NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 10TH JULY 2025, 9.00AM, BOARDROOM, LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	0900	P92/25	Welcome and Apologies for Absence – **Dr Dennis Okolo**	Janet Dawson	**Note**	
2	0902	P93/25	Declarations of Interests – and changes to be notified	Janet Dawson	**Note**	
3	0903	P94/25	Minutes of the Previous Meeting held on 8th May 2025	Janet Dawson	**Approval**	**Enc. 1**
4	0905	P95/25	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	**Note**	**Enc. 2**
5	0910	P96/25	Patient Story – Ness's Story	Kenny Laing	**Note**	**Video**
6	0925	P97/25	REACH Recognition Team Award – **Community Directorate – Greenfields Centre**	Dr Buki Adeyemo	**Note**	**Verbal**
7	0935	P98/25	Chief Executives Report	Dr Buki Adeyemo	**Discussion**	**Enc. 3**
8	0940	P99/25	Stoke-on-Trent and Staffordshire Integrated Care Board Briefing May 2025	Dr Buki Adeyemo	**Information**	**Enc. 4**
9	0945	P100/25	Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) Meeting June 2025	Dr Buki Adeyemo	**Information**	**Enc. 5**
10	0950	P101/25	Chairs Report	Janet Dawson	**Assurance**	**Enc. 6**
11	1000	P102/25	Questions from Members of the Public	Janet Dawson	**Note**	**Verbal**
			QUALITY			
12	1005	P103/25	DIPC Annual Report 2024/25	Kenny Laing	**Assurance**	**Enc. 7**

13	1010	P104/25	Mortality Surveillance Annual Report 2024/25 and Quarter 4 Report 2024/25	Dr Ravi Belgamwar	**Assurance**	**Enc. 8 & Enc 8a**
14	1015	P105/25	Patient Safety (SI) Quarter 4 Report (PSIRF)	Dr Ravi Belgamwar	**Assurance**	**Enc. 9**
15	1020	P106/25	Quality Committee Assurance Report from meeting held on the 3rd July 2025	Pauline Walsh	**Assurance**	**Enc. 10**
16	1025	P107/25	Improving Quality and Performance Report (IQPR) Month 2	Eric Gardiner	**Assurance**	**Enc. 11**
People We will attract, develop and retain the best people			**PEOPLE**			
17	1030	P108/25	People, Culture and Development Committee Assurance Report from the meeting held on 30th June 2025	Martin Evans	**Assurance**	**Enc. 12**
Sustainability We will increase our efficiency and effectiveness through sustainable development			**SUSTAINABILITY**			
18	1035	P109/25	Finance Report Month 2	Eric Gardiner	**Assurance**	**Enc. 13**
19	1040	P110/25	Finance and Resources Committee Assurance Report from the meeting held on the 3rd July 2025	Russell Andrews	**Assurance**	**Enc. 14**
20	1045	P111/25	Green Plan 2025-2028	Elizabeth Mellor	**Approval**	**Enc. 15**
CONSENT ITEMS						
21	1050	P112/25	Safer Staffing Monthly Report May 2025	Kenny Laing	**Information**	**Enc. 16**
22	1050	P113/25	Quality Committee Assurance Report from meeting held on the 5th June 2025	Pauline Walsh	**Information**	**Enc. 17**
23	1050	P114/25	Finance and Resource Committee Assurance Report from the meeting held on the 5th June 2025	Russell Andrews	**Information**	**Enc. 18**
24	1050	P115/25	Audit Committee Assurance Report from the meetings held on the 7th May 2025 and 6th June 2025	Prem Gabbi	**Information**	**Enc. 19**
25	1050	P116/25	Remuneration Committee Assurance Report from the meeting held on the 8th May 2025	Nicola Griffiths	**Information**	**Enc. 20**
26	1050	P117/25	Fit and Proper Persons Test Annual Report 2024/25	Nicola Griffiths	**Information**	**Enc. 21**

27	1050	P118/25	BAF Dashboard 2025/26	Nicola Griffiths	**Information**	**Enc. 22**
28	1050	P119/25	Any Other Business	Janet Dawson	**Note**	**Verbal**
29	1050	P120/25	Meeting Self-Assessment	Janet Dawson	**Note**	**Verbal**

Date and Time of Next Meeting
Thursday 11th September 2025 at 10.00am, Boardroom, Lawton House and via MS Teams

PUBLIC TRUST BOARD

Minutes of the Public Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 8th May 2025
At 10:00am in the Boardroom, Lawton House and via MS Teams

Present		
Janet Dawson	JD	Chair
Russell Andrews	RA	Vice Chair / Non-Executive Director
Dr Buki Adeyemo	BA	Chief Executive Officer
Eric Gardiner	EG	Chief Finance Officer
Kenny Laing	KL	Deputy Chief Executive /Chief Nursing Officer
Elizabeth Mellor	EM	Chief Strategy Officer
Dr Dennis Okolo	DO	Chief Medical Officer
Ben Richards	BR	Chief Operating Officer
Kerry Smith	KS	Interim Chief People Officer
Pauline Walsh	PW	Non-Executive Director / Senior Indepdendent Advisor (SID)
Martin Evans	ME	Non-Executive Director
Prem Gabbi	PG	Non-Executive Director
Katie Laverty	KL	Associate Non-Executive Director
In Attendance		
Nicola Griffiths	NG	Deputy Director of Governance / Board Secretary
Joe McCrea	JM	Associate Director of Communications
Jenny Harvey	JH	Staff Side Representative
Lisa Wilkinson	LW	Corporate Governance Manager (Minutes)
Public Attendance		
Alex Kuhne	AK	IESO Group
Karen Best	KB	Senior Quality Improvement and Assurance Manager Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)
REACH Individual Award – General Practice Administrative Team		
Jennifer Reynolds	JR	Discharge Pathway Lead
Jo Sherwin	JS	Quality Improvement Lead Nurse
Patient Story		
Amy Spruce	AS	Service Manager
Karen Linnell Cottage	KLC	Senior Community Perinatal Mental Health Nurse

Meeting commenced at 10.00am

65/25	**APOLOGIES FOR ABSENCE** Jennie Koo, Non-Executive Director Sherrine Khan, Senior Peer Support Worker Nicola Bullen, NExT Director Programme Dr Roger Banks, Associate Non-Executive Director	
66/25	**DECLARATIONS OF INTEREST RELATING TO AGENDA** There were no declarations of interest. ***Noted***	

67/25	**MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 13TH MARCH 2025** Minutes were approved as a true and accurate record ***Approved/Received***	
68/25	**ACTIONS** **46/25 – Minutes of the last Public Board Meeting – 13th February 2025. Martin Evans asked for a narrative to be added to the minutes in respect of the Crisis Care Centre. Martin Evans to provide a paragraph to Lisa Wilkinson to include.** *08.05.25 – Actioned.* **54/25 – Mortality Surveillance Quarter 3 Report 2024/25. Following discussion, it was agreed the report provided an overview of what was found but did not share details. Dr Dennis Okolo to ensure the report includes details going forward.** *08.05.25 – The report will offer further details where known for those reviews that have been approved by the Chief Medical Officer to support learning outcomes. Closed* **55/25 – Patient Safety Incident Response Framework (PSIRF) Quarter 3 Report 2024/25. Martin Evans highlighted a point of accuracy on slide 46 table 2 in relation to Quarter 3 by directorate figures and Dr Roger Banks highlighted a typing error. Dr Dennis Okolo to amend.** *08.05.25 – The table was inaccurate due to a formula error. This has been amended and submitted as completed. Closed* ***Received***	
69/25	**PATIENT STORY – Amy's Story** Kenny Laing, Chief Nursing Officer presented the patient story. Amy Spruce, a service manager in the Community Directorate, shared her personal experience with the Parent and Baby Services, providing valuable insights into the service from both a professional and patient perspective. Amy shared her journey with postpartum psychosis and the support she received from the parent and baby service, emphasising the importance of patient-centred care. Amy discussed the importance of having a clear plan and the support she received from her care team, including the involvement of her family. Amy noted the improvements in services over the years and the importance of joined-up care, including the support from the Royal Stoke Maternity. Amy emphasised the importance of being at the centre of care planning and the positive impact it had on her experience. Amy discussed the challenges of accessing services and the stigma associated with mental health, highlighting the importance of open conversations. Board members expressed their gratitude to Amy for sharing her story, acknowledging her bravery and the insights she provided. The Board discussed the importance of continuous service improvement, using patient stories like Amy's to guide enhancements in care delivery. Ben Richards talked about the investment into Parent and Baby and asked from a service level perspective whether we she felt we had made the changes we thought we had made and if the service had improved. Karen	

	Linell-Cottage felt the service had improved adding that Amy would have been expected to come to the unit whereas now the service was offered in the community and the team were able to visit Amy at home and meet the family. Karen advised that the service would offer more to Dads in the future. The Board discussed the importance of continuous service improvement, using patient stories like Amy's to guide enhancements in care delivery. Jenny Harvey talked about the importance of staff being aware of this story and others like it should they need to access our services and highlighted the need to communicate this. **ACTION: That extra level of vulnerability could be a barrier for staff accessing health and advice early on. It was agreed an action from today would be to look at communicating the service through a Comms channel.** Amy was thanked for sharing her story. The patient story is available to view on the Trust Public website. **Noted**	**KS**
70/25	**REACH RECOGNITION INDIVIDUAL AWARD – Jenny Reynolds, Discharge Pathway Lead, Acute and Urgent Care.** Kenny Laing, Chief Nursing Officer introduced the award. Jenny Reynolds commenced on a 6-month pilot as the Directorate's Discharge Pathway Lead in March 2023. Due to the significant success of this role, this became a permanent post. Jenny consistently goes above and beyond her role every day and strives for innovative ways to improve service delivery and staff development across the Directorate. Jenny has led on the development of this post with a clear vision to improve patient care, patient pathways and ensure effective discharge planning. Jenny implemented innovative practice, 'red to green' days within all Acute Inpatient wards. This had a significant impact on improved patient care, improved patient pathways and reduced length of stay. Jenny's attitude, aptitude, passion and dedication has been instrumental in not only the success of this role, but also the innovative shift in cultures across wards and crisis care services when applying appropriate patient pathways from the point of admission to discharge. In addition to this Jenny has worked tirelessly in forming collaborative partnerships with local authorities to ensure timely discharge remains a priority for all agencies. Whilst there remain challenges regarding this, which are outside of her control, Jenny continues to act in the patient's best interests, remaining professional and dedicated, enabling the right outcome for our patients. Jenny has worked with patients from a multiple disadvantaged background, ensuring that when discharged they have access to all appropriate services and that they have the provisions they need to commence their recovery journey. This has often been in collaboration with other services and Jenny has ensured completion of all tasks needed for a safe discharge.	

	Jenny is a strong advocate for all patients and her abilities in supporting and guiding the Ward Discharge Co-ordinator's and other staff to assist in their development has been commendable. The Board congratulated Jenny on her award. ***Received***	
71/25	**CHIEF EXECUTIVES REPORT** Dr Buki Adeyemo, Chief Executive Officer, updated the Board on activities since the last meeting and drew the Board's attention to the following: • The Trust's proactive response to the NHS Reset programme. • Continued support for staff wellbeing and community engagement. • A reaffirmation of the Trust's commitment to inclusion and dignity, particularly in light of recent legal rulings affecting trans individuals. It was noted that the Trust would continue to collaborate with staff networks to ensure inclusive practices were maintained and communicated clearly. The Trust would continue promoting kindness and psychological safety as core organisational values. ***Received***	
72/25	**STOKE-ON-TRENT AND STAFFORDSHIRE INTEGRATED CARE BOARD (ICB) BRIEFING** Dr Buki Adeyemo, Chief Executive Officer, presented the briefing and took the paper as read. ***Received***	
73/25	**CHAIRS REPORT** Janet Dawson, Chair presented the report. The Chair echoed Dr Buki Adeyemo's sentiments on inclusion and emphasised the importance of maintaining a safe and welcoming environment for all staff and service users. The Board acknowledged the emotional impact of recent legal changes and committed to upholding Trust values. Jenny Harvey acknowledged the Trust as an exemplar of how to respond with regards to recent issues. It was acknowledged that Staff Networks and the Equality, Diversity and Inclusion Team would facilitate ongoing dialogue and support for affected staff. With regards to the System the Chair thanked people, particularly Execs, for their ongoing support of the System activity acknowledging interactions come with a lot of pressure. Martin Evans highlighted there were a number of equality, diversity and inclusion events coming up over the next few weeks, namely Staff Network Day and Pride Month in June. ***Noted***	
74/25	**QUESTIONS FROM MEMBERS OF THE PUBLIC** The Trust continued to encourage the use of Ask the Board Online as part of its ongoing commitment to openness, transparency and innovation.	

	There were no questions received from the public. ***Noted***	
75/25	**INTENSIVE OUTREACH UPDATE AND INDEPENDENT MENTAL HEALTH HOMICIDE REVIEW** Kenny Laing, Chief Nursing Officer presented the report and highlighted the following: Every NHS Trust has been asked to discuss at their Public Board how the Trust is responding to events in Nottingham that took place in June 2023 and to offer assurance. The Board reviewed the Trust's response to national learning from the Nottingham incident. A total of 893 service users were identified as potentially high-risk, prompting a review of assertive outreach capabilities. A Task and Finish Group has been established to: - Refine the high-risk cohort using digital tools. - Develop a digital flagging system for risk monitoring. - Draft a new risk entry for the Trust Risk Register. - Establish clear timeframes and report progress to the Quality Committee. **ACTION: Kenny Laing to ensure a risk is included on the risk register regarding the management of individuals with high-risk factors identified in the Nottingham review.** Quality Committee will monitor implementation and provide assurance to the Board. Karen Best asked if there would be a triangulation process across the community mental health survey results and this piece of work. Kenny Laing confirmed it would. ***Received***	**KL**
76/25	**COMMUNITY MENTAL HEALTH TRANSFORMATION PROGRAMME: EVALUATION AND REVIEW** Ben Richards, Chief Operating Officer presented the report and highlighted the following: Ben Richards highlighted the achievements of the community mental health transformation programme, including improvements in care planning, remote working and medicines management. Ben Richards identified areas for improvement, such as engagement with specific communities and the importance of the voluntary and community sector in delivering mental health services. ***Received***	

77/25	**QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 1st MAY 2025** Pauline Walsh, Non-Executive Director / Committee Chair, presented the report and highlighted the following: The Committee discussed the management of out-of-area placements, emphasising the need for detailed information on how these placements were handled and the impact on patient care. A detailed report will be presented at the next Quality Committee meeting to better understand the processes and challenges associated with out-of-area placements. The Committee reviewed the sickness absence data, noting the need for further analysis to understand the underlying reasons for the figures, aiming to develop targeted interventions. The Committee also received: - The Quality Account in draft. - The Safer Staffing Report for assurance. - The Improving Quality and Performance Report (IQPR) – focussing on complaints, response times, clinical supervision compliance and out of area placements. - The Clinical Audit Report - Policies and Risk registers were approved. ***Received***	
78/25	**IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 12** Eric Gardiner, Chief Finance Officer, presented the IQPR Month 12 report. The report showed strong overall performance, with ongoing concerns around DNA rates, supervision compliance and sickness absence. Ben Richards confirmed the Performance Team were conducting a deep dive into SMI screening data and DNA trends. Russell Andrews highlighted that Directorates were ensuring Performance Improvement Plans (PIPs) were realistic, time-bound and regularly reviewed. ***Received***	
79/25	**FREEDOM TO SPEAK UP (FTSU) / BEING OPEN ANNUAL REPORT** Kenny Laing, Chief Nursing Officer, presented the report. An increase in concerns raised was noted, particularly around race and team culture. The Freedom to Speak Up Guardian has expanded demographic analysis to include all protected characteristics and will collaborate with teams to address overrepresentation of ethnic minority staff in concerns. The People, Culture and Development Committee will monitor impact of interventions and report to Board. ***Received***	

80/25	**PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 28TH APRIL 2025** Martin Evans, Non-Executive Director / Committee Chair presented the report highlighting the following: Martin Evans highlighted the ongoing work to address sickness absence and employee relations. The Committee reviewed sickness absence trends, workforce planning, and the new Equality, Diversity and Inclusion (EDI) dashboard. The Committee took assurance that the Trust was continuing to: - Target interventions in high-sickness areas. - Improve access to psychological wellbeing services. - Promote early resolution of employee relations issues. The Committee will continue to track progress of team-based working programme and EDI initiatives. ***Received***	
81/25	**FINANCE REPORT MONTH 12** Eric Gardiner, Chief Finance Officer, presented the report. Eric Gardiner reported on the Trust's financial performance, noting a surplus of £3.5 million and significant reductions in agency spending and full delivery of Cost Improvement Programme (CIP) targets. ***Received***	
82/25	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 1ST MAY 2025** Russell Andrews, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Russell Andrews reported on the Finance and Performance Committee, noting the strong financial position and the need to focus on recurrent cost improvement savings. The Finance Team continue to monitor CIP delivery monthly and support Directorates in shifting from non-recurrent to recurrent savings. Finance and Resource Committee continue to track progress and escalate risks as needed. ***Received***	
83/25	**BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 4 REPORT 2024/25** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the report and highlighted the following: It was noted that risk scores had been updated and the need for a more dynamic dashboard was discussed by the Board.	

	ACTION: It was agreed the Board Secretary would ensure BAF and Risk Register would appear earlier on agendas going forward and ensure all risks had assigned owners and timeframes. ***Approved / Received***	**NG**
84/25	**GIFTS, HOSPITALITY AND SPONSORSHIP ANNUAL REPORT / REGISTER** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the report. Gifts, Hospitality and Sponsorship declarations were reviewed. Nicola Griffiths advised that the Governance Team continue to educate on declaration responsibilities and monitor compliance. **ACTION: The Board felt that gifts, hospitality and sponsorship were underreported and requested the policy be publicised more.** ***Received***	**NG**
85/25	**SELF-CERTIFICATION G6 AND FT4** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the licences. The Board approved the self-certification process, ensuring compliance with NHS provider license conditions. No objections but one error on the exec summary to be published by June 2024 should read June 2025. It was noted this would be updated and the licence retained for audit purposes. ***Approved / Received***	
86/25	**SAFER STAFFING MONTHLY REPORT JANUARY 2024** Circulated for information.	
87/25	**QUALITY COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 3RD APRIL 2025** Circulated for information.	
88/25	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 3RD APRIL 2025** Circulated for information.	
89/25	**COMMITTEE EFFECTIVENESS ANNUAL REPORT 2024/25** Circulated for information.	
90/25	**ANY OTHER BUSINESS** There were no items of other business. Janet Dawson acknowledged this was Kerry Smith's last Public Board and took the opportunity to thank her for all her support and the contribution she had made to the Board as Interim Chief People Officer. ***Noted***	

91/25	**MEETING SELF ASSESSMENT** No feedback was recorded.	
	DATE AND TIME OF NEXT MEETING Thursday 10th July 2025 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12.04pm

Signed: _____ Date_____
Chair

Board Action Monitoring Schedule

Trust Board - Action monitoring schedule - (Public)

No.	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
1	8th May 2025	69/25	**PATIENT STORY** Jenny Harvey talked about the importance of staff being aware of this story and others like it should they need to access our services and highlighted the need to communicate this. That extra level of vulnerability could be a barrier for staff accessing health and advice early on. It was agreed an action from today would be to look at through a Comms channel.	Kerry Smith	10th July 2025	Complete. Discussed at People,Culture and Development Committee
2	8th May 2025	75/25	**INTENSIVE OUTREACH UPDATE AND INDEPENDENT MENTAL HEALTH HOMICIDE REVIEW** Task and Finish Group to draft a risk to go on the risk register regarding the management of individuals with high-risk factors identified in the Nottingham review.	Kenny Laing	10th July 2025	The risk has been drafted and will be added and brought through the Trust Risk Review Group and Quality Committee
3	8th May 2025	83/25	**BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 4 REPORT 2024/25** The Board requested this agenda item be moved to the top of future agendas and ensure all risks had assigned owners and timeframes.	Nicola Griffiths	10th July 2025	Complete. Exec PA's and the Assistant Trust Board Secretary will now action BAF moving to the top of all agendas across SLT, Committees and Board.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 3

CEO BOARD REPORT

Report provided for:			
Information	☐	Assurance	☐
Discussion	☒	Approval	☐

Report to:	Trust Board
Date of Meeting:	10th July 2025

Presented by:	Dr Buki Adeyemo, Chief Executive
Prepared by:	Joe McCrea, Associate Director of Communications
Executive Lead:	Dr Buki Adeyemo, Chief Executive

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	Execs
Strategic Priorities:	The report contains information that aligns to the Trusts strategic priorities of - Prevention, Access and Growth
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	Report contains details of activities during black History Month
ICS Alignment / Implications:	Strategic fit with system priorities
Recommendation / Required Action	Receive and discuss
Executive Summary	The Report updates the Board on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.

	These include: • The NHS 10 Year Plan • New NHS Oversight Framwork • Government announces plans to address health inequalities • Government announces investment of £750 million for hospitals across England • Commissioner Guidance for Community Mental Health (CMH) Rehabilitation services • Bid to make Biddulph the first mental health friendly town • Infected Blood Psychological Service (IBPS) opens for self-referrals • NHS England publishes urgent and emergency care (UEC) • REACH 2025 is launched • Holmcroft Surgery receives 'good' CQC rating • Combined colleagues win Tessa Jowell Centre of Excellence Award • Combined wins Highly Commended at HSJ Digital Awards for Keep Warm, Keep Well • Frieza Mahmood joins as Chief People Officer • Dr Buki Adeyemo appointed as chair of the NHS Confederation's Mental Health Network

VERSION CONTROL:

Version	Report to	Date Reported

Chief Executive's Report to the Trust Board
10 July 2025

1.0 PURPOSE OF THE REPORT

This report updates the board on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.

2.0 NATIONAL CONTEXT AND UPDATES

The NHS 10 Year Plan

The NHS 10 Year Plan was published on 3rd July.

Three key shifts

The 10 Year Health Plan aims to get the NHS back on its feet and to make it fit for the future, delivered through three big shifts:

- **From hospital to community;** transforming healthcare with easier GP appointments, extended neighbourhood health centres, better dental care, quicker specialist referrals, convenient prescriptions, and round-the-clock mental health support - all designed to bring quality care closer to home.
- **From analogue to digital**; creating a seamless healthcare experience through digital innovation, with a unified patient record eliminating repetition, AI-enhanced doctor services and specialist self-referrals via the NHS app, a digital red book for children's health information, and online booking that ensures equitable NHS access nationwide.
- **From sickness to prevention**; shifting to preventative healthcare by making healthy choices easier—banning energy drinks for under-16s, offering new weight loss services, introducing home screening kits, and providing financial support to low-income families.

Neighbourhood Health Services

Neighbourhood Health Services will be rolled out across the country, bringing diagnostics, mental health, post-op, rehab, and nursing to people's doorsteps.

Neighbourhood teams will include staff like nurses, doctors, social care workers, pharmacists, health visitors, palliative care staff, and paramedics. Community health workers and volunteers will play a pivotal role in these teams, and local areas will be encouraged to trial innovative schemes like community outreach door-to-door – to detect early signs of illness and reduce pressure on GPs and A&E.

Neighbourhood health centres will house services under one roof, open at evenings and weekends The Plan for Change will rebuild the NHS to train thousands more family doctors, transform hospital outpatient appointments, and provide personalised care plans for complex needs. Millions of patients will be treated and cared for closer to their home by new teams of health professionals.

Open letter to NHS staff

The Secretary of State has also released an open letter to all NHS staff to coincide with the launch of the new Ten year Plan. You can download a copy of the full letter by clicking here.

In the letter, Wes Streeting says

"Thank you for everything you do, each and every day, on behalf of our patients. You are the people who make the NHS so special and, through your commitment, compassion and creativity, we will take this plan and create an NHS that is truly fit for the future."

New NHS Oversight Framework

The new NHS Oversight Framework 2025/26 was published at the end of June. It describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement. It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

The 1-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan

Government announces plans to address health inequalities

Health Secretary Wes Streeting has announced a funding pledge of more than £2bn to improve healthcare infrastructure in deprived areas of England.

This funding was previously set aside for deficit support for NHS trusts and integrated care boards; however, this is now planned to be phased out by 2026-27. Instead, the funding will be used for staff, medicines and equipment in deprived regions with poor access to quality primary and hospital care. The announcement is ahead of the government's 10-year plan to reform the NHS, which is due to be fully unveiled soon.

Government announces investment of £750 million for hospitals across England

Over 400 hospitals, mental health units and ambulance sites will receive investment to tackle long-term problems including leaks, poor ventilation and electrical issues, to help prevent cancelled operations and appointments – as the government claims NHS services were disrupted over 4,000 times between 2023-2024 due to building maintenance issues. The funding is part of the government's focus on public service infrastructure as part of its Plan for Change.

Commissioner Guidance for Community Mental Health (CMH) Rehabilitation services

Guidance has been published on the Commissioner Guidance for Community Mental Health (CMH) Rehabilitation services. The guidance will support systems with the continued implementation of Community Mental Health transformation programmes - including Community Mental Health Rehabilitation services. The goal is for all adults have access to support for rehabilitation in their community, providing opportunities to regain or learn skills, lost or not acquired, due to mental illness.

Bid to make Biddulph the first mental health friendly town

Adam Parkes, chairman of Staffordshire Moorlands District Council has trained 60 mental health first-aiders as part of his drive to make Biddulph, Staffordshire, the country's first mental health friendly town. The chairman has had his own struggles with mental illness and nearly took his own life a decade ago. He says he was 'saved by strangers', and his hope is to have enough residents who can spot when people were having difficulties and would know how to reach out to them.

Infected Blood Psychological Service (IBPS) opens for self-referrals

A service offering bespoke psychological support for people who have been infected and affected by contaminated blood or blood products has now opened for self-referrals, with 16 centres across England now offering this service.

NHS England publishes urgent and emergency care (UEC) plan

NHS England has published its urgent and emergency care plan, setting out plans to improve services over the next year. The plan recognises the problems that UEC has faced in the NHS, particularly during the winter, and sets out how the NHS will try and avoid this from happening again. Key goals include faster ambulance response times, a reduction in A&E waiting times, improved patient flow with increased same-day discharge where possible, increased community care, improved mental health support initiatives for early intervention and access to care during crisis, along with increased vaccination uptake among frontline staff.

3.0 STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE SYSTEM (ICS)

Local NHS leaders discuss savings plans with Stoke-on-Trent Health and Wellbeing Board Elizabeth Disney, Chief Transformation Officer at Staffordshire and Stoke-on-Trent Integrated Care Board (ICB), recently met with the Stoke-on-Trent Health and Wellbeing Board to discuss the significant £306 million total savings target, which represents around nine per cent of NHS spending in the county.

During the meeting, NHS representatives emphasized that all changes to services will be implemented thoughtfully and with engagement from partners, including the Health and Wellbeing Board. They also highlighted the focus on quality improvement as a means to achieve financial savings, along with increased productivity and better oversight of contracts.

4.0 OUR TRUST

REACH 2025 is launched

The 2025 awards will take place on 13 November at the DoubleTree by Hilton, Stoke-on-Trent. For those not able to attend in person, the whole event will be broadcast live via our social media and this website. We are delighted to be presenting REACH in partnership with our new main event sponsor, Dedalus.

We are also grateful for awards and event sponsorship from the following organisations:

- Browne Jacobson
- Interclass
- LEDsynergy
- Port Vale FC
- RLDatix
- Rowtype Printers Ltd
- SERCO
- Stoke City FC
- Town Hospitals Ltd
- UNISON

The range of sponsors ensures that, once again, we will be able to deliver REACH at nil net cost to the Trust.

The awards recognise outstanding achievements in the following categories:

- Diversity and Inclusion Award
- Leading with Compassion Award
- Learner of the Year Award
- Lived Experience Shining Star Award
- Partnership Award
- Proud to CARE Award (staff-voted award)
- Research and Innovation Award
- Rising Star Award
- Service User and Carer Council Award (nominations only by service users)
- Team of the Year Award
- Unsung Hero Award
- Chair's Award (chosen by the Chair)

Nominations are open now and can be made by our staff, service users and stakeholder at any time up until midnight on Sunday 10 August.

REACH truly embodies the best of Combined Healthcare and our vision to be Outstanding in ALL we do and HOW we do it. We don't just gather each year to hand out accolades and awards – as important as that is. We come together to have fun, reconnect with familiar colleagues, and meet new ones. It's an opportunity to learn more about the incredible breadth and diversity of our work and how we do it."

The fantastic submissions we receive each year demonstrate the relentless pursuit of continuous improvement and innovation that burns brightly at Combined. Being part of these Awards is the highlight of my year. I eagerly look forward to reading all the wonderful nominations we will receive and encourage everyone to submit as many as they can."

Holmcroft Surgery receives 'good' CQC rating

The Care Quality Commission (CQC) has published its report following a recent inspection of Holmcroft Surgery, granting a score of 'good' across all domains for the site.
This was the first CQC inspection at Holmcroft Surgery since the site's integration with Combined Healthcare, and involved large evidence submissions, completion of staff questionnaires and interaction with key stakeholders including the Patient Participation Group and Integrated Care Board.

Holmcroft Surgery is a community GP practice based on Holmcroft Road in Stafford. The surgery is one of four GP practices that make up Combined Healthcare's primary care provision – alongside Keele Practice, Moorcroft Medical Centre and Moss Green Surgery. During its visit to the surgery, the CQC found that people were protected and kept safe, with facilities and equipment that met the needs of people and were clean and well-maintained. People were treated with kindness and compassion and their privacy and dignity was protected, with staff wellbeing supported.

The CQC also found that the surgery was well-led, with leaders visible, knowledgeable, and supportive, helping staff develop in their roles. People were involved in assessments of their needs, with staff who reviewed assessments taking account of people's communication, personal and health needs.

Combined colleagues win Tessa Jowell Centre of Excellence Award

Dr Gemma Wall and Dr Gill Cooke, Consultant Clinical Neuropsychologists at North Staffordshire Combined Healthcare NHS Trust, are part of the team at the West Midlands Neuro-Oncology Network, which has just received the Tessa Jowell Centre of Excellence award.

NHS teams, charity leaders and MPs gathered in May to celebrate 14 UK hospitals being designated Tessa Jowell Centres of Excellence for their outstanding brain tumour care and research, including the West Midlands network.

Inspired by Dame Tessa Jowell's vision of better treatments and more equitable care, Tessa Jowell Centres of Excellence represent a lasting commitment to improving brain tumour care, showing what the NHS can do even in a tough funding climate. Patients can have confidence that they are able to access good care in every part of the UK, with Centres of Excellence leading the way on world-class treatment, cutting-edge clinical trials, and compassionate, patient-centred care.

The West Midlands Centre of Excellence is a collaboration between University Hospitals of North Midlands NHS Trust (UHNM), University Hospitals Birmingham NHS Foundation Trust and the University of Birmingham. To receive the award, the network met rigorous, expert-led criteria to ensure the highest standards of patient treatment, innovation, and research.

Combined wins Highly Commended at HSJ Digital Awards for Keep Warm, Keep Well

We are delighted that Combined Healthcare was 'highly commended' in the 'Driving Change Through Data and Analytics' category at the HSJ digital awards in June. The project was a collaboration with UHNM rolling out the Keep Warm Keep Well scheme at the Moorcroft Medical Centre. The project is entirely digital in its approach - using the One Health and Care digital shared care record to target and refer the neediest children (those with an asthma diagnosis and living in high levels of deprivation). This is still in place now and is funded through grant awards.

4.2

People
We will attract, develop and retain the best people

Frieza Mahmood joins as Chief People Officer

The Trust is delighted to welcome Frieza Mahmood as its new Chief People Officer. Frieza is an experienced NHS Board Director having previously worked as a Chief People Officer for the last 5 years at Sandwell and West Birmingham NHS Hospitals Trust where she led the development and implementation of an innovative workforce planning model and transformational change programme to support the opening of the new Midland Metropolitan University Hospital.

Frieza has an undergraduate degree in BSc Human Resource Management from Aston Business School and carried out further postgraduate qualifications in Human Resources, Organisational Development and Healthcare Leadership.

Frieza carries out several other regional and national roles outside of her responsibilities at Combined Healthcare. These include a role within the education sector as non-executive director for Washwood Health Multi Academy Trust, one of the largest academy school trusts in the country and also working as a careers ambassador for the Midlands and East region. She is also active in the field of leadership development, for which she speaks and dedicates her time to the organisation of professional development and training in her role as a vice president for the national Healthcare People Management Association (HPMA). Frieza is passionate about widening access to opportunities and facilitating participation for hard-to-reach groups. She is also actively focused on improving staff experience to aid retention and deliver better outcomes for service users.

4.3

Partnerships
We will actively promote partnership and integrated models of working

Dr Buki Adeyemo appointed as chair of the NHS Confederation's Mental Health Network

Finally, I am delighted to share that I have been appointed as the new chair of the NHS Confederation's Mental Health Network, replacing Ifti Majid who stepped down in April this year. After serving on the Mental Health Network advisory board as an NHS Chief Executive representative for the last two years. The Mental Health Network represents providers from across the statutory, independent and third sectors. Working with government, regulators, opinion formers, media and the wider NHS to promote excellence in mental health services and the importance of good mental health.

5.0 Conclusion

Once again, it has been a busy month at Combined, full of further examples of the initiatives and activities that continue to contribute to us being outstanding in all we do and how we do it.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 4

Integrated Care Board (ICB) Update

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Dr Buki Adeyemo, Chief Executive Officer
Prepared by:	ICB
Executive Lead:	Dr Buki Adeyemo, Chief Executive Officer

Aligned to Board Assurance Framework Risk	Risk 7 Failure to implement a strategic approach to partner relationships impacting negatively on whole population outcomes
Approval / Review:	N/A
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	We will actively promote partnership and integrated models of working
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	Board are asked to receive the paper for information
Executive Summary	The briefing aims to keep partners informed of the discussions of the Integrated Care Board (ICB) meetings held in public on 15th May 2025.

	Items discussed were: - ICB Chair and Chief Executive Update - Local Dental Plan - National Planning Submission and Re-submission - Update on Intensive and Assertive Community Mental Health Care - Quality and Safety Report - Quality and Safety AAA Chairs Report - Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report – March - Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report – April - ICS Finance and Performance Report - Finance and Performance Committee AAA Chairs Report – April - Finance and Performance Committee AAA Chairs Report - May - ICS People Culture and Inclusion Committee Report - ICS People Culture and Inclusion Committee AAA Chairs Report - Staffordshire and Stoke-on-Trent ICB Strategic Commissioning and Transformation Committee AAA Chairs Report - Staffordshire and Stoke-on-Trent ICB Audit Committee AAA Chairs Report - Staffordshire and Stoke-on-Trent ICB Remuneration Committee AAA Chairs Report

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	01/05/2025
V2	Public Trust Board	27/06/2025

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated Care Board Briefing

Staffordshire and Stoke-on-Trent ICB Meeting

15 May 2025

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

This briefing aims to keep partners informed of the discussions at the NHS Integrated Care Board (ICB) meeting in public. To watch the recording and read the papers visit the ICB website.

ICB Chair and Chief Executive update

- David Pearson, Chair, and Peter Axon, Chief Executive Officer, presented the report.
- The Chair paid tribute to Peter Axon and Paul Brown, Chief Finance Officer, as it was their final ICB Board meeting. The Chair shared thanks to the outstanding contribution they have made nationally and locally, including their contributions to the establishment of the Integrated Care Board.
- The Chair shared thanks to David Wakefield, Chair of University Hospital of North Midland's NHS Foundation Trust, who is stepping down in his role, and welcomed Jackie Small who is stepping into the role as interim Chair.
- The Chair also shared thanks to Alan White, the outgoing leader of Staffordshire County Council, for his ongoing service and engagement with the ICB and Integrated Care Partnership (ICP).
- The Chair welcomed councillor Ian Cooper, who has been elected as leader for Staffordshire County Council.
- The Chair referenced the Fit and Proper Person Test as an important part of the governance undertaken on Board members, noting that the process is being returned to NHS England at the end of May, and it will be reported on formally at the next Board meeting in July.
- Peter Axon commented on the ICB cost reduction work as part of the ICB Reform, stating that the ICB are working at pace to get to the deadline submission point (30 May 2025) for a clear understanding of how we will achieve cost reduction. Peter added that the pace of this work is rapid, and updates will be provided at future Board meetings.
- Peter Axon stated that there is a lot of work ongoing around the operating plan, noting the scale of the challenge as significant.
- Peter Axon added that we are in the process of creating a committee to oversee the risks and mitigations associated with failure of delivering these processes, which will be underpinned by working groups and reported on formally to the Board.

The Board thanked the Chair and Peter Axon for the report. The Board thanked executives and all staff members the rapid work being undertaken following the Blueprint and objectives for the ICB.

Local Dental plan

- Paul Edmondson-Jones, Chief Medical Officer, Sarah Jeffrey, Director of Primary Care, and Tracy Cox, Associate Director of Primary Care, presented the report.
- Sarah Jeffrery stated that work is ongoing locally to improve the current position, including the Local Dental Health Equity Audit which has been carried out by a consultant in dental public health.
- Sarah Jeffery noted that this has provided a wide range of data intelligence and patient feedback, which has been used to prioritise targeted action, improve access and reduce health inequalities.
- Sarah Jeffery stated that the audits have supported the identification of 12 initial priority areas with the poorest level of oral health and lowest level of access to services. Sarah noted the overall aim is to improve access to NHS dentistry across all of Staffordshire and Stoke-on-Trent, not just the 12 areas identified.

- Sarah Jeffery advised that the increase to the rates of pay to local dentists means that we are in line with the West Midlands average, and therefore more likely to recruit and retain dentists locally over a longer period of time.
- Sarah Jeffrey stated that as per the governments guidance to ensure more urgent dentistry is available, urgent appointments will be allocated daily, and patients will be able to access this by going through a dental advice line that directs patients to the nearest dentist with same-day availability. Sarah added that this will be supported by a communications campaign so patients know where they can access urgent care.
- Sarah Jeffrery added that plans also include investing more in the oral health improvement and prevention team, who will support schools with teeth brushing techniques, along with support for residents in care homes, particularly focusing on areas of deprivation.
- Sarah Jefferey concluded that in summary, the plan focuses on the following areas: To make sure the right activity is in the right place, to ensure there is earlier prevention for younger people and support for older people, and to provide easier access for people in Staffordshire and Stoke-on-Trent to urgent care services without compromising routine activity.
- Sarah Jeffery advised that the plan has been approved through the joint commissioning arrangements of the West Midlands wide governance.

The Chair thanked Sarah Jefferey for the report. The Board asked for more information around the communications plan and messaging to the public. Sarah Jefferey assured the Board that along with a wider campaign, they are working closely with the communications team on a focused approach to identify relevant channels to reach people within the twelve priority areas identified. The Board was asked about the incentive 'golden hello' scheme and how this will ensure retention of dentists locally. Sarah Jefferey advised this is a national scheme, and the significant factor in retaining dentists locally is the increase of pay rates for dentists in Staffordshire and Stoke-on-Trent. Nadeem Ahmed, NHS Birmingham and Solihull ICB, assured the Board that conditions within the scheme outline that if practitioners were to leave before the end of their agreed period, the money given through the scheme will need to be paid back. The Board was asked how the dentistry plan will be monitored to measure progress against key performance indicators, and if plans need to be adjusted, how this will be factored in. Tracey Cox assured the Board that the team will continue to monitor data and refresh the equity audit to ensure resources are utilised effectively.

The Board endorsed and noted the recommendations presented to them.

National Planning Submission and Re-submission

- Peter Axon, Chief Executive Officer, and Paul Brown, Chief Financial Officer, presented the report.
- The Chair commented that this planning round has been incredibly challenging, noting that all partner members have engaged assertively and fully with the process.
- The Chair stated that local authority members have recorded their concerns around the scale of the ask and have reinforced the requirements for effective impact assessments to be carried out.
- The Chair added that following a full and robust discussion, the Board formally approved the 2025/2026 system plan at the closed Board meeting on 25 March. The Chair noted that as part of the submission of the plan and associated templates to NHS England, it was recognised that further work would be required to ensure that robust quality impact assessments have been completed.

- The Chair reinforced the quality and safety of our services as paramount, with steps being taken to ensure that additional non-executive member scrutiny is deployed through the Quality and Safety Committee. The Chair noted that Julie Holder, Non-Executive Chair of the Audit Committee, will review the System Board Assurance Framework and associated risk registers to ensure that they reflect the risks presented in the planning assumptions and manage these effectively.
- The Chair noted the consideration of the internal audit role in providing added assurance around the delivery of the plan throughout the year, alongside working with NHS England to regularly review the safety and delivery of the plan.
- The Chair stated that the Board has signed off the plan, noting that it is financially balanced but contains significant risk, which requires forensic scrutiny throughout the year to ensure the objectives are delivered safely alongside financial delivery.
- Peter Axon stated that going forward, work will involve converting the plan into detailed deliverables alongside implementation, changing certain ways of working, improving quality and the transition from reactive to proactive services, all in an inclusive way across the system.
- Paul Brown shared thanks to providers and local authority colleagues in forming the plan that is within the resources but also delivers on the major objectives that were set out.
- Paul Brown added that in terms of finance, the £306m efficiency plan is almost 10% of our revenue and resource limit. Paul noted that there is a weekly process of executives coming together to look at building plans, with the level of risk reducing as the plans are being worked through.
- Paul Brown stated that ongoing work involves working through all schemes and developing quality impact assessment assessments for each, which is to be completed by the end of May.
- Paul Brown added that there are plans for reductions in the workforce that is just short of 1100 full time equivalents, and a large proportion that is aimed at reducing agency and bank staff, with the focus being a substantive workforce.
- Paul Brown also noted the challenging activity plan, which has been agreed as a system to plan for a 3% increase of volume recognising the growth of population. Paul advised this is a very significant productivity gain that the system is planning to make.

The Chair thanked Peter Axon and Paul Brown for the report. The Chair stated that as the plan moves forward, every articulated piece needs to move forward together including the quality oversight, the delivery needs and the working of the subcommittee of the Board.

The Board accepted the ask to formally sign off the system plan for 2025/2026, which is a financially balanced plan compliant with the majority of the national ambitions and targets, and to note the refreshed assurance statements that will be returned to NHS England.

Update on Intensive and Assertive Community Mental Health Care

- Elizabeth Disney, Chief Transformation Officer, and Nicola Bromage, Associate Director of Mental Health, Learning Disabilities and Autism, presented the report.
- Elizabeth Disney introduced the report noting the work has been instigated nationally following a CQC special review into mental health services at Nottingham Mental Health Services, Nottingham Healthcare Foundation Trust.
- Elizabeth Disney stated the ask is to ensure there are clear policies and practices in place for patients with serious mental illness who require intensive community treatment and follow up care where engagement is a challenge.
- Nicola Bromage stated that the paper provides an update on the action plan that previously went to Board in October 2024 but additionally outlines the 10 key

recommendations for ICB's following the independent review into the care and treatment of Valdo Calocane.

- Nicola Bromage added that the paper also includes progress against those actions, along with new actions that have been picked up following the Clare Murdoch letter, and what is required in terms of implementation.
- Nicola Bromage noted that the 'staying safe from suicides' work requires trusts to implement new risk assessment procedures. Nicola advised that following a clinically led review of all ICB plans, there are recommendations in terms of good practice.
- Nicola Bromage stated that a series of webinars have taken place issuing several guiding principles to understand what an intensive, assertive outreach approach would look like. Nicola added that this includes elements around key workers, care and family engagement and multi-agency working.
- Nicola Bromage stated that a document around the Personalised Care Framework is currently out for consultation. Nicola explained that this document outlines the standards that aim to guarantee all individuals with a serious mental illness to receive a minimum level of high quality, personalised care and treatment, which will be organised and coordinated across multiple teams to inform the action plan going forward.
- Nicola Bromage stated that both Midlands Partnership NHS Foundation Trust and North Staffordshire Combined Healthcare Trust have task and finish groups in place with a strong organisational process embedded.
- Nicola Bromage noted the delay in the 'Right Care Right Person' planning, reassuring the Board that following the National Partnership Agreement, ongoing conversations are taking place with Staffordshire Police, West Midlands Ambulance Service (WMAS) and the Fire and Rescue service in continuing to improve that response.
- Nicola Bromage explained that the actions which require significant investment have been put on hold, and moving forward, plans include consolidating the recent guidance and adapting plans to reflect the consultation around the Personalised Care Framework.

The Chair thanked Elizabeth Disney and Nicola Bromage for the report. The Chair asked how this will feed into assurance processes for the ICB whilst linking in local providers. Nicola Bromage responded that a deep dive has taken place with the Quality and Safety Committee and this process will continue throughout the year. Josie Spencer, Chair of the Quality and Safety Committee, added that a great amount of detailed work has taken place and shared thanks to all involved. The Board asked about the CQC reviews that are expected to take place following the actions that have been pushed back due to no additional resources. Nicola Bromage explained that the national team are correlating information around what systems have said that they need to deliver to make sure that this cohort of patients is effectively cared for. Nicola Bromage added that it is still to be determined in terms of what the future model will look like, but ongoing work will continually look at the improvements that can be made within current resources. Additionally, the Board requested more detail around timescales and numbers of people participating in training to be included within future reports. The Board noted and accepted the recommendations presented to them.

Quality and Safety Report

- Becky Scullion, Director of Nursing Quality Assurance and Improvement, presented the report.
- Becky Scullion stated that following the CQC improvements against University Hospitals of North Midlands NHS Trust (UHNM), they have received a good rating and

all the section 29a warning notice requirements have been lifted. Becky added that University Hospitals of Derby and Burton (UHBD) were also inspected in December 2024, and the outcome report for this is still pending.

- Becky Scullion highlighted that the working age adults and psychiatric intensive care unit at MPFT was reinspected by CQC, to which they received good ratings.
- Becky Scullion commented on the Home and Host Commissioner pilot which has been rolled out across the Integrated Care System (ICS), stating that two hospitals have opened within Staffordshire and Stoke-on-Trent to support the ambition of placing patients within a 50-mile radius of their home area and the compliance rate of 83%.
- Becky Scullion added that following the implementation plans set out to reduce the number of people waiting for wheelchair services, routine quality visits have been undertaken with progress being monitored. Becky noted that whilst there has been continued improvement to the waiting list over the past ten months, work is still required to strengthen the approach towards ensuring patients are waiting well.
- Becky Scullion advised that work is still ongoing around the Paediatric Hearing Programme to achieve the targets that have been set in the delivery of improvements across both MPFT and UHNM services. Becky noted that the 5-year lookback review at UHNM has now been commissioned, with the outputs following the review expected towards the end of quarter two or quarter three.
- Becky Scullion advised the Board of the alignment and close working with the efficiency working group and Finance and Performance Committee regarding the Quality Impact Assessments (QIA) process.

The Chair thanked Becky Scullion for the report. Josie Spencer echoed that the QIA outcomes and adherence are reported to the Quality and Safety Committee tri-annually, with some changes and more scrutiny expected within the next report due in June 2025.

The Board accepted the acknowledgements and recommendations presented to them.

Quality and Safety AAA Chairs Report

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer stated that work is ongoing around the infectious disease response commissioning guidance for ICB's. Josie noted that a gap analysis has been undertaken, but there are some risks outstanding that need to be managed. Josie added that this work will come back to the committee in six months' time to ensure full assurance.
- Josie Spencer advised that the committee has received the final report on the progress being made in relation to All Age Continuing Health Care and the transition from the CSU into the ICB, with positive feedback received regarding this process.
- Josie Spencer informed the Board that the Quality and Safety Committee approved the Mental Health, Learning Disability and Autism Host/Home Commissioner Standard Operating Procedure, along with endorsing the Staffordshire and Stoke-on-Trent Alcohol Strategy.

The Chair thanked Josie Spencer for the report. The Board accepted and acknowledged the recommendations presented to them.

Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report - March

- Paul Edmondson-Jones, Chief Medical Officer, presented the report.
- Paul Edmondson-Jones highlighted the technical items for noting from the Integrated Medicines Optimisation Group summary, the approval of the gynaecology pathway for

the system, noting this as an important document as part of the Women's Health strategy, and the All-Age Palliative Care and End of Life strategy.

The Chair thanked Paul Edmondson-Jones for the report. The Board received and noted the recommendations presented to them.

Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report - April

- Paul Edmondson-Jones, Chief Medical Officer, presented the report.
- Paul Edmondson-Jones highlighted the Integrated Medicines Optimisation Group summary, the Ear Wax Removal Policy and Individual Funding Request Policy to note for approval.

The Chair thanked Paul Edmondson-Jones for the report. The Board received and noted the recommendations presented to them.

ICS Finance and Performance Report

- Paul Brown, Chief Finance Officer and Phil Smith, Chief Delivery Officer, presented the report.
- Paul Brown noted the year-end position as successful in getting to the control total of £17.8m variance to plan, which was agreed with the regional team.
- Paul Brown highlighted the work that has been undertaken within Continuing Healthcare as a real success in reducing spend as a result of having less intrusive packages of care, whilst continuing to improve lives for people and patients. Paul credited Heather Johnson and Claire Underwood for this work, and shared thanks to Neil Carr, Chief Executive at Midlands Partnership University NHS Foundation Trust, for his support and the support of his team within the system collaborative.
- Phil Smith stated that March saw a continuation of pressures around urgent and emergency care, noting that demand was the highest recorded within one month since pre-pandemic. Phil added that this has somewhat settled since going into the new financial year, and the four-hour target has improved.
- Phill Smith stated that there continues to be significant challenges in terms of ambulance response times and handover times, with UHNM reporting an average handover of 1 hour, 32 minutes in April.
- Phil Smith shared that a learning event was held earlier in the week bringing all partners together with a particular focus on critical incidents and the learning from these. Phil stated that following this, findings will be reported to the Finance and Performance Committee and then to the Board.
- Phil Smith stated that following a previous report around the impact of planned care procedures due to the the pressures of urgent and emergency care, the impact is still felt. Phil explained the aim was to eliminate 65 week waits by the end of March, but the year ended with an additional 233. Phil explained that despite this, annually, we saw 10,000 less people on the waiting list across our population.
- Phil Smith was pleased to share that we're currently ahead of plan in terms of the reduction around 52 week waits, and the plan for this year is to clear the 65 week waits by July 2025 and continue productivity through the summer months before heading into the winter period.

The Chair thanked Paul Brown and Phill Smith for the report. The Board received the recommendations presented to them.

Finance and Performance Committee AAA Chairs Report - April

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer noted the overarching financial and efficiency figures in the plan that are going to be a real challenge alongside workforce reduction.
- Josie Spencer stated that as a committee, full assurance will be ensured in terms of the progress of the plan and early sight of any risks and issues.
- Josie Spencer assured the Board that there will be a clearer understanding of delivery following June's meeting, and associated risks will be discussed in more detail following this.

The Chair thanked Josie Spencer for the report. The Board noted and acknowledged the recommendations presented to them.

Finance and Performance Committee AAA Chairs Report - May

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer advised that the system and performance group regularly provide a formal assurance report to the committee, which outlines specific areas of concern to ensure a greater focus on these areas.
- Josie Spencer highlighted an escalation regarding mental health and the access/ wait times for autism assessments. Josie assured the Board that SPG are looking into this in more detail and will provide a report to the committee in due course.
- Josie Spencer noted the policies that have been approved by the committee including the mental health assessment payment policy, along with a business case that will be put forward to the West Midlands CAMHS provider collaborative around supporting children and young people with challenging behaviour.

The Chair thanked Josie Spencer for the report. The Board noted and acknowledged the recommendations presented to them.

ICS People Culture and Inclusion Committee Report

- Mish Irvine, Chief People Officer, presented the report.
- Mish Irvine stated that the system reported a position of 1271 over the operational planning figure as per the end of the financial year. Mish advised that this is broken down by 880 more substantive colleagues than we'd expected to see.
- Mish Irvine stated that although the agency figure reported at 1.6 against a target of 3.2%, assurance processes need to be clear, along with articulating CIP programmes, the risk involved in delivering them, the workforce numbers and deployment of workforce that will enable them to be delivered safely.
- Mish Irvine stated that work is ongoing with finance colleagues within provider organisations to understand the reason for variance, and actions are being taken through the People, Culture and Inclusion Committee and the Finance and Performance Committee.

The Chair thanked Mish Irvine for the report. The Board acknowledged the recommendations presented to them.

ICS People Culture and Inclusion Committee AAA Chairs Report

- Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Shokat Lal highlighted the escalation around workforce growth and mitigations.
- Shokat Lal advised that the committee will continue to closely monitor the data around variations and bring more detailed feedback to the Board in due course.

The Chair thanked Shokat Lal for the report. The Board received the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB Strategic Commissioning and Transformation Committee AAA Chairs Report

- Julie Houlder, Non-Executive Chair of the Audit Committee, presented the report.
- Julie Houlder advised that a positive discussion around NHS reset had taken place in their latest meeting, which was led by Elizabeth Disney.
- Julie Houlder stated that the role of this committee is increasingly important as further guidance is received around strategic commissioning for outcomes.
- Julie Houlder advised the committee will continue to be mindful about the interface between the Strategic Commissioning Transformation Committee and the Transition Committee.

The Chair thanked Julie Houlder for the report. The Board received and noted the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB Audit Committee AAA Chairs Report

- Julie Houlder, Non-Executive Chair of the Audit Committee, presented the report.
- Julie Houlder advised that the committee met to approve the submission of the draft annual report and accounts.
- Julie Houlder noted that the committee received a positive outcome of the audit undertaken by Grant Thornton on the 2023/2024 Mental Health Investment Standard.
- Julie Houlder added that the committee agreed on the 2025/2026 internal audit plan, noting this will need to be reviewed in line with the assurance of processes to support the delivery of the plan.
- Julie Houlder advised that there is nothing to alert the Board to regarding the annual report and accounts, which is going out to audit.
- Julie Houlder shared thanks to all involved in the production of report, noting it was produced in tight timescales.

The Chair thanked Julie Houlder for the report. The Board received and noted the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB Remuneration Committee AAA Chairs Report

- Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Shokat Lal noted the ratification of the appointment of the Chief Finance Officer for an interim period.

The Chair thanked Shokat Lal for the report. The Board received and noted the recommendations presented to them.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Date and time of next meeting in public: 17 July 2025 at 1pm held in public, in person at the Midlands Partnership NHS Foundation Trust Headquarters Boardroom, Mellor House, St George's Hospital, Corporation Street, Stafford, ST16 3SR.

Enclosure No: 5

Integrated Care Partnership Briefing

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Dr Buki Adeyemo, Chief Executive Officer
Prepared by:	Staffordshire and Stoke-on-Trent Integrated Care Partnership
Executive Lead:	Dr Buki Adeyemo, Chief Executive Officer

Aligned to Board Assurance Framework Risk	Risk 7 Failure to implement a strategic approach to partner relationships impacting negatively on whole population outcomes
Approval / Review:	N/A
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	We will actively promote partnership and integrated models of working
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	Board are asked to receive the paper for information
Executive Summary	The briefing aims to keep partners informed of the discussions of the Integrated Care Partnership (ICP) Meeting held in June 2025.

	Items discussed were: - Alcohol Strategy - Neighbourhood Health and Care Programme

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	27/06/2025

Staffordshire and Stoke-on-Trent Integrated Care System

Integrated Care Partnership Briefing

Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) Meeting

June 2025

This briefing aims to keep partners and members of the public informed of the discussions at the NHS Integrated Care Partnership (ICP) meeting.

Alcohol Strategy

This is public health strategy underpinned by data, evidence of good practice, engagement with stakeholders and produced through partnership from the Integrated Care System. Our vision for the Alcohol Strategy:

“Staffordshire and Stoke-on-Trent to be a place where alcohol-related harm is minimised, to improve the health and wellbeing of our local population, making Staffordshire and Stoke-on-Trent the healthiest places to live and work.”

The reason for an alcohol-specific focus:

- An estimated 10 million people in England regularly exceed the Chief Medical Officers’ low-risk drinking guidelines, including 1.7 million who drink at higher risk and around 600,000 who are dependent on alcohol.
- Shifting patterns of alcohol consumption, with consumption increasing in those with alcohol user disorder during and after the COVID-19 pandemic.
- An estimated 79% of people living with alcohol dependency in Staffordshire and Stoke-on-Trent are not in contact with treatment.
- Evidence shows that on average, every £1 spent on treatment immediately delivers £3 of benefit and significantly more in the longer term.
- Alcohol harm costs society in England £27.44 billion each year with an estimated cost to Staffordshire and Stoke-on-Trent Integrated Care System (ICS) of £449million, of which an estimated £81million is on health and care services.
- Alcohol-related deaths have increased with risk factors including being male, living in rural areas, increased deprivation and occurring most frequently in the population aged 50-69 years.
- There hasn’t been a national alcohol strategy since 2012, and strategic focus has been more on reducing drug harm.
- The opportunity to address harmful impacts of alcohol on our population is clear from different system strategy and assessments of need.

What is our response?

We have taken a joint public health approach to the strategy and its development.

Extensive engagement has taken place, and we have undertaken an evidence review ensuring we have a strategy that is rooted in the needs of the local population.

We have conducted an Alcohol Needs Assessment, which has been instrumental in providing data-driven insights and evidence to help us prioritise our areas of focus.

The Alcohol Needs Assessment provides valuable insight into how alcohol misuse and dependency is impacting the local population's health and wellbeing with evidence gathered from data provided by local and national partners, stakeholder views and research.

Staffordshire and Stoke-on-Trent Integrated Care System

Alcohol Needs Assessment outcome high-level summary:

- Our communities are affected by the significant availability of alcohol.
- Our social care system is burdened by alcohol-related disability and housing issues.
- Our health and care system is struggling with alcohol-related liver disease and health impacts from alcohol.
- Our criminal justice system has significant alcohol needs in prison and probation services.
- Our economy is paying more per capita for alcohol-related conditions than average in England.

Priorities of the Alcohol Strategy:

- Universal Prevention: Prevent the use of alcohol or to change behaviours so alcohol misuse and alcohol released crime is prevented from happening
- Targeted Prevention: Halt the progression of alcohol misuse by early identification and prompt support, reducing alcohol-related harm.
- Treatment and Recovery: Rehabilitate people with established alcohol misuse/dependence by providing tailored, effective support and recovery interventions.
- Enforcement and Criminal Justice: Manage the availability of alcohol and developing innovative criminal justice solutions/practices to reduce alcohol misuse or alcohol-related offending and recidivism.
- Attitudinal Change: Change attitudes and behaviours towards alcohol at a societal, community and personal level.

Neighbourhood Health and Care Programme

The Neighbourhood Health and Care Programme aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through three key shifts at the core of the government's health mission:

- From hospital to community: providing better care close to, or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
- From treatment to prevention: promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health.
- From analogue to digital: greater use of digital infrastructure and solutions to improve care.

Our vision

The population of Staffordshire and Stoke-on-Trent can access health and care services that can meet their needs proactively, shifting the focus from hospital to community and delivering care closer to home.

Our mission

- To develop a Neighbourhood Health and Care Programme which promotes integrated working between the NHS, local government, social care and partners to create healthier communities.
- To implement a consistent model of care that is fit for the future and enables person-centred and proactive health and care to be delivered close to home (own home or community setting).

Staffordshire and Stoke-on-Trent Integrated Care System

- Ensure equity of access, experience and outcomes for residents across Staffordshire and Stoke-on-Trent and support a move to a more sustainable financial position, investing in prevention and care in home, or community settings.

Our places

- Place – Accountability and Planning
    - Staffordshire
    - Stoke-on-Trent
- Localities – Delivery
    - Four localities in Stoke-on-Trent
    - Eight districts and boroughs in Staffordshire
- Neighbourhoods – Change
    - People and Communities
    - Wards, Primary Care Networks (PCNs), villages, parishes

Key principles

We will build upon the work of the Integrated Care System (ICS) portfolios to enhance and strengthen key areas to:

- Utilise population health level data to use segmentation and risk-stratification methodologies to identify those most at risk.
- Prioritise proactive preventative care services.
- Ensure our population know how to access the right care they need and support themselves to self-care.

We will work effectively with general practice and community and hospital specialist care (on both acute and community hospital sites) to reduce unplanned and inappropriate use of hospital resources and increase the ability of people to live independently for as long as safely possible. We will do this by:

- Enhancing our proactive care model for those with long-term conditions and frailty through the development of integrated community neighbourhood teams (building upon Fuller Stocktake report).
- Strengthening our out of hospital services for those people who are at risk of admission and need support in a crisis.
- Increase the numbers of people utilising digital/tech-enabled care to manage their own conditions.
- Supporting a community-based workforce that has the capacity, the capability and the morale to make a difference in people's lives.
- Living within the financial means available to the healthcare system of Staffordshire and Stoke-on-Trent.
- Making best use of local estate and capital budgets, and minimising risk to patients' health from inadequate facilities.

In our first year (2025/26) we will prioritise:

- Six core components for consistency
    1. Population Health Management
    2. Modern General Practice
    3. Standardising Community Health Services
    4. Neighbourhood Multidisciplinary Teams (MDTs)
    5. Integrated Intermediate Care ('Home First' Approach)
    6. Urgent Neighbourhood Services

Staffordshire and Stoke-on-Trent Integrated Care System

- Integrating services to improve coordination, starting with those with the most complex needs (7% of the population, responsible for approximately 46% of hospital costs).
- Scaling successful approaches to benefit more people.
- Evaluating impact to ensure better outcomes and effective use of resources.

- For 2025/26 through the standardisation and scaling of the initial six components, we are asking systems to focus on the innermost circle (on the diagram to the right) to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles (on the diagram to the right).

Integrated Neighbourhood Teams – where we want to be in Staffordshire and Stoke-on-Trent

- Person health outcomes: Improvement in clinical health metrics and reduction in hospital admissions and readmissions.
- Service efficiency: Timeliness of care delivery and increased number of people supported within a neighbourhood.
- User satisfaction: High satisfaction scores and positive feedback from community engagement.
- Service performance: Effective coordination and communication, adherence to care protocols and guidelines.
- Cost effectiveness: Reduction in overall health and care costs and savings from decreased hospital admissions and improved preventative care.
- Community engagement: Active participation of the community in health programmes and success of outreach and education initiatives.

Implementing Integrated Neighbourhood Teams in Staffordshire and Stoke-on-Trent

- Quarter 1 (25/26): Initial assessment and strategic planning
- Quarter 2 (25/26): Operating model
- Quarter 3 (25/26): Pilot implementation
- Quarter 4 (25/26): Further rollout
- Quarter 1 (26/27): Monitoring and evaluation

Community engagement will take place throughout all quarters.

Staffordshire and Stoke-on-Trent Integrated Care System

Improving Population Health – Population Health Management (PHM)

PHM is an approach that underpins all our community transformation work including:

- Locality Improvement Framework (LIF)
- Core20 PLUS5 (adults)
- Core20 PLUS5 (children and young people)
- Neighbourhood development
- Inclusion groups
- Presentation programmes/projects

Feedback

The partnership split into groups to discuss and capture feedback on the following topics of discussion:

- What should / can partners bring to the neighbourhood programme?
- How do we build upon the work currently underway?
- How to we support people to look after their own health?

The following points were fed back to the group:

- Anchor institutions were discussed and leveraging their assets within communities.
- Identify clinical needs or vulnerabilities and enable follow-up support.
- Recognising that not one size fits all, tailored approaches are needed.
- Acknowledgement that different partners contribute uniquely.
- Stronger collaboration with Fire and Rescue and Police services was highlighted.
- Engagement with community team is essential to understanding local assets.
- Importance of:
    - Consistent language and common purpose
    - Simplifying messages to support clarity
    - Balancing immediate action with longer-term commissioning changes
    - Creating space for joint service development.
- Universal commitment to collaboration.
- Build on existing work rather than reinventing the wheel.
- Opportunity for a mapping exercise to identify and build upon existing programmes and assets.
- Emphasis on the importance of data:
    - Data sharing is essential for informed decision making
    - Supports deeper understanding of patient and population needs.
- Need to shift the focus to prevention to achieve real impact.
- Tackling health inequalities by rejection of one-size fits all solutions
- Services must be delivered in ways that reflect community preference and realities.
- We need to help people to understand how to access services.
- Focus on improving health literacy not just for patients, but also for families, carers and the wider community.
- It is important that we understand and map current resources and investments.
- Cross-boundary issues were noted as a challenge to service consistency.
- There is a need for flexibility, especially as PCNs often span multiple geographical boundaries.

Date and time of next meeting: Monday 1st September 2025, 3pm – 5pm, via MS Teams.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 6

Chairs Report – July 2025

Report provided for:			
Information	☒	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Janet Dawson, Chair
Prepared by:	Janet Dawson, Chair
Executive Lead:	

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	N/A
Strategic Priorities:	Prevention - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Strategic fit with system priorities
Recommendation / Required Action	For information and assurance
Executive Summary	The report updates the Board on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. This included: The NHS 10 Year Plan

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	03.07.25

Chair's report July 2025

The NHS 10 Year Plan

There have already been thousands of words written about the NHS 10 Year Plan and it is only a few days old although heavily trailed by the media in the days running up to its publication and there will be many more to come as the plan evolves. It is helpful to reflect on where we are against the priorities of the plan for our services.

In terms of the three key shifts, we are familiar and experienced in Mental Health provision with the concept of hospital to community and have been operating this successfully for many years. Mental health provision is an exemplar of how to do this well and provides an opportunity for mental health providers to share their experience and expertise with other sectors. It is great to see we have had more recognition of our transformative use of data and analytics to improve patient care, and we already meet one of the specific requirements for mental health of ensuring there are apps and platforms to allow self-referral to Talking Therapies. We are also active in the other mental health priority areas; working with our local emergency department to provide mental health support and our 24/7 crisis support team, our work in schools supporting children and young people and working in partnership with our Local Authority in caring for the most vulnerable children particularly those in care. We are acutely aware of the impact of health inequalities on people's mental wellbeing and are active in our communities in support of those most impacted and of the importance of co-production with our staff and our service users and patients. The work we have done in the past few years has set us up well to align with the 10 Year Plan and we await with interest the delivery and workforce plans to support its aspirations which are yet to be published.

It is good to have this stable platform from which to move forward as many other elements of the NHS are moving around us providing both challenges and opportunities. There is a significant amount of work to be done in developing comprehensive Neighbourhood Health Services which will require collaboration between all those involved including local authorities in which ever form they end up, other NHS Providers, GPs and PCNs, the voluntary sector and other Government departments. It will require us to be creative and flexible on how budgets are deployed, staffing and professional supervision arrangements, estates and more. In the meantime, the familiar roles within the ICB will change as will the footprints of many including Staffordshire and Stoke on Trent as it is clustered with Shropshire, Telford and Wrekin ICB.

So much change can be overwhelming and confusing, and I can identify with that, and know that for many of our staff, there will be concerns about where this is all going. Some of you will have heard me say this before but at times like these focussing on the basics can be helpful. It's a 10 year plan and while we must get on with it, not everything will change at once and we have the day to day to deliver in the meantime; safe and compassionate care to our patients and service users, our financial targets as a Trust and the well-being of our staff, listening to concerns and communicating well.

As ever, I want to thank the executive teams and all our staff for their continued hard work and for all that you do every day.

Janet Dawson

Chair

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 7

DIPC Annual Report

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Kenny Laing, Chief Nursing Officer & Director for Infection Prevention and Control
Prepared by:	Clare Williams – Head of Infection Prevention and Control
Executive Lead:	Kenny Laing, Chief Nursing Officer & Director for Infection Prevention and Control

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	SLT
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	None identified
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Demonstrate where we are aligning our Strategy to the ICS
Recommendation / Required Action	The Board are asked to receive for information and assurance
Executive Summary	The purpose and content of this annual report is to inform the Trust Board of the Infection Prevention and Control Team (IPCT) activities during the period of 01 April 2024 to 31 March 2025. The annual DIPC report is aligned to the ten compliance criteria as

outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated July 2022). The compliance framework is used by the Care Quality Commission to assess a registered provider on how they comply with Cleanliness and Infection Prevention & Control requirements as detailed in the legislation. (Table 1 of main report).

The highlights are as follows: -

- Receive the report
- Assured that The Trust complies with the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections
- Completion of the IPC annual work-plan for 2024/25 (appendix 1)
- Audit plan for inpatient and community service completed for 2024/25 (appendix 2)
- A comprehensive IPC Provision within the Trust
- Re-introduced IPC champion network, sessions provided each quarter.
- A continued and ongoing response to the COVID-19 and other winter pressures
- Advising on estates and facilities issues including refurbishments and new builds
- Ongoing involvement and support to external services e.g. Occupational Health provision
- Water Safety Management
- Public Health response to emergency situations i.e. Outbreak Management and new emerging pathogens
- The Trust performed seconded highest in the seasonal influenza programme within the system, 792 (48.9%) NSCHT staff received their flu vaccine.
- MPFT vaccination team supported the delivery of on-site Covid-19 vaccination for both patients and staff on selected dates.
- Providing a response to and supporting the Trusts regulatory and mandatory requirements i.e. CQC and NHSEI.
- Compliance with national mandatory surveillance of MRSA, MSSA, Gram-negative bacteraemia and C. difficile infections. During 2024/25, 5 cases of Clostridioides difficile Toxins were reported, four cases were deemed Community Onset Healthcare Associated (COHA) with a further case attributed to the Trust.
- During this reporting period, the IPC Patient safety incident response framework (PSIRF) has been implemented.
- IPC mandatory training Level 1 and 2 (e-learning), the overall annual trust compliance as of the 31 March 2025 for Level 1 was 96.25% - this is slight decrease from 97% from the previous year. Level 2 mandatory training for clinical staff was 86.16%. Level 2 training was introduced in April 2024 as part of the

	physical health competency framework. ➢ Quality improvement, ANTT Clinical Practice Framework has been implemented with LMS training available for clinical staff This report should be accepted as assurance of the actions taken to maintain and further improve the infection prevention and control performance at North Staffordshire Combined Healthcare Trust (NSCHT).

VERSION CONTROL:

Version	Report to	Date Reported
V1	Infection Prevention and Control Group	12.05.2025
V2	SLT	17.06.2025
V3	Quality Committee	27.06.2025
V4	Public Trust Board	04.07.2025

DIPC Annual Report 2024/25

Foreword by Director of Infection Prevention and Control (DIPC)

This Annual report covers the period 1st April 2024 to 31st March 2025 and has been written in line with the ten Criterion as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022). The ten Criterion outlined in the code are used by the Care Quality Commission (CQC) to determine if a registered provider is compliant with Cleanliness and Infection Prevention & Control requirements as detailed in the legislation.

This report reflects the hard work, professionalism and dedication of, not just our dedicated Infection Control Team, but our colleagues in Facilities and Estates who work tirelessly to maintain high standards of cleanliness across our Trust.

Throughout the period of this report, the Infection Prevention and Control Team (IPCT) and extended workforce of the organisation have continued to be responsive in all matters relating to infection prevention and control. As a Trust, we would like to take this opportunity to express our gratitude and appreciation to our Infection prevention and control team and workforce for their sustained energy and commitment in keeping colleagues, patients and visitors safe by providing effective IPC practice.

I commend this report which provides the evidence relating to how we have maintained and, in some areas, strengthened our practice to achieve the aims of the 10 criteria outlined within the Health and Social Care Act.

Kenny Laing

Chief Nursing Officer & Director for Infection Prevention and Control (DIPC)

Introduction:

North Staffordshire Combined Healthcare NHS Trust (NSCHT) provides a wide range of mental health, learning disability, substance misuse, and primary care services. These include inpatient services, community mental health teams, crisis care, and specialist services like CAMHS, substance misuse services, and psychological therapies. Services are provided from approximately 30 sites, including hospital, GP practices and community-based premises serving a population of around 464,000 people of all ages and diverse backgrounds in our core area of Stoke-on-Trent and across North Staffordshire.

The purpose of this report is to inform patients, service users, public, staff, the Trust Board and Governors of the infection prevention and control work undertaken from 01 April 2024 to 31 March 2025, and outlines the infection prevention and control activities undertaken to fulfil the statutory requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections. All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections in accordance with the Act. The report also provides assurance of the control measures in place at NSCHT and the Trusts' compliance to the Act.

High standards of infection prevention and control (IPC) are crucial to ensure prevention of infection(s) in all health care facilities and at its core are the fundamentals of care, good management and evidenced based clinical practice to reduce infection risks. Emphasis is given to the prevention of healthcare associated infection, the reduction of antibiotic resistance and the sustained improvement of cleanliness in all premises and hospital settings. Evolving clinical practice presents new challenges in infection prevention and control, which were continuously reviewed and implemented.

To support this, the IPC team have worked in collaboration with directorates and other corporate teams to continue the Trusts' extensive efforts to prevent all avoidable infections and minimise the risk of resistant organisms across our Healthcare Economy footprint.

The Chief Nursing Officer is the Trusts designated Director of Infection Prevention and Control (DIPC). The code states that the DIPC produces an annual report.

The IPC team wish to acknowledge and recognise the hard work and commitment of staff within the trust and across the healthcare economy. In working collaboratively, we continue to strive for the highest quality IPC standards to ensure patient safety for those who access our services. The report has been supported and produced with contributions from other members of the Infection Prevention and Control Group (IPCG).

Purpose of the Report (Executive Summary):

The Trust has a statuary responsibility to comply with the Health and Social Care Act (2008), Code of Practice on the prevention and control of infections and related guidance (revised 2022), for the purpose of this report, this will be referred to as 'the Act'. All NHS organisations must ensure that effective systems are in place to control healthcare associated infections (HCAIs) and as such, NSCHT is committed to ensuring that a robust Infection Prevention and Control (IPC) function operates within the Trust, which supports the delivery of high-quality healthcare and protects the health of those who use its services. Appendix 2 of this report details the completed IPC annual audit plan which provides assurance and evidence of compliance to the Act.

NSCHT continues to participate in the mandatory surveillance of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, E. coli bacteraemia and Clostridioides difficile infection via the national UK Health Security Agency (UKHSA) healthcare associated infections Data Capture System (HCAI DCS). In addition, mandatory reporting of P. aeruginosa and Klebsiella species was introduced in 2017.

Incidents and outbreaks were managed as they occurred throughout 2024/25. The management of Covid-19, influenza and seasonal outbreaks remains high on the Trust's agenda and local policies and procedures are updated and reviewed annually in line with national guidance.

The annual DIPC report is aligned to the ten compliance criteria as outlined in the Act, this compliance framework is used by the Care Quality Commission to assess a registered provider on how they comply with Cleanliness and Infection Prevention & Control requirements detailed in the legislation. (Table 1). Many responses sit in more than one criterion however, to avoid duplication the information has been placed within the most relevant criteria applicable to the response, but it should be acknowledged that more than one criterion will be assured by the responses.

The ten Criterion outlined in the code are:

Table 1: The requirements of the Health and Social Care Act (2008) updated with revised guidance issued July 2022.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Good Infection Prevention and Control (IPC) is essential to ensure that people who use Trust services receive safe and effective care. This Annual Report shows how the Trust is performing against the Code of Practice criteria, what the Trust has achieved during 2024/25, and where the Trust would like to improve for 2025/26.

Key Recommendations and achievements to Consider:

- Receive the report
- Assured that The Trust complies with the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections
- Completion of the IPC annual work-plan for 2024/25 (appendix 1)
- Audit plan for inpatient and community service completed for 2024/25 (appendix 2)
- A comprehensive IPC Provision within the Trust
- Re-introduced IPC champion network, sessions provided each quarter.
- A continued and ongoing response to the COVID-19 and other winter pressures
- Advising on estates and facilities issues including refurbishments and new builds
- Ongoing involvement and support to external services e.g. Occupational Health provision
- Water Safety Management
- Public Health response to emergency situations i.e. Outbreak Management and new emerging pathogens
- The Trust performed seconded highest in the seasonal influenza programme within the system, 792 (48.9%) NSCHT staff received their flu vaccine.
- MPFT vaccination team supported the delivery of on-site Covid-19 vaccination for both patients and staff on selected dates.
- Providing a response to and supporting the Trusts regulatory and mandatory requirements i.e. CQC and NHSEI.
- Compliance with national mandatory surveillance of MRSA, MSSA, Gram-negative bacteraemia and C. difficile infections. During 2024/25, 5 cases of Clostridioides difficile Toxins were reported, four cases were deemed Community Onset Healthcare Associated (COHA) with a further case attributed to the Trust.
- During this reporting period, the IPC Patient safety incident response framework (PSIRF) has been implemented.
- IPC mandatory training Level 1 and 2 (e-learning), the overall annual trust compliance as of the 31 March 2025 for Level 1 was 96.25% - this is slight decrease from 97% from the previous year. Level 2 mandatory training for clinical staff was 86.16%. Level 2 training was introduced in April 2024 as part of the physical health competency framework.
- Quality improvement, ANTT Clinical Practice Framework has been implemented with LMS training available for clinical staff

Background:

Infection Prevention and Control Team Structure 2024/25 (Criteria 1)

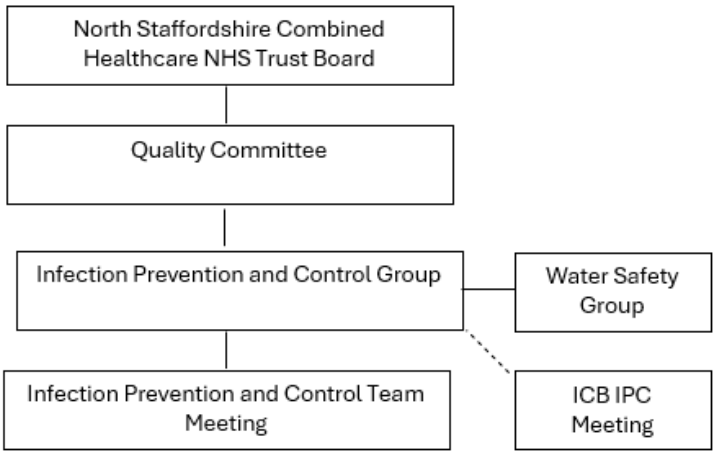
The IPC service is provided through a structured annual programme including expert advice, audit, teaching, education, surveillance, policy development and review, as well as advice and support to staff, service users and visitors. The main objective of the annual programme is to sustain the high standard already achieved and enhance quality improvement when learning is identified. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. As observed in appendix 1, the annual programme is agreed and monitored by the IPCG, and compliance is reported to the Trust Board.

The IPCG meets quarterly and the IPCT produces quarterly assurance reports, all quarterly IPCG meetings were held with minutes and actions recorded. Membership of the IPCG includes the DIPC, IPC Team, Estates, Facilities, directorate/corporate leads and matrons. Other representatives may attend as a one-off according to the agenda. Divisional updates are also provided and after IPCG approval, these reports are presented to the Quality and Safety Committee and Trust Board. External stakeholders such as our local Integrated Care Board (ICB) also receive these reports.

The Trust has a pro-active infection prevention and control team (IPCT) who implement and support the actions necessary to deliver and maintain patient, visitor and staff safety. On-call out of hours cross cover arrangements are in place for the IPCT with Midlands Partnership Foundation Trust (MPFT). The Director for Infection Prevention and Control (DIPC) has overall responsibility to provide strategic direction and leadership to the Trust on all IPC matters. The DIPC is supported by the Deputy DIPC (Deputy Chief Nursing Officer) and IPCT. The team is managed by the Head of IPC with 2 qualified and experienced IPC Nurses. The IPCT organisational structure and governance framework at the time of this report is:

IPCT Organisational Chart

IPCT Governance Framework



The purpose of the IPCG is to gain assurance that the Trust is fulfilling national and local infection prevention and control requirements. Performance on the number and status of specific reportable and non-reportable Healthcare Associated Infections (HCAI) in the Trust is reported to the IPCG quarterly.

IPCG agreed the 2024/25 Annual IPC Work Plan (appendix 1) and monitors progress against the plan. This oversight ensures Trust IPC priorities are agreed, implemented and any IPC issues are identified early. The 2024/25 Annual IPC Work Plan was refreshed to mirror the 10 criteria in the Health and Social Care Code of Practice.

The Water Safety Group reports into the IPCG via the Estates and Facilities Report.

As the threat and risk from COVID-19 decreased, the decision was taken to continue the weekly Integrated Care Board IPC meetings to promote a systemwide approach to managing IPC.

The specialist IPCT provides a wide variety of support and advice to all Trust staff, wards and departments in relation to infection prevention and control matters and liaise regularly with information on alert organisms, offering advice and reassurance when required. Supporting clinicians, AD's, QI Matrons and ward managers who have responsibility for the operational delivery of IPC, clinical governance and risk management. The team continues to support frontline staff and prioritise urgent IPC issues during winter pressures and the ongoing response to outbreak management.
The remit of the team includes:

- Education and training to ensure that the principles of infection control recognition and its application is accurate and appropriate to the relevant staff groups.
- Surveillance of hospital infection - to work with other clinicians to improve surveillance and to strengthen prevention and control of infection in the Trust.
- National bacteraemia data reporting
- UKHSA data reporting
- Investigation, control and reporting of outbreaks
- Development, implementation and monitoring of Infection Prevention and Control policies procedures and guidelines for the prevention, management and control of infection are in place across the organisation.
- Audit and quality improvement
- Support Health and Safety in the sign off from an IPC perspective for new items of equipment
- Assessment and input into service development and buildings / estate works
- Patient care/ incident reviews
- Mortality surveillance reviews
- To communicate information relating to communicable disease to all relevant parties within the Trust.
- To provide appropriate infection control advice to key Trust committees, taking national guidance into account.

Water Safety Group (Criteria 1)

The Water Safety Group, chaired by the DIPC/Deputy DIPC, follows and implements the standards and guidance set out in Health Technical Memorandum (HTM) 04-01, Safe Water in Healthcare Premises. The

HTM 04-01 gives guidance on the legal requirements, design applications, maintenance and operation of hot and cold-water supply, storage and distribution systems in all types of healthcare premises. A Water Safety Plan is in place, which provides detail on how the risks from microbiological and scalding hazards associated with the supply and use of water are assessed, managed and controlled, and is owned and managed by the Water Safety Group (WSG).

The groups' function is to:

- ensure good water safety and monitoring across the Trust to keep staff and services users safe from water related risks.
- to develop, implement and monitor the annual strategic water safety program to reflect the requirements of the Water Safety Plan.
- to review and monitor untoward incidents across the Trust relating to water safety.
- develop, maintain a risk register to reflect any Water Safety issues and escalate concerns appropriately.
- to review advice and monitor any actions identified in relation to water quality and safety issues.
- Inform and escalate water safety issues, and provide assurance to IPCG

Following the completion of the annual water safety audit by the Trust's appointed Water Authorising Engineer on 16 September 2024. A formal review of the WSG structure, terms of reference and roles and responsibilities was completed. 8 staff have now completed the responsible persons training with a further 14 staff completing the City and Guilds training for departmental managers. The WSG meets quarterly and reports into the IPC Group. During this reporting period all quarterly meetings took place with 30 extra-ordinary WSG meetings been held in response to adverse water sample results and the ongoing support required in relation to Project Chrysalis and the site wide monitoring of the flow and return water temperatures in accordance with HTM 04-01.

Water Risk Assessments are monitored by the WSG and, as of 31 March 2025, all Water Risk Assessments were in date. On completion of Water Risk Assessments, any actions are added to the Trust's Water Safety Action Plan. Remedial works are prioritised and monitored by the designated Responsible Person in the Estates Team and the WSG.

Cleaning and Environmental Standards (Criteria 2)

The Trust is now working to the new National Standards of Healthcare Cleanliness 2021 and delivering services in accordance with Functional Risk (FR) category and corresponding target audit score FR2 in all our inpatient units. This being a commitment to achieve a score of 95% or above monthly. During 2024/2025 we achieved an average score of 96.53% for inpatients areas.

In our community clinical premises, we are working to Functional Risk (FR) category score FR3. With a target commitment to achieve a score of 90% or above and audited on a bi-monthly basis to comply with the new standards. During 2024/25 we achieved an average score of 95.20% in these areas.

Cleanliness scores are an agenda item at the Trust IPC group. This is in line with and supports our cleanliness strategy, decontamination responsibilities, and the Infection Prevention & Control (IPC) assurance framework (Criterion 2).

Patient Led Assessment Care Environment (PLACE) 2024

From the table below, our organisation scored well above both the overall National Average scores, and the National Average scores per MH/LD site category in all elements. All assessments were completed in accordance with the PLACE guidelines with at least 50% patient representation on each team and an independent validator on two of our assessments. Pleasing and favourable comments have been received by our Patient Representatives and Independent Reviewer, resulting in the Trust maintaining their PLACE assessment scores with a noted improvement in some areas. The below results demonstrate the hard work and high standards that are being delivered and maintained by our staff and our PFI partners at the Harplands.

Table 1: PLACE scores 2024

PLACE 2024	Cleanliness %	Food and Hydration			Privacy, Dignity and Well Being %	Condition, Appearance and Maintenance %	Dementia %	Disability %
		Food %	Organisation Food %	Ward Food %				
Harplands Hospital	99.35	96.76	92.36	98.96	98.54	94.51	98.87	97.88
Dragon Square	100	N/A	N/A	N/A	100	100	N/A	100
A&T Unit	100	94.51	90.43	100	95.12	97.62	N/A	90.74
Darwin Centre	100	94.54	89.54	100	97.44	100	N/A	92.31
Hilda Johnson House	100	N/A	N/A	N/A	94.59	98.75	N/A	92.31
Summers View	100	N/A	N/A	N/A	94.87	97.50	N/A	92.31
NSCHT Organisation score 2024	**99.52**	**96.46**	**92.01**	**99.10**	**97.88**	**95.72**	**98.87**	**96.68**
National Mental Health and LD average scores 2024	**98.07**	**92.09**	**89.52**	**94.33**	**95.67**	**95.91**	**91.93**	**90.39**

National (mean) average score –all site types 2024	**98.31**	**91.32**	**92.17**	**91.38**	**88.22**	**96.36**	**83.66**	**85.20**

Waste Management including Sharps

The overall responsibility for correct processing of waste in the Trust, sits with the Estates and Facilities team. The Trust Waste Policy is in place and available to staff via the Trust intranet. The Trust has contracts with an external service provider for the collection and disposal of clinical, offensive, pharmaceutical waste and sharps. The Trust has implemented the offensive waste stream as their standard healthcare waste, over the previous clinical waste streams.

Monitoring and audit of the policy:

- Clinical waste streams are audited in accordance with HTM 07-10 and Environment Agency guidance and any issues highlighted to the service provider.
- The safe handling and disposal of sharps is covered by the Inoculation Injuries policy and is monitored by Occupational Health and Health and Safety.

Laundry

A high-quality linen hire service is provided to the Trust by Elis. This contract was awarded in November 2018 for a 3-year period with the option to extend for a further 2 x 24-month periods. The Trust are now procuring this service for a further 12 months. Procurement services will be leading a collaboration for future tender exercises. All laundering and finishing process follow HTM 01-04. This contract is managed and monitored by the Trust Facilities team.

Nutrition

All patients have received good quality, nutritious meals that consider their individual needs and preferences, including age, gender, ethnic and religious beliefs. We have promoted hydration with both our patients and staff, offering a wide range of fluids at the correct temperature and texture.

Protected mealtimes are promoted in all areas. Menu boards and menu files promoting catering services are available and promoted in all areas. Every inpatient area has a food allergen information regulations 2014 (FIR) folder that is bespoke to each site in line with their menus.

Food Safety audits/inspections

Efficient and accurate record keeping is completed by Support Services and SERCO teams to demonstrate both food safety and successful application of food safety management and provide evidence for due diligence to prove that all reasonable and satisfactory precautions have been taken.
Compliance against our managing food safety documentation is checked on a quarterly basis by the Support Services and SERCO supervisors/managers.

These audits are unannounced and identify non-compliances with: -

- Food Safety Practices & Procedures
- Structure, Equipment and Cleanliness
- Food Safety Management System, Hazard Analysis Critical Control Point (HACCP)

Planned inspections with the catering/facilities management team are also carried out to check on progress of audit action plans.

External Food Safety Inspections

All premises are registered with the Food Standards Agency and inspected by Environmental Health Officer (EHO), except for Hilda Johnson House, who due to the change of use of this premise no longer must be registered but does continue to be monitored by the Facilities team to ensure Food safety and hygiene standards are maintained. All premises inspected by EHO in 2024/25 have retained 5-star rating.

Refurbishment Projects - Infection Prevention and Control in the Built Environment

In accordance with the Act and Health Building Note 00-09: Infection Control in the Built Environment (2013), the IPCT continue to work closely with the Estates and Facilities Teams on issues related to IPC in the built environment. The IPCT is consulted by project managers in the initial planning stages and the ongoing process for new builds and refurbishments of existing buildings. The IPC Team and Facilities Team provided advice on refurbishment projects throughout the Trust and continue to support planned future projects.

Antimicrobial Stewardship (Criteria 3)

The Trusts Chief Pharmacist is the designated lead for antimicrobial stewardship for the Trust. The Trust has an SLA with University Hospital North Midlands (UHNM) for the provision of Consultant Medical Microbiologist support, expertise and guidance.

Monthly audits are completed to monitor antimicrobial prescribing with the aim to improve patient care by identification and challenge of prescriptions which do not follow local guidelines.

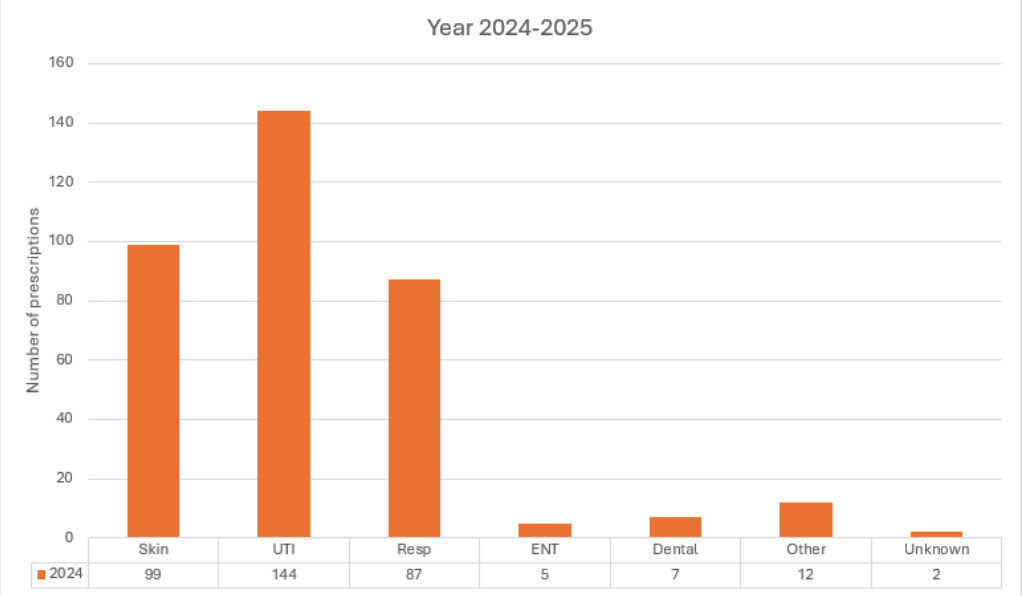
The audit provides information to the Clinical Effectiveness Group (CEG) and Infection Prevention and Control Group (IPCG) and forms part of antimicrobial (AMR) stewardship for the Trust in line with the IPCG assurance framework and work plan.

All inpatient areas of the Trust are audited. This is achieved by pharmacy staff completing the data collection spreadsheet whenever an antibiotic prescription is seen for the first time by the pharmacist.

Table 2: Antibiotic use by ward, by indication 2024/25

Infection	PICU	1	2	3	4	5	6	7	A&T	EDMY	SV	Darwin	Total
Skin	1	18	10	12	15	4	12	16	0	6	2	3	**99**
UTI	4	10	6	12	45	5	29	29	0	7	0	0	**144**
Respiratory	0	5	2	9	39	1	11	11	0	4	0	0	**87**
ENT	0	0	0	0	3	2	0	0	0	0	0	0	**5**
Dental	0	0	1	4	0	0	0	0	0	0	1	1	**7**
Other	0	2	0	2	2	1	4	1	0	0	0	0	**12**
Unknown	0	1	0	0	0	0	1	0	0	0	0	0	**2**
Total	**5**	**36**	**19**	**39**	**104**	**13**	**57**	**59**	**0**	**17**	**3**	**4**	**356**

Chart 1: Number of antibiotics used, by indication



Trust Antimicrobial Guidelines for specific body systems are in place. These are based on National Institute for Health and Care Excellence (NICE) guidance with local adaptation by the local microbiologist. Where clinically appropriate, guidelines in the Trust reflect those in the wider Staffordshire and Stoke on Trent health and care system.

There is a separate Local Health Economy Infection Prevention & Control and Antimicrobial Group, which is chaired by the Consultant Microbiologist from University Hospital North Midlands (UHNM) with

representation from pharmacy and IPC. On review of the annual work plan, these areas are sitting amber as the ICB system establishes a new lead.

Information for Service Users, Visitors and Carers (Criteria 4)

The IPCT is available to speak to any patient, visitor or carer at the request of the ward or when directly approached. Patient, visitor and carer information leaflets have been developed during this reporting period for alert organisms and can be accessed on the Trust internet by staff.

Communication Programme

The Trust has a dedicated communications team. The IPCT and communications team, work together to:

- Promote IPC events.
- Communicate campaigns to inform staff, patients and visitors around Influenza, seasonal winter infections e.g. Norovirus
- Update the Trust website and intranet.
- Support the preparation of media statements during outbreaks if required.
- Support the annual flu vaccination campaign
- Support the COVID vaccination programme
- Support communication of COVID-19 and other infection related information and guidance
- Awareness campaigns
- Dedicated IPC noticeboard in main Harplands reception

The IPC team have a dedicated telephone support and advice line (in-hours). Out of hours advice and support can be sought from the on-call Microbiologist.

The IPC team have followed national guidance in relation to information relating to visitor information and signage relating to respiratory symptoms. There is also information for these infections and general IPC information available on the internet. The IPC team have worked with Primary care teams to offer advice for patients regarding M-Pox.

Healthcare Associated Infections (HCAIs) and Surveillance (Criteria 1 and 5)

The Trust had a low incidence of reportable healthcare associated infections during 2024/25. There are currently no national or local trajectories assigned to NSCHT. However, this does not diminish the Trust's responsibility in preventing HCAIs. Investigations are undertaken in alignment with local and national guidance. Reports are escalated by exception and shared with external partners on request. Learning is cascaded to all relevant stakeholders to prevent future occurrences.

A proportion of the IPC Team's workload involves surveillance and identification of people who have or are at risk of developing an infection so that they can receive timely and appropriate treatment and to reduce the risk of transmitting the infection to others.

Some organisms are subject to mandatory reporting requirements to the UK Health Security Agency (UKHSA). These are:

- MRSA
- MSSA
- *C. difficile*

- Gram-negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)

There is a robust reporting system in place. The UHNM laboratory inform the IPC Team of alert organisms that need to be mandatorily reported, as well as other infections of significance, such as influenza, COVID-19, Norovirus or Tuberculosis (TB). Positive results are reported to clinical teams via email, so that clinical staff are notified at the earliest opportunity.

Clostridium Difficile Infection (CDI)

Clostridium Difficile (C. difficile) is an anaerobic spore-forming Gram-positive rod which can cause antibiotic-associated diarrhea and, less commonly, a severe and life-threatening disease, pseudo-membranous colitis. NSCHT is compliant with DOH testing guidance for CDI.

At the end of the year period, 4 cases of Clostridium Difficile Toxin were detected, post infection reviewed were completed, 3 cases were deemed Community Onset Healthcare Associated, (COHA) with 1 case deemed Hospital Onset, Healthcare associated (HOHA) and attributed to the Trust.

Gram Negative Blood Stream Infections (GNBSI)

GNBSI cases can occur in any healthcare setting, half of all community onset cases have had some level of healthcare interventions from either, Acute, Primary or Community Care. NSCHT continues to work collaboratively with our local health economy IPC group to reduce the impact of GNBSI.

At end of year, no reported cases of GNBSI were attributed to the Trust, this demonstrates the improvements made from 2023/24 where 2 cases of GNBSI were reported linked to indwelling urinary catheters. In the last 12 months a urinary catheter SOP has been implemented alongside the completion of a quality improvement program for Aseptic Non-Touch Technique (ANTT), a clinical practice framework focused on minimizing the risk of infection during invasive procedures.

MSSA Bacteraemia

Methicillin-susceptible Staphylococcus aureus, a type of bacteria that is commonly found on the skin and in the nose and if enters the bloodstream can cause serious infection. MSSA is susceptible to treatment with methicillin and other beta-lactam antibiotics, making it easier to treat than methicillin-resistant Staphylococcus aureus (MRSA).

At end of year, no reported cases of MSSA bacteraemia were attributed to the Trust.

MRSA Bacteraemia

Methicillin-Resistant Staphylococcus aureus (MRSA) a serious bloodstream infection caused by an antibiotic-resistant bacterium.

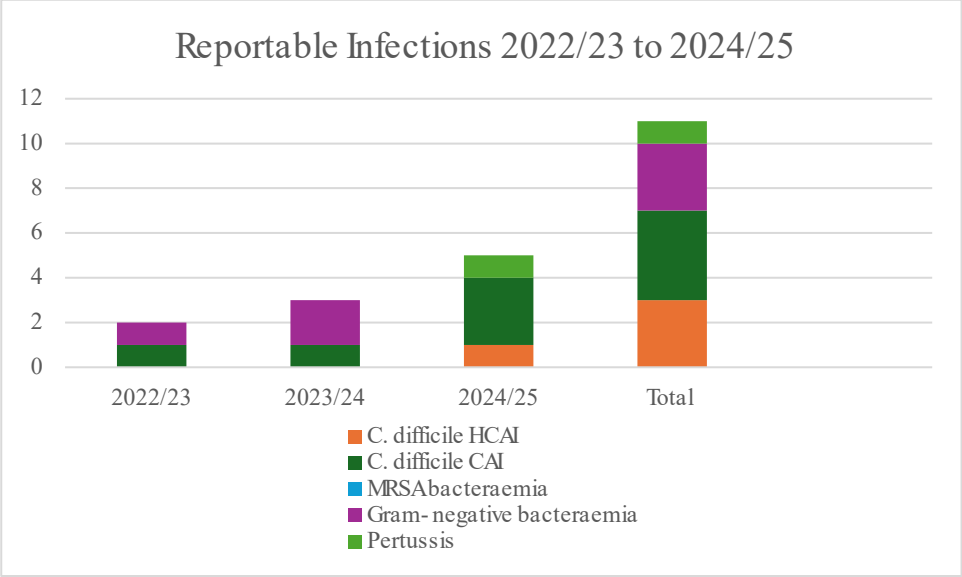
At end of year, no reported cases of MRSA bacteraemia were attributed to the Trust.

The table below shows the number of reportable infections for 2024/25, and the below chart shows the number of reportable HCAI cases in the Trust over the last 3 years.

Table 3: Reportable Infections 2024/25

2024-25	Q1	Q2	Q3	Q4	Total
Clostridioides *difficile* HCAI	1	0	0	0	**1**
Clostridioides *difficile* CAI	1	1	0	2	**4**
MRSA bacteraemia	0	0	0	0	**0**
Gram- negative bacteraemia (E. coli, Klebsiella spp., Pseudomonas aeruginosa)	0	0	0	0	**0**
MSSA bacteraemia	0	0	0	0	**0**
Pertussis	1	0	0	0	**1**

Chart 2: Number of reportable HACIs



MRSA Acquisitions

Up to 30% of the population carry MRSA on their skin or in their nose at any time without being aware of it, this is called colonization. Following guidelines set by NHS England, NSCHT conducted targeted MRSA screening for new admissions to in-patient services. The main objective is to suppress the number of MSRA bacteria on the skin to a level that is harmless and prevents onward transmission or infection.

During 2024/25 there were 12 MRSA acquisitions identified with 7 deemed HCAI, compared to 3 HCAI MRSA cases in 2023/24. The increase in MRSA HCAI colonization has been linked to non-compliance / refusal with admission screening.

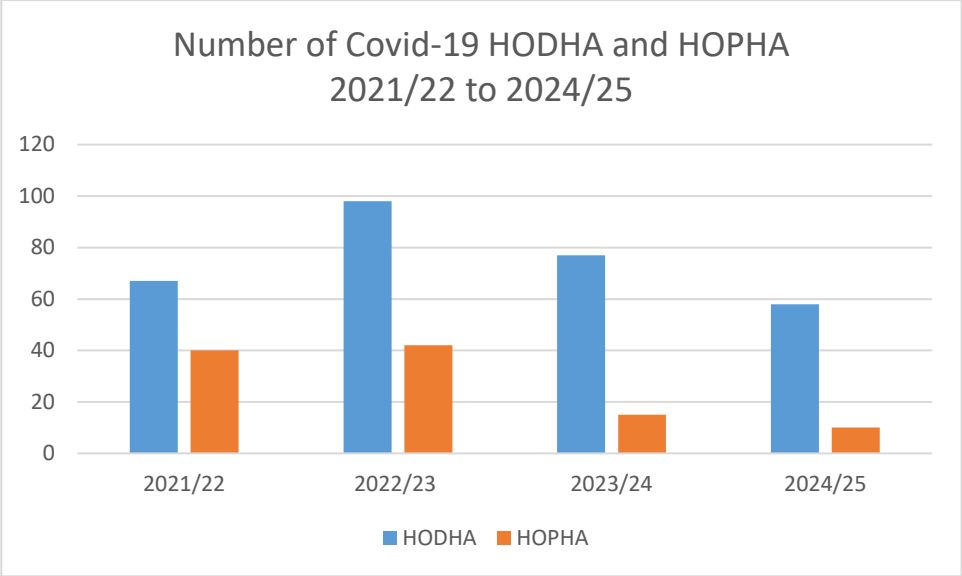
Covid-19

During 2024/25, there were 58 Hospital Onset Definite Hospital Acquired (HODHA) COVID-19 cases and 10 Hospital Onset Probable Hospital Acquired (HOPHA) COVID-19 in the Trust. The definitions for hospital acquired COVID-19 are:

- **HODHA -** Hospital Onset Definite Healthcare Acquired - first positive specimen taken 15 or more days after hospital admission
- **HOPHA -** Hospital Onset Probable Healthcare Acquired - first positive specimen taken 8-14 days after hospital admission.

The chart below shows the number of HODHA and HOPHA COVID-19 cases in the Trust over the last three years.

Chart 3: Number of COVID-19 HODHA and HOPHA Cases 2021/22 to 2024/25



Many mental health patients tested positive for COVID-19 after returning from home leave, which is an element of their recovery plan. It is likely that they acquired COVID-19 when they were not on the hospital ward, but the Trust is still required to report these cases as hospital acquired COVID-19, as they were under the care of the Trust at the time.

Extended Surveillance

As part of the wider surveillance process, inpatient care settings provide a weekly update, information is collected on all suspected cases of infection managed within the organisation. Table 2 is a breakdown of cases managed across the Trust during this report period.

In total, 185 urine samples were sent, of which, 92 samples identified sensitive organisms, 90 indicated mixed growth, with 3 resistant organisms (E coli ESBL) identified during this period. Over this reporting period there was an increase in reported chest infections and episodes of D&V, these were linked to the increase of respiratory and enteric virus circulating and were reflective of community prevalence. Where an IPC risk is identified, IPC transmission-based precautions with enhanced cleaning were advised and antibiotic treatments were reviewed and managed in accordance with antimicrobial prescribing.

Table 4: Enhanced Surveillance

Infection	2023-24	2024-25
Urinary Tract Infection	**182**	**185**
Catheter Associated Urinary Tract Infections	**13**	**15**
Suspected chest Infection	**44**	**54**
Device infections *(i.e. PICC lines)*	**0**	**0**
Diarrhoea & vomiting (including confirmed Norovirus)	**13**	**46**
Influenza	**8**	**2**
Human Rhinovirus	**0**	**1**
RSV	**0**	**5**
Staphylococcus aureus (wound)	**22**	**38**
MRSA colonisation CAI	**5**	**8**
MRSA colonisation HCAI	**3**	**7**
Shingles	**0**	**1**
Scabies	**0**	**7**

Outbreaks

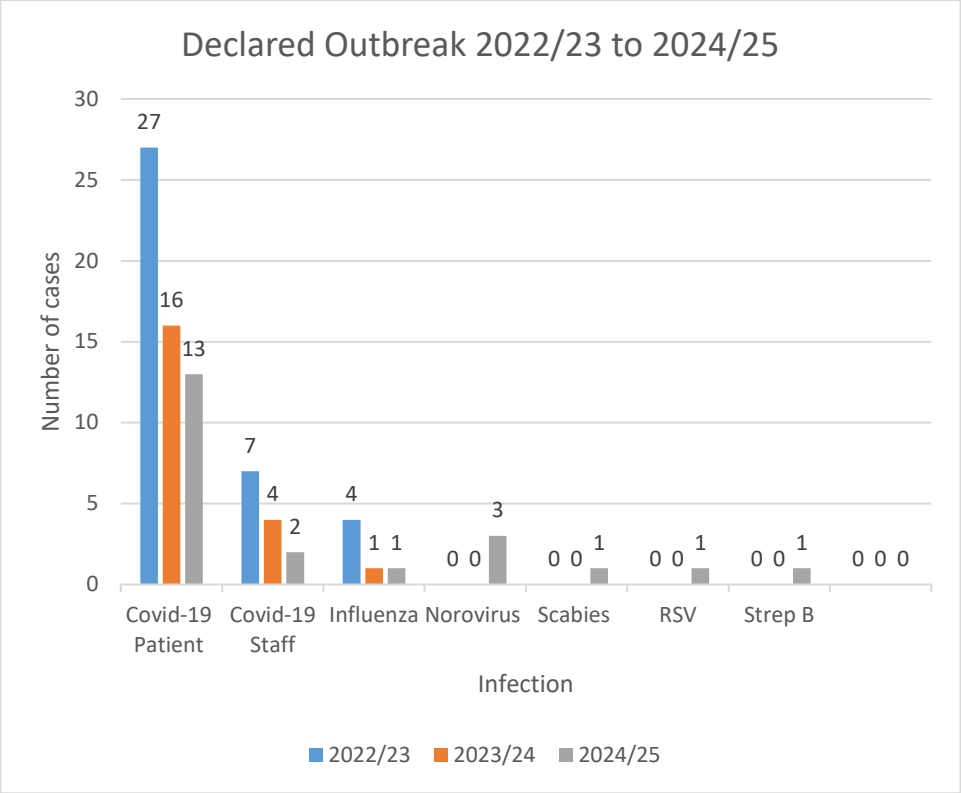
Outbreaks are identified and declared in line with the current national definitions; two or more test-confirmed or clinically suspected cases (including patients, health care workers and other hospital staff) who are associated with a specific setting (for example bay, ward or shared space) that are linked in time and place.

The process for managing declared outbreaks include convening internal outbreak groups and meetings with key external partners. These include representatives from the relevant Integrated Care Boards (ICB), UK Health Security Agency (UKHSA), NHS England Improvement, local authority Health Protection Teams. Meetings are recorded by minutes and action logs are populated to ensure actions are followed up. Actions and lessons learned are reported through the divisions to be cascaded to relevant teams with the aim of improving practice. Best practice is followed, and any required changes/improvements are implemented and monitored going forward.

Table 5: Summary of Declared Outbreaks

2024-25	Q1	Q2	Q3	Q4	Total
COVID-19 Inpatient	3	6	2	2	**13**
COVID-19 Staff Only	1	1	0	0	**2**
Influenza	0	0	0	1	**1**
Norovirus	1	0	0	2	**3**
Scabies	0	0	1	0	**1**
RSV	0	0	0	1	**1**
Strep B	0	0	0	1	**1**

Chart 4: Number of declared outbreaks and causative organisms declared in the Trust over the last three years.



COVID-19 was the organism responsible for causing majority of outbreaks in 2024/25. The duration of the outbreaks, and the impact for patients, was significantly reduced compared to 2022/23. This was partly due to the COVID-19 vaccination programme, prompt recognition and management of symptoms by clinical teams, LFT testing for early detection, implementation of effective transmission-based precautions in line with the National Infection Control manual and the eradication of dormitories. The IPC team supported the clinical teams to manage the respiratory outbreaks effectively.

During 2024/25, there were three outbreaks of viral gastroenteritis infection. The outbreaks on average lasted 10 days and a total of 27 patients and 27 staff were affected. Norovirus G2 was confirmed as the causative organism. Index cases were linked to community leave and patient transfers from UHNM. The wards were closed to non-urgent transfer of patients.

There were challenges managing outbreaks effectively within Mental Health units; staff found it difficult to encourage patients to isolate due to their mental health needs which increased viral transmission within the wards.

Training and Education (Criteria 6)

The IPCT are committed to ensure Trust staff are trained in appropriate IPC practices and support a range of education and training activity. Staff undertake IPC e-learning modules on LMS for mandatory training. All IPC related training is underpinned by national guidance and Trust policy and procedures and provides NHSEI the required assurance that staff are up to date with their mandatory training and are responsive to outbreak management. The overall annual trust compliance as of the 31 March 2025 for Level 1 was

96.25% - this is slight decrease from 97% from the previous year. Level 2 mandatory training for clinical staff was 86.16%. Level 2 training was introduced in April 2024 as part of the physical health competency framework for all clinical staff.

Infection prevention is included in all job descriptions for staff (clinical and non-clinical), including volunteers. Contractors working in servicer user areas must maintain good standards of IPC practice, including hand hygiene, and guidance is included in the Control of Contractors Policy. Clinical staff are responsible for ensuring contractors are aware of IPC expectations within the clinical environment.

Below is a brief outline of education and training delivered during this reporting period:

- Mandatory level 1 (e-learning) IPC training for non-clinical staff.
- Mandatory level 2 (e-learning) IPC training has been introduced for all clinical staff.
- IPC Champion meetings are held quarterly via face to face and Teams.
- Use of the weekly Newsround as a means of communication to staff.
- Quarterly IPC Newsletters.
- Use of the infection prevention and control message board on the CAT page.

In addition, the team have also offered:

- Additional daily support visits/calls to clinical areas.
- Additional IPC bite size training to clinical areas.
- Bank staff induction IPC training sessions delivered.
- Junior Doctor IPC training sessions delivered.

Isolation Facilities (Criteria 7)

All in-patients' admission complete an infection control risk assessment, when an IPC risk is identified or suspected, the IPCT will provide advice and guidance on isolation requirements and specific precautions required for each individual service user to minimise the risks of cross infection.

A large-scale refurbishment project of in-patient wards is now nearing completion for the eradication of dormitories. Lessons learnt from Covid-19 have been applied to the design and function, including increase access to hand hygiene sinks, increased ventilation, en-suite bedrooms and staff changing facilities.

Laboratory Support (Criteria 8)

Laboratory services for NSCHT are provided via a Service Level Agreement (SLA) with UHNM which has full Clinical Pathology Accreditation (CPA). Daily microbiology results are available via Lorenzo and iportal, both are electronic reporting systems. IPC worked closely with the Microbiology Laboratory during periods of high prevalence and winter pressures in relation to the management and submission of screening swabs.

Infection Prevention and Control Policies (Criteria 1, 5, 6 and 9)

The Trust has a range of IPC Policies and standard operating procedures (SOP) in place to support the prevention, reduction and control of risks of infections in line with the Act. The Trust invested in the electronic 'The Royal Marsden Manual of Clinical and Cancer Nursing Procedures' manual, both the local IPC policy, SOP and Marsden are available on the trust intranet site CAT.

Policies / SOPs are reviewed and updated to reflect any changing national or local guidelines or legislation as required. To support the overarching IPC policy, during 2024/25, 5 standard operating procedures have been produced/updated and can be found on the Trusts CAT page.
These consist of:

- IPC 3 Pet Visiting – including Therapy assistance dogs
- IPC 5 A to Z of infections – A quick reference guide
- IPC 7 Management, Recognition of outbreaks of communicable infectious disease
- IPC 8 Cleaning toys and play equipment
- IPC1e Exposure (BBV)

Assurance of compliance with Trust IPC Policies is monitored by the IPC Team through:

- An extensive audit program (appendix 2)
- Monitoring of incidents
- Post-infection reviews and outbreak reports
- Monthly surveillance
- Clinical IPC quality site visits, ward IPC dashboards and Matrons' clinical governance.

Staff Health and Wellbeing (Criteria 10)
Occupational Health services are provided by Optima Health who carry out pre-employment health assessments including assessment of Immunisation pre-employment. Where a blood borne (BBV) virus exposure is identified, Optima Health complete BBV assessments.

Seasonal influenza vaccination and COVID vaccination programmes were delivered through partnership working with MPFT, our GP practices and the wider targeted vaccination teams. Immunisation of frontline staff against influenza and COVID reduces the transmission of infection to vulnerable patients and other staff.

Flu Programme

The Trust has a responsibility to offer the seasonal influenza vaccine to 100% of frontline healthcare staff in order to protect vulnerable patients, staff members and visitors and support the resilience of the health and care system by reducing the number of Influenza infections amongst frontline healthcare staff, the campaign continues to promote the importance of staff being vaccinated annually against influenza, The Trust commenced its planning of the annual influenza vaccination campaign in March 2024.

For 2024/25 the flu campaign was facilitated in-house and compliance included in IPC reporting. Although the non-mandatory threshold for achievement is ambitious, at 65-75%, the Trust will continue to monitor performance against this benchmark moving forward. All frontline health care workers, including both clinical and non-clinical staff who have contact with patients, will be offered the influenza vaccine to protect themselves and those they care for as part of winter planning.

The below table shows the progress for 2024/25 influenza campaign and key highlights.

- 30 peer vaccinators were recruited compared to 46 on the previous year's data. Peer vaccinators attended flu vaccination training (or for those who had undertaken the training

previously on-line e-learning modules were undertaken). On completion of training all peer vaccinators completed individual competency assessments to enable them to assist the infection prevention and control team in administering staff flu vaccinations safely.

- Monthly seasonal flu planning meetings commenced in March 2024 to complete all the necessary actions to ensure the vaccine were made available from 25 September 2024 through to the end of February 2025, taking into consideration lessons learned from the previous year's campaign.
- Non-mandatory threshold for 65-75% of front-line healthcare workers to be vaccinated during 2024/25 campaign.
- 2 on site Covid-19 vaccination sessions were held for staff and patients, this service is provided by the targeted vaccination team from MPFT.
- Theme of 2024/25 flu campaign focused on staff wellbeing, staff were encouraged to take a break and received a wellbeing bag including travel mug, tea, coffee and a spoon.
- Uptake of staff flu vaccine reduced by 4.42% based on previous data. This suggests that the reduction of active peer vaccinators may have impacted on the overall performance.

Table 6: Staff Vaccination Rates

Year	Total number vaccines given to frontline staff at NSCHT as of	% of staff vaccinated at NSCHT
2024-25	792	48.9%
2023-24	916	53.32%
2022-23	610	31.39%

Sharps, Inoculation Injuries & Accidents involving Exposure to Blood & Body Fluids

Sharps and inoculation injuries are reported via the Ulysses Incident management system and reviewed by the Trust's Health and Safety advisor. Organisation wide Learning form part of the incident review. A report is submitted quarterly to the IPCG. During 2024/25, there were 77 BBV injuries reported via the Ulysses incident management system, table 7 shows the breakdown of incidents with the majority reported being in relation to minor scratch injuries sustained. The Trust monitors all BBV injuries and supports staff health and wellbeing following all reported incidents, which include the provision and promotion of Occupational Health services. On reporting an injury or exposure to Occupational Health, Optima Health complete an initial risk assessment and follow up appointments are arranged as appropriate. IPCT provide support around education where there has been a deviation from policy.

Table 7: Total Number of Inoculations Injuries

	Q1 2024-25	Q2 2024-25	Q3 2024-2025	Q4 2024-2025	Total
Bite	3	2	3	2	**10**
Scratch	7	11	18	18	**54**
Needlestick	0	1	2	0	**3**

Spitting	1	2	0	7	**10**

Recommendations and IPCT Aims 2025/26

The IPC Team have continued to provide a responsive service for the prevention of infections across all services provided by NSCHT. The intention for 2025/26 is to provide a proactive and equitable IPC service across all Trust services.

The focus and IPC priorities for 2025/26 will be to:

- Develop an equitable workplan that encompasses Trust Community Services, align team Localities with Trust Localities and improve IPC links with community teams
- Adopt a QI approach to improve hand hygiene in areas where reliability audits identify low compliance
- Review new NHSE IPC Education Framework and implement any changes
- Review IPC team documentation and processes to improve ways of working
- Monitor emerging threats, including Avian Flu, and collaborate with UKHSA
- Complete point prevalence audit on compliance to IPC5 in relation to MRSA admission screening
- UTI reduction strategy and hydration plan
- Implementation of electronic patient monitoring records for indwelling urinary catheters
- Increase peer vaccinator support with the help of directorate operational oversight for the recruitment and performance

Summary:

Throughout the period of this report, the Infection Prevention and Control Team (IPCT) and extended workforce of the organisation have continued to be responsive to the infection prevention and control challenges. The IPCT has continued to deliver the Trust IPC agenda, ensuring all staff in the Trust are aware of their responsibilities in relation to IPC. This was reflected in the low numbers of reportable infection identified within the Trust during this reporting period. Healthcare associated infections remain a high priority in the Trust for 2025/26.

The detail within this report provides assurance on how the risks relating to infection have been reduced and managed by the combined efforts of our clinical teams under the direction of the IPCT.

Keele University Teaching Trust
NHS North Staffordshire Combined Healthcare NHS Trust

Appendices

Appendix 1
Annual Work Plan 2024/25

Annual Infection Prevention and Control Work Plan 2024-2025

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008 (revised 2022). This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. This work programme is aimed at caring for patients in an environment which reduces the risk of them developing a Health Care Associated Infection.

Compliance criterion	What the registered provider will need to demonstrate
1.	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of passing on the infection to other people.
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

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NHS North Staffordshire Combined Healthcare NHS Trust

7.	Provide or secure adequate isolation facilities.
8.	Secure adequate access to laboratory support as appropriate.
9.	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10.	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

1. *Systems to manage and monitor the prevention and control of Infection*

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Preparation of a biannual report detailing activities in the previous 6 months, this will be consolidated at year end in the format of a DIPC annual report.	**Head of IPC**	• **Annual DIPC report to Board due in July 2024**					**Presented at SLT on 26.06.2024 and Quality Committee on the 04.07.2024** **COMPLETED Q1**
		• **Q1 DIPC report due July 2024**					**COMPLETED Q1**
		• **Q2 DIPC report due Oct 2024**					**COMPLETED Q2**
		• **Q3 DIPC report due Jan 2025**					**COMPLETED Q3**
		• **Q4 DIPC report due Apr 2025**					**COMPLETED Q4**

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NHS North Staffordshire Combined Healthcare NHS Trust

		• Exception reports at the request of the DIPC as required.					COMPLETED Q4
Escalation of emerging issues which may impact on patient safety and quality to Trust board from IPCG	DIPC	• Head of IPC to escalate concerns to DIPC in line with local and national issues.					COMPLETED Q4
Continue to develop the IPCT to ensure a Health economy approach to the Infection Control agenda and ensure the team have the appropriate skill mix.	Head of IPC	• Identify lead areas of responsibility within the team across the acute and community footprint					COMPLETED Q4
		• Support the development of IPC team to ensure they have the knowledge and skills required to deliver the service based on trust requirements					Band 7 - completed QI protected for ANTT Band 6 – funding granted via TNA for Marian Reed Development Program and BSc degree in Infection Prevention and Control
		• Identify development opportunities via 1-1 and appraisal process.					Band 6 and 7 appraisals completed in Q3
Ensure that the Infection Prevention and Control group chaired by the DIPC meets quarterly	DIPC	• Papers to be circulated in a timely manner to all members of the group.					COMPLETED Q4
		• Actions from IPCG are recorded and monitored					COMPLETED Q4
		• ToR are reviewed by the IPCG in 2024/25					ToR to reviewed in July 2024

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Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure IPC representation at key trust and partnership meeting	Head of IPC	• Clinical Professional Advisory Group (CPAG)					Meeting stood down
		• Water Safety					18.03.25 Water Safety Meeting COMPLETED Q4
		• Physical health group					25.03.25 – Physical Health Group COMPLETED Q4
		• Antimicrobial stewardship					IPC attended independent prescribing and medicine optimisation meeting 28.01.2025 COMPLETED Q4
		• ICB (formally CCG) Health Economy HCAI group / Health Economy IPC meeting					COMPLETED Q4 – meeting held 23/01/2025
		• Health Care Economy Anti-Microbial Group					COMPLETED Q4 – no meeting held during Q3
		• Incident Management Group (IMG)					No meeting required during Q4

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NHS North Staffordshire Combined Healthcare NHS Trust

		• Clinical Effectiveness Group (CEG)					COMPLETED Q4 – meeting held 29/01/2025, 26/02/2025 & 26/03/2025
		• ICB (formally CCG) /IPC leads Meeting					COMPLETED Q4 – weekly meeting attendance throughout Q4
Ensure mandatory reporting of alert organisms	Head of IPC	• Outbreaks reported as required.					COMPLETED Q4 – 7 outbreaks declared and reported during Q4
		• Influenza reporting					Imms submission due from February 2025
		• COVID reporting					National data capture stood down – internal monitoring only
		• Using iportal system to review results which support IPC advice and support to clinical areas on patient management					Plus, statutory alert organism reporting e.g. C. diff COMPLETED Q4
Monitor and review IC risk register including any infection control related risks added by Directorates.	Head of IPC	• Risk register is a standing agenda item at Infection Control Group – quarterly review					Risks are reviewed monthly by the HIPC COMPLETED Q4

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NHS North Staffordshire Combined Healthcare NHS Trust

Re-establishment of IPC operational sub-group of IPC Champions	**Clinical Specialist Practitioner IPC**	• **To support development of knowledge and skills to enable staff to support within their work area**					**Increased visibility within clinical areas has been the priority.** **COMPLETED Q4**
Plan & Priority Activities	**Lead**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Undertake Post Infection Reviews on MRSA, BSI, CDI and MSSA and other alert organisms in line with NHS England and Trust criteria.	**Clinical Specialist Practitioner IPC**	• **PIR's undertaken with Clinical teams for all acute attributable MRSA and CDi cases**					**COMPLETED Q4 – 2 C diff infections reported during Q4**
		• **Learning from reviews to be fed back into practice and policy as required.**					**COMPLETED Q4 – 2 Rapid reviews completed during Q4**
		• **Collaborative working with UKHSA, IPCT to undertake PIR on Community Onset Healthcare Associated (COHA) cases**					**COMPLETED Q4 – 1 external outbreak completed with UKHSA for GAS cases**
		• **Full PIR for MSSA cases where risk factors / concerns identified, this includes peripheral inserted lines and urinary catheters**					**COMPLETED Q4 – None reported during Q4**
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
Plan & Priority Activities	**Lead**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**

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NHS North Staffordshire Combined Healthcare NHS Trust

Environmental audit programme	**Head of IPC**	• **Identify best practice and/or areas requiring improvement within clinical areas. Develop action plans to address areas of concern**					**COMPLETED Q4**
		• **Quality improvement audit tool to review clinical standards and compliance with IC policies. To be fed back to QI leads and ward managers**					**COMPLETED Q4**
		• **SERCO to complete their monitoring audits submitting scores to Head of Facilities to address any issues, concerns.**					**COMPLETED Q4**
		• **IPCT to undertake period of increased audits in clinical areas to monitor environment to reduce transmission related to alert organisms e.g. MRSA/C.diff and respiratory illness e.g. COVID/flu. To be fed back to Matron and senior Sister**					**COMPLETED Q4**
		• **ICT to undertake specific audits including Hand Hygiene and commode audits following cases of CD when required. To be fed back to Matron and Senor Sister.**					**COMPLETED Q4**

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		• Undertake audits of community-based clinics feeding back to community service leads					Community audits scheduled for Q2, Q3 & Q4 as per annual audit plan
Plan & Priority Activities	**Lead**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
IPCG provides a forum for Health & Safety, Estates, Facilities, Wards and IPCT to explore collaborative working and information sharing	Clinical Specialist Practitioner, IPCT	• Ongoing oversight of IPC related issues pertaining to Estates, Soft FM, Medical Devices and/or cleaning					COMPLETED Q4
		• Devolved responsibility from IPCG to operationalise key work streams. IPCT to work with QI Lead Matrons to identify.					COMPLETED Q4
IPCT to advise on new builds and or any changes to existing areas	Head of IPC	• Provide IPC and technical advice on building re-configuration of Harplands site wards refurbishments and re-location					COMPLETED Q4
		• Provide ad hoc support to estates as required.					COMPLETED Q4

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NHS North Staffordshire Combined Healthcare NHS Trust

Participate in Cleanliness and Patient led Assessment of the Care Environment (PLACE)	**Head of Facilities**	• **Identify and provide leads from IPCT**					**COMPLETED Q4**
		• **Review/ implement actions through IPCG.**					**COMPLETED Q4**

3. *Ensure appropriate antibiotic use and optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance*

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Pharmacist input required to C.difficile and bacteraemia and MSSA post infection review process	**Antimicrobial Pharmacist**	• **Clinical assessment of antibiotic profile to be undertaken by antimicrobial pharmacist and entered into relevant documentation**					**COMPLETED Q4**
		• **Antimicrobial ward rounds on newly identified IC patients in particular newly identified patients with CDI**					**COMPLETED Q4 – 2 CDi cases were monitored and reviewed daily**
Antibiotic Stewardship	**Antimicrobial Pharmacist**	• **Actively involved in the AMR programme board for Staffordshire and SOT**					**COMPLETED Q4 – Next meeting is scheduled for Q1**
		• **Develop local action plan for AMR**					**COMPLETED Q4**
		• **Audit Antibiotic compliance and submit quarterly report to IPCG**					**COMPLETED Q4**
Health Economy Antimicrobial meetings	**Antimicrobial Pharmacist**	• **Link in with HE overview of AM use**					**COMPLETED Q4**

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		• Identify trends related to AM use in wider HE					COMPLETED Q4
		• Attendance at quarterly HE meetings					COMPLETED Q4

4. Provide suitable accurate information on infections to service users, their visitors, and any person concerned with providing further support or nursing / medical care in a timely fashion.

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC information on Trust intranet	Clinical Specialist Practitioner, IPCT	• Intranet CAT, page updated as appropriate, providing ward staff with access to IPC policies, UKHSA guidance, Patient information, Forms and audit tools, COVID specific information					COMPLETED Q4
Access to leaflets relating to specific infection control issues/ alert organisms.	Clinical Specialist Practitioner, IPCT	• Signpost staff and/or patients to relevant GOV or speciality specific web sites					COMPLETED Q4
Quarterly IPC newsletter	Clinical Specialist Practitioner, IPCT	• To update and inform staff of any IPC changes and include and educational element to support e-learning.					COMPLETED Q4

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IPC Notice Board	**Clinical Specialist Practitioner, IPCT**	• **Visible aid for IPC related information. Subject will be changed quarterly**					**COMPLETED Q4**
5. Ensure prompt identification of people who have or are at risk of developing and infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.							
Plan & Priority Activities	**Lead**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Ensure the correct placement of patients with a known infection	**Clinical Specialist Practitioner, IPCT**	• **Use of Iportal for early identification of patients with existing or new infections to ensure clinical review**					**COMPLETED Q4**
		• **Infection control notice board displaying information**					**COMPLETED Q4**
		• **Discharge EDNF to include IPC status**					**COMPLETED Q4**
The Trust is a key stakeholder in the Health Economy ECOLI reduction group	**Head of IPC**	• **Peer review of PIR to support a learning outcome and influencing change in practice**					**COMPLETED Q4**
Reduce the risk of avoidable MSSA infections by	**Clinical specialist**	• **Implementation of a mini-PIR process for all cases of trust attributable MSSA with IPCT**					**COMPLETED Q4 – no cases reported during Q4**

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NHS North Staffordshire Combined Healthcare NHS Trust

implementing an RCA process to establish lessons learnt.	**practitioner, IPCT**	• **Formal PIR on all cases identified as line related to include QI Lead Matron, Ward Manager**					**COMPLETED Q4**
Identify key themes/ lessons learnt from CDI against the new national criteria	**Clinical specialist practitioner, IPCT**	• **PIR on all cases attributed to the Trust using the new national objective criteria**					**COMPLETED Q4**
		• **Incident form completed by ward. Learning and actions identified and cascaded to clinical areas, via ward managers.**					**COMPLETED Q4**

6. *Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections*

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Collaborative working with education team, and clinical areas to ensure all staff are supported in accessing Infection Prevention and Control training commensurate with their needs	**Clinical specialist practitioner, IPCT**	• **Mandatory training via e-learning**					**COMPLETED Q4**
		• **Induction**					**COMPLETED Q4**
		• **Specific sessions for clinical areas**					**COMPLETED Q4**
		• **Hand hygiene in clinical practice. Areas to be supported with use of UV light disclosing educational box.**					**COMPLETED Q4**

Keele University Teaching Trust
NHS North Staffordshire Combined Healthcare NHS Trust

7. *Provide and source adequate isolation facilities*

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Respond and advise on the management of outbreaks.	**Clinical specialist practitioner, IPCT**	• **Identify risks of patients in side rooms as to who should take priority including opportunities to cohort nurse.**					**COMPLETED Q4**
		• **Support the clinical areas in managing changes relating to COVID 19 including redefining of clinical areas.**					**COMPLETED Q4**
		• **Implement screening process for staff and patients in line with UKHSA directives.**					**COMPLETED Q4**
		• **Cascading information from UKHSA ensuring staff understand the changes**					**COMPLETED Q4**
	Head of IPC	• **Attend Trust/ directorate meetings to give advice on overall situation as required**					**COMPLETED Q4**

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Identify risks around lack of side rooms for isolation	**Head of IPC**	• **Work with project Chrysalis in reviewing plans for refurbishment, to ensure side rooms identified which would support isolation**					**This project will continue into 25/26**
		• **Work with directorates on winter planning/ emergency preparedness to ensure that capacity is included to manage multiple cases of respiratory illnesses.**					**COMPLETED Q4**

8. *Secure adequate access to laboratory support as appropriate*

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure the lab has current CPA accreditation	**DIPC**	• **CPA accreditation in place, review as part of SLA**					**UHNM as it forms part of their accreditation requirement**
		• **Review alert organisms as required**					**COMPLETED Q4**

Keele University Teaching Trust
NHS North Staffordshire Combined Healthcare NHS Trust

Liaise with UHNM Lab and access consultant Microbiologist if clinically required	**Head of IPC and IPCT**	**•Work with Laboratory staff in use of early identification of specific organisms using PCR machine, prioritising cases as required.**					**COMPLETED Q4**
		•Early review of blood cultures relating to MRSA/ MSSA.					**COMPLETED Q4**

9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.							
Plan & Priority Activities	**Lead**	**Deliverables**	**Q1**	**Q2**	**Q3**	**Q4**	**Comments**
Ensure that any policy/ guidance reflect new directives from NHS England/ UKHSA and or any regional specialist groups.	**Head of IPC**	• **Amend policies/SOPs and guidance and any related documentation in response to legislation or evidence-based changes**					**COMPLETED Q4**
		• **Interpret and cascade changes to guidance due to emerging diseases e.g. COVID/Monkeypox. This includes recommendations for the management of patients and the use of PPE ensuring clinical areas are working to the most up to date guidance.**					**Guidance updated to reflect regional and national COVID related requirements**
		• **Any existing policies/SOPs due for renewal to be revised in line with new guidance / recommendations, evidence-based practice**					**Overview of polices renewal dates undertaken through the Policy working group**

Keele UNIVERSITY Teaching Trust
NHS North Staffordshire Combined Healthcare NHS Trust

10. Providers have systems in place to manage the occupational health needs to staff in relation to infection

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure that the trust has systems and process in place which reduces the risk of transmission of Influenza in line with UKHSA recommendations	**Head of IPC**	**Deliver a robust staff seasonal influenza campaign ensuring accessibility of all trust staff and key partners (SERCO/CDAS) across the organisational footprint and in accordance with the CQUIN**					• **Vaccination meeting commenced Q2** • **No CQUIN in place for flu performance for 2024/25**

Work plan and IPC Strategy submitted to IPCG for review and sign off

Q1	**25.07.24**	**Submitted to IPCG and updated by**	**Head of IPC -**	**Q3**	**03.02.25**	**Submitted to IPCG and updated by**	**Head of IPC -**
Q2	**21.10.24**	**Submitted to IPCG and updated by**	**Head of IPC -**	**Q4**	**12.05.25**	**Submitted to IPCG and updated by**	**Head of IPC -**

Appendix 2
Annual Audit Plan 2024/25

NSCHT INFECTION PREVENTION AND CONTROL AUDIT PLAN 2024/25

Introduction

The review of clinical practice through audit is a well-established means of monitoring and improving the quality of care and of supporting the implementation of change in practice. Care and services are safer and more effective when continuously monitored and systematically reviewed to improve standards.

The Health & Social Care Act 2008 (revised 2022) 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'; requires the Trust to audit standards. The original audit tools were adapted from the Infection Prevention Society (2016) Quality Improvement Tools. They have been reviewed annually and revised/updated to ensure they are user friendly and bespoke to the diverse clinical areas across the organisation. The tools are designed for detailed measurement of all aspects of practice/environment and will be used to measure baseline compliance with standards and identify areas for improvement. They include management of infection prevention and control, hand hygiene, decontamination of patient equipment, sharps, linen and waste handling, clinical practice, the environment and ward/department kitchens as part of the environment audit standard tool.

All audits will be scored in line with the Infection Prevention Society scoring system, which provides a clear indication of compliance:

0-65%	Major improvement required
66-84%	Moderate improvement required
85-94%	Minor improvement required
95%+	Compliant

Once an audit is completed, the score can be used to provide objective data on compliance with infection prevention and control practice and policies within the Trust. This data can then be used to

direct the Infection Prevention and Control Annual Programme in order to meet the needs of the Trust in relation to infection prevention and control.

Our IPCT/Matrons will ensure that all areas audited receive feedback of their results, which will enable staff to systematically identify where improvement is needed to minimise infection risks while enhancing the quality of patient care. The IPCT may decide to re-audit the ward/service/team if there are concerns or if a minimal compliance rating is found.

Audit outcomes will be discussed at the Infection Prevention and Control Group meetings and will be included in divisional reports, the Director of Infection Prevention and Control's Quarterly Report and Annual Report to the Trust Board, which is also shared with local ICB on request.

Infection Prevention and Control Link Workers/Champions

Link Workers/Champions will assist the IPCT with the infection prevention and control audit agenda and to ensure compliance within their workplace. They will be responsible for ensuring

That the annual audit programme is delivered within their service. They will ensure audits are completed as per the below programme and must flag any serious issues to their manager and the IPC Team. Champions may carry out additional audits within their areas as required and audit frequency may be increased if there are major compliance failings.

The IPCT will monitor the audits carried out by designated staff throughout the year and may undertake unannounced audits at any time.

References

- Infection Prevention Society (2016) Quality Improvement tools.
- Department of Health: The Health & Social Care Act (2008 amended 2022). Code of Practice for health and adult social care on the prevention and control of infections and related guidance

Table 1: Audit Schedule

INFECTION PREVENTION & CONTROL AUDIT PROGRAMME 2022/23 AUDITS TO BE COMPLETED LOCALLY	Q1			Q2			Q3			Q4		
	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Hand hygiene Audit (Link Worker to complete) ALL In-patient areas - New Tool	✓ By 10th	✓ By 10th	✓ By 10th	✓ By 10th	✓ By 10th	✓ By 10th	✓ By 10th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th

Sharps Audit (IPC to complete) **ALL In-patient areas**		✓			✓			✓			✓	
Hand Hygiene Audit (Link Worker to complete) **Primary Care, Ashcombe, Limebrook, Sutherland Centre** **Greenfields - New Tool**	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th
Sharps Audit (IPC to complete) **Community Teams & Primary Care WHERE APPLICABLE**		✓			✓			✓			✓	
Aseptic technique audit - Dressing or Injection (Link Worker to complete) **Observational Audit for in-patient and community teams WHERE APPLICABLE**		✓			✓			✓			✓	
PPE (IPC to complete) **ALL in-patient,**		✓			✓			✓			✓	
Annual IPC Audit **ALL in-patient, out-patient and community teams**		✓ **Inpatient Services Harplands Site - Annual IPC Audit**			✓ **Primary care – GP - Annual IPC Audit**			✓ **Community Services**				
Therapeutic toy audit **CAMHS teams only**		✓			✓			✓			✓	

Table 2: Quarter 1 Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Kitchen	Annual Environmental Audit score 2024-25
Ward 1	-	-	81% ↓	100% →	-	Scheduled for Q4
PICU	100%	81%	77%	100%	97%	93% ↑
Ward 2	----------DECANT WARD----------					
Ward 3	100%	88%	81%	100%	100%	96%
Ward 4	100% ↑	69% ↓	65% ↓	87% ↓	76% ↓	85% ↑
Ward 5	100% →	94% ↓	80% ↓	100% ↑	100% ↑	98% ↑
Ward 6	100% →	100% ↑	85% ↓	100% →	96% ↓	95% →
Ward 7	100% →	94%% ↓	85% ↓	88% ↓	88% ↓	94% ↓

A&T	94% ↑	88% ↑	92% ↑	100% →	75% ↑	91% (36%) ↑
Crisis Care Centre	67% ↓	80% ↓	83% ↓	100% ↑	77% ↑	88% ↓
Summers View	100% →	100% →	81% ↑	100% →	96% ↓	95% ↑
Dragon Square Respite	100% ↑	94% ↑	85% ↓	100% →	96% ↑	96% ↑
Darwin Centre IP	100% ↑	94% ↓	73% ↓	100% ↑	100% ↑	98% ↑
EMU	94% ↑	94% ↑	100% ↑	100% →	94% ↑	97% ↑
ECT	NA	94% ↓	92% ↓	100%	NA	98% ↓

Table 3: Quarter 2 In-patient Audit Performance

Adult Inpatient Ward / Area	Hand Hygiene Facilities	Sharps	PPE
Ward 1	-	96% ↑	100% →
PICU	90% ↑	92% ↑	100% →
Ward 3	-	92% ↑	100% →
Ward 4	-	92% ↑	100% ↑
Ward 5	95% ↑	96% ↑	100% →
Ward 6	100% →	85% →	100% →
Ward 7	100% →	92% ↑	100% →

Adult Inpatient Ward / Area	Hand Hygiene Facilities	Sharps	PPE
A&T	100% ↑	92% →	100% →
Crisis Care Centre	-	73% ↓	100% →
Dragon Square Respite	-	73% ↓	100% →
EMU	94% ↑	100% ↑	100% →
ECT	94% ↓	92% ↓	100%

Table 3 demonstrates an upward trajectory for improvement in relation to sharp management, actions identified from during quarter 2 were use of temporary closures, over filling of sharp bins, access to sharp safe device and decontamination of equipment. Areas where standards were not met were notified at the time of audit.

Table 4: Quarter 2 Primary Care Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Waste	Environment	Overall Annual Audit score 2024-25

Moorcroft Medical Centre	NA	93% ↓	88% ↓	87% ↓	100% ↑	77% ↓	92% ↓
Moss Green	NA	87% ↓	92% ↓	93% ↓	100% →	88% ↑	95% ↓
Holmcroft	NA	93% ↓	96% ↑	100% ↑	100% →	100% ↑	98% ↑
Keele	NA	69% ↓	69% ↓	100% ↑	100% ↑	33% ↓	84% ↑

Actions identified during quarter two primary care audits were; clinical staff not bare below the elbow, nail extensions and nail varnish evident. Hand wash sinks were not clean and in a good condition, hand wash sinks not compliant with HTM64, out of date soap and gel dispensers. Furniture and fixings not visibly clean, furniture in patient areas not made from impermeable and wipeable material. Sharp bins labelled incorrectly, access to sharp safe device. Areas where standards were not met were notified at the time of audit.

Table 5: Quarter 3 Community Services Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Waste	Kitchen	Environment	Overall Annual Audit score 2024-25
Bennett Centre Adult ASD	NA	87% →	67% ↓	100% →	100% →	93% ↓	71% ↓	↓ 92%
Bennett Centre Neuro Team	NA	86% ↓	93% ↓	100% →	100% →	93% ↓	67% ↓	↓ 93%
North Stoke CAHMS	NA	100% →	50% ↓	0% ↓	100% →	93% ↓	78% ↓	↓ 90%
The Willows	NA	87% →	100% →	100% →	100% →	95% ↑	89% ↓	↑ 95%

Actions identified during quarter three Community Services audit were, clinical staff not bare below the elbow, no access to hand wash sink within physical health room at The Willows. Out of date alcohol hand gel found within the community services, with one area having no access to PPE. Furniture and fixings not visibly clean with damage noted to walls and floors within some of the community settings. Furniture within some the patient areas were not made from impermeable and wipeable material. Sharp

bins labelled incorrectly with temporary closure not in place. Areas were not displaying inoculation first aid posters. Inappropriate items storage in kitchen (i.e. ground salt and photocopier paper) Areas where standards were not met were notified at the time of audit with any repairs been log via the estate's helpdesk.

Table 6: Quarter 3 In-patient Audit Performance

Adult Inpatient Ward / Area	Hand Hygiene Facilities	Sharps	PPE
Ward 1	-	85% ↓	100% →
PICU	100% ↑	96% ↑	100% →
Ward 2	-	92% ↑	100% →
Ward 3	80% ↑	100% ↑	100% →
Ward 4	-	100% ↑	100% →
Ward 5	-	100% ↑	100% →
Ward 6	100% →	96% ↑	100% →

Adult Inpatient Ward / Area	Hand Hygiene Facilities	Sharps	PPE
Ward 7	80% ↓	100% ↑	100% →
A&T	-	100% ↑	93% ↓
Crisis Care Centre	-	88% ↑	100% →
Dragon Square Respite	-	73% ↓	100% →
EMU	-	100% →	100% →
ECT	94% ↓	92% ↓	100%

Table 6 demonstrates a continued improvement in relation to sharp management, actions identified from during quarter 3 were, use of temporary closures, over filling of sharp bins, access to sharp safe device. Areas where standards were not met were notified at the time of audit.

Table 7: Quarter 4 Community Services Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Kitchen	Environment	Overall Annual Audit score 2024-25
Ashcombe	NA	87% ↓	100% →	100% →	100% →	100% ↑	99% →
Bennett Centre: Mother & Baby	88%	93%% ↓	67% ↓	86% ↓	94% ↓	89% ↓	91% ↓
Broom Street	NA	100% ↑	100% →	100% →	100% →	100% ↑	100% ↑
Darwin Centre OP/School/Offices	NA	93% ↑	NA	100% →	100% →	100% ↑	99% ↑
Greenfields	NA	87% ↓	92% ↓	100% →	100% →	100% ↑	98% →

Lymebrook: CMHT / Memory Clinic/Older Adult	NA	100% →	93% ↓	62% ↓	91% ↑	100% ↑	89% ↓
Marrow House	NA	100% →	NA	88% ↓	100% ↑	89% ↓	98% ↑
Sutherland	NA	88% ↓	93% ↓	100% →	100% ↑	100% ↑	98% ↑
South Stoke CAMHS Blurton HC	NA	81% ↓	NA	75% ↓	96% ↓	78% ↓	87% ↓
Dragon Square out-patients & LD & CAHMS	NA	100% ↑	93% ↑	100% →	100% →	89% →	98% ↑
Hope Centre	NA	94% ↓	88%	100% →	79% ↑	56% ↓	85% ↑

Actions identified during quarter four Community Services audit were, clinical staff were not bare below the elbow, out of date alcohol hand gel found within the community services, with one area having no access to eye protection. Furniture and fixings not visibly clean with damage noted to walls and floors within some of the community settings. Furniture within some the areas were not made from impermeable and wipeable material. Sharp bins not labelled with temporary closure not in place. Areas were not displaying inoculation first aid posters. Areas where standards were not met were notified at the time of audit with any repairs been log via the estate's helpdesk.

Table 8: Quarter 4 In-patient Audit Performance

Table 8 demonstrates an ongoing improvement in relation to sharp management, actions identified from during quarter 4 were, use of temporary closures, sharps not disposed at time of use and sharp container over the 3 month use period. Areas where standards were not met were notified at the time of audit.

Adult Inpatient Ward / Area	Hand Hygiene Facilities	Sharps	PPE
Ward 1	-	85% →	100% →
PICU	100% →	96% →	100% →
Ward 2	-	92% →	100% →

Ward 3	70% ↓	100% →	100% →
Ward 4	90%	83% ↓	100% →
Ward 5	100%	88% ↓	100% →
Ward 6	-	73% ↓	100% →

Adult Inpatient Ward / Area	Hand Hygiene Facilities	Sharps	PPE
Ward 7	100% ↑	100% →	100% →
A&T	90%	88% ↓	100% ↑
Crisis Care Centre	-	88% →	100% →
EMU	100%	92% ↓	100% →
ECT	100%	100% ↑	100% →

Summary

All IPC audits required in quarter four have been completed as per the audit schedule. Each area received feedback and action plans developed by area leads. Areas which have been identified as either major or moderate improvements are followed up by the IPCT and monitored through the Infection Prevention and Control Group (IPCG). The sharps audit completed in Q1, Q2, Q3 and Q4 are benched marked against the Trust Waste Policy. This has identified areas for improvement and amendment of overarching policy.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 8

Mortality Surveillance Report – Annual Report 2024/25

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Dr Ravi Belgamwar, Deputy Chief Medical Officer
Prepared by:	Craig Stone, Head of Patient and Organisational Safety
Executive Lead:	Dr Dennis Okolo, Chief Medical Officer

Aligned to Board Assurance Framework Risk	Risk 5 Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff
Approval / Review:	Quality Committee
Strategic Priorities:	Prevention - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	Nil
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	
Recommendation / Required Action	The Board is asked to accept the report as assurance to the governance and oversight of eth mortality surveillance process within the organisation and accept the areas of learning from this report
Executive Summary	Please see key findings from the report: • Slight reduction in natural cause deaths reported from previous year (5 deaths and 12 mortality review reports)

	• 58% (39) of deaths were recorded as unexpected natural (death from a natural cause)
	• 51% (34) of deaths were recorded as a physical health only as a contributory cause
	• 94% of care delivered was reported as being good or better
	• Challenges noted for the year are:
	  ○ 3 patients died because of a diagnosis of sepsis in Q2
	  ○ Physical health cause features in 65 out of 67 reports completed, with respiratory disease and cancer being the main contributory factor to their cause of death
	  ○ Increased prevalence of multiple co-morbidities faced by our patient cohort as reviewed and defined in the reports and multiple death categories reported on death certificate

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	18/06/2025
V2	Quality Committee	27/06/2025
V3	Public Trust Board	04/07/2025

Introduction

This annual report provides and overview of the Mortality Surveillance Process for the period from 1st April 2024 to 31st March 2025.

A multi-disciplinary group chaired by a consultant psychiatrist review the care delivered by the Trust teams and services, for each person who:

- died of natural causes, before the age of 75 years,
- were in a receipt of Trust services at time of their deaths,
- or have been in receipt of Trust services within the last 6 months of their death.
- In addition, people open to the learning disability services, who died of natural causes, are also reviewed via the Mortality Surveillance process. There is however no upper age limit implemented for those cases.
- Furthermore, Mortality Surveillance is also completed for people known to the Trust who have alcohol related issues. The drug related deaths were reviewed through the Serious Incident Framework.

The Mortality Surveillance Review Group meetings are scheduled monthly. There are on average ten cases reviewed at each meeting. The group consist of various professionals, including consultant psychiatrist, junior doctor, Head of Patient and Organisational Safety, Head of IPC, community teams managers, QILNs, service managers, etc.

It must be acknowledged that there is a delay between reported death and the review as the group must await the confirmed cause of death from HM Coroner, in order to complete the Mortality Surveillance review.

Background:

Since 2017, all trusts in England have been required to have a process in place for mortality reviews, following the publication of the National Quality Board paper 'National Guidance on Learning' from deaths. This paper followed the CQC 'Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (December 2016). These reports found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. It also pointed out, that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

The purpose of reviewing the circumstances of or investigating a death is:

- to establish if there is any learning for the Trust around the circumstances of the death and the care provided leading up to a death;
- to learn from any care and delivery problems that need to be addressed to prevent future deaths and improve services;
- to identify if there is any untoward concern in the circumstances leading up to death;
- to be in a position to provide information to HM Coroner if requested;
- to be able to work with families to understand the full circumstances and answer questions;
- to have the full detail of the events available for any subsequent complaint or legal investigation.

Purpose of the Report

This report provides the Trust with assurance, in regards to the scrutiny of care for people open to Trust, who have died of natural causes before the age of 75 years.

The quarterly Mortality Surveillance reports are also produced and discussed at the Clinical Safety Improvement Group and Quality Committee. This ensures that the Trust is sighted on all natural cause deaths in addition to those deaths subject to Patient Safety Incident Investigations and rapid reviews, and that any gaps in service delivery/lessons learnt are discussed and cascaded for action as appropriate.

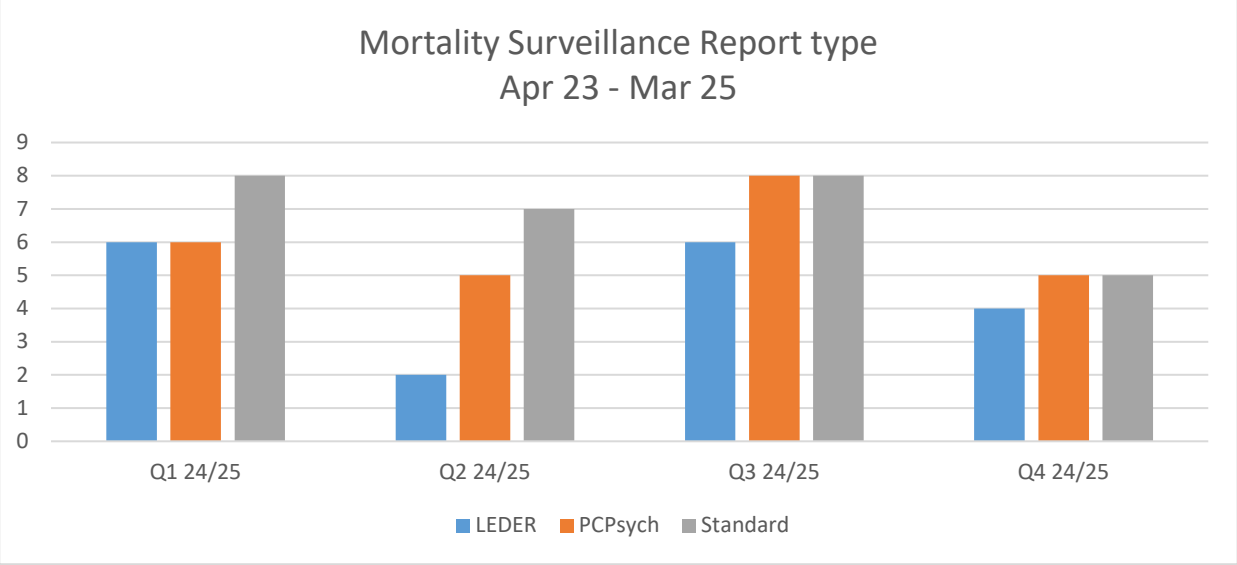
To illustrate the number of reported deaths (these include natural cause, death in receipt of care and death not in receipt) on annual basis, in comparison with the number of deaths being reviewed either via the Mortality Surveillance process in that year, table 1 was created covering the last two financial years.

Table 1 – Deaths and those reported as Mortality Surveillance

Reporting period	All patient related deaths reported	Mortality Surveillance Reports	% of those deaths reviewed via mortality surveillance
2023/24	190	79	41.58%
2024/25	185	67	36.22%

Chart 1 relates to the report types that are used for review during the Mortality Surveillance meeting.

Chart 1 - Mortality Surveillance Reports by type



This report notes the learning that the Mortality Surveillance group has recognised from analysis of the Mortality Reviews reported by staff. The learning is focused both, on the areas required improvement, as well as the examples of exceptional practice. The feedback has been provided to each team involved.

Mortality Surveillance Report Categories for review

Death Category

Prior review of the case at the MS review meeting, the formal Cause of Death is obtained. This is to help to establish the death category. The definitions for the death category are shown below:

- EN1 - Expected Natural. Deaths that were expected to occur in an expected timeframe e.g., terminal illness.
- EU - Expected Unnatural. Deaths that are expected but not from the cause expected or timescale e.g., misuse of drugs, alcohol dependant, eating disorders.
- UN1 – Unexpected Natural. Death from natural causes e.g., sudden cardiac condition, stroke.
- UN2 – Unexpected Natural. Death from natural causes but didn't need to be e.g., alcohol and drug dependency, care concerns.
- UU – Unexpected Unnatural. Suicide, homicide, abuse/neglect – investigation to be completed under the Serious Incident Framework.

Phase of Care Score
The mortality surveillance group consider the phase of care score based upon evidence provided from the electronic patient care record (EPR), liaison with external services (where indicated) as well as families and/or significant others

Excellent care – is determined by the evidence of high level care being documented that involves all those directly involved in patient care (inclusive of external teams and families or significant others) with person centred care evident and all key components of care being delivered and evidenced within clinical documentation (both for acts or omissions)

Good care – is determined by the evidence of the staff providing a good level of support, responded quickly and appropriately to situations where deterioration in physical health was noted.

Adequate care - is determined to be care where the basic standards of expected support are given.

Poor Care - is determined where the group consider that the actions of the clinicians did not meet the standards required by the Trust.

Very poor care – is determined exceptional care scores available for the respectively very low standards of care provided and the outstanding care identified.

However, in part these determinations are dependent upon the quality of the documentation contained within the mortality surveillance review tools and the electronic patient records. Feedback to the directorate/team on the quality of documentation is sent to the clinical teams to improve future entries in the patient records.

Thematic Review category
The group also reviews the causes of deaths for each case and consequently categorises under four different themes: Clozapine, physical health, drug and alcohol, learning disability. There are cases where more than one theme applies.

Mortality Surveillance Review Reports
The Trust currently uses two types of Mortality Surveillance tool to ensure all patient group meet the review criteria:

- the Mortality Surveillance tool published by the Royal College of Psychiatrists (November 2018). This tool is used for people who had diagnosis of Serious Mental Illness (SMI)
- the Trust designed tool to allow review of care of people within the Learning Disability services, not diagnosed with SMI and who also possibly died of alcohol related issues.

Findings from Mortality Surveillance Meetings in 2024/25

During the 2024/2025, the group met eleven times and reviewed seventy cases during those meetings.

Table 2 – Types of reports used

	LEDER	RCPsych	Standard	Total
Q1 24/25	6	6	8	20
Q2 24/25	2	5	7	14
Q3 24/25	6*	8*	8	22
Q4 24/25	4*	5*	5	14
Total	18	24	28	70

NB- * some deaths have been reported using multiple reports due to SMI diagnosis and being under Learning Disability Service and therefore the LeDeR process. (Q3 = 1 occasion, Q4 = 2 occasions)

Chart 2 – Mortality Surveillance Report Type

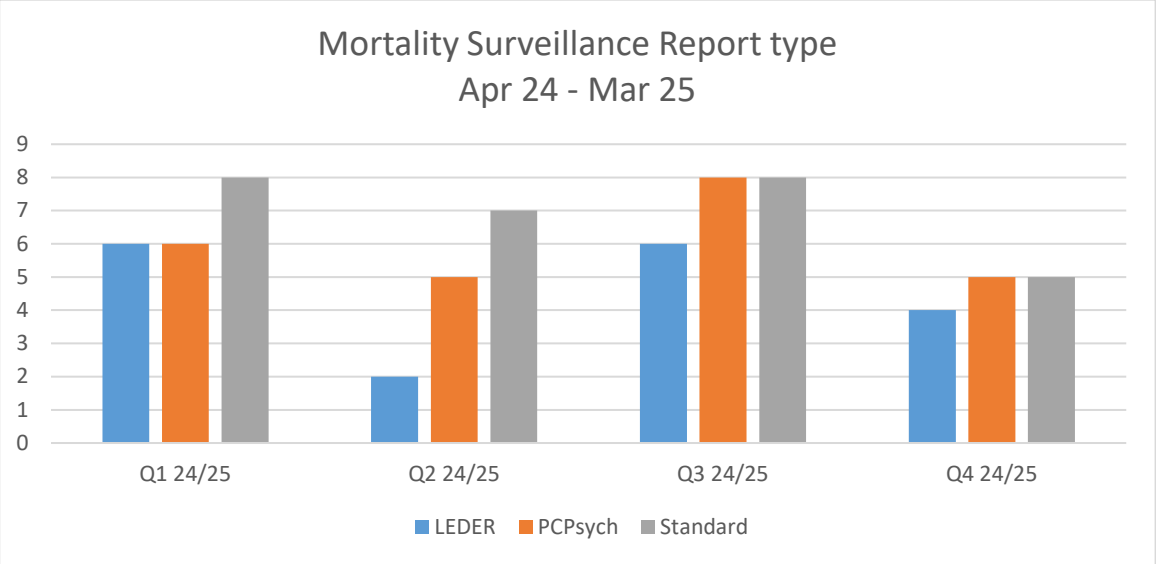


Table 3 – Death Category Reported Against

DEATH CATEGORY	Q1	Q2	Q3	Q4	Total
Expected Natural (EN1)	6	4	10	0	20
Expected Unnatural (EU)	0	0	1	1	2
Unexpected Natural 1 (UN1)	10	9	10	10	39
Unexpected Natural 2 (UN2)	4	0	0	1	5
Unexpected Unnatural (UU)	0	1	0	0	0
Total	20	14	21	12	67

Chart 3 – Death Category Reported Against

The most common death category (65%) was the Unexpected Natural (UN1), which would be death from natural causes e.g., sudden cardiac condition, stroke. Followed by the Expected Natural (EN1) (20%)- deaths that were expected to occur in an expected timeframe e.g., terminal illness.

DOMAIN CATEGORY	Q1	Q2	Q3	Q4	Total
Physical health	9	11	9	5	34
Physical Health & Drugs & Alcohol	2	1	1	1	5
Physical Health & Learning Disability	7	0	7	5	19
Physical Health & Clozapine	2	1	3	1	7
Drug and Alcohol	0	1	0	0	1
Clozapine	0	0	0	0	0
Learning Disability	0	0	1	0	1
Total	20	14	21	12	67

NB- some deaths have been categorised under more than one domain.

PHASE OF CARE SCORE	Q1	Q2	Q3	Q4	Total
Excellent care	8	3	17	6	34
Good care	9	10	4	6	29
Adequate care	2	1	0	0	3
Poor care	1	0	0	0	1
Very poor care	0	0	0	0	0
Total	20	14	21	12	67

In 51% of all the reviewed cases, the group score the care provided as excellent. 43% of cases was scored as good, 4.5% as adequate and 1.5% was poor.

Feedback and learning points were send back to the teams in order to initiate the improvements and also to celebrate exceptional practice of many of out practitioners and whole teams.

Learning opportunities:

Successes

- 63 out of 67 cases care was rated as good or excellent
- Effective escalation of patients concerns
- Good family involvement with care
- Documentation completed to the required standards of the trust

Challenges

- 3 patients died because of a diagnosis of sepsis in Q2
- Physical health cause features in 65 out of 67 reports completed, with respiratory disease and cancer being the main contributory factor to their cause of death

- Increased prevalence of multiple co-morbidities faced by our patient cohort as reviewed and defined in the reports and multiple death categories reported on death certificate

Summary

Upon review of natural case deaths that meet the inclusion criteria, the Mortality Surveillance reviews undertaken help to provide assurance into the identification of success or challenges noted within the service delivery of care.

During the reporting timeframe of 2024/25 the Trust has reviewed 67 cases using the Mortality Surveillance process. Following review, it was determined that 94% of the care provided was of a good or excellent standard.

The has been an increased reporting of physical health comorbidities that has contributed to the death of the patients and this has primarily been respiratory disease and a diagnosis of a cancer.

Next Steps

The Trust continues to monitor the deaths of people whose deaths are outside of the Patient Safety Incident Framework process. The Mortality Surveillance Group receives and reviews investigations to provide assurance as to the quality of the care provided by the Trust on a monthly basis. What we would like to develop further is the generic mortality surveillance report that is completed where the threshold for a RCPsych report is not met so that we can use PSIRF methodology to review these natural cause deaths to help illicit further learning that we have seen through our Comprehensive Safety Reviews, this enhancing our clinical review of natural cause deaths. This is to be reviewed with a proposed implementation date of January 2025.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 8a

Mortality Surveillance Report – Q4 2024/25

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Dr Ravi Belgamwar, Deputy Chief Medical Officer
Prepared by:	Craig Stone, Head of Patient and Organisational Safety
Executive Lead:	Dr Dennis Okolo, Chief Medical Officer

Aligned to Board Assurance Framework Risk	Risk 5 Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff
Approval / Review:	Quality Committee
Strategic Priorities:	Prevention - To continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	The Board is asked to accept the report as assurance to the governance and oversight of the mortality surveillance process within the organisation and accept the areas of learning from this report
Executive Summary	Please see key findings form the report: • Current mortality reporting rate is below the 2-year reporting average (23), currently at 20 for Q4

	• Most reported category correlating to a person's physical health deterioration was UN1 (Unexpected Natural) 10 cases. • 12 episodes of care rated as good or excellent (100%) • All care delivered was good or excellent • Respiratory disease continues to be reported (6) as being a contributory factor to deaths i.e. pneumonia, aspiration pneumonia, respiratory failure • Good evidence of family involvement in care • Increased prevalence of multiple co-morbidities faced by our patient cohort from reviews reports and multiple death categories reported on death certificate • Documentation for patient assessment completed to a good standard and inline with required Trust timeframes. • There was one case in which the category Clozapine was identified, however had no contributory factor to the patient's death. This was thought to be incidental as patient received the medication and all required monitoring was in place and no concerns.

VERSION CONTROL:

Version	Report to	Date Reported
V1	CSIG – Dr Okolo	11/04/2025
V2	SLT	20/05/2025
V3	Quality Committee	30/05/2025
V4	Public Trust Board	04/07/2025

Mortality Surveillance Report – Q4 2024/25

Purpose of the Report

This report is for the Q4 reporting cycle 2024/25 and provides information for the period from 1st January 2025 to 31st March 2025.

A multi-disciplinary group chaired by a consultant psychiatrist meets monthly to review the care delivered by the Trust teams and services, for each person who:

- died of natural causes, before the age of 75 years,
- were in a receipt of Trust services at time of their deaths,
- or have been in receipt of Trust services within the last 6 months of their death.
- In addition, people open to the learning disability services, who died of natural causes, are also reviewed via the Mortality Surveillance process. There is however no upper age limit implemented for those cases.
- Furthermore, Mortality Surveillance is also completed for people known to the Trust who have alcohol related issues.

The purpose of reviewing the circumstances of or investigating a death is:

- to establish if there is any learning for the Trust around the circumstances of the death and the care provided leading up to a death.
- to learn from any care and delivery problems that need to be addressed to prevent future deaths and improve services.
- to identify if there is any untoward concern in the circumstances leading up to death.
- to be in a position to provide information to HM Coroner if requested.
- to be able to work with families to understand the full circumstances and answer questions.
- to have the full detail of the events available for any subsequent complaint or legal investigation.

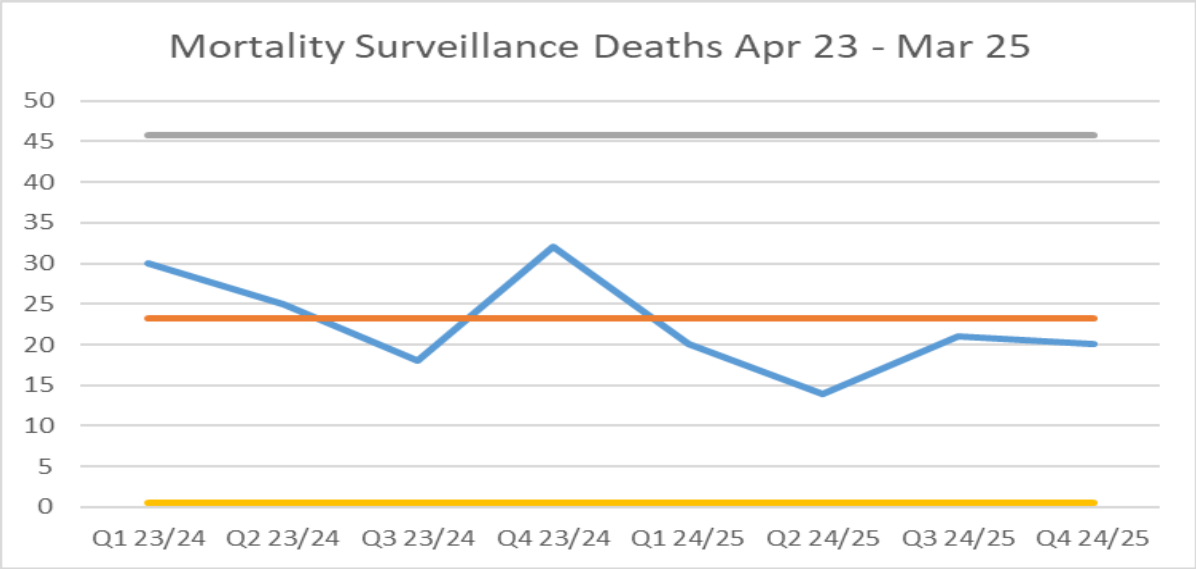
It is worthy of note that there is a delay between reported death and the review as the group must await for the confirmed cause of death in order to complete the Mortality Surveillance review.

The quarterly Mortality Surveillance report is produced and discussed at the Clinical Safety Improvement Group and Quality Committee. This ensures that the Trust is sighted on all natural cause deaths in addition to those deaths subject to Patient Safety Incident Investigations and rapid reviews, and that any gaps in service delivery/lessons learnt are discussed and cascaded for action as appropriate.

Patient reported deaths

To illustrate the number of reported deaths on annual basis, in comparison with the number of death being reviewed either via the Patient Safety Incident Response Framework (PSIRF) or Mortality Surveillance process in that year, the graph was created covering the last two financial years. This graph does not correspond to the review completed this quarter but aims to illustrate the percentage of cases being reviewed on average.

Graph 1: Mortality surveillance death reviews



In the above graph 1, this provides a trend of those deaths that have been reported for the preceding 2 years which have met the criteria for this review. There were 180 reported deaths in total.

For the reporting period for Q4, there were 20 deaths reported for mortality surveillance review:

Month	Jan 25	Feb 25	Mar 25
MS reports	8	5*	7**

*** In February 2025, a LeDeR review was also converted an completed on the RSPsych form as requested by the team due to the threshold for this form being completed gives the total of 5, when only 4 new reported cases identified.**
**** Meeting for March was cancelled due to not being quorate, so forwarded to the meeting in April 2025**

Categorisation of deaths

Prior review of the case at the MS review meeting, the formal Cause of Death is obtained. This is to help to establish the **death category**. The definitions for the death category are shown below:

- EN1 - Expected Natural. Deaths that were expected to occur in an expected timeframe e.g. terminal illness.
- EU - Expected Unnatural. Deaths that are expected but not from the cause expected or timescale e.g. misuse of drugs, alcohol dependant, eating disorders.
- UN1 – Unexpected Natural. Death from natural causes e.g. sudden cardiac condition, stroke.
- UN2 – Unexpected Natural. Death from natural causes but didn't need to be e.g. alcohol and drug dependency, care concerns.
- UU – Unexpected Unnatural. Suicide, homicide, abuse/neglect – investigation to be completed under the Serious Incident Framework.
- U- Unascertained

Phase of care scoring

The mortality surveillance group consider the rating of care received based upon the narrative of the report and the presentation of this by the author. The scores are as follows:

- **Excellent care** – care exceeding the standard for good care
- **Good care** - had been provided where there was evidence of the staff providing a good level of support, had responded quickly and appropriately to situations where deterioration in physical health was noted.
- **Adequate care** - is determined to be care where the basic standards of expected support are given.
- **Poor care** - is determined where the group consider that the actions of the clinicians did not meet the standards required by the Trust.
- **Very poor care** – care falling below the standard for poor care

However, these determinations are dependent upon the quality of the documentation contained within the mortality surveillance review tools and the electronic patient records for the reviewing members of the Mortality Surveillance group. Feedback to the directorate/team on the quality of documentation is sent to the clinical teams to improve future entries in the patient records, this is done whilst the author and/or team manager are present during the review or externally outside of the meeting.

Thematic review category

The group also reviews the causes of deaths for each case, in addition an incident can have multiple categories attached to the review. The categories are as follows:

- Clozapine
- Physical health
- Drug and alcohol
- Learning disability

Mortality surveillance reporting tools

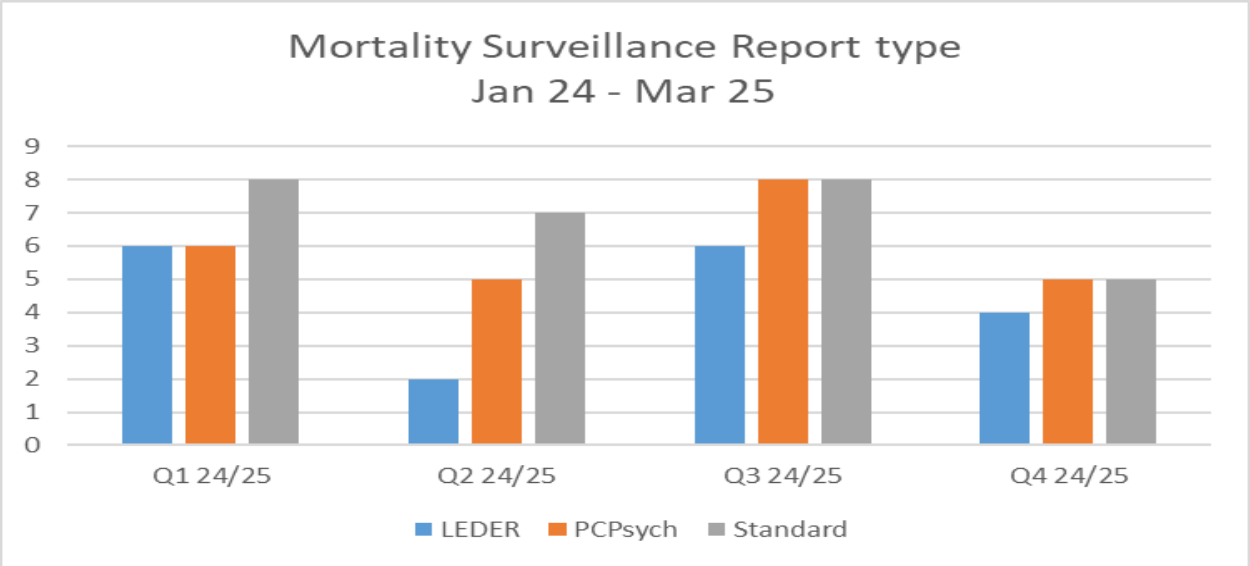
The Trust currently uses two types of Mortality Surveillance tools to ensure all patient group meet the review criteria:

- Mortality Surveillance tool published by the Royal College of Psychiatrists (November 2018). This tool is used for people who meet the required criteria as set out by the Royal College of Psychiatrists

- Trust designed tool to allow review of care of people within the Learning Disability services, not diagnosed with SMI and who also possibly died of alcohol related issues.

Mortality surveillance report findings

During the period January to March 2025, the group met twice, the March meeting was cancelled due to membership not being quorate and reviewed **twelve** cases during those meetings.



NB - It is important to note for Q4 2024/25 that there was two review which was on the RCPsych form that also was a LeDeR reportable review therefore was counted in both columns totalling 14 not the 13 reported.

Death category	Total for Q4 - 12	Percentage
Expected Natural (EN1)	0	0%
Expected Unnatural (EU)	1	8.3%
Unexpected Natural 1 (UN1)	10	83.3%
Unexpected Natural 2 (UN2)	1	8.3%
Unexpected Unnatural (UU)	0	0%

Domain category	Total for Q4 - 12	Percentage
Physical health	5	41.7%
Physical Health & Drugs & Alcohol	1	8.3%
Physical Health & Learning Disability	5	41.7%
Physical Health & Clozapine	1	8.3%
Drug and Alcohol	0	0%
Clozapine	0	0%
Learning Disability	0	0%

NB- some deaths have been categorised under more than one domain.

Phase of score	Total for Q4 - 12	Percentage
Excellent care	6	50%
Good care	6	50%
Adequate care	0	0%
Poor care	0	0%
Very poor care	0	0%

Key Learning from mortality reviews

From the 12 reviews completed in Q4, please see below a summary of the key learning points that have been extrapolated from the reviews completed.

- All care delivered was good or excellent
- Continuation in respiratory disease processes being reported (6) as a contributory factor to their death i.e. pneumonia, aspiration pneumonia, respiratory failure
- Good evidence of family involvement in care
- Increased prevalence of multiple co-morbidities faced by our patient cohort from reports and multiple death categories reported on death certificate
- Documentation for patient assessment completed to a good standard and inline with required trust timeframes.
- There was one case in which the category Clozapine was identified, however had no contributory factor to the patient's death. Incidental as was in receipt of the medication, all required monitoring in place and no concerns.

Recommendation

The committee is asked to accept the report as assurance to the governance and oversight of the mortality surveillance process within the organisation and accept the areas of learning from this report

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 9

Patient Safety Incident Response Framework (Previous Serious Incident) report – Q4 2024/25

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Dr Ravi Belgamwar, Deputy Chief Medical Officer
Prepared by:	Craig Stone, Head of Patient and Organisational Safety
Executive Lead:	Dr Dennis Okolo, Chief Medical Officer

Aligned to Board Assurance Framework Risk	Risk 5 Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff
Approval / Review:	Quality Committee
Strategic Priorities:	Prevention - To continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	Not applicable
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	The Board are asked to receive this report, which notes the learning that the Trust has recognised from analysis of the incidents reported by staff onto the Trust incident reporting system (Ulysses) alongside patient experience feedback

Executive Summary	Please see the highlights for the below report:
	• 1 Patient Safety Incident Investigation (PSII) has been commissioned due to a potential deficit in care upon review at the comprehensive safety review (CSR) stage
	• There was an increase in the number of proportionate reviews being completed (11) though comparable to the same reporting period in 2023/24
	• 3 reported suspected suicides reported during this period. An area of concern being reviewed through the CSR process will be the potential contribution/impact of a suicide in relation to a person exceeding a 16 week wait for assessment.
	• Key themes from reviews
	  ○ Completion of a safety plan to support the management of suicidal ideation risk, particularly the SAFE tool
	  ○ Services responsiveness commended in care management
	  ○ Good transition between services noted as notable practice
	  ○ Required documentation not being completed within timescales (post falls assessment)
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VERSION CONTROL:

Version	Report to	Date Reported
V1	Clinical Safety Improvement Group	10/04/2025
V2	SLT	20/05/2025
V3	Quality Committee	30/05/2025
V4	Public Trust Board	04/07/2025

This report provides assurance to SLT and the Quality committee of the Trusts processes relating to Patient Safety Incidents which will encompass the incidents that we used to report as Serious Incidents (SIs) and Duty of Candour (DoC).

The Trust reports patient safety incidents via the Patient Safety Incident Response Framework (PSIRF) which does not acknowledge serious incidents as a category by itself and will be replaced for this report by the review process under PSIRF known as Patient Safety Incident Investigation. This is used for those severe incidents that require a strategic oversight and review due to the level of harm that has occurred as outlined in the PSIRF policy and plan.

All patient safety incidents are managed under the new PSIRF framework policy and plan.

The report covers the Q4 period from 1st January 2025 to 31st March 2025 and details the following:

- The status of incidents that are open and trend data for the period Q4 2022/23 to Q4 2024/25 inclusive.
- Proportionate reviews completed for the period Q4 2022/23 to Q4 2024/25 inclusive.
- Themes, learning and changes arising from Serious Incident investigations.
- The Duty of Candour report.

Patient Safety Incident Proportionate Response

For the purpose of this report, we no longer reflect the reporting against the serious incident framework (SIF) due to the change and impact of PSRIF and proportionate responses to incidents, these will be continued to be tracked in the proportionate review table.

The table 1 below illustrates the total number of proportionate reviews reported by quarter for the period October 2023 to September 2024.

Table 1: Proportionate Reviews

Proportionate review	Q1	Q2	Q3	Q4	Total 2023/24	Q1	Q2	Q3	Q4	Total 2024/25
Rapid Review	N/A	N/A	8	11	19	11	5	3	2	21
After Action Review	N/A	N/A	2	9	11	2	8	9	12	31
MDT Review	N/A	N/A	0	0	0	0	0	0	0	0
Patient Safety Review	N/A	N/A	2	2	4	0	1	0	0	1
Comprehensive Safety Review	N/A	N/A	10	14	24	5	7	11	14	37
Falls Comprehensive Safety Review	N/A	N/A	0	0	0	0	0	0	6	6

Thematic Review	N/A	N/A	0	0	0	1	0	1	0	2
Patient Safety Incident Investigation (PSII)	N/A	N/A	0	0	0	0	1	0	1	2
Total	0	0	22	36	58	19	22	24	35	100

Comprehensive Safety Review (CSR) Data by Team and Directorate

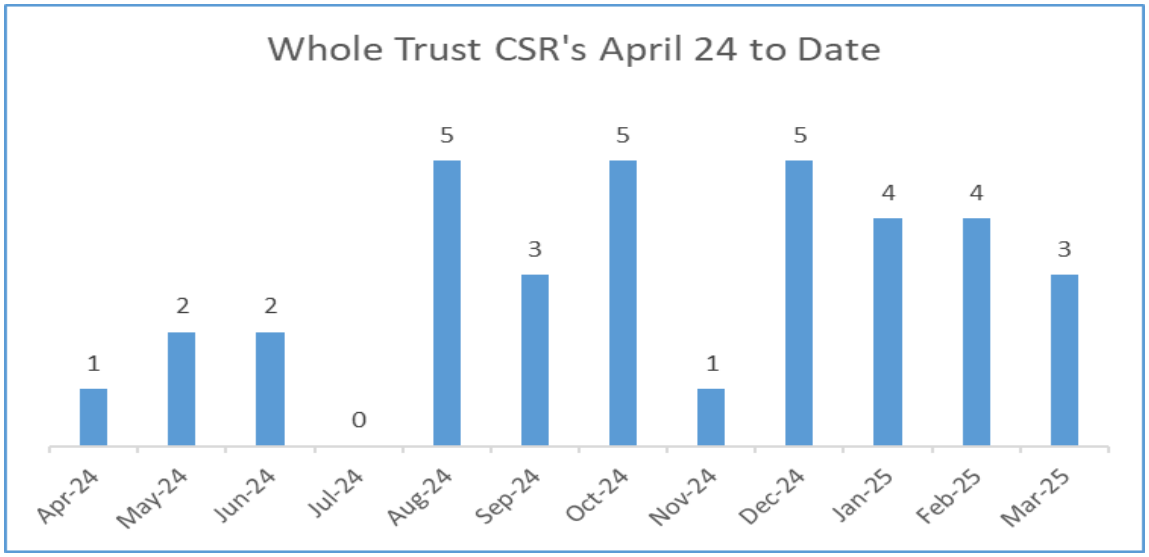
Table 2: CSR's by Directorate

	Jan	Feb	Mar
Acute & Urgent Care	2	1	1
NSCHT Community	1	3	2
Primary Care			
Specialist Services	1		
Grand Total	**4**	**4**	**3**

The table 2 above shows the incidents reported in Q4 by directorate.

*There is a discrepancy of 3 between the CSR data in table 1 for Q4 than in table 2 (total of 11) due to the date the incident was reported to LFPSE being outside of the reported month of occurrence, this was a result of delays around the Christmas period in reporting. All required reviews have/are being completed as per policy.

Graph 1: Trust – wide CSRs April 2024 to date



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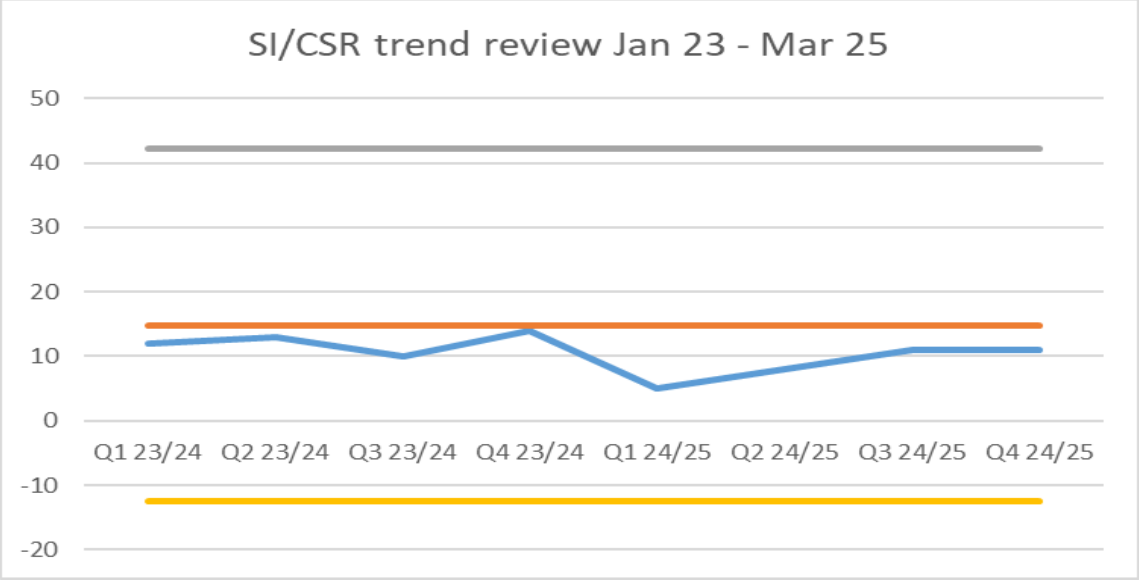
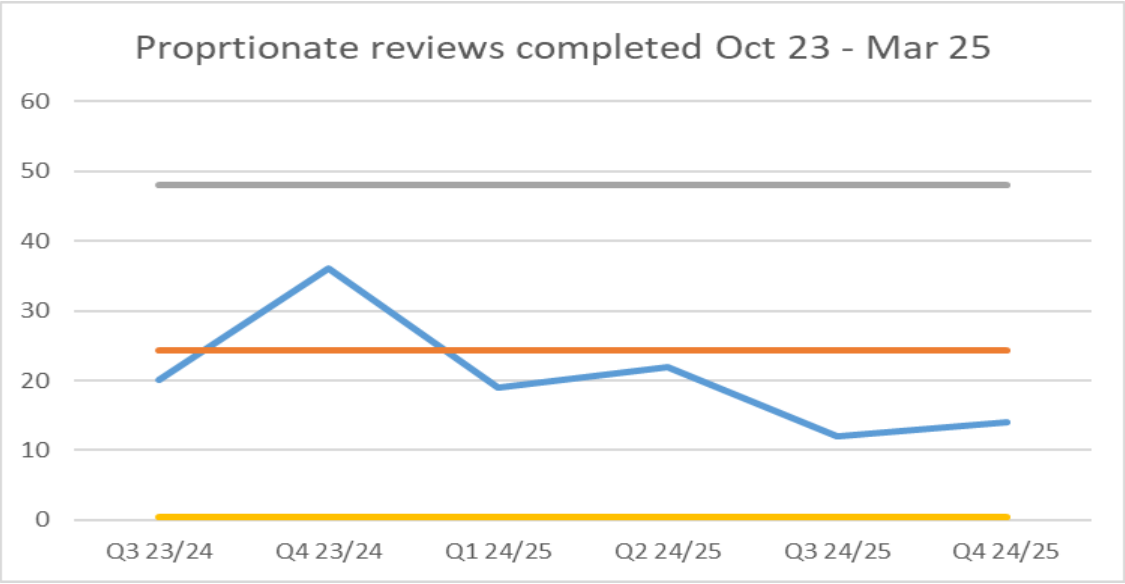


Graph 2 above show the trends of SI / CSR for the last 2 years of reporting from January 2023 – March 2025, we have remained below the reporting average for the last 2 years however it does show that we are consistently using the PSIRF framework to understand the incident and elicit learning for sharing and dissemination through current governance structures as well as monthly learning lesson events.

Proportionate reviews

Graph 3: Proportionate reviews



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incidents using these templates as more reassurance however starting to see a consistent use of these now with very positive learning identified and outcomes shared. These are shared at our weekly Learning from Patient Safety Events group for dissemination of learning, success and challenges.

For this reporting period the after-action review was completed most frequently on 12 occasions into incidents that have contributory factors primarily in process concerns, a selection of themes from these are as follows:

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- Late Request For Renewal – Mental Health Act Paperwork
- Apparent/Actual/Suspected Homicide
- Death - In Receipt
- Documentation - No Access To
- Access To Service - Delay/failure

There are no current themes that have raised concerns by the reviewing officer, and all learning outcomes are found within the harm reviews completed.

Suspected Suicides

For this reporting period there were 3 incidents of suspected suicide, they involved 1 female (f) and 2 males (m), aged 39 (m), 49 (f) and 73 (m).

The reported chosen methods for suicide were:

- 1 via hanging
- 1 via overdose
- 1 found by the police with no circumstances reported at time of report

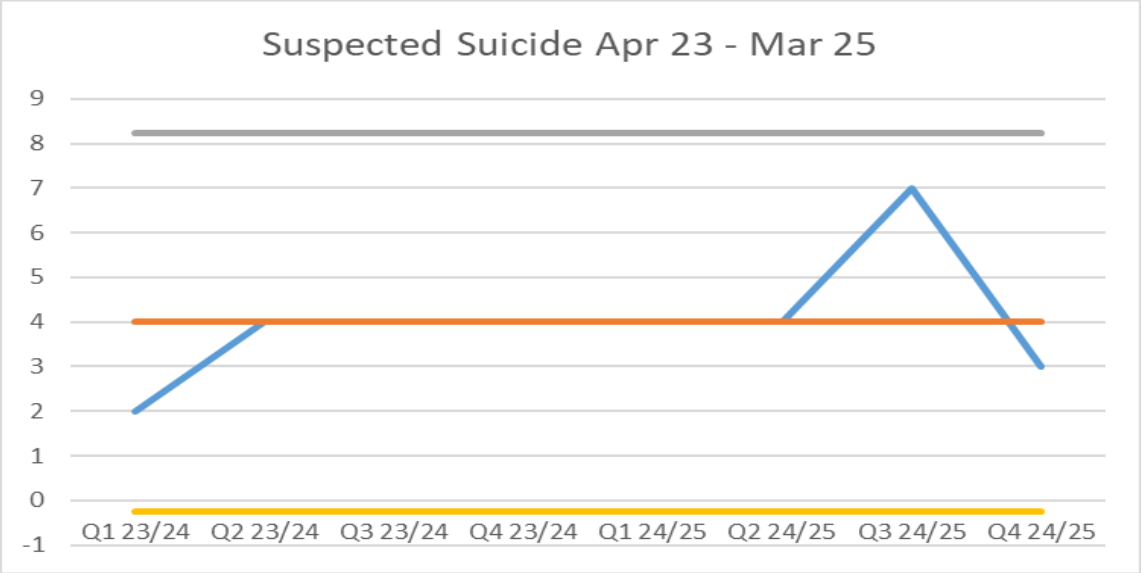
These reports will be fed back into the suicide prevention strategy group for review against current workstreams that are in place and where there is a need to review this then the group will be tasked to review the contributory factor and to see what is clinically possible to support this risk being reduced to an appropriate level.

Current early learning into these incidents indicate:

- Regular clinical contact from patient with clear clinical outcomes defined
- Timely interventions and responses from services documented
- There was a 16 week wait between assessment and intervention offered in one case, which led to a delay in care being provided

Themes and trends

Graph 4: Suspected Suicides



The above graph represents the reported suspected suicides of our patients in receipt of care for the last 2 years, level of reporting of suicide has been relatively static with a spike in Q3 of 2024/25.

In the last 12 months we have reported 18 incidents of suspected suicide, it is difficult to ascertain any themes and/or trends within these as they range across so many of our teams. However, we utilise the learning from these reviews to communicate to teams for their awareness to help improve service delivery, this is also supported by the monthly Trust wide learning lesson events.

However, data over the past 12 months show the following predominantly:

Data	Findings	
Method of suicide	➢ Hanging ➢ Overdose ➢ Found deceased unknown cause ➢ Fall/jump from bridge ➢ Found in lake ➢ Found unresponsive	➢ 6 ➢ 4 ➢ 3 ➢ 2 ➢ 2 ➢ 1
Age	Average 54 years old	
Sex	Male Female	11 7
Ethnicity	White British Black or Black British – African	16 1

	Not stated	1

Action – There has been a review of the Trusts Suicide Prevention Steering Group utilising support from the Transformational Management Office (TMO) to help review the current position and utilise their expertise in the knowledge of current Trust projects and how they intersect with this agenda. This has allowed a further look at the wider system approach and the involvement of the rejuvenated Integrated Care Board (ICB) led system steering group. There has been the amalgamation of the new system 5 areas of focus and they are:

• **Area of Focus 1: Monitor and improve our understanding of the evidence**

Intended outcome: Real time evidence led approach to reducing suicide across Staffordshire and Stoke-on-Trent

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Intended outcome: A reduction in suicidal activity at identified high priority locations.

• **Area of Focus 5: Minimise further harm following a suicide**

Intended outcome: Ensure that people affected or bereaved by suicides are given timely support, and that ongoing escalation of harm is minimised

Learning from Serous Incident reviews

Recommendations and learning from SI/CSR reviews are disseminated upon completion by the Directorate Quality Improvement Lead Nurses. This process includes the production, implementation and evaluation of action plans and information is reported back and discussed/actioned through individual meetings, team meetings and directorate forums.

Learning is also discussed at the Trust Clinical Safety Improvement Group and with the ICB colleagues at the monthly PSIRF touch base meetings.

The learning that was found from closed SI's/CSR during Q4 2024/25 includes the following outcomes:

- Completion of a safety plan to support the management of suicidal ideation risk, particularly the SAFE tool
- Services responsiveness commended in care management
- Good transition between services noted as notable practice
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- Unclear intervention plan
- Reduced awareness of needs due to potential gaps in information sharing during the handover process

It should be noted that in these above general errors and/or omissions identified through the review process are addressed through the set action plans and the owner of these, updates to these actions are monitored via the directorate and communicated back to the Clinical Safety Improvement Group (CSIG) for oversight and assurance of work completed.

Action – To continue to enhance and develop the work commenced in relation to the action plans linked to the CSR process - (with an additional review being implemented post 30 - day review meeting with the ward/team manager; this enables relevant actions from the report to be structured as SMART Actions – with support from the Patient and Organisational Safety Team (P&OST).

Duty of Candour

The Trust policy Being Open, incorporating Duty of Candour (DoC) ensures that all staff are aware of their responsibilities with regards to DoC. However, this is further supported by the secondary reviews provided through the Patient and Organisation Safety Team reviews and the Weekly Incident Review Group, which is attended by senior representatives from the directorates and corporate Nursing and Quality Teams.

In the case of SIs/ CSR's, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. Letters are issued by the Directorate of the treating team, expressing the Trust condolences and explaining that the Trust will be undertaking a review of the care provided. However, should any investigation identify causal links between patient harm and service delivered, the DoC process would be initiated and a letter outlining the issues sent to the patient or next of kin.

The current ongoing SI investigations / CSRs may identify issues that meet the DoC criteria and therefore the requirements for DoC would be met through the CSR process.

During Q4 there have been one incident that have met the criteria for action regarding the DoC requirements.

This was highlighted as a case for Duty of Candour following a 30 day review of a comprehensive safety review where there was felt that there was a few missed opportunities to deliver the care that we would have expected to have delivered, the contributory factors for learning have been reported as:

- Review of falls risk assessment and no clarity around care needs in relation to staff support required
- Lack of documented evidence for the checking of specialist equipment to support falls prevention i.e. bed sensors
- Lack of clarity on observation levels required for the patient

Current actions to remedy the concerns raised are reported as:

- Management team reviewing the escalation process for falls if the post falls documentation is not completed in line with practice
- Report completed in relation to the "lodging out" of patients completed

- Specialist equipment checks to be audited by the ward management team regularly to ensure functioning equipment is in use
- Review the handover process to ensure it allows for information to be shared across the wider MDT in a timely and informative way
- Falls prevention group to be re-instated to support the oversight and governance of such issues

Conclusion

The Board is requested to note that the Trust will continue to monitor patient safety incidents monthly through the Clinical Safety Improvement Group, demonstrating compliance with Trust policies and processes.

Appendix 1 – What is PSIRF

The Patient Safety Incident Response Framework (PSIRF) supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Reviews under this framework follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose.

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. PSIRF supports the Trusts patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

It is important that our approach, just culture is being able to explain the approach that will be taken if an incident occurs in a way that support understanding the identification of lessons that are learnt as a result of a patient safety incident occurring and not apportioning blame when an incident does occur, adhering to this policy it will help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises

compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. It is the role of the patient safety incident investigation (PSII) oversight and learning lead to be the lead point of contact for patients, families and staff.

Appendix 2 – Proportionate Reviews

Activity / Learning Response	Description	Impact score threshold for activity	Examples However not an exhaustive list, please contact POST / PSII oversight lead for support if required
Ulysses incident form completion	Standard response to all identified patient safety incidents	Identification of patient safety incident	Any patient safety incident regardless of impact
Rapid review	This is completed on incidents where there was a deviation from the perceived normal outcome requiring review into circumstance to identify concern and mitigation for this episode of care. This would be completed as a precursor to any death of patient in receipt of service (last 6 months) to determine further patient review response. To be completed if request is received from an external reviewer in relation to a current PSII, if further learning response is required then this can be agreed upon to illicit the correct response.	Patient safety incident that meets threshold of minor impact	Medication errors, self-harm, violence and aggression, post notification of a death to be completed for initial review and findings (within 72 hours)
MDT review / After Action Review (AAR)	These should be completed where there has been a deviation from the perceived normal outcome requiring further review due to the impact of the incident to patient care. These reviews are to be completed alongside CSIM or formal debriefs if there has been psychological trauma identified from the incident as to not adversely affect staffs wellbeing. If concern please review appropriateness with PSII oversight lead	Patient safety incident that meets the threshold of minor / moderate impact	MDT review / AAR - Falls, medication error leading to harm caused, self-harm leading to treatment required, patient on patient incidents
Patient Safety Review (PSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery in care that require a detailed review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of minor / moderate impact and there is a potential deficit in care identified	Falls leading to a fracture of a minor bone, harm caused direct from episode of care, harm caused requiring external acute hospital treatment, breach of mental health act framework
Comprehensive Safety Review (CSR), Falls Comprehensive safety Review	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery that require an in depth review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of moderate / severe / catastrophic impact and there is a potential deficit in care identified	Injury requiring hospitalisation / complex treatment, death, falls leading to a fracture of a major bone, safeguarding concern as a result of care received

Thematic Review	This is completed on a selection of incidents/reviews where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery that require an in depth review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of moderate / severe / catastrophic impact and there is a potential deficit in care identified	When there is an identified theme or trend across a team or area that warrants further exploration to understand the contributory factors into these events to reduce the likelihood of occurrence due to there repetitive nature
Patient Safety Incident Investigation (PSII	This is completed when an incident or near-miss indicates significant patient safety risks and potential for new learning	Patient safety incident that meets the threshold of severe / catastrophic impact and there is an identified deficit in care identified	Deaths related to care delivery received, death of an inpatient detained upon the mental health act, never events

Patient Safety Incident Response Framework (Previous Serious Incident) report – Q4 2024/25

This report provides assurance to SLT and the Quality committee of the Trusts processes relating to Patient Safety Incidents which will encompass the incidents that we used to report as Serious Incidents (SIs) and Duty of Candour (DoC).

The Trust reports patient safety incidents via the Patient Safety Incident Response Framework (PSIRF) which does not acknowledge serious incidents as a category by itself and will be replaced for this report by the review process under PSIRF known as Patient Safety Incident Investigation. This is used for those severe incidents that require a strategic oversight and review due to the level of harm that has occurred as outlined in the PSIRF policy and plan.

All patient safety incidents are managed under the new PSIRF framework policy and plan.

The report covers the Q4 period from 1st January 2025 to 31st March 2025 and details the following:

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MDT Review	N/A	N/A	0	0	0	0	0	0	0	0
Patient Safety Review	N/A	N/A	2	2	4	0	1	0	0	1
Comprehensive Safety Review	N/A	N/A	10	14	24	5	7	11	14	37

Falls Comprehensive Safety Review	N/A	N/A	0	0	0	0	0	0	6	6
Thematic Review	N/A	N/A	0	0	0	1	0	1	0	2
Patient Safety Incident Investigation (PSII)	N/A	N/A	0	0	0	0	1	0	1	2
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Comprehensive Safety Review (CSR) Data by Team and Directorate

Table 2: CSR's by Directorate

	Jan	Feb	Mar
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The table 2 above shows the incidents reported in Q4 by directorate.

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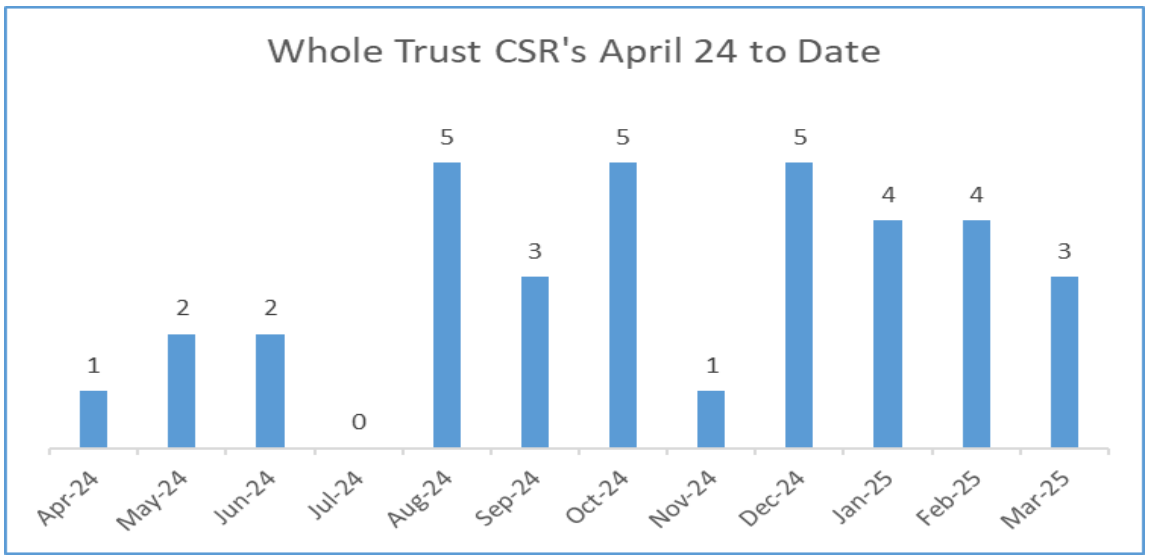

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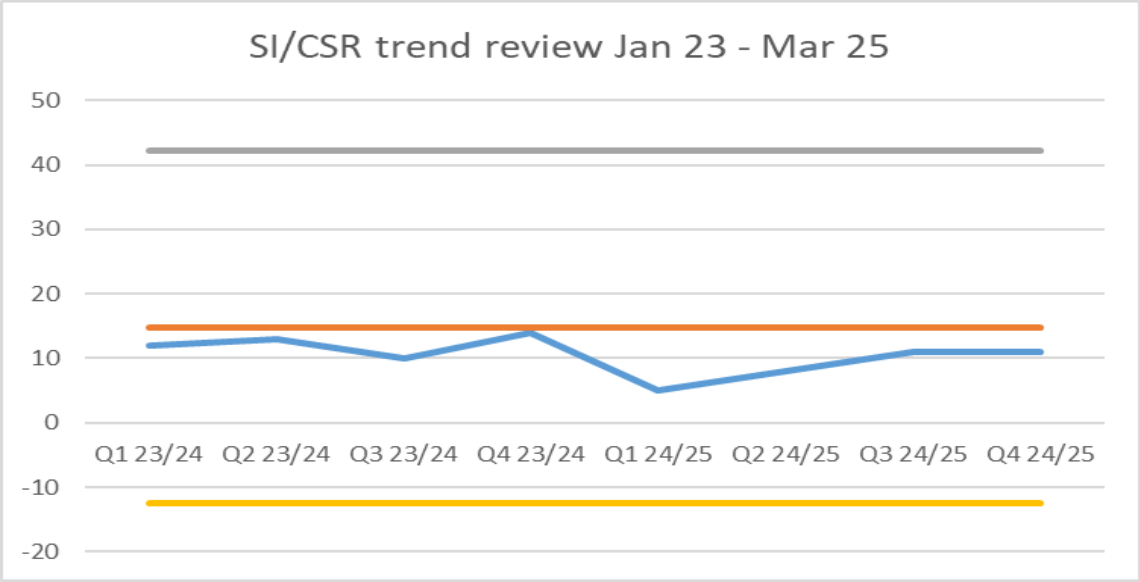

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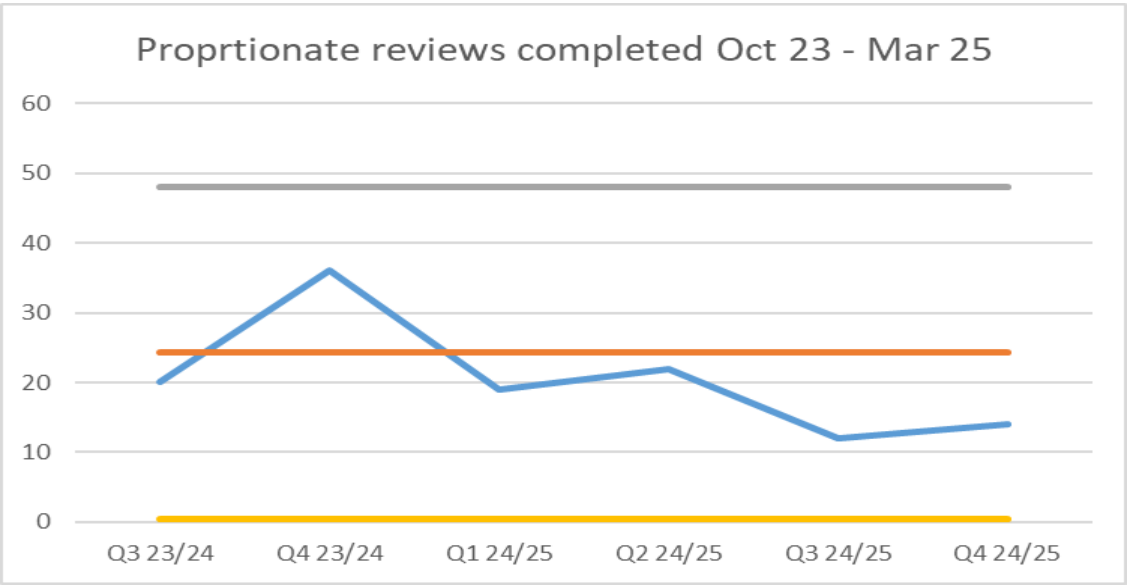

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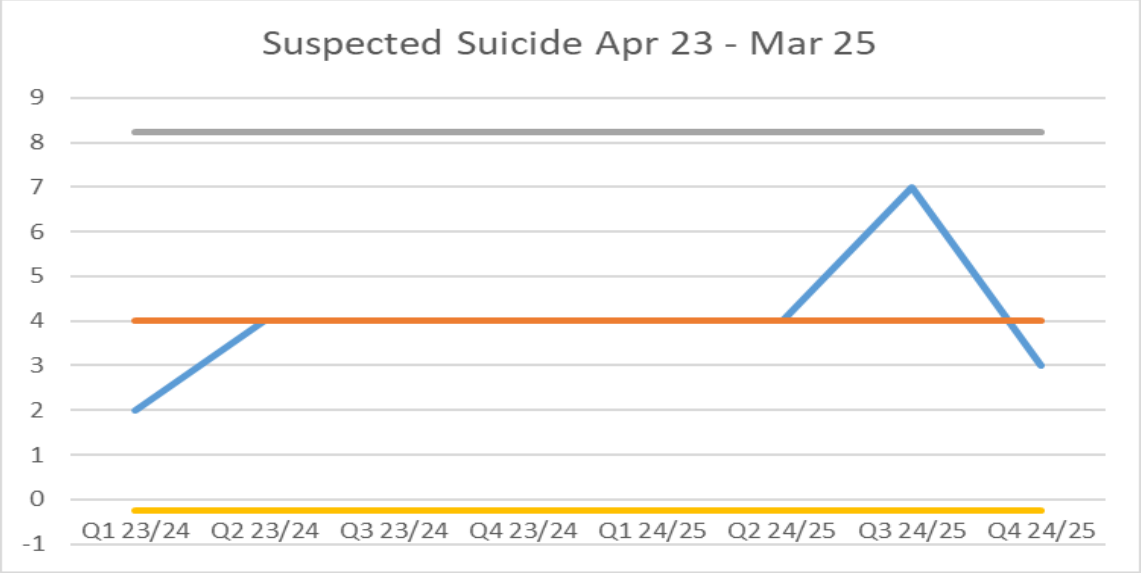

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- Reduced awareness of needs due to potential gaps in information sharing during the handover process

It should be noted that in these above general errors and/or omissions identified through the review process are addressed through the set action plans and the owner of these, updates to these actions are monitored via the directorate and communicated back to the Clinical Safety Improvement Group (CSIG) for oversight and assurance of work completed.

Action – To continue to enhance and develop the work commenced in relation to the action plans linked to the CSR process - (with an additional review being implemented post 30 - day review meeting with the ward/team manager; this enables relevant actions from the report to be structured as SMART Actions – with support from the Patient and Organisational Safety Team (P&OST).

Duty of Candour

The Trust policy Being Open, incorporating Duty of Candour (DoC) ensures that all staff are aware of their responsibilities with regards to DoC. However, this is further supported by the secondary reviews provided through the Patient and Organisation Safety Team reviews and the Weekly Incident Review Group, which is attended by senior representatives from the directorates and corporate Nursing and Quality Teams.

In the case of SIs/ CSR's, it is not always possible to immediately determine which, if any of the deaths under investigation meet the Duty of Candour requirements. Letters are issued by the Directorate of the treating team, expressing the Trust condolences and explaining that the Trust will be undertaking a review of the care provided. However, should any investigation identify causal links between patient harm and service delivered, the DoC process would be initiated and a letter outlining the issues sent to the patient or next of kin.

The current ongoing SI investigations / CSRs may identify issues that meet the DoC criteria and therefore the requirements for DoC would be met through the CSR process.

During Q4 there have been one incident that have met the criteria for action regarding the DoC requirements.

This was highlighted as a case for Duty of Candour following a 30 day review of a comprehensive safety review where there was felt that there was a few missed opportunities to deliver the care that we would have expected to have delivered, the contributory factors for learning have been reported as:

- Review of falls risk assessment and no clarity around care needs in relation to staff support required
- Lack of documented evidence for the checking of specialist equipment to support falls prevention i.e. bed sensors
- Lack of clarity on observation levels required for the patient

Current actions to remedy the concerns raised are reported as:

- Management team reviewing the escalation process for falls if the post falls documentation is not completed in line with practice
- Report completed in relation to the "lodging out" of patients completed
- Specialist equipment checks to be audited by the ward management team regularly to ensure functioning equipment is in use
- Review the handover process to ensure it allows for information to be shared across the wider MDT in a timely and informative way

- Falls prevention group to be re-instated to support the oversight and governance of such issues

Conclusion

The Board is requested to note that the Trust will continue to monitor patient safety incidents monthly through the Clinical Safety Improvement Group, demonstrating compliance with Trust policies and processes.

Appendix 1 – What is PSIRF

The Patient Safety Incident Response Framework (PSIRF) supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Reviews under this framework follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose.

The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. PSIRF supports the Trusts patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents.

It is important that our approach, just culture is being able to explain the approach that will be taken if an incident occurs in a way that support understanding the identification of lessons that are learnt as a result of a patient safety incident occurring and not apportioning blame when an incident does occur, adhering to this policy it will help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient

safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. It is the role of the patient safety incident investigation (PSII) oversight and learning lead to be the lead point of contact for patients, families and staff.

Appendix 2 – Proportionate Reviews

Activity / Learning Response	Description	Impact score threshold for activity	Examples However not an exhaustive list, please contact POST / PSII oversight lead for support if required
Ulysses incident form completion	Standard response to all identified patient safety incidents	Identification of patient safety incident	Any patient safety incident regardless of impact
Rapid review	This is completed on incidents where there was a deviation from the perceived normal outcome requiring review into circumstance to identify concern and mitigation for this episode of care. This would be completed as a precursor to any death of patient in receipt of service (last 6 months) to determine further patient review response. To be completed if request is received from an external reviewer in relation to a current PSII, if further learning response is required then this can be agreed upon to illicit the correct response.	Patient safety incident that meets threshold of minor impact	Medication errors, self-harm, violence and aggression, post notification of a death to be completed for initial review and findings (within 72 hours)
MDT review / After Action Review (AAR)	These should be completed where there has been a deviation from the perceived normal outcome requiring further review due to the impact of the incident to patient care. These reviews are to be completed alongside CSIM or formal debriefs if there has been psychological trauma identified from the incident as to not adversely affect staffs wellbeing. If concern please review appropriateness with PSII oversight lead	Patient safety incident that meets the threshold of minor / moderate impact	MDT review / AAR - Falls, medication error leading to harm caused, self-harm leading to treatment required, patient on patient incidents
Patient Safety Review (PSR)	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery in care that require a detailed review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of minor / moderate impact and there is a potential deficit in care identified	Falls leading to a fracture of a minor bone, harm caused direct from episode of care, harm caused requiring external acute hospital treatment, breach of mental health act framework

Comprehensive Safety Review (CSR), Falls Comprehensive safety Review	This is completed on incidents where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery that require an in depth review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of moderate / severe / catastrophic impact and there is a potential deficit in care identified	Injury requiring hospitalisation / complex treatment, death, falls leading to a fracture of a major bone, safeguarding concern as a result of care received
Thematic Review	This is completed on a selection of incidents/reviews where there has been a deviation from the perceived normal outcome where we need to explore potential implications of care delivery that require an in depth review to understand the circumstances that lead to the event	Patient safety incident that meets the threshold of moderate / severe / catastrophic impact and there is a potential deficit in care identified	When there is an identified theme or trend across a team or area that warrants further exploration to understand the contributory factors into these events to reduce the likelihood of occurrence due to there repetitive nature
Patient Safety Incident Investigation (PSII	This is completed when an incident or near-miss indicates significant patient safety risks and potential for new learning	Patient safety incident that meets the threshold of severe / catastrophic impact and there is an identified deficit in care identified	Deaths related to care delivery received, death of an inpatient detained upon the mental health act, never events

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 10

Quality Committee Assurance Report – July 2025

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Trust Board
Date of Meeting:	10 July 2025

Presented by:	Pauline Walsh, Chair/Non-Executive Director – Quality Committee
Prepared by:	Zoe Grant, Deputy Chief Nursing Officer
Executive Lead:	Kenny Laing, Chief Nursing Officer Dr Dennis Okolo, Chief Medical Officer

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	Quality Committee
Strategic Priorities:	Prevention - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	-
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Not applicable
Recommendation / Required Action	For information and assurance.
Executive Summary	The attached assurance report describes the business and outputs from the meeting of the Quality Committee on 3 July 2025.

VERSION CONTROL:

Version	Report to	Date Reported

Trust Board Assurance Report from the Quality Committee meeting held on 3 July 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Quality Committee. The meeting was completed using Microsoft Teams and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key Quality performance indicators and the Quality Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under the Quality Committee's remit and programmes of work.

ALERT:

This section summarises the key points that members of the Trust Board need to be aware of.

- **Out of Area Placements (OOA) report**

Currently there are 18 OOA patients, the process around OOA escalations has been reviewed and refined. These include daily bed flow meetings with the support of system colleagues.

The national benchmarking in relation to OOA patients does suggest that Trusts with the lower number of patients who are Clinically Ready for Discharge (CRFD) do tend to have less OOA patients.

The Acute & Urgent Directorate will be presenting the work on reducing OOA placements in the deep dive session at the next Quality Committee in August.

- **System Update**

The committee received an update around winter planning being underway. The Deputy Chief Operating Officer gave an overview of current pressures being faced within the system, particularly UHNM as such the Trust are currently seeing an increase in Mental Health assessments within the Mental Health Liaison service and have also seen arise in 136 detentions.

ADVISE:

This section advises of key activity and updates in relation to programmes of work.

- **CQC Update**

The Crisis Care service CQC report is awaited following inspection visit.
Chief Nursing Officer gave an update on potential amendments to the way that the Trusts rate Organisations with the potential of Trusts no longer receiving overall Trust CQC ratings, instead Trusts will receive overall rating to core services and then a rating around the Trusts Well led.

ASSURE:

This section provides assurance of the quality of service and activity delivered under the Quality Committee's remit and programmes of work.

The following reports were received for assurance:

- **Safe staffing report May 2025**

Report received for assurance the overall staffing fill rate was 107.3% and were assured that the Trust's Staffing levels are adequate and safe.

The following reports were presented for assurance with good level of discussion at the Committee

- Infection, Prevention and Control Annual Report 2024/25
- Mortality Surveillance Annual Report 2024/25
- Suicide Prevention Annual Report 2024/25
- IQPR
- Clinical Audit Programme 2025/26

APPROVE:

This section provides an update of items which were discussed and approved by the Committee.

- **Board Assurance Framework Dashboard 2025/26**

To note - Discussion was held around the re-phrasing of the Quality and Safety risk outlined in the paper presented to the Committee, there was consensus on risk, however it was agreed that this will be re-worded to articulate the risk more clearly.

- **Risk Register Deep Dive**

The Committee undertook a review of all quality related risks, noted updates and approved the risks pertinent to the committee.

- **Policies**

The committee approved for 3 years:

1. MHA01 Mental Health Act – Section 17A Community Treatment Order Policy
2. MHA02 - Mental Health Act – Policy for allocating or changing a Responsible Clinician and Selecting Second Professionals
3. MHA03 - Mental Health Act Policy - Holding Powers of Section 5 – (includes Section 5(4) Nurses Power and Section 5(2) Doctors Power)
4. MHA06 - Mental Health Act – Guidance on Conflict of Interest
5. MHA12 - Mental Health Act 1983 - Leave of Absence Policy

6. MHA15 - Mental Health Act – Patient Rights
7. 1.75a - Staff Domestic Abuse Policy

The committee also approved an extension for the following policy for 12 months:

1. 1.15 Dress Code and Uniform Policy

The committee also approved removal of the below policies;

1. MHA04 - Holding Powers of Doctors and Approved Clinician Section 5(2) Policy Remove Combined two policies – Section 5(4) and Section 5(2) into one policy - ***Combined two policies – Section 5(4) and Section 5(2) into one policy***

2. 7.23 Information Sharing Agreement: Safeguarding Information Requests. ***There is no longer a need for this policy as it is already law***

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 7 August 2025 at 2pm In Person at Lawton House.

Committee Chair: Pauline Walsh, Chair of the Quality Committee.

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 11

IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) M02 2025/26

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Eric Gardiner, Chief Finance Officer
Prepared by:	Victoria Boswell, Associate Director of Performance
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk	**Risk 5**: Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff.
Approval / Review:	Performance Review Meeting
Strategic Priorities:	**Access** - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access.
Key Enablers:	**Quality** - We will provide the highest quality, safe and effective services.
Sustainability:	Share learning and best practice.
Resource Implications:	None directly
Funding Source:	None directly
Diversity & Inclusion Implications	The Trust is seeking to ensure that all Directorates are recording in a timely way the protected characteristics of all service users to enable monitoring of service access and utilisation by all groups in relation to the local population. This will support a Population Health Management approach in the Trust. The Trust is using the 2021 census data to develop a suite of activity and workforce reports to help to promote health equity. These enable actions to be taken to address health inequalities that can be measured to provide assurance that the Trust is working to provide equitable access and outcomes for all.
ICS Alignment / Implications:	The IQPR Board report is provided to the ICB as part of our contractual reporting requirements in 2025/26 and includes performance against national priorities in advance of the national publication through MHSDS.

Recommendation / Required Action	**The Board is asked to**: • Receive the report as outlined • Note the Management actions
Executive Summary	**Performance Summary** There are 2 special cause variations (orange variation flags) – signifying concern. 1. Sickness Absence 2. Appraisal There are 5 special cause variations (blue variation flags) – signifying improvement. 1. Early Intervention - a maximum of 2 week waits for Referral to Treatment 2. Risk Assessment Compliance 3. Staff Turnover 4. Statutory and Mandatory Training 5. DQMI **Highlights** • Referral to treatment within 18 weeks remains above standard at 96.1% in M02 from 95.9% in M01. • Mental Health Liaison 1 hour, 4 hour and 24 hours are all above the 95% standard in M02. • 48 hour and 7 day follow up metrics achieved standard in M02. • Early Intervention has achieved 100% during M02 for the second consecutive month. • Average Length of Stay for Adults has improved to 34 days in M02 compared to 41 days in M01. • Risk assessments have achieved standard for the third consecutive month in M02 at 95.8%. • DQMI rate is at 98.3% in January (latest published national position). • Staff turnover is at 9.7% in M02 from 9.8% in M01 and the vacancy rate remains at 8.3% in M02, both metrics meeting the <10% requirement. **Exceptions** • Referral to Assessment within 4 weeks has further improved to 94.7% in M02 from 94.2% in M01, still below trust standard. • CYP 4-week RTA standard has dipped slightly to 90.9% in M02 from 91.1% in M01. • Compliance within CYP 18 weeks RTT has improved to 91.8% in M02 from 87.6% during M01. • Care plan compliance is at 94.5% in M02 from 94.6% during M01, showing an under performance of 0.5%. • There are 2 complaints exceeding the 40 working day standard in M02. • Friends and Family recommended rate in M02 is 72% from 57% in M01, against the new standard of 80%.

	• Sickness Absence continues to operate above the upper control limit at 6.3% during M02 from 6.4% in M01. • Clinical Supervision has improved further to 83% in M02 from 81% in M01, under target for the fourth consecutive month. • Appraisal performance is 84% in M02, under standard for the first time in the last 12 months. **Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts M02 2025/26** M02 performance against the forecasts submitted to the ICB and NHSE for 2025/26. To note: • Out of Area Placements – There were 19 reportable Out of Area placements at the end of M02. 18 due to the availability of acute beds and 1 due to the availability of PICU beds. There were 25 OOAs during the month of May, with 18 of these open to Community teams. • Inpatient Stays – The target for the average Length of Stay for Adult and Older Adult Acute and PICU beds has not been met in M02, 44 against the plan of 39. • Perinatal Access – The perinatal access metric has met standard in M02, achieving 701 against the plan of 608. • CYP in contact – This metric has met standard in M01, achieving 8,489 against the plan of 7,955. • Individual Placement Support Access – This metric is set against an ICB performance plan figure, we are working towards collecting MPFT performance so that we can report against the plan.

VERSION CONTROL:

Version	Report to	Date Reported
1.0	Quality Committee	20.06.25
2.0	Public Trust Board	04.07.25

North Staffordshire Combined Healthcare NHS Trust

Improving Quality and Performance Report (IQPR)

Trust Report

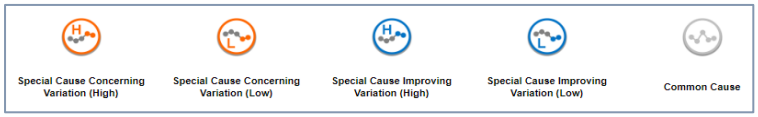
Reporting Period: M02 (May 2025)

Contents

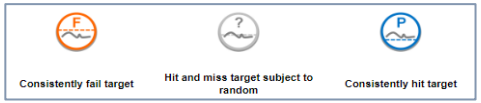
Using Statistical Process Control (SPC)

An SPC chart is a time series with three reference lines, the mean, upper and lower control limits. The limits help to understand variability of the data. We use them to distinguish between natural variation (common cause) in performance and unusual patterns (special cause) in data which are unlikely to have occurred due to change and may require further analysis. They can provide assurance on whether a target will reliably be achieved or whether the process is incapable of meeting the required standard without a change.

Variation Icons



Assurance Icons



There are 2 special cause variations (orange variation flags) – signifying concern.

1. Sickness Absence
2. Appraisal

There are 5 special cause variations (blue variation flags) – signifying improvement.

1. Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment
2. Risk Assessment Compliance
3. Staff Turnover
4. Statutory and Mandatory Training
5. DQMI

There are 8 metrics with Performance Improvement Plans (PIPs) in place for:

1. Referral to Assessment within 4 weeks-Specialist Services and Community Directorates
2. Risk Assessment – Community Directorate
3. Sickness Absence - All Directorates
4. Complaints - Nursing and Medical Directorate
5. Friends and Family Test - Nursing and Medical Directorate
6. Statutory and Mandatory Training – Nursing and Medical Directorate
7. Clinical Supervision – Acute and Urgent Care and Community Directorates
8. Care Plan Compliance-Specialist Directorate

Key Performance Indicator Glossary

The KPI Glossary contains all current IQPR metrics to enable clear visibility of the measure definition, indicator calculation formulae, standard/ target and tolerance, and inclusions and exclusions for all metrics.
Contact performanceinformationteam@combined.nhs.uk to request a copy.

Balanced Scorecard

Access & Waiting Times

SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	9 met, 3 unmet		
Highlights	Referral to Treatment within 18 weeks	92%	96.1%
	MH Liaison 1 hour response (Emergency)	95%	95.7%
	MH Liaison 4 hour response (Urgent)	95%	97.6%
	MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	95.9%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60%	100.0%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48%	50.2%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	67%	70.1%
	48 Hour Follow Up	95%	95.6%
	7 day follow up (All Patients)	95%	100.0%
Exceptions	Referral to Assessment within 4 weeks	95%	94.7%
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95%	90.9%
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92%	91.8%

Community & Quality

SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	1 Met, 1 unmet		
Highlights	Risk Assessment Compliance	95%	95.8%
Exceptions	Care Plan Compliance	95%	94.5%

Performance Improvement Plans (PIPs)

Directorate	Metric	Standard	Performance
Acute and Urgent Care Directorate	Sickness Absence (in-month)	<4.95%	4.5%
	Clinical Supervision	85%	80.0%
Community Directorate	Referral to Assessment within 4 weeks-CYP	95%	79.4%
	Referral to Assessment within 4 weeks-Adult	95%	92.1%
	Risk Assessment Compliance	95%	96.2%
	Clinical Supervision	85%	87.0%
	Sickness Absence (in-month)	<4.95%	3.8%

Inpatient & Quality

SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	3 met, 0 unmet		
Highlights	Average Length of Stay - Adult	40*	34
	Average Length of Stay - Older Adult	90*	81
	Emergency Readmissions rate (30 days)	<7.5%	1.6%

Organisational Health & Workforce

SPC variations signifying concern	Metric	Standard	Performance
	Appraisal	85%	84.0%
	Sickness Absence (12-month)	<4.95	6.2%
RAG rated standards	4 met, 6 unmet		
Highlights	Vacancy Rate	<10%	8.3%
	Staff Turnover	<10%	9.7%
	Statutory and Mandatory Training	85%	91.0%
	DQMI	95%	98.3%
Exceptions	Friends and Family Test	80%	72.0%
	Sickness Absence (12-month)	<4.95%	6.2%
	Clinical Supervision	85%	83.0%
	Safe Staffing	95%-105%	107.3%
	Appraisal	85%	84.0%
	Complaints Open Beyond Agreed Timescale*	0	2

Performance Improvement Plans (PIPs)

Directorate	Metric	Standard	Performance
Specialist Services	Referral to Assessment within 4 weeks	95%	77.8%
	Sickness Absence (in-month)	<4.95%	4.3%
	Care Plan Compliance	95%	90.0%
Nursing & Medical Directorate	Statutory and Mandatory Training - Resident Doctors I	85%	76.0%
	Statutory and Mandatory Training - Resident Doctors II	85%	91.0%
	Complaints Open Beyond Agreed Timescale	0	2
	Friends and Family Test	80%	72.0%
Primary Care Directorate	Sickness Absence (in-month)	<4.95%	3.8%

Core Indicators – Monthly

Domain	Indicator	Target	Mar-25	Apr-25	May-25	Assurance	Variation
Access & Wait Times	Referral to Assessment within 4 weeks	95%	93.1%	94.2%	94.7%		
	Referral to Treatment within 18 weeks	92%	95.6%	95.9%	96.1%	P	
	CAMHS Compliance within 4 Week Waits (RTA)	95%	85.7%	91.1%	90.9%		
	CAMHS Compliance within 18 Week Waits (RTT)	92%	86.6%	87.6%	91.8%		
	CYP Eating Disorders-1 Week (Urgent)	95%	72.7%	N/A	N/A	Run chart	Run chart
	CYP Eating disorders-4 Weeks (Routine)	95%	100.0%	N/A	N/A	Run chart	Run chart
	MH Liaison 1 hour response (Emergency)	95%	90.0%	95.7%	95.7%		
	MH Liaison 4 hour response ((Urgent)	95%	94.0%	95.4%	97.6%		
	MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	98.2%	95.2%	95.9%		
	Early Intervention-A maximum of 2 Week Waits for Referral to Treatment	60%	92.0%	100.0%	100.0%	P	H
	48 Hour Follow Up	95%	98.1%	90.9%	95.6%		
	7 Day Follow Up (All Patients)	95%	100.0%	94.5%	100.0%		
	Talking Therapies for Anxiety and Depression Reliable Recovery Rate	48%	51.6%	50.5%	50.2%	Run chart	Run chart
	Talking Therapies for Anxiety and Depression Reliable Improvement	67%	73.2%	74.1%	70.1%	Run chart	Run chart

Domain	Indicator	Target	Mar-25	Apr-25	May-25	Assurance	Variation
Inpatient & Quality	Average Length of Stay - Adult	40	28	41	34		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	14.0%	20.0%	20.7%	Run chart	Run chart
	Average Length of Stay - Older Adults	90	59	41	81		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	17.0%	10.0%	38.1%	Run chart	Run chart
	Emergency Readmissions rate (30 days)	7.5%	3.5%	3.5%	1.6%		
	Clinically Ready for Discharge (CRFD)	No Target	5	11	20	Run chart	Run chart

Domain	Indicator	Target	Mar-25	Apr-25	May-25	Assurance	Variation
Community & Quality	Care Plan Compliance	95%	94.6%	94.6%	94.5%		
	Risk Assessment Compliance	95%	95.3%	95.2%	95.8%		
	Comprehensive Safety Review	No Target	3	2	5	Run chart	Run chart
	Proportionate Reviews	No Target	5	2	7	Run chart	Run chart

Domain	Indicator	Target	Mar-25	Apr-25	May-25	Assurance	Variation
Organisational Health & Workforce	Complaints Open Beyond Agreed Timescale	0	4	3	2		
	Friends and Family Test-Recommended	80%	100.0%	57.0%	72.0%		
	Safe Staffing	95%-105%	107.8%	106.7%	107.3%	Run chart	Run chart
	Vacancy Rate	<10%	7.5%	8.3%	8.3%		
	Staff Turnover	<10%	9.5%	9.8%	9.7%		
	Sickness Absence	<4.95%	6.4%	6.4%	6.3%		
	Clinical Supervision	85%	79.0%	81.0%	83.0%		
	Appraisal	85%	86.0%	85.0%	84.0%		
	Statutory and Mandatory Training	85%	91.0%	91.0%	91.0%		

Long Term Plan and National Mental Health Priorities: Operational Planning Forecasts 2025/26

	Out of Area Bed days	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	Active inappropriate adult acute mental health out of areas placements (OAPs) (end of month position)	end of period position	*Plan*	2	2	2	2	2	2	2	2	2	2	2	2	2
			Actual	15	11	19										
			Variance	-13	-9	-17										

	Inpatient Stays	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2	Total number of bed days for spells ending in the period	3-month rolling	*Plan*	7,995	7,995	7,995	7,995	7,995	7,995	7,995	7,995	7,995	7,995	7,995	7,995	7,995
	Count of spells ending in the period			205	205	205	205	205	205	205	205	205	205	205	205	205
	Average length of stay for adult acute beds			39	39	39	39	39	39	39	39	39	39	39	39	39
	Total number of bed days for spells ending in the period		*Actual*	8,373	8,407	8,338										
	Count of spells ending in the period			195	202	188										
	Average length of stay for adult acute beds			43	42	44										
	Total number of bed days for spells ending in the period		*Variance*	-377.5	-412	-343										
	Count of spells ending in the period			10	3	17										
	Average length of stay for adult acute beds			-4	-3	-5										

	Perinatal access	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
3	Number of people accessing specialist community PMH and MMHS services in the reporting period (12-month rolling)	12-month rolling	*Plan*	608	608	608	608	608	608	608	608	608	608	608	608	608
			Actual	692	682	701										
			Variance	84	74	93										

	Numbers of CYP in contact	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (12-month rolling)	12-month rolling	*Plan*	7,955	7,955	7,955	7,955	7,955	7,955	7,955	7,955	7,955	7,955	7,955	7,955	7,955
			Actual	8,502	8,515	8,489										
			Variance	547	560	534										

	Individual Placement Support Access	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5	Number of people accessing IPS in the reporting period (12-month rolling)	12-month rolling	*Plan*	913	820	827	846	865	883	902	921	940	958	977	996	1,015
			Actual		*	*										
			Variance													

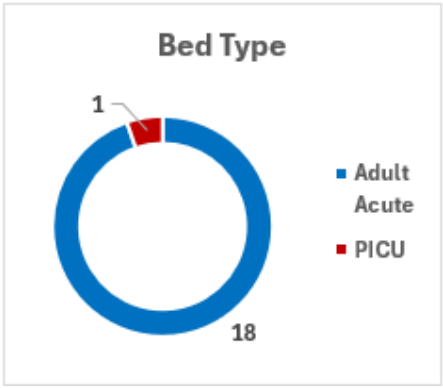
*Not yet available

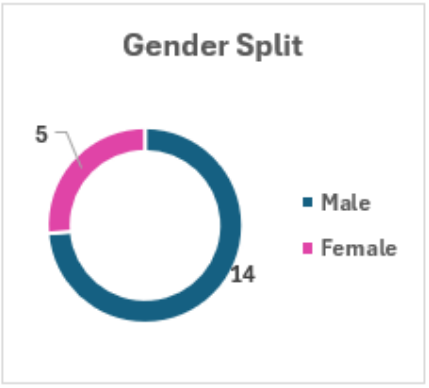
Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (1 of 2)

- **Out of Area Placements** – There were 19 reportable Out of Area placements at the end of M02. 18 due to the availability of acute beds and 1 due to the availability of PICU beds. There were 25 OOAs during the month of May, with 18 of these open to Community teams. They had an average length of stay of 16 days, reflecting efforts to stay connected with those in OOA placements and to bring patients back quickly to local beds.
  This reflects the pressure across the system and on the ACUC Directorate. There is a low number of adult acute and PICU beds at the present time due to Project Chrysalis (50 beds). The current bed stock is the lowest since September 2020. There is also the added pressure due to CRFDs (20 in M02). The wards are operating to capacity, and the Home Treatment team has increased activity, caseload, and level of risk to avoid admissions.

- An OOA SOP is currently being ratified and will provide assurance regarding roles and responsibilities regarding the daily and weekly input and oversight that staff on the wards are providing to patients in OOA beds. ACUC staff attend weekly ward rounds for each OOA patient. In addition, discharge coordinators and the discharge pathway team remain in frequent contact with the placements throughout the week. Where community teams are involved, they too are involved in the patients journey whilst OOA. The Trust only place patients in hospitals with CQC rating 'good' / 'outstanding, and where possible, ensure the minimum distance from home.

Key	Name of Hospital	Distance from Harplands *(mi)*	No. of Placements
	Cygnet Hospital Wyke	84	1
	Kneesworth House Hospital	139	4
	Priory Arnold	62	3
	Priory Cheadle	45	1
	Priory Barnt Green	52	1
	Priory East Midlands	60	1
	Priory Southampton	190	1
	Priory Norwich	184	7
	Harplands Hospital		





Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (2 of 2)

- **Inpatient Stays** – added to the National Operational Priorities in financial year 2025/26 with the target of improving patient flow through mental health crisis and acute pathways, reducing average length of stay in adult acute beds. This is a 3-month rolling measure of Adult Acute, Older Adut Acute & PICU Occupied Bed Days (OBDs), discharges and length of stay (LoS). The average LOS for this metric has not met standard in M02 achieving 44 against the plan of 39.

- **Perinatal Access –** The perinatal access metric has met standard in M02, achieving 701 against the plan of 608.

- **CYP in contact –** This metric has met standard in M02, achieving 8,489 against the plan of 7,955.

- **Individual Placement Support Access** – This metric is set against an ICB performance plan figure, we are working towards collecting MPFT performance so that we can report against the plan.

Core Indicators - Trends

Indicator	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Referral to Assessment within 4 weeks	95%	95.7%	94.7%	93.5%	93.9%	93.9%	94.9%	95.9%	92.2%	90.0%	91.7%	93.1%	94.2%	94.7%
Referral to Treatment within 18 weeks	92%	95.1%	96.4%	96.4%	94.7%	94.5%	94.2%	95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%
CAMHS Compliance within 4 Week Waits	95%	88.0%	78.9%	78.8%	78.6%	89.2%	90.7%	92.0%	76.4%	67.3%	76.2%	85.7%	91.1%	90.9%
CAMHS Compliance within 18 Week Waits	92%	79.5%	85.0%	87.6%	74.3%	87.3%	86.5%	87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%
MH Liaison 1 Hour response (Emergency)	95%	95.5%	96.0%	95.8%	96.2%	95.1%	95.6%	92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%
MH Liaison 4 hour response (Urgent)	95%	95.4%	97.5%	96.4%	96.8%	97.1%	95.6%	91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%
MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	88.8%	99.3%	99.2%	96.1%	97.3%	96.2%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%
CYP Eating Disorders-1 Week (Urgent)	95%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	83.3%	N/A	N/A	72.7%	N/A	N/A
CYP Eating disorders-4 Weeks (Routine)	95%	N/A	97.7%	N/A	N/A	90.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A
Early Intervention-A maximum of 2 Week Waits for Referral to Treatment	60%	100.0%	83.0%	67.0%	92.0%	89.0%	100.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%
48 Hour Follow Up	95%	97.3%	96.2%	91.4%	96.6%	94.2%	94.7%	100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%
7 Day Follow Up (All Patients)	95%	100.0%	98.1%	94.9%	100.0%	96.2%	98.4%	100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%
Talking Therapies for Anxiety and Depression Reliable Recovery Rate	48%	52.0%	52.4%	54.4%	53.9%	53.0%	50.7%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%
Talking Therapies for Anxiety and Depression Reliable Improvement	67%	73.1%	76.3%	75.8%	73.4%	74.5%	71.2%	74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%
Average Length of Stay - Adult	40	30	21	38	23	41	20	28	33	42	24	28	41	34
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	15.0%	8.0%	15.0%	6.0%	16.0%	5.0%	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%
Average Length of Stay - Older Adults	90	79	41	71	61	56	64	51	48	57	75	59	41	81
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	30.0%	5.0%	14.0%	17.0%	22.0%	21.0%	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%
Emergency Readmissions rate (30 days)	<7.5%	2.1%	3.5%	2.0%	2.7%	1.4%	1.4%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%
Clinically Ready for Discharge (CRFD)	No Target	19	19	20	22	13	10	15	10	9	14	5	11	20
Care Plan Compliance	95%	95.7%	96.2%	96.1%	96.2%	96.1%	96.2%	96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%
Risk Assessment Compliance	95%	92.6%	92.9%	93.5%	94.0%	92.7%	94.1%	94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%
Comprehensive Safety Review	No Target	2	2	0	4	3	5	1	5	4	2	3	2	5
Proportionate Reviews	No Target	2	4	3	4	3	2	3	2	4	3	5	2	7
Complaints Open Beyond Agreed Timescale	0	11	11	8	1	0	1	3	2	1	5	4	3	2
Friends and Family Test-Recommended	80%	80.0%	80.0%	78.0%	75.0%	89.0%	83.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%
Safe Staffing	95%-105%	97.9%	96.9%	95.8%	99.7%	104.6%	98.3%	100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%
Vacancy Rate	<10%	11.0%	10.8%	11.3%	11.1%	9.8%	7.9%	8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%
Staff Turnover	<10%	11.6%	11.5%	11.0%	10.6%	10.2%	10.2%	10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%
Sickness Absence	<4.95%	5.5%	5.4%	5.6%	5.6%	5.6%	5.7%	5.8%	6.0%	6.1%	6.2%	6.4%	6.4%	6.3%
Clinical Supervision	85%	85.0%	85.0%	81.0%	83.0%	83.0%	85.0%	82.0%	79.0%	85.0%	82.0%	79.0%	81.0%	83.0%
Appraisal	85%	91.0%	91.0%	88.0%	87.0%	87.0%	87.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	84.0%
Statutory and Mandatory Training	85%	89.0%	89.0%	89.0%	88.0%	88.0%	87.0%	87.0%	89.0%	89.0%	89.0%	91.0%	91.0%	91.0%

In M02 there are 34 metrics monitored; 16 have achieved the required standard (see SPC Trend achieved in month) and 10 have not achieved the required standard (see SPC Trend exceptions in month). 5 metrics have no target and are being monitored. 2 metrics are not applicable as they are reported quarterly. 1 metric is provided by NHS England with the current month not yet published.
Safer staffing RAG rated values have aligned retrospectively to the thresholds agreed in M01.

Performance Improvement Plans (PIPs)

Performance Improvements Plans (PIPs) may be put in place for those national and contractual measures that have not met the target. In addition, they may be required for those measures showing a special cause variation indicating concern.

The PIPs are monitored monthly through Performance Review meetings until the standard has been achieved for three consecutive months or otherwise agreed. This will ensure that the actions outlined by the Associate Directors are embedded and performance levels are sustained.

PIPs currently in place:

Metric	Directorate	Status
Referral to Assessment within 4 weeks	**Specialist Services**	The Specialist Directorate voluntarily implemented a PIP in M06 (2024/25) for 4-week referral to assessment as performance has been below the required standard since April 2024. Revised trajectories and actions were received in February 2025, and the aim is for achievement of the 95.0% standard by August 2025. Performance is 77.8% during M02 which is not meeting the 90.0% trajectory or 95.0% required standard. *Updated actions have been received for M02*.
	Community-CYP	A PIP was requested in M01 (2024/25). Community directorate aimed for achievement of the 95% standard by January 2025. This has been extended to March 2025, and has since been revised to July 2025 and September 2025. Trajectories were set in April 2024 and have been revised in May 2025 for the period covering May to September 2025. CYP performance is 79.4% during M02 which is meeting the 70.0% trajectory but not the 95% required standard. *Updated actions have been received for M02.*
	Community-Adult	A PIP was requested in M01 (2024/25). Community Directorate aimed for achievement of the 95% standard by March 2024, this was revised to October 2024, March 2025, May 2025, and August 2025. The trajectories set in January 2025 have been revised in May, with performance to be achieved by August 2025. Adult performance is 92.1% during M02 which is meeting the 92% trajectory but not the 95% required standard. *Updated actions have been received for M02.*
Risk Assessment	**Community**	A PIP was requested in M01 (2024/25). Community Directorate aims for achievement of the 95% standard by April 2025. Trajectories were set in April 2024. During M10 the trajectory was removed as a full review was to be undertaken and a revised trajectory set for achievement in April 2025. Performance is 96.2% which has met the required standard for the third consecutive month. *Updated actions have been received for M02. Performance has been consecutively met during the last three months, and the PIP is to be closed.*

Metric	Directorate	Status
Sickness Absence (In-month)	**Acute & Urgent Care**	A PIP was requested in M05 (2024/25), and actions were provided in M07. The trajectories were set in November 2024 and revised in January and March 2025 to return the sickness absence rate to the 4-year average position of 6.9% by end of March 2026, which exceeds the <4.95% required standard. Sickness absence 12-month rolling period during M02 is 8.1% and 6.4% in-month. The in-month trajectory of 7.8% in M02 is being met. The 6.9% 4-year average is being met. The in-month <4.95% target is not being met. The 12-month required standard is not being met. *Updated actions have been received for M02.*
	Primary Care	A PIP was requested in M10 (2024/25). The PIP trajectory will be updated in M01 to bring sickness rate back to the 4-year average position of 4.4% which is within the <4.95% required standard. Trajectories have been set in M02 covering the period April 2025 to March 2026. The Primary Care directorate aims for the standard to be met in December 2025. Sickness absence 12-month rolling period during M02 is 7.0% and 5.4% in-month. The in-month trajectory of 3.8% in M02 is not being met. The 4.3% 4-year average is not being met. The in-month <4.95% target is not being met. The 12-month required standard is not being met. *Updated actions have been received for M02.*
	Community	A PIP was issued in M12 (2024/25). Trajectories were set in March 2025. The current PIP trajectory aims for performance to be at 4.9% by August 2025. Sickness absence 12-month rolling period during M02 is 5.7% and 4.5% in month. The in-month trajectory of 5.2% in M02 is being met. The 3.9% 4-year average is not being met. The in-month <4.95% target is being met. The 12-month required standard is not being met. *Updated actions have been received for M02.*
	Specialist Services	A PIP was requested in M03 (2024/25). The trajectories were set in February 2025 to return the sickness absence rate to the 4-year average position of 5.97% by end of March 2026, which exceeds the <4.95% required standard. Sickness absence 12-month rolling period during M02 is 7.2% and 7.0% in-month. The in-month trajectory of 7.1% for M02 is being met. The 6.0% 4-year average is not being met. The in-month <4.95% target is not being met. The 12-month required standard is not being met. *Updated actions have been received for M02.*
Complaints	**Nursing & Quality**	A PIP was requested in M05 (2024/25) and then reissued in M09 for review and refresh of the actions and trajectory. A trajectory aimed for the standard to be met by September 2024, this was extended to April 2025 and then to July 2025. During M02 there are two complaints exceeding the 40-day response timescale. Performance is meeting the required trajectory but is below the required standard. *Updated actions have been received in M02.*

Metric	Directorate	Status
Friends and Family Test	**Nursing & Quality**	A PIP has been issued in M10 (2024/25). A target rate of 80.0% for recommended rate has been agreed in M02 2025/26. Trajectories have been set in May 2025, covering the period February to July 2025. Performance for the recommended rate during M02 is 72.0%. *Updated actions and trajectory have been received in M02.*
Statutory and Mandatory Training	**Medical and Clinical Effectiveness (MACE)**	A PIP was requested in M01 (2024/25). MACE aims for achievement of the 85% standard by January 2025, extended to May 2025. • Resident Doctors I performance is 76.0% during M02 and is not meeting the required 85.0% standard or planned trajectory. • Resident Doctors II performance is 91.0% during M02 and is meeting the required 85.0% standard for the third consecutive month. *Updated actions have not been received in M02.*
Clinical Supervision	**Community**	A PIP was issued in M10 (2024/25). Community Directorate aims to achieve the 85.0% standard by May 2025. Trajectories were set in February 2025. Performance during M02 is at 87.0% and has met the 85.0% planned trajectory and required standard. *Updated actions have been received for M02.*
	Acute & Urgent Care	A PIP was issued in M12 (2024/25). Trajectories were set in March 2025. Acute and Urgent Care Directorate aims to achieve the 85.0% standard by May 2025. Performance during M02 is 80.0% and the planned 85.0% trajectory and required standard has not been met. *Updated actions have been received for M02.*
Care Plan Compliance	**Specialist**	A PIP was issued in M01 (2025/26). Performance in M02 is at 90.0% and is not meeting the required standard. Trajectories will be set in M03 as there is work underway to ensure that the new personalised care plan documents are being recorded in the correct way to pull through in the reporting. *Updated actions have been received for M02.*

Change Control

As set out in the Performance Management Framework, the IQPR Change Control Process is formalised through a quarterly review of the metrics targets and measure definitions reported to the Board. The review and changes for the 2025/26 IQPR were approved by SLT on 27 May 2025 and are set out below:

To be reported from M02:

Friends and Family Test – *Actual response numbers to be provided* - *Completed*

Safer staffing – *Actual reported with thresholds 95.0% - 105.0%* - *Completed*

New metrics

- **Actual WTE in post v Workforce Plan** - *Completed*
- **YTD CIP achievement against the YTD CIP plan** - *Completed*
- **40% agency reduction from the 2024/25 M8 forecast outturn position** - *Completed*
- **10% bank reduction from the 2024/25 M8 forecast outturn position** - *Completed*
- **Primary Care - Reduction in GP DNA rates** - *target 5.0%* - *Ongoing as data is not readily available*

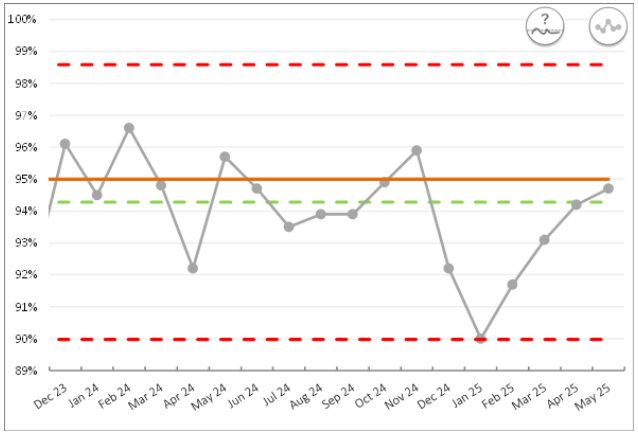
To be reported from Quarter 2:

Reporting of 2025/26 plan vs actual activity

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

Referral to Assessment within 4 weeks (Trust indicator)



12 Month Trend

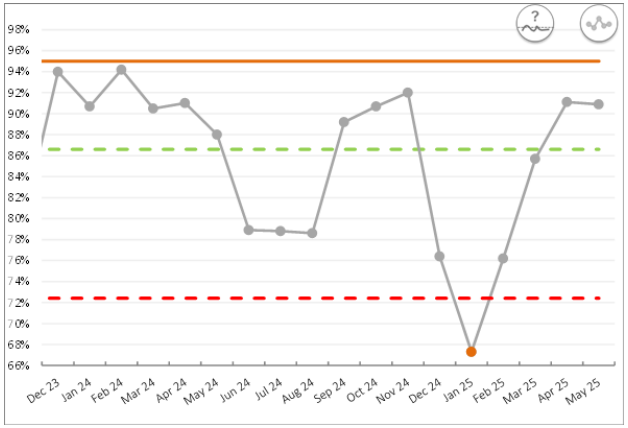
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
94.7%	93.5%	93.9%	93.9%	94.9%	95.9%	92.2%	90.0%	91.7%	93.1%	94.2%	94.7%

Performance is at **94.7%** in M02. The variation is showing common cause.

Current Performance: Community-90.4%, Specialist-77.8%, ACUC-97.7%.

A PIP is in place for Specialist Services and Community directorates.

CAMHS Compliance within 4 weeks Waits (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
78.9%	78.8%	78.6%	89.2%	90.7%	92.0%	76.4%	67.3%	76.2%	85.7%	91.1%	90.9%

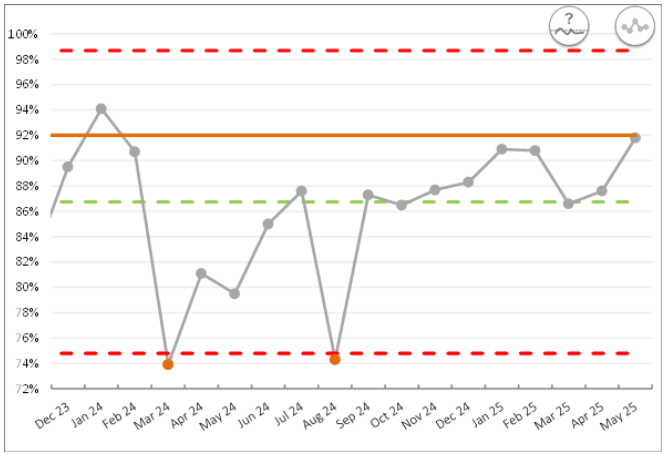
Performance is at **90.9%** in M02. The variation is common cause.

A PIP is in place for Community directorate.

Current performance: Community-79.4%, Specialist-N/A, ACUC-96.1%.

Fortnightly meetings established with Performance team and core CAMHS teams to support waiting time management.

CAMHS Compliance within 18 week Waits Referral to Treatment (Trust indicator)



12 Month Trend

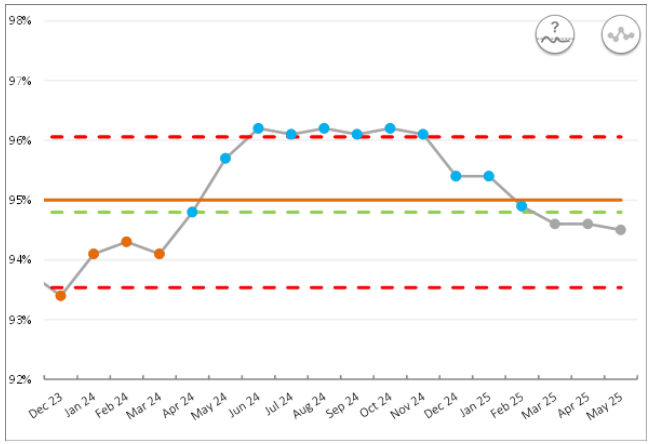
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
85.0%	87.6%	74.3%	87.3%	86.5%	87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%

Performance is at **91.8%** in M02. The variation is common cause.

Current performance: Community 94.1%, Specialist-N/A, ACUC-76.9%.

COMMUNITY AND QUALITY

Care Plan Compliance (Trust indicator)



12 Month Trend

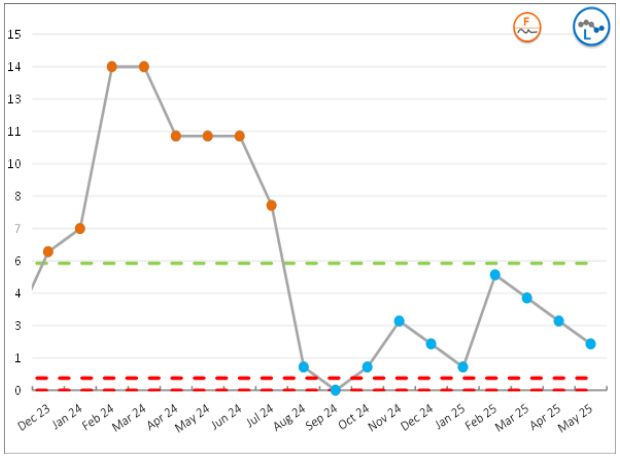
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
96.2%	96.1%	96.2%	96.1%	96.2%	96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%

Performance is at **94.5%** in M02. The variation is common cause.

A PIP is in place for Specialist Services directorate.

ORGANISATIONAL HEALTH AND WORKFORCE

Complaints (Trust indicator)



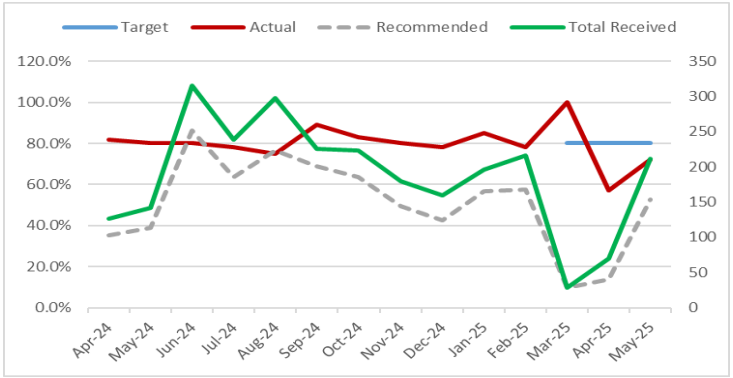
12 Month Trend

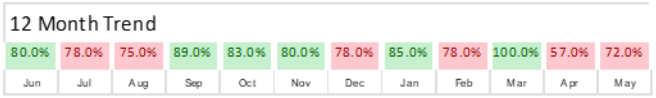
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
11	8	1	0	1	3	2	1	5	4	3	2

There are **two** complaints exceeding the 40-day response timescale. The variation is showing as a special cause of improvement. A PIP remains in place for Nursing and Quality.

- One complaint relates to the Community directorate and is complete but on hold due to consent issues.
- One relates to the Specialist directorate and a meeting is being arranged to try to resolve the complexities through mediation, RO continues to progress complaint.

Friends and Family Test – Recommended (National indicator)





Performance during M02 is **72.0%**. (154/212 people rated their experience of our services as being very good and good). The variation is showing as common cause. Performance for the recommended rate during M02 is 72.0%.

A target rate of 80% for recommended rate has been agreed in M01 2025/26.

A PIP is in place for Nursing and Quality.

There are several mechanisms to collect FFT feedback to ensure accessibility and inclusion:
Indirect contact made by the Trust/ voluntary methods:

- FFT Cards
- Trust website
- Posters displaying a QR code in clinical areas

Direct contact made by the Trust:

- A text message is sent to all Patients who have been discharged from Trust community and inpatient services. Additionally, our GP surgeries send 50 text messages randomly per week to patients that have booked an appointment using there ACCURX system.

What changed:

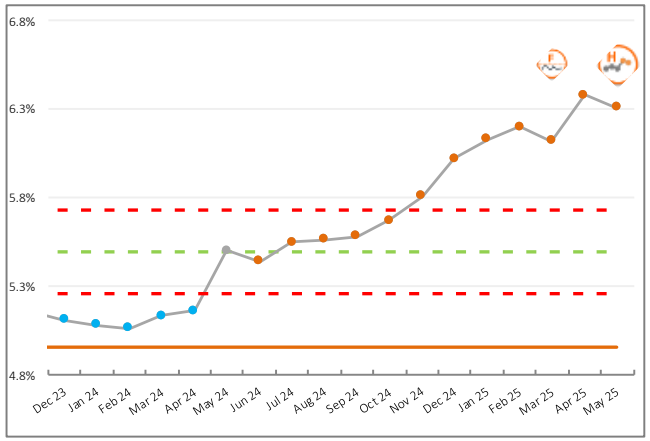
- Crisis care centre and CAMHS services are now included in all above process for collection of FFT
- Moved from Smart survey text messaging service to GOV.UK Notify - reduced costs
- We include any discharge from inpatient services within the text messages sent
- Text messages are sent once every week and are sent to anyone that has been discharged from our services in the last 7 days (excluding GP surgeries).

The main themes identified from the feedback for 'neither good nor poor/poor and very poor' that have affected the overall rating are:

Communication	No contact, unclear communication
Access	Inaccessible appointment systems, long waits
Discharge	Sudden or unexplained discharges
Mental Health	Poorly supported in crisis
Staff Attitude	Some staff described as rude or dismissive
Care Quality	Incomplete treatment, miscommunication of diagnosis, misinformation in records

Each Directorate has received their detailed FFT feedback and actions will be monitored through the monthly QILN/Patient Experience Team Interface meeting.

Sickness Absence (Trust indicator)



12 Month Trend											
5.44%	5.55%	5.56%	5.58%	5.67%	5.81%	6.02%	6.13%	6.20%	6.12%	6.38%	6.31%
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Sickness absence performance is at **6.3%** in M02. A special cause variation of concern remains in place as performance is operating outside of the upper control limit.

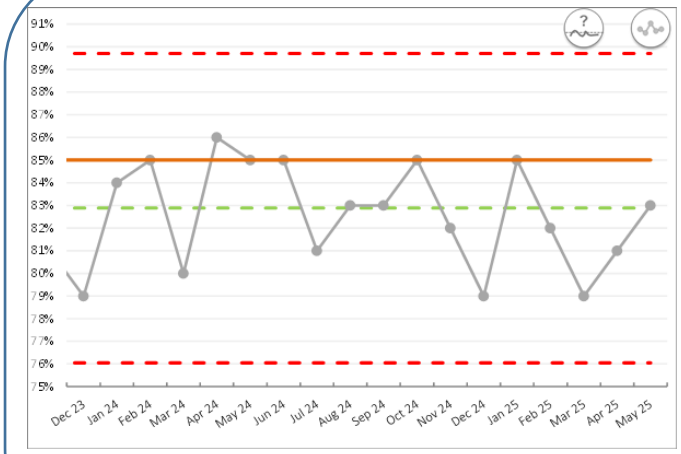
Current performance: Community-5.7%, Specialist-7.2%, ACUC-8.1%, Primary Care-7.0%, Corporate-3.6%.

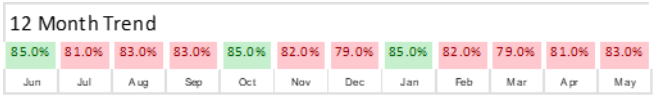
There has been a slight decrease in sickness over the period, work continues with directorates to ensure that staff are supported back to work in a timely manner with a return to work in place.

Additional training is being provided to managers on how to conduct Return to Work (RTW) and a specific session was held with consultant doctors on how to conduct RTW and Stage 1 sickness reviews. Feedback has been positive from the sickness surgeries and directorate leads are now ensuring service managers undertake reviews and provide feedback to them on open sickness cases.

PIPs remain in place in all directorates.

Clinical Supervision (Trust indicator)





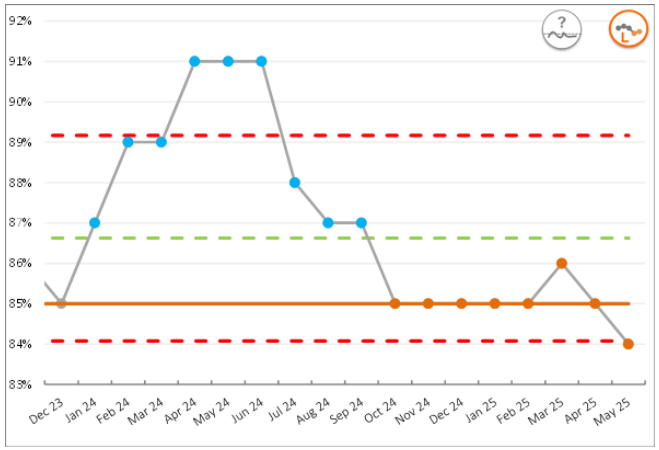
Performance is at **83.0%** in M02. The variation is showing a common cause.

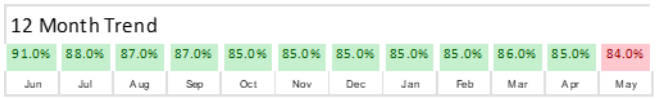
Current performance: Community-87.0%, Specialist-84.0%, ACUC-80.0%, Primary Care-80.0%, Corporate-27.0%.

A PIP is in place for Acute and Urgent Care and Community.

Reports identifying non-compliance rates, names of those non-compliant and their line managers are sent to the Associate Directors and line managers fortnightly for action. New Supervision Policy approved. LMS module currently under review to align with new policy. Survey in development to ascertain any issues and improve ease of recording method. Screensaver agreed to highlight Supervision needs and recording.

Appraisal (Trust indicator)





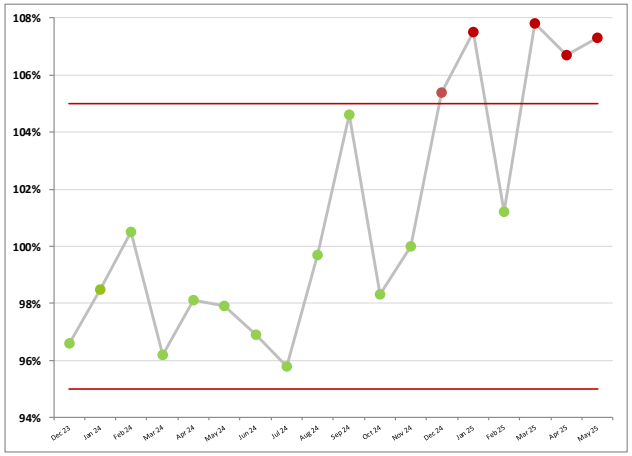
Performance is at **84.0%** in M02. The variation is showing a special cause variation of concern, as performance is operating below the lower control limit.

Current performance: Community-86.0%, Specialist-84.0%, ACUC-83.0%, Primary Care-83.0%, Corporate-81.0%.

A PIP is in place for Acute and Urgent Care and Community.

Reports identifying non-compliance rates, names of those non-compliant and their line managers are sent to the Associate Directors and line managers fortnightly for action. Clinical Supervision Policy is currently being reviewed by the Nursing Directorate. LMS module currently under review to ascertain any issues and ease of recording method.

Safe Staffing (National indicator)



12 Month Trend

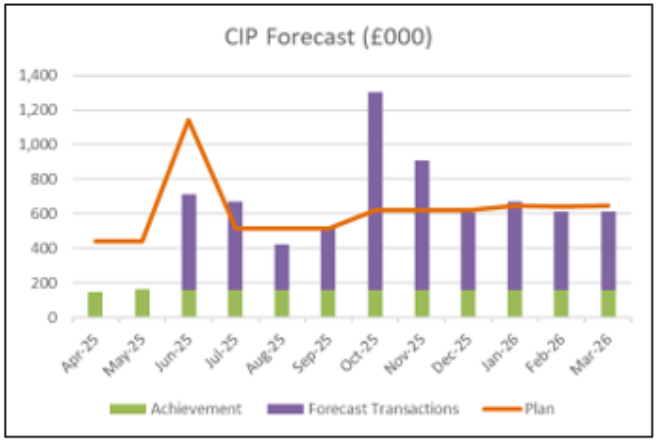
Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
96.9%	95.8%	99.7%	104.6%	98.3%	100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%

Performance is at **107.3%** in M02. The overall safer staffing fill rate was above the Trust's locally set threshold of 95.0% - 105.0% and was breached in 6 inpatient areas.

The Darwin Centre was marginally below the threshold with an overall fill rate of 94.9%. The remaining five areas had a fill rate over the 105.0% threshold.

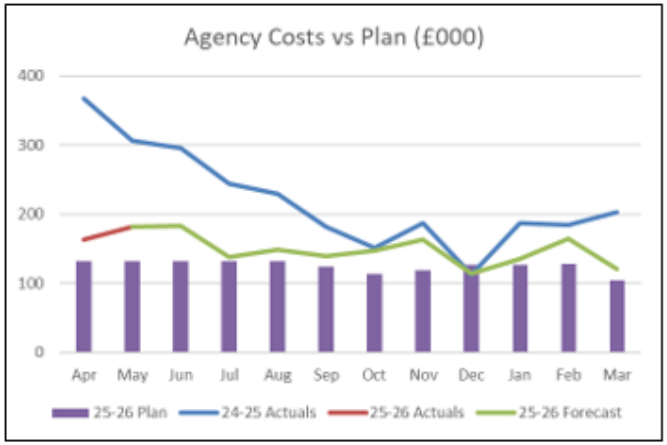
Financial Performance

CIP Delivery v Plan



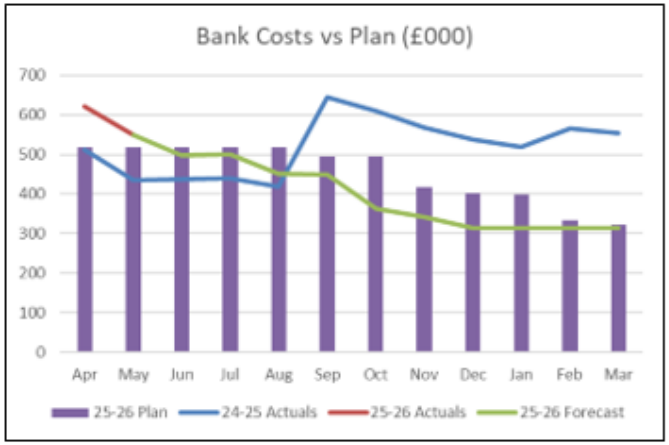
- The CIP graph above shows CIP forecast against a £7.4m plan.
- The Trust is forecasting full achievement of the plan, with current achievement (transacted) £1.9m, £0.5m fully developed, £4.1m plans in progress and £0.9m opportunities identified.

Agency Cost v Plan (40% reduction)



- The agency graph above shows forecast against £1.5m plan.
- The Trust is forecasting total agency costs of £1.8m, with £1.2m Community, £0.4m Specialist and £0.2m Primary Care.

Bank Cost v Plan (10% reduction)



- The bank graph above shows forecast against a £5.4m plan.
- The Trust is forecasting total bank costs of £5.0m, with £2.7m Acute, £1.6m Specialist, £0.5m Community and £0.2m Corporate.

Workforce Actual vs Plan

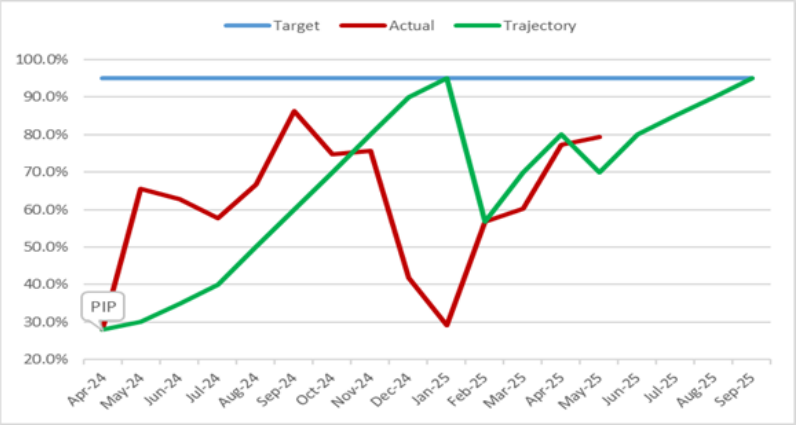
May-25	Plan	Actual	Variance From Plan			YTD Change	
	WTE	WTE	WTE	%	Supporting Information for variance to plan	WTE	%
Total	**1,837.5**	**1,850.4**	**12.9**	**+0.7%**	(WTE and details of additional business cases, non-delivery of CIPs etc)	**+31**	**+1.7%**
Substantive	**1,718.4**	**1,724.1**	**5.7**	**+0.3%**	84.92 WTE has not been included in the data set as this relates to services	**+15**	**+0.9%**
Medical and Dental	53.9	53.4	-0.5	**-0.9%**	not included within our 2025-26 workforce plan	-0	-0.9%
Registered nursing, midwifery and health visiting staff	525.5	534.9	9.4	**+1.8%**		+13	+2.5%
Registered scientific, therapeutic and technical staff	301.3	289.8	-11.5	**-3.8%**	Holmcroft Surgery	-3	-1.0%
Support to clinical staff	478.0	497.4	19.4	**+4.1%**	Keele Practise	+16	+3.3%
Total NHS infrastructure support	356.3	345.2	-11.1	**-3.1%**	Moorcroft Surgery	-11	-3.0%
Any other staff	3.4	3.4	0.0	**0.0%**	GP & FY Resident Doctors	0	0.0%
Bank	**109.1**	**110.7**	**1.6**	**+1.5%**		**+8**	**+8.3%**
Medical and Dental	5.0	4.8	-0.2	**-4.8%**		+0	+10.1%
Registered nursing, midwifery and health visiting staff	24.0	22.5	-1.5	**-6.4%**		-2	-6.4%
Registered scientific, therapeutic and technical staff	1.3	3.1	1.8	**+144.7%**		-0	-7.8%
Support to clinical staff	75.5	78.1	2.6	**+3.4%**		+12	+17.4%
Total NHS infrastructure support	3.3	2.3	-1.0	**-31.5%**		-2	-43.6%
Any other staff	0.0	0.0	0.0			0	
Agency	**10.0**	**15.5**	**5.5**	**+55.7%**		**+7**	**+89.1%**
Medical and Dental	6.6	6.6	0.0	**0.0%**		0	0.0%
Registered nursing, midwifery and health visiting staff	3.0	4.8	1.8	**+61.4%**		+4	+290.5%
Registered scientific, therapeutic and technical staff	0.0	0.9	0.9			+1	
Support to clinical staff	0.3	3.2	2.8	**+885.6%**		+3	+885.6%
Total NHS infrastructure support	0.0	0.0	0.0			0	
Any other staff	0.0	0.0	0.0			0	
Vacancies		**156.3**					
Medical and Dental		14.9					
Registered nursing, midwifery and health visiting staff		59.4					
Registered scientific, therapeutic and technical staff		35.6					
Support to clinical staff		20.7					
Total NHS infrastructure support		24.6					
Any other staff		1.1					

Staff Group	Primary reason	WTE
HCSW	High Acuity	2.49
	Establishment Shortfall	0.53
	Vacancies	0.14
HCSW Total		**3.15**
Nursing (Mental Health)	High Acuity	1.69
	Vacancies	1.50
	Establishment Shortfall	1.49
	Bank Training	0.10
	Redeployed	0.06
Registered Nursing Total		**4.84**
Grand Total		**8.00**

Performance Improvement Plans (PIPs)

Performance Improvement Plan: Referral to Assessment within 4 weeks – CYP (Trust indicator)

Community Directorate PIP



A PIP was requested in M01 (2024/25). Community directorate aimed for achievement of the 95% standard by January 2025, this had been extended to March 2025 and has since been revised to July 2025 and September 2025. Trajectories were set in April 2024 and have been revised in May 2025 for the period covering May to September 2025.

CYP performance is **79.4%** during M02 which is meeting the 70.0% trajectory but not the 95.0% required standard. *Updated actions have been received for M02.*

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	65.5%	62.7%	57.6%	66.7%	86.3%	74.7%	75.6%	41.8%	29.2%	56.8%	60.2%	77.2%	79.4%
Trajectory	30.0%	35.0%	40.0%	50.0%	60.0%	70.0%	80.0%	90.0%	95.0%	56.8%	70.0%	80.0%	70.0%

The above table RAG rating measures actual performance against Trust target

Actions:

- All teams to mirror North Staffs working by completing more ADHD digital contacts resulting in a 50% increase in number of ADHD triage capacity by completing via telephone rather than face-face (September 2025).
- Transfer all ADHD referrals to Neurodevelopmental Service Line to a stand-alone team to enable effective caseload management for CORE CAMHS and clear distinguished reporting to understand demand for Core CAMHS (September 2025). **19/05/25 Progress update:** *All referrals are on Lorenzo for ADH ready to move over to the Neurodevelopmental Service Line.*
- Pro-active and timely recruitment **19/05/25 Progress update:** *All vacant posts progressing through TRAC and recruitment processes.*
- Reduction in absence rates impacting on ability to meet demand. **19/05/25 Progress update:** *Service line in month sickness rate 3.45% a reduction from 5.61%.*
- Review of assessment and treatment pathways, Increase assessment and caseload capacity through timely throughput and effective discharge planning. **19/05/25 Progress update:** *Five clinical pathways now developed and plan in place to deliver awareness sessions to all staff by May 2025 Standard Assessment Framework (SAF) model has been agreed and will be six sessions prior to moving to the appropriate clinical treatment pathway. Materials for the SAF sessions in development to align with the getting help/more help of the Thrive model. Pilot to be reviewed in June 2025.*

New action M01

- Contacts to be recorded on Lorenzo in a timely manner. **19/05/25 Progress update:** *Teams leads to scrutinise weekly unset appointment data and taking appropriate action. Report is then sent to service manager to review.*

Risk Description:

- There is a risk of the Community CAMHS Team not achieving the 4 WW due to increased demand against current capacity because of this there will be increased waiting times. There is a risk that achieving the 4WW will impact on 18WW.
- There is a risk of Community CAMHS not achieving the 4WW due to the demand for Tier 2 referrals and lack of resource to meet this demand. Because of this it will increase the workload for Core CAMHS practitioners and increase waiting times.

Mitigation:

- Proactive recruitment. Strengthen partnership and MDT working with Tier 2 providers. Regular supervision and staff support. Weekly scrutiny of 4WW performance by team leads. Monthly performance clinics with AD and Team leads. Review of pathways.
- Contract mobilisation meeting is now in place that include discussions to increase capacity to triage referrals. Changes practitioners now involved in the triage MDT to ensure a timelier response and logging of contacts to referrals.

Performance Improvement Plan: Supporting Information - Waiting and Waited Times CYP

Community Directorate PIP

Apr-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	386	62	2	0	450	85.8%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	33	0	0	0	33	100.0%
North Stoke CAMHS	24	4	1	0	29	82.8%
South Stoke CAMHS	4	13	0	0	17	23.5%
CAMHS Total	**61**	**17**	**1**	**0**	**79**	**77.2%**

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	9	0	0	1	10	90.0%
North Stoke CAMHS	23	1	0	0	24	95.8%
South Stoke CAMHS	14	24	3	1	42	33.3%
CAMHS Total	**46**	**25**	**3**	**2**	**76**	**60.5%**

May-25

RTA Waited

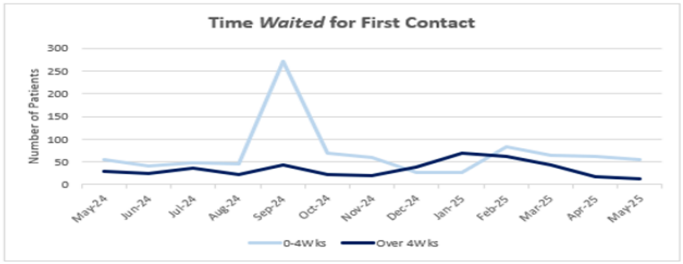
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	403	38	5	0	446	90.4%

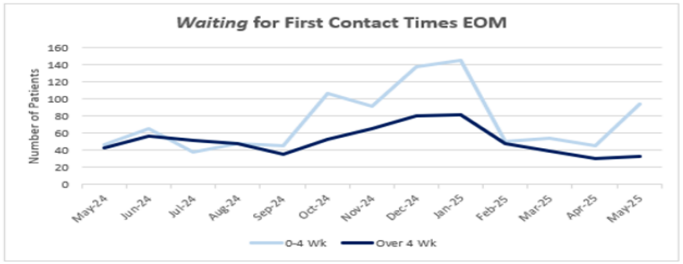
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	21	2	0	0	23	91.3%
North Stoke CAMHS	16	1	0	0	17	94.1%
South Stoke CAMHS	17	11	0	0	28	60.7%
CAMHS Total	**54**	**14**	**0**	**0**	**68**	**79.4%**

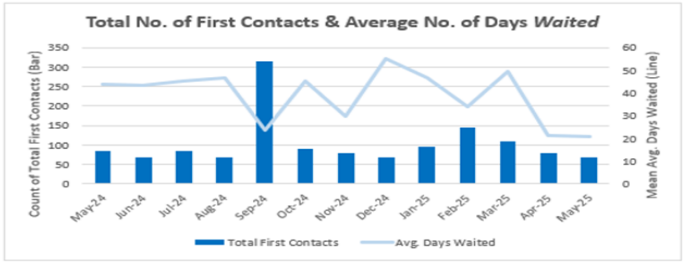
RTA Waiting

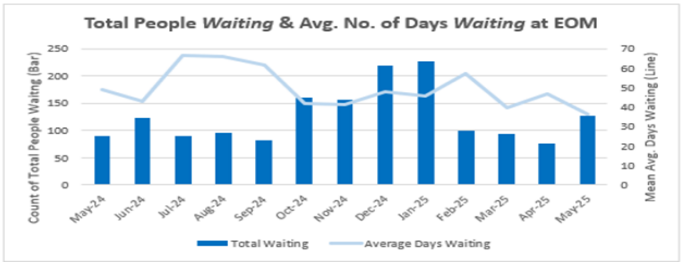
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	19	0	0	0	19	100.0%
North Stoke CAMHS	73	8	2	1	84	86.9%
South Stoke CAMHS	2	17	5	0	24	8.3%
CAMHS Total	**94**	**25**	**7**	**1**	**127**	**74.0%**

- The Community directorate has seen a significant improvement of 4.6% in RTA performance when comparing M01 to M02.
- The directorate are however underperforming against a target of 95% by 4.6%.



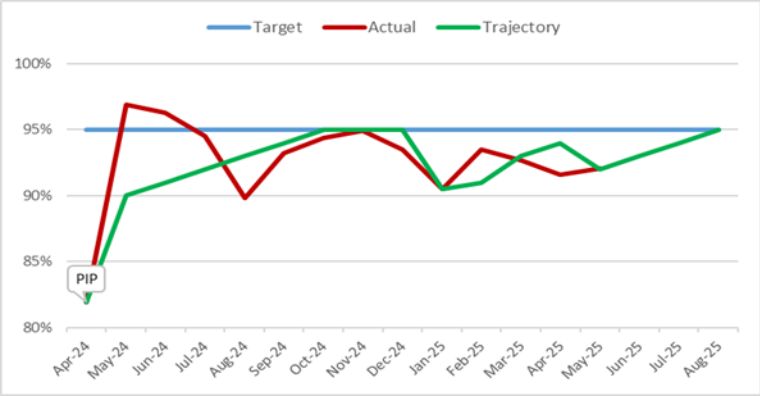






Performance Improvement Plan: Referral to Assessment within 4 weeks – Adult CMHTs (Trust indicator)

Community Directorate PIP



A PIP was requested in M01 (2024/25). Community Directorate aimed for achievement of the 95.0% standard by March 2024, this was revised to October 2024, March 2025, May 2025 and August 2025. The trajectories set in January 2025 have been revised in May, until August 2025. To note the original trajectory for May 2025 was 95.0%, this has been amended to 92.0%.

Adult performance is **92.1%** during M02 which is meeting the 92.0% trajectory but not the 95.0% required standard. *Updated actions have been received for M02*.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	96.9%	96.3%	94.5%	89.8%	93.2%	94.4%	94.9%	93.5%	90.5%	93.5%	92.7%	91.6%	92.1%
Trajectory	90.0%	91.0%	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%	90.5%	91.0%	93.0%	94.0%	92.0%

The above table RAG rating measures actual performance against Trust target

Actions:

New actions M01

- Review of adherence to the triage and IA pathway at Sutherland Centre (July 2025). **19/05/25 Progress update:** d*eep dive completed into the referral process, and service users are being transferred for a SAF without an initial assessment so not having the second contact with the team. Discussed with team and changes to be made to how they are triaging referrals.*
- Effective management of absences. **19/05/25 Progress update:** *Service line in month sickness rate 5.23% slightly reduced from 5.25%.*
- Offer additional hours paid or Toil (using vacancy underspend) to support initial assessments and triage before 9am and after 5pm. (Ongoing). **19/05/25 Progress update:** o*ffer remains ongoing.*
- Review current team structures and manage resources across all CMHT's. **19/05/25 Progress update:** c*ontinually under review with demand and resources allocated appropriately to improve waits. Lymebrook and Ashcombe to provide additional capacity to Sutherland Centre to support with increased IA demand.*
- Pro-active and timely recruitment. **19/05/25 Progress update**: *All vacant posts progressing through TRAC and recruitment processes. Overall Directorate recruitment KPI is 57.5 days against the target of 60 days or less. Lymebrook are recruiting to a fixed term B6 MHP to support with demand for assessment.*
- Effective review of data. **19/05/25 Progress update:** w*eekly review of data of 4WW breaches and those approaching a 4WW by team leads and service manager. Deep dive into current breeches of 4WW, for Greenfields and Ashcombe these are attributed to those who have previously been on the ADHD pathway. Impact of sickness at Sutherland Centre on number of initial assessments that are being offered. TL to review how initial assessments are allocated and increase capacity.*
- Sutherland Centre to have a dedicated Initial Assessment Day on 17th April to reduce the backlog. **19/05/25 Progress update:** complete*.*

Risk Description:

There is a risk of CMHT's not achieving the 4 WW due to staffing shortfalls and increased demand against current capacity because of this there will be increased waiting times.

Mitigation:

- Proactive recruitment. Strengthen partnership and MDT working. Regular supervision and staff support. Weekly scrutiny of 4WW performance by team leads. Monthly performance clinics with AD, SM and Team leads.

Performance Improvement Plan: Supporting Information - Waiting and Waited Times – Adult CMHTs

Community Directorate PIP

Apr-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	386	62	2	0	450	85.8%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	65	0	0	0	65	100.0%
City CMHT - Sutherland	6	13	0	0	19	31.6%
County CMHT Moorlands	20	0	0	0	20	100.0%
County CMHT Newcastle	62	1	0	0	63	98.4%
CMHT Total	**153**	**14**	**0**	**0**	**167**	**91.6%**

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	4	0	0	0	4	100.0%
City CMHT - Sutherland	20	14	0	0	34	58.8%
County CMHT Moorlands	1	0	0	0	1	100.0%
County CMHT Newcastle	1	3	0	0	4	25.0%
CMHT Total	**26**	**17**	**0**	**0**	**43**	**60.5%**

May-25

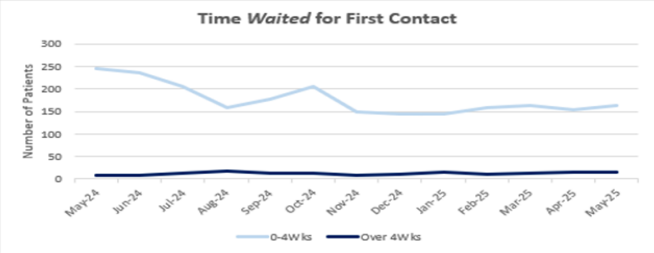
RTA Waited

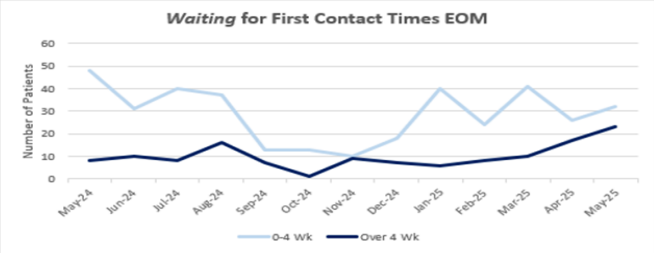
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	403	38	5	0	446	90.4%

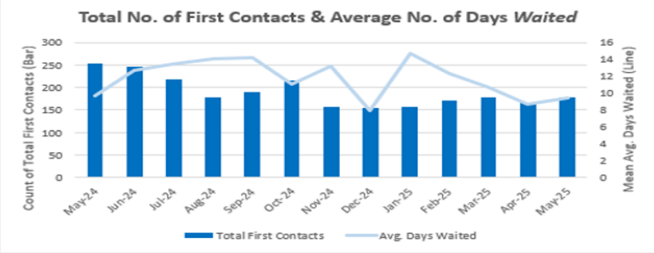
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	85	1	1	0	87	97.7%
City CMHT - Sutherland	7	10	0	0	17	41.2%
County CMHT Moorlands	24	1	1	0	26	92.3%
County CMHT Newcastle	48	0	0	0	48	100.0%
CMHT Total	**164**	**12**	**2**	**0**	**178**	**92.1%**

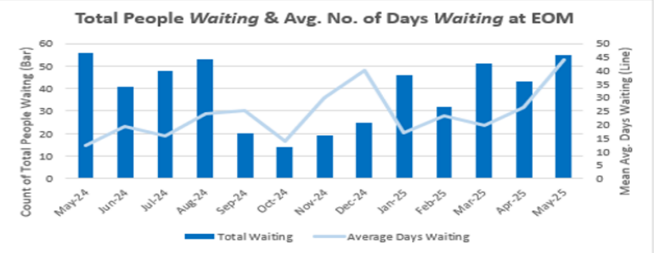
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	1	0	0	0	1	100.0%
City CMHT - Sutherland	30	15	2	1	48	62.5%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	1	4	1	0	6	16.7%
CMHT Total	**32**	**19**	**3**	**1**	**55**	**58.2%**





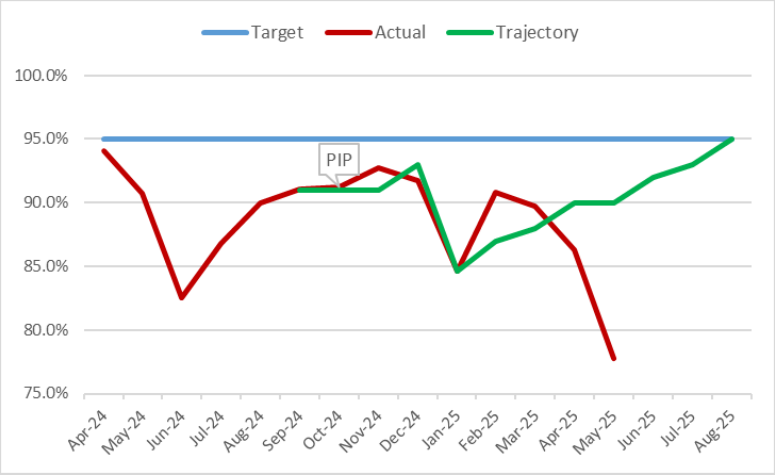




- Adult CMHT services are a main driver for the directorates RTA performance, making up 39.9% of the total RTAs completed in M02.
- RTA performance for Adult CMHTs has not met standard in M02, achieving 92.1% against a target of 95%.

Performance Improvement Plan: Referral to Assessment within 4 Weeks (Trust indicator)

Specialist Directorate PIP



The Specialist Directorate has voluntarily implemented a PIP in M06 (2024/25) for 4-week referral to assessment as performance has been below the required standard since April 2024. Revised trajectories and actions were received in February 2025, and the aim is for achievement of the 95.0% standard by August 2025.

Performance is at **77.8%** during M02 which is not meeting the 90.0% trajectory nor the required 95.0% standard.

Updated actions have been received for M02.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	90.7%	82.5%	86.8%	90.0%	91.1%	91.2%	92.7%	91.7%	84.6%	90.8%	89.7%	86.3%	77.8%
Trajectory					91.0%	91.0%	91.0%	93.0%	84.6%	87.0%	88.0%	90.0%	90.0%

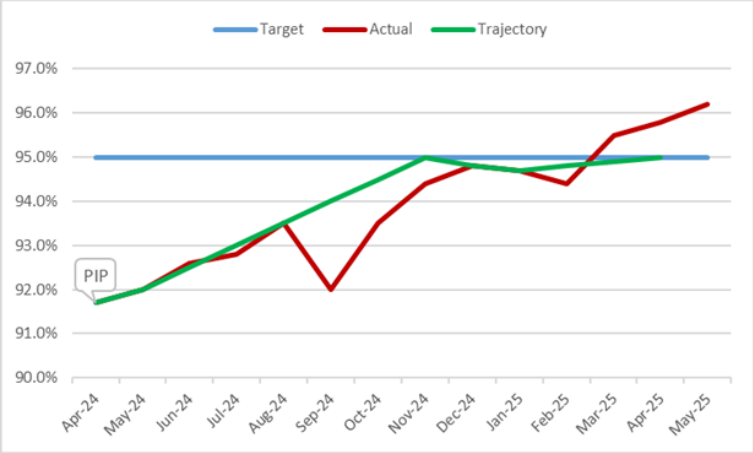
The above table RAG rating measures actual performance against Trust target

Actions M12 2024/25:

- Staff reminded of the importance to record timely and accurate information. Support and training offered to colleagues. Weekly meetings and reports in place. Performance improving however challenges remain in CYP LD (Ongoing reminders).
- Tuesday meeting held with Team managers using the Trust Current Waiters report to provide live monitoring of any pending breaches **13/06/25 Progress update:** p*erformance clinics to be reintroduced with a focus on prevention rather than explanation. Need to understand the impact of the move to PROMS and new care planning methods is impacting on performance.*
- Reaffirm the guidance within the Trust Access to Services and Waiting Times Policy that for an RTA this will be measure by the presence of and assessment contact-face to face or telephone/ digital (skype) contact. Patients who may breach a face-to-face contact which is always the preference are to receive a telephone contact to comply with wait time directives and a face-to-face contact is to be arranged at the earliest convenience thereafter. **13/06/25 Progress update:** *ongoing discussions around meeting this target including how the move to PROMS will impact this, as this needs to be understood.*
- Review capacity concerns in CYP LD Community Team. There is an amount of backfill money for consultant nurse that can be used to support practitioner hours as the stepped care model and further NMP training has impacted on wait times **13/06/25 Progress update:** *Review and work ongoing.*

Performance Improvement Plan: Risk Assessment (Trust indicator)

Community Directorate PIP



A PIP was requested in M01 (2024/25). Community directorate aims for achievement of the 95.0% standard by April 2025. Trajectories were set in April 2024. During M10 the trajectory was removed as a full review was to be undertaken and a revised trajectory set for achievement in April 2025.

Performance is **96.2%** during M02 which has met the required standard for the third consecutive month.
Updated actions have been received for M02. Performance has been consecutively met during the last three months and the PIP is to be closed.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	92.0%	92.6%	92.8%	93.5%	92.0%	93.5%	94.4%	94.8%	94.7%	94.4%	95.5%	95.8%	96.2%
Trajectory	92.0%	92.5%	93.0%	93.5%	94.0%	94.5%	95.0%	94.8%	94.7%	94.8%	94.9%	95.0%	

The above table RAG rating measures actual performance against Trust target

New Actions M01:
CAMHS

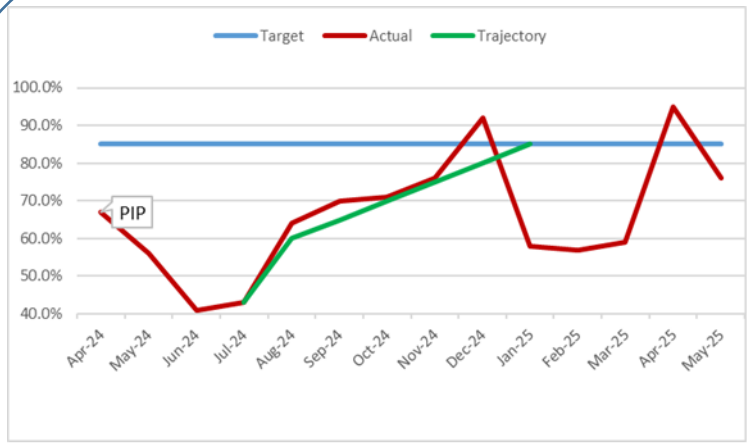
- Increased referral rates across all CAMHS teams. Access pathways for getting help support (Changes) are currently under resourced. Increased demand requires more appointments for initial assessment and Risk Assessment. **19/05/25 Progress update:** *Referral pathway reviewed and amended to incorporate a TAG risk assessment at the point of triage. There are issues with unset appointments that are now being addressed in teams through service line meetings.*

New Actions M02:

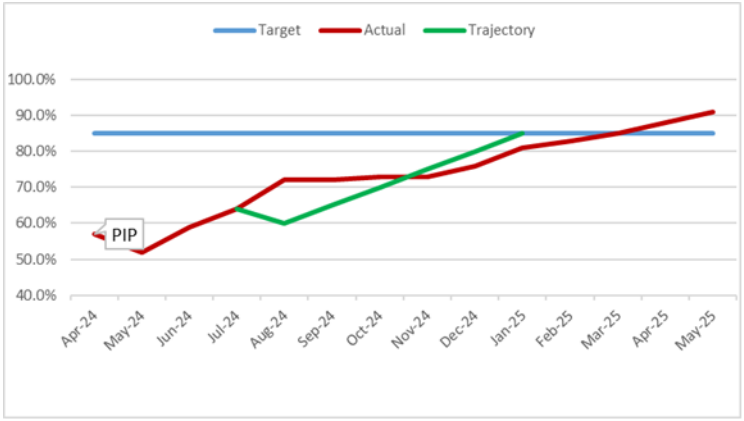
- NOAP County CMHT - Staff member allocated to dedicate a week to review risk assessment compliance and complete. **13/06/25 Progress update:** *This is now business as usual with shared ownership across the teams for the review of RA compliance and completion of risk assessments.*
- Service Line Meetings - have a detailed session on the new DQ master with all team leads with expected ownership of weekly performance data and action planning to improve performance. **13/06/25 Progress update:** *Service line meetings continue to have a focused session on performance to ensure areas are improved and maintained. Emphasis placed on team leads to own performance and KPI's at team level and use the DQ master to inform caseload management.*
- Team lead scrutiny of the weekly DQ report – a team weekly performance report is then created which highlights target area / responsible person / actions taken i.e. direct email to responsible person – discussion in business meeting to highlight need. Team weekly performance report is emailed to all team members with actions and updates included **13/06/25 Progress update** (ongoing).
- Lymebrook - Overtime utilised to update out of date risk assessments. Junior Doctors do not seem to be updating the risk assessments. Team leads to raise this with medical colleagues at the Leadership and Medic catch up and in the next Team Meeting. **13/06/25 Progress update:** *RA compliance now above 95% for the team.*

Performance Improvement Plan: Statutory & Mandatory Training (Trust indicator)

Medical and Clinical Effectiveness PIP



Resident Doctors I	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Actual	56.0%	41.0%	43.0%	64.0%	70.0%	71.0%	76.0%	92.0%	58.0%	57.0%	59.0%	95.0%	76.0%
Trajectory			43.0%	60.0%	65.0%	70.0%	75.0%	80.0%	85.0%				85.0%



Resident Doctors II	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Actual	52.0%	59.0%	64.0%	72.0%	72.0%	73.0%	73.0%	76.0%	81.0%	83.0%	85.0%	88.0%	91.0%
Trajectory			64.0%	60.0%	65.0%	70.0%	75.0%	80.0%	85.0%				85.0%

The above table RAG rating measures actual performance against Trust target

A PIP was issued in M01. The aim is for the 85.0% standard to be met by January 2025; this has been extended to May 2025.

Resident Doctors I performance is **76.0%** during M02, which is not meeting the 85.0% planned trajectory or required 85.0% standard.

Resident Doctors II performance is **91.0%** during M02, which has met the planned trajectory and required standard for the third consecutive month.

Trajectories were set in August 2024. The trajectories extending beyond April 2025 were reset in May 2025 and confirm the expectation for performance to continue to meet the standard for Residents I and II Doctors.

Updated actions have not been received for M02.

Issue:
The Medical Education Lead and the Education Team are actively addressing contributing factors to the non-compliance. There are (3) intakes during the academic year meaning this a particular transient section of the workforce, actions will need to recognise this.

Actions:

- Two dedicated stat/mand training days is scheduled for all new medics joining the Trust to allow completion of their training before they start placements, however it has been recognised that this may not be enough time. Therefore, an additional day will be allocated to medics starting from the next induction in December and will continue thereafter (December 2024 and onwards).
- Supervisors are requested to monitor compliance during their weekly supervision. If non-compliant, supervisors are to allocate additional time for the junior doctors to complete as a priority, with clear timelines for completion. Weekly monitoring and protected time to complete training should improve performance significantly (ongoing).
- Both cohort and individualised reminder emails are sent to trainees to support completion with target times (ongoing).

New actions 11/04/25

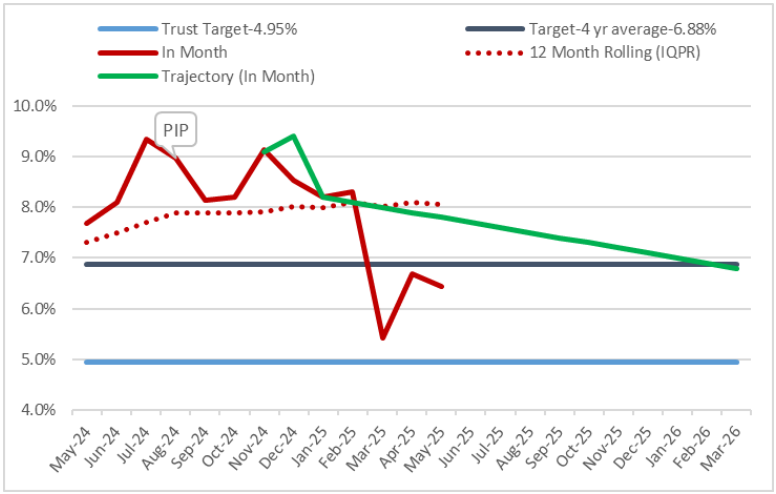
- Medics will receive F2F Conflict Resolution training on their first induction day to the Trust. Dates have been shared with relevant trainers to pre-book and customise the training package for future induction dates (ongoing).
- Individuals will be contacted via email and will be encouraged to complete outstanding training urgently. Supervisors will be made aware and requested to prioritise. (from February 2025).
- Medical Education Lead to request this to be added to the JDF agenda to establish what the issues are, if any, as to why they are unable to complete training (February 2025 – onwards).

New actions 15/05/25

- Trainees that remain non-compliant will be expected to attend the Harplands Hospital during their teaching break in August to have protected time to complete their outstanding training. During holiday periods, there are no CPD teaching sessions. Therefore, medics can use this time during the teaching breaks, to have allocated specific time for compulsory training (April 2025 onwards).
- Liaising with UHNM to ascertain the Resident Doctors training records to enable this to be updated on our LMS system for compliance purposes.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care PIP



A PIP was requested in M05 (2024/25), and actions were provided in M07. The trajectories were set in November 2024 and revised in January and March 2025 to return the sickness absence rate to the 4-year average position of 6.9% by end of March 2026, which exceeds the <4.95% required standard.

Sickness absence 12-month rolling period during M02 is 8.1% and 6.4% in-month. The in-month trajectory of 7.8% in M02 is being met. The 6.9% 4-year average is being met. The in-month <4.95% target is not being met. The 12-month required standard is not being met. *Updated actions have been received for M02.*

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Trust Target-4.95%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Target-4 yr average-6.88%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%
In Month	7.7%	8.1%	9.4%	9.0%	8.1%	8.2%	9.1%	8.5%	8.2%	8.3%	5.4%	6.7%	6.4%
12 Month Rolling (IQPR)	7.3%	7.5%	7.7%	7.9%	7.9%	7.9%	7.9%	8.0%	8.0%	8.1%	8.0%	8.2%	8.1%
Trajectory (In Month)							9.1%	9.4%	8.2%	8.1%	8.0%	7.9%	7.8%

The above table RAG rating measures in-month performance against Trust target

Actions:

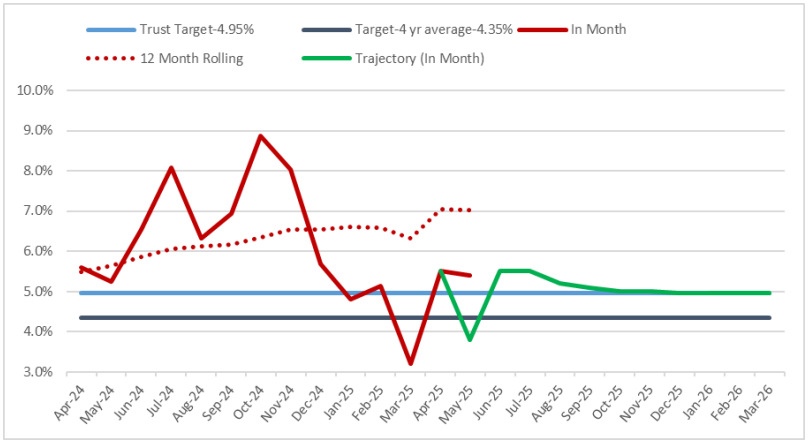
- Workforce clinics within the Directorate held with the Matrons / Service Managers to ensure close monitoring of sickness absence. **Progress update 13/03/25:** *Workforce clinics continue monthly with ongoing robust monitoring of vacancies, turnover and sickness.*
- Lack of data to support Directorate to fully understand the workforce position which limits the detail and scrutiny that is required to inform more appropriate actions to address sickness absence. Continue to promote the Wellbeing opportunities within the Trust; Combined Voices (Choir), Combined Run/Walk Club, Monthly Menopause Group, weekly weight loss group. Devise and implement seasonal and health promotion campaigns to provide education to the workforce and to support health and wellbeing and incorporate targeted messaging i.e. those working nights, in highly complex environments.
- Specific programmes of support in relation to MSK and Psychological support for the workforce, however, requires more detailed data to inform this piece of work. Ensure there is a clear and robust plan in relation to reducing the current vacancy rate ensuring effective recruitment processes are in place and effective workforce planning and retention oversight.

M02 Updates

- In-month sickness has continued to remain below the 6.91 target for 2 consecutive months with M02 at a provisional of 4.5% which is below the Trust target.
- Turnover rate has now been recorded under target and has maintained around the 10% target for 6 consecutive months.
- Vacancy rates remain at their lowest for over 18 months, again for consecutive months.
- OOH sickness reporting has now been implemented.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Primary Care Directorate PIP



A PIP was requested in M10 (2024/25). The PIP trajectory will be updated in M01 to bring sickness rate back to the 4-year average position of 4.4% which is within the <4.95% required standard. Trajectories have been set in M02 covering the period April 2025 to March 2026. The Primary are directorate aims for the standard to be met in December 2025.

Sickness absence 12-month rolling period during M02 is 7.0% and 5.4% in-month. The in-month trajectory of 3.8% in M02 is not being met. The 4.3% 4-year average is not being met. The in-month <4.95% target is not being met. The 12-month required standard is not being met.

Updated actions have been received for M02.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Trust Target-4.95%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Target-4 yr average-4.35%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%	4.4%
In Month	5.3%	6.6%	8.1%	6.3%	6.9%	8.9%	8.0%	5.7%	4.8%	5.1%	3.2%	5.5%	5.4%
12 Month Rolling	5.6%	5.9%	6.1%	6.1%	6.2%	6.4%	6.5%	6.5%	6.6%	6.6%	6.3%	7.1%	7.0%
Trajectory (In Month)												5.5%	3.8%

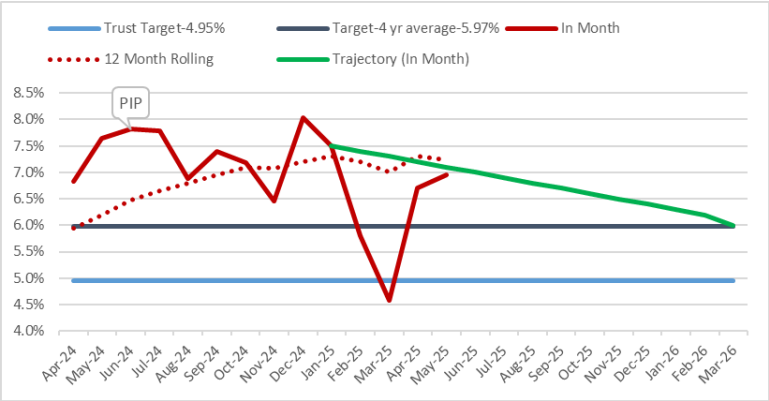
The above table RAG rating measures in-month performance against Trust target

Actions:

- Wellbeing ambassadors in place within the Directorate.
- Sickness management clinics in place with service managers to enable a clear understanding of team members being supported via the Supporting Attendance at Work process and triggers and associated supportive actions. **13/06/25 Progress update:** *Sickness management clinics continue to take place across all services, with the development of a monitoring sheet to support this. (ongoing).*
- Review of sickness reasons identifies stress/anxiety as primary reason for sickness. Ensure all team members are referred to occupational health as appropriate. Workplace stress risk assessments undertaken and wellbeing action plans. **13/06/25 Progress update:** *Occupational health referrals, stress risk assessment and wellness action plans are being discussed as part of sickness management clinics.*
- Staff survey review with identified actions from this focussing on specific team with highest levels of variance in comparison to Trust averages. This is to support teams to identify key trends from the survey and actions.**13/06/25 Progress update***: Staff survey analysis underway with focus on team with biggest level of variance in comparison to Trust averages. Key trends identified and actions developed as part of this including focus groups with team*. (October 2025).

Performance Improvement Plan: Sickness Absence (Trust indicator)

Specialist Services Directorate PIP



A PIP was requested in M03 (2024/25). The trajectories were set in February 2025 to return the sickness absence rate to the 4-year average position of 5.97% by end of March 2026, which exceeds the <4.95% required standard.

Sickness absence 12-month rolling period during M02 is 7.2% and 7.0% in-month. The in-month trajectory of 7.1% for M02 is being met. The 6.0% 4-year average is not being met. The in-month <4.95% target is not being met. The 12-month required standard is not being met.

Updated actions have been received for M02.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Trust Target-4.95%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Target-4 yr average-5.97%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
In Month	7.6%	7.8%	7.8%	6.9%	7.4%	7.2%	6.5%	8.0%	7.5%	5.8%	4.6%	6.7%	7.0%
12 Month Rolling	6.2%	6.5%	6.7%	6.8%	7.0%	7.1%	7.1%	7.2%	7.3%	7.2%	7.0%	7.3%	7.2%
Trajectory (In Month)									7.5%	7.4%	7.3%	7.2%	7.1%

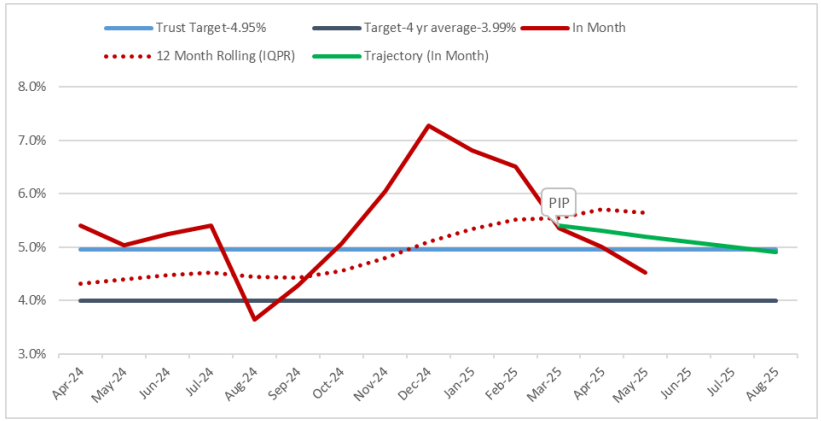
The above table RAG rating measures in-month performance against Trust target

Actions:

- Commence monthly sickness clinics chaired by service managers and supported by People Operations to review all sickness in service line monthly. Ensure sickness themes are identified and addressed where possible. Ensure sickness management is being followed as per policy. Review alternatives to return staff to work in different areas (March 2025) **13/06/25 Progress update:** *These are in place and ongoing.*
- AD and People operations Team to review all Long-Term Sickness cases with Team managers. Ensure all cases are being managed to policy and to review wider options for returning staff to work (March 2025) **13/06/25 progress update:** *regular reviews ongoing, with regular meetings scheduled and progression made as suitable.*
- Wellbeing schedule for 25/26 to be developed and embedded ahead of new financial year. Staff wellbeing initiatives can help to reduce sickness episodes and improve morale and culture **13/06/25 progress update:** *meeting took place, action plan to be formulated.*
- Bespoke support to be offered by AD and Peoples Business Partner to team managers of high sickness areas. Managing high sickness can be challenging for managers, the directorate will need to ensure the managers have the appropriate skills and training to effectively support their teams and maintain their own wellbeing. **13/06/25 progress update:** *To be closed. This action and guidance will come out of the monthly sickness clinics and senior advice and support from AD as required.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Community Directorate PIP



A PIP was issued in M12 (2024/25). Trajectories were set in March 2025. The current PIP trajectory aims for performance to be at 4.95% by August 2025.

Sickness absence 12-month rolling period during M02 is 5.7% and 4.5% in month. The in-month trajectory of 5.2% in M02 is being met. The 3.9% 4-year average is not being met. The in-month <4.95% target is being met. The 12-month required standard is not being met.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Trust Target-4.95%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Target-4 yr average-3.99%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
In Month	5.0%	5.3%	5.4%	3.6%	4.3%	5.1%	6.1%	7.3%	6.8%	6.5%	5.4%	5.0%	4.5%
12 Month Rolling (IQPR)	4.4%	4.5%	4.5%	4.5%	4.4%	4.6%	4.8%	5.1%	5.3%	5.5%	5.5%	5.7%	5.7%
Trajectory (In Month)											5.4%	5.3%	5.2%

The above table RAG rating measures in-month performance against Trust target

Improvement in M02 - Staff returning from long term sick as planned. Service managers/People team working with team leads to review progress and ensure they are collaborating with the People team following the Supporting Attendance at Work policy in a timely way has had an impact and team leads have felt more supported in managing absences.

Actions:

- Commenced workforce clinics for top 3 areas of high sickness. These are held with the Service Manager & Team lead to ensure close monitoring of sickness absence to ensure that team leads take responsibility in the management of workforce compliance, including sickness absence and are taking appropriate action to support staff whilst improve compliance. (September 2025).
- To ensure compliance with policy and that it is managed in accordance with the Supporting Attendance at Work (September 2025).
- Well-being activities and Team away days will be promoted and encouraged across the Directorate (September 2025).

Risk Description

The Community Directorate sickness levels are above Trust target and consequently could result in:

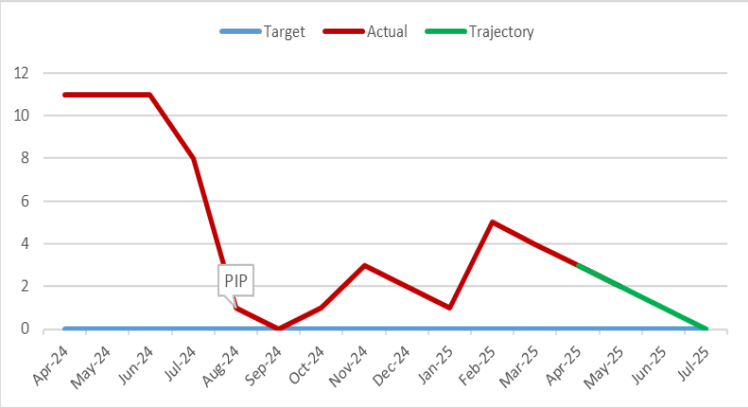
- increased workload for others
- higher costs
- lower morale
- reduced productivity
- talent retention issues
- health & safety risks
- impact on Team dynamics
- Potential compliance issues
- Impact on quality service provision

Risk Mitigation

Commencement of robust sickness review processes detailed above is ensuring that sickness is kept to a minimum.

Performance Improvement Plan: Complaints (Trust indicator)

Nursing and Quality Directorate PIP



A PIP was requested in M05 (2024/25) and then reissued in M09 for review and refresh of the actions and trajectory. A trajectory aimed for the standard to be met by September 2024, this was extended to April 2025 and then to July 2025.

During M02 there are **two** complaints exceeding the 40-day response timescale. Performance is meeting the required trajectory but is below the required standard.

Updated actions have been received.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Actual	11	11	8	1	0	1	3	2	1	5	4	3	2
Trajectory												3	2

The above table RAG rating measures actual performance against Trust target

Actions:

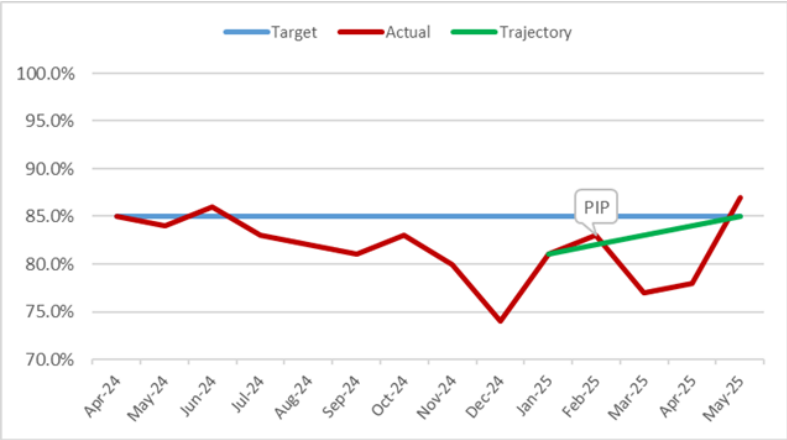
- Ensure our values-based approach and consistency in our complaints review process (July 2025) **15/05/25 Progress update:** *review remains under way; due to coproduced nature this has taken a little longer than originally expected.*
- Weekly complaints reports show delays in chasing complaints and those that are going or have gone red. PET to chase directorates for a weekly update. Narrative to be provided on weekly report summary explaining reasons for delay. **15/05/25 Progress update:** *Increase in supporting directorates has been implemented, feedback from QILNs this has helped and is supporting to meet the 40-day timeline set out in the policy. (Implement 17/03/25, then ongoing –* ***completed).***

Risk Description:
There is a risk that ongoing delays in responding to patient and carers complaints could have a negative impact on patient / carer wellbeing and experience of our Trust.

Mitigation:
Actions above are all in place to mitigate this risk.

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Community Directorate PIP



A PIP was issued in M10. Community Directorate aims to achieve the 85% standard by May 2025. Trajectories were set in February 2025.

Performance during M02 is at **87.0%** and has met the 85% trajectory and required standard.

Updated actions have been received for M02.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Actual	84.0%	86.0%	83.0%	82.0%	81.0%	83.0%	80.0%	74.0%	81.0%	83.0%	77.0%	78.0%	87.0%
Trajectory									81.0%	82.0%	83.0%	84.0%	85.0%

The above table RAG rating measures actual performance against Trust target

Actions:

- Productive time management and booking of supervision with supervisors to achieve performance target and ensure staff are receiving regular supervision sessions. **10/04/25 Progress update:** *Weekly reports continue to be supplied to all team leads on supervision status for their respective areas.*
- Regular data cleansing to ensure accuracy to ensure supervision records complete and accurate.
- Recording of supervision on LMS to prevent any delay in recording and on-going and pro-active recording of supervision.
- Temporary arrangements put in place to cover team lead absence with County Older Adult CMHT resulting in improved service line compliance due to additional capacity to conduct staff supervision.

Risk Description

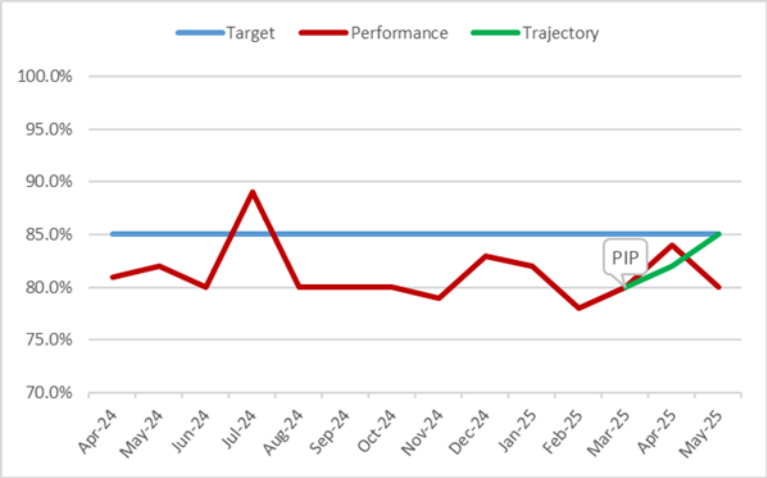
There is a risk of staff not receiving supervision in a timely and regular basis and because of this it could lead to staff burnout, lack of guidance and ineffective clinical interventions.

Mitigations

- Scrutiny of weekly reports
- Data cleansing
- Proactive booking and recording of supervision

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Acute and Urgent Care PIP



A PIP was issued in M12 (2024/25). Trajectories were set in March 2025. Acute and Urgent Care Directorate aims to achieve the 85% standard by May 2025.

Performance during M02 is **80.0%,** the planned 85% trajectory and required standard has not been met.

Updated actions have not been received for M02.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Performance	82.0%	80.0%	89.0%	80.0%	80.0%	80.0%	79.0%	83.0%	82.0%	78.0%	80.0%	84.0%	80.0%
Trajectory											80.0%	82.0%	85.0%

The above table RAG rating measures actual performance against Trust target

The Acute & Urgent Care Directorate has not met the Clinical Supervision target of 85% since July 2024 with impact on:

1. Patient Safety: Inadequate supervision can lead to errors in patient care, compromising patient safety and potentially causing harm.
2. Quality of Care: The effectiveness of care can be diminished, leading to poorer health outcomes for patients.
3. Staff Well-being: Healthcare professionals may experience increased stress and anxiety, reduced job satisfaction, and burnout due to lack of support and guidance.
4. Professional Development: Opportunities for learning and skill enhancement are limited, affecting the overall competency and growth of healthcare staff.

Actions

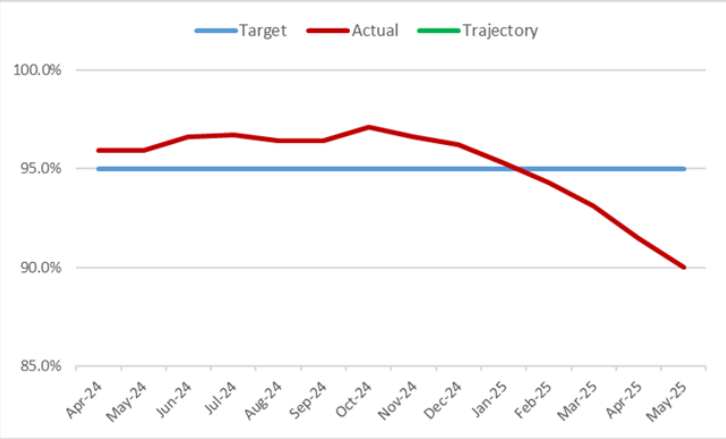
- Stat / Mand training is monitored within all teams, reviewed as part of Workforce clinics held with the Senior leadership Team, and as part of Service Line.
- Discussion to be held with a view to removing the 'written copy mandated question' as part of the recording of clinical supervision (June 2025).
- To ensure Crisis Resolution and Home Treatment review their current supervision structure and are supported to significantly improve on their compliance. It has been identified that full use of team members is not being utilised in the delivery of effective clinical supervision. (June 2025).
- Ensure clinical supervision for registered and non-registered staff continues to be monitored at team level through to Directorate oversight and during the monthly Workforce clinics. For the Associate Director to establish contact with staff who remain non-compliant for 2 consecutive months. (ongoing).
- To ensure the compliance figures are accurate and the data contained is of good quality**.**

M02 Update

- Significant pressures across all services, with clinical delivery being prioritised.

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services Directorate PIP



A PIP was issued in M01 (2025/26).

Performance in M02 is at **90.0%** and is not meeting the required standard. Trajectories will be set in M03 as there is work underway to ensure that the new care plan documents are being recorded in the correct way to pull through in the reporting.

Updated actions have been provided.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	95.9%	96.6%	96.7%	96.4%	96.4%	97.1%	96.6%	96.2%	95.3%	94.3%	93.1%	91.5%	90.0%
Trajectory													

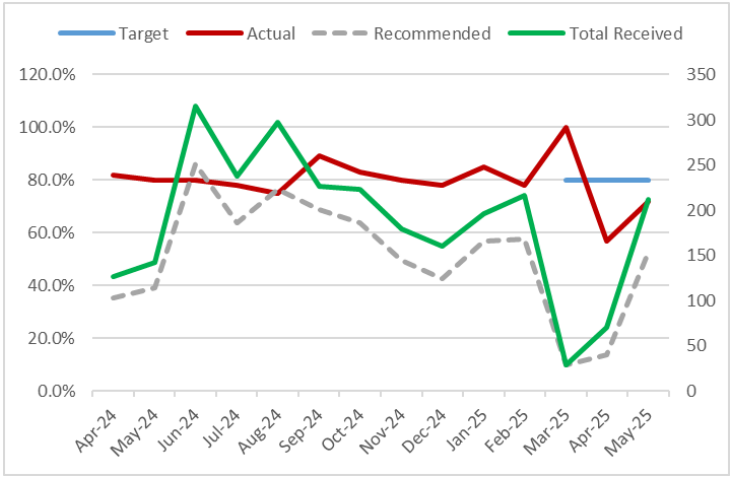
The above table RAG rating measures actual performance against Trust target

Actions in M02
Review to be completed for each service to establish the progress of care planning changes to provide a clear understanding of where each service is in the transition over, how this impacting on performance reporting and on patient care.

Risk Description:
Care plan compliance for the Specialist Directorate has fallen below Trust target for 4 consecutive months. This has the potential to impact on the recovery of patients under the care of these services if the Trust target is not maintained.

Mitigation:
Review into care planning progress to be completed for each service area to understand the current challenges and performance impact of current changeover of care plan process. Once identified consider mitigations.

Performance Improvement Plan: Friends and Family Test (Trust indicator)



A PIP has been issued in M10 (2024/25). A target rate of 80% for recommended rate has been agreed in M01 2025/26.

Performance for the recommended rate during M02 is **72.0%.** There have been 212 friends and family responses received, of which 154 (72.0%) have provided feedback on their experience of our service as being very good or good.

Updated actions and trajectories have been received in M01.

	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Target											80.0%	80.0%	80.0%
Actual	80.0%	80.0%	78.0%	75.0%	89.0%	83.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%
Recommended	114	251	186	223	201	186	144	124	166	168	29	40	154
Total Received	142	315	238	297	226	223	179	160	196	216	29	70	212
Trajectory										78.0%	No improvement/ possible reduction	No improvement/ possible reduction	No improvement/ possible reduction

The above table RAG rating measures actual performance against Trust target

Actions:

- Ensure all feedback cards and Posters are visibly displayed in clinical areas, near the exits. Increase response rate from cards, website and QR code via raising awareness to directorate leads, (change from smart survey to Ms Forms). Reports to directorates showing their response rates. **15/05/25 Progress update:** *All posters have been updated with the new QR code and approved by trust Coms team and being delivered to teams.*
- Consistency in data reporting from NHSE and internally in the Trust and Clarity on data reported against criteria for FFT. **15/05/25: Progress update:** *External reporting to NHSE continues. Change control paper will advise of the Internal reporting, which will show percentage of response rates at 'good/very good' with a target to reach 80% or above. This will also track the amount of response rates we have had per month going forward* ***(completed).***
- Develop a SOP that includes GP process for FFT, as these differ from the rest of the organisation (June 2025). **18/06/25 Progress update:** *SOP has been finalised from directorate comments and ready for approval.*

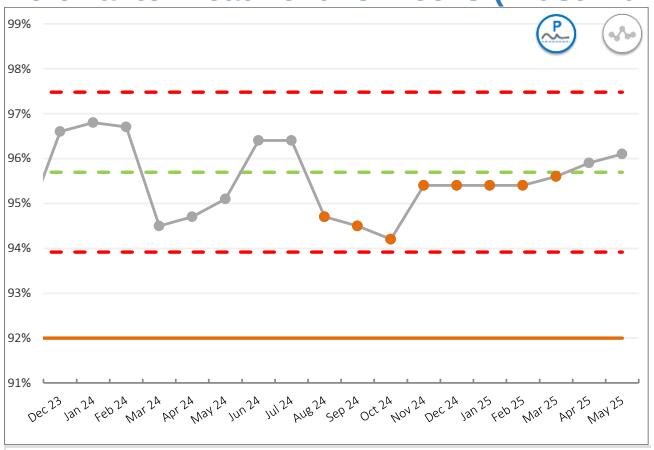
Risk description:

- There is a risk that our FFT feedback is reducing, and we may not be accessible/digitally accessible enough to capture FFT feedback.
- There is a risk as we move from smart survey to the Government website and requiring a DPIA to be agreed that the recommended rates (and response rates monitored by PET) will reduce in the coming two months. This is reflected in the trajectory.
- To mitigate against a reduction in recommended the rates, the actions above are to improve response rate to FFT cards and website access.

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

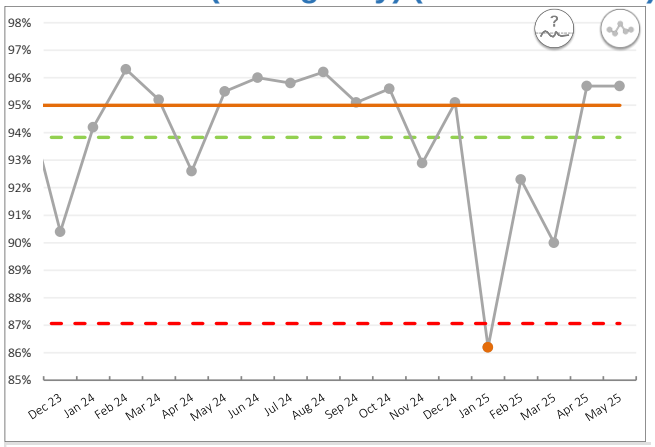
Referral to Treatment 18 Weeks (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
96.4%	96.4%	94.7%	94.5%	94.2%	95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%

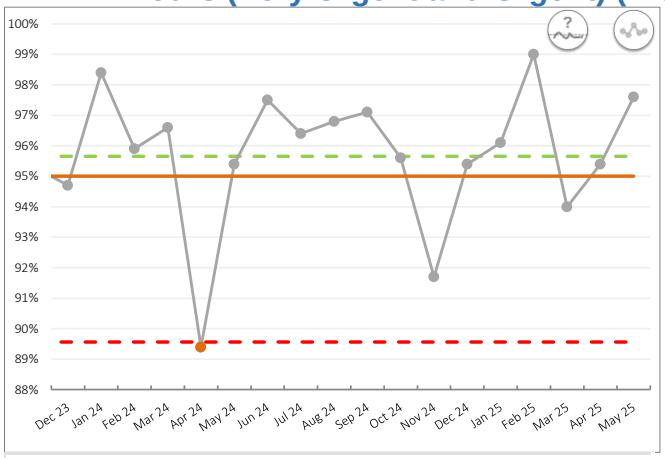
MHLT 1 hour (Emergency) (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
96.0%	95.8%	96.2%	95.1%	95.6%	92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%

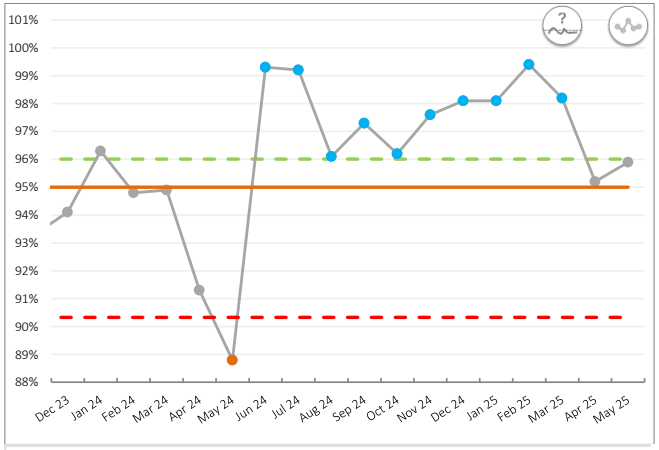
MHLT 4 hours (Very Urgent and Urgent) (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
97.5%	96.4%	96.8%	97.1%	95.6%	91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%

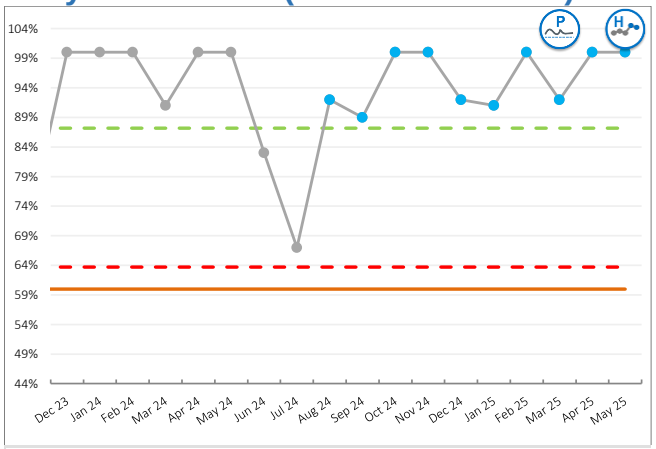
MHLT 24 hours (Routine) (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
99.3%	99.2%	96.1%	97.3%	96.2%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%

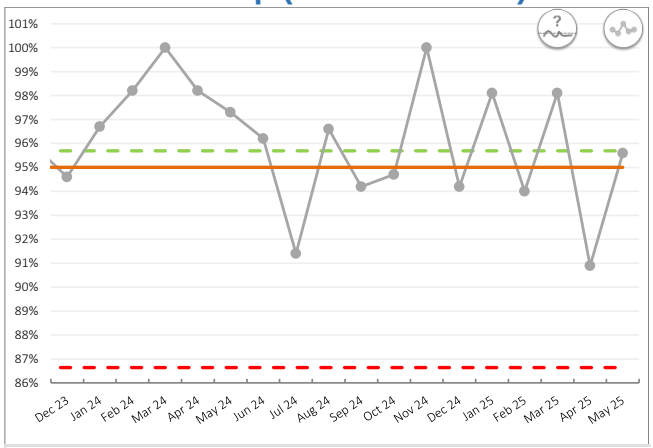
Early Intervention (National indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
83.0%	67.0%	92.0%	89.0%	100.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%

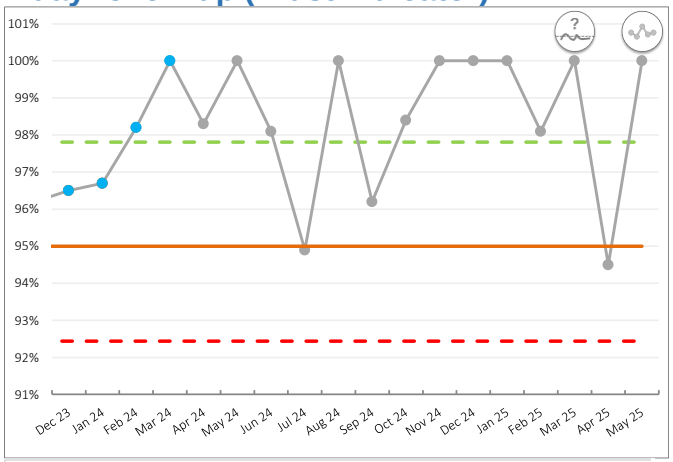
48 Hour follow up (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
96.2%	91.4%	96.6%	94.2%	94.7%	100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%

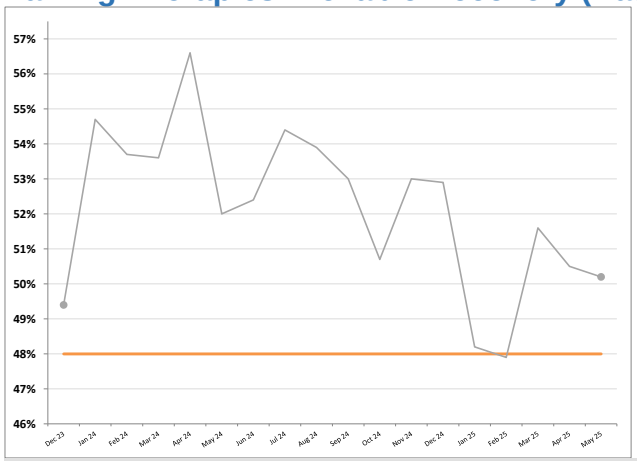
7 day follow up (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
98.1%	94.9%	100.0%	96.2%	98.4%	100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%

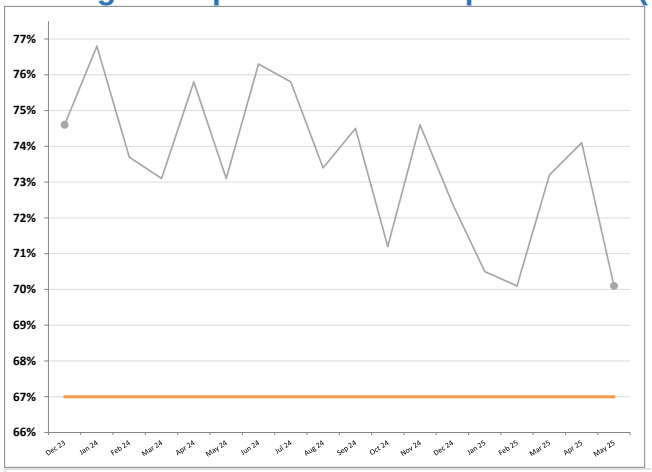
Talking Therapies: Reliable Recovery (National indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
52.4%	54.4%	53.9%	53.0%	50.7%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%

Talking Therapies: Reliable Improvement (National indicator)

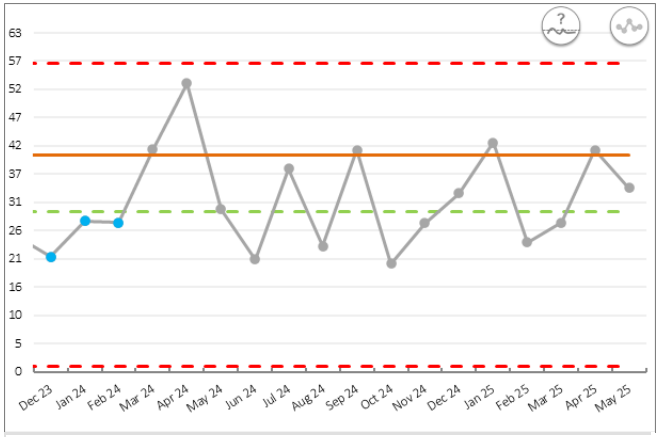


12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
76.3%	75.8%	73.4%	74.5%	71.2%	74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%

Core Indicators – SPC Trend (Inpatient and Quality)

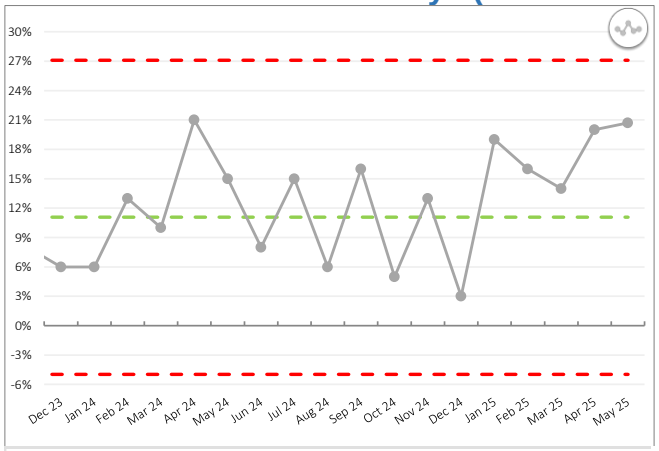
Average Length of Stay–Adult (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
21	38	23	41	20	28	33	42	24	28	41	34

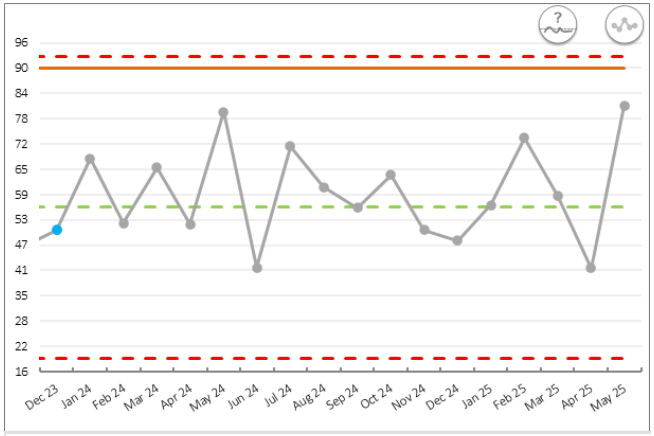
Adult Acute LoS-Over 60 days (National indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
8.0%	15.0%	6.0%	16.0%	5.0%	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%

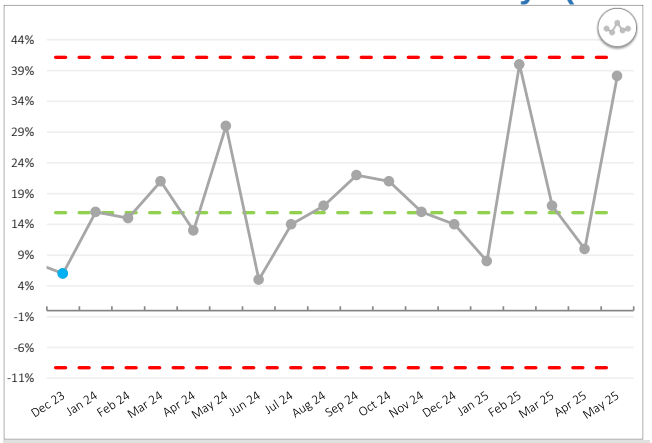
Average Length of Stay-Older Adult (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
41	71	61	56	64	51	48	57	73	59	41	81

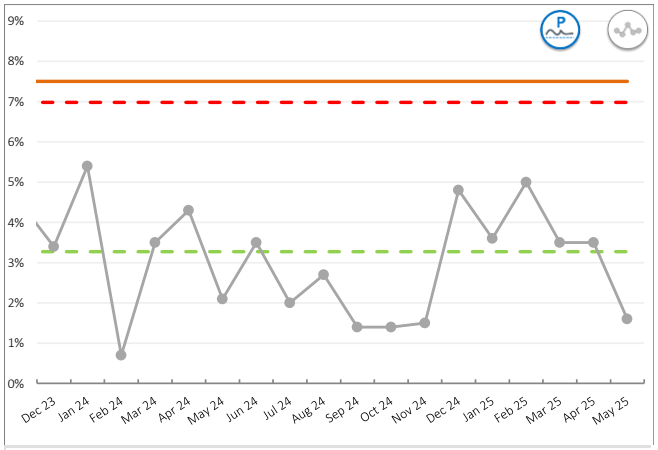
Older Adult Acute LoS-Over 90 days (National indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
5.0%	14.0%	17.0%	22.0%	21.0%	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%

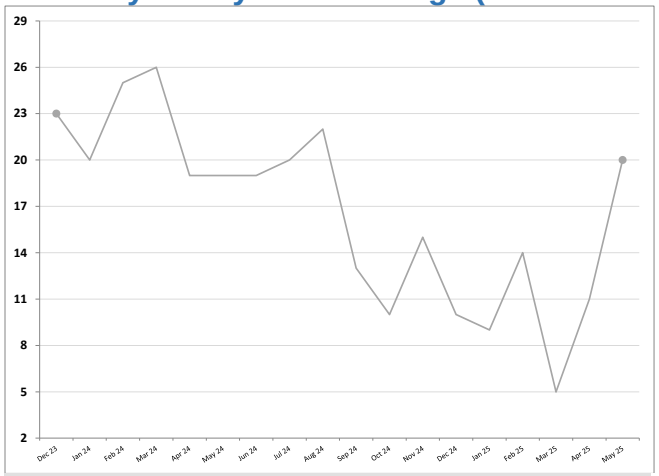
Emergency Readmissions (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
3.5%	2.0%	2.7%	1.4%	1.4%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%

Clinically Ready for Discharge (Trust indicator)

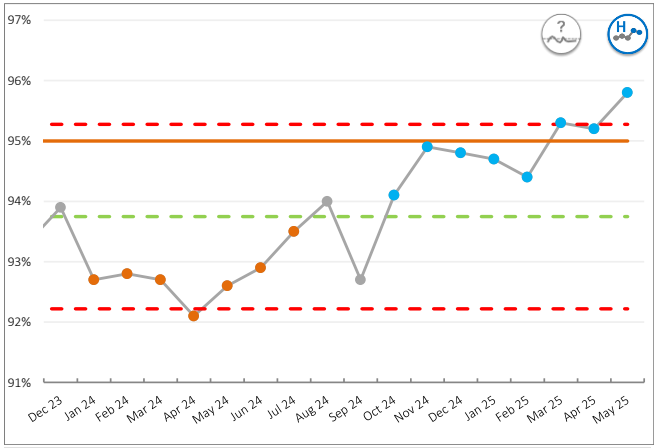


12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
19	20	22	13	10	15	10	9	14	5	11	20

Core Indicators – SPC Trend (Community and Quality)

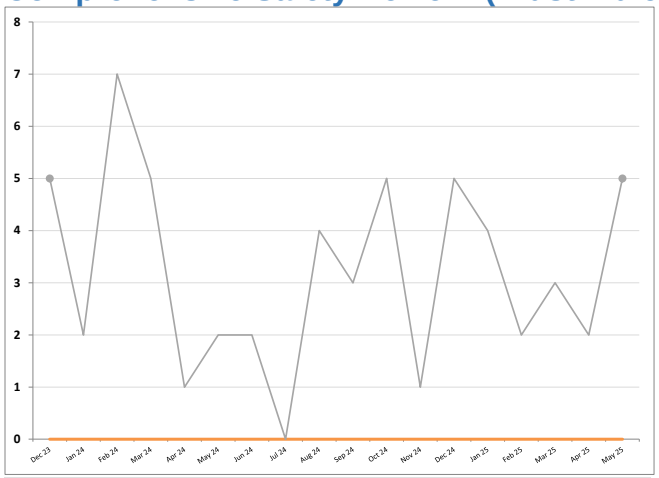
Risk Assessment Compliance (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
92.9%	93.5%	94.0%	92.7%	94.1%	94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%

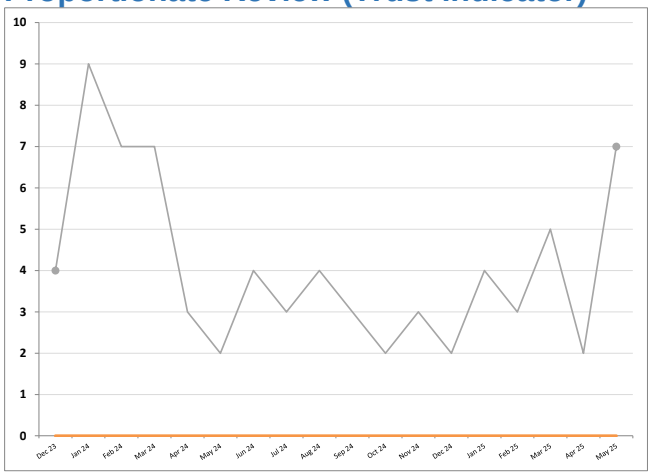
Comprehensive Safety Review (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
2	0	4	3	5	1	5	4	2	3	2	5

Proportionate Review (Trust indicator)

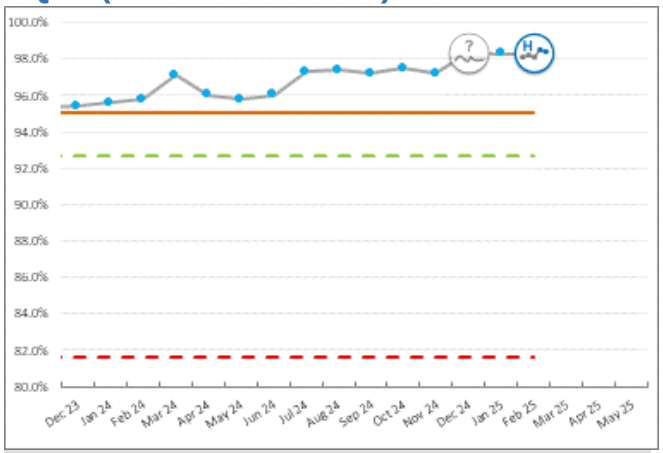


12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
4	3	4	3	2	3	2	4	3	5	2	7

Core Indicators – SPC Trend (Organisational Health)

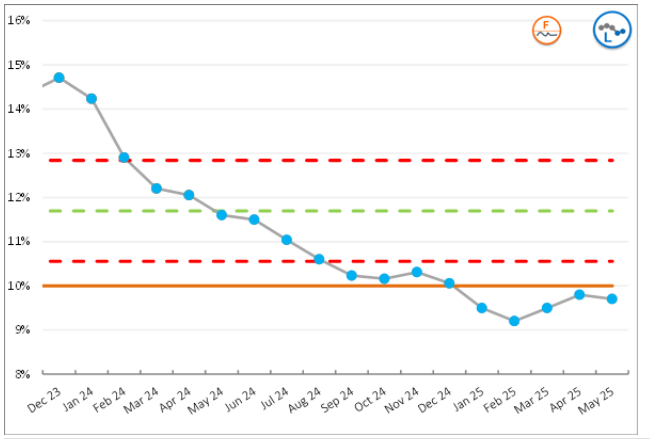
DQMI (National indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
96.0%	97.3%	97.4%	97.2%	97.5%	97.2%	98.4%	98.3%	98.3%			

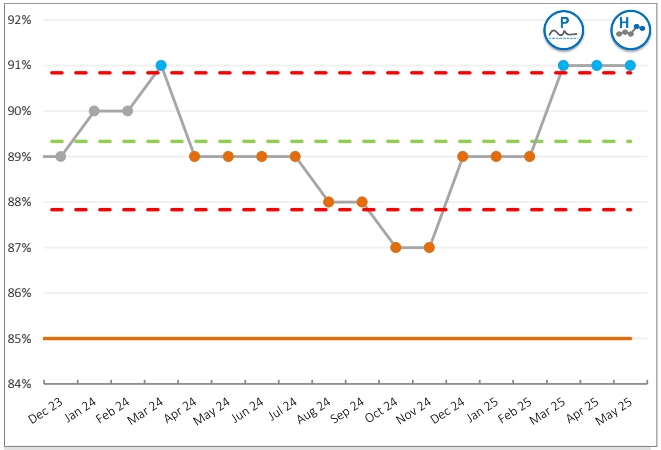
Staff Turnover (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
11.5%	11.0%	10.6%	10.2%	10.2%	10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%

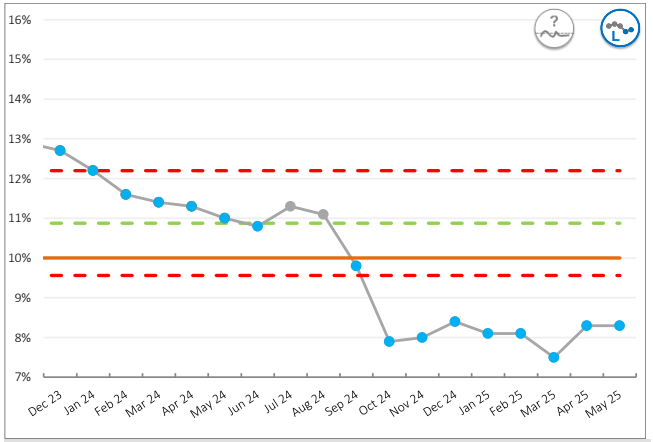
Statutory and Mandatory Training (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
89.0%	89.0%	88.0%	88.0%	87.0%	87.0%	89.0%	89.0%	89.0%	91.0%	91.0%	91.0%

Vacancy Rate (Trust indicator)



12 Month Trend

Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
10.8%	11.3%	11.1%	9.8%	7.9%	8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 12

TRUST BOARD ASSURANCE REPORT FROM THE PEOPLE, CULTURE & DEVELOPMENT COMMITTEE

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Trust Board
Date of Meeting:	10th July 2025

Presented by:	Martin Evans, Chair, People, Culture & Development Committee
Prepared by:	Kerry Smith, Deputy Chief People Officer
Executive Lead:	Frieza Mahmood, Chief People Officer

Aligned to Board Assurance Framework Risk	Risk 3 There is a risk that the Trust is unable to maintain a sustainable workforce model which meets the People Promise
Approval / Review:	People, Culture and Development Committee
Strategic Priorities:	Prevention - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	Not Applicable
Diversity & Inclusion Implications	All D&I implications are considered as part of the People Plan and ongoing commitments.
ICS Alignment / Implications:	The Trust People Plan, aligns to both the ICB and national People Plan.
Recommendation / Required Action	To note the updates and assurance provided by the People, Culture & Development Committee and approve as necessary.
Executive Summary	The Quad A report provides assurance from the People, Culture & Development Committee to Trust Board on a number of issues and concerns in the form of Alert, Advise, Assure and Approve

VERSION CONTROL:

Version	Report to	Date Reported
1.0	Trust Board	10.06.2025

Trust Board Assurance Report from the People, Culture and Development Committee meeting held on 30th June 2025

Introduction:

This assurance report is produced following the latest PCDC, which was held on Microsoft Teams and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key People performance indicators and the National NHS People Plan Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under PCDC's remit and programmes of work.

ALERT: This section summarises the key points that members of the Trust Board need to be aware of.

Staff Story:
Highlighted issues regarding site accessibility and timeliness of reasonable adjustments for wheelchair users. Limited assurance was provided regarding site accessibility, noting equipment blocking stairwells and the need for clear evacuation procedures across the Trust's sites. The Committee discussed the wider importance of inclusive recruitment, addressing health inequalities and the importance of lived experience in informing organisational changes. It was noted further work is required with regards to Diversity & Inclusion and remains a challenge within existing resourcing and funding to make adaptations.

ADVISE: This section advises of key activity and updates in relation to programmes of work.

Performance:

- **Sickness Absence**: Continues to operate above the upper control limit at 5.4% during M02 down from 6.4% in M01 which is a positive step. However, the Trust remains an outlier and limited updates were provided in the PIPs resulting in limited assurance being received. Sickness will remain a priority area of focus for the committee.

- **Appraisals:** Have fallen below target at 84% and the committee noted that last year there was a noticeable fall in appraisal compliance for a number of months from July onwards. Only limited assurance was provided regarding compliance improvement.

NHS Pay award announcements:
The government has accepted the headline pay recommendations of the independent Pay Review Bodies (PRB). All pay awards will be backdated to 1 April 2025 (staff are expected to receive their backdated pay uplifts from August) and include:

- 3.6 % consolidated uplift for all Agenda for Change staff on NHS terms and conditions.
- Consultants and Speciality and Specialist Doctors (SAS) salaries will be uplifted by 4% on a consolidated basis.
- Doctors and dentists in training will be uplifted by 4%, plus £750 on a consolidated basis.
- VSM recommended a 3.25% uplift for very senior managers. Subject to NOF confirmation and REMCO assessment and approval. The DHSC and NHS England has published (Thursday 15 May) the new NHS very senior managers (VSM) pay framework and associated guidance. Alongside the board member

appraisal guidance and the NHS leadership competency framework for board members, is expected to help drive consistency, increase transparency, and offer flexibility to attract talented candidates.

EDI Calendar of Events - Looking Forwards:

June-July 2025:

Month-long awareness events

- LGBTQ+ Pride Month – Celebrating LGBTQ + Identities and rights with parades and events nationwide.
- Gypsy, Roma and Traveller History Month – Recognising the contributions and culture of GRT communities.
- South Asian Heritage Month (18 July – 17 August) – Celebrating South Asian cultures and histories.

Staff Networks

Leadership, LGBT+ network chairs, staff-side rep and our ICS colleagues have come together to share best practice following the recent High Court ruling concerning the Equality Act 2010 which significantly impacts Transgender people. While we await further guidance from NHS England and DHSC, there are no changes to our current workforce or patient policies.

Organisational Development – Affina Programme

During April 2025 we launched the Affina OD Team Journey programme across the Trust. Throughout May 2025 we have utilised Staff Survey results and other soft intelligence to prioritise the first team leaders to be invited to take part in the programme with their teams. The committee will receive further progress updates in due course.

ASSURE: This section provides assurance of the quality of service and activity delivered under the PCDC's remit and programmes of work.

PCDC RISKS

The committee received the PCDC risks. There were no new risks, no score changes and no closures.

Performance:

- Staff turnover is at 9.7% in M02 from 9.8% in M01 and the vacancy rate remains at 8.3% in M02, both metrics meeting the <10% requirement.
- Statutory and Mandatory training during M02 is 91.0% and is currently operating above the upper control limit.

Exceptions

- Clinical Supervision has improved further to 83.0% in M02 from 81.0% in M02, still under target for the fourth consecutive month.
- Workforce plan: As of M2 the Trust's WTE are over plan by 1.10% which is a 2.13% substantive difference, however these posts are within current establishment budget and income backed.

Education and Development Annual Report 24/25

The committee received and were assured by the report.

Statutory and Mandatory Education Review

The committee received the review for information. The committee noted the significant amount of workforce time that will be saved and redirected back to productivity as a result of the review.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data submissions
The committee received both reports and were assured that the key actions were being added to the existing EDI and Workforce plans.

Communications Delivery Plan Update – Quarter 4
Updates received under consent item for assurance/information.

Trade Union Facility Time Report
This was reported under consent items for assurance/information and noting the legal requirement. The data will now be published to the website.

APPROVE: This section provides an update of items which were discussed and approved by the Committee.

BAF/ PCDC Risk
The PCDC risks were approved with no new risks, closures or score changes. It was noted that a review remains ongoing and an updated will be provided at the next committee.

The proposed BAF Risks for 2025/26 of Strategic Direction (New), Partnerships, Quality and Safety (Amalgamated from 2 risks in 24/25), People, Performance (New), Financial Sustainability and Digital (New) were approved.

Policies
No policies were submitted for approval, review or extension.

Next Steps (including timeframes):
The next PCDC business meeting will be held on: 1st September 2025

Committee Chair: Martin Evans, Chair of the People, Culture & Development Committee
REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 13

Finance Position Month 2

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Eric Gardiner – Chief Finance Officer
Prepared by:	Michelle Wild – Financial Controller / Michelle Geddes – Assistant Chief Finance Officer / Rachel Heath – Project Accountant
Executive Lead:	Eric Gardiner – Chief Finance Officer

Aligned to Board Assurance Framework Risk	Risk 2 The Trust fails to deliver a balanced financial plan in 24/25.
Approval / Review:	SLT
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care.
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development.
Sustainability:	Share learning and best practice.
Resource Implications:	No.
Funding Source:	Not applicable.
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Part of the aggregate ICS reported financial position.
Recommendation / Required Action	Receive the Month 2 position noting: • The year-to-date deficit of £173k for system reporting purposes. • Agency expenditure year to date of £345k. • Bank expenditure year to date of £1,171k. • Note CIP delivery position. • Note the month 2 capital position. • The cash position of the Trust on 31st May with a balance of £31.7m.

Executive Summary	The Adjusted Financial Performance in month is an £89k deficit against a planned deficit of £106k giving a positive variance of £17k. The year to date position is a deficit of £173k against a planned deficit of £212k giving a positive variance of £39k. The Trust has a recurrent CIP target of £6.0m, a non-recurrent target of £1.4m. At Month 2 the Trust is reporting delivery of £315k CIP against a target of £882k, an adverse variance of £567k. CIP schemes have been identified for the full target with 32% being either implemented or fully developed, 55% have plans in progress and 12% are opportunities. In month agency expenditure was £182k against a plan of £138k representing an adverse variance of £44k against the 40% agency expenditure reduction from 2024/25. In month bank expenditure was £550k against a plan of £581k representing a positive variance of £31k against the 10% bank expenditure reduction from 2024/25. The Trust's capital expenditure year to date was £459k against a plan of £509k giving a positive variance of £50k. In month, 96% based on the number of invoices and 99% based on the value of invoices received by the Trust were paid within 30 days against the Better Payment Practice Code target of 95%.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	17/06/2025
2	F&R	27/06/2025
3	Public Trust Board	04/07/2025

NHS
North Staffordshire
Combined Healthcare
NHS Trust

PUBLIC TRUST BOARD – 10th July 2025
Finance Position Month 2

PROUD TO CARE
COMPASSIONATE · APPROACHABLE · RESPONSIBLE · EXCELLENT

safe · personalised · accessible · recovery focused
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Finance Position

Introduction

This report summarises the Trust's financial position as of 31st May 2025.

Key financial performance metrics are included for the following:

- Income & expenditure position.
- Forecast
- Agency expenditure.
- Bank expenditure.
- CIP delivery.
- Capital Expenditure.
- Statement of Financial Position.
- Better Payment Practice Code.

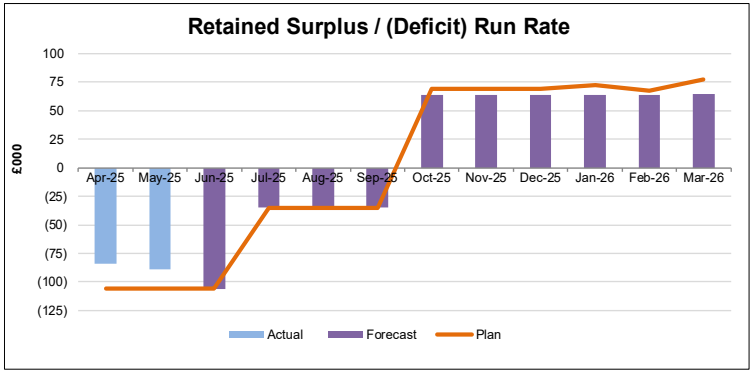
Finance Position Executive Summary

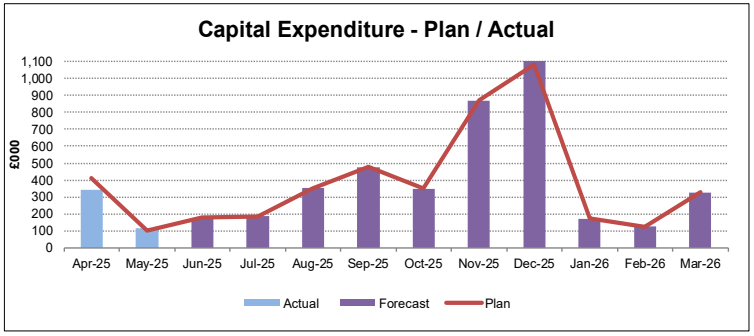
North Staffordshire Combined Healthcare NHS Trust

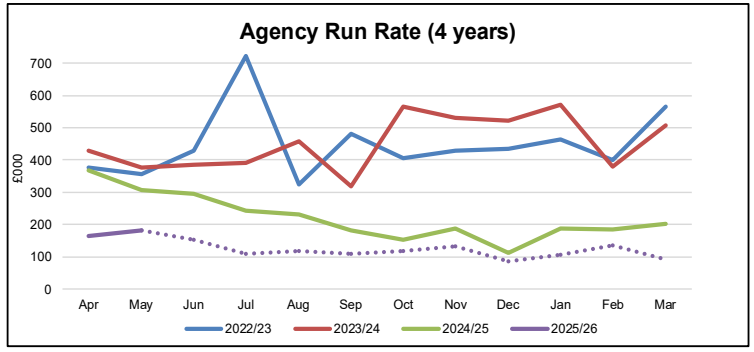
Financial Overview as at 31st May 2025

Key Metrics

£000	M1	M2	YTD	Average	Forecast	Target	RAG
Variance to Plan							
In month financial position	22	17	39	19			
YTD financial position	22	39	39	19	0	0	
Run Rates (Actuals)							
Income	15,694	13,709	29,402	14,701	177,584	176,900	
Pay	(8,970)	(8,929)	(17,899)	(8,949)	(107,023)	(109,394)	
Non-pay	(6,522)	(4,585)	(11,106)	(5,553)	(66,936)	(64,039)	
Finance & Other Non Operating Costs	(242)	(239)	(481)	(240)	(3,106)	(2,991)	
Agency (Actuals)	(163)	(182)	(345)	(173)	(1,504)	(1,504)	
Agency Variance To Plan	**(22)**	**(44)**	**(66)**	**(33)**	**(0)**	**0**	
Medical Agency	(13)	(11)	(23)	(12)	(0)	0	
Nurse Agency	(7)	(16)	(24)	(12)	(27)	0	
Other Agency	(2)	(17)	(19)	(10)	27	0	
Non Clinical Agency	0	0	0	0	0	0	
Bank (Actuals)	(622)	(550)	(1,171)	(586)	(5,453)	(5,453)	
Bank Variance To Plan	**(37)**	**(37)**	**(73)**	**(37)**	**(0)**	**0**	
Medical Bank	9	9	18	9	(11)	0	
Nurse Bank	270	270	540	270	(2,738)	0	
Other Clinical Bank	(308)	(308)	(616)	(308)	2,694	0	
Non Clinical Bank	(7)	(7)	(15)	(7)	55	0	
CIP (Variance)	(291)	(276)	(567)	(284)	0	0	
Cash balance	31,734	32,027	32,027	31,881	29,424	29,424	
Capital expenditure (Variance)	67	(17)	50	25	0	0	
BPPC							
Number	96.5%	96.0%	96.0%	96.3%		95%	
Value	99.5%	99.5%	99.5%	99.5%		95%	







RAG	Description
	Above plan / budget (more than 5%).
	Above plan / budget (within 5%).
	Within plan / budget.

Finance Position

Income & Expenditure Position

North Staffordshire Combined Healthcare NHS Trust

High Level Analysis	Annual Plan £000	In Month Budget £000	In Month Actuals £000	Variance £000	Year to Date Budget £000	Year to Date Actuals £000	Variance £000	Forecast Budget £000	Forecast Actuals £000	Variance £000
Income from Patient Care Activities	160,534	13,412	12,248	(1,164)	26,817	26,549	(267)	160,902	160,683	(220)
Income from Other Operating Activities	15,692	1,410	1,461	51	2,762	2,853	91	15,998	16,901	903
Income	**176,226**	**14,822**	**13,709**	**(1,113)**	**29,578**	**29,402**	**(176)**	**176,900**	**177,584**	**684**
Pay Costs	(105,754)	(9,165)	(8,929)	236	(18,328)	(17,899)	430	(109,394)	(107,023)	2,370
Non Pay Costs	(66,956)	(5,471)	(4,585)	886	(10,880)	(11,106)	(227)	(64,039)	(66,936)	(2,896)
Finance & Other Non Operating Costs	(3,040)	(249)	(239)	10	(498)	(481)	18	(2,991)	(3,106)	(115)
Expenditure	**(175,750)**	**(14,886)**	**(13,753)**	**1,133**	**(29,706)**	**(29,486)**	**220**	**(176,424)**	**(177,065)**	**(641)**
Retained Surplus / (Deficit)	**476**	**(64)**	**(44)**	**20**	**(128)**	**(84)**	**44**	**476**	**518**	**42**
Technical Adjustments	(476)	(42)	(45)	(3)	(84)	(90)	(6)	(476)	(518)	(42)
Adjusted Financial Performance	**0**	**(106)**	**(89)**	**17**	**(212)**	**(173)**	**39**	**(0)**	**0**	**0**

Note: The Adjusted Financial Performance removes the impact of donated asset additions and depreciation and adjusts for the impact of the PFI revenue costs under IFRS16 compared to on a UK GAAP basis.

- In month deficit of £89k against a planned deficit of £106k giving a positive variance of £17k.
- Year to date position is a deficit of £173k against a planned deficit of £212k giving a positive variance of £39k.
- The Trust is forecasting to be breakeven at year end.

- Income year to date is under performing due to patient placement income (£97k - offset with decreased non pay expenditure) and service development slippage.
- Pay year to date is underspent due to vacancy slippage particularly in the Community teams.
- Non-pay year to date is overspent due unmet CIP and premises costs and is offset by underspend relating to patient placements costs (£97k - offset with increased income).
- Finance & other non-operating costs are slightly underspent due to reduced depreciation.

PROUD TO CARE

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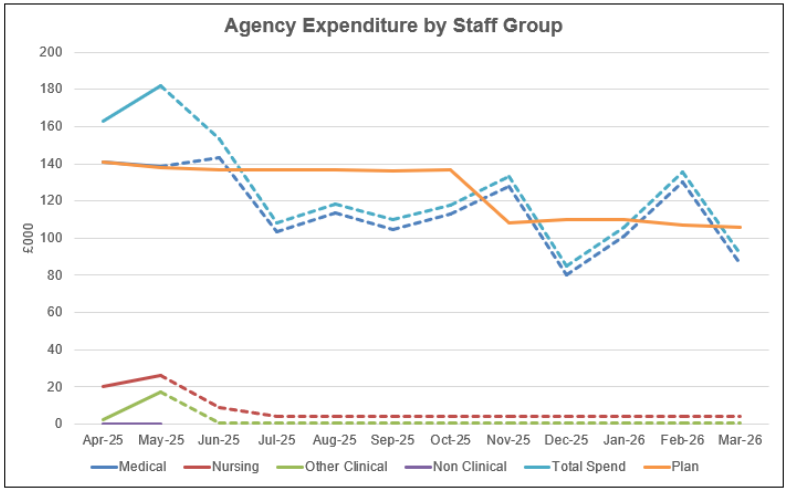
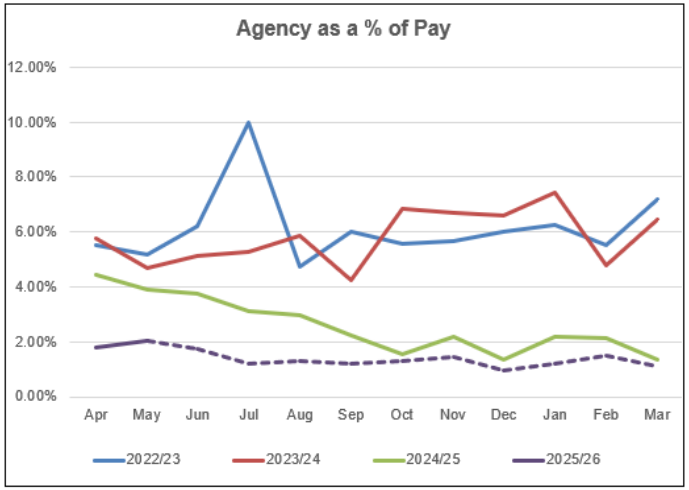
Finance Position

Agency Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Agency Expenditure	Actual		YTD	Forecast										Total
	Apr-25 £000	May-25 £000	£000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	Oct-25 £000	Nov-25 £000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical														
Community	(96)	(95)	(191)	(132)	(87)	(86)	(99)	(99)	(124)	(74)	(99)	(124)	(74)	**(1,191)**
Specialist Care	(17)	(19)	(36)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	**(203)**
Primary Care	(28)	(24)	(52)	(17)	(21)	(32)	(10)	(18)	(9)	(10)	(6)	(11)	(17)	**(204)**
Central Services	0	0	0	22	22	22	22	22	22	22	22	22	22	**215**
Nursing														
Acute Services & Urgent Care	(2)	(10)	(12)	(5)	0	0	0	0	0	0	0	0	0	**(17)**
Quality & Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Primary Care	(5)	1	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	**(32)**
Specialist Care	(13)	(17)	(31)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	**(127)**
Central Services	0	0	0	8	8	8	8	8	8	8	8	8	8	**83**
Other Clinical														
Acute Services & Urgent Care	(1)	(0)	(2)	0	0	0	0	0	0	0	0	0	0	**(2)**
Quality & Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Specialist Care	(1)	(12)	(13)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(20)**
Primary Care	0	(5)	(5)	0	0	0	0	0	0	0	0	0	0	**(5)**
Non Clinical														
Quality & Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
People & OD	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total Agency	**(163)**	**(182)**	**(345)**	**(153)**	**(108)**	**(119)**	**(110)**	**(118)**	**(133)**	**(85)**	**(106)**	**(135)**	**(91)**	**(1,504)**
Agency as a % of Pay	1.82%	2.04%	3.85%	1.73%	1.22%	1.33%	1.22%	1.30%	1.46%	0.94%	1.19%	1.52%	1.09%	**1.30%**
Plan	(141)	(138)	(279)	(137)	(137)	(137)	(136)	(137)	(108)	(110)	(110)	(107)	(106)	**(1,504)**
Variance to Plan (Overspend) / Underspend	(22)	(44)	(66)	(16)	29	18	26	19	(25)	25	4	(28)	15	**0**
Agency Variance as a % of Plan	15.74%	31.84%	23.71%	12.03%	(20.99%)	(13.47%)	(19.26%)	(14.01%)	23.16%	(22.74%)	(3.81%)	26.56%	(13.78%)	**(0.02%)**





- Planned agency expenditure for 2025/26 is £1,504k this represents a mandated 40% reduction of 2024/25 expenditure levels.
- In month expenditure is £182k against planned expenditure of £138k representing an adverse variance of £44k.
- Year to date expenditure is £345k against planned expenditure of £279k representing an adverse variance of £66k.
- Forecast agency expenditure is to plan.
- Year to date nursing (qualified and unqualified) and medical spend are the main drivers of the adverse variance.
- Use of locums continues to be the main agency driver both year to date and forecast outturn, particularly within the Community Directorate.

PROUD TO CARE

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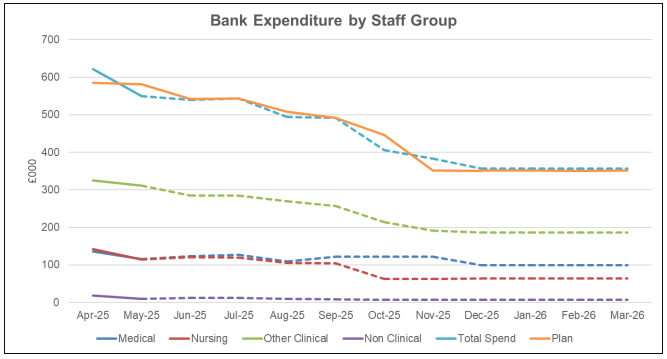
Finance Position

Bank Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Bank Expenditure	Actual		YTD	Forecast										Total
	Apr-25 £000	May-25 £000	£000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	Oct-25 £000	Nov-25 £000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical														
Acute Services & Urgent Care	(18)	(24)	(42)	(21)	(21)	(21)	(21)	(21)	(21)	(21)	(21)	(21)	(21)	**(250)**
Community	(64)	(38)	(102)	(31)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	(36)	**(456)**
Specialist Care	(54)	(54)	(108)	(49)	(49)	(31)	(44)	(44)	(44)	(20)	(20)	(20)	(20)	**(449)**
Central Services	0	0	0	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	**(215)**
Nursing														
Acute Services & Urgent Care	(101)	(88)	(189)	(84)	(84)	(74)	(74)	(33)	(33)	(33)	(33)	(33)	(33)	**(706)**
Community	(4)	(4)	(8)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	**(36)**
Quality & Nursing	(1)	0	(1)	(1)	(1)	(1)	(1)	0	0	0	0	0	0	**(6)**
People & OD	(2)	(3)	(5)	(2)	(1)	(1)	(1)	(1)	(1)	(2)	(2)	(2)	(2)	**(18)**
Primary Care	(1)	(2)	(3)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(13)**
Specialist Care	(32)	(16)	(48)	(21)	(21)	(18)	(16)	(16)	(16)	(16)	(16)	(16)	(16)	**(222)**
Central Services	0	0	0	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)	**(83)**
Other Clinical														
Acute Services & Urgent Care	(200)	(186)	(386)	(174)	(174)	(164)	(160)	(120)	(108)	(103)	(103)	(103)	(103)	**(1,694)**
Community	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Quality & Nursing	0	(0)	(0)	0	0	0	0	0	0	0	0	0	0	**(0)**
MACE	(5)	(3)	(8)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	**(50)**
Operations	(3)	(3)	(6)	(3)	(3)	(3)	0	0	0	0	0	0	0	**(15)**
People & OD	(6)	(3)	(9)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	**(40)**
Specialist Care	(111)	(114)	(225)	(87)	(87)	(82)	(76)	(73)	(63)	(63)	(63)	(63)	(63)	**(945)**
Primary Care	(1)	(1)	(2)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(14)**
Central Services	0	0	0	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	**(127)**
Non Clinical														
Acute Services & Urgent Care	(1)	(0)	(2)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	**(5)**
Chief Executive Office	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MACE	(0)	(0)	(1)	(0)	(0)	(0)	(0)	0	0	0	0	0	0	**(3)**
Quality & Nursing	(5)	(3)	(8)	(3)	(3)	(1)	0	0	0	0	0	0	0	**(14)**
Strategy & Development	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
People & OD	(8)	(3)	(11)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	**(68)**
Primary Care	(2)	(2)	(4)	(2)	(2)	0	0	0	0	0	0	0	0	**(7)**
Rechargeables	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Specialist Care	(1)	(1)	(2)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(17)**
Total Bank	**(622)**	**(550)**	**(1,171)**	**(540)**	**(543)**	**(495)**	**(491)**	**(405)**	**(383)**	**(356)**	**(356)**	**(356)**	**(356)**	**(5,453)**
Bank as a % of Pay	6.93%	6.16%	6.54%	6.07%	6.12%	5.55%	5.47%	4.46%	4.21%	3.94%	4.00%	3.99%	4.24%	**4.37%**
Plan	(585)	(581)	(1,166)	(542)	(543)	(508)	(492)	(446)	(352)	(351)	(351)	(350)	(352)	**(5,453)**
Variance to Plan (Overspend) / Underspend	(37)	31	(5)	2	(0)	13	1	41	(31)	(5)	(5)	(6)	(4)	**0**
Bank Variance as a % of Plan	6.24%	(5.36%)	0.46%	(0.40%)	0.05%	(2.62%)	(0.21%)	(9.16%)	8.84%	1.46%	1.46%	1.75%	1.17%	**(0.00%)**



- Planned bank expenditure for 2025/26 is £5,453k this represents a mandated 10% reduction of 2024/25 expenditure levels.
- In month expenditure is £550k against planned expenditure of £561k representing a favourable variance of £31k.
- Year to date expenditure is £1,171k against planned expenditure of £1,166k representing an adverse variance of £5k.
- Forecast bank expenditure is to plan.
- 73% of expenditure to date relates to nursing (qualified and unqualified) representing a small favourable variance to plan.
- 21% of expenditure to date relates to medical staffing with a favourable variance to plan.
- The unfavourable variance to plan is due to therapeutic staff to date totalling £40k.

Finance Position

CIP Delivery

NHS North Staffordshire Combined Healthcare NHS Trust

2025/26 Efficiency Identified Schemes	Target £000	YTD 2025/26 Plan £000	YTD 2025/26 Actual £000	YTD 2025/26 Variance £000	Total Forecast Plan £000	Total Forecast Actual £000	Total Forecast Variance £000	*Of which is Recurrent Plan £000*	*Of which is Recurrent Actual £000*	*Of which is Recurrent Variance £000*
Clinical										
Acute	360	41	0	(41)	360	548	188	*360*	*548*	*188*
Community	2,045	235	248	13	2,045	1,903	(143)	*2,045*	*1,903*	*(143)*
Specialist	644	74	33	(41)	644	378	(266)	*644*	*378*	*(266)*
Primary Care	19	2	0	(2)	19	8	(11)	*19*	*8*	*(11)*
Clinical Total	**3,069**	**353**	**281**	**(72)**	**3,069**	**2,837**	**(232)**	***3,069***	***2,837***	***(232)***
Corporate										
CEO	42	5	0	(5)	42	0	(42)	*42*	*0*	*(42)*
Q&N	300	34	0	(34)	300	2	(298)	*300*	*2*	*(298)*
S&D	364	42	0	(42)	364	251	(113)	*364*	*251*	*(113)*
Finance	93	11	0	(11)	93	0	(93)	*93*	*0*	*(93)*
Performance	32	4	0	(4)	32	0	(32)	*32*	*0*	*(32)*
Estates	56	6	0	(6)	56	150	94	*56*	*150*	*94*
MACE	104	12	0	(12)	104	0	(104)	*104*	*0*	*(104)*
Operational	1	0	0	(0)	1	0	(1)	*1*	*0*	*(1)*
People	174	20	0	(20)	174	0	(174)	*174*	*0*	*(174)*
Corporate Total	**1,166**	**134**	**0**	**(134)**	**1,166**	**403**	**(764)**	***1,166***	***403***	***(764)***
Trustwide	**1,532**	**129**	**33**	**(96)**	**1,532**	**2,528**	**996**	***167***	***1,163***	***996***
Productivity	**1,600**	**266**	**0**	**(266)**	**1,600**	**1,600**	**0**	***1,600***	***1,600***	***0***
Total Trust CIP	**7,367**	**882**	**315**	**(567)**	**7,367**	**7,367**	**(0)**	***6,002***	***6,002***	***(0)***
Total Efficiency identified	**7,367**	**882**	**315**	**(567)**	**7,367**	**7,367**	**(0)**	**6,002**	**6,002**	**(0)**
Total Efficiency unidentified						**0**	**0**		**0**	**0**
Total Trust Efficiency YTD & Forecast		**882**	**315**	**(567)**	**7,367**	**7,367**	**0**	***6,002***	***6,002***	***0***

- The efficiency target is £7.4m (reflecting 5.4% of the Trust total cost base excluding TCP & Complex Care) and includes £1.6m recurrent productivity target.
- Of the £7.4m target, £6.0m is recurrent and £1.4m non-recurrent.
- At Month 2 the Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £1.9m transacted, £0.5m fully developed, £4.1m plans in progress and £0.9m opportunities identified.

PROUD TO CARE

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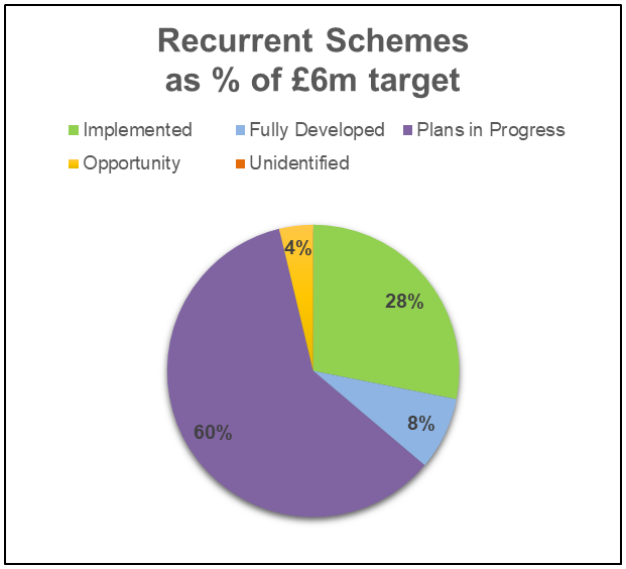
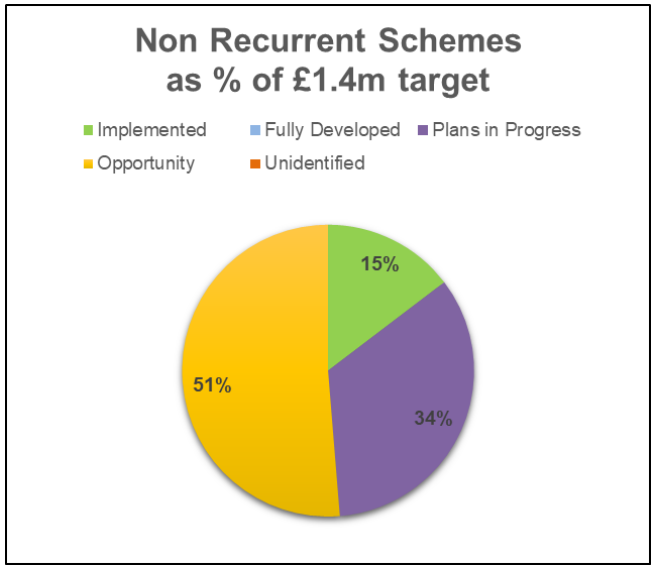
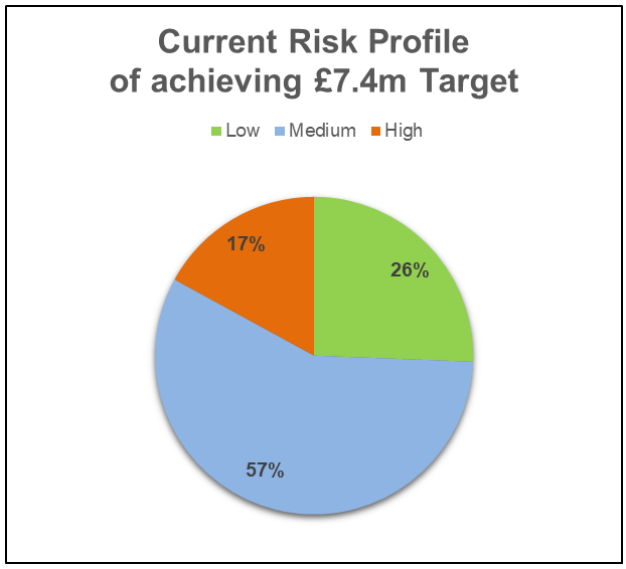
Finance Position

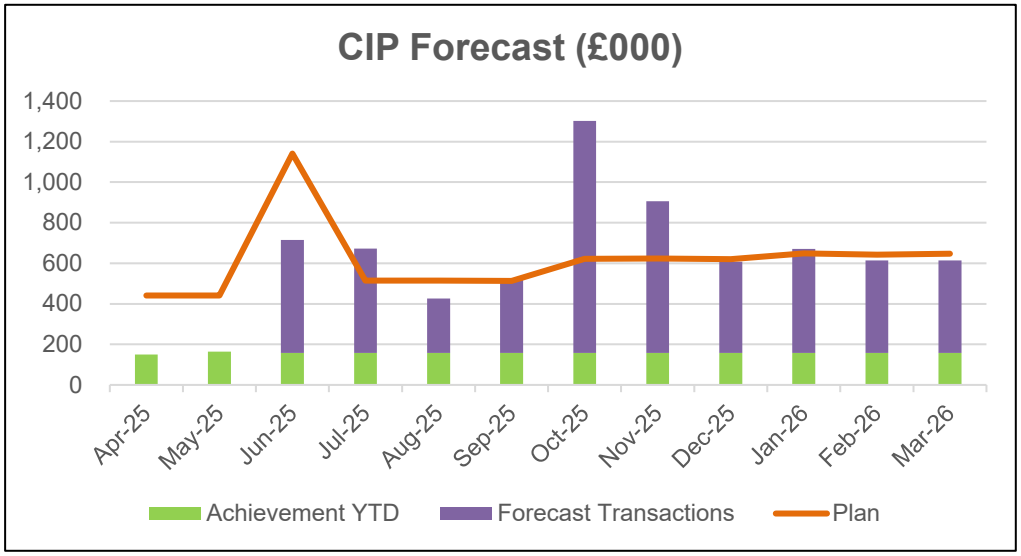
CIP Delivery

North Staffordshire Combined Healthcare NHS Trust









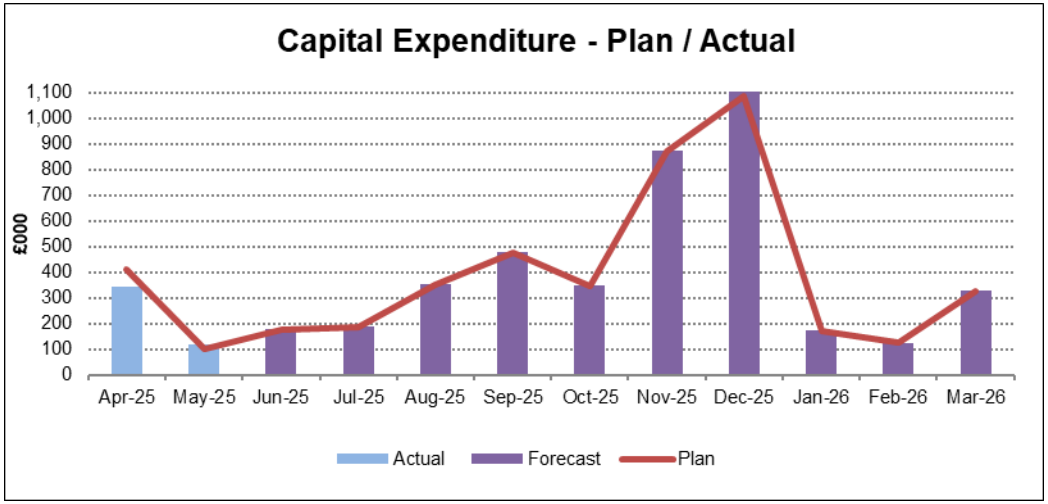
- 28% of the recurrent target has been implemented (transacted) and 8% fully developed.
- 60% of the recurrent target are plans in progress and 4% opportunities identified.
- 15% of the non-recurrent target has been implemented (transacted).
- 51% of the non-recurrent target are opportunities identified and 34% plans in progress.
- Currently 17% of schemes are considered high risk, 57% medium risk and 26% low risk.

Finance Position

Capital Expenditure

North Staffordshire Combined Healthcare NHS Trust

Capital Expenditure	Annual Plan £000	Year to Date Against Plan			Forecast Outturn Against Plan		
		Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Operational Schemes							
IFRS16 Leases	199	0	0	0	199	199	0
Medical Equipment	30	0	0	0	30	30	0
Backlog Maintenance	470	0	0	0	470	470	0
Estates Fleet	120	0	0	0	120	120	0
Energy Efficiency	75	0	0	0	75	75	0
Capital freedom & flexibilities	362	0	0	0	362	362	0
Digital							
IT Digital Replacement	239	0	0	0	239	239	0
Capitalised Salaries - IT Device Replacement	40	6	7	1	40	40	0
Digital Innovations	50	0	0	0	50	50	0
Digital Infrastructure	100	0	0	0	100	100	0
Strategic Schemes							
Dormitory Conversion Trust funded	1,943	503	456	(47)	1,943	1,943	0
Contingency/Reactive Schemes							
Contingency	0	0	(3)	(3)	0	0	0
Total Trust Funded Capital Expenditure	**3,628**	**509**	**459**	**(50)**	**3,628**	**3,628**	**0**
Frontline Digitisation Programme PDC Funded	1,000	0	0	0	1,000	1,000	0
Total Gross Capital Expenditure	**4,628**	**509**	**459**	**(50)**	**4,628**	**4,628**	**0**
Lease de-recogniton	0	0	0	0	0	0	0
Add back charitable funds expenditure	0	0	0	0	0	0	0
Total Charge against Capital Resource Limit	**4,628**	**509**	**459**	**(50)**	**4,628**	**4,628**	**0**



- The Trust's annual capital plan is £4,628k.
- The Trust's year to date gross capital expenditure is £459k against planned expenditure of £509k representing a favourable variance of £50k.
- The favourable variance is due to timing in relation to the eradication of dormitories at the Harplands and is expected to deliver plan levels by the end of the financial year.
- Forecast expenditure is to plan.
- The total charge to the Trust's Capital Resource Limit at Month 2 is £459k, £50k below plan.

Finance Position

Statement of Financial Position

North Staffordshire Combined Healthcare NHS Trust

SOFP	M12 £000	M1 £000	M2 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	19,669	19,966	20,040
Property, Plant and Equipment	16,577	16,492	16,402
Right of Use Assets	3,009	2,969	2,933
Intangible Assets	1,833	1,790	1,747
NCA Trade and Other Receivables	612	606	597
Total Non-Current Assets	**41,701**	**41,823**	**41,720**
Current Assets			
Inventories	84	66	81
Trade and Other Receivables	6,394	9,118	5,847
Cash and Cash Equivalents	31,906	31,735	31,726
Total Current Assets	**38,384**	**40,919**	**37,653**
Current Liabilities			
Trade and Other Payables	(21,163)	(23,989)	(20,864)
Provisions	(1,622)	(1,622)	(1,622)
Borrowings	(2,990)	(3,141)	(3,072)
Total Current Liabilities	**(25,775)**	**(28,752)**	**(25,558)**
Net Current Assets / (Liabilities)	**12,609**	**12,167**	**12,096**
Total Assets less Current Liabilities	**54,310**	**53,990**	**53,816**
Non Current Liabilities			
Provisions	(1,341)	(1,340)	(1,341)
Borrowings	(17,205)	(16,926)	(16,795)
Total Non-Current Liabilities	**(18,546)**	**(18,266)**	**(18,135)**
Total Assets Employed	**35,764**	**35,724**	**35,680**
Financed by Taxpayers' Equity			
Public Dividend Capital	23,983	23,983	23,983
Retained Earnings reserve	4,804	4,764	4,720
Revaluation Reserve	6,977	6,977	6,977
Total Taxpayers' Equity	**35,764**	**35,724**	**35,680**

Current receivables are £5,847k of which:

- £2,431k is based on accruals (not yet invoiced).
- £3,416k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,616k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.
- Local Authority and Non-NHS invoices overdue by 91+ days are included in the bad debt provision.

Current Liabilities are £25,558k of which:

- Trade and Other payables remain high at £20,864k because of deferred income and patient placement invoices and accruals.

Liquidity ratio:

- A good liquidity ratio should be above 1.0.
- The Trust current ratio is 1.5 showing the Trust can cover its current debt obligation.

PROUD TO CARE

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Finance Position

Better Payment Practice Code

NHS North Staffordshire Combined Healthcare NHS Trust

Better Payment Practice Code	In Month			YTD Total		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices						
Total Paid	17	901	918	45	1,700	1,745
Total Paid within Target	17	861	878	44	1,632	1,676
% Number of Invoices Paid	100%	96%	96%	98%	96%	96%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**5%**	**1%**	**1%**	**3%**	**1%**	**1%**
Value of Invoices						
Total Value Paid (£000s)	469	8,175	8,644	940	16,430	17,370
Total Value Paid within Target (£000s)	469	8,128	8,597	938	16,343	17,281
% Value of Invoices Paid	100%	99%	99%	100%	99%	99%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**5%**	**4%**	**4%**	**5%**	**4%**	**4%**

The BPPC target is to pay at least 95% of invoices in terms of number and value within 30 days for NHS and Non-NHS suppliers.

- During Month 2, the Trust has achieved the 95% target on both the value and number of invoices paid at 99% on value and 96% on the number paid within 30 days.
- Year to date the Trust has achieved the 95% target on both the value of invoices paid at 99% and number of invoiced paid within 30 days at 96%.
- The finance team will continue to monitor and target those areas that are not promptly authorising invoices.

PROUD TO CARE

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Finance Position Summary

North Staffordshire Combined Healthcare NHS Trust

The Board are asked to receive the Month 2 position noting:

- The year-to-date deficit of £173k.
- Agency expenditure of £345k.
- Bank expenditure of £1,171k.
- CIP delivery position.
- The Month 2 capital position.
- The cash position of the Trust on 31st May with a balance of £31.7m.

Enclosure No: 14

F&R Committee Assurance Report

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Russell Andrews, Committee Chair, Non-Executive Director
Prepared by:	Lisa Dodds, Deputy Chief Finance Officer
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk	Risk 2 The Trust fails to deliver a balanced financial plan in 24/25
Approval / Review:	Finance and Resource Committee
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Part of the aggregate ICS reported financial position
Recommendation / Required Action	The Board is asked to receive the contents of this report and take assurance from the review and challenge evidenced in the Committee.

Executive Summary	This paper details the items discussed at the Finance and Resource Committee meeting held on the 3rd July 2025. Updates were received relating to: • M2 Trust Performance • Risk Register • Board Assurance Framework • M2 Finance Position • M2 ICS Finance • Cost Improvement Programme • Q4 2024/25 Service Line Reporting • Estates and Capital • Business Opportunities • Digital Project updates

VERSION CONTROL:

Version	Report to	Date Reported
1	Public Trust Board	03/07/2025

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 3rd June 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Finance & Resource Committee. The meeting was completed using Microsoft Teams and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key Finance & Resource Committee performance indicators and the Finance & Resource Committee Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the three categories of Alert, Advise and Assure. Each category provides assurance on the quality of service and activity delivered under the Finance & Resource Committee's remit and programmes of work.

ALERT:

This section summarises the key points that members of the Trust Board need to be aware of.

Heading:

Concerns were raised regarding extensions of the risk of the water temps, noting that this is outside of the Trust's control. Discussions took place on the contract management of the PFI.

ADVISE:

This section advises of key activity and updates in relation to programmes of work.

Heading:

Committee were advised that the Trust is awaiting scoreboard for the new NHS Oversight Framework due to be published on 7th July. Discussions took place on metrics included and how these are calculated.

ASSURE:

This section provides assurance of the quality of service and activity delivered under the Finance & Resource Committee's remit and programmes of work.

Heading:

IQPR M2
Committee received the report with highlights made regarding new metrics included in the report, out of area placements and inpatient length of stay. Discussions took place on safer staffing, out of area patients and clinical fit for discharge.

Finance Position M2
Key messages highlighted included a small year-to-date deficit position, however this is better than plan. Bank and agency costs in month were both above the required reductions. 26% of CIP schemes have been transacted in Month 2 against the annual target. Capital expenditure is lower than planned year-to-date, forecast to be on plan. Discussions on bank and agency spend.

ICS Finance Update M2
At Month 2 the System reported a year-to-date deficit of £16.0m, £2.9m adverse to plan. The net risk has reduced to £70.5m.

Cost Improvement Programme
Key messages highlighted included in month progress on CIP deliverability and specifically the significant movement in scheme status over the last couple of weeks. Discussion took place on quality impact assessments and reporting into Quality Committee.

Service Line Reporting Q4
Committee received the report with highlights on the inclusion of WTE in the report and how this information is being shared with the Directorates. Discussions took place on what do we want to see and what does good look like.

Estates Update
Committee received the report with highlights on fire doors and the final stage of Project Chrysalis. Discussions took place on leases and fire safety report progress.

Digital Update
Committee received the report highlighting change in the reporting for governance purposes. Discussion took place on how Committee gain assurance on key digital projects.

Business Opportunities
Committee received the report highlighting an expression of interest opportunity with the Local Authority and Neighbourhood health pilots.

APPROVE:

This section provides an update of items which were discussed and approved by the Committee.

Heading:

Risk Register
No new risks, no closures and one score change for approval relating to data quality and reporting due to insufficient capacity in the Performance team. Three existing risks have been updated.

Board Assurance Framework

Proposed BAF risks for the 2025/26 were approved as work in progress noting that this is an iterative process. It was agreed that the new BAF risk on 'Digital' needs further work.

Green Plan Refresh

The Green Plan refresh was approved by Committee for onward approval at Trust Board. The Green Plan is due to be publication before the end of July.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 7th August 2025 at 10am in the Boardroom at Lawton House.

Committee Chair: Russell Andrews, Chair of the Finance & Resource Committee.

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 15

Green Plan 2025-2028

Report provided for:			
Information	☐	Assurance	☐
Discussion	☐	Approval	☒

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Liz Mellor, Chief Strategy Officer
Prepared by:	John Cousins, TMO Service Manager Sarah Newton, TMO Senior Service Manager
Executive Lead:	Liz Mellor, Chief Strategy Officer

Aligned to Board Assurance Framework Risk	Risk 6 Failure to embed and sustain net zero principles in the planning and delivery of care and support
Approval / Review:	SLT approval: 24.06.25 Finance and Resource Committee approval: 03.07.25
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent
Resource Implications:	No direct implications related to the Green Plan launch. Actions related to deliverables that require resource will be considered throughout the 3-year term of the Green Plan.
Funding Source:	No direct funding source aligned to Green Plan launch and delivery.
Diversity & Inclusion Implications	We aspire towards achieving a diverse network of sustainability champions from across the Trust and ensuring a culture of inclusion for all.
ICS Alignment / Implications:	This programme of work is aligned to the Staffordshire and Stoke-on-Trent Integrated Care System (SSoT ICS) Green Delivery plan, for which NSCHT is a partner provider.

Recommendation / Required Action	Following SLT and Committee approval, Board is asked to: • Approve the content of the proposed Green Plan (2025-28), enabling the Trust to meet national governance expectations and timescales for publication (July 2025). • Endorse the publication of a public facing Green Plan that will be paired with an internal Green Action Plan to monitor and track delivery over the next 3 years.
Executive Summary	The Trust's Green Plan 2025–2028 outlines our renewed commitment to environmental sustainability as a pillar of delivering outstanding healthcare. Building on national NHS ambitions and regional partnerships, the Trust sets out a pathway to reduce its environmental impact and achieve Net Zero by 2045. The Green Plan will be a public-facing document. A detailed and operational Green Action Plan will underpin the Green Plan. This will set out measurable targets aligned to our strategic aims. **Strategic Context** This Green Plan aligns with NHS England's Green Plan Guidance, the Royal College of Psychiatrists' climate emergency declaration, and the broader Staffordshire and Stoke-on-Trent Integrated Care System (SSOT ICS) sustainability goals. The Trust also recognises the UK government's climate targets and sector-wide sustainability standards. **Governance and Delivery** The sustainability programme is led by the Chief Strategy Officer and overseen by the Transformation Management Office. A Greener Working Group and Sustainability Steering Group ensure structured governance, regular reporting, and staff engagement across the Trust's 30+ sites. Finance and Resource Committee will act as the designated Board committee to receive a quarterly assurance report, outlining progress against the Trust's plan. **Key Focus Areas and Commitments (2025-28)** The Plan is structured around nine core sustainability domains, consistent with national NHS priorities: 1. Workforce & Leadership – Enhancing staff training, engagement, and integrating sustainability into recruitment and leadership. 2. Estates – Reducing building-related emissions via LED upgrades, heating decarbonisation, and smarter waste contracts. 3. Travel & Transport – Promoting low-emission vehicles and active travel, informed by regular travel surveys. 4. Food & Nutrition – Reducing food waste and offering more

plant-based, low-carbon meal choices.
5. Digital Transformation – Scaling digital care, reducing printing, and moving to paperless systems.
6. Adaptation – Embedding climate resilience in estates planning and emergency preparedness.
7. Medicines – Minimising pharmaceutical emissions through initiatives like Patient Own Drugs and e-prescribing.
8. Net Zero Clinical Transformation – Delivering high-quality, preventative, and low-carbon models of care.
9. Supply Chain & Procurement – Prioritising recycled materials and sustainability impact assessments in purchasing.

Achievements to Date (2022–2025)

The Trust has made measurable progress, including:

- A carbon footprint reduction to 1,308 tCO2e in 2022, down from the 2020/21 baseline.
- Expansion of LED lighting and heating decarbonisation plans.
- Training 389 staff through the Sustainability Champion initiative.
- Significant food waste reduction (over 70%) at Harplands Hospital.
- Transition to fully recycled paper and sustainable procurement practices.

Case Studies

The Plan includes practical examples such as the Team Reward Scheme (incentivising team-led sustainability efforts), a Cycle to Work initiative, and successful strategies for reducing food waste, showcasing collaboration, staff engagement, and innovation.

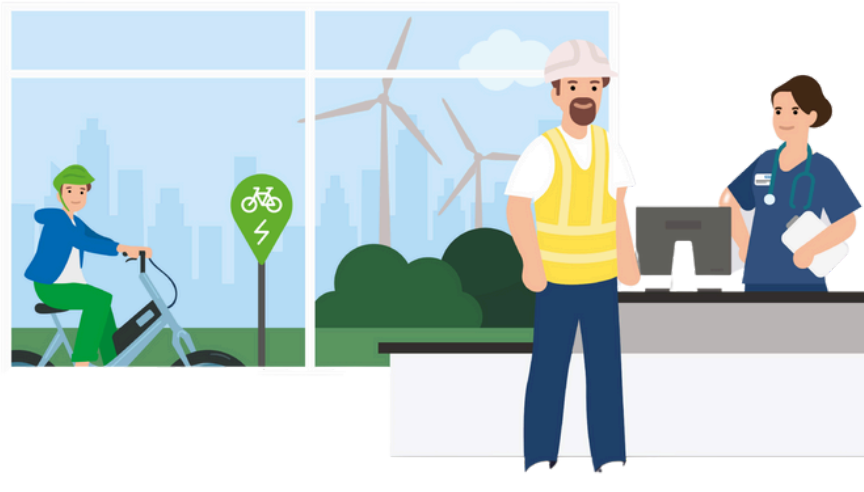
VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	24.06.25
V2	F&R Committee	03.07.25
V3	Public Trust Board	10.07.25

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Our Green Plan
2025-28

HEALTHIER PLANET
HEALTHIER PEOPLE



Contents

Foreword

At North Staffordshire Combined Healthcare NHS Trust, our vision has always centred on delivering outstanding care through people. This same ambition guides our commitment to environmental sustainability. As an 'outstanding' provider of mental health, learning disability, substance misuse and primary care services, we understand that the health of our people is deeply linked with the health of our planet.

The publication of our updated Green Plan marks an important milestone in our journey towards a net zero NHS. This document is not just a plan, it is a pledge. A pledge to our patients and service users, our staff, our partners, and the wider community we serve across North Staffordshire and Stoke-on-Trent. It outlines the practical steps we are taking to reduce emissions, adapt our services, and embed sustainability at the heart of everything we do. This includes thinking about the way we power our buildings, to how we travel, procure goods, and deliver care.

Our actions are rooted in national guidance and driven by local innovation. We are aligning with the NHS's net zero targets, the Royal College of Psychiatrists' call for climate action, and the aspirations of our partners in the Staffordshire and Stoke-on-Trent Integrated Care System. Together, we are building a future where environmental responsibility and health equity go hand in hand.

Progress is already underway. We have seen reductions in our carbon footprint, launched innovative sustainability programmes and empowered our workforce with the tools and training to lead the way. But we know that we must go further, and faster. This Green Plan therefore reflects our determination to lead by example. It sets out how we will continue to reduce our environmental impact while delivering safe, effective, and compassionate care.

I would like to thank all our staff, partners, and sustainability champions who have contributed to this important work. Your commitment is helping to shape a greener, healthier, and more resilient future for our local communities.

Liz Mellor (Chief Strategy Officer)
North Staffordshire Combined Healthcare NHS Trust

Introduction

As a leading provider of inpatient and community mental health, learning disability, substance misuse and primary care services across North Staffordshire and Stoke-on-Trent, the Trust is committed to the NHS ambition to reduce its carbon footprint. This commitment spans our estates and the services we deliver.

We also recognise the importance of our role with system partners to reduce emissions across the Staffordshire and Stoke-on-Trent Integrated Care System (SSOT ICS), to support the transition to a net zero NHS. This Green Plan has been informed by the Trust's learning to date and its commitment to this agenda. National legislation and NHS requirements also underpin our approach to ensure we minimise the adverse impacts we have on the environment.

The foundations of our Green Plan

Our work is aligned with the recommendations in the:

- Delivering a Net Zero National Health Service Report
- NHS Operational Planning and Contracting Guidance
- Estates Net Zero Carbon Delivery Plan
- Net Zero Building Standard
- Net Zero Supplier Roadmap
- Net Zero Travel and Transport Strategy

We also acknowledge the net zero pledges made by the Royal College of Psychiatrists (RCPsych) and the role we play in this as a mental health and learning disability care provider in the UK.

Sustainability at a national level

Climate change is considered the greatest environmental threat to global health in the 21st century by many organisations including, but not limited to, the World Health Organisation (WHO), British Medical Association (BMA), the Royal College of Physicians, the Royal College of Psychiatrists (RCPsych) and the Royal College of Nursing.

In 2019, the UK set a legally binding target to achieve net zero carbon emissions by 2050, aligning with the 2008 Climate Change Act. Since then, multiple frameworks have been produced to guide progress towards this goal. The most recent of these is the 'Environmental Manifesto' which outlines the current government's (2025) aims to position the UK as a 'clean energy superpower'. This commits the country to achieving zero-carbon electricity by 2030, ending new oil and gas licenses, and advancing the green sector. This strategy emphasises reducing carbon emissions, making it a priority for all organisational operations.

Sustainability in the NHS

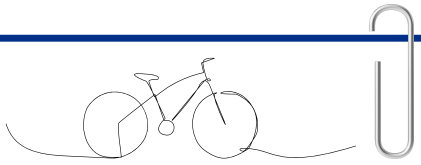
In 2025, NHS England published their 'Green Plan Guidance' to which all updated Trust Green Plans should align. This sets out three overarching aims for Trusts over the upcoming period.

1. To prioritise interventions which support patient care and population health whilst ensuring climate change and sustainability issues are considered.
2. To support planning and investments whilst ensuring increased efficiency of services.
3. To ensure all NHS organisations follow net zero emissions targets.

Sustainability within mental health care provision

As a mental health and learning disability care provider, we have a particular interest in the RCPsych's declaration of a climate and ecological emergency (2021). The 'Delivering Greener, More Sustainable and Net Zero Mental Health Care' (2023) document provides guidance on how mental health care providers can become greener, more sustainable and net zero with a focus on ensuring mental health services comply with environmental sustainability standards, providing learning and development programs on sustainability, and aligning building, food and waste management systems with national sustainability requirements.

Case study



-Cycle to Work Day, working in partnership.

The challenge

Our staff travel to work survey identified barriers to cycling to work, including:

- lack of cycle storage
- cycling confidence/proficiency
- cost of cycling equipment
- route planning

The solution

The Trust used the national Cycle to Work Day as an opportunity to tackle some of the common barriers to cycling, in collaboration with Staffordshire County Council and INTO Newcastle. The event aimed to raise awareness of the many benefits of cycling to work, both in terms of health and wellbeing and environmental sustainability. A range of activities took place on the day to showcase and promote the support available to colleagues.

Our impact

A series of events on the day generated a wide-range of benefits.

- The Combined Cycling Club participated in a 40-mile charity bike ride.

- The Trust has enhanced staff access to sustainable travel resources through updates to the travel section of the sustainability page on our internal website. This now includes links to journey planning tools, cycling proficiency support, and Vivup; our employee benefits platform which offers discounted bikes and cycling equipment via payroll deduction.
- A supporting podcast was also produced and shared to raise awareness. These initiatives promote low-emission commuting options, reduce reliance on car travel, and support our wider goals around carbon reduction and staff wellbeing.
- 10 bikes were donated to the Staffordshire County Council waste minimisation programme which refurbishes and donates bikes to people across North Staffordshire.
- A service called 'INTO Newcastle' promoted their offer to staff and patients. Their service is open to anyone who lives in the area local to our main hospital site.

Sustainability at a local and regional level

Our Trust has a long-standing history of working in collaboration with our patients and service users, our partners, and the wider system. As an outstanding organisation, we have a well-established network of anchor organisations and partners to work with towards net zero.

As a Trust, we operate across 30 sites and from a range of community-based premises. Therefore, we are committed to working collaboratively with others and aligning our own goals and ambitions with those of our partners.

We also align efforts with system partners from across the SSOT ICS to achieve net zero by 2045. The SSOT ICS is responsible for the health and care of 1.16 million people who live in Staffordshire and Stoke-on-Trent, across a geographical area of 1,048 square miles. We are aligned with two local authorities, Staffordshire County Council and Stoke-on-Trent City Council.

The SSOT ICS includes:

- 7 integrated care system portfolios
- 2 local authorities (1 upper tier and 1 unitary)
- 8 district councils
- 26 primary care networks

- 143 GP practices
- 2 acute hospital Trusts
- 2 mental health Trusts
- 1 community health Trust

These organisations, alongside a wide range of voluntary, community, and social enterprise (VCSE) partners, as well as public and private sector stakeholders, collectively support the health and wellbeing of the population across Staffordshire and Stoke-on-Trent. The Trust recognises that the Green Plans developed by our partner organisations are critical enablers of system-wide sustainability, fostering alignment and shared action. For example, local authority commitments to expanding sustainable public transport networks can directly benefit our workforce and service users, by improving access to services while reducing carbon emissions through more cost-effective and environmentally responsible travel across the city and county.

The governance structure of our sustainability programme

Our sustainability programme is led by our Chief Strategy Officer. The Transformation Management Office (TMO) oversee this with support from area of focus leads and sustainability champions.

The following diagram illustrates the current governance structure for sustainability at the Trust.

Figure 1 – our governance structure for sustainability at Combined.

Our Greener Working Group meets regularly. This forum provides key updates on deliverables and is a platform to share ideas, celebrate good news stories and discuss emerging opportunities.

The targets set in our Green Plan are based on NHS net zero targets, along with local and regional key performance indicators. Therefore, highlight reporting provides assurance and includes:

- completed actions to support delivery and implementation
- next actions to support delivery and implementation
- escalation issues and actions required
- risks and mitigation actions required

The Greener Working Group reports to the Sustainability Steering Group where progress and assurance is monitored and subsequently communicated into the wider Trust governance system at executive, committee and board level.

Tracking and reporting progress: metrics and targets
Sustainability reporting requirements for NHS organisations are set out by the Department of Health and Social Care (DHSC) group accounting manual, the Trust annual reporting manual and the NHS Standard Contract.

NHS England acknowledge that in the short term, it is difficult to use emissions alone as an indicator of progress towards the NHS' long-term net zero targets, due to lags in data availability, limitations of spend-based calculations and factors over which the NHS has no control (NHSE, 2025).

Progress within each area of focus is reported against identified metrics on the NHS England Greener NHS Dashboard and the Estates Return Information Collection.

Areas of focus

An overview of the nine key areas of focus.

The NHS Green Plan focuses on achieving net zero carbon emissions by 2040, across nine key areas of focus.

1. Workforce and Leadership

Actions which support staff and leaders to learn, innovate and embed sustainability into everyday actions.

2. Estates

Actions to reduce emissions and lower costs, while improving energy resilience and patient care.

3. Travel and Transport

Actions to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

4. Food and Nutrition

Actions which deliver high-quality, healthy and sustainable food and minimise waste.

5. Digital Transformation

Actions which transform care by improving access, quality, productivity and reducing emissions.

6. Adaptation

Actions which build resilience and adaptation into business continuity and longer-term planning, to avoid climate-related service disruptions.

7. Medicines

Actions which reduce point of use emissions, while improving patient care and reducing waste.

8. Net Zero Clinical Transformation (previously Sustainable Models of Care)

Actions which ensure high-quality, preventative, low-carbon care is provided to patients at every stage.

9. Supply Chain and Procurement

Actions which embed circular solutions, such as using reusable, remanufactured or recycled solutions when clinically appropriate, which are often cost saving.

Our key achievements (2022-2025)

Workforce and leadership

- Launch and roll out of NHSE Net Zero Training.
- Roll out of Carbon Literacy Training.
- Creation of a Sustainability Champion network with representation from across directorates, supporting the delivery of key objectives across teams.
- Delivery and embedding of greener NHS workshops in various forums including Leadership Academy and into our last two cohorts of both Foundations in Leadership and Management and Combined Connects programmes.
- Inclusion of sustainability in recruitment processes and inductions.

Estates

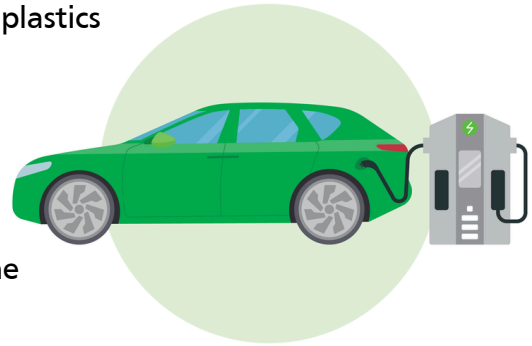
- Installation of LED lighting as standard across premises.
- Heating decarbonisation plans completed across 14 sites.
- Initial roll out of an improved waste and recycling contract.
- Exploration of opportunities for external funding to deliver against decarbonisation plans.

Travel and transport

- Completion of travel survey, with subsequent analysis to inform future plans.
- Feasibility study completed across 11 sites to inform estates planning for EV charging.
- Promotion of active travel through a range of media. For example, the launch of the Cycle to Work scheme.
- New salary sacrifice car scheme launched, promoting only low and zero emission vehicles.

Food and nutrition

- Reduction in food waste across inpatient services.
- Expansion of lower carbon meal choices.
- Promotional and educational events focused on new plant-based menu options.
- Initiatives undertaken to reduce single use plastics and packaging at the on-site hospital café.

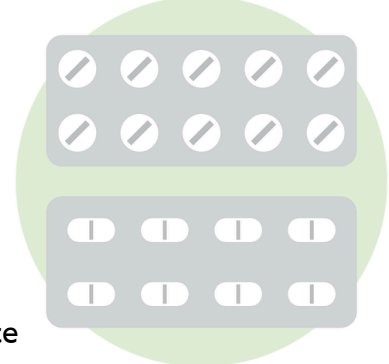


Digital transformation

- Introduction and scaled use of text messaging reminder service.
- Improved Wi-Fi networks installed across the Harplands Hospital site.
- Pre-set of all printing to black and white.
- Ongoing effort to convert and archive historic patient paper records to a digital alternative.

Adaptation

- System delivery plan in progress.
- System working group established.



Medicines

- Initial launch and pilot of Patient Own Drugs (POD) initiative.
- Implementation of Electronic Prescribing and Medicines Administration (EPMA).
- Launch and roll out of QR codes as part of Choice and Medication scheme.

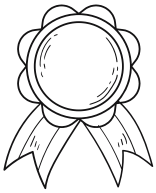
Supply chain and procurement

- Only recycled paper now purchased and used across the Trust.
- Implementation of 2024 net zero supplier road map requirements, including:
  - all NHS procurements include a minimum of 10% net zero social value and social value weighting in procurement tenders
  - all new contracts over £5m require suppliers to publish a carbon reduction plan

Net zero clinical transformation (previously sustainable models of care)

- Launch and roll out of Patchs Health across our primary care services.
- Investment in green spaces and gardens across many inpatient areas, in co-production with patients as part of therapeutic activities.

Case study



-Team reward scheme.

The challenge

To embed the Green Plan principles across all the directorate teams within the Trust. The aim was to grow and strengthen staff awareness and bring cultural change.

The solution

All Trust teams were given the opportunity to participate in a team reward scheme designed to promote engagement, achievement, and ownership of sustainability goals. Through this initiative, teams earned recognition and rewards for their ideas, contributions, and delivery of targeted activities or transformation projects. By completing a series of tasks and challenges aligned with specific criteria, teams could achieve bronze, silver or gold level awards. This demonstrated their active support for, and commitment to, sustainability and the Trust's green agenda.

Our impact

The scheme achieved strong engagement across all Trust directorates, with over 389 staff members from 17 teams actively participating. Each team pledged their commitment to our Green Plan, helping to raise awareness and inspire colleagues across the organisation.

Feedback

I really enjoyed taking part in the team reward scheme for sustainability... the team have recognised ways both at home and at work in which they can participate more towards sustainability. – LW (Digital Transformation Team)

I really enjoyed working on the team reward scheme. Besides the wonderful hampers which were really appreciated, personally I've enjoyed the green conversations with colleagues; the sharing of information, the hints and tips and just expanding my understanding. – LDS (People Operations Team)

Our carbon footprint

The NHS Delivering a Net Zero National Health Service Report (2020) considers NHS emissions across three scopes, with the addition of emissions from patient and visitor travel.

The NHS has the overarching targets to achieve a net zero carbon footprint by 2040 and carbon footprint plus by 2045.
We have created a carbon baseline against which we can monitor and compare our annual CO2e emissions. This section details the methods used to establish the scope of our baseline and the changes in our emissions we have achieved so far. The Greenhouse Gas Protocol (GHGP) divides greenhouse gas emissions into three scopes.

- Scope 1: direct emissions from owned or directly controlled sources on-site.

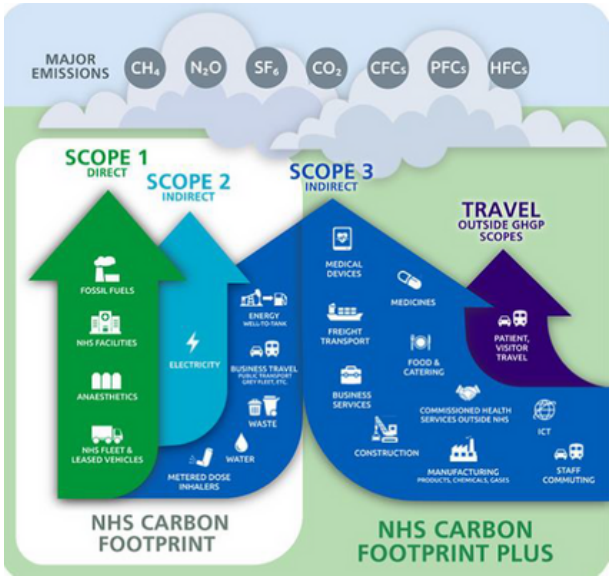


Figure 2 – NHS carbon footprint and carbon footprint plus.

- Scope 2: indirect emissions from the generation of purchased energy, mostly electricity.
- Scope 3: all other indirect emissions that occur in producing and transporting goods and services, including the full supply chain.

Developing our carbon baseline

The Trust's carbon baseline is measured by reporting the annual carbon dioxide equivalent (CO2e) emissions. In the previous Green Plan (2020-21) data was used as our baseline, giving a carbon footprint of 1,683 tCO2e. However, the quality of our data and collection methods has since improved, meaning our updated baseline contains a far greater level of detail and accuracy of our total emissions. We have therefore re-established our baseline as 2022, and this is the year against which all annual CO2 emissions are compared.

Methodology

To calculate our carbon emissions, we have multiplied our annual consumption data (e.g. kWh for gas consumption) by carbon conversion factors. Carbon conversion factors are produced annually by the Department for Energy Security and Net Zero (DESNZ) and Office for National Statistics (ONS) greenhouse gas emissions intensity by industry. This gives us the annual CO2e emissions for each aspect monitored.

Scope of the carbon baseline

The following key aspects of operations within the Trust, which produce carbon emissions are included in our carbon baseline:
scope 1: consists of natural gas and fleet vehicle use emissions
scope 2: consists of electricity
scope 3: consists of water, business travel and waste
scope 3+: consists of ICT for homeworking, virtual consultations and video call

Our overall carbon baseline

In 2022, our baseline year, we produced 1,308 tonnes of CO_2e (tCO_2e). Energy consumption at the Trust was the largest contributor to emissions in the baseline year, contributing to 80% of CO_2e emissions. Emissions from business travel had the next greatest impact on our baseline, making up 11% of total CO_2e emissions.

Since 2022 we have successfully collected and analysed emissions data for 2023 and 2024, comparing these figures against our 2022 baseline. While the Trust's total emissions initially increased, our focused efforts to reverse this trend proved effective. By 2024, we achieved a total reduction compared to the previous year.
The delivery of this Green Plan and the associated action plan is essential to ensure we continue the downward trajectory with the aim of meeting our interim target of an 80% reduction by 2032.

Case study

-Promoting awareness across our workforce

The challenge

To further promote and diversify engagement and learning opportunities about the greener NHS programme and our Green Plan through alternative routes other than the e-learning package available on the LMS.

The solution

In co-production with sustainability champions, a presentation was co-designed and presented to different teams across directorates, which included global climate change matters, and outlined the NHS net zero aspirations and our commitments as a Trust. This enabled wider reach and improved accessibility through attendance at different events and forums to promote knowledge, education and practical steps to more of the workforce.

Our impact

Since 2024, the presentations have been delivered in over 20 team meetings and additionally reached 160 individuals via attendance at:

- team away days
- the Combined Leadership Academy
- the last two cohorts of both the Foundations in Leadership and Management and Combined Connects Leadership Programmes

Feedback has been maintained at a 4.53/5 overall rating and the main topic rated as 'good' or 'excellent' for the workshop. We have intentions of further refinements to the content events that we run for future delivery.

Our green plan commitments

Area of focus: workforce and leadership

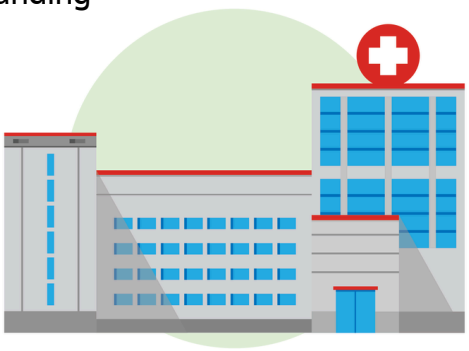
Action: in recognising that our transition to a net zero NHS is driven by our people, we will continue to promote workforce engagement and active participation in our Green Plan. We will explore ways to further develop the Sustainability Champion role through targeted engagement.

Measure: we will continue to increase compliance of NHSE net zero training. We will provide ongoing assurance reporting to executives, committees and Trust Board. We will focus on raising the agenda, for example, an annual presentation in Leadership Academy and the regular and ongoing collation of case studies for communications. The Trust will endeavour to include sustainability in our standard recruitment process.

Area of focus: estates

Action: we will focus on reducing the carbon emissions arising from the organisation's buildings and infrastructure, and consider green plan deliverables in all refurbishment or building works undertaken.

Measure: we will run a co-ordinated 'switch-off' lighting and power campaign in 2025/26. We will pursue future decarbonisation funding opportunities, and further roll out a new waste and recycling contract to deliver the requirements of the current national mandate (in partnership with facilities). We will maintain a 0% position on oil heating systems across all Trust owned premises and consider and implement innovative design solutions across Trust estates that will contribute to Green Plan deliverables.



Area of focus: travel and transport

Action: we will work towards supporting our workforce and our service users to use more sustainable forms of transport and promote and support active travel.

Measure: to continue to work towards reducing emissions from fleet vehicles and travel across scopes 1 and 3, through new initiatives and promoting the use of public transport where feasible.

Explore opportunities to switch Trust fleet to low and zero emission vehicles in line with national timescales *subject to capital funding.

We will encourage completion of the bi-annual travel and transport survey, with results analysis informing future planning and decision-making.

We will continue to collaborate and engage with system partners to effect change for local residents and Trust service users.

Area of focus: food and nutrition

Action: we will continue to work towards reducing our food waste through set reduction targets and offer healthy, seasonal, high quality meal choices including low carbon/plant-based meal options.

Measure: we will maintain a reduction in food waste at our Harplands Hospital site throughout 2025 and beyond, and introduce carbon footprint data on menus.

We will launch and evaluate a digital meal ordering service for service users staying in our inpatient settings, and explore the validity of food wastage disposal via an anaerobic digestion system.

Area of focus: digital transformation

Action: we recognise that strong digital foundations are essential for transforming care by improving access, quality, productivity and reducing emissions. We will support colleagues, service users, and local communities to fully realise the benefits of digital transformation, enhancing patient care while contributing to emissions reduction and environmental sustainability.

Measure: we will continue to recycle all old IT equipment, and work to align our local patient electronic portal to the NHS App.
We will continue conversion and archiving of historic patient paper records to a digital alternative, and focus on printing reduction and the recycling of printer cartridges used across the Trust.

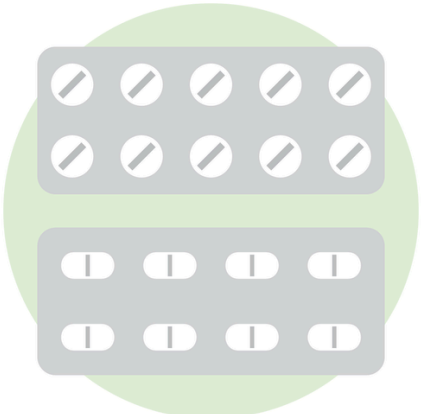
Area of focus: adaptation

Action: we will work to ensure that resilience and adaptation is built into business continuity and longer-term planning to avoid climate-related service disruptions. We will ensure partnership working between sustainability leads, public health, emergency response teams and estates leads in order to do this effectively.

Measure: we will factor in the effects of climate change when making infrastructure decisions and designing new facilities.
We will continue to ensure the cascade of weather health alerts and relevant messaging across the Trust, in line with the government's Adverse Weather and Health Plan.
We will continue our engagement and contribution with partners from across the SSOT ICS.

Area of focus: medicines

Action: we recognise that medicines account for around 25% of NHS emissions and are committed to playing our part with partner providers in reducing emissions from medicines.
Measure: we will reduce medication waste with wards, through expanding the scope of Patients Own Drugs (POD) initiative.
We will explore the use of technology to optimise prescribing practices across the Trust, reducing waste and offering patient choice.



Area of focus: net zero clinical transformation

Action: we are committed to moving to out-of-hospital and digitally enabled care, where clinically appropriate, improving prevention of ill health and reducing health inequalities.

Net zero clinical transformation will work towards ensuring high-quality, preventative, low-carbon care for our service users at every stage.

Measure: quality improvement projects will routinely consider sustainability factors.

We will focus on a measurable reduction in emissions, with co-benefits for outcomes, quality of care, efficiency and reducing healthcare inequalities.

Area of focus: supply chain and procurement

Action: we will continue to work with NHS Supply Chain to reduce and remove waste, sourcing alternative sustainable products where possible.

Measure: we will maintain provision of recycled paper across the Trust, business case templates will also include the requirement to complete a sustainability impact assessment.

Case study

-Tackling food waste.

The challenge

The National Standards for Healthcare Food and Drink state that 'organisations must assess their level of food waste, and set food waste reduction targets and minimisation plans using the WRAP approach - target, measure, act'. The aim being to reduce overall food waste and CO2e, reduce costs and improve the nutrition received by patients.

Since 2023/24, NHS providers have been asked to report food waste data via the Estates Return Information Collection (ERIC) platform across weighed food waste, broken down into:

- preparation waste
- plate waste
- unserved meals
- spoilage

Over the past financial year, our internal facilities team have worked in close partnership with our catering department and the clinical teams to reduce food waste across the Harplands Hospital Site.

The solution

Through strong partnership working, careful monitoring of patient meal orders, and education on recommended portion sizes, teams have successfully maintained menu variety without compromising service quality. This achievement reflects a fantastic collaborative effort between colleagues in facilities, Serco, and our clinical teams.

Our impact

Colleagues at Harplands Hospital have achieved a significant reduction in monthly food waste — from over 2,000 kg during the first and second quartiles of the 2024–2025 financial year to just over 700 kg. This represents a monthly reduction of more than 1,600 kg, or over 70%.

Feedback

> Serco, our soft services provider, have clearly demonstrated their commitment and partnership working with the Trust to implement this initiative. They remain focused on managing and monitoring food waste daily in partnership with the Trust Facilities team. - Staff member (Facilities Team)

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 16

Safer Staffing Monthly Report –May 2025

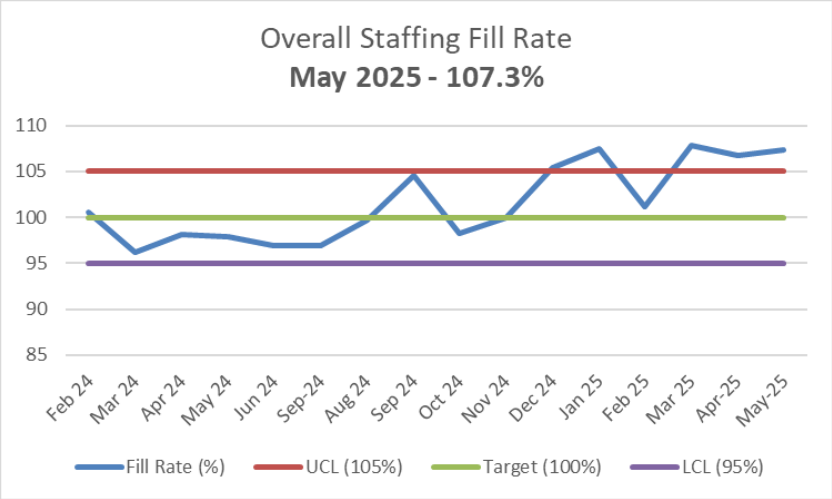
Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

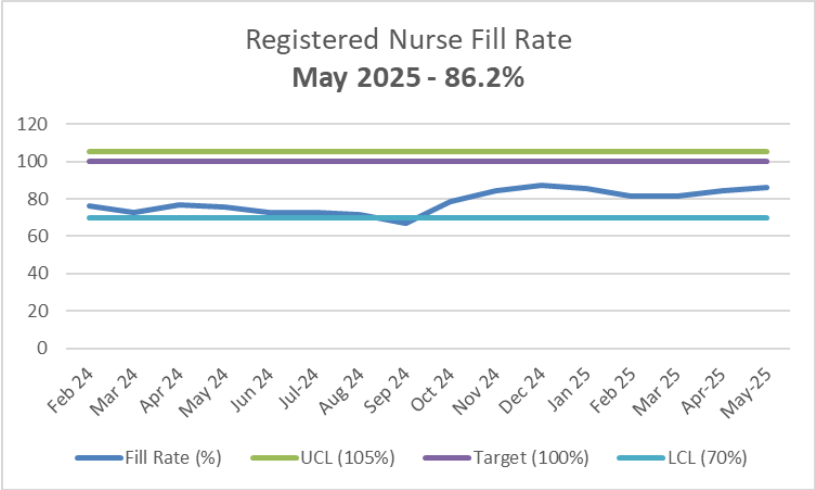
Report to:	Public Trust Board
Date of Meeting:	10th July 2025

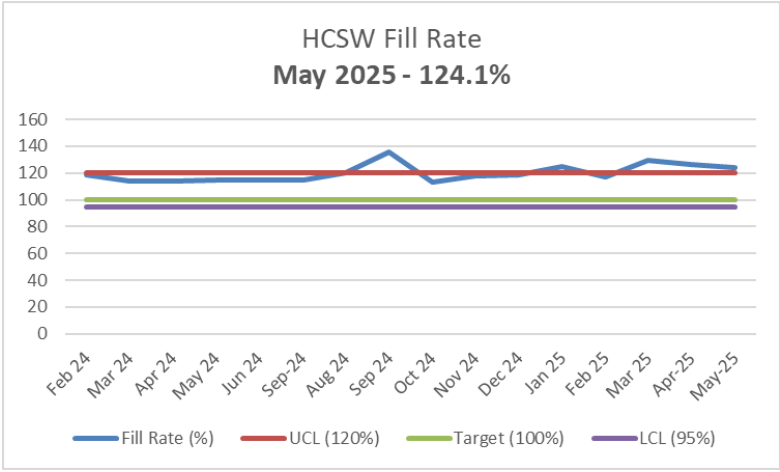
Presented by:	Kenny Laing – Chief Nursing Officer
Prepared by:	Zoe Grant – Deputy Chief Nursing Officer
Executive Lead:	Kenny Laing – Chief Nursing Officer

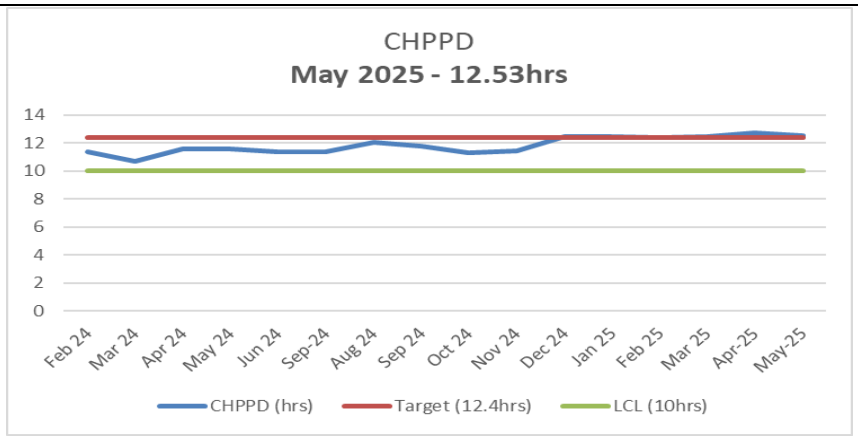
Aligned to Board Assurance Framework Risk	Risk 5 Failure to respond to the demands of services caused by internal and external factors, which might impact on the access, quality and overall experience of services and the wellbeing of service users and staff
Approval / Review:	SLT
Strategic Priorities:	Prevention - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	NA
Diversity & Inclusion Implications	None identified
ICS Alignment / Implications:	None identified
Recommendation / Required Action	The Board is asked to receive the report for information.
Executive Summary	The report details staffing levels for May 2025, including Care Hours per Patient Day (CHPPD) reported to NHS Digital.

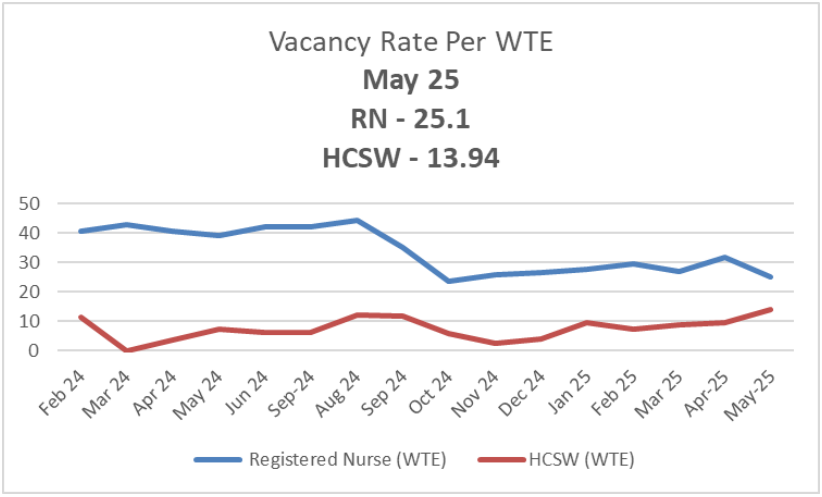
Key Findings

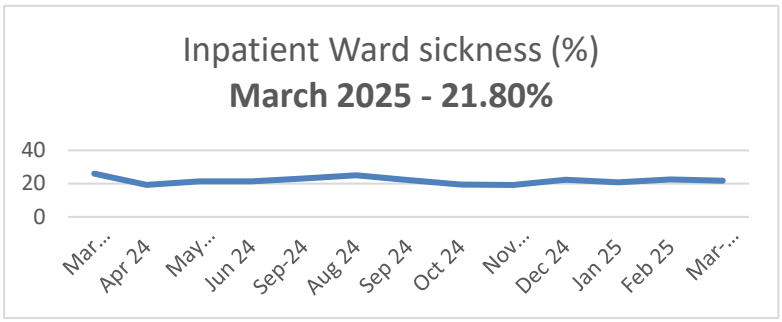


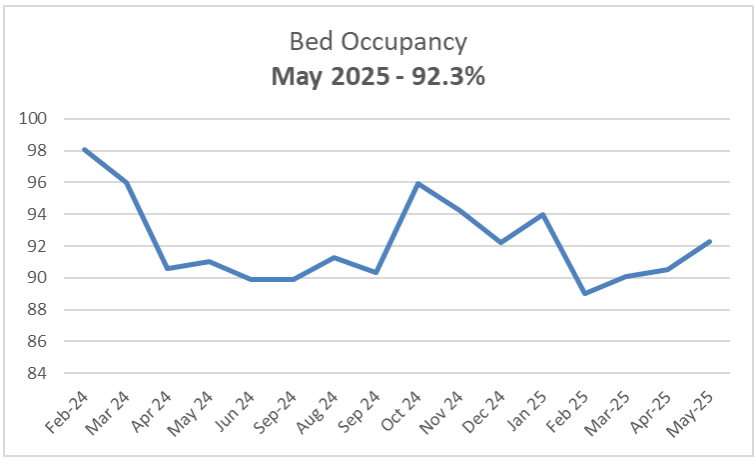





CHPPD
May 2025 - 12.53hrs
14
12
10
8
6
4
2
0
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Sep-24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr-25
May-25
CHPPD (hrs)
Target (12.4hrs)
LCL (10hrs)


Vacancy Rate Per WTE
May 25
RN - 25.1
HCSW - 13.94
50
40
30
20
10
0
Feb 24
Mar 24
Apr 24
May 24
Jun 24
Sep-24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr-25
May-25
Registered Nurse (WTE)
HCSW (WTE)


Inpatient Ward sickness (%)
March 2025 - 21.80%
40
20
0
Mar...
Apr 24
May...
Jun 24
Sep-24
Aug 24
Sep 24
Oct 24
Nov...
Dec 24
Jan 25
Feb 25
Mar-...


Bed Occupancy
May 2025 - 92.3%
100
98
96
94
92
90
88
86
84
Feb-24
Mar 24
Apr 24
May 24
Jun 24
Sep-24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar-25
Apr-25
May-25

	Recommendations **Assurance of Safe Staffing**: Confirm that safe staffing levels have been maintained In inpatient areas and note changes to the community safer staffing report going forward into 2025/26.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	17/06/25
V2	Quality Committee	27/06/25
V3	Public Trust Board	04/07/25

May 2025
Monthly Safer Staffing Report

1. Introduction:

This report details the ward daily staffing levels during the month of May 2025 following the reporting of the planned and actual hours of both Registered Nurses (RN) and Health Care Support Workers (Care Staff) to NHS Digital. Since 2018 Care Hours per Patient Day (CHPPD) have also been required to be reported to NHS Digital. The CHPPD calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours (appendix 1).

2. Purpose of the Report

Purpose:

This paper outlines the monthly performance of the Trust in relation to planned vs actual nurse staffing levels during May 2025 in line with the National Quality Board requirements.

3. Background:

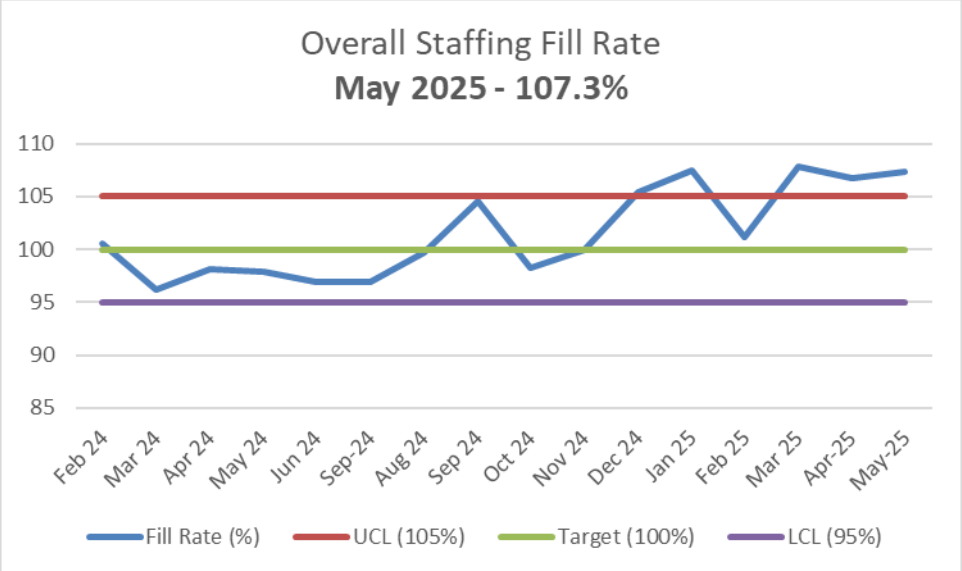
The monthly reporting of safer staffing levels is a requirement of NHS England and the National Quality Board in order to inform the Board and the public of staffing levels within in-patient units.

In addition to the monthly reporting requirements the Chief Nursing Officer is required to review ward staffing on a six-monthly basis and report an annual outcome of the reviews to the Trust Board of Directors.

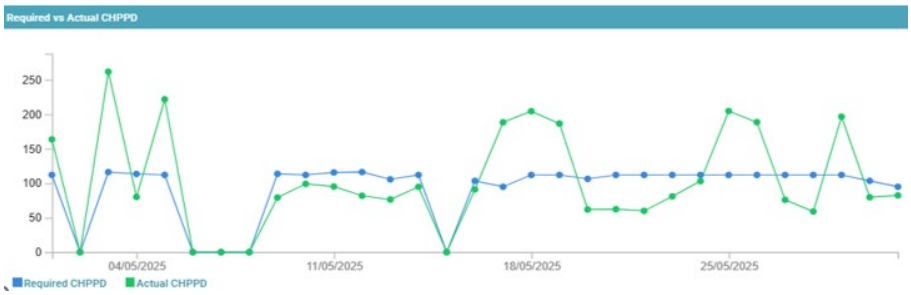
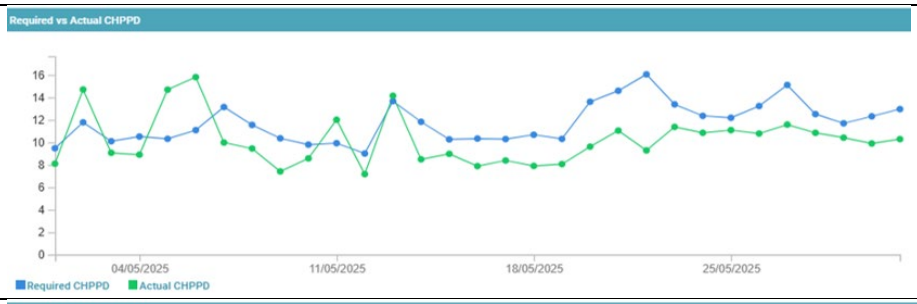
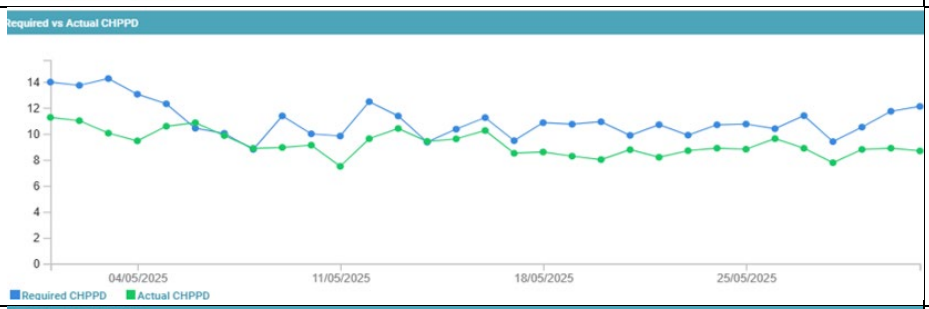
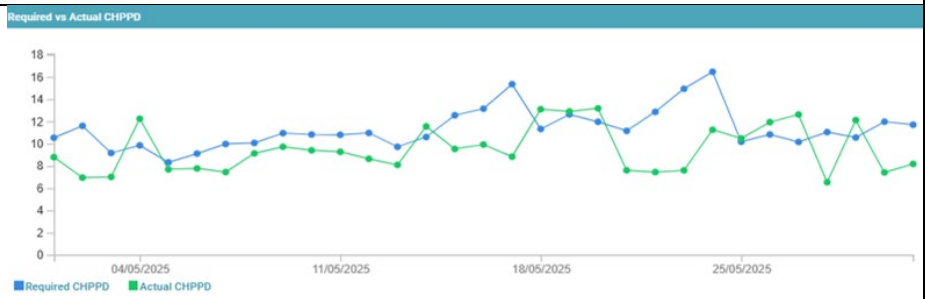
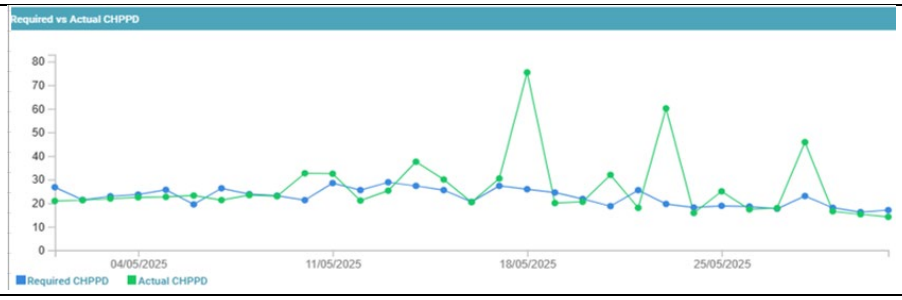
A comprehensive annual report for 2023/24 was presented to the September 2024 Trust Board and the recommendations relating to safer staffing reviews are progressed and monitored through the Safer Staffing Group. The subsequent six-monthly review was reported to the Trust Board in January 2025.

4. Summary:

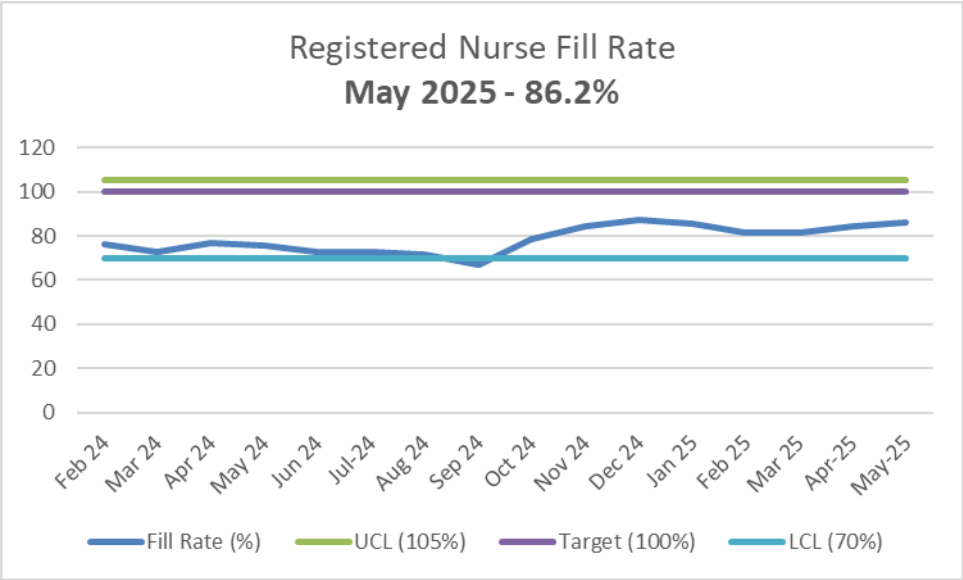
5.1. Trust Performance
Overall Fill Rate



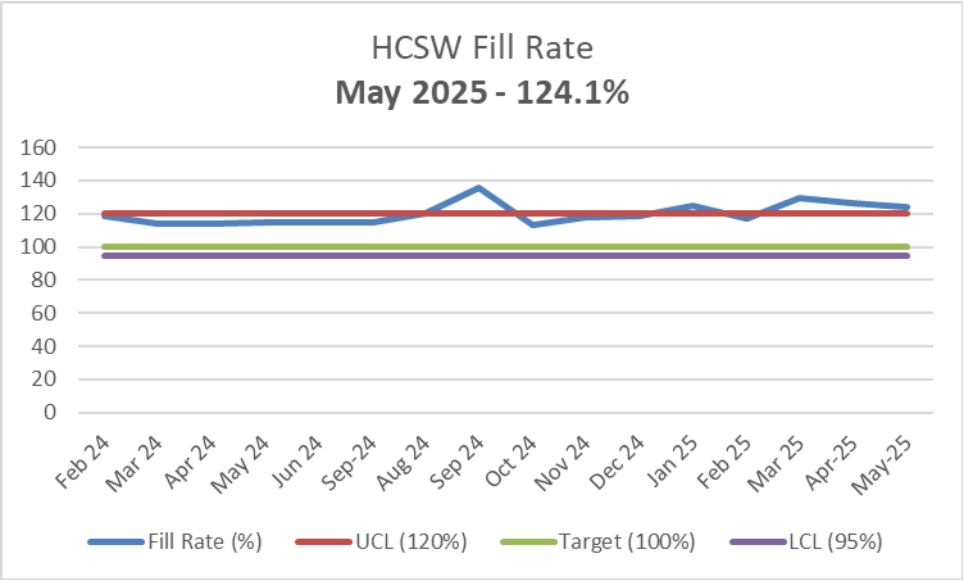
To note for May 25, the overall safer staffing fill rate was above the Trust's locally set threshold of 95% - 105% was breached in 6 Inpatient areas.
The Darwin centre was very slight below the threshold with 94.9% overall fill. The other 5 areas had a fill rate of over 105% threshold.
The table below offers a more detailed overview for each of the 7 wards in relation to their Required CHPPD and their Actual CHPPD. The data is dependent on the daily recording of patient acuity into the safecare tool:

Ward Area & % Fill rate	Required V's Actual CHPPD for May 2025	Average CHPPD
A&T 162%		55.86
Ward 1 107.5%		9.89
Ward 2 108.4%		9.38
Ward 3 105.6%		8.70
Ward 5 116.8%		18.79

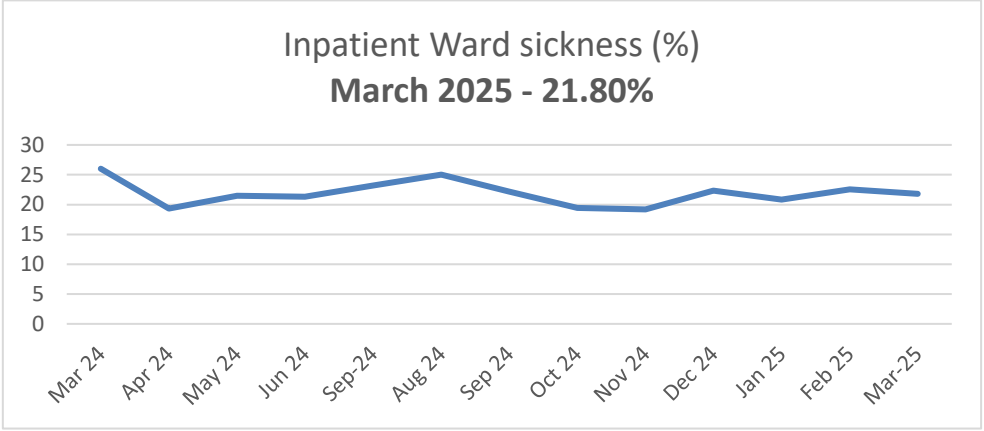
Registered Nurse Fill rate



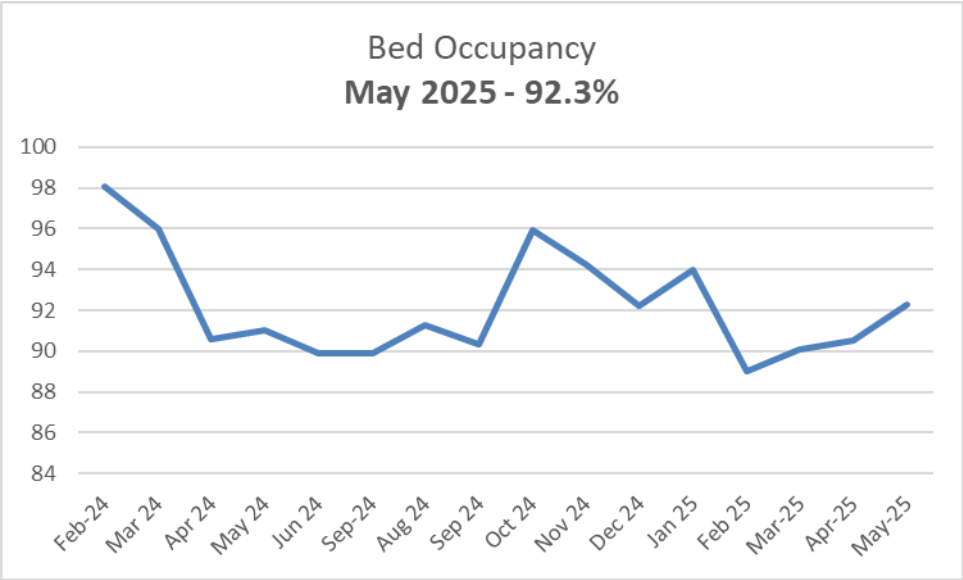
HCSW Fill Rate



Overall Inpatient Staff Sickness



Overall Bed Occupancy



Details of the actions taken to maintain safe staffing levels are provided below. Staffing data, including established, planned (clinically required) and actual hours; are provided in appendix 2, further details of vacancies and bed occupancy are summarised in Appendix 3.

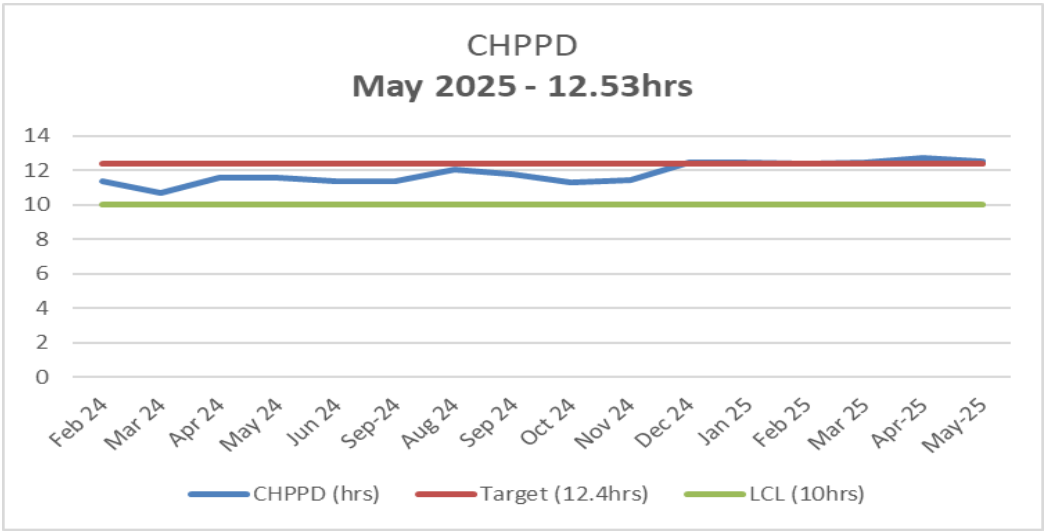
The Safer Staffing Group continues to oversee the safer staffing work plan and Safer Staffing Action Plan.

5.2. Care Hours per Patient Day (CHPPD)

The Trust is required to report CHPPD on a monthly basis. The calculation is based on the cumulative total number of patients daily over the month divided by the total number of care hours.

Benchmarking for CHPPD is available through the Model Hospital for Mental Health Trusts (see Appendix 1).

Our local reporting for May 2025:



4.3. Impact

Ward Managers report the impact of unfilled shifts on a shift-by-shift basis with staffing escalation requests being managed appropriately in line with agreed processes. Where staff have staffing related concerns which could or have impacted on safety, they are advised to complete incident reports.

4.4. Incidents reported relating to staffing levels

There were 7 staffing related incidents within the Trust during May 2025.

Three areas contributed to the reported safe staffing related concerns throughout May 2025.

The themes of these were.

- 3 x concerns from Crisis Resolution and Home Treatment Service; they reference Crisis response breaches and also reporting that TAG (initial risk screen) assessments were not completed during the shift. This is an area of concern. Assurance has been sort from the service leads who have an escalation process in place, with clinical leads reviewing the risk and impact of missed TAGs. This concern is being reviewed and considered for escalation via the services risk register and the patient safety lead has also been asked to review in more detail to ensure all relevant steps are being taken to resolve the issues.

- One incident was reported where duty was not covered due to a staffing shortfall, the reporter felt that this caused undue stress due to a delay in intervention for a few patients.

- One incident was reported for Assessment & Treatment inpatient ward, the ward was unable to provide staffing cover on one shift for a patient being nursed in the Royal Stoke due to a short notice staffing shortfall.

- One incident was reported for ward 1 due to staffing shortfall and high acuity.

None of the incidents reported resulted in harm.

4.5. Impact on Patient Experience

Staff continue to prioritise patient experience and direct patient care.

Patients have access to a range of therapeutic interventions during their stay on the inpatient wards, these are delivered from a wide range of multi-disciplinary professionals who support the patients during their inpatient stay and are not all reliant on Registered Nurses or HCSW's availability.

However, ensuing patients are routinely occupied and engaged in a meaningful way is a fundamental aspect of inpatient registered nurses and HCSW roles and responsibilities; this will be apparent in their presence on the ward and day to interactions with patients.

Additionally, the ward manager and nurses are responsible for overseeing a programme of activities on each of the wards. This includes ensuring that the scheduled activities are delivered as planned, are appropriate to the needs of the patient group, and are facilitated by suitably trained staff.

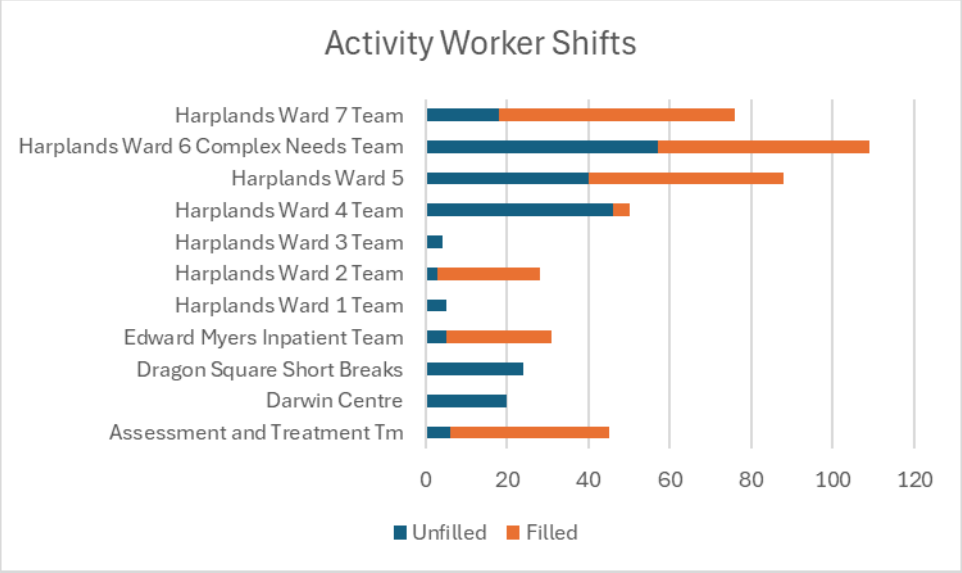
These activities not only reduce boredom and distress but also promote social interaction, enhance self-esteem, and support the development of coping skills. Furthermore, a well-structured timetable contributes to a therapeutic ward environment, shifting the perception of inpatient care from one of containment to one of active recovery.

We currently manually collect information in relation to Activity worker availability as an indication as to whether a routine scheduled programme of activities is going ahead, which can be seen in the graph below.

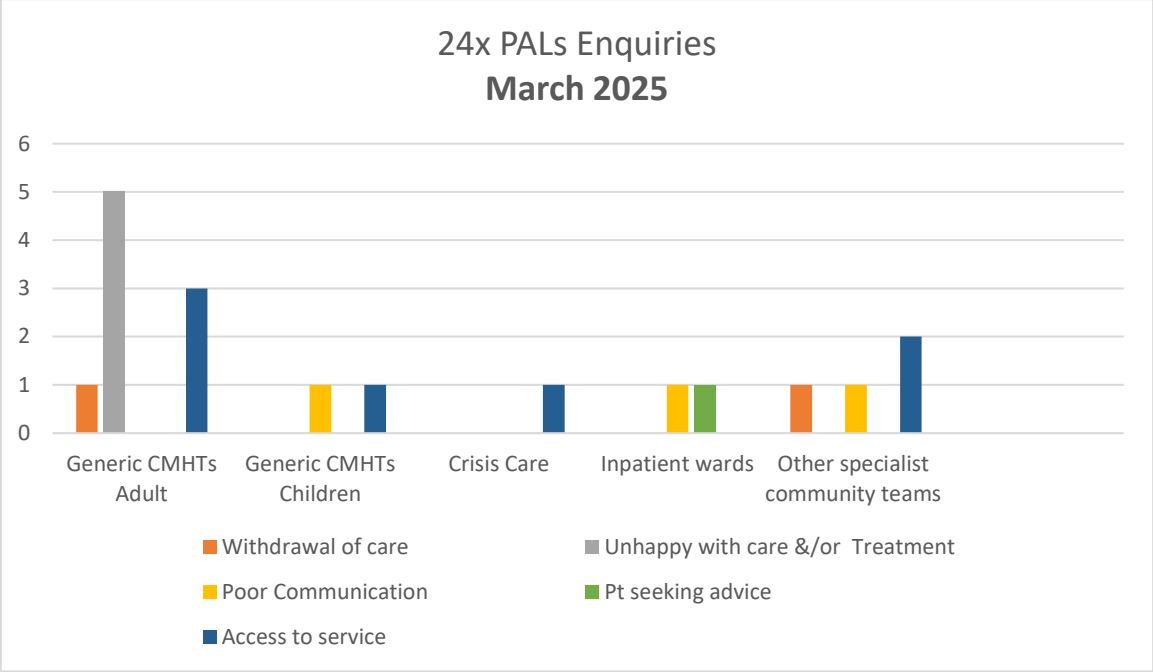
As referenced the graph below is only an indication, we are therefore updating the patient electronic record system so that documented information within each individual patient record can be more easily expedited into automated reports around activities which are available and activities which have been accessed by patient during their stay. This is important to understand the therapeutic nature of the ward but will equally offer an insight into where this is impacted by staffing availability. We are aiming to report on this from September 2025.

Patient Activities

The graph below shows the occasions where the activity worker has been unavailable throughout the month and therefore it's unlikely that the planned activities have taken place:



PALs Enquiries:
During May there were 18 PALs enquiries made via the Patient Advice and Liaison Service (PALs).



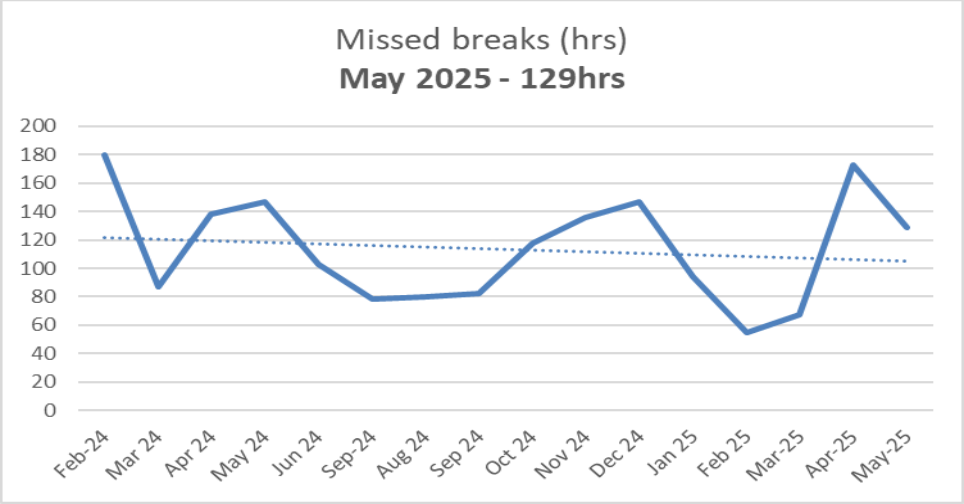
It is difficult to draw a conclusion on any direct links to safer staffing when considering these concerns in particular, however thematic reviews of concerns via the learning from experience reporting would consider any capacity challenges which would be reflected in learning going forward.

4.6. Impact on Staff Experience

Missed Breaks
In order to maintain safe staffing levels, the following actions were taken by Ward Managers during May 2025.

Taking a break within the shift is important for staff; missing breaks can lead to errors and work-related stress and therefore breaks are actively promoted and supported. However, on occasions decisions are taken to miss breaks to ensure that the ward maintains a safe staffing numbers throughout the shift.

The Total Hours gained to patient care due to staff missing their breaks. This is 0.24% of the total hours worked in May.



4.7. Other incidents to consider:

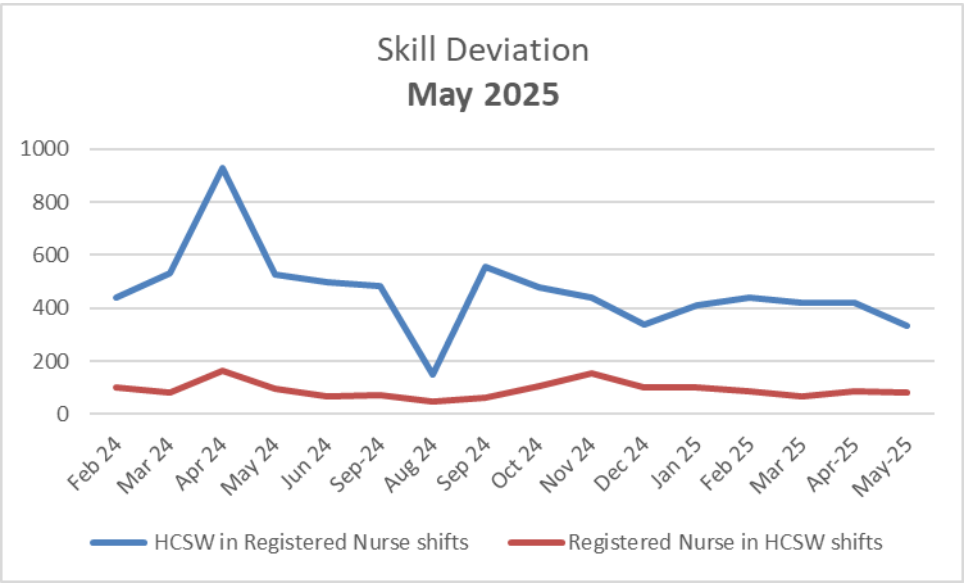
There were 0 IPC related outbreak during May 2025.

4.8. Mitigating Actions:

Within the confines of the safer staffing establishment requirements, there are occasions where the shifts are covered by a different grade type than that which is required to meet the establishment requirement for that shift.

- 331 Registered Nurse shifts were covered by HCSW's where Registered Nurse temporary staffing was unavailable during May 2025.
- 80 HCSW shifts were covered by Registered Nurses during May 2025.

The graph below illustrates the number of times a HCSW has covered a Registered Nurse shift and how many times a Registered Nurse has filled a HCSW shift.

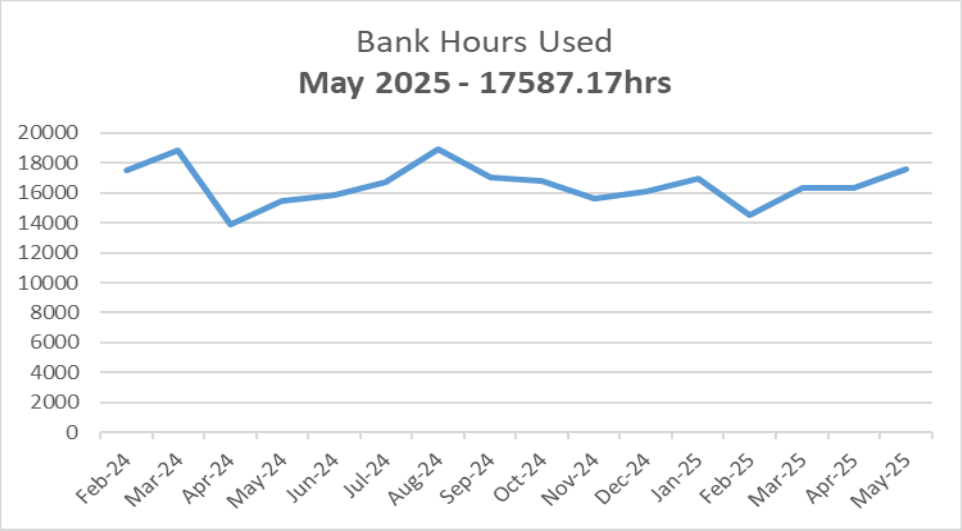


4.9. Bank and Agency Usage

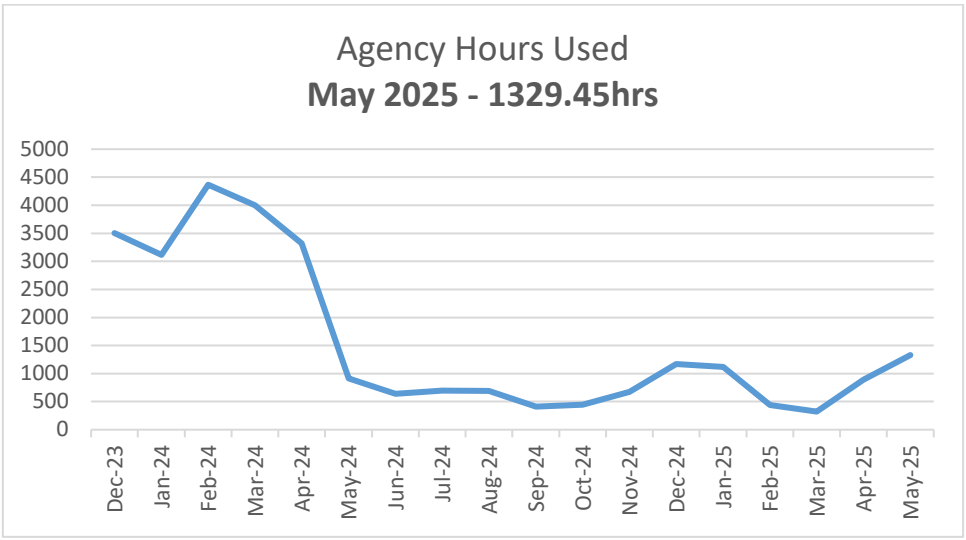
The Temporary Staffing Team have continued to engage bank and agency staff to cover staffing shortfalls.

This is demonstrated in the two graphs below:

4.9.1. **Bank usage within inpatient areas =** 33.7% of total hours worked in May 2025.



4.9.2. Agency usage within inpatient areas = 2.5% of total hours worked in May 2025**.**



Additionally, Ward manager continues to report that the MDT are supporting and cover shortfalls and increase their visibility on the ward at times when the staffing levels or patient acuity requires.

Due to the stability of the Safer Staffing Fill Rates over the previous 12months, the Safer Staffing huddles are now led by the Matrons. Their role is to co-ordinate day to day staffing, ensuring that the safecare tool is utilised to make more informed decisions regarding staffing requirements and escalations.

The commitment and dedication of all Trust staff in supporting and responding to staffing requests continues to be recognised.

The annual report for 2023/24 was presented to the September 2024 Trust Board, and an additional uplift to staffing in ward 4 was approved, giving them an increase by 1wte staff member for their night shifts. The additional recommendations from the review will be progressed and monitored through the Safer Staffing Group.

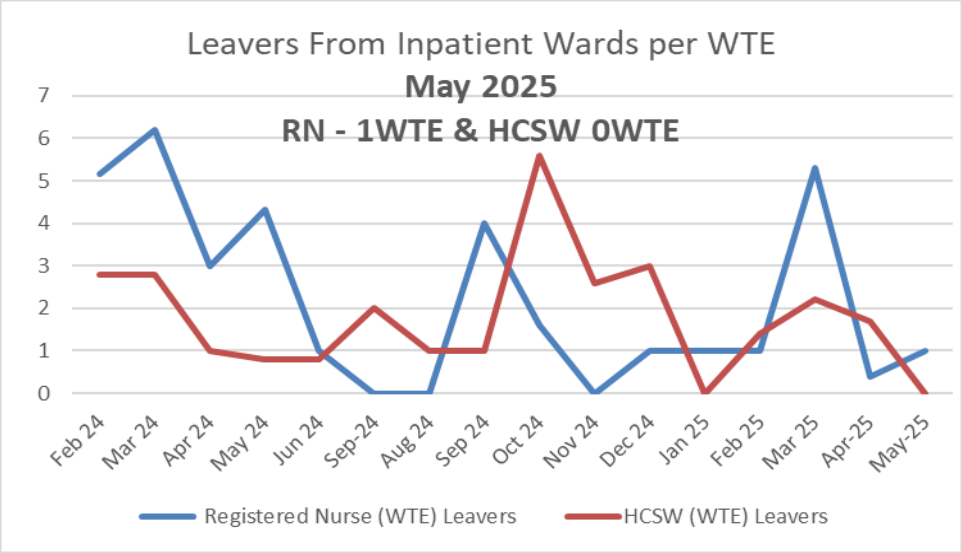
5. Recruitment

Although the local picture for uptake of people onto the Mental Health Nurse programmes via our local HEI's is looking positive, there remains a national challenge around recruiting into Registered Nurse positions. The Nursing, Operational and Workforce Directorates are continuing to employ a number of strategies to attract both Registered Nurses and HCSW's during this time. Our next intake of Newly Registered Nurses is October 2025 where we expect to recruit 56WTE Nurses.

There were 5 Registered nurses recruited in May 2025 and 0 HCSW in the Inpatient Wards

5.1. Vacancies:

5.2. Registered Nurse and HCSW Retention



During May 2025, 1 Registered Nurse left the Trust's (1WTE); from the inpatient wards
0 HCSW's left the inpatient wards.

There were no other Trust Leavers.

The Registered Nurse was a White – British staff members.

6. Staff support and well-being

The Nursing Directorate continue to offer support and advice on staffing issues, and they receive staffing updates from Ward Managers, Quality Improvement Nurses (Matrons) and the E-Rostering and Temporary Staffing Team as appropriate.

Despite capacity issues within the team throughout the year, the E-rostering team have continued to maintain the co-ordination and allocation of the bank staff and agency staff. The operational directorates have welcomed this support and intervention. The addition of a Temporary Staffing Lead into the Team is enabled more focused attention and support of our temporary staffing workforce.

We have 19 active (and a further 7 completing their Level 7 Accredited training) Professional Nurse Advocates within the Trust who offer dedicated support to Registered Nurses within the Inpatient wards. It supports the facilitation of restorative clinical supervision in practise, with quality improvement initiatives being a key component of the model.

The Ward Managers Reflect and Connect Forum takes place each month. Dedicated time is provided for reflection, group supervision, and wellbeing discussions. Additionally, the senior nursing team continue to maintain visibility within ward inpatient areas.

There are ongoing quality visits conducted throughout Trust services, actions plans and improvement activity is reported and monitored via the Trusts Quality Assurance Group.

Each ward team have access to the staff wellbeing support networks and also have regular reflective practice sessions within the wards.

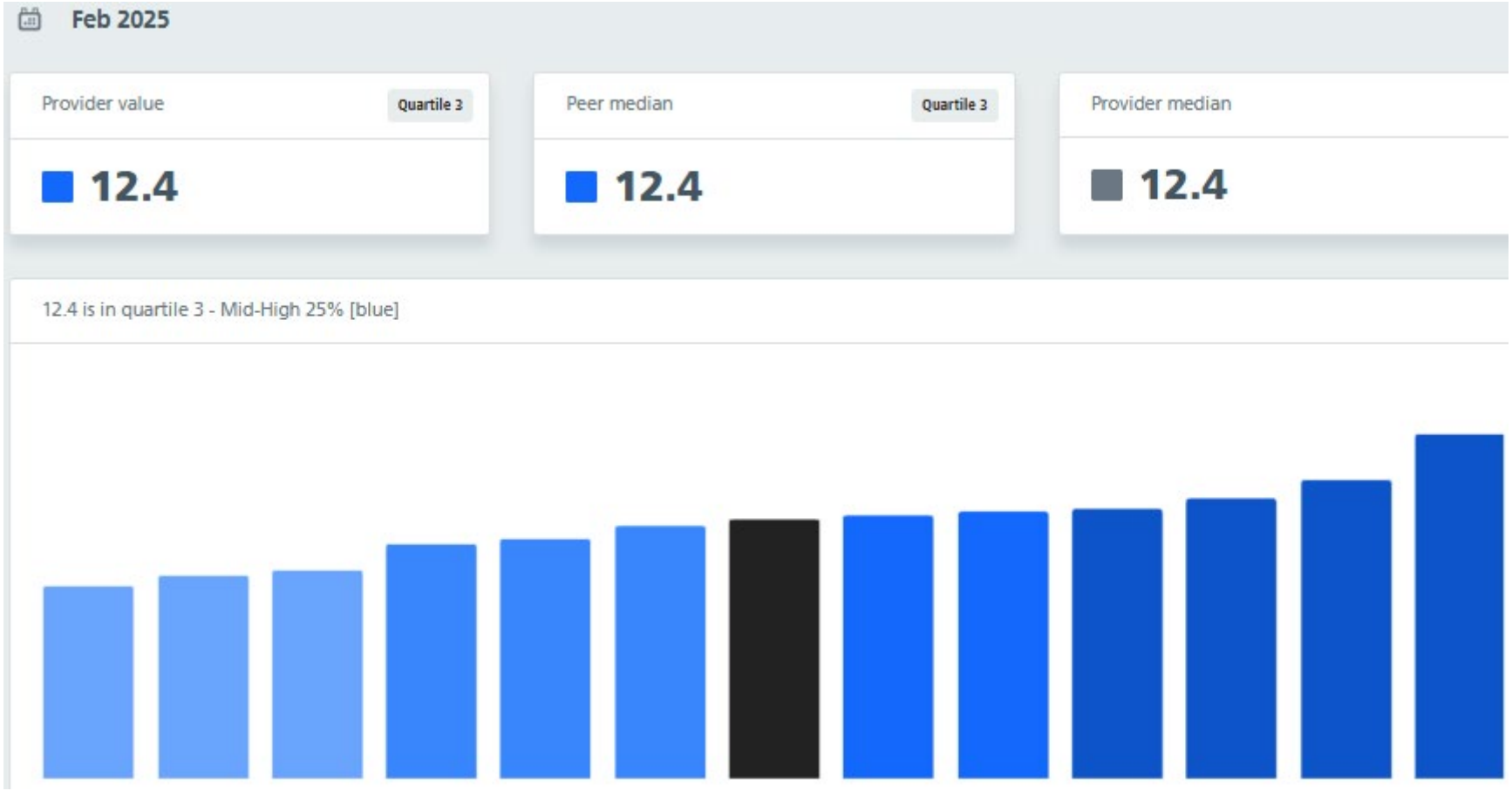
7. To Conclude:

The Registered Nurse Fill Rate was 86.2%
Overall Fill rate was 107.3%
Ward Occupancy was 92.3%
CHPPD was 12.53hrs.

APPENDIX 1

CHPPD – Model Hospital – benchmark –February 2025 (latest update)

12.45 CHPPD



Appendix 2

Appendix 2 -May 2025 Safer Staffing:

	RMN				CARE STAFF				Registered Nurse		Care Staff		Total Nursing Staffing					
Ward	Day Clinically Required	Day Actual	Night Clinically Required	Night Actual	Day Clinically Required	Day Actual	Night Clinically Required	Night Actual	Day Fill Rate (%)	Night Fill Rate (%)	Day Fill Rate (%)	Night Fill Rate (%)	Overall RN %	Overall Care Staff %	Overall Staffing	Total Hours Per Day	Patients	CHPPD
Assessment & Treatment	785.25	798.50	679.10	503.65	1,564.25	2,475.08	688.20	2,255.23	101.69%	74.16%	158.23%	327.70%	88.9%	210.0%	162.3%	6032.46	108	55.86
Darwin Centre	1,542.25	1,048.00	1,032.30	779.30	1,514.00	1,870.17	1,376.40	1,488.30	67.95%	75.49%	123.53%	108.13%	71.0%	116.2%	94.9%	5185.77	310	16.73
Edward Myers Unit	945.50	926.25	344.10	344.10	784.50	740.00	688.20	677.10	97.96%	100.00%	94.33%	98.39%	98.5%	96.2%	97.3%	2687.45	319	8.42
Summers View	964.77	932.73	332.22	332.22	852.98	831.00	664.43	664.43	96.68%	100.00%	97.42%	100.00%	97.5%	98.6%	98.1%	2760.38	270	10.22
PICU	1,144.25	1,081.00	688.20	577.20	1,529.50	1,683.50	1,376.40	1,478.00	94.47%	83.87%	110.07%	107.38%	90.5%	108.8%	101.7%	4819.70	189	25.50
Ward 1	1,313.97	1,053.50	688.20	477.30	1,243.25	1,604.45	699.30	1,106.70	80.18%	69.35%	129.05%	158.26%	76.5%	139.6%	107.5%	4241.95	429	9.89
Ward 2	1,302.50	1,221.75	677.10	547.50	1,572.75	1,793.75	688.20	1,034.10	93.80%	80.86%	114.05%	150.26%	89.4%	125.1%	108.4%	4597.10	490	9.38
Ward 3	1,301.25	1,222.33	688.20	556.30	1,174.75	1,407.50	907.05	1,113.20	93.94%	80.83%	119.81%	122.73%	89.4%	121.1%	105.6%	4299.33	494	8.70
Ward 4	1,559.25	1,257.92	344.10	345.77	1,538.75	1,712.50	1,176.60	1,367.10	80.67%	100.49%	111.29%	116.19%	84.3%	113.4%	101.4%	4683.29	445	10.52
Ward 5	1,154.22	1,139.00	688.20	455.10	1,229.27	1,580.65	1,032.30	1,617.00	98.68%	66.13%	128.58%	156.64%	86.5%	141.4%	116.8%	4791.75	255	18.79
Ward 6	1,145.00	1,000.00	688.20	566.10	1,673.00	1,806.25	1,032.30	1,144.20	87.34%	82.26%	107.96%	110.84%	85.4%	109.1%	99.5%	4516.55	438	10.31
Ward 7	1,445.75	1,283.75	344.10	344.10	1,301.75	1,460.50	1,021.20	1,008.60	88.79%	100.00%	112.20%	98.77%	90.9%	106.3%	99.6%	4096.95	460	8.91
Totals	14603.96	12964.73	7194.02	5828.64	15978.75	18965.35	11350.58	14953.96	88.78%	81.02%	118.69%	131.75%	86.2%	124.1%	107.3%	52712.68	**4,207**	12.53

Appendix 3

Ward	Total Nursing Staffing			Total Hours Per Day	Patients	CHPPD	Bed Occupancy	RN Vacancies	HCSW Vacancies
	Overall RN %	Overall Care Staff %	Overall Staffing						
Assessment & Treatment	88.9%	210.0%	162.3%	6032.46	108	55.86	116.1%	0.76 ↑	3.65 ↑
Darwin Centre	71.0%	116.2%	94.9%	5185.77	310	16.73	71.4%	5.94 ↑	2.19 ↑
Edward Myers Unit	98.5%	96.2%	97.3%	2687.45	319	8.42	85.8%	1.56 ↑	0.80 ↔
Summers View	97.5%	98.6%	98.1%	2760.38	270	10.22	87.1%	(0.84) ↑	2.59 ↓
PICU	90.5%	108.8%	101.7%	4819.70	189	25.50	101.6%	3.25 ↓	(0.28) ↔
Ward 1	76.5%	139.6%	107.5%	4241.95	429	9.89	115.3%	5.44 ↔	(1.28) ↔
Ward 2	89.4%	125.1%	108.4%	4597.10	490	9.38	98.8%	1.94 ↑	(0.15) ↓
Ward 3	89.4%	121.1%	105.6%	4299.33	494	8.70	99.6%	3.02 ↔	(0.09) ↓
Ward 4	84.3%	113.4%	101.4%	4683.29	445	10.52	95.7%	1.71 ↓	3.47 ↓
Ward 5	86.5%	141.4%	116.8%	4791.75	255	18.79	82.3%	1.60 ↔	1.47 ↔
Ward 6	85.4%	109.1%	99.5%	4516.55	438	10.31	94.2%	0.99 ↑	1.11 ↓
Ward 7	90.9%	106.3%	99.6%	4096.95	460	8.91	82.4%	0.27 ↔	(0.12) ↓
Totals	86.2%	124.1%	107.3%	52712.68	4,207	12.53	92.3%	25.1 ↑	13.94 ↓

KEY
↑ Improved since previous month
↓ Deteriorated since previous month
↔ No change

Enclosure No: 17

Quality Committee Assurance Report – 05 June 2025

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Pauline Walsh, Chair/Non-Executive Director – Quality Committee
Prepared by:	Zoe Grant, Deputy Chief Nursing Officer
Executive Lead:	Kenny Laing, Chief Nursing Officer Dr Dennis Okolo, Chief Medical Officer

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	Quality Committee
Strategic Priorities:	Prevention - To continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	-
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Not applicable
Recommendation / Required Action	For information and assurance.
Executive Summary	The attached assurance report describes the business and outputs from the meeting of the Quality Committee on 5th June 2025.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	06.06.25
V2	Public Trust Board	27/06/25

Trust Board Assurance Report from the Quality Committee meeting held on 5 June 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Quality Committee. The meeting was completed using Microsoft Teams and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key Quality performance indicators and the Quality Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under the Quality Committee's remit and programmes of work.

ALERT:

This section summarises the key points that members of the Trust Board need to be aware of.

Out of Area Placements report
The committee received the report for assurance in response to the recent increase in the use of Out of Area (OOA) beds (54 patients between October 24 and May 25). The report provided information in relation to processes in place to oversee and review patients placed OOA.

It was agreed that the committee will receive ongoing detailed oversight and impact of Out of Area Patients as a standing agenda item going forward.

ADVISE:

This section advises of key activity and updates in relation to programmes of work.

- **Deep Dive – Specialist Directorate 'Coproduction in Learning Disability (LD) & Autism Services'**

The Committee received a deep dive presentation from the Specialist Directorate LD team in relation to Co-production in Learning Disability and Autism services. Examples were provided and members had the opportunity to ask questions in relation to how this is having an impact.

- **CQC**

The Committee were advised that the CQC data request submission following the recent CQC inspection at the Crisis Resolution and Home Treatment Service has now been submitted. We are awaiting the initial report which we will have an opportunity to review for factual accuracy.

- **CQC Community Mental Health Survey 2024**

The Committee received a paper for assurance in relation to the survey results. The Trust had a response rate of 21% which is just above the national average. The Trust was rated "About the same" as other NHS mental health Trusts in all 13 section scores

Key focus areas for improvement were identified as;
• Support with other areas of life (e.g., employment, finances)
• Carer support during crisis
• Improved user feedback mechanisms.

The committee were assured that the key areas of focus identified are the correct ones and noted work already underway in these areas

ASSURE:

This section provides assurance of the quality of service and activity delivered under the Quality Committee's remit and programmes of work.

The following reports were received for assurance:

- **Safe staffing report April 2025**

Report received for assurance the overall staffing fill rate was 106.7% and were assured that the Trust's Staffing levels are adequate and safe.

The following reports were presented for assurance with good level of discussion at the Committee

- Co-production, Involvement and Volunteers Report Q4 2024/25
- Infection, Prevention and Control Q4 2024/25
- Learning from Experience Q4 2024/25
- Mortality Surveillance Q4 2024/25
- PSIRF Q4 2024/25
- Restrictive Practice Report Q4 2024/25
- Safeguarding Report Q4 2024/25
- IQPR

Key area discussed in response to the report;

Care planning; additional support and focus is in place for specialist Services who are in the early phases of the wider co-produced care planning programme of work.

The committee were updated regarding metrics within the IPQR relating to the Quality Committee from month 2

- Friends and Family Test – Actual response numbers to be provided
- Safer staffing – Actual reported with thresholds 95% - 105%

APPROVE:

This section provides an update of items which were discussed and approved by the Committee.

- **Quality Account**

The Committee approved the final draft of the Quality Account, noting there may be slight amendments before final version is seen at the Trust Board as a result of pending feedback from Stoke -on- Trent and Staffordshire Overview & Scrutiny Committee's and the ICB.

- **Risk Register**

To note, Risk 1919 regarding the risk associated with the capacity within ADHD service has moved under the Quality Committee to enable committee oversight regarding impact to quality of care**.**

There was a discussion regarding risk mitigation and trends.

Approval of the risk report was confirmed.

- **EPRR**

Approval was provided by Committee Members via email as the Committee was not quorate for this final item

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 3 July 2025 at 2pm Via MS Teams.

Committee Chair: Pauline Walsh, Chair of the Quality Committee.

REPORT END

Enclosure No: 18

F&R Committee Assurance Report

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Russell Andrews, Non-Executive Director / Committee Chai
Prepared by:	Michelle Geddes, Assistant Chief Finance Officer
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk	Risk 2 The Trust fails to deliver a balanced financial plan in 24/25
Approval / Review:	Finance and Resource Committee
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Part of the aggregate ICS reported financial position
Recommendation / Required Action	The Board is asked to receive the contents of this report for information
Executive Summary	This paper details the items discussed at the Finance and Resource Committee meeting held on the 5th June 2025. Updates were received relating to:

	• M1 Trust Performance & Performance Management Framework • Risk Register • M1 Finance Position • M1 ICS Finance • Cost Improvement Programme • National Cost Collection Pre-Submission • Estates and Capital • Business Opportunities • Digital Project updates

VERSION CONTROL:

Version	Report to	Date Reported
1	Private Trust Board	05/06/2025
2	Public Trust Board	27/06/2025

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 5th June 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Finance & Resource Committee. The meeting was completed using Microsoft Teams and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key Finance & Resource Committee performance indicators and the Finance & Resource Committee Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the three categories of Alert, Advise and Assure. Each category provides assurance on the quality of service and activity delivered under the Finance & Resource Committee's remit and programmes of work.

ALERT:

This section summarises the key points that members of the Trust Board need to be aware of.

Heading:

N/A

ADVISE:

This section advises of key activity and updates in relation to programmes of work.

Heading:

N/A

ASSURE:

This section provides assurance of the quality of service and activity delivered under the Finance & Resource Committee's remit and programmes of work.

Heading:

IQPR M1 & Performance Management Framework
Committee received the report with highlights made regarding changes due to new national targets including out of area patients (reduction to zero by the end of the year) and inpatient length of stay. Discussions took place regarding friends and family recommendation rate reduction, PIPs trajectory escalation and progress monitoring against targets during the year.

Finance Position M1
Key messages highlighted included a small year-to-date deficit position, however this is better than plan. Bank and agency costs in month were both above the required reductions. 24% of CIP schemes have been transacted in Month 1 against the annual target. Capital expenditure is lower than planned year-to-date, forecast to be on plan. Discussions on bank and agency spend.

ICS Finance Update M1
At Month 1 the System reported a year-to-date deficit of £9.3m, delivering 71% of the planned efficiencies in month. Discussions on CIP and corporate savings return.

Cost Improvement Programme
Key messages highlighted included in month progress on CIP deliverability. Discussion took place regarding transformation and innovation within schemes.

Estates Update
Committee received the report with highlights on fire doors, Chrysalis Ward 6 hand over, water safety and ventilation. Discussions on capital funding received to date, fire doors and Girpi pipework replacement.

Business Opportunities
Committee received the report highlighting an expression of interest opportunity with the Local Authority.

Digital Update
Committee received the report highlighting data protection toolkit and Orbis.

APPROVE:

This section provides an update of items which were discussed and approved by the Committee.

Heading:

Risk Register
No new risks, no closures and one score change for approval relating to the deliverability of the Trust's CIP. Four existing risks have been updated.

National Cost Collection Pre-submission
Committee received the report and asked to approve the plan in place to submit the 2024/25 National Cost Collection.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 3rd July 2025 at 11am via MS Teams.

Committee Chair: Russell Andrews, Chair of the Finance & Resource Committee.

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 19

Audit Committee Assurance Report

Report provided for:			
Information	☐	Assurance	☒
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Prem Gabbi, Non-Executive Director
Prepared by:	Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	Audit Committee
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	The Board is asked to receive for information
Executive Summary	The paper details the items discussed at the Audit Committee meeting held on the 7th May 2025 and the 6th June 2025. Updates were received relating to:

7th May 2025

Audit Committee held on Wednesday 7th May was not quorate. Internal Audit & Counter Fraud requested the Committee members agree the plans for 2025/26 to ensure work could progress as planned and that there were no delays. Members of the Audit Committee were asked to approve the Internal Audit Plan 2025/26 and the Anti-Fraud Work Plan 2025/26 following on from the discussions held in Committee. Same was approved via email.

Going Concern Assessment 24/25 and the Internal Audit Progress Report was deferred to next the Committee.

Other items received were:

- Internal Audit Progress Reports - E-Rostering, NSCHT Assurance Framework Briefing note 2024/25. Q4 Follow Up Report 2024/25
- Draft NSCHT Annual Report 2024/25
- Finance Report Q4 2024/25
- 2024/25 Draft Annual Accounts
- Head of Internal Audit Opinion
- External Audit Update
- Register of Declared Interest/ gifts and Hospitality
- Q4 Board Assurance Framework (BAF)

6th June 2025

- The Committee agreed to take an action to further support the development of the Trust's Annual Report next year (25/26).
- The CSU appointed independent auditors Deloitte LLP to undertake the Service Auditor Report for the period 1st April 2024 to 31st March 2025.
- The Committee received the External Audit Findings Report, and the External Auditors Annual Report
- The Committee approved the following items:
    - Annual Accounts
    - Annual Report including the Annual Governance Statement
    - Going Concern – Finance presented the report which was deferred from the last meeting.
    - Letter of Representation
    - Cycle of Business- the report was deferred from the last meeting.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	07.06.2025
V2	Public Trust Board	27/06/2025

Trust Board Assurance Report from the Audit Committee. Meeting held on 7th May 2025 via MS Teams.

Introduction:

This assurance report to the Trust Board is produced following the latest Audit Committee. The meeting was completed using Microsoft Teams and was not quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key performance indicators and the Committee Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

ALERT:

This section summarises the key points that members of the Trust Board need to be aware of.

Heading:

- The meeting held on the 7th May 2025 was not quorate and therefore a number of approvals have taken place post the meeting via email. Please see approvals section of this report for details. Other items will defer to the next meeting of the Committee.

ADVISE:

This section advises of key activity and updates in relation to programmes of work.

Heading:

- An action outstanding relating to the Internal Audit Progress Report- regarding E-rostering- is requested to come to next Committee for an update on same.
- A draft version of the NSCHT Annual Report 2024/25 was discussed. Feedback included that the report would benefit from further reduction and focus on the report being easier/simpler to read. This feedback will be incorporated into the next and final version that comes to Committee in June 2025.

ASSURE:

This section provides assurance of the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

Heading:

- Q4 Finance Report- Assurance was requested and provided by the Finance Team on the long duration of outstanding credit notes and the re-occurring issue of retrospective PO's.
- 2024/25 Annual Accounts- The Committee acknowledged the draft annual accounts and the strong financial performance. The final audited accounts will be reviewed and approved at the next Audit Committee meeting on the 6th June 2025.
- Internal Audit Progress Report –
  NSCHT Assurance Framework Briefing Note 24/25. The assurance framework briefing note was provided to meet NHS requirements, with minor improvements suggested.
  NSCHT Quarter 4 Follow Up Report 24/25- All high-risk recommendations from 24/25 were completed.

There were a few medium and low-risk recommendations from 23/24 which were still outstanding, primarily related to policy ratification. The Chair emphasised the importance of meeting deadlines and for timely completion of actions. Extensions should be exceptional and justified.

- Head of Internal Audit Opinion- The Trust received a substantial assurance rating, indicating a good system of internal control designed to meet organisational objectives, with controls being applied consistently.
- External Audit update- clarity was provided as regards the linkage between audit risks and the Trust's risk management framework and that audit risks focus on the potential for misstatement in the accounts, while VFM work assesses the effectiveness of governance and risk management processes.
- Register of Declared Interest/Gifts and Hospitality. There has been a significant improvement in compliance rates, with the Trust achieving 97% compliance in declarations, up from 66% in previous years. The importance of educating staff that reporting gifts and hospitality is not a negative action and can help prevent issues was noted and there are ongoing efforts to engage with staff to further improve awareness.
- Q4 Board Assurance Framework- Committee discussion underscored the Trust's commitment to improving risk management processes and the importance of a cohesive approach to risk management. The committee recognised the progress made and the need for continued efforts to address gaps and enhance the BAF.

APPROVE:

This section provides an update of items which were discussed and approved by the Committee.

Heading:

- Audit Committee held on Wednesday 7th May was not quorate. Internal Audit & Counter Fraud requested the Committee members to agree the plans for 2025/26 to ensure work can progress as planned and that there are no delays. Members of the Audit Committee were asked to approve the Internal Audit Plan 2025/26 and the Anti-Fraud Work Plan 2025/26 following on from the discussions held in Committee. Same was approved via email.
- Going Concern Assessment 24/25 and the Internal Audit Progress Report will defer to next Committee.

Next Steps (including timeframes):

The next Audit Committee meeting will be held on: Friday, 6th June 2025 at 10:00am via MS Teams.

Committee Chair: Prem Gabbi Chair of the Audit Committee.

REPORT END

Trust Board Assurance Report.
Extraordinary Audit Committee Meeting
6th June 2025 via MS Teams.

Introduction: This assurance report follows the latest extraordinary Audit Committee meeting held on the 6th June 2025. The meeting was completed using Microsoft Teams and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key performance indicators and the Committee Objectives.

Purpose of the Report (Executive Summary): The report provides an update on the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

ALERT: This section summarises the key points that members of the Trust Board need to be aware of.

Heading:

- No alerts noted from today's meeting.

ADVISE: This section advises of key activity and updates in relation to programmes of work.

Heading:

- The Committee agreed to take an action to further support the development of the Trust's Annual Report next year (25/26).
- Finance Shared Services Audit Reports- Finance presented the report to Committee. To gain assurances over the internal controls and the control procedures operated by the CSU, the CSU have engaged a reporting accountant to prepare a report in internal controls (known as a Service Auditor Report). The CSU appointed independent auditors Deloitte LLP to undertake the Service Auditor Report for the period 1st April 2024 to 31st March 2025.

ASSURE: This section provides assurance of the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

Heading:

- External Audit Findings Report, and the External Auditors Annual Report was presented to Committee by Grant Thornton

APPROVE: This section provides an update of items which were discussed and approved by the Committee.

- Annual Accounts
- Annual Report including the Annual Governance Statement
- Going Concern – Finance presented the report which was deferred from the last meeting.
- Letter of Representation
- Cycle of Business- the report was deferred from the last meeting.

Next Steps (including timeframes):

The next Audit Committee meeting will be held in July 2025 via MS Teams.

Committee Chair: Prem Gabbi Chair of the Audit Committee. **REPORT END**

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 20

Remuneration Committee Assurance Report – 8th May 2025

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Janet Dawson, Chair
Prepared by:	Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary
Executive Lead:	Frieza Mahmood, Chief People Officer

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	Remuneration Committee
Strategic Priorities:	Prevention - To continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	-
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	Not applicable
Recommendation / Required Action	For information
Executive Summary	The attached assurance report describes the business and outputs from the meeting of the Remuneration Committee on 8th May 2025. Changes to the Cycle of Business were agreed: The Remuneration report that forms part of the Trust Annual Report, will come to July

	Committee for information only. The Executive Director Objectives will come to Committee in July as these were still being finalised through the appraisal process currently underway within the Executive Team. Objectives for Remuneration Committee for 25/26 were agreed: • The Committee are assured that the Trust has robust succession plans in place and has identified individuals within the organisation with high potential for support and development into future Executive roles. • That remuneration is being fairly and effectively used to support the performance of the Trust within the parameters set by NHSE. The Committee Cycle of Business and Terms of Reference were approved.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	06.06.25
V2	Public Trust Board	27/06/25

Trust Board Assurance Report from the Remuneration Committee Meeting held on 8th May 2025. Board room, Lawton House.

Introduction:

This assurance report to the Trust Board is produced following the latest Remuneration Committee. The meeting was completed in person at the Boardroom Room, Lawton House and was quorate. Governance of the Committee focuses on achievements against Trust vision, Strategic Objectives, Trust performance against key performance indicators and the Committee Objectives.

Purpose of the Report (Executive Summary):

The report provides an update on the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

ALERT:

This section summarises the key points that members of the Trust Board need to be aware of.

Two items from the Committee Cycle of Business had not been included in the agenda:

- Remuneration Section of the Trust's Annual Report
- Executive Director Objectives.

Nicky Griffiths informed Committee that following discussion with the Chair, the Remuneration report that forms part of the Trust Annual Report, would come to the next Remuneration Committee in July for information only. The Executive Director Objectives would come to Committee in July as these were still being finalised through the appraisal process currently underway within the Executive Team.

ADVISE:

This section advises of key activity and updates in relation to programmes of work.

- There were no actions recorded at the last meeting.

ASSURE: This section provides assurance of the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

All Committees of the Board need to set yearly objectives and these should be done every 12 months in line with the annual review and approval of Committee Terms of Reference.

It was discussed and agreed that
Objectives for Remuneration Committee for 25/26 would be:

- The Committee are assured that the Trust has robust succession plans in place and has identified individuals within the organisation with high potential for support and development into future Executive roles.
- That remuneration is being fairly and effectively used to support the performance of the Trust within the parameters set by NHSE.

APPROVE:

This section provides an update of items which were discussed and approved by the Committee.

Committee Cycle of Business.

Consultation around Committee cycles of business has been undertaken with Executive Leads and Chairs and aligned to the Senior Leadership Team and Trust Board cycles of business.

The new format will enable monitoring of papers received as scheduled, those which are deferred and those that have not been received- to enable a fuller committee effectiveness analysis of papers for the 2025/26 Board / Committee Effectiveness Review.

- Committee was asked to approve the Cycle of Business for 2025/26
- Committee members agreed that the following items should be removed from the 2025/26 Cycle of Business.
  - Agreement to any bonus, incentive or recruitment or retention premium to be paid to staff including earn-back.
  - Fit and Proper Persons Declarations.

- Committee noted that for Succession Planning Executive Directors- a summary from the Chief Executive Officer as regards succession planning and the identification of individuals in the organisation considered have high potential for support and development into potential future Executive roles would also be helpful in line with the Executive Director performance reviews. Both of which are scheduled to be received by Committee in September 2025.

- **Decision of the Committee- Approved.**

Terms of Reference

The report informed the Committee that a full review of the Terms of Reference had been undertaken. The report made recommendation to the Committee to approve the Terms of Reference for 12 months.

- **Decision of the Committee- Approved.**

Next Steps (including timeframes):

The next Remuneration Committee meeting will be held on: 10th July 2025 at 16;00 at the Boardroom Room, Lawton House and via MS Teams.

Committee Chair: Janet Dawson. Chair.

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 21

Annual Fit and Proper Persons Test – 2024/25

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary
Prepared by:	Lisa Wilkinson, Corporate Governance Manager
Executive Lead:	Freiza Mahmood, Chief People Officer

Aligned to Board Assurance Framework Risk	Risk 1 The Trust fails to deliver effective care leading to regulatory restrictions
Approval / Review:	Trust Board
Strategic Priorities:	Prevention – We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Funding Source:	N/A
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	N/A
Recommendation / Required Action	The Board are asked to receive for information
Executive Summary	The Fit and Proper Person (FPPT) requirement was introduced in 2014 to ensure that only the most qualified and ethical individuals were appointed to leadership positions within the National Health Service (NHS). This requirement applied to all board members of NHS organisations, and it was designed to assess their character,

	qualifications, experience, and fitness for their roles. NHS England published a revised Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The Fit and Proper Person Test Framework set out the expectations that Chairs of all NHS provider and commissioner organisations would carry out a Fit and Proper Person assessment for all individual board members and summarise the outcomes annually to the relevant NHSE Regional Director. The annual FPPT assessment has been completed for all Board members and attached is the final submission which was submitted to the Regional Director ahead of the 27th June 2025 deadline.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	10.06.25
V2	Public Trust Board	27.06.25

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION *Select organisation*		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
North Staffordshire Combined Healthcare NHS Trust	X	Trust	Janet Dawson	Submission June 2025 Test period Jan - May 2025
		Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	8	8	0	0	0	
Executive board members	8	8	0	0	1	1
Partner members (ICBs)						
Total						

**** See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.***

***** Do not enter names of board members.***

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	No

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Reviewed by Governance Team / Board	June 2025	We need to streamline a number of Board recruitment and appraisal processes across the entirety of the board membership	FPPT Trust Policy will be reviewed in July 2025	Ongoing

Add additional lines as needed

Part 3: Declarations

<table>
<tr><th colspan="6">DECLARATION FOR North Staffordshire Combined Healthcare NHS Trust 2025</th></tr>
<tr><td colspan="6">For the SID/deputy chair to complete:</td></tr>
<tr><td rowspan="2">FPPT for the chair (as board member)</td><td>Completed by (role)</td><td>Name</td><td>Date</td><td colspan="2">Fit and proper?
Yes/No</td></tr>
<tr><td>Senior Independent Director</td><td>Pauline Walsh</td><td>29.05.25</td><td colspan="2">Yes</td></tr>
<tr><td colspan="6">For the chair to complete:</td></tr>
<tr><td rowspan="2">Have all board members been tested and concluded as being fit and proper?</td><td>Yes/No</td><td colspan="4">If ‘no’, provide detail:</td></tr>
<tr><td>Yes</td><td colspan="4"></td></tr>
<tr><td rowspan="2">Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?</td><td>Yes/No</td><td colspan="4">If ‘yes’, provide detail:</td></tr>
<tr><td>No</td><td colspan="4"></td></tr>
<tr><td colspan="6">As Chair of North Staffordshire Combined Healthcare NHS Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.</td></tr>
<tr><td>Chair signature:</td><td colspan="5">  </td></tr>
<tr><td>Date signed:</td><td colspan="5">10th June 2025</td></tr>
</table>

For the regional director to complete:	
Name:	
Signature:	
Date:	

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 22

Board Assurance Framework (BAF) 2025/26

Report provided for:			
Information	☒	Assurance	☐
Discussion	☐	Approval	☐

Report to:	Public Trust Board
Date of Meeting:	10th July 2025

Presented by:	Nicky Griffiths-Deputy Director Governance / Trust Board Secretary
Prepared by:	Nicky Griffiths-Deputy Director Governance / Trust Board Secretary
Executive Lead:	Buki Adeyemo-Chief Executive Officer

Aligned to Board Assurance Framework Risk	This report contains the proposed BAF risks for 2025/26
Approval / Review:	Executive Meeting 22nd May 2025 Private Board 12th June 2025 SLT 24th June 2025
Strategic Priorities:	The Trust BAF describes any identified risks to the delivery of the Trust Strategy – and its key priorities.
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	
Resource Implications:	N/A
Funding Source:	N/A
Diversity & Inclusion Implications	N/A
ICS Alignment / Implications:	
Recommendation / Required Action	The Board is to receive the proposed BAF Dashboard 25/26 for information.
Executive Summary	The Board of each public sector organisation should actively seek to recognise risks and direct the response to these risks. It is for each Accounting Officer, supported by the Board, to decide how. The Board and Accounting Officer should be supported in advising on and scrutinising the management of key risks and the operation of efficient and effective internal controls. The Board, in setting strategy and policy, should use horizon scanning and scenario planning collectively and collaboratively to identify and consider the nature of

emerging risks, threats and trends.
The Board has an inherent role in protecting and assuring the public, which includes taking cost-effective action to reduce risk to a tolerable level and providing accurate and timely information about risks to the public. It has a responsibility to determine and continuously assess the nature and extent of the principal risks that the organisation is willing to take to achieve its objectives. (The Orange Book. Management of Risk-Principles and Concepts 2023.)

The NSCHT BAF Dashboard 25/26 has been engaged at various points including:
Board seminar session in March 2025.
Executive Team meetings in April and May.
Executive Meeting 22nd May 2025
Private Board 12th June 2025
Individual 1-1's with Chief Officers and deputies.

Proposed BAF Risks 2025/26. (Appendix 1)

1) Strategic Direction (New)
2) Partnerships
3) Quality and Safety (Amalgamated from 2 risks in 24/25)
4) People
5) Performance (New)
6) Financial Sustainability
7) Digital (New)

Next Steps.

- Further 1-1's with Execs over coming weeks
- Dashboard to SLT 24th June
- Dashboard to Committees from 3rd July
- Q1 reporting from August 2025
- Trust Secretary continues to meet with System partners as regards the System BAF on a quarterly basis via the ICB Risk and Governance Meeting.

Version	Report to	Date Reported
Version 1	Executive Team Meeting	9th April 2025
Version 2	Executive Meeting	23rd May 2025
Version 3	Private Board	12th June 2025
Version 3	SLT	24th June 2025
Version 4	Committees	27th June 2025
Version 4	Public Trust Board	4th July 2025

BAF DASHBOARD Version 4

Theme	Strategic Priority	Description – Title	Mitigations	Scores Qtr. 1
Strategic Direction	Prevention	There is a risk that the Trust will be unable to maintain its strategic direction due to the changing NHS operating model and as a consequence of this the trust ability to provide high quality sustainable services may be compromised.	• Local Government Operating Models/Delegated Responsibilities • Mental Health Act Reform • Legal Implications (NELFT H&S)	Gross – TBC Residual – TBC Target - TBC
Partnerships	Growth	There is a risk that the Trust may be unable to fulfil the role in delivering the NHS 10 Year Plan due to ineffective strategic relationships with partner organisations. As a consequence, we may fail to deliver integrated community and neighbourhood health services, limiting our ability to respond to population health needs.	• Delivery of the NHS 10 Year Plan • Provider Collaboratives and delivery of 25/26 priorities • Partnership Plan 2025-2028	Gross – 16 Residual – 12 Target - 8
Quality & Safety	Access	There is a risk that the Trust fails to meet the needs of its local communities, particularly those with the most significant health inequalities, due to pathways of care needing to be accessible and inclusive and fully	• 5 Year Quality Plan • Quality Assurance Framework with a focus on maintaining CQC rating • Health Inequalities	Gross – 15 Residual – 15 Target - 10

		representative of communities we serve. This is likely to result in worsening health outcomes for the most vulnerable and regulatory action being taken against the Trust.		
People	**Access**	**There is a risk that we will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors. As a consequence, we will not be able to support our people to continue to deliver outstanding, compassionate care.**	• **Recruitment and retention including talent management** • **Clinical Supervision and Professional Development** • **TBC**	**Gross – 16** **Residual – 16** **Target - 12**
Performance	**Access**	**There is a risk of non-delivery of our financial plans and/or an impact on service quality due to the level of transformation required, with the consequence being an effect on clinical outcomes and/or the Trust's financial viability.**	• **Achievement of CIP** • **Impact of CIP on Quality** • **Maintaining/Improving KPI's specifically with a focus on areas of transformation**	**Gross – 16** **Residual - 16** **Target - 12**
Financial Sustainability	**Growth**	**There is a risk to the Trust's long term financial sustainability due to failure to deliver the recurrent savings programme, and higher than planned bank and agency expenditure. This could lead to a financial deficit, reduced liquidity, a lack of investment in service delivery and potentially impact the future viability of the Trust. In**	• **Variable Pay include measures, agency, bank and overtime** • **Capital Funding** • **Recruitment Savings**	**Gross – 15** **Residual - 10** **Target - 5**

BAF DASHBOARD Version 4

		addition, limited capital funding and the lack of clarity regarding long term capital and financial planning.		
Digital		**There is a risk of failure to transform and innovate across our digital and data solutions, due to outdated practice and inadequate cybersecurity risks and as a consequence this could result in poor data quality, compromised quality of care and operational inefficiencies.**	• **Digital Infrastructure and Solutions** • **Data Quality** • **Cyber Threat**	**Gross – 16** **Residual - 16** **Target - 12**