AGENDA

RWT/WHT Group Board of Directors Meeting - to be held in Public

Tuesday 21 July 2026 @ 12:30-16:10
Rooms 12 & 13, MLCC, 3rd Floor, Walsall Manor Hospital

Agenda Item	Item Description	Report Ref	Lead	Purpose	Time
1	Chair's Welcome, Apologies and Confirmation of Quorum	Verbal	Sir David	To inform & assure	12:30
2	Register of Declarations of Interest The Registers of Declarations of Interest can be located on the Trust websites: https://www.walsallhealthcare.nhs.uk https://www.royalwolverhampton.nhs.uk	Verbal	Sir David	To inform & assure	12:32
3	Patient Story (please copy and paste link below to browsers): https://youtu.be/RXEhUCySHiQ	Verbal	L Carroll	To inform	12:34
4	Minutes of the Previous RWT/WHT Group Board of Directors Meeting held in Public on 19 May 2026	Enclosure 4	Sir David	To approve	12:49
4.1	Group Board Action Log and Matters Arising	Enclosure 4.1	Sir David	To inform & assure	12:52
5	Chair's Report – Verbal	Verbal	Sir David	To inform	12:57
6	Group Chief Executive's Update	Enclosure 6	J Chadwick-Bell	To inform	13:02
6.1	Assurance on maternity services (Ockenden, Amos and Human Tissue Authority recommendations – Fuller Inquiry & Board Assurance Statement (BAS) return by 31 July 2026	Enclosure 6.1	L Carroll	To inform, assure and approval for Chair's action on the BAS	13:17
6.2	Freedom to Speak Up Report	Enclosure 6.2	J Chadwick-Bell	To inform & assure	13:25
6.3	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	Enclosure 6.3	C Radley	To inform & assure	13:40

Agenda Item	Item Description	Report Ref	Lead	Purpose	Time
7	Integrated Committee Chairs Report - Finance & Productivity Committee, Quality Committee, People Committee, Partnerships and Transformation Committee and Digital and Estates Strategy Committee	Enclosure 7	P Assinder L Toner D Brathwaite L Sadler-Todd R Barber	To inform & assure	13:50
7.1	Group Board Assurance Framework for Assurance	Enclosure 7.1	K Bostock	To inform & assure	
8	Strategy (Section Heading)				
8.1	Transforming Care Together – Progress Report	Enclosure 8.1	S Evans	To inform & assure	14:05
8.2	Anchor Development	Enclosure 8.2	J Chadwick-Bell	To inform	14:15
9	COMFORT BREAK (10 MINS)				14:30
10	Integrated Quality and Performance Reports (Section Heading)				
10.1	Group Finance Plan and Workforce Report	Enclosure 10.1	J Green D Mortiboys C Radley	To inform & assure	14:40
10.2	Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - Quality, People, Access Standards, Finance and Productivity	Enclosure 10.2	A Godson	To inform & assure	14:50
10.3	Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) - Quality, People, Access Standards, Finance and Productivity	Enclosure 10.3	G Nuttall	To inform & assure	15:05
10:4	Patient and Public Engagement - Good News Story including Annual Patient Experience Reports for RWT & WHT	Enclosure 10.4	L Carroll D Hickman	To inform & assure	15:20
10.5	Update on Mental Health Services	Enclosure 10.5	Z Din	To inform & assure	15:35
11	Corporate Governance (Section Heading)				
11.1	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	Enclosure 11.1	M Martin J Jones	To assure	15:45
11.2	Group Standing Financial Instructions and Standing Orders (as endorsed at RWT and WHT Audit Committees)	Enclosure 11.2	J Green D Mortiboys K Bostock	To approve	15:55
12	Questions Received from the Public	Verbal	Sir David	To inform	16:00
13	Any Other Business	Verbal	Sir David	To inform	16:05
14	Date and Time of Next Meeting	Verbal	Sir David	To inform	16:07

Agenda Item	Item Description	Report Ref	Lead	Purpose	Time
	Tuesday 15 September 2026, Meeting Room 8, WMI, The Royal Wolverhampton NHS Trust				
15	Resolution	Verbal	Sir David	To approve	16:08

Enclosure 4

MEETING OF THE PUBLIC GROUP TRUST BOARD MEETING
TUESDAY 19 MAY 2026 AT 12:45pm
held at Meeting Room 8 WMI Building New Cross Hospital The Royal Wolverhampton NHS Trust

PRESENT

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

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

In Attendance

Ms J Toor	Group Trust Board Secretary
Ms K Shaw	Chief Operating Officer at RWT
Ms H Langford	Planned Care District Nurses & Rapid Access Social Care & Interim Matron – Community Ambulator Care (for Item 164/26 only)
Ms L Ponsford	Senior Sister-Community Ambulator Care (for Item 164/26 only)

Apologies

Ms G Nuttall	Managing Director, RWT
Mr M Laverty	Group Non-Executive Director
Ms M Martin	Non-Executive Director, WHT

163/26	**Chair's Welcome, Apologies and Confirmation of Quorum**
	Sir David welcomed everyone to the meeting and apologies were received and noted. Sir David confirmed the meeting as quorate. **Resolved: that the Group Trust Board Meeting held in public be confirmed as quorate.**
164/26	**Patient Story - Darren Musgrove - RWT Community Ambulatory Clinics**
	Sir David explained that each Trust Board meeting began with a patient story so that Board discussions remained grounded in-patient experience and service improvement and emphasised the importance of maintaining a clear line of sight to patient outcomes. Ms Hickman introduced Darren Musgrove's story, explaining that Darren lived with a long-term autoimmune condition and that his story highlighted his engagement with the Community Ambulation Care Service, which demonstrated the value of proactive, community-based support for people with long-term conditions. She welcomed Ms Langford and Ms Ponsford to present an overview of the community-based care for people with long term conditions. Ms Langford said Darren had presented with chronic venous leg ulcers and heel ulcers and had ultimately required an amputation. She said his remaining leg had responded extremely well to treatment and had fully healed in December 2025. She said that after taking up her role 2 years ago, she had raised concerns with her matron about the lack of structured follow-up for patients after their ulcers had

	healed which she felt could cause substantial mental, emotional and social impact for patients. She reported that recurrence rates for venous leg ulcers were 24–65% within 12 months without preventative support. She said she had then developed the Well-Leg Pathway, approximately 18 months ago, to which patients discharged with healed leg ulcers had been added to a Well-Leg caseload and where they were now reviewed every 6–12 months, depending on need and remained under proactive monitoring. She said the focus with the pathway was prevention rather than treatment. Ms Langford noted that when Darren first attended the service, he required daily appointments, and under the Well-Leg model, he now attended once weekly, with significantly improved outcomes. She reported that the Well-Leg caseload currently included just under 120 patients discharged over the past 14 months and only 10–15 patients required re-entry into treatment during that period which represented a substantial reduction in recurrence and clinic demand, as well as improved patient wellbeing. Ms Langford reported that based on recurrence statistics, approximately 135 patients would have been expected to return to clinic within 12 months, however, only 10–15 patients required re-entry, demonstrating that the Well-Leg Pathway was outperforming national recurrence expectations. She said that the pathway benefited both patients and the service, with patients able to access a clinic appointment within 7 days, and usually within one to two days whereas previously, patients would require a GP referral, often taking 6–8 weeks. She said the service exceeded the national standard for lower limb wounds to be seen within 28 days. Prof Toner said that the model clearly supported improved patient outcomes by enabling rapid access back into the service and asked whether they saw all patients with previous leg ulcers or only those with more complex needs. Ms Langford confirmed the service saw all patients registered with Wolverhampton GPs, covering all lower-limb wounds and, in practice, wounds “head to toe”. She said the Well-Leg Pathway was for non-housebound patients attending 3 clinic sites across the city, and that housebound patients were supported by district nurses and healthcare support workers. Prof Toner referenced the national estimate of £8.3 billion spent on wound care and noted the importance of services like this in reducing long-term system costs. Mr Assinder reflected on the patient’s stoicism following limb loss and highlighted the importance of addressing the mental health and emotional impact of chronic wounds. He asked how the service supported patients and families in this regard. Ms Langford said patients often experienced severe mental health challenges, social isolation, and even family breakdowns. She reported the service prioritised holistic care, recognising the psychological and social dimensions of long-term wound conditions with staff spending time listening to patients’ experiences, providing reassurance, and signposting to wider support where needed, within the Community including social prescribers and the mental health team Ms Ponsford said that Darren’s story reflected the emotional and physical toll of chronic wounds, and the relief patients often felt when their pain was finally addressed. Ms Cartwright commented on how valuable it was to hear not only Darren’s experience but also the team in identifying a service gap and proactively designing a solution. She asked whether Ms Langford and team felt supportive in making changes. Ms Langford confirmed that she felt supported to innovate and that drawing on her background as a tissue viability specialist nurse, she had long recognised the need for structured follow-up after healing. She explained that many services discharged patients once healed, leaving them without specialist support. She said the team monitored referrals and noticed a pattern of patients being discharged and then re-referred within weeks due to recurrence. She said this evidence strengthened the case for the Well-Leg Pathway, which had demonstrated clear benefits. Sir David said the key themes from Darren’s story included patient empowerment and said the NHS could not be sustainable unless patients were supported to take greater control of their own health and that the Well-Leg Pathway was a strong example of enabling patients to manage their condition confidently. He said that with continuity of care, the model prevented patients from being “lost” in the system and reduced inappropriate presentations to A&E, GPs, or other services and with accessible support. He said Darren’s ability to contact the service directly, as Darren had described in the video, was a powerful example of how open access improved outcomes and reduced system pressure. Ms Langford described further developments within the service to support patient accountability and

	self-management with a new self-care link recently introduced in clinic, where patients were able to attend clinic once for assessment, and then undertake their own wound care at home. She said this reduced unnecessary clinic attendance while increasing patient empowerment. She said that the aim was not to reduce contact with patients, but to ensure that patients had the knowledge and skills to manage their condition safely and independently. She said the team was passionate about continuing to develop preventative, patient-centred approaches, recognising that this was essential for the sustainability of the NHS and aligned with the Trust's commitment to patient empowerment and self-management Prof Toner commented that the work presented was "fantastic" and an example of what the NHS, and Wolverhampton should be proud of. Prof Toner queried whether the work had been written up formally. Ms Langford confirmed that she was currently developing a Well-Leg leaflet for patients and intended to produce a written article as part of the service's five-year development plan, showcasing the outcomes achieved and the potential for wider adoption. Sir David thanked Ms Langford and Ms Ponsford for attending and for their continued commitment to improving patient care and said the Board commended the team for demonstrating the kind of staff empowerment the Trust aimed to encourage, recognising a problem, proposing change, and implementing improvements. **Resolved: that the Patient Story RWT Community Ambulatory Clinics be received for information and assurance.**
165/26	**Register of Declarations of Interest**
	Sir David confirmed that no further declarations of interest had been received that were not already included within the register of interests. **Resolved: that the Register of Declarations of Interest be received and noted that there were no further declarations of interest declared that were not already included within the Register of Interests.**
166/26	**Minutes of the Previous RWT/WHT Group Trust Board Meeting held in Public on 17 March 2026**
	Sir David approved the minutes of the Group Trust Board Meeting held on 17 March 2026 as an accurate record. **Resolved: that the minutes of the previous meeting held on 17 March 2026 be received and APPROVED.**
167/26	**Group Board Action Log and Matters Arising**
	Resolved: it was noted there were no outstanding actions or previous matters arising
168/26	**Chair's Report – Verbal**
	Sir David referred to current periods of political turbulence, as reported in the media, including the appointment of a new Secretary of State and said that despite this, all indications suggested that the Prime Minister's priorities for the NHS remain unchanged which include improving elective access, strengthening primary care, ensuring financial stability and delivering the NHS plan. He emphasised that the Trust three-year strategy and said the focus must remain on delivering that plan consistently and effectively. Sir David reported that he had recently spoken at a conference hosted by the Race and Health Observatory, delivered through the NHS Alliance. He said the event launched a significant new data set and an accompanying evidence-based toolkit designed to support organisations in improving outcomes for patients from diverse backgrounds together with staff working within diverse teams. He explained that part of the session he contributed to had explored the question of why progress on inequalities had been slow, despite long-standing leadership attention. He had spoken alongside Lord Nigel Crisp in a reflective discussion on organisational responsibility and system-wide change. He commended the new toolkit to the Board, noting that it provided clear, research-driven guidance on interventions most likely to reduce inequalities. He anticipated that Ms Radley and her team would bring forward proposals in due course on how the Trust could adopt and implement the recommendations . #He stressed the importance of taking evidence-based action to ensure the organisation continued to improve how it supported a diverse workforce and delivered services to a diverse population. **Resolved: that the Chair's update be received for information**
169/26	**Group Chief Executive's Report – including Trust Priorities**
	Ms Chadwick- Bell provided an overview of year-end achievements, noting that the Integrated Quality and Performance Reports (IQPR) would provide more detail. She reported that the Trusts had delivered significant improvements in financial performance, operational delivery and key safety indicators which had been achieved despite a challenging winter period and the co ntinued impact of industrial action across the NHS. She expressed her thanks to all staff across both organisations, emphasising that progress had been delivered collectively. She acknowledged that while the achievements were notable, there remained substantial work

	over the coming years, some of which would require difficult decisions and a willingness to embrace change. She said that alongside progress made, there remained challenges, and the organisation was committed to being open and transparent about them. Ms Chadwick-Bell advised that RWT had moved from the National Oversight Framework (NOF) Segment 3 to Segment 4, primarily due to the financial position at the point of submission. She said the expectation was that the organisation would return to Segment 3 for Quarter 4. She advised WHT remained in Segment 3, where it would remain until deficit support funding was fully addressed over the coming years. She advised that a new National Oversight Framework was expected for Quarter 1 although it had not yet been published, early indications suggested a more predictable scoring methodology together with additional indicators, particularly relating to community services. She advised further detail would be shared once the framework was released. Ms Chadwick-Bell confirmed the Medium-Term Plan covering 2026–27 had been submitted and the Five-Year Integrated Delivery Plan was approved by NHS England. She said there were a small number of exceptions noted where delivery may not have fully aligned with the required pace, reflecting recognised challenges. Ms Chadwick-Bell reiterated several national priorities, all of which aligned with existing Trust programmes and work was being undertaken with the Integrated Care Board (ICB) and wider system to collectively drive this. She said outpatient transformation was already embedded within the Transforming Care Together priorities and governance in place through the Partnerships and Transformation Committee. She advised on the key areas of work for the Trusts which were to look at a step-change in reducing hospital bed days for high-risk cohorts, which aligned with the Community First programme together with some elements of urgent care transformation and operational urgent care delivery; driving technology-enabled productivity improvements, where traditionally, digital solutions had focused on improving care quality and streamlining processes for system users and that whilst this remained important, the next phase must ensure that digital investment also delivered tangible productivity gains across services. She cited the Ambient Voice Technology **(**AVT) programme as a strong example of this direction of travel. Ms Chadwick-Bell advised on the Trusts three priorities for the year as 'colleagues feel cared about', 'improving safety by reducing patient waiting times' and 'to deliver services efficiently'. Ms Chadwick-Bell highlighted the positive news regarding capital allocations in that funding had been announced for the Community Diagnostic Centre, though this remained at an early business case stage. She said additional capital would support Urgent care reconfiguration at Wolverhampton, a new Cath Lab and the development of community hubs, with plans still being developed. Ms Chadwick-Bell advised that further detail on her verbal report was available within the written report provided. **Resolved: that the Group Chief Executive's Report be received for information and assurance**
170/26	**Black Country Acute Trusts - Future Group Structure Arrangements**
	Ms Chadwick- Bell advised that the paper was also being presented by the Dudley Group NHS Foundation Trust and the Sandwell and West Birmingham NHS Trust Group Board the following day. She reported that the content aligned across all four organisations, with minor wording adjustments to reflect local contexts. She reminded the Board that the four organisations came together as a Collaborative several years ago and continued to progress along that journey and whilst significant progress had been made, further work was required to fully optimise the Group model, including, development of a clinical roadmap, delivery of a single strategy and the advancement of wider transformation programmes. She emphasised the intention by RWT and WHT to recommit to the Group model and said the organisations did not wish to disperse back into standalone Trusts, nor was there a proposal to move towards a single Black Country-wide group at this stage and that the report sought to formalise ongoing Group arrangements. Ms Chadwick-Bell advised that the Board was not being asked to approve arrangements on behalf of Dudley or Sandwell; and that each (group) organisation would consider and approve the paper independently. Sir David added that due to recent media reports regarding Group arrangements, it was timely and sensible for the four Black Country organisations to reaffirm their shared position, set out a clear strategic direction, and establish firmer foundations for future collaboration. He said this included exploring, in time, whether any organisations wished to pursue closer managerial alignment. He said given the wider system changes discussed earlier in the meeting, the Board agreed that it was important to clarify the future of the Group

	model. He reiterated that the paper sought approval from the Group Board at RWT and WHT to formalise their ongoing Group arrangements. **Resolved: that the Black Country Acute Trusts Future Group Structure Arrangements be received for approval**
171/26	**Integrated Committee Chairs Report - Finance & Productivity Committee, Quality Committee, People Committee and Partnerships and Transformation Committee and Digital and Estates Strategy Committee**
	Mr Assinder informed the Board that all Sub-Committees of the Board had met since the previous meeting in March 26 and said the summary of key issues were available in the report. He highlighted the matters for escalation to the Board and reported on ophthalmology performance. He said that issues had been identified with the implementation of the PAS system, specifically affecting ophthalmology patient waiting lists and advised that the Group Quality Committee (GQC) was continuing to review the matter in detail, and an ophthalmology-specific meeting had been convened to understand what had occurred, the scale of the impact and required remedial actions. Mr Assinder advised early remedial plans were already in place which the GQC had scrutinised and said the Integrated Care Board (ICB) had been contacted to explore whether any mutual aid could be provided by neighbouring organisations to support recovery. Dr McKaig said that ophthalmology remained a high-volume and high-risk specialty, with longstanding pressures exacerbated by rising demand. He said following Covid-19, the Trust had already implemented additional capacity and risk-stratification processes in response to glaucoma-related harm. He said that demand in ophthalmology continued to rise, placing sustained pressure on the service. He reported some constraints related directly to issues arising from the rollout of the new PAS system, which was affecting scheduling and follow-up processes and said a fundamental redesign of the ophthalmology pathway was required, working with system partners, including providers outside the NHS, rather than relying solely on internal capacity. He said there was very little available mutual aid across the region, as most ophthalmology departments were experiencing similar pressures. Dr McKaig said that the timeliness of reviews meant a number of patients remained at risk and that an Executive Oversight Group continued to monitor harm reviews and operational processes closely. He emphasised the need to shift a significant proportion of outpatient follow-up activity into community settings, high-street optometrists and other qualified providers and said work was already being discussed with the ICB, who recognised the scale of the challenge and the need for a system-wide redesign. Ms Chadwick-Bell confirmed that the issue had been formally raised with David Melbourne, Chief Executive of the ICB to work together to deliver a full end-to-end redesign of the ophthalmology pathway, recognising that the challenges described were not unique and were being experienced across the NHS. She added that the ICB had acknowledged both the risks and the opportunities, and work was now underway to scope a programme that would address the issues. Mr Assinder reported increases in community waiting lists at WHT. He said over recent months, the Board had been tracking a rise in both waiting lists and waiting times across several pathways, including, Musculoskeletal (MSK), Dietetics, Speech and Language Therapy (SALT) and Community Paediatrics. He noted that Walsall's community services were highly regarded, and in some respects felt the Trust had been a victim of its own success, with strong demand driven by service quality and reputation. He said in addition, some of the increase reflected more accurate recording, with the Trust counting activity differently and more comprehensively than before. He advised work was underway to validate and manage the waiting lists, understand the underlying drivers of demand, address recording inconsistencies and identify sustainable solutions to capacity pressures. Ms Cartwright added both organisations were working jointly on the issue, recognising the cross-system nature of community demand and what opportunities there were to manage the demand. Ms Godson reported there had been increased national focus on community waiting lists over the past 6–12 months. She advised specifically for WHT, the growth in the waiting list reflected several factors, one being high demand driven by strong service reputation and reiterated that the organisation was now recording activity more accurately, which had increased the reported waiting list size. She also mentioned WHT provided specialist services not routinely available elsewhere in the Black Country, including musculoskeletal support and psychological support, which added to local demand. She said teams had been working to ensure robust clinical prioritisation, so patients were seen in the correct order of need, additional capacity, including extended use of community venues and external providers and commissioner engagement, to ensure appropriate funding for any additional activity. She reiterated that demand currently exceeded capacity, and

	whilst work was underway to address this, resolution would take time. Ms Godson advised that a detailed report was attached to the WHT Integrated Quality and Performance Report to have been discussed later in the meeting as part of the joint report with RWT. Mr Assinder reported on financial performance across both Trusts. He congratulated both organisations for achieving their financial targets for the year ending 31 March 2026, subject to final audit. He said the Group Chief Finance Officer had confirmed confidence in completing the audit process successfully. He reported both Trusts had delivered the highest level of efficiency savings on record, contributing significantly to the year-end position. He advised that in respect of productivity the organisations ended the financial year in a stronger and more efficient position and early Month 1 figures indicated that performance was continuing in line with plan. Mr Assinder reported that the Committee Chairs had highlighted a cross-cutting theme emerging from all Board sub-committees which related to the ongoing "left shift" in service delivery. He said the Committees were examining, from their respective perspectives, the enablers required to shift care from hospital-based to community-based provision, including, workforce, digital capability, estates, financial frameworks and clinical models. Sir David asked what actions were being taken, ahead of longer-term transformation, to ensure patient safety in ophthalmology. Dr McKaig confirmed that several immediate mitigations were in place, and a dedicated facility at National Park was currently operating to measure eye pressures and ensure that high-risk patients were prioritised for review. He said work was underway to support the implementation of the Electronic Patient Records (EPR), including both the PAS system and a bespoke ophthalmology EPR module, with additional funding secured to accelerate rollout and reduce reliance on paper-based processes. He said the service was focused on identifying and managing the highest-risk patient groups, supported by strengthened logistics and scheduling processes. He said a series of escalation and recovery plans were also in place and would be overseen by the relevant committees. The Chair confirmed that the committees would continue to oversee progress and thanked the team for the assurance provided. **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**
172/26	**Group Board Assurance Framework (GBAF)**
	Mr Bostock presented the GBAF in its new style and format and advised that this had been reviewed by all Board sub-committees and received positive feedback. He advised the updated format was simpler than previous iterations and included a consolidated dashboard, detailed BAF entries, referenced any changes to controls and assurance levels, a summary of the risk appetite statements and the current strategic objectives. Mr Bostock reminded the Board that this was the final GBAF aligned to the current strategic objectives. He said the Board would be receiving a report to consider the closure of the existing objectives and the launch of the revised strategic objectives. He reported that the next iteration of the GBAF, to be presented at the following Board meeting, would use the same format but would be aligned to the new strategic objectives and associated risks and that a Board workshop was scheduled for 9 June 2026 to support preparation for this transition. **Resolved: that the RWT and WHT Audit Committee Chair verbal updates be received for information and assurance**
173/26	**NHS National Staff Survey Results**
	Ms Radley presented the results of the National Staff Survey, outlining the importance in the actions that the Trusts would take in response to the findings. She summarised that both Trusts had seen a decline across all nine People Promise indicators, as well as the two overarching measures of staff engagement and morale. She said all scores were below national averages, with declines that were steeper than national trends. She noted that response rates had also fallen across both organisations. She advised that the responses had highlighted several areas of concern, which included reduced confidence in health and wellbeing support, increased reports of discrimination and unwanted behaviours, rising work pressure, a higher proportion of staff considering leaving and a marked drop in advocacy scores, which also impacted the National Oversight Framework metrics. She said it was important what the Trusts do next and confirmed that plans were already in place to respond to the survey findings.

	Ms Radley advised there had been visible acknowledgement of feedback and structured communication across both Trusts and divisions and teams were running extensive listening and engagement activities. She said there was also alignment with the Transforming Care Together strategy, particularly the priority that colleagues should feel cared about. She reported that work was underway to improve sickness absence management and that a target had been set to increase quarterly pulse survey response rates, to provide early insight into next year's results. Ms Radley reported additional related work included a refresh of the Equality Diversity and Inclusion (EDI) action plan and restarting work on sexual safety. She explained that the emerging Cultural Development Plan, would be presented to the Group People Committee in Quarter 3 which would bring together some of the more traditional workforce elements such as flexible working, appraisals, and reducing vacancies but would also go significantly further. She said the survey results indicated that culture was central to staff experience, and that longstanding unspoken norms across the Group and the two Trusts needed to be surfaced and addressed to enable meaningful change. She noted that this work would take time, but there were short-term opportunities to demonstrate visible progress. She said one example was the forthcoming Freedom to Speak Up governance changes taking effect from 1 July, which provided an opportunity for clear, group-wide communication about why speaking up was fundamental to the culture the organisations wanted to build. Ms Radley reiterated that whilst a significant shift in this year's Staff Survey results was unlikely, visible actions, combined with genuine change, could begin to rebuild hope and optimism among staff for longer-term improvement. Ms Brathwaite noted that this was a difficult and complex area, and the Group People Committee had spent considerable time interrogating the results in depth. She said the challenges identified would require sustained effort, as the issues related to culture, engagement, and systemic behaviours, and there was no single solution. She said the Committee had emphasised the importance of ongoing triangulation of intelligence from multiple sources, including Freedom to Speak Up, Health and Wellbeing data and Staff Survey results. She said it was also important to ensure the Board listened to and accepted what staff were saying together with understanding the clear and consistent messages that had been emerging throughout the year with improvement needed on how the organisation heard staff voices and how it communicated back about what was acceptable, what would change, and how change would be embedded at all levels. Ms Brathwaite stressed that there was a significant amount of work to do, and that progress would take time. She said however, the Group People Committee was confident that it was asking the right questions, providing appropriate challenge, and it was hopeful that the organisation would begin to see positive shifts as actions took effect. Ms Jones said that whilst the report was informative, the low response rate meant the results did not yet reflect the views of majority of staff. She emphasised the importance of developing innovative, time-efficient ways to understand what staff really thought, without relying solely on lengthy forms or surveys. She noted that fewer staff had responded online compared with paper responses, suggesting that convenience and accessibility were key factors in engagement. She expressed particular interest in how the organisation would reach those staff who did not contact Freedom to Speak Up and did not complete surveys, describing them as the "hard-to-reach" groups whose voices were essential to understanding the true staff experience. Sir David agreed, noting that this represented one of the biggest leadership challenges facing the organisation. He stressed that improving culture was not solely the responsibility of the Group Chief People Officer, but a responsibility shared by all leaders in how they interacted, lead and managed the organisations. He acknowledged that the past 2 years had been exceptionally tough, with significant reductions in resources and workforce. He said whilst short-term pressures had required a degree of grip and control, the results clearly showed that sustainable cultural change could not be achieved through grip and control alone. Sir David emphasised the importance of strengthening the quarterly pulse surveys and embedding the new Transforming Care Together strategy as a foundation for cultural change. He reiterated that this was not solely a People function responsibility, but a collective leadership responsibility. **Resolved: that the NHS National Staff Survey Results be received for information and assurance**
174/26	**Strategy (Section Heading)**
175/26	**Final Review & Progress Update on the 2022-2027 Group Strategy**

	Sir David noted that the Group Strategy was a key building block in addressing many of the cultural and organisational challenges discussed under the previous agenda item. Mr Evans said that the Board had had extensive discussions during Board development sessions and at the last Board meeting regarding the launch of the new Group Strategy: Transforming Care Together (TCT). He said to launch the new strategy on a strong foundation, the paper presented the formal close-down of the existing four-year Group strategy. He explained that although the previous strategy was due to run until 2027, several significant developments meant it had been appropriate to close it down early, including a new government, a new 10-year plan, the emergence of the three shifts, and the realisation during transformation planning, that the work being developed constituted a new strategy, not simply a transformation plan. He said accordingly, the previous strategy (2022–2027) had been formally closed one year early, and the new strategy, Transforming Care Together (TCT), had been launched. Mr Evans emphasised that the Group had remained true to its vision, which continued unchanged, and that the four Cs remained the right strategic aims, aligned to the national 10-year plan and that within the documentation was an evaluation of the objectives that sat under each of the Four Cs. He provided a brief overview of progress of the Group Strategy. He said for 'Care' significant delivery had been achieved, including a major shift towards a quality improvement (QI) approach, with over 1,000 staff trained in QI principles. He said learning from this period had informed the new strategy, which moved beyond improvement to embedding a quality management system, a core component of TCT. Mr Evans reported that the required thresholds and recovery positions had been achieved for Referral to Treatment (RTT) and Cancer, despite challenges, RWT had shown improvement in cancer performance. He said opportunities for further progress were identified within the report. Mr Evans referred to the earlier Staff Survey discussion, and said this area required the greatest improvement. He advised the organisation had not delivered as much as intended, and staff survey results had deteriorated. He said this learning had shaped one of the in-year priorities within TCT, ensuring all colleagues felt cared for, supported by a structured programme of work and clear metrics. Mr Evans informed the Board that strong progress had been made in relation to communities with both Trusts having successfully established place-based partnerships, which now provided a solid foundation for the next phase of the community-first approach in both localities. He said the Group had also launched its new Health Inequalities Strategy, supported by a structured reporting framework to ensure systematic oversight and delivery. Mr Evans reported that the Group's Green Plan was well regarded and nationally recognised, with all early milestones achieved. He said the sustainability agenda extended well beyond the life of the previous strategy, and the new Group strategy would continue this work through to 2040. He also highlighted the evolution of the Group's collaborative work and said that when the previous strategy had launched, the system had been emerging from COVID-19, and much of the early focus had been on mutual aid. He said the Group now worked effectively with system partners and had identified priority areas for future collaboration, including robotic surgery and the development of centres of excellence. He said learning from the past four years had shown the importance of not over-extending collaborative programmes whilst significant internal priorities remained. He said the Group had refined and refocused its objectives with the Provider Collaborative to ensure a more targeted and deliverable programme of work. Mr Evans noted that the Group had made meaningful progress against its strategic objectives, providing a strong platform for the launch of Transforming Care Together. He said the learning from the previous strategy had directly informed the development of the new strategic objectives, referred to as "the wheel", which would underpin the next phase of transformation. Mr Evans recommended that the Board: • Note the progress made against the 2022–2027 strategy • Formally approve the early close-down of that strategy • Confirm that Transforming Care Together was now the Group's active strategy **Resolved: that the Final Review & Progress Update on the 2022-2027 Group Strategy be received for assurance and approved for close-down to be superseded by the Transforming Care Together Strategy (TCT).**

176/26	**Integrated Quality and Performance Reports (Section Heading)**
177/26	**Group Finance Plan and Workforce Report**
	Mr Stringer provided a summary of the 2023/24 year-end financial position, noting that although the year had been challenging, both Trusts had delivered the financial commitments they set out to achieve. He highlighted that both organisations had achieved their control totals, with revenue positions at break-even. He said due to meeting all three national criteria, delivering the plan, the system achieving its plan, and submitting a compliant plan for 2024/25 the Group had received an additional national deficit funding at year-end which resulted in £4.9m (RWT), £3.3m (WHT), enabling both organisations to end the year in surplus. Mr Stringer reported that the Group invested £54m in capital during the year, covering backlog maintenance, digital infrastructure and medical equipment. He noted that whilst this represented a significant achievement, demand continued to exceed available capital, particularly in relation to backlog maintenance and fire safety works, which would remain a pressure. He reported the Group had an ambitious £87m efficiency and waste reduction target, achieving 89% by year-end. He highlighted the substantial improvement made in Quarter 4, which enabled the Group to reach this level of delivery. Mr Stringer congratulated all teams and budget holders for their work in delivering the year-end financial position, noting the difficult choices made throughout a highly challenging year. He emphasised the importance of ensuring going forward that the Group delivered the activity levels agreed in plan, particularly given the move to elective tariff-based income and that starting the year strongly would be critical. Mr Stringer acknowledged the successful mid-year transition to a new financial ledger, recognising that this carried significant risk. He said whilst the transition had been completed, some issues arose in system configuration, including delays in supplier payments, which would need to be addressed going forward. He said looking ahead, the Group must focus on delivering the breakeven plan to 2026/27, which included a Cost Improvement Plan (CIP) requirement of just over 6%. He advised the long-term financial plan required the Group to eliminate a £37m deficit over the next two years. He confirmed Capital allocations for the next four years, rising from £37m to £40m annually, with an additional £45m earmarked for strategic schemes. Ms Radley reported on performance against their three workforce targets (internal, NHS, and recovery). She said whilst there had been improvement in the substantive workforce position, the Group had not met its workforce reduction targets due to continued reliance on temporary staffing, particularly agency spend. She said that some of the increased temporary staffing costs, especially in Month 12 had been attributed to rapid improvement events, industrial action, with over 80% of doctors participating, sprint activity to reduce waiting lists and additional staffing required to maintain safe services Sir David reiterated the importance of the workforce elements of the 2024/25 financial plan, including cost improvement delivery, workforce reduction plans and the operational approach required to achieve them. He noted that this was where significant pressure would fall in the coming year and asked whether the rapid improvement events would assist in dealing with this. Ms Radley said the rapid improvement events explained why some of temporary staffing spend was high, particularly in Month 12, where several factors drove higher temporary staffing spend. Sir David sought clarity on the next steps. Ms Godson explained that the higher temporary staffing spend in Month 12 had been driven by several operational pressures, including multiple sprint events, the need to use waiting-list initiative and bank staff, and significant industrial action, with over 80% of doctors participating. She said in addition, the rapid improvement events linked to the Community First programme had also required additional staffing. She noted that while sprint activity and industrial action would not continue into Month 1, the rapid improvement events would, and work was underway to improve reporting so these costs were clearly separated from the workforce reduction targets. Mr Assinder said that whilst the Group's target was 6%, once non-influenceable spend such as Private Finance Initiative (PFI) was removed, the challenge remained extremely significant. He emphasised the importance of hitting the ground running in Quarter 1, as early delivery would set the tone for the remainder of the year and ensure momentum behind the savings already in train. Ms Jones echoed these points, commending the finance team not only for achieving the financial position but also for doing so in a year that included a major finance system change. She noted that no implementation of a new financial system proceeded without issues, but the Audit Committees had been reassured by the swift action taken whenever support was required, whether through internal audit, rapid reviews, or additional

	technical assistance. She said this enabled the organisations to produce accurate year-end figures on time, and there were no current indications from external audit that the accounts would not be signed off. Sir David added that whilst the Group had delivered the financial plan, it had required significant effort to maintain grip. He acknowledged that the organisation's focus on financial recovery could sometimes be misinterpreted externally as being "only about the money," which was far from the truth. He emphasised that financial performance was a collective responsibility across the executive team, he noted the ownership and maturity of the executive team in managing financial and operational issues. He thanked the executive team and all colleagues involved for their contribution to resolving the financial challenges and supporting the wider organisational agenda. **Resolved: that the Group Finance Plan and Workforce Report be received for information and assurance**
178/26	**Comfort Break – 10 mins**
179/26	**Integrated Performance Report –Walsall Healthcare NHS Trust - including RWT/WHT Group Report on Community Waits**
	Ms Godson reported that 2025/26 had been a strong year for WHT with improvements across performance, quality and operational delivery. She said key achievements included National recognition for the Walsall Little Voices programme, which involved children acting as "hospital inspectors" with their feedback ranging from menu choices to hand-soap height and seating conditions in the waiting area which had already led to improvements in the paediatric environment. She also mentioned delivery of a strong Q4 national sprint programme, covering emergency care, Referral to Treatment (RTT)/elective care and diagnostics. She said across all key patient access targets, WHT had been the most improved Trust nationally, a significant achievement for the teams involved. She also highlighted Friends and Family Test scores had increased to 94%, and complaint response performance had also improved. She reported that safety indicators remained broadly stable, and the Trust achieved full compliance with the Clinical Negligence Scheme for Trusts (CNST) maternity safety standards. Ms Godson highlighted that WHT continued to hold first position in the Midlands for RTT performance at 73.5%, sustaining this for 17 consecutive months. She said this reflected sustained hard work across clinical and operational teams. She reported Cancer performance had improved significantly, highlighting that earlier in the year, two of the three standards had not been met, and now all three were being achieved and performance had been sustained. Ms Godson highlighted that four-hour emergency care performance had improved to 86.7%, exceeding both trajectory and national expectations. Ms Godson noted that the Trust had undertaken a substantial programme of staff engagement events, including both listening sessions and celebration events, supporting the wider organisational focus on improving staff experience. She advised there had been an improvement of ambulance handover performance and patient flow, supported by strengthened clinical leadership, operational oversight and increased visibility within departments. She reported that overall productivity remained strong, as reflected in the performance report, however, several areas required sustained focus and further improvement, which included, improving outpatient efficiency, particularly by reducing Did Not Attend (DNA) rates and increasing the use of specialist advice; strengthening elective productivity, including day-case rates and throughput and addressing ongoing workforce productivity challenges, including vacancy, sickness, and appraisal compliance Ms Godson said that Walsall had experienced a very strong year overall, though areas such as community waits would require further attention in the coming year. She thanked all colleagues for their hard work and commitment. Ms Carroll provided an update on the recent national alert regarding Hantavirus, noting that a small number of individuals in the UK were self-isolating following confirmed cases. She assured the Board that the Trust's High Consequence Infectious Disease (HCID) plans were up to date and had been tested. She said staff had been trained in the correct use of Personal Protective Equipment (PPE) and relevant infectious disease pathways. She also advised all national guidance had been reviewed and implemented and stated that the risk was low to their population. She said relevant clinicians had been briefed and any Trust with self-isolating individuals in their areas had been notified. Mr Assinder queried mental health treatment and access within the Trust, noting that this appeared to be a persistent worsening issue and asked whether there was any indication of improvement on the horizon. Dr Din reported that a senior meeting had taken place the previous day between WHT, Black Country Healthcare Mental Health Trust, the Chief Medical Lead, and mental health leads. He said this was timely, as

	the new Getting it Right First Time (GIRFT) Mental Health in Urgent and Emergency Care Standards had been launched nationally in April and that key points from this would include the Trust and partners undertaking a self-assessment against the new standards. He said this work would be taken through both the hospital group and the mental health interface group, where requirements and gaps would be reviewed. He advised that whilst the issue remained a national challenge, the new guidance provided a clearer framework for improvement. Sir David queried when it was expected that Trusts would see improvements . Dr Din explained that the self-assessment would be completed within one month and by that point, the Trust would have a clear understanding of gaps and the actions required. He advised an operational plan and trajectory for improvement would then be developed and brought back to the Board. Ms Hughes noted that mental health pressures particularly in urgent and emergency care were common across England and asked whether Group-wide data showed any common themes. Dr Din confirmed that the Group had established interface standards for how acute and mental health services worked together. He said the main challenge remained capacity, and improvement would require robust demand and capacity modelling. He said the newly released national standards included timeframes for mental health attendance in A&E. Ms Chadwick-Bell provided further assurance regarding mental health access and performance. She confirmed that the issue had been discussed openly at the Group Management Committee (GMC), the senior governance forum spanning both organisations. She said that a clear mental health strategy would be provided at the GMC within two months, aligned to the timelines already discussed. She emphasised the importance of discussing challenges transparently in this forum identifying, what had already been done, what remained unresolved and where the system-level blocks lay. She stressed that this was not about attributing blame, but about ensuring the Board fully understood the detail required to move the issue forward. She advised that the work would return to GMC first and then to the Board as timelines allowed. **Action: Dr Din to provide an update and trajectory for mental health treatment and access to the July Board meeting following the submission of the self-assessment.** Dr Din provided an update on Safeguarding Adults Collection (SAC), noting that although it had been a challenge, significant progress had been made. He mentioned current compliance was 95–100%, with full completion expected by June and had been discussed at the GMC and was being closely monitored. Sir David noted the strong and consistent year of performance at WHT and commended the way performance had become embedded and sustained across teams. He thanked all colleagues for their contribution. **Resolved: that the Integrated Performance Report including RWT/WHT Group Report on Community Waits for WHT be received for information and assurance**
180/26	**Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT)**
	Dr McKaig, in the absence of Ms Nuttall reflected on the significant progress made over the past year. He said whilst the financial position had already been discussed, he emphasised the importance of recognising the operational achievements delivered from a challenging starting point. He reminded the Board that last year the Trust had been in a very difficult RTT position, with performance below 50%, with scepticism from NHS England about the Trust's ability to deliver the required 10% improvement. He advised through coordinated work led by operational teams, the Trust had achieved an 11% improvement, taking RTT performance to over 60%. He mentioned although it was still short of the constitutional standard, this represented a major improvement and had resulted in patients receiving a better, more timely service. He said to support further progress, teams from NHS England and GIRFT were now working with the Trust across four of the most challenged specialties Urology, Gynaecology, Gastroenterology and Acute Stroke and Community Paediatrics. He said this work aimed to strengthen pathways and improve RTT performance in these areas. Dr McKaig provided an update on the three major fire safety programmes underway across the Trust: • Cannock Hospital. He advised Fire safety works were on track for completion in November, after which the site would be assessed by Staffordshire Fire and Rescue Service. • New Cross Hospital – Main Theatre Block. He said Fire safety works in the nucleus area had been completed, and assessment was taking place this week. • Block 32 (Maternity Services). He said this was the most significant programme, involving extensive collaboration with West Midlands Fire Service and external partners. Work was focused on ensuring safe ongoing services, alongside a clear short-term and long-term plan for fire safety in maternity.

	Dr McKaig reported that the Trust had experienced further resident doctor industrial action, with 55% of resident doctors participating, higher than previous rounds. Despite this fewer than 5% of elective procedures were cancelled, there was no patient harm and Urgent and Emergency Care (UEC) performance remained strong. Dr McKaig provided two regulatory updates and advised that following The Ionising Radiation (Medical Exposure) Regulations IR(ME)R Inspection in April 2026, the Trust had received their report following which a small number of actions relating to governance and documentation had been completed, and said the action plan would be submitted to the Care Quality Commission (CQC) by the end of June 2026. Dr McKaig reported on the Emergency Department CQC Inspection which took place in November 2025, whereby the service had been rated Requires Improvement overall, with Inadequate for safety. He reported significant work was underway through CQC, with improvements seen in triage times, ECG times, and medical estate utilisation. He said a table-top review with NHS England and the ICB had confirmed reassurance in the Trust's action plan, with no additional actions required. Dr McKaig said that cultural work within ED remained essential, alongside whole-system improvements aligned to the Community First programme. Dr McKaig highlighted notable success in the Cannock Surgical Hub Re-Accreditation and advised that the Trust was the first in the Country to be accredited three years ago and had received exceptionally positive verbal feedback during its first re-accreditation visit. He said improvements had been noted in teamworking, reduced length of stay, pre-operative processes, and productivity for hips and knees and the formal report was expected at the end of June 2026. He also referenced the Bowel Cancer Screening Recognition and advised that the Trust had received a 2 minute 49 second feature on national radio, which highlighted a positive patient experience and successful treatment outcomes within the Bowel Cancer Screening Programme. Ms Sadler-Todd raised concerns regarding community waiting times, noting that the current action plan appeared to focus primarily on "doing the same things faster". She asked where the scope existed for more fundamental pathway redesign, and how the patient voice, particularly from families using community paediatrics was being incorporated. She emphasised the importance of hearing the patient voice, noting that Board walkabouts had surfaced valuable insights, particularly in community paediatrics, where families had described unique and sometimes challenging experiences. She asked whether the Trust had explored alternative pathways and whether patients and families were being actively involved in those conversations. Ms Shaw said that two areas at RWT represented the most significant challenges, Speech and Language Therapy was primarily a demand and capacity mismatch, with around 100 referrals per month and insufficient capacity to meet that demand. She said recruitment was underway to increase capacity. She said the second challenge was Community Paediatrics and said the Trust was establishing focus groups with children, young people and families to understand what worked, what did not, and what needed to change. She said this would inform a more fundamental redesign of pathways. She emphasised that improvement required two parallel workstreams, immediate operational actions, including clarifying the service specification, ensuring appropriate triage with mental health partners, and maximising team productivity. She also mentioned longer-term transformation involving co-design with families, rethinking pathways, and challenging assumptions about traditional models of care. Ms Godson added that, from a Group perspective, the work also involved strengthening clinical triage to ensure patients were seen in the correct clinical order as well as addressing the lack of digital enablement in community services, which currently limited the ability to validate waiting lists in the same way as acute services. She said running this validation work in tandem with service redesign, ensured the patient voice was central to the process. She reiterated that redesign must focus on creating services that were faster, more accessible and more responsive, with patients actively shaping the future model. **Resolved: that the Integrated Performance Report - The Royal Wolverhampton NHS Trust (RWT) be received for information and assurance**
181/26	**Special Educational Needs and Disabilities (SEND) Reform Plan**
	Ms Carroll reported that the Government's SEND Reform Plan guidance required all local area partnerships to develop and submit their plans, supported by a maturity matrix assessment, to NHS England by 19 June 2026. She explained that both Trusts were part of separate local area partnerships, and each had undertaken extensive co-production to develop their SEND Reform Plans. She mentioned this work had involved health, education, social care, parent carers, children and young people, and wider system partners to ensure the

	plans reflected the needs and priorities of the local population. She reported that a series of workshops had been held to shape and refine the plans, and that each plan had been taken through the relevant local area partnership governance for sign-off and both Trusts had worked closely with partners throughout the process. She highlighted that the most significant element for health across both Trusts was the Experts at Hand model. She said this model focused on strengthening support into education settings, particularly in Speech and language therapy, Educational psychology and Occupational therapy. She noted that a substantial amount of national funding had been allocated to support this work, enabling the development of new capacity rather than adding responsibilities to already stretched teams. Ms Carroll confirmed that the paper presented to the Board included a summary of each SEND Reform Plan; the initial one-year ambition; the three-year overarching strategy; each partnership's self-assessment against the maturity matrix; key risks and areas requiring further development. She explained that the full plans were extensive and had therefore not been included within the Board pack however they had been reviewed at the GMC, with sufficient time to consider them in detail and approval was sought today from the Board for submission to the ICB and NHSE. Sir David queried what difference the SEND Reform Plans would make for an individual child, beyond the planning and governance processes. Ms Carroll stated that the reforms were designed to make a tangible, practical difference to children with special educational needs and disabilities by keeping children in mainstream school wherever possible, rather than requiring them to leave school for multiple, fragmented appointments. She said also ensuring easier access to the right support, delivered in a coordinated way around the child, together with reducing the need for children to attend numerous separate clinics by bringing services into schools and community setting. She said this included providing a comprehensive, joined-up plan for each child, rather than relying solely on an Education, Health and Care Plan (EHCP) to trigger support, and lastly ensuring children could access speech and language therapy, occupational therapy, educational psychology, and wider support in the right place and at the right time. Ms Carroll noted that this approach had been developed through close collaboration with the Department for Education, local advisors, and system partners, ensuring that support would be delivered around the child, not around organisational boundaries. Sir David asked whether this would help address the earlier concerns about speech and language therapy waits. Ms Carroll confirmed that by submitting the SEND plans on time would unlock significant national funding. She said this funding would support new workforce capacity, not simply add to existing pressures and recruitment would be phased, recognising the national shortage of speech and language therapists. She said training and development would be used to grow the workforce, supporting sustainability over the three-year programme. Sir David asked whether the additional national funding attached to the SEND Reform Plans created a genuine opportunity for service transformation, rather than simply expanding existing activity. Ms Carroll confirmed that it did and explained that the three-year programme had been designed to allow for meaningful transformation, with clear plans for the first year and further detail to be developed over the longer term. She emphasised that the funding would support new capacity, not place additional pressure on existing teams. Ms Hickman added that the reforms would also help address the underlying demand already present in the system. She said these were children already known to services, not new referrals, and the programme therefore dovetailed with existing pressures. She noted that demand for SEND support continued to grow, and the reforms provided an opportunity to consider the issue in a wider system context. She said that the SEND reforms provided a framework for a more integrated approach. Ms Jones reflected that the paper had been very strong, particularly in its articulation of the workforce risks within the SEND system. She said that whilst early intervention, faster diagnosis and quicker access to support were essential, these improvements inevitably increased demand for educational psychology and speech and language therapy professions already in critically short supply. She noted that although the SEND reforms brought funding, this was not "new money" in the system, rather, it would be redirected from schools' existing EHCP funding, shifting resource rather than expanding it and that the core challenge was finding and training the specialists, not simply funding them. She said the public sector lacked a stable training pipeline or long-term commissioning certainty to retain staff and said that the Experts at Hand model would only succeed if the individuals recruited were genuinely experts, not trainees. She expressed strong interest in

	understanding, at a future point, what had been done on the ground to build and sustain this workforce. Ms Barber asked whether the Trusts were engaging with the Ministry of Justice, noting that magistrates frequently made decisions about children in split-family arrangements who were still waiting for access to SEND-related support. She highlighted that delays in assessments and interventions could directly affect contact arrangements and family outcomes, and she queried whether stakeholder engagement extended to the justice system. Ms Carroll said that the Trusts were exploring alternative workforce models, including the use of assistant practitioner roles, to support the delivery of care in schools and under this model, qualified specialists would undertake the initial assessment and develop the care plan, while trained assistants would help maintain ongoing support within schools. She said that, given national shortages in professions such as speech and language therapy, the Trusts needed to think differently about how the workforce was structured. She confirmed that, to date, engagement with the Ministry of Justice had been coordinated primarily through the local authority, and the Ministry had not played a major role in the development of the SEND Reform Plans. However, she noted that the plans were still evolving and that there was no reason why the Ministry of Justice could not be brought into the partnership if it was identified as an area requiring focus. Ms Chadwick-Bell noted that one of the key workstreams within Transforming Care Together focused on workforce redesign, and she linked this directly to earlier discussions about the need for new and different roles within the SEND system. She reported that she had recently met with the University of Wolverhampton, and the University had expressed strong interest in developing new curriculum to support the future workforce required for SEND services. She emphasised that these would not be quick fixes, but that without these conversations the system would not be able to meet future demand. She highlighted a wider challenge in identifying how the system could reinvest funding to support the development of advanced practitioners and other specialist roles, while still maintaining day-to-day service delivery. She noted that there was no simple answer, but that the conversation needed to begin to enable meaningful workforce redesign. Prof Toner added that some universities had already increased their speech and language therapy training places, and that apprenticeships and postgraduate routes were available, however, she noted that many qualified therapists were choosing to work in the private sector, where pay and flexibility were more attractive, and that this continued to create shortages within the NHS and local authorities. She suggested that the Trusts consider what more could be done to “grow their own” workforce. Sir David said that this was a critical area of work, particularly given the need for strong collaboration with partners to deliver the SEND reforms effectively. He noted that the plans brought together multiple strands, funding, workforce, service redesign and partnership working and that the Trusts needed to ensure that the incoming resources were used not only to improve services for children in mainstream schools, but also to leverage the workforce changes required for long-term sustainability, including through partnerships with local universities. He sought and received Board approval for the submission of the SEND Reform Plans to the ICB and NHS England. **Resolved: that the Special Educational Needs and Disabilities (SEND) Reform Plan be received for approval**
182/26	**Governance (Section Heading)**
183/26	**WHT Bi-Annual Skill Mix Review**
	Ms Carroll presented the Walsall biannual establishment review, confirming that the review related specifically to inpatient wards. She reported that no changes to the current establishments were required at this stage and that going forward, the establishment review would be presented to the Group Board annually, aligned to the annual planning cycle. Ms Chadwick-Bell queried how the Board should reconcile the assurance provided through the professional establishment review with the lived experience observed during Board walkabouts, where staff frequently reported feeling short-staffed. She asked how the Trust could help staff understand the difference between the agreed establishment and the day-to-day staffing reality, particularly when staff were moved between wards. Ms Carroll explained that the establishment review confirmed the budgeted establishment, but that several operational factors affected the staffing picture on any given day, vacancies across several wards, sickness absence, which varied daily, patient acuity and dependency, which could increase workload significantly and enhanced observations, particularly for patients with dementia or complex needs, requiring one-to-one or bay-based supervision She noted that these pressures meant that staffing sometimes felt stretched even when the establishment was technically correct. She explained that the Trust held twice-daily

	staffing meetings to review acuity and allocate staff safely across wards and added that the Trust continued to focus on reducing vacancies, managing sickness, and improving the enhanced observation model. Ms Carroll informed the Board that, in the previous week, the Trust had reconfigured several wards and created a dedicated ward for patients with dementia, known as the Sister Dora Suite. She explained that consolidating majority of patients with dementia into one area would concentrate specialist expertise, improve the quality and consistency of care, reduce the need for one-to-one enhanced observations across multiple wards and support more efficient use of the workforce. She noted that some patients with dementia would still be cared for on other wards, but the new configuration would significantly reduce the operational pressures associated with dispersed enhanced observation requirements. Ms Carroll acknowledged that staff continued to express concern about feeling short-staffed during Board walkabouts. She emphasised the importance of ongoing conversations with ward teams to help them understand their established staffing levels, the skill mix required, the acuity and dependency of their patients and how safe staffing was assessed in real time. She noted that staff often felt reassured once these discussions took place but acknowledged that the environment remained busy and that sickness, vacancies and enhanced observation needs continued to create pressure. **Resolved: that the WHT Bi-Annual Skill Mix Review be received for approval**
184/26	**RWT & WHT Audit Committee Chair Reports**
	Mr Assinder presented the update from the Walsall Audit Committee on behalf of Ms Martin and reported that the Committee had secured from the Executive Team an 18-month programme for the automation of medical records at WHT. He said WHT remained one of the few hospitals still reliant on paper records for a significant proportion of its activity, and the Committee had pressed for progress and that the establishment of a clear 18-month plan represented a positive step forward. He advised that the Internal Auditors had presented their annual audit opinion, which concluded that Walsall had an adequate and effective framework of risk management, governance and internal control. Ms Jones reported that as RWT Audit Committee had met only a few days earlier to the Board no formal written report had been made available for this meeting. She advised that the agenda had been similar to Walsall's, with a slightly different set of internal audit findings, but the overall position had been positive and had provided the Committee with the assurance required. She confirmed that RWT had received a clean year-end position from Internal Audit and Counter Fraud, no issues raised at that stage by the External Auditors and that full opportunity to review the year-end accounts, the draft Annual Report, and the associated accounting policies and treatments. Ms Jones emphasised that, given the challenging financial year, receiving positive opinions across all areas provided strong assurance regarding the robustness of internal controls. She described it as a busy and important meeting and confirmed that there were no matters requiring escalation to the public Board. **Resolved: that the RWT & WHT Audit Committee Chair Reports be received for information and assurance**
185/26	**RWT & WHT Charitable Funds Committee Chair Reports (verbal update)**
	Prof Levermore provided a verbal update on both RWT and WHT Charitable Funds Committees. He noted that the wider global and economic context continued to create uncertainty, which in turn affected the ability of the Charities to maintain fundraising levels, particularly as local communities were also experiencing the impact of the cost-of-living crisis. He said both Charities were performing reasonably well, and any issues were being monitored closely. He reported that the Charities were seeing an increasing number of outstanding action points, largely because the governance arrangements for both organisations required strengthening. He emphasised that establishing clear governance was essential before the Charities could finalise a coherent charity strategy and an updated fundraising plan. He suggested that if internal capacity remained limited, the Corporate Trustees might need to consider commissioning external support to review governance and help accelerate progress. He also noted that a number of charity events and activities were planned, and he encouraged both Non-Executive and Executive Directors to support these where possible. Ms Chadwick-Bell referred to the paper included in the meeting pack, which covered the Charitable Trust Deeds and the fundraising strategy, and suggested that the Corporate Trustees should hold a separate meeting outside the Board to review the detail. She noted that whilst good work was taking place, the Charities were not yet as aspirational as they could be, and a dedicated session would allow Trustees to clarify the future direction, expectations and priorities for both Charities.

	Ms Chadwick-Bell noted that the discussion highlighted the need for two separate conversations: one within the Board meeting and one within the Corporate Trustee forum. She observed that the Charities had been operating without fully aligned governance arrangements for some time, and that this pre-dated his tenure. She emphasised the importance of taking dedicated time to clarify the strategy for each Charity, the governance framework and responsibilities, the Standing Financial Instructions (SFIs) relevant to charitable funds and the ambition for both Charities over the short and long term Ms Chadwick-Bell stressed that without clarity on ambition, it would not be possible to develop a meaningful or effective fundraising strategy. Prof Levermore agreed, noting that the strategy must be set by the Corporate Trustees, not by operational teams. He commented that staff were waiting for Trustees to articulate a clear, curated direction for the future of both Charities and highlighted that the current fundraising strategy was approximately 18 months out of date, and therefore no longer fit for purpose. Sir David said Trust Board meetings were typically followed by a separate Corporate Trustee meeting, ensuring that governance was not duplicated but remained distinct and suggested adopting a similar approach. He asked that arrangements be made to establish a separate Corporate Trustee session, potentially aligned with the upcoming Board Development Session, to allow Trustees to consider governance, ambition and strategy in depth. **Action: A separate Corporate Trustee meeting be arranged to consider the governance, strategy and future development of the Charities in more depth** **Resolved: that RWT & WHT Charitable Funds Committee Chair verbal update be received for information and assurance**
186/25	**Delegation of Partner Trusts to the Joint Provider Committee (JPC) for the agreed 2026/27 BCPC priorities**
	Mr Evans reminded the Board that, as a sovereign Board, it was required to review annually the delegation of authority to the Joint Provider Committee (JPC). He clarified that the JPC had been established on behalf of the four provider organisations in the Black Country to oversee the work plan of the Black Country Provider Collaborative. Mr Evans noted that the work plan, set out in the accompanying paper, covered both the Clinical Service Transformation Programme and the Corporate Service Transformation Programme, with detail provided on the specific areas of work included within each. He confirmed that from the Trust's perspective, the Chair, Deputy Chair, and Chief Executive sat on the JPC and therefore held delegated authority to make decisions on behalf of the Board solely in relation to the items listed within the work plan. He noted that this was the third annual review of the delegation arrangements. Mr Assinder commented that the JPC continued to function effectively and that, although the scope of the collaborative was expected to reduce in future, the governance arrangements were well-established and reliable. He confirmed that he was content for the Board to approve the delegation. The Board approved the delegation of authority to the Joint Provider Committee for the forthcoming year. **Resolved: that the Delegation of Partner Trusts to the Joint Provider Committee (JPC) for the agreed 2026/27 BCPC priorities be received for approval**
187/26	**Questions Received from the Public**
	Sir David reminded the Board that this was a meeting held in public, rather than a public meeting, but that a dedicated slot had been identified for questions submitted by members of the public. He noted that written questions were encouraged, both to support those unable to attend in person and to ensure that accurate information could be provided in response. He advised that seven questions had been received from Dr Tinsa, a regular attendee at Board meetings. He confirmed that he would read each question and provide a brief response to each during the meeting, with full written responses to be included in the minutes and emailed separately to Dr Tinsa. The first question asked why, for the first time in two years and five months, the individual had been addressed as a "member of the public" rather than as "Dr Tinsa." *Sir David acknowledged that this had been an error and confirmed that the minutes would be amended accordingly.* The second question asked why the Chair selected which questions were put to the Board. *Sir David responded that, the substantive point was that the Chair was responsible for ensuring that the meeting remained focused on the Board's business while still enabling appropriate public engagement. He explained that questions were therefore managed to ensure relevance, fairness and the effective use of meeting time.*

	Sir David explained that the Board could not allocate unlimited time within a public meeting to address every question in detail, as this would risk overtaking the agenda and detracting from the Board's statutory business. He confirmed that the Board was always willing to provide full written responses, but that during the meeting the Chair had to exercise judgement about which questions were taken verbally. He added that he had previously discussed this approach directly with Dr Tinsa. The next question asked why members of the public were not permitted to put their questions directly to the Board, rather than the Chair reading them out. *Sir David responded that members of the public were always welcome to ask their own questions, but that the expectation was that they would ask the question they had submitted, rather than additional or unrelated questions. He confirmed that this was a procedural matter and that the Board would continue to communicate with Dr Tinsa to ensure clarity.* Sir David noted that the next set of questions from Dr Tinsa related to the CQC's recent inspection of Emergency Care noting that they referred to the CQC's report of 26 March, which had rated Emergency Services as Inadequate, and had rated the Trust overall as Requires Improvement. The question asked why this contrasted with the positive narrative in the Board papers for the meeting scheduled for 19 May, and whether the Board should be "honest and truthful" about the current position. 1. Why the Board papers appeared positive when the CQC had rated Emergency Services as Inadequate in the safety domain and the Trust overall as Requires Improvement. 2. What steps the Trust had taken to rectify the issues identified. 3. Whether any sanctions had been imposed on the Trust as a result. Dr McKaig confirmed that the CQC had rated Emergency Services as Requires Improvement overall, with an Inadequate rating in the safety domain. He clarified that no sanctions had been imposed on the Trust. However, there was a clear requirement and expectation from both the CQC and NHS England that the Trust deliver improvements. He reported that a detailed action plan had been developed and was being reviewed by both NHS England and the ICB. Progress against the plan was monitored monthly through the GQC, bi-weekly through Executive and Divisional meetings and through an unannounced internal review undertaken by the Chief Nurse, Chief Operating Officer, Chief Medical Officer, Non-Executive Directors and Pharmacy colleagues. He noted that while there had been significant improvements in several metrics, challenges remained, including, cultural issues within parts of the service, recruitment difficulties in key clinical roles, the need to embed new pathways and practices and ongoing work to strengthen leadership, culture and governance within the department. Dr McKaig confirmed that the Trust had brought in external organisational development support to assist with leadership and cultural development within the Emergency Department. He emphasised that this was a wide-ranging programme of work, externally scrutinised, and being implemented with regular reporting to GCQ. Sir David added that the Board had not, at any stage, sought to "sugarcoat" the issues within the Emergency Department. He reiterated that the Executive Team remained fully focused on delivering the required improvements and that the Board continued to oversee progress closely. The following questions and answers would also be emailed to Dr Tinsa: Question 1. Why, for the first time in 2 years and 5 months, I am being addressed as a member of the public rather than Dr Tinsa? *Answer . The minutes of the meeting will be amended to reflect that the questions were raised by Dr Tinsa, a member of the public.* Question 2. Why does the Chairman choose the question that is put to the Board? *Answer . In Trust Board meetings held "in public", it is common to limit each member of the public to one question. This isn't a legal rule, but a local policy decision we have taken based on practical governance principles. Trust Board meetings (even when "in public") are not primarily public Q&A sessions, they are to conduct formal governance in a structured way and the Chair decides how to keep order. Public attendance is about transparency, not turning the meeting into an open forum.*

	Question 3. Why isn't a member of the public allowed to put the question to the Board himself/herself rather than the Chairman deciding that he would do it? *Answer 3. A member of the public may put a question to the Board themselves, or the Chair may decide to read if to the board himself, there is no rule, it is a matter for the chair to decide in maintaining order in managing the conduct of the meeting.* Question 4. On 27 March 2026, CQC released a report in which it found the emergency services to be INADEQUATE. The overall assessment was that RWT required improvement. This is in stark contrast to the narrative given by the Agenda of the Board Meeting that is due to take place on 19 May 2026. Instead of saying how well RWT are doing, shouldn't the Board be honest and truthful to the state of RWT at the moment? *Answer 4. The board papers present an honest and truthful account which balances the CQC findings (which are openly available in the public domain) with improvement narrative to demonstrate actions taken since inspection, recovery plans and areas of progress. This can sound positive because it is about improvement whilst acknowledging that "We recognise the problem" and "We are fixing it". It is important to maintain staff morale, demonstrate confidence to stakeholders and emphasise achievements alongside problems. The CQC inspection reflects past conditions (e.g. November 2025) we are now in May 2026 so the board papers emphasise changes since the inspection.* Question 5. Why is the Chief Executive's Report authored by her ex-personal assistant Gale Nightingale? It is unclear who visited the various wards and RWT sites. Was it Joe Chadwick-Bell or Gale Nightingale? Why didn't Joe Chadwick-Bell make her usual report rather than sponsoring it, or rather delegating it to lower managers? *Answer 5. It is common and normal in NHS Trusts for the Chief Executive's Report to be drafted by a senior member of staff then reviewed, edited, and approved ("signed off") by the Chief Executive. Accountability still sits fully with the Chief Executive (Joe Chadwick Bell) who is responsible for accuracy, tone, completeness, and honesty of the report. The report clearly states "I visited" which means the CEO visited because it is the CEO's Report.* Question 6. What steps have RWT taken to rectify the INADEQUATE emergency department? *Answer 6. The ED department at RWT has not been rated 'Inadequate', it has been rated 'requires improvement'. The Trust responded immediately to feedback from CQC Inspectors during the visit and some improvement actions were taken. We continue to address issues raised as we recognise this is not the service we wish to provide for our patients or communities. Immediate actions included waiting room oversight by clinically trained staff, timeliness of access to and triage itself, first assessments, review pathways for example see and treat, chest pain, effective use of audit data to enhance quality improvement, use of national benchmark data to focus areas for further improvement, these are not exhaustive. Progress is reviewed by Senior Executives weekly and evidenced through updates monthly via the Trusts Quality Committee. The Trust has evidenced improvements in triage, first assessments and ECG times. Additional trained clinical support staff have been based in the waiting areas of both ED and SDEC. The Trust sought a subsequent review by the National 'Getting Right First Time – GIRFT' team, which took place shortly after the CQC visit to advise regards any pathway amends. The Trust has piloted and continued to operate a Medical SDEC which has had a positive impact on waiting times and flow through both the ED and SDEC areas.* *The staff continue to work extremely hard in sometimes very challenged circumstances, however the departments and the Trust collectively is committed to providing safe quality care to patients accessing the department, the responsiveness of the Senior Leads was noted by the CQC Inspection team both at the time of and following the visit.* Question 7. Have any sanctions been imposed on RWT for the INADEQUATE emergency services? *Answer 7. No enforcement action has been taken against the Trust in relation to the inspection in November 2025 at the date of the meeting.*
188/26	**Any Other Business**
	There was no other business raised
189/26	**Date and Time of Next Meeting – Tuesday 21 July 2026 at MLCC Walsall NHS Trust**
	Sir David confirmed the date and time of the next meeting as Tuesday 21 July 2026

Enclosure 4.1

13 July 2026 11:57

List of action items

Agenda item		Assigned to	Deadline	Status
RWT/WHT Group Board of Directors Meeting - to be held in Public 19/05/2026 12.3 RWT & WHT Charitable Funds Committee Chair Reports (RWT Report will be a verbal update)				
3707.	Corporate Trustee meeting	Chadwick-Bell , Joe	21/07/2026	Pending
	Explanation action item A separate Corporate Trustee meeting be arranged to consider the governance, strategy and future development of the Charities in more depth			
RWT/WHT Group Board of Directors Meeting - to be held in Public 19/05/2026 11.2 Integrated Performance Report - Walsall Healthcare NHS Trust (WHT) - including RWT/WHT Group Report on Community Waits				
3706.	trajectory for mental health treatment and access	Din, Zia Dr	07/07/2026	Completed
	Explanation action item Dr Din reported that a meeting had taken place between WHT, Black Country Healthcare Mental Health Trust, the Chief Medical Lead, and mental health leads. He advised the new Getting it Right First Time (GIRFT) Mental Health in Urgent and Emergency Care Standards had been launched nationally in April. He said key points included the Trust and partners undertaking a self assessment against the new standards. He said this work would be taken through both the hospital group and the mental health interface group, where requirements and gaps would be reviewed. He advised that whilst the issue remained a national challenge, the new guidance provided a clearer framework for improvement. Dr Din explained that following the self assessment the Trust would have a clear understanding of gaps and actions required. He advised an operational plan and trajectory for improvement would then be developed and brought back to the Board. Sir David requested that an update and trajectory be presented at the next Board meeting Update: An update on mental health services at RWT and WHT to be presented at the July board meeting, noting that the submission of the self-assessments are not due until later in the year.			

Tier 1 - Paper ref:	Enclosure 6

Report title:	Group Chief Executive's Report
Sponsoring executive:	Joe Chadwick-Bell, Group Chief Executive
Report author:	Gayle Nightingale, Business Manager to the Group Chief Executive
Meeting title:	Group Trust Board
Date:	21 July 2026

1. Summary of key issue

Since the last board there have been a number of key events and publications, we have a new Secretary of State for Health, who has committed to maintaining the current NHS priorities. Alongside the reports from Donna Ockenden into Maternity Care at Nottingham and Baroness Valerie Amos and independent investigation into NHS maternity and neonatal services, and the settling of the resident doctors' dispute, there have also been a number of key policies/guidance shared.

- National maternity triage specification
- Preventing unlawful access to patient records
- Model discharge pathway
- Minimum standards of patient experience - elective care

Maternity and Neonatal Care

I would like to begin by reflecting on the Ockendon and Amos reports into maternity and neonatal care, which highlighted the devastating impact of failures in care. While data is important, it cannot alone provide true reassurance about the safety and suitability of our services; it is essential that we actively listen to the experiences of both patients and staff if we are to fully understand and improve the care we provide. Although these actions were prompted by concerns in maternity and neonatal care, we believe that this compassionate approach should extend to all services. Much of the leaning is focused on culture, compassion, consideration of all information sources in particular 'hearing' the patient voice as well as those of staff members.

It is vital that each of us plays a part in fostering open communication and raising concerns, not only in our own service areas but wherever we notice issues. By working together and supporting one another, we can help ensure that every patient receives the care, dignity and respect they deserve.

We are reviewing how we hear from patients and staff in such a way, although themes and trends are important, equally so is hearing actual and individual voices.

Key actions include:

- Maternity and neonatal (10-point plan)
- Dual board accountability (CMO and CNO)
- Real time transparent experience and audit data acted on at board level
- 24/7 safe staffing and assurance on home births
- Safe triage and Martha's rule rolled out everywhere
- Review of mortuary care and processes (see separate report)

Preventing unlawful access to patient records – NHS England national guidance

Patients expect their information to be kept secure, so recent reports of staff accessing records without authorisation are deeply concerning. Unlawful access is not harmless curiosity—it

undermines trust, causes harm, and is illegal. NHS England has issued new guidance and launched a campaign to reinforce the message that patient data must be protected, and those who misuse it face serious consequences. The Trust Board has been strongly encouraged to provide staff education and to take decisive action in the event of non-compliance with these principles. I wish to assure the Board that Dr Brian McKaig, Group Chief Medical Officer and Caldicott Guardian, has communicated clear expectations to all staff. Furthermore, we will be undertaking a comprehensive review of training provision, ensuring that the most effective combination of online and face-to-face training is implemented.

National Focus

As we move forward, we need to focus on quality (safety, outcomes and experience) as we build and deliver services around the needs of patients. The national quality strategy will be released shortly by NHSE.

As a group, we have developed our strategy, Transforming Care Together (TCT) but we will also look to how we operate, what conversations and assurance is sought to ensure we focus on quality, access and finance in year, but that we also develop a system built to last with self-sustaining improvement, strong leadership and culture which is ready for the next phase of the NHS. We need to ensure that we are re-setting the bar and have moved beyond 'recovery'.

National priorities for which we are focused include setting out what good looks like for patients:

- Urgent and Emergency Care (UEC) – scheduling and creating space for sickest patients
- Outpatient (OP) reform – putting patients in control of their own appointment as we move away from the follow-up culture
    - Rapid deployment of Single Point of Access (SPOA) and Advice and Guidance (A&G) by default
    - Facing the follow-up opportunity, put patients in control
    - Active commissioning to manage demand
    - Digital solutions to help patients take control
- Neighbourhoods visible in places – more care closer to home without a trip to hospital, this should be addressing urgent care and electives, local focus on specific patient cohorts, joined up proactive care and must include all health partners
- Implementing the 'model urgent and emergency care':
    - Single digital-first front door
    - Senior decision making earlier
    - Better discharge and on-ward care (model discharge to be issued shortly)
    - Less unwarranted follow-up
    - Active commissioning and board owned and driven deployment of Model Emergency Department (ED) and Model discharge

As a group we have a strong set of services as recognised by NHSE, but as we move forwards, we need to ensure our group operating model supports the future of the NHSE, building strong leaders and strengthening clinical leadership.

Financial Change

NHSE is reviewing its approach to productivity and is aligning plans to 5 key pillars, as such our medium term financial plan (years 2 and 3) will be shaped with a business as usual efficiency requirement alongside more major schemes, aligned with Transforming Care Together (TCT) as

financial sustainability will require transformation and more creative thinking about how we use the resources we do have. Essentially, we need to live within our means.

- operational
- workforce
- left shift
- technology
- reducing wate

In order to support transformation, it is recognised that the financial framework (incl deconstructing the block in community and mental health) will need to change and the aim at this stage is for this to be reflected in contracts for next year's contracts:

- this is a moment for board led transformation not incremental change
- deliver the plans we have signed off
- relentless focus on quality and productivity

EPRR exercise

I would like to formally acknowledge the Emergency Planning exercise held at Walsall Manor Hospital on 24 June 2026. This event involved The Royal Wolverhampton NHS Trust, West Midlands Ambulance Service (WMAS), and partners from the local region. The exercise provided a valuable opportunity to test our collective response to a simulated emergency scenario. Exercises such as this are essential for improving our preparedness for catastrophic incidents. I wish to thank everyone for their hard work and support in making this exercise a success. Highlights of the event are available at: https://youtu.be/FUUoEFb5X30

Heat wave

The impact of the extreme heat has posed significant challenges throughout the NHS system. It is clear that, as in many other sectors, much of the NHS's infrastructure was not designed for such demanding conditions. I want to sincerely thank and acknowledge everyone for their extraordinary efforts, especially the estate teams, who worked tirelessly to find ways of mitigating these testing circumstances. Your dedication and hard work in coping with the heat have been truly remarkable, I am deeply grateful for everything you have done.

NHS Oversight Framework – Q4 2025/26 segmentation summary

NHS England has published the segmentation and league table data for the fourth quarter of the 2025/26 financial year, providing a comprehensive overview of organisational performance across the service. This dataset, which marks the conclusion of the 2025/26 NHS Oversight Framework, includes detailed segmentation outcomes and comparative league positions for all NHS trusts and integrated care systems, including the latest information for The Royal Wolverhampton Trust (RWT) and Walsall Healthcare Trust (WHT) – see below.

It is important to note that this release represents the final quarterly reporting cycle under the current framework. Looking ahead, from the 2026/27 financial year onwards, the NHS will, for the first time, benefit from the availability of consecutive annual data. This development will enable more robust and nuanced analysis of performance trends and variations over time, thereby supporting improved benchmarking, strategic planning, and targeted intervention as the dataset matures and expands.

The Royal Wolverhampton NHS Trust		
Average Metric Score	Segment	League table position (*out of 134*)
2.47	**3**	**90**

Walsall Healthcare NHS Trust		
Average Metric Score	Segment	League table position (*out of 134*)
2.21	**3**	**58**

Industrial action – resident doctors

The resident doctors have now settled their dispute with a new pay offer, however we need to play our part in delivering some of the agreements, specifically through the 10-point plan.

These discussions resulted in a mutually agreeable settlement that includes tangible improvements such as enhanced opportunities for career progression and meaningful advancements in the training experience for resident doctors. This agreement marks a significant step forward in addressing the concerns raised by medical staff and demonstrates a commitment to supporting their professional development.

I would like to extend my heartfelt thanks to all staff members for your dedication and resilience throughout this period. Your meticulous efforts in preparing for the potential industrial action, as well as your swift and effective work in reinstating nearly all patient appointments once the action was suspended, ensured continuity of care and minimised disruption for our patients. The workload involved was substantial, and your professionalism and teamwork were greatly appreciated. Thank you for your continued commitment to excellence in patient care and for supporting each other during this challenging time.

Nursing Times Awards - RWT

I am pleased to announce that the 'Bathroom First' initiative has been shortlisted for a prestigious Nursing Times award. This recognition highlights the project's commitment to enhancing patient care by prioritising dignity, independence, and comfort during hospital stays. The primary objective of 'Bathroom First' is to encourage patients to use bathroom facilities as their first option, promoting mobility and reducing the risk of complications associated with prolonged bed rest.

The initiative has made a significant difference to patient wellbeing, fostering a culture where staff actively support patient autonomy and recovery. By focusing on practical, patient-centred solutions, 'Bathroom First' has contributed to measurable improvements in both care quality and overall patient experience.

This achievement would not have been possible without the dedication and teamwork of our staff, whose passion and professionalism have driven the project's success. Congratulations to everyone involved in making 'Bathroom First' a beacon of innovation in our healthcare and wishing you good luck!

Staff long service awards

On 2 July 2026, I had the honour of recognising and celebrating the commitment, loyalty and contribution of colleagues who have dedicated many years of service to the organisation. Long Service Awards provide an opportunity to acknowledge the experience, knowledge and continuity that staff bring, while reinforcing a culture of appreciation and belonging. Recognising service milestones not only demonstrates gratitude for individual contributions but also helps to strengthen staff engagement, retention and morale across the workforce. In an NHS environment, where colleagues consistently go above and beyond to deliver high-quality care and support services. Long Service Awards highlight the vital role that sustained commitment plays in achieving organisational success and delivering the best possible outcomes for patients and communities. This aligns with wider staff recognition initiatives that emphasise the importance of celebrating and valuing our people.

Site visits across Walsall and Wolverhampton

Throughout May and June, I undertook some sites visits across both WHT and RWT. One particular highlight was joining the community paediatric team at the Gem Centre. The building itself is truly state-of-the-art, thoughtfully designed to cater to the needs of our younger patients. I was deeply impressed by the high standard of care and the unwavering dedication of the staff, who go above and beyond to provide exceptional service. I am genuinely grateful to all the team members for generously sharing their time and insights with me during my visit; their commitment and passion were evident at every turn.

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

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

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

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

Tier 1 - Paper ref:	Enclosure 6.1

Report title:	Mortuary Board Assurance Statement
Sponsoring executive:	Lisa Carroll Chief Nursing Officer
Report author:	Christian Ward Deputy CNO and Designated Individual HTA
Meeting title:	Trust Board in Public
Date:	21 July 2026

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

The Ockenden Report into maternity services at Nottingham University Hospitals Trust was published on 24 June 2026 and the Baroness Amos report was published on 30 June 2026.

The Ockenden report details concerns regarding post-death care, and these findings should be considered alongside the findings of the Independent Inquiry into the crimes committed by David Fuller, published in July 2025. On the 26 June all Trusts were written to by NHSE outlining key actions they are required to take in response.

The letter reminds boards of the following:
Every Board member and senior leader involved in the care of the deceased should ask themselves if this could be happening in their organisation.

Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are required to complete and return a Board Assurance Statement by 31 July 2026.

The board assurance statement has been completed by the Groups Designated Individual and provides assurance that the Group is compliant with the 5 assurance statements in the document. The assurance statement details the evidence available to support compliance and an action tracker to support continued improvement and assurance.

In October 2025 the Group was inspected by the Human Tissue Authority, the comprehensive 72-point inspection provided external assurance that there are substantive controls in place across Walsall Manor Hospital, New Cross Hospital and Goscote Hospice Body Store to support the dignity, security, traceability and safe care of deceased people. This includes controlled access, authorised access lists, CCTV at the acute mortuary sites, supervised family viewings, trained mortuary/portering staff, SOPs and incident reporting arrangements.

The inspection and local assurance process identified no serious concerns and several residual actions which are strengthening actions. A time limited action plan is in place to address the

residual actions identified. Currently there are 3 open Corrective and Preventative Actions. These relate to Mortuary security access and CCTV (RWT), Maternity Fridge (RWT) remote temperature monitoring and Postmortem Table servicing (WHT).

One maternity specific targeted action relating to maternity pathways at WHT remains open following HTARIs involving deceased babies/fetal remains not being placed into mortuary facilities in a timely manner, and a breakdown in the pathway. A SOP has been developed and implemented and a training video based on good practice from RWT has been disseminated to all maternity staff to address this. Compliance will be audited and reported through the HTA Governance meeting and Assurance report.

In addition to the assurance statement all Trusts are required to complete a Premises Assurance Model statement regarding facilities for mortuary services by 8 September 2026. This is currently being progressed by the Estates team.

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

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*
The assurance statement has been reviewed and discussed at GMC on 8 July 2026

4. Recommendation(s)/Action(s)
a) The Trust Board is asked to support submission of the assurance statement by the 31st July 2026
b) The Trust Board is asked to delegate approval of the Premises Assurance Model statement to the Chief Executive as submission is required prior to the next Trust Board meeting

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

TASK59437 Board Assurance Statement for NHS Provider Trusts

Trust Name	Trust CEO/AO name	Date	Trust Chair Name	Date
The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust Group (covering New Cross Hospital, Walsall Manor Hospital and Goscote Hospice body store)	Joe Chadwick-Bell, Group Chief Executive	03-Jul-26	Sir David Nicholson KCB CBE, Group Chair	06-Jul-26

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	• Assurance position: Yes, with qualifications. There is a defined Group governance structure for mortuary care and related storage areas. • Accountable roles and governance route. The Designated Individual (DI) provides HTA licence oversight for Walsall Manor Hospital licence 12102 and the New Cross Hospital satellite. The Corporate Licence Holder / Chief Executive provides senior corporate accountability. Operational responsibility sits with Mortuary, Pathology, Bereavement, Portering, Estates, Security, Safeguarding, Maternity, and Emergency Department, and is supported by Governance leads, with escalation through the HTA Governance Process, QSOG, Quality Committee and Board. There are a number of Persons Designated (PDs) for this licence given the complexity of the licencable activities, including PDs, for Mortuary, Pathology, Bereavement (incorporating Consent and Post-Mortem), Portering, Maternity, and Emergency Departments. • Site-specific scope. Walsall Manor Hospital is the licenced hub. New Cross Hospital is a satellite licenced area. Goscote Hospice is outside the HTA licence but is included in Group assurance because deceased people are cared for there in the short term and should be subject to HTA equivalent dignity, identification, storage, transfer, access and escalation controls. • Safeguarding interface after publication of the 2026 SAAF. Following publication of NHS England's Safeguarding children, young people and adults at risk in the NHS: Safeguarding accountability and assurance framework, fifth edition (2026), which expressly references dignity of the deceased, the Safeguarding Team recognising this wider assurance interface, has met to adjust relevant policies, SOPs and training. Local policy review describes dignity and safeguarding related assurance across the life course, including pregnancy loss and fetal remains where applicable, babies, children and young people, adults and older people. • Testing arrangements: The Quarterly HTA Governance Meeting is utilised to bring together PDs and the DI to confirm roles, discuss incidents, HTARIs, HTA updates and note policy changes. The annual HTA pathway walk through by the Corporate Licence Holder / Chief Executive supplement the current checks to test whether roles are understood at the point of care, including identity checks, release, transfer, viewing, out of hours access, escalation, incident reporting, HTARI screening, safeguarding interface, estates/security controls and documentation. • Current evidence to retain. Evidence includes attendance, route testing, observations, actions, photographs (if appropriate), an action log, minutes of the HTA Governance and Safeguarding Team meeting, updated policy/SOP versions, training records, access, incident trend reports, and the annual walk through. • Qualification and residual action. Before assurance can be described as unqualified, the Group needs to finalise a single RACI/pathway map covering Walsall Manor, New Cross and Goscote; confirm named Person Designate and out of hours escalation; document the safeguarding interface; further evidence testing of release/viewing/access scenarios; and show that actions from walk throughs and audits are closed or risk assessed. However, it is noted that the Group is in receipt of full 72 standard inspection and subsequent CAPA plan, of which, at the time of writing the assurance statement has only 3 outstanding actions to close. All policies and SOPs were either accepted at the time of inspection as compliant or have been accepted as compliant following amendment since the October 2025 inspection.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	• Assurance position: Yes, with qualifications. Board-level review has taken place and this return provides infromation realting to the latest HTA and Fuller Inquiry assurance report that has been discussed at Group Quality Committee The Board should continue to receive evidence-based updates until all residual Fuller and HTA actions are fully closed. • Mapping against the 29 Fuller recommendations. The Group has reviewed the recommendations immediately relevant to NHS providers and has considered mortuary governance, CCTV and access, swipe card control, release and viewing arrangements, mortuary manager/DI oversight, safeguarding after death, temporary facilities, Board reporting and estates assurance. • Latest Board assurance incorporated. This board assurance statment reflects the recommendations, outputs and assurance position from the latest HTA and Fuller Inquiry Recommendation Assurance Report. This includes the overall assurance position, targeted WHT maternity actions, New Cross actions linked to estates completion and the inclusion of Goscote in Group assurance. • External regulatory assurance. The October 2025 HTA inspection provides important external assurance because it confirmed the DI and Licence Holder as suitable and the establishment as suitable to be licenced, subject to corrective and preventative actions. That is positive assurance. • Known residual shortfalls. The inspection and local assurance work identified areas requiring action across governance/SOPs, staff training and competency, risk assessment, traceability, tissue disposal, premises, security, access control, CCTV and environmental controls. These must remain visible to Board until evidence of closure is available. Currently there are 3 remaining CAPA actions to close. Remaining standard shortfalls are Mortuary security access and CCTV (RWT), Maternity Fridge (RWT) remote temperature monitoring and Post Mortem Table servicing (WHT). • Site-specific assurance. Walsall Manor Hospital provides the licenced hub assurance base. New Cross Hospital remains rated as qualified assurance until estates and security related standard breaches are completed and verified. Goscote remains within Group assurance as a related body store environment, even though it is outside the HTA licence. • Incident intelligence. Incidents reported on the Trust Incident Management System Datix within licenced areas of activity are sent to the DI for oversight, allowing earlier review of HTARI reportability, repeated themes, local learning, safeguarding interface, estates/security implications and escalation requirements. • Qualification and residual action. The Board will not rely on narrative assurance alone. A time-limited action plan is in place to show each Fuller and HTA action, owner, due date, evidence required, current status, overdue items, risk rating, committee route and closure approval. Actions will only be closed when supporting evidence is attached or clearly referenced. This is included in the HTA and Fuller Inquiry Recommendation Assurance Report presented to Group Quality Committee June 2026.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	• Assurance position: Yes, with qualifications. Executive leadership has been reviewed in light of the 2026 NHS England Safeguarding Accountability and Assurance Framework, but sustained evidence is rneeded to demonstrate that this is embedded in policy, training, incident review, and Board reporting. • Safeguarding framework change. The fifth edition of the SAAF, updated in 2026, expressly addresses the upholding of the dignity of the deceased. Locally, this is being treated as a new, explicit assurance interface among safeguarding, care after death, mortuary governance, bereavement, maternity, paediatrics, adult services, estates/security, and corporate incident governance. The Safeguarding Team has met to review the new framework position and adjust relevant safeguarding policies and SOPs to incorporate the deceased. The review has included escalation of concerns, interface with child death review and adult safeguarding processes, police/coroner routes, family concerns, professional curiosity, documentation and post incident learning, and is sighted on the Fuller Inquiry findings and the Ockendon review. • Whole life-course approach. Post-Mortem Policies and SOPs use inclusive life-course wording, covering pregnancy loss and fetal remains where applicable, babies, children and young people, adults and older people. This supports consistency across maternity, paediatrics, adult inpatient areas, emergency care, community/hospice pathways and mortuary services. • Executive oversight. The Chief Nursing Office, DI, the Corporate Licence Holder/Chief Executive and safeguarding leads have a shared route for assurance regarding deceased person dignity, particularly where concerns arise about care before death, treatment after death, identity, viewing, release, access, security, or communication with families. • Incident Reporting and learning route. Incidents reported on the Trusts Incident Management System Datix within licenced areas of activity are sent to the DI for oversight. This strengthens the ability to triangulate safeguarding concerns, HTARI considerations, complaints, estates/security issues, SOP breaches, training needs and recurring themes. Learning is shared with discussion of HTARIs and near misses amongst PDs at the quarterly HTA Governance Meeting. • Qualification and residual action. Before the Board can take unqualified assurance, updated safeguarding policy/SOP wording need be approved through the Groups govenance process and where necessary, staff guidance needs to be communicated and training references updated. Annual safeguarding reporting will include the deceased person dignity interface and a sample of relevant incidents should demonstrate that the DI/safeguarding interface is working.
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	• Assurance position: Yes, with qualifications. A Group oversight plan exists for mortuaries and related areas where deceased people are cared for, but the strength of that assurance depends on completing evidence, triangulating incidents/audits, and confirming the closure of estates and governance actions in relation to both normal evolution and regulatory inspection. • Governance framework. Oversight is provided through the HTA Governance Meeting, chaired by the DI, with escalation to QSOG, the Group Quality Committee, and the Board. The framework includes HTARI reporting, Datix incident review, SOP review, training compliance, access/CCTV audit, estates/security actions, tissue audit actions and Board assurance reporting. • Coverage of areas where deceased people are cared for. The plan covers Walsall Manor Hospital as the licenced hub. New Cross as a satellite licenced area and Goscote Hospice as a related body-store are. Goscote will remain visible in Group assurance even though it is not part of the HTA licence, because dignity, identification, storage, access, transfer and escalation risks still apply. • External inspection assurance. Assurance can be taken from the October 2025 HTA inspection because it confirmed the suitability of the DI, Licence Holder and establishment, subject to corrective and preventative actions. This supports the overall Board assurance position and confirms that some standards require improvement (this is an unremarkable (pragmatically) regulatory position). • Incident oversight and escalation. Licenced area incident reports are now routed to the DI. This allows the DI to screen for HTARI reportability, check whether immediate escalation is required, identify themes, request evidence of local learning and ensure relevant issues are reported through the HTA Governance and Quality Committee. • Information and performance pack. A defensible oversight plan includes a routine dashboard covering HTARI/reported incidents, complaints and family concerns, access/CCTV audits, temperature monitoring, training and competency, tissue traceability/disposal audits, estates actions, policy review status, overdue actions and Goscote assurance. This information is included in the quarterly report to the Group Quality Committee. • Specific residual risks. Residual risks include pending completion of New Cross estates/security works, equipment servicing, and temperature monitoring reliability in Maternity to ensure the closure of HTA CAPA actions from the October 2025 inspection. • Qualification and residual action. The Board can take qualified assurance that a plan is in place. To move towards unqualified assurance, the Group maintains a single evidence log that confirms all action owners and due dates, reviews overdue actions at each HTA Governance Meeting, documents executive risk acceptance when actions are delayed, and provides a concise exception report to the Group Quality Committee/Board.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	• PAM submission requirement. Estates and facilities leads will complete the current PAM self-assessment within the 2026 submission window, with Board sign-off before submission. The submission will explicitly address mortuary and related body-store questions introduced following the Fuller Inquiry. • Standards and references. The assessment will cross-reference HBN 16-01, HTA inspection findings, Fuller recommendations, local risk assessments, fire/security requirements, infection prevention and control requirements, contingency storage arrangements and local business continuity plans. • Site-specific estates scope. Walsall Manor Hospital, New Cross Hospital and Goscote Hospice will all be reflected in the estates assurance position. • Interim risk management. Until works are completed and verified, the residual risk will remain visible through the risk register or action tracker, with mitigation and controls where necessary. • Qualification and residual action. The Board can take qualified assurance that there is a plan and an agreed route to complete PAM and current estate governance.

Evidence area	How it supports the assurance statement	Source URL
NHS England Board Assurance Statement request	Confirms the purpose of the Board Assurance Statement, scope of mortuaries/related storage areas and return deadline of 31 July 2026.	https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/
NHS England Annex 1 and Annex 2	Maps Fuller recommendations to PAM, HBN 16-01, Insightful Provider Board guidance, safeguarding, HTA and Hospice UK guidance.	https://www.england.nhs.uk/long-read/nottingham-maternity-review-findings-on-post-death-care-and-key-actions-required-following-the-fuller-inquiry/
Government interim update on Fuller Phase 2	Sets out NHS-facing recommendations on CCTV, access audit, swipe cards, mortuary manager/DI roles, Board reporting, safeguarding after death and temporary facilities.	https://www.gov.uk/government/publications/fuller-inquiry-government-interim-update-on-phase-2-recommendations/interim-update-on-government-progress-in-responding-to-the-fuller-inquiry-phase-2-report
Fuller Inquiry Phase 2 report	Primary report for recommendations on mortuary assurance, monthly/annual reporting, security audits and senior oversight.	https://assets.publishing.service.gov.uk/media/688258b96a7ea0e1ce1d3653/fuller-inquiry-phase-2-report-hc-1092-web-accessible.pdf
HTA establishment page: Walsall Manor Hospital	Confirms HTA licence number 12102, licenced premises, DI, licence status and licenced activities.	https://www.hta.gov.uk/professional/establishments/walsall-manor-hospital
HTA inspection report 29 and 30 October 2025	Confirms licenced hub/satellite scope, suitability of DI/Licence Holder, establishment suitability subject to CAPA, and identified shortfalls requiring action.	https://www.hta.gov.uk/sites/default/files/2026-01/2025-10-29%2030%2012102%20Walsall%20Manor%20Hospital%20inspection%20report%20-%20FINAL.pdf
RWT/WHT Board member information	Confirms Joe Chadwick-Bell as Group Chief Executive and Sir David Nicholson as Group Chair.	https://royalwolverhampton.nhs.uk/about-our-trust/who-we-are/our-board/meet-our-board-members/
WHT public Board papers page	Confirms public access to 2026 Group/Trust Board papers including January, March and May 2026 packs.	https://www.walsallhealthcare.nhs.uk/about-us/how-we-are-run/board-papers/
RWT public Board papers page	Confirms public access to 2026 Joint Trust Board papers including January, March and May 2026 packs.	https://royalwolverhampton.nhs.uk/about-our-trust/who-we-are/our-board/
January 2026 Group Board pack	Searchable public pack referencing HTA licence inspection matters in Group Board reporting.	https://royalwolverhampton.nhs.uk/wp-content/uploads/2026/01/RWT_WHT_Group_Board_January_2026_Bundle_v2.pdf
March 2026 Group Board pack	Searchable public pack referencing WHT mortuary refurbishment project costs being brought back through committee for approval.	https://royalwolverhampton.nhs.uk/wp-content/uploads/2026/03/RWT_WHT_Group_Board_March_2026_Bundle_v2.pdf
May 2026 Group Board pack	Searchable public pack available through the Board papers pages; relevant to ongoing Board assurance context.	https://royalwolverhampton.nhs.uk/wp-content/uploads/2026/05/RWT_WHT_Meeting_Pack_for_Group_Trust_Board_in_Public_190526.pdf
Latest HTA and Fuller Inquiry Recommendation Assurance Report to Board	Workbook updated to incorporate the report's recommendations, outputs and assurance position, including substantial assurance overall, targeted Walsall maternity actions, New Cross moderate assurance pending estates completion and Goscote moderate assurance.	Internal Board/Committee assurance report
Annual HTA pathway walk-through by Corporate Licence Holder and Group Chief Executive	Supports assurance that senior executive roles, responsibilities, escalation routes and pathway controls are understood, visible and tested in practice rather than relying only on paper governance.	Internal executive walk-through / annual assurance evidence
Grouo Incident Management System, Datix, notification to DI for licenced activity incidents	Provides additional oversight and triangulation of incidents within licenced areas of activity, including HTARI consideration, theme review, learning, and escalation through HTA governance.	Datix governance process / DI oversight
RWT/New Cross Hospital mortuary estates work	Provides evidence that remaining premises, access-control, CCTV/security and related standard breaches identified at New Cross Hospital Mortuary are being addressed through estates delivery.	RWT estates work programme / HTA CAPA evidence
NHS Safeguarding Accountability and Assurance Framework, fifth edition, 2026	Confirms that the fifth edition of the NHS Safeguarding Accountability and Assurance Framework, updated in 2026, expressly references upholding the dignity of the deceased. Supports the local safeguarding policy/SOP review, life-course wording, and the clarification that deceased-person dignity is an assurance interface rather than a simple extension of all living-person statutory safeguarding duties.	https://www.england.nhs.uk/long-read/safeguarding-children-young-people-and-adults-at-risk-in-the-nhs/

Area	Action to evidence before final Board sign-off/submission	Owner / route	Suggested timeframe	Status
Roles and responsibilities	Confirm site-level role maps for Walsall Manor, New Cross and Goscote, including out-of-hours viewing, release, transfer, access, escalation and on-call arrangements.	DI with Mortuary, Pathology, Bereavement, Portering, Safeguarding, Estates and Corporate Governance leads	Before final submission	For confirmation
Fuller/HTA action plan	Ensure each HTA inspection shortfall and Fuller gap has a named owner, evidence requirement, due date and escalation route, including tissue audit closure and SOP/training evidence.	DI / HTA Governance Meeting / QSOG / Quality Committee	Monthly until closed	In progress
Safeguarding after death	Document that the Safeguarding Team has reviewed the 2026 SAAF change, agreed the whole life-course interface with deceased-person dignity after death, and updated relevant policies/SOPs, training references and escalation routes accordingly.	CNO executive leads with Safeguarding leads and DI	2026/27 reporting cycle, with interim confirmation before final Board submission where available	In progress
Security and access	Evidence access-list review, CCTV/access audit, key/lift control and visitor/contractor oversight for Walsall and New Cross; apply HTA-equivalent assurance to Goscote.	Estates/Security/Mortuary leads through HTA Governance	Before PAM submission	In progress
PAM/HBN 16-01	Complete PAM self-assessment covering all mortuary/body-store settings and cross-reference HBN 16-01, Fuller recommendations, HTA findings and local risk assessments.	Estates and Facilities with DI oversight	Board sign-off before 8 September 2026	For confirmation
Executive walk-through	Document the annual HTA pathway walk-through by the Corporate Licence Holder and Group Chief Executive, including attendees, route tested, risks observed, actions agreed and evidence retained for Board assurance.	Corporate Licence Holder / Group Chief Executive / DI	Annual cycle before next Board assurance update	In progress
Board assurance report alignment	Cross-reference this BAF return to the latest HTA and Fuller Inquiry Recommendation Assurance Report to Board and retain evidence that recommendations and residual actions have been incorporated.	DI / Corporate Governance / Quality Committee	Before final submission	Completed in workbook
Incident oversight	Maintain the process that incidents reported on Datix within licenced areas of activity are sent to the DI for oversight, HTARI screening, trend review and escalation through HTA Governance.	Patient Safety / Mortuary leads / DI	Ongoing	In place
New Cross estates remediation	Track RWT/New Cross Hospital mortuary estates works through to completion and confirm closure evidence for the remaining HTA standard breaches relating to premises, access control, CCTV/security and associated environmental controls.	RWT Estates / Mortuary leads / DI	Until works completed and verified	In progress
RACI and pathway map	Produce a single site-level RACI/pathway map covering Walsall Manor, New Cross and Goscote, including named deputies, out-of-hours escalation, release, viewing, transfer, access/security, safeguarding interface and DI escalation.	DI with site operational leads	Before final Board submission or next HTA Governance cycle	For completion
Safeguarding policy/SOP evidence	Retain Safeguarding Team minutes, approved policy/SOP amendments, staff communication, training references and at least one sample incident review showing the deceased-person dignity interface in practice.	Safeguarding leads with DI and CNO oversight	2026/27 reporting cycle	In progress
Assurance dashboard	Develop a concise routine dashboard for HTA Governance and Quality Committee covering Datix/HTARI, complaints/family concerns, access/CCTV, temperature monitoring, estates actions, training, tissue audits, overdue actions and Goscote assurance.	DI / Corporate Governance / Patient Safety	Next two governance cycles	Recommended
Post-works verification	After RWT/New Cross estates works, complete post-works validation, update risk assessments and confirm closure evidence for premises, CCTV/security, access-control and environmental-control standard breaches.	RWT Estates / Mortuary leads / DI	On completion of works	Pending works

Enclosure 6.2

Report title:	Joint WHT RWT Freedom to Speak Up Report
Sponsoring executive:	Dr Claire Radley Group Chief People, Culture and Improvement Officer
Report author:	Miss Shabina Raza (WHT) and MsGiselle Padmore-Payne (RWT) Lead Guardian.
Meeting title:	Trust Board
Date:	21 July 2026

1. Summary of key issues

The Freedom to Speak Up service remains well-established and trusted across both Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT). A total of **606 concerns were raised** during 2025/26 (359 WHT; 247 RWT), demonstrating continued staff willingness to speak up and seek support.

The service is being accessed across a broad range of staff groups and departments, suggesting strong visibility and accessibility. Staff feedback about the Guardian services is consistently positive, highlighting professionalism, support and approachability.

Leadership engagement, FTSU Champions, ward walkarounds, induction programmes and staff engagement activities continue to strengthen awareness and accessibility. Collaboration between the two Trusts is also growing, with shared training, engagement initiatives and learning.

Training compliance remains strong, particularly at RWT where FTSU training is mandatory (Speak Up 98.3%, Listen Up 95.3%, Follow Up 88%). WHT has also shown improvement, achieving 84.3% Speak Up training compliance despite the training not being mandatory.

The report identifies several issues requiring continued executive oversight:

1. Staff attitudes and behaviours remain the most significant and recurring concern across both Trusts.
2. Patient safety and quality concerns have increased in some operational areas, potentially linked to workforce pressures and service demand.
3. Continued use of anonymous reporting and non-disclosure of personal information suggests some staff may still fear repercussions from speaking up.
4. Inconsistent management responses and feedback to staff can undermine confidence in the speaking up process.
5. The transfer of FTSU oversight from the National Guardian's Office to NHS England will require strengthened governance, reporting arrangements and alignment with emerging national expectations.

The report provides strong assurance that Freedom to Speak Up is active, visible and valued across both Trusts, with high levels of staff engagement and increasingly collaborative working. However, sustained focus is required on improving organisational culture, psychological safety, management responsiveness, and addressing persistent concerns around behaviours and bullying to maintain staff confidence and support continuous improvement.

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 Joint Freedom to Speak Up Annual Report for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) has been reviewed by both Group People Committee on the 26 June 2026 and Group Management Committee on the 8 July 2026.

Enclosure 6.2

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

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

Enclosure 6.2

WHT & RWT Freedom to Speak Up (FTSU) Annual Report

1.0 Executive Summary

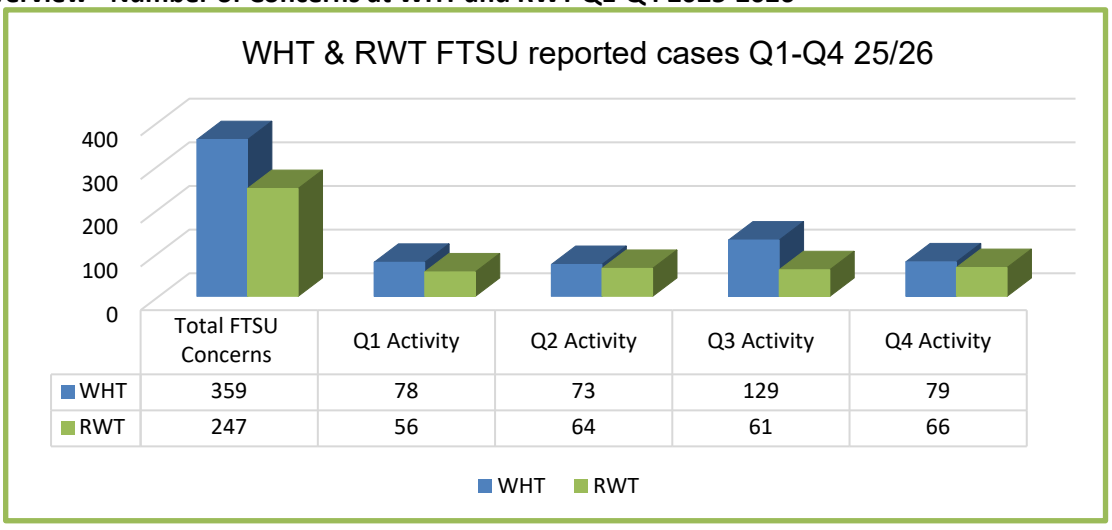
This report provides an overview of FTSU activity across Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) for Q1–Q4 2025/26, with comparison to 2024/25. The data indicate sustained and increasing engagement with FTSU across both sites, with a clear upward trend in reporting in Q4. As in prior periods, behaviour-related concerns, alongside bullying and staffing-related safety issues, remain prominent themes requiring continued leadership focus and executive support.

A key challenge identified across both organisations is the need for a more timely and consistent organisational response to concerns raised through the Freedom to Speak Up process. Whilst there is evidence of positive engagement from senior leaders and divisional teams, delays in responding to concerns and providing updates can impact staff confidence and perceptions of organisational responsiveness.

At WHT, there is a particular opportunity to strengthen the process for closing the feedback loop, ensuring staff receive timely updates on actions taken and outcomes achieved following the raising of concerns. At RWT, whilst robust mechanisms are already in place and feedback is routinely provided, there remains an opportunity to further improve the speed of responses and communication to staff, particularly during periods of operational pressure.

Continued focus on leadership visibility, accountability, and effective feedback mechanisms will be essential to maintaining confidence in the Freedom to Speak Up process and reinforcing the message that concerns raised by staff lead to meaningful action and improvement. We are currently in the process of producing a joint policy and updating our case/data collection system, this will support the improvement models

1.2 Overview - Number of Concerns at WHT and RWT Q1-Q4 2025-2026



The proportion of concerns versus the number of staff across both Trusts.

Trust	Headcount	Proportion of concerns to headcount	Q1	Q2	Q3	Q4
WHT	5,288	6.79%	1.48%	1.38%	2.44%	1.49%
RWT	11,807	2.09%	0.47%	0.54%	0.52%	0.56%

As per the (2024/25) annual reports based on the headcount/ workforce size, WHT recorded 6.79 concerns per 100 staff, compared with 2.09 concerns per 100 staff at RWT. Whilst this may reflect higher reporting activity and engagement at WHT. Across both Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust, there continues to be sustained engagement with the Freedom to Speak Up (FTSU) service, with concerns raised across a diverse range of clinical and non-clinical staff groups and services. This broad distribution provides assurance that the service is visible, accessible, and trusted by staff throughout both organisations, rather than being concentrated within a small number of teams or professions. The nature and spread of concerns demonstrate that FTSU is functioning as an effective mechanism for identifying cultural, workforce and patient safety issues, providing valuable organisational intelligence to support learning and continuous improvement. Continued reporting across all staff groups also reflects ongoing awareness and engagement initiatives, although opportunities remain to further strengthen psychological safety, increase confidence in speaking up openly, and ensure staff consistently receive timely feedback and evidence of action taken in response to their concerns. Both Trusts continue to demonstrate sustained staff engagement with the FTSU service, with concerns raised across a broad range of staff groups and services.

1.3 WHT Q1 – Q4 2024/25

Previous year total number of concerns: **359**

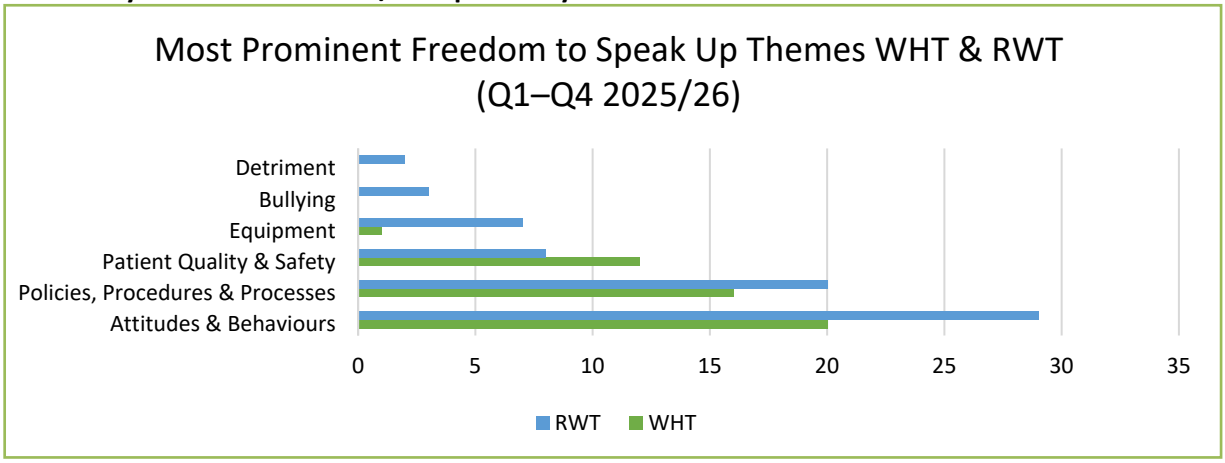
- Quarterly comparison: Q3 shows a 65.38% increase versus the same quarter in 2024/25. There was a 37.8% decrease in concerns in Q4 in comparison to last year.
- Likely contributors to high concerns reported included increased cross-professional engagement, targeted FTSU events, and wider NHS operational pressures. In Q4 there was extremely limited guardian cover due to leave; in one instance there was no guardian cover in most of March which could explain the decrease in concerns reported.
- Effective feedback remains critical to maintaining staff confidence that their voice is heard and acted upon

1.4 RWT Q1-Q4 2024/2025

Previous year total number of concerns: 247

- There is a steady number of reported cases across all quarters.
- Identified reporting across professional groups, likely due to targeted FTSU activity and raised awareness across trusts as well as broader operational pressures.

2.0 Joint Key Themes and Issues / Complaints by Theme



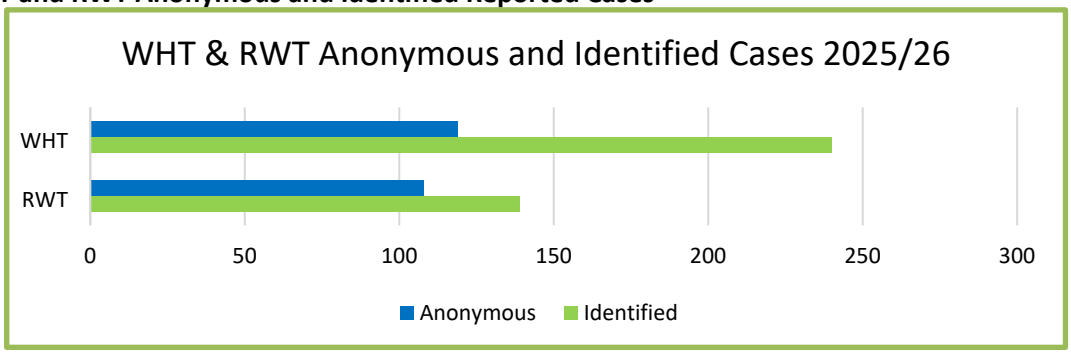
Across both Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT), Freedom to Speak Up concerns continue to provide valuable organisational intelligence on workforce culture, patient safety, and opportunities for quality improvement. The breadth of concerns raised demonstrates that staff are using the FTSU service appropriately to raise both cultural and safety-related issues, with reporting spanning a wide range of themes, professional groups, and services. There is sustained reporting with no evidence of underreporting.

Staff attitudes and behaviours remain the most prominent theme across both organisations and continue to require sustained executive focus. At RWT, behaviour-related concerns remained consistently high throughout the year, with approximately 29 concerns reported in Q1 and continuing as the dominant theme across all quarters, suggesting systemic cultural issues rather than isolated incidents. Similarly, WHT experienced an 11.1% increase in attitudes and behaviour concerns in Q4 compared with the previous year (20 in 2025/26 compared with 18 in 2024/25), reinforcing the need for continued investment in compassionate leadership, psychological safety, and early intervention.

Policies, Procedures and Processes also remain a significant theme across both Trusts and should be viewed as an opportunity for organisational learning rather than solely as an area of concern, jointly we have dealt with concerns around flexible working, disciplinary actions, signposting for HR policies, early resolution dispute, uniform policy, payroll enquires, lone workers and behavioural framework enquiries. At RWT, this was the second most frequently reported category, increasing from approximately 11 concerns in Q1 to 20 in Q4, with reporting peaks coinciding with periods of operational pressure. Similarly, WHT experienced a 23.08% increase in Q4 compared with the previous year (16 in 2025/26 compared with 13 in 2024/25), highlighting opportunities to review systems, improve processes, and strengthen organisational learning.

Quality and Patient Safety concerns continue to provide important intelligence across both organisations. WHT experienced a notable increase in Q3 and Q4, particularly within Medicine and Long-Term Conditions, Women's, Children's and Clinical Support Services, Surgery, Community Services and the Medical Directorate, reflecting workforce pressures, service changes and increased operational demand. At RWT, patient quality and safety concerns remained a recurring theme throughout the year, peaking in Q3 before reducing in Q4. In both Trusts, these concerns are routinely triangulated with quality governance and senior leadership teams to ensure timely review and appropriate action.

3.0 WHT and RWT Anonymous and Identified Reported Cases



Across both Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT), anonymous and identified reporting continues to provide an important indicator of organisational culture and psychological safety. Staff continue to utilise both reporting routes, demonstrating confidence in the accessibility of the Freedom to Speak Up service while recognising that some individuals remain more comfortable raising concerns anonymously.

Anonymous reporting should not be viewed in isolation as a negative indicator; rather, it provides an essential mechanism for staff who may otherwise feel unable to speak up and offers valuable organisational intelligence. Trends should therefore be considered alongside NHS Staff Survey findings, behavioural themes, and wider workforce indicators.

At WHT a total of 359 concerns were reported during Q1–Q4 2025/26, of which 240 (66.85%) were raised as identified and 119 (33.15%) anonymously. The highest level of identified reporting occurred in June (42 cases), whilst the highest level of anonymous reporting occurred in December (28 cases), coinciding with a period of increased operational pressure.

Enclosure 6.2

At RWT, a total of 247 concerns were reported during Q1–Q4 2025/26, of which 139 (56.3%) were raised as identified and 108 (43.7%) anonymously, representing an identified-to-anonymous ratio of approximately 2:1. The highest level of identified reporting occurred in August (23 cases), whilst the highest level of anonymous reporting occurred in December (20 cases), coinciding with a period of increased operational pressure.

Overall, the reporting profile provides assurance that staff continue to engage with the Freedom to Speak Up service and that the majority of concerns are raised openly. Continued focus should remain on strengthening psychological safety, visible leadership, and timely feedback mechanisms to further increase staff confidence in speaking up without fear of detriment. There were 3 alleged reports of detriment these were escalated and investigated as per protocol.

4.0 Report by Professional Groups

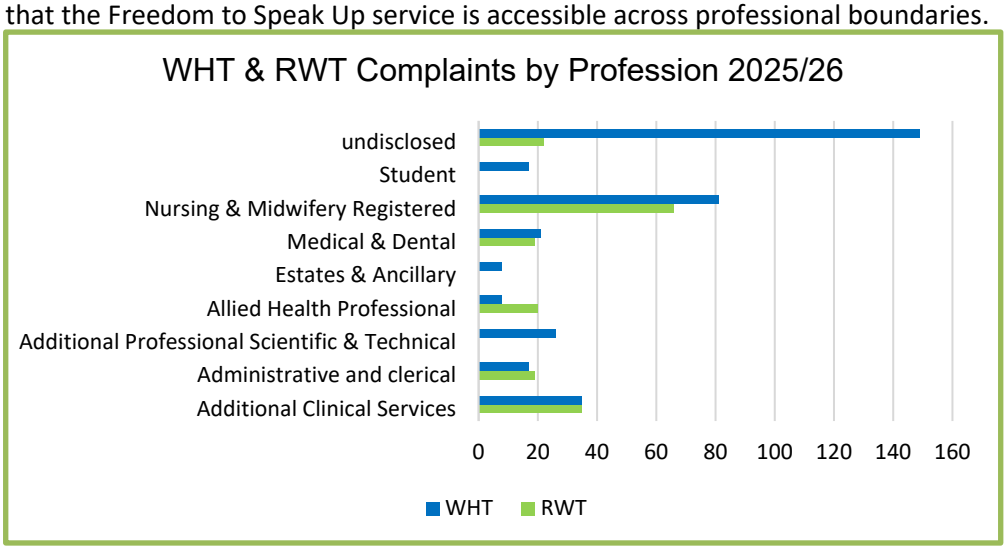
Across both Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT), Freedom to Speak Up concerns continue to be raised by a broad range of professional groups, providing assurance that the service is visible, accessible, and utilised across both clinical and non-clinical staff groups.

At WHT there was a high volume of concerns from undisclosed professional groups (149) across Q1 – Q4 2025/26, potentially indicating a fear of detriment. This was followed by Nursing & Midwifery Registered staff (81 concerns), Additional Professional Scientific & Technical staff (26 concerns), Allied Health Professionals (8 concerns), Medical & Dental staff (21 concerns), and Administrative & Clerical staff (17 concerns). A further 35 cases were received from Additional Clinical Services staff.

The high volume of concerns from undisclosed staff groups is recognised as a potential indicator of reduced confidence in being identified when speaking up. In response, targeted actions are in place to strengthen psychological safety, increase visibility of the FTSU service, reinforce non-retaliation messaging, and enhance leadership accountability. Progress will be monitored through speaking up data, staff survey insights, and regular Board reporting.

At RWT, Nursing & Midwifery Registered staff accounted for the highest volume of reports (66 concerns) across Q1–Q4 2025/26, reflecting both workforce size and strong engagement with the FTSU service. This was followed by Additional Professional Scientific & Technical staff (28 concerns), Allied Health Professionals (20 concerns), Medical & Dental staff (19 concerns), and Administrative & Clerical staff (19 concerns). A further 29 cases were recorded as Not Known or Blank, highlighting an opportunity to improve data quality and recording processes.

Reporting across both organisations spans a wide range of professional groups and organisational areas, demonstrating that the Freedom to Speak Up service is accessible across professional boundaries.



Enclosure 6.2

5.0 Complaints by Division / Highlighted Areas of Concern for WHT & RWT

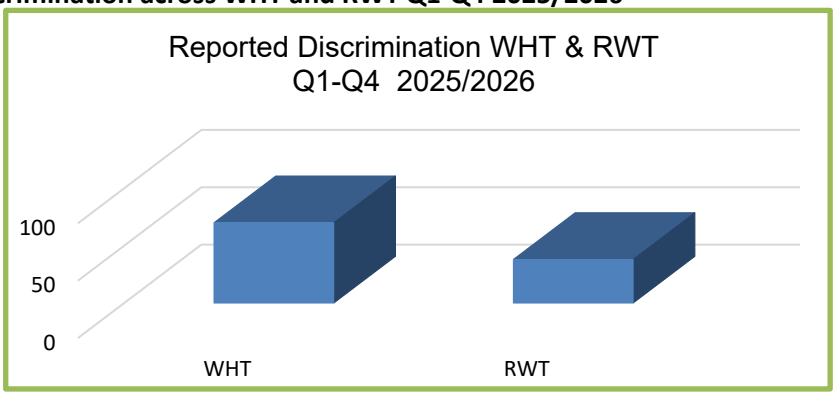
At WHT, the highest levels of reporting were identified within Women's, Children's, and Clinical Support Services (including Maternity, Pharmacy, Neonatal and Sexual Health Services), Surgery, Medicine and Long-Term Conditions (MLTC), Community Services, Estates and Facilities, Corporate Directorates and BCPS. Within these areas, concerns were raised across services including Accident & Emergency, ICU, Theatres, Medical Wards, Renal, Respiratory, Endoscopy, Health Visiting, the 0–19 Service and Governance functions.

Similarly, at RWT, concerns were reported across a wide range of divisions, with the highest levels of reporting originating from Women's & Neonatal Services, Paediatrics, Surgical & Patient Services, Renal & Diabetes, Older People & Rehabilitation, Radiology, Community Services, Estates & Facilities, Accident & Emergency and BCPS (Pathology Services).

The distribution of concerns across multiple specialties and corporate functions provides assurance that the Freedom to Speak Up service is embedded across both organisations and is being utilised appropriately to raise cultural, workforce and patient safety concerns. Many of the reported themes reflect areas experiencing increased operational pressure and are routinely triangulated with divisional leadership teams, workforce, quality, and patient safety governance processes to support timely intervention and organisational learning.

A small number of cases across both organisations were recorded with incomplete or unknown divisional information, highlighting an opportunity to further improve data quality and reporting consistency as part of the development of a Group-wide reporting framework.

6.0 Reported Discrimination across WHT and RWT Q1-Q4 2025/2026



Across the Group, Freedom to Speak Up continues to provide an important route for staff to raise concerns relating to discrimination and protected characteristics under the Equality Act. During Q1–Q4 2025/26, WHT received 70 concerns alleging discrimination, while RWT recorded 38 allegations of discrimination across the reporting period (Q1: 10, Q2: 7, Q3: 4, Q4: 17).

At RWT, a significant number of individuals chose "Prefer not to say" when asked whether their concern related to a protected characteristic. This may reflect concerns about being identified and reinforces the importance of continuing to strengthen psychological safety, trust, and confidence in speaking up.

Overall, discrimination-related concerns continue to provide valuable organisational intelligence and is considered in the wider Equality, Diversity, and Inclusion (EDI) data to inform targeted interventions and organisational learning. This is shared via monthly dataset to divisional and senior leaders at RWT.

7.0 National Guardian Office (NGO) Element Summary National Comparison

The Data collected and shared by both trusts are comparative with those that have been reported nationally. The NHSE website is now replacing the NGO. The new NHSE website link: *NHS England » The future of Freedom to Speak Up* in conjunction with the *CQC Well-Led aspect and Freedom to Speak up Quality Statement: Freedom to speak up: "We foster a positive culture where people feel that they can speak up and that their voice will be heard".*

Freedom to speak up - Care Quality Commission

Enclosure 6.2

8.0 Champion Activity

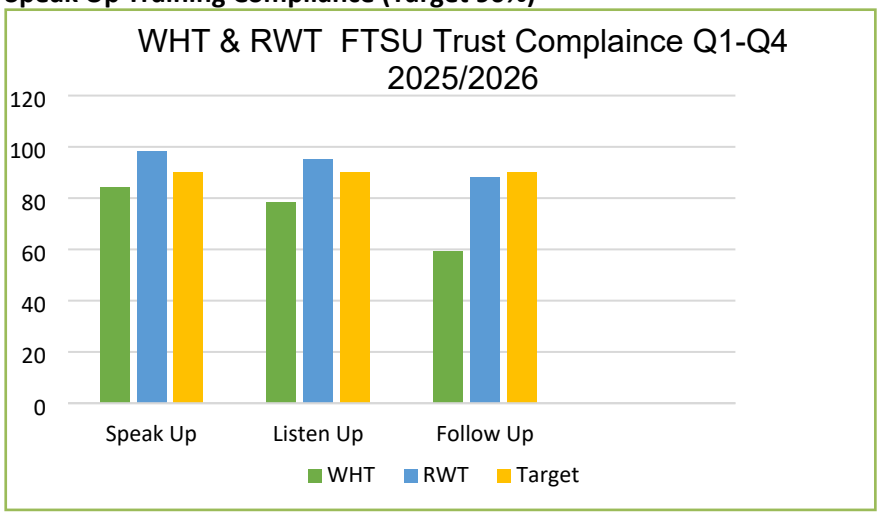
The Freedom to Speak Up (FTSU) Champion networks across Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) continue to play a vital role in promoting an open speaking up culture, increasing local accessibility to the FTSU service, and supporting staff to raise concerns at an early stage.

At WHT, Champion activity indicates that the majority of concerns related to worker safety and wellbeing, followed by patient safety and quality concerns and other workplace issues. Inappropriate behaviours accounted for 12 Champion-supported cases, with one reported case of bullying and harassment and no reported cases of detriment. Jointly they are reported as part of the overall number of complaints.

At RWT, the Champion network continues to mature through bi-monthly Champion meetings, providing a psychologically safe environment for case discussion, peer support, debriefing, and shared learning. During Q1–Q4 2025/26, Champions referred 20 cases directly to the Freedom to Speak Up Guardians, predominantly relating to staff attitudes and behaviours, bullying and harassment, and patient safety concerns. A co-designed Champion signposting flowchart has been implemented to improve consistency and accessibility, and annual recognition events continue to acknowledge and celebrate the contribution Champions make to embedding a positive speaking up culture.

We are particularly proud of our multidisciplinary approach to Freedom to Speak Up, working collaboratively with our network of champions to promote a positive speaking-up culture and ensure staff feel heard, supported, and empowered to raise concerns. The strength of this partnership working has been recognised nationally, with our Champion Network highlighted in the National Guardian's Office annual report, laid before Parliament, as "A Multidisciplinary Champion Network that Changes Culture." This recognition reflects the commitment, engagement, and impact of our champions in embedding openness, learning, and continuous improvement throughout our organisations.

9.0 Freedom to Speak Up Training Compliance (Target 90%)



At WHT, compliance stands at 84.29% for Speak Up (All Staff), 78.22% for Listen Up (Managers) and 59.17% for Follow Up (Senior Leaders). Whilst Speak Up compliance has shown continued improvement, lower uptake of the Follow Up module within some divisions, including the Medical Directorate, Surgery and Medicine and Long-Term Conditions, highlights an opportunity for further targeted engagement. It should be noted that this training is currently not mandatory, which may be contributing to lower compliance rates.

At RWT, training compliance remains consistently high, with 98.30% for Speak Up (All Staff), 95.30% for Listen Up (Managers) and 88.00% for Follow Up (Senior Leaders). These completion rates provide assurance that staff and leaders are well equipped to recognise, respond to and appropriately escalate concerns, while supporting the Trust's strategic ambition of embedding a positive speaking up culture. Although Follow Up compliance remains strong, there is an opportunity to further increase completion towards the Trust's aspirational 90% target.

Enclosure 6.2

10.0 Engagement & Accessibility

10.1 WHT

- FTSU outreach includes induction training, drop-ins, student and clinical forums, and ward walks.
- Establishment of Matrons FTSU forum, divisional FTSU forums including medical committees.
- Regular engagement at student forums.
- Regular Executive and FTSU 'cultural hotspot' meetings chaired by the Managing director to ensure effective triangulation and follow up of areas of concern.
- Speak Up Month attracted over 250 staff. We delivered snacks to colleagues on the wards and had meaningful discussions with staff about the importance of speaking up. We also hosted 1:1 drop-in sessions where staff could share concerns confidentially.
- Confidential Speak Up clinics were arranged to address potential barriers that staff had in speaking up with the opportunity to engage with them to look for solutions and incorporate projects like QI.
- Active and ongoing work with Governance, OD, patient groups for triangulation including Health and Safety forum.
- Collaborative leadership walkabouts, including executives and non-executive walkabouts.

10.2 RWT

- In the last year we have had 15 drop ins (177 attendees; 26 spoke up) and 40 awareness sessions reaching 1,042 staff from all activity.
- Activities span from 17 MDT inductions, forums, and ward/unit walkarounds and accreditation team visits (11 Staff interviews).
- Additionally, 4 Trust staff events were attended resulting in 151 staff attending to receive information. 3 Executive and EVG (BAME) Walkabouts took place in Speak Up Week 2025, attending 8 clinical areas.
- During 2025-26, the Black Country ICB network also hosted two FTSU events, in June 2025 for senior leaders and Executives, an in-person event was held. In October 2025, an online FTSU event called 'Not Just a Tick Box Exercise' was also held for all healthcare staff across the system as part of the national Speak Up week activities.
- Joint work with Senior Managers, FTSU Champions, Education, HR, OD, and Employee Voice Groups; new collaboration with the Trust Quality Team on accreditation.
- Monthly triangulation with senior divisional leaders and cross-site governance/assurance teams; engagement with CQC inspections and external reviews.
- Updated FTSU intranet page; QR codes embedded; joint feedback via "We Each Have a Voice / Have Your Say" tools; quarterly newsletter issued.
- Three Executive and one EVG walkabouts during Speak Up Month.
- Speak Up Month included bite-size Psychological Safety and Resilience sessions with Corporate Learning Services (attendees included FTSU Champions and BAME Employee Voice members), Pop up stalls in conjunction with Black History month and Wellbeing month.

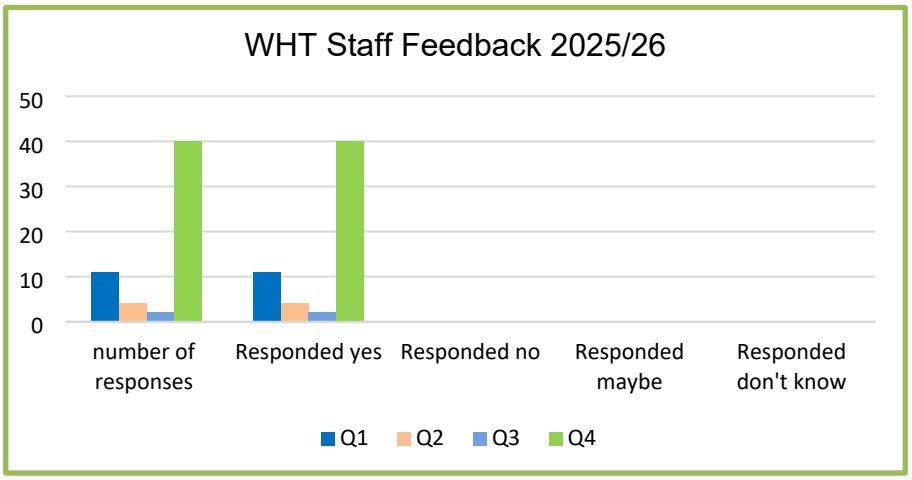
11.0 FTSU Service Specific Staff Feedback

All Freedom to Speak Up Guardians across the NHS seek feedback from individuals who have used the service to understand whether they would feel confident to speak up again following their experience. This metric is collected nationally on a quarterly basis and is a key indicator of trust, psychological safety, and service effectiveness. (See table below)this illustrates the feedback from staff across the trust.

11.1 WHT

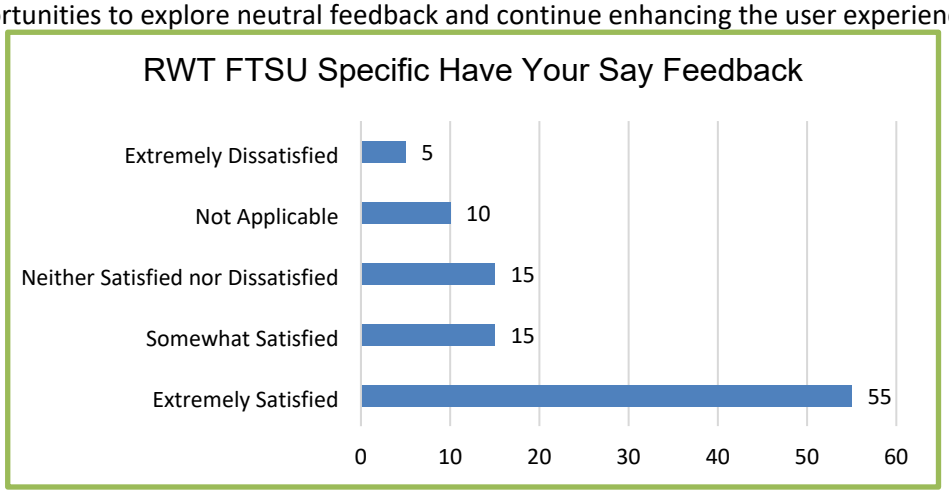
At Walsall Healthcare NHS Trust, feedback remains exceptionally positive. Of those who responded after their concerns had been addressed, 100% indicated that they would speak up again, demonstrating strong confidence in the FTSU process and the support provided. This reflects positively on the accessibility, responsiveness, and integrity of the service. However, response numbers remain relatively low, and increasing participation in feedback collection is a key priority to ensure a more representative understanding of staff experience and to further strengthen organisational learning.

Enclosure 6.2



11.2 RWT

Overall, staff feedback regarding the Freedom to Speak Up service is positive. A total of 70% of respondents reported a positive experience**,** with 55% extremely satisfied and 15% somewhat satisfied. A further 15% were neither satisfied nor dissatisfied, indicating opportunities to better understand and improve their experience, while 10% selected 'Not Applicable'. Only 5% of respondents reported being extremely dissatisfied, suggesting low levels of negative feedback. Overall, the results demonstrate good staff confidence in the service while highlighting opportunities to explore neutral feedback and continue enhancing the user experience.



12.0 NHS Staff Survey Results 2025

12.1 WHT

Recent NHS Staff Survey results for Walsall Healthcare NHS Trust indicate a concerning downward trend in the proportion of staff who feel safe and confident to speak up, particularly in relation to key indicators such as feeling secure in raising concerns, confidence that concerns will be addressed and not experiencing detriment as a result of speaking up. Performance across these measures remains below the national average, reinforcing the need for sustained organisational focus.

This position presents an important contrast to local FTSU feedback, where 100% of respondents reported they would speak up again, highlighting that staff who access the FTSU service have a positive experience and trust the process. The divergence between these two data sources suggests that while the FTSU function is effective and well-regarded, there remain wider cultural, structural, and perceptual barriers that prevent staff from speaking up in the first instance. Both teams are currently undertaking a service review so that we can standardise data collection and reporting methods.

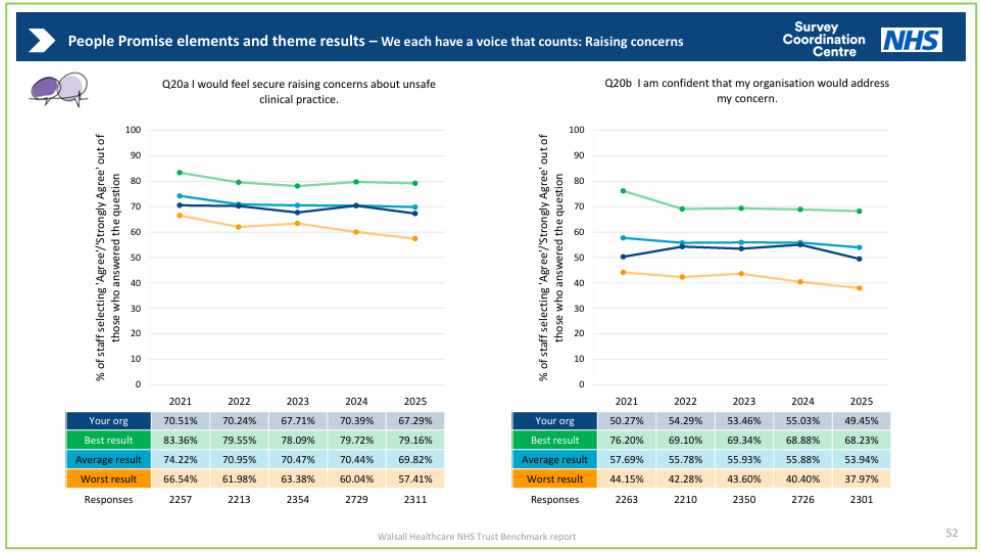
12.2 Correlation between Trust Staff Survey and FTSU Intelligence

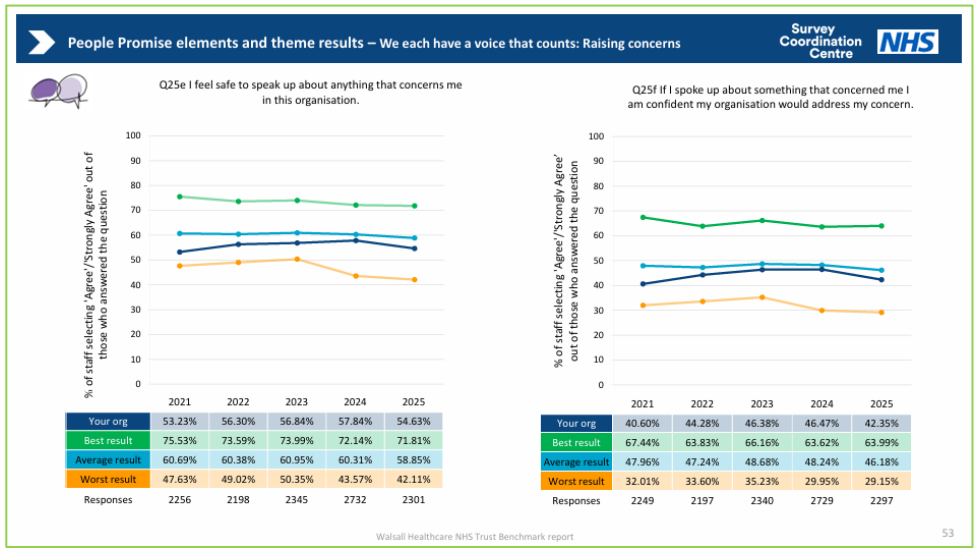
The Staff Survey findings broadly align with Freedom to Speak Up intelligence (see extracted graphs below from staff survey). Whilst the Trust continues to demonstrate strong engagement with the Freedom to Speak Up

service, the NHS Staff Survey highlights a decline in staff confidence that concerns will be addressed. Strengthening psychological safety, visible leadership, and organisational feedback mechanisms should remain a strategic priority to support an open, inclusive, and learning culture through:

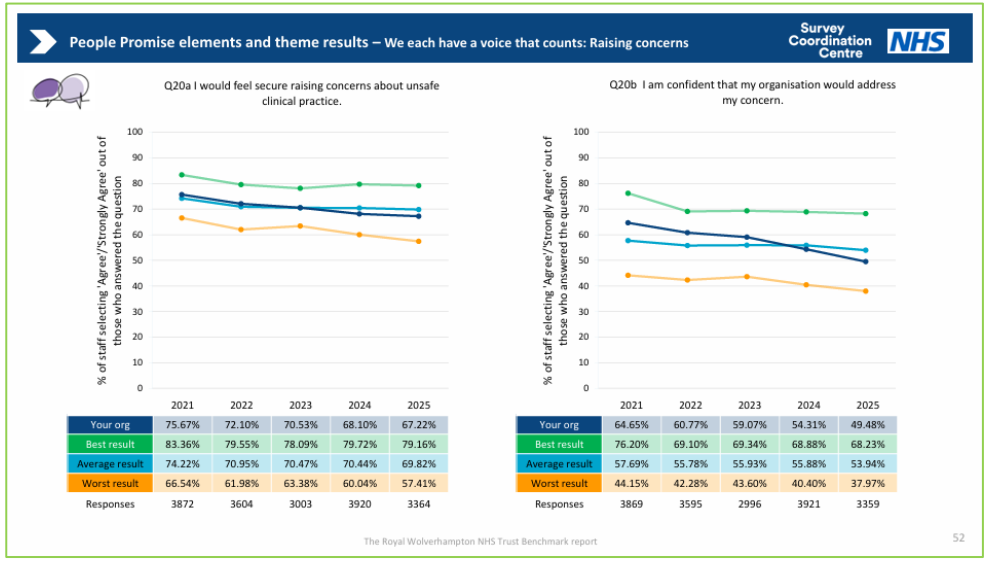
- Continued reporting which demonstrates staff engagement with the FTSU service.
- Periodic increases in anonymous reporting suggest some staff remain concerned about speaking up openly.
- Persistent themes relating to behaviours and workplace culture reinforce the survey findings.
- The staff survey decline in confidence that concerns will be addressed supports the need to strengthen FTSU 'Have Your Say' "feedback mechanisms which has been implemented by the guardians this allows for clear differentiation between staff survey and FTSU specific staff feedback tools.
- There is wider joint collaborative culture transformation and Organisational and Development Improvement work planned and on the way.

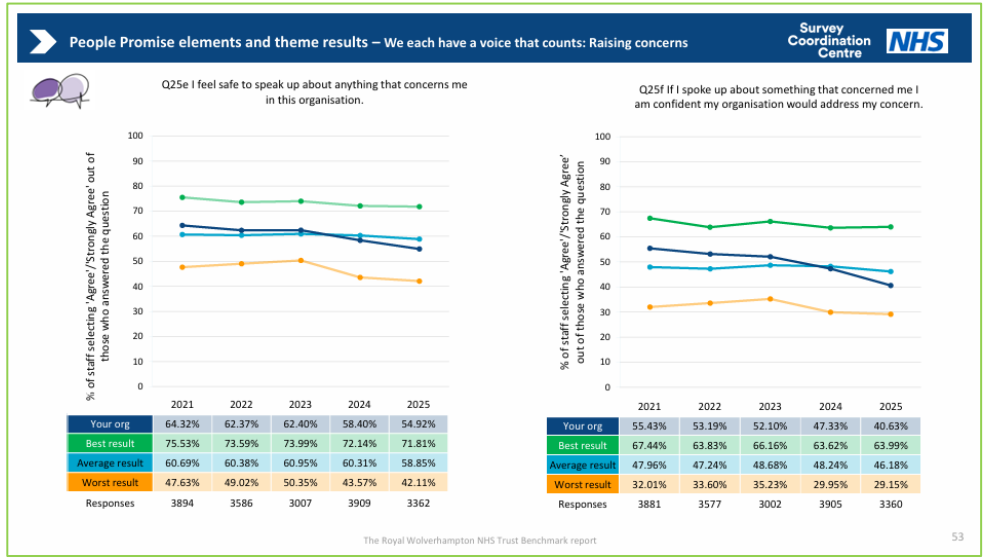
12.3 WHT





12.4 RWT





13.0 Freedom to Speak Up – Supporting Sexual Safety and National Recommendations Context and Assurance

13.1 WHT and RWT

There is increasing national focus across the NHS on the role of Freedom to Speak Up (FTSU) in strengthening sexual safety and fostering psychologically safe working environments. Central to this is ensuring that staff feel confident to raise concerns about inappropriate behaviours, harassment, and misconduct without fear of reprisal.

At WHT and RWT FTSU respective services provides a confidential and independent route for speaking up, enabling early identification of cultural and behavioural concerns. This is particularly important in relation to sexual safety, where underreporting remains a recognised challenge across healthcare settings. The RWT lead guardian is part of the Joint Sexual Safety Working Group.

Both Trusts continue to align their approach with emerging national expectations, including implementation of recommendations arising from the Lord Mann review. Key areas of focus include:

- Strengthening accessible and trusted reporting mechanisms.
- Reinforcing a clear zero-tolerance stance on inappropriate behaviour.
- Ensuring timely and appropriate support for those who raise concerns.

Through this, the FTSU service provides assurance that staff voices are heard, protected, and acted upon.

13.2 Impact

FTSU contributes directly to the Trust's commitment to a safe, inclusive, and respectful workplace culture by ensuring that concerns inform learning, improvement, and accountability.

A recent example of this impact is the volume of concerns raised by patients, service users, and staff regarding the provision and accessibility of spiritual spaces at WHT. These concerns reflected a range of themes, including privacy, dignity, inclusivity, and sexual safety. Some individuals also highlighted the importance of access to appropriate single-sex facilities.

Through the FTSU route, these concerns have been surfaced, validated, and escalated, enabling the Trust to identify risks that may otherwise have remained unrecognised. In response, joint working between the FTSU function and the Spiritual Spaces Oversight Group has strengthened understanding of the barriers and supported the implementation of practical improvements.

This demonstrates FTSU's core purpose: providing a trusted mechanism for raising concerns, ensuring they lead to meaningful action, and embedding learning that drives measurable cultural and environmental change.

14.0 Joint Next Steps WHT and RWT

- Support the smooth transition following the closure of the National Guardian's Office (NGO) on 30 June 2026, ensuring continuity of Freedom to Speak Up arrangements under NHS England.
- Work closely with NHS England to understand and implement any revised national guidance, reporting requirements, and governance arrangements for Freedom to Speak Up Guardians.
- Review and update local FTSU policies following a group model, reporting processes, and communication materials to reflect the new national arrangements.
- Continue to strengthen psychological safety and promote an open and inclusive speaking up culture through visible leadership and compassionate management.
- Enhance 'FTSU Have Your Say' feedback mechanisms.
- Grow and support the FTSU Champion network.

- Maintain high training compliance and targeted engagement.
- Continue cross-Trust collaboration and organisational learning.
- Continue triangulation of FTSU intelligence with Workforce, Quality, Patient Safety, HR, and Equality, Diversity, and Inclusion (EDI) data to identify emerging risks and opportunities for improvement.
- Progress a modernised FTSU data system across both WHT and RWT.
- Reduce behaviour-related concerns via compassionate leadership and early intervention.
- Maintain vigilance for patient safety and use policy feedback for learning.

15.0 Joint Recommendations to Group People Committee

The Board is asked to:

- Note the Freedom to Speak Up activity and emerging themes across RWT and WHT for Q1–Q4 2025/26, recognising sustained staff engagement with both services.
- Take assurance from the continued accessibility and visibility of the Freedom to Speak Up service, including high levels of staff engagement, strong training compliance, and ongoing executive support.
- Support continued executive focus on addressing persistent concerns relating to staff attitudes and behaviours, bullying, workplace culture, and staffing-related safety concerns through compassionate leadership and early intervention.
- Endorse the continued strengthening of psychological safety, ensuring staff feel confident to speak up without fear of detriment and receive timely and meaningful feedback on concerns raised.
- Support the development of a modernised joint FTSU reporting system to improve data quality, reporting consistency, organisational learning, and Board assurance across both Trusts.
- Support the continued development of the FTSU Champion network, with appropriate protected time and representation across all divisions to enhance local visibility and accessibility.
- Support the transition of national Freedom to Speak Up arrangements from the National Guardian's Office to NHS England, ensuring local governance, reporting processes, and policies remain aligned with national guidance and best practice.
- Endorse continued triangulation of FTSU intelligence with workforce, quality, patient safety, HR, and Equality, Diversity, and Inclusion (EDI) data to identify emerging risks, inform organisational learning, and drive continuous improvement.
- Support a group model for FTSU services.
- Continue to receive regular Board assurance reports on Freedom to Speak Up activity, emerging themes, and progress against agreed actions and strategic priorities.

Enclosure 6.3

Report title:	The Lord Mann Review into Antisemitism and Racism in the NHS
Sponsoring executive:	Dr Claire Radley, Group Chief People, Culture, and Improvement Officer
Report author:	Clair Bond, WHT People Director and Emma Ballinger, RWT People Director.
Meeting title:	Trust Board
Date:	21 July 2026

1. Summary of key issues

The Lord Mann review was commissioned by Sir Keir Starmer in November 2025 to investigate antisemitism and other forms of racism reported by health professionals and patients within the NHS.

Lord John Mann, the government's independent adviser on antisemitism, led the review to assess how the health service could better protect patients and staff and ensure perpetrators are held accountable.

The report by Lord Mann, published on 4 June 2026, emphasises the need for a system-wide reset with stronger leadership, clearer expectations and the implementation of widespread reforms to strengthen accountability and protect patients and staff from all forms of racism and antisemitism. This report highlights the key elements of the report, and how each of these applies to the RWT and WHT Group. This report provides key actions for the Group to consider to safe-guard our patients, staff and service users.

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 report was received at Group Management Committee (GMC) on the 8 July 2026 whereby recommendation 2, to adopt the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism was approved. In recognition that racism extends beyond antisemitism, GMC noted that this would require wider communication and engagement with colleagues in the context of the broader Equality, Diversity and Inclusion (EDI) agenda to support colleagues to understand the implications and individual responsibilities. The GMC welcomed and endorsed recommendations 1 & 3.

4. Recommendation(s)

It is recommended the Board consider: -

1. That a set of specific objectives aligned to the recommendations and findings within the national report are developed for the Group in conjunction with our staff and patients. It is proposed that these are reviewed through the Joint EDI Group and POD during the Summer with an update to Board in Autumn 2026.
2. With immediate effect the Group (via both Trusts) adopts the IHRA definition of antisemitism [Appendix 1]
3. That specific training is provided to Board members on antisemitism and racism as part of a continual Board development programme.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
Group Assurance Framework Risk GBR01	☐	*Break even*
Group Assurance Framework Risk GBR02	☒	*Performance standards*

Enclosure 6.3

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

Enclosure 6.3

The Lord Mann Review into Antisemitism and Racism in the NHS

1. Introduction

The Lord Mann review was published on 4 June 2026. The report emphasises the need for a system-wide reset with stronger leadership, clearer expectations and the implementation of widespread reforms to strengthen accountability and protect patients and staff from all forms of racism and antisemitism.

This report highlights the key elements of the report, and how each of these applies to the RWT and WHT Group. This report provides key actions for the Group to consider to safeguard our patients, staff and service users and specifically request the Committee to support the adoption of the IHRA definition of antisemitism [Appendix 1]

2. Background

The Commission on Antisemitism report, co-chaired by Lord Mann and the Right Hon Dame Penny Mordaunt DBE and published in July 2025, found a specific unaddressed issue of antisemitism within the NHS. The report highlights the impact on both the confidence of Jewish patients to access care and marginalised and unheard Jewish NHS staff, who report that discrimination against them is not being addressed.

The review sought to answer 2 principal questions:

1. How do we make sure in the NHS in England that perpetrators of antisemitism and other forms of racism are held to account with effective action taken to tackle behaviour?
2. How do we make sure that patients and staff are protected from racism within the NHS in England and across the UK health and care professional regulation system?

While there is a focus throughout the review on antisemitism and the experiences of Jewish people working within and seeking care from the NHS, it does not address antisemitism in isolation and recognises that race and religious discrimination and hatred should be addressed more broadly. Many of the recommendations of the review set out how in particular antisemitism must be recognised, acknowledged, and addressed but the majority speak to the need to address racism at every level, no matter its form.

The report emphasises the need for a system-wide reset with stronger leadership, clearer expectations, and greater accountability and reforms to improve the reporting and investigation processes in order to embed an anti-racist culture across the health system to ensure that patients and staff are better protected from discrimination and abuse.

The IHRA Working Definition of Antisemitism is captured in Appendix 1.

3. Key Findings of the Lord Mann Report

3.1 Antisemitism affects both staff and patients

The national review found evidence that Jewish NHS staff experience discrimination, exclusion and "routine ostracism." Some Jewish employees reported to the review, that they were considering leaving the NHS because of their experiences. Jewish patients also reported delaying or avoiding treatment due to concerns about discrimination. In particular, patients and NHS reported concerns around the addition of religious or nationalist symbols and imagery on staff uniforms.

It is important to understand the Jewish population locally to RWT and WHT. According to the 2021 Census, Walsall recorded 32,107 Muslim residents (about 11.3% of the borough's population). In Wolverhampton, 14,500 residents identified as Muslim (approximately 5.5% of the local population). The number of Jewish

people in both areas is statistically very low, with both districts registering below 0.1% of their total populations

Currently, at Walsall Healthcare NHS Trust there are 470 colleagues who have disclosed they are of Muslim faith equating to 11.53% of the substantive workforce and 2 colleagues disclosing Jewish faith 0.02% of the substantive workforce. At The Royal Wolverhampton NHS Trust 554 colleagues have disclosed that are Muslim faith equating to 5% of the substantive workforce and there is no data reflecting colleagues disclosing Jewish faith.

Upon reviewing patient data via careflow it is not possible to identify how many patients access healthcare services via both Trusts are of Jewish faith as recording religion is not a mandatory field.

3.2 Racism extends beyond antisemitism

While the review focused on antisemitism, it concluded that racism, more broadly remains a serious issue within the NHS. The report highlighted discrimination experienced by Black, Asian, Muslim, and other minority ethnic staff and patients. The recommendations were therefore designed to tackle all forms of racism rather than antisemitism alone.

The report reflected on the 2024 Brap report Too Hot to Handle, which examined a number of employment tribunal cases and responses from over 1,000 NHS staff, highlighting deeply concerning experiences of NHS staff facing racism and discrimination.

The latest NHS Staff Survey results (2025) for both Trusts show

- At RWT, only 108 Muslim colleagues responded to the survey, of which 16.3% stated they had experienced discrimination from colleagues at work. Only 1 respondent to the RWT staff survey disclosed they were of Jewish belief.
- At WHT, only 126 Muslim colleagues responded to the survey, of which 16.3% stated they had experienced discrimination from colleagues at work. No survey responders disclosed they were of Jewish belief.
- At RWT; 23.37% of Black and minority ethnic responders faced discrimination from patients or the public in the last 12 months compared to 20.82% of white responders, whilst 17.56% of Black and minority responders experienced discrimination from colleagues or managers compared to 7.39% of white responders.
- At WHT; 34.17% of Black and minority ethnic responders faced discrimination from patients or the public in the last 12 months compared to 25.63% of white responders, whilst 17.88% of Black and minority responders experienced discrimination from colleagues or managers compared to 6.65% of white responders.

From a Group perspective, many colleagues would agree with Lord Mann that it is profoundly troubling that NHS staff of all religions, and black and minority ethnic NHS staff, are more likely to experience discriminatory behaviour at work from patients or the public than they were 5 years ago and urgent changes are needed to address this.

3.4 Weaknesses in reporting and accountability

Lord Mann concluded that the existing regulatory framework for doctors was too slow and bureaucratic, preventing timely action against those engaging in racist or antisemitic conduct. The review highlighted that the General Medical Council (GMC) lacked sufficient powers to act decisively, and oversight mechanisms were inadequate to safeguard patients and NHS staff. The review identified shortcomings that's organisations should consider:

- Incident reporting systems.

- Investigations into complaints.
- Data collection and transparency.
- Consistency among professional regulators.
- Leadership accountability for tackling racism.

The GMC, CQC and NMC, with 6 other health and care professional regulators, have subsequently endorsed joint principles on Advancing Workforce Race Equity in Health and Social Care and jointly released statements alongside this (see recommendation 22 in Appendix 2).

Across the Group, Freedom to Speak data records 61 concerns relating to racism and there are 6 formal ER cases relating to racism with 2 formal cases relating to discrimination. It should be noted that the current number of staff reporting that they have experienced discrimination of racism in our national staff survey results is significantly higher than the number of formal and informal employee relations cases. Further work is needed to understand the reasons for this and encourage staff to raise concerns.

3.4 Impact on trust in healthcare

The review concluded that racism is not only a workforce issue but as a patient safety and public trust issue. According to the review, when patients believe discrimination may affect their care, trust is healthcare organisations declines. To improve trust, the review proposes several measures to:

- Increase accountability with stronger mechanisms to investigate and address racist incidents and clear consequences for discriminatory behaviour
- More transparent reporting by improving systems for reporting racism and tracking outcomes and greater oversight of regulatory decisions.
- Embedding an anti-racist culture by training, leadership expectations, and organisational change across the NHS, and more protection and support for both patients and staff who experience discrimination.
- Restoring confidence among minority communities by increasing trust and confidence among Jewish and other minority ethnic patients and staff an organisation-wide priority

3.5 Conclusion and Recommendations

The review concluded that antisemitism and other forms of racism remain endemic within parts of the NHS and healthcare regulatory system which undermines confidence in NHS services and negatively affects both patient care and workforce retention. The review found that current mechanisms for managing concerns were often insufficient to protect staff and patients or to hold perpetrators accountable. The report made 36 recommendations (see Appendix 2 for full list of recommendations). Key themes included:

Area	**Recommendations**
Leadership	Stronger accountability for NHS leaders and boards regarding racism and discrimination.
Training	Mandatory anti-racism and antisemitism training, particularly for senior leaders
Reporting	Improved reporting mechanisms and clearer national guidance on handling complaints.
Data	Better collection and publication of workforce race equality and discrimination data.
Regulation	Greater consistency among healthcare professional regulators in addressing racist behaviour.
Culture	Promoting an organisation-wide anti-racist culture and improving trust among minority staff and patients.
Professional Standards	Stronger expectations around conduct, including consideration of political symbols and behaviours that may intimidate patients or colleagues

4. Government Response

The Government accepted all recommendations directed at the Department of Health and Social Care and NHS England. It signalled a commitment to significant reforms aimed at improving accountability, reporting, training, and organisational culture across the NHS.

The proposed actions include;

- Introducing new NHS staff standards.
- Mandatory anti-racism training.
- Strengthening oversight of NHS organisations.
- Improving regulatory processes.
- Reporting progress to Parliament, with an initial update due by October 2026 and a more detailed report within 12 months.

5. Recommendations

Recommended for Board consideration:

1. That a set of specific objectives aligned to the recommendations and findings within the national report are developed for the Group in conjunction with our staff and patients. It is proposed that these are reviewed through the Joint EDI Group and Group People Committee POD during the Summer with an update to Board in Autumn 2026.
2. With immediate effect the Group adopts the IHRA definition of antisemitism [Appendix 1]
3. That specific training is provided to Board members on antisemitism and racism as part of a continual Board development programme.

Enclosure 6.3

APPENDIX 1 – Definition of Antisemitism

Antisemitism appears today in many different forms and from all parts of society. On 26 May 2016, the IHRA Plenary in Bucharest decided to adopt the following working definition of antisemitism: IHRA Working Definition of Antisemitism

Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or nonJewish individuals and/or their property, toward Jewish community institutions and religious facilities.

Manifestations might include the targeting of the state of Israel, conceived as a Jewish collectivity. However, criticism of Israel similar to that levelled against any other country cannot be regarded as antisemitic.

Antisemitism frequently charges Jews with conspiring to harm humanity, and it is often used to blame Jews for "why things go wrong." It is expressed in speech, writing, visual forms and action, and employs sinister stereotypes and negative character traits.

Contemporary examples of antisemitism in public life, the media, schools, the workplace, and in the religious sphere could, take into account the overall context, include, but are not limited to:

- Calling for, aiding, or justifying the killing or harming of Jews in the name of a radical ideology or an extremist view of religion;
- Making mendacious, dehumanising, demonising, or stereotypical allegations about Jews as such or the power of Jews as a collective — such as, especially but not exclusively, the myth about a world Jewish conspiracy or of Jews controlling the media, economy, government or other societal institutions;
- Accusing Jews as a people of being responsible for real or imagined wrongdoing committed by a single Jewish person or group, or even for acts committed by nonJews;
- Denying the fact, scope, mechanisms (e.g. gas chambers) or intentionality of the genocide of the Jewish people at the hands of National Socialist Germany and its supporters and accomplices during World War II (the Holocaust);
- Accusing the Jews as a people, or Israel as a state, of inventing or exaggerating the Holocaust;
- Accusing Jewish citizens of being more loyal to Israel, or to the alleged priorities of Jews worldwide, than to the interests of their own nations;
- Denying the Jewish people their right to self-determination, e.g., by claiming that the existence of a State of Israel is a racist endeavour;
- Applying double standards by requiring of it a behaviour not expected or demanded of any other democratic nation;
- Using the symbols and images associated with classic antisemitism (e.g., claims of Jews killing Jesus or blood libel) to characterise Israel or Israelis;
- Drawing comparisons of contemporary Israeli policy to that of the Nazis;
- Holding Jews collectively responsible for actions of the state of Israel.

Antisemitic acts are criminal when they are so defined by law (for example, denial of the Holocaust or distribution of antisemitic materials in some countries). Criminal acts are antisemitic when the targets of attacks, whether they are people or property – such as buildings, schools, places of worship and cemeteries – are selected because they are, or are perceived to be, Jewish or linked to Jews.

Antisemitic discrimination is the denial to Jews of opportunities or services available to others and is illegal in many countries.

Enclosure 6.3

APPENDIX 2 – LIST Of RECOMMENDATIONS

Recommendation 1: the Department of Health and Social Care and the NHS should adopt the 7 NHS Race and Health Observatory workforce principles and encourage wider NHS organisations to do so.

Recommendation 2: the Secretary of State for Health and Social Care should consider including Jewish and Sikh as ethnicities in data collection. This could include consulting on this question for the health service as part of a wider update and equalisation of data capture across the NHS, as part of the update of the Unified Information Standard for Protected Characteristics (UISPC).

Recommendation 3: in considering their work to develop robust, evidence-based workforce race equality standard (WRES) action plans, with specific, measurable targets, trusts should ensure they monitor progress against WRES action, applying the 'explain or reform' principles for any persistent inequalities. They should ensure any WRES plans are easily accessible to the public and should discuss their WRES planning at least annually at a public board meeting to help facilitate this. In the absence of Jewish ethnicity data trusts must also look at staff survey data in relation to Jewish staff alongside WRES indicators to understand how they are performing and addressing the experience of Jewish staff.

Recommendation 4: NHS boards and leaders should be held accountable for race equality and staff experience metrics, as part of the recently added score in the NHS Oversight Framework (NOF) that will support compliance with the new NHS Staff Standards. The metrics supporting this new NOF score, and trusts' performance on these, should be made publicly visible.

Recommendation 5: there should be board-level oversight of all investigations related to racism through annual reporting on volume, themes, outcomes and timelines, deep-dives into hotspots or repeated patterns, and assurance that recommendations are implemented and monitored. Existing governance systems can also be strengthened.

Recommendation 6: NHS England should work with system partners, such as the NHS Race and Health Observatory, to strengthen how it supports and celebrates organisations that make positive progress in the anti-racism agenda. The NHS should further build on existing recognition initiatives, and the development of an accreditation mark should be considered.

Recommendation 7: all NHS board members and senior leaders should have explicit, measurable equality, diversity and inclusion objectives embedded within their performance goals. Assessment against these objectives should reference the themes in the NHS Race and Health Observatory's 7 anti-racism principles as a framework for evidencing delivery.

Recommendation 8: some political identifiers can and do cause distress to patients, and employers should develop local policies to be clear about what is acceptable. In order to create an inclusive NHS, upholding the aim of everyone feeling safe to seek and receive care, NHS England should update national uniform guidance, in line with reviewing broader guidelines for those in the NHS using its name, logo or branding, including in relation to social media accounts.

Recommendation 9: all staff, including volunteers and sub-contracted staff, should be made fully aware of and have easy access to the documents, contracts and agreements that contain details of the expectations on them with respect to anti-racism, discrimination and fostering an inclusive NHS culture, including the NHS constitution, leadership and management standards (once published), and any volunteer agreements or codes of conduct.

Recommendation 10: the Department of Health and Social Care should work across the health and care regulators, including the Care Quality Commission, to secure an agreed approach on definitions of racism and religious hatred.

Recommendation 11: as part of the ongoing development of the NHS staff standards and the accountability processes around them, the staff experience questions in the annual NHS staff survey should be reviewed, with input

from a wide range of staff representatives and networks, to ensure they continue to be relevant in capturing ethnic minority staff's experience of racism and discrimination in the NHS, including those of Jewish NHS staff.

Recommendation 12: training for Patient Advice and Liaison Services and/or complaints handlers should be rolled out to better identify and handle complaints about racism and support their organisations in responding to racism. Complaints handlers in all settings should have clear process set out for sharing information and insights with other internal NHS functions and leadership, including taking advantage of tools like artificial intelligence to better understand their complaints data, supporting identifying trends.

Recommendation 13: a single national set of policy frameworks should be developed and clearly signposted to support more effective handling and investigation of racial harassment and discrimination. Work should be undertaken to develop the skills and cultural capability to deal with these issues better in trusts, including how they are investigated and staff supported.

Recommendation 14: trusts should take into account the relevant Advisory, Conciliation and Arbitration Service (ACAS) code in developing their processes and strongly consider routes for early intervention and resolution. The forthcoming review of the ACAS disciplinary and grievance code should support this.

Recommendation 15: the Care Quality Commission (CQC), working with the Department of Health and Social Care (DHSC), should make greater use of powers to inspect NHS organisations on their equality, diversity and inclusion (EDI) performance, against patient inequalities and for staff workforce, under the 'well-led' domain. In doing so, it should ensure that NHS boards and leaders are held accountable for delivering the staff standards as reflected in the NOF, including how organisations handle racist incidents and the effectiveness of reporting systems. More broadly, DHSC should consider how CQC might enhance its assessment of all NHS organisations for EDI performance and the role of the organisation's leadership in addressing racism. As referenced in the section of this report on reporting and investigation of racist incidents, this should include the handling of racist incidents.

Recommendation 16: health and care system and professional regulators should establish a taskforce to clarify and reinforce the appropriate mechanisms, including the emerging concerns protocol, for sharing information about local areas of concern, racist incidents, thematic issues related to antisemitism and other forms of racism, and best practice for employers and regulators to address them. Health and care system and professional regulators should co-ordinate actions where more than one regulator has a role to play in responding to issues or incidents and the Department of Health and Social Care should work closely with the devolved nations.

Recommendation 17: the existing inter-regulatory equality, diversity and inclusion working group should be strengthened to provide a dedicated forum for sharing good practice, and the Secretary of State for Health and Social Care should convene a dedicated session or roundtable for regulatory bodies on addressing antisemitism, and other forms of racism.

Recommendation 18: the review recommends that:

- the Department of Health and Social Care, NHS England and the Care Quality Commission should work with the health and care professional regulators to develop a clear, single set of national guidance for employers (in England), clearly defining employers' responsibilities in tackling discrimination incidents and providing guidance and examples of the types of incidents that may require a regulatory referral, to build consistency. This guidance should complement and build on work that regulators already do to support employers to determine when incidents might also be referred to a regulator alongside the employer taking action or referring matters to the police. This should also be publicly available
- health and care professional regulators should work together to develop communications for patients and the public to raise awareness of what is being done to tackle antisemitism and other forms of racism more widely and who they contact if they have a concern
- health and care professional regulators should work with patient representative groups to develop material that is clear, brief, and helpful for navigating the system

- this work is urgent and must be a priority. The Professional Standards Authority for Health and Social Care should oversee and report back on this work within 6 months and include an assessment of progress on implementation within their annual report to Parliament

Recommendation 19: the Professional Standards Authority for Health and Social Care should further use its powers to set guidance for all health and care professional regulators on equality, diversity and inclusion matters.

Recommendation 20: the Professional Standards Authority for Health and Social Care should more regularly convene and issue joint communications to health and care professional regulators regarding their responsibilities.

Recommendation 21: health and care professional regulators, including the General Medical Council and the Medical Practitioners Tribunal Service should work with the Professional Standards Authority for Health and Social Care to develop a clear process for securing expert advice on relevant fitness to practise decisions, particularly where they involve matters relevant to those with protected characteristics, to support cultural awareness and learning among relevant decision makers.

Recommendation 22: on 13 May 2026 the national UK health and care professional regulators signed up to the NHS Race and Health Observatory principles of antiracism to help tackle racism. Each regulator should report back within 6 months of the publication of this report on how they propose applying and embedding these principles.

Recommendation 23: the Professional Standards Authority for Health and Social Care should convene fitness to practise staff across health and care professional regulators to probe their approach to cases involving racism, including antisemitism and discrimination. With complaints potentially arising from staff, patients, volunteers, contractors, students and members of the public, consistency is required.

Recommendation 24: on all of the above, the Professional Standards Authority for Health and Social Care should formally report to the Health and Social Care Committee on its progress following this review within 6 months and include updates specifically on this area in its annual reports to Parliament.

Recommendation 25: the government should carefully consider the results of the General Medical Council (GMC) reform consultation, which contains the proposals set out in this subchapter, to ensure GMC reform includes efficient and proportionate regulatory oversight and decision making.

Recommendation 26: the Secretary of State should consider making amendments to the Performers List Regulations to enable conditions to apply on 'suitability' grounds, not only on 'efficiency' grounds. This may give more options to impose conditions in cases of practitioners expressing racist or extremist views where concerns relate to the conduct of the practitioner but not necessarily their clinical performance or the efficiency of the service.

Recommendation 27: establish national guidance, building on and updating the guidance issued following the 2024 riots, to support organisations when staff face violence or discrimination from patients or the public. This should include clear, context-specific guidance on how, in non-life threatening situations, trusts support staff to refuse access to services (to protect their safety and dignity). It is recommended that the NHS, the Department of Health and Social Care and others work closely with the UK healthcare professional regulators and patient and staff representatives to update this guidance, ensuring alignment with existing regulator guidance on this matter, and relevant legal duties. This should include real life examples of how NHS employers can protect staff. NHS employers should be held to account for implementing this guidance consistently and for taking firm action to protect staff.

Recommendation 28: the Secretary of State should confirm that NHS England faith and ethnicity-based networks will be supported during and after the transition into the Department of Health and Social Care with a structure agreed with its members. This includes supporting smaller networks, like NHS England Jewish Staff Network (JSN).

Recommendation 29: medical schools council leadership should undertake anti-racism training, specifically including antisemitism, and work with Lord Mann's offices on a communication to all medical schools about tackling racism including antisemitism, to be updated as required.

Recommendation 30: medical schools should consider the full range of disciplinary sanctions and processes at their disposal to address anti-Jewish hatred and abuse in educational settings. They should also ensure they comply with the relevant Office for Students (OfS) requirements around data collection and reporting on incidents of harassment. OfS should consider where they can add value through communications, engagement and reporting on anti-Jewish harassment, and the health and care professional regulators must review their student professionalism standards in line with the recommendations in this report.

Recommendation 31: the Academy of Medical Royal Colleges should work with its members, potentially using their equality, diversity and inclusion network to ensure each organisation has the training needed to fully understand anti-Jewish hatred and abuse, and other forms of racism.

Recommendation 32: the NHS mandatory training module on equality, diversity and human rights - which is accessed by 1.5 million people - requires urgent updating and the specific inclusion of quality assured content on antisemitism and anti-Muslim hostility. Subject matter experts should be consulted as part of the content review and update. Staff should be required to undertake this training, once updated, without delay and not wait until the 3-year cycle renews. This training will be replaced in 2026 with another training framework which must include the aforementioned quality-assured materials.

Recommendation 33: this review recommends that the Department of Health and Social Care convene a meeting specifically on training, with all of those bodies representing individuals not captured by NHS training, to discuss and find a path to delivering training.

Recommendation 34: there must be mandatory training for the approximately 400 chairs and chief executives of NHS provider trusts on antisemitism, anti-racism and building on the Macpherson principles, within the next 6 months.

Recommendation 35: the leaders of the UK health and care system and professional regulators should ensure they undertake similar training, if they have not already done so.

Recommendation 36: the proposed NHS College of Leadership and Management must reinforce the importance of the training elements on antisemitism and other forms of racism and play a major role in embedding expectations and providing access to further, comprehensive training for leaders and managers. The training should be monitored and reported on publicly with input from relevant stakeholders to ensure it is having the desired impact.

Tier 1 - Paper ref:	Enclosure 7

Report title:	Report of Escalation from Committee Chairs
Sponsoring executive:	Non-Executive Directors
Report author:	Paul Assinder – Group Vice Chair
Meeting title:	Group Board of Directors Meeting - in Public
Date of Meeting:	21 July 2026

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

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

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

In addition, the Audit Committee Reports and the Charitable Funds Committee Reports will continue to be provided separately.

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.

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

Group Committees of the Board
Chairs' Assurance Report

Meetings held in June and July 2026

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

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

In addition, the Audit Committee Chairs Reports and the Charitable Funds Committee Reports will continue to be provided separately.

Alert – matters of concern for escalation	
Finance & Productivity Committee	**Quality Committee**
Performance - May • Community Waiting List pressures with performance in the lower quartile nationally for 52+ week waits. Improvement work has commenced across the 4 initial pathways. Community Waits largest challenge within the specialty for both Trusts is Community Paediatrics, short and long term options are being explored. • Diagnostic DM01 performance for WHT has declined, driven by deterioration of MRI, NOUS, Audiology and Neurology. The main contributor towards the deterioration is MRI scans. The Trust have committed to a mobile scanner (+140 slots per week) for temporary mitigation and long term options are being explored. • 13 week+ breaches totalled to 978. • 62 Day Cancer (RWT) – The Trust continues to have risks in key specialities; Gynaecology and Urology in particular. The Trust continues to work to meet Chemotherapy and Radiotherapy demand. The team are looking at alternatives and 62 day recovery action plans are in place. • Ambulance handover delays persist. • 62 Day Cancer (RWT) – The Trust continues to have risks in key specialities; Gynaecology and Urology in particular. The Trust continues to work to meet Chemotherapy and Radiotherapy demand. The team are looking at alternatives and 62 day recovery action plans are in place. Performance – June • WHT – Community waiting list stands at 9560 (snapshot waiting list end of May) with 64.59% waiting 18 weeks or less. The Trust ranks in the lowest quartile nationally for over 52-week waits. Improvement work has commenced across several initial pathways: Frailty, Psychology, Dietetics (adult and Paediatrics), SaLT (adult and Paediatrics), CNRT. Community Paediatrics short term and long-term options are being scoped. • WHT: DM01 performance improved to 66.92% with latest bench marking placing the Trust 98th (out of 121 reporting general acute Trusts) and 15th regionally for DM01 performance. This is driven by challenges within in MRI, NOUS, Audiology and Neurology. • 13 week+ breaches totalled to 1093. There has been a significant impact in performance due to the capacity gap within MRI which has resulted in a worsening DM01 position, a mobile scanner is now operational (est 140 scans per week) and capacity continues to be utilised at Nuffield (approx 40 scans per week), long term options are progressing. Audiology recruitment continues. NOUS recruitment is progressing. Neurophysiology impacted by demand and workforce challenges. Agency support and enhanced bank rates in place.	• Ophthalmology capacity and demand pressures remain significant, particularly within Glaucoma services. The Ophthalmology Team attended Committee to outline the challenges associated with capacity and demand and the actions underway to improve performance. Discussions continue with the ICB regarding expansion of community-based services and two additional medical training places have been approved. Virtual delays have reduced from 5–6 months to approximately 2 months. Digital solutions, electronic patient records and AI opportunities continue to be explored. A review of out-of-area attendance at the walk-in service is required, as many patients attend from outside the locality despite services being available elsewhere. Consideration is also being given to service provision for Walsall patients through the SLA. Subject to business case approval, the purchase of a Pressor Flow and a fast SLT laser, which can be operated by non-medical staff, would significantly improve productivity within the service. The Committee found the presentation valuable in understanding the scale of the challenge, the actions underway and the further work required to align capacity with demand and improve productivity. A follow-up visit to the Ophthalmology Department is planned. • Discussions continue with West Midlands Fire Service regarding safety works within Block 32 Maternity Services at New Cross Hospital, with particular focus on risk assessments. The Fire Safety Enforcement Notice remains in force • Discussions continue with Staffordshire Fire and Rescue Service regarding outstanding works at Cannock Chase Hospital, which remains subject to a Fire Safety Enforcement Notice. Whilst formal written confirmation has not been received, the Fire Service has indicated that they are satisfied with progress to date. • Following the Health and Safety Executive Notice of Contravention issued in August 2025 relating to Entonox exposure within Delivery Suites at RWT and WHT, further staff testing has been undertaken with no breaches identified at WHT following the use of mobile destruction units. RWT has submitted a business case for permanent destruction unit • Following the Human Tissue Authority inspection in December 2025, the Corrective and Preventative Action Plan submitted by WHT as licence holder has been accepted. Outstanding actions remain, particularly in relation to mortuary services, and further discussions are scheduled.

Alert – matters of concern for escalation	
Finance & Productivity Committee	**Quality Committee**
Finance - May • Group position £0.96m behind plan at Month 1 (RWT 0.6m and WHT 0.36m) • Elective income underperformance (£0.8m) linked to reduced activity levels due to Industrial Action. • Industrial action cost pressures (£1.5m) are currently based on estimates, further detail will be available from month 2. • Total savings requirement for the Group of £81.3m presents a significant delivery challenge. NHS England require Trusts to identify 100% of the savings plan by 31st May 2026. • £36m of CIP schemes have been assessed as high risk of non/reduced delivery (£29m RWT, £6m WHT) Finance – June • The Group position is behind plan by £1.0m year-to-date, with RWT £0.6m behind plan, and WHT £0.4m behind plan, related to industrial action costs in April. Both Trusts are on plan in month. • Variable elective activity is behind the Group plan by £1.0m YTD, with each Trust below plan by £0.5m, impacted by industrial action in April by £0.5m at RWT and £0.2m for WHT. Blended UEC activity is £0.4m below plan for RWT and £2.4m above plan for WHT. • The total efficiency challenge in 2026/27 for the group is £81.3m; RWT £53.8m, WHT £27.5m. The in-month plan was £4.2m. In month 2 RWT overperformed by £1.4m against a plan of £2.2m. WHT underperformed by £0.1m in month against a plan of £1.2m. K Stringer informed the Committee that a CEO led meeting is taking place tomorrow to discuss a Cost Improvement Programme for both organisations. • Capital expenditure year to date is £3.6m (£2.6m RWT and £1.0m WHT), an underspend of £1.17m (£0.7m RWT and £0.47m WHT). • The cash position for both Trusts is positive at £54.3m for RWT, and £46.5m for WHT. The deficit support funding (DSF) for Q1 is recommended to be paid by NHS England Midlands based on in year performance. Future quarters DSF will also be assessed on financial performance. Workforce - May • Continued high reliance on bank staffing, impacting cost and stability. • Elevated long-term sickness absence, primarily driven by stress/anxiety. Revised sickness targets have been implemented. The workforce team are producing a strategic document for analysis. Additional workstreams have been compiled for medical productivity and temporary staffing. Workforce – June • Total WTE deployed across M2 26/27 was 202.7 WTE adverse to plan.	

Alert – matters of concern for escalation	
Finance & Productivity Committee	**Quality Committee**
• WHT is overall 92.1 WTE above plan, whilst RWT is overall 110.6 WTE above plan. Both Trust WTE positions have decreased since M12 25/26; however, deploying bank WTE relative to the 26/27 workforce plan remains a challenge. From a group perspective, there has been an overall decrease of 137.4 WTE since M12 25/26. • At WHT there has been an over delivery of planned workforce/pay cost savings driven by casual vacancies for the second consecutive month. • At RWT there is a negative variance of actual workforce/pay costs savings compared to plan.	

Alert – matters of concern for escalation	
People Committee	**Partnerships & Transformation Committee**
• The Committee received an update regarding performance against workforce plan. At the Committee's request the report has been structured to provide an update on delivery against people related efficiency schemes to support delivery of the financial plan • M1 26/27: Total WTE deployed was 286.32 adverse to plan. • M2 26/27: Total WTE deployed was 202.70 WTE adverse to plan. • Despite reductions, WHT is 92.1WTE and RWT is 110.6WTE above plan at M2. • Deploying bank WTE relative to the 26/27 workforce plan remains a challenge and there is currently no assurance that the workforce plan will be achieved. The Committee will monitor the e-rostering expansion to seek assurance whether the greater grip and control over temporary staff usage is having the planned outcome. • At the end of M2 the top 5 pay /WTE related schemes set out within the financial plan were received by the committee alongside an update regarding the top 5 pay/WTE schemes currently within delivery. • Sickness absence and appraisal compliance across both trusts remain challenged. The committee endorsed the commitment to provide an update of plans agreed by senior leaders across the Group to improve the timely completion of appraisals to Trust TMC and GMC in July.	• **Plans for the move into Community& Timing** - Hospital savings are underpinned by investment in a greater reliance on community-based care. We are concerned that plans for transitions are still in development. • Communications and Engagement Plan - Requirement for clear public and internal engagement plan to ensure that transformational activity is understood and new approaches are effective
Digital and Estates Strategy Committee	
• Estates and digital needs yet to be fully scoped against the clinical strategy. • Draft terms of reference have been produced for the Committee but await review as part of wider Governance review of Committees.	

Assure	
Finance & Productivity Committee	**Quality Committee**
<u>May</u> Assurance was provided regarding the deliverability of 69% RTT by the end of March 2027. An Insourcing and	• The West Midlands Fire Service Fire Safety Enforcement Notice relating to the Nucleus Theatres in Block 55 at New Cross Hospital has been lifted following completion

Assure	
Finance & Productivity Committee	**Quality Committee**
Outsourcing plan is also being developed. • Emergency Services are working through the CQC and GIRFT actions. • Medical E-rostering to commence for Junior Doctors July 2026. • Both RWT and WHT are performing above the national average for 4-hour standard, ranking 20th and 8th respectively, placing them in the upper quartile nationally. • WHT remains 1st quartile RTT 18-week performance, above national and regional averages. • WHT have committed to additional MRI capacity (+140 scans per week) as an interim measure to improve DM01, while further options are being explored. • Strong cash balances across both Trusts (£53.3m RWT/£50.5m WHT) <u>June</u> • <u>Winter Plan Debriefs</u> – Were noted and contents were approved. Early draft Winter Plan will be submitted to Trust Board in July and final plan to Trust Board in September. • <u>National Oversight Framework</u> – Informed re increase to number of indicators and way in which assessed has changed. Awaiting technical guidance. • <u>Group National Cost Collection Assurance</u> – noted and received for assurance. • <u>EPR Post Implementation Review</u> – Discussed and noted. Further reviews will be monitored via GDESC. • <u>BAF/Site Specific BAFs/TRR</u> – Transition phase and changes were noted.	of the required works. • Following the Nursing and Midwifery Council update regarding historic system failures relating to health and character declarations, both RWT and WHT confirmed that no staff within either organisation were affected. • The significant improvement in WHT 0–19 developmental checks for children aged 2–2.5 years, from 71% to 87%, was formally recognised by the Regional Director of Public Health, Professor Mike Ward. • The Dermatology Cancer Clinical Nurse Specialist Team received the Team of the Year Award at the Healthy Futures Awards in recognition of their contribution and achievements. • Duty of Candour compliance at WHT improved to 100% during June. • Review of 22 Martha's Rule Calls for Concern at RWT identified no deterioration-related concerns requiring escalation, with themes primarily relating to communication and information-sharing. • Both RWT and WHT remain compliant with Ockenden Immediate and Essential Actions. • No MOSS Alerts were reported across either Trust. • The Health Inequalities Report identified positive progress across all five delivery themes of the Joint Health Inequalities Enabling Strategy, demonstrating the benefits of collaborative working between Wolverhampton and Walsall.

Assure	
People Committee	**Partnerships & Transformation Committee**
The Committee received update reports on: • Use of Resources Workforce Programme. The Committee is assured that the delivery programme has been reviewed and includes five core workstreams; e-rostering, corporate integration, sickness absence, medical productivity and temporary workforce. • The Committee were pleased to received the Freedom to Speak Up Annual (F2SU) report detailing F2SU activity across the Group for 2025/26. Both Lead F2SU Guardians for each Trust attended the Committee and presented key messages. The Committee were assured that Group level objectives to continue to improve the effectiveness and impact of the service and 'speak up' activity across each Trust were reflected within the plan and the F2SU had the appropriate support of senior leaders across both organisations. The Committee requested that for 2026/27, the F2SU teams set an improvement target on increasing feedback from colleagues whom access the service. • The Committee has welcomed receipt of reports detailing workforce related internal audit activity	• Outpatient transformation updates provided and discussion regarding areas of progress. Agreed to redesign report to focus more on transformational journey than detailed metrics to prevent repetition of F&P responsibilities. • Effective utilisation of Go See visits and integration into committee agenda and discussions • Positive assurance regarding maturity of Place-Based partnerships and opportunities for further development • Progress with Community First programme including development of mobilisation teams

Assure	
including outcome of audit findings, recommendations and an understanding of the actions being undertaken in response to audit findings/recommendations. The Committee has received an update regarding the outcome of review of compliance against pre-employment check standards at RWT and an update on the application of medical staffing rules at WHT. The Committee are assured that all recommendations have corresponding actions in place.	
Digital and Estates Strategy Committee	
• **NHS framework** provider has been appointed for Estate surveys • Digital Innovation framework has been finalised • AVT Heidi 2 year contract is in place. ED, SDEC and outpatients will be first to be deployed into • Group Digital workforce capability program is being mobilised	

Advise	
Finance & Productivity Committee	**Quality Committee**
• A revised Corporate Services Transformation Plan has been requested for the Committee and Trust Board. • WHT0055 Datix Risk Management System (Retrospective Contract Renewal 20/5/26) – Committee approved on the understanding that the Governance Team are able to off-set the cost pressure. • Commercial Contract with PA Consulting Ltd for Community First Initiative – Committee Approved (under delegated Trust Board Authority) on the understanding that the Executives have been given delegated authority to negotiate parameters for the best ROI fee ratio. Packages will be presented to the Committee and Trust Board for assurance as each one is designed. • Risk Register – The 7 WHT risks allocated to the Committee were discussed. 228 was deferred to GDEC for action following the Estates Survey. 426 risk rating is being re-examined following DSPT. • Review of ToR For Group Capital Review Group – The Committee reviewed and agreed the new Terms of Reference for the Group CRG Meeting. • WHT MRI Paper – Supported by the Committee. • Proposal for the Deployment of the LUNA ROVA AI-Enabled RTT Validation Solution – Committee approved.	• The ED CQC Action Plan continues to be reviewed and expanded into a wider CQC improvement programme. Whilst progress is evident, further assurance is required regarding the sustainability of improvements, particularly triage and ECG performance. Shift pattern reviews are underway to improve efficiency and productivity. Following representations by the Trust, the anticipated Section 29A Warning Notice was withdrawn. • A constructive CQC engagement visit took place at RWT, including UEC and nursing focus groups. Initial feedback identified no specific concerns and a further UEC inspection is anticipated. • WHT is awaiting NHSE confirmation that submitted data satisfies SACT Level 3 reporting requirements. • The Clinical Accreditation Visit pilot was positively evaluated and will be implemented across both Trusts once a suitable digital platform becomes available. • MRSA and MSSA performance at RWT remains above trajectory following outbreaks within the neonatal unit. Improvement work continues regarding intravenous lines and catheter management, with national IPC data awaited. • Falls and pressure ulcers continue to increase, although remain within tolerance levels. Improvement work continues across both Trusts, including Falls Prevention, Bathroom First and Eat, Drink, Dress and Move initiatives. Two Category 4 pressure ulcers were reported in WHT community services during May. Delays in specialist mattress repairs at WHT continue to affect capacity for prevention and management. MUST compliance is improving; however, neurological observations remain below policy standards and a bespoke training package is available to improve compliance.

Advise	
Finance & Productivity Committee	**Quality Committee**
	• Formal complaints at RWT have increased by 50% compared with last year. Whilst few complaints progress to the Ombudsman, there is an increasing number where elements are upheld. Improvement work continues around communication, information sharing and local resolution. • Implications arising from recent Supreme Court rulings relating to DOLS will be reviewed through safeguarding governance arrangements and implemented as required. • Cancer performance remains positive overall. WHT Breast Services have recovered sufficiently to provide mutual aid to RWT. Both Trusts continue to exceed the Faster Diagnosis Standard. RWT remains slightly below the national 31-day standard, whilst WHT remains above standard. WHT's 62-day performance remains below trajectory due to Oncology and Diagnostic capacity pressures. RWT remains on track for trajectory recovery by October 2026, with Urology and Gynaecology remaining the most challenged pathways • M01 performance at WHT remains below target due to pressures within MRI, Non-Obstetric Ultrasound, Audiology and Neurophysiology. Additional MRI capacity is operational, sonographer and audiology recruitment continues, and agency support remains in place for Neurophysiology. Performance recovery remains anticipated by December 2026. • Lung Screening services are now established within Staffordshire and are expected to influence referral pathways into RWT. RWT plans to commence its own Lung Screening service in September 2026 and pathways are under review to manage future demand. • Ambulance handover performance remains challenged across both Trusts, with the 15-minute offload standard not achieved. Twelve-hour waits have increased at both organisations and corridor care continued to be utilised during May. • The 104-day harm review identified 85 patients at RWT and 28 patients at WHT, with no harms identified. A peer review will be undertaken at RWT and capacity pressures, particularly within Radiology and Chemotherapy services at WHT, continue to be escalated through appropriate networks. • WHT continues to review arrangements for identifying patients requiring five-year Hydroxychloroquine follow-up, with options being explored to address the current limitations of paper records. • Virtual Ward utilisation at WHT has reduced to 53% and continues to be monitored. • Community waiting lists at WHT continue to improve slowly. Over-52-week waits are expected to reduce significantly over coming months, although Paediatric Dietetics remains challenging. External specialist support is being introduced to assist recovery.

Advise	
Finance & Productivity Committee	**Quality Committee**
	• Challenges continue in securing timely Mental Health clinical support for patients attending WHT ED, particularly out of hours. • Perinatal reporting is now aligned across both Trusts. MIS Year 8 activity is underway and work continues against Saving Babies Lives and Maternal Care Bundle requirements. Placental Growth Factor Testing remains an LMNS service gap outside the Trusts' direct control. • Perinatal mortality at WHT has stabilised. Partnership work continues regarding wider determinants of health and development of an Infant Mortality Strategy across the ICB. • Discussions continue regarding Obstetric Ultrasound capacity at WHT and the ability to meet clinical demand, including reduced fetal movement pathways. • WHT continues to perform strongly within the Regional Heatmap. RWT performance was impacted by an internal process issue which has now been rectified. • Aseptic Unit capacity continues to affect commencement of chemotherapy at RWT. A range of actions remain in place, with resolution anticipated by autumn 2026. • The Board Assurance Framework, Trust Risk Registers and associated toolkit continue to evolve in line with Transforming Care Together and emerging strategic objectives. A pilot toolkit is being tested at WHT prior to wider rollout. • Complaints response performance at WHT has reduced to 32%, with Surgical Services achieving 9%. Recovery actions are underway. • The RWT Adult and Paediatric Inpatient Skill Mix Review was considered. No immediate actions are required pending the outcome of national NHSE workforce work; however, a separate business case will be developed should additional funding become available. • A Stroke Mortality Alert covering April 2024 to March 2025 is under review. Local data does not currently suggest the Trust is an outlier and concerns have been escalated to the national team.

Advise	
People Committee	**Partnerships & Transformation Committee**
• The Committee received a detailed report forecasting retirements across the group outlining key risks at Trust, division, staff group and specialty level. The Committee accepted that mitigating actions would be delivered through the Transforming Care Together (TCT) workstreams, Workforce Design and Culture and Improvement. • The Committee has requested a detailed plan specifying the actions that will be taken at Trust level to improve the 2026 NHS Staff Survey response rate and noted this is	• Funding allocations for Place are still not confirmed, the committee will monitor any impacts of partnership delivery and/or financial impact for the Group. • Go See visits have identified some themes regarding staff culture in relation to compliance and empowerment to drive transformation. These themes will be shared via Executives and People Committee • Chair observed Sandwell and Dudley equivalent

Advise	
People Committee	**Partnerships & Transformation Committee**
due to be received in July. • The Committee has noted the intention to review and receive for assurance in August; Trust level Annual Equalities Reports, Trust level Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) results. In parallel, the Committee has specifically requested clarification regarding the racial diversity of middle management across the Group. • The Committee has requested clarity regarding people metrics of the NHS National Operating Framework following confirmation of how the staff survey and people standards will be applied. • The committee has reviewed and agreed the workforce targets and thresholds for 26/27 financial year. In doing so, the Committee noted that the sickness absence target would need to be updated in line with the improvement trajectory and requirements of the financial plan. • The Committee received an updated Committee workplan and terms of reference, however, have noted the work being undertaken across all board sub-committees and agreed to defer consideration by the GPC until the Group level crosscutting review has been completed. This will now be considered by the GPC in July.	committees and highlights areas for consideration/development • Public and Patient engagement and involvement representation and focus • Secondary/Primary care interface • Health inequalities • Anchor institute role (not NHS Anchor traditional view as a community anchor) • There is progress with Community First delivery partner, but contract negotiations are ongoing and the learning review still needs to be completed to ensure full utilisation of partnership and learning to inform our approach and comply with NHSE caveats for approval. • 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.

Advise	
Digital and Estates Strategy Committee	
A good response was received for expressions of interest for Digital Partner. Due to competing priorities this will not be progressed further for 6 months. A framework for benefits realisation for Digital solutions needs a more structured approach and will be developed.	

Tier 1 - Paper ref:	Enclosure 7.1

Report title:	Board Assurance Framework
Sponsoring executives:	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 Stephanie Cartwright, Group Chief Officer for Community and Partnerships
Report author:	Paul Assinder, Group Vice-Chair
Meeting title:	Group Board of Directors Meeting – held in Public
Date:	21 July 2026

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

The Executive Directors and the Committee Chairs, at subsequent meetings, reviewed and closed the previous BAF Risks following the Boards decision to retire the previous Strategic Objectives and BAF Risks at the Board Meeting on 19 May 2026. The BAF presented at the meeting today, 21 July 2026 is based on the future Strategic Objectives derived from the Transforming Care Together Programme, it is presented as a DRAFT for Board approval prior to going into the board committee meeting cycle for adoption and oversight/assurance. It 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.

There will be additional Strategic Objectives added to the BAF as they are agreed.

The Board received, reviewed and approved a revised Risk Appetite Matrix at a Group Board Development session in June 2026, and this is reflected in the scoring in this report.

The revision of The Group Board Assurance Framework (GBAF) has been carried out alongside mapping of the site level BAFs at The Royal Wolverhampton and Walsall Healthcare NHS Trust.

The Board is asked to receive the site level BAF risks for information and assurance:

- **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).

- **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).

- **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).

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).
  Following an initial review of SR15, 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)).
  Following an initial review of SR17, it was agreed that the risk score of 16 (4 likelihood x 4 consequence) remains appropriate.
- **SR18 – Cyber** (Group Finance & Productivity Committee)
  Following an initial review of SR18, 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)
  Following an initial review of SR19, 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).
  Following an initial review of NSR 101, it was agreed that the risk score of 10 (2 likelihood x 5 consequence) remains appropriate.
- **NSR 102 – Culture** (Group People Committee).
  Following an initial review of NSR 102, it was agreed that the risk score of 12 (3 likelihood x 4 consequence) remains appropriate.
- **NSR 103 – Staffing** (Group People Committee)
  Following an initial review of NSR 103, it was agreed that the risk score of 9 (3 likelihood x 3 consequence) remains appropriate.
- **NSR 104 – Patient Safety** (Group Quality Committee)
  Following an initial review of NSR 104, it was agreed that the risk score of 9 (3 likelihood x 3 consequence) remains appropriate.
- **NSR 105 – Finance Resources** (Group Finance & Productivity Committee)
  Following an initial review of NSR 105, 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)
  Following an initial review of NSR 106, it was agreed that the risk score of 16 (4 likelihood x 4 consequence) remains appropriate.
- **NSR 107 – Meeting or Exceeding Constitutional Standards** (Finance & Productivity Committee)
  Following an initial review of NSR 107, 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 *[at which meeting[s] has this paper/matter been previously discussed?]*
This paper has not been presented to any other committee save for agreement by the executive directors following the retirement of the previous strategic objectives at the Board Meeting on 19 May 2026.

4. Recommendation:
The Board is asked to receive for information and approval the newly agreed BAF risks presented with this paper in DRAFT form as GBR TCT1, GBR TCT 2 and GBR TCT 3.
Consider any emerging potential risks included on or for inclusion on the summary 'Watch List' (see Annex 1).
Match future reports to the appropriate BAF Risk as either evidence (of control and/or assurance) or indicative of Negative Assurances and/or Gaps in Control.

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

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. Mis-management of patient care – long term/permanent consequences. Single or multiple substantiated complaints with long term/permanent consequences. Loss of body part; long term disability etc refer to matrix harm definitions. Complaint findings meets/ potential meets the serious incident criteria.	Substantiated complaint. Mis-management 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	4	5

Annex 1
Watch List - Summary potential new BAF risks June 2025

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

Strategic Aim & Objective Transforming Care Together 2026–2031 **Strategic Objective 1:** We want our colleagues to feel cared about	**Risk Title: 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: *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:**		**Trajectory:**	New risk for 2026/27 – baseline established
Group Chief People, Culture and Improvement Officer		People Committee	Workforce sustainability; safe staffing; culture and leadership			
Opened Date:	**Initial Score:** *with no controls applied*	**Current Score:** *with controls in place*	**Target Score:** *after actions are completed*			
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					

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**
• 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 **Strategic Objective 2:** We want to improve safety by reducing the time patients wait	**Risk Title: TCT2 – Timely and Safe Access to Care** **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: *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:**	**Trajectory:**	New risk for 2026/27 – baseline established
Managing Directors	Finance & Productivity Committee	Urgent and emergency care flow; elective recovery; cancer performance; community waits		

Opened Date:	**Initial Score:** *with no controls applied*	**Current Score:** *with controls in place*	**Target Score:** *after actions are completed*
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				

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**
• 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 monitor 2026/27 recovery trajectories for each constitutional standard • Consider transformation resource to the pathways with the greatest safety impact • Review system discharge and intermediate care capacity issues through the place partnerships

Strategic Aim & Objective Transforming Care Together 2026–2031 **Strategic Objective 3:** We want to deliver our services efficiently	**Risk Title: TCT3 – Financial Sustainability and Efficient Use of Resources** **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: *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:**	**Trajectory:**	
Group Chief Finance Officer	Finance & Performance Committee	CIP delivery; temp workforce; capital & estates; digital transformation		New risk for 2026/27 – baseline established

Opened Date:	**Initial Score:** *with no controls applied*	**Current Score:** *with controls in place*	**Target Score:** *after actions are completed*
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				

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**
• Financial delivery plans agreed for each Trust, division and corporate area • CIP governance with PMO oversight and delivery tracking of the £81m programme • 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	• Proportion of the CIP not yet identified or reliant on non-recurrent measures • 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

Tier 1 - Paper ref:	Enclosure 8.1

Report title:	Transforming Care Together 2026-31 - Progress Report
Sponsoring executive:	Simon Evans, Deputy CEO & Group Strategy Officer
Report author:	Kate Salmon, Deputy Chief Strategy Officer - Transformation
Meeting title:	Public Trust Board
Date:	21st July 2026

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

Assure

The Public Trust Board can be assured that all ten TCT workstreams are active, with governance structures and Executive SROs in place. Significant Q1 milestones have been delivered across the programme, including:

- the Ambient Voice Technology contract signed, and programme mobilised with clinical champions in post
- the Clinical Services Roadmap presented to the TCT Group with a tiered pipeline of service opportunities identified
- the Digital Transformation workstream delivering strong progress including noteless working live at WHT

Advise

- The Transformation Delivery Unit is being established under the leadership of the Deputy Chief Strategy Officer, with recruitment to Programme and Project Manager posts underway across the workstreams.
- Indicative savings have been identified across the four efficiency-generating workstreams (Outpatients, Planned Care, Digital Transformation and Community First) for the first three years of the programme; however, these figures are indicative and subject to Finance validation.
- The next TCT progress report to the Public Trust Board will be presented in October 2026, and will include an updated Programme RAG summary, benefits tracker, and the TCT KPI Dashboard
- Digital team capacity is stretched across concurrent programmes, with an options paper under executive consideration for the noteless workstream.
- Efficiency schemes across the programme are at an early stage of development.
- The capital funding landscape for the Estates Optimisation workstream remains uncertain, with dependency on NHSE capital allocations.

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 Transforming Care Together Strategy 2026-2031 was approved by the Group Trust Board in March 2026. It was formally launched across both organisations in April 2026. This is the first progress report to the Trust Board in public since formal launch.

4. Recommendation(s)/Action(s)

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

a) RECEIVE this first progress report on Transforming Care Together 2026-2031 across both Walsall Healthcare and The Royal Wolverhampton NHS Trusts.

b) NOTE the overall progress across workstreams

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

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 21st July 2026

Transforming Care Together 2026-31 - Progress Report

Executive Summary

The Transforming Care Together (TCT) 2026-2031 strategy was formally launched in April 2026 following Board approval in March 2026. This paper provides the first public progress report to the Trust Board, covering all ten TCT workstreams.

Programme Headlines – Q1 2026/27

- The TCT Group, chaired by the Group CEO, meets monthly with an agreed annual planner to monitor progress on all workstreams (excluding Productivity & Financial Sustainability – this workstream is monitored through the Use of Resources Programme).
- The Transformation Delivery Unit (TDU) has been established under the leadership of the Deputy Chief Strategy Officer, who will be the Transformation Programme Director. A proposal has been developed, setting out Programme and Project Manager roles across the workstreams, with cross-cutting support in Business Intelligence, Finance, Workforce, Communications and Administration. Recruitment to key posts is underway.
- A clear and structured savings profile has been established across the relevant TCT workstreams, distinguishing:
  - Efficiency generating programmes: Outpatient Transformation, Planned Care Redesign, Digital Transformation, Community First
  - Enabling workstreams: Staff Involvement, Culture & Improvement, Workforce Redesign, Neighbourhood Health
  - Workstreams still in development: Estates Optimisation and Clinical Services Roadmap

  An indicative savings profile has been identified for each of the first three years across the four efficiency generating workstreams (as above). This is an evolving financial pipeline over 3-5 years, and these figures are indicative, subject to Finance validation. Estates Optimisation and Clinical Services Roadmap contributions will be significant but remain in development.

  The enabling workstreams create the conditions for other workstreams to deliver, develop the workforce and culture needed for transformation, or address systemic challenges that, while strategically important, will not yield near-term efficiency savings.

- **Significant programme milestones have been delivered in Q1:**
  - ✓ The Ambient Voice Technology programme has moved into active mobilisation following contract signature with Heidi, with clinical champions in post and a Programme Steering Group overseeing delivery.
  - ✓ Both Trusts are targeting October 2026 go-live across ten specialties for Single Point of Access (Advice & Guidance) through e-RS, creating a single digital entry point for all GP referrals so that patients are triaged by a specialist and directed to the right care setting first time - reducing unnecessary outpatient appointments and supporting delivery of the 18-week RTT standard.
  - ✓ Work on the Clinical Services Roadmap has progressed with a structured assessment of service opportunities currently being defined.
  - ✓ The business case for the Bilston Community Diagnostic Centre (CDC) will be presented for approval in July.

- ✓ The Digital Transformation workstream has delivered strong progress across the Group Digital Enabling Plan, key achievements include:
  - Noteless working now live in WHT Dermatology
  - The deployment of the electronic Prescribing and Medicines Administration (ePMA) digital system (WHT) is underway, this replaces paper-based prescribing and drug charts, allowing clinicians to prescribe medications electronically and nurses to record when medicines have been given to patients, reducing the risk of prescribing errors and improves patient safety.
  - RWT Phase 2 EPR planning established
  - Group Readiness has been approved by NHSE for 2,000 Full AI co-pilot licences to be distributed across nominated services within the Innovation works programme.

- A TCT KPI and Milestones Dashboard has been developed and presented to the TCT Group for SRO validation of metrics and trajectories. The dashboard will be developed into a Power BI reporting tool by the Information Team, providing live RAG status, milestone tracking and quantitative KPI trend data (SPC) for both internal governance and Board assurance purposes. This will be shared in the next progress report to Trust Board.

Recommendations

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

a. Receive this first progress report on Transforming Care Together 2026-2031 across both Walsall Healthcare and The Royal Wolverhampton NHS Trusts.
b. Note the overall progress across workstreams.

Simon Evans
Deputy CEO & Group Strategy Officer

July 2026

Workstream Progress: Detail

1. Staff Involvement, Culture & Improvement	
Executive Sponsor	Dr Claire Radley
Summary of Progress Good progress has been made across a number of foundational activities since the TCT programme launched. A Group-wide staff engagement mapping exercise has been completed, undertaken collaboratively by the OD teams across both trusts, which provides a comprehensive picture of existing engagement forums and levers. The findings were presented to the Chief People Officer earlier this month and will inform decisions about whether current mechanisms are sufficient or whether new structures are required. In parallel, a 2026 NHS Staff Survey response rate improvement plan is being developed, which will be presented to the Group Management Committee in the coming week and to the Group People Committee at the end of July. The Improvement Director post has been appointed, providing important leadership capacity for developing an improvement system building on the existing improvement approach. Work is also underway to map current leadership and management development provision against the National Management Leadership Framework, ahead of its publication, and an improvement approach to colleague appraisal compliance is actively in progress given current performance against that metric. The cultural improvement programme - which will draw together strands across OD, communications, and quality improvement - is in development. The CPO, who joined in March 2026, has articulated a clear intention to build this programme progressively through 2026/27, with the Improvement Director's appointment seen as a key enabler. The Board Development session on staff survey results and risk appetite for people risk, held in April, has contributed to shaping priorities. Work is also progressing on EDI, sexual safety, and the Freedom to Speak Up annual report process, with both trusts operating their own internal feedback mechanisms; a proposal to introduce an improvement metric to increase colleague satisfaction in FTSU feedback was raised at Group People Committee (June).	
Key Milestones Q1 2026/27	• Improvement Director appointed - providing leadership capacity for the quality improvement strand • Staff engagement mapping exercise completed • Board Development session held on staff survey results • Joint EDI Steering Group established • Staff survey response rate improvement plan in development • Breakthrough objectives set • Mapping underway against National Management Leadership Framework • Improvement approach to colleague appraisal compliance initiated - internal work underway to improve both compliance rates and quality of appraisals, ahead of any national process changes
Risks / Issues	• Metrics under review - existing measures are currently under review, revised proposals will be brought through governance • Improvement Director not yet embedded • National Management Leadership Framework not yet published – potential further delays due to recently government changes. • National appraisal review outstanding – as above, limiting the ability to redesign the local process
Reporting Committee	Group People Committee

2. Clinical Services Roadmap	
Executive Sponsor	Dr Brian McKaig
Summary of Progress The Clinical Services Roadmap was presented in full to the TCT Group on 24 June 2026. A structured assessment of service consolidation and reconfiguration opportunities has been completed through a series of clinical panels and workshops, covering oncology, paediatrics, maternity, ophthalmology, rheumatology, spinal surgery, haematology, respiratory, sexual health, and pharmacy, among others. Our agreed priority specialties for initial focus are ophthalmology, rheumatology, spinal surgery, community paediatrics, and Trauma & Orthopaedics; a medium-term pipeline (6–18 months) including development of the Bilston Community Diagnostic Centre, theatre capacity decisions at Cannock, and maternity service integration; and longer-term strategic decisions, principally the future site configuration of multiple services. The Group endorsed the principle that service decisions must be clinically led and financially sound, demonstrating either equivalent service for less cost or better service for the same cost. As each opportunity is developed further, CIP will be identified and monitored through the TCT CIP tracker.	
Key Milestones Q1 2026/27	• Phase 1 Clinical Services Roadmap presented to Trust Board • Completion of all specialty panel meetings and workshops Q1 • Initial specialties scoped for roadmap development - Q2 2026/27 • Engagement with ICB/ICS clinical strategy underway
Risks / Issues	• Clinical capacity constraints are limiting engagement pace -escalated to Executive leads; additional TDU resource being deployed. • Risk that Trust-level service plans diverge from Black Country system strategy - mitigated through ongoing engagement with the ICB.
Reporting Committee	Trust Board

3. Outpatients Transformation	
Executive Sponsor	Dr Zia Din
Summary of Progress The Outpatients Transformation workstream is delivering strong momentum across all delivery programmes and is one of the most active workstreams in the TCT portfolio. **Single Point of Access (SPoA):** Both Trusts are members of three ICB working groups covering directory of services, pathway mapping, and standard operating procedures, ensuring a consistent system-wide approach. Both trusts have identified its top ten priority specialties, aligned with Black Country Primary Care Network priorities, with Task and Finish Groups established. RWT is rolling out its Clinical Assessment Service, with Ophthalmology having gone live, and Diabetes, General Surgery, Gynaecology, Urology, Dietetics and Rheumatology in the pipeline. Both Trusts remain on track for the October 2026 target of ten specialties live on electronic triage via e-RS although WHT has a technical blocker with the absence of e-RS/CareFlow integration. A bid has been submitted (June) for Frontline Productivity funding for a technical/digital solution with a self-build API option if the bid is unsuccessful. **Pathway Redesign:** WHT is making strong progress on Audiology; PEP rollout Q2, PIFU and virtual clinics for Balance Patients in development and focused improvement work is underway with ENT, Paediatrics and Gynaecology as outlier services for remote consultations. Both Trusts are actively working with the Black Country Primary Care Collaborative to implement BSOL/GIRFT best-practice pathways across the top ten priority specialties. **Performance:** Both trusts are making measurable progress against KPIs and have already exceeded the national 5% PIFU target, with a trajectory target of 8% (RWT) and WHT 10% stretch target. Outpatient	

Dashboards are in place providing real-time data. A directorate tiering system is also being implemented at RWT to target additional transformation support to the most challenged services. The efficiency savings profile from Outpatients is the most well-developed in the programme, savings are identified from follow-up reduction, SPoA diversion, PIFU improvement, remote consultations, and clinic template optimisation.	
Key Milestones Q1 2026/27	• Meetings held with exemplar organisations to share learning on Pathways development and PIFU • Bids submitted for Frontline Productivity Funding for a digital solution to integrate e-RS and Careflow (WHT) and additional support to accelerate AVT roll-out • Patient Engagement Portal (PEP) roll-out to all specialties (WHT)
Risks/Issues	• EPR integration risk – potential delays both for e-RS and AVT – mitigations are being developed
Reporting Committee	Group Partnerships & Transformation Committee

4. Planned Care Redesign	
Executive Sponsor	Gwen Nuttall & Amelia Godson
Summary of Progress • **Cannock Hospital Elective Hub**: Repatriation of Walsall orthopaedics to WHT's refurbished theatres (September 2026) releases Cannock Theatre 7 and other capacity for additional elective work and potential for private patient activity. Extending to 3-session days and weekend lists, could generate efficiency opportunities once operating at full capacity but requires further work and validation. • **Community Diagnostic Centre** (Bilston CDC): Good progress with all partners and positive feedback received from NHSE, business case due for sign off and submission July 2026. Longer term there will be an opportunity to reduce the use of mobile diagnostic services eg. MRI scanner currently at WHT. • **Theatre productivity and day case rate improvement**: Theatre utilisation improvement from current levels to 90% (stretch target) – focussed plans to be developed to complement BAU activities. • **Prehabilitation programme**: Reducing on-the-day surgical cancellations due to patients not fit for surgery (an issue at both sites - data to be collected and financial modelling). A multi-specialty prehabilitation programme will be developed.	
Key Milestones Q1 2026/27	• CDC business case completed • Private patients in scope confirmed
Risks / Issues	• None identified
Reporting Committee	Trust Board

5. Productivity and Financial Sustainability	
Executive Sponsor	Kevin Stringer
Summary of Progress The Productivity and Financial Sustainability workstream is reported through the Use of Resources Group and is not duplicated at TCT level; the overarching financial balance target is a programme-level output to which all workstreams contribute. The savings profile spanning all applicable TCT workstreams has been established, the paper sets out a clear framework distinguishing efficiency-generating workstreams (Outpatients, Planned Care, Digital, Community	

First), enabling workstreams (Staff Involvement, Workforce Redesign, Neighbourhood Health) and those still in development (Estates Optimisation, Clinical Services Roadmap). Indicative consolidated savings across the first three years has been identified, however all figures are subject to Finance validation and evaluation to remove the risk of duplication or double counting. This is being led jointly by the TCT Programme Director and the Operational Directors of Finance at both Trusts.	
Key Milestones Q1 2026/27	• TCT CIP register established covering all ten workstreams - May 2026 • In-year savings profile identified and entered in register - Q1 2026/27
Risks / Issues	• Efficiency schemes are at early stage; slippage risk is HIGH given Q1 identification - monitored at Programme Board monthly.
Reporting Committee	Group Finance & Productivity Committee

6. Workforce Redesign	
Executive Sponsor	Debra Hickman
Summary of Progress The Workforce Redesign workstream is at early stages and is appropriately designated as an enabling workstream within the TCT framework. A baseline assessment of nursing and AHP skill sets is underway across both Trusts, and engagement with HEI providers has commenced, particularly around Advanced Clinical Practitioner (ACP) programmes and frailty capability development. The workstream governance structure has been agreed, with strong interdependencies mapped to Staff Involvement, Culture & Improvement, Digital Transformation and the Clinical Services Roadmap. There is potential for a combined NHS/Local Authority band 2–3 community role to reduce duplication of staff visiting patients at home, and this will be taken forward jointly with Community First SRO. The workstream will align to the forthcoming NHS Workforce Plan once published, and the financial benefits of Workforce Redesign – principally reduced temporary staffing spend, agency reduction and ACP pipeline development – will be captured within the workstreams where savings manifest (Planned Care, Community First and Corporate HR) rather than as a standalone target.	
Key Milestones Q1 2026/27	• Workforce Redesign scope confirmed at Programme Board -June 2026 • Interdependency mapping with other TCT workstreams completed • HR and OD colleagues formally engaged in workstream governance
Risks / Issues	• The workstream will require workforce planning expertise and capability which is limited in the trusts • High interdependency with other workstreams creates coordination complexity - being managed through TCT Programme Board. • Industrial relations context requires careful stakeholder management for any workforce change proposals.
Reporting Committee	Group People Committee

7. Digital Transformation	
Executive Sponsor	Nick Bruce
Summary of Progress The Digital Transformation workstream is progressing across several concurrent programmes, all operating within the Group Digital Innovation Framework. This has been established to provide consistent governance, assurance, and strategic direction across both Trusts, aligning with the new finalised Group Digital Enabling Plan for 2026-2029. The overarching strategic aim is to deliver a Group-wide Electronic Patient Record (EPR),	

full patient portal functionality integrated with the NHS App, and a range of AI and automation tools - including Ambient Voice Technology across all clinical specialties - that together will reduce administrative burden, support noteless clinical working, and improve patient self-management.

The EPR programme is a major area of focus. At RWT, Phase 1 EPR is complete with residual optimisation work ongoing, and Phase 2 Discovery is now finished with Kick-Off sessions commenced, Functional Design Groups completed and clinical workflow events underway.

At WHT, the Frontline Digitisation programme is actively rolling out Electronic Prescribing and Medicines Administration (ePMA), Careflow Connect has expanded to additional wards, and noteless working is live in Dermatology Outpatients with a roadmap agreed for further specialties.

Both Trusts are also progressing cloud hosting migration for their EPR environments, a foundational enabler for future digital convergence, with WHT's migration to the cloud required by October 2026. Wi-Fi infrastructure and inter-site network capacity are being upgraded across both sites to support the growing demands of digital programmes including AVT.

The Ambient Voice Technology (AVT) programme has moved into active implementation following the formal signing of the Heidi Health two-year contract in April 2026. The original pilot specialties are continuing with a full roll-out to ED at WHT (Q2). A Group Clinical Lead has been appointed, clinical leads identified across Paediatrics, T&O, Gynaecology and General Surgery at both Trusts; clinical workflow mapping and template design sessions are underway. Key dependencies being actively managed include completion of the Data Protection Impact Assessment (DPIA), which is awaiting outputs from the clinical safety hazard workshop (July 2026), and resolution of BYOD (bring your own device) constraints. The clinical coding add-on module for Heidi has been deferred pending DGFT pilot outcomes in autumn 2026 and confirmation of Heidi's pricing model.
Across the Digital Innovation programme, several enabling schemes are progressing in parallel.

- A Group-wide e-Consent solution is in procurement, with supplier alignment discussions underway.
- A digital meal ordering pilot is being scoped across six wards and four sites.
- An automated waiting list validation tool business case has been approved for both Trusts.
- The Patient Engagement Portal has been fully deployed across all agreed Walsall services and outpatient clinics. RWT are continuing to work in transitioning to a new patient portal supplier.
- A Group Digital Workforce Capability programme is building AI literacy through a consolidated training catalogue and intranet-based learning packages.
- At WHT Four Eyes theatre efficiency pilot is also underway, using AI and Robotic Process Automation to optimise theatre slot utilisation and procedure time modelling.

Significant upgrade work across Group Infrastructure and Networks has commenced. External inter-site/Internet bearers across Group are being upgraded to ensure sufficient capacity and resilience to support increasing demand from Trust-wide initiatives, including AI/AVT and other major digital programmes where cloud based, or internet-based access is required. Bandwidths are being upgraded up to five times more performant than current established speeds, with Walsall upgrading to the latest Wi-Fi capabilities, which will ensure an enhanced performance, reliability, and user experience across sites.

On funding, twenty-four submissions were made across the Group to the national Frontline Productivity Programme, totalling £4.7m capital and £988k revenue in 2026/27 alone (rising to £21.9m capital and £6.1m revenue across the four-year period). Two further bids were submitted for WHT referrals and appointments digital tooling, with outcomes expected imminently.

Key Milestones Q1 2026/27	• Digital Innovation Framework established, bringing all divisional innovation schemes under a consistent Group-wide governance structure • From Q1, all new device procurements and replacement programmes have been aligned to HP Single Device, enabling volume-based purchasing efficiencies, reducing complexity, and delivering improved value for money.

Risks / Issues	• EPR integration risk for AVT implementation – mitigations are being developed by the EPR Integration Group. • Capacity of the digital team is stretched across concurrent programmes, where effective prioritisation is needed to deliver the urgent core strategic transformational enablers. • Insufficient resources to deliver the noteless programme of work within in expected timeframes – an options paper has been developed for executive consideration and review (mitigations)
Reporting Committee	Group Digital & Estates Strategy Committee

8. Community First	
Executive Sponsor	Steph Cartwright

Summary of Progress

A six-month Proof of Value phase has been completed, providing an important evidential foundation for the three-year programme. A series of Rapid Improvement Events were delivered across both Trusts, testing new ways of working in Medical Same Day Emergency Care at RWT and front door frailty at both Trusts, alongside ward-based processes at both sites. These were complemented by strong programme management, data analytics, clinical observations, and listening and mapping sessions with staff and services. The findings from this work confirmed the opportunities for left shift and have directly shaped the three-year delivery plan.

In terms of programme infrastructure, both Trusts have submitted their planning assumptions for Community First, including associated bed day reduction and closure modelling, to support system-level planning. Communications to date have included updates through the programme governance structure, targeted engagement with clinical teams involved in the Rapid Improvement Events, all-staff communications, and partnership and staff engagement sessions. Evidence from national and international best practice, GIRFT reviews, and participation in the national neighbourhood and frailty programmes have also been gathered to inform the developing interventions. A business case has been developed for continued delivery partner support as the programme transitions from the Proof of Value phase into full three-year delivery.

Community engagement sessions are underway through established networks, and an Easy Read version is available for community use. The Macmillan social investment fund opportunity (potentially up to £12m for the Black Country) is being actively explored; a two-page expression of interest has been submitted with Executive approval, though no commitment has as yet been made. The financial risks of a social investment model (based on payback in full) are being reviewed jointly with the Group. The indicative savings opportunity from this workstream is being validated. The SRO is working to clarify the operational boundaries between Community First, Neighbourhood Health and left-shift programmes to prevent duplication and ensure coherent messaging for staff and partners.

The Community First transformation programme has provided an opportunity for staff to bring their ideas to life through a carefully governed improvement process. High levels of staff morale have been observed and reported with a growing number of ideas for improvement coming through from across both organisations.

Key Milestones Q1 2026/27	• Proof of Value phase (October 2025 – April 2026) including five Rapid Improvement Events across a range of pathways and processes • Improvements made in frailty ward daily discharges and long lengths of stay, reduced admissions and conversion rates, reduced length of stay on surgery wards from 15 to 8 days, increased numbers through SDECs • Community First Business Plan 2026 – 2029 • Community First Three Year Transformation Plan business case supported by the Group Board, the ICB and NHSE

	• Community and clinical engagement sessions undertaken through existing Trust and partnership networks • Community First pillar programmes and interventions agreed
Risks / Issues	• Large scale transformational change incorporating significant shift in culture • Reduction in activity is filled with unmet need • Financial levers not aligned to left shift • Lack of engagement from partners in the next phase • Insufficient return on investment
Reporting Committee	Partnerships & Transformation Committee

9. Neighbourhood Health	
Executive Sponsor	Steph Cartwright
Summary of Progress The Neighbourhood Health workstream is progressing well within the context of a rapidly evolving national policy landscape and increased expectations from national directions. Significant progress has been made over the last six months including alignment of staff and services into neighbourhood footprints, identification of high risk cohorts based on population health data, identification of neighbourhood health centres across both places and the development of operating models for neighbourhood teams across both places. Alongside this work the ICB has also begun the process for delegation of place decision making in relation to provision of service to local place partners, through the NHS Trusts as anchor organisations. Developmental meetings with primary care in preparation for this transition have been held in both places. Development sessions have been held with both place-based partnership boards in preparation for resetting governance and plans alongside transfer of responsibilities to anchors and place commissioning. Refreshed plans have been agreed to support the implementation of neighbourhood health in both places. Claire Fuller, National Director of Neighbourhood Health visited Wolverhampton at the end of June to see our work on population health management and risk prediction through the complex care tool, our community first plans and our co-ordination of out of hospital care. Claire will be returning to visit the ICB cluster at the end of July where she will be looking at progress made across the Cluster in the implementation of neighbourhood health. Draft Neighbourhood Health Plans which were signed off by Health and Wellbeing Boards in March 2026, will be refreshed alongside Health and Wellbeing Board Strategies over the coming months.	
Key Milestones Q1 2026/27	• Draft Neighbourhood Health Plans signed off by Health and Wellbeing Boards in March 2026. • Staff aligned from partnership into integrated neighbourhood teams in each neighbourhood footprint • Development of Integrated Neighbourhood Teams (INT) Operating Models • Enabling neighbourhood care one of five pillars in the Community First Transformation Programme • Reset of place partnership priorities to support the implementation of neighbourhood health • Delegation through to place through Local Authority led commissioning and anchor led delivery
Risks / Issues	• Potential overlap with Community First transformation programme • Lack of engagement and prioritisation from partners • Significant culture shift for individual services and staff

Reporting Committee	Group Partnerships & Transformation Committee

10. Estates Optimisation	
Executive Sponsor	Gwen Nuttall, Amelia Godson, Chris Hodgson

Summary of Progress

- Integrated Women's and Children's Division and associated Maternity New Build: This is the most significant capital programme under consideration. NHS England has signalled that a new build at New Cross Hospital (Wrekin House extension or car park site) should future-proof maternity and neonatal capacity, including additional neonatal cot capacity requested informally by LNC. The Black Country ICB is conducting a root-and-branch capacity and demand review of maternity services across the cluster. An initial Strategic Outline Case to NHS England is being targeted for September/October 2026. This programme has major capital implications and potential cost avoidance (including avoiding substantial ventilation works at WHT and resolving Better Births funding pressures). It has not yet been costed.
- West Park future use: A valuation and strategic options assessment will be worked through.
- Site rationalisation and lease exits: Both sites are already delivering savings through lease exits, portacabin removal and building consolidation within divisional CIPs. This will be further driven by the Clinical Services Roadmap and needs to be considered in 2026/27.
- Staff environment improvements: A site-wide survey of staff rest areas and working environments across WHT and RWT is to be commissioned through the Group Director of Estates. This is most likely to be a cost rather than a saving - a phased investment programme to improve NHS Staff Survey scores and staff wellbeing.

The ICB has included six Wolverhampton sites on its Neighbourhood Health Centre list, including West Park; capital allocations and decision-making timelines are being clarified. The Cancer Centre feasibility has been deferred pending the outcome of the Clinical Services Roadmap and wider ICB oncology strategy work and is not expected to be a near-term priority. Efficiency opportunities from Estates are significant but remains in development, with West Park and Wilbraham Court options assessment and reprovision planning.

Key Milestones Q1 2026/27	• Appointment of Interim Group Director of Estates • Maternity and Women and Children's Hospital SOC: early scoping
Risks / Issues	• Capital funding landscape for 2026/27 is uncertain - dependency on NHSE capital allocations.
Reporting Committee	Group Digital & Estates Strategy Committee

Next Steps

- The next TCT progress report to the Public Trust Board will be presented in October 2026, covering Q1 and Q2 2026/27 progress across all ten workstreams.
- An updated Programme RAG summary, benefits tracker, and savings profile will be presented alongside the Q2 report.
- The Digital Transformation workstream risks (EPR integration and AVT clinical safety) will continue to be escalated and monitored at Group Director level, with a further update to the Board if risks materialise.

Impact Assessments	
Financial implications	There are no direct financial implications arising from this paper. CIP implications are tracked through the TCT CIP Register, reported to the Finance and Performance Committee.
Quality and patient safety	The TCT programme is designed to improve clinical quality, patient safety, and patient experience across both Trusts. Individual programme risks to patient safety are managed through the relevant workstream governance.
Equality and diversity	An Equality Impact Assessment will be completed for each workstream as delivery planning is confirmed. No adverse equality impacts are anticipated from this report.
Legal implications	None arising from this report.
Communications	An internal and external communications and engagement plan is in place for the TCT programme. This report is being presented in public.
Risks	Key programme risks are summarised in the workstream sections above.

Tier 1 - Paper ref:	Enclosure 8.2

Report title:	Anchor Development
Sponsoring executive:	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 Michelle Carolan, Advisor on Commissioning Integration
Meeting title:	Public Trust Board
Date:	21st July 2026

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

Following the presentation from ICB colleagues to the private meeting of the Board in May, the Board is asked to note the development of an Anchor approach across Wolverhampton and Walsall, and the next steps in this development.

This paper provides an overview of the Black Country Integrated Care Board's Anchor Framework, why it has been developed, how it aligns with national NHS policy, and how Wolverhampton and Walsall are developing their local Anchor approach in response. It is intended to provide strategic context for the Board and members of the public. More detailed work on governance, operating arrangements and delivery will be brought to the Board as the programme develops.

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 Private meeting of the Board received a presentation from the ICB on the proposed anchor arrangements in May 2026.

4. Recommendation(s)/Action(s)

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

a) The Board is asked to note the national and local direction of travel in relation to developing anchor arrangements, the progress made to date in developing the Anchor approach across Wolverhampton and Walsall, and the planned next steps

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

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

Report to the RWT/WHT Group Trust Board Meeting to be held in Public
on 21st July 2026
Anchor Development

1. Executive Summary

Why Anchor?

Our population increasingly need care that is joined up and co-ordinated across hospitals, community services, primary care, local authorities and the voluntary sector. Improving health outcomes therefore depends on organisations working together around the needs of local communities, rather than operating within organisational boundaries.

National policy is reinforcing this direction. The NHS 10 Year Health Plan sets out a clear ambition to develop a neighbourhood health service with a stronger emphasis on prevention, earlier intervention and care delivered closer to home.

In response to this national direction, the Black Country Integrated Care Board has developed an Anchor Framework that enables appropriate functions to be exercised closer to communities through capable place-based leadership, within a clear line of NHS accountability, and partners continue to work together through locally agreed partnership arrangements, each retaining its own statutory responsibilities, enabling decisions to be taken closer to local communities while maintaining clear accountability across the system.

Together, these developments create an opportunity for capable local organisations to take a broader leadership role, working with partners to improve health, reduce inequalities and join up care more effectively around local communities. The Anchor approach is our local response to that opportunity and is a significant step forward towards developing our Group of organisations as Integrated Health Organisations in the future.

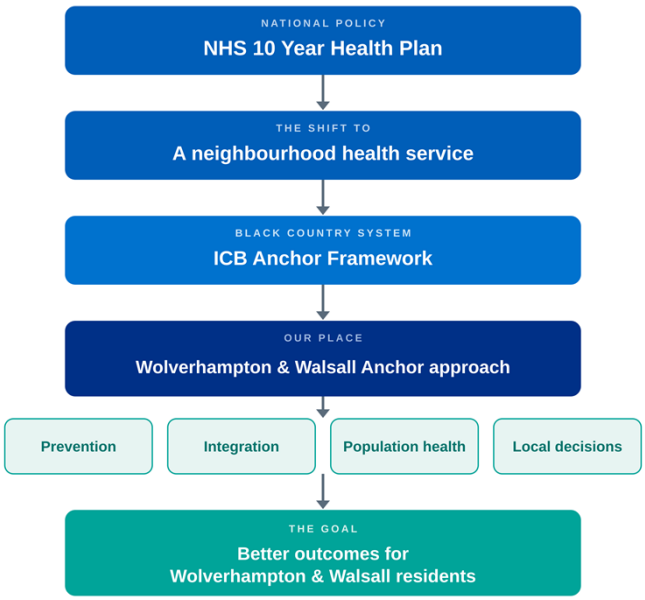


Figure 1: From national policy to local outcomes — the line of sight for the Anchor approach.

What is an Anchor?

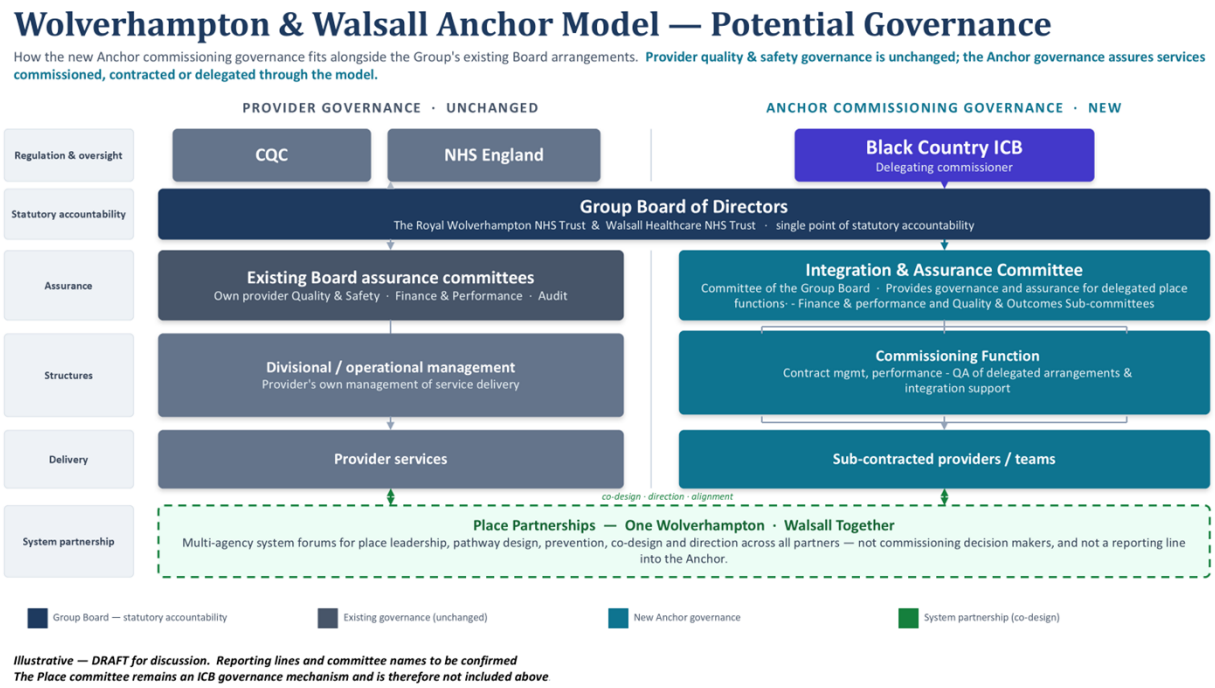
An Anchor provides leadership, as an integrator and a convenor, within a place-based approach, to improve health and wellbeing outcomes for a defined population. Its focus is on:

- improving population health
- preventing ill health wherever possible
- integrating services around people's needs
- supporting and enabling more care to be delivered closer to home
- strengthening local decision making and accountability.

An Anchor organisation will also deliver services, but its distinctive role sits above delivery providing the strategic leadership and commissioning capability to understand and respond to what the population needs, plan how care is organised across the place, and hold a clear focus on improving outcomes. Delivery itself stays with providers and the existing partnerships.

The Anchor approach does not change the statutory responsibilities of partner organisations. Any responsibilities exercised through an Anchor arrangement will operate through existing statutory powers, delegated functions and locally agreed partnership arrangements. Walsall & Wolverhampton Trusts acting as the Anchor for each place will be accountable to the ICB through an agreed lead provider contractual arrangement, separate to that of the core acute contract. See Figure 1 below for a suggested governance model that can be established to support the development of anchor arrangements across the Group. This suggested governance model would include primary care representation from both places to demonstrate commitment to partnership working and co-design of the anchor model for each place.

Figure 2: Potential Governance arrangement for anchor development:



As it develops, the Anchor approach will focus on the outcomes that matter most for local people, aligned to the priorities set out in the ICB's Clinical Strategy, local Health and Wellbeing Strategies informed by Joint Strategic Needs Assessments and the national ambition for neighbourhood health described through the Neighbourhood Health Framework. A central principle is that decisions are taken in the interest of the whole population, rather than any single organisation.

3. Current Position

Wolverhampton and Walsall have a strong history of partnership working through Walsall Together and OneWolverhampton and are well placed to build on this as national policy and local delegation evolves.

Following publication of the Black Country ICB Anchor Framework, a joint programme has been established to develop the approach across Wolverhampton and Walsall. Board development sessions have commenced, engagement with system partners is underway, a fortnightly steering group has been established including Executive and Non-Executive representation and work is progressing to develop the supporting governance and operating model.

Our initial focus is on strengthening community and Home First models of care, enabling more people to remain happy, healthy and independent and cared for within, or close to, their own homes wherever appropriate.

This is deliberate, phased development work. The current emphasis is on establishing shared principles, governance arrangements and strong partnerships before moving into implementation.

An important early step is to agree the scope of the approach, what is and isn't included and to build from a clear and shared baseline. Over time, and as confidence in the arrangements grows, the intention is for more of the planning and coordination of care to be led at place through the Anchor, always within a clear and continuing line of NHS accountability. This will be developed carefully and in collaboration with partners.

4. Next Steps

Over the coming months we will:

- continue engagement with and involvement of partners across Wolverhampton and Walsall, including primary care, local authority and the voluntary, community and social enterprise sector
- agree and develop the governance and leadership arrangements, including clear roles and decision making rights, so that responsibilities and accountability are well understood across partners
- work with the ICB to define the scope and contractual arrangements and confirm how the approach is funded and contracted, including reviewing existing contractual arrangements to align with the Trusts' three year financial plans, which set out how care and resources can increasingly be focused closer to home while remaining within available resources.
- agree the scope of the approach and the population outcomes it will be measured against, aligned to the ICB's strategic and clinical frameworks
- ensure continued connection with our Transforming Care Together Strategy in particularly as an enabler of significant transformation through Community First
- identify the initial priority pathways where an Anchor approach can deliver the greatest early benefit for our populations
- develop a phased and realistic implementation roadmap that the system is confident can be delivered
- provide further updates to the Board as the programme progresses.

Success will ultimately be measured through improved health outcomes, stronger integration between organisations and services, better experiences for local people and more effective use of public resources.

Recommendation

The Board is asked to note the national and local direction of travel in relation to developing anchor arrangements, the progress made to date in developing the Anchor approach across Wolverhampton and Walsall, and the planned next steps.

Report title:	Group Finance & Workforce Report
Sponsoring executive:	Kevin Stringer, Group Chief Finance Officer Claire Radley, Group Chief Officer for People, Culture and Improvement
Report author:	James Green, Director of Finance, RWT Dan Mortiboys, Director of Finance, WHT
Meeting title:	Group Trust Board held in public
Date:	21 July 2026

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

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

- Overall, the Group position is behind plan by £1.0m year-to-date, with RWT £0.6m behind plan, and WHT £0.4m behind plan, related to industrial action costs in April. Both Trusts are on plan in month. NHSE are currently holding a position that this will not be funded.
- Variable elective activity is behind the Group plan by £1.0m YTD, with each Trust below plan by £0.5m, impacted by industrial action in April by £0.5m at RWT and £0.2m for WHT. Blended UEC activity is £0.4m below plan for RWT and £2.4m above plan for WHT.
- The total efficiency challenge in 2026/27 for the group is £81.3m; RWT £53.8m, WHT £27.5m. The in-month plan was £4.2m. In month 2 RWT overperformed by £1.4m against a plan of £2.2m. WHT underperformed by £0.1m in month against a plan of £1.2m.
- Capital expenditure year to date is £3.6m (£2.6m RWT and £1.0m WHT), an underspend of £1.17m (£0.7m RWT and £0.47m WHT).
- The cash position for both Trusts is positive at £54.3m for RWT, and £46.5m for WHT. NHSE have verbally supported the Group to receive their Defcit Support Funding (DSF) for Q1. This assumes no deterioration in position in June. All DSF payments are required to be approved by NHSE.
- Workforce has decreased overall for the group in month, decreasing by 78 WTE at RWT and increasing by 26 WTE at WHT. Both Trusts are however 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?]*

Finance & Performance Committee meeting on 30th June.

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

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

Group Financial Performance & Workforce Report

for the month of May 2026

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

Care Colleagues
Collaboration Communities

I&E Summary

In-Month Income & Expenditure	RWT Plan M2 £m	RWT Actual M2 £m	RWT Surplus/ (Deficit) £m	WHT Plan M2 £m	WHT Actual M2 £m	WHT Surplus/ (Deficit) £m	Group position Plan M2 £m	Group position Actual M2 £m	Group position Surplus/ (Deficit) £m
Income	**85.9**	**86.3**	**0.4**	**39.1**	**39.3**	**0.2**	**125.0**	**125.6**	**0.6**
Expenditure									
Pay	56.0	56.5	(0.5)	27.0	26.8	0.2	83.0	83.3	(0.3)
Non Pay	21.8	21.6	0.1	9.5	9.7	(0.1)	31.3	31.3	0.0
Drugs	6.3	6.4	(0.1)	2.0	2.2	(0.1)	8.3	8.6	(0.2)
Other*	3.8	3.8	0.0	2.5	2.6	(0.1)	6.3	6.4	(0.1)
Total Expenditure	**87.9**	**88.3**	**(0.4)**	**41.1**	**41.3**	**(0.2)**	**129.0**	**129.6**	**(0.6)**
Net reported surplus/(Deficit)	**(2.1)**	**(2.0)**	**0.0**	**(2.0)**	**(2.0)**	**0.0**	**(4.0)**	**(4.0)**	**0.0**

Year-to-date Income & Expenditure	RWT Plan YTD £m	RWT Actual YTD £m	RWT Surplus/ (Deficit) £m	WHT Plan YTD £m	WHT Actual YTD £m	WHT Surplus/ (Deficit) £m	Group position Plan YTD £m	Group position Actual YTD £m	Group position Surplus/ (Deficit) £m
Income	**170.4**	**171.0**	**0.6**	**77.4**	**77.4**	**0.0**	**247.8**	**248.4**	**0.6**
Expenditure									
Pay	111.2	112.8	(1.6)	52.6	53.5	(0.9)	163.8	166.3	(2.5)
Non Pay	43.0	42.5	0.5	19.5	18.9	0.6	62.5	61.4	1.1
Drugs	12.8	12.8	(0.0)	4.7	4.5	0.2	17.5	17.3	0.2
Other(incl. depreciation)	7.7	7.6	0.0	5.1	5.3	(0.2)	12.8	12.9	(0.2)
Total Expenditure	**174.6**	**175.8**	**(1.2)**	**81.9**	**82.3**	**(0.4)**	**256.5**	**258.1**	**(1.6)**
Net reported surplus/(Deficit)	**(4.2)**	**(4.8)**	**(0.6)**	**(4.5)**	**(4.9)**	**(0.4)**	**(8.7)**	**(9.7)**	**(1.0)**

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

Key Headlines:

- Total YTD deficit of £9.7m,
- Performance in month 2 is on plan for both Trusts.
- Year to date performance is £1.0m behind plan; RWT £0.6m behind plan and WHT £0.4m behind plan due to industrial action.
- CIP overachieved in month by £1.3m, bringing the YTD overperformance to £0.8m; with RWT overperformance of £0.9m and WHT underperformance of £0.1m.
- Variable elective activity is behind the Group plan by £0.97m YTD, with WHT behind plan by £0.48m and RWT behind plan by £0.49m. The main cause of underperformance being reduced activity during the industrial action.
- Forecast: at this point in time, the Group is forecasting to achieve the plan.

Capital

- Capital expenditure year to date is £3.6m (£2.6m RWT and £1.0m WHT), an underspend of £1.17m (£0.7m RWT underspend, offset by underspend of £0.47m 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 other £1.0m will be repaid back in 27/28 as included in the Plan submission to NHSE.

Cash

- Following the receipt of YTD cash backed deficit support in 25/26 to enable a breakeven plan, both organisations have a good cash balance and do not foresee the need for any cash support for the year. Any under achievement against the efficiency plan will deteriorate the cash balance.

Better Payment Practice Code

- The Trust has a national target to reach 95% of invoices, in value and volume, to be paid within 30 days of receipt. Both organisations have been impacted by working capital management; the move to SBS and a new finance ledger and are below the target YTD but improving each month.

BPPC Performance	RWT		WHT	
	In-Month	YTD	In-Month	YTD
Value	87%	87%	90%	90%
Volume	68%	68%	89%	89%

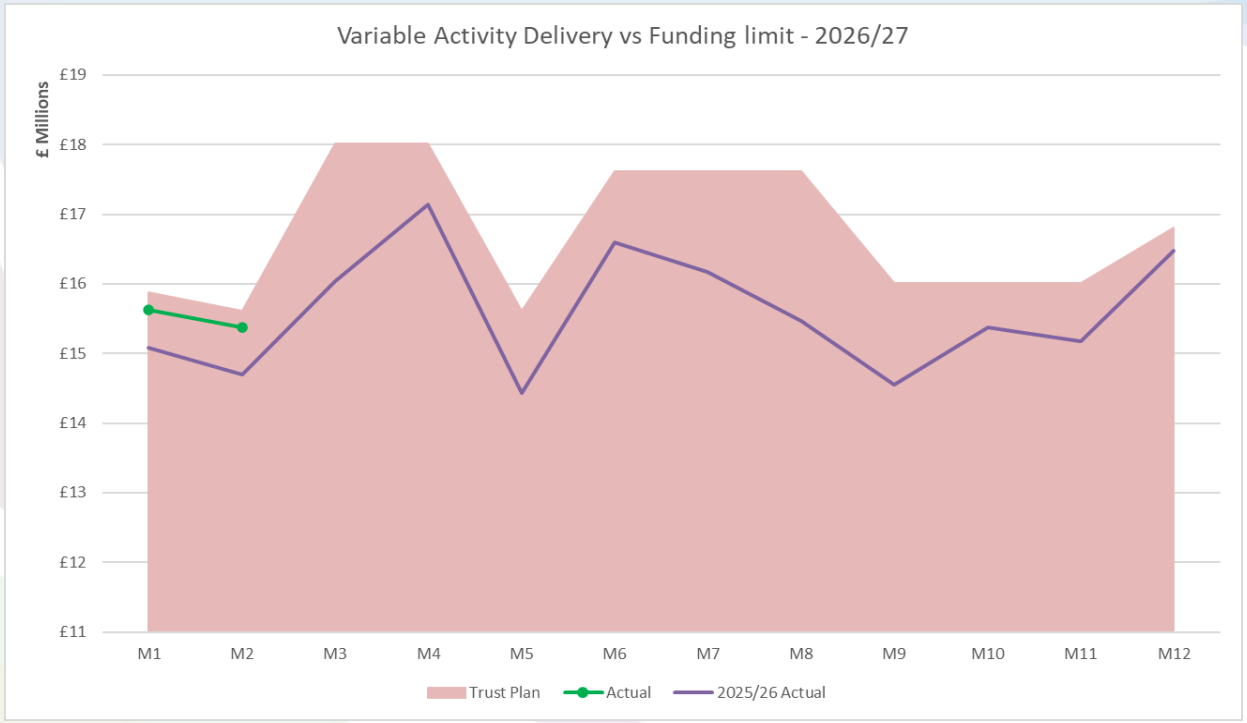
Key Month Items Within the Position

These include:

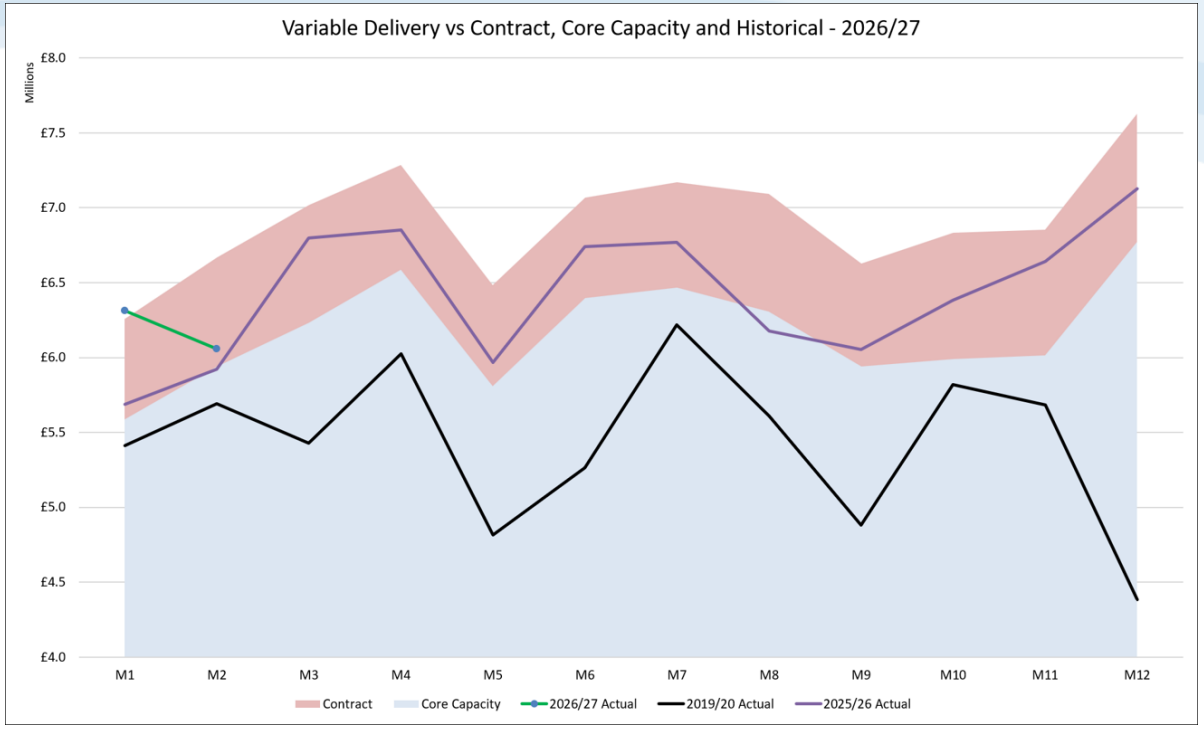
- **Income** overperformed against plan by £0.6m in month. Year to date there is overperformance on income of £0.6m, RWT is £0.6m ahead of plan due to maternity incentive income recognised earlier than planned, WHT is on plan.
- **Pay** is £0.3m worse than plan in month and £2.5m worse than plan YTD. YTD RWT is £1.6m worse than plan, of which £0.96m is due to unmet CIP and £0.58m is due to industrial action costs. WHT is £0.9m worse than plan YTD, the main driver for this is Industrial Action.
- **Non-Pay** is on plan in month and £1.1m better than plan YTD, with a RWT being £0.5m better than plan related GNRI releases. WHT is £0.6m better than plan due non-clinical areas such as transport and security.
- **Drugs** spend is £0.2m worse than plan in month and £0.2m better than plan YTD related to WHT, RWT's spend is on plan YTD.
- **Efficiency** performance is £1.3m better than plan in month and £0.8m better YTD - £0.1m behind plan at WHT and £0.9m better than plan at RWT.
- **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 2) the Group is forecasting achievement of the financial plan.

Variable Activity Performance – 2026/27 M2

RWT



WHT



RWT

Year to date variable elective income is performing £495k below plan. The reduction in activity seen during the industrial action period in April amounts to £481k and therefore explains the majority of the underperformance year to date.

NB The value of uncashed outpatient activity has been estimated within the above and is therefore subject to change once cashed.
In addition, Clinical coding for May was 0.5% complete and the value of uncoded activity has been estimated at average tariff and is therefore also subject to change once coded.

WHT

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 £0.475m behind contract but would be £0.25m behind without industrial action.

While some productivity plans are delivering the majority are planned to deliver later in the year.

Variable Performance YTD – 2026/27 M2

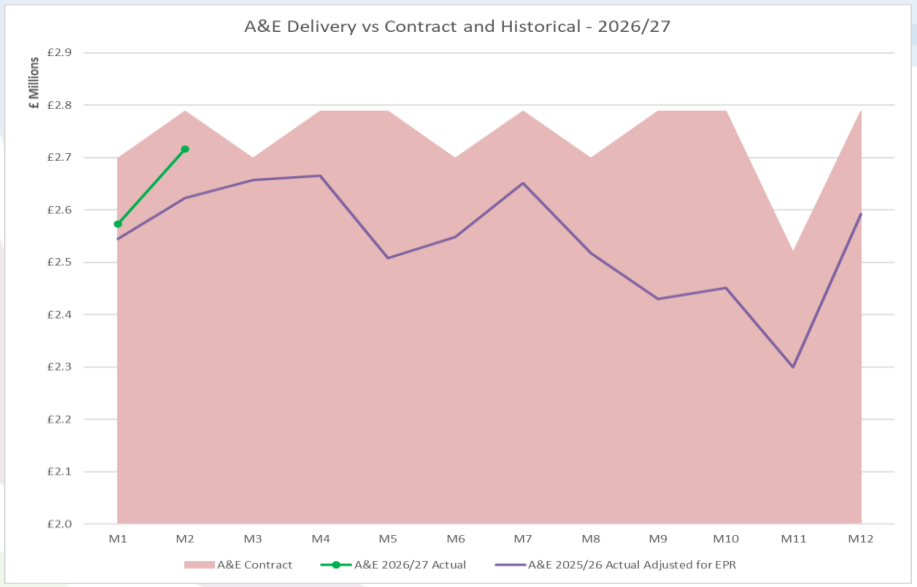
Point of Delivery	RWT			WHT			Group		
	Plan Activity	Actual Activity	Variance Activity	Plan Activity	Actual Activity	Variance Activity	Plan Activity	Actual Activity	Variance Activity
Elective	1,164	1,359	195	438	353	(85)	1,602	1,712	110
Planned Same Day	8,826	8,260	(566)	4,881	4,839	(43)	13,708	13,099	(609)
Outpatient Procedures	26,772	26,875	103	7,363	7,386	23	34,135	34,261	125
Procedures Total	**36,762**	**36,494**	**(268)**	**12,683**	**12,578**	**(106)**	**49,445**	**49,072**	**(374)**
Outpatient 1st	35,167	33,424	(1,743)	19,772	19,613	(159)	54,939	53,037	(1,902)
Diagnostic Imaging	13,156	13,929	773	17,944	17,684	(260)	31,099	31,613	514
Chemotherapy	2,347	2,513	166	995	1,109	114	3,343	3,622	280
Grand Total	**85,084**	**83,847**	**(1,071)**	**51,395**	**50,984**	**(411)**	**136,479**	**134,831**	**(1,648)**

	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective	7,560	7,961	401	1,958	1,684	(274)	9,518	9,644	126
Planned Same Day	9,812	9,045	(767)	4,016	3,859	(157)	13,828	12,904	(924)
Outpatient Procedures	4,764	4,785	21	1,467	1,521	54	6,232	6,306	75
Procedures Total	**22,136**	**21,790**	**(346)**	**7,442**	**7,064**	**(378)**	**29,578**	**28,854**	**(723)**
Outpatient 1st	7,069	6,817	(252)	3,659	3,563	(97)	10,728	10,379	(349)
Diagnostic Imaging	1,437	1,480	43	1,484	1,441	(43)	2,921	2,921	(0)
Chemotherapy	844	904	60	340	383	43	1,184	1,287	103
Grand Total	**31,486**	**30,991**	**(495)**	**12,925**	**12,451**	**(475)**	**44,412**	**43,442**	**(970)**

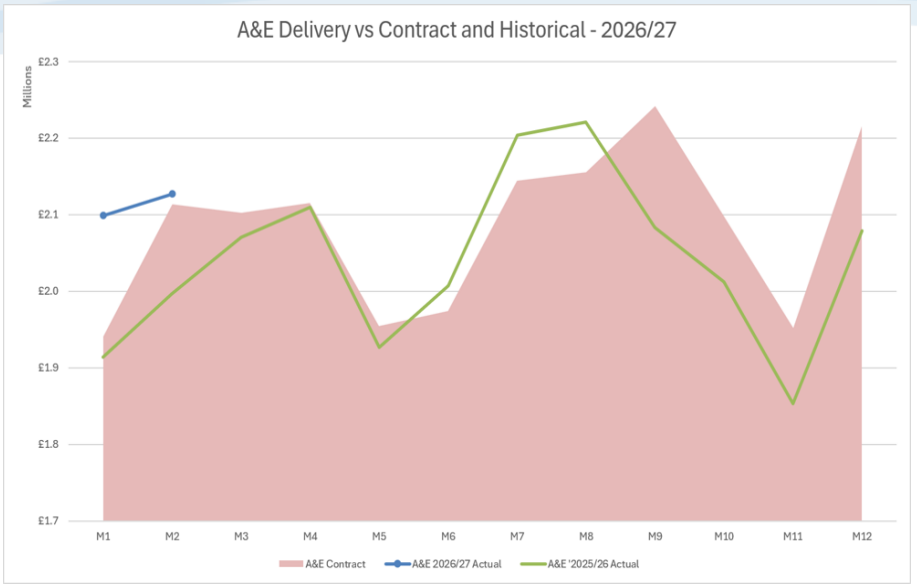
The group is £0.97m behind the RTT activity plan; with RWT underperforming by £0.495m and WHT underperforming by £0.475m. The point of delivery with the largest underperformance is planned same day. Both trusts experienced some variance due to the industrial action in month. RWT saw a reduction in activity of £0.48m in the strike period, WHT saw a £0.2m impact.

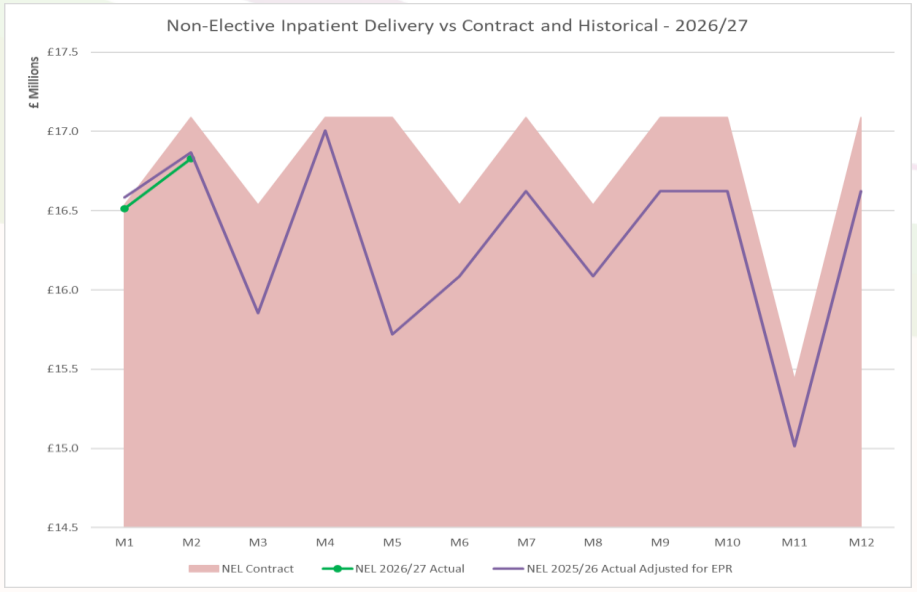
Blended (UEC) Performance – 2026/27 M2

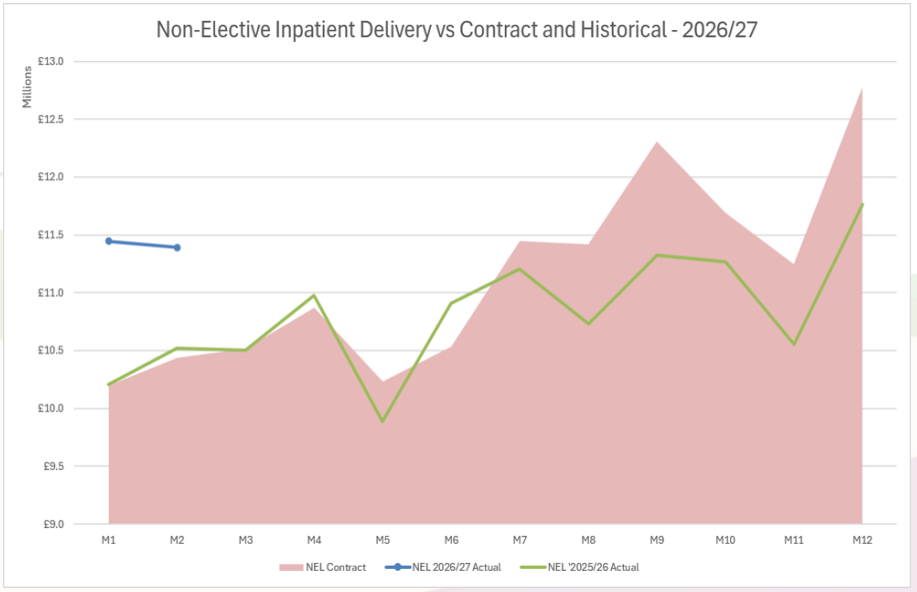
RWT



WHT







RWT UEC is £0.4m under contract with ED £0.2m (4%) under and NEL £0.2m (1%) under.

WHT UEC is £2.4m over contract with ED £0.2m (4%) over and NEL £2.2m (10.6%) over. £0.5m has been accounted as 20% as per blended rules.

CIP Performance YTD

	In Month			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
WHT	1.2	1.2	(0.1)	2.5	2.4	(0.1)
RWT	2.2	3.6	1.4	4.3	5.2	0.9
Group	**3.4**	**4.7**	**1.3**	**6.7**	**7.6**	**0.8**

The total efficiency challenge in 2026/27 for the group is £81.3m; RWT £53.8m, WHT £27.5m. The in-month plan was £4.2m.

In month 2 WHT underperformed by £0.1m against a plan of £1.2m. RWT overperformed by £1.4m in month against a plan of £2.2m, this is due to the achievement of the maternity incentive schemes and non-recurrent CIP related to non-pay underspends an GRN's.

Year to date the total overperformance against plan is £0.8m; £0.1m below plan at WHT and £0.9m above plan at RWT.

Statement of Financial Position

STATEMENT OF FINANCIAL POSITION Statement of Financial Position for the month ending May 2026	RWT			WHT		
	Mar 2026 Actual	May 2026 Actual	Movement YTD	Mar 2026 Actual	May 2026 Actual	Movement YTD
NON CURRENT ASSETS	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Property,Plant and Equipment - Tangible Assets	545,948	542,582	(3,366)	255,724	254,345	(1,379)
Intangible Assets	13,073	13,367	294	7,898	7,654	(244)
Other Investments/Financial Assets	15	15	0	0	0	0
Trade and Other Receivables Non Current	1,070	1,070	0	1,720	1,661	(59)
PFI Deferred Non Current Asset	5,155	5,155	(0)	0	0	0
TOTAL NON CURRENT ASSETS	**565,262**	**562,189**	**(3,072)**	**265,342**	**263,660**	**(1,682)**
CURRENT ASSETS						
Inventories	10,430	10,612	182	2,861	3,154	293
Trade and Other Receivables	52,586	38,305	(14,281)	27,258	9,858	(17,400)
Cash and cash equivalents	42,739	54,337	11,598	52,233	46,466	(5,767)
TOTAL CURRENT ASSETS	**105,755**	**103,255**	**(2,500)**	**82,352**	**59,478**	**(22,874)**
TOTAL ASSETS	**671,017**	**665,444**	**(5,572)**	**347,694**	**323,138**	**(24,556)**
CURRENT LIABLILITES						
Trade & Other Payables	(105,562)	(101,180)	4,382	(74,122)	(53,289)	20,833
Liabilities arising from PFIs / Finance Leases	(9,120)	(9,103)	17	(10,230)	(11,240)	(1,010)
Provisions for Liabilities and Charges	(2,855)	(2,460)	395	(860)	(860)	0
Other Financial Liabilities	(11,179)	(16,940)	(5,761)	(1,124)	(2,654)	(1,530)
TOTAL CURRENT LIABILITIES	**(128,716)**	**(129,681)**	**(965)**	**(86,336)**	**(68,043)**	**18,293**
NET CURRENT ASSETS / (LIABILITIES)	**(22,961)**	**(26,426)**	**(3,465)**	**(3,984)**	**(8,565)**	**(4,581)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**542,301**	**535,763**	**(6,537)**	**261,358**	**255,095**	**(6,263)**
NON CURRENT LIABILITIES						
Trade & Other Payables	0	0	0	0	0	0
Other Liabilities	(26,582)	(25,151)	1,431	(174,313)	(172,577)	1,736
Provision for Liabilities and Charges	(1,336)	(1,336)	(0)	(257)	(257)	0
TOTAL NON CURRENT LIABILITIES	**(27,918)**	**(26,487)**	**1,431**	**(174,570)**	**(172,834)**	**1,736**
TOTAL ASSETS EMPLOYED	**514,383**	**509,276**	**(5,107)**	**86,788**	**82,261**	**(4,527)**
FINANCED BY TAXPAYERS EQUITY						
Public Dividend Capital	350,852	350,853	1	283,327	283,326	(1)
Retained Earnings	31,045	25,936	(5,109)	(264,551)	(269,077)	(4,526)
Revaluation Reserve	133,711	133,711	0	68,012	68,012	0
Financial assets at FV through OCI reserve	(1,415)	(1,415)	0	0	0	0
Other Reserves	190	190	0	0	0	0
TOTAL TAXPAYERS EQUITY	**514,383**	**509,276**	**(5,107)**	**86,788**	**82,261**	**(4,527)**

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: £14.2m decrease with balances including prepayments, and accrued income. Trade & Other Payables: £4.4m increase with the decrease due to review of accruals. Most of the movement in Other Financial Liabilities relates to deferred income on non-recurrent projects such as PASEMR. Other Liabilities of £1.4m decrease due to movement in PFI/IFRS 16.

- WHT – Trade receivables and payables have been corrected for the receipt of additional cash at year end (payable at YE but now a prepayment in year). Cash and cash equivalents remain high due to the retained £12m on account from the ICB (April 26 mandate was not reduced for this), though this has reduced in month reflecting further movements in working balances and deficit position.

Care Colleagues Collaboration Communities

Cashflow as at 31st May

	RWT	WHT	Combined
	May-26	May-26	May-26
OPERATING ACTIVITIES	**Actual £'000**	**Actual £'000**	**Actual £'000**
Total Operating Surplus/(Deficit) (gross of control total adjustments)	**(2,777)**	**(2,248)**	**(5,025)**
Depreciation	5,629	2,627	8,256
Fixed Asset Impairments	0	0	0
Transfer from Donated Asset Reserve	0	0	0
Capital Donation Income	0	(24)	(24)
Interest Paid	(320)	(1,295)	(1,615)
Dividends Paid	0	(305)	(305)
Release of PFI /Deferred Credit	0	0	0
(Increase)/Decrease in Inventories	(182)	(293)	(475)
(Increase)/Decrease in Trade Receivables	14,598	17,488	32,086
Increase/(Decrease) in Trade Payables	(6,568)	(20,862)	(27,430)
Increase/(Decrease) in Other liabilities	5,759	1,530	7,289
Increase/(Decrease) in Provisions	(396)	0	(396)
Increase/(Decrease) in Provisions Unwind Discount	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**15,744**	**(3,382)**	**12,362**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received	428	336	764
Payment for Property, Plant and Equipment	(2,512)	(1,001)	(3,513)
Payment for Intangible Assets	(490)	0	(490)
Receipt of cash donations to purchase capital assets	0	24	24
Proceeds from sales of Tangible Assets	0	0	0
Proceeds from Disposals	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(2,575)**	**(641)**	**(3,216)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**13,170**	**(4,023)**	**9,147**
FINANCING			
New Public Dividend Capital Received	0	0	0
Capital Element of Finance Lease and PFI	(1,571)	(1,744)	(3,315)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(1,571)**	**(1,744)**	**(3,315)**
INCREASE/(DECREASE) IN CASH	**11,598**	**(5,767)**	**5,832**
CASH BALANCES			
Opening Balance at 1st April 2026	42,739	52,233	94,972
Closing Balance at 31st May 2026	**54,337**	**46,466**	**100,804**

Summary:
The cash balance is £100.8m, £54.3m at RWT and £46.5m at WHT. This is a decrease from last month of £4.6m (of which £1.1m is RWT increase offset by decrease by £5.7m from WHT). RWT's increase is due to payment of 25/26 accrued income.

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. This will be closely monitored throughout the year.

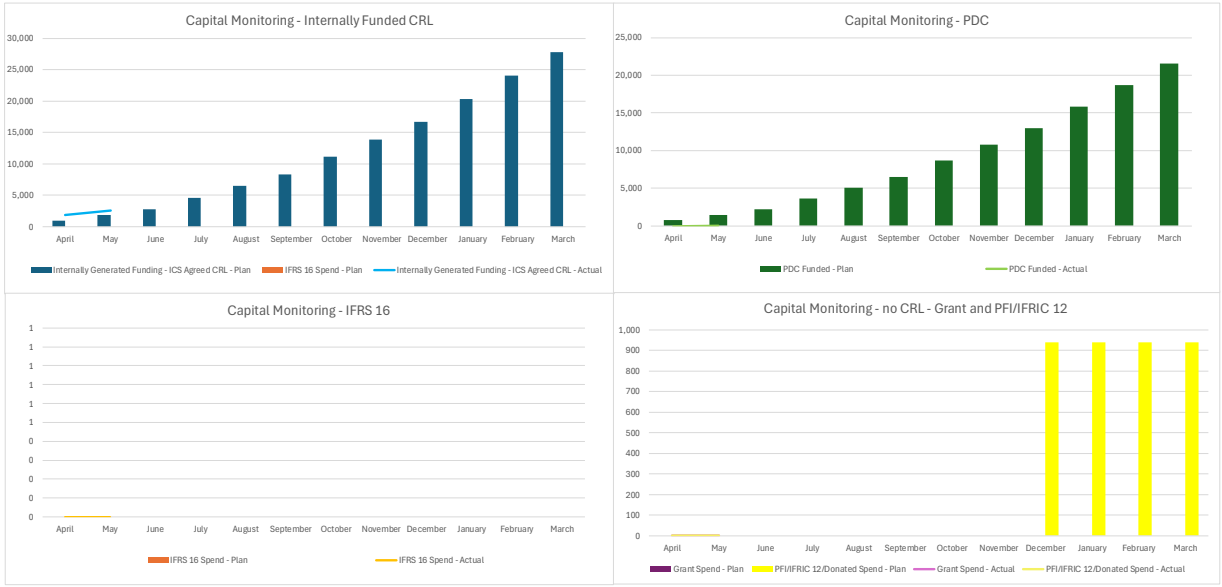
Care Colleagues Collaboration Communities

Capital RWT

The Trust has spent £2.6m of Capital to 31st May 2026, which is £0.7m lower than plan.

- CRL recorded a year to date spend of £2.5m which was £0.7m higher than plan. This is due to additional spend on Projects ahead of phasing, including conclusion of 25/26 Projects. The Trust anticipates meeting its FY CRL.
- PDC expenditure with a spend of £0.0m was £1.4m behind plan due to PDC bids although agreed by NHSE are still in planning stage, therefore phasing from 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 M2.



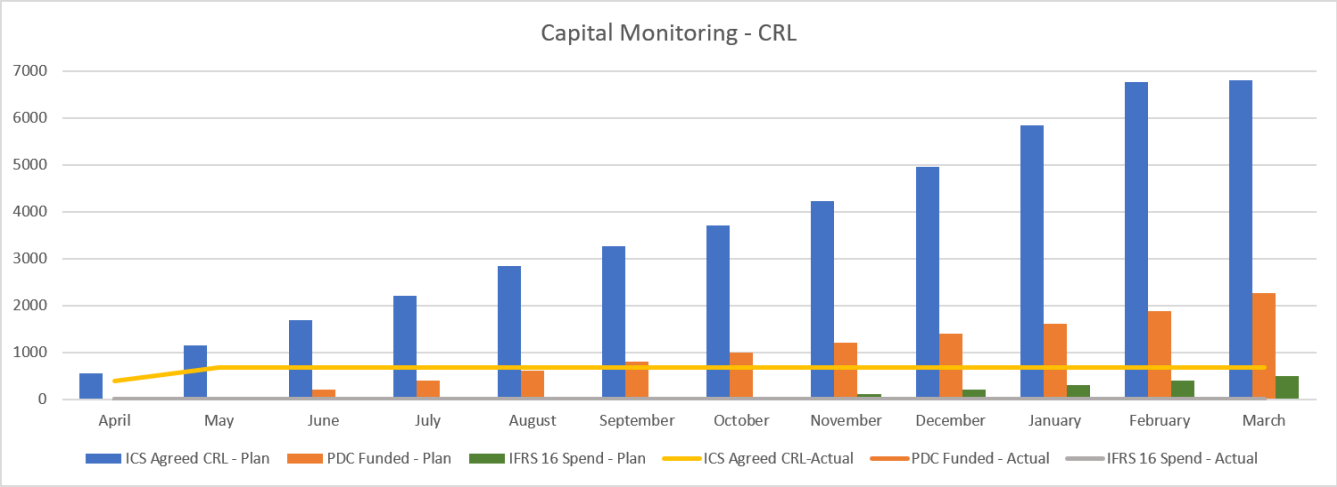
Care Colleagues Collaboration Communities

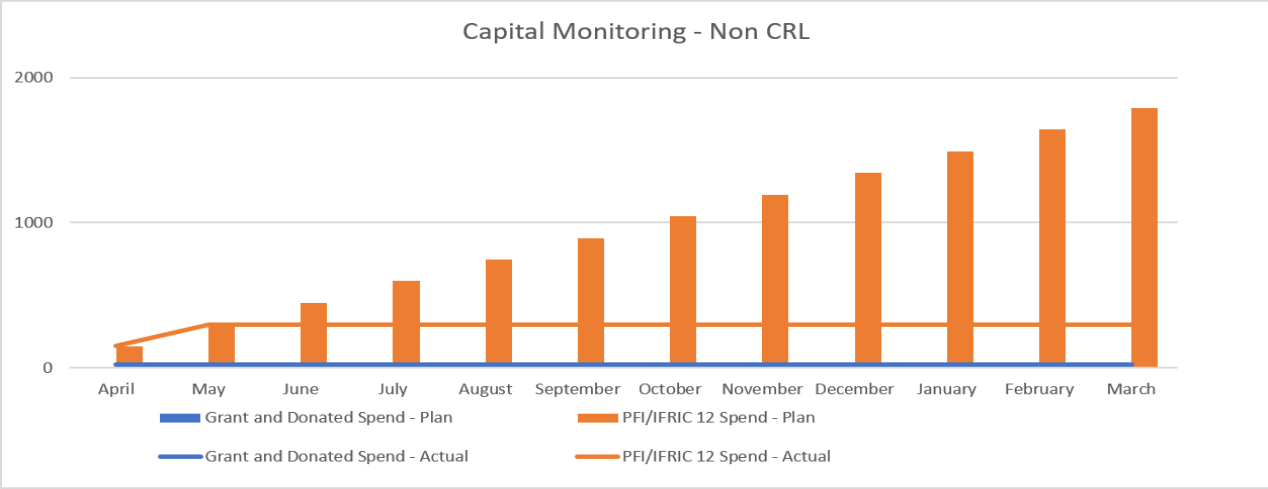
Capital WHT

• The Trust has spent £1.001m of Capital & IFRS16 YTD to 31st May 2026 against planned YTD Capital of £1.472m. Of the £1.001m YTD Spend

•£0.680m YTD Capital spend including IFRS16 relates to CRL the trust is measured against vs YTD Budget of £1.150m with a variance of £0.470m. No PDC Spend YTD. The trust plans to achieve CRL of £9.571m at the end of the year.

•The balance of the YTD Capital spend of £0.321m relates to Non CRL Capital with PFI/IFRIC 12 capital of £0.297m and donated medical equipment of £0.024m.





Scheme	M2 YTD Budget	M2 YTD Spend
CRL	**£'000s**	**£'000s**
Estates:		
ED Works - New Build - A&E/AAU	400	
Estates Lifecycle		235
Estates Lifts and Ventilation		
Estates Utilisation		
Theatres 1-4 Refurbishment	600	86
RWT Payback		
Estates Total	**1,000**	**321**
Medical Equipment:		
Medical Equipment		136
Medical Equipment Total	**-**	**136**
Information Management & Technology:		
IT Equipment	-	- 0
Data Centre / IT Replacement		48
ePrescriptions		
Electronic Prescribing Medicine Admin (EPMA)	150	
Ambient Voice Technology		
Frontline Digitisation		175
Information Management & Technology Total	**150**	**223**
PDC Funding		
Estates Safety Fund-PDC Funded		
PDC Funding Total	**-**	**-**
IFRS16		
Total IFRS16	**-**	**-**
Total CRL	**1,150**	**680**
Non CRL		
PFI Lifecycle:	298	297
Donated Medical Equipment	24	24
Total Non CRL	**322**	**321**
Grand Total	**1,472**	**1,001**

Care Colleagues Collaboration Communities

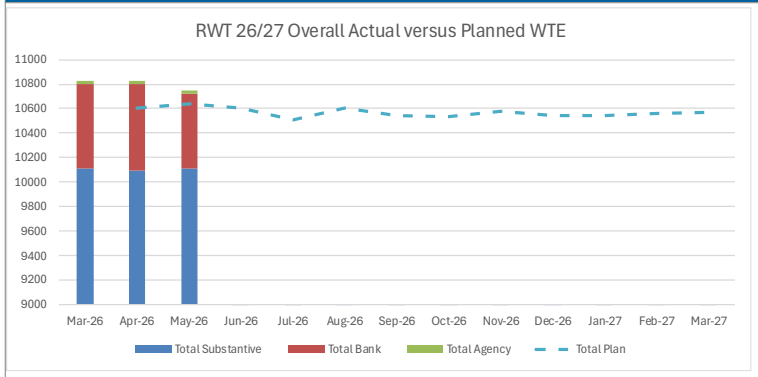
Workforce WTE Trends - RWT

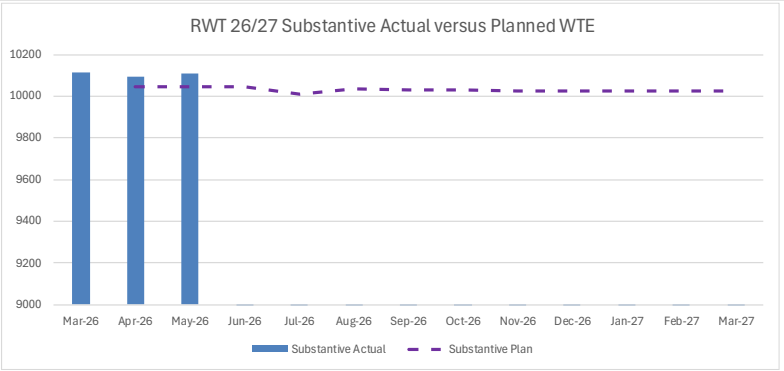
RWT's overall workforce decreased by 77.9 WTE (0.7%) during M2 26/27, reflecting a 92.9 WTE (13.1%) reduction in bank deployment, offsetting a 13.1 WTE (0.1%) increase in the substantive workforce and a 1.9 WTE (8.4%) rise in agency usage. The RWT overall workforce is 110.6 WTE (1.0%) above the M2 26/27 workforce plan trajectory.

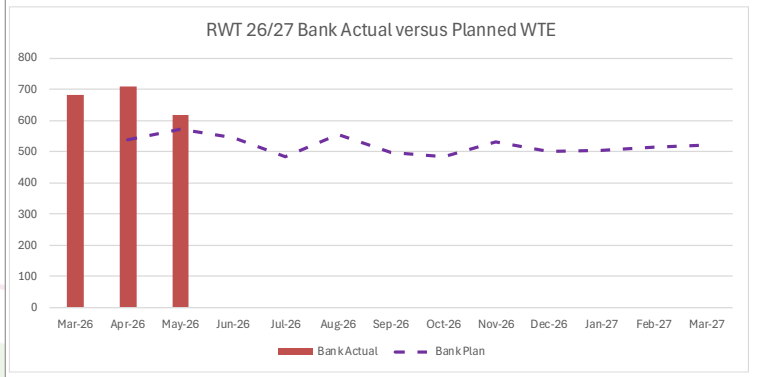
Actual WTE (March 2026 – May 2026)

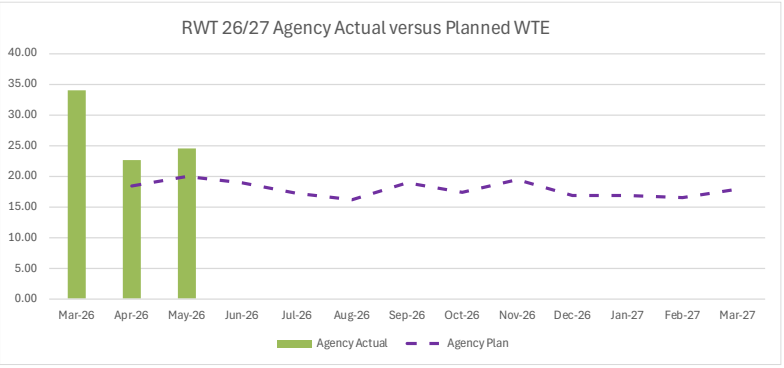
	Mar-26	Apr-26	May-26
ACTUAL TOTAL WORKFORCE BY STAFF GROUP (WTE)	**10830.52**	**10825.60**	**10747.66**
Registered Nursing, Midwifery and Health Visiting Staff	3073.01	3084.61	3057.19
Allied Health Professionals	616.47	613.00	612.70
Registered Scientific, Therapeutic and Technical Staff	252.42	255.87	253.65
Healthcare Scientists	511.59	509.35	507.34
Support to Clinical Staff	2705.68	2705.82	2686.06
NHS Infrastructure Support	2318.39	2323.44	2289.47
Medical and Dental	1352.96	1333.53	1341.26
ACTUAL SUBSTANTIVE STAFF BY STAFF GROUP (WTE)	**10113.12**	**10094.18**	**10107.24**
Registered Nursing, Midwifery and Health Visiting Staff	2923.36	2909.46	2923.59
Allied Health Professionals	609.26	608.70	608.97
Registered Scientific, Therapeutic and Technical Staff	247.69	249.99	247.99
Healthcare Scientists	509.12	506.18	503.94
Support to Clinical Staff	2361.19	2356.64	2349.96
NHS Infrastructure Support	2234.38	2233.47	2239.25
Medical and Dental	1228.12	1229.76	1233.55
ACTUAL BANK STAFF BY STAFF GROUP (WTE)	**683.36**	**708.75**	**615.84**
Registered Nursing, Midwifery and Health Visiting Staff	149.65	175.15	133.60
Allied Health Professionals	6.49	3.65	3.73
Registered Scientific, Therapeutic and Technical Staff	3.45	4.33	3.84
Healthcare Scientists	0.24	0.24	0.18
Support to Clinical Staff	326.98	348.21	326.12
NHS Infrastructure Support	84.01	89.97	50.22
Medical and Dental	112.54	87.20	98.15
ACTUAL AGENCY STAFF BY STAFF GROUP (WTE)	**34.04**	**22.67**	**24.58**
Registered Nursing, Midwifery and Health Visiting Staff	0.00	0.00	0.00
Allied Health Professionals	0.72	0.65	0.00
Registered Scientific, Therapeutic and Technical Staff	1.28	1.55	1.82
Healthcare Scientists	2.23	2.93	3.22
Support to Clinical Staff	17.51	0.97	9.98
NHS Infrastructure Support	0.00	0.00	0.00
Medical and Dental	12.30	16.57	9.56

2026/27 Actuals vs Planned









Since March 2026, the overall workforce has decreased by 83 WTE, with the substantive, bank, and agency workforces decreasing by 5.9 WTE, 67.5 WTE, and 9.5 WTE, respectively. The monthly substantive workforce increase reflects an RN&M rise offsetting decreases in the Scientific, Support to Clinical, and E&F staff groups. Despite increased M&D locum usage, overall bank WTE fell during M2 26/27, owing to reduced Admin & Estates bank usage and lower RN&M bank reliance across all clinical divisions. While M&D agency reliance fell by 42% in May 2026, increased agency usage for clinical support N&M (HCA) shifts in Div 2 contributed to an overall monthly rise.

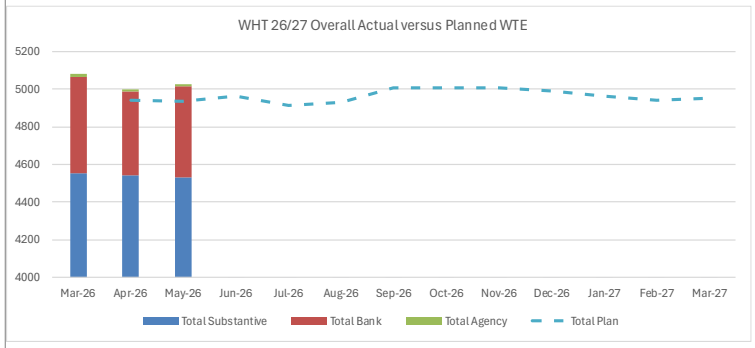
Workforce WTE Trends - WHT

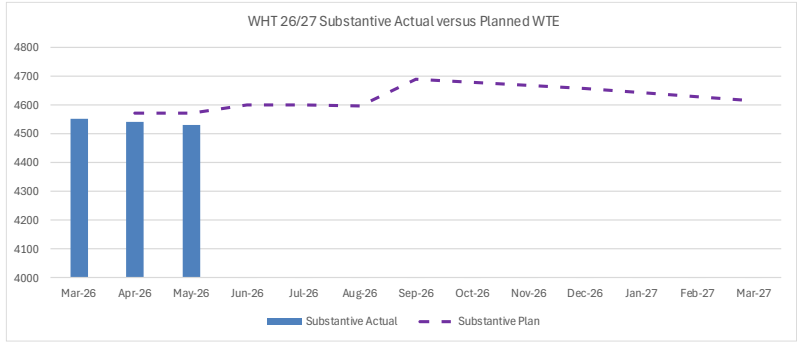
WHT's overall workforce increased by 25.7 WTE during M2 26/27, reflecting a substantive workforce decrease of 9.3 WTE, offset by a rise in bank deployment by 33.9 WTE and a 1.2 WTE increase in agency reliance. The WHT overall workforce is 92.1 WTE (1.9%) above the M2 26/27 workforce plan trajectory.

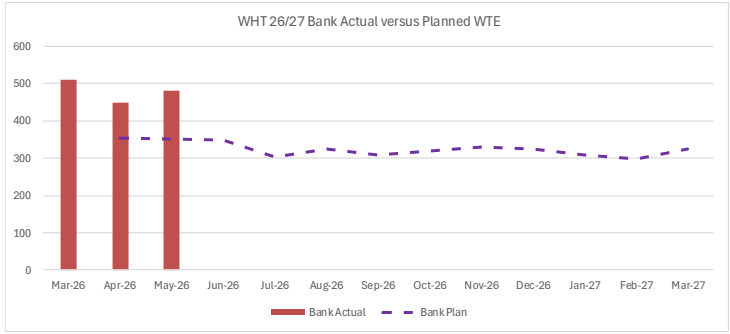
Actual WTE (March 2026 – May 2026)

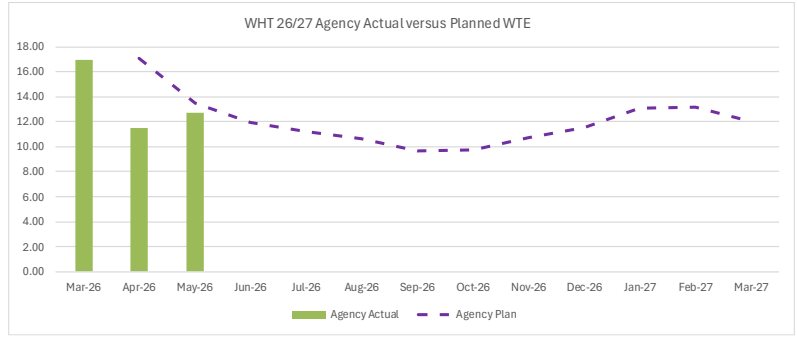
	Mar-26	Apr-26	May-26
ACTUAL TOTAL WORKFORCE BY STAFF GROUP	**5081.61**	**5001.36**	**5027.09**
Registered Nursing, Midwifery and Health Visiting Staff	1785.01	1741.44	1746.90
Allied Health Professionals	328.99	323.31	325.11
Registered Scientific, Therapeutic and Technical Staff	129.70	128.64	131.11
Healthcare Scientists	47.80	48.39	49.29
Support to Clinical Staff	1213.00	1190.98	1215.33
NHS Infrastructure Support	948.24	944.52	944.35
Medical and Dental	628.87	624.09	614.99
ACTUAL SUBSTANTIVE STAFF BY STAFF GROUP	**4553.21**	**4541.58**	**4532.24**
Registered Nursing, Midwifery and Health Visiting Staff	1638.58	1631.65	1616.83
Allied Health Professionals	313.43	311.93	315.16
Registered Scientific, Therapeutic and Technical Staff	118.72	116.31	116.20
Healthcare Scientists	47.80	48.39	49.29
Support to Clinical Staff	1026.10	1021.19	1022.40
NHS Infrastructure Support	827.73	833.41	834.06
Medical and Dental	580.86	578.70	578.29
ACTUAL BANK STAFF BY STAFF GROUP	**511.46**	**448.27**	**482.12**
Registered Nursing, Midwifery and Health Visiting Staff	137.88	107.23	127.64
Allied Health Professionals	14.09	10.44	9.20
Registered Scientific, Therapeutic and Technical Staff	9.02	8.18	9.07
Healthcare Scientists	0.00	0.00	0.00
Support to Clinical Staff	186.90	169.79	192.93
NHS Infrastructure Support	116.91	107.51	106.69
Medical and Dental	46.66	45.12	36.60
ACTUAL AGENCY STAFF BY STAFF GROUP	**16.93**	**11.51**	**12.73**
Registered Nursing, Midwifery and Health Visiting Staff	8.55	2.55	2.43
Allied Health Professionals	1.47	0.94	0.75
Registered Scientific, Therapeutic and Technical Staff	1.96	4.15	5.84
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	1.36	0.27	0.11

2026/27 Actuals vs Planned









Since March 2026, the overall workforce has decreased by 54.5 WTE, with the substantive, bank, and agency workforces decreasing by 21.0 WTE, 29.3 WTE, and 4.2 WTE, respectively. The monthly substantive workforce decrease reflects an RN&M fall offsetting increases in the AHP, Support to Clinical, and A&C staff groups. Despite reduced M&D locum usage, overall bank WTE rose during M2 26/27, owing to increased reliance on N&M (both registered and HCA) bank shifts across all clinical divisions. While agency reliance fell across most staff groups, overall agency WTE rose in May 2026, reflecting increased agency usage for Scientific staff groups within WCCSS.

Enclosure 10.2

Integrated Performance Report

Walsall Healthcare NHS Trust

May 2026 (Month 2)

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

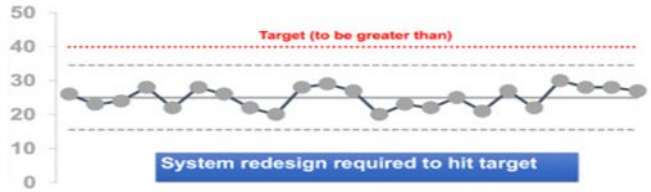
Care Colleagues
Collaboration Communities

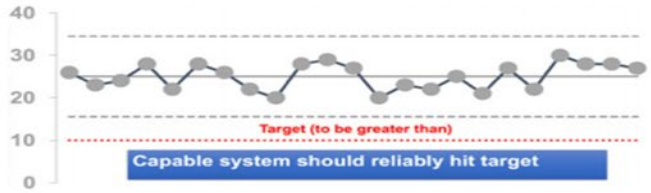
How to Interpret SPC (Statistical Process Control) charts

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

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

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





Care Colleagues Collaboration Communities

Managing Director Summary

WHT is off plan at Month 2 by £0.4m. Industrial Action (IA) costs of approx. £0.9m in Month 1 are offset by non pay underspends. 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. May was a busy month in ED resulting in £1m over performance across ED and Emergency Inpatients, this is driving £0.5m of UEC income accounted for above contract YTD. In May, the Trust delivered £0.6m of variable elective performance below contract (0.2m impacted by IA). CIP is £2.381m versus target of £2.448m, a negative variance of £67k.

Quality and safety continues to be our priority. There was one severe harm falls reported in May2026. Care Hours per Patient Day (CHPPD has remained at 8.2. In May 2026, the corridor space was used to support peak periods of ambulance offloads on 13 separate days, averaging 3.3 hours per episode. Venous Thromboembolism (VTE) compliance has improved by 0.5% and remains below national compliance at 88.91% vs 95%, improvement action plans are and overseen by Quality Committee. Formal complaint response compliance was low in May for both
Surgery (9%) and MLTC (22%), reviews of process and monitoring by CNO are in place. Progress against the HTA CAPA plan continues, with most actions now completed and submitted for review; only four of the original 18 standards remain open, all with clear plans for closure. Regular engagement with the HTA provides ongoing assurance, and no regulatory action is currently expected, while discussions continue regarding maternity pathway.

Maternity safety performance overall remains strong, with perinatal mortality stabilising in May and no new MNSI cases reported since March 2026. Regional maternity safety indicators continue to demonstrate positive performance, with the safety heatmap score improving from 31 in 2023 to 15 and no safety alerts or maternity claims reported in the last year. Compliance with MBRRACE reporting remains excellent, while ongoing safety walks and champion meetings continue to strengthen governance, leadership capacity, workforce resilience and service improvement.

Author

Amelia Godson
(Managing Director)

Care Colleagues Collaboration Communities

Managing Director Summary

Workforce deployment remains above plan due to short-term operational pressures, although overall WTE has reduced by 54.5 since March 2026. Vacancy rates, appraisal compliance and sickness absence remain key challenges, with improvement plans in place, including a healthy attendance programme and enhanced appraisal support, which has already increased compliance from 75% to 79%.

Operational performance remained strong for Month 2. Urgent and Emergency Care 4-hour performance exceeded trajectory at 80.1%, ranking 20th nationally and 5th regionally, supported by continued improvements in ambulance handovers and £2m capital investment secured through national UEC improvement work. Elective Care continues to perform well and on target, delivering 74.4% and maintaining its position as the top-performing Trust in the Midlands for RTT for the 19th consecutive month, while Cancer performance achieved two of three national standards, with the 62-day pathway impacted by imaging, histology and industrial action pressures, but expected to improve through strengthened oncology capacity. Diagnostic performance has also improved to 66.9%, supported by additional mobile MRI capacity introduced during June.

Whilst remaining in segment 3, WHT has seen a slight improvement in its score from Q3 2.32 to 2.21 in Q4.
The Trust continues to demonstrate strong productivity performance, with Implied Productivity Growth and Workforce Productivity Growth both ranked in the top national quartile, reflecting favourable growth in outputs relative to inputs. Strong theatre utilisation, outpatient procedures and non-elective productivity indicate effective use of clinical capacity, although opportunities remain to improve day-case rates, elective throughput, outpatient efficiency, DNA rates and Specialist Advice utilisation.

While the Trust maintains a strong national productivity position overall, focus remains on improving outpatient pathway efficiency, increasing elective activity per WTE and consultant productivity, and addressing sickness absence and temporary staffing expenditure to support long-term sustainability and further performance gains.

Author

Amelia Godson (Managing Director)

Care Colleagues Collaboration Communities

Balanced Scorecard

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		3.09	3.30	May 2026	5.17	Common Cause	No Target Set
2	Pressure Ulcers - Rate per 1,000 Beddays (Cat 1, 2, 3, 4 & Unstageables) - Hospital	No.		2.33	3.18	May 2026		Concern	No Target Set
3	Pressure Ulcers - Rate per 10,000 CCG Population (Cat 1, 2, 3, 4 & Unstageables) - Community	No.		1.01	1.12	May 2026		Concern	No Target Set
4	Patient Observations - % rechecked within time	%	90.00	89.38	88.96	May 2026	84.53	Common Cause	Inconsistent
5	VTE Risk Assessment - % within 14 hours	%	95.00	88.41	88.91	May 2026		Common Cause	Not Met
6	Sepsis Screening - ED	%							
7	Sepsis Screening - Inpatients	%							
8	Medication Errors - % of incidents causing harm	%		7.92	16.09	May 2026		Common Cause	No Target Set
9	ED - Mental Health Patients spending over 24 hours in ED	No.		9.00	9.00	May 2026		Common Cause	No Target Set
10	Clostridium Difficile - Number of Cases	No.		6.00	3.00	May 2026	3.00	Common Cause	No Target Set
11	MRSA - Number of Cases	No.	0.00	0.00	0.00	May 2026	0.00	Improvement	Inconsistent
12	Complaints - No. of Complaints as a % of Admissions	%		0.47	0.44	May 2026		Common Cause	No Target Set
13	Complaints - % responded to within agreed timescales	%		54.72	33.33	May 2026	48.65	Concern	No Target Set
14	Friends and Family : % Recommended - Trust (Average)	%		93.00	94.00	May 2026		Improvement	No Target Set
15	Maternity - Midwife to Birth Ratio - (1 to)	Ratio	28.00	27.93	29.54	May 2026	26.90	Common Cause	Inconsistent
16	CHPPD - Total Nursing & Midwifery Staff Actual	No.		8.20	8.20	May 2026		Improvement	No Target Set
17	CHPPD - Registered Nursing & Midwifery Staff Actual	No.		4.70	4.70	May 2026		Improvement	No Target Set
18	Mortality - SHMI (NHS Digital) (12 Month Rolling Position) - Manor Hosp Site	No.	1.00	0.97	0.96	Jan 2026	1.09	Common Cause	Achieving
19	Mortality - Crude Mortality Rate	Rate		2.60	2.42	Jan 2026	4.22	Common Cause	No Target Set
20	Incidents - Never Events	No.	0.00	0.00	0.00	May 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	May-26	4532.24	4541.58	4552.29	Concern	Achieving
Bank (WTE) Trust	324.79	May-26	482.12	448.27	439.86	Common Cause	Not Met
Agency (WTE) Trust	12.04	May-26	12.73	11.51	11.63	Improvement	Not Met
Vacancy Rate	6.00%	May-26	11.18%	11.50%	10.67%	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	May-26	8.31%	7.69%	9.09%	Improvement	Inconsistent
Retention Rate (12 Months)	90.00%	May-26	94.59%	93.72%	92.93%	Improvement	Achieving
Sickness Absence (In Month)	5.00%	May-26	6.27%	5.89%	5.64%	Common Cause	Inconsistent
Appraisals	90.00%	May-26	75.23%	74.40%	72.52%	Concern	Not Met
Statutory & Mandatory Trainin	90.00%	May-26	91.41%	91.46%	90.58%	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	72.19	74.38	May 2026	91.04	Improvement	Not Met
2	18 Weeks Referral to Treatment - 52 Week Breaches as % of the Total PTL	%	1.00	0.01	0.01	May 2026	0.00	Improvement	Not Met
3	18 Weeks Referral to Treatment - Total Incomplete PTL	No.	26,150.00	27,974.00	27,784.00	May 2026	14,338.00	Improvement	Not Met
4	Cancer - 28 Day Faster Diagnosis - % Compliance - Overall	%	80.05	87.24	86.14	Apr 2026		Common Cause	Inconsistent
5	Cancer - 31 Day Treatment - % Compliance - Combined Standard	%	94.57	100.00	98.63	Apr 2026	99.15	Common Cause	Inconsistent
6	Cancer - 62 Day Referral to Treatment - % Compliance - Combined Standard	%	80.00	80.60	68.85	Apr 2026	80.90	Common Cause	Inconsistent
7	Criteria to Reside - No. of patients no longer meeting the Criteria to Reside	No.		39.00	14.00	May 2026		Common Cause	No Target Set
8	Diagnostics - Diagnostic waiting within 6 weeks from referral	%	77.96	65.17	66.92	May 2026	93.52	Concern	Inconsistent
9	ED - ED Attendances Admitted, Transferred or Discharged over 12 hours of Arrival	%	6.46	3.52	5.33	May 2026	3.17	Common Cause	Inconsistent
10	ED - ED Attendances Admitted, Transferred or Discharged within 4 hours of Arrival	%	82.08	84.66	80.13	May 2026	80.68	Common Cause	Inconsistent
11	Community - Waiting List - Total	No.	8,345.00	9,501.00	9,560.00	May 2026		Concern	Achieving
12	Community - Waiting List - % Within 18 Weeks	%	72.01	64.35	64.59	May 2026		Concern	Inconsistent

Finance	Target	Previous Month	Current Month	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£'000) - in month	(1,998)	(2,910)	(1,983)	0	Improvement	Achieving
Surplus/(Deficit) (£'000) - YTD	(4,533)	(2,910)	(4,893)	86	Concern	Not Met
Surplus/(Deficit) (£'000) - FOT	0	0	0	50	Concern	Not Met
ERF (£'000) - in month	6,670	6,315	6,136	N/A	Concern	Not Met
ERF (£'000) - YTD	12,925	6,315	12,451	N/A	Concern	Not Met
ERF (£'000) - FOT				N/A		
Efficiency (£'000) - in month	1,224	1,236	1,146	1,676	Common Cause	Not Met
Efficiency (£'000) - YTD	2,448	1,236	2,382	3,401	Common Cause	Not Met
Efficiency (£'000) - FOT	27,517	27,517	27,517	27,659	Common Cause	Achieving
Capital (£'000) - YTD	1,448	552	1,001	N/A	Concern	Not Met
Capital (£'000) - FOT	11,364	11,364	11,364	11,704	-	Achieving
Cash (£'000) - in month	23,328	50,456	46,466	1,083	Deterioration	Achieving
Cash (£'000) - FOT	12,463	12,463	12,463	9,056	-	Achieving

Care Colleagues
Collaboration Communities

Quality, Safety and Patient Experience

Quality, Safety & Patient Experience | Executive Summary

Falls per 1,000 Bed Days

- May 2026 rate: 3.30 (↑ from 3.09 in April 2026), below the national mean of 6.1 (Royal College of Physicians).
- One severe harm fall was reported in May 2026.
- Actions are reviewed and monitored through the severe harm falls review process with themes and learning shared across the Trust

Pressure Ulcers per 1000 Bed Days

- Two category 4 pressure ulcers were reported in May 2026. Key themes are skin check and equipment check non-compliance.
- Improvement actions: Review of re-positioning charts and timings of re-positioning, Bathroom First wider roll out, EDDMI, new skin cleansing products and continence product. Divisional action plans in place and monitored through QSOG, Deputy CNO's are supporting the divisions.

Observations on Time

- May 2026 compliance: 88.96% including ED (↓ from 89.38%) and 91.81% excluding ED ↑(from 90.50%). ED improved slightly to 72.7% from 71.15%.
- 20 of 27 clinical areas achieved the 90% target in May 2026, unchanged from April 2026. Senior divisional and deputy CNO oversight continues.
- Improvement Actions: Ongoing review of observation frequency led by Divisional Director of Nursing MLTC, Digital Nursing, and ED teams.

Infection Control

- In May 2026, 2 HOHA and 1 COHA C. difficile cases were reported; the national trajectory for 2026/2027 has not yet been released.
- Other May gram negative activity included 0 MRSA bacteraemia, 1 HOHA MSSA, 2 HOHA and 1 COHA E. coli, 1 COHA Klebsiella, and 1 Pseudomonas case.
- Improvement actions: Ensure prompt sampling, isolation and appropriate use of antibiotics

Authors

Lisa Carroll (Chief Nursing Officer)

Zia Din (Medical Director)

Quality, Safety & Patient Experience | Executive Summary Cont.

Sepsis Screening

- Adult inpatients: 76.12% in May 2026 (↑ from 71.84% in April 2026); adult ED: 83.16% (↓from 84.91%); paediatrics: 100% (↑ from 93%). Clinical assessment and de-escalation remain positive.
- The Martha's Rule wellness question rollout took place in March 2026, with compliance auditing planned via InPhase, dedicated temporary staffing resource is being used (using roll out monies).

Safe Staffing

- Twice-daily staffing meetings continue, with matrons redeploying staff to maintain safety. In May 2026, 849 RN hours and 1430 CSW hours were redeployed; 321 hours / 40 shifts required ward manager redeployment. This was a reduction from the previous month, with the exception of CSW, which rose considerably.
- Overall clinical areas were green for 67% of the time (70.32% in April 2026). MLTC remained under the greatest pressure and was amber for 48.98% of shifts.
- Overall fill rate combined (RN + CSW): May 2026 88.08%; lowest fill rate was CSW day shifts at 77.89%.
- CHPPD remained 8.2

FFT Recommendation Rate – Trust Wide

- Current position: 94% in May 2026 (↑ from 93% in April 2026).
- Improvement actions: Divisional leads continue to monitor FFT returns, address themes, and escalate issues through the Patient Experience Group.

Complaints

- Formal complaint response compliance was 32% in May 2026 (from 55% in April 2026). Surgery 9%; MLTC 22%; WCCSS 78%; Community 100% .
- Deputy CNO has attended divisional safety huddles , and early contact with complainants has been reinforced, as some complaints may be downgraded following this. This has worked well in WCCSS. The surgical division have reviewed their process to address poor compliance. This will be closely monitored by the CNO

SEND Reforms

- System wide action plan and maturity matrix submitted to NSE in accordance with the deadline of 19th June 2026

Authors

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

Medication Errors - % causing harm

- Latest data (April 2026): 101 medication incidents were reported, up from 89 in March 2025. There were no moderate or severe harm incidents reported;
- Improvement actions continue through the Safe Medication Pillar, with focus on high-risk prescribing, medicines management audits and TTO processes.

Mental Health

- Work being completed with GIRFT self-assessment against standards in urgent care for MH, standards of which the trust (6 and 2 joint) are complaint with, this work is being completed with BH MH trust, with their self-assessment standards pending (22). Data submission required at June end to NHSE.
- IKON training compliance has been recommended by H&S to be at 80%. Challenge with low numbers of facilitators (x3 in the trust for the group). Training is for 12-14 staff at a time, costs in the region of £12k to train a group to be train the trainers, need to seek support for agreement on this, and support to release staff to be trained
- Timely mental health assessments remains a challenge due to BCH capacity, with delays occurring in both adult and Child and Adolescent Mental Health Services (CAMHS). During this period, there were 2 Section 136's and one section 5:2
- Delirium clinic now operational and receiving good uptake

ED Corridor Care

- In May 2026, the corridor space was used on 13 separate days, averaging 3.3 hours per episode. The previous usage was in February 2026. This usage was predominantly to support ambulance activity in the early evening and overnight.

Human Tissue Authority

- Progress continues against the HTA CAPA plan, with a number of actions are now completed and submitted to the HTA for review.
- Of the 4 standards remaining unclosed (of the 18 original), 2 are major and 2 are minor. All have actions in place to close.
- The Designated Individual continues to meet regularly with the HTA to provide assurance on completed actions, progress against outstanding requirements, and any risks to delivery. The HTA remains sighted on the progress being made, and no regulatory action is currently expected as a result of the delays.
- The Trust and HTA will meet on June 29th to discuss issues related to deviations in the Maternity Service Pathway.

Authors

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

VTE Risk Assessment

- May 2026 compliance is at 88.91 % (higher than April's 88.41%) but remains below the national target of 95%
- Elective pathways continued to maintain the good VTE assessment performance of above 95%
- For alternative assurance we are reviewing Hospital acquired Thrombosis data and spot audits. Spot Audit on AMU an area recording lower compliance demonstrated 93.2% completion of prescribing in time. Focus areas remain AMU and SACU.
- Improvement Actions: Reviewing Divisional performance every month. Reviewing improvement action plans. Sharing of selected VTE cases at the Thrombosis Group meeting for learning.

SHMI (Summary Hospital-level Mortality Indicator)

- Latest data available: In January 2026, the SHMI decreased further to record a value of 0.96, which is another 0.01 lower since the previous month. This continues to be monitored closely via Learning from Deaths Group.
- SHMI alert for Respiratory Failure has been audited and presented at June Learning from Deaths meeting. Most deaths were deemed expected and appropriate care delivered.
- SHMI alert relating to 'Other Liver Diseases' is due to be presented at July Learning from Deaths meeting.
- Improvement actions: Focus remains on outstanding Structured Judgement Reviews. Outstanding backlog has been reduced dramatically – updates continue to be reported monthly at Learning from Deaths Group.

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary Cont.

Maternity

- Perinatal Mortality has stabilised in May with no further increase seen in the rate. The service will be meeting with the Walsall Public Health to propose a subgroup specifically for WHT which will look at the wider determinants of health and national asks from the Maternity Care Bundle such as preconception care.
- The Regional Heatmap and Maternity Safety Signal continue to demonstrate that WHT is one of safest places to give birth in the midlands. There have been no safety alerts to the Trust within the last year and WHT is currently scoring 15 on the heatmap down from 31 in 2023.
- There have been no new MNSI cases since March 2026
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) reporting has consistently reported all eligible cases in line with CNST requirements.
- There were no maternity claims reported in May 2026. The service triangulates Claims, Complaints and Incidents quarterly
- Monthly safety walks and bimonthly safety champion meetings have taken place through out 2026. The board level safety champions have been able to support the service with recruitment into interim senior leadership roles, strengthening staffing within maternity triage while awaiting substantive funding and addressing ultrasound concerns regarding sonographers declining scan requests.

Authors

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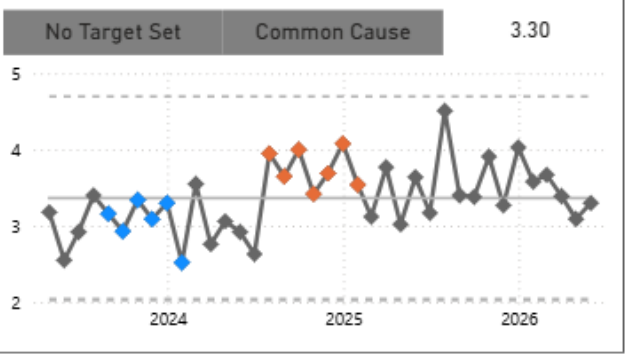
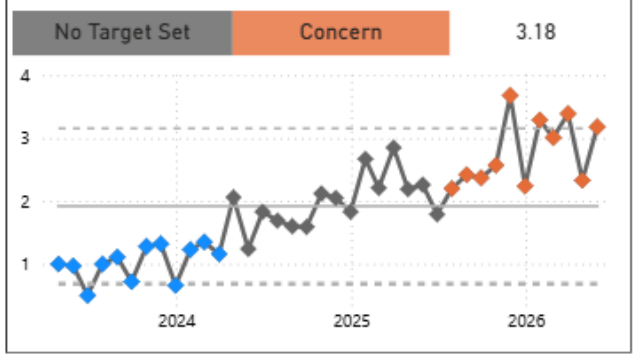
Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

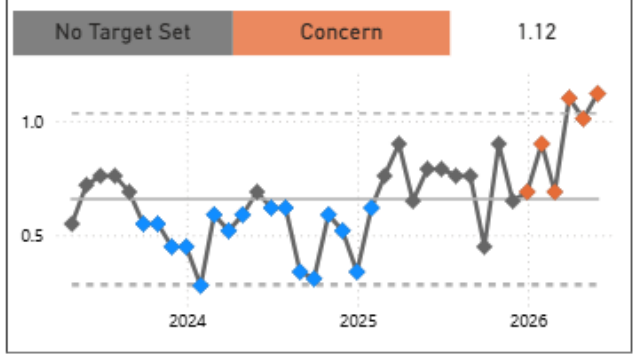
Falls - Rate per 1000 Beddays



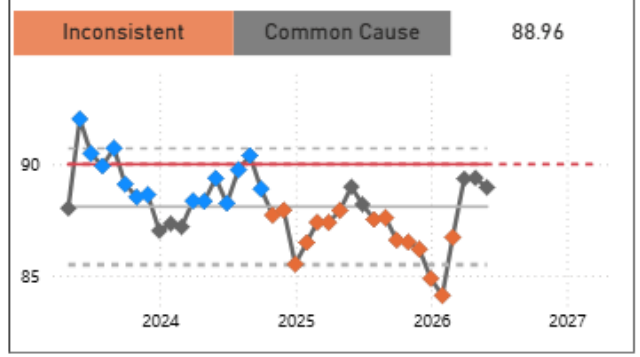
Pressure Ulcers - Rate per 1,000 Beddays (Cat 1, 2, 3, 4 & Unstageables) - Hospital



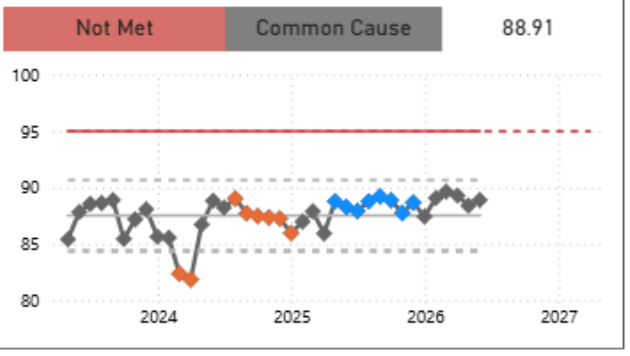
Pressure Ulcers - Rate per 10,000 CCG Population (Cat 1, 2, 3, 4 & Unstageables) - Community



Patient Observations - % rechecked within time



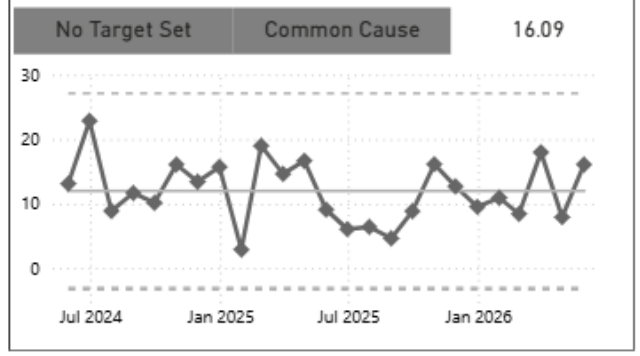
VTE Risk Assessment - % within 14 hours



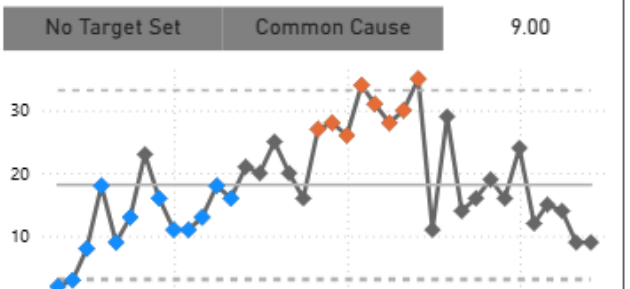
Sepsis Screening - ED

Sepsis Screening - Inpatients

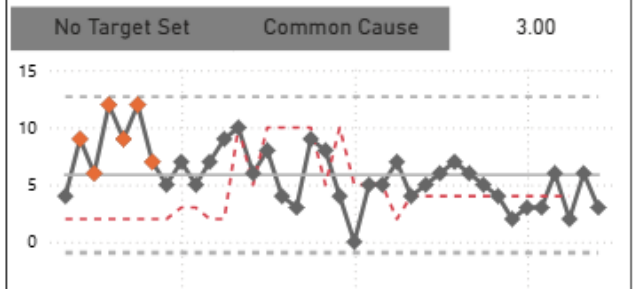
Medication Errors - % of incidents causing harm



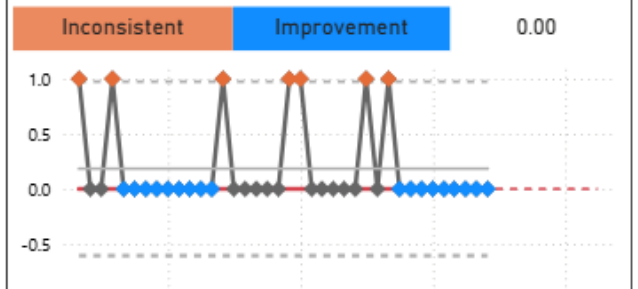
ED - Mental Health Patients spending over 24 hours in ED



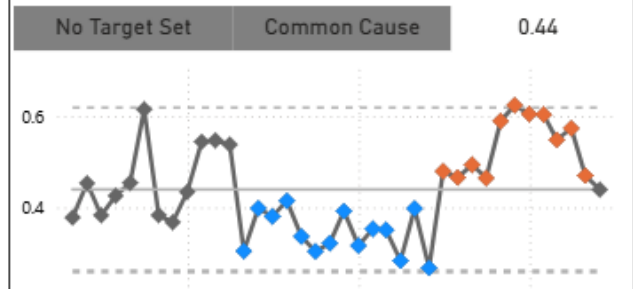
Clostridium Difficile - Number of Cases



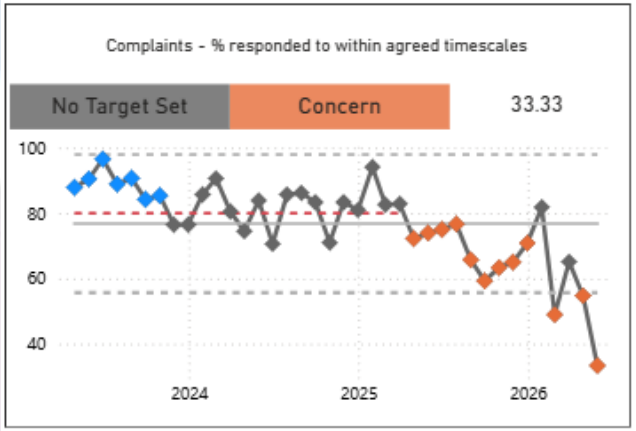
MRSA - Number of Cases

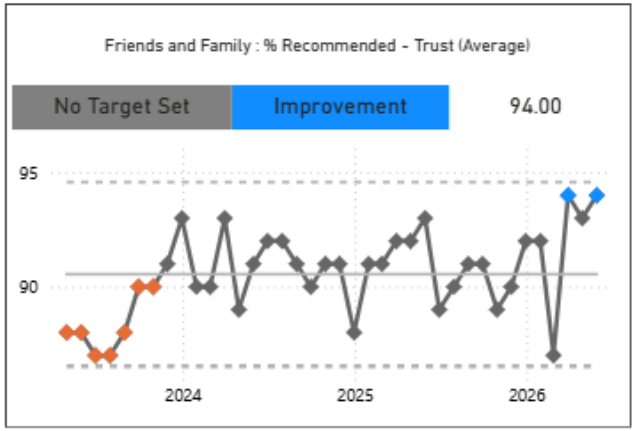


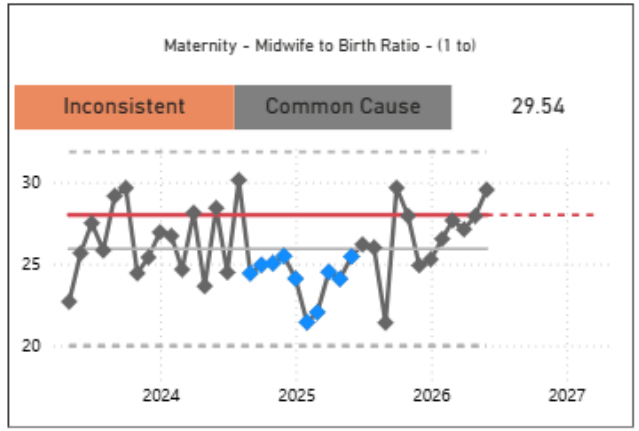
Complaints - No. of Complaints as a % of Admissions

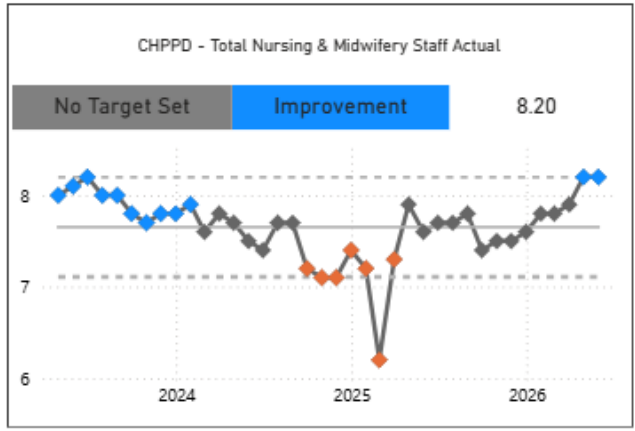


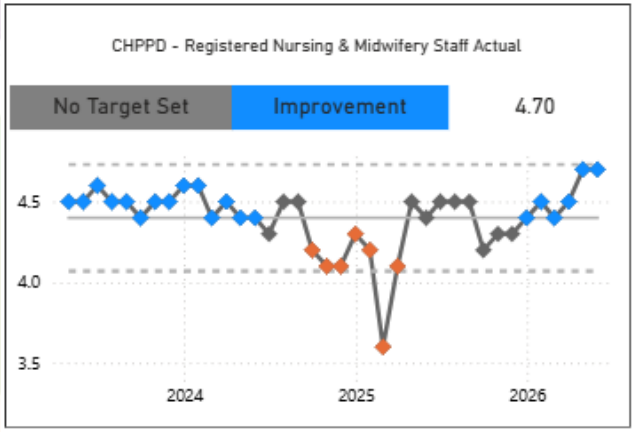
Quality, Safety & Patient Experience | Core Metrics

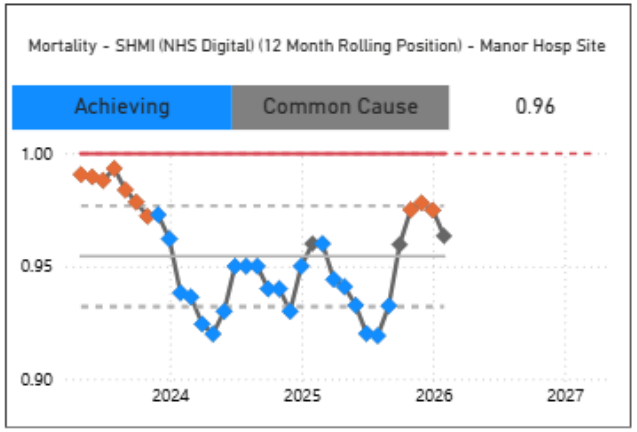


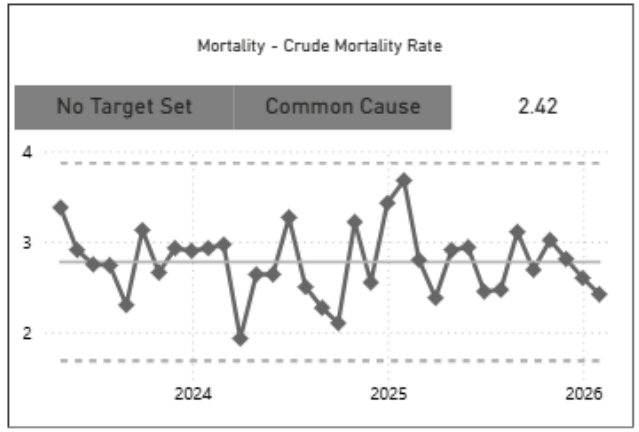


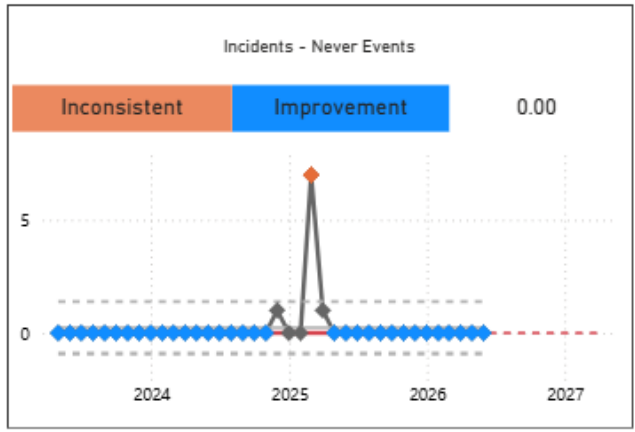












Care Colleagues
Collaboration Communities

People

People | Executive Summary

- Whilst the Trust was able to further deliver against substantive WTE deployment by 9.34 WTE in month, increased bank (+33.85) and agency WTE deployment (+1.22) provided the Trust with an overall increase of total WTE of 25.73 WTE resulting in the Trusts adverse variance to plan worsening to +92.07 WTE. Whilst adverse to the submitted plan, the trust has reduced overall WTE deployment by 54.52 WTE since March 2026.
- Increased deployment of temporary staff in month was driven by short period of increased activity during mid-May aligned with seasonal and system pressures, including increased patient acuity, staff absence school holiday and bank holiday demand. This peak is temporary and returns to baseline levels.
- Despite month on month improvement, three of the workforce six metrics are outside of KPI parameters; (i) vacancy rate, (ii) appraisal compliance and (iii) in-month sickness absence.
- Since Apr-24, the average length of long-term sickness episodes amongst WHT colleagues rose by 15% to 80 FTE days lost. This represents a monthly increase versus the average of 78 FTE days per long-term sickness episode during Apr-26. As at the end of May there were 323 recorded cases of long term sickness absence with 231 (72%) between 1-3 months in length. A paper detailing the planned improvement approach to improving healthy attendance at work was presented to June's Trust Management Committee and supported by the Committee.
- The Trust is piloting an additional reminder process to support the timely improvement of appraisals this has increased the percentage of completed appraisals from 75% at the end of May to 79% at the end of June. The mandatory national quarterly pulse survey for staff due to be undertaken in July will seek feedback regarding the quality of appraisals.

Authors

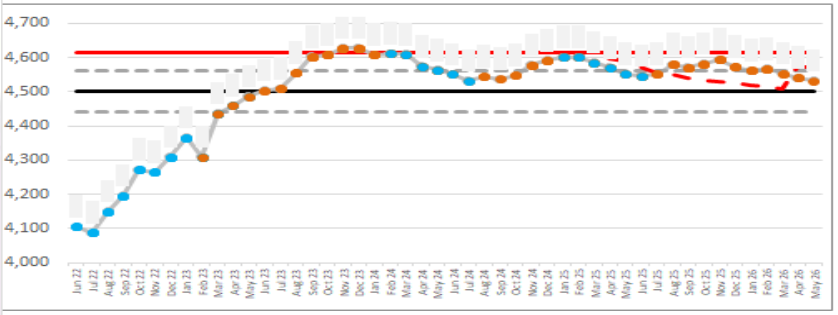
Dr Claire Radley (Group Chief of People, Engagement and Improvement)

Care Colleagues Collaboration Communities

People | Core Metrics

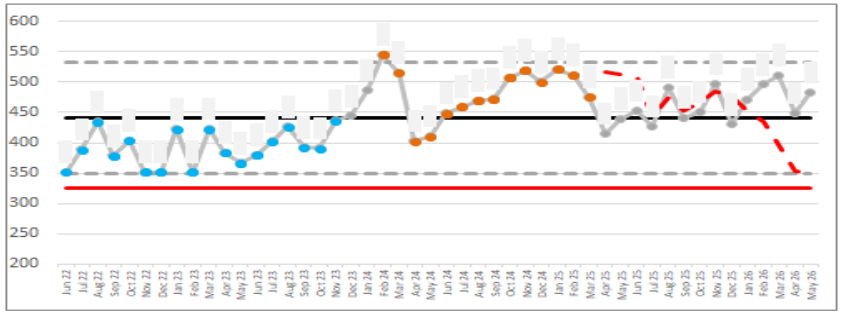
Substantive (WTE) Trust

Achieving	Concern	4532.24



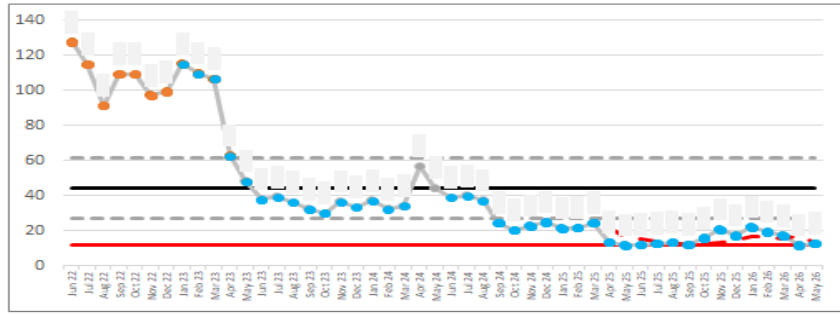
Bank (WTE) Trust

Not Met	Common Cause	482.12



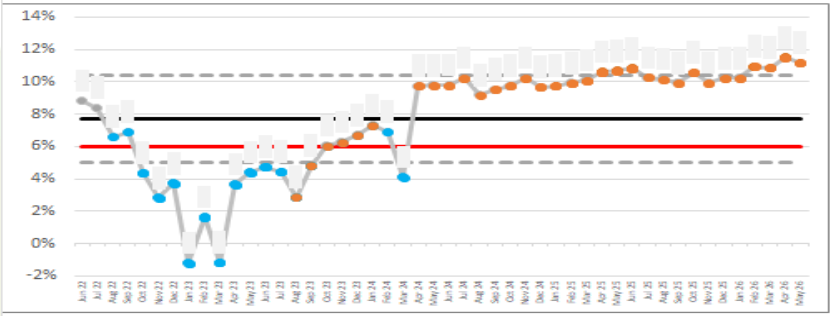
Agency (WTE) Trust

Not Met	Improvement	12.73



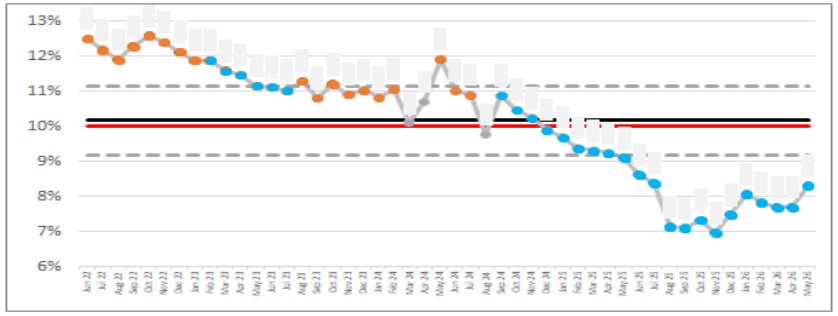
Vacancy Rate

Inconsistent	Concern	11.18%



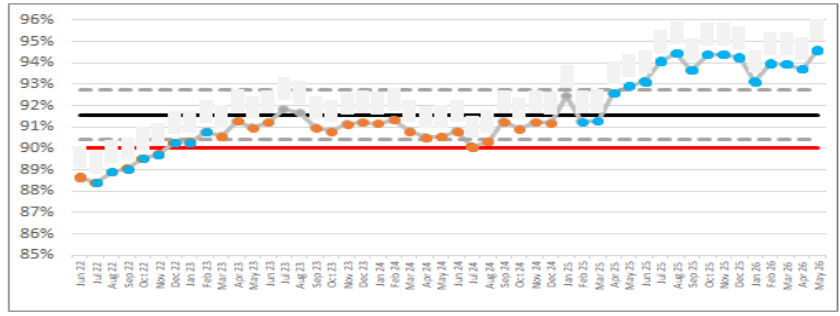
Turnover Rate (12 Months)

Inconsistent	Improvement	8.31%



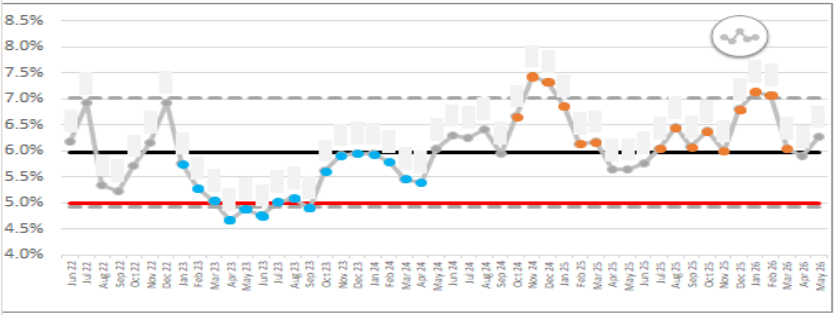
Retention Rate (12 Months)

Achieving	Improvement	94.59%



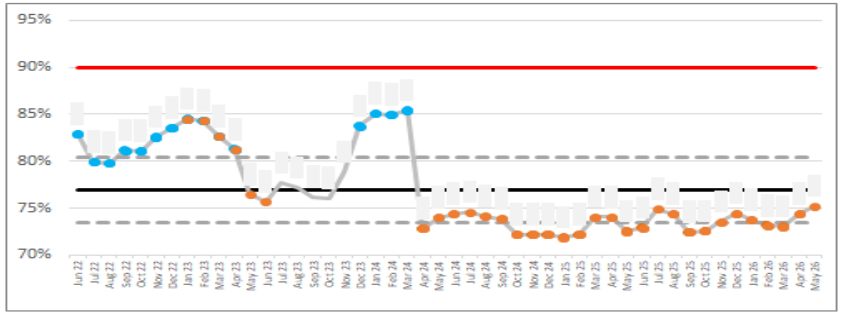
Sickness Absence (In Month)

Inconsistent	Common Cause	6.27%



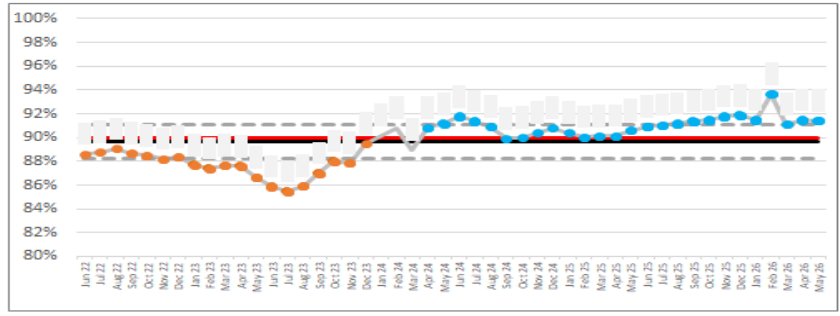
Appraisals

Not Met	Concern	75.23%



Statutory & Mandatory Training

Inconsistent	Improvement	91.41%



Operational Performance

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 May achieving 80.13%. Our EAS ranking is 20th nationally and 5th in the region. Type 1 ED attendances were 5.23% higher than May 2025 and 4.08% if adjust for additional overnight UTC patients. Ambulance Handover within 15 minutes was 37.39% , the Trust is ranked 7th regionally. Average hand time was 18 minutes 49 seconds. Looking ahead, during June we are focused on operational processes and coordination in the Emergency Department and opportunities to improve our Frailty Service and further optimise Medical SDEC and flow to the Assessment Units. We have a had confirmation of £2m Capital funding associated with our performance improvement during the March National UEC Sprint.

Cancer Care

The Trust achieved 2 out of the 3 of the cancer standards in April. Latest national ranking was 3rd for 28-day FDS, 14th for 31-day and 67th for 62-day standard. The 62-day standard was impacted by a reduced number of treatments contributed compared to March, due to Histology and Imaging delays, and Industrial Action. Whilst Oncology remains a challenge it has stabilised and will improve further with a substantive appointment starting in August.

Elective Care

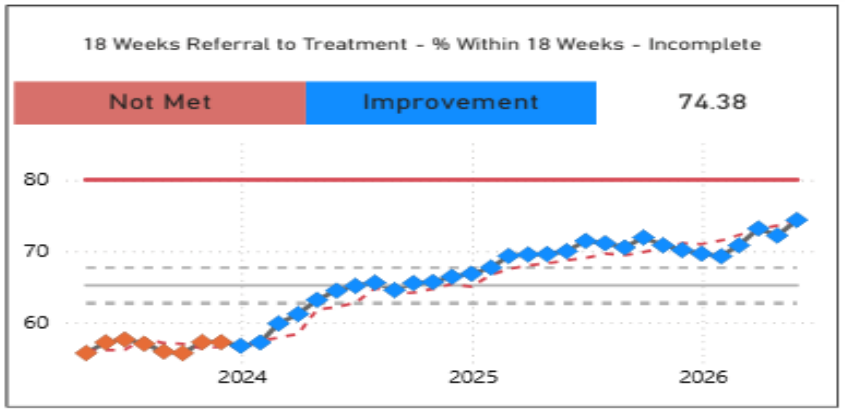
The Trust has now ranked 1st in the Midlands for Referral to Treatment performance for 19 consecutive months, with RTT performance of 74.38%. This is marginally above our trajectory of 74.32% and places the Trust 16th nationally. There has been a slight reduction in the Patient Tracking List (PTL) size to 27,784. For 1st appointments within 18 weeks the Trust is above trajectory with performance of 82.83%. The percentage of 52-week breaches was 0.01% in line with our target, placing the Trust 3rd regionally and 6th nationally.

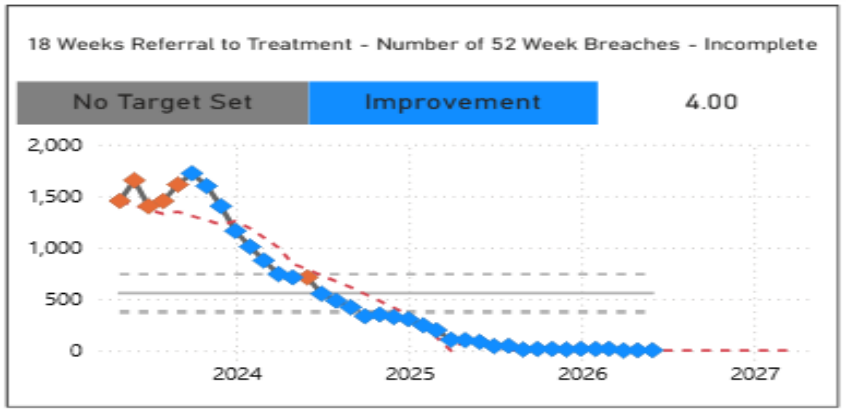
Diagnostics

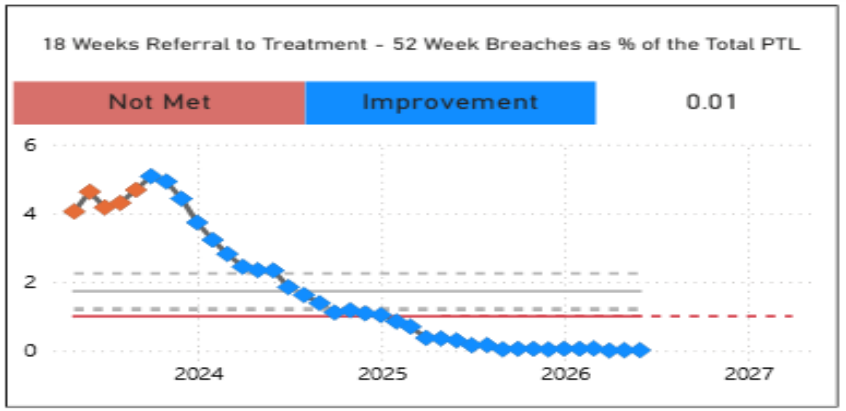
DM01 performance improved to 66.92% during May. The challenged modalities are; Magnetic Resonance Imaging (MRI), Audiology, NOUS, and Neurophysiology. Capacity has been increased during June for MRI with the utilisation of an on-site Mobile Unit.

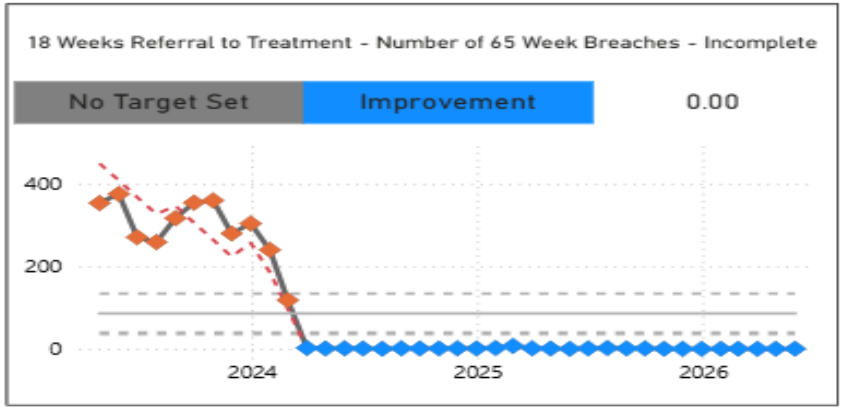
Care Colleagues Collaboration Communities

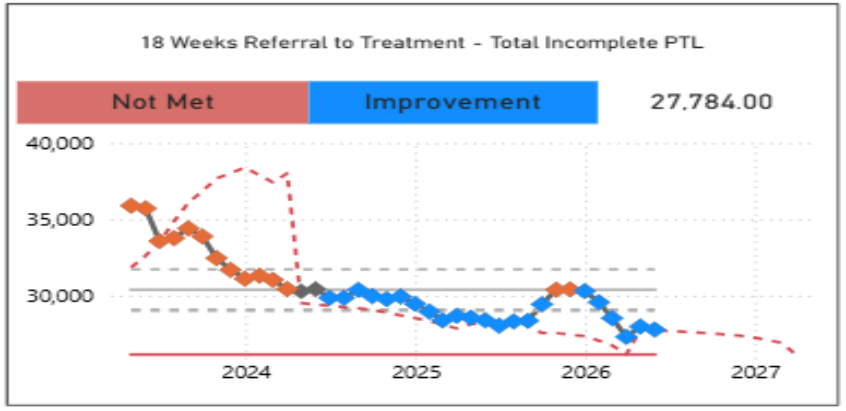
Operational Performance | Core Metrics

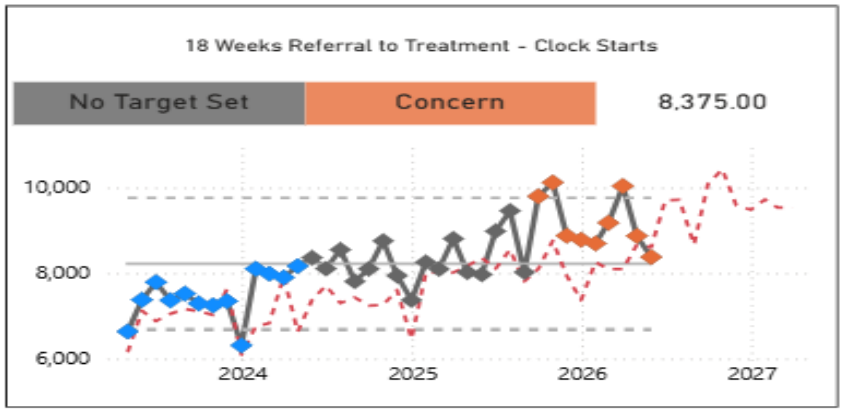


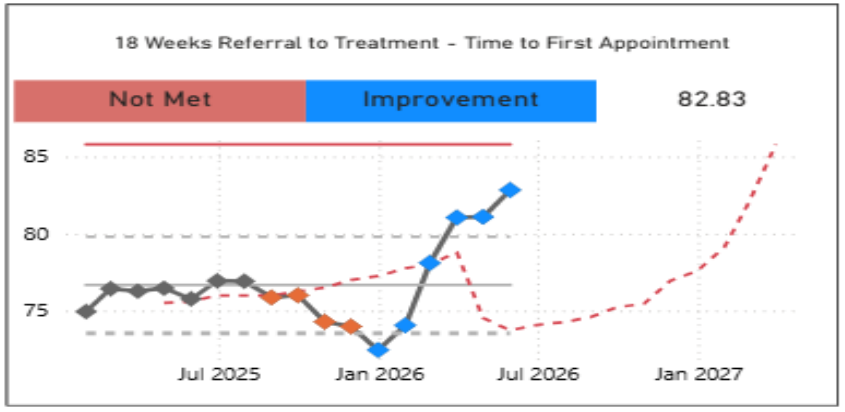


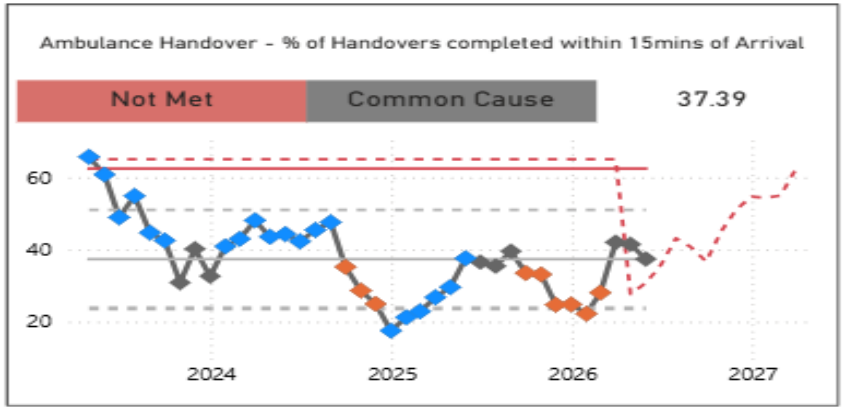


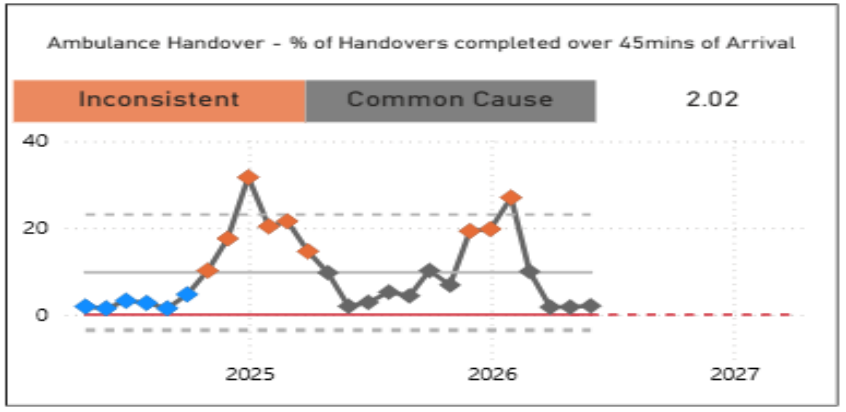




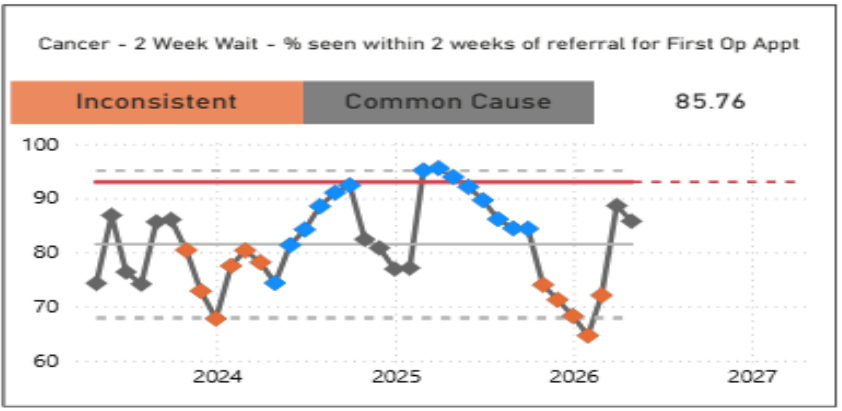


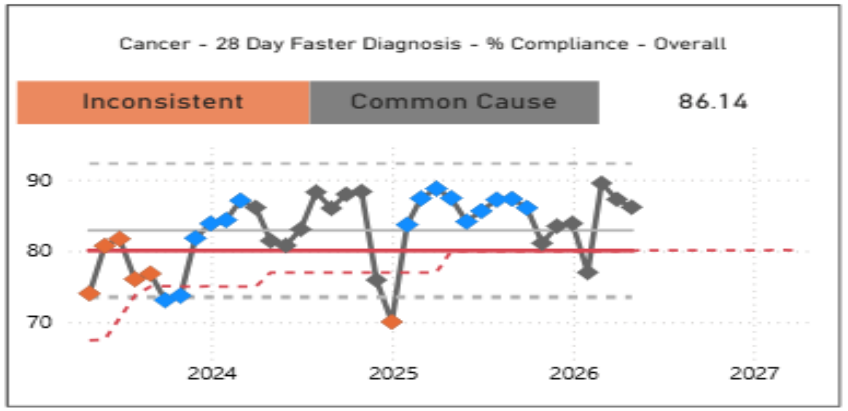


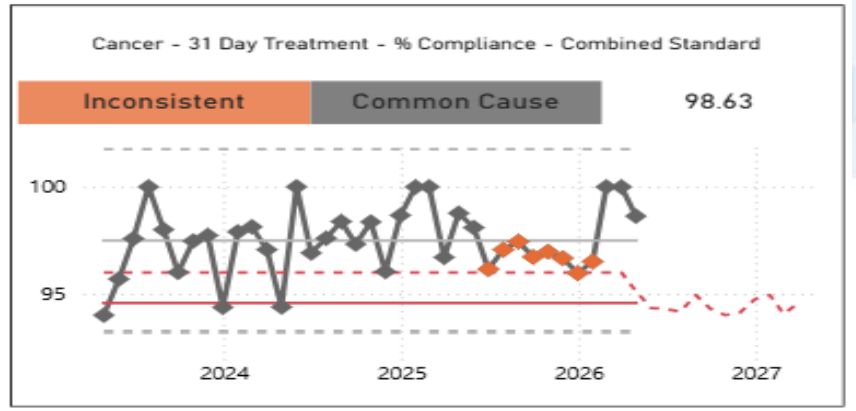


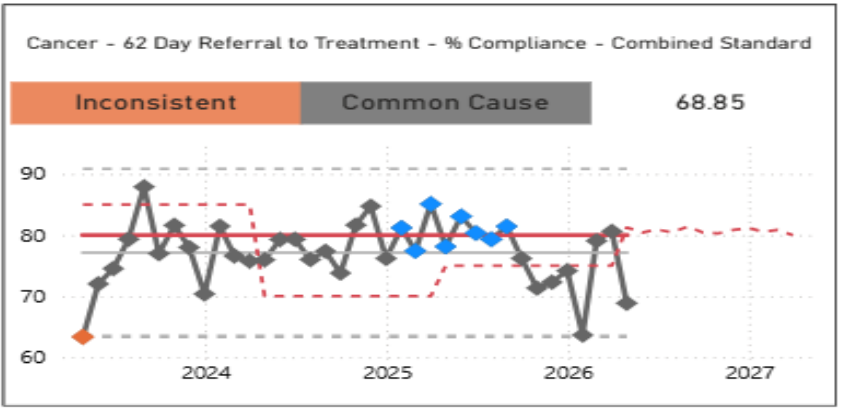


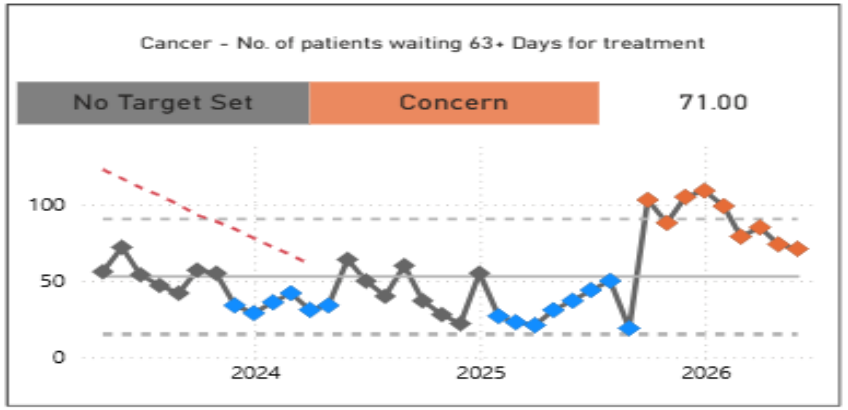
Operational Performance | Core Metrics

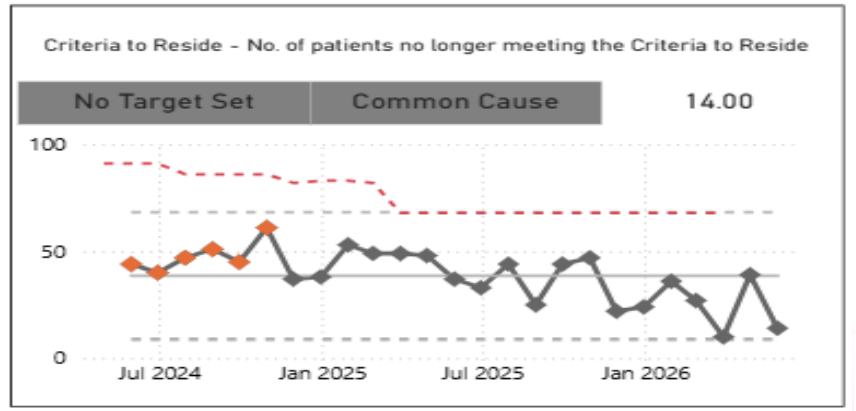


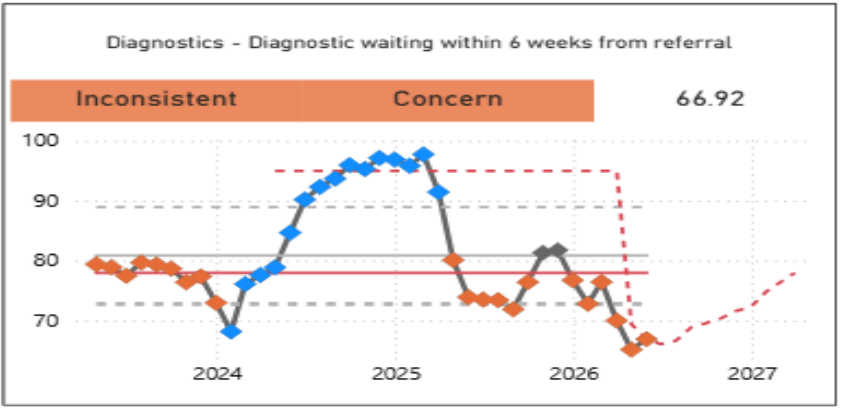


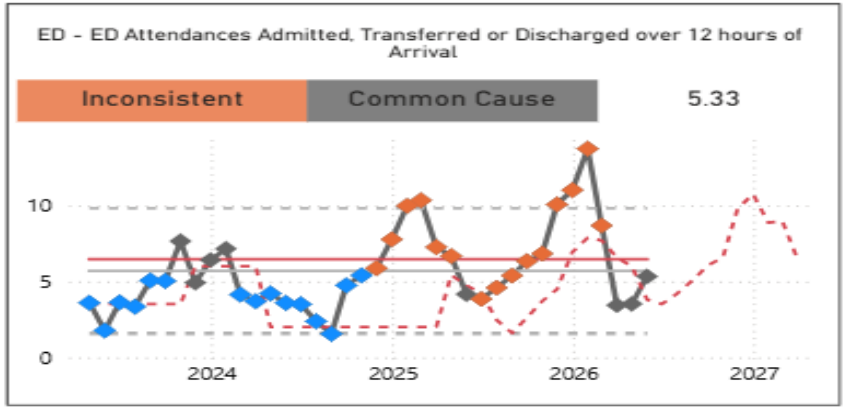


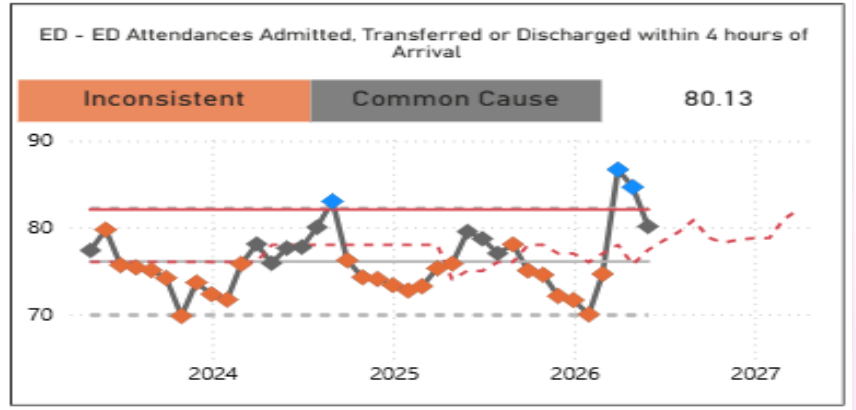






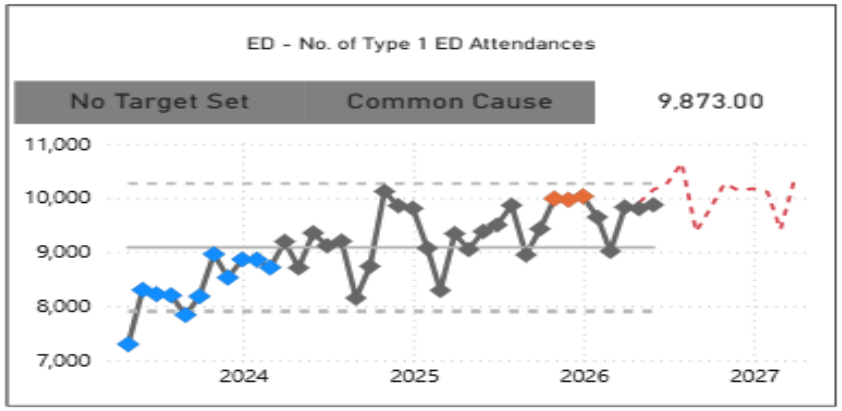




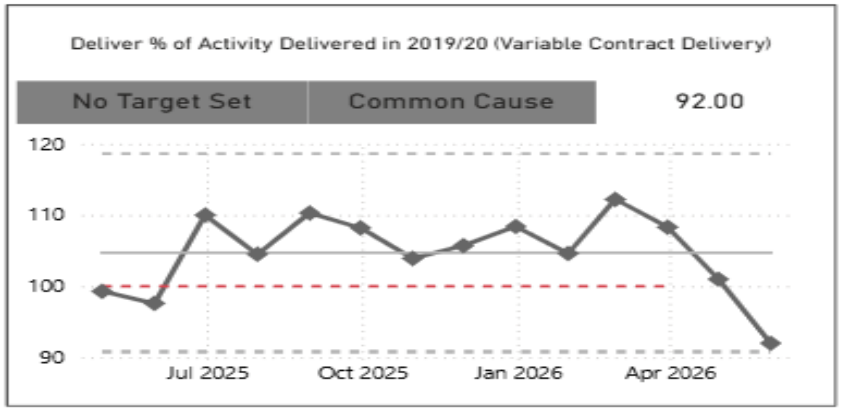


Operational Performance | Core Metrics

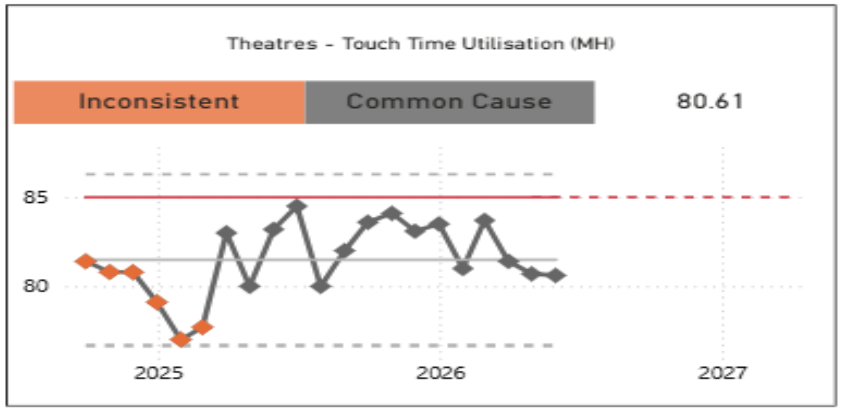
ED - No. of Type 1 ED Attendances



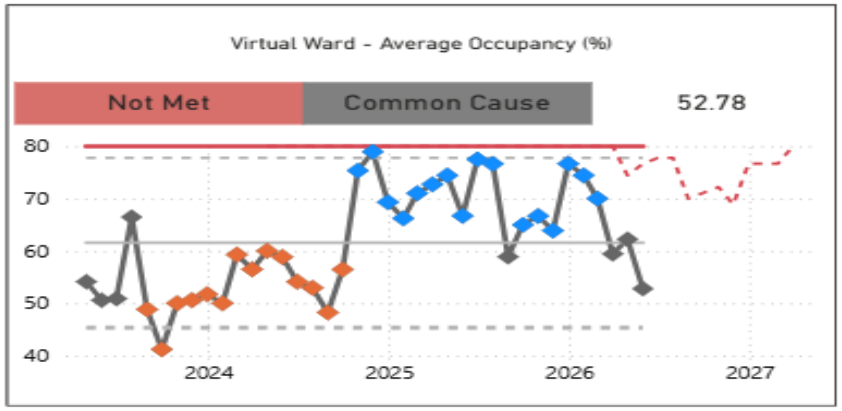
Deliver % of Activity Delivered in 2019/20 (Variable Contract Delivery)



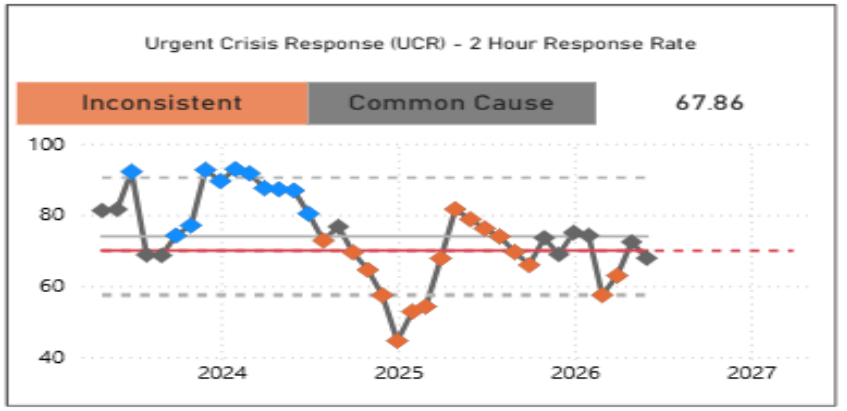
Theatres - Touch Time Utilisation (MH)



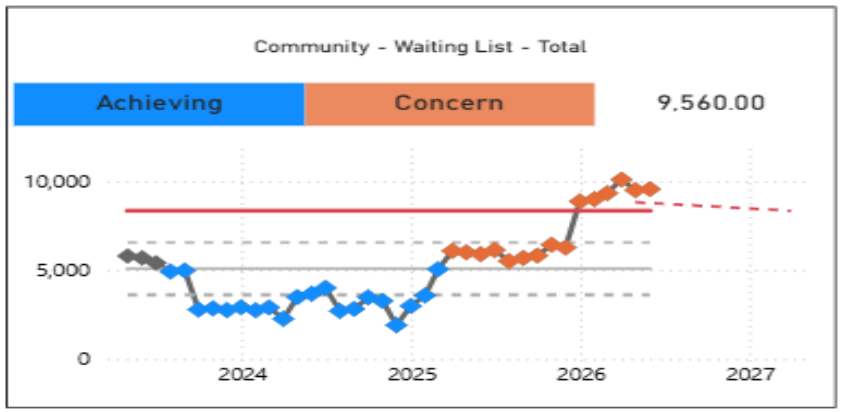
Virtual Ward - Average Occupancy (%)



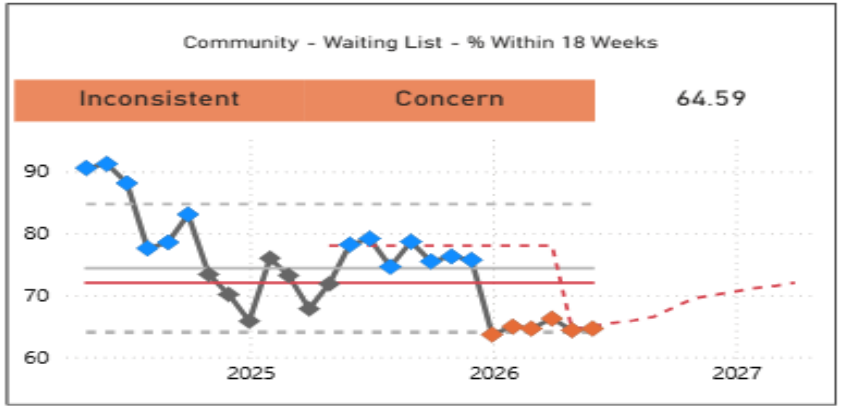
Urgent Crisis Response (UCR) - 2 Hour Response Rate



Community - Waiting List - Total

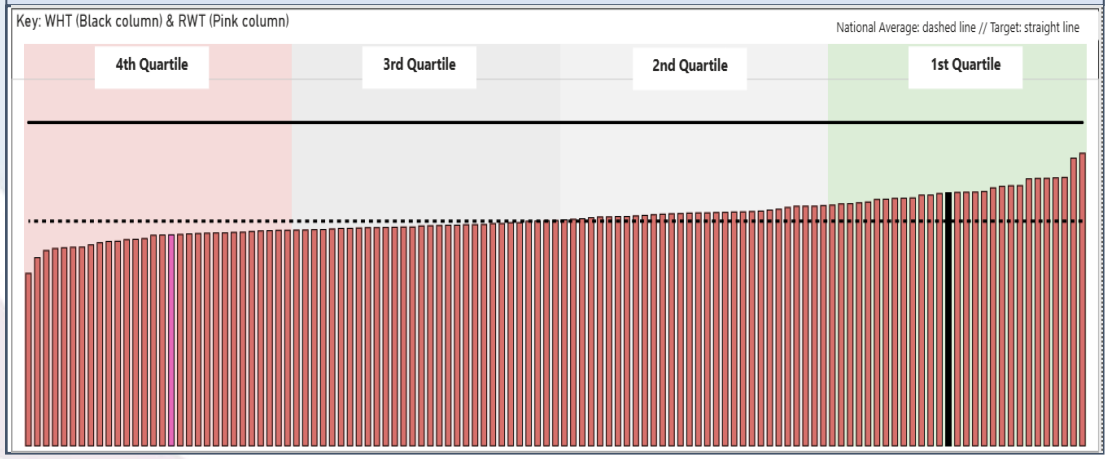


Community - Waiting List - % Within 18 Weeks

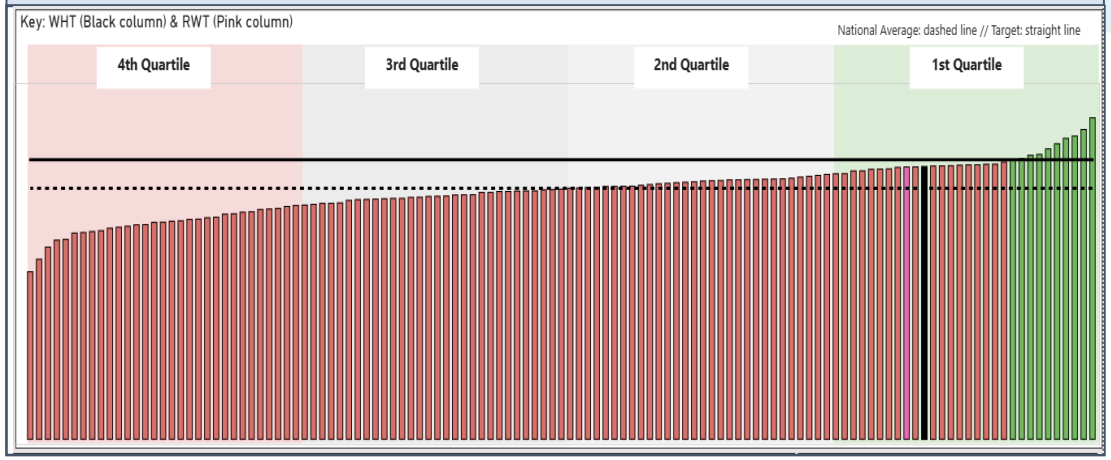


Operational Performance | Benchmarking

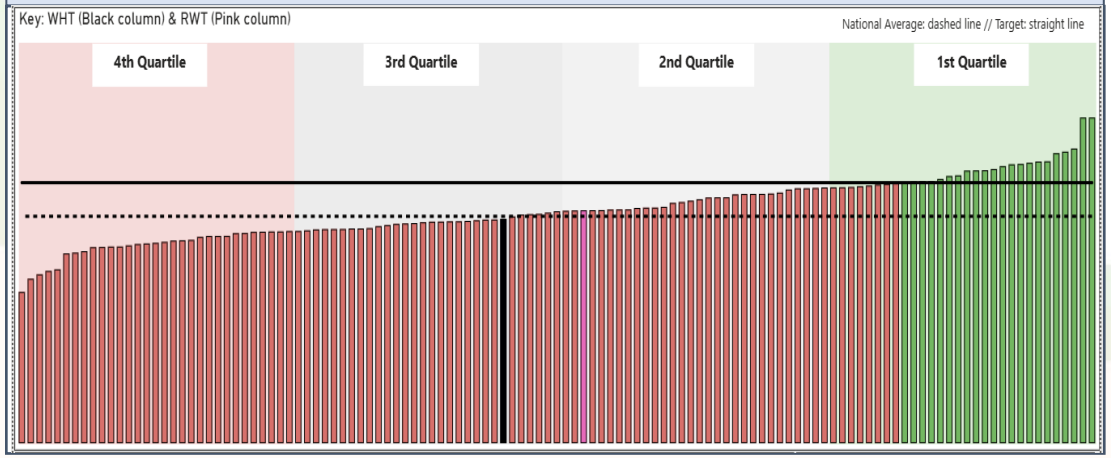
Referral to Treatment



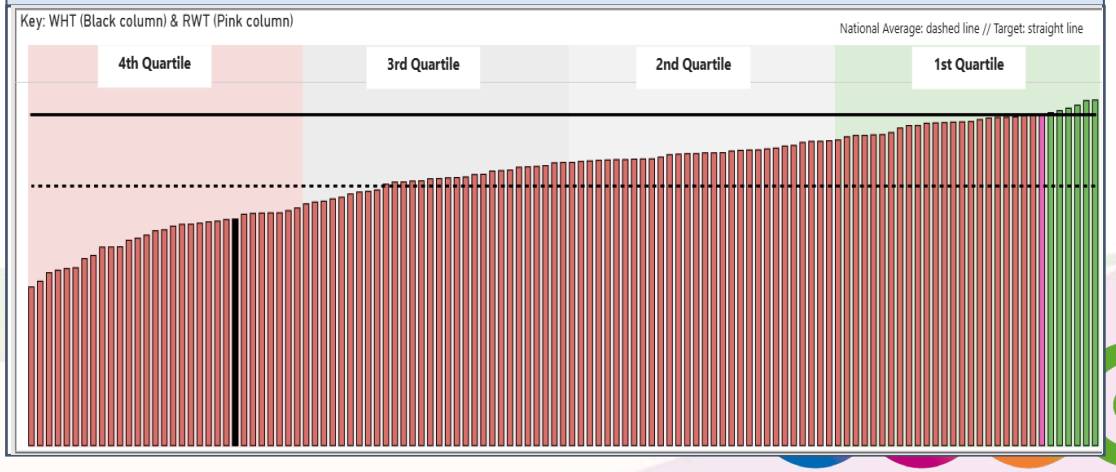
A&E 4 Hour



Cancer 62 Day



Diagnostic Waiting Times



Care Colleagues
Collaboration Communities

Finance

Finance | Executive Summary

Revenue

- WHT is off plan at Month 2 by £0.4m. Industrial Action costs of approx. £0.9m in Month 1 are offset by non pay underspends.
- 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. May was a busy month in ED resulting in £1m over performance across ED and Emergency Inpatients, this is driving £0.5m of UEC income accounted for above contract YTD. In May, the Trust delivered £0.6m of variable elective performance below contract. This would have been £0.4m below contract if there was no industrial action.
- CIP is £2.381m versus target of £2.448m, a negative variance of £67k.

Capital

- Year to date capital expenditure at Month 2 is £1.001m.
- The Theatres refurbishment and reconfiguration project continues from 25/26 the capital programme following numerous delays and is now expected to complete in quarter 2 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 2 is £46.5m. 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

In-Month Income & Expenditure	Plan M2 £m	WHT Actual M2 £m	Surplus/ (Deficit) £m
Income	**39.08**	**39.31**	**0.23**
Expenditure			
Pay	26.46	26.80	(0.35)
Non Pay	10.04	9.67	**0.37**
Drugs	2.04	2.16	(0.12)
Other*	2.54	2.65	(0.11)
Total Expenditure	**41.08**	**41.29**	(0.21)
Net reported surplus/(Deficit)	(2.00)	(1.98)	**0.02**

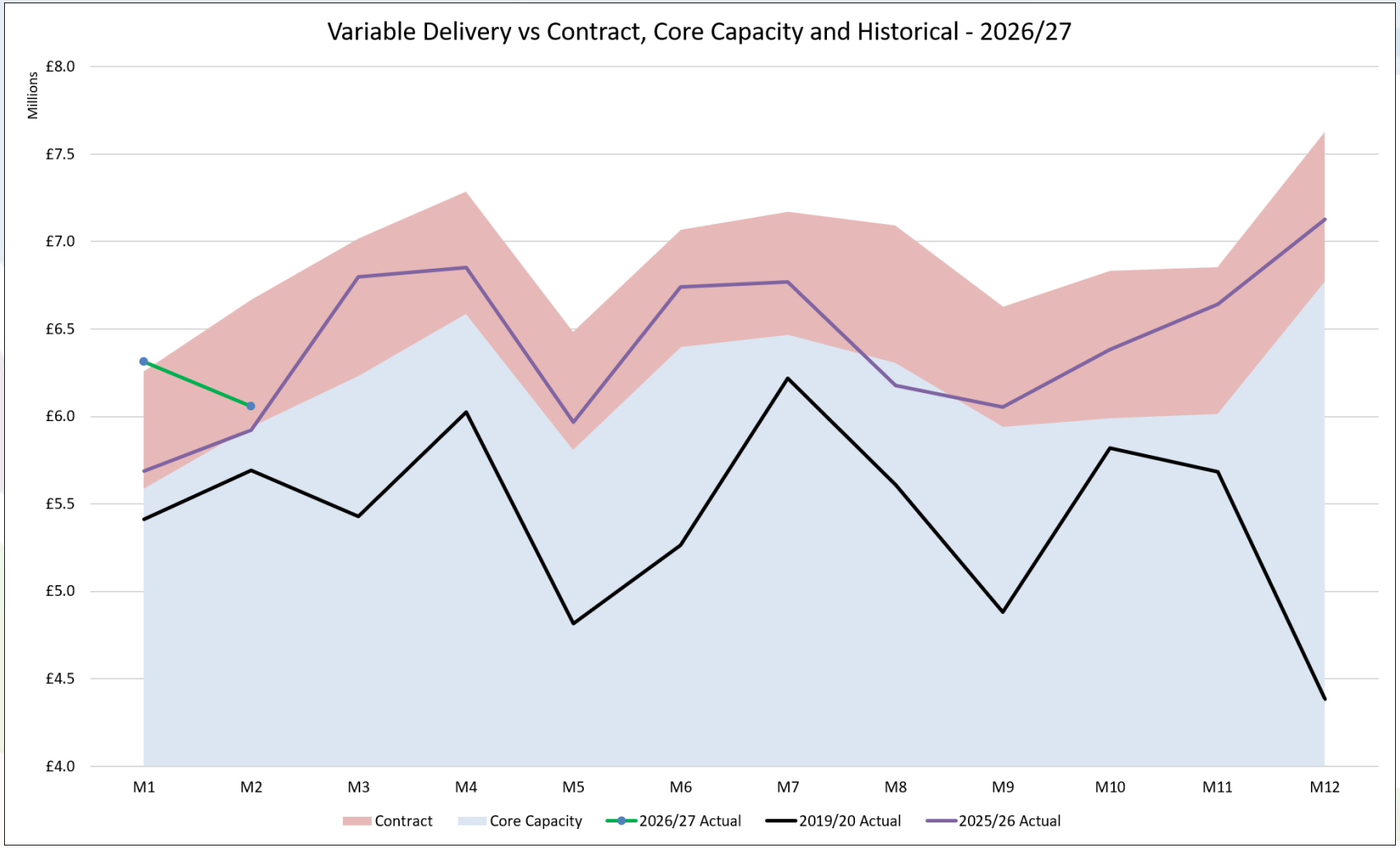
Year-to-date Income & Expenditure	Plan YTD £m	WHT Actual YTD £m	Surplus/ (Deficit) £m
Income	**77.35**	**77.36**	**0.01**
Expenditure			
Pay	52.08	53.51	(1.43)
Non Pay	20.00	18.93	**1.07**
Drugs	4.70	4.53	**0.17**
Other(incl. depreciation)	5.09	5.27	(0.18)
Total Expenditure	**81.88**	**82.25**	(0.37)
Net reported surplus/(Deficit)	(4.53)	(4.89)	(0.36)

M2 Key headlines

- YTD deficit is £4.9m, £0.4m greater than the planned deficit.
- Variable income is below contract by £0.6m and was impacted by £0.2m IA . Blended UEC income is above contract by £2.4m driving an additional £0.5m (20%) of income.
- Education & Training income is £0.1m ahead of plan based on an estimate ahead of receiving the current year's schedule, and Other income is behind plan due to underperformance against P2P SLAs.
- Staffing Expenditure is overspent by £1.4m, this includes the cost of Industrial Action, which was approx. £0.9m in month 1. It also includes under- delivery against Pay savings targets of £0.5m
- Non-Pay is underspent due to 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 £0.4m.

Care Colleagues
Collaboration Communities

Variable Elective Contract Performance – 2026/27 M2



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 £0.5m behind contract but would be £0.3m behind without IA.
- More activity was delivered in the IA month of April compared to no IA in May
- While some productivity plans are delivering the majority are planned to deliver later in the year.

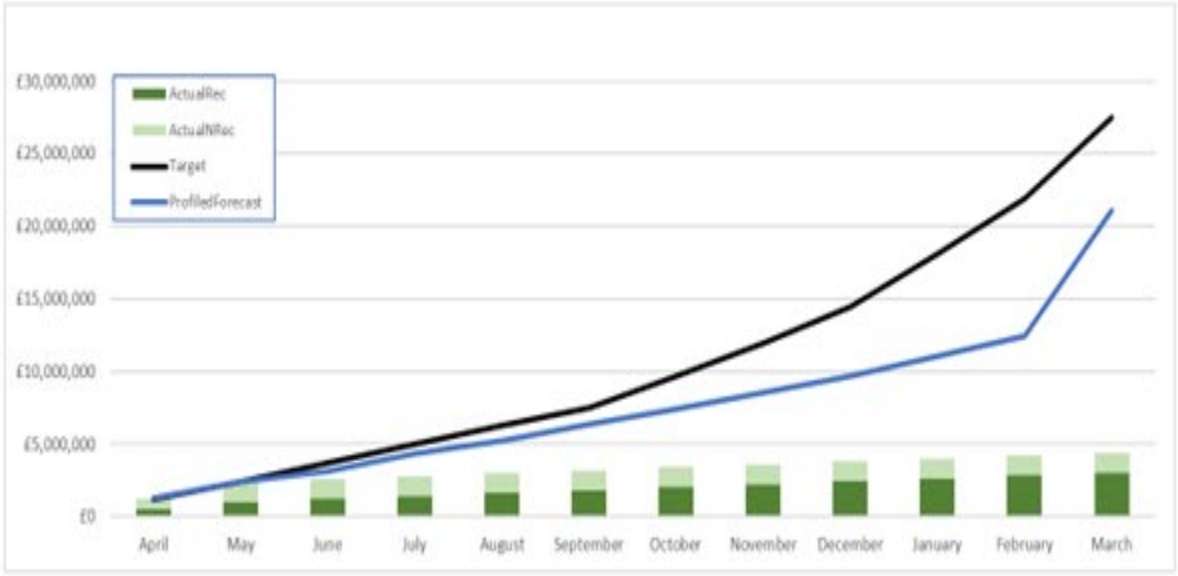
WHT: CIP Performance Overview

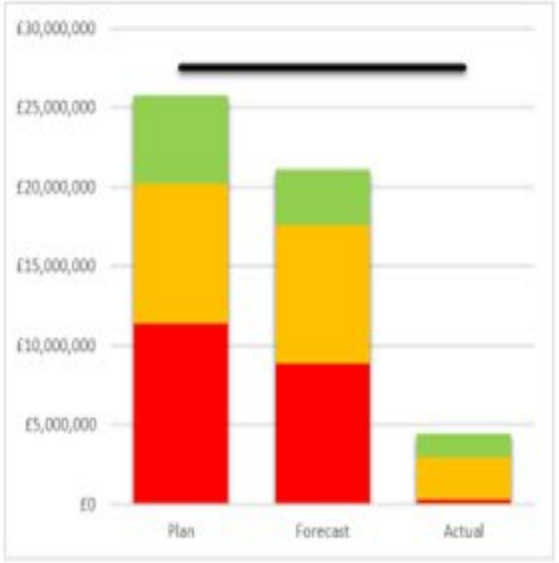
Programme Dashboard Period: 2 Trust WHT

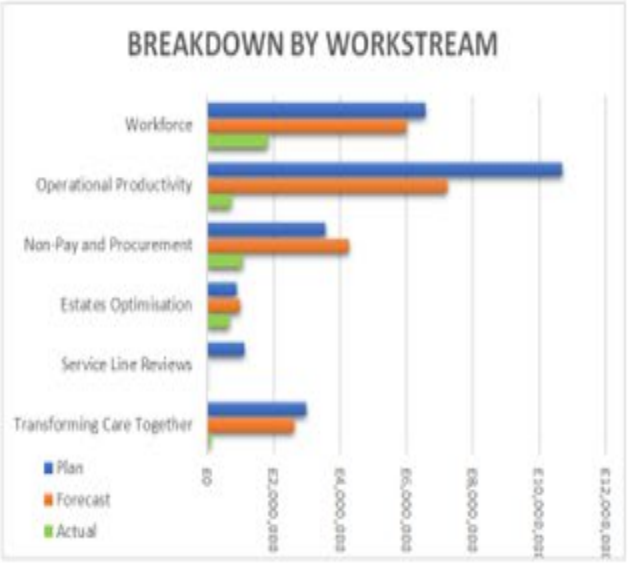
Current Position (Annual)	Plan	Forecast	Actual
Target		£27,517,003	
Recurrent	£20,001,124	£15,591,709	£3,036,186
NonRecurrent	£5,796,636	£5,522,266	£1,357,084
Subtotal	£25,797,760	£21,113,975	£4,393,270
Variance	(£1,719,243)	(£6,403,028)	(£23,123,733)
	93.8%	76.7%	16.0%

Current Position (YTD)	Plan	Forecast	Actual
Target		£2,448,330	
Recurrent	£1,222,966	£1,024,637	£1,024,637
NonRecurrent	£727,201	£1,357,084	£1,357,084
Subtotal	£1,950,167	£2,381,721	£2,381,721
Variance	(£498,163)	(£66,609)	(£66,609)
	79.7%	97.3%	97.3%

Current Position (InMonth)	Plan	Forecast	Actual
Target		£1,224,165	
Recurrent	£633,540	£518,281	£518,281
NonRecurrent	£258,911	£627,758	£627,758
Subtotal	£892,451	£1,146,039	£1,146,039
Variance	(£331,714)	(£78,126)	(£78,126)
	72.9%	93.6%	93.6%







National Oversight Assurance Framework Dashboard

National Oversight Assurance Framework Dashboard

National Oversight Framework - WHT			Q3 25/26			Q4 25/26			Internal	Internal	Internal
			Published			Published					
Metric	Time Period Reported	Target	Perf	Score	Rank	Perf	Score	Rank	Apr-26	May-26	Jun-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%	
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%	
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%	
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%	19.55%	
Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80%	82.74%	1.00	23/118	84.93%	1.00	5/117	86.14%		
Cancer - 62 Day Referral to Treatment	Aggregated quarterly position	75%	72.58%	2.29	52/118	74.08%	2.10	40/118	68.85%		
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%	
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%	
Planned Surplus / Deficit	Annual plan	0	-6.31	4.00	117/134	-6.31	4.00	117/134	2910	1983	
Year to date variation from plan	Year to date		1.14	1.00	2/134	0.65%	1.00	18/134	2910	4893	
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				
Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	2.00	2.28		2.00	2.27				
Rate of E-Coli infections (Rolling 12 Months)	12-month rolling	1	1.52	3.74		1.27	3.27				
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		
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%	
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%	

Model Health System

NHS Oversight Framework Summary

Overall Domain and Segment Scores	**Latest Published Data**
	Q4 25/26
Headlines	**NOF Score**
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.

Care Colleagues Collaboration Communities

National Oversight Assurance Framework Dashboard
WHT - Comparison

			WHT				
Domain	**Metric**	**Data Period**	**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			**1.4**	**1.58**	**2.17**	**1.83**	**-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**	

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.

Care Colleagues
Collaboration Communities

Productivity Dashboard

Productivity

The Trust continues to demonstrate strong productivity performance. Latest Model Health System data places overall *Implied Productivity Growth* in the top quartile nationally, reflecting favourable growth in outputs relative to inputs compared with the prior year.

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. However, **day-case rates** have fallen into the **second lowest quartile**, while the **average number of cases per equivalent four-hour elective session** remains in the lower quartiles, indicating opportunities to improve efficiency and throughput.

Outpatient Productivity
Outpatient services present clear opportunities for improvement. While PIFU has continued to improve and remains in the upper third quartile, further adoption remains achievable. DNA rates persist in the lowest quartile, exceeding both peer and national averages, 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.
Targeted improvements in outpatient efficiency, elective throughput, and workforce sustainability will be critical to sustaining and enhancing performance over the coming period.

Care Colleagues
Collaboration Communities

Productivity Dashboard

WHT Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target			2026/27											
			Source	Baseline	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	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										
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										
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	National planning	annual	92.00%	94.06%	92.50%										
5	Bed Occupancy classed as clinically ready for discharge (% of acute)	The average number of patients across the month who do not meet the criteria to reside (Question 2), divded by the total number of patients in hospital or discharged by 23:59 each day (sum of Question 3a and 3b).	Model Health System	Quartile 1 (lowest provider)	22.20%	18.68%	19.46%										
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%	80.61%										
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	1.82										
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	Internal		93%	91.34%	90.43%										
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%										
11	DNA Rate	Number of outpatient missed outpatient appointments divded by total outpatient appointments	Careflow	Trust Internal	8.00%	8.33%	8.25%										
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	National planning	annual	5.00%	5.47%	5.19%										
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referral) divded by total number of outpatient first attendances	National planning	NHSE	13.00%	11.67%	10.39%										
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	1,333	0										
Coding/ Income																	
15	Mean price per spell charged	Total income for elective inpatient, daycase and non-elective patients divided by total volume of elective inpatient, daycase and non-elective activity.	Model Health System	N/A	N/A	£1,726	£1,719										
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes		Trust Internal	tbc	£0 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										

Productivity Dashboard

WHT Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target			2026/27											
			Source	Baseline	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Non Pay																	
19	Procurement CIP	Value of procurement cost improvement savings delivered		Trust Internal	tbc	£231 k	£196 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										
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	1.62										
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	147.85	138.62										
23	A&E attendances (Type & 2) per Emergency Medicine Consultant	The number of A&E attendances (Type 1 & 2) in month, divded by the number of Emergency Medicine Consultants (WTEs) including substantive, bank and agency staff.	Model Health System	Quartile 1 (lowest provider)	613	508.89	494.94										
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										
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%										
26	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	Trust	Internal	5%	5.89%	6.30%										
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%										
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										
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												

Enclosure 10.3

Integrated Performance Report

The Royal Wolverhampton NHS Trust

May 2026 (Month 2)

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

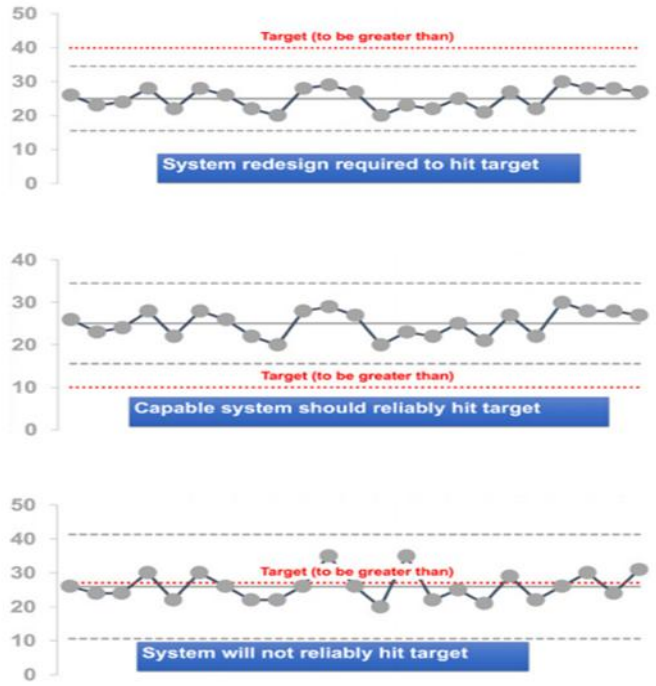
Care Colleagues
Collaboration Communities

How to Interpret SPC (Statistical Process Control) charts

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

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

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



Care Colleagues
Collaboration Communities

Managing Director Summary

- On 28th May 26 we received communication from the CQC stating they have upheld the Trust Representations regarding the 29A Warning notice, issued to the Emergency Department (ED) at New Cross Hospital in February 26, concluding that the notice was not sufficiently detailed to meet the legal threshold for enforcement.

- The action plan submitted following the focused Ionising Radiation (Medical Exposure) Regulations inspection of the Diagnostic Imaging Department at New Cross Hospital has been accepted, and the inspection file is now formally closed

- There are significant challenges in the Ophthalmic Department, regarding managing demand and capacity, which have been escalated throughout the Trust committees in recent months. This has been escalated to the ICB and a programme of work with ICB and Trust colleagues has already meet to develop plans to reduce the risk for patients. This is more specific to patient on Glaucoma There have also been two never events in Ophthalmology in April and May 26. More detail in the Quality and Safety section and escalation/discussion has taken place at the Trust Quality Committee.

- There has also been a never event in Gastroenterology Ward – detail in quality section.

- There has been two significant reports for Maternity that have been recently published, Independent review of Maternity Services at Nottingham University Hospital by Ockenden and the Baroness Amos - Independent National Maternity and Neonatal Investigation. Eight Key recommendations for Trusts to review, consider and implement. These issues are subject to separate discussion at Trust Quality Committee and this Trust Board.

- Pleased to report that settlement has been reached between the BMA on behalf of Resident Doctors and the Government and therefore there will be no further strike action and impact for patients.

Authors

Gwen Nuttall (Managing Director)

Care Colleagues Collaboration Communities

Managing Director Summary continued……

- Cannock Chase Elective Hub has been reaccredited under the National Elective Hub Accreditation Programme, confirmed by the Accreditation Panel on 24th June 26 following a site visit on 7th May 26. This renews the Hub's original 2023 accreditation for a further three years. Feedback for the clinical team was overall positive. A Hub Optimisation Plan is due to Getting it Right First Time (GIRFT) by 5th August 26 for sign-off.

- Progress has been made with regard to fire enforcement notice for Nucleus Theatres (Block 55) New Cross Hospital, which has been closed down by West Midlands Fire Service, following a review and inspection in May 26. All required works to ensure appropriate fire safety works were completed on time and to required standard.

- Discussion with Staffordshire Fire Service also continue in a constructive way, as progress on the fire alarm works continue.

- Block 32 – Maternity issues are picked up as part of another report.

- Finance, Workforce and Performance all reported in their relevant section. Metrics relate to May 26; however, June 26 has been a challenging month with regard to Urgent and Emergency Care delays. The presentation of some patients changed during the hot weather and the Trust reviewed its hot weather plan for patients and staff during this time.

- The Trust has been notified that it has returned to NOF segment 3, with financial improvement noted for Quarter 4.

- New metrics have been issued to be included in segmentation going forward, the Trust is working through an assessment of potential impact and position, although not all methodology for calculation has been published at the time of this report.

Authors

Gwen Nuttall (Managing Director)

Care Colleagues Collaboration Communities

Balanced Scorecard

Quality, Safety & Patient Experience	Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	19/20 Same Period	Variation	Assurance
Patient falls - rate per 1,000 occupied bed days	4.50	3.02	2.82	May-26	-	Improvement	Achieving
Pressure ulcers per 1,000 occupied bed days	1.50	1.30	1.87	May-26	1.01	Common Cause	Inconsistent
Community acquired pressure ulcers per 10,000 population	0.90	0.83	0.87	May-26	-	Common Cause	Inconsistent
Observations on time (Trust wide)	90.00%	87.53%	88.67%	May-26	-	Common Cause	Not Met
VTE risk assessment - % within 14 hours	95.00%	87.02%	88.04%	Apr-26	-	Concern	Not Met
Sepsis screening - ED	90.00%	98.00%	98.00%	May-26	-	Common Cause	Achieving
Sepsis screening - Inpatients	90.00%	88.40%	87.40%	May-26	-	Common Cause	Inconsistent
Clostridioides difficile	-	7	4	May-26	4	Improvement	No Target Set
MRSA Bacteraemia	0	0	0	May-26	-	Common Cause	Inconsistent
Number of complaints as a % of admissions	0.50%	0.71%	0.60%	May-26	-	Concern	Inconsistent
FFT recommendation rates - Trust wide	92.00%	88.00%	88.00%	May-26	93.00%	Common Cause	Not Met
Care hours per patient - total nursing & midwifery staff actual	7.6	8.0	7.9	May-26	7.7	Common Cause	No Target Set
Care hours per patient - registered nursing & midwifery staff actual	4.5	5.2	5.1	May-26	-	Common Cause	No Target Set
SHMI	1.00	0.94	0.94	May-26	-		No Target Set
Never events	0	1	1	May-26	-	Concern	Inconsistent

Workforce Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
Substantive (WTE) Trust	-	10094.18	10107.24	Jun-26	-	Improvement	No Target Set
Agency (WTE) Trust	-	22.67	24.58	Jun-26	-	Common Cause	No Target Set
Bank (WTE) Trust	-	708.75	615.84	Jun-26	-	Common Cause	No Target Set
Vacancy Rate	6.00%	6.03%	6.33%	Jun-26	-	Concern	Inconsistent
Turnover Rate (12 Months)	10.00%	7.82%	7.86%	Jun-26	-	Improvement	Achieving
Retention Rate (12 Months)	90.00%	91.72%	91.72%	Jun-26	-	Improvement	Inconsistent
Sickness Absence (In Month)	5.00%	5.47%	5.16%	Jun-26	-	Common Cause	Inconsistent
Appraisals	90.00%	77.00%	77.77%	Jun-26	-	Concern	Not Met
Statutory & Mandatory Training	90.00%	97.87%	93.34%	Jun-26	-	Improvement	Achieving

Operational Performance	Target / Limit	Previous Month	Current Month	Latest Time Period	19/20 Same Period	Variation	Assurance
18 Weeks RTT - % Within 18 Weeks - Incomplete	69.60%	60.25%	60.42%	May-26	82.13%	Improvement	Not Met
18 Weeks RTT - 52 wk breaches as a % of PTL	0.99%	2.58%	2.47%	May-26	0.00%	Improvement	Not Met
18 Weeks RTT - Total Incomplete PTL	61077	73776	73165	May-26	39142	Improvement	Not Met
Cancer - 28 Day Faster Diagnosis	80.00%	80.39%	80.72%	Apr-26	-	Improvement	Inconsistent
Cancer - 31 Day Treatment	94.00%	93.16%	92.57%	Apr-26	90.93%	Improvement	Inconsistent
Cancer - 62 Day Referral to Treatment	80.00%	72.77%	71.52%	Apr-26	64.34%	Improvement	Not Met
No. of patients no longer meeting the Criteria to Reside	-	66	51	May-26	-	Common Cause	No Target Set
Diagnostics - % within 6 weeks from referral	95.00%	95.13%	95.43%	May-26	84.70%	Improvement	Not Met
Total Time Spent in ED - % over 12 Hours	2.00%	14.51%	15.09%	May-26	-	Concern	Not Met
Total Time Spent in ED - % within 4 Hours	82.00%	80.95%	80.05%	May-26	81.83%	Common Cause	Inconsistent
Community - Waiting List - Total	-	2496	2564	May-26	-	Improvement	No Target Set
Community - Waiting List - within 18 weeks	-	45.79%	45.48%	May-26	-	Concern	No Target Set
GP Practice Group - Total Triage Medical Requests	-	7930	7726	May-26	-	Not Enough Points	Not Enough Points
GP Practice Group - Total Triage Administrative Requests	-	3671	3568	May-26	-	Not Enough Points	Not Enough Points
Single GP Practice - Total Triage Medical Requests (Coalway Rd)	-	875	948	May-26	-	Not Enough Points	Not Enough Points
Single GP Practice - Total Triage Administrative Requests (Coalway Rd)	-	447	483	May-26	-	Not Enough Points	Not Enough Points
Single GP Practice - Total Triage Medical Requests (Thornley St)	-	1431	1452	May-26	-	Not Enough Points	Not Enough Points
Single GP Practice - Total Triage Administrative Requests (Thornley St)	-	586	599	May-26	-	Not Enough Points	Not Enough Points

Finance	Target / Limit	Previous Month	Current Month (Latest Available)	Latest Time Period	19/20 Same Period	Variation	Assurance
Surplus/(Deficit) (£000) - in month	601	10672	-2740	Apr-26	-	Common Cause	Inconsistent
Surplus/(Deficit) (£000) - YTD	-4399	4927	-2740	Apr-26	-	Improvement	Inconsistent
Surplus/(Deficit) (£000) - FOT	-	0	0	Apr-26	-	Improvement	No Target Set
Elective Variable (£000) - in month	15695	16531	15908	Apr-26	-	Common Cause	Inconsistent
Elective Variable (£000) - YTD	146472	187610	15908	Apr-26	-	Improvement	Inconsistent
Elective Variable (£000) - FOT	195523	195523	195523	Apr-26	-	Improvement	Not Met
Efficiency (£000) - in month	6075	4317	2515	Apr-26	-	Common Cause	Inconsistent
Efficiency (£000) - YTD	44212	46159	2515	Apr-26	-	Common Cause	Achieving
Efficiency (£000) - FOT	57240	50475	63448	Apr-26	-	Common Cause	Inconsistent
Capital (£000) - YTD	23691	31916	0	Apr-26	-	Common Cause	Inconsistent
Capital (£000) - FOT	29350	31916	0	Apr-26	-		Inconsistent
Cash (£000) - in month	25878	42739	-60946	Apr-26	-		Inconsistent
Cash (£000) - FOT	26018	42739	44709	Apr-26	-	Common Cause	Inconsistent

Quality, Safety and Patient Experience

Quality, Safety & Patient Experience | Executive Summary

- On 28th May 26 we received communication from the CQC stating they have upheld the Trust Representations regarding the 29A Warning notice, issued to the Emergency Department (ED) at New Cross Hospital in February 26, concluding that the notice was not sufficiently detailed to meet the legal threshold for enforcement.
- On 4th June 26, The Care Quality Commission (CQC) Engagement team undertook a clinical walkabout within ED and held focus groups with Nursing staff bands 2-6. The visit did not identify any issues requiring immediate action or escalation.
- There were 2 Never Events reported in month, one in the Ophthalmology Directorate under the description of wrong site surgery which resulted in the patient receiving bilateral PRP (Pan-retinal Photocoagulation) laser treatment on 11th April 26, the error was identified at follow-up on 11th June 26 . A previous wrong site surgery in Ophthalmology was also reported in April 26. The second Never Event occurred in the Gastroenterology Directorate under the description of wrong route medication on 26th May 26, when oral medication was mistakenly administered via a Hickman line, of which the patient was clinically reviewed with no immediate harm, Duty of Candour was completed and immediate actions taken.
- Overall Falls remain stable with no Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents.
- Pressure ulcers per 1,000 occupied bed days have risen but remain within tolerance, with a new trend of sacral ulcers and 25% linked to end-of-life skin changes and targeted improvements underway including updated repositioning guidance.
- The Trust continues to await publication of its national infection prevention trajectories in month, however, in May 26 there have been 4 C.difficile cases, 0 Methicillin – resistant Staphylococcus aureus bacteraemia's, 9 Escherichia coli bacteraemia's reported. There were 7 device-related hospital-acquired bacteraemia (DRHAB) cases this month. These consisted of 4 central lines, 2 peripheral lines and 1 urinary catheter. In response we have launched a dedicated DRHAB task-and-finish group in June to drive reductions in line-associated infections and have ongoing multidisciplinary reviews and Trust wide Peripheral Venous Cannula Audits to underpin quality improvement initiatives.

Authors

Debra Hickman (Chief Nursing Officer)

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

- The annual schedule for Nursing skill-mix reviews are on schedule, with the first bi-annual inpatient skill mix review of the year now completed, the annual report will be presented at Board in the Autumn.

- A rise in complaints has been noted, total numbers received equates to a 0.06% of overall activity. Themes remain around delays with some planned care specialties such as Urology and Gynaecology reflecting their overall waiting list position. The Emergency Department has seen a downward trend in numbers received and themes associated with long waits/delays. Other categories that continue to feature is communication and general attitude. There is activity currently underway addressing complaint backlog in aforementioned areas, local resolution focus and general communication/customer care, which triangulates with themes from 'Call for Concern' data.

- June 26 Supreme Court ruling overturned the Cheshire West "acid test," introducing a multi-factorial approach to Deprivation of Liberty (DoL) that recognises valid consent from some individuals lacking capacity, likely reducing DoLS authorisations while raising questions about safeguards; further analysis on operational impact will follow.

- The Nursing & Midwifery Council (NMC) has issued a national update after identifying a 12-year process failure in handling health and character declarations; a rapid review found only 421 of 18,060 cases required further assessment, with up to 15 registrants potentially facing removal, as far as we are aware no RWT staff are currently affected. We continue to monitor the situation and will respond promptly to any NMC enquiries.

- NHS England has mandated a full review of all Band 5 nursing roles, with a delivery plan due by 31st July 26 and implementation by October 2028; Black Country collaborative work has already highlighted variation across the system of which the Chief Nursing Officers are collectively looking to align.

Authors

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

Antimicrobial Stewardship(AMS):

Call to Action Letter: The Trust has responded and is now actively working towards the targets.
Total consumption: National databases have been retrospectively updated to include FP10 antibiotic prescribing. Although this previously placed RWT in the middle quintile, recent improvements mean RWT remained in the best national quintile for Q3 2025/26.
Watch and reserve antibiotics: In Q3 2025/26, RWT was in the best national quintile for consumption of Watch and Reserve antibiotics.
Carbapenem usage: The antimicrobial stewardship team has worked to reduce carbapenem consumption. In Q3 2025/26, RWT remained in the middle quintile; however, usage continues to trend downwards, providing assurance that the Trust is moving in the right direction.
Intravenous antibiotics: The Trust remained in the best quintile for Q3 2025/26 for consumption of IV antimicrobials compared with the national average.

SHMI: The Standardised Hospital Mortality Indicator (SHMI) is 0.94; 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 7 diagnosis groups are managed as internal alerts, they include Peripheral and visceral atherosclerosis, Diseases of kidneys and ureters, Intestinal infection, Epilepsy, Short Gestation, Sepsis and Pneumonia.

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

- **Glaucoma service Quality and Risk update**

The Glaucoma service at RWT is facing significant demand pressures, exacerbated by COVID-19 legacy impacts and patients bypassing community ophthalmology services. Approximately 10,000 patients are on the waiting list, 5,500 of whom are overdue and RAG-rated (2,000 Green, 2,000 Amber, 1,500 Red).

Seven patients have come to harm and harm reviews and associated learning have been requested.

Following a meeting with ICB colleagues immediate action is focused on the 1,500 Red-rated patients, with a broader recovery plan to follow for remaining cohorts. A working group has been established to develop sustainable out-of-hospital pathway options, with the next meeting on 30th June 26.

This risk sits on the Trust risk register and will be a standing Care quality Review Meeting (CQRM) agenda item until closed. It has been discussed in detail at the June 26 Quality Committee.

These pressures mirror the national challenges facing glaucoma services across the NHS, indicating that this is not just an isolated local issue but part of a wider system-level capacity problem.

- **Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection of the Diagnostic Imaging Department at New Cross Hospital**

The action plan submitted following the focused IR(ME)R inspection of the Diagnostic Imaging Department at New Cross Hospital has been accepted, and the inspection file is now formally closed. Ongoing compliance and delivery of the action plan will be monitored by CQC colleagues through routine trust engagement, supported locally by Divisional governance structures and oversight through QSOG, which will continue to review progress, provide assurance, and escalate any emerging risks related to IR(ME)R practice.

Authors

Debra Hickman (Chief Nursing Officer)

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Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Executive Summary

- **Cannock Chase Elective Hub National Reaccreditation**

The Cannock Chase Elective Hub has been reaccredited under the National Elective Hub Accreditation Programme, confirmed by the Accreditation Panel on 24th June 26 following a site visit on 7th May 26. This renews the Hub's original 2023 accreditation for a further three years. The review found strong staff engagement, positive culture, and excellent patient experience, particularly in the joint school and enhanced recovery pathway. Most criteria across the five assessed domains were fully met, with three partially met.

Key improvement areas include staggered admission times, weekend/evening Day 0 discharge resourcing, embedding Martha's Rule, and ring-fencing of ward nursing staff to strengthen service resilience and morale.

A Hub Optimisation Plan is due to Getting it Right First Time (GIRFT) by 5th August 26 for sign-off.

Authors

Debra Hickman (Chief Nursing Officer)

Brian McKaig (Chief Medical Officer)

Care Colleagues Collaboration Communities

Perinatal Service | Executive Summary

Latest CQC Summary

17 September 2024 assessment Overall Good

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

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

	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			
Grades Maternity/neonatal	A1	A1	A2	A1	A3	A1	A2	A0	A2	A0		
	B4	B2	B3	B2	B2	B3	B3	B2	B2	B2		
	C0	C0	C0	C0	C0	C0	C0	C0	C0	C1		
	D0	D0	D0	D0	D0	D0	D0	D0	D0	D0		
Final MNSI Reports Received	1		1		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			
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			
Coroner Reg 28	0		0		0		0		0			
Obstetrics/Gynaecology Trainees Quality of Clinical Supervision reported annually												

CNST & Training Position May 2026

Staff Group	PROMPT	Fetal monitoring	NLS
Obstetricians	80%	91%	80%
Midwives	95%	93%	95%
Support Staff	94%	NA	NA
Anaesthetists	75%	NA	NA
Neonatal Doctors	NA	NA	100%
Neonatal Nurses	NA	NA	90%

Full compliance with Maternity Incentive Scheme Year 8 training requirements.

Care Colleagues Collaboration Communities

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			Midwifery workforce review near completion following BR+ report
Obstetrics RCOG Compliant on delivery suite	Yes	Yes	Yes					Audit in progress
Neonatal Nurses BAPM Compliant	87%	82%	79%	97%	71%			Nursing numbers against actual acuity
Neonatal Doctors BAPM Compliant	Yes	Yes	Yes	Yes	Yes			

Safety Champion feedback

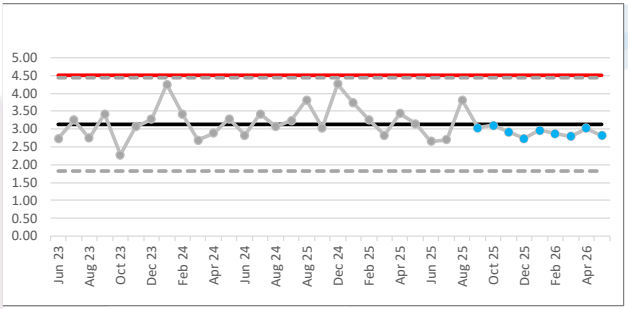
Zero Maternity Outcomes Signal System (MOSS) signals in May
Maternity Incentive Scheme Year 8 in progress. Perinatal Directorate have agreed halfway Point review for training compliance will take place in July and November in line with MIS standard for training.
Safety Champion discussions included Nitrous Oxide exposure risk – Perinatal Directorate exploring introducing Destruction units on Delivery Suite.
Fire Evacuation training continues in Maternity Block.

Care Colleagues
Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

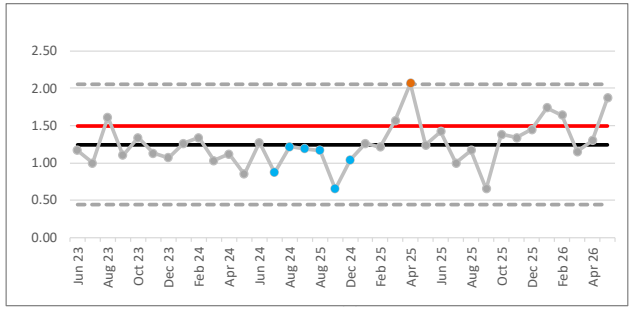
Patient falls - rate per 1,000 occupied bed days

Achieving	Improvement	2.82



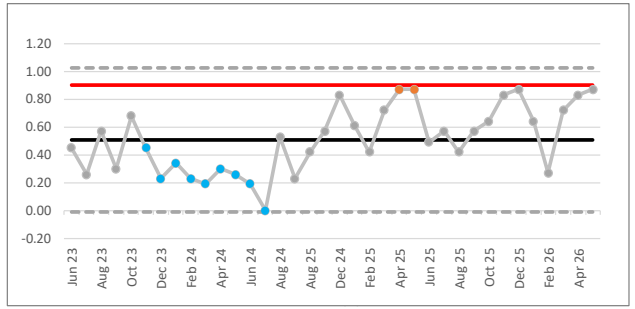
Pressure ulcers per 1,000 occupied bed days

Inconsistent	Common Cause	1.87



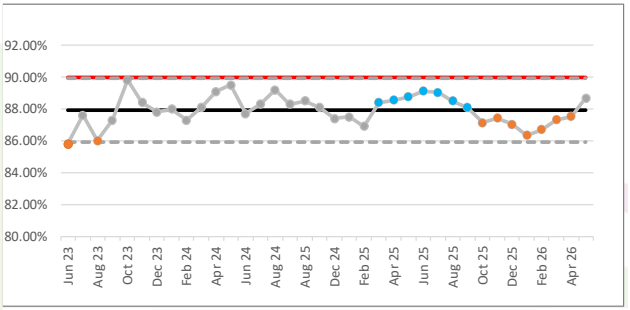
Community acquired pressure ulcers per 10,000 population

Inconsistent	Common Cause	0.87



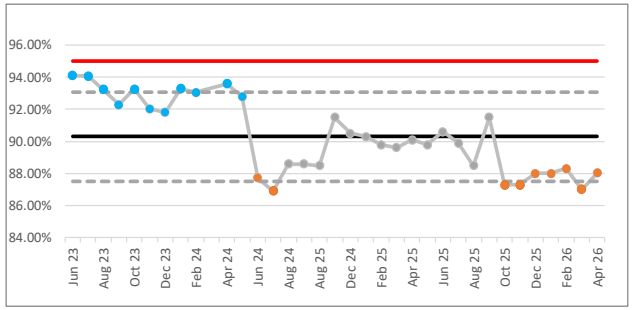
Observations on time (Trust wide)

Not Met	Common Cause	88.67%



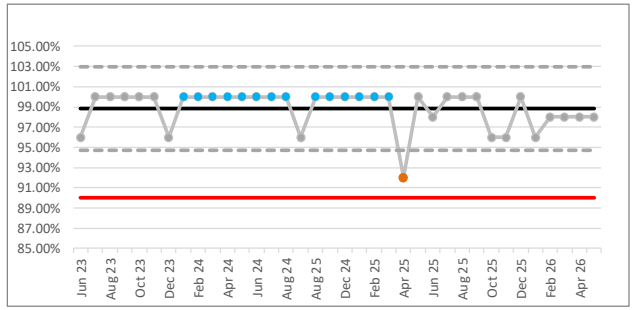
VTE risk assessment - % within 14 hours

Not Met	Concern	88.04%



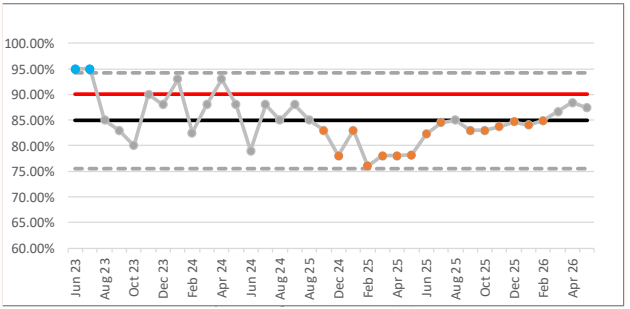
Sepsis screening - ED

Achieving	Common Cause	98.00%



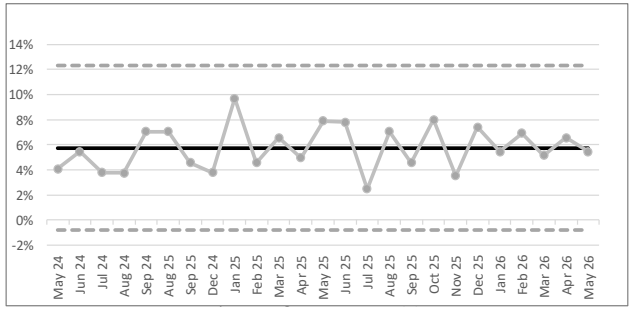
Sepsis screening - Inpatients

Inconsistent	Common Cause	87.40%



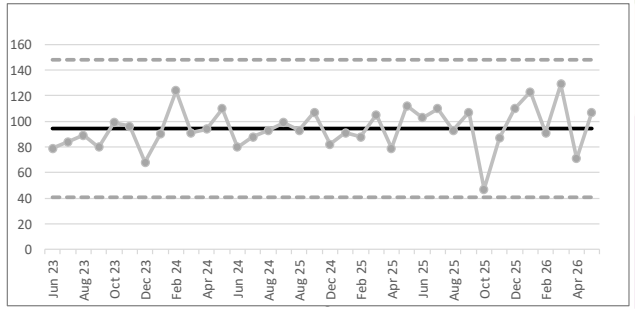
Medication error - % of incidents causing harm

No Target Set	Common Cause	5.46%



Mental health patients spending over 12 hours in A&E

No Target Set	Common Cause	107

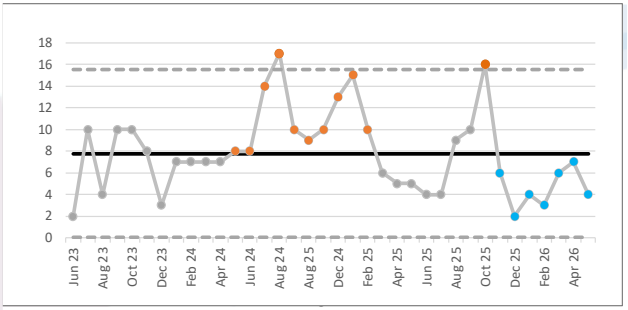


Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

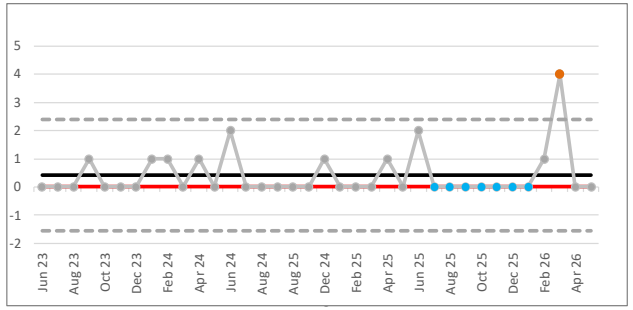
Clostridioides difficile

No Target Set	Improvement	4



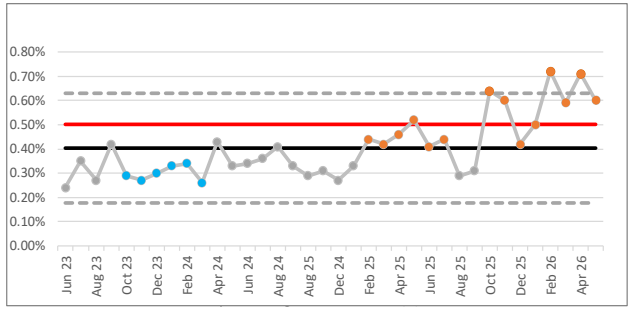
MRSA Bacteraemia

Inconsistent	Common Cause	0



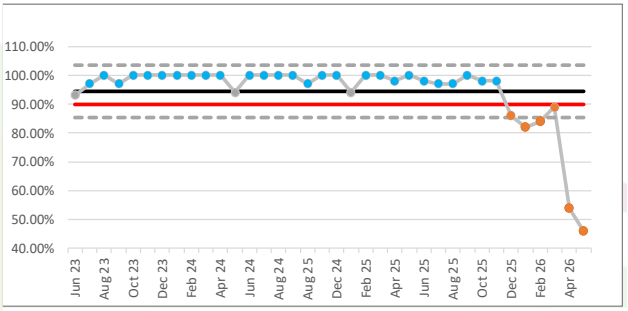
Number of complaints as a % of admissions

Inconsistent	Concern	0.60%



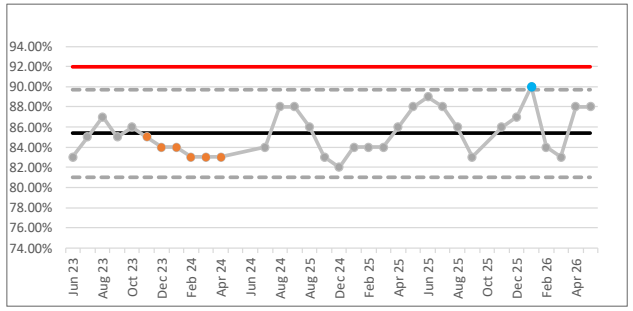
Complaints response rate against policy

Inconsistent	Concern	46.00%



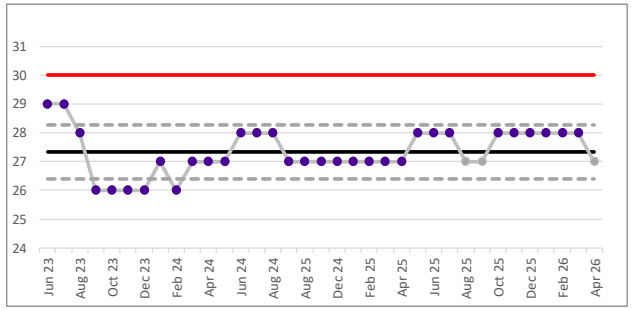
FFT recommendation rates - Trust wide

Not Met	Common Cause	88.00%



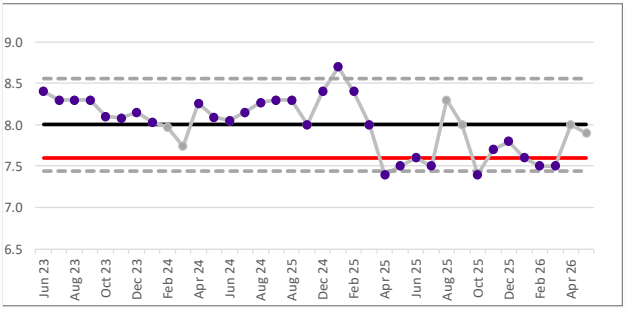
Midwife to birth ratio (1 to)

No Target Set	Common Cause	27.0



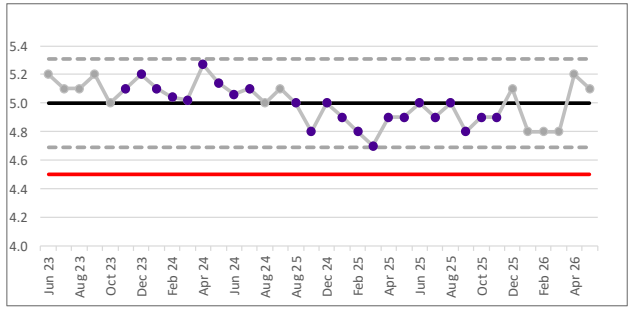
Care hours per patient - total nursing & midwifery staff actual

No Target Set	Common Cause	7.9



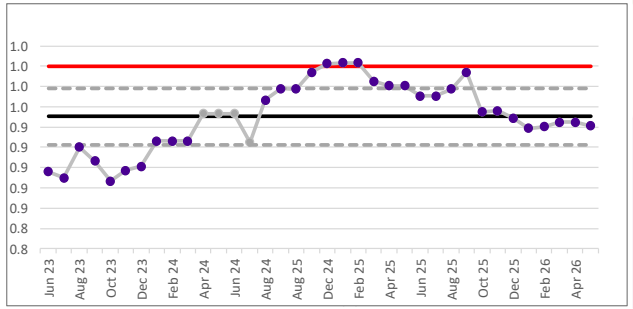
Care hours per patient - registered nursing & midwifery staff actual

No Target Set	Common Cause	5.1



SHMI

No Target Set	Common Cause	0.94

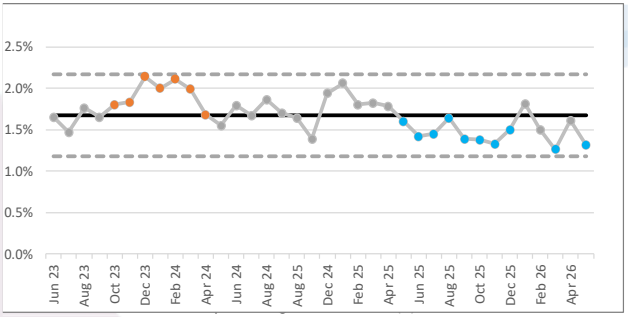


Care Colleagues Collaboration Communities

Quality, Safety & Patient Experience | Core Metrics

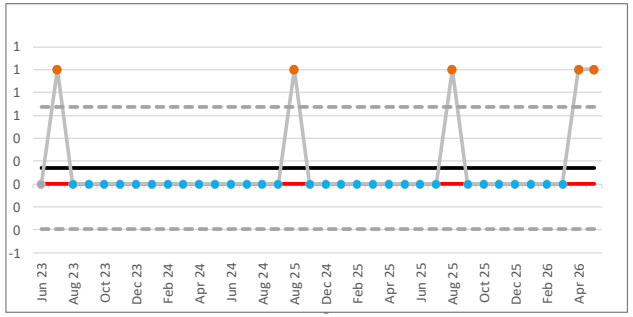
Crude Mortality Rate

No Target Set	Improvement	1.31%



Never events

Inconsistent	Concern	1



Care Colleagues Collaboration Communities

People

People | Executive Summary

During May 26, the overall workforce reduced by 77.9 WTE. This movement was driven by a reduction in temporary staffing, partially offset by growth in the substantive workforce

- Substantive workforce increased by 13.1 WTE.
- Bank utilisation reduced by 92.9 WTE.
- Agency utilisation increased by 1.9 WTE.

Year-to-date workforce has reduced by 83 WTE, largely through reductions in temporary staffing (-68 WTE Bank and -9 WTE Agency), with substantive workforce broadly stable (-6 WTE).

While this represents a continued month-on-month reduction in overall workforce, the Trust remains 111 WTE above the NHSE workforce plan at M2.

Appraisal compliance increased to 77.8%, continuing a three-month upward trend, but remains below target. The greatest improvement challenge remains within the Corporate Division and Division 1.

Sickness absence reduced to 5.16% in April 26, down from 5.47% improving performance Amber. Division 3 showing the largest improvement (-0.96%).

The rolling 12-month sickness rate decreased to 5.51%, reflecting a positive long-term trend, with average long-term sickness episodes reducing by 10% since April 24 to 80 FTE days lost.

Authors

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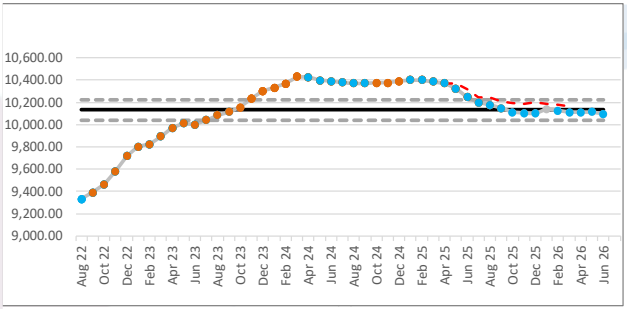
Care Colleagues Collaboration Communities

People | Core Metrics

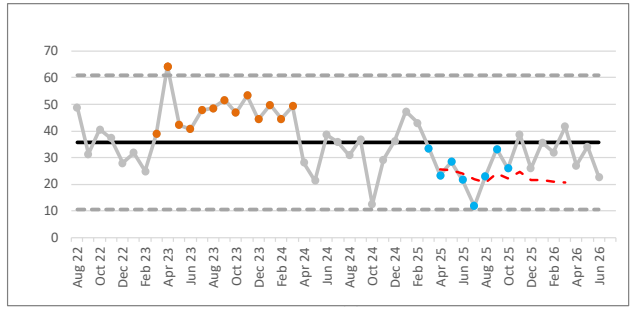
Substantive (WTE) Trust

No Target Set	Improvement	10107.24



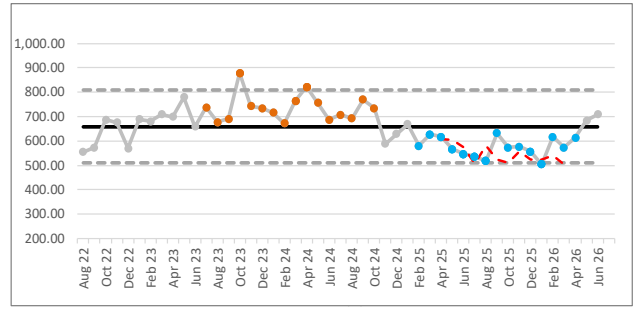
Agency (WTE) Trust

No Target Set	Common Cause	24.58



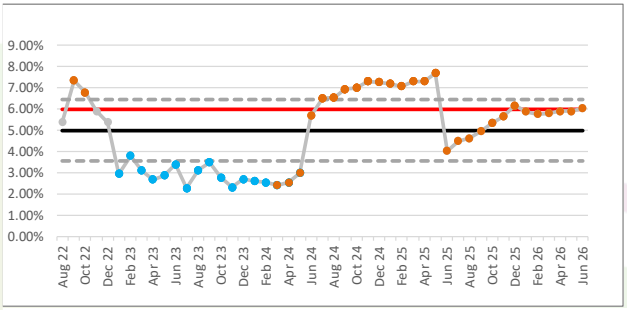
Bank (WTE) Trust

No Target Set	Common Cause	615.84



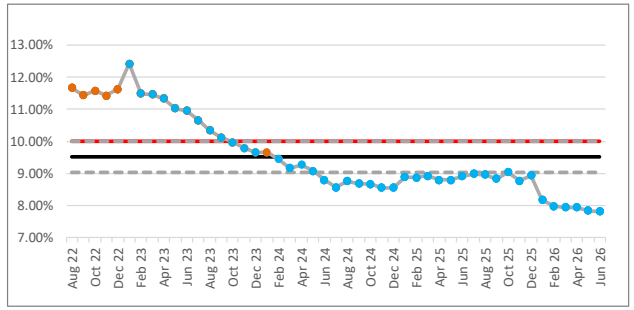
Vacancy Rate

Inconsistent	Concern	6.33%



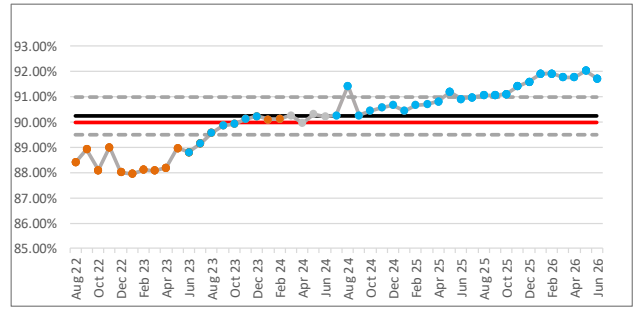
Turnover Rate (12 Months)

Achieving	Improvement	7.86%



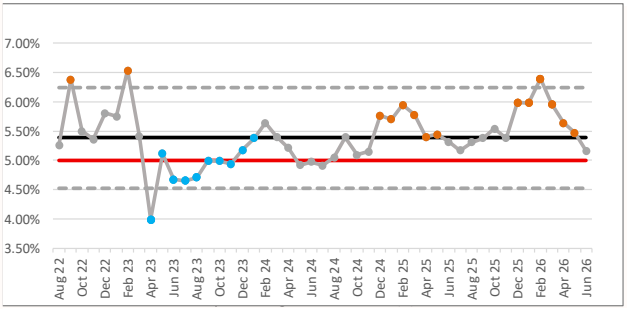
Retention Rate (12 Months)

Inconsistent	Improvement	91.72%



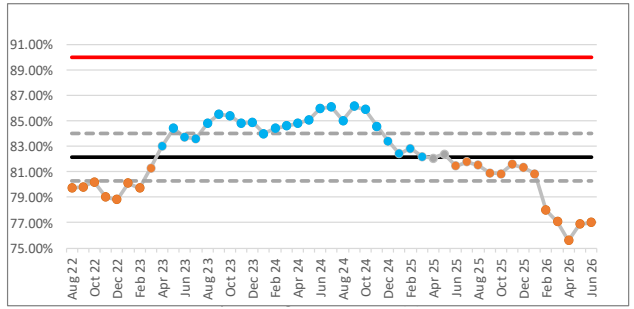
Sickness Absence (In Month)

Inconsistent	Common Cause	5.16%



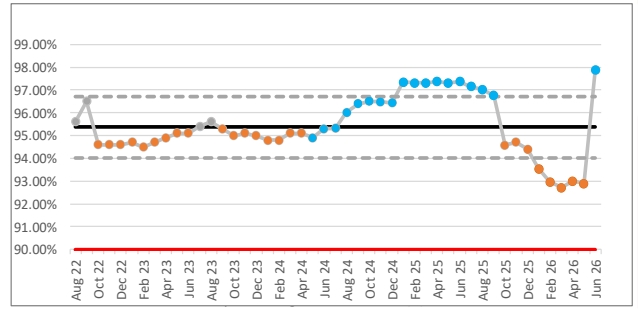
Appraisals

Not Met	Concern	77.77%



Statutory & Mandatory Training

Achieving	Improvement	93.34%



Care Colleagues Collaboration Communities

Operational Performance

Operational Performance | Executive Summary

- Performance continued to improve across the majority of the constitutional standards in May 26. The dedicated project (Optimisation) to manage the operational impact of the new EPR system within Phase 2 of the Blueprint Programme has held its first full meeting. Timelines and plans are in place to close issues down and move fully to business as usual as soon as possible.
- The Resident Doctor Industrial Action planned for June 26 was stood down. Cancelled planned activity was rebooked and capacity 'stood-back up' for the week of 15th to 19th June 26.
- UEC – delivery of the 4-hr patient access standard dipped marginally in May 26 to 80.05% (from 80.95% in April 26). The 12-hr standard remained high at 15.09%, having been 14.51% for April 26. Ambulance handover times deteriorated from the April 26 position. 38.87% of patients were handed over within 15 minutes and 28.40% waited longer than 45 minutes. ED length of stay and ambulance handovers continue to be an area of focus for the whole organisation recognising the interdependencies across teams and services.
- The impact of the hot weather has put all UEC services across the country under pressure throughout June 26. Patients have experienced long delays at access points to and within ED and the organisations emergency portals. Additional actions have been put in place to refocus the medical workforce (week commencing 29th June 26) as the Trust's usual Level 4 response actions failed to have the required impact.
- Work progresses with clinical and operational teams on the Community First programme. The dedicated Medical SDEC opened on 13th April 26. This is being delivered through a temporary workforce as investment cases are progressed through the Trust/Groups governance and approvals processes. This also applies to the Frailty In-reach Team working within ED. Alongside the Ward Processes and Frailty SDEC work, this aims to reduce admissions, improve non-elective flow and improve access to the Trusts UEC services.
- The Community Services access standard for 2-hr UCR was maintained with the standard being achieved at 83.50%. Virtual ward occupancy remains very high.

Authors

Kate Shaw
(Chief Operating Officer)

Care Colleagues
Collaboration Communities

Operational Performance | Executive Summary

- RTT – 60.42% of patients on an incomplete pathway were treated within 18 weeks. The total waiting list reduced to 73,165 and the number of patients waiting over 52 weeks also reduced to 1,809. There were no 65-week breaches at the end of May 26.
- Community waiting times continue to be out of standard. 45% of patients were seen within 18 weeks at the end of 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 now being monitored weekly through the Trust's performance and PTL meetings.
- Plans are in place to increase and sustain RTT performance to achieve 69% by the end of March 2027. This work includes a focus on productivity and clinical best practice. The provision of additional capacity through insourcing was agreed at June's Finance and Productivity Committee for services with large numbers of long waiting patients and where workforce gaps will not be filled over the coming months. This will commence late July and will conclude in December 26.
- The work with the NHSE GIRFT team on demand and capacity for four challenged specialities (Gynaecology, Urology, Gastroenterology and Paediatrics – Acute and Community) continues.
- Cancer – based on the latest available data, performance for cancer is largely maintained for 28-day FDS at 80.72% and 92.5% for 31-days.
- The 62-day standard (71.52%) continues to be at risk due to the ongoing capacity challenges in Urology and Oncology. Late referrals for tertiary services (in particular Lung) also continue to impact on this standard.
- The risks and impact of the launch of the Lung Cancer Screening Programme in South Staffordshire are starting to be experienced, and this has been escalated to commissioners and the WMCA as leads for its roll-out. The programme within Wolverhampton and Walsall is on target for delivery late September 26 with the modelled impact of downstream assessment and treatment being worked through.
- DM01 – access to diagnostics remains positive with 95.43% of patients seen within 6 weeks with no concerns.

Authors

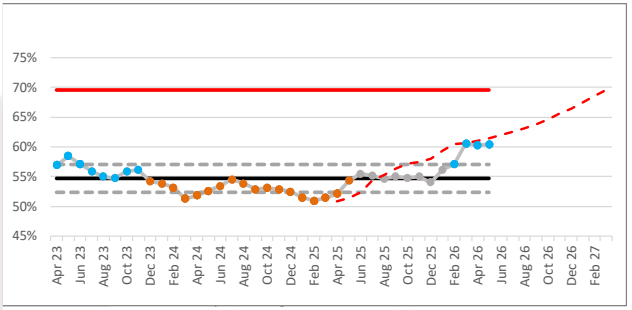
Kate Shaw
(Chief Operating Officer)

Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

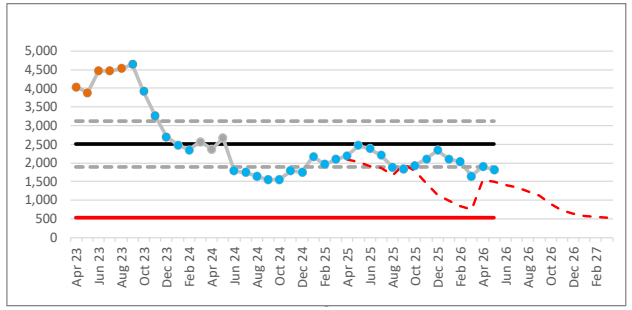
18 Weeks RTT - % Within 18 Weeks - Incomplete

Not Met	Improvement	60.42%



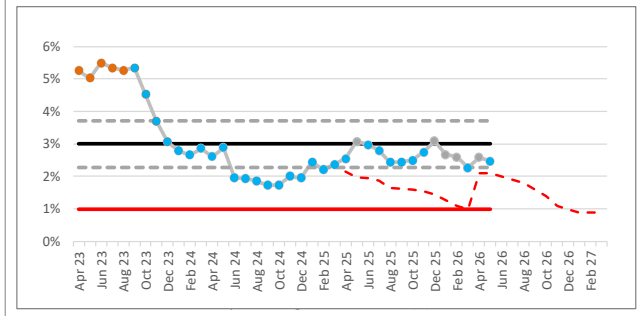
18 Weeks RTT - No. of 52 wk breaches

Not Met	Improvement	1809



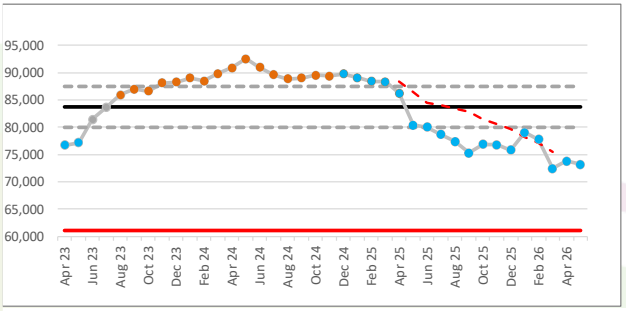
18 Weeks RTT - 52 wk breaches as a % of PTL

Not Met	Improvement	2.47%



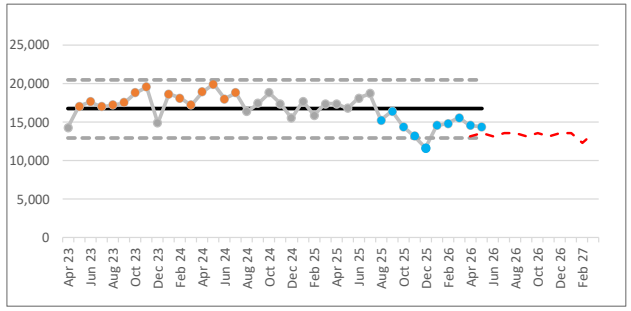
18 Weeks RTT - Total Incomplete PTL

Not Met	Improvement	73165



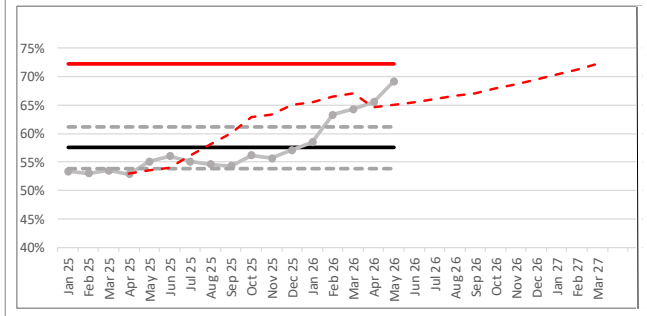
18 Weeks RTT - Clock Starts

No Target Set	Improvement	14369



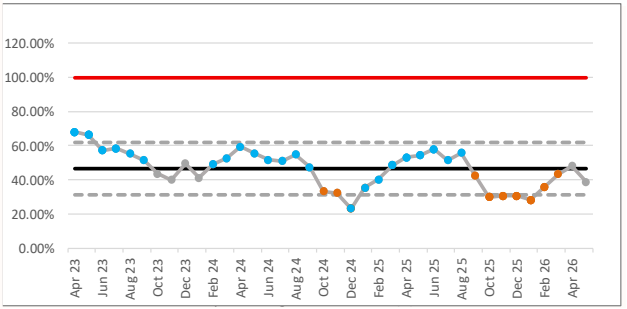
18 Weeks RTT - Time to First Appointment

Not Met	Improvement	69.20%



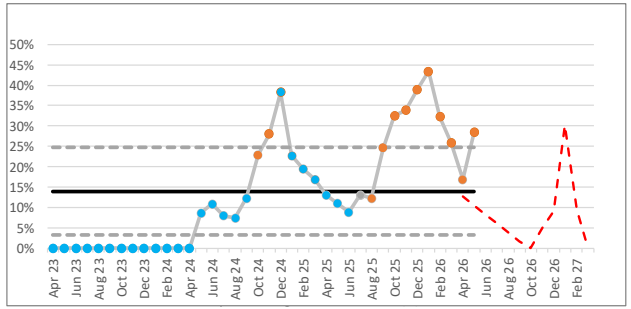
Ambulance Handover - % within 15mins

Not Met	Common Cause	38.87%



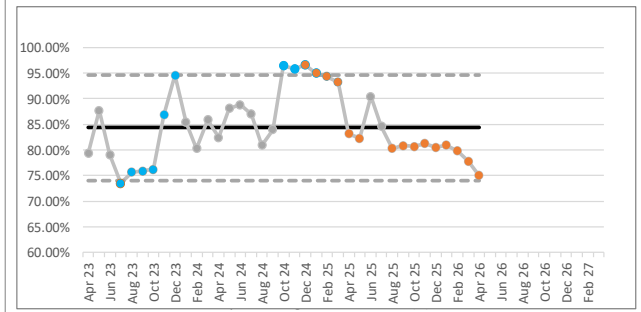
Ambulance Handover - % >45mins

No Target Set	Concern	28.40%



Cancer - 2 Week Wait

No Target Set	Concern	75.02%

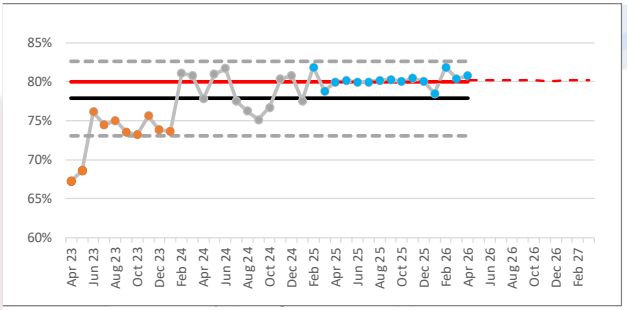


Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

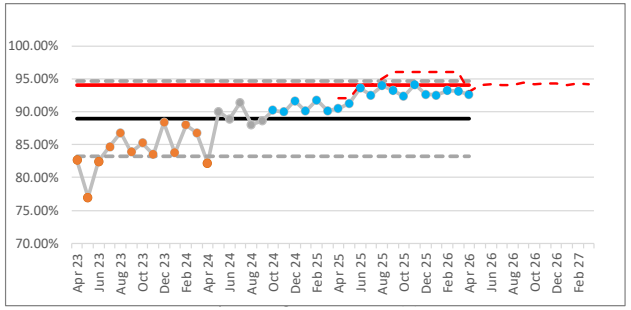
Cancer - 28 Day Faster Diagnosis

Inconsistent	Improvement	80.72%



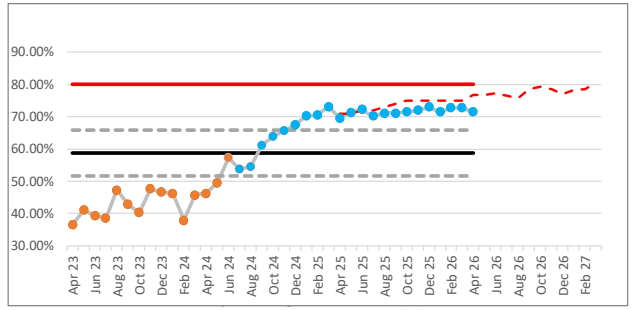
Cancer - 31 Day Treatment

Inconsistent	Improvement	92.57%



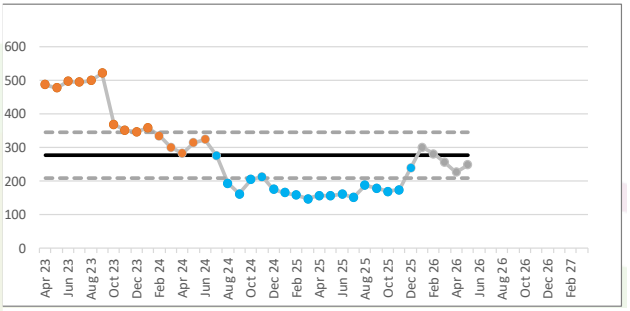
Cancer - 62 Day Referral to Treatment

Not Met	Improvement	71.52%



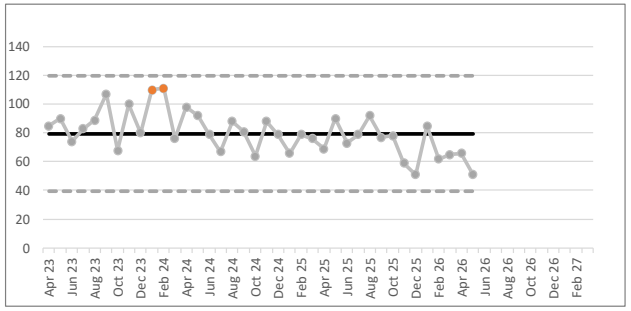
Cancer - No. of patients waiting 63+ Days for treatment

No Target Set	Common Cause	248



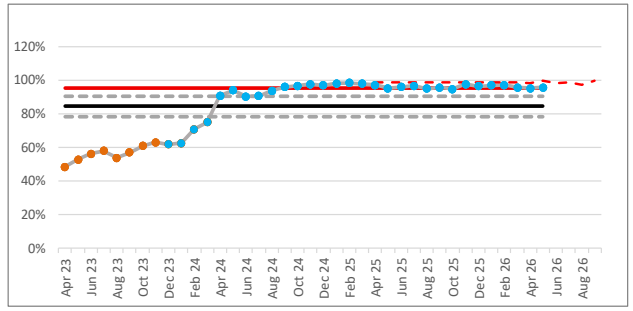
No. of patients no longer meeting the Criteria to Reside

No Target Set	Common Cause	51



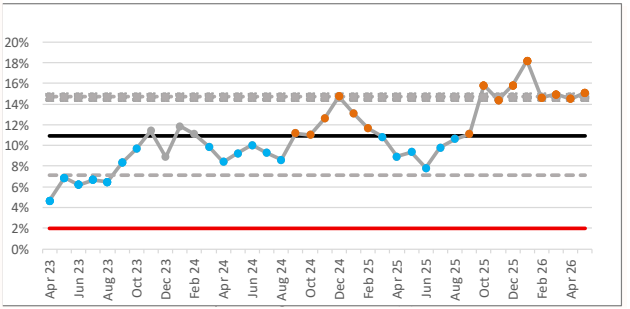
Diagnostics - % within 6 weeks from referral

Not Met	Improvement	95.43%



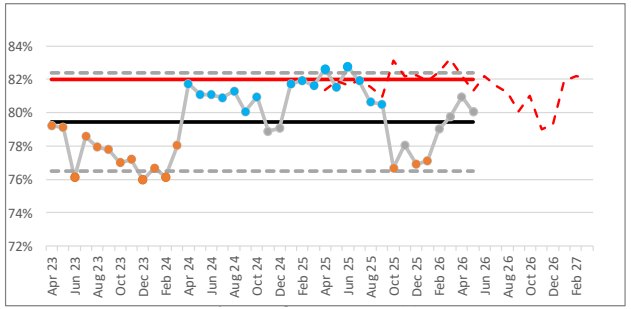
Total Time Spent in ED - % over 12 Hours

Not Met	Concern	15.09%



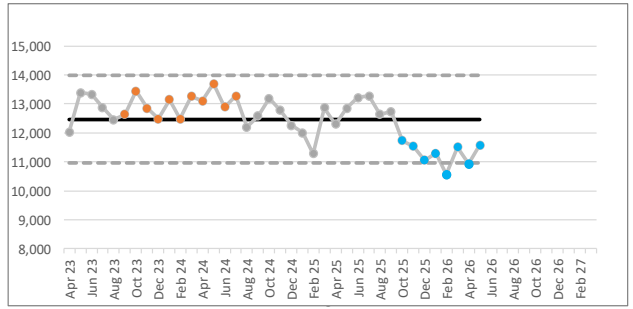
Total Time Spent in ED - % within 4 Hours

Inconsistent	Common Cause	80.05%



Type 1 ED Attendances

No Target Set	Improvement	11574

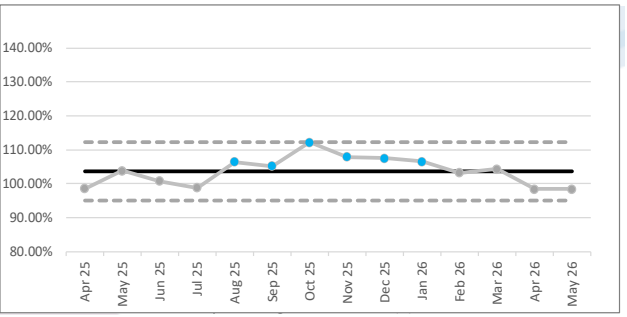


Care Colleagues
Collaboration Communities

Operational Performance | Core Metrics

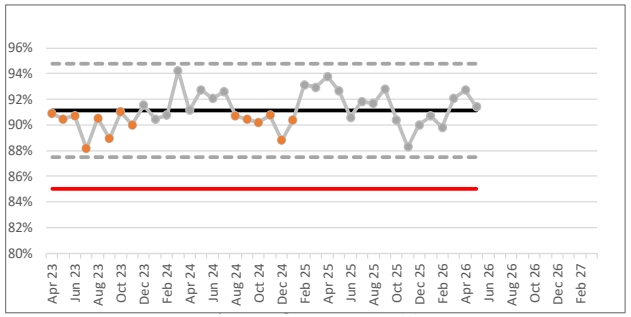
Variable Contract Delivery

No Target Set	Common Cause	98.44%



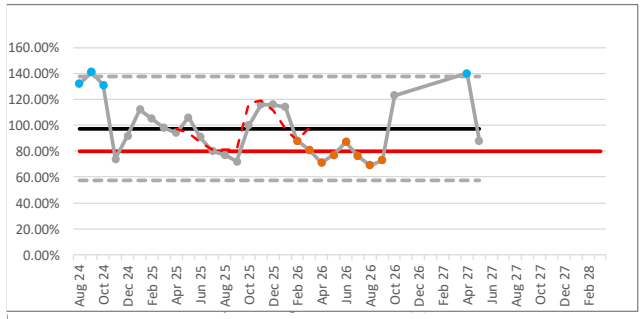
Theatres - Touch Time Utilisation (MH)

Achieving	Common Cause	91.40%



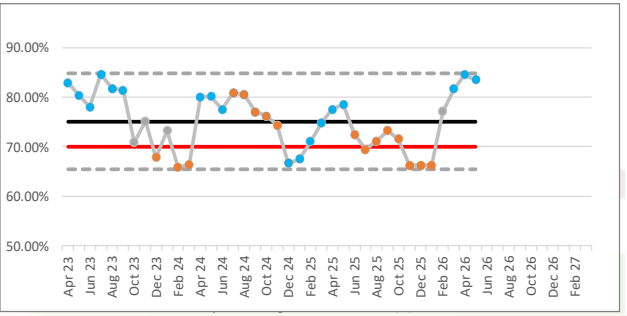
Community - Virtual Ward % Occupancy

No Target Set	Common Cause	88.00%



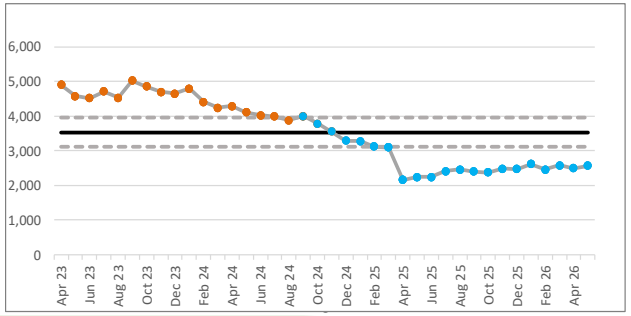
Community - Urgent Care Response (UCR) 2 Hour Response

Inconsistent	Improvement	83.50%



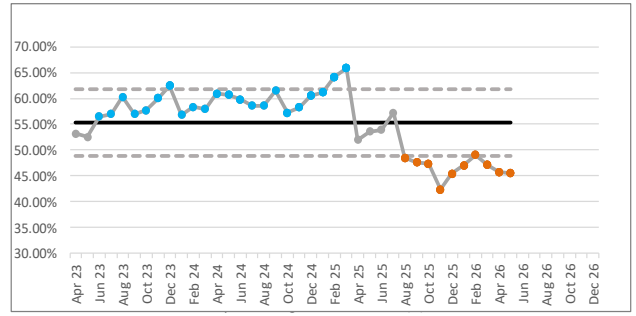
Community - Waiting List - Total

No Target Set	Improvement	2564



Community - Waiting List - within 18 weeks

No Target Set	Concern	45.48%

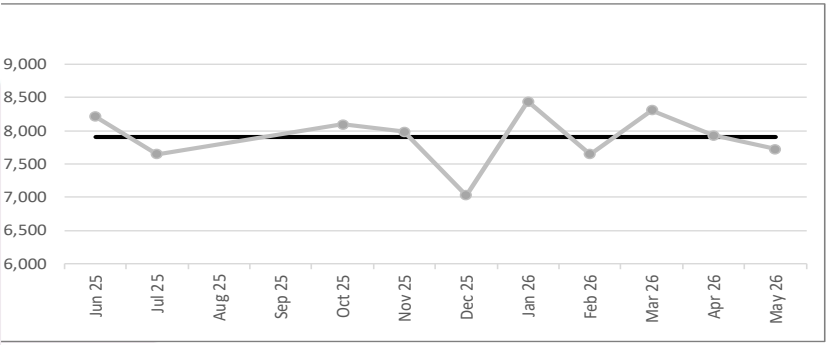


Care Colleagues
Collaboration Communities

Operational Performance (Primary Care) | Core Metrics

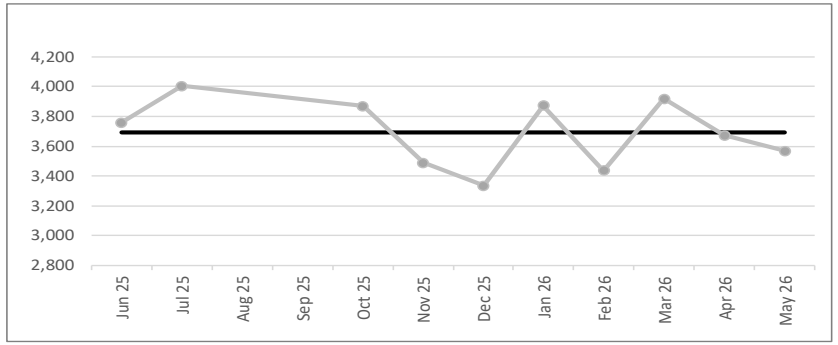
GP Practice Group - Total Triage Medical Requests

Not Enough Points	Not Enough Points	7726



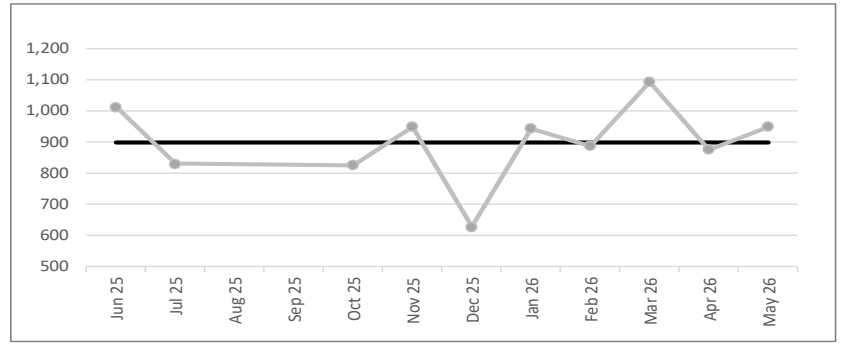
GP Practice Group - Total Triage Administrative Requests

Not Enough Points	Not Enough Points	3568



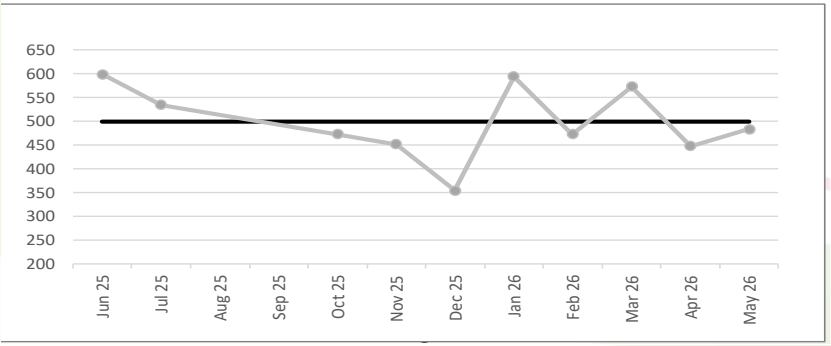
Single GP Practice - Total Triage Medical Requests (Coalway Rd)

Not Enough Points	Not Enough Points	948



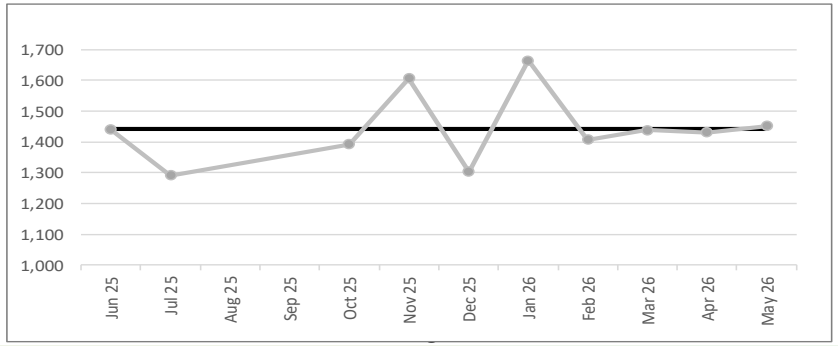
Single GP Practice - Total Triage Administrative Requests (Coalway Rd)

Not Enough Points	Not Enough Points	483



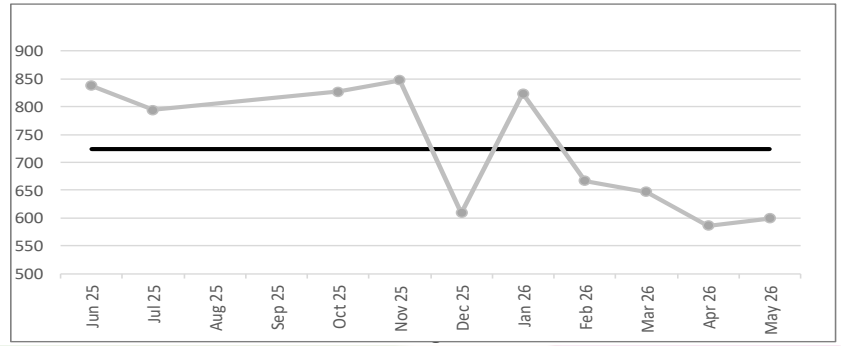
Single GP Practice - Total Triage Medical Requests (Thornley St)

Not Enough Points	Not Enough Points	1452



Single GP Practice - Total Triage Administrative Requests (Thornley St)

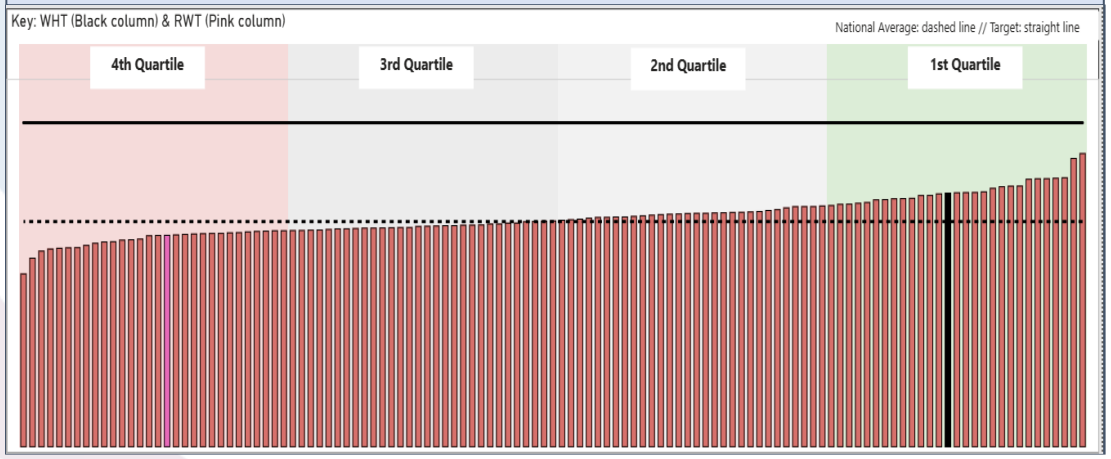
Not Enough Points	Not Enough Points	599



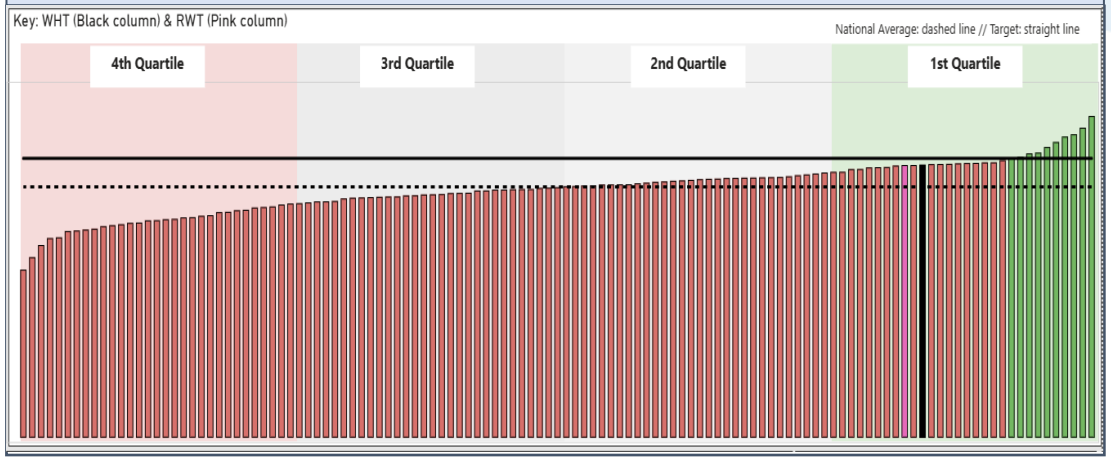
Care Colleagues
Collaboration Communities

Operational Performance | Benchmarking

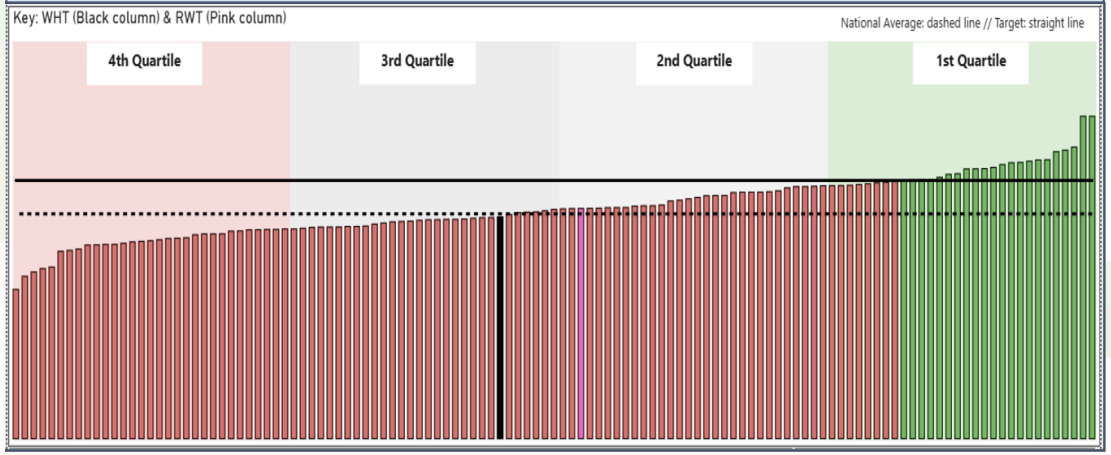
Referral to Treatment



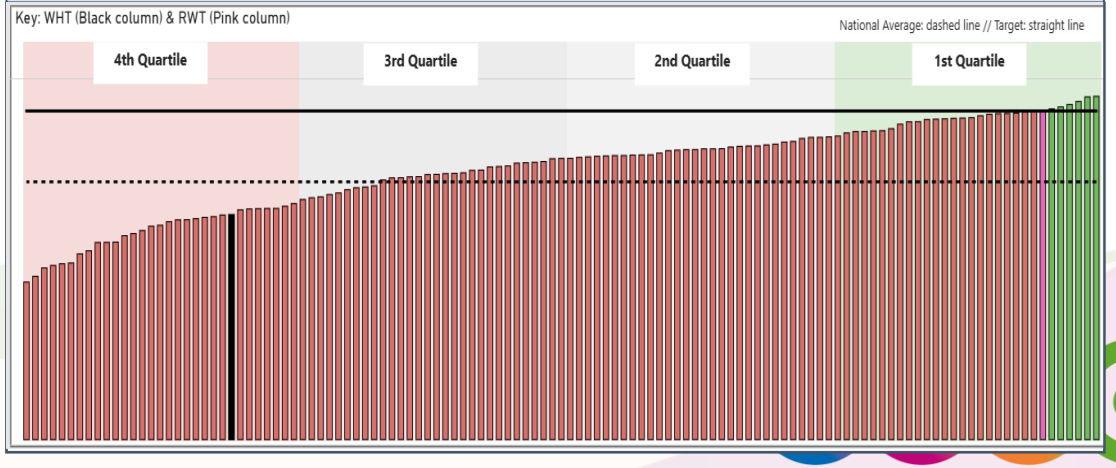
A&E 4 Hour



Cancer 62 Day



Diagnostic Waiting Times



Care Colleagues
Collaboration Communities

Finance

Finance | Executive Summary

Key Headlines – Month 2 2026/27

In month deficit of £2.046m, which is £4k better than planned deficit of £2.050m.

Year to date deficit of £4.8m, which is £0.6m worse than plan. The key driver of this being the inclusion of costs related to industrial action (£0.58m) for which no income has been assumed.

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

CIP overachieved by £1.4m in month, bringing the year-to-date overperformance to £0.9m above plan, with 21%of schemes reported at recurrent year-to-date.

Variable elective activity is underperforming against the RTT plan by £0.5m, impacted by industrial action by £0.4m. Variable UEC activity is underperforming by £0.4m YTD.

Authors

Kevin Stringer (Group Chief Finance Officer)

Care Colleagues Collaboration Communities

Finance | I&E Summary

In-Month Income & Expenditure	RWT Plan M2 £m	RWT Actual M2 £m	RWT Surplus/ (Deficit) £m
Income	**85.9**	**86.3**	**0.4**
Expenditure			
Pay	56.0	56.5	(0.5)
Non Pay	21.8	21.7	0.1
Drugs	6.3	6.4	(0.1)
Other*	3.8	3.7	0.1
Total Expenditure	**87.9**	**88.3**	**(0.4)**
Net reported surplus/(Deficit)	**(2.1)**	**(2.1)**	**(0.0)**

Year-to-date Income & Expenditure	RWT Plan YTD £m	RWT Actual YTD £m	RWT Surplus/ (Deficit) £m
Income	**170.4**	**171.0**	**0.6**
Expenditure			
Pay	111.2	112.8	(1.6)
Non Pay	43.0	42.6	0.4
Drugs	12.8	12.8	(0.0)
Other(incl. depreciation)	7.7	7.6	0.1
Total Expenditure	**174.6**	**175.9**	**(1.2)**
Net reported surplus/(Deficit)	**(4.2)**	**(4.8)**	**(0.6)**

In month deficit of £2.046m, which is £4k better than the planned deficit of £2.05m. YTD deficit of £4.8m.

- Income is above plan, £1.1m of Maternity Incentive income has been reported ahead of plan. Education and Training income has over-achieved in month due to LDA income being higher than planned. Other Directorate Income has under-performed in month due to lower recharges to other NHS organisations following underspends in BCPS.
- Pay is overspent in month due to additional bank, WLI and overtime usage particularly in Division One.
- Non-pay is overspent in month due to additional patient equipment and consumables which are partially offset by GRN releases.
- Drugs is overspent in month due the impact of expected savings now not occurring.

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

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Finance | ERF Performance

Point of Delivery	Plan £'000	Actual £'000	Variance £'000
Elective	7,560	7,961	401
Planned Same Day	9,812	9,045	(767)
Outpatient Procedures	4,764	4,785	21
Procedures Total	**22,136**	**21,790**	**(346)**
Outpatient 1st	7,069	6,817	(252)
Diagnostic Imaging	1,437	1,480	43
Chemotherapy	844	904	60
Total Elective	**31,486**	**30,991**	**(495)**
ED	5,488	5,289	(199)
NEL	33,544	33,340	(203)
Total UEC	**39,032**	**38,629**	**(403)**
Grand Total Variable Activity	**70,518**	**69,621**	**(898)**

Year to date variable elective income is performing £0.495m below plan. The reduction in activity seen during the industrial action period in April 26 amounts to £481k and therefore explains the majority of the underperformance year to date. UEC activity is £0.403m behind plan.
No variance to contract income has been accounted for on the assumption the activity will return to plan and the contract value will be met.

The value of uncashed outpatient activity has been estimated within the above and is therefore subject to change once cashed. In addition, clinical coding for May 26 was 0.5% complete and the value of uncoded activity has been estimated at average tariff and is therefore also subject to change once coded.

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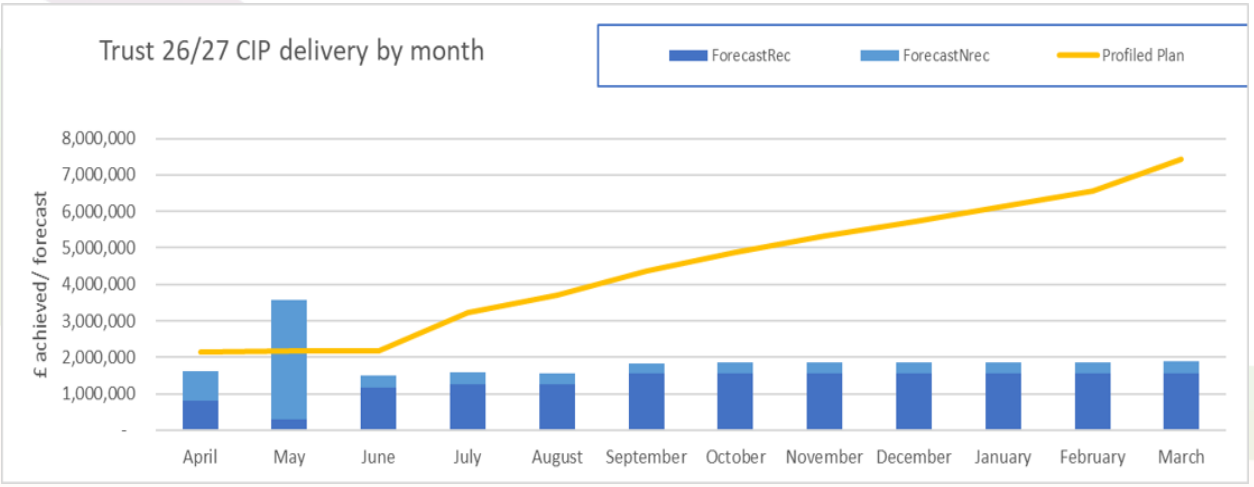
Finance | Cost Improvement Plans

Delivery against Plan (by Division)					
Division	Annual target £	YTD Plan £	YTD Recurrent £	YTD Non-recurrent £	% recurrent
Division 1	24,190,071	1,452,656	194,179	1,993,296	9%
Division 2	12,812,923	397,912	214,541	393,704	35%
Division 3	9,705,852	1,198,846	370,281	338,175	52%
Corporate	4,198,548	699,757	5,275	203,754	3%
Estates and Facilities	2,917,224	221,501	67,641	97,944	41%
Trustwide	-	324,425	253,037	1,053,000	19%
Total	**53,824,618**	**4,295,097**	**1,104,954**	**4,079,874**	**21%**



In Month 2 the Trust has achieved £3.6m of CIP in month, however £3.3m of this was achieved non-recurrently, which is 91% of the in-month achievement.

There are 2 schemes that have been brought forward into Month 2, which are the maternity incentive schemes (£1.1m) and GRNI's (£1.0m). These were originally planned to be achieved later in the financial year.

Year to date there is an over-achievement of CIP of £0.9m, which relates to the non-recurrent savings mentioned above. There are a number of schemes that are under-delivering that are being reviewed to ensure they maximise the savings delivered.

The current forecast indicates a significant gap against the target, which is across all divisions. Divisions are being challenged to explain the variance to plans at this early point in the financial year and this will be explored in DPR meetings.

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National Oversight Framework Dashboard

National Oversight Framework

RWT has fallen into Segment 4 having seen the overall average score fall from 2.49 to 2.71.

The primary driver for RWT's deterioration into Segment 4 is the deterioration in scoring within the Finance and Productivity segment – specifically the variance to financial to plan. The Trust was reporting a negative variance to plan at the end of Quarter 3 when the snapshot was taken for oversight scoring. This was immediately prior to an agreement being reached with the ICB (as reported at the last PRM meeting) to inject £8m. This has supported the Trust to deliver its financial plan for 2025/26.

Other drivers of the segmentation include the deterioration in A&E performance since the introduction of the new EPR as well as our RTT performance where the variance to plan had increased by the end of Quarter 3.

Even though the recent staff survey results will be included within the next quarters segmentation (and will bring our score down), having delivered our financial plan for 2025/26 and delivered our RTT plan, we anticipate the **Trust returning to Segment 3 for Quarter 4 when the results are released in June 26.**

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National Oversight Framework Dashboard

National Oversight Framework - RWT

Code	Metric	Time Period Reported	Target	Q3 25/26 Published Perf	Q3 25/26 Published Score	Q3 25/26 Published Rank	Q4 25/26 Published Perf	Q4 25/26 Published Score	Q4 25/26 Published Rank	Internal Apr-26	Internal May-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
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
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	-0.80	-1.08
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
OF0010	Cancer - 28 Day Faster Diagnosis	Aggregated quarterly position	80	80.16	1.00	40/118	80.26	1.00	48/118	80.72	
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	
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
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
OF0079	Planned Surplus / Deficit	Annual plan	0	-3.26	4.00	164/205	-3.26	4.00	164/205		
OF0081	Year to date variation from plan	Year to date		-0.64	3.00	142/205	0.46	1.00	80/205		
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-Difficle infections (Rolling 12 Months)	12-month rolling	1	1.15	2.55	73/134	0.90	1.00	31/134	93.83	92.59
OF0020	Number of MRSA infections (Rolling 12 Months)	12-month rolling	0	3	2.66	71/134	7	3.51	112/134	7	7
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
OF0025	Average number of days between planned and actual discharge date	Latest month in the period		0.37	1.52	23/127	0.41	1.64	28/128	3.60	
OF1046	Summary Hospital Level Mortality Indicator (Rolling 12 Months)	12 month rolling			2.00			2.00		0.9447	0.941
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	83.50
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	5.51	

- Green
- Amber/Green
- Amber/Red
- Red

Care Colleagues Collaboration Communities

Productivity Dashboard

Productivity Dashboard

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

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

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

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

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

Care Colleagues
Collaboration Communities

Productivity Dashboard

Ref no.	Theme and KPI	Definition	Target	Basis of Target	2026/27 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	**Implied Productivty Growth (year to date compared to last year)**	Output growth (cost-weighted activity) divded by input growth (workforce) compared to the same in last years period.	4.3%	Achievement required to improve to next quartile (top)												
Operational and Clinical Productivity / Best Practice																
2	Average LOS for elective admissions (excluding daycases)	Average length of stay for all elective patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	2.8%	Achievement required to improve to next quartile (second)	3.58	4.28										
3	Average LOS for non-elective admissions	Average length of stay for all patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted	9.6%	Achievement required to improve to next quartile (top)	5.72	5.58										
4	Bed Occupancy	Number of occupied beds divided by total number of available beds	92%	Nationally set	93.0%	95.2%										
5	Bed Occupancy classed as clinically ready for discharge (% of acute)	The average number of patients across the month who do not meet the criteria to reside (Question 2), divded by the total number of patients in hospital or discharged by 23:59 each day (sum of Question 3a and 3b).	22.2%	Achievement required to maintain top quartile performance	17.2%	16.0%										
Theatre Utilisation																
6	Capped elective theatre utilisation	Total capped touch time within valid elective sessions as a proportion of total planned theatre session duration	85%	Nationally set	82%	84%										
7	Average number of cases completed per theatre list	Total number of cases completed divided by total number of sessions utilised	2.3	Achievement required to improve to next quartile (top)	2.08	2.23										
8	% of theatre sessions utiilised	Total number of theatre sessions utilised divided by total number of sessions funded	93%	Achievement required to equal best performing Trust in Group	86%	90%										
9	CT, MRI & ultrasound utilisation		95%	Local planning target agreed												
Outpatients					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
10	Outpatient slot utilisation	Number of slots booked into divided by total number of slots on clinical template	95%	Local planning target agreed												
11	DNA Rate	Number of outpatient missed outpatient appointments divded by total outpatient appointments	6%	Local planning target agreed	8.9%	9.4%										
12	PIFU Utilisation Rate	The number of episodes moved or discharged to a PIFU pathway divded by total outpatient activity.	5%	Local planning target agreed	3.3%	3.7%										
13	Specialist Advice Utilisation Rate	Number of processed specialist advice requests (pre or post referra) divded by total number of outpatient first attendances	13%	Local planning target agreed	3.7%	3.9%										
14	Number of FUs taking place unfunded (by virtue of exceeding cap)	Number of follow ups taking place over and above 2019/20 amount	0	Nationally set	0	0										
Coding/ Income					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15	Mean price per spell charged	Total income for elective inpatient, daycase and non-elective patients divided by total volume of elective inpatient, daycase and non-elective activity.	>£2,053	Improvement on last year performance	2,283	2,277										
16	Additional income delivered through coding and counting changes	Additional income delivered through coding and counting changes	£970k		£0	£0										
17	Number of unfunded services being delivered	Number of services being delivered that do not have any form of funding arrangement in place	0		3											

Productivity Dashboard

					Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Workforce Productivity																
19	Non-elective admissions per clinical WTE	The number of non-elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	1.9%	Achievement required to maintain top quartile performance	2.18	2.19										
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	1.46	1.42										
21	Outpatient attendances per consultant WTE	The number of outpatient admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.	TBC	TBC	119.93	111.30										
22	A&E attendances (Type & 2) per Emergency Medicine Consultant	The number of A&E attendances (Type 1 & 2) in month, divded by the number of Emergency Medicine Consultants (WTEs) including substantive, bank and agency staff.	613	Achievement required to maintain top quartile performance	410.55	400.94										
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										
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%										
25	Sickness Absence Rate	A percentage of overall staff who are absent because of sickness	6%	Nationally set	5.17%	4.07%										
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%										
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										
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										
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										

Care Colleagues
Collaboration Communities

Tier 1 - Paper ref:	Enclosure 10.4

Report title:	Patient Experience – Engagement, Involvement & Co-Production
Sponsoring executive:	Lisa Carroll, Chief Nursing Officer (WHT) Debra Hickman, Chief Nursing Officer (RWT)
Report author:	Garry Perry Associate Director Patient Voice
Meeting title:	Trust Board
Date:	21 July 2026

1. Summary of key issues

This report provides assurance regarding the Group's approach to engagement, involvement and co-production during 2025/26 and highlights how patient, carer and community voices have informed service improvement, quality initiatives, strategic development and organisational culture.

During the year, the Group has continued to embed the principles of the Patient Experience Enabling Strategy 2025–2028 through a coordinated Patient Voice framework which brings together engagement, involvement, co-production, volunteering, accessibility, health inequalities and lived experience leadership.

Key achievements include:

- Delivery of a coordinated programme of engagement activities including national and local surveys, focus groups, community engagement, forums and co-design workshops.
- Expansion of patient involvement through the development of the Lived Experience Partner model.
- Delivery of a collaborative Patient Experience Summit, bringing together patients, carers, volunteers, VCSE partners, Healthwatch, Lived Experience Partners and staff.
- Targeted engagement with underserved communities including LGBTQ+ people, veterans, carers, children and young people, and people accessing stroke rehabilitation services.
- Demonstrable evidence of engagement influencing service redesign, quality improvement and inclusion initiatives.
- Independent assessment identifying approximately £2.4 million social value generated through volunteering activities.
- Growing external recognition of the Group's patient voice approach through national presentations, conference invitations and sharing of good practice with NHS partners and the Department of Health and Social Care.
- Development of a strengthened Partners in Care approach and refreshed commitment to John's Campaign, informed by direct engagement with carers and families and now attracting national interest.

The Board can be assured that engagement and involvement are increasingly embedded within governance, quality improvement and service transformation activity across the Group.

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

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

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

n/a

4. Recommendation(s)/Action(s)
The Group Trust Board in Public is asked to:
Note the progress made in strengthening engagement, involvement and co-production during 2025/26.
Receive assurance that patient, carer and community voices are informing service improvement, quality priorities and strategic development.
Recognise the contribution of patients, carers, volunteers, Lived Experience Partners, Healthwatch, VCSE partners and community organisations in shaping services.
Support the continued development of co-production, lived experience leadership and inclusive engagement approaches across the Group.

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

Report to the Group Trust Board Meeting to be held in Public

1. Executive summary

2025/26 has seen continued progress in embedding patient, carer and community voice across The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

Through the Patient Experience Enabling Strategy, the Group has adopted a structured approach based on the principles of Hear it. Learn it. Change it., ensuring that engagement activity does not simply gather feedback but translates insight into measurable action and improvement.

The Group has continued to mature its approach from consultation towards co-production. This has included expansion of Lived Experience Partners, strengthened partnerships with VCSE organisations and Healthwatch, targeted engagement with underserved communities, and increased involvement of patients and carers in service redesign, communications, recruitment and governance.

Examples of impact include the Stroke Rehabilitation Transformation Programme, LGBTQ+ Voices in Health, Little Voices, Carers Voice initiatives, volunteering programmes, accessibility improvements and the development of the Partners in Care approach.

The year has also seen increasing recognition of the Group's work at a regional and national level, with invitations to present at national conferences, share learning with NHS organisations and contribute to wider discussions regarding carers, visiting policies and patient experience improvement.

2. Introduction or background

The Patient Experience Enabling Strategy 2025–2028 sets out the Group's ambition to place patient, family, carer and community voices at the heart of care delivery and improvement. The strategy is underpinned by three interconnected pillars:

Pillar 1: Involvement – Patients as Active Partners
Supporting people to influence decisions about their care and services.

Pillar 2: Engagement – Patients as Co-Designers
Working collaboratively with communities to design and improve services.

Pillar 3: Experience – Every Interaction Matters
Promoting person-centred care throughout every stage of the patient journey.

Our approach recognises that meaningful engagement extends beyond feedback collection and includes co-production, partnership working, inclusion and community collaboration.

2.1 How We Listen and Involve People

The Group has developed a comprehensive and coordinated engagement framework designed to maximise participation and ensure the voices of patients, carers and communities are heard through multiple routes.

Surveys and Insight
Engagement activity has included a coordinated programme of national and local surveys, including:

- Stroke Rehabilitation Transformation Survey
- LGBTQ+ Voices in Health Survey
- Little Voices engagement activities
- Volunteer experience surveys
- Pets as Therapy surveys

- Local service-specific engagement exercises

These activities have enabled targeted exploration of patient priorities and informed improvement activity across services.

Focus Groups, Forums and Co-Design
The Group has utilised:

- Co-design workshops
- Focus groups
- Community engagement events
- Patient and carer forums
- Lived experience conversations

to support redesign and improvement across several pathways.

Community and VCSE Partnerships
Strong partnerships have continued with:

- Voluntary, Community and Social Enterprise (VCSE) organisations
- Community hubs and networks
- Local Authorities
- Veterans' groups
- Carer organisations
- Equality and inclusion networks

These partnerships have enabled engagement to take place within communities and have strengthened participation amongst groups traditionally underrepresented in healthcare engagement.

Patient Experience Summit
A significant achievement during the year was the delivery of the Patient Experience Summit. The event brought together patients, carers, volunteers, Healthwatch, VCSE organisations, Lived Experience Partners, community representatives and staff to share learning, identify priorities and strengthen collaborative approaches to improvement.

Importantly, the Summit was shaped with patients and community representatives and reinforced the Group's commitment to co-production and partnership working.

2.2 Embedding Co-Production and Lived Experience

A major area of progress during 2025/26 has been the continued development of involvement opportunities and the evolution towards a strengthened Lived Experience Partner model.

Lived Experience Partners have contributed to:

- Service redesign
- Quality improvement programmes
- Recruitment and selection processes
- Governance discussions
- Strategic development
- Review of patient-facing communications

The Readership Panel has continued to review patient information materials, appointment letters, digital communications and guidance to improve accessibility, understanding and patient experience. This represents a continued shift from seeking opinions to working in partnership with patients and carers as active contributors to improvement.

2.3 Impact of Engagement and Involvement

Stroke Rehabilitation Transformation
Engagement with stroke survivors, families and carers has informed the redesign of stroke rehabilitation pathways. Feedback highlighted opportunities to improve communication, transitions between services and continuity of care. Insight gathered has directly informed pathway development and supports a more personalised approach to rehabilitation.

LGBTQ+ Voices in Health
The LGBTQ+ Voices programme explored experiences of care and access to services.
Engagement led to the development of the LGBTQ+ Forum and has informed wider work relating to inclusion, visibility, representation and staff awareness.

Carers and Families
The Group has continued to strengthen its commitment to recognising carers as partners in care. Engagement through the Carers Voice Forum and wider partnership activity identified themes relating to communication, involvement in decision-making, discharge planning and recognition of carers.

This work has informed development of a strengthened Partners in Care approach and a refreshed commitment to John's Campaign, supporting a culture where carers are recognised as active contributors to care rather than visitors. The Group has worked collaboratively with carers and partners to develop resources and training materials to support this approach and has subsequently shared learning with national stakeholders, including the Department of Health and Social Care.

Children and Young People – Little Voices
Little Voices continues to provide an innovative and award-winning approach to involving children and young people in service improvement. Engagement has informed improvements relating to:

- Clinical environments
- Accessibility
- Waiting areas
- Food and mealtime experiences
- Patient information
- Individualised care approaches

The programme remains a strong example of meaningful involvement and co-design.

Pets as Therapy
Patient feedback regarding Pets as Therapy has demonstrated positive impacts on wellbeing, anxiety reduction and patient experience. Learning from this engagement has supported expansion of the programme across additional clinical settings.

Volunteering
Volunteers continue to make a significant contribution to patient experience and community wellbeing. Independent evaluation identified approximately £2.4 million in annual social value generated through volunteering activity, demonstrating benefits for patients, communities and volunteers alike.

2.4 Reducing Health Inequalities
A key focus throughout the year has been ensuring engagement activities are inclusive and representative of the diverse communities served by the Group.

Targeted activity has included engagement with:

- LGBTQ+ communities

- Veterans
- Carers
- Children and young people
- Stroke rehabilitation patients and families
- Community and VCSE groups
- Asian Women's Empowerment

Partnership working has enabled wider reach into communities and strengthened understanding of barriers affecting access, participation and experience.

2.5 External Recognition and Sector Leadership

The Group's work in engagement, involvement and co-production continues to attract external recognition. During the year, we have been invited to share learning and good practice through regional and national events, including:

- Rebuilding Trust in the NHS: Transparency, Accountability and Patient Experience
- Learning and collaboration with York and Scarborough Teaching Hospitals NHS Foundation Trust
- Regional and national patient experience networks
- NHS Excellence Midlands Champion – Little Voices

The Group's work on carers as partners in care and implementation of John's Campaign principles has also attracted interest from the Department of Health and Social Care, who have sought to learn from local approaches and consider opportunities to share this work more widely.

In addition, the Group has been featured through the national John's Campaign network, highlighting its work on hearing patient and carer voices and developing a Partners in Care ethos. This growing external recognition demonstrates that the Group is not only adopting good practice but increasingly contributing to wider NHS learning and improvement.

2.6 Conclusion

The Board can be assured that the Group has continued to strengthen engagement, involvement and co-production during 2025/26.

The organisation has moved further towards a model where patients, carers, volunteers and communities are active partners in improvement, supported through strong community relationships, lived experience leadership and meaningful co-design.

The increasing influence of patient voice within service redesign, together with growing national recognition of the Group's work, demonstrates the maturity of the current approach and provides a strong foundation for continued delivery of the Patient Experience Enabling Strategy 2025–2028.

3. Recommendations

The Group Board held in public is asked to:

a. Note the progress made in strengthening engagement, involvement and co-production during 2025/26.
b. Receive assurance that patient, carer and community voices are informing service improvement, quality priorities and strategic development.
c. Recognise the contribution of patients, carers, volunteers, Lived Experience Partners, Healthwatch, VCSE partners and community organisations in shaping services.
d. Recognise the contribution of patients, carers, volunteers, Lived Experience Partners, Healthwatch, VCSE partners and community organisations in shaping services.

Tier 1 - Paper ref:	TB in Public
Report title:	Annual Patient Voice Report – 2025/2026 Feedback, Involvement, and Engagement with Public and Patients
Sponsoring executive:	Debra Hickman, Chief Nursing Officer
Report author:	Alison Dowling, Associate Director – Patient Relations Garry Perry, Associate Director – Patient Voice
Meeting title:	Trust Board
Date:	21 July 2026

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

Advise

The Annual Patient Voice Report for 2025/26 incorporates the Trust's annual complaints reporting requirements and provides a triangulated summary of patient feedback, complaints, concerns, Friends and Family Test intelligence, national and local insight, patient involvement, interpreting and accessibility provision, volunteering, Welcome Hub activity, visiting, family and carers support, and Spiritual, Pastoral and Religious Care.

The report demonstrates that the Trust continues to provide kind, compassionate and professional care, with positive feedback themes including patients feeling treated with dignity and respect, staff being described as caring and compassionate, good communication during hospital stays, and consistently strong experience within community services.

However, the report also identifies a deterioration in some patient experience indicators, including a substantial increase in formal complaints, reduced compliments, and variable FFT performance across services. Priority improvement themes include continuity across services, discharge and aftercare, communication after treatment, delays in appointments and treatment, and care coordination.

Assure

The Trust has maintained arrangements to meet statutory complaints reporting requirements and continues to align complaint handling with PHSO principles. The report includes complaint volumes, complaint outcomes, complaint themes, PHSO/Ombudsman activity, matters of general importance, and actions being taken in response to learning.

During 2025/26, the Trust received 847 formal complaints compared with 563 in 2024/25, representing a 50% increase. Despite this, complaint-handling arrangements have been strengthened through real-time dashboards and complaint tracking, formal complaint investigation e-learning, language services e-learning, an updated complaint investigation toolkit, and promotion of early contact as a standard part of the complaints process.

Further assurance is provided through enhanced digital access to interpreting services, strengthened co-design and patient involvement, continued community service performance, and greater visibility of patient feedback within governance and quality improvement processes.

What does this mean? The Trust has strengthened the infrastructure for listening, learning and responding to patient feedback, but this now needs to translate into demonstrable improvement in the recurrent themes identified through

complaints and patient experience intelligence.

Alert

The increase in formal complaints represents the main area requiring Board and Committee oversight. Increased demand creates pressure on response timeliness, complaint quality, operational capacity, and complainant experience. Although improvements are noted in complaint tracking and escalation arrangements, the report identifies continued fluctuation in compliance with local complaint response standards.

Formal complaints represented 11.0% of total Patient Relations contacts in 2025/26, compared with 9.5% in 2024/25, indicating that the increase reflects both higher overall contact activity and a modest increase in the proportion of contacts progressing as formal complaints.

The report also highlights recurrent themes in high-pressure services and at pathway transition points, including delays in receiving appointments and treatment, discharge and aftercare, communication after treatment, general care, care coordination, and experience in urgent and emergency care. These themes present a risk to patient confidence, regulatory assurance and organisational reputation if they are not addressed through targeted divisional improvement.

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?]*

4. Recommendation(s)
The Quality Committee is asked to:
Note the 2025/26 Patient Voice Annual Report and the key themes from complaints, concerns, compliments, FFT, national surveys, Mystery Patient activity, local engagement, accessibility and lived-experience involvement.
Recognise that the key assurance issue is whether the Trust can reduce variation in experience at waits, transitions, discharge, aftercare and communication points, rather than whether patients value staff compassion.
Support continued implementation of the Patient Experience Enabling Strategy 2025-2028 and the actions underway to improve complaint handling, accessible communication, co-design and evidence of impact.
Request continued assurance through Quality Committee on complaint timeliness recovery, pathway-focused improvement and equity of experience across population groups.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
RWT Board Assurance Framework Risk SR15	☐	*Financial sustainability and funding flows.*
RWT Board Assurance Framework Risk SR16	☐	*Activity levels, performance and potential delays in treatment.*

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

Report to Trust Board

Patient Experience Annual Report 2025/26

Feedback, involvement and engagement with patients, families, carers and communities

1. Executive summary

Patient experience intelligence for 2025/26 shows that The Royal Wolverhampton NHS Trust continues to provide kind, respectful and compassionate care, with national survey results broadly in line with national benchmarks. However, there has been a clear increase in formal complaints, variable FFT performance and pressure on complaint response timeliness.

Overall judgement

Moderate assurance can be taken overall. The Trust has strong foundations in compassionate care, community services, birth experience, volunteering, language support and involvement. However, the scale of complaint growth, reduction in timeliness and variation in FFT performance require targeted improvement and sustained divisional grip.

Summary area	Key messages
What is working well	• National surveys show patients are treated with dignity and respect, involved in decisions and supported by caring and professional staff. • Community services continued to achieve consistently high FFT scores, and Birth services performed strongly across all quarters, exceeding national and Black Country ICB comparators. • Complaint management has been strengthened through a joint Group policy, e-learning, complaint investigation toolkit, early contact, weekly dashboards, a forecasting tool and a new risk matrix. • Language support remained strong with 29,120 bookings, 96% 5-star satisfaction and a 41% increase in virtual interpreting. • The Beat managed 3,941 enquiries, supporting wayfinding, transport and first impressions; volunteer activity was valued at £115,298.08, with wider joint social value estimated at £2.4m.
What requires focus	• Formal complaints increased by 50%, from 563 in 2024/25 to 847 in 2025/26. • Complaint timeliness reduced, with 43 non-compliant cases and only two months achieving 100% compliance against the local 30 working day standard. • Under PHSO timescales, 86% were completed within 3 months compared with 96% in 2024/25; six cases exceeded six months. • FFT was below national average across most services, with Community and Birth the exceptions; Quarter 4 response volumes were affected by PAS implementation issues. • Experience variation remains evident for younger patients and some ethnically diverse communities.

What does this mean?

The Trust's direct care is often experienced positively, but patients are less consistently positive when services are under pressure, when they wait, when communication is uncertain, or when care moves between teams and settings. The Board should view patient experience as a pathway reliability issue as well as a relational care issue.

2. Purpose and scope

This annual report summarises patient voice and patient experience activity and insight for The Royal Wolverhampton NHS Trust during 2025/26. It incorporates the Trust's annual complaints report for the year ending 31 March 2026, in accordance with Regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The wider patient voice content provides additional assurance on experience, involvement, accessibility and learning.

The report brings together intelligence from complaints, concerns, compliments, the Friends and Family Test (FFT), national surveys, local engagement, mystery patient activity, involvement partners, volunteers, accessibility data and language support. It is designed to support Quality Committee and Board oversight by highlighting what is working well, what requires sustained focus, and the actions required to improve experience in 2026/27.

2.1 Statutory complaints reporting statement

For statutory complaints reporting, complaints that were upheld or partially upheld are reported as complaints well-founded in whole or in part. This report includes the number of complaints received, the number well-founded in whole or in part, the number of complaints referred to the Parliamentary and Health Service Ombudsman, the subject matter of complaints, matters of general importance arising from complaints and complaint handling, and actions taken or planned to improve services. Following approval, the report will be published on the Trust website and made available to any person on request.

Statutory reporting requirement	How this report addresses the requirement
Annual reporting period	The report covers 2025/26 and explicitly incorporates the annual complaints report for the year ending 31 March 2026.
Number of complaints received	Reported in Section 3: Patient relations, complaints and learning.
Number of complaints well-founded in whole or in part	Reported in Section 3 through upheld and partially upheld complaint outcomes.
Number referred to the Parliamentary and Health Service Ombudsman	Reported in Section 3 through the PHSO activity summary.
Subject matter of complaints	Reported in Section 3 through complaint themes and divisional/service pressures.
Matters of general importance arising from complaints or complaint handling	Reported through the executive summary, Section 3 interpretation and the priorities/actions in Section 7.
Actions taken or planned to improve services	Reported through the complaint handling assurance narrative, Section 7 priorities and Section 8 governance recommendations.
Availability on request	The report will be published on the Trust website and made available to any person on request following approval.

What does this mean?

Patient voice is most useful when it is presented as actionable intelligence rather than a description of activity. The structure of this report therefore focuses on assurance, variation, improvement priorities and the actions required to close the loop with patients, families, carers and communities.

3. Patient relations, complaints and learning

Patient Relations data shows a substantial increase in formal complaint activity in 2025/26. The Trust maintained complaint handling processes aligned to statutory requirements and PHSO principles, but growth in demand created clear timeliness and reputation risks.

Indicator	2025/26 position	Interpretation
Formal complaints received	847 formal complaints compared with 563 in 2024/25, a 50% increase.	This is the clearest escalation signal in the report and requires divisional ownership of recurring themes. Representation of complaints within Patient Relations activity It is important to interpret the increase in formal complaints in the context of overall Patient Relations activity. During 2025/26, formal complaints accounted for 847 of 7,708 total Patient Relations contacts, representing 11.0% of activity. This compares with 563 formal complaints from 5,907 contacts in 2024/25, representing 9.5% of activity, and 460 formal complaints from 4,757 contacts in 2023/24, representing 9.7% of activity.
Areas of complaint pressure	Emergency Department complaint volume increased by 58%; General Surgery remained a prominent complaint area.	High-pressure pathways require targeted patient experience improvement, particularly around access, waiting and communication.
Safeguarding-related complaints	Safeguarding concerns processed through complaints decreased from 79 to 61.	The reduction reflects review of criteria and management routes, but interface with Quality Matters and Local Authority pathways should continue to be monitored.
Local timeliness standard	Only two months achieved 100% compliance; 43 cases were non-compliant during the year.	Complaint timeliness is a material governance pressure and may affect confidence if not recovered.
Compliments	1,880 compliments were received, down from 2,418, representing 24.4% of all contacts.	Compliments continue to evidence positive staff behaviours, but the reduction should be considered alongside increased complaints.
Complaint outcomes	Of 762 closed cases, 28% were not upheld, 60% partially upheld and 9% upheld. For statutory reporting, upheld and partially upheld outcomes are treated as complaints well-founded in whole or in part.	The increase in partially upheld cases suggests greater scrutiny and recognition of patient concerns.
PHSO activity	Six cases were assessed with no escalation to formal investigation, one of which resulted in an apology and £1,000 financial remedy. A further 11 cases were under assessment for possible escalation. No cases were accepted for mediation. Five cases were subject to full investigation: one was upheld, one was not upheld and three remained under investigation at year end.	The PHSO position reinforces the importance of early resolution, clear explanations, action plans and tracking evidence of learning. Cases closed in year may not correlate directly with cases received in year.
PHSO timeliness standard	86% completed within 3 months compared with 96% in 2024/25; 99% completed within 6 months in both years; six cases exceeded 6 months.	Most cases remain within 6 months, but the reduction within 3 months indicates pressure in the system.

The strongest recurring themes from complaints and concerns relate to clinical care/treatment, communication, attitude, discharge or aftercare, and access/appointments. These themes are consistent with national patient experience findings and indicate that improvement activity needs to be targeted at pathway reliability, information and responsiveness rather than isolated complaint closure alone.

What is working well?

Complaint management has become more proactive and intelligence-led. The Trust has introduced a joint Group Complaint Handling Policy, updated patient information, e-learning, complaint handler toolkit, early contact, weekly dashboards, a complaints forecasting tool, a more risk-based final sign-off process and improved handling of non-Section 42 safeguarding complaints.

What does this mean?

The rise in complaints should not be interpreted only as dissatisfaction. It also reflects accessible routes for raising concerns and greater scrutiny. However, the scale of growth and reduced timeliness mean the organisation needs a more systematic divisional response to recurring themes, particularly in urgent care, discharge, communication and general care.

4. Patient experience feedback

Patient experience feedback shows a mixed position. National surveys provide assurance on compassionate and respectful care, while FFT indicates variation by service, touchpoint and quarter. Quarter 4 FFT response capture was affected by PAS implementation issues and should therefore be interpreted with that caveat.

4.1 Friends and Family Test

Community and Birth services were the most consistently positive FFT areas. Inpatient, Outpatient and ED scores were below comparator performance overall, and ED remained variable despite Quarter 4 improvement.

Touchpoint	Q1	Q2	Q3	Q4	Key interpretation
Inpatients	87	90	77	83	Below 2024/25 and below national/ICB comparator performance overall.
Outpatients	93	93	88	75	Strong early-year performance but significant Quarter 4 reduction affected by response capture issues.
Emergency Department	72	69	51	73	Variable across the year; Quarter 4 recovered from Quarter 3 but remained below comparator levels.
Community	93	94	96	x	Consistently strong where data was available; above ICB by one point overall and aligned to national performance.
Antenatal	90	81	89	82	Variable but aligned to Black Country ICB overall.
Birth	94	95	95	96	Consistently strong and above national and ICB comparators.
Postnatal Ward	86	82	81	84	Below comparator performance overall and requires maternity-focused improvement.
Postnatal Community	89	83	84	88	Below national and ICB comparators overall, despite Quarter 4 improvement.

Table 1: FFT recommendation scores by quarter, 2025/26.

4.2 National surveys and local insight

Strengths identified	Improvement opportunities
Patients reported being treated with dignity and respect and supported by caring, professional staff.	Patients reported difficulty waiting for diagnostic results, appointments and follow-up, and uncertainty about who to contact after discharge.
Adult inpatient, maternity, children's and cancer services showed high scores for kindness, privacy and respectful communication.	Discharge and post-hospital support require clearer follow-up arrangements, information on recovery and advice on when to seek help.
Improvements were seen in discharge conversations, antenatal care and selected inpatient measures.	Children and young people highlighted the importance of ward environment, activities, comfort, food and drink access.
Core clinical care remained a strength, including confidence in care, medication management and basic care needs.	Cancer and maternity feedback highlight the need for better emotional support and postnatal/home support.

What is working well?

Local surveys and UEC engagement confirm that patients recognise staff professionalism, kindness and clinical care, particularly once contact with clinicians is established. This is an important positive message: the human interaction with staff remains a core strength, even when pathways are under pressure.

What does this mean?

The pattern is consistent: experience is strongest inside direct care encounters and weaker at the edges of pathways. Improvement work should therefore focus on communication while waiting, visibility of processes, discharge and post-discharge advice, and consistent comfort and support for vulnerable patients.

5. Involvement, engagement, volunteers and carer support

The Trust continued to strengthen involvement and engagement through local surveys, patient partners, the Readership Panel, The Beat and volunteering. These functions provide essential context to formal feedback data by capturing what patients, carers and communities value in practice.

Area	What happened in 2025/26	Why this matters
Local surveys	Surveys explored LGBTQ+ voices in health, Pets As Therapy, volunteer experience, children's entertainment, children's mealtime choices, stroke rehabilitation and urgent/emergency care.	Local surveys show practical and service-specific learning, including communication, environment, comfort, digital resources and pathway continuity.
Urgent and Emergency Care survey	Feedback recognised staff professionalism, kindness and clinical care, while identifying the need for clearer updates during waits and better visibility of pathways.	This provides a clear improvement route for high-pressure services: increase clarity and reduce uncertainty for patients and carers.
Patient Involvement Partners and Readership Panel	Partners contributed to quality improvement, service design, patient information review, the Patient Experience Summit and Patient Voice Enabling Strategy.	Lived experience is helping to improve the tone, clarity and accessibility of information and strategy.
The Beat	3,941 enquiries were managed, with wayfinding/general enquiries most common, followed by car parking and	The service improves first impressions, reduces anxiety and helps patients and visitors navigate a complex site.

	transport-related enquiries.	
Voluntary Services	Volunteer activity was valued at £115,298.08, with support across New Cross, Cannock, breastfeeding support, arts and heritage, The Beat and wellbeing hub roles.	Volunteers add value at points where patients need navigation, reassurance, companionship and practical help.
Volunteering Social Impact Report	A joint WHT/RWT report estimated volunteering generates approximately £2.4m annual social value.	Volunteer impact is wider than activity hours and supports wellbeing, confidence, skills and community connection.

What is working well?

Involvement activity is increasingly moving from broad listening to targeted insight that influences improvement. The Trust has a strong story to tell about patient partners, local surveys, The Beat, volunteers and the Patient Experience Enabling Strategy.

What does this mean?

The next step is to make the impact of involvement more visible in governance. Reports should clearly show the line from patient insight to action, and from action to improvement, so that Board members can see what changed.

6. Accessibility, inclusion and inequalities

Accessibility and inclusion insight shows strong language support provision, but ongoing variation in experience by age and ethnicity. These patterns should be considered alongside Core20PLUS5 and equality objectives.

Area	2025/26 insight	Improvement focus
Language support	29,120 interpreting bookings were completed, broadly stable compared with 29,187 in 2024/25. 96% satisfaction was maintained.	Continue to ensure interpreting is available, timely and appropriate to clinical complexity.
Virtual interpreting	44% of sessions were telephone or video; video interpreting increased to 2,483 bookings from 1,683, and virtual interpreting increased by 41%.	Continue expansion across services while ensuring staff are trained and patients are supported to use digital interpreting safely.
Age-related variation	Younger patients reported lower FFT recommendation scores than older patients, with highest scores among those aged 65 and over.	Targeted engagement with younger adults is needed to understand expectations, barriers and communication needs.
Ethnicity-related variation	White patients reported the highest FFT experience, with lower scores among several minority ethnic groups, including Asian or Asian British and Other ethnic groups.	Strengthen culturally competent communication and use data to focus improvement with PLUS populations.
Complaint demographics	From 2,256 formal and informal complaints where the complainant was the patient, 70% identified as White British, 11% Asian and 6% Black; 61% were female and 39% male.	Improve demographic completeness and use complaints data to identify underrepresented voices and potential hidden inequalities.

What does this mean?

The Trust has strong access infrastructure, but patient experience is not uniform. Improvement work should explicitly

consider who is reporting poorer experience, who is not using feedback routes, and which communication barriers may be influencing outcomes.

7. Priorities and actions for 2026/27

The proposed priorities for 2026/27 are intended to convert patient voice intelligence into a smaller number of measurable improvement actions.

Priority	Action for 2026/27	Assurance route
Complaint demand and timeliness	Recover response timeliness through early contact, weekly dashboards, risk-based sign-off, forecasting and clear divisional escalation.	Patient Relations dashboard; CNO and divisional oversight.
Urgent and emergency care experience	Use UEC survey, complaints and FFT to agree clear actions on waiting updates, wayfinding, comfort and communication during delays.	Divisional urgent care governance; Quality Committee reporting.
Discharge and post-care support	Strengthen follow-up information, recovery advice and routes for patients to contact services after leaving hospital.	Divisional quality meetings; national survey action plans.
Maternity postnatal experience	Focus improvement on postnatal ward and postnatal community touchpoints, including continuity, support at home and contact arrangements.	Maternity governance; Patient Experience Strategy reporting.
Equity of experience	Use FFT, complaints, interpreting and local engagement data to target younger patients and ethnically diverse communities.	EDI governance; Core20PLUS5 aligned reporting.
Visible impact of patient voice	Introduce clearer “You said, we did, this changed” reporting for local surveys and patient involvement activity.	Patient Voice governance; Quality Committee.

What does this mean?

The Trust has the mechanisms to hear patients; the priority now is to show a reliable response. Future reports should focus on fewer improvement priorities, clear accountability, measurable impact and Board-visible assurance.

8. Governance, risk and recommendations

The report identifies a manageable but material risk to patient experience, confidence and reputation if increased complaint activity and reduced timeliness are not addressed. There is no indication that a new corporate risk is required solely from this annual report, but complaint response timeliness, ED experience, maternity postnatal experience and inequalities in experience should remain under active governance review. The report also serves as the Trust's annual complaints report for the year ending 31 March 2026 and will be made available to any person on request following approval.

Recommendations

The Quality Committee is asked to:

- Note the 2025/26 Patient Experience Annual Report and the key themes arising from complaints, concerns, compliments, FFT, national surveys, local surveys, involvement and accessibility data.
- Confirm that the report incorporates the statutory annual complaints report for the year ending 31 March 2026 and that it will be made available to any person on request following approval.
- Take assurance from the positive feedback on compassionate staff, respectful care, community services, birth experience, language support, involvement, The Beat and volunteering.

- Acknowledge the areas requiring sustained focus, particularly the 50% increase in formal complaints, complaint response timeliness, ED experience, postnatal experience, discharge support and variation in experience across population groups.
- Support the proposed 2026/27 priorities and request progress through existing Quality Committee, QSOG and divisional governance routes.
- Agree that future reports should continue to highlight “what is working well”, “what requires focus” and “what does this mean” so that patient experience reporting remains concise and actionable.

Walsall Healthcare NHS Trust

Tier 1 - Paper ref:	TB in Public

Report title:	Annual Patient Voice Report – 2025/2026 Feedback, Involvement, and Engagement with Public and Patients
Sponsoring executive:	Lisa Carroll, Chief Nurse Officer
Report author:	Garry Perry, Associate Director – Patient Voice Alison Dowling, Associate Director – Patient Relations
Meeting title:	Trust Board
Date:	21 July 2026

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

Advise

The Annual Patient Voice Report for 2025/26 incorporates the Trust's annual complaints reporting requirements and triangulates patient feedback from complaints, concerns, Friends and Family Test returns, national and local surveys, Mystery Patient activity, interpreting and accessibility data, volunteering, engagement, and lived experience involvement.

Patient Voice intelligence demonstrates that patients continue to report positive experiences of direct clinical care, particularly feeling safe, respected, treated with dignity, and cared for by compassionate and professional staff. However, consistent improvement themes remain in relation to communication during waiting periods and delays, transitions between services, discharge, emotional reassurance, environment and comfort, and variation in experience for some population groups, including younger patients, carers, ethnically diverse communities, and people experiencing digital or language barriers.

Assure

The Trust has established and maturing Patient Voice arrangements, with insight routinely gathered, triangulated and used to inform quality improvement, service redesign, policy development, workforce learning, and delivery of the Patient Experience Enabling Strategy 2025–2028.

The report provides assurance that statutory complaints reporting requirements have been addressed, including complaint volumes, complaint outcomes, PHSO/Ombudsman activity, key themes, matters of general importance, and actions taken or planned in response to learning. During 2025/26, the Patient Relations Team received 3,749 contacts, including 719 written complaints, with early resolution and conversion to concerns used where appropriate. Complaint outcomes demonstrate that the majority of closed complaints were partially upheld, supporting a balanced approach to recognising patient concerns while identifying specific learning.

Key areas of assurance include implementation of complaint standards, expansion of interpreting and accessibility provision, strengthened volunteering and engagement, increased co-design and lived experience involvement, and continued governance oversight through established quality and patient experience routes.

Alert

There are no immediate unmanaged risks identified within the report. However, continued oversight is required in relation to complaint response timeliness, which reduced during 2025/26 and has been affected by demand, case complexity, and strengthened quality assurance processes.

Formal complaint-handling activity represented 14.1% of total Patient Relations contacts in 2025/26, compared with 8.9% in 2024/25, indicating that although total contact activity reduced slightly, a greater proportion of contacts required formal complaint management.

The report also highlights ongoing variation in experience across some pathways, particularly urgent and emergency care, discharge and transitions, and persistent inequalities in experience for some population groups. These areas require sustained divisional ownership and targeted improvement to prevent recurrent feedback themes becoming a risk to confidence, equity and overall experience.

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?]*

4. Recommendation(s)
The Quality Committee is asked to:
Note the 2025/26 Patient Voice Annual Report and the key themes from complaints, concerns, compliments, FFT, national surveys, Mystery Patient activity, local engagement, accessibility and lived-experience involvement.
Recognise that the key assurance issue is whether the Trust can reduce variation in experience at waits, transitions, discharge, aftercare and communication points, rather than whether patients value staff compassion.
Support continued implementation of the Patient Experience Enabling Strategy 2025-2028 and the actions underway to improve complaint handling, accessible communication, co-design and evidence of impact.
Request continued assurance through Quality Committee on complaint timeliness recovery, pathway-focused improvement and equity of experience across population groups.

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
RWT Board Assurance Framework Risk SR15	☐	*Financial sustainability and funding flows.*
RWT Board Assurance Framework Risk SR16	☐	*Activity levels, performance and potential delays in treatment.*
RWT Board Assurance Framework Risk SR17	☐	*Addressing health inequalities and equality, diversity and inclusion.*
RWT Board Assurance Framework Risk SR18	☐	*Potential cyber vulnerabilities and data breaches.*
WHT Board Assurance Framework Risk NSR101	☐	*Data and systems Security (Cyber-attack)*

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*		
WHT Board Assurance Framework Risk NSR102	☐	*Culture and behaviour change (incorporating Population Health)*
WHT Board Assurance Framework Risk NSR103	☐	*Attracting, recruiting, and retaining staff*
WHT Board Assurance Framework Risk NSR104	☐	*Consistent compliance with safety and quality of care standards*
WHT Board Assurance Framework Risk NSR105	☐	*Resource availability (funding)*
WHT Board Assurance Framework Risk NSR106	☐	*Equality, Diversity, and Inclusion (incorporating Staff, Patients and Population Health)*
Corporate Risk Register [Datix Risk Nos]	☐	
Is Quality Impact Assessment required if so, add date:		
Is Equality Impact Assessment required if so, add date:		

Walsall Healthcare NHS Trust

Report to Trust Board

Annual Patient Voice Report 2025/26

Feedback, involvement and engagement with patients, families, carers and communities

1. Executive summary

Patient voice intelligence for 2025/26 demonstrates a broadly positive picture of direct care at Walsall Healthcare NHS Trust. Patients continue to describe staff as caring, professional and compassionate, with strong feedback on safety, dignity and respect. The report also identifies clear and recurring opportunities to improve communication, continuity and support at points of transition.

Overall judgement

Substantial assurance can be taken that patient voice arrangements are established, multi-source and increasingly linked to improvement. Moderate assurance is offered in relation to complaint timeliness and variation in experience, which require continued grip through divisional governance and the Patient Experience Enabling Strategy.

Summary area	Key messages
What is working well	• FFT remained strong across most touchpoints, with Community consistently high at 97-99%, Outpatients at 92-94%, and Inpatients improving to 92% in Quarter 4. • Patients consistently reported feeling safe, respected and treated with dignity during direct contact with clinical teams. • Patient voice is now supported by stronger infrastructure, including the Patient Experience Enabling Strategy, lived-experience input, the Readership Panel, real-time dashboards, complaint standards implementation and local engagement activity. • Access and inclusion improved through 13,740 interpreting bookings, a 5% increase from 2024/25, with 96% 5-star satisfaction and expanded virtual interpreting. • Practical support for patients and visitors remained strong, including more than 32,000 Welcome Hub enquiries, volunteer activity valued at £225,479.84 and family/carer support encounters increasing by 13%.
What requires focus	• Complaint response timeliness reduced to an average 67% within agreed timeframe, down from 82% in 2024/25. • The most common complaint themes remained clinical care/treatment, appointments, attitude, communication and discharge. • National surveys and local feedback continue to highlight communication during waits, discharge support, emotional reassurance and environment/comfort as priorities. • Experience is not consistent across all groups, with younger patients and people from non-White backgrounds reporting less positive experience. • ED FFT remained variable, although Quarter 4 improved, and maternity touchpoints showed mixed performance.

What does this mean?

The core experience of care is strong when patients are in direct contact with staff. The less reliable part of experience is what happens around that care: waiting, moving between services, discharge, follow-up and access to understandable information. The improvement agenda therefore needs to focus less on describing feedback and more on reducing variation and closing the loop with patients.

2. Purpose and scope

This annual report summarises patient voice and patient experience activity and insight for Walsall Healthcare NHS Trust during 2025/26. It incorporates the Trust's annual complaints report for the year ending 31 March 2026, in accordance with Regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The wider patient voice content provides additional assurance on experience, involvement, accessibility and learning.

The report brings together intelligence from complaints, concerns, compliments, the Friends and Family Test (FFT), national surveys, local engagement, mystery patient activity, involvement partners, volunteers, accessibility data and language support. It is designed to support Quality Committee and Board oversight by highlighting what is working well, what requires sustained focus, and the actions required to improve experience in 2026/27.

2.1 Statutory complaints reporting statement

For statutory complaints reporting, complaints that were upheld or partially upheld are reported as complaints well-founded in whole or in part. This report includes the number of complaints received, the number well-founded in whole or in part, the number of complaints referred to the Parliamentary and Health Service Ombudsman, the subject matter of complaints, matters of general importance arising from complaints and complaint handling, and actions taken or planned to improve services. Following approval, the report will be published on the Trust website and made available to any person on request.

Statutory reporting requirement	How this report addresses the requirement
Annual reporting period	The report covers 2025/26 and explicitly incorporates the annual complaints report for the year ending 31 March 2026.
Number of complaints received	Reported in Section 3: Patient relations, complaints and learning.
Number of complaints well-founded in whole or in part	Reported in Section 3 through upheld and partially upheld complaint outcomes.
Number referred to the Parliamentary and Health Service Ombudsman	Reported in Section 3 through the PHSO activity summary.
Subject matter of complaints	Reported in Section 3 through complaint themes and divisional/service pressures.
Matters of general importance arising from complaints or complaint handling	Reported through the executive summary, Section 3 interpretation and the priorities/actions in Section 7.
Actions taken or planned to improve services	Reported through the complaint handling assurance narrative, Section 7 priorities and Section 8 governance recommendations.
Availability on request	The report will be published on the Trust website and made available to any person on request following approval.

What does this mean?

Patient voice is most useful when it is presented as actionable intelligence rather than a description of activity. The structure of this report therefore focuses on assurance, variation, improvement priorities and the actions required to close the loop with patients, families, carers and communities.

3. Patient relations, complaints and learning

Patient Relations activity remained high during 2025/26, with a continued focus on early resolution, improved complaint handling and embedding the PHSO NHS Complaint Standards. The data suggests that patients and families are using feedback routes to raise concerns about both clinical care and the reliability of supporting processes.

Indicator	2025/26 position	Interpretation
Total Patient Relations contacts	3,749 contacts, including complaints, concerns, queries, compliments, care opinion and MP letters.	Demand remains high and requires continued proactive triage and early resolution to avoid escalation.
Formal complaint activity	719 written complaints were received; 199 were converted to concerns and 10 concerns were escalated to formal complaints. Formal complaints requiring written response increased to 520.	The rise in written-response work adds pressure to timeliness and quality assurance. It is important to interpret complaint activity in the context of overall Patient Relations contact. During 2025/26, the Patient Relations Team received 3,749 contacts. Of these, 520 were complaints requiring a written response, representing 13.9% of total contact activity. In addition, 10 concerns were escalated to a complaint. When these escalated concerns are included, formal complaint-handling activity represented 530 contacts, or 14.1% of total Patient Relations activity. This compares with 2024/25, when complaints requiring a written response accounted for 343 of 3,943 contacts, representing 8.7% of total activity. When concerns escalated to complaints are included, the equivalent figure for 2024/25 was 349 contacts, or 8.9% of total activity.
Response timeliness	Average response rate within an agreed timeframe was 67%, compared with 82% in 2024/25.	This is the main governance pressure in the complaints process and requires sustained divisional ownership.
Complaint outcomes	Of 380 closed cases, 20% were not upheld, 74% partially upheld and 6% upheld; one complaint was withdrawn. For statutory reporting, upheld and partially upheld outcomes are treated as complaints well-founded in whole or in part.	The high partially upheld position suggests the Trust is recognising elements of legitimate concern, often linked to communication and coordination.
PHSO activity	Two cases were assessed with no escalation to formal investigation; two were under assessment; nine were subject to full investigation. Of the investigated cases, one was upheld, seven were partially upheld, two were not upheld and one further case remained under investigation at year end.	The Ombudsman position reinforces the need for clear explanations, timely action plans, evidence of learning and sustained improvement in communication and coordination.

Compliments	694 compliments were received, representing 18.5% of contacts.	Despite reduced volume compared with the previous year, compliments continue to evidence compassionate, person-centred care.

The strongest recurring themes from complaints and concerns relate to clinical care/treatment, communication, attitude, discharge or aftercare, and access/appointments. These themes are consistent with national patient experience findings and indicate that improvement activity needs to be targeted at pathway reliability, information and responsiveness rather than isolated complaint closure alone.

What is working well?

The Trust has strengthened complaint handling through a joint Group Complaint Handling Policy, updated literature, complaint investigation e-learning, a formal investigation toolkit, early contact with complainants, real-time dashboards and increased use of interpreting support. The 68.6% increase in complaints downgraded following early contact indicates that earlier conversations are helping to resolve concerns more proportionately.

What does this mean?

The principal issue is not whether patients can raise concerns; routes are visible and active. The issue is whether responses are timely, clearly owned and demonstrably linked to improvement. Complaint learning should therefore be reviewed alongside FFT, survey and safety data at divisional level so that recurring themes are acted on as pathway issues rather than managed only as individual complaints.

4. Patient experience feedback

Patient experience feedback was gathered through FFT, national patient surveys, mystery patient activity and local surveys. Taken together, the intelligence shows strong relational care, with more mixed experience where patients wait, transfer between services or return home.

4.1 Friends and Family Test

FFT performance remained strong overall and compared favourably with the Black Country ICB across all reported touchpoints. Community services remained particularly strong, while ED performance improved in Quarter 4 after a variable year. Maternity touchpoints showed a more mixed picture.

Touchpoint	Q1	Q2	Q3	Q4	Key interpretation
Inpatients	89	89	90	92	Gradual improvement through the year and above Black Country ICB by one point overall.
Outpatients	93	92	93	94	Consistently high recommendation scores and above Black Country ICB by three points overall.
Emergency Department	81	79	78	83	Variable but improved in Quarter 4; above national and Black Country ICB comparators.
Community	99	99	98	97	Sustained excellent performance despite a small end-year reduction.
Antenatal	83	87	89	94	Improved through the year, although below national benchmark.
Birth	94	94	90	90	Strong performance overall and above Black Country ICB.
Postnatal Ward	95	91	87	91	Generally positive, with variation across quarters.
Postnatal Community	97	93	97	86	Strong early-year performance with a Quarter 4 decline requiring review.

Table 1: FFT recommendation scores by quarter, 2025/26.

4.2 National surveys and local insight

Strengths identified	Improvement opportunities
Patients reported feeling safe, respected and well cared for. Privacy and dignity were strong across emergency, inpatient and cancer pathways.	Communication during waiting periods remains a recurring issue, including updates during emergency attendance, inpatient waits for ward admission and maternity triage waits.
Cancer services demonstrated strengths in diagnostic communication, privacy and having a main point of contact.	Post-discharge support is inconsistent, particularly GP/community links after treatment, recovery advice and postnatal follow-up.
Adult inpatient feedback identified improvements in information about medicines and equipment needs at home.	Emotional and psychological support requires strengthening across cancer, maternity and urgent care pathways.
Maternity services showed strengths in efficient discharge following birth.	Environmental comfort, including noise, lighting, sleep and access to refreshments, remains an important experience issue.

What is working well?

Mystery patient and local insight confirm that staff compassion, professional behaviour and clinical expertise are visible to patients. Local surveys also show that patient voice is shaping tangible improvements, including therapy animal visits, children's entertainment and mealtime choices, stroke rehabilitation redesign and patient-facing information.

What does this mean?

The Trust is performing well where clinical interaction is immediate and relational. The recurring negative themes relate to uncertainty, lack of updates and insufficient preparation for the next stage of care. Improvement should therefore focus on predictable communication standards during waits, discharge and follow-up.

5. Involvement, engagement, volunteers and carer support

Involvement and engagement activity matured during 2025/26, with patient partners, local surveys, volunteers, carers and digital tools increasingly used to shape service design and improvement.

Area	What happened in 2025/26	Why this matters
Patient Involvement Partners and Readership Panel	Partners contributed to quality improvement, service design, patient information review, the Patient Experience Summit and the Patient Voice Enabling Strategy.	Lived experience is increasingly influencing strategic decisions and patient-facing communication, rather than being limited to consultation.
Welcome Hub	More than 32,000 enquiries were managed, including over 17,700 outpatient queries, 5,300 inpatient location enquiries, 3,600 wheelchair enquiries and over 1,000 scooter-service requests.	The Hub reduces anxiety, improves navigation and helps patients and visitors overcome practical barriers to care.
Voluntary Services	Volunteer activity was valued at £225,479.84, with roles across wards, ED,	Volunteers add capacity and improve experience at key touchpoints including

	maternity, ICU, community services and self-care management.	navigation, ward experience, mealtimes and companionship.
Volunteering Social Impact Report	A joint WHT/RWT assessment estimated volunteering generated approximately £2.4m annual social value.	The volunteer model contributes beyond activity hours, with wider benefits for wellbeing, skills, confidence and community connection.
Family and Carer Support	593 support encounters were recorded, a 13% increase from 2024/25. The Carers Voice Forum engaged 26 carers.	Carer feedback highlights the need to recognise unpaid carers earlier, provide clearer information and support carers' own wellbeing.
Children and young people	Little Journey app usage increased in paediatric pathways, and Little Voices provided direct feedback on ED, PAU, Ward 21 and Neonatal Unit.	Children's voices are generating practical improvement actions around information, play, accessibility, food and child-friendly environments.

What is working well?

The Trust has moved from collecting patient stories to using patient and carer insight to shape strategy, information, environments and pathway redesign. This is a major area of assurance and should be presented more prominently in Board reporting.

What does this mean?

The strongest opportunity is to connect involvement activity more explicitly to measurable change. Committees should be able to see not only what patients said, but what changed as a result, by when, and how this will be reported back.

6. Accessibility, inclusion and inequalities

Accessibility and inclusion data demonstrates good progress on language support, while FFT and complaint demographic monitoring show that experience and engagement are not evenly distributed across all population groups.

Area	2025/26 insight	Improvement focus
Language support	13,740 bookings were completed, a 5% increase from 2024/25. 62% were telephone or video, 38% face-to-face, and satisfaction was 96% 5-star.	Maintain access to face-to-face interpreting where clinically necessary while expanding responsive digital options.
Virtual interpreting	Video interpreting increased from 2,360 to 4,354 bookings, with a 71% increase in virtual interpreting overall.	Continue rollout and training, with targeted relaunch of Wordskii Connect in Maternity Triage.
Age-related variation	FFT results show younger patients report less positive experience, with satisfaction increasing steadily with age.	Use targeted engagement to understand expectations, communication preferences and barriers affecting younger patients.
Ethnicity-related variation	Patients from non-White backgrounds reported poorer experience overall, with Asian or Asian British patients reporting the lowest levels of satisfaction.	Strengthen culturally competent communication and use FFT, complaints and language data together to identify unmet need.
Complaints engagement	Equality monitoring showed 88% of respondents identified as White British, a predominance of older age groups and 71% female respondents.	Improve feedback capture from underrepresented groups so that hidden inequalities are not missed.

What does this mean?

Access is improving, particularly through interpreting and digital support, but experience is still unequal. The Board should therefore treat patient experience variation as a health inequalities issue, not only a satisfaction issue.

7. Priorities and actions for 2026/27

The proposed priorities for 2026/27 are drawn from recurring themes across complaints, FFT, national surveys, local surveys and involvement activity.

Priority	Action for 2026/27	Assurance route
Communication during waits	Agree minimum communication standards for waiting, delay and escalation updates in ED, maternity triage, outpatients and inpatient transfers.	Divisional governance; Patient Experience Strategy reporting.
Transitions and discharge	Strengthen discharge information, recovery advice, post-discharge contact routes and links with community/primary care.	Quality and Safety Oversight Group; divisional quality meetings.
Complaint timeliness	Recover complaint response performance through early contact, risk-based sign-off, divisional escalation and weekly dashboard oversight.	Patient Relations dashboard; CNO oversight.
Equity of experience	Use FFT, complaints, language services and local engagement data to target younger patients, ethnically diverse communities, carers and people with communication barriers.	EDI governance; Core20PLUS5 aligned reporting.
Evidence of change	Introduce clearer “You said, we did, this changed” reporting against patient voice priorities.	Quality Committee annual and quarterly reporting.
Lived experience model	Progress transition from Patient Involvement Partners to Lived Experience Partners, with role clarity, support and broader recruitment.	Patient Voice governance.

What does this mean?

The next phase should focus on fewer, clearer priorities that can be tracked through governance. The Committee should expect future reports to show measurable improvement, not only a description of activity.

8. Governance, risk and recommendations

No immediate unmanaged risk is identified from the report. The main areas requiring continued oversight are complaint response timeliness, variation in experience across urgent and emergency care and maternity touchpoints, and persistent inequalities in experience for younger patients and some ethnic minority groups. These issues should continue to be monitored through established quality governance and Patient Experience Strategy reporting. The report also serves as the Trust's annual complaints report for the year ending 31 March 2026 and will be made available to any person on request following approval.

Recommendations

The Quality Committee is asked to:

- Note the 2025/26 Annual Patient Voice Report and the key themes arising from complaints, concerns, compliments, FFT, national surveys, local engagement, mystery patient activity and lived-experience involvement.

- Confirm that the report incorporates the statutory annual complaints report for the year ending 31 March 2026 and that it will be made available to any person on request following approval.
  - Take assurance from the strength of direct care feedback, high FFT performance across most touchpoints, improved language support, volunteer contribution and maturing patient involvement arrangements.
  - Acknowledge the areas requiring sustained focus, particularly complaint response timeliness, communication during waits, continuity at discharge and experience variation across population groups.
  - Support the proposed 2026/27 priorities and receive progress through existing Quality Committee, QSOG and divisional governance routes.
  - Agree that future reports should continue to foreground “what is working well”, “what requires focus” and “what does this mean” so that patient voice is presented as actionable assurance.

Tier 1 - Paper ref:	Enclosure 10.5

Report title:	Mental Health and GIRFT Clinical Operational Standards for Mental Health in Urgent & Emergency Care
Sponsoring executive:	Dr Zia Din, Medical Officer, WHT
Report author:	Jade Rolls, Head of Nursing Mental Health /Learning Disability /Safeguarding jade.rolls1@nhs.net Caroline Whyte – Deputy Chief Nursing Officer caroline.whyte3@nhs.net
Meeting title:	Public Trust Board
Date:	06/07/2026

1. Summary of key issues

- Background information – Mental Health Act
- GIRFT Clinical Operational Standards for Mental Health in Urgent & Emergency Care overview
- Current position with GIRFT self-assessment and implementation plan

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

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

n/a

4. Recommendation(s)/Action(s)

The Group Trust Board in Public is asked to:

1. **Note** the contents of this report and the Trust's 100% compliance with its direct acute responsibilities under the GIRFT Clinical Operational Standards.
2. **Support** ongoing collaborative intervention with Black Country Healthcare Mental Health Trust to reduce 12-hour ED breaches and improve broader system flow.

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

Report to the Group Trust Board Meeting to be held in Public

1.0 Executive Summary

This paper outlines the statutory obligations of Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton Trust (RWT) as registered providers of mental health care under the Mental Health Act (MHA). It details the newly released NHS England Getting It Right First Time (GIRFT) Clinical Operational Standards for Adult Acute Mental Health Urgent & Emergency Care (April 2026) Appendix 1 in response to national performance pressures and presents a progress update on the self-assessment against the standards.

The board is asked to review our current compliance, acknowledge system-wide challenges and support the next steps for localised action planning.

2. Background & Context

The Trust's Statutory MHA Responsibilities

Since 2021, WHT and RWT have been registered as providers of mental health with the CQC. This enables both trusts to act as detaining authorities under the MHA (1983, updated 2025). The Trust boards hold the primary legal responsibility as "Hospital Managers" to ensure that any MHA detention is lawful, human rights are upheld, and patients are supported in exercising their statutory rights.

Common sections managed across our acute sites include:

- Section 136: Police detention for up to 24 hours to access an assessment.
- Section 2 & 3: Detentions for assessment (up to 28 days) and treatment (up to 6 months).
- Section 5(2): Short-term doctor's holding powers (up to 72 hours).
- Section 17 Leave: Authorized leave for individuals detained elsewhere who require acute physical health intervention at WHT/RWT.

Currently, a formal contract is in place with BCHMHT to provide the 'Responsible Clinician' (RC) functions required for Section 3 treatment compliance. Whilst the trusts remain compliant, operational misunderstandings have occasionally generated delays in patient care pathways, which are being proactively managed via inter-trust meetings.

As an organisation it must be evidenced that there is compliance with:

- The Mental Health Act 1983/2025
- The Code of Practice 2015
- The Mental Capacity Act 2005

The acute mental health team support the organisations with governance, support / advice to acute colleagues, ensuring compliance with the above, providing clinical advice, monitoring training compliance, and working in collaboration with Black Country Healthcare Mental Health Trust to monitor delays in patient care, risks and incidents. The team supports timely application for an RC to be identified to support treatment of those patients with mental health presentations under the act, and support colleagues in addressing any barriers to discharge or transfer, for all ages.

3. The Driver for GIRFT Standards

National data from the GIRFT Summary Emergency Department Indicator Table (SEDIT) in January 2026 highlighted that 26% of all mental health presentations breach the 12-hour threshold in Emergency Departments (EDs). Prolonged waits place immense pressure on acute staff and compromise patient outcomes.

In response, NHS England mandated the implementation of the GIRFT Clinical Operational Standards to standardise best practice, drive joint accountability between acute and mental health trusts, and embed these pathways as standard practice before winter 2026.

4. Overview of the 4 Key GIRFT Pillars

The GIRFT framework outlines 28 specific clinical operational standards span across 4 distinct areas of the urgent and emergency pathway:

Clinically Deteriorating Community Patients

- Proactive Care: Community mental health services must utilise daily team meetings to identify deteriorating patients and offer face-to-face responses within 24 hours.
- Crisis Planning: Co-produced, multi-agency crisis plans must be visible 24/7 on accessible IT systems.
- Assertive Management: Includes regular prescriber medication reviews, tracking of depot medication, and assertive outreach if a patient misses appointments to prevent emergency escalations.

Patients Requiring an Emergency Response

- 24/7 Access: Ensuring NHS 111 option 2 has the capacity to triage effectively using local Directories of Services (DoS).
- Crisis & Home Treatment Teams (CRHT): Staff must provide face-to-face responses within 4 hours, with management plans reviewed daily by senior (Tier 2/3) clinicians.
- Environment: Restricting ED use for Section 136/135 detentions, ensuring Health-Based Places of Safety (HBPoS) are utilized unless physical health needs dictate otherwise.

Patients in the Emergency Department (ED)

- Parallel Assessments: Mental Health Liaison Teams (MHLT) must respond to ED referrals within a maximum of 1 hour. A parallel tracking system for both physical and mental health needs must begin at triage.
- Biopsychosocial & Trauma-Informed Care: A comprehensive care plan must be completed within 4 hours of arrival.
- Environment & Safeguarding: EDs must have at least one room suitable for high-risk assessments meeting Psychiatric Liaison Accreditation Network (PLAN) standards. We note BCMHT does not currently have PLAN accreditation.
- Escalation Protocols: Jointly agreed escalation metrics must activate before a 12-hour breach occurs, with bed management utilizing the NHS Risk Matrix Tool and the Operational Pressures Escalation Level (OPEL) framework.

Mental Health Inpatient Flow

- Purposeful Admission: Admissions must be time-limited with clear criteria-led discharge objectives defined upon entry.
- Clinical Review Timeframes: Treatment plans must be reviewed by Tier 2/3 clinicians within 24 hours and fully formulated by an MDT within 72 hours.
- Daily Progression: Utilising Red2Green (R2G) principles to minimize unnecessary delay, active daily tracking of Clinically Ready for Discharge (CRFD) statuses, and formal reviews for long lengths of stay (>60 days for adults; >90 days for older adults).

5. Current Position and Self-Assessment Progress

NHS England requested a two-part data submission to benchmark systems against these expectations:

- Part 1 (Completed): A retrospective review of the last 10 patients per hospital who breached the 12-hour mark in ED with mental health needs. This evaluated 47 data points per patient, including MHLT response times, transport availability, and bed delays. Data collation was completed jointly with BCHMHT; initial indicators show variances in data recording practices between organizations which are currently being audited.
- Part 2 (In Progress): A comprehensive self-assessment against all 28 GIRFT standards. The submission deadline was extended to 7th July 2026 at BCHMHT's request due to regulatory inspection schedules.

Acute Trust Position: Of the 28 standards, only 6 directly apply to WHT/RWT as acute providers. Internal audits confirm that our acute sites meet 100% of these 6 direct standards.

6. Next Steps & Action Plan

Upon successful cross-system data submission on 7th July, the acute mental health team will take the following steps:

1. Analyse the collective system data to identify external gaps (e.g., community crisis response or MHLT availability) that delay patient care within our front doors.
2. Agreement with BCHMHT to look at any gaps in services, and how we can improve access to appropriate crisis services and effective signposting on attendance at ED
3. Formulate a collaborative action plan with BCHMHT through the Mental Health Steering Group to resolve recording discrepancies and streamline psychiatric liaison flow.
4. Embed the relevant operational workflows over the next 6 months to secure standard practice.

7. Recommendations

The Group Trust Board is asked to:

1. Note the contents of this report and the Trust's 100% compliance with its direct acute responsibilities under the GIRFT Clinical Operational Standards.
2. Support ongoing collaborative intervention with Black Country Healthcare Mental Health Trust to reduce 12-hour ED breaches and improve broader system flow.

(GIRFT Clinical Operational Standards: Adult Acute Mental Health Urgent & Emergency Care April 2026 is available as Appendix 1)

GIRFT
GETTING IT RIGHT FIRST TIME

NHS England

GIRFT Clinical Operational Standards: Adult Acute Mental Health Urgent & Emergency Care

Standardising best practice to improve patient flow and reduce waiting times in emergency and acute care

April 2026

GIRFT Clinical Operational Standards:
Adult (age 18+) Acute Mental Health Urgent & Emergency Care

NHS England

Introduction

The NHS continues to face significant challenges in delivering timely and effective urgent and emergency mental health care. Demand for mental health support is rising, with increasing numbers of people presenting in crisis and requiring immediate assessment, intervention and support. National priorities emphasise the need to reduce long waits for mental health assessment and treatment, improve the timeliness of crisis responses in the community, and ensure that people receive the right care, in the right place, at the right time.

Local audits show that most patients referred to liaison psychiatry also have concurrent medical needs. While an emergency department (ED) should never be the default location for same-day, non-emergency mental health care, EDs remain an appropriate and necessary setting for joint assessment, care and treatment by emergency medicine and liaison psychiatry - provided patients can be discharged or transferred in a timely manner. However, current performance varies significantly across England, and many services face pressures that affect their ability to deliver consistently high-quality, responsive mental health urgent and emergency care.

These challenges are reflected in national data (GIRFT's Summary Emergency Department Indicator Table (SEDIT) for January 2026), where 26% of all mental health presentations now breach 12 hours in ED, with marked regional variation. While some delays relate to mental health pathways, many patients with mental health needs awaiting admission to acute specialties - such as medicine, surgery and orthopaedics - also experience extended stays. These delays harm patient experience and outcomes and place significant pressure on ED staff. Improving this requires shared responsibility across emergency medicine, acute specialties and mental health services to provide suitable clinical environments, co-ordinated inter-specialty decision-making, and equitable access to medical and surgical care.

In response to these challenges, GIRFT has developed these Clinical Operational Standards (COS), which define best practice in mental health Urgent and Emergency Care (UEC). These standards draw upon national policy and guidance, local protocols and expert clinical opinion across crisis, community and acute mental health services. By reviewing current practice against these standards, systems and providers can identify gaps, understand variation and prioritise areas for improvement across the whole pathway.

Progress is already being made: crisis response services continue to expand; 24-hour urgent and emergency mental health services are increasing; and 82% of acute hospitals with a Type 1 ED are now commissioned to the minimum Core 24 standard (8th National Survey of Liaison Psychiatry in England, 2024). Nevertheless, prolonged waits for specialist mental health assessment and delays in accessing inpatient beds remain areas of significant concern. Addressing these issues is essential if we are to deliver a safer, more responsive experience for people in mental health crisis.

The NHS is making meaningful progress across urgent and emergency care, and these mental health Clinical Operational Standards aim to help trusts, systems and partners build on that momentum - ensuring that people experiencing a mental health crisis receive timely, safe, high-quality care wherever and whenever they need it. We need to embed these standards – developed by clinicians, for clinicians and operational teams – before next winter as a minimum standard.

Professor Tim Briggs CBE - ***GIRFT programme lead and National Director for Clinical Improvement, Elective Recovery and UEC for NHS England***

GIRFT GETTING IT RIGHT FIRST TIME

GIRFT Clinical Operational Standards:
Adult (age 18+) Acute Mental Health Urgent & Emergency Care

NHS England

What are the operational standards?

GIRFT has developed the Clinical Operational Standards (COS) for adult (18+) acute mental health urgent and emergency care to support effective 'front door' care for adults presenting to emergency departments with acute mental health needs. More comprehensive standards for specific disorders and related sub-specialty pathways will be developed in collaboration with key stakeholders.

Based on national policy, guidance and expert clinical opinion, these standards set out care, from deterioration in the community requiring an emergency mental health response through to admission to an inpatient mental health bed.

These standards should be used in conjunction with the UEC Mental Health Winter Action Cards which provide brief, operational prompts designed to help teams turn the wider mental health urgent and emergency care standards into immediate actions at pathway level.

The standards describe how staff are expected to work, including the required actions, responses and associated timeframes needed to deliver optimal patient outcomes.

All clinical and operational staff should be familiar with the standards, and their views should be actively sought and considered. The standards should remain focused on patient care, championed by clinical leaders, and applied in a way that keeps the patient central to all decisions.

How should the standards be used?

- Operational teams and clinicians should work together to assess whether their service is delivering the care and behaviours described in the standards.
- Acute care teams should identify any gaps and collaborate with specialty teams to ensure the standards are implemented.
- Successful implementation of the standards requires engagement and support from the trust executive team.

How can the standards be embedded?

Having a written document alone is not enough. The standards should be used as a framework during the induction of new staff and included in annual updates for existing staff. They should become part of routine practice so that they are recognised as normal daily interactions. Senior staff can reinforce this by modelling the expected behaviours, particularly during periods of pressure or stress, to demonstrate what good practice looks like.

We need to embed these ways of working over the next six months as standard practice, certainly before next winter. They should represent 'how we do things here every day'. This can no longer be optional.

This document outlines key areas for improvement and should be read alongside the Red Tape Challenge report, which sets out the wider changes needed across the NHS to reduce bureaucracy and increase the time clinicians can spend on direct patient care.

Contents

UEC MH Winter Action Cards 25-26

Clinical Operational Standards - Emergency Care pathways

Case Studies - Mental Health Improvement Support Team Network - Futures

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Clinically deteriorating community patients and those at risk of admission

Many patients whose mental health deteriorates are already under the care of community mental health services. To support deteriorating patients on community caseloads, the following standards should be adhered to:

1. Community services must have a clear process (e.g. through a daily team meeting or emergency duty system) to identify patients who are clinically deteriorating. Patients identified as at risk of admission must receive an urgent face-to-face response within 24 hours, alongside an urgent MDT discussion led by a senior (Tier 2) or expert (Tier 3) clinical decision-maker, as clinically appropriate.

2. Clinically deteriorating patients or those frequently using emergency departments must have co-produced, multi-agency (e.g. ambulance, NHS 111, and non-health agencies as appropriate) care and crisis plans reviewed and shared in written form. The plan must include diagnosis, biopsychosocial formulation and interventions to improve mental health and prevent relapse, and actions to respond to emerging crisis and risks. Crisis plans must be recorded on a system accessible 24/7 to mental health urgent and emergency care services and the patient and their carers/family should have a copy as appropriate.

3. Clinically deteriorating patients must receive regular medication reviews by their prescriber, including a review of concordance. Teams must ensure depot medication is tracked so it is administered as prescribed. Deteriorating patients under a Section 17A Community Treatment Order (CTO) of the Mental Health Act, must receive an urgent assessment of the need to 'recall' in line with relevant guidance (e.g., NICE NG53, MHA Code of Practice).

Tiers of clinical decision makers

Tier 1: Resident doctors and Band 6 mental health practitioners and above (not including Tier 2 and 3 decision makers)

Tier 2: Specialty psychiatrists, specialty registrars (ST4-ST6) and non-medical consultant grade mental health practitioners

Tier 3: Consultant psychiatrists, specialist psychiatrists, non-medical consultant mental health practitioners who are prescribers and/or non-medical approved clinicians.

MHA Code of Practice

NHS Clinically-led Review of Access Standards

RCPsych Accreditation for Community Mental Health Services

NICE Guidance NG53

GETTING IT RIGHT FIRST TIME

Clinically deteriorating community patients and those at risk of admission (continued)

4 Admission of a patient with a predictable course of deterioration, whether informal or under the Mental Health Act, should be timely rather than as a last resort. This may prevent escalation of risk and a prolonged admission. Senior (Tier 2) or expert (Tier 3) clinical decision-makers should consider nature and not only degree when assessing the threshold for admission under the Mental Health Act.

5 Care plans for co-morbid substance misuse must be developed jointly with Co-occurring Substance Use and Mental Health Disorders (CoSUM) services. Patients with co-morbid substance use must not be excluded from crisis support services.

6 Clinically deteriorating patients must have their support needs reviewed though a Care Act assessment, and an assessment of carers needs where appropriate. Both assessments must be repeated at least annually, or more frequently if clinically indicated.

7 If a clinically deteriorating patient does not attend appointments, staff must take an assertive approach to follow up, including liaising with appropriate agencies (e.g. social services, housing, criminal justice system) and seeking collateral information from family and carers, as appropriate, taking into account the principles of the Triangle of Care and Confidentiality: NHS Code of Practice.

- NICE Guideline NG58
- Care Act 2014 Section 9
- Mental Health Act 1983
- Triangle of care and Confidentiality
- Co-occurring substance use and mental health disorders (CoSUM)
- NHS Code of Practice-Confidentiality

Patients requiring an emergency response

If a patient presents with mental health problems and there are risks to their health/safety, or to others, they will require immediate support, assistance and care from urgent and emergency mental health services. These situations must be met with urgent and immediate responses in line with the following standards:

1. NHS 111 #2 (mental health) must be available 24/7, with sufficient capacity to provide a timely response and prevent abandoned calls. Staff must have access to a Directory of Services (DoS), to refer patients to appropriate support in a timely manner, to avoid unnecessary emergency department attendance.

2. The Adult Crisis and Home Treatment Team (CRHT) must provide a face-to-face response **within four hours (24/7)** with the management plan signed off by a senior (Tier 2) or expert (Tier 3) clinical decision-maker **within 24 hours**. CRHT must complete a full biopsychosocial assessment to formulate an urgent and emergency mental health care plan, co-produced with the patient and, where appropriate, their family or carers. This must be reviewed at least **every 24 hours**, or more frequently as clinically indicated, by a senior (Tier 2) or expert (Tier 3) clinical decision-maker.

3. Mental Health Response Vehicles (MHRVs) must be part of a core emergency mental health response to provide appropriate interventions in situ (e.g. active listening, validation) or an onward referral (e.g. to CRHT, or conveyance to crisis cafes, mental health emergency departments), as well as to reduce unnecessary conveyance to emergency departments.

4. Where a patient is detained under Section 136 or 135 of the Mental Health Act, the assessment should take place in a Health Based Place of Safety (HBPoS), which must be **available 24/7**, and identifiable to police through a managed system. Emergency departments should only be used where a HBPoS is not available or physical health care needs are present. Inappropriate use of emergency departments as a HBPoS must be monitored with appropriate operational action.

- Tees, Esk & Wear Valleys NHS Foundation Trust: NHS 111 +2 Case Study
- Mental Health Crisis Care for Londoners: Section 136 Pathway and HBPoS Specification
- RCPsych Practice Guidelines for Crisis Line Response & Crisis Resolution & Home Treatment Teams
- NHSE Mental Health Access & Waiting Time Standards
- The Model ED
- NICE Guidance NG10

Patients in the emergency department of acute hospitals

While an emergency department should never be the default option for non-emergency same day mental health care, most patients with mental health presentations also have concurrent physical health needs. It is imperative that emergency departments, acute hospitals, and mental health services work collaboratively to optimise patient experience and outcomes.

- Liaison outcome measures
- Liaison Side by Side assessment
- Mental Health Units (Use of Force) Act 2018
- NICE guidance- Self Harm
- PLAN accreditation

1. Mental Health Liaison Teams (MHLT) must respond to an emergency department referral within a **maximum of one hour** of presentation. A parallel system of mental and physical health assessment must begin at emergency department reception or triage, including a personalised risk assessment and safety plan to support the patient while they remain in the emergency department.

2. MHLT must complete a full biopsychosocial assessment, co-produce an urgent and emergency mental health care plan **within four hours** of the patient entering the emergency department. Wherever clinically appropriate and safe, the MHLT should also arrange referral, transfer or discharge within this timeframe. The assessment and care plan must be trauma-informed, proportionate and developed collaboratively with the patient and, where appropriate, their family or carers, and must include alternative treatment options such as home-based care, crisis assessment services, or crisis houses. The care plan must be reviewed at least **every 24 hours**, or more often if clinically indicated, by a senior (Tier 2) or expert (Tier 3) clinical decision-maker, particularly where undue delays occur, such as for a Mental Health Act assessment or inpatient admission.

3. Every emergency department must have at least one room suitable for high-risk assessments that meets Royal College of Psychiatrists' Psychiatric Liaison Accreditation Network (PLAN) standards and has appropriate environmental design (NG10). Emergency departments must ensure that patients with mental health needs receive care and treatment in the most suitable and least restrictive environment.

Coding of mental health presentations in the ED

Staff must complete the chief complaint and/or diagnosis field for all emergency department attendances with confirmed or suspected mental health needs for Emergency Care Data Set (ECDS) reporting. If mental health needs are uncertain, the diagnosis must be recorded as suspected. Where an injury is present, staff must complete the injury intent field and code the injury as self-inflicted only when the harm was intentional. Attendances should be recorded as mental health-related only when mental health need is the reason for the visit, not when mental health conditions are incidental.

Patients in the emergency department of acute hospitals (continued)

4 Emergency departments must provide one-to-one observation by suitably skilled healthcare staff, with the need for observation, frequency of review, medications, and brief interventions jointly agreed by emergency medicine and liaison psychiatry. All interventions must follow least-restrictive practice guidance. Acute behavioural disturbance to be managed in line with RCEM guidance.

5 Before MHLT consider admission, they must assess all community treatment options as part of their gatekeeping function, including seeking telephone advice from a CRHTT practitioner or a Tier 2 senior or Tier 3 expert clinical decision maker. If the decision maker needs to attend in person to advise or provide care, support or treatment, they must attend the emergency department immediately to avoid undue delay.

6 When a decision is made to admit a patient to a mental health ward, staff must clearly formulate the purpose of admission and the criteria for discharge. A hospital bed alone is not a treatment. The rationale must include why alternative settings are not clinically suitable. An initial treatment plan must be outlined on admission and agreed by a senior (Tier 2) or expert (Tier 3) clinical decision-maker.

7 If there is a risk of a 12-hour breach due to, for example, delays in either a Mental Health Act assessment or admission to a mental health inpatient bed, MHLT and/or the acute trust must escalate this through jointly agreed operational and on-call protocols. The patient's treatment should commence in the ED and be reviewed as per Standard 2.

8 Mental Health Trust bed management teams must operate a clear and consistently applied admissions prioritisation protocol, using principles such as those in the NHS Risk Matrix Tool, recognising the significant risks to patient safety and the poor patient experience associated with prolonged waits in an emergency department. Inpatient capacity must be managed in accordance with the Operational Pressures Escalation Level (OPEL) framework.

9 Mental health trusts must routinely monitor and address the key drivers of 12 hour+ mental health emergency department breaches, including delays related to Approved Mental Health Professionals (AMHPs) and Section 12 doctors, using the GIRFT Mental Health Emergency Department Breach Analysis Tool. Data on mental health emergency department breaches, associated incidents and patient experience must be reported to and reviewed by trust boards, with appropriate clinical and operational mitigations implemented in response.

RCEM Absconding Guidance

NHS OPEL Framework

GIRFT 12-hour+ MH ED Breach Analysis Tool

UEC MH Winter Action Cards 25-26

GETTING IT RIGHT FIRST TIME

Mental health inpatient flow

The lack of available acute admission beds (including Psychiatric Intensive Care Unit (PICU), adult and older adult organic and functional beds) can significantly delay the transfer of patients from emergency departments. To maximise inpatient capacity and minimise these delays, a proactive, flow-focused approach to inpatient care must be adopted, incorporating the following standards:

1. Admission to inpatient care must be purposeful and time-limited, with care and treatment plans linked to clearly defined outcomes that cannot be safely achieved in any other setting. These outcomes must determine criteria-led discharge and the estimated duration of admission.

2. A senior clinical decision-maker (Tier 2) or expert clinical decision-maker (Tier 3) must review care and treatment plans within twenty-four hours of admission.

3. Multidisciplinary team (MDT) formulation and care and treatment plans, including the purpose of admission and criteria for transition into the community, must be available or updated within seventy-two hours of admission.

4. There must be a daily multidisciplinary team (MDT) review focused on progress against the purpose of admission, treatment outcomes, and any barriers to discharge, with named actions allocated and tracked. Red2Green (R2G) principles should be applied to reduce unnecessary 'red days' in hospital.

5. There must be clear multi-agency systems for the escalation and resolution of patients who are deemed Clinically Ready For Discharge (CRFD), with actions allocated and tracked on a daily basis.

6. Early discharge must be facilitated by proactive in-reach from the patient's CMHT and/or CRHT, other relevant community services, in line with the principles of discharge to assess. The patient, family and carers must also be involved in co-producing the discharge plan as appropriate.

7. There must be systems in place to review patients with very long length of stay i.e. >90 days on older adult, organic and functional beds, and >60 days for adults and PICU patients.

GETTING IT RIGHT FIRST TIME

NHS England Oversight Framework

GETTING IT RIGHT FIRST TIME

NHS England

GettingItRightFirstTime.co.uk

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Getting It Right First Time (GIRFT)

@NHSGIRFT

GIRFT is part of an aligned set of programmes within NHS England

Walsall Healthcare NHS Trust

Title of Report	Exception Report from Audit Committee	Enc No: 11.1
Author:	Mary Martin, Non-Executive Director	
Presenter:	Mary Martin, Chair Audit Committee	
Date(s) of Committee Meetings since last Board meeting:	22 June 2026	

Action Required			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY**
• The Committee received a verbal update on the Cyber Assessment Framework – aligned Data Security and Protection Toolkit. The Trust is currently unable to meet 2/47 outcomes These are outcome A4A (Supply Chain) and B2A (Identity and Access Control). However, the Trust remained on track to submit a "Standards Met" position. The mandatory Internal Audit of the Trust self-assessment showed a confidence level of medium and an overall risk rating as High.	• The Cyber Assessment Framework (CAF) and Data Security & Protection Toolkit (DSPT) submission report be presented to the September 2026 Audit Committee meeting to provide further assurance on the final position following submission
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Internal Auditors presented their Final Annual Opinion which rated the Trust as having an adequate and effective framework for risk management, governance and internal control but with further enhancements required to ensure that it remains adequate and effective • The External Auditors reported they will give a "clean opinion" on the 25/26 financial statements. • The External Auditors assessment of Value for Money was an amber rating (No significant weakness, improvement recommendations made) across all three criteria: Financial Sustainability, Governance and Improving economy, efficiency and effectiveness.	• Under delegated authority from the WHT board the committee agreed to adopt the 2025/26 annual accounts. • The committee recommends the signature of the letter of representation requested by Grant Thornton (External audit) • The committee agreed to approve the Annual Report.

The Royal Wolverhampton NHS Trust

Title of Report	Exception Report from Audit Committee	Enc No: 11.1
Author:	Julie Jones, Chair of RWT Audit Committee	
Presenter:	Julie Jones, Chair of RWT Audit Committee	
Date(s) of Committee Meetings since last Board meeting:	22 June 2026	

Action Required			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☐	Yes☐No☐	Yes☐No☐	Yes☒No☐

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	**MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY**
• None	• None
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee noted the Data Security and Protection Toolkit 25/26 final submission, with 4 standards unmet against 3 objectives. • The finalised Annual Internal Audit Opinion was received, with an overall positive opinion that "the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective". • The internal audit advisory review of Clinical Coding – diabetic and respiratory patients was a positive review, with 30 advisory recommendations. • The internal audit report on the Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit was received, noting two low priority and five medium priority recommendations. • The External Auditors presented their findings reports, noting their intention to give an unqualified opinion on the Trust's financial statements and value for money. Their ISA 260 report to those charged with governance was received, noting adjusted and unadjusted audit misstatements. No high priority recommendations were raised.	• The Trust's Annual Report for the year ended 31 March 2026 was approved. • The Trust's Annual Accounts for the year ended 31 March 2026 were approved.

Tier 1 - Paper ref:	Enclosure 11.2

Report title:	Group Standing Financial Instructions and Standing Orders
Sponsoring executive:	Kevin Stringer, Group Chief Financial Officer
Report author:	Michelle Collins, Head of Financial Governance and Transactions (RWT)
Meeting title:	Group Trust Board held in Public
Date:	21st July 2026

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

The review of the Standing Orders and Standing Financial Instructions was undertaken as part of the annual review of the wider GI02 Financial Management policy. This is the first year where WHT and RWT's policies have been merged into a Group policy. The Standing Orders and Scheme of Reservation and Delegation were reviewed by the Group Chief Safety & Assurance Officer. The Standing Financial Instructions were combined utilising the current WHT format and including additional relevant items from the RWT version to bring together a Group policy.

The policy has been approved by both WHT and RWT Audit Committees in May, and the Standing Financial Instructions and Standing Orders ratified. The Group Board is asked to receive the SFIs and SOs for approval.

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?]*

WHT Audit Committee on 11th May 2026 received and ratified the SFIs and SOs
RWT Audit Committee on 12th May 2026 received and ratified the SFIs and SOs

4. Recommendation(s)/Action(s)

The RWT/WHT Group Trust Board Meeting to be held in Public is asked to receive and approve the Group Standing Financial Instructions and Standing Orders.

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

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

Report to the RWT/WHT Group Trust Board Meeting to be held in Public on 21st July 2026

1. Executive summary

2. Introduction or background

2.1 On an annual basis GI02 Financial Management Policy is reviewed, and for the first time, in line with other policies WHT and RWT Financial Management policies have been merged into one group policy.

2.2 GI02 incorporates:

- Standing Orders
- Standing Financial Instructions
- Scheme of Reservation and Delegation
- Budget Management Principles and Guidance

2.3 Amendments to the Standing Financial Instructions, the Standing Orders and and Budget Management Principles and Guidance have been ratified by the Audit Committees at the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

2.4 The wider policy G102 has been approved by both WHT and RWT Audit Committees on 11th and 12 May 2026 and comments/amendments incorporated.

3. Recommendations

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

a. Note and approve the changes made to merge the Standing Financial Instructions and Standing Orders across the two Trusts into a Group policy.

Encs:

- Group Standing Financial Instructions
- Group Standing Orders

THE ROYAL WOLVERHAMPTON NHS TRUST

WALSALL HEALTHCARE NHS TRUST

Group Standing Financial Instructions

July 2026

Document Control

Name: Standing Financial Instructions	**Version:** V11 July 2026	**Status:** Final	**Author: Head of Financial Governance and Transactions** **Director Sponsor: Group Chief Financial Officer**

Version / Amendment History	Version	Date	Author	Reason
	V1	December 2010	Deputy Chief Financial Officer	Initial document
	V2	June 2014	Deputy Chief Financial Officer	Update of limits for West Midlands CRN;
	V3	Septemb er 2014	Deputy Chief Financial Officer	Update of limits for West Midlands CRN; certain payroll documents; and Capital Business Case approval limits
	V4	March 2015	Deputy Chief Financial Officer	Update to Appendix A – Authorised Limits
	V5	May 2017	Financial Controller	Update to Appendix A – Authorised Limits
	V6	April 2019	Head of Financial Control & Assurance	Review by Head of Financial Control & Assurance including updates to job titles, inclusion of document control and general relevant update Update to Appendix A – Authorised Limits
	V7	November 2021	Deputy Chief Finance Officer	Scheduled review of policy
	V8	December 2022	Head of Financial Governance and Transactions	Update to Appendix A – Authorised Limits
	V9	December 2023	Head of Financial Governance and Transactions	Review by Head of Financial Governance and Transactions including updates to job titles, inclusion of document control and general relevant update Update to Appendix A – Authorised Limits

	V10	December 2024	Head of Financial Governance and Transactions	Review by Head of Financial Governance and Transactions including updates to job titles, inclusion of document control and general relevant update Update to Appendix A – Authorised Limits
	V11	December 2025/April 2026	Head of Financial Governance and Transactions	Review and merge into Group SFI

Intended Recipients:

This policy will apply to all persons employed by The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. This incorporates community, acute staff, employees from other health or social care providers, educational establishments, volunteers, private contractors, agency workers working within Trust premises.

Consultation Group / Role Titles and Date: Group Director of Assurance; Finance and Productivity Committee, Audit Committee, Group Chief Financial Officer, Operational Directors of Finance.

Name and date of Trust level group where reviewed	Audit Committee May 2026 Trust Policy Group August 2026
Name and date of final approval committee	Trust Board July 2026
Date of Policy issue	August 2026
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	August 2027 annually

Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.

To be read in conjunction with: Standing Orders, Scheme of Reservation and Delegation, Conflicts of Interest Policy, and Anti-Fraud and Anti-Bribery Policy

Initial Equality Impact Assessment (all policies): **Completed Yes**

Full Equality Impact assessment (as required): **Completed NA**

If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.

Contact for Review	Head of Financial Governance and Transactions
Implementation plan / arrangements (Name implementation lead)	Group Chief Financial Officer
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board

Document summary / key issues covered:

These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree SFIs for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Trust's Standing Orders (SOs).

These SFIs detail the financial responsibilities and policies adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendment.

CONTENTS

STANDING FINANCIAL INSTRUCTIONS

SECTION C - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

10.1. **General**

10.1.1. These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2. These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Reservation and Delegation adopted by the Trust.

10.1.3. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust(s), Walsall Together and any constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Group Chief Financial Officer/Operational Director of Finance.**

10.1.4. Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Group Chief Financial Officer/Operational Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders (contained within the Trust Constitution), particularly in relation to tending and contracting procedures, which were previously contained within the Trust Constitution but are now reproduced within this document for ease of reference.

10.1.5. Failure to comply with Standing Financial Instructions and Standing Orders is a disciplinary matter that could result in dismissal.

10.1.6. **Overriding Standing Financial Instructions**

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance shall be reported to the Group Chief Financial Officer/Operational Director of Finance, Company Secretary and escalated to the Audit Committee as appropriate for referring action or ratification. All members of the Trust Board and officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Group Chief Financial Officer/Operational Director of Finance as soon as possible.

10.1.7 All instances of non-compliance in relation to this Policy where there is a suspicion of fraud or bribery must be reported to the Local Counter Fraud Specialist (LCFS) for investigation in accordance with the Anti-Fraud, Bribery and Corruption Policy.

10.2. **Responsibilities and delegation**

10.2.1. **The Group Trust Board**

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model;
(b) requiring the submission and approval of budgets within approved allocations/overall

income;
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Reservation and Delegation document.

10.2.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Reservation and Delegation and SOs.. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Reservation and Delegation document adopted by the Trust.

10.2.3. **The Group Chief Executive and Group Chief Financial Officer/Operational Director of Finance**

The Group Chief Executive and Group Chief Financial Officer/Operational Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Group Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Group Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.4. It is a duty of the Group Chief Executive to ensure that existing directors and officers and all new appointees are notified of and put in a position to understand their responsibilities within these SFIs.

10.2.5. **The Group Chief Financial Officer/Operational Director of Finance**

The Group Chief Financial Officer/Operational Director of Finance is responsible for:

(a) ensuring that the SFIs are maintained and regularly reviewed.
(b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
(c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
(d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Group Chief Financial Officer/Operational Director of Finance include:

(e) the provision of financial advice to other members of the Board and employees;
(f) the design, implementation and supervision of systems of internal financial control;
(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.6. **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:
(a) the security of the property of the Trust
(b) avoiding loss
(c) exercising economy and efficiency in the use of resources
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

10.2.7. **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Group Chief Executive to ensure that such persons are made aware of this.

10.2.8. For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Group Chief Financial Officer/Operational Director of Finance.

10.2.9. It shall be the duty of any officer having evidence of, or reason to suspect, financial or other irregularities or impropriety in relation to these SFIs to report these suspicions without delay to the Group Chief Financial Officer/Operational Director of Finance and/or the Trust's Local Counter Fraud Specialist for further investigation and action as appropriate, in line with the Trust's 'Anti- Fraud, Bribery and Corruption Policy'.

11. AUDIT

11.1. **Audit Committee**

11.1.1. In accordance with Standing Orders, and following guidance from the NHS Audit Committee Handbook, the Board shall establish a committee of non-executive directors as an Audit Committee with formal terms of reference, approved by the Board, to perform such monitoring, reviewing and other functions as are appropriate to provide an independent and objective view of internal control.

11.1.2. The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

11.1.3. The Audit Committee will provide an independent and objective view of internal control by:

(a) overseeing audit arrangements, including strategic and annual audit plans for Internal and External Audit services on behalf of the Trust Board;
(b) reviewing financial information and systems and monitoring the integrity of the financial statements and reviewing significant reporting judgements, including the draft Annual Accounts;
(c) reviewing the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical);
(d) reviewing schedules of write-offs and Losses and Special Payments on behalf of the Board and reviewing all occasions on which the Trust Board waiver standing orders;
(e) ensuring that agreed actions and recommendations arising out of internal and external audit reports are appropriately progressed;
(f) monitoring compliance with SOs and SFIs;
(g) reviewing the work of other committees and other significant assurance providers, where relevant and appropriate;
(h) overseeing counter fraud arrangements provided by the Local Counter Fraud Specialist within the Trust; and is accountable for gaining assurance that sufficient control and management mechanisms in relation to counter fraud, bribery and corruption are present within the organisation; and
(i) ensuring that the function of the Audit Committee complies, as appropriate, with the latest Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook recommendations.
(j) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

11.1.4. Where the Audit Committee considers there is evidence of ultra vires transactions, evidence

of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care (to the Group Chief Financial Officer/Operational Director of Finance in the first instance.)

11.1.5. It is the responsibility of the Group Chief Financial Officer/Operational Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.1.6. Matters pertaining to fraud, bribery and/or corruption must be reported to the LCFS for investigation in accordance with the Trust's Local Anti-Fraud and Anti-Bribery Policy.

11.1.7.

11.2. **Group Chief Financial Officer/Operational Director of Finance**

11.2.1. The Group Chief Financial Officer/Operational Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
(b) ensuring that the Internal Audit is adequate and meets the Public Sector Audit Standards (PSIAS);
(c) The Group Chief Financial Officer/Operational Director of Finance is accountable for the provision of strategic management of all counter fraud, bribery and corruption work within the organisation.
(d) The Group Chief Financial Officer/Operational Director of Finance responsible for the provision of assurance to the executive board in relation to the quality and effectiveness of all counter fraud bribery and corruption work undertaken.
(e) Deciding at what stage to involve Security Management and the police in cases of misappropriation and other irregularities not involving fraud or corruption;
(f) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:
    (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
    (ii) major internal financial control weaknesses discovered;
    (iii) progress on the implementation of internal audit recommendations;
    (iv) progress against plan over the previous year;
    (v) strategic audit plan covering the coming three years;
    (vi) a detailed plan for the coming year.

11.2.2. The Group Chief Financial Officer/Operational Director of Finance, designated auditors, Local Counter Fraud Specialist and Security Management are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
(c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
(d) explanations concerning any matter under investigation.

11.2.3. The Trust's Group Chief Executive and Chief Financial Officer/Operational Director of Finance are responsible for ensuring access rights are given to NHS Counter Fraud Authority (CFA) where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with NHS CFA Standards for NHS Providers.

11.3. **Internal Audit**

11.3.1. Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) the adequacy and application of financial and other related management controls;
(c) the suitability of financial and other related management data;
(d) the efficient and effective use of resources
(e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
    (i) fraud and other offences;
    (ii) waste, extravagance, inefficient administration;
    (iii) poor value for money or other causes.
    (iv) Any form of risk, especially business and financial risk, but not exclusively so.
(f) The adequacy of follow up actions to audit reports.
(g) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care

11.3.2. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Group Chief Financial Officer/Operational Director of Finance must be notified immediately.

11.3.3. The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Group Chief Executive of the Trust.

The Head of Internal Audit shall be accountable to the Group Chief Financial Officer/Operational Director of Finance. The reporting system for internal audit shall be agreed between the Group Chief Financial Officer/Operational Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the PSIAS; Audit Code; and the DHSC Group Accounting Manual. The reporting system shall be reviewed at least every three years.

Internal Audit terms of reference shall have effect as if incorporated within these SFIs. The terms of reference cover the scope of the internal audit work, authority and independence, management responsibilities, coordination of assurance work, reporting and key outputs and the operational responsibilities.

11.4. External Audit

11.4.1. The Local Accountability and Audit Act 2014 and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015 require the Trust to appoint external auditors. Audit Committee will ensure the Trust appoints external auditors. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Trust Board if the issue cannot be resolved.

11.4.2. The External Auditor is appointed by the Audit Committee and paid for by the Trust. The Audit Committee must ensure that the Trust receives a cost-effective, efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the National Audit Office if the issue cannot be resolved.

11.5. Fraud, Bribery and Corruption

11.5.1. In line with their responsibilities, the Group Chief Executive and Group Chief Financial Officer/Operational Director of Finance shall monitor and ensure compliance with the NHS Standard Contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to the NHS Requirements of the Government Functional Standards 013: Counter Fraud.

11.5.2. The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the Trust as specified in the Government Functional Standards 013: Counter Fraud.

11.5.3. The LCFS shall report to the Group Chief Financial Officer/Operational Director of Finance and shall work with staff in the NHS Counter Fraud Authority, in accordance with the Government Functional Standards 013: Counter Fraud, the Counter Fraud Manual and the NHS Counter Fraud Authority's Investigation Case File Toolkit.

11.5.4. The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust.

11.5.5. The Trust will report annually on how it has met the requirements of Government Functional Standards 013: Counter Fraud as set by the NHS Counter Fraud Authority in relation to anti-fraud, bribery and corruption work and the Group Chief Financial Officer/Operational Director of Finance shall sign-off the annual self-review and authorise its submission to the NHS Counter Fraud Authority. The Group Chief Financial Officer/Operational Director of Finance shall sign-off the annual Counter Fraud Functional Standard Return and submit it to the NHS Counter Fraud Authority.

11.5.6. The Trust will comply with relevant government standards including the NHS Requirements of the Government Functional Standard 013: Counter Fraud; this includes NHS Requirement 1B, which includes support of the role of the Counter Fraud Champion to promote awareness of fraud, bribery and corruption within the organisation.

11.6. **Security Management**

11.6.1. In line with his/her responsibilities, the Group Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

11.6.2. The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.

12. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

12.1. **Preparation and Approval of Plans and Budgets**

12.1.1. The Group Chief Executive shall prepare at least every five years or more regularly as required, a statement of strategic direction for approval by the Board.

12.1.2. The Group Chief Executive will compile and submit to the Board an annual business plan, which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

12.1.3. Prior to the start of the financial year (or in line with the internal reporting timetable) the Group Chief Financial Officer/Operational Director of Finance will, on behalf of the Group Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan;
(b) accord with financial and other targets including workload and manpower plans;
(c) be produced following discussion with appropriate budgetholders;
(d) be prepared within the limits of available funds;
(e) identify potential risks.

12.1.4. The Group Chief Financial Officer/Operational Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to Finance &

Productivity Committee and the Board.

12.1.5. All budget holders shall provide the Group Chief Financial Officer/Operational Director of Finance with all financial, statistical and other relevant information as necessary, for the compilation of such budgets, plans, estimates and forecasts. and financial performance against budgets to be monitored.

12.1.6. All budget holders will sign up to their allocated budgets at the commencement of each financial year.

12.1.7. The Group Chief Financial Officer/Operational Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully, and the expectations for senior Budget Holders including assessment of financial risk and holding to account for delivery.

12.2. **Budgetary Delegation**

12.2.1. The Group Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

12.2.2. The Group Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

12.2.3. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Group Chief Executive, subject to any authorised use of virement.

12.2.4. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Group Chief Executive, as advised by the Group Chief Financial Officer/Operational Director of Finance.

12.3. **Budgetary Control and Reporting**

12.3.1. The Group Chief Financial Officer/Operational Director of Finance will devise and maintain systems of budgetary control. These will include:
(a) monthly financial reports to the Board in a form approved by the Board containing:
  (i) income and expenditure to date showing trends and forecast year-end position
  (ii) movements in working capital;
  (iii) summary cash flow and forecast year-end position;
  (iv) capital project spend and projected outturn against plan;
  (v) explanations of any material variances that explain any movements from the planned retained surplus/deficit position at the end of the current
  (vi) details of any corrective action where necessary and the Group Chief Executive's and/or Group Chief Financial Officer/Operational Director of Finance's view of whether such actions are sufficient to correct the situation;
(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, workload and manpower budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers.

12.3.2. The Group Chief Financial Officer/Operational Director of Finance shall keep the Group Chief Executive and the Board informed of the financial consequences of changes in policy,

pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

12.3.3. Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;
(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
(c) no permanent employees are appointed without the approval of the Group Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

12.3.4. The Group Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

12.3.5. The Trust's business case procedure is to be followed by managers when proposing service changes.

12.3.6. Finance and Productivity Committee shall monitor and review performance against Business Cases and report to the Board. Business Cases will be reported to the Board by 'exception' where benefits have not been delivered as originally approved.

12.3.7. All major business cases must be subject to a benefits realisation process, which will be monitored by the Finance and Productivity Committee.

12.4. **Capital Expenditure**

The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contracting Procedures.

12.5. **Performance Monitoring Returns**

12.5.1. The Group Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the to the Independent Regulator and any other requisite monitoring organisation within the prescribed timescales; and also that:

(a) financial performance measures have been defined and are routinely monitored;
(b) reasonable targets have been identified for these measures;
(c) a robust system is in place for managing performance against the targets;
(d) reporting lines are in place to ensure that overall performance is managed effectively; and
(e) arrangements are in place to manage/respond to adverse performance.

13. ANNUAL ACCOUNTS, REPORTS AND QUALITY ACCOUNT

13.1. **Annual Accounts**

13.1.1. The Group Chief Financial Officer/Operational Director of Finance on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS).
(b) prepare and submit annual financial reports to the Department of Health and Social Care and NHS England certified in accordance with current guidelines.
(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

13.2. **Auditing of Accounts**

The Trust's annual accounts, financial returns and annual report must be audited by the External Auditor appointed by the Audit Committee in accordance with appropriate auditing standards.

The Trust's Audited Annual Accounts (including the Auditor's report) must be presented to the Board for approval or the Audit Committee (when specifically delegated the power to do so, under the authority of the Board). The Trust's audited accounts must be made available to the public.

13.3. **Publication of Annual Report**

The Group Chief People, Culture and Improvement Officer, will, on behalf of the Trust, prepare the annual report in accordance with the NHS General Accounting Manual (GAM), the provisions of the License Self-Assessment declaration (FT4/G6), and the requirements of the Code of Governance for NHS Trusts (2023). This annual report will be presented to the Board for approval. A copy will be forwarded to the Independent Regulator in line with the prescribed timescales.

13.4. **Quality Account**

The Chief Nursing Officer on behalf of the Trust will prepare the Quality Report in the format prescribed by NHSE. The Quality Report presents a balanced picture of the Trusts performance over the financial year and up to the June submission date. The Group Chief Executive and Chair shall sign off the "Statement of Directors Responsibilities in respect of the "Quality Report" under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010 as well as NHSE Quality Account requirements.

14. BANK AND GBS ACCOUNTS

14.1. **General**

14.1.1. The Group Chief Financial Officer/Operational Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by the regulator. The Board shall approve the banking arrangements.

14.1.2. The Board shall approve the banking arrangements in line with the Treasury Management Policy.

14.1.3. The Audit Committee will review banking arrangements periodically.

14.2. **Bank and GBS Accounts**

14.2.1. The Group Chief Financial Officer/Operational Director of Finance is responsible for:

(a) bank accounts and Government Banking Services (GBS) accounts
(b) establishing separate bank accounts for the Trust's non-exchequer funds/charitable funds
(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) reporting to the Board all arrangements and instances where the bank accounts became or may have become overdrawn, and the arrangements made with the Trust's bankers.
(e) monitoring compliance with NHSE or DHSC guidance on the level of cleared funds.
(f) Ensuring covenants attached to bank borrowing are adhered to.

14.3. **Banking Procedures**

14.3.1. The Group Chief Financial Officer/Operational Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:
(a) the conditions under which each bank and GBS account is to be operated, including the overdraft limit if applicable.;
(b) those authorised to approve payments, bank transfers, sign cheques or other orders drawn on the Trust's accounts.

14.3.2. The Group Chief Financial Officer/Operational Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

14.3.3. No-one but the Group Chief Financial Officer/Operational Director of Finance shall open a bank account in the name of the Trust.

14.4. **Tendering and Review**

14.4.1. The Group Chief Financial Officer/Operational Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders or benchmarking for the Trust's commercial banking business.

14.4.2. Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

14.5. **Purchase Cards**

14.5.1. The Group Chief Financial Officer/Operational Director of Finance shall approve the allocation, limits and operation of credit/purchase cards on behalf of the Trust (in line with SFIs 20 and 23); implement arrangements to monitor whether the credit/purchase cards are being used appropriately; and take action where inappropriate use is identified.

14.5.2 Changes to the limits of purchase cards can be approved by the Group Chief Financial Officer/Operational Director of Finance.

14.5.3 All changes to limits whether temporary or permanent must be reported to the Audit Committee.

14.5.4 The Group Chief Financial Officer/Operational Director of Finance will produce detailed procedures regarding their use. See SFI 19.2 for further information

15. SERVICE AGREEMENTS FOR PROVISION OF SERVICES

15.1. **Contracts with Commissioners**

15.1.1. The Board shall regularly review and shall at all times maintain and ensure the capacity of the Trust to provide the commissioner requested services referred to in the Provider License and other Terms of Authorisation and related schedules.

15.1.2. The Group Chief Executive, as Accounting Officer, supported by the Group Chief Financial Officer/Operational Director of Finance, is responsible for ensuring that contracts are in place with commissioners for the provision of services to patients in accordance with the Business Plan.

15.1.3. Contracts with commissioners shall comply with best costing practice and shall be so devised as to minimise contractual risk whilst maximising the Trust's opportunity to generate income. Contracts with commissioners are legally binding and appropriate legal advice, identifying the organisation's liabilities under the terms of the contract, should be considered.

15.1.4. Contracts with commissioners will be signed by both parties in accordance with the Scheme of Reservation and Delegation.

15.1.5. In carrying out these functions, the Group Chief Executive should take into account the advice of the Group Chief Financial Officer/Operational Director of Finance regarding:

(a) costing and pricing of services (in accordance with the National Financial Framework) and the activity/volume of services planned;
(b) payment terms and conditions;
(c) billing systems and cash flow management to ensure all activity is captured and coded to ensure full recovery of ERF;
(d) any other matters of a financial nature;
(e) the contract negotiation process and timetable;
(f) the provision of contract data;
(g) contract monitoring arrangements;
(h) amendments to contracts; and
(i) any other matters of a legal or non-financial nature.

15.1.6. Prices should match national tariff where appropriate, but the Trust can negotiate locally agreed prices where services are not covered by the national tariff.

15.1.7. The Group Chief Financial Officer/Operational Director of Finance shall produce regular reports (in the form of service line reports) detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income. These reports will be submitted to Finance and Productivity Committee and the Trust Board.

15.1.8. The Trust will maintain a public and up-to-date schedule of the authorised goods and services which are being currently provided, including non-mandatory health services, as set out in the Trust Licence.

15.2. **Other Contracts**

15.2.1. Where the Trust enters into a relationship with another organisation for the supply or receipt of services – clinical or non-clinical – the responsible officer should ensure that an appropriate contract is in place and signed by both parties.

15.2.2. No officer shall enter into any form of contract on behalf of the Trust unless they have specific authority to do so, in line with the (Group) Scheme of Reservation and Delegation and relevant Trust policies and procedures. This applies even if the contract has no obvious financial value attached to it, e.g. agreements to advertise on Trust premises or documentation..

15.2.3. Contracts should incorporate:

(a) a description of the service and indicative activity levels;
(b) the term of the agreement;
(c) the value of the agreement;
(d) lead officers;
(e) performance and dispute resolution procedures; and
(f) risk management and governance arrangements.

15.2.4. Contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement so as to ensure value for money and to minimise any potential loss of income and maximisation of income.

15.3. **Involving Partners and Jointly Managing Risk**

15.3.1. A good contract will result from a dialogue of clinicians, users, carers, public, health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Group Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

15.3.2. The Trust has a duty to work together collaboratively with all other local stakeholders. The interests of the Trust will not be pursued where this will adversely impact upon the interests of the local health and care system as a whole.

15.3.3. Services that are looking to enter a financial or non-financial contract/SLA/memorandum of understanding for a product and/or service, clinical or non-clinical, either as a supplier or purchaser, have a responsibility to contact both the internal contracting and procurement teams; which are part of the Finance directorate, prior to entering into any agreement. Together they advise on the contractual processes that need to be undertaken to avoid non-payment and/or legal consequences.

15.3.3 The Group Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract and SLA's. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

16. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

16.1 Income Systems

16.1.1. The Group Chief Financial Officer/Operational Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, early identification, appropriate invoicing, collection and coding of all monies due.

16.1.2. All such systems shall incorporate, where practicable, the principles of internal check and separation of duties.

16.1.3. The Group Chief Financial Officer/Operational Director of Finance is also responsible for the prompt banking of all monies received.

16.2. Fees and Charges

16.2.1. The Trust shall follow the Department of Health and Social Care's guidance and regulations in setting prices for NHS service agreements.

16.2.2. The Group Chief Financial Officer/Operational Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical Standards in the NHS: Managing conflicts of interest in the NHS: guidance for staff and organisations September 2024; and the Trust's Conflicts of Interest Policy and the Trust policy on Conflicts of Interest shall be followed.

16.2.3. All employees must inform the Group Chief Financial Officer/Operational Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions in order to facilitate the timely raising of invoices and collection of debt

16.2.4. Under no circumstances will the Trust accept cash payments in any currency in excess of £15,000 in respect of any single transaction or series of transactions which appear to be linked. Any attempts by an individual to effect payment above this amount should be notified immediately to the Group Chief Financial Officer/Operational Director of Finance.

16.3. Debt Recovery

16.3.1. The Group Chief Financial Officer/Operational Director of Finance is responsible for the

appropriate recovery action on all outstanding debts.

16.3.2. Outstanding debts will be reviewed periodically and follow up action taken, dependent upon the value of the debt and length of time outstanding.

16.3.3. Income and salary overpayments not received after all attempts at recovery have failed should be dealt with in accordance with losses procedures.

16.3.4. The Group Chief Financial Officer/Operational Director of Finance is responsible for ensuring systems are in place to prevent overpayments. Where overpayment occurs systems should be in place for their detection and recovery initiated. Overpayments should be detected (or preferably prevented) and recovery initiated.

16.4. Security of Cash, Cheques and other Negotiable Instruments

16.4.1. All officers have a responsibility to ensure that any Trust monies in their possession or under their responsibility are properly safeguarded and are held securely when not in use.

16.4.2. The Group Chief Financial Officer/Operational Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, card terminals, and for coin operated machines;
(d) prescribing systems and procedures for handling cash,negotiable securities and card terminals on behalf of the Trust.

16.4.3. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOUs.

16.4.4. All cheques, postal orders, payable orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Group Chief Financial Officer/Operational Director of Finance.

16.4.5. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16.5. Free of Charge/Donated Goods/Services

16.5.1. Free of charge or donated goods or equipment from any supplier or would be supplier to the Trust must not be used to avoid the procurement regulations.

16.5.2. A budget manager or budget holder must approve in writing the acceptance of such goods or services prior to delivery. If the goods are to be donated or accepted on loan, whether for service provision or testing, before such approval may be given:

(a) an official order number must be allocated if the acquisition by this method is part of a procurement process by the Trust;
(b) the owner must provide a written indemnity to the Trust, in a form approved by the Group Director of Assurance, which will be signed, if necessary, on the Trusts behalf by the Group Chief Executive or an officer authorised by the Group Chief Executive;
(c) responsibility for maintenance and other revenue consequences must be agreed in writing and must be approved in accordance with these SFIs.

16.5.3. The acceptance of any such goods or services must be confirmed in writing to the donor/owner and, except in the case of charitable donations, such confirmation shall include a notice that the acceptance does not amount to an express or implied obligation on the Trust to continue to use

the goods/services or to purchase any goods/services.

16.5.4. The donation of clinical equipment shall undergo the same rigour as applied to an NHS funded purchase.

16.5.5. Where there are revenue consequences arising out of the donation of any asset then the donation shall not be accepted or put into use until a budget has been agreed with the Group Chief Financial Officer/Operational Director of Finance in respect of the revenue consequences.

16.6. Payment in Kind to the Trust

16.6.1 A budget manager or holder may authorise the provision by the Trust of services to third parties in return for payments in kind provided:

(a) the value received is reasonably commensurate with the value given.
(b) the arrangement is confirmed in writing to the third party under the signature of a budget manager or budget holder and a copy retained.
(c) the confirmation includes a notice that the Trust reserves the right to joint ownership on terms to be agreed or fixed by arbitration of any intellectual property arising from the collaboration between the Trust and the third party.
(d) the confirmation includes a notice that the arrangement does not bind the Trust to continue any collaboration on the terms agreed or to purchase / use the benefits of any collaboration

17. TENDERING AND CONTRACTING

17.1. Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

In particular, directors and officers should be aware of the definition of “pecuniary interest” as set out in Standing Order 7.3. Directors and/or officers with a pecuniary interest in a contract or potential contract should declare any such interest to the Group Chief Executive and should not participate in any process (including any evaluation) associated with the award of the contract

The Bribery Act 2010 replaces the fragmented and complex offences at common law and in the Prevention of Corruption Acts 1889-1916. This broadly defines the new Act:

- Two general offences of bribery:
  - Offering or giving a bribe to induce someone to behave, or to reward someone for behaving, improperly; and
  - Requesting or accepting a bribe either in exchange for acting improperly, or where the request or acceptance is itself improper.

- A corporate offence of failure by a commercial organisation to prevent a bribe being given or offered by an employee or agent of the Trust, subject to a defence of 'adequate procedures' being in place at the Trust to prevent a bribe.

- Bribing a foreign official.

Staff must be aware of the provisions of the bribery risks associated with gifts and hospitality, conflicts of interest and abuse of authority within the procurement process.

Staff should be aware of the Trust's Anti-fraud, Bribery and Corruption policy and Conflicts of Interest policy.

Staff involved in tendering, procurement and contracting processes should make declarations regularly for each transaction of any interest that they may have, or family or friends may have in a supplier.

Declarations of Interests, and gifts and hospitality should also be sought regularly from staff engaged in procurement related activities.

17.2. **Government Directives Governing Public Procurement**

The United Kingdom joined the WTO Agreement on Government procurement on 1st January 2021. Under this agreement, the European Union and the United Kingdom have taken mutual commitments to give access to each other operators for goods and services and other public procurement opportunities.

Directives by the Government Procurement Agreement promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

17.3. **E-Tendering**

The Trust should have policies and procedures in place for the control of all tendering activity carried out using an e-tendering system, this will incorporate reverse auction processes.

17.4. **Capital Investment in accordance with IFRS and Department of Health and Social Care Guidance**

17.4.1 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care, IFRS and “Estate code” in respect of capital investment and estate and property transactions.

17.4.2 In the case of management consultancy contracts the Trust is required to seek prior approval from NHSE and shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS" and guidance from NHSE.

17.5. **Formal Competitive Tendering**

17.5.1. **General Applicability**

The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the tendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC); Prior approval from NHSE is required for Management Consultancy before engaging.

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

(d) For disposals.

17.5.2. **Testing/Quotations/Tendering**

(a) Informal price testing, i.e. written competitive quotes from one or more suppliers wherever possible. £0-£10,000

(b) Competitive quotations are required from three suppliers for contracts valued at between £10,000 and £50,000

(c) Competitive tenders should be obtained for all contracts where the estimated expenditure or income is likely to exceed £50,000+

All include VAT.

17.5.3. It is a breach of regulations to split contracts to avoid appropriate tendering / quotation thresholds. The value used should be the overall contract value for the life of the equipment or service not annual costs, and including VAT.

17.5.4. The Trust shall ensure that requirements are tendered openly in a clear and transparent manner or procured via approved framework agreements. Use of approved frameworks must be in line with the requirements of the framework. Any use of frameworks which is not through a mini competition exercise, for example a direct award, should be justified with a waiver.

17.5.5. **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with SFI No. 15.

17.5.6. **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 (life of contract) including VAT;
(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with (such as procure22);
(c) regarding disposals as set out in Standing Financial Instructions No.23;

In exceptional circumstances it may be impractical to follow the tendering process. If so, a request for waiver of Standing Financial Instructions (SFIs) (relating to quotations and tenders) must be completed.

The reason for waiving competitive tendering procedures shall be documented in a permanent record and approved, before any order may be placed or any financial commitment entered into, by the relevant Executive Director and Committee.

All waivers must be completed prospectively.

If any officer is uncertain about the Trust's tendering and quotation requirements or the waiver procedure they must contact the Trust's Procurement team for advice and guidance.

Failure to plan the work properly and as a result be time restricted is not a justification for waiver. Such instances will be recorded as non-compliant and reported to the Audit Committee.

All waivers will be reported to the Audit Committee for oversight and scrutiny purposes.

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Group Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;
(e) where the requirement is covered by an existing contract;
(f) where framework agreements are in place and have been approved by the procurement department;
(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(i) where specialist expertise is required and is available from only one source;
(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for

the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned;

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

All single source waivers MUST be authorised by the Deputy Director of Procurement or Director of Procurement (upto £25k) and Operational Director of Finance/Group Chief Financial Officer (over £25k).

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

17.5.7. **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

17.5.8. **Fair and Adequate Competition**

Where the exceptions set out in SFI Nos. 17.1 and 17.5.6 do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

Business partners and suppliers should be made aware in writing of the Trust's Anti-Fraud, Bribery and Corruption policy.

All suppliers should be required to declare any personal or family relations within the NHS organisation at the pre-contract stage.

Suppliers will be asked to complete a non-collusion declaration and non-canvassing declaration as part of the tendering process. Nil return declarations need to be made, and will be routinely sought from suppliers throughout the tendering process, at both the commencement and conclusion of the process.

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded with the approval of the ISPD Procurement board.

Where only one tender is sought and/or received, the Group Chief Financial Officer/Operational Director of Finance and the Deputy Director of Procurement shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the trust.

17.5.9. **List of Approved Firms**

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Group Chief Financial Officer/Operational Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Group Chief Executive (see SFI 17.6.8 List of Approved Firms).

17.5.10. **Building and Engineering Construction Works**

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health and Social Care approval.

17.5.11. **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Group Chief Executive/Audit Committee, and be recorded in an appropriate Trust record.

17.6. **Contracting/Tendering Procedure**

17.6.1. **Invitation to tender**

(i) All invitations to tender shall be exclusively submitted through the Trusts chosen e-tendering portal and will follow the protocols within the package. The e-tendering system must be compliant with HMG Security Policy to be used up to and including HM Government Information Security Impact Level Three (Restricted) supporting Risk Management Accreditation Document Set (RMADS).

(ii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works (except for maintenance work, when Estate code guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

17.6.2. **Receipt and safe custody of tenders**

The Group Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

For electronic tenders, an electronic date/time stamp of all actions is automatically created through the eTendering service. This audit trail is available for review in real-time by all officers with appropriate access rights and cannot be edited. Tenders cannot be 'opened' or supplier information viewed until the pre-determined time and date for opening has passed.

17.6.3. **Opening tenders and Register of tenders**

(a) .

(i) The e-tendering system must maintain a full audit trail registering expressions of interest prequalification invitations, clarification questions

and responses, date of invitation to tender and closure and any late responses.

(ii) The e-tendering system will automatically reject incomplete tenders.

17.6.4. **Admissibility**

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Group Chief Executive.
(b) Where only one tender is sought and/or received, the Group Chief Executive and Group Chief Financial Officer/Operational Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer for approval by the Group Chief Financial Officer/Operational Director of Finance.

17.6.5. **Late tenders**

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Group Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.
(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Group Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.
(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Group Chief Executive or their nominated officer.

17.6.6. **Acceptance of formal tenders**

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.
(b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;
(ii) understanding of client's needs;
(iii) feasibility and credibility of proposed approach;
(iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Group Chief Executive.

(c) The use of these procedures must demonstrate that the award of the contract was:
(i) not in excess of the going market rate / price current at the time the contract

was awarded

(ii) that best value for money was achieved.

(d) All tenders should be treated as confidential and should be retained for inspection.

17.6.7. **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

17.6.8. **List of Approved Firms (see SFI No. 17.5.8 List of Approved Firms)**

(a) Responsibility for maintaining list

A manager nominated by the Group Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be considered. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) Building and Engineering Construction Works

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147) or more recent guidance.

(ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

(iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) Financial Standing and Technical Competence of Contractors

The Group Chief Financial Officer/Operational Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.7. **Exceptions to using approved contractors**

If in the opinion of the Group Chief Executive and the Group Chief Financial Officer/Operational Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Group Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

17.8. **Quotations: Competitive and non-competitive**

17.8.1. **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed the amounts as laid down in the Trust's Scheme of Reservation and Delegation.

17.8.2. **Competitive Quotations**

(a) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust; or where it can be shown that less than three is a sufficient number of quotes to ensure fair and adequate competition as appropriate to ensure the Trust receives good value for money subject to market conditions.

(b) Quotations should be in writing unless the Group Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(c) All quotations should be treated as confidential and should be retained for inspection in line with SFI Section 28, Retention of Records.

(d) The Group Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

17.8.3. **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (17.5.6 (a), (b) apply.

17.8.4. **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Group Chief Executive or Group Chief Financial Officer/Operational Director of Finance.

17.9. **Authorisation of Tenders and Competitive Quotations**

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with (e.g. an appropriate budget exists), formal authorisation and awarding of a contract is stated in the Appendix.

17.9.1 All contract awards above £50,000 to be reported to Trust Board for information

17.10. **Instances where formal competitive tendering or competitive quotation is not required**

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use the NHS Supply Chain for procurement of all goods and services unless the Group Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £10,000 (WHT) or £20,000 (RWT) the

Trust shall procure goods and services in accordance with procurement procedures approved by the Group Chief Financial Officer/Operational Director of Finance.

17.11. **Private Finance for Capital Procurement**

The Trust should normally market-test for PFI (Private Finance Initiative) funding when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Group Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care team for approval or treated as per current guidelines.
(c) The proposal must be specifically agreed by the Board of the Trust in the light of such professional advice as should be reasonably sought in particular with regard to vires.
(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.12. **Compliance requirements for all contracts**

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;
(b) Government Directives and other statutory provisions;
(c) Any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;
(d) Such guides like the NHS Standard Contract Conditions as are applicable.
(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.
(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.
(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Group Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
(h) all contracts are subject to scrutiny and penalty clauses are actioned as appropriate.

17.13. **Personnel and Agency or Temporary Staff Contracts**

The Group Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts via framework approved suppliers.

It is important to note the difference between interim and management consultancy. An interim or independent contractor refers to self-employed workers engaged by the Trust to undertake specific work for which they directly invoice the Trust. These are generally interim contractors who are covering vacant posts or interims appointed to undertake a specific piece of work i.e. project management.

Management Consultancy is a service provided by a company to provide expertise and advice to the Trust on a specific issue where the Trust does not have the skills, expertise or capacity to deliver the required piece of work or advice.

17.14. **Procurement of Consultancy Services**

The Regulators have issued specific guidance setting out expenditure delegation limits for individual organisations and requiring central Regulator approval for all consultancy engagements above a certain value. All Trust budget holders must follow the latest iteration of this guidance whenever procuring consultancy services and ensure that they are approved by the Group Chief Finance Officer/Operational Director of Finance.

For consultancy engagements the latest Regulator guidance and the rules in these SFI's apply.

17.15. **Healthcare Services Agreements**

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the Care Act 2014 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Group Chief Executive shall nominate officers to commission service agreements with providers / purchasers of healthcare in line with a commissioning plan approved by the Board.

17.16. **Disposals**

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Group Chief Executive or his nominated officer;
(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
(c) items to be disposed of with an estimated sale value of less than £10,000 (WHT) / £20,000 (RWT) this figure to be reviewed on a periodic basis;
(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

All such instances will be fully documented.

17.17. **In-house Services**

17.17.1. The Group Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.17.2. In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be setup:

(a) Specification group, comprising the Group Chief Executive or nominated officer/s and specialist.
(b) In-house tender group, comprising a nominee of the Group Chief Executive and technical support.
(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Group Chief Financial Officer/Operational Director of Finance representative. For services having a likely annual expenditure exceeding £1,000,000, a non-executive member should be a member of the evaluation team.

17.17.3. All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.17.4. The evaluation team shall make recommendations to the Board.

17.17.5. The Group Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.18. **Applicability of SFIs on Tendering and Contracting to funds held in trust**

17.18.1. These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

17.18.2. Contracts Involving Funds Held on Trust - shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Acts/Charity Commission.

18. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

18.1. **Payment to Board Members (Chair and Non-Executive Directors)**

18.1.1 The Trust will pay allowances to the Chair and the Non- Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

18.2. **Board Remuneration and Terms of Service**

18.2.1. In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

18.2.2. The Committee will:

(a) Make decisions and inform the Board about appropriate remuneration and terms of service for the Group Chief Executive, other very senior managers including:
- all aspects of salary (including any performance-related elements / bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms;
- payable expenses.

(b) Agree and inform the Board on the remuneration and terms of service of officer members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

18.2.3. The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

18.2.4. The Board will consider and need to approve proposals presented by the Group Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

18.2.5. The Trust will pay allowances to the Chair and Non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

18.3. **Funded Establishment**

18.3.1. The workforce plans incorporated within the annual budget will form the funded establishment.

18.3.2. The funded establishment of any directorate or department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Group Chief Executive or Group Chief Financial Officer/Operational Director of Finance or their delegated officer.

18.3.3. Each Director must ensure that all of their budget holders operate within the agreed staffing establishment.

18.4. **Staff Appointments**

18.4.1. No officer or member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Group Chief Executive or nominated representative;

(b) within the limit of their approved budget and funded establishment.

(c) subject to a regular vacancy control panel (VCP) check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits. Ensure that approval is at an Executive level.

18.4.2. The Board will approve procedures presented by the Group Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

18.4.3. All staff engagements must comply with the latest regulations on staff appointments issued by the Independent Regulator and HM Revenue and Customs (HMRC).

18.4.4. Non-Clinical Agency can only be authorised at Director level and then will be forwarded to ICB for further authorisation.

18.4.5. Agency staff to be authorised by Executives or named senior managers.

18.4.6. Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll

18.5. **Payroll Arrangements**

18.5.1. The Group Chief Financial Officer/Operational Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

18.5.2. The Group Chief Financial Officer/Operational Director of Finance will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees, expenses and allowances;
(c) maintenance of subsidiary records for pension schemes, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act and General Data Protection Regulations (GDPR);
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheque, bank credit including BACS, or cash to employees and officers;
(I) procedures for the recall of cheques and bank credits including BACS;

(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;
(l) separation of duties of preparing records and handling cash;
(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

18.5.3. Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, travel, subsistence and removal expenses claims and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Group Chief Financial Officer/Operational Director of Finance's instructions and in the form prescribed by the Group Chief Financial Officer/Operational Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Group Chief Financial Officer/Operational Director of Finance must be informed immediately to consider appropriate action to prevent or recover any overpayment.

18.5.4. Regardless of the arrangements for providing the payroll service, the Group Chief Financial Officer/Operational Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

Managers and employees are jointly responsible and accountable for ensuring that claims for pay and expenses are timely and correct.

18.5.5. All employees have a responsibility to check their own payslips each month and bring any under or overpayments to the attention of the Trust's Payroll and Pensions department as soon as discovered so that appropriate corrective action can be taken. The Trust has specific policies in relation to the recovery of salary overpayments and also the correcting of salary underpayments.

18.6. **Contracts of Employment**

18.6.1. The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and
(b) dealing with variations to, or termination of, contracts of employment.

18.7. **Agency, Self-employed or Third Party Workers including Contract for Services and IR35**

18.7.1. Where exceptional circumstances exist within a department and agency, self- employed workers or workers supplied via a third party are to be retained then:

(a) the contract may only be entered into by a budget holder having sufficient resources within the limit of their budget who is authorised for that purpose by the Group Chief Executive or their delegated officer; and

(b) the Group Chief Financial Officer/Operational Director of Finance shall be consulted if the contractor is not on the current list of authorised suppliers; and

(c) the lead for Workforce shall be consulted with regard to the remuneration package; and

(d) contractual provisions shall be in place which allow the Trust to seek assurance regarding the income tax and national insurance contribution obligations of the engagee and the ability to terminate the contract if that assurance is not provided; and

(e) appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenues & Customs in line with current legal and regulatory requirements.

19. NON-PAY EXPENDITURE

19.1. Delegation of Authority

19.1.1. The Board will approve the level of non-pay expenditure on an annual basis and the Group Chief Executive will determine the level of delegation to budget managers (including approval of credit notes).

19.1.2. The Scheme of Reservation and Delegationwill set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;
(b) the maximum level of each requisition and the system for authorisation above that level.

19.1.3. The Scheme of Reservation and Delegation shall set out procedures on the seeking of professional advice regarding the supply of goods and services and this shall be followed when entering into any agreement. Contract terms and conditions used in contract shall only be those approved by the Trust.

19.1.4. Before entering in to contracts for the supply of goods and services or works contracts and especially overseas contacts, taxation advice (including where appropriate customs advise) shall be obtained from the Group Chief Financial Officer. Agreement of the Group Chief Financial Officer and also where relevant the Group Director of Estates, Facilities and Capital Development shall be obtained before entering into any potentially novel or contentious arrangement with a supplier or contractor.

19.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

19.2.1. Official Ordering and Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Group Chief Financial Officer/Operational Director of Finance (and/or the Group Chief Executive) shall be consulted.

19.2.2. System of Payment and Payment Verification

The Group Chief Financial Officer/Operational Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

19.2.3. The Group Chief Financial Officer/Operational Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;
(b) prepare procedural instructions or guidance within the Scheme of Reservation and Delegation on the obtaining of goods, works and services incorporating the thresholds;
(c) be responsible for the prompt payment of all properly authorised accounts and claims;
(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of employees (including specimens of their signatures) authorised to certify invoices and facilitate release of payment for goods and services.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- in the case of expenses claims, authorisation confirms that the claims reflect travel and journeys which were necessary in discharging the employee's work-related duties, and that the claim has been submitted within 3 months of the expense being necessarily incurred;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct, with discounts having being taken as appropriate;
- VAT has been correctly accounted for with the recovery being identified where appropriate; and
- the account is in order for payment, containing a valid cost code.

(iii) A timetable and system for submission to Group Chief Financial Officer/Operational Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 19.2.4 (Prepayments) below.

19.2.4. **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the economic advantages outweigh the disadvantages.
(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;
(c) The Group Chief Financial Officer/Operational Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account Government public procurement rules where the contract is above

a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Group Chief Executive if problems are encountered.

Exceptions to the requirements of (b) and (c) above are:

(i) Service and maintenance contracts which require payment when the contract commences;

(ii) Minor services such as training courses, conference bookings;

(iii) Prepayments of up to £500 where a value for money and financial risk assessment demonstrates clear advantage in early payment

19.2.5. **Purchase Cards**

19.2.5.1 The Purchasing Card

The main purpose of the Purchasing Card Scheme is to simplify the purchase of low value goods by avoiding, wherever possible, the generation and handling of paperwork, whilst maintaining accountability and audit trails.

It may also be used for those suppliers whose only acceptable payment method is card payment and/or for those items which cannot be transacted through the traditional purchase order route.

Purchasing Cards are for use ONLY in relation to the business of the Trust, including RWT Charity.

Goods can only be delivered to Trust premises.

Each card is issued to a single named cardholder and has pre-agreed limits on the value of single transactions and monthly expenditure, and categories of spend.

19.2.5.2 When to use the Card.

When the Cardholder decides to use their card, they must consider;-

(i) If the item/service they wish to order falls within the categories for which their card is set up, and is the item/service allowed to be ordered via the card in accordance with this guidance document?

(ii) Will the cost be within their credit limit (including vat, Postage and Packing or Delivery charges)?

If the answer to either of these points is 'No', then normal purchasing procedures (NHS Supply Chain or E-Proc) should be followed.

The cardholder also needs to consider if the items/service represents best "Value for Money". Further advice on VFM and access to NHS Contracts is available by contacting any member of the Procurement Dept.

19.2.5.3 How to use the Card

A purchase should never be split to avoid control limits.

The Purchasing Card should never be used to withdraw cash, and this action will be blocked on card issue.

The Purchasing card should never be used where a contract or Framework Agreement is in existence

The Card is set up with permitted categories of spend. Card Holders are not able to purchase outside of these categories.

The Cardholder is responsible for the completion of the Transaction Log as per the Purchasing Card guidance. This allows spend against the card to be monitored and audited. The Cardholder should check that the details on the monthly statement agree to the transaction log. If they do not, the Cardholder should attempt to rectify missing payments with the supplier where possible before contacting the Card Administrator to report any fraudulent purchases made against the card.

19.2.5.4 Misuse of Purchasing Card

The Purchasing Card must be used only as instructed by the Trust and used solely for purchases on behalf of the Trust. Although the card bears the Cardholder's name, the account and therefore the liability remain with the Trust and RWT Charity. There is no consequential impact on personal credit status.

The use of the card for any purpose that is not in accordance with the Purchase Card guidelines in this document may result in disciplinary action.

If a Cardholder does not comply with the instructions within Purchase Card Procedure Manual, the card can be removed, and disciplinary action may be taken.

All statements will be checked and audited for misappropriation of Trust monies. Detailed analysis data is available from the bank and is be used by the Trust for audit purposes.

19.2.6. **Petty Cash**

19.2.6.1 Petty cash floats

Petty cash floats are intended for patients' travel reimbursements and small departmental purchases where alternative purchase routes are not available. Under normal circumstances petty cash payments should only arise in the exceptional circumstances for low cost goods or services e.g. purchase of postage stamps or for minor urgent payments where purchasing via a Requisition/Purchase Order would compromise service delivery.

19.2.6.2 Petty cash claims

Petty Cash claims have an upper limit of £100 per single transaction. Receipts must not be split into separate claims in an effort to circumvent the £100 limit. General Office will only pay out £20 over the counter and any amounts over this have to be requested via email to the General Office email box rwh-tr.GeneralOfficeNX@nhs.net. General Office will then advise when the cash is ready to collect.

19.2.6.3 Petty cash approval

Prior to an employee spending their own money for Trust goods and services, approval must be obtained from an authorised signatory. The authorised signatory must be a different person to the petty cash claimant.

Staff are advised to claim their money as soon as possible. There is a three month limit on petty cash reimbursement.

19.2.6.4 Items that cannot be reimbursed

Examples of items that cannot be reimbursed through petty cash:

- Alcohol and Tobacco

- Expenditure on staff parties and staff presents
- Staff flowers
- Staff meals/accommodation whilst on courses – to be claimed via e-expenses system in line with Study Leave and Expenses Policy.
- Staff travel/parking/petrol: staff to claim via e-expenses system
- Petrol for lease cars: staff to claim via e-expenses system
- Reimbursement of company invoices
- Crockery, plates and cups for use by staff
- Staff/Client Refreshments (Drinks/Food)
- Staff salary must always be claimed through the normal payroll process as there may be possible tax implications.

19.2.6.5 Petty cash fraud

The Trust is committed to reducing fraud in the NHS as it diverts valuable resources away from patient care. Therefore, consideration has been given to the potential for fraud and corruption to occur in relation to this procedure and what action should be taken. Fraud is regarded by the Trust as a serious offence and is classified as gross misconduct. Failure to comply with or breaches of petty cash procedures may lead to an investigation in line with the Trust's Fraud, Bribery and Corruption Policy and / or Disciplinary Policy and Procedure. The Trust will ensure that the correct sanction is imposed against individual members of staff. Note: General Office can defer payment on any claim that is thought to be inappropriate Trust expenditure, until the matter has been referred to the Finance Department for a final decision.

19.2.7. **Official orders**

Official orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Group Chief Financial Officer/Operational Director of Finance;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Group Chief Executive.

19.2.8. **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Group Chief Financial Officer and that:

(a) all contracts (except as otherwise provided for in the Scheme of Reservation and Delegation) leases, tenancy agreements and other commitments which may result in a liability are notified to the Group Chief Financial Officer/Operational Director of Finance in advance of any commitment being made;
(b) contracts above specified thresholds are advertised and awarded in accordance with Government rules on public procurement;
(c) where consultancy advice is being obtained, the procurement of such advice must have prior approval from NHSE and be in accordance with guidance issued by the Department of Health and Social Care and NHS England
(d) Comply with Procurement Policy Notices issued by the Cabinet Office
(e) Offers of gifts and hospitality should be dealt with in line with the trust conflicts of interest policy.
(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Group Chief Financial Officer/Operational Director of Finance on behalf of the Group Chief Executive;
(g) all goods, services, or works are ordered on an official order except works and services

executed in accordance with a contract and purchases from petty cash or the purchasing card;

(h) verbal orders must only be issued very exceptionally - by an employee designated by the Group Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Group Chief Financial Officer/Operational Director of Finance;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Group Chief Financial Officer/Operational Director of Finance;

(m) petty cash records and purchases made using the Trust's credit card are maintained in a form as determined by the Group Chief Financial Officer/Operational Director of Finance.

(n) invoice/Purchase Order approvals are actioned in a timely manner to ensure late payment interest is avoided and BPPC target is achieved.

(o) Be raised for all goods/services in advance of receipt unless expressly excluded in SFIs

19.2.9. The Group Chief Executive and Group Chief Financial Officer/Operational Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with all applicable guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

19.3. **Joint Finance Arrangements with Local Authorities and Voluntary Bodies**

19.3.1. Payments to local authorities and voluntary organisations made under the powers of section 256 & 257 of the NHS Act 2006 **shall** comply with procedures laid down by the Group Chief Financial Officer/Operational Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

19.3.2 Section 75 partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated and functions can be reallocated between partners.

20. EXTERNAL BORROWING & INVESTMENTS

The Group Chief Financial Officer will be responsible for the management of the Trust's cash flow.

20.1. **External Borrowing**

20.1.1. The Group Chief Financial Officer/Operational Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay Public Dividend Capital (PDC) and any proposed new borrowing within the limits set by the Department of Health and Social Care. The Group Chief Financial Officer/Operational Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt (PDC) and all loans, overdrafts and associated interest.

20.1.2. The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Group Chief Executive, Deputy Group Chief Executive and the Group Chief Financial Officer/Operational Director of Finance.

20.1.3. The Group Chief Financial Officer/Operational Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts. Any application for a

loan or overdraft will only be made by the Group Chief Financial Officer/Operational Director of Finance or by an employee so delegated by them.

20.1.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and Social Care.

20.1.5. Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Group Chief Executive, Group Chief Financial Officer/Operational Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

20.1.6. All long-term borrowing must be consistent with the plans outlined in the current Annual Plan and be approved by the Trust Board as reported to the Department of Health and Social Care.

20.2. **Investments**

20.2.1. The Audit Committee will review and approve the Trust's Treasury Management Policy

20.2.2. Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Department of Health and Social Care and authorised by the Board

20.2.3. The Group Chief Financial Officer/Operational Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

20.2.4. The Group Chief Financial Officer/Operational Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

21. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

21.1. **Capital Investment**

21.1.1. The Group Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

21.1.2. For every capital expenditure proposal the Group Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the current Department of Health and Social Care guidance) is produced setting out:
  (i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
  (ii) the involvement of appropriate Trust personnel and external agencies;
  (iii) appropriate project management and control arrangements;
  (iv) that the Group Chief Financial Officer/Operational Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to NHSE and/or the Department of Health and Social Care in line with the current guidelines.

Every business case requiring authorisation above the division/directorate's delegated authorities will need an executive sponsor.

21.1.3. For capital schemes where the contracts stipulate stage payments, the Group Chief Executive will issue procedures for their management, incorporating the recommendations of Department of Health and Social Care.

21.1.4. The Group Chief Financial Officer/Operational Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs guidance.

21.1.5. The Group Chief Financial Officer/Operational Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure., which as a minimum shall include reporting to the Board on:

(a) The individual scheme/projects;
(b) The source and level of funding; and
(c) The expenditure incurred against the annual profile.

21.1.6. The approval of a capital programme shall not constitute approval for expenditure on any scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

The Group Chief Executive shall issue to the manager responsible for any scheme:
(a) specific authority to commit expenditure;
(b) authority to proceed to tender ;
(c) approval to accept a successful tender.

The Group Chief Executive will issue a Scheme of Reservation and Delegation for capital investment management and the Trust's Standing Orders.

21.1.7. The Group Chief Financial Officer/Operational Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as notified by the Department of Health and Social Care.

21.2. **Private Finance**

21.2.1. The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Group Chief Financial Officer/Operational Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care or in line with any current guidelines.
(c) The proposal must be specifically agreed by the Board.

21.3. **Asset Registers**

21.3.1. The Group Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Group Chief Financial Officer/Operational Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted at least once a year.

21.3.2. Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified within the International Financial Reporting Standards, (IFRS) and Capital Accounting Manual as issued by the Department of Health and Social Care.

21.3.3. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets held under a finance lease and capitalised.

21.3.4. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

21.3.5. The Group Chief Financial Officer/Operational Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

21.3.6. The value of each asset shall be indexed to current values in accordance with methods specified in IFRS or as specifically directed by the Department of Health and Social Care.

21.3.7. The value of each asset shall be depreciated using methods and rates as specified in IFRS or as specifically directed by the Department of Health and Social Care

21.3.8. The Group Chief Financial Officer/Operational Director of Finance shall calculate and pay capital charges as specified IFRS or as specifically directed by the Department of Health and Social Care.

21.3.9. All departments must ensure that where equipment is loaned out, it is reported to the Finance Department. A register of loan equipment will be maintained on behalf of the Group Chief Financial Officer/Operational Director of Finance.

21.3.10. The Group Chief Financial Officer/Operational Director of Finance shall calculate and pay PDC dividend as specified by the Department of Health and Social Care

21.4. **Security of Assets**

21.4.1. The overall control of fixed assets is the responsibility of the Group Chief Executive.

21.4.2. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Group Chief Financial Officer/Operational Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset;
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

21.4.3. All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Group Chief Financial Officer/Operational Director of Finance.

21.4.4. Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

21.4.5. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

21.4.6. Where practical, assets should be marked as Trust property.

21.5. **Contract Framework Agreements**

21.5.1. Contract framework agreements (including P22 schemes) should always be considered for all construction projects and used where in line with best practice as set out by HM treasury and the Cabinet Office as a set out in Health Building Notes – Strategic framework for the efficient management of health care estates and facilities. The management of contracts awarded under the P22 Framework Agreement shall follow the current guidelines issued by the Department of Health and Social Care.

21.5.2. All Contractual Framework Agreements should be reviewed at regular intervals, usually annually, to ensure anticipated benefits are being realised and that cost improvements and value for money objectives are achieved.

21.5.3. The Contractual Framework Agreement shall be subject to formal tender procedures and shall comply with the prevailing directives governing public procurement .

21.5.4. The Group Chief Financial Officer/Operational Director of Finance shall issue procedure notes governing the control, management, reporting and audit arrangements of the Contract Framework Agreement.

21.5.5. The committee overseeing the capital programme shall receive regular reports on the performance of the Contract Framework Agreement and detailed project progress reports on all on going schemes.

21.5.6. Any capital monies spent should be in accordance with the requirements laid down in the Manual for Accounts as issues by the Department of Health and Social Care.

21.6. **Leases**

21.6.1. Where it is proposed that leasing shall be considered in preference to capital procurement then the following should apply:

(a) the selection of a contract/finance company shall be on the basis of competitive tendering and quotations sought via the procurement department;

(b) All proposals to enter into a leasing agreement shall be referred to the Group Chief Finance Officer/Operational Director of Finance before acceptance of any offer;

(c) The Group Chief Finance Officer/Operational Director of Finance shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Group Chief Finance Officer/Operational Director of Finance prior to acceptance of any offer to the lease.

In the case of property leases the guidance in the Health Building Note – Strategic framework for the efficient management of healthcare estates and facilities shall be followed.

22. STORES AND RECEIPT OF GOODS

22.1. **General position**

22.1.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take (there shall be a physical check covering all items in store at least once a year);
(c) valued at the lower of cost and net realisable value.

22.2. **Control of Stores, Stocktaking, Condemnations and Disposal**

22.2.1. Subject to the responsibility of the Group Chief Financial Officer/Operational Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Group Chief Executive. The day-to-day responsibility may be delegated by the Group Chief Executive to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Group Chief Financial Officer/Operational Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any other stores such as theatres or fuel oil shall be the responsibility of a designated manager

22.2.2. The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

22.2.3. The Group Chief Financial Officer/Operational Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

22.2.4. Stocktaking arrangements shall be agreed with the Group Chief Financial Officer/Operational Director of Finance and there shall be a physical check covering all items in store at least once a year. External Audit and Internal Audit will be consulted on appropriate levels of stocktaking to ensure the trust has control but not onerous stock counting. High value items will be counted at least once per year. In exceptional circumstances alternative arrangements may be agreed with the Group Chief Financial Officer/Operational Director of Finance.

22.2.5. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Group Chief Financial Officer/Operational Director of Finance.

22.2.6. The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Group Chief Financial Officer/Operational Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Group Chief Financial Officer/Operational Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

22.3. **Goods supplied by NHS Supply Chain**

22.3.1. For goods supplied via the NHS Supply Chain central warehouses, the Group Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Group Chief Financial Officer/Operational Director of Finance who shall satisfy themselves that the goods have been received before accepting the recharge. If there are any discrepancies these should be reported to the Group Chief Finance Officer/Operational Director of Finance or delegated officer to avoid overpayments where such discrepancies cannot be resolved via the procurement team.

23. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

23.1. **Disposals and Condemnations**

23.1.1. **Procedures**

The Group Chief Financial Officer/Operational Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

23.1.2. When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Group Chief Financial Officer/Operational Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

23.1.3. All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Group Chief Financial Officer/Operational Director of Finance;
(b) recorded by the Condemning Officer in a form approved by the Group Chief Financial Officer/Operational Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Group Chief Financial Officer/Operational Director of Finance.

23.1.4. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Group Chief Financial Officer/Operational Director of Finance who will take the appropriate action.

23.2. **Losses and Special Payments**

23.2.1. **Procedures**

The Group Chief Financial Officer/Operational Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

23.2.2. Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their supervisor, line manager and head of department, except where fraud, bribery or corruption is suspected in which case a referral must be made to LCFS for investigation in accordance with the Trust's Local Anti-Fraud and Anti-Bribery Policy. The senior officer must immediately inform the Chief Executive and the Group Chief Financial Officer/Operational Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Group Chief Financial Officer/Operational Director of Finance and Group Chief Executive.

The Group Chief Financial Officer/Operational Director of Finance must notify the NHSCFA and the External Auditor of all frauds.

Where a criminal offence is suspected, the Group Chief Financial Officer/Operational Director of Finance must immediately inform the police if theft or arson is involved.

23.2.3 For significant losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Group Chief Financial Officer/Operational Director of Finance must immediately notify:

(a) the Board,
(b) the External Auditor.

23.2.4 Within limits delegated to it by the Department of Health and Social Care, the Audit Committee shall approve the writing-off of losses (including invoices and adjusting debtors in the balance sheet).

23.2.5 The Group Chief Financial Officer/Operational Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

23.2.6 For any loss, the Group Chief Financial Officer/Operational Director of Finance should consider whether any insurance claim can be made.

23.2.7 The Group Chief Financial Officer/Operational Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

23.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

23.2.9 NHS England must be consulted before making any special payments that are novel, contentious or repercussive.

23.2.10 All losses and special payments must be reported to the Audit Committee at regular intervals.

24 INFORMATION TECHNOLOGY AND DATA SECURITY

24.1 Responsibilities and Duties Group Chief Financial Officer/Operational Director of Finance

24.1.1 The Group Chief Finance Officer/Operational Director of Finance and SIRO is responsible for the accuracy and security of the computerised performance and financial data of the Trust they shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and the GDPR 2018.
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director or Data Protection Officer may consider necessary are being carried out.

24.1.2 The Group Chief Finance Officer/Operational Director of Finance and SIRO shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

24.2 Responsibilities and Duties of other Directors and Officers

24.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Group Chief Finance Officer/Operational Director of Finance and the SIRO:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

24.2.2 The Group Director of Assurance (WHT) / Chief Medical Officer (RWT) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

24.2.3 The Trust shall nominate an executive director or other senior member of the Board (or

equivalent senior management group/committee) to be responsible to the Board for information risk management, called a senior information risk owner (SIRO). The role of the SIRO is defined within the information governance toolkit. The SIRO is the leading advocate for information risk to the Board, advising on how information security risks could impact upon the strategic goals of the Trust.

24.3 Contracts for Computer Services with other health bodies or outside agencies

The Group Chief Finance Officer/Operational Director of Finance and SIRO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Group Chief Finance Officer/Operational Director of Finance and SIRO shall periodically seek assurances that adequate controls are in operation.

24.4 Risk Assessment

The Group Chief Executive and SIRO shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Group Chief Financial Officer/Operational Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Group Chief Financial Officer/Operational Director of Finance staff have access to such data;
(d) such computer audit reviews as are considered necessary are being carried out.

25 PATIENTS' PROPERTY

25.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital, or dead on arrival.

25.2 The Group Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

25.3 The Chief Operating Officer in liaison with the Group Chief Financial Officer/Operational Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the

management of a patient's money in order to maximise the benefits to the patient.

25.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Group Chief Financial Officer/Operational Director of Finance.

25.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 https://www.legislation.gov.uk/ukpga/1965/32/contents the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

25.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

25.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

25.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care and Department of Social Security instructions and guidelines.

26. FUNDS HELD ON TRUST

26.1. Corporate Trustee

Standing Order No. 2.9 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, and the need for compliance with Charities Commission latest guidance and best practice.

The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non- charitable purposes.

The Group Chief Financial Officer/Operational Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

26.2. Accountability to Charity Commission and Secretary of State for Health and Social Care

Although the management processes may overlap with those of the Organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

The Schedule of Matters Reserved to the Board and the Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

26.3. Applicability of Standing Financial Instructions to funds held on Trust

In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on Trust.

The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

The Group Chief Financial Officer/Operational Director of Finance is to arrange for the administration of all existing trusts in conjunction with the Legal Adviser if appropriate. They are to ensure that a governing instrument exists for every trust and are to produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines are to identify the restricted nature of certain funds.

The Group Chief Financial Officer/Operational Director of Finance is to periodically review the funds in existence and make recommendations, where appropriate. The Group Chief Financial Officer/Operational Director of Finance may recommend an increase in the number of funds where this is consistent with this Body's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific stations or departments.

26.4. **Sources of New Funds**

Donations. In respect of donations, the Group Chief Financial Officer/Operational Director of Finance is to:

a. provide guidelines to officers of the Trust as to how to proceed when offered funds. These include:
   i. the identification of the donors intentions;
   ii. where possible, the avoidance of new trusts;
   iii. the avoidance of impossible, undesirable or administratively difficult objects;
   iv. sources of immediate further advice;
   v. treatment of offers for personal gifts; and
b. provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's trust funds and that the donor's intentions have been noted and accepted.

Legacies and Bequests. The Group Chief Financial Officer/Operational Director of Finance is to:

a. provide guidelines to officers of the Trust covering any approach regarding:
   i. the wording of wills; and
   ii. the receipt of funds/other assets from executors;
b. where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Trust is the beneficiary.;
c. be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty.; and
d. be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

Fund-raising. The Group Chief Financial Officer/Operational Director of Finance is to:

a. after consultation with the Legal Adviser, deal with all arrangements for fund- raising by and/or on behalf of the Trust and ensure compliance with all statutes and regulations;
b. be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge. The Group Chief Financial Officer/Operational Director of Finance is the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;
c. be responsible, along with the Legal Adviser, for alerting the Board to any irregularities regarding the use of the Trust's name or its registration numbers; and
d. be responsible, after due consultation with the Legal Adviser, for the appropriate treatment of all funds received from this source.

Trading Income. The Group Chief Financial Officer/Operational Director of Finance is to:

a. be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by the Trust as corporate trustee; and
b. be primarily responsible, along with the Legal Adviser, for the appropriate treatment of

all funds received from this source.

Investment Income. The Group Chief Financial Officer/Operational Director of Finance is responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

26.5. **Investment Management**

The Group Chief Financial Officer/Operational Director of Finance is to be responsible for all aspects of the management of the investment of funds held on trust. The issues on which advice is to be provided to the Board include:

a. in conjunction with the Legal Adviser, the formulation of investment policy within the powers of the Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;
b. the appointment of advisers, brokers, and, where appropriate, fund managers:
   i. the Group Chief Financial Officer/Operational Director of Finance is to agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which
   ii. written agreements are to be signed by the Group Chief Executive;
c. pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;
d. the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;
e. that the use of Trust assets are to be appropriately authorised in writing and charges raised within policy guidelines;
f. the review of the performance of brokers and fund managers; and
g. the reporting of investment performance.

26.6. **Disposition Management**

The exercise of the Trust's dispositive discretion is to be managed by the Group Chief Financial Officer/Operational Director of Finance in conjunction with the Board. In so doing the Group Chief Financial Officer/Operational Director of Finance is to be aware of the following:

a. the objects of various funds and the designated objectives;
b. the availability of liquid funds within each trust;
c. the powers of delegation available to commit resources;
d. the avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer is discharged by trust funds at the earliest possible time;
e. that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and
f. the definitions of 'charitable purposes" as agreed by the DHSC with the Charity Commission.

26.7. **Banking Services**

The Group Chief Financial Officer/Operational Director of Finance is to advise the Board and, with its approval, is to ensure that appropriate banking services are available to the trust as corporate trustee. These bank accounts are to permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

26.8. **Asset Management**

Assets in the ownership of or used by the Trust as corporate trustee, are to be maintained along with the general estate and inventory of assets of the Trust. The Group Chief Financial Officer/Operational Director of Finance is to ensure:

a. in conjunction with the Legal Adviser, that appropriate records of all assets owned by

the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

b. that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

c. that donated assets received on trust rather than into the ownership of the Secretary of State are accounted for appropriately; and

d. that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Secretary of State.

26.9. **Reporting**

The Group Chief Financial Officer/Operational Director of Finance is to ensure that regular reports are made to the Board with regard to, *inter alia*, the receipt of funds, investments, and the disposition of resources.

The Group Chief Financial Officer/Operational Director of Finance is to prepare annual accounts in the required manner, which is to be submitted to the Board within agreed timescales.

The Group Chief Financial Officer/Operational Director of Finance, in conjunction with the Legal Adviser, is to prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the DHSC and to the Charity Commission for adoption by the Board.

26.10. **Accounting and Audit**

The Group Chief Financial Officer/Operational Director of Finance is to maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

The Group Chief Financial Officer/Operational Director of Finance is to ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. The Chief Financial Officer/Operational Director of Finance will liaise with external audit and provide them with all necessary information.

The Board is to be advised by the Group Chief Financial Officer/Operational Director of Finance on the outcome of the annual audit. The Group Chief Executive is to submit the Management Letter to the Board.

26.11. **Administration Costs**

The Group Chief Financial Officer/Operational Director of Finance is to identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, is to charge such costs to the appropriate trust accounts.

26.12. **Taxation and Excise Duty**

The Group Chief Financial Officer/Operational Director of Finance is to ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

27. ACCEPTANCE OF GIFTS BY STAFF

27.1. The Group Group Director of Assurance shall ensure that all staff are made aware of the trust's Conflicts of Interest Policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance issued by NHSE "Managing Conflicts of Interest in the NHS" and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

27.2 This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;
b) Conduct by an individual in a position to influence purchases;
c) Employment and business which may conflict with the interests of the Trust;
d) Relationships which may conflict with the interests of the Trust;
e) Hospitality and gifts and other benefits in kind such as sponsorship.

27.3 Declarations relating to the above must be made to the Group Director of Assurance via Civica for inclusion in the Register of Interests.

27.4 Staff must be made aware of and follow the law as set out in the Bribery Act 2010 at all times. Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

28. RETENTION OF RECORDS

28.1. The Group Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with NHS England and Department of Health and Social Care guidelines.

28.2. The records held in archives shall be capable of retrieval by authorised persons.

28.3. Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed before the specified guidance limits at the express authority of the Group Chief Executive or Group Chief Financial Officer/Operational Director of Finance. Proper details shall be maintained of records and information so destroyed.

29. RISK MANAGEMENT AND INSURANCE

29.1. **Programme of Risk Management**

The Group Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;
b) engendering among all levels of staff a positive attitude towards the control of risk;
c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
d) contingency plans to offset the impact of adverse events;
e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
f) a clear indication of which risks shall be insured;
g) arrangements to review the Risk Management programme.
h) appropriate levels of external accreditation.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health and Social Care guidance.

29.2. **Insurance: Risk Pooling Schemes administered by NHS Resolution**

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution (NHSR) or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the NHSR for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually

29.3. **Insurance Arrangements with Commercial Insurers**

There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **four exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

1) insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use;

2) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool.

   Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

4) Where it is necessary to ensure that the Trust is able to continue providing a service where adequate levels of insurance are not available under any of the schemes administered by the NHSR, the Trust arranges a policy in the name of "the employees of the Trust" or "members, for the time being, of a specific team". In such cases, the premium must be:
   i. Paid by the use of charitable funds, providing the Trust establishes through the Charities Commission, or other relevant regulatory bod, whether this is an appropriate use of funds, or

   ii. Paid by members of the team and then reimbursed by the Trust, or

   iii. Paid by the Trust, provided this is with the recognition, and approval, of the Group Chief Finance Officer and/or internal audit.

   In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Group Chief Financial Officer should first consult the NHSR and then the Department of Health and Social Care.

29.4. **Arrangements to be followed by the Board in agreeing Insurance Cover**

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Group Chief Financial Officer/Operational Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Group Chief Financial Officer/Operational Director of Finance shall ensure that documented procedures cover these arrangements.

(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Group Chief Financial Officer/Operational Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Group Chief Financial Officer/Operational Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses, which will not be reimbursed.

(c) All the NHSR risk pooling schemes require Scheme members to make some

contribution to the settlement of claims (the 'deductible'). The Group Chief Financial Officer/Operational Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

30. INTERNATIONAL FINANCIAL REPORTING STANDARDS (IFRS)

30.1 The Trust is required to report all its financial transactions in compliance with IFRS subject to amendments issued by the Department of Health and Social Care through the NHS Manual of Accounts. It is important that the reporting requirements of IFRS are anticipated and provided for when making decisions which have an impact on the Trust's financial position. This is particularly the case in respect of capital investment, leasing, use of external private finance and contractual relationships with other parties. The Group Chief Financial Officer/Operational Director of Finance and his team should be consulted for advice in such instances.

GI02 V8 **Standing Orders**	**Type: Standing orders** **Status: Public**

Developed in response to:	Regular scheduled review and revision, plus changes in structure
Contributes to CQC Standard number:	17

Consulted With	**Post/Committee/Group**	**Date**
Audit Committee		May 2026

Version Number	V8
Issuing Directorate	CEO Office
Ratified by:	Board of Directors
Ratified on:	(Trust Board)
Implementation Date	
Next Review Date	December 2026
Author/Contact for Information	Group Chief Safety & Assurance Director; Group Chief Financial Officer; Operational Directors of Finance
Policy to be followed by (target staff)	All Trust staff
Distribution Method	TrustNet, Website
Related Trust Policies (to be read in conjunction with)	Standing Financial Instructions; Scheme of Reservation & Delegation

Change History		
Version	Dare	Comments
2	4.2.2016	1. Introduction of version control 2. Amendment of Standing Orders and Scheme of Delegation to reference People and Organisation Development Committee 3. Amendment to Scheme of Delegation and Standing Financial Instructions to reference responsibility of the Charitable Funds Committee to authorise Charitable Funds expenditure
2.3	9.10.18	4. Full review to ensure that the SFIs and Scheme of Delegation reflect current organisational responsibilities and current guidance and legislation
2.4	11.2019	5. Minor changes to the policy
2.4.2	2.2022	6. Minor changes to the policy
3	8.2021	7. Major changes to the policy
4	2.2022	8. Major changes to the policy
5	10.2023	9 Minor changes to the policy in the light of organisational changes, revised national guidelines, and local policy requirements
6	06.2025	10 Regular scheduled review and revision commenced, plus changes in structure
7	11.2025	11 Consolidation into Group Policy between RWT and WHT
8	05.2026	12 Endorsed by the Audit Committees at RWT and WHT

Links with External Standards
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
https://www.nhsbsa.nhs.uk/sites/default/files/2017- 02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf

Executive Summary –

Standing Orders (SO), Standing Financial Instructions (SFi) and Scheme of Delegation (SoD)

Standing Orders set out the statutory framework within which the Trust operates. This includes how the Trust Board and governance arrangements operate.

The Scheme of Delegation defines the control framework for committing resources. It identifies which functions the Chief Executive shall perform personally and those which have been delegated to other Directors or Officers.

The Standing Financial Instructions provide a business and financial framework within which all Board Members and employees of the Trust will be expected to work**.**

1. Foreword to the Standing Orders

1.1 NHS Trusts are required by law to make **Standing Orders (SOs**), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

1.2 These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

1.3 The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

(1) Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
(2) Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff, and suppliers, and in the use of information acquired during NHS duties.
(3) Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients, and the public.
(4) Additional documents, which form part of these "extended" Standing Orders are:
(5) Standing Financial Instructions, which detail the financial responsibilities,

policies, and procedures to be maintained by the Trust.
(6) Schedule of Decisions Reserved to the Board of the Trust
(7) Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

1.4 These extended Standing Orders set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

1.5 All executive and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

1.6 This includes reference to and compliance with the NHS Code of Governance for NHS Provider Trusts (PR2076, October 2022, effective from April 2023). The revised Code of Governance includes expectations in line with the UK Corporate Governance Code (2018), the NHS Long-term Plan, the Health and Care Act 2022 and the requirements to participate constructively as part of the wider integrated care system (ICS) and the Integrated Care Board (ICB) as well as other system and provider organisations at place (OneWolverhampton) and as part of a system wide provider collaborative.

SECTION A-

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

1.7 Save as otherwise permitted by law, at any meeting, the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Group Chief Executive and/or Trust Board Secretary).

1.8 Any expression to which a meaning is given in the National Health Service Act 2006 (consolidating previous NHS Acts 1977 and 1990), Health & Care Act 2022, Procurement Act 2023, Data Protection Act 2018/UKGDPR, Code of Governance for NHS Provider Trusts 2023, Financial Directions 2025/26 or in the Financial Directions made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and, in addition:

(1) **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the (Group) Chief Executive Officer.

(2) **"Trust"** means Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust

(2a) **"Group"** means the partnership arrangements between the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

(2b) **"Joint Committee"** means the Joint Providers Committee (JPC) formed between the Boards of the four Trusts in the Black Country Provider Collaborative (BCPC).

(3) **"Board"** means the Chair, executive and non-executive members of the Trust collectively as a body.

(4) **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any, or all of the functions of the Trust.

(5) **"Budget holder"** means the director or employee with delegated authority to manage finances for a specific area of the organisation.

(6) **"Chair of the Board [or Trust]"** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

(7) **"Chief Executive Officer"** means the chief officer of the Trust.

(8) **"Committee"** means a committee of the Board created and appointed by the Trust, which may be held in Common or jointly across the Group.

(8)a "**Group**" refers to meetings and groups other than the Board or Committees of the Board.

(8)b **"Group"** also refers to , in the context of the Group partnership arrangements, Group Officers, Group Board, Group Committees and Group structures jointly entered by the Group partnership

organisations.

(9) **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.

(10) **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

(11) **"Group Chief Financial Officer"** means the Group Chief Financial Officer of the Group.

(12) **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

(13) **"Member"** means executive or non-executive member of the Board as the context permits. "Member" in relation to the Board does not include its Chair.

(14) **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

(15) **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations [SI 1990 / 2024] and subsequent amendments.

(16) **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders.

(17) **"Non-executive member"** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1[3] of the Membership, Procedure and Administration Arrangements Regulations. Non-executive members appointed by NHS England are regarded as voting non-executives. Non-executive members appointed by the Trust are regarded as Associate Non-executives.

(18) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

(19) **"Executive member"** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1[3] [i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member].

(20) **"SFIs"** means Standing Financial Instructions.

(21) **"SOs"** means Standing Orders.

(22) **"Deputy or Vice Chair"** means the non-executive member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

(23) **"Special Advisor to the Board"** refers to any appointee made by the CEO in agreement with the Chair, who is paid a nominal remuneration for advice and guidance provided.

(24) **"Independent Committee Chair"** refers to an appointee to Chair a

specific Committee of the Board on behalf of the Board, who holds no post within either organisation, and who is therefore accepted as independent as defined by the relevant Committee.

(25) "**Commissioning**" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

(26) "**Legal Adviser**" means the properly qualified person appointed by the Trust to provide legal advice.

(27) **Group Chief Safety & Assurance Officer"** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and Department of Health and Social Care guidance.

(28) "**Motion**" means a formal proposition to be discussed and voted on during a meeting.

(29) Wherever the title Group Chief Executive, Group Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

(30) Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

SECTION B- STANDING ORDERS

2. INTRODUCTION

2.1 Statutory Framework

The Walsall Healthcare NHS Trust (the Trust) is a statutory body came into existence on 01 April 2011 under The Walsall Healthcare National Health Service Trust (Establishment) Amendment Order 2011 No. 791 "Establishment Order". This was amended on 11 February 2013 by way of the Walsall Hospitals National Health Service Trust (Establishment) Amendment Order 2013 No. 59, amending Article 4 of the Establishment Order by increasing the number of directors of the trust.

The Royal Wolverhampton NHS Trust [the Trust] is a statutory body which came into existence on 1 April 1994 under The NHS Trust [Establishment] Order 1993 No 2574, [the Establishment Order]. This was amended under a statutory instrument 2012 No. 1837, NATIONAL HEALTH SERVICE, ENGLAND, The Royal Wolverhampton National Health Service Trust (Establishment) Amendment Order 2012 Amendment to Article 1 item 3.

2.2 Name of the Trust

Walsall Healthcare NHS Trust:

The trust is to be called Walsall Healthcare NHS Trust.

(1) The principal place of business of the Trust is Moat Road, Walsall, West Midlands, WS2 9PS.

(2) NHS Trusts are governed by Acts of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act1990) as amended by the Health Authorities Act 1995 and the Health Act 1999 and the Health and Social Care Acts 2012, 2022.
(3) The functions of the Trust are conferred by this legislation.
(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

a. (5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and now contained in the NHS Act 2006, to fund projects jointly planned with local authorities, voluntary organisations, and other bodies.
b. (6) The Code of Governance for NHS Provider Trusts (2022, implementation from April 2023) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions [SFIs] setting out the responsibilities of individuals, and a Scheme of Delegation (SoD) summarising the delegated responsibilities.
    1) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

<u>The Royal Wolverhampton NHS Trust:</u>
The Trust is to be called The Royal Wolverhampton National Health Service Trust instead of The Royal Wolverhampton Hospital National Health Service Trust. Accordingly in article 1(2) of the Establishment Order in the definition of "the Trust", and in article 2 of the Establishment Order (establishment of the Trust), omit "Hospital".

(1) The principal place of business of the Trust is New Cross Hospital, Wolverhampton.
(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 [NHS Act 1977], the National Health Service and Community Care Act 1990 [NHS & CC Act 1990] as amended by the Health Authorities Act 1995 and the Health Act 1999.
(3) The functions of the Trust are conferred by this legislation.
(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.
(5) The Code of Governance for NHS Provider Trusts (2022, implementation from April 2023) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions [SFIs] setting out the responsibilities of individuals, and a Scheme of Delegation (SoD) summarising the delegated responsibilities.
(6) The Trust will also be bound by such other statutes and legal provisions

which govern the conduct of its affairs.

2.3 NHS Framework

(1) In addition to the statutory requirements the Secretary of State for Health and Social Care, through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.

(2) The Code of Governance for NHS Provider Trusts (2023) requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Trust's Conflicts of Interest Policy, these Standing Orders and Codes of Conduct make various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness (Nolan Principles) in the NHS sets out the requirements for public access to information on the NHS and should be considered in conjunction with the Freedom of Information Act 2000.

(4) The revised Fit and Proper Persons Test (FPPT) (2023) sets out the standards of probity required by and of senior managers and appointees within the Trust.

2.4 Delegation of Powers

The Trust has powers to delegate and decide delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State for Health and Social Care may direct". Delegated Powers are covered in a separate document entitled 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2.5 Integrated Governance and Quality

Trust Boards continue to develop integrated governance to ensure that decision- making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality, and financial objectives.

3. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE, AND ROLE OF MEMBERS

3.1 Composition of the Membership of the Trust Board

3.1.1 In accordance with the Membership, Procedure and Administration Arrangements regulations set out the in the Establishment Order and subsequent revisions, the composition of the Board shall comprise of the Chair and six Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.:

3.1.2 The Executive Directors with voting rights shall include:

(a) Group Chief Executive
(b) Group Chief Financial Officer
(c) Group Chief Medical Officer
(d) Chief Nurse Officer, or equivalent
(e) Trust Managing Director

3.1.3 The Board may appoint additional Executive Directors, in crucial roles in the Trust, to be non-voting members of the Trust Board. They include:

(a) Group Chief People, Culture and Improvement Officer
(b) Group Chief Strategy Officer/Deputy CEO
(c) Group Chief Community and Partnerships Officer
(d) Group Chief Safety & Assurance Officer

3.1.4

(1) The Chair of the Trust [Appointed by the NHS England (NHSE)
(2) Up to 6 non-executive members [appointed by the NHS England]
(3) Up to 5 executive members [but not exceeding the number of non- executive members] including:
- the Chief Executive Officer (Group Chief Executive Officer)
- the Chief Finance Officer (Group Chief Finance Officer)
- a medical or dental practitioner (Group Chief Medical Officer)
- a registered nurse or midwife (Trust Chief Nursing Officer)
- a chief officer nominated by the Chief Executive Officer (in this case the Trust Managing Director (MD)).

(4) Voting Executive Director Members are:
- Group Chief Finance Officer (and Group Deputy CEO),
- Group Chief Medical Officer,
- Trust Chief Nursing Officer,
- Trust Managing Director (MD)
- Group Chief Executive Officer.

(5) Non-voting Executive Director Members are:
- Group Chief People, Culture and Improvement Officer,
- Group Chief Strategy Officer/Deputy CEO,
- Group Chief Community and Partnerships Officer
- Group Chief Safety & Assurance Officer

(6) Non-voting Associate Non-executive Director Members

At the discretion of the Chair and Trust Board, the Trust may appoint additional Associate Non-executive Directors through the same process and to the same standards as a voting NED's and for specified term periods. Associates are not members of the Remuneration Committee.

In addition, at the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors and/or Special Advisors who will attend the Trust Board as directed to do so by the CEO and Chair.

(7) Non-voting Group Chief Officer, Chief Officer, Group Directors, Director Members and very senior officers (in attendance at Trust Board).
At the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors and very senior officers who will attend the Trust Board as defined by the Chief Executive Officer and in agreement with the Chair. These attendees are not included in relation to Quoracy.

(8) Non-voting Director Members (not in attendance at Trust Board).
At the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors and/or Special Advisors who will not attend the Trust Board.

(9) Interim Appointments Voting Officer Responsibilities.
In the case of the Chief Executive Officer appointing an interim voting Chief Officer they are to be considered for all purposes in the Standing Orders as having the same responsibilities and role as a permanent appointee.

(10) This is not an exhaustive list, as the composition of additional posts will change over time, in relation to the requirements of the organisation.

This is not an exhaustive list, as the composition of additional posts will change over time, in relation to the requirements of the organisation.

3.2 Shared Appointments/Job Shares:

(11) Taking into account the above flexibilities, the overall balance of the Board between Executive and Non-executive attendees should be maintained as far as possible e.g. a balance of Officers and Non-executives with the Chair as ensuring that Non-Executive Directors are the majority of Board attendees.

(12) The Chief Executive Officer, in agreement with the Chair, may identify and appoint special advisors to the Board to provide expert opinion and insight to support the Board in making informed decisions. For the purposes of the Standing Orders special advisors are expected to be recruited to the same standards as an Associate Non-Executive with the same governance responsibilities. Their renumeration will be as per an Associate Non-Executive unless recommended and agreed otherwise by the Chief Executive Officer and approved by the Remuneration Committee. Such appointees will be known or be referred to as Special Advisor to the Board.

(13) The Trust Board shall have not more than 12 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and Social Care and set out in the Trust's Establishment Order or such other communication from the Secretary of State for Health and Social Care).

(14) The Trust Board shall have not more than 12 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and Social

Care and set out in the Trust's Establishment Order or such other communication from the Secretary of State for Health and Social Care).

3.1.5 The Board may appoint lay persons to the Trust Board and confer the title Associate Non- Executive Director on these individuals as an indication of their corporate responsibility. These individuals are entitled to attend meetings of the Trust Board but are not Board Members for the purpose of Membership and Procedure Regulations and as such they have no voting rights.

3.2 Appointment of Chair and Members of the Trust
Paragraph 3 of Schedule 3 to the NHS 2006 Act, provides that the Chair is appointed by the Secretary of State for Health and Social Care, but otherwise the appointment and tenure of office of the Chair and members are set out in the Membership and Procedure Regulations and terms and conditions as set out by the NHSE.

3.3 Terms of Office of the Chair and Members
The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in the Membership and Procedure Regulations.

3.4 Appointment and Powers of Deputy/Vice Chair

3.4.1 Subject to Standing Order 3.4.2 below, the Chair and members of the Trust may appoint one of their numbers, who is not also an Executive Director, to be Deputy/Vice Chair, for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them. For a Group Deputy/Vice Chair role, the member must be a member across both Trusts

3.4.2 Any member so appointed may at any time resign from the office of Deputy/Vice Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Deputy/Vice Chair in accordance with the provisions of Standing Order 2.4.1.

3.4.3 Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy/Vice Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy/Vice Chair.

3.4.4 The Deputy/Vice Chair must be appointed from the voting Non-executive Directors appointed to the single Trust of which they are Deputy/Vice Chair. The Deputy/Vice Chair cannot be a joint appointee, and the role of Deputy/Vice Chair cannot be shared across any other NHS Trust in the Group.

3.5 'Joint' Members (shared roles/job shares)
(1) Where more than one person is appointed jointly to a post mentioned in regulation

2[4][a] of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of the Standing Orders as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:
- [a] either or both of those persons may attend or take part in meetings of the Board;
- [b] if both are present at a meeting they should cast one vote if they agree;
- [c] in the case of disagreements no vote should be cast;
- [d] the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order Quorum.

3.6 Appointment of the Senior Independent Director

3.6.1 The Chair and members of the Trust should appoint one of their numbers, who is not also an Executive Director, to be the Senior Independent Director for such period, not exceeding the remainder of their term as a member of the Trust, as they may specify on appointing them.

3.6.2 Any member so appointed may at any time resign from the role of Senior Independent Director giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Senior Independent Director in accordance with the provisions of the Standing Orders.

3.6.3 The Senior Independent Director supports the Chair, conducts their annual appraisal, is available to members of the Trust if they have concerns that contact through the usual channels of the Chair, the Chief Executive, the Trust Board Secretary or the Secretary to the Board has failed to resolve or where it would be inappropriate to use such channels.

3.6.4 The Senior Independent Director shall not attend the renumeration committee so as to be available in the case of any dispute or appeal.

3.7 Role of Members

The Board will function as a corporate, unitary decision-making body, executive and non-executive members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

3.8 Members

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation. These are referred to as (Group) Chief Officers (voting), (Group) Chief Officers (non-voting) and (Group) Directors (where defined by the Chief Executive Officer and agreed by the Chair) and very senior officers (where defined by the Chief Executive Officer and agreed by the Chair).

(1) Group Chief Executive Officer

The Group Chief Executive Officer shall be responsible for the overall performance of the executive functions of the Trust. They are the Accountable/Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief

Executives.

(2) Group Chief Financial Officer

The Group Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Group Chief Executive Officer for ensuring the discharge of obligations under relevant Financial Directions.

(3) Non-Executive Members

The non-executive members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(4) Chair

[a] The Chair shall be responsible for the operation of the Board and shall chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

[b] The Chair shall liaise with the NHS Appointments Commission over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

[c] The Chair shall work in close harmony with the Group Chief Executive Officer and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

[d] The provisions for the division of responsibilities and the role of the Chair, senior independent director, Non-Executive Directors, Board appointments and Conflicts of Interests is set out in further detail in the Code of Governance for NHS Provider Trusts (2023) and the revised Fit and Proper Persons Test (FPPT) (2023).

3.9 Corporate Role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in the Standing Orders.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State. The Code of Governance for NHS Provider Trusts recommends an externally facilitated developmental review using the CQC Well-Led Framework every 3-5 years, according to circumstance. Any review must be identified in the annual report and any potential conflicts with those carrying out the report or any Board members declared as per Conflicts of Interest Policy.

(5) All members shall individually and collectively operate in line with the Nolan Principles of Public Life (the Nolan Principles) and meet the requirements of the revised FPPT (2023).

3.10 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the

Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

3.11 Lead Roles for Board Members

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

The lead roles for Non-Executive Directors and Executive Directors are set out in the lead roles descriptions held by the Group Trust Board Secretary.

Retained Lead Roles:
- Maternity Board Safety Champion (NED)
- Wellbeing Guardian (NED)
- Freedom to Speak Up Guardian (NED)
- Doctors Disciplinary Lead (NED)
- Security Management Lead (NED)

Lead Sponsor Roles:
- Senior Independent Director (SID) (NED)
- Deputy to the Trust Board Chair (NED)
- Remuneration Committee Chair (NED)
- Joint Committee Deputy Chair (NED)

Other Lead Roles Identified and Agreed by the Trust:
- Green Plan Lead (NED)
- Mental Health Lead (NED)

4. MEETINGS OF THE TRUST

4.1 Calling Meetings

4.1.1 Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

4.1.2 The Chair of the Trust may call a meeting of the Board at any time.

4.1.3 One third or more Members of the Board may requisition a meeting in writing (e.g., via email) to the chair. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the Members signing the requisition may forthwith call a meeting.

4.2 Notice of Meetings and the business to be transacted.

4.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member via the authorised electronic Board Papers system (ibabs Board Papers), so as to be available to members at least three working days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

4.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be considered to be signed by those members.

4.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under the Standing Orders.

4.2.4 A member desiring a matter to be included on an agenda shall make his / her request in writing to the Chair at least sufficient advance (no less than 4 working days) before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 4 working days before a meeting may be included on the agenda at the discretion of the Chair.

4.2.5 Before each meeting of the Board a public notice on the trust website of the time and place of the meeting, and the public part of the agenda, shall be given. A public notice shall be displayed at the Trust's principal offices and on its website at least three clear days before the meeting (required by the Public Bodies (Admission to Meetings) Act 1960 s.1(4)).

4.3 Agenda and Supporting Papers

The agenda will be sent to members three working days before the meeting, and supporting papers, whenever possible, shall accompany the agenda, but will otherwise be dispatched no later than three days before the meeting, save in emergency.

4.4 Petitions

Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

4.5 Notice of Motion

(1) Subject to the provisions of the Standing Orders a member of the Board wishing to move a motion shall send a written notice to the Chief Executive Officer who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least l0 working days before the meeting. The Group Chief Executive Officer shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

4.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of the Standing Orders 'Motions', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.7 Motions: Procedure at and during a Meeting

4.7.1 Who may Propose

A Motion may be proposed by the Chair of the meeting or any member present. It must also be seconded by another Member.

4.7.2 Contents of Motions

The Chair may exclude from the debate at their discretion and such Motion of which notice was not given on the notice summoning the meeting, other than a Motion relating to:

(a) the reception of a report.
(b) consideration of any item of business before the Trust Board.
(c) the accuracy of minutes.
(d) that the Board proceed to next business.
(e) that the Board adjourn.
(f) that the question be now put.

4.7.3 Amendments to Motions

- A Motion for amendment shall not be discussed unless it has been proposed and seconded.
- Amendments to Motions shall be moved relevant to the Motion and shall not have the effect of negating the Motion before the Board.
- If there are several amendments, they shall be considered one at a time. When a Motion has been amended, the amended Motion shall become the substantive Motion before the meeting, upon which any further amendment may be moved.

4.7.4 Rights of reply to Motions

(a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original Motion, who shall have the right of reply at the close of debate on the amendment but may not otherwise speak on it.

(b) Substantive/Original Motion

The member who proposed the substantive Motion shall have a right of reply at the close of any debate on the Motion.

4.7.5 Withdrawing a Motion

A Motion, or an amendment to a Motion, may be withdrawn.

4.7.6 Motions once under debate

When a Motion is under debate, no Motion may be moved other than:

(a) an amendment to the Motion.

(b) the adjournment of the discussion, or the meeting.
(c) that the meeting proceeds to the next business;
(d) that the question should be now put.
(e) the appointment of an 'ad hoc' committee to deal with a specific item of business.
(f) that a member/director be not further heard.
(g) a Motion under Section 1 (2) or Section 1 (8) of the Public Bodies (Admissions to Meetings) Act l960 resolving to exclude the public, including the press.

4.7.7 In those cases where the Motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

4.7.8 If a Motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive Motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

4.8 Motion to Rescind a Resolution

4.8.1 Notice of Motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

4.8.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any member other than the Chair to propose a Motion to the same effect within six months. This Standing Order shall not apply to Motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.9 Chair of Meeting

4.9.1 At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair (if the Board has appointed one), if present, shall preside.

4.9.2 If the Chair and Deputy Chair are absent, such member (who is not also an Officer Member of the Trust) as the Members present shall choose shall preside. This provision is also applicable to Board Committee meetings.

4.10 Chair's Ruling

The decision of the Chair of the meeting on questions of order, relevance, and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.11 Quorum

4.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Members, including at least one member who is also an Executive

Director of the Trust and one member who is a Non-Executive Director, is present.

4.11.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

4.11.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.12 Voting

4.12.1 Save as provided in Standing Orders - Suspension of Standing Orders and - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and eligible to vote on the question. In the case of an equal vote, the person presiding (i.e.: the Chair of the meeting) shall have the casting vote.

4.12.2 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot or an equivalent electronic ballot.

4.12.3 If at least one-third of the members present so request, the voting on any question may be recorded to show how each member present voted or did not vote (except when conducted by paper ballot).

4.12.4 If a member so requests, their vote shall be recorded by name.

4.12.5 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.

4.12.6 An Officer who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

4.12.7 An Officer attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

4.12.8 For the voting rules relating to joint members see the relevant Standing Order.

4.13 Suspension of Standing Orders

4.13.1 Except where this would contravene any statutory provision or any direction made by the

Secretary of State for Health and Social Care or the rules relating to the Quorum, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the Members of the Board are present, including at least one member who is an Executive Director of the Trust and one Member who is a Non-Executive Director, and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

4.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and members of the Trust.

4.13.3 No formal business may be transacted while Standing Orders are suspended.

4.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

4.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- Upon a notice of motion.
- Upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting.
- Upon the approval by the board as recommended by the Chair or Chief Executive as part of the regularly review and updating of the standing orders.
- That two- thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment.
- Providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State for Health and Social Care.
- Where periodic updates are required that do not change the circumstances of the Establishment Order or Secretary of State provision above.

4.15 Record of Attendance

The names of the Chair and Members present at the meeting shall be recorded.

4.16 Minutes

4.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting, where they shall be signed by the person presiding.

4.16.2 No discussion shall take place upon the minutes except upon their accuracy, or where the Chair considers discussion appropriate.

4.17 Admission of public and the press

4.17.1 Admission and exclusion on grounds of confidentiality of business to be transacted.

Admission and exclusion on grounds of confidentiality of business to be transacted. The public and press representatives may attend the meeting of the Board held in public. It is important to note the difference between a Board meeting held in public and a public meeting. In this case attendees not members of the Board are expected to observe only and if they have any questions or contributions relating to the business to be transacted that

they provide these in advance to the Group Trust Board Secretary as per the requirements published with the Board papers.

The Code of Governance for NHS Provider Trusts provides additional principles, guidance, and details in respect of the leadership of the Board and the role of the Chair, and these Standing Orders should be read in conjunction.

The public and representatives of the press may attend all meetings of the Trust, but shall be required to withdraw upon the Trust Board resolving as follows:

'That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960.

4.17.2 General Disturbances

The Chair (or Deputy Chair) or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

'That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

4.17.3 Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 4.17.1 and 4.17.2 above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

4.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

Where a meeting is conducted in public, and a recording is made this will only be referred to for the production of the minutes. It may be placed in the public domain subject to the approval of the Board.

Otherwise, recordings are only permitted for reference in the creation of the draft minutes. Once the minutes are approved the recording must be deleted. The approved minutes are regarded as the definitive record.

4.17.5 Virtual/Hybrid Meetings

Where circumstances do not allow for attendees in person, participation and observation to the public section will be made available on application to the Chair. Virtual attendance to the confidential section will be by agreement of the Chair.

Virtual meetings will be maintained whilst restrictions prevent face-to-face meetings in person until such time as the restrictions are lifted. Virtual attendance will continue to be made available thereafter by application.

Virtual attendance (or not) is the final decision of the Chair.

4.18 Observers at Trust Meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter, or vary these terms and conditions as it deems fit.

5. APPOINTMENT OF BOARD COMMITTEES AND SUB-GROUPS

5.1 Appointment of Committees

5.1.1 Subject to such directions as may be given by, or on behalf of, the Secretary of State for Health and Social Care, the Trust may, appoint Committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time. Minutes, or a representative summary of the issues considered, and decisions taken, of any committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting.

Any matters raised requiring reporting only to the closed section of the board meeting shall be redacted from the minutes made publicly available and unredacted set provided to the confidential section of the board.

The Chair of the board committee will prove a summary of the matters to the next available board meeting providing a focus of the board on matters of substance from that committee.

5.2 Joint Committees

(1) Joint committees may be appointed by the Trust by joining together with one or more

health service bodies consisting, wholly or partly, of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

(2) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees/groups consisting wholly or partly of members of the committees or joint committee [whether or not they are members of the Trust or health bodies in question] or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

(3) The Board can under this Standing Order and in line with the directions of the Secretary of State, delegate specific hours duties and responsibility to the joint committee on behalf of the Sovereign Organisation. Such delegation is not in perpetuity and can be ended or withdrawn by the Board at any time.

(4) The Code of Governance for NHS Provider Trusts (2023) sets out further principles and expectations regarding partnerships, collaborations, joint committees, and cooperation with other NHS Organisations including the Integrated Care System(s) and Place Based Partnerships.

Committee in Common

(1) The Trust can appoint committees in common (CiC) to meet with a shared agenda.

(2) Whilst the Committee in Common can meet together, each committee will only make decisions for its own Trust.

(3) A Committee in Common must not allow one Trust to delegate its functions to another

5.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriately apply to meetings and any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of other committees as the context permits, and the term “member” is to be read as a reference to a member of other committees also as the context permits. There is no requirement to hold meetings of committees established by the Trust in public.

5.4 Terms of Reference

Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State for Health and Social Care. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 Delegation of powers by Committees to Sub-Groups

Where Committees are authorised to establish committees or groups they may not delegate executive powers to the group unless expressly authorised by the Trust Board.

Each Committee shall approve the Terms of Reference of each sub-group reporting to it. Minutes, or a representative summary of the issues considered, and decisions taken of any committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

5.6 Approval of Appointments to Board Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State for Health and Social Care, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.

5.8 Mandatory and Statutory Committees to be established by the Trust Board

The Committees to be established by the Trust will consist of statutory and mandatory, and non-mandatory committees.

5.8.1 Role of Audit Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Code of Governance, and the Higgs report, an Audit Committee will be established and constituted to provide the Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

The terms of reference of the Audit Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Membership of the Audit Committee shall accord with the Local Audit and Accountability Act 2014 with respect to independence.

The Audit Committee shall engage independent Auditors, external to the Trust, as required for the purposes of conducting an Internal Audit Programme and the External Audit of the Annual Accounts and Annual Report.

5.8.2 Role of Remuneration (and Terms of Service) Committee

In line with the requirements of the NHS Code of Governance, and the Higgs report, a Remuneration Committee will be established and constituted.

The purpose of the Committee will be to advise the Board about appropriate remuneration and terms of service for the Chief Executive Officer and other Executive Directors.

In line with the Code of Governance for NHS Provider Trusts (2023) based on the Financial Reporting Council (FRC) UK Corporate Governance Code (2018) (Provision 32) and the FRC Board Effectiveness Guidance Provisions (2018) the Committee should have a minimum membership of 3 voting NED's, the Chair should not Chair the Committee, and the Committee Chair should have at least 12 months prior experience as a member of the Remuneration Committee.

The Committee may ask the Senior Independent Director (SID) or the Chair of Audit Committee to not be part of the Remuneration Committee to be available in their independent role should the need arise.

The Annual Report should describe the work of the Committee including descriptions of:

- The process for appointments
- Its approach to succession planning
- How both above support diversity
- How the Board has been evaluated including any external input and resulting outcomes and action taken including any that will influence the Board composition
- How it enacts the Trust policy on diversity and inclusion including all characteristics
- A breakdown of the ethnic diversity of the Board and senior managers as per the NHS Workforce Race Equality Standard (WRES) alongside the ethnic diversity of the Trust workforce and local communities served
- The gender balance of senior management and their direct reports

The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

The terms of reference of the Remuneration Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

5.8.3 Role of the Charitable Funds Committee

The Trust Board, acting as Corporate Trustee, shall appoint a Committee to be known as the Charitable Funds Committee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

The terms of reference of the Charitable Funds Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

5.8.4 Non-Mandatory Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities. These are:
Quality Committee of the Board
Finance and Productivity Committee of the Board
People Committee of the Board
Joint Provider Committee of the Board
Partnership & Transformation Committee of the Board

The CEO is required to have a well-governed Operational Management Structure, reporting via the CEO and Executive's to the Board and Committees as appropriate.

The Operational Structure introduced from April 2025 consists of
Group Executive Management Group
Group Executive Management Committee
WHT Management Group
RWT Management Group

5.8.5 Proceedings in Committee to be confidential

There is no requirement for meetings of Committees and sub-committees to be held in public, or for agenda or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, and there is no legal justification for non-disclosure.

Committee members should normally regard matters dealt with or brought before the Committee as being subject to disclosure, unless stated otherwise by the Chair of the

Committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Board.

Where a matter requires the maintenance of confidentially for legitimate reasons any approved minutes shall have those items redacted and the full unredacted minutes will be provided to the confidential section of the Board.

6. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

6.1 Delegation of Functions to Committees, Officers, or Other Bodies

6.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee or sub-committee appointed by virtue of the Standing Orders, or by an officer of the Trust, or by another body as defined in the Standing Orders, in each case subject to such restrictions and conditions as the Trust thinks fit.

6.1.2 Section 19 of the NHS Act 2006 allows for regulations to provide for the functions of Trust to be carried out by third parties. In accordance with the Membership and Procedure Regulations, the functions of the Trust may also be carried out in the following ways:

(a) By another Trust
(b) Jointly with any one or more of the following: NHS trusts, NHSE or Integrated Care Bodies
(c) By arrangement with the appropriate Trust Commissioning body, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies
(d) In relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more NHSE, NHS Trusts or Trust Commissioning body.

6.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e., delegation to committees, sub-committees/groups or officers, the Trust delegating the function retains full responsibility.

6.2 Emergency Powers and Urgent Decisions

The powers which the Board has reserved to itself within these Standing Orders may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair [or in his/her absence the Deputy-Chair]. The exercise of such powers by the Group Chief Executive Officer and Chair shall be reported to the next formal meeting of the Board in public session for formal ratification.

6.2.1 In the event of an urgent decision being required by the Group Finance and Productivity Committee to respond to an opportunity or risk, the Chief Executive, the Finance and Productivity Committee or their deputies shall consult formally with the Chair of the Trust, the Chair of Performance and Finance Committee and at least one other Non-Executive Director who will constitute a Committee of the Board for this purpose. The

decision of this Committee will be reported to the next Group Finance and Productivity Committee. The urgency procedure should only be applied in circumstances where it is not possible to hold an urgent extraordinary Performance and Finance Committee meeting.

6.3 Delegation to Committees

6.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, sub-committees, groups or joint committees, which it has formally constituted in accordance with directions issued by the Secretary of State for Health and Social Care. The constitution and terms of reference of these committees, sub-committees, groups or joint committees, and their specific executive powers shall be approved by the Board in respect of its committees.

6.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

6.3.3 Where a decision is required between board meetings, the board may formally delegate approval of specific contacts of business cases to a committee of the board. In such cases any matters approved will be reported to the next available board meeting. In line with the SFI's and the Scheme of Delegation no board committee has the power of approval without formal delegation of the board.

6.3.4 In line with the Code of Governance for NHS Provider Trusts (2023) the terms of reference for Committees shall be approved at Public Board Meeting and thereby made available to the public.

6.4 Delegation to Officers

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other Committee or sub-committee or joint committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which the Chief Executive will still retain accountability to the Trust.

6.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

6.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or Department of Health and Social Care requirements. Outside these statutory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

6.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders. Powers delegated by the sovereign Board to any Group 'Board' (Joint Committee) arrangement must be initially delegated to the joint arrangement by the Trust Board. Any such delegations can be rescinded at any time by the Trust Board.

6.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, must be reported to the next formal meeting of the Board (or delegated joint committee) for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

7. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS, AND THE STANDING FINANCIAL INSTRUCTIONS

7.1 Policy statements: general principles

7.1.1 The Trust Board will from time to time agree and approve high-level strategic policy statements/ procedures which will apply to all, or specific groups of staff employed by Walsall Healthcare NHS Trust and/or The Royal Wolverhampton NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions. All component Strategic Documents must be in accordance with and aligned to the Trust Strategic Objectives.

7.1.2 The policies (joint or individual Trust-wide) listed below, and any other policies the Trust may resolve to approve from time to time, are reserved to the Trust Board for approval. The Board have delegated the approval of joint/Trust wide policy documents to the Group Executive Management Committee, who have delegated approval to the Trust Policy Management Group.

7.1.3 In line with the Group/Trust Policy for the creation of Policy (G)OP01), the Trust Board sets out the Strategic Direction of and for the Trust.

7.1.4 **Specific Policy statements**

These Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policies, which shall have effect as if incorporated in these Standing Orders:

(a) Conflicts of Interest Policy.
(b) Disciplinary and Appeals Procedures, and

(a) Risk Management Policy
(b) Fit and Proper Person Requirements Policy

(c) Health and Safety at Work Policy

7.2 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders, as will the Reservation of Powers to the Board and Delegation of Powers.

7.3 Specific Guidance

These Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health and Social Care, including but not limited to:

(a) Caldicott Guardian 1997 (and all subsequent guidance).
(b) Human Rights Act 1998
(c) Freedom of Information Act 2000
(d) The NHS Code of Governance for NHS Provider Trusts (2023)
(e) The Fit and Proper Persons Guidance (2023)

8. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

8.1 Declaration of Interests

8.1.1 Requirements for Declaring Interests and applicability to Board Members

The NHS Code of Governance for NHS Provider Trusts (2023) requires Board members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment. The Code of Governance provides further detail in section B – Conflicts of Interest and appointments on those matters considered to potentially impair a non-executive directors independence and that should therefore be considered as part of the recruitment process, must be declared on the public register, and must be reconsidered and reviewed at appraisal.

8.1.2 Interests which are relevant and material

(a) Interests which should be regarded as "relevant and material" are:
   (i) Directorships, including non-executive directorships held in private companies or PLCs [except for those of dormant companies]
   (ii) Ownership or part-ownership of private companies, businesses, or consultancies likely or possibly seeking to do business with the NHS
   (iii) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
   (iv) A position of authority in a charity or voluntary organisation in the field of health and social care.
   (v) Any connection with a voluntary or other organisation contracting for NHS services.
   (vi) Research funding/grants that may be received by an individual or his / her department.

(vii) Interests in pooled funds that are under separate management.

(viii) An employee of the organisation within the last two years.

(ix) Has had or been part of a material business relationship with the Trust directly or indirectly.

(x) Has received remuneration other than their directors fee, of participates in any performance related pay scheme or is a member of the Trust's pension scheme.

(xi) Has close family ties with any of the Trust's advisors, directors or senior employees.

(xii) Holds cross directorships or has significant links with other directors for involvement with other companies or bodies – in any such cases written permission must be sought and gained from the Chair (non-executive directors) or the CEO (executive directors and senior staff) before taking up any of these potentially conflicting roles.

(xiii) Has served on the Trust Board for more than six years from the date of their first appointment – Please note Chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval.

(xiv) The Code of Governance specifies Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment and subject to the proviso above or anything in excess of six years. This can in special cases be extended beyond nine years for a limited time only where agreed with NHS England.

(xv) For these purposes a Non-Executive Director becoming Chair will reset the start of their term.

(xvi) Is an appointed representative of the Trust's university medical or dental school.

(xvii) Where any of these or other relevant circumstances apply, and the Board of Directors none the less considers a Non-Executive Director to be independent, has to be able to explain clearly why. (Please see relevant section of Code of Governance).

(b) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare their interest by giving notice in writing of such fact to the Trust as soon as practicable.

(c) Any member of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with him/her has any pecuniary interest, direct or indirect, the Board member shall declare his / her interest by giving notice in writing of such fact to the Trust as soon as practicable.

(d) Advice on Interests. If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair or the Group Chief Executive Officer of the Trust and with the advice of whomsoever is providing the equivalent of Board Secretary advice.

(e) Financial Reporting Standard No 8 [issued by the Accounting Standards Board] specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

(f) Recording of Interests in Board minutes. At the time Board members' interests are declared, they should be recorded in the Board minutes.

(g) Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

(h) Publication of declared interests in Annual Report. Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

(i) Conflicts of interest which arise during a meeting. During a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

(j) Any potential or actual Conflicts of Interest must be dealt with in line with the Group/Trust Conflicts of Interest Policy (G)OP109 and the Trust Anti-Fraud and Anti-Bribery Policy GP02. (3)

8.2 Register of Interests

8.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Trust Board members.

8.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

8.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicize arrangements for viewing it at Walsall Healthcare NHS Trust. (WHT) and The Royal Wolverhampton NHS Trust (RWT).

8.3 Exclusion of Chair and Members in proceedings on account of pecuniary interest

8.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) "Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) "Contract" shall include any proposed contract or other course of dealing.

(c) "Pecuniary interest" Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:

(i) They, or a nominee of them, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(ii) They are a partner, associate, or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) The extended definitions lie within the Conflicts of Interest Policy, and these must be followed.

8.3.2 Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:

(a) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or

(b) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

(c) those securities of any company in which they [or any person connected with him / her] has a beneficial interest do not exceed

(d) £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest.

8.3.3 Exclusion in proceedings of the Trust Board

(a) Subject to the following provisions of this Standing Order, if the Chair or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the

Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(b) The Secretary of State for Health and Social Care may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability should be removed.

(c) The Trust Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract, or other matter in which they have a pecuniary interest is under consideration.

(d) Any remuneration, compensation, or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 3 to the National Health Service Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(e) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not they are also a member of the Trust) as it applies to a member of the Trust.

8.3.4 Waiver of Standing Orders made by the Secretary of State for Health and Social Care

(a) Power of the Secretary of State for Health and Social Care to make waivers

- Under regulation 11[2] of the NHS [Membership and Procedure Regulations SI 1999 / 2024 ["the Regulations"], there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 [which prevents a chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which they have a pecuniary interest] is removed. A waiver has been agreed in line with sub-sections [2] to [4] below.
- A member of the Trust who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –
- Services under the National Health Service Act 2006; or
- Services in connection with a pilot scheme under the National Health Service Act 2006.

(b) Definition of 'Chair' for the purpose of interpreting this waiver

Definition of 'Chair' for the purpose of interpreting this waiver
The relevant Chair is

(i) At a meeting of the Trust, the Chair of that Trust
(ii) At a meeting of a committee

- In a case where the member in question is the Chair of that Committee, the Chair of the Trust.
- In the case of any other member, the Chair of that Committee.

(c) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest. It will apply to:

(i) A member of the Trust who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

- Services under the National Health Service Act 2006; or
- Services in connection with a pilot scheme under the National Health Service Act 2006.

For the benefit of persons for whom the Trust is responsible.

(i) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which they are present:
  - Arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons.
  - Has been declared by the relevant chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:
    - are members of the same profession as the member in question,
    - are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

d) Conditions which apply to the waiver and the removal of having a pecuniary interest. The removal is subject to the following conditions:

(i) The member must disclose their interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes.

(ii) The relevant chair must consult the Chief Executive before making a declaration in relation to the member in question pursuant to the paragraph above, except where that member is the Chief Executive.

(iii) In the case of a meeting of the Trust:
  - The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded.
  - May not vote on any question with respect to it.

(iv) In the case of a meeting of the Committee:
  - The member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded.

- May vote on any question with respect to it; but
- The resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

8.4 Standards of Business Conduct

8.4.1 Trust Policy and National Guidance

All Trust staff and members must comply with the national guidance contained in HSG[93]5 on 'Standards of Business Conduct for NHS Staff' and with any Trust policy derived therefrom and the subsequent requirements of the Code of Conduct in the NHS published by the Department of Health and Social Care in July 2004 and The Code of Governance (2023) and the Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England issued by the Professional Standards Authority in November 2013, and the subsequent additional guidance published alongside the Code of Governance for NHS Provider Trusts (2023)as summarised in Trust Policy GP01 Corporate Governance – Principles of Public Life and the FPPT (2023).

Standards of Business Conduct Policy NHS England and NHS Improvement.
Document first published: 12 July 2017, Page updated: 15 February 2022
https://www.england.nhs.uk/publication/standards-of-business-conduct-policy/

Managing Conflicts of Interest in the NHS: Guidance for staff and organisations
NHS England.

Document first published: 7 February 2017, Page updated: 22 August 2017
https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for- staff-and-organisations/

Bribery Act 2010
https://www.legislation.gov.uk/ukpga/2010/23/contents

Code of Governance for NHS Trusts (2022)

Revised Fit and Proper Persons Test Guidance (2023)

8.4.1.1 Public Confidence and behaviour

The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

The NHS Constitution 2016 identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the legal duties and expectations of all NHS staff, including:

(a) To accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory bodies.

(b) To act in accordance with the terms of contract of employment.
(c) not to act in a discriminatory manner.
(d) To protect confidentiality.
(e) To be honest and truthful in their work.
(f) To aim to maintain the highest standards of care and service.
(g) To maintain training and personal development to contribute to improving services.
(h) To raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest opportunity.
(i) To involve patients in decisions about their care and to be open and honest with them and
(j) To contribute to a climate where the truth can be heard and learning from errors is encouraged.

The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

Selflessness: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity: In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership: Holders of public office should promote and support these principles by leadership and example

All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

(a) Act in the best interests of the Trust and adhere to its values and this code of conduct.
(b) Respect others and treat them with dignity and fairness.
(c) Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
(d) Be honest and act with integrity and probity.

(e) Contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and functions.
(f) Recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the Trust.
(g) Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and
(h) Accept responsibility for their performance, learning and development.

All Directors must act in accordance with the Code of Governance (2022).

Gifts and hospitality shall only be accepted in accordance with the Trust's Conflicts of Interest Policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value

All gifts and hospitality, other than those that are of clearly minimal value (as determined by the Trust's Conflicts of Interest Policy), should be declared via the Electronic Staff Record. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act 2006 https://www.legislation.gov.uk/ukpga/2006/35/contents. Bribery Act 2010 https://www.legislation.gov.uk/ukpga/2010/23/contents

8.4.2 Interest of Officers in Contracts

(a) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with him/her has any pecuniary interest, direct or indirect, the officer shall declare his/her interest by giving notice in writing of such fact to the Chief Executive Officer as soon as practicable.
(b) An officer should also declare to the Chief Executive Officer any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.
(c) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.
(d) Senior Officers subject to very senior manager (VSM) after 2022 contracted terms and conditions must seek and gain in writing the CEO's permission before taking up a new declarable interest (as defined in these standing orders and Trust policy (G)OP109).

8.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order

shall not preclude a member from giving written testimonial of a candidate's ability, experience, or character for submission to the Trust.

8.4.4 Relatives of Members or Officers

(a) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

(b) The Chair and every member and officer of the Trust shall disclose to the Trust Board any relationship between themselves and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.

(c) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust

(d) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' 'Exclusion in proceedings of the Trust Board shall apply.

8.5 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.6 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive, or a manager nominated by them in a secure place.

8.7 Sealing of Documents

The common seal shall not be affixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers.

Where it is necessary that a document shall be sealed, it must be approved and signed by the Chief Financial Officer (or an officer nominated by them). The seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not from the originating department, and shall be attested by them.

8.8 Register of Sealing

The Chief Executive shall keep a register in which they, or another manager authorised by them, shall enter a record of the sealing of every document.

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Trust Board after each sealing. The report shall contain details of the seal number, the description

of the document and date of sealing.

8.9 Signature of Documents

8.9.1 Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

8.9.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g., sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS

9.1 Partnership Agreements

The Trust has established a process for the approval of Partnership Agreements (see (G)OP09, Corporate Policy and Framework for the Governance of Partnership Agreements) The Board shall be considered the approving body for any proposed partnership agreements. Any agreements approved will be placed on the Partnership Agreements Register by whomsoever is undertaking the duties of a Board Secretary. The Trust Board will ensure that the register is reviewed at least annually.

References:
Code of governance for NHS provider trusts -
https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

9.2 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 256 & 257 of the NHS Act 2006. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health-related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 256 & 257 of the NHS Act 2006.

See also Standing Financial Instructions.

Appendix 1:

For Standing Orders - Overview of those at Trust Board.

Membership & expected attendance	Required roles	Required other roles (**Includes as required by Agenda items and as confirmed by CEO/Chair)
Trust Board Executive Members (Voting and non-voting) required to be in attendance	• Chair • Group Chief Executive Officer • Voting Non-Executive Directors (6 excluding Chair) • Voting Executive Directors (4 + CEO)*	*Voting Executive Directors comprising: • Trust Managing Director • Trust Chief Medical Officer • Group Chief Finance Officer • Trust Chief Nursing Officer Non-Voting Executive Directors comprising: • Group Chief People, Culture and Improvement Officer • Group Chief Strategy Officer/Deputy CEO • Group Chief Community & Partnerships Officer • Group Chief Safety & Assurance Officer
Board Director Member (non-voting) required to be in attendance	• Associate Non-executive Directors • Board Administrator • Person or role undertaking the requirements of a Board Secretary	**Comprising by invitation only: • Trust Director(s) of Operational Finance • Trust Director of Midwifery • Trust Operational Director of People • Trust HR Directors •
Directors and others required to be in attendance for specific items		Potentially including (but not exclusive): • Group Chief Technology Officer • Group Director of Research • Group Director of Education • Group Head of Safeguarding • Group Director of Estates Development • Trust Director of Infection Prevention and Control (DIPC) • Trust Clinical Director of Pharmacy & Medicines Optimisation • Trust Director of Infection

		Prevention • Freedom to Speak Up Guardian • Guardians of Safe Working
Others as required/appropriate		