Black Country Provider Collaborative

NHS

# Annual Report 2023-25

## (October 2023 – March 2025)

**Working in partnership**

Sandwell and West Birmingham NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

# Introduction

**Diane Wake**
BCPC CEO and Group CEO for The Dudley Group NHS FT and Sandwell and West Birmingham NHS Trust

**Sir David Nicholson KCB CBE**
BCPC Chair
Shared Chair DGFT, RWT, SWBH and WHT

**2023–2025 has been a period of impact, innovation and collaboration – and we are excited to share what we've achieved together.**

This report provides an overview of The Black Country Provider Collaborative (BCPC) and our joint work supporting over 1.3 million people in our area.

The BCPC is a formal partnership of all four acute, community and primary care NHS Trusts in the region. As a key component of our Integrated Care System (ICS), we collectively address major issues affecting all NHS organisations and plan strategically for the future.

We are proud of our strong history of collaboration in the Black Country. Over the past 18 months, we've built on this foundation by enhancing our leadership, deepening partnerships, and improving care for patients and staff. These collaborative efforts have reduced inefficiencies and improved patient outcomes.

This progress comes during a challenging time. The NHS faces high demand, significant financial pressures, and the pandemic's lasting effects. We're also confronting more complex patient needs and persistent health inequalities.

To address these challenges, we must re-imagine how we deliver care. As providers, we are committed to working in innovative ways. We embrace our responsibility to champion better health, economic opportunity, and wellbeing throughout the region.

We've made significant progress with mutual aid, enabling all four Trusts to work together to ensure equal healthcare access across the Black Country. Our system-wide clinical leads are advancing ground-breaking developments, including a Black Country breast reconstruction service – the first time this will be available to NHS patients in the area.

Clinical networks have delivered numerous benefits, including reduced variance in clinical practice, improved care access, better health outcomes, and enhanced patient experience.

We've successfully applied for a capital bid for the Elective Hub (Sandwell) and submitted a business case for the Elective Hub (Cannock). Both facilities will serve patients throughout the Black Country.

While financial challenges have been significant this past year, we've implemented a system-wide financial plan that promotes mutual support and collaboration.

Our performance metrics continue to improve. We've successfully met our 18-week treatment target for cancer patients and wait times have decreased across all specialties.

We remain committed to creating an environment where the talents, expertise, and passion of our Black Country workforce can flourish, helping us achieve performance levels among the best in the country.

We thank you for your support on our journey to date, and hope that you will continue to play an active and important role in the ongoing improvement and transformation of health and care across the Black Country ICS through our agreed work plan in the years ahead.

# What have we been up to?

## Black Country Provider Collaborative (BCPC)

During the past 18 months, we have focussed our efforts across three key programmes:

- **Clinical Improvement Programme** – Supporting and improving cancer health outcomes and elective care recovery through clinical networks
- **Corporate Improvement Programme** – Exploring opportunities for consolidation and scaled delivery to enhance service productivity, resilience and efficiency
- **System & Transformation Priorities** – Identifying and advancing large-scale priorities that enable better service delivery, health outcomes, patient experience and care

We continue to identify key areas for joint work that align with our collaboration principles, addressing unwarranted variation, service fragility, and opportunities for large-scale modernisation and transformation.

- **Quality** – We've improved critical care, orthopaedics, and skin care pathways by establishing consistent system-wide guidelines. We've also enhanced care access by reducing waiting times in High Volume Low Cost (HVLC) specialties and improved health outcomes by meeting or exceeding Getting it Right First Time (GIRFT) metrics. We have also implemented various modernisation initiatives including new elective hubs for general surgery and urology, with additional plans set for near-term development
- **Strategic Developments** – We're exploring opportunities to repatriate services, allowing patients to receive care closer to home without out-of-area travel. This enhances accessibility, improves patient experience, and optimises resource use within our system healthcare network
- **Engagement** – We maintain active engagement with clinical and service leadership through regular Clinical Summits and dedicated planning and delivery workshops for our Clinical Networks

Our success stems from prioritising inclusion, engagement, and empowerment through partnerships.

The BCPC continues to mature and grow by further building trust and strengthening relationships, transforming the traditional culture of competition in our evolving healthcare landscape.

This partnership allows us to pursue strategic priorities at scale, use system-wide resources more effectively, and make faster decisions—resulting in quicker benefits. We look forward to sharing more positive outcomes from our collaborative work in the coming months.

# Who are we?


## The Black Country Provider Collaborative (BCPC)

Our Provider Collaborative has a simple ambition: ***to provide better, faster, and safer care to the population of the Black Country and beyond***—a goal encapsulated in our vision statement. Simply put, we aim to be amongst the best healthcare systems in the NHS.

The BCPC is a formal partnership of all four acute, community and primary care NHS Trusts in the Black Country Integrated Health System, which are:

- Sandwell and West Birmingham NHS Trust (SWBT)
- The Dudley Group NHS Foundation Trust (DGFT)
- The Royal Wolverhampton NHS Trust (RWT)
- Walsall Healthcare NHS Trust (WHT)

**Our key focus areas are:**

- Improving health outcomes and reducing inequalities
- Making care better, faster, and safer for Black Country residents
- Strengthening pride in our healthcare system through improved performance and quality

The Provider Collaborative is formally represented as a partner member on the Black Country Integrated Care Board (ICB).

# How are we set up?

**Each year, we establish specific priorities and deliverables for the coming year, ensuring our work supports the delivery of high-quality, equitable care across the Black Country.**

For the past 18 months, we have organised our work around three core programmes:

- Clinical Improvement
- Corporate Improvement
- System Transformation & Improvement

We maintain a light-touch programme management structure funded by the four partner NHS Trusts. This approach allows us to remain agile and responsive while ensuring strong coordination and alignment across the system.

Our goal is to drive innovation, improvement, and transformation in the provider sector by creating simple, effective ways to connect people, share learning, and collaborate on shared priorities.

## During the last 18 months, we saw some key personnel changes to our system at a senior leadership level.

**Professor David Loughton CBE**
Group CEO at The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust retired with effect from May 2024

**Richard Beeken**
CEO at Sandwell and West Birmingham NHS Trust, left with effect from December 2024

**Caroline Walker**
Appointed as Interim Group CEO of The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust from May 2024 to December 2024

**Joe Chadwick-Bell**
Appointed as Group CEO at The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust from January 2025

**Diane Wake**
Appointed as Group CEO at Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust from December 2024

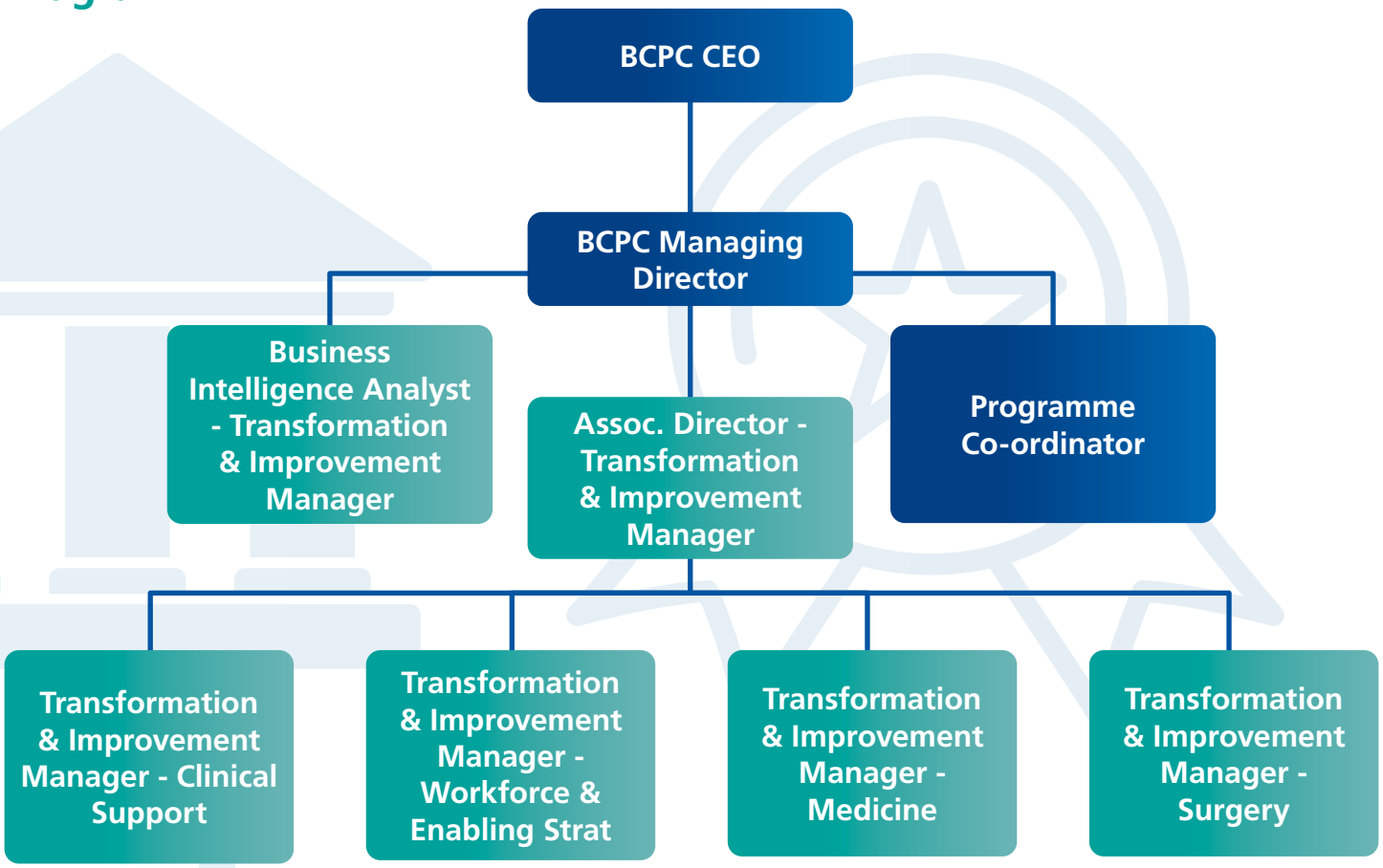
We thank our outgoing leaders for their tremendous contributions to the NHS and patient care in our region over many years.

To support the agreed BCPC work plan and wider programmes delegated by each partner Trust to the Joint Provider Committee, the BCPC Managing Director established a small, dedicated workforce with the appropriate skill mix on a short-term basis through fixed-term contracts or secondment arrangements.

This workforce is divided into the following teams (with diagrams 1 and 2 providing a structural overview):

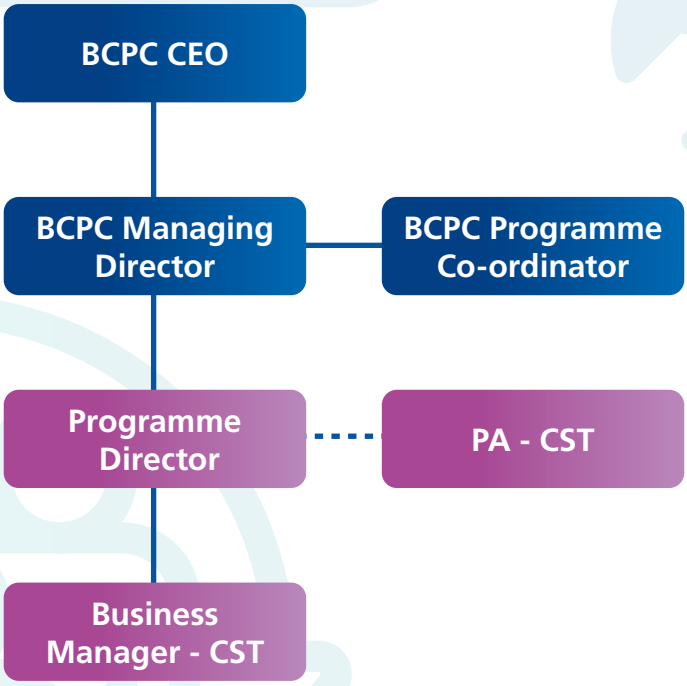
- **Transformation & Improvement Manager (TIM)** (Diagram 1) - supports the Clinical Leads and Networks in delivering priorities across the Clinical Improvement and Clinical Transformation programmes

## Diagram 1




See page 41 for current list of team members.

## Diagram 2




- **Corporate Service Transformation Team (CST)** (Diagram 2) - drives the Corporate Service Transformation programme
- **Executive & Clinical Leadership** - provides dedicated finance and medical leadership across all programmes, including 12 Clinical Leads who drive improvement and transformation activities

## The BCPC teams focus on:

- Developing clinical and functional service proposals
- Leading and organising professional, service, and public engagement activities
- Preparing briefing reports for key committees and clinical networks
- Workforce modelling
- Finance, capacity, and demand modelling
- Meeting regulatory requirements, including ICB screening documents, OSC papers, and business case writing

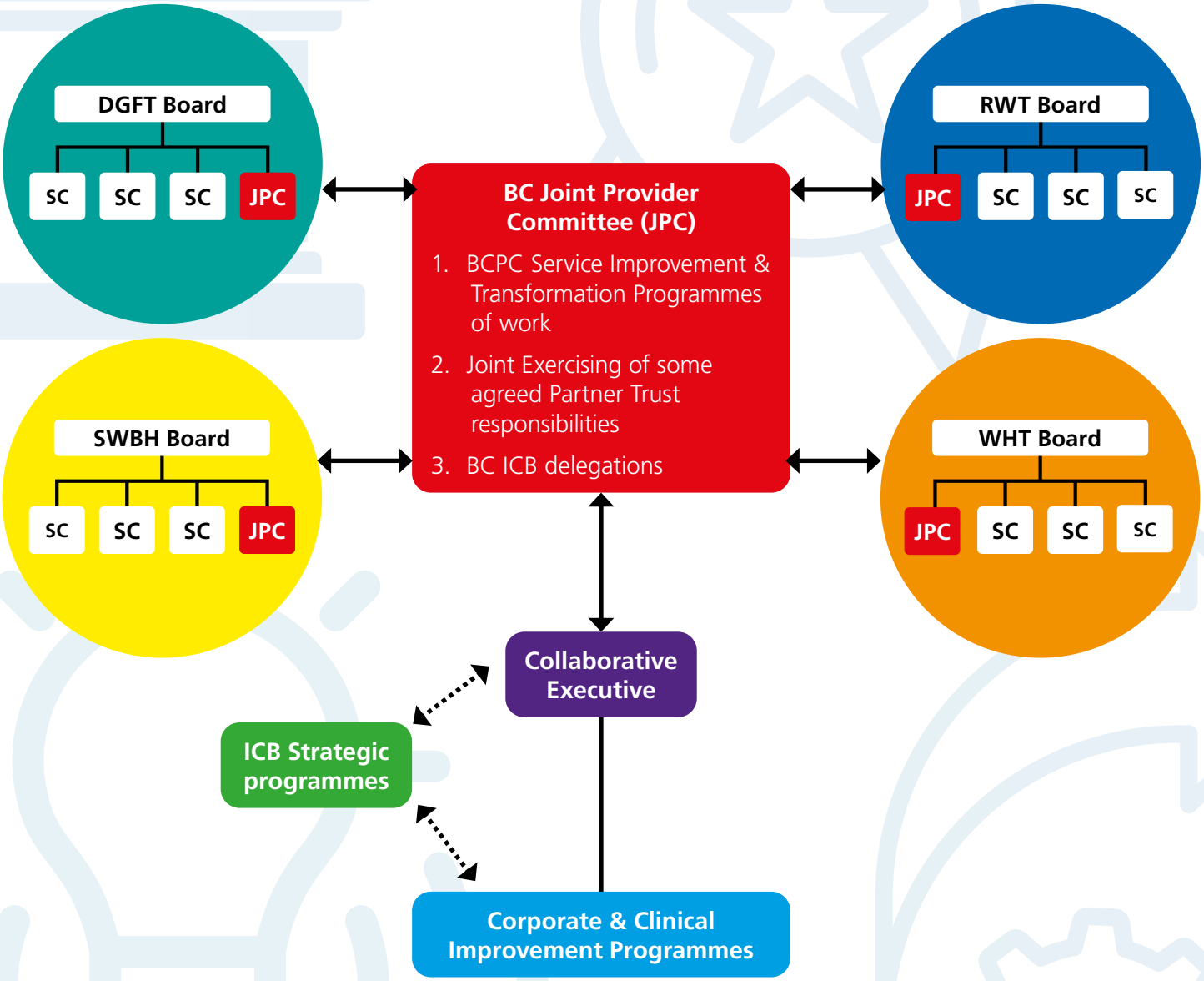
# How are we governed?

The BCPC's governance arrangements have evolved from an informal 'committee-in-common' to a more formal arrangement using new legislative powers from the NHS Health & Care Act (2022). This ensures decisions are timely and binding.

Our new governance arrangements are illustrated in Diagram 3 below, with the key components as follows:

- **Collaboration Agreement** (CA) - a framework that formalises the vision and principles agreed by the Partners. It sets out our commitment to working together and defines the governance structure for the collaborative, including the Joint Provider Committee (JPC)
- **Joint Provider Committee** (JPC) - the Collaboration Agreement includes the JPC Terms of Reference, which defines the scope of the JPC's work. It sets out how decisions will be made, who the members are, and how meetings will be convened

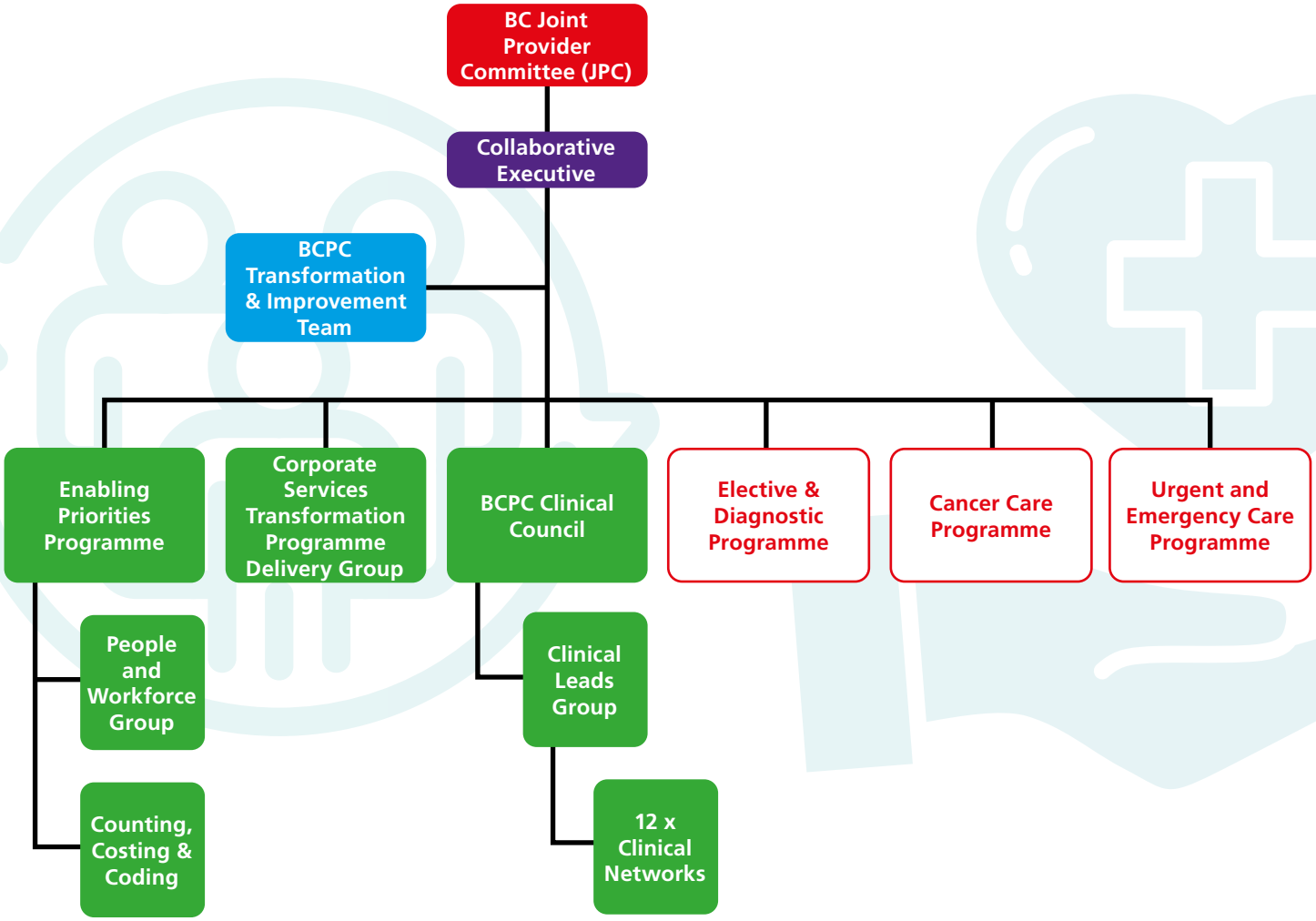
## Diagram 3



Operational delivery is illustrated in Diagram 4 and provided by the BCPC Executive, chaired by lead CEO Diane Wake and supported by BCPC Managing Director Sohaib Khalid. Functional Executives from across the four partners form the remainder of the BCPC Executive, supporting delivery of the agreed annual BCPC work plan.

Each programme has an identified Senior Responsible Officer (SRO). To strengthen governance arrangements, a regular SRO meeting has been established.

## Diagram 4




**Non-governance functional professional networks / groups**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chief Operating Officers** | Governance | Human Resources & Workforce* | Directors of Strategy** | Communications & Engagement** | Chief Medical Officers** | Digital, Data & Technology** | Chief Nursing Officers** |

The annual budget for the BCPC has been set at £2m by the Joint Provider Committee in accordance with section 3.24 of the Collaboration Agreement, with all four partners contributing equally to its establishment.

A summary of annual projected expenditure can be seen in Table 1 below:

## Table 1 – Summary of projected annual expenditure

| Recurrent Spend (Pay) | 2025/26 (Budget) |
|---|---|
| **Clinical Projects**<br>• Investment in Clinical Leads | £445,252 |
| **Governance & Implementation**<br>• Transformation & Improvement Team<br>• Corporate Services Team | £917,909 |
| **Short term Projects**<br>• Breast Stromal Microenvironment (SME)<br>• Pharmacy Aseptics Stromal Microenvironment (SME) | £95,892 |
| **Other Posts** | £265,947 |
| **Total Recurrent** | **£1,725,000** |
| **Non-Recurrent Spend (Non-Pay)** | |
| **Courses & Conferences** – Clinical Summits, Network away days, Joint Board Development Workshops etc | £85,000 |
| **Laptops** | £20,000 |
| **IT Hardware and Software** | £50,000 |
| **Engagement Activities** – Comms material, e.g. newsletters, websites, public involvement etc | £100,000 |
| **Consultancy** – e.g. Legal Advice | £20,000 |
| **Total non-recurrent** | **£275,000** |
| | |
| **Total** | **£2,000,000** |

The budget request accounts for the following:

- Ensuring adequate capacity and expertise to deliver the work plan centred on 'Scope 1', including the Corporate Services Transformation programme
- External consultancy support for transformation and governance activities, which are likely to require clinical leadership and engagement
- Additional engagement activities for proposals that may result in service changes
- An expanding programme of centralised Joint Board Development activities

The Collaborative Executive can only commit to priorities beyond this budget if all Partners agree to share the requested resources equally, with commitments beyond the approved budget requiring justification and approval by the JPC.

Looking ahead to the 2026/27 financial year, we will use the principles in the Collaboration Agreement to develop the BCPC budget based on agreed priorities in the annual work plan.

# What are our priorities?

## Scope 1 - Leadership for Improvement & Transformation

The BCPC work plan is organised around the following priorities, with a detailed action plan developed for review, approval, and oversight by the Collaborative Executive:

## Improvement

- **Clinical & Operational Productivity** (BCPC Cost Improvement Plans to deliver Financial Recovery Plan and requirements of the 'Undertakings')
- **Quality** - Improve access, health outcomes, patient experience, and reduce variation through "leveling up" activities such as consistent protocols, better care pathways, and standards of care
- **Service Productivity** - GIRFT & Further Faster 40
- **Service Change & Transformation** - Better organisation through new models of care. (e.g. Urology, ENT, Breast, Networked Service Solutions)

## Transformation

- **Corporate Service Transformation Programme**
- **Clinical Services Improvement & Transformation**

## Strategic & Enabling Priorities

- **Governance** – Pursuit of integration at the 'North' and 'South' of the Black Country.
- **Planning Guidance** – Support delivery of the key enabling priorities outlined in the NHS Planning Guidance (Comms and Engagement, DDaT, Estates, Service Change, Workforce)

Our priorities and delivery activities align with the core purposes of a Provider Collaborative – quality, productivity, resilience, and transformation – as outlined in the national 'Working Together' policy.

**We expect this work to produce several key outputs:**

- Clinical care pathways
- Service and clinical standards
- Clinical protocols
- Standard operating procedures
- Strategic business cases
- Target operating models

**For our Partners, these outputs will have implications for:**

- Business, service, and operational processes
- Resources (finance, workforce, and materials)
- Digital, data, and technology systems

The Collaborative Executive will continue managing this work portfolio on behalf of the Joint Provider Committee (JPC), ensuring proper governance throughout the process. All outputs and their implications will be clearly documented for discussion, review, and recommendation before any decisions are made by the Joint Provider Committee (JPC).

## Scope 2 – Joint Exercising of some agreed Partner Trust responsibilities

The four partner Trusts of the JPC agreed to maintain scope area 2 within the JPC terms of reference and preserve the existing delegations across three key areas:

- Strategic and capital planning
- Performance oversight
- System business cases

While the JPC serves as a formal decision-making arrangement between the four partner Trusts, it's important to note that the BCPC is not a statutory entity. As such, it holds no performance management responsibility over the four partner Trusts beyond the three agreed areas of scope defined in the JPC terms of reference.

## Scope 3 – BC ICB delegations

The four partner Trusts of the JPC agreed to retain scope area 3 within the JPC terms of reference but recognised that NHSE restrictions on delegations remain in place for 2024-25. However, the recently published BC ICB Operating Model has identified potential areas for delegation, creating opportunities to begin discussions about future delegations in 2025-26.

# What is our approach?

Our ambition of pursuing "better, faster and safer care" can only be achieved through integrated partnership across the Black Country.

While our initial efforts focused primarily on acute care priorities among the four partner organisations, their implementation affects other key areas of the health system.

We must therefore collaborate with diverse stakeholders throughout our Integrated Care System, including clinical professionals, healthcare organisations, local authorities, patients, and voluntary sector partners.

The foundations of our collaborative approach are now firmly embedded in our operations. We consistently seek stakeholder input and ownership of priorities, striving to be inclusive, engaging, and empowering in all our activities.

Key examples include:

- Active membership in the Black Country Integrated Care Board (BC ICB)
- National Health Service Executive (NHSE) and ICB colleagues serving on the BCPC Executive
- Clinical Leads Group comprising NHSE, ICB, and all Medical Directors and Chief Nursing Officers (CNOs) from the four partner organisations
- All partner Trusts participating in their respective place-based partnerships
- Active "matrix" working between all partners on strategic enabling boards (e.g., Elective and Diagnostics Board, Cancer Board, Out of Hospital Board)

# Clinical Programme

This year, our Clinical Programme has continued to focus on two key areas:

- Improving Elective Care and
- Improving Cancer Health Outcomes

We are working collaboratively across the system to support the recovery of elective services, ensuring patients receive timely access to care. At the same time, we are developing a more strategic, system wide approach to improving cancer outcomes for patients - helping to align resources, reduce variation, and improve outcomes. By focusing on these priorities, we aim to build a more resilient and responsive set of clinical service models that meets the evolving needs of our population.

We have a diverse range of clinical networks that support the delivery of achieving these two key strategic priority areas. Read how we have done this over the next few pages.

# Breast Clinical Network

**Clinical Lead:** Martin Sintler

**Associate Director – Transformation & Improvement:** Philippa Browne, BCPC

The Breast Clinical Network has achieved significant success over the past 18 months, using mutual aid to reduce patient waiting times. With all targets currently being met, the network is now progressing development in three key project areas to enhance patient experience and outcomes:

1. Development of a Black Country Breast Deep Inferior Epigastric Perforator (DIEP) Reconstruction Service
2. Review of current breast unit arrangements across the four BCPC partner Trusts to improve organisation
3. Exploration of a Black Country Breast Radiology Alliance

These initiatives were established as the Breast Clinical Network priorities for 2025/26.

While the Black Country Radiology Alliance project remains on hold due to financial constraints, cross-site collaboration has begun with a radiologist from SWBT now working at DGFT two days weekly.

## DIEP Breast Reconstruction

Currently, no reconstruction service exists in the Black Country NHS system. DIEP (Deep Inferior Epigastric Artery Perforator) flap breast reconstruction transfers tissue, including skin, fat, and blood vessels, from the lower abdomen to recreate a breast mound. As the gold standard for reconstruction, this surgery helps women regain confidence and return to normal life more quickly.

Engagement activities have included a multi-stakeholder workshop and two virtual events to gather system-wide input on these service models.

A consensus emerged to progress the DIEP Reconstruction Service via a business case hosted by DGFT, leveraging its existing expertise and expanding capacity.

A draft business case has been produced, outlining plans to meet an estimated annual demand of 40–60 cases, with capacity for future growth. This has navigated all governance processes and approved for implementation. Operational work has now commenced at DGFT to identify and organise theatre, workforce, and infrastructure required for mobilisation and confirm a full commencement date early in Q1 26/27.

## Breast Unit Review

Early review and engagement had identified significant variation and fragility in service provision across the four partner Trusts. However, through significant efforts across all four partners, performance has improved and fragility managed, with many areas developing new novel and best practice approaches.

Whilst workforce fragility remains a possible underlying issue, the four Breast Unit teams recently met to review options for better collaboration as an immediate next steps to harnessing some of the fantastic work being undertaken across the four Breast units.

Through continued discussion the Breast Unit teams hope to develop, shape and refine a model based on shared priorities, operational feasibility and patient centred-outcomes, which may consider a more robust and resilient Breast Unit service through consolidation in the future.

# Looking Ahead

## DIEP Reconstruction Service

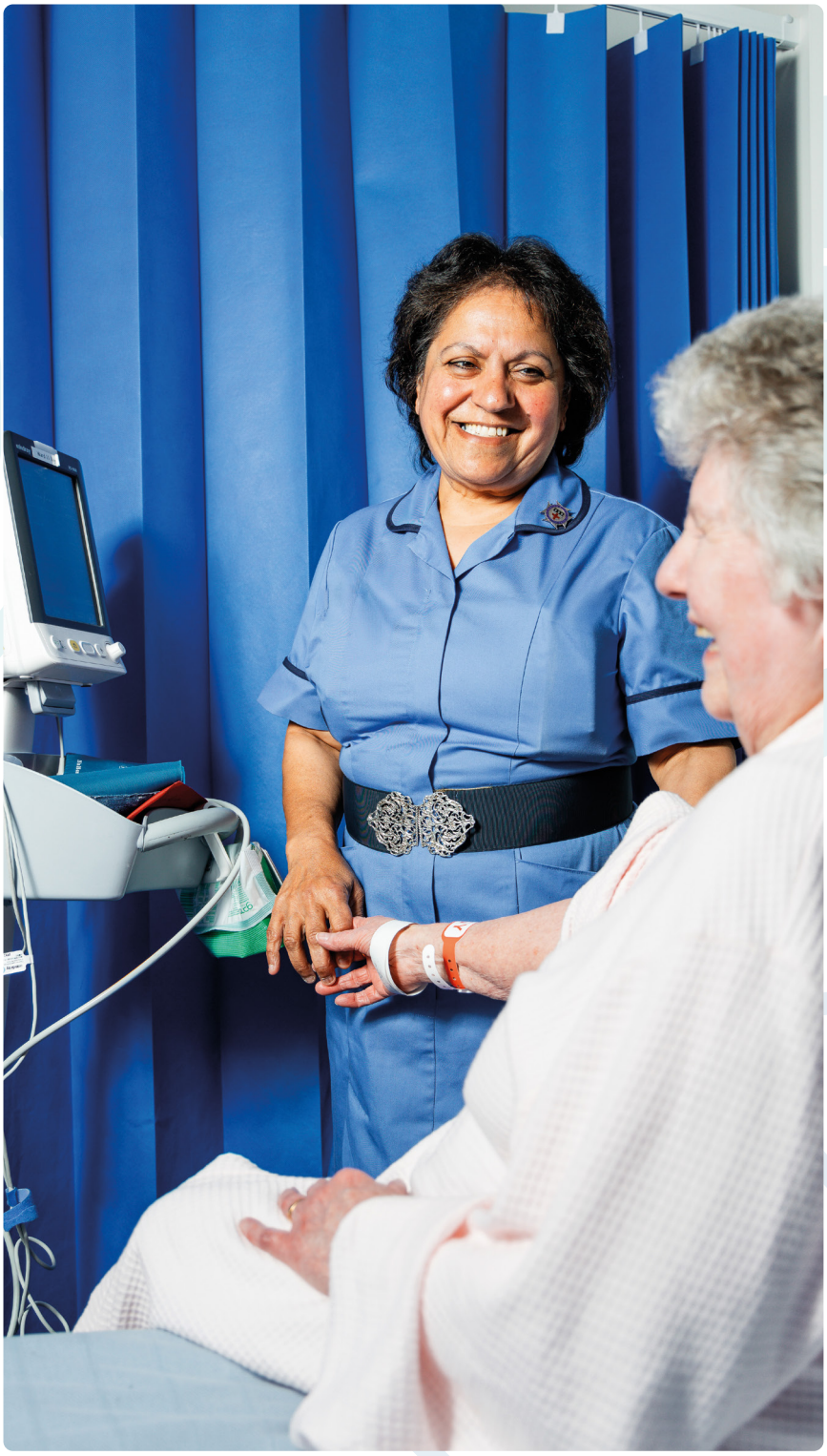
- Operational Readiness: Work collaboratively with DGFT to address required theatre capacity, staffing models and post-operative care pathways
- Ongoing Engagement: Maintain system-wide engagement to support inclusive and equitable implementation

## Breast Unit Review

- Focused Workshops: Facilitate further engagement events with all four Trusts to refine the proposed review model
- Data and Workforce Mapping: Conduct a detailed review of current resource distribution, service variation, and workforce capability
- Project planning: Develop a staged approach to aligning clinical pathways and workforce integration commencing in late 2025

## Network Objectives for 2025/26

- Deliver a sustainable, equitable DIEP Breast Reconstruction Service for the Black Country population
- Progress the review of breast units to improve efficiency, reduce variation, and enhance patient outcomes
- Align all transformation activity with NICE and GIRFT recommendations to build a resilient, gold standard breast service for the future



# Colorectal Network

**Clinical Lead:** Mr Shantanu Rout, SWBH and Mr Ben Liu, RWT

**Associate Director – Transformation & Improvement:** Philippa Browne, BCPC

The Colorectal Clinical Network has maintained active stakeholder engagement prioritising key quality improvement and transformation initiatives across the Black Country, which have included:

## 1. National Bowel Cancer Audit (NBOCA)

The Colorectal Network uses continuous data collection to monitor and improve colorectal cancer services across the Black Country. This enables early identification of challenges and targeted support through the BCPC. With the adoption of National Cancer Audit Collaborating Centre (NATCAN's) quarterly audit reports, the network is developing a performance dashboard to facilitate real-time discussion and quality improvement at each meeting.

## 2. Two-week wait FIT improvement programme

Building on the success of FIT-driven colorectal cancer pathways since 2023, the network identified the need to revise the FIT-negative safety netting strategy through ongoing monitoring and collaboration with Primary Care. A new, evidence-based pathway has been developed with the West Midlands Cancer Alliance and ratified across all four Trusts. It has been discussed in the Black Country engagement workshop and disseminated via the Primary Care communications team and the Black Country ICB, with agreement from the Black Country Primary Care collaborative.

## 3. Colorectal Robotics Programme

BCPC secured two new da Vinci Surgical robotic systems, expanding the robotics programme to three Trusts now performing colorectal resections using this state-of-the-art technology. This expansion has successfully reduced both patient length of stay and waiting times.

## 4. Reducing variation in early rectal cancer management

Early rectal cancer management previously showed significant variation across the Black Country. Common procedures like Transanal Endoscopic Microsurgery (TEMS) / Transanal Endoscopic Operation (TEO) and Transanal Minimally Invasive Surgery (TAMIS) were available in only two of the four Trusts. Through facilitated stakeholder discussions, the network has now extended these services to all four Trusts.

## 5. Consolidation of advanced rectal cancer services

Currently, advanced rectal cancer procedures are performed in only one Black Country Trust. Patients requiring complex treatment have historically been referred to University Hospitals of Birmingham NHS Trust, resulting in long travel times for patients and families. The network is establishing a second advanced rectal cancer centre using existing expertise. This will enable care repatriation, support succession planning, and potentially improve patient satisfaction. The initiative aims to standardise care, reduce health inequalities, and improve patient outcomes and survival rates.

## 6. Clinical Nurse Specialist (CNS) Workforce

The network completed a review of clinical nurse specialist (CNS) roles and responsibilities to address variations across the Black Country system.

This work is progressing well across the Trusts.

## 7. Regional Colonic Stenting Programme

The network assessed the feasibility of implementing a 7-day colonic stenting service across the system, primarily hosted at SWBH. However, since different specialties (Gastroenterology, Radiology, and Surgery) independently provide this service, creating a mutually agreed rota proved impossible. While the data collection process improved understanding of current service provision, the regional programme was ultimately abandoned due to logistical and financial constraints.

## Looking ahead

The Colorectal Clinical Network continues to deliver successes improvements and outputs including FIT implementation, Enhanced Recovery After Surgery (ERAS) pathways, and the robotics programme.

Future initiatives will focus on understanding and improving regional outcomes, advancing robotic equity across the Black Country, standardising early rectal cancer management pathways, and developing a robust advanced rectal cancer service.

It is important to recognise that success extends beyond meeting targets and realising benefits, with the colorectal clinical network fostering engagement with colleagues across all four sites, including collaboration with key groups such as operational managers and cancer managers.

# Skin Clinical Network

**Clinical Lead:** Mr. James Halpern, WHT & Mr. Aaron Wernham, WHT

**Associate Director – Transformation & Improvement:** Philippa Browne, BCPC

The implementation of Teledermatology and Mohs Micrographic Surgery (MMS) has delivered significant improvements for Black Country patients. Neither service was available 12 months ago, but thanks to the network's efforts, both are now fully operational.

## Teledermatology

A key priority for the skin network has been establishing a Teledermatology service across the Black Country. This service uses digital skin images to remotely triage, diagnose, monitor, or assess skin conditions without requiring the patient's physical presence.

This initiative represents one of the largest Teledermatology projects in the NHS, supporting patients with skin concerns by providing triage within 24 hours (excluding weekends).

### The key advantages of this approach are:

- Patients receive care closer to home
- Quick triage and response to referrals reduces anxious waiting time, improving patient experience and outcomes
- Patients gain faster access to treatment, including two-week wait skin cancer referrals
- The service helps address high backlogs in skin specialties and reduces future waiting times
- Substantial improvements in all cancer targets related to implementation
- Results include a 20% increase in outpatient attendances, 57% increase in outpatient procedures, 27% reduction in Referral to Treat (RTT) size, 46% reduction in RTT 18-week wait breaches, and 24% reduction in RTT 52-week wait breaches
- A recent audit of 2,000 two-week wait Teledermatology cases showed a 60% discharge rate back to primary care with advice
- Teledermatology has been successfully implemented for two-week wait pathways at WHT, DGFT, and RWT. The next step is to complete implementation at SWBT

## The provision of MMS surgery within the Black Country

MOHs micrographic surgery (MMS) is a precise, highly specialised technique where skin cancer is removed by taking serial horizontal sections of tissue and examining them under a microscope. This approach spares healthy tissue and leaves the smallest possible scar.

In summer 2022, a business case for Mohs was approved by the collaborative board. Mobilisation began in early summer 2023, with the service launching in late September 2023. This ensures Black Country patients (and those from surrounding ICSs) can now receive treatment closer to home.

The service is now delivered throughout the Black Country and surrounding areas (including Staffordshire and Shropshire). During 2024, all patients previously referred to University Hospitals Birmingham (UHB) NHS Foundation Trust have been repatriated to the Black Country.

Providing MOHs surgery in the Black Country ensures patients receive "gold standard" treatment closer to home, enhancing both health outcomes and patient experience.

Building works began in January 2023, creating a satellite laboratory within the existing SKIN footprint at New Cross Hospital, Wolverhampton. The project included procedure and recovery room enhancements, with appropriate air handling and ventilation systems to ensure infection prevention and control compliance.

The new MoHs service plays a significant role in attracting and retaining high-quality healthcare professionals within the Black Country who are committed to providing gold standard treatment and have an interest in this technique.

This service is expected to grow and mature, offering opportunities for ongoing team development and education while contributing to future research efforts. Next steps include developing the first accredited MoHs fellowship in the West Midlands and expanding capacity.

## Looking ahead

### Future initiatives include:

- Complete the final rollout of teledermatology at all partner Trusts
- Introduce teledermatology for non-cancer / Referral to Treatment (RTT) referrals, trialling at Walsall and RWT before rolling out to other Trusts
- Develop the first accredited Mohs fellowship in the West Midlands and expand Mohs surgery to three sessions per week, increasing patient capacity and reducing waiting times
- Introduce referral threshold criteria and clinical guidelines for primary and community care to support appropriate referrals into acute services

# Urology Clinical Network

**Clinical Lead:** Mr. Pete Cooke, RWT

**Associate Director – Transformation & Improvement:** Philippa Browne, BCPC

The Urology Clinical Network has reduced patient waiting times while boosting efficiency and implementing best practices.

Here are the network's four key priorities:

## 1. Implementation of a HVLC (High Volume, Low Complexity) Programme

The HVLC programme addresses high-volume service delivery reform, covering most of the Urology waiting list through five priority pathways.

This initiative reduces procedure backlogs while improving outcomes and day case performance.

GIRFT's five best practice pathways for HVLC activity:

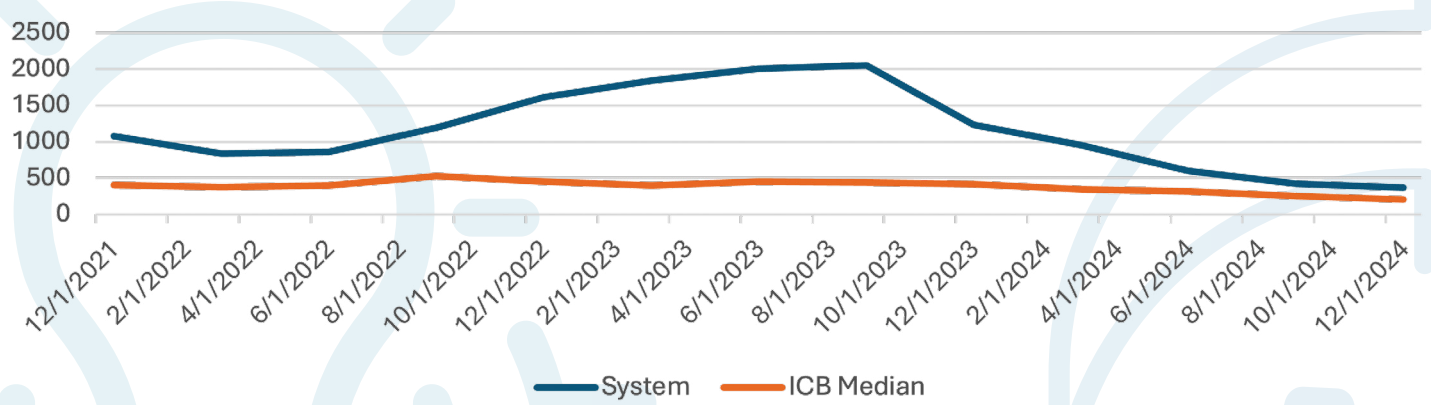
- Bladder outflow obstruction
- Transurethral Resection of Bladder Tumour (TURBT)
- Cystoscopy plus
- Minor peno-scrotal surgery
- Ureteroscopy and stent management

Improvements come through standardised pathways, surgical hubs, enhanced theatre productivity, and shifting to day case and outpatient procedures. Day case rates for TURBT, Ureteroscopy, and male bladder outflow surgery have steadily improved.

Variation in practice between providers has been identified.

52-week waiters have been significantly reduced through additional surgical lists and operational changes, including increased day case capacity, outpatient appointments, Botox clinics, and in-clinic bladder tumour ablation.

## Urology – Incomplete RTT Pathways >52 weeks



## 2. Specialist Cancer Pathways

SWBH has replicated RWT's one-stop Lower Urinary Tract Symptoms clinic, with plans for DGFT implementation. Additional theatre capacity at DGFT will benefit RWT once renal surgery transfers are completed in 2025.

The network is streamlining cancer MDT processes by dividing them between upper and lower tract, standardising methodologies, ensuring subspecialty support, and allocating patients based on clinical need. This work continues despite operational challenges and a 10% annual increase in prostate cancer cases.

Workforce development remains a priority, with recent recruitment of a pelvic surgeon, a surgical assistant, and ongoing CNS workforce development.

## 3. Local Anaesthetic Transperineal (LATP) biopsy service

Following national guidance to replace Trans Rectal Ultrasound Scan (TRUS) biopsy, we've implemented LATP biopsy services across all sites, supporting faster diagnosis, reducing theatre usage, and improving patient experience.

The nurse-led model enhances 28-day pathway performance while freeing consultant capacity, with telephone triage, MRI review, and biopsy performance now standard across sites.

The network is auditing this service change to refine pathways and ensure quality across all sites and staff.

## 4. Better organisation of specialist services

Restructuring complex surgery services aims to enhance patient care through procedure consolidation at dedicated sites, creating training hubs and building system resilience.

This aligns with the 'Centres of Excellence' concept for cancer work. Robotically assisted surgery for nephrectomy at DGFT and colorectal surgery at SWBH now complement RWT's existing program, with three trained robotic surgeons and two more in transition.

Ongoing and upcoming stages include:

- Phased renal patient transfer from RWT to DGFT
- Increasing RWT theatre capacity for pelvic cancer surgery
- Transitioning to specialized upper tract MDT
- Defining service models
- Developing the workforce for high-volume specialist centres

Complex stone surgery is being centralised at MMUH, with services including PCNL, laser surgery, and lithotripsy. By Q4 2025/26, this will improve emergency care and reduce theatre pressure.

Work is also underway to harmonise Benign Prostatic Hyperplasia (BPH) services regionwide, optimising treatment configurations while maintaining patient access and choice.

Progress has been made in standardising pre-assessment and reviewing minimally invasive techniques, including planned prostate Aquablation at RWT.

## Looking ahead

Additional network achievements include:

- Connecting subspecialty leads for learning and wider engagement
- Collaborating with ICB teams on system-wide tracking and demand modelling
- Engaging with pre assessment and consent areas
- Transforming outpatient services through one-stop clinics, PIFU, and virtual appointments
- Implementing GIRFT templates and primary care education programs

The network will advance these priorities and begin measuring benefits as initiatives complete

# ENT Clinical Network

**Clinical Lead:**
**Associate Director – Transformation & Improvement:** Gurpreet Rai, BCPC

The Ear, Nose, & Throat (ENT) Clinical Network collaborates across the Black Country to drive clinically-led improvements, support elective recovery and reduce outcome variations. This year focused on implementing GIRFT recommendations, delivering sustainable care models and embedding system-wide transformation through enhanced cross-Trust engagement. Strategic planning is establishing foundations for future enhancements.

Summary of programme focus areas and progress:

## 1. Reconfiguration of ENT Emergency and Oncology Services

A priority this year has been exploring a more sustainable model for emergency ENT services. Building on elective recovery and cancer pathway progress, the network has initiated an options appraisal to determine optimal service configuration.

One option is a "paired Trust" approach, consolidating emergency and inpatient ENT at two sites while others focus on day cases. This would improve resilience, strengthen on-call arrangements, and support Head and Neck cancer activity repatriation.

The network's Transformation Manager is leading data analysis and capacity modelling with all four Trusts to understand patient flows, workforce availability, and service pressures.

This work remains in analysis phase with no final decision yet made but represents an opportunity to shape future ENT services for safe, efficient, and equitable care.

## 2. Reduction in Paediatric Tonsillectomy Readmissions

Improving post-operative outcomes for paediatric patients has been a key focus, particularly tonsillectomy readmissions. The system rate stood at 11.6% in 22/23 but for 24/25 we have managed to bring this down to 9%. Although still above the national benchmark, this now aligns the system with our peers in the region.

Interventions include intracapsular techniques, standardised analgesic packs, and enhanced education. New 14-day medication schedules and pain diaries support consistent management and reduce unnecessary returns. Monitoring continues with the goal of reaching benchmark within 12 months.

## 3. Tonsillectomy Day Case Improvement – Adults and Children

Day case rates continue improving, with WHT at 92.6% and SWBT showing 15.1% improvement since Q2 2023/24.

System-wide standardisation includes day case as default, revised discharge protocols, and updated exclusion criteria. Analysis of inpatient conversions enables targeted interventions. Progress against the 90% benchmark is tracked through peer comparison and coding audits.

## 4. Reduction in the Utilisation of MRI IAM Scans for Sensorineural Hearing Loss

Reducing unnecessary imaging for Sensorineural Hearing Loss (SNHL) has been a priority. Internal Auditory Meatus (IAM) MRI scans should follow appropriate clinical criteria, especially from primary care.

A revised pathway ensures audiograms precede MRI requests, with new GP guidance and patient materials to promote informed decisions. Consultant oversight maintains consistency and safety.

The network is reviewing audit data to refine criteria, reduce unnecessary imaging, and align with best practice.

## 5. Shared Surgical Patient Tracking List (PTL) – ENT Programme

The network contributes to developing a shared surgical Patient Tracking List to improve access equity and reduce waiting time variations across providers.

Focus includes understanding variations in listing criteria, pre-operative assessments, and paediatric age thresholds. Questionnaires have gathered insights, with analysis planned for system-wide alignment.

Digital referral platforms are being explored to replace manual processes. Clinical engagement and governance remain central to developing a robust model for shared elective recovery.

## Key Focus Priorities for 2025–2026

For 2025–26, the network will embed and scale transformation while continuing to reduce variation. Focus will ensure sustainable, data-driven care models responsive to population needs.

- The head and neck cancer referral triage will move from pilot to full implementation, supported by training, communications, and Key Performance Indicators (KPI) tracking
- The MRI IAM pathway for SNHL will be refined using audit data
- Emergency ENT reconfiguration will advance with options appraisal findings informing final recommendations and implementation planning
- Elective care focus remains on tonsillectomy day case rates and reducing readmissions through standardised pathways
- The network will remain involved in developing a shared surgical PTL, aligning criteria and supporting digital referral processes

# General Surgery Clinical Network

**Clinical Lead:** Mr. Salman Mirza, WHT
**Transformation and Improvement Manager:** Gurpreet Rai, BCPC

The General Surgery Clinical Network has built on its foundation year, evolving into a collaborative forum for system-wide surgical improvement. During 2023–24, the network achieved tangible progress across several shared priorities, aligned with Getting It Right First Time (GIRFT) recommendations and high-volume, low-complexity (HVLC) surgical targets.

Efforts have centred on improving consistency across key clinical pathways, addressing outcome and access variations, and developing future system-wide service models. The network maintains its focus on operational excellence while ensuring surgical services meet growing demand safely, efficiently, and equitably.

Improving laparoscopic cholecystectomy day case rates remains a key priority, with providers reviewing current practices to align with GIRFT expectations. Variations in theatre list structure, patient assessment, and discharge processes have prompted local actions to optimise scheduling, strengthen perioperative protocols, and increase day case treatments. Similarly, the network has reviewed day case rates for inguinal and paraumbilical hernia repair. Data analysis has identified opportunities to reduce overnight stays by:

- Reviewing patient selection criteria
- Standardising discharge pathways
- Addressing differences in anaesthetic and booking practices

Developing a consistent hot gallbladder pathway has become a network priority, given the variation in how acute gallbladder patients are triaged, admitted, and operated on across the Black Country. With emergency cholecystitis length of stay remaining above GIRFT benchmarks, the network has collaborated with clinical teams to review current models and develop a standardised approach ensuring timely surgical access. A coordinated data collection process is underway to inform:

- System-wide mapping of current pathway models
- Identification of operational bottlenecks
- Feasibility of a unified pre-operative and theatre access model

The network has also reviewed appendicectomy pathways to help reduce average length of stay. Despite progress, variations in emergency theatre access, discharge timing, and post-operative processes continue to affect performance. Several providers are now developing formal written appendicitis pathways, with shared learning driving greater consistency across sites.

Strategic service development work has also advanced a business case for a system-wide bariatric surgery service, which is nearing completion, and the proposed model expected to deliver:

- Up to 600 procedures per year
- A hub-and-spoke delivery model across all four Trusts
- Improved patient access and continuity of care
- A system-wide income opportunity of approximately £3 million

The business case is scheduled for ICB submission by Q4 of 2025/26 and continues to be refined with clinical and operational input.

Progress has also been made on developing a position paper for laparoscopic adrenal surgery. Currently delivered by a single consultant within the system, this specialist pathway is being reviewed for long-term viability, workforce resilience, and service consolidation opportunities.

## Looking ahead

The coming year will focus on translating this work into visible service improvements. Priorities for 2025–26 include:

- Finalising and piloting the system-wide hot gallbladder pathway
- Supporting continued improvement in HVLC day case performance
- Reducing length of stay in emergency general surgery pathways
- Submitting the bariatric surgery business case and preparing for mobilisation and implementation
- Completing the laparoscopic adrenal surgery position paper
- Tackling operational variation through targeted data analysis and cross-site engagement

# Gynaecology Clinical Network

**Clinical Lead:** Mr. Ayman Ewies
**Transformation and Improvement Manager:** Gurpreet Rai, BCPC

The Gynaecology Clinical Network continues to drive collaboration across the Black Country, focusing on high-volume, low-complexity (HVLC) pathway optimisation, GIRFT alignment, and long-term service sustainability. During 2023–24, the network delivered significant progress on key metrics while strengthening strategic planning for more equitable specialist service access.

Improving surgical productivity and access to minimal access techniques remains a key priority. Retrospective audits confirmed that open hysterectomies were being performed more frequently than necessary across several sites. In response, the network implemented system-wide inclusion criteria for laparoscopic hysterectomies, with the goal of reaching the 77.7% national benchmark.

Minimal access hysterectomy activity has improved by 11% compared to last year, with procedures increasing from 83 to 147 for patients under 50. Reducing variation and ensuring equitable access remains a priority across all providers.

Length of stay metrics show notable progress. Three of the four acute Trusts now exceed the GIRFT benchmark for vaginal hysterectomy stays under two days – DGFT at 77.7%, SWBT at 88.2%, and WHT at 90.4%. These figures aren't yet fully reflected in national data, so efforts are underway to address coding discrepancies through re-audit.

A system-wide analysis of five HVLC pathways has been completed, with actions addressing referral and pre-operative variations. Endometrial ablation and hysteroscopy pathways now exceed 78% outpatient conversion. Total elective gynaecology activity reached 80.2% of 2019/20 levels in Q3 2024/25, while theatre utilisation improved to 84.1% in February 2025 – the highest in the Midlands.

The network has made substantial progress in subspecialist service development. A system-wide Complex Vulval Services MDT proposal has advanced, with SWBT as the host site. The model features quarterly MDT meetings supported by a cross-specialty clinical group and dedicated coordinator. Service mapping is underway to distinguish local versus regional referral needs, with a virtual MDT model being explored.

The Black Country Endometriosis Service (BCES) is evolving through a review of advanced endometriosis care delivery. This review focuses on creating sustainable, clinically robust, and equitable pathways that maximise expertise across sites. Work includes strengthening governance, aligning referral processes, standardising patient information, and enhancing MDT functions with supportive services like pain management, physiotherapy, and dietetics.

Workforce development remains central to transformation efforts. A 2024 review identified significant variation in consultant surgical capability – particularly for laparoscopic hysterectomy. The network has prioritised developing a surgical training roadmap and is facilitating cross-site mentorship and skill-sharing with high-performing sites.

Performance against GIRFT metrics has informed targeted improvements, including enhanced recovery protocols, expanded one-stop clinics, hot clinic models to reduce readmissions, and pilot access to robotic surgery for cancer procedures. All Trusts are aligning pathway design with GIRFT expectations through shared learning and data analysis.

## Key Focus Priorities for 2025–26

As the network enters its next development phase, priorities include:

- Full implementation of the Complex Vulval MDT, including referral guidance and clinical oversight
- Finalising and delivering the BC Endometriosis Service model compliant with national specification requirements
- Further reducing open hysterectomy rates through workforce planning and surgical training
- Aligning length of stay and day case rates for vaginal and laparoscopic hysterectomy across all sites
- Validating GIRFT performance data to ensure national datasets reflect local improvements
- Aligning all HVLC pathways with GIRFT principles, including improved coding, discharge planning, and pre-operative optimisation
- Addressing long waits and supporting equitable access to both elective and subspecialist services

# Ophthalmology Clinical Network

**Clinical Lead:** Mr. John Barry
**Transformation and Improvement Manager:** Gurpreet Rai, BCPC

The Ophthalmology Clinical Network made strong progress during 2023–24, driving system-wide collaboration to improve access, reduce variation, and embed sustainable, high-volume pathways across the Black Country.

Work by the clinical network has increased day-case cataract procedures, with more than 23 cases now performed at weekends.

High-volume cataract surgery remains a core focus, with Trusts across the region continuing to align delivery with GIRFT benchmarks.

## Day case cataracts

All providers now achieve day-case cataract rates close to or above 97%, with several sustaining performance at or near 100%. Pilot high-volume lists have been successfully delivered, including weekend sessions at Cannock and Dudley. However, utilization has occasionally been affected by last-minute patient dropouts—most commonly due to transport issues. A proposal to introduce transport support (such as funded taxi services) is now under consideration to improve list completion and reduce unused capacity.

In parallel, the network has supported work to align referral routes, reduce unnecessary independent sector leakage, and strengthen equity in access across all sites. Discussions are underway around a potential waiting time cap and Single Point of Access (SPA) for high-volume specialties such as cataracts. The ICB is scoping these options to improve patient choice and reduce pathway complexity.

## Glaucoma Enhanced Referral Service

Significant progress has been made in advancing a system-wide community pathway for glaucoma. The Glaucoma Enhanced Referral Service (GERS), successfully embedded in Wolverhampton, is now being prepared for rollout across the rest of the Black Country. Clinical consensus has been reached, with consultants and optometrists agreeing key delivery criteria, including the requirement for at least Level 2 glaucoma accreditation and the ability to capture fundus or OCT images to support quality assurance audits.

Audit samples and data governance principles are being finalized, and commissioning conversations are underway to support consistent implementation across Trusts. The introduction of image capture as part of the referral specification will enable more robust evaluation of false negatives and overall pathway quality.

Meanwhile, early discussions are ongoing to develop a similar model for stable post-treatment patients in medical retina. While consensus is still developing, stakeholders have acknowledged the need for enhanced triage and community care options to support long-term pathway sustainability. Work is currently focused on mapping optometry capability, training needs, and technology integration.

The network has also worked to strengthen specialist and emergency care pathways. Challenges remain in accessing a consistent on-call vitreoretinal (VR) service across the region, particularly at New Cross Hospital, where service pressures continue. Observational visits have taken place at Birmingham Midland Eye Centre (BMEC), and a proposal for regional cross-site collaboration is now being scoped, including potential shared rotas and emergency referral models.

To further support consistency and reduce variation, work has begun to consolidate local optometry referral guidance into a single Black Country-wide document. The aim is to produce a standardized, accessible framework that aligns expectations, improves referral quality, and supports equity of access across all four Trusts.

## Looking ahead

The network will continue to scale and embed this year's progress. Priorities include:

- Completing commissioning and launching the GERS pathway across all Trusts
- Finalizing the refreshed optometry referral guidance for system-wide use
- Establishing a taskforce to align cataract HVLC delivery and reduce inequity in list access
- Continuing early-stage development of a medical retina community model
- Strengthening collaboration with BMEC to improve VR and sub-specialist cover
- Supporting the ICB in scoping the Single Point of Access (SPA) and 30-week wait cap for high-volume services

With an increasingly aligned program of work and a strong commitment to collaborative delivery, the Ophthalmology Clinical Network continues to play a vital role in securing long-term improvements in patient care across the Black Country.

# Pharmacy Clinical Network

**Clinical Lead:** Mr. Puneet Sharma, SWBT
**Transformation and Improvement Manager:** Clinical Support Services: Alima Bibi, BCPC

The Pharmacy Clinical Network has focused on improving quality, safety, and efficiency.

## Pharmacy Improvement Projects

Pharmacy supports all clinical networks and ensures timely patient discharge. The network has a plan to address key development areas.

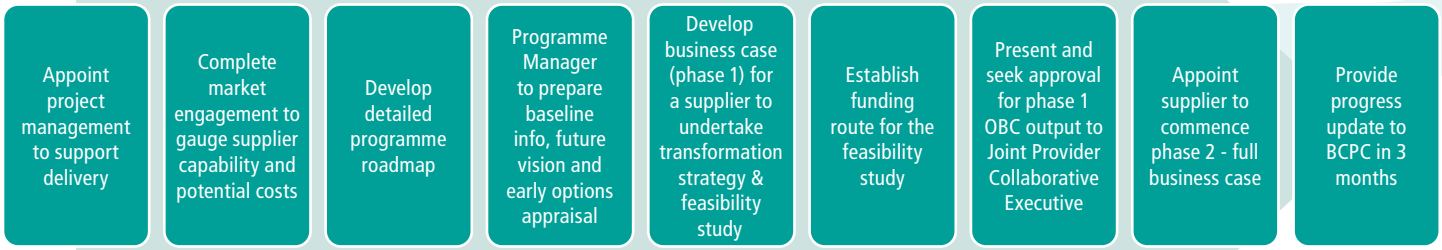
## Aseptics Programme

Chemotherapy, oncology, haematology, and clinical trials medicines must be produced in aseptic units. The four units across the Black Country are aging, fragile, and no longer meet Quality Assurance standards. While functional, they are past their lifecycle and at capacity.

In response, the Provider Collaborative Executive commissioned a feasibility study in June 2024 to assess facilities, identify gaps, and explore transformation options—including hub-and-spoke models. The study will evaluate risks, replacement options, future demand, and potential efficiency savings.

In early 2025, an external supplier was appointed to assess units and create a strategic outline case. This work has now concluded with the output due for presentation and agreement on a way forward.

## Diagram 5: Timeline of Aseptic Programme




## Biosimilar Workstream

The workstream identifies opportunities to facilitate uptake of biologic and generic medicines while rationalising medicines to deliver savings.

Biosimilar medicines have no clinically meaningful differences from originator medicines but are more cost-effective, helping the NHS save money.

The programme delivered over £21 million in savings for the Black Country ICS in 2024/25. For 2025/26, projected savings exceed £400,000 on in-tariff medicines and £4 million on ICB-funded medicines.

## Pharmacy Workforce

This programme ensures coordinated workforce recruitment, retention, and upskilling across all four Trusts, aligning plans, pathways, and training to build a skilled workforce.

The workstream has harmonized training pathways through guidance on induction, Protected Learning Time, and Structured Training and Education for Pharmacists (STEP) programmes, creating developmental career pathways for all pharmacy staff.

## Digital Medicines and Automation

Compliance with medication storage and management legislation has been problematic and is a Care Quality Commission (CQC) priority. Medication errors remain prevalent. Digital approaches can improve safety. A new workstream supports digital transformation and automation around medicines.

This programme aims to improve compliance with medicine storage legislation and reduce harm from medication administration.

## BCPC Trust Formulary Group

This workstream identifies and reduces variation in 'hospitals only' medicines use and identifies savings through national contracts and best-value lines.

## Looking ahead

Key priorities include:

1. Agree on a way forward for the future of Aseptic Services across the Black Country.
2. Continue medicines savings work.
3. Reduce variation in responsibilities across Trusts, strengthen Foundation Year training, expand Independent Prescribing,and support workforce upskilling.
4. Use technology to improve medicine storage adherence and medication administration safety.
5. Reduce variation in Trust formularies for 'hospital only' medications.

# Peri-Operative Medicine Network

**Clinical Lead:** Dr. Anna Pierson, DGFT

**Programme Lead - Elective Care Lead:** Hilary Lemboye, BCPC

**Transformation & Improvement Manager – Medicine Services:** Dr. Amit Rath, BCPC

## Overview

The Black Country has embedded perioperative medicine (POM) as a system-wide priority. Aligned with NHS England's Five Core Requirements, BCPC has progressed from baseline assessments to coordinated interventions that improve surgical outcomes, reduce inequalities, and advance value-based care.

## Establishing the Baseline (Jan 2024 – Oct 2024)

Initial assessments revealed variation in perioperative practices across Trusts, including fragmented digital systems, inconsistent pathways, and limited primary care integration. BCPC established a Perioperative Clinical Network for monthly collaboration, strengthened through engagement with the regional System Leads Group.

Standardised pathways were developed targeting conditions like anaemia and diabetes, plus interventions covering nutrition, smoking, physical activity, and mental wellbeing.

## Key Activities by October 2024

**1. Launch of the Surgery Hero Initiative (SHI) at DGFT**

SHI is a digital health coaching platform supporting patients preparing for surgery up to 12 weeks pre-operatively. By October 2024, 1,295 patients were supported, achieving a 22% reduction in length of stay, 69% fewer readmissions, and 79% reduction in perioperative transfusions.

**2. Early Health Screening (EHS) Away Day**

The October 2024 EHS Away Day strengthened primary and secondary care collaboration, focusing on workforce planning, resource optimisation, and development areas including frailty and nutrition. Providers committed to improving digital triage and standardising Standard Operating Procedures (SOPs).

Progress Update (Oct 2024 – March 2025)

## Key achievements included:

- Adoption of Waiting List Minimum Data Set (WLMDS) and development of live perioperative dashboards
- Participation in national audits including National Pre-Operative Assessment (POA) Postponement Audit and Sentinel Stroke National Audit Programme (SSNAP) audit
- Expansion of health optimisation services across Trusts
- Workforce planning informed by 2024 Annual Census and strengthened optimisation pathways
- Integration of digital patient portals with EPR, trialling CLEAR notes AI, and development of frailty pathways

Challenges remain including digital fragmentation, workforce limitations, variable Primary Care engagement, and pathway variation.

## Diagram 6: Heat map for key focus areas over time

| | DGFT | | | WHT | | | RWT | | | SWRH | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan 24 | Oct 24 | Mar 25 | Jan 24 | Oct 24 | Mar 25 | Jan 24 | Oct 24 | Mar 25 | Jan 24 | Oct 24 | Mar 25 |
| Early Health Screening | P | IP | IP | P | IP | Y | P | IP | Y | N | IP | IP |
| Individual Optimised Pathways | Y | Y | Y | P | P | P | Y | P | Y | P | P | P |
| No TCI before green | Y | Y | Y | N | P | IP | N | N | P | N | N | N |
| Shared Decision Making | Y | Y | Y | Y | Y | Y | Y | Y | Y | P | IP | Y |
| Keeping in touch | N | Y | Y | N | Y | Y | N | Y | Y | N | N | N |

No (N) | Partial (P) | In progress (IP) | Yes (Y)

## Looking Ahead

Strategic priorities include:

- Finalising a shared ICS-wide 3-year POM strategy
- Expanding Surgery Hero to more Trusts and specialties
- Strengthening Primary Care collaboration for early screening
- Scaling prehabilitation for high-risk patients via community delivery and Voluntary, Community, Social Enterprise (VCSE) partnerships
- Developing new workforce roles including Care Coordinators and Environment, Health, and Safety (EHS) Practitioners
- Embedding "No TCI before Green" to ensure clinical optimisation before scheduling
- Using dashboards for real-time monitoring and improvement
- Reinstating pandemic-paused services and aligning POA pathways
- Aligning digital systems through patient portals, shared electronic records, and AI tools

# Corporate Programme

Over the past 18 months, our Corporate Programme has focused on areas where we can drive meaningful change at scale across all four Trusts. Through collaborative working, we support the Trusts in making informed, collective decisions about resource allocation and strategic priorities to achieve maximum impact.

Key areas of focus include:

- Workforce and HR workstream
- Corporate Services Transformation programme

Through this shared approach, we have identified and advanced corporate programmes that deliver tangible benefits across the system. While each provider may adopt different methods, our focus remains on recognising common challenges, sharing insights, and co-developing practical, scalable solutions.

This collaborative model is embedding a culture of continuous improvement and innovation across the Black Country. We are not only responding to current pressures but actively shaping a more resilient, effective and sustainable future for our services and the communities we serve.

## Workforce and HR Workstream

**Workforce and HR Senior Responsible Officer:** Alan Duffell

**Transformation & Improvement Manager:** Lola Omotoso BCPC

The Workforce and HR workstream of the Black Country Provider Collaborative (BCPC) supports stronger collaboration between the four partner acute Trusts. Over the past year, we have made steady progress in aligning workforce processes and systems, improving consistency, and exploring better ways to support our people and services. The following are some highlights from across the agreed workstream priorities:

## Alignment of Bank Rates

A key area of progress this year has been aligning pay rates for temporary (bank) staff on Agenda for Change across the four acute Trusts. As of 1 September, all acute Trusts have aligned their temporary staffing rates to bottom of band. This work supports fairer pay, reduces competition between Trusts, and makes it easier for staff to work across different sites while ensuring financial savings.

Work has progressed to review and harmonise medical bank rates across the system. The proposed rates are now in consultation with the LNCs. These harmonised rates will help reduce variation across the Black Country and promote equity and consistency.

## Policy Alignment

We began aligning HR policies across all four Trusts. The Policy Alignment Group has agreed on a set of policy principles that are now ready for consultation with staff-side representatives in each Trust. These principles cover:

- Organisational change
- Special Leave policy
- Sickness Policy

Looking ahead, the group has outlined several priorities. A reference policy has been highlighted, with best practice being shared across the group. Work is also underway on a sexual safety policy, while temporary staffing and WLI policies will be prioritised. Additional developments include a draft group sickness policy at RWT/WHT and a group menopause policy now being implemented across the Black Country Provider Collaborative. The group is also assessing progress against the national policy framework development pipeline to ensure outcomes can be benchmarked and shared effectively across all Trusts.

## Workforce Alignment

The Trusts have successfully completed the review and alignment of Clinical Band 2 and 3 roles across all services. This initiative, forming part of a wider strategic workforce transformation programme, ensures consistency in job descriptions, competencies, and service delivery across our organisations.

## Band 2 and 3 Review—Completed and Standardised

Following an in-depth evaluation process, the Trusts have now harmonised the job descriptions and role expectations for Band 2 and Band 3 clinical roles. Each Trust has reviewed their clinical Band 2 workforce for an uplift. The uplifts and any associated back pay have now been processed, following consultation and support from the unions.

## Band 4–6 National Profile

Following the release of the national job profiles in June, work has already begun to align these across the Black Country, led by the Chief Nursing Officers. The focus is on Bands 4–6 job descriptions, aligning to the national profile and harmonising across the acute providers. The profiles will form the basis for a consistent regional approach to job design and workforce planning, supporting wider system-wide collaboration once fully implemented.

## Enhanced Collaboration

Engagement from HR, workforce, and operational teams has been strong and continues to build momentum. Regular group meetings, shared learning, and open communication have helped build trust and a shared sense of purpose. Collaborative working remains at the heart of this programme. There has been a real commitment from all teams to work together and solve problems in a joined-up way.

## Challenges and Learning

The alignment of Agenda for Change bank (temporary staffing) pay rates experienced delays in one Trust due to internal processes and priorities. However, with continued support and engagement, non-medical rates are now fully aligned across the system. Medical bank rates remain in consultation, highlighting the need for careful engagement and agreement before publication.

Policy alignment is making good progress, with the first phase of HR policies advancing and demonstrating the benefits of a phased approach with regular review.

## Looking Forward

- Publishing the proposed medical bank rates once consultation is complete
- Finalising and rolling out the first phase of aligned HR policies and reviewing additional policies for alignment
- Continuing to build consistency in workforce policies across the Black Country
- Developing the BEACON project with RLDatix as a potential solution for strengthening performance and productivity

# Corporate Services Transformation Programme

**Senior Responsible Owner:** James Fleet, Group Chief People Officer, DGFT & SWBT

**Programme Lead:** Cheryl Scott

Corporate services transformation is a key BCPC work plan commitment, supporting financial recovery and national planning guidance.

In early 2024, the Corporate Services Transformation Programme (CSTP) was reinvigorated with a small team and new Senior Responsible Owner.

CSTP aims to transform corporate services delivery across the Black Country system, addressing challenges including health inequalities, rising demand, financial constraints, and efficiency pressures while maintaining quality patient care and safety.

Partners must collaborate to increase productivity, transform corporate services, and improve outcomes while supporting financial sustainability.

Supporting the BCPC vision: ***"One healthcare system, across multiple sites, working in partnership to provide better, faster and safer care to the population of the Black Country and beyond."***, the CSTP aims to:

- Deliver high-quality collaborative corporate services enabling staff to perform effectively, deliver safe care and meet operational targets; and
- Direct limited funding to the front line while providing corporate services staff a great place to work.
- These objectives are underpinned by three key benefits:
- **Improvement:** reducing duplication, improving consistency, standardising processes, and simplifying to enable better demand management, service resilience and performance; and
- **Resilience:** improving colleague experience through multi-skilling, succession planning, career development, and service transformation via best practice, automation, digitisation, and self-service; and
- **Efficiency:** achieving a lower, sustainable cost base and reduced third-party expenditure

Following a revised governance framework, engagement workshops began in late Autumn 2024, well attended by senior corporate services leaders from the four BCPC partner Trusts and associate partners (Black Country Healthcare NHS Foundation Trust and Black Country Integrated Care Board).

Trade union representatives also attended, with follow-on briefing sessions for those unable to attend.

## Diagram 7: Engagement workshop overview

**Workshop One**
**Foundations of Change**

Bringing everyone together to **build a common understanding** of corporate services transformation

**Workshop Two**
**Building a Collaborative Approach 1**

Understanding our as-is position and **considering potential to-be opportunities** for collaborative transformation

**Workshop Three**
**Building a Collaborative Approach 2**

Reflecting on what the data tells us **could be possible and how this might inform our direction of travel**

## October 2024 – Engagement Workshop One

Participants sat with peers across nine professional working groups representing corporate services. The workshop established common understanding of transformation aspirations aligned to national and local priorities.

Groups reflected on current structures and functions, showing immense pride in staff responding to increased demand despite constrained resources.

Shared concerns emerged around service resilience, staff attraction and retention, and variations in service models and standards impacting user experience.

Interactive activities confirmed cross-system commitment to collaborative transformation opportunities for improvements, resilience, and efficiency.

## November 2024 – Engagement Workshop Two

This workshop built understanding of CSTP and reinforced collective ambition to explore alternative corporate services delivery models supporting staff, patients, and the system.

Participants shared ideas about collaborative transformation. A guest speaker from another five-trust NHS system shared lived experience and lessons learned, informing our local approach.

Through structured exercises, participants mapped existing ways of working and shaped ideas for future models, showing strong commitment to identifying scalable opportunities.

## January 2025 - Engagement Workshop Three

Workshop three strengthened understanding of CSTP's ambition to deliver large-scale corporate services improvements.

Held before 2025/26 planning guidance publication, participants reflected on anticipated impacts and existing challenges. The transformation programme is seen as an enabler for the right approach for the system, staff, and patients.

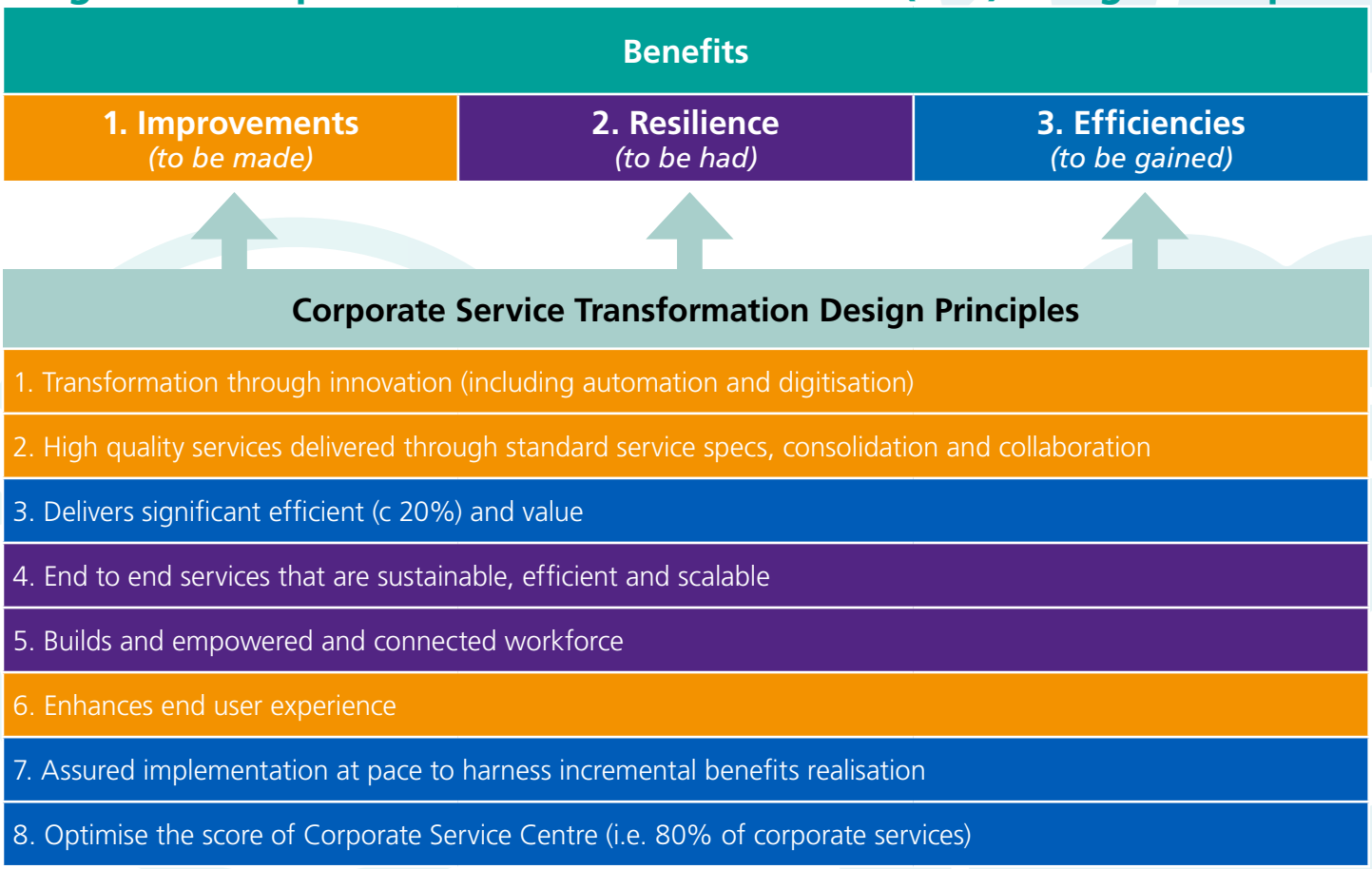
Participants considered the transformational ambition and a high-level emerging model, understanding how current services and functions could map to it.

## Diagram 8: Emerging Model Components & Characteristics

| Strategic | BC Corporate | Local Delivery |
|---|---|---|
| • Leadership & strategy<br>• Integrated strategic planning and delivery<br>• System improvement (i.e. Financial/Service improvement) and transformation (Group, Provider Collaborative and ICS)<br>• System development & sustainability<br>• Stakeholder relationship management | • Standardised service specifications for all transactional corporate functions delivered and optimised through<br>• Digitisation<br>• Automation<br>• Collaboration<br>• Performance KPI driven<br>• Highly efficient<br>• Reduced Full Time Establishment (FTE)<br>• Reduced cost<br>• Economies of scale<br>• Increased productivity | • Local contract management of the managed shared service<br>• Supporting local operational delivery<br>• Shaped by local operational requirements<br>• Local operational planning |

Proposed design principles were reviewed. These maintain consistency in future design work and provide the basis for decisions about the future model.

## Diagram 9: Corporate Service Transformation (CST) Design Principles




Workshop three marked the transition from engagement to delivery focus.

The programme remains on track with senior leadership support. Eight recommendations were approved at the February 2025 Joint Provider Committee, triggering follow-on actions with senior stakeholders.

Programme objectives remain consistent with national planning guidance, strengthened by NHS changes announced in March 2025. The Black Country Integrated Care Board confirmed they remain formally out of scope but supportive and engaged.

A continuous theme has been the desire to explore digitisation and automation opportunities.

Work continues to confirm the scale of opportunity corporate services transformation could deliver, through the following three repositioned delivery phases:

- **Phase 1A** - Trust-led productivity and efficiency improvements aligned to national guidance, establishing the foundation for future scale opportunities
- **Phase 1B -** Running alongside Phase 1A, CSTP progresses collaborative work (e.g. Collaborative Bank, Research & Development, Recruitment) and enabling digital activity for 2025/26, subject to governance and resources
- **Phase 2 -** Building on Phase 1, evaluating opportunities across remaining in-scope functions to deliver benefits at scale, including managed shared service approach, subject to appraisal, agreement and governance. Indicative timelines from late 2025/26 into 2026/27, subject to approvals

## Some of Our Achievements

**Engagement across the BCPC system:** Colleagues from in-scope Trusts and staff-side representatives participated in three cross-system workshops and briefings (including two trade union sessions), shaping progress with senior-level input. Stakeholders shaped progress through:

- **A shared case for change:** Workshops confirmed shared corporate services challenges and collaborative improvement opportunities
- **Codesigning the future model:** Colleagues collaboratively developed the emerging approach combining collaborative working in a managed shared service model
- **Programme oversight:** A monthly CST Programme Board maintains momentum and transparency with governance oversight from the Joint Provider Committee via the BCPC Executive, plus NHS England assurance support
- **Clear direction agreed:** The Joint Provider Committee, via the BCPC Executive, endorsed design principles and emerging direction, commissioning detailed work to test options and potential benefits at scale

## Key Activities Underway

Current CSTP delivery activities:

- **Robotic Process Automation –** all in-scope trusts exploring automation opportunities through NHS England's national RPA pilot programme
- **Digital Assessment –** working with a Digital Assessment Task and Finish Group to map digital resources and capabilities - including EPRR compliance - to inform decisions and potential investments
- **Research and Development (R&D) –** working with an R&D Task and Finish Group of SMEs from all five in-scope trusts to co-design a collaborative R&D service specification and test a proof-of-concept during late 2025 (subject to governance)
- **Collaborative Bank -** working with a Collaborative Bank Task and Finish Group to identify and explore options for implementing a system-wide Collaborative Bank
- **Recruitment -** working with a Recruitment Task and Finish Group on a comprehensive options appraisal to develop foundational work for progressing towards a Managed Shared Service model

## Next Steps - Aspirations for Delivery:

Activities progressing and planned for 2025/26, subject to governance, resources, and partner agreement:

- Collaborative Bank & Recruitment: Complete options reviews and agree next steps with partners and staff side (making it easier to fill shifts, reduce duplication and vacancy rates via shared resources, and support fair, consistent hiring)
- Research and Development: Complete proof-of-concept to test managed shared service for R&D support to inform future decisions
- Digital Assessment (with EPRR compliance): Complete system-wide assessment and develop prioritised roadmap supporting service resilience and EPRR requirements, with proposals progressed through standard partner governance
- Productivity (Robotic Process Automation, RPA): In partnership with NHS England's national pilot, explore opportunities to reduce administrative burden and evidence early productivity gains from existing resources

# Our future

As a partnership, we have made positive progress in planning for delivery. We are using a common tool (Strategic Planning Framework) and have agreed a BCPC work plan with resources to support its delivery.

However, our future environment will change considerably following publication of the NHS 10-year Plan (Fit for the Future - published on Thursday 3 July 2025). This plan builds on messages from the late 2024 Darzi review, including:

- A focus on three radical shifts: "hospital to community", "analogue to digital", and "sickness to prevention"
- A new operating model delivering a more diverse and devolved health service by repositioning the existing architecture and reintroducing incentives, penalties, and concepts that push "power" out to places, providers, and patients
- Greater transparency and focus on quality of care, enabling better patient choice through published "league tables" and adjustments to national bodies (e.g., Care Quality Commission and National Quality Board). The National Quality Board (NQB) will develop a quality strategy and modern service frameworks
- A review of NHS workforce standards, operating environment (e.g., recommendations from the Sir Gordon Messenger review), skill mix, and makeup to ensure the workforce is nimble, flexible, and adaptable for a fit-for-the-future NHS

While details and delivery plans continue to emerge, key concepts of the forthcoming operating environment include (not exhaustive):

- Local layers of commissioning and provision through Integrated Neighbourhood Teams (INTs) and some form of Accountable Care Organisations (ACOs), which may evolve from current PBPs
- Renewal of the Foundation Trust model for all NHS Trusts, with adjusted terms and conditions encouraging a return to a more robust business culture
- Greater freedoms for high-performing FTs through earned autonomy and a light-touch performance regime aligned to the refreshed NHS Oversight Framework
- A centrally driven approach to quality standardisation through National Service Frameworks (NSFs)

These elements aim to strip away perceived bureaucracy that has emerged over the last decade, focusing on creating a firm foundation for the future.

However, the behaviours that may emerge from these NHS Plan concepts could drive away from the collaborative approach we have been pursuing, encouraging competitive behaviours with sovereign organisations as the predominant unit of performance measurement.

It remains to be seen whether the future operating environment will strengthen the use of existing policy and guidance (e.g., Good Governance & Collaboration, Enforcement). With significant efforts made to build a collaborative ethos—much needed in the Black Country due to fractured relationships at many levels—it would be a backward step to return to a solely competitive environment. The hard-fought focus on trust and relationships through our work programmes could be lost, and many successes slowly eroded.

Recently, a range of guidance has been published to support NHS Plan delivery, including:

- **Planning Guidance** (Aug 25)—expanding the planning horizon from one year to five years and setting out planning parameters, principles, and intended behavioural shifts
- **Model ICB** (Jul 25) **& Model Region** (Sept 25)—establishing a focus for each part of the system and characteristics that will frame their future work
- **NHS League Tables** (Sept 25)—establishing a new performance regime aligned to the NHS Oversight Framework in a transparent manner for the public and NHS workforce
- **Assessing Provider Capability** (Sept 25)—a key building block of the forthcoming NHS Operating Model to ensure the correct capacity and capability to support delivery of the NHS Plan

Locally, the new ICB Clustering arrangements are slowly taking shape, with key transitional work to be identified shortly.

We are reviewing the implications of both the new guidance and emerging operating environment, alongside our own internal review of our achievements, reflections, and learnings from our journey to date. There may be a need to reset our future for collaborative and partnership working, with a focus on a smaller range of transformative priorities at scale.

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