

# Board of Directors (Group) Meeting Public Session

Wednesday 20<sup>th</sup> May 2026 14:10 – 17:30

Clinical Education Centre, 1<sup>st</sup> floor, South Block, Russells Hall Hospital, Dudley DY1 2HQ



Captions for images – from top left, clockwise

- Volunteers on hand at MMUH to show visitors where they need to go
- SWB staff celebrating their Long Service within the NHS
- Group Chief Nurse visiting staff across both Trusts
- Beautiful triplets born at Russells Hall Hospital
- Our young patients get a visit
- Dudley staff celebrated as our Healthcare Hero

**Board of Directors (Group)**  
**Wednesday 20<sup>th</sup> May 2026 14:00pm**  
**Room 7/8, Clinical Education Centre, Russells Hall Hospital, Dudley, DY1 2HQ**  
**AGENDA**

Item	Paper ref.	Lead	Purpose & scope (SWB/DGFT/Both)	Time
1. <b>Note of apologies</b>	Verbal	Chair	For noting <b>Both</b>	14:00
2. <b>Declarations of Interest</b> <a href="#">Click here for Dudley Register of Interests</a> <a href="#">Click here for Sandwell Register of Interests</a>		Chair	For noting <b>Both</b>	
3. <b>The Dudley Group Patient Story</b> – One Stop Biopsy, Lucy Smith, Lead Cancer Nurse  Introduced by M Morris, Chief Nursing Officer (Dudley), Deputy Group Chief Nursing Officer (Dudley and Sandwell Trusts)				14:05
4. <b>Strategy in Action</b> - Surgical Hub Accreditation - Q4 strategy & annual plan update report - enclosure 01		A Thomas	For discussion / approval <b>Both</b>	14:20
5. <b>Minutes of the previous meetings</b>  Wednesday 11 <sup>th</sup> March 2026 - Sandwell Thursday 12 <sup>th</sup> March 2026 - Dudley Action Sheets for Sandwell and Dudley	Enclosure 1 Enclosure 1a Enclosure 1b	Chair	For approval <b>Both</b>	14:35
6. <b>Chief Executive's Report</b>	Enclosure 2	D Wake	For information & assurance <b>Both</b>	14:40
7. <b>Chair's Update</b> - Appointment of Senior Independent Director	Verbal Enclosure 3	Chair	For information/ approval <b>Both</b>	14:50
8. <b>Integrated Committee upwards assurance report</b> <i>Quadrant reports in further reading pack</i> - Joint Provider Committee	Enclosure 4 Enclosure 4a	G Crowe / L Writtle	For approval <b>Both</b>	15:00
9. <b>Financial Position Month 12 (March 2026)</b> - Sandwell & West Birmingham Hospitals NHS Trust - The Dudley Group NHS Foundation Trust	Enclosure 5 Enclosure 5a	M Parmar C Walker	For approval <b>Both</b>	15:15
10. <b>Comfort break</b>				15:25
11. <b>Group Strategy 2026 - 2031</b>	Enclosure 6	A Thomas	For approval <b>Both</b>	15:35

<b>12. Our Patients</b>				15:45
Dudley - Deliver right care, in the right place, at the right time Sandwell - To be good or outstanding in everything we do				
<b>13. Group Chief Nurse &amp; Group Chief Medical Officer Report</b>	Enclosure 7	J Odum / M Morris	For assurance <b>Both</b>	
<b>14. Integrated Quality &amp; Operational Performance Report</b> <i>Full report data in further reading pack</i>	Enclosure 8	G Carter-Sandy / J Odum / J Richards / M Morris	For assurance <b>Both</b>	
<b>15. Group Perinatal Quality Oversight Report</b>	Enclosure 9	C Macdiarmid / M Morris	For assurance <b>Both</b>	
<b>16. Winter Plan 2025/26 close out report</b>	Enclosure 10	J Newens / J Richards	For approval <b>Both</b>	
<b>17. Our People</b>				16:20
Dudley - Be a brilliant place to work & thrive Sandwell - To cultivate and sustain happy, productive and engaged staff				
<b>18. Chief People Officer Report</b>	Enclosure 11	J Fleet	For approval <b>Both</b>	
<b>19. Staff Survey 2025</b>	Enclosure 12	J Fleet	For approval <b>Both</b>	
<b>20. Our Place / population</b>				16:35
Dudley - Build innovative partnerships to improve the health of our communities Sandwell - To work seamlessly with our partners to improve lives				
<b>21. Neighbourhood Health Framework</b>	Enclosure 13	K Rose	For information and discussion <b>Both</b>	
<b>22. Governance matters</b>				16:45
<b>23. Board Assurance Framework</b> - Sandwell & West Birmingham Hospitals NHS Trust - The Dudley Group NHS Foundation Trust	Enclosure 14	D Conway H Board	For approval <b>Both</b>	
<b>24. Group Board Governance</b> Black Country Acute/community Trusts – Future Group Structure Arrangements	Enclosure 15	D Wake	For approval <b>Both</b>	
<b>25. Black Country Provider Collaborative Delegations to Joint Provider Committee</b>	Enclosure 16	G Crowe / L Writtle	For approval <b>Both</b>	
<b>26. Any Other Business</b>  <b>Delegation to Audit Committee for sign off annual report and accounts</b> - Sandwell & West Birmingham Hospitals NHS Trust - The Dudley Group NHS Foundation Trust			M Parmar C Walker	
<b>27. Meeting close</b> <b>Date of next Board of Directors meeting</b> Wednesday 22 July 2026 Midland Metropolitan University Hospital, Smethwick B66 2QT				17:20

<b>REPORT TITLE:</b>	Strategy & annual plan progress report – Q4 2025/26		
<b>SPONSORING EXECUTIVE:</b>	Adam Thomas Group Chief Strategy & Digital Officer		
<b>REPORT AUTHOR:</b>	Martin Chadderton, Associate Director of Strategy, SWB Ian Chadwell, Deputy Director of Strategy, DGFT		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
	Decision		Approve		Both Trusts
x	Assurance		Agree		Sandwell and West Birmingham NHS Trust
	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
		x	Discuss		
		x	Note		

**Suggested discussion points**

This report shows progress in January – March 2026 against each of the in-year objectives and task & finish projects set for each trust at the start of the financial year 2025/26. These reports remain separate as the objectives are different in each trust but are presented alongside each other drawing out common themes across the group.

The Dudley Group NHS Foundation Trust

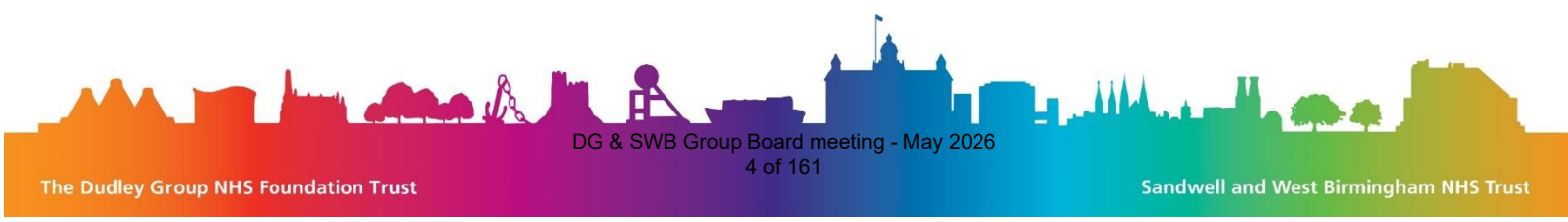
The report shows progress against each of the six in-year objectives and the task and finish projects.

- Care providers in Dudley can now access the Care Navigation Centre directly and work continues to develop urgent care pathways and improve access by primary care;
- There has been a rapid and marked improvement in ambulance handover times as a result of different initiatives put in place at the front door;
- Tender process for estates work required at Sandwell health campus for the elective hub has started;
- UEC activity was higher than plan with A&E attendances 6% over plan and non-elective admissions 4% above plan at the end of quarter 4. Elective activity was slightly higher than plan but the total RTT list was over 5,200 higher than plan at the end of February with improvement expected as a result of the elective sprint in March;
- At the end of March the trust was £8k better than financial plan;
- Total workforce was 6536 which was 141 wte higher than the revised forecast outturn.

Sandwell & West Birmingham Trust

The report provides an overview of performance at Quarter 4, covering delivery against in-year objectives, Strategic Measures of Success, productivity, and progress against the Annual Plan.

- Workforce deployment has stabilised following earlier reductions, with continued improvement in agency usage and tighter controls in place. The Trust was 19 wte higher than the revised forecast outturn illustrating an improved position.
- Planned care performance has improved across Quarter 4, with sustained delivery of elective activity, reductions in long waits, and continued progress in RTT recovery. Diagnostic and procedural throughput has increased, although performance remains below constitutional standards in some specialties, with variation at specialty level.
- Unplanned care continues to operate above plan, with sustained pressure across emergency pathways. This is reflected in Emergency Access Standard performance, ambulance handover delays, and bed occupancy. Increased utilisation of virtual wards and community capacity has supported flow but has not fully offset demand growth.



- The financial position remains materially adverse to plan. Financial recovery is the principal risk, driven by further workforce cost pressures, under-delivery of recurrent improvement, and confirmed risks. The year-end position is reliant on non-recurrent mitigations.

Following adoption of the Group Strategy and a shared set of in-year objectives, reporting will be revised to reflect this when reporting Q1 2026/27 and subsequent periods.

Alignment to our Vision					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x
The Dudley Group NHS Foundation Trust					
PATIENTS	x	PEOPLE	x	PLACE/POPULATION	x

#### Previous consideration

Executive Directors – 14<sup>th</sup> April 2026  
 Joint F&P Committee – 23<sup>rd</sup> April 2026  
 Joint Quality Committee – 29<sup>th</sup> April 2026  
 Joint People Committee – 29<sup>th</sup> April 2026  
 DGFT Integration Committee – 6<sup>th</sup> May 2026  
 Public board of directors – 20<sup>th</sup> May 2026

#### Recommendation(s)

a) Note the progress report for Q4

#### Escalation

Should any element of this report be escalated:

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

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
001: Deliver safe, high-quality care.		1.0: Failure to deliver right care, in the right place	
002: Make best strategic use of its resources		2.0: Failure to recruit, retain, train, and develop workforce	
003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships	
005: -Deliver the MMUH benefits case (CLOSED)		4.0: Failure to achieve financial plan	
004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements	
006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data			
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

## Enclosure 1

# MINUTES OF THE PUBLIC TRUST BOARD MEETING

**Venue:** Conference room, Sandwell Education Centre      **Date:** Wednesday, 11<sup>th</sup> March 2026, 10:00 – 13:00

**Voting Members:**

Sir D Nicholson (Chair) (DN)  
 Mrs R Hardy, Non-Executive Director (RH)  
 Mrs L Writtle, Non-Executive Director (LWr)  
 Mr M Laverty, Non-Executive Director (ML)  
 Mrs V Taylor, Non-Executive Director (VT)  
 Prof L Harper, Non-Executive Director (LH)  
 Mr A Argyle, Non-Executive Director (AA)  
 Mrs D Wake, Group Chief Executive (DW)  
 Dr M Anderson, Chief Medical Officer (MA)  
 Mrs J Newens, Chief Operating Officer (JN)  
 Mrs M Roberts, Group Chief Nursing Officer (MR)  
 Mrs M Parmar, Director of Finance (MP)

**Non-Voting Members:**

Mr M Hallissey, Associate Non-Executive Director (MH)  
 Dr J Fleet, Group Chief People Officer (JF)  
 Mrs R Barlow, Group Chief Development Officer (RB)  
 Mr A Thomas, Group Chief Strategy and Digital Officer (AT)  
 Miss K Rose, Interim Group Chief Integration Officer (KR)  
 Dr J Odum, Group Chief Medical Officer (JO)  
 Mrs L Broster, Group Director of Communications (LB)

**Service Story Presenters:**

Lisa Maxfield, Deputy Chief Partnerships Officer  
 Dr Imran Zaman, Lead West Locality GP and Locality Hub Clinical Lead  
 Daniel Brown, Locality Integration Manager  
 Amy Crumpton, Locality Group Manager

**In Attendance:**

Mrs J Riley, Interim Deputy Chief Nursing Officer (JR)  
 Hannah, Cardiology Professional Development Nurse  
 Charlotte, A8 Ward Manager  
 Mrs L Thirumalaikumar, Obstetric Clinical Director (LT)  
 Mrs C Macdiarmid, Interim Group Director of Midwifery (CM)  
 Ms K Hard, Head of Research & Development (KH)  
 Mr D Conway, Associate Director of Corporate Governance/Company Secretary (DC)  
 Mrs S Harris, Senior Executive Assistant (Minute taker) (SH)

**Members of the Public / Other**

Caitlin Tilley, Health Service Journal

**Apologies:**

Mr J Sharma, Associate Non-Executive Director  
 Mr A Ali, Associate Non-Executive Director  
 Mr A Ubhi, Associate Non-Executive Director  
 Mr L Williams, Associate Non-Executive Director  
 Mrs C Holland, Associate Non-Executive Director

Minutes	Reference
<b>1. Welcome, apologies and declaration of interest</b>	<b>Verbal</b>
The Chair welcomed members and attendees to the meeting. Apologies for absence were noted.	
<b>2. Population Story</b>	<b>Verbal</b>
Miss Rose welcomed the team who had joined the meeting to talk about population health delivery in West Birmingham. Lisa Maxfield and the team outlined the severe deprivation and health inequalities in West Birmingham, highlighting high rates of early death, infant mortality, coronary heart disease, and substance misuse, with residents three times more likely to be admitted for preventable conditions and to have long-term mental health issues.	
Amy Hampton described the hub's integrated approach, which includes navigation and coordination of community services, data-driven prevention and hospital avoidance, in-reach to MMUH, and co-location of health and social care professionals to reduce duplication and improve responsiveness.	
The team shared examples such as a high-intensity service user whose engagement improved through coordinated mental health and neighbourhood support, and a paediatric respiratory case where targeted diagnostics and intervention led to a dramatic improvement in quality of life and reduced hospital admissions.	

Dr Imran Zaman explained the establishment of a respiratory hub focusing on paediatric and adult care, which has resulted in West Birmingham achieving the lowest regional rates of ambulatory case-sensitive asthma and COPD admissions, despite high deprivation and low vaccination rates.

Mrs Writtle queried the systems in place to engage with local populations and the team explained the role of voluntary sector partners such as Flourish, who are based within the hub and are also represented on the partnership board.

Dr Anderson asked how the hub was funded and whether this was sustainable. The team highlighted that although funding had been allocated for primary care services, partners had been asked to redesign services to align with the locality model. It was noted that current funding streams were short-term and there would need to be creative approaches to maintain services amid uncertain long-term financial support.

The Chair thanked the team for their attendance and emphasised the Trust's commitment to moving services into the community and the need for consistent funding. Members of the West Birmingham locality team left the meeting.

<b>3. Strategy in Action</b>	<b>Presentation</b>
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Dr Anderson welcomed colleagues to the meeting who had joined to present on work taking place in relation to the management of deteriorating patients aligned with the Trust strategy.

Mrs Riley outlined the five-phase improvement process, which began with problem identification through staff workshops, mapping the complexity of observation and escalation processes, and establishing baseline metrics in pilot wards A8 and B9. The team described targeted interventions such as diary checks, staff education, and the introduction of the patient wellness questionnaire, which led to early identification of deterioration, reduced admissions, and improved escalation practices, with ongoing evaluation of compliance and outcomes. Challenges were noted in digital systems, such as the loss of visual traffic light prompts and issues with data entry affecting NEWS2 compliance, particularly in cardiology where standardised scoring conflicted with personalised care for patients with chronic conditions.

It was noted that the programme emphasised the importance of staff engagement, transparency, and valuing all roles in the escalation pathway, with positive feedback on the patient wellness questionnaire and a focus on building a culture of early recognition and proactive response. The team plans to evaluate the impact of interventions throughout the summer, refine solutions based on pilot learning, and then roll out the approach across additional wards, with ongoing monitoring of metrics and sharing of best practices at national level.

The Chair thanked colleagues for their attendance and presenting on the work to improve outcomes for deteriorating patients. Mrs Riley and the team left the meeting.

<b>4. Minutes of the previous meeting, action log and attendance register</b>	<b>TB (03/26) 001 / 001a</b>
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The minutes of the meeting held on Wednesday 14<sup>th</sup> January 2026 were reviewed and **APPROVED** as a true and accurate record of discussions. All actions had been completed.

<b>5. Chairs Opening Comments</b>	<b>Verbal</b>
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The Chair encouraged members to reflect on the final meeting of the Sandwell and West Birmingham NHS Trust Board in its current form, highlighting that the Board would meet at least once a year as a sovereign Trust. He acknowledged contributions of departing members, extending personal thanks to Mr Argyle, Mr Ubhi and Mr Ali for their ongoing professionalism and support.

The Chair honoured the late Wasim Zaffar, former Non-Executive Director of the Trust, who had passed away recently. He recognised Wasim's impactful work connecting the Trust with the community and highlighted that he was a strong advocate for the population and would be missed by many.

The Chair reflected on the major achievements for the organisation over the last few years such as the opening of the new hospital, improvements in operational performance, and recognition from external bodies like the CQC, while noting the ongoing need to address quality and community service development.

The Board discussed the projected £8 million deficit, shortfalls in cost improvement programme delivery, and the need for recurring savings, with plans to seek support from the ICB, NHS England, and regional partners to address funding gaps.

A decline in staff survey results was attributed to the impact of an ambitious workforce reduction programme, with the board committing to listen to staff feedback and balance financial pressures with quality and staff wellbeing.

The Board emphasised the importance of maintaining ambition for service improvement, learning from recent change initiatives, and preparing for further transformation through collaboration with the Dudley Foundation Trust and other partners.

The Board **NOTED** the Chairs opening comments.

## 6. Question from members of the public

Verbal

There were no questions from members of the public.

## 7. Chief Executive's Overview

TB (03/26) 003

Mrs Wake reflected on the presentation from the West Birmingham Locality, highlighting that the data clearly demonstrates the levels of deprivation faced within Sandwell and West Birmingham. She was disappointed to note that financial allocations are not weighted for deprivation as they were previously, and the presentation from the team clearly articulated the difference that could be made with small investments.

The Chief Executive's report was received, and the following key areas were noted:

An update on January performance was received, highlighting a slight dip in metrics but ongoing recovery in urgent and emergency care, ambulance handover times, and elective activity, with plans to integrate corridor care reporting into board discussions.

Collaborative work is ongoing in urology, breast reconstruction, and gynae-oncology across the Black Country, with some delays due to leadership changes and the need to align with national guidance, resulting in the rating for the clinical transformation programme changing from Green to Amber.

Mrs Wake was proud to confirm receipt of the 'Good' rating following the CQC Well Led inspection in November. She added that the Trust will continue to work on feedback from the CQC to support in moving to an 'Outstanding' rating.

Finally, Mrs Wake thanked Aston University for the opportunity to receive an honorary doctorate. The Board congratulated Mrs Wake.

Mr Laverty queried how the organisation would implement recommendations within the Emergency Department Model of Care recently published by NHS England. Mrs Wake advised that the national directive on emergency care is ever-changing including the narrative regarding corridor care. She assured the Board that recommendations would be built into the Trust's clinical strategy, ensuring that standard operating procedures were put in place.

The Board **NOTED** the Chief Executive's Overview.

## 8. Integrated Committee Upward Assurance Report

TB (01/26) 004

Mrs Writtle presented the report which outlined assurance levels and key issues identified from the subcommittees of the Board. She highlighted that there were opportunities and challenges associated with bringing together committees into a joint model. The following points from the report were noted:

- There were minimal changes in the financial position which is a significant area of focus for the Finance and Performance Committee. The Audit Committee reported a lack of assurance in relation to delivery of the Cost Improvement Programme (CIP) which would be discussed by the Board.
- The People Committee had requested oversight of more detailed plans to provide reasonable assurance on the Workforce Reduction plan for next year. Deterioration in the staff survey results was also discussed with a need to adopt clear engagement with staff. A communication is due to be shared with staff today.
- The Quality Committee had noted a sustained improvement with Standardised Hospital Mortality Index (SHMI) performance.

Mr Argyle acknowledged progress with the Internal Audit opinion and recommendations. Work on the deteriorating patient's pathway had contributed to some improvements following poor audit results.

The Board **NOTED** the report.

## Our Population

### 9. Community First

TB (03/26) 005

Miss Rose presented the report outlining that one of the multiyear commitments within the Group Strategy 'Fit for the Future' is 'Community First' which will focus on increasing care delivered closer to home. The report focused on the development of a Care Navigation Centre and the move towards a single point of access for community services, with recommendations for phased implementation.

Mr Laverty queried the level of investment required to support the changes required and how this would be obtained. Miss Rose confirmed that the teams were exploring productivity and efficiency opportunities, however, she emphasised the need to bring services together to develop a single point of access and in turn identify efficiencies.

Mrs Hardy raised that she had visited the Care Navigation Centre at SWB which she was impressed by, however, the team had discussed digital challenges and getting data sharing agreements in place. She asked Miss Rose what the likelihood is of getting this resolved during quarter 1. Miss Rose assured the Board that the team were committed to resolving this and getting data sharing agreements in place as quickly as possible. Digital resources in place at SWB were being utilised to support current gaps at DGFT and any risks to delivery would be escalated to the Integration Committee.

Professor Harper raised the importance of evaluation and ensuring partners are on the journey with the organisation. Miss Rose highlighted that the Improving Together team were supporting with evaluation with commissioners who had requested the work, however, she agreed to consider how the organisation would complete an interval evaluation. She added that key measures of success were being identified as part of the strategy which will continue to be tracked to ensure the desired impact is achieved.

The Chair asked members to refrain from referring to the places as "North" and "South", reinforcing that these are all individual places.

The Board **NOTED** the report and **APPROVED** the direction of travel outlined in relation to the Black Country proposal for a single point of access or urgent care in the right place at the right time, with further consideration of how this would be evaluated.

## BREAK

## Our Patients

### 10. Chief Nursing Officer and Chief Medical Officer's Report

TB (03/26) 006

The report was received, and the following points were noted:

Dr Anderson reported on a Never Event in Maternity relating to a retained swab which was identified post-procedure, prompting the development and rollout of enhanced safety standard-based procedures and training to ensure thorough swab counts and prevent recurrence.

An update was received in relation to the rollout of the national Paediatric Early Warning score which is reliant on an Oracle software upgrade, and timelines dependent on external vendors.

A quality assurance visit had been undertaken for the Cervical Screening and Colposcopy service which highlighted positive patient experiences and identified areas for improvement, with action plans implemented and ongoing monitoring.

Despite ongoing challenges with staffing and financial pressures, over 20 applications were received for research and development fellowships and 10 had been awarded for the year including projects being led by nursing and Allied Health Professionals staff as well as medical colleagues.

Mrs Roberts highlighted that concerns had been escalated to NHS England regarding the Newborn Hearing Screening programme particularly in relation to workforce resilience. An action plan had been submitted to with bi-monthly updates agreed. The service continues to perform strongly against national standards, despite the ongoing challenges, however, there were concerns raised regarding sustainability.

The Trust is participating in a national programme for Enhanced Therapeutic Observations in Care (ETOC), focusing on elderly care and Emergency Department mental health. Work had already commenced regarding policies and governance arrangements, as well as successful removal of agency staffing to support patients with a mental health condition.

An update was received in relation to the national Fairer Future deal for nurses and work had commenced across the Black Country system to review nursing roles and undertake a gap analysis to ensure nurses were not operating beyond their agreed scope of practice.

The Chair summarised that the issues in relation to the retained swab and Newborn Hearing Screening programme were being overseen by the Quality Committee. Mr Hallissey added that the committee had recognised the need for a consistent approach to LocSSIPs for clinical procedures and had received good assurance on the Newborn Hearing Screening Programme through paediatric updates.

The Board **NOTED** the report.

### 11. CQC Inspections Report

TB (03/26) 007

Mrs Roberts provided an update on the outcomes from the recent CQC Well Led inspection held in November and inspections of four core services. The outcomes were mainly positive with the Trust receiving a 'Good' rating for Well Led, Surgical Services at MMUH, Surgical Services at BMEC and the Emergency Department at MMUH. The CQC also recognised the improvements made in Maternity Services moving the rating for the 'Safe' domain from 'Inadequate' to 'Requires Improvement' with the overall rating being 'Requires Improvement'.

Mrs Roberts explained that MMUH had not been rated overall as only three core services had been inspected, therefore a fourth inspection was expected in the next 12 months to contribute to an overall rating. The rating for City Health Campus remains 'Requires Improvement' as no other services other than BMEC had been inspected. It was noted that although there were a number of actions ongoing to drive further improvements in Maternity Services as well as moving the Trust from Good to Outstanding for Well Led, this was a positive position for the Trust to be in.

The Chair congratulated the teams on the outcomes in all core services inspected and recognised the importance of the change in rating for Maternity services for the 'Safe' domain, which reflected the huge amount of improvement work ongoing.

The Board **NOTED** the content of the report.

### 12. Winter Plan Update 2025/26

TB (01/26) 008

Mrs Newens presented the report which outlined progress against the Winter Plan originally approved by the Board in July, focusing on performance against the access standards. The Trust saw gradual improvement in four-hour emergency care standards and maintained initial assessment times, with length of stay rising slightly but addressed through targeted actions in acute and elderly care.

Mrs Newens described ongoing corrective actions taking place including the replication of successful practices in Sandwell to support improvements in discharges with the West Hub, including weekly multidisciplinary reviews and census interventions, with early indications of increased discharge rates and plans for full evaluation.

The addition of a new CT scanner reduced diagnostic waiting times, and the Trust maintained strict controls to limit corridor care in line with the new Getting it Right First Time (GIRFT) recommendations, focusing on patient safety.

An update was received on the Flu vaccination rate and the Trust had achieved 28% compliance against a trajectory of 35%. The Infection Prevention and Control team had agreed to lead the programme for 2026/27 with a dedicated team of peer vaccinators, implementing lessons learnt from the DGFT team.

Members discussed the effectiveness of monthly census which was implemented at the time of opening MMUH. Mrs Newens highlighted that the multidisciplinary teams were not consistently engaging with the process which had

been implemented again as part of the winter plan. She explained that the census had been stepped up with acute medical leads resulting in an increase of discharges from 12 to 20 per day. She recommended that a full evaluation of the census approach be undertaken to ensure the desired impact was being achieved and to understand the capacity associated with this so that it could be factored into the plan for 2026/27. Dr Anderson highlighted that there were other tools put in place during the move to MMUH to limit capacity and speed up discharges.

The Board **ACCEPTED** the Winter Plan Update and requested an update on the outcomes of the evaluation and the impacts on the winter plan for 2026/27.

**ACTION: Update on the outcomes of the evaluation and the impacts on the winter plan for 2026/27 to be presented to the Board.**

### 13. Perinatal Quality Oversight Report

TB (03/26) 009

Mrs Roberts reflected on the 90-day value stream event that took place this week highlighting that although there was a lot of improvement work ongoing, there was a need to increase the pace and embed some quick wins. The team had gone away to explore some of the key actions that could be progressed at pace to make a difference and were also receiving some national support to drive improvements.

Mrs Thirumalaikumar and Mrs Macdiarmid presented the report including the latest perinatal mortality position. The rolling 12-month stillbirth rate is 4.23/1000 births; neonatal deaths is 1.77/1000 births and perinatal deaths is 6 per 1000 births which is higher than the national average. There had been 34 perinatal deaths in the previous 12 months, and the team is conducting thematic reviews, implementing action plans, and collaborating with external reviewers to address identified issues. It was noted that embargoed MMBRACE data had been released which suggested some improvements in perinatal mortality rates between 2023 and 2024.

The maternity regional heatmap was also presented with an unchanged score of 47. There were five stakeholder concerns outstanding, and action plans were in place with regional oversight. Mrs Macdiarmid confirmed that the Trust had achieved six out of ten safety actions for the Maternity Incentive Scheme year 7 which is a reduced position to that previously reported. Recovery plans were in place and a structured early engagement approach is being implemented for year 8.

The interim report from the National Maternity and Neonatal Investigation undertaken by Baroness Amos had been published at the end of February highlighting six system wide themes for review and Trusts were reflecting on actions required to respond to these. Trust-specific findings had not yet been published.

Mrs Writtle asked the team which issues needed to be addressed more quickly. Mrs Thirumalaikumar responded that the service had not met the required timeframe for category 1 caesarean sections. After some targeted work with the improvement team, it was recognised that trainees need additional education on categorisation. Mrs Macdiarmid noted that triage is another area where accelerated progress is necessary. She confirmed that while substantial improvements had occurred over the past year, these advancements have now plateaued. As a result, external support has been implemented to drive further enhancements and achieve compliance with national standards. The team is engaging with families, benchmarking against other organisations, and incorporating learning from national reviews and improvement teams to inform ongoing service development.

Members discussed the complexity of ongoing improvement work and felt that a development session would be beneficial to deepen board understanding and focus efforts.

The Board **NOTED** the content of the report and agreed to commit a Board Workshop to understanding the current position with perinatal services.

### 14. Finance Report Month 10 inc. Cost Improvement Update

TB (03/26) 010

Mrs Parmar presented the report highlighting that the Trust reported a £7.15 million deficit at the end of January, with 78% CIP delivered but only 53% recurrently, leading to a revised year-end forecast. As at the end of month 11, the Trust were on track to deliver the revised position as a result of tightening pay and non-pay grip and control. A Finance and Productivity Committee workshop is being planned to improve reporting of delivery of the CIP. A formal Cash Committee is also due to be established.

Mrs Parmar reflected on the discussions at the start of the meeting, noting that the organisation is more than a hospital and the level of deprivation within the local population. She reiterated that this is not reflected in the national payment system and providers were not funded by activity. It was noted that this continued to be reviewed within the organisation to understand the costs associated per patient.

The Board acknowledged that cost reporting would be valuable to support the Trust's change programme for 2026-27, with Mrs Parmar highlighting the need for resources to be targeted in the right place in order to achieve the ambitious CIP targets set.

Mr Laverty advised that the targets for 2026-27 should explicitly distinguish between recurrent and non-recurrent items, emphasising the need to achieve recurrent savings, which were not met this year.

The Chair expressed disappointment regarding the revised position, and despite there being external challenges, successful delivery of the cost improvements agreed at the beginning of the year would have prevented this position. He emphasised the need for lessons learned to be incorporated into next year's planning process, as failure to meet the plan would be unacceptable. Mrs Wake confirmed that the 2026/27 CIP would be developed by the end of March, aligned with the strategic plan. Plans for future years would also be available by the end of June.

The Board **NOTED** the report and expressed disappointment in the financial position.

## 15. Research and Development Report

TB (03/26) 011

Dr Anderson introduced Ms Hard who had joined the meeting to present an update on the research and development work ongoing within the Trust. He also thanked Ms Hard for her work and commitment to the organisation and wished her well in her new role at Birmingham Women and Children's NHS Trust.

Mrs Hard presented the report, including an update on the new 150-day clinical trial setup metric which was implemented in 2025-26, tracking regulatory approvals, site setup, and first patient visits, with performance monitored against regional and national benchmarks.

A new reporting system had been established to monitor compliance, with potential funding and reputational consequences for non-compliance. Ms Hard recommended that both the average number of days required for setup and the percentage passed or failed metrics would continue to be tracked to ensure that the timeframe and any underlying reasons for non-delivery were considered.

It was recognised that the data would be utilised by organisations to determine whether they choose to undertake clinical trials with the Trust. Ms Hard confirmed that progress would be monitored through the Research Delivery Oversight Group and reported 6-monthly to the Quality Committee.

Professor Harper expressed that patients could still be recruited to clinical trials whilst the study is being set up and therefore, this should not delay the process. She also felt that the Trust should be considering what trials were commercial and non-commercial. Ms Hard confirmed that the report developed for the Black Country Collaborative included information on all research projects and could be filtered by clinical trials that were commercial and non-commercial. She added that there may be some disparities within the national data, which would only be published for sponsors who had opted in to meet the 150-day metric and some sponsors were not engaging with this.

Dr Anderson assured the Board that the work would continue to be overseen by the Research and Development team and plans were in place to advertise for the lead role working across the group.

Mrs Hardy queried whether research trials were aligned with the Trust's strategy and Dr Anderson confirmed that the Trust's Research Strategy is due to be reviewed and will align with priorities included in the Group Clinical Services plan.

The report was **NOTED** by the Board.

## 16. Guardian of Safe Working

TB (03/26) 012

Dr Anderson presented the report highlighting that one of the recommendations from the CQC Well Led inspection was that the Board should receive more regular updates from the Guardian of Safe Working, noting the positive relationship the Trust has with its resident doctors. A report had been received in January which updated on national changes to the way in which exceptions were reported. The Trust had implemented these reforms from 4<sup>th</sup> February and had successfully transitioned reporting to the Allocate system which is more efficient and supports in avoiding

breaches of confidentiality. There had been an increase in reports initially which had been expected and was attributed to the system being easier to use and residents being encouraged to report. The new reporting system enabled the teams to monitor hotspot areas which were currently in Acute General Medicine and support is being provided to address this.

The Board **NOTED** the report.

## Our People

### 17. Performance against Workforce Forecast

**TB (03/26) 013**

Mr Fleet presented the report, reminding the Board that the plan for 2025/26 was to reduce deployed Full Time Equivalent (FTE) posts by 8.5% equating to 718 FTE. At month 10, the Trust had delivered a 5.4% reduction primarily through agency and bank reductions, equating to 466 posts. The Trust had significantly reduced agency staffing as set out in the plan but had not met the trajectory for reduction of bank staffing.

The Board were advised that the Trust is 43 FTE above the 2026 forecast outturn requirement of 8054 FTE and it was noted that the non-delivery of the agreed trajectory would have an impact on next year's plan. Efforts were being made to deliver reductions to achieve the forecast outturn including the closure of beds within Medicine and Emergency Care to reduce temporary staffing further. It was noted that staffing requirements to support sprint activity were being protected due to income associated with this.

Mr Fleet reflected on the workforce plan for 2025/26 noting that it was too ambitious and the need for the organisation to focus on transformational projects to deliver the workforce reduction over the next three years. Mrs Wake thanked Mr Fleet for his honesty and transparency and for reflecting on actions that need to be taken to improve the position.

The Chair acknowledged the persistent challenges faced by the organisation and their effect on workforce reduction efforts. He emphasises the importance of balancing operational demands and staff wellbeing.

The Board received and **NOTED** the month 10 workforce position.

## Governance, Risk & Regulatory

### 18. Board Assurance Framework

**TB (03/26) 014**

Mr Conway presented the quarterly update on the Board Assurance Framework (BAF) highlighting that internal audit had confirmed reasonable assurance at the Audit Committee and felt that it was aligned with the current risks for the organisation. Due to the recent resubmission of the Trust's medium-term plan it had been agreed that a deep dive would be undertaken into the BAF risks ensuring current appetite and scoring is correct. It was noted that actions had been agreed as part of the internal audit report and an update on these would be shared with the refresh report to the Board.

Mrs Writtle acknowledged progress made by the committees this year in relation to the BAF but highlighted the need for further support to the committee chairs in ensuring that their agendas are aligned with the BAF risks.

Mr Argyle highlighted that the Audit Committee had raised the importance of linking the BAF to the wider risks throughout the organisation. Mr Conway highlighted that this would be picked up as part of the work to refresh the Risk Management Framework.

The Board **APPROVED** the current position of the refreshed Board Assurance Framework (Q3 2025/26).

### 19. Group Board Governance Framework

**TB (03/26) 015**

The Chair highlighted that the full governance framework is required to implement a group model for Dudley Group Foundation Trust and Sandwell and West Birmingham NHS Trust. He reflected on the reasons that had supported the decision to move to a group model and the opportunities in aligning the strategic direction for both organisations and utilising the strengths on both sides to improve together going forward whilst maintaining local connections through place arrangements.

Mr Conway confirmed that the paper would be presented to both Trust Boards this week for approval of the full governance framework to be embedded as part of the move to the group model, including establishment of the Group Board as a lawful joint committee under NHS Act 2006. He reiterated that both Trusts would remain sovereign organisations with SWB remaining as an NHS Trust operating under its Establishment Order and DGFT remaining a Foundation Trust governed by its Constitution and accountable to its Council of Governors. A task and finish group had been set up to oversee the development of the framework and a user-friendly guide is also being developed to support Non-Executive Directors and Committee Chairs. Some wider communications would also be shared throughout the organisation.

It was noted that the full suite of documents had been reviewed by Hill Dickinson who confirmed that the proposed arrangements are lawful under the joint working provisions of the NHS Act 2006.

Mrs Parmar highlighted that the organisation would be entering a strengthened contractual regime with commissioners and recommended that the executive scheme of delegation be amended to reflect this. Mr Conway agreed to amend this outside of the meeting following approval by the Board.

The Chair and Mrs Wake thanked Mr Conway for his hard work in developing the framework and it was agreed that the naming would be amended to ensure the Trusts were named alphabetically within the document.

The Board **APPROVED** the full suite of Group Model governance documents presented and formally established the Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust Group Board as a joint committee effective 1 April 2026.

The Board **APPROVED** the establishment of the joint Board committees as constituted within the framework.

The Board **DELEGATED** authority to the respective Board Secretaries to make any final non-material formatting or technical amendments prior to publication.

## 20. Trust Seal Report

TB (03/26) 016

Mr Conway shared the report which is required to be submitted to the Board to outline the use of the Trust Seal during 2025/26.

The Board **APPROVED** the affixation of the Trust Seal.

### For Information

## 21. Any other business

Verbal

There was no other business.

Details of the next meeting of the Public Trust Board: Move to the Group Trust Board TBC

Meeting close

**Unconfirmed Minutes of the Board of Directors meeting (Public session)  
held on Thursday 12<sup>th</sup> March 2026 10:00hr  
Clinical Education Centre, 1<sup>st</sup> Floor, South Block, Russells Hall Hospital, Dudley, DY1 2HQ**

**Present:**

Rachel Barlow, Group Chief Development Officer (RB)  
Laura Broster, Group Chief Communications Officer (LB)  
Gary Crowe, Deputy Chair (CG)  
Peter Featherstone, Non-executive Director (PF)  
James Fleet, Chief People Officer (JF)  
Joanne Hanley, Non-executive Director (JHa)  
Paul Hudson, Medical Director (PH)  
Liz Hughes, Non-executive Director (LH)  
Karen Kelly, Chief Operating Officer/Deputy Chief Executive Dudley (KK)  
Mick Laverty, Associate Non-executive Director (ML)  
Mohit Mandiratta, Non-executive Director (MMA)  
Anne-Maria Newham, Non-executive Director (AMN)  
Sir David Nicholson (SDN) **Chair**  
Jonathan Odum, Group Chief Medical Director (JO)  
Vij Randeniya, Non-executive Director (VR)  
Mel Roberts, Group Chief Nurse (MR)  
Kat Rose, Interim Chief Partnership Officer (KR)  
Adam Thomas, Group Chief Strategy & Digital Officer (AT)  
Chris Walker, Director of Finance (CW)  
Diane Wake, Chief Executive (DW)  
Lowell Williams, Non-executive Director (LW)

**In Attendance:**

Karen Anderson, Head of Childrens Services [item 3]  
Helen Attwood, Directorate Manager (Minutes) (HA)  
Helen Board, Board Secretary (HB)  
April Burrows, Freedom to Speak up Guardian [item 10.2]  
Nick Conway, Specialist Practice Coach [item 4]  
Fouad Chaudhry, Guardian of Safe Working [item 10.3]  
Peter Lowe, Group Director of Improvement [item 4]  
Luke Purdy, Youth Worker [item 3]  
Jack Richards, incoming Chief Operating Officer  
Gail Parsons, Director of Research and Development [item 9.1 and 9.5]

**Apologies**

Catherine Holland, Non-executive Director, Senior Independent Director (CH)

**Governors, Members of the Public and External attendees**

Alex Giles, Public Elected Governor, Stourbridge, Lead Governor  
Sandra Harris, Public Elected Governor, Central Dudley  
Nandi Shelembe, FT Member  
Caitlin Tilley, Correspondent, Health Service Journal

**26/15 Apologies and Welcome**

The Chair welcomed Board and Trust colleagues, a Foundation Trust member and the Lead Governor. Apologies had been received from Catherine Holland. It was the final Board meeting before moving to a Group Board from April.

The Chair extended grateful thanks to Anne-Maria Newham, Joanne Hanley and Liz Hughes who would reach their end of term at the end of March. It was Karen Kelly's last Board meeting as Chief Operating Officer who was to become the Chief Officer for the Fit for the Future programme.

### **26/16 Declarations of Interest**

The Chair drew attention to the link to the declarations location on the Trust's website. He declared that he was the shared Chair of Sandwell and West Birmingham NHS Hospitals Trust, Royal Wolverhampton NHS Trust and Walsall Healthcare Trust. The Declarations of Interest Register for all Board members was available on the Trust website.

### **26/17 Patient Story – Youth Worker**

The meeting was joined by Luke Purdy, Youth Worker and Karen Anderson, Head of Childrens Services and the item was introduced by MR.

The Board heard about the positive benefits of supporting a young person diagnosed with a chronic illness who may feel isolated or anxious. While medical staff focus on treatment, a youth worker could provide ongoing emotional support, helping them process their feelings and build resilience, whether in hospital or later at school.

It was noted that the Charity had funded Luke's post for a further year and he was currently waiting to hear if funding would be confirmed for a further one to three years going forward.

PF applauded Luke's work and asked about support for young carers. Luke confirmed that the post supports young people with long term conditions only. KA confirmed that a piece of working was underway with Ian Chadwell on support for young carers.

In response to a question from LW asking if Luke felt he was embedded in the service LP replied to confirm he was fully embedded in the team and had a strong caseload.

MM asked about the complexity of cases since the pandemic. LP confirmed that there had been a significant increase in CAMHS referrals.

The Chair commented on the connection between hospital and community. LP added that there was evidence of a reducing number of ED attendances.

It was **RESOLVED** to

- Note the patient story

### **26/18 Strategy into Action**

KR introduced the Community First team and Frailty Service who delivered a presentation about the improvement work for the Frailty service and Community First work, its links to the Trust's Vision and Values and supporting a shift in services from hospital to community in line with the Ten Year Plan.

The Chair commented that frailty was a big strategic issue for the health service and the benefits of using improvement as the approach to the service. He asked about the reason for a referral approach. The team confirmed that GP practice data was inconsistent and there was a piece of work underway to ensure that frailty coding was accurate. The referral approach allowed the service to target those patients until the work was embedded.

In response to the query from DW about the rationale for splitting clinics, the team noted it allowed for more patients onto the pathway and avoid admission. DW added that it was vital to ensure the service did not become an overnight facility.

KR assured the Board that the work would be part of the Clinical Services Plan moving forward.

PF commented on the data and the admissions that have a drug related aspect and how this linked with Community Pharmacy. The Board noted that Dudley had an integrated Pharmacy Team with structured medication reviews built into the work plans.

The Chair thanked the teams for their work and welcomed the use of improvement techniques.

It was **RESOLVED** to

- Note the Strategy into action presentation

### **26/19 Minutes of the previous meeting held on 15<sup>th</sup> January 2026**

The minutes of the previous meeting were approved as a correct record.

It was **RESOLVED** to approve the minutes of the last meeting

### **Action Sheet of 15<sup>th</sup> January 2026**

25/52.1 Corporate transformation update – update provided to the private session of March 2026 Board.

26/10.1 Performance Against Workforce Forecast – it as confirmed that members of the People Committee and Finance & Productivity Committee had met to interrogate the plan. The action was complete and could be closed.

### **26/20 Chief Executive's Overview and Operational Update**

DW summarised her Chief Executive's report given as enclosure two and highlighted the following key areas:

Operational performance for Emergency showed fantastic improvements to the 4 hour wait target and ambulance handover performance and she thanked all involved for their hard work noting that the Trust was in the top 15% in the country for its 4 hour wait performance.

The work on the Learn, Adapt, Transform programme continued with surge capacity to be closed by the end of the month.

The Trust continued to be best performing Trust locally for Cancer and in the 10 top nationally and was exceeding the trajectory for diagnostic performance.

Turnround times for Histology was noted to be much improved.

The Trust had received a letter from NHSE confirming the removal of the financial undertakings that had been applied in July 2024.

The four Black Country Trust's continued to work together as a Black Country Provider Collaborative with more detail on the programme included in the paper.

DW commended the Pulmonary Rehab Service and Liver Service for their hard work and excellent feedback following recent reviews.

The national Cancer Plan for England had been launched and the Trust was actively taking forward the priorities.

LW welcomed the improved 4 hour wait performance and asked if it was sustainable. DW confirmed that the work was part of the Learn, Adapt, Transform programme and there was now a clinician at the front door triaging direct to specialities. The teams all owned the work and pulling patients from ED into specialities. There was an associated decrease in the length of stay and a high level of assurance around sustaining performance.

In response to a question from GC about corridor care, DW confirmed that the corridor was very rarely used and any activity would be reported to the Finance and Productivity Committee and Board and it was the intention to fully eradicate the use of corridor care. GC congratulated the teams for the fantastic performance. DW confirmed that ensures that all staff receive feedback on their achievements.

The Chair congratulated DW on becoming an honorary doctor.

It was **RESOLVED** to

- receive as assurance that The Dudley Group NHS Foundation Trust was represented and have a voice within the Black Country Integrated Care System and at regional and national levels.

## **26/21 Chair's Update**

### **Public Questions**

The Chair introduced the paper given as enclosure three noting questions that had been received from Foundation Trust members.

He invited DW to respond to the question received from Foundation Trust member Mr Dimitrov related to the Lung Cancer Screening programme and the psychological impact of 'scanxiety'.

DW confirmed that the Trust recognised the psychological impact of the wait for results post screening. She explained that there were conversations with patients to set pre-scan expectations and minimise waiting times for results and the unknown waiting window and there was a structured process for communicating results. Pathways were audited and work undertaken to stratify risks as well as a programme of health and wellbeing support.

He invited RB to respond to a question received from Foundation Trust member Mr Ron Adams related to the proposed use of land opposite the Russells Hall Hospital site to provide additional car parking facilities.

RB noted that the Trust had previously actively explored options for the expansion of car parking on the land and for a number of reasons was not feasible to pursue linked to funding, conservation restrictions, and local planning controls. The Trust was recently approached on this matter separately and had passed the correspondence on to the PFI partners as part of ongoing discussions around the potential for additional parking

The Chair thanked all for their contributions.

The Chair reflected on the Board and the move to joint Board and Committees. He added that the organisation was run extremely well and noted the sustained high level of performance; he particularly welcomed the sustained improvements within ED. The Trust was working on a holistic approach on how the acute and community would work together noting that Dudley community services had a real appetite for learning from others and an openness to new ideas. Financially, the Trust had delivered what it said it would recognising that we still had a deficit. He recognised the excellent feedback from visits and the external recognition of Trusts activities; in particular the standard of maternity services. Grip and control and the demands on staff were increasingly difficult. He acknowledged the importance of the Trusts Strategy "Fit for the Future". He noted the disappointing results from the staff survey and stated that the Trust needed to better align and bring staff along on the journey ahead and confirmed that a communication from the Board will be going out to all staff.

## **26/22 Integrated Committee Upward Assurance Report**

GC introduced the report given as enclosure four, including upward assurance from each of the Committees, Finance & Productivity, Quality, People, Integration and Infrastructure. Non-Executive Committee Chairs were invited to raise any particular items for escalation to the Board.

### **Assure**

The Board was advised that strong elective, cancer and discharge performance had been maintained, with productivity plans progressing and high EPRR compliance achieved. Assurance was provided on key quality metrics, including reduced falls, strong mortality indicators, improved maternity survey results, national recognition for end-of-life care, and continued digital and innovation progress. The Board was advised that although complaints had increased, harm incidents had reduced and targeting had improved, and broad assurance was maintained across workforce, safety and IPC. Further assurance was given on workforce KPIs (excluding sickness), FTSU activity, PA/AA supervision, closure of the Windows 10 NIS notice, establishment of new Digital and Estates teams, and strong community engagement with five integration priorities confirmed.

### **Advise**

The Board was advised of pressures relating to BCPS histology turnaround times, rising pressure ulcers, and required improvements in VTE, vital signs and sepsis compliance. Additional advice highlighted delays linked to out-of-area flow, risks raised by NHSE regarding UEC, finance and CIP, and potential costs relating to ultrasound interoperability. The Board was also advised of cultural barriers identified through community grants work, partial assurance on the care navigation model, and concerns regarding appointment accessibility and fragmented links with education services.

### **Alert**

The Board was alerted to deteriorating UEC performance, increasing financial pressures, and the workforce reduction plan being off track. Alerts were raised regarding worsening staff survey results, high sickness, limited progress from Learn, Adapt, Transform, divisional overspends, and insufficient detail in 2026/27 CIP planning. The Board was further alerted to the complaints backlog, increased incidents including significant harm, sustained staffing gaps, infection rates above trajectory, and emerging financial implications as practices moved away from the Dudley Outcomes Framework.

ML asked if the Trust was picking up on early warning signs from the staff survey and in terms of our KPIs. JF confirmed that the Trust undertook regular data points from the quarterly pulse survey and were considering other touch points for next year to give more live feedback. All metrics were green for sickness. Staff satisfaction would move to red following the publication of the staff survey results.

VR commented on a connection to the staff survey and that life was generally tough for our staff outside of work and the need to consider this in a wider context. The Chair added that whilst the message to all staff from Board is being given from the staff survey. We need to consider the indicators for the People Committee.

It was **RESOLVED** to

- approve and note the report of assurances provided by the Committees upward reports, the matters for escalation and the decisions made

## **26/23 Finance Report Month 10 (January 2026) including Cost Improvement Update**

CW presented the Month 10 (January 2026) Finance Report given as enclosure five. The Board noted the following key highlights:

The Board was advised that the Month 10 (January 2026) position showed a £6.133m deficit, £3.502m adverse to plan. The Trust continued to forecast breakeven for 2025/26, though delivery risk remained high and under active management. The Board was further advised that BCICS was

£0.105m above plan and that system-level breakeven was required to avoid repayment of deficit funding in 2026/27.

The Board was advised that cash remained healthy subject to plan delivery, though the deteriorating run rate had weakened the outlook. The worst-case year-end cash forecast was £20.5m.

The Board was alerted to a remaining £1.357m gap against the breakeven forecast, with February–March performance critical. Pay was overspent by £4.435m due to capacity pressures, industrial action and delayed CIP delivery, and bank/agency usage exceeded target by 69 WTE, creating a £1.819m overspend. Non-pay costs were £15.048m overspent, largely due to CIP shortfall and higher drugs and devices spend. A CIP under-delivery of £6.861m was forecast, posing a significant recurrent risk for 2026/27.

It was noted that there had been some changes to the position since the writing of the report and this would be discussed in detail during Private Board.

LW commented that it was disappointing that the Learn, Adapt, Transform (LAT) programme was slow to start delivering its targets.

ML drew attention to the CIP gap and the under delivery of recurrent CIP and the issues it caused for the following year. He asked about the reinvestment for the Fit for the Future Programme. DW confirmed that Dudley has a strong record for CIP delivery, including recurrent. The delay in LAT is responsible for the position with a need to drive the Fit for the Future work to over deliver on CIP and recurrent savings.

CW emphasised the importance of having a good measure of ambition to drive forward for the Trust to become self-sustainable and manage its own destiny.

It was **RESOLVED** to

- Note the financial performance for Month 10 (January 2026)

### ***Comfort Break***

### **26/24 Our Place**

#### **26/24.01 Community First**

KR introduced the report given as enclosure six and highlighted the following:

- As part of the Group Strategy: Fit for the Future, the Trust is committing to four multi-year priorities to improve outcomes for patients, people and population.
- One major commitment is Community First — redesigning care around neighbourhoods, strengthening community services, and reserving acute care for those who need it most.
- The aim is to deliver proactive, integrated care closer to home through partnership working and investment in community-based initiatives.

Focus areas for new pathways and models of care

- Frailty and nursing home support
- Development of the Care Navigation Centre
- Shifting outpatient services out of hospital

Two key delivery mechanisms highlighted

- Care Navigation Centre – including the proposal for a South Single Point of Access to direct urgent care to the right place quickly.

- Integrated Neighbourhood Teams (INTs) – building local, multidisciplinary teams to provide personalised, joined-up community care, aligned with NHSE’s 2025/26 neighbourhood care guidance.

GC ask how the Trust would get other partnerships involved. KR confirmed that there was ongoing work with Primary Care to move past some of the barriers around Neighbourhood Health. MMA added that the Trust was ahead of the curve with work already in place within localities.

PF welcomed the report and reflected on the work around data sharing and alignment of neighbourhood footprints.

VJ commented that it would be wise to understand our partners agendas.

The Chair confirmed that he did not like the use of North and South Groups.

It was **RESOLVED** to

- **Approve** the direction of travel that is outlined which aligns with the programme being proposed as part of the Black Country (BC) proposal for a North and South Single Point of Access for urgent care in the right place at the right time
- **Approve** the direction of travel for Dudley Integrated Neighbourhood Teams and the proposals within the draft Integrated Neighbourhood Team Implementation Plan

## **26/25 Deliver Right Care Every Time**

### **26/25.1 Chief Nurse and Medical Director Report**

Gail Parsons (GP), Director of Research and Development joined the meeting.

MR introduced JO and GP to present the combined Chief Nurse and Medical Director Report given as enclosure seven provided a Research and Innovation update that highlighted the following:

#### **Assure**

- NHS Licensing Department expected to approve Trust name change to include “University” by March 2026; ongoing work aligned to 5-year UHA trajectory plan covering Research, Education & Innovation.
- Research activity and staff engagement continue to grow, with increased studies and funding applications.
- Collaboration with Black Country partners progressing to expand regional research opportunities aligned to NHS long-term plan.

#### **Advise**

- University Hospital Association (UHA) had transitioned to NHS Providers; criteria currently under consultation.
- Trust had submitted formal feedback and expressed interest in joining review panel; revised criteria now with DHSC awaiting final approval.

#### **Alert**

- Proposed new UHA criteria introduce strengthened requirements, including:
  - **Governance & Leadership:** Clear board-level accountability for Research and Education.
  - **Research Workforce:** Trusts must state workforce research tiers as % of total staff.
  - **Research Funding:** Evidence of 3-year average research income required.
  - **Commercial income & reinvestment:** Now desirable, not mandatory.
  - **Education Standards:** Updated expectations for multi-professional training, placements, student experience and quality assurance.

LH welcomed the report and commented on the close work between Sandwell and Dudley in developing the Strategy together.

GP commented on the requirement for Board level representation which could be a shared representative.

ML asked about links with Birmingham University. GP commented that the Trust had close links in terms of education and training of medical students.

PF commented that it would be useful to see the impact in terms of outcomes from the Trust's research activities.

It was **RESOLVED** to

- receive the report for assurance
- support the ongoing work to implement the Trust's strategic plan to achieve University Hospital Association Status

### **26/25.2. Integrated Quality and Operational Performance Report**

The report given as enclosure eight was taken for assurance and had been scrutinised by individual Committees related to the following highlighted items:

#### **Assure**

- Falls: 110 falls in January; harm largely low (62 no harm, 47 low, 1 moderate). Two AARs completed under PSIRF; moderate harm remains rare.
- Flu Vaccination: Uptake 40.3%, above target and 2nd highest in ICB; focus now on bank staff. Programme ends 31 March. Maternity hub nominated for NHSE Excellence Award; system-wide research project in development.
- Discharge: DRD to discharge improved to 4.27 days.
- ED 4-hour: 73.4% vs 78% target; recovery plan in place focused on ED and downstream flow.
- Cancer:
  - 28-Day FDS: 84.4% (above 77% target).
  - 31-Day: 90.6%, impacted by Breast surgical capacity.
  - 62-Day: 75%, backlog reduction ongoing.
- DM01: 85% (above trajectory).
- RTT: 18-week performance fell to 61%, consistent with national seasonal pressures.

#### **Advise**

- Patient Experience: 80% positive; decline in maternity scores due to "don't know" responses from poor form timing—data issue, not care quality. Guidance and form review planned.
- Safer Staffing: CHPPD slightly reduced; RN bank use increased due to AMU unfunded beds and ED/Discharge surge spaces. 379 red flags, mainly due to staffing gaps.
- TES Use: 27 incidents; old ED resus and discharge lounge used for surge capacity (total 37 extra patients), creating staffing risk.
- Mental Health: Significant rise in MHA activity; Section 136 presentations increased; CYP attendances doubled.
- Sepsis: Antibiotics within 1 hour: ED 66.7%, Inpatient 58.4%—action plan in place.
- Ambulance Handover: Attendances increased to 9,856.
- Cancer: FDS trajectory sustained; urology remains focus.
- Elective: <0.1% waiting >52 weeks; no 65-week breaches.

GC asked about the issues with cancer diagnostics. KK confirmed additional Urology clinics were being held. DW confirmed that Urology had been a fragile service for a number of years; Wolverhampton did not have capacity for all areas of Urology work and were working to revolutionise pathways noting good progress was being made.

It was **RESOLVED** to

- Note the contents of this report providing assurance on oversight of quality, safety and operational performance

### **26/25.3 Winter Plan 2025/26 update**

KK presented the Winter Plan 2025/26 update given as enclosure nine. The Board noted the following key highlights:

#### Winter Plan & UEC Update

- Winter demand broadly matched modelling, but extra beds held at 60 vs predicted 100 due to improved discharge and reduced length of stay from LAT work.
- Rising admissions and acuity continue to offset some gains.

#### UEC Activity & Performance

- ED attendances increased to 9,851 in January; 34% conversion rate reflects higher acuity.
- Ambulance handovers remain the most challenged metric; improvement trajectory agreed with NHSE with new measures from 26 Feb 2026.
- Success depends on internal flow improvements and joint work with WMAS, including Call Before Convey and Care Navigation pathways.

#### Winter Mitigations – Impact

- Care Navigation Centre reducing ED conveyance; further expansion planned.
- REACCT and enhanced discharge now business-as-usual, supporting direct discharge from ED/assessment areas.
- MADES and Care Transfer Hub sustaining low delays; zero-delay for Dudley Pathway 1.
- Virtual Ward capacity flexed and newly extended to care homes.
- Electronic bed state and Target Discharge Dates improving operational visibility.

#### Key Ongoing Risks

- Ambulance handovers, rising acuity/admissions, ED estate constraints, and dependence on system partners for discharge flow.

In summary the Winter mitigations had reduced escalation, limited bed expansion, and strengthened UEC system working, despite ongoing pressures.

A staff Governor had asked for clarity on the provision of beds for the Paediatric virtual ward relating to the Financial recovery planning and considerations. PH confirmed that following post investment review there are plans to expand the service and there had been no reduction in beds.

GC raised the staff wellbeing summary and limited take up and asked how the Trust could make improvements. KK confirmed that there was a plan to improve as a result of the staff survey results. GC asked about medical staff. PH added that the 10 point plan was in place to improve junior doctor working conditions and acknowledged that more was needed in terms of the support offering and how the Trust supported staff through winter. MR confirmed that she and the senior nursing team was working with the Comms team to raise the awareness of the support offer. GC added that it was important to track the impact of our actions. KK confirmed that there had been really positive engagement with the cohort of registrars.

LW commented that this Winter Plan has largely been delivered and was in a much better place than in previous years. PF agreed noting there were a number of lessons learnt and some great work undertaken. GP commented on the opportunities around focus groups and home grown studies and offered her support.

The Chair agreed that the Plan was a big step forward from previous years and acknowledged that there was an issue around the health and wellbeing support offer to staff.

It was **RESOLVED** to

- Approve the paper as an update on progress against the Winter Plan 2025

#### **26/25.4 Learning from Deaths**

JO presented the report given as enclosure 10 and highlighted the following to the board:

Assure

- Perinatal & Paediatric Mortality: Sustained improvement; full compliance with MIS Safety Action 1 in Q1. Thematic review underway after a small rise in stillbirths.
- Mortality Metrics: SHMI (96.18) and HSMR (90.83) remain stable and within expected range.
- AQUA Conditions: Continued improvement, indicating better care and reduced mortality.
- Structured Judgement Reviews: 80% rated adequate–excellent care; poorer cases mainly triaged via Patient Safety. Most SJRs generated through Medical Examiner service.
- Stroke & #NoF: Ongoing improvement in SHMI and national KPIs; #NoF dashboard supporting early issue detection.
- AQUA Care Bundle: QI work strengthening care quality and mortality outcomes.

Advise

- HED Alerts: All monitored by Mortality Surveillance Group; concerns escalated to specialty mortality leads.
- GSF Recording: Transition to new flowsheet has reduced documentation to 12%; extra support from Specialist Palliative Care and oversight via End of Life Care Group.

Alert

- Fast-Track Discharge: Risk related to not meeting 48-hour target, particularly for out-of-area patients.

MR updated the Board on the positive news in terms of the MBRACE data and the reduction in perinatal mortality making the Trust green in all target areas.

The Chair asked that Governors were to be involved in any work in relation to the Medical Examiner service and rapid release arrangements. He recognised the excellent news in relation to Perinatal services and commented that the Trust still needed to consider those parents affected by perinatal mortality.

It was **RESOLVED** to

- **Note** the assurance of both the Summary Hospital-level Mortality Indicator (SHMI)/ Hospital Standardised Mortality Ratio HSMR within the expected range; the ongoing work in relation to mortality at the Trust and assurance of good care identified in the Structured Judgement Reviews

#### **26/25.5 Research Assurance report**

JO introduced GP who presented the report given as enclosure 10a and highlighted the following to the board related to the 150 Day directive for clinical trials:

Assure

The Board was advised that a digital monitoring system was in place to track performance against the 150-day clinical trial set-up target, with Principal Investigators actively engaged through weekly progress reviews.

Study selection had improved through multidisciplinary assessment and clearer recruitment planning, and broader opportunities were now available for Advanced Practitioners, CNS, AHPs and Pharmacists to act as Associate Principal Investigators, supporting more efficient study initiation.

Advise

The Board was advised that new operational models were being explored to strengthen consistent delivery of the 150-day target. Learning had been taken from studies that had met or breached the target over the past year, with actions implemented to reduce the risk of future delays.

#### Alert

The Board was alerted that some studies had exceeded the 150-day limit, which could adversely affect future NIHR RDN performance-linked funding. Operational pressures, including sickness and surge/TES support, continued to affect research delivery. The Board was further alerted to ongoing financial constraints, with no additional funding available for novice researchers or new Principal Investigators requiring job-planned research time, resulting in inconsistency across specialties.

The Chair confirmed that the same report was being presented at all the Blak Country Provider Board and the importance of achieving the new standards.

It was **RESOLVED** to

- Note the assurances provided and the challenges encountered resulting in some trials not meeting the 150 days

## **26/26 Our People - To be a Brilliant Place to Work and Thrive**

### **26/26.1 Performance Against Workforce Forecast**

JF presented the Performance against Workforce Forecast report given as enclosure 11 noting that the full data report was located in the reading room.

The Board was advised that the workforce had reduced by 131 WTE (2%) since March 2025, with agency usage remaining low at 13 WTE and tightly controlled for essential medical cover. Bank usage had decreased by 113 WTE, demonstrating strengthened management of temporary staffing, and corporate services continued to operate close to plan with minimal reliance on temporary staff.

The Board was advised that the workforce remained 241 WTE above plan at Month 10, with substantive staffing increasing by 70 WTE, predominantly within Medicine & Emergency and Surgery, Women's & Children's, both of which continued to use additional bank staff. Current deployment was approximately 100 WTE above forecast outturn, and divisional controls were being strengthened to improve productivity, deployment discipline and alignment to forecast delivery. The Board was further advised that persistent escalation capacity and under-delivery of Learn, Adapt, Transform CIP continued to pose risks to achieving planned workforce reductions. Governance had been tightened through stricter temporary staffing approvals, enhanced tracking of non-VAR bank usage and improved Right Shift, Right Band oversight.

The Board was alerted that Medicine and SWC remained the largest contributors to workforce variance, with operational pressures preventing reductions in temporary staffing. High sickness absence and ongoing escalation demands continued to drive staffing levels beyond plan, placing delivery of WTE reduction and LAT CIP requirements at risk. The Board was further alerted that failure to achieve the forecast outturn would impact in-year financial delivery and increase the workforce reduction requirement for 2026/27.

The Chair commented that he would be interested to know the reason for the improved performance at Sandwell compared to Dudley. He commented that the focus must be on bank reduction going forward. He expressed the Board's disappointment at missing the target but noted the reasons and the aim for future plans.

It was **RESOLVED** to

- Note the report in respect of the M10 position, including progress against plan and remaining variance to forecast outturn

## **26/26.2 Freedom to Speak up**

AB presented the report given as enclosure 12 and that included the findings from the executive & non-executive Reflective Questionnaire

There had been an increase in concerns raised (Q3 Data) - 35.1% rise in concerns (from 57 to 77), may reflect improving psychological safety, increased visibility, or emerging pressure points within the organisation. There has been a significant increase in anonymous concerns, rising from 9 in Quarter 2 to 18 in Quarter 3.

JH raised the themes around fear of repercussions meant there was still work to do in respect of psychological safety. The Chair commented on the connections to the work to be undertaken following the staff survey results.

LW commented on the anonymous concerns and the use of Microsoft forms. AB confirmed staff could choose to remain anonymous. JF confirmed that there was much research related to anonymous complaints that showed when investigated anonymous complaints were less well proven and at times could be weaponised. AB added that a number of anonymous complaints were the result of poor communication.

The Chair welcomed the report and that the Trust should build the findings into our response to the results of the staff survey.

It was **RESOLVED** to

- Note the increase in concerns raised (Q3 Data).
- Receive findings from the Executive & Non- Executive Reflective Questionnaire

## **26/26.3 Guardian of Safe Working**

FC presented the given as enclosure 13 covering the period from 1 September 2025 to 25 February 2026. The Guardian confirmed that Resident Doctors in Training continued to be safely rostered and compliant with the 2016 Terms and Conditions of Service, with no fines issued during the period. Exception reports were managed appropriately through a combination of time off in lieu and payment. Thirty-three new exception reports were submitted during the period, with an additional twelve carried forward, and the Board noted the current 37 vacancies within the Resident Doctor workforce.

The Board also noted national reforms to the Guardian of Safe Working process that came into effect from 4 February 2026. These include a new reporting pathway through HR and the Guardian of Safe Working Hours, extended reporting timeframes, revised fining guidance, and a mandatory requirement for employers to offer a choice of payment or time off in lieu of excess hours worked. The Board recognised the operational and compliance implications and acknowledged the need to embed the new arrangements across the organisation.

The Chair asked about the number of vacancies. PH confirmed that he worked with A Rehman on the “golden templates”. There had been an increase in the number of junior doctors undertaking part time working. Vacancies were much reduced compared to historic trends.

GC asked whether the report could be combined with the resident doctors 10 Point Plan and how the combined information could be considered to show a fuller picture.

The Chair noted that that consideration should be given as to how GoSW data connected with the 10 Point Plan going forward.

It was **RESOLVED** to

- Note the current Exception Reporting data
- Note the reforms that commenced from 04 February 2026

## **Governance and Regulatory**

### **26/27.1 Group Board Governance framework**

HB presented the paper given as enclosure 14 detailing the Governance Framework for the establishment of a Group Model between The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham Hospitals NHS Trust, which would take effect from 1 April 2026.

The paper outlined the full suite of “governance spine” documents - including the Provider Collaboration Agreement, Schemes of Reservation and Delegation, Executive Scheme of Delegation, and Terms of Reference for the Group Board and joint committees - all of which had undergone extensive Executive review and external legal assurance. The framework enabled a single Group Board to operate across both statutory organisations while preserving each Trust’s sovereign accountability, constitutional requirements, and independent regulatory relationships. The Board noted that the model was not a merger but a formalised governance alignment designed to strengthen collaboration, reduce unwarranted variation, and support shared strategic leadership.

The Board further noted the safeguards built into the framework, including clearly defined decision-rights, escalation processes, and protections for DGFT’s Council of Governors and statutory duties. The legal review confirmed the robustness and lawfulness of the arrangements under the NHS Act 2006, with no material risks identified. Subject to approval, the Group Board and joint committees would be established from 1 April 2026, with Standing Orders and governance documentation updated accordingly. A six-month post-implementation review would assess effectiveness and ensure any refinements required are made.

JH suggested a review by internal audit to provide assurance to Board.

GC thanked HB and DC for their work, he supported the spine as established and suggested the production of short “how to” guide for Board members. HB confirmed that the guide was being developed.

It was **RESOLVED** to

- Approve the full suite of Group Model governance documents as presented
- Formally establish The Dudley Group NHS Foundation Trust – Sandwell and West Birmingham Hospitals NHS Trust Group Board as a joint committee effective 1 April 2026.
- Approve the establishment of the joint Board committees as constituted within the framework.
- Delegate authority to the respective Board Secretaries to make any final non-material formatting or technical amendments prior to publication.

### **26/27.2 The Dudley Group NHS Foundation Trust - Accountability Framework**

The Board received the Accountability and Integrated Governance Framework given as enclosure 15, which set out the governance structures, accountability arrangements and performance monitoring processes required for the Trust’s transition into the new Group Model with Sandwell and West Birmingham Hospitals NHS Trust from April 2026.

The framework was presented as the key mechanism for ensuring statutory compliance, integrated oversight, strengthened risk management and alignment with national NHS priorities. It was noted that the framework had been developed to support delivery across the Trust’s strategic aims relating to patients, people and place, and that it directly supported several Board Assurance Framework risks, including quality, workforce, partnership development, finance and operational performance.

The Board noted that the Framework would provide the foundation for consistent and transparent decision-making across the Group Model and would underpin effective assurance as the new governance arrangements came into effect.

It was **RESOLVED** to

- Approve the Accountability and Integrated Governance Framework

### **26/27.3 Board Assurance Framework**

The Board received the updated Board Assurance Framework (BAF) given as enclosure 16, which provided an overview of progress against the Trust's six strategic risks and the assurance levels assigned by the relevant Board committees.

It was noted that three risks: Quality (BAF 1), Partnerships (BAF 3) and Operational Performance (BAF 5) had been rated as providing positive assurance, while Workforce (BAF 2), Finance (BAF 4) and Digital/Infrastructure (BAF 6) had been rated as inconclusive, reflecting ongoing pressures in these areas.

The Board also acknowledged that joint BAF reporting with Sandwell and West Birmingham NHS Trust had begun as part of the transition to Group working.

The Board further noted that the annual BAF audit, completed by RSM, had concluded that the Trust had a robust assurance framework in place, with only minor opportunities for refinement. A refreshed, integrated Group BAF would be developed during Q4 2025/26 and Q1 2026/27 to align with the emerging single Group strategy. The Board formally received the report and noted the planned next steps.

It was **RESOLVED** to

- Approve the Board Assurance Framework summary report

### **26/28 Trust Seal Report**

The Board received the Trust Seal Usage Report given as enclosure 17, which confirmed that all sealings between January 2025 and March 2026 had been recorded, authorised and witnessed in accordance with the Trust's Constitution. The report noted seven instances of seal use during the period, covering property-related documents including deeds of surrender, licences, leases and underleases for sites such as Treetops Nursery, Corbett Hospital, Ridge Hill and Merry Hill.

It was **RESOLVED** to

- Approve the Trust Seal report

### **26/29 Any other Business**

There was none raised.

### **26/30 Date of next Board of Directors Meeting**

The next meeting would be held on Wednesday 17<sup>th</sup> June 2026.

### **26/31 Meeting Close**

The Chair declared the meeting closed at 13:47 hr.

.....  
Sir David Nicholson  
**Chair**

Date:

**Action Sheet\***

**Board of Directors – Public session**

**Dudley - 12<sup>th</sup> March 2026**

Item No	Subject	Action	Responsible	Due Date	Comments
26/06	Chair's Update	Board to receive additional assurance directly from the MTI doctor in a report to a future board	PH	May'26 tbc	
26/9.4	Perinatal Quality Surveillance Dashboard	data supporting the heatmap to be explained in more detail at the next Board meeting.	CM/BM	May'26	Agenda item Complete
26/10.1	Performance Against Workforce Forecast	members of the People and Finance and Productivity Committee to meet to interrogate the Performance against workforce reduction plan	CH/LW	Mar'26	Complete

**Sandwell – 11<sup>th</sup> March 2026**

Ref	Action	Lead	Deadline	Update
1.	<b>ACTION: Update on the outcomes of the evaluation and the impacts on the winter plan for 2026/27 to be presented to the Board.</b>	JN	May 2026	<b>COMPLETE – to be included in the latest report</b>

*\*standard template to be used from July onwards*

<b>REPORT TITLE:</b>	Public Chief Executive Report		
<b>SPONSORING EXECUTIVE:</b>	Diane Wake, Group Chief Executive		
<b>REPORT AUTHOR:</b>	Helen Board, Board Secretary (Dudley) Dan Conway, Associate Director of Corporate Governance/Company Secretary (Sandwell)		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type:		Requested action: (place an 'x')		Applies to: (place an 'x')	
	Decision		Approve	x	Both Trusts
x	Assurance		Agree		Sandwell and West Birmingham NHS Trust
	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
		x	Discuss		
		x	Note		

#### Suggested discussion points

- NHS Excellence Awards
- Midland Metropolitan Learning Campus
- Operational Performance inc. Ambulance handovers
- Update from National Oversight Framework webinar
- NHS Foundation Trust Governors – Clarification
- Charity Update
- Healthcare Heroes/Staff Recognition
- Patient Feedback
- Awards
- Visits and Events

#### Alignment to our Vision

##### Sandwell and West Birmingham NHS Trust

<b>OUR PATIENTS</b>	x	<b>OUR PEOPLE</b>	x	<b>OUR POPULATION</b>	x
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##### The Dudley Group NHS Foundation Trust

<b>PATIENTS</b>	x	<b>PEOPLE</b>	x	<b>PLACE/POPULATION</b>	x
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#### Previous consideration

none

#### Recommendations

a) **Note and discuss** the contents of the report

#### Escalation

Should any element of this report be escalated:

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

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	x	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources	x	2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce	x	3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>	x	4.0: Failure to achieve financial plan

x	004: Deliver on its ambitions as an integrated care Organisation	x	5.0: Failure to achieve performance requirements
x	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
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 Group Public Trust Board on 20 May 2026

### Chief Executive's Report

#### 1. NHS Excellence Awards

- 1.1 The Employability Programme that has been established at Sandwell and West Birmingham NHS Trust has been selected as a regional champion in the **Valuing our people category** for the first NHS Excellence Awards. This is a fantastic achievement and a testament to the impact of our work.
- 1.2 As a regional champion, we are invited to attend the awards ceremony taking place at NHS ConfedExpo 2026 in Manchester in June 2026. The ceremony will also showcase the outstanding work taking place across the NHS and partner organisations and celebrate the national winners.

#### 2. Midland Metropolitan Learning Campus

- 2.1 The Midland Metropolitan University Hospital Learning Campus (MMLC) opened at the end of March 2026. Funded through the Smethwick Towns Fund and the West Midlands Combined Authority, the MMLC is a collaboration between the Trust and its Learning Works facility, Sandwell Council, Aston University, the University of Wolverhampton and Sandwell College, with a focus on regeneration, employability, community development and establishing a centre of excellence for education and skills, including Sandwell's first university campus.
- 2.2 The Campus is now operational, with Sandwell College teaching underway, the Trust's Learning Works and Apprenticeships teams delivering training and employability programmes from the site, and Occupational Health due to occupy the building in May. Early delivery is progressing well: education and employability programmes have transitioned smoothly, the University of Wolverhampton delivered the first Level 7 programme on 30 March with further modules planned for September, and new master's level modules are being developed with Aston University. Recent media coverage has been positive, highlighting regeneration, investment and workforce development, and planning is underway for an official opening later in the year.

#### 3. Operational Performance

##### 3.1 The Dudley Group - updates

**3.1.1 Emergency Access Standard Performance (EAS)** - In March 26, we saw a 16% increase for type 1 attendances compared to February. Despite this our performance against the EAS standard showed a 9% improvement in March with all attendance types contributing and achieving 85.40% vs 78% target. On going focused actions, with Deputy Matrons further highlighting 4hr performance whilst on clinical floor to teams and continued scrutiny that GP letters are being directly streamed to appropriate area to avoid being booked into ED.

**3.1.2 Ambulance Handover** - In March 2026, we saw an 11% increase in ambulance arrivals compared to February. Despite this 95% of all ambulances were handed over within 45 minutes. The key action focus remains on streamers and triage nurses to continue to utilise pathways as early as possible and sit out suitable patients; supported by the APEX Consultant during the day to filter referrals to Specialty teams; with additional overnight Medical Registrar support to monitor take and discharge appropriate patients from ED. We continue to request for all CAT 3 ambulances to contact the Dudley Clinical Hub, even if already

presented at hospital, to explore potential community-based interventions and avoid any unnecessary hospital admissions

**3.1.3 Discharge Ready Date (DRD) - March 2026** - In March, the average time from Date Ready for Discharge (DRD) to discharge increased slightly to 4.22 days, compared to 3.91 days in February. Whilst this represents a small deterioration month on month, performance remains below the January position of 4.27 days, indicating that overall progress has still been broadly sustained across the quarter.

### **3.1.3 Cancer Performance (February 26 validated)**

**28 Day Faster Day Standard (FDS):** achieved 84.6% vs 77% target.

Focus on tumour site level continues to further improve performance. Colorectal and Urology remain the most challenged sites for FDS at present. Work is ongoing with BCPS to help improve TAT's within the prostate and gynaecology pathway.

**31 Day Combined:** achieved an improved performance of 91.9% vs 96% target; and improvement is expected to continue in March 2026. Urology and Skin remain challenged due to capacity for surgical patients and biopsy capacity. As these are two of our largest tumour sites, we notice the impact when they are underperforming.

**62 Day Combined:** performance reduced to 72% vs 75% target, but we remain on track to achieve the March 26 trajectory. Breast and skin were the most challenged tumour sites in February. Reduction of 62 backlog remains an area of focus. Breast and Skin remain in focus to increase capacity for surgical patients and biopsy capacity, as these are two of our largest tumour site that are underperforming. There is ongoing work to improve capacity for the bladder pathway to improve capacity for first outpatient appointment.

### **3.1.4 DM01 Performance- Diagnostic tests**

DM01 for March 26 shows performance of 88.8% against a trajectory of 80%; with ongoing actions against:-

- Sleep Studies recovery to continue
- NOUS capacity to increase from April 2026 to support in reducing current backlog
- To review Dexa waiting times and develop plan to increase capacity
- Continue to monitor impact of reduced staffing levels across all modalities

### **3.1.5 Black Country Pathology Services (BCPS) Performance (February 26)**

**Histology** - The 10-day urgent Histology performance was 54% vs 70% target. Performance had declined due to impacts from: -

- Annual leave due to half term
- SBS Digital which involved scanners down for UAT testing
- New process with SBS digital did cause some problems within technical and admin workflow due to several technical issues.

**3.1.6 Elective Restoration & Recovery** - The trusts 18-week RTT standard had declined over the past month, achieving 62.8% of patients treated within 18 weeks in March. This is behind trajectory, consistent with national and seasonal trends. We have significantly reduced 52 week waits with fewer than 0.1% of patients waiting longer than 52 weeks and no 65-week breaches were reported, and none are expected. Performance against time to first outpatient appointment is ahead of plan, at 67.6% compared with a target of 65.7%.

**3.1.7** The total waiting list has stabilised but remains above plan with Specialty-level action plans in place. The Quarter 4 validation sprint was extended to the end of April, with longer-term plans to remunerate activity under "patient not present" tariffs. The Trust achieved 64.03%

## **3.2 Sandwell and West Birmingham- update**

**3.2.1 Urgent & Emergency Care** - EAS performance in March improved to 75.26%, the highest over the winter period. A robust 4hour recovery plan is currently under implementation to return performance to 78% and

above, recognising the sustained recovery relies on both ED owned changes and a material improvement in admitted patient flow beyond the department.

Ambulance handover also improved in March to 79.78% offloaded in 45 minutes with the average offload at 51.4 minutes. The Trust is committed to delivering the 45minute target and have implemented a suite of initiatives from end of April to achieve this.

Progress against the EAS metrics continue to be underpinned and driven via the UEC Improvement Programme with early indicators showing recovery from May onwards.

**3.2.2 Elective Restoration and Recovery** - Performance against the 18-week RTT standard improved in March, we delivered 63% versus a trajectory of 60% constituting a 4.58% improvement compared to Feb (58.42%).

- 52 weeks <1% - achieved 0.58% (improvement from February)
- Outpatient first new of 67% within 18 weeks - achieved 65.85% (3% improvement from February)
- PIFU - achieved 2.78% (against 5% target)

The Trust achieved 63% for RTT through the elective Sprint which was validated at the end of April

### 3.2.3 Cancer Performance

**28 Day FDS:** Performance for March 2026 was reported at 77% - 2% below the planned trajectory, with an estimated 33 additional patients required to have been seen within target to meet expectations. Breast and Lung services were performing strongly at over 90%, Skin and Upper GI were in the 81–85% range, while Haematology and Urology remained lower at 61–64%. Colorectal and Gynaecology were between 50–54%, with Head and Neck recording the lowest performance at 43.4%.

**3.2.3 31 Day Performance:** In February 2026, performance improved to 93.15% (vs 96% trajectory). Achieving the target would have required an additional 5 patients to be treated within the required timeframe. Pathway-level analysis shows that Gynaecology recorded 4 breaches, largely driven by capacity constraints. Skin and Breast pathways each had 2 breaches linked to similar pressures, while Colorectal and Urology recorded 1 breach each, primarily due to delays in histology.

**3.2.4 62 Day Performance:** In February 2026, performance improved to 70.3% following validation but remained approximately 5% below the planned March trajectory. To meet the target, an additional 5 patients would have needed to be treated within the required timeframe. Performance varied across pathways, with Upper GI achieving over 80%. Breast, Haematology, Lung, and Urology were in the 70–79% range, while Lower GI and Skin delivered between 60–69%. Head and Neck and Gynaecology recorded the lowest performance, at approximately 32–33%, indicating ongoing capacity and pathway challenges in these areas.

## 4. Update from National Oversight Framework webinar

4.1 The National Oversight Framework has been updated to include segmentation of ICBs and is now aligned with the Medium-Term Planning Framework and the new national quality strategy. The framework places greater emphasis on scored assurance metrics, with future iterations expected to move further towards outcomes rather than activity. Segment 5 has been removed, and integrated trusts will be required to report across all relevant service metrics (likely c.45 for DGFT). Scoring methodologies will be refined further in technical guidance. The framework will apply from Q1 performance once published, meaning it is likely to feature in September PRMs, alongside a reassessment of provider capability in May/June.

4.2 All providers will now be assessed against a flow metric; however, caution was noted in relation to NCTR/intermediate care measures given reliance on social care capacity. The financial override remains in place for this year but is under review, as it can disproportionately penalise organisations marginally off plan despite credible recovery trajectories, potentially undermining public confidence. NHSE is considering tolerance levels and moderation for future years, noting anomalies such as ambulance trusts being placed in widely differing segments despite broadly comparable operational performance.

## 5. NHS Foundation Trust Governors – Clarification

5.1 NHS England has issued guidance clarifying the position of NHS foundation trust governors following proposals in the emerging 10 Year Health Plan to remove the statutory requirement for councils of

governors. Any change to the role of governors would require primary legislation, Parliamentary approval and an agreed implementation date. Until such time, the role of governors remains unchanged in law, and trusts are expected to continue to work with councils of governors in line with their constitutions.

- 5.2 NHS England has advised that, if the statutory role is removed in future, trusts will still be expected to have robust arrangements for public and patient engagement, which will form part of assessments for advanced foundation trust status. In the interim, and while uncertainty remains, trusts may consider whether their constitutions allow for pausing governor elections where terms expire, provided a quorate council can be maintained.

## 6. Charity Update - Dudley

### 6.1 Community Bridge – Supporting Safe Discharge

The Community Bridge Service has launched at the Trust, providing practical, non-clinical support to help vulnerable patients settle safely at home following discharge. The service includes a home visit within 24–48 hours and follow-up support for up to four months, focusing on issues such as food, heating, isolation and confidence.

Community Bridge complements existing services and aims to reduce avoidable readmissions by addressing non-clinical barriers to recovery. The service is funded by Dudley Group NHS Charity, Black Country ICB and Dudley Adult and Social Care, and delivered in partnership with the Trust Charity, Volunteering Service, Dudley Care Transfer Hub and Dudley CVS.

### 6.2 Healthy Hearts, Healthy Workforce – New Wellbeing Project

The Dudley Group NHS Charity secured funding for *Healthy Hearts, Healthy Workforce*, a new wellbeing project funded by NHS Charities Together and NHS England. The project focused on improving cardiovascular health for colleagues most at risk.

It delivered workplace-based cardiovascular health checks for Black, Asian and Minority Ethnic staff aged over 40, removing barriers such as shift patterns and access to primary care. Using portable SiSU Health Stations, colleagues completed digital health assessments at work, with those at risk offered personalised follow-up support from Action Heart to promote early prevention and reduce health inequalities.

## 7. Will Week Success

- 7.1 The Dudley Group NHS Charity celebrated a successful Will Week 2025 in partnership with Wall James Chappell Solicitors. The firm provided will-writing services in exchange for donations and visited neonatal and elderly care services to see the impact of charitable support first-hand.

- 7.2 Will Week 2025, alongside additional fundraising, raised an impressive **£4,264** for the charity.



*Image: Will Week visit*

## 8. Dragon Boat Race

- 8.1 On Sunday 17th of May, colleagues from across the Trust will be taking part in the Dragon Boat Race at Himley Hall, coming together for a day of teamwork, friendly competition and fundraising.
- 8.2 Four fantastic teams: Communications and Recruitment, Pain Management, Corbett Outpatient and Therapy, and our Corporate Nursing Team are all raising funds for the Dudley Group NHS Charity, helping to support patients, staff and services across the Trust.
- 8.3 The event is supported by headline sponsor Jack Wolf Group, IPL Schoeller Wolverhampton and Barratt Homes.

To support the team please visit  
[www.facebook.com/DudleyGroupNHSCharity](https://www.facebook.com/DudleyGroupNHSCharity)

*Image: Dragon Boat Race promotion*



## 9. Healthcare Heroes/ Ambition, Respect & Compassion - Staff Recognition



In Dudley, Sasha Bursi was nominated for consistently providing excellent care to patients and dedication to her work. Sasha goes above and beyond for you patients to make sure their needs are being met. She also proactively identifies patients requiring elevated care and ensure appropriate further investigations with timely follow-ups are set up, ensuring patients get the care they need as soon as possible.

*Image: Chief medical officer presenting award*

In Sandwell, Scan4Safety team were nominated after they recently experienced a tragedy within their team, but despite this, they showed great resilience and worked together to ensure our wards, areas and departments had what they needed to continue to deliver care to patients.

*Image: Scan4Safety team receiving award*





*Image: ED team receiving an award*

Our Dudley Group ED Ambulance Triage team were nominated because of the incredible work they have done in reducing ambulance handover delays in line with the new 45-minute guidance. They have all worked hard to implement new processes and a different way of working to meet the target and everyone has been involved and worked as a team to make it work. On one day the team triaged 62 ambulances in one shift with average triage time of 15 minutes with 14 of those ambulances being triaged in an hour with no patient going over a 30-minute waiting time which is a brilliant achievement.

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**10. Awards**

SWB celebrated three colleagues who have each dedicated over 50 years to the NHS. Together, Dr Peter Good, Dr Bill Thomson and Stephen Turner represent an incredible 150 years of NHS service supporting patients, colleagues and communities.

*Image: long service awards to staff*



Dudley based Matron for Elderly Care & Frailty Rachael Collins has been announced as a finalist for the prestigious Outstanding Contribution to Respiratory Care Award

*Image: Matron Rachael Collins*

Congratulations to the 'More than a Job' programme, led by the SWB's Widening Participation team, which has been recognised by the NHS Excellence Awards. The programme has been named Midlands regional champion in the Valuing our People category, which recognises initiatives that improve career pathways, wellbeing and staff experience.



*Image: 'More than a job' participants*



The SWB stroke services have been given an A rating in a recent audit by the Sentinel Stroke National Audit Programme (SSNAP). SSNAP measures the quality and organisation of stroke care in the NHS across England, Wales and Northern Ireland, with an A rating being their best rating.

*Image: Stroke services staff*



The Dudley Group has recently achieved foundation level of the WM combined authority 'Thrive into Work Foundation' level. This award demonstrates that the Trust is recognised for improving the health and wellbeing of our employees. . [Accredited Employers - Thrive at Work](#)

## 11. Patient Feedback

- 11.1 Dudley Rehabilitation Service** - The physiotherapist was an extremely, friendly and helpful individual, he couldn't do enough to help us and was so attentive to our needs. Delightful character and made us feel very cared for and that we are definitely in good hands!
- 11.2 Midland Met Emergency Department**  
My brother was admitted to A and E having suffered a stroke. On arrival staff were so prompt to get him into a cubicle and he had a CT head scan and the result in less than 2 hours. Staff were very kind to myself and 2 others with me. We were given a cup of tea in A and E. My brother was transferred to a ward a short while after. Whilst there he was treated very well. Very impressed with this hospital. Keep up the good work and thank you.
- 11.3 Day Case Unit - Russells Hall Hospital**  
From beginning to end everyone was brilliant, helpful, friendly and made me feel safe and informed me of what was going to happen next, Natalie, Alison, Angela, Helen and theatre staff were amazing.
- 11.4 Dr Rathod (SWB)**  
A while back, my family and I went through something really stressful. It came out of nowhere and everything escalated so quickly that we barely had time to process what was happening. Walking into the hospital that day, I remember feeling completely lost. That's when we met Dr Rathod. From the start, he was calm in a way that didn't feel forced. He spoke to us like normal people, not in that overly formal or distant way you sometimes get. He actually took the time to hear us out. We had a lot of questions and probably repeated ourselves more than we realised, but he never made us feel awkward about it. Everything was handled carefully, and you could tell he takes his work seriously. At the same time, he made the whole situation feel a bit less overwhelming just by the way he spoke and carried himself.

## 12. Visits and Events – March and April 2026

4 March	Maternity Review Leaders Peer Group
5 March	NHSE Temporary Staffing Oversight Group
6 March	Birmingham, Black Country and Solihull Chief Executives Meeting
6 March	Joint Sandwell and Dudley Non-Executive Monthly Briefing
9 March	Audit Committee, Dudley Group
10 March	NHSE 100 Leaders Onboarding Event
11 March	Public and Private Trust Board Meeting, Sandwell and West Birmingham
12 March	Public and Private Trust Board Meeting, Dudley Group
13 March	Black Country Provider Collaborative Joint Board Workshop
16 March	Black Country ICS Cancer Board
16 March	NHSE Regional Performance and Delivery Group
20 March	Staff Project Search Coffee & Cake Event
20 March	Local MP Briefing
20 March	NHSE Sandwell and Dudley Provider Review Meeting
24 March	Staff 50+ Years Long Service Awards, Sandwell
25 March	Black Country Elective & Diagnostic Strategic Board
26 March	Joint Finance and Productivity Committee, Dudley and Sandwell
27 March	Birmingham, Black Country and Solihull Chief Executives Meeting
30 March	Birmingham and Solihull ICB Committee In Common
31 March	Staff Walkabout – Emergency Department
10 April	Joint Sandwell and Dudley Non-Executive Monthly Briefing
10 April	Corporate Services Transformation Programme Board
22 April	NHSE Black Country Performance Call
23 April	Joint Finance and Productivity Committee, Sandwell and Dudley
23 April	Integrated Primary Care Convention
24 April	Black Country Provider Collaborative Executive Meeting
27 April	Black Country ICS Cancer Board
27 April	Freedom To Speak Up Steering Group, Dudley
29 April	Sandwell Leadership and GP Leadership NHS Birmingham & Solihull
29 April	Black Country Elective and Diagnostic Strategic Board
30 April	NHS Oversight and Framework 2026/27 Webinar

<b>REPORT TITLE:</b>	Appointment of the Senior Independent Director (SID) for Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust		
<b>SPONSORING EXECUTIVE:</b>	Diane Wake, CEO		
<b>REPORT AUTHOR:</b>	Dan Conway, Associate Director of Corporate Governance/Company Secretary		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
x	Decision	x	Approve		Both Trusts
	Assurance		Agree	x	Sandwell and West Birmingham NHS Trust
	Discussion	x	Endorse	x	The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
			Note		

Suggested discussion points	
The purpose of this report is to	
<ul style="list-style-type: none"> <li>- Seek Board approval for the appointment of a Senior Independent Director (SID) for Sandwell and West Birmingham NHS Trust</li> <li>- Seek Board endorsement of the appointment of a Senior Independent Director (SID) for The Dudley Group NHS Foundation Trust noting the requirement for final approval by the Council of Governors.</li> </ul>	

Alignment to our Vision					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x
The Dudley Group NHS Foundation Trust					
PATIENTS	x	PEOPLE	x	PLACE/POPULATION	x

Previous consideration	
None	

Recommendations	
a)	<b>Approve</b> the appointment of Jatinder Singh as Senior Independent Director for Sandwell and West Birmingham NHS Trust and <b>Record</b> its thanks and appreciation to Mick Laverty for his contribution and service as Senior Independent Director.
b)	<b>Endorse</b> the appointment of Peter Featherstone as Senior Independent Director for The Dudley group NHS Foundation Trust noting the requirement for final approval by the Council of Governors and <b>Record</b> its thanks and appreciation to Catherine Holland for her contribution and service as Senior Independent Director.

Escalation	
Should any element of this report be escalated: none	

BAF Impact [indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	X	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources	X	2.0: Failure to recruit, retain, train, and develop workforce

x	003: Recruit, retain, train, and develop workforce	X	3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>	X	4.0: Failure to achieve financial plan
x	004: Deliver on its ambitions as an integrated care Organisation	X	5.0: Failure to achieve performance requirements
x	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

## Report to the Group Public Trust Board on 20 May 2026

### Appointment of the Senior Independent Director (SID) for Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust

#### 1. Purpose

- 1.1 The role of the Senior Independent Director (SID) is an important element of effective NHS Board governance and leadership arrangements. The SID acts as a sounding board for the Chair, provides support and challenge where appropriate, and is available as an additional point of contact for Non-Executive Directors, Executive Directors and external stakeholders where this may be helpful.
- 1.2 Following an internal expression of interest process open to eligible Non-Executive Directors, two applications were received for the SID position at Sandwell, and one expression of interest for the role at The Dudley Group.
- 1.3 The Chair, supported by the Deputy Chair, undertook a desktop assessment of the two applications for the Sandwell role applications against the requirements of the role and the current needs of the Board. Both candidates demonstrated strong commitment to the organisation and presented high-quality applications with differing strengths and experience relevant to the role.
- 1.4 Following careful consideration, the Chair is pleased to recommend the appointment of Jatinder Sharma as Senior Independent Director for the Sandwell Role and Peter Featherstone as the Senior Independent Director for the Dudley role.
- 1.5 The Board is also asked to formally acknowledge and record its thanks and appreciation to Mick Laverty and Catherine Holland for their service and contribution in the role of Senior Independent Director at Sandwell and Dudley respectively. Throughout their tenure, they have provided valued leadership, support, challenge, and counsel to the Board and Chair during a significant period of organisational development and transition.

#### 2. The recommended candidates

- 2.1 Jatinder Sharma has made a significant contribution to the Trust during his tenure as a Non-Executive Director and Board member. His experience, leadership qualities, understanding of governance, and commitment to the organisation were considered to align strongly with the requirements of the Senior Independent Director role. The appointment will support continued strong Board leadership and governance arrangements during a period of organisational and system-wide transformation.

Subject to Board approval, the appointment will take effect immediately following the meeting.

- 2.2 Peter Featherstone previously held the role of SID and later Vice Chair at Shropshire Community Health NHS Trust, and during his time at Dudley has contributed positively to Board discussions and Committee work, bringing both patient and system perspectives to governance, quality and productivity conversations. As SID, his approach would be to support the Chair in maintaining effective Board

dynamics and governance, while ensuring that Non-Executive Directors, Executive colleagues and governors have access to an independent and trusted route for discussion where appropriate. He would also contribute to Board appraisal, succession planning and Board development, helping to ensure the Group Boards continue to evolve as effective and cohesive leadership teams.

Subject to Board endorsement and approval by the Full Council of Governors, the appointment will take effect on 19<sup>th</sup> June 2026.

### 3. Governance and Assurance Implications

- 3.2 The appointment supports compliance with the principles of good corporate governance and strengthens the Board's leadership and assurance arrangements.
- 3.3 The role of the SID forms part of the Trust's wider governance framework and supports effective Board relationships, challenge, and accountability.

### 4. Financial Implications

- 4.1 Jatinder Sharma - there are no additional financial implications arising from this appointment beyond the existing remuneration arrangements as he is the Sandwell Audit Committee Chair he is already receiving the maximum pay of £19,000
- 4.2 Peter Featherstone – he will receive additional remuneration linked to the role: an amount of £1,000.

### 5. Equality and Diversity Implications

- 5.1 The expression of interest process was undertaken in line with the Trust's governance processes and commitment to fairness, transparency, and equality of opportunity.

### 6. Recommendations

- 6.1 The Group Public Trust Board is asked to:
  - a) **Approve** the appointment of Jatinder Singh as Senior Independent Director for Sandwell and West Birmingham NHS Trust and **Record** its thanks and appreciation to Mick Laverty for his contribution and service as Senior Independent Director.
  - b) **Endorse** the appointment of Peter Featherstone as Senior Independent Director for The Dudley group NHS Foundation Trust noting the requirement for final approval by the Council of Governors and **Record** its thanks and appreciation to Catherine Holland for her contribution and service as Senior Independent Director.

Dan Conway, Associate Director of Corporate Governance/Company Secretary, Sandwell  
Helen Board, Board Secretary, The Dudley Group  
May 2026

<b>REPORT TITLE:</b>	Integrated Committee Chairs Report		
<b>SPONSORING EXECUTIVE:</b>	Diane Wake, CEO		
<b>REPORT AUTHOR:</b>	Lesley Writtle, Non-Executive Director, Deputy Chair Dan Conway, Associate Director of Corporate Governance/Company Secretary		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')	Requested action: (place an 'x')	Applies to: (place an 'x')
<input type="checkbox"/> Decision	<input type="checkbox"/> Approve	<input checked="" type="checkbox"/> Both Trusts
<input checked="" type="checkbox"/> Assurance	<input type="checkbox"/> Agree	<input type="checkbox"/> Sandwell and West Birmingham NHS Trust
<input type="checkbox"/> Discussion	<input type="checkbox"/> Endorse	<input type="checkbox"/> The Dudley Group NHS Foundation Trust
<input type="checkbox"/> Information	<input type="checkbox"/> Recommend	
	<input type="checkbox"/> Discuss	
	<input checked="" type="checkbox"/> Note	

### Suggested discussion points

This report provides a consolidated overview of assurance levels and the key issues identified by Trust Sub Committee Chairs. It supports the Board in reviewing and triangulating assurance, highlighting areas requiring escalation, and recognising examples of good practice aligned with the Trust's strategic priorities.

The report also reflects ongoing work to strengthen the alignment between key issues, the Board Assurance Framework (BAF), and the Trust's strategic risks. Committee Chairs have re-viewed the relevant risks and their associated scores. As a result, the priority issues highlight-ed in this report are now directly mapped to the five refreshed BAF risks, enabling clearer tracking and oversight.

This is the first joint Trust Board assurance report and reflects all the planned joint sub committees work that are now in place. This work will mature over time as committees develop and align with agendas. This month's report places greater emphasis on forward-looking assurance, focusing on the actions required from the executive team to deliver material improvement and, in turn, create a credible pathway to improved BAF scores.

- Joint Quality Committee – chaired by Lorraine Harper
- Joint Infrastructure Committee – chaired by Mick Laverty
- Joint People Committee – chaired by Catherine Holland
- Joint Finance and Productivity Committee – chaired by Lowell Williams
- Joint Remuneration Committee – chaired by Lesley Writtle
- Dudley Audit Committee – chaired by Rachel Hardy
- SWB Audit Committee – chaired by Jatinder Sharma
- Dudley Integration Committee – chaired by Vij Randeniya
- SWB Integration Committee – chaired by Val Taylor
- Charity Committee – chaired by Gary Crowe

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

Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	<input checked="" type="checkbox"/>	OUR PEOPLE	<input checked="" type="checkbox"/>	OUR POPULATION	<input checked="" type="checkbox"/>
The Dudley Group NHS Foundation Trust					
PATIENTS	<input checked="" type="checkbox"/>	PEOPLE	<input checked="" type="checkbox"/>	PLACE/POPULATION	<input checked="" type="checkbox"/>

**Previous consideration**

Recommendation(s)	
a)	<b>NOTE</b> the report and assurance provided.
b)	<b>PROVIDE</b> feedback for any identified issues shared for escalation
c)	

**Escalation**  
Should any element of this report be escalated:

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

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	x	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources	x	2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce	x	3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>	x	4.0: Failure to achieve financial plan
x	004: Deliver on its ambitions as an integrated care Organisation	x	5.0: Failure to achieve performance requirements
x	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		

Is Quality Impact Assessment required if so, add date:

Is Equality Impact Assessment required if so, add date:

**KEY ITEMS DISCUSSED AT THE BOARD COMMITTEES**

**ALERT**

**Financial Improvement**

The Dudley Group reported a year-end surplus of £3.284m, which is £8k better than the revised plan, although this position is supported by a reliance on non-recurrent funding. Sandwell and West Birmingham also achieved a slightly favourable outturn against the revised deficit position of £12.6m; however, this similarly reflects significant reliance on support funding and non-recurrent CIP delivery.

The Committee noted that The Dudley Group has a well-developed CIP programme for 2026/27, with all required savings identified, of which approximately 80% are recurrent. However, a risk of delivery slippage in the early months was highlighted, requiring ongoing monitoring and mitigation. The Committee also noted the need for a clear recovery trajectory through the Learn, Adapt, Transform programme, which will require focused delivery and sustained grip to ensure impact is realised at pace.

The Committee expressed serious concern regarding the current lack of development of the 2026/27 CIP programme at Sandwell and West Birmingham, which at present provides only **minimal assurance**. As a result, the Finance Committee has recommended that this area be escalated through the Executive Performance Management process and reported to Board. It was noted that development work is now progressing, however auditors have also identified a deterioration in early-stage planning and the overall maturity of the plan remains a concern. It must be noted that it is clear that a lot of work and focus is being given to this task and this is not underestimated by sub committee chairs.

To strengthen assurance and improve financial performance, a step-change is required in the robustness, pace, and credibility of financial recovery planning across both Trusts. This includes the urgent development of a fully costed, deliverable, and prioritised CIP pipeline within SWB, supported by clear executive ownership, defined milestones, and accountable delivery mechanisms.

Strengthening financial grip and control across both organisations will be essential to reduce cost pressures and improve sustainability. Enhanced reporting, earlier identification of financial risks, and more rigorous performance management will be required to provide the Board with greater assurance and evidence of a credible trajectory towards financial balance and long-term sustainability

#### **Primary BAF linkages**

- SWB BAF 002 – Make best strategic use of its resources
- Dudley BAF 4.0 – Failure to achieve financial plan

#### **Secondary linkages**

- SWB BAF 004 – Deliver on its ambitions as an integrated care organisation
- Dudley BAF 5.0 – Failure to achieve performance requirements

#### **BAF implication:**

Improvement in this BAF area will depend on:

- Delivery of a robust, fully costed, and credible CIP programme across both Trusts.
- Strengthened financial grip and control arrangements with clearer executive accountability.
- Improved monitoring and early escalation of financial risks and delivery slippage.
- Delivery of recurrent savings to reduce reliance on non-recurrent support funding.
- Stronger linkage between operational recovery, workforce plans, and financial sustainability.

#### **Workforce planning**

The People Committee reviewed performance against the workforce plan. It was noted that although both Trusts achieved reductions in staffing levels, the targeted reductions were not fully met. To ensure the Board has a clear and realistic understanding of the workforce position and likely outturn. While the executive team expressed confidence in the actions being taken for 2026/27, the Committee concluded that current plans lack sufficient detail and demonstrable impact. As a result, assurance was assessed as **Partial Assurance**. However, the Committee noted that full workforce plans, including detailed FTE figures, were not available for review as they remained in development. As such, assurance could not be fully substantiated at this stage and remains partial pending completion and review of final plans.

To strengthen assurance in this area, the Board will need clear evidence that workforce and culture risks are being actively managed rather than described. This includes demonstrable progress in delivering workforce plan reductions with reduced variance, early evidence of improvement in staff experience, and confirmation that planned changes are achievable and being delivered as intended. Improvement will also require a more collaborative and transparent approach to organisational change, with meaningful engagement of staff in developing solutions. Stronger leadership visibility, clearer communication of workforce challenges, and more timely and robust reporting of workforce and culture risks will be essential.

This level of assurance and delivery confidence will be required before reductions in the Workforce and Culture risk scores within the BAF can be appropriately justified.

#### **Primary BAF linkages**

- SWB BAF 003 – Recruit, retain, train, and develop workforce
- Dudley BAF 2.0 – Failure to recruit, retain, train, and develop workforce

#### **Secondary linkages**

- SWB BAF 002 – Make best strategic use of its resources

- Dudley BAF 4.0 – Failure to achieve financial plan

**BAF implication:**

Improvement in this BAF area will depend on:

- Delivery of workforce reductions against agreed trajectories with reduced variance to plan.
- More accurate workforce forecasting and reporting to improve Board assurance.
- Clear evidence that organisational change plans are deliverable and achieving intended outcomes.
- Stronger staff engagement, communication, and leadership visibility during change processes.
- Improved alignment between workforce planning, operational demand, and financial recovery.

**ADVISE**

**Joint Quality approach**

The Quality Committee held its first joint meeting in May, marking an important step in developing integrated oversight across Trusts. It is evident that, over the coming months, increased understanding, shared learning, and alignment will deliver significant benefits. However, it is recognised that culturally this will take time, sustained commitment, and continued engagement to realise its full potential.

The meeting provided a strong opportunity for cross-Trust learning and constructive discussion across several areas. This included consideration of approaches to reducing unnecessary corridor care within Emergency Departments, a deep dive into differing approaches to minimising formal complaints through increased use of the PALS route, and wider opportunities for shared learning between organisations.

A number of areas were identified where further work is required to provide stronger assurance on mitigations and improvement actions. These included:

- Skin cancer service capacity and staffing challenges within SWB
- An increase in complaints within Dudley
- Incidents of patients being underfed within SWB due to the need to improve access to snacks and nutritional support
- A backlog of approximately 30,000 clinic letters within Dudley

To strengthen assurance and improve the effectiveness of future meetings, it would be beneficial to ensure papers are consistently timely, with clearly articulated assurance frameworks and mitigation plans. This would support smoother meeting flow, reduce the need for retrospective escalation of items, and ensure that improvement actions and risk mitigations are more clearly visible and trackable at the point of discussion.

**Primary BAF linkages**

- SWB BAF 001 – Deliver safe, high-quality care
- Dudley BAF 1.0 – Failure to deliver right care, in the right place

**Secondary linkages**

- SWB BAF 004 – Deliver on its ambitions as an integrated care organisation
- Dudley BAF 3.0 – Failure to build innovative partnerships

**BAF implication:**

Improvement in this BAF area will depend on:

- Continued development of joint quality governance arrangements and integrated oversight.
- Stronger consistency in committee reporting, mitigation planning, and assurance frameworks.
- Sustained cross-Trust collaboration and shared learning to support improvement delivery.
- Improved visibility of risks, mitigations, and delivery trajectories within committee discussions.

## Sickness Absence

This remains a key concern. It was noted that considerable focus is being given to this, and new management reporting and tools are available, in addition to SWB testing out some advanced tools, including resources for staff. Reasonable assurance was taken from this, but close monitoring and analysis will be required to identify clear benefits and reductions in absence levels resulting from these approaches

### Primary BAF linkages

- SWB BAF 003 – Recruit, retain, train, and develop workforce
- Dudley BAF 2.0 – Failure to recruit, retain, train, and develop workforce

### Secondary linkages

- SWB BAF 001 – Deliver safe, high-quality care
- Dudley BAF 5.0 – Failure to achieve performance requirements

### BAF implication:

Improvement in this BAF area will depend on:

- Sustained reduction in sickness absence levels supported by targeted interventions and management oversight.
- Effective use of workforce reporting tools and analytics to identify trends and support early intervention.
- Evidence that wellbeing initiatives are improving attendance, resilience, and staff experience.
- Continued focus on workforce culture, engagement, and psychological safety.

## Maternity Services

The Quality Committee received a comprehensive update on maternity services, including progress against key actions and improvement priorities. Members reviewed the significant programme of work underway and noted clear evidence of progress across several areas.

The Committee particularly welcomed the strengthened approach to the Maternity Improvement Plan, with clearer methodologies now supporting improved prioritisation, stronger oversight, and greater clarity regarding delivery milestones. During the first joint Quality Committee meeting, members also noted the considerable benefit of hearing about the positive improvement journey within the Dudley Group, recognising the value of shared learning and mutual support across organisations.

The ability to review performance and data across the Trusts was considered especially helpful and generated constructive discussion around shared learning opportunities in several areas, including the establishment of “Cultural Boards” and the sharing of outcomes from reviews.

The SWB Audit Committee received feedback regarding the Trust’s approach to the NHS Resolution Maternity Incentive Scheme (MIS), which supports safer maternity and perinatal care through compliance with ten national safety actions.

The review recognised that a number of safety actions were assessed as compliant; however, it also identified areas requiring further improvement, particularly in relation to transitional care implementation, workforce planning, and the strength of Board oversight and assurance arrangements. Opportunities were also identified to strengthen evidence management processes, organisational learning, and engagement with parents and staff.

The Committee noted that, to support ongoing assurance and sustain improvement, further work is required to strengthen governance, oversight, and evidencing arrangements across maternity services in SWB. Key priorities include embedding transitional care pathways, addressing workforce and staffing challenges, and ensuring that evidence supporting compliance is robust, accessible, and consistently maintained. Further enhancement of Board assurance processes will be required, including deeper review of maternity performance, clearer demonstration of

risk management and learning, and continued focus on openness, transparency, and shared learning across Trusts. These actions will support sustained improvement and strengthen confidence in the quality and safety of maternity services.

**Primary BAF linkages**

- SWB BAF 001 – Deliver safe, high-quality care
- SWB BAF 003 – Recruit, retain, train, and develop workforce
- Dudley BAF 1.0 – Failure to deliver right care, in the right place

**Secondary linkages**

- SWB BAF 004 – Deliver on its ambitions as an integrated care organisation
- Dudley BAF 5.0 – Failure to achieve performance requirements

**BAF implication:**

Improvement in this BAF area will depend on:

- Delivery and embedding of maternity improvement actions and national safety requirements.
- Strengthened workforce resilience, transitional care arrangements, and governance oversight.
- Improved Board assurance processes with clearer evidence of compliance and risk mitigation.
- Continued cross-Trust learning, openness, and transparency to support maternity safety improvement.

Medical Job Planning

The Dudley Audit Committee received a report on medical job planning, undertaken at the request of the Trust. The review resulted in a **minimal assurance** rating, which was not unexpected given the current maturity of the process. The Executive Medical Lead confirmed that an action plan is in place and will be actively progressed. There is confidence that improvements can be delivered at pace, with early and sustained progress expected. Delivery against the action plan will be subject to regular monitoring and reporting to ensure ongoing oversight, assurance, and visibility of improvement actions to the Committee

Greater assurance would typically be achieved once the Committee can see that controls are operating effectively, compliance levels are improving, risks are reducing, and improvements are embedded and sustainable.

**Primary BAF linkages**

- Dudley BAF 4.0 – Failure to achieve financial plan

**Secondary linkages**

- Dudley BAF 5.0 – Failure to achieve performance requirements
- Dudley BAF 2.0 – Failure to recruit, retain, train, and develop workforce

**BAF implication:**

Improvement in this BAF area will depend on:

- Delivery of the agreed medical job planning improvement plan.
- Increased oversight, consistency, and governance of job planning processes.
- Better alignment between workforce deployment, service demand, productivity, and financial recovery objectives.
- Regular monitoring and reporting to evidence sustained improvement.

**ASSURE**

Learning Campus

People committee and Infrastructure committee reported The Leaning Campus (SWB) handover has been completed and has proved a very positive development, impacting directly on local employment opportunities. It was noted however that there is a financial gap currently.

**Primary BAF linkages**

- SWB BAF 004 – Deliver on its ambitions as an integrated care organisation

**Secondary linkages**

- SWB BAF 003 – Recruit, retain, train, and develop workforce

**BAF implication:**

Improvement in this BAF area will depend on:

- Delivery of a sustainable operational and financial model for the Learning Campus.
- Continued development of workforce, education, and community partnership opportunities.
- Alignment of infrastructure and workforce planning to maximise social value and local employment impact.

The Dudley Charity Committee received assurance that the charity continues to make strong progress across its strategic priorities, with clear evidence of positive impact for patients, staff and the wider community alongside continued strengthening of its financial and organisational position. Members endorsed the proposed investment in stroke unit equipment, recognising it as an appropriate and evidence-based use of charitable funds that will enhance patient outcomes and rehabilitation beyond core NHS provision. Assurance was also provided regarding governance, procurement controls, staff training and value for money. The Committee further noted a productive fundraising period, including successful partnership development, grant activity and increased engagement, and welcomed the charity's collaborative approach to addressing workforce wellbeing and health inequalities. In addition, the Committee supported progression of the staff wellbeing rooms initiative, recognising the positive feedback received and its alignment with the charity's strategic objectives.

**BAF: N/a**

At both the Dudley and Sandwell & West Birmingham Integration Committees, an update was received on NHS England's Neighbourhood Health Framework and the implications for the Trust, alongside the ICB's strategic intent to identify NHS Anchor Organisations within each Place.

A key strategic risk was identified in relation to Sandwell and West Birmingham NHS Trust acting as host organisation for the West Birmingham locality within Birmingham Place. Members agreed that the Trust should take a proactive approach to positioning itself as a key strategic partner within Birmingham Place as emerging Place governance and Anchor arrangements are developed.

The Committees also noted that the Neighbourhood Health Framework sets out a defined set of delivery metrics. Further work is required to understand the detailed requirements of these measures and ensure that the Trust is able to capture and report data in line with the framework. In addition, there is a need across each Place partnership to establish clear accountability for delivery against each metric across partner organisations. It was agreed that development of a baseline position against the framework metrics should be progressed as the next step.

**Primary BAF linkages**

- SWB BAF 004 – Deliver on its ambitions as an integrated care organisation
- Dudley BAF 3.0 – Failure to build innovative partnerships to improve the health of our communities

**Secondary linkages**

- SWB BAF 001 – Deliver safe, high-quality care
- SWB BAF 002 – Make best strategic use of its resources
- Dudley BAF 5.0 – Failure to achieve performance requirements
- Dudley BAF 6.0 – Failure to take sustained action on infrastructure, digital and data

**BAF implication:**

Improvement in this BAF area will depend on:

- The Trust taking a proactive and influential leadership role within emerging Place-based governance and Anchor Organisation arrangements across Birmingham and the Black Country.
- Development of strong partnership arrangements and clear accountability frameworks across Place partners to support delivery of the NHS England Neighbourhood Health Framework.
- Establishment of robust baseline positions and reporting arrangements against the Neighbourhood Health Framework metrics to support performance oversight and improvement.
- Improved data infrastructure, analytics capability, and cross-organisational collaboration to enable consistent capture, monitoring, and reporting of neighbourhood health outcomes.
- Continued alignment of Trust strategic priorities with Place-based population health objectives, prevention strategies, and integrated neighbourhood delivery models.

# Enclosure 4a

## Joint Provider Committee – Report to Trust Boards

**Date:** **20<sup>th</sup> May 2026**

<b>TITLE OF REPORT:</b>	Report to Trust Boards from the JPC meeting of 1 <sup>st</sup> May 2026
<b>PURPOSE OF REPORT:</b>	To provide a summary of the key messages from the Friday 1 <sup>st</sup> May 2026 meeting of the Joint Provider Committee.
<b>AUTHOR(S) OF REPORT:</b>	Sohaib Khalid, BCPC Managing Director
<b>MANAGEMENT LEAD/SIGNED OFF BY:</b>	Sir David Nicholson, Group Chair (DGFT, RWT, SWBT, & WHCT) Diane Wake, Group CEO DGFT & SWBH Joe Chadwick-Bell, Group CEO RWT & WHT
<b>KEY POINTS:</b>	<p>The Joint Provider Committee (JPC) was held, and was quorate with attendance by the Chair, two Deputy Chairs, one CEO, and a Deputy CEO.</p> <p>The following are the key points to note:</p> <ul style="list-style-type: none"> <li>a) CEOs provided an update on the key governance actions undertaken aligned to the agreed 26/27 BCPC workplan.</li> <li>b) The BCPC Managing Director and CEO's presented a brief paper outlining progress in each of the agreed clinical service transformation programme areas supplemented by a PowerPoint dashboard in the Reading Pack.</li> <li>c) The CSTP SRO provided a detailed update across all Phases of the CSTP work programme, supplemented by a paper in the Reading pack on the progress within the 'Recruitment' sub-function.</li> <li>d) A short review paper on 'hosting' and its implications but rooted in a reviewing the BCPS arrangements was presented by the BCPC Managing Director, with some suggestions for consideration in establishing the CST Managed Shared Service.</li> </ul>
<b>RECOMMENDATION(S):</b>	<p>The partner Trust Boards are asked to:</p> <ul style="list-style-type: none"> <li>a) <b>RECEIVE</b> this report as a summary update of key discussions from the 1<sup>st</sup> May 2026 JPC meeting.</li> <li>b) <b>NOTE</b> the key messages, agreements, and actions in section 2 of each report.</li> </ul>
<b>CONFLICTS OF INTEREST:</b>	There were no declarations of interest.
<b>DELIVERY OF WHICH BCPC WORK PLAN PRIORITY:</b>	The Joint Provider Committee oversees and assures progress against the agreed BCPC annual Work Plan, as outlined in schedule 3 of the Collaboration Agreement.
<b>ACTION REQUIRED:</b>	<input checked="" type="checkbox"/> Assurance <input checked="" type="checkbox"/> Endorsement / Support <input checked="" type="checkbox"/> Approval <input checked="" type="checkbox"/> For Information

## 1. PURPOSE

- 1.1 To provide all partner Trust Boards with a summary of key messages from the 1<sup>st</sup> May 2026 Joint Provider Committee.

## 2. SUMMARY

- 2.1 The Joint Provider Committee was held on Friday 1<sup>st</sup> May 2026. The meeting was quorate with attendance by the Chair, two Deputy Chairs, one CEO's and a Deputy CEO.
- 2.2 The minutes of the previous meeting were accepted as an accurate record, and the Action Log was reviewed for progress with completed actions noted.
- 2.3 The following is a summary of discussions with agreements noted.

### a) Items for Noting

- i. **CEO highlight report** – The JPC received an update report from the Chair of the BCPC Executive, which was taken as read, but highlighted the following:
  - Repositioning of the BCPC workplan from four programmes to two.
  - Confirmed with BCPC Executive the agreed priorities across the two work programmes.
  - Confirmed the 50% reduction in budget for 26/27 to £1m, enabling the small support team to be extended to 31/03/27.
  - Identified Clinical Service Transformation programme SRO's and CSTP Executive Leads.
  - Drafted report to Trust Boards seeking delegations to comply with requirements of the Collaboration Agreement.
  - Governance arrangements are actively being implemented at the earliest possible time.It was noted that two meetings of the BCPC Executive (02/03/26 & 24/04/26) and one meeting of the CSTP Board (10/04/26) have been held since the last JPC.

### b) Items for Discussion

- ii. **Clinical Service Transformation Programme** – The CEO and BCPC Managing Director presented a short paper supplemented with a dashboard summarising the progress being made against the agreed priorities. Key highlights included:
  - **Breast DIEP Reconstruction** continues to expand, with a draft SOP under review, workforce recruitment progressing, and full expansion expected from autumn 2026.
  - **ENT** is validating its demand and capacity model ahead of an operating model paper in July 2026.
  - **Gynae-Oncology** has improved service resilience through partial recruitment, with further appointments planned and agreement of a joint operating model and SOP over the summer.
  - **Pharmacy Aseptics** remains fragile across the Black Country; modelling work continues, estates input is awaited, and urgency has been escalated for interim and long-term solutions.
  - **Urology** progress includes drafted SOPs for renal surgery and stones/ESWL, with consultant recruitment and MDT leadership underway. Plans for bladder cancer expansion and repatriation of out-of-area activity are pending completion of earlier phases.
  - **Vascular services** aim to agree a SOP and move to a joint DGFT/SWBH model by summer 2026, subject to outstanding data resolution.
  - **Endometriosis**, Option 2 (one centre, two sites) was agreed, with each group progressing establishment of their endometriosis service.

## AGREEMENT(s)

Through discussion, it was agreed that the BCPC Executive should:

- Review Group Clinical Strategies to identify priorities common to both that could / should be pursued at scale
- Review services considered as fragile or for repatriation that may form part of a future prioritisation list
- Consider how we are to collectively spread good practice and innovation

- iii. **Corporate Service Transformation Programme** – The JPC received a detailed report from the Programme SRO providing an update across all phases. Key highlights included:

### Phase 1A

- Sovereign Trusts are verifying a 25/26 out-turn position which should be available shortly.

### Phase 1B

- **Collaborative Bank** - Market testing exercise completed. Additional clarifications undertaken during April. Validation exercise now being undertaken. Comparative Black Country option now being worked up, alongside criteria for assessment and subsequent recommendation.
- **Research & Development** – Worked with CMO's to reach a consensus on an outline future target operating model for a collaborative R&D service. A further session to refine this took place on 17<sup>th</sup> April 2026. A presentation capturing this model is being shared with the CEOs during w/c 27<sup>th</sup> April, in advance of the JPC on 1<sup>st</sup> May.
- **Occupational Health** - The Occupational Health market testing exercise closed on 6<sup>th</sup> April. A session has been arranged on 30<sup>th</sup> April to review the tenders and determine the next steps.
- **Recruitment Baseline** - The recruitment baselining exercise has now been concluded. This work demonstrates that there is an opportunity to improve productivity in the recruitment process (i.e. hires/FTE, Time-to-Hire) through 'levelling up' to the most productive recruitment service within the collaborative, and then a further opportunity exists for the collaborative provider Trusts from levelling up to the national best performing trust in Model Health's Quartile 1 (West London NHS Trust).
- **Digital Enabling** - The Digital workstream is mobilising interactive supplier sessions to co-design solutions and quantify investment requirements.

### Phase 2

- **Governance** – Exec leads were identified with on-boarding commencing shortly.
- **Scope** – Agreed by JPC in February, with the mechanics further reviewed by the CSTP Board on 10<sup>th</sup> April 26.
- **Procurement** – Initial diagnosis work nearing completion, with Director of Finance now reviewing the merits of further work. Output and proposal to be received at next CSTP Board in May 2026.
- **Managed Shared Service** – decision required on host, which will then unlock the development and finalisation of the work centred on the Legal Framework.

- iv. **Hosting** – The BCPC Managing Director presented JPC a short paper on 'Hosting' which:

- Briefly reviewed the current partnership arrangements for the Black Country Pathology Services highlighting:
  - consistency with best practice in the development of its Partnership Agreement / SLA
  - A 10-year duration period for 'hosting' these services commencing from 2018, with RWT identified as the host.
  - Some 'hosting standards' drawn and developed from local discussions rather than any national 'Hosting' standards

- A recommendation that the remainder of the duration period be used to consider what next, rather than any wholesale change at this time.
- A review of an exam question centred around “*what it means to be a host, and what the implications for both the host and partners are?*”. A variety of sources were explored with no national standard found. Some common themes were identified and shared within the paper. Possible implications for both being a ‘host’ to services and a partner to a hosted arrangement were outlined for future consideration.
- And finally, practical implications for our work within the Black Country, specifically the pursuit of a Managed Shared Service for the Corporate Service Transformation Programme were briefly reviewed with, with some suggested / possible action identified for pursuit.

#### **AGREEMENT(s)**

Through discussion JPC agreed:

- With the broad assessment of the current BCPS arrangements
- That no further changes would be made to the BCPS arrangements, but these and other hosted service arrangements, would be reviewed carefully for appropriate inclusion within any Managed Shared Services arrangements.
- Work would continue to explore the best possible arrangements (contractual versus corporate joint venture) for the future establishment of a Managed Shared Service as an initial strategic vehicle for corporate services, across the BCPC partners.

### **3. REQUIRED ACTIONS**

- 3.1 The partner Trust Boards are asked to:
- a. **RECEIVE** this report as a summary update of key discussions at the 1<sup>st</sup> May 2026 JPC meeting.
  - b. **NOTE** the key messages and agreements in section 2 of the above report.

<b>REPORT TITLE:</b>	Month 12 Finance Report (March 2026)		
<b>SPONSORING EXECUTIVE:</b>	Madi Parmar – Director of Finance		
<b>REPORT AUTHORS:</b>	Paul Stanaway – Associate Director of Finance Craig Higgins – Associate Director of Finance		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
	Decision		Approve		Both Trusts
X	Assurance		Agree	X	Sandwell and West Birmingham NHS Trust
	Discussion		Endorse		The Dudley Group NHS Foundation Trust
X	Information		Recommend		
		X	Discuss		
		X	Note		

**Suggested discussion points**

**Assure**

1. The Trust delivered the 2025/26 final M12 and year end outturn financial performance of a £12.6m deficit position, which is adverse to its original plan but in line with the revised forecast and control total agreed with the ICB and NHS England.
2. The healthcare system as a whole achieved its break-even duty through coordinated delivery and thus did not incur additional financial penalties.
3. This is also the final year end position for the Trust per the draft (unaudited) accounts and as such has been reported at both Finance and performance and Audit committees.

**Advise**

4. The Trust delivered 80% of it's required CIP target and only 39% on a recurrent basis; this has been reflected in 2026/27 plans and contributed to the stretching 7% challenge for 2026/27

**Alert**

5. The M12 and year end position is draft and unaudited at this point in time; figures in this paper are consistent with the draft accounts present to the May Audit Committee, however Final audited accounts will be present to June Audit committee following satisfactory completion of the annual external audit review.

**Alignment to our Vision**

Sandwell and West Birmingham NHS Trust					
OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
The Dudley Group NHS Foundation Trust					
PATIENTS		PEOPLE		PLACE/POPULATION	

**Previous consideration**

Finance and Performance Committee, Audit Committee, Executive Group; Divisional Confirm & Challenge sessions

**Recommendations**

a) **Note** Month 12 position

**Escalation**

Should any element of this report be escalated:

**BAF Impact**

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
	001: Deliver safe, high-quality care.		1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources		2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>		4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		

Is Quality Impact Assessment required if so, add date:

Is Equality Impact Assessment required if so, add date:



# Report to the Group Public Board on 20<sup>th</sup> May 2026

## Sandwell and West Birmingham NHS Trust Month 12 Finance Report

### 1. Executive Summary

- 1.1 This report updates the Trust Board on the 2025/26 financial position against the income & expenditure plan and the capital and cash programmes as at Month 12. It also provides an update on the Cost improvement programme.
- 1.2 As previously reported to the Board and its sub-committees in March:
- 1.2.1 The Trust submitted an original plan of breakeven for 2025/26. This was inclusive of £14.2m of national deficit funding and a cost improvement programme of £50.8m.
- 1.2.2 A reassessment of forecast delivery at the end of quarter 3 crystallised a number of income risks within the plan, subsequently a revised year end forecast was agreed with both NHSE and the Trust of -£12.6m deficit.
- 1.3 The key performance measures at the end of March 2026 (month 12):
- The Trust has reported a deficit of £12.598m which is £0.002m adverse to the revised deficit plan.
  - £67.39m capital spend against a plan of £66.98m, a variance of £-0.41m
  - £40.84m delivered against the financial improvement (efficiency) target of.
  - An adverse pay position of £40.82m but offset by £32.54m of related income, the difference is related to the shortfall on CIP delivery.

### 2. Month 12 Headlines

- 2.1 The details at Month 12 are shown in the annexes with the summary position below:

Income and Expenditure Summary	Year To Date			
	Plan £000s	Actual £000s	Variance £000s	%
Operating Income	792,479	827,372	34,893	4.4%
Agency Pay	(3,397)	(5,382)	(1,985)	(58.4%)
All other employees expenses	(483,323)	(524,142)	(40,819)	(8.4%)
Operating Non Pay	(284,300)	(288,083)	(3,783)	1.3%
<b>Total Operating surplus/(defecit)</b>	21,459	9,765	(11,694)	
Non Operating items	(21,459)	(22,363)	(904)	(4.2%)
<b>Adjusted Financial performance surplus/(defecit)</b>	0	(12,598)	(12,598)	
Less Non Recurrent Defecit Support	(14,197)	(14,197)	0	0.0%
<b>Adjusted Financial performance surplus/(defecit) excluding non recurrent defecit funding</b>	(14,197)	(26,795)	(12,598)	

- 2.2 At Month 12, the Trust reported a £12.598m deficit, against a revised deficit plan of £12.6m.
- 2.3 The income position was £34.893m favourable to plan. Key drivers were:
- £28.053m relates to centrally funded pension costs (offsetting pay costs)

- £1.34m sprint income
- £3.2m of Industrial Action income

2.4 Pay expenditure was adverse to plan by £40.819m. Key drivers were:

- £28.053m relating to centrally funded pension costs
- the Resident Doctors Industrial Action £2.428m (offset by income),
- an increase in maternity leave payments
- an increase in waiting list payments to support elective activity and deliver elective sprint targets

2.5 Non pay expenditure was adverse to plan by £4.687m. Key drivers were:

- £0.59m loss on disposal of assets
- £3.85m adverse variance on impairment of receivables (offsetting income)
- £1.009m of MARS/Redundancy payments
- £1.065m relating to failure to deliver Maternity Standards target

### 3. Income & Activity

3.1 The following chart summarises the monthly profile for 2025/26 in terms of the plan and actuals for activity linked to elective recovery.



3.2 Month 12 financial performance can be summarised in the following tables. By point of delivery, we can see a favourable position against ERF £1.470m. (£640k overperformance for all variable activity). This is an increase from Month 11 of £0.260m, this position excludes BCICB overperformance which was not recoverable in addition to local deficit support per the Black Country system in year agreement.

Performance for Current Month and Year-to-Date by Activity Type

Activity Super Group	Activity Type	Current Month						Year-to-Date					
		Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
				£000	£000	£000				£000	£000	£000	
Elective Activity	DC	1,746	1,834	89	1,857	1,920	£63	19,989	21,230	1,241	21,230	22,642	£1,412
	EL	252	345	92	931	1,002	£71	2,903	10,663	7,760	10,663	11,883	£1,220
	OPA	10,938	11,831	892	1,862	2,001	£138	125,681	21,401	-104,280	21,401	20,511	-£890
	OPROC	10,046	8,413	-1,632	1,795	1,548	-£248	115,344	20,626	-94,718	20,626	20,354	-£272
<b>Elective Activity Total</b>		<b>22,982</b>	<b>22,423</b>	<b>-559</b>	<b>£6,445</b>	<b>£6,470</b>	<b>£25</b>	<b>263,917</b>	<b>73,920</b>	<b>-189,998</b>	<b>£73,920</b>	<b>£75,390</b>	<b>£1,470</b>
Diagnostics and Nuclear Medicine	DIAGNOSTICIMAGING	4,209	4,444	235	376	439	£63	52,590	4,902	-47,688	4,902	5,414	£512
	NUCLEAR MEDICINE	460	0	-460	113	0	-£113	5,312	1,359	-3,952	1,359	0	-£1,359
<b>Diagnostics and Nuclear Medicine Total</b>		<b>4,669</b>	<b>4,444</b>	<b>-225</b>	<b>£489</b>	<b>£439</b>	<b>-£50</b>	<b>57,902</b>	<b>6,261</b>	<b>-51,640</b>	<b>£6,261</b>	<b>£5,414</b>	<b>-£847</b>
Chemotherapy	CHEMOTHERAPY DELIVERY	235	186	-49	68	49	-£19	2,704	781	-1,923	781	798	£17
<b>Chemotherapy Total</b>		<b>235</b>	<b>186</b>	<b>-49</b>	<b>£68</b>	<b>£49</b>	<b>-£19</b>	<b>2,704</b>	<b>781</b>	<b>-1,923</b>	<b>£781</b>	<b>£798</b>	<b>£17</b>
<b>Grand Total</b>		<b>27,886</b>	<b>27,053</b>	<b>-832</b>	<b>£7,002</b>	<b>£6,957</b>	<b>-£45</b>	<b>324,523</b>	<b>80,962</b>	<b>-243,561</b>	<b>£80,962</b>	<b>£81,602</b>	<b>£640</b>

#### 4. Efficiency

- Total 2025/26 CIP target was £50.8m
  - Total delivered CIP was £40.84m with a full year value of £32.44m or 80% of the target, of which 39% of the target was recurrent (£19.9m)
  - This is in line with the 2026/2027 start point plan; FYE of recurrent CIP is embedded in the run rate basis 26/7 plans offsetting non recurrently delivered 25/6.
  - Total Pay CIP delivered was £32.4m, 64% of the target, albeit only 29% of the overall target recurrently

	Plan	Actual	Variance	Full Year Effect	In year delivery
	Year ending	Year ending	Year ending	Year ending	of Target
	£'000	£'000	£'000	£'000	%
<b>Recurrent</b>					
Pay - Recurrent	31,215	14,488	(16,727)	24,231	29%
Non-pay - Recurrent	5,850	5,401	(449)	8,160	11%
Income - Recurrent	500	50	(450)	50	0%
<b>Total recurrent efficiencies</b>	<b>37,565</b>	<b>19,939</b>	<b>(17,626)</b>	<b>32,440</b>	<b>39%</b>
<b>Non recurrent</b>					
Pay - Non-recurrent	0	17,946	17,946		35%
Non-pay - Non-recurrent	13,220	1,259	(11,961)		-24%
Income - Non-recurrent	0	1,678	1,678		3%
<b>Total non-recurrent efficiencies</b>	<b>13,220</b>	<b>20,883</b>	<b>7,663</b>	<b>0</b>	<b>41%</b>
<b>Total Efficiencies</b>	<b>50,785</b>	<b>40,822</b>	<b>(9,963)</b>	<b>32,440</b>	<b>80%</b>
<b>Total Pay</b>	31,215	32,434	1,219	24,231	64%
<b>Total Non Pay</b>	19,070	6,660	(12,410)	8,160	13%
<b>Total Income</b>	500	1,728	1,228	50	3%
<b>Total Efficiencies</b>	<b>50,785</b>	<b>40,822</b>	<b>(9,963)</b>	<b>32,440</b>	<b>80%</b>

#### 5. Identified Risks and mitigations

5.1 The original break even 2025/26 financial plan was stretching and ambitious, the organisation had identified that there was no clear route to achievement of this plan. This resulted in a revised forecast deficit of £12.6m in agreement with NHSE. This included negotiated support and a requirement for internal actions around expenditure control (a vacancy pause and enhanced non pay controls), capital to revenue and delivery of elective sprint target.

- 5.2 The outturn position on sprint delivered slightly less income than planned, but an improved margin on February, falling very slightly short of the planned margin of 50%.

	<b>Income £000's</b>	<b>WTE</b>	<b>Expenditure £000's</b>	<b>Margin %</b>
<b>Medicine and Emergency Care</b>	605	4.92	-267	55.83%
<b>Primary Care Community and Therapies</b>	162		-48	70.25%
<b>Surgical Services</b>	578		-382	33.91%
<b>Womens and Child Health</b>	120		-47	61.11%
<b>Imaging</b>		1.85	-11	
<b>TOTAL</b>	<b>1,465</b>	<b>6.77</b>	<b>-744</b>	<b>49.21%</b>

## 6. Conclusion: Year to Date position

- 6.1 The Trust has signed off a revised forecast outturn deficit of £12.6m. With support from external sources, the risk around delivery was minimal, and the Trust has submitted final draft accounts that meet the forecast position.

## 7. Capital and Cash

- 7.1 The Capital Position in Annex 4 shows the final spend to March 25. The plan was measured against the revised forecast profile, shared with the Committee in October 2025. There was a small underspend on PDC funded Capital, predominantly due to late awards. Internal Capital resources and additional funding as a result of asset disposal in year, were fully utilised.
- 7.2 The year end cash position is £10.3m favourable to plan as a result of late awards as identified above (Annex 2).

## 8. Recommendations

- 8.1 The Board is asked to:
- a) **Note** and **discuss** the Month 12 report.

### ANNEXES located in the reading room

- Annex 1: Key Data  
 Annex 2: Headlines  
 Annex 3: I&E Performance  
 Annex 4: Capital Expenditure

<b>REPORT TITLE:</b>	Month 12 Financial Position		
<b>SPONSORING EXECUTIVE:</b>	Chris Walker, Director of Finance		
<b>REPORT AUTHOR:</b>	Chris Walker, Director of Finance		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
	Decision		Approve		Both Trusts
x	Assurance		Agree		Sandwell and West Birmingham NHS Trust
x	Discussion		Endorse	x	The Dudley Group NHS Foundation Trust
x	Information		Recommend		
		x	Discuss		
		x	Note		

### Suggested discussion points

#### Assure

- The Board is asked to note the Month 12 (March 2026) Trust financial position. After technical changes the March cumulative position is a £3.284m surplus. This position is £3.284m better than the financial plan submitted to NHS England in March 2026 due to the inclusion of £3.276m of the wider NHS's unearned Deficit Support Funding (DSF) from NHS England.
- The Trust therefore achieved the control total set by the Black Country System and NHS England for the 2025/26 financial year.
- The Trust achieved the capital control total set by the Black Country Integrated Care Board for 2025/26.
- The Board is asked to note the Black Country Integrated Care System March 2026 financial position. The March position is £0.645m above the financial plan submitted to NHS England in March 2025. The System has received all four quarters of the deficit funding from NHS England relating to 2025/26.

#### Advise

- The Trust ended the year with a healthy cash position with several large income accruals due to bring additional cash into the Trust in quarter 1 of 2026/27. The Trust will need to ensure it achieves its cost improvement programme in 2026/27 and phased financial plan to maintain a stable cash balance going forward.

#### Alert

- While the Trust achieved its financial plan the use of further non-recurrent income has had an impact on the underlying financial position of the Trust. This has worsened to £40.6m deficit from a £39.1m deficit at plan submission stage. While some of this has been mitigated by additional contract income above plan in 2026/27 it does mean the Trust will need to find an additional £0.968m CIP to achieve the 2026/27 financial plan.
- Pay expenditure after technical adjustments was overspent against plan by £7.885m. Pay costs have continued to deteriorate since the middle of the financial year as a result of capacity pressures, industrial action and delays in cost improvement schemes linked to both capacity pressure and delivery capacity.
- Bank and agency expenditure usage continues to see an increase against plan and was above the target by 144 whole time equivalents resulting in a cumulative overspend of £2.440m at the end of March. The use of bank and agency needs to be reduced as we enter into the 2026/27 financial year.

4. Non-pay expenditure was above plan at the end of March by £20.551m. This is related to cost improvement savings shortfall and increased drug and devices expenditure. Continued non-pay over spending was seen in the Surgery, Women's and Children's division in the final quarter of the financial year.

5. The Cost Improvement Programme under delivered by £7.579m in 2025/26. The variance comprises of a shortfall in the Cost Improvement Programme of £2.437m and non-delivery of identified schemes of £5.142m. This performance has had an impact on the underlying financial position and increased the Cost Improvement Programme target for 2026/27.

Alignment to our Vision					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x
The Dudley Group NHS Foundation Trust					
PATIENTS	x	PEOPLE	x	PLACE/POPULATION	x

#### Previous consideration

Month 12 (March 2026) detailed finance report presented to the Finance and Productivity Committee on the 23rd April 2026. Summary Month 12 financial report presented to Executive Directors on 14th April 2026.

#### Recommendations

- Note** the financial performance for the month of March 2026 for assurance.
- Note** the reported Trust and System 2025/26 financial year end position for assurance.

#### Escalation

Should any element of this report be escalated:

#### BAF Impact

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
	001: Deliver safe, high-quality care.		1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources		2.0: Failure to recruit, retain, train, and develop workforce
	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>	x	4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
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 Group Public Trust Board on 20 May 2026

### The Dudley Group NHS Foundation Trust

### Month 12 Financial Position

#### 1. Executive summary

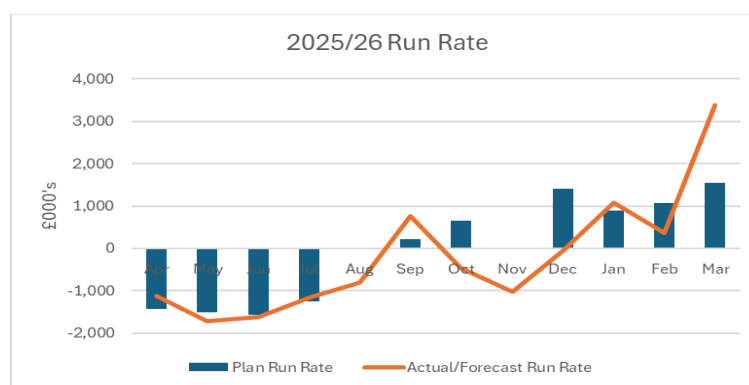
- 1.1 After technical changes the **March cumulative position is a £3.284m surplus**. This position is £3.284m better than the financial plan submitted to NHS England in March 2026 due to the inclusion of £3.276m of the wider NHS's unearned Deficit Support Funding (DSF) from NHS England. This increased the Trusts financial plan from a breakeven position to a £3.276m surplus. The Trust therefore overachieved its financial plan in 2025/26 by £0.008m.
- 1.2 The achievement of the plan was not without its challenges. The Trust had set itself a stretching financial recovery plan that it operated since November 2025. This required divisions to achieve their individual financial recovery targets. Continued pressure in urgent and emergency care meant the Trust was not able to enact its efficiency programme as planned and this led to the medicine division missing its recovery plan which included several overspending areas. The surgery, women's and children's division also overspent against their recovery plan. Both these issues meant the Trust had to use additional income from Black Country ICB to achieve the financial plan. This has then created pressures for the following financial year that will require additional cost improvement delivery initiatives to be identified.
- 1.3 Income after technical adjustments is £31.841m better than the plan. This relates to several one-off items including £6m additional income from Black Country ICB, £2m of industrial action funding from NHS England, additional waiting list sprint funding to improve 52-week wait and outpatient targets and year-end incomplete spells. As previously reported the Trust has also had a benefit from the final agreed healthcare contracts compared to plan for 2025/26, one-off improvements relating to 2024/25 Elective Recovery Fund settlements with out of area Integrated Care Boards, additional income for increased levels of passthrough drugs and devices (off-set by increases in non-pay) and other non-core healthcare income received during the financial year that wasn't in the original financial plan.
- 1.4 Pay expenditure after technical adjustments was overspent against plan by £7.885m. Whole time equivalents were 337 higher than the plan at the end of March. Pay costs have continued to be above plan during December and for quarter 4 as a result of capacity pressures and delays in cost improvement schemes linked to both capacity pressure and delivery capacity.
- 1.5 Non-pay expenditure was above plan at the end of March by £20.551m. This is related to cost improvement savings shortfall (the unidentified/opportunity cost improvement value in the original plan) and increased drug and devices expenditure (some offset by increased pass-through income). March did see an increase in the average non-pay expenditure.
- 1.6 The phased Cost Improvement Programme plan cumulatively for March equated to £38.958m. Achievement to March totals £31.379m, which is lower than plan by £7.579m. The under delivery increased against the February forecast mainly due to non-delivery of the 'learn, adapt and transform' programme.
- 1.7 While the Trust achieved its financial plan the use of further non-recurrent income has had an impact on the underlying financial position of the Trust. This has worsened to £40.6m deficit from a £39.1m deficit at plan submission stage. While some of this has been mitigated by additional contract income above plan in 2026/27 it does mean the Trust will need to find an additional £0.968m CIP to achieve the 2026/27 financial plan.

1.8 The Integrated Care System reported an actual aggregate surplus of £0.645m for 2025/26. This is £0.645m better than the financial plan submitted to NHS England in March.

## 2. INCOME AND EXPENDITURE

2.1 After technical changes the **March cumulative position is a £3.284m surplus**. This position is £3.284m better than the financial plan submitted to NHS England in March 2026 due to the inclusion of £3.276m of the wider NHS's unearned Deficit Support Funding (DSF) from NHS England. This increased the Trusts financial plan from a breakeven position to a £3.276m surplus. The Trust therefore overachieved its financial plan in 2025/26 by £0.008m.

2.2 The achievement of the plan was not without its challenges. The Trust had set itself a stretching financial recovery plan that it operated since November 2025. This required divisions to achieve their individual financial recovery targets. Continued pressure in urgent and emergency care meant the Trust was not able to enact its efficiency programme as planned and this led to the medicine division missing its recovery plan which included several overspending areas. The surgery, women's and children's division also overspent against their recovery plan. Both these issues meant the Trust had to use additional income from Black Country ICB to achieve the financial plan. This has then created pressures for the following financial year that will require additional cost improvement delivery initiatives to be identified.



2.3 Income after technical adjustments was £31.841m better than the plan. Some of this variance relates to several one-off items including £6m additional income from Black Country ICB, £2m of industrial action funding from NHS England and the inclusion of a partially completed spells accrual of £3.4m. The Trust has also benefitted from the 'sprint' initiative from NHS England which aims to reduce 52-week waits and improve out-patient performance. Taking 'sprint' income and non-Black Country 2025/26 Elective Recovery Fund overperformance a total of £3.743m has been received in March. As previously reported the Trust also had a benefit from the final agreed healthcare contracts compared to plan for 2025/26, one-off improvements relating to 2024/25 Elective Recovery Fund settlements with out of area Integrated Care Boards, additional income for increased levels of passthrough drugs and devices (off-set by increases in non-pay) and other non-core healthcare income received during the financial year that wasn't in the original financial plan.

2.4 Substantive staff are 192 Whole Time Equivalent (WTE) above the target in March (January 172 WTE above the target). Substantive pay costs were £5.450m above plan at the end of March (January £2.623m above). There has been continued overspending against the planned position for substantive staff during February and March. The Trust has not seen the planned reduction in workforce in urgent and emergency care over the past two months, which has also impacted on the Trusts bed closure programme. While an enhanced vacancy freeze for all posts except clinically critical posts continued to be in place, the Trust continued to overspend on workforce.

2.5 Bank is over target by 140 Whole Time Equivalent (WTE) (January 62 WTE over the target). There is a cumulative overspend of £1.610m against plan at the end of January (January £0.713m over). In March there was an increase in bank usage; not the planned reduction expected as part of the bed closure

programme. The continued capacity pressures have inhibited the Trust from reducing bank as expected and with bed closure programme not delivering core bed closures as expected. Some of the cumulative variance relates to the three periods of industrial action during the financial year as well as extra bank staff taken on to deliver the 'sprint' initiative in the last quarter.

- 2.6 Agency usage saw an increase when compared to the previous month and was above the target by 4 whole time equivalents at the end of March resulting in a cumulative overspend of £0.830m. The majority of the agency expenditure relates to consultants and career grade doctors in the emergency department and older people specialty with the spend comprising 0.77% of the total pay expenditure. The divisions will need to remove agency in total in the early part of 2026/27.
- 2.7 Non pay expenditure exceeded plan by £20.551m to March. Part of the overspent related to the non-delivery of Cost Improvement Programme savings classed as non-pay in the financial plan linked to productivity schemes (£19.0m). Other notable overspends included costs associated with the lung screening programme (offset by increased income) and clinical supplies and drugs, some of this is offset by the pass-through income the Trust receives for these costs from NHS England. The Surgery, Women's and Children's division were the main contributors to the March variance with increased theatre consumables over and above their recovery plan.
- 2.8 While the Trust achieved its financial plan the use of further non-recurrent income has had an impact on the underlying financial position of the Trust. This has worsened to £40.6m deficit from a £39.1m deficit at plan submission stage. While some of this has been mitigated by additional contract income above plan in 2026/27 it does mean the Trust will need to find an additional £0.968m CIP to achieve the 2026/27 financial plan.
- 2.9 Overall, the Trust achieved its 2025/26 financial plan and by doing this earned an additional £3.276m in NHS England funding improving the Trusts cash position going forward.

### **3. Capital and cash**

- 2.10 The cash position at the end of March was £2.650m lower than the previous month's forecast. Receipts were £0.852m above the forecast position. Black Country ICB income was £0.367m above the forecast. This related to additional risk pool payments that were over and above the forecast. Non-patient income was £0.485m above the forecast, this related to non-healthcare intra-NHS invoices paid earlier than planned. Payments were £3.466m higher than the forecast. Supplier payments were £4.078m higher than forecast. This related to the timing of the final payment run of the month. Capital payments were £0.619m lower than forecast. This related to capital creditors being higher than forecast.
- 2.11 The cash movement from the original plan is a combination of working capital movements (the Trust has a large amount of NHS debtors at year end that will be paid in the new financial year) and non-recurrent non-cash items (e.g. partially completed spells). The rolling 12-month cash flow shows that there is minimal movement from the planned cash for 2026/27 when all outstanding debtors are paid.
- 2.12 Compliance with the Better Practice Payment Code was 94.6% in terms of number of invoices paid to non-NHS suppliers and 94.2% for NHS suppliers as at 31st March 2026.
- 2.13 In month 12 there was year to date capital expenditure of £22.218m against the original planned spend of £18.478m. PFI lifecycle overspend (£2.129m) is a non-cash technical entry and doesn't impact on the capital control total. Replacement medical equipment underspend (£1.590m) relates to the reallocation of funds due to equipment being purchased in 2024/25. Ridgehill lease overspend (£1.353m) is a new development funded from slippage in the overall capital allocation. The UEC development (£1.250m) is a new scheme funded by the UEC capital allocation. The EPR development (£0.969m) is a new scheme funded from the medical equipment spare capital.
- 2.14 Capital expenditure of £22.218m has been incurred in the 2025/26 financial year an increase of £3.740m from plan. The Trust received an additional allocation of £1m in July relating to UEC incentive capital for

2024/25 improved UEC performance. This will be used as the capital element of the Newton contract. The Trust received a PDC allocation of £0.388m relating to CDC, a further PDC allocation of £0.634m relating to RAAC, has £0.083m of donated assets and £0.063m of asset disposals increasing the plan. Medical equipment allocation has been reviewed as several items were brought forward into 2024/25 because of additional capital received by the Trust. An EPR development & Ridge Hill scheme has been funded from this. The remainder of the plan movement is PFI lifecycle, a technical change of £2.129m. For 2025/26 the Trust achieved its capital control total set by the System.

#### 4. Cost improvement programme

- 2.15 The phased Cost Improvement Programme plan cumulative to March equated to £38.976m. Achievement to March totals £31.397m, which is lower than plan by £7.579m. From the middle of the financial year the Trust moved from overachieving the plan to a material underachievement.
- 2.16 The under delivery of £7.579m relates to the following. A shortfall in the Cost Improvement Programme of £2.437m and non-delivery of identified schemes of £5.142m. The main schemes contributing to the non-delivery total are the Learn, Adapt, Transform Programme (Newton) (£1.8m), Outpatients (£1.7m) and medical bank rates contained within the divisional CIP programme (£0.6m).
- 2.17 Of the total programme in the original plan 77% was planned to be recurrent (£29.978m) with 23% non-recurrent (£8.998m). Of the £31.397m achieved at the end of March, 61% are recurrent.
- 2.18 The Trust had planned for 2026/27 that £13.172m of full year effect CIP savings from 2025/26 would contribute to the CIP plan. Following the final CIP position for 2025/26 this has reduced to £12.428m (a reduction of £0.744m). With a larger number of non-recurrent schemes also contributing to the 2025/26 financial position a further £0.968m of CIP schemes is now required in 2026/27.

#### 5. Integrated care system (ics) and system working.

- 2.19 The Integrated Care System reported an actual aggregate surplus of £0.645m for 2025/26. This is £0.645m better than the financial plan submitted to NHS England in March. One provider did not achieve their financial plan with the System achieving the plan following over achievement of plans in the Integrated Care Board.

#### 6. Recommendations

- 6.1 The Trust Board is asked to:
- a) **Note** the financial performance for the month of March 2026 for assurance.
  - b) **Note** the reported Trust and System 2025/26 financial year end position for assurance.

**Chris Walker**  
**Director of Finance**  
**3<sup>rd</sup> May 2026**

<b>REPORT TITLE:</b>	Group Strategy 2026 – 2031		
<b>SPONSORING EXECUTIVE:</b>	Adam Thomas Group Chief Strategy & Digital Officer		
<b>REPORT AUTHOR:</b>	Laura Broster, Group Director of Communications Martin Chadderton, Associate Director of Strategy, SWBT Ian Chadwell, Deputy Director of Strategy, DGFT		
<b>MEETING:</b>	Public Joint Board of Directors	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
<input checked="" type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Approve	<input checked="" type="checkbox"/>	Both Trusts
<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Agree	<input type="checkbox"/>	Sandwell and West Birmingham NHS Trust
<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Endorse	<input type="checkbox"/>	The Dudley Group NHS Foundation Trust
<input type="checkbox"/>	Information	<input type="checkbox"/>	Recommend		
		<input type="checkbox"/>	Discuss		
		<input type="checkbox"/>	Note		

#### Suggested discussion points

This first public joint board of Directors is requested to formally approve the Group Strategy 2026 – 2031 which has been under development for several months. Following discussion at both the private boards in March 2026 and at the joint board development session in April 2026, the document has been shortened and simplified. Changes have been made to 'our commitments' in light of the discussion at Board Development.

The draft document was shared with partners across Dudley and Sandwell and West Birmingham inviting comments. A total of 19 responses were received via MS Forms with a further written response from Healthwatch Birmingham and Solihull. Written feedback was also received from statutory partners including Birmingham, Black Country and Solihull ICB cluster and Dudley Metropolitan Borough Council. Overall, feedback on the draft strategic plan was **largely positive**, with strong levels of agreement across key sections—including the vision, strategic objectives, commitments, and involvement approach. Most respondents feel the strategy is **heading in the right direction**, but they also highlight important areas where clarity and stronger partnership working are needed. Appendix 1 contains a summary of the feedback received from patients and the public.

Appendix 2 contains the communications and engagement plan. A formal launch is planned for 5<sup>th</sup> June with a new webpage, CEO and chair message to staff and stakeholders and staff briefing packs.

#### Alignment to our Vision

Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	<input checked="" type="checkbox"/>	OUR PEOPLE	<input checked="" type="checkbox"/>	OUR POPULATION	<input checked="" type="checkbox"/>
The Dudley Group NHS Foundation Trust					
PATIENTS	<input checked="" type="checkbox"/>	PEOPLE	<input checked="" type="checkbox"/>	PLACE/POPULATION	<input checked="" type="checkbox"/>

#### Previous consideration

Private Board of Directors – 11<sup>th</sup>, 12<sup>th</sup> March 2026  
 Joint Board development session – 15<sup>th</sup> April 2026  
 Executive directors – 5<sup>th</sup>, 12<sup>th</sup> May 2026  
 Joint public board of directors – 20<sup>th</sup> May 2026

**Recommendation(s)**

- a) Approve the content of the document;
- b) Note the planned activities for launch and ongoing engagement.

**Escalation**

Should any element of this report be escalated:

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

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	x	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources	x	2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce	x	3.0: Failure to build innovative partnerships
	<del>005: -Deliver the MMUH benefits case (CLOSED)</del>	x	4.0: Failure to achieve financial plan
x	004: Deliver on its ambitions as an integrated care Organisation	x	5.0: Failure to achieve performance requirements
x	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		

Is Quality Impact Assessment required if so, add date:

Is Equality Impact Assessment required if so, add date:



## Appendix 1

### **Draft Strategic Plan- Summary of Public & Partner Views**

In developing our Strategic Plan for the Group, we used what local people have told us matters most to them. We complimented this with 2 public meetings (one online and one face to face). Once the draft document was produced we circulated to key partners, the public and our patient groups for comments. Below is a summary of that feedback on our draft document.

Overall, feedback on the draft strategic plan was **largely positive**, with strong levels of agreement across key sections—including the vision, strategic objectives, commitments, and involvement approach (which was also circulated). Most respondents feel the plan is **heading in the right direction**, but they also highlight important areas where clarity and reference to stronger partnership working are needed.

- **A compelling vision, grounded in health and prevention**

Respondents broadly support the vision, particularly valuing its emphasis on **improving life chances, health outcomes, and wellbeing**. The focus on **prevention and population health** resonates strongly, alongside recognition of local health challenges and inequalities.

However, a minority feel the vision could go further, especially in clearly articulating **how partnerships, particularly with voluntary and community sectors, will be embedded** in delivery.

- **Strategic objectives seen as relevant and people-focused**

There is strong agreement with the strategic objectives, which are viewed as clear, ambitious, and aligned to patient and community needs. Respondents particularly value:

- The focus on community-based care
- The principle of delivering the right care, in the right place, at the right time
- Recognition of health inequalities and population health

That said, feedback suggests a need to ensure objectives are consistently understood and clearly linked to real-world delivery, especially across organisations and settings.

- **Support for long-term commitments, with emphasis on prevention**

Multi-year commitments are well received, especially the shift toward prevention and care closer to home. Respondents see these as essential to improving outcomes and reducing pressure on services.

However, there is a clear call for:

- Stronger visibility of partnership working
- More explicit inclusion of the voluntary and community sector
- Greater clarity on how commitments will translate into tangible change for local people
- **“What matters to you” reflects key priorities—but access and equity stand out**

Most respondents agree that the summary captures community voice effectively. The most important themes emerging are:

- The need for quick, simple access to care
- Concerns about waiting times and service pressures
- The importance of equitable access across diverse communities

There is also a strong emphasis on ensuring that all communities feel represented and supported, particularly those who may face barriers to access.

- **Ease of reading**

The documents were rated a 3.63 out of 5 with more work required to shorten, use infographics and ensure accessibility.

- **What changes are we making as a result of this feedback**

As a result of this feedback, we have made a number of important refinements to the strategic plan. We have reordered our commitments to place community first, ensuring that our approach is clearly grounded in what matters most to local people. We have also simplified the language throughout to improve clarity and accessibility. In response to strong calls for stronger partnership working, we have made explicit reference to the role of community and voluntary sector partners in both design and delivery. Finally, we have developed an inclusive communications and engagement plan to support the launch of the strategy and ensure it is clearly understood, widely shared, and brought to life in a meaningful and accessible way.

Our Group Strategic Plan will go to Trust Board meetings in May for final sign off before publication in June 2026.

Thank you for taking the time to respond.

# How we bring the strategy to life



## Design

- Staff briefing packs + team huddles
- Shared with TMG
- Shared with members of partnership boards
- Shared with patient and public groups
- Shared with BCPC members



## Launch – 5th June

- Strategy website hub containing:
  - Accessible versions (easy read, talking newspaper, translated copy via html)
    - **Case studies**
      - Inclusive Talent Development
      - Lung Cancer Screening
      - Care Navigation Centres
- CEO & Chair message to staff and stakeholders
- Staff briefing packs, plans on a page posters, screensavers, team brief



## Always-On Campaign

- Board “strategy in action” stories
- Quarterly stakeholder newsletter with sections on:
  - Community First
  - Lead with Prevention
  - Invest in people and culture
  - Fit for the Future Programme
  - Place Based Partnerships x 3
- Social + local media storytelling



## Engagement & Influence

- MP briefings + site visits linked to our strategy
- Partner updates (ICS, VCSE, Healthwatch, Stakeholder Newsletter)
- Establishment of quarterly patient forum for each Trust
- Staff engagement:
  - Leader visibility
  - Two-way feedback sessions
  - People Engagement Teams

The Dudley Group NHS Foundation Trust

Sandwell and West Birmingham NHS Trust



**Group Strategy  
2026 – 2031**





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# Welcome

Welcome to the first joint strategy of The Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust. Over recent months, our organisations have been working ever more closely to improve the services we provide to our patients and communities. We now share a Chair and Chief Executive, alongside an increasing number of senior leadership roles. From April 2026, we will operate within a formal Group model with each trust retaining its sovereignty but working to our new shared vision and strategy to be 'Fit for the Future'.

We serve a largely shared population, face similar operational and financial pressures, and hold aligned ambitions for quality, equity and long-term sustainability. The collaboration we have already established is delivering real benefits, but the scale of the challenge facing the NHS means we must now go further and faster. Demand is rising, needs are becoming more complex, and financial constraints mean that continuing to deliver care in the same way is not sustainable.

Fit for the Future is our commitment to reshape how we work so that we live within our means while protecting what matters most: safe, high-quality care. This includes a clear shift towards stronger community-based care and healthier neighbourhoods, supporting people earlier, closer to home, and in partnership with local services, so we can improve outcomes, reduce avoidable pressure on hospitals, and build more resilient communities for the long term.

Both trusts have experienced significant change in recent years. In October 2024, Sandwell and West Birmingham NHS Trust opened the Midland Metropolitan University Hospital, creating a state-of-the-art facility for acute and specialist care while retaining most planned care at existing sites and expanding community-based models of care. At the same time, The Dudley Group NHS Foundation Trust took on responsibility for additional primary care support services, including two GP practices. This has all taken place against a backdrop of rising demands and legitimate questions about productivity and how

increased investment translates into improved access and activity. Our Group strategy responds directly to these challenges.

The government's 10-year health plan for England, published in July 2025, sets out three major shifts for the NHS: moving care from hospital to community, from analogue to digital, and from treatment to prevention. Our strategy translates this national direction into local action. We know we must deliver within the funding already announced for the NHS, and therefore have a responsibility to use our people, facilities, technology and equipment in the most effective and responsible way possible.

We know that when people use our services, they expect the fundamentals of care to be there: being able to get an appointment, clear and simple pathways, support while they wait, and care that feels compassionate and fair. Our strategy is built upon the principle of getting these basics right, improving access, making services easier to navigate, using digital in a way that helps rather than excludes, and working better with community partners so care feels joined up and rooted in local neighbourhoods.

At the heart of this strategy is a commitment to improving population health. If we are to create a financially sustainable NHS, we must help our communities to stay well for longer.

We will partner with others, helping people to stay well and reducing avoidable illness. Working closely with partners across primary care, local authorities and the voluntary and community sector, we will act earlier to identify risk, tackle the causes of poor health and address the inequalities that affect our communities.

Our focus will include reducing the risk of the most significant conditions affecting our population, particularly cardiovascular disease, and improving early detection so that illness is identified and treated sooner, before it becomes more complex and costly.

A healthier population is better for individuals and families and essential to the long-term resilience of our services.

We will make better use of digital technology to improve access, quality and efficiency across our services. For patients, this means simpler ways to book appointments, access information and receive care closer to home, without unnecessary travel. For staff, it means better systems, joined-up information and tools that reduce duplication and release time to focus on care. Digital will enhance, not replace, compassionate, person-centred services.

Fit for the Future is also about ensuring our estate is fit for modern care. Much of our estate was designed for a different era of healthcare. We will continue to develop

flexible, digitally enabled environments that support care closer to home, improve staff experience, and make better use of space and resources so that our buildings enable, rather than constrain, new models of care.

Our actions will be grounded in the values of our respective organisations and our commitment to inclusion for staff, patients, families and communities. We also recognise our role as anchor institutions, contributing to local employment, skills and economic wellbeing. By working together as a Group, we believe we can meet the challenges ahead, improve life chances, and deliver better health outcomes for the population we serve both now and for the future.



Sir David Nicholson, Chair



Diane Wake, Chief Executive

## Working Together

Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust are strengthening how we work together by moving to a formal NHS Group model, with our Boards and decision-making committees meeting in common from April 2026.

This approach allows both Trusts to remain legally independent and locally rooted, while benefiting from shared leadership and vision, clearer governance and closer collaboration across our organisations. By working together at scale, we are building stronger foundations to respond to growing demand, workforce challenges and financial pressures, making sharing of learning easier and ensuring our organisations are fit for the future.

By working more closely, we can go further and faster in improving care, tackling waiting lists, developing our workforce and making the best use of public resources. Facing similar operational pressures, the Group model helps us reduce unwarranted variation in care and outcomes,

improve access to safe, high-quality services, and strengthen consistency in leadership and decision-making.

While we are coming together for strategic alignment, we strongly value the differences across our three places. We will continue to invest in place- and neighbourhood-level partnerships, working with local authorities, primary care, the voluntary and community sector and wider system partners to address the specific health needs of the populations we serve. Local identity, relationships and priorities will remain central to how care is planned and delivered.

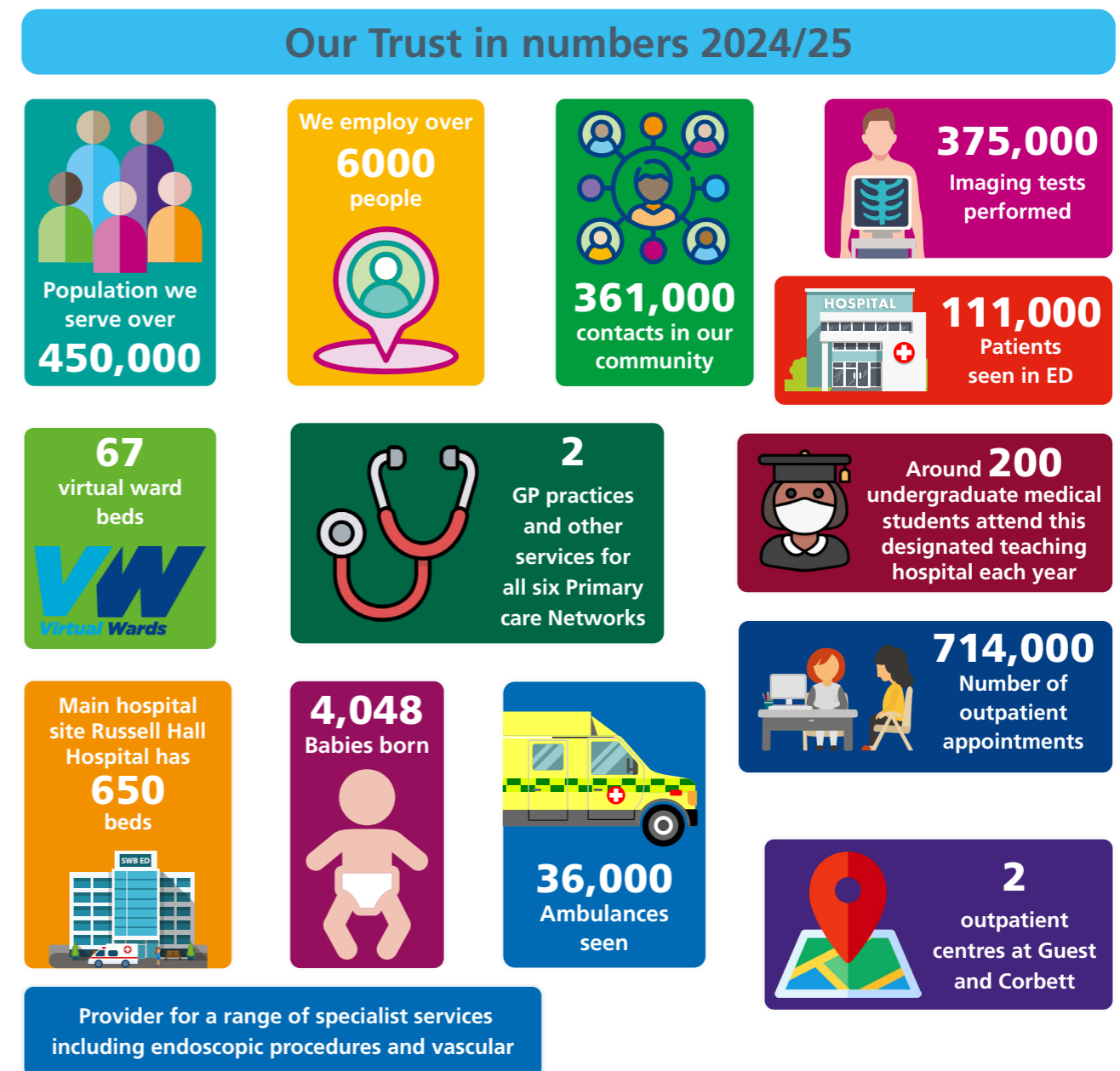
The new Group Board will support joint working on quality, finance, people and infrastructure, reducing duplication and strengthening assurance. This creates a strong platform for shared strategy, innovation and learning helping us modernise services, make better use of digital technology and build a more resilient and sustainable NHS for the long term.



## About The Dudley Group NHS Foundation Trust

The Dudley Group NHS Foundation Trust provides acute, community and some specialist services to people in Dudley and surrounding areas. The Trust plays a key role in supporting care closer to home, strengthening links between hospital, community and primary care services, and working in partnership to improve health outcomes for local communities.

As a major local employer and teaching organisation, the Trust supports education, training and research, helping to grow the future workforce. Working as part of an NHS Group strengthens its ability to attract, develop and retain staff, while continuing to respond to the specific needs of Dudley's communities.



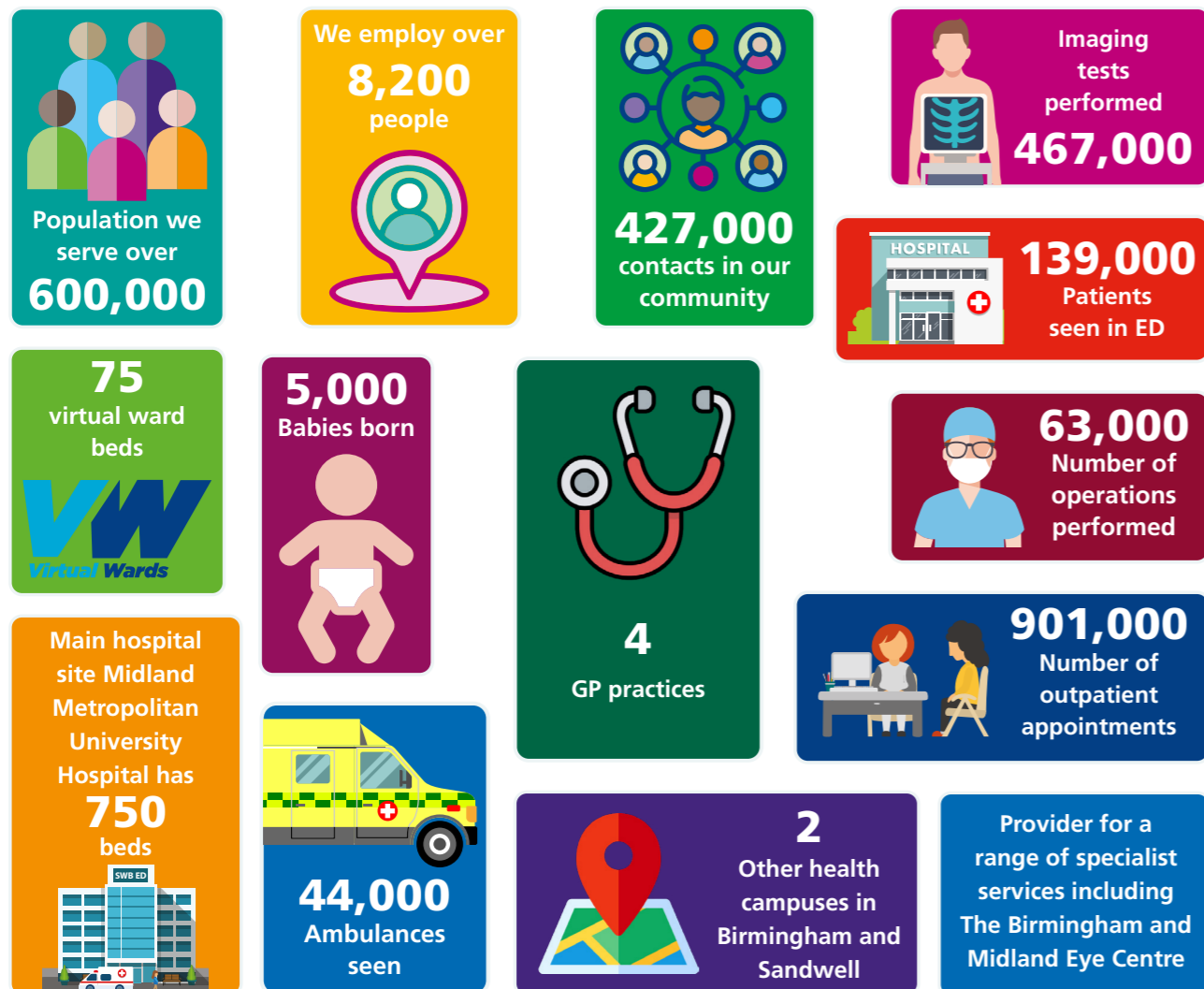
CQC Well Led rating 'Requires improvement' (Feb 2019)

# About Sandwell and West Birmingham NHS Trust

Sandwell and West Birmingham NHS Trust provide hospital, community and primary care services across Sandwell and West Birmingham. The Trust works closely with partners to deliver joined-up care across neighbourhoods, with a strong focus on prevention, early intervention and reducing health inequalities.

Being part of an NHS Group strengthens the Trust's ability to plan for the future, invest in digital and service transformation, and build resilient clinical and leadership teams that can meet rising demand and increasingly complex patient needs.

## Our Trust in numbers 2024/25



**CQC Well Led rating 'Good' (Feb 2026)**

# About the communities we serve

We have used data and intelligence from the most recent joint strategic needs assessments (JSNA) undertaken by local authorities to summarise the populations we serve. The following table shows the population variation including demographics that reinforces the importance of maintaining strong and locally responsive services:

Aspect	Dudley	Sandwell	Birmingham
<b>Population (2024)</b>	331,930	353,860	263,919
<b>Median Age</b>	41.3 yrs	36.6 yrs	33.7 yrs (very young)
<b>Ethnic Diversity</b> <i>Source: Census 2021</i>	White 84.9%, Asian 8.4%, Black 2.5%, Other 4.2%	White 57.2%; Asian 25.8%, Black 8.7%, Other 8.3%	White 48.6%; Asian 31%; Black 11%, Other 9.4%
<b>Deprivation Rank / Profile</b> <i>Source: IMD 2019</i>	Deprivation (IMD 2019 – rank of average rank, out of 317 LAs)		
	<b>Dudley: 104 / 317</b> (mid-range nationally). 11% of Dudley neighbourhoods in most deprived Decile. (26.1%) of children live in absolute poverty	<b>Sandwell: 8 / 317</b> (among the most deprived nationally) 20% of Sandwell neighbourhoods in most deprived Decile. (25%) of children live in absolute poverty	<b>Birmingham: 6 / 317</b> (among the most deprived nationally) 41% of Birmingham neighbourhoods are in the most deprived Decile. 37.5% of children live in absolute poverty
<b>Home Owner</b>	66.4%	53.7%	52.6%
<b>Adult Unemployment</b> <i>Source:</i>	4.4%	6.0%	* 7.2%
<b>Young People (16-17yr olds), Not in Employment, Education or Training (NEET)</b> by local authority 2024/25 academic year Midlands average total: 6.2% England average total: 5.6% <i>Source: DoE</i>	2.4% NEET 19.1% Not known <b>Total 21.5%</b>	1.9% NEET 0.7% Not known <b>Total 2.6%</b>	**3.2% NEET ** 3.2 Not known <b>** Total 6.4%</b>
<b>Health Outcomes</b>	<b>Life Expectancy (years):</b> Male: 78.9 Female: 83 <b>England Life Expectancy</b> Male: 79.5 Female: 83.3 <b>Healthy Life Expectancy</b> Male: 61.5 Female: 61.9 <i>Source: dept. of Health and Social Care 2021-2023.</i>	<b>Life Expectancy (years):</b> Male: 76.7 Female: 81.2 <b>Healthy Life Expectancy</b> Male: 55.5 (6 years less than England average) Female: 54.8 (7.1 years less than England average)	<b>Life Expectancy (years):</b> Male: 77.1 Female: 81.2 <b>Healthy Life Expectancy</b> Male: 57.6 (3.9 years less than England average) Female: 57.2 (4.7 years less than England average)

\*Higher than average (economic challenges noted; no single rate in source). Birmingham city (ONS modelled estimate) had an unemployment rate of about 7.2% (year to Dec 2023)

\*\* Figures for Birmingham local authority as a whole (not split to West Birmingham)

## What matters to local people

Drawing on a synopsis of recent public involvement activities across the Black Country, we have used those valuable insights, gathered through a variety of means to look at the key themes and challenges.

We know that for local people, access to services remains a major challenge, with persistent difficulties getting GP and specialist appointments, long waiting times, and too little support while people wait. There is a clear call for simpler, more transparent pathways, and for digital services that enhance access without excluding those who lack digital skills or connectivity.

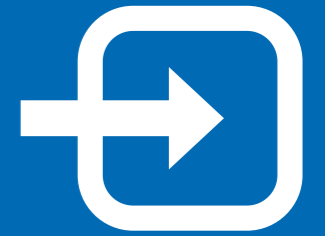
In addition, communities strongly support greater investment in local organisations, with sustainable funding for the voluntary, community, faith, and social enterprise sector. People feel that care must be personalised, culturally competent, and accessible to all.

People believe that compassion and trust are central - people want dignified, empathetic, and non-judgmental care, with underrepresented voices genuinely heard. Finally, there is a need for whole-system collaboration across health, social care, and community partners, addressing wider determinants like housing, employment, and safety.



### Access to Services

- Persistent difficulties in obtaining GP and specialist appointments.
- Long waiting times, with concerns over lack of interim support.
- Calls for more streamlined, clear, and accessible service pathways.
- Digital options must not exclude those with limited digital access or skills



### Community Investment and Personalised Care

- Strong support for increased collaboration with community organisations.
- Sustainable funding for voluntary, community, faith, and social enterprise (VCFSE) services is vital.
- Services must be tailored to individuals' needs, ensuring cultural competency and accessibility.



### Compassion and Trust in the NHS

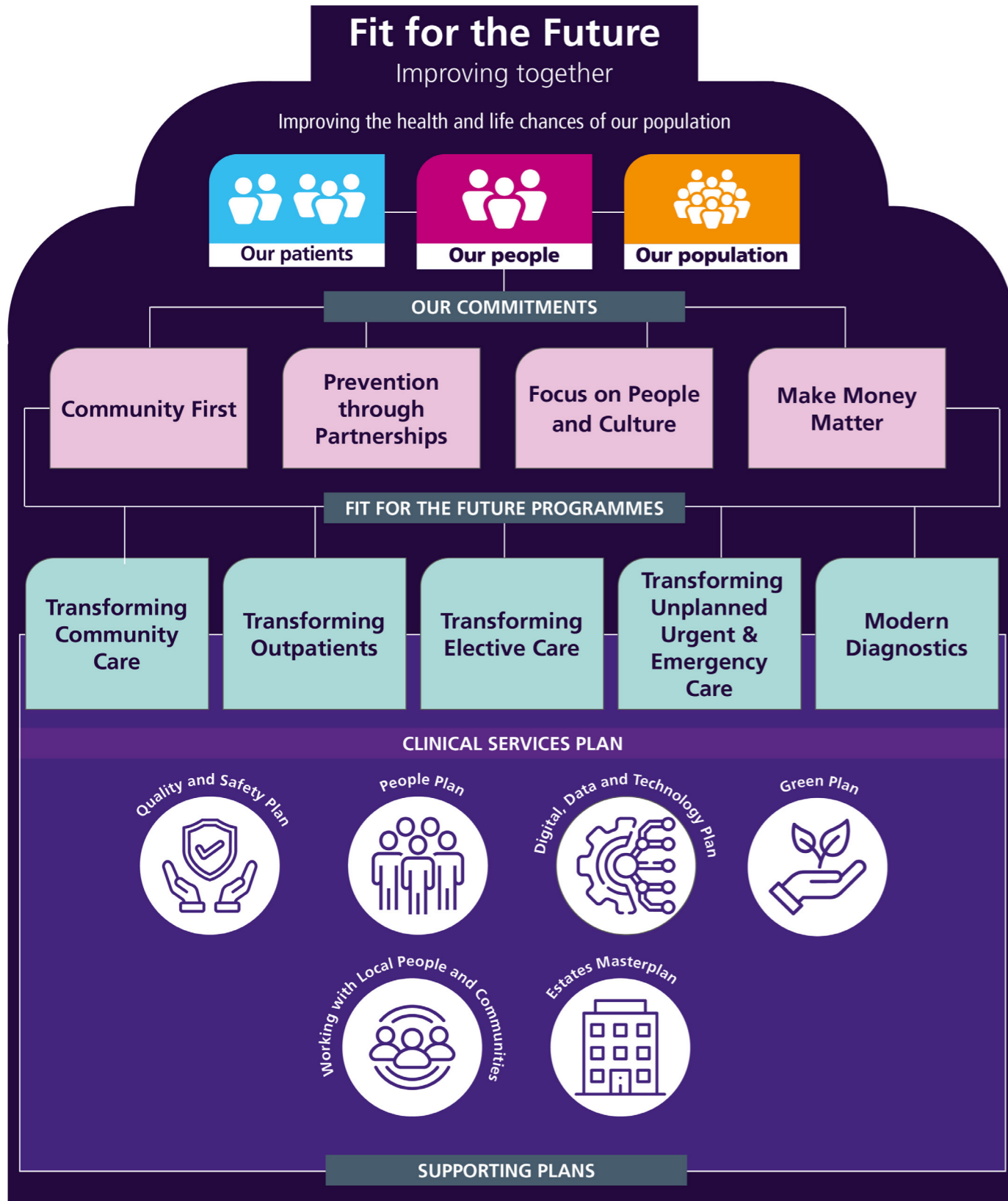
- The importance of a dignified, empathetic, and non-judgemental approach to care.
- A call to amplify the voices of underrepresented communities and ensure inclusivity.



### Collaboration and Whole-System Thinking

- A need for stronger integration between health, social care, and community partners.
- Addressing wider determinants of health, such as housing, employment, and community safety.





We believe that in order to deliver these objectives, we need to fundamentally re-think how services are delivered in the future. We believe that this is best achieved by learning from our experience of designing and opening the Midland Metropolitan University Hospital in 2024 so that our future model will be based around a community first approach supported by two acute hospitals and planned care (admissions and outpatients) taking place in dedicated centres protected from the varying peaks and troughs in demand for urgent and emergency care.



The government's 10-year health plan for England and subsequent policy documents signal the intention that far more care needs to be delivered in neighbourhoods in the future. As a Group we are already actively working with partners in primary care, social care and the voluntary sector to establish models of neighbourhood health. We will continue to do this, recognising the unique position we are in to act as the host provider for population-based contracts in the future.

**Our values**

Both trusts have a set of values that been embedded into the way they work over a period of years. We do not propose the change the values but rather work together to align these.

**The Dudley Group NHS Foundation Trust**

**Sandwell and West Birmingham NHS Trust**

**Care**

We provide safe, quality healthcare for every person – every time.

**Ambition**

We are ambitious for our communities. We want to make a difference, improving life chances and health outcomes.

**Respect**

We show respect for our patients, our visitors and each other – at all times.

**Respect**

We are a place of inclusivity. We value, celebrate and draw strength from the diversity among us, and in our communities.

**Responsibility**


We take responsibility for everything we do – every day.

**Compassion**

We are a welcoming friendly Trust. We have care, kindness and compassion at our heart.

## Our patients

Deliver high-quality care, by the right person in the right place, at the right time



### What we want to do by 2031 (Group-wide):

- Deliver care in the community or at home, so that action is taken early, represents local needs in our neighbourhoods and is co-ordinated with ongoing support.
- Be known for our high-quality, outstanding services, with sustained improvements in the safety and efficiency no matter where they are provided.
- Be recognised by our patients and service users for providing the best experience of care.
- Reduce waiting lists for specialist appointments or surgery, so that our communities are healthy, well, have better life chances and actively supporting the black country to thrive.
- By being brilliant at the basics, ensuring everything from appointment notification to diagnostics to the care we provide is a frictionless as possible – and striving for continuous improvement.
- Ensure consistency in the prevention and management of the deteriorating patient with demonstrable improvements in key quality indicators including sepsis management, timely vital sign recording, timely escalation and treatment and reduction of associated incidents.
- Optimise technology to assure quality and use insights to drive better service decisions.

### For patients, this will mean:

- Clearer and simpler pathways across hospital, community and primary care
- More care delivered closer to home where safe and appropriate.
- Better support while waiting and earlier decisions about treatment.
- Fewer repeated assessments and less duplication
- Services that feel joined-up, compassionate and easy to navigate



## Our people

Be a brilliant place to work and thrive through happy, engaged, productive teams.



### What we want to do by 2031 (Group-wide):

- Deliver consistently positive staff experience through a culture of safety, inclusion and compassion.
- Strengthen inclusive, compassionate leadership at all levels, aligned to the Messenger Review.
- Improve retention, wellbeing and attendance through flexible working and proactive support.
- Ensure fair access to development, progression and workplace adjustments.
- Deliver integrated Group workforce planning aligned to activity, productivity and finance.
- Optimise workforce systems, digital tools and analytics to support workforce deployment and productivity.

### For our people, this will mean:

- Clear expectations about the future direction of care and their role within it
- Rotas and job plans better aligned to patient demand, reducing avoidable pressure.
- Leadership that models our values and addresses poor culture promptly.
- Joined-up systems and tools that reduce duplication and administrative burden.
- Clearer development pathways and opportunities to grow across the Group



## Our population

Work together with our partners to improve life chances and health outcomes.



### What we want to do by 2031 (Group-wide):

- Redesign care pathways with our patients and our workforce to focus on local population health needs, within our local places and neighbourhoods – away from the hospital setting.
- Build strong partnerships with local agencies, academia, the voluntary sector industry and national programmes because we know we cannot do this alone,
- Prevent long-term conditions developing in our communities, whilst ensuring our effort in the meantime are upon finding and addressing the needs of these ‘populations’ now.
- Be the anchor institute for employment opportunities, local recruitment and economic drive in our local area.
- Harness technology to enable the majority of our local communities to connect with care remotely, to meet their needs, so that we can focus direct availability to those who are not online.
- To support digital inclusion, enablement, access and literacy



## Our commitments

We are making four focused commitments as a Group.

These commitments represent the key shifts we will deliver over the next five years to improve outcomes, reduce inequalities and ensure long-term sustainability.

They define how care will change across our system and provide a clear focus for the organisation. Progress in delivering these will be monitored through our measures of success.

### Community First



**We will** increase the proportion of care delivered closer to home.

Our commitment is to shift the focus of care from hospital settings to community-based services, promoting a holistic approach to health, wellbeing and earlier intervention. Through our continued work in our local health and care partnerships and by investing in community health initiatives, we aim to provide proactive, integrated care that supports patients in, or as close as possible, to their own home. Our goal is to enhance health outcomes, reduce hospital admissions, and foster a healthier, more resilient community.

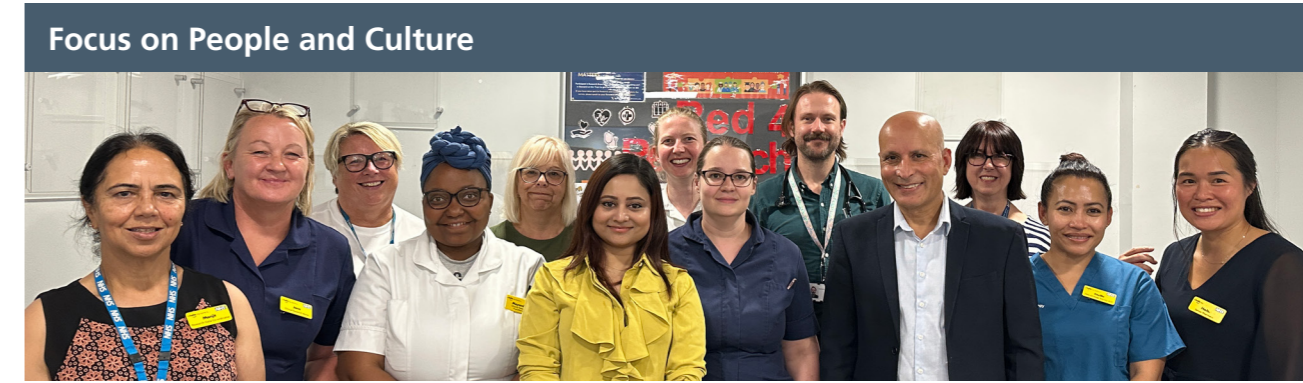
A key dependency of this is the interconnected improvement work to reduce waiting lists and the backlogs the pandemic created, ensuring people are treated promptly and get back to a state of wellbeing.

In practice, our divisions will be developing new pathways and models of care to focus on the following areas:

- Frailty and nursing homes
- Development of the Care Navigation Centre
- Moving outpatient services out of hospital

#### For our communities, this will mean:

- Earlier identification of risk and proactive support to stay well
- Targeted action in our most deprived neighbourhoods to reduce inequality
- Better coordination between health, social care and voluntary partners
- More consistent support for people living with long-term conditions
- A focus on improving healthy life expectancy across our places



## Prevention Through Partnerships



**We will** prioritise being a strong partner to deliver a fundamental shift from reactive care to proactive population health, placing prevention at the centre of how we design services, deploy our workforce and work with partners.

Our approach is to reduce avoidable illness and demand on hospital services by acting earlier, targeting risk and addressing the wider determinants of health. This is essential to improving healthy life expectancy, reducing inequalities and delivering a financially sustainable health system.

We will use data and local intelligence to identify those most at risk, focusing on our most deprived communities and priority clinical areas through the Core20PLUS5 framework. Prevention will not sit alongside care — it will be embedded within every interaction, pathway and service model.

As anchor institutions, we will also use our role as major local employers to improve health and wellbeing through inclusive employment, skills development, healthy environments and partnership with local organisations.

### In practice, this means we will:

- Identify and act on risk earlier, using data and community insight to target prevention where it will have the greatest impact

- Embed prevention into everyday care, making Every Contact Count (MECC) a standard part of clinical and non-clinical interactions
- Design pathways that intervene earlier, particularly for high-impact conditions such as cardiovascular disease
- Work with partners across primary care, local authorities and the voluntary sector to deliver coordinated, community-based prevention and early intervention
- Address health inequalities directly, targeting action in the most deprived populations and neighbourhoods
- Act on the wider determinants of health, including employment, education and housing, particularly for groups such as young people not in education, employment or training (NEET)
- Support the health and wellbeing of our workforce, recognising its direct link to patient outcomes and system sustainability

Through this approach, prevention becomes the foundation of our Community First model, reducing pressure on acute services while improving outcomes for our population.

## Focus on People and Culture



**We will** create an environment where our people feel safe, valued and engaged, with the skills, support and leadership needed to deliver outstanding care now and in the future. We will nurture a compassionate, inclusive and high-performing culture across the Group, recognising that staff experience is fundamental to patient experience, quality and sustainability.

### Why this matters

A motivated, healthy and inclusive workforce is essential to delivering safe, high-quality care, improving productivity and ensuring long-term financial and workforce sustainability. Our staff work in complex and pressured environments, and we know that how people are led, supported and listened to directly affects outcomes for patients and communities. By listening to our people and acting on what they tell us, we will retain critical skills, reduce absence and turnover, strengthen leadership capacity and enable new models of care, including care delivered closer to home and through digitally enabled services.

### What will change over the next five years

We will strengthen inclusive, compassionate leadership at all levels, aligned to the Messenger Review, with clear expectations of behaviour and accountability across the Group.

- We will actively tackle bullying, harassment and discrimination, building a culture of psychological safety, civility and respect.
- We will redesign rotas and job plans to better align workforce deployment with patterns of demand, improving fairness,

reducing avoidable pressure and supporting productivity.

- We will create clearer, credible career pathways and shared roles across acute, community and primary care.
- We will embed consistent listening frameworks and ensure feedback leads to visible action and measurable improvement.
- Through effective workforce planning, digital enablement and a sustained focus on wellbeing, engagement and inclusion, we will support our people to work at the top of their licence, adapt to changing service models and deliver high-quality, compassionate care for our communities now and in the future.

### Our staff will experience:

- Clear direction and boundaries about the future model of care, including the shift to community-first where safe and appropriate.
- Leadership that models expected behaviours and addresses poor culture promptly.
- Rotas and job plans that reflect real service demand rather than historic patterns.
- Better access to digital tools, diagnostics and support services that make new ways of working sustainable.
- Greater clarity about development opportunities and progression across the Group.
- A workplace where speaking up leads to change, not repetition.

## Make Money Matter



**We will** prioritise our resources on things that add value, so every pound has purpose.

Our commitment is to achieve the best possible value for the taxpayer by eliminating duplication and using our resources - people, estates, equipment and technology—in the most effective way. Many of our assets, including imaging equipment and operating theatres, are expensive to run and must be optimised to maximise benefit for patients. Greater use of digital technologies will support this, releasing clinical time and enabling staff to focus on delivering high-quality care. Our people are central to this commitment. We will support our workforce to work in new ways, develop the skills required for digital and service transformation, and operate at the top of their licence. Through integrated workforce planning, shared roles and strong leadership, we will ensure capacity and capability are aligned to demand, productivity and financial sustainability. Our corporate services will work collaboratively across the Group to deliver high-quality services at reduced cost, while maintaining a positive staff experience.

### What will change in the next 5 years

Our teams will make the best use of our estates, facilities, equipment and clinical capacity

Workforce deployment and skill-mix will better match to service demands, and high productivity services.

We will reduce the frustration of administrative issues, duplicated and absent information to form frictionless access for patients. This will involve greater use of the NHS App and digital channels.

Better use of data across our primary, community and secondary-care services will support early decision making and streamlined appointments

We will develop the digital literacy of staff and patients, as well as supporting our workforce in building confidence and new capabilities in working with data and delivering service improvement

Where clear benefits have been demonstrated for our patients and our people to create more productive services, we will use digital and AI solutions at scale

Delivery of these commitments will be enabled through the Fit for the Future programmes and supported by aligned measures of success, providing a clear line of sight from strategic intent through to delivery and performance.

## Our measures of success

We will monitor progress in delivering our commitments through a focused set of measures of success. These measures provide a balanced view of performance across access, quality, workforce and financial sustainability, and indicate whether the changes set out in our multi-year commitments are being realised.

With these measures of success, we are defining 'how' we expect to make changes and keep our public service commitments. We have developed these measures using our *Improving Together* methodology so that they can translate directly into how we manage, support and assure the right changes are happening in balance, and not one at the expense of another.

Delivery	Quality
<p><b>Must do:</b></p> <ul style="list-style-type: none"> <li>Meet constitutional access standards</li> </ul> <p><b>Choose to:</b></p> <ul style="list-style-type: none"> <li>Reduce Bed occupancy</li> <li>Increase Community activity</li> </ul>	<p><b>Must do:</b></p> <ul style="list-style-type: none"> <li>Improve overall patient experience score</li> <li>Reduce Mortality (SHMI/ HSMR)</li> </ul> <p><b>Choose to:</b></p> <ul style="list-style-type: none"> <li>Making Every Contact Count (MECC) (prevention)</li> </ul>
Cost	Morale
<p><b>Must do:</b></p> <ul style="list-style-type: none"> <li>Balance our finances</li> <li>Improve Implied productivity</li> </ul> <p><b>Choose to:</b></p> <ul style="list-style-type: none"> <li>Reduce Underlying deficit</li> </ul>	<p><b>Must do:</b></p> <ul style="list-style-type: none"> <li>Improve NHS staff survey results</li> <li>Reduce sickness absence</li> </ul> <p><b>Choose to:</b></p> <ul style="list-style-type: none"> <li>Increase National leadership competency</li> <li>Increase workforce retention &amp; local employment</li> </ul>

**How the Board Will Use These Measures**

The Group Board will have a clear line of sight on progress, enabling effective oversight of quality, performance, workforce, and financial sustainability, so that it may act to provide public assurance.

We will break down our multi-year commitments into clear objectives for each year to describe how we will deliver improvements and keep our collective focus on achieving this.

**Implementing our strategy**

This section describes the main ways that we will use to implement our strategy.

**Fit for the Future delivery programme**

There are three key facets to the programme and its resourcing:

1. Placing an executive director in a portfolio senior responsible officer role (SRO), to spearhead the clinical and operational service change over multiple years, who will identify areas of specialist resource input;
2. Underpinning the delivery through raising key operational and clinical talent from our teams and backfilling behind to maintain operational delivery, whilst strengthening group leadership across services;
3. Creating a strong single wrap-around strategic delivery support model from corporate services including programme management office, Improving Together, digital, data and technology, with finance, organisational development, HR, quality, communications focussed on aiding programme delivery.



There are five programmes designed to deliver major change for a sustainable future. These are:

- Transforming Community Care
- Transforming Planned Elective Care
- Transforming outpatients
- Transforming Un-planned Urgent & Emergency Care
- Modern Diagnostic

National bids have been placed for capital investment for development. This exciting opportunity is being refined into programme business cases that will see a £100m injection of transformative funds into the programme over the next four years. In addition, a compelling investment plan to convert estates issues and national capital investment into major modernisation, for the benefit Our Patients, Our People and Our Population are in the planning and initiation phase.



**Improving Together**

*Improving Together* is our design and delivery improvement methodology and management system. This is a matured, well adopted home-grown quality improvement mindset, supported by a growing network of improvement champions to sustain the approach. Each division, department and team will use the vision and goals to guide their improvement efforts by defining objectives specific to their work area. Using a variety of methods appropriate to the work, and a ward to board reporting information cascade of virtual or physical improvement boards and team huddles, every member of staff will know how their work is contributing to the strategy.

**Our underpinning plans**

The group strategy is underpinned by several cross-linked detailed delivery plans, that set out the key milestones, projects and programmes of work that delivery our vision and strategic objective. Our Board Assurance Framework (BAF) captures the strategic risks that may inhibit successful delivery and actively manages these risks with clear unitary board ownership.

Further information about these plans can be found at [www.swbh.nhs.uk](http://www.swbh.nhs.uk) and [www.dfgt.nhs.uk](http://www.dfgt.nhs.uk)

- Clinical Services Plan
- Quality and Safety Plan
- People Plan
- Digital Data and Technology Plan
- Estates and Facilities
- Green Plan

### Board Assurance Framework

The Group has reviewed the strategic risks that will prevent our goals from being delivered; in line with the Group's Risk Management Framework and agreed risk appetite. The joint Board Assurance Framework will document the joint Board's strategic risks alongside its appetite for risk in the achievement of strategic objectives. The Board Assurance Framework is reviewed throughout the year at the joint board and its committees to monitor the management of identified risks in line with its agreed risk appetite. Corrective action is taken to mitigate these risks and to the attain the target score.

The Group's strategic risks reflect the delivery of our commitments, ensuring that risks to achieving these shifts are actively identified and managed.



### Working with people and communities

We have developed a shared approach to involving people and communities and we will follow these as we deliver our strategy. We are committed to building collaborative and meaningful partnerships that start with people and focus on what really matters to our communities. Our organisations have adopted the following principles to set out our ambitions for building positive, trusted and enduring relationships with communities to improve services, support and outcomes for people.

- Centre decision-making and governance around the voices of people and communities
- Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
- Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
- Build relationships based on trust, especially with marginalised groups and those affected by health inequalities
- Work with Healthwatch and the voluntary, community and social enterprise sector
- Provide clear and accessible public information
- Use community-centred approaches that empower people and communities, making connections what works already
- Have a range of ways for people and communities to take part in health and care services
- Tackle system priorities and service reconfiguration in partnership with people and communities
- Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.



You can read more about this approach, our priorities and examples of our recent patient and public involvement work on our websites.

**Involvement at Dudley Group**

[www.dgft.nhs.uk/about-our-trust/get-involved/involvement-at-dudley-group/](http://www.dgft.nhs.uk/about-our-trust/get-involved/involvement-at-dudley-group/)

**Engagement events & activities (public, patients and community)**

[www.swbh.nhs.uk/get-involved/events/](http://www.swbh.nhs.uk/get-involved/events/)

# By 2031 we will be ...

- **Fit** for quality, safety, and patient experience
- **Fit** for care closer to home
- **Fit** for rising demand and growing complexity
- **Fit** for prevention and healthier communities
- **Fit** for reducing health inequalities
- **Fit** for our workforce – now and in the future
- **Fit** for joined-up working with partners
- **Fit** for digital and new ways of working
- **Fit** for a modern, flexible estate
- **Fit** for better use of our buildings and space
- **Fit** for financial sustainability
- **Fit** for long-term sustainability, not short-term fixes
- **Fit** for the future needs of our population

The Dudley Group NHS Foundation Trust  
Sandwell and West Birmingham NHS Trust

<b>REPORT TITLE:</b>	Group Chief Nursing Officer and Group Chief Medical Officer Report		
<b>SPONSORING EXECUTIVE:</b>	Melaine Roberts, Group Chief Nursing Officer Jonathan Odum, Group Chief Medical Officer		
<b>REPORT AUTHOR:</b>	Corporate Medical and Nursing Teams		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type:	Requested action:	Applies to:
<input type="checkbox"/> Decision	<input type="checkbox"/> Approve	<input checked="" type="checkbox"/> Both Trusts
<input checked="" type="checkbox"/> Assurance	<input type="checkbox"/> Agree	<input type="checkbox"/> Sandwell and West Birmingham NHS Trust (SWB)
<input type="checkbox"/> Discussion	<input type="checkbox"/> Endorse	<input type="checkbox"/> The Dudley Group NHS Foundation Trust (DGFT)
<input type="checkbox"/> Information	<input type="checkbox"/> Recommend	
	<input checked="" type="checkbox"/> Discuss	
	<input checked="" type="checkbox"/> Note	

### Suggested discussion points

#### Alert

- **Sandwell and West Birmingham NHGS Trust (SWB)** - There are over 800 Sandwell Children We Care For (CWCF) previously known as Children in Care. The safe staffing guidance outlined within the Intercollegiate document confirms that the service is currently under-resourced.

#### Advise

- **SWB/The Dudley Group (DGFT)** During six days of industrial action by resident doctors, both Trusts with comprehensive delivery plans put in place. Approximately 95% of usual elective activity was still provided. No derogations were requested and no significant safety concerns or incidents were reported. The percentage of doctors who took action varied across the Trusts.
- **SWB** Gynaecologist, Sudha Sundar, recently presented her work on inequalities in Ovarian Cancer diagnosis to MPs at the House of Parliament. Her research aims at improving pathways from Primary Care to Secondary Care, improving ultrasound quality.
- **SWB/DGFT** - A range of staff engagement events have commenced across both Trusts including the Chief Nurse on Tour roadshows, celebrating the nursing and midwifery profession and a new consultant programme at DGFT.
- **DGFT** - Congratulations to Phillipa Brazier on her National CNO Silver Award and to DGFT consultant colleagues on the publication of their book 'Stroke Mimics'.

#### Assure

- **DGFT** has completed the biannual safer staffing review of the inpatient areas, Acute Assessment Units and Emergency Department, in line with national safer staffing guidance. Overall, the safer staffing establishments remained generally in a positive position to provide and deliver safe, effective, high-quality care. No significant quality and safety concerns were identified by Divisional Chief Nurses associated with their current establishments, although patient acuity has increasingly been very challenging in some areas requiring additional temporary staff to maintain patient safety and quality. The main negative impact has been on patient experience especially with corridor care due to lack of privacy and dignity, affecting patients being able to sleep due to lighting and noise. A series of recommendations are included in this paper.
- **SWB** is compliant with 4 out of 5 GIRFT corridor-care recommendations with no outstanding quality or safety actions. **DGFT** are currently assessing their position.
- Following focused improvement work in the stroke service at **SWB** the service has moved to grade A in the last year.

- **SWB** Harm Review Group serves as a multidisciplinary forum to examine patient harm incidents, promote shared learning, and drive organisational improvement. Meeting monthly, the group reviews divisional reports on patient cases with prolonged waits and assesses any resulting harm, while sharing mitigation actions. The group oversees Duty of Candour compliance, tracks thematic trends, and evaluates the effectiveness of actions taken to enhance safety. A similar process is followed at **DGFT**, and both groups are considered regional best practice, with ongoing efforts to streamline and learn from each other.

Alignment to our Vision					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x
The Dudley Group NHS Foundation Trust					
PATIENTS	x	PEOPLE	x	PLACE/POPULATION	x

Previous consideration

Recommendations
a) <b>Discuss</b> the alert section for assurance
b) <b>Note</b> the Advise and Assurance section

Escalation
Should any element of this report be escalated:

BAF Impact [indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	x	1.0: Failure to deliver right care, in the right place
	002: Make best strategic use of its resources	x	2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>		4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

# Report to the Group Public Trust Board on 20 May 2026

## Group Chief Nursing Officer and Group Chief Medical Officer Report

### 1. Purpose

1.1 This paper provides highlights from the Group Chief Nursing Officer and Group Chief Medical Officer (CMO/CNO) portfolios across both Trusts, presented as items to Assure, Advise and Alert on.

### 2. Background

2.1 Both organisations have previously provided assurance reports to their individual Boards with a focus on specific topics. This is the first report for the Group and it is proposed the focus of the paper alternates between a wider assurance paper and a focused assurance piece moving forward.

### 3. ALERT – SWB/DGFT

#### 3.1 Sandwell Children We Care For

There are over 800 Sandwell Children We Care For (CWCF) previously known as Children in Care. The safe staffing guidance outlined within the Intercollegiate document confirms that the service is currently under-resourced. This position is reflected on the Trust's Risk Register, discussed at Quality Committee and has been escalated to the ICB for review of the existing contractual arrangements. The ICB has asked for costs for the staffing required to care for this number of children on the caseload. The ICB Chief Nurse is also discussing the radius within which we are expected to care for children which is currently 50 miles and these do include children who are not ours but are part of other Local Authorities. There is currently a conversation ongoing to only manage the caseloads within your own patch regardless of the local authority

### 4. ADVISE - DGFT/SWB

#### 4.1 Group - Industrial action taken by Resident Doctors

The BMA carried out a full six-day period of industrial action by resident doctors from the morning of 07 April to 13 April. The period was well managed at both Trusts with comprehensive delivery plans put in place. Approximately 95% of usual elective activity was still provided. No derogations were requested and no significant safety concerns or incidents were reported. The percentage of doctors who took action varied across the Trusts.

	Dudley Resident Drs taking industrial action as a % of those rostered	SWB Residents Drs taking industrial action as a % of those rostered	Overall Group % of resident drs taking industrial action each day
07/04/26	117/346 = 33%	275/416 = 66%	392/762 = 51%
08/04/26	124/358 = 34%	285/432 = 65%	409/790 = 51%
09/04/26	105/346 = 30%	289/428 = 67%	394/774 = 50%
10/04/26	108/320 = 33%	279/414 = 67%	387/734 = 52%
11/04/26	52/153 = 33%	83/111 = 74%	135/264 = 51%

12/04/26	50/133 = 37%	87/116 = 75%	137/249 = 55%
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4.2 The BMA is currently balloting the consultant workforce over their willingness to take strike action, and the result is expected on 06 July. Changes to the rules around industrial action mean that the BMA will only need to give 10 days' notice before rounds of action (having previously given 14 days notice).

- **SWB - Presentation to Houses of Parliament on inequalities in Ovarian cancer**

Recently one of our gynecologists, Sudha Sundar, presented her work on inequalities in Ovarian Cancer diagnosis to MPs at the House of Parliament. Her work has shown that;

- 40% of OC diagnosis occurs after an emergency admission.
- 40% of those women will never receive any anticancer therapy.
- Women diagnosed as emergency have 50% survival over 1 year compared to 80% of those diagnosed through GP referrals - this mainly explains why national survival for OC for the UK is static in the last decade despite stellar improvements in targeted therapies.
- We have identified that women identified as emergency with OC are older, frailer and importantly from deprived populations - so this is an issue of inequality and postcode lotteries in diagnostic pathways (in Birmingham and Black country 1 in 2 women with OC will be diagnosed as emergency admission).
- Her research aims at improving pathways from Primary Care to Secondary Care, improving ultrasound quality such that women can be diagnosed with OC early whilst women without cancer can be promptly discharged.

4.3 Her work also featured on BBC West Midlands as the West Midlands Cancer Alliance is funding a rollout of improved ultrasound training, quality assurance and an ultrasound model based on her research trial ROCKETS. SWBH recruited enthusiastically to the trial, so this was a benefit to local patients as well as leading to a change in European guidance.

- **Group - Chief Nurse on Tour** - A number of roadshows/visits have been set up across the Group as an action following the recent staff surveys as drop-in sessions with the Group Chief Nurse and Directors of Nursing to discuss issues pertinent to staff. Two roadshows have happened so far at MMUH and BTC and themes have been staffing, visibility, investigation processes. There has also been positive feedback about managers support to staff who are ill and currently off sick.
- **Group- International day of the Midwife/ Nurses Day** - We celebrated International Day of the Midwife and International Nurses Day on 05 and 12 May respectively. Various celebrations were in place within wards and departments such as bed making competitions, trolley dashes to share information on areas such as TRIM (peer led support system to help staff cope with the psychological impact of traumatic incidents in clinical settings) in midwifery, launch of the CNO fellowship for both Trusts. Videos about nursing and midwifery and the plethora of different career options were communicated as well as walkabouts and thank you cards and emails to all staff.
- **DGFT - England CNO Silver Award** - Across England there are a number of national nursing awards that can be bestowed by the England Chief Nurse on any nurse that has been nominated. Our Associate Chief Nurse for Workforce at DGFT has been awarded the Silver Award in recognition of the work she has undertaken to strengthen the safer staffing process amongst other things across DGFT. Nina Morgan, the regional Chief Nurse, awarded Philippa with her Silver Medal on 08 May. Congratulations to Philippa!

- **DGFT - New Consultant Programme** - Our new consultant programme launched on 30 April with new colleagues who have joined the Trust in the last 18 months invited to attend an evening session to meet the Executive. Further sessions are scheduled throughout the year showcasing opportunities to get involved with key work around Quality Improvement, Education and Research.
- **DGFT - Congratulations to Dr Abdul Salam, Dr Shams Duja, Dr Muqueet Enver, and Dr Zerlene Lim** on the publication of their book, 'Stroke Mimics - A series of interactive cases'. The book brings together a decade of noteworthy stroke mimics encountered at the Trust and illustrates key learning points to support clinicians in refining their diagnostic approach to acute neurological presentations.

## 5. ASSURE - DGFT/SWB

### 5.1 DGFT Safer Staffing Review

The Dudley Group NHSFT (DGFT) has completed its next biannual safer staffing review of the inpatient areas, Acute Assessment Units and Emergency Department, in line with national safer staffing guidance. In summary, the outcome was as follows (please see in the reading room):

- Overall, the safer staffing establishments remained generally in a positive position to provide and deliver safe, effective, high-quality care.
- No significant quality and safety concerns were identified by Divisional Chief Nurses associated with their current establishments, although patient acuity has increasingly been very challenging in some areas requiring additional temporary staff to maintain patient safety and quality. The main negative impact has been on patient experience especially with corridor care due to lack of privacy and dignity, affecting patients being able to sleep due to lighting and noise.
- It remains evident from the quantitative data collected as part of the review, that we must always apply professional judgement and triangulate it with nurse sensitive indicators alongside the data to agree safe staffing establishment. This approach has been a key guiding principle and the knowledge of seasonal variation within the patient cohorts, the impact of flow and capacity challenges during the data collection month and the additional measures undertaken to support patient flow, safety and experience.
- The significant change from the last 3 staffing reviews in the increase in 1b category of patients, who require increase of nursing care as they are dependent on nursing care teams to meet most or all their care needs and a decrease of acuity 0, that are patients who may only require minimum care.
- Detailed review was conducted by the Divisional Chief Nurses, together with HR and Finance business partners and clinical leaders from each area.
- The majority of clinical area staffing establishments have not been identified as requiring amendments.
- In terms of Medicine, full realisation of the Learn, Adapt and Transform (LAT) project remains a priority, with ensuring that Surge area is closed, Discharge Lounge is reinstated and identified clinical areas closed as per the plan. AMUA closure is already being progressed with plans being developed for closure of AMU 3 (A4). This will result in staff being moved to other clinical areas, which will significantly help with vacancy management across the Trust and could support with the proposed establishment changes as outlined below.
- Equality and Quality Impact Assessments (E/QIAs) will be completed by the Divisions to outline any risks and mitigations associated with any staffing related decisions.

## 5.2 Site Chief Nurse recommendations for establishment changes

Following the Divisional review, each Divisional Chief Nurse has met with the site Chief Nurse and Associate Deputy Chief Nurse - Workforce and Professional Development to discuss their recommendations and provide constructive challenge, using data triangulation, professional judgement, quality indicators and wider intelligence. The site Chief Nurse recommendations are as follows:

- Agreement on no staffing establishment changes in most clinical areas as articulated in Table 5 of this report. From the clinical areas listed in the table, no changes are supported for C6, B3, C2 and B5 at the present time.
- Medicine - AMU2 and C1a should develop a business case if no funding is available within the current financial envelope or other opportunities for staff moves identified, to increase their staffing as articulated in the table. In addition, consideration should be given to support an increase in cubicle use within resus to 6 and 1:1 care provision, subject to business case approval.
- Surgery - B2 Hip and B4 should develop a business case if no funding is available within the current financial envelope or other opportunities for staff moves identified, to increase their staffing as articulated in the above table.
- E/QIA must be completed as part of the process.

## 5.3 Group Chief Nurse recommendations

Further to the Group Chief Nursing Officer review and discussion with the Executive team, the following are the Group Chief Nurse actions and recommendations:

- Group Chief Nurse and DOF to meet with all 4 areas following discussions with the divisional Chief Nurses for surgery and to explain decision making.
- Plan to increase ED resus to 6 beds from October as part of winter planning. ED to undertake demand and capacity exercise in relation to resus ensuring only patients that are within resus receiving resus support are included in this work. Share learning from Sandwell ED regarding flexing beds in times of high demand.
- Triangulate with finance at Group level as it has been highlighted that some areas were not staffing to baseline, and budgets had been set at Month 10 run rate so would include any bank usage and there has been a vacancy freeze in place.
- Aim to reassess staffing levels in three months following the LAT work and closure of beds alongside the community shift to assess impact.
- Patient acuity work to be encompassed into the safer staffing paper every 6 months.
- Share ETOC work from Sandwell across DGFT to support 1:1 observational needs. Access requirements for 1:1 observations over a 3-year period to gain a reflection of need and demand of DGFT patient group.
- Implement triumvirate meeting of DOF, COO and Group CNO 6 monthly to review staffing paper prior to submission to Executive meeting.

5.4 SWB are still finalising their report. A detailed DGFT report is enclosed in the reading room.

- **SWB/DGFT - GIRFT Corridor Care Recommendations**

SWB is compliant with 4 out of 5 GIRFT corridor-care recommendations with no outstanding quality or safety actions, and although corridor care has not been required for several weeks, there remains a clear need for both clinical and operational teams to further develop and strengthen operational control and safe-flow processes to ensure sustained compliance and resilience.

DGFT is currently assessing their position.

- **SWB - Improvements in stroke service SSNAP data**

SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales, and Northern Ireland. Following focused improvement work in the stroke service at Sandwell and West Birmingham, progress was recognised in the SSNAP data. The most recent report covers up to December 2025. This assesses 40 areas in 7 domains encompassing the patient pathway, and the service has moved to grade A in the last year, which some areas having previously been a grade D. It is the only Trust in the Midlands to have done so.

- **SWB/DGFT - Harm Review Group**

SWB Harm Review Group provides a structured, multidisciplinary forum for review of patient harm incidents, ensuring shared learning, accountability, and improvement at organisational level; reporting into established clinical governance structures with Associate Director for Governance and Patient Safety lead being core members of the group.

- 5.5 The group meets monthly receiving reports from each division providing high level detail on numbers of patients identified with a long wait for treatment, investigation or clinical review and any actual or potential clinical harm as a result, sharing any mitigating and supportive actions taken. The focus is then on understanding contributory factors, and triangulating intelligence from incidents, complaints and patient experience.
- 5.6 The SWB Harm Review Group offers assurance that when harm is identified, it is reviewed consistently, and translated into meaningful learning and quality improvement, with oversight of thematic trends, Duty of Candour compliance, and effectiveness of actions taken to reduce future risk and improve safety and experience for patients and staff.
- 5.7 A similar process is in place at DGFT and both are seen as good practice across the region and we are currently reviewing both to ensure learning from each other and one single process.

## 6. RECOMMENDATIONS

6.1 The Group Public Trust Board Is asked to:

- a. **Discuss** the alert section for assurance
- b. **Note** the Advise and Assurance section

**CMO and CNO Offices**  
**May 2026**

**Paper ref:**

<b>REPORT TITLE:</b>	Integrated Quality and Operational Performance Report The Dudley Group NHS Foundation Trust (DGFT)		
<b>SPONSORING EXECUTIVE:</b>	Martina Morris, Chief Nursing Officer (CNO) DGFT and Group Deputy CNO DGFT & Sandwell and West Birmingham NHS Trust (SWBH) Paul Hudson, Chief Medical Officer DGFT Jack Richards, Chief Operating Officer (interim) DGFT Mel Roberts, Group Chief Nursing officer Jonathan Odum, Interim Group Medical Officer		
<b>REPORT AUTHOR:</b>	Leigh Dillon, Associate Deputy Chief Nurse		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')	Requested action: (place an 'x')	Applies to: (place an 'x')
<input type="checkbox"/> Decision	<input type="checkbox"/> Approve	<input type="checkbox"/> Both Trusts
<input checked="" type="checkbox"/> Assurance	<input type="checkbox"/> Agree	<input type="checkbox"/> Sandwell and West Birmingham NHS Trust
<input checked="" type="checkbox"/> Discussion	<input type="checkbox"/> Endorse	<input checked="" type="checkbox"/> The Dudley Group NHS Foundation Trust
<input checked="" type="checkbox"/> Information	<input type="checkbox"/> Recommend	
	<input checked="" type="checkbox"/> Discuss	
	<input checked="" type="checkbox"/> Note	

**Suggested discussion points**

**Below summarises the IPQR for Quality and performance for March 2026 for DGFT only.**

There is work ongoing to develop a Group IQPR which will cover, quality, performance and productivity. This should be in place in draft format for the July Trust Board. For assurance SWB quality metrics are discussed in detail at the Quality Committee via the Fundamentals of Care Dashboard and for performance and productivity metrics at Finance & Productivity Committee in detail and any issues or concerns are included within either the committee upward reports, CEO report or CNO/CMO report.

**Reading room papers:**

- IPC BAF
- Safer Staffing Report

**Assure**

**Quality:**

**Incidents:** Incident reporting increased in March and remains above the rolling average, within expected upper limits. The sustained upward trend in reporting across the period reflects a strengthening and positive reporting culture within the Trust. While overall reporting has risen, the number of patient safety incidents reported has decreased slightly. The increase is largely attributable to non-patient safety incidents, particularly inherited pressure ulcers identified on admission, safeguarding concerns, incidents of violence and aggression towards staff, and staffing-related issues.

There were four new Swarm reviews commissioned during March, representing a slight increase compared to the previous month. In addition, five incidents were reported as resulting in significant harm to patients; all cases have had Duty of Candour appropriately applied. One new Patient Safety Incident Investigation (PSII) was initiated in March, relating to a patient who died following absconding and subsequent cardiac arrest. A Structured Judgement Review (SJR) is currently underway to assess the level of harm and determine preventability.

**Complaints and Patient Experience (PE):** Overall patient experience improved in March 2026, with 81% of respondents rating services as “very good” or “good”, compared to 79% in February. Negative feedback reduced slightly to 7%, indicating a modest positive shift. Improvements were seen across key divisions, with Maternity increasing to 74% and the Emergency Department rising to 70%, both showing a 4% improvement from the previous month. The Place Division recorded the highest level of satisfaction at 92%. Despite this progress, Friends and Family Test scores remain below the national average across all divisions, highlighting need for improvement. A deep dive has been requested via quality committee in relation to the backlog of complaints across both Trusts.

**Sepsis:** In March 2026, timely administration of antibiotics for patients screening positive for sepsis improved, with 70.12% receiving antibiotics within one hour in the Emergency Department and 60.95% in inpatient areas. Work to improve overall sepsis compliance is ongoing within the Division of Medicine, including benchmarking against other organisations across the Midlands to identify effective practice. An agreed action plan is in place, focusing on key improvement actions, and progress is being monitored through regular oversight.

**Vital Signs Compliance:** Observation (vital signs) compliance has improved to 72.03% in March. 10% of electronic observations (e-obs) were completed late; however, all of these were completed within 15 minutes of the scheduled due time. Quality leads are meeting with ward areas who have a consistently low compliance to see what support they need. Main area for improvement is around the 30-minute frequency observations, which impact the compliance.

#### **Performance:**

**Ambulance Handover:** In March 2026, there were 3318 ambulance arrivals to RHH, an 11% increase on February. 95% of all ambulances were handed over within 45 minutes. Streamers and triage nurses continue to utilise pathways as early as possible and sit out suitable patients to free up ambulance. We continue to utilise pathways to allow efficient ambulance offload. APEX Consultant in place during the day filtering Referrals to specialty ensuring that admission profile is more accurately reflected. Overnight Additional Medical Reg to monitor take and discharge patients specifically from ED. Requirement for all CAT 3 ambulances to contact Dudley Clinical Hub, even if already presented at hospital, to explore potential community-based interventions and avoid any unnecessary hospital admissions- In progress, on-going work to streamline communication and ensure full implementation.

**Cancer (Validated data to February):** 28-day FDS - Colorectal and Urology remain the most challenging sites for FDS at present. Work ongoing with BCPS to help improve turnaround times (TAT's) within the prostate and gynaecology pathway.

31 day combined & 62 day combined - March 2026 trajectories on track to achieve for 28 day and 62 days combined. 31 day remains a challenge; February 2026 performance improved and is expected to further improve in March 2026. Recent regional benchmarking shows the Trust has the smallest total backlog as a proportion of overall PTL (with exception of Birmingham Women's and Children's NHS Foundation Trust).

**DM01:** Sleep Studies recovery continues with further improvement expected during April and May 2026 with waiting list validation exercise and improved triage/scrutiny of referrals.

**Community:** UCR - Actions continue with monitoring of admin processes to support primary data submission. MSK - Review of GIRFT recommendations linked to MSK clinics.

**Elective Restoration & Recovery:** We have significantly reduced 52 week waits with fewer than 0.1% of patients waiting longer than 52 weeks. No 65-week breaches were reported, and none are expected. Performance against time to first OPA is ahead of plan, at 67.6% compared with a target of 65.7%.

#### **Advise**

##### **Quality:**

**Safer staffing:** In March 2026, Care Hours Per Patient Day (CHPPD) were recorded at 4.89 for Registered Nurses and 3.34 for Care Support Workers. Bank usage increased across both staff groups, most notably within the Surgery division, driven in part by higher levels of sickness absence. Variations in CHPPD and temporary staffing

usage continue to be influenced by patient acuity, the requirement for enhanced (1:1) care, and the opening of additional capacity areas. Within community services, CHPPD remains lower than expected, reflecting high vacancy rates, with some posts recently recruited to and others awaiting approval, alongside low uptake of bank shifts.

A total of 182 red flags were raised during March, predominantly within Medicine (104) and Surgery (82). The majority related to inadequate staffing levels on shift, with 47.8% of incidents reflecting staffing at 70–90% of required registered nurse levels and a further 19.3% at 50–70%. Additional concerns included inability to provide 1:1 care (12.9%), delays in physiological observations exceeding 30 minutes (9.6%), and challenges in completing quality rounds, care bundles and care plans (4.7%). Despite this, only 15 red flags were formally recorded on Datix, indicating a gap between real-time escalation and formal reporting processes.

The latest Safer staffing report was presented to the Executive team and People's Committee in April 2026 and is provided in the Trust Board papers reading room. The report sets out the Trust's six-monthly safer staffing review, undertaken in line with National Quality Board guidance. It assesses staffing establishments, skill mix, and patient acuity, alongside the application of professional judgement. Overall, staffing levels were found to be largely safe and effective, with no significant quality or safety concerns identified. However, there has been a notable increase in patient acuity, particularly a rise in highly dependent patients over the last three review periods. The primary impact has been on patient experience, most notably through the use of corridor care, resulting in reduced privacy and dignity, as well as poor sleep due to lighting and noise.

As part of winter planning, there is a proposal to increase Emergency Department (ED) resuscitation capacity to six beds from October 2026. The ED will undertake a demand and capacity exercise in relation to resus provision, ensuring that only patients requiring resuscitation level care are included within this modelling.

Learning will be shared from the Sandwell and West Birmingham ED regarding the flexing of beds during periods of high demand. In addition, the Enhanced Therapeutic Observation and Care (ETOC) model implemented at Sandwell will be shared across Dudley to support the management of 1:1 observational requirement. Clinical areas will also review access and demand for 1:1 observation over a three-year period to better understand trends and inform future planning for this patient cohort.

**Corridor Care Incidents:** The term 'Temporary Escalation Spaces (TES)' has now been replaced with 'corridor care', in line with updated national guidance. NHS England defines corridor care as any instance where a patient spends 45 minutes or more in a clinically inappropriate area within an Emergency Department or general and acute ward. Trust systems are currently being updated to support accurate data collection and reporting against this definition, with national publication of data expected from May 2026.

Within the Trust, areas currently meeting the corridor care definition include the Emergency Department, particularly the Frailty Assessment Unit where patients are accommodated beyond designated cubicles or bed spaces, as well as ED corridor, ward corridors, and non-designated bed spaces within ward bays.

In March, 11 incidents relating to corridor care were reported, representing a decrease compared to the previous month. The majority of these incidents were recorded as site-wide (55%), with a further 36% originating from the Forget Me Not Unit.

**Dementia care:** Initial ward screening (FIND) performance remains compliant at 96.04%. However, performance against the Investigate standard is currently non-compliant at 64%, primarily due to staffing shortages impacting timely completion. Compliance for patients referred following investigation remains high at 96%, indicating effective follow-through once patients enter the pathway. The most recent readmission data, available is for January 2026, which demonstrates a continued downward trend since October 2025, suggesting sustained improvement in reducing avoidable readmissions.

**Infection Prevention and Control (IPC):** Please refer to the IPR slides located in the reading room for a detailed breakdown of hospital and community acquired infections. Overall, the Trust remains above its expected trajectory for this point in the year and has exceeded all infection trajectories for 2025/26. However, this represents an improvement compared to the position in 2024/25.

There is no single identified common cause to explain the current increase in infections, although similar trends are being observed across neighbouring trusts. It is also important to note that, while the Trust has exceeded its 2024/25 thresholds, the 2025/26 thresholds have either remained static or been reduced, which is impacting comparative performance. This issue has been escalated to NHS England. During March, there was one reported case of Norovirus.

The Infection Prevention & Control Team is pleased to report that the Trust is fully compliant, with zero areas of non-compliance, against the NHS England Infection Prevention & Control Board Assurance Framework (updated April 2025).

A small number of areas are currently rated as partially compliant, as outlined below:

- The National Standards of Cleanliness in Healthcare 2025 have not yet been formally agreed between the Trust and PFI partners, with financial discussions ongoing.
- Two Infection Prevention and Control (IPC) policies, the MRSA policy and the gastrointestinal illness policy, are currently under review.
- New High Consequence Infectious Disease (HCID) PPE training is scheduled to commence in May 2026.

These areas are actively being progressed, and further updates will be provided in due course.

IPC Board Assurance Report is located in the reading room.

## Alerts

### Performance:

**Discharge Ready Date (DRD) - March 2026:** In March, the average time from Date Ready for Discharge (DRD) to discharge increased slightly to 4.22 days, compared to 3.91 days in February. Whilst this represents a small deterioration month on month, performance remains below the January position of 4.27 days, indicating that overall progress has still been broadly sustained across the quarter.

**Emergency Performance:** Performance against the Emergency Access Standard showed a 9% improvement in March with all attendance types contributing. We achieved 85.40% for March against the national target of 78% and above the Sprint performance of 85%.

**Cancer Performance (February validated):** 28 Day FDS achieved 84.6% against national target of 77% (March 2026 national target is 80%). 31 Day Combined achieved 91.9% against national target of 96%. Decline was due to surgical capacity for Breast. 62 Day Combined achieved 72% against national target of 75% by end of March 2026 (this target does not supersede the 85% constitutional standard but set to support tiering measures for cancer performance). Breast and skin were the most challenged tumour sites in February. Reduction of 62 backlog remains an area of focus.

**DM01 Performance:** DM01 for March shows performance of 88.8% against a trajectory of 80%.

**BCPS Performance:** Histology - The 10-day urgent Histology performance is 54% for February 2026 against a national target of 70%.

**Community – UCR:** Urgent Care Response 2-hour target >70% continues to be met with compliance at 86%. March data shows 872 2-hour UCR referrals managed during March.

**Community 52 week waits / Virtual Ward:** Adult Community Health Services Proportion of patients waiting over 52 weeks met by Community services (with exception of Audiology service) who have 7 patients at 52 weeks. Virtual Ward occupancy >80% since November 2025 has dropped below target during March.

**Elective Restoration & Recovery:** Performance against the 18-week RTT standard has declined over the past month, with 62.8% of patients treated within 18 weeks in March. This is behind trajectory, consistent with national and seasonal trends.

Alignment to our Vision					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	X	OUR PEOPLE	X	OUR POPULATION	X
The Dudley Group NHS Foundation Trust					
PATIENTS	X	PEOPLE	X	PLACE/POPULATION	X

#### Previous consideration

Joint Quality Committee, Joint Finance & Productivity Committee

#### Recommendation

- a) **Note** and **discuss** contents of this report and gain assurance on oversight of quality, safety and operational performance.

#### Escalation

Should any element of this report be escalated:

BAF Impact			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
001: Deliver safe, high-quality care.	X	1.0: Failure to deliver right care, in the right place	
002: Make best strategic use of its resources	X	2.0: Failure to recruit, retain, train, and develop workforce	
003: Recruit, retain, train, and develop workforce	X	3.0: Failure to build innovative partnerships	
<del>005: Deliver the MMUH benefits case (CLOSED)</del>	X	4.0: Failure to achieve financial plan	
004: Deliver on its ambitions as an integrated care Organisation	X	5.0: Failure to achieve performance requirements	
006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data			
Is Quality Impact Assessment required if so, add date: N/A			
Is Equality Impact Assessment required if so, add date: N/A			

<b>REPORT TITLE:</b>	Group Perinatal Quality Oversight Paper		
<b>SPONSORING EXECUTIVE:</b>	Melanie Roberts – Group CNO, Jonathan Odum, Group CMO		
<b>REPORT AUTHOR:</b>	Claire Macdiarmid – Interim Group Director of Midwifery		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
	Decision	X	Approve	X	Both Trusts
X	Assurance		Agree		Sandwell and West Birmingham NHS Trust
X	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
			Note		

**Suggested discussion points**

**Dudley Group**

Dudley Group Perinatal services continue to demonstrate sustained improvement across several key maternity and neonatal quality and safety indicators. The Midlands Maternity Heatmap currently ranks Dudley as the strongest performing organisation in the region, with a score of 14, reflecting low numbers of open stakeholder concerns and minimal workforce risk.

Perinatal mortality outcomes remain below national benchmarks, with the March 2026 stillbirth rate reported at 2.26 per 1,000 births and neonatal death rate at 1.26 per 1,000 births. No stillbirths were reported during Quarter 4 2025/26. Extended perinatal mortality rates also remain below national averages.

One new case was accepted for Maternity and Newborn Safety Investigations (MNSI) during March 2026 relating to shoulder dystocia and therapeutic cooling. One Patient Safety Incident Investigation was concluded relating to extreme prematurity and neonatal death, with learning identified regarding antenatal risk assessment, management planning and results management processes. Actions have already been implemented to strengthen daily review of results and referral management.

No MOSS signals or Coroner Regulation 28 notices were received during the reporting period. Maternity Safety Champion walkarounds and governance meetings remain established, with discussions focused on mandatory training compliance, PMRT oversight, neonatal monitoring and workforce planning. Mandatory training compliance has improved across key safety areas including fetal monitoring, PROMPT and neonatal resuscitation, although safeguarding compliance remains below target and recovery plans remain in place.

**Sandwell and West Birmingham**

The Midlands Maternity Heatmap score currently stands at 44, which is an improved score, with opportunities identified to improve the position through reduction in workforce vacancies, completion of Birthrate Plus work, strengthening MIS compliance and recruitment to key leadership roles.

Perinatal mortality rates for March 2026 are reported as: neonatal death rate 1.78 per 1,000 births, stillbirth rate 4.60 per 1,000 births and overall perinatal mortality rate 6.38 per 1,000 births. Four perinatal deaths occurred during the month. Eight cases were reviewed through weekly incident review processes, with learning focused on earlier recognition of fetal compromise, multidisciplinary escalation, higher-risk pregnancy management, neonatal resuscitation, emergency caesarean section pathways, growth surveillance and responding to maternal concerns.

No new cases were referred to MNSI during March 2026. One level one MOSS signal was received relating to a baby with a known lethal genetic abnormality receiving palliative care following birth. A critical safety check identified no

new safety concerns, although existing themes continue to include induction of labour pathways, maternity triage, theatre capacity, staffing and interpreting services.

National Education and Training survey (NETS) Midwifery learner feedback demonstrated significant improvement during 2025, with reductions in negative outlier areas and improved learner experience scores across multiple domains. Work continues to embed the Safe Learning Environment Charter (SLEC) within the directorate.

Targeted improvement work also continues in response to Section 29A concerns relating to interpreting services, induction of labour capacity and workforce modelling. A fortnightly interpreting task and finish group has been established, whilst theatre capacity and second theatre team availability remain active risks on the Trust risk register. Birthrate Plus and NHSE community workforce reviews are due during May and will inform future workforce planning and required improvement planning.

Sandwell and West Birmingham NHS Trust have commissioned a thematic review of all stillbirths occurring during 2025 where antenatal care and/or birth was provided by the Trust, in order to strengthen organisational learning, identify recurrent themes and contributory factors, and support improvements in the safety and quality of maternity care. Family voice will form a central part of the review, with affected families being contacted by letter and telephone and offered the opportunity to share their experiences and perspectives to help inform the review findings and recommendations.

*Full report located in reading room.*

Alignment to our Vision				
Sandwell and West Birmingham NHS Trust				
OUR PATIENTS	X	OUR PEOPLE	X	OUR POPULATION
The Dudley Group NHS Foundation Trust				
PATIENTS	X	PEOPLE	X	PLACE/POPULATION

Previous consideration
Quality Committee

Recommendation
a) The Board is asked to accept the report against the recommendations as per the requirements of the Perinatal Quality Oversight Model and note current position against Saving Babies Lives V3.2

Escalation
Should any element of this report be escalated: No

BAF Impact			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	x	1.0: Failure to deliver right care, in the right place
	002: Make best strategic use of its resources		2.0: Failure to recruit, retain, train, and develop workforce
	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	005: -Deliver the MMUH benefits case (CLOSED)		4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

<b>REPORT TITLE:</b>	Winter Plan 2025/26 close out report – Sandwell and West Birmingham NHS Trust & The Dudley Group Foundation Trust		
<b>SPONSORING EXECUTIVE:</b>	Johanne Newens, Jack Richards Chief Operating Officers		
<b>REPORT AUTHOR:</b>	Giselle Carter-Sandy Deputy Chief Operating Officer SWBH, Jack Richards, Johanne Newens		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
	Decision		Approve	X	Both Trusts
	Assurance		Agree		Sandwell and West Birmingham NHS Trust
X	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
		x	Note		

### Suggested discussion points

This report outlines key activity and urgency and emergency care performance changes during the winter period. It reviews key contributors that impact on DGFT and SWBH activity and performance against the emergency access standard (EAS) and ambulance handover times.

#### Assure

The winter planning process in both organisations demonstrated an improved approach to that which had been conducted in previous years and this led to a more joined up approach across the local system.

#### Advise

Internal modelling at DGFT identified a requirement for approximately 100 additional inpatient beds at peak pressure, including a year-round embedded shortfall, seasonal winter demand and the impact of strategic conveyancing. ICB modelling corroborated the scale of the challenge, identifying sustained pressure above the Trust's core bed base across the winter period, particularly in the new year phase. Whilst at SWBH, internal modelling suggested there would be a reduced bed demand in Medicine, no change to MMUH bed occupancy from 2024/25 and a return to 2022/23 LOS.

However, both Trusts entered winter 2025/26 with a materially challenged capacity position.

DGFT adopted a whole-system winter plan focused on five core principles delivered at a cost of £3.79m versus £3.18m plan:

- Avoiding unnecessary attendance at hospital
- Reducing avoidable admission
- Reducing length of stay and avoidable discharge delay.
- Strengthening discharge co-ordination with partners
- Using surge capacity only where demand could not be managed through flow, community capacity and virtual wards.

SWBH adopted an internal cost neutral plan focused on

- Admission avoidance
- Reduction in length of stay
- Discharge acceleration

The central lesson from winter 2025/26 is that acute resilience is now inseparable from discharge effectiveness, community responsiveness and system-wide coordination. Future plans will therefore continue to prioritise internal flow, home-first discharge, pathway control, avoidance of unnecessary conveyance, and productive use of virtual capacity.

**Alert**

The lessons learned at both trusts require a year-round improvement model, not just a seasonal response, which is the aim of the work that is currently underway. With the work that has commenced in relation to Fit for the Future, across both trusts, and the Learn, Adapt, Transform programme at Dudley the focus will also include delivery of efficiencies in productivity the emergency and non- elective pathways.

Alignment to our Vision <i>[indicate with an 'X' which Strategic Objective[s] this paper supports]</i>			
Sandwell and West Birmingham NHS Trust			
OUR PATIENTS	X	OUR PEOPLE	OUR POPULATION
The Dudley Group NHS Foundation Trust			
PATIENTS	X	PEOPLE	PLACE/POPULATION

**Previous consideration**  
 Performance metrics in greater detail have been submitted to the joint Finance and performance committee

Recommendation(s)	
a)	<b>Note</b> the paper as an update on delivery against the 2025/26 winter plan
b)	<b>Discuss</b> and <b>note</b> the improvement schemes that have already commenced and links to the Fit for the Future programme.

**Escalation**  
 Should any element of this report be escalated:

BAF Impact <i>[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]</i>			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
X	001: Deliver safe, high-quality care.	X	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources		2.0: Failure to recruit, retain, train, and develop workforce
	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>		4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation	x	5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

# Report to the Group Public Trust Board on 20 May 2026

## Winter Plan 2025/26 Close Out Report - Sandwell and West Birmingham NHS Trust & The Dudley Group Foundation Trust

### 1. Purpose

- 1.1 This report provides an update to the Board of Directors on delivery of the Winter Plan 2025/26 mitigations and learning from the winter period to improve our performance across Urgent and Emergency Care (UEC) and ensure we are more resilient for the coming winter. This report covers both The Dudley Group Foundation Trust (DGFT) Russells Hall Hospital and Sandwell and West Birmingham NHS Trust (SWBH) Midland Metropolitan Hospital.

### 2. Background

#### 2.1 DGFT:

Demand across UEC remained in line with the modelling assumptions set out in the Winter Plan. Whilst modelling anticipated a requirement for approximately 100 additional beds above baseline during peak winter pressures, the Trust contained this to an average of 60 additional beds. Although this represented continued operational pressure, it was materially below the level predicted by the ICB modelling. Improvements in daily discharge performance and length of stay compared to the same period last year demonstrated a positive impact from the Learn, Adapt and Transform (LAT) program; however rising admissions and increasing patient acuity had offset some of these gains.

Emergency Department attendances increased month-on-month in January to 9,851 with conversion rates stabilising at c.34%, reflecting the anticipated rise in acuity. Ambulance handover performance remained the most challenged aspect of UEC delivery. A formal improvement trajectory had been agreed with NHS England, with measures scheduled to go live from 26 February 2026 to achieve the 45-minute average handover standard.

Delivery was dependent on both internal process improvement and strengthened partnership working with West Midlands Ambulance Service, particularly expansion of Call Before Convey and Care Navigation Centre pathways.

Core Winter Schemes:

- Care Navigation Centre
- Rapid Emergency Assessment and Care Team
- Multi-agency Discharge Events (MADE)
- Care Transfer Hub
- Roll out of electronic bed state
- Length of stay reductions
- Ridge Hill Development
- Paediatric Assessment Unit and Paediatric Emergency Department Co-Location
- Ward reconfiguration of B6/C6
- Winter Vaccination Plan

Key risks remain centred on ambulance handover performance, rising acuity and admissions, estate constraints within ED, and reliance on system partners to sustain discharge flow. Nonetheless, delivery of the Winter Plan mitigations had reduced the scale of escalation required, limited additional bed opening below forecast levels, and strengthened system working across UEC pathways.

## DGFT Urgent and Emergency Care Plan 25/26 key deliverables

UEC Plan 25/26 Priority	March 2026 Trajectory	March 2026 Delivery
A minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours	78%	85.47%
Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes	30-minute average	19 min 45 seconds
Reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time	10%	4.3%

### 2.2 SWBH:

This year's winter plan focused on continuing to deliver the Operating Framework targets that as a Trust we committed to deliver. In addition, it included additional clinical metrics focused on admission avoidance and reduction in length of stay (LOS) and safety metrics. The modelling plan assumed no change to MMUH bed occupancy from 2024/25 and a return to 2022/23 LOS. The modelling suggested there would be a reduced bed demand in Acute Medicine, Geriatric Medicine and Gastroenterology - the medicine deficit was expected to reduce to 22 beds, with surplus in AMU partly offsetting deficits in Cardiology & General Medicine.

The demand for beds had been higher than expected (Acute Medicine +4% over target; Geriatric Medicine +9% and Gastroenterology +7%), primarily due to increased conversion rates from ED and higher numbers of readmissions. In September, the LOS recovery had been good and overall, on track at 6.0 days for Medicine. However, a criteria change to access community beds was implemented in October which resulted in an increase in NCTR patients and LOS.

Core Winter schemes:

- Reducing Length of Stay (Medicine division)
- Discharge acceleration
- Reducing Imaging delays
- Improve paediatric SDEC pathways

### SWBH Winter Plan 25/26 Key Deliverables

Winter Plan 25/26 Priority	March 2026 Trajectory	March 2026 Delivery
6.0 days LOS across medicine bed base	6 days	6.9 days
Discharge acceleration	Increase in virtual ward utilisation >67%	86.6%
Reduce Paeds LOS in ED (Type 1 attendances)	78% 4hr performance	88.7% 4hr performance

Increased LoS on the base wards has been the challenge this winter, P2 delays being the main driver to this.

### 3. Attendances during the Winter Period

3.1 DGFT Emergency Department attendances increased month-on-month in January to 9,851 with conversion rates stabilising at c.34%, reflecting the anticipated rise in acuity. Ambulance handover performance remained the most challenged aspect of UEC delivery. A formal improvement trajectory had been agreed with NHS England, with measures scheduled to go live from 26 February 2026 to achieve the 45-minute average handover standard. Delivery was dependent on both internal process improvement and strengthened partnership working with West Midlands Ambulance Service, particularly expansion of Call Before Convey and Care Navigation Centre pathways.

3.2 SWBH Emergency Department attendances increased month-on-month in April to (Type 1): 11,478 (Type 2): 1179 (Type 3): 8,388 with a 12.8% increase in conversion rate, reflecting the rise in acuity. Overall 4hr performance in April was 75.26% (3.78% increase from the previous month – 71.48%). Ambulance handover and 4hr performance remained the most challenged aspect of UEC delivery.

### 4. DGFT position

4.1 Ambulance handover and Type 1 EAS Performance

Table 1: Ambulance Handover times (mins) - Monthly Monitoring against plan, Source: WMAS dataset

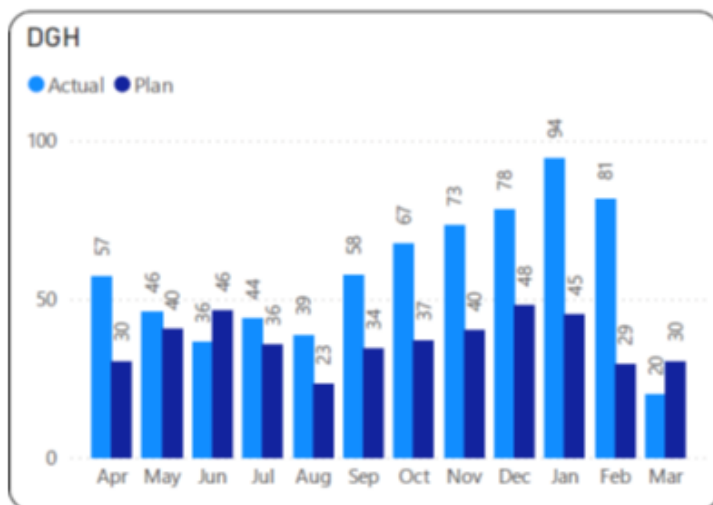
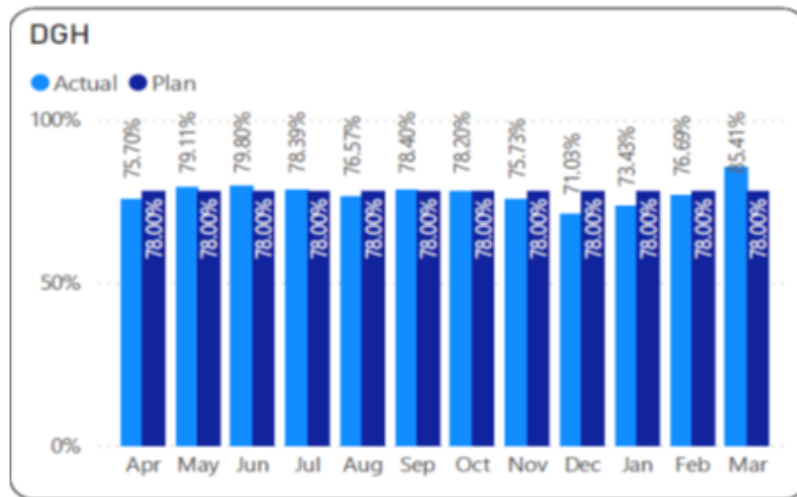


Table 2 – 4 hr Monitoring against plan, Source NHSE published file.

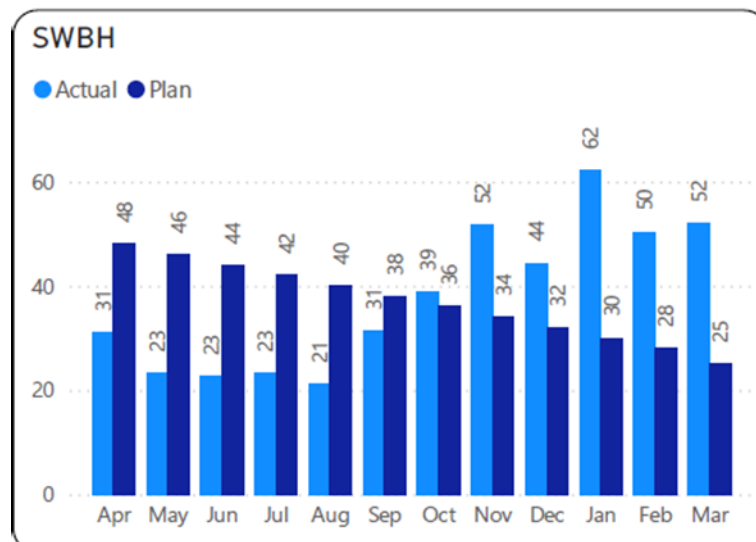


As DGFT entered the winter period all modelling had demonstrated that there was a forecasted deficit in bed availability of approximately 100 beds, whilst the mitigations did not prevent the opening of surge capacity in entirety, the resultant beds opened in the Discharge Lounge and Surge areas amounted to 36 additional spaces, with a further 10 open across the AMU areas. Additional patients were also held in ward areas particularly in the division of medicine. Although significantly pressured, this amounted to a number far fewer than the 100 beds anticipated which demonstrated that the mitigations in place around admission and attendance avoidance, virtual ward utilisation and improvement in the processes through the care transfer hub did support a reduction in the amount of surge capacity required.

## 5. SWBH position

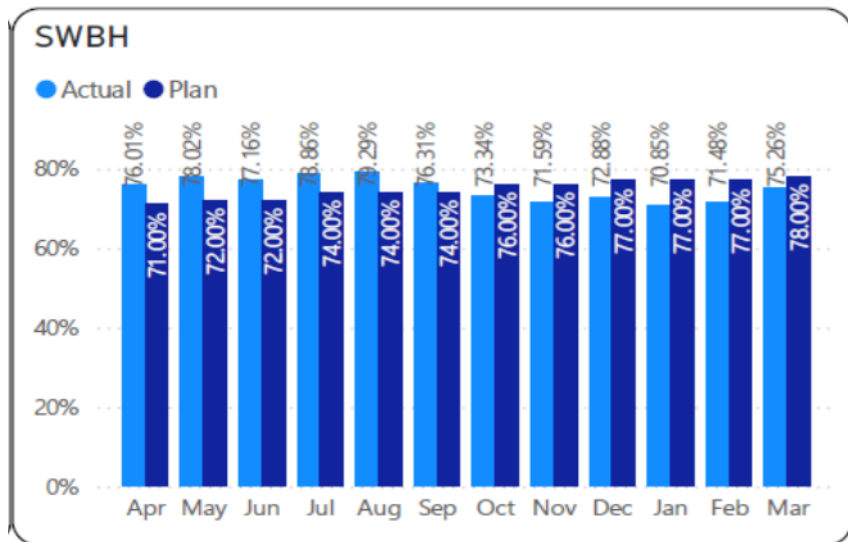
### 5.1 Ambulance handover and Type 1 EAS Performance

Table 1 – Ambulance Handover times (mins) - Monthly Monitoring against plan, Source: WMAS dataset



The table above shows a bar graph. The vertical axis shows the average wait time in minutes and the horizontal axis shows the month. The light blue bars are the actual average minutes whilst the dark blue bars are the planned/forecasted average minutes.

Table 2 – 4 hr Monitoring against plan, Source NHSE published file.



The table above shows a bar graph. The vertical axis shows the percentage performance of the 4-hour target and the horizontal axis shows the month. The light blue bars are the actual percentage whilst the dark blue bars are the planned/forecasted percentage.

The 45-minute offload standard was consistently achieved until October 2025 and was often the best performer in the region as a result of the availability of acute (B7) and community beds (Rowley) capacity and the introduction of a streamlined handover process. The 78 percent EAS performance target was delivered ahead of plan until October 2025 through continued quality improvement which included a focus on Emergency Department operational process, reduction in Medicine length of stay, development of Same Day Emergency Care (SDEC) services and diagnostic pathways. However, from November, we saw an increase in emergency attendances and ambulance conveyances; higher acuity presentations (leading to Resus demand exceeding the funded capacity); closure of 16 acute beds (B7) and early closure of community beds (Rowley), and a decision not to stand up Temporary Escalation Spaces (TES) which left us unable to sustain the improvements in the 45-minute ambulance offload and EAS performance that had been made.

## 6. Learning from Winter 2025/26 to be taken forward to Winter 26/27

### 6.1 SWBH:

Acknowledging the importance of reducing length of stay for enhancing patient experience and EAS performance, targeted measures were implemented, encompassing various aspects such as patient journey, bed base management, and access to support services in Medicine and Emergency Care. These targeted measures with the objective of bringing average length of stay down to 6 days were agreed and implemented by the Medicine Length of Stay project team. This group developed a data tool which is now used daily to identify wards that required additional support and intervention if daily discharge targets are not met.

An average length of stay of 6 days was delivered consistently until the final 4 months due to several factors including patient acuity and delays in discharging patients who required short term rehabilitation, assessment or recovery support in the community. A series of patient census interventions are planned throughout the year with the first one scheduled for week commencing the 1st of June.

Our focus now is to drive the improvements to deliver EAS performance month on month and to improve our performance against clinical quality indicators. From the 1<sup>st</sup> May we implemented the national W45 standard setting a maximum 45-minute handover time for ambulances. Changing how we stream patients from ambulances and walk in patients direct to made day emergency care has also begun. This will build resilience that will enable us to sustain operational performance over the winter months.

## 6.21 DGFT:

- Accountability of the plan held more widely than purely in the acute trust has worked well, and this model needs to be replicated in the coming winter. Engagement held early improved relationships and the ability to raise issues identify solutions was much easier as a result.
- A robust plan of identified and risk assessed surge areas needs to be maintained throughout the year, with the requirement increasing in winter to maintain oversight of areas. Learning from across the Black Country is that it is not possible to completely mitigate the necessity to increase the bed footprint during winter and this needs to have a staffing plan prepared which was not in place effectively this winter placing a high reliance on bank requirements.
- Early mobilisation of plans and resources is critical to achieving timely impact, particularly ahead of peak winter pressures.
- Clear ownership and consistent operational grip at divisional and speciality level significantly improves delivery and pace of change.
- The Learn, Adapt, Transform programme, although there was no impact on this winter there will be benefits in place for the coming winter.
- Data quality and real time visibility are fundamental enablers of flow and require early prioritisation and ongoing oversight.

## 7. Conclusion

### 7.1 DGFT

The modelling and planning for winter 26/27 is not underway with initial presentations planned in June 2026. The focus of this plan will build on the learning from winter 25/26, in particular the improved utilisation of SDEC facilities, the strategy for streaming of patients more rapidly in ED to reduce the ambulance turnaround time and continued improvements in the care navigation centre.

The teams are focused on the Learn, Adapt and Transform programme, improving flow through the acute medical pathway in particular which should also assist with building resilience as we enter the next winter period.

### 7.2 SWBH

Bed Occupancy was at its highest in January (97%) compared to previous 2 winters. The decision to maintain the summer acute bed numbers and reduce community bed base undoubtedly had an impact in flow out of ED.

Focus on direct streaming from ambulance assessment and front door will continue, aiming to divert more activity away from ED, allowing ED to focus on those patients whose clinical presentation are best suited to ED.

Bed modelling has already taken place which will be used to drive a plan that that delivers our non-elective performance targets in the most safe and efficient way. This plan also delivers the efficiency opportunities identified in the Fit for the Future programme.

## 8. Recommendations

### 8.1. The Group Public Trust Board is asked to:

- a) **Note** the paper as an update on delivery against the 2025/26 winter plan.
- b) **Discuss** and **note** the improvement schemes that have already commenced and links to the Fit for the Future programme.

Giselle Carter-Sandy, Jack Richards, Johanne Newens  
11/05/2026

<b>REPORT TITLE:</b>	Sandwell and West Birmingham NHS Trust & The Dudley Group NHS Foundation Trust Group Board – Chief People Officer Board Report		
<b>SPONSORING EXECUTIVE:</b>	Dr James fleet, Group Chief People Officer		
<b>REPORT AUTHOR:</b>	Dr James fleet, Group Chief People Officer		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type:		Requested action:		Applies to:	
	Decision		Approve	<b>X</b>	Both Trusts
<b>X</b>	Assurance		Agree		Sandwell and West Birmingham NHS Trust
	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
		<b>X</b>	Note		

### Suggested discussion points

The Board of Directors is asked to receive the following updates in respect of Sandwell (SWB) and Dudley (DGFT) Trusts:

#### ASSURE:

- Progress of the Corporate Service Transformation programme
- Opening of the Midland Metropolitan Learning Centre (MMLC)
- Performance against turnover etc. KPIs
- Staff Engagement & Experience - 2025 Staff Survey Improvement actions
- Appointment of the SWB BME Chair and Deputy Chair and changes being made to transition to single Group Network Chairs and Deputy Chairs
- Plans to implement Medi-rota within MEC at DGFT
- High level of response to the High Potential Scheme
- Outcome of the Widening Access Demonstrator bid

#### ADVISE:

- Development of 2026/27 workforce plans

#### ALERT:

- M12 workforce performance v plan 2025/26
- Structural Increase in Sickness Absence Levels

### Alignment to our Vision

Sandwell and West Birmingham NHS Trust					
<b>OUR PATIENTS</b>	<b>X</b>	<b>OUR PEOPLE</b>	<b>X</b>	<b>OUR POPULATION</b>	<b>X</b>
The Dudley Group NHS Foundation Trust					
<b>PATIENTS</b>	<b>X</b>	<b>PEOPLE</b>	<b>X</b>	<b>PLACE/POPULATION</b>	<b>X</b>

### Previous consideration

Joint People Committee

### Recommendations

a)	<b>Take</b> positive assurance on the developments within the report - (ASSURE) items
b)	<b>Note</b> and consider the ADVISE items and ongoing progress in these areas
c)	<b>Consider</b> the mitigating action being taken to address the ALERT issues

d) **Note** the forward look items for future Board discussion

**Escalation**

Should any element of this report be escalated: Sickness absence represents the primary strategic workforce risk across the Group, with evidence suggesting a structural rather than seasonal shift.

**BAF Impact**

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
	001: Deliver safe, high-quality care.		1.0: Failure to deliver right care, in the right place
X	002: Make best strategic use of its resources	x	2.0: Failure to recruit, retain, train, and develop workforce
	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>		4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

# Report to the Group Public Trust Board on 20 May 2026

## Group Chief People Officer (CPO) Board Report

### 1. Assure

#### 1.1 Corporate Services Transformation Programme (CST)

- The CST programme continues to make demonstrable progress, as reported to the recent CST Board (date) and the Provider Collaborative Executive (20th April 2026). All Phase 1B areas (Collaborative Bank, Research & Development, Recruitment and Occupational Health) are on track to be completed between May-July. Executive leads have now been identified for all Phase 2 services, with the strategic vision of establishing a Corporate Shared Service for the Black Country providers.
- The Executive leads will work with the CST SRO (James Fleet) and the BC Provider Collaborative Managing Director (Sohaib Khalid) during May and July to review the indicative efficiency opportunities that were identified through the recent work with BAIN Consulting, develop detailed function level plans to transform services (Finance, People Services, DDaT and Estates & Facilities).
- The scale of transformation vision within the CST programme aligns well with the national direction of travel, i.e. Future People Services Operating Model for the NHS and expectations for delivering corporate services efficiently and at scale.

#### 1.2 The Midland Metropolitan University Learning Campus (MMLC)

- The MMLC became operational at the end of March 2026 following the successful completion of construction, handover and activation activity. Funded through the Smethwick Towns Fund and the West Midlands Combined Authority, the development represents a collaborative partnership between the Trust and its Learning Works facility, Sandwell Council, Aston University, the University of Wolverhampton and Sandwell College. The Campus has been established to support regeneration, employability and community development, while creating a centre of excellence for education and skills, including Sandwell's first university campus, further education provision and targeted employment support.
- The Campus is now fully operational, with Sandwell College teaching programmes underway, the Trust's Learning Works and Apprenticeships teams delivering training and employability activity from the site, and Occupational Health scheduled to relocate into the building during May. Early implementation has progressed positively, with education and employability programmes transitioning smoothly to the new facility. The University of Wolverhampton delivered its first Level 7 programme on 30 March, with additional modules planned from September, while new Masters-level modules are currently being developed in partnership with Aston University. Media coverage to date has been positive, highlighting the Campus's contribution to regeneration, investment and workforce development, and preparations are underway for an official opening later in the year.
- Updates on the Learning Campus will now report into the Joint People Committee. The Learning Campus provides a unique opportunity to further scale employability and in doing so, further improve the life chances of local communities.

#### 1.3 Workforce KPIs

- Workforce KPIs (including turnover, appraisal and ESR indicators) are used as leading indicators of culture, engagement and operational sustainability, triangulated with staff experience data to inform targeted intervention rather than blanket action.
- Turnover remains within target (DGFT ~6.1%, SWB ~9.6%), supporting workforce continuity and stability. Vacancy levels continue to reflect active vacancy management, with DGFT at ~4.0% and SWB at ~11.2%.
- Bank fill rates remain resilient (DGFT ~83%, SWB ~86–87%), mitigating agency reliance.
- Employee relations performance is mixed, with DGFT stabilised and SWB caseloads elevated. Overall, while workforce metrics are controlled, sustained sickness absence continues to require focused management and executive oversight.
- In addition to action already underway to address sustained levels of sickness absence, SWB is piloting a range of innovative digitally enabled interventions at no additional cost through the Goodshape platform, moving beyond a principally compliance-based approach to absence management towards more proactive, preventative and support-based interventions. This includes TeleHealth and AI Assistant

functionality being made available from 1st May to support all staff and managers within SWB, alongside Navigator and Complex Case Management / Patient Advocate support for Surgical Services, MEC and Soft FM. In parallel, an AI-based staff fatigue predictor hosted through the Oceans Blue rostering platform will be piloted within Surgery from June 2026 for a six-month period. The use of digital platforms to support earlier intervention, manager support and self-service wellbeing provision aligns with the emerging national People Services Operating Model for the NHS. These interventions have been supported by the Trust Executive and Joint People Committee in response to sustained elevated sickness absence levels.

- SWB has been asked to discuss the above at a Midlands Regional Sickness Absence Summit, which is scheduled for June 2026.

#### **1.4 Staff Engagement & Experience - 2025 Staff Survey Improvement Actions**

- A paper summarising the 2025 Staff Survey results is being presented to the May meeting of the Joint Board.
- Work to deliver all of the Q1 improvement actions is underway and on track to deliver against the timelines approved by the March Trust Board meetings (held in private), given the embargo which ended on 12th March 2026. This includes use of the NHS IMPACT Maturity Framework to undertake focused improvement work with those areas that have the poorest positivity scores, supported by the OD and Improving Together teams.
- A formal report on the progress and delivery of all Q1 actions will be presented to the Joint people Committee at its July meeting, with a formal report to the Joint Trust Board in September 2026, in advance of the launch of the 2026 Annual Staff Survey campaign.
- A programme of Manager Briefing sessions have been held during March and April and a workshop with Inclusion Network Leads is also taking place in April. A session is also being held with People Engagement Teams at SWB, Divisional and corporate leaders at DGFT and Staff Networks to ensure that local improvement actions are being prioritised, based on the team level feedback data and free text comments.

#### **1.5 PULSE Survey**

- The April Pulse Survey completed at the end of April 2026. SWB achieved a response rate of 22% and DGFT achieved a response rate of 16.2%. The survey results are currently being analysed and will be reported to the People Committee in June 2026.
- A heatmap capturing the engagement scores from the Annual Staff Survey and PULSE Surveys, alongside key workforce metrics such as sickness absence, turnover, training compliance and PDR uptake, has been developed for all Divisions and Corporate Directorates across the Group. This will be used to present ongoing developments in staff engagement to the Joint people Committee.
- Staff Inclusion Networks: A new Chair and Deputy have been appointed to lead the SWB BME Network.
- I would like to welcome Natalie Whitton (Deputy Director of Nursing, Surgery, SWB) and Nashili Mann (Interim Directorate General Manager, PCCT) in their new roles as Chair and Deputy Chair of the SWB BME Network (soon to be re-named).
- Natalie and Nashili have been extremely active over the last few weeks in arranging network meetings and launching a process to test new names for the Network with the membership and others.

#### **1.6 Implementing Medi-rota**

- The Medicine & Emergency Care Division in DGFT have mobilised a 6-month programme of work to implement and embed the Medi-rota e-rostering system.
- The Medi-rota system will support and enable effective job planning which underpins the medical workforce productivity improvements which are necessary to realise the forecast benefits from the Fit for the Future and the Learn Adapt Transform programmes.

#### **1.7 High Potential Scheme**

- Applications for the High Potential Scheme closed in March 2026. The HPS scheme is a talent development programme for staff that are seeking to achieve Executive/Board level roles within 5-8 years.

- The HPS programme is a national; programme that is sponsored by NHSE and delivered at cluster level (Black Country/BSoL Cluster). The programme is focused on identifying talent, developing, and supporting much more diverse cohorts of people from different disciplines, backgrounds and experiences to progress into senior leadership roles at a faster pace.
- James Fleet (Group Chief People Officer) has taken the role as SRO for the programme for the Black Country and BSoL Cluster, including jointly chairing the HPS Steering Group Roisin Fallon-Williams (CEO, Birmingham and Solihull NHS Foundation Trust). Both SWB and DGFT have actively promoted the HPS programme and have seen a high level of response (ref below). The process for selecting those staff to join the programme is undertaken by an independent panel, with all applications reviewed anonymously. Each Trust will be advised of the successful candidates during May.
- This programme directly supports the Group's commitment to develop a more diverse future executive and senior leadership pipeline and aligns with the emergent Group Inclusive Talent Management Framework.

*Table showing response levels*

Organisation	Totals
Sandwell and West Birmingham NHS Trust	35
Birmingham and Solihull Mental Health Trust	30
University Hospitals Birmingham	23
The Dudley Group NHS Foundation Trust	20
Black Country Healthcare NHS Foundation Trust	16
Birmingham Women's and Children's	13
Birmingham Community Healthcare Trust	5
Walsall Healthcare NHS Trust	5
The Royal Wolverhampton NHS Trust	5
Royal Orthopaedic Hospital	2
Black Country ICB	1
Sandwell Metropolitan Borough Council	1
Voluntary, community and social enterprises (including One Walsall and Community Associations)	1
West Midlands Ambulance Service	1
Primary Care Commissioning	1
<b>Grand Total</b>	<b>159</b>

## 1.8 Widening Access Demonstrator

- SWB has successfully secured funding through the NHS England Widening Access Demonstrator (WAD) programme following an expression of interest submitted by the Group Careers and Employability Team as part of the wider BSOL and Black Country bid.
- The WAD pilot begins in June and supports the Government's "Get Britain Working" strategy, giving 15 ICBs extra funding to help at least 1,800 young people and people from highly deprived communities move into employment programmes, entry-level roles, or training posts in local health and care services. Alongside this, the Careers and Employability Team continues to support recruitment through the social bank and talent pool model, including apprenticeships, and has also secured King's Trust funding to deliver employability programmes for local young people.
- Furthermore, based on the success of the SWB Employability programmes, Emma Dalton (Group Widening Participation Manager) has been asked to take on the SRO role for the Employability workstream within the Black Country & BSoL Cluster Workforce Programme.

## 2. Advise

### 2.1 2026/27 workforce plans

- Whilst indicative, the 26/27 workforce plans for both Trusts involve ambitious headcount reductions.
- SWB plans reduce FTE deployment by circa 503 FTE's, therefore exiting March 2027 with an FTE deployment of 7647FTE. This will be delivered principally through Divisional CIP schemes and year 1 delivery of the Fit for the Future (Fff) Transformation programmes.
- DGFT will reduce FTE deployment by 144 FTE's, therefore exiting March 2027 with an FTE deployment of 6251, through fully implementing the Learn, Adapt, Transform (LAT) programme, Divisional CIPs as well as year 1 delivery of the Fit for the Future (Fff) Transformation programmes.
- The focus for both Trusts will be reducing bank deployment, eradicating the minimal outstanding agency use and continuing to ensure that robust workforce controls are in place. Priority substantive recruitment will be supported for critical clinical and corporate roles.

- Detailed workforce plans, fully aligned to Divisional CIP schemes and FfF schemes, are being developed. The Joint People Committee receives regular updates on the progress of workforce plans. The next substantive update is due to the May meeting of People Committee.

### 3. Alert

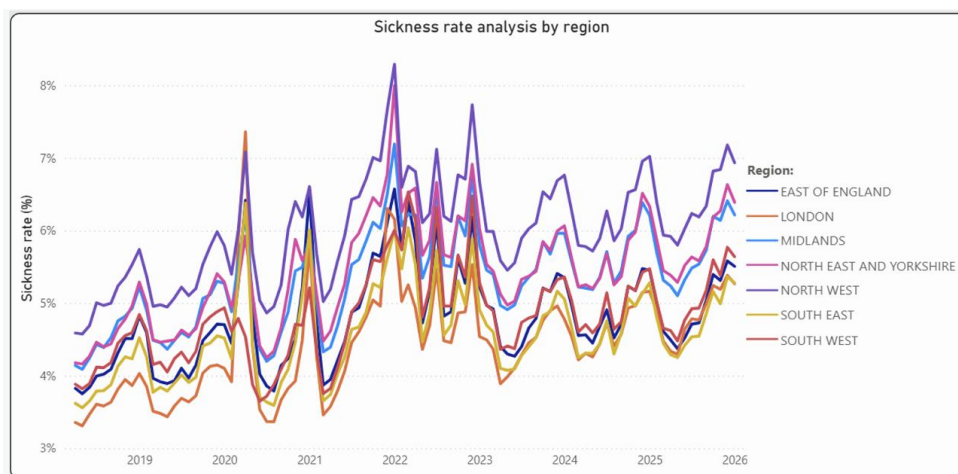
#### 3.1 M12 Workforce performance v plan (2025/26)

- Both Trusts closed the year below their M12 2024/25 workforce baseline positions, confirming that reductions were delivered during the year.
- DGFT reduced from 6,626 FTE at M12 last year to 6,536 FTE (-90 FTE), whilst SWBH reduced from 8,563 FTE to 8,170 FTE (-393 FTE), confirming that both Trusts delivered year-on-year workforce reductions. However, the March positions remained above the underlying trajectory due to additional staffing deployed during the final quarter to support SPRINT activity, operational capacity pressures and elevated sickness absence. Despite this, the scale of reduction achieved at SWB remains significantly higher than both the local (Black Country and BSol Cluster) and regional average FTE reduction.
- DGFT exited the year 141 FTEs above the forecast outturn (6536 FTEs) and SWB 19 above the forecast outturn (8170 FTEs). The SWBH forecast outturn has been revised from 8,053 FTE to 8,150 FTE following completion of the 2026/27 budget setting process, translating the £34m pay CIP into a phased FTE trajectory and establishing a consistent baseline for forward planning.
- The variance to plan is concentrated within operational services and reflects a combination of temporary and substantive workforce pressures. At SWBH, reductions have been primarily delivered through bank and agency, with substantive staffing remaining broadly stable. At DGFT, the position reflects continued reliance on bank staffing alongside growth in substantive deployment, increasing the underlying workforce base relative to plan.
- 10.7 FTE's were deployed at DGFT between January and March 2026 to deliver SPRINT activity. 6.8 FTEs were deployed at SWB between January and March 2026 to deliver SPRINT activity.

#### 3.2 Structural Increase in Sickness Levels

- Sickness absence across the NHS have become structurally elevated, with national and regional data demonstrating a sustained upward shift in baseline levels rather than a temporary post-pandemic fluctuation (reference NHSE data below). On this basis, a Midlands regional Sickness Absence Summit for Chief People Officers has been arranged in June to review a newly developed regional prevention focused toolkit, an interactive digital dashboard, as well as a discussion regarding regional funding to support health and wellbeing initiatives and local action planning.

Table showing sickness levels as a comparison across areas of England



- Whilst in-month sickness absence for both Trust has reduced through March and April 2026, SWBH's 12-month rolling absence is currently operating at c.6% and DGFT at 5.7%. Reducing sickness absence to the level assumed within the Medium-Term Planning Framework (4.1%) will require sustained intervention focused on prevention, early identification and proactive support. This includes greater use of predictive insight, advocacy support for long-term absence, enhanced self-help provision and strengthened manager support through timely access to data, guidance and intervention tools. Reliance on traditional

reactive absence management approaches alone is unlikely to deliver the scale of improvement required.

- SWB has now implemented and embedded the Goodshape health platform, with 85%+ utilisation in most areas, over 18,000 reports run (c.90% by managers), over 9,100 return-to-work interviews completed using the Goodshape platform and more than 24,000 care plan interactions recorded within the system. Furthermore, as referenced earlier in this report SWB will be piloting a range of digitally enabled early intervention approaches, through the Goodshape platform and other existing digital workforce systems, to help address the impact of increased absence. These interventions will be formally evaluated and reviewed through the Group Executive and Joint people Committee.

#### 4. Looking Ahead

- The Ten-Year Workforce Plan for the NHS is expected in June 2026.
- The new NHS Leadership and Management Framework is expected in June 2026.
- The new Statutory Management Framework is expected in June 2026.

#### 5. Recommendations

5.1 The Board is asked to:

- a) **Take** positive assurance on the developments within the report - (ASSURE) items
- b) **Note** and consider the ADVISE items and ongoing progress in these areas
- c) **Consider** the mitigating action being taken to address the ALERT issues
- d) **Note** the forward look items for future Board discussion

Dr James Fleet  
Group Chief People Officer  
1<sup>st</sup> May 2026

Sandwell & West Birmingham NHS Trust  
The Dudley Group NHS Foundation Trust

<b>REPORT TITLE:</b>	2025 Annual Staff Survey – Summary Results		
<b>SPONSORING EXECUTIVE:</b>	Dr James Fleet, Group Chief People Officer		
<b>REPORT AUTHOR:</b>	Frances Jackson, Group Head of People Engagement & Experience Andrea Lester, Retention Business Partner (DGFT)		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type:		Requested action:		Applies to:	
	Decision		Approve	X	Both Trusts
X	Assurance		Agree		Sandwell and West Birmingham NHS Trust
	Discussion	X	Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
		X	Discuss		
			Note		

### Suggested discussion points

#### 2025 Annual Staff Survey

The 2025 Annual Staff Survey was undertaken within Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust during October and November 2025.

The Annual Staff Survey results were released from embargo on 12<sup>th</sup> March. The staff survey results were reported within the Health Service Journal, along with wider media coverage on the same day. Given the embargo restrictions, the staff survey results, and the proposed improvement plan was considered, in detail, by the Joint People Committee at its meeting in February 2026. The People Committee also considered the proposed improvement plan and recommended that the Board release a message of support and commitment to all staff. This message was endorsed by both Trust Boards in March (meeting in private) and released on the day that the embargo was lifted.

#### Staff Survey Results

The 2025 Staff Survey shows a marked decline in staff experience across both SWB and DGFT. Staff engagement fell to 6.5 at both Trusts. Over half of SWB's scores and a third of DGFT's were significantly worse than last year. The scores highlighted a deterioration across the NHS People Promises, with common concerns around learning and development, reward and recognition, and health, safety and wellbeing.

#### Staff Survey Improvement Actions

A coordinated robust response has been developed is at Group, Trust and Divisional levels, including strengthened local action planning through line managers and the People Engagement Team (PET) model, targeted improvement support for the lowest-scoring teams, and a set of Group-level corporate actions focused on the three lowest-scoring People Promise elements.

#### Board Oversight & Assurance

The *Medium-Term Planning Framework, delivering change together 2026/27 to 2028/29* places an enhanced requirement for Trusts Boards to in response to the Annual Staff Survey results. Therefore, this paper, along with the detail within the reading room, including the detailed free text analysis, presents a full summary of the Annual Staff Survey results for SWB and DGFT and provides assurance that a robust and comprehensive action plan (*located in the reading room*) is being driven forward to address the key issues, themes and challenges that have been highlight through the results. Specifically, this paper:

1. Provides the Group Trust Board with a summary of key headlines results from the 2025 annual staff survey for Sandwell and West Birmingham NHS Trust (SWB) and The Dudley Group Foundation NHS Trust (DGFT),

including analysis of the free text comments, as well as alignment to the IMPACT Maturity Self-Assessment, which provides evidence of progress in embedding an improvement-based approach.

2. Summarises the key actions to be taken at Divisional, Trust and Group levels to address the survey feedback, including a targeted leadership support intervention by the OD and Improvement Team (Improving Together) for those teams with the lowest positivity scores.
3. Presents the communication and engagement plan for sharing results with colleagues across the Group.
4. Directs Board members to the reading room to access more detailed analysis of the 2025 national staff survey results and action plan.

#### Alignment to our Vision

Sandwell and West Birmingham NHS Trust				
OUR PATIENTS		OUR PEOPLE	X	OUR POPULATION
The Dudley Group NHS Foundation Trust				
PATIENTS		PEOPLE	X	PLACE/POPULATION

#### Previous consideration

Individual Trust Boards during March 2026, Joint People Committee February 2026

#### Recommendation(s)

a)	<b>Receive, Consider</b> and <b>Note</b> the summary analysis of the 2025 annual staff survey results.
b)	Take <b>Assurance</b> that the survey results have been fully analysed, understood and that a robust plan is in place to drive forward actions to secure improvements for future surveys.
c)	<b>Support</b> the key actions that are outlined in this paper for responding to the survey feedback and improving staff satisfaction.

#### Escalation

Should any element of this report be escalated:

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

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
	001: Deliver safe, high-quality care.		1.0: Failure to deliver right care, in the right place
X	002: Make best strategic use of its resources	X	2.0: Failure to recruit, retain, train, and develop workforce
X	003: Recruit, retain, train, and develop workforce		3.0: Failure to build innovative partnerships
	005: Deliver the MMUH benefits case (CLOSED)		4.0: Failure to achieve financial plan
	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		

Is Quality Impact Assessment required if so, add date:

Is Equality Impact Assessment required if so, add date:

# Report to the Group Public Trust Board on 20 May 2026

## 2025 Annual Staff Survey – Summary Results

### 1. Introduction

- 1.1 The NHS Staff Survey measures progress and improvement against the seven elements of the NHS People Promise and key themes of Staff Engagement and Morale. It provides valuable insights into how to improve the way that the Trust engages, resources, supports, develops and communicates with staff across our organisations.
- 1.2 The Medium-Term Planning Framework “Delivering change together 2026/27 to 2028/29” sets out a requirement that “...every NHS board will be expected to use the 2025/26 staff survey findings to commit to:
- A full and detailed analysis of all free text comments generated through the staff survey.
  - Identifying, as a minimum, 3 areas where the data shows the greatest staff dissatisfaction, generating a detailed analysis where those issues impact most within the organisation and developing detailed action plans to resolve those issues within year wherever possible.
- 1.3 This paper summarises the emergent key themes from the detailed free text analysis (see reading room for full details/data) and sets out the Trust’s approach and actions to addressing the areas with the greatest levels of staff dissatisfaction. Board members should note that the Joint People Committee in February 2026 reviewed an extensive summary of the staff survey results, including both the data and free-text analysis. This detail was also provided in the Reading Room for the private Trust Boards for Sandwell & West Birmingham and Dudley Group in March 2026.
- 1.4 The purpose of this paper is to:
- 1 Provide the Group Trust Board with a summary of key headlines results from the 2025 annual staff survey for Sandwell and West Birmingham NHS Trust (SWB) and The Dudley Group Foundation NHS Trust (DGFT), including analysis of the free text comments, as well as alignment to the NHS IMPACT Maturity Self-Assessment, which provides evidence of progress in embedding an improvement-based approach.
  - 2 Summarise the key actions to be taken at Divisional, Trust and Group levels to address the survey feedback, including a targeted leadership support intervention by the OD and Improvement Team (Improving Together) for those teams with the lowest positivity scores.
  - 3 Present the communication and engagement plan for sharing results with colleagues across the Group.
  - 4 Direct Board members to the reading room to access more detailed analysis of the 2025 national staff survey results.

### 2. Background and Context

- 2.1 The 2024 Staff Survey results demonstrated notable improvements across a number of the People Promises and survey domains for SWB, which received formal recognition from the NHSE for improving across all seven of the People Promises in the 2024 annual Staff Survey, as well as a further improvement in the Staff Engagement score which had improved consistently during the previous 12 months, as highlighted through the quarterly pulse surveys. DGFT demonstrated a broadly stable picture with minor decreases in some results.
- 2.2 Furthermore, since the previous staff survey, both Trusts have made positive progress in relation to their actions in response to the 2024 staff survey results, alongside implementation of the respective Trust People Plans. Example actions include; implementing and embedding culture, values and behaviour frameworks; enhancing and delivering leadership development; enhanced wellbeing support, plus targeted actions to improve access to reasonable adjustments; improved PDR completion rates; revision and

relaunch of FTSU frameworks; launching and embedding new anti-bullying, anti-discrimination policy as a single goal from NSS24 results (at DGFT); focused flexible working workstream (at DGFT); launched a Listen, Act & Feedback framework (at DGFT); developed new “With you all the way” employee value proposition and culture programme (at SWB); continued with ARC team development (at SWB); relaunched long service awards (at SWB). In addition, SWB has further embedded the People Engagement Teams (PET) model.

2.3 However, over the last year both Trusts have faced significant challenges, which have necessitated extensive and enhanced ‘grip and control’ measures, as well as implementing a significant corporate Management of Change programme, involving Trust wide MARS and redundancy schemes and transitioning to Group organisational arrangements. SWB also opened the Midland Metropolitan University Hospital (MMUH), requiring new clinical and staffing models and major changes to ways of working. The 2025 staff survey results show that **both Trusts experienced broad-based declines across the People Promise elements alongside lower staff engagement and morale**. This contrasts with the trend seen over the previous 4 years, which had shown both stability and improvement across the 7 People Promises elements up until this point.

2.4 The national benchmarking data, which compares organisational scores to peer group averages, highlights that both Trusts have seen statistically significant deteriorations in positivity scores across the majority of People Promise elements and themes in 2025 compared to 2024. The only People Promise elements without a significant change were “We are always learning” and “We are a team” for SWB and “We work flexibly” for DGFT. This is in clear contrast to 2024 when SWB had statistically significant improvements in 3 scores as well as 6 statistically higher scores across the People Promises and Themes. At DGFT, whilst the changes for the 2024 scores were not statistically significant (with the exception of a statistically significantly lower staff engagement score), there was not the broad decline seen this year.

**Table 1: Significance Testing 2024 v 2025**

People Promise Element	SWB			DGFT		
	2024 score	2025 score	Statistically significant change?	2024 score	2025 score	Statistically significant change?
We are compassionate and inclusive	7.21	7.09	Significantly lower	7.25	7.12	Significantly lower
We are recognised and rewarded	5.94	5.79	Significantly lower	5.81	5.63	Significantly lower
We each have a voice that counts	6.61	6.45	Significantly lower	6.56	6.41	Significantly lower
We are safe and healthy	6.24	6.04	Significantly lower	5.99	5.88	Significantly lower
We are always learning	5.44	5.40	Not significant	5.64	5.40	Significantly lower
We work flexibly	6.27	6.11	Significantly lower	6.17	6.14	Not significant
We are a team	6.70	6.67	Not significant	6.70	6.55	Significantly lower
Themes	2024 score	2025 score	Statistically significant change?	2024 score	2025 score	Statistically significant change?
Staff Engagement	6.75	6.49	Significantly lower	6.71	6.46	Significantly lower
Morale	5.97	5.75	Significantly lower	5.75	5.54	Significantly lower

### 3. 2025 Staff Survey Results - Group Headlines

#### 3.1 Response Rates

3.1.1 The 2025 annual staff survey had a response rate of **38% for DGFT** and **36% for SWB** against a peer average of **47%** for similar organisations. This was a **11% reduction for DGFT** and **2% increase for SWB**. Considerable efforts were made, both locally and corporately, to promote and encourage completion of the survey. Historically, DGFT have seen an improving response rate in line with benchmark average, however a decision to withdraw an incentive for survey completion (which SWB does not offer) has anecdotally contributed to a reduced response rate, alongside anecdotal disengagement with the survey. SWB’s incremental gain is notable given the challenging operating environment, however response rates remain below average.

#### 3.2 National Benchmarking data

3.2.1 National Benchmarking data show that both Trusts are scoring lower than national average across all People Promise elements and themes. For SWB, this is in contrast with 2024 scores when it had 4 people promises and themes scoring above national average (i.e. We are recognised and rewarded, We are safe and healthy, We work flexibly, Morale). For DGFT “We are always learning” scored in line with national average in 2024, whilst other scores were slightly lower than national average. Whilst there has been a general decrease in the national average scores compared to 2024, the deterioration has been more significant across the Group.

Chart 1: SWB National Benchmarking Scores

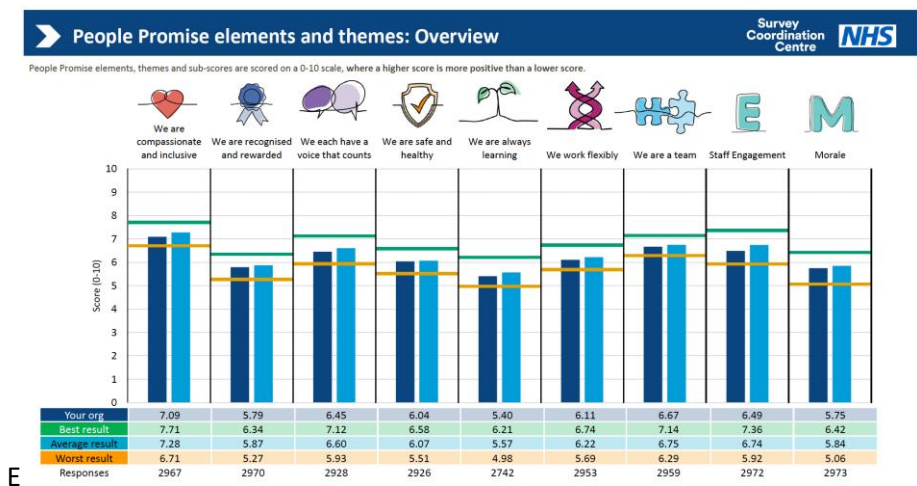
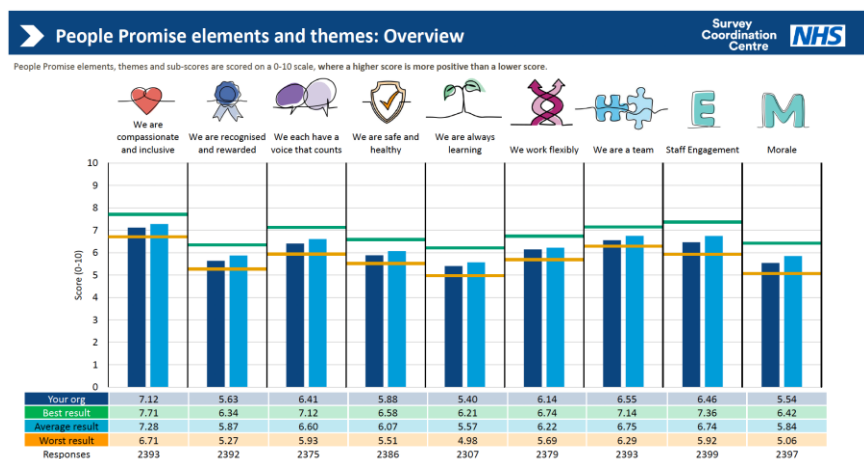


Chart 2: DGFT National Benchmarking Scores



3.2.2 The table below shows the 2025 results in comparison with the national average and best scores for our peer group.

Table 2: 2025 Score Comparison to National Average/Best

People Promise	SWB	DGFT	National Avg	Best	SWB vs Avg	DGFT vs Avg	SWB vs Best	DGFT vs Best
Compassionate & Inclusive	7.09	7.12	7.28	7.71	-0.19	-0.16	-0.62	-0.59
Recognised & Rewarded	5.79	5.63	5.87	6.34	-0.08	-0.24	-0.55	-0.71
Voice that Counts	6.45	6.41	6.60	7.12	-0.15	-0.19	-0.67	-0.71
Safe & Healthy	6.04	5.88	6.07	6.58	-0.03	-0.19	-0.54	-0.70
Always Learning	5.40	5.40	5.57	6.21	-0.17	-0.17	-0.81	-0.81
Work Flexibly	6.11	6.14	6.22	6.74	-0.11	-0.08	-0.63	-0.60
Team Working	6.67	6.55	6.75	7.14	-0.08	-0.20	-0.47	-0.59
Staff Engagement	6.49	6.46	6.74	7.36	-0.25	-0.28	-0.87	-0.90
Morale	5.75	5.54	5.84	6.42	-0.09	-0.30	-0.67	-0.88

From this comparison the following observations are noted:

- **Compassionate & Inclusive:** Both Trusts sit modestly below average (-0.19 SWB; -0.16 DGFT).
- **Recognised & Rewarded:** Both are below average, with DGFT further from benchmark (-0.24 vs -0.08 SWB).
- **Voice that Counts:** Moderately below average at both Trusts (-0.15 SWB to -0.19 DGFT).
- **Safe & Healthy:** SWB is broadly aligned to average (-0.03), while DGFT is further below (-0.19). Neither is close to best performance (-0.54 SWB to -0.70 DGFT).
- **Always Learning:** Identical scores (5.40) and below average (-0.17). This represents one of the largest structural gaps to best (-0.81), making it a clear priority area.
- **Work Flexibly:** Close to average at both Trusts (-0.11 SWB; -0.08 DGFT). However, both remain ~0.6 below best.
- **Team Working:** The closest theme to benchmark performance. SWB is -0.08 from average and -0.47 from best; DGFT further away (-0.20 from average, -0.59 from best).
- **Staff Engagement:** Below average at both Trusts (-0.25 SWB; -0.28 DGFT) and the largest gap to best (-0.87 SWB; -0.90 DGFT). This is the most material structural variance in performance.
- **Morale:** Below average, particularly at DGFT (-0.30); SWB is -0.09. Gap to best is substantial (-0.67 SWB; -0.88 DGFT), reinforcing this as a priority concern.

### 3.3 Staff Engagement & Morale

3.3.1 Both Trusts recorded **declines in staff engagement** to a score of **6.5** (DGFT -3.9%, SWB -4.3%), with the largest deterioration in the **Advocacy** sub-score. The fall was sharper at SWB, including reduced confidence that family/friends would receive good care. This is concerning for both organisations, but particularly so for SWB given the anticipated benefits to patients of opening MMUH. **Morale** also declined (**SWB score 5.8, -3.7%; DGFT score 5.5, -3.9%**), driven by workload pressure and increased intentions to leave.

**Table 3: Advocacy Question Score Movements**

<b>Advocacy Question Score Movement:</b>	<b>DGFT Movement</b>	<b>SWB Movement</b>
Care of patients/service users is organisation's top priority	-5%	-10%
Would recommend organisation as place to work	-7%	-8%
If friend/relative needed treatment would be happy with standard of care provided by organisation	-2%	-7%

### 3.4 People Promise Scores and Sub-scores

3.4.1 All seven People Promise elements deteriorated in both Trusts, as shown in the table below.

**Table 4: People Promise Scores and Movement**

People Promises	SWB				Dudley			
	2024	2025	Movement %		2024	2025	Movement %	
Compassionate culture sub-score	6.9	6.6	-4.6%	↓	6.9	6.6	-3.7%	↓
Compassionate leadership sub-score	7.0	7.0	-0.1%	↓	7.0	6.8	-2.6%	↓
Diversity and equality sub-score	8.3	8.2	-1.3%	↓	8.4	8.4	-0.2%	↓
Inclusion sub-score	6.7	6.6	-1.7%	↓	6.7	6.7	-1.1%	↓
Overall 'We are compassionate and inclusive' score	7.2	7.1	-1.9%	↓	7.3	7.1	-1.8%	↓
Overall 'We are recognised and rewarded' score	6.0	5.8	-3.0%	↓	5.8	5.6	-3.4%	↓
Autonomy and control sub-score	6.9	6.7	-2.7%	↓	6.9	6.7	-2.1%	↓
Raising concerns sub-score	6.4	6.2	-3.1%	↓	6.3	6.1	-3.0%	↓
Overall 'We each have a voice that counts' score	6.6	6.4	-3.0%	↓	6.6	6.4	-2.5%	↓
Health and safety climate sub-score	5.7	5.5	-3.6%	↓	5.3	5.1	-4.4%	↓
Burnout sub-score	5.2	4.9	-4.4%	↓	4.8	4.7	-2.5%	↓
Negative experiences sub-score	8.0	7.9	-1.2%	↓	7.9	7.9	-0.3%	↓
Overall 'We are safe and healthy' score	6.3	6.1	-2.8%	↓	6.0	5.9	-2.1%	↓
Development sub-score	6.3	6.1	-4.0%	↓	6.3	6.1	-3.7%	↓
Appraisals sub-score	4.5	4.6	1.8%	↑	5.0	4.7	-5.9%	↓
Overall 'We are always learning' score	5.5	5.4	-1.6%	↓	5.7	5.4	-4.7%	↓
Support for work-life balance sub-score	6.3	6.2	-2.0%	↓	6.3	6.2	-1.3%	↓
Flexible working sub-score	6.3	6.0	-4.3%	↓	6.2	6.2	0.4%	↑
Overall 'We work flexibly' score	6.3	6.1	-3.1%	↓	6.2	6.2	-0.5%	↓
Team working sub-score	6.6	6.5	-1.6%	↓	6.6	6.5	-2.2%	↓
Line management sub-score	6.8	6.8	0.0%	↓	6.9	6.7	-2.4%	↓
Overall 'We are a team' score	6.7	6.7	-0.9%	↓	6.7	6.6	-2.3%	↓

- 3.4.2 At SWB, “**We work flexibly**” showed the greatest deterioration (-3.1%). After multi-year improvements linked to the *Flex for the Future* programme, scores declined. Reduced temporary staffing and tighter recruitment controls have limited flexible working options and fewer staff feel the organisation supports their work-life balance. At DGFT, a small gain was achieved in the **Flexible Working sub-score** (+0.4%), reflecting the focused workstream over the last year. We work flexibly was the only People Promise element with no significant change at DGFT.
- 3.4.3 At DGFT, the greatest deterioration was in “**We are always learning**” (-4.1%), which is also the lowest scoring People Promise element. This was driven by marked drops in perceptions of career opportunities (-7.7%), support to develop potential (-4.2%) the value of appraisal (-3.3%), and access to learning & development (-3.3%). The planned appraisal redesign was paused to align with the new NHS Leadership and Management Framework and to explore alignment with SWB.
- 3.4.4 The lowest scoring People Promise element for both Trusts was “**We are always learning**” (both scoring 5.4). At SWB, the appraisal sub-score rose modestly (+1.8%) following a reset of the PDR cycle, though questions on appraisal quality still declined similar to DGFT. Appraisal was the lowest scoring sub-score for both Trusts. Both Trusts have a robust training and development offer, however staff feedback and high training DNA rates suggest that **release time** is the central barrier to development access. This underlines the strategic imperative to address this theme to enable the development of a skilled workforce fit for the future, protect retention and ensure staff feel valued and invested in.
- 3.4.5 The highest scoring People Promise element for both Trusts was “**We are compassionate and inclusive**” (both scoring 7.1), with strong **diversity and equality** scores, albeit with small decreases in 2025 (DGFT -0.2%, SWB

-1.3%). SWB's **Compassionate Leadership** sub-score only had a minor decrease (-0.1%), which is positive given the challenging organisational context (at DGFT the decrease was -2.6%). The relative stability of these People Promise scores reflects the focused work that has been undertaken on inclusive recruitment and development practices, strengthened anti-bullying and anti-discrimination policy (DGFT) and work done in line with Just and Learning Culture. To avoid complacency when considering the survey results, which highlight the need for more extensive interventions and focus in this area to drive substantial improvements.

3.4.6 Analysis of the People Promise sub-scores highlights concern around appraisals and development (We are always learning); health, safety and burnout (We are safe and healthy) and organisational culture (which links to staff engagement and morale).

### 3.5 Staff Survey Domains and Sub-Scores

3.5.1 The Staff Survey results are also broken down into 7 'domains'; deemed to be key contributors to positive staff engagement. There is overlap in the questions that feed into the People Promises and the 7 domains.

3.5.2 Positivity declined across all seven domains for both Trusts, with the steepest falls in **"Your Organisation"** (-4.2% DGFT, -5.4% SWB) driven by declining advocacy and morale. Within this domain, two questions around freedom to speak up have each declined reflecting a further shift in organisational culture. The smallest declines were in **"Your Health, Wellbeing and Safety at Work"** (DGFT) and **"Your Managers"** (SWB). For DGFT, the relatively stable **"Your Health, Wellbeing & Safety at Work"** score reflects an increase in positive responses to 8 questions related to experiences of bullying, harassment and physical violence. These small improvements (less than 1% improvement per question) provide an early indicator that the launch and embedding of the new anti-bullying, anti-discrimination policy in April 2025 are having a positive impact. 7 of these questions now also score above the Picker average for 2025. **"Your Managers"** is now SWB's highest domain after a multi-year upward trajectory, reflecting the emphasis on compassionate leadership and investment in manager development across both Trusts, notwithstanding minor 2025 dips. This reflects positive perceptions around manager support, wellbeing focus, feedback, and valuing staff contributions, which has been broadly maintained during a challenging organisational context. **"Your Personal Development"** remains the lowest domain, aligned to the "We are always learning" theme.

**Table 5: Positivity Scores and Movement by Survey Domain**

Domain	2025 Positivity Score - DGFT	2025 Positivity Score - SWB	Movement 2025 vs 2024 - DGFT	Movement 2025 vs 2024- SWB
People in your Organisation	62.1%	60.0%	-1.3%	-3.7%
Your Health, Wellbeing and Safety at Work	61.9%	62.8%	-1.2%	-1.4%
Your Job	53.9%	54.7%	-2.3%	-3.5%
Your Managers	66.3%	67.8%	-1.6%	-0.5%
Your Organisation	51.7%	51.7%	-4.2%	-5.4%
Your Personal Development	50.4%	49.5%	-2.6%	-2.8%
Your Team	64.2%	63.9%	-1.3%	-1.7%

### 3.6 Free Text Analysis

3.6.1 The free text comments from the survey help to provide context to the quantitative data. **638** free text comments were received for DGFT and **550** for SWB. The comments pointed to several positives including:

**Table 6: Summary of Positive Comments**

DGFT	SWB
Strong team culture and compassionate managers	Pride in patient care and NHS values
Pride in patient care	Strong teamwork and local support

Flexible working benefits	Supportive local leadership
Pockets of effective leadership	Positive impact of development where it exists

3.6.2 However, **the overriding sentiment from the free text comments across both Trusts is that finance is being prioritised over patient care and staff wellbeing**; this is having a significant impact on advocacy, morale and burnout. Analysis of the comments across both Trusts showing different levels of prevalence are themed as follows. A detailed summary of the free text analysis is provided within the reading room.

- Understaffing and unsafe workload (DGFT 60%+; SWB 30-35%)
- Leadership & Management (Visibility, behaviour and fairness) (DGFT 50%; SWB 25-30%)
- Pay, bank rates and financial constraints (DGFT 40%; SWB 20-25%)
- Career progression, recognition & development (DGFT 35%; SWB 15-20%)
- Inequality, discrimination and bullying (DGFT 30%; SWB 12-15%)

3.6.3 Whilst the Group is unable to control certain aspects (e.g. national pay rates) or where informed decisions have been made which may not be popular (e.g. revised bank rates), there are a number of key themes that align to the quantitative data which we propose to address through our joint action plan.

### 3.7 Alignment to the NHS IMPACT Maturity Self-Assessment

3.7.1 The five recommendations from the NHS Improvement Review place a strong emphasis on human factors, including leadership behaviours, organisational culture, and staff engagement, as key enablers of sustainable improvement.

3.7.2 NHS England has mapped relevant questions from the NHS National Staff Survey to these recommendations, enabling the use of staff experience data as an indicator of progress in embedding an improvement-focused culture over time.

3.7.3 This has been aligned to the NHS IMPACT Maturity Self-Assessment Framework (NHS England, 2023), providing a structured approach for organisations to assess and evidence their progress in adopting a consistent, improvement-based approach to care delivery.

3.7.4 This approach also supports the identification and spread of good practice at group level and across the provider collaborative, as well as within organisations (e.g. across Divisions and specialties), in line with the ambitions set out in the NHS Long Term Plan (2019) and NHS IMPACT: Improving Patient Care Together.

3.7.5 The table below summarises the results of this mapping exercise for DGFT and SWB. This analysis adds to the richness of the overall survey analysis, with a particular focus on key opportunities for improvement practice. These results will inform the work that the OD and Improvement Team will take forward with the 10 teams that have the lowest positivity scores.

3.7.6 A more detailed summary of the IMPACT analysis is provided in the reading room.

Key:	
Below ICB Score	
Above ICB Score	

NHS Approach to Improvement Staff Survey mapping		National	Midlands	Black Country ICB	Sandwell and West Birmingham Hospitals NHS Trust	The Dudley Group NHS Foundation Trust
Shared purpose and vision	2a: I Look forward to coming to coming to work	52.3%	51.7%	47.8%	48.8%	47.3%
	2b: I am enthusiastic about my job	66.3%	66.2%	62.6%	63.4%	62.3%
	25a: Care of patients/service users in my organisations as a place of work	71.8%	70.3%	64.5%	63.4%	65.3%
	25c: I would recommend my organisation as a place to work	58.1%	56.5%	50.9%	51.8%	50.6%
	7a: The team I work in has a shared set of objectives	73.6%	72.1%	68.5%	68.4%	71.0%
	8a: Teams within this organisation work well together to achieve their objectives	53.7%	52.3%	47.1%	48.3%	48.6%
Building improvement capability and capacity	3d: I am able to make suggestions to improve the work of my team / department	69.9%	68.5%	66.1%	66.1%	67.7%
	3e: I am involved in deciding on changes introduced that affect my work area	48.6%	47.5%	44.9%	46.7%	44.7%
	3f: I am able to make improvements happen in my area of work	54.2%	52.8%	50.0%	50.8%	50.5%
	7d: Team members understand each other's roles	71.4%	70.4%	67.7%	68.4%	70.5%
	5b: I have a choice in deciding how to do my work	53.0%	53.4%	51.2%	49.2%	50.1%
Development of leadership Behaviours	9a-i: My immediate manager encourages me a work	73.0%	72.1%	70.0%	71.2%	69.4%
	9b: gives me clear feedback on my work	66.6%	65.7%	64.8%	66.3%	64.6%
	9f: works together with me to come to an understanding of problems	70.3%	69.6%	67.8%	68.7%	66.6%
	9g: is interested in listening to me when I describe challenges, I face	72.6%	72.0%	69.7%	71.1%	67.8%
	9h: cares about my concerns	71.3%	70.6%	68.3%	69.7%	67.5%
	9i: takes effective action to help me with any problems I face	68.1%	67.6%	65.9%	66.9%	65.6%
Investing in culture and people	24a: This organisation offers me challenging work	68.2%	67.1%	64.9%	63.0%	66.7%
	24b: There are opportunities for me to develop my career in this organisation	51.1%	49.9%	44.5%	46.4%	43.4%
	24c: I have opportunities to improve my knowledge and skills	68.5%	67.3%	62.3%	64.1%	63.2%
	24d: I feel supported to develop my potential	55.2%	54.3%	50.8%	51.5%	50.2%
	24e: I am able to access the right learning and development opportunities when I need to	58.2%	57.4%	54.1%	54.7%	55.7%
Using Quality Management System	25b: My organisation acts on concerns raised by patients / service users	69.2%	67.9%	63.0%	63.1%	66.6%
	25e: I feel safe to speak up about anything that concerns me in this organisation	60.3%	59.3%	55.4%	57.5%	53.8%
	25f: If I spoke up about something that concerned me I am confident my organisation would	47.6%	46.6%	42.5%	43.0%	43.4%
	6a: I feel that my role makes a difference to patients/service users	87.8%	87.0%	85.0%	84.7%	86.8%

### 3.8 Equality, Diversity and Inclusion (EDI) Staff Experience

3.8.1 There are continued **disparities for Black and Minority Ethnic (BME) and disabled colleagues** compared with organisational averages. For ethnicity, there is a mixed picture, with some improvements in bullying/harassment indicators for BME colleagues but persistent differentials versus white colleagues. For disabled staff, overall positivity is starkly lower than for non-disabled staff, with declines in career progression and feeling valued; both Trusts report fewer colleagues receiving reasonable adjustments.

### 3.9 Staff Experience by Ethnicity

3.9.1 Across the Group, the survey results continue to show **notable disparities in experience between staff from Black and Minority Ethnic (BME) backgrounds and those from white backgrounds**. The pattern, however, is complex and with similarities across both Trusts showing a mixed and nuanced picture, with improvements for some groups but persistent inequities overall.

3.9.2 **Workforce Race Equality Standard (WRES) Indicators** showed very slight overall improvement for BME staff (+0.1% at DGFT; +0.2% at SWB). At DGFT, three of five WRES questions improved for BME staff (compared with one for white staff). Notable improvements include fewer BME staff experiencing harassment, bullying or abuse from colleagues. This correlates with the launch of a new anti-bullying and anti-discrimination policy. This is part of a 3-year priority for the Trust which is showing positive early signs. At SWB, three of five questions improved for BME staff and none improved for white staff. Improvements include BME colleagues reporting reduced bullying, harassment and discrimination from colleagues and a very small increase (+0.1%) in perceptions of fair career progression for BME staff. This likely reflects the Trust's work to ensure recruitment and progression processes are more inclusive and transparent. A major issue for both Trust's is the high proportion reporting bullying, harassment or discrimination from patients/public, linked to wider service pressures.

### 3.10 Staff Experience by Disability

- 3.10.1 Disabled staff report **significantly poorer experiences** than non-disabled staff across both Trusts. Positivity scores are **≥3% lower** than organisational averages in **over 80%** of questions for disabled colleagues, with no comparable detriment for non-disabled staff. Both Trusts show only small overall improvements.
- 3.10.2 **Workforce Disability Equality Standards (WDES) Indicators** show disabled staff reported overall declines (**-2.6% at DGFT; -0.2% at SWB**), with five of eight measures worsening at each Trust. At **DGFT**, disabled colleagues reported improvements in bullying/harassment and reporting behaviours (from colleagues and patients/public), but significant deterioration in perceptions of career progression (-17.8%) and feeling valued (-16.6%). At **SWB**, improvements were noted in reporting bullying/harassment, and reduced bullying/abuse from colleagues and managers. Declines were seen in experiences of harassment from patients/public (-2.5%), feeling pressure to attend work when unwell (-3.9%), and reduced perceptions of fair career progression (-3.9%).
- 3.10.3 A new **Reasonable Adjustment Framework** and **Health Passport** has since been launched at SWB (already in place at DGFT) alongside a range of other measures (e.g. enhanced training on reasonable adjustments, strengthened Attendance at Work policy, focus groups with Disability Network and managers to identify barriers). A priority focused joint piece of work will be undertaken with the Disability Staff Networks at both Trusts to better understand the improvements that will have the greatest positive impact for disabled staff across the Group.

### 3.11 Addressing the Experience Gap

- 3.11.1 Both Trusts have updated **WRES and WDES action plans**, with Group work progressing on inclusive succession planning and talent management to improve representation and ensure quality career conversations for all staff. Both Trusts are also championing the national High Potential Scheme, with individual schemes being run at Cluster level.
- 3.11.2 A new **Reasonable Adjustment Framework** and **Health Passport** has been launched at SWB since the 2024 survey results (already in place at DGFT), alongside a range of other measures (e.g. enhanced training on reasonable adjustments, strengthened Attendance at Work policy, focus groups with Disability Network and managers to identify barriers). The Group will continue implementing the Six High Impact Disability Actions, working towards a consistent Group-wide approach, alongside undertaking focused work with both Trust's Disability Networks to better understand their lived experiences and co-develop a targeted improvement plan which addresses the disparities in staff experience for disabled staff.
- 3.11.3 In addition, a Joint Task and Finish group has been established with divisional and directorate leaders, staff networks and EDI Leads to inform the development of a Group Integrated Anti Racism Framework. A dedicated maternity anti racism plan has also been developed in response to the Baroness Amos Review, working in conjunction with Baroness Amos' team.

## 4. The Dudley Group headlines

### 4.1 Positivity scores by Division, Directorate and Teams

4.1.1 Positivity decreased across all five Divisions, with key changes as follows:

- **Community & Core Clinical Services (CCCS)** recorded the lowest overall score and the greatest deterioration, with eight teams in the bottom quartile.
- **Corporate** remained the highest-scoring Division, though it showed declines in motivation, enthusiasm, and career development likely connected to workforce reductions and organisational change.

- **Place** ranked second overall and is the highest-performing clinical division, with no teams in the bottom quartile.
- **Medicine** experienced the second-largest decline, with the highest proportion of results falling >3% below the Trust average.
- **Surgery** also showed an overall decline, though most scores remained near organisational averages.

**Table 7: Divisional Positivity Scores - DGFT**

Division - Dudley	2024	2025	Movement	
253 Community & Core Clinical Services	60.0%	55.3%	-4.6%	↓
253 Corporate / Mgt	66.1%	65.2%	-0.9%	↓
253 Dudley Place		63.3%		
253 Medicine & Integrated Care	58.1%	55.7%	-2.4%	↓
253 Surgery	59.9%	58.6%	-1.3%	↓

- 4.1.2 A common weakness across all divisions was “We are always learning”, particularly in appraisal quality. Other low-scoring elements varied by Division.
- 4.1.3 Among 35 Directorates (27 comparable year-on-year): 7 improved (20%) and 20 declined (57%). Cancer Services Management was the highest and most improved (+6.6%), Pathology scored the lowest (44.8%), and Breast Screening Services had the largest deterioration (-18%).
- 4.1.4 Of 180 teams (99 meeting reporting thresholds):
- 47% scored significantly above Trust average
  - 34% scored significantly below
  - 18% were around average
- 4.1.5 Top performer: Out of Hours Team (82.7%, +19%) Lowest performer: Coseley, Sedgley & Lower Gornal District Nursing Team (40%, -19.9%)

## 5. Sandwell & West Birmingham headlines

### 5.1 Positivity Scores by Division, Directorate and Teams

- 5.1.1 Positivity scores fell in all but one Division. **Corporate** recorded the largest decline (-4.4%), having historically been the highest performing staff group for both Trusts by a sizeable margin. This change reflects the impact of the significant management-of-change processes during the year, which has delivered the largest reduction in corporate staff (FTEs) at SWB. The Management of Change process was required to deliver the requirement to reduce corporate cost growth by 50% to pre-COVID levels, as well as to deliver Trust CIPs and implement the new Group structures. **Imaging** delivered a substantial improvement (+6.7%), reversing two years of deterioration and rising above both 2023 and 2024 baselines. Previously the lowest-scoring division, this recovery reflects a robust action plan, including targeted OD support and strengthened divisional leadership. **PCCT** was the highest-performing division overall, despite a 3% reduction and **Medicine & Emergency Care** was the lowest-scoring, with multiple sub-scores falling significantly below organisational averages.

**Table 8: Divisional Positivity Scores - SWB**

Positivity Scores by Division - SWB	2024	2025	Movement	
Corporate	64.9%	60.5%	-4.4%	↓
Imaging	49.5%	56.2%	6.7%	↑
Surgical Services	58.7%	55.8%	-2.9%	↓
Medicine and Emergency Care	56.6%	55.0%	-1.6%	↓
Primary Care Community and Therapies	64.3%	61.3%	-3.0%	↓
Women and Child Health	62.1%	60.4%	-1.6%	↓

5.1.2 Across 29 directorates, 5 improved (17.2%) and 16 declined (55.2%). Diagnostic Radiology Outpatients and Medical Records achieved the largest improvement (+9.4%); the steepest falls were Strategy & Digital (-13.3%) and Theatres (-10.8%). Highest scoring directorates were Chief Executive Officer (70.7%), Chief Nursing Officer (68.4%) and iBeds (67.4%); lowest were Emergency Medicine (45.9%), Theatres (47.5%) and Maternity & Perinatal Medicine (50.9%).

5.1.3 Of 205 teams, 109 met reporting thresholds. Among these:

- 44% scored significantly below the Trust average
- 41% scored significantly above
- 15% scored around average

5.1.4 Infection Control achieved the highest team score (83.98%), while Emergency Department Management & Admin scored lowest (35.92%).

## 6. Shaping our Organisational Response to improve Staff Engagement and Satisfaction

6.1 Our Trusts are strongly committed to taking focused action, at both organisational and local level, based on the feedback received through the survey to improve staff experience. This will be achieved through a three-tiered response and a series of actions focused on our three lowest scoring People Promise elements (*i.e. We are always learning, We are recognised and rewarded, We are safe and healthy*), but with cross cutting impact on other themes (*e.g. advocacy, We are compassionate and inclusive*). Delivering these improvements will also be a critical enabler to the 3 year *Fit for the Future* transformation programme. A set of joint actions has been developed and tested through the Trust Executive Teams, Staff Inclusion networks and the Joint People Committee in February 2026, as well as individual Trust Boards in March 2026. Improvement actions and interventions will be targeted to the areas where the highest levels of staff dissatisfaction have been identified through the staff survey data (both quantitative and qualitative). Robust governance of the improvement plans will be maintained through the Group Executive, as well as the Joint People Committee, and the Group Board.

### 6.2 Group/Trust-Wide Response – Key Areas of Focus

6.2.1 The organisation is facing challenges across several areas: staff perceive limited internal mobility and want stronger support for their development, with meaningful appraisals and access to agreed learning opportunities. Many employees do not feel valued, which affects morale, retention and engagement, especially during periods of high pressure. Workload, burnout, rising sickness absence and increased incidents of violence and aggression are negatively impacting wellbeing, and some staff feel moral injury from the perception that finances are being prioritised over patient care. Additionally, declining net promoter scores reflect concerns about organisational decision-making.

6.2.2 The Joint People Committee emphasised that improving this requires strong, consistent, authentic communication from leaders at all levels (*i.e. the Trust Board, the Executive and from line managers*). A Board message which addressed some of these points in response to the staff survey results was released on the 12<sup>th</sup> March, the same day that the staff survey results were released nationally.

6.2.3 **A Group level action plan (see Annex 1) has been developed**, which is underpinned by a clear improvement plan. Our four key areas of focus for 2026/27 are:

- We are always learning
- We are recognised and rewarded
- We are safe and healthy
- Advocacy

These actions have been clearly communicated across the organisation, supported by an infographic and work is in progress against a set of Q1 actions.

6.2.4 A process to review progress against the improvement plan has been established, which reports into the Trust Executive and Joint People Committee. The Board will receive a full update on the progress against the Q1 actions at its meeting in September 2026. The Board should be assured that all Q1 actions are currently on track to be fully delivered.

### 6.3 Local Response

6.3.1 Line managers have been asked to share and discuss directorate and/or team-level results with their staff and agree local actions to address key concerns.

6.3.2 In addition, the **People Engagement Team (PET)** model will be strengthened at SWB, with a workshop with leads from each Division and Corporate Directorate having taken place on 21<sup>st</sup> April. A similar model will also be introduced at DGFT. PETs will be asked to identify key actions at Division level to include support with implementing corporate-level actions at local level.

### 6.4 Supported Improvement Response

6.4.1 Ten medium-to-large teams (five from DGFT and five from SWB) with the greatest staff dissatisfaction have been identified for targeted improvement support, selected from a spread of Divisions. Selection is based on lowest positivity scores and team size, but with consideration of wider people metrics where relevant and balanced with existing organisation development work already taking place.

6.4.2 The leaders of these teams will be provided with a data pack to support a deep dive of the issues driving dissatisfaction and will be supported through the Improvement and Organisation Development (OD) teams to develop the capability and confidence to effectively engage with their staff, identify and implement relevant interventions.

6.4.3 A paper setting out the ten teams to receive this targeted support, along with an outline of the support activities and measures of success was considered and supported by the Trust Executive in April. The ten teams are:

Dudley			Sandwell		
Division	Team	Team Size	Division	Team	Team Size
Medicine	ED Nursing	123	Medicine	Ward A9	45
Surgery	Ward C2 (Paediatrics)	64	Surgery	Surgical Assessment Unit inc SEACU	53
CCCS	Community Nursing Teams x 4: Urgent Care Response & SPA Team, Coseley, Sedgely & Gornal, Brierly Hill and Dudley District Nursing Teams	117	PCCT	District Nursing	166
CCS	Breast Screening	42	Imaging	Breast Screening	53
Corporate	EBME Team	17	Corporate	Security Services	40

## 6.5 Governance

- 6.5.1 Progress against action plans will be reported through the Joint Executive, Divisional Review Meetings (Chaired by the CEO), Trust Management Group and also People Committee on a quarterly basis. An interim progress report on corporate level actions will be taken to People Committee in September.
- 6.5.2 A Cross Directorate steering group, which was set up at SWB to support completion of the staff survey, will be reinstated but for leaders across both Trusts. Its purpose will be to receive assurance that actions plans are progressing, as well as a forum to share ideas, good practice and discuss support requirements.
- 6.5.3 The corporate action delivery plan will be monitored through the newly established Staff Experience and Inclusion Group.

## 7. Communication and Staff Engagement Plan

- 7.1 Division and Directorate Results Summary Packs have been issued to divisional and directorate leads across the Group to support the identification of key areas for improvement.
- 7.2 To support leaders to understand their responsibilities for sharing the data and engaging with staff on actions, the following communications have taken place through March/April:
1. **Line manager briefing sessions** chaired by the Group Chief People Officer and supported by Staff Engagement & Experience leads to share high-level results, clarify expectations, support data interpretation, and guide team engagement and action planning.
  2. **Manager resources** - A briefing pack has been published to support managers to understand how to use their staff survey data, how to engage with their teams and to create actions plans. People Promise posters have been provided for managers to display their team results and key areas of focus. A People Promise toolkit has also been shared to signpost managers to useful resources to support their improvements. A **Listen, Act and Feedback Framework**, which is a one-page summary outlining how survey results are shared and acted upon, has been introduced at SWB to support wider communications. This is already in place at DGFT.
  3. **Board led messaging** - recognising the decline and period of transition we are in, a Board led message was cascaded to set the tone of the response.
  4. **General staff communication** - results have been shared across the wider organisations through our range of established communication channels, as well as Team Talk.
  5. **Staff Side and Staff Networks** – briefing sessions have taken place with our staff side representatives and staff networks to engage them in our plans and ensure staff voices are heard.
  6. **PET Workshops** – a workshop was held in April at SWB to review and strengthen the model with People Engagement Team members based on the planned local response for 2026/27. A session was also held on 6<sup>th</sup> May at DGFT to begin to introduce a similar model there. Both sessions were well attended.

## 8. Conclusion

- 8.1 The 2025 survey evidences a **material decline in staff experience**, with significant deterioration in advocacy, morale, development access and perceptions of recognition and wellbeing. The findings reflect a challenging operational and financial context, as well as ongoing organisational change and sustained workforce pressures. There are, however, credible strengths to build upon: inclusion indicators remain comparatively

strong; line-manager domains are relatively resilient; and reporting behaviours have improved. A disciplined combination of **targeted local support** and **Group-level action** on learning and development, recognition, wellbeing will be taken to restore confidence, improve experience and protect retention and service quality.

## **9. Recommendations**

9.1 The Board is asked to:

- a) **RECEIVE, CONSIDER** and **NOTE** the summary analysis of the 2025 annual staff survey results.
- b) Take **ASSURANCE** that the survey results have been fully analysed, understood and that a robust plan is in place to drive forward actions to secure improvements for future surveys.
- c) **SUPPORT** the key actions that are outlined in this paper for responding to the survey feedback and improving staff satisfaction.

**Frances Jackson, Group Head of People Engagement & Experience**

**Andrea Lester, Retention Business Partner (DGFT)**

**21<sup>st</sup> April 2026**

## **Appendices**

Annex 1 – Action Plan located in the reading room

<b>REPORT TITLE:</b>	Neighbourhood Health Framework		
<b>SPONSORING EXECUTIVE:</b>	Kat Rose, Interim Group Chief Partnership Officer		
<b>REPORT AUTHOR:</b>	Lisa Maxfield, Deputy Chief Partnership Officer Sally Cornfield, Dudley Health and Care Partnership - Programme Director Steve Philips, Deputy Chief Partnership Officer		
<b>MEETING:</b>	Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type:		Requested action:		Applies to:	
	Decision		Approve	<input checked="" type="checkbox"/>	Both Trusts
	Assurance		Agree		Sandwell and West Birmingham NHS Trust
<input checked="" type="checkbox"/>	Discussion	<input checked="" type="checkbox"/>	Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
		<input checked="" type="checkbox"/>	Discuss		
			Note		

### Suggested discussion points

The NHS is undergoing a fundamental shift from a hospital-centric model of care to a neighbourhood-based, population health system, as set out in the Neighbourhood Health Framework. The NHS England Neighbourhood Health Framework was published on 17th March 2026. This paper provides a brief to the Board on the published Neighbourhood Health Framework (Annex 1). This is being operationalised locally through the development of Place-based delivery models and NHS Anchor organisations, supported by a new financial and contracting architecture. The Group is actively engaged with partners about the evolving place-based delivery model and NHS Anchor Organisation and this will be discussed in more detail at the Trust Private Board.

In Sandwell, Dudley and West Birmingham while the place-based delivery models are evolving we are continuing to work with partners and teams to implement neighbourhood health model. The delivery of Neighbourhood health is a key part of the Group Fit for the Future Strategy, and the delivery of Integrated Neighbourhood Teams has been built into the Group Fit for the Future programme.

On 15<sup>th</sup> April 2026 the Neighbourhood health centre (NHC) guidance for regions and integrated care board was published alongside Neighbourhood health centre design and performance specification, activity calculator, schedule of accommodation and illustrative layout drawings. ([NHS England » Neighbourhood health centres](#))

Since the publication NHSE have asked the ICB, which has now been passed to place, to urgently think about Neighbourhood Health Estate and potential locations for a NHC in each Neighbourhood/PCN. The ask from the ICB is to submit a prioritised list by 8th May so the ICB can submit to National Team on 15th May 2026.

The Trust's Partnership team have been working with colleagues in Estates and partners in place to pull together a prioritised list (Annex 2) and this paper gives an overview as to where the discussions have got to and what we have submitted to the ICB for Sandwell, West Birmingham and Dudley.

It is clear that Neighbourhood Health is now the core NHS operating model and not a transformation programme. The Neighbourhood Health Framework establishes Integrated Neighbourhood Teams (INTs) as the core delivery model and Place partnerships as the organising unit. This represents the most significant shift in NHS operating architecture in over a decade.

For our organisations as provider Trusts, the implications extend beyond service redesign: influence, financial sustainability, and organisational identity will increasingly be shaped at Place rather than at provider level. Trusts

unable to demonstrate readiness to deliver neighbourhood-based care will see commissioning, pathway leadership, and resource allocation gravitate toward more capable organisations.

As Place leaders, the Trust's must strengthen neighbourhood delivery by; scaling up Integrated Neighbourhood Teams (INTs), expand the Locality Hub models and support delivery of care closer to home. We must look to redesign Urgent and Emergency Pathways to increase Same Day Emergency Care, reduce admissions and length of stay and improve discharge flow and step-down capacity. We must prepare for the new financial models and contracting mechanisms such as pathway-based financial envelopes, population-based funding and align internal planning across all divisions to reduced acute growth. We will need to act as a System Leader at Place through shaping and lead neighbourhood delivery models with partners and look at our Trust's becoming Foundation Trusts that become NHS Integrated Health Organisations.

In order to do this the whole organisation needs to be committed to this way of working and the changes required and we need to consider how we ensure we have a workforce that is able to adapt to this new way of working and have the capacity, skills and capabilities that support the delivery of a Neighbourhood Health Model.

Alignment to our Vision			
Sandwell and West Birmingham NHS Trust			
OUR PATIENTS	x	OUR PEOPLE	OUR POPULATION
			x
The Dudley Group NHS Foundation Trust			
PATIENTS	x	PEOPLE	PLACE/POPULATION
			x

**Previous consideration**  
 Group Executive Team on 31<sup>st</sup> March 2026. Sandwell & West Birmingham NHS Trust Integration Committee on 8<sup>th</sup> April 2026, Dudley Integration Committee on the 6<sup>th</sup> May 2026, Group Executive Team on 5<sup>th</sup> May 2026.

- Recommendations**
- a) **DISCUSS** the national requirement to deliver Neighbourhood Health.
  - b) **ENDORSE** the proposed Neighbourhood Health Centre locations (Annex 2).

**Escalation**  
 Should any element of this report be escalated:

BAF Impact			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	X	1.0: Failure to deliver right care, in the right place
	002: Make best strategic use of its resources		2.0: Failure to recruit, retain, train, and develop workforce
	003: Recruit, retain, train, and develop workforce	X	3.0: Failure to build innovative partnerships
	005: -Deliver the MMUH benefits case (CLOSED)		4.0: Failure to achieve financial plan
X	004: Deliver on its ambitions as an integrated care Organisation		5.0: Failure to achieve performance requirements
	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		
Is Quality Impact Assessment required if so, add date:			
Is Equality Impact Assessment required if so, add date:			

# Report to Group Public Board on 20<sup>th</sup> May 2026

## Neighbourhood Health Framework

### 1. Background

- 1.1 On 17<sup>th</sup> March 2026, NHS England published the Neighbourhood Health Framework and along side this they published guidance for population health delivery:
- <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>
  - [NHS England » Fit for the future: towards population health delivery models](#)
- 1.2 The Neighbourhood Health Framework describes how health and care systems should organise services around neighbourhood populations, typically aligned to Primary Care Networks. The model integrates General Practice, community services, mental health services acute services (where appropriate), Social care and public health.
- 1.3 Key principles include:
- Person-centred, proactive and preventative care
  - Care delivered closer to home
  - Integration as the default way of working
  - Joint NHS and Local Authority leadership
  - Flexibility in local delivery models
  - The framework does not mandate organisational change, but requires a shift in how partners work together, supported by new contracting and governance arrangements from 2027/28).
- 1.4 On 15<sup>th</sup> April 2026 the Neighbourhood health centre guidance for regions and integrated care board was published alongside Neighbourhood health centre design and performance specification, activity calculator, schedule of accommodation and illustrative layout drawings. ([NHS England » Neighbourhood health centres](#))
- 1.5 Since the publication NHSE have asked the ICB, which has now been passed to place, to urgently think about Neighbourhood Health Estate and potential locations for a NHC in each Neighbourhood/PCN. The ask from the ICB was to submit a prioritised list by 8th May so the ICB can submit to National Team on 15th May 2026. Trust Partnership team have worked with colleagues in Estates and partners in place to pull together a prioritised list (Annex 2).

### 2. Neighbourhood Health Framework

- 2.1 The Neighbourhood Health Framework establishes a clear national ambition to:
- deliver care closer to home as the default to organise services around neighbourhood populations (based on populations of 30–50k)
  - scale Integrated Neighbourhood Teams (INTs)
  - shift focus from treatment to prevention, hospital to community and align funding and contracts to population outcomes.
- 2.2 A key point to note is that following this publication on the 17th March 2026, Neighbourhood Health is now the core NHS operating model and not a transformation programme. The Neighbourhood Health Framework establishes Integrated Neighbourhood Teams (INTs) as the core delivery model and Place partnerships as the organising unit. This represents the most significant shift in NHS operating architecture in over a decade. For provider Trusts, the implications extend beyond service redesign: influence, financial sustainability, and organisational identity will increasingly be shaped at Place rather than at provider level. Trusts unable to demonstrate

readiness to deliver neighbourhood-based care will see commissioning, pathway leadership, and resource allocation gravitate toward more capable Anchors.

2.3 The Neighbourhood Health Framework establishes a phased implementation trajectory; however, it is important to note that delivery will be performance-managed through NHS England and ICB oversight frameworks, with clear expectations for measurable improvement in system flow and hospital utilisation. The Neighbourhood Health Framework metrics are set out in Annex 1.

2.4 These improvements will be reflected in system performance oversight, contractual expectations and financial envelope assumptions. For context, delivery of these expectations for SWBT/DGFT is likely to require a material reduction in admissions and occupied bed days at scale, with further work required to quantify the exact impact across both Places.

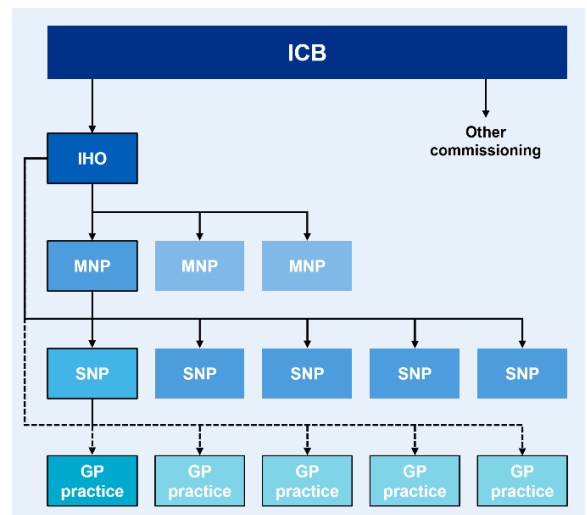
2.5 In addition to performance expectations, NHS England requires systems during 2026/27 to establish the foundational conditions for delivery. This includes:

- agreement of neighbourhood footprints
- development of INT models focused on priority cohorts
- confirmation of organisational accountability for delivery
- establishment of data-sharing arrangements to support population health management
- confirmation of approach to pooled funding (e.g. Better Care Fund)

2.6 Governance will be delivered through the ICB, Health and Wellbeing Boards and Local Authorities, ensuring aligned priorities and shared accountability at Place.

2.7 Alongside the Neighbourhood health framework that was published on the 17th March 2026 NHS England also published guidance for population health delivery models (NHS England » Fit for the future: towards population health delivery models). The below infographic shows the structure of the proposed national contracting model.

2.8 Single Neighbourhood Providers (SNPs) operate at neighbourhood level (50k population), enabling primary care to deliver additional integrated services alongside core GP contracts, working closely with local practices and integrated neighbourhood teams. Multi-Neighbourhood Providers (MNPs) operate at a larger scale (250k+), coordinating delivery across multiple neighbourhoods, setting consistent outcomes, and using scale to design and, where appropriate, directly deliver services. Integrated Health Organisations (IHOs) sit above this as whole-population budget holders, responsible for planning and allocating resources across the full care pathway, shifting investment toward prevention and community-based care through partnerships with MNPs and neighbourhood providers. Together, these form a nested, population-based model: the ICB contracts an IHO - the IHO works with MNPs - MNPs coordinate SNPs - SNPs work with GP practices to deliver care at neighbourhood level.



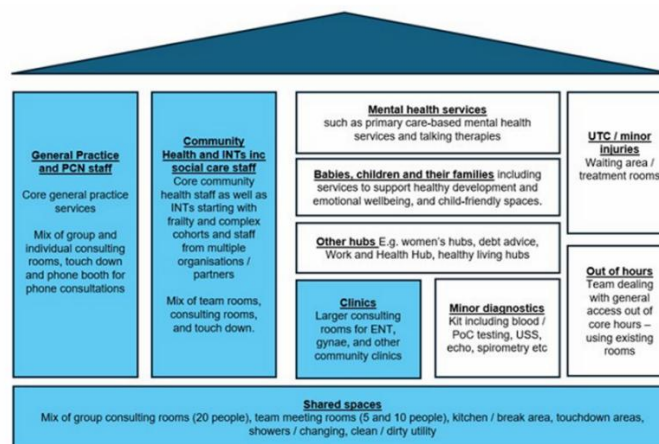
### 3. What This Means for us

3.1 The Trust's should note that these requirements are not discretionary. Delivery will be performance-managed through the ICB and NHS England, with expectations built into financial planning assumptions and contractual frameworks. This will require a planned and managed reduction in hospital based activity over the next 2–3 years.

- 3.2 To align with national expectations, we must accelerate pathway shifts and move care out of hospital across:
- frailty
  - urgent care
  - long-term conditions
  - Reduce reliance on inpatient care through systematic pathway redesign
- 3.3 Work has progressed on a Frailty model already and we have embarked upon a “Fit for the Future” programme across both Trusts and thereby will transform areas of delivery as a Group Model. This is in its early stages and is being designed and developed but could be focussed to support the redesign of key pathways in line with the neighbourhood health requirement
- 3.4 Delivery of the Neighbourhood Health Framework will require a fundamental shift in how primary, community and secondary care work together. Strengthening the primary / secondary care interface is critical to reducing avoidable admissions, improving flow and enabling care to be delivered closer to home. The Trusts must therefore:
- Strengthen relationships with Primary Care Networks (PCNs) and General Practice as equal partners in neighbourhood delivery
  - Expand and standardise Advice & Guidance (A&G) and clinical triage models to reduce unnecessary outpatient activity and admissions
  - Improve direct communication and shared decision-making between primary and secondary care clinicians
  - Reduce administrative burden and duplication across the interface (aligned to national “Red Tape Challenge”)
  - Support Primary Care with rapid access to specialist advice, clear pathways and consistent clinical thresholds.
- 3.5 This represents a cultural as well as operational shift, moving from transactional interactions to shared accountability for population outcomes at neighbourhood level.
- 3.6 In Sandwell, Dudley and West Birmingham while the place-based delivery models are evolving we are continuing to work with partners and teams to implement neighbourhood health model. The delivery of Neighbourhood health is a key part of the Group Fit for the Future Strategy, and the delivery of Integrated Neighbourhood Teams has been built into the Group Fit for the Future programme. Dudley, Sandwell and West Birmingham have variable readiness across both Places:
- SWBT has undertaken a whole programme of length of stay reduction in readiness for the move to the Midland Metropolitan Hospital site.
  - INT development is progressing but lacks standardisation and dedicated management support.
  - Whilst work has commenced on a Frailty model and UEC pathways, further work is required to impact on pathways that are still hospital reliant.
  - Community capacity is constrained, particularly around rapid response and step-down, requiring joint commissioning solutions.
  - An emerging joint Care Navigation Centre is being planned for both Trusts.
  - All three places have developed Neighbourhood plans and there is an established Locality Hub in West Birmingham, focussing on reducing occupied bed days and lengths of stay.
  - Anchor capability is emerging but not yet clearly defined or resourced, with a need to understand our internal capability and capacity to deliver the requirements needed.
  - Although all three Local Authorities bring strengths, one operates from a lower starting point. Tailored support and a more intensive development plan will be necessary to ensure alignment across the system.
  - There is a different mix of relationships with Primary Care Providers across the two Trusts.
  -

## 4. Neighbourhood Health Centres (NHC)

- 4.1 NHCs should be planned as part of an asset-based neighbourhood model, connected to wider networks of support, health promotion and community activity, rather than as stand-alone clinical facilities. As part of the Autumn Budget the Government set out plans in more detail which confirmed it would deliver 250 NHCs by 2035, with 120 of those by 2030. These will comprise a mixture of upgrades to existing buildings and new build centres, with the balance between the two to be informed over time by local need, value for money and deliverability. NHC will be expected to:
- be open at least 12 hours a day and 6 days a week providing access to coordinated services locally
  - include on-site general practice as a core element of the model, not solely GP staff or sessional input.
- 4.2 Core components are detailed in the infographic below: (Blue boxes represent the minimum requirements for designation as an NHC. As a minimum, this includes an on-site GP practice and a model capable of operating at scale over time.)



- 4.3 The guidance takes about different ways of delivering the centres and these are outlined below:
- Archetype 1: Hub-and-spoke (existing NHS estate) Upgrade or extend existing NHS sites, supplemented by mobile or satellite spokes; fastest, lowest-cost option where estate quality is high.
  - Archetype 2: Repurposed community/civic spaces. Adapt high-street or civic assets (e.g. libraries, leisure centres) to deliver some neighbourhood services locally, quickly and at low cost.
  - Archetype 3: Cohort-specific hubs Integrate existing group-focused hubs (e.g. women's health, family, mental health) into the neighbourhood offer, aligned or co-located where appropriate.
  - Archetype 4: Purpose-built neighbourhood health centres. New, purpose-designed facilities built to deliver the full neighbourhood health service offer.
- 4.4 Annex 2 shows the prioritised list of sites for Sandwell, Dudley and West Birmingham that have been pulled together following discussion with primary care and has been agreed by the wider partnership in each place. This list have been submitted to the ICB for inclusion within their return.
- 4.5 For some Neighbourhoods there are clear options and confirmation of a direction of travel. In some areas there is still further work to do to develop the preferred way forward so we have put forward a number of options to the ICB.

## 5. Conclusion

- 5.1 It is clear that Neighbourhood Health is now the core NHS operating model and not a transformation programme. The Neighbourhood Health Framework establishes Integrated Neighbourhood Teams (INTs) as the core delivery model and Place partnerships as the organising unit.
- 5.2 For our organisations as provider Trusts, the implications extend beyond service redesign: influence, financial sustainability, and organisational identity will increasingly be shaped at Place rather than at provider level. Trusts unable to demonstrate readiness to deliver neighbourhood-based care will see commissioning, pathway leadership, and resource allocation gravitate toward more capable organisations.
- 5.3 As Place leaders, the Trust's must strengthen neighbourhood delivery by; scaling up Integrated Neighbourhood Teams (INTs), expand the Locality Hub models and support delivery of care closer to home. We must look to redesign Urgent and Emergency Pathways to increase Same Day Emergency Care, reduce admissions and length of stay and improve discharge flow and step-down capacity. We must prepare for the new financial models and contracting mechanisms such as pathway-based financial envelopes, population-based funding and align internal planning across all divisions to reduced acute growth.
- 5.4 We will need to act as a System Leader at Place through shaping and lead neighbourhood delivery models with partners and look at our Trust's becoming Foundation Trusts that become NHS Integrated Health Organisations. In order to do this the whole organisation needs to be committed to this way of working and the changes required and we need to consider how we ensure we have a workforce that is able to adapt to this new way of working and have the capacity, skills and capabilities that support the delivery of a Neighbourhood Health Model.

## 6. Recommendations

- 6.1. The Group Public Trust Board asked to:
  - a) **DISCUSS** the national requirement to deliver Neighbourhood Health.
  - b) **ENDORSE** the proposed Neighbourhood Health Centre locations.

**Kat Rose**  
**11<sup>th</sup> May 2026**

## Annex 1 – Neighbourhood Health Framework Metrics

Goal 1:	<b>Improve health outcomes</b>
Metrics	<p>By March 2029</p> <ul style="list-style-type: none"> <li>• 10 per cent reduction in non-elective admissions/bed days for frailty and housebound cohorts</li> <li>• 10 per cent increase in identification of people approaching end of life and a 10 per cent reduction in their non-elective admissions/bed days</li> <li>• 10 per cent improvement in clinical outcomes for major long-term conditions where warranted, and 10 per cent increase in diabetes patients receiving all eight care processes</li> <li>• 10 per cent reduction in outpatient appointments for under-16s and significant progress on reducing community waits.</li> </ul>
Goal 2:	<b>Improve access to general practice</b>
Metrics	<ul style="list-style-type: none"> <li>• 90 per cent of clinically urgent patients seen the same day by March 2027</li> <li>• Routine GP access and satisfaction baselined in 2026–27 with local goals set by ICBs in the interim</li> </ul>
Goal 3:	<b>Improve experience of planned care</b>
Metrics	<ul style="list-style-type: none"> <li>• 25 per cent diversion of referrals via single points of access for ten high-volume specialties by March 2027, supporting RTT recovery.</li> <li>• 10 per cent reduction in secondary care follow-up outpatient activity by March 2027, with neighbourhood-based follow-up for priority cohorts and cancer metrics aligned with the National Cancer Plan.</li> </ul>
Goal 4:	<b>Improve urgent and emergency care performance</b>
Metrics	<p>Objectives by March 2029</p> <ul style="list-style-type: none"> <li>• Reduce non-elective admissions and emergency department (ED) attendances for high-priority cohorts (defined as severe frailty, in a care home or housebound and end of life)</li> <li>• Contribute towards 82 per cent ED four-hour performance by March 2027, moving to 85 per cent in the longer term.</li> <li>• Reduce category 3/4 ambulance conveyances for high-priority cohorts by expanding urgent care response.</li> <li>• Improve discharge efficiency (more patients discharged on their ready date; quicker discharge where delays occur).</li> </ul>
Goal 5:	<b>Improve patient and staff satisfaction</b>
Metrics	<p>From 2026/27</p> <ul style="list-style-type: none"> <li>• Introduce new patient experience and outcome measures with year-on-year improvement</li> <li>• 95 per cent of people with complex needs to have a care plan by 2027</li> <li>• New staff experience measures introduced in neighbourhoods with annual improvement trajectories.</li> </ul>

## Annex 2 Place Prioritised Neighbourhood Health Centres

Sandwell			
Priority	Town/ Neighbourhood	Location	Comments / Considerations
1	Smethwick	Victoria Health Centre	Old building in need of development and modernising. Has GP practice and community services currently operating out of the building and is central in Smethwick. Smethwick also has pride of place funding which should be considered for an opportunity for Health on the Hight street.
2	Tipton	Glebefields Health centre or Neptune Health centre	Would need a review of existing space and ability to expand on space available. Both have GP within and some community services already.
3	Oldbury	Oldbury Health Centre	Central to Oldbury with existing GP and some community services, opportunity for additional space following refurb. This has already been identified in the first wave of Neighbourhood Health Centres.
4	Wednesbury	Richard Nugent Centre or Tame Valley or Millenium Centre	Would need some further debate, as Richard Nugent is closer to main town but need development for additional space. However, Friar Park is a key deprivation hotspot and has pride of place funding and so could consider development of the Millenium Centre which sits between the 2x Friar Park practices.
5	Rowley	Rowley Hospital or Regis Medical Centre (YHP)	Rowley Hospital would be a good location; issue is no primary care and car park charges. Only other consideration could be Regis Medical Centre in Black Heath near the town but would need expanding to accommodate for additional services.
6	West Bromwich	Lyng Centre for Health	Currently has 4x GP practices, community services and is ideal for a Neighbourhood centre.

Dudley			
Priority	PCN / Neighbourhood	Location	Comments / Considerations
1	Dudley	Dudley High Street	Central to Dudley - health on the high street. Landlord has approached LA - capital funding to repurpose shops to clinical spaces. NHSE capital funding may also be available. Requires relocation of primary and secondary care services
2	Halesowen	Halesowen Health Centre Potential to look at Halesowen Shopping centre.	Central to Halesowen - close to the high street. GP practice onsite Would need a review of existing space and ability to expand on space available. Some community services (approx 4) already provided. Potential to work with landlords for Cornbow Shopping Centre
3	Kingswinford	Kingswinford Health Centre or Wordsley Green Health Centre or potential new build.	GP practice on site and community services (1/2 on each). Would need some further debate, as Wordsley Green is closer to "high street" but predict development for additional space required at both sites.

<b>Dudley</b>			
<b>Priority</b>	<b>PCN / Neighbourhood</b>	<b>Location</b>	<b>Comments / Considerations</b>
4	Coseley, Sedgley and Gornal	Ladies Walk	No GP presence, community services (approx 4) Would need a review of existing space and ability to expand on space available.
5	Stourbridge Wollescote and Lye	Stourbridge Health and Social Care Centre Or Lion Health	Currently has GP practices, Pharmacy, community services (approx 17)
6	Brierley Hill	Brierley Hill Health and Social Care Centre	Currently has GP practices, Pharmacy, community services (approx 20) Community Diagnostic Centre, Mental Health and LA.

<b>West Birmingham Site</b>	<b>Location</b>	<b>Property Owner</b>
Summerfield Health Centre	Winson Green	CHP
St Stephens Health centre	Handsworth	BCHC
Bloomsbury Health Centre	Nechells	NHS PS
Finch Road Health Centre	Lozells	CHP
Attwood Green Health Centre	City Centre	CHP
Aston Pride Health Centre	Aston	CHP

<b>REPORT TITLE:</b>	Board Assurance Framework		
<b>SPONSORING EXECUTIVE:</b>	Diane Wake, Group Chief Executive		
<b>REPORT AUTHOR /PRESENTER:</b>	Helen Board, Board Secretary (Dudley) Dan Conway, Associate Director of Corporate Governance/Company Secretary		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type:		Requested action:		Applies to:	
<input checked="" type="checkbox"/>	Decision	<input checked="" type="checkbox"/>	Approve	<input type="checkbox"/>	Both Trusts
<input type="checkbox"/>	Assurance	<input type="checkbox"/>	Agree	<input type="checkbox"/>	Sandwell and West Birmingham NHS Trust
<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Endorse	<input checked="" type="checkbox"/>	The Dudley Group NHS Foundation Trust
<input type="checkbox"/>	Information	<input type="checkbox"/>	Recommend	<input type="checkbox"/>	
		<input type="checkbox"/>	Discuss	<input type="checkbox"/>	
		<input type="checkbox"/>	Note	<input type="checkbox"/>	

### Suggested discussion points

#### Background

The Board Assurance Framework Report provides the Board with a summary view on the status of progress towards the achievement of its agreed strategic goals and the Trust objectives supporting each of them. This includes the risks, controls and gaps in controls, assurances, and mitigations associated with each.

#### Summary of changes since the last report: January 2026

Each of the Committees have scrutinised their assigned risks and determined an assurance rating cognisant of the impact of mitigations. All BAF risks have been reviewed and a close out report issued except for the Infrastructure BAF that will be taken at their May meeting.

Reflecting the move towards Group working with Sandwell and West Birmingham NHS Trust, joint BAF reporting has been developed with joint reports being considered by the People Committee, the Finance & Productivity Committee, Infrastructure Committee and the Quality Committee. Separate BAF risk reporting remains in place for the Integration Committee.

#### Dudley

The Board of Directors is asked to receive a summary of each of the six BAF risks and the Trust's Board Assurance Framework current position given as appendix 1. Of the six risks listed, committee assurance ratings are assigned as follows:

- three are assigned a 'positive' rating - BAF 1,3 & 5
- three are assigned an 'inconclusive' – BAF 2,4 & 6
- none were assigned a 'negative' rating

#### Sandwell

The Board of Directors is asked to receive a summary of each of the five BAF risks and the Trust's Board Assurance Framework current position given as appendix 2. Of the five risks listed, committee assurance ratings are assigned as follows:

- All BAF risks 1,2,3,4 & 6 are assigned as 'inconclusive'
- none were assigned a 'negative' rating

#### Quality

##### Dudley

BAF Risk 1 (failure to deliver the right care, in the right place at the right time) remained stable throughout the year at a score of 9 (3x3), within the Trust's defined risk appetite. The Trust maintained a mature control environment, underpinned by comprehensive patient safety data, established governance arrangements and positive external assurance.

The stability of the score reflected sustained performance against quality and safety objectives. Further material risk reduction was not considered realistic due to the inherent complexity of the services provided. The focus therefore remained on maintaining effective controls and embedding improvement, particularly in strengthening the consistency of harm review processes and improving the translation of data into measurable quality and safety outcomes.

## **Sandwell**

BAF 001 (inability to deliver consistently safe, high-quality care) reduced over the course of the year from an initial score of 20 (5×4) to a current and proposed Quarter 4 score of 12 (4×3). This reduction reflected significant strengthening of the Trust's control environment, including embedding the Fundamentals of Care framework, developing real-time dashboards, and establishing structured PSIRF learning arrangements.

Despite this progress, the risk remained outside the defined risk appetite. The Committee consistently recognised that, while visibility and governance oversight had improved, variability in clinical reliability persisted and there was limited evidence of sustained improvement in key safety outcomes. As a result, the residual risk was driven less by gaps in control and more by the pace and consistency of operational delivery.

### **Control Environment and Assurance – Year-End Position**

Across both Trusts, 2025/26 has seen a material strengthening of the quality and safety control environment. At Sandwell, the Fundamentals of Care framework now provides a clear operational backbone for quality delivery, supported by ward-level dashboards and improved visibility of safety metrics. This has been complemented by the full establishment of PSIRF governance and the development of more structured approaches to safety learning and triangulation.

At Dudley, the control environment has remained strong and well established, with a comprehensive data architecture supporting oversight across mortality, patient experience and safety indicators. Governance processes are embedded and supported by a wide range of internal and external assurance mechanisms.

Notwithstanding these strengths, the overall assurance position at year end remains mixed. Governance and reporting arrangements provide a reasonable level of assurance across both organisations, and there is clear evidence of improved oversight and escalation. However, assurance relating to operational delivery and outcomes remains partial. In both organisations, there is limited consistent evidence that learning is systematically translated into improvement, and that improvement is sustained over time.

## **Workforce**

### **Dudley**

The workforce BAF risk has similarly remained at 12 (3×4), within the defined risk appetite tolerance. The Trust has maintained a broad and established set of controls, including delivery of the People Plan, improvements in workforce data systems and targeted interventions across recruitment, retention and wellbeing. However, emerging pressures, particularly in relation to rising sickness absence, workforce plan delivery and the impact on staff experience, have limited the opportunity for further reduction in risk score.

### **Sandwell**

At Sandwell and West Birmingham, the workforce BAF risk has remained at 12 (4×3) throughout the year. This stability reflects a position where there has been significant strengthening of controls, including the embedding of workforce optimisation approaches, the rollout of leadership development programmes and the implementation of a Group People Services operating model. However, the risk has not reduced further due to continued pressures relating to sickness absence, staff morale, workforce capacity and delivery of workforce reduction plans, all of which are influenced by national workforce constraints and financial recovery requirements.

BAF refresh as reset point: The 2026/27 BAF refresh will revalidate the workforce risk, strengthen outcome-based assurance and align the framework to Group People priorities and financial recovery requirements.

### **Control Environment and Assurance – Year-End Position**

During 2025/26, both Trusts have strengthened the underlying control environment for workforce risk. At Sandwell, this has been characterised by the embedding of workforce optimisation as business-as-usual, including improvements in rostering, job planning and utilisation of workforce systems. This has been complemented by the delivery of the ARC leadership and team effectiveness programme at scale, alongside the continued development of the "With You All the Way" culture programme and the implementation of the Group People Services operating model.

At Dudley, the control environment has remained comprehensive and structured, with a wide range of People Plan workstreams, workforce data systems and governance arrangements providing strong oversight. Progress has been evident in areas such as ESR optimisation, exit data collection, leadership development and targeted workforce interventions, supported by clear reporting through the People Committee and associated governance structures.

## **Operational Performance**

### **Dudley**

BAF Risk 5 (Operational Performance) was proposed at a score of 12 (3x4) for Quarter 4, reflecting improvements in ambulance handover performance, a improving RTT trajectory and improved cancer performance. However, it was noted that there remained a risk of score escalation in Quarter 1, subject to the outcome of the LAT work. The risk was managed within the Trust's risk appetite tolerance.

The Committee considered the detail provided in the supporting documentation regarding the articulation of the risk and the controls in place. Where gaps in controls were identified, the Committee reviewed the mitigating actions and assurances to determine the appropriate level of assurance based on the evidence received.

In March 2026, the Committee assigned a positive assurance level, based on confidence that the risk could be reduced to its target score within 12 months. This reduction was achieved. In recognition of the progress made, the Committee reviewed the position and agreed to retain the assurance level, assigning an inconclusive assurance rating going forward.

## **Finance**

### **Sandwell**

BAF Risk 002 remains scored at 20 (Almost Certain x Major), outside the Trust's cautious risk appetite. Governance of the financial position has improved since January 2026, including stronger scrutiny through the Finance & Productivity Committee, clearer Executive ownership of CIP delivery, and better alignment of strategic, medium-term and transformation plans. Despite this, delivery risk remains high due to the scale of the structural deficit, uncertainty around recurrent efficiencies, workforce and productivity pressures, and staff morale challenges. The Committee has therefore maintained its assurance rating pending further evidence of recurrent financial recovery, stronger plan integration, and completion of the 2026/27 BAF refresh.

### **Dudley**

BAF Risk 4 (Finance) is scored at 16 (Almost Certain x Major); was 20. The Trust set a breakeven plan incorporating £26.95m of deficit funding and ICB surplus distribution, requiring delivery of a £38.976m Cost Improvement Programme. While the Trust achieved its 2025/26 financial plan, this relied on additional non-recurrent funding, increasing the underlying deficit. The risk is currently being managed within the Trust's risk appetite.

## **Control Environment and Assurance – Year-End Position**

The joint presentation of the finance, productivity and operational performance Board Assurance Framework provides improved comparative visibility and assurance across both Trusts, while maintaining clear and separate ownership of risks at individual Board level. There is assurance that meaningful progress is being made in strengthening finance, productivity and operational performance related controls, governance and delivery discipline.

However, key finance and operational risks remain across both organisations. In both cases, continued focus on the development of the financial plan and sustained operational performance will be critical to securing further risk reduction in 2026/27.

## **Partnerships**

### **Dudley**

BAF Risk3: Risk position stable and risk remains at 12, reflecting the long term nature of changing the risk profile and been able to measure the impact of partnership working to demonstrate any reducing risk and improve the overall health of our community.

The key challenge to partnership working is the changing environment in terms of national policy and politics that impact on our own organisations and our partners. There remains a challenge to measure the tangible impact of partnership working on improving health outcomes.

BAF refresh as reset point: The 2026/27 BAF refresh will revalidate the partnership risk, strengthen outcome-based assurance and align the framework to Group Fit for Future Strategy and latest National Guidance and Local developments such as the development of Anchor organisations in each of the 6 places across the Birmingham, Solihull and the Black Country.

### **Sandwell**

BAF Risk 4: Risk position remains stable at 12, recognising that improving population health and reducing inequalities through partnership working is a long-term strategic ambition requiring sustained collaboration across the wider system. While strong relationships continue to develop across place, provider collaborative, local authority and voluntary sector partners, demonstrating measurable impact on health outcomes and reducing variation remains challenging due to the complexity and timescales associated with system transformation.

The external environment continues to create uncertainty and pressure across partner organisations, including changing national policy direction, financial constraints, operational pressures and wider system reform. These factors can impact

organisational capacity, priorities and pace of delivery across partnership programmes. Despite this, work continues to strengthen collaborative arrangements across the Black Country and Birmingham and Solihull systems, including the development of place-based approaches and anchor organisation models to support prevention, health improvement and community resilience.

BAF refresh as reset point: The 2026/27 BAF refresh will provide an opportunity to reconfirm the strategic partnership risk, strengthen outcome-focused measures and align assurance arrangements to the emerging Group Fit for Future Strategy, NHS England priorities and evolving Integrated Care System and Place arrangements. This will include further development of measurable indicators linked to population health, inequalities and partnership impact across Sandwell, Birmingham and Solihull and the wider Black Country.

**Infrastructure**

The current Q3 risk score 20 (4x5) is an aggregate of a large portfolio of strategic risks and opportunities. Collectively these have a substantial strategic significance in terms of enabling and catalysing the three big shifts of the NHS 10-year plan, with the associated reputational, quality, performance, financial risks to two organisations.

The main driver for the current risk score being set at the inherent risk score is due to ongoing baselining and establishing joint group portfolios – representing the lack of surety in some areas. It is expected that ongoing work will establish a more clearly evidenced residual score by the end of Q4.

The Target risk score is set based on a risk appetite ‘seeking’ opportunities with a confident understanding of supporting governance and the potential for greater reward. This places the focus on the committee to seek strategies to reduce the likelihood of negative consequences to balance this with taking the opportunity of greatest reward. The consequence level is set at 4 (major) as the worst-case scenario of building failure or incident or major cyber-security incident taking resources and capacity away from strategic progress.

The assigned risk appetite is ‘Seek’ and advise the committee that the risk is not being managed within its risk appetite tolerance score of 12-16.

The Committee meets bi-monthly and the close out report and Q4 score will be considered at the May meeting and thereafter the Committee will meet monthly.

**Next Steps**

In January 2026, RSM completed the annual BAF audit that has been undertaken in conjunction with the audit of the Sandwell and West Birmingham NHS Trust BAF.

Audit findings revealed that a robust framework is in place and flag that there are a small number of refinement opportunities to further strengthen the BAF. RSM state that the board can take reasonable assurance that the controls relied on are suitably designed, consistently applied and effective.

Work has been undertaken to align the Risk Management Strategy for the Group trusts with sign off expected at the July board meeting. The board is asked to note that the alignments will bring together the Risk scoring currently applied.

It’s that time of year when we get look ahead to the refreshed BAF for the 26/27. The close out report for the end of the year has seen all mitigating actions updated and any Gaps in Control reviewed to provide a close out position in conclusion of quarter 4 2025/2026.

Identification of strategic risks is part of the BAF refresh work underway for 2026/27 with draft documents considered at Committees in May or June ahead of sign off at the July Board meeting.

Alignment to our Vision					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x
The Dudley Group NHS Foundation Trust					
PATIENTS	x	PEOPLE	x	PLACE/POPULATION	x

**Previous consideration**  
At Committees in Q4 and Q1 26/27

**Recommendation**

a) **Receive** the BAF summary report noting the next steps relating to establishment of joint reporting, audit activity and the BAF refresh work aligned to the development of a single strategy for the Group.

**Escalation**

Should any element of this report be escalated: None

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

<b>Sandwell and West Birmingham NHS Trust</b>		<b>The Dudley Group NHS Foundation Trust</b>	
x	001: Deliver safe, high-quality care.	x	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources	x	2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce	x	3.0: Failure to build innovative partnerships
	<del>005: Deliver the MMUH benefits case (CLOSED)</del>	x	4.0: Failure to achieve financial plan
x	004: Deliver on its ambitions as an integrated care Organisation	x	5.0: Failure to achieve performance requirements
x	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		

Is Quality Impact Assessment required if so, add date: n/a






Is Equality Impact Assessment required if so, add date: n/a

## Appendix 1 Summary - Board Assurance Framework (BAF): Dudley update BoD\_AC

- The following table captures the progress related to development of BAF risks with proposed scores

ID	Area	Risk Description	Lead Exec	Lead Committee	Inherent Risk score	Current Residual Risk score	Target Risk Score	Risk Appetite	Committee Assurance Rating/ last reviewed
1	Quality	Failure to deliver the right care, in the right place at the right every time resulting in poor clinical outcomes and patient experience.	Medical Director Chief Operating Officer Chief Nurse	Quality	20 (4x5)	9 (3x3)	9 (3x3)	Cautious 9	Positive March '26
2	Workforce	Failure to recruit, retain, train, develop, engage, and support an effective workforce will compromise the ability to deliver safe and effective care, maintain staff morale and regulatory compliance.	Chief People Officer	People	20 (4x5)	12 (4x3)	6 (3x2)	Seek 16	Inconclusive March '26 <i>Meeting held 1/4</i>
3	Partnerships	Failure to build innovative partnerships, there is a risk that the Trust will be unable to transform the way services are delivered which will impact on the Trust's ability to improve the health of our communities	Interim Group Chief Partnerships Officer	Integration	12 (3x4)	12 (3x4)	8 (2x4)	Significant 20	Positive March '26
4	Finance	Failure of the Trust to achieve its financial plan in 2025/26 may result in NHS England taking regulatory action	Director of Finance	Finance and Productivity	20 (5x4)	16 (4x4)	12 (4x3)	Open 12	Inconclusive February '26
5	Operational Performance	Failure to achieve operational performance requirements and deliver strategic goals	Chief Operating Officer	Finance and Productivity	20 (5x4)	16 (4x4)	12 (4x3)	Open 12	Positive March '26
6	IT and Digital Infrastructure	Failure to take sustained, ambitious action to optimise estates, facilities, digital, data, and technology functions risks undermining strategic transformation goals leading to financial strain, reduced quality and safety, weaker cyber-resilience, impaired collaboration, and loss of public trust.	Group Chief Strategy & Digital Officer Group Chief Development Officer	Infrastructure	20 (4x5)	20 (4x5)	16 (4x4)	Seek 16	Inconclusive January '26

## Appendix 2 Summary - Board Assurance Framework (BAF): Sandwell update

BAF Risk No	Description	Initial Score	Current Score	Target Score	Risk Appetite	Committee Assurance Level descriptors	Trend
BAF001	Safe, high-quality care (QC)	16	12	8	OPEN	Inconclusive	Static 
BAF002	Strategic use of resources (F&P)	16	20	4	CAUTIOUS	Inconclusive	High Concern 
BAF003	Workforce (PC)	16	12	4	OPEN	Inconclusive	Static 
BAF004	Integrated care delivery (IC)	16	12	4	OPEN	Inconclusive	Static 
BAF006	Infrastructure: Digital, Estates, and Facilities	20	20	16	SEEK	Inconclusive	Static 

<b>REPORT TITLE:</b>	Black Country Acute/Community /Community Trusts - Future Group Structure Arrangements		
<b>SPONSORING EXECUTIVE:</b>	Diane Wake, CEO		
<b>REPORT AUTHOR:</b>	Dan Conway, Associate Director of Corporate Governance/Company Secretary		
<b>MEETING:</b>	Group Public Trust Board	<b>DATE:</b>	20 May 2026

Paper Type: (place an 'x')		Requested action: (place an 'x')		Applies to: (place an 'x')	
x	Decision	x	Approve	x	Both Trusts
	Assurance		Agree		Sandwell and West Birmingham NHS Trust
	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
			Note		

**Suggested discussion points**

The four Black Country acute/community /community trusts have, over recent years, developed increasingly mature collaborative arrangements through both the Black Country Provider Collaborative and the evolution of formal Group operating models. This has resulted in the establishment of two distinct and operationally mature Groups: The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust; and The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust. Alongside these developments, Black Country-wide collaboration has continued to strengthen through the Provider Collaborative, supporting joint working across clinical, operational, workforce, digital and financial programmes.

This paper seeks agreement from the four Boards to formally recognise and continue the current operating structure of two Group models supported by the wider Black Country Provider Collaborative framework. The proposal does not alter the sovereign status or statutory accountability of any organisation, but instead reflects the maturity of the current arrangements and the benefits already being realised through closer collaboration, aligned leadership, shared strategic delivery, and system-wide partnership working.

Alignment to our Vision <i>[indicate with an 'X' which Strategic Objective[s] this paper supports]</i>					
Sandwell and West Birmingham NHS Trust					
OUR PATIENTS	x	OUR PEOPLE	x	OUR POPULATION	x
The Dudley Group NHS Foundation Trust					
PATIENTS	x	PEOPLE	x	PLACE/POPULATION	x

**Previous consideration**

None

- Recommendation(s)**
- a) **Formally** recognise the maturity and establishment of the two existing Group operating models across:
    - Dudley and Sandwell
    - Wolverhampton and Walsall
  - b) **Approve** the continuation of the current operating structure comprising:
    - Two distinct Group models
    - Supported by the Black Country Provider Collaborative framework
  - c) **Note** that sovereign organisational accountability and statutory Board responsibilities remain unchanged.

d)	<b>Support</b> the continued development of collaborative arrangements both within each Group model and across the wider Black Country system.
e)	<b>Approve</b> submission of the agreed future operating arrangements to NHS England following approval by the four sovereign Boards as part of ongoing regional engagement regarding provider collaboration and Group operating models across the Black Country.

#### Escalation

Should any element of this report be escalated: No

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

Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
x	001: Deliver safe, high-quality care.	X	1.0: Failure to deliver right care, in the right place
x	002: Make best strategic use of its resources	X	2.0: Failure to recruit, retain, train, and develop workforce
x	003: Recruit, retain, train, and develop workforce	X	3.0: Failure to build innovative partnerships
	005: -Deliver the MMUH benefits case (CLOSED)	X	4.0: Failure to achieve financial plan
x	004: Deliver on its ambitions as an integrated care Organisation	x	5.0: Failure to achieve performance requirements
x	006 (Joint): Failure by the Group to take sustained, ambitious action to optimise estates, facilities, digital, data		

Is Quality Impact Assessment required if so, add date:

Is Equality Impact Assessment required if so, add date:

## Report to the Group Public Trust Board on 20 May 2026

### Black Country Acute/Community Trusts - Future Group Structure Arrangements

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#### 1. Purpose

1.1 The four Black Country acute/community trusts have, over recent years, developed increasingly mature collaborative arrangements through both the Black Country Provider Collaborative and the evolution of formal Group operating models.

1.2 Since 2023, a single shared Chair arrangement has supported closer partnership working across the four organisations, enabling greater strategic alignment, stability, and collaboration during a period of significant system transformation.

1.3 During this period, two distinct and increasingly mature Group models have emerged:

- The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust
- The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

1.4 Both Group arrangements have now evolved beyond early collaboration into more mature operating models with established shared leadership structures, aligned governance arrangements, joint strategic programmes, and increasingly integrated approaches to operational delivery.

1.5 Alongside this, the Black Country Provider Collaborative has continued to mature as the overarching partnership framework across the wider Black Country system, enabling collaborative delivery at scale across a population of approximately 1.3 million people.

- 1.6 The proposed operating approach reflects a deliberate and evidence-based evolution of provider collaboration across the Black Country. In considering future organisational form, the four organisations have recognised that the current model of two mature Group arrangements, operating within a wider Black Country Provider Collaborative framework, provides the optimal balance between scale, operational effectiveness, local responsiveness, governance assurance and delivery pace.
- 1.7 The approach avoids the risks associated with fragmentation across four entirely separate organisations, whilst also avoiding the complexity, scale and potential dilution of operational focus associated with establishing a single Black Country-wide Group model across all four trusts.
- 1.8 The current arrangements therefore represent a pragmatic and proportionate organisational model that is aligned to the operational realities, leadership maturity and service integration patterns that have developed organically across the Black Country acute/community sector.
- 1.9 The purpose of this paper is therefore to seek agreement from all four Boards to formally recognise and continue the current strategic operating structure comprising:
- Two distinct Group models:
    - Dudley and Sandwell Group
    - Wolverhampton and Walsall Group
  - Supported by continued collaboration through the Black Country Provider Collaborative framework
- 1.10 This paper does not propose organisational merger or changes to statutory accountability arrangements. Sovereign Boards and organisational accountabilities would remain fully intact.
- 1.11 The proposed approach reflects the operational and strategic maturity now evident across both Group models whilst preserving the wider collaborative benefits already established across the Black Country.

## **2. Background**

### **Black Country Collaboration**

- 2.1 The Black Country acute/community trusts have a longstanding history of collaborative working through the Black Country Provider Collaborative, established to improve the sustainability, resilience and quality of services across the region.
- 2.2 The collaborative has enabled joint working across a broad range of clinical and non-clinical programmes including:
- Clinical pathway transformation
  - Workforce and recruitment initiatives
  - Mutual operational support
  - Digital and data transformation
  - Shared governance approaches
  - Elective recovery and urgent care improvement
  - Finance and productivity programmes
- 2.3 This collaboration has strengthened considerably in recent years in response to:
- Increasing operational pressures
  - Workforce challenges

- Financial sustainability requirements
- National policy direction supporting provider collaboration
- The development of Integrated Care Systems

### 3. Development of Group Models

#### Dudley and Sandwell Group

3.1 During 2024 and 2025, The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust undertook extensive work to explore and implement a formal Group operating model.

3.2 This work recognised the significant opportunities associated with:

- Geographical proximity
- Complementary clinical services
- Shared population health challenges
- Opportunities arising from the opening of Midland Metropolitan University Hospital
- Shared workforce and operational pressures

3.3 A phased implementation programme has subsequently culminated in the establishment of a formal Group Board arrangement from 1 April 2026, whilst preserving the sovereignty and statutory accountability of both organisations.

3.4 The Group model is intended to:

- Improve consistency of care and outcomes
- Reduce unwarranted variation
- Strengthen strategic leadership
- Improve operational resilience
- Reduce duplication
- Enable shared learning and capability development
- Preserve strong place-based leadership arrangements

#### Governance Spine Development

3.5 Alongside the operational development of the Group model, significant work has been undertaken to establish a strengthened “governance spine” across the Dudley and Sandwell Group arrangements. This has included the development of aligned governance frameworks, joint committee structures, consistent assurance processes, shared standards of Board reporting, and clearer escalation and decision-making arrangements across the Group.

3.6 The governance spine work has been designed to provide greater organisational consistency whilst preserving sovereign accountability within each Trust. The approach supports improved oversight, more consistent assurance, clearer strategic alignment, and enhanced organisational resilience across the Group model.

3.7 The development of these arrangements has also enabled the organisations to strengthen collective leadership capability, embed shared governance standards, and improve organisational readiness for future regulatory and inspection activity.

#### Wolverhampton and Walsall Group

3.8 The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust have similarly developed a mature Group operating arrangement with shared executive leadership and aligned strategic priorities.

3.9 The Group has established a clear joint vision centred around:

- Care
- Colleagues
- Communities
- Collaboration

3.10 The partnership has enabled increasing alignment across operational delivery, workforce strategy, governance, digital transformation and service improvement.

3.11 Recent developments have included the appointment of a Group Chief Executive and further strengthening of joint leadership arrangements across the organisations.

#### **4. Consideration of Alternative Operating Models**

4.1 In determining the proposed future operating arrangements, consideration has been given to a range of alternative organisational models across the Black Country acute/community sector.

4.2 These included:

- Continuation of four largely autonomous organisations with limited collaboration
- A single Black Country-wide Group model across all four trusts
- The continuation and further maturation of two distinct Group models supported by the Black Country Provider Collaborative

4.3 Following consideration of organisational maturity, operational delivery, governance assurance, workforce leadership, geographical alignment, service integration and system effectiveness, the proposed continuation of two Group models is considered to provide the most balanced and deliverable approach.

#### **Four Standalone Organisations**

4.4 A return to a model based primarily on four independent organisations was not considered optimal given the increasing operational, workforce and financial pressures facing the NHS.

4.5 Such an approach would risk:

- Reduced resilience and mutual support arrangements
- Duplication of leadership and corporate infrastructure
- Greater unwarranted variation in governance and operational delivery
- Slower pace of transformation
- Reduced ability to standardise pathways and clinical models
- Reduced leverage in workforce, digital and procurement programmes
- Fragmentation of strategic planning across the Black Country

4.6 The current collaborative and Group arrangements have already demonstrated measurable benefits through shared leadership, improved organisational stability, aligned governance, operational support and accelerated improvement activity.

#### **Single Black Country-wide Group Model**

- 4.7 Consideration was also given to the potential establishment of a single Black Country-wide Group operating model across all four trusts.
- 4.8 Whilst this model could theoretically provide greater scale, it was not considered proportionate or operationally advantageous at this stage of organisational maturity and system development.
- 4.9 A single Group structure across four large acute/community organisations serving a population of approximately 1.3 million people would introduce significant complexity across:
- Governance and decision-making
  - Executive span of control
  - Organisational culture and leadership visibility
  - Place-based responsiveness
  - Operational prioritisation
  - Service configuration
  - Regulatory oversight
- 4.10 There is also a significant risk that a single large Group model could dilute local accountability, reduce agility, and create overly complex governance arrangements which may hinder rather than accelerate operational improvement and transformation delivery.
- 4.11 The current model of two mature Groups supported by a strong Provider Collaborative is considered to provide a more proportionate balance between:
- Local autonomy and system collaboration
  - Strategic scale and operational grip
  - Standardisation and place sensitivity
  - Organisational identity and collective delivery
- 4.12 Importantly, the Provider Collaborative framework already enables Black Country-wide collaboration where scale adds value, without necessitating a single overarching statutory or Group structure.

### **Current Position**

- 4.13 The Black Country acute/community sector now operates through two mature Group models, each with distinct strategic priorities, leadership arrangements, and organisational development trajectories.
- 4.14 At the same time, the Black Country Provider Collaborative continues to provide the overarching system-wide framework for collaboration across all four trusts.
- 4.14 The current structure has enabled:
- Greater organisational stability
  - More focused operational leadership
  - Improved strategic alignment
  - Enhanced collaboration at scale
  - Continued preservation of sovereign organisational accountability
  - Stronger partnership working across the wider system
- 4.15 The maturity of the Dudley and Sandwell Group arrangements has also been evidenced through recent regulatory assurance outcomes, including the achievement of a move from 'Requires Improvement' to

a 'Good' rating Well-Led assessment at Sandwell and West Birmingham NHS Trust. This reflects the strength of leadership, governance, organisational culture, and strategic oversight that has developed across the Group model.

- 4.16 The learning, governance arrangements, and organisational development arising from this work are expected to provide significant benefit in supporting the continued organisational development and inspection readiness of the wider Group organisations, including upcoming regulatory inspections across Dudley and the wider Black Country acute/community sector.
- 4.17 The continued development of aligned governance, assurance and improvement approaches across the Group models is expected to strengthen consistency, organisational learning and system resilience whilst supporting delivery of high-quality, sustainable services across the Black Country.
- 4.18 The current arrangements have matured organically and now reflect the practical operational reality across the Black Country acute/community sector.

## 5. Proposal

- 5.1 It is proposed that the four Boards formally agree to continue the current strategic operating structure comprising:

### Two Distinct Group Models

#### 5.2 Dudley and Sandwell Group

- The Dudley Group NHS Foundation Trust
- Sandwell and West Birmingham NHS Trust

#### 5.3 Wolverhampton and Walsall Group

- The Royal Wolverhampton NHS Trust
- Walsall Healthcare NHS Trust

#### 5.4 Supported by:

- Continued Black Country-wide collaboration through the Black Country Provider Collaborative

## 6. Strategic Rationale

- 6.1 The proposed approach reflects the maturity and evolution of the current arrangements and provides the opportunity to:

- Maintain strategic cohesion across the Black Country
- Enable focused Group-level leadership and delivery
- Strengthen operational and clinical integration within each Group
- Continue collaborative delivery where scale adds value
- Preserve sovereign organisational accountability
- Reduce duplication and governance complexity
- Support sustainable workforce and service models
- Retain strong place-based leadership and identity
- Align organisational arrangements with operational reality
- Support the continued development of the Group governance spine and aligned assurance arrangements

- Strengthen organisational readiness and resilience for future regulatory inspections and oversight activity
- Enable the spread of organisational learning and best practice across Group partners
- Build on the positive Well-Led foundations established within Sandwell and West Birmingham NHS Trust
- Improve consistency of governance, leadership and assurance processes across the Group models
- Provide an organisational scale that remains operationally manageable and clinically connected
- Maintain stronger executive visibility and organisational grip than would likely be achievable within a single large-scale Black Country Group model
- Enable faster operational decision-making and implementation
- Support stronger place-based partnerships with local authorities, primary care and community partners
- Preserve organisational culture, identity and staff engagement within manageable organisational footprints
- Reduce the risk of excessive governance complexity associated with a single large-scale Group arrangement
- Allow collaboration to operate at the most appropriate level — Group-level where operational integration adds value and Black Country-wide where scale and standardisation are beneficial
- Create a more resilient and sustainable leadership model through shared executive capability whilst maintaining proximity to operational delivery
- Support clearer accountability and assurance arrangements through more focused governance structures
- Avoid destabilisation and organisational distraction associated with large-scale structural reorganisation

6.2 The approach also remains consistent with the broader national direction of travel supporting provider collaboration, Group operating models and system partnership working.

6.3 Collectively, the proposed arrangements are considered to represent the most proportionate, operationally effective and strategically sustainable organisational model currently available to the Black Country acute/community sector. The model enables collaboration and scale where beneficial, whilst preserving sufficient organisational focus, agility and place-based leadership to support effective operational delivery and continued improvement.

## 7. Governance Implications

7.1 Under the proposed arrangements, all four trusts would remain sovereign statutory organisations, each retaining its own Board, statutory responsibilities, and organisational accountabilities. The proposal does not seek to alter the legal status of any organisation, nor does it represent a merger or transfer of statutory functions.

7.2 The existing governance arrangements already established within the Dudley and Sandwell Group and the Wolverhampton and Walsall Group would continue to operate in support of their respective strategic and operational priorities. This includes the continuation of Group-level leadership, joint working arrangements, aligned committee structures, and shared governance processes where these support improved delivery, consistency, organisational resilience and stronger collective oversight.

7.3 As part of the continued maturation of the Group model arrangements, significant work has been undertaken to develop a strengthened governance spine across the organisations. This has included the alignment of governance frameworks, committee structures, reporting arrangements, assurance

processes, escalation routes, and strategic oversight mechanisms designed to support clearer accountability and more consistent organisational governance across the Groups.

- 7.4 The maturity of these arrangements has been positively reflected through recent regulatory assurance activity, including the achievement of a positive Well-Led assessment at Sandwell and West Birmingham NHS Trust. The governance and leadership learning arising from this work is expected to provide wider benefit across the Group arrangements and support ongoing organisational development and inspection readiness across the partner organisations, including forthcoming inspections.
- 7.5 Alongside the continued development of the two Group models, Black Country-wide collaboration would remain a central component of the wider strategic approach through the established Black Country Provider Collaborative framework. This would ensure that opportunities for collaboration at scale, pathway transformation, shared learning, workforce development, and system-wide improvement continue to be progressed collectively across the region.
- 7.6 The proposed model also provides stronger governance assurance than either a fully fragmented or wholly consolidated organisational approach. The existence of two mature Group arrangements enables:
- More manageable governance structures and committee oversight
  - Clearer lines of accountability and escalation
  - Greater executive and non-executive oversight capacity
  - Stronger operational visibility and performance management
  - More effective organisational risk management
  - Greater consistency of governance standards across paired organisations
  - Improved organisational responsiveness to regulatory oversight and inspection activity
- 7.8 The development of aligned governance spines within each Group arrangement provides a scalable and resilient governance architecture which supports both sovereign accountability and collaborative delivery.
- 7.9 Subject to approval by the four sovereign Boards, the proposed arrangements and future operating approach would also be shared with NHS England for approval as part of ongoing regional engagement and oversight discussions relating to provider collaboration, Group operating models, and system governance arrangements across the Black Country.
- 7.7 Importantly, any future changes to governance structures, leadership arrangements, or organisational form would remain subject to formal consideration and approval by the relevant sovereign Boards and, where required, completion of the appropriate statutory and regulatory processes.

## 8. Risks

- 8.1 Potential risks associated with the proposed approach include:
- Risk of divergence between Group priorities and wider Black Country objectives
  - Potential duplication between Group and collaborative governance structures
  - Requirement for continued clarity regarding decision-making accountabilities
  - Maintaining equitable focus across place-based populations
- 8.2 These risks are considered manageable and materially lower than the risks associated with either organisational fragmentation across four standalone trusts or the creation of a single large-scale Group arrangement across all four organisations.

8.2 The proposed approach benefits from:

- Existing operational maturity
- Established leadership relationships
- Embedded collaborative behaviours
- Proven governance arrangements
- Existing regulatory assurance
- Incremental rather than disruptive organisational change

8.4 The continuation of the current arrangements therefore represents a lower-risk and more deliverable organisational model than undertaking major structural reorganisation at this stage of system maturity.

## 9. Recommendations

9.1. The proposed model reflects the principle that collaboration should occur at the most appropriate level: locally where operational proximity and place leadership are critical, at Group level where deeper integration improves delivery and resilience, and across the wider Black Country where scale and standardisation add greatest value.

9.2 The Group Public Trust Board Is asked to:

- a) **Formally** recognise the maturity and establishment of the two existing Group operating models across:
  - **Dudley and Sandwell**
  - **Wolverhampton and Walsall**
- b) **Approve** the continuation of the current operating structure comprising:
  - Two distinct Group models
  - Supported by the Black Country Provider Collaborative framework
- c) **Note** that sovereign organisational accountability and statutory Board responsibilities remain unchanged.
- d) **Support** the continued development of collaborative arrangements both within each Group model and across the wider Black Country system.
- e) **Approve** submission of the agreed future operating arrangements to NHS England following approval by the four sovereign Boards as part of ongoing regional engagement regarding provider collaboration and Group operating models across the Black Country.

Dan Conway, Associate Director of Corporate Governance/Company Secretary  
May 2026

# Joint Provider Committee – Report to Trust Boards

Date: 20<sup>th</sup> May 2026

<b>TITLE OF REPORT:</b>	Delegation of Annex A from partner Trusts to the Joint Provider Committee (JPC) for the agreed 2026/27 BCPC priorities.
<b>PURPOSE OF REPORT:</b>	To provide all partner Trust Boards of the Black Country Provider Collaborative (BCPC) with an opportunity for each Trust Board to consider delegating appropriate decisions to the Joint Provider Committee (“JPC”) to enable it to progress the 2026/27 BCPC priorities, and the underpinning workplan.
<b>AUTHOR(S) OF REPORT:</b>	Sohaib Khalid – <i>BCPC Managing Director</i>
<b>MANAGEMENT LEAD/SIGNED OFF BY:</b>	Sir David Nicholson - <i>Chair of BC JPC &amp; Group Chair of DGFT, SWBT, RWT, &amp; WHT</i> Gary Crowe – <i>Deputy Group Chair for DGFT</i> Lesley Writtle – <i>Deputy Group Chair for SWBH</i>
<b>KEY POINTS:</b>	<p>The following are the key points to note:</p> <ul style="list-style-type: none"> <li>▪ A quorate JPC was held on 26<sup>th</sup> February 2026 which discussed and approved the BCPC priorities within two key programmes of work to be overseen and managed by JPC.</li> <li>▪ This is consistent with the formal requirements of the Collaboration Agreement which requires an annual review of delivery / progress and agreement of priorities for progression at scale through partnership aligned to the agreed 3 scope areas.</li> <li>▪ The annual budget of the BCPC has been reduced by 50% to £1m for 2026/27. In parallel, the priorities have been focused into two work programmes – clinical service transformation and corporate service transformation.</li> <li>▪ Governance arrangements will be adjusted with a refreshed BCPC Executive established, alongside a re-invigorated PMO arrangement and minor updates to key schedules of the Collaboration Agreement e.g. Terms of Reference.</li> <li>▪ The BCPC partner Trusts and Group Boards are asked to reiterate and endorse the priorities and give effect to these proposals by making the delegations sought and ensure that local SORDs (Schemes of Reservation and Delegations) and / or SFI’s (Standing Financial Instructions) are appropriately adjusted to reflect these delegations (if required).</li> </ul>
<b>RECOMMENDATION(S):</b>	<p>Each of the BCPC partner Trust Boards are asked to:</p> <ol style="list-style-type: none"> <li>a) <b>RECEIVE</b> this report</li> <li>b) <b>NOTE</b> the agreed BCPC priorities for 26-27 as outlined at 1.3 in section 1</li> <li>c) <b>APPROVE</b> the delegations sought in Annex A to this report and adjust the Trust SORD / SFI to reflect the delegations made (if required)</li> </ol>
<b>CONFLICTS OF INTEREST:</b>	There were no declarations of interest.

<b>DELIVERY OF WHICH BCPC WORK PLAN PRIORITY:</b>	The JPC oversees and assures progress against the agreed BCPC priorities, as outlined in schedule 3 (and updated annually in Annex A) of the Collaboration Agreement.
<b>ACTION REQUIRED:</b>	<input type="checkbox"/> Assurance <input checked="" type="checkbox"/> Endorsement / Support <input checked="" type="checkbox"/> Approval <input type="checkbox"/> For Information

**Possible implications identified in the paper:**

<b>Financial</b>	<p>The following agenda items have a potential financial implication:</p> <ul style="list-style-type: none"> <li>▪ The BCPC annual workplan – budget required for delivery which will be apportioned to each of the four partner Trusts</li> <li>▪ Corporate Services Transformation programme of work, for which resource requirements are yet to be determined.</li> <li>▪ Clinical Service Transformation work may require some capital resource in some of the early proposed changes.</li> </ul>
<b>Risk Assurance Framework</b>	<p>The following agenda items have a potential risk implication:</p> <ul style="list-style-type: none"> <li>▪ The BCPC 26 / 27 annual workplan – capacity and capability to deliver the agreed workplan.</li> <li>▪ Corporate Services Transformation – require a clear plan of planned efficiency savings, productivity improvement, and resilience.</li> </ul>
<b>Policy and Legal Obligations</b>	N/A
<b>Health Inequalities</b>	<p>The following agenda item has a potential health inequalities implication:</p> <ul style="list-style-type: none"> <li>▪ Clinical and Corporate Service Transformation – there will be potential implications of a specialisation and consolidation service model pursued for best use of resources and key benefits such as resilience, improvement and productivity. Health Inequity Assessments will be required to assess these on a case-by-case basis.</li> </ul>
<b>Workforce Inequalities</b>	<p>The following agenda item has a potential health inequalities implication:</p> <ul style="list-style-type: none"> <li>▪ Clinical Service Transformation work will require workforce modelling to ensure there are no workforce inequalities.</li> </ul>
<b>Governance</b>	<p>The following agenda item has a potential health inequalities implication:</p> <ul style="list-style-type: none"> <li>▪ Corporate Services Transformation – decision making may have potential governance implications for sovereign Trusts.</li> <li>▪ Adjustment of partner Trust SORD / SFI (if required).</li> </ul>
<b>Other Implications (e.g. HR, Estates, IT, Quality)</b>	N/A

# Annex A: Delegation

## 1. CONTEXT

- 1.1 At its meeting on 26<sup>th</sup> February 2026 the BCPC Joint Provider Committee (“JPC”) approved a set of work priorities considered best undertaken once together at scale, that form the workplan for the period between 1<sup>st</sup> April 2026 and 31<sup>st</sup> March 2027.
- 1.2 For 2026/27 the workplan is focused on two programmes which are:
- **Clinical Service Transformation Programme** – a small defined number of service changes at scale across the BC system
  - **Corporate Service Transformation Programme** – focused on consolidating key corporate service at scale across the BC system
- 1.3 Against this context, the initial specific priorities agreed for completion include the following:
- **Existing Clinical Transformation work** - Breast Reconstruction, Endometriosis, ENT transformation, Gynae-Oncology, Pharmacy Aseptics, Urology-Renal & Bladder Cancer
  - **Clinical work at scale** - Colorectal (new service models), Surgical Robotic strategy
  - **Fragile services** - Breast Unit review, Future of BC Oncology services, Community Paediatrics – all subject to paper or Outline Proposal(s) being approved
  - **Corporate Service Transformation** - confirm the Phase 2 programme of work through appropriate governance arrangements and a Business Case
  - **Clinical Productivity** - consider a proposal from CMO’s in due course.
- 1.4 To that end, in addition to decision making that may occur through the Dudley Group Foundation Trusts (DGFT’s) and Sandwell & West Birmingham Hospitals NHS Trust (SWBH) Group CEO and their membership of the JPC, DGFT & SWBH seek to delegate the following matters to the JPC to enable these agreed priorities and supporting workplan to be efficiently and effectively progressed by all Partners through the BCPC JPC and to further align the Partners, as envisaged by and already agreed in accordance with the Collaboration Agreement.

## 2. DELEGATION

In accordance with the Standing Orders (SO), Scheme of Reservation and Delegation (SORD) and Standing Financial Instructions (SFI) of DGFT and SWBH, and pursuant to its statutory powers under section 65Z5 and 65Z6 of the NHS Act 2006:

- 2.1 The Joint Boards of DGFT and SWBH hereby resolves:

to delegate responsibility to the JPC for the carrying on of the following functions – consistent with the three scopes as part of the JPC’s terms of reference identified in section 1) and to update its governance framework accordingly:

- **Scope 1** - BCPC clinical and corporate service transformation programmes of work, focused across a small number of priorities outlined in section 1 above.
- **Scope 2** – Joint Exercising of some agreed Partner Trust responsibilities as currently incorporated in the priorities & workplan and focused on supporting delivery of things best done at scale once centred on issues such as strategic & capital planning, performance

oversight, and system business cases. Specifics include:

- a) Lead and collaborate for the development and delivery of the BCPC clinical service transformation programme.
- b) Lead and collaborate for the development and delivery of the BCPC corporate services transformation programme (CSTP), for which on-going delivery is to be managed through JPC
- c) Oversight for strategic developments to ensure service delivery alignment across the four partners of the BCPC and connectivity with the wider health system.
- d) Oversight for monitoring and reviewing of system wide performance across the four partners of the BCPC
- e) Oversight for the commissioning of any external 'Delivery Partner(s)' and their on-going delivery of support to the partner organisations.
- f) Oversight for the development of further integrated system working
- g) Co-ordination of Strategic & Annual Planning processes (where appropriate) across the four Partner Trusts.

together the "Delegated Functions."

2.2 The Joint Board of DGFT and SWBH acknowledges that there is a further 'scope' area, Scope 3 – BC ICB delegations, which is not active in 2026/27. The Board will keep this area under review and may consider whether further delegations are appropriate in the future.

2.3 The identified BCPC priorities and supporting workplan are focused primarily within scope 1 and scope 2 (as outlined in 2.1 above) for 26/27.

2.4 The role of the JPC in exercising the "Delegated Functions" includes:

- Carrying out any relevant needs and/or opportunities assessment or analysis, including regular reviews of such assessment and analysis, with a view to service development, improvement and/or transformation as per Scope 1 and the best discharge of the Partner Trust responsibilities referenced in Scope 2.
- Identifying and assessing what changes are needed to meet any unmet needs or to take advantage of identified opportunities, together with any risks and benefits that they entail and taking into account any necessary public involvement or other engagement processes and any other steps mandated by law or statutory guidance.
- Designing preferred options to meet any unmet needs or to take advantage of identified opportunities, which may include making recommendations to DGFT and SWBH as to the proposed way forward, and implementing any such recommendation that is approved.
- Actively managing and overseeing the delivery and performance of any of the BCPC work programmes for these purposes.
- Ensuring that it obtains value for money on behalf of DGFT and SWBH in any decisions made for these purposes.
- Implementing and overseeing information, reporting and recording requirements in respect of any such programmes of work to ensure progress and evaluate success.

2.5 These matters shall be delegated to the JPC with effect from 1<sup>st</sup> April 2026 (“the Effective Date of Delegation”), subject to the limits set out below.

2.6 In exercising the Delegated Functions, the JPC shall:

- Notify the Board of DGFT and SWBH within an appropriate time period but not greater than 30 days of any actionable act or omission or purported act or omission by the JPC to properly discharge the Delegated Functions.
- Work with partners to respond to any requests for information from the public and media on the matters covered by the Delegated Functions, including requests made pursuant to the Freedom of Information Act 2000.
- Provide further information and assistance as required by the DGFT and SWBH on any aspect of the JPC’s exercise of the Delegated Functions.

### **3. LIMITS**

3.1 The JPC shall exercise the Delegated Functions in accordance with:

- the Collaboration Agreement, including the agreed Objectives and Collaborative Principles
- all applicable law and guidance and in line with good practice.

3.2 The JPC may not delegate any or all of the Delegated Functions to the BCPC Executive except in relation to operational delivery and implementation.

3.3 The JPC may only exercise the Delegated Functions where:

- DGFTs and SWBH’s Group CEO and Deputy Chairs are present as part of the quorum of the JPC when making a decision on the Delegated Functions affecting DGFT and SWBH.
- Special arrangements are made to enable a decision to be taken urgently, when it is not possible for the JPC to meet, which are approved by the Joint Board of DGFT and SWBH.

### **4. REPORTING**

4.1 The JPC shall provide a written report to the Trust Board after each meeting through the Deputy Chairs, providing a summary of any decisions made by the JPC on the Delegated Functions and any progress against the workplan, together with relevant extracts from any minutes of decisions on the Delegated Functions taken at JPC meetings.

4.2 The Trust Board may require one or more members of the JPC to attend a meeting of (or to answer questions from or provide information to) the Trust Board.

### **5. ACCOUNTABILITY AND LIABILITY**

5.1 Accountability and liability for the exercise of the Delegated Functions on behalf of the DGFT and SWBH shall remain with DGFT and SWBH at all times.

Made on [date] at a quorate meeting of the DGFT Board held at [location].