



**The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust
Group Board of Directors Meeting –held in Public
Tuesday 15th September 2026**

BOARD PAPERS

INFORMATION FOR MEMBERS OF THE PUBLIC

Welcome to the Group Board of Directors Meeting being held in Public.

The Board is meeting in public, not holding a public meeting.

Members of the public are welcome to observe the proceedings.

To help the meeting run smoothly, please note the following:

During the Meeting

- Please switch mobile phones and electronic devices to silent mode.
- The Chair will manage the conduct and timing of the meeting.
- Questions should be submitted in advance in accordance with the Trusts' Public Questions arrangements, as published on the Trust websites.

Thank you for attending and for your interest in the work of the Trusts.

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The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

**RWT/WHT Group Board of Directors Meeting –
to be held in Public
Tuesday 15th September 2026
Room 8, WMI, Building 11, New Cross Hospital**

Agenda Item	Format	Item Description	Lead	Purpose	Time
1	Verbal	Chair's Welcome, Apologies and Confirmation of Quorum	Sir David Nicholson	To inform	12:30
2	Verbal	Register of Declarations of Interest The Registers can be located on the Trust websites.	Sir David Nicholson	To inform & assure	12:32
3	Verbal	Patient Story – The High Intensity Use Service (HIUS)	B McKaig	To inform	12:34
4	Enc	Minutes of the Previous RWT/WHT Group Board of Directors Meeting held in Public on 21 July 2026	Sir David Nicholson	To approve	12:49
4.1	Enc	Group Board Action Log	Sir David Nicholson	To inform	12:52
4.2	Enc	Matters arising Action 3863 - Ophthalmology Action Plan with Timescales for Delivery	B McKaig G Nuttall	To inform & assure	12:57
4.3	Verbal	Matters Arising Action 3864 – Mental Health Update -- verbal update on performance against key response times (1hr/4hr standards)	D Hickman	To inform & assure	13:05
5	Verbal	Chair's Report – Verbal	Sir David Nicholson	To inform & assure	13:10
6	Enc	Group Chief Executive's Update	J Chadwick-Bell	To inform & assure	13:18
6.1	Enc	Progress Report on Anchor Development	J Chadwick-Bell	To inform & assure	13:26
7	Enc	Integrated Committee Chairs Report	P Assinder L Toner D Brathwaite L Sadler-Todd(formerly Cowley) R Barber	To inform & assure	13:34
7.1	Enc	Group Board Assurance Framework	P Assinder	To inform & assure	13:44
8	Strategy				
8.1	Enc	Health Inequalities Progress Report	S Cartwright	To inform & assure	13:49
8.2	Enc	Transforming Care Together – Operating Model for Neighbourhood Teams	S Cartwright	To inform & assure	14:04
9	Comfort Break (14:14-14:24)				
10	Quality & Performance (Section Heading)				
10.1	Enc	Maternity and Neonatal Quality Assurance	D Hickman	To inform & assure	14:24

Agenda Item	Format	Item Description	Lead	Purpose	Time
10.1.1	Verbal	Maternity and Neonatal – 10 Point Plan – Assurance Process	D Hickman	To assure & delegate approval of the plan to the Group Quality Committee	14:34
10.2	Enc	Group Finance & Workforce Update Report	K Stringer C Radley	To inform & assure	14:42
10.3	Enc	Integrated Performance Report - Walsall Healthcare NHS Trust (WHT)	A Godson	To inform & assure	14:52
10.4	Enc	Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT)	G Nuttall	To inform & assure	15:07
10.5	Enc	RWT & WHT Winter Plans & Assurance Statement	A Godson G Nuttall	To inform, assure & approve	15:22
11	Governance (Section Heading)				
11.1	Enc	Guardian of Safe Working Progress Report	B McKaig	To inform & assure	15:37
11.2	Enc	Medical Revalidation & Fitness to Practice: - Annual Report and - Statutory Statement of Compliance	B McKaig	To inform, assure	15:45
11.3	Enc	Workforce Race (WRES) and Disability (WDES) Equality Standards: 2026 Data Return and Key Actions	C Radley	To approve	15:50
11.4	Enc	Modern Slavery and Human Trafficking Statutory Statements for RWT & WHT	K Stringer C Radley	To approve	15:58
11.5	Enc	NHS Premises Assurance Model (PAM) 2025/26 Annual Assessment and Submission	K Stringer	To inform, assure & approve	16:03
11.6	Enc	RWT Audit Committee Chair's Report	J Jones	To inform & assure	16:11
12	Verbal	Questions Received from the Public	Sir David Nicholson	To inform	16:19
13	Verbal	Any Other Business	Sir David Nicholson	To inform	16:24
14	Verbal	Date and Time of Next Meeting - Tuesday 17 November 2026 at MLCC Walsall Healthcare Trust	Sir David Nicholson	To inform	16:26
15	Verbal	Resolution	Sir David Nicholson	To approve	16:28

Agenda Item 2 - Register of Declarations of Interest

Board members to advise of any conflicts of interest pertaining to any item on the agenda which have not already been declared on the Board of Directors registers of interest which can be found on the trust websites.

The Registers can be located on the Trust websites.

Item 3 - Patient Story - Link to Youtube Video:

<https://youtu.be/vAeALO6BoJM?si=OatISm4kzYFj-i4P>

MEETING OF THE PUBLIC GROUP TRUST BOARD MEETING
TUESDAY 21 JULY 2026 AT 12:30pm - held at Meeting Rooms 12&13 MLCC
3rd Floor Walsall Manor Hospital Walsall Healthcare NHS Trust

PRESENT

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

Sir D Nicholson	Group Chair
Ms J Chadwick-Bell	Group Chief Executive Officer
Ms R Barber	Group Associate Non-Executive Director
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
Mr S Evans	Deputy Group Chief Executive Officer & Chief Strategy Officer
Ms J Jones	Non-Executive Director, RWT
Dr B McKaig	Group Chief Medical Officer,
Dr Z Din	Chief Medical Officer, WHT
Mr P Assinder	Group Vice-Chair
Ms A Heseltine	Group Associate Non-Executive Director
Prof L Toner	Group Non-Executive Director
Lord Carter	Specialist Advisor to the Board, RWT
Dr U Daraz	Group Associate Non-Executive Director
Ms D Brathwaite	Group Non-Executive Director
Ms A Godson	Managing Director, WHT
Mr K Bostock	Group Chief Safety & Assurance Officer
Ms C Radley	Group Chief People, Culture, and Improvement Officer
Prof E Hughes	Group Non-Executive Director
Prof M Levermore	Group Non-Executive Director
Ms G Nuttall	Managing Director, RWT
Mr M Laverty	Group Non-Executive Director
Ms M Martin	Non-Executive Director, WHT

In Attendance

Ms J Toor	Group Trust Board Secretary
Mr C Hodgson	Interim Director of Estates & Facilities
Mr J Green	Operational Director of Finance, RWT (attending on behalf of Mr Stringer)
Mr D Mortiboys	Operational Director of Finance, WHT (attending on behalf of Mr Stringer)
Dr J Aslam	Emergency Medicine Consultant and Group Clinical Lead for Ambient Voice Technology (ref: 192/26)
Ms K Salman	Deputy Chief Strategy Officer – Transformation (ref: 192/26)
Ms S Raza	Freedom to Speak Up Guardian for (ref: 198/26)
Mr G Perry	Associate Director Patient Voice/Experience) (ref: 210/26)
Mr C Ward	Deputy Chief Nurse, RWT (shadowing)

Apologies

Mr K Stringer	Group Chief Financial Officer
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For ease of reference, the minutes have been recorded in agenda order rather than the chronological order of discussion.

190/26	Chair's Welcome, Apologies and Confirmation of Quorum
	Sir David welcomed attendees to the meeting, noted apologies received, and confirmed that the meeting was quorate. He welcomed Mr Laverty, Group Non-Executive Director, Mr Green and Mr Mortiboys who were supporting the Finance Director function in the absence of Mr Stringer, and Mr Ward, Deputy Chief Nursing Officer who was shadowing the Board. Sir David noted that this was Dr Din's final meeting as a Board member and thanked him for his contribution as Chief Medical Officer at WHT. He advised that Dr Din would continue as Medical Officer at WHT and would attend future meetings as required. He welcomed Dr McKaig to the Board in his role as the Group Chief Medical Officer. Resolved: that the Group Trust Board Meeting held in public be confirmed as quorate.
191/26	Register of Declarations of Interest
	Sir David reminded members that the Register of Interests were published on the Trust website. Members were also reminded of their responsibility to declare any interests, including the receipt of gifts or hospitality, in accordance with the Trust's policies and governance requirements. No additional declarations were made. 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.
192/26	Patient Story
	Sir David reminded the Board that patient or staff stories were routinely shared at the start of meetings to ensure

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discussions remained focused on the experiences of patients, staff and the delivery of care.

Ms Carroll introduced Dr Aslam, Group Clinical Lead for Ambient Voice Technology, and Ms Salmon who had been leading the implementation of the project across the Group. She said the patient story demonstrated the impact of Ambient Voice Technology (AVT) within Audiology Services and said the technology had been introduced across various services at WHT. She advised that feedback received had been that following the implementation of AVT, patients felt they now received the clinician's full attention throughout the consultation, instead of spending a proportion of time entering information into clinical systems, which enhanced overall patient experience. She reported staff had also highlighted the benefits of the technology, which enabled them to focus more fully on listening to patients rather than documenting information during appointments. She said the technology had improved the timeliness of clinical correspondence, enabling letters and records to be produced more efficiently, and the positive impact on both patient experience and clinical productivity was noted.

Sir David welcomed the positive impact demonstrated in the video and noted that successful implementation of new technology within the NHS had often been challenging but there appeared to have been strong enthusiasm and demand from staff to adopt AVT and asked what had contributed to the successful implementation and acceptance of the technology.

Dr Aslam advised that the initiative had been driven by patient feedback, with the aim of giving clinicians more time to focus on patient care. He said a patient's experience of feeling unheard during a consultation highlighted the need for a solution that would improve clinician-patient engagement. He said that successful adoption had been achieved by focusing on clinical and patient benefits rather than the technology itself. He advised implementation initially targeted services with significant documentation backlogs, and positive feedback from early adopters, supported by communications and demonstration videos, had generated strong interest across the Group, with demand for AVT continuing to grow, and specialties proactively requesting access to the system.

Ms Salmon said that implementation had focused on priority specialties with significant documentation backlogs and following positive feedback from early adopters, supported by staff and patient communications, had generated growing interest across the Group and interest now exceeding the current pace of rollout.

Prof Toner queried the efficiency and effectiveness of AVT to sense-check and review the content of a letter, particularly in terms of understanding and assessing the message being conveyed. Dr Aslam advised the system could generate and draft clinic letters in real time, with an initial review taking approximately 30 to 40 seconds. He said correspondence was routinely reviewed and sense-checked by clinicians as a mandatory governance requirement and emphasised that, whilst AI could be used to draft clinical documentation, responsibility for clinical judgement, decision-making and the accuracy of the final output remained with the clinician. He said once checked and approved by the clinician, letters could be uploaded to the electronic patient record and sent immediately to patients and GPs.

Ms Salmon said the quality of clinical documentation was improved, with greater detail being captured and clinical quality scores increasing. She reported that that reviewing correspondence immediately following a consultation also reduced administrative time and enabled clinicians to make amendments in real time.

Ms Chadwick-Bell said as part of a proposed two-year implementation programme, further work had been requested to identify the outcomes and benefits that would justify a faster rollout of the system. She said it was recognised, however, that adoption of the technology would require significant cultural change, and any acceleration would need to be carefully assessed alongside the associated financial implications. She said this also highlighted the potential impact on patient experience, particularly in ensuring that patients felt listened to and understood during consultations. She reflected that this could reduce situations where patients sought second opinions because they had not felt heard. She said that further conversations on the roll out time of the system needed to be had.

Ms Chadwick-Bell She welcomed the reduction in the time taken to issue clinical correspondence and sought assurance regarding any clinical risks associated with delays in letter production. Dr McKaig advised that the average turnaround time for routine clinic letters was approximately 10 to 14 days. He said these letters generally communicated information that was not time-critical, whilst urgent actions, such as cancer referrals or immediate medication changes, were communicated through alternative pathways and escalated as required. He assured the Board that there was no evidence of patient harm or increased clinical risk arising from current letter turnaround times.

Dr Daraz sought assurance that sufficient resources and capacity were in place to support the safe and effective rollout of the programme at scale. Dr Aslam advised that the current team was not sufficiently resourced to deliver the level of rollout required to meet demand and maximise benefits realisation and that additional clinical engagement, project management support and organisational commitment would be required to support adoption and address cultural resistance to changes in ways of working. He advised that successful deployment would require appropriate infrastructure, including IT systems, devices and supporting equipment, to ensure that the programme could be scaled and sustained effectively. He reported that immediate priorities remained as information governance, cyber security and clinical safety approvals. He noted that a two-year rollout timeframe was longer than desirable and that opportunities to accelerate delivery should be explored.

	Dr Din commented that the programme provided a strong example of quality improvement and innovation working effectively together. He highlighted the importance of communications and engagement activities in supporting adoption and driving change, noting that many successful pilots did not always achieve wider implementation. He also commended the team for successfully promoting and showcasing the work across the wider region and congratulated them on the external recognition received, including recent coverage by the BBC. Ms Brathwaite advised on having seen a demonstration of the technology in Dermatology and commented positively on its effectiveness. She asked for assurance regarding the arrangements that would be put in place to monitor and evaluate the rollout at scale, recognising that adoption and outcomes might vary across departments and that a poorly managed implementation could undermine an otherwise successful initiative. Ms Salmon advised that robust project management and governance arrangements would underpin the rollout, including the use of risk registers, hazard logs and ongoing oversight of implementation risks. She said the introduction of trust-issued devices and mobile technology was also recognised as a significant change in practice requiring careful management. She said a range of performance measures and monitoring arrangements had been established, including metrics relating to clinician uptake and adoption, to support ongoing evaluation and enable any issues to be identified and addressed promptly during implementation. She advised that experience to date had been overwhelmingly positive, with clinicians and specialties that had initially been sceptical becoming supportive after seeing the technology in practice. She said whilst significant resistance had not yet been encountered, adoption and implementation would continue to be monitored closely as the programme expanded. Dr Aslam said that robust governance arrangements would be maintained throughout implementation, including clinician oversight and ongoing quality assurance processes, to ensure the accuracy and safety of AI-generated outputs. He said a key risk to scaling the programme at pace related to varying levels of digital maturity across partner organisations. He said whilst there was strong appetite to adopt the technology, some services remained reliant on paper-based records, limiting their ability to implement the solution immediately. He mentioned progress in some areas would be dependent on the successful rollout of Electronic Patient Record (EPR) systems and wider digital transformation programmes. He said these dependencies would need to be carefully considered as plans for wider implementation were developed. Sir David thanked the team for the presentation and recognised the programme as a significant service transformation rather than simply a technology implementation. He acknowledged the resource, governance and clinical safety considerations associated with scaling the initiative and emphasised the importance of getting these arrangements right to ensure long-term success. He commended the team's innovation and ambition, expressing its support for the programme and appreciation for their work in driving improvement and change across the system. Resolved: that the Patient Story Ambient Voice Technology (AVT) be received for information and assurance.
193/26	Minutes of the Previous RWT/WHT Group Trust Board Meeting held in Public on 19 May 2026
	Sir David approved the minutes of the Group Trust Board Meeting held on 19 May 2026 as an accurate record. Resolved: that the minutes of the previous meeting held on 19 May 2026 be received and APPROVED.
194/26	Group Board Action Log and Matters Arising
	Sir David received the Group Board Action Log and updates were received as below Action 3707: A separate Corporate Trustee meeting be arranged to consider the governance, strategy and future development of the Charities in more depth. A meeting has been arranged to take place in September 2026. Action to be closed. Action 3706: Dr Din to provide an update and trajectory of work being undertaken in relation to Mental Health. This action was listed as an item on the agenda 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
195/26	Chair's Report – Verbal
	Sir David presented the Chair's Report and reflected on the recent appointment of a new Prime Minister and Secretary of State, noting, the core priorities for the NHS remained largely unchanged. He said these included reducing waiting lists, improving emergency care performance, shifting services from hospital settings into community-based care, and accelerating digital transformation. Sir David noted that there was likely to be an increased focus on place-based working and the role of anchor institutions, topics which would be discussed later in the meeting. He also highlighted the Government's renewed focus on homelessness and rough sleeping, noting that this was an area where further progress and partnership working may be required. He said that despite changes in Government, significant additional funding for the NHS was not anticipated beyond previously announced allocations and as a result, maintaining strong financial discipline would remain essential. He noted that the new Secretary of State brought considerable experience across government, particularly in relation to social care, welfare and employment, which would support future developments in integrated

	health and care services and whilst the overall strategic direction remained consistent, there was likely to be an increased expectation regarding the pace of delivery and implementation. Sir David reported on the recent 10th anniversary celebrations of the Walsall Well Wishers Charity. He described the event as a significant success, bringing together supporters, local businesses, community representatives and beneficiaries to celebrate the achievements and impact of the charity over the past decade. He advised that a video had been filmed, showcasing the work of the charity and the difference it had made to patients, staff and services and reflected on the strong community spirit demonstrated throughout the event. He thanked all those involved in its organisation and delivery and noted the importance of continuing to strengthen charitable fundraising and engagement activities across the Group. Resolved: that the Chair's update be received for information
196/26	Group Chief Executive's Update Ms Chadwick- Bell advised that further to the changes within Government, a significant volume of national policy, guidance and best practice documentation was now being released following a period of delay. She assured the Board that emerging requirements would continue to be reviewed and reported through the appropriate governance processes. Ms Chadwick-Bell advised on the continued importance of preventing unlawful access to patient records. She said staff were reminded that inappropriate access to confidential patient information was unacceptable and could result in disciplinary action. She advised that staff had received clear communications and mandatory training on information governance responsibilities and that further national communications were anticipated. Ms Chadwick-Bell noted the ongoing focus on productivity, financial sustainability and organisational transformation and recognised that there was a need to increase the pace of improvement activity whilst maintaining a strategic focus on long-term service development. She highlighted the impact of recent periods of hot weather on both patients and staff and said concerns had been raised regarding temperature management across a number of sites, particularly within older estate areas where cooling systems were limited. She advised that the implications of rising temperatures would need to be considered as part of future capital investment and estate development plans. She thanked staff for their continued dedication whilst working in challenging conditions. Ms Chadwick-Bell advised that industrial action by resident doctors had concluded following national agreement. She noted efforts of all those involved nationally and the importance of local implementation through workforce and recovery plans. She also reflected on the recent Long Service Awards, recognising the dedication and commitment of staff who had devoted 20, 30, 40 and, in some cases, 50 years of service to the NHS. Ms Chadwick-Bell provided an update on maternity and neonatal services. She noted that responsibility for oversight of maternity services now sat jointly with the Chief Nursing Officers and the Group Chief Medical Officer, reflecting the importance of both clinical and professional leadership in this area. She referred to the findings of the Ockenden reports, and noted that, whilst clinical outcomes remained critically important, the reports had also highlighted the significance of patient and family experience throughout the care journey, including experiences following adverse outcomes. She said these findings reinforced the need to ensure that patient experience was given equal consideration alongside clinical quality and safety measures. She also mentioned importance of organisational culture, patient voice and staff voice, recognising that assurance could not rely solely on performance data and metrics. She emphasised the need for continued curiosity when reviewing information and understanding services, to ensure that the voices and experiences of patients, families and staff were actively sought and acted upon. She said that whilst mechanisms such as the Friends and Family Test, complaints processes and patient feedback systems remained valuable sources of information, there was a need to consider whether these approaches were sufficient to fully understand the experiences of patients and local communities. Ms Chadwick-Bell reflected on the role of community engagement and participation groups, including Maternity Voices Partnerships, and discussed the importance of ensuring that these arrangements effectively captured and represented the views and experiences of the diverse populations served by the Group. She discussed the importance of strengthening the use of patient and community feedback to gain a more complete understanding of service quality and patient experience. She felt valuable insights could be obtained through engagement with community groups and informal community leaders, as well as through wider sources of feedback which may not be captured through formal complaints processes. She said it was recognised that complaints data alone may not fully reflect the experiences of all patients and highlighted the need to ensure that the voices of those who do not formally raise concerns are also heard, and that particular emphasis was placed on the importance of understanding the experiences of women and families using maternity services. Ms Chadwick-Bell said it was important to consider how patient feedback, staff voice and other sources of intelligence could be better triangulated to provide a fuller picture of service performance and areas for improvement. She advised a further report would be presented in September 2026 -to provide assurance on the safety and quality of maternity services, informed by a broader range of evidence and learning from recent reviews undertaken elsewhere in the NHS. Action: Prof Hickman and Ms Carroll to provide a further report be presented in September to provide assurance on the safety and quality of maternity services, informed by a broader range of evidence and learning from recent reviews undertaken elsewhere in the NHS.

Prof Hickman said from reflections arising from recent maternity safety discussions, including learning from national reviews and local engagement activity, it had been recognised that there was value in considering whether existing assurance arrangements provided the appropriate balance between internal and external scrutiny and whether current approaches sufficiently captured changes in culture, leadership and team dynamics. She said that there was a need to strengthen the triangulation of quantitative data with softer intelligence, including patient, family, staff and student feedback and noted the importance of ensuring that feedback mechanisms, including the Maternity and Neonatal Voices Partnership (MNVP), were representative of the diverse communities served and provided timely, meaningful insight into patient experience.

Prof Hickman reported that work was underway to make greater use of real-time feedback and thematic learning to identify wider trends and opportunities for improvement. She noted the importance of adopting a more proactive and targeted approach, particularly in addressing health inequalities and advised that further work was being undertaken to triangulate available information and intelligence to provide a more comprehensive assessment of maternity services.

Dr McKaig reflected on the significant learning arising from recent national discussions and experiences shared by organisations affected by maternity service failures. He said it was noted that, in some cases, organisational data had not identified services as outliers or highlighted concerns about safety, reinforcing the importance of looking beyond quantitative measures alone. He discussed the value of the patient voice as a powerful source of insight and challenge and said it was recognised that feedback received directly from patients and families often had a greater impact on clinicians and service improvement than performance data or management direction alone. He said it was also acknowledged that opportunities existed to strengthen how patient feedback was captured, analysed and used to inform service delivery.

Dr McKaig said the potential of digital solutions and emerging technologies to support the real-time collection of patient feedback and experience data had also been considered with agreement that the principles discussed should not be limited to maternity services and should be applied consistently across all services within the Group.

Ms Carroll said opportunities to engage more effectively with communities, community leaders and partner organisations were highlighted as an important part of this approach. She emphasised the importance of creating a culture in which patients feel safe and confident to speak up, without fear of adverse consequences or detriment. She noted that the effectiveness of any feedback system depended not only on the ability to collect and analyse information, but also on ensuring that individuals felt able and willing to share their experiences.

Ms Barber said as with colleagues raising concerns, patients must also be assured that providing feedback or speaking up would not result in any adverse consequences or detriment. She said before seeking to collect more feedback, it was important to consider whether patients currently felt able to raise concerns when needed. She said triangulating patient experience data with other sources of information was valuable and could provide important insights into service quality and patient outcomes. She said the priority should remain about ensuring that patients were encouraged and supported to share their experiences and that the organisations listens and responds effectively.

Prof Toner reflected on her role within Maternity and Neonatal Voices Partnership (MNVP) meetings, noting that attendance by women and families was often limited. She said it was observed that many women who had positive experiences move on with family life following their maternity journey, making it challenging to capture feedback after discharge. She reported that a recent patient story shared at an MNVP meeting demonstrated the significant value of patient insight, providing learning opportunities from both community and hospital perspectives.

Prof Toner noted that the challenges associated with engaging women and families, that whilst technology presented opportunities to gather real-time feedback, it was recognised that a range of engagement methods would be required to ensure all communities across Walsall and Wolverhampton could participate and have their voices heard. She shared reflections from a recent discussion with a governance midwife at RWT, highlighting the strength of the Trust's governance processes, escalation mechanisms and executive oversight arrangements. She said it was noted that lessons from national reviews, including Ockenden, had emphasised the importance of organisations listening to concerns and ensuring that issues were appropriately escalated and acted upon. She welcomed the assurance provided regarding current governance arrangements while recognising that continued improvement was required to strengthen both patient and staff engagement.

Sir David said it important to maintain curiosity within the organisation and said that a lack of challenge and acceptance of initial explanations were common themes in organisations that had experienced significant service failures. He agreed that improvement depended not only on knowing what actions to take, but on how they were embedded in practice and culture. He supported aligning this work with the Group's wider cultural and improvement programmes, ensuring staff were empowered to take ownership of change. He also endorsed the principle of placing patient voice at the heart of service improvement and looked forward to further proposals from the team.

Resolved: that the Group Chief Executive's Report be received for information and assurance

197/26 Assurance on maternity services (Ockenden, Amos and Human Tissue Authority recommendations – Fuller Inquiry & Board Assurance Statement (BAS))

Ms Carroll reported that based on the national review findings relating to post-death care one requirement from NHS

	England had been for all relevant trusts to complete and submit a Board Assurance Statement by 31 July 2026. She said the assurance statement had been completed and been submitted to the Executive Team by the designated individual and drew on evidence from the Human Tissue Authority (HTA) inspection undertaken in October 2025, which provided external assurance regarding compliance with relevant standards and regulations. She said no significant concerns were identified through the inspection, and actions arising had been incorporated into the submission. Ms Carroll advised that the assurance statement had been reviewed by the Group Medical Committee and would be presented to the Group Quality Committee (GQC) following Board consideration. She requested approval be granted for submission of the Board Assurance Statement to NHS England by the required deadline. Ms Carroll noted the requirement to submit a Premises Assurance Model Statement by 8 September 2026, which was being progressed by the Estates Team. She said given the submission timescale, the Board was asked to authorise the Chief Executive to approve the final submission, following review through the appropriate committee process. Sir David acknowledged the significant amount of work being undertaken in relation to these matters and emphasised that this should not be regarded as the final consideration of the issues. He noted the importance of maintaining ongoing oversight and continuing to monitor progress and improvement. The Board confirmed its support for the submission of the Board Assurance Statement to NHS England by 31st July 2026 and the submission of the Premises Assurance Model Statement by the 8th September Resolved: that the Board support submission of the Board Assurance Statement to NHS England and Assurance on maternity services (Ockenden, Amos and Human Tissue Authority recommendations – Fuller Inquiry & Board Assurance Statement (BAS) be received for information and assurance.
198/26	Freedom to Speak Up Report
	Ms Radley noted that the Freedom to Speak Up report provided a logical continuation of the earlier discussion regarding patient experience and patient voice. She advised that, whilst not detailed within the report, a review of maternity-related complaints and concerns had been undertaken by the Freedom to Speak Up Guardians. She said the review had identified opportunities for further learning and improvement and reinforced the importance of maintaining organisational curiosity by exploring issues in greater depth rather than focusing solely on explanations. She explained that the report had been intentionally redesigned as a concise Group report, moving away from separate Walsall and Wolverhampton sections to focus on shared themes, learning and opportunities across both organisations. Ms Raza advised that the Freedom to Speak Up service remained visible, trusted and well utilised across both Trusts, with over 600 concerns raised during the reporting period. She said was noted that a minor typographical error had been identified within the Walsall data, with the total number of concerns amended from 359 to 362; however, this did not alter the overall analysis or conclusions presented. Ms Raza noted that concerns had been raised by staff from a broad range of both clinical and non-clinical roles, which demonstrated accessibility of the service and confidence in the reporting mechanisms available. She said staff behaviours and attitudes continued to represent a significant theme across both organisations and reflected a trend seen nationally. She said the importance of compassionate leadership and management responses was emphasised, particularly in ensuring concerns were addressed consistently, appropriately and in a timely manner. She advised information received through Freedom to Speak Up provided valuable patient safety intelligence and was routinely triangulated with intelligence from governance, quality and divisional teams. She noted that spikes in quality and safety concerns had been identified in some areas during periods of heightened operational pressure and acuity and said the triangulation of data enabled concerns to be identified promptly and appropriate action taken to safeguard patient safety. Ms Raza reported on the importance of organisational responses following concerns being raised. She said whilst the Freedom to Speak Up service played an important role in receiving concerns and signposting issues, it was acknowledged that responsibility for investigating concerns, implementing actions and providing feedback rests with managers and operational teams. She said it was recognised that further work was required to ensure concerns lead to meaningful action and that staff were able to see the outcomes and improvements resulting from issues they had raised. Ms Raza explained that a significant proportion of concerns continued to be raised anonymously across both Trusts and it was considered whether this indicated concerns regarding detriment or potential repercussions associated with speaking up. She said whilst only a small number of formal detriment cases had been reported, it was acknowledged that detriment may occur many months or years after a concern had been raised and may therefore be difficult to identify. She said focussed discussions had taken place on the need for a more systematic approach to measuring and understanding detriment across the Group, which could include greater analysis of workforce information, trends within speaking up data and learning from staff exit interviews. Ms Raza said that both organisations were working collaboratively to review and update the Freedom to Speak Up Policy and a revised policy would establish clearer reporting pathways, response timescales and expectations for managers, supported by flowcharts and alignment to national guidance. She mentioned ongoing national developments, including the transition of the National Guardian's Office into NHS England were also noted, and

	acknowledged that further changes to the Freedom to Speak Up framework may emerge nationally. Ms Raza highlighted the importance of embedding speaking up as part of normal organisational practice, rather than viewing it solely as the responsibility of a dedicated team. She said that recent national reports had reinforced the need to ensure concerns were not only heard but acted upon and that in response, the service had continued to strengthen its approach through staff feedback surveys, newsletters and engagement activities, alongside ongoing monitoring and triangulation of concerns raised by both staff and patients through established patient safety and governance processes. She mentioned that progress was being made to strengthen speaking up arrangements, organisational learning and the visibility of actions arising from concerns raised across both Trusts. Mr Levermore questioned whether the organisation fully understood what it meant to be "in the moment of power" and how this influenced the development of organisational culture. Ms Radley acknowledged that this remained a significant area for ongoing development. She said when concerns were raised, the quality of the initial response was critical. She noted that staff should be thanked for speaking up and that conversations should be approached with curiosity and a willingness to understand concerns, rather than through justification or explanation. She said it was recognised that this required a culture that actively welcomed challenge, feedback and differing perspectives. She said Freedom to Speak Up remained one of the strongest indicators of organisational culture and provided valuable insight into how individuals experience the organisation. She said whilst progress had been made, it was acknowledged that further work was required to embed these behaviours consistently across the Group. Ms Raza emphasised the importance of identifying and responding to early warning signs, noting that organisations should "listen to the whispers before they become screams". She said intelligence gathered through Freedom to Speak Up processes, staff networks and other feedback mechanisms should be acted upon proactively, rather than waiting for concerns to escalate or for national reviews to highlight issues. Sir David thanked Ms Raza for her report and for attending the Board. Resolved: that the Freedom to Speak Up report be received for information and assurance
199/26	Recommendations following Lord Mann's Review into Tackling Racism and Antisemitism, including the Adoption of the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility
	Ms Radley advised on the findings of the Lord Mann's Review into Antisemitism and Racism, which was published in June 2026 and included 36 recommendations for NHS organisations. She said the review identified antisemitism and wider racism as significant issues within the NHS, with particular emphasis placed on the experiences of both staff and patients. She said local workforce data was reviewed and, whilst the Group had a relatively small number of colleagues who identified as Jewish, it was noted that a significant proportion of the workforce identified as Muslim. She said survey data highlighted that approximately 16% of Muslim staff and up to one-third of Black and Minority Ethnic staff reported experiencing discrimination from patients or members of the public. Ms Radley said the review concluded that reporting systems were not consistently effective, accountability arrangements were variable, and many staff did not feel sufficiently confident in raising concerns. She noted that these reflected themes discussed earlier in the meeting regarding organisational culture, speaking up and the importance of responsive leadership. She said it was further noted that 61 racism-related concerns had been raised through Freedom to Speak Up processes during the previous year, providing a valuable source of intelligence and learning for the organisation. She advised Lord Mann's report recommended three immediate actions for the Group, firstly, adoption of the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism, in line with advice from NHS England. She said whilst acknowledging that there was ongoing national debate regarding interpretation of the definition and concerns raised by some groups regarding freedom of expression, she assured the Board that clear supporting guidance would be developed to ensure appropriate and proportionate application. Ms Radley advised that the second recommendation was for to note the importance of ongoing Board development in relation to equality, diversity and inclusion, including ensuring Board members understood the implications of the antisemitism definition and were equipped to address racism and discrimination effectively. She said thirdly, the report recommended that the Group undertook a comprehensive assessment of its ability to respond to the 36 recommendations contained within the review, working in partnership with staff and patients to inform this work. She advised a detailed action plan and assessment of compliance against the recommendations would be developed through the Equality, Diversity and Inclusion Steering Group and presented initially to the Group People Committee. She said a further report outlining proposed actions and progress against the recommendations would be brought back to the Board in the autumn. Ms Chadwick-Bell reflected on the number of national reviews and recommendations that organisations were required to respond to, including Ockenden, and questioned how the organisation could move beyond action plans and compliance exercises to ensure that learning became embedded within the organisational culture. She noted that whilst recommendations and actions were necessary, the greater challenge was translating them into meaningful behavioural and cultural change. She discussed the importance of ensuring that equality, diversity and inclusion were not viewed solely as the responsibility of specific committees or staff networks, but as a core part of how the organisation operated.

	Ms Chadwick-Bell referenced the earlier discussion regarding patient voice, suggesting that the experiences and perspectives of patients may be a powerful catalyst for cultural change. She encouraged consideration of how patient feedback and lived experience could be used more effectively to help shape organisational behaviours and culture, rather than focusing solely on delivery against action plans. Sir David agreed noting that performance indicators and workforce metrics could sometimes present a more positive picture than that described through the lived experiences of staff. He emphasised the importance of considering qualitative information alongside quantitative data to gain a more complete understanding of organisational culture. Sir David noted that a common theme emerging from both the Ockenden Review and reviews relating to racism and discrimination were not simply that concerns existed, but how organisations responded when concerns were raised. He observed that the most significant indicator of organisational culture was whether concerns were listened to, acted upon and followed through. He said a failure to respond appropriately could be more indicative of cultural problems than the issues themselves. The Board agreed that the proposed approach was appropriate and supported adopting the three recommendations set out in the report. The Board approved the recommendations and noted the intention to develop a more comprehensive response to the review's findings through the appropriate committee structure before returning to the Board for further consideration. Resolved: that the Recommendations following Lord Mann's Review into Tackling Racism and Antisemitism, including the Adoption of the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility be approved.
200/26	Integrated Committee Chairs Report - Finance & Productivity Committee, Quality Committee, People Committee and Partnerships and Transformation Committee and Digital and Estates Strategy Committee
	Mr Assinder presented the Committee Chairs' Assurance Report and advised that, since the previous Board meeting on 19 May 2026, each of the Group's sub-committees had convened at least once. He advised that, whilst the report contained a comprehensive range of issues, further work would be undertaken over the coming months to synthesise committee reporting and ensure that the most significant risks, themes and matters requiring Board escalation were highlighted more clearly. Mr Assinder reported by exception and advised that there continued to be concerns regarding community waiting times within Walsall services. He said waiting lists had risen to approximately 9,500 patients at the end of May, with more than one-third of patients waiting longer than 18 weeks. He said community paediatrics remained the area of greatest concern and continued to be monitored. He also reported the ongoing pressures within ophthalmology services at RWT, where demand continued to exceed capacity. He said the waiting list had exceeded 10,000 patients, with around half of those patients experiencing extended waits for treatment. He said particular concern was expressed regarding patients awaiting glaucoma services, given the potential clinical implications associated with delayed care. Mr Assinder advised that three Never Events had occurred at RWT during May and June 2026, two of which related to wrong-site surgery within ophthalmology services, and one involved the administration of medication by the incorrect route within gastroenterology services. He advised that the Group Quality Committee (GQC) had reviewed each incident in detail, including the findings of root cause analyses and the actions implemented to prevent recurrence. He said appropriate mitigations and improvement actions were being monitored through the established governance framework. Mr Assinder advised that after the first two months of the financial year, the Group was reporting a deficit position of approximately £1 million adverse to plan. He reported the variance was largely attributable to the unfunded costs associated with industrial action during the reporting period. He said assurance had been received that each matter would continue to be monitored through the relevant committee structures and reported through subsequent executive reports. Prof Toner provided feedback on a recent presentation to GQC and a subsequent visit to Ophthalmology services undertaken by Non-Executive Directors and the Chief Nursing Officer. She said the visit had provided valuable insight into the challenges facing the service and the actions required to address them, and that staff had articulated the key issues clearly and demonstrated a strong understanding of the improvements needed. She said opportunities had been identified to improve productivity through greater use of technology, including electronic patient records and digital solutions, alongside changes to workforce deployment and service delivery models. She said it was noted that investment in additional equipment could significantly improve capacity, in particular, the purchase of advanced laser equipment which would enable appropriately trained non-medical staff to undertake procedures currently requiring medical staff, thereby increasing productivity and improving patient flow. She advised that funding opportunities had been identified, including existing ophthalmology funds and potential charitable support, and that business cases were being developed to support the proposed investments. Prof Toner said significant risks remained within the service due to ongoing capacity and demand pressures, particularly in relation to the glaucoma services. She expressed concern regarding the potential for patient harm arising from delays in treatment if sustainable solutions were not implemented. She said it had been noted that staff across the service remained highly engaged, committed and focused on improving patient care despite the operational

challenges being experienced. She said discussions had highlighted that ophthalmology had been identified as a longstanding risk area, having been included on the Trust's risk register since 2018. Sir David asked whether this issue had been raised for the second time. Prof Toner confirmed it had been raised previously and acknowledged that actions had been taken in response to concerns raised previously; however, the underlying challenges related to capacity, demand and service configuration remained.

Prof Toner said ongoing discussions were taking place with the Integrated Care Board regarding commissioning arrangements and the development of community-based pathways to ensure that specialist hospital capacity was focused on patients requiring consultant expertise, particularly those with glaucoma who were at risk of sight loss. She said proposals were still being developed and had not yet been fully evaluated through the governance process and it was agreed that further consideration would be given through GQC, with detailed plans and progress updates to be brought back for further scrutiny before assurance could be provided regarding the anticipated outcomes.

Dr McKaig advised that the fundamental challenge facing ophthalmology services, particularly glaucoma care, was that demand continued to increase as the population aged and glaucoma required ongoing monitoring and management, resulting in a continuously growing patient cohort. He said that service capacity had not increased at a rate sufficient to meet this growth in demand. He advised that a range of alternative service models were being explored, many of which relied on greater involvement of community optometrists. He said discussions were underway with the Integrated Care Board regarding commissioning arrangements and the development of community-based pathways to help manage demand more effectively and noted that current financial arrangements did not always provide an attractive model for independent community providers, creating additional challenges in implementing sustainable solutions.

Dr McKaig advised that, whilst initiatives were being progressed, it was not yet possible to provide assurance that a comprehensive long-term solution was in place. He said delivering a sustainable model would require contributions from several partners, including the ICB, community optometrists, workforce planners and training providers. He advised in the interim, the service had been maximising existing resources and utilising insourcing arrangements to mitigate immediate risks, although this was not considered a sustainable long-term approach.

Ms Sadler-Todd provided broader assurance regarding the work being undertaken to address ophthalmology capacity and demand challenges. She advised that ongoing discussions had taken place with executive colleagues regarding alternative service models and opportunities to learn from good practice beyond the Black Country. She noted that the Integrated Care Board (ICB) had been actively engaged in considering potential solutions and was exploring these in the context of patient experience and patient preferences. She said it had been reported that this work had previously been considered through the Black Country Provider Collaborative, where there had been some reluctance from clinicians regarding the transfer of services into community settings, partly due to assumptions that patients would prefer hospital-based care.

Ms Sadler-Todd advised that feedback from patients had generally indicated strong support for receiving care closer to home. She said positive feedback had consistently been received regarding ophthalmology services delivered within community settings, including services provided at Ashmore Park and that patients appreciated the accessibility and convenience of community-based services. She said a number of established community pathways already existed, including post-cataract monitoring, minor eye condition services and optometry-led care. She said these services were regarded positively by patients and had demonstrated the ability to manage care effectively outside the acute hospital setting.

Ms Sadler-Todd advised that community glaucoma monitoring schemes had achieved encouraging outcomes, with only a small proportion of patients subsequently requiring referral back into hospital services and that these models offered potential opportunities to reduce pressure on hospital services. Prof Toner noted feedback from the recent ophthalmology visit, during which staff advised that the service received very few formal patient complaints which could be seen as a positive indicator of patient experience within the service.

Dr McKaig advised that discussions with the ICB regarding ophthalmology commissioning arrangements had been positive and were progressing well and aligned with wider discussions regarding service commissioning and the opportunity to develop different models of care. He said the ICB had responded positively to concerns raised, particularly in relation to the glaucoma pathway and urgent ophthalmology access. He said it was noted that approximately 40% of attendances at the emergency ophthalmology service originated from outside the local catchment population, placing additional demand on services for which the Trust was not currently commissioned.

Ms Chadwick-Bell welcomed the positive engagement that had taken place with the Integrated Care Board (ICB) and noted that discussions with system partners were progressing well and that concerns had been appropriately escalated and that the ICB had responded quickly and constructively to the issues raised. She emphasised that the next step was to establish a clear timeline and agreed action plan to ensure progress could be monitored and delivered. She noted that discussions with colleagues had highlighted a range of potential solutions and opportunities, and that these now needed to be consolidated into a coherent programme of work.

	Ms Chadwick-Bell advised that the emerging proposals would be reviewed through the Executive Committee and that the Trust's charity would also explore how it might support elements of the proposed improvements. She proposed that all relevant workstreams, actions and system discussions should be triangulated into a single plan which could then be presented to the Board for oversight and assurance. The Board agreed that a further update, including a comprehensive action plan and clear timescales for delivery, should be brought to the September Board meeting. Action: Dr McKaig & Ms Nuttall to provide a further update, including a comprehensive action plan and clear timescales for delivery of ophthalmology services, to be brought to the September Board meeting. Resolved: that the Integrated Committee Chairs Report - Finance & Productivity Committee, Quality Committee, People Committee and Partnerships and Transformation Committee and Digital and Estates Strategy Committee be received for information and assurance
201/26	Group Board Assurance Framework (GBAF)
	Mr Bostock reported, following approval of the Group's revised strategic objectives at the Board meeting on 19 May 2026, the previous strategic objectives had been retired. He advised that the report presented the first iteration of the Board Assurance Framework (BAF) aligned to the new strategic objectives, with further objectives from the <i>Transforming Care Together</i> framework to be incorporated as they are developed. Mr Bostock explained that the three strategic risks had been reviewed in detail by the relevant Executive Directors and would be considered through the appropriate Board Committee structure following Board approval. The Board considered the following strategic risks: • Colleague Experience and Engagement under the objective "<i>We want our colleagues to feel cared about</i>", with a current risk score of 12 and a target risk score of 8. • Timely and Safe Access to Care under the objective "<i>We want to improve safety by reducing the time patients wait</i>", with a current risk score of 16 and a target risk score of 12. • Financial Sustainability and Efficient Use of Resources under the objective "<i>We want to deliver our services efficiently</i>", with a current risk score of 15 and a target risk score of 10. He noted that the report also included the detailed site-level BAF risks and the current risk watchlist, which would continue to be reviewed through the Risk Management Executive Group and Executive Team. He advised that the purpose of the report was to seek approval for the three strategic objectives and associated BAF risks to proceed through the Committee structure for ongoing scrutiny and assurance. He also noted that the risks reflected the three organisational priorities previously agreed by the Board. Resolved: The Board approved the three strategic objectives and associated Board Assurance Framework risks and agreed that they should be taken forward through the relevant Board Committees for detailed review and oversight.
202/26	Strategy (Section Heading)
203/26	Transforming Care Together (TCT) – Progress Report
	Mr Evans presented the first progress update report following the launch of <i>Transforming Care Together</i>, the Group's five-year strategy. He advised that the report provided an overview of progress made to date, highlighted key achievements, and identified areas requiring further development and Board attention. He reported that significant progress had been made in relation to the implementation of the Group's digital programme, including the development of the AVT programme, which represented one of the most significant transformation initiatives currently underway and was expected to deliver substantial benefits for both patients and staff. He noted the strong organisational commitment to the programme and the ambition to maintain momentum in delivery. Mr Evans noted positive progress against the Clinical Services Roadmap and advised that following previous presentations to the Board, a series of detailed discussions had taken place to develop the individual workstreams required to deliver the roadmap, with further engagement and development planned during the coming months. He reported progress had also been made in establishing the Transformation Delivery Unit. He said additional resources were being recruited to support the delivery of priority workstreams, with some appointments already made and others currently being recruited. Mr Evans advised that all transformation workstreams had now been established and that updates on each were included within the report. Senior Responsible Owners (SROs) had been identified for each workstream and were accountable for overseeing delivery and reporting progress. He said looking ahead, work was underway to develop a performance dashboard incorporating key performance indicators, benefits realisation measures and RAG ratings. He said this would provide enhanced oversight and assurance regarding delivery of the programme and would be presented as part of future progress reports. He also noted the close alignment between the <i>Transforming Care Together</i> programme and the Group's Medium Term Financial Plan. He explained that each workstream had been assessed to determine its contribution to future financial sustainability, with work underway to validate the anticipated financial benefits over the next three years. He said this would support the organisation's ambition to move from a largely transactional approach to one focused on long-term transformational change. Mr Laverty welcomed the report and the ambition of the <i>Transforming Care Together</i> programme. He emphasised the

	importance of clearly defining and tracking benefits from the outset, noting that robust benefits realisation would help maintain focus on intended outcomes and support decisions regarding prioritisation, sequencing and investment. Mr Evans provided assurance that each workstream had detailed project documentation in place, including benefits, milestones and KPIs. He advised that this information would be aggregated into a programme-level dashboard to provide clearer Board oversight. Ms Chadwick-Bell welcomed the progress made in developing the <i>Transforming Care Together</i> programme and noted that this was the first time the Board had seen all the workstreams brought together within a single overarching plan and acknowledged the complexity of bringing the various programmes together. She said that, whilst the programme represented a positive start, there was a need to maintain ambition, particularly in relation to delivery over Years 2 and 3. She noted that the programme should continue to evolve and be refreshed as learning emerged and opportunities developed. She agreed that transformation priorities, particularly digital initiatives, should be reviewed regularly to ensure that they remained appropriately ambitious and transformational rather than becoming routine business-as-usual activity. Ms Chadwick-Bell advised that there should be a focus on the importance of managing organisational expectations. She said it was recognised that staff would want to understand what changes were planned and when they could expect to see benefits delivered and suggested that greater emphasis should be placed on communicating the longer-term roadmap in a simple and accessible format that clearly demonstrated the sequencing and timing of planned improvements. Sir David sought assurance that clear benefits had been identified for each of the workstreams and for the programme. Mr Evans confirmed that benefits realisation plans and supporting documentation had been developed for each workstream and had previously been considered through Board development sessions. He advised that future reports would present this information in a more aggregated format to provide clearer Board oversight. Ms Sadler-Todd highlighted that a recurring theme within discussions at the Transformation Committee had been the importance of public and patient engagement. She noted that, whilst communications and engagement plans had been discussed, there was a need to ensure that transformation activities were focused on addressing the issues that matter most to patients and communities, rather than solely those identified by the organisation. She said drawing on experience from elsewhere in the Black Country, she had observed that alternative approaches to community engagement had been adopted successfully and suggested there was an opportunity for the Group to further strengthen its approach. She expressed concern that there was a risk of consulting on plans that had already been developed, rather than involving patients and communities earlier in the process to help shape priorities and solutions. She noted that this was not due to a lack of commitment, however may reflect limitations in current capacity and capability. Ms Chadwick-Bell acknowledged that the discussion aligned closely with the earlier debate regarding patient voice. She agreed that the organisation would need to review how patient engagement was organised and delivered to ensure that patient and community perspectives were routinely incorporated into transformation planning and decision-making. She said it was recognised that communication alone would not be sufficient, and that greater emphasis should be placed on listening, engagement and co-production. She advised that a dedicated <i>Transforming Care Together</i> communications and engagement workstream had been established, bringing together communications and patient voice colleagues to strengthen this approach. The Board agreed that further work was required to ensure that patient and community voices were consistently reflected in transformation activity and noted the commitment to develop a more effective engagement model as the programme progresses. Resolved: that the Transforming Care Together (TCT) – Progress Report be received for information and assurance
204/26	Anchor Development Ms Chadwick-Bell provided an update on the development of the Group's role as an anchor organisation and convener of local place-based arrangements. She explained that the ambition was for the Group to hold a prime contract and delegated budget, enabling it to commission services across care pathways and subcontract delivery where appropriate. She said this would provide greater local influence over the design and delivery of end-to-end patient pathways. Ms Chadwick-Bell noted, by way of example, that in the future, a single budget for ophthalmology services could enable the Group and its clinical teams to commission services across the pathway in a more integrated way, rather than relying on multiple organisations and commissioning arrangements. She noted that support was being provided by colleagues from the ICB to help develop the model, including consideration of governance arrangements and learning from other systems. She said a Board working group, including Non-Executive Director representation, had been established to oversee the development of the proposals. She advised that engagement with primary care was a key component of the work and that discussions were ongoing to ensure appropriate primary care involvement in future decision-making arrangements whilst avoiding duplication with existing place-based and Black Country collaborative structures. She said whilst discussions with the ICB regarding delegated responsibilities and

	commissioning arrangements were still progressing, it was anticipated that the Group could begin operating under the new contractual arrangements from the start of the next financial year. Ms Cartwright advised that work was being developed in close collaboration with system partners across the wider cluster, with a similar report due to be considered by partner Boards. She explained that development of the model differed in some areas from arrangements being considered elsewhere, including Birmingham and Solihull, where alternative provider models and partnership arrangements were in place. However, regular engagement was taking place to share learning and support the development of the emerging model. Ms Cartwright reported that the proposals supported implementation of the NHS 10-Year Plan and represented an important step towards more integrated models of care. She said the proposed arrangements would support greater local responsibility for population health management and enable partners to work collectively across care pathways to improve outcomes for patients and communities. She highlighted the draft governance arrangements outlined within the paper, including the potential establishment of a Board Committee to oversee future commissioning responsibilities. She said consideration would be given to appropriate representation within these arrangements, including partner organisations and primary care colleagues, to support effective decision-making. Ms Cartwright advised regular discussions were continuing with primary care representatives and the ICB, supported by a dedicated fortnightly steering group to oversee development of the model and associated governance arrangements. She reported that the proposed anchor organisation arrangements should be viewed as an important step towards future integrated health organisation models, rather than an end state in themselves. Mr Green said that one of the key factors that would contribute to success would be stronger clinical involvement from across acute, primary care and community services. He noted that previous approaches had often been driven primarily through commissioning structures, whereas greater clinical leadership and engagement could support more effective service redesign and implementation. He observed that delegated commissioning arrangements could create opportunities to further develop the Community First approach and support the shift of care from hospital into community settings. He noted that, under existing tariff-based arrangements, there could be challenges in balancing increasing demand for acute services while simultaneously investing in community alternatives. Mr Green suggested that a delegated budget model could provide greater flexibility to invest resources across pathways and support care in the most appropriate setting. He acknowledged that such arrangements would also introduce financial risks and noted that a more locally led model, involving primary care, acute clinicians, community services, mental health and social care partners, would have a greater likelihood of delivering integrated care and improved population health outcomes. Ms Radley said that she did not wish the original concept of an anchor institution to be lost as the proposals developed. She said that the traditional definition extended beyond commissioning responsibilities and included the organisation's role as a major local employer, contributing to widening participation, skills development, recruitment pathways and wider improvements in population health. She said that these principles should continue to be reflected within the Group's People Strategy and workforce plans, even if they were not a central feature of the current proposals and stressed the importance of maintaining focus on the organisation's broader social and economic contribution to local communities. Sir David said it was acknowledged that the term "anchor organisation" was being used in a different context within the current proposals, which could sometimes create confusion. He agreed that both aspects of the anchor role should be recognised and taken forward. He noted that, whilst the proposals could appear technical in terms of commissioning arrangements and resource allocation, their success would ultimately depend on behaviours, relationships and a willingness to facilitate change. He recognised that the proposed model could provide greater opportunities to influence service redesign and support transformational change, although this would require effective leadership and a willingness to utilise the levers available to the organisation. Ms Martin welcomed the opportunity presented by the proposed model but highlighted the need to develop appropriate systems, infrastructure and workforce capacity to support its delivery. She said it was important to maintain simple and effective arrangements to enable genuine partnership working and transparent use of data. Ms Cartwright agreed that the proposed model represented a significant opportunity but noted that it would also require a substantial cultural shift in the way the organisations operated. She acknowledged the potential for the model to significantly transform how services are planned and delivered and noted the opportunities it presented for improving outcomes for the local population. Resolved: that the Anchor Development report be received for information and assurance
205/26	Comfort Break- 10 mins
206/26	Integrated Quality and Performance Reports (Section Heading)
207/26	Group Finance Plan and Workforce Report
	Mr Green reported the Group's financial position as at the end of Month 2 as a Group deficit of £9.7 million, compared to a planned deficit of £8.7 million, resulting in an adverse variance of £1.0 million. He reported that this variance was primarily attributable to the costs associated with industrial action during April. He advised the Cost Improvement

	Programme (CIP) had overachieved year-to-date by £0.8 million, predominantly within Wolverhampton and that income remained £0.6 million below plan, whilst the costs of industrial action had exceeded £1.5 million, partially offset by favourable expenditure variances elsewhere within the Group. He reported capital expenditure was slightly behind plan at Month 2; however, a substantial capital programme was underway and it was anticipated that expenditure would accelerate during the year. He reported the Group's cash balance at approximately £100 million at the end of Month 2 and said that despite the current variance, the Group continued to forecast delivery of its planned financial position by year-end. Mr Green reported a positive trend in establishment reductions, with the Wolverhampton workforce decreasing by 83 whole-time equivalents and the Walsall workforce decreasing by 15 whole-time equivalents between Month 12 and Month 2. He also noted that the continued level of bank staffing represented an ongoing challenge and remained an area of focus for management action. Resolved: that the Group Finance Plan and Workforce Report be received for information and assurance
208/26	Integrated Performance Report –Walsall Healthcare NHS Trust Ms Godson presented the Integrated Performance Report and advised that one severe harm incident had been reported during the month and advised that the patient had made a full recovery and had been discharged back to their care home. She reported care hours per patient day remained stable at 8.2, however, the Emergency Department corridor area had been utilised on 13 days during the month, primarily to support ambulance offloading and patient flow. She said there had been a slight improvement in venous thromboembolism (VTE) assessment compliance, although performance remained below the national target and continued to require focused improvement. Ms Godson reported safety indicators remained positive for maternity services, with no new safety investigations identified since March 2026 and positive regional maternity safety performance was also acknowledged. She said operational performance remained strong during the reporting period and urgent and emergency care performance continued to exceed trajectory, with four-hour performance achieving 80%, placing the Trust first in its peer group, twentieth nationally and fifth regionally. She said that although attendances were higher than during the same period in the previous year, ambulance handover performance had continued to improve, with average handover times of 18 minutes and 49 seconds. Ms Godson advised that elective care performance also remained strong, with the Trust ranked first in the Midlands for Referral to Treatment (RTT) performance for the nineteenth consecutive month. She reported that performance was slightly above trajectory, and the patient tracking list continued to reduce following focused improvement work undertaken during the previous quarter. She said improvement continued in cancer performance, with two of the three national cancer standards being achieved. She said the 62-day standard remained challenging, particularly within colorectal and gynaecology pathways, due primarily to imaging and histology delays and work was ongoing to address these pressures and associated backlogs. She reported diagnostic performance had improved and MRI, audiology, non-obstetric ultrasound and neurophysiology continued to present challenges. She noted significant progress in reducing the number of patients waiting over 13 weeks, from 1,093 in May to 578 at the time of reporting. She said this improvement had been supported by the deployment of a mobile MRI scanner and the use of independent sector capacity. Ms Godson advised that the Trust remained in Segment 3 under the NHS Oversight Framework (NOF), with a slight improvement in its overall score. She said key areas of ongoing focus included productivity, outpatient performance, elective care and sickness absence. Mr Assinder queried the ongoing issue relating to community waiting times. Ms Godson reported progress had been made in reducing adult community waiting lists. She advised that seven priority areas had been identified through a task and finish group and that significant improvement had been achieved, with only one specialty now having patients waiting longer than 52 weeks. She said work was continuing with the Integrated Care Board (ICB) to secure funding to support further reduction of the backlog. She acknowledged that progress within community paediatrics had been more limited and there were currently 2,344 patients on the community paediatric waiting list. She said work was underway with colleagues in Wolverhampton to explore opportunities to combine resources and capacity in order to reduce waiting times. Ms Godson advised that plans were being developed across individual specialties, including dietetics, speech and language therapy, and psychology, to address both the existing backlog and future demand and identifying actions needed to deliver a sustainable solution. She said that whilst plans were being developed, achieving a long-term resolution would require additional investment, as some services had been under-resourced for a considerable period. She advised that discussions were therefore continuing with commissioners regarding future funding requirements and service sustainability. Ms Chadwick-Bell noted that significant validation processes were undertaken for acute waiting lists and queried whether similar digital systems and validation approaches were in place for community services to ensure waiting list data accurately reflects the true demand and backlog position. Ms Godson advised that community waiting lists were not currently managed through a fully digital system and therefore required manual validation to provide a more accurate picture of demand and waiting times. She reported that work was underway with digital teams to move

	patient booking and waiting list management onto a digital platform to improve oversight and list management. Ms Nuttall advised that Wolverhampton was experiencing similar challenges. Sir David commended the Trust's performance and recognised the significant effort made by teams in delivering strong performance across urgent and emergency care, elective care and diagnostics. He said that the Board acknowledged the progress achieved but noted that challenges remained, particularly in relation to community waiting times. He said it was recognised that the positive performance reflected the hard work and commitment of staff across the organisation. Sir David emphasised that, whilst attention should continue to be given to areas requiring improvement, it was important that the Board also recognised and celebrated the organisation's achievements and the strong performance being delivered across a number of key areas. Resolved: that the Integrated Performance Report including RWT/WHT Group Report on Community Waits for WHT be received for information and assurance
209/26	Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) Ms Nuttall advised that for community waiting times at RWT, a comprehensive improvement plan remained in place following a detailed report presented to the Board in May 2026. She noted that delivery of the required improvements was likely to take the remainder of the current financial year. She advised remained challenges within community paediatrics and speech and language therapy services and said that validating community waiting lists remained a complex and resource-intensive process, particularly where children and families were involved. Ms Nuttall reported that the Care Quality Commission (CQC) had responded to the Trust's representations regarding the section 29A warning notices issued following the urgent and emergency care inspection. She was pleased to report that the Trust's response had been accepted and that no warning notice remained in place. She said work against the associated action plan continued and was subject to ongoing oversight through the CQC. Ms Nuttall advised on the CQC inspection relating to the Ionising Radiation (Medical Exposure) Regulations which had taken place. She said that whilst a number of questions had been raised during the inspection, including around stroke pathways and the use of artificial intelligence in reporting, the matter had subsequently been formally closed by the CQC. Ms Nuttall noted that ophthalmology performance and glaucoma services had been discussed earlier in the meeting and advised that a clear action plan was being developed. She also highlighted the three Never Events reported during the period, comprising two incidents in ophthalmology and one in gastroenterology, all of which were being managed through the Trust's governance processes. She noted the positive news regarding the Elective Hub, and advised that it had become the first elective hub in the Country to achieve reaccreditation. She said the accreditation panel had been particularly complimentary about the multidisciplinary approach adopted by the team and the contribution of allied health professionals. Ms Nuttall reported significant progress in relation to fire safety. She said the enforcement notice relating to the Nucleus Theatre Block (Block 55) had been formally closed following completion of all required actions and a successful inspection by West Midlands Fire Service. She said constructive discussions also continued with Staffordshire Fire and Rescue Service regarding arrangements at Cannock Chase Hospital, and maternity-related infrastructure issues within Block 32 continued to be monitored and would be subject to a further detailed report. Ms Nuttall advised that referral to treatment performance continued to improve steadily and remained close to trajectory. She said approved outsourcing and waiting-list validation activity were supporting these improvements and diagnostic performance remained strong and continued to rank favourably nationally. She reported Cancer performance as broadly stable, although some risks remained in relation to oncology capacity, which reflected wider challenges across the Black Country. She reported that pressures also remained within renal and gynaecology pathways, and urgent and emergency care remained the area of greatest concern. She said whilst significant improvement work was underway, including changes to same day emergency care and frailty pathways, improvements in waiting times and ambulance handovers had not yet been realised to the extent expected. She noted that these initiatives formed part of the wider Community First programme and remained a key focus for operational teams and system partners. She reported there had been an increase in the number of patients with no criteria to reside, particularly within Wolverhampton, and heard that this was being addressed through ongoing discussions with system partners. Prof Levermore recommended that the organisation should do more to celebrate and promote its achievements. He highlighted the Joint School as an example of outstanding practice, noting the positive engagement from staff and patients and the excellent regulatory outcome achieved. He said that the initiative demonstrated effective multidisciplinary working and deserved greater recognition across the organisation and beyond. Sir David referred to a recent presentation from the Robert Jones and Agnes Hunt Orthopaedic Hospital, where innovative practice had been showcased, and noted the importance of ensuring that the Group received appropriate recognition for its own achievements.

	Sir David referenced activity at Cannock Chase Hospital and noted feedback from system partners that the site was delivering high-quality services whilst attracting patients from outside the immediate catchment area. He said it was acknowledged that some patients from Staffordshire continued to access alternative providers, including the independent sector. Ms Nuttall advised that the Trust was aware of these arrangements and confirmed that repatriating appropriate activity formed part of the <i>Transforming Community Care</i> strategy. She noted that, particularly within orthopaedics, there were opportunities to increase local provision at Cannock Chase Hospital for the benefit of patients. She said however, this would need to be balanced against the requirement to further reduce waiting times while maintaining patient choice. Resolved: that the Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) be received for information and assurance
210/26	Patient Experience – Engagement, Involvement & Co-Production Prof Hickman welcomed Mr Perry and introduced the report, reflecting on the themes emerging from the Annual Patient Experience Report and noting the significant variation in patient experience across services. She said whilst recognising examples of excellent practice, she observed that there remained considerable inconsistency and that the organisation often found itself operating in a reactive rather than proactive manner. She said more effective use of patient voice and real-time feedback could help identify issues earlier and support service improvement. Mr Perry thanked the Board for the invitation and reflected on the significant progress that had been made in responding to national priorities and strategic developments, including the National Quality Strategy and the emerging expectations of the NHS 10-Year Plan. He said that patient and community voices were increasingly shaping decisions from the outset and emphasised that meaningful involvement and co-production should be regarded as a core component of service development rather than an additional activity and noted that further work remained to strengthen this approach. Mr Perry highlighted the important role that engagement played in improving quality, enhancing safety and reducing delays and provided examples of work undertaken to support patients waiting for services, including the development of the “Waiting Well” network. He said, whilst acknowledging that service teams could not always influence the length of waiting times, that they had been able to support individuals to manage their experience more effectively while awaiting care. He said that greater involvement of patients, families and communities contributed to more effective service delivery and helped foster a culture in which people felt valued, involved and listened to. Examples included the “Little Voices” initiative, the Partners in Care approach to visiting, and the contribution of lived experience partners in service design and improvement. Mr Perry highlighted the <i>Little Voices</i> programme as a key example of effective co-production in practice. He said children and young people had historically limited opportunities to directly influence healthcare services, with their views often being represented through parents, carers or other adults and that <i>Little Voices</i> had been established as a mechanism to give children and young people a genuine voice in decisions relating to their care and the services they accessed, recognising their right to have their views heard and considered. He advised that the programme was now in its second cohort and continued to make a significant contribution to service improvement. He said participants had directly influenced a range of changes, including enhancements to clinical environments, improvements in the accessibility of waiting areas, and the development of patient information materials. He referenced a recent children's food tasting session held at Wolverhampton, where young people had been invited to provide feedback on a proposed children's menu and whose input had helped ensure that mealtime experiences and menu choices better reflected the needs and preferences of children and young people. Mr Perry advised these improvements demonstrated how services could be designed in partnership with young people rather than solely on their behalf. He reported that the programme had received regional recognition through the NHS Midlands Excellence Champion Award for Patient Involvement and Choice and that this achievement reflected the commitment of the children involved, the supporting school and participating staff. He noted that the success of <i>Little Voices</i> was not an isolated achievement but reflected a broader cultural shift across the Group towards embedding patient voices and lived experience within improvement activity and service development and demonstrated how meaningful engagement could support improved access, better-designed services and enhanced patient experience. Ms Cartwright thanked Mr Perry and his team for the comprehensive report and presentation, recognising the significant impact of the work and the leadership shown in delivering it. She referenced the Stroke Rehabilitation service review, which had been a complex programme of work and thanked Mr Perry and his team who had led the engagement process with care, sensitivity and a clear understanding of the needs of those affected by the proposed changes. She said it was noted that the quality of engagement with patients, carers and other stakeholders had been instrumental in helping those affected to understand the rationale for the proposed changes and the intended benefits for patient outcomes. She said this approach had made a significant positive difference to the process and had helped build understanding and confidence that the proposals would improve stroke rehabilitation services. Mr Perry reflected on the discussion regarding digital capability and said that effective digital design should include simplifying existing processes and ensuring that users, in this case patients, are actively involved in shaping services. He emphasised the importance of keeping patient experience and service design at the centre of the Group's digital ambitions to ensure that future services meet the needs of those who use them.

Sir David invited Mr Perry to comment further on how the Group could continue to develop its approach to patient involvement and service improvement. He noted that discussions at Board had previously focused on how the organisation could become more forward-looking and preventative, rather than concentrating primarily on retrospective issues. He said that the Organisation held a significant amount of data and suggested there was an opportunity to make greater use of this information to support improvement and inform future planning.

Sir David said the NHS App was a potential gateway to increased patient engagement and sought Mr Perry's perspective on how digital tools and patient involvement could support the Group's ambitions in this area. Mr Perry acknowledged that whilst the NHS App represented an important future direction for patient engagement, significant challenges remained in relation to digital exclusion across the populations of Wolverhampton and Walsall. He noted that some patients lacked access to digital devices, internet connectivity and the skills required to engage with digital services. He said that the Group was working with local partners to improve digital inclusion, including initiatives providing connectivity support for specific patient groups. He advised that digital upskilling remained a key priority and that partners with experience were being involved in the development and testing of digital services to ensure they were accessible and user-friendly.

Mr Perry reported that ambitious targets had been set to increase uptake of the NHS App, supported by staff training and patient support initiatives across both Trusts. He cited the *My Pre-Op* programme as an example, where patients were being supported to complete online assessments, helping to reduce delays and cancellations. He said that whilst further improvements were required, progress was being made and patient feedback would remain central to future digital developments.

Ms Chadwick-Bell reflected on how the Group could build on the considerable progress already made in patient and community involvement. She suggested that patient and community feedback should become increasingly central to the culture of the organisation and be considered alongside other sources of intelligence and performance information. She noted that there was a significant opportunity to further embed this approach across the Group and expressed confidence that the Executive Team and Board were committed to supporting this ambition. She proposed that further discussion and reflection be undertaken to consider how patient and community voices could be more fully integrated into the Group's strategic and operational decision-making processes.

Ms Godson thanked Mr Perry and his team for their work and reflected that they had eloquently demonstrated the importance of sharing power with patients and communities. She said that hearing directly from children and families often had a greater impact on her as a leader than formal inspections or performance reports. She highlighted how discussions with children had generated valuable insights into their wider experience of care, including the importance of maintaining normal family interactions whilst in hospital.

Ms Godson noted that engagement had encouraged staff to raise concerns and ideas for improvement, including feedback regarding support provided to parents during hospital stays. She agreed that building trust with both patients and staff was an important part of creating a positive organisational culture. She emphasised the need to ensure that financial pressures and efficiency requirements did not discourage innovation. She observed that the ideas and perspectives of children, patients and families often provide valuable opportunities for improvement and could challenge the organisation to think differently about service delivery.

Prof Levermore sought clarification regarding the social value generated through the volunteer programme and noted that the independently assessed impact of £2.4 million represented a significant achievement for the organisation. He reflected on the earlier discussion regarding the Group's role as an anchor institution and observed that the work being undertaken through patient, volunteer and community engagement also delivered wider public health and social value benefits. He noted that, as resources become increasingly constrained, the organisation should consider how patient and community voices can be combined with clinical expertise to support prevention, improve population health and maximise the impact of available resources.

Mr Perry said that a key challenge for the organisation was ensuring that patient voice was consistently valued and embraced. He noted that there could sometimes be reluctance to engage with patient feedback, particularly where it was perceived as criticism or challenge. He emphasised that patient voice should not be feared but recognised as a valuable source of learning and improvement, particularly when services are being redesigned or concerns are raised regarding patient outcomes.

Mr Perry said that patient experience data was already available across the organisation and contained valuable insight into what patients were saying about services. He encouraged leaders and staff to look beyond performance metrics and recognise that each data point represents the experience and voice of an individual patient. He noted the importance of not only collecting feedback but actively listening to and acting upon it. He also drew attention to the relationship between staff experience and patient experience, noting that the annual staff survey consistently asks whether staff would recommend the organisation as a place of care for themselves or their families. He suggested that there was an opportunity to better connect staff survey findings with patient experience intelligence to understand the factors influencing both staff and patient perceptions.

	Sir David thanked Mr Perry and his team for their work and noted the significant contribution that patient and community engagement makes to service improvement. He reflected on the importance of being more exposed to patient voice and linked this to the earlier discussion on curiosity and openness to challenge. He welcomed the success of the Little Voices programme and asked that thanks be passed on to the children and schools involved, recognising the positive impact their involvement has had on patient experience and service development. Resolved: that the Patient Experience – Engagement, Involvement & Co-Production update be noted
211/26	Mental Health Service Update
	Dr Zia provided a report covering Mental Health Act compliance and the implementation of the national Mental Health Improvement Standards. He advised that the report had been prompted by previous Board discussions regarding Section 3 compliance and the wider national focus on mental health provision within urgent and emergency care settings. He provided assurance that the Trust remained compliant with its statutory responsibilities under the Mental Health Act and that appropriate Responsible Clinician arrangements were in place. He said compliance continued to be monitored through the Mental Health Group and relevant governance committees and said that national data indicated that approximately 26% of organisations were breaching the mental health care waiting time standard. He said current performance at Walsall and Wolverhampton was below the national average, although improvement remained necessary. Dr Din advised that the national improvement programme required organisations to submit data on patients who had breached standards and undertake a detailed self-assessment against four domains of the Mental Health Improvement Standards. He advised the self-assessment had now been completed jointly with Black Country Healthcare NHS Foundation Trust and submitted. He advised that the initial assessment had identified improvement opportunities, particularly relating to workforce capacity, communication processes and pathway arrangements between partner organisations. He advised that six standards fell directly within the remit of Walsall and Wolverhampton services and that assurance had been obtained that both organisations were fully compliant with all six standards. He said further work would now be undertaken collaboratively with Black Country Healthcare NHS Foundation Trust to review the self-assessment findings, agree improvement actions and identify any pathway changes required. He advised progress would be monitored through the established governance framework and reported to the GQC. Ms Heseltine sought further clarification regarding a statement in the report indicating that delays had arisen due to a misunderstanding regarding delays and patients not being seen as expected. Dr Zia explained that some issues had arisen from inconsistencies in the recording and interpretation of timing information within the patient pathway. He said these discrepancies had been identified by the team, corrective action had been implemented, and an audit process was underway to provide assurance that recording arrangements were operating effectively. Prof Toner said she welcomed the report and the assurance that both organisations were fully compliant with the six standards that fall within their remit. She said that, despite this positive position, there remained patients within the Emergency Department who were not always receiving timely access to the mental health care and support they required and if any action was being taken. Dr Zia said any agreed actions and improvement plans would need to be implemented ahead of the forthcoming winter period. He said it was recognised that this was not solely a Trust issue and would require a coordinated response involving partner organisations across the Black Country, including Dudley and Sandwell. Ms Chadwick-Bell emphasised the importance of ensuring that the Group fulfilled its own responsibilities whilst also seeking assurance that system partners were delivering against agreed standards. She noted that the introduction of agreed performance measures provided a stronger basis for constructive challenge and escalation where appropriate. She noted that the introduction of nationally defined standards and measures would enable more effective monitoring and escalation of concerns where required. She requested that a further update be brought to the September Board meeting, including performance against key response times, particularly the one-hour and four-hour standards, together with an update on improvement actions and any issues requiring escalation within the wider system. Action: Prof Hickman and Ms Carroll to provide a further update on Mental Health services be brought to the September Board meeting, including performance against key response times, particularly the one-hour and four-hour standards, together with an update on improvement actions and any issues requiring escalation within the wider system. Sir David agreed that future reporting should provide assurance both on the actions within the Group's control and on the contribution of system partners to delivering the required improvements. Resolved: that the Mental Health Service Update be received for information and assurance
212/26	Corporate Governance (Section Heading)
213/26	RWT & WHT Audit Committee Chairs Reports including confirmation that the Audit Committee exercised its delegated authority on behalf of the Board, and approved the final audited reports, and successfully submitted them to NHS England
	Ms Martin presented the Audit Committee exception report and advised that the Trust's Annual Accounts had been

	approved under delegated authority within the required timescales and had received an unqualified audit opinion. She also highlighted the recent achievement of the Walsall Finance Team, which had been recognised as Finance Team of the Year. She acknowledged the hard work, professionalism and dedication of the Finance Team in achieving this recognition. Ms Jones advised that the position for Wolverhampton as similar to that reported by Ms Martin for Walsall. Resolved: that the RWT & WHT Audit Committee Chair Reports be received for information and assurance
214/26	Group Standing Financial Instructions and Standing Orders Mr Mortiboys presented the revised Group Standing Financial Instructions (SFIs) and Group Standing Orders (SOs). He advised that this represented the latest iteration of the SFIs and SOs and that, whilst the changes from the previous version were limited, this was the first occasion on which a single set of Group SFIs and SOs had been developed and adopted across both Trusts. Mr Mortiboys advised that the move to a shared Oracle financial system had enabled the creation of a common policy framework and that the SFIs had been updated to reflect current best practice. He said revised SFIs and SOs had also been reviewed by both Audit Committees prior to submission to the Board. Resolved: that the Group Standing Financial Instructions and Standing Orders be approved
216/26	Questions Received from the Public Sir David welcomed Mr Shires to the meeting and invited him to present his public question regarding the provision of robotic surgery services across the Black Country. Mr Shires outlined his personal experience as a cancer patient and expressed concern regarding perceived inequalities in access to robotic surgery, particularly for patients in Walsall. He noted the potential benefits of robotic surgery in improving recovery times, reducing hospital stays and enhancing patient outcomes, drawing on both personal and wider patient experiences, he questioned whether Walsall patients were receiving equitable access to robotic surgery compared with patients elsewhere in the region. Mr Shires highlighted national policy ambitions relating to cancer care, reducing inequalities and expanding access to innovative treatments. He suggested that the current arrangements may disadvantage some patients, particularly those requiring emergency treatment who do not have the opportunity to select an alternative provider. He asked that the Board consider the issue and sought clarification regarding how his question would be addressed and the process for providing a formal response. Sir David thanked Mr Shires for his question and for sharing his personal experience. He acknowledged Mr Shires' extensive experience as a patient representative and advocate and recognised the importance of the issues raised. He noted the concern regarding the distribution and accessibility of robotic surgery services across the Black Country and invited an executive response to the specific points raised. Dr McKaig advised that robotic surgery services had historically developed in an opportunistic manner, with investment often dependent on local funding availability rather than strategic planning. He noted that the West Midlands remained comparatively under-served in terms of robotic surgery capacity and that a Black Country-wide robotics strategy was currently being developed to address this. He said the strategy would assess current provision, identify inequalities in access and consider how patients can access pathways where robotic surgery offers the greatest clinical benefit, regardless of place of residence and it would also examine future capacity requirements and the expansion of robotic surgery services across the system. Dr McKaig advised that current estimates suggested that, over the next ten years, between 10 and 15 robotic systems may be required across Walsall and Wolverhampton. He said at present, soft tissue robotic surgery was available within the Group through existing arrangements, but significant future investment and development would be required to meet anticipated demand. He advised, whilst evidence regarding long-term clinical outcome benefits continues to develop, robotic surgery was associated with benefits in patient recovery and experience. He said it was also recognised that access to robotic surgery could be important in attracting and retaining high-quality clinical staff and supporting future workforce development. Dr McKaig emphasised that the Clinical Services Roadmap seeks to ensure equitable access to high-quality care for patients across both Trusts and that future pathway development may require new ways of organising services to achieve this objective. Sir David acknowledged the points raised by Mr Shires regarding both patient experience and the potential operational benefits associated with shorter hospital stays and improved patient flow. He noted that the overall requirement for increased robotic surgery capacity across the Black Country was recognised and that work was underway to determine future deployment priorities through the developing robotics strategy. He thanked Mr Shires for his contribution and noted that a formal response would be provided, with further engagement to take place outside the meeting in relation to the issues raised. <i>Mr Shires left the meeting.</i> Sir David advised on further questions had been received from members of the public. He acknowledged that some

	had been submitted by individuals who were not present at the meeting and that all responses would be provided through the appropriate processes. Sir David advised that the submitted questions would be circulated and responded to outside the meeting. The following questions were received from Dr Tinsa and acknowledged that responses would be emailed: Question 1. Why am I being restricted to only one question when no other members of the public are asking questions? <i>Answer. The arrangements for public questions are intended to apply consistently to all members of the public, irrespective of how many people submit questions for any particular meeting. The purpose of having a limit on the number of questions is to ensure that the process is fair, manageable, and capable of accommodating participation from any member of the public who may wish to engage with the Board. The arrangements are therefore based on principle rather than the number of questions submitted for a specific meeting.</i> Question 2. Why are only five minutes allowed for public questions when ten minutes have previously been allowed? <i>Answer. The Board periodically reviews the structure and timing of its meetings to ensure that sufficient time is available to conduct all business effectively. Five minutes is the standard allocation currently provided for public questions. The Chair retains discretion in managing the meeting agenda and ensuring that all items receive appropriate consideration. While other NHS organisations may adopt different arrangements, each Board is entitled to determine procedures that best meet its own governance requirements.</i> Question 3. If the Board meeting finishes early, why cannot the time for questions be extended? <i>Answer. The published agenda is established in advance so that all participants understand how the meeting will be conducted. Whilst a meeting may conclude earlier than anticipated, this does not automatically create an entitlement to extend any particular agenda item. The Chair is responsible for determining how the meeting is conducted in accordance with the Trust's governance arrangements.</i> Question 4. Why can the Chair ask the question on behalf of a member of the public? <i>Answer. The purpose of the public question process is to ensure that questions are put before the Board and answered appropriately. The Chair may summarise or present a question to facilitate the efficient conduct of the meeting, particularly where questions have been submitted in advance. Members of the public do not have an absolute right to participate in debate during Board meetings. The Board's obligation is to provide an opportunity for questions in accordance with its agreed procedures.</i> Question 5. Why does the Chair give an oral report rather than a written report? <i>Answer. The Chair and Chief Executive have different constitutional roles. The Chief Executive is responsible for the operational management of the Trust and therefore routinely provides detailed written reports concerning performance and delivery of services. The Chair's role includes leadership of the Board, governance, stakeholder engagement, and oversight of the Board's effectiveness. The format of any report provided by the Chair is a matter for the Board's agreed arrangements and does not diminish the importance of maintaining appropriate accountability.</i> Question 6. Why can members of the public not ask questions arising from discussions on the day of the meeting? <i>Answer. The requirement for advance submission of questions helps ensure that accurate and informed responses can be prepared and that meeting business can be conducted in an orderly manner. It also ensures fairness and consistency for all participants. While members of the public may wish to ask follow-up questions arising from discussions during the meeting, Board meetings held in public are not public meetings in the sense of being open forums or debates. They are meetings of the Board which the public are entitled to observe. The procedures for questions are therefore designed to balance public engagement with the Board's responsibility to conduct its formal business.</i> Question 7. Allegation that the Chair is acting irrationally, unreasonably and disproportionately <i>Answer. The Board does not accept that the Chair has acted irrationally, unreasonably, disproportionately, or unlawfully. The arrangements governing Board meetings and public questions are established to support effective governance, transparency, fairness, and the efficient conduct of business. Decisions concerning the management of meetings are taken in accordance with the Trust's governance procedures. Any individual remains entitled to pursue such routes of challenge as are available to them in law, but the Board considers that its arrangements are lawful and appropriate</i>
216/26	Any Other Business
	There was no other business raised
217/26	Date and Time of Next Meeting – Tuesday 15 September 2026 at WMI Building, The Royal Wolverhampton NHS Trust
	Sir David confirmed the date and time of the next meeting as Tuesday 15 September 2026 and as there was no further business to conduct, closed the meeting. Resolved: that the meeting of the Board of Directors held in Public on 21 July 2026 be closed.

List of action items

Agenda item		Assigned to	Deadline	Status
RWT/WHT Group Board of Directors Meeting - to be held in Public 21/07/2026 10.5 Mental Health Service Update				
3864.	Mental Health Services update - Ms Hickman and Ms Carroll to provide a further update on Mental Health services be brought to the September Board meeting, including performance against key response times, particularly the one-hour and four-hour standards, together with an update on improvement actions and any issues requiring escalation within the wider system.	- Carroll, Lisa - Hickman, Debra	03/11/2026	 Pending
<i>Explanation action item</i> Ms Hickman and Ms Carroll will be providing a verbal update at the September Board under matters arising. It was noted that a fuller report would not be available until the next Board meeting in November 2026.				
RWT/WHT Group Board of Directors Meeting - to be held in Public 21/07/2026 7 Integrated Committee Chairs Report - Finance & Productivity Committee, Quality Committee, People Committee, Partnerships and Transformation Committee and Digital and Estates Strategy Committee				
3863.	Ophthalmology Services - Dr McKaig & Ms Nuttall to provide a further update, including a comprehensive action plan and clear timescales for delivery of ophthalmology services, to be brought to the September Board meeting.	- McKaig, Brian Dr - Nuttall, Gwen	01/09/2026	 Completed
<i>Explanation action item</i> This report will be provided under Matters Arising at the September Board.				

RWT/WHT Group Board of Directors Meeting - to be held in Public 21/07/2026 6 Group Chief Executive's Update				
3862.	Safety and quality of maternity services - Ms Hickman and Ms Carroll to provide a further report be presented in September to provide assurance on the safety and quality of maternity services, informed by a broader range of evidence and learning from recent reviews undertaken elsewhere in the NHS.	● Carroll, Lisa ● Hickman, Debra	01/09/2026	■ Completed
	<i>Explanation action item</i> A report is scheduled on September's agenda.			

Tier 1 - Paper ref:	Enclosure 4.2
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Report title:	Ophthalmology Briefing Paper (ref: Action 3863)
Sponsoring executive:	Brian McKaig, Group Chief Medical Officer Gwen Nuttall, Managing Director
Report author:	Maggy Guirguis and Louise Jones
Meeting title:	Group Trust Board Meeting held in Public
Date:	15 September 2026

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

The Ophthalmology Service is experiencing significant pressures due to sustained growth in demand, increasing waiting lists and insufficient capacity. Ophthalmology now accounts for 62% of the Trust's RTT backlog, with over 6,000 patients awaiting a first appointment and more than 34,000 awaiting follow-up care.

These pressures are increasing clinical risk, particularly within Glaucoma, Diabetic Retinopathy, Corneal and Urgent Eye Care services, and are contributing to rising complaints and incidents associated with delays in care.

A programme of immediate recovery actions is underway, including additional clinical capacity, enhanced oversight, outpatient transformation and development of community pathways. Longer-term transformation proposals include expansion of virtual services, a new urgent eye care model and progression towards a single-provider Ophthalmology service across Wolverhampton and Walsall. The Birmingham and Black Country ICB are involved in the discussion around alternative community pathways.

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?]

Discussion and escalation to previous board, in terms of harm / risk – July 26
 Discussion and escalation to Quality Committee – July / Aug 26. Follow up requested to future QC.
 Discussion and escalation to CQRM meeting with Commissioners June 26.
 Discussion and escalation with Chief Executives – Joe Chadwick Bell and David Melbourne – action to establish task and finish group. May 26.

4. Recommendation(s)/Action(s)

The Group Board is asked to:

- Note the risk to delivery of Ophthalmology Service.
- Agree to the formal monitoring of the action plan via the Group Quality Committee.

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 on 15 September 2026

Ophthalmology Briefing Paper

1. Executive summary

Demand for Ophthalmology services continues to exceed capacity. Rising waiting times have led to increased complaints, incidents and patient safety concerns.

The most significant risks are within Glaucoma, Diabetic Retinopathy and Corneal services, where delays in assessment and follow-up create a risk of avoidable harm.

Recovery actions are underway, additional clinical capacity, enhanced waiting list oversight, expansion of virtual clinics, outpatient transformation initiatives and development of community-based pathways. Longer-term plans include introducing a new urgent eye care model and progressing towards a single-provider Ophthalmology service across Wolverhampton and Walsall.

The Board is asked to note the significant challenges facing the service, endorse the recovery actions currently being implemented, support the proposed transformation programme, and support, via executive oversight, the progression of business cases required to increase capacity and improve patient safety.

2. Introduction

This paper provides the Trust Board with an overview of the operational, performance and patient safety challenges facing the Ophthalmology Service. It outlines the actions being taken to recover performance, reduce patient harm and implement sustainable long-term improvements to meet growing demand.

3. Current position

The Ophthalmology Service is facing sustained demand growth that is exceeding available capacity. Since 2021/22, accepted referrals have increased by 23.5%, contributing to substantial waiting lists, with over 6,000 patients awaiting a first outpatient appointment and more than 34,000 patients awaiting follow-up care.

Ophthalmology now represents 62% of the Trust's overall Referral to Treatment (RTT) backlog. As graph 1 shows, 61.3% (June 26) of patients are currently receiving treatment within 18 weeks of referral. Despite additional activity being delivered through insourcing and waiting list initiatives, improvement in waiting times remains challenged.

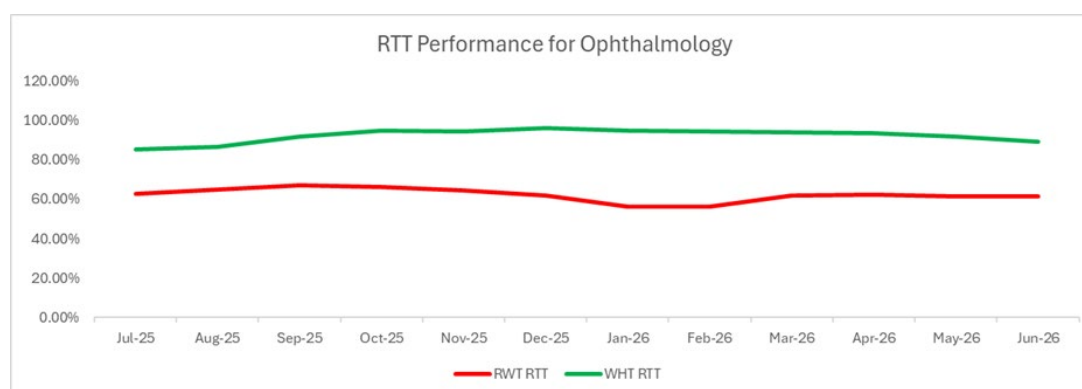


Table 1.0 Ophthalmology complaints, delay subcategory

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The increasing gap between demand and capacity has led to a rise in patient complaints. Delays in access to care account for the largest proportion of complaints, while incidents relating to delayed assessments and follow-up appointments have increased over recent years. As table 1.0 demonstrates, there has been a steep increase in complaints relating to delays in receiving an outpatient appointment during 2025/26.

Delay category	21/22	22/23	23/24	24/25	25/26	Total
Delay in receiving outpatient appointment	3	2	0	1	19	25
Delay in diagnosis	2	1	0	1	9	13
Delay in receiving treatment	2	3	0	2	5	12
Delay in elective admission (waiting list)	0	1	1	3	7	12
Delay in appointment for diagnostic tests	0	1	0	0	1	2

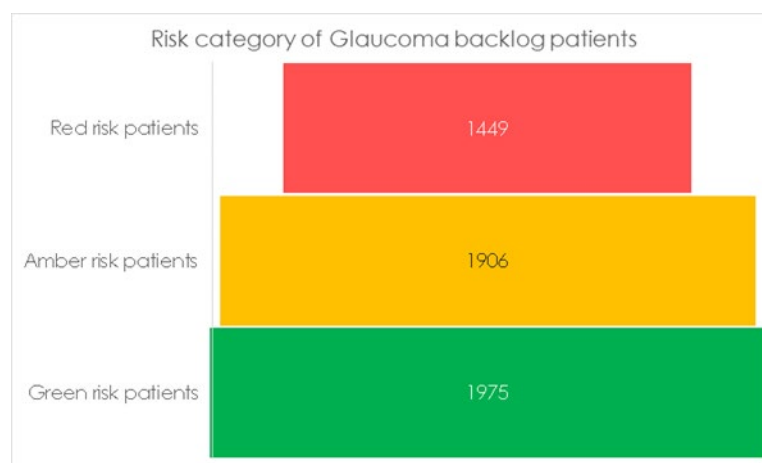
Table 1.0 Ophthalmology complaints, delay subcategory

There has also been an increase in the number of incidents reported as a percentage of referrals received, particularly during 2025/26. 27% of the incidents reported over the last 5 years relate to cancelled appointments, delay in follow-up care or similar.

4. Key risks and challenges

The most significant clinical risks are within:

- 4.1 Glaucoma Services, where more than 9,400 patients are on the backlog waiting list and over 5,300 patients are overdue for a follow-up appointment. Patients need to be seen face to face and have a diagnostic test in order to manage this condition and prevent sight loss. To prioritise patients for review the Glaucoma-Strat-Fast clinical risk stratification tool has been applied. As graph 2.0 shows this places patients in either the green, amber or red risk category with clinical priority given to the patients in the red category.



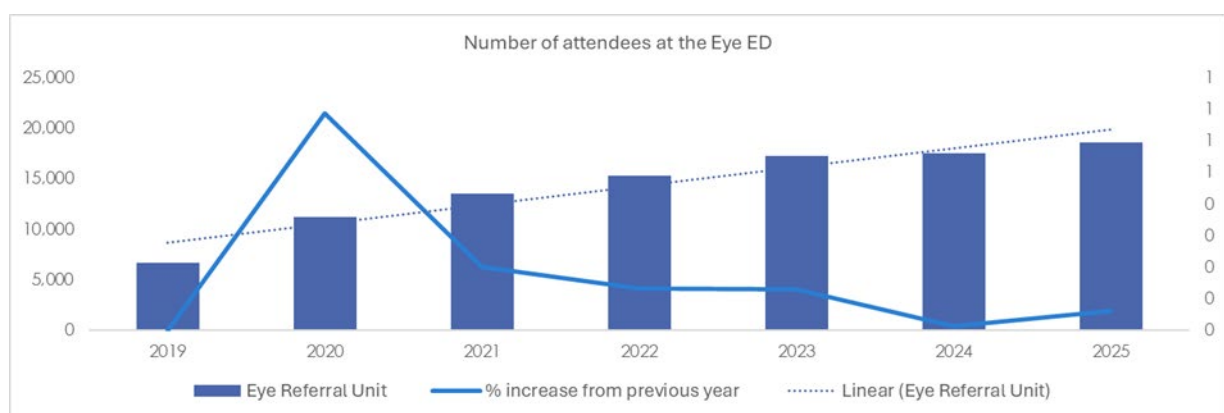
Graph 2.0 Risk category of Glaucoma patients requiring follow-up

The Trust is working with ICB colleagues to develop alternative pathways, enabling patients that are in the green category to receive the care they need in the community setting. Ensuring that acute hospital-based services can support those patients in the amber and red categories, with the greatest clinical need. This is expected to deliver a considerable improvement in patients accessing timely care.

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- 4.2 Diabetic Retinopathy Services, where performance against national screening standards remains below target, particularly for routine patients requiring an appointment within 13 weeks of referral. Delay in accessing timely care can present a risk to these patients. Proposals are being developed to increase capacity for virtual clinics, enabling face to face capacity to be diverted to seeing urgent patients more sooner.
- 4.3 Corneal Services, where limited specialist capacity has resulted in long waits for treatment and follow-up care. It is proposed that the service moves to a team-based, protocol driven, digitally enabled model.
- 4.4 Delivering a sustainable model of care for urgent eye patients, where the current walk-in model of care presents significant operational challenges in being able to respond to the surge of activity presenting late on during the day. This means patients often experience lengthy delays and staff are working beyond their contracted hours. This has been exacerbated by a significant increase in the number of patients attending for urgent eye care of 180% in the last 6 years (graph 3.0).



Graph 3.0 Eye ED attendances

A proposal to move to same day bookable appointments will ensure patients get access to the urgent eye care they need within a sustainable operating model.

- 4.5 The Ophthalmology Service is also experiencing significant workforce and operational pressures, with vacancies across clinical, nursing and support services with an increasing concern regarding staff wellbeing.

5. Recovery and transformation actions

A number of immediate recovery actions are underway to address the risk to patients and reduce waiting times including:

- Recruitment where possible to outstanding vacancies.
- Enhanced monitoring of waiting times
- The use of private healthcare providers and additional Trust based clinical activity to reduce waiting lists.
- Continued implementation of outpatient transformation initiatives, including patient-initiated follow-up pathways where clinically appropriate.
- Development of community pathways to ensure acute hospital-based capacity is allocated to those with the greatest clinical need.
- Introduction of targeted actions to improve Glaucoma care including regular meetings with ICB colleagues to progress new models of care for the management of patients with low-risk Glaucoma.
- Expansion of virtual clinics and digital solutions to improve access for patients.

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- Progression towards a single-provider Ophthalmology model across Wolverhampton and Walsall to improve equity of access for patients, optimise the clinical, nursing and support workforce and ultimately improve the care we provide.
- Targeted operational support to ensure sustained delivery of transformation programmes of work.

6. Conclusion

The Ophthalmology Service is experiencing significant and sustained pressures resulting from rising demand, insufficient staffing resource and historic service models that are no longer able to meet population needs. These pressures are impacting on waiting times for patients and increasing clinical risk.

Whilst immediate recovery actions are helping to reduce risk and improve waiting times, long-term improvement will require investment and service transformation across the Trust and wider healthcare system. With continued organisational and system support, the proposed programme of recovery and transformation will improve patient safety, reduce waiting times and establish a more resilient and sustainable Ophthalmology Service for the population of Wolverhampton and Walsall.

7. Recommendations

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

- Note the serious challenges within the Ophthalmology Service**, including increasing demand, insufficient capacity, growing waiting lists, challenged performance, rising complaints and incidents, and the associated risk of patient harm.
- Endorse the immediate recovery actions being implemented** to improve patient safety and reduce waiting times, including insourcing, enhanced performance oversight, outpatient transformation initiatives, and targeted backlog reduction plans.
- Support the proposed transformational changes** required to deliver a sustainable Ophthalmology service, including:
 - Development of community-based pathways for Glaucoma, Diabetic Retinopathy and Corneal patients
 - Introduction of the new urgent eye care model
 - Expansion of virtual and digitally enabled services
 - Progression towards a single-provider Ophthalmology model across Wolverhampton and Walsall
- Support, once approved via Trust Governance process, the submission and progression of business cases**, particularly for the Diabetic Retinopathy service, to enable additional diagnostic, failsafe and virtual clinic capacity.

Ophthalmology Directorate Recovery Action Plan
Version 1.0 August 2026

	Workstream	Action	Lead	Timescale	Outcome Measure
1.0	Patient Safety & Governance	Continue weekly Ophthalmology performance meetings chaired by COO	COO / Deputy COO Division 1	Immediate and ongoing	Weekly review of RTT, harm reviews and recovery actions
2.0	Patient Safety & Governance	Maintain weekly review of all patients waiting over 52 weeks and those at risk of harm	Divisional General Manager for Ophthalmology	Immediate and ongoing	Reduction in 52+ week waits and harm incidents
3.0	Demand & Capacity Recovery	Continue insourcing programme to increase new and follow-up appointment capacity	Divisional General Manager for Ophthalmology	Immediate to March 2027	Reduction in RTT and follow-up backlog
4.0	Demand & Capacity Recovery	Develop specialty-level demand and capacity model for all ophthalmology subspecialties	Divisional General Manager / Head of PMO Portfolios/ Elective Transformation Lead	Mar-27	Agreed sustainable capacity plan
5.0	Demand & Capacity Recovery	Develop ophthalmology outpatient dashboard with real-time performance reporting	Divisional General Manager / Head of PMO Portfolios/ Elective Transformation Lead	Oct-26	Improved operational management
6.0	Glaucoma Transformation	Finalise business model and commissioning arrangements for community management of Green-risk glaucoma patients	Directorate Team / ICB	Oct-26	Community pathway approved
7.0	Glaucoma Transformation	Implement transfer of low-risk glaucoma patients into community services	ICB / Ophthalmology Directorate	Dec-26	33% reduction in glaucoma demand on secondary care
8.0	Glaucoma Transformation	Prioritise medium and high-risk glaucoma patients for accelerated follow-up reviews	Clinical Lead for Glaucoma	September 2026 onward	Reduction in overdue high-risk patients
9.0	Diabetic Retinopathy Improvement	Submit business case for additional diagnostic and failsafe capacity	Divisional General Manager for Ophthalmology	Jan-27	Business case approved
10.0	Diabetic Retinopathy Improvement	Procure additional OPTOS imaging machine	Divisional General Manager for Ophthalmology	<i>subject to BC approval</i>	Additional diagnostic capacity operational
11.0	Diabetic Retinopathy Improvement	Recruit Imaging Technician	Divisional General Manager for Ophthalmology	<i>subject to BC approval</i>	Improved patient throughput
12.0	Diabetic Retinopathy Improvement	Recruit two Failsafe Officers	Divisional General Manager for Ophthalmology	<i>subject to BC approval</i>	Improved referral and follow-up management
13.0	Diabetic Retinopathy Improvement	Establish two additional virtual clinics per week	Divisional General Manager for Ophthalmology	<i>subject to BC approval</i>	Improved urgent and routine screening KPI performance
14.0	Corneal Service Improvement	Maintain insourcing arrangements to address long wait patients	Divisional General Manager for Ophthalmology	Immediate	Reduction in >45 week waits
15.0	Corneal Service Improvement	Submit business case for community model	Divisional General Manager for Ophthalmology	Jan-27	Business case approved
16.0	Corneal Service Improvement	Implement community and virtual corneal care model	Divisional General Manager for Ophthalmology	<i>subject to BC approval</i>	Reduced consultant follow-up demand
17.0	Urgent Eye Care Transformation	Implement SOCAP model replacing walk-in access with booked urgent appointments	Ophthalmology Directorate	Nov-26	Improved patient flow and staff wellbeing
18.0	Urgent Eye Care Transformation	Monitor urgent care activity, conversion rates and patient outcomes	Ophthalmology Directorate	Monthly from implementation	Stable activity and improved patient experience
19.0	Digital Transformation	Complete implementation of Medinet electronic patient record	Ophthalmology Directorate	Jun-27	Reduction in paper-based processes
20.0	Workforce Stabilisation	Recruit substantive Clinical Director and operational leadership vacancies	Divisional Leadership Team	Oct-26	Improved leadership resilience
21.0	Workforce Stabilisation	Review workforce establishment including nursing, optometry, technician and administrative staffing	Divisional General Manager for Ophthalmology	Nov-26	Workforce plan agreed
22.0	Walsall Service Integration	Develop proposal to transition from SLA arrangement to single provider model	Divisional General Manager for Ophthalmology	Oct-26	Formal options appraisal completed
23.0	Walsall Service Integration	Implement agreed provider model across Wolverhampton and Walsall	Divisional General Manager for Ophthalmology	<i>subject to Exec approval</i>	Equitable RTT delivery across both sites
24.0	Transformation Programme	Launch Tier 1 Transformation Programme Board	Divisional Team	Oct-26	Programme established
25.0	Transformation Programme	Implement programme management support and track delivery of all actions	Tier 1 Programme Lead	Ongoing	Monthly report to Planned Care Committee

Tier 1 - Paper ref:	Enclosure 6
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Report title:	Group Chief Executive's Report
Sponsoring executive:	Joe Chadwick-Bell, Group Chief Executive
Report author:	Gayle Nightingale, Business Manager to the Group Chief Executive
Meeting title:	Group Trust Board
Date:	15 September 2026

1. Summary of key issue

Firstly, I will note the number of key national policies/guidance shared:

- National maternity and neonatal assurance process
- Winter planning 2026/27
- Quality strategy
- New - NHS Oversight Framework (NOF) 2026/27
- Provider Capability Assessments 2026

Maternity and Neonatal 10 Point Plan assurance process

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's independent review of maternity services at the Nottingham University Hospitals NHS Trust, the clinical leadership community came together to discuss a 10 Point Plan of urgent actions for maternity and neonatal services. Following this NHS England wrote to all trusts to outline the assurance process and expectations.

Trusts will be expected to reflect on the findings of both reports, the immediate priority is delivery of the 10 Point Plan. This sets out the most urgent actions arising from the reports and will be the focus of local leadership, improvement activity and board oversight while the National Maternity and Neonatal Taskforce develop a comprehensive action plan. The assurance process is intended to support and evidence progress with clear accountability for delivery embedded within existing governance arrangements wherever possible. Trusts will need to submit a baseline assessment on 25 September 2026, which we are on course to deliver through Debra Hickman

Alongside this, 'Amos into action' will launch an NHS-wide opportunity for an open conversation for all our maternity and neonatal staff to help shape real and sustainable change in services. Further details will follow shortly about how staff can get involved and how the outputs will help support culture change and improvement work within trusts. This builds on feedback from more than 9,000 staff members who contributed their views to the Amos investigation.

Winter planning 2026/27

NHS England has set out national expectations for winter preparedness, requiring all providers and systems to complete and test robust winter plans by September 2026. Key requirements include the appointment of a named Executive Winter Lead, implementation of national urgent and emergency care pathways, elimination of corridor care as a patient safety priority, and maintenance of elective activity throughout winter.

The Board will be required to provide assurance that the Trust has effective arrangements in place for escalation, infection prevention and control, workforce resilience, and operational delivery to meet anticipated winter demand. Formal Board Assurance Statements must be submitted to NHS England by 30 September 2026. I can confirm that Executives along with colleagues are working to these deadlines as will be noted in Winter Planning reports to Board.

The NHS Oversight Framework (NOF) 2026/27

NHS England's national framework for assessing and overseeing NHS trusts, foundation trusts and

Integrated Care Boards (ICBs). It sets out how organisations will be measured, benchmarked and supported, and determines the level of oversight and intervention applied to each organisation.

What is changing in 2026/27?

The updated framework introduces a more structured, rules-based approach to oversight, linked to the Government's 10-Year Health Plan and NHS operating model. NHS England will assess organisations across key domains including:

- Access and waiting times
- Quality and patient outcomes
- Productivity
- Workforce and people
- Finance
- Organisational capability and leadership

Performance will be compared nationally, with public league tables and segmentation used to determine the level of support, freedom or intervention an organisation receives.

How will it affect an NHS Trust?

For trusts, the framework will have several practical implications:

1. Greater focus on measurable performance

Trusts will be judged against a wider range of national metrics covering quality, access, finance and productivity. Boards will need stronger oversight of these indicators and clear improvement plans where performance is below average.

2. Public benchmarking and league tables

Performance results are published nationally, enabling comparisons between organisations. This increases transparency and places greater emphasis on board assurance and performance management.

3. Segmentation determines oversight

Trusts are allocated to segments based on performance and capability. Higher-performing organisations may receive greater autonomy, while those performing less well may receive additional scrutiny, support or intervention.

4. Financial performance remains critical

Financial deficits can directly affect a trust's segmentation position.

5. Increased Board accountability

Trust Boards will need to demonstrate robust governance, leadership capability and active use of performance intelligence to drive improvement. Capability assessments sit alongside performance metrics when determining overall oversight.

What does it mean for The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust?

Based on our assessment we are expecting to have a neutral overall impact on The Royal Wolverhampton NHS Trust's score, with positive and negative metric changes balancing each other. However, Walsall Healthcare NHS Trust's position was predicted to deteriorate due to a greater number of negatively affected metrics. In addition the financial override would continue to limit segmentation performance for both organisations.

Provider Capability Assessments 2026

Following the inaugural approach last year, NHS England is now launching the 2026 provider capability assessment process. NHS trusts are asked to self-assess against a set of capability statements across the

domains derived from [The insightful provider board](#). These statements have been slightly altered this year, to reflect areas including:

- cybersecurity and digital maturity at board-level, and
- board-level overview of staff wellbeing.

The purpose of this self-assessment is to strengthen NHS trust boards' assurance, focusing attention on key areas of governance. It will also help establish the level of oversight for the organisation over the year.

1. The board will conduct a self-assessment, and using a form set out their view of their capability in each of the six domains, referencing: the evidence the board has used to derive assurance; any areas of concern or requiring development; and any changes implemented following the process in 2025. Our Board will also need to consider whether they have governance arrangements in place but also their effectiveness.
2. The trust board will submit the self-assessment to their regional team. However, as last year, they can submit the board paper covering the self-assessment process if they wish. Oversight teams will triangulate this self-assessment against their own views of the trust, third party information and the board's recent track record in leading the organisation to arrive at an overall view of capability in the form of a Green/Amber-Green/Amber-Red/Red rating.
3. This rating and supporting evidence will go to the national provider capability moderation panel and subsequently NHS England's executive board for ratification, after which providers will be informed and ratings will be refreshed on NHS England's website.
4. As the year progresses, teams will monitor capability as part of their general oversight function and may propose changes to ratings – up or down – to reflect matters at trusts.
5. Timing for self-assessments
 - The trust will return the completed self-assessment form on **Friday 2 October 2026**
 - Trusts should expect their finalised capability rating by **December 2026**.

NHS England Quality Strategy

The recently launched NHSE Quality Safety strategy positions quality as the organising principle for all NHS-funded care. Whilst the group strategy - TCT contains significant quality ambitions, in conjunction there are other enabling documents that provide direction for both Trusts. It is timely to bring these together to strengthen our ambitions for Safe, Effective care delivery and the Experience of our communities' accessing services.

The Group Quality Strategy will provide a clear line of sight between:

- NHS England Quality Strategy
- NHS 10-Year Health Plan
- Transforming Care Together
- The Quality Framework
- Divisional and service-level improvement plans.
- Wider enabling strategies- e.g. Patient Experience Enabling Strategy.

Providing a single framework, explicitly describe how the Group will improve safety, effectiveness and experience through its Quality Management System, Community First model, neighbourhood health programmes, digital transformation agenda and workforce development plans.

More locally I would like to update you on some organisational items:

Picker Experience Network Awards (PENNA) 2026 National Finalists

The Group has achieved outstanding national recognition at the Picker Experience Network Awards (PENNA) 2026, with six initiatives shortlisted as national finalists across five award categories. The PEN Awards are the UK's leading programme recognising excellence in patient experience and person-centred care, making

this a significant achievement for both Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust.

The shortlisted entries showcase the breadth of innovation and collaboration taking place across the Group. Walsall's Calm Connections Clinic has been recognised in the Excellence in Personalised Care category for its trauma-informed maternity service supporting women following birth trauma, pregnancy loss and complex perinatal experiences through personalised, multidisciplinary care.

In the Joined-Up Care Experience category, Care Without Conveyance has been shortlisted for bringing senior emergency medicine decision-making into patients' homes, reducing unnecessary hospital attendance and improving urgent care pathways. Frailty Without Boundaries has also been recognised for creating a single, integrated frailty pathway across health, social care and voluntary sector partners, improving coordination, independence and outcomes for older people.

The Group's award-winning Little Voices programme has been shortlisted in the Long-Term Improvement in Experience of Care category, recognising its sustained success in empowering children and young people to influence service design and decision-making, and its lasting impact on patient experience and organisational culture. The Little Voices approach has also been shortlisted for the 2026 HSJ NHS Communications Initiative of the Year Award and is among more than 230 projects and individuals making it this far in the annual celebration that recognises best practice, those who improve patient outcomes and innovating drivers of better service.

Two Group-wide initiatives have also been recognised in the Teams Making a Difference to Experience category. The Patient Voice Team has been shortlisted for embedding co-production, engagement and lived experience at the heart of service improvement and organisational decision-making. The Golden Thread, bringing together Patient Voice, Volunteer Services and wider engagement functions across both Trusts, has been recognised for creating a coordinated approach to improving experiences for patients, carers, volunteers and communities.

These six national finalist nominations reflect the Group's continued commitment to listening, learning and improving in partnership with patients, families, carers and communities, and provide further recognition of the dedication and innovation demonstrated by colleagues across both organisations.

Digital solutions – Heidi

Both Trusts, along with 15 NHS Trusts in the West Midlands, have jointly procured a transcription tool called 'Heidi', which is being put to use in urgent care, outpatients and GP surgeries. The mobile phone tool listens to conversations between doctors and patients using AI to generate written medical notes and letters, enabling medical staff to spend less time typing and more time on patient care.

Dr Mohammed Jamil Aslam, one of our emergency consultant at Walsall Manor Hospital, said "that using AI to transcribe conversations with patients saves him time typing medical notes and letters, helping more patients to be diagnosed and treated. Doctors are actively listening and patients feel heard."

HSJ Patient Safety Awards

The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust are celebrating multiple shortlisting's in this year's HSJ Patient Safety Awards.

The five shortlisted initiatives are:

- Developing a Positive Safety Culture Award – Walsall Healthcare NHS Trust: From Listening to Acting: Developing a Positive Safety Culture Through a Locally Led Approach to Patient Wellness Questions
- Digital Clinical Safety Initiative of the Year – The Royal Wolverhampton NHS Trust: Safer Care by Design – Our Digital BluEPRint for Transforming Patient Safety: The Digital Clinical Safety Model

- Improving Safety for Older People Initiative of the Year – Walsall Healthcare NHS Trust: Reducing Harm Through Timely Discharge: Improving Safety for Older People in Trauma & Orthopaedics
- Patient Safety Team of the Year – The Royal Wolverhampton NHS Trust: Bridging the Digital Divide to Deliver Safer Patient Care
- Surgical Care Safety Initiative of the Year – Walsall Healthcare NHS Trust: Reducing Length of Stay and Cost in Elective Lower Limb Arthroplasty

These nominations demonstrate how our staff are listening to patients, using data and technology, challenging established ways of working and working together to make care safer. I am incredibly proud of everyone involved and wish all of our shortlisted teams the very best at the HSJ Patient Safety Awards. Winners will be announced at the awards ceremony on 28 September 2026.

Best Practice initiatives

TCT discussed all the Best Practice initiatives, focusing on productivity, discharge pathways, sickness absence, procurement, and operational models. It was agreed that a mechanism would be established to track the adoption of recommended best practices, including reasons for any non-adoption. The team committed to comparing current clinical productivity practices against recognised models, identifying gaps and implementing proportionate monitoring measures. They also decided to review discharge pathways holistically, considering the full patient journey and aiming to balance new and follow-up patient ratios. Further actions included improving sickness absence recording and policy consistency, initiating discussions on procurement collaboration with a value case, and investigating operational models that could support community-first pathways and enhance acute-community interface. These agreed actions will inform future board updates, ensuring transparency and rationale behind each approach.

NHS staff survey

The NHS staff survey will open mid-September until 28 November 2026. The survey provides every member of staff with an opportunity to have their voice heard and help shape the future of our organisation. We recognise that rates for completion are low and this is what we are doing to actively increase numbers:

- A small financial incentive
- A communications campaign that sets a new and different tone, and that links the survey to the wider cultural work
- A weekly Tactical Command meeting, focused on driving the response rate
- Daily executive walk-about, focussed on key messaging and providing support to managers where the response rates are lowest and learning from those with good response rates
- Creation of dedicated computer spaces across both sites for staff who otherwise have limited access
- IT support to ensure email addresses remain active during the time-period for staff who only access their emails intermittently
- A support pack for managers to engage with their teams to encourage survey completion
- An 'overall' winner award for the team with the highest response rate (small, medium, large teams)

Changes to the executive team

In March this year the board approved our new strategy, Transforming Care Together. It sets out an ambitious vision for how Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust will work together to improve health and care for our communities by 2031.

Healthcare is changing. Demand continues to grow, people are living longer with more complex health needs, and there are significant inequalities in health outcomes across the communities we serve. At the same time, advances in technology create new opportunities to improve how care is accessed and delivered. Our strategy recognises that continuing to do more of the same is not enough. Instead, we must transform how care is delivered, ensuring services are organised around people, communities and partnerships rather than organisations and buildings.

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The strategy is built around four simple, connected objectives:

- Care – excellent clinical outcomes, delivered closer to home.
- Colleagues – a supported, empowered workforce able to do its best work.
- Collaboration – working seamlessly with GPs, councils, charities and other partners.
- Communities – services designed around local people, tackling health inequalities.

To best ensure we have a leadership team in place to support the organisations to deliver our strategy and ensure colleagues are supported, I have been reviewing how the executive team is structured to ensure we have a focus on day to day delivery but also with a more strategic focus, ensuring we optimise the resources across Walsall and Wolverhampton to deliver the best care for patients and our local population.

With this in mind I have decided, in conjunction with executive colleagues to bring the team together in a more unified way, I have reduced the executive team already but there will be some further changes leading to a smaller team with all posts working across the two trusts.

I have already moved to a single group Chief Medical Officer and will be following suit with a single Chief Nursing Officer in October and a single Chief Delivery Officer in December when Gwen (RWT Managing Director) retires. As part of this change, we will also look to strengthen our leadership at Group level for our perinatal services (maternity and neonatal care), reflecting national priorities as well as leading on the development of our much needed development of a new maternity and neonatal building at New Cross.

Dr Brian McKaig (previously CMO at RWT) is the Group Chief Medical Officer and started in post in June, Lisa Carroll (currently CNO at WHT) will become the Group Chief Nurse and Amelia Godson (currently Managing Director at WHT) will become the Group Chief Delivery Officer. Debra Hickman who is a midwife and currently CNO at RWT has chosen to move into the Chief Perinatal Officer role working to Brian and Lisa to provide strategic direction and professional leadership at such an important time.

Site visits across Walsall and Wolverhampton

Throughout July and August, I undertook some sites visits to the Critical Care Unit (CCU) – RWT, met with the paediatric consultants at RWT and visited both WHT and RWT maternity services, of everyone I met I was impressed by the professionalism, compassion, and commitment demonstrated by staff caring for some of our most seriously ill patients to ones starting their life with us.

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:

- Note the contents of the report.

Tier 1 - Paper ref:	Enclosure 6.1
Report title:	.1 Progress Report on Anchor Development
Sponsoring executives:	Joe Chadwick-Bell, Group Chief Executive Officer Stephanie Cartwright, Group Chief Community and Partnerships Officer
Report author:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Meeting title:	Public Trust Board
Date:	15 th September 2026

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

Advise: The emerging Anchor model offers the Group a significant opportunity to move from providing commissioned activity to shaping care, capacity and resources for defined populations across Walsall and Wolverhampton. This is a fundamental shift in the way that care is commissioned and delivered in each place, co-ordinated through our Group of Trusts as Anchors for integrated care.

Assure: The Anchor Steering Group has been established with Executive and Non-Executive membership and is chaired by the Group Chief Executive Officer. General practice representatives from Walsall and Wolverhampton will join the Group from September 2026.

Alert: The model remains under development. Its contractual form, scope of services, financial envelope, risk sharing, governance and implementation arrangements will be finalised over the coming months.

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 Board received a private presentation from the ICB on the proposed Anchor arrangements in May 2026. At its public meeting in July 2026, the Board received a report on potential governance arrangements for an Anchor organisation.

4. Recommendation(s)/Action(s)

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

- Note the progress being made to develop anchor arrangements across Walsall and Wolverhampton and the strategic opportunity presented by the emerging anchor model and its potential to improve population outcomes and integrated care.
- To note the work underway to define the scope of services, contract form, financial envelope, risk sharing, governance and implementation arrangements.
- To note the establishment of the Anchor Development Group within inclusion of general practice representation from both places from September.
- Receive further discussion papers over the coming months setting out the proposed scope of services, operating and contractual model, financial implications, due diligence, outcomes framework and implementation plan.

Quality and equality impact assessments will be completed as the proposed scope and operating model are developed and before any formal transfer or delegation is approved. The findings, required mitigations and any implications for health inequalities will be reported to the relevant assurance committees and the Board.

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**Report to the RWT/WHT Group Trust Board Meeting to be held in Public on
15th September 2026
Progress Report on Anchor Development**

1. Executive Summary

The Anchor model would give the Trusts a greater role in planning, coordinating and delivering care for the populations of Walsall and Wolverhampton, working with primary care, local authorities, mental health services and voluntary-sector partners. It would increase collective responsibility for improving outcomes and making best use of available resources. Its principal value would be to support earlier, more coordinated action on the factors that influence demand, capacity and long-term sustainability, rather than responding only when people require treatment.

This paper provides an update on the development of the Anchor model. No final decision is sought at this stage. Any future proposal involving delegated responsibilities, contractual commitments, financial arrangements or changes to accountability will be subject to due diligence and brought to the Board for formal consideration.

The proposed direction of travel aligns with the 10 Year Health Plan published in July 2025. It seeks to address fragmentation between services, the concentration of resources on treatment after people become unwell, limited local influence over decisions and missed opportunities to use shared intelligence for earlier action. The intended future state is more coordinated care, stronger local decision-making and a population budget that supports investment in interventions expected to improve outcomes for local people.

Subject to formal agreement and the completion of due diligence, the transition would be phased. A shadow year would be used to confirm the current commissioning and contractual scope and to test the proposed governance and operating arrangements. Formal delegation of defined commissioning responsibilities, including accountability for expenditure and outcomes, would follow only if the necessary approvals and assurances were secured.

2. Purpose and Strategic Context

National and system policy is moving towards proactive, population-based care, with stronger neighbourhood delivery and greater accountability for outcomes. This report sets out the emerging direction of travel and the work required to develop it. It does not seek approval of a final contractual, financial or governance arrangement.

3. Strategic benefits

The benefits are as follows:

- **System leadership:** with greater influence over delegated commissioning priorities, outcomes and resource decisions.
- **Whole-pathway design:** coordinated redesign across hospital, community, primary care, mental health, local authority and voluntary-sector partners.
- **Earlier intervention:** use of population insight, segmentation and risk stratification to support priority cohorts before needs escalate.
- **Demand, flow and capacity:** stronger alternatives to crisis, improved discharge and recovery, and more effective use of acute capacity.
- **Scale and spread:** faster adoption of successful models across both Trusts while retaining local adaptation.

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- **Shared capability:** common population health, analytics, contracting, digital, workforce and transformation infrastructure where this adds value.
- **Social Value:** use the Group's wider 'Anchor' role as an employer, purchaser, estate owner and civic partner to support employment, skills, local procurement and the wider determinants of health.

4. What will be different?

Benefits will be assessed against agreed baseline measures for population health outcomes, inequalities, patient experience, quality and safety, access, workforce, activity, finance and use of community based care. Future reports will identify the proposed measures, accountable owners, milestones and arrangements for independent evaluation.

For patients and communities	For staff and services
Earlier, proactive support; integration and coordination; less repetition; more care at home or in neighbourhoods; timely discharge support; more equitable access.	Clearer pathway ownership; better access to shared information; fewer hand-offs and workarounds; greater clinical influence; improved use of collective capacity and increased awareness of partner colleagues in co-ordinating and integrating care.

Development of the model will include engagement with patients, carers, communities, staff, general practice, local authorities, mental health services and voluntary and community-sector partners. Future proposals will explain how this engagement has influenced the model and identify any further consultation or statutory engagement requirements.

5. Proposed governance and accountability arrangements

Detailed governance and accountability arrangements remain under development. These will need to define the respective roles of the Board, the ICB, the Anchor Development Group and partner organisations; decision rights and reserved matters; clinical and financial accountability; reporting and escalation routes; and arrangements for managing conflicts of interest. The proposed arrangements will be brought back to the Board before any formal delegation or transfer of responsibility.

6. Material risks and mitigations

Material risk	Required mitigations
Responsibility without sufficient authority	Approved map of responsibilities, decision rights, partner commitments and escalation routes.
Underfunding, commissioning gaps and population need	Validated baseline, independent financial review and agreed treatment of gaps, unfunded activity and legacy arrangements.
Dependence on partner delivery	Signed partnership and delivery agreements with realistic capacity plans and shared measures.
Service destabilisation and stranded costs	Costed transition and provider-impact plan covering double-running, residual costs and safe sequencing.
Unclear clinical responsibility or variable quality	Named clinical leaders, common standards and clinical governance approval before transfer.
Insufficient data and incompatible systems	Data-readiness assessment, minimum dataset and tested information-sharing arrangements.
Insufficient workforce and change capacity	Costed operating model, workforce impact assessment and transformation capacity.
Benefits fail to materialise or inequalities worsen	Baselines, realistic milestones, independent evaluation and regular Board reporting with corrective action.

7. Development of Anchor Model

The Anchor Development Group has been established and will include general practice representatives from Walsall and Wolverhampton. Executive meetings receive weekly updates, and formal progress is reported through the Transforming Care Together Executive Team and relevant Board committees. The next steps are:

1. **Define:** confirm populations, scope of services in and out, contract form, interfaces and principles.
2. **Diagnose:** establish baselines for need, outcomes, activity, cost, workforce, contracts, assets and inequalities.
3. **Design:** agree governance, decision rights, clinical accountability, financial mechanisms, data and outcomes.
4. **Assure:** complete legal, financial, clinical, workforce, data and equality due diligence, including downside scenarios.
5. **Mobilise:** implement in phases with transition funding, protected capacity, benefits tracking and escalation.
6. **Scale or reset:** expand only where evidence demonstrates safety, quality benefit and sustainability.

The next phase will develop the detailed scope, operating model, contractual and financial arrangements, governance, outcomes framework and implementation plan. Each element will be subject to appropriate clinical, financial, legal, workforce, information-governance and equality assurance. A further paper will set out the timetable, decision gateways and matters requiring formal Board approval.

Recommendations:

The Group Trust Board is asked to:

1. Note the progress being made to develop anchor arrangements across Walsall and Wolverhampton, the strategic opportunity presented by the emerging anchor model and its potential to improve population outcomes and integrated care.
2. Note the work under way to define the scope of services, contractual form, financial envelope, risk-sharing, governance and implementation arrangements.
3. Note the establishment of the Anchor Development Group, including general practice representation from both Walsall and Wolverhampton from September 2026.
4. Receive further papers over the coming months setting out the proposed scope of services, operating and contractual model, financial implications, due diligence, outcomes framework and implementation plan for the Board's consideration.

Stephanie Cartwright
Chief Community and Partnerships Officer
September 2026

Tier 1 - Paper ref:	Enclosure 7
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Report title:	Integrated Committee Chairs' Report.
Sponsoring executive:	Non-Executive Directors
Report author:	Paul Assinder – Group Vice-Chair
Meeting title:	Group Trust Board Meeting - in Public
Date of Meeting:	15 September 2026

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

The Integrated Chairs' report comprises a joint summary from the meetings of the Group Committees of the Board held in July and August 2026:

- Group Finance & Productivity Committee (GFPC)
- Group Quality Committee (GQC)
- Group People Committee (GPC)
- Group Partnerships & Transformation Committee (GPATC)
- Group Digital and Estates Strategy Committee (GDESC)

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 receive the report for information and assurance

Group Committees of the Board Chairs' Assurance Report

1. Common themes and areas of discussion

What themes are consistently appearing across committee discussions and therefore warrant Board-level visibility and oversight?

Theme/Issue	Board Lead	Notes / Mitigations / Assurance
Workforce capacity, supply and sustainability impacting service delivery and quality.	Chief Nursing Officers/Chief Officer for People, Culture and Improvement	Workforce pressures impacting service delivery, quality and financial plans. Recruitment, attendance and workforce planning actions in place.
Capacity, Access & Service Resilience	Managing Directors Chief Nursing Officers Group Chief Medical Officer	Service pressures across ED, cancer pathways, community services and mental health, with workforce availability a key dependency.
Financial resilience and sustainability	Chief Executive Chief Financial Officer	Future financial resilience is being undermined by the Group's inability to identify and deliver a supply of recurrent efficiency savings. It is likely that in future periods CIP targets will be missed.

2.1 Alert – matters of concern for escalation	
Group Finance & Productivity Committee	Group Quality Committee
- Financial sustainability remains a significant risk, particularly at RWT, with increasing cost improvement programme (CIP) delivery requirements, reliance on non-recurrent measures and emerging financial pressures within Division 1. - Community waiting times remain well below national targets, with particular concern regarding neurodevelopmental services (ADHD and Autism), workforce shortages, commissioning arrangements and prolonged waits in Community Paediatrics and Speech & Language Therapy. - Operational performance continues to be impacted by the PAS transition, resulting in data quality issues affecting performance reporting, including DM01 compliance data. - Urgent and Emergency Care pressures continue at RWT, including prolonged Emergency Department waits, ambulance handover delays and challenges relating to discharge and criteria-to-reside. - The Committee noted that RWT submitted a "standards not met" position for the Data Security and Protection Toolkit (DSPT). The Committee requested a further update on remedial actions at its October meeting. - The CDC funding proposal carries an accounting risk, as anticipated financial benefits remain dependent	- The Group has received a Regulation 28 Prevention of Future Deaths Report relating to urgent inter-hospital transfer arrangements between RWT and WHT. A response is required by 29 September 2026 and improvement actions are underway. - A Fire Safety Enforcement Notice remains in place in relation to Block 32 (Maternity Services) at New Cross Hospital. Risk mitigations remain in operation whilst remedial works progress. - A Fire Safety Enforcement Notice remains active at Cannock Chase Hospital pending completion of agreed works, anticipated in November 2026. - The Committee continues to oversee actions arising from engagement with the Human Tissue Authority following inspection activity and ongoing national scrutiny of mortuary services.

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2.1 Alert – matters of concern for escalation	
Group Finance & Productivity Committee	Group Quality Committee
upon confirmation that IFRS16 lease accounting does not apply.	

2.1 Alert – matters of concern for escalation	
Group People Committee	Group Partnerships & Transformation Committee
- Workforce deployment remains adverse to plan and there is currently no assurance that the Group Workforce Plan will be achieved. The Committee will continue to monitor delivery and seek further assurance regarding workforce reductions and associated financial recovery plans. - Levels of sickness absence remain a concern across both organisations. The Committee noted that the updated Group Attendance Policy is currently being considered by Staff Side and will continue to monitor improvement activity. - WRES and WDES results demonstrate continuing inequalities in staff experience, appointment, progression and engagement, with widening disparities for ethnic minority colleagues. The Committee expects further assurance following receipt of the consolidated Equality, Diversity and Inclusion Plan and Cultural Development Plan.	No matters of concern or escalation to report
Group Digital and Estates Strategy Committee	
- Increase threat for Cyber was reported to Committee. This will be reviewed by ARC - EPR phase II is delayed due to supplier issues, the plan has been revised.	

2.2 Assure	
Group Finance & Productivity Committee	Group Quality Committee
- The Committee received assurance that the Group financial position remained ahead of plan year-to-date and that both Trusts continued to maintain positive cash balances. - The Committee received assurance that Group cost improvement programme delivery remained ahead of plan year-to-date, whilst noting continued reliance on non-recurrent delivery. - The Committee received assurance regarding WHT's operational performance, including achievement of cancer standards, strong referral-to-treatment performance and continued delivery of the four-hour standard above trajectory. - The Committee received assurance regarding improvements in patient flow, length of stay performance, therapy waiting times and reductions in 52-week waits.	- The Committee received assurance from external CHKS assessment activity that the Trust is expected to retain full accreditation and ISO certification. The Deanesly Unit will remain subject to a 12-month certification review. - CQC have accepted evidence of the closure of actions following their Ionising Radiation Regulations (IR(ME)R) Inspection in April 2026. - Following completion of the SANDS National Bereavement Care Pathway Self-Assessment Tool, WHT Maternity and Neonatal services scored as having a well-established solid foundation with good practice in bereavement care with opportunities to embed further. - The Committee received assurance from MOSS reporting that no alerts were identified at RWT. A Level 1 alert at WHT was anticipated and is being reviewed through established perinatal governance processes.

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2.2 Assure	
Group Finance & Productivity Committee	Group Quality Committee
	- The Committee received assurance regarding progress in maternity triage arrangements, with improving performance at RWT and further actions in place to strengthen compliance. Arrangements at WHT remain under review. - The Committee received assurance regarding implementation of Martha's Rule, with phased expansion into Maternity, Neonatal Services and Emergency Departments supported by national funding. - The Committee received assurance that implementation of the Saving Babies Lives Care Bundle continues, with Placental Growth Factor Testing remaining the only outstanding element requiring system-wide resolution. - The Committee received assurance that both Trusts remain on track to deliver Maternity Incentive Scheme (MIS) Year 8 requirements. - The Committee received assurance regarding the overall quality and safety of Maternity and Neonatal Services, with both Trusts performing positively against regional benchmarking measures.

2.2 Assure	
Group People Committee	Group Partnerships & Transformation Committee
- The Committee received assurance that a comprehensive Trust-wide improvement plan is in place to maximise participation in the 2026 NHS Staff Survey. - The Committee received assurance that the implications of the Lord Mann Report have been reviewed and that actions to strengthen safeguards against racist and discriminatory behaviours have been identified. - The Committee received assurance that delivery of the Sexual Safety agenda is being progressed through a structured five-step framework encompassing prevention, reporting, recording, response and organisational learning. - The Committee received assurance that a targeted improvement plan, supported by clear escalation arrangements and executive oversight, is in place to improve appraisal compliance. - The Committee received assurance through the Annual Revalidation Reports that the statutory responsibilities of the Responsible Officer are being effectively discharged across both Trusts. - The Committee accepted the Guardian of Safe Working Reports for both organisations and was assured that areas of increased activity are being	- Positive feedback received from Claire Fuller, National Director for Neighbourhood Health, following the Neighbourhood Health assessment visit in July 2026. - Committee are assured that both Places have completed the Neighbourhood Health self-assessment with partners and scores are significantly ahead of levels expected at this stage. - Place transformation plans and development funds updates received and noted, the Group should note that the majority of funds will not be accessible to the Group as targeted at community organisations, but the interventions may result in benefits. - Updates received on Outpatient transformation progress to date and positive discussion regarding organisational cultural shifts regarding new models of working. - Committee received positive updated regarding Community First programme, including confirmation of delivery partner contract, governance structure implementation and analysis of lessons learnt from phase one and phase two design and approval.

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2.2 Assure	
Group People Committee	Group Partnerships & Transformation Committee
identified, monitored and escalated through the appropriate governance routes. The Committee agreed their Terms of Reference and recommended to Board for approval.	
Group Digital and Estates Strategy Committee	
The Committee agreed their Terms of Reference and recommended to Board for approval.	

2.3 Advise	
Group Finance & Productivity Committee	Group Quality Committee
- The Committee requested a detailed update on Community Paediatric waiting times, including the underlying causes of delays and planned actions to improve performance. - Following review of the Group Data Security and Protection Toolkit (DSPT) submission, the Committee requested a further update on progress against the identified actions at its October meeting. - The Committee approved contract awards and variations under delegated authority. - The Committee endorsed the contract award for Maternity Fire Remedial Works at New Cross Hospital for approval through Trust Board governance processes. - The Committee endorsed the Modern Slavery Statement for submission to Trust Board for approval. - The Committee received and approved the Group Board Assurance report - The Committee reviewed winter planning arrangements across both Trusts and noted that plans will build on lessons learnt from winter 2025. Final Winter Plans will be submitted to Trust Board in September. - The Committee supported the proposed upgrade from Oracle R12 to Oracle Fusion, with implementation planned for October 2027. - The Committee requested a deep-dive review of Division 1 financial and performance pressures at RWT and will continue to oversee recovery actions, including insourcing activity and divisional performance reviews. - The Committee requested further work on the Medium-Term Financial Plan, corporate restructuring and theatre efficiency programmes, with a Board seminar to be arranged. - The Committee requested a further review of internal and external discharge delays and criteria-to-reside pressures. - The Committee commissioned a six-month update on community waiting time improvement plans,	- The Committee reviewed a Never Event relating to retained equipment during surgery and received assurance that the matter was managed appropriately, with no patient harm and actions implemented to prevent recurrence. - Following the presentation by the RWT Ophthalmology team, a visit to the service took place with all four GQC NED's in attendance. The meeting was very useful and a follow-up meeting is currently being arranged to discuss progress. - The Committee noted the national requirement for all Maternity and Neonatal Services to submit baseline assessments against the NHSE 10-Point Plan and National Maternity Triage Specification Benchmark Audit Tool following the Amos and Ockenden reviews. This matter is being reported separately on the agenda and will seek Board support for delegated authority being granted to the Group Quality Committee to approve the final submissions ahead of the national deadline. - Capacity constraints within Oncology and Haematology services at RWT continue to impact timely access to treatment, including delays to commencement of chemotherapy. A Black Country review of cancer services is underway. - Ongoing Emergency Department pressures continue to impact performance across the Group, including ambulance handover delays, prolonged waits and intermittent use of corridor care. - Workforce challenges remain within maternity and neonatal services, including neonatal nursing vacancies across both Trusts and a consultant obstetric workforce risk at RWT which may affect capacity and standards. - The Committee advises the Board that West Wing Theatres at WHT were temporarily closed following routine water testing which identified Legionella and Pseudomonas. Decontamination work was undertaken and all affected patients were successfully rebooked for surgery.

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2.3 Advise	
Group Finance & Productivity Committee	Group Quality Committee
including system partner feedback and discussions regarding ICB funding. - The Committee will continue to oversee theatre productivity improvements, corporate restructuring programmes and delivery of cost improvement programmes, including revised savings trajectories. - The Committee noted the PA Consulting Community First contract which will continue to be monitored and reported through the Committee. - The Committee agreed its Terms of Reference and recommended them to Board for approval.	- The Committee noted ongoing challenges in identifying patients requiring Hydroxychloroquine retinal screening at WHT and will continue to receive updates regarding solutions to improve compliance with screening requirements. - Risks associated with duplicate patient records and continuing PAS implementation impacts on operational performance and data quality remain under active review. - RWT has reported non-compliance with DSPT standards and remediation activity is ongoing. - A Non-Hodgkin Lymphoma survival outlier alert has been received and is currently under review. - Significant challenges remain in paediatric community waiting times and timely access to mental health support for patients presenting to Emergency Departments. - The Committee reviewed the new format Corporate BAF, site-specific BAFs and Trust Risk Registers. Whilst no changes were proposed, clarification was sought regarding the absence of Patient Safety Objectives within the Corporate and RWT BAF risks. The Committee noted that discussions are ongoing and that additional risks will be added moving forward. - The Committee noted that Fire Compartmentation reviews are being undertaken across New Cross Hospital, with a specific emphasis on Blocks 14, 24, 54/55 and 75/76. Similar reviews will be undertaken across WHT retained site premises, with a specific focus on the Maternity block, as part of the continuing fire safety improvement programme.

2.3 Advise	
Group People Committee	Group Partnerships & Transformation Committee
- The Committee received an update on the NHS England Leadership and Management Framework and noted that a further report will be presented following completion of an internal assessment against the framework. - The Committee received a briefing on the implementation of the NHS England Six Staff Standards, noting that progress against the standards will be reflected within the NHS National Operating Framework from Quarter 4. A self-assessment against the expected employer actions for each standard will be presented to the Committee in October 2026. - The Committee noted that executive-led planning continues to identify further efficiencies through the	- Funding allocations from the ICB for Place are being reviewed, the committee will monitor any impacts of partnership delivery and/or financial impact for the Group. - The committee notes that there will be significant requirements across the Group and partners under the Neighbourhood Health self-assessment and associated action plans. The oversight of progress will be across a number of committees. - There is still work required to define the data required to track the impact of integrated neighbourhoods teams for the Group, for the system, for patients and population health. - There is further work required to develop the Outpatient transformation programme in line with Neighbourhood Health requirements. This requires

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2.3 Advise	
Group People Committee	Group Partnerships & Transformation Committee
integration of corporate services and requested a detailed update at a future meeting.	further progress in relationships with Primary Care and assessment of capacity and competency within primary care partners. The committee note concerns regarding Executive capacity in relation to transformation programme and potential NHS Anchor. It was noted this was also raised in Sandwell & Dudley committees and reference made to alternative models employed in those trusts.
Group Digital and Estates Strategy Committee	
- The Committee noted that the Digital Board Assurance Framework risk is being drafted - AVT roll out is strong and implications with EPR are being worked through - Work is required to understand how the 5 regulatory principles for AVT, outlined by MHRA, are being adhered to and this will be reported to the October meeting - Fire Condition surveys are underway and will be completed mid 2027. Matters will be reported bimonthly to the Committee and onto the Group Board.	

Tier 1 - Paper ref:	Enclosure 7.1
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Report title:	Group Board Assurance Framework
Sponsoring executive:	Kevin Bostock, Group Chief Safety & Assurance Officer Kevin Stringer, Group Chief Finance Officer Claire Radley, Group Chief People, Culture and Improvement Officer Amelia Godson, Managing Director, WHT Gwen Nuttall, Managing Director, RWT
Report author:	Kevin Bostock, Group Chief Safety & Assurance Officer
Meeting title:	Committees of the Board
Date:	August 2026

1. Summary of key issues

The Executive Directors and the Committee Chairs, at subsequent meetings, reviewed the Group Board Assurance Framework (BAF) and The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust site BAFs.

The Group BAF is currently mapped to the three priority objectives for 2026-27:

1. We want our colleagues to feel cared about.
2. We want to Improve safety by reducing the time patients wait.
3. We want to deliver our services efficiently.

Additional risks will be added to the BAF as they are agreed.

Following a review undertaken by the Executive Leads for the Group People Committee (GPC) and the Group Finance and Productivity Committee (GF&PC), the BAF updates were presented to the Committees for review and approval. The Risk Appetite Matrix approved at a Group Board Development session held in June 2026, has been reflected in the scoring.

- **GBR TCT1 – Colleague Experience and Engagement** (Group People Committee (GPC). Executive Lead: Group Chief People, Culture and Improvement Officer.
The assessed current risk score is 12 (3 likelihood x 4 consequence) – No change since last review.
- **GBR TCT 2 – Timely and Safe Access to Care** (Group Finance and Productivity Committee (GF&PC). Executive Lead: Managing Directors
The assessed current risk score is 16 (4 likelihood x 4 consequence) – No change since last review
- **GBR TCT 3– Financial Sustainability and Efficient Use of Resources** (Group Finance and Productivity Committee (GF&PC). Executive Lead: Group Chief Finance Officer
The assessed current risk score of is 15 (3 likelihood x 5 consequence) – No change since last review

The Executive Directors reviewed and assessed The Royal Wolverhampton NHS Trust Board Assurance Framework (SR) and approved the risk scores for:

- **SR 15 –Future Funding Flows** (Group Finance and Productivity Committee).
It was agreed that the risk score of 20 (5 likelihood x 4 consequence) remains appropriate.
- **SR17 – Equality, Diversity and Inclusion (EDI)** (Group People Committee (GPC)).
It was agreed that the risk score of 16 (4 likelihood x 4 consequence) remains appropriate.
- **SR18 – Cyber** (Group Finance & Productivity Committee)
It was agreed that the risk score of 10 (2 likelihood x 5 consequence) remains appropriate.
- **SR19– Meeting or Exceeding Constitutional Standards** (Group Finance & Productivity Committee)
It was agreed that the risk score of 12 (3 likelihood x 4 consequence) remains appropriate.

The Executive Directors reviewed and assessed the Walsall Healthcare NHS Trust Board Assurance

Framework (NSR) and approved the risk scores for:

- **NSR 101 – Cyber** (Group Finance and Productivity Committee).
It was agreed that the risk score of 10 (2 likelihood x 5 consequence) remains appropriate.
- **NSR 102 – Culture** (Group People Committee).
A review NSR102 has not been undertaken since the last review, where the risk score of 12 (3 likelihood x 4 consequence) was agreed and remains appropriate.
- **NSR 103 – Staffing** (Group People Committee).
A review of NSR103 has not been undertaken since the last review, where the risk score of 9 (3 likelihood x 3 consequence) was agreed and remains appropriate.
- **NSR 104 – Patient Safety** (Group Quality Committee).
It was agreed that the risk score of 9 (3 likelihood x 3 consequence) remains appropriate.
- **NSR 105 – Finance Resources** (Group Finance & Productivity Committee).
It was agreed that the risk score of 20 (5 likelihood x 4 consequence) remains appropriate.
- **NSR 106 – Equality, Diversity and Inclusion (EDI)** (Group People Committee).
A review of NSR106 has not been undertaken since the last review, where the risk score of 16 (4 likelihood x 4 consequence) was agreed and remains appropriate.
- **NSR 107 – Meeting or Exceeding Constitutional Standards** (Finance & Productivity Committee).
It was agreed that the risk score of 12 (3 likelihood x 4 consequence) remains appropriate.

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

- Executive Led Reviews
- Assurance and approval by relevant Committees of the Board

4. Recommendation(s)/Action(s)

The Group Trust Board Meeting held in Public is asked to receive the report for assurance.

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. Complaint findings had potential to cause harm but was prevented/not realised in this case. Complaint fully and easily resolved locally.	Unsatisfactory experience readily resolvable. Substantiated complaint peripheral to clinical care eg. Minor staff attitude. Substantiated findings required extra observation, minor treatment, caused minimal harm. Complaint 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.	Substantiated complaint. Mismanagement 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 definitions. Complaint findings meets/ potential meets the serious incident criteria.	Substantiated complaint. Mismanagement of patient care leading to or potentially leading to death refer to matrix harm definitions. 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		5

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Annex 1

Watch List - Summary potential new BAF Risks June 2025

Headings/Issues/themes	Specific ly	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.

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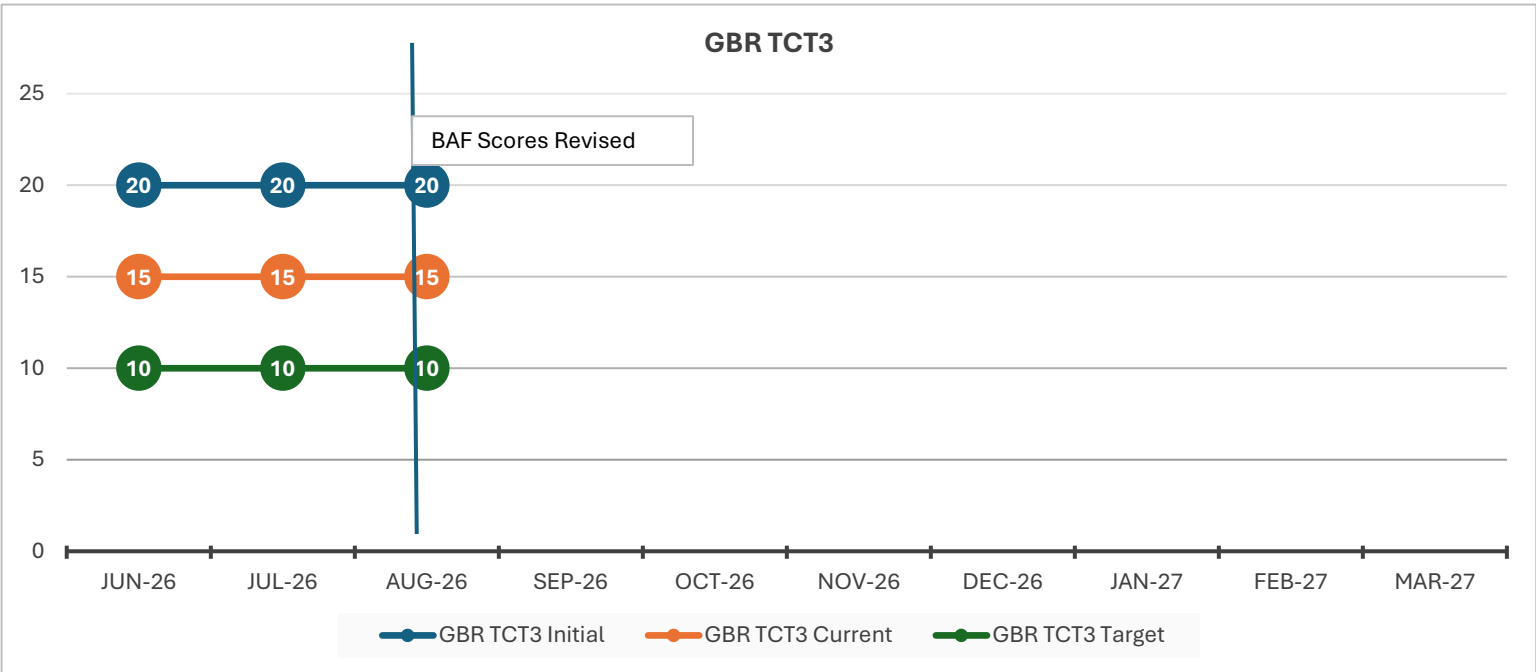
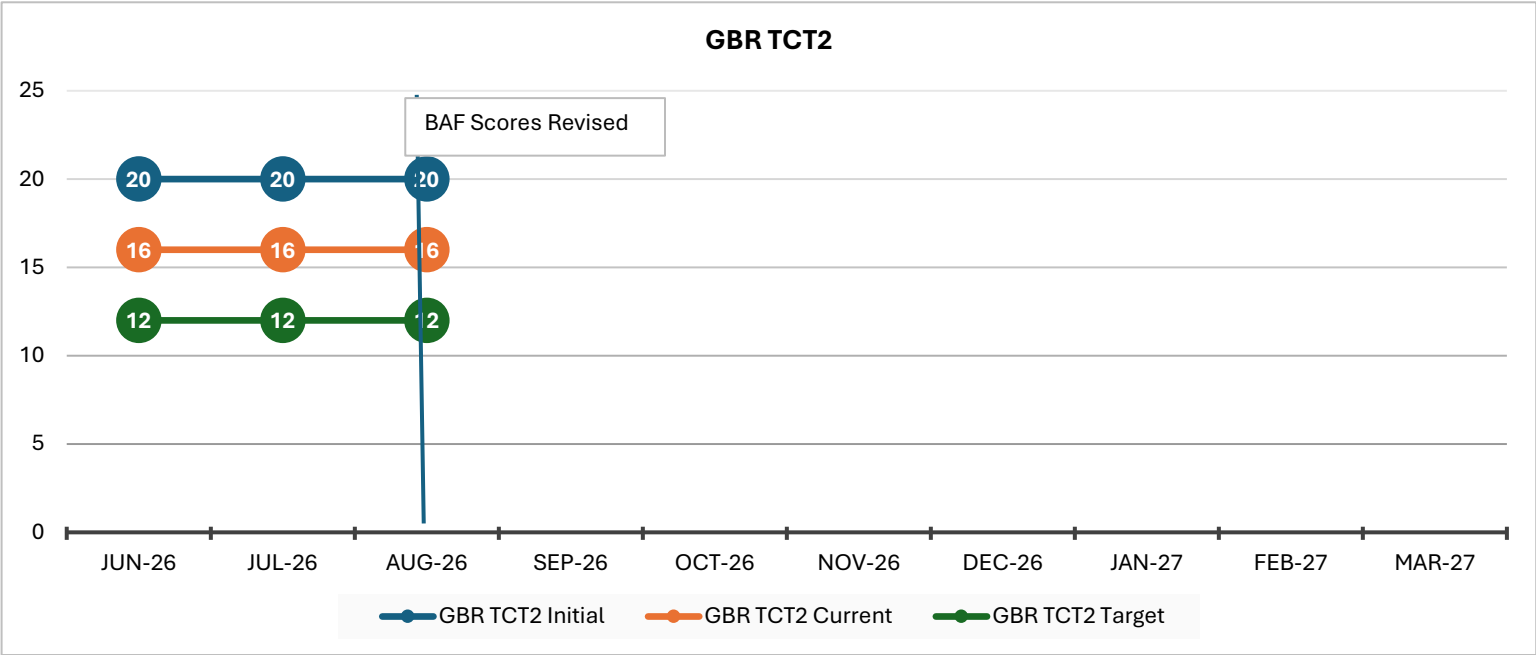
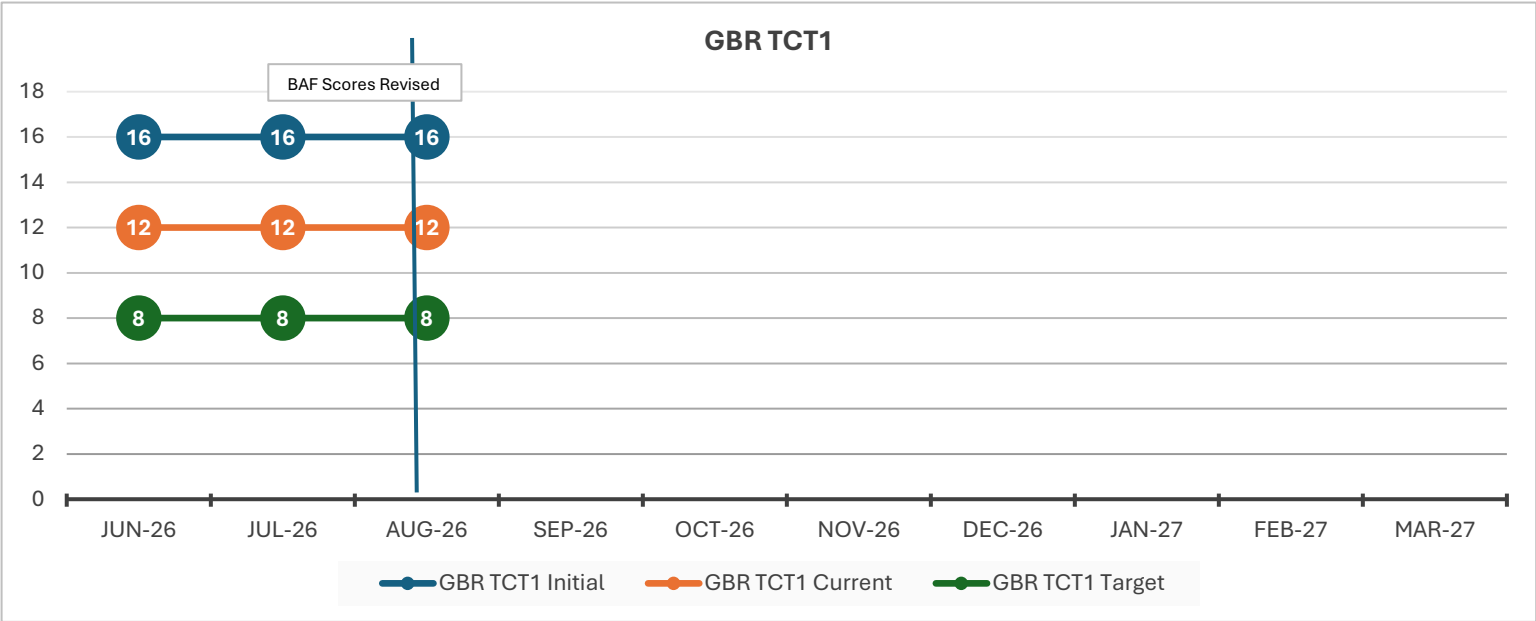
Risk Appetite Matrix (Adapted GGI risk appetite matrix) to establish Risk Appetite Statements RWT/WHT Group June 2026

Number	Risk Types	Risk Appetite Level	1 None / Averse <i>Avoidance of risk is a key organisational objective.</i>	2 Minimal <i>Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.</i>	3 Cautious <i>Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.</i>	4 Open <i>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.</i>	5 Seek <i>Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).</i>	Risk Tolerance Score (L)x(C)=RT
0	Strategy Risks in pursuing current strategy / strategic direction.		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. RWT SR19 & WHT NSR 107	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.		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. TCT3 & RWT SR15 & WHT NSR 105	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 / Regulation How will we be perceived by our regulator?		We have no appetite for decisions that may compromise compliance with statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	3x3=9
3	Quality – Safety How will we deliver safe services?		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. TCT2 WHT NSR 104	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.		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.		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?		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?		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. TCT1 & RWT SR17 & WHT NSR 102 & WHT NSR 103 & WHT NSR 106	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	5x4=20
8	Organisational Architecture		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.	3x4=12
9	Systems and Partnership working (including Commercial).		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.	4x5=20

10	Technology, Information and Data & Security.	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 WHT NSR 101 & RWT SR 18	We are eager to be innovative and to choose options offering potentially higher rewards despite greater inherent risk.	2x5=10
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BAF Risk Trajectory

Commentary: New TCT Group BAF Risk



Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 1: We want our colleagues to feel cared about		Risk Title: GBR TCT1 – Colleague Experience and Engagement If we do not improve how colleagues experience working across the Group – feeling listened to, respected, recognised and safe to speak up, then engagement, attendance and retention will deteriorate, and we will not embed the cultural change the Transforming Care Together strategy requires, resulting in poorer patient care and experience, higher sickness absence and temporary staffing costs, loss of talent, and failure to deliver our 2026/27 priority for colleagues to feel cared about.			
Risk Tolerance:	(L) 5 x (C) 4 = 20	Risk Appetite:	(3) Cautious: <i>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.</i>		
Risk Owner:		Board Committee:	Linked Risks:	Trajectory:	
Group Chief People, Culture and Improvement Officer		People Committee	Workforce sustainability; safe staffing; culture and leadership		
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>	
July 2026	(L) 4 x (C) 4 = 16	(L) 3 x (C) 4 = 12		(L) 2 x (C) 4 = 8	
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027
	(L) 3 x (C) 4 = 12	(L) 3 x (C) 4 = 12			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration
- TCT strategy and three annual priorities launched and communicated to all 15,000 colleagues - Leadership visibility programme – go-and-see visits, listening events and Team Brief - One-to-ones, appraisals (PDRs) and development plans in place for every colleague - Sickness absence reduction plan - Developing the Freedom to Speak Up arrangements - Flexible working policies and team-level local plans informed by staff survey data - Introduction of an Improvement System, supported by a People, OD, Leadership and Education offer, - Staff engagement strategy		- Staff survey and pulse survey results reported to People Committee and Board - Workforce metrics in the Integrated Performance Report – sickness absence, 12-month retention, PDR compliance, temporary workforce use - Freedom to Speak Up Guardian reports to Board; patient and staff stories - TCT strategy monitoring dashboard tracking Priority 1 measures - Cultural heatmap used to provide rounded assessment of team performance	- Variation in the quality of appraisal and one-to-one conversations between teams - Line manager capability in coaching-style leadership still developing - Approach to managing long-term sickness not yet embedded - Improvement system not integrated across local team working - Separate provision across Improvement, OD and leadership development teams - Approach to staff engagement not yet fully developed	- Staff survey indicates some colleagues feel disengaged and excluded from decisions that affect them - Sickness absence and temporary workforce use above plan in some areas - Lack of confidence in raising concerns - High number of employee relations investigations - Lack of alignment between teams receiving support and those flagging on the cultural heatmap	- Review the 2026/27 staff experience improvement trajectory and monitor quarterly - Consider targeted support for teams with the poorest survey results and flagging on the cultural heatmap

Strategic Aim & Objective Transforming Care Together 2026–2031		Risk Title: GBR TCT2 – Timely and Safe Access to Care				
Strategic Objective 2: We want to improve safety by reducing the time patients wait		If demand for urgent, planned and community services continues to exceed capacity and we do not redesign pathways and align resources to demand, then patients will continue to wait longer than national standards and our own expectations across urgent, elective, cancer and community services, resulting in avoidable harm and deterioration, poorer outcomes and experience, breaches of constitutional standards, increased regulatory scrutiny and reputational damage.				
Risk Tolerance:	(L) 3 x (C) 4 = 12	Risk Appetite:	(3) Cautious: <i>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.</i>			
Risk Owner: Managing Directors		Board Committee: Finance & Productivity Committee		Linked Risks: Urgent and emergency care flow; elective recovery; cancer performance; community waits		Trajectory: 
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>		
July 2026	(L) 4 x (C) 5 = 20	(L) 4 x (C) 4 = 16		(L) 3 x (C) 4 = 12		
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027	
	(L) 4 x (C) 4 = 16	(L) 4 x (C) 4 = 16				
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>		Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>		Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>
- Urgent and emergency care improvement plans – SDEC, discharge lounge and ambulance handover actions - Elective recovery programme – theatre and outpatient utilisation, validation and booking improvements - Single points of access and GIRFT pathway redesign in high-volume specialties - Community waiting list management with 18-week and 52-week trajectories - Clinical Services Roadmap (CSRII) aligning capacity and services across both Trusts - Daily operational oversight through site management and escalation frameworks		- Integrated Performance Report to Board – ED 4-hour and 12-hour waits, ambulance handover, RTT, cancer 62-day, length of stay and community waits - Harm reviews for long-waiting patients reported to Quality Committee - NHSE oversight and tiering meetings - GIRFT and benchmarking reviews of pathway performance		- Capacity and demand misalignment in some specialties - Discharge delays dependent on system partner capacity - Data quality in community waiting lists		- Performance below trajectory in some specialties, with 12-hour ED waits continuing - Long community waits, including children and young people's services
Review and acknowledge the current risk and controls.						

Strategic Aim & Objective Transforming Care Together 2026–2031		Risk Title: GBR TCT3 – Financial Sustainability and Efficient Use of Resources				
Strategic Objective 3: We want to deliver our services efficiently		If we do not deliver the 2026/27 cost improvement programme of £81m (6.4%) and transform how services are delivered while national deficit support funding (£60m) reduces each year, then the Group will not live within its c.£1.5bn resource envelope, resulting in an unsustainable financial position, reduced ability to invest in services, colleagues and estate, increased regulatory intervention and an adverse impact on the CQC well-led assessment.				
Risk Tolerance:	(L) 4 x (C) 5 = 20	Risk Appetite:	(3) Cautious: <i>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</i>			
Risk Owner:		Board Committee:		Linked Risks:		Trajectory: 
Group Chief Finance Officer		Finance & Productivity Committee		CIP delivery; temp workforce; capital & estates; digital transformation		
Opened Date:	Initial Score: <i>with no controls applied</i>		Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>	
July 2026	(L) 4 x (C) 5 = 20		(L) 3 x (C) 5 = 15		(L) 2 x (C) 5 = 10	
April 2026	June 2026		August 2026	October 2026	December 2026	February 2027
	(L) 3 x (C) 5 = 15		(L) 3 x (C) 5 = 15			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>		Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration
- Financial delivery plans agreed for each Trust, division and corporate area - CIP governance with PMO oversight and delivery tracking of the £81m programme - Financial recovery and CIP plan presented to Trust board 21 July 2026 with actions - TCT strategy with underpinning Clinical Roadmap, Estates and Digital Transformation plans - Benchmarking through Model Hospital and GIRFT to identify efficiency opportunities - Grip and control measures including temporary workforce reduction and procurement controls - Budget-holder training and improved financial information to support decision making		- Monthly finance report to Finance & Performance Committee and Board – position against plan, CIP delivery and run rate - Model Hospital productivity metrics and activity versus plan in the Integrated Performance Report - Internal and external audit reviews - NHSE oversight of the financial plan and deficit support conditions - Site BAFs related to finance - CIP plans by site		- Transformation capacity alongside operational delivery pressures - Efficiency schemes dependent on digital and estates enablers	- Reliance on non-recurrent measures in prior-year delivery - Run rate above plan in some divisions, with temporary workforce spend above target	- Review the CIP pipeline and monitor recurrent delivery monthly - Review prioritisation of investment against the strategic delivery plans - Review the plan to exit national deficit support funding - Approve the controls / assurance in particular the recovery and CIP plan.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 3: Financial Sustainability and Efficient Use of Resources		Risk Title: RWT SR15 – Future funding flows for the Trust If the future funding flows for the Trust are insufficient to fund the levels of service and activity undertaken then the Trust will be in an increasing underlying deficit position resulting in significant financial challenge to viability with system pressures, external inspection, and potential adverse reputational impact.			
Risk Tolerance	(L) 4 x (C) 5=20	Risk Appetite	(3) Cautious: 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.		
Risk Owner:		Board Committee:		Linked Risks	Score History <i>Movement from last period</i> 
Kevin Stringer, Group Chief Financial Officer		Finance and Productivity		5751	
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>	
November 2021	(L) 5 x (C) 4 = 20	(L) 5 x (C) 4 = 20		(L) 2 x (C) 4 =8	
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027
(L) 5 x (C) 4 = 20	(L) 5 x (C) 4 = 20	(L) 5 x (C) 4 = 20			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration
- Group Chief Finance Officer provides detailed monthly reports to F&P and each Board on the financial position and predicted year end out-turn - Meeting with Black Country ICS leaders to manage the position and discuss proposals - Black Country ICB - GCEO or Group Chief Strategy Officer attends monthly meetings. - Monthly meetings with Staffordshire ICB to discuss ICP progression and implications - ODoF attends Staffordshire and Black Country ICS work streams providing a report as and when appropriate. - The Group Chief Financial Officer provides a monthly verbal progress update at the Group Finance & Performance Committee Meeting regarding financial performance - Internal controls mechanisms in place - Use of Resources programme (Efficiency) in place, led by GCEO continues to meet monthly with outputs reported to F&P. - Executive Led Divisional Performance reviews in operation, including monthly financial recovery review. - Capital Review Group in operation regarding capital spend and shortfall, impact, and consequences. - A discretionary spend panel is in place and operating.		- Reported via GF&PC, Board and external submission - CQC FTSU meetings - TMC - GMC - NHSE - Vacancy Panels - PRM	- The efficiency programme is underdelivering and causing pressure in delivering the outturn position and the underlying deficit. - Financial awareness across the Trust requires improvement for required impact and discipline.	- CIP efficiency programme contains a significant level of high risk schemes which have yet to begin delivery. - Future long term financial plans suggest a gap in the balanced underlying financial position.	For committee to agree score and content.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 1: We want our colleagues to feel cared about		Risk Title: RWT SR17 – EDI If Equality Diversity and Inclusion indicators are not improved and considerations and actions are insufficiently embedded across the whole organisation then staff and patient experience improvements may not be realised resulting in inequalities in terms of health outcomes, sub-optimal attraction, retention, and engagement of staff from diverse backgrounds and damage to the Trust reputation in the community.							
Risk Tolerance	(L) 5 x (C) 4=20	Risk Appetite	(3) Cautious: 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.						
Risk Owner: Claire Radley, Group Chief People, Culture and Improvement Officer			Board Committee: People Committee		Linked Risks		Score History <i>Movement from last period</i> 		
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>					
Sept 2022	(L) 4 x (C) 4 = 16	(L) 4 x (C) 4 = 16		(L) 3 x (C) 4 =12					
April 2026		June 2026		August 2026		October 2026		December 2026	February 2027
(L) 4 x (C) 4 = 16		(L) 4 x (C) 4 = 16		(L) 4 x (C) 4 = 16					
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>		Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>		Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>		Actions for Committee Consideration	
• Joint EDI Steering Group in place (review of governance structure underway) • Annual Equality Report and Equality Delivery Plan in place shows improvements in WRES data regarding harassment, bullying and abuse. • Six High-Impact Actions on recruitment in place. • Active employee voice groups covering a range of protected characteristics and other demographic factors (BAME, LGBTQ+, Carers', Disability and Long-Term Conditions, Male Nurses, Armed Forces) reported • EDI Delivery Plan in place (WRES WDES annual data) • Staff Survey result for the proportion of staff who say their employer has made reasonable adjustments • Staff Survey • Cultural heatmap plans • Executive and senior management advocacy • The relative likelihood score of non-disabled person being appointed from shortlisting compared to disabled staff • Disability indicators monitored for reporting pressure to return to work when sick. • Disability indicators monitored for the perception from disabled staff that the Trust values their work. • The relative likelihood score of white staff accessing non-mandatory training and continuing professional development (CPD) compared to ethnically diverse staff shown here as BAME • EDI Scorecard in place for Race.		• Report to TMC and GPC. • Joint EDI Steering Group, GPC & Trust Board report. • Group BAF related to culture		• WRES data shows an increase in BAME staff experiencing discrimination from managers. 2024 - White staff: 7.6%, BAME: 17.47% • WRES data shows difference in staff experience metrics between White and BAME staff		• Lack of consistent metrics across equality groups (including protected characteristics) • Staff Survey • WRES WDES data and annual report		• For committee to agree score and controls.	

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 3: We want to deliver our services efficiently		Risk Title: RWT SR 18 – Cyber If the Trust suffers a successful cyber-attack via any one of a number of access points and vulnerabilities, then there is the potential denial of access (Ransomware) and/or compromise of data (copying/data breach) resulting in a data breach, denial of access to critical systems and impact on access to patient information and clinical care systems with consequential denial of care, potential harm and/or delay in patient care with reputational loss, financial risk of fines from the Data Commissioner.						
Risk Tolerance	(L) 2 x (C) 5 =10	Risk Appetite	(4) Open: 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					
Risk Owner:		Board Committee:		Linked Risks		Score History <i>Movement from last period</i> 		
Kevin Stringer, Group Chief Financial Officer		Finance and Productivity						
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>				
Dec 2022	(L) 3 x (C) 5 = 15	(L) 2 x (C) 5 = 10		(L) 1 x (C) 5 = 5				
April 2026		June 2026		August 2026		October 2026	December 2026	February 2027
(L) 2 x (C) 5 = 10		(L) 2 x (C) 5 = 10		(L) 2 x (C) 5 = 10				
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>		Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>		Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>		Actions for Committee Consideration
• Data Security & Protection Toolkit (DSPT) Submission • External cyber audit by NHS Digital approved specialists • Monthly cyber status report through divisional governance. Half yearly cyber audit committee report. • Quarterly external penetration testing (DSPT related) • Appropriate cyber team/skills in place • Cyber awareness mandatory training with regular testing and communications campaign • Privileged access supplier management process.		• Reported Report via IGSG, Board and external submission • Reported to Execs • Report to Divisional Governance, Audit Committee & NHS Digital • Report to SIRO		• Privileged access supplier management process is a manual system with limited audit trail functionality.				• For committee to agree score and content.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 2: We want to improve safety by reducing the time patients wait		Risk Title: RWT SR19 – Meeting or exceeding constitutional standards If the Trusts in the Group are individually and/or 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						
Risk Tolerance	(L) 3 x (C) 5=15	Risk Appetite		(4) Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward				
Risk Owner:		Board Committee:		Linked Risks		Score History <i>Movement from last period</i> 		
Gwen Nuttall, Managing Director		Finance and Productivity		85, 144, 226, 227, 231				
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>				
April 2025	(L) 4 x (C) 4 = 16	(L) 3 x (C) 4 = 12		(L) 1 x (C) 4 = 4				
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027			
(L) 3 x (C) 4 = 12	(L) 3 x (C) 4 = 12	(L) 3 x (C) 4 = 12						
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>		Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>		Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>		Actions for Committee Consideration
- IQPR pack to F&PC monthly reporting compliance against trajectories agreed as part of organisations planning return. Further discussion at GMC monthly and triangulation with Quality Committee also monthly. - Routine corporate assurance meetings in place across both Trusts with escalation meetings on an extraordinary basis according to need, e.g. CEO meeting at RWT on RTT and UEC - Corporate meetings above are underpinned by governance structure at Divisional and Directorate level. - Participation in planned care and UEC sprints, insourcing capacity in place for RTT delivery. - Monthly assurance meetings in place to oversee CQC and GIRFT UEC action plans with Division 2 and monthly with Division 2 and Emergency Services Directorate Team - Weekly Divisional assurance meeting in place for RTT and Cancer within Division 1 - Weekly Flash Reports shared with Executives and Lead - Increasing joint working opportunities with WHT in the immediate term for challenged specialities and those within Transforming Care Together and longer term as part of the Group's Clinical Services Strategy - Operational Delivery Group for community first in place.		- RWT is not tiered for UEC - IQPR pack to F&P and Trust Board. - RWT in segment 3 of the National Oversight Framework for access to services - Performance Review quarterly with NHSE/ICB - Membership of Black Country System meetings monthly for Cancer, RTT and UEC – - Harm review process in place for patients with extended access time (over 104 days) for cancer treatment - Community First Programme Board overseeing transformation progress		- Elective community waiting times have not historically been a national priority. Community Paediatric waits require system wide transformation. Monthly improvement trajectories are in place in the immediate term. - Updated Demand and Capacity modelling in development for elective care across all specialties with support from NHSE for 4 most challenged		- 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 - Clear impact of EPR implementation at RWT impacting on activity recording - ED length of stay over 12hours particularly for patients being admitted - Ambulance handover delays over 45 minutes, performance dashboards and flash reports.		For committee to agree score and content.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 3: We want to deliver our services efficiently		Risk Title: WHT NSR 101 – Cyber If the Trust suffers a successful cyber-attack via any one of a number of access points and vulnerabilities, then there is the potential denial of access (Ransomware) and/or compromise of data (copying/data breach) resulting in a data breach, denial of access to critical systems and impact on access to patient information and clinical care systems with consequential denial of care, potential harm and/or delay in patient care with reputational loss, financial risk of fines from the Data Commissioner.			
Risk Tolerance	(L) 2 x (C) 5 = 10	Risk Appetite	(4) Open: 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		
Risk Owner:		Board Committee:		Linked Risks	Score History <i>Movement from last period</i> 
Kevin Stringer, Group Chief Financial Officer		Finance and Productivity		426	
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>	
Dec 2022	(L) 3 x (C) 5 = 15	(L) 2 x (C) 5 = 10		(L) 1 x (C) 5 = 5	
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027
(L) 2 x (C) 5 = 10	(L) 2 x (C) 5 = 10	(L) 2 x (C) 5 = 10			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration
- Data Security & Protection Toolkit (DSPT) Submission - External cyber audit by NHS Digital approved specialists - Monthly cyber status report through divisional governance. Half yearly cyber audit committee report. - Quarterly external penetration testing (DSPT related) - Appropriate cyber team/skills in place - Cyber awareness mandatory training with regular testing and communications campaign - Privileged access supplier management process.		- Reported Report via IGSG, Board and external submission - Reported to Execs - Report to Divisional Governance, Audit Committee & NHS Digital - Report to SIRO	Privileged access supplier management process is a manual system with limited audit trail functionality.		For committee to agree score and content.

Strategic Aim & Objective		Risk Title: WHT NSR 102 – Culture				
Transforming Care Together 2026–2031		If the Trust is unable to implement a positive culture of inclusion, innovation, behaviour change (at all levels), radical, and continuous improvement, then the culture and leadership will be unable to address critical workforce gaps, improve services and provide value for money, resulting in staffing gaps in critical areas, poor staff morale, managers and leaders who are unable to practice compassionate and inclusive leadership, leading to a negative impact on patient care, reputational damage, increased costs, and poor-quality services.				
Strategic Objective 1: We want our colleagues to feel cared about						
Risk Tolerance	(L) 5 x (C) 4 = 20	Risk Appetite	(3) Cautious: 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			
Risk Owner:		Board Committee:		Linked Risks	Score History <i>Movement from last period</i> 	
Claire Radley, Group Chief People, Culture and Improvement Officer		People Committee		2489, 3487		
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>	Target Score: <i>after actions are completed</i>			
Jan 2023	(L) 4 x (C) 4 = 16	(L) 3 x (C) 4 = 12	(L) 2 x (C) 4 = 8			
April 2026		June 2026	August 2026	October 2026	December 2026	February 2027
(L) 3 x (C) 4 = 12		(L) 3 x (C) 4 = 12	(L) 3 x (C) 4 = 12			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration	
• Deloitte Well-led review (Dec 2022), • CQC Well-led Review (Dec 2022) • Board Self-assessment Evaluation (Dec 2022) • Staff Survey (Feb 2024) • Staff Networks • Enhanced HWB offer including additional financial wellbeing support via pension support services and financial support services • Freedom to Speak Up Guardian Service and networks in place. • Employment relations activity is reported on a regular basis • Junior colleagues in supporting role with senior support for EDI strategic leadership • Behaviour framework supported to manage high performance - Joint Behaviour framework co-designed and launched enabled by robust management of misconduct and poor performance • Behaviours not consistent with the Trust Values - Delivery of civility & respect programme following proactive Resolution of Dispute resolution Framework • People Plan required to support Joint Trust Strategy - Co-design and launch People Plan with defined actions		• Reported Report via GPC, Board and external submission • CQC FTSU meetings • TMC • GMC	• Deloitte Well-led review (Dec 2022), • CQC Well-led Review (Dec 2022) • Board Self-assessment Evaluation (Dec 2022) • Succession Planning (including talent mapping) • Lack of consistent leadership capacity and capability. • Sickness Absence level continues to remain higher than NHS average. WHT Feb 26 SA level was 7.07% with a declining trend. • Staff survey indicates low levels of advocacy (reinforced by results of latest Pulse survey). • Instances of sexual misconduct and sexual harassment in the workplace have been reported.	• Reasons for low engagement being explored, heat map analysis of cultural data awaited as part of Staff Survey Results.	• For committee to agree score and content.	

Strategic Aim & Objective		Risk Title: WHT NSR 103 – Staffing				
Transforming Care Together 2026–2031		If there is a failure to attract, recruit, and retain staff, and offer improved positive action on health and wellbeing, EDI, workplace culture, and leadership at all levels then there is the risk of critical workforce gaps, including key clinical and support areas resulting in workforce exhaustion and burn-out, poor staff morale, inability of managers and/or leaders practicing compassionate and inclusive leadership behaviours with the negative impact on patient care, staff morale and organisational reputation.				
Risk Tolerance	(L) 5 x (C) 4 = 20	Risk Appetite	(3) Cautious: 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			
Risk Owner:			Board Committee:	Linked Risks	Score History <i>Movement from last period</i> 	
Claire Radley, Group Chief People, Culture and Improvement Officer			People Committee	2489, 3043, 3487,2926		
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>	Target Score: <i>after actions are completed</i>			
Jan 2023	(L) 4 x (C) 3 = 12	(L) 3 x (C) 3 = 9	(L) 3 x (C) 3 = 9			
April 2026		June 2026	August 2026	October 2026	December 2026	February 2027
(L) 3 x (C) 3 = 9		(L) 3 x (C) 3 = 9	(L) 3 x (C) 3 = 9			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>		Actions for Committee Consideration
- Local workforce plan in place 24/25 - Implementation of collaborative staff bank (medics) - Anchor employer model within local community - Participation in the annual NHS Staff Survey and national quarterly pulse survey - Performance against Workforce Equality and Workforce Disability Standards (WRES/WDES). - EDI Delivery Plan in place (see NSR102 GC11) now under review - HWB Framework in place - Development of leadership capability and capacity (see also NSR 102) - Comprehensive weekly reporting and monitoring consolidation visible to senior manager and Board - Financial Recovery Group and Divisional Performance Reviews have enhanced the governance framework surrounding performance against the 24/25 workforce plan - The Trust is part of NHSE National retention programme (cohort 2) and have completed the required diagnostic to identify high impact actions. - Sickness Absence reduction plan in place, attendance policy in place and training for managers provided.		- Reported Report via GPC, Board and external submission - CQC FTSU meetings - TMC - GMC - NHSE	- Any future investment cases for growth of workforce may lead to inability to fund gaps in resources. - Optimising use of apprenticeship funds to support H&SC sector and current staff. - Retention programme high impact actions identified for: flexible working, 'we are always learning', compassionate and inclusive	Scale of financial challenge and impact on long term workforce plan and retention		For committee to agree score and content.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 2: We want to improve safety by reducing the time patients wait		Risk Title: WHT NSR 104 – Patient Safety If there is a failure to maintain consistent standards of patient safety and quality of care then there is the risk of increased incidence of harm resulting in potential regulatory investigation and action, negative impact on the Trust reputation, and adverse impact on recruitment and safety.			
Risk Tolerance	(L) 3 x (C) 4 = 12	Risk Appetite	(3) Cautious: 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.		
Risk Owner:		Board Committee:		Linked Risks	Score History <i>Movement from last period</i> 
Lisa Carroll, Chief Nursing Officer		Quality		25, 208,1528,2163,2325,3002, 3061, 3391, 3435, 2066, 3466, 3536	
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>	
Jan 2023	(L) 3 x (C) 3 = 9	(L) 3 x (C) 3 = 9		(L) 2 x (C) 3 = 6	
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027
(L) 3 x (C) 3 = 9	(L) 3 x (C) 3 = 9	(L) 3 x (C) 3 = 9			
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration
- Maternity action plan – to address recruitment of midwives (see risk 2245). The associated risk has been downgraded as it is controlled. - Safeguarding action plan including process improvements, training compliance improvements and more consistent implantation of mental capacity act/deprivation of liberty safeguards (see risk 2540). The action plan has become a wider safeguarding development plan which is reported to Safeguarding group monthly and includes responses to any new guidance and planned service developments - Action plan in place to respond to increased levels of young people with significant mental health needs and a lack of accessible specialist placements nationally. - Action plan in place to address health inequalities in care for people with a learning disability (see risk 3061) reported quarterly to safeguarding group - Action plan in place to address issues raised regarding medicines management by the CQC (see risk 2737). - Infection prevention and control Board Assurance Framework in place. Updated for 2024/25 and aligned with RWT - Rapid tranquilisation policy and procedure in relation to young people. - Levels of required staff E-Learning training regarding prescription and administration of medicines monitored. - Datix cloud IQ – has completed embedding and reporting – ongoing training programmes are in place and system is fully operational		- Reported at QSOG to GQC. - Reported to GQC and up to Board and external submission - CQC FTSU meetings - TMC - GMC - NHSE - Safeguarding reports - Quality reports - Medicines Management reports	- Paediatric CAMHS action plan highlights gaps in specialist mental health staffing to support paediatric staff in dealing with young people in crisis. - Paediatric CAMHS action plan highlights gap regarding lack of access to appropriate section 136 suite and/or crisis bed at Walsall Manor Hospital and/or tier 4 admissions. - Compliance with learning disability & autism training below required levels. - Levels of mental health support Core 24/7 are variable and inconsistent. - Medical records and loose filing tracking and retrieval processes not being implemented resulting in gaps in records, multiple records, and multiple Incident reports.	Extent of disadvantage of patients with a Learning Disability is unknown at present.	For committee to agree score and content.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 3: We want to deliver our services efficiently		Risk Title: WHT NSR 105 – Finance Resources If the future funding flows for the Trust are insufficient to fund the levels of service and activity undertaken then the Trust will be in an increasing underlying deficit position resulting in significant financial challenge to viability with system pressures, external inspection, and potential adverse reputational impact.			
Risk Tolerance	(L) 4 x (C) 5 = 20	Risk Appetite	(3) Cautious: 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.		
Risk Owner:		Board Committee:		Linked Risks	Score History <i>Movement from last period</i> 
Kevin Stringer, Group Chief Financial Officer		Finance & Productivity		1005, 2081, 2082, 3435	
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>	
Jan 2023	(L) 5 x (C) 4 = 20	(L) 5 x (C) 4 = 20		(L) 2 x (C) 4 = 8	
April 2026		June 2026	August 2026	October 2026	December 2026
(L) 5 x (C) 4 = 20		(L) 5 x (C) 4 = 20	(L) 5 x (C) 4 = 20		
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>	Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>	Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>	Actions for Committee Consideration
- Group Chief Finance Officer provides detailed monthly reports to F&P and each Board on the financial position and predicted year end out-turn - Meetings with Black Country ICS leaders to manage the position and discuss proposals - Black Country ICB - CEO or GCSO attends monthly meetings. - PRM meeting with NHSE - - The Group Chief Financial Officer provides a monthly verbal progress update at the Group Finance & Performance Committee Meeting regarding financial performance. - Internal controls mechanisms in place including Executive vacancy process. - Use of Resources programme (Efficiency) in place, led by GCEO continues to meet monthly with outputs reported to F&P. - Executive Led Divisional Performance reviews in operation, including monthly financial recovery review. - Capital Review Group in operation regarding capital spend and shortfall, impact, and consequences. - A discretionary spend panel is in place and operating.		- Reported via GF&PC, Board and external submission - CQC FTSU meetings - TMC - GMC - NHSE - Vacancy Panels - PRM	- The efficiency programme is underdelivering and causing pressure in delivering the outturn position and the underlying deficit. - Financial awareness across the Trust requires improvement for required impact and discipline.	- CIP efficiency programme contains a significant level of high risk schemes which have yet to begin delivery. - Future long term financial plans suggest a gap in the balanced underlying financial position.	For committee to agree score and content.

Strategic Aim & Objective		Risk Title: WHT NSR 106 – EDI					
Transforming Care Together 2026–2031		If staff, patients and population health related Equality, Diversity, and Inclusion indicators do not improve, and actions to provide equity are insufficient then staff, patient and population health provision and experience may not be improved					
Strategic Objective 1: We want our colleagues to feel cared about		resulting in inequalities in health outcomes, sub-optimal attraction, retention, and engagement of staff from diverse backgrounds and damage to the Trust reputation in the community.					
Risk Tolerance	(L) 5 x (C) 4 = 20	Risk Appetite	(3) Cautious: 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				
Risk Owner:		Board Committee:		Linked Risks	Score History Movement from last period		
Claire Radley, Group Chief People, Culture and Improvement Officer		People		2489, 3487			
Opened Date:	Initial Score: with no controls applied	Current Score: with controls in place		Target Score: after actions are completed			
Jan 2023	(L) 4 x (C) 4 = 16	(L) 4 x (C) 4 = 16		(L) 3 x (C) 4 = 12			
April 2026		June 2026		August 2026	October 2026	December 2026	February 2027
(L) 4 x (C) 4 = 16		(L) 4 x (C) 4 = 16		(L) 4 x (C) 4 = 16			
Controls What are we doing to manage the risk?		Assurances How do we know it's working?		Gaps in Controls Are there any missing, weak, or ineffective risk controls?		Negative Assurances Evidence suggesting the controls may NOT be working effectively	Actions for Committee Consideration
- Group EDI Steering Forum will be in place - Annual Equality Report and Equality Delivery Plan in place shows third of staff reflect local population & improvements in WRES data regarding disciplinary, harassment, bullying and abuse. Staff survey indicates decline of experience – response plans under development. - Active employee voice groups covering a range of protected characteristics and other demographic factors (BAME, LGBTQ+, Carers', Women and Allies Network, Neurodiversity) - EDI Delivery Plan being renewed in consideration with local, regional, and national plans. - Staff Survey indicates decline of proportion of staff who say the employer has made adequate adjustments. - Disabled staff are more likely to be appointed from shortlisting than non-disabled staff. - Trust achieved re-accreditation of Race Equality Code in September 2025. - Deloitte Well-led review (Dec 2022), - CQC Well-led Review (Dec 2022) - Civility and Respect Programme in place - All Chief Officers / Executive Directors and Non-Executive Directors have an EDI objective related to latest appraisal. - Joint People Enabling Strategy in place, focuses on four joint people ambitions one of which is “ensuring equality, diversity and inclusion in everything we do”. - Anti-Racism e-learning modules have been made available for all staff to complete. - EDI dashboard has been developed with Joint EDIG and published via intranet are in place and system is fully operational		- Reported Report via GPC, Board and external submission - CQC FTSU meetings - TMC - GMC - NHSE - EDI Steering Group - Deloitte Well Led Review (2022)		2025 WRES indicator 6 improvement from 29.11% in 2024 to 26.60% of BAME colleagues advising they have experienced harassment, bullying or abuse from other staff compared to 20.90% of White staff, this is higher than the national average of 24.06% of BAME staff in 2025 - WRES data shows decline in BAME colleagues believing in equal opportunities for career progression and promotion (from 48.15% in 2024 to 44.60% in 2025 against 25 national average of 49.11%) 2025 WRES data shows a deterioration in this indicator with white staff being 1.91 more likely to access non-mandatory training than BAME staff.(deterioration from 1.58 in 2024) - In January 2025 BAME staff representation at Band 7 and Band 8a 27.2 % (increase from 26.3% in April 2024). Overall BAME representation across the Trust has increased from 37% in April 2023 to 39% in January 25. - WDES metrics show disabled staff are significantly more likely to enter a formal capability process than non-disabled staff. - Colleagues from a BAME background are more likely to report experiencing discrimination from staff in the last 12 month, Decrease from 19.2% in 2023 to 17.1% in 2024 - Gender pay gap reporting shows that at WHCT there is an overall pay gap of 29.46% between male and female employees. The mean bonus pay between male and female employees is 13% at Walsall compared to a mean gender pay gap of 14.7% across the NHS (2022 data as at 31 March 2023) - Anti-racism e-learning training available for all staff as core to role. - Develop ethnicity pay gap report		.	For committee to agree score and content.

Strategic Aim & Objective Transforming Care Together 2026–2031 Strategic Objective 2: We want to improve safety by reducing the time patients wait		Risk Title: WHT NSR 107 – Meeting or exceeding constitutional standards If the Trusts in the Group are individually and/or 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						
Risk Tolerance	(L) 3 x (C) 5=15	Risk Appetite		(4) Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward				
Risk Owner:		Board Committee:		Linked Risks		Score History <i>Movement from last period</i>		
Amelia Godson, Managing Director		Finance and Productivity		85, 144, 226, 227, 231				
Opened Date:	Initial Score: <i>with no controls applied</i>	Current Score: <i>with controls in place</i>		Target Score: <i>after actions are completed</i>				
April 2025	(L) 4 x (C) 4 = 16	(L) 3 x (C) 4 = 12		(L) 1 x (C) 4 = 4				
April 2026	June 2026	August 2026	October 2026	December 2026	February 2027			
(L) 3 x (C) 4 = 12	(L) 3 x (C) 4 = 12	(L) 3 x (C) 4 = 12						
Controls <i>What are we doing to manage the risk?</i>		Assurances <i>How do we know it's working?</i>		Gaps in Controls <i>Are there any missing, weak, or ineffective risk controls?</i>		Negative Assurances <i>Evidence suggesting the controls may NOT be working effectively</i>		Actions for Committee Consideration
• IQPR pack to F&PC monthly reporting compliance against trajectories agreed as part of organisations planning return. • Routine corporate assurance meetings in place with escalation meetings on an extraordinary basis according to need • Corporate meetings above are underpinned by governance structure at Divisional level. • Participation in planned care and UEC sprints. • Divisional performance reviews. • Data pack. • Weekly flash reports • GMC discussion monthly • Accountability framework. • CQC engagement meeting. • F&P & Quality committee – triangulation meeting • Task and finish group monthly catch up with BCT – MH response times. • Working with RWT. • Mobile scanner now in place.		• WHT is not tiered for either UEC or electives. • IQPR pack to F&P and Trust Board. • In segment 3 of the National Oversight Framework for access to services • PRM meeting quarterly. • Black Country System meeting • Harm reviews • Clinical prioritisation • Community First Programme Board		• Achieving RTT requires confirmation of sufficient ERF. (CRR) subject to income associated with activity growth • Changes in referral practices from Sandwell for emergency care increasing. • Historic issues – community waits – trajectory by month • Capacity and demand, identified capacity gaps, plan to mitigate. Invest to save. • Monitoring external SLAs re service reliability • Community waits & diagnostics.		• 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.		• For committee to accept and agree score

Tier 1 - Paper ref:	Enclosure 8.1
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Report title:	Health Inequalities Report
Sponsoring executive:	Stephanie Cartwright - Group Chief Community and Partnerships Officer
Report author:	Dr Kate Warren – Consultant in Public Health
Meeting title:	Group Trust Board in Public
Date:	15th September 2026

1. Summary of key issues/Assure, Advise, Alert
This report provides an overview of progress against the Delivery Plan for the Joint Health Inequalities Enabling Strategy, during the period February 2026 to August 2026. There are five themed areas of work; prevention, research, inclusive services, information, and leadership.

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
Group Quality Committee

4. Recommendation(s)/Action(s)
The Group Trust Board is asked to
a) Note the contents of the report for information

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 15th September 2026

Health Inequalities Report

1. Overview

This report provides an overview of progress against the Delivery Plan for the Joint Health Inequalities Enabling Strategy, during the period February 2026 to August 2026. There are five themed areas of work; prevention, research, inclusive services, information, and leadership.

2. Thematic updates

Details of actions and progress can be found in the delivery plan in the Appendix.

2.1 Prevention

Tobacco dependency teams continue to support people from the most deprived areas and the quit rates achieved are benchmarking well against the NCSCT standard. Teams are working with Public Health to access funds from the Smoke Free Generation Grant, supporting expansion into New Cross ED and Walsall Manor outpatients this year.

2.2 Research and development

Strategic developments are underway to bring more research investment into the area and ensure that participants are representative of our local populations. Targeted recruitment for the Genes and Healthy study has shown that it is possible to engage ethnic minority and deprived groups with the right approach. Place-based partners in the voluntary sector have shared findings of community-led research.

2.3 Inclusive Services

Wolverhampton is evaluating a pilot of Specialist Support Navigator posts in ED providing holistic support for social complexities, to reduce future attendance and support timelier discharge. Issues identified include homelessness, domestic abuse, safeguarding concerns, substance misuse and sex work. An evaluation is underway and we are requesting commissioners extend the service. EDI midwives report that early booking (before 10 weeks) is now consistently above the 70% target, but challenges remain around interpreting inpatient settings, and cost of travel to frequent appointments.

2.4 Information

The Information teams are supporting operational teams with dashboards that include age, sex, deprivation and ethnic group. Early discussions have taken place to ensure that digital inclusion is included in the Digital Workforce training programme. The patient experience team are building collection of demographics into future rounds of Friends and Family Test so that variation in experience can be assessed.

2.5 Leadership and governance

Development and awareness sessions have been held with Trust Board, paediatrics, and the Quality Improvement team. Public Health Consultant remit has been extended across WHT as well as RWT and both Place-based partnerships. A refresh of the Enabling Strategy will begin this year ready for launch in 2027.

Delivery Plan

Ref	Objective	Action	RWT / WHT	Deadline	Measures of Success	Progress Notes - June 2026
003	Leadership / Governance	Collaborate with RWT and WHT Communications team to showcase and promote health inequalities work to increase awareness, education and empower staff to take action within their areas	RWT / WHT	Rolling programme of work	Board engagement evaluated with the NHS Providers' self assessment tool Social media engagement Key message delivery in staff briefings	Awaiting confirmation from Comms regarding Trust brief. QI team development session held. Attended Digital Workforce Capability Programme Group to ensure digital inclusion is considered in the Digital Strategy.
010	Inclusive Services	Share the results of the maternity interpreting audits from RWT. These findings should also be shared with the EDI team as an example of good practice.	RWT	Summer 2026	Audit findings formally presented by EDI team and maternity leadership. Improvement in completeness of preferred language.	Interpreting services are used effectively in the ante-natal period but gaps were present in post-natal care and they are currently re-auditing for 2026.
014	Information	Phase 2 developments for the 0-19 dashboard include building on the patient classifications and attributes with items such as breast feeding, universal plus, special education needs, children in need.	RWT	Winter 2026	New metrics (breastfeeding, SEND, CIN, SEMH etc.) added and validated within dashboard. Increase in dashboard usage.	Information Team update on September agenda of Steering Group
015	Prevention	Place-based engagement for Health Inequalities improvement including Rough Sleeper project and Asylum seeker access to healthcare.	RWT	Ongoing	Full evaluation reports published Audit against Core20plus5 framework targets	Shared evaluation report with steering group. Discussions are underway with Public Health Commissioners and Place-based Partnership to

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Ref	Objective	Action	RWT / WHT	Deadline	Measures of Success	Progress Notes - June 2026
						shape an inclusion health offer in the city.
019	Research and Development	Work with the University of Wolverhampton to create a better local economy by creating a clinical trials unit that benefits the local community. Creating a Black Country wide research data hub to understand the inequalities. Promotion of 'bench to bedside research' within our Trusts.	RWT	Ongoing	Publication of WODEN research in peer-reviewed journal Uptake of Digital learning resources Audit of representativeness of participants annually	Working with University of Wolverhampton to open medical school. Infrastructure grant secured for Clinical Research Facility at RWT. Genes and health study opened at both Trusts with targeted outreach to Pakistani and Bangladeshi population.
022	Research and Development	Ensure workforce digital capabilities are fully integrated and addressed during the EPR implementation	RWT	Winter 2025	Digital competency framework embedded into EPR training	Proposal for Workforce training and digital champions submitted to the Digital Workforce group, included digital exclusion in competencies.
024	Research and Development	Team to identify ways to amplify the patient voice and expanding patient access to new treatments via clinical trials	RWT / WHT	Ongoing	Recruitment by deprivation and ethnicity reported	By addressing barriers to Research, WHT R&D has seen the proportion of Asian research participants go up from 6.4% in 2024/25 to 12.7% in 2025/26. No update from RWT due to staffing changes.
026	Leadership / Governance	Further embed the WHT priorities into the place health inequalities programme to avoid duplication and enhance progress	WHT	December 2024	Walsall Together Board sign off	Consultant in Public Health now attends the Walsall Together Population Health Management, Wellbeing and Inequalities Steering Group.
027	Prevention / Inclusive Services	Implement and evaluate specialist support navigators for ED	RWT	December 2026	Navigators recruited, trained, and embedded into ED. Process evaluation completed and recommendations made for commissioners.	Pilot has been running since November 2025, independent evaluation is being conducted by a Registrar in Public Health supervised by University of

Ref	Objective	Action	RWT / WHT	Deadline	Measures of Success	Progress Notes - June 2026
						Birmingham. Discussions with commissioners are underway to secure an extension.
029	Leadership / Governance	Develop the Health Inequalities Strategy for 2027–2030, outlining priorities, objectives, and measurable outcomes.	RWT / WHT	Spring 2027	Strategy approved by both Trust Boards	
030	Leadership / Governance	Find e-learning availability for WHT staff	WHT	Summer 2026	Catalogue of HI-aligned modules identified and quality-assured	
031	Prevention	Implement and evaluate RWT tobacco dependency service within ED	RWT	Summer 2027	Number of attendees seen by advisors, number of referrals into community tobacco dependency services	Commissioners working on contract.
032	Information	Health Intelligence Team to produce reports on friends and family test, DNAs and ethnicity recording to assess access and experience by age, sex, ethnicity and deprivation	RWT	Autumn 2026	Quarterly reports covering FFT, DNAs, access by protected characteristics	Friends and family test does not currently capture the required demographic information for an equity audit. Ethnicity recording has been assessed and currently community services and outpatients have low levels of completeness, with plans to improve this.
033	Leadership / Governance	Empowering teams to understand own data, review patient experience and deliver care differently	RWT / WHT	Ongoing	Documented pathway improvements addressing inequalities, inequalities referenced within corporate transformation programmes	Inequalities embedded in dashboards on both sites from September 2026. Further work required with key leads to understand how the data can be used and understood to inform action.
034	Information	Ensure digital strategy considers inequalities requirements	RWT / WHT	Ongoing	Population health data factored into developing digital architecture and governance	Health Information Team (public health analysts) now working within Information Team, arrangements to access Walsall data require further work

Ref	Objective	Action	RWT / WHT	Deadline	Measures of Success	Progress Notes - June 2026
035	Prevention	Consider improvements to screening for tobacco and alcohol in WHT	WHT	Summer 2026	Business case submitted for a standardised screening tool	Matron submitted bid for TDS on VitalPac - awaiting update.
036	Leadership / Governance	Clarification of roles and remit across ICB, Place based partnerships and the Trust	RWT / WHT	Winter 2026	Roles and responsibilities framework approved by leadership	Awaiting further clarification on ICB roles
037	Leadership / Governance	Produce the 2025–2026 Annual Report summarising key achievements, performance insights, and progress against health inequalities goals.	RWT / WHT	Autumn 2026	Report approved by Group Management Committee	Draft report to be signed off at September 2026 HI meeting and Quality Committee.
038	Leadership / Governance	Consider how inequalities can be considered as part of the Quality Improvement approach	RWT / WHT	Autumn 2026	Inequalities lens built into QI templates and training, QI team upskilled to consider inequalities, including use of data, patient and resident involvement	QI team development session held - attended QI Hustle in March 2026.
039	Research and Development	Consider how the community research would be given further exposure within WHT	WHT	Spring 2027	Research shared internally and influences service improvements	Initial reports shared with Clinical Strategy team.
040	Inclusive Services	Explore transport support options with Transport West Midlands for women with complex pregnancies	RWT / WHT	Winter 2026	Transport options assessed and viable solution identified	Meetings with TfWM held, data collection planned and an options appraisal is in development.
041	Inclusive Services	Share evaluation findings with commissioners in Walsall and Wolverhampton in relation to specialist support navigators. Consider extending this provision.	RWT / WHT	Spring 2027	Evaluation shared; decision on extending navigator provision made	Evaluation nearly finalised, to be discussed by commissioners in September to inform decisions about possible extension.

Tier 1 - Paper ref:	Enclosure 8.2
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Report title:	Transforming Care Together - Operating Model for Neighbourhood Teams
Sponsoring executives:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Report author:	Stephanie Cartwright, Group Chief Community and Partnerships Officer
Meeting title:	Group Trust Board Meeting to be held in Public
Date:	15 th September 2026

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

Advise – The Board is advised that the Operating Model for Integrated Neighbourhood Teams has now been produced and are attached for information. The operating models are co-produced across the Walsall Together and OneWolverhampton place partnerships.

Assure – The operating models are person-centred and include multidisciplinary integrated teams that bring professionals together across organisational boundaries to coordinate care for a defined population. The proposed operating model connects neighbourhood networks, Integrated Neighbourhood Teams and multidisciplinary team working, with population health management and risk stratification used to identify need, support earlier intervention and reduce inequalities. The Board can be assured that the model is being developed through the established place partnerships in Walsall and Wolverhampton. Eleven neighbourhood footprints have been confirmed across the two places, operating models are currently in discussion with all partners, and priority-cohort models are being tested.

Alert – Successful implementation will depend on agreement of cohort definitions, partner roles, clinical and operational leadership, data-sharing arrangements, risk stratification, workforce alignment and digital capability. The model will require existing resources and activity to shift progressively from reactive care towards proactive, preventative and community-based care.

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

The proposed Operating Model for Neighbourhood Teams has previously been shared with the Group Management Committee (August 2026) and the Partnerships and Transformation Committee (September 2026).

4. Recommendation(s)/Action(s)

- Note the national and local direction of travel for neighbourhood health and the role of Integrated Neighbourhood Teams as the core delivery model for proactive, coordinated care.
- Support the proposed operating models for continued development and implementation across Walsall and Wolverhampton.
- Support the next phase of work to finalise neighbourhood governance, target cohorts, workforce requirements, data and digital enablers, outcome measures and mapping existing teams to each element of the model.
- Receive further assurance on implementation progress, outcomes, risks and resource implications through the appropriate Trust and place-based governance routes.

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 on
15th September 2026**

Operating Model for Neighbourhood Teams

1. Executive Summary

Neighbourhood health is the national model for organising care around defined local populations rather than organisational boundaries. Its purpose is to support the right care, closer to home, through earlier intervention, prevention and coordinated working across general practice, community health, mental health, social care, local authorities and the voluntary, community and social enterprise sector.

An Integrated Neighbourhood Team is a person-centred, multidisciplinary team that coordinates care for a defined population. The operating models described have three connected layers: the wider neighbourhood network serving the whole population; the core Integrated Neighbourhood Team focused on people who would benefit from proactive and coordinated support; and multidisciplinary team working for individuals and families with the most complex needs. Across Walsall and Wolverhampton, eleven neighbourhood footprints have been confirmed and local models are being developed through Walsall Together and OneWolverhampton. The approach supports the strategic shift from hospital to community and from sickness to prevention. It also aligns with the Community First transformation programme by strengthening proactive care, admission avoidance, care closer to home and use of community assets. The model will be implemented through a phased, test-and-learn approach. Initial priorities include agreeing target populations and inclusion criteria, establishing shared ways of working, implementing population health management and risk stratification, and putting in place the governance, workforce, information-sharing, digital and required for sustainable delivery.

2. Neighbourhood Teams in Walsall and Wolverhampton

Neighbourhood teams organise services around local populations and communities so that professionals can act collectively rather than through separate organisational pathways.

Walsall and Wolverhampton have eleven confirmed neighbourhood footprints. In Walsall there are seven neighbourhood teams aligned to the Primary Care Network geographies. In Wolverhampton, the Primary Care Networks are not geographical, therefore teams have been formed in the North, South, East and West of the City. The teams and geographies provide the basis for aligning services, population health intelligence and community assets.

3. Operating Model for Neighbourhood Teams

The proposed model comprises three connected layers: the **Neighbourhood Network**, which is the wider ecosystem of statutory, independent, voluntary and community organisations serving the whole population; the **Integrated Neighbourhood Team**, which is the core multi-agency team accountable for a defined population; and **multidisciplinary teams**, through which professionals jointly assess, plan, deliver and review care for individuals and families with the most complex needs.

The model will use linked data, population segmentation and risk stratification to identify people at rising or elevated risk. Care will be organised around agreed cohorts, with clear referral routes, case coordination, shared care planning and access to neighbourhood and specialist services.

Core enablers of the model are:

- clinical and operational shared leadership and accountability;
- agreed neighbourhood footprints and target populations;
- workforce alignment and organisational development;
- data-sharing agreements, shared records and analytical capability;
- digital tools to support identification, coordination and evaluation;
- involvement of residents and communities;
- coordinated use of estates and community assets;
- outcome-based commissioning
- consistent measurement of quality, experience, inequalities, activity and system impact.

The next phase will involve:

- agreement on the operating model for each place following engagement with all partner organisations
- mapping of organisational teams to each layer of the model
- identification of the top 1% complex patients for each INT, moving to 3% over time

6. Operating Model Feedback from the Claire Fuller Neighbourhood Health Assessment on 31st July 2026

The ICB Cluster neighbourhood health assessment was undertaken by Dr Claire Fuller, National Director for Neighbourhood Health on 31 July 2026. The visit provided positive feedback on progress in both Walsall and Wolverhampton. Particular strengths included the Integrated Neighbourhood Team operating model, Wolverhampton's Single Point of Access for urgent and emergency care, the visual description and narrative of proposed governance for the shadow year of delegation and the breadth and success of partnership engagement.

Recommendations:

1. Note the national and local direction of travel for neighbourhood health and the role of Integrated Neighbourhood Teams as the core delivery model for proactive, co-ordinated care.
2. Support the proposed operating models as the basis for continued development and phased implementation across Walsall and Wolverhampton.
3. Support the next phase of work to finalise neighbourhood governance, target cohorts, workforce requirements, data and digital enablers, outcome measures and mapping existing teams to each layer of the model.
4. Receive further assurance on implementation progress, outcomes, risks and resource implications through the appropriate Trust and place-based governance routes.

Stephanie Cartwright

Chief Community and Partnerships Officer

September 2026

7 Neighbourhoods

4 Localities

WEST

West 1 PCN

Darlaston Family Practice
 Darlaston Health Centre (Khan & Qureshi)
 Modality Kingfisher Darlaston Practice
 New Invention Health Centre
 Stroud Practice

38,830
5 Practices



West 2 PCN

Darlaston Health Centre (Drs Ali & Syed)
 Keys Family Practice
 Lockfield Surgery
 Lockstown
 Moxley Medical Centre
 Rough Hay
 Sina Health Centre
 Willenhall Medical Centre

48,082
8 Practices

NORTH

North PCN

Birchills Health Centre
 Blakemall
 Bloxwich Medical Practice
 Harden Health Centre
 Khan Medical Practice
 Lower Farm
 Mossley and Dudley Fields
 Pinfold Medical Practice
 St Lukes Surgery
 St Mary's

56,833
10 Practices



SOUTH

South 1 PCN

Ambar Medical Centre
 Beechdale Health Centre
 Brace St (Dr Kumar)
 Brace St (Dr Mahbub)
 Brace St (Dr Sinha)
 Forrester Street
 Little London Surgery
 Pleck Health Centre
 Saddlers Health Centre

47,829
9 Practices



42,847
4 Practices

South 2 PCN

Broadway Medical Centre
 Palfrey Health Centre
 St Peter's Surgery
 Umbrella Medical

EAST

East 1 PCN

Chapel Street Surgery
 Holland Park Surgery
 New Road Medical Centre
 Parkside Medical Practice
 Pelsall Village Surgery
 St Johns Medical Centre
 Streets Corner Surgery
 Walsall Wood Health Centre

33,112
8 Practices



42,877
5 Practices

East 2 PCN

Blackwood Surgery
 Collingwood Practice
 Northgate Practice
 Portland Medical Practice
 Rushall Medical Centre

Walsall Neighbourhood Population Summary

PCN	North PCN	East 1 PCN	East 2 PCN	South 1 PCN	South 2 PCN	West 1 PCN	West 2 PCN	TOTAL
Population	56,833	33,112	42,877	47,829	42,847	38,830	48,082	310,410

Source: NHS England, Patients Registered at a GP Practice — 1 June 2026

Maps © Crown copyright and database rights 2026 Ordnance Survey AC0000811014

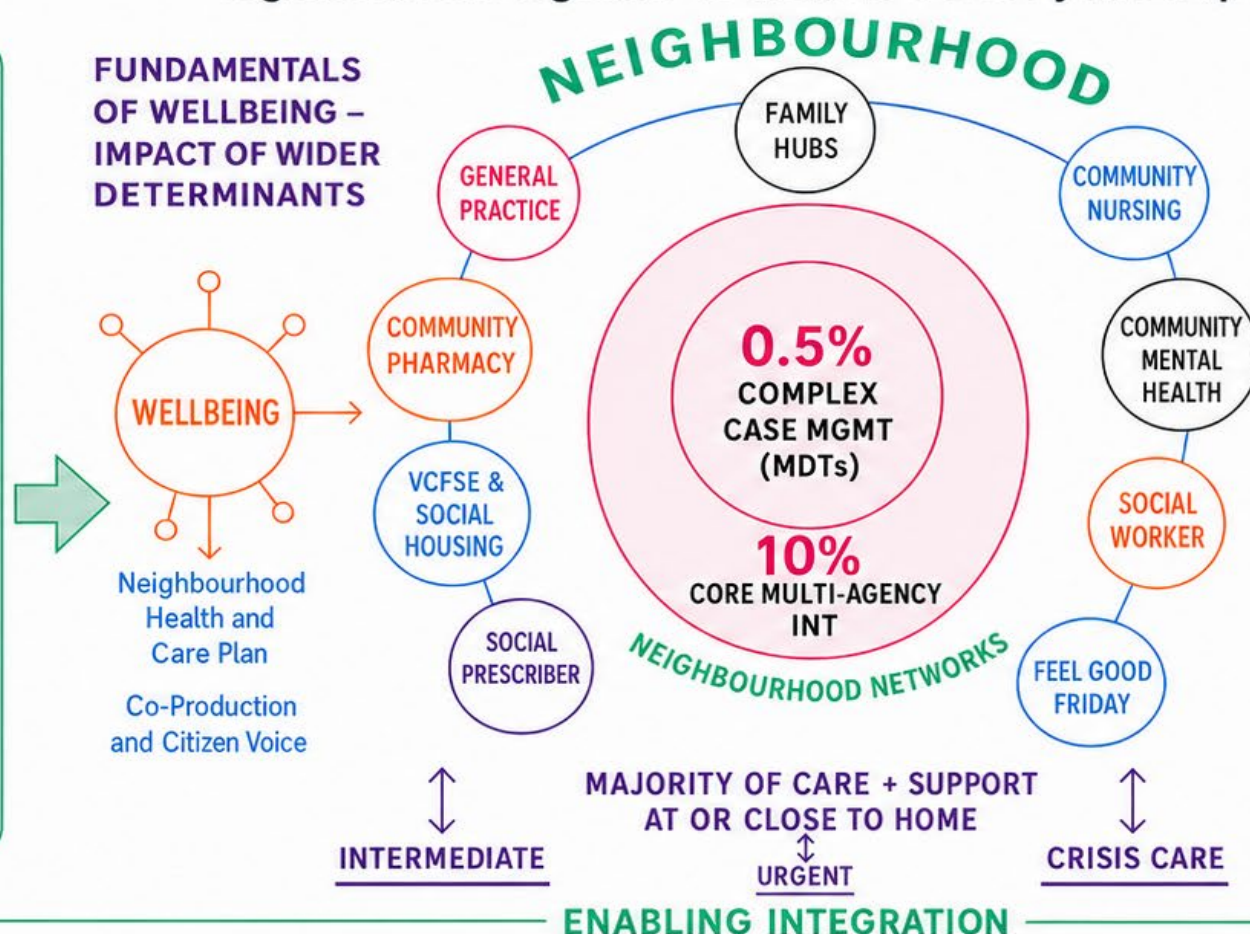
NEIGHBOURHOOD AND LOCALITY TEAMS

Brings health, care, housing, and community organisations together to work in a more joined up way.



SUPPORT is centered around individuals and families, helping them stay independent and well.

TEAMS share resources, information and expertise to develop personalised care and support, delivered at home or closer to home, improving access and reducing inequalities.



IMPACT



Improving outcomes for adults and children

Improving the access, experience and outcomes for people of all ages with complex needs and long term conditions



Accessible primary care

Making it easier for people to access GP and primary care services when and where they need them.



Proactive neighbourhood care

Delivering planned, coordinated care through neighbourhood teams, bringing together health, social care, and community services around local people.



Rapid local response

Providing timely, coordinated support in urgent situations, closer to home and avoiding unnecessary hospital use.



Empowered people and teams

Improving the experience of people who use care and support services and those who deliver them.

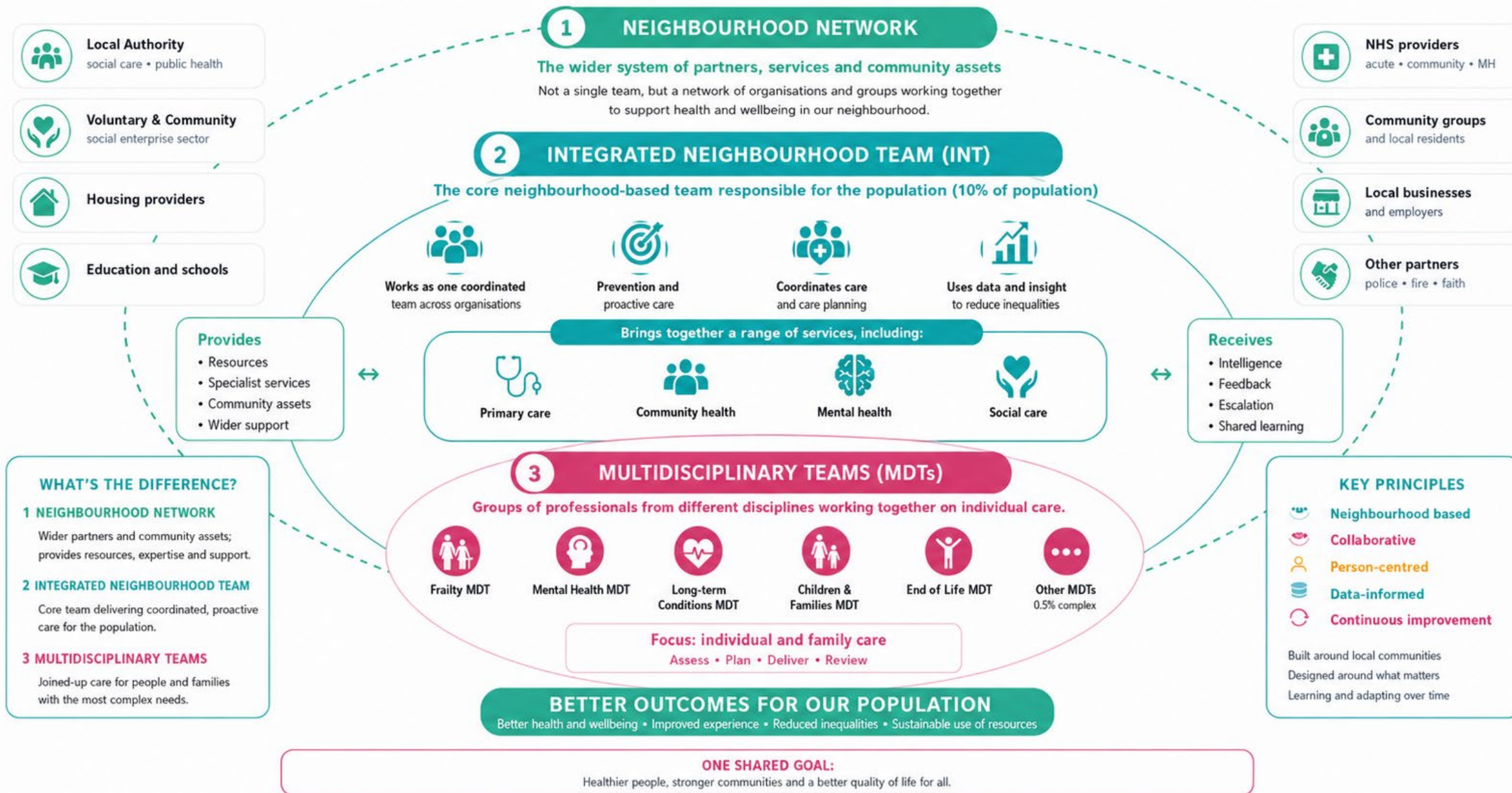


Home-first recovery

Supporting people to recover, stay well, and live independently at home for longer.

Neighbourhood Health: How it Fits Together

Three connected layers working together to improve outcomes for our local population



One Wolverhampton Locality Configuration

NORTH

Population size:
59,212

Practice name	PCN	INT 4NB
Woden Road Surgery	WNN	North
Oxley Surgery (merged with Penn Manor)	RWT	North
Probert Road Surgery	UE	North
Poplars Medical Practice	UE	North
Primrose Lane	UE	North
Prestbury Medical Practice	WNN	North
Bushbury Health Centre	WNN	North
Ashfield Road Surgery	WNN	North
Keats Grove Surgery	WNN	North
Cannock Road Medical Practice	WNN	North
MGS Medical Practice	WNN	North
MGS Medical Practice	WNN	North
Showell Park Health Centre	WNN	North
Pendeford Health Centre	WTH	North
Fordhouses Medical Centre	WTH	North
Fordhouses Medical Centre	WTH	North

WEST

Population size:
97,231

Practice name	PCN	INT 4NB
Ednam Road Surgery	WTH	West
Coalway Road Surgery	RWT	West
Lea Road Medical Practice (merged with Penn Manor)	RWT	West
Penn Manor Medical Practice	RWT	West
Warstones Health Centre (merged with Penn Manor)	RWT	West
Thornley Street Surgery	RWT	West
West Park Surgery (merged with Penn Manor)	RWT	West
The Surgery (Tettenhall Road) (merged with Penn Manor)	RWT	West
Castlecroft Medical Practice	UW	West
Penn Surgery	UW	West
Pennfields Health Centre	UW	West
Tettenhall Medical Practice	UW	West
Tettenhall Medical Practice	UW	West
Owen Road Surgery	WTH	West
Tudor Medical Centre	WTH	West
Leicester Street Medical Centre	WTH	West
Newbridge Surgery	WTH	West
Whitmore Reans Health Centre	WTH	West



EAST

Population size:
66,502

Practice name	PCN	INT 4NB
Alfred Squire Medical Centre (merged with Penn Manor)	RWT	East
Mayfield Medical Centre	UE	East
Ashmore Park Health Centre	UE	East
Griffith Drive Practice	UE	East
Wellington Road Surgery	WTH	East
East Park Medical Practice	WTH	East

SOUTH

Population size:
63,167

Practice name	PCN	INT 4NB
Health and Beyond (Caerleon Surgery)	WSEC	South
IH Medical (Bilston Health Centre)	UW	South
The Bilston Family Practice	UW	South
Bradley Health Centre	WNN	South
Health and Beyond (Bradley Medical Centre)	WSEC	South
Health and Beyond (Church Street Surgery)	WSEC	South
Bilston Health Centre	WSEC	South
Bilston Urban Village Medical Centre	WSEC	South
Health and Beyond (Hill St Surgery)	WSEC	South
Ettingshall Medical Centre	WSEC	South
Health and Beyond (Grove Medical Centre)	WSEC	South
Health and Beyond (All Saints Surgery)	WSEC	South
Health and Beyond (Parkfields Medical Centre)	WSEC	South
Health and Beyond (Woodcross Medical Centre)	WSEC	South
Duncan Street Surgery	WTH	South

Wolverhampton population Summary

	North	East	South	West	TOTAL
Population	59,212	66,502	63,167	97,231	291,112
GP Practices	16	6	15	18	54

NEIGHBOURHOOD TEAMS

Brings health, care, housing, and community organisations together to work in a more joined up way.



One Wolverhampton

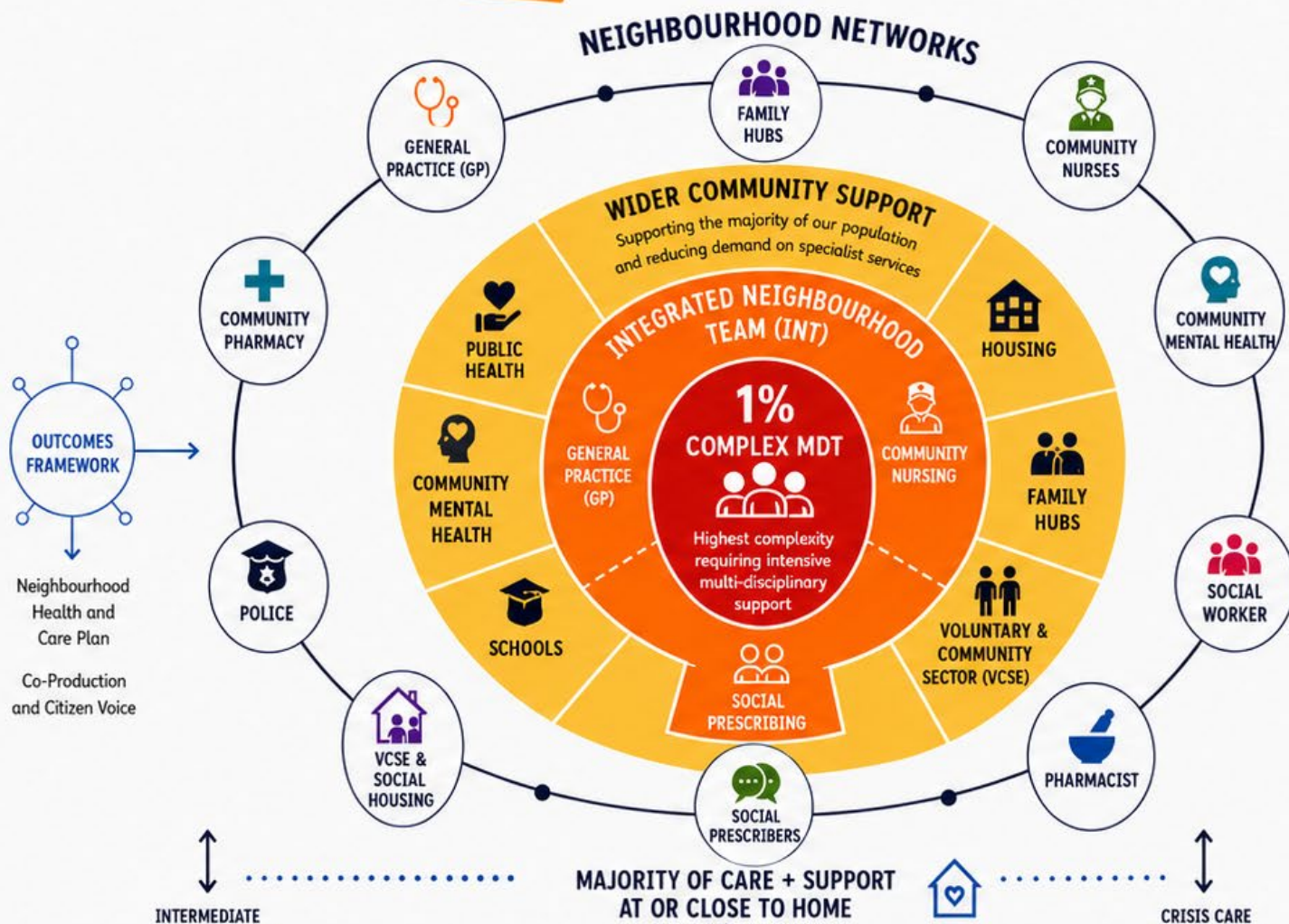
Working together for better health and care

SUPPORT

is centered around individuals and families, helping them stay independent and well.

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share resources, information and expertise to develop personalised care and support, delivered at home or closer to home, improving access and reducing inequalities.



IMPACT



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Home-first recovery

Supporting people to recover, stay well, and live independently at home for longer.

ENABLING INTEGRATION



PIVOT CURRENT RESOURCES TO NEIGHBOURHOODS

Align resources to local needs and priorities.



DATA SHARING ACROSS ALL SECTORS

Use data and insight to inform decisions and target support.



CARE COORDINATION ACROSS ALL SECTORS AT NEIGHBOURHOOD LEVEL

Joined up care and support around the person.



CARE BY CONVERSATION / NEW WAYS OF WORKING (OD)

Changing culture through collaboration, co-production and continuous improvement.

COMFORT BREAK

Tier 1 – Paper Ref:	Enclosure 10.1
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Report title:	Assurance process for perinatal services following latest national investigations into maternity and neonatal services
Sponsoring executive:	Lisa Carroll, Chief Nursing Officer; Debra Hickman, Chief Nursing Officer
Report author:	Amy Boden, Deputy Chief Nursing Officer; Tracy Palmer, Director of Midwifery and Perinatal Services; Joselle Wright, Director of Midwifery, Gynaecology and Sexual Health.
Meeting title:	Group Trust Board held in Public
Date:	September 2026

1. Summary of key issues
This report aims to provide the Trust Board with a baseline thematic analysis of current maternity and neonatal performance metrics, governance and assurance arrangements, benchmarking existing reporting against the themes emerging from the Amos and Ockenden reviews and to identify opportunities for strengthening oversight and continuous improvement. The Board is asked to note the findings of this baseline assessment and approve the proposed next steps. Given the NHS England submission deadline of 25 September 2026, which falls after the September Board meeting, the Board is also requested to delegate authority to the Group Quality Committee to provide final approval of the Maternity and Neonatal 10 Point Plan baseline assessment submission on behalf of the 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
N/A

4. Recommendation(s)
The Group Public Trust Board are asked to:
a) Are asked to note the findings of the paper and approve the next steps
b) Delegate the authority to approve the 10-point maternity and neonatal plan baseline assessment submission to Group Quality Committee

Report to the Group Trust Board Meeting - held in Public September 2026

Assurance Process for perinatal services following latest national investigations into maternity and neonatal services

1. Executive Summary

The publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust has reinforced the need for robust oversight, transparent reporting and demonstrable improvement in maternity and neonatal services across England. In response, NHS England has established a Maternity and Neonatal 10 Point Plan and associated assurance process requiring all provider boards to undertake a baseline assessment of current arrangements and provide board-level oversight of delivery: [NHS England » Maternity and Neonatal 10 Point Plan assurance process](#)

This report presents a baseline review of the Trust's existing maternity and neonatal metrics, governance arrangements and assurance processes against the key themes emerging from the national investigations and the NHS England 10 Point Plan. It aims to provide the Board with an assessment of current performance, identify areas of strength and highlight opportunities for further improvement.

The review considers measures relating to safety, clinical outcomes, patient experience, workforce, governance, incident management, audit activity and service responsiveness. It also evaluates the extent to which current metrics support the Board in obtaining assurance regarding the quality and safety of maternity and neonatal services.

This baseline assessment demonstrates that both Trusts have well-established governance, safety and assurance arrangements that are broadly aligned to the themes arising from the Amos Investigation, Ockenden Review and the NHS England Maternity and Neonatal 10 Point Plan. There is evidence of strong Quality Committee oversight and routine oversight at Board, with opportunity to strengthen this through the application of the NHSE published Model Board Report.

The findings and recommendations within this report will support the Trust's ongoing response to the national maternity and neonatal improvement programme and inform future development of the maternity and neonatal dashboard and assurance framework.

2.0. Background

In 2026, two significant national investigations into maternity and neonatal services were published:

- Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England.
- Donna Ockenden's Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust.

Both reports identified themes relating to leadership, culture, listening to women and families, patient safety, staffing, clinical governance, responsiveness to concerns and the need for stronger organisational accountability for quality and safety outcomes. The findings highlighted the importance of effective board oversight and the use of meaningful metrics to support assurance and improvement.

Following publication of these reports, NHS England introduced a Maternity and Neonatal 10 Point Plan setting out the most urgent actions required of providers while a broader national action plan is developed. NHS England has requested that trusts undertake a baseline assessment and provide board-approved assurance regarding progress against the plan. The assurance process is intended to support improvement through existing governance arrangements and minimise additional reporting burden by drawing on evidence already

available through board reports, committee papers, dashboards, audits and Maternity Incentive Scheme submissions.

The Trust following publication of both national reports commenced an undertaking of a baseline review of existing maternity and neonatal metrics and assurance arrangements. The purpose of this review is to:

- Assess the extent to which current metrics align with national expectations and emerging areas of focus.
- Evaluate whether the current dashboard provides sufficient oversight of quality, safety, experience and outcomes.
- Identify gaps in reporting, assurance or triangulation of information.
- Support Board oversight of maternity and neonatal services.
- Establish a baseline position against which future improvements can be monitored and measured.

3.0. Key Assurance Domains

The following assurance domains consist of a range of data sets across the Trusts; the narrative of themed analysis has been supported using AI with review by the report authors/ subject matter experts.

Data sets that have been included for this analysis include:

- Trust Board Integrated Performance Report- Monthly Perinatal Services Update (from Trust Board in Public papers)
- Director of Midwifery reports to Group Quality Committee
- Analysis of all patient safety incident reports in maternity and neonatal services
- All Inphase Audit reports in the last 12 months
- Freedom to Speak Up activity in maternity and neonatal services
- Staff and NETS surveys
- Analysis of patient complaints and other patient experience data (e.g. Mystery Patients narrative)
- Data packs and initial feedback from Unannounced Internal Assurance Visits (RWT)

3.1. Safety Outcomes and Clinical Quality

A thematic review of maternity and neonatal incident reporting across both Trusts demonstrates that most reported events relate to system pressures rather than isolated episodes of unsafe individual practice. This aligns with the findings of both the Amos Investigation and Ockenden Review, which identified that adverse outcomes frequently arise from interacting system factors rather than single clinical errors.

Group Incident Themes

Across both organisations, recurring themes were identified in relation to:

- Delays in assessment, review and intervention.
- Workforce and staffing pressures.
- Service capacity constraints.
- Escalation and response to deterioration.
- Communication and coordination of care.
- Pathway reliability and flow through maternity services.

Whilst serious maternity trigger events such as postpartum haemorrhage, severe perineal trauma, neonatal admissions, stillbirths and maternal critical care admissions were represented within incident reporting, many reflected expected national reporting requirements rather than evidence of failures in care.

WHT Themes

- Delays within induction of labour pathways.
- Delays in transfer to delivery suite.

- Delays to Caesarean section.
- Workforce and staffing pressures.
- Neonatal capacity affecting maternity flow.
- Escalation challenges during periods of high acuity.

RWT Themes

- Delays in transfer through induction and labour pathways.
- Staffing pressures.
- Communication failures.
- Follow-up and pathway coordination issues.
- Community and postnatal pathway reliability.
- Neonatal jaundice readmissions.
- Documentation and governance processes.

3.2. Listening to Women, Families and Experience of Care

A review of complaints and concerns across maternity and neonatal services at both The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) provides valuable insight into the experiences of women and families and identifies common themes consistent with the findings of the Amos and Ockenden reviews.

During the reporting period (August 2025 to July 2026), RWT received 98 maternity and neonatal complaints and concerns, while WHT received 102 patient experience cases. Both organisations experienced increasing complaint activity during the latter part of the year, highlighting the importance of maintaining a strong focus on patient experience and engagement.

Across both organisations, the most common themes related to:

- Communication with women, families and between clinical teams.
- Quality and consistency of care.
- Staff attitude and compassionate care.
- Delays in assessment, treatment and clinical decision-making.
- Involvement of women in decisions regarding their care and treatment.

The themes identified demonstrate significant commonality across both Trusts. These findings align closely with national recommendations that maternity services must improve how they listen to women and respond to concerns in real time.

Complaint hotspots were concentrated within core maternity pathways. At RWT, the highest complaint volumes arose from the Postnatal Ward (D10), Antenatal Clinic, Delivery Suite and Maternity Triage Unit. At WHT, the highest complaint volumes were reported within Outpatient Services, Delivery Suite and Postnatal Services. In both organisations, concerns commonly related to communication, postnatal support, delays in care, clinical decision-making, pain management and discharge processes.

Both organisations have demonstrated evidence of learning from patient feedback. Common improvement actions include strengthening communication and consent processes, improving documentation standards, enhancing staff training and reflection, reviewing pathways and escalation processes, increasing use of patient stories and birth reflection services, and embedding learning through governance and quality improvement structures.

Analysis of Mystery Patient Feedback

Walsall

Mystery Patient Programme provides largely positive assurance regarding the compassion, kindness and professionalism of frontline staff, particularly within the Midwifery Led Unit and Delivery Suite. Respondents frequently described staff as caring, supportive, knowledgeable and attentive.

The feedback also identifies recurring themes for improvement, particularly:

- Delays in access to assessment and treatment.
- Maternity triage responsiveness.
- Staffing and capacity pressures.
- Communication during delays.
- Ward environment and facilities (mostly in relation to Ward 25)
- Consistency of experience across teams and shifts.

Wolverhampton

Overall, the Mystery Patient feedback provides mixed but generally positive assurance regarding the kindness, compassion and professionalism of maternity staff across RWT services. Women and families frequently praised individual staff members, particularly within the Midwifery Led Unit, Antenatal Services, Delivery Suite and Fetal Assessment Unit. Respondents commonly described staff as caring, supportive, knowledgeable and reassuring.

A recurring theme across the feedback is maternity triage delays, access to medical review, communication during waiting periods and postnatal ward experience.

Maternity and Neonatal Voices Partnership (MNVP) feedback

The themes identified through MNVP engagement closely mirror those emerging from complaints, incident reviews, mystery patient feedback and national investigations, providing additional assurance that the key opportunities for improvement are well understood within services.

Both organisations recognise the importance of ensuring that the voice of women, families and neonatal parents remains central to service improvement. Arrangements for MNVP engagement, participation and representation are currently being reviewed across both Trusts, alongside wider work to strengthen patient and family involvement in quality improvement, governance and service development. This will support continued alignment with the recommendations arising from the Amos Investigation, Ockenden Review and the NHS England Maternity and Neonatal 10 Point Plan.

3.3. Workforce, Culture and Leadership

Midwifery Staffing and Birthrate Plus

- Both Trusts undertake regular monitoring of staffing levels against Birthrate Plus recommendations and report workforce metrics through established governance routes. At WHT, recruitment is ongoing to address vacancies, meet the BirthRate+ requirements and improve workforce resilience. There were no escalations requiring mutual aid support or service diversion, and one-to-one care in labour was maintained throughout the reporting period.
- Workforce pressures at WHT were primarily associated with maternity leave, long-term sickness absence and difficulties filling vacant shifts. However, there was evidence of improvement, including reductions in acuity-related staffing factors, delayed clinical activities and management interventions required to maintain safe services.
- At RWT, workforce assurance reporting similarly identified ongoing challenges relating to consultant workforce standards, maternity triage staffing requirements and neonatal workforce capacity, although governance processes demonstrated active monitoring and mitigation of these risks.

Neonatal Staffing

- Neonatal staffing remains an area of focus across both organisations.
- At WHT, nursing retention remained strong and bank usage remained below the national average. However, compliance with Qualified in Specialty (QIS) standards remained below expected levels at 60%, and workforce risks relating to specialist neonatal roles, training capacity and community outreach services remained on the risk register. Twenty-five neonatal red flags were recorded during the reporting period, all of which were mitigated on the day.
- RWT similarly identified neonatal workforce capacity as an area requiring ongoing attention, particularly in relation to specialist staffing availability and wider neonatal assurance arrangements.

Both Trusts have ongoing recruitment programmes in place and continue to monitor staffing risks through workforce reports and governance structures. WHT has a plan in place to increase the number of staff undertaking QIS training.

Training Compliance

- At WHT, PROMPT, fetal monitoring and neonatal life support training were all progressing towards the national compliance standard of 90%, although attainment was delayed due to non-attendance by a small number of anaesthetic staff. Maternity-specific training compliance showed some deterioration in antenatal screening and GAP training, attributed to workforce pressures and limited release capacity.
- Both Trusts recognise the significant level of specialty-specific training required within maternity and neonatal services and continue to monitor compliance through Maternity Incentive Scheme and local workforce governance processes.

Staff Experience and Culture

- At WHT, staff experience is monitored through the NHS Staff Survey, Professional Midwifery Advocate (PMA) contacts, staff engagement activities and the Perinatal Culture Action Plan. Between January and June 2026 there were 255 contacts with the PMA team, with restorative supervision, wellbeing and work-life balance being the most common themes. Fifteen of twenty-four actions arising from the culture action plan have been completed, with further work planned to align the programme to the recommendations arising from the Amos and Ockenden reviews.
- WHT Staff survey findings identified stronger experiences within community midwifery, early pregnancy services and obstetric consultant groups, whilst delivery suite, neonatal services, resident doctors and antenatal/postnatal wards reported more challenging experiences. Staffing pressures were the most frequently cited concern. A programme of engagement sessions, manager-led discussions and wellbeing initiatives has been implemented in response.
- At RWT, the service is currently consolidating learning from FTSU cases, staff feedback, cultural conversations and the ongoing maternity culture improvement programme into a single maternity culture improvement plan, supported by Organisational Development and aligned to wider Trust culture priorities. The programme has included active involvement from the Trust QUAD, providing senior leadership oversight and engagement to support cultural development within maternity services. Four staff have been trained to facilitate cultural conversations, with themes emerging from these discussions informing future improvement actions. Leadership discussions are also underway through the maternity leadership structure to ensure alignment with broader Trust culture and staff experience programmes.

National Education and Training Survey (NETS)

RWT

- Following the 2023 NETS results, a comprehensive improvement programme was implemented, including strengthened student induction processes, improved allocation of practice supervisors, enhanced learner

support through Professional Midwifery Advocates and Freedom to Speak Up arrangements, increased engagement with Higher Education Institutions and improvements to placement quality and capacity.

- Subsequent NETS results demonstrated sustained improvement. The service continues to be monitored through routine quality assurance processes, and a formal closure request for the improvement plan has been submitted following continued positive NETS results in 2025 and 2026. Further review by NHS England is awaited to determine whether the remaining ISF Category 1 status can be removed.

Freedom to Speak Up Themes

RWT

There is limited evidence of recurring themes from maternity-specific FTSU cases due to the small number and diverse nature of concerns raised. However, feedback and local culture work have identified relationships between delivery suite coordinators and medical staff as an area of focus. In response, targeted interventions have been implemented, including VIBE training in partnership with Organisational Development and the continuation of facilitated cultural conversations with maternity staff.

WHT

A review of Freedom to Speak Up concerns within maternity services at Walsall identified a workforce that remains engaged and committed to improving the quality and safety of care, whilst highlighting several important organisational themes. Concerns raised during 2024/25 and 2025/26 primarily related to workplace culture and behaviours, quality and safety, policies and processes, communication and equality, diversity and inclusion. There is clear evidence of the Trust taking supportive action with wider culture reviews and action plans with the teams, which is also reflected in ongoing actions within this report.

3.4. Governance, Oversight and Board Assurance

Current Board Assurance

The Trust has established a formal governance structure for oversight of maternity and neonatal services through the monthly Integrated Performance Report (IPR). Perinatal services are reported as a dedicated section within the Quality, Safety and Patient Experience domain, with a Perinatal Quality Oversight Model (PQOM) dashboard presented to Trust Board. The reports explicitly state that PQOM measures are drawn from items reported in detail through the Group Quality Committee and presented by the Directors of Midwifery, providing a clear escalation route from operational governance to Board oversight. Inclusion of MOSS reporting provides Board visibility of nationally monitored outcomes and emerging concerns.

Opportunities to Strengthen Board Assurance

Whilst the Trust has established arrangements for maternity and neonatal oversight, the findings of the Amos and Ockenden reviews highlight opportunities to further strengthen Board assurance through:

- Enhanced triangulation of information by bringing together clinical outcomes, patient experience, workforce indicators, complaints, incidents and learning into a single assurance narrative.
- Greater visibility of the voices of women and families, including maternity-specific feedback, complaints themes, birth reflections and engagement outcomes.
- Stronger assurance on organisational learning, demonstrating how themes from incidents, PMRT reviews and investigations translate into measurable and sustained improvements.
- Broader oversight of culture and workforce indicators, including staffing, training compliance, speaking-up culture and staff experience measures that are known contributors to safe maternity care.
- The Group will review the NHS England Model Board Report for Maternity and Neonatal Services to determine how its principles can be incorporated into existing Board reporting arrangements, with the aim of strengthening assurance, improving triangulation of information and enhancing oversight of maternity and neonatal quality and safety.
- Embracing the role of Safety Champions across the Group with the support of the Group Chair

Quality Committee: Director of Midwifery Reports.

Both Trusts have established formal maternity and neonatal governance frameworks, with routine reporting through Group Quality Committee, Quality and Safety Oversight Groups, Board Safety Champions, Perinatal Quality Oversight Model dashboards, workforce reports, patient experience reports and national quality surveillance processes. There is clear evidence of Board-level visibility of safety, workforce, culture, patient experience, quality improvement and compliance with national standards.

The reports demonstrate proactive engagement with the NHS England Maternity and Neonatal 10 Point Plan, Maternity Incentive Scheme Year 8, Maternity Outcomes Signal System (MOSS), PSIRF, PMRT, Saving Babies' Lives Care Bundle, Perinatal Equity programmes, Martha's Rule rollout and national maternity triage requirements.

Additionally, both Trusts are part of the Black Country Local Maternity and Neonatal System which gives additional levels of scrutiny and assurance regarding services provided. This is facilitated through several dedicated forums, Maternity Improvement Group, Perinatal Quality Surveillance Group, Neonatal Board and LMNS Board where services are assessed against local, regional and national standards.

The review has identified several common areas requiring continued focus and monitoring through existing governance structures, principally workforce sustainability, implementation of national maternity improvement programmes, service capacity and responsiveness, and the completion of assurance processes against evolving national standards.

Specific areas of ongoing development include maternity and neonatal workforce resilience, full implementation of the Maternal Care Bundle, strengthening maternity triage arrangements in line with emerging national requirements, maintaining compliance with specialist training and workforce standards, and further embedding mechanisms that ensure women, families and staff are able to influence service improvement. In addition, both Trusts continue to progress actions relating to national assurance requirements, including Maternity Incentive Scheme standards, bereavement care, Baby Friendly accreditation, equity programmes and patient engagement initiatives.

These themes are recognised within existing risk and governance frameworks and are subject to routine scrutiny through Trust, Group and system-level governance processes. Quality Committee receives detailed oversight of these areas and monitors progress against agreed action plans and improvement programmes.

3.6. Assurance Against National Standards and Audit

A review of maternity and neonatal assurance processes across both Trusts demonstrates comprehensive oversight of national maternity safety standards through established governance arrangements including Maternity Incentive Scheme (MIS) reporting, Perinatal Quality Surveillance, PMRT reviews, Saving Babies' Lives monitoring, maternity triage assessments and regular audit programmes. Quality Committee and governance reports provide evidence of routine scrutiny of compliance, risks and improvement actions.

Clinical Negligence Scheme for Trusts (CNST) and Maternity Incentive Scheme (MIS)

- Both Trusts have embedded oversight of MIS standards within their governance frameworks and use these processes to monitor compliance with national maternity safety requirements.
- At RWT, MIS Year 8 requirements are being actively monitored with planned reviews of training compliance, consultant workforce standards, family engagement, simulation training and other evidence requirements. Governance reports demonstrate active tracking of standards and identification of areas requiring further evidence and assurance.

- At WHT, MIS Year 8 progress is routinely reported through the Director of Midwifery governance framework, with evidence of active oversight of training compliance, workforce standards, PMRT performance, staff and service user engagement and national quality requirements.

Saving Babies' Lives Care Bundle

- Both organisations continue to monitor implementation of Saving Babies' Lives Care Bundle elements through maternity governance structures with strong compliance.
- RWT and WHT have been validated by the LMNS as being 99% compliant with the care bundle.
- Areas that require support from WHT are obstetric ultrasound capacity to enable 24-hour ultrasound following episodes of reduced fetal movement and the ability to perform Placental Growth Factor (PLGF) testing for detection of pre-eclampsia. Ultrasound capacity and ability to complete PLGF testing is a challenge across the system and has been escalated within the organisation and to the ICB.

Maternal Care Bundle

Implementation of the Maternal Care Bundle remains dependent on several external system and digital enablers, creating a risk to delivery against the national 2027 timescale. This continues to be actively monitored.

Maternity Triage Standards

- Both Trusts have commenced assessment against the National Maternity Triage Specification following NHS England publication of the national standards. Governance reports demonstrate active gap analysis and review processes in preparation for formal board assurance requirements.
- At RWT, maternity triage activity and performance are routinely monitored- latest performance shows 83.75% of women were triaged within 15 minutes of arrival. Whilst this provides assurance regarding responsiveness, the service recognises that achievement of the national aspiration regarding earlier assessment remains an area for continued improvement.
- At WHT, triage processes are subject to ongoing review and feature within complaints analysis, workforce planning and service improvement workstreams. Data captured within the maternity audit processes identify that WHT is meeting the initial triage assessment within 15 mins 68% of the time, against the BSOTs target of 80%. 91% at 30 minutes.

Perinatal Mortality Review Tool (PMRT)

PMRT governance arrangements are comprehensive across both Trusts, are well embedded and align closely with national expectations. All PMRT cases have external reviewer attendance to provide assurance that cases are given an impartial case review.

Clinical Audit and Assurance

A review of all Inphase maternity and neonatal audit programmes across both The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) during the last 12 months provides some assurance regarding compliance with key safety, quality and governance standards whilst identifying areas requiring further improvement.

Across both organisations, audit findings demonstrate consistently strong performance in infection prevention and control, hand hygiene compliance, environmental standards and maternity theatre safety processes. Maternity theatres at both Trusts evidenced high levels of compliance with WHO safer surgery standards, surgical counts and theatre governance processes.

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Both Trusts also demonstrated positive performance in core maternity standards, including intrapartum and postnatal care audits, with evidence of embedded clinical governance arrangements and ongoing quality monitoring. Community midwifery services generally achieved acceptable levels of compliance, although greater variation was observed compared with acute maternity services.

A recurring theme across both organisations relates to medicines governance, which emerged as the principal area requiring improvement. Controlled drug audits did not consistently achieve expected assurance thresholds and identified weaknesses in medicines management, storage, security and documentation processes.

The review also identified specific service-level risks. At RWT, declining compliance within antenatal audit programmes and limited reporting of neonatal specialty audits create challenges in demonstrating full assurance regarding neonatal practice. At WHT, Ward 25 (Postnatal Services) demonstrated the greatest concentration of audit concerns, particularly relating to medicines management and aspects of fundamental care.

The review identified variability in the completion and reporting of some maternity and neonatal audit programmes across both Trusts. Whilst this does not necessarily indicate concerns regarding the quality of care delivered, it limits the level of assurance available to demonstrate compliance with expected standards, ongoing oversight and the impact of improvement activity. This was most evident within some neonatal, safeguarding and medicines-related audit programmes. In response, a joint review of the maternity and neonatal audit programme will be undertaken with the Quality Team to ensure that audits recorded within InPhase appropriately reflect service priorities, national requirements and local risks. This work will also support the development of an improvement plan to strengthen audit completion rates, reporting compliance and the overall level of assurance available.

3.7. Equity, Inclusion and Reducing Health Inequalities

Both Trusts demonstrate a clear commitment to addressing health inequalities within maternity and neonatal services, with governance arrangements in place to monitor equity of access, experience and outcomes. The review identified evidence of targeted programmes to address inequalities, improve engagement with underserved communities and strengthen culturally responsive care, reflecting the recommendations within both the Amos Investigation and NHS England's focus on reducing variation in maternity outcomes.

Outcomes by Ethnicity

- Both Trusts are commencing participation in the NHS England funded Perinatal Equity and Anti-Discriminatory Programme (PEADP) in response to national findings highlighting the impact of discrimination and racism on maternity outcomes. This programme aims to improve safety, culture and outcomes for mothers, babies and families through multidisciplinary improvement work.
- WHT also routinely monitors demographic information within patient experience services, including the Birth Reflections Service, to assess access across different ethnic groups and identify opportunities for targeted engagement and service development.
- WHT has identified which geographical area's are seeing the poorest outcomes and for 3 years have based a maternity outreach one stop clinic in that location to capture women from the Indian community and those who are most deprived. Recent audits have also provided assurance that interpreting services are consistently used to ensure the voice of the woman is heard.
- RWT has similarly undertaken targeted work with diverse communities, including engagement with the African Caribbean Community Initiative and development of support mechanisms for migrant women accessing maternity care.

Deprivation and Vulnerable Groups

- Patient engagement mechanisms have been developed to gather the views of women from diverse communities and to understand barriers to accessing care and support.
- At WHT, Healthwatch-style surveys specifically targeting ethnically diverse populations provide an additional source of patient intelligence.
- The national reports highlight the importance of understanding variation in outcomes and experience across different population groups. Whilst there is evidence of proactive engagement activity, routine reporting of outcomes stratified by deprivation and wider socioeconomic indicators could be strengthened further to enhance Board assurance.

Smoking at Delivery

Whilst smoking-at-delivery performance data was not routinely reported within the governance papers reviewed, both Trusts monitor compliance with national maternity standards and care bundle requirements through established maternity governance arrangements. Continued inclusion of smoking-at-delivery metrics within future assurance reporting would strengthen oversight of health inequality indicators.

5.0. Current and upcoming activity:

- **10 Point Plan-** Assurance completions in accordance with the National requirements with identified actions, with submission of baseline assessment on the 25th September 2026, request for final sign off to be delegated to the Group Quality Committee.
- **MEWS implementation**
A working group has been established at both Trusts and MEWS rollout is scheduled for Quarter 3. This provides sufficient time for staff to be familiar with MEWS on the maternity electronic records system. There has been cross divisional work with the emergency department to ensure that the utilisation of MEWS scoring meets the national mandate. The maternity and emergency department teams are currently undergoing training regarding the new observation parameters and escalation prompts.
- **Martha's Rule in Maternity and Neonatal Settings**
Both Trusts have commenced a collaborative implementation programme for Martha's Rule within maternity and neonatal services. Governance structures have been established, implementation steering groups are in place, and roll-out plans are being aligned with existing escalation pathways to strengthen the recognition and response to concerns raised by women, families and staff.
- **Maternity Triage assessment**
Both Trusts are currently benchmarking against the national maternity triage specification to determine opportunities to strengthen oversight.
- **Culture reviews**
WHT completed the Perinatal Cultural Leadership programme in 2023/24. From this a cultural survey (SCORE) was completed and an action plan developed. The service is now in the process of reviewing the actions and will be conducting another culture review considering recent national reviews and NHS Staff survey.
- **Transitional care arrangements at WHT** are insufficient for the needs of the service, the area currently has 4 beds in its specification, however 6 beds are required. There is insufficient capacity on the postnatal ward to support expansion of transitional care so the service is currently putting together a working group to fully understand the issue and solutions that can be supported.

- **Internal Assurance Visits (Unannounced)**

The compliance team have coordinated two internal assurance visits- one for each Trust incorporating perinatal services. This involves a range of internal and peer reviewers with a comprehensive assessment process, undertaken to a similar format as an external inspection.

Plans include:

- *26th August 2026 at the Royal Wolverhampton NHS Trust Maternity Services:* D10, Triage, Delivery Suite, Delivery Theatres. At time of report, no immediate safety, quality or governance concerns have been raised. Informal feedback has been positive, highlighting good practice. Evidence collation from the assurance visit is currently being collated to develop a report. Provisional ratings will be reviewed, validated and agreed by the assessor team.
- *Scheduled in September 2026 at Walsall Healthcare Maternity Services:* Wards 24/25, Triage, Delivery Suite, Delivery Theatres. This will follow the same process as RWT.

We will await further outcomes of the National taskforce following the Baroness Amos review expected Autumn 2026.

Item 10.1.1 Maternity and Neonatal - 10 Point Plan - Assurance Process - Verbal Report

Tier 1 - Paper ref: Enclosure 10.2

Report title:	Group Finance and Workforce Report
Sponsoring executives:	Kevin Stringer, Group Chief Finance Officer Claire Radley, Group Chief People, Culture and Improvement Officer
Report author:	James Green, Director of Operational Finance Dan Mortiboys, Director of Operational Finance Emma Ballinger, Director of People Clare Bond, Director of People
Meeting title:	Group Trust Board in Public
Date:	15 th September 2026

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

This report presents the financial and workforce performance of the Group for the period April 2026 to July 2026, with the notable points being:

- Overall, the Group position is £0.1m better than plan year to date, with RWT on plan and WHT achieving £0.1m better than plan.
- Variable elective activity is behind the Group plan by £1.06m YTD, mainly at RWT where the variance is £1.12m behind plan. Blended UEC activity is £0.44m above plan for the Group, mainly at WHT where the variance is £0.42m above plan.
- The efficiency plan was £4.5m in month, RWT underperformed by £0.7m against a plan of £3.2m. WHT underperformed by £0.2m in month against a plan of £1.3m.
- Capital expenditure year to date is £6.7m (£4.5m RWT and £2.2m WHT), an underspend of £4.8m (£3.8m RWT and £1.0m WHT).
- The cash position for both Trusts is positive at £54.5m for RWT, and £38.0m for WHT.
- Whilst there has been a decrease in Workforce by 113.4 since the end of March there has been an increase overall for the group in month by 40.0 WTE at RWT and decreasing by 11.6 WTE at WHT. Both Trusts are above the workforce plan 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?]

Group Finance & Productivity Committee meeting on 1st September 2026.

4. Recommendation(s)/Action(s)

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

- Note the contents of the report
- Receive the report for assurance

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Group Financial & Workforce Performance

for the month of July 2026

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Walsall Healthcare NHS Trust



Care Colleagues
Collaboration Communities

I&E Summary

In-Month Income & Expenditure	RWT			WHT			Group position		
	Plan	Actual	Surplus/	Plan	Actual	Surplus/	Plan	Actual	Surplus/
	M4	M4	(Deficit)	M4	M4	(Deficit)	M4	M4	(Deficit)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	87.0	87.5	0.5	40.5	41.3	0.8	127.5	128.8	1.3
Expenditure									
Pay	56.0	56.4	(0.4)	26.4	26.4	0.0	82.4	82.8	(0.4)
Non Pay	21.5	21.5	(0.0)	10.2	10.9	(0.7)	31.7	32.4	(0.7)
Drugs	7.1	7.1	0.0	2.6	2.6	(0.1)	9.7	9.7	(0.1)
Other*	3.8	3.9	(0.0)	2.6	2.6	(0.0)	6.4	6.5	0.0
Total Expenditure	88.4	88.9	(0.5)	41.7	42.5	(0.7)	130.1	131.4	(1.2)
Net reported surplus/(Deficit)	(1.5)	(1.4)	0.0	(1.2)	(1.2)	0.1	(2.6)	(2.6)	0.1

Year-to-date Income & Expenditure	RWT			WHT			Group position		
	Plan	Actual	Surplus/	Plan	Actual	Surplus/	Plan	Actual	Surplus/
	YTD	YTD	(Deficit)	YTD	YTD	(Deficit)	YTD	YTD	(Deficit)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	344.4	346.6	2.1	158.3	158.7	0.4	502.7	505.3	2.5
Expenditure									
Pay	223.1	226.2	(3.2)	106.6	106.5	0.0	329.7	332.7	(3.2)
Non Pay	86.8	85.6	1.2	38.8	39.1	(0.3)	125.6	124.7	0.9
Drugs	27.1	27.2	(0.1)	9.8	9.7	0.1	36.9	36.9	0.0
Other(incl. depreciation)	15.3	15.4	(0.0)	10.2	10.5	(0.3)	25.5	25.9	(0.3)
Total Expenditure	352.3	354.4	(2.1)	165.4	165.8	(0.4)	517.7	520.2	(2.5)
Net reported surplus/(Deficit)	(7.9)	(7.8)	0.0	(7.1)	(7.1)	0.1	(15.0)	(14.9)	0.1

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

Key Headlines:

- Total YTD deficit of £14.9m,
- Performance in month 4 and year to date is £0.1m better than plan, on plan for RWT and £0.1m ahead of plan for WHT.
- CIP underachieved in month by £0.9m, bringing the YTD overperformance to £1.0m; with RWT overperformance of £0.6m and WHT overperformance of £0.4m.
- Variable elective activity is behind the Group plan by £1.1m YTD, with RWT behind plan by £1.1m and WHT on plan.
- UEC activity is ahead of group plan by £2.2m, with RWT ahead of plan by £0.1m and WHT ahead of plan by £2.1m. Payment is made on 20% of under/over.
- Forecast: at this point in time, the Group is forecasting to achieve the plan.

Capital

- Capital expenditure year to date is £6.7m (£4.5m RWT and £2.2m WHT), an underspend of £4.8m (£3.8m RWT and £1.0m WHT).
- The capital plan for both Trusts is expected to delivered including transfer from of £1.0m from WHT to RWT which has been agreed by NHSE. This repaying half of £2.0m loaned from RWT to WHT in 25/26. The remaining £1.0m will be repaid back in 27/28 as included in the Plan submission to NHSE.

Cash

- Both organisations have a healthy cash balance at this point in time and are not forecasting the requirement of cash support through 2026/27. 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 the move to SBS and a new finance ledger and are below the target.

BPPC Performance	RWT		WHT	
	In-Month	YTD	In-Month	YTD
Value	92%	90%	72%	83%
Volume	75%	71%	87%	89%

Key Month Items Within the Position

These include:

- **Income** overperformed against plan by £1.3m in month. Year to date there is overperformance on income of £2.5m, RWT is £2.1m ahead of plan due to maternity incentive income recognised earlier than plan and prior year provision releases. WHT is £0.4m ahead of plan due to E&T and R&D income.
- **Pay** is £0.4m worse than plan in month and £3.2m worse than plan YTD, all the variance being at RWT. £1.4m is due to unmet CIP and £0.58m is due to industrial action costs, the remainder of the variance is mostly related to bank, overtime and mental health agency costs. WHT is on plan YTD.
- **Non-Pay** is £0.7m worse than plan in month and £0.9m better than plan YTD, with a RWT being £1.2m better than plan related to GRNI releases and lower costs associated with RTT activity delivery. WHT is £0.3m worse than plan due to overspends in outsourced services and increased spend in clinical consumables.
- **Drugs** spend is £0.1m worse than plan in month and on plan YTD.
- **Forecast** : The plan includes a stretching efficiency challenge for 2026/27, along with a number of risks which have been assessed at a high level later in this report. However, at this point in time (month 4) the Group is forecasting achievement of the financial plan.

Variable Performance YTD

Point of Delivery	RWT			WHT			Group		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	16,417	16,232	(185)	4,101	3,907	(194)	20,518	20,139	(379)
Daycase	21,142	20,304	(838)	8,680	8,278	(403)	29,823	28,582	(1,241)
Outpatient Procedures	10,581	10,866	285	3,174	3,347	173	13,755	14,214	458
Procedures Total	48,140	47,402	(738)	15,956	15,532	(424)	64,096	62,934	(1,162)
Outpatient 1st	15,409	14,969	(440)	7,521	7,821	301	22,930	22,790	(140)
Diagnostic Imaging	3,123	3,039	(84)	3,015	3,173	157	6,138	6,212	73
Chemotherapy & Radiotherapy	3,982	4,201	219	735	763	28	4,717	4,964	247
Total Elective	22,514	22,209	(305)	27,228	27,290	62	49,742	49,498	(243)
<i>Payment Variance Elective</i>			(1,124)			62			(1,062)
A&E	10,816	11,086	270	8,272	8,666	394	19,088	19,752	664
NEL	67,188	67,029	(158)	42,017	43,702	1,685	109,205	110,731	1,527
Total UEC	78,003	78,115	112	50,289	52,368	2,079	128,292	130,483	2,191
<i>Payment Variance UEC</i>			22			416			438
Grand Total	148,658	147,726	(932)	77,517	79,658	2,141	226,175	227,384	1,209
<i>Payment Variance</i>			(1,102)			478			(624)

The group variable activity is £1.1m below plan year to date. RWT is underperforming by £1.1m - due to planned activity underperformance in General Surgery, Orthopaedics and Urology, UEC activity is above plan by £22k for RWT after applying blended payment rules. WHT is overperforming by £2.1m, with a £2.1m overperformance on UEC and variable elective activity delivering on contract.

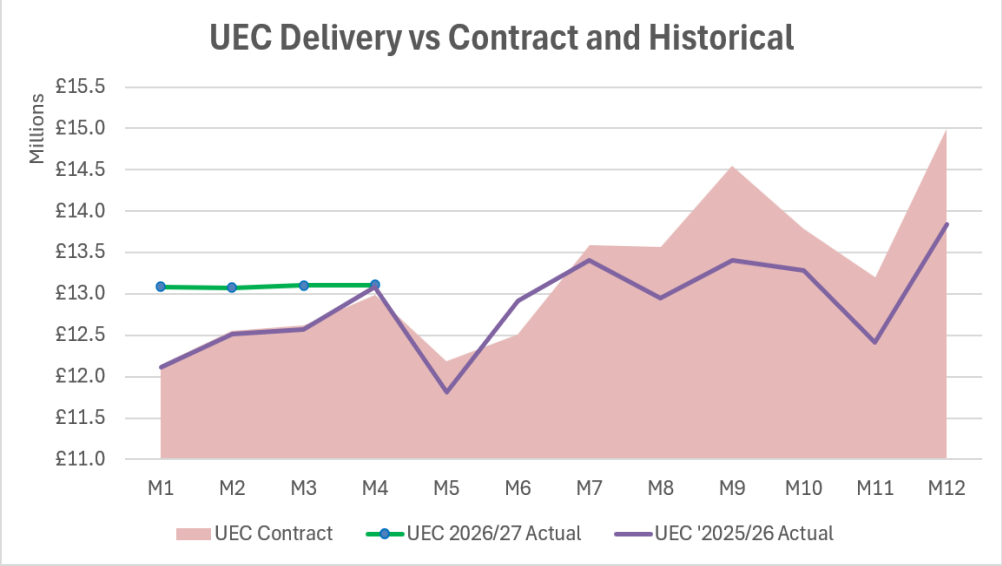
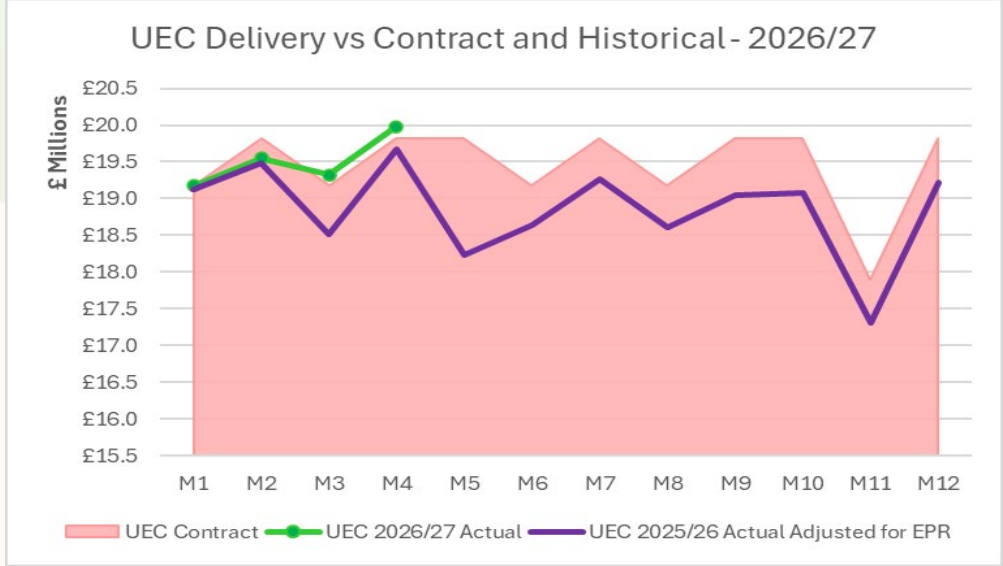
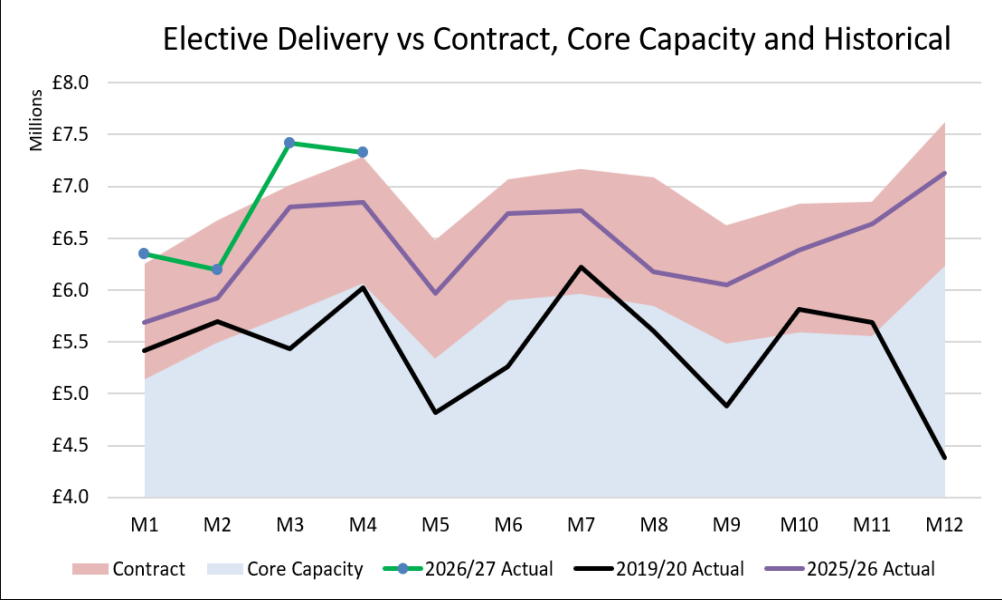
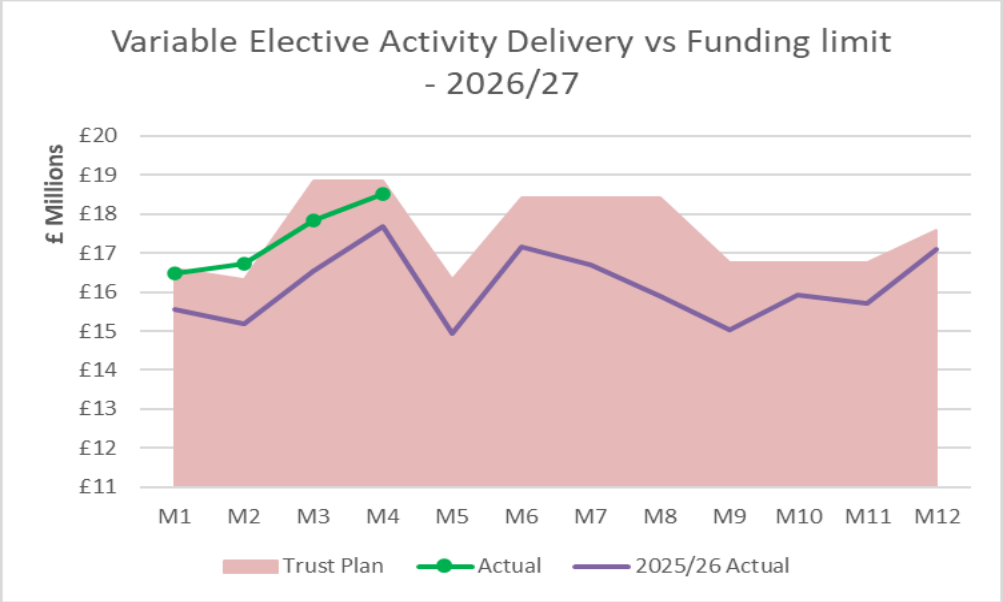
The reduction seen in April due to industrial action was £0.5m at RWT and £0.2m for WHT.

A large proportion of RWT's activity is uncoded and uncashed and so an estimate at average tariff is being applied. Coding completeness for July was 45%.

Variable Activity Performance Trend – 2026/27 M4

RWT

WHT



CIP Performance YTD

	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
WHT Total	1.3	1.1	(0.2)	5.0	5.4	0.4
<i>Recurrent</i>	1.1	0.6	(0.5)	4.3	2.9	(1.4)
<i>Non Recurrent</i>	0.2	0.5	0.3	0.7	2.5	1.8
RWT Total	3.2	2.5	(0.7)	9.7	10.3	0.6
<i>Recurrent</i>	2.3	1.7	(0.6)	7.4	3.6	(3.8)
<i>Non Recurrent</i>	0.9	0.8	(0.1)	2.3	6.7	4.4
Group	5.8	4.6	(1.2)	19.7	21.0	1.4
<i>Recurrent</i>	3.4	2.2	(1.2)	11.7	6.5	(5.2)
<i>Non Recurrent</i>	1.1	1.3	0.2	3.0	9.2	6.3

The total efficiency challenge in 2026/27 for the group is £81.3m; RWT £53.8m, WHT £27.5m. The in-month plan was £3.4m.

In month 4 WHT underperformed by £0.2m against a plan of £1.3m, this is due to under delivery of productivity savings. RWT underperformed by £0.7m in month against a plan of £3.2m, this is mainly due to underperformance of activity and productivity related schemes in Division 1.

Year to date the total overperformance against plan is £1.0m; £0.4m above plan at WHT and £0.6m above plan at RWT.

Both Trust are recognising a higher proportion of non recurrent savings compared to plan due to slippage in recurrent schemes

Statement of Financial Position

STATEMENT OF FINANCIAL POSITION				WHT			
Statement of Financial Position for the month ending July 2026							
	Mar 2026	July 2026	Movement	Mar 2026	July 2026	Movement	
	Actual £000	Actual £000	YTD £000	Actual £000	Actual £000	YTD £000	
NON CURRENT ASSETS							
Property, Plant and Equipment - Tangible Assets	545,948	538,405	(7,544)	255,724	253,096	(2,628)	
Intangible Assets	13,073	13,709	636	7,898	7,483	(415)	
Other Investments/Financial Assets	15	15	0	0	0	0	
Trade and Other Receivables Non Current	1,070	1,070	0	1,720	1,683	(37)	
PFI Deferred Non Current Asset	2,883	2,883	0	0	0	0	
TOTAL NON CURRENT ASSETS	562,990	556,082	(6,908)	265,342	262,262	(3,080)	
CURRENT ASSETS							
Inventories	10,431	10,779	348	2,861	3,236	375	
Trade and Other Receivables	55,177	42,120	(13,058)	27,258	18,433	(8,825)	
Cash and cash equivalents	42,739	54,488	11,749	52,233	37,985	(14,248)	
TOTAL CURRENT ASSETS	108,347	107,386	(960)	82,352	59,654	(22,698)	
TOTAL ASSETS	671,337	663,469	(7,868)	347,694	321,916	(25,778)	
CURRENT LIABILITIES							
Trade & Other Payables	(105,917)	(99,754)	6,163	(74,122)	(52,559)	21,563	
Liabilities arising from PFIs / Finance Leases	(9,102)	(9,103)	(1)	(10,230)	(12,264)	(2,034)	
Provisions for Liabilities and Charges	(2,855)	(2,181)	674	(860)	(860)	0	
Other Financial Liabilities	(11,141)	(21,317)	(10,176)	(1,124)	(4,669)	(3,545)	
TOTAL CURRENT LIABILITIES	(129,016)	(132,355)	(3,339)	(86,336)	(70,352)	15,984	
NET CURRENT ASSETS / (LIABILITIES)	(20,669)	(24,968)	(4,299)	(3,984)	(10,698)	(6,714)	
TOTAL ASSETS LESS CURRENT LIABILITIES	542,321	531,114	(11,207)	261,358	251,564	(9,794)	
NON CURRENT LIABILITIES							
Trade & Other Payables	0	0	0	0	0	0	
Other Liabilities	(26,601)	(23,707)	2,894	(174,313)	(170,925)	3,388	
Provision for Liabilities and Charges	(1,336)	(1,336)	0	(257)	(257)	0	
TOTAL NON CURRENT LIABILITIES	(27,937)	(25,043)	2,894	(174,570)	(171,182)	3,388	
TOTAL ASSETS EMPLOYED	514,384	506,071	(8,313)	86,788	80,382	(6,406)	
FINANCED BY TAXPAYERS EQUITY							
Public Dividend Capital	350,852	350,853	1	283,327	283,326	(1)	
Retained Earnings	31,045	22,733	(8,312)	(264,551)	(270,956)	(6,405)	
Revaluation Reserve	133,711	133,710	(1)	68,012	68,012	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	514,384	506,071	(8,313)	86,788	80,382	(6,406)	

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: £13.1m decrease with balances including prepayments and accrued income, with accrued income being majority of the decrease following receipt of 25/26 income. Trade & Other Payables: £6.2m decrease with the movement being a reduction in trade payables of £14.2m offset by an increase in PDC Dividends £4.5m and Divisional Accruals £3.5m. The majority of the movement in Other Financial Liabilities relates to deferred income on non-recurrent projects such as PASEMR. Other Liabilities of £2.9m decrease due to movement in PFI/IFRS 16.
- WHT – Trade payables has reduced by £16m reflecting the movements associated with the YE prepayment (this is offset by a reduction in cash during May and June. Increase in Trade and Other receivables reflecting invoices activity in the period of £8.8m. Non-Current Liabilities reduction of £3.4m due to PFI/IFRS 16.

Cashflow as at 31st July

	RWT Jul-26 Actual £'000	WHT Jul-26 Actual £'000	Combined Jul-26 Actual £'000
OPERATING ACTIVITIES			
Total Operating Surplus/(Deficit) (gross of control total adjustments)	(3,881)	(1,829)	(5,710)
Depreciation	11,363	5,243	16,606
Fixed Asset Impairments	0	0	0
Transfer from Donated Asset Reserve	0	0	0
Capital Donation Income	0	(24)	(24)
Interest Paid	(624)	(2,591)	(3,215)
Dividends Paid	0	(609)	(609)
Release of PFI /Deferred Credit	0	0	0
(Increase)/Decrease in Inventories	(324)	(375)	(699)
(Increase)/Decrease in Trade Receivables	13,057	6,806	19,863
Increase/(Decrease) in Trade Payables	(1,048)	(19,536)	(20,584)
Increase/(Decrease) in Other liabilities	10,176	3,545	13,721
Increase/(Decrease) in Provisions	(674)	0	(674)
Increase/(Decrease) in Provisions Unwind Discount	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	28,045	(9,370)	18,675
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	875	654	1,529
Payment for Property, Plant and Equipment	(13,008)	(2,166)	(15,174)
Payment for Intangible Assets	(1,024)	0	(1,024)
Receipt of cash donations to purchase capital assets	0	24	24
Proceeds from sales of Tangible Assets	0	0	0
Proceeds from Disposals	0	5	5
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	(13,157)	(1,483)	(14,640)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	14,888	(10,853)	4,035
FINANCING			
New Public Dividend Capital Received	0	0	0
Capital Element of Finance Lease and PFI	(3,138)	(3,395)	(6,533)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	(3,138)	(3,395)	(6,533)
INCREASE/(DECREASE) IN CASH	11,750	(14,248)	(2,498)
CASH BALANCES			
Opening Balance at 1st April 2026	42,739	52,233	94,972
Closing Balance at 31st July 2026	54,489	37,985	92,474

Summary:

The cash balance is £92.5m; £54.5m at RWT and £38.0m at WHT. This is an increase from last month of £2.7m (of which £1.24m increase relates to RWT and £1.45m relates to WHT).

Following the receipt of cash backed deficit support in 25/26 to enable a breakeven plan, both organisations have a good cash balance to being the year and do not foresee the need for any cash support for the year. Cash balances will continue to be closely monitored throughout the year.



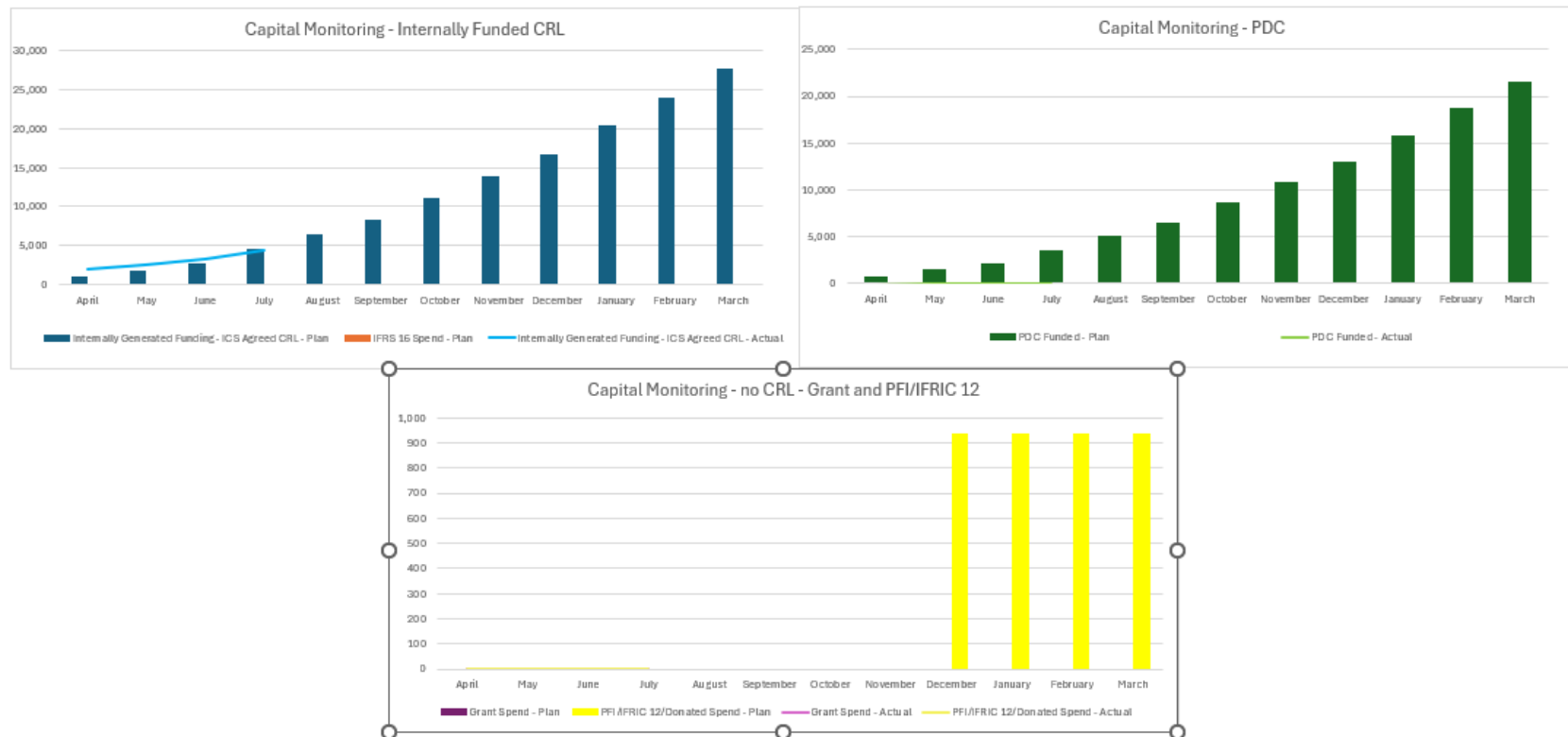
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Capital RWT

The Trust has spent £4.5m of Capital to 31st July 2026, which is £3.8m lower than plan.

- CRL recorded a year to date spend of £4.4m which was £0.2m lower than plan. This is due to additional spend on projects slightly behind the planned phasing, including the conclusion of 25/26 projects. The Trust anticipates meeting its FY CRL and will review capital plan to meet this.
- PDC expenditure with a spend of £0.0m was £3.6m behind plan due to the delay of PDC bids which although agreed by NHSE are still in planning stage. The phasing of the plan vs actual will be different; however the FY PDC CRL is forecast to be met.
- IFRS 16 (or renewed leases) CRL with a YTD spend of £0.0m is in line with plan.
- IFRIC 12 related capital spend is £0.0m YTD which is in line with plan.

In addition to the items above monitored by NHSE, the Trust also receives grant funding and donated assets, however nothing has been received in Month Four.



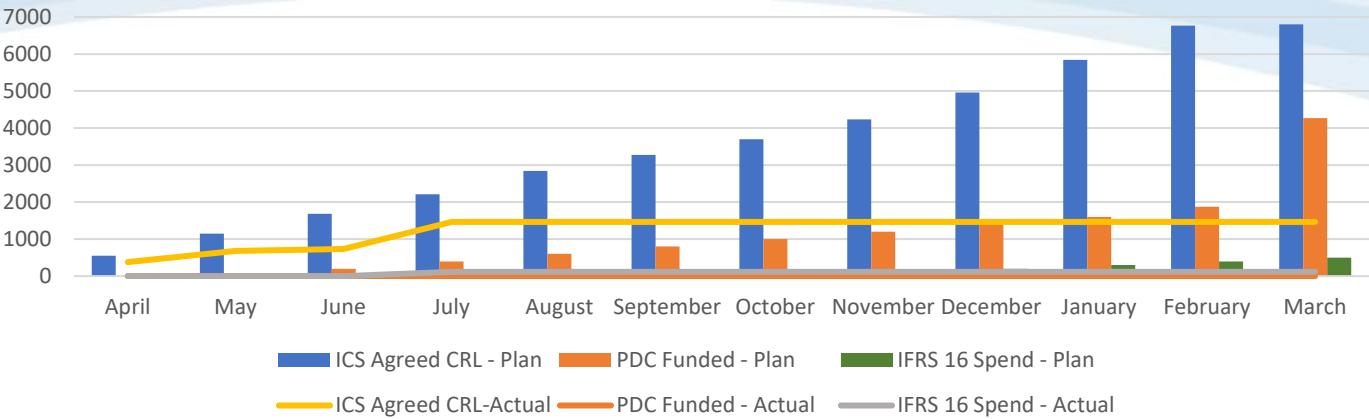
Capital WHT

The trust has spent £2.199m of Capital & IFRS16 YTD to 31st July 2026 against planned YTD Capital of £3.231m. Of the £2.199m YTD Spend:

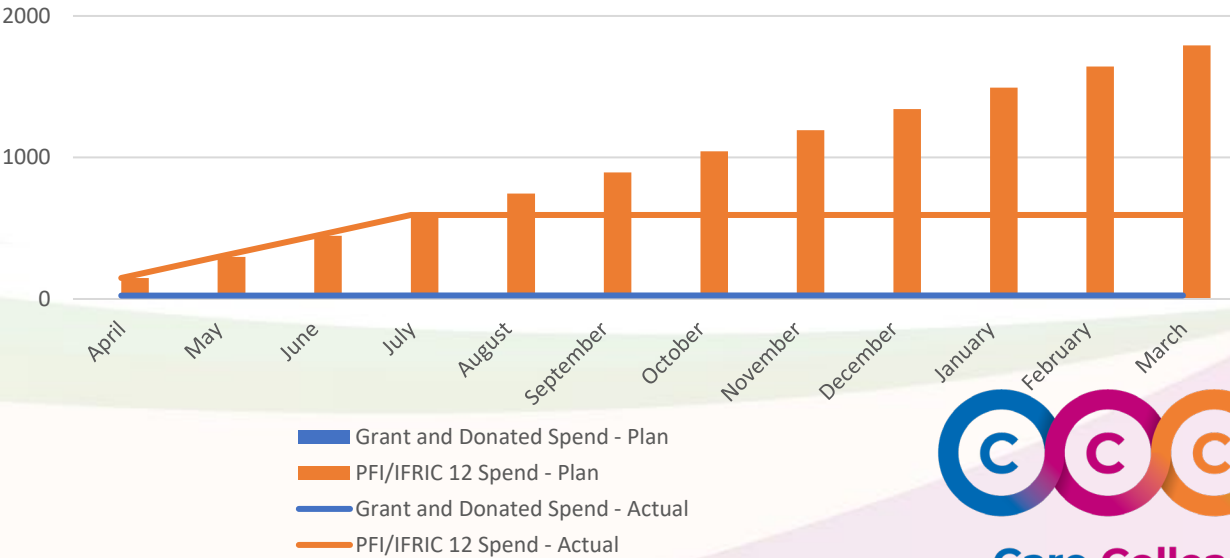
- £1.580m YTD Capital spend including IFRS16 relates to CRL the trust is measured against vs YTD Budget of £2.610m with a variance of £1.030m. No PDC Spend YTD. The trust has received notification of additional capital of £2m UEC Incentive scheme. The trust plans to achieve CRL of £11.571m at the end of the year.
- The balance of the YTD Capital spend of £0.619m relates to Non CRL Capital with PFI/IFRIC 12 capital of £0.594m on plan and donated medical equipment of £0.025m.

Scheme	M4 YTD Budget	M4 YTD Spend
CRL	£'000s	£'000s
Estates:		
ED Works	800	-
Estates Lifecycle	200	200
Estates Lifts and Ventilation		
Estates Utilisation		
Theatres 1-4 Refurbishment	600	736
Estates Total	1,600	936
Medical Equipment:		
Medical Equipment		145
Medical Equipment Total	-	145
Information Management & Technology:		
IT Equipment	-	-
Data Centre / IT Replacement	200	-
ePrescriptions		
Electronic Prescribing Medicine Admin (EPMA)	350	
Ambient Voice Technology	60	185
Frontline Digitisation		213
Information Management & Technology Total	610	383
PDC Funding		
Estates Safety Fund-PDC Funded	400	
PDC Funding Total	400	-
IFRS16		
Total IFRS16	-	116
Total CRL	2,610	1,580
Non CRL		
PFI Lifecycle:	596	594
Donated Medical Equipment	25	25
Total Non CRL	621	619
Grand Total	3,231	2,199

Capital Monitoring - CRL



Capital Monitoring - Non CRL



Workforce

Executive Summary

Item	Headline
RWT 26/27 Workforce Plan	Schemes relating to Pay at RWT provide £23.6m worth of the total schemes in year (44%) Total Delivery YTD £2.7m in M4.
WHT 26/27 Workforce Plan	Since the M2 review of Pay related CIP, the Trust has developed a full CIP plan to meet the £27.5m target. Consequently, all Pay related schemes have been reviewed to understand likely forecast deliverables. Forecast in year savings relating to Pay CIP are £16.0m.
Group M4 Performance against workforce plan	- There has been an overall decrease of 113.4 total WTE in M426/27 compared to M12 25/26. - Group total WTE deployed during M4 26/27 was 374.7 WTE adverse to plan (an increase from 203.3 WTE adverse to plan at the end of M3 26/27). WHT is overall 80.1 WTE adverse to plan, whilst RWT is overall 294.5 WTE adverse to plan, having been 161.3 WTE adverse to plan during M3 26/27.
RWT M4 Performance against workforce plan	- There was an overall increase of 40.0 WTE for RWT during Jul-26, reflecting a 7.3 WTE (18.0%) reduction in agency reliance being offset by a 14.5 WTE (0.1%) increase in the substantive workforce and a 32.7 WTE (5.4%) rise in bank usage. - The total RWT WTE deployed for M4 26/27 was 10805.95 WTE against a plan to deploy 10511.43 WTE; therefore 294.52 WTE adverse to the plan.
WHT M4 Performance against workforce plan	- Total WHT WTE deployment for M4 26/27 was 4992.83 WTE against a plan to deploy 4912.70 WTE; therefore 80.13 WTE adverse to the plan. - WHT's overall workforce decreased by 11.6 WTE during M4 26/27, reflecting a 5.6 WTE (0.1%) reduction in substantive deployment, a 2.4 WTE (0.5%) decrease in bank reliance and a 3.6 WTE (22.5%) fall in agency usage during July 2026.

Workforce Group Summary of M4 26/27 Performance against Plan

The table demonstrates the workforce position for M4 for the group. Both Trust WTE positions have decreased since M12 25/26; however, reliance on temporary staffing relative to the 26/27 workforce plan remains the greatest challenge.

From a group perspective, there has been an overall decrease of -113.35 WTE since M12 25/26.

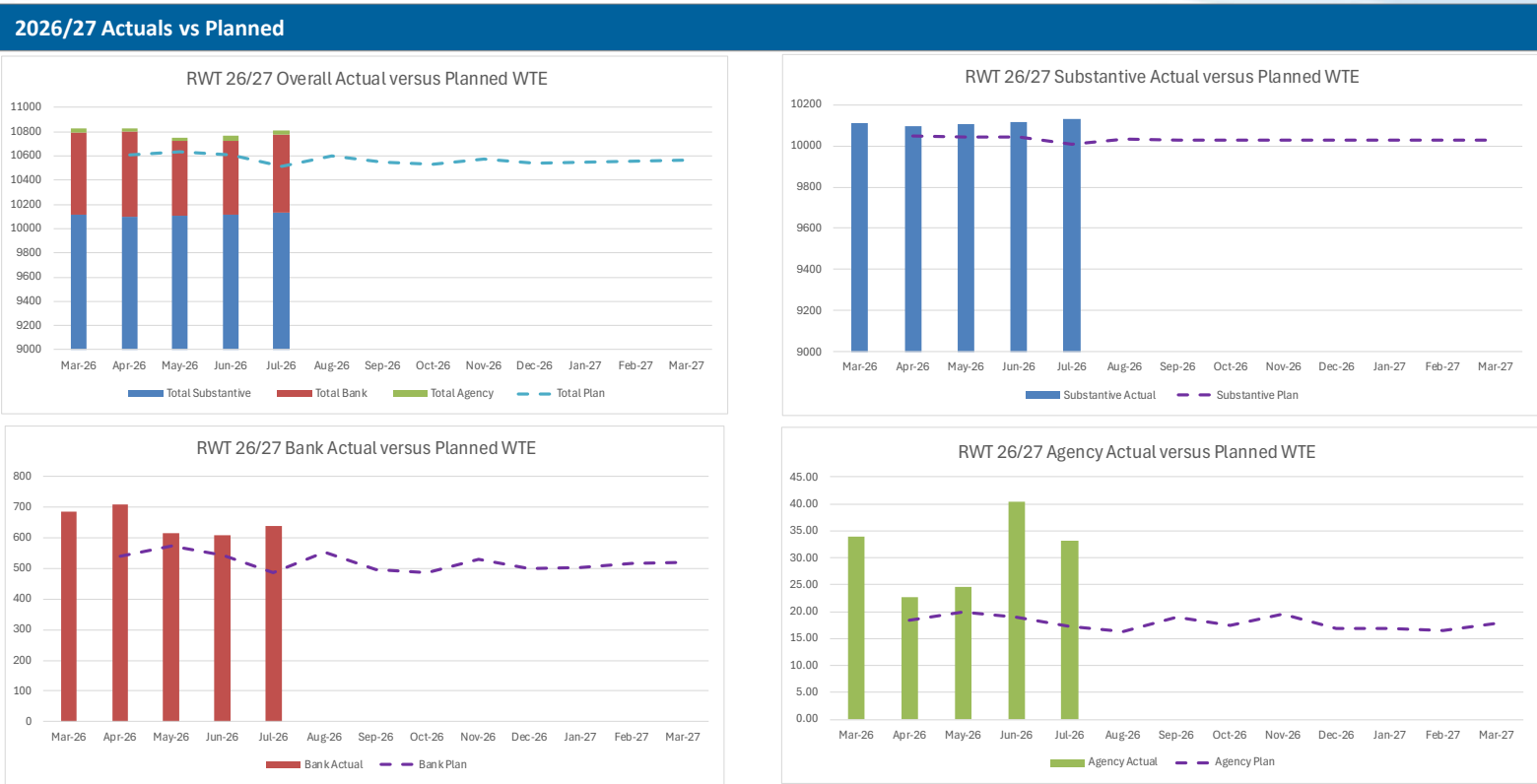
- The substantive workforce has decreased by -12 WTE, with substantive increase at RWT since 25/26 year-end offset by WHT substantive reductions.
- Bank deployment has decreased across both Trusts since the 25/26 year-end position, contributing to an overall group decrease of -95.72 WTE.
- Bank WTE for both Trusts remains above the 26/27 plan, +312.02 WTE above the group plan.
- Agency reliance has reduced by 5.5 WTE since Mar-26, overall agency usage across the group is +17.1 WTE above the workforce plan trajectory submitted to NHSE.

M12 (25/26) to M4 (26/27) WTE Changes					
RWT	M12 25/26 (Actual)	M4 26/27 (Actual)	M4 26/27 (Plan)	Variance M4 26/27 (Plan) vs M4 26/27 (Actual)	Variance M12 25/26 (Actual) vs M4 26/27 (Actual)
Total Workforce (WTE)	10830.52	10805.95	10511.43	+294.52	-24.57
Total Substantive	10113.12	10133.27	10009.38	+123.89	+20.15
Total Bank	683.36	639.58	484.86	+154.72	-43.78
Total Agency	34.04	33.10	17.19	+15.91	-0.94
WHT	M12 25/26 (Actual)	M4 26/27 (Actual)	M4 26/27 (Plan)	Variance M4 26/27 (Plan) vs M4 26/27 (Actual)	Variance M12 25/26 (Actual) vs M4 26/27 (Actual)
Total Workforce (WTE)	5081.61	4992.83	4912.70	+80.13	-88.78
Total Substantive	4553.21	4520.93	4599.29	-78.36	-32.28
Total Bank	511.46	459.52	302.22	+157.30	-51.94
Total Agency	16.93	12.38	11.18	+1.19	-4.56
Group	M12 25/26 (Actual)	M4 26/27 (Actual)	M4 26/27 (Plan)	Variance M4 26/27 (Plan) vs M4 26/27 (Actual)	Variance M12 25/26 (Actual) vs M4 26/27 (Actual)
Total Workforce (WTE)	15912.13	15798.77	15424.13	+374.65	-113.35
Total Substantive	14666.33	14654.20	14608.68	+45.53	-12.13
Total Bank	1194.82	1099.10	787.08	+312.02	-95.72
Total Agency	50.97	45.48	28.37	+17.10	-5.50

Workforce WTE Trends - RWT

RWT’s overall workforce increased by 39.97 WTE (0.37%) during M4 26/27, reflecting a 7.25 WTE (17.97%) reduction in agency deployment being offset by a 14.48 WTE (0.14%) increase in the substantive workforce and a 32.74 WTE (5.40%) rise in bank usage. The RWT overall workforce is 294.52 WTE (2.80%) above the M4 26/27 workforce plan trajectory.

Actual WTE (May 2026 – July 2026)			
	May-26	Jun-26	Jul-26
ACTUAL TOTAL WORKFORCE BY STAFF GROUP (WTE)			
Registered Nursing, Midwifery and Health Visiting Staff	3057.19	3047.68	3071.97
Allied Health Professionals	612.70	609.83	616.10
Registered Scientific, Therapeutic and Technical Staff	253.65	252.26	255.55
Healthcare Scientists	507.34	509.57	513.38
Support to Clinical Staff	2686.06	2704.14	2704.81
NHS Infrastructure Support	2289.47	2309.43	2314.82
Medical and Dental	1341.26	1333.07	1329.32
ACTUAL SUBSTANTIVE STAFF BY STAFF GROUP (WTE)			
Registered Nursing, Midwifery and Health Visiting Staff	2923.59	2929.56	2936.85
Allied Health Professionals	608.97	606.29	612.28
Registered Scientific, Therapeutic and Technical Staff	247.99	247.40	248.35
Healthcare Scientists	503.94	506.94	510.64
Support to Clinical Staff	2349.96	2340.47	2333.42
NHS Infrastructure Support	2239.25	2252.23	2258.79
Medical and Dental	1233.55	1235.90	1232.94
ACTUAL BANK STAFF BY STAFF GROUP (WTE)			
Registered Nursing, Midwifery and Health Visiting Staff	133.60	118.12	135.12
Allied Health Professionals	3.73	3.54	3.82
Registered Scientific, Therapeutic and Technical Staff	3.84	3.04	5.56
Healthcare Scientists	0.18	0.15	0.23
Support to Clinical Staff	326.12	337.15	352.12
NHS Infrastructure Support	50.22	57.20	56.03
Medical and Dental	98.15	87.64	86.70
ACTUAL AGENCY STAFF BY STAFF GROUP (WTE)			
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	1.82	1.82	1.64
Healthcare Scientists	3.22	2.48	2.51
Support to Clinical Staff	9.98	26.52	19.27
NHS Infrastructure Support	0.00	0.00	0.00
Medical and Dental	9.56	9.53	9.68

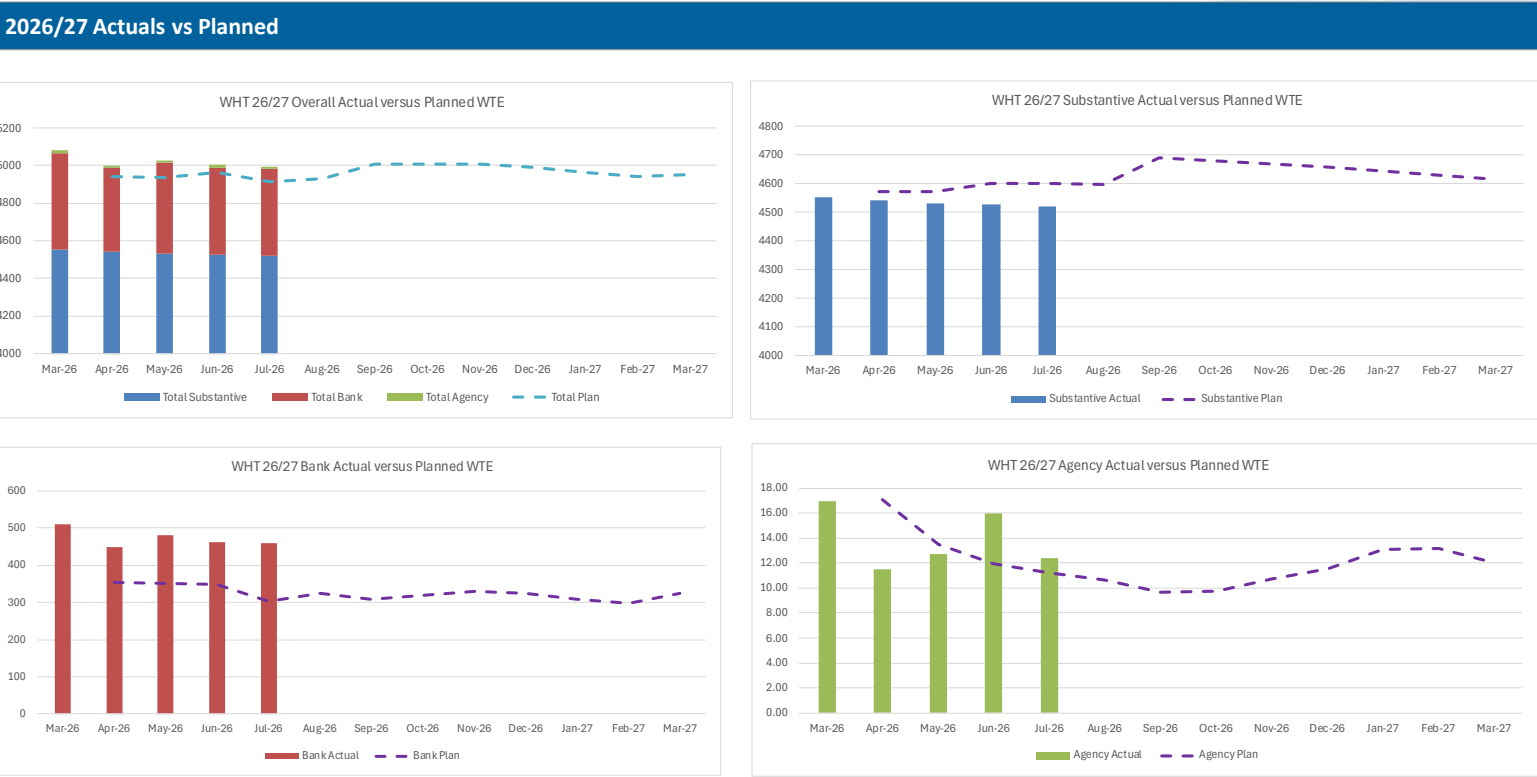


Since March 2026, the overall workforce has decreased by 24.57 WTE; the bank and agency workforces have decreased by 43.78 and 0.94 WTE, respectively, offsetting a 20.15 WTE rise in substantive deployment since 25/26 year-end. The monthly substantive workforce increase reflects a rise in Infrastructure Support, AHPs, Healthcare Scientists and RN&M offsetting decreases in the other core staff groups. Despite a decrease in Infrastructure Support and M&D bank usage during M4 26/27, reliance on bank colleagues increased across all other staff groups. Support to Clinical agency reliance fell by 27.3% in July 2026, contributing to an overall reduction in agency usage.

Workforce WTE Trends - WHT

WHT’s overall workforce decreased by 11.6 WTE during M4 26/27, reflecting a 5.6 WTE (0.1%) reduction in substantive deployment, a 2.4 WTE (0.5%) decrease in bank reliance and a 3.6 WTE (22.5%) fall in agency usage during July 2026. The WHT overall workforce is 80.1 WTE (1.6%) above the M4 26/27 workforce plan trajectory.

Actual WTE (May 2026 – July 2026)			
	May-26	Jun-26	Jul-26
ACTUAL TOTAL WORKFORCE BY STAFF GROUP			
Registered Nursing, Midwifery and Health Visiting Staff	1746.90	1731.75	1728.77
Allied Health Professionals	329.06	333.41	333.86
Registered Scientific, Therapeutic and Technical Staff	127.16	128.31	132.40
Healthcare Scientists	49.29	46.29	45.39
Support to Clinical Staff	1185.57	1157.16	1151.56
NHS Infrastructure Support	974.11	989.64	985.56
Medical and Dental	614.99	617.87	615.30
ACTUAL SUBSTANTIVE STAFF BY STAFF GROUP			
Registered Nursing, Midwifery and Health Visiting Staff	1616.83	1616.21	1612.68
Allied Health Professionals	315.16	316.97	321.08
Registered Scientific, Therapeutic and Technical Staff	116.20	117.15	118.39
Healthcare Scientists	49.29	46.29	45.39
Support to Clinical Staff	1022.40	1014.08	1007.97
NHS Infrastructure Support	834.06	835.68	836.69
Medical and Dental	578.29	580.14	578.74
ACTUAL BANK STAFF BY STAFF GROUP			
Registered Nursing, Midwifery and Health Visiting Staff	127.64	113.51	115.41
Allied Health Professionals	9.20	10.93	8.24
Registered Scientific, Therapeutic and Technical Staff	9.07	8.38	10.95
Healthcare Scientists	0.00	0.00	0.00
Support to Clinical Staff	163.17	143.07	143.59
NHS Infrastructure Support	136.45	150.36	145.27
Medical and Dental	36.60	35.67	36.05
ACTUAL AGENCY STAFF BY STAFF GROUP			
Registered Nursing, Midwifery and Health Visiting Staff	2.43	2.03	0.68
Allied Health Professionals	4.70	5.51	4.54
Registered Scientific, Therapeutic and Technical Staff	1.89	2.78	3.06
Healthcare Scientists	0.00	0.00	0.00
Support to Clinical Staff	0.00	0.00	0.00
NHS Infrastructure Support	3.60	3.60	3.60
Medical and Dental	0.11	2.06	0.50



Since March 2026, the overall workforce has decreased by 88.8 WTE, with the substantive, bank, and agency workforces decreasing by 32.3, 51.9, and 4.6 WTE, respectively. The monthly substantive workforce decrease reflects reductions in Community-based RN&M and clinical support colleagues, which offset increases in the AHP, Scientific, and Infrastructure Support staff groups. Overall bank WTE fell during M4 26/27, owing to decreased reliance on AHP and Infrastructure Support bank shifts. Agency reliance fell across RN&M, AHP, and M&D staff groups, contributing to a month-on-month overall decrease, despite rising Pharmacy-related agency usage.

Integrated Performance Report

Walsall Healthcare NHS Trust

July 2026 (Month 4)

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:

SPC Key

—●— Performance	— Mean	----- LCL	----- UCL
● Point of Concern	● Point of Improvement	— Target	--- Trajectory



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Managing Director Summary

WHT is on plan at Month 4. Industrial Action costs of approx. £0.9m in Month 1 are offset by non pay underspends and increased CIP delivery in Month. 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£10.5m in the first half of the financial year and then a surplus of c£10.5m in the second half of the year. In 26/27 Urgent and Emergency Care is “blended” meaning the Trust can earn or lose 20% of any over/under performance. July ED activity provided £2.1m over performance across ED and Emergency Inpatients, this is driving £0.4m of UEC income accounted for above contract YTD. In July YTD, the Trust delivered £0.1m of variable elective performance above contract. This would have been £0.3m above contract if there was no industrial action. CIP is £5.373m versus target of £4.980m, a positive variance of £393k.

Quality and safety and care improvement is our priority. No severe harm falls were reported in July 2026. Care Hours per Patient Day (CHPPD) has reduced slightly to 8.0 from 8.2 in June 2026. In July 2026, the corridor space was used to support peak periods of ambulance offloads on 6 separate days, averaging 4.5 hours per episode. Venous Thromboembolism (VTE) compliance has improved again in July and remains above the 90% mark but is below the national target of 95%. Improvement action plans are and overseen by Quality Committee. Formal complaint response compliance improved again in July with 70% of all complaints being responded to in time frame. Progress against the HTA CAPA plan continues, with most actions now completed and submitted for review. Regular engagement with the HTA provides ongoing assurance, and no regulatory action is currently expected.

The perinatal team are working through the national submission of a baseline assessment against the 10 key priority areas following the publication of the Ockenden report into maternity services at NUH and the Baroness Amos report. Plans are being developed to roll out Martha’s Rule across the Group in maternity services. An audit of maternity triage is underway in line with the national requirement regarding maternity triage and publication of the audit tool.

Workforce deployment has decreased during month 4 with a substantive, bank, and agency usage reduction. Vacancy rates, appraisal compliance and sickness absence remain key challenges, with improvement plans in place, including a healthy attendance programme which has provided positive improvements on absence, and enhanced appraisal support.

Author



Amelia Godson
(Managing
Director)

Managing Director Summary

Operational performance remained positive for our latest reporting period and saw improvement in a number of areas. Urgent and Emergency Care 4-hour performance was above trajectory at 80.1%, ranking 17^h nationally and 3rd regionally, supported by continued improvements in ambulance handover processes and pathway optimisation across our wards. Elective Care performance has stabilised with 73.77% with continuation as the top-performing Trust in the Midlands for RTT for the 21st consecutive month, while Cancer performance achieved all three national standards, benefiting from Oncology service improvements and strengthened MRI capacity. Diagnostic performance has continued to improve with a positive increase of patients seen within 6 weeks achieving 78.87% against the DM01, supported by additional mobile MRI capacity introduced during June.

The Trust continues to maintain a strong national productivity position overall, but focus remains on improving outpatient pathway efficiency by optimising clinic templates, reducing follow ups, and increasing elective activity per WTE. We are also working to reduce sickness absence and temporary staffing expenditure to support long-term sustainability and further performance gains.

Author



Amelia Godson
(Managing
Director)



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Balanced Scorecard – to update

Quality and Patient Safety

	Metric Name		Target	Previous Month	Current Month	Latest Time Period	2019/20 Same Period	Variation	Assurance
1	Falls - Rate per 1000 Beddays	Rate		3.18	3.08	Jul 2026	5.01	Common Cause	No Target Set
2	Pressure Ulcers - Rate per 1,000 Beddays (Cat 1, 2, 3, 4 & Unstageables) - Hospital	No.		2.72	2.22	Jul 2026		Concern	No Target Set
3	Pressure Ulcers - Rate per 10,000 CCG Population (Cat 1, 2, 3, 4 & Unstageables) - Community	No.		1.36	1.12	Jul 2026		Concern	No Target Set
4	Patient Observations - % rechecked within time	%	90.00	89.42	88.29	Jul 2026	85.18	Common Cause	Inconsistent
5	VTE Risk Assessment - % within 14 hours	%	95.00	91.21	90.69	Jul 2026		Improvement	Not Met
6	Sepsis Screening - ED	%							
7	Sepsis Screening - Inpatients	%							
8	ED - Mental Health Patients spending over 24 hours in ED	No.		15.00	13.00	Jul 2026		Improvement	No Target Set
9	Clostridium Difficile - Number of Cases	No.		4.00	3.00	Jul 2026	2.00	Common Cause	No Target Set
10	MRSA - Number of Cases	No.	0.00	1.00	0.00	Jul 2026	0.00	Common Cause	Inconsistent
11	Complaints - No. of Complaints as a % of Admissions	%		0.55	0.45	Jul 2026		Common Cause	No Target Set
12	Friends and Family : % Recommended - Trust (Average)	%		93.00	93.00	Jul 2026		Common Cause	No Target Set
13	CHPPD - Total Nursing & Midwifery Staff Actual	No.		8.20	8.00	Jul 2026		Improvement	No Target Set
14	CHPPD - Registered Nursing & Midwifery Staff Actual	No.		4.80	4.70	Jul 2026		Improvement	No Target Set
15	Mortality - SHMI (NHS Digital) (12 Month Rolling Position) - Manor Hosp Site	No.	1.00	0.97	0.98	Mar 2026	1.08	Concern	Achieving
16	Incidents - Never Events	No.	0.00	0.00	0.00	Jul 2026	0.00	Improvement	Inconsistent

Workforce Performance	Target / Limit	Latest Time Period	Current Month	Previous Month	Period Year (Same Period)	Variation	Assurance
Substantive (WTE) Trust	4615.08	Jul-26	4520.93	4526.53	4551.43	Improvement	Achieving
Bank (WTE) Trust	324.79	Jul-26	459.52	462.22	426.48	Concern	Not Met
Agency (WTE) Trust	12.04	Jul-26	12.38	15.98	12.55	Improvement	Not Met
Vacancy Rate	6.00%	Jul-26	10.65%	11.39%	10.26%	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	Jul-26	7.88%	7.79%	8.38%	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	Jul-26	94.07%	95.25%	94.08%	Improvement	Achieving
Sickness Absence (In Month)	5.00%	Jul-26	6.56%	6.47%	6.05%	Common Cause	Not Met
Appraisals	90.00%	Jul-26	78.23%	80.00%	74.93%	Common Cause	Not Met
Statutory & Mandatory Training	90.00%	Jul-26	91.30%	91.39%	91.08%	Improvement	Inconsistent

Operational Performance

	Metric Name		Target	Previous Month	Current Month	Latest Time Period	2019/20 Same Period	Variation	Assurance
1	18 Weeks Referral to Treatment - % Within 18 Weeks - Incomplete	%	80.04	74.80	73.77	Jul 2026	88.83	Improvement	Not Met
2	18 Weeks Referral to Treatment - 52 Week Breaches as % of the Total PTL	%	1.00	0.01	0.05	Jul 2026	0.00	Improvement	Not Met
3	18 Weeks Referral to Treatment - Total Incomplete PTL	No.	26,150.00	27,966.00	27,855.00	Jul 2026	15,279.00	Improvement	Not Met
4	Cancer - 28 Day Faster Diagnosis - % Compliance - Overall	%	80.05	86.49	88.60	Jun 2026		Common Cause	Inconsistent
5	Cancer - 31 Day Treatment - % Compliance - Combined Standard	%	94.57	98.88	98.10	Jun 2026	100.00	Common Cause	Inconsistent
6	Cancer - 62 Day Referral to Treatment - % Compliance - Combined Standard	%	80.00	77.94	80.22	Jun 2026	88.54	Common Cause	Inconsistent
7	Criteria to Reside - No. of patients no longer meeting the Criteria to Reside	No.		33.00	3.00	Jul 2026		Improvement	No Target Set
8	Diagnostics - Diagnostic waiting within 6 weeks from referral	%	77.96	72.29	78.87	Jul 2026	99.67	Concern	Inconsistent
9	ED - ED Attendances Admitted, Transferred or Discharged over 12 hours of Arrival	%	6.46	3.18	5.75	Jul 2026	1.04	Common Cause	Inconsistent
10	ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival	%	83.01	83.26	80.09	Jul 2026	84.57	Common Cause	Not Met
11	Community - Waiting List - Total	No.	8,345.00	9,341.00	9,290.00	Jul 2026		Concern	Achieving
12	Community - Waiting List - % Within 18 Weeks	%	72.01	65.85	64.27	Jul 2026		Concern	Inconsistent

Finance	Target	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£'000) - in month	(1,219)	(1,026)	(1,168)	52	Deterioration	Achieving
Surplus/(Deficit) (£'000) - YTD	(7,145)	(5,919)	(7,087)	181	Deterioration	Achieving
Surplus/(Deficit) (£'000) - FOT	0	0	0	50	Concern	Not Met
ERF (£'000) - in month	7,286	7,126	7,324	N/A	Improvement	Achieving
ERF (£'000) - YTD	27,228	19,965	27,290	N/A	Improvement	Achieving
ERF (£'000) - FOT	N/A	N/A	N/A	N/A		
Efficiency (£'000) - in month	1,307	1,922	1,062	623	Common Cause	Not Met
Efficiency (£'000) - YTD	4,980	4,304	5,373	2,789	Common Cause	Achieving
Efficiency (£'000) - FOT	27,517	27,517	27,517	0	Common Cause	Achieving
Capital (£'000) - YTD	3,231	1,204	2,199	N/A	Concern	Not Met
Capital (£'000) - FOT	13,364	13,364	13,364	11,704	-	Achieving
Cash (£'000) - in month	18,328	36,539	37,985	2,623	Improvement	Achieving
Cash (£'000) - FOT	12,463	12,463	12,463	9,056	-	Achieving



Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

•Falls per 1,000 bed-days

- July 2026 falls rate: 3.08 (down from 3.18 in June), below the Royal College of Physicians mean of 6.1.
- Enhanced Therapeutic Observations and Care (ETOC) bundle testing is planned on four wards in August; AMU began a bathroom-sensor trial on 20 July.
- Neurological-observation compliance after falls was 42.11% (June: 58%) and remains under targeted review; the Deputy Medical Director is reviewing regional and national guidance on the duration of observations post-fall.

•Pressure Ulcers per 1,000 Bed Days

- Hospital: 36 incidents, 2.22 per 1,000 bed days (June: 2.72). Community: 32 incidents, 1.12 per 10,000 population (June: 1.26).
- 68 Trust-acquired pressure ulcers were reported in July (June: 77); no Category 4 ulcer has been reported since February 2026.
- SMART divisional plans, targeted education, mattress assurance and review of continence products continue.

•Observations on Time

- July compliance was 88.29% including ED and 91.86% excluding ED; ED was 68.52% (June: 71.20%).
- 19 of 26 areas met the 90% target; Surgery and WCCSS remained above 90%.
- Senior Divisional Team continue to provide oversight of work to improve compliance in MLTC with a particular focus on ED.

•Infection Control

- Three C. difficile cases were reported in July: 3 HOHA and 0 COHA; the 2026/27 national trajectory is 47.
- July bacteraemia position: MRSA 0; HOHA MSSA 2; E. coli 2 HOHA/3 COHA; Klebsiella 0 HOHA/2 COHA; Pseudomonas 1 HOHA.

Authors



Lisa Carroll (Chief Nursing Officer)



Zia Din
(Medical Director)

Quality, Safety & Patient Experience | Executive Summary Cont.

•Sepsis Screening

- July antibiotics within one hour: adult inpatients 89.13% (June: 79.71%); adult ED 85.43% (80.90%); paediatrics 97% (100%).
- Clinical assessment and de-escalation remain positive. NEWS2 e-learning compliance was 79.5% and Scale 2 training 77.1%.
- The Martha's Rule wellness question is fully implemented, with an InPhase audit created to monitor compliance.

•Safe Staffing

- Clinical areas were green for 64% of shifts (June: 65.44%). MLTC remained most pressured: 54.68% amber and 1.04% red.
- Overall fill rate was 88.99%; the lowest was CSW days at 77.10%. Trust-average CHPPD was 8.0 (June: 8.2).
- In July, to maintain safe staffing, 1,564 RN and 900 CSW hours were redeployed; ward managers covered 576 RN hours across 67 shifts.

•FFT Recommendation Rate: Trust-wide

- Trust-wide recommendation remained 93% in July. Inpatients 92%, ED 84%, Outpatients 95% and Community 94%.
- Maternity: Antenatal 98%, Birth 89%, Postnatal Ward 89% and Postnatal Community 100%.

•Complaints

- Formal complaint-response compliance improved to 70% in July (June: 64%); 69 formal complaints were received (June: 83).
- Early contact supported 21 early resolutions. Weekly divisional huddles continue to address delays in appointing handlers and validating responses.
- A streamlined final-response template has been developed; in order to deliver timely responses, respondents are supported by AI, subject to final clinical and managerial review.

Authors



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Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

•**Medication Errors: % causing harm**

- July 2026 harm rate: 9.60%; SPC shows common-cause variation, and no target is set.
- Latest incident data (June): 119 medication incidents (May: 86); Medicines Safety Index 12.6% against a national benchmark of 11.69%, with three moderate-harm incidents.
- Medicines-management audit completion was 63%, with 93% compliance. SACT Version 3 data is complete; a one-year Version 4 extension has been requested while Chemocare is upgraded.

•**Mental Health**

- July: 10 Section 136 incidents. Achieving timely adult and CAMHS assessments remains challenged by delays and limited out-of-hours psychiatric cover.
- Two children and young people required 2:1 observation; a complex ITU patient also required 2:1 observation and experienced delayed discharge.
- The delirium clinic is now operational on Sister Dora Suite

•**ED Corridor Care**

- Corridor space was used on six days in July, averaging 4.5 hours per episode (June: six days, 3.8 hours).
- The area continues to operate under the agreed SOP, with harm review and audit after use and mandated reporting for stays over 45 minutes.

•**Human Tissue Authority**

- The maternity transfer theme remains principally linked to WHT; the latest linked incident was in December 2025.
- Updated WHT and RWT maternity SOPs have been shared with the HTA. The WHT maternity fridge is installed but awaits staff training before use.
- The Evidential Compliance Assessment (ECA) reviews incidents from 1 April 2015 to 30 June 2026. The DI declaration is due 18 September, with any previously unreported HTARIs due by 30 September.
- CAPA work continues: RWT estates work is resourced; the Tutela upgrade remains pending with interim three-times-daily monitoring; WHT mortuary-table servicing is progressing.

Authors



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(Medical Director)

Quality, Safety & Patient Experience | Executive Summary Cont.

VTE Risk Assessment

- July 2026 compliance is at 90.69 %, the second consecutive month which crosses the 90% mark , but remains below the national target of 95%
- For benchmarking the quarterly performance is 89.34% for Jan-Mar 2026. The results for Apr-Jun 2026 have yet to be released.
- Regular Spot audits for alternative assurance.
- Elective pathways continued to maintain the good VTE assessment performance of above 95%
- Improvement Actions: Reviewing Divisional performance every month. Reviewing improvement action plans at focused areas (AMU, SACU). Sharing of selected VTE cases at the Thrombosis Group meeting for learning.

SHMI (Summary Hospital-level Mortality Indicator)

- Latest data available: In March 2026, the SHMI increased to a value of 0.98, which is an increase of 0.2 but remains within the expected. This is monitored closely via Learning from Deaths Group.
- SHMI alert relating to 'Fluid & Electrolyte Disorder' is due to be presented at September Learning from Deaths meeting.
- Improvement actions: Focus remains on outstanding Structured Judgement Reviews. Updates continue to be reported monthly at Learning from Deaths Group.

Authors



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Quality, Safety & Patient Experience | Executive Summary Cont.

Perinatal Quality Oversight Model (PQSM) Dashboard 2026/27

CQC maternity inspection 2021	Safe	Effective	Caring	Well Led	Responsive
	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
CNST Year 7	Full compliance with 10 Safety Actions				

	February		March		April		May		June		July	
PMRT Reviews	2		3									
Grade	N	M	N	M	N	M	N	M	N	M	N	M
N = neonatal	A 0	A 0	A 0	A 0	A 0	A 0	A 0	A 2	A 2	A 0	A 0	A 0
	B 0	B 1	B 0	B 1	B 0	B 1	B 0	B 0	B 0	B 1	B 0	B 4
M = Maternal	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 0	C 1	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		1		0		0		0		0	
Incidents Moderate & Above	13		11		12		14		7		19	
Service feedback FFT recommendation	91%		95%		95%		95%		92%		92%	
Service user & Staff Feedback to Board Level Safety Champions Walk & Bi-Monthly meeting	No Safety Walk		Neonatal Unit		Antenatal/ Postnatal ward		Antenatal clinic/ fetal assessment		Community		Delivery Suite	
					Bimonthly				Bimonthly			
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 47.84% NHS Staff Survey											
Obstetrics/ Gynaecology Trainees Quality of Clinical Supervision reported annually	Quality of Supervision 86.76% GMC national trainee survey											

Overview of progress on MIS year 8 safety action requirements



Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	0	7	0	0	7
B	0	0	5	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	1	0	2	0	0	2
F	1	0	3	0	0	3
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	2	0	25	0	0	

CNST Year 8 Compliance

Progressing to plan: NLS, PROMPT and foetal monitoring training 90% compliant. A maternity safety oversight signal drill and out of hospital simulation is planned for September 2026.

	NLS	PROMPT	Foetal surveillance
MW	94%	94%	94%
Obstetric Consultant	95%	95%	100%
Obstetric Residents	100%	100%	100%
Maternity support workers	100%	100%	NA
Anaesthetics	97%	97%	NA
Neonatal Nurses	90%	NA	NA
Neonatal Consultants	94%	NA	NA
Neonatal Residents	90%	NA	NA

Authors

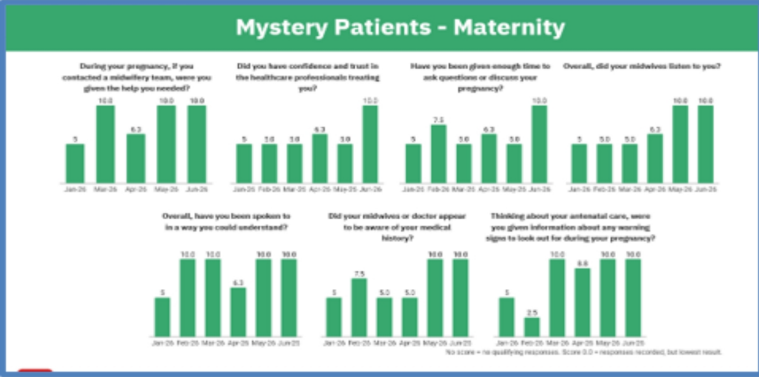


Lisa Carroll (Chief Nursing Officer)



Zia Din (Medical Director)



Item	Themes	Action
PMRT	- Blood pressure management (this remains on ongoing theme) - Perception of fetal movement and the information being disseminated to woman - Uses of interpreter- need for further exploration regarding the woman’s understanding during consultations, particularly if woman declines interpreter Good practice - New HTA guideline in place - Cases reviewed in line with national guidance within required time frame and with external reviewer present - All cases completed with the recommended timeframe	- Ensure all clinicians are up to date with MCU training and e-learning relating to the management of hypertension in pregnancy, - Resident doctors to complete an audit of reduced fetal movements, including a information provided to women regarding reduced fetal movements, compliance with the reduced fetal movements checklist, attendances for reduced fetal movements, and evaluation of actions.
MNSI	No new cases have been reported	
Incident &/or PSIRF themes	- Perinatal mortality & Morbidity - Post Partum Haemorrhage (PPH) - Third degree tears - PSIRFF theme for last 12 months readmissions.	- Perinatal Mortality 4.37:1000 (MBRRACE comparator rate 4.77:1000). - Stillbirth 3.26: 1000 (MBRRACE rate 3.18:1000). - Term babies to the neonatal unit rate Q1 5.0 % (national target <5%) - All MBRRACE reportable cases complete and reported via SPEN - Multi professional PPH reviews conducted, themes around operative delivery - Thematic review completed regarding maternal readmissions being presented at audit meeting in September.
Service user feedback		- Maternity CQC Survey action plan continues and the questions in the mystery patient data are aligned with the CQC maternity survey. - The service also runs a birth reflection and a calm connections clinic. During Quarter 1 2026, 82 women were referred to the Birth Reflections Service. 70.7% of referrals identifying as White British and 29.3% identifying as Black, Asian or Minority Ethnic groups - Both complaints and compliments to the service saw an increase in Q1 2026, complaints were driven by staff attitude (though paradoxically this was also seen as a positive trend in complements), communication and implementation of care. - MNVP enjoyment and support inadequate at WHT, this has been escalated to the CNO and also a meeting has been held with MNVP lead to discuss how this can be improved - Martha’s Rule is in the process of being implemented with a group approach being adopted. Meetings between the WHT and RWT teams are in process.
Staff & Safety Champions feedback	- Community & Delivery Suite Walks taken place, Maternity Triage & staff sickness absence - Bimonthly meeting took place in June 2026 - Staff support provided by PMA for resilience , health and well being	- Transitional Care capacity not meeting the needs of the service and potential Group approach to this. - Sickness absence in community placing addition challenge for staff, this is now reducing - PMA’s have had 255 staff contacts in 1st 6 months of 2026, support provided with resilience, working relationships and work life balance
Regional Heatmap	Q1 2026 overall score 16	In Q1 WHT one of remained 3 Trust’s in the region with the best overall score which demotes a safe service. In July the score increased to 24 due to vacant Head of midwifery position and MSW vacancy. The Head of Midwifery commenced in post at the end of August 2026.
Maternity Oversight Safety Signal (MOSS)	No alerts received	In line with CNST year 8 simulated MOSS response will be completed if there are no alerts.

Authors



Lisa Carroll (Chief Nursing Officer)



Zia Din (Medical Director)

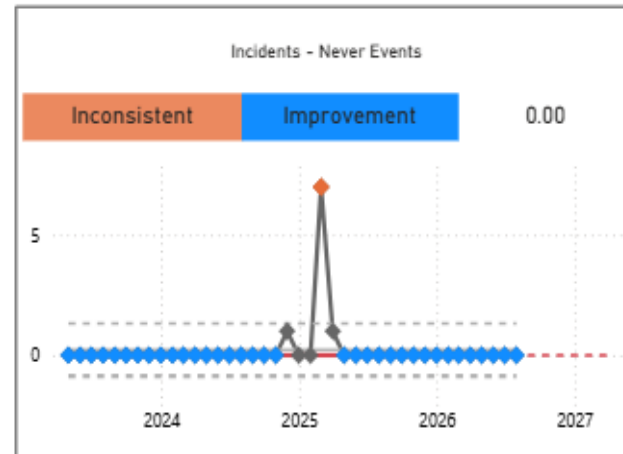
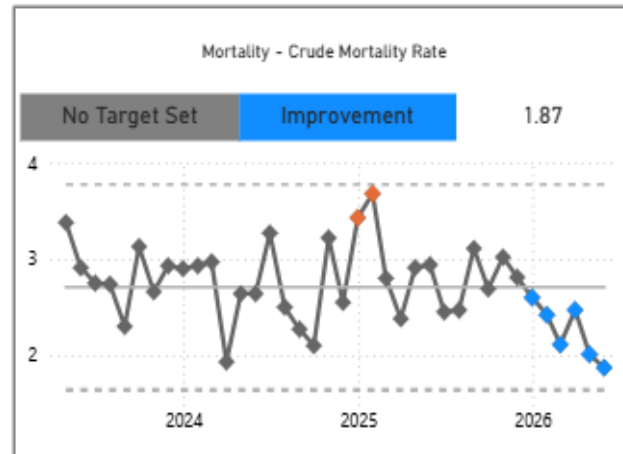
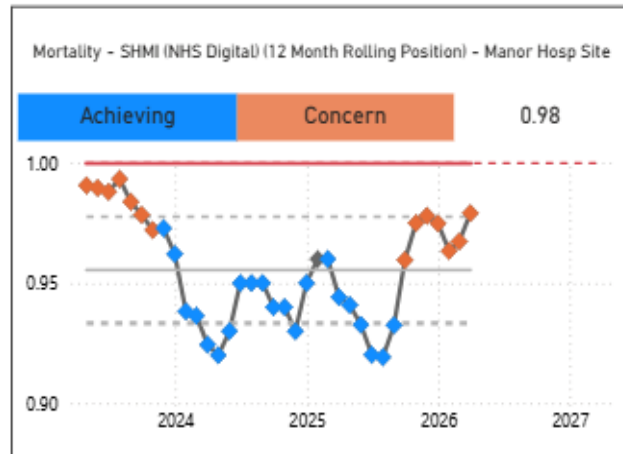
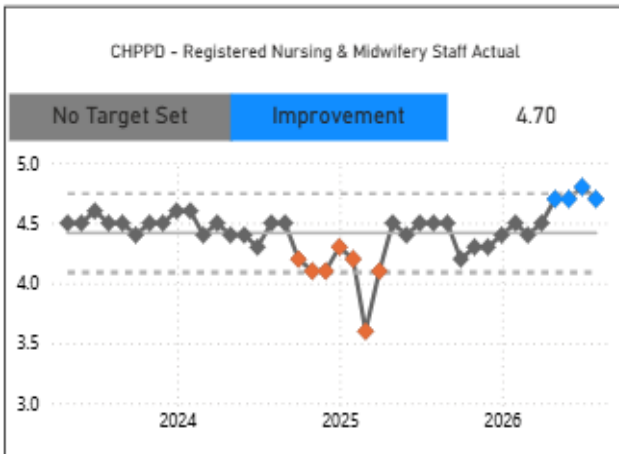
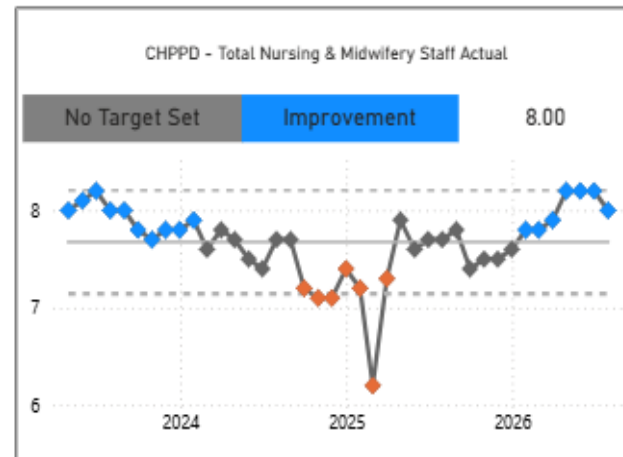
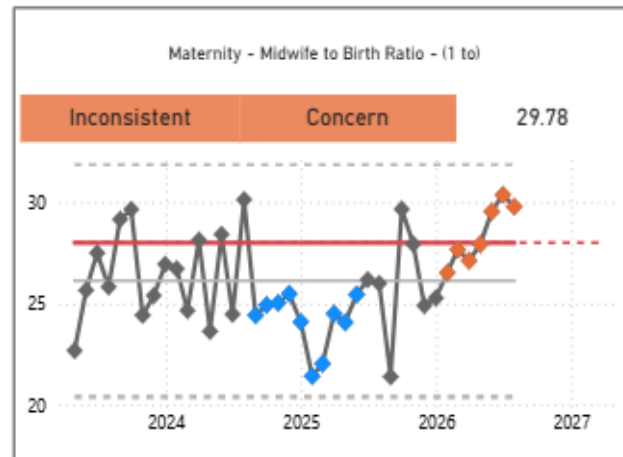
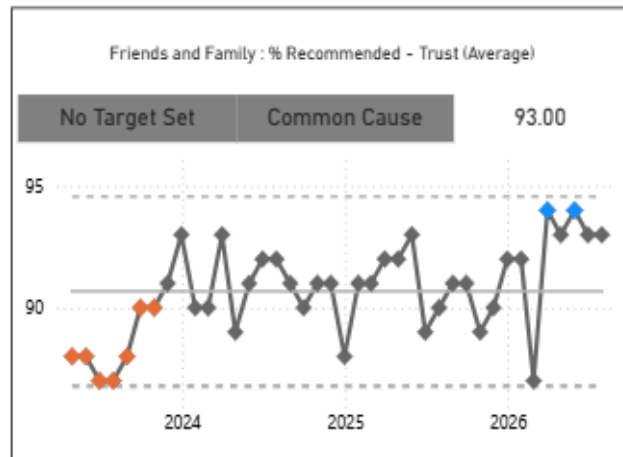
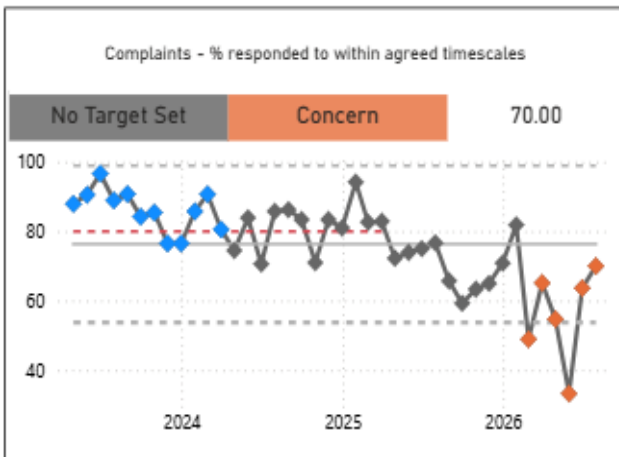


Leagues
Communities

Quality, Safety & Patient Experience | Core Metrics



Quality, Safety & Patient Experience | Core Metrics



Care Colleagues
Collaboration Communities

People | Executive Summary

Performance against Trust 2026/27 Workforce Plan

During July 2026, the overall workforce decreased by 11.6 WTE. This movement reflects a reduction in substantive deployment, a decrease in bank reliance, and a fall in agency usage

- Substantive workforce decreased by 5.6 WTE (0.1%).
- Bank utilisation reduced by 5.6 WTE (0.1%).
- Agency reliance fell by 3.6 WTE (22.6%).

Since March 2026, the overall workforce has decreased by 88.8 WTE, with the substantive, bank, and agency workforces decreasing by 32.3, 51.9, and 4.6 WTE, respectively.

While this represents a continued year-to-date reduction, the overall workforce is 80.1 WTE (1.6%) above the M4 26/27 workforce plan trajectory.

Performance against Key Workforce Metrics

In July 2026 the appraisal compliance reduced slightly to 78.2%. Reduction in compliance has been notable among Nursing and Midwifery Registered staff, dropping by 9.5%, and Additional Clinical Services staff by 9.2%.

Sickness absence rose to 6.6% in July 2026. The average length of long-term sickness episodes dropped month on month by 5% to 79 FTE.

The 12-month turnover rate fell to 7.9% and remains on target. The 12-month retention rate, at 94.1% in July 2026, continues to meet the target.

Authors



Claire Radley
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Director)

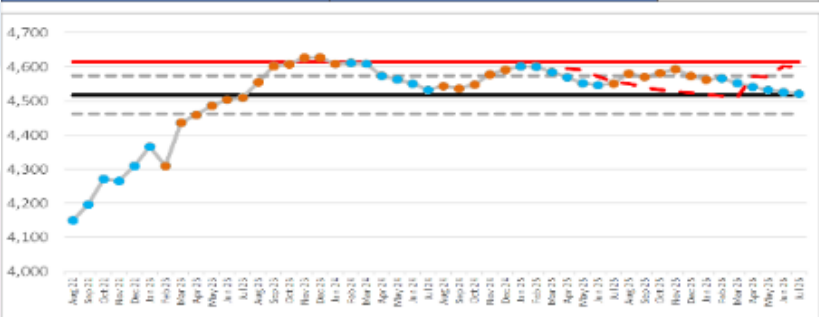


Care Colleagues
Collaboration Communities

People | Core Metrics

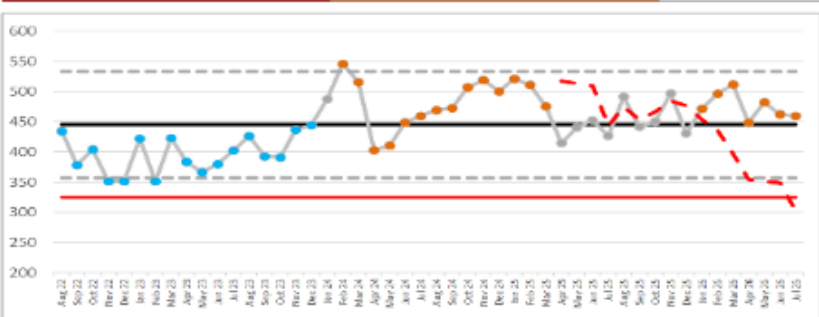
Substantive (WTE) Trust

Achieving	Improvement	4520.93
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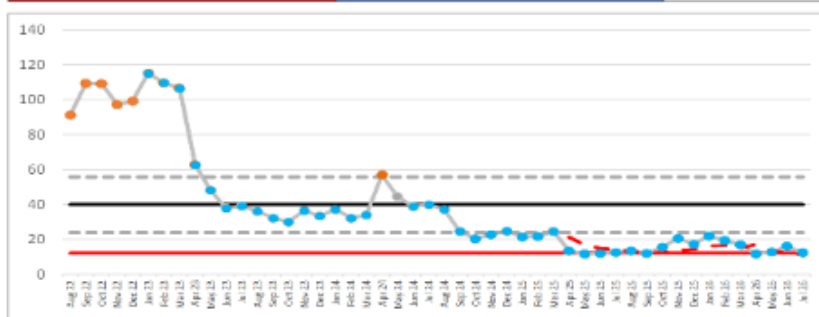
Bank (WTE) Trust

Not Met	Concern	459.52
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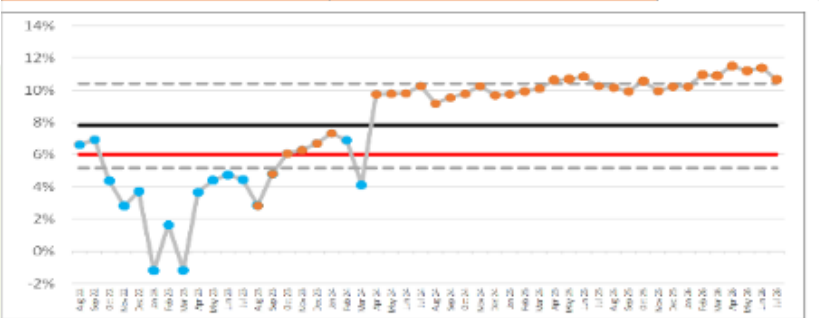
Agency (WTE) Trust

Not Met	Improvement	12.38
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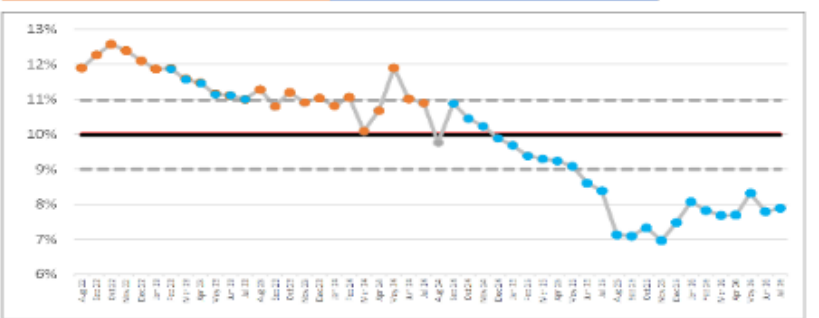
Vacancy Rate

Inconsistent	Concern	10.65%
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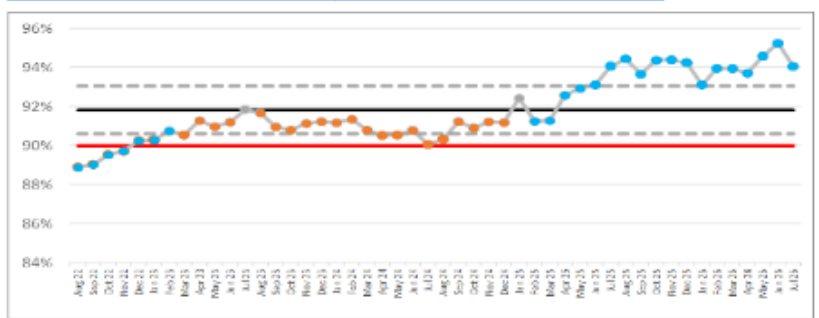
Turnover Rate (12 Months)

Inconsistent	Improvement	7.88%
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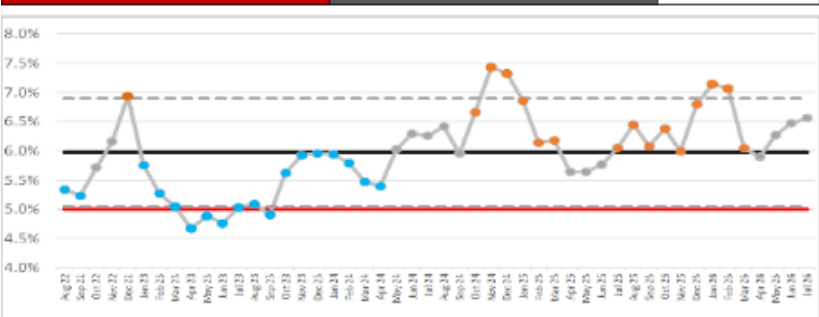
Retention Rate (12 Months)

Achieving	Improvement	94.07%
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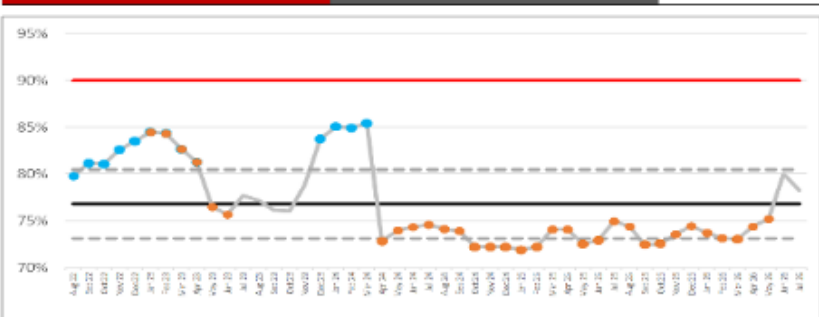
Sickness Absence (In Month)

Not Met	Common Cause	6.56%
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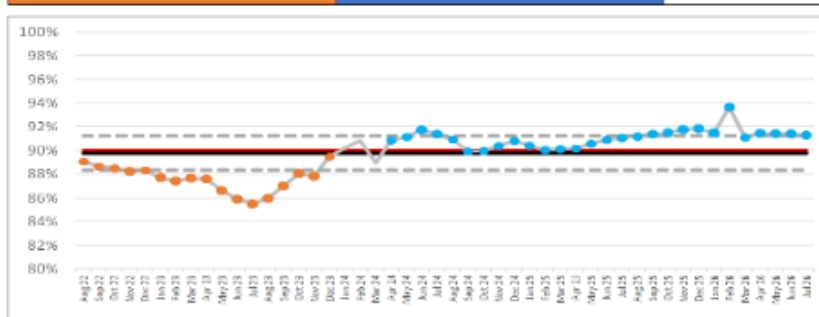
Appraisals

Not Met	Common Cause	78.23%
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Statutory & Mandatory Training

Inconsistent	Improvement	91.30%
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Operational Performance | Executive Summary

Authors



Demetri Wade
(Chief Operating
Officer)

Urgent & Emergency Care

The Trust has seen performance against the 4-hour Emergency Access Standard (EAS) continue to exceed the trajectory during July achieving 80.1%. Our EAS ranking is 17th nationally and remains 3rd in the region. Type 1 ED attendances were the highest recorded month at 10,476, with a year to date 6.28% increase (5.4% due to the overnight closure of the UTC). Ambulance Handover within 15 minutes was 32.88%, the Trust is ranked 7th regionally. Average handover time was 20 minutes 33 seconds. Looking ahead, during August we are conducting a focused week on ambulance offloads to review further opportunities for improvement.

Cancer Care

The Trust achieved all 3 cancer standards in June. Latest national ranking was 4th for 28-day FDS, 22nd for 31-day and 24th for 62-day standard. The 62-day standard improved to 80.22% against the 80% standard. Improved MRI access is providing a positive pathway benefit. Oncology provision has stabilised with a substantive appointment.

Elective Care

The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for 21 consecutive months, with RTT performance of 73.77%. This is below our trajectory of 75.37% and places the Trust 9th nationally. There has been a decrease in the Patient Tracking List (PTL) size to 27,855. For 1st appointments within 18 weeks the Trust is above trajectory with performance of 81.50%. The percentage of 52-week breaches was 0.05%, placing the Trust 2nd regionally and 6th nationally.

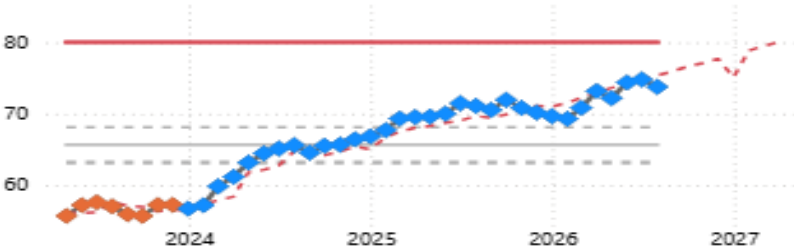
Diagnostics

DM01 performance improved to 78.87% during July. The challenged modalities remain; Magnetic Resonance Imaging (MRI), Audiology, NOUS, and Neurophysiology, but we are seeing good improvement with capacity increased.

Operational Performance | Core Metrics

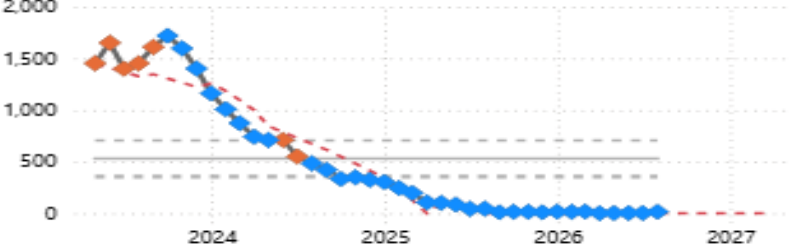
18 Weeks Referral to Treatment - % Within 18 Weeks - Incomplete

Not Met Improvement 73.77



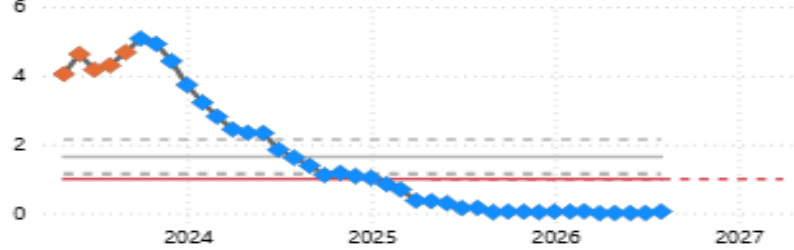
18 Weeks Referral to Treatment - Number of 52 Week Breaches - Incomplete

No Target Set Improvement 15.00



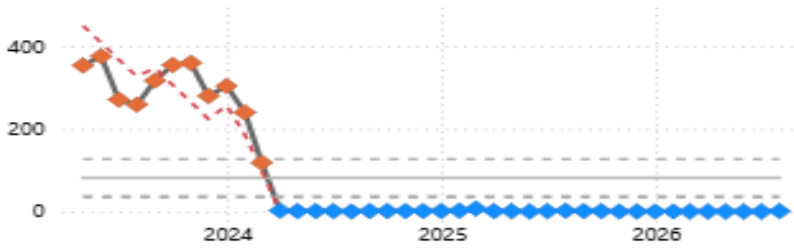
18 Weeks Referral to Treatment - 52 Week Breaches as % of the Total PTL

Not Met Improvement 0.05



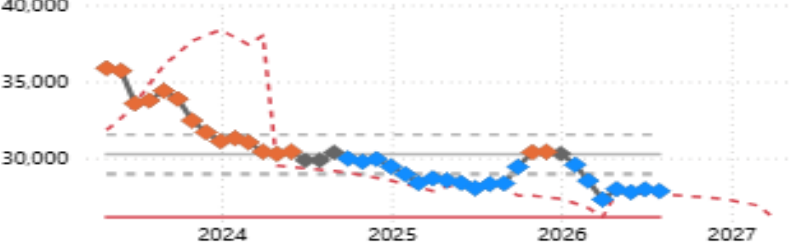
18 Weeks Referral to Treatment - Number of 65 Week Breaches - Incomplete

No Target Set Improvement 1.00



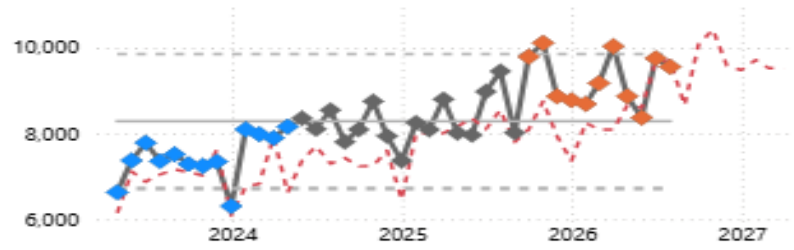
18 Weeks Referral to Treatment - Total Incomplete PTL

Not Met Improvement 27,855.00



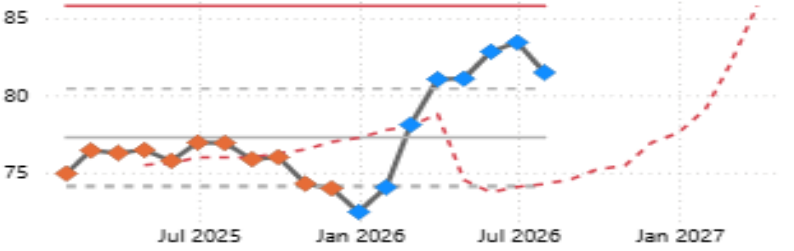
18 Weeks Referral to Treatment - Clock Starts

No Target Set Concern 9,561.00



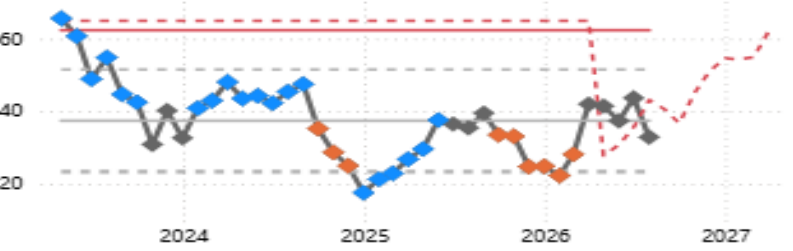
18 Weeks Referral to Treatment - Time to First Appointment

Not Met Improvement 81.49



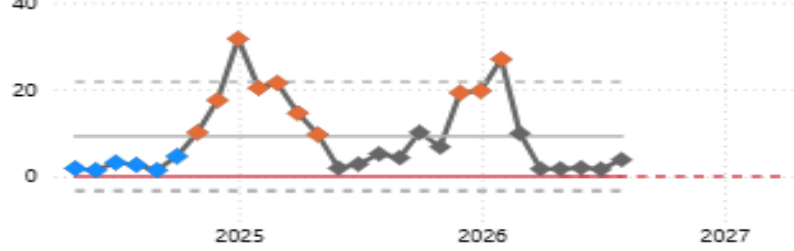
Ambulance Handover - % of Handovers completed within 15mins of Arrival

Not Met Common Cause 32.88



Ambulance Handover - % of Handovers completed over 45mins of Arrival

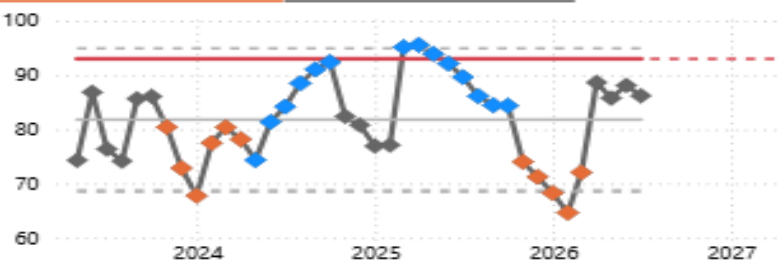
Inconsistent Common Cause 3.87



Operational Performance | Core Metrics

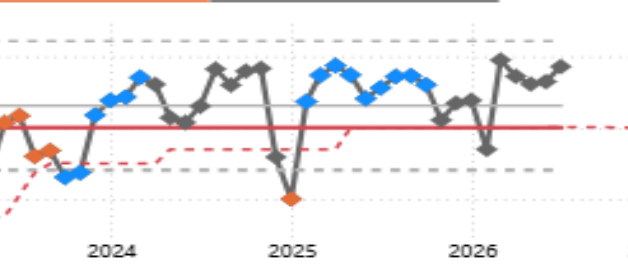
Cancer - 2 Week Wait - % seen within 2 weeks of referral for First Op Appt

Inconsistent Common Cause 86.18



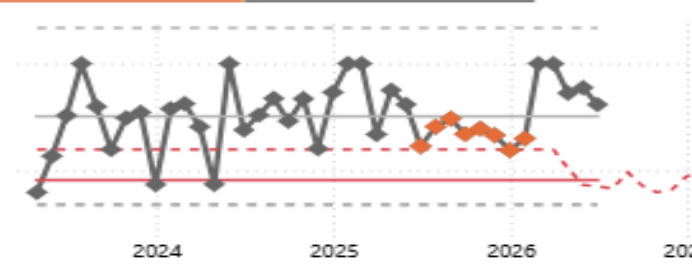
Cancer - 28 Day Faster Diagnosis - % Compliance - Overall

Inconsistent Common Cause 88.60



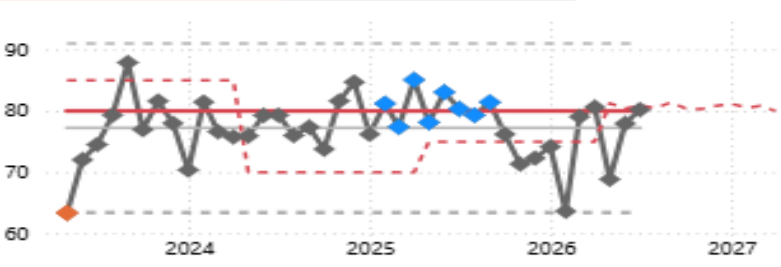
Cancer - 31 Day Treatment - % Compliance - Combined Standard

Inconsistent Common Cause 98.10



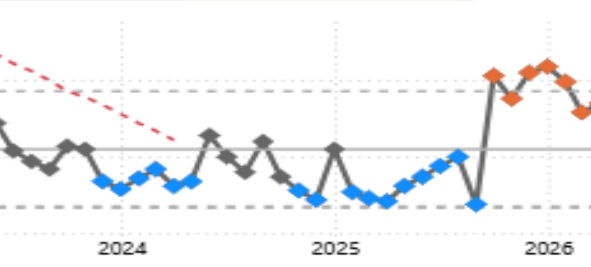
Cancer - 62 Day Referral to Treatment - % Compliance - Combined Standard

Inconsistent Common Cause 80.22



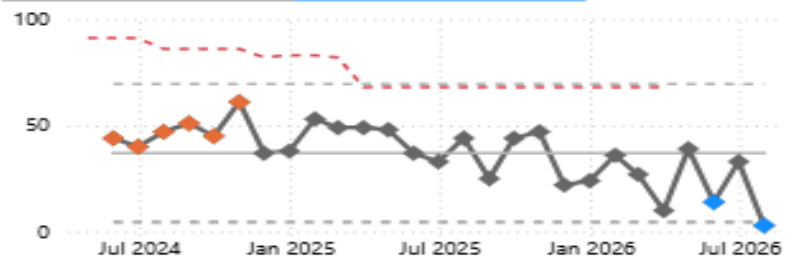
Cancer - No. of patients waiting 63+ Days for treatment

No Target Set Concern 100.00



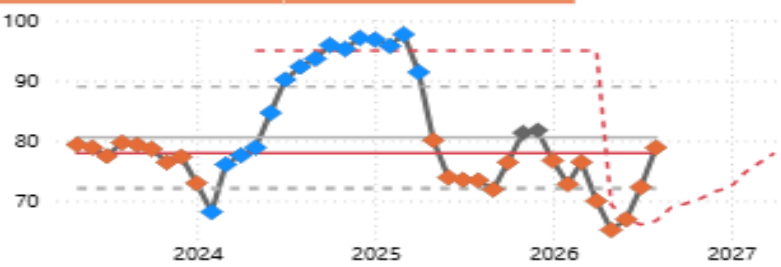
Criteria to Reside - No. of patients no longer meeting the Criteria to Reside

No Target Set Improvement 3.00



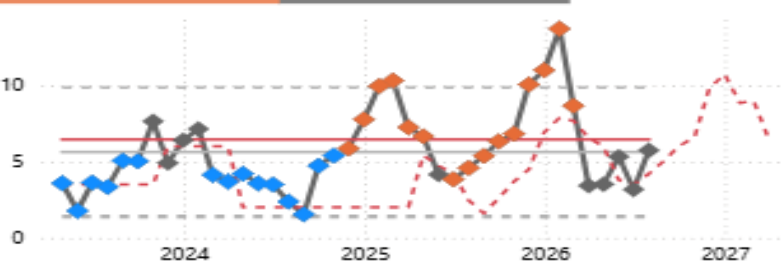
Diagnostics - Diagnostic waiting within 6 weeks from referral

Inconsistent Concern 78.87



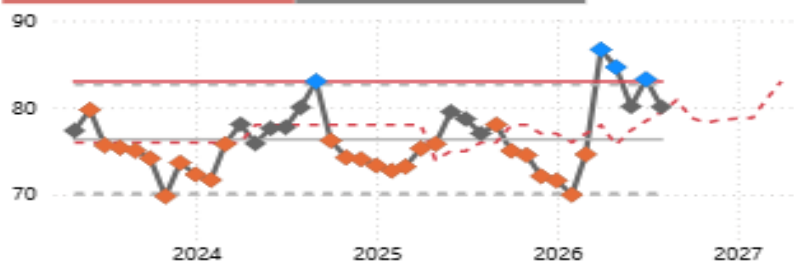
ED - ED Attendances Admitted, Transferred or Discharged over 12 hours of Arrival

Inconsistent Common Cause 5.75

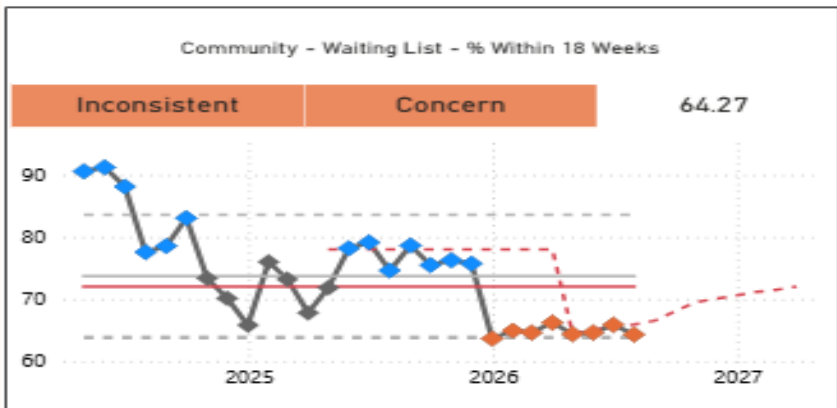
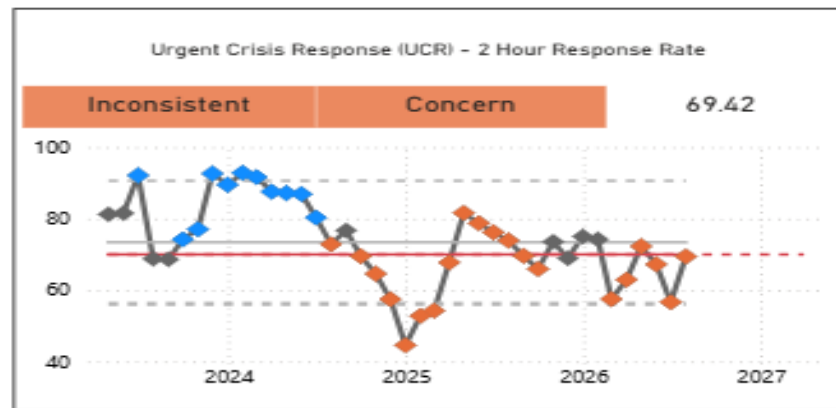
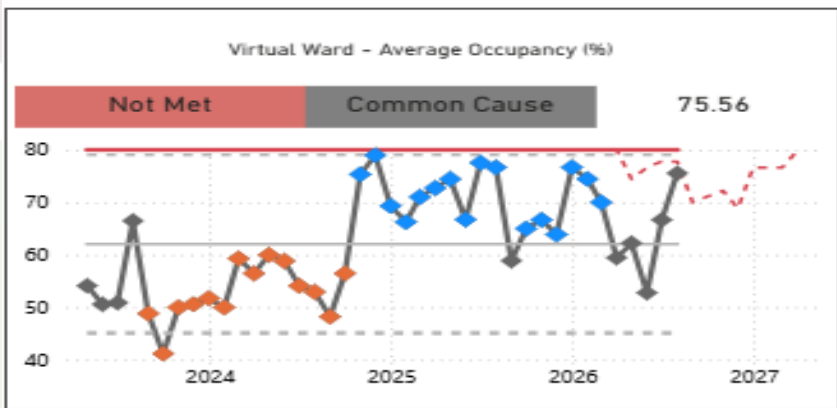
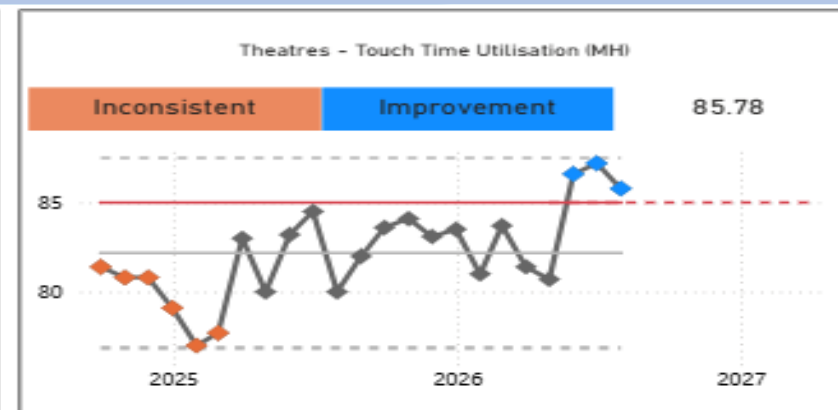
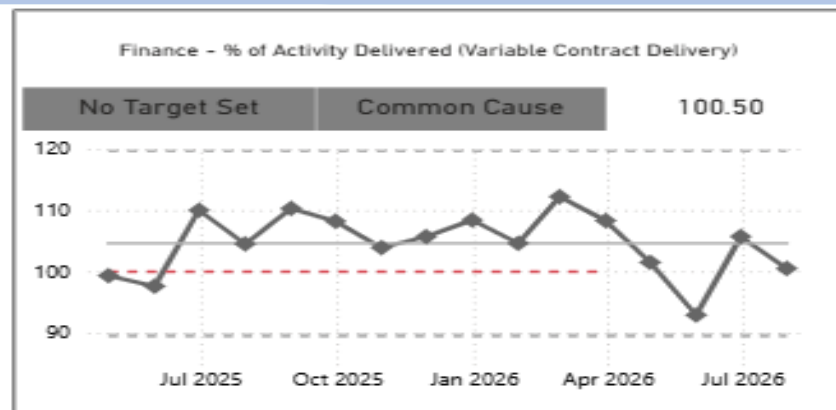
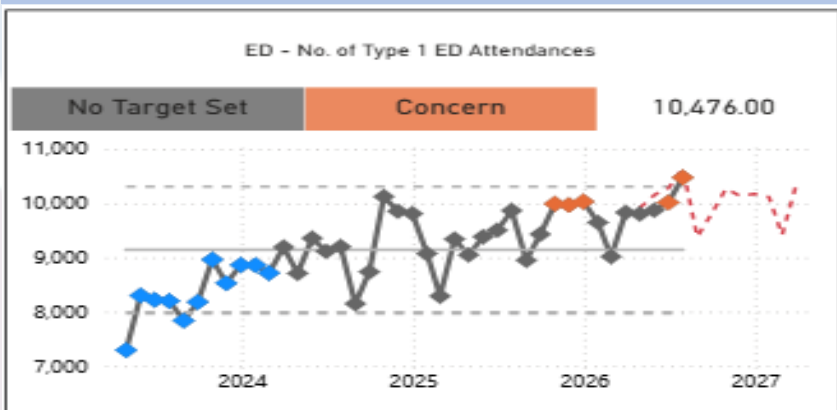


ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival

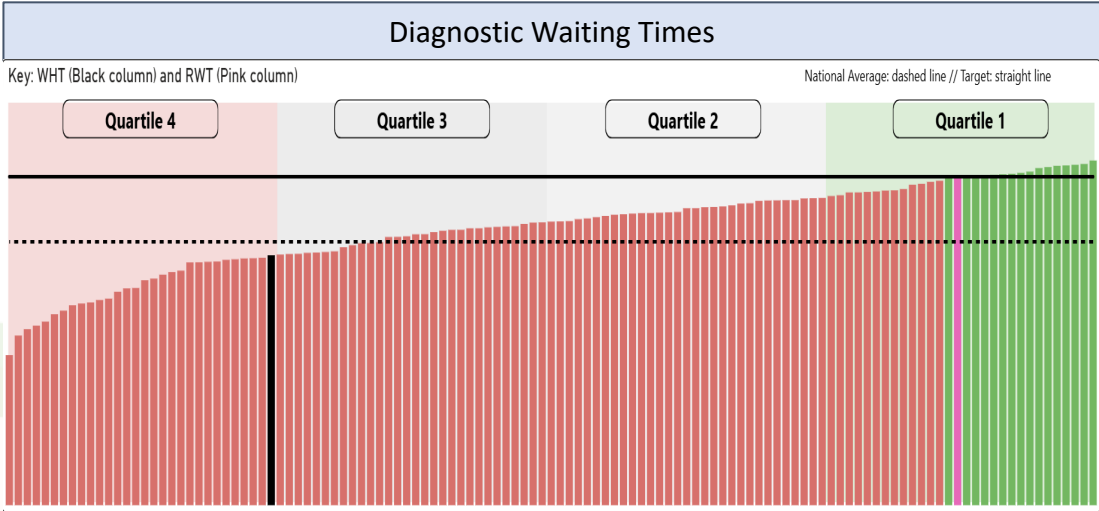
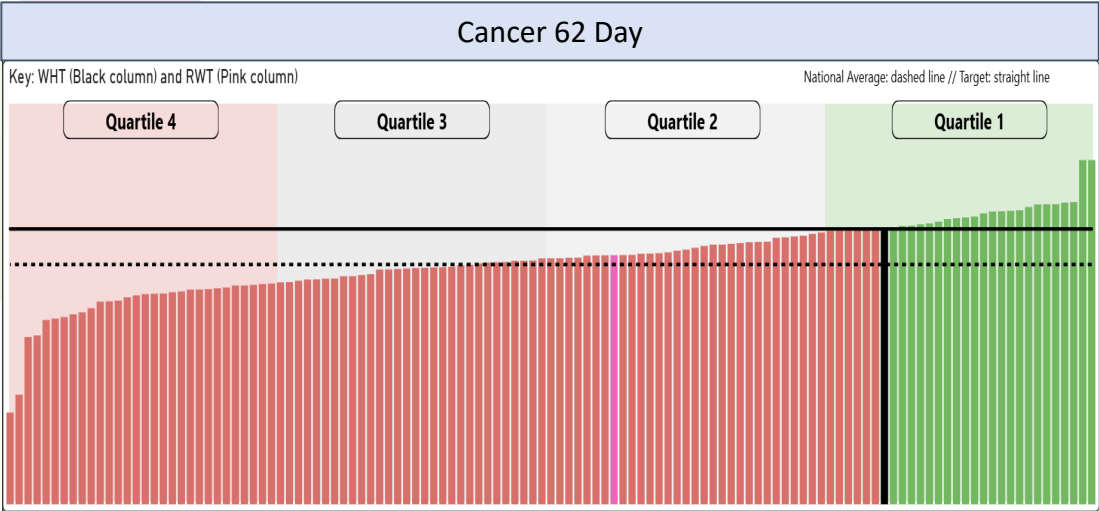
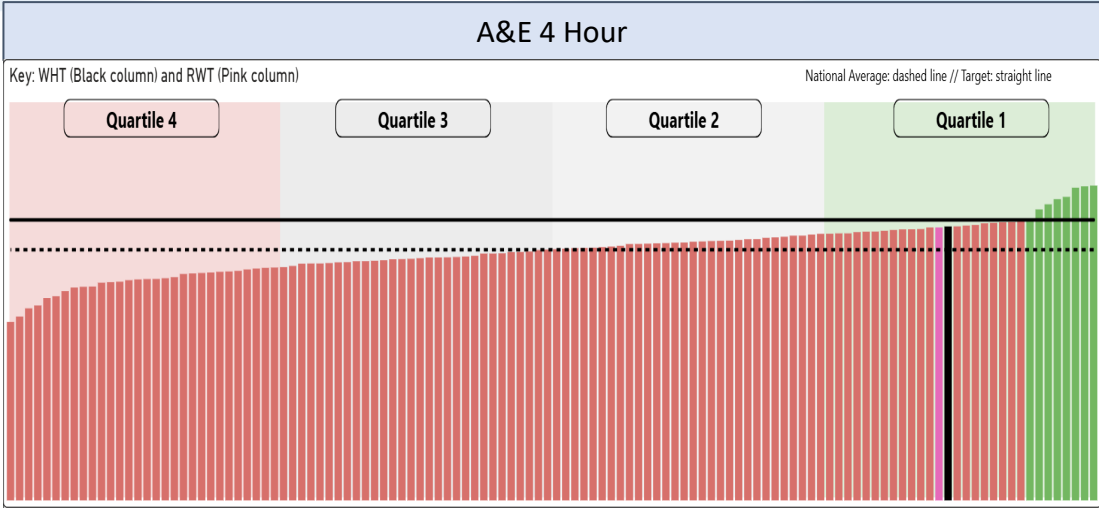
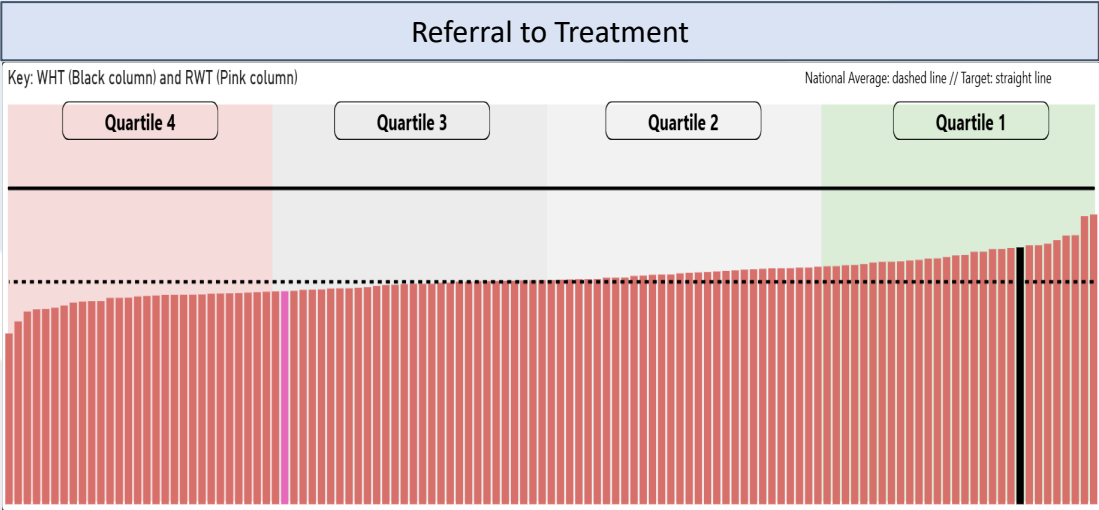
Not Met Common Cause 80.09



Operational Performance | Core Metrics



Operational Performance | Benchmarking



Finance | Executive Summary

Revenue

- WHT is on plan at Month 4. Industrial Action costs of approx. £0.9m in Month 1 are offset by non pay underspends and increased CIP delivery.
- 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£10.5m in the first half of the financial year and then a surplus of c£10.5m in the second half of the year.
- In 26/27 Urgent and Emergency Care is “blended” meaning the Trust can earn or lose 20% of any over/under performance. July was again a busy month in ED resulting in £2.1m over performance across ED and Emergency Inpatients, this is driving £0.4m of UEC income accounted for above contract YTD. In July YTD, the Trust delivered £0.1m of variable elective performance above contract. This would have been £0.3m above contract if there was no industrial action.
- CIP is £5.373m versus target of £4.980m, a positive variance of £393k.

Capital

- Year to date capital expenditure at Month 4 is £2.199m.
- The Theatres refurbishment and reconfiguration project continues from 25/26 the capital programme following numerous delays and is now expected to complete in quarter 3 of 26/27.
- The 2026/27 programme includes significant investment into IT infrastructure, estates maintenance and medical equipment and is in receipt of increased capital allowances for 26/27 for critical estates infrastructure. The total programme being £11.3m in 2026/27

Cash

- The Trust cash position at end of Month 4 is £37.9m. Cash is currently higher due to receipt of £12m ICB advance from 25/26 (to reduce future months payments and receipt of addition Year end settlements from the ICB. 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

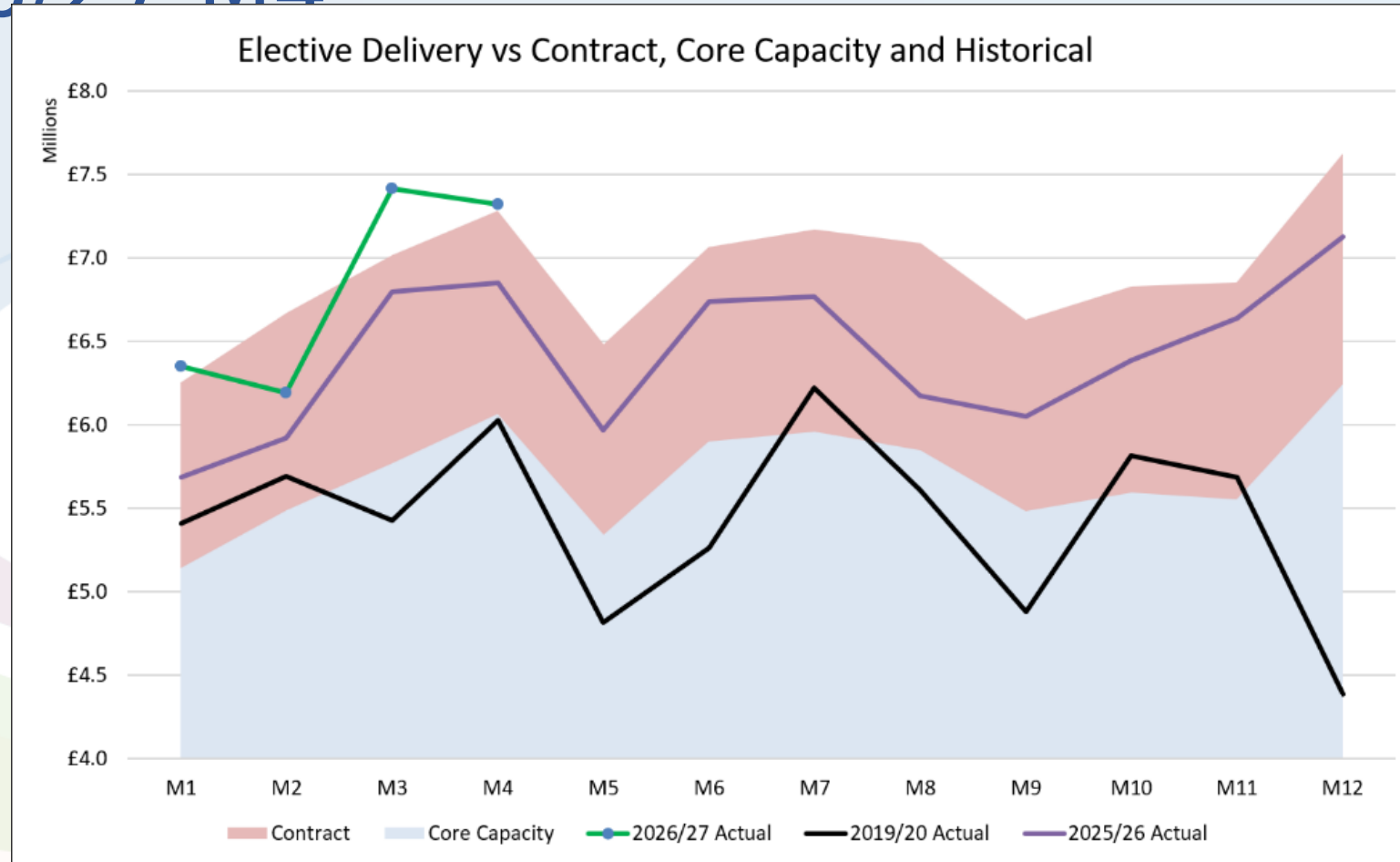
<u>In-Month Income & Expenditure</u>	Plan M4 £m	WHT Actual M4 £m	Surplus/ (Deficit) £m
Income	40.5	41.3	0.8
Expenditure			
Pay	26.4	26.4	0.0
Non Pay	10.2	10.9	(0.7)
Drugs	2.6	2.6	(0.1)
Other*	2.6	2.6	(0.0)
Total Expenditure	41.7	42.5	(0.7)
Net reported surplus/(Deficit)	(1.2)	(1.2)	0.1

<u>Year-to-date Income & Expenditure</u>	Plan YTD £m	WHT Actual YTD £m	Surplus/ (Deficit) £m
Income	158.3	158.7	0.4
Expenditure			
Pay	106.6	106.5	0.0
Non Pay	38.8	39.1	(0.3)
Drugs	9.8	9.7	0.1
Other(incl. depreciation)	10.2	10.5	(0.3)
Total Expenditure	165.4	165.8	(0.4)
Net reported surplus/(Deficit)	(7.1)	(7.1)	0.1

M4 Key headlines

- YTD deficit is £7.1m, in line with the planned deficit.
- Variable income is above contract by £0.1m and was impacted by £0.2m IA . Blended UEC income is above contract by £2.1m driving an additional £0.4m (20%) of income.
- Education & Training income is ahead of plan, following receipt of the new years schedule, and Other income is also ahead of plan due to R&D income and recovery of P2P SLAs.
- Staffing Expenditure is on plan Year to Date, this includes the cost of Industrial Action, which was approx. £0.9m in month 1. It also includes the pay savings target which is underdelivered by £0.4m (offset in Non-Pay).
- Non-Pay is on plan with overspends in outsourced services and clinical consumables offset by lower than planned spend on drugs as well as non-clinical spend on areas such as transport, security, and over-performance on Non-Pay CIP of £0.8m.

Variable Elective Contract Performance – 2026/27 M4



Performance

- Variable contracts contain growth to deliver the required RTT step change and the significant demand growth seen in 25/26. No 26/27 organic demographic growth was agreed with commissioners, but referral growth seen allows for funded over performance subject to the usual contract terms.
- Variable activity is £0.1m ahead of contract but would be £0.3m ahead without IA.
- While some productivity plans are delivering the majority are planned to deliver later in the year.

WHT: CIP Performance Overview

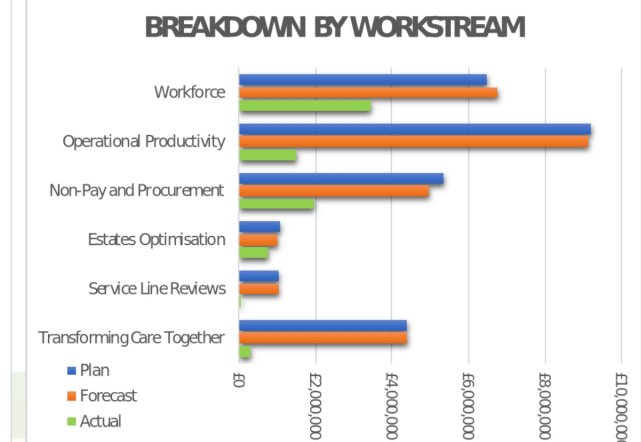
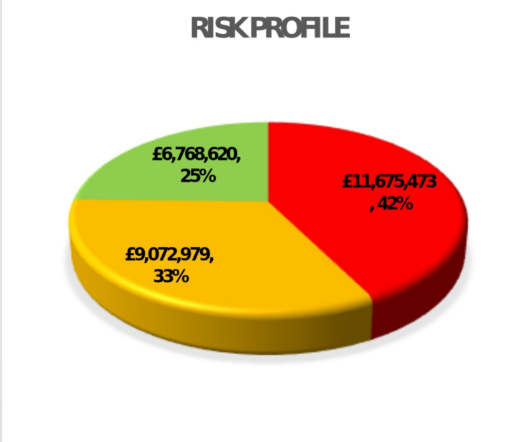
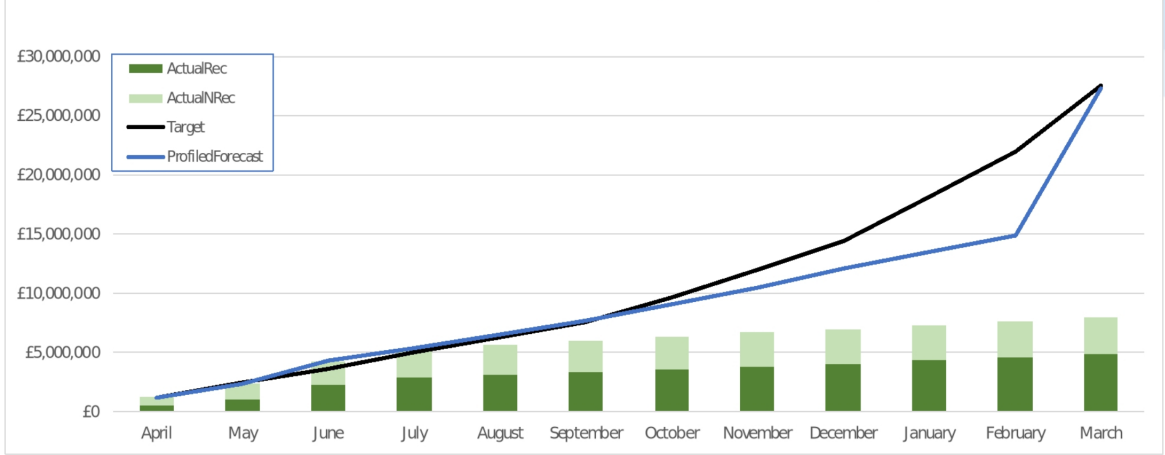
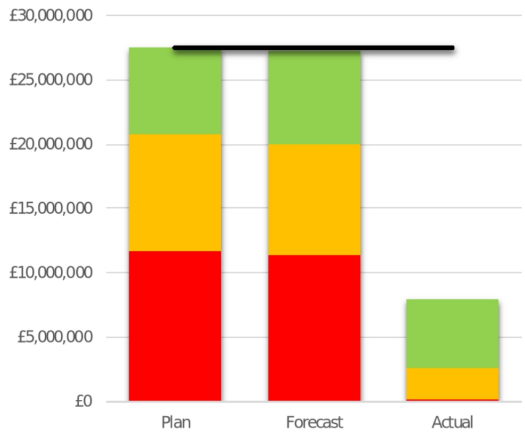
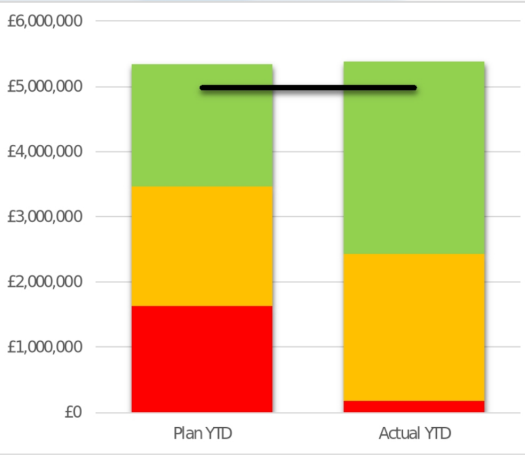
Programme Dashboard

Period: 4

Current Position (Annual)			
	Plan	Forecast	Actual
Target	£27,517,003		
Recurrent	£18,569,129	£17,914,260	£4,825,051
NonRecurrent	£8,947,943	£9,371,270	£3,119,275
Subtotal	£27,517,072	£27,285,530	£7,944,327
Variance	£89	(£231,473)	(£19,572,676)
	100.0%	99.2%	28.9%

Current Position (YTD)			
	Plan	Forecast	Actual
Target	£4,979,662		
Recurrent	£3,743,671	£2,865,096	£2,865,096
NonRecurrent	£1,586,001	£2,507,550	£2,507,550
Subtotal	£5,329,673	£5,372,645	£5,372,645
Variance	£350,011	£392,983	£392,983
	107.0%	107.9%	107.9%

Current Position (InMonth)			
	Plan	Forecast	Actual
Target	£1,307,167		
Recurrent	£1,682,008	£574,277	£574,277
NonRecurrent	£329,994	£487,435	£487,435
Subtotal	£2,012,002	£1,061,712	£1,061,712
Variance	£704,835	(£245,455)	(£245,455)
	153.9%	81.2%	81.2%



National Oversight Assurance Framework Dashboard

National Oversight Framework - WHT			Q3 25/26			Q4 25/26						
Metric	Time Period Reported	Target	Published			Published			Internal	Internal	Internal	Internal
			Perf	Score	Rank	Perf	Score	Rank	Apr-26	May-26	Jun-26	Jul-26
18 Weeks RTT - % Within 18 Weeks - Incomplete	Latest month in the period		69.70%	1.39	18/131	73.19%	1.37	17/130	72.19%	74.38%	74.80%	73.77%
18 Weeks RTT - 52 wk breaches as a % of PTL	Latest month in the period	1%	0.06%	1.00	9/131	0.01%	1.00	4/130	0.01%	0.01%	0.01%	0.05%
Difference between actual and planned 18 week elective performance	Latest month in the period	0%	-1.35%	2.46	60/131	0.15%	1.00	79/130	-1.43%	0.06%	0.01%	-1.60%
Percentage of patients waiting over 52 weeks for community services	End of period		17.63%	3.59	66/77	17.76%	3.57	66/78	19.40%	19.81%	20.66%	21.03%
Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80%	82.74%	1.00	23/118	84.93%	1.00	5/117	86.14%	86.49%	88.60%	
Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75%	72.58%	2.29	52/118	74.08%	2.10	40/118	68.85%	77.94%	80.22%	
Total Time Spent in ED - % within 4 Hours	Aggregated quarterly position	78%	72.77%	2.76	67/123	77.38%	2.14	41/123	84.66%	80.13%	83.26%	80.09%
Total Time Spent in ED - % over 12 Hours	Aggregated quarterly position		9.50%	2.89	78/123	8.70%	2.49	61/122	3.52%	5.33%	3.18%	5.75%
Planned Surplus / Deficit	Annual plan	0	-6.31	4.00	117/134	-6.31	4.00	117/134	2910	1983	1026	1168
Year to date variation from plan	Year to date		1.14	1.00	2/134	0.65%	1.00	18/134	2910	4893	5919	7087
Implied level of productivity	In-year figure to latest month vs same period in previous year		6.8	1.32	15/134	6.51%	1.32	15/134				
CQC inpatient survey satisfaction rate	Annual			2.00			2.00					
Staff survey- raising concerns sub-score	Annual		6.34	2.85	83/134	6.07	3.48	111/134				
CQC safe inspection score	Periodic inspection											
Rate of C-Difficle infections (Rolling 12 Months)	12-month rolling	1	0.91	1.00		0.82	1.00		1.17	1.13	1.09	1.00
Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	2.00	2.28		2.00	2.27		2	2	2	2
Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.52	3.74		1.27	3.27		1.21	1.19	1.15	1.15
Average number of days between planned and actual discharge date (one month in arrears)	Latest month in the period		0.31	1.43	19/127	0.26	1.38	17/128	0.2	0.2	0.2	
Summary Hospital Level Mortality Indicator (Rolling 12 Months)	12 month rolling			2.00			2.00					
Community- Urgent Care Response (UCR) 2 Hour Response	Quarterly aggregated figure	70%	67.00%	4.00	50/50	66.03%	4.00	50/51	71.86%	67.86%	56.41%	69.42%
Staff survey engagement theme score	Annual		6.80	2.89	85/134	6.54	3.28	102/134				
Staff Sickness Rate	Quarterly - aggregated monthly figures		6.35	3.54	129/134	6.84%	3.47	126/134	5.89%	6.30%	6.47%	6.56%

Model Health System	
NHS Oversight Framework Summary	
Overall Domain and Segment Scores	
Latest Published Data	
Q4 25/26	
NOF Score	
Headlines	
Oversight Framework Segment Latest Distribution	3
Average Metrics Score	2.21
Pre-Adjusted Segment	2
Is this segment down graded due to financial deficit	Yes
Is the Organisation in the Provider Improvement Programme	No

The Trust has been placed into Segment 3 for Quarter 4 of 2025/26.

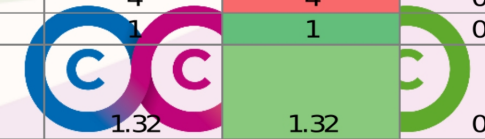
The updated NOF for 2026/27 is expected to be published for Q1 during September 2026.



National Oversight Assurance Framework Dashboard

WHT - Comparison

Domain	Metric	Data Period	WHT				
			Qtr 1	Qtr 2	Qtr 3	Qtr 4	Var (Qtr 4 vs 3)
Access to Services	%of patients waiting <18 weeks	End of period	1.4	1.28	1.39	1.37	0.0
Access to Services	% waiting >52 weeks (acute)	End of period	1.28	1	1	1	0.0
Access to Services	Difference between planned and actual 18 week performance	Monthly	1	1	2.46	1	-1.5
Access to Services	% waiting >52 weeks (community)	End of period	3.05	3.29	3.59	3.57	0.0
Access to Services	%of urgent referrals diagnosed within 4 weeks	Rolling 12-month	1	1	1	1	0.0
Access to Services	%treated within 62 days of referral	Rolling 12-month	1	1	2.29	2.1	-0.2
Access to Services	%of ED attendances seen within 4 hours	Rolling 3-month	1	2.26	2.76	2.14	-0.6
Access to Services	%of ED attendances >12 hours	In month	1.86	1.84	2.89	2.49	-0.4
Access to Services Sub-Total			14	158	217	183	-0.3
Effectiveness and Experience of Care	Summary Hospital-Level Mortality Indicator (SHMI)	Rolling 12-month	2	2	2	2	0.0
Effectiveness and Experience of Care	Average days from discharge-ready to actual discharge	In month	1.5	1.44	1.43	1.38	-0.1
Effectiveness and Experience of Care	CQC inpatient survey satisfaction rate	Annual	2	2	2	2	0.0
Effectiveness and Experience of Care	Urgent community response 2-hour performance	In month	2.82	4	4	4	0.0
Effectiveness and Experience of Care Sub-Total			2.08	2.36	2.36	2.34	0.0
Patient Safety	NHS Staff Survey – raising concerns sub-score	Annual	2.85	2.85	2.85	3.48	0.6
Patient Safety	12 month rolling count of MRSA cases	Rolling 12-month	2.63	2.89	2.28	2.27	0.0
Patient Safety	12 month rolling count of C. difficile cases as a proportion of trust threshold	Rolling 12-month	1	1	1	1	0.0
Patient Safety	12 month rolling count of E. coli cases as a proportion of trust threshold	Rolling 12-month	3.96	3.96	3.74	3.27	-0.5
Patient Safety Sub-Total			2.69	2.73	2.59	2.83	0.2
People and Workforce	Sickness absence rate	Rolling 12-month	3.78	3.66	3.54	3.47	-0.1
People and Workforce	NHS staff survey – engagement theme score	Annual	2.89	2.89	2.89	3.28	0.4
People and Workforce Sub-Total			3.34	3.28	3.22	3.37	0.2
Finance and Productivity	Planned surplus/ deficit	Annual plan	4	4	4	4	0.0
Finance and Productivity	Variance to financial plan	Year to date	1	1	1	1	0.0
Finance and Productivity	Implied productivity level	In-year figure to latest month vs same period in previous year	1.95	1.36	1.32	1.32	0.0
Finance and Productivity	Combined finance score	Annual	2	2	2	2	0.0
Finance and Productivity Sub-Total			1.97	1.68	1.66	1.66	0.0
Overall Average Metric Score			1.97	2.08	2.32	2.21	



Collaboration Communities

National Oversight Assurance Framework Dashboard - WHT

- Whilst remaining in segment 3, WHT has seen a slight improvement in its score from Q3 2.32 to 2.21 in Q4.
- The unadjusted segment was 2, with financial override scoring segment 3.
- As has been the case all year, scoring for the People segment remains the biggest challenge.
- The 2026/27 framework has now been published, including 14 additional metrics. Draft technical guidance is available, and an internal monitoring system is currently being developed. Q1 segmentation is expected to be published in September 2026

Productivity

The Trust continues to perform strongly on productivity, with Model Health System data showing **top-quartile implied productivity growth nationally**, driven by outputs increasing faster than inputs.

Key operational indicators remain positive. Performance in **outpatient procedures** (the proportion of first and follow-up attendances attracting a procedure tariff) and **theatre utilisation** continues to be strong, demonstrating effective use of clinical capacity. **Day-case rates** remain **second highest quartile**, while the **average number of cases per equivalent four-hour elective session** has improved to quartile 2 (1 being lowest), reflecting the T&O initiative work.

Outpatient Productivity

Outpatient services present clear opportunities for improvement. **PIFU** has remained constant with opportunities for further adoption whilst remaining in the upper third quartile for bench marking. **DNA rates** remains 2nd lowest quartile for bench marking, and **Specialist Advice** usage remains below the national benchmark. Together, these indicators suggest unwarranted demand and inefficiencies within outpatient pathways that should be a priority focus.

Workforce Productivity and Sustainability

Workforce productivity remains a significant strength. **Workforce Productivity Growth** is ranked in the top quartile, supported by strong non-elective activity per clinical WTE and high emergency consultant utilisation. In contrast, both **elective** activity per WTE and **outpatient** attendances per consultant remain in the lower quartile two.

Temporary staffing expenditure continues to exceed national benchmarks, and **sickness absence** remains above the Trust target, presenting ongoing risks to productivity sustainability.

Summary

Overall, the Trust maintains a strong productivity position nationally.

The main area for improvement is **outpatient productivity and higher-than-benchmark temporary staffing costs and sickness absence** above target continue to pose risks to sustaining productivity improvements.



Care Colleagues
Collaboration Communities

Productivity Dashboard

WHT Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target			2026/27											
			Source	Baseline	Target	Apr	May	J un	J ul	Aug	Sep	Oct	Nov	Dec	J an	Feb	Mar
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%												
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	3.00	3.20	2.80	2.80								
3	Average LOS for non-elective admissions	Average length of stay for all patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	Model Health System	N/A	N/A	7.60	7.90	7.50	7.80								
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	National planning	annual	92.00%	94.06%	92.50%	92.63%	94.01%								
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), divided 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%	18.68%	19.46%	20.81%	16.31%								
Theatre Utilisation																	
6	Capped elective theatre utilisation (month in arrears)	Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration	Model Health System	NHSE	85.00%	80.70%	86.60%	87.20%	85.78%								
7	Average number of cases completed per theatre list (month in arrears)	Total number of cases completed divided by total number of sessions utilised	Model Health System / Internal	Quartile 3 (lowest provider)	2.3	1.90	2.00	1.79	1.84								
8	% of theatre sessions utilised	Total number of theatre sessions utilised divided by total number of sessions funded	Internal		93%	91.34%	90.43%	96.23%	91.96%								
9	CT, MRI & ultrasound utilisation		National planning	annual	95%												
Outpatients																	
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	Careflow	Trust Internal	95.00%	79.15%	79.86%	80.37%	80.63%								
11	DNA Rate	Number of outpatient missed outpatient appointments divided by total outpatient appointments	Careflow	Trust Internal	8.00%	8.33%	8.25%	8.21%	8.31%								
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divided by total outpatient activity.	National planning	annual	5.00%	5.47%	5.19%	5.81%	5.37%								
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referral) divided by total number of outpatient first attendances	National planning	NHSE	13.00%	11.67%	10.39%	11.16%	11.95%								
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	1,350	0	2,482	955								
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	£1,722	£1,729	£1,699	£1,699								
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes		Trust Internal	tbc	£0 k	£0 k	£368 k	£0 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	3	3	0	0								

Productivity Dashboard

WHT Productivity Dashboard																	
Ref no.	Theme and KPI	Definition	Source	Target		2026/27											
				Baseline	Target	Apr	May	J un	J ul	Aug	Sep	Oct	Nov	Dec	J an	Feb	Mar
Non Pay																	
19	Procurement CIP	Value of procurement cost improvement savings delivered		Trust Internal	tbc	£237 k	£196 k	£202 k	£11 k								
Workforce Productivity																	
20	Non-elective admissions per clinical WTE	The number of non-elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	Model Health System	Quartile 1 (lowest provider)	1.90	3.50	3.45	3.56	3.64								
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	1.69	1.63	1.88	1.94								
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	148.37	141.59	166.28	160.66								
23	A&E attendances (Type & 2) per Emergency Medicine Consultant	The number of A&E attendances (Type 1 & 2) in month, divided by the number of Emergency Medicine Consultants (WTEs) including substantive, bank and agency staff.	Model Health System	Quartile 1 (lowest provider)	613	508.89	494.94	502.55	595.83								
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	0.54	0.57	0.56	0.58								
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%	10.57%	11.41%	9.63%	10.20%								
26	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	Trust	Internal	5%	5.89%	6.30%	6.47%	6.56%								
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%	7.69%	8.30%	7.79%	7.88%								
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	4.70	4.70	4.80	4.70								
Support Services																	
29	Estates and Facilities Cost per m2	Total estates and facilities running costs divided by total occupied floor area	Model Health System	2023/24 quartile 2 (2nd best)	£495.67												
30	Pathology cost per test	The average cost of undertaking one test across all disciplines, taking into account all pay and non-pay cost items			N/A	£1.65	£1.64	£1.59	£1.68								

Integrated Performance Report

The Royal Wolverhampton NHS Trust

July 2026 (Month 4)

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust



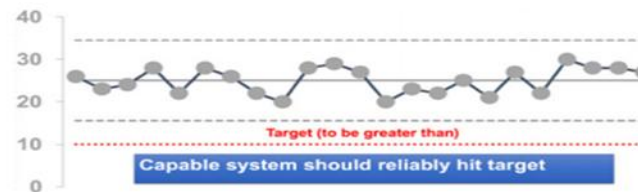
Care Colleagues
Collaboration Communities

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:



Managing Director Summary

- There was a Never event reported in July 26 in the Trauma & Orthopaedics Directorate under the description of Retained foreign object post procedure – See detail in quality section. The Learning Response Panel have commissioned a Patient Safety Investigation (PSIER) under the Trusts PSIRF framework.
- Disappointingly, in this financial year we have a total of 4 never events against a target of 0. Three are within the Surgical Division and 1 within the Medicine Division.
- The clinical and operational changes of Phase 1 implementation of EPR are concluding and focus is on ensure benefits realisation. Phase 2, for more clinical changes are progressing with associated timelines, training and impact being developed and worked through within an amended leadership and governance structure to reflect this phase. This work will be reported to the Trust Board via the Digital and Estates Committee.
- The role out of Martha's rule continues across Perinatal and Emergency Department – see detail in quality section.
- Performance against the Urgent and Emergency Care Metrics, deteriorated in July 26, with the hot weather a factor in presentations to the Trust. Actions against the CQC improvement plan continue and the collaborative work with PA consulting. Operational teams are assured focus is on the right workstreams to ensure left shift will occur; however, this is yet to materialise. Performance across the community metrics, especially virtual ward and urgent community response remain strong.
- Progress with Fire Works at Cannock and Maternity Block continue and positive meetings held with West Midlands and Staffordshire Fire Service regarding progress.
- Operational challenges to achieve workforce reductions and CIP remain, although the Trust is currently on forecast for month 4. Insourcing to support RTT and delivery of income commenced in August 26, so this activity will more likely impact in September/October 26.

Authors



Gwen Nuttall
(Managing
Director)

Managing Director Summary continued.....

Snap Shot of positive stories from Divisions since July 26 Trust Board

- The Trust will continue to be part of the national Frailty Improvement Programme, and all the actions are aligned to work started or planned to start as part of the Community First schemes.
- Following a visit from Dr Claire Fuller – Primary Care Medical Director for NHS England, the Trusts Care Coordination Centre has been recognised as the best in the Country.
- The Trust has been part of a national Macmillan Podcast over the summer, with a focus on work that has been undertaken alongside Prisons for prisoners with Cancer.
- Following on from the announcement in July 26 about the planned use of the orthopaedic robot, BBC West Midlands ran an article of the First Robotic Knee replacement, undertaken at Cannock Chase Hospital. The first patient was a portering member of staff, who reported a good patient experience and is recovering well.
- Other operational performance for RTT and diagnostics are improving/remain strong – see performance section for detail. It is pleasing that RTT performance at the end of July 26 was above trajectory and the number of patients waiting over 52 weeks, significantly reduced from April 26.
- There are signs of improvement against Trust sickness metrics across most of the operational teams.

Authors



Gwen Nuttall
(Managing
Director)

Balanced Scorecard

Quality, Safety & Patient Experience								Operational Performance							
Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	19/20 Same Period	Variation	Assurance		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	2.84	2.72	Jul-26	-	Improvement	Inconsistent	18 Weeks RTT - % Within 18 Weeks - Incomplete	69.60%	62.09%	63.89%	Jul-26	82.13%	Improvement	Not Met
Pressure ulcers per 1,000 occupied bed days	1.50	1.63	2.14	Jul-26	1.36	Concern	Inconsistent	18 Weeks RTT - 52 wk breaches as a % of PTL	0.99%	1.69%	1.47%	Jul-26	0.00%	Improvement	Not Met
Community acquired pressure ulcers per 10,000 population	0.90	0.76	0.87	Jul-26	-	Common Cause	Inconsistent	18 Weeks RTT - Total Incomplete PTL	61077	72008	70399	Jul-26	39142	Improvement	Not Met
Observations on time (Trust wide)	90.00%	88.47%	88.26%	Jul-26	-	Common Cause	Not Met	Cancer - 28 Day Faster Diagnosis	80.00%	81.61%	82.10%	Jun-26	-	Improvement	Inconsistent
VTE risk assessment - % within 14 hours	95.00%	88.33%	87.75%	Jun-26	-	Concern	Not Met	Cancer - 31 Day Treatment	94.00%	91.80%	92.19%	Jun-26	90.93%	Improvement	Inconsistent
Sepsis screening - ED	90.00%	100.00%	98.00%	Jul-26	-	Common Cause	Achieving	Cancer - 62 Day Referral to Treatment	80.00%	74.06%	72.37%	Jun-26	64.34%	Improvement	Not Met
Sepsis screening - Inpatients	90.00%	89.50%	90.50%	Jul-26	-	Improvement	Inconsistent	No. of patients no longer meeting the Criteria to Reside	89	72	94	Jul-26	-	Common Cause	Inconsistent
Clostridioides difficile	-	8	10	Jul-26	4	Common Cause	No Target Set	Diagnostics - % within 6 weeks from referral	95.00%	95.23%	95.33%	Jul-26	84.70%	Improvement	Not Met
MRSA Bacteraemia	0	0	1	Jul-26	-	Common Cause	Inconsistent	Total Time Spent in ED - % over 12 Hours	2.00%	14.90%	14.97%	Jul-26	-	Concern	Not Met
Number of complaints as a % of admissions	0.50%	0.85%	0.65%	Jul-26	-	Concern	Inconsistent	Total Time Spent in ED - % within 4 Hours	82.00%	80.46%	79.83%	Jul-26	81.83%	Common Cause	Inconsistent
FFT recommendation rates - Trust wide	92.00%	90.00%	84.00%	Jul-26	92.00%	Common Cause	Not Met	Community - Waiting List - Total	-	2720	2843	Jul-26	-	Improvement	No Target Set
Care hours per patient - total nursing & midwifery staff actual	7.6	7.9	8.2	Jul-26	7.5	Common Cause	No Target Set	Community - Waiting List - within 18 weeks	-	48.20%	45.76%	Jul-26	-	Concern	No Target Set
Care hours per patient - registered nursing & midwifery staff actual	4.5	5.1	5.0	Jul-26	-	Common Cause	No Target Set	GP Appts - routine face to face	▼ -	2904	2778	Jul-26	-	Common Cause	No Target Set
SHMI	1.00	0.94	0.94	Jul-26	-		No Target Set	GP Appts - same day face to face	-	2364	2220	Jul-26	-	Common Cause	No Target Set
Never events	0	0	1	Jul-26	-	Concern	Inconsistent	DNA % rate	-	5.13%	5.38%	Jul-26	-	Common Cause	No Target Set
Workforce Performance								Finance							
Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance		Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	19/20 Same Period	Variation	Assurance	
Substantive (WTE) Trust	10027.42	10118.79	10133.27	Jul-26	-	Improvement	Not Met	Surplus/(Deficit) (£000) - in month	601	-1635	-2373	Jul-26	-	Common Cause	Inconsistent
Agency (WTE) Trust	17.92	40.35	31.26	Jul-26	-	Common Cause	Inconsistent	Surplus/(Deficit) (£000) - YTD	-4399	-6416	-8789	Jul-26	-	Improvement	Inconsistent
Bank (WTE) Trust	519.98	606.84	639.58	Jul-26	-	Common Cause	Inconsistent	Surplus/(Deficit) (£000) - FOT	-	0	0	Jul-26	-	Improvement	No Target Set
Vacancy Rate	6.00%	5.86%	6.15%	Jul-26	-	Concern	Inconsistent	Elective Variable (£000) - in month	15695	37105	38505	Jul-26	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	7.84%	8.18%	Jul-26	-	Improvement	Achieving	Elective Variable (£000) - YTD	146472	108964	147469	Jul-26	-	Common Cause	Inconsistent
Retention Rate (12 Months)	90.00%	91.65%	91.71%	Jul-26	-	Improvement	Inconsistent	Elective Variable (£000) - FOT	195523	440055	443518	Jul-26	-	Improvement	Inconsistent
Sickness Absence (In Month)	5.00%	5.19%	5.14%	Jul-26	-	Common Cause	Inconsistent	Efficiency (£000) - in month	6075	3501	3268	Jul-26	-	Common Cause	Inconsistent
Appraisals	90.00%	78.02%	77.78%	Jul-26	-	Concern	Not Met	Efficiency (£000) - YTD	44212	10289	13557	Jul-26	-	Common Cause	Inconsistent
Statutory & Mandatory Training	90.00%	92.94%	93.09%	Jul-26	-	Concern	Achieving	Efficiency (£000) - FOT	57240	63448	63448	Jul-26	-	Common Cause	Inconsistent
								Capital (£000) - YTD	23691	3282	4458	Jul-26	-	Concern	Inconsistent
								Capital (£000) - FOT	29350	51161	51161	Jul-26	-	Common Cause	Inconsistent
								Cash (£000) - in month	25878	53250	45527	Jul-26	-	Common Cause	Inconsistent
								Cash (£000) - FOT	26018	44709	86756	Jul-26	-		Inconsistent

Quality, Safety & Patient Experience | Executive Summary

- **Falls;** Despite evidence of increasing patient dependency and complexity in July 26, reflected by rising numbers of patients requiring enhanced observation and care, the Falls rate reduced from 2.84 to 2.72 per 1,000 occupied bed days and is within tolerance.
- **Pressure ulcer incidence** increased during the month compared with June's figures in brackets: Division 1 recorded 22 incidents (8), Division 2 recorded 32 incidents (19), and Division 3 recorded 24 incidents (21). Division 1 saw an ICCU device related rise, mainly naso-gastric tube related prompting staff education. The rise in Division 2 likely reflects an improved reporting following learning from incidents and Community services rise in July is likely due to heatwave related Moisture associated skin damage. The Coroners inquest relating to the previously reported Grade 4 pressure ulcer, which spanned the patient pathway across emergency services, stroke and rehabilitation has now concluded. The Coroner recorded a narrative conclusion.
- ***Clostridioides difficile (C. diff)*** has increased in month to 10 (last month it was 8). This equates to 29/65 cases to date, against the external annual trajectory target of 65 for 26/27. There is ongoing participation in Trust quality improvement initiatives e.g. Healthcare Acquired Pneumonia (HAP) Intervention Group, Bathroom First and EDDMI and all to Action for Antimicrobial Resistance actions. Ongoing support from the Patient Equipment Cleaning Centre (PECC) team to provide proactive cleaning of patient beds and commode swap out scheme and the sustained cleaning activity is overseen by the Infection Prevention and Control Group (IPCG). Areas of increase incidence are having proactive deeper cleaning of bathrooms and utilities weekly including making use of ultraviolet disinfection.
- **An MRSA bacteraemia** was identified in a patient on Ward C16 during July 26; investigation suggests a likely association with a recent orthopaedic surgical wound/underlying hip collection following surgery at a different hospital. Screening and decolonisation were undertaken, appropriate antimicrobial treatment commenced, and learning actions were identified.
- **Formal complaints** reduced to 93 in month (last month there were 116). The data shows that the top complaint themes have remained broadly consistent with the previous month; Delays, General Care and Communication. Directorate teams are reviewing complaint themes monthly to identify opportunities for early intervention and reduction of repeat concerns. Service-specific interventions include: Reinforcement of communication standards with patients and families, review of appointment bookings, cancellation and escalation processes. Targeted reviews of delays within outpatient and diagnostic pathways and feedback to clinical teams regarding patient experience concerns and standards of care.

Authors



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Officer)



Brian McKaig
(Chief Medical
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Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

- **Martha's Rule** is being extended to Perinatal Services and ED (Steering Groups launched), supporting Ockenden/Amos recommendations, with NHSE's phased 2-year rollout backed by funding of up to £20k (maternity/neonatal) and £10k (ED) for workforce training, QI activity and communications.
- The UK Health Security Agency (UKHSA) have advised in a letter to the Trust that the Surgical Site Infection (SSI) data we have submitted for Q1 suggest we may be an outlier for hip surgery SSI. As requested, we will present the examined data at the Infection Prevention and Control Group and take action accordingly. They have also advised it is important to note that the outlier analysis uses data to indicate if a result is higher than expected, it does not confirm an issue exists.
- There was a Never event reported in July 26 in the Trauma & Orthopaedics Directorate under the description of Retained foreign object post procedure. The patient underwent an internal fixation of the upper arm and the surgical guiding device, used to assist in the precise placement of screws was unfortunately not removed before closure. The Learning Response Panel have commissioned a Patient Safety Investigation (PSIER) under the Trusts PSIRF framework. In this financial year we have a total of 4 never events against a target of 0. Three are within the Surgical Division and 1 within the Medicine Division.

Mental Health (MH) Update

There were 427 attendances to ED relating to MH Issues in June 26. 330 were Adults and 97 were Children and Young People. The combined monthly average is 14 crisis presentations per day/437 per month. Mental Health Act Administrators continue to support Mental Health Act compliance by ensuring the legality and quality of the RWT Mental Health documents.

We have 4 ongoing risks recorded with scores provided after mitigation;

- **RISK: 6017** Children and Young People Quality of Care – score 12-CAMHS provision remains non-compliant with best practice guidelines of having face-to-face patient assessments available 24 hours a day, 7 days a week. In June 60% (↓2%) of CAMHS referrals from ED occurred out of hours, resulting in extended waits for patients until day staff on duty to clinically assess
- **RISK: 6017** Children and Young People (CYP) Mental Health Delays in access to Tier 4 Bed- score 9
- **RISK: 6018** Adult Mental Health quality of Care – score 12
- **RISK: 6467** No internal Mental Health team physical presence at RWT – score 12 with recruitment in train.

We are regularly monitoring our MH risks to the organisation and updating with relevant audit data as it becomes available for assurance.

Authors



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Quality, Safety & Patient Experience | Executive Summary

Right Care, Right Person (RCRP):

Challenges remain in the department around shared (Police/NHS) handover and risk documentation. The RCRP SOP has been uploaded to the staff intranet to aid with operational guidance for mental health patients within ED.

Compliance against best practice criterion remains challenged, with no positive movement of risk scores for CYP, Adult RCEM audit for April 26 (March data) demonstrated an overall compliance rate of 42% (+13). The Acute Mental Health and ED teams will work to put an action plan in place with ongoing monthly monitoring.

Caspe Healthcare Knowledge Systems (CHKS) Triennial Survey & Accreditation Visit – Deanesly Centre (April 26): CHKS conducted its three-yearly full survey (Radiotherapy, Radiotherapy Physics and Oncology) against the CHKS Health and Care Standards 2024, confirming re-accreditation and ISO certification. The result were 99.08% compliance against 653 standards with the shortfall relating to factors outside the service's control, acknowledged by the survey team. Strengths noted were robust governance and shared learning; embedded patient safety; strong person-centred care; communication a particular strength; positive workforce wellbeing and retention success. Opportunities to review service capacity and pathways may also enhance efficiency, reduce pressures on related services and improve both staff and patient experience. The organisation continues compliance with the clauses of ISO 9001:2015 and has been commended for our organisational leadership and management. It is recommended that the Deanesly Centre maintains their ISO certification for a further 12 months.

SHMI: The Standardised Hospital Mortality Indicator (SHMI) is 0.9389; within the expected range. Individual diagnostic groups with higher-than-expected SHMI values are reviewed via clinical pathway meetings and the Trust is proactively managing the Learning from Deaths agenda overseen by the Mortality Review Group. Currently there are no outliers, and 5 diagnosis groups are managed as internal alerts, they include Peripheral and visceral atherosclerosis, Epilepsy, Short Gestation, Sepsis and Pneumonia.

As previously reported, the Trust has received a potential outlier notification from the NNHLA relating to risk-adjusted two-year survival outcomes for patients with Non-Hodgkin Lymphoma. A detailed review of the data, methodology and local patient cohort is currently underway.

Authors



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Perinatal Service | Executive Summary

Perinatal Quality Oversight Model (PQOM) Dashboard Royal Wolverhampton NHS Trust

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

	Jan		Feb		Mar		Apr		May		June		July	
PMRT Reviews (including babies >28 days old or not born at RWT)	5 OBS/NN		5 OBS/NN		6 OBS/NN		5 OBS/NN		5 OBS/NN		5 OBS/NN		6 OBS/NN	
Grades Maternity/neonatal	A1	A1	A2	A1	A3	A1	A2	A0	A2	A0	A3	A0	A3	A1
	B4	B2	B3	B2	B2	B3	B3	B2	B2	B2	B1	B3	B3	B2
	C0	C0	C0	C0	C0	C0	C0	C0	C0	C1	C0	C2	C0	C0
	D0	D0	D0	D0	D0	D0	D0	D0	D0	D0	D0	D0	D0	D0
Final MNSI Reports Received	1		1		0		0		0		0		0	
Incidents Moderate & Above (all new MNSI cases and those assigned PMRT C and D, and those assigned moderate harm on datix)	0		2		0		1		2		1		1	
Service user & Staff Feedback to Board Level Safety Champions	Positive feedback re: the cultural conversation re: Maternity Triage.		MNVP Service user group focus on C/S pathway.		15 steps Positive feedback re: service.		Health Pregnancy event good attendance and feedback from users.		International Day of the Midwife included hearing from midwives - shared on social media		MNVP quarterly meeting theme from feedback communication and care. SC meeting update on Entonox RA NED BLSC spend monitoring with governance lead.		Service user feedback themes that women want postnatal care near to home provided in family hubs. Staff feedback to safety champions theme coping in the hot weather has proven a challenge with limited access to air conditioning on wards.	
Coroner Reg 28	0		0		0		0		0		0		0	
Obstetrics/Gynaecology Trainees Quality of Clinical Supervision reported annually														

CNST & Training Position July 2026

Staff Group	PROMPT	Fetal monitoring	NLS
Obstetricians	73%	95%	73%
Midwives	94%	94%	95%
Support Staff	96%	NA	NA
Anaesthetists	92%	NA	NA
Neonatal Doctors	NA	NA	90%
Neonatal Nurses	NA	NA	90%

Full compliance with Maternity Incentive Scheme Year 8 training requirements.

Plan is in place to address the non-compliance for Obstetricians.



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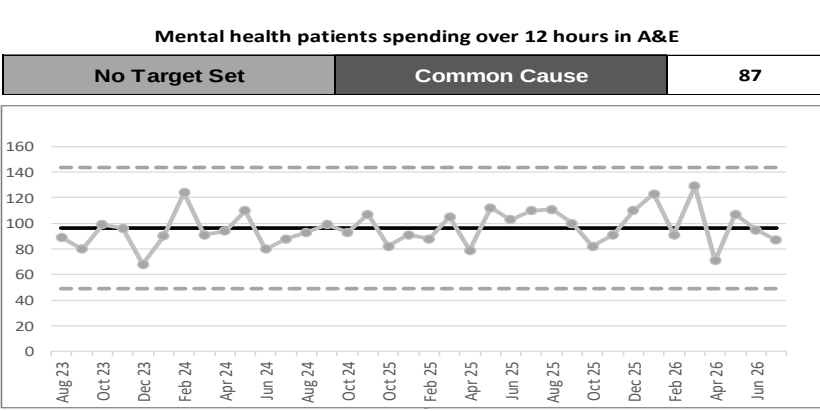
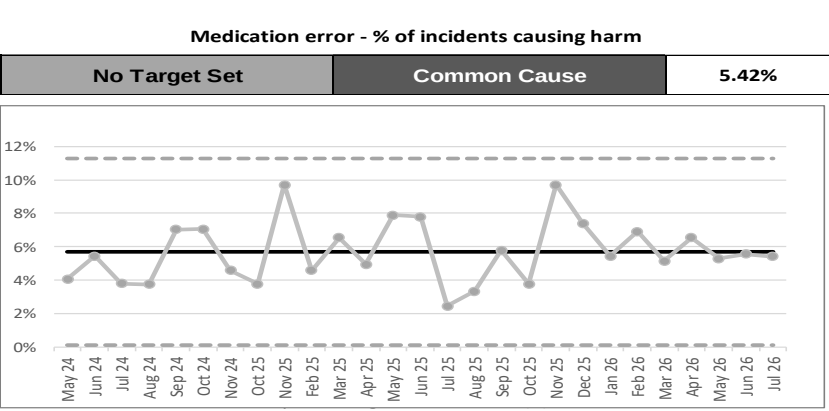
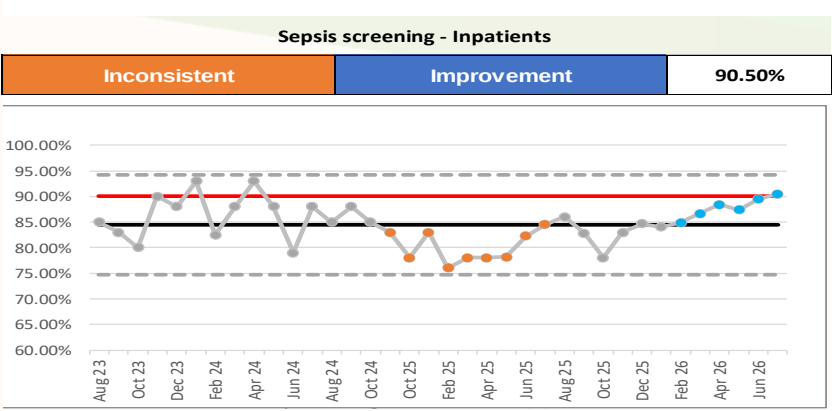
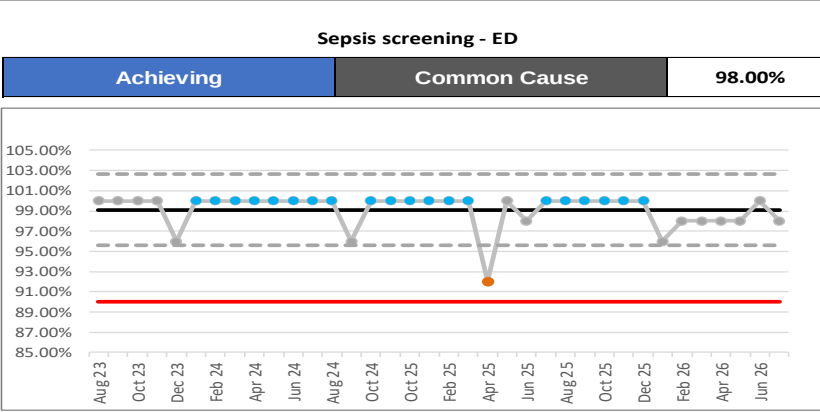
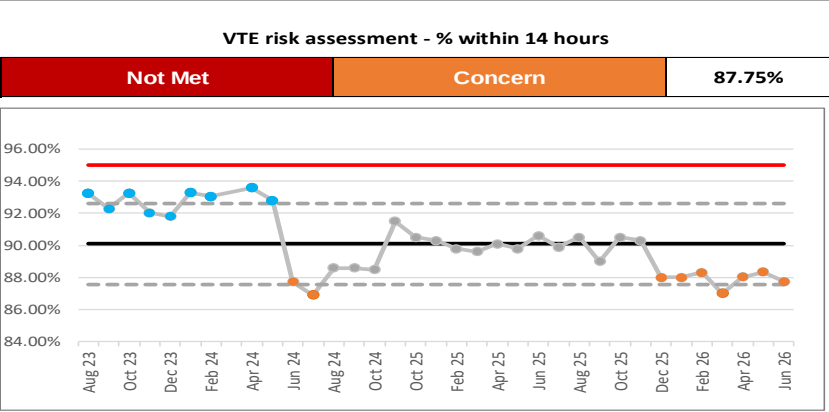
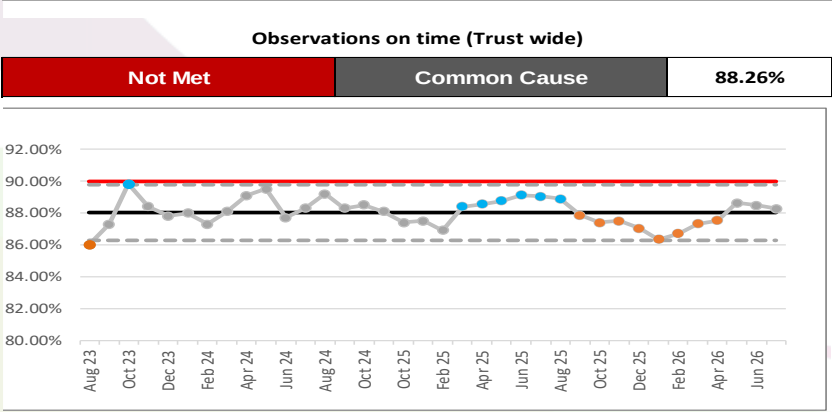
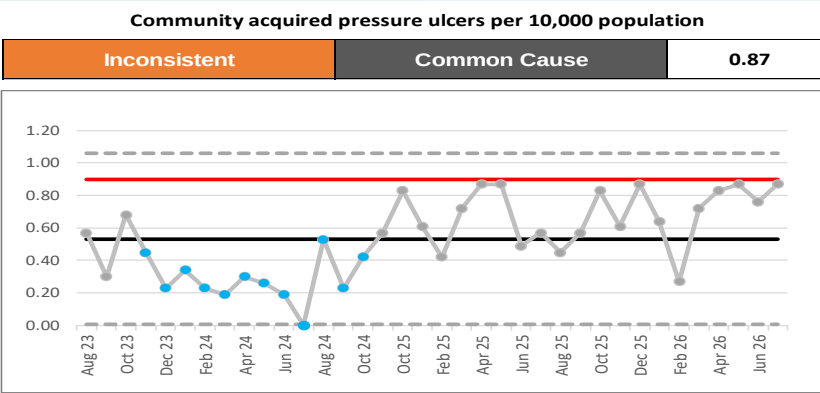
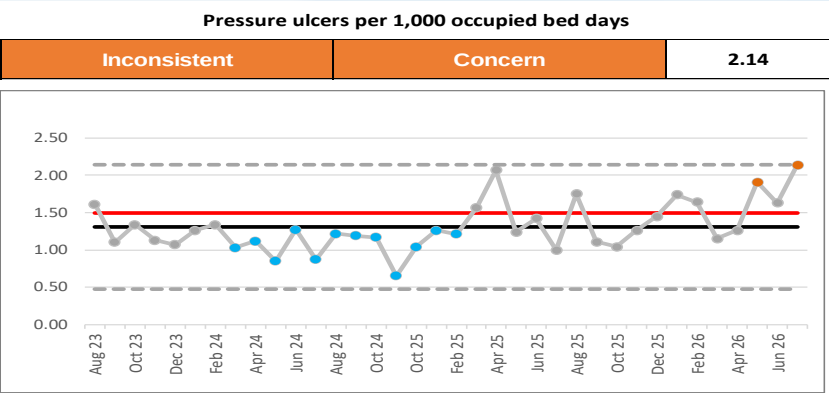
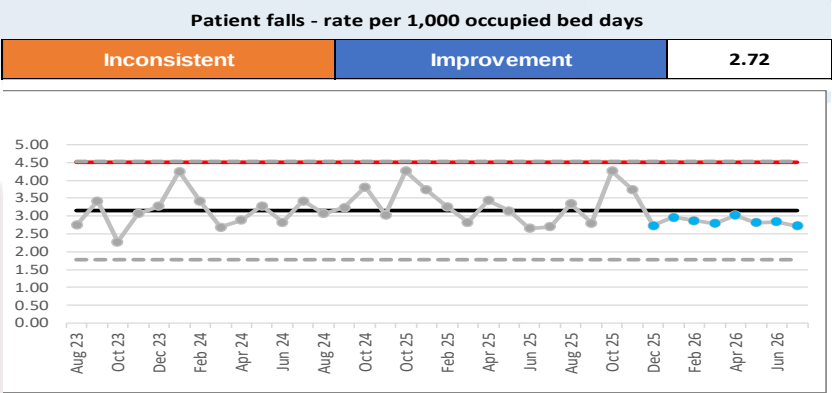
Perinatal Quality Oversight Model (PQOM) Dashboard

Staff Group	Jan		Feb		Mar		Apr	May	June	July	Comments
Midwives Birth to midwifery ratio Actual	27		27		27		27	26	26	26	Midwifery workforce EOI bid for NQM's to NHSE submitted
Obstetrics RCOG Compliant on delivery suite	Yes		Yes		Yes					Yes	Audit complete and 95% compliance achieved
Neonatal Nurses BAPM Compliant	82%		79%		63%		95%	71%	63%	80%	Nursing numbers against actual acuity
Neonatal Doctors BAPM Compliant	Yes		Yes		Yes		Yes	Yes			Compliant

Safety Champion feedback

- Zero Maternity Outcomes Signal System (MOSS) Signals in July 26 and critical safety drill completed.
- 10-point plan template is being completed with evidence to support compliance – this is work in progress.
- Maternity tirage baseline assessment is being completed.
- Fire Evacuation training continues in Maternity Block.

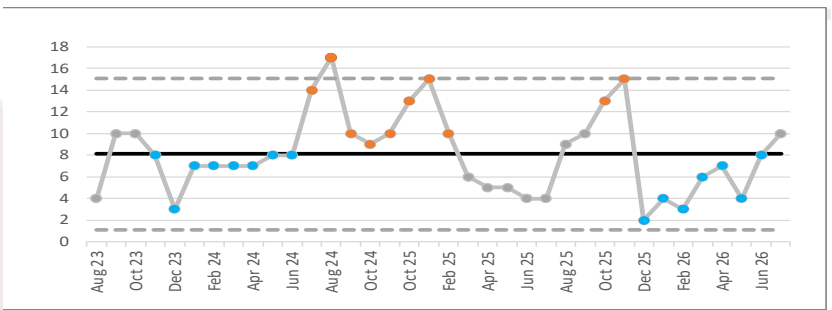
Quality, Safety & Patient Experience | Core Metrics



Quality, Safety & Patient Experience | Core Metrics

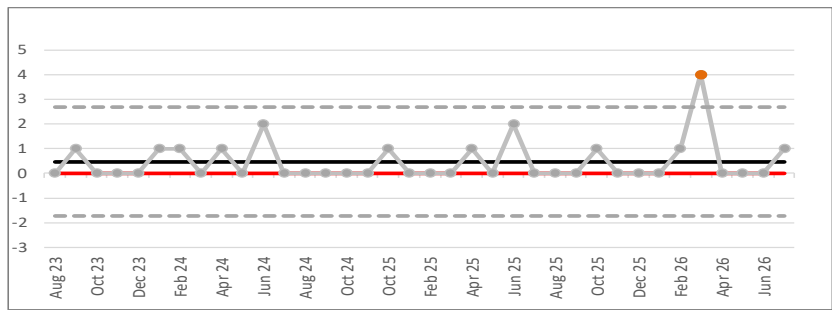
Clostridioides difficile

No Target Set	Common Cause	10
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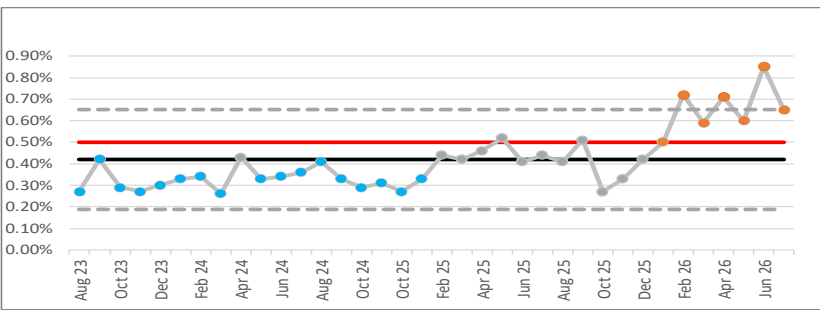
MRSA Bacteraemia

Inconsistent	Common Cause	1
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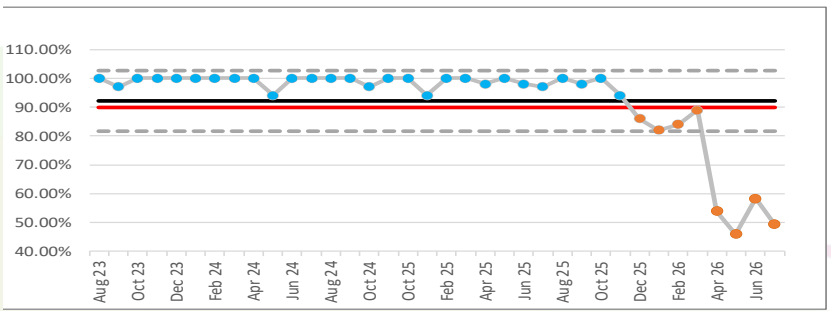
Number of complaints as a % of admissions

Inconsistent	Concern	0.65%
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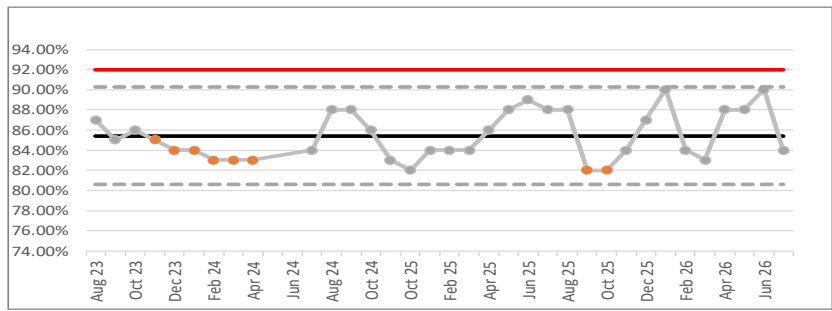
Complaints response rate against policy

Inconsistent	Concern	49.40%
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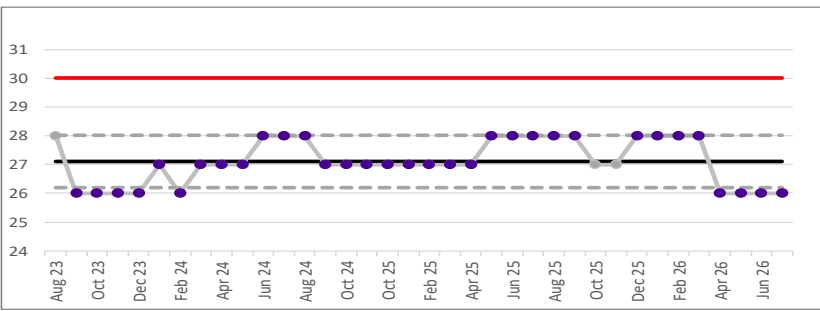
FFT recommendation rates - Trust wide

Not Met	Common Cause	84.00%
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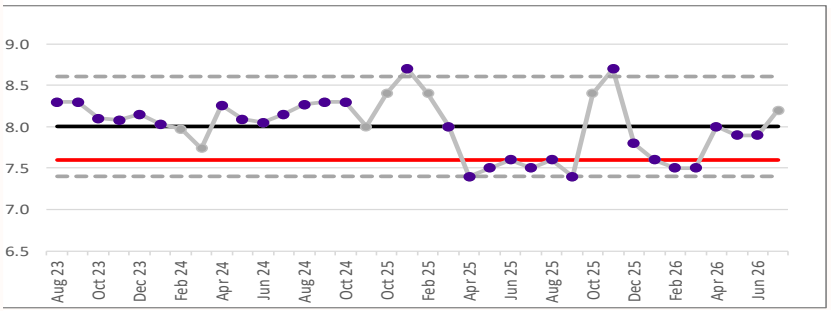
Midwife to birth ratio (1 to)

No Target Set		26.0
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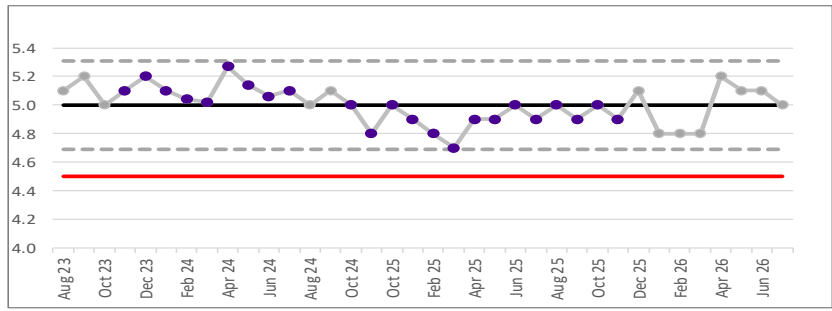
Care hours per patient - total nursing & midwifery staff actual

No Target Set	Common Cause	8.2
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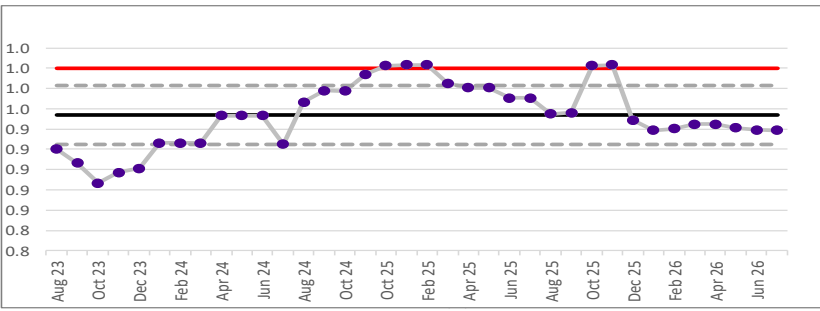
Care hours per patient - registered nursing & midwifery staff actual

No Target Set	Common Cause	5.0
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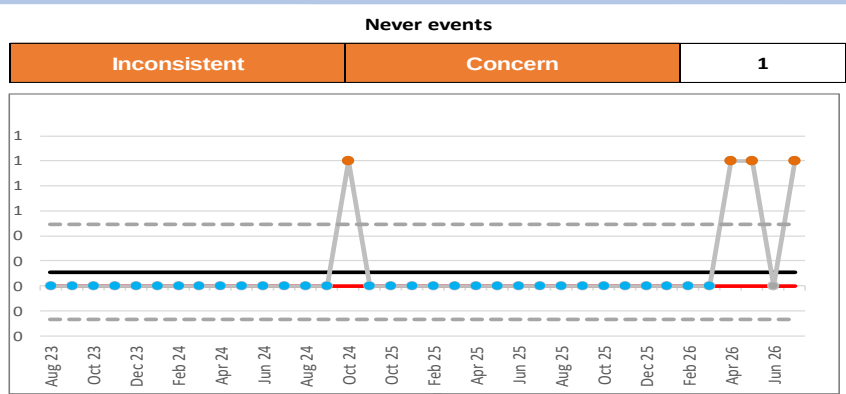
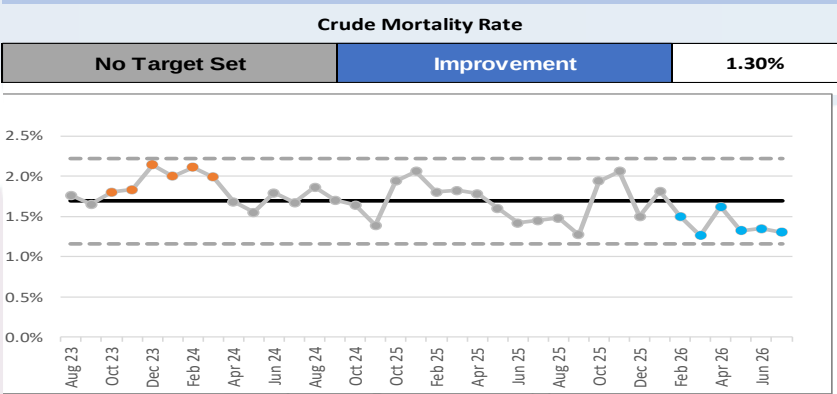


SHMI

No Target Set		0.94
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Quality, Safety & Patient Experience | Core Metrics



People | Executive Summary

Performance against Trust 2026/27 Workforce Plan

During July 26, the overall workforce rose by 40.0 WTE. This movement was driven by a rise in the substantive and bank workforce offsetting a decrease in agency usage.

- Substantive workforce increased by 14.5 WTE (0.14%).
- Bank utilisation rose by 32.7 WTE (5.40%).
- Agency reliance fell by 7.3 WTE (17.97%).

Since March 26, the overall workforce has decreased by 24.57 WTE; the bank and agency workforces have decreased by 43.78 and 0.94 WTE, respectively, offsetting a 20.15 WTE rise in substantive deployment since 25/26 year-end.

While this represents a continued year-to-date reduction, overall workforce is 294.52 WTE (2.80%) above the M4 26/27 workforce plan trajectory.

Performance against Key Workforce Metrics

Appraisal compliance decreased to 77.78% in July 26. Appraisal compliance is not meeting the target across the board, with continued focus required in the Corporate Division and Division 1, where appraisal completion is most challenged.

Authors



Claire Radley
(People
Director)

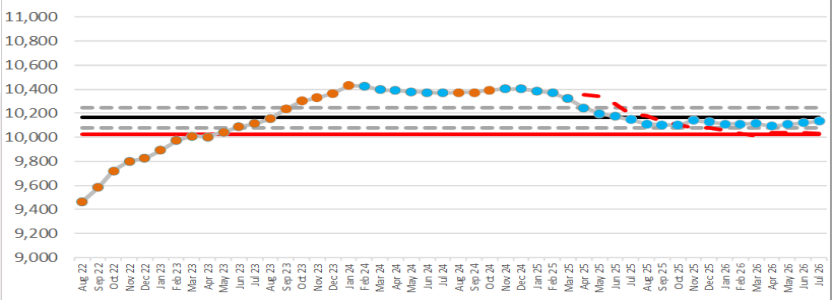


Care Colleagues
Collaboration Communities

People | Core Metrics

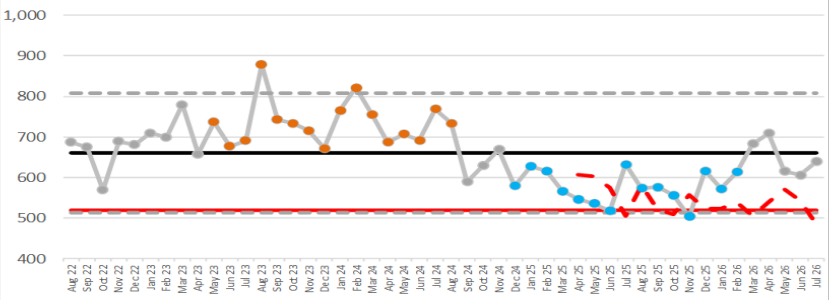
Substantive (WTE) Trust

Not Met	Improvement	10133.27
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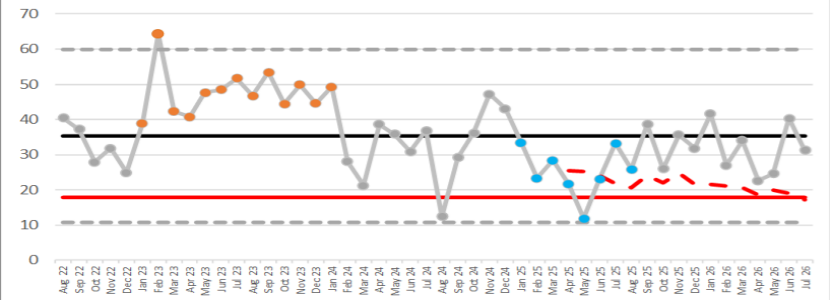
Bank (WTE) Trust

Inconsistent	Common Cause	639.58
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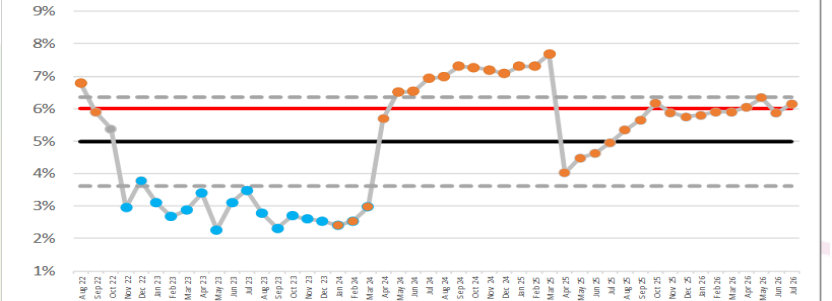
Agency (WTE) Trust

Inconsistent	Common Cause	31.26
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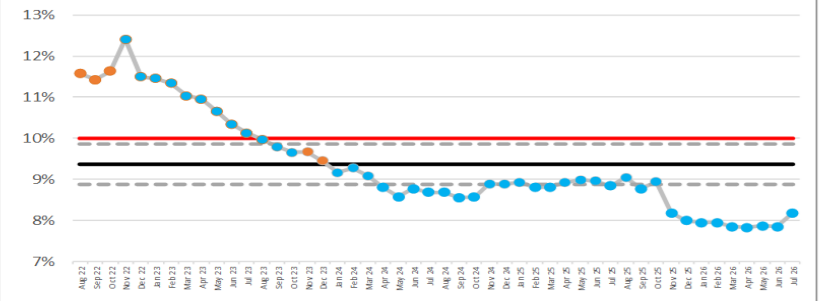
Vacancy Rate

Inconsistent	Concern	6.15%
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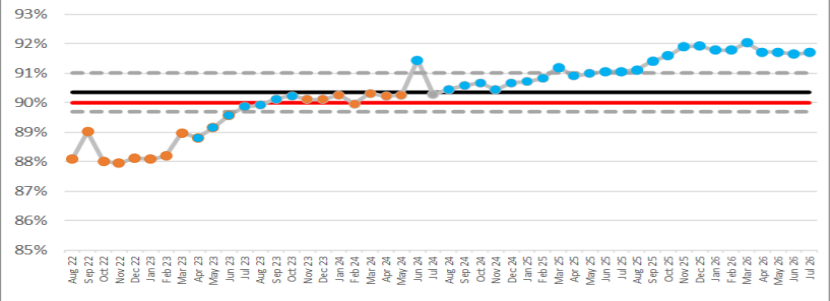
Turnover Rate (12 Months)

Achieving	Improvement	8.18%
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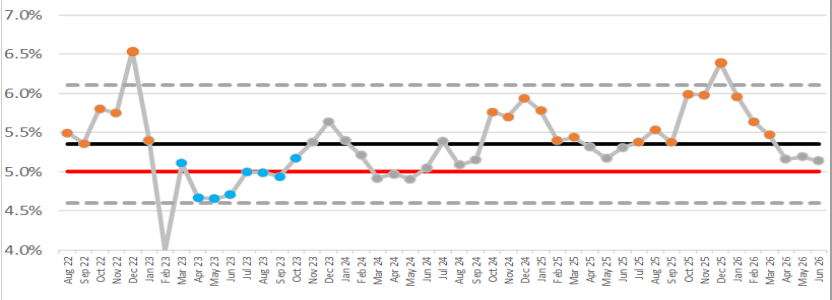
Retention Rate (12 Months)

Inconsistent	Improvement	91.71%
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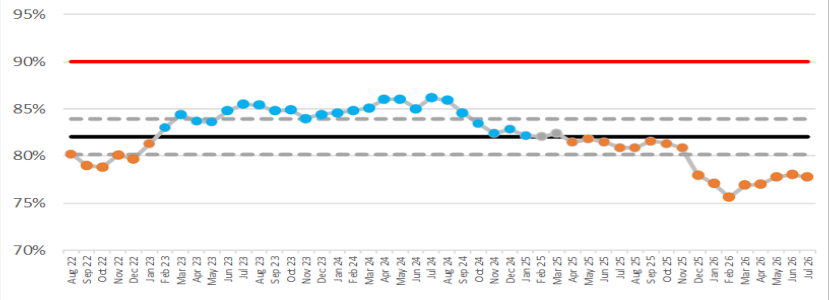
Sickness Absence (In Month)

Inconsistent	Common Cause	5.14%
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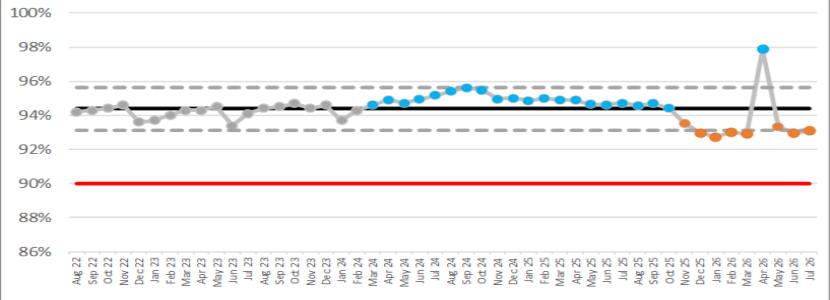
Appraisals

Not Met	Concern	77.78%
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Statutory & Mandatory Training

Achieving	Concern	93.09%
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Operational Performance | Executive Summary

- Performance continued to improve across most of the constitutional standards in July 26. As previously reported, progress continues in closing the residual issues associated with the operational impact of the Phase 1 of the EPR system with oversight provided within the Optimisation Project within Phase 2 of the Blueprint Programme.
- UEC – delivery of the 4-hr patient access standard deteriorated marginally in July 26 from 80.46% to 79.83% with increased Type 1 attendances in month. The 12-hr standard remained high at 14.97%, having been 14.90% for June 26. Ambulance handover times deteriorated further in July 26. 35.88% of patients were handed over within 15 minutes (a deterioration from 42% in June 26). 36.78% of patients waited longer than 45 minutes (a deterioration from 28.84%). Recognition of the impact that this has on patients and their outcomes, ED length of stay and ambulance handovers remain an area of focus for the ED team as well as the whole organisation.
- Nationally, all UEC services continue to be impacted by the hot weather with service pressures continuing into August 26. Patients have experienced long delays at access points to and within ED and the organisations emergency portals.
- The Community First programme continues to be delivered with focus on Ward Processes, SDECs, and Frailty In-reach. Whilst progress is being made, the Trust's ED, emergency portals and medical bed capacity continue to be under significant pressure. National and local bed modelling are showing a current bed capacity deficit as Community Services and alternatives are not fully operational and able to manage 24/7 demand.
- The Community Services access standard for 2-hr UCR was maintained throughout July 26 with the standard being achieved at 87.2%. Virtual ward occupancy remains very high at 110%.
- GP face to face appointments deteriorated slightly in July 26. 2,220 same day face to face appointments were delivered (2,364 in June 26) and 2,778 routine face to face appointments (2,904 in June 26).

Authors



Kate Shaw
(Chief Operating
Officer)

Operational Performance | Executive Summary

- The final national submission date for RTT was extended for July 26. The Trusts recovery continues to be delivered with an increased performance of 63.89% (above trajectory). In addition, the number of patients waiting over 52 weeks reduced to 1,038 (1.47% of the total waiting list and better than trajectory).
- Community waiting times continue to be out of standard and performance deteriorated slightly to 45.76% from 48.20% in May 26. Actions are in place to improve access to this range of community services with particular issues in Paediatrics and Speech and Language Therapy. This is being monitored weekly through the Trust's performance and PTL meetings with ongoing data quality issues being addressed.
- Plans are in place to increase and sustain RTT performance to achieve 69% by the end of March 27 with weekly monitoring in place. This work also includes a focus on productivity and clinical best practice. The provision of additional capacity through insourcing is in place with provision now underway in all agreed services. Implementation of the Luna Rova validation tool has also started and is due for completion in November 26.
- Cancer – based on the latest available data, performance for cancer has improved slightly for 28-day FDS at 82.10% and 92.19% for 31-days.
- The 62-day standard (72.37%) continues to be at risk due to the ongoing capacity challenges in Urology and Oncology. Late referrals for tertiary services also continue to impact on this standard. Agreement has been reached to pause the long-standing mutual aid to Sandwell and West Birmingham for Breast Cancer services and to Walsall (from earlier in the year) to enable waiting times and access to improve. An Oncology Peer Review commenced on 17th August 26 to identify additional areas of focus for recovery and improvement.
- The impact of the launch of the Lung Cancer Screening Programme in South Staffordshire is being monitored with increased numbers of patients being referred than predicted (and worked through). The 'downstream' impact of the programme within Wolverhampton and Walsall is being re-reviewed and mapped. Although the programme remains on target for delivery late September 26, work progresses to analyse and model the impact.

Authors



Kate Shaw
(Chief Operating
Officer)

Operational Performance | Executive Summary

- DM01 – access to diagnostics remains positive with 95.33% of patients seen within 6 weeks with no concerns. The works to upgrade the washers within Endoscopy at New Cross has the risk of impacting on Gastroenterology investigations. Mitigation plans are in place, and this is being monitored.

Authors

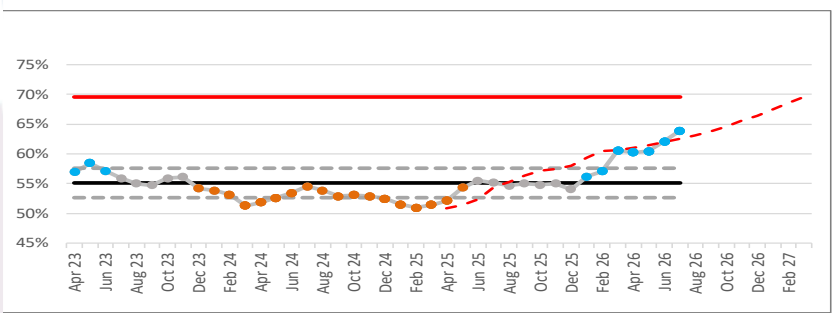


Kate Shaw
(Chief Operating
Officer)

Operational Performance | Core Metrics

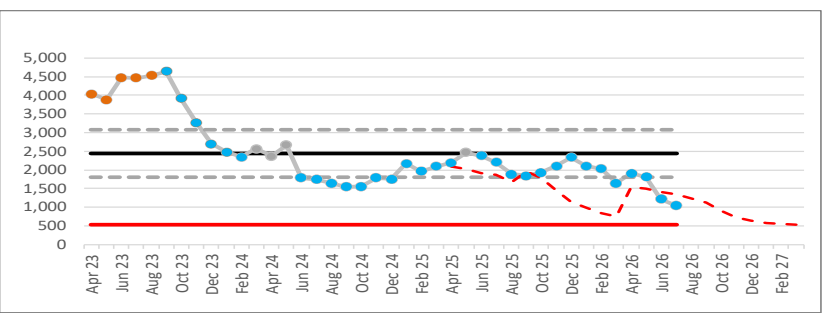
18 Weeks RTT - % Within 18 Weeks - Incomplete

Not Met	Improvement	63.89%
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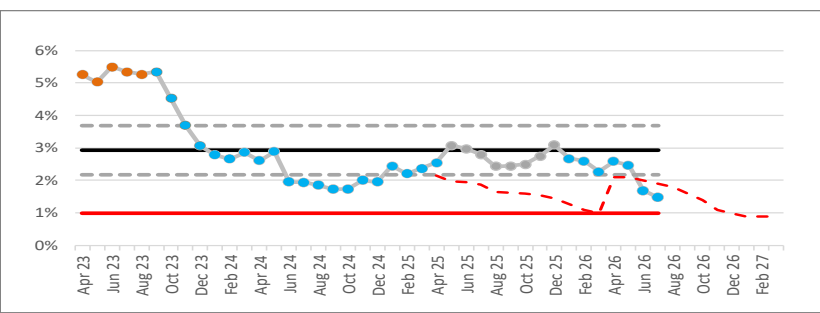
18 Weeks RTT - No. of 52 wk breaches

Not Met	Improvement	1038
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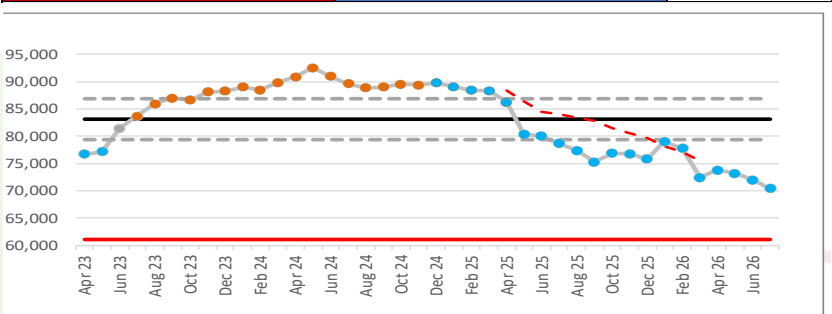
18 Weeks RTT - 52 wk breaches as a % of PTL

Not Met	Improvement	1.47%
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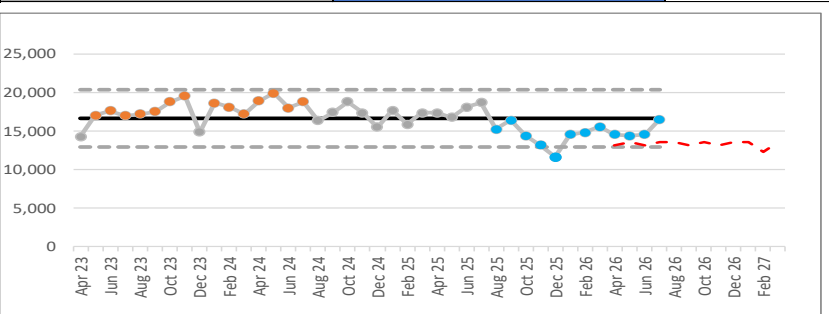
18 Weeks RTT - Total Incomplete PTL

Not Met	Improvement	70399
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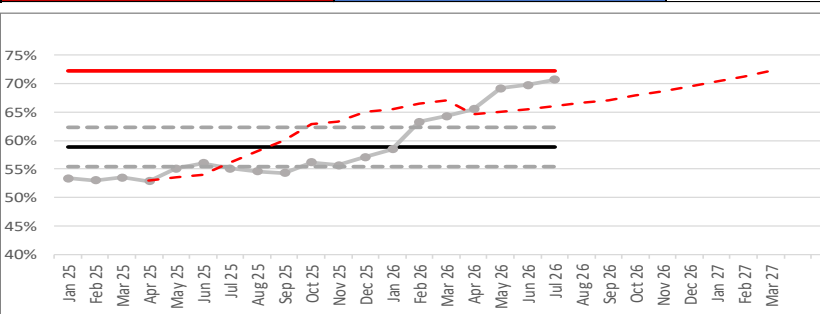
18 Weeks RTT - Clock Starts

No Target Set	Improvement	16519
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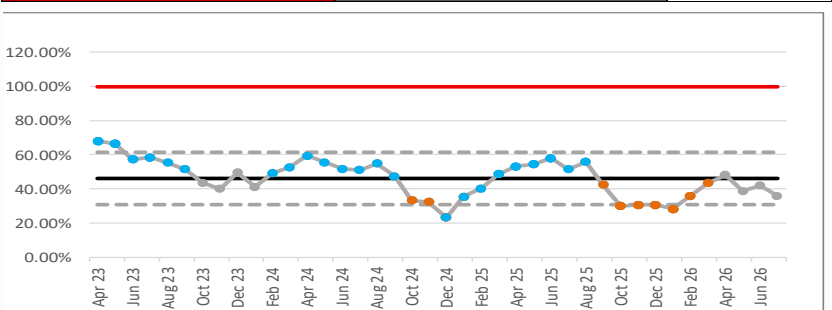
18 Weeks RTT - Time to First Appointment

Not Met	Improvement	70.70%
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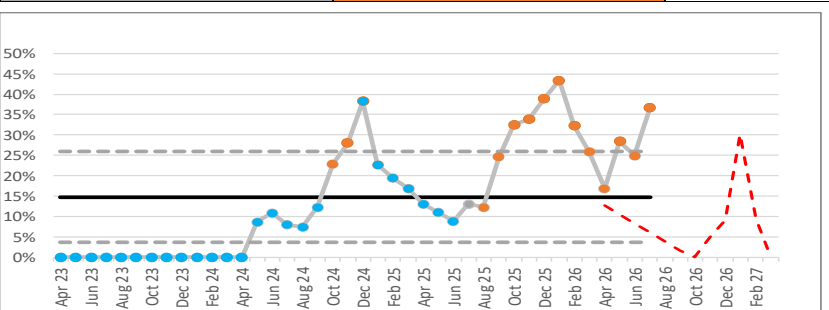
Ambulance Handover - % within 15mins

Not Met	Common Cause	35.88%
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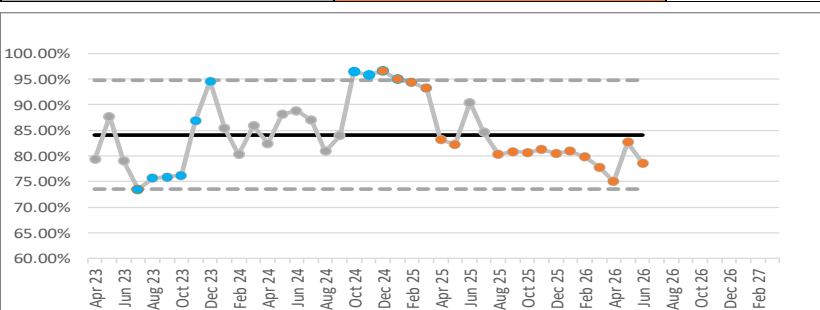
Ambulance Handover - % >45mins

No Target Set	Concern	36.78%
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Cancer - 2 Week Wait

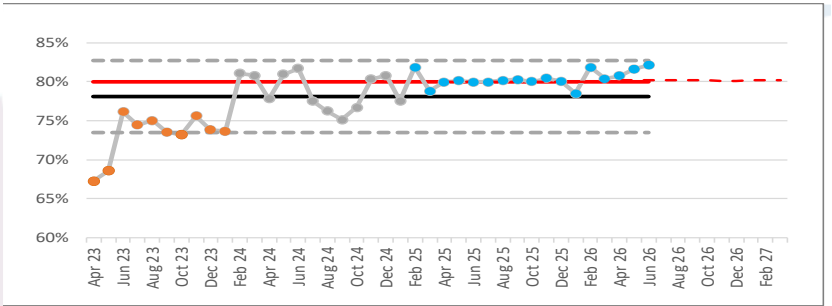
No Target Set	Concern	78.58%
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Operational Performance | Core Metrics

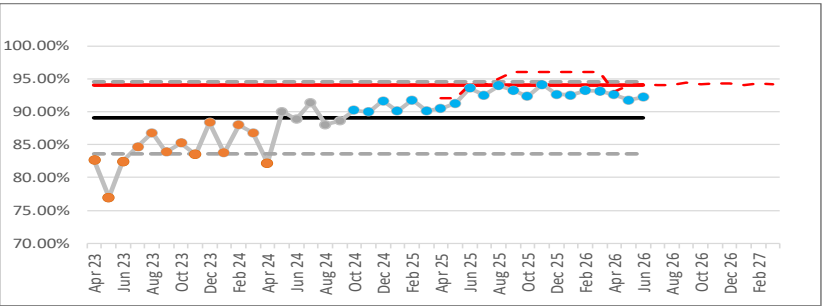
Cancer - 28 Day Faster Diagnosis

Inconsistent	Improvement	82.10%
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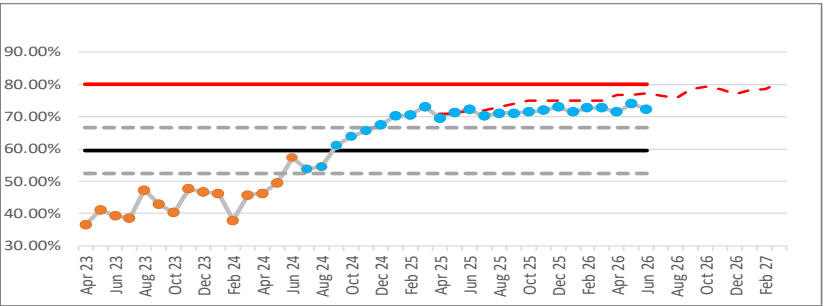
Cancer - 31 Day Treatment

Inconsistent	Improvement	92.19%
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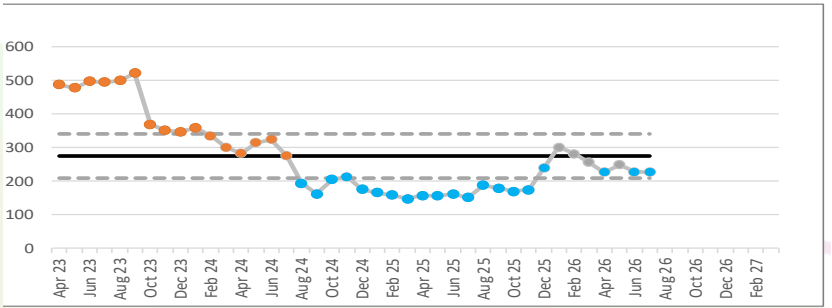
Cancer - 62 Day Referral to Treatment

Not Met	Improvement	72.37%
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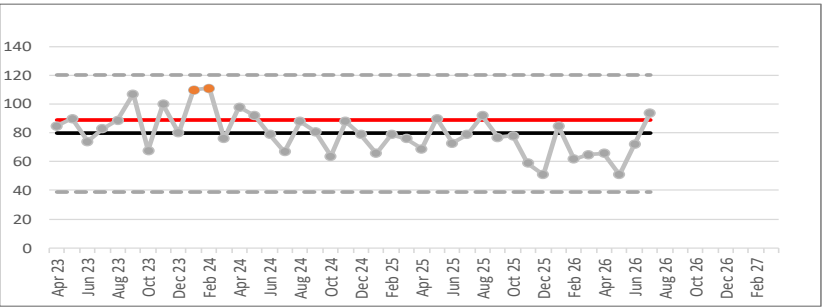
Cancer - No. of patients waiting 63+ Days for treatment

No Target Set	Improvement	226
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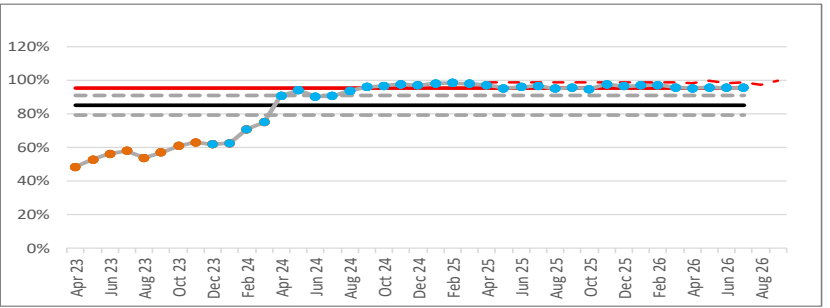
No. of patients no longer meeting the Criteria to Reside

Inconsistent	Common Cause	94
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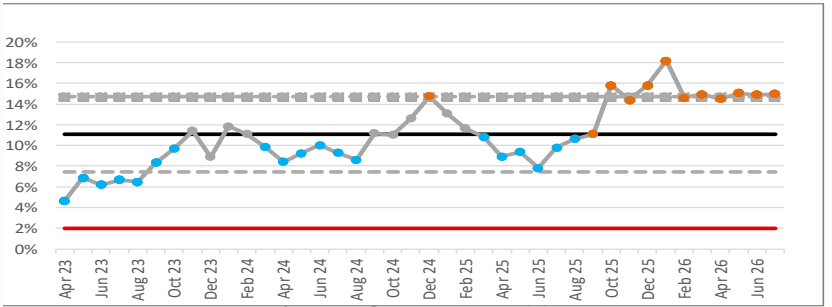
Diagnostics - % within 6 weeks from referral

Not Met	Improvement	95.33%
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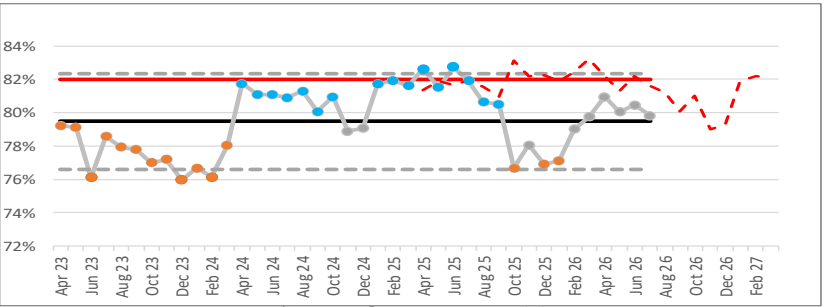
Total Time Spent in ED - % over 12 Hours

Not Met	Concern	14.97%
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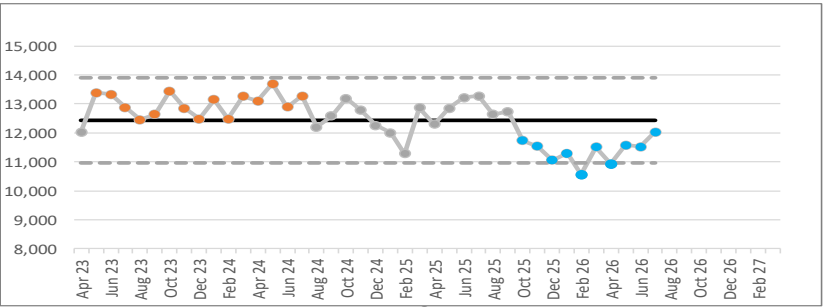
Total Time Spent in ED - % within 4 Hours

Inconsistent	Common Cause	79.83%
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Type 1 ED Attendances

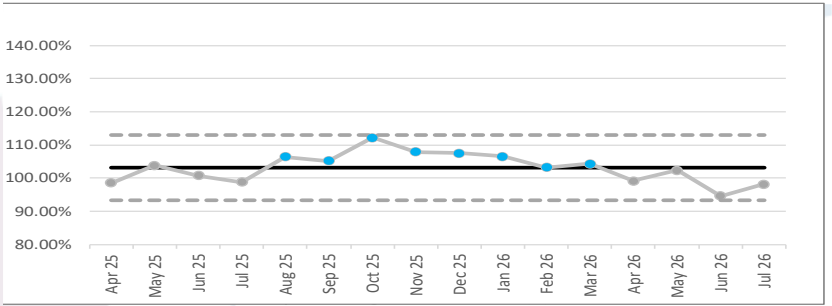
No Target Set	Improvement	12024
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Operational Performance | Core Metrics

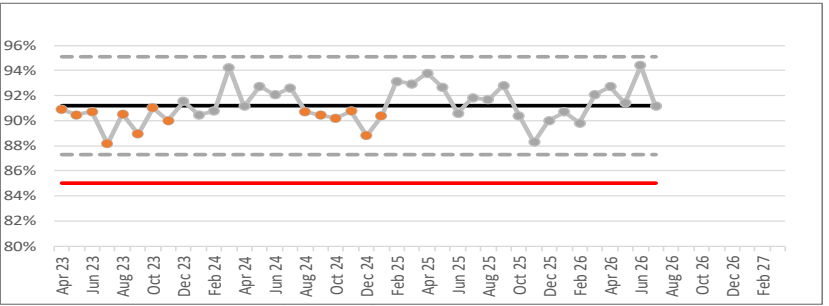
Variable Contract Delivery

No Target Set	Common Cause	98.14%
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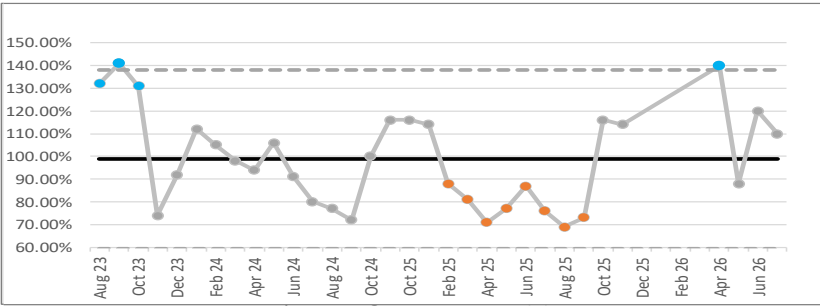
Theatres - Touch Time Utilisation (MH)

Achieving	Common Cause	91.14%
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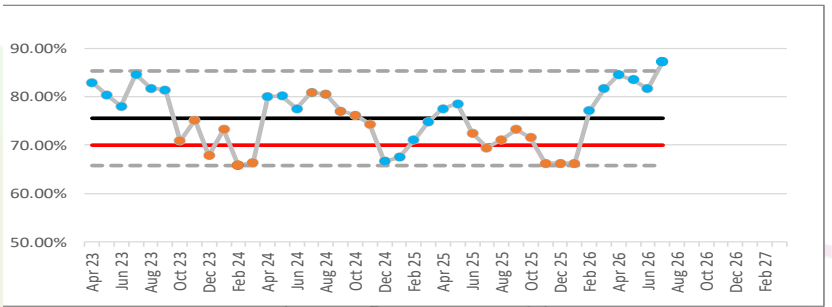
Community - Virtual Ward % Occupancy

No Target Set	Common Cause	110.00%
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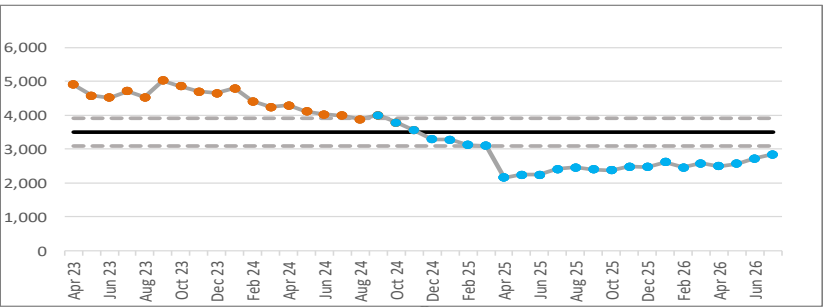
Community - Urgent Care Response (UCR) 2 Hour Response

Inconsistent	Improvement	87.20%
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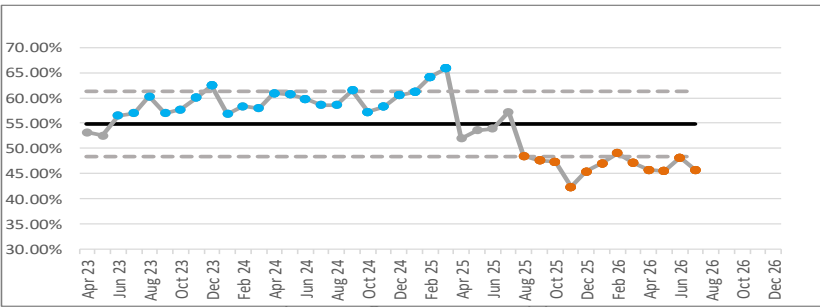
Community - Waiting List - Total

No Target Set	Improvement	2843
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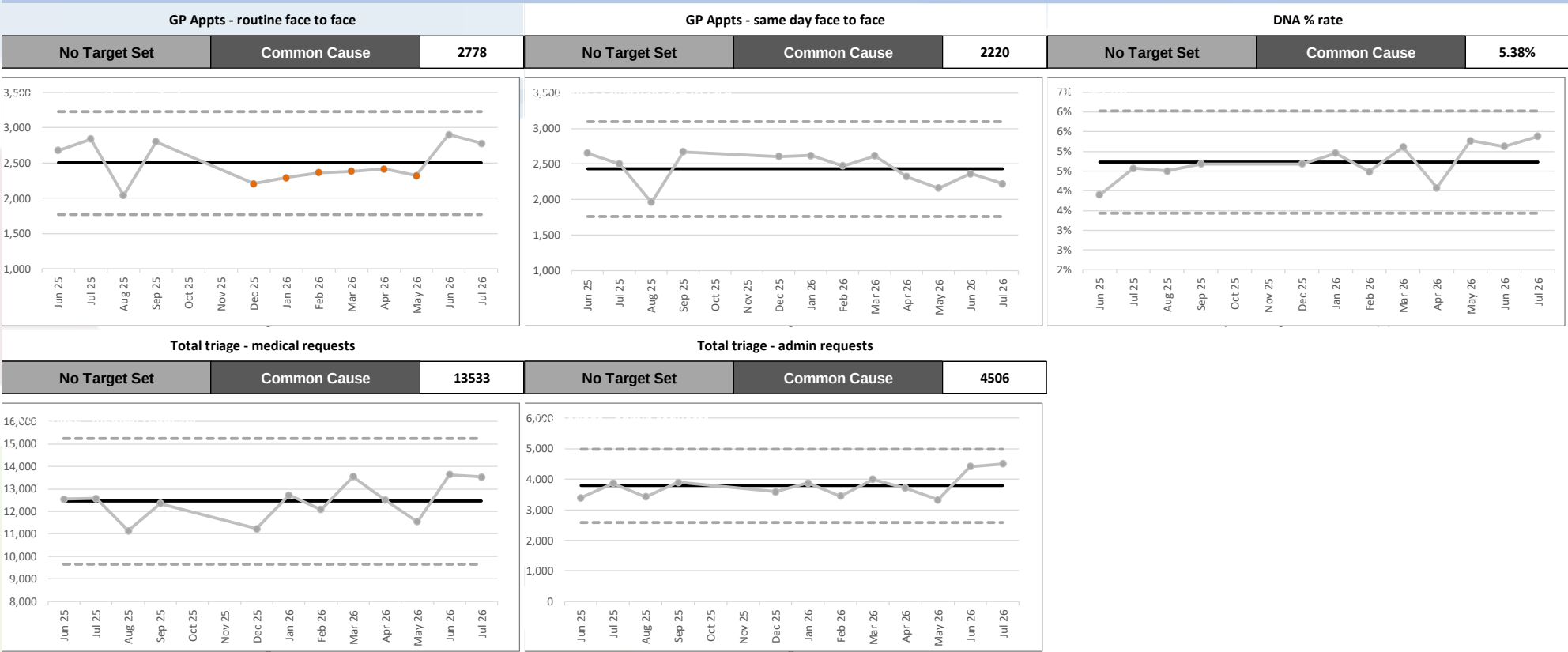


Community - Waiting List - within 18 weeks

No Target Set	Concern	45.76%
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Operational Performance (Primary Care) | Core Metrics



Our data indicates that between June and July 26, demand did not surge; it plateaued (a minute 0.1% decrease in total triage volume). The operational bottleneck was driven by a reduction in resource supply as daily GP sessions fell from 19.43 to 18.83 leading to 198 fewer delivered GP appointments and a worsening same-day shortfall.

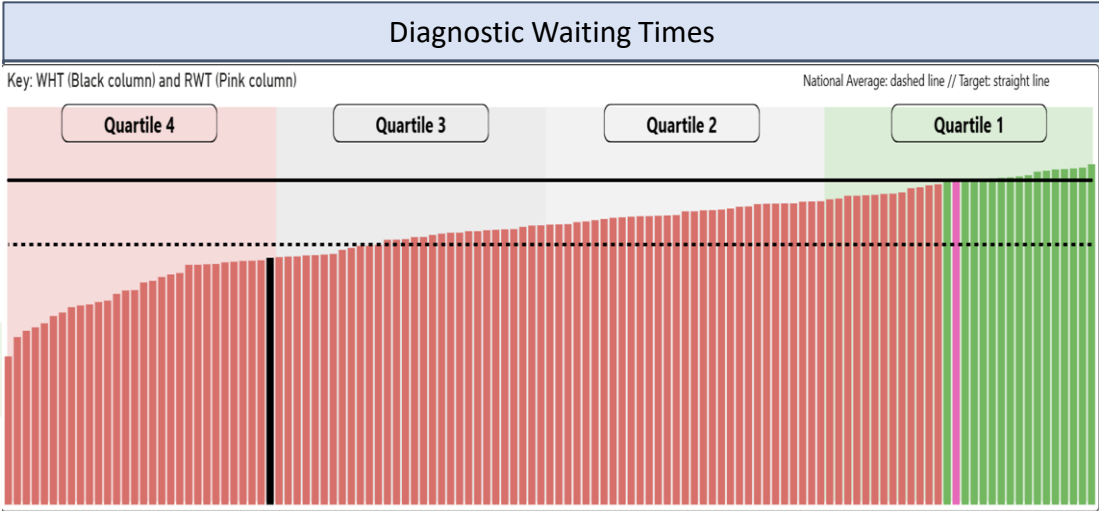
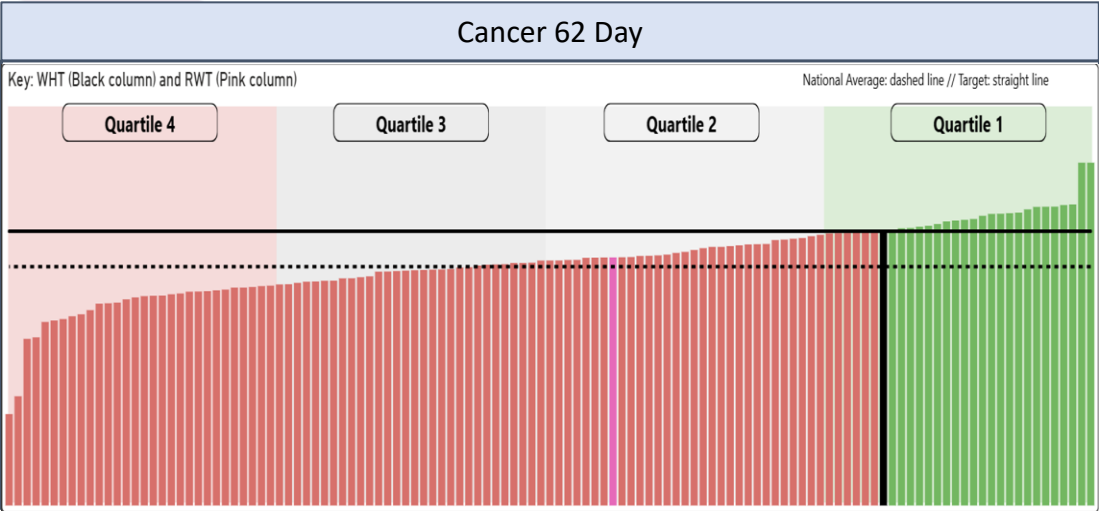
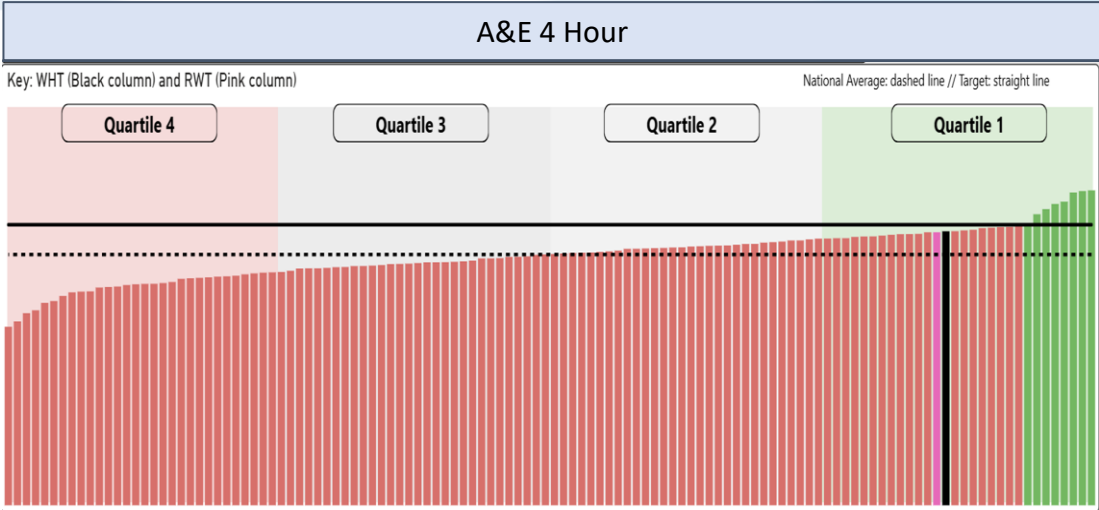
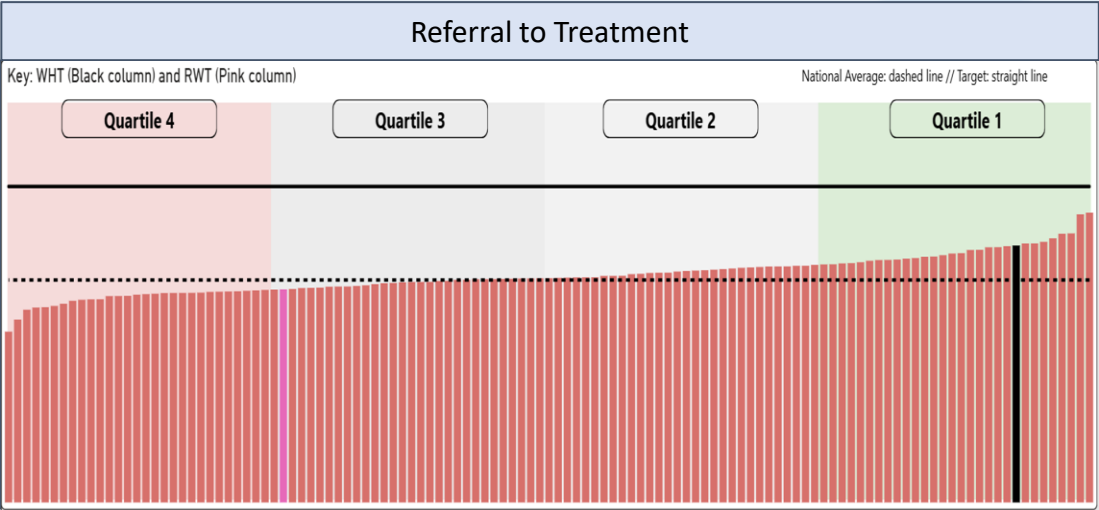
While the overall DNA percentage rate fluctuated slightly, the raw number of wasted GP slots has risen steadily from 230 in May to 334 in July 26. This means in July 26 alone, 334 appointment windows were lost due to patients not attending their appointment, exacerbating the widening same-day capacity shortfall. Despite this we continue to benchmark very favourably when compared to the national average of 7.5%.

There is a clear structural shift from phones to digital access routes. Year-on-year, total calls dropped by 1,190, while total triage requests jumped by 1,597. Patients did not seek care less frequently; they simply moved from phone queues to digital forms.



Care Colleagues
Collaboration Communities

Operational Performance | Benchmarking



Finance | Executive Summary

Key Headlines – Month 4 2026/27

Performance in month 4 is on plan, and also on plan YTD. The total YTD deficit is £7.8m.

The annual plan is breakeven following national deficit support of £16.6m. The plan requires £53.8m of efficiencies for the year.

CIP underachieved in month by £0.7m, bringing the YTD overperformance to £0.6m.

Variable activity is £1.1m below plan YTD, £1.12m below plan for Elective and £0.02m above plan for UEC.

Authors



Kevin Stringer
(Group Chief
Finance Officer)



Care Colleagues
Collaboration Communities

Finance | I&E Summary

In-Month Income & Expenditure

	Plan M3 £m	RWT Actual M3 £m	Surplus/ (Deficit) £m
Income	87.0	87.5	0.5
Expenditure			
Pay	56.0	56.4	(0.4)
Non Pay	21.5	21.5	(0.0)
Drugs	7.1	7.1	0.0
Other*	3.8	3.9	(0.0)
Total Expenditure	88.4	88.9	(0.5)
Net reported surplus/(Deficit)	(1.5)	(1.4)	0.0

Year-to-date Income & Expenditure

	Plan YTD £m	RWT Actual YTD £m	Surplus/ (Deficit) £m
Income	344.4	346.6	2.1
Expenditure			
Pay	223.1	226.2	(3.2)
Non Pay	86.8	85.6	1.2
Drugs	27.1	27.2	(0.1)
Other (incl. depreciation)	15.3	15.4	(0.0)
Total Expenditure	352.3	354.4	(2.1)
Net reported surplus/(Deficit)	(7.9)	(7.8)	0.0

In month deficit of £1,429k which is £29k favorable to the plan of £1,458k.

- Patient income is above plan in month mainly due to prior year gains.
- Directorate Income is under plan due to shortfalls against SLA's, parking income and a correction to the P11D salary sacrifice income.
- Pay is overspent in month due to additional bank, overtime and WLI costs as well as Mental Health Agency nurses.
- Non-pay is underspent in month due to accrual releases relating to RTT and Strategic Change Funding.
- Drugs is overspent in month due to additional Ophthalmology drugs and a shortfall against CIP.



Care Colleagues
Collaboration Communities

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

Finance | ERF Performance

Point of Delivery	RWT		
	Plan	Actual	Variance
	£'000	£'000	£'000
Elective	16,417	16,232	(185)
Daycase	21,142	20,304	(838)
Outpatient Procedures	10,581	10,866	285
Procedures Total	48,140	47,402	(738)
Outpatient 1st	15,409	14,969	(440)
Diagnostic Imaging	3,123	3,039	(84)
Chemotherapy & Radiotherapy	3,982	4,201	219
Total Elective	22,514	22,209	(305)
<i>Payment Variance Elective</i>			(1,124)

A&E	10,816	11,086	(154)
NEL	67,188	67,029	(173)
Total UEC	78,003	78,115	(327)
<i>Payment Variance UEC</i>			(65)

Grand Total	148,658	147,726	(932)
<i>Payment Variance</i>			(1,102)

Year to date variable elective income is performing £1.12m below plan, with Division One underperforming by £2.0m.

UEC is performing £0.1m above plan, a variance of 20% of this is recognised as per guidance.

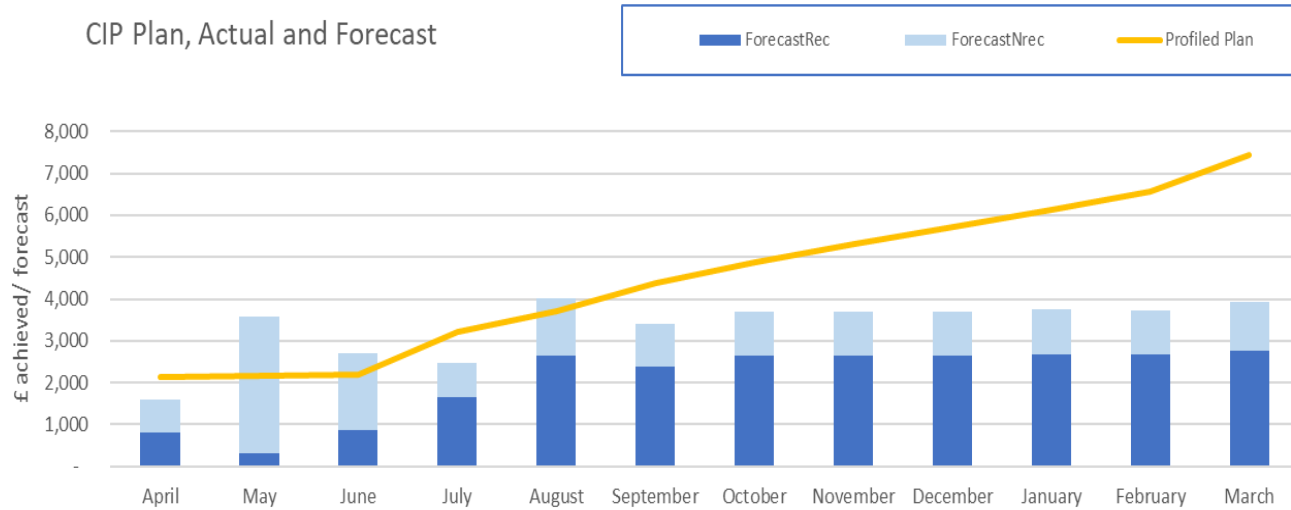
Clinical coding for July 26 was 45% complete, a significant improvement in month. The value of uncoded activity has been estimated at average tariff and is therefore also subject to change once coded. An estimate for uncashed outpatient has also been added to the above, as well as estimate for uncoded ED activity and other known missing coding. The total estimated YTD amounts to £20.5m.



Care Colleagues
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Finance | Cost Improvement Plans

CIP Plan, Actual and Forecast



In month 4 the Trust has achieved £2.5m of CIP, against it's target of £3.2m.

Of the in-month achievement, 67% was achieved recurrently. This is an improvement in month but relates to additional patient income schemes, which have been reported for months 1-4 in month 4, following agreement to report the schemes as CIP.

Schemes have been identified up to the full Trust target, however, there are many of these that are red rated or forecasting lower delivery than planned and actions will need to be put in place to ensure that the schemes deliver the savings expected. The forecast has dropped by £2.5m since month 3 as there are a number of schemes that are now not expected to deliver. Mitigating schemes will need to be identified to fill the currently forecast shortfall of £13.6m.

Delivery against Plan (by Division)

Division	Annual Target £	YTD Plan £	YTD Recurrent £	YTD Non- recurrent £	% Recurrent
Division 1	24,190,071	3,313,619	561,007	2,381,582	19%
Division 2	12,812,923	1,412,706	770,515	966,535	44%
Division 3	9,620,904	2,508,356	1,584,412	749,161	68%
Corporate	4,283,491	1,341,403	31,879	999,075	3%
Estates & Facilities	3,017,224	536,732	430,972	231,290	65%
Trustwide	(100,000)	581,384	253,817	1,396,160	15%
Total	53,824,614	9,694,200	3,632,602	6,723,803	35%



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National Oversight Framework

Quarter 4 Oversight Framework scores have been published which show a rise in Wolverhampton's league ranking back into Segment 3 having seen the overall average score rise from 2.71 to 2.47.

As was the case in Quarter 3, scoring related to Access to Services remains relatively good, particularly for cancer and urgent care. The Trusts RTT performance is starting to show some improvement, with the exception of the percentage of patients waiting >52 weeks in community services. Effectiveness scoring has remained strong.



Care Colleagues
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National Oversight Framework Dashboard

National Oversight Framework - RWT				Q3 25/26			Q4 25/26							Green Amber/Green Amber/Red Red
Code	Metric	Time Period Reported	Target	Published			Published			Internal	Internal	Internal	Internal	
				Perf	Score	Rank	Perf	Score	Rank	Apr-26	May-26	Jun-26	Jul-26	
OF0023	18 Weeks RTT - % Within 18 Weeks - Incomplete	Latest month in the period		54.10	3.65	118/131	60.62	3.65	115/131	60.25%	60.42%	62.09%	63.89%	
OF0003	18 Weeks RTT - 52 wk breaches as a % of PTL	Latest month in the period	1%	3.10	3.71	117/131	2.27	3.53	116/131	2.58%	2.47%	1.69%	1.47%	
OF0106	Difference between actual and planned 18 week elective performance	Latest month in the period	0%	-3.89	3.33	100/131	0.01	1.00	83/131	-0.8%	-1.08%	0.14%	1.34%	
OF0005	Percentage of patients waiting over 52 weeks for community services	End of period		2.64	3.00	79/118	8.25	3.27	91/120	8.25%	7.45%	8.49%	11.75%	
OF0010	Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80%	80.16	1.00	40/118	80.26	1.00	48/118	80.72%	81.13%	81.45%		
OF0011	Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75%	72.16	2.39	56/118	72.32	2.41	53/118	71.52%	72.74%	72.61%		
OF0013	Total Time Spent in ED - % within 4 Hours	Aggregated quarterly position	78%	77.07	2.07	36/123	78.71	1.00	27/123	80.96%	80.49%	80.48%	79.83%	
OF0014	Total Time Spent in ED - % over 12 Hours	Aggregated quarterly position		7.56	2.28	53/123	8.06	2.24	51/123	14.51%	14.81%	14.84%	14.97%	
OF0079	Planned Surplus / Deficit	Annual plan	0	-3.26	4.00	164/205	-3.26	4.00	164/205	-2,041	-2,041	-1,635	-2,373	
OF0081	Year to date variation from plan	Year to date		-0.64	3.00	142/205	0.46	1.00	80/205	-2,740	-4,781	-6,416	-8,789	
OF0085	Implied level of productivity	In-year figure to latest month vs same period in previous year		1.3	3.03	91/134	-0.54	3.53	113/134					
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	6.04	3.55	115/134					
OF1067	CQC safe inspection score	Periodic inspection												
OF0088	Rate of C-Difficile infections (Rolling 12 Months)	12-month rolling	1	1.15	2.55	73/134	0.90	1.00	31/134	93.83	92.59	97.53	104.94	
OF0020	Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	3	2.66	71/134	7	3.51	112/134	7	7	5	6	
OF0048	Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.23	3.17	87/134	1.22	3.14	81/134	271.03	276.64	268.22	270.09	
OF0025	Average number of days between planned and actual discharge date (one month in arrears)	Latest month in the period		0.37	1.52	23/127	0.41	1.64	28/128	3.60	3.50	3.80		
OF1046	Summary Hospital Level Mortality Indicator (Rolling 12 Months)	12 month rolling			2.00			2.00		0.9447	0.941	0.9393	0.9389	
OF0057	Community - Urgent Care Response (UCR) 2 Hour Response	Quarterly aggregated figure	70%	70.00	3.00	80/88	70.00	3.00	80/88	84.47%	83.89%	83.05%	87.19%	
OF0084	Staff survey engagement theme score	Annual		6.73	3.21	99/134	6.4	3.75	123/134					
OF0082	Staff Sickness Rate	Quarterly – aggregated monthly figures		5.33	2.62	122/205	6.06	2.79	122/205	5.17%	5.19%	5.14%		

National Oversight Framework Dashboard – RWT Comparison

Domain	Metric	Data Period	RWT				Var (Qtr 4 vs 3)
			Qtr 1	Qtr 2	Qtr 3	Qtr 4	
Access to Services	% of patients waiting <18 weeks	End of period	3.54	3.61	3.65	4	0.4
Access to Services	% waiting >52 weeks (acute)	End of period	3.21	2.77	3.71	4	0.3
Access to Services	Difference between planned and actual 18 week performance	Monthly	1	2.9	3.33	1	-2.3
Access to Services	% waiting >52 weeks (community)	End of period	2.68	2.56	3	3	0.0
Access to Services	% of urgent referrals diagnosed within 4 weeks	Rolling 12-month	1	1	1	1	0.0
Access to Services	% treated within 62 days of referral	Rolling 12-month	2.64	2.4	2.39	2	-0.4
Access to Services	% of ED attendances seen within 4 hours	Rolling 3-month	1	1	2.07	1	-1.1
Access to Services	% of ED attendances >12 hours	In month	2.48	2.68	2.28	2	-0.3
Access to Services Sub-Total			2.19	2.36	2.68	2.26	-0.4
Effectiveness and Experience of Care	Summary Hospital-Level Mortality Indicator (SHMI)	Rolling 12-month	2	2	2	2	0.0
Effectiveness and Experience of Care	Average days from discharge-ready to actual discharge	In month	1.74	1.73	1.52	2	0.5
Effectiveness and Experience of Care	CQC inpatient survey satisfaction rate	Annual	2	2	2	2	0.0
Effectiveness and Experience of Care	Urgent community response 2-hour performance	In month	2.77	3	3	3	0.0
Effectiveness and Experience of Care Sub-Total			2.13	2.18	2.13	1.88	-0.3
Patient Safety	NHS Staff Survey – raising concerns sub-score	Annual	3.19	3.19	3.19	4	0.8
Patient Safety	12 month rolling count of MRSA cases	Rolling 12-month	3.01	2.89	2.66	4	1.3
Patient Safety	12 month rolling count of C. difficile cases as a proportion of trust threshold	Rolling 12-month	3.57	3.02	2.55	1	-1.6
Patient Safety	12 month rolling count of E. coli cases as a proportion of trust threshold	Rolling 12-month	3.6	3.31	3.17	3	-0.2
Patient Safety Sub-Total			3.29	3.13	2.99	3.05	0.1
People and Workforce	Sickness absence rate	Rolling 12-month	2.71	2.9	2.62	3	0.4
People and Workforce	NHS staff survey – engagement theme score	Annual	3.23	3.21	3.21	4	0.8
People and Workforce Sub-Total			2.96	3.05	2.91	3.27	0.4
Finance and Productivity	Planned surplus/deficit	Annual plan	4	4	4	4	0.0
Finance and Productivity	Variance to financial plan	Year to date	1	1	3	1	-2.0
Finance and Productivity	Implied productivity level	In-year figure to latest month vs same period in previous year	3.53	2.87	3.03	4	1.0
Finance and Productivity	Combined finance score	Annual	2	2	4	2	-2.0
Finance and Productivity Sub-Total			2.76	2.44	3.52	2.76	-0.8

	Green
	Amber/Green
	Amber/Red
	Red

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.



Care Colleagues
Collaboration Communities

Productivity Dashboard																
Workforce Productivity					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	2.14	2.07	2.14	2.23								
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	1.51	1.52	1.67	1.69								
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	123.41	115.28	136.61	136.22								
22	A&E attendances (Type & 2) per Emergency Medicine Consultant	The number of A&E attendances (Type 1 & 2) in month, divided by the number of Emergency Medicine Consultants (WTEs) including substantive, bank and agency staff.	613	Achievement required to maintain top quartile performance	410.42	400.88	435.74	453.12								
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	0.31	0.31	0.32	0.31								
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)	6.77%	6.67%	6.55%	6.65%								
25	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	6%	Nationally set	5.17%	5.19%	5.14%	5.27%								
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	7.82%	7.86%	7.84%	8.18%								
27	Care hours per Patient Day	Total care hours worked by registered nurses & midwives divided by total patient bed days	7.6		8.00	7.90	7.50	8.20								
Support Services																
28	Estates and Facilities Cost per m2	Total estates and facilities running costs divided by total occupied floor area			£24.79/m2	£24.93/m2	£24.31/m2	£25.59/m2								
29	Pathology cost per test	The average cost of undertaking one test across all disciplines, taking into account all pay and non-pay cost items			1.65	1.64	1.59	1.68								

Tier 1 - Paper ref:	Enclosure 10.5
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Report title:	Walsall Healthcare NHS Trust - Winter Plan 2026/27
Sponsoring executive:	Amelia Godson, Managing Director
Report author:	Demetri Wade, Chief Operating Officer Stephen Jackson, Deputy Chief Operating Officer
Meeting title:	Group Trust Board Meeting – held in Public
Date:	15 th September 2026

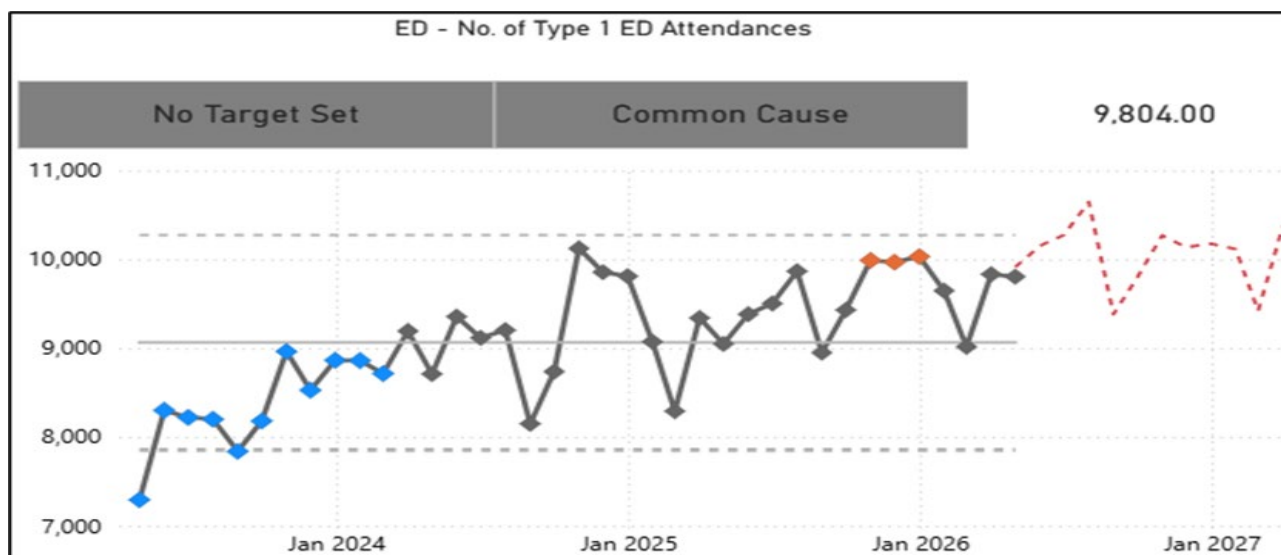
1. Summary of key issues FPC
The Trust has a demonstrable record of improved urgent and emergency care (UEC) performance in recent years, now placing the Trust in the upper quintile nationally across both the 4-hour constitutional standard and the GIRFT Emergency Medicine Index of patient flow (GEMI). This paper sets out the WHT Winter Plan for 2026/27 and is aligned to NHS England’s Urgent and Emergency Care Plan and the Medium-Term Planning Framework. Planning for winter has commenced early, informed by lessons learned from previous winters, evaluation of prior schemes, stakeholder engagement and a Trust-wide Winter Review. The Winter Plan in 2026/27 has been considered in the context of the Trust’s Community First plan. This has seen 51 beds close in 2025/26 and a further 21 beds have been closed to date during 2026/27. Additionally, the plan accounts for the provision made with the Trust financial plan and the commitments made by the Trust in terms of workforce reduction. Forecasting by the Black Country ICB utilising the same approach adopted to prepare for Winter in previous years, indicates an expected 59 bed shortfall relating to additional local Walsall winter demand. Plans are in place to mitigate this shortfall to 43 beds. Options for our Winter Plan are considered, all of which carry risk. Board should be sighted on research from the GIRFT Emergency Medicine programme, and endorsed by the Royal College of Emergency Medicine, which evidences that there will be one additional death associated with every 72 patients that experience an 8–12-hour wait in ED prior to their admission and thus that delays in the UEC pathway are directly associated with harm. A prioritised portfolio of winter schemes has been developed, with proven interventions from previous years identified for implementation.

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		
Group Finance & Productivity Committee Group Management Committee Group Trust Board held in Private -July 2026		
4. Recommendation(s)		
The Public Trust Board is asked to:		
• Endorse the deployment of £900,000 of the allocated funding for Winter within the Trust's 2026/27 financial plan to mitigate the anticipated urgent and emergency care demand this, Winter. • Approve the WHT 2026/27 Winter Plan		

1.0 Executive Brief

The Winter of 2025/26 persisted as a challenging period for Urgent & Emergency Care at both Walsall Healthcare NHS Trust, across the West Midlands region, and indeed nationally. At Walsall we saw a continued increase in type 1 Emergency Department attendances, which demonstrated a statistically significant increase which has not receded. So far in 2026/27 – as can be seen in figure 1 – activity is materially higher than as seen in 2025/26 in comparison months, year to date, there has been a 2.7% increase.

Figure 1: Type 1 Emergency Department attendances SPC chart, January 2023 – May 2026



The Trust has further developed the Urgent & Emergency Care pathway and benefited from the implementation of previous development decisions. Several of these developments will be in place for the entire Winter period for the first time in 2026/27. This includes:

1. The relocation of the Medical Same Day Emergency Care Unit, expanding the space from five to fifteen assessment spaces.
2. The opening of the Hot Imaging Suite, providing both a dedicated emergency CT scanner and ultrasound provision for the Urgent & Emergency Care Centre.
3. The Trust have also committed a significant investment to mitigate the changes in UEC patient flows due to the Midland Metropolitan University Hospital opening on 6th October 2024. Both a £5.9 million capital investment and £10.1 million per annum revenue investment were endorsed by Trust Board in 2024/25. The mitigations to the opening of MMUH includes but is not limited to:
 - The opening of seven additional cubicles in the Emergency Department from January 2025.
 - The expansion of the Acute Medical Unit from 37 to 61 beds, bringing it in line with Society of Acute Medicine Standards¹. There is no net increase in total available beds as part of this expansion as 24 beds have been closed on Ward 6 to accommodate the expansion.

Despite the aforementioned challenges, performance against many urgent & emergency care metrics have continued to improve in the Trust. This includes but is not limited to:

- Leading performance for ambulance handovers within 30 minutes across the West Midlands, consistently ranking in the ranking performing Trusts.
- Upper quintile performance nationally against the 4-hour constitutional standard.
- Upper decile performance nationally for rates of same day emergency care.
- 12-hour waits in ED (from time of arrival) significantly lower than the national average.
- Continued reduction in the number of medically fit for discharge patients.

- Upper decile performance nationally against the GIRFT Emergency Medicine Index.
- Upper decile performance nationally against the GIRFT Acute Medicine Index.
- Upper decile performance nationally for rates of same day emergency care.

We know that traditionally emergency care services face greater pressure during the winter months because of patients being more acutely unwell and thus staying in hospital longer. In addition, given Walsall is the 25th most deprived English Local Authority out of 317 and the link between deprivation and the burden of health need within a population, this will have a disproportionate effect on Communities the Trust serves. As an anchor institution for the Borough of Walsall with a commitment to reducing health inequality, it is crucial the Trust factors this into the Winter Plan.

1. With this challenging context in mind, the central tenets of the Winter Plan are as follows:
A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than simply opening more hospital inpatient beds.
2. Following the success of our targeted approach to managing the Festive period over the last three years, the same approach will be adopted for 2026/27 running from Saturday 12th December 2026 to Sunday 3rd January 2027. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

The Winter Plan in 2026/27 must also be considered in the context of the Trust's Community First plan. This has seen 51 beds close in 2025/26 and a further 21 beds have been closed to date during 2026/27 with some of the avoided costs being reinvested in community services. The target bed closure opportunity for Walsall as detailed through the work undertaken by PA Consulting is a total of 35 for the financial year 2026/27. Whilst the opportunity needs to be validated, the Winter plan for 2026/27 needs to consider a potential further reduction in the overall bed number available.

In addition, the Trust has committed to a further workforce reduction in 2026/27 this would see a reduction in overall staff by 130 wte inclusive of reductions in substantive, bank and agency staff. The 2026/27 Winter plan will therefore also need to be planned and delivered in this context in order not to impact the Trust's ability to deliver against this plan.

Getting Winter right is really important, and is a whole hospital, whole Trust, and whole health economy responsibility. It is important because if we don't get it right, patients will spend excessive time in the ED and will be at increased risk of iatrogenic harm under our care.

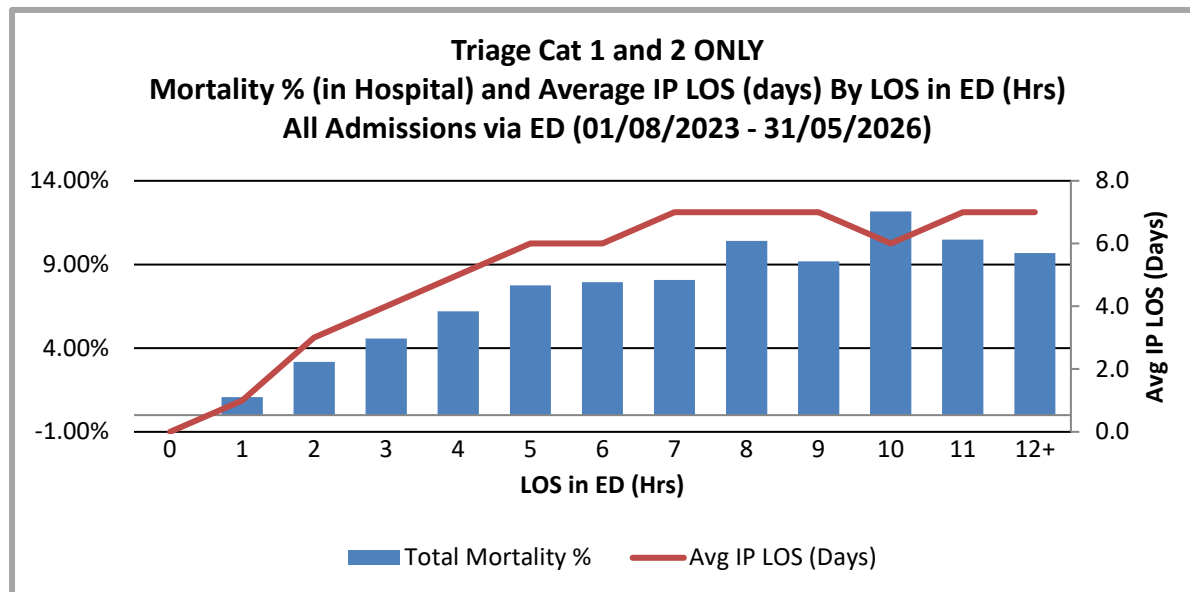
The 4-hour Emergency Access Standard is a relatively simple measurement. However, we know that for our sickest patients, where the triage category is either Category 1 (critical) or Category 2 (very urgent), mortality increases by almost 4% when waiting above 4 hours. Furthermore, research completed by the GIRFT Emergency Medicine programme, and endorsed by the Royal College of Emergency Medicine, evidences that there will be one additional death associated with every 72 patients that experience an 8–12-hour wait in ED prior to their admission¹.

The risks are not currently just within hospitals. Indeed, some of the greatest risks are for patients in the community facing delays in receiving an emergency ambulance to attend to them².

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

² College of Paramedics and Royal College of Emergency Medicine (2021), *Increased ambulance handover delays threatening patient safety, RCEM and College of Paramedics warn*

Figure 2: In Hospital Mortality Rate (%) and average inpatient length of stay, by length of stay in the Emergency Department, Cat 1 and 2 patients only, August 2023 – May 2026



We also know that emergency care services are high pressure environments, with a greater burnout rate for staff. Research on the NHS Staff Survey 2024 highlighted that 30% of staff feel burnt out due to work¹. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and crucially to protect the wellbeing of hard-working staff working in highly challenging environments. Importantly, and directly to support staff experience and wellbeing.

NHS England's Urgent and Emergency Care Plan published in June 2025 outlines three key areas of focus:

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

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

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

https://www.rcem.ac.uk/RCEM/News/News_2021/Increased_ambulance_handover_delays_threatening_patient_safety_RCEM_and_College_of_Paramedics_warn.aspx

¹ [Which NHS Staff Are Most Burnt Out According to the Staff Survey 2023? - Myles Wellbeing](#)

7. Seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25.

We know that the standard we hold at Walsall meets and often exceeds these expectations. However, we must recognise the risk associated with heightened demand and the exacerbation of acute illness Winter often brings. The detailed demand modelling that is provided for Winter recognises the challenges as a result of:

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

Approval of the 2026/27 Winter Plan will be subject to the following Governance approval process:

- Group Performance & Finance Committee
- Trust Management Committee
- Black Country Urgent & Emergency Care Board
- Group Trust Board

2.0 Purpose of this document

1.1 The purpose of this Urgent & Emergency Care Resilience Winter Plan is to:

- Provide the operational plan for the delivery of the workforce and estates plan to manage the additional activity that is forecasted over the Winter period of 2026/27
- Inform all relevant organisations and individuals of the way in which the system intends to manage Urgent and Emergency Care demand and provide resilience over the winter 2026/27.
- Hold information on the approach taken to building the Winter Plan

3.0 Approach to planning for winter 2026/27

3.1 As in previous Winters, the 2026/27 Winter Plan reflections and lessons learned workshops were developed, co-ordinated and reported upon by the Head of EPRR. A detailed database of reflections, new ideas, areas that succeeded and interventions/arrangements that can be improved upon were documented. This report was shared to all Divisions and key departments and formed a strong foundation to fine tune arrangements for the winter ahead. Supplemented by strong and consistent datasets, both offered planners an excellent starting point for 2026/27 and were shared before and briefed at the initial planning meeting.

3.2 Divisions have produced strategic plans following similar principles to the previous winter.

- We know delayed admission from ED to inpatient wards is harmful, and contributes to increased mortality^{1 2}
- We know boarding additional patients on inpatient wards is harmful, and contributes to increased mortality³
- We know outlying medical patients to non-medical wards increases length of stay (and by proxy increases exposure to harm events), ultimately increasing bed occupancy as a result⁴

¹ Getting it Right First Time (2021), *Emergency Medicine: GIRFT Programme National Specialty Report*, <https://www.gettingitrightfirsttime.co.uk/medical-specialties/emergency-medicine/>

² Jones S, Moulton C, et al (2022), *Association between delays to patient admission from the emergency department and all-cause 30-day mortality*, Emerg Med J. 2022 Mar;39(3):168-173. <https://pubmed.ncbi.nlm.nih.gov/35042695/>

³ Nuffield Trust (2022), *Should Emergency Departments move patients to other wards even when there is no bed space available*, <https://www.nuffieldtrust.org.uk/news-item/should-emergency-departments-move-patients-to-other-wards-even-when-there-s-no-bed-space-available>

⁴ Nuffield Trust (2022), *Should Emergency Departments move patients to other wards even when there is no bed space available*, <https://www.nuffieldtrust.org.uk/news-item/should-emergency-departments-move-patients-to-other-wards-even-when-there-s-no-bed-space-available>

- We know short inpatient hospital length of stay is associated with favourable outcomes¹
- We know consultant-delivered care is associated with improved outcomes (including reduced length of stay)²
- We know well coordinated care (particularly for older patients) is associated with reduced length of stay³
- We know community alternatives to hospital for urgent & emergency care can deliver high quality urgent care for patients⁴

Our strategic focus remains aligned with this evidence.

3.3 In line with NHSE Winter Planning 2026/27- expectations and assurance, Walsall Healthcare and its partners will review operational and clinical capacity across community services and primary care specifically with a focus on:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector.

Walsall Healthcare and the Royal Wolverhampton Hospitals are working collaboratively on a shared UEC Single Point of Access with the ambition of operationalizing this in readiness for this winter. This will provide an easier interface for partners, additional resilience and ensure access to a senior clinical decision maker,

In addition, Walsall Healthcare is undertaking improvement work through its Community First program that will improve the organisation's ability to manage demand through the winter period. Workstreams focussing on ward processes, Frailty SDEC, Frailty Hubs, Virtual Wards and Urgent Treatment Centre will increase the effectiveness of admission avoidance, patient flow and discharge response during this key period.

Walsall Healthcare has a nationally recognised model for Intermediate Care that perform well in terms of discharging patients on pathways 1-3 for Discharge to Assess in the community. The service has seen year on year improvements in their key performance metrics and further work is being undertaken this year with partners to enhance the service's attendance avoidance performance in readiness for winter.

4.0 Winter plan modelling methodology and plans to mitigate risk

¹ Han T et al (2022), *Evaluation of the association of length of stay in hospital and outcomes*, International Journal for Quality in Health Care, Volume 34, Issue 2, 2022, mzab160, <https://doi.org/10.1093/intqhc/mzab160>

² Academy of Medical Royal Colleges (2012), *The Benefits of Consultant delivered care*, http://www.aomrc.org.uk/wp-content/uploads/2016/05/Benefits_consultant_delivered_care_1112.pdf

³ Miani C, Ball S, Pitchforth E, et al (2014). *Organisational interventions to reduce length of stay in hospital: a rapid evidence assessment*. Southampton (UK): NIHR Journals Library; 2014 Dec. (Health Services and Delivery Research, No. 2.52.) Scientific summary. <https://www.ncbi.nlm.nih.gov/books/NBK263809/>

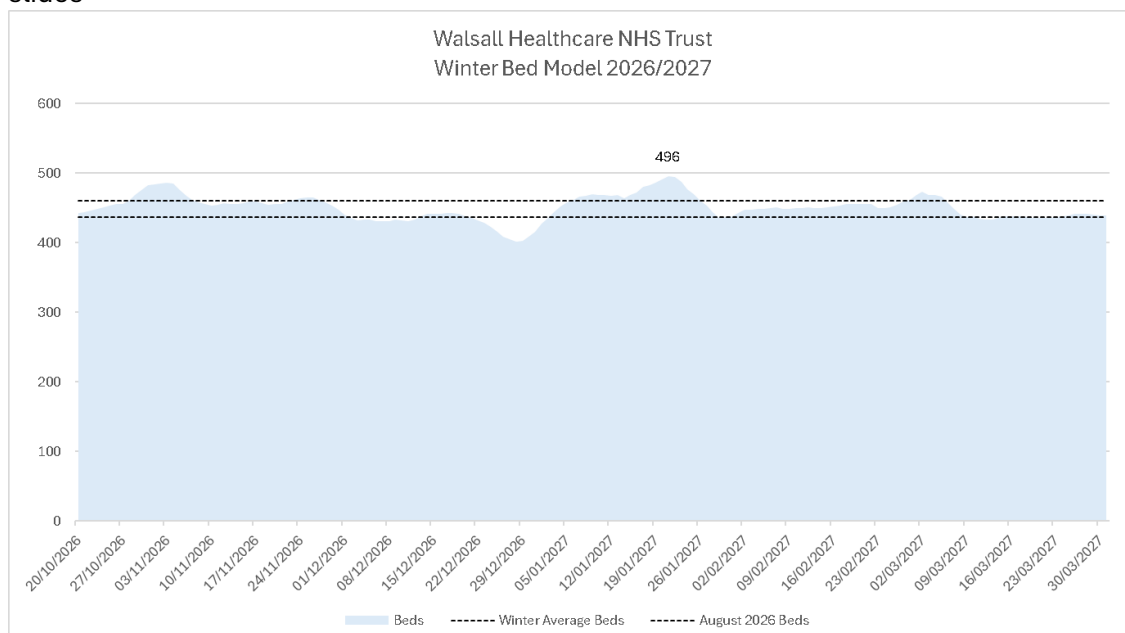
⁴ The Strategy Unit (2022), *Urgent Community Response: Evidence Scan*, <https://www.strategyunitwm.nhs.uk/sites/default/files/2022-05/Urgent%20Community%20Response%20Evidence%20Scan%202022%20%281%29.pdf>

The winter planning for 2026/27 was conducted by the ICB BI using a discrete event modelling methodology. This approach allocates both activity levels and lengths of stay randomly from a distribution. In this case, the distribution is taken from the prior 24 months, such a statistical approach better reflects the likely variation in factors that provide a challenge to hospital bed occupancy.

The detailed bed modelling undertaken by the ICB adopts a Discrete Event Simulation (DES) methodology that accounts for:

- i. Length of Stay (LoS) was input as a probability distribution, derived from observed LoS patterns during both summer and winter periods. For each simulated patient, the model randomly selects a LoS value, capturing the natural variability in patient journeys and enhancing the accuracy of bed utilisation forecasts.
 - ii. Winter Uplift Factors were applied based on trends from the past two winters, with a weighting towards the 2025/26 period to reflect the most recent seasonal pressures.
 - iii. Ambulance conveyances, including both local and out-of-area arrivals, as well as intelligent conveyance patterns.
 - iv. Emergency Department (ED) walk-in activity.
 - v. Changes in LoS for both medical and surgical cohorts.
- Excluding day case elective beds, the Trust has a total of 437 bed spaces, made up of:
 - 325 medical beds,
 - 112 Surgical beds
 - At the peak of winter pressures, the modelling indicates a shortfall of 59 beds
 - The inpatient bed deficit lasts for a total of 4 weeks, from late December 2026 to end of January 2027 with a peak requirement of 496 beds

Figure 3: Bed Demand Predictions, Walsall Manor Hospital, October 2025 – March 2026 updated from ICB slides



The modelling is inclusive of Urgent Treatment Centre activity that has been categorised as Type 1 ED attendances due to the lack of overnight provision in Walsall. The conversion rate used assumes that 50% of this activity will convert to an admission as per normal Type 1 attendances. The average Type 3 activity is 26.5% and therefore the bed deficit would be proportionately reduced with this taken into account.

The impact of the Winter Plan 2026/27 is expected to partially mitigate the bed gap, but an unmitigated gap remains. Whilst the exact schemes are being finalised, those contained in figures 4 and 5 are considered high impact and will be prioritised for inclusion. The unmitigated bed gap following inclusion of 16 beds is 43 beds

with other mitigating schemes reducing the rate of admissions and expediting discharge to bring this down to 25.

Figure 4: Detail of schemes included within Option 1 of the Winter Plan 2026/27

Division	Description	Time period
MLTC	Additional Middle Grade Doctor overnight in ED	Nov-Mar
MLTC	Additional Acute Consultant in ED overnight	Nov-Mar
MLTC	Speciality In-reach Cardiology across 7 days	Oct-Mar
MLTC	Middle Grade Doctor supporting discharge lounge for EDS	Oct-Mar
MLTC	Opening of 16 additional beds on wards 5/6	Dec-Feb
MLTC	2 Consultants to support discharges for Modular Wards at weekends	Oct - Mar
Comm	Additional Therapists to support the Front Door and discharge planning extend delivery hours to 7pm	Oct - Mar
Comm	Acute Therapies- Extend operational hours to 7pm across 7 days	Oct - Mar

Figure 5: Detail of schemes included within Option 2 of the Winter Plan 2026/27

Division	Description	Time period
DoS	Additional trauma capacity, 20 additional theatre sessions (10 days) over Festive Period	Dec-Jan
WCCSS	3 x B6 Patient Flow Pharmacists	Nov-Mar
WCCSS	Patient Flow Medicines Management Technician	Nov-Mar
WCCSS	Patient Flow Medicines Management Assistant	Nov-Mar
WCCSS	1 x B7 Patient Flow Pharmacists	Nov-Mar
WCCSS	Patient Flow Medicines Management Technician	Nov-Mar
Corporate	Additional cover for Infection Control over weekends	Nov-Feb
Corporate	Operations Centre Extended Hours	Nov-Feb
Corporate	Additional patient transport to support discharges	Nov-Feb
Comm	Additional capacity into ICS to support discharge	Oct-Mar

* Option 2 provides schemes that are in addition not in place of those in option 1

5.0 Options

The 2026/27 Annual Plan allocated a minimum of £900,000 and a maximum of £1,200,000 to the Winter Plan. Two options are presented, in order to mitigate the level of risk that the organisation may experience.

Option 1: Minimum required interventions to mitigate risk

Option 1 involves spending £900,000 of the available funding. This option contains the critical initiatives that are determined to have the most impact on diminishing gaps in bed capacity and are reflective of lessons learnt from last winter.

Option 2: Pipelines schemes as a contingency

Option 2 involves spending an additional £300,000. This option provides a number of additional initiatives that would enhance the impact of the initial interventions detailed in option 1 to mitigate the level of risk that the organisation may experience. These additional initiatives may need to be implemented in the event of significant sustained pressure.

It should be noted that both options make no provision for actions that may be needed to be taken in line with the Trust declaring an Internal Critical Incident, following the exhaustion of the ED Escalation Plan and the Trust Escalation Plan.

6.0 Summary

The 2026/27 Winter Plan set out intends to spend the allocation to mitigate the impact that the forecasted demand will have on the Trust throughout the winter period. Several considerations should also be set out at this stage:

- The Trust is entering the Winter period with a lower number of G&A beds than in previous winters and whilst there is a strong belief in the preparations that have been planned to support the closure of wards and winter planning, there is a risk to the organisation in reducing its bed stock.
- There is a risk that neighbouring Boroughs will not support the placement of their locality patients stepping down to care facilities upon being confirmed as medically fit for discharge.

This Winter Plan paper will be taken through the following governance:

- Group Executive Team meeting
- Group Finance & Productivity Committee
- Black Country Urgent & Emergency Care Board
- Group Trust Board

The Winter Plan will also be subject to endorsement by the Quality Committee and Partnerships & Transformation Committee.

7.0 Recommendations

The Group trust Board is asked to:

- Endorse the deployment of £900,000 of the allocated funding for Winter within the Trust's 2026/27 financial plan to mitigate the anticipated urgent and emergency care demand this, Winter.

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

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

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

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

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

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

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

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down): Walsall Healthcare Trust

If Other, write Provider/Trust Name:

Contact details (email, phone number): 01922 721172

Date: 01/07/2026

Assurance statement			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	Approve in draft in July, full sign off for Board in September.	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Specific consideration given to vulnerable groups and health inequalities. The Board is assured that appropriate mitigations are in place to support equitable access and patient outcomes throughout winter.	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Engagement with ICB and Walsall Together.	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Attending ICB Winter Stress Test 02/09 and Regional NHSE 10/09.	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	In Place.	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Winter governance, escalation and operational leadership arrangements are in place through established Trust, Community First and OPEL governance structures.	

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: - the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; - that both walk-in and bookable appointments are available; - that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and - the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	The flu campaign contained within this plan offers both drop in and roaming vaccination options, alongside a Trust-wide communications plan.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	The flu campaign contained within this plan offers both drop in and roaming vaccination options, alongside a Trust-wide communications plan.	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	The flu campaign includes the vaccination of patients with a length of stay of 21 days and above and for this being discharged to Care Homes.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Coordination of the support to vulnerable patients and high risk cohorts is undertaken through Walsall Together with the guidance of Public Health	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Activity modelling is conducted yearly for the Intermediate Care Service that is inclusive of expected numbers of patients per pathway and these are modelled according to the activity that is expected based on seasonal variance. This is developed with system partners and the commissioners of the service.	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: - coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. - executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. - targeted operational actions to reduce long discharge delays. - Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	WHT operates an Intermediate Care Service that is an integrated health and social care model. The pathways are optimised with a home first ethos. Contained within the Winter plan is a provision of escalation beds to mitigate the risk of a surge in demand during expected times of peak activity.	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	WHT optimises its operational efforts in the lead up to Christmas to get as many patients home for Christmas as possible and create the bed capacity to safely manage through the festive period.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	SDEC optimisation work has been conducted as part of the Community First program	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Additional capacity for senior clinical decision making is built into the winter plan in order to ensure that only those patients that require admission are admitted. Additionally, work has been completed to optimise community pathways and frailty care pathways, such as virtual wards in	
Capacity					
	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Safe staffing levels are monitored daily	

3	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Medical rotas are optimised to account for peak periods of demand. Included within the winter plan is the provision of additional senior clinical decision making capacity.	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Additional surgical capacity has been included in the winter plan to ensure that elective and cancer access are maintained through winter.	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Trajectories submitted account for seasonal variation in demand.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Community capacity is reviewed with partners to ensure that admission avoidance services are optimised during the winter period.	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Action cards as escalation policy in place with divisional teams to support mitigation of corridor care.	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Early escalation planning in place through local SOP to maintain ambulance hand overs	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Twice daily escalation touch points to be maintained through winter.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	Model ED and Model Discharge principles underpin current front door and back door policy and procedure.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	There is a policy in place regarding the safe cohorting of patients to support the control of infections.	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Additional provision for IPC is included within the Winter plan	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	FIT testing training and compliance are monitored	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	There is a policy in place regarding the safe cohorting of patients to support the control of infections.	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	An effective on call system operates all year round	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	The Trust has a clear escalation and policy that covers key actions	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes		

	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.			
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.			

Executive Approval

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

Trust / Provider Name: Walsall Healthcare NHS Trust

Provider CEO name: Joe Chadwick-Bell

Date reviewed:

Provider Chair name: Sir David Nicholson

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Amelia Godson (amelia.godson1@nhs.net)

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

All responses have been reviewed and approved

Please confirm date reviewed

15/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	Awaiting assessment

Tier 1 - Paper ref:	Enclosure 10.5
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Report title:	The Royal Wolverhampton NHS Trust - Winter Plan
Sponsoring executive:	Gwen Nuttall, Managing Director
Report author:	Kate Shaw, Chief Operating Officer RWT Gwyneth Kidd, Service Improvement Programme Manager, Div 2
Meeting title:	Group Trust Board Meeting (to be held in Public)
Date:	15 September 2026

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

This paper sets out the RWT draft Winter Plan for 2026/27 and is aligned to NHS England's Urgent and Emergency Care Plan; the Medium-Term Planning Framework; the WHT Winter Plan; and the wider OneWolverhampton Winter Plan. Delivery will continue through established system-wide governance arrangements led by the Home First Strategic Working Group, with strong partnership working across health, social care and voluntary sector organisations.

Planning for winter has commenced early, informed by lessons learned from previous winters, evaluation of prior schemes, stakeholder engagement and a Trust-wide Winter Planning Workshop held on 20 May 2026. The plan builds on the Community First Programme and a range of admission avoidance, hospital flow and community-based care initiatives designed to improve patient outcomes, increase capacity and strengthen system resilience.

The Winter Bed Model for 2026/27 projects a peak requirement of 839 beds on 14 December 2026. The Trust is therefore forecast to face a peak bed shortfall of 81 beds. A number of the RWT schemes are interconnected and optimised for flexibility of workforce and response. Further mitigation would be possible if further funding was available.

There is around £4 million investment and transformation monies available for Wolverhampton, made up from various funding streams including Neighbourhood Health Funding, Better Care Fund, Discharge Funding. This funding is all non-recurrent and is needed to support all providers within OneWolverhampton over the winter. In addition, within this year's Operating Plan, funding for a winter ward was agreed (£800k). However, additional capacity has opened early due to sustained non-elective demand.

Robust planning arrangements are in place and the Trust is continuing to work closely with system partners to develop a coordinated response to winter pressures. The plan also maintains a strong focus on addressing health inequalities through targeted support for frail older people, care home residents, people experiencing homelessness, individuals with mental health needs and other vulnerable groups, with utilisation and outcomes monitored throughout the winter period.

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 - 7 July 2026
- Group Trust Board held in Private – 21 July
- Group Finance & Productivity Committee – 28 July

4. Recommendation(s)/Action(s)
The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
a) Approve the RWT 2026/27 Winter Plan

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 15 September 2026

Winter Plan 2026/27

1. Executive summary

This paper presents the Trust's draft Winter Plan for 2026/27, which has been developed in line with NHS England's Urgent and Emergency Care Plan published in June 2025, and the Medium-Term Planning Framework published in October 2025.

The draft Winter Plan was approved at July's Trust Board meeting held in private, pending the outcome of the bed winter modelling. Sections of the plan have also been strengthened following receipt of NHS England's Winter planning 2026/27 – Expectations and Assurance letter dated 17 July 2026.

The Winter Plan is aligned to both the Walsall Healthcare NHS Trust Winter Plan and the wider OneWolverhampton Winter Plan. The plan reflects the continued commitment to collaborative system working and shared responsibility for winter resilience across Wolverhampton and the Black Country. Governance is provided through the Home First Strategic Working Group, with established arrangements in place to ensure executive, clinical and operational oversight across partner organisations.

A key enabler of delivery is the Community First Programme, a clinically led transformation programme focused on improving patient flow and system capacity through admission avoidance, urgent care redesign, neighbourhood care development, hospital flow optimisation and enhanced community-based support. Together, these initiatives support the strategic ambition to deliver more care closer to home, reduce reliance on hospital services and improve outcomes for patients.

The plan has been informed by learning from previous winters, including formal evaluation of winter schemes, review of system performance and outputs from the Trust-wide Winter Planning Workshop held in May 2026. A prioritised portfolio of winter initiatives has been developed, with schemes demonstrating positive impact during 2025/26 identified for potential continuation through the City of Wolverhampton Council and Black Country ICB (Wolverhampton Place) Discharge Fund, subject to funding availability.

In addition, a number of Community First initiatives are already being progressed ahead of winter, including enhanced admission avoidance pathways, hospital flow improvements and community-based models of care, supporting sustainable improvements in resilience and capacity before peak seasonal pressures are experienced.

The Winter Bed Model for 2026/27 projects a peak requirement of 839 beds on 14 December 2026. The Trust is forecast to face a peak bed shortfall of 81 beds. A number of the RWT schemes are interconnected and optimised for flexibility of workforce and response. Further mitigation would be possible if further funding was available.

Robust planning arrangements are in place and the Trust is continuing to work closely with system partners to develop a coordinated response to winter pressures. The plan also maintains a strong focus on addressing health inequalities through targeted support for frail older people, care home residents, people experiencing homelessness, individuals with mental health needs and other vulnerable groups, with utilisation and outcomes monitored throughout the winter period.

2. Introduction or background

The Urgent and Emergency Care Plan outlines three key areas of focus:

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

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

1. Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes;
2. Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes;
3. A minimum of 82% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours by March 2027;
4. Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time;
5. Reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission. This will provide faster care for thousands of people in crisis every month;
6. Tackling the delays in patients waiting once they are ready to be discharged – starting with reducing the 30,000 patients staying 21 days over their discharge-ready-date;
7. Seeing more children within 4 hours, resulting in thousands of children receiving more timely care than in 2024/25.

More recently, the Medium-Term Planning Framework sets out further required improvements:

Success measure	2026/27 target	2028/29 target
4hr A&E performance	Every trust to maintain or improve to 82% by March 2027	National target of 85% as the average for the year
12-hour A&E performance	Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26	Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours
Category 2 response times	Improve upon 2025/26 standard to reach an average response time of 25 minutes	Further improvement so that by the end of 2028/29 the average response time is 18 minutes, with 90% of calls responded to within 40 minutes

Table 1: UEC performance targets set out in the Medium-Term Planning Framework

These priorities support the ambitions of the 10-Year Health Plan, which seeks to reduce avoidable hospital attendance through improved community-based urgent care, digital innovation, enhanced mental health crisis provision and better system flow.

The combined pressure of improving cancer waiting times and delivering elective recovery whilst simultaneously managing increasingly complex non-elective demand, is putting significant strain on the Trust and the wider system. These challenges are only expected to increase during the winter months when

emergency care services face greater pressure because of patients being more acutely unwell with a longer stay in hospital longer.

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

3. The predicted bed deficit

The ICB is working in partnership with NHS England and provider organisations to develop a consistent and transparent winter bed model, enabling scenario testing, supporting operational planning, and ensuring assumptions accurately reflect local system pressures and capacity constraints.

The Winter Bed Model for 2026/27 projects a peak requirement of 839 beds on 14 December 2026. The Trust is therefore forecast to face a peak bed shortfall of 81 beds.

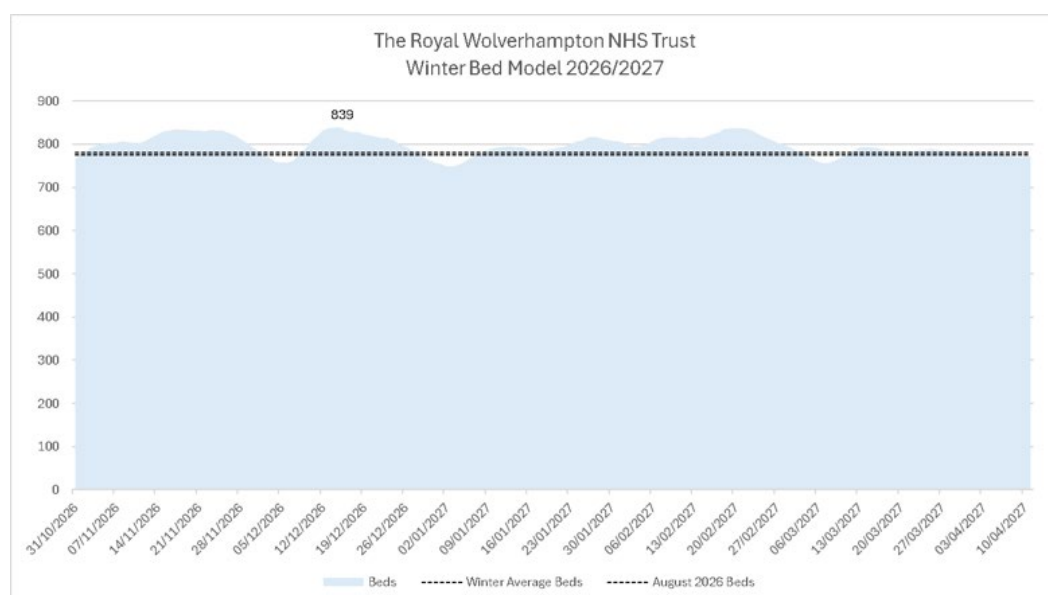


Figure 1: RWT Winter Bed Model 2026/27

3.1 Mitigating schemes

The impact on the bed base has been forecasted based on the mitigating schemes listed below and have been aligned to the five areas of spend within the funding allocation;

1. Neighbourhood Health
2. SEND Reforms
3. Prevention and Wellbeing
4. Mental Health and Inclusion
5. Hospital discharge and community support

A number of the RWT schemes are interconnected and optimised for flexibility of workforce and response. Further mitigation would be possible if funding was available – these schemes are RAG rated as red below in table 3.

The unmitigated bed demand against available funding is acknowledged at 21 beds at the peak of Winter. The proposed impact on emergency admissions and flow from the funding of schemes and initiatives of partners within One Wolverhampton is being finalised and will be included once available. Work on alternative pathways within the Community First Programme will also continue over the coming weeks and months with the aim of further reducing avoidable demand and mitigating the winter bed deficit further.

Additional detail regarding system schemes can be found in the draft OneWolverhampton plan which is available on request.

Allocation category (1 – 5)	Initiative	Mitigation	Detail	RAG rating
1 – Neighbourhood health	Winter escalation ward	28	28-bed winter escalation ward to provide additional inpatient capacity during periods of increased seasonal demand associated with winter viruses.	
5 - Hospital discharge and community support	Admission avoidance by senior decision maker and Virtual Ward transfer	5	Enhanced Medical Physician of the day and Midnight - 7am consultant cover in ED enabling earlier assessment and treatment, reducing avoidable admissions, and facilitating timely transfer of appropriate patients to Virtual Wards as an alternative to inpatient admission.	
1 - Neighbourhood Health	Community respiratory physio for children and young people	2	Proactive acute respiratory physiotherapy to specialist subset of CYP, aiming to reduce admissions due to sputum retention and respiratory distress, and facilitate earlier discharge of patients admitted who are receiving intensive respiratory care.	
5 - Hospital discharge and community support	Enhanced site team	3	To expedite discharges and maintain site safety overnight and at weekends.	
5 - Hospital discharge and community support	Pharmacy provision in Same Day Discharge Centre	2	Ensure accurate medicines reconciliation, reduce delays and omissions, support timely discharge and patient flow, optimise medication use and costs, and enhance patient counselling and safe transfer of care.	
3 - Prevention and Wellbeing	Enhanced first assessment and clerking	2	Strengthening front-end clinical assessment processes, the service will support more efficient patient management, reduce delays in care, and contribute to improved operational performance across the wider urgent and emergency care pathway.	
3 - Prevention and Wellbeing	Escalation of Medical SDEC (6 days)	3	6-day service to ensure equitable access to specialist assessment and treatment.	
3 - Prevention and Wellbeing	Frailty in reach team / Rapid Intervention Team	6	Frailty Intervention Team (FIT) made up of community MDT colleagues working at the front door, to help admission avoid for older adults. RIT provides 24/7 urgent community response (UCR).	

Allocation category (1 – 5)	Initiative	Mitigation	Detail	RAG rating
5 - Hospital discharge and community support	Virtual Ward - ongoing provision of VW capacity	4	To support earlier discharge and admission avoidance.	
3 - Prevention and Wellbeing	Community Neuro Therapy	1	Funding to support additional neuro rehab capacity over the winter period.	
5 - Hospital discharge and community support	RWT Intermediate Care (to incorporate RASC and Home First)	4	Supporting early facilitated hospital discharge for patients waiting for start dates of social care funded packages of care. Rapid Access to Social Care (RASC) will help to bridge the gap, impacting on the number of patients on the medically fit lists while reducing deconditioning for patients and improving flow.	
	Total mitigation – funded schemes	60		

Table 2: Schemes to mitigate the bed capacity gap – indicative numbers only.

Allocation category (1 – 5)	Initiative	Mitigation	Detail	RAG rating
5 - Hospital discharge and community support	Additional Virtual Ward capacity	6	Additional VW capacity to support earlier discharge and admission avoidance.	
5 - Hospital discharge and community support	Additional patient transport	2	Increased patient transport capacity to support flow and reduced discharge delays.	
5 - Hospital discharge and community support	Increased hours of Periodic Equipment Cleaning	0.5	To support cleaning as currently unable to decant.	
5 - Hospital discharge and community support	Enhanced Flow team overnight and at weekends – <i>full ask</i>	1.5	To expedite discharges and maintain site safety overnight and at weekends. Additional hours for Discharge facilitators and ED flow team.	
3 - Prevention and Wellbeing	Enhanced first assessment and clerking – <i>full ask</i>	2	Strengthening front-end clinical assessment processes, the service will support more efficient patient management, reduce delays in care, and contribute to improved operational performance across the wider urgent and emergency care pathway.	

Allocation category (1 – 5)	Initiative	Mitigation	Detail	RAG rating
3 - Prevention and Wellbeing	Escalation of Medical SDEC, to include weekends (7 Days)	3	7-day service to ensure equitable access to specialist assessment and treatment.	
5 - Hospital discharge and community support	Extended opening hours for Same Day Discharge Centre	1	Open from 06:00 weekdays, 07:30 weekends; to create space in ED earlier in the day, and to create earlier flow on wards.	
5 - Hospital discharge and community support	Additional D2A Beds	5	Supporting earlier discharge.	
	Total mitigation – unfunded schemes	21		

Table 3 : Unfunded schemes to mitigate the bed capacity gap - indicative numbers only.

4. Risks

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

Risk	Mitigation	RAG rating
Lack of mutual aid across system as unable to take divers	- Participation in Black Country mutual aid arrangements - Use of OPEL escalation processes to coordinate support - Close working with WMAS and system partners during periods of pressure - Ongoing monitoring of capacity and patient flow	
Sustained increase in attendance and lack of use of alternative pathways including Call Before Convey	- Increase uptake of CBC through enhanced monitoring and feedback - Review capacity and accessibility of alternative pathways - Targeted communications to support demand management	
Staff sickness and workforce resilience	- Trust processes in place - Annual winter vaccination programme to be launched - both Covid booster and flu – as part of wider 'Winter Ready' campaign - Divisional and Trust staff allocation meetings - Prioritising the wellbeing of our staff	
Transport failure	- Escalation and utilisation of alternative provider as now - Additional funding required	
Covid, Flu, Norovirus, etc. impacting on inpatient flow and nursing home closures	- IP processes and guidelines in place - Joint work with Capacity - IP input to Nursing Homes - Community infection and vaccination rates are routinely monitored by the system and within the Trust	

Risk	Mitigation	RAG rating
45-minute offload mandate creates heightened pressure in Emergency Services	- Physical space identified in UEC - Ongoing engagement with teams to ensure specialty reviews are undertaken promptly - Ongoing monitoring	

Table 4: Risks associated with delivering the Winter Plan

5. Funding

There is around £4 million investment and transformation monies available for Wolverhampton, made up from various funding streams including Neighbourhood Health Funding, Better Care Fund, Discharge Funding. This funding is all non-recurrent and is needed to support all providers within OneWolverhampton over the winter. In addition, within this year's Operating Plan, funding for a winter ward was agreed (£800k). However, additional capacity has opened early due to sustained non-elective demand.

As with previous years, this will follow the governance route of the Home First Strategic Working Group with final sign off at the Place Integrated Commissioning Committee.

The RWT schemes have been costed and are detailed in the tables below, split by funded and unfunded. The unfunded schemes will be commissioned if further monies become available.

Funded scheme	Indicative Cost £
28-bed Winter Escalation Ward	918,713
Admission avoidance by senior decision maker and Virtual Ward transfer	165,397
Community respiratory physio for children and young people	61,537
Enhanced site team overnight and at weekends	116,000
Pharmacy provision in SDDC	18,000
Enhanced first assessment and clerking	92,000
Escalation of Medical SDEC, to include weekends	137,000
Frailty in reach team / Rapid Intervention team	65,000
Virtual Ward - ongoing provision of VW capacity	176,953
Community Neuro Therapy	£60,000
RWT Intermediate Care (to incorporate RASC and Home First)	£450,000
Total funded schemes	£1,750,600

Table 5: Funded schemes

Unfunded scheme	Indicative Cost £
Additional Virtual Ward capacity	100,000
Additional patient transport	71,400
Increased hours of PECC, plus hire of x2 additional HPV machines	102,724
Enhanced Flow team overnight and at weekends – full ask	109,092
Enhanced first assessment and clerking – full ask	178,229
Escalation of Medical SDEC, to include weekends (7 Days)	137,000
Extended opening hours of SDDC	19,639
Additional D2A Beds	164,055
Total unfunded schemes	£882,139
Total schemes (funded + unfunded)	£2,632,739

Table 6: Unfunded schemes

6. Recommendations

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

- a. Approve the 2026/27 RWT Winter Plan

Annex 1: Board Assurance Statement

Annex 2: Infection Prevention measures

Annex 3 - Infection Prevention (IP) measures

Respiratory viruses include seasonal, avian, and pandemic influenza, respiratory syncytial virus (RSV) and severe acute respiratory syndromes (SARS). COVID-19, along with many other respiratory infections such as influenza (flu), can spread easily and cause serious illness in some people. You may be infected with a respiratory virus such as COVID-19 and not have any symptoms but still pass infection onto others. The common respiratory viruses are seasonal influenza and RSV. They can infect any age group although the severe complications of such infection are often restricted to children and the elderly. These viruses are most transmitted by airborne, droplets or nasal secretions and can lead to a wide spectrum of illness. In the UK many of these viruses are seasonal in their activity and tend to circulate at higher levels during the winter months.

The risk of catching or passing on respiratory viruses is greatest when someone who is infected is physically close to or sharing an enclosed and/or poorly ventilated space with other people. When someone with a respiratory viral infection breathes, speaks, coughs or sneezes, they release small particles that contain the virus which causes the infection. These particles can be breathed in or can come into contact with the eyes, nose, or mouth. The particles can also land on surfaces and be passed from person to person via touch.

The Trust's infection prevention team have been providing outbreak management support to care homes and other high-risk areas, e.g., workplaces and schools for several years. This support continues as part of the core service.

Community infection and vaccination rates are routinely monitored by the system and within the Trust. The uptake in vaccination rates and variation by area support demand forecasting and subsequent operational decisions.

Vaccinations are on offer to all Trust staff – both Covid booster, if the staff member is eligible as per national vaccination program guidance, and annual Flu vaccine. A refreshed communication plan is in place to promote the benefits of receiving vaccinations.

Uptake of staff vaccinations is monitored at Trust level with compliance reported to line managers and NHS England.

Vaccinations are available for those patients at high risk or long stay patients who are eligible.

[PRT04 Respiratory Illnesses Protocol](#) was updated in April 2025.

[Managing healthcare staff with symptoms of a respiratory infection or a positive COVID-19 result](#)

[COVID-19 Advice and Guidance \(xrwh.nhs.uk\)](https://www.xrwh.nhs.uk)

Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	The Royal Wolverhampton Trust
<i>If Other, write Provider/Trust Name:</i>	
Contact details (email, phone number):	Kate Shaw, Chief Operating Officer
Date:	30/07/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	Approve in draft in July, full sign off for Board in September.	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Specific consideration given to vulnerable groups and health inequalities. The Board is assured that appropriate mitigations are in place to support equitable access and patient outcomes throughout winter.	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Engagement with ICB and One Wolverhampton	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Attending ICB Winter Stress Test 02/09 and Regional NHSE 10/09	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	In Place	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Winter governance, escalation and operational leadership arrangements are in place through established Trust, Community First and OPEL governance structures.	

Winter Planning 26/27

Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	Staff vaccination programme planned.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	IPC plan and training incorporated to Winter Plan.	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Staff vaccination programme planned.	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Population health intelligence is used through Community First, neighbourhood teams, Care Coordination, High Intensity User processes and proactive community reviews with a particular focus on frailty, care home residents, mental health pts and other vulnerable groups	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Winter Bed modelling has been undertaken with ICB and NHSE. Discharge pathways are reviewed as part of BAU with NCTR meetings taking place 3x Weekly. These will be scaled up through Winter. Regular escalation meetings in place with LA.	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •Targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Home First remains the default discharge model. Seven-day discharge arrangements are supported through Care Coordination, DDA pathways, virtual wards, the Same Day Discharge Centre and integrated escalation processes across health and social care.	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Enhanced discharge and patient flow arrangements will be in place throughout the festive period to minimise occupancy pressures and maintain system resilience.	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Ongoing SDEC Optimisation workstream currently in place in preparedness for Winter.	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Ongoing Frailty Workstream to optimise Frailty pathways and admission avoid.	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Nursing Skillmix undertaken bi-annually. Staff wellbeing support in place and actively promoted.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	In place and enhanced SDM support is part of Winter Plan.	Winter Funding
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Ring-fenced elective capacity will be maintained at New Cross and Cannon Chase. Elective recovery, cancer performance and diagnostic activity are monitored alongside winter demand planning.	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Trajectories monitored monthly and where there is deviation, recovery plans are in place.	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Urgent community capacity is prioritised through Care Coordination, Rapid Intervention Team services, Virtual Wards, Frailty pathways and Urgent Community Response arrangements	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Elimination of corridor care remains a patient safety priority. Mitigations include enhanced streaming, SDEC capacity, discharge improvement initiatives, winter escalation capacity, strengthened Push Model arrangements and executive oversight through OPEL governance	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Trajectories monitored monthly and where there is deviation, recovery plans are in place.	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Escalation meetings in place as part of BAU.	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	Supported through the Community First programme, SDEC expansion, improved patient flow and Home First discharge arrangements.	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	In place and incorporated into Winter Plan.	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	IPC input incorporated as part of Winter Plan.	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Fit-testing processes, PPE stock management and escalation arrangements are established and can be expanded rapidly in response to increased respiratory or gastrointestinal infection pressures	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	A risk-based patient cohorting framework is embedded within Trust IPC procedures and supported through daily operational management and infection prevention oversight.	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Robust On Call System in place with Silver and Gold Command.	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	Regular reporting via OPEL.	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	The Trust participates in Black Country mutual aid arrangements and regional escalation processes, including support for patient flow, specialist pathways, critical care and discharge arrangements where required.	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Business Continuity Plans reviewed annually by Directorates and tracker in place.	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	Contingency arrangements for severe weather and infrastructure disruption have been reviewed and are supported through business continuity and escalation planning processes.	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Industrial action contingency arrangements remain in place and have been reviewed as part of winter preparedness planning.	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Staff wellbeing support in place and actively promoted.	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	The Trust works closely with system partners to support timely assessment, crisis management and access to appropriate community and inpatient mental health services during periods of increased demand.	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Robust High Intensity User Group in Place and re-attenders report receives clinical validation daily.	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	Liaison psychiatry pathways remain resilient through established escalation processes and partnership working with mental health providers	

Executive Approval

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

Trust / Provider Name: Royal Wolverhampton NHS Trust

Provider CEO name: Joe Chadwick-Bell

Date reviewed:

Provider Chair name:

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Kate Shaw, kate.shaw5@nhs.net

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Yes

Please confirm date reviewed

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



		Rating
Section B	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

Tier 1 - Paper ref:	Enclosure 11.1
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Report title:	Joint report of the Guardians of Safe Working Hours (GoSWH) for The Royal Wolverhampton NHS Trust (RWT) and for Walsall Healthcare Trust (WHT) January-June 2026
Sponsoring executive:	Dr Brian McKaig Group Chief Medical Officer
Report author:	Dr Nanthakrishna Navaneetham GoSWH RWT Dr Milena Sirakova GoSWH WHT
Meeting title:	RWT/WHT Group Trust Board Meeting to be held in Public
Date:	15 September 2026

1. Summary of key issues	
Assure	a) Accept assurance that exception reporting for doctors and dentists in training remains in place at WHT and RWT and now follows the new processes for exception reports. b) The GOSWH in RWT and WHT can provide assurance based on the data from exception reporting that the majority of shifts the working hours of doctors and dentists and training are within safe limits. c) A Group Standard Operating Procedure (SOP) for Work Schedule Reviews and Exception Reporting for Doctors and Dentists in Training in WHT and RWT has been drafted by WHT and is currently at the stage of review and comments. d) The GOSWH Fine Fund for penalties is in place in WHT and fund has senior management approval in RWT and is being set up. A Standard Operating Procedure SOP for the utilisation of the money is in the process of discussion and completion. The funds will be used for training and education purposes for trainee's benefit. e) Both GoSWH in RWT and WHT seek opportunities to support trainees by organising Resident Doctors Forum, Ward Walks (WHT) and contribution to induction. This is in line with the 10-Point Plan to improve resident doctors' working lives NHS England.
Advise	On 1 st June 2026 version 14 of Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 came into effect. This new version has no further amendments to exception reporting or the role of the GOSWH.
Alert	The number of Exception Reports (ERs) this April-June exceeds these from previous years – likely reflecting the changes in the process in terms of confidentiality and the ease in evidencing it (with snapshot of google map location). This also demonstrates that the new system for exception reporting is working and trainees have awareness of it.

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 People Committee 24/8/26

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Walsall Healthcare NHS Trust

4. Recommendation(s)/Action(s)
The Group Trust Board in Public is asked to receive:
a. For assurance the joint Guardians of Safe Working hours as per the report summary
b. For assurance the role of the GoSWH in the implementation of the 10-Point Plan to improve resident doctors' working lives NHS England.

Report to the Group Trust Board Meeting to be held in Public Guardian of Safe Working Hours Report 2025:

A joint report of the Guardians of Safe Working Hours (GoSWH) for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare Trust (WHT) for the months of January to June 2026

1. Executive summary

1.1 Assure

The GOSWH in RWT and WHT can provide assurance that the data collected through exception reporting indicates that majority of shifts for resident doctors and dentists are within safe limits.

1.2 Advise

On 1st June 2026 version 14 of Terms and Conditions of Service (TCS) for NHS Doctors and Dentists in Training (England) 2016 came into effect. This new version has no further amendments to exception reporting or the role of the GOSWH.

1.3 Alert

Looking at trends in exception reporting (ER), there has been an ongoing tendency of increasing numbers in exception reporting January-June over the past 5 years in both RWT and WHT. Following the implementation of legislation changes in February 2026 there is a clear rise in the numbers of exception reports (ERs) for the period April-June 2026 in both trusts. At this point we feel that this is likely due to the anonymity and ease of the new process of exception reporting and the growing confidence and awareness in trainees.

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. Executive summary

All changes to national terms and conditions this quarter have been implemented. There has been an increase in exception reporting numbers for Q1 2026.

The guardian fund for the penalty fines in WHT is in place. SOP for the use of the funds for education and training purposes is awaiting discussion and completion.

4. Introduction and background

4.1 Doctor and dentists in training posts can report exceptions to their working hours under the oversight of the Guardian of Safe Working. The exception reporting reform was implemented as of 4th February 2026 and now provides confidentiality and anonymity to doctors and dentists for exception reports (ERs) of up to 2 hours duration (i.e. Supervising consultants' meetings with their trainees are no longer required).

4.2 Walsall Healthcare Trust Q1 2026:

4.2.1 A total of **(48) forty-eight exception reports** were submitted in this quarter (April to June 2026) in WHT, and all of these were from FY level doctors.

4.2.2 Exceptions submitted were more compared to Q1 of 2025 (26 ERs Q1 2025) and compared to Q4 of 2025/26 (16 ERs Q4 2025/26).

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Walsall Healthcare NHS Trust

- 4.2.3 Divisional distribution of ERs-70% were from the Division of Medicine (31/48 General Medicine; 1/48 Geriatrics; 2/48 Acute medicine), and the remaining 30% from the Division of Surgery (5/48 T&O, 5/48 O&G and 4/48 General Surgery).
- 4.2.4 No ISC (Immediate Safety Concerns) were reported in this period.
- 4.2.5 **Three (3) ERs have attracted Fines for exceeding shift length and not achieving 11-hours rest period (from division of Surgery (T&O)).**
- 4.2.6 Eight exception reports (8/48) were submitted for lack of opportunity to take breaks due to the workload (6/8 General medicine; 1/8 T&O; 1/8 Acute medicine). These did not require payment as contractual breaks are already paid for doctors and only require departmental fine if breaks are missed on 25% of occasions over a 4-week period.
- 4.3 **Royal Wolverhampton Trust Q1 2026:**
- 4.3.1 A total of (40) forty exception reports were submitted in this quarter (April to June 2026) in RWT.
- 4.3.2 Exceptions submitted were more compared to Q1 of 2025 (14 ERs Q1 2025) and compared to Q4 of 2025/26 (8 ERs Q4 2025/26).
- 4.3.3 Distribution of ERs – 55% (22/40) were from Ophthalmology, 1/40 from General Surgery, 1/40 from Oral and Maxillo-facial surgery, 2/40 from Radiology, 5/40 from Obstetrics and Gynaecology, 1/40 from Neonatology, 7/40 from General Medicine and 3/40 from Renal medicine.
- 4.3.4 Four ISC (Immediate Safety Concerns) were reported in this period. 3/4 were from General medicine and 1/4 were from Obstetrics and gynaecology.
- 4.3.5 **Ten (10) ERs have attracted Fines for exceeding shift length of over 13 hours and not achieving 11-hours rest period. 9/10 of these were from ophthalmology and 1 was from Oral and Maxillo-facial surgery.**
- 4.3.6 Two exception reports (2/40) were submitted for lack of opportunity to take breaks due to the workload (1/2 from Obstetrics and Gynaecology and 1/2 from Radiology). These did not require payment as contractual breaks are already paid for doctors and only require departmental fine if breaks are missed on 25% of occasions over a 4-week period.

Total of ERs RWT and WHT for Q4 2025/26 and Q1 2026

Exception Reports (ER) January to June 2026:		
Reference period of report	01/01/2026 - 30/06/2026	
Trust	WHT	RWT
Total number of exception reports received	64	81
Number relating to immediate patient safety issues	0	5
Number relating to hours of working	56	63
Number relating to pattern of work	0	7
Number relating to educational opportunities	2	6
Number relating to service support available to the doctor	0	5

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5. GoSWH Fund

- 5.1.1 Penalty fines can be levied by the GOSW within Version 13 of the Terms and Conditions of Service for Doctors and Dentists in Training. These are payable into a guardian fund. Some categories of penalty fines have been in contract from 2016, with others being new to the February 2026 version.
- 5.1.2 **RWT:** Set up of fund approved at executive level. Currently awaiting Finance for creation of budget code.
- 5.1.3 **WHT:** Fine fund in place. Standard Operating Procedure (SOP) for the use of the money for education and training purposes for trainees in process of discussion and formulation.

6. Recommendations

- 6.1 The RWT/WHT Group Trust Board Meeting to be held in Public is asked to:
 - Receive for assurance of the joint Guardians of Safe Working hours as per the report summary
 - Note for assurance the role of the GoSWH in the implementation of the 10-Point Plan to improve resident doctors' working lives NHS England.

Tier 1 - Paper ref: Enclosure 11.2

Report title:	Revalidation of Medical Staff – Annual Reports for The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust
Sponsoring executive:	Dr Brian McKaig – Group Chief Medical Officer
Report author:	Dr Zia Din, Medical Director, WHT Samantha Pope – Business Support Manager, RWT Mark Read, Medical Revalidation and Job Planning Manager
Meeting title:	Group Trust Board Meeting – in Public
Date:	15 September 2026

1. Summary

This report describes the progress of the management of medical appraisal and revalidation during 2025/26 for The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

The Royal Wolverhampton NHS Trust

- The Trusts Medical Appraisal compliance as of 31st March 2026 was 100%.
- During 2025/26 there were 10 approved missed appraisals, 7 for Maternity Leave; 2 Sabbatical; 1 Career break
- During 2025/26 there were 56 positive revalidation recommendations were made to the GMC, there was also 14 agreed deferrals
- Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety, and increasing public trust and confidence in the medical system
- As at 31st March 2026, there were:
474 Consultants in Post – 468 completed appraisals
45 Staff Grade, Associate Specialist, Specialty Doctors – 45 completed appraisals
326 Temporary or short-term contract holders – 322 completed appraisals

Medical appraisal compliance is monitored at various levels within the Trust, from Board Level (annually) to individual compliance reminders (monthly). In addition, appraisal is a divisional KPI and is contained within the Trust's integrated performance repository which is monitored through divisional performance meetings. Compliance is also monitored externally, to NHSE annually. Non-compliance with Medical Appraisal is managed through the Trust's Local Decision-Making Group as per HR46, the Trust's Medical Appraisal Policy.

- The Trust has 144 approved medical appraisers. Each medical appraiser has undertaken NHSE approved training
- An appraiser forum chaired by Dr Chipu Ndlovu continues to meet quarterly. The forums have been well attended by appraisers from across all specialties
- During 2025/26 there have been coaching sessions run by Corporate Learning Services being made available for appraisers. The purpose of these sessions is to raise awareness with the appraisers about coaching methods that can then be used when conducting appraisals. These sessions have been well received and have been well attended
- The Medical Appraisal to Support Revalidation Policy (HR46) is being updated to a group version, work is ongoing
- **GMC Connect**
Connect is the General Medical Councils (GMC) database used by designated bodies to view and

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Walsall Healthcare NHS Trust

manage the list of doctors who have a prescribed connection to their organisation. The database is maintained by the Trusts Revalidation Support Office on behalf of the Trust's Responsible Officer. The Trusts Electronic Staff Record management system (ESR) is used as its main information source in relation to starters and leavers and is updated in 'real time'. GMC Connect also allows doctors to directly add themselves onto the system, where this happens, contact is made with the doctor through the Revalidation Office, to check the validity of the prescribed connection, which is done by using the NHSE prescribed connection algorithm.

Walsall Healthcare NHS Trust

- As of 31 March 2026, the Trust had 421 Connected doctors, and appraisal compliance was 99%.
- Monthly meetings with the Responsible Officer (RO), Medical Appraisal Lead and Medical Revalidation team, to review portfolios of doctors under notice for revalidation. These meetings are minuted and actions recorded.
- 93% (41) of revalidation decisions were a positive recommendation, 7% (3) were to defer the revalidation decision. Of the decisions to defer, all 3 were due to insufficient supporting information (2 of the deferral recommendations relate to the same doctor).
- As at 31 March 2026, there are 84 appraisers employed by the Trust to appraise the 421 connected doctors, a ratio of 1:5.
- Appraiser Refresher Training for the 84 current appraisers will be undertaken from October 2026 onwards. This is undertaken every 3 years as per Policy.
- All connected doctors are checked, and the connected list has been validated. An audit off all connections is also undertaken every 6 months (last completed February 2026, next due August 2026).
- The Trust's Medical Practise Assurance Specialist, supported by the Datix Data system, strengthens the data input to appraisal and medical governance by highlighting any concerns with doctors to support appraisal through a new Template.
- A new Trust Lead Appraiser, Dr Shelley Raveendran, was appointed 01/07/2025 as the previous Lead Dr. Riaz Bavakunji stepped down after 5 years in the role.

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

Group People Committee

4. Recommendation(s)

The Group Trust Board is asked to receive for information and assurance:

- The Designated Body Annual Report and Statement of Compliance 2025_26 for The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. This year's reports will be shared with the higher-level responsible officer at NHSE.

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The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative Section

2 – Metrics

Section 3 - Summary and conclusion Section

4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of The Royal Wolverhampton NHS Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	None required
Comments:	Chief Medical Officer continues to be the nominated responsible officer for the Trust.

Action for next year:	None Required
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1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	None required
Comments:	Adequate resources are provided to ensure the responsible officer carry out the responsibilities.
Action for next year:	Continue with support given

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	None required
Comments:	An accurate record of prescribed connections is kept up to date and maintained by the revalidation department.
Action for next year:	Continue with maintaining a prescribed connection list.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Y
Action from last year:	None required
Comments:	Trust policy has been reviewed and ratified through the required groups for approval. The next review will be due in 2028.
Action for next year	None required.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Maintain the ongoing work with Walsall Healthcare NHS Trust.

Comments:	Regular contact between the teams across both organisations to continue
Action for next year:	To continue the working relationship between the two organisations

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	None required
Comments:	Support is in place for locum and short-term placement doctors to gather information required for appraisal (incidents and complaints) as well as support for CPD depending on length of placement.
Action for next year	Continue with the support given from the revalidation team.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	None required
Comments:	The appraisal team ensure that all doctors are assigned appraisers 3 months in advance of their appraisal date
Action for next year:	Continue with the support provided for allocating appraisers within a timely manner

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Y
Action from last year:	None required
Comments:	If this occurs doctors receive support from the appraisal team and the appraisal lead within the Trust
Action for next year:	Continue with support provided.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	None required
Comments:	Trust policy has been reviewed and is currently being ratified through the required groups for approval. The next review will be due in 2028.
Action for next year:	None required

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Continue to recruit appraisers in line with the medical workforce plan
Comments:	Appraisers are continuously being recruited within the Trust and training is provided for any new appraisers
Action for next year:	Continue with the recruitment of appraisers

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Y
Action from last year:	Continue with appraiser forums and explore different ways of presenting CPD opportunities
Comments:	Appraiser forums are undertaken quarterly
Action for next year:	Continue with appraiser forums and explore other ways to support CPD

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	None required
Comments:	Appraisals are quality assured by the revalidation lead for the Trust. All findings are reported to the Chief Medical Officer and Trust Board on an annual basis
Action for next year:	Continue with quality assurance and completion of the annual report.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year	None required
Comments:	All recommendations are made to the responsible officer with reasons for fitness to practice positively or negatively.
Action for next year:	Continue with the support given to the responsible officer from the revalidation team to support recommendations to the GMC.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood

Y/N	Y
Action from last year:	None required
Comments:	Support is given to all doctors who are in the process of revalidation.
Action for next year:	Continue with support to doctors.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	None required
Comments:	Governance systems exist at departmental and Trust level.
Action for next year:	No changes planned

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	None required
Comments:	Systems are in place to monitor all doctors within the Trust
Action for next year:	Continue with the system in place.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	None required.
Comments:	System is in place that presents all the information required for an appraisal in a convenient and easy to understand format.

Action for next year:	Continue with the support via the system and revalidation team
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1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	None required
Comments:	Process and policy is in place between the revalidation team and responsible officer to respond to concerns.
Action for next year:	Continue with support given.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	None required
Comments:	Annual report to Trust Board advises of number of recommendations within the year and if any deferrals/negative recommendations.
Action for next year:	Continue to provide the annual report.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	None required
Comments:	Medical Practice Information Transfer forms utilised.
Action for next year:	No changes planned

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Y
Action from last year:	None required
Comments:	Trust has processes and policy for responding to concerns.
Action for next year:	No changes planned

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	None required
Comments:	Trust participates in national reviews within departments.
Action for next year:	No changes planned

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	None required
Comments:	
Action for next year:	No changes planned

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	None required
Comments:	HR process is in place for pre-employment checks.
Action for next year:	Continue with checks within the HR department.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	None required
Comments:	Every staff member has the opportunity to contribute positively towards organisational culture.
Action for next year:	Continue with culture being supported across the Trust.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	None required.
Comments:	Every staff member has the opportunity to contribute positively towards organisational culture.
Action for next year:	Continue with culture being supported across the Trust.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Comments:	Freedom to speak up champions are advertised and roles are recruited within departments.
Action for next year:	Continue with the awareness of the Freedom to Speak up champions.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	None required.
Comments:	
Action for next year:	No changes planned

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Y
Action from last year:	None required.
Comments:	
Action for next year:	No changes planned

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	None required
Comments:	Collaboration with neighbouring Trust to discuss process is currently undertaken.
Action for next year:	Continue with collaboration.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026 . All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	845
Total number of appraisals completed	835
Total number of appraisals approved missed	10
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	70
Total number of late recommendations	0
Total number of positive recommendations	56
Total number of deferrals made	14
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	10
Total number of trained case managers	7
Total number of concerns received by the Responsible Officer ²	0
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	62
Median duration of concerns processes closed (working days) ³	136
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	n/a
Total number of new doctors joining the organisation	130
Total number of new employment checks completed before commencement of employment	130
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	n/a

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Compliance within appraisals and recommendations has continued at a high level within the medical workforce over the last 12 months.
Actions still outstanding
None, previous actions are ongoing work that will be continued to be worked through next year.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Current issues
None
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To continue the working relationship between the two organisations Continue with the support provided for allocating appraisers within a timely manner Continue with appraiser forums and explore other ways to support CPD Continue with quality assurance and completion of the annual report. Continue with the support given to the responsible officer from the revalidation team to support recommendations to the GMC. Continue with checks within the HR department. Continue with culture being supported across the Trust. Continue with the awareness of the Freedom to Speak up champions.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The Trust's Medical Appraisal compliance remains high and there are no current issues. Appraisal compliance as of 31st March was 100% when the number of accepted missed appraisals are taken into account. Systems and processes are in place to ensure that the Trust can continue with the high compliance rate into the coming year.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	The Royal Wolverhampton NHS Trust
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Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	Brian McKaig
Email address:	brian.mckaig@nhs.net

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher-Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

- Section 1 – Qualitative/narrative
- Section 2 – Metrics
- Section 3 - Summary and conclusion
- Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses.

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Walsall Healthcare NHS Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	None
Comments:	Dr Zia Din, Medical Director and Responsible Officer.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Complete a training programme for New Medical Appraisers in Spring 2026.
Comments:	A training programme for New Medical Appraisers is booked for September 2026.
Action for next year:	Complete a training programme for New Medical Appraisers in 2027.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Complete Audit of GMC Prescribed Connections in August 2025 and February 2026.
Comments:	Doctors with a prescribed connection are managed and updated via GMC Connect online, by the Medical Revalidation Team. A twice-yearly audit takes place.
Action for next year:	Complete Audit of GMC Connections in August 2026 and February 2027.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review Medical Revalidation & Appraisal Policy by 22nd November 2025.
Comments:	Policy is currently out for consultation, and the Medical Revalidation & Appraisal Policy is expected to be ratified by November 2026.
Action for next year	Ratify Medical Revalidation & Appraisal Policy by November 2026.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	None
Comments:	An Independent Verification Visit was last undertaken by NHS England in November 2021, and Grant Thornton's Governance Review was undertaken in January 2022.
Action for next year:	None

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	QIP to improve short term locum and agency access to IT systems
Comments:	All doctors including those on short term placement are provided with an induction and are offered continuing professional development proportionate to their length of placement and role. All eligible locum doctors have access to appraisal, revalidation and governance oversight data and support.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Embed NCIP data within the appraisal system for doctors in surgical specialties
Comments:	The Medical Practise Assurance Specialist monitored practise through continuous evaluation of data related to clinical outcomes and behaviour. A doctor profile is provided to the Revalidation Team regarding complaints, claims, incidents and PSIRF events and inquest data covering the doctor's scope of practise within the trust for the appraisal period. This information is shared with the doctor's Divisional Director prior to appraisal, for comment. The doctor is required to disclose under 'scope of practise' other organisations they work for, and the Medical Revalidation Team ensure relevant information from these organisations, including information about complaints, significant events and outlying clinical outcomes, is included in the doctor's appraisal forms.
Action for next year:	None

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1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	None
Comments:	The doctor's appraisal forms are checked by their appraiser during the appraisal process and prior to GMC Revalidation submission, they are reviewed by the Trust's Medical Appraisal Lead and the Trust's Responsible Officer, to ensure all required supporting information is included prior to any recommendation being made.
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Review Medical Revalidation & Appraisal Policy by the scheduled review date of 22 November 2025.
Comments:	All relevant Policies are in place, but a new Policy is currently under consultation.
Action for next year:	Ratify Medical Revalidation & Appraisal Policy by November 2026.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	No
Action from last year:	Deliver a new Medical Appraiser Course in Spring 2026 to increase the number of Trained Appraisers in line with anticipated increase of connected doctors. Ringfencing at least 10 PAs of Consultants and SAS doctors SPAs from all divisions to support appraisers. To ensure time is allocated for organisational support for appraisal and revalidation is incorporated into the surcharges.
Comments:	The Medical Appraiser cohort is 84 and based upon 420 connected doctors (July 2026), the ratio of appraisers to doctors is now approximately 1: 5. Divisions are identifying suitable candidates to attend the New Medical Appraiser Training session September 2026.
Action for next year:	Deliver a new Medical Appraiser Course in September 2026 to increase the number of Trained Appraisers in line with anticipated increase of connected doctors. Ringfencing at least 10 PAs of Consultants and SAS doctors SPAs from all divisions to support appraisers. To ensure time is allocated for organisational support for appraisal and revalidation is incorporated into the surcharges.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	None

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	Appraiser refresher training was conducted October 2024 and is being scheduled again for September 2026. The policy stipulates that this delivered every 3 years and will be scheduled again in 2029. Appraisers are also required to attend at least 2 quarterly Trust Appraiser Support Group Meetings per annum.
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Review other Quality Assurance tools to strengthen the appraisal system while continuing with the ASPAT to ensure it remains fit for purpose. The Annual Board Report is presented to the board for comment and approval. The annual Statement of Compliance is then submitted to NHS England by 30 September 2026.
Comments:	None
Action for next year:	Review other Quality Assurance tools to strengthen the appraisal system while continuing with the ASPAT to ensure it remains fit for purpose. The Annual Board Report is presented to the board for comment and approval. The annual Statement of Compliance is then submitted to NHS England by 30 September 2027.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	The trust to have 0 late recommendations to the GMC.
Comments:	All recommendations were made on time.
Action for next year:	Ensure 0 late recommendations to the GMC.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	The doctor receives confirmation in writing of a positive GMC revalidation decision. Before any decision to defer is made, this is discussed at the monthly RO Revalidation Review Meeting and Maintaining Professional Standards Group (MPSG), and the doctor is advised of the decision. All decisions are recorded on both GMC Connect and Allocate RO Dashboard.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has implemented Datix Cloud IQ which enables oversight of all reported incidents, PSIRF events, complaints, claims, and inquests. Other performance data related to clinical outcomes, audit and behaviour for each doctor is monitored by the Medical Practise Assurance Specialist to feed into the CMO and the doctors appraisal. Learning is discussed at the mortality group, divisional quality and clinical care group meetings, safety huddles and reported to the patient safety group.
Action for next year:	None

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Continue to develop consultant development programme, medical leadership programme and mentorship scheme.
Comments:	The Trust monitors data as follows: clinical audit attendance (departmental clinical audit lead/facilitator); mandatory and in-house training, complaints and significant events (patient safety/PALS) and e-360 feedback (revalidation team); Consultant Appraisal Summary Reports (Health Evaluation Data) to provide Consultants with an overview of their individual performance, trust specialty performance and national specialty performance. When concerns arise regarding a doctor's conduct or capability, these are discussed and monitored at the Monthly Medical Professional Standards Group (MPSG) Meeting chaired by the RO with clear actions identified and recorded. All decisions are discussed with the Practitioner Performance Advice Service (PPAS) and GMC ELA. The Trust has trained Doctors who are in medical leadership positions in MHPS case investigation and case management roles.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	None

Action for next year:	None
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1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has a Policy which follows the Maintaining High Professional Standards framework for the handling of concerns about doctors and dentists in respect to an individual's conduct and capability whilst working in the NHS, in conjunction with liaising with the Practitioner Performance Advice Service (PPAS) and GMC. When concerns arise regarding a doctor's conduct or capability, these are discussed and monitored at MPSG monthly.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	None
Comments:	All employee relations cases are analysed for quality and assurance to ensure due process has been followed and a report is generated on a quarterly basis. This report is submitted to the Group People Committee.
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	The Medical Practice Transfer of Information Form (MPIT) supports the appropriate transfer of information about a doctor's practice to and from the doctor's Responsible Officers (RO). The Revalidation Team continue to support this process for newly connected doctors and also processes requests from other organisations regarding ex-employees. RO level approval is obtained before issuing these. An SOP is in place.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	Monitoring compliance that a members of MPSG to complete the trust mandatory training on psychological safety, freedom to speak up for managers and follow ups, and anti-racism e-learning. Review terms of reference for MPSG to anonymise data of individuals being discussed and review membership.
Comments:	Confirmed through MPSG. Individuals are references using a unique identifier.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Include "Medical Appraisal Inputs Proforma – Governance Intelligence" form on doctor's appraisal
Comments:	All national inquiries or reports are presented to the board and action plans developed in line with recommendations which are then integrated into policy with relevant training and oversight. Recent examples include the outcomes of a recent Royal College of Surgeons visit with actions being highlighted relevant to clinicians and their appraisal.
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Y/N	Yes
Action from last year:	None
Comments:	MPSG for Medical staff. Advanced Practise Standards Group has been established in Walsall Healthcare, acts as an advisory capacity to the CNO on matters relating to the training, supervision, development and Governance to the EAC (enhanced advanced or consultant practitioners).
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	Standard Trust Recruitment Policy pre-employment checking process includes references, DBS checks, right to work checks and Occupational Health Assessment for new starters. This applies to all substantive, short-term contract holders and Trust Bank doctors. Doctors employed through an Agency are subject to checks by the Agency. As part of the Recruitment process, candidates are expected to demonstrate that they are up to date with their practise and that they have an up-to-date Medical Appraisal. This requirement is incorporated into the local Medical Recruitment procedures. A SOP for booking of locums was created and circulated to relevant stakeholders.
Action for next year:	Audit compliance for locum and agency with Bank Staff Plus system implementation

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	None
Comments:	The Trust employs a continuous improvement process. There are periodic cultural reviews and information regarding culture is triangulated between the intelligence systems and the freedom to speak up process and staff surveys. The current Trust mandatory training includes psychological safety, civility and respect, Freedom to speak up, and anti-racism e-learning
Action for next year:	None

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has Cultural Ambassadors, whose primary aim is to help ensure fairness, equity and transparency in the Recruitment and Selection Process and in Employee Relations cases. The Cultural Ambassador is a full member of the interview panel and contributes to the decision-making process. They are available to provide information to the panel on any equality, diversity and cultural bias issues, particularly where unfair bias (conscious or unconscious), less favourable treatment or discrimination, is identified as part of the process. The Trust has an Equality, Diversity and Inclusion Steering group. The purpose of the group is to provide a facilitative forum for the implementation of the Trust's Equality & Diversity

	agenda. The Group meet every three months to review progress against the Plan and regularly provides progress reports to the Group People Committee. The Trust's Behavioural Framework forms part of the cultural aspects of the people plans, policies and procedures, such as appraisals and supervision sessions which supports a cohesive and positive culture and expected behaviour to work towards. This cultivates a safe and healthy working environment that everyone can thrive in and receive great care and service from. Joint Behavioural Framework materials include a Framework booklet which gives detail into the individual framework values and what staff should expect to see from colleagues across the organisation.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	The Trust has Freedom to Speak Up Guardians who focus on raising the profile of reporting concerns within the Trust, providing confidential advice and support to colleagues. They are committed to improving patient safety and making the hospital and community services a better place to work. The Trust has a Rasing Concerns at Work (Whistleblowing) Policy in place and a 'speak up' Mandatory Training Module for staff.
Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

Y/N	Yes
Action from last year:	None
Comments:	With respect to any grievances relating to the MHPS process and/or procedures, the Maintaining High Professional Standards Policy for Medical Staff advises staff to raise concerns with the appointed Non-Executive Director overseeing the case.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	None
Comments:	All employee relations cases are analysed and a report generated quarterly which contains types of cases, timelines, outcomes and details equality information covering the protected

	characteristics such as race, gender, ethnicity. This report is submitted to the Group People Committee.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None
Comments:	The Trust's Responsible Officer meets with PPAS monthly to discuss cases, the GMC Liaison Officer and has quarterly meetings with independent sector healthcare providers. The RO also works closely with the RO of The Royal Wolverhampton NHS Trust and local CMOs and attends regional network meetings, and regional RO events. An independent verification visit was undertaken by NHS England in November 2021 and Grant Thornton's Governance Review was undertaken in January 2022.
Action for next year:	None

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	421
Total number of appraisals completed	370
Total number of appraisals approved missed	5
Total number of unapproved missed	2
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	44
Total number of late recommendations	0
Total number of positive recommendations	41
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	2
Total number of trained case investigators	14
Total number of trained case managers	5

Total number of concerns received by the Responsible Officer ²	4
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March (working days)	261
Median duration of concerns processes closed (working days) ³	76
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	63
Total number of new employment checks completed before commencement of employment	63
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
All actions have been completed.
Actions still outstanding
None
Current issues
Insufficient Medical Appraisers (84) to appraiser 421 Connected Doctors. There is an action to train new Medical Appraisers as detailed below.

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- Deliver a new Medical Appraiser Course in September 2026 to increase the number of Trained Appraisers in line with anticipated increase of connected doctors. Ringfencing at least 10 PAs of Consultants and SAS doctors SPAs from all divisions to support appraisers. To ensure time is allocated for organisational support for appraisal and revalidation is incorporated into the surcharges.
- Complete a further training programme for New Medical Appraisers in 2027.
- Complete Audit of GMC Connections in August 2026 and February 2027.
- Ratify Medical Revalidation & Appraisal Policy by November 2026.
- Review other Quality Assurance tools to strengthen the appraisal system while continuing with the ASPAT to ensure it remains fit for purpose.
- The Annual Board Report is presented to the board for comment and approval. The annual Statement of Compliance is then submitted to NHS England by 30 September 2027.
- Ensure 0 late recommendations to the GMC.
- Audit compliance for locum and agency with Bank Staff Plus system implementation

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

In terms of performance, as of 31 March 2026, the Trust had 421 Connected doctors (and increase of 15 from last year) and appraisal compliance was 99%. 93% (41) of GMC revalidation decisions were a positive recommendation and 7% (3) were to defer the revalidation decision. Of the decisions to defer, 3 due to insufficient supporting information (2 decisions related to the same doctor).

As at 31 March 2026, there was an insufficient number of appraisers (84) employed by the Trust to appraise the 421 connected doctors, a ratio of 1:5. The Trust is seeking to address this risk by conducting New Appraiser Training in September 2026, to train between 10-15 new Medical Appraisers.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of the designated body:	Walsall Healthcare NHS Trust
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Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Tier 1 - Paper ref:	Enclosure 11.3
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Report title:	Workforce Race (WRES) and Workforce Disability (WDES) Equality Standard - Combined Report 2026 Royal Wolverhampton and Walsall NHS Trusts
Sponsoring executive:	Claire Radley, Group Chief Officer for People, Culture & Improvement.
Report author:	Kerry Bentley, Head of EDI, RWT and Clair Bond, People Director WHT
Meeting title:	Group Trust Board – held in Public
Date:	15 September 2026

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

This report presents the 2025/26 Workforce Race Equality Standard (WRES) results for both The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT).

WRES and WDES are nationally mandated standards designed to identify differences in workforce outcomes and workplace experience. The combined results provide insight into workforce representation, recruitment, disciplinary and capability processes, access to development, colleague experience, career opportunity, discrimination, engagement and Board representation.

Assure : There has been some positive progress. The 2025/26 WRES report records increased Black and Minority Ethnic, workforce representation and improved appointment rates from shortlisting at both Trusts. RWT improved in two of the nine WRES indicators; WHT improved in four, with two WHT indicators exceeding the national benchmarks.

The 2025/26 WDES analysis also identifies areas of improvement. Both Trusts increased recorded disability disclosure; both reported that disabled colleagues were not disproportionately likely to enter a formal capability process; and improvements were recorded in several measures relating to bullying, harassment and abuse. However, the remaining inequalities are material and require sustained action.

Advise: The Board should not interpret improvement in individual metrics as evidence that the underlying inequalities have been resolved. In particular:

- White candidates remain more likely to be appointed from shortlisting than BME candidates at both Trusts.
- BME colleagues remain more likely than White colleagues to report bullying, harassment, abuse and discrimination at work, and confidence in equal opportunity for career progression has declined.
- Disabled colleagues continue to report less favourable experiences than non-disabled colleagues across several workplace-experience measures, notwithstanding some year-on-year improvements.
- Disability non-disclosure remains high across both Trusts.

Alert: A full five-year trend analysis is not included in this report. Some measures have been affected by changes in definitions, source data, questions, denominators and reporting conventions. However, future reporting will include trend data wherever the underlying measures are directly or broadly comparable.

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

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

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

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4. Recommendation(s)/Action(s)

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

- | |
|---|
| <ul style="list-style-type: none">a) Note the 2025/26 WRES and WDES results for RWT and WHTb) Recognise the areas of improvement, including increased workforce representation and disability disclosure, improved recruitment outcomes and reductions in some WDES harassment measuresc) Note that significant inequalities remain in recruitment, formal processes, bullying, harassment, discrimination, career opportunity, feeling valued and senior representationd) Support continued delivery of targeted improvement actions through the Group's wider culture, leadership, talent and inclusion programmese) Note that future annual reports will include multi-year trend information where measures are comparable. |
|---|

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 15 September 2026

Purpose of the Report

The purpose of this report is to:

1. Present the 2025/26 WRES and WDES results available for RWT and WHT;
2. Provide assurance that results have been reviewed at Group level;
3. Highlight positive movement and areas of continuing or widening inequality;
4. Support oversight of the actions required to improve workforce equality and colleague experience;
and
5. Set out the proposed approach to multi-year trend reporting in future Board papers.

Background

The Workforce Race Equality Standard comprises nine indicators. Four indicators are derived from the NHS Staff Survey, with the remaining indicators drawing on workforce, recruitment, disciplinary, training and Board data.

The Workforce Disability Equality Standard comprises ten headline metrics, including sub-measures. Its Staff Survey components consider experiences of bullying and harassment, career opportunity, pressure to work when unwell, feeling valued, workplace adjustments and engagement. Other measures use workforce, recruitment, capability and Board data.

Headline 2025/2026 position (full details can be found at Appendix 1 and Appendix 2) Workforce Race Equality Standard

The combined 2025/26 WRES position shows mixed progress. Both Trusts increased BME workforce representation and improved recruitment outcomes from shortlisting. However, White candidates remained more likely to be appointed. RWT improved in two of the nine indicators, while WHT improved in four; two of the WHT indicators were above the national benchmarks used in the report.

Against those improvements, the report identifies deterioration in several staff-experience and equal opportunity measures. BME colleagues remained more likely than White colleagues to enter formal disciplinary processes, experience bullying, harassment and abuse, and report discrimination at work. Confidence that the Trust provides equal opportunity for career progression or promotion also declined.

Area	RWT 2025/26 position	WHT 2025/26 position	
Overall indicator movement	Improved in 2 of 9 indicators	Improved in 4 of 9 indicators	Progress is not consistent across the full standard
National comparison	Workforce representation continued to be above the national average used in the report	2 indicators exceeded the relevant national benchmarks	Benchmark position should be considered alongside the gap between colleagues' experiences
Workforce representation	BME representation increased	BME representation increased	Positive movement, but representation by seniority also requires consideration
Recruitment	Appointment rate from shortlisting improved, but White candidates remained more likely to be appointed	Appointment rate from shortlisting improved, but White candidates remained more likely to be appointed	Recruitment inequality remains despite improvement
Disciplinary processes	Continuing inequality affecting BME colleagues	Continuing inequality affecting BME colleagues	Small event numbers and case characteristics need to be considered
Staff experience	Deterioration reported across several experience measures	Deterioration reported across several experience measures	Bullying, harassment and discrimination remain significant concerns
Career progression	Confidence in equal opportunity declined	Confidence in equal opportunity declined	Work is required to connect talent, succession and development actions

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Workforce Disability Equality Standard

The combined WDES findings show improvement in some areas but continuing differences between disabled and non-disabled colleagues.

Both Trusts recorded increased disability disclosure. This is positive because more complete workforce information improves our ability to understand representation and experience. However, non-disclosure remains high across both Trusts, and changes in declaration rates must be considered when comparing annual workforce distributions.

For recruitment, non-disabled candidates remained more likely to be appointed from shortlisting than disabled candidates at both Trusts. In relation to formal capability processes, the 2025/26 results did not identify a disproportionate likelihood of disabled colleagues entering a formal capability process at either Trust.

WDES area	RWT 2025/26 position	WHT 2025/26 position	
Disability disclosure	Recorded disclosure increased, but non-disclosure remains high	Recorded disclosure increased, but non-disclosure remains high	Improved data completeness is positive
Recruitment	Non-disabled candidates remained more likely to be appointed from shortlisting	Non-disabled candidates remained more likely to be appointed from shortlisting	Recruitment inequality remains
Formal capability	No disproportionate likelihood was identified for disabled colleagues	No disproportionate likelihood was identified for disabled colleagues	Small event numbers and case characteristics need to be reviewed
Harassment from patients, service users, relatives or the public	A small positive reduction was reported for disabled colleagues	A small positive reduction was reported for disabled colleagues	Direction is positive, but adverse experience remains material
Harassment from managers	A reduction was reported for disabled colleagues	A reduction was reported for disabled colleagues	National evidence still shows disabled colleagues experiencing poorer outcomes
Harassment from other colleagues	A reduction was reported for disabled colleagues	A reduction was reported, with the most significant improvement of the two Trusts	A material gap between disabled and non-disabled colleagues remains
Feeling safe to report harassment	The current summary identifies continuing disparity and the need for follow-up	The current summary identifies continuing disparity and the need for follow-up	Reporting confidence must be considered alongside incident prevalence
Career progression	Disabled colleagues continue to report less favourable experience	Disabled colleagues continue to report less favourable experience	Requires alignment with talent and succession arrangements
Presenteeism	Disabled colleagues continued to report pressure to work when unwell	Disabled colleagues continued to report pressure to work when unwell	Requires management, wellbeing and reasonable-adjustment action
Feeling valued	Disabled colleagues continued to report poorer experience	Disabled colleagues continued to report poorer experience	A key culture and engagement issue
Reasonable adjustments	Current results require continued organisational attention	Current results require continued organisational attention	Timeliness and consistency of adjustments remain important
Engagement	Disabled colleague experience remained less favourable	Disabled colleague experience remained less favourable	Should be considered alongside the broader Staff Survey decline

Next Steps

The Group will be avoiding developing action plans in response to Trust WRES and WDES data, opting instead to include key actions in the strategic design and delivery of the cultural improvement programme aligned to Transforming Care Together. For the Board's assurance, key elements of the improvement programme are described below, all enabled by the integration of the People Directorate across both Trusts.

- Focus on fair and inclusive recruitment and employment practices and strengthening the voice of our global majority colleagues.
- Triangulation of key workforce information supplementing WRES and WDES data will identify services / staff groups whereby focused support through an integrated resource function can enhance best practices and develop and implement alternative approaches to inclusive recruitment.
- Anonymised case reviews across the Group to identify learning and improve practice in line with restorative learning. This work will be supported by learning from the NHSE Employment Relations Training that selected HR colleagues are currently participating in.

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- The integration of the Corporate Education Team and Improvement Portfolio into the wider People Directorate provides coherent opportunity to understand the differences in data to identify improvement actions.
- Existing and new workstreams aligned to the new NHS Staff Standards enshrined in the cultural improvement programme will ultimately improve the experience of colleagues and consider enhanced interventions for colleagues with protected characteristics.
- A structured talent management approach will be developed to identify and manage interest of colleagues in available development programmes and provide ongoing support to maximise opportunities.
- WRES and WDES outcomes to be reviewed through divisional performance arrangements, with clear ownership of actions and evidence of impact.

Future reports will seek to present up to five reporting years for each WRES and WDES metric. However, this will only be done where the data have been reconciled and the basis of comparison is sufficiently consistent. The principal limitations are: -

- Changes in the definitions or presentation of individual metrics;
- Changes in ethnicity and disability disclosure;
- Small numbers within disciplinary, capability and Board measures;
- Use of rolling periods in some metrics; and
- Changes in national comparators

Risks and assurance

The principal risk is that persistent inequality adversely affects colleague experience, recruitment, retention, progression, engagement and confidence in the organisation.

The current results provide assurance that the mandated measures have been collected, reviewed and submitted. They do not provide assurance that equality has been achieved. The mixed pattern of progress and deterioration requires continued oversight of delivery and impact.

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Enclosure No:	Enclosure 11.4
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Report title:	Modern Slavery and Human Trafficking Statement 2026/27 for The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust
Sponsoring executive:	Kevin Stringer, Group Chief Financial Officer Claire Radley, Group Chief People, Culture and Improvement Officer
Report author:	Nathan Joy-Johnson, Group Director of Procurement Jaswinder Toor, Group Board Secretary
Meeting title:	Group Trust Board Meeting – in Public
Date:	15 th September 2026

1. Summary of key issues
Section 54 of the Modern Slavery Act 2015 requires organisations to publish an annual statement outlining the steps they have taken to prevent modern slavery and human trafficking within their operations and supply chains. The legislative framework has been further strengthened by the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025, which came into force on 17th May 2026. The Regulations reinforce the NHS's commitment to preventing modern slavery and human trafficking by strengthening procurement requirements, enhancing supply chain due diligence and promoting greater transparency and accountability across NHS procurement activities. As a legal requirement, each NHS Trust must publish its own annual Modern Slavery Statements. Accordingly, separate statements have been prepared for the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust for the 2026/27 reporting period. The principal change for 2026/27 is the inclusion of a more developed procurement and supply chain section, reflecting the enhanced NHS procurement requirements and information provided by Procurement colleagues. Given the nature of these changes, the statements have been reviewed through the Finance & Performance Committee on this occasion and the Chief Financial Officer has been included as a report author. The workforce, people and safeguarding elements of both statements are unchanged from the Trusts' existing published Modern Slavery Statements. The purpose of this report is therefore to seek endorsement of the additional procurement and supply chain assurance content prior to Board consideration.

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
Group Finance and Productivity Committee – 1/9/2026
4. Recommendation(s)/Action(s)
The Group Trust Board is asked to: Approve the additional procurement and supply chain content for inclusion within the RWT & WHT Modern Slavery Statements and note that the workforce, people and safeguarding elements of both statements are unchanged from the Trusts' existing Modern Slavery Statements published on their respective websites.

Statement Relating to Modern Slavery and Human Trafficking The Royal Wolverhampton NHS Trust

Additional Procurement and Supply Chain Assurance

The North Midlands and Black Country Procurement Group (NMBC), which covers all aspects of Procurement services for The Royal Wolverhampton NHS Trust (RWT), is fully committed to supporting the UK Government's objective to eradicate modern slavery and human trafficking. Modern slavery is a serious violation of human rights and includes forced labour, servitude, human trafficking, and other forms of exploitation. The scale and complexity of the NHS supply chain mean that proactive, consistent action is essential to ensure all goods and services procured are free from unethical labour practices. This commitment aligns with the Modern Slavery Act 2015 and subsequent government guidance mandating transparency in public-sector supply chains, including NHS bodies.

The NMBC oversees annual procurement spend across approximately 3,400 suppliers for RWT, covering medical products, equipment, food, logistics, services, and digital solutions. Much of this activity is delivered via NHS Supply Chain, which manages more than 8 million orders annually and distributes over 28 million lines of goods to NHS organisations.

The NMBC Procurement Group adheres to all Policies in Relation to Modern Slavery and Human Trafficking, such as:

- Modern Slavery Act 2015 – Section 54 (Transparency in Supply Chains).
- Procurement Policy Notes (PPNs) including PPN 02/23 and PPN 05/19, which set minimum due-diligence standards for managing modern slavery risks in public-sector supply chains.
- NHS Terms and Conditions and NHS Standard Contract, which require suppliers to comply with modern slavery-related legislation.
- Government Commercial Agency (GCA) standard procurement processes, including mandatory exclusion questions for suppliers under the Modern Slavery Act.

We recognise that risks of modern slavery can arise in:

- Global manufacturing of medical consumables and PPE
- Logistics and warehousing
- Outsourced cleaning, catering, and facilities services
- IT hardware supply chains
- Recruitment of temporary and agency labour

NHS Supply Chain, Accredited Framework Hubs and NHS England conduct ongoing assessments of risk areas, using supplier self-assurance, independent audits, and enhanced scrutiny for high-risk geographic or product categories, of which we can access via the Central Government Tendering & Contract management Portal "ATAMIS", which allows us to assess ongoing and incumbent procurements.

The NMBC team continue to be trained and upskilled within Modern Slavery legislation and need to ensure that they competent across all Public Procurement Law requirement before undertaking any procurement activity for the Trust.

Existing Modern Slavery Statement

The Royal Wolverhampton NHS Trust (RWT) is fully committed to preventing modern slavery and human trafficking in all its forms. As part of the NHS and one of the largest employers in the local area, we take our responsibilities seriously and are dedicated to ensuring that modern slavery has no place within our organisation, supply chains, or services. This statement sets out the actions we have taken, and are continuing to take, to meet the requirements of the Modern Slavery Act 2015, and to ensure transparency in tackling modern slavery.

Our organisation

The Royal Wolverhampton NHS Trust provides healthcare services to the people of Wolverhampton, Walsall, and beyond. We deliver a wide range of services across multiple sites; we employ more than 11,000 staff and work with a large network of suppliers and partners.

We recognise that we have a duty to uphold the highest ethical standards in all aspects of our operations, including our supply chains, where modern slavery risks can arise. We are committed to working collaboratively with our stakeholders to ensure that we play an active role in combating modern slavery.

Our commitment

At RWT, we are committed to:

- Ensuring that there is no modern slavery or human trafficking in our supply chains, services, or any part of our business
- Upholding and promoting fair employment practices
- Encouraging transparency and accountability among our suppliers and partners

Ethical procurement

The Trust sources its Procurement function through the North Midlands and Black Country Procurement Group (NMBC) hosted by the University Hospitals of North Midlands which is committed to:

- Achieving full compliance with all aspects of Ethical Procurement / Modern Slavery as set out in NHS England's guide '*Applying net zero and social value in the Procurement of NHS goods and services*' (PAR 1030 – 1 March 2022) which builds on the requirements outlined in the Procurement Policy Note 06/20 '*Social Value Model, including net emissions requirements*' (1 April 2021).
- All procurement undertaken will contribute to the NHS Net Zero and Social Value goals in line with a clear approach outlined in the aforementioned guide (PAR 1030) to adopt and apply the principles outlined in PPN 06/20 to all commissioning and purchasing.
- Reducing carbon emissions and improving labour standards are very important areas for the health and social care sector. All Trusts have an ethical duty to protect and promote health and wellbeing and contract with suppliers of goods and services that operate in a socially responsible way with good environmental practices and employment practices. The Trusts will use Ethical Procurement for Health (EPH) to support this. Products used will have sustainable specifications using Government Buying standards and Green Public Procurement criteria. Their aim is to use their buying power to generate social benefits and consider economic, social, and environmental wellbeing when negotiating public service contracts as enshrined in the Public Services (Social Value) Act 2012.

In addition, the NHS Terms and Conditions of Contract for goods and services specifies the following terms for suppliers to adhere to in relation to equality and human rights:

- Ensure that (a) it does not, whether as employer or as provider of the Services, engage in any act or omission that would contravene the Equality Legislation, and (b) it complies with all its obligations as an employer or provider of the Services as set out in the Equality Legislation and take reasonable endeavours to ensure its Staff do not unlawfully discriminate within the meaning of the Equality Legislation.
- In the management of its affairs and the development of its equality and diversity policies, cooperate with the Authority in light of the Authority's obligations to comply with its statutory equality duties whether under the Equality Act 2010 or otherwise. The Supplier shall take such reasonable and proportionate steps as the Authority considers appropriate to promote equality and diversity, including race equality, equality of opportunity for disabled people, gender equality, and equality relating to religion and belief, sexual orientation, and age; and the Supplier shall impose on all its Sub-contractors and suppliers, obligations substantially similar to those imposed on the Supplier.

Statement Relating to Modern Slavery and Human Trafficking
Walsall Healthcare NHS Trust

Additional Procurement and Supply Chain Assurance Statement

The North Midlands and Black Country Procurement Group (NMBC), which covers all aspects of Procurement services for Walsall Healthcare NHS Trust (WHT), is fully committed to supporting the UK Government's objective to eradicate modern slavery and human trafficking. Modern slavery is a serious violation of human rights and includes forced labour, servitude, human trafficking, and other forms of exploitation. The scale and complexity of the NHS supply chain mean that proactive, consistent action is essential to ensure all goods and services procured are free from unethical labour practices. This commitment aligns with the Modern Slavery Act 2015 and subsequent government guidance mandating transparency in public-sector supply chains, including NHS bodies.

The NMBC oversees annual procurement spend across approximately 2,000 suppliers for WHT, covering medical products, equipment, food, logistics, services, and digital solutions. Much of this activity is delivered via NHS Supply Chain, which manages more than 8 million orders annually and distributes over 28 million lines of goods to NHS organisations.

The NMBC Procurement Group adheres to all Policies in Relation to Modern Slavery and Human Trafficking, such as:

- Modern Slavery Act 2015 – Section 54 (Transparency in Supply Chains).
- Procurement Policy Notes (PPNs) including PPN 02/23 and PPN 05/19, which set minimum due-diligence standards for managing modern slavery risks in public-sector supply chains.
- NHS Terms and Conditions and NHS Standard Contract, which require suppliers to comply with modern slavery-related legislation.
- Government Commercial Agency (GCA) standard procurement processes, including mandatory exclusion questions for suppliers under the Modern Slavery Act.

We recognise that risks of modern slavery can arise in:

- Global manufacturing of medical consumables and PPE
- Logistics and warehousing
- Outsourced cleaning, catering, and facilities services
- IT hardware supply chains
- Recruitment of temporary and agency labour

NHS Supply Chain, Accredited Framework Hubs and NHS England conduct ongoing assessments of risk areas, using supplier self-assurance, independent audits, and enhanced scrutiny for high-risk geographic or product categories, of which we can access via the Central Government Tendering & Contract management Portal "ATAMIS", which allows us to assess ongoing and incumbent procurements.

The NMBC team continue to be trained and upskilled within Modern Slavery legislation and need to ensure that they are competent across all Public Procurement Law requirements before undertaking any procurement activity for the Trust.

Existing Modern Slavery Statement

Walsall Healthcare NHS Trust response to the requirements of the Modern Slavery Act 2015.

This statement comprises the modern-day slavery and human trafficking statement of Walsall Healthcare NHS Trust (The Trust) in accordance with Section 54, Part 6 of the Modern Slavery Act 2015. The act requires all organisations to set out the steps it has taken to ensure that slavery and human trafficking is not taking place in any of its supply chains, or in any part of its own business.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men using force, coercion, abuse of vulnerability, deception, or other means for the purpose of exploitation.

Individuals may be trafficked into, out of, or within the UK. They may be trafficked for several reasons, including sexual exploitation, forced labour, domestic servitude and/or organ harvesting.

Section 54 of the Modern Slavery Act (2015) requires all organisations to set out the steps it has taken to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business

The Trust has zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking would be escalated as part of the organisational safeguarding processes and in conjunction with partner agencies, such as the Local Authority and Police.

The Trust recognises that it has a responsibility to take a robust approach to slavery and human trafficking and is committed to preventing slavery and human trafficking. This statement sets out actions taken by the Trust to minimise risks associated with modern slavery and human trafficking and demonstrates that the Trust has effective systems in place to prevent these.

Organisation structure and business

Walsall Healthcare NHS Trust provides local general hospital and community services to around 260,000 people in Walsall and the surrounding areas. The Trust is the only provider of NHS acute care in Walsall, providing inpatient and outpatient services at the Manor Hospital as well as a wide range of services in the community. Walsall Manor Hospital houses the full range of district general hospital services under one roof.

We provide high quality, friendly and effective community health services from some 60 sites including Health Centre's and GP surgeries. Covering Walsall and beyond, our multidisciplinary services include rapid response in the community and home-based care, so that those with long-term conditions and the frail elderly, can remain in their own homes to be cared for.

The Trust's Palliative Care Centre in Goscote is our base for a wide range of palliative care and end of life services. Our teams, in the Centre and the community, provide high quality medical, nursing and therapy care for local people living with cancer and other serious illnesses, as well as offering support for their families and carers.

The Trust employs approximately 4695 members of staff, and the organisation's recruitment and selection processes are in line with best practice principles, aligning with NHS terms & conditions and equitable pay.

The Trust works in accordance with and adhering to the NHS England (NHSE) Modern Slavery and Human Trafficking Statement. The NHSE statement incorporates the Trust's responsibilities as the part of the wider NHS, supported by NHSE to address the risk of modern slavery in the health service and points to actions best delivered nationally and locally. For further detail and assurance, it can be accessed here: [NHS England modern slavery and human trafficking statement](#)

Tier 1 - Paper ref:	Enclosure 11.5
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Report title:	NHS Premises Assurance Model (NHS PAM) 2025/26
Sponsoring executive:	Kevin Stringer, Group Chief Financial Officer
Report author:	Chris Hodgson Interim Director, Estates, Facilities and Capital
Meeting title:	Group Trust Board Meeting
Date:	8/9/26

1. Summary of key issues/Assure, Advise, Alert
To inform the Board/Executive of the changes to the NHS Premises Assurance Model (PAM) for 2025/26, to note/explain the expected impact on the Trust's reported compliance position, and to seek the Board's endorsement of the proposed approach to completion, reporting and the national submission deadline of Monday 28 th September 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?]
Executive Directors 2/9/26 Group Digital and Estates Strategy Committee (DESC) 4/9/26

4. Recommendation(s)/Action(s)
The Board is asked to:
a) Endorse completion of the return in line with NHS England's expectation
b) Agree that the primary focus of the 2025/26 return will be the quality and completeness of the submissions and focus on where we might make improvements and be more aligned between the sites within the Group

Report to the Group Trust Board – held in Public
NHS Premises Assurance Model (NHS PAM) 2025/26: change of methodology, expected results and proposed approach

1. Executive summary

To inform the Board of the changes to the NHS Premises Assurance Model (PAM) for 2025/26, to explain the expected impact on the Trust's reported compliance position, and to seek the Board's endorsement of the proposed approach to completion, reporting and of the national submission deadline of Monday 28th September 2026.

NHS PAM is scored under 5 sections Hard FM, Soft FM, Estate Competency, Patient Experience and Helipad Compliance. Separate returns are provided for both RWT and WHT.

2. Introduction or background

2.1 The NHS PAM 2025/26 collection is open for completion via the national Data Collections Framework. NHS England has confirmed a submission deadline of 28 September 2026.

2.2 The 2025/26 collection represents a fundamental change of methodology. Previous returns were assurance based, using a graded (outstanding/ good/ requires minimal improvement/ requires moderate improvement/ inadequate) self-assessment of maturity. The 2025/26 return is compliance based, with binary yes/no responses to scored questions. A standard is either met, with evidence available, or it is not.

2.3 Under the new scoring treatment there is no partial credit. Unanswered scored questions count as zero, and only a genuine “not applicable” response removes a question from the calculation. Numeric and free-text responses are captured for context and do not contribute to the compliance score.

3. Expected impact on the Trust's reported position

3.1 The removal of the graded scale means the amber middle ground no longer exists. Positions previously reported as amber will now report as non-compliant unless the standard is fully met and evidenced. A question that would previously have been rated as requiring only minimal improvement, for example a position that is 95% compliant, will this year be answered “No” and will score in the same way as a position that is 0% compliant

3.2 The Group should therefore expect a materially higher proportion of red results in 2025/26, even where nothing on the ground has changed. NHS England has advised trusts nationally to expect this effect. It is a function of the methodology, not an indication of deterioration in the condition or management of the estate.

3.3 Results that reflect reality provide the Board with a stronger basis for assurance than graded results that reflect optimism. An accurate compliance position will also allow investment to be prioritised by compliance, risk and national benchmarking, returning the model to one of its original purposes: directing capital and maintenance funding to where the assurance gaps are largest.

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Walsall Healthcare NHS Trust

4. NHS England's expectation: a pragmatic and honest return

- 4.1. NHS England has set out how it expects trusts to approach completion. Where a question asks whether the Trust is compliant or specifies a numerical requirement the Trust does not meet, the expectation is that this is reported accurately. In the national PAM User Group, we understand that NHS England has stated:

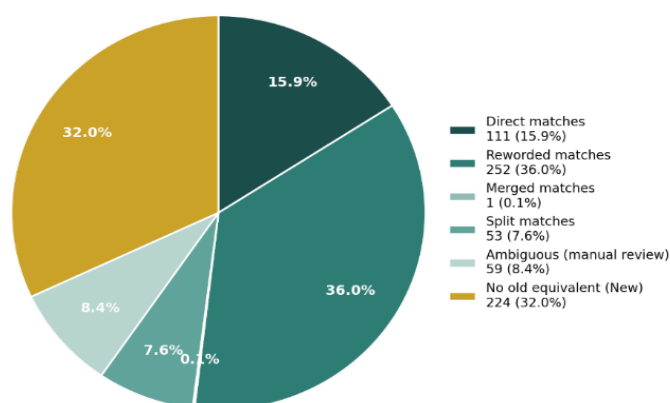
“We do want a pragmatic approach where we are asking if you are compliant, but where our leads have requested a specific number and trusts are not in line, it is important for us to see this, so that we can either support trusts in achieving it or adjust our internal targets next year to make these more aligned to what is happening on the ground. We do understand concerns around looking non-compliant in areas, but please be assured trends will be picked up, especially where the majority of trusts are not compliant because the view is that the request is unreasonable or overly cautious. But we do need to see this rather than gloss over and have similar issues again next year.”

- 4.2. The implication for the Trust is that an accurate “no” serves a purpose both at local and national level: attracting support and/or correcting an unrealistic target in future years. Where a majority of trusts return the same non-compliance, we understand that NHS England has confirmed this will be read as a signal about the standard itself rather than a failing of individual organisations.

5. Year-on-year comparability

- 5.1. A full mapping of the 2025/26 question set against 2024/25 has been undertaken (CompliMind, 2026).

2025/26 NHS PAM question mapping — 700 new rows



Of approximately 700 questions in the 2025/26 collection, only around 16% map directly onto a prior-year equivalent. A further 36% map only with rewording that changes their scope or intent, roughly one third are new questions with no prior-year equivalent, and 151 of last year's questions have no place in the new structure.

- 5.2. Combined with the change in scoring treatment described at 1.3, a like-for-like comparison between the Trust's 2024/25 and 2025/26 results is not achievable and will not be presented. NHS England has confirmed this position nationally: a general comparison is possible by averaging scores at head-question level, but only as an approximation

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5.3 From 2025/26 onwards, the binary methodology removes local interpretation and grading judgement from the score. Future year-on-year trends will therefore be built on objective, evidence-linked answers that are consistent across trusts, improving the reliability of both internal trend reporting and national benchmarking

6. Scores Obtained for RWT & WHT

6.1. As shown in the full retune that was presented to DESC on 4/9/26 the scorecard highlights a number of Red-rated compliance areas, predominantly within Hard FM services at the New Cross site. It should be noted that a red rating reflects non-compliance with one or more assessment criteria, rather than a complete absence of compliance.

One of the most significant areas of concern remain Fire Safety. A targeted improvement programme is underway to address the identified risks, with particular focus on achieving compliance with the Fire Service enforcement notices currently in place. The Trust continues to work closely with West Midlands Fire Service and Staffordshire Fire Service, and progress will be monitored through the relevant governance and assurance frameworks.

There are also other areas of improvement at New Cross which are in the process of being enacted e.g. Authorised person cover, but which have been scored as red as they have yet to be fully implemented.

6.2. The table below presents an indicative score, based on the headline sections of the submission, showing the percentage achieved across the five assessment domains for both Trusts. The scores have been aligned to the previous year's rating methodology and colour coding to enable an approximated like-for-like comparison with the prior year's submission. This comparative analysis provides assurance that performance has been maintained. Whilst some challenges remain, the overall trajectory demonstrates incremental progress across the assessment domains, indicating that the Trusts are continuing to strengthen compliance and are not regressing against previous performance levels.

Question Set	WHT	RWT
Hard FM compliance	85.45%	76.46%
Soft FM compliance	81.86%	86.75%
Estate Competency compliance	85.14%	85.11%
Helipad compliance	N/A	N/A
Patient Experience compliance	100.00%	100.00%

Colour Key - Question Compliance
Outstanding (100%)
Good (85-99%)
Requires Minimal Improvement (41-84%)
Requires Moderate Improvement (21-40%)
Inadequate (0-20%)

6.4. An improvement plan is being developed to address areas of non-compliance, including identification of the investment required to achieve the necessary compliance standards. This will be presented to a future meeting of the monthly divisional performance meeting, together with the Executives where appropriate. This will allow us to establish a clear understanding of compliance gaps, associated risks, and prioritised investment requirements. Together, these initiatives will provide a robust evidence base

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to support strategic decision-making, ensuring that resources are targeted effectively towards the highest-risk areas and those requiring the most urgent remediation to achieve and sustain compliance.

The improvement plan will be also managed/updated at a departmental level via the Estates Premises Assurance Group (EPAG), with regular upwards quarterly reporting to the Estate and Facilities Divisional Performance Review (monthly meeting).

7. Recommendations

The Board is asked to:

- i. Note the change from an assurance-based to a compliance-based model with binary responses, and the resulting expectation of a higher proportion of non-compliant results in 2025/26.
- ii. Endorse completion of the return in line with NHS England's stated expectation of pragmatic, honest answers, including where the Trust does not meet specified numerical requirements.
- iii. Note that a like-for-like comparison with the 2024/25 return is not achievable and agree that trend reporting will be presented as an approximation at head-question level only.
- iv. Agree that the primary focus of the 2025/26 return will be quality of the return and focus on where we might make improvements and be more aligned between the sites within the Group.

8. Conclusion

- 7.1 The 2025/26 NHS PAM will report a lower headline compliance position than previous years as a consequence of the change of methodology. It should provide the Board with a more objective statement of the Trust's compliance position than the graded model allowed, and a costed, prioritised action plan against which funding decisions can be made. The Board is asked to endorse the approach set out at recommendations 7i to 7iv.