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

Board of Directors (Group) Meeting Public Papers

Thursday 22nd July 13:00 – 16:30

Lecture Theatre, Midland Metropolitan University Hospital, Smethwick, B66 2QT

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

Board of Directors (Group)
Wednesday 22nd July 13:00hr
Lecture Theatre, Midland Metropolitan University Hospital, Smethwick, B66 2QT

AGENDA

Item		Paper ref.	Lead	Purpose & scope (SWB/DGFT/Both)	Time
1.	**Note of apologies**	Verbal	Chair	For noting Both	13:00
2.	**Declarations of Interest** Click here for Dudley Register of Interests Click here for Sandwell Register of Interests		Chair	For noting Both	
3.	**The Sandwell Patient Story** – Introduced by M Roberts, Group Chief Nurse Electronic Prescribing for System/ One Palliative Care				13:05
4.	**Strategy in Action** - Role of digital in transforming service	Presentation	A Thomas	For discussion / approval Both	13:15
5.	**Minutes of the previous meetings** Wednesday 20th May 2026 Action Sheet	Enclosure 1a Enclosure 1b	Chair	For approval Both	13:35
6.	**Chief Executive's Report** *Supplementary information in further reading pack*	Enclosure 2	D Wake	For information & assurance Both	13:40
7.	**Chair's Update** - Public questions	Verbal	Chair	For information/ approval Both	13:55
8.	**Integrated Committee upwards assurance report** *Quadrant reports in further reading pack*	Enclosure 3	L Writtle	For assurance Both	14:00
9.	**Financial Position Month 2 (May 2026) including Cost Improvement Plan update** - Sandwell & West Birmingham Hospitals NHS Trust - The Dudley Group NHS Foundation Trust	Enclosure 4a Enclosure 4b	M Parmar C Walker A Thomas	For assurance Both	14:15
10.	**Sandwell & West Birmingham Hospitals NHS Trust –** Addressing Financial and Operational Non-Compliance	Enclosure 5	M Parmar	For assurance SWB	14:25
11.	**EPRR Annual Report, EPRR and Business Continuity Policy** - Sandwell & West Birmingham Hospitals NHS Trust - The Dudley Group NHS Foundation Trust *Supplementary information in further reading pack*	Enclosure 6	J Newens /J Richards	For assurance Both	14:35
12.	**Comfort break**				
13.	**Our Patients** Deliver high-quality care, by the right person, in the right place at the right time				14:50
14.	**Group Chief Nurse & Group Chief Medical Officer Report**	Enclosure 7	M Anderson / M Roberts	For assurance Both	

15.	**Integrated Quality & Operational Performance Report**	Enclosure 8	M Anderson /J Richards/ M Roberts	For assurance Both	
16.	**Clinical Services Plan** *Supplementary information in further reading pack*	Enclosure 9	M Anderson / M Roberts	For approval Both	
17.	**Baron Amos National Maternity and Neonatal Independent Investigation** Sandwell & West Birmingham Hospitals NHS Trust *Supplementary information in further reading pack*	Enclosure 10	M Roberts	For assurance Both	
18.	**Group Perinatal report** *Supplementary information in further reading pack*	Enclosure 11	M Roberts	For assurance Both	
19.	**Anti-Microbial Prescribing** performance against national target/ action plans - The Dudley Group NHS Foundation Trust - Sandwell & West Birmingham Hospitals NHS Trust	Enclosure 12	M Roberts	For approval Both	
20.	**Our People** Be a brilliant place to work and thrive through happy, engaged, productive teams				15:35
21.	**Chief People Officer Report** Culture change & Improvement	Enclosure 13	J Fleet	For assurance Both	
22.	**Our Population** Work together with our partners to improve life chance and health outcomes				15:45
23.	**Anchor Organisations - update** *Supplementary information in further reading pack*	Enclosure 14	S Cornfield	For assurance Both	
24.	**Governance matters**				15:55
25.	**Risk Management Framework** *Supplementary information in further reading pack*	Enclosure 15	M Roberts	For approval Both	
26.	**Risk Appetite Statement**	Enclosure 16	H Board	For approval Both	
27.	**Group Board Architecture Framework** *Supplementary information in further reading pack*	Enclosure 17	D Wake	For approval Both	
28.	**Board Assurance Framework 2026/27**	Enclosure 18	D Conway/ H Board	For approval Both	
29.	**Any Other Business**				
30.	**Meeting close** **Date of next Board of Directors meeting** Wednesday 18 September 2026 Sandwell Health Campus, Hallam Street, West Bromwich, B71 4HJ				16:30

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

Unconfirmed Minutes of the Group Board of Directors meeting (Public session)
held on Wednesday 20th May 2026 14:00hr
Clinical Education Centre, 1st Floor, South Block, Russells Hall Hospital, Dudley, DY1 2HQ

Present:
Mark Anderson, Medical Director, SWB) (MA)
Rachel Barlow, Group Chief Development Officer, Group Deputy CEO (RB)
Laura Broster, Group Chief Communications Officer (LB)
Giselle Carter-Sandy, Deputy Chief Operating Officer (SWB) (GCS)
Gary Crowe, Deputy Chair (DGFT) (CG)
Peter Featherstone, Non-executive Director (PF)
James Fleet, Group Chief People Officer (JF)
Mike Hallissey, Non-executive Director (MH)
Lorraine Harper, Non-executive Director (LH)
Catherine Holland, Non-executive Director, Senior Independent Director (CH)
Paul Hudson, Medical Director, DGFT (PH)
Marsha Jones, Director of Nursing (DGFT)
Martina Morris, Chief Nurse & Deputy Group Chief Nursing Officer (DGFT) (MMo)
Mohit Mandiratta, Non-executive Director (MMa)
Sir David Nicholson (SDN) **Chair**
Jonathan Odum, Group Chief Medical Director (JO)
Madi Parmar, Director of Finance (SWB) (MP)
Vij Randeniya, Non-executive Director (VR)
Jack Richards, Interim Chief Operating Officer (DGFT) (JR)
Kat Rose, Interim Chief Partnership Officer (KR)
Jatinder Sharma, Non-executive Director (JS)
Nicky Taylor, Director of Nursing (SWB)
Valerie Taylor, Non-executive Director (VT)
Adam Thomas, Group Chief Strategy & Digital Officer (AT)
Chris Walker, Director of Finance (DGFT) (CW)
Diane Wake, Chief Executive (DW)
Lesley Writtle, Deputy chair (SWB) (LW)

In Attendance:
Helen Attwood, Directorate Manager (Minutes) (HA)
Helen Board, Board Secretary (HB)
Dan Conway, Associate Director of Governance/Company Secretary (SWB) (DC)
Claire Mcdiarmid, Interim Group Director of Midwifery [item 15]
Kelly Pettifer, Director of Operations, Surgery Division (DGFT) [Strategy in Action]
Sr Alison Pyatt-Payne, (Team Leader, Day Surgery Ward) (DGFT) [Strategy in Action]
Hywel Rees, Directorate Manager, Theatres, Critical Care, Anaesthesia, Pain and Pre-op [Strategy in Action]
Lucy Smith, Macmillan Trust Lead Cancer Nurse [Patient story]

Apologies:
Rachel Hardy, Non-executive Director (RH)
Karen Kelly, Chief Officer, Fit for the Future (KK)
Mick Laverty, Non-executive Director (ML)
Johanne Newens, Chief Operating Officer (SWB) (JN)
Mel Roberts, Group Chief Nurse (MR)
Lowell Williams, Non-executive Director (LW)

Governors, Staff, Members of the Public and External attendees:
Alex Giles, Public Elected Governor, Stourbridge, Lead Governor
Anser Khan, staff member, GMB & MLG (SWB)
Ken and Barbara Pritchard, Foundation Trust Members
Nandi Shelembe, Foundation Trust Member
Grahame Tibbetts, Foundation Trust Member and Trust volunteer
Helena Vasconcelos, Staff member (DGFT)

26/01.0 Apologies and Welcome

The Chair opened the meeting and welcomed all to the first meeting of the Group Board as a Committee in Common between Sandwell and West Birmingham Hospitals NHS Trust and The Dudley Group NHS foundation Trust. The Chair welcomed Board and Trust colleagues, Foundation Trust members and the Lead Governor.

Apologies had been received as listed above.

26/02.0 Declarations of Interest

The Chair 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.

26/03.0 Patient Story – One Stop Biopsy

The meeting was joined by Lucy Smith; Macmillan Trust Lead Cancer Nurse and the item was introduced by MMo.

The Board heard about the Direct to Surgery Skin Cancer Project at The Dudley Group NHS Foundation Trust. It was noted that the pilot had been developed to streamline pathways for suspected skin cancer referrals, improve performance against cancer targets, and enhance patient experience through reduced hospital visits and improved use of surgical hub capacity. The Board noted that all patients had been treated safely and within national targets, with overwhelmingly positive patient feedback and improved operational efficiency, including increased consultant capacity.

The Board further noted the key learning from the pilot, including the importance of collaborative working, clear communication, and continuous improvement in delivering service transformation. It was recognised that the project had demonstrated strong alignment with strategic objectives and provided a foundation for future expansion, with plans to scale the model across additional sites and further develop one-stop pathways within the surgical hub.

SDN commented that the point of the Trust Strategy is to make sure we are all aligned. He commented that the future of the NHS depends on staff like Lucy and her colleagues coming up with new pathways and initiatives.

PH asked about opportunities for delivering in the Community. LS confirmed that this was absolutely a pathway could be delivered in the Community.

NT commented that she would be happy to work with LS to share learning with Sandwell.

JR commented on Cancer Services overall and welcomed the use of technology for improving patient experience.

RH asked what the Board could do to help others develop services. LS would welcome a forum to discuss issues and that could help with the delivery of change.

SCS asked if there was patient pre-engagement. LS confirmed that she hadn't don't this but was aware that telephone engagement already worked well for our patients and there had been no issues around communication.

SDN commented on the remarkable story and that it is possible for staff to make change happen and thanked LS for her exemplar work.

It was **RESOLVED** to

- Note the patient story

26/04.0 Strategy into Action

AT introduced colleagues Kelly Pettifer, Director of Operations, Surgery Division (DGFT), Sister Alison Pyatt-Payne, (Team Leader, Day Surgery Ward) (DGFT) and Hywel Rees, Directorate Manager, Theatres, Critical Care, Anaesthesia, Pain and Pre-op.

The Board received a presentation on the Dudley Elective Surgical Hub at Russells Hall Hospital, outlining its role as a dedicated, ring-fenced facility delivering high-volume elective surgery with a focus on productivity, patient flow, and quality outcomes. It was noted that the Hub operated as a standalone unit with dedicated staff and facilities, achieving high utilisation and supporting streamlined pathways through pre-operative assessment, day surgery theatres, and minor procedure rooms. The Board noted that the Hub had achieved GIRFT Elective Surgical Hub accreditation following a formal assessment process in 2025, with ongoing monitoring to support continuous improvement in utilisation, governance, and patient experience

The Board noted that, over the previous year, the Hub had delivered care to more than 10,000 patients across multiple specialties, with initiatives such as high-intensity theatre lists, "Super Saturday" clinics, and one-stop pathways contributing to improved access, reduced waiting times, and excellent patient feedback. It was recognised that the Hub aligned strongly with strategic objectives, enhancing patient experience, supporting workforce engagement, and improving population health outcomes.

GC confirmed that he was part of the accreditation visit and was very proud of the work being undertaken by the team. He asked about the impact on productivity and uptake from other areas. HR confirmed that there has been a 3% increase in productivity and 85% utilisation (which is third best performance in the Region). We continually look at how we can improve further.

VR asked about Theatre utilisation rates and asked about the options for patients who would want surgery outside of the current 9am to 5pm coverage. It was noted that it was possible to attend during a weekend.

SDN welcomed the fantastic presentation and thanked the team for their contribution.

It was **RESOLVED** to

- Note the planned next steps, including further expansion of capacity, increased use of minor procedure facilities, and continued digital development to strengthen pre-operative pathways and overall efficiency

26/05.0 Minutes of the previous meeting held on 15th January 2026
The minutes of the meetings held on the following dates were reviewed:

- Wednesday 11th March – Sandwell and West Birmingham Hospitals NHS Trust
- Thursday 12th March – The Dudley Group NHS foundation Trust

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

Action Sheet of 15th January 2026

Dudley
26/9.4 Perinatal Quality Surveillance Dashboard data supporting the heatmap to be explained in more detail at the next Board meeting. On agenda – closed

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 met and action closed

Sandwell
Action 1 – evaluation and impact of winter plan to be presented to board On agenda – closed

26/06.0 Chief Executive's Overview and Operational Update

DW summarised her Chief Executive's report given as enclosure two and noted key updates including national recognition through the NHS Excellence Awards and the successful opening and early operation of the Midland Metropolitan Learning Campus.

The Board noted improvements in urgent and emergency care performance across both Trusts, including ambulance handover times and Emergency Access Standard performance, despite ongoing demand pressures. DW personally thanked JR and his teams for their efforts.

The Board reviewed elective and cancer performance, noting progress in reducing long waits and improving access, alongside continued challenges in some pathways and specialties requiring focused action.

The Board noted updates on the National Oversight Framework and clarification regarding the ongoing statutory role of Foundation Trust Governors, with no immediate changes to governance arrangements.

The Board recognised a range of charity initiatives, staff recognition achievements, and awards across both Trusts, highlighting workforce contribution, resilience, and long service.

The Board noted positive patient feedback and a broad programme of engagement activity, visits, and events undertaken across March and April 2026.

JS welcomed the work on the Health Campus.

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.

26/07.0 Chair's Update

26/07.1 Appointment of Senior Independent Directors

Sandwell and West Birmingham NHS Trust
The Board considered a report seeking approval for the appointment of a Senior Independent Director (SID), noting the importance of the role in supporting effective governance, providing

challenge to the Chair, and acting as an additional point of contact for stakeholders. Following an internal expression of interest process and assessment by the Chair, the Board approved the appointment of Jatinder Sharma, recognising his experience, leadership, and strong contribution as a Non-Executive Director, which were considered well aligned to the requirements of the role.

The Board also recorded its thanks and appreciation to Mick Laverty for his service as SID, acknowledging his valued leadership, support, and contribution during a significant period of organisational development. It was noted that the appointment would support continued strong governance, with no additional financial implications beyond existing arrangements, and would take immediate effect following approval.

The Dudley Group NHS Foundation Trust
The Board considered a report seeking endorsement of the appointment of a Senior Independent Director (SID) for The Dudley Group NHS Foundation Trust, noting that final approval would be subject to endorsement by the Council of Governors.

SDN commented on his recent attendance at the Improving Race Equality event the previous week and how we would work to improve equality and diversity within the organisation.

Public Questions
Question received from Grahame Tibbetts, Foundation Trust Member Patient experience. Are there any plans to introduce touch screen technology for patient to self-attend. (as found in the GP surgery). With the intention of improving the patient's hospital experience.

AT confirmed that there were patient kiosks across the Group with plans to introduce touch screen and smartphone technology as part of our outpatient transformation programme.

Question received from Ansar Khan, staff member at the Sandwell Trust and GMB & MLG, as follows; There are concerns within the community that services will be merged, requiring local residents from Aston Witton and others local area to travel to Dudley for appointments. Additionally, given the financial difficulties facing the Trust, will services be cut, and what impact could this have on the local community?

KR confirmed that the Trust's were using opportunities work together for the benefit of our patients and part of that work is to move more services to the community/closer to patients.

The Chair confirmed that both questions will be answered in detail in writing.

26/08.0 Integrated Committee Upward Assurance Report

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

Advise
The Integrated Committee Chairs Report, provided a consolidated overview of assurance across sub-committees and highlighted key priorities aligned to the refreshed Board Assurance Framework (BAF). It was noted that the report marked the first joint assurance framework across both Trusts, strengthening alignment between committee oversight, strategic risks and BAF scoring. The Board was advised of the importance of developing integrated approaches, particularly through joint quality governance and partnership working, and the need to maintain a strong focus on forward-looking assurance and delivery actions to improve BAF positions.

Assure

The Board received assurance in several areas, including progress in maternity services improvement, learning from joint quality committee working, and positive developments such as the Sandwell Learning Campus and Dudley Charity activity. It was noted that governance arrangements were strengthening, with evidence of effective oversight, cross-Trust collaboration, and improving quality management systems. Reasonable assurance was also noted in areas such as sickness absence management, where enhanced tools and interventions were being implemented to support workforce wellbeing and performance.

Alert
The Board was alerted to significant risks relating to financial sustainability, workforce planning, and operational delivery, with **limited or partial assurance** in key areas.

It was noted that while both Trusts had delivered year-end positions, these were reliant on non-recurrent measures, and concerns remained regarding the maturity and delivery of the 2026/27 CIP programme, particularly at Sandwell and West Birmingham. Workforce plans were not yet sufficiently developed to provide full assurance, and issues were also highlighted within quality (including complaints, service capacity, and clinical letter backlogs) and medical job planning and patient nutrition at Sandwell.

These risks were directly linked to BAF priorities, notably financial sustainability (SWB BAF 002 / Dudley BAF 4.0), workforce (SWB BAF 003 / Dudley BAF 2.0), and quality and performance (SWB BAF 001 / Dudley BAF 1.0), and required strengthened oversight, clearer accountability, and accelerated delivery of improvement actions

JR updated the Board on the outstanding clinical letters and confirmed that there was a trajectory in place to clear all outstanding letters. The use of AI going forward would significantly improve productivity. No harm had been identified as a result of the outstanding letters. PH added that no backlogs existed that related to urgent or cancer patients.

MMo confirmed that the increase in complaints in March had been escalated and a deep dive was being undertaken and an end-to-end mapping of the whole complaints process. Complaints numbers had reduced in April. An update would be presented to the Quality Committee in June and noted review activity underway against the patient experience framework. GC asked if the incidents were considered as a Group. MMo confirmed that the Quality Committee reviewed all issues to gain assurance ahead of an update to the next Board.

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

26/09.0 Joint Provider Committee

The Board received a report given as enclosure 4a summarising the Joint Provider Committee meeting held on 1 May 2026, noting that governance arrangements were progressing and that the Black Country Provider Collaborative workplan had been streamlined to focus on two core programmes within a reduced budget.

It was noted that progress continued across the Clinical Service Transformation Programme, with developments in key pathways including breast reconstruction, urology, vascular and endometriosis, alongside ongoing challenges in areas such as pharmacy aseptics capacity.

The Board noted progress within the Corporate Service Transformation Programme, including opportunities to improve productivity and standardise services across recruitment, occupational health, research and development, and digital enablement. It was highlighted that further work was required to develop governance arrangements, procurement approaches and a Managed Shared Service model, including decisions regarding hosting arrangements to support future delivery.

The Board further noted that no immediate changes were proposed to existing hosting arrangements, including Black Country Pathology Services, but that these would be reviewed as part of future shared service development.

It was **RESOLVED** to

- agree that further work would continue to explore the most appropriate collaborative models and identify opportunities to align priorities, consolidate services, and spread best practice across the system

26/10.0 Finance Report Month 12 (March 2026)

Sandwell and West Birmingham Hospitals NHS Trust
The Board received the Month 12 Finance Report given as enclosure five for March 2026, noting that the Trust reported a year-end deficit of £12.6m, in line with the revised plan agreed with NHS England, although adverse to the original breakeven plan. It was noted that this reflected a reassessment of income risks during the year and that the wider healthcare system achieved an overall break-even position. The Board also noted that the figures remained draft and unaudited, with final accounts subject to external audit approval.

The Board noted that performance was influenced by a favourable income position, largely driven by centrally funded pension costs, offset by significant pressures on pay expenditure, including industrial action, maternity costs, and elective activity delivery. It was further noted that non-pay pressures, including asset impairments and redundancy costs, also contributed to the overall position. Capital expenditure was broadly in line with plan, with a small underspend, and the year-end cash position was favourable due to timing of funding.

The Board noted that delivery of the Cost Improvement Programme (CIP) achieved approximately 80% of target; however, only 39% of savings were recurrent, which would create further financial challenge in 2026/27. It was recognised that the original financial plan had been highly ambitious, requiring in-year mitigation actions, and that future financial sustainability would depend on delivering a more robust and recurrent CIP programme, alongside strengthened financial control and performance management.

The Chair commented on the amount of CIP delivered on a recurring basis adding that there was no fully developed CIP plan and resulted in the minimal assurance as raised under the Committee Assurance Report. MP confirmed that there would be a fully developed CIP plan available by the end of June. VT asked about workforce growth being above plan and the reliance on bank staff. JF confirmed that he would update the Board under his Workforce Report.

The Dudley Group NHS Foundation Trust
The Board received the Month 12 Financial Position report given as enclosure 5a and noted that the Trust achieved a year-end surplus of £3.284m, exceeding the planned position following the inclusion of deficit support funding. It was noted that the Trust met both its financial and capital control totals for 2025/26 and that the wider system also delivered a small surplus position. The Board recognised that this performance reflected a combination of operational delivery and external financial support.

The Board noted that the reported position had been supported by favourable income, including one-off funding streams and contract settlements, but was offset by continued cost pressures. Pay expenditure remained above plan due to workforce levels, industrial action, and capacity pressures, while non-pay costs were also adverse, driven by increased drug, device and clinical supply costs. It was further noted that the Cost Improvement Programme under-delivered against plan, contributing to underlying financial pressures.

The Board recognised that the underlying financial position had deteriorated, with increased reliance on non-recurrent income to achieve the year-end position. It was noted that this would create additional financial challenges for 2026/27, including the requirement to deliver further cost improvements and reduce reliance on bank and agency staffing. The Board noted that sustained financial stability would depend on strengthened cost control, delivery of recurrent savings, and improved workforce productivity.

It was **RESOLVED** to

- Note the financial performance for Month 12 (March 2026)

26/11.0 Group Strategy 2026-2031

AT presented the report given as enclosure six.

The Board considered the Group Strategy 2026–2031, noting that it had been developed over several months with input from Board discussions, partners, and wider stakeholder engagement. It was noted that feedback on the strategy had been largely positive, with broad support for the vision, strategic objectives, and commitments, particularly the focus on prevention, population health, and care closer to home, although respondents highlighted the need for stronger clarity on partnership working and delivery.

The Board noted that the Strategy set out a shared vision for both Trusts operating within a Group model, aiming to respond to rising demand, financial pressures, and health inequalities through a shift towards community-based care, prevention, and digital enablement. Key commitments included delivering more care closer to home, strengthening partnerships, improving workforce experience and culture, and ensuring better use of resources to support long-term sustainability. It was recognised that the strategy aligned with national policy direction and emphasised improving access, simplifying pathways, and enhancing patient and staff experience.

The Board further noted the planned approach to implementation, including delivery through the Fit for the Future programme, supported by aligned operational plans and clear measures of success across quality, access, workforce and financial performance. It was highlighted that a joint Board Assurance Framework would underpin delivery by identifying and managing key strategic risks, with ongoing monitoring through Board and committee structures to ensure progress against the Strategy.

AT thanked all stakeholders, Board members, staff and in particular Ian Chadwell, Martin Chadderton, Peter Lowe, Emily Smith, Laura Broster and Mark Breen who have all contributed to the production of the Strategy.

CH welcomed that structure and language of the Strategy. GC agreed about the improvements on previous draft. He welcomes the embedding of improvement themes. LH added that it was disappointing that there was no focus on Research. AT confirmed that this would be developed further in the underpinning work of the Strategy.

LW commented on the importance of the influence on other supporting plans. The deployment of our plan/delivery of our services is critical. JS welcomed the focus on people and Place and sense of belonging rather than corporate KPIs. RH welcomed the document and looks forward to seeing how we bring it to life over the coming months.

The Chair commented on the strength of the document and how the Strategy was the overarching direction for the Board to lead the organisation. The Chair thanked AT for his contribution.

It was **RESOLVED** to

- **Approve** the Group Strategy 2026–2031

Comfort Break

26/12.0 Our Patients

26/12.1 Chief Nurse and Medical Director Report

JO and MMo presented the first joint Group Chief Nursing Officer and Chief Medical Officer report given as enclosure seven, noting that it provided updates across assurance, advisory, and alert areas for both Trusts. The Board noted the alert regarding the Sandwell Children We Care For service, where staffing levels were currently insufficient against national guidance, and that this risk had been escalated to the ICB for review of contractual arrangements and funding requirements.

The Board noted that industrial action by resident doctors had been effectively managed across both Trusts, with approximately 95% of elective activity maintained and no significant safety concerns reported. It was also noted that ongoing staff engagement initiatives, celebrations of professional achievements, and national recognition of clinical work demonstrated positive workforce engagement and innovation, alongside continued focus on addressing health inequalities and improving clinical pathways. MA asked the Board to note that the percentage of Doctors taking industrial action at Dudley was higher than detailed in the paper and was more in line with Sandwell's figures.

The Board received assurance that safer staffing arrangements at Dudley were generally effective, with no significant safety concerns identified, although increasing patient acuity and pressures on patient experience were noted. The Board further noted improvements in quality and governance, including compliance with corridor care standards at Sandwell, enhanced stroke service performance, and effective harm review processes across both organisations, supporting shared learning and continuous improvement.

MMa commented on the higher percentage of Doctors taking action at Sandwell. MA confirmed that Sandwell were actually aligned with numbers striking at other Trusts and Dudley was an outlier (lower).

LH commented on the need for Research to included in the Strategy as its part of the core business for the NHS.

Action To invite the mentioned Gynaecologist who had undertaken key research to deliver a patient story at a future Board meeting. **PH**

It was **RESOLVED** to
- **receive** the report for assurance

26/12.2. Integrated Quality and Operational Performance Report

The report given as enclosure eight was taken for assurance and the board noted it contained Dudley data that had been scrutinised by individual Committees related to the following highlighted items:

Advise
The Board received the Integrated Quality and Operational Performance Report for March 2026 for DGFT, noting continued pressures across staffing, infection control, and demand. It was advised that safer staffing metrics reflected increased reliance on temporary staffing and gaps in reporting, with rising patient acuity impacting delivery. The Board noted ongoing work to improve corridor care management, dementia pathway compliance, and infection prevention performance, alongside system developments to enhance reporting and benchmarking.

Assure
The Board received assurance that overall quality and performance remained stable, with evidence of a strengthening reporting culture, improved patient experience scores, and progress against key clinical indicators. Improvements were noted in sepsis management, vital signs compliance, ambulance handovers, and emergency access performance, alongside strong performance in reducing long waits and maintaining cancer and diagnostic trajectories in several areas. It was further noted that patient safety processes, including Duty of Candour and incident review mechanisms, remained embedded and effective.

Alert
The Board was alerted to areas requiring continued focus, including delays in discharge processes, declining elective performance against RTT standards, and whilst performance was positive, there was ongoing challenges in cancer pathways, particularly 31-day performance and histology turnaround times. Additional concerns included corridor care incidents, staffing pressures impacting care delivery, and variability in community and virtual ward performance. These risks were aligned to key Board Assurance Framework priorities relating to quality, workforce, and operational performance, and required sustained improvement action and oversight.

GC asked about the areas that were off trajectory. PH confirmed that in relation to Sepsis the Trust was reviewing the data as outcomes are good and confirmed that there was a good harm and mortality review process in place.

JR confirmed that in relation to RTT it was important to treat our urgent patients in a timely manner but continue to reduce the backlog of longer waiters.

MH asked about the reasons for the issue with date for discharge. JR confirmed that there was a problem with local authority capacity and out of area patients and noted that the position was improving.

GC raised the issue with Histology performance. MA confirmed that AI was being used to speed up turnround times adding that the problem was exacerbated with all samples being classed as urgent. An update on BPS performance would come to a future Board meeting.

The Chair commented on the use of AI to make Board papers more forward looking.

It was **RESOLVED** to

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

26/12.3 Group Perinatal Quality Oversight Report

Claire Macdiarmid, Interim Group Director of Midwifery presented the report given as enclosure nine and highlighted:

Advise
The Board received the Group Perinatal Quality Oversight report, noting continued improvement activity across both Trusts. It was advised that Dudley continued to demonstrate strong performance across maternity and neonatal services, with positive outcomes below national benchmarks and strengthened governance processes.
At Sandwell and West Birmingham, improvement work was ongoing, supported by enhanced training, workforce planning, and targeted actions to address known themes including induction pathways, triage, and interpreting services.

Assure

The Board received assurance that robust governance, review processes, and learning mechanisms were in place across both organisations. At Dudley, there was evidence of sustained improvement, low levels of safety concern, and effective implementation of learning from incidents, alongside improved training compliance. At Sandwell and West Birmingham, assurance was provided through regular incident reviews, improved learner experience, and the commissioning of a thematic review of stillbirths to strengthen organisational learning and quality improvement.

Alert
The Board was alerted to areas requiring continued focus, particularly at Sandwell and West Birmingham, including workforce vacancies, theatre capacity, and service pressures impacting maternity performance. It was noted that perinatal mortality rates remained higher than at Dudley and that ongoing risks related to workforce capacity, induction of labour pathways, and interpreting services were being actively managed. These issues were aligned to Board Assurance Framework priorities relating to delivery of safe, high-quality care and workforce sustainability, requiring continued oversight and improvement action.

The Chair raised the matter of stillbirth reviews and the national issue of the difference for people from a diverse background and others. CM confirmed that the review would identify a high level of detail.

The Board noted that the Baroness Amos report was expected soon and the Trust were prepared in their response to give confidence to our communities.

The Chair thanked CM and the Maternity teams for their work on a day-to-day basis.

It was **RESOLVED** 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

26/12.3 Winter Plan 2025/26 close out report

The Winter Plan close out report given as enclosure 10 was presented by GSC and JR.

Sandwell and West Birmingham NHS Trust
The Board noted that the Trust had delivered a structured, cost-neutral winter plan focused on admission avoidance, reduction in length of stay, and accelerated discharge. It was noted that performance improved early in the winter period, with delivery against Emergency Access Standard (EAS) and ambulance handover targets exceeding trajectory prior to October 2025, supported by operational improvements, use of Same Day Emergency Care, and strengthened discharge processes.

The Board noted that performance deteriorated later in the winter due to increased demand, higher patient acuity, reduced bed capacity, and extended lengths of stay, particularly following changes to community bed access. It was recognised that these factors impacted both ambulance handover times and EAS performance, with bed occupancy peaking at 97% and discharge delays becoming a significant challenge.

The Board further noted key learning and next steps, including the need to maintain focus on reducing length of stay, improving patient flow, and strengthening discharge pathways.
It was recognised that future plans would prioritise real-time data use, improved streaming from the front door, and continued development of system-wide flow solutions, supported by modelling and alignment with the Fit for the Future programme to improve resilience ahead of winter 2026/27.

The Dudley Group NHS Foundation Trust

The Board noted that the Trust had implemented a whole-system winter plan focused on reducing admissions, improving discharge, and managing demand through community and virtual capacity. It was noted that, although modelling predicted a requirement for approximately 100 additional beds, the Trust was able to contain demand to a significantly lower level, supported by improved discharge performance, reduced length of stay, and effective system coordination.

The Board noted that emergency attendances and patient acuity increased during the winter period, placing pressure on urgent and emergency care, particularly ambulance handover performance, which remained the most challenging area. However, it was recognised that key performance indicators were achieved, including exceeding EAS targets, reducing long waits, and maintaining strong ambulance handover performance following targeted improvement actions.

The Board further noted the key learning from the winter period, including the importance of early planning, system-wide accountability, and strengthened data visibility to support flow. It was recognised that ongoing programmes, including Learn, Adapt and Transform, would support further improvements in operational resilience, with a continued focus on patient flow, discharge coordination, and urgent care pathways in preparation for winter 2026/27.

The Board noted that preparation for the Group Winter Plan for next year was underway.

LW commented that it felt like the report had been written working in conjunction with partners and that was positive.

The Chair commented that the Trusts should not have a tactical Winter Plan; it needed to take account of the strategic direction going forward.

It was **RESOLVED** to

- **Note** the paper as an update on delivery against the 2025/26 winter plan

26/13.0 Our People

26/13.1 Chief People Officer report

JF presented the report given as enclosure 11 noting the refreshed format that highlighted:

Sandwell and West Birmingham NHS Trust
The Board noted continued progress across key workforce and organisational development programmes. It was noted that the Corporate Services Transformation programme remained on track, with Phase 1 delivery progressing well and plans for shared services developing, alongside the successful opening and early operation of the Midland Metropolitan Learning Campus, supporting education, employability and community development. Workforce indicators were reported as broadly stable, with turnover within target and strong bank fill rates supporting operational resilience, alongside ongoing staff engagement and leadership development initiatives.

The Board noted that workforce planning for 2026/27 included significant planned reductions in staffing levels, primarily through transformation programmes and cost improvement activity, with a continued focus on reducing bank and agency use while protecting critical roles. It was further noted that staff engagement activity, inclusion initiatives and talent development programmes were progressing, including a high level of participation in the High Potential Scheme and successful external funding for widening access programmes.
The Board was alerted to ongoing risks relating to workforce performance, particularly sustained levels of sickness absence and pressures in delivering workforce reductions against plan. It was noted that sickness absence remained structurally elevated and required continued focus through digital tools, early intervention and wellbeing support, alongside targeted management action to address workforce gaps and ensure delivery of workforce plans.

The Dudley Group NHS Foundation Trust
The Board noted positive progress in workforce development and transformation activity. It was noted that initiatives such as the implementation of Medi-rota within Medicine and Emergency Care were underway to support improved workforce planning and productivity, aligned to wider transformation programmes. Workforce indicators demonstrated stability, with turnover within target, strong bank utilisation, and continued progress in staff engagement and development, including participation in national talent programmes.

The Board noted that workforce plans for 2026/27 included planned headcount reductions delivered through the Learn, Adapt, Transform programme, divisional cost improvement plans and wider transformation initiatives. It was recognised that the focus would remain on reducing reliance on temporary staffing, maintaining robust workforce controls, and aligning staffing levels to operational demand and financial plans.
The Board was alerted to ongoing workforce pressures, including performance against plan and reliance on temporary staffing to support operational delivery, particularly during periods of increased demand. It was further noted that sickness absence remained elevated and represented a key strategic risk, requiring sustained intervention and improved workforce management approaches to support long-term productivity, wellbeing, and delivery of organisational objectives

VT asked about workforce growth being above plan and the reliance on bank staff. JF confirmed 100% of the 503 was Bank and also the majority for Dudley. Both Trust's had delivered a sizeable workforce reduction in the last 12 months, although despite the size of reduction both organisations failed to meet the Workforce Plan. He confirmed that both organisations have continued to see further workforce reductions since March 2026. VT asked if JF was giving the Board assurance that it was an affordable plan. JF gave assurance on the workforce reduction.

The Chair asked if the current workforce was affordable. JF confirmed that it was not currently affordable.

VR asked about the high-performance scheme. JF confirmed that it was also open to local authorities.

VT asked about the usage of Goodshape and whether it was cost effective. JF confirmed that 85% of the organisation was using Goodshape with over 18,000 reports of usage and were keen to see an impact on sickness levels.

It was **RESOLVED** to

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

26/13.2 Staff survey 2025

JF presented the report given as enclosure 12 and that included the findings from staff survey 2025;

Sandwell and West Birmingham NHS Trust
The Board noted a significant decline in staff experience, with engagement falling to 6.5 and all People Promise elements showing deterioration compared to the previous year. It was noted that scores were below national averages across all domains, with particular concerns in morale, advocacy, and perceptions of organisational support, reflecting the impact of organisational change, workforce pressures, and the opening of Midland Metropolitan University Hospital.
The Board noted key themes from the survey and free-text feedback, including concerns regarding workload, staffing levels, leadership visibility, and perceptions that financial pressures were affecting patient care and staff wellbeing. Variability in performance was also highlighted across divisions,

with corporate and medicine areas experiencing notable declines, although some areas such as imaging showed improvement following targeted interventions.

The Board noted that a comprehensive improvement plan was in place at Group, Trust and divisional level, focusing on learning and development, recognition, and staff health and wellbeing. It was recognised that action would be supported through strengthened local engagement, targeted support for low-scoring teams, and robust governance through the Joint People Committee to drive improvements in staff experience and engagement.

The Dudley Group NHS Foundation Trust
The Board noted a decline in staff experience, with engagement reducing to 6.5 and decreases observed across most People Promise elements, particularly in learning and development. It was noted that the Trust continued to perform below national averages, with sustained concerns in morale, career development opportunities, and access to training, despite some stability in flexible working indicators.

The Board noted feedback highlighting pressures relating to workload, staffing levels, leadership, and recognition, alongside concerns regarding wellbeing and burnout. Analysis demonstrated variability across divisions and teams, with some areas performing strongly, but others showing significant deterioration, particularly within community services and parts of medicine.

The Board noted that a structured improvement response had been developed, including targeted organisational development support for the lowest-scoring teams, strengthened engagement through line managers, and a focus on key priorities such as learning, recognition, wellbeing, and advocacy. It was recognised that delivery of these actions would be critical to improving staff experience, supporting retention, and enabling wider transformation programmes

CH confirmed that the People Committee would be monitoring action plans.

It was **RESOLVED** to

- **Note** assurance that the survey results have been fully analysed, understood and that a robust plan was in place to drive forward actions to secure improvements for future surveys.
- **Support** the key actions that were outlined in the report

26/14.0 Our Place

26/14.1 Neighbourhood Health Framework

Sandwell and West Birmingham NHS Trust
KR presented an update on the Neighbourhood Health Framework, noting the significant national shift from a hospital-centric model to a neighbourhood-based, population health approach, with Integrated Neighbourhood Teams (INTs) as the core delivery model. It was noted that the Trust was actively working with partners to implement place-based delivery models and identify locations for Neighbourhood Health Centres, aligned to national requirements and the Fit for the Future programme.

The Board noted that Sandwell and West Birmingham had made progress in preparing for this transition, including work on reducing length of stay, developing locality hub models and improving system flow. However, it was recognised that demand had remained high, with pressures on bed capacity and discharge pathways highlighting the need for further development of community capacity, step-down services, and integrated pathways to support care closer to home.

The Board further noted that future success would depend on strengthening partnerships with primary care and system partners, expanding neighbourhood delivery models, and aligning workforce, financial planning, and service redesign to support a reduction in hospital-based care. It

was recognised that this represented a fundamental cultural and operational shift requiring sustained organisational commitment and leadership at Place level.

The Dudley Group NHS Foundation Trust
The Board noted the requirement to transition towards neighbourhood-based care delivery, with a focus on prevention, integration, and care closer to home. It was noted that Dudley was working with partners to develop place-based models and identify priority sites for Neighbourhood Health Centres, supporting the delivery of integrated care across local populations.

The Board noted that progress had been made in developing priority pathways, including frailty and urgent care, alongside early implementation of integrated care models and neighbourhood planning. However, it was recognised that further work was required to reduce reliance on hospital-based care, strengthen community capacity, and improve coordination across primary, community and acute services.

The Board further noted that the Framework would require a fundamental shift in the Trust's operating model, including reductions in admissions and bed utilisation, and alignment to new population-based funding and contracting arrangements. It was recognised that delivering this model would depend on strong system leadership, enhanced partnership working, and development of workforce capability to support sustainable neighbourhood-based care.

The Chair asked about the neighbourhoods shown in the Annex and asked if they had been agreed. KR confirmed that they were established in Dudley and in Sandwell they were using Towns.

PF was interested to see the Neighbourhood Health Centres and commented on the hub and spoke arrangements.

JS asked if there were opportunities to align properties. KR confirmed that there would be.

The Chair welcomed the document and took the report for assurance.

It was **RESOLVED** to

- **Endorse** the proposed Neighbourhood Health Centre locations

26/15.0 Governance and Regulatory

26/15.1 Board Assurance Framework

DC and HB presented the joint report given as enclosure 14;

Sandwell and West Birmingham NHS Trust
The Board received the Board Assurance Framework (BAF) summary and noted that all five strategic risks were currently rated as inconclusive, with no risks assessed as negative. It was recognised that whilst the control environment had strengthened, including improvements in quality governance and workforce optimisation, assurance remained limited due to challenges in translating improvements into sustained operational outcomes. Key risks remained in financial sustainability, performance delivery, workforce pressures and infrastructure, with finance continuing to present the highest level of concern.

The Dudley Group NHS Foundation Trust
The Board received the Dudley BAF summary and noted that of the six strategic risks, three were rated as positive assurance and three as inconclusive, with none rated as negative.
It was recognised that the Trust maintained a strong control environment, particularly in quality and governance, with stable risk positions in quality, workforce and partnerships. However, financial performance, operational delivery and infrastructure risks remained areas requiring continued focus,

particularly due to reliance on non-recurrent funding and ongoing system pressures, with overall assurance assessed as mixed.

The Board noted that the annual BAF audit confirmed a robust framework was in place, with only minor opportunities identified to further strengthen controls, which were considered effective and consistently applied. Work was underway to align the Group Risk Management Strategy, with approval expected in July, alongside ongoing BAF refresh activity. The Board further noted that all mitigating actions and control gaps had been reviewed at year end, with updated strategic risks scheduled to be considered by Committees ahead of final approval in July 2026.

Meetings would be arranged with respective Committee Chairs and Executive Lead.

It was **RESOLVED** to

- 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

26/15.2 Group Board Governance

DW presented the report on the future Group structure arrangements across the Black Country, noting that collaboration between the four acute and community trusts had matured significantly in recent years. It was noted that two distinct and operationally developed Group models had been established, supported by the wider Black Country Provider Collaborative, enabling strengthened leadership alignment, shared governance, and delivery of joint strategic and operational programmes while retaining sovereign organisational accountability.

The Board noted that, following consideration of alternative models, continuation of the current structure was proposed as the most balanced and effective approach, avoiding the risks of fragmentation or excessive complexity. It was recognised that the model supported operational resilience, reduced duplication, and enabled collaboration at scale, whilst maintaining local responsiveness and clear accountability, and that formal recognition and continuation of these arrangements would be submitted to NHS England following Board approval.

The Chair added that it was important to present to NHSE the consolidated position and clear governance structures.

The full suite of Governance documents would be shared with NHSE once the Board Architecture has been presented to the July Board.

GC noted that group governance were taken through Audit Committees.

It was **RESOLVED** to

- **Formally** recognise the maturity and establishment of the two existing Group operating models across:
    - Dudley and Sandwell
    - Wolverhampton and Walsall
- **Approve** the continuation of the current operating structure comprising:
    - Two distinct Group models Supported by the Black Country Provider Collaborative framework
- **Note** that sovereign organisational accountability and statutory Board responsibilities remain unchanged.

26/16.0 Black Country Provider Collaborative

The Board received the updated Board Assurance Framework (BAF) given as enclosure 16, which

The Board received a report seeking approval to delegate specific functions to the Joint Provider Committee (JPC) to support delivery of the Black Country Provider Collaborative (BCPC) 2026/27 priorities. It was noted that the workplan had been streamlined into two core programmes - clinical and corporate service transformation aligned to a reduced £1m budget, and that updated governance arrangements, including a refreshed Executive and strengthened programme management, would support delivery at scale.

The Board noted that the proposed delegations would enable the JPC to oversee transformation programmes, system planning, performance monitoring, and shared decision-making across partner organisations, while retaining ultimate accountability within each Trust. It was recognised that clear reporting arrangements and governance safeguards were in place to ensure oversight, transparency, and alignment with statutory responsibilities as the collaborative work progressed.

GC updated the Board on decisions made at the last Committee meeting and in particular the progress in relation to Corporate Service Transformation.

MP asked about the responsibility of Value for Money aspect for JPF and F&P. GC suggested that MP discuss with the Collaborative Managing Director outside of the meeting.

It was **RESOLVED** to

- **Note** the agreed BCPC priorities for 26-27 as outlined at 1.3 in section 1
- **Approve** the delegations sought in Annex A to this report and adjust the Trust SORD / SFI to reflect the delegations made (if required)

26/17.0 Any other Business

CW requested delegation to the Dudley Audit Committee for the approval of The Dudley Group NHS Foundation Trust's Annual Report and Accounts.

MP requested delegation to the Sandwell Audit Committee for the approval of the Sandwell and West Birmingham Hospitals NHS Trust's Annual Report and Accounts.

It was **RESOLVED** to

- Approve the delegation of authority to the respective sovereign Audit Committee for the Trust Annual Report and Accounts as per the preamble to this minute

26/18.0 Date of next Board of Directors Meeting

The next meeting would be held on Wednesday 17th June 2026.

26/31 Meeting Close

The Chair declared the meeting closed at 17:40 hr.

……
Sir David Nicholson
Chair Date:

Action Sheet*

Board of Directors – Public session

Dudley - 12th 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 – 11th March 2026

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

**standard template to be used from July onwards*

Enclosure 2

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

REPORT TITLE:	Public Chief Executive Report		
SPONSORING EXECUTIVE:	Diane Wake, Group Chief Executive		
REPORT AUTHOR:	Helen Board, Board Secretary (Dudley) Dan Conway, Associate Director of Corporate Governance/Company Secretary (Sandwell)		
MEETING:	Group Public Trust Board	**DATE:**	22 July 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

- Outcome of the Capital Incentive Scheme, 2025/26 UEC March Sprint
- Maternity and neonatal inspection reports
  - Baroness Amos' independent investigation into maternity and neonatal services in England
  - Ockenden review into maternity services at Nottingham University Hospitals NHS Trust: final report
- Provider Capability assessment letter – SWB
- Minimum standard of patient experience
- NHS England Quality Strategy for NHS-Funded Care in England (2026)
- Preventing unlawful access to patient records - a letter from Sir James Mackey
- National Guardians Office Annual report 2025/26
- Healthwatch annual reports 2025/26
  - Dudley
  - Birmingham & Solihull
- West Birmingham CVD Prevention Event – short para – see email from AF 1/6 14:23
- West Midlands Research Delivery Network Trauma and Emergency Care Speciality Lead Position
- National Oversight Framework Segmentation 31st March 2026
- Band 5 review directive
- NHS Foundation Governors – future role
- The Man Review JF to check the para
- Operational Performance
- SAS Excellence in Development Recognition (SEiD) Silver Award
- Charity Update
- Healthcare Heroes/Staff Recognition
- Patient Feedback
- Awards
- Visits and Events

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
None

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

Escalation
Should any element of this report be escalated: None

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026
Chief Executive's Report

1. Outcome of the Capital Incentive Scheme, 2025/26 UEC March Sprint

NHS England has confirmed that The Dudley Group NHS Foundation Trust will receive £2 million in capital funding through the 2025/26 Urgent and Emergency Care (UEC) Capital Incentive Scheme. This allocation recognises improved performance during the year, with March 2026 4-hour A&E performance reaching 77.1% (just below the 78% national target) and 12-hour performance at 10% year-to-date. Despite narrowly missing the national standard, this represents the Trust's best March performance in the past five years, alongside a significant increase in patient throughput, with over 500,000 more patients treated within four hours compared to the previous year.

The awarded funding will be issued as capital departmental expenditure limit (CDEL) and made available across 2026/27 and 2027/28 to support further improvements in urgent and emergency care. The Trust is required to forecast and confirm planned use of this funding through in-year financial monitoring, with flexibility to amend plans up to Month 8 of 2026/27; however, any unused allocation in that year will not be carried forward. NHS England has advised that access to cash should not be a constraint, with additional support available via public dividend capital where required, subject to eligibility criteria.

2. Maternity and neonatal inspection reports

Baroness Amos' independent investigation in maternity and neonatal services in England
On the 1st of July 2026, Baroness Amos has published the findings of the Independent National Maternity and Neonatal Investigation, which reviewed maternity and neonatal services across 12 NHS trusts, including Sandwell and West Birmingham NHS Trust. The national report concludes that significant and sustained improvement is required across maternity and neonatal services in England, identifying common themes including women not feeling listened to, inequalities in care, workforce pressures, safety concerns and the need for stronger organisational cultures focused on compassion, inclusion and learning.

The Trust-specific report highlights a number of areas requiring improvement within SWBT maternity and neonatal services, including concerns regarding patient safety, workforce pressures, organisational culture and experiences of racism and discrimination reported by both families and staff. The Trust has publicly acknowledged the findings, apologised to affected women and families, and outlined a range of actions already underway to strengthen leadership, improve staffing levels, address discrimination and enhance the quality and safety of care. A full report on the findings, implications and proposed response will be presented to the Board by the Group Chief Nurse later on the agenda.

Ockenden review into maternity services at Nottingham University Hospitals NHS Trust: final report
In June 2026, Donna Ockenden published the final report of the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust. Based on a review of more than 2,500 family cases, the report identifies significant failures in leadership, governance, culture, safety, learning and the listening to women and families, and sets out a number of Immediate and Essential Actions together with wider system-wide recommendations for all NHS organisations providing maternity and neonatal services. The findings serve as an important reminder that effective board oversight, a culture of openness and learning, and a relentless focus on patient safety must remain central to the delivery of high-quality care.

In addition, NHS England has issued a national requirement for all provider boards to review and assure themselves regarding arrangements for post-death care, mortuary oversight, security, safeguarding and governance, reflecting concerns identified in both the Ockenden report and the Fuller Inquiry. Trust boards are required to submit a formal Board Assurance Statement by 31 July 2026 confirming that robust oversight, leadership accountability and governance arrangements are in place for mortuaries and all areas where deceased patients are cared for. A more detailed report on the implications of the Ockenden review, together with the Trust's response to the associated NHS England mortuary assurance requirements, is included elsewhere on this agenda and will be presented by the Group Chief Nurse.

3. Provider Capability

NHS England has advised in a recent letter to the Trust that is has revised Sandwell and West Birmingham NHS Trust's Provider Capability Assessment rating from Amber Green to Amber-Red following its Quarter 1 2026/27 review. The assessment reflects concerns regarding the Trust's financial performance in 2025/26 and the challenges associated with the 2026/27 planning process. NHS England highlighted the need for strengthened financial grip and control, delivery of recurrent efficiencies, and continued assurance regarding governance, forecasting and risk management arrangements.

The Trust is working closely with NHS England, the ICB and system partners to address the issues identified and support delivery of its recovery plans. Ongoing oversight and targeted improvement actions are in place to strengthen financial sustainability, organisational capability and confidence in the delivery of the 2026/27 plan.

4. Minimum standards of patient experience

NHS England has introduced new minimum standards of patient experience for elective care, setting out the baseline level of communication and information that all patients should receive once referred to a planned care pathway. The standards, announced by Sir Jim Mackey in July 2026, are intended to address longstanding concerns that some patients feel uninformed while waiting for treatment and include expectations around timely confirmation of referrals, regular waiting list updates, communication support, reasonable adjustments, advance notice of appointments and clear information when care is completed.

NHS England has asked trust boards to review their performance against each standard, put improvement plans in place where required, and publish a statement during 2026/27 describing how compliance will be achieved and monitored. Progress will be assessed nationally over the coming months, with a particular focus on improving patient confidence, involvement and overall experience while waiting for elective care. A communications toolkit is being developed to support trusts in ensuring patients understand the standards they should expect from NHS services. A rep[ort will be brought to the next board meeting.

5. NHS England Quality Strategy for NHS-Funded Care in England (2026)

The recently published NHS England Quality Strategy (2026) is closely aligned with the Trust's strategic ambitions and reinforces many of the priorities already reflected within our improvement plans. The strategy places quality at the centre of all organisational decision-making, with a focus on safety, effectiveness, patient experience, reducing inequalities and improving outcomes. Its ten conditions for improvement strongly align with our focus on leadership, governance, patient engagement, digital transformation, continuous improvement and partnership working.

The strategy provides an opportunity to further strengthen our Quality Management System and to demonstrate how improvements in quality, safety, patient experience and equity are delivered through a coherent organisational approach. As implementation guidance emerges, we will review our current

arrangements against the ten conditions for improvement and consider any further actions required to support delivery of our strategic objectives and the ambitions of the NHS 10 Year Health Plan.

6. Preventing unlawful access to patient records - a letter from Sir James Mackey

NHS England has written to all trusts regarding the prevention of unlawful access to patient records, following recent incidents of staff accessing records without a legitimate clinical or professional reason. In his letter of 7 July 2026, Sir Jim Mackey, NHS England Chief Executive, emphasises that such actions are illegal, can cause significant harm and distress to patients, undermine public trust, and may result in disciplinary action, professional regulatory referral, dismissal, or criminal prosecution. Trust boards are asked to reinforce staff understanding of their legal and professional responsibilities and ensure a robust organisational response where inappropriate access is identified.

To support this, NHS England has issued updated guidance for staff, patients and information governance professionals, alongside a national awareness campaign under the banner **"Don't let curiosity kill your career."** Our Trusts will adopt the campaign encourages trusts to use posters and digital media to increase staff awareness of the consequences of unlawful record access and to strengthen local arrangements for prevention, monitoring and investigation. The letter highlights the importance of maintaining public confidence in the NHS's stewardship of sensitive patient information, particularly as digital transformation programmes continue to develop

7. Healthwatch Annual report 2025/26

Dudley

The Healthwatch Dudley's Annual Report for 2025/26 highlights a continued focus on reducing health inequalities and understanding the experiences of seldom-heard communities. Key themes emerging from the report include ongoing challenges in accessing GP services, particularly for people who are digitally excluded or have additional communication needs, the impact of poverty on access to healthcare, and the importance of ensuring services are designed around the needs of vulnerable groups. The report also identifies concerns regarding accessibility for people with sensory impairments and the need for greater flexibility in communication and appointment arrangements across health and care services.

The report contains several areas of direct relevance to The Dudley Group NHS Foundation Trust, including Healthwatch engagement on Patient Initiated Follow-Up (PIFU), access to GP services and wider system work to address inequalities. Healthwatch notes positive collaboration with the Trust during the year and highlights its commissioned work exploring patient experiences of PIFU, which found broad support for the model while identifying the need for clear communication pathways and robust administrative processes to ensure equitable access for all patient groups. The report also reflects the value of partnership working across the Trust, local authority, voluntary sector and Integrated Care Board in ensuring community feedback informs service improvement and decision-making.

Sandwell

The Healthwatch Birmingham & Solihull's Annual Report highlights the continuing importance of access, communication and health inequalities across health and care services. Key themes identified through engagement with over 10,000 residents included difficulties accessing GP services, particularly where digital routes were the primary means of access, challenges experienced by families awaiting autism and ADHD assessments, and concerns regarding communication and consistency within community and domiciliary care services. The report also highlights ongoing work to ensure the experiences of vulnerable and seldom-heard communities are reflected in service improvement discussions.

The report is broadly positive about the willingness of NHS and local authority partners to engage with patient feedback and identifies examples where public insight has informed service developments, including Urgent Treatment Centre planning, neurodevelopmental pathways and primary care access initiatives. Whilst neither The Dudley Group NHS Foundation Trust nor Sandwell and West Birmingham NHS Trust are specifically referenced within the report, many of the themes identified align closely with system priorities around access, communication, patient experience and reducing health inequalities.

8. National Guardians Office Annual report 2025/26

In May 2026, the National Guardian's Office (NGO) published its final Annual Report for 2025/26. Whilst the Board receives regular Freedom to Speak Up (FTSU) updates for both SWBT and DGFT, the report highlights a number of national trends that remain relevant locally. Most notably, the NHS Staff Survey shows a decline in staff confidence that concerns raised will be acted upon, with the FTSU score falling to a five-year low. Although 61.5% of staff reported feeling safe to raise concerns, fewer than half believed their organisation would take action in response, creating what the NGO describes as a significant "action gap". The report emphasises that visible leadership, psychological safety and demonstrable follow-up remain critical factors in maintaining staff confidence and supporting patient safety.

The report also highlights that concerns relating to inappropriate attitudes and behaviours (41.6% of all cases), workforce wellbeing (39.2%) and bullying and harassment (17.7%) continue to represent the most common reasons for staff speaking up nationally. In addition, reviews undertaken during the year identified particular barriers for temporary workers and overseas-trained staff, including concerns about detriment, exclusion, fairness and confidence in organisational processes. These findings reinforce the importance of ensuring that speak up arrangements are accessible, inclusive and responsive for all staff groups, particularly within organisations with a diverse workforce.

It is noteworthy that both Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust participated in a system-wide board development session facilitated by the National Guardian's Office during the year. The report cites this work as positive practice in supporting board understanding of organisational culture, governance and the importance of ensuring that concerns raised by staff are heard, acted upon and followed through. A fuller update on local Freedom to Speak Up arrangements and associated organisational metrics continues to be provided regularly to the Board.

9. West Birmingham CVD Prevention Event

The Sandwell NHS Trust supported a West Birmingham cardiovascular disease (CVD) prevention event, delivered in partnership with community organisations, attracted over 150 local residents and demonstrated strong community engagement, with individuals returning alongside family members to access health checks and advice. The event identified a significant number of previously undetected risks, including 31 individuals with raised blood pressure, 16 with elevated blood glucose and 5 with abnormal pulse rhythms, with all appropriately signposted for GP follow-up and one urgent hospital referral. This highlights the value of locality-based prevention in identifying high-risk individuals early and intervening before more serious illness develops.

This work reflects national priorities, as CVD remains a leading cause of premature mortality and is strongly associated with undiagnosed conditions such as hypertension and atrial fibrillation. Early detection through community outreach is proven to improve outcomes, reduce health inequalities and prevent serious events such as heart attacks and stroke. The Trust will build on this success through further partnership-led prevention initiatives and a structured learning review to inform future delivery across local communities.

10. West Midlands Research Delivery Network Trauma and Emergency Care Speciality Lead Position

Dr Gail Parsons, Nurse Consultant in Trauma and Orthopaedics and Director of Research and Innovation, has been appointed as the West Midlands RRDN Trauma and Emergency Care Specialty Lead. This regional role will focus on strengthening and embedding research across trauma and emergency care services, further supporting the Trust's commitment to research, innovation and improving patient outcomes through evidence-based practice.

11. National Oversight Framework Segmentation 31st March 2026

Latest NHS England Oversight Framework league tables (NOF acute dashboard) indicate that both organisations sit in the lower to mid tiers of national performance, reflecting wider system pressures across the Black Country. The Dudley Group NHS Foundation Trust is positioned in the top third nationally 58th within Segment 3, indicating comparatively stronger performance locally but still requiring improvement against national benchmarks.

In contrast, Sandwell and West Birmingham NHS Trust is ranked 100th nationally placing it among more challenged providers but within segment 3 but highlighting ongoing pressures financially and in operational performance. Overall, the league table reflects variation across the system, with Dudley performing relatively

better, while both trusts remain focused on recovery trajectories and improvement priorities against national standards.

12. Band 5 review directive

The NHS England directive (2 June 2026) sets out a nationally mandated programme to review all Band 5 nursing roles to ensure staff are paid correctly and consistently under Agenda for Change. Organisations are required to submit a robust delivery plan by 31 July 2026, with full completion of reviews by October 2028. This follows national evidence that implementation of job evaluation guidance has been variable and reinforces the contractual right of staff to have roles assessed against accurate job descriptions using the national framework.

The programme represents a significant organisational undertaking requiring clear board-level oversight (CNO, CPO, CFO), strong partnership working with trade unions, and active engagement with nursing staff. Boards are accountable for ensuring delivery, governance, and financial oversight, including managing any pay impacts. Additional funding will be provided through national tariff adjustments to support both delivery capacity and implementation, with progress monitored nationally through milestone reporting and data collection to ensure fairness, consistency, and compliance with equal pay obligations.

13. NHS Foundation Trust Governors – future role

NHS England guidance (May 2026) signals potential legislative changes to the role of Foundation Trust Governors, including removal of the statutory requirement for a Council of Governors. No changes are currently in force; governors' duties remain unchanged pending Parliamentary approval and implementation. The proposals emphasise maintaining strong public accountability, transparency and meaningful engagement with patients and communities.

The Trust continues to work with governors under existing arrangements and is proactively preparing for potential changes. A Task and Finish Group is being established to consider future arrangements, supported by ongoing engagement with governors and senior teams, to ensure patient and public voice remains central to Trust decision-making.

14. The Mann Review

The report marks a step change in expectations for NHS trusts, reframing racism—including antisemitism—as a core issue of patient safety, workforce wellbeing, governance and public confidence rather than solely an EDI or HR concern. For our Trust, this places emphasis on visible board leadership, stronger accountability, and demonstrable improvement in outcomes for staff and patients. There is a clear expectation that boards will have oversight of racism-related investigations, ensure transparent handling of incidents, and provide public assurance that services are safe, fair and inclusive.

Operationally, this will require a whole-organisation response led by the Executive Team. Key priorities include strengthening governance and reporting on race equality, improving the quality and use of workforce and patient data, and ensuring investigations and complaints are handled consistently and credibly. The report also raises expectations around culture—ensuring racism is identified early, staff feel psychologically safe to speak up, and both staff and patients have confidence in reporting routes and support mechanisms. In addition, trusts are expected to review policies and enhance leadership capability through targeted training, with a sharper focus on antisemitism and other forms of racial discrimination.

Given the strategic importance of this agenda this is being treated as a significant priority through our new Culture Improvement Approach, which places staff experience, psychological safety, speaking up, patient safety and inclusion (including anti racism) at its core. The Board will be considering this work as part of the wider cultural improvement programme.

We will continue to review and strengthen existing arrangements to ensure they remain robust across leadership visibility, data and reporting, investigation processes, and support for staff and patients. A gap analysis against the report's recommendations has been undertaken to ensure alignment with ongoing work across quality, patient safety, EDI and governance programmes, will help ensure a coordinated and comprehensive response. This will be taken to People Committee in August. By building on the significant

work already underway, we will further strengthen staff experience, patient confidence and regulatory assurance, while demonstrating its commitment to fostering an open, inclusive and safe culture where concerns are listened to and acted upon effectively.

15. Operational Performance

Dudley

Emergency Department

Performance against the Emergency Access Standards (EAS) showed a sustained performance above the 78% target with 80.8% for May 26. Ambulance Handovers in May 2026, there were 3164 ambulance arrivals with the average ambulance offload time of 58 mins. This is above the 45min target and has been significantly affected by the flow for admitted patients. This has been additionally challenged as DGFT has seen an 11% increase in emergency activity and admissions.

Cancer Performance

Cancer Performance (April validated) - 28 Day Faster Diagnosis Standard: achieved 85.9% against national target of 83%. Achievement of monthly trajectory continues to be sustained in April 2026. 31 Day Combined: achieved 94% against national target of 96%. Urology and Skin remained challenged due to capacity for surgical patients and biopsy capacity. 62 Day Combined: achieved 75.4% against April monthly target of 74.3%. Breast, Urology and Skin remain an area of focus. Target for end of March 2027 is 81.0%.

Referral to Treatment (RTT) Standards

Performance against the 18-week RTT standard for May was 65.14% of patients treated within 18 weeks vs 73.01% planned target March 27. At the end of May, 0.02% of patients (11 patients) were waiting over 52 weeks, against the planned target of 0%. We continue to proactively monitor high-risk specialties and escalate issues promptly to minimise further delays. Focus also remains on Total Waiting List, ours has spiked and continues to rise as referrals continue to increase; working with Specialty teams to understand this further.

6-Week Diagnostic (DM01) Standard

DM01 for May shows performance of 87.71%, an improvement compared to April. Main areas of focus are Dexa and Non-Obstetric Ultrasound, and a recovery plan is in development. Sleep studies recovery is expected to continue.

Community Standards - Urgent Community Response (UCR) Performance

Urgent Community Response 2-hour target >70% continues to be met with compliance at 88% April 26. May data shows 840 - 2-hour UCR referrals managed during May.

Sandwell

Urgent and Emergency Care (UEC)

SWB continued to show gradual recovery in urgent and emergency care performance during May 2026 despite ongoing system pressures. Performance against the 4-hour standard improved to 76.12%, approaching the 78% target and building on improvements seen in previous months. Ambulance handover times improved by 5.9% to an average of 32 minutes, despite a 7.5% increase in ambulance arrivals at MMUH. A number of recovery initiatives have been implemented to support delivery of UEC standards in 2026/27, although increasing demand continues to pose challenges to sustaining improvements and maintaining patient experience.

Referral to Treatment (RTT)

Planned care performance at SWB exceeded trajectory, with 62.26% of patients treated within 18 weeks, compared with a planned trajectory of 57.70%. Long waits remained within target, with 0.49% of patients (319 patients) waiting over 52 weeks, achieving the requirement to keep this below 1%. Further improvement plans are focused on reducing long waits in higher-risk specialties and continuing progress against elective recovery objectives.

Cancer Standards

Cancer performance was mixed in April 2026. The 31-day diagnosis-to-treatment standard was achieved at 95.74%, exceeding trajectory by 3.93%, with confidence that this performance can be sustained. However, performance against the Faster Diagnosis Standard (63.96% vs 80% target) and the 62-day treatment standard (70.20% vs 76.16% target) was below planned levels, indicating ongoing challenges in delivering timely

diagnostic and treatment pathways. Focused improvement actions remain in place to support recovery in specific pathways.

16. **SAS Excellence in Development Recognition (SEiD) Silver Award**

Sandwell and West Birmingham Hospitals NHS Trust has received a SAS Excellence in Development (SEiD) Silver Award, recognising the Trust's commitment to the development, support and retention of Specialist, Associate Specialist and Specialty (SAS) doctors. In a letter dated 8 July 2026, Danny Mortimer, Director General for People at the Department of Health and Social Care, congratulated the Trust on this achievement, describing it as a testament to the leadership, culture and support within the organisation that enables SAS doctors to thrive and make a valuable contribution to patient care.

The letter highlights the importance of this work in strengthening the SAS workforce, improving career development opportunities and creating an inclusive and supportive environment for colleagues. National leaders recognised the Trust's success at the SEiD Awards ceremony on 1 July 2026, noting the innovation and good practice demonstrated across the NHS and praising the Trust's role in supporting SAS doctors to reach their full potential. The correspondence concludes with thanks and congratulations to all those involved in securing this national recognition.

17. **Charity Updates**

Your City & Metropolitan Hospitals Charity Update

Community Celebrates Charity Black-Tie Quiz Night Supporting Local NHS

In May, supporters, sponsors, businesses, and education partners from across the Midlands gathered at Millennium Point for an evening of fun, friendly competition, and fundraising at the first ever Your City & Metropolitan Hospitals Charity Black-Tie Quiz Night. Hosted by celebrity broadcaster Manish Bhasin, it brought together members of the local business community, colleges, universities, donors, and supporters, all united by a shared goal: raising vital funds to support patients, staff, and communities served by Your City & Metropolitan Hospitals Charity. Guests enjoyed an evening of networking, entertainment, and quiz rounds, all while helping to raise an incredible total of £22k towards local healthcare initiatives.

New exhibitions in The People's Gallery at Midland Metropolitan University Hospital.

Thanks to a grant from the Heritage Lottery Fund, Your City & Metropolitan Hospitals Charity has recently installed the following for all staff and patients to experience and enjoy:

- Heritage Audio Trail exploring the history of healthcare - download the app and listen to the stories behind our healthcare
- Embers of Care collection created by Yayen, a Filipino nurse and contemporary artist
- New exhibition by Spectra, who are creating healing through nature in our Commons outdoor garden space
- 'Art of Hospital: Hospital Art' retrospective featuring watercolours of City Hospital by Lawrence Hayfield

The Dudley Group NHS Charity Update

Community Bridge Project (Hospital Discharge Support)

The charity funded Community Bridge Project is now successfully operational, supporting vulnerable patients following discharge from hospital. Early demand has been strong, with 61 referrals received and positive feedback from patients who report feeling more supported, confident and connected to community services. A diverse volunteer workforce has been mobilised alongside strong partnerships with local voluntary sector organisations, helping patients access practical, emotional and wellbeing support. While formal outcome data is still emerging, the project is demonstrating clear alignment with system priorities around reducing health inequalities and supporting independent living.

Healthy Hearts, Healthy Workforce

Launched in May 2026, the charity funded staff wellbeing initiative focused on staff over 40 from a BAME background has achieved a positive start, delivered over 60 cardiovascular health checks and generating strong

engagement, particularly among staff aged 40–64. Early findings indicate that accessible, workplace-based health checks are increasing awareness of cardiovascular health and encouraging preventative action. The next phase will focus on expanding participation further, particularly among underrepresented groups, to maximise the programme's impact on workforce health and wellbeing.

Dragon Boat Race

The Charity's annual Dragon Boat Race at Himley Hall raised an impressive £12,000, bringing together staff, sponsors and supporters for a day of friendly competition and community engagement. Despite challenging weather conditions, five Dudley Group teams took part alongside 30 other boats, showcasing outstanding teamwork and raising the profile of the Charity across the local community.

Staff Wellbeing Rooms

The charity's future investment in staff wellbeing continues through the development of three additional wellbeing rooms across the Trust. The programme remains on schedule for completion by September 2026 and will provide high-quality restorative spaces that support staff wellbeing, resilience and recovery. This builds on the success of the initial six rooms completed last year and demonstrates the charity's ongoing commitment to improving the working environment for colleagues.

Patient Transport Vehicle

The charity-funded patient transport service is approaching launch, with the vehicle purchased, volunteer drivers recruited and trained, and final preparations underway. The service will provide practical support for patients and enhance discharge pathways, while also showcasing the tangible impact of charitable funding. Opportunities for regional media coverage are expected to further raise awareness of both the service and the charity's contribution to patient care.

Awards

Dudley Healthcare Heroes

Emergency Department Ambulance Triage team- They were nominated for all the work they have done to reduce ambulance handover delays at Russells Hall Hospital. On one shift they successfully triaged 62 ambulances where the average triage time was 15 minutes!

Ward B4- They were nominated for their clinical expertise and compassion whilst embodying the very best of our Trust values. A patient also specifically mentioned the team for the excellent care they provided following a stay on the ward after bowel cancer surgery.

ICB Cancer Awards

SWB and Dudley staff were recognised for their outstanding work with patients at the recent Black Country ICB Cancer Awards. Claire Murphy, Health Promotion Specialist for the City, Sandwell and Walsall Breast Screening Service, was named Sandwell Individual of the Year. Beth Harvey and her team scooped Sandwell Team of the Year for their innovative 'Cuppa and Catch-up' sessions.

John Schneider from The Dudley Group was recognised as Dudley Individual of the Year for his inspirational leadership of the Cancer Services team we also scooped the award for Dudley Team of the Year.

Congratulations to Dr Clare

Dr Sarb Clare MBE, Acute Medical Consultant at Sandwell and West Birmingham NHS Trust, has been awarded the Elizabeth Garrett Anderson Oral Abstract Prize at the Medical Women's Federation (MWF) Spring Conference, recognising her work into the gendered impact of professional titles in clinical practice.

Patient Feedback

B1- Elective Surgery - **Dudley** - "Excellent, staff were amazing and showed empathy to those having operations. They were ably supported by the physio team."

Acute Medical Unit - Dudley "I appreciate all staff everyone was very kind they checked me very nicely. It was very good experience. Thanks to all staff at Russells Hall."

GI Unit – Dudley "The nurse practitioner who performed the procedure was amazing as was the two nurses who assisted him, all very professional. Everything about my visit was good, no complaints at all, many thanks to all concerned."

Day Surgery Unit - Dudley - "Day surgery and nurse was fantastic as well as student nurse. Also, the anaesthetist was excellent in listening to my allergies and anxieties around this."

Ward A7 – SWB - Superb staff, looked after Mom with care. From Ambulance to Resus to ward all involved were amazing and dealt with Mom efficiently. Big Thankyou to Ward A7. Lovey designed building, very smart.

Theatres – SWB - Best hospital I've ever been to. The staff are amazing and the people are lovely that I spoke to. I had keyhole surgery to remove appendix unexpected. A big thank you to you all.

A&E – SWB - Brilliant! Today I was taken there with a dislocated shoulder. Very painful. Within an hour it had been re fitted. Fantastic team. Very professional

Visits and Events – May and June 2026

#MEFestival- Funded by Dudley Group NHS Charity, #MEFestival 2026 brought together more than 400 Year 5 and 6 pupils from 16 schools across the Dudley borough for a day focused on wellbeing, confidence and resilience. Held at Himley Hall, the festival featured a wide range of interactive workshops and activities centred around the Five Ways to Wellbeing, delivered through partnerships with local health, education, charity and community organisations.

Health and Wellbeing Carnival - More than 800 people attended the Health and Wellbeing Carnival held as part of Armed Forces Day. The Health and Wellbeing Carnival were hosted by The Dudley Group NHS Foundation Trust's Involvement Team. The event welcomed special guests, including MP Sonia and the Mayor and Deputy Mayor, who joined attendees to support a day dedicated to improving access to health, care and wellbeing services for the Armed Forces community and residents. There was a wide range of stallholders and partner organisations, offering valuable information, expert advice and practical support across physical and mental health topics. Visitors had the opportunity to access services including cancer screening information, mental health support, mini health checks and employment advice.

Event Raises Awareness about the Danger of Cardiovascular Disease

The community came together to remember the late Councillor Waseem Zaffar at a free community healthy heart event by The West Birmingham Locality Partnership in May. The event was aimed at improving heart health and raising awareness of cardiovascular disease (CVD) as it particularly affects the south Asian heritage community. The aim was to support people to make positive lifestyle changes. Held at Aspire & Succeed in Lozells, the venue was chosen because of its special significance to Waseem.

The event offered a range of free activities and support, including free diabetes and blood pressure checks, expert advice on how to look after your heart, healthy living guidance, information on healthy eating, exercise, smoking cessation, and local heart-health activities and advice on basic life support.

Cllr Zaffar, a former non-executive director at Sandwell and West Birmingham NHS Trust, was a passionate advocate for clean air, health equity, and the wellbeing of local communities. His commitment to improving heart health continues to inspire the work of the West Locality Partnership. Members of his family attended the event, and organisers have expressed their gratitude for their support.

18. Visits and Events – May and June 2026

1 May	Black Country Provider Collaborative Joint Provider Committee
6 May	Sandwell and West Birmingham Audit Committee
8 May	Chief Nursing Officer Interviews Dudley Group and Sandwell and West Birmingham
11 May	Dudley Group Audit Committee
13 May	Black Country ICB Cancer Celebrations Awards
15 May	NHSE Provider Review Meeting SWBT/DGFT
18 May	NHSE Regional Performance Delivery Group
18 May	Sandwell Charity Trustee Board
19 May	Sandwell Charity Workshop
20 May	Dudley Group and Sandwell Joint Board Public and Private meeting
22 May	Birmingham, Black Country and Solihull ICB Chief Executive Officers meeting
26 May	GP Engagement meeting
27 May	Sonia Kumar MP engagement
27 May	Maternity Review Leaders Peer Group
28 May	Sandwell and West Birmingham and Dudley Group Joint Finance and Productivity Committee
1 June	Black Country Elective and Diagnostic Strategic Board
15 June	Black Country Integrated Care System Cancer Board
17 June	Dudley Group and Sandwell and West Birmingham Joint Board Workshop
18 June	Dudley Group Council of Governors meeting
19 June	Birmingham, Black Country and Solihull Chief Executive Officers meeting
22 June	Dudley Group Audit Committee
22 June	Sandwell and West Birmingham Audit Committee

23 June	Group Chief Medical Director Interviews
24 June	Black Country Elective Diagnostic Board
24 June	Maternity Review Leaders Peer Reivew
25 June	Sandwell and West Birmingham and Dudley Group Joint Finance and Productivity Committee

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

REPORT TITLE:	Integrated Committee Chairs Report		
SPONSORING EXECUTIVE:	Diane Wake, Group Chief Executive Officer		
REPORT AUTHOR:	Lesley Writtle, Non-Executive Director, Deputy Chair		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

Paper Type: (place an 'x')		**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		
			Discuss		
		x	Note		

Suggested discussion points

This report provides a consolidated overview of the assurance levels and key issues identified by Trust Sub-Committee Chairs. It supports the Board's **Alert, Advise and Assure** responsibilities by highlighting matters requiring Board attention or escalation, providing insight into emerging risks and opportunities, and offering assurance regarding the effectiveness of controls and progress against the Trust's strategic objectives. The report also recognises examples of good practice that contribute to the delivery of the Trust's strategic priorities.

This report is more detailed than usual due to in depth analysis of 2 key alert issues.

The report reflects ongoing work to strengthen the alignment between key issues, the Board Assurance Framework (BAF) and the Trust's strategic risks. Committee Chairs have reviewed the relevant risks and associated scores, and the priority issues highlighted within this report.

The BAF linkages included within this report have been mapped against the refreshed Group Board Assurance Framework. These linkages are intended to support clearer alignment between Committee discussions, strategic risks and Board oversight. They should be regarded as an initial mapping at this stage, as the refreshed BAF risks, associated controls, assurances and interdependencies are still to be fully worked through and agreed by the relevant Committees during July.

This month's report places greater emphasis on forward-looking assurance, focusing on the actions required to deliver sustainable improvement and provide a credible trajectory towards reduced risk exposure and improved BAF scores.

The full Sub-Committee Assurance Reports are available separately and should be read in conjunction with this report. The issues highlighted have been discussed and agreed with Sub-Committee Chairs and reflect themes that have emerged consistently across committee meetings during the reporting period.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
none

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

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 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
x	004: Finance	x	004: Finance
X	005: Operational performance	x	005: Operational performance
	006 (Joint): Infrastructure		
Is Quality Impact Assessment required if so, add date: n/a			
Is Equality Impact Assessment required if so, add date: n/a			

Integrated Committee Chairs Report

KEY ITEMS DISCUSSED AT THE BOARD COMMITTEES

ALERT

SWB Financial Position and Recovery

Sandwell and West Birmingham NHS Trust reported a £1.64m adverse variance against plan in June consistent with the Month 1 position. The year-to-date deficit continues to be driven by higher-than-planned bank staffing expenditure, the impact of resident doctors' industrial action, under-delivery of the Cost Improvement Programme (CIP), and reduced activity levels. Whilst the pay run rate remains above plan, there are early signs of improvement. The People Committee also noted a reduction in workforce establishment of 229 WTE, indicating progress against workforce control measures.

NHS England remains actively engaged with the Trust and is fully sighted on the current financial challenges. Discussions are ongoing regarding potential external support, including the appointment of a financial improvement expert to undertake a detailed review of the underlying drivers of the deficit. Consideration has also been given to the potential benefits of appointing a Turnaround Director to provide focused leadership and support the delivery of sustained financial improvement.

To provide the Board with assurance regarding the findings of the lessons learned exercise undertaken following NHS England's letter dated 6 February 2026 from Nicola Hollins, Regional Director of Finance, NHS England, a summary report is placed in Appendix 1

Financial Improvement and CIP Assurance

The Finance Committee remains seriously concerned regarding the current development of the Trust's 2026/27 CIP programme, which continues to provide only Partial Assurance. Audit findings in parallel have highlighted a deterioration in both the quality of early-stage planning and the overall maturity of the programme, increasing concerns regarding its deliverability. A proportion of CIP schemes remain unidentified, whilst a number of identified schemes are currently assessed as being at risk of delivery. As the Finance Committee did not receive a completed Financial Improvement Plan at its most recent meeting an extraordinary meeting has been scheduled prior to the July Trust Board meeting to review the plan.

The Committee noted that its assurance role extends beyond monitoring progress against agreed targets. Where evidence indicates that delivery could be increasingly unlikely, despite management actions, the Committee has a responsibility to advise the Board of the likelihood of achievement, the residual risks, and the implications for the Trust, enabling informed decision-making and effective risk oversight.

Primary BAF linkages

- **BAF 004a – Finance: SWB**

• **BAF 002 – People, Workforce and Culture**
• **BAF 005b – Operational Performance: SWB**

Secondary linkages
• **BAF 001 – Quality and Safety**
• **BAF 006 – Infrastructure**
• **BAF 003 – Integration / Partnership**

BAF implication:

The adverse financial position, under-delivery of CIP and limited assurance on the maturity of the Financial Improvement Plan indicate significant exposure against the SWB Finance BAF. The drivers of the deficit are also linked to workforce controls, temporary staffing reliance, industrial action impact and reduced activity, creating secondary pressure on operational performance and quality. Until there is a credible, fully costed and deliverable recovery plan, supported by clear ownership and milestones, the Board should assume that the current BAF risk exposure remains elevated.

ALERT

Sandwell Maternity Services

The Quality Committee received a comprehensive update on maternity services, including progress against key actions and improvement priorities. Members noted evidence of improvement in some areas; however, concern was expressed regarding the increase in the maternity heatmap score, driven by high Maternity Outcomes Signal System (MOSS) indicators. The Committee also discussed the pace of delivery of the improvement plan and emphasised the importance of maintaining momentum to ensure timely and sustainable progress.

The Committee recognised the value of learning from the improvement journey being undertaken at Dudley Group NHS Foundation Trust and supported continued opportunities for shared learning across the Group. In particular, members found the ability to review performance and quality data across organisations beneficial, enabling constructive challenge, benchmarking and the identification of opportunities to adopt best practice and strengthen improvement efforts

At the time of the Committee's June meeting, the National Maternity and Neonatal Investigation Team (NMNIT) report had not been formally received; however, emerging themes were discussed. The report, which is considered in greater detail elsewhere on the agenda, identified significant concerns relating to patient safety, neonatal outcomes, workforce pressures, patient and family experience, racism and discrimination, organisational culture, leadership and governance, communication, teamworking, and variation in the quality of care provided.

The Committee noted that these findings present significant assurance concerns and will require sustained improvement and oversight. Since publication, the Trust has formally accepted the findings of the report and is working closely with Baroness Amos' team to oversee the required improvements. A dedicated Maternity Transformation and Assurance Group has been established to provide oversight of the improvement programme, monitor delivery of actions and support the Trust in addressing the report's recommendations. The Committee will continue to seek assurance that improvements are being embedded and translated into measurable improvements in safety, culture, outcomes and patient experience.

Primary BAF linkages
- BAF 001 – Quality and Safety
- BAF 002 – People, Workforce and Culture

Secondary linkages
- BAF 005b – Operational Performance: SWB
- BAF 003 – Integration / Partnership
- BAF 006 – Infrastructure

BAF implication:
The issues identified in maternity services represent a significant risk exposure against the Quality and Safety BAF, with linked concerns around workforce stability, culture, leadership, governance and patient/family experience. The findings also reinforce the need to address variation in standards and improvement maturity across the Group, using learning from DGFT where this can support accelerated improvement at SWB.

ADVISE

Financial Position and Recovery

The Dudley Group NHS Foundation Trust reported a £221k surplus, representing an £81k favourable variance against plan. Whilst the overall financial position remains positive, underlying pay pressures continue to present a challenge. These pressures are primarily attributable to delays in delivering planned bed closures through the Learn, Adapt, Transform (LAT) programme, the opening of unfunded beds to manage operational capacity pressures, and the impact of industrial action during April.

The LAT programme generated considerable discussion across Committees. In addition to concerns regarding delivery of the associated CIP savings, members highlighted potential risks relating to bed closures, the removal of non-designated bed capacity and the potential impact on patient flow. Particular emphasis was placed on ensuring that recurrent savings are delivered without compromising operational resilience, patient flow, or the quality and safety of patient care.

The Auditor's Annual Report also identified a deterioration in staff survey results compared with previous years. Members noted that this may reflect the cumulative impact of the financial recovery programme and associated grip and control measures on staff morale and engagement. The Board should seek assurance that the workforce implications of planned efficiencies are being actively monitored and mitigated, and that staff wellbeing, engagement and organisational culture remain key considerations in the delivery of the Trust's financial objectives. Maintaining staff support for the improvement agenda will be critical to sustaining performance, retention and the quality of care provided.

Notwithstanding these concerns, the Finance Committee concluded that Reasonable Assurance could be provided. Whilst the CIP programme is currently £900k behind plan, the Committee was satisfied that mitigating actions have been identified and are being actively pursued to address delivery risks. The Committee will continue to monitor progress closely, particularly in relation to the LAT programme, to ensure that financial improvement plans remain achievable and are delivered alongside the maintenance of safe and effective patient care.

Primary BAF linkages

- **BAF 004b – Finance: DGFT**
- **BAF 005a – Operational Performance: DGFT**
- **BAF 002 – People, Workforce and Culture**

Secondary linkages

- **BAF 001 – Quality and Safety**
- **BAF 003 – Integration / Partnership**
- **BAF 006 – Infrastructure**

BAF implication:

DGFT is currently reporting a favourable financial position and the Finance Committee has provided Reasonable Assurance**;** however, the underlying risk remains material due to pay pressures, CIP under-delivery and reliance on the LAT programme to deliver recurrent savings. The key BAF risk is that financial recovery actions, including planned bed closures and grip and control measures, may affect operational resilience, patient flow, workforce morale and quality of care if not actively monitored and mitigated. The £900k CIP shortfall should remain a clear area of Board focus until delivery is recovered and the sustainability of mitigating actions is evidenced

Fit for the Future Strategy

An update on the Fit for the Future Strategy was presented to all Committees during June. Whilst Chairs acknowledged the significant work being undertaken by Executive leads and programme teams, there was a consistent view that the programme remains at an early stage of development. As a result, concerns were expressed regarding the level of optimism attached to the delivery of financial and productivity benefits within the current financial year. Committees were assured that substantial effort is being invested in developing and mobilising the programme; however, there was a view that the majority of benefits are more likely to be realised in years two and three rather than in year one.

Quality and Integration Committees also raised concerns regarding the potential impact of the programme on quality improvement and service development priorities. Members noted a perceived tension between the drive to deliver financial savings and productivity improvements and the need to maintain focus on quality and

transformational change. At this stage, committees felt that some elements of the programme remain insufficiently developed to provide full assurance that benefits can be delivered without unintended consequences for service quality, patient outcomes or staff experience.

Primary BAF linkages

- **BAF 004a / 004b – Finance: SWB and DGFT**
- **BAF 005a / 005b – Operational Performance: DGFT and SWB**
- **BAF 001 – Quality and Safety**
- **BAF 003 – Integration / Partnership**

Secondary linkages

- **BAF 002 – People, Workforce and Culture**
- **BAF 006 – Infrastructure**

BAF implication:

The Fit for the Future Programme is central to delivery of the Group's financial, productivity, integration and transformation ambitions, but the current level of programme maturity limits the assurance available to Committees and the Board. The main BAF risk is that expected benefits may be over-optimistic in-year, with a greater likelihood that material benefits will be realised in years two and three. There is also a linked risk that the focus on savings and productivity could create unintended consequences for quality, patient outcomes, service development, staff experience and operational resilience if not actively managed.

Key Quality and Workforce Risks

The Committees considered a number of significant quality, operational and workforce risks during the reporting period.

Concerns were raised regarding long term incidents of incorrect blood labelling in Dudley, particularly in relation to the effectiveness of training, compliance and the implementation of corrective actions.

The Endoscopy backlog at MMUH remains a significant concern, with over 1,950 patients awaiting treatment and eight cases of harm associated with delayed cancer diagnoses. Progress is being monitored through monthly reporting to the ICB, with additional Waiting List Initiative activity in place to support recovery.

The Complex Endometriosis Service at SWB remains suspended following non-compliance with British Society for Gynaecological Endoscopy (BSGE) accreditation requirements, affecting 13 women. Assurance was provided that affected patients continue to receive appropriate care and that plans to restore service compliance are progressing.

A significant increase in complaints has been reported across the Group, particularly within Medicine, Surgery and front-door services, where complaints have increased by 50%. Whilst complaint themes are well understood, Committees received only limited assurance that learning and improvement actions are being implemented consistently. Concerns were also raised regarding the capacity of teams to manage the increasing volume and complexity of complaints.

The Committees also noted a continued rise in violence and aggression towards staff, including an increase in incidents resulting in injury. MMUH Emergency Department accounts for 47% of reported incidents, with concerns that this may be linked to high patient acuity, significant numbers of patients presenting with mental health needs and prolonged waiting times. Assurance was provided that the Trust is working proactively with Mental Health providers to address these challenges and reduce associated risks.

The BMEC backlog, currently exceeding 11,000 patients, remains a significant operational risk. Whilst mitigating arrangements are in place, there is currently no clear trajectory for complete backlog clearance and further assurance is required regarding the sustainability of recovery plans.

In addition, the Committee reviewed the clinical correspondence backlog at Dudley, primarily affecting Neurology and Dermatology services. Assurance was provided that mitigation plans are in place, including additional clinic

and staffing capacity, regular harm reviews and the introduction of Ambient Voice Technology to reduce administrative burden and support more timely clinical documentation.

Sickness absence remains the most significant workforce risk across the Group, with rolling 12-month rates above target at DGFT (5.7%) and SWB (6.1%). Whilst there are early signs of improvement, particularly within DGFT, absence levels continue to impact workforce capacity, productivity and reliance on temporary staffing. Sustained improvement will be required to strengthen workforce resilience ahead of winter pressures.

Primary BAF linkages

- BAF 001 – Quality and Safety
- BAF 002 – People, Workforce and Culture
- BAF 005a / 005b – Operational Performance: DGFT and SWB

Secondary linkages

- BAF 004a / 004b – Finance: SWB and DGFT
- BAF 003 – Integration / Partnership
- BAF 006 – Infrastructure

BAF implication:
The combination of clinical quality risks, backlogs, complaints, violence and aggression, correspondence delays and sickness absence indicates cross-cutting pressure across quality, workforce and operational performance. These issues are likely to limit the ability to reduce BAF scores unless recovery plans demonstrate measurable improvement, sustained control and clear evidence that harm, experience and workforce impacts are being reduced.

Single Point of Access (SPoA) Development Update

Good progress has been made in the development of a Dudley and Sandwell Single Point of Access (SPoA). The proposed direction of travel aligns with the wider Black Country strategy to establish two integrated SPoAs: a Wolverhampton and Walsall SPoA, and a Dudley and Sandwell SPoA. The primary objective of the SPoA model is to ensure that individuals receive urgent care in the most appropriate setting, at the right time, thereby reducing avoidable ambulance dispatches and conveyances, Emergency Department attendances, and unplanned hospital admissions. The preferred option is to implement a merged, single-site Dudley and Sandwell SPoA. This will create a consistent approach to triage, referral management and urgent care navigation across both localities, while supporting greater operational efficiency and service resilience. The merged service would adopt standardised operating hours to provide a consistent service offer for patients, professionals and partner organisations across Dudley and Sandwell.

Primary BAF linkages

- BAF 003 – Integration / Partnership
- BAF 005a / 005b – Operational Performance: DGFT and SWB

Secondary linkages

- BAF 001 – Quality and Safety
- BAF 004a / 004b – Finance: SWB and DGFT
- BAF 006 – Infrastructure

BAF implication:
The SPoA model provides a positive opportunity to reduce avoidable demand, improve urgent care navigation and support delivery of the right care in the right setting. If implemented effectively, it should contribute to reduced pressure on ambulance conveyance, Emergency Department attendance and unplanned admissions. If delayed or insufficiently standardised, the benefits to operational performance, quality and financial recovery may not be realised.

ASSURE

Stroke Services

The Committee noted the continued strong performance of stroke services across the Group. Sandwell remains the only department nationally to achieve an SSNAP 'A' rating, demonstrating sustained excellence in the delivery of stroke care. Members recognised this as a significant achievement and acknowledged the dedication and commitment of clinical and operational teams in achieving this outcome despite the challenges faced across the service. Additional assurance was provided following the successful completion of the CQC registration visit,

resulting in approval for Ridge Hill in Dudley to deliver stroke rehabilitation services. Members expressed their appreciation to teams across the service for their continued commitment to improving stroke care and outcomes for patients.

Primary BAF linkages

- **BAF 001 – Quality and Safety**

Secondary linkages

- **BAF 005a / 005b – Operational Performance: DGFT and SWB**
- **BAF 003 – Integration / Partnership**
- **BAF 002 – People, Workforce and Culture**

BAF implication:
Stroke services provide a positive assurance signal against the Quality and Safety BAF and demonstrate that strong pathway controls, clinical leadership and operational discipline can deliver sustained high performance. This should be used as an exemplar for Group learning and spread, particularly for services where quality, access and pathway reliability remain variable.

Antimicrobial Resistance (AMR) and Infection Prevention

The Quality Committee received assurance that both Trusts are aligned to the NHS England national Antimicrobial Resistance (AMR) strategy. Joint working arrangements are well established, with two shared Trust-level AMR priorities agreed across the Group, alongside organisation-specific priorities for Infection Prevention and Control (IPC).

Antibiotic prescribing across both organisations remains in line with national benchmarking, providing assurance regarding appropriate antimicrobial stewardship. Strong governance arrangements are in place through Medicines Management, Infection Prevention and Control, and Quality Governance structures to oversee delivery of AMR objectives, monitor performance and support continued compliance with national requirements.

Primary BAF linkages

- BAF 001 – Quality and Safety

Secondary linkages

- BAF 003 – Integration / Partnership
- BAF 002 – People, Workforce and Culture
- BAF 006 – Infrastructure

BAF implication:
The alignment of both Trusts to the national AMR strategy and the establishment of shared Group priorities provide positive assurance against the Quality and Safety BAF. However, AMR and IPC remain high-consequence safety risks requiring continuous surveillance, prescribing compliance, governance and escalation where variation or deterioration is identified.

Targeted careers and employability initiatives
Schemes continue to deliver measurable social and workforce benefits. Since June 2023, the Sandwell Employing Local People programme has supported over 2,000 local residents and enabled more than 300 individuals into employment through workforce pipelines, work experience, apprenticeships and social value programmes. Similarly, the Dudley ICAN project demonstrates success in widening access to NHS careers for disadvantaged young people, supporting social mobility and improving employability through structured development opportunities. Whilst these outcomes provide strong evidence of impact and community benefit, a key strategic risk remains that workforce contraction and recruitment constraints across the NHS may limit the availability of substantive employment opportunities. The Trust is therefore focusing not only on participation and access measures, but also on progression and conversion into sustainable employment, apprenticeships and career pathways across the wider health and care system, ensuring that investment in these programmes continues to deliver both workforce and population benefits.

Primary BAF linkages

- **BAF 002 – People, Workforce and Culture**
- **BAF 003 – Integration / Partnership**

Secondary linkages

- **BAF 004a / 004b – Finance: SWB and DGFT**
- **BAF 001 – Quality and Safety**
- **BAF 005a / 005b – Operational Performance: DGFT and SWB**

BAF implication:
The careers and employability programmes provide positive assurance against the workforce pipeline, local employment and population benefit elements of the BAF. However, the strategic benefit will be limited if workforce contraction, vacancy controls or recruitment constraints reduce conversion into substantive employment, apprenticeships or sustainable career pathways.

Board Assurance Report Appendix 1
Lessons Learned Exercise Following NHS England Letter Dated 6 February 2026

To provide the Board with assurance regarding the findings of the lessons learned exercise undertaken following NHS England's letter dated 6 February 2026 from Nicola Hollins, Regional Director of Finance, NHS England. The review considered the positive assurances provided throughout 2025/26 regarding delivery of the financial plan and the subsequent material change in both in-year and forecast outturn reporting following the appointment of the new Director of Finance.

This section summarises the key findings and sources of assurance for the Board.

Areas Reviewed and Key Findings

1. To what extent did internal and external reporting provide appropriate information and assurance?

The review concluded that whilst financial risks and concerns were identified within detailed financial reports, these were not consistently reflected within high-level reports presented to Board Committees, the Trust Board or NHS England. As a result, the assurances provided through formal governance arrangements did not fully align with the underlying level of financial risk facing the organisation. In addition, forecasting processes lacked a robust and consistent methodology, with insufficient focus placed on expenditure run rates, recurrent financial performance and underlying trends. This limited the organisation's ability to develop a comprehensive understanding of its true financial position and likely year-end outturn.

Board Assurance: Partial assurance was provided during 2025/26 due to weaknesses in the escalation, transparency and presentation of financial risks. Actions have subsequently been implemented to strengthen reporting and forecasting arrangements.

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2. To what extent was there transparency and understanding of the Trust's financial position by those charged with governance throughout the year, including key assumptions and risks within the 2025/26 Plan?

The review found that there was insufficient organisational understanding of the risks underpinning delivery of the 2025/26 financial plan. Reporting was heavily reliant on divisional service line forecasts, particularly in relation to activity and income assumptions, which contributed to an overly optimistic view of financial performance. The Cost Improvement Programme (CIP) lacked sufficient granularity in a number of areas and was supported by a significant level of non-recurrent mitigations. Whilst these measures supported delivery of the financial position reported during the year, they reduced visibility of the underlying recurrent deficit and long-term sustainability of the plan. Consequently, those charged with governance did not always have a full appreciation of the scale of the underlying financial challenge or the extent to which delivery relied upon assumptions and one-off measures.

Board Assurance: Partial assurance was provided due to the absence of sufficient transparency regarding underlying financial performance, recurrent risks and delivery assumptions.

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3. To what extent did the finance function have the capacity and capability to support the organisation on all matters relating to financial management, reporting and governance?

The review determined that the finance function was operating with staffing levels below those of comparable organisations and experienced a number of key vacancies throughout 2025/26. These resourcing pressures affected the department's ability to provide proactive financial analysis, business partnering and challenge across operational services. Benchmarking identified specific areas requiring strengthening, including income and contracting expertise. The review also identified opportunities to improve financial literacy across the wider organisation and reinforce the principle that effective financial stewardship is a responsibility shared by all budget holders and leaders, rather than solely the finance function.

Board Assurance: Partial assurance. The finance function maintained core financial processes; however, workforce and capability challenges limited the level of support, challenge and oversight that could be provided.

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4. To what extent did the efficiency programme deliver in 2025/26, including its impact on expenditure run rates?

The review found that the Trust achieved its CIP forecast for 2025/26; however, delivery was heavily dependent upon non-recurrent measures. Whilst these actions supported achievement of the reported position, they did not sufficiently address the Trust's underlying recurrent cost base, leaving a significant structural financial challenge entering 2026/27. Programme management arrangements were not fully established until Quarter 2, reducing available time to identify, develop and implement sustainable efficiency opportunities. Furthermore, many schemes were developed later in the financial year, limiting their overall impact and reducing the opportunity to realise full-year benefits. As a result, the organisation remained reliant on short-term mitigations rather than transformational cost reduction initiatives capable of delivering sustainable recurring benefits.

Board Assurance: Partial assurance. Reported delivery was achieved, but the sustainability and recurrent value of a significant proportion of schemes was limited.

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5. To what extent did the Financial Recovery Plan introduced at Month 6 deliver, and what was its impact on expenditure run rates and the March 2026 exit position?

The review found that the Financial Recovery Plan contributed to a reduction in expenditure run rates during the second half of the financial year and strengthened organisational focus on financial performance. A number of expenditure control measures were successfully implemented and improved financial discipline across the Trust. However, delivery of the recovery plan remained heavily reliant on non-recurrent interventions and optimistic assumptions regarding income recovery. Whilst these measures improved the reported position, they did not fully resolve the underlying recurrent financial deficit. A key lesson learned from the review was the importance of earlier identification, escalation and mitigation of financial risks. More robust forecasting methodologies, greater focus on expenditure trends and clearer reporting of

financial risks and assumptions are now being implemented to strengthen financial management arrangements from 2026/27 onwards.

Board Assurance: Partial assurance. The recovery plan delivered improvements in expenditure control and financial management; however, benefits were largely non-recurrent and did not fully address the underlying financial position.

Overall Conclusion and Board Assurance

The lessons learned exercise identified that the principal issue was not the absence of identification of financial risks, but the extent to which those risks were understood, challenged, escalated and transparently reported through governance arrangements.

The Board can take assurance that the underlying causes have been identified and that actions are in place to strengthen financial governance, forecasting and reporting. Going forward, assurance should be derived from transparent reporting of the recurrent financial position, forecast accuracy, expenditure run rates, CIP delivery and sustainability, together with timely escalation of financial risks and evidence of effective challenge through the Trust's governance framework.

This should be reinforced by robust scrutiny and challenge from Non-Executive Directors. Where concerns remain unresolved, NEDs should seek additional assurance, including independent review where appropriate, and ensure concerns are formally escalated through Board and Committee structures. Through these arrangements, the Board will be better placed to identify emerging risks at an earlier stage, support timely intervention and mitigation, and maintain effective oversight of the Trust's financial performance and long-term sustainability.

Enclosure 4a

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

REPORT TITLE:	Sandwell & Birmingham NHS Trust, Finance Report – Month 02 2026/27		
SPONSORING EXECUTIVE:	Madi Parmar – Director of Finance SWB		
REPORT AUTHOR:	Madi Parmar – Director of Finance SWB Craig Higgins – Associate Director of Finance SWB Bal Malhi – Deputy Director of Finance SWB		
MEETING:	Group Public Trust Board	**DATE:**	22 July 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
x	Discussion		Endorse		The Dudley Group NHS Foundation Trust
x	Information		Recommend		
		x	Discuss		
		x	Note		

Suggested discussion points

Assure

The Board is asked to note:

- Financial Plan – The Trust plan £8m deficit outturn, £58.1m of efficiency required to deliver the plan, £14m deficit support within the plan. Agency Plan £2.663m.
- Year to Date Position against plan – At month 2, the Trust reported a (£5.52m) deficit, against a deficit plan of (£3.90m), an adverse variance of (£1.62m). This represented a steadying of the run rate from M1 with no further year to date deterioration.

Advise

Key Driver of the Month 2 position:

- (£1.74m) under-delivery against the M2 efficiency plan
- (£1.59m) under-delivery against the M2 contract income plan
- (£0.80m) Industrial Action costs

These have been mitigated in part by:

- £1.10m non pay underspends (in part related to the under-delivery of contract income)
- £0.51m increase in recognition of sprint income
- £0.59m of other income over performance (SLA, RTA and overseas, net of bad debt provision)

Alert

Performance against Trust efficiency plan:

- (£1.74m) adverse to plan (£4.75m delivery against a plan of £6.49m)
- Recurrent schemes (£2.03m) adverse to plan (£1.52m against a plan of £3.54m)
- Non-recurrent schemes £0.29m favourable to plan (£3.24m against a plan of £2.95m)

Performance against the Trust activity plan:

- (£1.59m) adverse to plan at M2; this includes an estimated value for uncoded M1 and M2 activity arising from the move from OPCS 4.10 to 4.11, a known national issue. An update has been released early June, and the financial impact will be reported in M3.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
Finance and Performance Committee, Executive Group, Divisional Confirm and Challenge sessions

Recommendation	
a)	Note the Month 2 financial position, together with the key risks identified and the corresponding mitigation measures.

Escalation
Given the deficit position of the Trust and shortfall on year-to-date CIP delivery, it is recommended that this is highlighted to the Board.

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026

SWB Finance Report – Month 02 2026/27

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1. CFO Commentary

The M2 financial position saw no further deterioration from plan, from M1 but it remains a deficit position, off plan year to date, with a considerable challenge to achieve the required year end position. Full delivery of the ambitious 7% CIP requirement (£58.1m full year) remains the key risk.

National messaging strongly indicates no further funding becoming available to support industrial action costs or for winter remediation, therefore it is imperative that the trusts continues to try and reduce the expenditure run rate. As a result of this the Executive have reviewed the level of prospective cover available within budgets to try and reduce further the utilisation of bank and this will be actioned as additional CIP; as a second order action the full investment of circa £9m (original investment in 2024/25) into 7-day working at MMUH is under review for potential disinvestment, albeit a proportion of this has already been given up within the establishment review CIP. This together with model hospital signalled excess cost opportunity reduction enables us to close out CIP identification and move into a delivery and mitigation against anon recurrent savings in year, however work remains ongoing to identify further recurrent savings for year 2 and year 3 of the plan.

The Trusts monthly Financial Improvement group has been refreshed, to have a strong focus on run rate reporting, impact on the underlying position, forecasting to year end and CIP delivery, to highlight and escalate risk of non-delivery in a timely fashion and as a vehicle to request and review remedial action delivery plans.

A Lessons learned report (on the Trusts 2025/26-year end position and hence underlying deficit) has been drafted for sharing with NHSE and was shared with the Finance and Performance committee.

In addition, the Trust has commissioned an independent review of the drivers of the deficit position, as required by NHSE in their plan sign off letter. The conclusion of NHSE is that the SWB plan is "non-compliant" as it is an £8m deficit plan including £14m of deficit support funding, a revision from the expected view of "near compliant". As a result of this the Trust will be having detailed monthly financial, workforce and Cost improvement programme monthly reviews in addition to the regular cycle of PRMs with the Midlands regional team and the usual statutory monthly national financial reporting templates.

2. Executive Summary

2.1 A summary of the key financial performance indicators for the period ending 31 May (Month 2) are set out in the table overleaf.

Table 1: Key Financial Metrics

	In Month Plan £ms	In Month Actual £ms	In Month Variance £ms	Year to Date Plan £ms	Year to Date Actual £ms	Year to Date Variance £ms
I&E Performance	(1.95)	(1.93)	0.02	(3.90)	(5.52)	(1.62)
Agency Costs	0.27	0.23	0.03	0.53	0.53	(0.01)
Financial Improvement Programme	3.25	3.52	0.27	6.49	4.75	(1.74)
Capital Expenditure (ICB Allocation)	2.64	0.41	2.23	5.28	0.86	4.42
Capital Expenditure (Other)	1.18	0.00	1.18	2.34	0.00	2.34
Cash Balance	34.28	42.59	8.31	34.28	42.59	8.31

2.2 The key issues at month 2 are:

2.2.1.1 Year-to-date adjusted deficit of (£5.52m), (£1.62m) adverse variance to the plan.

2.2.1.2 The total pay variance is (£1.47m) adverse to plan. This includes £0.8m of Industrial Action costs incurred in April 2026.

2.2.1.3 Agency expenditure is £0.53m, (£0.01m) adverse to plan. This represents 0.6% of total pay expenditure.

2.2.1.4 Bank expenditure is £7.35m, (£2.17m) adverse to plan. This represents 8.6% of total pay expenditure.

2.2.1.5 Year-to-date income position is £131.87m, £1.14m favourable to plan. This includes an under performance against healthcare contract income offset by other income.

2.2.1.6 Efficiency schemes have delivered £4.75m of savings, of which 68.1% of delivery to date is non recurrent. This is (£1.74m) adverse to plan year to date.

2.2.1.7 Cash balances are £42.59m, £4.54m lower than the previous month and £18.8m favourable to plan for the month.

3. Income and Expenditure

3.1 Income and Expenditure: Year to Date Position

The year-to-date income and expenditure position is set out in table 2 below. The trust has reported a deficit of £5.52m, against a deficit plan of £3.90m, (£1.62m) adverse to plan. The main drivers of the year-to-date variance are the costs of Industrial Action of £0.8m and slippage on efficiency schemes of £1.74m and under performance against income from patient care activities (£1.59m). These have been partially mitigated by activity related non pay under spends (activity below plan), and income (Sprint, SLAs, RTA and overseas net of bad debt).

Table 2: Income and Expenditure

I&E - FINANCIAL PERFORMANCE	Current Month			Year to Date			Forecast Outturn		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Income	**65,366**	**66,752**	**1,386**	**130,732**	**131,867**	**1,135**	**784,345**	**784,345**	**0**
Substantive	(40,280)	(38,237)	2,043	(80,560)	(76,824)	3,736	(487,400)	(486,211)	1,189
Bank	(1,086)	(3,743)	(2,657)	(2,172)	(7,350)	(5,178)	(6,298)	(7,488)	(1,190)
Agency	(263)	(236)	27	(526)	(534)	(8)	(2,663)	(2,663)	0
All Other pay	(174)	(179)	(5)	(348)	(363)	(15)	(2,088)	(2,088)	0
Pay	**(41,803)**	**(42,395)**	**(592)**	**(83,606)**	**(85,071)**	**(1,465)**	**(498,449)**	**(498,450)**	**(1)**
Non-Pay	(23,368)	(24,364)	(996)	(46,736)	(48,466)	(1,730)	(268,142)	(268,182)	(40)
Non Operating Items	(2,146)	(1,921)	225	(4,291)	(3,848)	443	(25,754)	(25,713)	41
TOTAL Provider Surplus/(Deficit)	**(1,951)**	**(1,928)**	**23**	**(3,901)**	**(5,518)**	**(1,617)**	**(8,000)**	**(8,000)**	**0**
Less Non Recurrent Deficit Funding	(1,166)	(1,166)	0	(2,332)	(2,332)	0	(14,000)	(14,000)	0
TOTAL Provider Surplus/(Deficit) Excluding Non-Recurrent Deficit Funding	**(3,117)**	**(3,094)**	**23**	**(6,233)**	**(7,850)**	**(1,617)**	**(22,000)**	**(22,000)**	**0**

3.2 Income and Expenditure: In Month Position

The in-month income and expenditure position is a deficit of £3.09m, £0.02m favourable to plan. The Trust reported an improved position against healthcare income, with the estimate of uncoded activity in April, which was subsequently coded in May resulting in an improved position (circa £1m). However, it should be noted that the Trust continues to underperform against variable patient related healthcare income, further details are provided in section 2.5.

3.3 Pay Expenditure

Pay expenditure is (£1.47m) adverse to plan at the end of Month 2. Of this, the position includes £0.8m of Industrial Action costs and £0.4m of efficiency under delivery. It should be noted, of the £3.7m of pay savings delivered to date, £3.2m are currently classed as non-recurrent albeit where these relate to temporary staff further work is being undertaken to embed this recurrently.

Substantive pay costs reduced by £350k compared to the previous month, and this was largely due to one off Industrial Action costs in April offset by a provision for medical pay award costs in May (this is offset by income). Bank costs saw an increase of £136k compared to the previous month, however from a WTE there was a reduction (staff group/grade impact from a £ value perspective).

Table 3 below provides detail on WTE, and this shows that 7,941 wte in post May compared to a plan of 7,937, an overall variance of 4 wte. However, a significant reduction is still required by year end to deliver the workforce efficiency requirement for 2026/27 and the mitigating actions identified in terms of enhanced pay controls and temporary staff eligibility should support further reductions, as well as further embedding of identified CIP.

Table 3: WTE Plan versus Actual

	2025 / 2026			2026 / 2027											
Pay Group	**M10**	**M11**	**M12**	**M01**	**M02**	**M03**	**M04**	**M05**	**M06**	**M07**	**M08**	**M09**	**M10**	**M11**	**M12**
Plan	8,170	8,170	8,170	7,848	7,937	7,872	7,806	7,741	7,676	*7,609*	*7,583*	*7,571*	*7,571*	*7,571*	*7,571*
Actual: Substantive (FTE)	7,414	7,410	7,342	7,338	7,316										
Actual: Bank (FTE)	663	701	810	628	613										
Actual: Agency (FTE)	20	20	17	16	12										
Actual: Total (FTE)	**8,097**	**8,131**	**8,170**	**7,982**	**7,941**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Month on Month Change (FTE)		34	39	-188	-41										
Month on Month Change (%)		0.4%	0.5%	-2.3%	-0.5%										
Cumulative Change %		0.4%	0.9%	-1.4%	-1.9%										
Variance to Plan (FTE)				134	4										
Variance to Plan (%)				1.7%	0.1%										
Run Rate Projection (Based on Last Actual Month)	**Run Rate Analysis**			**7,982**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**	**7,941**
Variance to Plan (FTE) (Based on Last Actual Monti	**Run rate reflects the latest**			134	4	-7,872	-7,806	-7,741	-7,676	-7,609	-7,583	-7,571	-7,571	-7,571	-7,571
% Variance to Plan (Based on Last Actual Month)	**actual month held constant**			1.7%	0.1%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%	-100.0%
	through the remainder of														
	the year.														
Trend Analysis (From M10 2025/2025)	**Trend Analysis**			**7,982**	**7,941**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Variance to Plan (FTE) (Based on Trend)	**Trend analysis reflects the**			134	4	-7,872	-7,806	-7,741	-7,676	-7,609	-7,583	-7,571	-7,571	-7,571	-7,571
% Variance to Plan (Based on Trend)	**months from M10**			1.7%	0.1%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	2025/2026.														

3.4 Non-Pay Expenditure

Non pay expenditure is (£1.29m) adverse to plan at the end of Month 2. This includes £1.67m of under delivery against the efficiency programme and bad debt (£0.64m) partially mitigated by underspends related to lower than planned activity levels.

3.5 Income

Income has reported a favourable variance to plan of £1.13m. This comprises a provision for pay award funding (£1.33m), and the release of RTT sprint income (£0.51m) previously under query. This is offset by healthcare contract income under performance (£1.59m). The position includes estimated values for uncoded activity, including the mandated national move to OPCS 4.11 from 4.10. A fix has been released, and an updated income position will be provided for Month 3 reporting.

Table 4: Variable Healthcare Income

		Current Month						Year-to-Date					
Variable Group	**Variable Type**	**Activity Plan**	**Activity Actual**	**Activity Diff**	**Price Plan £000**	**Price Actual £000**	**Price Diff £000**	**Activity Plan**	**Activity Actual**	**Activity Diff**	**Price Plan £000**	**Price Actual £000**	**Price Diff £000**
Variable	Variable ERF	35,362	34,125	(1,238)	£11,034	£10,672	(£362)	72,584	71,053	(1,532)	£22,648	£21,777	(£871)
	Variable Other Elective	9,874	8,543	(1,331)	£996	£856	(£139)	20,267	18,338	(1,929)	£2,044	£1,847	(£197)
	Blended UEC	25,371	24,286	(1,085)	£16,180	£15,751	(£428)	50,537	48,750	(1,787)	£31,958	£31,397	(£562)
	Variable Non-NHS	127	91	(36)	£24	£24	(£1)	261	216	(45)	£50	£53	£3
	Variable Other	547	258	(290)	£13	£9	(£4)	1,109	463	(647)	£26	£14	(£12)
	Variable Pass-through	316	389	73	£2,014	£1,988	(£26)	632	700	68	£4,028	£4,079	£51
Fixed		516,859	496,006	(20,853)	£27,054	£27,054	£0	1,060,110	1,038,238	(21,872)	£53,877	£53,877	£0
Grand Total		**588,456**	**563,697**	**(24,759)**	**£57,314**	**£56,355**	**(£960)**	**1,205,500**	**1,177,757**	**(27,744)**	**£114,630**	**£113,043**	**(£1,587)**

4. Efficiency Programme

4.1 The 2026/27 financial plan set a requirement to deliver £58.1m of efficiency savings. The table below summaries delivery for the period ending 31 May (Month 2).

Table 5: Efficiency Programme Year-to-Date Delivery

	2026/27 Plan	YTD Plan	YTD Actual	YTD Variance
	£m	£m	£m	£m
Recurrent	31.65	3.54	1.52	(2.03)
Non-Recurrent	26.45	2.95	3.24	0.29
Total	58.10	6.49	4.75	(1.74)

For the year to date the Trust has recorded delivery of £4.8m, (£1.7m) adverse to the phased plan, with a substantial reliance on non-recurrent schemes (68% of total delivery) in the first two months of the financial year.

4.2 The Trust has submitted a forecast as part of the monthly M2 return to NHSE of £52.92m, which implies a delivery risk of £5.18m against the 2026/27 requirement. However, we are reviewing the delivery risk stratification of the identified £58.1m total annual programme and reporting on this in more detail through an extra-ordinary F&P focussed on the cost improvement programme on 20th July and subsequently through the ordinary F&P committees from M3 onwards. This will also feed to into our overall Income and expenditure forecasting, escalation of risk and drive for rectification plans.

5. Risks and Mitigations

5.1 The 2026/27 financial plan is stretching and ambitious. The risks are linked to the key elements of the plan:

- Delivery of the £58.1m Efficiency Programme
- Delivery of the Trusts Income and Activity Plan
- Management of the Workforce Plan

5.2 Mitigating actions include:

- Further pay controls – all vacancies, temporary staff requests and contractual changes reviewed at weekly Executive lead panel.
- Enhanced rules on eligibility for temporary staff requests, in relation to short notice sickness cover and ad hoc requests.
- All clinical divisions and corporate directorates are undertaking reviews of all pre pipeline schemes, with a view to progressing suitable schemes into fully developed once quality impact assessments and financial implications have been through an approval process.
- In addition, a review of “unpalatable options”/” difficult decision” options to reduce run rate further (with associated quality impact assessment), were collated, reviewed by the Executive and rag rated to proceed/develop further/not proceed and rated as Green/Amber have been added to the CIP pre-pipeline tracker for further development.
- A review of outstanding Model hospital opportunity not yet addressed and Cost per Weighted Activity Unit” opportunity to focus the remaining £5m of expected CIP delivery.

This enables the Trust to now focus on absolute run rate, CIP delivery and risk management going forwards.

6. Capital and Cash

6.1 The Capital Programme requires prioritisation to ensure schemes can be progressed and to ensure a more even spend throughout the year as a result performance is behind ahead plan to the end of May (as is shown in the key metrics table 1 in paragraph 1.1). Progress on the MMUH UTC scheme is underway and an agreed profile of spend is being worked up. The Capital Management Group continues to meet monthly to monitor and manage delivery of the programme.

6.2 Cash was ahead of plan for May and will be closely monitored through 26/27; Cash balances are £42.59m, £4.54m lower than the previous month and £18.8m favourable to plan for the month. As in previous years, delivery of the Trust's Efficiency Programme is key to maintaining cash balances and to reduce the risk of applying for cash support through NHSE. The forecast shows a cash balance at 31/3/27 of £18.4m, which is based on the Trust achieving an £8m deficit I&E position. The Trust is holding a monthly cash committee to manage risk and report upwards to the Finance and Performance committee.

6.3 The Trust aims to manage cash through flexibility in working balances whilst maintaining payment performance (BPPC). Failure to effectively manage balances may require the Trust to consider applications to NHSE for revenue cash borrowing, the requirement for this will be monitored throughout the year, considering the cash balance and I&E run rate each month. Work continues to deliver the 2% spend commitment with local suppliers in line with Anchor Institution commitments and is reported through Audit and Risk Management Committee.

7. Recommendations

The Group Public Trust Board Is asked to:

a) Note the Month 2 financial position, together with the key risks identified and the corresponding mitigation measures.

Madi Parmar, Director of Finance SWB
10th July 2026

Enclosure 4b

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

REPORT TITLE:	The Dudley Group NHS Foundation Trust, Month 2 Financial Position		
SPONSORING EXECUTIVE:	Chris Walker, Director of Finance		
REPORT AUTHOR:	Chris Walker, Director of Finance		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

Paper Type:		**Requested action:**		**Applies to:**	
	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

1. The Board is asked to note the Month 2 (May 2026) Trust financial position. After technical changes the May cumulative position is a £0.221m surplus. This position is £0.081m better than the financial plan submitted to NHS England in February 2026.

2. The Trust is forecasting that we will achieve our 2026/27 financial year planned break even position after technical adjustments but there is associated risk to delivery that the Trust is actively mitigating.

3. The Trust is forecasting a healthy cash balance for the 2026/27 financial year.

4. The Trust achieved the capital plan for the period to the end of May and forecasts that it will achieve the full 2026/27 capital plan.

Advise

1. The Trust's financial forecast for the 2026/27 financial year remains in line with the plan at a breakeven position. The Trust continues to review the financial risk to achieve the plan which stands at £9.484m all related to delivery of the cost improvement programme. The Trust has a plan to mitigate this risk which will be fully developed by the end of July.

Alert

1. Pay expenditure was overspent against plan by £1.661m. While some of this related to the increase in the pay award compared to the plan (this will be funded by NHS England through income) the Trusts bank expenditure is a concern as at the end of May. The Trust is currently £2.560m overspent against our plan and over the bank cap set by NHS England.

2. The phased Cost Improvement Programme plan cumulatively for May equated to £5.217m. Achievement to May totals £4.289m, which is lower than plan by £0.928m. Phasing of the final plan compared to the submitted NHS England plan contributes £0.547m to this variance with the remainder relating to 'Learn, Adapt, Transform' and 'Fit for the Future' programme under delivery.

3. The Trust has forecasted the delivery risk associated with the current cost improvement programme of £35.180m. As at the end of May the Trust highlights a delivery risk of £9.484m. The schemes contributing

to the total delivery risk are the Learn, Adapt, Transform Programme (Newton) (£2.011m) and Fit for the Future (£7.473m). The Trust has identified mitigation opportunities to fully mitigate the delivery risk.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
Month 2 (May 2026) detailed finance report presented to the Finance and Productivity Committee on the 25th June 2026. Summary Month 2 financial report presented to Executive Directors on 9th June 2026.

Recommendations	
a)	Note the financial performance of the Trust for the month of May 2026 for assurance.

Escalation
Should any element of this report be escalated: none

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
Is Quality Impact Assessment required if so, add date: n/a			
Is Equality Impact Assessment required if so, add date: n/a			

FINANCE REPORT TO PUBLIC BOARD OF DIRECTORS ON 22 JULY 2026

1. EXECUTIVE SUMMARY

1.1 After technical changes, the **May cumulative position is a £0.221m surplus.** This position is £0.081m better than the financial plan submitted to NHS England in February 2026.

1.2 The cumulative actual position in May compared to plan shows the Trust being better than plan. This continues the position from April. The medicine division is overspent during this period predominantly due to continued capacity pressures in urgent and emergency care, impacting on the delivery of the required 'Learn, Adapt, Transform' (LAT) programme and requiring unfunded additional bed capacity. This is offset by underspends in other clinical divisions linked to positive pay positions and additional healthcare income. The Trust also incurred unfunded pay costs associated with the resident doctors' strike in April that it has been able to manage within the cumulative financial position.

1.3 Income is £1.525m better than the plan. This relates to additional income associated with the final NHS pay award settlement which was not included in the Trusts' original plan and one-off benefits relating to the old financial year as activity has been finalised with performance above our estimated position. The Trust has also seen an increase in emergency activity during the first two months of the financial year, which has contributed to the income variance.

1.4 Pay expenditure was overspent against plan by £1.661m. Whole time equivalents were 6 higher than the plan at the end of May which was an improvement from April. Pay costs are above the financial plan cumulatively to May as a result of increased bank expenditure against plan and predominantly the inclusion of the additional NHS pay award of £1.040m (this is off set by the increase in income for the associated funding).

1.5 Non-pay expenditure was below the financial plan at the end of May by £0.095m. This is related to underspending on both clinical and non-clinical supplies offset by small overspending on medicines.

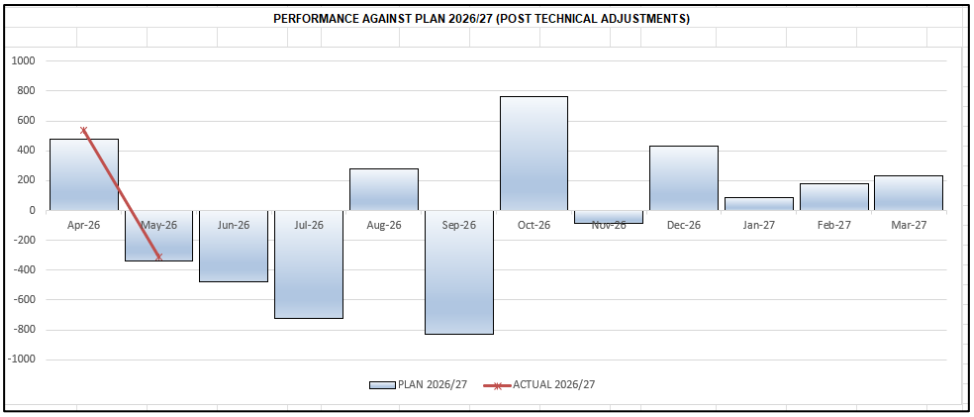
1.6 The phased Cost Improvement Programme plan cumulatively for May equated to £5.217m. Achievement to May totals £4.289m, which is lower than plan by £0.928m. Phasing of the final plan compared to the submitted NHS England plan contributes £0.547m to this variance with the remainder relating to 'LAT' and 'Fit for the Future' programme under delivery.

1.7 The Trust's financial forecast for the 2026/27 financial year remains in line with the plan at a breakeven position. The Trust continues to work through the cost improvement programme to ensure all schemes are delivered and where there are forecast shortfalls in delivery the Trust has mitigating schemes to cover any shortfalls.

2. INCOME AND EXPENDITURE

2.1 After technical changes, the **May cumulative position is a £0.221m surplus.** This position is £0.081m better than the financial plan submitted to NHS England in February 2026.

2.2 While the Trust is achieving its financial plan at this stage of the financial year it is not without its challenges. The medicine division is overspent during this period, predominantly due to continued capacity pressures in urgent and emergency care, impacting on the delivery of the required 'LAT' programme and requiring unfunded additional bed capacity. This is offset by underspends in other clinical divisions linked to positive pay positions and additional healthcare income. The Trust also incurred unfunded pay costs associated with the resident doctors' strike in April that it has been able to manage within the cumulative financial position. The Trust will need to mitigate the current under delivery on the cost improvement programme in order to achieve the financial plan.



2.3 Income is £1.525m better than the plan. This relates to additional income associated with the final NHS pay award settlement which was not included in the Trusts' original plan and one-off benefits relating to the old financial year as activity has been finalised with performance above our estimated position. The Trust has also seen an increase in emergency activity during the first two months of the financial year, which has contributed to the income variance. While increased levels of emergency care have been seen year to date planned care activity has been below plan for both April and May. This is not ideal as emergency care operates on a blended tariff basis so overperformance will only attract 20% of tariff whereas planned care is adjusted at full tariff. Recovery plans are in place for planned care to ensure we achieve our income plan.

2.4 Substantive staff are 62 Whole Time Equivalents (WTE) better than target in May. Substantive pay costs were £1.072m below plan at the end of May. From a vacancy perspective there is a £2.112m underspend at the end of May which is then offset by the inclusion of the additional NHS pay award of £1.040m (this is off set by the increase in income for the associated funding). An enhanced vacancy freeze for all posts except clinically critical posts continues to be in place as it was for the majority of the previous financial year.

2.5 Bank is over the target by 64 Whole Time Equivalents (WTE) with a cumulative overspend of £2.560m against plan at the end of May. Included in bank are the costs of covering Aprils' industrial action by resident doctors, estimated at £0.364m. The majority of the overspend relates to slippage on the 'LAT' programme together with the opening of additional unfunded beds due to capacity pressures. The Trust achieved the closure of AMU Assessment on 6th May (21 beds) and Ward A4 on 15th May (12 beds) but subsequently saw the equivalent Ward A4 beds reopened by the end of May. The Trust is set a cap on bank expenditure by NHSE England, at the end of May the Trust was £0.194m above the cap.

2.6 Agency is over target by 4 Whole Time Equivalents (WTE). There is a cumulative overspend of £0.173m against plan at the end of May. The majority of the agency expenditure relates to medical staff in the emergency department, Older People specialties and Obstetrics. Whilst above plan, the expenditure is within the cap set by NHS England.

2.7 Non pay expenditure was below the financial plan at the end of May by £0.095m. This is related to underspending on both clinical and non-clinical supplies offset by small overspending on medicines.

2.8 While the Trust is achieving its financial plan as at the end of May this is not without challenge. The Trust is not achieving its cost improvement plan to date and is continuing to see additional costs being incurred within the urgent and emergency care services. While these areas have been mitigated so far this cannot continue and the Trust must ensure it achieves its cost improvement financial trajectory.

2.9 At this stage of the financial year the Trust is forecasting it will achieve its 2026/27 financial plan.

3. CAPITAL AND CASH

3.1 Receipts were £4.640m above plan, driven mainly by £2.478m of additional Black Country ICB income, reflecting prior-year income received earlier than expected and therefore a timing difference. Other

healthcare income was also higher due to deficit support funding being received one month earlier than planned, partly offset by lower specialised services income.

3.2 Payments were £2.699m below forecast, primarily due to supplier payments being £2.838m lower than expected. This largely relates to disputed NHS invoices, which are anticipated to be settled in June.

3.3 The cash forecast is the same as the submitted plan to NHS England (£24.233m). This has been reduced from the previous month with changes to the income assumptions around the receipt of activity income. At this stage, the Trust is not forecasting any material cash movements in 2026/27 however as the year progresses non-achievement of the CIP and/or overspending budgets will impact on the cash position. The downside cash position shows a cash balance of £12.983m taking into consideration scenarios based on the above.

3.4 Compliance with the Better Practice Payment Code was 89.6% in terms of number of invoices paid to non-NHS suppliers and 94.9% for NHS suppliers as at 31st May 2026.

3.5 In month 2, year-to-date capital expenditure was £0.850m, against planned expenditure of £0.859m. CHP and NHS Property Services lease remeasurements resulted in a £0.204m underspend due to non-cash technical capital adjustments, with confirmation of 2026/27 indexation still awaited for two properties. A £0.181m overspend on replacement medical equipment reflects earlier-than-planned deliveries, while a £0.014m overspend on statutory standards relates to minor works completed ahead of schedule.

3.6 Capital expenditure of £13.987m is forecast to be spent in the 2026/27 financial year, which is as per plan. The Trust has received a strategic capital allocation of £3.008m relating to constitutional standards. These schemes are currently progressing through the business case process. The Trust is currently working with NHS England to bid for the 2026/27 RAAC allocation. This will be added to the Trust's capital programme once the amount is confirmed.

4. COST IMPROVEMENT PROGRAMME

4.1 The phased Cost Improvement Programme plan cumulative to May equated to £5.217m. Achievement to May totals £4.289m, which is lower than plan by £0.928m. Phasing of the final plan compared to the submitted NHS England plan contributes £0.547m to this variance with the remainder relating to 'LAT and 'Fit for the Future' under delivery. Of the total programme in the original plan 81% were planned to be recurrent (£28.597m) with 19% non-recurrent (£6.583m). Of the £4.289m achieved at the end of May, 80% are recurrent.

4.2 The Trust has forecasted the delivery risk associated with the current cost improvement programme of £35.180m. As at the end of May the Trust highlights a delivery risk of £9.484m. The schemes contributing to the total delivery risk are the 'LAT' (Newton) (£2.011m) and Fit for the Future (£7.473m). The Trust has identified mitigation opportunities to fully mitigate the delivery risk. Some of the mitigations are fully worked up and are increases to existing schemes while other schemes require project documentation to be completed. The Trust expects to have a fully mitigated cost improvement programme by the end of July.

4.3 The Trust slippage on the 'LAT' programme will contribute to some full year effect cost improvement in 2027/28. To ensure the underlying financial position of the Trust isn't impacted by the cost improvement programme changes the mitigating schemes will maintain or improve the target of 80% of the cost improvement programme being recurrent in nature.

5. RECOMMENDATIONS

5.1 The Trust Board is asked to note the financial performance for the period up to May 2026.

Chris Walker
Director of Finance, 5th July 2026

Enclosure 5

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

REPORT TITLE:	Addressing Financial and Operational Non-Compliance		
SPONSORING EXECUTIVE:	Madi Parmar, Director of Finance, SWB		
REPORT AUTHOR:	Madi Parmar, Director of Finance, SWB		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

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

Suggested discussion points

The purpose of this report is to update the Board on the consequences and issues arising from submitting a non-compliant plan for the financial year 2026/27.

The financial plan submitted by Sandwell and West Birmingham is classed as non-compliant by NHS England as it is a plan to deliver an £8m deficit financial position by 31st March 2027, rather than delivering a break-even position between our income and our expenditure.

The £8m deficit plan is accepted by NHSE within the overall NHS control total with conditions.

The plan sign off conditions were set out in a letter from NHSE dated 5th June 2026.

It is intended to:

Assure the Board of the Executive ownership of the issues raised and commitment to improvement.

Advise the Board of the specific actions taken to address the conditions of the financial plan sign off as outlined by NHS England.

Alert the Board to the ongoing independent review of 'Drivers of the Deficit' and 'Grip and Control' and any actions that may arise from this alongside the medium-term planning work being undertaken over the summer, in line with national deadlines, to inform the 2027/28 planning round in the Autumn.

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

Previous consideration

Recommendation(s)	
a)	**Be assured** of the Executive ownership of the issues raised and commitment to improvement.

b)	**Be advised** of the specific actions taken to address the conditions of the financial plan sign off as outlined by NHS England.
c)	**Be alert** to the ongoing independent review of 'Drivers of the Deficit' and 'Grip and Control' and any actions that may arise from this alongside the medium-term planning work being undertaken over the summer, in line with national deadlines, to inform the 2027/28 planning round in the Autumn.

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 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026
Addressing Financial and Operational Non-Compliance
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1. Addressing the issues arising from a Non-Compliant Trust plan for the financial year 2026/27

1.1 The purpose of this report is to update the Board on the consequences and issues arising from submitting a non-compliant plan for the financial year 2026/27.

1.2 The financial plan submitted by Sandwell and West Birmingham is classed as non-compliant by NHS England as it is a plan to deliver an £8m deficit financial position by 31st March 2027, rather than delivering a break-even position between our income and our expenditure.

1.3 The £8m deficit plan is accepted by NHSE within the overall NHS control total with conditions.

1.4 The plan sign off conditions were set out in a letter from NHSE dated 5th June 2026.

2. Background

2.1 The Medium-Term Planning Framework sets a clear expectation that organisations will work over multiple years, to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. There should be a continued focus on delivery and ongoing foundational work as you continue to work on to understand changes in the demand and capacity of our services and population health needs.

2.2 The Trust plan sign off letter Was received from NHSE on 5th June 2026 and set out the assessment of non-compliance due to the financial position and activity plan.

2.2.1 The Trusts agreed financial plan is an £8m deficit position including £14m of national deficit support funding i.e. an unsupported deficit position of £22m.

2.2.1 The detailed activity plan submission highlighted some rounding errors in the headline targets re: the percentage of people treated beginning first or subsequent of cancer within 31 days and 12-hour A&E breaches. These have subsequently been corrected, and the Trust is monitoring in year performance against compliant targets.

2.3 The plan sign off letter included some specific conditions relating to the financial plan for 2026/27:

2.3.1 The commissioning of an independent “Drivers of the Deficit” review, including a risk assessment of financial controls and recommendations for interventions to rapidly improve the run rate and efficiency programme delivery.

2.3.2 Demonstrable progress towards development of medium-term plans by 31st August 2026, showing a route to financial balance. This should include firm efficiency plans for 2027/28 and outline high level plans (describing the main areas of saving and the likely “route to cash”) for 2028/29 by the same date.

2.3.3 Year 1 (2026/27) triangulated organisational plans should demonstrate a credible trajectory for delivery with an expectation that at 100% of efficiencies are fully developed and quality impact assessed during quarter one.

2.3.4 Full engagement with national pay and non-pay savings initiatives, in particular around national agreements for medicines and other non-pay purchasing.

2.3.5 Monitoring of agency usage and compliance with usage and rate limits, with compliance with a similar set of conditions in relation to bank staff.

2.3.6 Ensuring prior approval for any consultancy expenditure above £50,000 from NHS England regional team based on the agreed regional process.

2.3.7 Adoption of a range of best practice measures supporting: activity data, counting and coding, improvements in productivity and driving down unwarranted excess corporate and overhead costs.

2.4. In addition, the regional team have put in place monthly Performance Review Meetings under the new national performance regime.

3. Trust response to the financial plan sign off conditions

3.2 The Trust is committed to owning the performance issues raised and is focussed on driving the require financial improvements over the next 3 years and this is a focus of the Trusts Finance & Productivity committee and the People committee reporting up to Board. Board assurance process have been enhanced as part of the restructure into a Group board.

3.3 The Trust has reflected, discussed and challenged on the issues arriving at the current position and has written a full lessons learned report which has been shared with NHS England colleagues. This reviewed:

- The extent to which internal and external reporting has provided appropriate information and assurance
- The transparency and understand of the financial position and key assumptions within the 2025/26 plan
- Grip and control measures
- The capacity and capability of the finance function and organisation wide financial literacy.
- The efficacy of the 2025/26 efficiency programme delivery and impact upon the expenditure run rate and underlying position.

As a result of this reflective learning, the Trust has:

- Improved internal committee reporting and external NHSE financial reporting with a clear emphasis on run rate reporting, underlying, monthly updated year end forecasting from the outset, transparency of risk and much more granular efficiency reporting and risk assessment.
- Improved consistency of reporting across the Group model to improve board level understanding.
- Removed optimism bias from the 2026/27 plan, particularly with respect to income recovery.
- Reviewed and enhanced key Pay and Non-Pay controls, along with a re-review of the self-assessment against best practice controls.
- Strengthened the finance team with appointments made into key vacancies and ongoing work to develop a Finance Directorate improvement strategy and commencement of a rolling financial education and training programme from the end of quarter. Alongside this further work to promote a Value based culture throughout the organisation, from a bespoke “Make Money Matter” campaign to developing a multi-disciplinary clinical financial stewardship culture.
- Embedded enhanced programme governance and support to the CIP programme, improved reporting and delivery risk segmentation.

- Provided dedicated support and resource to the Trusts transformational efficiency programme to support the medium-term financial recovery.

3.4 The Trust submitted a business case to NHS England to commit up to £250k of consultancy expenditure for an external comprehensive Drivers of the Deficit review and initial financial turnaround support to an agreed and defined scope. Approval was granted and this work is expected to commence from the 20th of July 2026 with an approved framework provider.

3.5 Work has also commenced on the development of a refreshed medium term financial Plan, including multiyear transformational efficiency identification supported by the Trusts "Fit for the Future" programme in line with the end of August prescribed deadline.

3.6 Alongside this expenditure planning work, the Trust is also engaged on the national "deconstruction of the block" exercise for out of hospital care, covering our Trust provided community provision which will inform a 2027/28 commissioner contract discussions. Our host ICB has also committed to a parallel full block contract review in line with best planning practice.

3.7 The Trust is actively engaged in and supporting national and regional pay and non-pay initiatives and workstreams.

3.8 The Trust is benchmarking activity data quality, counting and coding to ensure best practice compliance.

3.9 The Trust continues to improve its productivity score, and this is being reported through the Trusts Finance and Performance committee. and is fully engaged with the Regional Provider Efficiency and Productivity forum.

3.10 The Trust as completed and submitted its annual corporate costs benchmarking return on time to NHS England and will report back our relative performance (function cost per £100m income) to the Trusts Finance and Performance committee once advised. In 2024/25 the Trust was in the lowest cost quartile nationally for HR, Governance and Risk, Finance and Legal and the second lowest quartile for procurement and Payroll. The Trust benchmarked in the upper quartile for Digital costs, partly in relation to the move into MMUH, addressing key risks and progress towards the national ten-year plan ambitions but these costs have reduced in 2025/26. In all other areas we expect relative performance to be stable or marginal difference only.

3.11 The Trust is working transparently and openly with the regional performance and intervention teams with detailed reporting and discussion in the monthly Performance Review meetings.

4. Conclusion

4.1 The Trust has taken steps to understand the drivers of the deficit and to have this externally validated. The outcome of this review will be reported back to the Trusts Finance and Performance committee as well as to NHS England as a business case closure report for the consultancy spend.

4.2 The Trust has also put in place measures to strengthen financial governance, forecasting and reporting, specifically to: improve understanding, transparency and clear identification and timely escalation of risk, forecasting accuracy, expenditure run rate reporting, and CIP identification, risk stratification and delivery.

4.3 The Trust has improved capacity and capability in both finance and transformation programme management and is committed to ongoing review of effectiveness through external review, work with our regulators and internal and external audit.

4.4 The Trust is committed to improving the culture of financial stewardship across the Trust at all levels, through effective communications, visible leadership and ongoing education and training.

5. Recommendations

5.1. The Group Public Trust Board is asked to:

a) **Be assured** of the Executive ownership of the issues raised and commitment to improvement.

b) **Be advised** of the specific actions taken to address the conditions of the financial plan sign off as outlined by NHS England.

c) **Be alert** to the ongoing independent review of 'Drivers of the Deficit' and 'Grip and Control' and any actions that may arise from this alongside the medium-term planning work being undertaken over the summer, in line with national deadlines, to inform the 2027/28 planning round in the Autumn.

Madi Parmar, Director of Finance, SWB
9th July 2026

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

REPORT TITLE:	Annual Emergency Preparedness, Resilience Board Report		
SPONSORING EXECUTIVES:	Jack Richards – Interim Chief Operating Officer (Accountable Emergency Officer) DGFT Johanne Newens - Chief Operating Officer (Accountable Emergency Officer) SWB		
REPORT AUTHOR:	Simone Smith – Head of Corporate Resilience Caroline Rennalls & Phil Stirling - Assistant Director of Operations and Resilience Management & EPRR Officer		
MEETING:	Group Public Trust Board	**DATE:**	22 July 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
	Discussion		Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
			Note		

Suggested discussion points

Annual review for Dudley Group Foundation Trust (DGFT) and Sandwell and West Birmingham NHS Trust (SWB) Emergency Preparedness, Resilience and Response (EPRR) arrangements for 2025/26

DGFT position

Assure

The Board can be assured that the Trust has maintained a robust Emergency Preparedness, Resilience and Response (EPRR) framework that supports compliance with the Civil Contingencies Act 2004, Health and Care Act 2022, NHS Standard Contract requirements and NHS England Core Standards. Governance arrangements continue to mature, with effective oversight provided through the EPRR Assurance Group, regular reporting to the Finance and Productivity Committee, and Board assurance processes.

During 2025/26, all EPRR policies and incident response plans were reviewed and updated, a comprehensive programme of training and exercising was delivered, and lessons identified from incidents and exercises have been incorporated into service improvements. The Trust achieved **94% compliance (58 of 62 standards fully compliant, no domains where non- complaint)** against the NHS England EPRR Core Standards, demonstrating substantial compliance and continued organisational improvement. Business continuity arrangements have been strengthened through revised documentation, enhanced governance, peer audit and the introduction of divisional performance reporting, providing greater assurance over organisational resilience.

Advise

The Board is asked to note the significant progress made in strengthening business continuity management and governance arrangements in response to previous NHS England and Integrated Care Board feedback. The focus for 2026/27 will be on embedding the revised Business Continuity Management System across all divisions through

delivery of new training programmes, implementation of performance indicators, increased assurance reporting and further testing of business continuity arrangements.

Continued partnership working across the Integrated Care System and Local Resilience Forum remains essential to maintaining organisational resilience, alongside further embedding of learning from operational incidents, exercises and peer review into routine practice.

Alert

Whilst substantial assurance can be provided, several areas require continued Board oversight. Four NHS England Core Standards remain partially compliant, relating primarily to Business Continuity Management System maturity, supplier assurance and Data Security and Protection Toolkit compliance. These actions are incorporated within the 2026/27 EPRR work programme and monitored through Corporate Risk FE2620.

The Board should also note that Accountable Emergency Officer representation at Local Health Resilience Partnership meetings was not achieved during 2025/26 and should be strengthened to ensure full system-level engagement. In addition, the frequency of business continuity and digital infrastructure incidents experienced during the year reinforces the need to continue improving organisational resilience, embedding revised business continuity arrangements, strengthening incident command capability, and maintaining oversight of digital, infrastructure and operational safety risks.

SWB position

Assure

The Board can be assured that the Trust has implemented and maintained a robust Emergency Preparedness, Resilience and Response (EPRR) framework that supports SWB being substantially compliant, with the Civil Contingencies Act 2004, Health and Care Act 2022, NHS Standard Contract requirements, NHS England Core Standards and all related legal guidance. The EPRR Forum chaired by the Chief Operation Officer (COO) ensures scrutiny and oversight of clinical and non-clinical services for EPRR, reporting to the Finance & Productivity Committee, and the Board assurance.

During 2025/26, all EPRR policies, Plans, related Standard Operating Procedure and incident response Plans were reviewed updated, included national, NHSE guidance and consulted on. An enhanced and comprehensive programme of training and exercising was delivered. SWB exceeded the national requirements for the following area

- **Live exercises,** CCA 2004 requirements is 1 live exercise in 3 years, we ran 4 live exercises in 25/26.
- **Communication exercises**, CCA 2004 require 2 per year every 6 months, we have delivered 5
- **Tabletop exercises:** CCA 2004 require 1 annually, delivered 2.

Lessons identified from incidents and exercises have been incorporated into service improvements, reflected in Plans, SOPs and BCM Templates. The Trust achieved **89% compliance (55 of 62 standards fully compliant, no domains where non- complaint)** against the NHS England EPRR Core Standards, demonstrating substantial compliance and continued organisational improvement from the 24/25 non**-complaint status**. Business continuity arrangements have been strengthened through a full rewrite of the Plan to including national guidance and best practice, enhanced governance with clear roles and responsibilities for the Director of Operations and Divisional Directors of Nursing reporting to COO at the EPRR Forum. The initiation of a peer review cycle with DGFT added value by enhancing learning. The next peer review is scheduled for Nov 2026. This offers assurance over organisational resilience and inter-relational working.

Advise

The Board is asked to recognise the progress made in all EPRR plans, polices and governance framework to achieve substantially compliance for the NHSE Core standards from being non-complaint. Business Continuity is

incorporated within these improvements. There has been a real focus on the process for the fire management and evacuation in lift failure at MMUH and the maintenance, distribution and restorative processes should we have a significant telecoms communication failure across acute and non-acute sites. Developments have been included in the EPRR KIPs, and we have seen an upward trajectory against all training domains. We have included Operational Commander training in June 2026 and will exercise this after 6 months of the training being delivered. This will equip and compliment the Strategic and Tactical actions in response to an incident.

We continue to work in partnership with Cat1, 2 and national teams. Attendance at the Exercise Penelope, Pegasus, and Exercise Unbaited which promotes and provides shared learning.

There is a requirement to upgrade 10 handheld radios which may incur a cost pressure in 26/27

Alert

Whilst substantial assurance can be provided for the 26/7 NHSE Core Standard submission, several areas require continued Board oversight. Four NHS England Core Standards is felt to have partially met the standard. The four domains include core standard CS07, Corporate Risk Register, CS37 LHRP attendance must be from Accountable Emergency Officer (75% attendance to be achieved, 3 of 4 meeting annually. This should be met in 2026/7. CS49 Data Security and Protection Toolkit compliance. These actions are incorporated within the 2026/27 EPRR work programme. EPRR are working with the Governance team who collate and make the annual submission, IT and People. CS53 Assurance of commission providers and suppliers. Significant progress was made in 2025.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration

Recommendation(s)	
a)	**Receive** the EPRR annual reports as assurance that there is an effective framework in place to ensure DGFT and SWB meet both statutory and non-statutory requirements in respect of the Civil Contingencies Act 2004 and associated national guidance.

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 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
Is Quality Impact Assessment required if so, add date: n/a			
Is Equality Impact Assessment required if so, add date: n/a			

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors Wednesday 22 July 2026

Report title:	EPRR and Business Continuity Policy
Sponsoring executive / Presenter:	Jack Richardson – Chief Operating Officer
Report author:	Simone Smith – Head of Corporate Resilience

1. Summary of key issues

- This newly developed document consolidates the previous EPRR Strategy and separate Business Continuity Policy into a singular policy document.
- By combining both documents, the Emergency Preparedness, Resilience and Business Continuity Response framework is now located within one document, aiding access for all staff particularly those with specific accountabilities.
- This aligns to practice shared by the ICB and other partner organisations.
- The policy has been consulted on internally and shared with BCICB, NHS England, Local Authority and other relevant partners.
- The full document is located in the reading room associated with this meeting

2. Alignment to our Vision

Patients: Deliver high-quality care, by the right person in the right place, at the right time	**X**
People: Be a brilliant place to work and thrive through happy, engaged, productive teams	**X**
Population: Work together with our partners to improve life chances and health outcomes	**X**

3. Report journey

EPRR Assurance Group – Virtual Consultation (27/01/2025), Finance and Productivity Committee (26/02/2026), Trust Board (22/07/2026)

4. Recommendation

The Board of Directors is asked to:

a) **Approve** the EPRR and Business Continuity Policy

5. Impact reflected in our Board Assurance Framework (BAF)

BAF Risk 1.0	X	Failure to deliver the right care, in the right place every time
BAF Risk 2.0	X	Failure to ensure Dudley is a brilliant place to work and thrive
BAF Risk 3.0	X	Failure to build innovative partnerships to improve the health of our communities
BAF Risk 4.0	X	Failure to remain financially sustainable in 2025/26 and beyond
BAF Risk 5.0	X	Failure to achieve operational performance requirements & deliver strategic objectives
BAF Risk 6.0	X	Failure to take sustained action on infrastructures that enables strategic objectives

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

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

Enclosure 7

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

REPORT TITLE:	Group Chief Nursing and Group Chief Medical Officer Report		
SPONSORING EXECUTIVE:	Melanie Roberts, Group Chief Nursing Officer Jonathan Odum, Group Chief Medical Officer		
REPORT AUTHOR:	Corporate Medical and Nursing Teams		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

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

Suggested discussion points

Alert

Two Never Events in SWB
Extreme heat impact in DGFT

Advise

SWB Blood Borne Virus (BBV) screening in ED project
SWB/DGFT - Band 5 to Band 6 Job Evaluation
SWB/DGFT - Introduction of Liberty Protection Safeguards (LPS), and Impact of the Attorney General for Northern Ireland (AGNI) Ruling - Overview
SWB/DGFT - HSJ nominations

Assure

SWB - SAS development award
SWB/DGFT – Ionising Radiation (Medical Exposure) Regulations IR(ME)R Inspection - initial feedback
DGFT - Chief Registrar award
DGFT - 95% job plan agreed
DGFT - Improving Quality of Liver Services (IQLS) Royal College of Physicians Accreditation

Alignment to our Vision					
OUR PATIENTS	x	**OUR PEOPLE**	x	**OUR POPULATION**	x

Previous consideration
None

Recommendations	
a)	Discuss the Alert section for assurance.
b)	Note the Advise and Assurance section.

Escalation
Should any element of this report be escalated: None

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026
Group Chief Nursing and Group Chief Medical Officer Report

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1. Purpose

This paper provides highlights from the Group Chief Nursing (CMO and Group Chief Medical Officer Report (CNO) portfolios across both Trusts, The Dudley Group NHS Foundation Trust (DGFT) and Sandwell and West Birmingham NHS Trust (SWB) presented as items to Assure, Advise and Alert to the Board.

2. ALERT - SWB/DGFT

- **SWB Never Event 2 (wrong lens, spinal wrong side injection)**

A Never Event occurred on 21 May 2026 in the Birmingham Treatment Centre (BTC) Ophthalmology department. The incorrect lens size (21.5) was implanted when a 12.5 lens was required. This is a complex case, with further complications when the carer supporting the patient collapsed in the anaesthetic room requiring emergency treatment. An After Action Review (AAR) has been completed and learning identified. Environmental factors are being reviewed to support correct lens identification, and clerical forms are being reviewed for redesign opportunities to make checking clearer and strengthening the sign out processes.

A further Never Event involving a wrong site fascia iliac block, occurred on 23 June 2026. The patient was an intubated and sedated trauma patient. Information gathered to date indicates the 'stop before you block' check was not completed. Significant work is being undertaken between the theatre teams and patient safety team to review the contributing factors to why the existing checks, standard operating procedures and policies are not being adhered to.

Early anecdotal feedback has suggested that this may be in part due to the increased list sizes recently implemented. However, a rapid review undertaking a full SEIPS, process map, Hierarchical Task Analysis (HTA), and use of two behavioural marker systems (Non-Technical Skills for Surgeons - NOTSS, and the Anaesthetists' Non-Technical Skills - ANTS) to evaluate the social and cognitive skills of those involved is planned to be completed as soon as possible to determine the drivers of the behaviours. Good practice has been observed, with the team escalating the incident immediately and reporting the incident in a timely manner. Duty of Candour is being completed by the anaesthetist involved in the incident.

- **DGFT - Extreme weather response**

The recent heatwave was challenging for the Trust, as it was for many trusts across the country. We experienced an increase in patient deaths which we are currently reviewing as part of our normal processes as to why this occurred and whether heat was a contributory factor in this or not. As part of this we will be formally reviewing individual deaths, along with mortality rates.

The Trust has already undertaken Medical Examiner reviews and made Coronial referrals as appropriate, and we will also be undertaking a thematic Structured Judgement Review (SJR) panel as part of a harm review.

The Trust has had a post-heatwave debrief to assure ourselves that we put everything possible in place, support both patients and staff, and to ensure any learning is applied to any future heatwave planning.

3. ADVISE - DGFT/SWB

- **SWB Blood Borne Virus (BBV) screening in ED project**

In collaboration with our sexual health team and our hepatology team, our ED has been running a programme of default testing for HIV and viral hepatitis whenever blood tests are taken in the Emergency Department. As part of this process, we have found around 140 patients who may not have otherwise known they had these conditions. Those patients can now prevent onward transmission and can receive treatment.

Whilst these results are important, rollout of the process was intermittent during winter months, so there is more to be gained and the team are working on improved consistency with the process.

	Number of tests: HIV, HBV surface antigen, HCV antibody	New diagnoses	Previously diagnosed, not in care	Previously diagnosed, in care
HIV	26,167	8	3	39
Hepatitis B	26,633	75	0	7
Hepatitis C current infection (RNA+)	26,633	56	0	2
Total	79,433	139	3	48

- **SWB/DGFT - Band 5 to Band 6 Job Evaluation**

NHS England has mandated that all NHS Trusts review Band 5 nursing roles to ensure the consistent and equitable application of the NHS Job Evaluation Scheme and Agenda for Change principles. All Trusts are required to submit a delivery plan by 31 July 2026 and complete all reviews by October 2028. This programme delivers the Secretary of State's commitment to undertake an employer-led review of all Band 5 nursing roles employed directly by NHS Trusts. The programme is focused on ensuring the consistent and fair application of existing NHS Job Evaluation arrangements and does not represent a new national policy. It supports the commitments contained within the 2023 Agenda for Change non-pay deal requiring employers to ensure staff are paid appropriately for the work they are asked to undertake.

The Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust will undertake this work through a structured programme led jointly by Corporate Nursing and Workforce/HR, supported through partnership arrangements with Staff Side representatives.

The programme will align with a collaborative Black Country approach to develop and implement standardised Band 5 and Band 6 nursing job descriptions, supporting consistency across organisations and reducing unnecessary variation in role interpretation and job matching.

The programme will provide assurance that:

- All Band 5 nursing staff have an accurate and current job description.
- Staff have the opportunity to review and validate the role description.
- Matching and Job Evaluation processes are undertaken appropriately.
- Any outcomes are implemented fairly and consistently.
- Equality impacts are monitored and addressed.

- The Trust satisfies all NHS England requirements.
- Reviews will be undertaken in partnership with recognised Trade Unions and Staff Side representatives.
- Band 5 nurses will have the opportunity to confirm whether their job description accurately reflects the work they are asked to undertake.
- Reviews will be undertaken in accordance with the NHS Job Evaluation Scheme and Annex 31 of the Agenda for Change Terms and Conditions Handbook.

- **SWB/DGFT - Introduction of Liberty Protection Safeguards (LPS), and Impact of the Attorney General for Northern Ireland (AGNI) Ruling - Overview**

A landmark 2026 UK Supreme Court ruling arising from the Attorney General for Northern Ireland's reference, which redefines what constitutes a deprivation of liberty. Together, these developments significantly reshape legal duties, operational practice, and organisational risk.
Impact of the AGNI Supreme Court Ruling (2026) - The ruling overturns the Cheshire West "acid test" and replaces it with a multifactorial test aligned with European human rights case law.

Key legal shifts
New definition of deprivation of liberty: Contextual, not binary.
Valid consent possible: A person who lacks capacity may still *consent* through their wishes, feelings, or behaviour.
Higher threshold: Fewer care arrangements will meet the Article 5 threshold.
Immediate UK-wide effect: Applies to England, Wales, Scotland, and Northern Ireland.

Operational consequences
Significant reduction in DoLS/LPS authorisations expected and reassess current DoLS caseloads using the multifactorial test.
Greater reliance on professional judgement rather than formulaic tests.
Increased importance of documenting wishes, feelings, and indicators of consent.

Implications for Organisations
Update care planning templates to capture consent indicators and contextual factors.
Review AMCP workforce planning in light of reduced demand.

Strategic
LPS implementation will occur within a new legal landscape, requiring updated policies, training, and governance.
Reduced authorisation volumes may ease pressure but increase complexity in borderline cases.

Executive Priorities:
Conduct a policy and caseload audit aligned with the AGNI ruling, safeguarding services to oversee cases across the Group.
Establish governance oversight for high-risk or borderline cases.
Continue to work with legal services to define and refine understanding and policy impact.

- **HSJ Nominations - SWB/DGFT**

- Maternity DGFT - for maternity, midwifery & neonatal safety initiative of the year and advancing patient safety with data and analytics.

- Epilepsy Team DGFT - reduction of waiting times and patients safety.
- ITU DGFT - implementing Gold standards framework within ITU services.
- Marthas Rule SWB - wellness questionnaire.

ASSURE - DGFT/SWB

- **SWB SAS development award**

We are pleased to inform the Board that the Trust, following a detailed and extensive submission and assessment process, has been selected for a SAS Excellence in Development (SEiD) Recognition Award.

The SAS Excellence in Development Recognition Award is a national framework launched by NHS England to celebrate and incentivise NHS Trusts that provide exceptional professional support and development opportunities for Specialty Associate Specialists and Specialist (SAS) doctors.

The award recognises and celebrates organisations that demonstrate outstanding commitment to the development, support and retention of Specialist, Associate Specialist and Specialty (SAS) doctors across the NHS. This work is critical to delivering the ambitions set out in the NHS 10 Year Plan, particularly in strengthening the SAS workforce and improving career development opportunities.

The award ceremony will take place in London on 01 July (5-7pm). The event will bring together senior system leaders, clinicians, and award recipients for an evening of recognition and celebration. Award Structure & Purpose - Levels of Recognition: Trusts are evaluated and awarded at Bronze, Silver, or Gold levels.

Key Focus Areas: The framework measures equitable promotion, career diversification, targeted professional development, and overall workforce retention.

Assessments: Applications are co-designed by NHS England, the BMA, and the GMC, and are assessed quarterly by Regional SAS Associate Deans and the National Dean of Inclusive Integrated Careers.

The benefits of the award are:

- Attracts Talent: The award acts as a badge of honour that helps Trusts recruit high-quality SAS doctors and dentists.
- Reduces Turnover: Demonstrating strong career support increases job satisfaction and keeps existing staff from leaving.
- Limits Locum Costs: Better permanent staff retention heavily reduces a Trust's reliance on expensive temporary locum cover.
- National Recognition: It serves as public, national proof that a Trust meets the highest standards set by NHS England.
- CQC Alignment: The evidence gathered for the award directly supports the "Well-Led" criteria evaluated during Care Quality Commission (CQC) inspections.

- **CQC IR(ME)R inspection DGFT/SWB**

On 23 and 24 June 2026 both Trusts underwent a CQC IR(ME)R inspection within Nuclear Medicine.

DGFT - Overall, there were no breaches under IR(ME)R17 and the CQC found good compliance with IR(ME)R across multiple areas, however some areas for improvement were identified. They found arrangements for the justification and authorisation of exposures, including exposures to carers and comforters to be an example of good practice. However, they identified areas for improvement relating to quality control testing of equipment held outside of the nuclear medicine department and training

records for operators. Factual accuracy checking needs to be returned by 20 July and an action plan will be submitted by 01 September and managed through Quality Committee.

SWB - Overall, there were no breaches under IR(ME)R17 and the CQC found good compliance with IR(ME)R across multiple areas, however some areas for improvement were identified. Whilst the service demonstrated safe practice and several areas of good practice were identified, gaps in compliance were found during the inspection. A significant proportion of these issues related to the employer's procedures, which lacked sufficient procedural detail for duty holders. The CQC identified areas of good practice around optimisation, training records and clinical audit projects in nuclear medicine. Areas for improvement identified were around the study of risk for Y-90 therapies and the QC records for the SLN probes. Factual accuracy checking as to be returned by 21 July and an action plan by 02 September.

Both action plans and reports will be managed via the Trust individual Quality & Safety meetings with upwards reports to Quality Committee.

- **DGFT "From Delay to Flow" won the Best Group Project Award at the Royal College of Physicians**

The award was presented on the final day of the RCP Leadership Development Programme for Chief Registrars and recognises the work undertaken together over the past year. The project competed with QI work from other Trusts/Chief Registrars and was scored for various domains QI methodology, impact on patients, impact on the Trust and innovation. There are plans to scale the project across the whole Trust in coming months.

- **DGFT Improving Quality of Liver Services (IQLS) Royal College of Physicians Accreditation**

Accreditation has been awarded for 12 months. Accreditation is granted to services which have demonstrated they meet best practice quality standards covering all aspects of a liver service, including person-centred care, clinical care and the workforce. Two recommendations were provided regarding formalising the annual and three year plan and ensuring specialist nurses have sufficient autonomy and appropriate peer support.

- **DGFT Job Planning**

The 2026/7 Job Planning round has now closed in Dudley with the NHSE target of 95% plans signed off achieved. Focus has now shifted to Team Service Planning Meetings to be held in Autumn 2026 ahead of the next round launching and plans being reopened in January 2027.

4. RECOMMENDATIONS

The Group Public Trust Board is asked to:

a. Discuss the Alert section for assurance.
b. Note the Advise and Assurance section.

NAME: CMO and CNO Offices
DATE: July 2026

Enclosure 8

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

REPORT TITLE:	Integrated Quality and Performance Report
SPONSORING EXECUTIVE:	Melanie Roberts Group CNO, Jack Richards, Interim Chief Operating officer, Jonathan Odum Interim Group Chief medical Officer, Johanne Newens, Chief Operating Officer
REPORT AUTHOR:	Marsha Jones Director of Nursing, DGFT Jennifer Riley Deputy Director of Nursing, SWB
MEETING:	Group Public Trust Board **DATE:** 22 July 2026

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

Suggested discussion points

This report outlines the highlights of the DGFT IQPR, the joint operational performance and productivity dashboard and the SWB fundamentals of care dashboard. There is ongoing work to replicate the operational performance and productivity dashboard for quality & safety

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

Previous consideration

Quality Committee 1.6.26 DGFT

Recommendation(s)	
a)	**Note** the contents of this report.
b)	**Receive** overall assurance regarding the effectiveness of quality, patient safety and governance arrangements across both Trusts but acknowledge there is further improvement work to do in the areas highlighted above
c)	**Note** and discuss the operational pressures in relation to urgent care flow and capacity pressures and cancer performance at SWB

Escalation

Should any element of this report be escalated: Not applicable

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	1: Quality	x	1: Quality
	2: Workforce	x	2: Workforce
	3: Partnerships		3: Partnerships
	4: Finance		4: Finance
x	5: Operational Performance	x	5: Operational Performance

BAF Impact [indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]			
	6: IT & Digital Infrastructure		6: IT & Digital Infrastructure
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 22 July 2026

Integrated Quality and Performance Highlight Report

1. Purpose

1.1 The purpose of this report is to provide the Group Public Trust Board with oversight and assurance regarding key quality, patient safety and operational performance indicators across The Dudley Group NHS Foundation Trust (DGFT) and Sandwell and West Birmingham NHS Trust (SWBH) for the reporting period of May 2026.

2. Executive Summary

2.1 Performance during May 2026 demonstrates that both Trusts continue to maintain effective quality governance arrangements and a positive patient safety culture. Patient experience remains generally positive, incident reporting levels continue to indicate an open and transparent reporting culture, and strong performance is evident in a number of clinical quality indicators, including stroke care, falls management, pressure ulcer prevention, audit activity and mandatory training compliance.

2.2 However, the overall assurance position remains moderated by ongoing operational and capacity pressures. Key areas requiring continued oversight include

- complaints performance,
- urgent and emergency care flow,
- safeguarding compliance,
- mental health transfer delays,
- workforce pressures
- compliance with deteriorating patient pathways.

2.3 Improvement programmes are in place across all identified areas of concern and continue to be monitored through established quality governance arrangements.

3. Joint DGFT and SWBH Position

3.1 DGFT IQPR, the joint operational performance and productivity dashboard and SWBH Fundamentals of Care dashboards are presented to both Quality Committee and Finance & Productivity Committee monthly. Work is ongoing to mirror the operational performance and productivity dashboard for Quality & Safety. The National Oversight Framework (NOF) metrics have also started to be presented at each committee.

3.2 Quality & Patient Safety Metrics

3.2.1 Patient Experience

3.2.2 Both Trusts continue to report positive patient experience outcomes, with more than 80% of patients rating services as good or very good. Patient feedback mechanisms remain well established, with intelligence routinely disseminated to clinical and operational teams to support local quality improvement initiatives.

3.2.3 At DGFT, maternity services achieved a sustained positive rating of 95%, demonstrating significant improvement and continued delivery of high-quality care. All complaints received during May were acknowledged within the required timeframe.

3.2.4 At SWBH, community services continue to exceed national benchmarks for patient experience. Improvements have also been observed within maternity services and emergency care following the transition to the Midland Metropolitan University Hospital, although emergency department performance remains below national expectations.

3.2.5 For both trusts work need to be done to increase the response rates

3.2.6 Patient Safety and Incident Management

3.2.7 Incident reporting levels across both organisations remain above historical averages and continue to demonstrate a strong reporting culture that supports organisational learning and patient safety improvement.

3.2.8 Patient safety incidents resulting in moderate harm or above remain within expected limits and account for less than 1% of all reported incidents. Robust investigation processes are in place across both organisations, supported by Patient Safety Incident Response Framework (PSIRF) methodologies, Patient Safety Incident Investigations (PSIIs), swarm reviews and after-action reviews where appropriate.

3.2.9 SWBH has undertaken a focused review of Never Events following a spike in never events in relation to wrong site block and wrong lens, incorrect administration route reported during the current financial year, with findings being reviewed through established governance arrangements.

3.2.10 Falls and Pressure Ulcer Management

3.2.11 Falls resulting in significant harm remain rare across both organisations. Dedicated improvement programmes continue to strengthen prevention strategies, risk assessment processes and organisational learning.

3.2.12 DGFT has successfully implemented PURPOSE-T, an evidence-based pressure ulcer risk assessment tool designed to support early identification of risk, improve care planning and enhance compliance with national standards. All pressure ulcers requiring review during the reporting period were appropriately assessed, with no cases resulting in moderate or severe harm.

3.2.13 SWBH has established a multidisciplinary Falls Working Group to coordinate improvement activity focused on risk assessment, patient footwear and pathway optimisation. Pressure ulcer incidence has reduced during the reporting period, although compliance with pressure ulcer risk assessment remains below the organisational target.

3.2.14 Stroke Care

3.2.15 Stroke services continue to demonstrate strong performance across both organisations.

3.2.16 Validated data for DGFT demonstrates compliance with key national standards, including stroke unit admission, swallow screening and transient ischaemic attack management.

3.2.17 SWBH has achieved the highest system Sentinel Stroke National Audit Programme (SSNAP) rating of Grade A, reflecting exceptional performance across the stroke pathway and recognition as a national exemplar service.

3.2.18 End of Life Care

3.2.19 Both organisations continue to demonstrate progress in delivering high-quality end-of-life care.

3.2.20 At DGFT, patients approaching end of life are being identified appropriately, with achievement against preferred place of care measures remaining positive. Accreditation programmes remain on track, and the Intensive Care Unit has been shortlisted for a national patient safety award in recognition of its implementation of Gold Standards Framework principles.

3.2.21 At SWBH, improvement activity continues in response to findings from the National Audit of Care at the End of Life (NACEL). Progress has been demonstrated across four of the five assessed domains, supported by mandatory training and specialist palliative care provision.

3.3 Areas Requiring Continued Oversight for Quality & Safety Metrics

3.3.1 Complaints Performance

3.3.2 Complaints management remains a significant area of concern across both organisations.

3.3.3 DGFT received 101 complaints during May, with only 30.6% of first responses completed within the 30-working-day target. A backlog of open complaints remains, largely attributable to workforce capacity constraints.

3.3.4 SWBH continues to experience substantial backlog pressures, with 687 complaints open and 462 categorised as backlog cases. Capacity challenges continue to impact response times despite ongoing improvement activity.

3.3.5 A deep dive has been undertaken and presented to Quality Committee and recovery plans are in place; however, sustained improvement in timeliness and backlog reduction remains necessary.

3.3.6 Safer Staffing

3.3.7 Workforce pressures continue to require close monitoring.

3.3.8 DGFT reported a significant number of staffing red flags during the reporting period, although formal escalation rates remain comparatively low.

3.3.9 At SWBH, 4 red flags were reported. Workforce utilisation data indicates opportunities to improve roster efficiency and reduce reliance on temporary staffing. A bank reduction programme with each clinical division is in place

3.3.10 Governance arrangements are established; however, workforce pressures and utilisation require continued scrutiny.

3.3.11 Mental Health Pathway Delays

3.3.12 Both Trusts continue to experience delays in transferring patients requiring inpatient mental health care, reflecting wider system capacity challenges.

3.3.13 The resulting delays impact patient experience, emergency department flow and organisational capacity.

3.3.14 Delays are predominantly attributable to system-wide constraints; however, the impact on patient care and operational performance remains significant.

3.3.15 Safeguarding

3.3.16 Safeguarding performance requires continued oversight across both organisations.

3.3.17 DGFT has reported concerns regarding Multi-Agency Referral Form (MARF) completion, child protection medical delays and training compliance. SWBH continues to monitor safeguarding training compliance, with specific focus required in a number of mandatory training areas.

3.3.18 Focused improvement activity is required to strengthen compliance and support effective safeguarding practice.

3.3.19 Deteriorating Patient Pathways

3.3.20 Compliance with deterioration monitoring and escalation processes remains below expected standards across both organisations at an average of just over 70%

3.3.21 While improvement is evident, particularly in relation to The National Early Warning Score (NEWS2) compliance and Martha's Rule implementation, progress remains slower than anticipated and compliance levels continue to present potential patient safety risks.

3.4 Operational Performance

3.4.1 Urgent and Emergency Care Flow

3.4.2 Both organisations continue to experience significant operational pressures associated with patient flow and capacity. Emergency department patient experience scores remain lower than those reported elsewhere within both organisations. Delays associated with admission processes, ambulance handovers and discharge pathways continue to impact patient flow.

3.4.3 DGFT - Performance against the Emergency Access Standard standard showed a sustained performance above the 78% target – 80.8% for May 26. However, this performance is driven by our non-admitted performance which has remained below the 4hr window – our average admitted performance deteriorated by a further 26 minutes bringing the total decline to 126 minutes (2hrs) since March 26. Ambulance Handovers in May 26, there were 3164 ambulance arrivals to RHH, a 1.4% drop compared to April 26, with the average ambulance offload time of 58 mins. This is above the 45min target and has been significantly affected by the flow for our admitted patients with admitted patients now having a Length of Stay of over 526mins (8.7hours). RHH has also had 36 In-Patient bed closures and no active emergency department corridor for 1 week. A number of improvement actions are in place

3.4.4 SWBH - Urgent and Emergency Care metrics are again continuing to show some improvement this month after a challenging winter period. In May 2026, 76.12% of emergency attendances were seen within 4 hours (target: 78%), building on the gains made in previous months. Although the 12-hour breach rate was similar to that reported last month, the improvements delivered in April were maintained. Ambulance handover times averaged 32 minutes, a 5.9% improvement on the previous month with a 7.5% increase in ambulance conveyances to MMUH. New interventions outlined number of improvement actions are in place in this paper have been developed and implemented to support recovery and meet UEC targets for 26/27. A number of Improvement actions in place

3.4.5 While performance improvements have been observed increasing demand continues to challenge sustainability.

3.4.6 Improvement initiatives are in place; however, operational pressures continue to present quality and patient experience risks.

3.4.7 Referral to Treatment (RTT) Standards

3.4.8 DGFT

3.4.9 Performance against the 18-week RTT standard for May was 65.14% of patients treated within 18 weeks vs 73.01% planned target March 27. At the end of May, 0.02% of patients (11 patients) were waiting over 52 weeks, against the planned target of 0%. We continue to proactively monitor high-risk specialties and escalate issues promptly to minimise further delays.

3.4.10 There have challenges with imaging services due to the upgrade of the OPG/CBCT equipment and Imaging Room. To mitigate the impact, we arranged for OPG imaging to be undertaken at SWBH and prioritised Cone Beam Computed Tomography scans for patients who were anticipated to require them before the X-ray room was closed. The work is now complete and normal service resumes 22nd June. Unfortunately, our Endometriosis Surgeon is currently unable to operate. We are exploring options to bring the Endometriosis Surgeon from SWBH to provide surgical cover; however, this requires significant coordination, including amendments to the surgeon's existing job plan and alignment with the availability of Colorectal and Urology Surgical colleagues. We have continued to experience some delays in diagnostics for specialist tests. Electives remain pressured due to theatre capacity. We are bringing forward OPAs to mitigate listing later in the pathways.

3.4.11 Focus also remains on Total Waiting List, which has spiked and continues to rise as referrals continue to increase; working with Specialty teams to understand this further with trajectory recovery plans.

3.4.12 SWBH

3.4.13 Planned care was reported at 62.26% against a trajectory of 57.70%. 0.49% (equating to 319 patients) of our waiting lists were above 52 weeks at the end of April, maintaining achievement against the <1% target with plans to improve performance through additional interventions in higher risk specialties.

3.4.14 Cancer Standards

3.4.15 DGFT

3.4.16 Cancer Performance (April validated)

3.4.17 28 Day Faster Diagnosis Standard: achieved 85.9% against national target of 83%. Achievement of monthly trajectory continues to be sustained in April 2026.

3.4.18 31 Day Combined: achieved 94% against national target of 96%. Urology and Skin remained challenged due to capacity for surgical patients and biopsy capacity.

3.4.19 62 Day Combined: achieved 75.4% against April monthly target of 74.3%. Breast, Urology and Skin remain an area of focus. Target for end of March 2027 is 81.0%.

3.4.20 SWBH

3.4.21 Cancer performance metrics for April 26 showed some deterioration. The Faster Diagnosis Standard was reported at 63.96% against a target of 80%.

3.4.22 62-day performance was below trajectory in April 26 at 70.20% against a target of 76.16%.

3.4.23 The 31-day diagnosis to treatment target was achieved and reported at 95.74%, 3.93% above trajectory with the expectation that we will continue to deliver against this target.

3.4.24 Risks

3.4.25 The principal risks requiring ongoing Board oversight are:

- Patient flow and capacity pressures affecting emergency care performance, ambulance handovers, corridor care at DGFT, and discharge processes.
- Complaints backlog and response timeliness.
- Safeguarding compliance, including training, MARF completion and child protection processes.
- Compliance with deteriorating patient pathways and escalation standards.
- Delays in access to inpatient mental health services arising from system-wide capacity constraints.
- Cancer Performance at SWB
-

4. Conclusion

4.1 Sustained operational pressures continue to affect a number of quality and performance indicators. Particular focus remains necessary in relation to urgent and emergency care flow, complaints management, safeguarding compliance, deteriorating patient pathways, workforce pressures and mental health transfer delays.

4.2 Improvement programmes are established across all identified areas and progress will continue to be monitored through the quality governance framework.

5. Recommendations

5.1 The Group Public Trust Board is asked to:

a) **Note** the contents of this report.
b) **Receive** overall assurance regarding the effectiveness of quality, patient safety and governance arrangements across both Trusts but acknowledge there is further improvement work to do in the areas highlighted above
c) **Note** and discuss the operational pressures in relation to urgent care flow and capacity pressures and cancer performance at SWB

Enclosure 9

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

REPORT TITLE:	Group Clinical Services Plan – Final Draft		
SPONSORING EXECUTIVE/PRESENTERS	Mark Anderson – Group CMO Mel Roberts – Group CNO		
REPORT AUTHOR:	Sohaib Khalid – BCPC Managing Director		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

Paper Type:		**Requested action:**		**Applies to:**	
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

- Approval of the Final draft of the Group Clinical Services Plan
- Next steps – transitioning to delivery

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration

Previously discussed at the January and March 2026 Private Boards and Board development Workshops.

Recommendation(s)

a)	**NOTE** the update on the development of the Group Clinical Strategy provided in section 2
b)	**APPROVE** the final draft of the Group Clinical Services Plan provided in Appendix A
c)	**NOTE** the work being undertaken to transition from conceptual direction to delivery outlined in section 3, including the approach identified at 3.3 and 3.4 supplemented by Appendix B

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 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026

Group Clinical Services Plan – Final Draft

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1. Purpose

1.1 To present the final draft of the Group Clinical Services Plan (GCSP) for review and approval by the Joint Board.

2. Background

2.1 The Joint Board has previously received updates on the development of the Group Clinical Services Plan at its meetings in January and March 2026, in addition to several Board development workshops.

2.2 Our GCSP has been developed with our broader organisational architecture in mind - Group Strategy, Integrated Delivery Plan, and the 'Building a better future' programme – seeking to ensure alignment but recognising that it is a plan developed at a point in time, which will require regularly refreshing as our environment evolves.

2.3 The design of our GCSP has followed a simple model identifying key Clinical Themes, and focusing on three key questions:

- **Where are we now?** … *a brief descriptor of how the service currently feels and operates*
- **Where do we want to be?** … *aspiration of how we want the service to feel and operate*
- **How will we get there?** … *early priorities that will support us to get to where we want to be*

2.4 Through a task & finish group we have undertaken a progressive engagement process (outlined in an Appendix of the GCSP), presenting to numerous professional forums, engaging staff, public focus groups, and stakeholders, culminating in a large "Engagement Workshop" on the 5th of February 2026 attended by over 130 staff and stakeholder delegates.

2.5 This range of engagement has provided 'rich' input and feedback (all outputs have been collated and available separately) to both our current understanding of our services, as well as our aspirations and emerging early priorities for progression over the short to medium term.

3. Transitioning to Delivery

3.1 As the final draft ascends for Board approval, work has already commenced in transitioning for delivery.

3.2 A full version of the GCSP (Appendix A) has been developed. The Communications Team is now preparing a concise summary document alongside a communications plan to support its roll-out and socialisation.

3.3 Planning teams are developing a standard template (Appendix B) to be used by all services within the internal planning process.

3.4 This will provide annual-level detail against the high-level priorities for each theme, with clear divisional, specialty or sub-specialty deliverables, as appropriate.

3.5 No credible plan remains static; therefore, in-year revisions are expected to reflect emerging developments at Group, sub-regional and national levels.

3.6 Due to their sensitive nature, particularly where service reconfiguration may require public engagement or consultation, some transformation initiatives have not yet been fully reflected within the priority lists and will be considered for inclusion at an appropriate stage.

3.7 Finally, executives from across both Groups are beginning to work with the BCPC Managing Director to identify opportunities for collaboration at scale in areas targeted for development, improvement or

transformation through their respective GCSPs. This work will be incorporated into the BCPC annual work plan where appropriate.

4. Recommendations

4.1. The Group Public Trust Board Is asked to:

a) **NOTE** the update on the development of the Group Clinical Strategy provided in section 2.
b) **APPROVE** the final draft of the Group Clinical Services Plan provided in Appendix A.
c) **NOTE** the work being undertaken to transition from conceptual direction to delivery outlined in section 3, including the approach identified at 3.3 and 3.4 supplemented by Appendix B.

Sohaib Khalid
BCPC Managing Director & SRO for the Group Clinical Strategy

APPENDICES – located in the reading room associated with this meeting:
Appendix A - FINAL DRAFT Group Clinical Strategy
Appendix B - Draft Template to be used by services in developing detailed plans

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

REPORT TITLE:	Baroness Amos Report Briefing		
SPONSORING EXECUTIVE:	Mel Roberts – Group Chief Nurse		
REPORT AUTHOR:	Mel Roberts, Group Chief Nurse		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

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

Suggested discussion points

Baroness Valerie Amos was appointed in August 2025 to chair the independent National Maternity and Neonatal Investigation (NMNI), tasked with examining systemic issues in NHS maternity and neonatal services across England. The investigation has focused on 12 NHS trusts, selected to capture a diverse range of experiences, including urban, rural, and coastal areas, and aims to develop one set of national recommendations to improve safety, quality, and equity in maternity care.

In January 2026, Baroness Amos and her team visited Sandwell over a two-day period where several interviews, focus groups and presentations were held at the time and post the 2-day visit. Initial feedback was received in the form of a letter on the 9th February 2026 with concerns regarding racism, discrimination and behaviours within Perinatal Services. The CEO met with Kathryn Whitehill Director of the investigation and Baroness Amos. These issues were raised across professional groups and varying levels of seniority. Following this, the maternity people plan was created to address the issues outlined in the letter and verbal feedback. On June 11th, 2026, the Trust received its individualised draft report in advance of the overall final national report which is due to be published on the 30th June.

This individual draft report was sent ahead of publication so that any factual errors can be identified, or to allow us to respond to any criticism relating to the organisation that we consider to be unfair. The Trust responded to the report (see annex 1) and the final report was published on the 30th June 2026.

This report outlines the key points of the report for Trust Board to consider. It outlines our response, our position against the 10-point plan for maternity, next steps in relation to the maternity and neonatal taskforce and the perinatal people plan.

In the Reading Room:

- Appendix 1 – Baroness Amos Response
- Appendix 2 – Maternity 10-point plan position – both Trusts

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
Not applicable

Recommendations

a)	**Discuss** and challenge the report.
b)	**Debate** the improvement journey and challenge are we doing enough.
c)	**Discuss** the wider implications and evidence of Culture & racism & discrimination across maternity and the wider organisation

Escalation
Should any element of this report be escalated: Not applicable

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
	003 (Joint): Partnerships		
	004: Finance		004: Finance
	005: Operational performance		005: Operational performance
	006 (Joint): Infrastructure		
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 meeting on Wednesday 22nd July 2026

Baroness Amos Report - National Maternity and Neonatal Independent Investigation

1. Introduction

The National Maternity and Neonatal Investigation Team visited Sandwell and West Birmingham NHS Trust (from here on referred to as SWBH or the Trust) on 22 and 23 January 2026. The Trust has one site that delivers hospital-based maternity and neonatal services: Midland Metropolitan University Hospital.

The aim of the visit to the Trust was to speak to families about their experiences and understand the experience of staff working there. It was also important for the team to view the estate itself, as staff and families reported the impact this could have on services. The Trust visit contributed to our understanding of what is happening in maternity and neonatal services in England. The report was clear to say that each individual trust report provides a snapshot in time, based on the evidence gathered during the site visit and review. These reports were not intended to replicate the role of the Care Quality Commission (CQC), and they should not be read as equivalent to a formal inspection or rating.

An initial draft report was received on the 11th June and the Trust needed to respond by the 24th June (see Annex 1 Trust Response). The final report was received on the 29th June 2026.

This report represents the most significant national review of maternity and neonatal services since Ockenden. Its conclusions are systemic rather than targeted at individual organisations. However, there are important implications for Sandwell & West Birmingham (SWBH) and the Black Country, particularly because SWBH was one of only 12 trusts selected for detailed investigation.

2. Overall national findings

The report concludes that the NHS maternity and neonatal system is not currently designed to consistently deliver safe, equitable and compassionate care. Rather than identifying isolated failures, it identifies structural weaknesses across England including:

- Women not being listened to.
- Embedded racism and discrimination.

- Fragmented services with poor continuity.
- Weak governance and accountability.
- Workforce shortages and poor culture.
- Outdated estates and IT.
- Poor learning after incidents.

The report therefore recommends fundamental reform including:

- a statutory National Maternity and Neonatal Commissioner
- a new national Modern Service Framework
- racism being treated as a patient safety issue.
- national maternity triage standards
- stronger regulation and accountability.

3. Particular implications for Sandwell & West Birmingham

Although this national report does not single out SWBH for criticism, its inclusion among the 12 investigation trusts means the organisation contributed directly to the evidence underpinning the recommendations. For SWBH there are several particularly relevant themes.

Health inequalities – which is the single biggest issue for SWBH. The report repeatedly highlights deprivation, ethnicity, language, migration and social disadvantage as major determinants of maternity outcomes.

These reflect the demographic profile served by Sandwell and much of Birmingham. The report argues Trusts serving these populations require services specifically designed around inequality rather than assuming a “one size fits all” model.

4. Listening to women

The report repeatedly states that women from ethnic minority communities were less likely to feel believed, more likely to have symptoms dismissed, less likely to receive compassionate care.
For SWBH this reinforces the need for culturally competent communication, interpreters, continuity of care and community engagement.

5. Workforce culture

The investigation identifies: bullying, racism, hierarchy and fear of speaking up as threats to patient safety. This is relevant across large teaching organisations like SWBH where multidisciplinary working is essential.

6. Community integration

The report strongly criticises fragmentation between GPs, maternity, neonatal services, community and mental health.

This aligns closely with the Black Country Integrated Care System ambition to provide more integrated neighbourhood services.

7. Black Country implications

Although the Black Country is not discussed as a system, many recommendations align directly with existing Black Country priorities. These include:

- reducing health inequalities
- improving continuity
- better digital integration
- stronger community care
- neighbourhood models

- integrated pathways.

The report therefore supports much of the direction already being pursued locally.

8. Ethnicity and race

This is one of the strongest themes in the report. The Chair states racism is: “embedded within the system” and identifies it as one of the fundamental causes of poorer outcomes.

The report highlights maternal mortality compared with White women, in particular black women have approximately 2.7 times the maternal mortality rate, Asian women also have significantly higher mortality. Babies from Black ethnic backgrounds are over twice as likely to be stillborn.

9. Families’ Experiences

Evidence describes longer waits, being dismissed, racial stereotyping, assumptions about pain tolerance, delayed escalation, poorer communication. The report includes evidence that Black and Asian women were stereotyped as exaggerating symptoms, contributing to delayed intervention and emergency complications.

10. Structural racism

Importantly, the report goes beyond individual prejudice. It concludes racism exists within policies, clinical tools, training, governance, service design, data systems. Therefore, racism should be treated as a patient safety issue, not solely as an equality issue.
The report recommends that Trusts should:

- analyse outcome data by detailed ethnic group.
- investigate variation.
- use inequality data as patient safety intelligence.
- escalate concerns to Board level.
- evaluate anti-racism training.
- improve ethnicity data quality.
- review regulatory referrals for evidence of racial bias.

11. What this means specifically for us

Given the population we serve, we should increase board scrutiny of the following:

- maternity outcomes by ethnicity
- continuity of carer for women from deprived communities
- interpretation and communication support
- maternity triage performance
- workforce culture
- staff experience by ethnicity
- patient experience by ethnicity
- learning from incidents involving minority ethnic families.

These areas will become core components of future quality assurance and Care Quality Commission oversight.

12. Responding to the report upon publication

From the outset, our approach has been guided by a commitment to openness, honesty and ensuring we put patients and families first. We recognised that this report would rightly generate significant public interest and scrutiny, and that our responsibility was not to shy away from difficult conversations, but to engage with them transparently and compassionately.

Working closely with colleagues across maternity, nursing and executive teams, we developed and delivered a comprehensive external communications plan to support publication day and the days that followed. Our activity focused on ensuring that patients, families, stakeholders, media and the wider public could access accurate information, understand our response to the findings, and hear directly from Trust leaders about both the challenges identified and the actions being taken to improve services.

We firstly wrote to bereaved families, then ensured that those who are booked to birth with us have the information they need and details on where to go if they have questions.

On publication day we facilitated broadcast interviews with both BBC and ITV, hosted within the Serenity Birthing Suite at Midland Met, followed by a live broadcast from the Winter Garden on the evening of the publication. We also coordinated the recording of interview clips for radio broadcast and responded to a significant volume of media enquiries from local, regional and specialist media outlets.

Alongside media activity, we supported publication of our open letter to the local community, stakeholder communications (including messages to local GPs and MPs), a significant website content update and the production of an open and honest video from our Director of Midwifery. this video has also been made available in our top community languages.

For our staff, senior maternity leaders were prepared for the themes that may emerge in the Baronesses final report and a staff briefing was arranged for all those in maternity & neonatal services. Our wider staff were briefed via email on the day of publication.

Baroness Amos Report Activity and sample of coverage:

- **Open letter to the community**: https://www.swbh.nhs.uk/news/an-open-letter-to-our-community
- **Video from the Director of Midwifery:** https://youtu.be/rVGfd7nXLMQ?si=9E--T8zhNFWzDQ-w
- **Smethwick hospital says sorry to patients amid racism and safety claims:** https://www.itv.com/news/central/2026-06-29/smethwick-hospital-says-sorry-to-patients-amid-racism-and-safety-claims
- **Amos 'concerned about safety' of parents and babies at Smethwick hospital:** https://www.itv.com/news/central/2026-06-30/amos-concerned-about-safety-of-parents-and-babies-at-smethwick-hospital
- **Damning report into West Midlands NHS Trust maternity services painted picture of widespread racism:** https://www.expressandstar.com/news/damning-report-into-west-midlands-nhs-trust-maternity-services-painted-picture-of-widespread-racism-8770061
- **Widespread racism and safety issues' throughout Sandwell hospital's maternity and neonatal service:** https://www.birminghammail.co.uk/news/midlands-news/widespread-racism-safety-issues-throughout-34209880
- **Deeply-embedded racism found in maternity services review at hospital trust| ITV News Central (West):** https://www.youtube.com/watch?v=l2QajdkDyRs

Moving forwards our commitment remains to keep listening and learning from our community, families and staff. Over the coming months we will lean into requests to visit the Trust, welcome invites to talk to local community groups and support our staff and those using our services with opportunities to talk and have any queries answered. Our focus is on rebuilding trust through our actions, and we will share this progress openly too.

13. National Maternity Neonatal Taskforce

Following publication of the Baroness Amos Independent National Maternity and Neonatal Investigation, the Government confirmed that the National Maternity and Neonatal Taskforce will lead the national response to the report. Chaired by the Secretary of State for Health and Social Care and supported by a newly appointed Maternity and Neonatal Commissioner, the Taskforce has been established to develop a comprehensive national action plan by the end of 2026. The action plan will bring together the recommendations of the Baroness Amos Investigation alongside other national maternity improvement recommendations, including those from the Ockenden Review, to provide a single, coordinated programme for improvement.

The Taskforce is responsible for overseeing implementation of the national action plan, holding the maternity and neonatal system to account for delivery, improving outcomes and experiences for women, babies and families, and reducing health inequalities. The intention is to move away from repeated national reviews and towards a coordinated approach that delivers sustained improvement through clear accountability, consistent national standards and strengthened oversight.

The Trust will continue to monitor national developments and will review the national action plan on publication to ensure any required actions are incorporated into local improvement programmes and governance arrangements.

In the interim the interim 10-point maternity plan has been received and the position for both DGFT and SWB are in Appendix 2.

A national maturity triage tool specification has also been published This guidance establishes consistent national principles to strengthen, protect and sustain this core part of maternity services. It will ensure there is equitable access to this vital service and support seamless pathways from early pregnancy services into maternity triage. NHS trust boards are responsible for the delivery and trust-level oversight of maternity triage services. All trusts will begin by completing a board-level audit within 3 months (a maternity triage diagnostic tool will be shared shortly) and must implement improvements in line with this national triage guidance within 12 months to ensure that women and families receive safe, timely urgent care when they need it. Both Trusts are currently assessing themselves in relating to this new specification.

14. Maternity and Neonatal Improvement Support Team (MatNeoIST

Following a meeting held with the Regional Chief Nurse, Regional Chief Midwife, Trust Chief Executive and Group Chief Nurse, discussions were held around the continuing emerging concerns, inclusive of the concerns raised from Baroness Amos, and the National Maternity and Neonatal Investigation Team it was agreed to receive additional support from the Maternity and Neonatal Improvement Support Team (MatNeoIST), as previously offered following a Rapid Quality Review in January 2025.

The purpose of the diagnostic review is to provide an independent external review of maternity services at the Trust to ensure a robust governance framework underpins the review. This will follow on from the regional review that took place in July 2025 and will be reflective of where improvements have been made by the Trust, as well as identifying any further opportunities for improvement.

This review will be undertaken by National Maternity Improvement Advisors, Midwifery, Obstetric, and Neonatal alongside other national leads and colleagues.

The team will be on site from 13th July 2026 13.00hrs to 16th July 2026 13.00hrs, with high level feedback being provided at the end of the visit and a report thereafter.

The team will gain as much intelligence by reviewing systems and processes around workforce, efficiency, safety, effectiveness, and experience. Information will be gathered via both virtual and face to face meetings. This will be a combination of one-to-one meetings, with key members of the MDT and executive teams, focus groups with staff, attendance at scheduled meetings during the review period, reviewing requested documents and walk abouts within the clinical areas. The team will use the previous regional diagnostic to measure improvement and highlight any areas of further support.

15. Perinatal People Plan

The Perinatal People Plan complements the wider Group Culture Improvement Programme, supporting delivery of the Fit for the Future Strategy, the NHS Staff Standards, and the NHS Leadership and Management Standards.

At its core, the plan aims to create a consistently inclusive, compassionate and anti-racist culture in which all staff are treated with dignity and respect, experience a strong sense of belonging, and are supported to achieve their full potential. Recognising the direct relationship between workforce culture, staff experience and patient outcomes, the plan focuses on both immediate actions and sustainable long-term change across Perinatal Services.

Key Priorities

The Perinatal People Plan is focused on four key priorities:

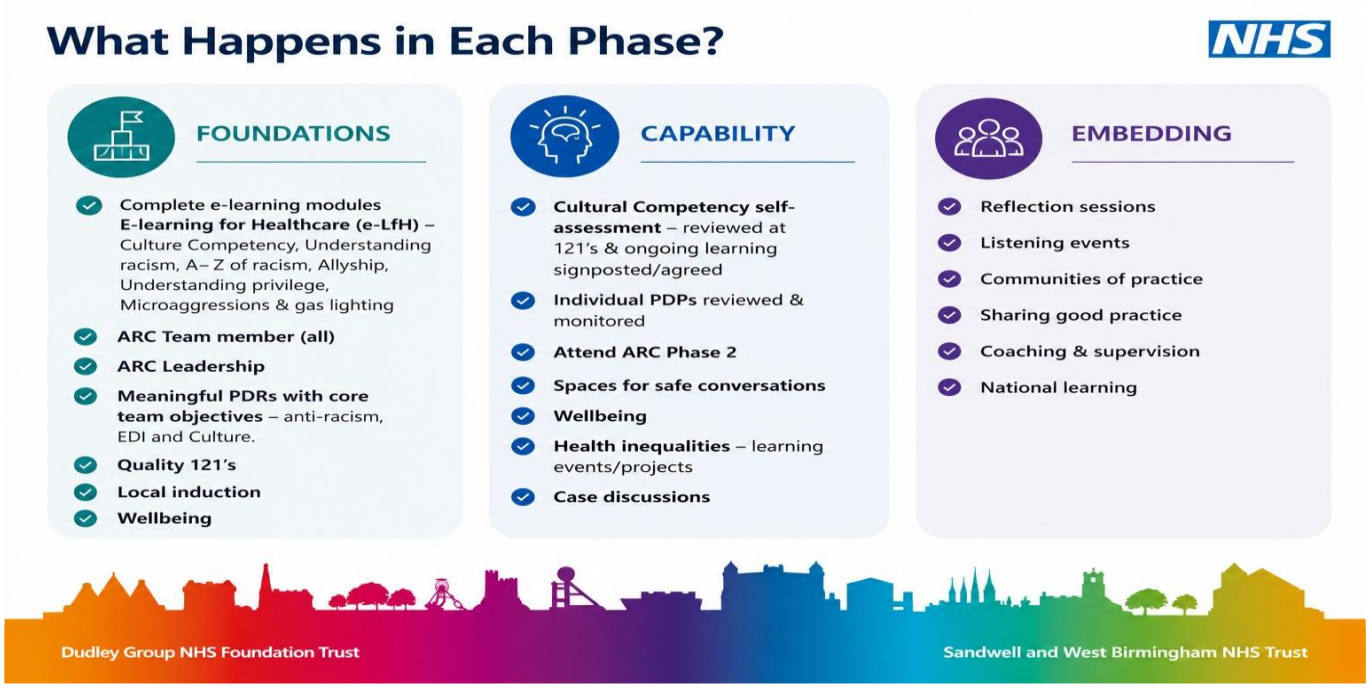
- Delivering a medium- to long-term Organisational Development (OD) Team Development programme across Perinatal Service.
- Implementing immediate targeted interventions within Neonatal Services to address identified cultural, behavioural, leadership, inclusion and team effectiveness issues across all staff groups.
- Embedding anti-racism, equity, inclusion and accountability into leadership practice, workforce processes and everyday team behaviours.
- Strengthening leadership, multidisciplinary collaboration and team effectiveness across maternity and neonatal services through a coordinated, system-wide approach.

Delivery Approach

Our approach is deliberately phased to establish strong foundations, build capability and embed sustainable change across Perinatal Services.

Central to this programme is a commitment to improving culture, addressing inequity, tackling racism and discrimination, and ensuring that behaviours consistently reflect Trust values and expected professional standards.

To support this work, governance arrangements have been strengthened through the establishment of the Perinatal Culture Oversight Group, providing leadership, assurance, oversight and accountability for the delivery of the culture improvement programme.
The programme is structured across three phases:



Phase 1: Laying the Foundations (July – September 2026)
This phase focuses on creating the conditions for meaningful and lasting change by increasing awareness, understanding lived experiences and enabling psychologically safe conversations about culture, behaviours, racism, discrimination, inclusion and belonging.

A key objective is to ensure staff understand the impact that individual behaviours, conscious and unconscious bias, and organisational culture can have on colleagues, women, babies and families. Alongside this, clear expectations will be established regarding professional conduct, civility, inclusion and accountability, ensuring behaviours that fall below Trust standards are appropriately challenged and addressed.

Phase 2: Building Capability (September 2026 – March 2027)
Building on the foundation phase, this stage focuses on developing leadership capability, strengthening team effectiveness and embedding inclusive leadership behaviours across Perinatal Services.

Through leadership coaching, compassionate and inclusive reflective practice, cultural intelligence development and multidisciplinary team interventions, leaders and staff will be equipped with the skills, confidence and behaviours required to create respectful, inclusive and high-performing teams.

Particular emphasis will be placed on developing leaders who actively model inclusive behaviours, recognise and address inequity, challenge racism and discrimination and create psychologically safe environments in which staff feel valued, heard and able to speak up.

Phase 3: Embedding Sustainable Change (March – September 2027)
The final phase focuses on ensuring improvements are sustained and embedded into everyday practice. There will be a continued and visible focus on tackling racism, discrimination and exclusion through leadership accountability, facilitated dialogue, reflective learning and robust management of behaviours that fall below expected standards.

Equality, Diversity and Inclusion objectives will be embedded within leadership, team and individual performance frameworks, ensuring ownership for culture change is shared across the service rather than being viewed as a standalone initiative.

By embedding compassionate leadership, inclusion and anti-racist practice into day-to-day behaviours, the service aims to create an environment where all staff feel respected, valued and able to contribute fully, regardless of their background, ethnicity or identity.

Neonatal Service Focus

Alongside the wider Perinatal People Plan, the Neonatal Service will continue to receive targeted support through a dedicated Organisational Development programme focused on improving culture, behaviours, inclusion and multidisciplinary team working.
This multi-faceted programme combines:

- Leadership alignment and development
- Cultural intelligence education
- Anti-racism development
- Self-assessment and diagnostic activity
- Reflective practice
- Team effectiveness interventions
- Coaching and facilitated team development

The approach moves beyond one-off interventions and focuses on embedding inclusive behaviours, strengthening accountability, improving workforce experience and ensuring anti-racism and inclusion become integral to how the service operates, collaborates and leads in the future.

The ARC Team Effectiveness Programme will continue to be delivered throughout the implementation period to support the development of psychologically safe, compassionate and high-performing teams.

Impact of the Plan
This plan is not simply a programme of training and development; it is a structured culture change programme designed to deliver measurable improvements in staff experience, team effectiveness and patient care.

The expected impact is:

- **Improved staff experience and retention** through a more inclusive, respectful and supportive working environment.
- **Reduced experiences of bullying, discrimination and exclusion**, supported by clearer expectations, greater accountability and stronger leadership behaviours.
- **More confident and capable leaders** who can effectively manage performance, address poor behaviours and foster psychological safety.
- **Stronger multidisciplinary working**, leading to improved collaboration, communication and team functioning across maternity and neonatal services.
- **Increased staff voice and engagement**, ensuring concerns are heard early and acted upon appropriately.
- **Greater equity in workforce experience and opportunity**, supporting the Trust's commitment to addressing racial and other inequalities.
- **A sustainable culture of compassion, inclusion and accountability**, embedded within everyday practice rather than delivered through isolated initiatives.
- **Better outcomes for women, babies and families**, recognising that positive staff culture and effective teamwork are critical enablers of safe, high-quality care.

In summary, this plan strengthens the conditions in which staff can thrive, teams can perform effectively, and patients can receive consistently safe, compassionate and equitable care.

Measuring Impact and Success
To ensure the Perinatal People Plan delivers meaningful and sustainable change, a robust evaluation framework will be implemented. This will provide regular assurance to the Perinatal Culture Oversight Group and the Board that interventions are translating into measurable improvements in culture, leadership, inclusion, staff experience and service delivery.

Impact will be monitored through a combination of quantitative metrics, qualitative feedback and workforce indicators, enabling the organisation to review progress, identify areas requiring further intervention and adapt the programme accordingly.

There is also a separate report for Trust Board relating to the wider organisational culture improvement work.

16.Summary

The key message for Trust Board is that this is not primarily a maternity report—it is a systems governance report. The investigation concludes that safety depends on culture, leadership, governance, digital infrastructure, workforce, and tackling inequality. For organisations such as ourselves serving highly diverse and deprived populations, the recommendations imply that equity should be treated as a core patient safety and quality objective, with measurable assurance at Board level rather than as a standalone equality initiative.

The report outlines our response to the Baroness Amos Report, the improvement journey the Trust is on, our position against the 10 point maternity plan, the perinatal people plan which is a subset of the wider work we the Trust will be undertaking over the next 12 months to tackle culture and racism and discrimination and next steps in continuing our journey of improvement.

17. Recommendations

a) **Discuss** and challenge the report.
b) **Debate** the improvement journey and challenge are we doing enough.
c) **Discuss** the wider implications and evidence of Culture & racism & discrimination across maternity and the wider organisation

Mel Roberts
Group Chief Nursing Officer
8th July 2026

Appendix 1 – Baroness Amos Response
Appendix 2 – Maternity 10-point plan position – both Trusts

Enclosure 11

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

REPORT TITLE:	Group Perinatal Quality Oversight Paper		
SPONSORING EXECUTIVE:	Melanie Roberts – Group Chief Nursing officer, Jonathan Odum, Interim Group Chief Medical Director		
REPORT AUTHOR:	Claire Macdiarmid – Interim Group Director of Midwifery		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

Paper Type:		**Requested action:**		**Applies to:**	
	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

The Dudley Group (DGFT)

Stillbirth and extended perinatal mortality rates remain below the national comparator, although four neonatal deaths in Quarter 1 have increased the neonatal death rate to 2.01 per 1,000 births, above the national benchmark of 1.60 per 1,000 births. A joint maternity and neonatal multidisciplinary review is underway to identify any common themes or learning.

There have been no new cases referred to and accepted by the Maternity and Newborn Investigations (MNSI) during June 2026. There have been no MNSI cases concluded during June 2026. There have been no new Patient Safety Incident investigations commenced in June 2026. There have been no Patient Safety Incident Investigation concluded during June 2026 at Dudley Group. 0 MOSS Signals have been received.

A benchmarking exercise against the NHS England Maternal Care Bundle has been completed, with a formal gap analysis underway to support development of a prioritised implementation plan.

The Dudley Group has been nationally recognised with two shortlisted entries in the 2026 HSJ Patient Safety Awards, reflecting the Trust's commitment to innovation, quality improvement and safer maternity care, with the awards taking place in Telford in September 2026.

Sandwell and West Birmingham (SWB)

Perinatal mortality remains above the national average at 7.40 deaths per 1,000 births, with 12 perinatal deaths reported during Quarter 1 (6 stillbirths and 6 neonatal deaths). Several cases involved severe fetal anomalies or specialist cardiac conditions; however, themes relating to reduced fetal movements, delayed attendance to triage and communication barriers have been identified.

Four MNSI investigations were concluded during the quarter, producing recommendations covering CTG management, interpreting services, neonatal resuscitation, antenatal clinic processes, clinical guidance management, triage processes and induction of labour pathways. Action plans are being implemented.

A Level 2 MOSS safety signal was received in May 2026. Following review, the overall position was assessed as amber, reflecting known safety issues within triage, induction of labour and achievement of Category 1 caesarean section standards, with improvement plans in place but not progressing at the required pace.

The Trust has entered the NHS England Maternity and Neonatal Improvement Support Team (MatNeoIST) programme. An independent diagnostic review is scheduled for July 2026 to support further improvement in leadership, governance, safety and quality.

Improvement trajectories are being monitored for:

- Triage assessments within 15 minutes of arrival.
- Category 1 caesarean section decision-to-delivery times.
- Induction of labour waiting times.
- Reduction in babies born before arrival.
- Use of interpreting services and access for women whose first language is not English.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
Not applicable

Recommendation(s)	
a)	**Accept** the report against the recommendations as per the requirements of the Perinatal Quality Oversight Model.

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 (Joint): Quality		
x	002 (Joint): Workforce		
	003 (Joint): Partnerships		
	004: Finance		004: Finance
x	005: Operational performance	x	005: Operational performance
	006 (Joint): Infrastructure		
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 Trust Public Board on 22nd July 2026

Group Perinatal Quality Surveillance paper

1. Purpose

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety as outlined in the NHS England (NHSE) document "Perinatal Quality Oversight Model' (August 2025).

The purpose of the report is to inform the Joint Quality Committee, Joint Trust Board and Local Maternity and Neonatal System (LMNS) board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of ward to board insight across the multidisciplinary multi professional maternity and neonatal service teams. The Perinatal Quality Oversight Model (PQOM) has been developed in response to the need to proactively identify trusts that require support before serious issues arise.

It provides consistent and methodical oversight of NHS perinatal services and ensures we collect the information and insight we need to drive service improvement.

While provider trusts and their boards ultimately remain responsible for the quality of the services they provide and for their improvement, the PQOM supports trusts and Integrated Care Boards (ICBs) to discharge their duties and provides a mechanism for escalation of any emerging risks, trends or issues that cannot be resolved at local level or would benefit from wider sharing.

2. Background

In line with the perinatal quality oversight model, both Trusts are required to report the information outlined in the data measures proforma bimonthly to the trust board.

3. Group Headlines

3.1 Perinatal Surveillance Dashboard

The latest perinatal surveillance dashboards for both organisations are enclosed in the Reading room.

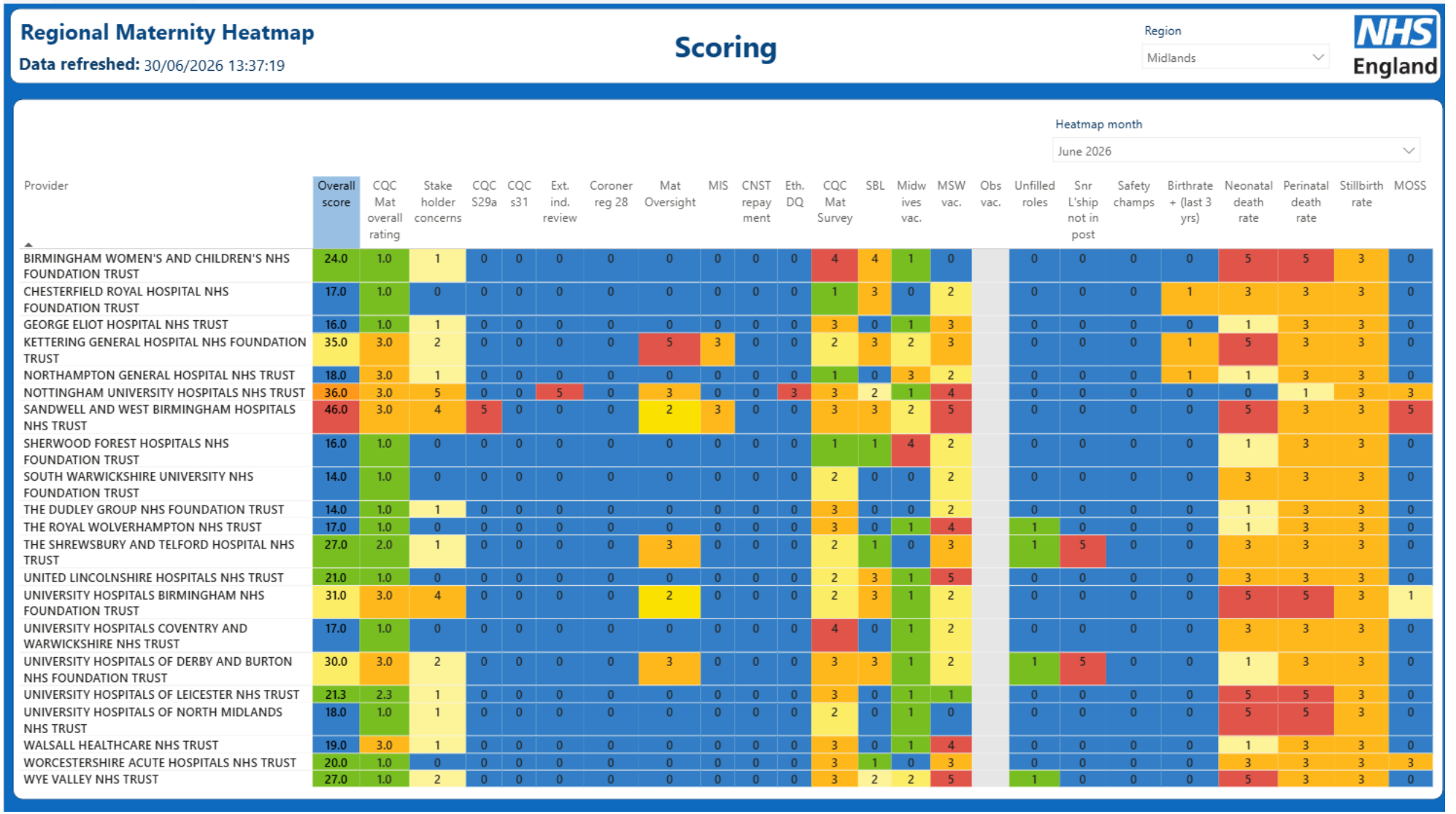
3.2 Heatmap scoring

Sandwell (SWB) is awaiting scoring to reflect the reduction in Maternity Support Worker (MSW) vacancy, to reduce this score from 5. The midwifery vacancy should reduce from a score of 2 over the coming months as remaining vacancy is filled with Newly qualified midwives.

The Dudley Group score has reduced to 14, as one stakeholder concern has been removed. MSW vacancy has also been fully recruited to, therefore a reduction of one point is expected.

Table 2- Regional Maternity Heatmap

Heatmap



Regional Maternity Heatmap

Data refreshed: 30/06/2026 13:37:19

Scoring

Region: Midlands

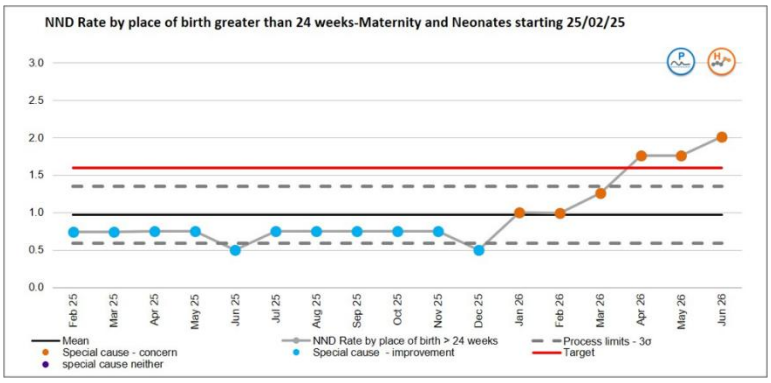
NHS England

Heatmap month: June 2026

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate	MOSS
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	24.0	1.0	1	0	0	0	0	0	0	0	0	4	4	1	0		0	0	0	0	5	5	3	0
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	17.0	1.0	0	0	0	0	0	0	0	0	0	1	3	0	2		0	0	0	1	3	3	3	0
GEORGE ELIOT HOSPITAL NHS TRUST	16.0	1.0	1	0	0	0	0	0	0	0	0	3	0	1	3		0	0	0	0	1	3	3	0
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	35.0	3.0	2	0	0	0	0	5	3	0	0	2	3	2	3		0	0	0	1	5	3	3	0
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	18.0	3.0	1	0	0	0	0	0	0	0	0	1	0	3	2		0	0	0	1	1	3	3	0
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	36.0	3.0	5	0	0	5	0	3	0	0	3	3	2	1	4		0	0	0	0	0	1	3	3
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	46.0	3.0	4	5	0	0	0	2	3	0	0	3	3	2	5		0	0	0	0	5	3	3	5
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	16.0	1.0	0	0	0	0	0	0	0	0	0	1	1	4	2		0	0	0	0	1	3	3	0
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST	14.0	1.0	0	0	0	0	0	0	0	0	0	2	0	0	2		0	0	0	0	3	3	3	0
THE DUDLEY GROUP NHS FOUNDATION TRUST	14.0	1.0	1	0	0	0	0	0	0	0	0	3	0	0	2		0	0	0	0	1	3	3	0
THE ROYAL WOLVERHAMPTON NHS TRUST	17.0	1.0	0	0	0	0	0	0	0	0	0	3	0	1	4		1	0	0	0	1	3	3	0
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	27.0	2.0	1	0	0	0	0	3	0	0	0	2	1	0	3		1	5	0	0	3	3	3	0
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	21.0	1.0	0	0	0	0	0	0	0	0	0	2	3	1	5		0	0	0	0	3	3	3	0
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	31.0	3.0	4	0	0	0	0	2	0	0	0	2	3	1	2		0	0	0	0	5	5	3	1
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	17.0	1.0	0	0	0	0	0	0	0	0	0	4	0	1	2		0	0	0	0	3	3	3	0
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	30.0	3.0	2	0	0	0	0	3	0	0	0	3	3	1	2		1	5	0	0	1	3	3	0
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	21.3	2.3	1	0	0	0	0	0	0	0	0	3	0	1	1		0	0	0	0	5	5	3	0
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	18.0	1.0	1	0	0	0	0	0	0	0	0	2	0	1	0		0	0	0	0	5	5	3	0
WALSALL HEALTHCARE NHS TRUST	19.0	3.0	1	0	0	0	0	0	0	0	0	3	0	1	4		0	0	0	0	1	3	3	0
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	20.0	1.0	0	0	0	0	0	0	0	0	0	3	1	0	3		0	0	0	0	3	3	3	3
WYE VALLEY NHS TRUST	27.0	1.0	2	0	0	0	0	0	0	0	0	3	2	2	5		1	0	0	0	5	3	3	0

3.3 Perinatal Mortality data:

The Dudley Group



The Trust has seen an increase in the neonatal death rate for babies born at ≥24 weeks' gestation (place of birth), with the crude rate increasing to 2.01 per 1,000 births in June 2026, above the national comparator of 1.60 per 1,000 births. Four neonatal deaths occurred during Quarter 1. Initial review has not identified any common clinical themes or recurring system issues. In response to the increase, the maternity and neonatal teams are undertaking a joint multidisciplinary deep dive into all cases to identify any shared learning, opportunities for improvement and any emerging trends. Findings and resulting actions will be reported through the Trust's governance processes.

The Trust's stillbirth and extended perinatal mortality rates have remained below the national comparator throughout Quarter 1 2026/27. Although there has been normal month-to-month variation, performance has remained consistently better than the national average. All stillbirths and perinatal deaths continue to undergo robust multidisciplinary review through established governance processes, including 72-hour reviews and the Perinatal Mortality Review Tool (PMRT), to identify learning and drive continuous improvement.

Sandwell and West Birmingham NHS Trust (SWB)

SPC Chart 1 : Perinatal Mortality (Rolling 12-month rate / 1000 births) Sandwell & West Birmingham
SPC Chart 2: Stillbirth rate (Rolling 12-month rate / 1000 births) Sandwell & West Birmingham

Chart 1

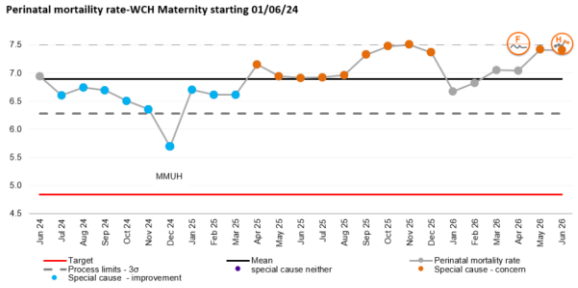
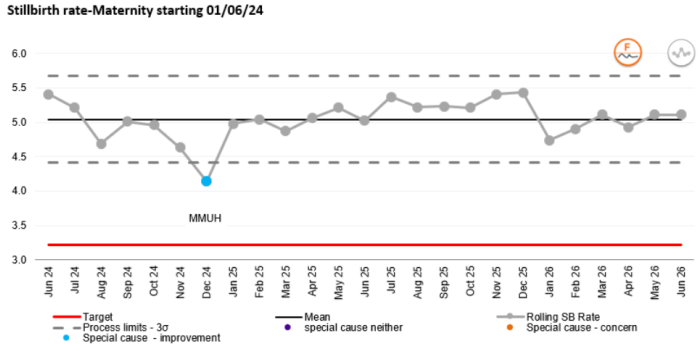
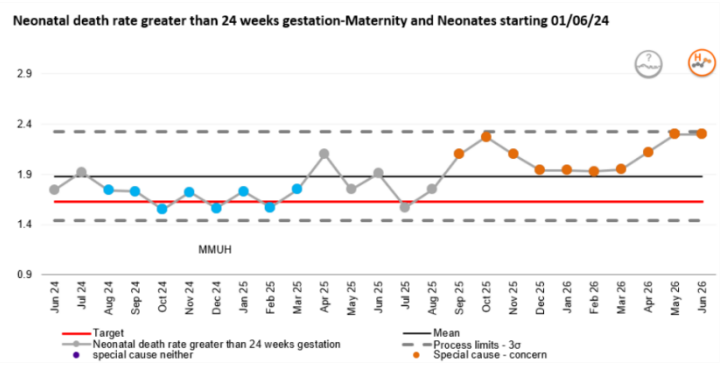


Chart 1



SPC Chart 3 : Neonatal Death rate (Rolling 12-month rate / 1000 births) Sandwell & West Birmingham

Chart 3



The overall perinatal mortality rate at Sandwell and West Birmingham NHS Trust remains above the nationally reported average for England, at 7.40 deaths per 1,000 births at the end of Quarter 1. Twelve perinatal deaths reportable under the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom criteria occurred within the Trust during Quarter 1 of 2026/27. Of these, six were stillbirths and six were neonatal deaths. The stillbirth rate remains stable but above the nationally reported rate, at 5.11 deaths per 1,000 births, while a statistically significant increase in neonatal deaths has been observed, at 2.3 deaths per 1,000 births.

Two babies died during, or shortly after, surgery for major cardiac abnormalities at a specialist centre. Two stillbirths and one neonatal death occurred in babies with a known serious or lethal fetal anomaly.

Three stillbirths occurred following an episode of reduced fetal movements. In all three cases, a delay was identified in the women attending maternity triage for urgent assessment. Work is ongoing to understand the barriers that may prevent women with reduced fetal movements from attending maternity triage promptly and to improve access for this group.

One neonatal death occurred at 38 weeks and one day of gestation following a placental abruption. The mother attended hospital with ongoing vaginal bleeding, and a Category 1 caesarean section was performed within 30 minutes of arrival because of fetal bradycardia and suspected placental abruption. The baby was born with no signs of life but responded to extensive resuscitation and, following stabilisation, was transferred to a Level 3 neonatal unit. Sadly, care was subsequently redirected towards comfort care, and the baby died at three days of age.

The mother developed pre-eclampsia and haemolysis, elevated liver enzymes and low platelet count syndrome. She was admitted to the critical care unit at Sandwell and West Birmingham NHS Trust for ongoing treatment and has since recovered well. The case was referred to the Maternity and Newborn Safety Investigation programme. However, the parents declined an external investigation of their care because they felt that the care they had received had been good.

One neonatal death occurred following a birth at home at 28 weeks and four days of gestation. The mother had been under observation following prolonged preterm rupture of membranes from 25 weeks of gestation and subsequently went into premature labour. This case has been referred to the coroner.

One stillbirth occurred at 33 weeks and four days of gestation in a mother who developed pre-eclampsia and haemolysis, elevated liver enzymes and low platelet count syndrome.

One neonatal death occurred at 41 weeks and four days of gestation. The mother had booked to give birth at a neighbouring Trust but attended maternity triage at Sandwell and West Birmingham NHS Trust with signs of labour. A Category 1 caesarean section was performed because an abnormal fetal heart pattern was detected on admission. The baby was born in a poor condition but did not respond to advanced resuscitation and sadly died at 40 minutes of age.

A rapid review of the case identified inconsistent use of interpreting services, which resulted in the mother not fully understanding the plan for induction of labour at 41 weeks of gestation. The case has been referred to the Maternity and Newborn Safety Investigation programme, and a joint review of care will be completed with the Trust at which the birth had originally been planned.

All cases of perinatal mortality are reviewed using the Perinatal Mortality Review Tool. A full mortality report for Quarter 1 of 2026/27 will be presented to the Trust Quality Committee in August 2026.

3.4 Patient Safety Incident Investigations and Maternity and Newborn Safety Investigations: Dudley Group

There were no new cases referred to and accepted by the Maternity and Newborn Safety Investigation programme during June 2026. No Maternity and Newborn Safety Investigation cases were concluded during June 2026.

No new Patient Safety Incident Investigations were commenced during June 2026.

No Patient Safety Incident Investigations were concluded at The Dudley Group NHS Foundation Trust during June 2026.

3.5 Patient Safety Incident Investigations and Maternity and Newborn Safety Investigations Sandwell and West Birmingham

In Q1 2025/26, four cases, two neonatal deaths and two cases of suspected brain injury, have been referred to the Maternity and Newborn Safety Investigation program.

Four Maternity and Newborn Safety Investigations (MNSI) investigations have been concluded in Q1 with safety recommendations for the Trust.

Case Reference	Safety Recommendation
MI-048157	It is recommended that the Trust works with clinicians to identify and address the barriers to categorising and managing cardiotocography traces in accordance with national and local guidance.
MI-047470	It is recommended that Trust A develop a mechanism to identify mothers who are immigrants and may be unfamiliar with the UK maternity system to support information sharing and informed decision making about care.
	It is recommended that Trust A explores the barriers to clinicians responding to any possible vaginal bleeding with a full clinical assessment including electronic fetal monitoring and obstetric review if needed.
	It is recommended that Trust A reviews its newborn resuscitation processes and training to ensure all staff are familiar with clinical areas and support an optimised environment to responded to neonatal emergencies
	It is recommended that Trust A provide mechanisms to ensure staff attending emergencies to be familiar with the contents and use of emergency equipment, enabling prompt access to equipment and preventing delays to resuscitation measures.
	It is recommended that Trust A put systems in place that equip all neonatal 2222 call responders with current newborn life support training to support effective teamwork in emergencies
MI-050568	It is recommended that the Trust reviews the design, resourcing, and scheduling of antenatal clinics. This will reduce the risk of antenatal reviews being constrained by time and system factors to allow full exploration of risk factors and a comprehensive management plan.
	It is recommended that the Trust aligns their management of chronic hypertension in pregnancy guideline with national guidance and provides education around this guideline. (National Institute for Health and Care Excellence 2023). This will support ongoing risk assessment, care planning, and treatment of chronic hypertension.
	It is recommended that the Trust develops robust systems and processes relating to obstetric follow up appointments in the outpatient antenatal clinics to ensure that mothers are offered and receive the required ongoing care.
	It is recommended that the Trust reviews its arrangements for the development, review, approval, and oversight of maternity clinical guidance to help reduce the risk of incomplete, outdated, or inconsistently applied guidance influencing clinical decision-making for mothers.
	It is recommended that the Trust reviews how maternity clinical guidance is accessed, maintained, and communicated to staff to help reduce the risk of clinical decision-making being undertaken without access to current and reliable guidance.
	It is recommended that the Trust reviews its arrangements for the assessment, documentation, and obstetric consultant oversight of birth planning for mothers with prior uterine surgery. This will help recognise the degree of risk and allow this to influence the timing and mode of birth
	It is recommended that the Trust reviews its arrangements for scheduling and amending planned caesarean births to help reduce the risk that changes to timing are made without a documented, consistent assessment of maternal and fetal risk.
	It is recommended that the Trust reviews the maternity telephone triage process, including the experience of staff working in triage, to support risk assessments being completed in full. This will support ongoing care planning and decision making

MI-049602	It is recommended that the Trust review and strengthen processes and electronic record prompts to ensure that immediate induction of labour is consistently offered to mothers with term pre labour rupture of membranes, in accordance with local and national guidance, so that mothers can make informed decisions about their care.
	It is recommended that the Trust review how it supports clinicians to undertake a holistic assessment of the mother, enabling them to recognise progress in labour to be able to provide the recommended one to one labour care, including continuous fetal heart rate monitoring where indicated.
	It is recommended that the Trust reviews and strengthens fetal monitoring, to identify when a cardiotocograph is required, considering relevant risk factors, and that reviews of cardiotocographs include a face-to-face holistic assessment and supporting documentation. This will support personalised care plans to reflect the level of risk present and fetal monitoring needed.
	It is recommended that the Trust strengthen processes and training so that staff use the emergency call bell when a baby's heartbeat cannot be heard on auscultation in labour. This will enable timely escalation and urgent clinical assessment to determine whether the baby's heartbeat is present.

Action plans are in place, or are being developed, to address all recommendations.

No new Patient Safety Incident Investigations were commenced or completed at Sandwell and West Birmingham NHS Trust during Quarter 1 of 2026/27.

One Patient Safety Incident Investigation was completed during Quarter 1 of 2026/27 following an incident involving a retained swab. Actions have been completed within the directorate to address the findings, including the introduction of a Local Safety Standard for Invasive Procedures for instrumental births undertaken outside the operating theatre.

3.6 MOSS Signals

The Maternity Outcomes Signal System (MOSS) is a new, real-time NHS safety tool in England designed to detect, highlight, and prevent serious risks in maternity and neonatal care. It analyses routinely recorded data to identify unusual, emerging patterns (signals) that suggest potential safety issues.

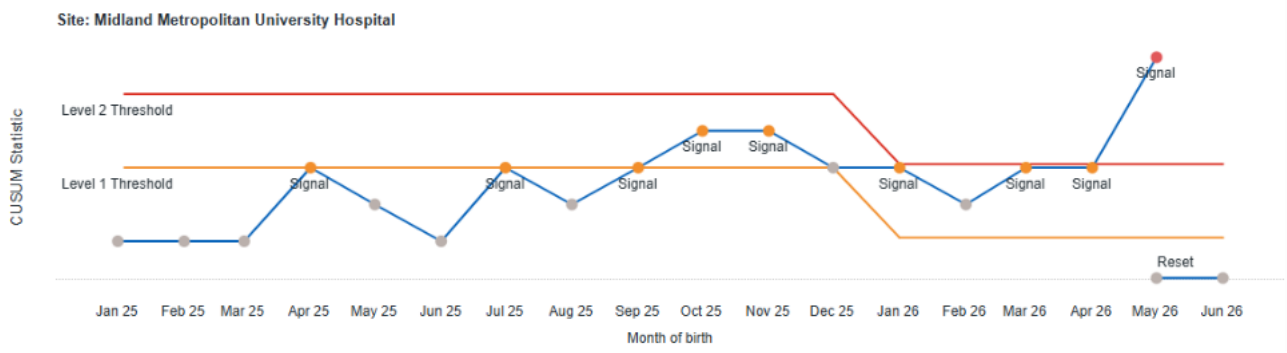
The Dudley Group

Dudley Group received 0 MOSS signals May or June 2026. Any signals that occur will be discussed with the non-executive and executive Maternity safety champions and will be escalated to this committee and onto the Board.

Sandwell and West Birmingham

Since implementation of the system and release of live data on the 31st of August 2025 for the Trust, seven level one signals have been received in September, October and November of 2025, and January, March, April and May of 2026. A level 2 signal was received in May following three term stillbirths and one term neonatal death and a critical safety check was completed.

Chart: MOSS Cumulative SUM chart



1.5 Chart: MOSS Excess Events Chart

Six cases have been included in the most recent alert – three term neonatal deaths, two term stillbirths and a termination of pregnancy at 36+4 weeks.

The first case is a neonatal death of a baby born at 37 weeks' gestation in March 2026 by category 3 caesarean section. The mother had been under the care of the fetal medicine unit due to known lethal genetic anomalies incompatible with life. A termination of pregnancy was offered but declined by the parents who wished to spend as much time with their baby as possible following birth. A palliative care plan was developed to facilitate time with baby but not to provide active resuscitation. The baby was born with signs of life and was supported to remain with parents until death was confirmed at two hours of age.

The second case involved the neonatal death of a baby born at 38 weeks and two days of gestation. The baby had been diagnosed antenatally with a significant cardiac abnormality, specifically an atrioventricular septal defect. The mother was under the joint care of the local fetal medicine unit and the regional specialist centre.

Antenatal screening indicated a high chance of trisomy 21, at 1 in 2, and trisomy 13 or trisomy 18, at 1 in 7. However, non-invasive prenatal testing returned a negative result.

Following birth, the baby was admitted to the neonatal unit before being transferred to Birmingham Children's Hospital for ongoing specialist care.

The third case is a neonatal death of a baby born at 40+3 weeks. The baby had been diagnosed postnatally with a cardiac anomaly (moderate to severe aortic stenosis and moderate pulmonary stenosis) after being transferred to the neonatal unit at six hours of age due to abnormal pulse oximetry testing and requirement for respiratory support. The baby was later transferred to Birmingham Children's Hospital for ongoing treatment but sadly died at 17 days of age in theatre.

The fourth case is a term stillbirth diagnosed at 40+2 weeks gestation. The baby had been antenatally diagnosed with lethal fetal anomalies including Trisomy 18, absent corpus callosum, ventricular septal defect and multicystic dysplastic kidney. A palliative care plan was in place should the baby be born with signs of life following antenatal counselling but sadly this mother presented to Triage with a history of reduced fetal movements and an intrauterine death was confirmed.

The fifth case was a termination of pregnancy at 36+5 weeks where feticide was performed due to severe fetal brain anomalies likely to result in severe neurological disability. This case was included within MOSS trigger events as labour was induced and a female infant delivered at 37 weeks' gestation.

The sixth case was a stillbirth at 39+5 weeks gestation following presentation to Triage with a first episode of reduced fetal movements over the previous 48 hours. The pregnancy had been consultant led due to a history of previous caesarean birth, but no other medical or obstetric risk factors were noted. Fetal growth surveillance was completed appropriately, and birthweight was within the expected range on the 61st centile. No initial issues with care were identified and no clear cause of death. There was a delay in presentation to triage with reduced fetal movements, however there is clear evidence that the importance of fetal movement monitoring and responding to changes in fetal movement patterns was discussed with the mother during pregnancy. Placental histology was accepted by the parents, but a postmortem examination of the baby was declined.

The potential avoidability of all six perinatal deaths was considered, with three deaths being considered unavoidable due to lethal fetal anomalies and three deaths likely being unavoidable due to significant cardiac anomalies which required specialist treatment at a tertiary centre and delay in mother attending triage for reduced fetal movements. No immediate issues with care that may have made a difference to the outcome in these cases were found on initial

review, however all four cases will undergo a full multidisciplinary review of care using the Perinatal Mortality Review Tool.

Known safety themes within the service include language barriers and the use of interpreting services, the induction of labour pathway, maternity Triage, management of reduced fetal movements, Perinatal staffing, access to a second theatre team and expansion of elective caesarean section capacity.

A review of achievement of safety timelines concluded that compliance with initial triage assessment within 15 minutes of arrival is not meeting the local target of 80%, with women receiving assessment within 15 minutes on 68.2% of occasions in Q4 2025/26.

Category one caesarean section timing also did not meet the required standard, with 33.9% of category one births not being completed within the 30-minute time frame in Q4 2025/26. Performance against the target of 80% for completion of Category 2 caesarean sections within 75 minutes was met in February and March 2026.

The outcome of the critical safety check was summarised as Amber – There is at least one known safety issue in our intrapartum service, with a plan of action in place but it is not progressing as planned. This conclusion was reached due to improvement cells being in place to drive improvements in Triage, the induction of labour pathway and achievement of Category 1 Caesarean Sections but local targets not being met.

The outcome of the review must be discussed with the Trust Board within four weeks, with an agreement to get plans back on track within twelve weeks.

3.7 Coroner Regulation 28 made directly to the Trust

There were 0 Coroner regulation 28 made directly to either Trust in respect of perinatal or maternal deaths in June 2026.

3.8 Maternity Safety Champions (MSC) The Dudley Group

No escalation from Maternity Safety Champion walkarounds. Bimonthly MSC updates continue. June's MSC walkaround was positive with no immediate safety concerns and positive experiences described by women and families. Speak up sessions continue quarterly with plans for dedicated sessions for medical staff.

The Dudley quarterly feedback includes the implementation planning for Maternal Care bundle, including agreement of named consultant to undertake the initial gap analysis. Obstetric job planning, recruitment and business case development continue to mitigate ongoing challenges relating to locum and middle grade staffing.

3.9 Maternity Safety Champions (MSC) Sandwell and West Birmingham

Walkarounds and feedback sessions for staff and families continue regularly - particularly considering the publication of the baroness Amose review. Families have voiced concerns over the findings of the report, and this has led to some families choosing to birth their babies at other organisations. Families are being contacted as they are highlighted, to support their decision making.

Staff have raised concerns regarding the findings of the report also and support is being offered via Professional Nurse Advocate (PNA) and Professional Midwifery Advocate (PMA) and Trauma Risk Management (TRiM) practitioners as well as 1:1 support via line managers and HR support.

3.10 National Maternity and Neonatal Investigation

Please see separate paper. Sandwell and West Birmingham NHS Trust are one of 12 organisations included within the National maternity and neonatal investigation.

3.11 NHS Resolution Maternity (and Perinatal) Incentive Scheme Year 8

Joint planning across both trusts' have occurred to ensure MIS has been considered, reported and evidenced appropriately during the compliance period, Updates will continue to QC and upwards to Board across this time. Implementation challenges noted in QC papers and actions to mitigate these commenced. Training requirements noted and pre-selected checkpoint of 31st July confirmed as well as 30th Nov to ensure continued compliance. Community PROMPT programme now reinstated, plans for non-hospital setting sim to be arranged within compliance period. Sandwell Birthrate plus is due to be published in July 2026.

Growth Chart Mitigation for Dudley by cessation of the use INTERGROWTH use and implementation of a temporary solution whist longer term IT enabled solution progresses. This needs to be a priority that is resolved in a timely manner. Sandwell remains compliant with usage of PI charts. SBL continues to be 99% compliant with Placental Growth Factor (PIGF) being the only outstanding factor, funding has now been resolved.

At Sandwell & West Birmingham, implementation of the Saving Babies Lives Care Bundle was validated by the Local Maternity and Neonatal System in May 2026 for Q4 2025/26. Progress towards full implementation remains at 91% overall due to Element 1 (Smoking in Pregnancy) and Element 6 (Diabetes) not meeting the target for compliance with Carbon Monoxide monitoring in pregnancy and HbA1C monitoring for women with pre-existing diabetes. Data collection and validation for Q1 2026/27 is in progress and improvement is expected in compliance with diabetes testing. Element 2 remains partially implemented across the system due to the lack of access to Placental Growth Factor testing. A business case has been developed within the system and funding secured for the Trusts contribution to the implementation of this service.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	70%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	67%
All Elements	TOTAL	Partially implemented	93%	Partially implemented	91%

3.12 NHS England Maternity and Neonatal Improvement Support Team (MatNeoIST)

SWB has entered the NHS England Maternity and Neonatal Improvement Support Team (MatNeoIST) programme. MatNeoIST is a national improvement programme that provides independent expert support to maternity and neonatal services to accelerate improvement, strengthen leadership and governance, and improve outcomes and experiences for women, babies and families. It is anticipated the support will remain ongoing for 12- 18 months.

As part of the programme, a four-day multidisciplinary diagnostic review will take place from 13–16 July 2026. The review will include engagement with frontline staff, service users, senior leaders and Board members, alongside a review of governance, quality, safety and clinical processes. The diagnostic will identify areas of good practice alongside opportunities for further improvement and will inform a diagnostic report, including recommendations and, where appropriate, a tailored improvement plan with mutually agreed milestones.

The Trust welcomes this opportunity for independent external review and challenge, recognising the progress already made while using the programme to further strengthen maternity and neonatal services. The findings and recommendations will be incorporated into the Trust's existing improvement programme and reported through established governance arrangements.

Please see the reading room for both Trusts responses to the refresh of the Ockenden initial seven Immediate and Essential actions (EASs). Please note this does not relate to the most recently published recommendations from the report into Nottingham NHS Trust.

3.13 Maternal Care Bundle Implementation:

The NHS England Maternal Care Bundle is a nationally developed package of evidence-based interventions designed to improve outcomes for women by standardising the prevention, recognition and management of the leading causes of maternal morbidity and mortality. The bundles focus on delivering consistent, high-quality care through multidisciplinary working, timely recognition of deterioration and adherence to national best practice, helping to reduce unwarranted variation and improve maternal safety.

Sandwell & West Birmingham

A Gap analysis has been completed by the Directorate to identify the actions required to fully implement the Maternal Care Bundle by March 2027. At the end of Q1 2026/27, no elements of the bundle are assessed as fully implemented however actions have been agreed to address process gaps.

A key challenge has been identified in the implementation of Element 2, which requires the use of the National Maternity Early Warning Score for all pregnant and newly postnatal women in the hospital setting, including in non-maternity areas. The tool has been successfully integrated into the Maternity Electronic Patient Record (EPR) since March 2026 but will need to be built into the UNITY EPR

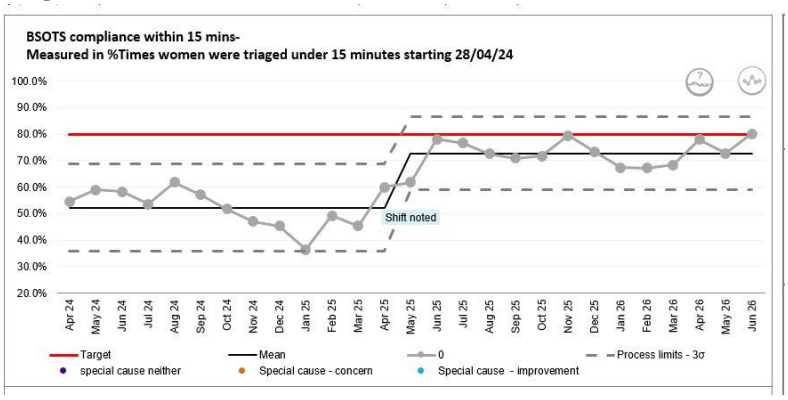
The Dudley Group

A benchmarking exercise has been completed against the national Maternal Care Bundle recommendations. Initial review suggests that many of the recommended practices are already in place; however, a formal gap analysis is underway to map existing policies, pathways and assurance processes against each intervention. The detailed assessment of compliance, evidence of implementation and identified actions is currently being completed, following which a prioritised implementation plan with named leads and timescales will be developed.

Quarterly updates on the progress towards full implementation will be provided to the Board relating to both organisations, in line with the requirements of the Maternity Incentive Scheme Year 8.

3.14 Quality and Safety Improvements

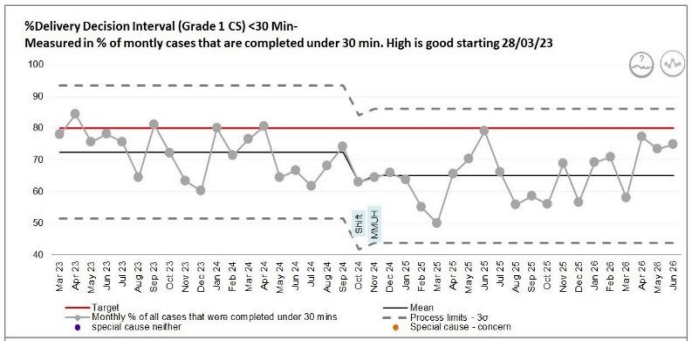
Triage data- SWB



The graph shows the monthly average for women seen within 15mins of arrival. Following a revised improvement approach, interim targets of 85% by the end of July 2026, and 90% by the end of August 2026 have been set.

This shows an improvement from previous month. However, we still have some further improvements to be made to achieve our initial 85% target by the end of July. The daily breakdown of data for the month shows a significant variation in the % compliance for 15 min initial Triage showing that the process is not yet in control and will not consistently meet the average or target. Weekly data is being reported to the executive team and daily data is being analysed by the senior leadership team.

Category 1 caesarean section response times (within target time of 30 minutes)



Performance remains below the desired target of compliance with the 30-minute decision-to-delivery standard. Decision regarding target standard is ongoing with support from NHSe.

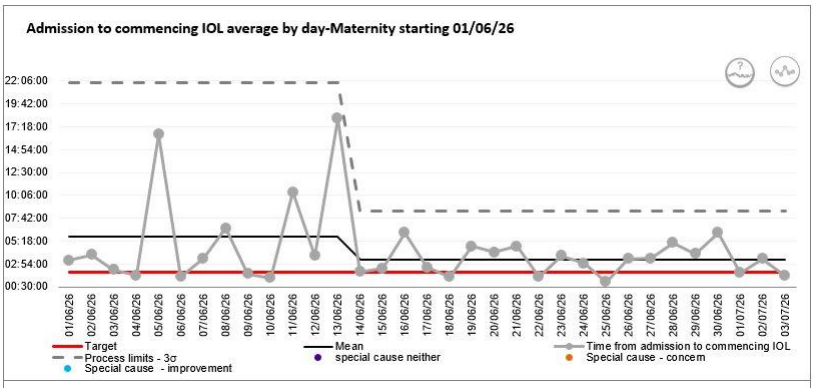
Continued improvement required to increase the proportion of Category 1 Caesarean Sections completed within 30minutes. The Number of Cat 1 LSCS is small making percentage reporting open to wide variation.

Born Before Arrival - SWB

During the month of June there were 6 Babies Born Before Arrival (BBA) which is significantly less than previous months. The increased rate of number of babies born before arrival to hospital has been a concern due to the

potential risk of harm to these mothers and babies. All cases have been reviewed to map ethnicity, language and calls to Triage prior to delivery. There have been no identified able themes however, it is noted that calls to triage for women that do not speak English are challenging and often delayed. There have also been reports of the unit being difficult to access. To remedy these factors the direct translation telephone number is due to be launched and a video of how to find Triage as well as exploring the option of written instructions. Further education to all pregnant women encouraging early calls to triage is underway as well as enhanced training for operators of the telephone triage line.

Induction of Labour - SWB



The cleansed baseline data for January and February showed an admission to induction commencement average of 9hrs 50 mins (target 2 hours). Following the opening of the induction of labour bay the process has improved inefficiency and is largely stable but not consistently meeting the 2hr target. The average for June was 4hrs 35minutes, showing a significant improvement however further improvement work is underway.

3.15 HSJ Award nomination- Dudley

The Dudley Group has received national recognition for its commitment to improving maternity safety, with two initiatives shortlisted in the 2026 HSJ Patient Safety Awards. 'Reducing Regional Escalation within the Acute Maternity Setting' has been shortlisted in the Maternity, Midwifery and Neonatal Safety Initiative of the Year category, while 'Development of a Quality Management System to Sustain Patient Safety in Maternity Services' has been shortlisted in the Advancing Patient Safety with Data and Analytics category. The awards will be presented in Telford in September 2026, recognising outstanding innovation and improvement in patient safety across the NHS.

3.16 Service user feedback

Dudley

'Every interaction we had over the 3 nights has been amazing and made a difficult time more comfortable

special thanks to following midwives: Emily, Ava, Grace, Nana and Heather'

'We were really looked after and the staff made sure baby was safe. Special thank you to Jenifer, Abbey,

Bella and Vicky, they were all brilliant and couldn't have asked for a better team'

'Understanding more about emergency process and understanding point of conclusion of direction of care'

I truly believe having the continuity of care from one midwife positively impacted on my birth outcomes and experience. With Cordie's expert advice, support, advocacy and guidance, I had two beautiful homebirths which couldn't have gone any better. I will never forget her and feel so lucky to have been supported by such a wonderful midwife during a very special time of life.

Sandwell

Recently I birthed a baby, and I got support whatever and whenever I needed.

I've had two births here in Sandwell and very happy with the midwives

Sometimes scans/appts were cancelled but the NHS app/appt letters were not updated and we were not informed otherwise. Waiting times for doctors are extremely long, particularly when heavily pregnant and there's no food.

Appropriate care was given to me for my conditions (gestational diabetes). Had plenty of growth scans and checks on glucose levels. Birth plan was discussed with a consultant and our decision was respected.

4. Recommendation

4.1 The Public Trust Board is asked to:

a) **Accept** this paper as assurance against the national requirements of Perinatal Quality Oversight Model, Saving babies Lives version 3.2 and Ockenden 2022.

Claire Macdiarmid
Interim Group Director of Midwifery

13th July 2026

Enclosure 12

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

REPORT TITLE:	National Antimicrobial Resistance (AMR) Call to Action		
SPONSORING EXECUTIVE:	Melanie Roberts (Group Director Infection Prevention & Control)		
REPORT AUTHORS:	Dr Syed Gilani (Consultant Antimicrobial Pharmacist DGFT, on behalf of the Antimicrobial Stewardship Team) Andrew Brush (Lead Antimicrobial Pharmacist SWB) Dr Tranprit Saluja (Consultant Microbiologist and SWB Antimicrobial Stewardship lead) David Shakespeare (Group Deputy Director Infection Prevention & Control)		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

Paper Type: (place an 'x')		**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	X	Endorse		The Dudley Group NHS Foundation Trust
	Information		Recommend		
			Discuss		
			Note		

Suggested discussion points

Background

- Antimicrobial resistance (AMR) is recognised internationally as one of the greatest threats to human health.
- This report provides formal assurance to the that DGFT and SWB have responded to NHS England's "AMR call to action" (November 2025) by Q1 2026.
- The Dudley Group NHS Foundation Trust (DGFT) and Sandwell and West Birmingham NHS Trust (SWB) have jointly agreed two Trust level AMR priorities in line with national priorities for 2026/27 with an additional Infection Prevention & Control priority for each of DGFT and SWB
- The Board is asked to note that the report has followed a robust governance route and received appropriate scrutiny at the Quality Committee held in June 2026 where a 'reasonable' assurance was assigned.

Overall position:

The Dudley Group NHS Foundation Trust: Performance against nationally mandated antimicrobial stewardship (AMS) and infection prevention and control (IPC) metrics remains strong, with antimicrobial usage comparing favourably against peer and national benchmarks. The Trust achieved good compliance with the national IPC Board Assurance Framework and has established improvement plans to further reduce Clostridioides difficile and gram-negative bacteraemia rates during 2026/27. Overall, the report provides assurance that DGFT is meeting NHS England requirements and contributing effectively to the national antimicrobial resistance agenda.

Sandwell and West Birmingham NHS Trust: Antimicrobial stewardship arrangements continue to support the management of a diverse and complex infection profile. Antibiotic consumption remains broadly in line with national averages, with positive trends evident in recent years. Whilst audits have identified opportunities for further improvement, targeted work is underway to optimise prescribing practice, strengthen stewardship arrangements and support safe, effective patient care. Overall, the report provides assurance that appropriate governance and improvement plans are in place.

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

Previous consideration
Trust board receives annual report on antimicrobial stewardship and infection prevention and control and is asked to note that it was considered at the June meeting of the Quality Committee. This extraordinary report is in response to an NHS England directive "Act now: protect our present, secure our future".

Recommendations	
a)	**Note** and receive assurance on performance against antimicrobial resistance targets.
b)	**Endorse** the agreed antimicrobial resistance priorities aligned to national AMR objectives.
c)	**Support** continued Executive and Board level oversight of antimicrobial stewardship and receive an annual formal assurance report

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 (Joint): Quality		
	002 (Joint): Workforce		
	003 (Joint): Partnerships		
	004: Finance		004: Finance
	005: Operational performance		005: Operational performance
	006 (Joint): Infrastructure		
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 22 July 2026
National Antimicrobial Resistance (AMR) Call to Action

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1. Purpose

1.1 This report provides formal assurance that The Dudley Group NHS Foundation Trust (DGFT) and Sandwell & West Birmingham NHS Trust (SWB) have responded to NHS England's "AMR call to action" (November 2025) by Q1 2026.

1.2 It describes antimicrobial resistance management at DGFT and SWB, including:

- Board-Level review and Executive oversight
- Risk and Capability Assessments
- Priority areas for AMR improvement and arrangements for delivery.

2. Background

2.1 Antimicrobial resistance (AMR) is recognised internationally as one of the greatest threats to health. In the UK, AMR is associated with twice as many deaths annually as breast cancer. It makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death.

2.2 National surveillance (including English surveillance programme for antimicrobial utilisation and resistance "ESPAUR") continues to demonstrate rising rates of resistant infections, increased complexity of treatment, and significant impact on mortality, length of stay and healthcare costs.

3. Group headline

3.1 The Trusts have well-established, highly specialised antimicrobial stewardship (AMS) and Infection prevention and control (IPC) services, with robust governance, strong clinical engagement, and routine monitoring against national benchmarks. These teams work collaboratively to manage AMR in line with NHS England's call to action and the associated targets from UK 5-year national action plan for AMR.

3.2 Each Trust has an Antimicrobial Stewardship team tasked with supporting AMS across the organisation. The core membership (in line with NICE NG15) is outlined below.

DGFT	SWB
Consultant Antimicrobial Pharmacist (Band 8c) • Trust Antimicrobial Stewardship lead • Chair of ICB AMS group Consultant Microbiologists Principal Pharmacist: Antimicrobial Therapy (Band 8b)	Consultant Microbiologist (1PA / week) • Trust Antimicrobial Stewardship lead Lead Antimicrobial Pharmacist (0.8 WTE, Band 8b) Antimicrobial Pharmacists (1 WTE, Band 8a)

Table 1 – Core membership of antimicrobial stewardship teams at DGFT and SWB

3.3 NHS England is shortly expected to release a national AMS staffing toolkit for acute providers. Once available, the Trusts will use this toolkit to undertake a formal gap analysis and appropriately escalate any deficiencies.

3.4 Both Trusts have robust governance and clear reporting structures outlined below. Risks are assessed, recorded and mitigated. Monthly updates are provided via medicines management and IPC groups with an annual report to board. Executive oversight is via the Group Director of Infection Prevention and Control.

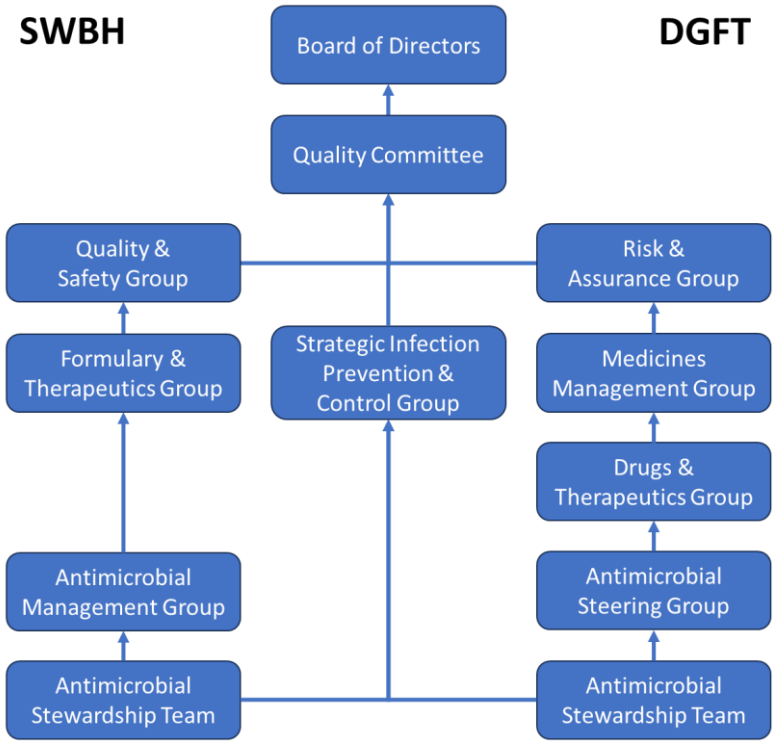

Figure 1 – Summary of the reporting arrangements from antimicrobial stewardship teams to board.

3.5 AMS and IPC teams at both Trusts have agreed three priority areas for AMR. These are aligned with the UK National Action Plan for confronting AMR, regional priorities set by the Regional AMS Lead and locally identified opportunities for improvement in clinical care. IPC priorities arise from an assessment of compliance with the Hygiene Code via the NHSE IPC Board Assurance Framework.

#	DGFT	SWB
1	Increase and sustain proportion of Access category antibiotic use	
2	Reduce intravenous antibiotic consumption through improved IV to oral switch (IVOS)	
3	Achieve compliance with IPC BAF criteria 2.1: There is evidence of compliance with national cleanliness standards including monitoring and mitigations.	Achieve compliance with IPC BAF criteria 2.7: The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01

Table 2 – Three antimicrobial resistance priority areas at DGFT and SWB

3.6 Each priority area will be managed by the local stewardship / IPC team with the executive sponsorship of the Group Director of Infection Prevention and Control.

3.7 Each team will explore local practice, identify opportunities, implement improvements and report progress through the existing reporting arrangements detailed above.

Priority 1 – Increase proportion of antibiotic consumption from "Access" group

3.8 The UK Health Security Agency classifies antibiotics into three main groups – access, watch and reserve. Access antibiotics are narrower-spectrum, effective for common infections, and associated with a lower risk of resistance and healthcare associated harm.

3.9 The UK AMR National Action Plan prioritises increasing the proportion of prescribing from the Access category. Acute Trusts have been given a 2026/27 target of 61% access antibiotic use.

3.10 Access antibiotics represent 60% of total use at both DGFT and SWB. This compares to a regional peer median and national median of 55% (Model Hospital Dashboard, accessed April 2026).

Priority 2 – Reduce intravenous antibiotic consumption through improved IV to oral switch (IVOS)

3.11 ESPAUR consistently reports that intravenous (IV) antibiotics are continued longer than clinically necessary across NHS hospitals, even when patients meet established criteria for oral switch.

3.12 Reducing IV antibiotic use is a core element of the UK AMR National Action Plan and NHS antimicrobial stewardship programmes. In addition to controlling AMR, reduced IV antibiotic use is associated with:

- Fewer line related infections and thrombosis
- Reduced length of stay
- Increased patient comfort and mobility
- Reduced nursing workload and cost
- Recused carbon impact

3.13 IV antibiotics represent 24% of total use at DGFT and 28% at SWB. This compares to a regional peer median of 25.5% and national median of 24% (Model Hospital Dashboard, accessed April 2026).

Priority 3a – Improve compliance with national cleanliness standards [DGFT].

3.14 DGFT assessment of compliance identified 46 of 54 criteria achieving full compliance. Of the outstanding 8 areas of partial compliance, perhaps the most significant is criteria 2.1 around environment cleaning.

3.15 The Trust cleaning contractor does not currently clean in accordance with 2025 national cleanliness standards. There are negotiations between the Trust and MITIE to resolve this. This does not imply that

cleaning is inadequate as it is not and is audited monthly with good cleaning scores but is not in line with currently issued guidance and there remains a challenge to compliance with the hygiene code.

3.16 The IPC Matron is currently working on re-establishing a dedicated UVC Decontamination Team.

Priority 3b – Improve compliance with national waste management standards [SWB]

3.17 SWB assessment of compliance identified 46 of 54 criteria achieving full compliance. Of the outstanding 8 areas of partial compliance, perhaps the most significant is criteria 2.7 around waste management.

3.18 The Trust has challenges regarding waste segregation at the point of disposal and appropriate storage. E.g., wider roll out of tiger waste required, incorrect placement of bins, issues with segregation at waste once removed from wards to ensure separation of waste streams, and appropriate consignment prior to leaving site. Poor management of waste holds.

3.19 The most recent Dangerous Goods Safety Advisor (DGSA) report identifies the actions required.

3.20 The Trust has established a waste audit action group to agree actions & owners for 47 identified points in the DGSA report with oversight through the Chief Development Officer and Health & Safety Committee.

4. DGFT position

4.1 DGFT demonstrates compliance with, and performance aligned to, nationally mandated antimicrobial stewardship metrics. Benchmarking data show that:

- Access antibiotic prescribing remains within national targets and above the provider median.
- Total antibiotic consumption and Watch and Reserve antibiotic use sit within the lowest national quartiles when compared with peer Trusts.
- Intravenous antibiotic prescribing is broadly comparable with similar organisations, with recognised opportunities for further optimisation through improved IV-to-oral switch practices.
- Overall performance indicates effective antimicrobial stewardship oversight with ongoing improvement activity in place.

4.2 The board can be assured that local metrics RAG rated Amber represent recognised national stewardship challenge areas rather than a performance concern for DGFT. Delivery plans have been agreed and led by AMS group and outcomes are reported via Medicines Management, IPC and Quality Committee.

4.3 While DGFT performance currently provides assurance, residual risk remains due to factors outside local control, including national resistance patterns, system pressures and workforce constraints.

4.4 Antimicrobial resistance remains a significant and escalating risk nationally.

5. SWB position

5.1 SWB treats an exceptionally challenging population with many risk factors for poor health outcomes. The latest ESPAUR report quantifies significant health inequalities seen in infection and AMR.

- The most deprived local authorities see the highest burden of infection, AMR and emergency hospital admissions due to infection. Sandwell and Birmingham are national outliers.
- Resistance is also clearly stratified by ethnicity (highest in Asian or Asian British and lowest in White British). Sandwell and Birmingham are national outliers.
    - Not all “resistance” is equal – SWB sees high rates of some of the most resistant bacteria <u>including pan-resistant organisms resistant to all known antibiotics.</u>

5.2 Sandwell local authority is a national outlier with one of the highest mortality rates from infectious & parasitic disease and from influenza & pneumonia. SWB's top two causes of excess mortality are pneumonia and urinary tract infection.

5.3 Local audit demonstrates that SWB has room for improvement. However, antibiotic use is not expected to be average due to the significantly higher burden of disease, resistance and mortality seen at SWB. National comparisons must be cognizant of differences between Trusts and the patients they serve.

Key Concerns and Immediate Actions Required

5.4 SWB is yet to realise the benefits of electronic prescribing. Unity change proposals have been made, reviewed and approved but resource limitations, the MMUH move, and high workload have so far frustrated all attempts to embed AMS practices. This work will be prioritised and implemented.

5.5 SWB AMS team provide clinical support to a number of services which warrant dedicated staff. Business cases are being formulated in line with national good practical recommendations for staff to take on HIV clinics, tuberculosis (per recent GIRFT report) and outpatient parenteral antimicrobial therapy service.

6. Conclusion

6.1 DGFT - Overall, the organisational performance against nationally mandated metrics, demonstrates that antimicrobial usage at The Dudley Group NHS Foundation Trust is good compared to peer and national averages and is both evidence-based and actively governed. DGFT achieved good compliance with the national infection prevention and control board assurance framework but furthers seeks to reduce the incidence of C. difficile and gram-negative bacteraemia during 2026-27. Clear improvement priorities and delivery plans are in place for AMS and IPC. This provides assurance that the Trust is meeting NHS England expectations and contributing to the national effort to mitigate antimicrobial resistance.

6.2 SWB manages unusually diverse and complex infections within a district general hospital setting. Despite this, antibiotic consumption trends are generally average with positive trends seen in recent years. Local audit has demonstrated room for improvement in several areas and significant opportunities for sustainable, practical change exist (e.g. Unity changes). Work is ongoing to optimise antibiotic use, deliver effective clinical care and provide assurance to the Trust.

7. Recommendations

7.1. The Group Public Trust Board Is asked to:

a) Note and receive assurance on performance against antimicrobial resistance targets.
b) Endorse the agreed antimicrobial resistance priorities aligned to national AMR objectives.
c) Support continued Executive and Board level oversight of antimicrobial stewardship and receive an annual formal assurance report

Enclosure 13

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

REPORT TITLE:	Culture Change & Improvement		
SPONSORING EXECUTIVE:	James Fleet, Group Chief People Officer		
REPORT AUTHOR:	James Fleet, Group Chief People Officer Meagan Fernandes, Director of People and OD (SWB) Karen Brogan, Director of People and OD (DGFT) Peter Lowe, Group Director of Improvement		
MEETING:	Joint Trust Board	**DATE:**	22 July 2026

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

Suggested discussion points

- As the Board has recently discussed, delivering the Groups *Fit for the Future* strategy, requires a high impact and systematic approach to driving culture improvement, including addressing racism, inequity and declining staff engagement.

- Tackling racism, embedding equity and inclusion is an immediate organisational priority for the Group. The Group CEO is the Executive SRO for tackling racism and has personally reaffirmed a zero-tolerance approach to racism, discrimination and all forms of unacceptable behaviour.

- This paper sets out a Group Culture Improvement Framework, underpinned by a programme of actions and interventions which will deliver measurable improvements and impact across six evidence-based drivers of culture. These actions will deliver improvements in patient experience, workforce wellbeing, governance and public confidence.

- Delivery will be monitored through the People Committee and Group Board using a digitally enabled Culture Dashboard, supported by a sustained programme of active engagement, listening and Safe Space conversations led by senior leaders and supported by our Staff Inclusion Networks, trade unions, FTSU guardians, as well as professional networks and community partners.

- The Board will provide visible leadership and strategic oversight.

- The Board is asked to consider, discuss and challenge the Culture Improvement Framework and associated high impact actions, and in doing so take assurance that they:

1. Respond directly and robustly to the Board's request for a consistent approach to delivering culture improvement across the Group (the *'what'*, *'how'* and *'when'*).
2. Authentically capture the scale and nature of the current culture challenges, and as well as set out a clear future vision and roadmap for the establishing the optimal cultural conditions for our people, patients, populations and communities**.**
3. Define the Board and Executive's visible leadership role in setting the climate and conditions for culture improvement.

4. Build on key actions already in progress, e.g. the Group CEO reaffirming a zero-tolerance approach to racism, discrimination and all forms of unacceptable behaviour, the Maternity and Perinatal improvement programme, external support and Staff Survey improvement actions.
5. Align with and support the delivery of national culture interventions and priorities, including: the new NHS Staff Standards, new Leadership and Management Framework, Lord Mann recommendations, the Race and Health Observatory 7 principles of Racism, as well as the established NHS People Promise.
6. Support leadership action to improve performance against the National Oversight Framework and Provider Assurance Framework.
7. Set out a robust and consistent approach to reviewing the impact and benefits (the *'so what'*) of the culture improvement actions, particularly for improving the experience of our people, patients and populations.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
None

Recommendations	
a)	**Consider**, discuss and challenge the robustness of the proposed Culture Improvement Framework and improvement actions for delivering the scale of culture change and improvement required. Highlight any concerns, risks or gaps that the Board believes should be considered.
b)	**Endorse** the Group Culture Improvement Framework and improvement actions. Commit to championing the Culture Improvement Framework as a key enabler for the Group strategy, including requiring regular reporting, as well as upward reporting through People Committee.
c)	**Note** that NHS England launched the new NHS Staff Standards on 6th July and that delivery is mandatory and measured through the National Oversight Framework. Note that Boards and Executive teams are accountable for making sure the standards are understood, implemented and monitored.
d)	**Take** assurance that the Group Culture Framework will support the delivery of the new Staff Standards.
e)	**Require** a Board briefing paper, with an assessment and improvement plan for the Staff Standards to be developed and presented to the People Committee and future Group Board 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**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 Board on 22 July 2026

Culture Change & Improvement

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1. Executive Summary

1.1 NHS policy, organisational research and improvement science consistently demonstrate that culture is a key determinant of staff experience, patient outcomes, organisational performance and the successful delivery of strategic change.

1.2 As the Board has recently discussed, delivering the Groups *Fit for the Future* strategy, requires a high impact and systematic approach to driving culture improvement, including addressing racism, inequity, poor patient experience and declining staff engagement. The Culture Improvement Framework and actions set out within this paper position culture as a strategic enabler for improving patient experience, workforce wellbeing, governance and public confidence.

1.3 The Executive team recognises that delivering sustainable culture change requires visible leadership that creates the conditions and climate for improvement through shared purpose, psychological safety, accountability and continuous learning (Schein, 2010; NHS England, 2023; NHS England, 2024). All Executive Directors have a 2026-27 PDR objective for championing equity, inclusion, dignity and respect, including role-modelling inclusive leadership behaviours and tackling racism.

1.4 The Group CEO has recently reaffirmed her personal commitment to a zero-tolerance approach to racism, discrimination and all forms of unacceptable behaviour. The Group CEO will be the Executive Senior Responsible Officer for tackling racism. All Board members will be participating in a cultural competence development programme in September. Lead Group Non-Executive roles for staff wellbeing, FTSU and EDI will also play a key role in supporting the organisational focus on culture improvement.

1.5 This paper sets out a Group Culture Improvement Framework, underpinned by a programme of targeted high impact actions and interventions to deliver measurable improvements across six evidence-based drivers of culture. These actions will enable improvements in patient experience, workforce wellbeing, governance and public confidence. The Culture Improvement Framework, as set out within this paper, fully aligns with the actions required to implement the new NHS Staff Standards (Annex 1), which now form part of the NHS Oversight Framework, the Race and Health Observatory 7 principles of Racism and the recommendations from the Lord Mann Review. Implementing the Culture Improvement Framework, in a sustainable way, will establish the leadership and organisational conditions in which colleagues, teams and services thrive.

1.6 Delivery and impact will be monitored through the People Committee and Group Board, supported by a digitally enabled Culture Dashboard which draws across a range of culture KPIs and data points, supported by a sustained programme of active engagement, listening and Safe Space conversations led by senior leaders and supported by our Staff Inclusion Networks, trade unions, FTSU guardians, as well as professional networks and community partners. Visible Board sponsorship will be critical to success to establishing culture improvement as a strategic enabler of *Fit for the Future*, therefore creating the conditions in which colleagues thrive, services are transformed, high quality care is safeguarded and financial sustainability is achieved.

2. Introduction: Culture Change & Improvement

2.1 Organisational culture comprises the shared values, beliefs, behaviours and norms that shape how people work together, make decisions and deliver services. Often described as *"the way things are done around here"* (Deal & Kennedy, 1982), culture is driven as much by informal "unspoken rules" (Argyris & Schön, 1978) as by formal policies. Sustainable cultural change therefore requires

addressing the underlying assumptions that shape everyday behaviours, not simply introducing new values or expectations.

2.2 The NHS People Plan and NHS People Promise position culture at the heart of organisational performance, recognising that *"the culture we create for our people determines the care we provide for our patients"* (NHS England, 2020). This is reinforced by the NHS Leadership Competency Framework (2024), as well as the new NHS Leadership and Management Framework and Staff Standards, which strengthen expectations for compassionate, inclusive leadership, staff experience and organisational accountability. As the 10 Year Health Plan for England states, *"A positive experience of work and the workplace should not be a 'nice to have'.*

2.3 Organisational culture influences how people feel, learn, solve problems and respond to change. Evidence from the NHS Staff Survey, Pulse Survey, Race and Health Observatory, organisational psychology and the Shingo Institute shows that cultures characterised by psychological safety, curiosity, humility and continuous learning are better able to adapt, innovate and sustain improvement.

2.4 While the Group Strategy (*Fit for the Future*) defines the organisation's ambition and priorities, culture determines how they are translated into everyday practice. Discussions at the recent Board development session in June highlighted the Board's critical role in creating the climate and conditions required to enable cultural change and improvement. This paper responds directly to the Board's request for a consistent and systematic approach to delivering culture change and improvement across the Group**.** This paper sets out a Group Culture Improvement Framework, supported by a programme of high impact actions, leadership responsibilities and governance. This Framework provides the strategic approach to embedding the cultural improvements required to deliver *Fit for the Future*. The actions set out within this paper respond to the findings of the recent external review by Baroness Amos and set out a programme of targeted interventions to tackle racism, inequity, poor patient and staff experience.

2.5 Delivery will be supported through a new Group People Plan, an integrated organisational development and improvement approach, shared values and behavioural expectations, and clear leadership accountability at every level. Lasting culture change will also involve active partnership working with our Staff Inclusion Networks, trade unions, FTSU guardians, professional networks, local health and care partners, and community organisations.

3. Group Strategy: People & Culture

3.1 The new Group Strategy, *Fit for the Future*, sets a shared vision for safe, high-quality and financially sustainable care across Dudley Group NHS Foundation Trust (DGFT) and Sandwell & West Birmingham NHS Trust (SWB).

3.2 A core element of the Group strategy is our commitment to being a *'brilliant place to work and thrive through happy, productive and engagement teams*', and where colleagues are supported by inclusive and compassionate leadership.

4. Drivers of Culture and Improvement

4.1 Culture is shaped through leadership and sustained organisational effort. Research identifies leadership behaviour, psychological safety, team climate, fairness, wellbeing and aligned systems as key influences on staff experience, organisational performance, quality of care and the ability to deliver successful change. While leadership attention is often drawn to immediate challenges and risks, evidence shows that lasting cultural improvement requires a consistent focus across the key drivers of culture. Addressing individual cultural issues in isolation will not deliver sustainable

improvement (NHS IMPACT Framework, NHS People Promise, CQC Single Assessment Framework and the new Staff Standards).

4.2 Building on existing and established OD interventions (i.e. ARC leadership development, staff survey improvement actions, Maternity and Perinatal improvement programme), the Culture Improvement Framework sets out the high impact actions required to deliver measurable improvements across six evidence-based drivers of culture. These actions will enable improvements in patient experience, workforce wellbeing, governance and public confidence.

4.3 The Culture Framework will also support the delivery of the new Staff Standards which were launched by NHSE on 6th July, these standards are mandatory for all NHS organisations and form part of the National Oversight framework. The 6 drivers of the Culture Framework are explicitly aligned to the new Staff Standards, both in terms of delivery and impact.

4.4 The Board and Executive will have accountability for the effective implementation of the Culture Improvement Framework. Senior leaders across the Group will have a visible role in setting the climate and environment for culture improvement, including setting expectations for respectful, inclusive and supportive behaviours by all staff and teams, role modelling compassionate leadership and tackling all forms of racism and discrimination.

4.5 Delivering the actions and interventions within the Culture Framework will be supported by the Organisational Development and Improving Together teams. Leadership development, staff engagement, team effectiveness and improvement capability will be developed as mutually reinforcing components of a single approach to improving organisational performance.

4.6 A high-level summary of the programme of culture improvement actions is set out below:

GROUP CULTURE FRAMEWORK – ACTION PLAN WITH DATES

Six Drivers of Culture Change & Improvement

DRIVER	ACTION	TARGET DATE
1. IMPROVEMENT LEADERSHIP THAT SHAPES CULTURE	• Inclusive leadership, anti-racism and cultural competence programme • Board and Executive leadership development • Hate crime awareness and inclusion e-learning rollout • Coaching and leadership development across both Trusts • Launch Inclusive Talent Management Programme • Implement digital Succession & Talent System • Targeted leadership development in priority services • Group Leadership Development Framework • Mandatory Compassionate & Inclusive Leadership training for managers	July 2026 – Ongoing Q3 2026 Q3 2026 Q3 2026 – Ongoing September 2026 December 2026 September 2026 – March 2027 April 2027 April – September 2027
2. AN INCLUSIVE AND RESPECTFUL CULTURE	• Reinforce zero-tolerance approach to racism and discrimination • Launch Safe Space Conversations (Maternity) • Expand Safe Space Conversations Group-wide • Implement Perinatal People Plan • Compassionate & Inclusive Reflective Sessions for Perinatal staff • Strengthen Staff Inclusion Networks • Establish Anti-Racism & Antisemitism Group • Disability inclusion improvement programme • Implement Lord Mann recommendations • Implement Maternity 10-Point Plan • Race Equality Code accreditation programme • Targeted EDI programmes (including Estates & Facilities)	July 2026 – Ongoing August – October 2026 November 2026 – March 2027 August 2026 – March 2027 October 2026 September 2026 September 2026 October 2026 – March 2027 October 2026 – June 2027 July 2026 – March 2027 October 2026 – September 2027 October 2026 – Ongoing
3. STAFF ENGAGEMENT, VOICE AND IMPROVEMENT	• Strengthen People Engagement Teams • Rollout of engagement model across Group • Launch Money Matters campaign • Staff Survey improvement plans in all Divisions • Intervention programme for lowest-scoring teams • Address lowest-scoring People Promise themes • Enhanced partnership with Trade Unions and Networks	September 2026 October 2026 – March 2027 September 2026 October 2026 October 2026 – March 2027 November 2026 – July 2027 Ongoing from July 2026
4. HIGH-PERFORMING AND COMPASSIONATE TEAMS	• Deploy Group Team Effectiveness model • Priority team interventions (ED, Imaging, Surgery, BMEC, Perinatal) • Support lowest-scoring staff survey teams • Launch Group Coaching Academy • Self-service team development toolkit • Align OD and Improvement delivery model • Align team development programmes to Group priorities	September 2026 September 2026 – June 2027 September 2026 – March 2027 January 2027 December 2026 December 2026 December 2026 – Ongoing
5. EMBEDDING A LEARNING AND IMPROVEMENT-ORIENTED CULTURE	• Align Freedom to Speak Up and HR processes • Consistent employee relations framework • Introduce restorative practice approach • Embed Just Culture principles • Review disciplinary and grievance learning • Equality impact review of ER processes • Perinatal deep dive review • Use continuous improvement to drive learning and fairness	September 2026 October 2026 October 2026 – March 2027 January – September 2027 Quarterly from October 2026 December 2026 November 2026 Ongoing from July 2026
6. WELLBEING AND SUSTAINABLE WORK	• Wellbeing communications campaign • Embed Sexual Safety Charter • Optimise e-Rostering, e-Job Planning and Activity Manager • Manager briefings on PDRs and wellbeing conversations • Black Country Occupational Health review • Capacity and demand management training rollout	September 2026 December 2026 March 2027 October 2026 – March 2027 December 2026 January – June 2027

GOVERNANCE AND ASSURANCE MILESTONES

MILESTONE	TARGET DATE	PURPOSE / OUTPUT
Culture Framework approved by Board	July 2026	Formal endorsement and launch of delivery
Group Values & Behaviours Framework co-design begins	September 2026	Co-produce with colleagues, networks, unions and stakeholders
Draft Group Values & Behaviours Framework	January 2027	Draft for consultation and feedback
Launch Group People Plan	April 2027	Integrated people and culture delivery plan
Culture Dashboard operational	October 2026	Dashboard live with key culture indicators
First Culture Dashboard report to People Committee	November 2026	Regular reporting to People Committee
Mid-year culture review	March 2027	Review progress and adjust actions
Annual culture impact assessment	July 2027	Assess impact, learning and next steps

All dates are target dates and will be reviewed through the Culture Dashboard and reported via the Joint People Committee and Group Board.
Q3 2026 = July – September 2026

4.7 A fuller summary of the culture improvement actions, the role of the Board, Executive, and senior leaders for driving culture improvement, as well as the approach to measuring impact and organisational governance is set out within this paper.

5. Driver 1: Improvement Leadership that Shapes Culture

5.1 Leaders at all levels shape the values, behaviours and priorities that define how organisations operate and improve. Leaders create the climate for successful culture improvement and change. NHS IMPACT identifies leadership as critical to creating the conditions for improvement through clear purpose, continuous learning, empowerment and accountability.

5.2 As well as highlighting the key responsibilities of Boards and senior leaders, the new NHS Staff Standards emphasise the important role of line managers: *"Staff can expect supportive, fair, developmental and compassionate line management, enabled by employers' support for line managers, to help staff perform well, feel valued and fulfil their potential."* In parallel, the new NHS

Leadership and Management Framework sets out a clear code of practice, standards and competencies for leaders and managers at every level of the NHS.

5.3 Whilst the staff survey results for both Trusts have shown improved perceptions of leadership (*Your Manager* domain) over the past 5 years, particularly within the Compassionate Leadership People Promise theme, both Trusts saw a decline in 2025.

5.4 The Group is committed to embedding a leadership culture that reflects the vision and values set out in *Fit for the Future*. This includes developing the capability and confidence of leaders and line managers at all levels, while fostering consistent compassionate, inclusive and improvement-focused leadership across the organisation. This responds directly to themes identified through the 2025 NHS Staff Survey, recent Pulse Survey results, engagement with Staff Networks and trade unions, and the findings of Baroness Amos' national investigation, particularly in relation to racism, inclusion, staff experience and the impact on patient care.

5.5 The successful delivery of *Fit for the Future* will require leadership that creates the climate and conditions for equity, learning, collaboration and continuous improvement.

What we are doing

5.6 The Group is delivering a comprehensive programme of education, awareness and leadership development to strengthen inclusive leadership, build cultural competence, embed anti-racist practice and reinforce a zero-tolerance approach to discrimination across the Group. Alongside Board and senior leadership development, hate crime awareness training and inclusion-focused e-learning, the Group is investing in coaching and leadership development to build compassionate and inclusive leadership capability across DGFT and SWB.

5.7 Building on the ARC Leadership Programme at SWB and Managers Essentials at DGFT, an integrated Group Leadership Development Framework will be introduced from April 2027 for approximately 4,000 leaders. This will include a mandatory Compassionate and Inclusive Leadership module for all line managers alongside core leadership and management development.

5.8 Targeted leadership development and coaching is also being prioritised for services where specific challenges have been identified, including those teams with the poorest staff survey results. This support is currently being deployed within: Maternity and Neonatal, Emergency, Imaging, Estates and Facilities, and Logistics. These interventions will strengthen leadership and line manager capability (particularly first-line managers), improve team culture and support service improvement.

5.9 The image below summarises the leadership development interventions.

Programme / Activity	Facilitator	Audience	Description
Cultural Competence, Inclusion & Anti-racism	Dr Joan Myers OBE and Nesta Williams	Board and Senior Leaders	Builds confidence to address racism, discrimination and workplace harm, and lead inclusively with dignity, courage and accountability.
Hate Crime Awareness & Antisemitism Awareness	Stop Hate UK	Line Managers / Staff across the Group	Increases understanding of hate crime, antisemitism and discrimination, and develops confidence to support colleagues and foster psychologically safe workplaces.
Understanding Racism	E-learning	All Group Colleagues	Explores forms of racism and their impact on people and organisations.
A–Z of Anti-Racism	E-learning	All Group Colleagues	Introduces anti-racism concepts, language and practical actions.
Allyship	E-learning	All Group Colleagues	Develops skills to support and advocate for underrepresented groups.
Understanding Privilege	E-learning	All Group Colleagues	Encourages reflection on privilege and its impact on equity and opportunity.
Micro-aggressions and Gaslighting	E-learning	All Group Colleagues	Helps identify and address subtle discriminatory behaviours.
Cultural Competency Training	E-learning	All Group Colleagues	Builds cultural awareness and skills for inclusive communication and care.
Group Leadership Development Framework	Group OD Team	Approximately 4,000 Leaders and Line Managers	NHS-aligned leadership framework designed to strengthen compassionate, inclusive leadership and improve diversity in senior roles.
Targeted Leadership Development Interventions (ARC and Managers Essentials)	Group OD Team	Priority Teams (Maternity/Neonatal, ED, Imaging, Estates & Facilities, Logistics)	Targeted leadership coaching and development to strengthen capability in priority services.
Leadership Coaching for Team Effectiveness	Group OD Team	High-priority Services and Lowest-Scoring Teams	Coaching support to improve leadership effectiveness, team performance and staff experience.

5.9 Annex 2 summarises the Culture Change and Improvement Roadmap, which maps how these interventions deliver cultural change and improvement through building foundations, capability and sustainable improvement.

5.10 An Inclusive Talent Management Programme will launch in September 2026. The first cohort will target the 51 participants from the Birmingham & Black Country High Potential Scheme (58% female representation, 30% BME representation, 9% disability representation and 6% LGBTQ+ representation). A digital Succession & Talent system will provide oversight of talent pipelines, succession risks and future Executive and Board diversity, with key metrics reported through the Trust People Performance Dashboard to the Joint People Committee and Group Board.

HPS selection and representation: executive overview

Band 8A–9 workforce benchmark compared with unsuccessful and successful HPS applicants | all shares use the full relevant population as denominator

Band 8+ workforce	Applicants	Successful	Unsuccessful	Success rate
889	53	19	34	35.8%
Source Data Sheet population	successful + unsuccessful	selected to HPS	unsuccessful applicants	successful ÷ applicants

Representation compared with the Band 8+ workforce

Trust	Division	Band 8+ benchmark share
DGFT	Community & Core Clinical Services	11.8%
DGFT	Corporate / Mgt	15.2%
DGFT	Dudley Place	6.9%
DGFT	Medicine & Integrated Care	7.4%
DGFT	Surgery	6.6%
SWB	Corporate	20.8%
SWB	Imaging	2.2%
SWB	Medicine and Emergency Care	6.0%
SWB	Primary Care Community and Therapies	12.1%
SWB	Surgical Services	6.9%
SWB	Women and Child Health	4.0%

Share columns describe representation within each population. Applicant gap vs

Executive reading

Future executive pipeline under a two-year promotion cycle

Applicants (successful + unsuccessful) | one pay-band step every two years | VSM is the ceiling | no attrition, vacancy or appointment probability applied

Applicants	VSM 2032	VSM 2034	Band 9 or VSM 2034
53	7	22	53
successful + unsuccessful	projected at VSM	projected at VSM	entire applicant pool

Projected applicant cohort position (headcount)

Band	2026	2028	2030	2032	2034
Band 8A	31	0	0	0	0
Band 8B	15	31	0	0	0
Band 8C	7	15	31	0	0
Band 8D	0	7	15	31	0
Band 9	0	0	7	15	31
VSM	0	0	0	7	22

By 2034, 22 of 53 applicants are projected at VSM and 53 are at Band 9 or VSM. The model changes band position only; applicant cohort diversity is fixed unless attrition, vacancy or appointment probability is introduced.

Projected applicant VSM representation compared with Band 8+

Characteristic	Band 8+ benchmark share	VSM 2034	VSM 2034 gap vs Band 8+ (pp)
Female	69.7%	72.7%	+3.0%
BME	26.5%	45.5%	+18.9%
Disabled	7.9%	9.1%	+1.2%
LGB+	4.2%	13.6%	+9.5%

VSM gap is projected applicant VSM representation minus the Band 8+ benchmark share, measured in percentage points.

6. Driver 2: An Inclusive and Respectful Culture

6.1 A culture of fairness, inclusion and belonging is fundamental to a high-performing NHS workforce. Evidence from Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), the Lord Mann Review, the Race & Health Observatory and wider research demonstrates that discrimination, under-representation and unequal access to opportunities undermine staff wellbeing, engagement, retention and progression, ultimately affecting organisational culture and performance.

6.2 Whilst the most recent Workforce Race Equality Scheme (WRES) results indicate early signs of improvement in some of the duties, the overall staff survey results for both Trusts continues to evidence that staff from diverse backgrounds, including disabled staff, have a significantly poorer experience. The detailed staff survey data, at Divisional and team level, highlights that experiences of discrimination and bullying and harassment are particularly prevalent and disproportionately high in specific areas, i.e. maternity and perinatal services at SWB. The most recent Workforce Disability Equality Scheme (WDES) also highlights a deterioration in the experience of disabled staff in both Trusts. These data points are reflected in wider staff feedback, and the lived experiences shared through Staff Networks and Trade Union partners.

6.3 The Baroness Amos Independent Investigation into Maternity Services at SWB highlighted the impact of racism, discrimination and exclusion on staff and patients, identifying serious concerns about behaviours, culture and practice. These findings reinforce the need for transformative action across the Group.

What we are doing

6.4 Recent staff briefings have reinforced the Group CEO's unequivocal message that racism, discrimination, harassment, bullying and exclusion will not be tolerated, with a clear zero-tolerance

approach to racism. Leaders at every level will be held accountable for creating an inclusive, psychologically safe culture. This reflects the new NHS Staff Standards, which state that *"Staff should feel safe and supported at work, in an environment where their organisation takes sustained and meaningful action to prevent all instances of racism and discrimination in the workplace."*

6.5 The Executive Team and board are committed to understanding the lived experiences of staff, patients and communities through meaningful engagement, safe dialogue and decisive action to remove barriers to inclusion, equity and belonging. A programme of Safe Space conversations, supported by our Staff Inclusion Networks and trade unions, are being launched across the Group, beginning with Maternity services between August and October.

6.6 In response to the Baroness Amos investigation, a dedicated Perinatal People Plan has been developed to address racism, discrimination, incivility and poor behaviour. It includes leadership coaching, multidisciplinary team workshops, team effectiveness programmes, cultural intelligence education, reflective learning and a mandatory Compassionate and Inclusive Reflective Session for all maternity and perinatal staff.

6.7 Leaders at all levels will be expected to, and held accountable for, role modelling inclusive behaviours, sponsor Staff Networks and create psychologically safe environments where concerns can be raised without fear. External support to embed effective Divisional EDI arrangements, working with Divisional leaders and the Group EDI team, has recently been commissioned.

6.8 A full gap analysis against the 36 recommendations from the Lord Mann Review is currently being led by the Group Chief People Officer, this will inform further actions to strengthening governance and reporting on race equality, improve the quality and use of workforce and patient data and ensure investigations and complaints are handled consistently and credibly.

6.9 The Group's ambition extends beyond improving WRES, WDES and other EDI metrics, to embedding inclusion in everyday practice, where racism and discrimination are consistently challenged and every colleague and patient experiences respect, belonging and equitable opportunity. Leaders will be accountable for delivering measurable improvements in culture and outcomes.

7. Driver 3: Staff Engagement, Voice and Improvement

7.1 Staff engagement is both a key indicator and a powerful driver of organisational culture. High engagement is associated with greater trust, stronger teamwork, improved wellbeing, higher retention and better patient outcomes. The NHS People Plan, NHS People Promise and NHS Long Term Workforce Plan identify staff voice, involvement and belonging as essential to workforce sustainability, organisational performance and high-quality care. The 10 Year Health Plan introduced the NHS Staff Standards to ensure staff experience receives the same focus and accountability as finance, operational performance and quality of care (NHS England, July 2026). A stated aim for the new NHS Staff Standards is *"to see staff experience given the same level of focus and grip given to other organisational priorities such as finance, operational performance and quality of care" (NHS England, July 2026).*

7.2 Evidence consistently shows that staff are more engaged when they feel they have a meaningful voice in shaping the work around them

7.3 Both Trusts have experienced a significant decline in staff engagement over the past year, reflected in the 2025 NHS Staff Survey and further deterioration in the 2025/26 Q4 and 2026/27 Q1 Pulse Surveys.

What we are doing

7.5 In March 2026 the Board approached a comprehensive programme of improvement actions to improve staff engagement and experience, which is included the development of local Divisional specific improvement plans, as well as targeted intervention and support for the 10 teams with the poorest staff survey results and Group level leadership actions which drive improvements at scale. The Group level actions include improving the quality of PDRs, strengthening staff recognition, a Group wide programme of staff engagement supported by Partnership working with trade unions and Staff Inclusion Networks and visible executive leadership.

7.6 A formal update on the progress and delivery of these actions, along with the April PULSE Survey results was presented to the Group People Committee in June.

8. Driver 4: High-performing & Compassionate Teams

8.1 Team effectiveness is one of the primary mechanisms through which organisational culture is experienced, reinforced and changed. Research demonstrates that staff experience culture through the quality of local leadership and team working, with high-performing teams characterised by clear purpose, effective leadership, strong relationships, psychological safety and continuous learning (West & Lyubovnikova, 2013; West et al., 2014).

8.2 Sustainable improvement depends on leaders creating the conditions in which teams are empowered to learn, innovate and improve together (NHS IMPACT). Strengthening team effectiveness is a core component of the Group's approach to culture improvement.

8.3 High-performing organisations develop improvement capability at every level, enabling teams to understand variation, solve problems scientifically, learn from data and adapt quickly to changing circumstances. Improvement capability therefore represents a strategic organisational asset that supports quality, productivity, safety and workforce sustainability.

What we are doing

8.4 Building on the success of the SWB ARC Team Effectiveness approach, a consistent Group-wide Team Effectiveness approach is being deployed to support organisational development and culture improvement across a number of priority teams, including the Emergency Department, Imaging, Surgery, BMEC, Perinatal Services and the ten teams with the lowest staff survey results. This approach brings together a consolidated Organisational Development (OD) and Continuous Improvement model, delivered jointly by the OD and Improving Together teams and supported by a new Group Coaching Academy.

8.5 To improve sustainability and build local ownership, a suite of self-service tools and team development resources has been introduced, enabling teams to lead and sustain their own improvement journeys.

9. Driver 5: Embedding a Learning and Improvement-Oriented Culture

9.1 A learning culture is fundamental to safe, high-quality care and continuous improvement. By enabling staff to speak up, learn from mistakes and challenge concerns without fear, these approaches strengthen trust, psychological safety and collaboration, creating the conditions for sustained culture improvement and better outcomes for patients and staff.

9.2 Both Trusts have seen an increase in Freedom to Speak Up concerns and employment-related issues over the past 12 months. While this may reflect greater confidence to speak up, it also highlights the

need to strengthen organisational responses, address underlying causes and promote learning through restorative practice.

What we are doing

9.3 The Group is strengthening alignment between Freedom to Speak Up (FTSU) and HR processes and introducing a consistent approach to the management of employment issues that emphasises early intervention, restorative practice and organisational learning

9.4 The Group is also reviewing learning from disciplinary, grievance and other employee relations processes to better understand underlying themes, identify opportunities for prevention and improve staff experience with targeted work underway to understand and address the disproportionate impact of organisational processes on different staff groups, including a focused deep dive within perinatal services within SWB, to identify inequities and inform improvement action.

10. Driver 6: Wellbeing & Sustainable Work

10.1 Recent staff survey results across both Trusts highlight workload, fatigue and capacity pressures as key risks to staff wellbeing, engagement and experience. NHS evidence consistently demonstrates that staff wellbeing is closely linked to organisational culture, patient safety, quality of care, retention and organisational performance. The new NHS Staff Standards emphasise that, *"Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for, and able to perform well"*.

10.2 Cultures that promote wellbeing, inclusion and sustainable working practices and arrangements are associated with higher levels of engagement, productivity and retention, while excessive pressures can undermine morale, increase burnout and reduce the capacity for learning and improvement. Supporting staff wellbeing is therefore both a cultural and strategic priority. The new Staff Standards now mandate NHS organisations to ensure that effective provisions are in place for *flexible working*, *championing sexual safety* as well as *violence prevention and reduction* for all staff.

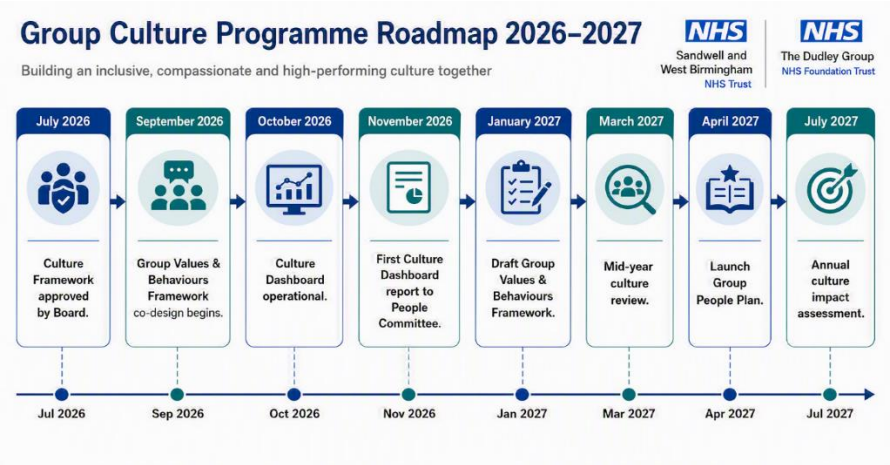
What we are doing

10.3 A range of initiatives are being progressed across the Group, including better communications with staff to publicise the health and wellbeing offers available, implementing and fully embedding the Sexual Safety Charter, optimising workforce planning and productivity tools, including e-Rostering, e-Job Planning and Activity Manager which enable staff to have more control over their working lives, manager development and briefing sessions to improve the quality of Performance and Development Reviews (PDRs), including well-being conversations, a Black Country-wide review of Occupational Health services and roll-out of capacity and demand management training for leaders.

11. Creating our Group Values & Behaviours Framework

11.1 A shared culture narrative will be co-produced with colleagues from across the Trust, Staff Networks, Trade Unions, Freedom to Speak Up Guardians, and other key stakeholders.

11.2 This shared cultural narrative will inform the development of a Group Values, Behaviours and Accountability Framework and a new Group People Plan, providing the foundation for accelerated culture improvement.



12. Measuring Culture Improvement

12.1 The impact of the culture improvement programme will be measured through a combination of hard quantitative measures, including: Staff Survey and PULSE Survey results, the new Staff Standards, WRES/WDES, sickness absence levels, leadership development participation, as well as direct feedback from our staff, Staff networks, trade unions, FTSU and external community partners, including community groups and networks.

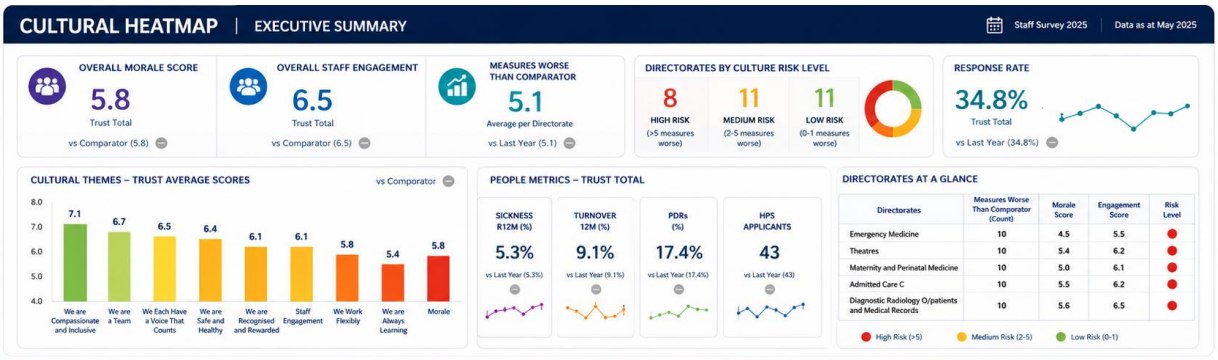
12.2 Capturing the live feedback and lived experiences of our staff is essential and will be a priority for the Executive team. This will be facilitated through an active programme of engagement and safe space conversations with staff across all parts of the Group.

12.3 The image below summarises the approach to measuring the impact and success of the culture improvement approach, with regular reports to the Group People Committee and Group Board.

DRIVER	OUTCOME AREA	WHAT WE WILL MEASURE	KEY METRICS / EVIDENCE	IMPACT
DRIVER 1 Improvement Leadership that Shapes Culture	Culture and Staff Experience	Staff perceptions of culture, inclusion, belonging and psychological safety	• NHS Staff Survey • Pulse Surveys • Local culture surveys • Staff listening events • Focus groups • Cultural competence self-assessments	• Increased sense of belonging, respect and inclusion • Improved confidence to speak up • Reduction in reports of bullying, harassment and discrimination
DRIVER 2 An Inclusive and Respectful Culture	Equality, Diversity and Inclusion	Progress in reducing workforce inequalities and improving equitable experiences for all staff groups	• WRES and WDES indicators • Recruitment, promotion and disciplinary data • Development programme participation • Survey data by protected characteristic	• Reduction in disparities experienced by ethnically diverse staff and other underrepresented groups • Increased perceptions of fairness and equal opportunity
DRIVER 3 Staff Engagement, Voice and Improvement	Leadership Effectiveness	Development of compassionate, inclusive and accountable leadership behaviours	• ARC programme completion rates • Leadership assessments • Quality and completion of PDRs • Compliance with one-to-ones • Staff feedback on leadership visibility and support	• More confident and capable leaders • Improved people management • Greater accountability and role modelling of Trust values
DRIVER 4 High-performing & Compassionate Teams	Team Effectiveness	Strength of multidisciplinary working, team relationships and psychological safety	• ARC Team Effectiveness diagnostics • Team climate assessments • Reflective practice participation • MDT development feedback	• Improved collaboration, communication and trust across teams • Stronger multidisciplinary working and collective problem solving
DRIVER 5 Embedding a Learning and Improvement-Oriented Culture	Workforce Wellbeing	Staff wellbeing, engagement and support utilisation	• Wellbeing survey results • Uptake of wellbeing services • Staff feedback • Occupational health data	• Improved staff wellbeing • Increased use of support services • Stronger engagement and resilience
DRIVER 6 Wellbeing & Sustainable Work	Retention and Attendance	Ability to retain and support staff	• Turnover rates • Vacancy rates • Sickness absence • Exit interview themes	• Improved retention • Reduced sickness absence, particularly stress-related absence • Greater workforce stability
	Anti-Racism and Inclusion Practice	Extent to which anti-racist and inclusive practices are embedded into everyday behaviours and decision-making	• Training completion • Reflective learning ounputs • Case discussions • Community of practice participation • Staff feedback	• Greater confidence in addressing racism and discrimination • Increased accountability • Evidence of more inclusive behaviours and decision-making
	Patient Safety and Quality	Impact of culture and team effectiveness on care delivery	• Safety culture measures • Incident reporting trends • Maternity and neonatal quality indicators • Patient feedback • Learning review themes	• Stronger safety culture • Improved communication and teamwork • Better outcomes and experiences for women, babies and families
	Programme Delivery	Delivery of planned interventions and engagement levels	• Training attendance • Coaching uptake • Compliance with PDRs and one-to-ones • Participation in listening events and development programmes	• Assurance that planned interventions are being delivered, sustained and reaching all staff groups

12.2 Progress will be monitored through an integrated Group Culture Dashboard (see image of the DRAFT Culture Dashboard below). NHSE provided positive feedback on a DRAFT version of the Culture Dashboard at a recent Performance Management Review meeting.

12.3 Reflecting the intrinsic relationship between staff engagement, wellbeing and patient experience, a piece of work will be undertaken to embed key patient quality metrics as part of the Culture Dashboard, in order to capture the impact and benefits of culture improvement for patient experience.



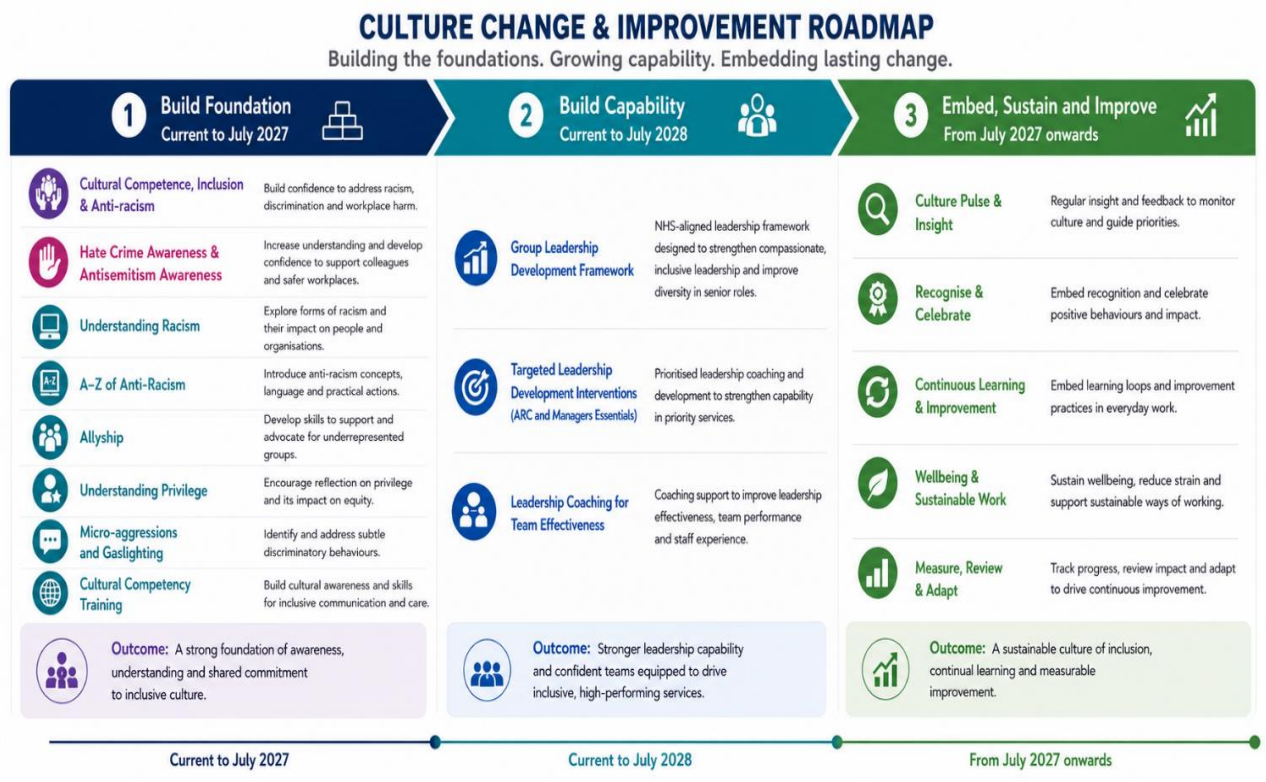
13. Recommendations

13.1 The Group Board is asked to:

1. Consider, discuss and challenge the robustness of the proposed Culture Improvement Framework and improvement actions for delivering the scale of culture change and improvement required. Highlight any concerns, risks or gaps that the Board believes should be considered.
2. Endorse the Group Culture Improvement Framework and improvement actions. Commit to championing the Culture Improvement Framework as a key enabler for the Group strategy, including requiring regular reporting, as well as upward reporting through People Committee.
3. Note that NHS England launched the new NHS Staff Standards on 6th July and that delivery is mandatory and measured through the National Oversight Framework. Note that Boards and Executive teams are accountable for making sure the standards are understood, implemented and monitored.
4. Take assurance that the Group Culture Framework will support the delivery of the new Staff Standards.
5. Require a Board briefing paper, with an assessment and improvement plan for the Staff Standards to be developed and presented to the People Committee and future Group Board for assurance.

Dr James Fleet, Group Chief People Officer
Meagan Fernandes, Director of People and OD (SWB)
Karen Brogan, Director of People and OD (DGFT)
Peter Lowe, Director of Improvement
8th July 2026

Annex 2: Culture Change & Improvement Roadmap



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

REPORT TITLE:	Developing an Anchor Approach for Dudley, Sandwell and Birmingham		
SPONSORING EXECUTIVE:	Kat Rose, Group Chief Partnerships Officer Presenter: Sally Cornfield, Programme Director Dudley Health and Care Partnerships		
REPORT AUTHOR:	Kat Rose, Group Chief Community and Partnerships Officer		
MEETING:	Group Public Trust Board	**DATE:**	22 July 2026

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

Suggested discussion points

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

This paper summarises the Black Country and Birmingham and Solihull Integrated Care Board's Anchor Framework, including its purpose, alignment with national NHS policy, and how Dudley and Sandwell are developing local Anchor approaches in response.

It also outlines Sandwell and West Birmingham Hospitals NHS Trust's involvement in shaping the Birmingham Anchor Framework for the West Birmingham population served by the Trust. The paper provides strategic context for the Board and members of the public, with further detail on governance, operating arrangements and delivery to be presented as the programme progresses.

Alignment to our Vision					
OUR PATIENTS	x	**OUR PEOPLE**	x	**OUR POPULATION**	x

Previous consideration

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

Recommendation(s)

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

Escalation

Should any element of this report be escalated:
N/A

BAF Impact

Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance

X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026

Developing an Anchor Approach for Dudley, Sandwell and Birmingham

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1. **Purpose**

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

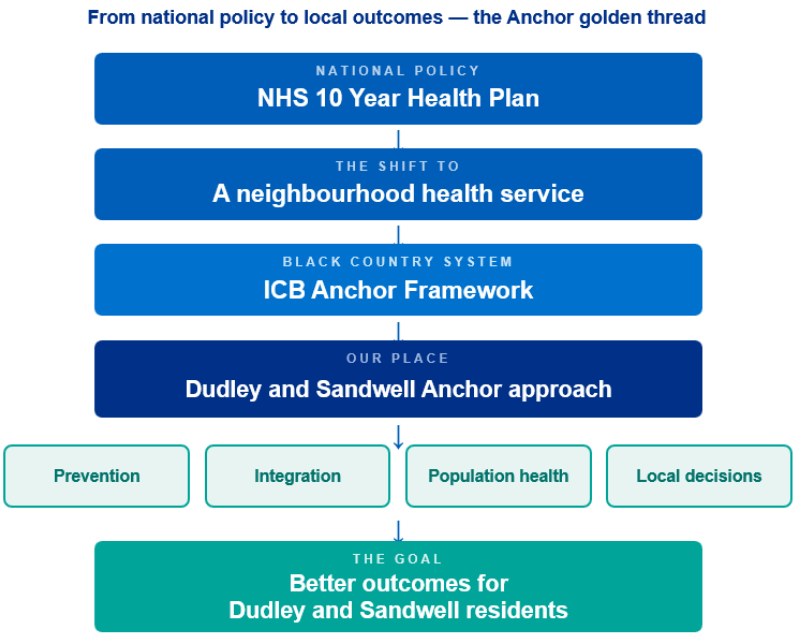
This paper provides an overview of the Black Country and Birmingham and Solihull Integrated Care Board's Anchor Framework, why it has been developed, how it aligns with national NHS policy. It describes how Dudley and Sandwell are developing their local Anchor approach in response and it outlines how Sandwell and West Birmingham Hospitals NHS Trust (SWBH) are involved in the development of the Anchor Framework in Birmingham for the population the Trust serves in West Birmingham. It is intended to provide strategic context for the Board and members of the public. More detailed work on governance, operating arrangements and delivery will be brought to the Board as the programme develops.

2. **Why Anchor?**

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

While existing place based partnership arrangements have delivered improvements, local outcomes continue to be affected by inequalities in healthy life expectancy, rising demand for urgent and planned care, variation in outcomes between communities and increasing financial pressures across the health and care system. The Anchor approach seeks to strengthen place-based leadership and collective accountability to address these challenges more effectively.

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



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

In response to this national direction, the Birmingham, Black Country and Solihull (BBCS) Integrated Care Board has developed an Anchor Framework that enables appropriate functions to be exercised closer to communities through capable place-based leadership, within a clear line of NHS accountability, and partners continue to work together through locally agreed partnership arrangements, each retaining its own

statutory responsibilities, enabling decisions to be taken closer to local communities while maintaining clear accountability across the system.

Together, these developments create an opportunity for capable local organisations to take a broader leadership role, working with partners to improve health, reduce inequalities and join up care more effectively around local communities. It also recognises the role NHS bodies play as anchor organisations within the local community, such as employing local people, buying local goods and services which support the wider economic and social factors that contribute to addressing the wider determinants of inequality. The Anchor approach is the BBCS ICB response to that opportunity and is a significant step forward towards developing our Group of organisations as Integrated Health Organisations in the future.

3. What is an Anchor?

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

Its focus is on:

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

An Anchor organisation will also deliver services, but its distinctive role sits above delivery providing the strategic leadership and commissioning capability to understand and respond to what the population needs, plan how care is organised across the place, and hold a clear focus on improving outcomes. Through agreed contractual mechanisms and delegation arrangements, the ICB will set strategic commissioning intentions and outcomes they expect to be delivered via an Anchor, while the Anchor will coordinate local delivery and partnership working to deliver the outcomes set that will improve population health and reduce inequalities.

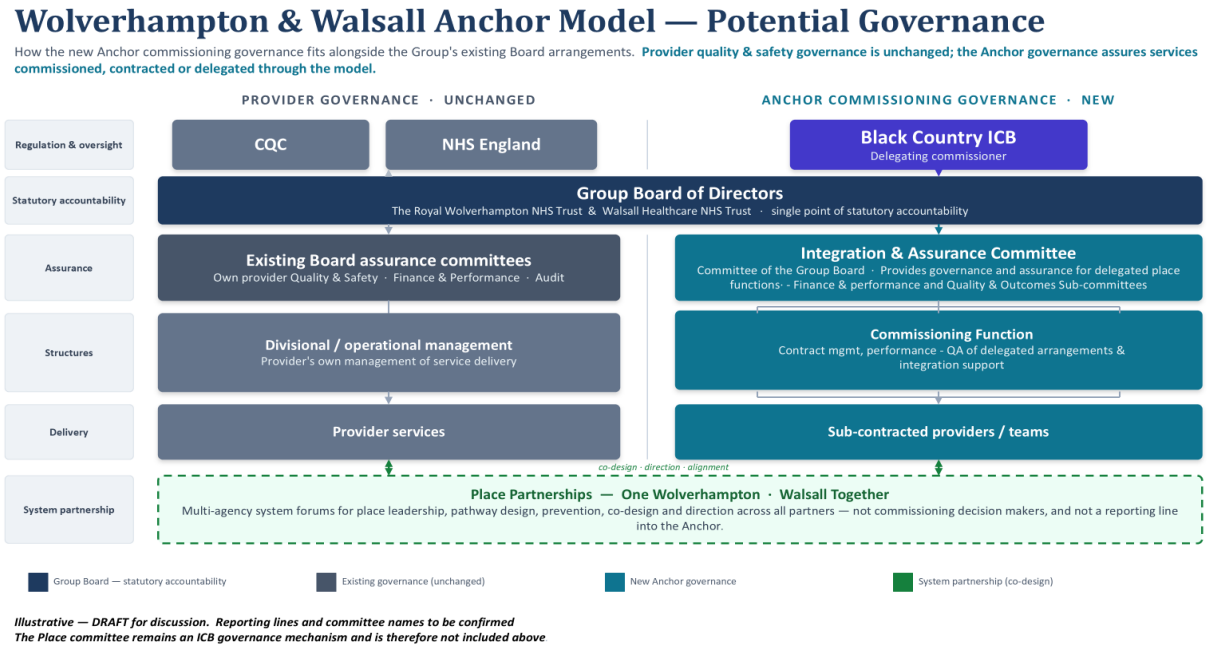


Figure 2: Potential Governance arrangement for anchor development

The Anchor approach does not change the statutory responsibilities of partner organisations. Any responsibilities exercised through an Anchor arrangement will operate through existing statutory powers, delegated functions and locally agreed partnership arrangements. Dudley Group NHS Foundation Trust (DGFT) & Sandwell and West Birmingham Hospitals NHS Trust acting as the Anchor for each Dudley and Sandwell will be accountable to the ICB through an agreed lead provider contractual arrangement, separate to that of the core acute contract. See Figure 1 below for a suggested governance model that can be established to support the development of anchor

arrangements across the Group. This suggested governance model would include primary care representation from both places to demonstrate commitment to partnership working and co-design of the anchor model for each place.

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

For Birmingham the BCCS have designated University Hospitals Birmingham NHS Foundation Trust (UHB)as the designated Anchor Organisation for Birmingham. The West Birmingham Locality Partnership is currently hosted by the Sandwell and West Birmingham NHS Foundation Trust. The West Birmingham Locality sits within the Birmingham Place and as such will form part of the Birmingham Anchor arrangements.

4. Current Position

Dudley and Sandwell have a strong history of partnership working through Dudley Health and Care Partnership and Sandwell Health and Care Partnership and are well placed to build on this as national policy evolves.

Since October 1st, 2024, DGFT has provided a number of commissioning functions on behalf of the ICB and is therefore in a strong position to move forward with the proposed Anchor arrangements with the staff with the necessary skills already in post. The focus in the first place will be for DGFT to become the Anchor for Dudley and look at how the commissioning skills and experience that sits within DGFT can support SWBH to become the anchor as SWBH work toward ensuring they become financially sustainable. As a group we would look to put similar arrangements in place across Dudley and Sandwell so SWBH operate as an Anchor until the ICB agree that SWBH can formally become an Anchor for Sandwell.

Following publication of the Black Country ICB Anchor Framework, a joint programme has been established to develop the approach across Dudley and Sandwell. A weekly operational working group made up of representatives from the Trust and ICB in the first instance has been established led by the Group Chief Community and Partnership Officer with the initial focus on the DGFT Anchor arrangements, engagement with system partners is underway, and work is progressing to develop the supporting governance and operating model. A Dudley Anchor Steering group has been set up led by the Chief Executive and will have representatives from DGFT's and SWBH Executives and Non-Executive Directors and Dudley Primary Care Collaborative. The Operational Working Group and Steering group will ensure that arrangements developed are in line and supporting SWBH anchor approach. The first meeting will take place at the beginning of August where the terms of reference will be discussed and agreed.

In Dudley, Sandwell and West Birmingham our partnerships 'focus is on strengthening community and Home First models of care, enabling more people to remain happy, healthy and independent and cared for within, or close to, their own homes wherever appropriate. To support this the immediate focus is to agree a joint set of local outcomes with partners that support the National Neighbourhood Health framework, ICB Clinical Strategy and local Health and Wellbeing Board priorities informed by local Joint Strategic Needs Assessments. ICB as the commissioners of the anchor will confirm which of these outcomes will sit directly within the Anchor arrangements and contracts.

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

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

While Dudley and Sandwell arrangements are developing through the Group, West Birmingham forms part of Birmingham Place and therefore provides an opportunity to share learning and promote consistency in neighbourhood health development across geographical boundaries.

For the Birmingham Anchor arrangements SWBH are ensuring they are represented in the new Birmingham Anchor arrangements that are being established by UHB. Initial meetings have been held with ICB and UHB colleagues to understand what the Birmingham Anchor arrangements will mean for SWBH and the services we are commissioning to deliver for the West Birmingham population. West Birmingham Locality Partnership is one of the most mature and well-developed locality partnerships. The SWBH Deputy Chief Partnership Officer has developed a draft Target Operating Model for the West Birmingham Locality Partnership (this can be found in the reading room). The model could provide a scalable blueprint for implementation across other Birmingham localities, supporting greater consistency while retaining flexibility to meet local population needs.

5. Key risks

Risk	Potential Impact	Mitigation
Perceived duplication with existing partnership arrangements	Confusion over roles, duplication of meetings and weakened accountability across the system.	• Clearly define the relationship between the Anchor, Dudley Health and Care Partnership, Health and Wellbeing Board and neighbourhood arrangements. • Adopt a principle that the Anchor strengthens existing partnerships rather than creating new structures. • Produce a governance map showing how responsibilities align across the system.
Governance ambiguity	Delayed decision making and accountability gaps	Formalise governance arrangements with ICB and place partners as part of the process of becoming an anchor.
Financial Pressure	Additional leadership and programme responsibilities could place pressure on Trust resources and affect financial sustainability.	• Develop a clear financial framework agreed with the ICB. • Align Anchor priorities with the Group's financial strategy and productivity programmes. • Prioritise interventions that support prevention and reduce avoidable demand. • Undertake annual review of costs, benefits and resource requirements.
Workforce and leadership capacity	Insufficient programme, analytical or clinical leadership capacity could delay implementation and impact delivery of existing priorities.	• Use existing expertise transferred from commissioning functions within DGFT to support delivery of DGFT as an anchor for Dudley. • ensure clear plan is agreed with ICB of how resources are in place to support the Group in taking on the on additional responsibilities that will be part of any anchor arrangements

6. Next Steps

Over the coming months we will:

- understand the financial consequence and benefits of becoming an Anchor
- continue engagement with and involve partners across Dudley and Sandwell, including primary care, local authority and the voluntary, community and social enterprise sector
- agree the scope of the approach and the population outcomes it will be measured against, aligned to the ICB’s strategic and clinical frameworks
- agree and develop the governance and leadership arrangements, including clear roles and decision-making rights, so that responsibilities and accountability are well understood across partners
- ensure continued connection with our Fit for the Future Strategy in particular community first
- work with the ICB to confirm how the approach is funded and contracted, including reviewing existing contractual arrangements to align with the Trusts’ three-year financial plans, which

set out how care and resources can increasingly be focused closer to home while remaining within available resources.
- identify the initial priority pathways where an Anchor approach can deliver the greatest early benefit for our populations
- develop a phased and realistic implementation roadmap that the system is confident can be delivered
- provide further updates to the Board as the programme progresses.

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

7. Conclusion and Recommendation

The development of an Anchor approach presents a significant opportunity to strengthen place-based partnerships and improve outcomes for local populations. While further work is required to finalise governance, financial and operating arrangements, the proposed approach builds on the maturity of existing partnerships and provides a framework through which organisations can collectively address health inequalities, improve integration and deliver more care closer to home. Continued development will be undertaken in partnership with local authorities, primary care, the VCSE sector and local communities, with further proposals being brought to the Board as arrangements mature.

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

Kat Rose – Group Chief Community and Partnerships Officer

7th July 2026

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

REPORT TITLE:	Joint Risk Management Framework		
SPONSORING EXECUTIVE/PRESENTER:	Melanie Roberts – Group Chief Nurse		
REPORT AUTHOR:	Dr Amanda Last – Deputy Director of Governance (DGFT) Helen Board – Board Secretary (DGFT) Dan Conway – Associate Director of Corporate Governance/Company Secretary (SWB)		
MEETING:	Group Public Trust Board	**DATE:**	22 July 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 aim of this Joint Risk Management Framework, located in the reading room, is to achieve a consistent and effective application of a robust risk management process across the Group that supports the delivery of high standards of patient care and the achievement of strategic objectives.

In devising this Framework, a comparative analysis has been undertaken of the key elements of risk management process across SWB and DGFT. The fundamentals of risk management were consistent across the two Trusts. Where differences in process were identified, collaborative discussions have taken place with executive directors and best practice has been agreed and incorporated into the document.

Implementation of aspects of the Framework have already commenced to support consistent reporting to Board committees; following approval of the document, a more formal implementation plan will be instigated.

The Framework has been subject to extensive consultation; feedback has been considered, and changes have been collectively agreed and incorporated. Internal auditors have reviewed the draft Framework and have provided feedback. Only one suggestion for improvement was raised. This was regarding the terminology used to define risk appetite statements, recommending a simplified behaviours-based language. This change was agreed at the Executive Team Meeting and Appendix 1 of the Framework has been updated accordingly.

The Joint Board of Directors is requested to approve the Joint Risk Management Framework.

Alignment to our Vision

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

OUR PATIENTS	**X**	**OUR PEOPLE**	**X**	**OUR POPULATION**	**X**

Previous consideration

Executive Team Meeting 8th April 2026
Executive Team meeting 23rd June 2026
Quality Committee 24th June 2026

Recommendation

a)	Approve the Framework for implementation

Escalation
Should any element of this report be escalated: N/A

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
Is Quality Impact Assessment required if so, add date: n/a			
Is Equality Impact Assessment required if so, add date: n/a			

Enclosure 16

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

REPORT TITLE:	Risk Appetite - assignment to BAF Risks and Risk Appetite Statement - Sandwell and West Birmingham and The Dudley Group Foundation Trust Review July 2026		
SPONSORING EXECUTIVE:	Diane Wake, Group CEO		
REPORT AUTHOR:	Helen Board, Board Secretary Dan Conway, Associate Director of Corporate Governance/Company Secretary		
MEETING:	Board of Directors	**DATE:**	22 July 2026

Paper Type:		**Requested action:**		**Applies to:**	
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

Background

Whilst there is no specific statutory requirement for NHS organisations to publish a Risk Appetite Statement, establishing and articulating risk appetite is recognised as a fundamental component of effective corporate governance and risk management. NHS England's Well-led Framework and the Code of Governance for NHS Provider Trusts emphasise the Board's responsibility for determining the nature and extent of risk that the organisation is willing to accept in pursuit of its strategic objectives and for ensuring appropriate oversight of principal risks.

Accordingly, the Board of Directors retains ultimate accountability for determining the Trust's risk appetite and tolerance. Good practice is for the Risk Appetite Statement to be reviewed and approved by the Board on a regular basis, typically annually, and to be used as a key reference point in strategic decision-making, risk management, and the development of the Board Assurance Framework (BAF). Many NHS organisations also publish their approved Risk Appetite Statements to support transparency and good governance.

Board members will be aware of the programme of work undertaken to align key elements of the risk management arrangements across Sandwell and West Birmingham NHS Trust (SWB) and The Dudley Group NHS Foundation Trust (DGFT) in support of a consistent Group-wide approach to risk management. A key component of this work has been the review and alignment of the respective Risk Appetite Statements, recognising that the two organisations previously applied different descriptors and definitions.

Whilst risk appetite remains a matter for determination by each sovereign Board, alignment of terminology and approach, where appropriate, supports consistent decision-making, strategic planning, and risk oversight across the Group.

A review of the risk appetite framework, see appendix 1, was undertaken with external input from the Trust's auditors, RSM. As a result, a refreshed set of appetite descriptors has been adopted to better reflect contemporary risk management practice and the current strategic context. This includes replacing the descriptor *"Significant"* with *"Transformational"* and *"Cautious"* with *"Averse"* and so on, providing greater clarity regarding the level of risk the organisation is willing to accept in pursuit of its objectives.

Recommendations

The Board of Directors is asked to note that the revised Risk Appetite descriptors have been incorporated within the aligned Risk Management Framework and applied to the draft 2026/27 Board Assurance Framework risks, see appendix 2.

The Board of Directors is asked to approve the Risk Appetite Statements given as appendix 3 for each Trust and note that, once approved, will be published on each Trust website.

Alignment to our Group Strategy Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration
None

Recommendation	
a)	**Approve -** The Board of Directors is asked to approve the Risk Appetite Statements for each Trust and note that, once approved, will be published on each Trust website.

Escalation
Should any element of this report be escalated: none

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
Is Quality Impact Assessment required if so, add date: n/a			
Is Equality Impact Assessment required if so, add date: n/a			

Appendix 1 Revised Risk Appetite descriptors 2026/27

Risk Type	
Quality, Safety and Patient Experience *How will we deliver safe, effective and compassionate care?*	**Transformational:** Higher levels of risk are acceptable where the potential benefits are substantial, mitigations are robust, and alignment with long-term strategic objectives is clear.
Finance, Productivity and Value for Money *How will we use our resources?*	
Regulatory, Statutory and Compliance *How will we meet our duties?*	**Progressive:** Higher levels of risk are acceptable where benefits are clear, mitigations are robust, and alignment with strategic objectives is maintained.
People, Workforce and Culture *How will we support and develop our people?*	
Operational Performance and Access *How will we deliver timely care?*	**Measured:** We are willing to accept moderate risk where there is compelling evidence of benefit and robust mitigation measures in place supported by strong governance.
Strategy, Integration and Partnerships *How will we work as a Group and with partners?*	
Digital, Data and Information Governance *How will we use data and technology safely?*	**Limited**: We take a cautious approach, accepting only low levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance..
Estates, Infrastructure and Capital *How will we provide safe and sustainable environments?*	
Reputation and Public Confidence *How will we be perceived by patients, staff, regulators, partners and the public?*	**Averse:** We adopt an extremely cautious stance, Any exposure is tolerated only when unavoidable and subject to rigorous controls.
Research, Innovation and Continuous Improvement *How will we learn, improve and innovate?*	

Appendix 2 Summary Board Assurance Framework (BAF): Risk Appetite Proposal 2026/27

The following table captures the progress related to development of BAF risks with proposed risk appetite assignment

ID	Area	Risk Description	Lead Exec	Risk Appetite & upper tolerance score 25/26	Proposed Risk Appetite 26/27
1	Quality and Safety:	Failure to consistently deliver safe, high-quality care and the quality ambitions of Fit for the Future.	Group CMO Group CNO Chief Operating Officers SWB/DG	Cautious (DG) 9 Open (SWB)	Measured
2	People / Workforce:	Failure to secure the workforce capacity, capability, leadership, culture and staff experience required to deliver the Group strategy.	Chief People Officer	Seek 19	Progressive
3	Partnership / Integration:	Failure to build innovative and outcome-focused partnerships to deliver Community First, Prevention through Partnerships and improved health outcomes.	Group Chief Partnerships Officer	Significant 20	Transformational
4a	Financial Sustainability SWB:	Failure of SWB to achieve financial sustainability and deliver the Financial Delivery Plan 2026–2029.	Director of Finance	Open 12	Measured
4b	Financial Sustainability DG:	Failure of DGFT to achieve its 2026/27 financial plan, resulting in NHS England regulatory action.	Director of Finance	Open 12	Measured
5a	Operational Performance SWB:	There is a risk that the Trust fails to achieve operational performance as a result of demand and capacity exceeding available resources in acute and community settings.	Chief Operating Officer	Open 12	Measured
5b	Operational Performance DG:	Failure to achieve operational performance and deliver strategic goals due to demand and capacity pressures.	Chief Operating Officer	Open 12	Measured
6	Infrastructure	Failure to transform infrastructure, estates, facilities, digital, data, technology and sustainability capabilities in line with the Group Strategy.	Group Chief Strategy & Digital Officer Group Chief Development Officer	Seek 16	Progressive

Appendix 3 Proposed Risk Appetite Statement

A Group strategy 2026-2031 has been developed as part of a collaboration and Group model working with Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust, through which it aims to improve services and health outcomes for local people, and to support and develop its workforce. This strategic framework is based around three strategic goals:

- **Our Patients:** Deliver high-quality care, by the right person in the right place, at the right time
- **Our People:** Be a brilliant place to work and thrive through happy, engaged, productive teams.
- **Our Population:** Work together with our partners to improve life chances and health outcomes.

The NHS operates in a challenging environment, affected by economic pressures and is aspiring to deliver the vision set out in the Fit for the Future: 10 Year Health Plan for England. To fulfil its aspirations in changing times, the Group has established its own Fit for the Future Programme that will need to be innovative and has committed to a series of multi-year commitments.

- ✓ Community First
- ✓ Prevention through Partnerships
- ✓ Focus on People and Culture
- ✓ Make Money Matter

This will mean doing some things differently to how they have been done before, introducing new types of service and activity, and collaborating with other organisations to provide services. Transformational change such as this is never without an element of risk.

As the provider of essential public services funded by the taxpayer, and also one of the largest employers locally, we have a duty to identify and manage reasonably foreseeable risks that affect our organisation, its patients and staff. We have a robust, formal process to do this using a Risk Management Framework. However, we recognise that risk is inherent to healthcare, and that sometimes it is necessary to take risks in pursuit of opportunity. We are risk-aware rather than risk-averse. This means that we use data, information and our shared risk appetite to guide us in our decisions about the risks we are willing to take, and how we manage them.

Risk appetite

Risk appetite is defined as a decision about the level of risk that an organisation is prepared to accept, after balancing the potential opportunities and threats a situation presents. It takes into account the potential benefits of innovation and the threats that change inevitably brings. Our Trust board has defined its appetite for each of the main types of risk facing NHS organisations: Quality Safety and Patient Experience; Finance, Productivity and Value for Money; Regulatory, Statutory and Compliance; People, Workforce and Culture; Operational Performance and Access; Strategy, Integration and Partnerships; Digital, Data and Information Governance; Estates, Infrastructure and Capital; Reputation and Public Confidence; Research, Innovation and Continuous Improvement.

Quality Safety and Patient Experience

Measured: We are willing to accept moderate risk where there is compelling evidence of benefit and robust mitigation measures in place supported by strong governance.

Finance, Productivity and Value for Money

Measured: We are willing to accept moderate risk where there is compelling evidence of benefit and robust mitigation measures in place supported by strong governance.

Regulatory, Statutory and Compliance

Limited: We will take a cautious approach, accepting only low levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance.

People, Workforce and Culture

Progressive: We will accept higher levels of risk where benefits are clear, mitigations are robust, and alignment with strategic objectives is maintained.

Operational Performance and Access

Measured: We are willing to accept moderate risk where there is compelling evidence of benefit and robust mitigation measures in place supported by strong governance.

Strategy, Integration and Partnerships

Transformational: We acknowledge that there are higher levels of acceptable risk where the potential benefits are substantial, mitigations are robust, and alignment with long-term strategic objectives is clear.

Digital, Data and Information Governance

Limited: We will take a cautious approach, accepting only low levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance.

Estates, Infrastructure and Capital;

Progressive: We will accept higher levels of risk where benefits are clear, mitigations are robust, and alignment with strategic objectives is maintained.

Reputation and Public Confidence

Limited: We will take a cautious approach, accepting only low levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance.

Research, Innovation and Continuous Improvement

Limited: We will take a cautious approach, accepting only low levels of risk. Any risk must be well understood, tightly controlled, and supported by strong assurance.

Reviewed July 2026

Enclosure 17

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

REPORT TITLE:	Board Architecture and Governance Planner		
SPONSORING EXECUTIVE:	Diane Wake, Group CEO		
REPORT AUTHOR:	Dan Conway, Associate Director of Corporate Governance/Company Secretary Helen Board, Board Secretary		
MEETING:	Public Trust Board	**DATE:**	22 July 2026

Paper Type:		**Requested action:**		**Applies to:**	
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

This paper presents the Board Architecture developed for Sandwell and West Birmingham Hospitals NHS Trust and The Dudley Group NHS Foundation Trust.

It explains how the architecture will be used to plan and manage Board, committee and executive business across the Group, while maintaining the statutory accountability and sovereignty of each Trust Board.

The Board is also asked to agree the next steps for implementing, maintaining and reviewing the architecture.

The full Board Architecture Planner is available to Board members in the Board Reading Room. This paper provides a public summary of its purpose, operation and governance arrangements.

Alignment to our Vision					
OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration

None

Recommendation	
a)	**Approve** the Board Architecture as the framework for planning and coordinating Board, committee and executive business.
b)	**Agree** that it will be used to develop annual workplans, manage the corporate calendar, clarify reporting and assurance routes and reduce unnecessary duplication.
c)	**Confirm** that matters reserved to the sovereign Boards will continue to be considered and approved by the relevant Trust Board.
d)	**Note** that the architecture will be maintained and reviewed by the Corporate Governance Team.

Escalation

Should any element of this report be escalated: none

BAF Impact			
Sandwell and West Birmingham NHS Trust		The Dudley Group NHS Foundation Trust	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026

Board Architecture and Governance Planner

1. Purpose

1.1 This paper presents the Board Architecture for Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust and explains how it will be used to plan and manage Board, committee and executive business across the Group.

1.2 The full Board Architecture Planner is available in the Board Reading Room.

2. Background

2.1 The Group model requires governance arrangements that support collective working while maintaining the statutory accountability of each Trust.

2.2 Both organisations remain separate legal entities with their own Boards, statutory duties, regulatory responsibilities and Schemes of Reservation and Delegation. The architecture has therefore been designed to provide a consistent Group governance framework while preserving the authority of each sovereign Board.

3. The Board Architecture

3.1 The Board Architecture is a detailed governance planner covering the sovereign Boards, Board committees, Executive Group, Trust Management Group and relevant provider collaborative arrangements.

3.2 It identifies the matters that must be considered across the governance structure, how frequently they should be reported, whether they are delegated and the route through which scrutiny, assurance, escalation or approval should take place.

3.3 The architecture covers the main areas of Board and committee responsibility, including quality, people, finance and productivity, audit, integration and infrastructure. It also identifies whether each requirement is statutory, regulatory, mandatory, strategic or recognised best practice.

4. How the Architecture Will Be Used

4.1 The architecture will become the master framework for developing Board and committee workplans and the Group corporate calendar.

4.2 It will help ensure that each matter is considered by the correct forum, at the correct time and for a clear purpose. This will support better sequencing of reports, decisions and assurance, while reducing the risk of the same information being presented unnecessarily to several meetings.

4.3 The architecture will also help distinguish between matters requiring a Board decision, committee scrutiny, executive approval, assurance by exception or provision through the Board Reading Room.

4.4 Committee assurance reports will provide the principal route for reporting detailed committee business to the Board. These reports will identify the level of assurance received, any material concerns, decisions taken under delegated authority and matters requiring Board approval or escalation.

4.5 Detailed supporting documents that do not require separate Board discussion may be placed in the Reading Room and referenced through the relevant assurance report.

5. Delegation and Accountability

5.1 The architecture does not change the statutory responsibilities of either Trust Board.

5.2 Matters reserved to the Boards will continue to be considered and approved by the relevant sovereign Board. Matters delegated to committees or executive forums will be managed in accordance with approved Terms of Reference and Schemes of Reservation and Delegation.

5.3 Delegation does not remove Board accountability. The Boards will continue to receive assurance on how delegated responsibilities are being discharged.

6. Risk and Assurance

6.1 The Board Assurance Framework will form a central part of the architecture.

6.2 Each principal risk will be assigned to a lead Board committee for detailed scrutiny, with assurance reported to the Board. The architecture will provide a clearer connection between strategic objectives, principal risks, controls, committee oversight, executive actions and Board accountability.

6.3 It will also support clearer escalation of significant corporate and operational risks through the appropriate governance route.

7. Provider Collaborative Arrangements

7.1 The architecture includes the interface with the Black Country Provider Collaborative and Joint Provider Committee.

7.2 It identifies where responsibilities are exercised collaboratively and where further approval is required from the Group or sovereign Trust Boards. These arrangements do not replace the statutory responsibilities of the partner organisations.

8. Next Steps

8.1 Following approval, the architecture will be aligned with committee and executive Terms of Reference, Schemes of Reservation and Delegation and existing annual workplans.

8.2 The Corporate Governance Team will use the architecture to establish a coordinated a standardise report commissioning and committee assurance reporting and identify any gaps or duplication within current arrangements. This will be supported with the input of the executive leads and committee chairs.

8.3 The architecture will be maintained as a controlled document and updated as statutory, regulatory, strategic or governance requirements change. Its effectiveness will be reviewed after an initial period of operation and thereafter through the annual governance review process.

9. Risks

9.1 The main risk is that Group working could create uncertainty about accountability or decision-making authority. This will be managed through clear delegation arrangements, Terms of Reference and explicit recording of decisions taken by each sovereign Board.

9.2 There is also a risk that existing reports are transferred into the new structure without removing duplication. The architecture will therefore be used to identify a single principal reporting and assurance route for each matter wherever possible.

10. Conclusion

10.1 The Board Architecture provides a single framework for managing Board, committee and executive business across the Group.

10.2 It will strengthen forward planning, clarify accountability, improve assurance and support compliance with statutory and regulatory requirements while preserving the sovereignty of each Trust Board.

10.3 The full Board Architecture Planner is available in the Board Reading Room.

11. Recommendations

11.1 the Joint Trust Board is asked to:

a) **Approve** the Board Architecture as the framework for planning and coordinating Board, committee and executive business.
b) **Agree** that it will be used to develop annual workplans, manage the corporate calendar, clarify reporting and assurance routes and reduce unnecessary duplication.
c) **Confirm** that matters reserved to the sovereign Boards will continue to be considered and approved by the relevant Trust Board.
d) **Note** that the architecture will be maintained and reviewed by the Corporate Governance Team.

Enclosure 19

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

REPORT TITLE:	Board Assurance Framework Refresh 2026/27 Proposed Reporting Approach and July 2026 Approval Route		
SPONSORING EXECUTIVE:	Diane Wake, Group CEO		
REPORT AUTHOR:	Dan Conway, Associate Director of Corporate Governance/Company Secretary Helen Board, Board Secretary		
MEETING:	Public Trust Board	**DATE:**	22 July 2026

Paper Type:		**Requested action:**		**Applies to:**	
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 Group Board Assurance Framework has been refreshed to provide a clearer, more consistent and strategically focused view of the principal risks that could prevent delivery of the Group Strategy and Fit for the Future priorities. The refresh has brought together the previous Trust-specific approaches, removed duplication, strengthened alignment with the new Group governance arrangements and standardised each risk statement using the format: "There is a risk that… due to… this may result in…".

The proposed principal risks cover quality and safety, people and workforce, integration and partnerships, finance, operational performance and infrastructure. Some financial and operational risks remain Trust-specific to reflect the statutory accountability and differing risk profiles of each organisation.

The Board is asked to agree that the proposed risk statements correctly frame the Group's principal risks and are set at the appropriate level for strategic oversight. Subject to this agreement, the relevant Committees will continue to refine the detailed controls, assurances, gaps, actions, risk scores, measures and interdependencies before the completed BAF is returned through the agreed reporting cycle.

Alignment to our Group Strategy Vision

OUR PATIENTS	**x**	**OUR PEOPLE**	**x**	**OUR POPULATION**	**x**

Previous consideration

None

Recommendation

a)	**Approve** the proposed risk statement for each principal BAF risk.
b)	**Confirm** that, collectively, the risk statements: ○ reflect the principal risks that could prevent delivery of the Group Strategy; ○ are appropriately aligned to the Fit for the Future priorities;

	○ are framed at the correct strategic level for Board oversight; and ○ provide an appropriate basis for the continued development of the Group Board Assurance Framework.
c)	**Note** that, following agreement of the risk statements, further work will continue through the relevant Board Committees to refine controls, assurances, gaps, actions, measures and interdependencies

Escalation
Should any element of this report be escalated: none

BAF Impact			
Sandwell and West Birmingham NHS Trust		**The Dudley Group NHS Foundation Trust**	
X	001 (Joint): Quality		
X	002 (Joint): Workforce		
X	003 (Joint): Partnerships		
X	004: Finance	X	004: Finance
X	005: Operational performance	X	005: Operational performance
X	006 (Joint): Infrastructure		
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 22 July 2026

Group Board Assurance Framework Refresh

1. Purpose

1.1 To provide the Board with an overview of the work undertaken to refresh the Group Board Assurance Framework and to seek agreement to the proposed principal risk statements (**Appendix 1**).

2. Summary

2.1 The Board Assurance Framework has been refreshed to support the development of the Group and the delivery of the Group Strategy and Fit for the Future programme.

2.2 The refresh has moved the BAF from a collection of historically Trust-specific or operationally focused risks towards a coherent set of Group-level principal risks. The intention is to provide the Board with a clearer and more consistent view of the strategic risks that could prevent the Group from achieving its objectives.

2.3 The work has included reviewing the existing BAFs of both organisations, considering the emerging Group Strategy and Fit for the Future priorities, engaging Executive risk owners and relevant teams, standardising the format and construction of risk statements, and beginning to align the risks with the new Group committee structure.

2.4 Each proposed risk statement has been developed using a consistent formulation:

2.4.1 There is a risk that… due to… this may result in…

2.5 This approach is intended to ensure that each risk clearly distinguishes between the uncertain event, its underlying causes and its potential strategic consequences.

2.6 At this stage, the Board is not being asked to approve every component of the detailed BAF documentation. The immediate decision sought is confirmation that the principal risks themselves are correctly identified and framed. This will provide the strategic foundation on which the remaining BAF components can be finalised.

3. Background

3.1 The establishment of the Group, alongside the development of the Group Strategy and Fit for the Future programme, requires a Board Assurance Framework that reflects the Group's strategic objectives, governance arrangements and operating context.

3.2 The previous arrangements were principally based on the separate BAFs of Sandwell and West Birmingham and The Dudley Group. Although these provided oversight of material risks within each organisation, the development of a Group model created a need to review whether:

- the risks remained the most significant risks to the achievement of the Group's objectives;
- risks were framed consistently at a strategic rather than operational level;
- duplication existed between the two organisations;
- the BAF reflected Group-wide priorities and interdependencies;
- accountability for oversight was clear within the new committee structure; and
- the risks adequately reflected the ambitions and delivery requirements of Fit for the Future.

3.3 The refresh has therefore been undertaken as more than a consolidation exercise. It has sought to redefine the principal risks from a Group perspective and establish a consistent basis for their future management and assurance.

4. The Journey of the BAF Refresh

1. Review of the Existing Position

The first stage involved reviewing the existing BAF risks across both organisations, together with associated corporate risks, strategic priorities, committee responsibilities and areas of existing Board concern.

This identified a number of challenges:

- variation in the way risks were described and scored;
- inconsistent distinction between principal strategic risks and operational delivery risks;
- duplication or overlap between BAF risks;
- controls and actions being described at different levels of detail;
- limited visibility of the interdependencies between quality, workforce, finance, infrastructure, integration and operational delivery; and
- a need to strengthen alignment between the BAF and the emerging Group Strategy.

The review confirmed that simply combining the existing documents would not provide a sufficiently coherent Group Board Assurance Framework.

2. Identification of the Group's Principal Risk Areas

The next stage focused on identifying the principal uncertainties that could prevent the Group from delivering its strategic objectives.

This work considered:

- the Group Strategy;
- Fit for the Future priorities and delivery requirements;
- the strategic objectives and responsibilities of the Group Board;
- existing Trust BAFs and corporate risk registers;
- financial recovery and productivity requirements;
- quality, safety and patient experience priorities;
- workforce capacity, capability, culture and leadership;
- operational performance and access standards;
- infrastructure, digital and estates requirements;
- the development of integrated care and Group working; and
- the external regulatory, financial and system environment.

This resulted in the development of a more focused set of proposed Group-level principal risks.

Where some risks remain specific to an individual statutory organisation, particularly in relation to financial and operational delivery, these have been retained separately. However, they have been framed consistently and considered as part of the overall Group risk profile.

3. Standardisation of Risk Statements

A common approach has been applied to the construction of each risk statement.

Each statement now seeks to describe:

- **the risk event** — what may happen;
- **the causes** — why it may happen; and
- **the consequences** — what the strategic impact could be.

The standard formulation is:

There is a risk that [risk event], due to [principal causes]. This may result in [strategic consequences].

This has helped to:

- improve consistency across the BAF;
- separate the risk from the controls or actions intended to manage it;
- avoid risk statements becoming descriptions of current performance issues;
- maintain focus on matters requiring Board-level oversight; and
- make the relationship between causes, consequences, controls and actions clearer.

4. Alignment with the Group Strategy and Fit for the Future

Each proposed principal risk has been reviewed against the Group Strategy and the priorities of Fit for the Future.

The intention has been to ensure that the BAF does not operate as a parallel governance document, but instead provides the principal mechanism through which the Board oversees the risks to delivery of its strategy.

The proposed risks therefore reflect the main strategic dependencies for successful delivery, including:

- safe, high-quality and person-centred care;
- workforce capacity, capability, leadership and culture;
- sustainable financial performance and productivity;
- reliable operational delivery and improved access;
- infrastructure, estates and digital capability;
- effective integration and Group working; and
- delivery of transformational change without unintended consequences for quality, staff experience or organisational resilience.

The BAF is also being developed to show the linkages between the principal risks. For example, workforce capacity may affect quality, operational performance and financial recovery, while infrastructure constraints may affect productivity, patient flow and staff experience.

These interdependencies are derived from the refreshed Group BAF and will continue to be worked through in greater detail by the relevant Committees.

5. Executive Review and Development

Executive risk owners and relevant corporate and operational leads have contributed to the development of the risk statements and the supporting BAF content.

This has included reviewing:

- the scope and wording of each principal risk;
- the principal causes and potential consequences;
- existing controls;
- sources of assurance;
- gaps in control or assurance;
- planned mitigating actions;
- risk appetite;
- current and target risk scores; and
- proposed measures and indicators.

The process has also sought to ensure that individual BAFs do not become overly detailed action trackers. Controls and actions are being consolidated into broader strategic themes wherever possible, with detailed operational delivery continuing to be managed through supporting programmes, corporate risks and directorate governance arrangements.

6. Committee Engagement

The refreshed BAF risks are being aligned to the responsibilities of the new Group Committees.

Committees will have an important role in:

- scrutinising the risks within their remit;
- assessing the effectiveness of the principal controls;
- reviewing the adequacy and reliability of assurances;
- identifying gaps in control or assurance;
- monitoring delivery of mitigating actions;

- considering whether the risk score remains appropriate; and
- escalating matters requiring Board attention.

The initial Committee discussions have supported refinement of the risks and have highlighted the importance of ensuring that financial and productivity ambitions are considered alongside potential implications for quality, patient outcomes, staff experience and operational resilience.

The detailed committee-level review of controls, assurance, actions and risk interdependencies will continue following Board agreement of the principal risk statements.

4.1 Why Board Agreement Is Required at This Stage

4.1.1 The principal risks are ultimately owned by the Board. Although detailed scrutiny may be delegated to Committees, the Board remains responsible for confirming that the BAF reflects the most significant risks to achievement of the Group's strategic objectives.

4.1.2 Agreement of the risk statements at this stage will provide confirmation that:

- the correct principal risks have been identified;
- risks are expressed at the appropriate strategic level;
- the potential causes and consequences are sufficiently clear;
- the risk profile reflects the Group's strategic ambitions and operating environment; and
- the subsequent development of controls, assurances and mitigating actions is based on an agreed strategic foundation.

4.1.3 Without this confirmation, there is a risk that detailed BAF development continues around risks that have not been explicitly endorsed by the Board.

4.1.4 The decision sought is therefore deliberately focused. The Board is being asked to agree the framing of the principal risks, rather than approve the BAF as complete and final.

5. Proposed Approach Following Board Agreement

5.1 Following agreement of the principal risk statements, the next phase of work will include:

- finalising the mapping of each risk to the Group Strategy and Fit for the Future priorities;
- reviewing current and target risk scores;
- confirming the application of the agreed risk appetite;
- refining the principal controls and assurance sources;
- identifying gaps in control and assurance;
- consolidating actions into a manageable number of strategic delivery themes;
- strengthening the articulation of interdependencies between BAF risks;
- aligning relevant corporate and operational risks to the BAF; and

5.2 The BAF will continue to evolve as the Group governance arrangements mature and as the Fit for the Future programme becomes more fully developed.

6. Governance and Reporting Arrangements

6.1 Proposed Layered BAF Reporting Model

Layer 1: Board Strategic Overview
A single summary page **(See appendix 2 working example)** should be produced showing all strategic BAF risks, current ratings, target ratings, trends, risk appetite position, assurance ratings and key areas requiring Board attention. This will give the Board and Executive Team a whole-framework view of the principal risks, allowing them to focus on strategic risk framing, escalation, prioritisation and material risk movement.

Layer 2: Committee One-Page Summary for Each Respective BAF
Each Committee should receive a one-page summary **(see appendix 3 working example)** for the BAF risk within its remit. The People BAF one-page summary provides the proposed model, including current rating, target rating, trend, risk appetite, committee assurance rating, clear risk statement, "due to" causes, "could result in" impacts, overall assurance statement, control map and focused challenge questions.

This format supports Committee-level scrutiny by making the key assurance signal visible, while still enabling appropriate challenge on controls, gaps, actions, evidence and organisation-specific differentials.

Layer 3: Detailed BAF in Reading Room
The full detailed BAF should be retained as the supporting assurance document and placed in the Board and Committee reading room. This preserves the analytical depth and audit trail, while keeping the formal Board and Committee papers focused and usable.

6.2 Benefits

6.2.1 This approach will improve clarity, reduce Board and Committee pack burden, and strengthen the quality of strategic risk discussion. It maintains the full assurance detail while ensuring the main reporting route remains focused on risk statement, risk movement, assurance gaps, required action and escalation.

6.3 Reporting rhythm and escalation

6.3.1 The proposed reporting rhythm is:

- **monthly reporting to the relevant Committee**, recognising that where significant development work is underway, some reports may initially focus on material changes, exceptions and escalations;
- **quarterly reporting to the Board**, providing a consolidated view of the Group's principal risk profile, material movements, cross-cutting themes and matters requiring Board attention; and
- **twice-yearly review by the Audit Committee**, focusing on the effectiveness of the overall BAF process, the robustness of assurance and the relationship between the BAF, corporate risks, internal audit and the Annual Governance Statement.

6.4 The Board will continue to receive immediate escalation outside this cycle where a principal risk changes materially or exceeds the agreed risk appetite.

7. Conclusion

7.1 The BAF refresh represents an important step in developing the Group's governance and strategic assurance arrangements.

7.2 The work has moved the framework towards a more consistent, strategically focused and Group-wide assessment of the risks that could prevent delivery of the Group Strategy and Fit for the Future priorities.

7.3 Board agreement of the proposed risk statements will establish a clear strategic foundation for the next phase of work and provide confirmation that the principal risks are framed correctly and aligned to the Board's oversight responsibilities.

7.4 The Board is therefore asked to agree the proposed risk statement for each BAF risk and note the continuing work to develop and refine the supporting controls, assurances, actions, measures and interdependencies.

8. Recommendations

8.1 The Board is asked to:

a) **Approve** the proposed risk statement for each principal BAF risk.
b) **Confirm** that, collectively, the risk statements:
    a. reflect the principal risks that could prevent delivery of the Group Strategy;
    b. are appropriately aligned to the Fit for the Future priorities;
    c. are framed at the correct strategic level for Board oversight; and
    d. provide an appropriate basis for the continued development of the Group Board Assurance Framework.
c) **Note** that, following agreement of the risk statements, further work will continue through the relevant Board Committees to refine controls, assurances, gaps, actions, measures and interdependencies

Appendix 1

BAF	Principal Risk	Draft Risk Statement
BAF 001: Quality and Safety	**Failure to consistently deliver safe, high-quality care and the quality ambitions of the Fit for the Future programme.**	**There is a risk** that the Group is unable to consistently deliver safe, high-quality, person-centred care and the quality ambitions set out in the Fit for the Future programme, **due to** variation in clinical standards, patient safety systems, pathway reliability, data triangulation, workforce capacity and the maturity of Group-wide quality governance. **This may result i**n avoidable harm, poorer patient experience, increased mortality or deterioration in outcomes, regulatory intervention, reduced public confidence, and failure to deliver the Group's strategic commitment to provide the right care, in the right place, at the right time.
BAF 002: People, Workforce and Culture	**Failure to secure the workforce capacity, capability, leadership, culture and staff experience required to deliver the Group strategy.**	**There is a risk** that the Group is unable to secure the workforce capacity, capability, leadership, culture and staff experience required to deliver the Fit for the Future strategy and wider strategic ambitions for 2031, **due to** gaps in inclusive and compassionate leadership, line management capability, retention, sickness absence, health and wellbeing, fair access to development and progression, and integrated workforce planning aligned to service demand, productivity and financial recovery requirements. **This may result i**n reduced staff engagement and experience, workforce instability, increased absence and turnover, inconsistent leadership behaviours, constrained service delivery, reduced

		productivity, and failure to deliver the Group's strategic ambitions.
BAF 003: Integration / Partnership	**Failure to build innovative and outcome-focused partnerships to deliver our strategic commitments of Community First and Prevention through Partnerships and improved the health outcomes of the communities we serve.**	**There is a risk** that the Group is unable to build and maintain mature, trusted and outcome-focused partnership relationships across NHS providers, ICBs, local authorities, primary care, voluntary, community, faith and social enterprise organisations and local communities, **due to** variation in partnership maturity across Sandwell, West Birmingham and Dudley, wider system reform, financial and capacity pressures, inconsistent community engagement and co-production arrangements, and data-sharing limitations. **This may result in** fragmented pathways, reduced impact of Community First and Prevention through Partnerships, missed opportunities to improve population health, poorer outcomes for local communities, duplication of effort, and failure to deliver the Group's strategic commitments.
BAF 004a: Finance — SWB	**Failure to achieve financial sustainability.**	**There is a risk** that Sandwell and West Birmingham Hospitals NHS Trust is unable to achieve financial sustainability, **due to** sustained pressures arising from increasing demand for services, inflationary impacts, underlying deficit, productivity challenges, and the requirement to deliver recurrent efficiency improvements while maintaining safe, high-quality patient care. **This may result in** failure to achieve the Financial Delivery Plan 2026–2029, increased financial deficit, reduced investment capacity, constrained service transformation, regulatory intervention, and failure to deliver the Make Money Matter commitment.
BAF 004b: Finance — DGFT	**Failure to achieve the 2026/27 financial plan.**	**There is a risk** that The Dudley Group NHS Foundation Trust is unable to achieve its 2026/27 financial plan, **due to** demand and capacity pressures, inflationary costs, productivity challenges, delivery risk against efficiency plans, and the requirement to maintain safe, high-quality patient care within available resources. **This may result in** financial deterioration, failure to deliver the agreed financial plan, reduced investment capacity, constrained service transformation, regulatory intervention by NHS England, and failure to deliver the Make Money Matter commitment.
BAF 005a: Operational Performance DGFT	**Failure to achieve operational performance and deliver strategic goals.**	**There is a risk** that The Dudley Group NHS Foundation Trust is unable to achieve and sustain operational performance, **due to** demand and capacity pressures exceeding available resources across acute and community settings, workforce constraints, pathway delays, diagnostic capacity, system flow and transformation delivery risks. **This may result in** failure to deliver constitutional standards, long waits, delayed diagnosis or treatment, poorer patient experience, avoidable clinical harm, regulatory intervention, reduced productivity, and failure to deliver the Fit for the Future model, including care closer to home, planned care hubs and two acute hospitals.
BAF 005b: Operational Performance SWB	**Failure to recover and sustain operational performance across SWB, with Group dependencies for access, flow, diagnostics, transformation and productivity.**	**There is a risk** that Sandwell and West Birmingham Hospitals NHS Trust is unable to recover and sustain operational performance, **due to** demand, acuity, frailty, workforce availability, diagnostic capacity, pathway variation and system flow exceeding available capacity across acute, community and out-of-hospital settings. **This may result in** failure to deliver constitutional standards, long waits,

		delayed diagnosis or treatment, poorer patient experience, avoidable clinical harm, regulatory intervention, reduced productivity, lost income, and failure to realise Fit for the Future and Make Money Matter benefits.
BAF 006: Infrastructure	**Failure to transform the Group's infrastructure, estates, facilities, digital, data, technology and sustainability capabilities in line with the Fit for the Future Group Strategy.**	**There is a risk** that the Group is unable to modernise, optimise and align its infrastructure, estates, facilities, digital, data, technology and sustainability capabilities with the Clinical Services Plan and Fit for the Future strategy, **due to** variation in legacy estate condition, ageing digital infrastructure, data quality, cyber resilience, capital prioritisation, contract governance, Green Plan delivery, workforce capability and the maturity of Group-wide infrastructure governance. **This may result in** constrained community-first and digitally enabled models of care, reduced operational resilience and productivity, weaker statutory, cyber and estate compliance, increased quality and patient safety risks, increased financial pressure, limited value for money and benefits realisation, and failure to deliver the Make Money Matter commitment.

GROUP QUALITY BAF 001 | One-page assurance summary for Quality Committee

CURRENT RATING	TARGET RATING	TREND	RISK APPETITE	COMMITTEE ASSURANCE
16 WITHIN appetite	**8** BELOW appetite boundary	**New Group baseline** Higher residual score: SWB 12 / DGFT 9 -> Group 16 to reflect Group-level convergence risk	**PROGRESSIVE** Quality, Safety and Patient Experience Tolerance 15-16; current 16 is within appetite	**INCONCLUSIVE** Formal BAF assurance rating Progress evident; impact not yet proven

Framework risk type

Quality, Safety and Patient Experience - "How will we deliver safe, effective and compassionate care

Applied appetite statement

Progressive: higher levels of risk are acceptable where benefits are clear, mitigations are robust, and alignment with strategic objectives is maintained.

Committee assurance rating used

Inconclusive: actions are progressing, but not all are complete or demonstrating the desired impact; sufficiency to reach target remains uncertain.

Clear risk statement

There is a risk that the Group is unable to consistently deliver safe, high-quality, person-centred care and the quality ambitions set out in the Fit for the Future programme.

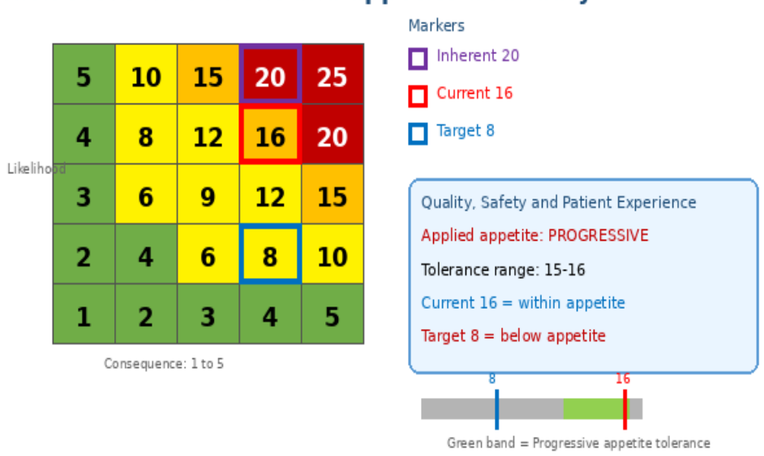
DUE TO

- variation in standards and Fundamentals of Care adoption
- new Group quality governance and delivery framework not yet embedded
- variable PSIRF, mortality and harm learning loops
- incomplete triangulation across safety, experience, harm, mortality, workforce and pathway data
- workforce capacity, skill mix, leadership and culture affecting reliability of care
- pathway reliability and interface risks in admission, transfer, discharge and UEC

COULD RESULT IN

- avoidable harm or delayed recognition/escalation
- poorer patient experience, complaints and failure demand
- mortality variation or deterioration in outcomes
- inconsistent delivery of maternity, neonatal, deteriorating patient and care standards
- regulatory intervention, reduced public confidence and non-delivery of right care/right place/right time

Risk score movement and appetite boundary



Overall assurance statement

INCONCLUSIVE assurance is recommended. Controls and actions are visible, and there is reasonable assurance in some specific areas. However, most core controls remain partial, the Group quality delivery framework is not yet embedded, intelligence is not consistently outcome-focused, and sustained impact is not yet evidenced.

Positive	Approach appropriate/effective; confidence target can be reached within 12 months.
Inconclusive	Progress is being made, but impact and pace are uncertain.
Negative	Lack of progress; major revision required.

Why not Positive yet? A1 and A11 actions are not started; most actions are Amber; measurable Group-wide outcomes and SWB/DGFT differential assurance are not yet complete.

Control map: what needs grip to move from 16 to 8

A1/A11 Group quality governance and Fit for the Future delivery [Partial / Not started] • Control: committee architecture, divisional governance and strategic quality measures. • Gap: framework, milestones, escalation/reporting standards not standardised. • Evidence required: committee map, SROs, baselines and trajectories.	**A2 Quality intelligence and triangulation [Partial / AMBER]** • Control: dashboards, PSIRF, mortality, patient experience, CQC and ward-to-board data. • Gap: uneven whole-pathway data; Board triangulation not outcome-focused. • Evidence required: core measures, source systems, data gaps and Trust drill-down.	**A3 Fundamentals of Care and accreditation [Reasonable / AMBER]** • Control: Tendable, ward dashboards, safety checklists and accreditation. • Gap: not yet standardised as a Group control or impact-evidenced. • Evidence required: adoption, audit compliance, escalation and improvement impact.
A4/A5 Safety learning, mortality and harm [Partial / AMBER] • Control: PSIRF, incident learning, mortality surveillance, SJRs and coroner learning. • Gap: timeliness, capacity, closed-loop learning and triangulation with NEWS/sepsis/experience. • Evidence required: actions closed, overdue actions and impact.	**A6/A7 Workforce, maternity and perinatal quality [Partial/Reasonable / AMBER]** • Control: safe staffing, perinatal plans, MIS, LMNS and external review follow-up. • Gap: workforce fragility and culture remain quality exposures; sustained standards required. • Evidence required: safe staffing, vacancy, culture and perinatal standards by Trust.	**A8-A10 Pathway reliability, QIA and patient experience [Partial/Reasonable / AMBER]** • Control: harm review, discharge/UEC controls, QIA/EQIA, complaints/PALS/FFT. • Gap: communication, discharge, learning loops and mitigation tracking not fully embedded. • Evidence required: pathway actions, complaints themes and QIA mitigation impact.

Committee focus: decisions and challenge required today

1. Confirm score	2. Confirm appetite	3. Endorse assurance	4. Demand evidence	5. Pick deep dive
Does 16 accurately reflect Group quality exposure, including SWB/DGFT differential risks and red corporate risks?	Is Progressive appetite right for Quality and Safety, noting current 16 is within appetite but target 8 is below the appetite band?	Does the Committee agree Inconclusive assurance rather than Positive or Negative?	What outcome trajectories prove movement to 8: patient experience, mortality, harm, FoC, PSIRF, maternity, discharge?	Next deep dive: quality intelligence, Fundamentals of Care, mortality/PSIRF, pathway reliability or maternity/perinatal?

The Executive Team will focus on in the next quarter

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Q2 2026 Board Assurance Report

RISK	SCORE (likelihood x Consequence)	CURRENT POSITION
BAF 001 – Quality and Safety: Failure to consistently deliver safe, high-quality care and the quality ambitions of Fit for the Future.	**Current: 16** **Target: 8**	Quality controls are in place, but Group-wide governance, triangulation, learning loops and consistent delivery across SWB and DGFT are not yet fully embedded.
BAF 002 – People / Workforce: *Failure to secure the workforce capacity, capability, leadership, culture and staff experience required to deliver the Group strategy.*	***Current 16*** ***Target: 8***	*Workforce risk remains high due to capacity, sickness, retention, leadership, culture, temporary staffing and inconsistent workforce systems across both Trusts.*
BAF 003 – Partnership / Integration: *Failure to build innovative and outcome-focused partnerships to deliver Community First, Prevention through Partnerships and improved health outcomes.*	***Current:16*** ***Target: 8***	*Partnership arrangements are in place, but maturity varies across Sandwell, West Birmingham and Dudley, with limited evidence of measurable impact on outcomes.*
BAF 004 a– Financial Sustainability: SWB*: Failure of SWB to achieve financial sustainability and deliver the Financial Delivery Plan 2026–2029.*	***Current: 16*** ***Target: 15***	*SWB remains under significant financial pressure, with delivery dependent on grip and control, productivity improvement and full identification of recurrent CIP.*
BAF 004b – Financial Plan: DGFT*: Failure of DGFT to achieve its 2026/27 financial plan, resulting in NHS England regulatory action.*	***Current:16*** ***Target: 8***	*DGFT has established financial controls, but the CIP is not yet fully identified and some recovery schemes are not yet delivering at the required pace.*
BAF 005a – SWB Operational Performance: *Failure to recover and sustain operational performance across SWB, with Group dependencies for access, flow, diagnostics, transformation and productivity.*	***Current: 12*** ***Target: 9***	*SWB has seen improvement in UEC, ambulance handover, planned care and 52-week waits, but assurance remains partial due to cancer, diagnostics/pathology, demand, capacity, productivity and Fit for the Future benefits.*
BAF 005b – DGFT Operational Performance: *Failure to achieve operational performance and deliver strategic goals due to demand and capacity pressures.*	***Current: 12*** ***Target: 9***	*DGFT performance has improved in ambulance handover, RTT trajectory and cancer performance, but risk remains due to demand and capacity pressures, LAT delivery, bed base constraints and constitutional standards.*
BAF 006 – Infrastructure: *Failure to transform infrastructure, estates, facilities, digital, data, technology and sustainability capabilities in line with the Group Strategy.*	***Current: 16*** ***Target: 8***	*Infrastructure risk remains high due to variation in digital, data, estates, cyber, capital and sustainability maturity across the Group.*

Overview

The Trust continues to face intense pressure across emergency, elective and diagnostic services, with workforce shortages, high sickness and a significant ER caseload adding to operational strain. Severe financial constraints, an ageing estate and digital infrastructure, and the Trust's SHMI mortality outlier status further heighten risk. Patient flow remains heavily dependent on system partners, and regulatory expectations around governance and assurance contin to increase. Despite these challenges, the Trust is making steady progress. Stabilisation plan priorities are being delivered, quality governance is strengthening, and targeted improvements in digital resilience and estates safety are underway. Integration with ICB and community partners is improving, and enhanced reporting structures including the updated IQPR, revised BAF and clearer committee oversight are becoming embedded across the organisation.

Common Group-level delivery themes across all BAF Risks Actions

Group delivery theme	*Detail*	*Origin*
1. Group operating model, governance and assurance	*Committee ownership; escalation thresholds; reporting cycles; divisional, place and Trust-to-Group assurance routes.*	*All BAF risks*
2. Group intelligence, data and triangulation	*Quality intelligence; mortality and harm triangulation; workforce, finance and productivity metrics; data quality; shared dashboards; population health insight.*	*Quality; Finance, Operational; Infrastructure; Integration; People*
3. Workforce capacity, deployment, leadership and culture	*Workforce optimisation; safe staffing; sickness; retention; leadership; EDI; FTSU; employee relations; workforce pipelines.*	*People; Quality (for safe staffing)*
4. Quality, safety and pathway reliability	*Fundamentals of Care; PSIRF; mortality; patient experience; maternity and neonatal improvement; discharge; UEC and outpatient pathway reliability.*	*Quality, Finance and Operational*
5. Financial recovery, productivity and Make Money Matter	*CIP; grip and control; budget accountability; vacancy and pay controls; non-pay control; productivity opportunities; contract convergence; capital discipline; benefits realisation.*	*Finance Operational, Infrastructure; People; Quality*
6. Community First, Prevention through Partnerships and care model transformation	*Place priorities; neighbourhood models; patient and public involvement; local authority partnerships; primary and secondary care interface; provider collaborative priorities; community activity.*	*Integration, Quality; Finance and Operational*
7. Infrastructure, digital, estates, cyber and sustainability	*Digital maturity; three-year digital plan; data platform; cyber resilience; technology lifecycle; estate strategy; RAAC; backlog maintenance; Green Plan; strategic estates partnerships.*	*Infrastructure, Finance, Operational and Quality*

The Executive Team will focus on in the next quarter:

Workforce, Culture & Leadership

- Reduce burnout and sickness through targeted wellbeing interventions
- Strengthen divisional leadership capability and accountability
- Accelerate delivery of cultural improvement actions (FTSU, ER reform)
- Improve recruitment pipeline in clinical shortage specialties
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Operational Performance, Flow & Quality

- Increase SAFER compliance and embed new flow model
- discharge partnership work
- Reduce mortality variation through targeted SHMI improvement programmes
- Accelerate sepsis and deteriorating patient pathway compliance

Financial Recovery & Productivity

- Strengthen run-rate control and budget management discipline
- Improve CIP delivery through PMO-supported programmes
- Optimise job planning, e-rostering and agency reduction