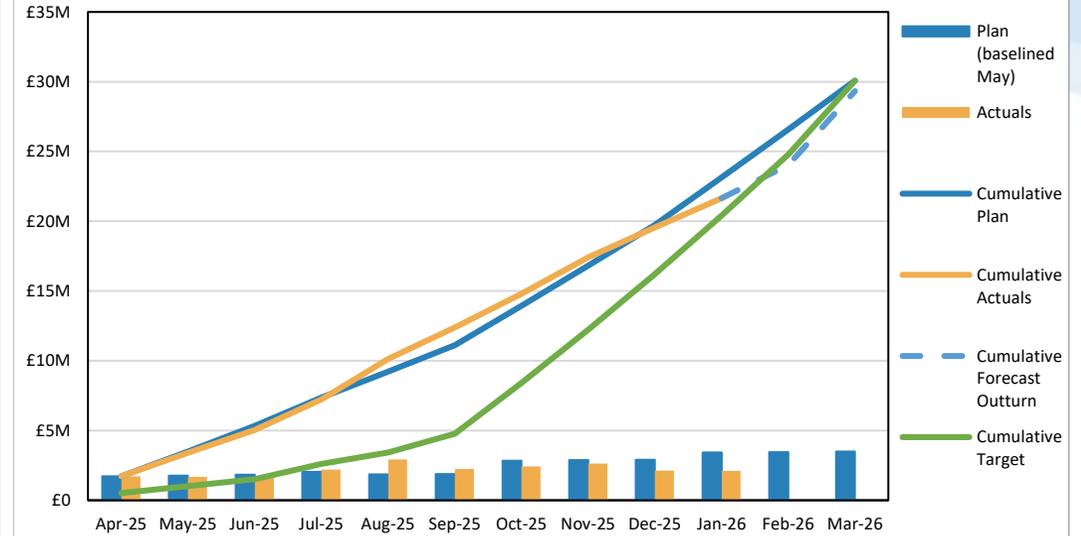
Development Status of Schemes (£M FOT)
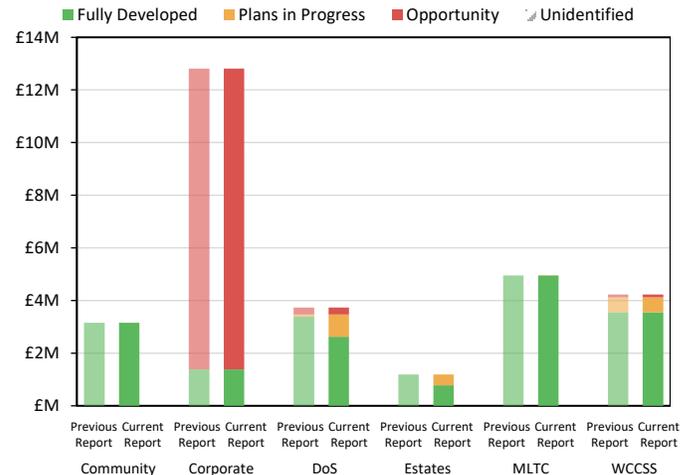
Delivery Status of Schemes (£M FOT)
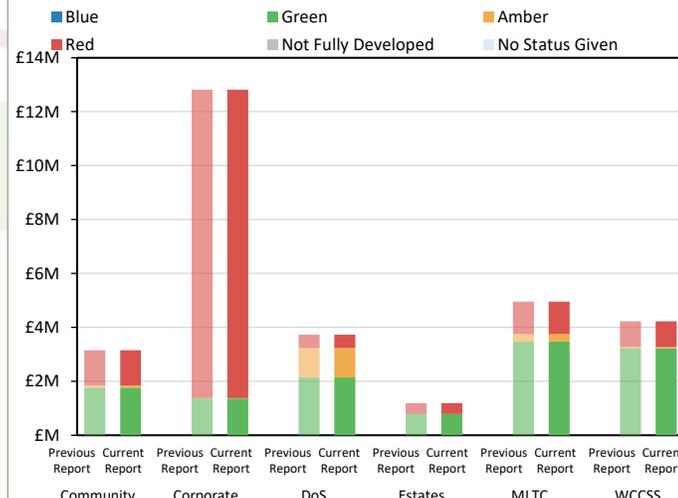
Figures by Month (£M)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
In Month Target	0.52	0.50	0.50	1.08	0.83	1.34	3.63	3.82	4.00	4.19	4.38	5.29	30.08
In Month Plan (baselined May)	1.73	1.77	1.84	2.04	1.85	1.89	2.82	2.89	2.90	3.42	3.44	3.49	30.08
In Month Actual	1.73	1.68	1.63	2.19	2.92	2.25	2.42	2.62	2.12	2.11	0.00	0.00	21.65
In Month Forecast Outturn (FOT)	1.73	1.68	1.63	2.19	2.92	2.25	2.42	2.62	2.12	2.11	1.75	4.45	27.85
Variance (Target to FOT)	-1.21	-1.17	-1.13	-1.11	-2.08	-0.91	1.22	1.19	1.88	2.09	2.63	0.84	2.23

National Oversight Assurance Framework Dashboard

National Oversight Assurance Framework Dashboard

National Oversight Framework - WHT

Code	Metric	Time Period Reported	Target	Q2 25/26 Published Perf	Q2 25/26 Published Score	Q2 25/26 Published Rank	Internal Oct-25	Internal Nov-25	Internal Dec-25	Internal Jan-26
OF0023	18 Weeks RTT - % Within 18 Weeks - Incomplete	Latest month in the period		71.93%	1.28	13/131	70.83%	70.17%	69.66%	69.29%
OF0003	18 Weeks RTT - 52 wk breaches as a % of PTL	Latest month in the period	1%	0.05%	1.00	7/131	0.05%	0.04%	0.06%	0.05%
OF0106	Difference between actual and planned 18 week elective performance	Latest month in the period	0%	2.04%	1.00	31/131	0.35%	-0.96%	-1.35%	-2.21%
OF0005	Percentage of patients waiting over 52 weeks for community services	End of period		6.95%	3.29	61/79	5.89%	5.80%	17.63%	17.96%
OF0010	Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80%	86.87%	1.00	1/118	81.10%	83.49%	83.87%	
OF0011	Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75%	78.57%	1.00	20/118	71.33%	72.30%	74.15%	
OF0013	Total Time Spent in ED - % within 4 Hours	Aggregated quarterly position	78%	76.70%	2.26	55/123	74.54%	72.10%	71.44%	69.97%
OF0014	Total Time Spent in ED - % over 12 Hours	Aggregated quarterly position		5.47%	1.84	34/119	6.83%	10.06%	11.01%	13.72%
OF0079	Planned Surplus / Deficit	Annual plan	0	-6.31	4.00	117/134	519	39	1712	-655
OF0081	Year to date variation from plan	Year to date		2.20	1.00	1/134	-3204	-3243	-1531	-2186
OF0085	Implied level of productivity	In-year figure to latest month vs same period in previous year		6.50	1.36	17/134				
OF1069	CQC inpatient survey satisfaction rate	Annual			2.00					
OF0061	Staff survey - raising concerns sub-score	Annual		6.34	2.85	83/134				
OF1067	CQC safe inspection score	Periodic inspection								
OF0088	Rate of C-Diffcile infections (Rolling 12 Months)	12-month rolling	1	0.95	1.00	1/134	0.89	0.86	0.91	0.88
OF0020	Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	4.00	2.89	71/134	4	3	2	2
OF0048	Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.77	3.96	131/134	1.75	1.63	1.54	1.40
OF0025	Average number of days between planned and actual discharge date (one month in arrears)	Latest month in the period		0.31	1.44	19/125	0.4	0.4	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%	67.06%	4.00	49/51	73.37%	68.49%	74.84%	71.71%
OF0084	Staff survey engagement theme score	Annual		6.80	2.89	85/134				
OF0082	Staff Sickness Rate	Quarterly – aggregated monthly figures		6.08	3.66	130/134	6.40%	5.99%	6.80%	7.14%

Model Health System

NHS Oversight Framework Summary

Overall Domain and Segment Scores

	Latest Published Data
	Q2 25/26
Headlines	**NOF Score**
Oversight Framework Segment Latest Distribution	3
Average Metrics Score	2.08
Pre-Adjusted Segment	2
Is this segment down graded due to financial deficit	Yes
Is the Organisation in the Provider Improvement Programme	No

The Performance Assurance Framework has now been confirmed with the indicators applicable to the Trust. The Trust has been placed into Segment 3 for Quarter 2 of 2025/26.

Care Colleagues Collaboration Communities

National Oversight Assurance Framework Dashboard WHT - Comparison

Domain	Metric	Data Period	WHT		
			Qtr 1	Qtr 2	Var
Access to Services	% of patients waiting <18 weeks	End of period	1.4	1.28	-0.12
Access to Services	% waiting >52 weeks (acute)	End of period	1.28	1	-0.28
Access to Services	Difference between planned and actual 18 week performance	Monthly	1	1	0.00
Access to Services	% waiting >52 weeks (community)	End of period	3.05	3.29	0.24
Access to Services	% of urgent referrals diagnosed within 4 weeks	Rolling 12-month	1	1	0.00
Access to Services	% treated within 62 days of referral	Rolling 12-month	1	1	0.00
Access to Services	% of ED attendances seen within 4 hours	Rolling 3-month	1	2.26	1.26
Access to Services	% of ED attendances >12 hours	In month	1.86	1.84	-0.02
Access to Services Sub-Total			**1.4**	**1.58**	**0.18**
Effectiveness and Experience of Care	Summary Hospital-Level Mortality Indicator (SHMI)	Rolling 12-month	2	2	0.00
Effectiveness and Experience of Care	Average days from discharge-ready to actual discharge	In month	1.5	1.44	-0.06
Effectiveness and Experience of Care	CQC inpatient survey satisfaction rate	Annual	2	2	0.00
Effectiveness and Experience of Care	Urgent community response 2-hour performance	In month	2.82	4	1.18
Effectiveness and Experience of Care Sub-Total			**2.08**	**2.36**	**0.28**
Patient Safety	NHS Staff Survey – raising concerns sub-score	Annual	2.85	2.85	0.00
Patient Safety	12 month rolling count of MRSA cases	Rolling 12-month	2.63	2.89	0.26
Patient Safety	12 month rolling count of C. difficile cases as a proportion of trust threshold	Rolling 12-month	1	1	0.00
Patient Safety	12 month rolling count of E. coli cases as a proportion of trust threshold	Rolling 12-month	3.96	3.96	0.00
Patient Safety Sub-Total			**2.69**	**2.73**	**0.04**
People and Workforce	Sickness absence rate	Rolling 12-month	3.78	3.66	-0.12
People and Workforce	NHS staff survey – engagement theme score	Annual	2.89	2.89	0.00
People and Workforce Sub-Total			**3.34**	**3.28**	**-0.06**
Finance and Productivity	Planned surplus/deficit	Annual plan	4	4	0.00
Finance and Productivity	Variance to financial plan	Year to date	1	1	0.00
Finance and Productivity	Implied productivity level	In-year figure to latest month vs same period in previous year	1.95	1.36	-0.59
Finance and Productivity	Combined finance score	Annual	2	2	0.00
Finance and Productivity Sub-Total			**1.97**	**1.68**	**-0.29**
Overall Average Metric Score			**1.97**	**2.08**	**0.11**

Care Colleagues
Collaboration Communities

National Oversight Assurance Framework Dashboard - WHT

Quarter 2 Overall Position

- Trust league ranking has decreased **from 36 → 40** due to the average metric score increasing **from 1.97 → 2.08** (unadjusted this would place the Trust in Segment 2). Due to the financial plan, the Trust **remains in Segment 3.**

Key Areas of Strong Performance

- **Access to Services** remains strong:
  - Sustained performance in **18-week RTT** and **cancer pathways**.

Areas of Deterioration

- **A&E performance** has worsened compared to Quarter 1.
- **Community 52-week waits** remain among the weakest performers nationally and have deteriorated further.
- **Urgent Community Response times** have declined further, reducing the Effectiveness and Experience of Care overall domain score to **2.36**.

Ongoing Challenges

- **Patient Safety** and **Workforce** continue to depress overall scoring:
  - Driven by **infection control** metrics and **staff sickness rates** (rolling 12-month methodology means recent improvements are **not yet reflected**).

Care Colleagues Collaboration Communities

Productivity Dashboard

Productivity

The Trust continues to demonstrate strong productivity performance, with the latest Model Health System data placing overall Implied Productivity Growth in the **top quartile nationally** (a calculation that essentially compares inputs to outputs, compared to last year)

Key operational metrics show sustained strengths in day-case rates, outpatient procedures (proportion of outpatient's attendances that are for 1st or follow up appointments attracting a procedure tariff), and theatre utilisation, reflecting effective use of clinical capacity.

Despite these positives, outpatient services present notable opportunities for improvement.
DNA rates remain in the **worst quartile**, and both PIFU utilisation and Specialist Advice activity are below national average performance. Additionally, a proportion of follow-up activity continues to be delivered without corresponding income due to the 2019/20 fixed-income baseline.

Workforce productivity remains a major asset for the Trust, with Implied Workforce Productivity ranked in the **best quartile**, supported by high levels of non-elective activity per clinical WTE and strong emergency consultant utilisation.
However, elective activity per WTE and outpatient attendances per consultant lag behind national comparators, and temporary staffing expenditure continues to exceed the national benchmark.

Overall, while the Trust's productivity position remains strong, targeted improvements in outpatient efficiency, elective throughput, and workforce sustainability will be key to improving future performance.

Care Colleagues Collaboration Communities

Productivity Dashboard

WHT Productivity Dashboard

Ref no.	Theme and KPI	Definition	Source	Target Baseline	Target	2025/26 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
1	Implied Productivity 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%	7.9%	6.5%	6.5%	6.1%	6.5%	6.7%				
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	3.60	3.30	2.40	2.60	2.90
3	Average LOS for non-elective admissions	Average length of stay for all patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	Model Health System	N/A	N/A	8.70	8.10	8.10	7.70	7.90	8.20	8.20	7.90	8.40	8.10
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%	93.52%	94.09%	92.21%	94.17%
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%	22.38%	19.75%	19.22%	18.53%
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%	84.10%	82.90%	83.10%	
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	1.96	1.96	1.72	1.88
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%	95.62%	93.04%	88.39%	91.87%
9	CT, MRI & ultrasound utilisation		National planning	annual	**95%**										

Productivity Dashboard

WHT Productivity Dashboard

Ref no.	Theme and KPI	Definition	Source	Target Baseline	Target	2025/26									
						Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
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%	80.50%	80.61%	81.08%	82.22%
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%	7.94%	8.14%	8.47%	8.87%
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%	4.80%	4.85%	5.27%	4.96%
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%	11.75%	10.34%	11.29%	10.96%
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	986	0	0	1,000	0	0	837	0
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	£1,828	£1,879	£1,822	£1,802	£1,840	£1,838	£1,749	£1,789	£1,857	£1,857
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	£186 k	£130 k	£266 k	£150 k	£237 k	£171 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	4	4	4	3
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	£204 k	£217 k	£267 k	£196 k

Care Colleagues
Collaboration Communities

Productivity Dashboard

WHT Productivity Dashboard

Ref no.	Theme and KPI	Definition	Source	Target Baseline	Target	2025/26 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
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	3.02	3.07	3.02	3.20	2.90	3.28	3.36	3.12	3.24	3.29
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	1.60	1.76	1.85	1.57	1.76	1.88	1.64	1.62	1.72
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	131.27	131.77	138.32	140.94	130.06	159.44	156.96	141.20	139.55	146.57
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	450.65	527.32	555.92	558.04	529.79	508.66
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	0.58	0.61	0.70	0.53	0.60
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%	10.01%	12.01%	10.07%	11.56%
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%	6.40%	5.99%	6.80%	7.14%
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%	7.30%	6.95%	7.47%	7.42%
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	4.30	4.30	4.40	4.50

Enclosure 9.2

Integrated Performance Report

The Royal Wolverhampton NHS Trust

January 2026 (Month 10)

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:

Target (to be greater than)

System redesign required to hit target

Target (to be greater than)

Capable system should reliably hit target

Target (to be greater than)

System will not reliably hit target

Care Colleagues
Collaboration Communities

Managing Director Summary

I wish to acknowledge the resilience and commitment from all staff throughout January and February (January metrics in this report) as the seasonal pressures across all our services took hold. Staff from Estates worked exceptionally long hours to ensure that the site was safe to access during the heavy snow period during January.

Undoubtedly this has been a challenging month for the Trust as mentioned in the Chief Executive report and is reflected in some of the performance and quality metrics.

Unfortunately, the Trust performance with regard to referral to treatment (RTT) as outlined in the performance section, has led to the Trust being re-escalated into Tier 2, which means weekly oversight from NHS England (Midlands). The operational teams are focussed on ensuring that more patient are treated during this quarter (Qtr 4) and this is occurring. There are however some residual challenges post the go-live of the EPR system in Oct, which are proving time consuming to resolve and these are having an impact on the Trust performance. The issues are known and detailed plans in place to resolve, however there is a large volume to work through. The evidence is that these issues are process and training related and are not delaying the treatment of patients. These process issues are also having an impact on the Elective Recovery Fund (ERF) as reported in the financial section. Actions to resolve need to be completed by the end of April to ensure there is no impact in 26/67 financial year.

Overall performance is good, but there are challenges within each sections. National quartile for each of the metrics is :-
UEC - 2nd quartile, Cancer 62 day - 3/2 quartile (significantly improved), Diagnostics - 1st Quartile, RTT, bottom 4th quartile and overall implied productivity 2nd quartile.

Improvement activity continues following the unannounced CQC Inspection visit of Emergency Services at Royal Wolverhampton NHS Trust Hospital on 24 -26 November 2025 and oversight of the action plan is provided via bi- weekly meetings between Directorate and Division with weekly escalation to Executive colleagues. The draft report received is currently within the factual accuracy process and has been returned to the CQC.

Authors

Gwen Nuttall
(Managing Director)

Care Colleagues
Collaboration Communities

Managing Director Summary continued……………

Authors

Gwen Nuttall
(Managing Director)

- The Trust continues to work on all 3 of the fire enforcement notices, covering Maternity Block, Nucleus Theatres and Cannock Chase. I'm pleased to report that Nucleus Theatre work is schedule to complete on time and the ongoing work continues across Maternity Block and Cannock Chase.

- Workforce metrics have been stable throughout January / Feb and a small reduction in sickness. The management of sickness absence continues to be a focus for all teams across the Trust (and Group)

- There was a national shortage of bone cement, used to treat orthopaedic patients in February and I'm pleased to report that the Trust managed this shortage well, 2 patients were postponed (new dates for their treatment agreed) whilst a new alternative was sourced from Europe.

- All 10 Maternity Incentive Scheme Standards have been signed off by the CEO and ICB.

- The Trust had a member of staff interviewed (positive) by ITV on the support provided by the Trust and the opportunity that Clinical Apprenticeship Scheme provides during the national Apprenticeship week.

**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	2.73	2.96	Jan-26	-	Common Cause	Achieving
Pressure ulcers per 1,000 occupied bed days	1.50	1.45	1.74	Jan-26	0.96	Common Cause	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.87	0.61	Jan-26	-	Concern	Inconsistent
Observations on time (Trust wide)	90.00%	87.01%	86.28%	Jan-26	-	Common Cause	Not Met
VTE risk assessment - % within 14 hours	95.00%	87.30%	88.00%	Dec-25	-	Concern	Not Met
Sepsis screening - ED	90.00%	100.00%	96.00%	Jan-26	-	Common Cause	Achieving
Sepsis screening - Inpatients	90.00%	84.70%	84.00%	Jan-26	-	Common Cause	Inconsistent
Clostridioides difficile	5	2	4	Jan-26	2	Common Cause	Inconsistent
MRSA Bacteraemia	0	0	0	Jan-26	-	Improvement	Inconsistent
Number of complaints as a % of admissions	0.50%	0.42%	0.50%	Jan-26	-	Concern	Inconsistent
FFT recommendation rates - Trust wide	92.00%	86.00%	87.00%	Jan-26	91.00%	Improvement	Not Met
Care hours per patient - total nursing & midwifery staff actu	7.6	7.8	7.6	Jan-26	9.7		No Target Set
Care hours per patient - registered nursing & midwifery staf	4.5	5.1	4.8	Jan-26	-	Common Cause	No Target Set
SHMI	1.00	0.95	0.94	Jan-26	-	Common Cause	Achieving
Never events	0	0	0	Jan-26	-	Improvement	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	10057.19	10126.61	10110.41	Jan-26	-	Concern	Inconsistent
Agency (WTE) Trust	21.46	31.87	41.62	Jan-26	-	Common Cause	Inconsistent
Bank (WTE) Trust	523.10	616.10	572.56	Jan-26	-	Improvement	Inconsistent
Vacancy Rate	6.00%	5.75%	5.80%	Jan-26	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	7.99%	7.94%	Jan-26	-	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	91.92%	91.78%	Jan-26	-	Improvement	Inconsistent
Sickness Absence (Rolling 12 Months)	5.00%	5.45%	5.49%	Dec-25	-	Concern	Not Met
Appraisals	90.00%	77.99%	77.09%	Jan-26	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	92.96%	92.72%	Jan-26	-	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%	54.06%	56.21%	Jan-26	82.13%	Common Cause	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	0.99%	3.09%	2.67%	Jan-26	-	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	75489	75763	79019	Jan-26	39142	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	80.42%	80.05%	Dec-25	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	96.00%	94.14%	92.62%	Dec-25	89.05%	Improvement	Not Met
Cancer - 62 Day Referral to Treatment	75.00%	71.96%	73.00%	Dec-25	56.85%	Improvement	Not Met
No. of patients no longer meeting the Criteria to Reside	89	51	85	Jan-26	-	Common Cause	Inconsistent
Diagnostics - % within 6 weeks from referral	95.00%	96.34%	96.68%	Jan-26	84.70%	Improvement	Not Met
Total Time Spent in ED - % over 12 Hours	-	15.83%	18.19%	Jan-26	-	Concern	No Target Set
Total Time Spent in ED - % within 4 Hours	78.00%	76.89%	77.13%	Jan-26	81.83%	Common Cause	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	-3436	1058	Jan-26	-	Common Cause	Inconsistent
Surplus/(Deficit) (£000) - YTD	-3379	-9535	-8479	Jan-26	-	Improvement	Inconsistent
Surplus/(Deficit) (£000) - FOT	-	0	0	Jan-26	-	Improvement	No Target Set
Elective Variable (£000) - in month	14631	14191	14699	Jan-26	-	Common Cause	Inconsistent
Elective Variable (£000) - YTD	28905	139407	154106	Jan-26	-	Concern	Inconsistent
Elective Variable (£000) - FOT	180585	195523	195523	Jan-26	-	Improvement	Inconsistent
Efficiency (£000) - in month	2907	3451	4342	Jan-26	-	Common Cause	Inconsistent
Efficiency (£000) - YTD	5707	37156	41498	Jan-26	-	Concern	Inconsistent
Efficiency (£000) - FOT	57240	57240	57240	Jan-26	-	Concern	Inconsistent
Capital (£000) - YTD	1636	11655	16314	Jan-26	-	Improvement	Inconsistent
Capital (£000) - FOT	29350	35122	33683	Jan-26	-	Not Enough Points	Not Enough Points
Cash (£000) - in month	48124	34245	30243	Jan-26	-	Common Cause	Inconsistent
Cash (£000) - FOT	26081	32370	34372	Jan-26	-	Not Enough Points	Not Enough Points

Care Colleagues
Collaboration Communities

Quality, Safety and Patient Experience

Quality, Safety & Patient Experience | Executive Summary

- There have been 4 *Clostridioides difficile* cases reported in January 26, bringing the annual trajectory totals to 65/81. The testing platform utilised by BCPS for the Black Country region introduced a secondary test following an alert from the company re batch sensitivity. This has now resolved and the usual testing platform recommenced, colleagues within the ICS and NHSE were made aware. We await thresholds for 26/27.

- Pressure ulcers per 1,000 occupied bed days has increased in month, albeit within tolerance, although links to longer length of stay can be drawn a new theme of increased pressure ulcer to the heels has emerged. Improvement actions are in place e.g. use of heel balms and the addition of 450 new Medstrom standard hospital beds have been received as part of the Trust replacement programme.

- Falls Rate per 1,000 Occupied Bed Days is within tolerance, scrutiny regards a recent increase of falls within ED and any links with extended waits to be admitted is in progress as omissions/themes and subsequent learning.

- There has been an increase in the volume of complaints received compared to previous month with an increasing theme of poor attitude. Targeted improvement activity has commenced in areas with a cluster and will be overseen by the Patient Experience steering Group, chaired by Group Deputy Chief Nursing Officer.

- Marthas rule Wellness Round Task and Finish Group has brought forward the Trust wide rollout date to 30th March 26 for the Patient Wellness Document. This will be supported by a comprehensive education plan, a communication plan, and defined assurance processes.

- Bi-annual Inpatient Nursing skill mix reviews are in progress and will report through to Board in due course.

- Model Hospitals Care Hours Per Patient day Nursing workforce metric remains stable.

- Total antimicrobial consumption fell by about 5% from January 25 to January 26, with similar reductions seen in watch and reserve antibiotics despite a rise in total Defined Daily Doses due to higher admissions. IV antimicrobial use showed a very small increase year-on-year, but the longer-term trend remains downward and continues to support national AMS targets.

Authors

Debra Hickman
(Chief Nursing Officer)

Brian McKaig
(Chief Medical Officer)

Care Colleagues
Collaboration Communities

Antimicrobial Stewardship | Executive Summary

- The Trust remains on track to meet the national target of a 5% reduction in antimicrobial consumption by 2029, despite a temporary winter-related rise; use has fallen by approximately 15% since 2019.

- There was a seasonal rise in Watch antibiotics; mainly co-amoxiclav and clarithromycin for pneumonia which temporarily reduced the overall proportion of Access agents during the winter period. This is expected to normalise with updated guidance and targeted AMS actions. The ICB remains on track toward achieving the 70% Access-category target by 2029, which reflects combined prescribing across both primary and secondary care.

- IV antibiotic use has decreased by around 12% since 2019/20, primarily driven by participation in the non-mandatory IVOST CQUIN initiative in 2024/25. On-going AMS work will continue to promote timely IV-to-oral switch to support stewardship and reduce bloodstream infection risks.

Figure 1 – Shows the total consumption of antimicrobials from January 19 to January 26 adjusted to DDD's/1,000 admissions,
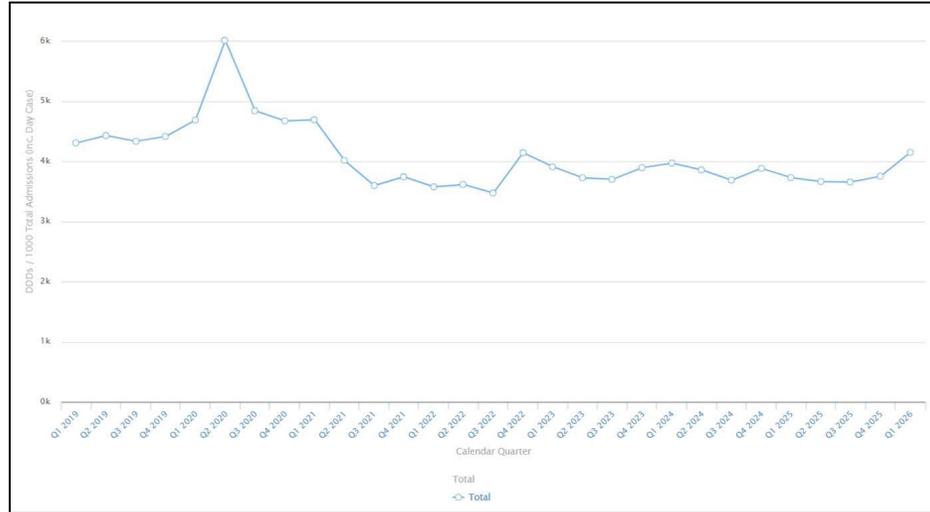
Figure 2 - shows consumption of access antibiotics (light blue line), in comparison to watch (orange line), compared to reserve (dark blue line) from January 24 to January 26 adjusted to DDD's/1,000 admissions
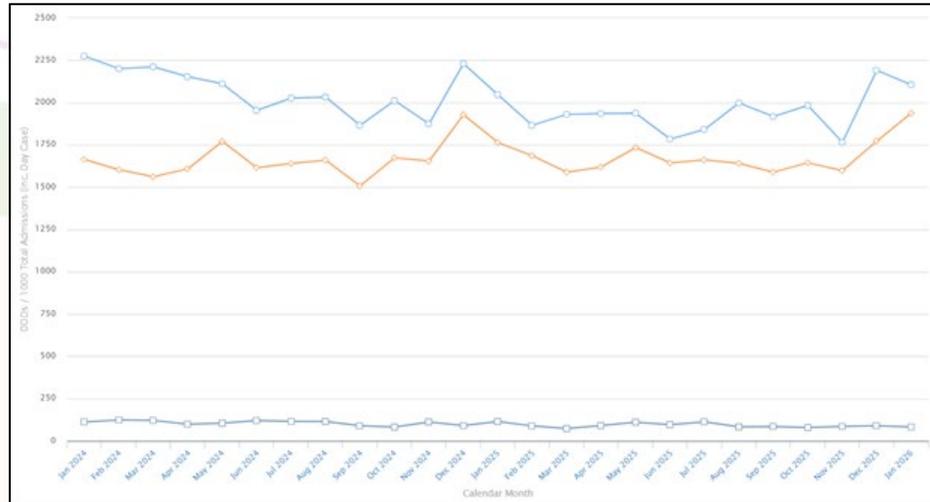
Authors

Debra Hickman
(Chief Nursing Officer)

Brian McKaig
(Chief Medical Officer)

Care Colleagues Collaboration Communities

Perinatal Service | Executive Summary

Actions									
Staff Group	Jan	Feb	Mar	Apr	May	June	July		comments
Midwives Birth to midwifery ratio Actual	27								Midwifery workforce review near completion following BR+ report
Obstetrics RCOG Compliant on delivery suite	yes								
Neonatal Nurses BAPM Compliant	87%								
Neonatal Doctors BAPM compliant	Yes								

Safety Champion feedback

- **Maternity Incentive Scheme Year 8**

Key Dates for Trusts 3 March 2026	Final submission date for MIS year 7
31 March 2026	Expected publication of full MIS Year 8 core standards and separate supplemental guidance
23 April 2026	National MIS Year 8 launch event (online)
2 March 2027	Final submission date for MIS year 8

- **Maternity and Neonatal Safety Investigation (MNSI) COMPASS Pilot 2**

The Royal Wolverhampton NHS Trust have been selected into phase 2 of the COMPASS pilot by MNSI.

MNSI have developed a cultural assessment tool called COMPASS – Culture of Organisations and its Impact on Patients' Safety.

Pilot 2 commenced on the 9th February 2026 for 4 – 6 months.

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

	January	February	March	April	May	June	July
PMRT Reviews (including babies >28 days old or not born at RWT)	5 OBS/NN						
Grades Maternity/neonatal	A1 A1						
	B4 B2						
	C0 C0						
	D0 D0						
Final MNSI Reports Received	1						
Incidents Moderate & Above (all new MNSI cases and those assigned PMRT C and D, and those assigned moderate harm on datix)	0						
Service user & Staff Feedback to Board Level Safety Champions	MNVP - focus on Caesareans pathway. Positive feedback re: the cultural conversation re: Maternity Triage						
Coroner Reg 28	0						
Obstetrics/Gynaecology Trainees Quality of Clinical Supervision reported annually							

CNST & Training Position 30/11/2025

Staff Group	PROMPT	Fetal monitoring	NLS
Obstetricians	90%	90%	90%
Midwives	90%	98%	90%
Support Staff	78%	NA	NA
Anaesthetists	90%	NA	NA
Neonatal Doctors	NA	NA	100%
Neonatal Nurses	NA	NA	90%

Full compliance with Maternity Incentive Scheme Year 7 training requirements.

Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

Patient falls - rate per 1,000 occupied bed days
| Achieving | Common Cause | 2.96 |
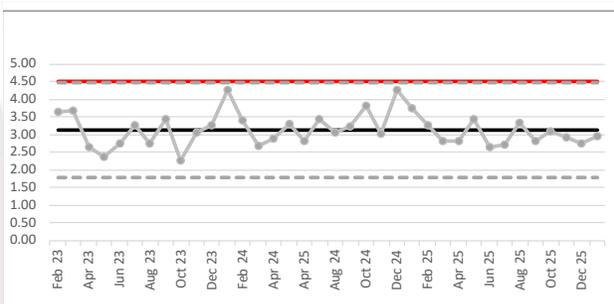
Pressure ulcers per 1,000 occupied bed days
| Inconsistent | Common Cause | 1.74 |
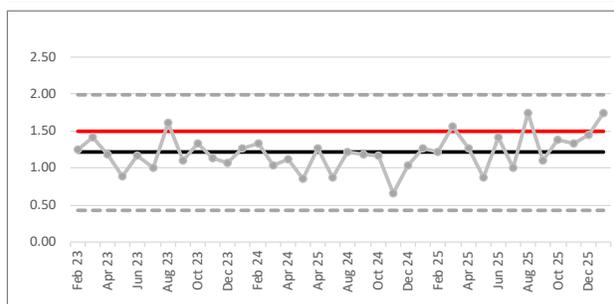
Community acquired pressure ulcers per 10,000 population
| Inconsistent | Concern | 0.61 |
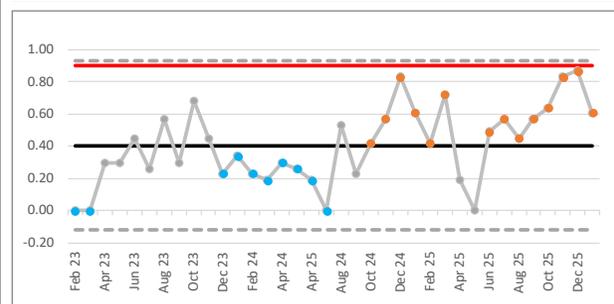
Clostridioides difficile
| Inconsistent | Common Cause | 4 |
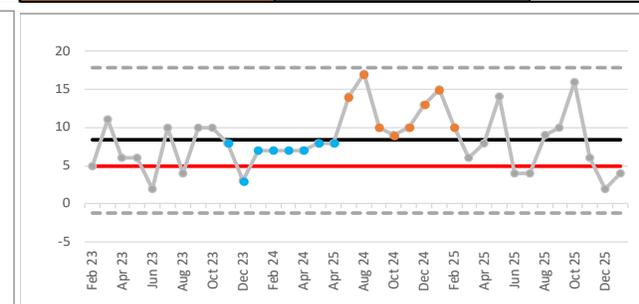
Observations on time (Trust wide)
| Not Met | Common Cause | 86.28% |
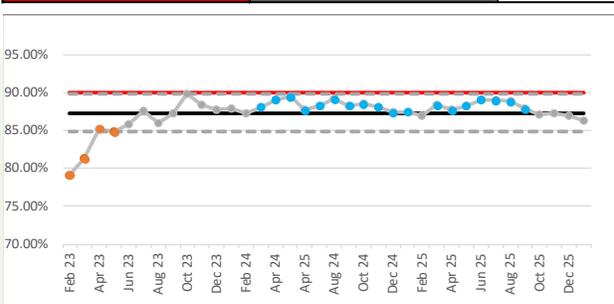
VTE risk assessment - % within 14 hours
| Not Met | Concern | 88.00% |
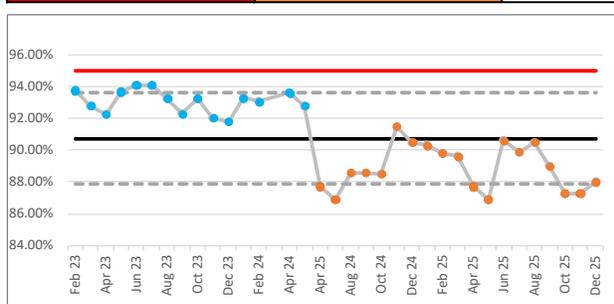
Sepsis screening - ED
| Achieving | Common Cause | 96.00% |
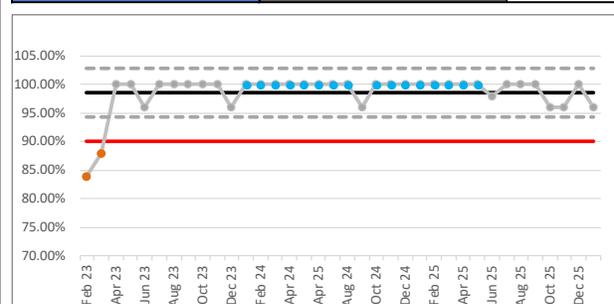
MRSA Bacteraemia
| Inconsistent | Improvement | 0 |
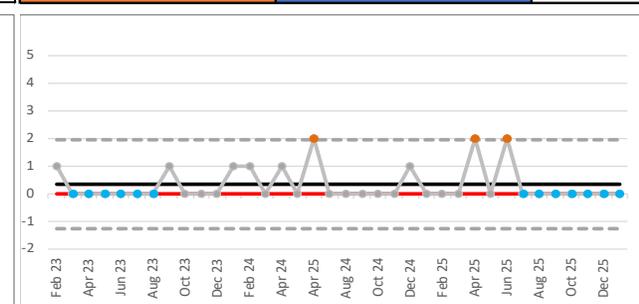
Sepsis screening - Inpatients
| Inconsistent | Common Cause | 84.00% |
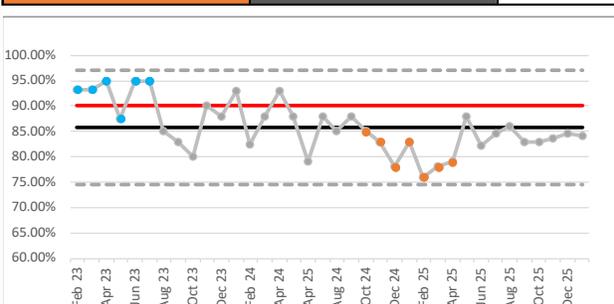
Medication error - incidents causing serious harm
| No Target Set | Improvement | 0 |
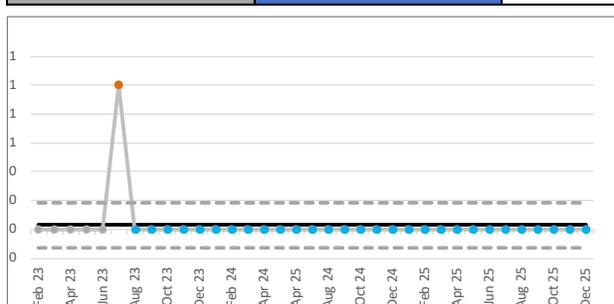
Mental health patients spending over 12 hours in A&E
| No Target Set | Common Cause | 110 |
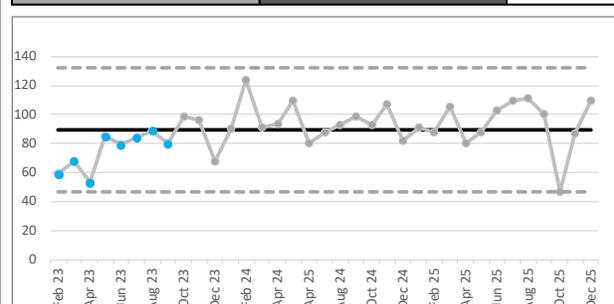
Number of complaints as a % of admissions
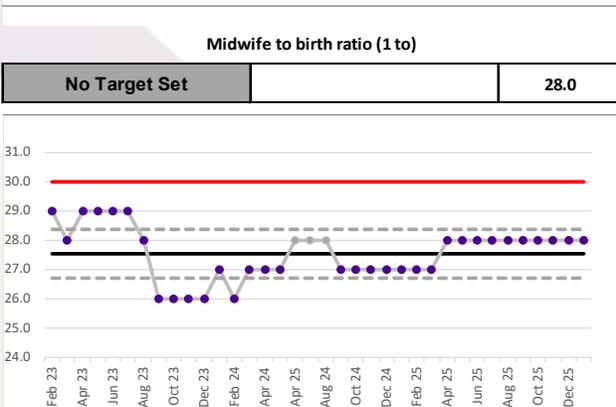| Inconsistent | Concern | 0.50% |

Quality, Safety & Patient Experience | Core Metrics

Complaints response rate against policy

| Achieving | Concern | 82.00% |

FFT response rates - Trust wide

| No Target Set | Common Cause | 13.50% |

FFT recommendation rates - Trust wide

| Not Met | Improvement | 87.00% |

Midwife to birth ratio (1 to)

| No Target Set | | 28.0 |

Care hours per patient - total nursing & midwifery staff actual

| No Target Set | | 7.6 |

Care hours per patient - registered nursing & midwifery staff actual

| No Target Set | Common Cause | 4.8 |

SHMI

| Achieving | Common Cause | 0.94 |

Crude Mortality Rate

| No Target Set | Common Cause | 1.80% |

Never events

| Inconsistent | Improvement | 0 |

Care Colleagues
Collaboration Communities

People

People | Executive Summary

The total workforce in M10 decreased by 49 WTE compared to M9. The substantive workforce decreased by 15.2 WTE, bank usage fell by43.5 WTE, and agency reliance increased by 9.8 WTE. Agency increases are due to mental health patient need.

YTD performance, from M12 24/25 to M9 25/26, saw an overall reduction of 194 WTE. This reflects a 213 WTE decrease in substantive staff, versus a 6 WTE rise in bank reliance, and a 13 WTE increase in agency usage.

Pay is £2.4m overspent in month due to continued underperformance of pay CIP schemes. Other areas of pay are underspent due to vacancies, which are mostly offset by bank and agency costs. Bank costs have decreased by £0.5m from M9 to M10, falling from £3.5m to £3.0m, with reductions seen across Medical areas.

In month sickness levels improved in January, decreasing from 6.39% to 5.96%. The two divisions showing the greatest improvement were Corporate, with a 1.2% reduction, and Division 3, which reported a 0.98% decrease during the month.

Appraisal compliance remains a challenge, with January recording the lowest rate of the financial year. In month BCPS reported the lowest compliance at 70.08%, followed by Division 2 at 74.93% and Division 1 at 75.33%.
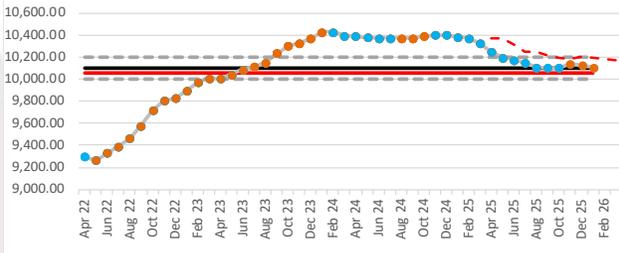
Authors

Emma Ballinger (People Director)

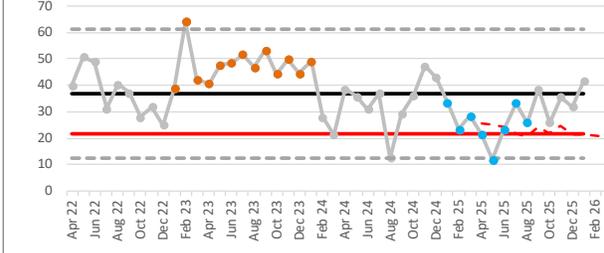**Care Colleagues Collaboration Communities**

Operational Performance

Operational Performance | Executive Summary
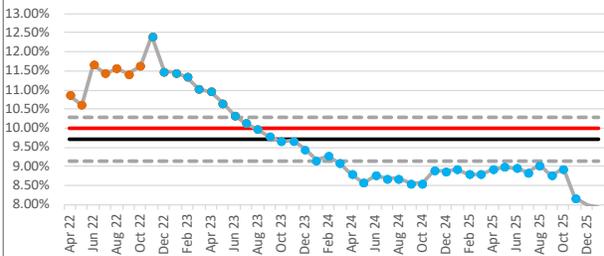
- Delivery of the constitutional standards were a challenge in January across all points of delivery. The work to understand, amend and stabilise new ways of working and the impact of the new EPR system continues across operational, clinical and corporate teams. All focus and actions continue but new and significant issues continue to be identified

- RTT and UEC4hr Re-sets remain in place with clear priorities and metrics for improvement.

- RTT – 56.2% of patients on an incomplete pathway were treated within 18 weeks (an improvement from 54% in December). At the end of the month there were 79,019 patients on the total waiting list. This increased from the previous month due to the rectification of data quality issues relating to the EPR described above. There were no 65week breaches at the end of January which has been maintained to date.

- Support for the Q4 sprint is in place (outpatients, over 52weeks and the independent sector) with daily and weekly oversight in place. The target of achieving 60.6% RTT at the end of March will be significantly challenged but all efforts continue.

- UEC – delivery of the 4hr patient access standard improved in January to 77.13% whilst the 12hr standard deteriorated (18.19%). Additional inpatient capacity (27 beds) remained open throughout the month in response to significant challenges in ambulance handovers and patients waiting for an inpatient bed. 22 of these beds have now been closed and performance against the 4hr and 12hr standard is improving.

- A reset of the 45-minute ambulance handover is planned for 09 March. There is strong involvement and commitment from clinical and non-clinical teams in achieving this improvement. Community First work continues with improvements being sustained in Ward Processes and Frailty SDEC.

- Cancer – December performance for the cancer was 80.05% for 28day FDS and 92.62% for 31days. The 62-day standard continues to be at risk for the end of March due to the ongoing challenges in Urology and issues at University Hospitals Birmingham.

- DM01 – access to diagnostics remains positive with 96.68% of patients seen within 6 weeks with no concerns.

- Access standards within community pathways were challenged in January for 2hr UCR performance but have now improved. Virtual ward occupancy remains high at over 120%. Community waiting times for Paediatrics and Speech and Language Therapy continue to be out of standard with a Black Country wide response required for ADHD/ASD.

Authors

Kate Shaw
(Chief Operating Officer)

Care Colleagues Collaboration Communities

Operational Performance | Core Metrics

18 Weeks RTT - % Within 18 Weeks - Incomplete

| Not Met | Common Cause | 56.21% |
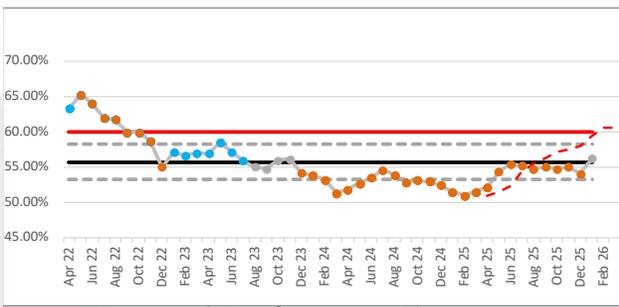
18 Weeks RTT - No. of 52 wk breaches

| Not Met | Improvement | 2110 |
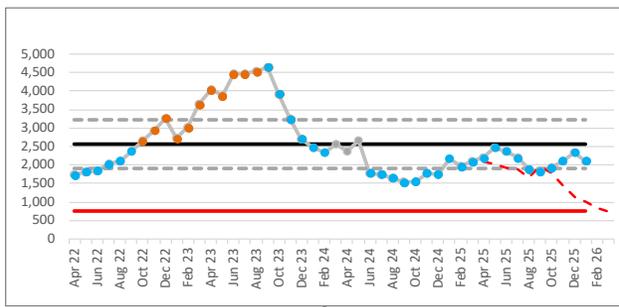
18 Weeks RTT - 52 wk breaches as a % of PTL

| Not Met | Improvement | 2.67% |
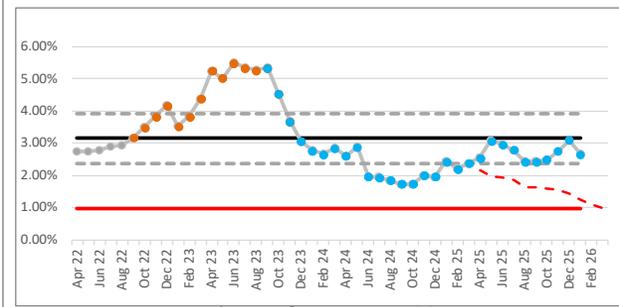
18 Weeks RTT - No. of 65 wk breaches

| Not Met | Improvement | 0 |
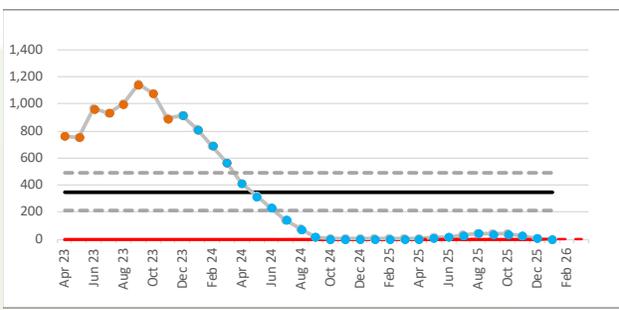
18 Weeks RTT - Total Incomplete PTL

| Not Met | Improvement | 79019 |
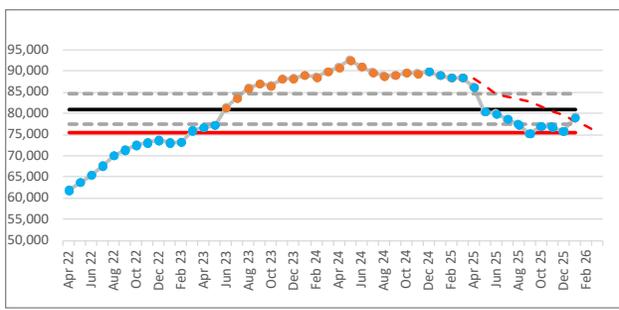
18 Weeks RTT - Clock Starts

| No Target Set | | 14558 |
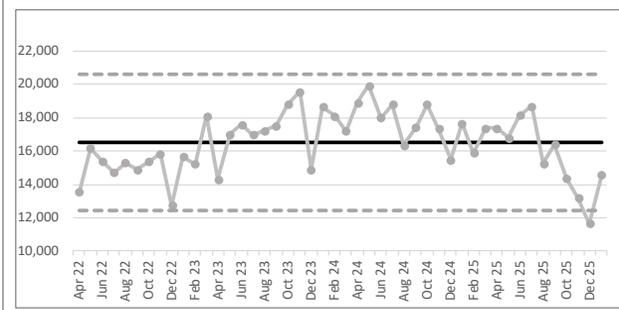
18 Weeks RTT - Time to First Appointment

| Not Met | Improvement | 58.50% |
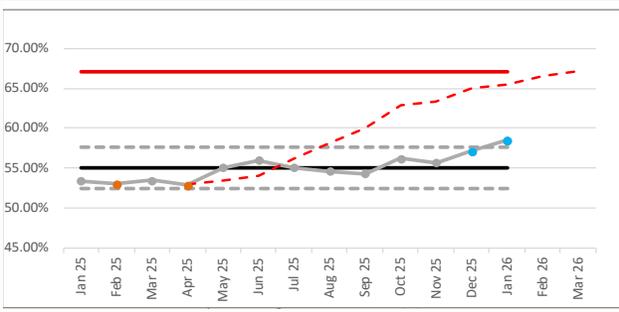
Ambulance Handover - % within 15mins

| Not Met | Concern | 28.33% |
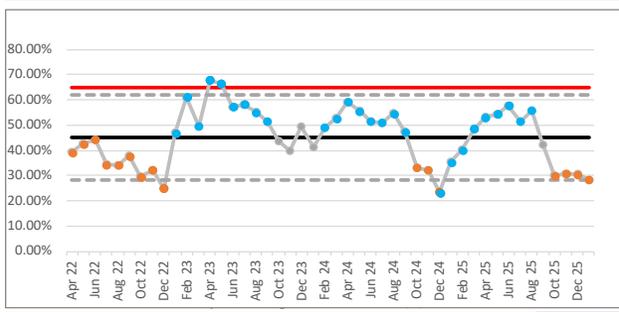
Ambulance Handover - % within 30mins

| Not Met | Concern | 49.07% |

Care Colleagues
Collaboration Communities
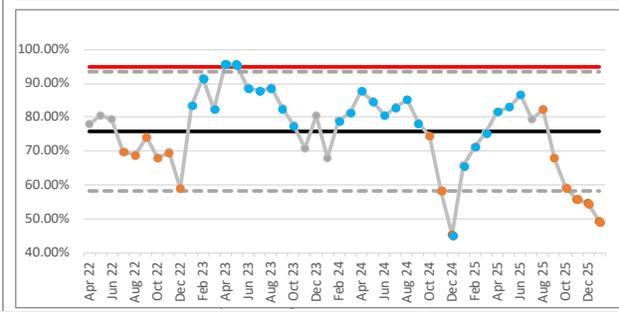
Operational Performance | Core Metrics

Ambulance Handover - % >60mins

| Not Met | Concern | 38.80% |
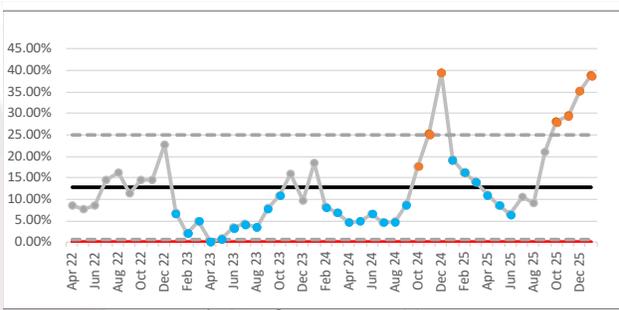
Cancer - 2 Week Wait

| Inconsistent | Common Cause | 80.51% |
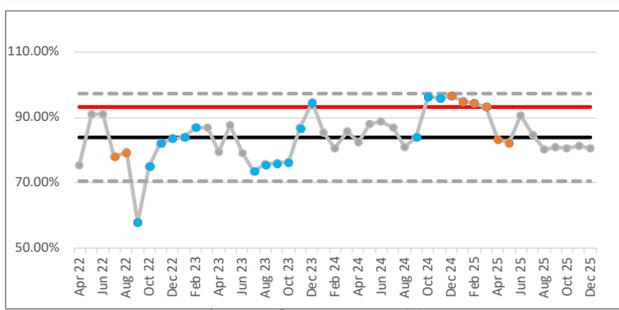
Cancer - 28 Day Faster Diagnosis

| Inconsistent | Improvement | 80.05% |
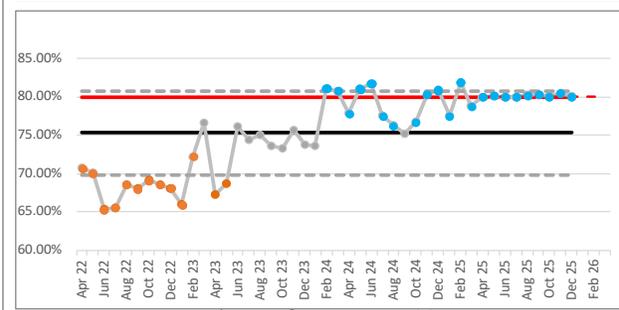
Cancer - 31 Day Treatment

| Not Met | Improvement | 92.62% |
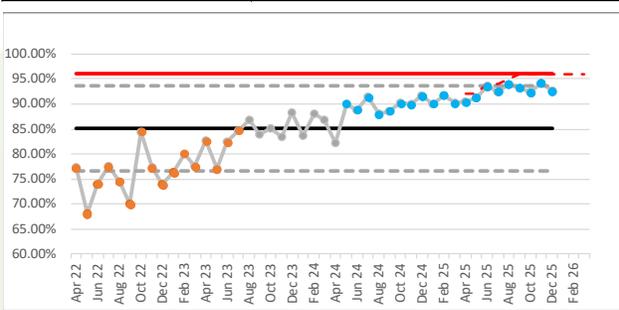
Cancer - 62 Day Referral to Treatment

| Not Met | Improvement | 73.00% |
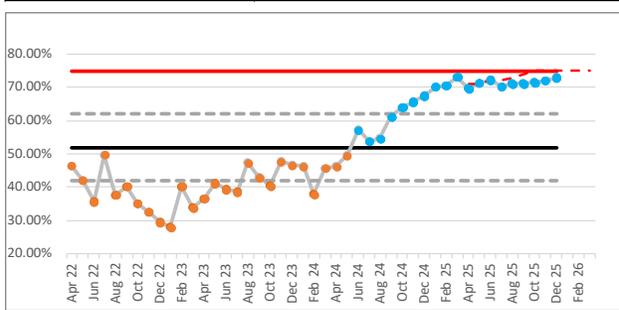
Cancer - No. of patients waiting 63+ Days for treatment

| No Target Set | Common Cause | 300 |
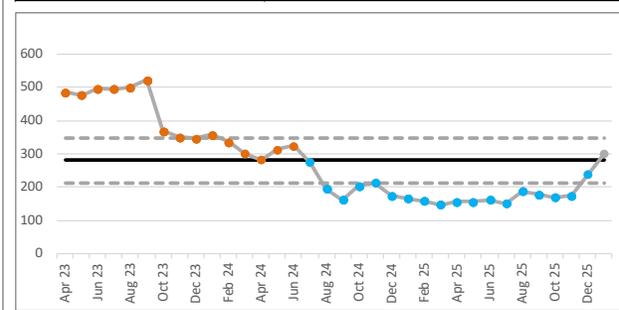
No. of patients no longer meeting the Criteria to Reside

| Inconsistent | Common Cause | 85 |
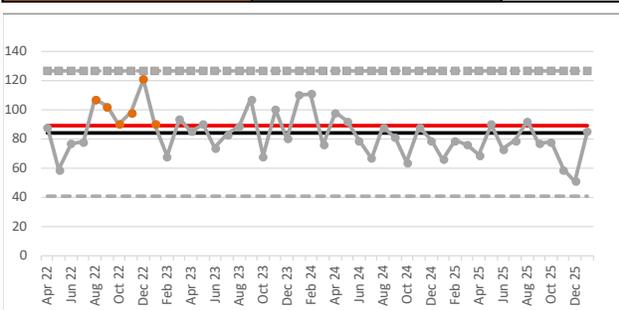
Diagnostics - % within 6 weeks from referral

| Not Met | Improvement | 96.68% |

Total Time Spent in ED - % over 12 Hours

| No Target Set | Concern | 18.19% |

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

Finance
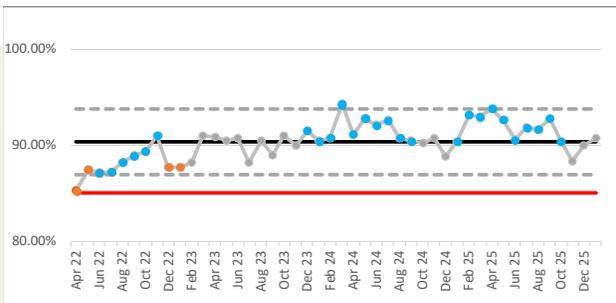
Finance | Executive Summary

Key Headlines – Month 10 2025/26

In month surplus of £1,057k, which is £257k above the plan of £800k surplus. Year to date there is a negative variance of £4,540k.

- Patient income has overperformed in month by £0.9m due to recognition of additional non-recurrent support funding from BCICB.

- Education and Training income has over-achieved due to the release of additional R&D income, which is offset by non-pay costs.

- Pay is overspent in month due to additional bank and agency spend which is mostly offset by vacancies. CIP has under-achieved against plan.

- Non-pay is underspent in month due to over-achievement of CIP and the release of non-recurrent benefits following a review of all accruals.

- Drugs is underspent due to underutilised reserves and a reduction in spend in Division Two.

Authors

Kevin Stringer
(Group Chief
Finance Officer)

**Care Colleagues
Collaboration Communities**

Finance | I&E Summary

In-Month Income & Expenditure	RWT		
	Plan M10 £m	Actual M10 £m	Surplus/ (Deficit) £m
Income	85.7	87.1	1.4
Expenditure			
Pay	51.7	54.2	(2.5)
Non Pay	21.5	21.1	0.4
Drugs	7.5	6.8	0.7
Other*	4.1	3.9	0.2
Total Expenditure	84.9	86.0	(1.2)
Net reported surplus/(Deficit)	0.8	1.1	0.3

Year-to-date Income & Expenditure	RWT		
	Plan YTD £m	Actual YTD £m	Surplus/ (Deficit) £m
Income	844.8	847.2	2.4
Expenditure			
Pay	527.4	542.6	(15.3)
Non Pay	211.4	205.4	6.1
Drugs	70.7	69.1	1.6
Other (incl. depreciation)	39.2	38.6	0.6
Total Expenditure	848.7	855.6	(6.9)
Net reported surplus/(Deficit)	(3.9)	(8.5)	(4.8)

Performance in month 10 is £0.3m better than plan, and £4.6m worse than plan YTD. The in-month performance is £5k better than the financial recovery plan.

Total YTD deficit £8.5m.

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.

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

Finance | ERF Performance

Point of Delivery	RWT		
	Plan	Actual	Variance
	Activity	Activity	Activity
Elective	6,534	6,423	(111)
Planned Same Day	46,166	43,423	(2,744)
Outpatient Procedures	135,519	136,480	960
Procedures Total	**188,219**	**186,325**	**(1,894)**
Outpatient 1st	189,231	174,219	(15,012)
Diagnostic Imaging	74,750	69,480	(5,270)
Chemotherapy	11,804	12,546	742
Grand Total	**452,200**	**430,024**	**(21,433)**

	£'000	£'000	£'000
Elective	41,753	39,486	(2,267)
Planned Same Day	49,734	45,963	(3,771)
Outpatient Procedures	23,320	23,332	12
Procedures Total	**114,807**	**108,781**	**(6,026)**
Outpatient 1st	35,978	33,487	(2,491)
Diagnostic Imaging	8,067	7,565	(502)
Chemotherapy	3,963	4,273	310
Grand Total	**162,813**	**154,106**	**(8,708)**

Year to date the variable elective income is £8.7m below the agreed plan with commissioners to meet 60% RTT. Issues relating to activity counting and coding due to EPR implementation are estimated to account for approximately £3.3m of this variance, giving an estimated underlying variance of £5.4m. This is driven by lower than planned RTT performance of 55%. The Trust is aiming for a year end RTT position of 60.6% with the aid of the Q4 sprint.

The Trust is not funded for the required activity levels, therefore, the estimated underlying variance, adjusting for uncoded and uncashed activity against the funded plan is £3.25m.

Care Colleagues
Collaboration Communities

Finance | Cost Improvement Plans

Efficiencies 2025/26	Plan approved by Board £m	YTD recurrent achievement Month 10 £m	YTD non-rec achievement Month 10 £m	YTD achievement Month 10 £m	YTD Plan Month 10	YTD Variance Month 10 £m
Affordable Urgent Care	4.5	0.9	0.0	0.9	3.1	(2.2)
Cessation of Unfunded Schemes	1.0	0.0	0.0	0.0	0.7	(0.7)
Counting and Coding	2.1	0.4	1.5	1.9	1.5	0.4
Estates Utilisation	1.0	1.2	0.4	1.7	0.7	0.9
Non-Pay and Procurement	14.6	10.0	12.6	22.6	12.0	10.6
Operational Productivity	11.9	1.2	0.7	1.9	8.9	(6.9)
Workforce	22.1	1.0	11.5	12.5	17.2	(4.8)
Sub Total - internal plans	57.2	14.7	26.8	41.5	44.2	(2.7)
Total efficiency plan	57.2	14.7	26.8	41.5	44.2	(2.7)

In Month 10 the Trust under-achieved against its plan by £1.89m.

Of the in-month savings of £4.2m, £2.1m (50%) has been achieved recurrently.

Of the YTD achievement of £41.5m, 35% (£14.7m) has been achieved recurrently.

The key areas of underperformance continue to be schemes relating to Operational Productivity and Workforce. Some of these schemes are delayed, whilst others have no detailed plans in place to ensure delivery.

Care Colleagues
Collaboration Communities

National Oversight Framework Dashboard

National Oversight Framework

Quarter 2 Oversight Framework scores have been published which show a slight reduction in Wolverhampton's league ranking from **79** to **84**, on account of the Trusts average metric score falling from **2.45** to **2.49**. As a result of the Trust's financial plan, it remains in **Segment 3**.

As was the case in Quarter 1, scoring related to Access to Services remains relatively good, particularly for cancer and urgent care. The Trusts RTT performance is the exception with scoring impacted by our relatively poor percentage performance; number of 52 week waits and the distance from our submitted plan.

Effectiveness scoring remains strong with an improvement in accuracy of discharge recording.

As was the case in Quarter 1, the Trusts ranking is brought down by Patient Safety and Workforce scores, specifically related to infection control and staff sickness. This is not surprising given the metrics are generally based on a rolling 12-month period so although infection control performance is generally improving, it will take some time before this impacts on the oversight framework scoring.

Finally, our finance score has improved, driven by a material improvement in our Implied Productivity Rate. Further work is required to understand the reason for this.

Care Colleagues
Collaboration Communities

National Oversight Framework Dashboard

National Oversight Framework - RWT

Code	Metric	Time Period Reported	Target	Q1 25/26 Published Perf	Score	Rank	Q2 25/26 Published Perf	Score	Rank	Internal Apr-25	Internal May-25	Internal Jun-25	Internal Jul-25	Internal Aug-25	Internal Sep-25	Internal Oct-25	Internal Nov-25	Internal Dec-25	Internal Jan-26
OF0023	18 Weeks RTT - % Within 18 Weeks - Incomplete	Latest month in the period		55.46	3.54	111/131	54.97	3.61	114/131	52.41	54.30	55.46	55.17	54.69	54.99	54.77	55.00	54.06	56.21
OF0003	18 Weeks RTT - 52 wk breaches as a % of PTL	Latest month in the period	1	2.98	3.21	91/131	2.44	2.77	76/131	2.54	3.07	2.97	2.80	2.43	2.44	2.50	2.75	3.09	2.67
OF0106	Difference between actual and planned 18 week elective performance	Latest month in the period	0	3.16	1.00	32/131	-1.34	2.90	91/131	0.91	2.74	3.37	1.94	2.52	2.61	9.37	3.99	3.23	0.84
OF0005	Percentage of patients waiting over 52 weeks for community services	End of period		1.41	2.68	45/80	0.63	2.56	23/80	2.97	2.36	1.47	1.41	1.18	1.21	0.63	1.41	1.54	2.64
OF0010	Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80	80.03	1.00	27/118	80.14	1.00	20/118	79.97	80.06	80.03	79.98	80.07	80.14	80.01	80.21	80.16	
OF0011	Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75	71.02	2.64	60/118	70.72	2.40	53/118	69.55	70.43	71.01	70.20	70.55	70.73	71.43	71.72	72.16	
OF0013	Total Time Spent in ED - % within 4 Hours	Aggregated quarterly position	78	82.30	1.00	16/123	81.20	1.00	21/123	82.62	82.07	82.29	81.90	81.28	80.99	76.68	77.36	77.20	77.14
OF0014	Total Time Spent in ED - % over 12 Hours	Aggregated quarterly position		8.34	2.48	61/123	10.04	2.68	67/123	8.93	9.15	8.69	9.81	10.21	10.51	15.82	15.12	15.35	18.18
OF0079	Planned Surplus / Deficit	Annual plan	0	-3.26	4.00	92/134	-3.26	4.00	92/134										
OF0081	Year to date variation from plan	Year to date		0.02	1.00	29/134	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	0.60	2.87	84/134										
OF1069	CQC inpatient survey satisfaction rate	Annual			2.00			2.00											
OF0061	Staff survey - raising concerns sub-score	Annual		6.26	3.19	98/134	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	1.23	3.02	83/134	153..09	149.38	145.68	133.33	123.46	123.46	132.10	127.16	113.58	100.00
OF0020	Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	4.00	3.01	77/134	4.00	2.89	71/134	4	4	4	4	4	4	4	4	3	3
OF0048	Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.36	3.60	112/134	1.27	3.31	95/134	293.46	288.79	296.26	288.79	287.85	284.11	292.52	272.90	274.77	277.57
OF0025	Average number of days between planned and actual discharge date	Latest month in the period		0.50	1.74	32/126	0.45	1.73	31/126	4.5	5.1	5.4	5.5	6.1	4.8		3.1	3.8	
OF1046	Summary Hospital Level Mortality Indicator (Rolling 12 Months)	12 month rolling			2.00			2.00		0.9807	0.9807	0.9707	0.9707	0.955	0.9559	0.955	0.956	0.9489	0.9389
OF0057	Community - Urgent Care Response (UCR) 2 Hour Response	Quarterly aggregated figure	70	76.50	2.77	40/51	70.48	3.00	43/51	77.73	78.18	76.35	73.41	70.94	70.87	71.54	69.65		
OF0084	Staff survey engagement theme score	Annual		6.73	3.21	99/134	6.73	3.21	99/134										
OF0082	Staff Sickness Rate	Quarterly – aggregated monthly figures		5.49	2.71	88/134	5.14	2.90	88/134	5.36	5.39	5.39	5.37	5.41	5.41	5.42	5.45	5.49	

Legend:
- Green
- Amber/Green
- Amber/Red
- Red

Care Colleagues Collaboration Communities

Productivity Dashboard

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 other 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.

Care Colleagues
Collaboration Communities

Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target	Basis of Target	2025/26 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
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.	4.3%	Achievement required to improve to next quartile (top)	-14.5%	-12.1%	-10.6%	-9.7%						

Operational and Clinical Productivity / Best Practice

Ref no.	Theme and KPI	Definition	Target	Basis of Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2	Average LOS for elective admissions (excluding daycases)	Average length of stay for all elective patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	2.8%	Achievement required to improve to next quartile (second)	3.84	3.55	3.60	3.91	3.80	3.50	3.23	4.15	4.03	3.73
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	9.6%	Achievement required to improve to next quartile (top)	6.10	5.96	5.89	5.79	5.62	5.68	6.05	5.56	5.99	5.74
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	92%	Nationally set	94.3%	95.1%	94.3%	93.9%	91.9%	94.7%	95.8%	96.5%	95.1%	96.3%
5	Bed Occupancy classed as clinically ready for discharge (% of acute)	The average number of patients across the month who do not meet the criteria to reside (Question 2), divded by the total number of patients in hospital or discharged by 23:59 each day (sum of Question 3a and 3b).	22.2%	Achievement required to maintain top quartile performance	17.5%	17.7%	18.8%	17.7%	18.3%	18.2%	16.8%	16.3%	16.7%	18.5%

Theatre Utilisation

Ref no.	Theme and KPI	Definition	Target	Basis of Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
6	Capped elective theatre utilisation	Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration	85%	Nationally set	85%	83%	84%	83%	81%	82%	80%	79%	80%	78%
7	Average number of cases completed per theatre list	Total number of cases completed divided by total number of sessions utilised	2.3	Achievement required to improve to next quartile (top)	2.15	2.18	2.13	2.18	2.15	2.05	2.01	2.04	2.00	2.05
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	93%	Achievement required to equal best performing Trust in Group	84%	86%	87%	79%	77%	81%	83%	85%	83%	90%
9	CT, MRI & ultrasound utilisation		95%	Local planning target agreed	To follow next month									

Outpatients

Ref no.	Theme and KPI	Definition	Target	Basis of Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	95%	Local planning target agreed	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%	Local planning target agreed	8.4%	8.7%	9.0%	8.6%	8.7%	8.8%	9.5%	9.8%	9.9%	10.7%
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	5%	Local planning target agreed	2.9%	2.6%	2.8%	2.7%	2.5%	3.9%	2.9%	3.5%	4.5%	3.7%
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referra) divded by total number of outpatient first attendances	13%	Local planning target agreed	5.8%	6.3%	6.5%	7.3%	7.8%	11.0%	6.6%	6.5%	8.5%	8.2%
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	Nationally set	1185	0	3153	1214	0	1640	0	0	0	0

Productivity Dashboard

Coding/ Income				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
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.	>£2,053	Improvement on last year performance	2,207	2,182	2,129	2,177	2,133	2,200	2,269	2,258	2,337	2,415
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes	£970k		£0	£0	£0	£0	£12,093	£273,446	£36,969	£36,969	£152,545	£85,545
17	Number of unfunded services being delivered	Number of services being delivered that do not have any form of funding arrangement in place	0		6	6	4	4	4	3	3	3	3	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	£6.9m	Use of resources target	£2,531k	£2,997k	£2,425k	£3,247k						

Workforce Productivity				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
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%	Achievement required to maintain top quartile performance	1.94	1.98	1.99	2.00	1.98	1.99	2.19	2.12	2.08	2.21
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%	Achievement required to maintain top quartile performance	1.43	1.46	1.52	1.58	1.42	1.61	1.54	1.54	1.40	1.62
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.	TBC	TBC	119.79	122.32	123.60	125.86	120.05	139.63	126.52	119.33	108.12	111.74
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	Achievement required to maintain top quartile performance	473.89	498.78	493.52	436.79	498.23	491.57	548.93	462.75	391.78	426.44
23	Corporate services cost per £100m income (£m)	The total cost of corporate services divided by £100m.	0.27	20% reduction on March 25 position	0.25	0.27	0.28	0.26	0.25	0.26	0.27	0.31	0.28	0.26

Workforce Drivers													
24	Temporary Staff Spend as a % of Total Spend	Proportion of financial year-to-date total staff spend that is on temporary staffing (a combination of agency and bank staff	5.7%	Achievement required to improve to next quartile (top)	5.85%	5.99%	6.14%	6.82%	6.75%	6.41%	6.61%	6.83%	6.97%	6.37%
25	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	6%	Nationally set	5.32%	5.17%	5.31%	5.38%	5.54%	5.34%	5.99%	5.98%	6.39%	5.96%
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%	Local planning target agreed	8.92%	8.99%	8.96%	8.84%	9.04%	8.77%	8.94%	8.18%	7.99%	7.94%
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	7.40	7.70	7.80	7.60

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	£25.64/m2	£27.80/m2	£28.16/m2	£28.48/m2

Tier 1 - Paper ref:	Enclosure 9.2.1

Report title:	Guardian of Safe Working Hours Report 2025: A joint report of the Guardians of Safe Working Hours (GoSWH) for Walsall Healthcare Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) for the calendar year 2025
Sponsoring executive:	Dr Zia Din Chief Medical Officer WHT Dr Brian McKaig Chief Medical Officer RWT
Report author:	Dr Milena Sirakova GoSWH WHT Dr Sophie Reynolds GoSWH RWT With thanks for contributions from Dr Rayasandra B Gireesh former GoSWH WHT
Meeting title:	RWT/WHT Group Trust Board Meeting to be held in Public
Date:	17th March 2026

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

Assure

The GOSWH in WHT and RWT are able to provide assurance that data indicates for the majority of shifts the working hours of doctors and dentists and training are within safe limits.

Advise

On 4th February 2026 version 13 of Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 came into effect. The main amendment is a reform of exception reporting.

Alert

Vacancy rates are 7% for doctors and dentists in training allocated to the Group by the Postgraduate Deanery. These gaps are not equally distributed across specialities and over time impacting on the ability of directorates to forward 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?]

Matters of exception reports and exception reporting reforms discussed at Medical Education Group in both organisations and the Group People Committee.

4. Recommendation(s)/Action(s)

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

a) Accept the assurance of the joint Guardians of Safe Working hours as per the report summary

4. Recommendation(s)/Action(s)
b) Support full implementation of Version 13 of the Terms and Conditions of Service, to include the reforms to exception reporting, the generation of a Guardian fund at RWT, and levying of all categories of penalty fines specified in the national contract.

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 17th March 2026

Guardian of Safe Working Hours Report 2025:
A joint report of the Guardians of Safe Working Hours (GoSWH) for Walsall Healthcare Trust (WHT)and The Royal Wolverhampton NHS Trust (RWT) for the calendar year 2025

1. Executive summary

1.1 Assure

The GOSWH in WHT and RWT are able to provide assurance that data indicates for the majority of shifts the working hours of doctors and dentists and training are within safe limits.

1.2 Advise

On 4th February 2026 version 13 of Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 came into effect. The main amendment is a reform of exception reporting.

1.3 Alert

Vacancy rates are 7% for doctors and dentists in training allocated to the Group by the Postgraduate Deanery. These gaps are not equally distributed across specialities or over time impacting on the ability of directorates to forward plan.

2. Introduction

The purpose of the report is to provide a joint update and assurance from the Guardians of Safe Working Hours to the Group Trust Board on the safety of doctors and dentists working hours and rota gaps as required under the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016.

3. Report

3.1 Vacancy data

Number of doctors in training   WHT 222.5 WTE   RWT 394.6 WTE
Annual vacancy rate   ≈ 7% in both organisations

3.2 Exception report data

Exception Reports (ER) over 2025:		
Reference period of report	01/01/2025 - 31/12/2025	
Trust	WHT	RWT
Total number of exception reports received	139	95
Number relating to immediate patient safety issues	4	7
Number relating to hours of working	136	77
Number relating to pattern of work	1	8
Number relating to educational opportunities	0	4
Number relating to service support available to the doctor	2	6

3.3 Guardian fund

3.3.1 The Guardian fund is generated through penalty fines levied by the GoSWH in respect of working hours breaches as specified in TCS. Distribution of funds has been agreed through the Resident Doctors Forum (RDF) as per the contract.

3.3.2 **WHT:** Audited amounts in the GoSWH fund as of **01st December 2025: £ 13,465.51** with 9 penalty fines from December 2025 pending.

3.3.3 **RWT:** Guardian fund not currently in place. This will be addressed in 2026 to align with TCS.

3.4 Issues arising

3.4.1 Vacancies are approximately 7% in this staff group. Doctors and dentists are allocated into these posts by the postgraduate deanery so this vacancy is beyond the control of the organisations. Gaps are unequally distributed across specialties and over time, impacting on the ability of directorates to forward plan for this.

3.4.2 Exception reporting numbers have risen marginally from the previous year. It is reassuring that exceptions are reported, as this demonstrates effectiveness of this as a tool for monitoring safe working hours. There have been delays in supervisors actioning exception reports across both organisations, frequently necessitating GoSWH intervention. Exception reports for immediate patient safety concerns remain low and all were addressed rapidly with appropriate escalation.

3.4.3 On 4th February 2026 version 13 of TCS came into effect. The main amendment is a reform of exception reporting. This reform removes the requirement for the doctor or dentist's supervisor to review the exception report, introduces confidentiality and anonymity to exception reports, and introduces additional categories of penalty fines.

3.5 Actions taken to resolve issues

3.5.1 Vacancies are managed by individual departments through use of the locum bank or fixed term locally employed doctors' posts. Greater oversight of this will be possible with the implementation of e-rostering at RWT and alignment with WHT.

3.5.2 More Proactive Junior clinical fellow recruitment to fill the training vacancies.

3.5.3 Exception reporting will continue to be encouraged as a tool for monitoring and improving safe working hours. The challenges around supervisor reviews will resolve with the exception report reform.

3.5.4 Implementation of version 13 TCS is underway and progressing well. Approval is requested from Group Trust Board to support full implementation of all updated terms and conditions to include the levying of penalty fines, as specified in version TCS, for delays in access to exception reporting software or breaches in confidentiality of exception reports.

4.0 Summary

3.5.5 **Assurance:** The GOSWH in WHT and RWT are able to provide assurance that data indicates for the majority of shifts the working hours of doctors and dentists and training are within safe limits. Eventualities do occur where these working hours are breached. Exception reporting data demonstrates that doctors are alerting the GoSWH to these events and the Guardians can confirm that these are escalated appropriately within the organisation and actions are taken to prevent recurrences.

3.5.6 **Forward view:** Implementation of TCS version 13 reduces potential for barriers to exception reporting, supporting exception reporting as a tool for monitoring adherence to safe working hours. E-Rostering will enhance GoSWH oversight of working patterns and hours (It is already implemented in WHT and planned for implementation in WRT).

4.   Recommendations

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

   a.   Accept the assurance of the joint Guardians of Safe Working hours as per the report summary
   b.   Support full implementation of Version 13 of the Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016, to include the reforms to exception reporting, the generation of a Guardian fund at RWT, and levying of all categories of penalty fines specified in the national contract.

2nd March 2026

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

Title of Report	Exception Report from Audit Committee	Enc No: 12.1
Author:	Mary Martin, Non-Executive Director	
Presenter:	Mary Martin, Chair Audit Committee	
Date(s) of Committee Meetings since last Board meeting:	9 February 2026	

Action Required			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Internal Audit report covering Key Financial Controls – System implementation was received and it had a Partial Assurance opinion with 1 high, and 3 medium actions agreed. The high recommendation is concerned with accurate transfer of supplier and customer balances to the new SBS system.	• The review of updated Standing Orders and Standing Financial Instructions is still underway. A programme of reviews and approvals is being worked through to get final Board sign off as close to the start of the new financial year as possible. • Ms Godson to attend the May committee meeting to present (1) the latest programme for management of patient records due to slow implementation of Internal Audit recommendations (2) the management of Internal Audit recommendations and related time extensions.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Internal Audit report covering Accounts Payable and Accounts Receivable and had a reasonable assurance opinion. There is still ongoing work to validate the information transferred to the new SBS accounting system. • Counter Fraud services reported that they were working with the CPS on the potential prosecution of case involving time sheet fraud. • The External Audit plan continues to be on target.	• The Internal Audit plan for 2026/27 was approved.

Title of Report	Exception Report from Audit Committee	Enc No: 12.1
Author:	Julie Jones, Chair of RWT Audit Committee	
Presenter:	Julie Jones, Chair of RWT Audit Committee	
Date(s) of Committee Meetings since last Board meeting:	24 February 2026	

Action Required			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• A negative internal audit opinion of 'partial assurance' was given for the Authorised Engineers Review. A high priority recommendation was raised because high risk actions arising out of authorised engineer reviews had not been added to the strategic risk register or reported to the Trust Board. The committee was updated on the subsequent actions to address the findings in this report and a follow-up audit will be undertaken in due course. • Negative internal audit opinions of 'partial assurance' were given in respect of a review and a deep dive into the new finance system implementation. The committee continues to seek assurance that the issues are being addressed and the risk of incorrect financial information being prepared is being mitigated. The committee was assured that matters would be resolved in time for financial year-end. • The RWT Chief Nursing Officer provided an update on unused nurse hours following a discussion at the December committee meeting about the internal audit review of nurse rostering. As at 7 December 2025 unused nurse hours totalled 89,853 which represent hours paid but not marked as having been worked. In view of the existence of historic errors in calculating unused hours she shared her options appraisal for the management of unused hours going forward. The committee received assurance on the system improvements to ensure unused hours did not continue to accumulate.	• Work is still underway transferring internal audit actions to the RSM software that we will use for tracking the implementation of recommendations going forward. Executive colleagues were asked to continue their completion of internal audit actions, and retention of evidence and to continue with agreed timetables whilst the new system was populated and tested. • In view of a requested write-off of debts in December 2025 relating to Welsh patients that Betsi Cadwaladr University LHB and Aneurin Bevan LHB which had not been paid, a report was requested for the February committee meeting on how this issue would be addressed and policy strengthened. This report was not available due to taking longer than expected to formulate and has therefore been deferred to the May Audit Committee meeting. • A number of detailed questions were raised about Single Tender Waivers and SFI breaches for which further clarification by email was requested.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The internal audit plan for 2026/27 was approved, with core activity covering the Board Assurance Framework and risk management, key financial controls, Fit and Proper Persons regulations, the Cyber Assessment Framework, theatre utilisation, referral to treatment, and A&E 4 hour waits. • Internal audit gave 'reasonable assurance' in their report on Data Quality – Cancer Waits. • The External Audit plan for the year ending 31 March 2026 was reviewed. • The Local Counter Fraud Service annual work plan was approved.	• Recommend approval of losses and special payments write offs to Board. • The Group Standing Orders and Standing Financial Instructions update paper was deferred to allow further review by officers.

Title of Report	Exception Report from Charity Committee	Enc No: 12.2
Author:	Professor Martin Levermore	
Presenter:	Professor Martin Levermore	
Date(s) of Committee Meetings since last Board meeting:	22nd January 2026	

Action Required			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☒	Yes☐No☒	Yes☒No☐	Yes☒No☐

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Charity's cash flow position remains negative at the start of the year, with revised projections showing ongoing challenges. • At the end of quarter financial position showed a net deficit of £46,000, this reflects a cash flow shortfall of approximately £250,000 by financial year end. • Note: the Charity's current financial challenge is related to cash flow, not insolvency, but there is a need to prevent further deficits taking place.	• Charity Effectiveness Survey had been completed and discussed, this prompted personal reflection on Committee members' own understanding and responsibilities, highlighted its value for individual development. • There is a need for both RWT and WHT charities to be working closer together and sharing resources NHS Charities were in the progress of putting together some guidelines on how charities work together, committee to follow up and incorporate into joint MoU between the Trusts. • Review individual Charity's strategy to underpin a group fund-raising strategy.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• 2024/25 accounts were submitted to the Charity Commission on 19th December, and the charity will participate in the NHS Charities Together comparison survey for financial benchmarking with other local NHS charities. • Both short- and long-term investment portfolios were in good health. • The committee will continue with a full external audit for 2025/26, using WR Partners for this year, a review of the audit provider is planned for next year due to the upcoming investment tender.	• Financial policies - charity currently holds sufficient freely available funds to cover six months of commitments if required. • Approved Review of Terms of Reference. • Approved purchase of ICCU – Pupillometer under £5k • Approved purchase of ICCU – Simulator Pacing Box under £5k • Approved purchase of Cardiac – Rapid Infuser under £5k

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

Tier 1 - Paper ref:	Enclosure 12.3

Report title:	Board Assurance Framework
Sponsoring executive:	Kevin Bostock, Group Chief Safety & Assurance Officer
Report author:	Cody Long, Group Deputy Director of Assurance
Meeting title:	Trust Board Meeting to be held in Public
Date:	17 March 2026

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

Assure

The Executive Directors reviewed and assessed the Group Board Assurance Framework in February 2026 and the BAF was presented at the following Committees of the Board for Approval:

- Group Finance and Productivity Committee
- Group People Committee
- Group Quality Committee
- Group Partnerships and Transformation Committee

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 (no change)
- **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 (no change)
  - **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 (no change)
  - **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 (no change)

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

- o **If** the Trusts/Group workforce transformation plan (reduced staffing, use of new technology, culture & behaviour) is not achieved
- o **then** there may be a disconnect between the corporate aspirations, targets and requirements
- o **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.
- **BAF GBR5 -** 3 likelihood x 4 consequence = 12 (no change)
  - o **If** the Trusts/Group clinical service transformation plan is unable to achieve its aims and objectives &/or maintain or improve quality & safety
  - o **then** quality and safety standards may fall and/or become compromised
  - o **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 February 2026 by Executive Directors and approved by the Committees of the Board in February 2026.

---

4. Recommendation(s)/Action(s)
The Group Trust Board held in Public is asked to:
a) Receive for information and assurance the Group Board Assurance Framework as approved by the Committees of the Board.

---

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*
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

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

Board Assurance Framework

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.

   <u>Contents</u>
   1 Front Sheet and Summary including initial 'Watch List' Annex June 2025.
   2 Pictorial Summary of Group Risks at end of Q1 25-26.
   3 Summary of Risk Appetite Statements and Risk Tolerance levels.
   4 Summary of Group Risks with initial sources of control, assurance, Negative Assurance and Gaps in Control.

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

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

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.

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

Board Assurance Framework (BAF) Summary February 2027

Kevin Bostock

Group Chief Safety & Assurance Officer

GBR 3	Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	F&P
	25													5	
	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	

Left axis label: Risk Score 5x5 ANZ Matrix (including Risk Tolerance)

Right axis label: Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)

Risk Score 5x5 ANZ Matrix (including Risk Tolerance)

Risk Appetite Levels (including Primary Statement Level, Low/High Risk Universe)

Time	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Time	PC
25													5	
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 Appetite Matrix (Adapted GGI risk appetite matrix) to establish initial Risk Appetite Statements refinement RWT/WHT Group June 2025

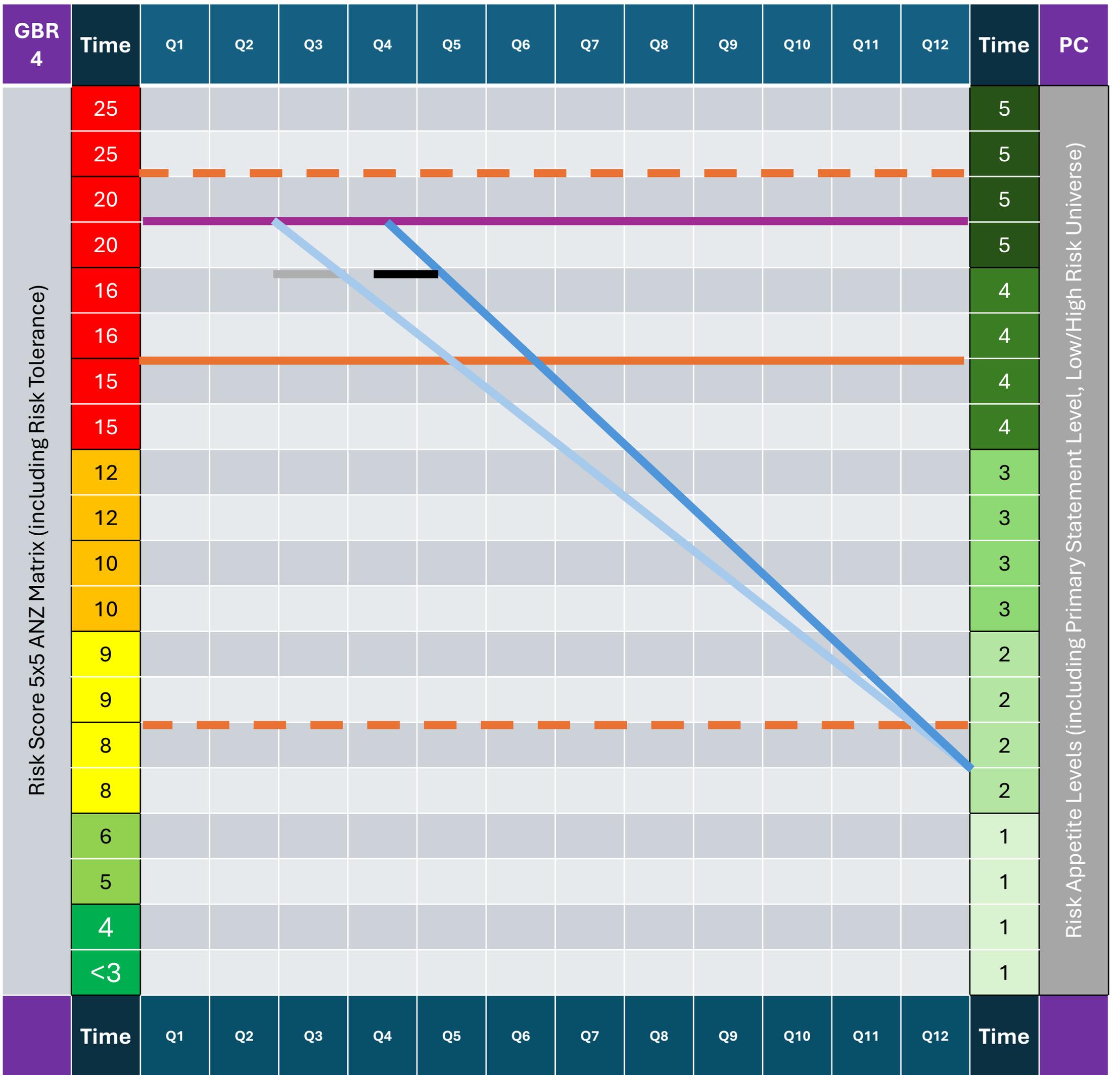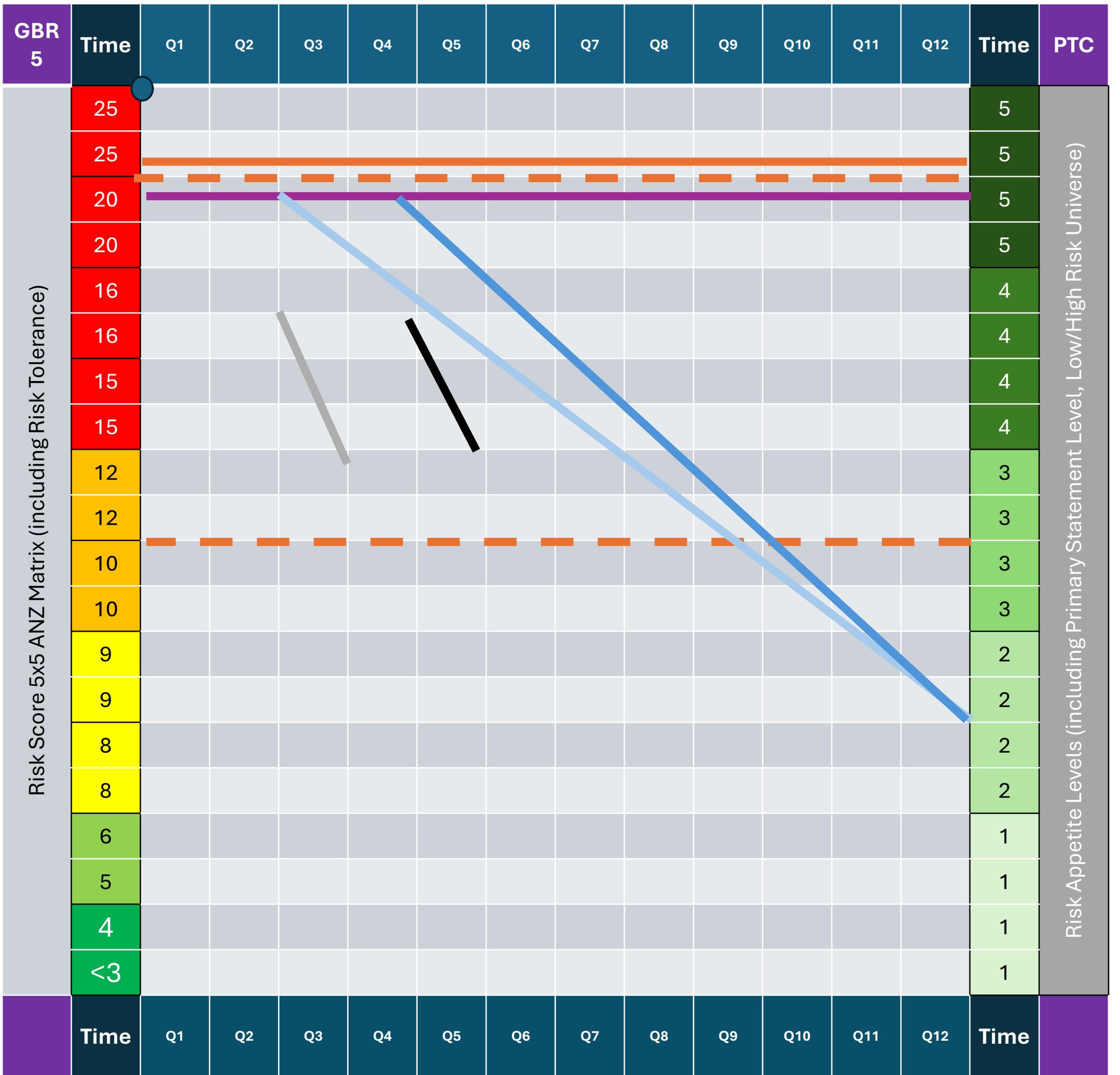| Number	Risk Types	Risk Appetite Level	1 None / Averse — *Avoidance of risk is a key organisational objective.*	2 Minimal — *Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.*	3 Cautious — *Preference for safe delivery options that 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 February 2026

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.	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. Use of Resources	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. Discussions with the ICB have secured additional financial support Continuous updates of the Group Recovery Financial Plan which is shared at F&P and Board	Strike action and pay awards Termination costs funding Severance costs ICS - not paying for ERF over activity plan. Winter pressures Scale of CIP required Likelihood of further tariff and payment rules in 2027/28	Not a fully identified CIP plan. 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/or collectively unable to meet the in year access standards over the next 3-5 years (e.g. RTT)	**then** the Trusts individually and/or collectively will be non-compliant with future contract and regulatory requirements	**resulting in** potential special measures regime imposition and reputational damage	4 likelihood x 4 consequence = 16

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 reporting compliance against trajectories agreed as part of organisations planning return.

Routine corporate assurance meetings in place across both Trusts with escalation meetings on an extraordinary basis according to need, eg. CEO meeting at RWT on RTT.

Corporate meetings above are underpinned by governance structure at Divisional level. Participation in planned care and UEC sprints. | WHT is not tiered for either UEC or electives.

RWT is not tiered for UEC

IQPR pack to F&P and Trust Board.

Both trusts in segment 2 of the National Oversight Framework for access to services | 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.

RWT is in Tier 2 for Elective performance.

Clear impact of EPR implementation at RWT impacting on activity recording, UEC and RTT performance. | 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.	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. The Bain work completed and presented to corporate services transformation group, DW and JCB as Group CEOs across the collaborative. A proposal paper has been drafted with recommendations for the following function, finance, people, digital and technology, estates and facilities and procurement to go to the next JPC 26 February 2026.	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.	**Review undertaken 10/2/26** Initial – 5 likelihood x 4 consequence = 20 Current – 4 likelihood x 4 consequence = 16 Target – 2 likelihood x 4 consequence = 8	GCPO	PC October 2025	Sickness Absence Reduction Plan Yr 2 People Strategy evidence Freedom to Speak up Service Equality Impact Assessment Process in Place Executive Vacancy / Recruitment review panels. Workforce trajectory plan to PC on a monthly basis. Team briefs Go Look See (Executive Walkabouts)	Sickness absence measurement Measurement of performance against Strategy Freedom to Speak Up Quarterly Report provided to People Committee and Bi-Annually to Board Cultural conversations taking place with staff and Chief Officers. Performance against plan Staff Survey feedback Patient and Staff Feedback Surveys	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. Patient and Staff Feedback Surveys	E-rostering implementation - ongoing Clear-note/Heidi systems – O.P. transformation group 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 undertaken Feb 2026** Initial 5 likelihood x 4 consequence = 20 Current 3 likelihood x 4 consequence = 12 Target 2 likelihood x 4 consequence = 8 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 reached 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). Monthly meetings with PA taking place to review progress with an output report for the 6 month pilot due end March 2026.	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. Rapid improvement events RIE have been held across both trusts. This has identified opportunities to improve pathways of care and revised operating procedures. Currently being monitored to determine in the changes are delivering the improvements at the desired pace and scale.	10-year Plan impact. Changing NHS Operating Model post-ICB and ACO.	