Public Trust Board

Tue 09 December 2025, 13:00 - 14:30

Teams

Agenda

13:00 - 13:05
5 min

1. Welcome and Apologies for Absence

Information *Russell Hardy*

Apologies have been received from Ali Koeltgen

13:05 - 13:05
0 min

2. Declarations of Interest

Information *Russell Hardy*

13:05 - 13:05
0 min

3. Minutes of WAHT Board Meeting held on 14 October 2025

Decision *Russell Hardy*

3. Public Trust Board Minutes 14 Oct 25.pdf (3 pages)

3.1. Actions and Matters Arising from the meeting held on 14 October 2025

Information *Russell Hardy*

No open actions

3.2. Foundation Group Public Board Meeting Minutes 5 November 2025

Decision *Russell Hardy*

3.2. Draft Public FGB Minutes - 5 November 2025.pdf (17 pages)

3.3. Foundation Group Board Meeting Actions

Information *Russell Hardy*

3.3. Public Matters Arising and Actions Update Report - 5 November 2025.pdf (1 pages)

13:05 - 13:10
5 min

4. Chief Executive's Report

Information *Stephen Collman*

4. CEO Board Report 09.12.2025 Final.pdf (3 pages)

13:10 - 13:30
20 min

5. Integrated Performance Report

Information *Stephen Collman*

5. Trust Board IPR Dec-25 (Oct-25_Data)_0-1 Final.pdf (23 pages)

5.1. Introduction

Stephen Collman

5.2. Quality & Safety

Jules Walton/Hayley Flavell

5.3. Operational Performance

Chris Douglas

5.4. Workforce

Liz Faulkner

5.5. Finance

Neil Cook

13:30 - 13:40
10 min

6. Safe Staffing Report

6.1. Midwifery

Information *Justine Jeffery*

6.1 Midwifery Safe Staffing Report October 2025.pdf (6 pages)

6.2. Nursing

Information *Hayley Flavell*

6.2 1 Staffing report cover.pdf (2 pages)
6.2 2 Staffing paper October 25 final.pdf (8 pages)

13:40 - 13:50
10 min

7. Maternity Reports

Information *Justine Jeffery*

7.1. Perinatal Safety Report

Information *Justine Jeffery*

7. 1 Q2 2025-2026 Perinatal Safety Report.pdf (29 pages)

7.2. CNST

Information *Justine Jeffery*

7. 2 CNST MIS Year 7 Quarter 2 Report 25-26.pdf (4 pages)
7. 2 App 1 CNST PMRT.pdf (3 pages)

13:50 - 13:55
5 min

8. Board Committee Reports

8.1. Quality Governance Committee

Information *Dame Julie Moore*

8.1 Minutes for Quality Governance Committee October 2025.pdf (8 pages)

8.2. Audit & Assurance Committee

Information *Colin Horwath*

8.2 Audit & Assurance Committee Escalation & Assurance Report November 2025.pdf (2 pages)

8.3. People & Culture Committee

Information *Karen Martin*

8.3. 07.10.25 PC Minutes.pdf (5 pages)

8.4. PFI Exit Committee

Information *Tony Bramley*

8.4 PFI Exit Committee Escalation & Assurance Report December 2025.pdf (1 pages)

13:55 - 14:05
10 min

9. Freedom To Speak Up Guardian Report

Information *Liz Faulkner/Melanie Stinton*

9. FTSU report V1 Nov 25.pdf (7 pages)

14:05 - 14:10
5 min

10. Board Assurance Framework

Information *Gwenny Scott*

10. BAF Coversheet Board December 2025.pdf (1 pages)
10. Board Assurance Framework December 2025.pdf (13 pages)

14:10 - 14:15
5 min

11. Biannual Register of Seal Report

Information *Gwenny Scott*

11. Report on the Use of the Trust Seal 2025-26.pdf (1 pages)

14:15 - 14:20
5 min

12. Charles Hastings Education Centre Update

Information *Tony Bramley*

12. CHEC Update.pdf (2 pages)

14:20 - 14:25
5 min

13. Date of Next Meeting

Information *Russell Hardy*

WAHT Trust Board - 10 February 2026

14:25 - 14:30
5 min

14. Any Other Business & Questions from the Public

Information *Russell Hardy*

14:30 - 14:30
0 min

15. Acronyms

Information

15. Acronyms.pdf (3 pages)

Trust Board
14 October 2025 at 1:00pm
Via Microsoft Teams and live streamed on YouTube
Part 1 in Public

Board Members Present (voting)			
Russell Hardy MBE, Chair	RH	Simon Murphy, Non-Executive Director/Deputy Chair	SM
Stephen Collman, Acting Chief Executive Officer	SC	Hayley Flavell, Chief Nursing Officer	HF
Tony Bramley, Non-Executive Director	TB	Colin Horwath, Non-executive Director	CH
Neil Cook, Chief Finance Officer	NC	Julie Moore, Non-Executive Director	JM
Jules Walton, Chief Medical Officer	JW	Karen Martin, Non-Executive Director	KM
Board Members Present (non-voting)			
Ali Koeltgen, Chief People Officer	AK	Chris Douglas, Interim Chief Operating Officer	CD
Julian Berlet, Chief Clinical Strategy Officer	JB	Sue Sinclair, Associate Non-Executive Director	SSi
Rebecca Brown, Chief Digital Information Officer	RB	Alex Moran, Associate Non-Executive Director	AM
Attending			
Gwenny Scott, Company Secretary	GS	Jo Wells, Deputy Company Secretary	JWe
Richard Haynes, Director of Communications & Engagement	RH	Justine Jeffery, Director of Midwifery	JJ
Rosemary Smart, Patient & Public Forum Chair	RS		
Apologies			
Catherine Driscoll, Associate Non-Executive Director	CDr	Michelle Lynch, Associate Non-Executive Director	ML

Ref	Item	Lead	Purpose	Format
1	Welcome and Apologies for Absence	RH	Information	Verbal

RH opened the meeting by summarising the Board workshop held earlier in the day where a patient story had been shared, as well as discussion in relation to Artificial Intelligence, Annual planning and the Medium-Term Financial Plan.
Recognition was given to Allied Health Professionals on National AHP Day and to Black History Month. RH emphasised the Trust's commitment to inclusivity and zero tolerance for discrimination of any kind.
Freedom to Speak Up Month was also highlighted and colleagues encouraged to raise any concerns.

2	Declarations of interest	RH	Information	Verbal

No new declarations of interest were raised.

3	Minutes and Actions Arising	RH	Approval	Report 1

The minutes of the meeting held on 9th September 2025 were approved.

The action log was reviewed and JW confirmed that stroke incidence is increasing, correlating with the ageing population.

4	Chief Executive's Report	SC	Information	Report 2

SC presented the report and provided the following update:

- Winter preparedness was underway
- Focus was on performance and financial planning
- NHSE and the ICB were reviewing the Trust's forward plans
- Focused work was underway to achieve good vaccination levels across staff groups and the wider population.
- Achievements were recognised with SAS Doctors, apprenticeships and Ward 1 at Kidderminster receiving an exemplary Healthcare Excellence Award.

The Board noted the report.

5	Integrated Performance Report	SC	Information	Report 3

SC introduced the report, highlighting challenges in urgent and emergency care pressures.

Operational Performance (CD)
UEC pathways remain a concern. The Trust is in Tier 2 escalation.
12 hour waits were challenged in September as were ambulance handovers due to high levels of attendance and occupancy.
Initiatives underway include ED navigation, virtual wards and refreshed board rounds.
Positive progress was being made with cancer faster diagnosis performance but challenges remain with 62 day standards and gynaecological commissioning.
Elective care is on track for most targets and specialty improvement plans are in place.

Quality (HF and JW)
Quality standards for fractured neck of femur patients were improving.
Sepsis pathways work was ongoing, integrated with the deteriorating patient pathways, Marthas rule and linked to EPR.
Electronic prescribing to launch next month.
Positive feedback had been received following a visit by NHSE in relation to IPC. The final report was awaited.
An improvement had been seen in complaint response quality and timeliness.

Workforce (AK)
Temporary capacity remains open and teams are scrutinising rates paid to temporary staff.
There is high reliance on temporary staffing, particularly bank staff despite reduced agency usage.
Low vacancy and turnover rates were reported.
Focus was on efficient resource utilisation and scrutiny of recruitment to non-clinical roles.
Sickness remains a concern with initiatives in place to support staff wellbeing and vaccination uptake.

Finance (NC)
The Trust remains at break-even at month five, but there are increasing challenges in the second half of the year.
There is an underlying run-rate challenge of approximately £1 million per month.
The Trust must deliver 4% cost and productivity improvement (CPIP) annually for the next 3.5 years to achieve break-even.
Risks include the delivery of £6 million in system-wide savings related to community bed usage.
Mitigation plans are in place, but further work is needed to mature savings schemes and maintain cash flow.

The Board noted the report.

6	Safer Staffing Reports	JJ/HF	Information	Report 4

Midwifery (JJ)
All shifts were safely staffed in August.
Support staff sickness was reported below target for the first time in 5 years.

Nursing (HF)
Safe nurse staffing levels were maintained throughout the Trust.
RN vacancies were improving.
There was continued focus on reducing bank and agency usage, particularly in areas of additional capacity.

The Board noted the report.

7	Committee Summary Reports & Minutes	RH	Information	Report 5

Quality Governance Committee (JM)
The report taken as read. All relevant matters had been covered during the agenda items.

Audit and Assurance Committee (CH)
An Internal Audit report on Safeguarding was presented to the Committee and provided significant assurance.
An Emergency Preparedness self-assessment had been undertaken, reporting that the Trust was compliant in 59 of 62 standards. 3 were partially compliant.

People & Culture Committee (KM)
The Women's Network is making strong progress.
Updates were received on the resident doctor's plan along with planning progress.

The Committee reports and minutes were accepted.

8	Responsible Officer Report	JW	Information	Report 6

JW presented the report which provided NHSE with assurance that the Trust is compliant with and continues to improve Responsible Officer functions.
KPI's were being developed to allow monitoring and early identification of issues or delays.
Succession planning is underway for the current Deputy Appraisal and Revalidation Lead.

The Board noted the report.

9	Patient & Public Forum Report	HF	Information	Report 7

Ms Smart presented the report and highlighted the following key points:

- Membership had increased to 17, with improved diversity.
- Good engagement was reported with voluntary sector representatives to enhance understanding of community concerns.
- Improvements were noted in Subject Access Request processes.
- A hearing loop audit had been completed and further work was planned with Estates.
- Outpatient cancellations and appointment letter consistency remained areas of concern.

The Patient & Public Forum is open to further Board engagement and welcomed suggestions for increasing diversity.

The Board noted the report.

10	Provider Capability Assessment	SC	Approval	Report 8

A self-assessment had been made against the oversight framework which confirmed compliance in most areas, with partial compliance in health inequalities data and agency reduction monitoring.

The submission was presented for approval to NHSE, following minor amendments made as per Executive feedback.

The Provider Capability Assessment was approved.

11	Date of Next Meeting	RH	Information	n/a

The next WAHT Trust Board meeting in public would be held on 9 December 2025.
The Foundation Group Board would be held in public on 4 November 2025.

12	Any Other Business and Questions from the Public	RH	Information	n/a

There was no other business.

The Board resolved to exclude members of the public from Part II of the meeting as matters under discussion were exempt from disclosure to the public under the Freedom of Information Act.

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams

GEH, SWFT, WAHT and WVT make up the Foundation Group. Every quarter they meet in parallel for a joint Boards meeting. It is important to note that each Board is acting in accordance with its Standing Orders.

Present		
Russell Hardy	(RH)	Group Chair
Ravi Basi	(RB)	Interim Chief Finance Officer GEH/SWFT
Yasmin Becker	(YB)	Non-Executive Director (NED) SWFT
Julian Berlet	(JB)	Chief Clinical Strategy Officer WAHT
Glen Burley	(GB)	Group Chief Executive
Fiona Burton	(FB)	Chief Nursing Officer GEH/SWFT
Adam Carson	(AC)	Acting Chief Executive GEH/SWFT
Oliver Cofler	(OC)	NED SWFT
Neil Cook	(NC)	Chief Finance Officer WAHT
Stephen Collman	(SC)	Acting Chief Executive WAHT/WVT
Lucy Flanagan	(LF)	Chief Nursing Officer WVT
Hayley Flavell	(HF)	Chief Nursing Officer WAHT
Paramjit Gill	(PGi)	Nominated NED SWFT
Sharon Hill	(SH)	NED WVT
Harkamal Heran	(HH)	Chief Operating Officer GEH/SWFT (Non-Voting for GEH)
Colin Horwath	(CH)	NED WAHT
Ian James	(IJ)	NED WVT
Frances Martin	(FM)	NED and Vice Chair WVT
Karen Martin	(KM)	NED WAHT
Dame Julie Moore	(JM)	NED WAHT
Simon Murphy	(SMu)	NED and Vice Chair WAHT
Katie Osmond	(KO)	Chief Finance Officer WVT
Grace Quantock	(GQ)	NED WVT
Sarah Raistrick	(SR)	NED and Vice Chair GEH
Najam Rashid	(NR)	Chief Medical Officer GEH/SWFT
Sarah Shingler	(SS)	Managing Director WVT
David Spraggett	(DS)	NED GEH/SWFT and Vice Chair SWFT
Nicola Twigg	(NT)	NED WVT
Jules Walton	(JW)	Chief Medical Officer WAHT
Robert White	(RW)	NED SWFT

In attendance:		
Leigh Brooks	(LB)	Interim Head of Communications SWFT
Rebecca Brown	(RBr)	Chief Information Officer WAHT
John Burnett	(JB)	Head of Communications WVT
Sarah Collett	(SCo)	Trust Secretary GEH/SWFT
Alan Dawson	(AD)	Chief Strategy Officer WVT
Chris Douglas	(CD)	Acting Chief Operating Officer WAHT
Catherine Driscoll	(CDr)	Associate Non-Executive Director (ANED) WAHT
Geoffrey Etule	(GE)	Chief People Officer WVT
Sophie Gilkes	(SG)	Chief Strategy Officer GEH/SWFT
Richard Haynes	(RH)	Director of Communications WAHT
Oli Hiscoe	(OH)	ANED SWFT

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams

In attendance continued:

Alison Koeltgen	(AK)	Chief People Officer WAHT
Chelsea Ireland	(CI)	Foundation Group EA (Meeting Administrator)
Kieran Lappin	(KLa)	ANED WVT
Tom Morgan-Jones	(TMJ)	Deputy Chief Medical Officer WVT (deputising for Chief Medical Officer WVT)
David Mowbray	(DM)	Group Medical Advisor
Alex Moran	(AMo)	ANED WAHT
Andrew Parker	(AP)	Chief Operating Officer WVT
Bharti Patel	(BP)	ANED SWFT
Jo Rouse	(JR)	ANED WVT
Gwenny Scott	(GS)	Associate Director of Corporate Governance/Company Secretary WAHT/WVT
Vidhya Sumesh	(VS)	Group Business Information Specialist (Observer)
Robin Snead	(RS)	Chief Digital Officer GEH/SWFT
James Turner	(JT)	Head of Communications GEH (present from Minute 25.074)
Ashi Williams	(AW)	Chief People Officer GEH/SWFT
Lesley Writtle	(LW)	Deputy Chair Sandwell and West Birmingham NHS Trust (Observer)

Apologies:

Chizo Agwu	(CA)	Chief Medical Officer WVT
Tony Bramley	(TB)	NED WAHT
Ellie Bulmer	(EB)	ANED WVT
Paul Capener	(PC)	NED GEH
Phil Gilbert	(PG)	NED SWFT
Michelle Lynch	(ML)	NED WAHT
Jackie Richards	(JR)	NED GEH
Sue Sinclair	(SSi)	ANED WAHT
Adrian Stokes	(AS)	Group Strategic Financial Advisor
Umar Zamman	(UZ)	NED GEH

There were five SWFT Governors and two members of public also in attendance.

MINUTE		ACTION
25.063	**CHAIRS REMARKS** The Group Chair highlighted the exceptional work that Andrew Wiliams, Portering and Transport Coordinator for WAHT, had been doing to reduce taxi bills at WAHT. The Group Chair thanked the Portering and Transport Coordinator for WAHT, for his leadership and commitment. The Group Chair also took the time to thank the Urgent and Emergency Care (UEC) team at SWFT for their continued hard work despite significant pressures. He explained that Warwick Hospital's Emergency Department (ED) had seen 393 attendees in one day at the end of October 2025, and only five type one (more unwell patients) attendees less then University Hospitals Coventry and Warwickshire NHS Trust (UHCW). For perspective UHCW's ED was over twice the size of Warwick Hospital's ED.	

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams

MINUTE		ACTION
	The Group Chair ended by welcoming the Chief Nursing Officer for WAHT, and the Managing Director for WVT to their first Foundation Group Boards meeting in their new roles. **Resolved – that the position be noted.**	
25.064	**DECLARATIONS OF INTEREST** Bharti Patel, ANED SWFT, declared that she had been involved in a commercial consultancy capacity with Corbett Keeling Ltd as a healthcare specialist advisor. She also declared that she been supporting University Hospitals Birmingham NHS Foundation Trust (UHB) and SWFT on Aseptic Services, as well as supporting other NHS Trusts where needed. Bharti Patel, ANED SWFT, declared that her daughter had fully qualified as a General Practitioner (GP) and would be taking up a role within the Coventry and Warwickshire system. Her daughter had also expressed an interest to be involved in research activity to support Warwickshire. **Resolved – that the position be noted.**	
25.065	**PUBLIC MINUTES OF THE MEETING HELD ON 6 AUGUST 2025** **Resolved – that the public Minutes of the Foundation Group Boards meeting held on 6 August be confirmed as an accurate record of the meeting and signed by the Group Chair.**	
25.066	**MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.066.01	Completed Actions All actions on the Actions Update Report had been completed and would be removed. **Resolved – that the position be noted.**	
25.067	**OVERVIEW OF KEY DISCUSSIONS FROM THE FOUNDATION GROUP BOARDS WORKSHOP** The Group Chair provided an overview of the Foundation Group Boards Workshop. A series of presentations were received including one on the work that the Foundation Group were doing to be at the forefront of working with Veterans and their families. The Group Chair thanked the Chief Information Officer at WAHT for the work she was doing to support veterans, and WVT who were at the heart of a community who were proud to have a military association. The Group Chair explained that a discussion then took place on the Foundation Group's sustainability work, particularly the work on carbon reduction. The Foundation Group Boards Workshop also talked about neighbourhood plans,	

MINUTE		ACTION

which were part of the NHS 10-Year Plan (10YP), to push healthcare closer to home. Each of the Chief Strategy Officers across the Foundation Group were advancing that work, especially in Warwickshire with the desire to become an Integrated Healthcare Organisation (IHO).

The Group Chair concluded that the Group Chief Executive had also provided a presentation on some of the work he had been doing nationally, including on the National Oversight Framework.

Resolved – that the Overview of Key Discussions from the Foundation Group Boards Workshop be received and noted.

25.068 **FOUNDATION GROUP PERFORMANCE REPORT**

GEH

The Acting Chief Executive for GEH/SWFT provided a summary of performance at GEH. He informed the Foundation Group Boards that it was pleasing to see sustained improvement in cancer targets, particularly the 52-week performance. He explained that GEH were significantly ahead of trajectory with less than 1% of patients on the waiting list waiting over 52-weeks. The Acting Chief Executive for GEH/SWFT continued that his biggest worry was relating to ED performance, and the 12-hour standard. He explained that the Trust had made good progress with 4-hour waits in ED, however far too many patients continued to wait over 12-hours for a bed. This pointed to a wider issue of flow within the hospital, which was driven by a longer than expected length of stay (LoS) for patients, and the number of patients medically fit for discharge (MFFD). The Acting Chief Executive for GEH/SWFT explained that these two areas were the focus for GEH teams, and for the new joint Executive Team for GEH and SWFT over the coming months. He assured the Foundation Gorup Boards that several areas had already been identified where improvements could be made. The Acting Chief Executive for GEH/SWFT highlighted one of the benefits to the new joint Executive Team for GEH and SWFT was the ability to easily share learnings. For example, LoS and MFFD were two areas that SWFT did well, which would support the improvements needed at GEH.

SWFT

The Acting Chief Executive for GEH/SWFT presented the performance summary for SWFT to the Foundation Group Boards. He explained that ED continued to see a sustained increase over the past five years, around 35%, however it had been particularly challenged during October 2025 with some of the busiest days on record. Despite this it was reassuring to see the Trust's Same Day Emergency Care (SDEC) areas working well and helping manage emergency admissions. The Acting Chief Executive for GEH/SWFT explained that this had meant the Trust had not seen the same level of increases in admissions as it had attendances to ED. However, if demands continued at the current rate, the challenge would be unstainable as the Trust did not have the beds or capacity to manage.

MINUTE **ACTION**

The Acting Chief Executive for GEH/SWFT also highlighted SWFT's cancer performance and Referral to Treatment (RTT) target. He explained that the Trust had been slightly off track for the last few months, notably the cancer Faster Diagnostic Standard (FDS). However, it was reassuring to see that in October 2025 numbers had improved. The Acting Chief Executive for GEH/SWFT explained that challenges around the FDS and RTT had been driven primarily due to staffing issues in Dermatology, and an increase in referrals. However, these had been improving with extra staffing, resulting in extra capacity. The Acting Chief Executive for GEH/SWFT was confident that by the end of 2025/26 SWFT would have recovered performance against the FDS, however cancer generally remained challenged across the Coventry and Warwickshire (C&W) system. He assured the Foundation Group Boards that discussion was taking place to address these issues with system partners.

The Acting Chief Executive for GEH/SWFT concluded by raising sickness rates as a challenge for both GEH and SWFT. However new absence management policies had been approved during October 2025, which would support managers with managing sickness but also support staff to remain in work.

The Group Chair invited questions and perspectives and of particular note was the following point.

The Group Chair highlighted UEC demand, and that it was frustrating to see the imbalance across the C&W system compared to other Trusts in the area. He continued that SWFT and GEH were being overloaded with demand and West Midlands Ambulance Service (WMAS) activity, whereas other Trusts were seeing declines in their UEC activity. He expressed the need for rebalancing, echoing the Acting Chief Executive for GEH/SWFT's comments that the current activity was unsustainable. The Group Chair also noted MFFD and agreed that this was an area for focus. He explained that NHS England (NHSE) had conducted a piece of work looking at the costs of MFFD patients being stranded in acute settings. For C&W, the number was £48m a year net cost wasted from patients being in an acute bed when they should be at home. The Group Chair explained that SWFT were amongst the very best in terms of MFFD performance. He concluded by thanking the Chief People Officer for WVT and his team for the work they had done on sickness protocols.

The Group Chief Executive noted that one of the issues with UEC demand was due to patient choice but also there was a bigger issue around flow and patients being treated at home where they could be. However, he reassured the public that work was taking place to look at how capacity could be expanded.

WVT

The Managing Director for WVT provided an update on WVTs performance, starting with its finance. She explained that the Trust's financial position was strong, sitting at £1m better than the planned year to date (YTD) position. The Managing Director for WVT expressed that she was 'blown away' by the

MINUTE		ACTION

engagement from both the clinical and operational teams in relation to cost improvement. She continued that despite this, the Trust was not being complacent and recognised that the second half of the year would be more challenging. Teams were working hard to support divisions to deliver targets.

The Managing Director for WVT reported that UEC continued to present challenges. Type one attendances had spiked in September 2025 but had started to reduce in October 2025, with the Trust remaining below the national average. WVT was undertaking a review to confirm whether the reduction was genuine and to understand the causes, noting that Primary Care had introduced new initiatives. Early Access Standard (EAS) performance remained challenged, with overall performance at 66.7%, which was 0.7% off trajectory. The gap was closing, and improvements were being made. Non-admitted performance stood at 78%, while admitted performance was significantly lower at 38%, which was identified as a key focus area moving forward. The Chief Operating Officer for WVT and other senior leaders were working with teams to improve 12-hour performance. The Managing Director for WVT explained that ED performance was not at the required level and was 1.4% off trajectory. Ambulance handover delays were reported at 68%. An increase in pathway delays was observed in October 2025, partly due to the loss of a care provider in Herefordshire, which necessitated sourcing several emergency care packages over a one-week period. The Managing Director for WVT highlighted ongoing issues related to Powys patients. These patients accounted for 30% of bed days lost, the highest level since May 2025, and stayed in beds 1.8 days longer than English patients. Work was ongoing with the Group Chief Executive supporting discussions with the national team to address this position.

The Managing Director for WVT concluded with an update on the RTT position. The position for September 2025 was 62.2%, with 42 patients waiting over 65 weeks at the end of the month. Improvements were noted, and the Trust was delivering its plan. For 52-week waits, there were 6,198 cases at the end of September 2025, representing an improvement of 80 cases from the end of August 2025. The unvalidated position was reported at 62.8%.

The Group Chair invited questions and perspectives and of particular note was the following point.

The Group Chief Executive noted that highlighting the delivery of some of the financial improvement targets was important. He explained that, beneath the surface, two key factors were driving this progress. Firstly, undertaking more elective work to reduce waiting times for patients; and secondly, innovation and improvement initiatives. He emphasised that this was not about cutting the cost of services in a negative way, but rather about making them more efficient. He commended the team for their efforts.

WAHT

The Acting Chief Executive for WAHT/WVT updated the Foundation Group Boards on WAHT's performance and noted that similar themes had been

MINUTE		ACTION

picked up, however with a slightly different emphasis in terms of messaging and priorities. He reported that the Trust had performed well in the first half of the year financially but faced a significant challenge in delivering the largest efficiency programme the Trust had ever undertaken. He acknowledged the scale of the task but confirmed that the organisation was committed to achieving it. Two areas of progress were highlighted as part of this. Firstly, job planning, which had historically been a difficult area for the Trust, was now showing improvement. Benchmarking had previously placed the Trust amongst the lowest performers, but it was now achieving around 70%, bringing it back into line with peers. A clear plan was in place, led by the Chief Medical Officer for WAHT and the team, and there was positive engagement from divisional leadership, which was encouraging for the remainder of the year and into the next. The Acting Chief Executive for WAHT/WVT continued that reductions in temporary staffing were being seen. The Trust had previously been one of the highest users at 8%, with a target to reduce this to around 2%. Current usage was between 3–4%, representing a six-month downward trajectory. This progress was balanced with bank work, providing headroom to implement structural changes.

The Acting Chief Executive for WAHT/WVT went on to emphasise a cultural shift within the Trust towards simplification, moving away from layering processes and instead focusing on keeping systems straightforward. Linked to this was progress on patient flow, particularly in increasing the number of daytime discharges and reducing length of stay (LoS). This was a major focus within UEC work for November 2025. Plans were in place to standardise the acute medical, frailty, and surgical assessment models for the first time, ensuring consistent timeframes. Work had also been undertaken to reduce bed moves, which were a key indicator of hospital pressure, early results of this were encouraging.

The Acting Chief Executive for WAHT/WVT highlighted an increase in demand, particularly ambulance conveyances, which had risen by 11%. This was likely to be due to Worcestershire work previously being managed outside the county. While this created challenges for frontline teams, the Acting Chief Executive for WAHT/WVT stressed the importance of senior leadership taking responsibility and working collaboratively to develop solutions for UEC pathways in Worcestershire, rather than expecting radical changes from other partners. He concluded by reiterating that behind the performance data were real people, and the Trust remained mindful of patient experience. He noted that he and the Chief Nursing Officer for WAHT had met with individuals who had not had positive experiences within the UEC pathway. The Trust was committed to using this feedback as a springboard for improvement while ensuring clinical teams were not overloaded.

The Group Chair invited questions and perspectives and of particular note were the following points.

MINUTE		ACTION
	The Group Chief Executive noted the issue of UEC demand profile and the increase in ambulance attendances. He highlighted that, across all Accident and Emergency (A&E) departments in the Foundation Group, there was a clear correlation between patients' home addresses and their proximity to the A&E department in terms of attendance rates. He queried whether alternative primary care pathways could be further encouraged in those areas. The Acting Chief Executive for WAHT/WVT agreed, confirming that analysis had demonstrated proximity to hospital as a significant driver of attendances. He reported that work was ongoing with primary care colleagues, Integrated Care System (ICS) partners, and community teams to identify intervention points to prevent patients from presenting at ED. **Resolved – that the Foundation Group Performance Report be received and noted.**	
25.069	**CANCER PERFORMANCE DEEP DIVE** The Acting Chief Operating Officer for WAHT started the Cancer Performance Deep Dive by emphasising that earlier diagnosis and quicker treatment for cancer patients remained a key priority for the NHS and the Foundation Group. He noted that whilst progress had been made, further improvement was required to meet standards and deliver the best outcomes for patients. The Acting Chief Operating Officer for WAHT outlined the standards against which performance was monitored, and this was as follows: • 28-Day FDS – time from referral with suspected cancer to diagnosis. • 31-Day Standard – time from decision to treat to commencement of treatment. • 62-Day Standard – time from referral to treatment completion. The Acting Chief Operating Officer for WAHT explained that the data presented covered April 2025 to August 2025 and longer-term trends. 28-day FDS performance varied across the Foundation Group, while some organisations were performing well compared to peers, none were meeting the national target of 80%. Areas for improvement included Lower Gastrointestinal (GI) and Lung pathways at GEH, Head and Neck and Skin at SWFT, Urology at WAHT, and Breast at WVT. He explained that collaborative work was underway between WVT and WAHT to improve elements of the Breast pathway and noted that achieving the 28-day FDS was critical to improving 62-day performance. The Acting Chief Operating Officer for WAHT continued that the 31-day Standard target was 96%, and GEH demonstrated strong performance. However, WAHT faced challenges at 83.7%, particularly in Skin, Urology, and Head and Neck. SWFT had opportunities to improve in Gynaecology, and WVT in Breast. He explained that access to tertiary providers remained a challenge for GEH and SWFT, impacting reported performance and patient experience. The Acting Chief Operating Officer for WAHT highlighted that WAHT's skin	

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pathway performance at 60% was unacceptable and assured the Foundation Group Boards and members of the public that a recovery plan was in place.

The Acting Chief Operating Officer for WAHT concluded with the 62-day Standard update, noting that the target was 85% and all organisations needed improvement. Specific areas for development included Lower GI, Upper GI, and Colorectal at GEH; Lung, Neurology, and Head and Neck at SWFT; Breast and Neurology at WAHT; and continued progress at WVT in Lower GI, Lung, Skin, and Urology. Collaborative work was ongoing to share capacity across the Foundation Group, particularly to support WAHT's Urology service. He noted significant variation in monthly performance and reiterated that tertiary referrals were a major factor impacting compliance with the 62-day standard.

The Chief Operating Officer for GEH/SWFT presented further detail into the data presented above and emphasised the importance of transparency in reporting cancer performance across the Foundation Group. She highlighted that GEH and SWFT were facing significant challenges and the result of that had seen GEH be put into Tier 1 under the NHSE performance regime. This involved national oversight for areas of significant concern. This status was due to being off trajectory for both the 28-day FDS and the 62-day Standard. Despite this, there had been an improving picture since June 2025, with backlogs reducing and trajectories being met. The aim was to achieve the 28-day Standard by the end of November 2025 and the 62-day Standard by the end of December 2025. The Chief Operating Officer for GEH/SWFT noted that key delays were linked to Diagnostics capacity, which impacted the entire pathway, and actions to address these issues included escalation plans, waiting list initiatives, and process improvements. The Chief Operating Officer for GEH/SWFT explained that SWFT was currently in Tier 2 but was expected to move to Tier 1 due to continued challenges, primarily driven by unprecedented Skin Cancer demand and consultant sickness in Dermatology. The Trust had proactively escalated its position, recognising the risk, including additional pressures such as out of area demand. The Chief Operating Officer for GEH/SWFT offered assurance that recovery plans were in place, and trajectories for improvement were broadly on track, despite sustained high referral volumes.

The Chief Operating Officer for GEH/SWFT outlined systemic challenges across all four Trusts in the Foundation Group, including workforce shortages, reliance on Bank and Locum staff, recruitment difficulties, and Diagnostics constraints, particularly in Pathology. These issues made achieving the FDS difficult, which in turn impacted the 62-day Standard. Variability in Electronic Patient Record (EPR) systems and cancer dashboards added further complexity, although there was good practice to share, such as the adoption of a robust dashboard model.

The Chief Operating Officer for GEH/SWFT stressed the importance of collaborative learning, noting examples where this had been beneficial such as improvements in CT waiting times, one-stop Gynaecology clinics, and shared

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escalation policies. The Chief Operating Officer for GEH/SWFT also highlighted that observing cancer meetings across Trusts had helped empower Nurse Specialists and informed new joint posts and training modules. She also highlighted the 'Living With and Beyond Cancer' programme, which supported patients from diagnosis through treatment and beyond, as a key priority. While performance metrics were critical, the real impact on patients' lives must remain central. Challenges included completing treatment summaries, stratifying follow-up, and addressing funding constraints.

Finally, the Chief Operating Officer for GEH/SWFT referred to cancer patient survey results, which had informed action plans to improve patient experience. She concluded that workforce sustainability was vital and that ongoing collaboration across the Foundation Group was invaluable in addressing performance and process challenges. It was noted that having an external perspective to observe work, particularly in relation to Cancer Services, was extremely valuable given the national challenges in this area.

The Group Chair invited questions and perspectives and of particular note were the following points.

The Group Chief Executive noted the positive level of sharing across the Foundation Group, particularly the collaboration between Cancer Managers. He highlighted a potential opportunity to implement wider best practice around the Teledermatology pathway, referencing the model developed at WVT. He queried whether the impact on reducing activity in the acute setting had been assessed. The Chief Operating Officer for GEH/SWFT responded that progress at SWFT had only been possible due to support from the Chief Operating Officer for WVT and his team. She explained that implementation at SWFT had been challenging, and the ability to lift and shift established pathways had been critical. She noted that the data for SWFT did not currently demonstrate the same level of referral avoidance seen at WVT, but this was likely due to SWFT being later in implementation and having insufficient data at present. She confirmed that baseline data and learning from WVT had been invaluable and expressed gratitude for their support in establishing the pathway at SWFT.

The Group Medical Advisor observed that some cancer pathways were highly complex and largely manual, involving coordination of Multidisciplinary Teams (MDTs), Magnetic Resonance Imaging (MRIs), patient choice, and consultant availability. He queried whether there was any detailed work underway to provide software support for these pathways, noting that inefficiencies had previously arisen due to factors such as consultant leave or equipment downtime. The Chief Operating Officer for GEH/SWFT confirmed that while some tools were in use, coverage was limited. She acknowledged the significant complexity introduced by patient choice and diagnostic requirements. Examples included the use of 'Be True' for follow-up patients, enabling stratification and risk assessment, but there was no system currently managing the pathway end-to-end. She advised that NHSE was developing a tool aimed at streamlining cancer pathways, and GEH and SWFT had

expressed interest in participating in a pilot. Progress was constrained by the EPR implementation at both sites, but she agreed that this represented a gap in NHS capability and an area requiring further development.

Robert White, NED SWFT, asked about the national and regional tiering support and whether these interventions were linked to medical workforce planning, including coordination with postgraduate or pipeline planning. He acknowledged that cancer care extended beyond medical posts but queried whether tiering could influence workforce supply. The Acting Chief Operating Officer for WAHT responded that WAHT had previously been in tiering for cancer and remained in Tier 2. He advised that tiering interventions were primarily focused on immediate recovery and returning to plan rather than addressing longer-term workforce planning. While conversations about additional support occurred, they did not typically feed into strategic workforce development. The Group Chief Executive added that NHSE was reviewing the tiering process in two key areas: firstly, ensuring that organisations delivering agreed trajectories were not unnecessarily retained or escalated within tiering; and secondly, improving the value of interventions offered. He noted that meetings often focused on performance data already known to Trusts and stressed the need for interventions to add tangible value, such as connecting organisations to IT solutions. He confirmed that the review was underway.

The Group Chair noted that evidence clearly showed early diagnosis led to better outcomes and asked the Chief Operating Officers what the three key factors were that were delaying early diagnosis and treatment. The Chief Operating Officer for GEH/SWFT explained that diagnostic capacity was a major constraint. There had been a significant increase in imaging demand from both UEC and suspected cancer referrals, and while straight-to-test pathways were being implemented, workforce shortages and limited capital funding for additional scanners remained significant challenges. She noted that initiatives such as FIT testing for Colorectal Cancer had demonstrated the benefits of early diagnosis, but success depended on sufficient diagnostic capacity. She added that early engagement in Primary Care was another critical factor. Analysis at SWFT had shown that some patients presenting via the ED with suspected Urological Cancer had not previously engaged with their GP despite having symptoms, highlighting the need for improved intervention at Primary Care level. Finally, she identified Pathology constraints as a key issue. Delays in Pathology processes significantly impacted the ability to meet the 28-day FDS, as Pathology was essential for confirming diagnosis. Any delay in this stage affected the entire cancer pathway.

The Chief Operating Officer at WVT agreed and noted that WVT faced similar challenges, particularly in Endoscopy capacity, which was a major constraint for meeting the 28-day FDS. He explained that the introduction of Community Diagnostic Centres (CDC) should improve access to Computed Tomography Colonography (CTC) and MRI prostate scans, but Pathology and reporting remained key bottlenecks. The Acting Chief Operating Officer for WAHT explained that there were numerous screening programmes already in place or

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	being launched, such as lung cancer screening and FIT testing. He stressed the need for providers and systems to ensure that adequate resources were available to deliver these programmes effectively. He added that it was equally important for members of the public to access screening when eligible, as this was the point at which cancers could be detected earlier, making treatment quicker and easier. He noted that early detection not only improved patient outcomes but also reduced treatment costs, highlighting the multiple benefits of screening uptake. The Group Chief Executive agreed with the importance of the public health message around screening and added that the challenge for all trusts was to ensure that the increased diagnostic capacity, including the new CDCs, was being fully utilised. He confirmed that the WVT CDC would officially open within the next few weeks and stressed the need to provide direct-to-test access for primary care, avoiding unnecessary consultant referrals. He suggested reviewing whether best practice in straight-to-test pathways was being delivered. The Group Chair concluded the discussion by requesting a deep dive on capacity constraints and the actions being taken to address the issues. He specifically would like a focus on whether these were within the Foundation Group's control or related to system partners such as Pathology Services or tertiary providers. He reiterated the need to focus on the three key areas previously highlighted by the Chief Operating Officer for GEH/SWFT and confirmed that this would be revisited at the March 2026 meeting. He acknowledged the significant effort across the Foundation Group to improve cancer performance. **Resolved – that** **A) The Chief Operating Officers provide a deep dive on Cancer Services in relation to capacity constraints, the actions being taken to address the constraints and delayed diagnosis, and** **B) the Cancer Performance Deep Dive be received and noted.**	**COOs**
25.070	**GENDER PAY GAP ANNUAL UPDATE** The Chief People Officer for GEH/SWFT introduced the Gender Pay Gap Annual Update report, noting that this was a statutory requirement for public sector organisations and formed part of the wider Equality, Diversity and Inclusion (EDI) compliance framework, alongside the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). She confirmed that the report covered 2025 data and highlighted that women comprised 70–80% of the NHS workforce nationally, a pattern reflected within the Foundation Group. Women were disproportionately represented in lower-paid roles, while men were more likely to occupy managerial and higher-paid clinical positions. Work was ongoing to address this imbalance. She also advised that a new mandatory update was expected in 2026–27 to incorporate	

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intersectionality, enabling reporting on gender pay gaps by disability and ethnicity.

The Chief People Officer for WAHT emphasised that the gender pay gap was not an equal pay issue, which would be unlawful, but rather a result of representation across job bands. Nationally set terms and conditions and incremental pay progression also influenced the gap. While progress had been made, it was too slow, and further action was required. She outlined measures within the Foundation Group's control, including promoting flexible working, supporting carers, and enabling career progression. Initiatives such as flexible paternity leave, women's networks, and showcasing positive progression stories were highlighted as key actions. She stressed the importance of reviewing policies continuously and staying ahead of legislative changes to remove barriers and support women's career development.

The Chief People Officer for WVT reinforced that closing the gender pay gap was not solely about numbers but about creating a supportive environment for female employees. He referenced leadership development, mentoring, and coaching programmes, which would be extended across the Foundation Group. He confirmed that female leadership networks had been established and would work closely with Human Resources (HR) and Organisational Development (OD) teams to implement actions identified in the report. He expressed confidence that these measures would address priority areas and ensure best practice was shared across the Foundation Group, positioning organisations as an attractive and compassionate employer of choice.

The Group Chair invited questions and perspectives and of particular note were the following points.

The Group Chief Executive thanked colleagues for the update and raised a concern about the potential unintended consequence of promoting flexibility as a key organisational priority. He questioned whether increased part-time working could negatively impact career progression and role stability and asked whether this issue was being considered by the working groups. The Chief People Officer for WVT confirmed that this was an important point and would be addressed as part of the ongoing work. He noted that data analysis was a key component of the action plan and that the working groups would explore this area further.

The Group Chair sought clarification on the pay quartile data presented in the report, asking whether the figures indicated that 83% of employees in the upper quartile of pay at GEH were female, compared to 67% at WAHT. The Chief People Officer for WVT confirmed that this interpretation was correct. The Group Chair reflected on the progress made in addressing gender inequality over recent decades, noting that the figures demonstrated significant improvement. He emphasised the importance of continuing this journey and extending progress to other areas of equality, including race and disability. He reiterated that the Foundation Group valued talent, competence, hard work,

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and organisational values above all else and thanked colleagues for the update.

Resolved – that the Gender Pay Gap Annual Update be received and noted.

25.071 **PATIENT INITIATED FOLLOW UP (PIFU) AND CLINICAL ENGAGEMENT UDPATE**

The Chief Medical Officer for WAHT introduced the update on PIFU explaining that PIFU allowed patients and their carers to arrange follow-up appointments as and when needed, based on symptoms and individual circumstances. This approach applied to both long-term and short-term conditions across a range of specialties and supported patient empowerment, shared decision-making, and a more patient-centred model of care. She explained that from an organisational perspective, PIFU contributed to elective recovery plans and waiting list management, enabling more efficient and timely treatment. The Chief Medical Officer for WAHT noted that the Foundation Group was performing well against the national target of 5% of follow-ups being PIFU, with most trusts achieving this threshold. GEH was slightly below target but had made significant progress and was expected to meet the standard shortly. All Foundation Group Trusts were performing strongly in several specialties, placing them in the upper quartile nationally. She emphasised the importance of clinical engagement and leadership in driving success, noting that specialties with strong clinical leads were achieving the best results. The discussion among Chief Medical Officers had highlighted that some services performing less well in PIFU were also considered fragile, and the Chief Medical Officer for WAHT suggested that a future deep dive into fragile services across the Group could be valuable for the Foundation Group Boards. She concluded by inviting questions and comments on the data provided and a broader discussion around clinical engagement and service resilience.

The Group Chair invited questions and perspectives and of particular note were the following points.

The Group Chair supported the proposal regarding a deep dive into fragile services and requested it be added to a future Foundation Group Boards agenda.

The Group Chief Executive raised a concern about whether patients were being placed on PIFU pathways when they could instead be discharged from secondary care. He asked if there was any correlation between PIFU usage and new-to-follow-up ratios, and whether specialties with high follow-up ratios but low PIFU uptake could be targeted for improvement. The Chief Medical Officer for WVT acknowledged the importance of the question but advised that data was not immediately available and committed to providing feedback. The Chief Medical Officer for GEH/SWFT agreed with the Group Chief Executive's observation and noted that some specialties reported strong discharge rates,

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	which needed to be considered alongside PIFU performance. He highlighted that GEH's current PIFU performance was 3.5%, significantly lower than other organisations, and identified opportunities for improvement through alignment with SWFT and closer collaboration across the Foundation Group. He also referenced the potential for shifting follow-up care into community settings via neighbourhood care teams and integrated Primary Care-led models. The Deputy Chief Medical Officer for WVT reiterated the need for further data to address the Group Chief Executive's question but confirmed that some areas demonstrated good discharge rates and increasing use of community pathways to reduce secondary care follow-up. The Vice Chair for WVT stressed the importance of taking a broader view, including referral rates and the impact of CDCs in reducing unnecessary referrals. She emphasised the need for consistency across the Foundation Group, adopting best practice where strong examples existed, while recognising individual clinical practice. The Acting Chief Executive for WAHT/WVT added that patient and population engagement was critical when implementing new models such as PIFU. He cautioned against a paternalistic approach and advocated for incorporating patient voice to ensure changes aligned with patient expectations and improved experience. **Resolved – that** **A) a deep dive into fragile services be added to a future Foundation Group Boards agenda;** **B) the Chief Medical Officers look into whether there was any correlation between PIFU rates, new-to-follow up ratios and discharge rates, and** **C) the PIFU and Clinical Engagement update be received and noted.**	**CMOs /CI** **CMOs**
25.072	**FOUNDATION GROUP BOARDS CALENDAR OF MEETINGS FOR 2026/27** **Resolved – that the Foundation Group Boards Calendar of Meetings for 2026/27 be approved and ratified.**	
25.073	**FOUNDATION GROUP STRATEGY COMMITTEE REPORT FROM THE MEETING HELD ON 18 SEPTEMBER 2025** **Resolved – that the Foundation Group Strategy Committee report from the meeting held on the 18 September 2025 be received and noted.**	
25.074	**ANY OTHER BUSINESS**	
25.074.01	WAHT Staff Car Park	

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	The Group Chair took the time to remind WAHT staff that the Worcestershire County Council car park was available for them to use. **Resolved – that the position be noted.**	
25.075	**QUESTIONS FROM MEMBERS OF THE PUBLIC AND SWFT GOVERNORS**	
25.075.01	SWFT Public Governor (West Stratford and Borders) The following question was asked by a SWFT Governor (West Stratford and Borders): *'What are we doing with our strategy for developing community estate to accommodate the community pathways that we've talked about today?'* The Acting Chief Executive for GEH/SWFT confirmed that significant investment had been made in the community estate, including developments at Lillington Health Hub, Ellen Badger Hospital, and the Orchard Centre in Rugby. He noted that the greatest challenges were in the north of Warwickshire, where there were shared premises with Coventry and Warwickshire Partnership NHS Trust (CWPT). However, a recent agreement had been made with CWPT to improve some of the worst areas in the next financial year. He advised that national changes to NHS Property Services were expected, which could provide greater flexibility and ownership for future investment. A review of the community estate strategy was planned over the next six to twelve months. **Resolved – that the position be noted.**	
25.076	**ADJOURNMENT TO DISCUSS MATTERS OF A CONFIDENTIAL NATURE**	
25.077	**CONFIDENTIAL DECLARATIONS OF INTEREST**	
25.078	**CONFIDENTIAL MINUTES OF THE MEETING HELD ON 6 AUGUST 2025**	
25.079	**CONFIDENTIAL MATTERS ARISING AND ACTIONS UPDATE REPORT**	
25.080	**FOUNDATION GROUP STRATEGY COMMITTEE MINUTES FROM THE MEETING HELD ON 17 JUNE 2025**	
25.081	**ANY OTHER CONFIDENTIAL BUSINESS**	
25.082	**DATE AND TIME OF NEXT MEETING** The next Foundation Group Boards meeting would be held on Wednesday 4 March 2026 at 1.30pm via Microsoft Teams.	

GEORGE ELIOT HOSPITAL NHS TRUST (GEH)
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST (SWFT)
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST (WAHT)
WYE VALLEY NHS TRUST (WVT)

Public Minutes of the Foundation Group Boards Meeting
Held on Wednesday 5 November 2025 at 1.30pm via Microsoft Teams

Signed _____ (Group Chair) Date: 4 March 2026
Russell Hardy

SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
WYE VALLEY NHS TRUST

PUBLIC ACTIONS UPDATE REPORT: FOUNDATION GROUP BOARDS MEETING – 5 NOVEMBER 2025

AGENDA ITEM	ACTION	DUE DATE	LEAD	COMMENT
ACTIONS COMPLETE				
ACTIONS IN PROGRESS				
25.069 (05.11.2025) Cancer Performance Deep Dive	The Chief Operating Officers provide a deep dive on cancer services in relation to capacity constraints, the actions being taken to address the constraints and delayed diagnosis.	March 2026	H Heran / C Douglas / A Parker	
25.071 (05.11.2025) Patient Initiated Follow Up (PIFU) and Clinical Engagement Update	A deep dive into fragile services from the Chief Medical Officers be added to a future Foundation Group Boards agenda. The Chief Medical Officers look into whether there was any correlation between PIFU rates, new-to-follow up ratios and discharge rates.	March 2026 March 2026	N Rashid / J Walton / C Agwu / C Ireland N Rashid / J Walton / C Agwu	
REPORTS SCHEDULED FOR FUTURE MEETINGS				
25.050 (06.08.2025) Equality Update Report	The Chief People Officers include impact data in the annual Equality, Diversity and Inclusion (EDI) report moving forward.	August 2026	A Williams / A Koeltgen / G Etule	An update will be included in the Equality Update Report scheduled for Foundation Group Boards in August 2026.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**09/12/2025**
Title of Report:	Chief Executive Officer's Report
Lead Executive Director:	**Chief Executive Officer**
Author:	Stephen Collman
Reporting Route:	
Appendices included with this report:	None
Purpose of report:	☐ **Assurance** ☐ **Approval** ☒ **Information**

Brief Description of Report Purpose

This report is to brief the Board on various local and national issues.

Recommended Actions required by Board or Committee

The Trust Board is requested to note this report.

Executive Director Opinion[1]

1. Medium term Planning Framework

The national Medium Term Planning Framework was published on the 24th October 2025 and its implications for the framework signals a fundamental shift in how the NHS is expected to plan, finance and deliver care, moving from short-term annual cycles to three time periods.

It sets out both the operational standards we must achieve and the structural reforms we are required to implement. The expectations of the board will be to provide assurance that our response is credible, deliverable and aligned to both national expectations and local need.

The aim is to move away from centralised, directive control towards a model where local organisations are expected to lead change, but with much tighter accountability for delivery and financial discipline.

[1] Executive director opinion must be included and approved by the director concerned prior to issue, except when the director has given their consent for the report to be released.

The framework has three core intentions:

- Stabilise access and performance while redesigning services for long-term sustainability.
- Shift care closer to people's homes through neighbourhood-based models.
- Introduce a more transparent and disciplined financial regime based on productivity and value.

Planning and governance, we are now required to produce:

- 3-year numerical plans covering finance, workforce and operational performance.
- 5-year strategic narrative plans setting out how we will transform services.
- Board assurance statements confirming plans are robust, risk assessed and deliverable.

The Performance expectations are by 2028/29 the NHS is expected to achieve:

- 92% of patients treated within 18 weeks.
- A&E performance of 85% within four hours.
- Diagnostics waits over six weeks reduced to 1%.
- Sustained delivery of cancer standards.

Financial regime and productivity, the financial model is being reset. Core requirements include:

- Delivery of at least 2% productivity improvement each year.
- Balanced or surplus financial position across the planning period.
- Exit from reliance on deficit support funding.
- Replacement of block contracts with new payment and incentive models.

Service transformation, the framework requires deep structural change, including:

- Moving outpatient care to digital-first, patient-led models.
- Reducing low-value and unnecessary follow-up appointments.
- Expanding neighbourhood health services to reduce hospital dependency.
- Greater use of Advice and Guidance and direct access to diagnostics.
- Full adoption of digital platforms and electronic patient records.

2. Flu and Urgent Care pressures

The Trust has experienced a significant increase in attendances to our Emergency Departments, Same Day Emergency Care Centres and Kidderminster Minor Injuries Units. This has been for adults and children. We have seen an upturn in respiratory conditions including flu.

We are encouraging our colleagues and anybody eligible for a vaccine to take it. We are in a crucial two-week period leading up to Christmas.

3. Digital

The Trust is holding an Artificial Intelligence clinical summit on Monday 15th December. We are engaging with our clinical teams to drive the uptake and deployment of clinical solutions.

4. More From Our Great Teams

Congratulations to everyone who has been involved in the implementation of Electronic Prescribing and Medicines Administration (EPMA) across our hospitals, following months of hard work and planning.

EPMA is the next phase of our Electronic Patient Record (EPR) system 'Sunrise EPR' which went live in 2023 and provides the Trust with a digital system to improve patient safety and efficiency in managing medications.

EPMA will streamline the process of prescribing, dispensing, and administering medicines, replacing our paper-based systems, and supporting improvements in safety, efficiency, and the accuracy in medicines management for our patients. It will also support our efforts to improve patient flow, enabling efficient discharge by allowing digital prescriptions to be finalised ahead of time and shared directly with GPs and community pharmacies.

The phased rollout, which represents the next stage on our journey of continuous improvement and digital transformation, took place in November over an intensive week-long period. It was fully supported by a dedicated 24/7 helpline, digital team walkabouts and face-to-face support supported by one hundred Digital Champions across all implementation areas.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Integrated Performance Report

Trust Board

DECEMBER 2025

ACTING CHIEF EXECUTIVE OFFICER – EXECUTIVE SUMMARY

Stephen Collman

Acting Chief Executive Officer

As in the last report, managing the high demand for our urgent and emergency care (UEC) services remains our highest operational priority. The number of people attending our Emergency Departments (ED) continues to grow and in October we saw even higher numbers than in October 2024, meaning we were unable to improve our waiting time performance. We continue to collaborate with our partners to improve the flow of patients into and out of ED and back home after treatment and we are taking a wide range of actions to improve long waits within ED. Our Friends and Family Test results for ED indicate a small improvement in patient experience.

We have seen our first flu and norovirus of the season – managing this well over winter will be essential but challenging if demand continues to exceed capacity but we have positive assurance that we are compliant with national infection control standards.

Due to the high demand for UEC, we frequently need to use areas to treat or admit patients which are not ideal for that purpose. We have changed the way we monitor and report this to NHS England so that we can better understand the issue and put plans in place to reduce and make it as safe as possible.

Away from UEC, our performance continues to improve on our cancer and elective care metrics and we are confident in hitting our year-end targets.

In terms of our workforce, our metrics are largely positive and while sickness absence is up a little compared to last year, I am pleased to see that stress as a cause of sickness has reduced significantly.

Reducing our use of temporary staffing remains a considerable challenge and priority. We have enhanced oversight with a new Agency Programme Board, as our performance so far this year is having an impact on the delivery of our financial plan.

Although year to date we report a break-even position against our financial plan, achieving the plan for the full year is dependent on delivery of our cost and productivity improvement programme (CPIP), which is not where we need it to be. We have a financial recovery plan in place which is being very closely monitored by the Executive Team.

OUR QUALITY & SAFETY

Dr Jules Walton

Chief Medical Officer

Fractured neck of femur surgery is still not quite where we need it to be to deliver best outcomes for our patients, especially with respect to time to theatre. The opening of the additional trauma ward has had a positive benefit, and the length of stay of this patient group is generally good. Challenges remain in moving patients across from the Alexandra Hospital to Worcestershire Royal for surgery.

Care of the deteriorating patient, including sepsis remains under review with working parties looking at integrating NICE guidance with our EPR and allowing a workflow that follows national best practice. The hospital outreach team is working, and components of Martha's rule to identify early deterioration on wards are being trialled this month. Overall, sepsis outcomes remain as expected for our hospital.

In October cases of CDiff increased to 70 (from 58 in September) but still below the threshold of 75. E Coli has increased with a YTD total of 69 (threshold 65). MSSA increased by 3 with a YTD total of 22, with the threshold at 25. MRSA had 0 cases in month with a Year to date total of 5, already failing threshold of zero. Klebsiella increased in month with a total of 26 (threshold 20) along with pseudomonas aeruginosa BSI is increasing in month with a YTD total of 13 (threshold 8). All of the eleven high impact intervention audits were compliant in October . The Trust has seen its first flu and norovirus outbreaks of the Winter season, and risks that continue to be identified are the timely isolation of infective patients alongside the capacity challenges, which sits as an extreme risk number 4816.

Hayley Flavell

Interim Chief Nursing Officer

The complaint compliance target to close within 25 days decreased to 62.5% in October . The Trust had an increased number of complaints still open at the end of October at 137 compared to 117 in September 25. Surgery Division account for 42 of the 137 open complaints followed by Urgent Care at 33, and a total of 35 complaints overall had breached 25 days.

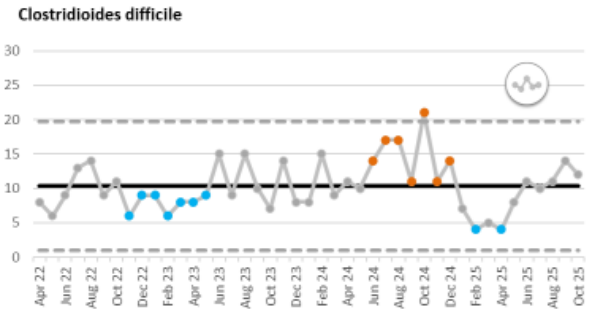
The total number of falls in October has increased to 122 (from 104 in September) but remains below the national benchmark with 4.5 total falls per 1,000 bed days (national benchmark of 6.63). Highest number of falls were in Urgent Care (41) due to increased LOS and acuity, with 0.82% classed as moderate harm, and 0% with severe harm. 379 people presented to ED with a fall as the chief complaint in October (319 in September) The total number of HAPUs in October increased to 29 from 20 in September . (There were 1.09 HAPU per 1,000 bed days an increase from 0.77 in September). There were 2 x cat 3 (Speciality Medicine) and 1 x Cat 4 (Surgery) HAPU's reported in October. Round tables are in progress.

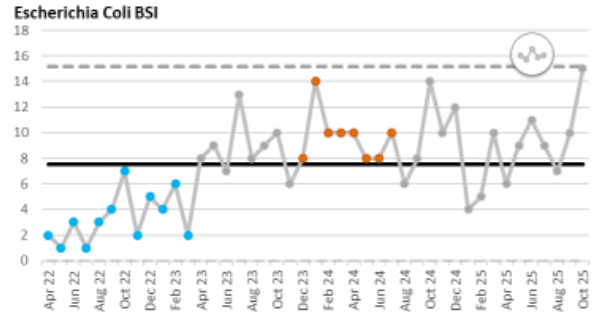
The friends and family recommended rates have met the recommended target (95%) across inpatients (96.5%) Maternity have decreased this month to 93% failing to reach the target along with Outpatients at 93.8% . ED rates have increased to 82.3.%. The Healthcare Standards Team continue to monitor and review the use of FFT throughout QAV visits and Ward Accreditation processes, alongside the Inpatient Survey. New reporting in IPR in October is Planned escalation and temporary spaces (TES). The total number of patients that spent time in a planned or TES in October was 1115, at an average of 36 patients per day. This is an increase from September where there were 998 (average 33).

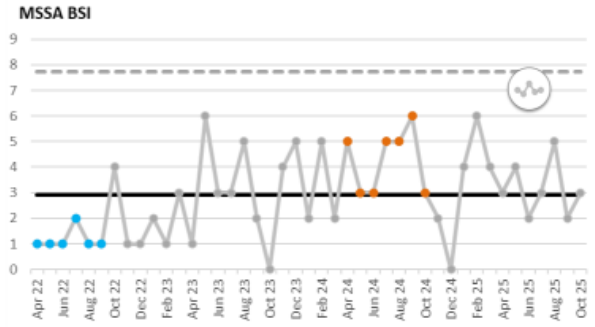
OUR QUALITY AND SAFETY – INFECTION PREVENTION & CONTROL (IPC) (part 1)

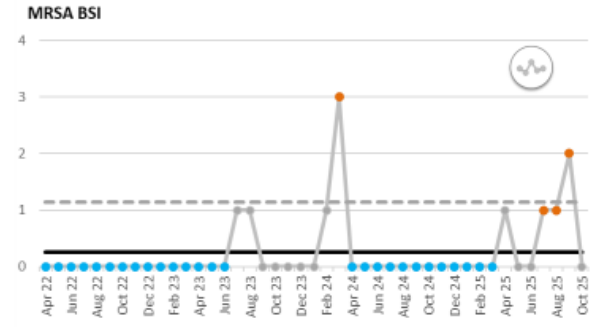
We are driving this measure because

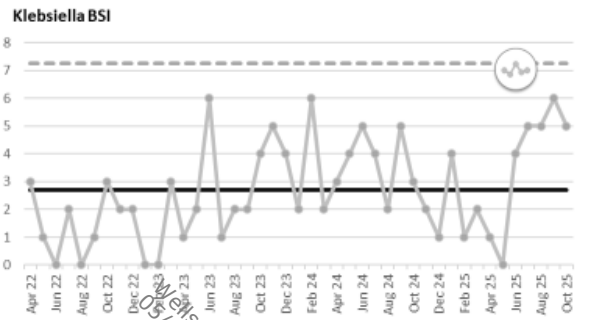
There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.

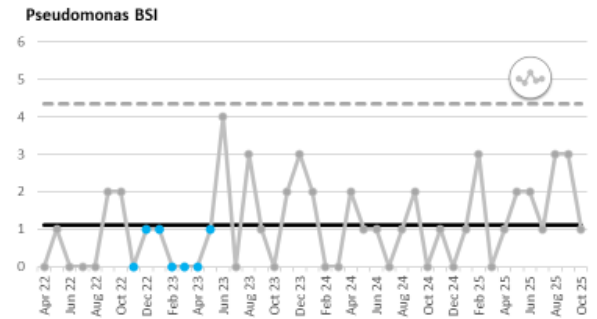


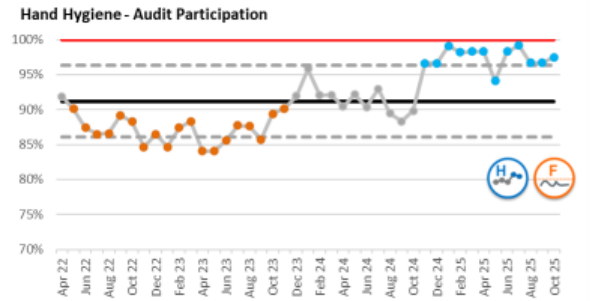


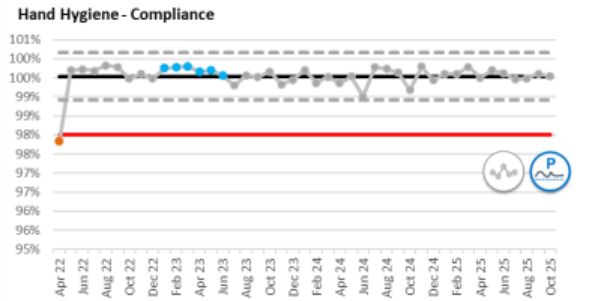












Alexis Jo
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OUR QUALITY AND SAFETY – INFECTION PREVENTION & CONTROL (IPC) (part 2)

We are driving this measure because

There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.

Understanding the performance

- *Clostridiodes difficile* (C.diff) dropped in Oct-25 (12 c.f. 14 in Sep-25) and the year-to-date total of 70 is **below** the target (75).
- E-Coli BSI increased in Oct-25 (15 c.f. 10 in Sep-25) and the year-to-date total of 69 is **above** the target (65).
- Internal ambition: MSSA BSI increased in Oct-25 (3 c.f. 2 in Sep-25) and the year-to-date total of 22 is **below** the target (25).
- MRSA BSI dropped in Oct-25 (0 c.f. 2 in Sep-25) but the year-to-date total of 5 has already **failed** the year-end target (0).
- Klebsiella species BSI dropped in Oct-25 (5 c.f. 6 in Sep-25), but the year-to-date total of 26 is **above** the target (20).
- *Pseudomonas aeruginosa* BSI dropped in Oct-25 (1 c.f. 3 in Sep-25) , but the year-to-date total of 13 has **exceeded** the target (8).
- Hand Hygiene Compliance (99.5%) has met the target (98%) every month since Apr-22 and is showing common cause variation.
- Hand Hygiene Audit participation increased in Oct-25 (97.5%) and is still showing special cause variation of improvement.
- All eleven of the High Impact Intervention (HII) audits were compliant (95%) in Oct-25.
- The Trust has seen its first flu and norovirus outbreaks of the winter season along with continued COVID outbreaks which put pressure on flow with blocked beds.
- Our internal ambition for no more than 40 cases of MSSA per year will remain in place for the new financial year, focus needs to continue on the use of PVD packs and documentation on EPR system.

Actions (SMART)

- Focus during October has been on diarrhoea and vomiting management to prevent outbreaks of C.diff. The Trust has not reported any C.diff outbreaks. The Trust continues to be below threshold however the ICB and NHSE have raised concerns over the PII's that the Trust has declared. All samples have been sent for ribotyping and have shown no links. Therefore, no C.diff outbreaks have been declared. The ICB will attend weekly the Trust weekly meetings between the IPC team and consultant microbiologists.
- Divisions have reviewed patients with C.diff for October and are due to be presented to the TIPCC HCAI Scrutiny and Learning Group in November.
- AMS pharmacist is reviewing all cases of CDI and ward Hot Spots/PII's. Any issues identified with antibiotic prescribing is fed back to the prescriber. All cases are reviewed at the weekly Microbiology meeting. Reviews from previous cases show delays in sampling and isolation of patients as recurrent themes and trends. These are being actioned in divisions.
- The team continue to participate in the system IPC meetings led by NHSE to review C.diff and continue to attend the weekly NHSE briefings. The Trust is also attending the CDI review meetings instigated by the ICB focusing on the identification and treatment of C.diff relapses.
- All MRSA cases are reviewed by an MDT and lessons learned shared throughout all divisions. Current themes and trends identified include correct admission screening to include urine and wounds, PVD management and MRSA decolonisation for previously colonised patients.
- The MRSA policy has been adopted at TIPCC meeting as Is being launched with a newsletter throughout the Trust.
- IPC have continued to support capacity and flow with guidance for isolation of patients and the development of the Winter Respiratory Virus plan and the CPE contact SOP for the allocation of side rooms.
- IPC team held link staff day for Trust staff focusing on winter management and cleaning of equipment and the findings from the NHSE visit in September
- IPC projects and focus – gloves off, Scrub the hub, reduction in the use of couch roll. Single use BP cuffs and the removal of the I am clean stickers and replace them with ward and area cleaning checklists are in progress.
- The implementation of bed cradles for alcohol hand gel for hand hygiene at the point of care has been completed.
- IPC monthly newsletter has been distributed

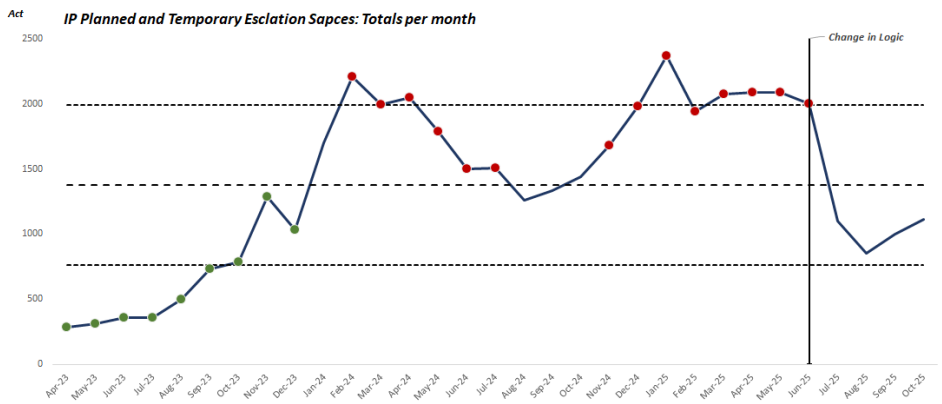
Risks

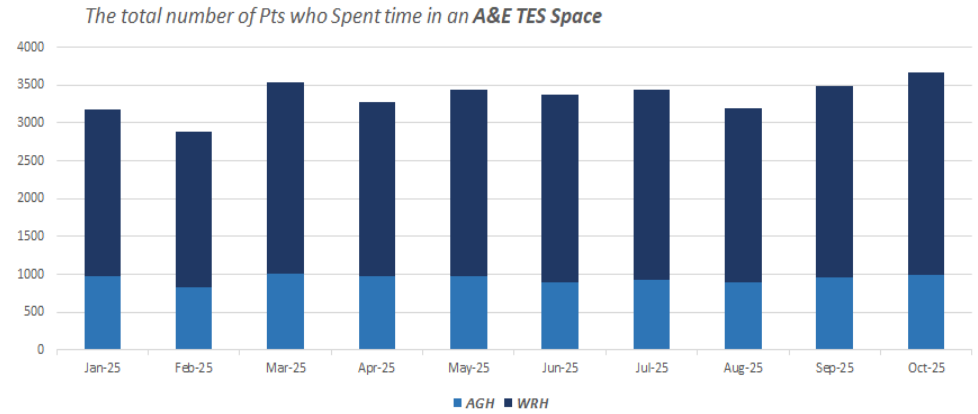
- Capacity: Extreme risk 4816. The level of activity and high level of bed occupancy limits the ability to isolate patients in a timely manner, increasing risk of infection spread. This has been particularly challenging during this summer period. The impact is mitigated where possible, but a number of patients with infections have been unable to be isolated. This has impacted on the cleaning and deep cleaning of areas.
- The Trust has seen an increase of COVID positive patients during September and October
- Winter Respiratory plan has been developed and shared with key stakeholders including capacity. There is a risk matrix for the implementation of fluid resistant face masks throughout the organisation
- IPC team attend capacity meetings to ensure flow through the organisation
- IPC staffing: The Data Administrator has retired, and the nursing staff have picked up some of the roles but are unable to take on all-background codes for ICNet, this will affect how the surveillance system functions. IPC Nursing the team has long term sickness, which affects our viability and time for completion of proactive projects. IPC team sickness for quarter 2 showing a sickness rate of 13.09%
- Continuing bedpan washer issues impact the ability to undertake high level disinfection of bedpans and other items. Work on a solution is in progress with trials of equipment now completed and a preferred supplier identified.. Estates are working with Equans on the commercials to replace the bedpan washers with maceraters.
- Food macerators in zonal kitchens. These have now been capped off but do not meet the Trusts expectations, a view which is supported by ISS. Discussions in progress with PFI partners to remedy this.
- Mattresses – concerns have been raised that mattress covers are failing their fluid ingress tests sooner than expected and soiled mattress covers returned to the company for disposal have been returned to site. The mattress team have robust procedures in place to ensure that the damaged mattresses and covers are not being reused. Meetings are taking place with the company to resolve the issues.
- IPC staffing:

OUR QUALITY AND SAFETY – PLANNED ESCALATIONS AND TEMP SPACES

We are driving this measure because

The submission of Planned and Escalation spaces is part of our national Urgent Care SITREP Submission, and we are monitoring this to eradicate the use of temporary or planned escalation spaces used to treat patients. .





Understanding the performance

- Numbers submitted nationally for IP are split into two areas which are Planned Escalation spaces and Temporary Escalation Spaces.
- Planned escalation spaces include patients that are boarding and those patients that might have been bedded in an SDEC area overnight.
- TES numbers relate to those numbers where a ward is exceeding their core capacity

- The total number of Pts that spent time in a planned or Temporary Escalation space in October was 1,115 patents which accounted for an average of 36 patients per day.
- Most of these patients are at Worcestershire Royal Hospital .
- This has seen an increase compared to the previous month of September where there were 998 patients spend time in a planned or escalation space - which is 33 per day on average

- Numbers submitted for A&E TES spaces are based on any Patient in the previous 24-hour period who has spent Over 5 mins in an ED TES space which is a Corridor or a location marked as overflow. Pts are only counted once in a 24-hour period should they occupy more than 1TES Space
- In October across the 2 ED Sites a total of 3,674 patients met the above criteria – this was an average of 118 per day
- This EAS an increased from September where there were 3,485 instances or 116 per day

Actions (SMART)

- The logic behind the Planned TES numbers both for A&E and IP is constantly under review to ensure that it is a representation of the situation throughout the trust.

- A SOP is currently being worked on by the Deputy CNO's around TES and planned occupancy throughout the trusts and discussions are going around what is deemed as a TES and planned escalation space.

- Along with submitting these numbers nationally each day as part of the UEC SITREPS, numbers are provided to Clinical Governance each month as part of there reporting.

- The information team also produced a report at patent level which provides the details of all patients that have been a boarder showing which ward they were on and the total time spent boarding. This can be used for quality reviews or any DATIC if there are any.

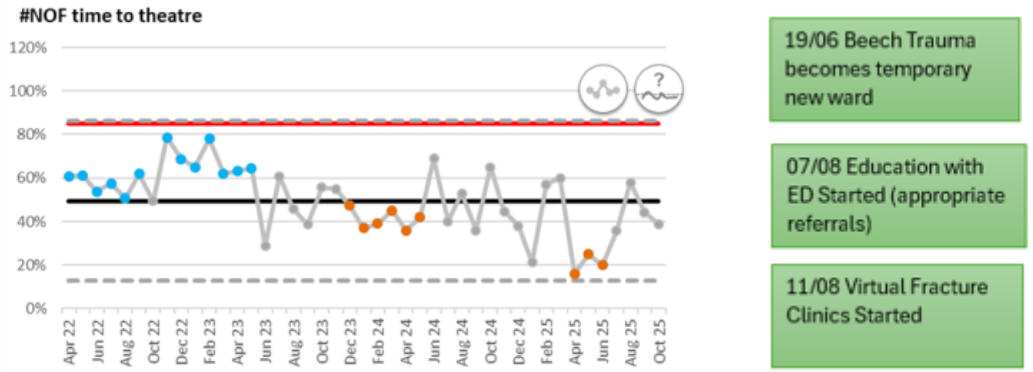
Risks

- Risk to the quality of care received by the patient due to being in an inappropriate clinical area
- Overcrowding in A&E and on IP wards
- Reputational damage to the Trust due to high numbers.

OUR QUALITY AND SAFETY – FRACTURED NECK OF FEMUR (#NOF)

We are driving this measure because

Prompt surgery and appropriate involvement of geriatric medicine has benefits in terms of improved patient outcomes, increased number of independent individuals and reduced mortality, shorter length of stay and more cost-effective care.



Understanding the performance

- #NOF compliance dropped in Oct-25 to 36.2% for BPT patients, and 38.8% for All patients.
- The target (36 hours) has still not been achieved since Mar-20.
- There were 69 (BPT) and 80 (All) #NOF Admissions in Oct-25
- There were a total of 44 (BPT) and 49 (All) breaches in Oct-25
- The primary reasons for BPT breaches in Sep-25 were Theatre capacity (27) and medically unfit patients (9).
- The average time to theatre was 49.1 hours (BPT) and 47.9 hours (All).
- The Trusts Crude Mortality Rate for the period Sep-24 to Aug-25 was 13.68% for the diagnostic group #NOF (in-hospital 5.36% & Out of hospital 8.32%)[1]
- This is the 16th lowest (of 20 Midland Acute Trusts), with the figures ranging from 6.85% to 19.02%.[1]
- The ALOS for #NOF patients in the period Sep-24 to Aug-25 was 13.87 days.
- This is the 4th lowest ALOS amongst Midland Acute Trusts during this period, with figures ranging between 10.99 days and 30.62 days[1]

[1] *Source: HED, accessed 14/11/2025.*

Actions (SMART)

- *Not provided*

Risks

- **Risk 4873 (15)** - Risk of patient harm due to exceeding 36 hours to theatre for repair of fractured neck of femur. Risk action 30877 – 30/04/2026 Continue to monitor effectiveness of Beech Trauma as a temporary solution
- Theatre and bed capacity continue to be the biggest risks to the effective delivery of the #NOF pathway.

OUR OPERATIONAL PERFORMANCE

Chris Douglas

Chief Operating Officer

Our hospitals have continued to remain busy in October, with high numbers of people attending our Emergency Departments, with almost 5% more attendances compared to the same month last year, with over 14000 attendances. Capacity in our systemwide urgent care services has not kept pace with this demand and this has contributed to continued delay in our ability to bring patients into our Emergency Department as well as challenges with increasing the number of patients from our inpatient beds who are ready to leave earlier in the day. Teams within the organisation are working hard to drive forward the improvements we need to make. This includes new initiatives including our Care Navigation pilot in our Emergency Department at Worcestershire Royal site and the reconfiguration of our Acute Medical capacity to create capacity for patients referred to our medical teams can be seen in an alternative setting away from the Emergency Department, which launched two days ago at the time of writing, and we are already seeing benefits for our people – both colleagues and patients. Our new approach to providing care to patients will launch in December too. There is more work to do with system partners from the Health and Care Trust and ICB, with the support of regional and national colleagues from GIRFT to continue our improvement journey.

For patients referred to us with suspected cancer, we have seen a good recovery of our diagnostic performance, with 79% of patients receiving their diagnosis within 28 days, just 1% point short of the national target and we are on track to deliver this in line with our planning commitments. At this stage though this has not translated into increasing the number and percentage of patients who are receiving treatment within 62 days of referral and have too many patients waiting more than this time. Our immediate focus in on reducing the number of patients who have waited more than 62 days, whilst not increasing their number so our reported performance against this standard isn't likely to recover until the early part of 2026. We have been fortunate to have the support of the West Midlands Cancer Alliance who have provided funding for a number of schemes, which are supporting our clinical and operational teams to make it better for our patients.

Our performance in elective care continues to improve and we have seen further reductions in the number of patients waiting for more than 52 weeks, however we are behind our plan with four specialties which are gastroenterology, ENT, OMFS and T&O requiring further actions. Additional capacity for gastroenterology to see nearly 800 patients waiting for a new appointment has commenced and teams are working with local independent sector providers to support work in our ENT and T&O services. Our planned care improvement journey isn't just focussed on doing more of the same, but also in the transformation of the way we deliver services including the increasing the number of patients we are able to treat on our theatre lists and increasingly given more choice to our patients about whether they need to come to our hospitals for follow up appointment through our adoption of Patient Initiated Follow Ups.

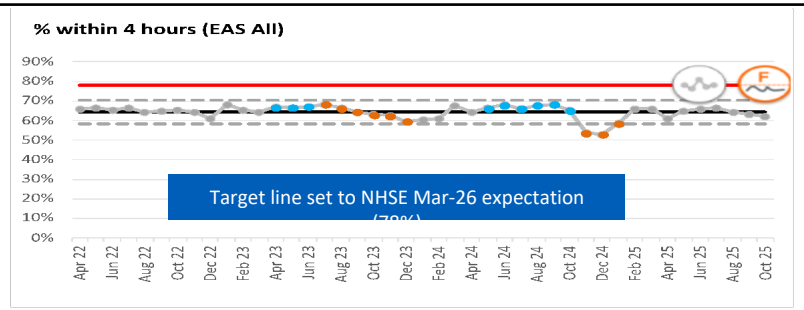
We continue to seek new and improved ways of delivering our services and work has commenced to scope out use of the volunteer sector to help reduce theatre cancellations and during November we are working with stakeholders to shape the future of our outpatient's strategy for the next 5 years which will inform our plans for improvement and transformation aligned to the 10-year plan ambitions and medium-term planning framework.

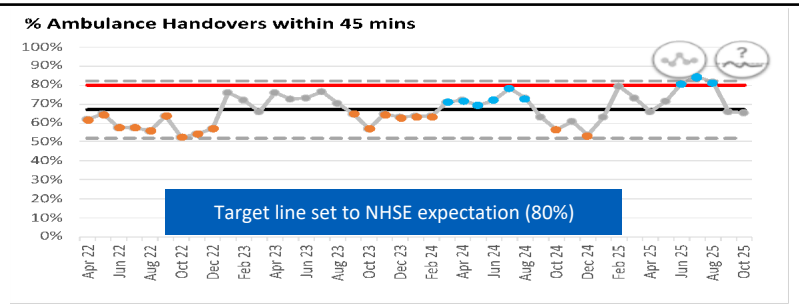
To support all of this, in November we have launched our very own Proud2bOps@Worcestershire Acute, bringing together over 50 operational managers as the starting point of our development and professional network for our operational management teams, who will lead service delivery, improvement and transformation into the future as we continue our improvement journey.

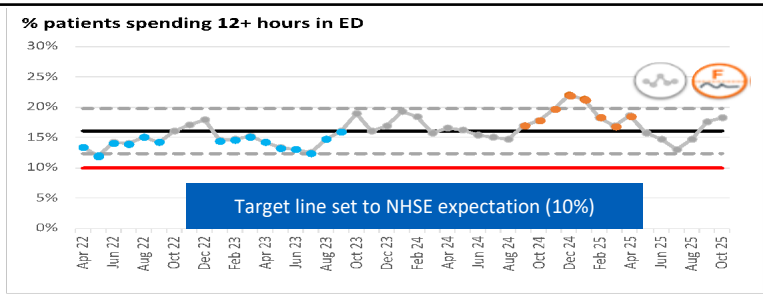
OUR OPERATIONAL PERFORMANCE – URGENT & EMERGENCY CARE

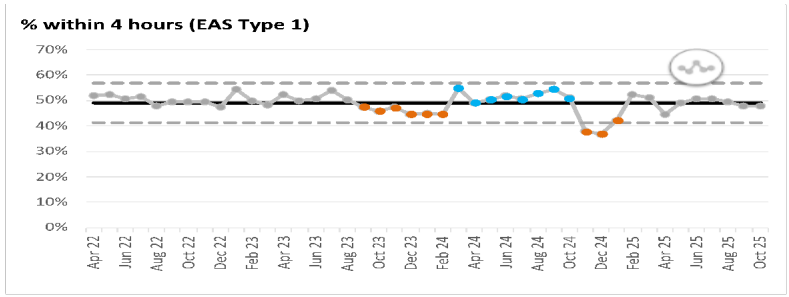
We are driving this measure because

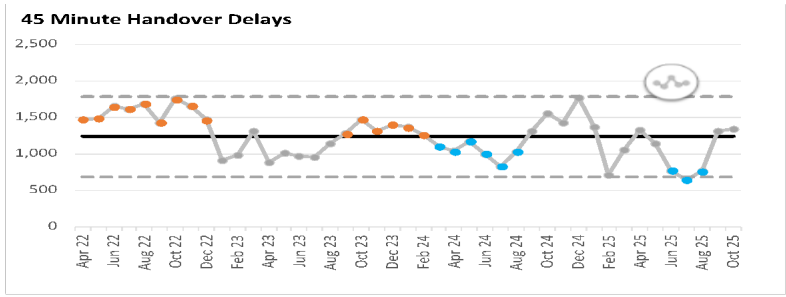
The national Emergency Access Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at any Emergency Department. In addition, the effective and timely handover of patients arriving by ambulance enables patients waiting in the community to access care in a timelier manner and is an indicator of system flow.

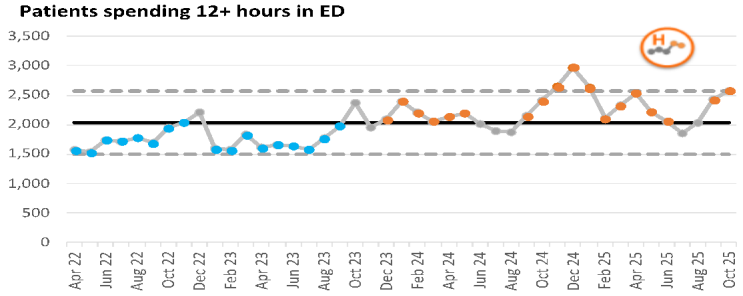












Understanding the performance

- There is no change in statistical significance across the metrics in this report apart from % ambulance handovers within 45 minutes.
- 14,073 patients attended our type 1 sites in October (at an average of 454 per day) which is a 4.3% increase compared to October 2024.
- October was the eight month in a row where WRH had more than 8,000 attendances.
- The percentage of ambulance handover breaches under 45 minutes was 65.2%; 80% is the NHSE baseline expected performance for this measure.
- The percentage of patients spending more than 12 hours in our emergency departments is showing normal variation even though the number of patients breaching is a concern.
- Time to triage performance has been steadily improving.

Actions (SMART)

- ED rota's being reviewed 3 ED consultants recruited and this will allow for substantive cover 8-10pm. Consultant start dates are 20th October, 5th Jan and one already in post. ECIST report awaited (still live action as of 17/11/25 – ECIST contacted)
- Acute Medicine focus on Ward Round and Consultant cover until 7pm being explored – job plans are being reviewed to support this later ward cover. ECIST support in place.
- Internal proactive triggers and escalations process – meeting scheduled 18th November. Meeting arranged with Health and Care Trust to look at co-designed escalation process. This is a large programme of work that will require a systematic approach to ensure delivery of the triggers.
- Paediatric winter plan being circulated prior to DMT sign off
- Data review complete on ED/Radiology processes – meeting to be held next week to create improvement plan and finalise KPI's internally
- Live speciality review time dashboard now in use – All teams to review and action in real time
- AMU reset PDSA live on both sites from 17th Nov – 4 week pilot of AMA model
- As per above – all GP Expected to go to AMU from reset date
- AFU effective boards rounds live – objective to drive LOS down to 72 hours using GIRFT acute care standards implementation
- Review of progress chaser roles underway, posts now approved as interim arrangement whilst role reset completed within Division
- Extra 'fit to sit' chairs added to medical SDEC to increase capacity
- SAU audit underway to establish main roots causes for flow before creating an improvement plan for SAU and trauma wards.
- Proud to be Op's launch on 20th November. National team to support. Paret of this programme will support linking operational development programme to collaborative improvement in patient pathways.

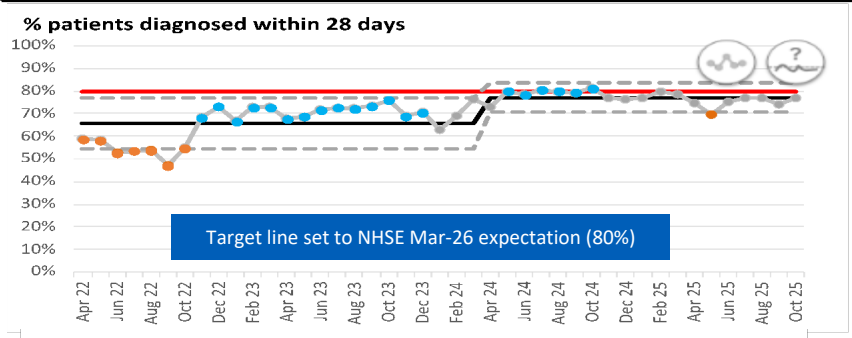
Risks

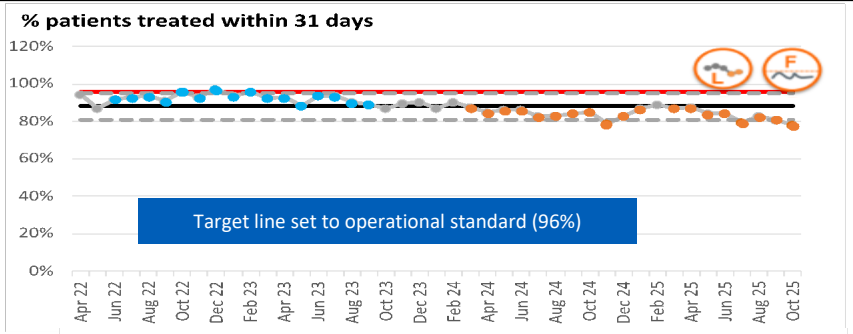
- Patient delays in waiting room and public behaviour (attending ED as opposed to accessing alternatives)
- Continued growth in attendances, which is above expected levels.
- Engaged approach to delivery of escalation actions, which could be challenging. New approach and time to embed may prove hard to accommodate.
- Inconsistency in offer of alternative pathways for ED/SPOA to access
- Hospital flow and late discharges – transport capacity
- Navigator streaming options external to organisation in development and consistency of use by WMAS
- Long delays for Ambulance Patients resulting in increased risk of harm and deteriorating patient (GRAT process in place for assessment)
- Acute Oncology capacity
- WMAS uptake of call before you convey and redirection before ED
- Financial risk associated with managing safety in overcrowded department
- Additional capacity driving overspend and need to implement mitigating action to manage safety.
- Organisational challenges regarding increased reporting/assurance and resource
- System wide closure of beds resulting in increased length of stay for pathway patients
- Potential closure of PDU reducing bed base
- Long waits for time to be seen in ED, Rota changes delayed and time to implement may not meet timescales for required change.

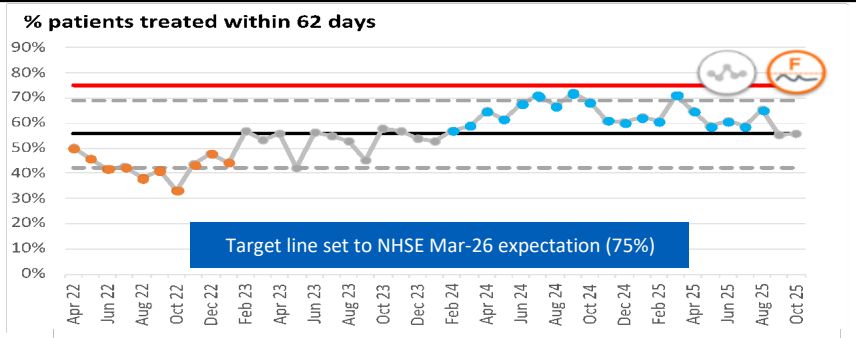
OUR OPERATIONAL PERFORMANCE - CANCER

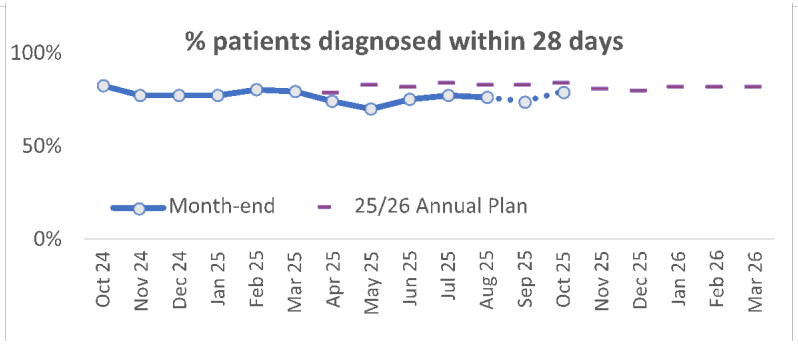
We are driving this measure because

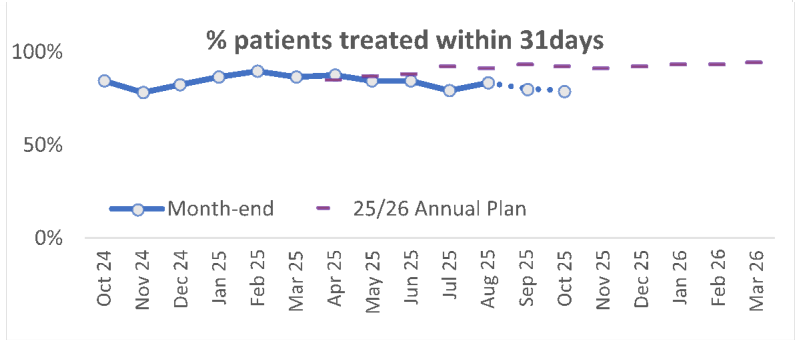
Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime.

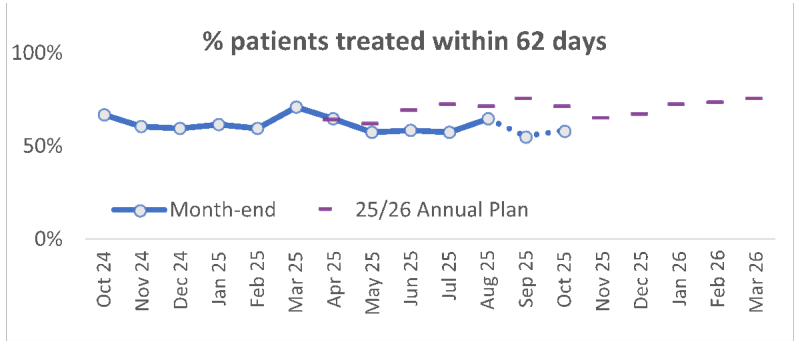












Understanding the performance (provisional)

- We received 2,950 cancer referrals in October; this is now a "normal" amount in a month. Skin accounted for 27% of all referrals received.
- 28-day performance is at 79% and below our annual plan target but in-line with our recovery trajectory.
- The 31-day performance (80%) is below our annual plan target. 5 specialties achieved the 96% operational standard but were all low volume contributions.
- The 62-day performance (59%) is below our annual plan target.
- Skin and Urology are the specialties that are contributing 61% of patients to the backlog of patients waiting over 62 days.

Actions (SMART)

- Ongoing weekly oversight meetings with ICB and NHSE as part of tier 2 oversight framework.
- Breast – action plan in place with improvements starting to show in performance. Success with bids to WMCA and NHS England to support outsourcing arrangements alongside increased capacity through use of regular bilateral theatre list commenced Oct 25. Recently developed low risk breast pain pathway aiming for go-live aimed for Dec 25, subject to being fully approved.
- Gynaecology – short term plan to use WLI's for diagnostic stage of pathways, PMB pathway review completed which has demonstrated it has prevented 39% of referrals coming to acute, however the overall volume of referrals has remained high. Work is now starting around demand and capacity modelling.
- Head & Neck – process mapping complete and results of clinic audit under review to consider changes to front end of BPTP pathways, which includes reviewing options to move straight to test for specific cohorts of patients.
- Lung – Continued micro-management of the PTL amid ongoing workforce shortfall challenges. Successfully secured CNS funding for one year to support capacity shortfall. Deep dive into pathway commenced and agreed that demand and capacity modelling is required with IST support requested.
- Skin – Teledermatology launched in one PCN week commencing 29th Sept. Further roll out to include another PCN being aimed for December with full rollout planned for January 2026, subject to support from Digital. This project aims to reduce demand on OPA capacity and allow more timely access to those who do need to be seen. Re-introduction of one-stop / see and treat clinics to include Max Fax provision being aimed for early 2026. Three locum consultants starting Oct/Nov. Success with bid to NHSE for cancer recovery funds in support of eradicating the Max Fax MOP's backlog.
- Urology – New locum consultant (WMCA funded) has been appointed. Once in post this will support timeliness of post MDT OPA. Continued micro-management of access to first OPA, MRI and MRI reporting, and reporting of LATP's, as well as FU OPA's for surgical treatments and timeliness of TCI dates.
- Oncology – Partial success with bids with funding awarded from WMCA. Prioritisation of funds undertaken and supported by ICB and WMCA.
- Development of a business case to extend operating capacity to support delivery of the 31 day and 62 cancer standards for both Urology and Colorectal.

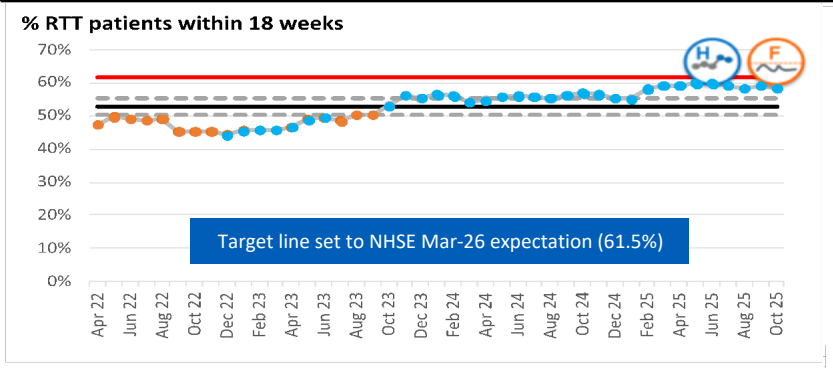
Risks

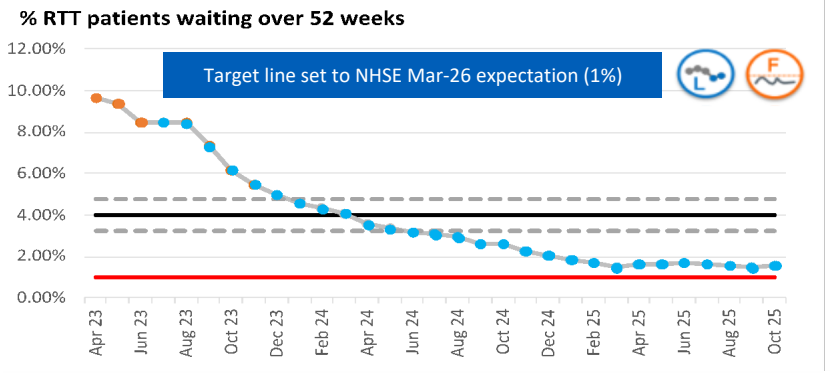
- Impact to achieving delivery of 31 and 62 days resulting from insufficient Oncology and radiotherapy capacity.
- Failure to reach annual plan target for FDS due to the fragility of our Breast and Gynaecology services (amid increased demand).
- Ongoing financial impacts associated with the use of high-cost diagnostic outsourcing solutions in histology and radiology.
- Risk to delivery of FDS, 31- and 62-day targets due to service model fragility particularly for Skin (which also relates to fragile Max Fax service) though please see mitigating actions.
- Delays in pathology turnaround times impacting on all tumour site pathways.
- Delays in imaging, particularly MRI, impacting on all tumour site pathways.

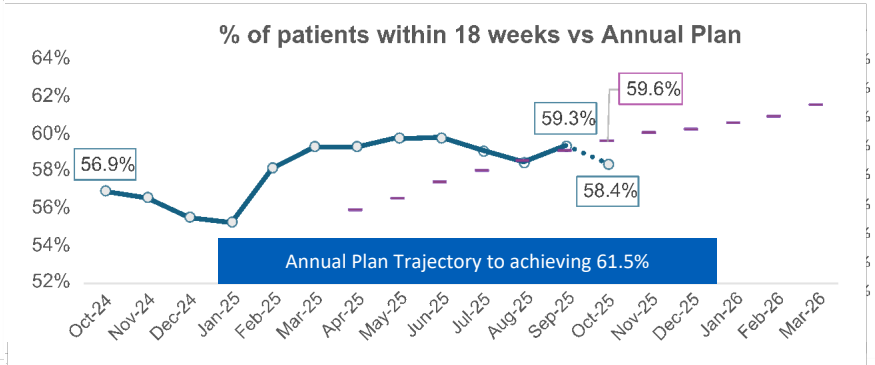
OUR OPERATIONAL PERFORMANCE – REFERRAL TO TREATMENT

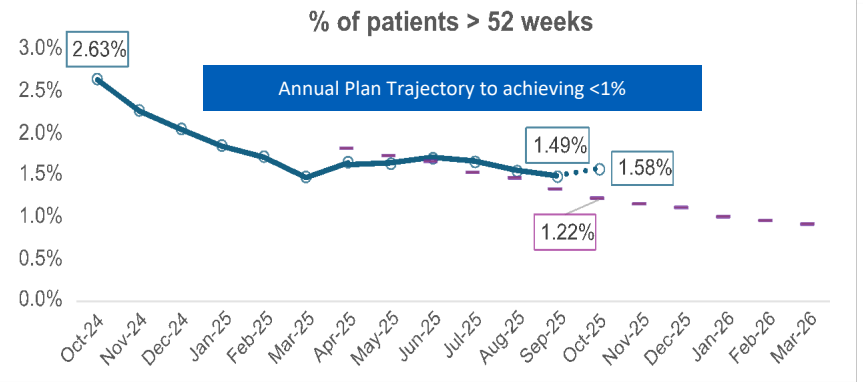
We are driving this measure because

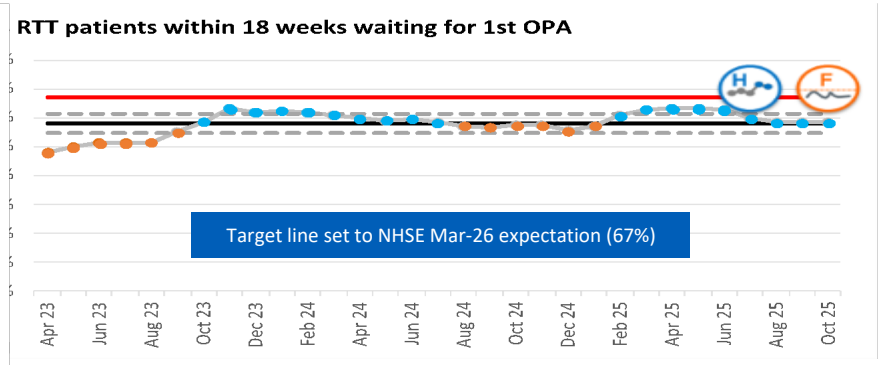
It is a key priority to ensure that patients can access the elective treatment they need in as timely a manner as possible and to continue to recover to the 18-week Referral to Treatment standard as set out in the NHS constitution.

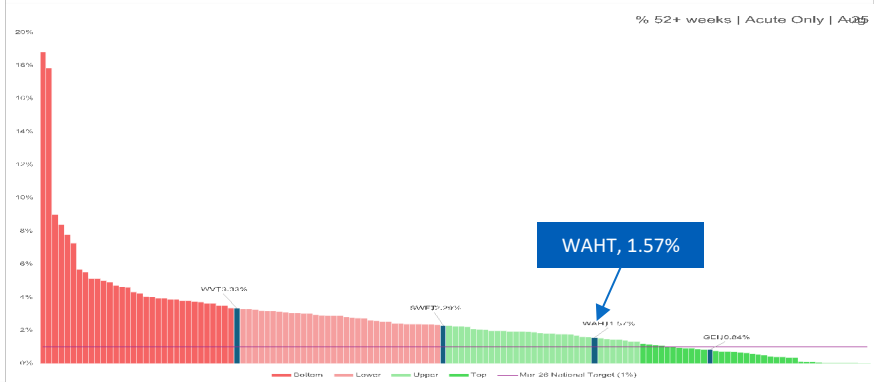












Understanding the performance (provisional)

- At the end of Oct-25, 58.4% of patients, of a waiting list of 58,593, were waiting less than 18 weeks for their first definitive treatment. This continues the recent trend of significant improvement, but the year end target is not yet achievable without further change.
- For those patients waiting for their first appointment, the proportion waiting less than 18 weeks continues to show significant improvement.
- The number of patients waiting over 52 weeks has increased to 923 from 855 the previous month and is 1.58% of the total waiting list.
- 4 specialties (ENT, T&O, Gastroenterology and OMFS) with 52-week waiters contribute 93% of patients to the Trust overall position.
- In August's NHSE RTT publication, WAHT benchmark in the upper quartile of performance with 1.57% of the waiting list over 52 weeks.

Actions (SMART)

- Weekly oversight, monitoring and support from ICB and NHSE
- Weekly DCOO oversight and monitoring of our longest wait patients
- Gastroenterology insourcing solution commenced 25th Oct to address 65-week breaches and support achievement of end of year 52-week target. 9-week programme to see ~800 patients waiting for their first appointment.
- ENT and OMFS insourcing plans submitted to support recovery of 52-week breaches in line with annual plan. Commencement end of November.
- T&O working with foundation group and IS for mutual aid for foot and ankle and hand surgery and commencing work in treatment room 2 in Kidderminster as part of right procedure right place which aims to protect theatre resource for theatre only procedures with smaller cases now been managed through an upgraded treatment room.
- Divisional oversight and micro-management of patients on admitted pathways requiring surgical treatments which exceed 52 weeks
- Pressured services identified as gastroenterology, ENT, T&O and OMFS for delivery of 52 weeks. As a result, all other services working aiming to eliminate 52 weeks from September onwards.

Risks

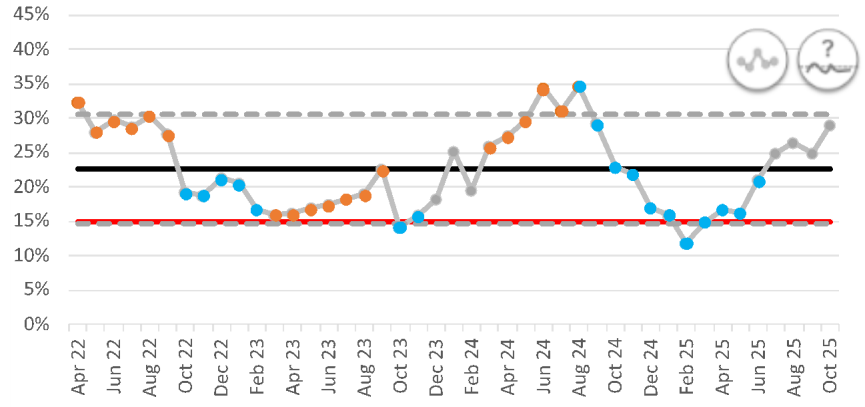
- Risk to elimination of 65+ week waiters due to late onward referral to external diagnostic services with limited capacity i.e. manometry, HIDA scans, impacts gastro and general surgery pathways
- Risk to delivery of eliminating all waits over 52 weeks by Mar 2026 particularly for ENT, T&O, OMFS and gastroenterology services, without in year process change/ services transformation
- Financial impacts of ongoing use of insourcing and outsourcing solutions particularly
- Delivery of 52 weeks target for OMFS due to fragility of service resulting from medium to long term absence of Consultants.

OUR OPERATIONAL PERFORMANCE – DIAGNOSTICS

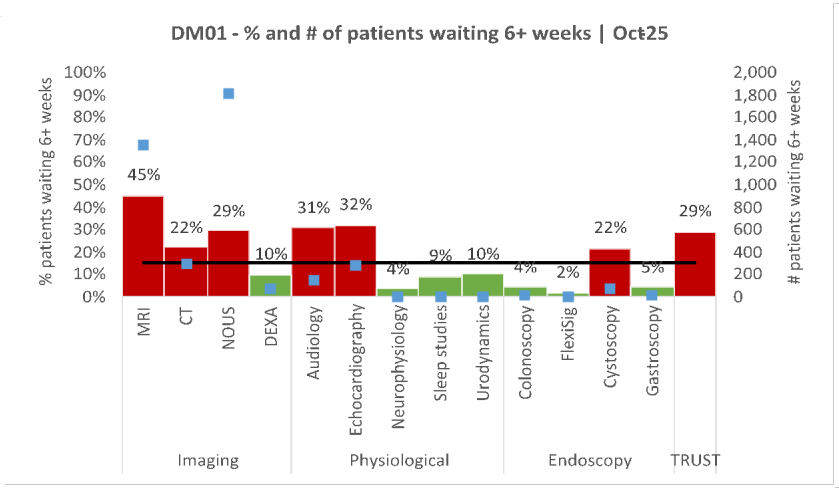
We are driving this measure because

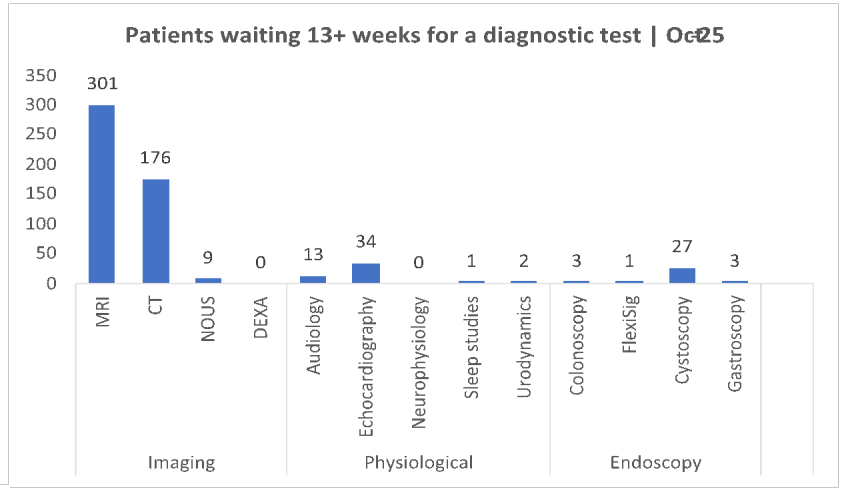
Early diagnosis is important to patients and central to improving outcomes, for example early diagnosis of cancer improves survival rates. Bottlenecks in diagnostic services can significantly lengthen patient waiting times to start treatment.

% patients waiting over 6 weeks



Target line set to NHSE expectation (no more than 15%)





Understanding the performance (provisional)

- 4,111 (29.0%) patients were waiting over 6 weeks at the end of Oct-25. This means that performance remains within our normal variation range.
- The target is achievable, although not consistently.
- 6 modalities are above the 15% threshold. They account for 97% of all patients breaching 6 weeks at the end of October.
- NOUS still has the most patients over 6 weeks followed by MRI, CT, Echocardiography and Audiology.
- MRI and CT account for 84% of the 570 patients reported as breaching 13 weeks at the end of the month.

Actions (SMART)

- **MRI –** Insufficient capacity to meet demand with a marked increase in responding to urgent and cancer demand. Service have been successful with a bid for external funding to increase capacity with use of a mobile. This will support improved access for patients on routine and cancer pathways. Mobile was delayed but was operational from mid-Nov
- **NOUS –** service is delivering planned activity however demand is higher than expected. Additional WLIs sought to support position. Alternative options been explored to improve overall 6-week performance
- **Audiology** action plan continues to support overall recovery, though recent spike in audiology referrals is evident in October which is under investigation. Immediate actions taken to provide additional activity.
- **Echocardiography –** Recovery plan is continuing to support the reduction in overall waiting list. Actions include increased capacity from conversion of facilities and continued recruitment to vacancies of physiologists.
- **Cystoscopy** – Continued use of waiting list initiatives to reduce backlog

Risks

- Risk to delivery of DM01 performance resulting from carve out of capacity to support cancer pathways e.g. urology prostate MRI
- Risk to permanent recruitment to audiology vacancies could impact on delivery.
- Impact from Resident Doctor Industrial Action

OUR WORKFORCE – M7 2025

Ali Koeltgen

Chief People Officer

Recruitment

Establishment increased at budget setting by 193.76 wte mainly in Medicine. Substantive Funded establishment has increased by a further 9.26 wte this month (increase in 15.6 wte in Paediatrics (Nursing and HCAs) offset by reductions in SCSD, Medicine and Surgery. Our funded establishment is 337.92 wte higher than M7 last year due to agreed business cases. We have recruited 112 new staff in M7 and have 55 more starters than leavers. There has been reduction in Staff in Post in Women and Childrens. All other divisions have increased - 18.36 wte in Medicine, 17.34 wte in Surgery, 2.38 wte in SCSD. Estates and Facilities have increased by 10.19 and Corporate increased by 2.24 wte which is against the direction of travel required in our annual plan

Vacancy Rate

Our vacancy rate has reduced to 6.24% (477.73 wte vacancies). This now meets the Trust revised target of 6.5%.

Our **Non Clinical vacancies** are relatively low. We have 97.81 wte Admin and Estates vacancies (8.14%), 12.74 wte Managers vacancies (4.18%), and 1.80 wte other infrastructure support (0.69%).

Monthly Bank and Agency Spend

Temporary staffing spend remains our biggest challenge. There has been a 0.55 wte increase in agency worked in October but this has translated into a 1.06% reduced agency spend. Medicine continue to be outliers although have reduced agency spend by 0.68% to 5.97% as a % of gross cost. Surgery have also reduced by 2.52% to 3.19%. We are quartile 4 (worst) on Model Hospital (revised August 2025 rates). There is an increased focus on bank usage/spend as our M7 usage means that we are 52.40 wte adrift of our 25/26 plan.

Annual Staff Turnover

Our annual staff turnover has reduced again to 7.9%, which continues to comfortably meet our target of 11.5% and is improving compared to rates of 10.06% last year. We benchmark well against other Trusts at Quartile 1 (best) on Model Hospital (July 2025 rates). All Divisions meet the target although Estates and Facilities are outliers at 11.16%.

Sickness Absence

Monthly sickness absence has increased by 0.19% from last month to 5.72%. This is 0.23% worse than the same month last year. The % of absence attributed to stress has reduced to 26% of total sickness. Corporate are outliers although reduced to 39%. Digital are high but this is distorted by comparatively low sickness rates in a small Division. The highest sickness levels are in Estates and Facilities (8.11%) overall with and increase in long term sickness to 4.54%. This group are nationally historically higher than other staff groups, but we improved to Quartile 3 on Model Hospital in July 2025 for this group.

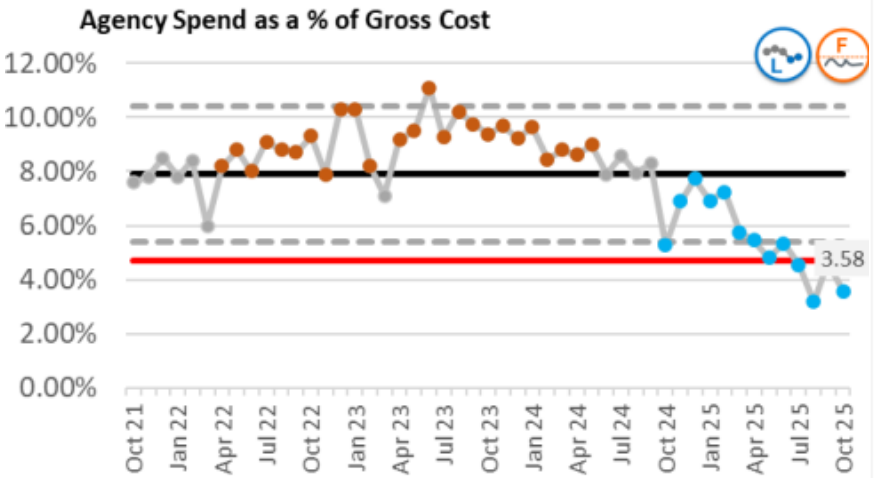
Job Planning

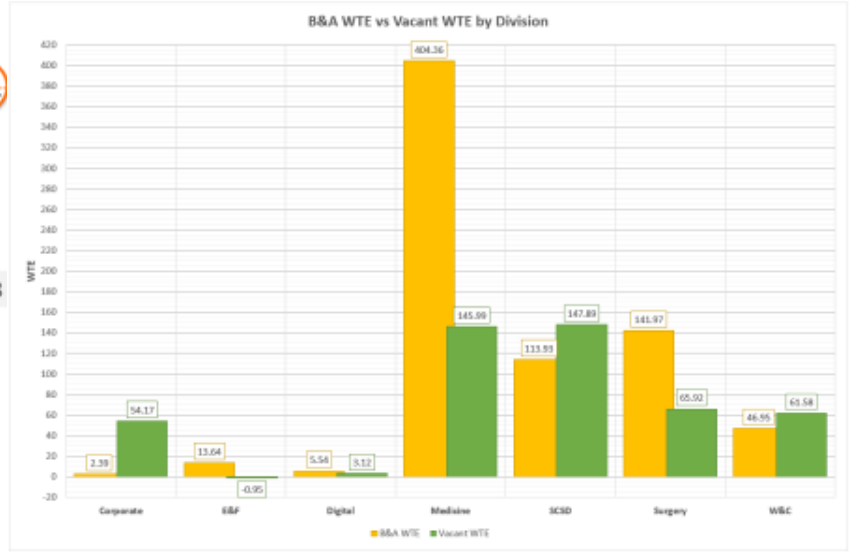
Consultant Job Planning has dropped by 2% to 69% against target of 95%. Women and Children's are close to target with 94%. Surgery are significant outliers with a drop to 50%. Medicine has had a 14% drop this month to 53%.

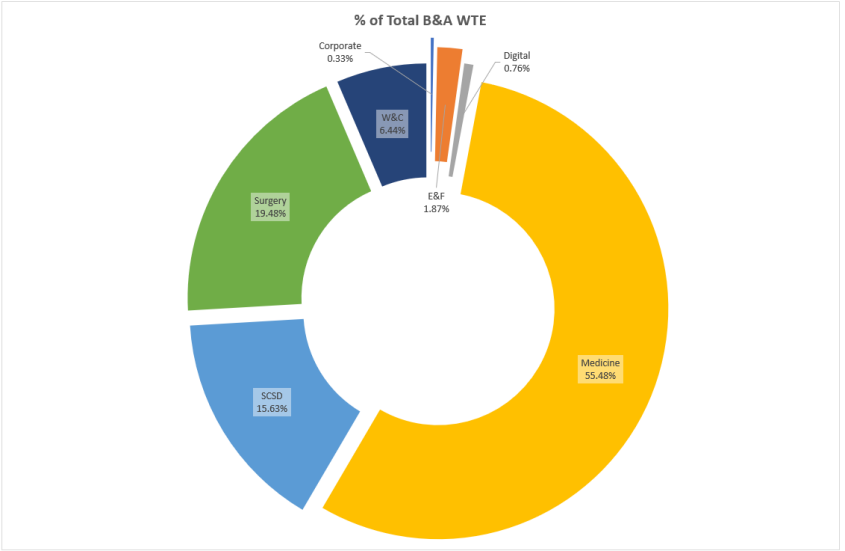
OUR WORKFORCE PERFORMANCE – REDUCTION OF AGENCY SPEND – M7 2025

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.







Understanding the performance

There has been a reduction in Agency spend in October to 3.58% compared to 4.64% in September. This remains significantly better than last year when agency costs were 5.26%. Work now needs to focus on reducing bank usage/expenditure which has increased this month.

The Trust have been identified by NHSE of being at risk of delivering bank and agency spend targets for 25/26 and therefore will receive additional support from the NHSE regional team.

Short notice requests remain an issue and have increased to 17% in October indicating increased short-term sickness or opportunities to improve rostering behaviours.

The bar chart above shows in green where divisions are using WTE bank and agency above or below their vacancies.

Actions

The monthly Agency Programme Board launched in September.

Professional Leads are currently undertaking Quality Impact Assessments relating to potential agency and bank rate reductions across all staff groups.

The Trust are participating in the Midlands Price Cap Compliance group across all staff group.

Band 2/3 agency removal work ongoing with an enhanced focus on Clinical Support Worker recruitment.

Continuing to identify long standing agency workers to migrate to trust or NHSP to support trust cost reduction targets.

Risks

Retrospective agency bookings leading to inaccurate reporting on agency usage and spend.

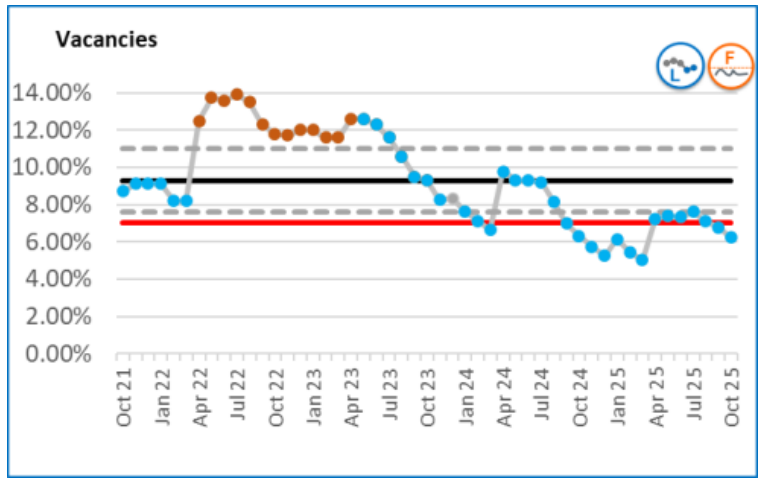
Potential reduction of agency worker pool due to continued pressure to reduce rates to price cap in line with NHSE Price Cap Compliance project.

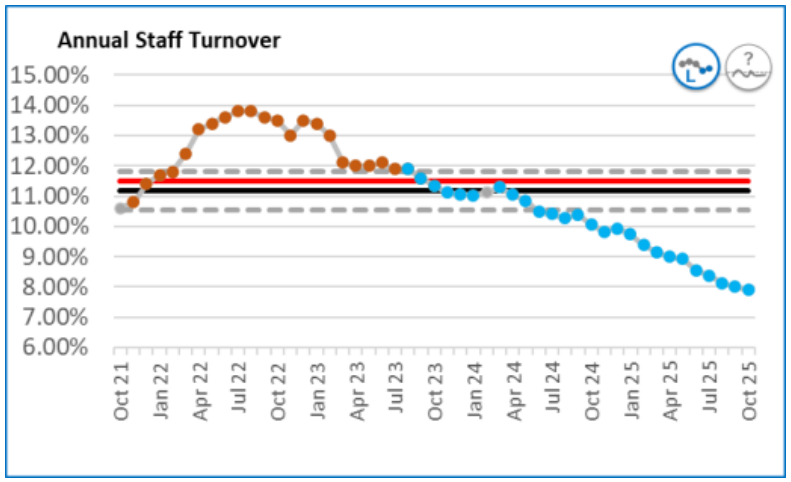
Ongoing risk to financial performance and compliance with the annual plan to reduce temporary staff by 40%.

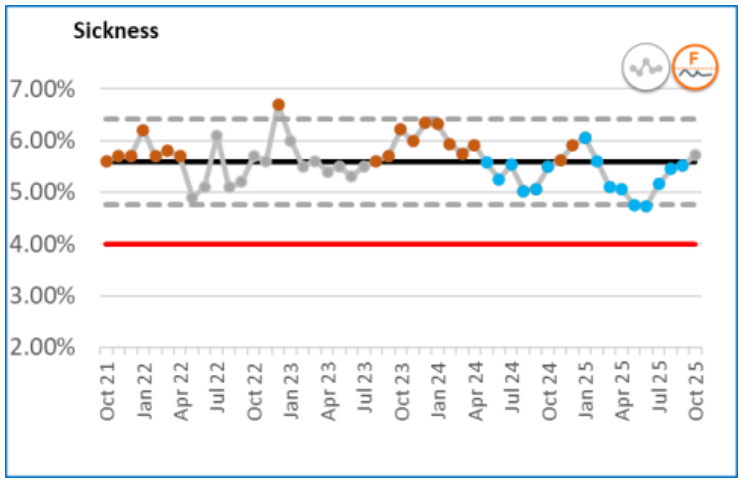
OUR WORKFORCE PERFORMANCE – VACANCIES, TURNOVER AND SICKNESS – M7 2025

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.







Understanding the performance

- **Trust-wide Vacancies** Staff in Post has increased by 50.12 wte this month. An increase in establishment at budget setting, and a further 9.26 wte increase this month, has impacted our vacancy rate which is currently 6.24% against a revised target of 6.5%. Women and Children's have the highest clinical vacancy rate at 7.48% directly related to the 15.6 wte increase in establishment in Paediatrics.
- **Starters and Leavers** - We have 55 more starters than leavers this month . We have processed 112 new starters in month (headcount) and 57 leavers.
- **Annual Staff Turnover** continues to reduce and comfortably meets our 11.5% target at 7.9% which is 2.16% better than the same period last year and better than pre-pandemic levels.
- **Monthly sickness absence** has increased by 1.9% to 5.72% which is 0.23% worse than last year. There has been increased sickness absence in all clinical divisions except Medicine. Estates and Facilities are outliers with a 0.98% increase to a very high 8.11%. Digital meet the 4% Group target, and Corporate are near target.

Actions (SMART)

- We have a **Sickness and Health and Wellbeing strategy**.
- **Continued Support** is being offered to staff through Occupational Health, Staff Support, Employee Assistance Programme (EAP) and Wellbeing interventions.
- **Targeted intervention meetings** implemented with managers in areas of highest sickness absence levels, with support from the HR Advisory team. Identifying hotspot areas and getting back to basics to ensure processes are in place to manage absence effectively within a timely manner as well as providing drop in sessions for managers.
- **Trigger reports** have been discussed at divisional meetings to drive compliance with policy and ensure sickness is appropriately addressed

Risks

Performance to Plan Our 2025/26 workforce plan includes challenging bank, agency and infrastructure workforce reductions. At present we are better than plan for Agency but above plan by 52.4 wte for bank. Medicine, Surgery and Estates and Facilities and Digital have used more wte than their establishment.

Healthcare Support Workers Vacancy rate has increased to 12.56% (147.46 wte vacancies) from 12.07%. This increase is directly due to an increase in funded establishment in Paediatrics.

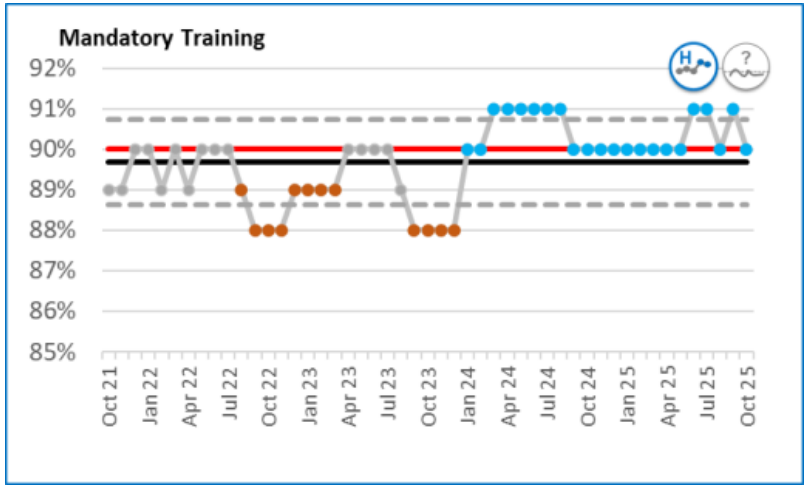
Sickness for Estates and Facilities continues to be high and increasing at 8.11%. This staff group has historically higher sickness across the NHS and we have improved to Quartile 3 on Model Hospital (July 2025 data). HCA sickness is also high at 8.50% (Quartile 3 on Model Hospital).

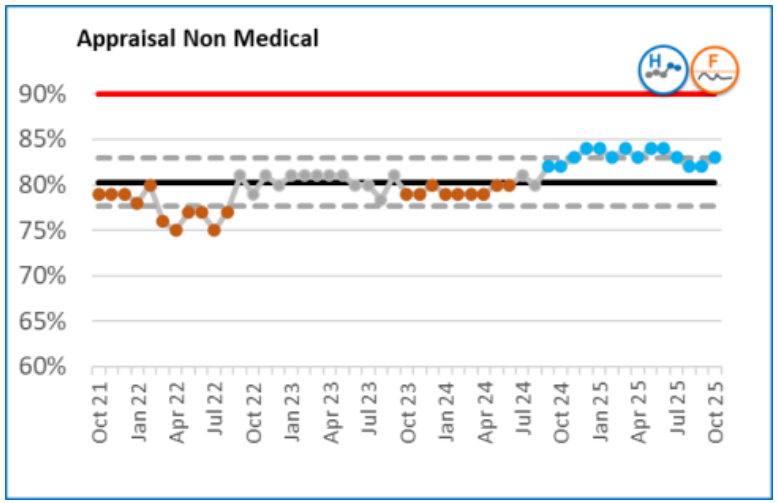
Absence due to stress remains higher than pre-pandemic levels. Corporate are significant outliers although reduced to 39%.

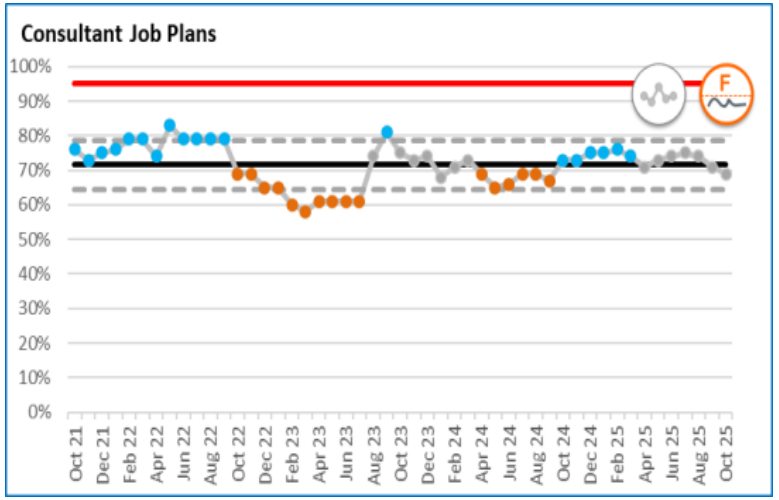
OUR WORKFORCE COMPLIANCE – MANDATORY TRAINING, APPRAISAL & JOB PLANNING – M7 2025

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.







Understanding the performance

Overall Mandatory Training has declined to 90% but continues to meet target. This is against a Model Hospital average of 91.6% (revised 2024/25 rates). We are Quartile 2 (good) on Model Hospital. Women and Children's Division are outliers at 86% (declining). Medicine Division has dropped to 89%. All other divisions meet the target of 90%.

Appraisal Rate has improved aby 1% to 83% against a target of 90% with improvements in Digital, Estates and Facilities, and Surgery. Compliance is 1% higher than last year. Corporate have dropped by 2% and are now outliers at 69%, followed by Digital at 71%. Surgery are closest to target with 88%. Medical appraisal rates are good and improved at 96%.

Consultant Job Planning has dropped by 2% to 69% against target of 95%. Women and Children's are the only division to meet target with 94%. Surgery are significant outliers at 50% (declined).

Actions (SMART)

Revised Appraisal Form and submission process have been rolled out. Working Group led by divisions has reviewed and made improvements to the system.

NHSE have implemented a national **job plan target of 95%** effective from February 2025 and require compliance to be reported via the Provider Workforce Return on a monthly basis.

A project to **fully roster** medics is being rolled out which will improve transparency and should improve clinic and theatre productivity.

Divisions to focus on Job Planning to improve productivity and transparency. A consistency panel and Job Planning Committee are in place.

Risks

Medical and Dental are outliers for Mandatory Training at 78% (2% reduction). All other Staff groups meet the 90% Trust target with the exception of Scientific and Technical (89% unchanged).

Poor Appraisal rates raises concerns that some staff are not meeting regularly with their manager which will impact on Staff Survey scores and morale.

Corporate and Digital remain **outliers** for Appraisal which is a concern although Digital have improved by 10%.

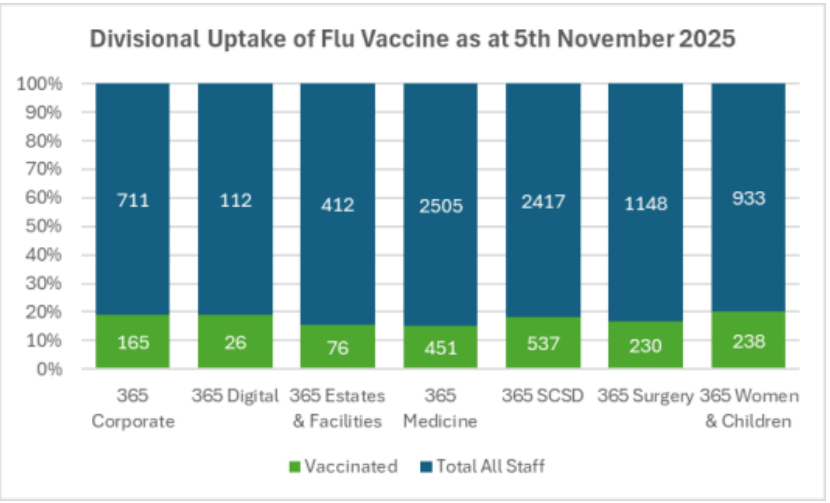
Consultant Job Plans are low and declined at 69% against the NHSE monitored target of 95%.

OUR WORKFORCE – VACCINATION UPTAKE – M7 2025

We are driving this measure because

Getting flu vaccination is the most effective intervention for reducing harm from flu infection

Local report from RAVS looked up into our current Staff in Post as of 5th November 2025



Division	Vaccinated	Total All Staff	%vaccinated
365 Corporate	165	711	23%
365 Digital	26	112	23%
365 Estates & Facilities	76	412	18%
365 Medicine	451	2505	18%
365 Specialised Clinical Services Divisior	537	2417	22%
365 Surgery	230	1148	20%
365 Women & Children	238	933	26%
Grand Total	1723	8238	21%

10 highest and lowest Directorates as of 5th November 2025

65 Corporate Affairs Service	2	4	50.00%
65 Neurophysiology Service	6	12	50.00%
65 PFI Services	2	4	50.00%
65 Surgery Daycase Service	11	23	47.83%
65 ITU ACCPs & Medics	10	21	47.62%
65 Paediatric Service	86	185	46.49%
65 Chief Executive Services	18	39	46.15%
65 Estates Alex/KTC	12	27	44.44%
65 Dermatology Services	10	23	43.48%
65 Palliative Care Service	8	19	42.11%
65 HR Corporate Services	6	51	11.76%
65 Geriatric Medicine	21	180	11.67%
65 MADEL Funding	2	18	11.11%
65 Urology	14	126	11.11%
65 Discharge Services	2	19	10.53%
65 Cancer Services	5	50	10.00%
65 SIFT Funding WRH	2	24	8.33%
65 Neurology Service	2	25	8.00%
65 A&E WRH	18	278	6.47%
65 General Internal Medicine Service	3	129	2.33%

Understanding the performance

When a member of staff receives a flu vaccination, data is collected on Record a Vaccination Service (RAVS) which feeds through to the NHS Federated Data Platform (FDP) which is used nationally to monitor vaccination rates.

However, there are limitations with the FDP as it can only report at Trust Level and only includes clinical staff. For Divisional and Directorate splits and for our Immform National reporting, we have to look up a national report from RAVS into our Staff in Post on ESR which gives us a percentage of 21%.

The national FAQ guidance states: "FDP denominators include all staff employed by a Trust regardless of job role or employment status (substantive / non-substantive). The FDP report defaults to show uptake for active staff in frontline roles. There may be differences in FHCW population/denominator figures between Immform and FDP".

Actions (SMART)

Ongoing vaccination clinics arranged for November as well as peer vaccinators and the option to book an appointment in OH across all 3 sites.

We have raised concerns with the FDP that we believe their figures are inflated as they appear to include patients and external contractors/agency staff.

In the meantime, we will use our own RAVS report looked up into current SIP in ESR (21%). This is necessary in order to breakdown our uptake into Divisional and Departmental level for FPE packs.

The Top 10 and Bottom 10 Departments/Directorates are shown above.

Risks

As the flu vaccination is not mandatory the risk is that we will have frontline healthcare workers who are not vaccinated who may then spread flu to their patients and/or cost the Trust in sickness absence if they catch flu.

There is an identified risk that the national report from FDP is inflated to include people who are not employees of this Trust. This is remedied in our own internal reports from RAVS looked up into our actual Staff in Post from our Payroll.

OUR FINANCIAL PERFORMANCE

Neil Cook

Chief Finance Officer

Financial Plan 2025/26

A balanced plan was submitted for 2025/26, this included Non-Recurrent System Deficit Support funding of £47.3m.

Income & Expenditure Performance – At the end of Month 7 we report a **year to date (YTD) break even position against plan** despite a material increase in CPIP requirement aligned to the phased plan. Non recurrent recovery plan items including Balance sheet release are supporting this position.

- **Income is £5.7m favourable YTD** – Favourable variances including £2.2m on pass through Drugs and Devices and £1.9m deferred income release supporting CPIP non recurrently, £1m system income and £0.3m over delivery of CPIP and £0.6m additional income for various small items across a number of Divisions are offsetting small adverse variances including the clawback of 24/25 contribution to capital charges (£0.1m).
- **Employee expenses are £5.8m adverse YTD** – adverse variances include £3.3m CPIP under delivery, additional resources supporting flow £1.9m, £0.5m costs of Industrial action, £0.7m of over-establishment and additional Bank and Agency usage in E&F driven by additional substantive staff and bank covering vacancies and sickness, £0.6m additional Stroke Consultant and ACPs, £0.4m of backdated job plans, £0.9m of WLI, the remainder is driven by additional cover for sickness, specialling and maternity leave and erosion of vacancy factor through additional recruitment with no temporary staffing offset. This is partially offset by £3.2m of balance sheet release and £0.7m of Dermatology vacancies (offsetting non-pay insourcing spend).
- **Operating expenses excluding Employee Expenses are £0.6m adverse YTD** – adverse variances include £1.7m of pass-through Drugs and Devices (£0.5m difference to income due to fixed nature of income contract with H&W ICB), £0.9m of tariff drugs driven by activity, £2.6m CPIP under delivery (excluding c£2.7m of Balance Sheet releases declared as CPIP), £0.8m Dermatology Insourcing and £1.4m of non pay costs of activity in Theatres and Surgery. Partially offset favourable variances include £4.7m of balance sheet release, £1.4m of utilities underspend, and £0.4m DCR milestone payment deferred into 26/27.

Delivery of a balanced financial plan is critically dependent on achieving our CPIP target. The Trust has commenced Financial Recovery actions comprising a series of workstreams based on the outcome of the Financial Mitigation Plan workshops held on 11 and 30 September. Fortnightly CPIP review meetings continue to focus on cost out CPIP schemes as well as productivity opportunities.

Capital – The YTD capital spend at Month 7 is £9.4m, the majority of which is spend on the ALX Fire Scheme (£3.3m), IFRIC 12/PFI Lifecycle replacements (£2.2m) additional digital schemes including laptops purchased in year (£783k) and the CHEC Lease (£1.4m) leading to a variance against budget YTD of £532k.

Cash – The Trust cash position at the end of Month 7 was £6.390m (cash in bank). The Trust has received the notified deficit support of £3.942m in October totalling £27.592m to date.

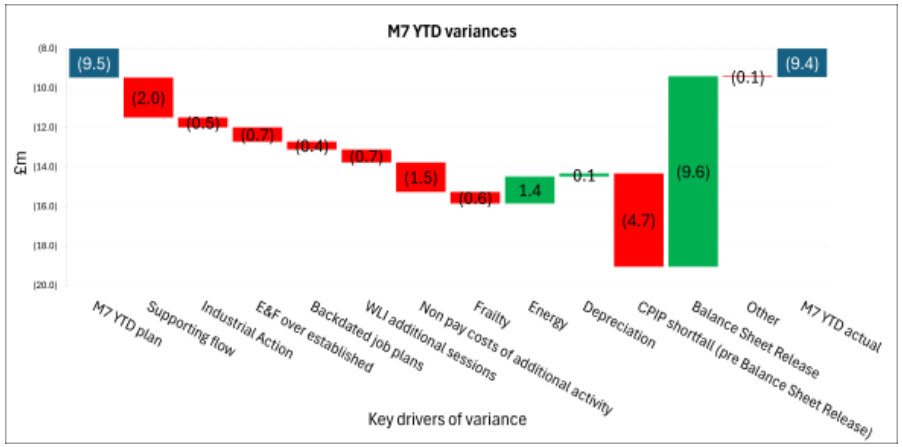
Clinical Coding – October coding was at 100% on the 5th working day. Total of FCE's for October was 15,841 compared to 15,105 in September.

BEST USE OF RESOURCES – INCOME & EXPENDITURE

We are driving this measure because

The Income and Expenditure plan reflects the Trust's operational plan, and the resources available to the Trust to achieve its objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

Statement of comprehensive income	Year to Date Plan £'000	Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Operating income from patient care activities	435,716	439,184	3,468
Other operating income	20,728	23,006	2,278
Employee expenses	(285,648)	(291,402)	(5,754)
Operating expenses excluding employee expenses	(166,124)	(166,698)	(574)
OPERATING SURPLUS / (DEFICIT)	**4,673**	**4,090**	**(583)**
FINANCE COSTS			
Finance income	860	1,360	500
Finance expense	(6,215)	(6,075)	140
PDC dividends payable/refundable	(2,944)	(2,942)	2
NET FINANCE COSTS	**(8,299)**	**(7,657)**	**642**
Other gains/(losses) including disposal of assets	0	(171)	(171)
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(3,626)**	**(3,738)**	**(112)**
Remove capital donations/grants/peppercorn lease I&E impact	105	(63)	(168)
Remove PFI revenue costs on an IFRS 16 basis	21,791	24,158	2,367
Add back PFI revenue costs on a UK GAAP basis	(27,737)	(29,802)	(2,065)
Adjusted financial performance surplus/(deficit)	**(9,467)**	**(9,445)**	**22**



Understanding the performance

- **At the end of Month 7 we report a year to date (YTD) break-even position against plan.** Adverse variances are primarily driven by under-delivery against recurrent CPIP and additional resources supporting flow. This position has been supported by non recurrent benefits.
- **Income is £5.7m favourable YTD** – Favourable variances including £2.2m on pass through Drugs and Devices and £1.9m deferred income release, £1m system income, £0.3m over delivery of CPIP and £0.6m additional income for various small items across a number of Divisions.
- **Employee expenses are £5.8m adverse YTD** – adverse variances include £3.3m CPIP under delivery, additional resources supporting flow £1.9m, £0.5m costs of Industrial action, £0.7m of over-establishment and additional Bank and Agency usage in E&F driven by vacancies and sickness, £0.6m additional Stroke Consultant and ACPs, £0.4m of backdated job plans, £0.9m of WLI, the remainder is driven by additional cover for sickness, specialling and maternity leave and erosion of vacancy factor through additional recruitment with no temporary staffing offset. This is partially offset by £3.2m of balance sheet releases and £0.7m of Dermatology vacancies (offsetting non-pay insourcing spend).
- **Operating expenses excluding Employee Expenses are £0.6m adverse YTD** – adverse variances include £1.7m of pass-through Drugs and Devices (£0.5m difference to income due to fixed nature of income contract with H&W ICB), £0.9m of tariff drugs driven by activity, £2.6m CPIP under delivery (excluding c£2.7m of Balance Sheet releases declared as CPIP), £0.8m Dermatology Insourcing and £1.4m of non pay costs of activity in Theatres and Surgery. Partially offset favourable variances include £4.7m of balance sheet releases, £1.4m of utilities underspend, and £0.4m DCR milestone payment deferred into 26/27.
- The bottom up forecast presented at M5 was a YTD deficit position of £14.5m at M7, the actual position of £9.4m is £5.1m favourable to that forecast due to additional balance sheet releases and income.

Actions (SMART)

The Trust has commenced a Financial Recovery Plan comprising a series of workstreams based on the outcome of the Financial Mitigation Plan workshops held on 11 and 30 September.

Fortnightly CPIP review meetings continue which focus on cost out CPIP schemes as well as productivity opportunities.

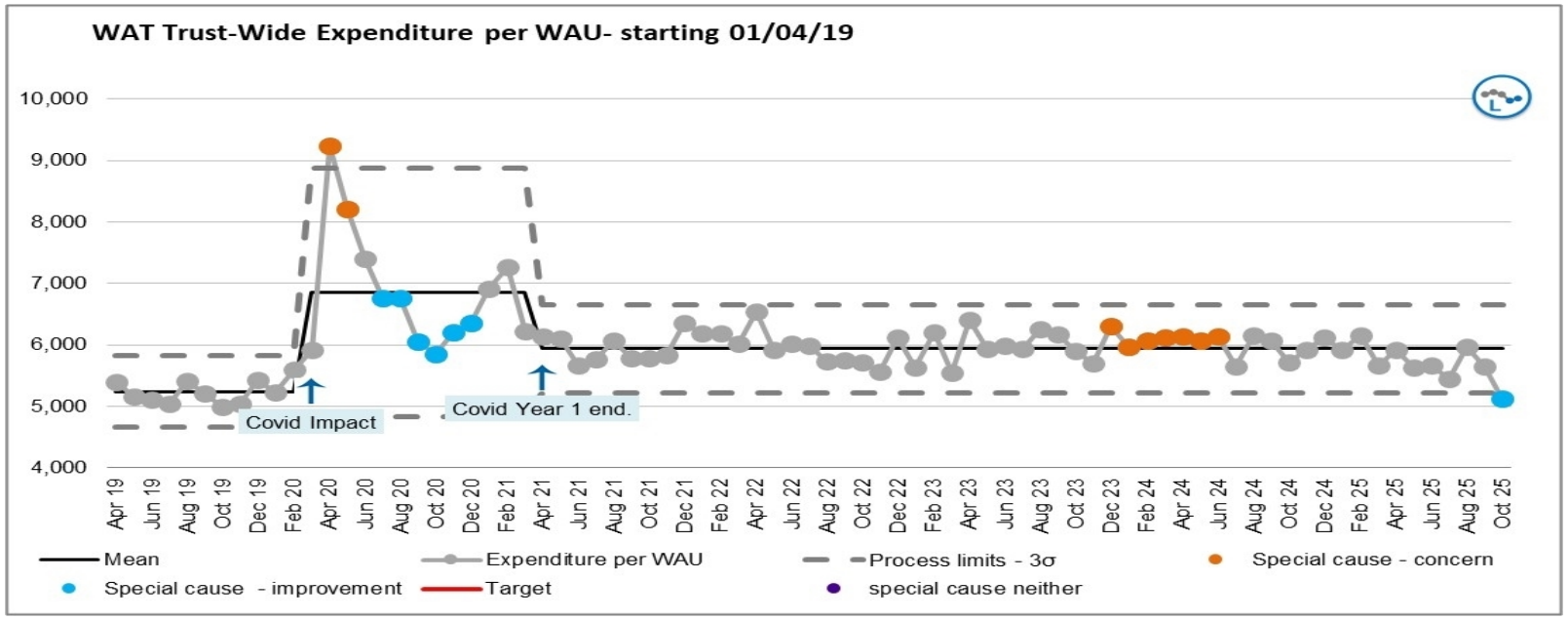
Risks

If CPIP plans do not progress through maturity to delivery in line with the plan the Trust will experience cash flow problems and be challenged by NHSE regarding release of deficit support funding.

BEST USE OF RESOURCES – ADJUSTED EXPENDITURE PRODUCTIVITY TREND

We are driving this measure because

This SPC measures expenditure against activity, allowing us to follow productivity changes. Tracking is currently available at Trust wide level only. Weighted Activity Unit (WAU) has been developed within the Foundation Group using Inpatient/Outpatient/ED/Critical Care activity, adjusted to be weighted equally. There is no adjustment for working day variations.
Previous years Expenditure is adjusted up for inflation to make them comparable with the current year. As the WAU relies on coded activity, recent months can still move until coding is complete.



Monthly Movement	Sep - Oct	Adjusted for Working Days
Exp per WAU	-9.1%	-5.6%
Expenditure	-3.8%	-3.8%
WAU	5.8%	1.9%

Costing Team Update

- Costing teams across the Foundation Group are looking at updating the Cost per WAU measurement to use more up to date weighting to bring it in line with the NHS England's Implied productivity methodology.

Understanding the performance

In October, our Cost per WAU is **9.1% lower than last month** This means that we are spending less per unit of activity delivered for a second month, though one-off impacts to the financial position are partly driving this.

WAU is **5.8% higher than September, 1.9% higher when elective is adjusted for working days.** (Note uncoded activity can impact this position).

This is driven by primarily by Outpatient activity increasing and Non-Elective Inpatient discharges and ED Attendances both increasing. We had 8% more ED attendances than in September, the highest volume of the year.

Actions (SMART)

The Costing team continue to support Divisions in identifying opportunities to improve productivity.

Risks

If the Trust cannot reduce expenditure whilst also increasing activity levels, then achievement of financial and performance targets are at risk.

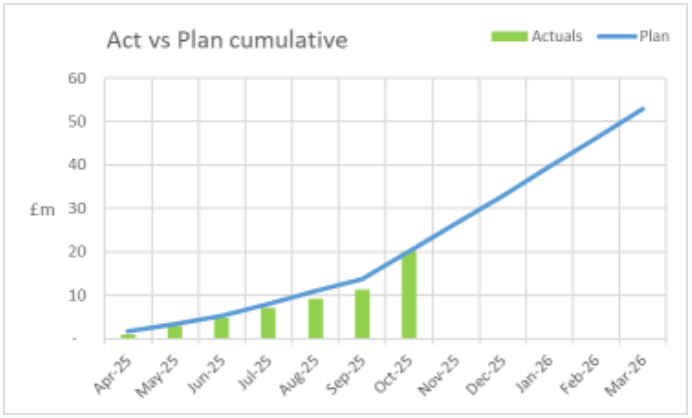
BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

We are driving this measure because

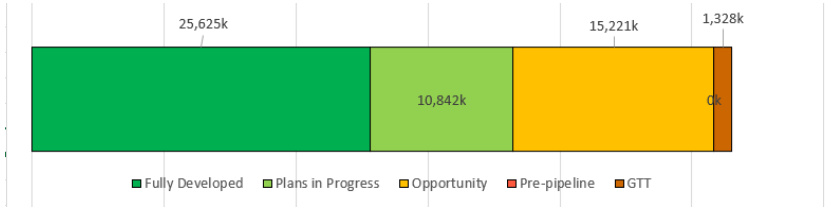
If the Trust fails to identify recurrent Cost and Productivity Improvement Plans (CPIP) and put in place sufficient resources and governance arrangements to drive delivery, then it will not achieve financial sustainability.

YTD CPIP achieved
vs plan target (£53.016m)
monthly

YTD CPIP achieved
vs plan target (£53.016m) cumulative



Schemes identified (forecast) vs target (£53.016m)



Understanding the performance	Actions (SMART)	Risks
The Trusts 25/26 target as submitted to NHSE is £53.016m. M7 Plan figure was £6.387m. M7 Actuals delivered £8,732m, an over delivery of £2.345m. M7 Actuals comprise £1.983m recurrent and £6.749m non-recurrent The improved YTD position has been achieved through the following additions to the CPIP actuals based on clarification provided by NHSE: £4.665m Balance Sheet adjustments £1.000m risk share to cover bed reduction plans (system) £0.556m coding corrections for MRSA swabs	The Trust has commenced a Financial Recovery Plan comprising a series of workstreams based on the outcome of the Financial Mitigation Plan workshops held on 11 and 30 September. Fortnightly CPIP review meetings continue which focus on cost out CPIP schemes as well as productivity opportunities. Please note additional maturity rating introduced via NHSE for 25/26, broadly summarised below: The Trust has commenced identification of 26/27 CPIP opportunities as part of the Integrated Planning process	Delivery of the 25/26 target is challenging. Work is continuing to develop existing schemes as well as identifying further cost saving and productivity savings via the workshops referenced above to bridge the gap to target (GTT)