

NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 11TH SEPTEMBER 2025, 10.00AM, BOARDROOM,
LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P121/25	Welcome and Apologies for Absence – Nicola Bullen, Elizabeth Mellor, Dr Roger Banks, Ben Richards	Janet Dawson	Note	
2	1002	P122/25	Declarations of Interests – and changes to be notified	Janet Dawson	Note	
3	1003	P123/25	Minutes of the Previous Meeting held on 10 th July 2025	Janet Dawson	Approval	Enc. 1
4	1005	P124/25	- Action Monitoring Schedule - Matters arising not covered by the rest of the Agenda	Janet Dawson	Note	Enc. 2
5	1009	P125/25	Patient Story – To be viewed in Private at 12.30pm prior to Private Board Session at Service Users request.	Kenny Laing	Note	Verbal
6	1010	P126/25	REACH Recognition Individual Award – Primary Care Directorate – Rachel Hughes, Directorate Senior Business Administrator	Dr Buki Adeyemo	Note	Verbal
7	1020	P127/25	Chief Executives Report	Dr Buki Adeyemo	Discussion	Enc. 3
8	1030	P128/25	Stoke-on-Trent and Staffordshire Integrated Care Board (ICB) Briefing July 2025	Dr Buki Adeyemo	Information	Enc. 4
9	1035	P129/25	Chairs Report	Janet Dawson	Assurance	Enc. 5
10	1045	P130/25	Board Assurance Framework (BAF) Quarter 1	Nicola Griffiths	Assurance	Enc. 6

22	1230	P142/25	Board To Team Annual Report 2024/25	Nicola Griffiths	Information	Enc. 17
23	1230	P143/25	Medical Revalidation Annual Organisational (AOA)	Dr Dennis Okolo	Information	Enc. 18
24	1230	P144/25	Any Other Business	Janet Dawson	Note	Verbal
25	1230	P145/25	Meeting Self-Assessment	Janet Dawson	Note	Verbal

Date and Time of Next Meeting
Thursday 13th November 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 10th July 2025
At 9:00am 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 / Deputy Chief Executive
Kenny Laing	KL	Chief Nursing Officer / Deputy Chief Executive
Elizabeth Mellor	EM	Chief Strategy Officer
Ben Richards	BR	Chief Operating Officer
Frieza Mahmood	FM	Chief People Officer
Pauline Walsh	PW	Non-Executive Director / Senior Independent Advisor (SID)
Jennie Koo [arrived 9.53am]	JK	Non-Executive Director
Martin Evans	ME	Non-Executive Director
Prem Gabbi	PG	Non-Executive Director
Dr Roger Banks	RB	Associate Non-Executive Director
Katie Laverty	KL _a	Associate Non-Executive Director
Nicola Bullen	NB	NExT Director Programme
Dr Ravi Belgamwar	RBe	Deputy Chief Medical Officer
In Attendance		
Nicola Griffiths	NG	Deputy Director of Governance / Board Secretary
Joe McCrea	JM	Associate Director of Communications
Jenny Harvey	JH	Staff Side Representative
Sherrine Khan	SK	Senior Peer Support Worker
Lisa Wilkinson	LW	Corporate Governance Manager (Minutes)
Public Attendance		
No members of the public were present.		
REACH Team Award – Greenfields Community Mental Health Team		
Members of the Greenfields Community Mental Health Team joined in person and via MS Teams		
Patient Story		
Ness – Space Programme		

Meeting commenced at 9.00am

92/25	APOLOGIES FOR ABSENCE Dr Dennis Okolo, Chief Medical Officer	
93/25	DECLARATIONS OF INTEREST RELATING TO AGENDA There were no declarations of interest. Noted	

94/25	MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 8TH MAY 2025 Minutes were approved as a true and accurate record <i>Approved/Received</i>	
68/25	ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 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. <i>10.07.25 – Complete. Discussed at People, Culture and Development Committee.</i> 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. <i>10.07.25 – The risk has been drafted and will be added and brought through the Trust Risk Review Group and Quality Committee</i> 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. <i>10.07.25 – 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.</i> <i>Received</i>	
96/25	PATIENT STORY – Ness's Story Kenny Laing, Chief Nursing Officer / Deputy Chief Executive presented the patient story. Ness introduced herself and shared that her daughter Erin had severe Obsessive Compulsive Disorder (OCD), which manifested suddenly and severely impacted their family life. She described how Erin's OCD caused her to fear that certain words and actions would lead to catastrophic events, leading the family to avoid those triggers. Ness explained that they were referred to the Intensive Support Hub (ISH) and commenced the Space Programme, which is designed to help parents manage their child's OCD. She emphasised that the programme was challenging and required a lot of hard work and emotional resilience from parents. Ness detailed the process of creating an announcement which involved listing all the accommodations they had made for Erin's OCD and gradually removing them. She described the emotional difficulty of this process, including Erin's initial negative reaction and the family's perseverance in following through with the plan.	

	Ness shared the positive changes they observed in Erin as a result of the Space Programme, including her increased ability to manage her fears and the significant reduction in OCD-related behaviours. She highlighted that Erin was now able to say the word "mum" again and was participating in online schoolwork. Ness advised other parents to trust the process, seek support from the ISH team, and take care of their own well-being. She expressed gratitude to the ISH team for their support and emphasised the importance of consistency and courage in helping their child overcome OCD. Pauline Walsh highlighted the importance of empowering parents to help their children manage OCD. She noted that the Space Programme not only supported the child but also empowered the parents to take an active role in their child's treatment. Ben Richards asked Ness if there was anything she wished she had known at the start of the journey that would have made it easier. Ness responded that understanding the cycle of anxiety and OCD earlier would have been helpful and highlighted the need for better initial support and resources for parents. Russell Andrews shared his experience and gave reassurance 'there was light at the end of the tunnel' and congratulated Ness in being able to share her story. Kenny Laing talked about All Age Access and challenges advising the Trust had practitioners with knowledge across all age ranges but acknowledging if there had been a failure the Trust would look into this. Kenny Laing felt it would be helpful to have a conversation with Ness to ensure the right pathways were in place Ness agreed. ACTION: Kenny Laing to arrange. Ness was thanked for sharing her story. The patient story is available to view on the Trust Public website. Noted	KL
97/25	REACH RECOGNITION TEAM AWARD – Greenfields Community Mental Health Team Dr Buki Adeyemo, Chief Executive Officer introduced the award. Despite significant staff shortages and operational pressures, the team has consistently demonstrated resilience, professionalism, and a strong commitment to high-quality care. Their ability to maintain key performance indicators under such circumstances is a testament to their dedication. Exceptional leadership has provided stability and clear direction, ensuring effective resource use while safeguarding team wellbeing. Their collaborative spirit fosters mutual support and high morale. A recent complex case, involving the safe return of an unwell service user from abroad, showcases their initiative, responsiveness, and unwavering focus on patient care. These qualities exemplify excellence and make them worthy of recognition. The team will continue their efforts to recruit and retain staff, exploring creative staffing solutions such as flexible roles, secondments, or partnerships with other services.	

	The team will formalise peer support and morale-boosting practices and implement structured wellbeing initiatives to prevent burnout and maintain high morale. The team will use lessons from recent complex cases to refine crisis management protocols, including international incidents, and explore ways to enhance service accessibility and responsiveness and invest in emerging leaders to strengthen succession planning and ensure continued high-quality leadership during future pressures. The Board congratulated the team on their award. Received	
98/25	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: Dr Buki Adeyemo drew attention to recent successes and awards within the report and congratulated Jason Snape from the Greenfields who was awarded a merit token for dedication to Veterans. Martin Evans asked in relation to the bid to make Biddulph the first mental health friendly town how much involvement the Trust had in identifying and supporting the bid. Ben Richards advised the Trust had reached out to be involved. Prem Gabbi asked about the Governments plans to address health inequalities and the investment of £750m enquiring as to whether the Trust would receive any of this investment and how it would be shared. Eric Gardiner confirmed there were opportunities to bid further and detail was awaited. Received	
99/25	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. Jenny Harvey advised there was now a group of Trade Unions representing ICB members across Staffordshire and Shropshire. Significant cuts and job losses currently are challenging within the ICB, but there is now a forum where Unions can negotiate talks on this. ICB are looking for expressions of interest for voluntary redundancy which Jenny confirmed had been approved across West Midlands as an approach. Received	
100/25	STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE PARTNERSHIP (ICP) MEETING Dr Buki Adeyemo, Chief Executive Officer, presented the paper and took the paper as read. Received	

101/25	CHAIRS REPORT Janet Dawson, Chair presented the report. Janet Dawson talked about the 10-year plan and reflected on how well we were placed compared with many as far as the aspirations of the 10-year plan. Janet acknowledged the Trust was in the right place to move forward and wanted to recognise the work undertaken thus far to get us there. Janet took the opportunity to thank everyone within the organisation for their hard work. Noted	
102/25	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	
103/25	DIPC ANNUAL REPORT 2024/25 Kenny Laing, Chief Nursing Officer / Deputy Chief Executive presented the report and highlighted the following: Kenny Laing presented the annual report, noting the low rates of infection within the organisation. He emphasised the importance of ongoing surveillance and training to maintain these low rates and ensure patient safety. Kenny Laing highlighted the robust surveillance systems in place to monitor infection rates and the comprehensive training programmes for staff to ensure compliance with infection prevention and control protocols The report included detailed results from audits, which showed high compliance rates across various services. Kenny noted that any areas with lower compliance were addressed promptly, and follow-up audits were conducted to ensure improvements. Kenny Laing outlined future plans, including continued focus on surveillance, training, and addressing any emerging risks. He assured the Board that the organisation was well-prepared to manage infection risks and maintain high standards of patient care. Prem Gabbi queried if an outbreak meant more than one case. Kenny Laing advised this was dependent on the pathogen. Influenzas or COVID would require a linked case whereas high contagious diseases did not. Frieza Mahmood asked if staff were consulted with regards to the focus moving forward for 25/26 priorities or if this was from the horizon scan. Kenny Laing confirmed some were mandated in terms of infection, prevention and control the rest was surveillance data. Received	
104/25	MORTALITY SURVEILLANCE ANNUAL REPORT 2024/25 AND QUARTER 4 REPORT 2024/25	

	Dr Ravi Belgamwar, Deputy Chief Medical Officer presented the report and highlighted the following: Dr Ravi Belgamwar presented the mortality surveillance annual report, which showed a slight reduction in deaths from natural causes compared to the previous year. He highlighted the importance of monitoring mortality rates and identifying any trends or areas for improvement. Dr Ravi Belgamwar noted that many of the deaths were related to physical health issues, such as respiratory conditions and cancer. He emphasised the need to address these physical health issues in patients to improve overall outcomes. The report indicated that 94% of the care provided was rated as good or better. However, there was one case rated as poor, which was reviewed in detail to identify any lessons learned and areas for improvement. Dr Ravi Belgamwar outlined the future actions to be taken based on the report's findings, including continued focus on improving physical health care for patients and ensuring high standards of care are maintained across all services. The Board noted there were some errors within the report. ACTION: Dr Ravi Belgamwar apologised and advised he would ensure the date was corrected and spelling errors amended. ACTION: Following discussion, it was agreed there was a need to consider implementing an external review process for the Mortality Surveillance Report to ensure objectivity and accuracy and we needed to clarify the purpose and requirements of the report, including its mandated aspects and the objectives it aimed to achieve. Janet Dawson advised there was a need to refer to the BAF risk and record this within the report. ACTION: Janet Dawson asked for a review of the report writing process to ensure that all reports acknowledged and referred to the relevant BAF risks, providing context and assurance. <i>Received</i>	RB RB NG
105/25	PATIENT SAFETY (SI) QUARTER 4 REPORT (PSIRF) Dr Ravi Belgamwar, Deputy Chief Medical Officer presented the report and highlighted the following: Dr Ravi Belgamwar reported that 1 Patient Safety Incident Investigation (PSII) had 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). There were 3 reported suspected suicides during this period. An area of concern being reviewed through the CSR process was the potential contribution/impact of a suicide in relation to a person exceeding a 16 week wait for assessment. Key themes from reviews were noted within the report. The Board discussed learning lessons and how that was shared across the Trust and triangulating with quality assurance visits. It was felt there was a gap that needed to be addressed to fully address. Kenny Laing provided	

	assurance that Trust wide learning lessons events were taking place on a rolling programme and felt the gap was around how this was reported. Quality Committee will continue to see through to ensure triangulation. Received	
106/25	QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 3RD JULY 2025 Pauline Walsh, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Pauline Walsh discussed the ongoing issue of out-of-area placements, noting the challenges and costs associated with these placements. She emphasised the need to find solutions to reduce the number of patients placed out of area and improve local care options. Pauline Walsh provided updates on the Care Quality Commission (CQC) inspections, including the awaited report on Crisis Care Services. Potential changes to the way the CQC rates organisations were discussed and implications for the Trust. Pauline Walsh highlighted the importance of triangulating learning from incidents to ensure that lessons were shared and implemented across the organisation noting that this was an area that required further work to ensure effective dissemination and application of learning. The Committee approved a number of policies. Received	
107/25	IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 2 Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the IQPR Month 2 report. Eric Gardiner reported improvements in appraisals and training compliance, noting that the organisation was on track to meet its targets in these areas. He highlighted the importance of maintaining high levels of compliance to ensure staff were well-prepared and supported. Eric Gardiner discussed the ongoing challenges with staffing levels, particularly in relation to agency and bank staff usage. He noted that while there had been some improvements, there was still work to be done to reduce reliance on temporary staff and ensure stable staffing levels. Eric Gardiner provided an overview of the key performance metrics, noting that the organisation was performing well in most areas. He highlighted areas of concern, such as sickness absence, and outlined the actions being taken to address these issues. Received	
108/25	PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 30TH JUNE 2025 Martin Evans, Non-Executive Director / Committee Chair presented the report highlighting the following:	

	Martin Evans discussed the Committee's focus on sickness absence, appraisals, and the Affina Programme. He emphasised the need for a detailed people plan to address these issues. WRES and WDES data submissions were received by the Committee with assurance that key actions were being picked up within workforce plans. Frieza Mahmood added that the first wave of the Affina Programme had been funded but acknowledged this did not release time for staff and managers and this was something that needed to be considered further for the next wave. Elizabeth Mellor highlighted the need to consider how sustainable it was in the current financial climate. Received	
109/25	FINANCE REPORT MONTH 2 Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the report. Eric Gardiner provided an update on the finance report, noting a slight positive variance and ongoing efforts to reduce agency spend. He also highlighted the need for a resolution around capital funding. Received	
110/25	FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 5TH JUNE 2025 Russell Andrews, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Concerns were raised regarding extensions of the risk of the water temperature, noting that this was outside of the Trust's control. Discussions took place on the contract management of the PFI. The Committee will continue to monitor. The Committee were advised that the Trust was awaiting scoreboard for the new NHS Oversight Framework due to be published on 7th July. Russell Andrews acknowledged finances were good, but agency spend was slightly ahead of target compared to the last 10 months. Progress around the Cost Improvement Programme (CIP) deliverability took place, specifically the significant movement in scheme status over the last couple of weeks. The Committee received a Digital report highlighting change in the reporting for governance purposes. Discussion took place on how Committee could gain assurance on key digital projects. The Committee approved the risk register and Board Assurance Framework (BAF). Received	

111/25	GREEN PLAN 2025-28 Elizabeth Mellor, Chief Strategy Officer presented the report and highlighted the following: Elizabeth Mellor presented the refreshed Green Plan, outlining the strategic framework for achieving net zero by 2045. The plan was approved, and it was agreed that the detailed delivery plan would be monitored through the Finance and Resource Committee. Janet Dawson congratulated the team on an excellent report and thanked all involved for their contribution. <i>Approved / Received</i>	
112/25	SAFER STAFFING MONTHLY REPORT MAY 2025 Circulated for information.	
113/25	QUALITY COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 5TH JUNE 2025 Circulated for information.	
114/25	FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 5TH JUNE 2025 Circulated for information.	
115/25	AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 7TH MAY 2025 AND 6TH JUNE 2025 Circulated for information.	
116/25	REMUNERATION COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 8TH MAY 2025 Circulated for information	
117/25	FIT AND PROPER PERSONS TEST ANNUAL REPORT 2024/25 Circulated for information.	
118/25	BAF DASHBOARD 2025/26 Circulated for information.	
119/25	ANY OTHER BUSINESS There were no items of other business. <i>Noted</i>	
120/25	MEETING SELF ASSESSMENT Russell Andrews felt discussion around Board Assurance Framework (BAF and reporting was good and highlighted the importance of revisiting this more intentionally. Janet Dawson felt there were some good challenges which was refreshing and healthy.	
	DATE AND TIME OF NEXT MEETING Thursday 11th September 2025 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 11.00am

Signed: _____
Chair

Date _____

Board Action Monitoring Schedule

Trust Board - Action monitoring schedule - (Public)						
<u>No.</u>	<u>Meeting Date</u>	<u>Minute No</u>	<u>Action Description</u>	<u>Responsible Officer</u>	<u>Target Date</u>	<u>Progress / Comment</u>
1	10th July 2025	96/25	PATIENT STORY Kenny Laing talked about All Age Access and challenges advising the Trust had practitioners with knowledge across all age ranges but acknowledging if there had been a failure the Trust would look into this. Kenny Laing felt it would be helpful to have a conversation with Ness to ensure the right pathways were in place Ness agreed. Kenny Laing to arrange.	Kenny Laing	11th September 2025	Kenny Laing met with Ness in August to discuss her experience and Kenny will agree actions for improvement with the Acute & Urgent Care Clinical Director.
2	10th July 2025	104/25	MORTALITY SURVEILLANCE ANNUAL REPORT 2024/25 AND QUARTER 4 REPORT 2024/25 (1) Correct the date and spelling errors in the Mortality Surveillance Report and ensure it reflects the current year. (2) Consider implementing an external review process for the Mortality Surveillance Report to ensure objectivity and accuracy. (3) Clarify the purpose and requirements of the Mortality Surveillance Report, including its mandated aspects and the objectives it aims to achieve. (4) Review the process of report writing to ensure that all reports acknowledge and refer to the relevant BAF risks, providing context and assurance.	Dr Ravi Belgamwar Dr Ravi Belgamwar Dr Ravi Belgamwar Nicola Griffiths	11th September 2025 11th September 2025 11th September 2025 11th September 2025	Actioned This has been considered and also discussed at Quality Committee (QC), a review of presentation of Mortality Surveillance process and additional information of staff involved will be included to contextualise reports and objectivity - to go to QC The Mortality Surveillance and review of all mortality within NHS organisations is a requirement; good practice and follows a National tool guidance the Royal College toolkit, these reviews serve as opportunities for learning and improvement of care within the Trust. Report Writer training (aimed specifically at report authors) for the new executive summary report template, has been developed and will be delivered via four online sessions in September facilitated by Nicky Griffiths. This will include the need for papers to identify and relate content to the Trust's Board Assurance Framework and the relationship to/impact on key strategic risks'

Enclosure No: 3

CEO BOARD REPORT

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☐	Date of Meeting:	11th September 2025
Discussion	☒	Approval	☐		

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	Activities of the Chief Executive Officer support the Trusts approach to Diversity and Inclusion.
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:

- Guidance for education settings responding to a sudden unexpected death being treated as a suspected suicide published
- Staffordshire and Stoke-on-Trent Integrated Care Board plan to cluster with Telford and Wrekin Integrated Care Board
- Supporting children and young people with behaviours of distress project
- Epilepsy Model
- Memory Clinic welcomes Allison Gardner MP
- Crisis Care Centre receives 'good' CQC rating
- Combined Healthcare publishes Green Plan for 2025-28
- Combined pioneers use of virtual walkthroughs to increase access to mental health services
- Darwin Centre opens 'first of its kind' specialist treatment area
- Kenny Laing elected Vice Chair of the National Mental Health Nurse Directors Forum

VERSION CONTROL:

Version	Report to	Date Reported

Chief Executive's Report to the Trust Board September 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 STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE SYSTEM (ICS)

Guidance for education settings responding to a sudden unexpected death being treated as a suspected suicide published

Staffordshire and Stoke-on-Trent Integrated Care System (ICS) has published a new guidance document to support leaders in schools, colleges and education settings across Staffordshire and Stoke-on-Trent around the immediate processes involved in a child death by suspected suicide, and to provide advice about ongoing support and communications.

The guidance was developed through system-wide collaboration with oversight from Combined Healthcare's Chief Operating Officer and Senior Responsible Officer for Mental Health, Learning Disability and Autism across Staffordshire and Stoke-on-Trent ICS, Ben Richards.

The guidance aims to support those effected by a suspected suicide, who may become at higher risk of suicide themselves.

Staffordshire and Stoke-on-Trent Integrated Care Board plan to cluster with Telford and Wrekin Integrated Care Board

There are plans to cluster Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) with Telford and Wrekin ICB, as the six West Midlands ICBs (Birmingham and Solihull ICB, Black Country ICB, Herefordshire and Worcestershire ICB, Coventry and Warwickshire ICB, Shropshire, Telford and Wrekin ICB, and Staffordshire and Stoke-on-Trent ICB) group into three 'strategic clusters' with a view to reducing costs.

If the plans go ahead, the ICBs will remain their own statutory organisations with their own legal responsibilities and local accountability.

Supporting children and young people with behaviours of distress project

The Staffordshire and Stoke-on-Trent ICS Children and Young People's Project, led by Liz Mellor, Chief Strategy Officer has now been completed. The initiation phase of the project has delivered training to over 300 professionals across health and social care, developed a new crisis pathway and designed an integrated workforce model to support children and young people with behaviours of distress. This new pathway is a tailored intervention offering a dedicated MDT approach to providing co-ordinated, trauma informed care across health, social care and education.

Adoption of this integrated MDT pathway will enable the system to shift from reactive crisis intervention to proactive coordinated care. This transformation will lead to better outcomes for children, young people and their families, reduced financial strain on services, and long-term systemic improvements in health and social care partnerships.

A business case to secure funding has been developed and is currently going through external governance arrangements. Funding is being sought via the West Midlands CAMHS Provider Collaborative (Toucan), following the outcome a formal mobilisation process would be enacted across local partners in health and both Local Authorities.

Epilepsy Model

Following a review of the national bundle of care a project group as part of the Health and Wellbeing Board has agreed that the initial areas of focus would be to address the variation in care and supporting the mental health and wellbeing of CYPs.

Access to an Epilepsy Specialist Nurse (ESN) is key to reducing the variation in care experienced by our children and young people; locally we are below the recommended ratio levels. The clinical teams have scoped the skill mix required to provide an effective robust service and the associated risks with current practice have been escalated within the ICS; a business case with a view to securing additional resource is under discussion via governance routes.

Following a request from SSOT ICB to provide a psychology service to children with epilepsy (under are primarily under the paediatric team at UHNM), for which they have provided £110k additional funding, we have proposed a clinical model, (to which commissioners have now agreed), we are currently finalising the associated activity and outcome measures.



3.0 OUR TRUST

Memory Clinic welcomes Allison Gardner MP

The Memory Clinic at Marrow House was delighted to welcome local MP, Allison Gardner, for a visit on 7th August. The City Memory Clinic is one of two memory services which support the population of North Staffordshire and Stoke on Trent. The service offers assessment, diagnosis and the initiation of treatment for Dementia (Alzheimer's/Vascular etc) con-current mental health issues related to dementia are also supported.

The Memory Service continues to excel in achieving high dementia diagnostic rates. The service achieved accreditation with the Memory Services National Accreditation Programme (MSNAP) which promotes learning and excellence in order to deliver the best possible service.

The multi-disciplinary team is made up of doctors, occupational therapists, health care support workers, nursing staff and administrative support.. Additionally, they have dementia primary care nurses working closely with general practitioners (GPs), who also support and manage people living with dementia.

The Memory Clinic also has close links and solid working relationships with the Alzheimer's Society, Drivability and other agencies/ stakeholders that support the patients and carers. Growing and expanding relationships like this remains a key priority.

Crisis Care Centre receives 'good' CQC rating

The Crisis Care Centre was inspected by the Care Quality Commission (CQC) in May 2025. The report has now been published with the CQC rating our mental health crisis services and health-based places of safety based at the Harplands Hospital as 'good'.

The inspection was conducted over three days, with inspectors visiting the site on each occasion. They found that the service had enough appropriately trained staff to ensure patient safety and to meet their needs, it also found that care records demonstrated that patients were fully assessed and risk was managed well, while patients said they felt included in their treatment planning.

The CQC found that, overall, people's experience with the service was positive, and they felt staff had helped and supported them. People said staff were kind, compassionate and knowledgeable and felt the team had helped them through their crisis period and arranged appropriate aftercare which had been communicated well.

The CQC also found areas for improvement around care plans and person-centred goal setting, and regular supervision and appraisals for staff.



Combined Healthcare publishes Green Plan for 2025-28

North Staffordshire Combined Healthcare NHS Trust is proud to support the NHS ambition to achieve Net Zero by 2045.

The Trust's Green Plan 2025-28 outlines the steps we will take over the next three years to reduce carbon emissions, improve sustainability, and build climate resilience across our services.

This plan builds on the progress we've already made and reflects our ongoing commitment to a healthier environment for our patients, staff, and communities. It is intended that this plan will help people to stay well, closer to home and reduce health inequalities through smarter, more sustainable services.

Combined pioneers use of virtual walkthroughs to increase access to mental health services

Combined Healthcare is pioneering the use of virtual walkthroughs of its mental health services to allow service users and their loved ones to preview the facilities they will be using. In doing so, the Trust is breaking down barriers to accessing mental healthcare facilities by dispelling myths or misconceptions about what modern, compassionate NHS mental healthcare looks and feels like.

The use of virtual walkthroughs has been highlighted through the launch of a new film called 'Sarah and Barry – a 360-degree virtual walkthrough of Ward 4'. In this short film, created in partnership with Matterport, we meet Barry and his daughter, Sarah. Before she agreed to her dad being admitted to Ward 4, Sarah was able to use our 360-degree virtual walkthrough of Ward 4 to see the facilities and allay any concerns or preconceptions she may have had about what a mental health facility looks like.

The film is available on the Trust's YouTube channel at <https://youtu.be/qx0qcKwzGg>

We have now completed walkthroughs for the majority of our facilities, and they are available on each individual service's page at <https://www.combined.nhs.uk/services/> or together in one showcase at <https://discover.matterport.com/account/DW3mbfdc1vC>



CEO Board Report



Darwin Centre opens 'first of its kind' specialist treatment area

The Darwin Centre, an inpatient mental health service for children and young people, has opened its doors to a new multifunctional enhanced support suite – the first of its kind in the UK.

Its aim is that the 'Peace Pod' will help the Darwin Centre to avoid admissions to a psychiatric intensive care unit (PICU) or specialist eating disorder unit (SEDU), reduce the length of stay for patients with complex needs through timely therapeutic interventions tailored to the individual, and meet the multi-faceted requirements of patients with complex or dynamic needs.

Funding for the Peace Pod was awarded for an Enhanced Support Model through Toucan, the West Midlands CAMHS (Child and Adolescent Mental Health Services) Provider Collaborative. Funding covers the development of the centre itself, as well as training for the inpatient MDT (multidisciplinary teams) and community teams.

The launch of the Peace Pod was featured by BBC Online at <https://www.bbc.co.uk/news/articles/czxeyy1rw7zo>

Kenny Laing elected Vice Chair of the National Mental Health Nurse Directors Forum

Finally, I am delighted to inform you that Kenny Laing, Chief Nursing Officer and Deputy Chief Executive at North Staffordshire Combined Healthcare NHS Trust, has been elected as the new Vice Chair of the National Mental Health Nurse Directors Forum.

He will work alongside Vanessa Smith, Chief Nurse at South London and Maudsley NHS Foundation Trust, who will be stepping into the role of Chair.

4.0 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.



Enclosure No: 4

Integrated Care Board (ICB) Update

Report provided for:				Report to:	Public Trust Board
Information	☒	Assurance	☐	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

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 17 th July 2025.

Items discussed were:

- ICB Chair and Chief Executive Update
- Fit for the Future – 10 Year Plan
- Joint Health and Wellbeing Strategy
- SBAF Quarter 1 2025/2026 Report
- Fit and Proper Persons (FPPT) Report
- Quality and Safety Report
- Quality and Safety AAA Chairs Report – June
- Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report – May and June
- ICS Finance and Performance Report
- Finance and Performance Committee AAA Chairs Report – June and July
- ICS People, Culture and Inclusion Committee Assurance and Performance Report
- Staffordshire and Stoke-on-Trent ICB People, Culture and Inclusion Committee AAA Chairs Report – July
- 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	Public Trust Board	01/09/2025

Integrated Care Board Briefing

Staffordshire and Stoke-on-Trent
ICB Meeting

17 July 2025

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 Paul Edmondson-Jones, interim Chief Executive Officer, presented the report.
- The Chair formally acknowledged his decision to step down from his role as Chair of Staffordshire and Stoke-on-Trent Integrated Care Board. The Chair advised that, in agreement with NHSE Regional Director Dale Bywater, a transition period has been arranged to ensure his departure aligns with the appointment of the incoming Chair and the implementation of the new clustering arrangements. The Chair stated that this approach is intended to support a safe, thorough, and well-managed handover.
- The Chair commended the work going on between Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent, reminding the Board that this is not a merger, it's a clustering arrangement where two Boards will operate in parallel with a single Chair and Chief Executive.
- The Chair noted that progress will accelerate in the coming months, with structures expected to be defined by the end of the calendar year and further updates will be brought to the Board in due course.
- The Chair advised that Janet Dawson, Chair of North Staffordshire Combined Healthcare Trust, will be taking on the role of Chair for the Provider Collaborative, noting that Janet is already establishing governance arrangements involving several other Non-Executive Members to ensure effective progress moving forward.
- Paul Edmondson-Jones advised that while structures are beginning to take shape within plans for the ICB reset, progress depends on the appointment of a cluster Chair and Chief Executive, and transition committees and working groups are in place with further updates to follow as the work develops.
- The Chair noted an error within Chair and CEO report regarding the Local Improvement Framework, and clarified that the award for Tamworth was £300,000, not £100,000 as reported.
- Paul Edmondson-Jones highlighted the significant partnership work across organisations in response to the Ministry of Defence (MOD) request for support for Op Lazurite, which resulted in the ICS supporting over 1200 evacuees through MOD Swynnerton from 2024-2025. The work has been widely recognised including formal thanks from the MOD and several personal awards, marking a major achievement for the ICS.
- Paul Edmondson-Jones recognised Gill Boast, General Practice Nurse with the Staffordshire Training Hub, for receiving the national Chief Nursing Officer Silver Award for her longstanding contribution to the system.
- Paul Edmondson-Jones provided a brief update on the recent GP Patient Survey, noting that Staffordshire and Stoke-on-Trent saw improvements across four key areas, all above national and regional averages. Paul highlighted significant progress at Gordon Street practice following the Board's decision to end the previous contract and appoint a new provider. Paul thanked the Board and primary care teams for their support, noting this as a strong example of system-wide improvement.

The Board thanked the Chair and Paul Edmondson-Jones for the report. The Board was asked about the community neighbourhood events referenced in the report and whether any supporting documentation was being produced for those unable to attend. On this point, the Board was also asked about health literacy and why frailty was not included among the identified focus areas. Paul Edmondson-Jones advised that the priorities were identified collaboratively, with a recognition that only three or four areas could be

meaningfully addressed at this stage. While acknowledging that frailty is an important issue, Paul noted that it was considered broader and more complex than the other selected areas. Paul advised that frailty should be considered in future work but confirmed that the current focus was based on a collective decision to start with the chosen four areas. Elizabeth Disney, interim Deputy Chief Executive and Chief Transformation Officer, assured the Board that as standard practice, a written summary is produced following community events, which are documented and made publicly available. The Board was asked about the metrics presented, which appears to show an increase in walk-in attendances, alongside a decrease in 111 calls and GP visits during the same period. The Board was asked for clarification on the correlation between these trends. Phil Smith, Chief Delivery Officer, advised that a deep dive has been conducted into recent numbers which show significant increase for walk-in demand and ambulance arrivals at acute sites during the first months of the year. Phil Smith added that no clear cause has been identified from the nature of presenting conditions, and this pattern has been mirrored across the region. Phil Smith also stated that by the end of June, levels appear to have returned to expected norms, and ongoing monitoring will continue to better understand these trends. Phil noted that 111 services and the focus on primary care will be key moving forward, especially for winter planning.

The Board commented on the recent decision to abolish Healthwatch England, expressing concern over the lack of clarity about its replacement and emphasizing the need to keep the patient voice central in future arrangements. The open letter to Parliament and the accompanying petition was noted.

Mike Lawton, Non-Executive Chair of the Strategic Commissioning and Transformation Committee, commented on his involvement with the Locality Improvement Framework panel as an exceptionally valuable and engaging experience, highlighting the strong collaboration between agencies working to support the 'left shift' and deliver targeted support to specific communities.

Fit for the Future – 10 Year Plan

- Paul Edmondson-Jones, interim Chief Executive presented the report.
- Paul Edmondson-Jones stated that five key themes emerged from the recent national consultation, with a particular emphasis on challenges around accessing care, including GPs, dental services, and ambulance wait times. The five key themes were:
 - Getting the care that you need
 - Seamless healthcare
 - Fixing the basics
 - Sickness to prevention
 - Great place to work
- Paul Edmondson-Jones outlined the NHS's long-term direction through three major shifts: hospital to community care, analogue to digital transformation, and a move from treating sickness to preventing it.
- Paul Edmondson-Jones highlighted that, although this is a 10-year plan, Integrated Care Boards and Integrated Care Systems will be expected to develop medium-term plans targeting 2028/2029.
- Paul Edmondson-Jones also noted specific priorities under each shift, such as improving digital access through the NHS App. Paul advised that this must remain one of several access routes to avoid excluding those unable to use digital tools.
- Paul Edmondson-Jones highlighted the focus on prevention, linking it to existing work around smoking, obesity, physical activity, and alcohol through the Local Prevention

Board, and emphasised the importance of using this plan as a long-term mandate for systemic change.

The Chair thanked Paul Edmondson-Jones for the report. The Board welcomed the acknowledgment that digital access, particularly via the NHS App, should not be the sole 'front door' to services, highlighting the need for a data and demographic led approach, especially in more deprived communities where digital-only solutions may not be accessible or appropriate. The Board echoed the point around digital access, adding that achieving equity for various groups, particularly the elderly, will require significant effort and should not be underestimated.

The Board endorsed and noted the recommendations presented to them.

Joint Health and Wellbeing Strategy

- Elizabeth Disney, interim Deputy Chief Executive and Chief Transformation Officer, and Stephen Gunther, Stoke-on-Trent City Council, presented the report.
- Stephen Gunther stated that the ICB is a key partner in the Stoke-on-Trent Health and Wellbeing Board, whose role is to promote, drive, and improve the health and wellbeing of local residents and patients.
- Stephen Gunther noted that the strategy presented to the Board has been developed through a range of consultation processes and is closely aligned with the broader priorities of the NHS and the Integrated Care Partnership. For example, the priorities within the children and young people's section align with the work of the Children and Young People's Partnership Board, with clear outcomes mapped to it.
- Elizabeth Disney added that the strategy presents a valuable opportunity to build on discussions already held at the Board, particularly around the Neighbourhood Health agenda.
- Elizabeth Disney emphasised the importance of having clarity on how to prioritise and understand population needs at the place level, which is a critical element for the future.
- Elizabeth Disney noted that the strategy enables continued focus on this area with greater precision and alignment and will remain a vital part of how the ICB works with partners both at place level and within more detailed neighbourhood structures.

The Chair thanked Elizabeth Disney and Stephen Gunther for the report, praising the clarity and readability of the document, noting that it clearly sets out the priorities. The Board noted that personal responsibility is a key theme within the strategy, with emphasis on working collaboratively with residents and patients to support informed decision-making and improved wellbeing. The Board also noted that individuals are more likely to make positive choices when part of strong, resilient communities, and that the Neighbourhood Health approach should be used to build community confidence and peer support. The Board confirmed plans to align the strategy with the upcoming Locality Improvement Framework for Stoke-on-Trent and report back on its application. The Board approved the Stoke-on-Trent Joint Health and Wellbeing Strategy 2025-2028.

SBAF Quarter 1 2025/2026 Report

- Claire Cotton, University Hospital of North Midlands (UHNM) Director of Governance, presented the report.
- Claire Cotton advised that the executive summary provided a thorough overview of strategic risks, reminding the Board that in April, a decision was made to carry forward the eight strategic risks from the previous year.

- Claire Cotton advised that these risks have since been refreshed and reassessed by the team, and while most risk levels have remained static, reducing health inequalities is showing a downward trend and sustainable finances an upward trend.
- Claire Cotton noted that committee scrutiny is captured in the reports, and work is underway to streamline the presentation of risks, moving towards a 'BAF on a page' format to ensure key messages are not lost in the detail.
- Claire Cotton added that when all quarter one BAFs are available, a refreshed mapping exercise will be undertaken across the system to assess alignment.
- Claire Cotton acknowledged the significant contribution of Tracey Shewan and the wider team in delivering this work.

The Chair thanked Claire Cotton for the report, recognising the significant effort in embedding this work across committees. The Board commented that Audit committee expressed concern over the lack of reduction in risk levels and has requested a thorough review to ensure the right mitigations are in place, seeking clarity on why the risks remain unchanged despite ongoing efforts. Tracey Shewan, Director of Corporate Governance, added that quarter two will reveal how future actions are tracked, enabling clearer scrutiny of what has or hasn't been done, and whether those actions are effectively mitigating the risks to ensure accountability. The Board accepted and acknowledged the recommendations presented to them.

Fit and Proper Persons (FPPT) Report

- Tracey Shewan, Director of Corporate Governance, presented the report.
- Tracey Shewan shared thanks to all involved in supporting the process and confirmed that all Board members have been signed off as Fit and Proper Persons.
- Tracey Shewan noted that internal audit activity has also taken place, which may highlight areas for improvement in the recruitment process.

The Chair thanked Tracey Shewan for the report. The Board received and noted the recommendations presented to them.

Quality and Safety Report

- Heather Johnstone, Chief Nursing and Therapies Officer, presented the report.
- Heather Johnstone advised that the Multi-agency Safeguarding Hub (MASH) has been renamed the Safeguarding Integrated Front Door (SIFD).
- Heather Johnstone added that this is a significant development supporting several key areas of the safeguarding agenda, particularly in streamlining access to support, ensuring timely intervention, enhancing integration and information sharing, and eliminating duplication, which is critical in this area of work.
- Heather Johnstone shared that the Continuous Quality Improvement Network continues to go from strength to strength and is now reaching approximately 713 members across Staffordshire and Stoke-on-Trent, reflecting a 56% increase over the past year. Heather noted that this provides an excellent launchpad for future cluster level work.
- Heather Johnstone added that the LeDeR (Learning from Lives and Deaths of People with a Learning Disability and Autistic People) programme continues to make strong progress, with a primary focus on streamlining processes and sharing learning. Heather noted that collaboration is now underway with colleagues in Shropshire, Telford and Wrekin, and emphasised the importance of embracing every opportunity to learn from current practice.
- Heather Johnstone advised that the System Quality Group received a report on harm reviews for patients who spent over eight hours in an ambulance or over 48 hours in

an emergency department. Heather acknowledged that further work is required to fully understand and analyse the findings.

- Heather Johnstone also advised that data for South Staffordshire patients accessing urgent care through other providers has been requested, and once this information has been gathered and a comprehensive report compiled, it will be brought back to the Board for review and assurance.
- Heather Johnstone noted that NHS England have been undertaking a comprehensive review of the Quality Impact Assessment (QIA) process, following concerns raised by partners and the Board.
- Heather Johnstone advised that a draft report has now been received for comment, and early indications suggest it will be positive. Heather stated that feedback is due to NHS England by 21 July, with the final report expected by the end of the month.

The Chair thanked Heather Johnstone for the report. The Board asked what opportunities digital technology has provided to facilitate data transfer and enable systems to communicate with each other. John Rouse, City Director, City of Stoke-on-Trent Council, advised that this remains a challenging area, but there has been a recent transition to an electronic portal for receiving referrals. John Rouse added that although digital systems can support more efficient information sharing, care must be taken not to let this replace critical human interaction, and work is ongoing to find the right balance.

The Chair praised the work around the System Wide Urgent and Emergency Care Winter Quality Review. The Chair asked for assurance around capacity for the LeDeR reviews. Heather Johnstone assured the Board that there is capacity, and a detailed report on the trends over the past year will be provided to demonstrate this. The Board received and accepted the recommendations presented to them.

Quality and Safety AAA Chairs Report – June

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer stated that the committee met formally in June, and all approved items were ratified virtually.
- Josie Spencer noted that while some improvements have been observed in the Initial Health Assessments (IHA), consistency remains a concern, along with a decline in compliance with review health assessments, advising that additional data has been requested.
- Josie Spencer added that the report suggested lowering the risk score for this issue, to which the committee pushed back due to ongoing variability and inconsistency. Josie advised that this matter will be revisited at the Quality and Safety Committee in August.
- Josie Spencer noted that the Committee approved The Patient Safety Incident Response Plan for Midlands Partnership University NHS Foundation Trust (MPFT), The Patient Safety Incident Response Plan for the National Unplanned Pregnancy Advisory Service (NUPAS), and the Stoke-on-Trent Joint Dementia Strategy.
- Josie Spencer acknowledged this as her final formal meeting as Chair of the committee, with Siobhan Heafield taking over the role. Josie stated that it had been a pleasure working with the team.

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

Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report – May and June

- Rachel Gallyot, Interim Chief Medical Officer, presented the report.
- Rachel Gallyot advised that in May, the senate approved the Integrated Medicines Optimisation Group (IMOG) decisions from the meeting held on 2 April 2025.
- Rachel Gallyot noted the review of palliative care medication on the formulary and a position statement to prescribe of bath and shower gels, which are of low clinical value.
- Rachel Gallyot advised that the Staffordshire and Stoke-on-Trent Alcohol Strategy was endorsed, which will be delivered through the Drugs and Alcohol Partnership.
- Rachel Gallyot also advised that the Senate clinically approved the revised service specification for Community Ear Nose and Throat (ENT).
- Rachel Gallyot stated that Integrated Medicines Optimisation Group (IMOG) decisions were also approved at the June Senate, along with the streamline recommendation for the medical treatment of Ulcerative Colitis and the Crohn's disease pathway. Rachel added that Lurasidone antipsychotic medication was also approved for shared care use and put on the formulary.
- Rachel Gallyot noted that an important part of the June Senate was around the approval of the clinical model for weight management.
- Rachel Gallyot advised that the first phase is around those with a Body Mass Index (BMI) of over 40, together with four out of five comorbidities (hypertension, dyslipidaemia, obstructive sleep apnoea, cardiovascular disease and type 2 diabetes). Rachel noted that this also includes support for the primary care delivery model.
- Rachel Gallyot advised that some discussion took place around the stoppage criteria and financial implications.
- Rachel Gallyot added that the Senate also clinically approved the diagnostic strategy and the terms of reference for the Value-Based Steering Group, which is a sponsorship for the Senate through the Clinical Values Programme. Rachel advised that, in summary, the programme aims to reduce waste and promote evidence-based, high-value interventions, with plans to expand its implementation across the wider system.

Chair thanked Rachel Gallyot for the report. The Board was asked about public communications regarding the weight management programme, particularly the impact of limited public understanding of the strict eligibility criteria. On this point, the Board was asked about the resulting pressure on GPs and what support will be provided to help manage this. The Board was also asked, given these constraints, how many individuals are currently being supported through this clinical model. Rachel Gallyot advised that the rollout will be staged and close collaboration with primary care is in place, supported by a hub-and-spoke model to ease pressure on general practice. Rachel added that communication has been effective with engagement from the outset. Rachel advised that as the eligibility criteria and funding model evolve, the approach will remain agile and regularly reviewed with updates provided to the Board. Rachel confirmed that data on numbers is available and will be shared. Paul Edmondson-Jones, interim Chief Executive added that primary care hubs are proactively contacting individuals based on the criteria, with strong communication efforts in place. Paul noted there has been less public noise locally compared to other regions, likely due to the primary care-led model, which also enables links to community weight management support.

The Board was asked about the risk level of acute pancreatitis, currently at 0.4%, acknowledging that this risk is likely to become more significant as uptake increases. The Board was also asked to consider the potential impact on secondary and tertiary care services from individuals who may experience related symptoms. Rachel Gallyot advised that the risk of acute pancreatitis is being closely monitored in those receiving treatment through the NHS, in line with NICE guidance and supported by robust monitoring processes. Rachel added that the greater concern lies with individuals accessing the

medication privately, where appropriate oversight is often lacking, presenting a hidden risk to the system which may lead to increased pressure on NHS services.

The Chair acknowledged the work of Rachel Gallyot in establishing the clinical Senate, commending the quality of the report and the effective functioning of the group. The Board noted the acknowledgements presented to them and supported the escalations brought forward.

ICS Finance and Performance Report

- Claire Finn, interim Chief Finance Officer, and Phil Smith, Chief Delivery Officer, presented the report.
- Claire Finn advised that at month two, the position is £2.9m adverse variance to plan, and the main driver for this being Cost Improvement Programme (CIP) slippage. Claire noted that all organisations are committed to delivering the plan, with ongoing work supported by MINT London to identify further efficiencies. This work aims to ensure that overall risk is being assessed and that progress continues in identifying efficiencies.
- Claire Finn noted that the overall month-on-month risk has reduced, with continued progress being made against the efficiency plan.
- Claire Finn noted that £22m has been moved into implementation.
- Claire Finn advised that a balanced plan has now been reported with no year-to-date variance. Claire added that the plan is underpinned by £95m of deficit support funding, which is not automatically provided. Claire added that Q1 and Q2 deficit support funding has been received, but Q3 will have a stricter criteria based on the month five position, national metrics which are being finalised, year-to-date performance forecast, confidence in efficiency, and level of mitigated risk.
- Claire Finn noted that if the plan is delivered this year, the £95m will not need to be repaid next year. Claire noted that £11m has had to be repaid in this financial year which has put a strain on the financial position.
- Phil Smith stated that winter preparations are progressing at pace, emphasising that the approach to managing winter this year is critical to the success of the operational plan.
- Phil Smith advised that the work being undertaken is informed by the new national Urgent and Emergency Care plan, along with the system winter learning event.
- Phil Smith emphasised the important role of community neighbourhoods in preventing unnecessary escalation to acute services, enabling early warning and tactical interventions. Phil stated that the way we work, and the design of work programmes are just as vital as the additional capacity being put in place for winter.
- Phil Smith advised that the approach for this year has been approved by Chief Executives, noting that there are 12 pillars and an executive lead for each area.
- Phil Smith added that NHSE will conduct a winter assurance visit during the first week of September and will lead an EPRR readiness assessment. Phil advised that the Board will be required to submit an assurance statement to the region by the end of September.
- Phil Smith also noted that preparations are underway to manage the impact of the upcoming five-day industrial action by resident doctors, scheduled from 25 to 30 July.
- Elizabeth Disney, interim deputy Chief Executive and Chief Transformation Officer, advised that while there is pressure and challenge with out-of-area placements, the number of beds removed from normal capacity related to Project Crystallise has been inaccurately reported. Elizabeth stated that an updated figure on the beds taken out of circulation because of this project is required.

The Chair thanked Claire Finn and Phill Smith for the report. The Chair asked about the level of assurance behind the plan and how it will ensure maximum impact and delivery. Claire Finn advised that month six will be particularly challenging and the CIP will need to have significant impact. Claire also highlighted a positive meeting with UHNM where assurance was provided around the actions being taken to minimise risk, and the ICB position is being reviewed in granular detail daily to reduce unmitigated risk, and financial recovery workshops are ongoing. Claire noted that progress continues, with £22 million recently moved from opportunity into implementation. Claire advised that this is a positive step, though not without risk, and emphasised the importance of maintaining momentum and traction.

The Board was asked for clarity on the criteria being purely financial and not including performance improvement. Claire Finn advised that for the deficit support funding, the draft metrics are purely financial metrics.

The Board was asked to provide clarity on the plan being based on a reduction of 1,000 posts across the system, noting that the workforce report showed a net reduction of only six posts as of month two. The Board was also asked how much of the current delivery relies on non-recurrent spend, and what implications this has for the next financial year. Claire Finn advised that a significant portion of the pay area is focused on reducing corporate costs, which have seen substantial national growth and remains a key focus for the system. Claire added that bank and agency staffing, particularly agency use, represents an area of inefficiency that needs to be addressed, along with waiting list initiatives that also contribute to premium costs, and efforts are being made to target and reduce these high-cost areas.

The Board commented that the approach to winter planning is positive in ensuring the Board is cited on the key issues. The Board asked for further details on the plan to increase virtual ward occupancy and optimise the use of virtual beds. Phil Smith advised that challenges with virtual ward occupancy include not reaching planned capacity, ongoing cultural hesitation and limited trust in the model, and underutilisation of step-up care. Phil noted that efforts are underway through medical teams and the integrated discharge hub to address these issues. Phil also emphasised that virtual wards are a key focus of the winter plan, with variation in use across the region, highlighting the need to build greater trust and consistency.

The Board acknowledged and received the recommendations presented to them.

Finance and Performance Committee AAA Chairs Report – June and July

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer noted that the Digital Strategy Progress Report was reviewed in July, and a key concern that remains is the significant financial risk associated with the Electronic Patient Record (EPR) business case, with the risk rating increasing to level 20. Josie advised that work is underway to explore options to mitigate the revenue impact and this will continue to be closely monitored.
- Josie advised that in terms of workforce, while there have been some improvements in workforce figures against plan, the pay bill remains misaligned and further work is required in this area. Josie advised that a more detailed update is expected at the next Finance and Performance meeting on 5 August.
- Josie Spencer advised that the committee discussed the system-wide lessons learnt from the winter review, which was well received.

- Josie Spencer noted that a verbal update was provided on the Provider Collaborative Assurance Report. Josie acknowledged that some elements remain unclear but hopes for greater clarity now that lead Chief Executives have been identified, along with support from GPs where appropriate.
- Josie Spencer confirmed that the System Performance Group Terms of Reference were approved at the July meeting.

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

ICS People, Culture and Inclusion Committee Assurance and Performance Report

- Gemma Treanor, Head of ICS People Function, presented the report.
- Gemma Treanor highlighted the month three workforce position at year-to-date is minus 482 whole time equivalent (WTE) in terms of plan.
- Gemma Treanor reported a reduction of 10 WTEs in month three, noting that the system remains 42 WTE under the planned performance level. Gemma stated that this reflects a mixed picture across providers, with some areas over plan and others under, particularly driven by bank usage, where work is ongoing to better understand the variation.
- Gemma Treanor advised that agency staffing continues to reduce, currently 52 WTEs under plan, noting this attributed to enhanced workforce and financial controls, as well as transformation activities that are expected to have further impact throughout the year.
- Gemma Treanor added that the mismatch between the pay bill and workforce continues to be closely monitored in collaboration with finance and workforce colleagues. Gemma acknowledged that this mismatch is also seen across the region and confirmed that efforts are underway to address it.
- Gemma Treanor advised that workforce metrics show the 12-month rolling sickness rate stands at 5.6%, but the monthly rate dropped to 4.8% in May, with June figures pending.
- Gemma Treanor advised that turnover rates are also continuing to decline, though this presents challenges for providers due to assumptions built into the plan regarding turnover and possible vacancies.
- Gemma Treanor highlighted the importance of staff experience during ongoing system the transition, which is being closely monitored through the People, Culture and Inclusion Committee and the Health and Wellbeing Committee as part of the wider 'Looking After Our People' agenda.
- Gemma Treanor stated that the Staff Survey and Annual Report were reviewed by the PCI Committee with a positive outcome for the system, noting that Staffordshire and Stoke-on-Trent was the best performing system across the Midlands ICSs, with higher overall scores across all themes.
- Gemma Treanor explained that while scores have improved in some areas, remained stable in others, and declined in a few areas, key overarching areas for improvement have been identified including health and well-being, staff experience, leadership, and discrimination.
- Gemma confirmed that these areas will be addressed through the PCI Committee, as well as the Health, Well-being and Experience and Equality, Diversity and Inclusion Committee, and leadership workstreams moving forward.
- Gemma Treanor highlighted that, as part of the annual report, several successful national pilots have taken place including the Volunteering for Health programme, which involved close collaboration with the voluntary sector, T Levels and care leavers,

contributing to a continued emphasis on widening participation and access, as well as embedding the Anchor Institution Strategy.

- Gemma advised that the 2025/2026 delivery plan has been refreshed, and the team is awaiting the updated Long Term Workforce Plan which will help shape the necessary activities to address current risks and challenges. Gemma noted that the approach will continue to evolve in collaboration with providers and partners across Shropshire, Telford, and Wrekin.

The Chair thanked Gemma Treanor for the report. The Board asked about sickness rates and their impact on the ICB, particularly in the context of the ongoing system transition. The Board also asked about appraisal rates, noting that these are not currently at a high level. Gemma Treanor advised that sickness rates are part of the risks identified at the beginning of the year, specifically relating to the impact of system changes on staff health and well-being. Gemma highlighted that softer intelligence provides a fuller picture of staff experience. Gemma also reassured the Board that appraisal rates will be addressed through the PCI Committee and confirmed that the feedback will be taken on board and reflected in future discussions.

The Board acknowledged the continued professionalism of staff, despite the ongoing challenges and changes. The Board echoed the value of these surveys and emphasised the importance of maintaining regular communication with staff. The Board also noted that the results reflect a positive culture of speaking up across the system.

The Board accepted and acknowledged the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB People, Culture and Inclusion Committee AAA Chairs Report – July

- Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Shokat Lal emphasised the importance of establishment control and maintaining a balance between workforce establishment, finance, and performance, as well as how this is being managed across the system.
- Shokat Lal also highlighted the Annual Report, acknowledging the contributions of Chief People Officers across the system, reinforcing the need to sustain this work.
- Shokat Lal stressed the importance of staff well-being and communication, particularly in managing uncertainty and ongoing change.

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

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

- Mike Lawton, Non-Executive Chair of Strategic Commissioning and Transformation Committee, presented the report.
- Mike Lawton shared thanks to Elizabeth Disney for growing the credibility of the Strategic Commissioning and Transformation Committee.
- Mike Lawton acknowledged the local authority for achieving their CQC ratings of 'good'.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

- Mike Lawton highlighted cost pressures and the demand in social care, stating that there is an agreed approach between the local authority and ICB to manage the funding and eligible aftercare under 117.
- Mike Lawton noted the Staffordshire County Council recommissioning of living care services, along with Stoke-on-Trent County Council promoting the integration of health and care services.
- Mike Lawton advised that the ICS Green Plan has been assured.

The Board commented that the establishment of a robust engine room for commissioning and transformation provides a solid foundation to collectively resolve issues that require commissioning solutions.

The Chair thanked Mike Lawton 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 highlighted the counter fraud narrative, noting that additional support will be provided to primary care going forward.
- Julie Houlder advised that guidance on the new corporate offence of failure to prevent fraud is due to be produced, and internal auditors will be providing support, including training.

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 advised that there were no issues requiring escalation in relation to this report.

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

Date and time of next meeting in public: 18 September 2025 at 1pm held in public, in person at North Staffordshire Combined Healthcare NHS Trust Boardroom at Lawton House, Stoke-on-Trent, ST4 8HH.

Enclosure No: 5

Chairs Report – September 2025

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

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 a visit to Stoke Talking Therapies Team

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	05.09.25

Chair's report September 2025

People

In July I was delighted to be invited to the Stoke Talking Therapies Team to visit them and find out more about their work. It was a pleasure to meet Stephanie Woodall, the Clinical Lead and her team who had kindly put together a presentation covering all the aspects of the services offered by Talking Therapies. I was interested to learn about not on the wide range of interventions offered but the different ways in which people could access services, online, face to face, telephone, walk in, self and professional referral are all available. The service is not 24/7 but opens until 8.00 pm and offers Saturday mornings too.

I met a dedicated and enthusiastic team that delivers an impressively fast response time to those in need of their services which range from therapy pathways of every kind through to support with returning to or maintaining work through the Employment Advisor Service. The Employment Advisor Service works with local employers to encourage the creation of inclusive work environments for those living with or recovering from the wide range of conditions the team supports.

What came through strongly was great teamwork and a shared passion for helping others. It was great to spend some time with them. Thanks to them for sparing the time to give me an insight into one of our frontline services.



Chair

Enclosure No: 6

Board Assurance Framework Qtr. 1 Report

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☐	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☒		

Presented by:	Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary
Prepared by:	Jayne Mottram, Risk and Assurance Manager
Executive Lead:	Dr Buki Adeyemo, Chief Executive Officer

Aligned to Board Assurance Framework Risk	This report details progress against all risks identified within the Board Assurance Framework.
Approval / Review:	BAF risks are approved by the relevant Committees and Trust Board.
Strategic Priorities:	Prevention – 0 Risks Access – Risks 2,3,4 Growth – Risks 1,5,6
Key Enablers:	The Trust key enablers are aligned to individual BAF risks.
Sustainability:	Share learning and best practice
Resource Implications:	Yes A number of mitigations/actions identified within the Board Assurance Framework (BAF) risks will require funding/ have resource implications. These are detailed in narrative sections of each risk within the BAF.
Funding Source:	See above.
Diversity & Inclusion Implications	There is no direct impact on the protected characteristics as part of the completion of this report.
ICS Alignment / Implications:	The Trust continues to support the development of a system BAF through its membership of the ICS Governance and Risk meeting.
Recommendation / Required Action	The paper is the Board Assurance Framework (BAF) Qtr. 1 update for the Trust Board for approval.

Executive Summary

Risk 1 - 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.

Reporting through to Finance & Resource Committee.

Chief Officer Lead - Chief Strategy Officer.

BAF updated in Qtr. 1 and approved by CSO.

Residual Score 16, proposed a score decrease at the Risk Review Group on the 8th July to a revised residual score of 12, reducing the likelihood from 4 (*Likely*) to 3 (*Possible*).

This was not approved, rationale given is that the detail in the document may not align to the 10 Year NHS Plan due to the Plan was only just published the week prior to the Risk Review Group.

Risk 2 - There is a risk that the Trust fails to deliver timely, safe and effective care for people who use our services, due to increasing demand for our services, increasing needs of people who use our services and a failure to provide evidence interventions which support recovery. This is likely to result in patient harm and / or worsening health outcomes for the most vulnerable people in our communities and result in regulatory action being taken against the Trust.

Reporting through to Quality Committee.

Chief Officer Lead – Chief Medical Officer and Chief Nursing Officer.

Residual score 15.

BAF Updated in Qtr. 1 resulting in no impact on residual score change.

Deputy Director of Nursing will update the Assurance Table in Qtr. 2.

Risk 3 - 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.

Reporting through to People, Culture & Development Committee.

Chief Officer Lead – Chief People Officer.

Residual score 16.

BAF Updated in Qtr. 1 and approved by CPO resulting in no impact on residual score change.

Risk 4 - 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.

Reporting through to Quality Committee.

Chief Officer Lead – Chief Operating Officer.

Residual score 16.

BAF Updated in Qtr. 1 and approved by COO resulting in no impact on residual score change.

Risk 5 - 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. As a consequence, 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.

Reporting through to Finance & Resource Committee.

Chief Officer Lead – Chief Finance Officer.

BAF updated in Qtr. 1 and approved by CFO.

Residual Score 15, proposing a score decrease at Finance & Resource Committee on the 7th August to a revised residual score of 10, reducing the likelihood from 3 (*Possible*) to 2 (*Unlikely*).

This was approved at the Risk Review Group on the 8.7.25 and Finance and Resource Committee.

Rationale - Based on a review of qtr. 1 financial position performing better than plan taking into account the pay underspend and slippage on developments.

Risk 6 - There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.

Reporting through to Finance & Resource Committee.

Chief Officer Lead – Chief Strategy Officer.

Residual score 16.

BAF Updated in Qtr. 1 and approved by CSO resulting in no impact on residual score change.

Summary of other BAF related activities during Qtr. 1.

- Risk titles have all been approved by the Executive team.
- All mitigations actions have been updated and refreshed.
- A quarterly progress RAG rating column has been added to track progress against each mitigation action, to help inform whether the actions are on track to be delivered by the target date.
- Removed the linked Trust and Operational Risks Table from the BAF document as this is currently in further development.
- The Qtr. 1 report has now been approved by all Committees of the Board.

Next Steps

- There is a need for a Risk Appetite Framework to be implemented across the organisation following internal audit recommendations and the Trusts own Well Led Action Plan. MIAA, the Trust's internal auditors are supporting the Trust in the development of same and following a Board Development session delivered by MIAA on the 14th August the Qtr. 2 BAF report will now include risk appetite statements.

VERSION CONTROL:

Version	Report to	Date Reported
1	Risk Review Group	8.7.25
2	Public Trust Board	11.9.25



PREVENTION



ACCESS



GROWTH



NHS
North Staffordshire
Combined Healthcare
NHS Trust

Board Assurance Framework 2025/26

Welcome to the Board Assurance Framework for North Staffordshire Combined Healthcare NHS Trust.

The Trust Board is responsible for ensuring that North Staffordshire Combined Healthcare NHS Trust consistently follows the principles of good governance applicable to NHS organisations. The Board does this through the development of systems and processes for financial and organisational control, clinical and information governance and risk management.

Our Board Assurance Framework identifies the procedures for risk management against our new key strategic objectives, encompassing the management of all types of risk to which the Trust may be exposed, our controls and the assurances we have in place. This includes the effective integration and management of clinical and non-clinical risk.

Those key risks, mapped against our current new three strategic priorities are set out in the following pages.



Strategic Priorities	1. PREVENTION - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce. 2. 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 them. 3. GROWTH - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care.

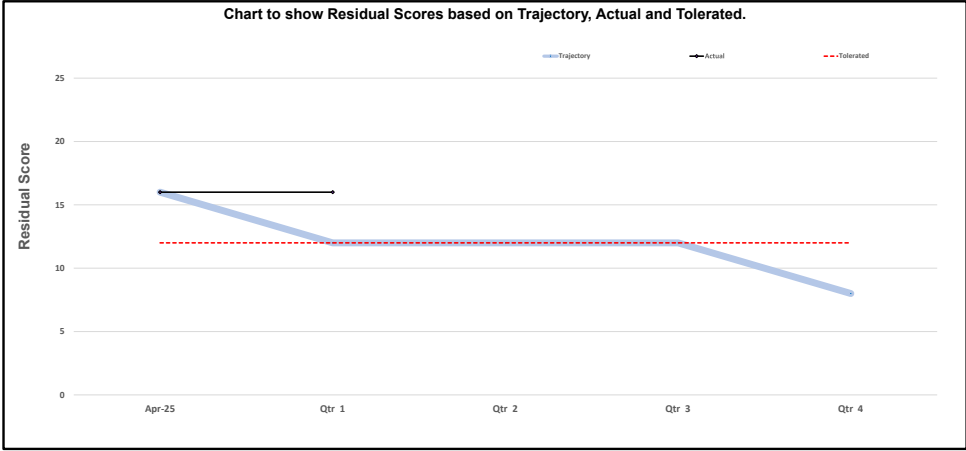
BOARD ASSURANCE FRAMEWORK 2025-2026

Risk No.	Strategic Priority	Themes	Risk Description	Executive Lead	Gross Score	Residual Risk Score Qtr. 1	Risk Movement from Previous Qtr.	Target Score	Target Achievement Date	Lead Committee
1	Growth	Strategic Direction & Partnerships	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.	Chief Strategy Officer	16	16	↔	8	31st March 2026	Finance & Resource
2	Access	Quality & Safety	There is a risk that the Trust fails to deliver timely, safe and effective care for people who use our services, due to increasing demand for our services, increasing needs of people who use our services and a failure to provide evidence interventions which support recovery. This is likely to result in patient harm and / or worsening health outcomes for the most vulnerable people in our communities and result in regulatory action being taken against the Trust.	Chief Nursing Officer & Chief Medical Officer	15	15	↔	10	31st March 2026	Quality
3	Access	People	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.	Chief People Officer	16	16	↔	12	31st March 2026	People, Culture and Development
4	Access	Performance	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.	Chief Operating Officer	16	16	↔	12	31st March 2026	Quality
5	Growth	Financial Sustainability	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. As a consequence, 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.	Chief Finance Officer	15	10	↓	5	31st March 2026	Finance & Resource
6	Growth	Digital	There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.	Chief Strategy Officer	16	16	↔	12	31st March 2026	Finance & Resource

BAF Risk 1	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.				
Risk Appetite Statement	TBC				
Risk Context	The NHS 10 Year Plan is expected to be published in July. The plan is likely to require significant change and transformation to deliver the vision for integrated neighbourhood health services. Effective collaboration across system partners will be crucial to deliver this however the plan is being released at a time of significant change for both individual organisations and systems, as a consequence of restructuring within NHS England and Integrated Care Boards, ambitious efficiency targets for NHS providers and local government devolution. The Trust must ensure it continues to operate effectively within the partnership arena to identify and maximise opportunities to deliver services and outstanding care to the local population in a way that improves outcomes.				
SPAR	Accessible		Risk Appetite	TBC	
Executive Lead	Chief Strategy Officer		Strategic Priority	Growth	
Committee	Finance & Resource Committee				

Residual Risk Score					
Gross Score	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16				Impact 4 x Likelihood 2 = 8
Arrows Indicate Score Movement	↔				31st March 2026

Quarter	Rationale for Score Change/ Score Remaining the Same.
Qtr. 1	The Trust Partnership Plan has been developed in draft and shared with Trust Board for discussions. Several actions within the plan have already commenced delivery including scoping activity to determine opportunities within the Primary Care Directorate to lead on pilots and initiatives that support the delivery of the Neighbourhood Health agenda. Proposing score change from 12 to 16 reducing the likelihood from 4 (Likely) to 3 (Possible). 8.7.25 - Risk Review Group did not approve the score reduction, rationale - the detail may not be aligned to the 10 Year NHS Plan.
Qtr. 2	
Qtr. 3	
Qtr. 4	



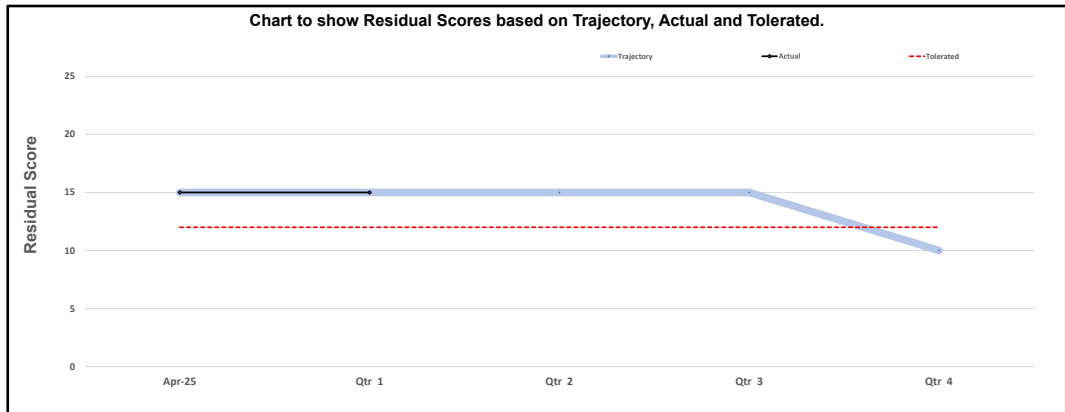
Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps in Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 1 Analyse, understand and agree immediate actions required to commence delivery against the requirements of the NHS 10 Year Plan.	31st October 2025	On Target for Delivery	Qtr.1 Whilst awaiting publication of the 10 Year Plan, existing intelligence on the content of the plan and other information shared to date by NHSE e.g. Neighbourhood Health Guidance is being used to inform our approach and activities being undertaken in readiness including conversations within the Primary Care Directorate. The 10 Year Plan has been scheduled as part of the Senior Leadership Team Business (SLTB) and Senior Team Leadership Development (SLTD) Cycle of Business to support dissemination and engagement.	Qtr.1 The 10 Year Plan is unpublished so current planning is based on information shared to date rather than a complete picture. There is currently a fragmented approach to planning for and responding to the Neighbourhood Health agenda across the Integrated Care System, posing a risk of duplication and/or failure to deploy resource effectively	Qtr. 1 Engagement and contribution across relevant system meetings to ensure the Trust is aware of and engaged in all relevant activities, also providing constructive criticism and challenge where required.
Action 2 To play an active role in the Provider Collaborative and delivery of 25/26 priorities which include a focus on piloting and delivering approaches that support a reduction in winter bed pressures at UHNM.	31st March 2026	On Target for Delivery	Qtr.1 Attendance and active participation in a Provider Collaborative workshop in May 25 with a follow-up clinically-led workshop scheduled for July 25. Early discussions around the potential to deliver a pilot through the Primary Care Directorate with options currently being developed including cross-directorate involvement to also consider role of secondary care.	Qtr.1 Potential challenge in terms of pace at a system level due to cancellation of Provider Collaborative Board meetings and a lack of clarity around leadership and specific deliverables.	Qtr. 1 Focused cross-directorate activity within the Trust to develop pilot opportunities to be discussed and progressed following the Provider Collaborative workshop in July. Focus on what the Trust can deliver within its sphere of control and influence and seeking to be proactive in developing opportunities for new partnership opportunities e.g. with local Primary Care Networks (PCNs).
Action 3 To implement the Trust Partnership Plan 2025-2028 and specifically deliver against the embedded action plan.	31st March 2026	On Target for Delivery	Qtr.1 Partnership Plan developed in draft and shared with Board for discussion and feedback. Final draft scheduled for discussion at SLTD in September following which any amendments will be made prior to being approved at Finance and Resource Committee in October 25. Several of the actions within the plan align to the mitigation actions for this (Board Assurance Framework) BAF risk and therefore delivery has already commenced.	Qtr.1 Partnership Plan still to be fully mobilised and implemented. Capacity to ensure sufficient levels of stakeholder management and effective communication in a rapidly changing partnership landscape may present a challenge along with willingness of partners to engage.	Qtr. 1 Timeline in place for full sign-off and implementation of Partnership Plan from October 25 with activity continuing prior to this as part of business as usual.

Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
Action 1	10 Year Plan scheduled as part of SLT(Business & Development) Cycle of Business.	Level 1	Six Monthly	N/A it is expected that the 10 Year Plan will be published during Q2			
Action 2	Provider Collaborative and Neighbourhood Health agenda reporting via ICB Strategic Commissioning and Transformation Committee.	Level 2/3	Monthly	Yes updates delivered on Provider Collaborative workshop held in May			
Action 3	Quarterly reporting on progress against the Partnership Plan via Finance and Resource Committee	Level 2	Quarterly	Yes -draft partnership plan discussed at Board in advance of formal reporting through F&R	N/A it has been agreed that reporting will progress through F&R following discussion at SLTD in September		

BAF Risk 2	There is a risk that the Trust fails to deliver timely, safe and effective care for people who use our services, due to increasing demand for our services, increasing needs of people who use our services and a failure to provide evidence interventions which support recovery. This is likely to result in patient harm and / or worsening health outcomes for the most vulnerable people in our communities and result in regulatory action being taken against the Trust.				
Risk Appetite Statement	TBC				
Risk Context	Health Inequalities data demonstrates that people from more deprived communities and those with protective characteristics find this more challenging to access services and or have poorer experiences of care when they do access the care.				
SPAR	Accessible		Risk Appetite	TBC	
Executive Lead	Chief Medical Officer and Nursing Officer		Strategic Priority	Access	
Committee	Quality Committee				

Residual Risk Score					
Gross Score	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Impact 5 x Likelihood 3 = 15	Impact 5 x Likelihood 3 = 15				Impact 5 x Likelihood 2 = 10
Arrows Indicate Score Movement	↔				31st March 2026

Quarter	Rationale for Score Change/ Score Remaining the Same.
Qtr. 1	There is a need for wider engagement with communities and stakeholders to understand our local key areas of focus. PCREF programme of work is in its infancy currently.
Qtr. 2	
Qtr. 3	
Qtr. 4	



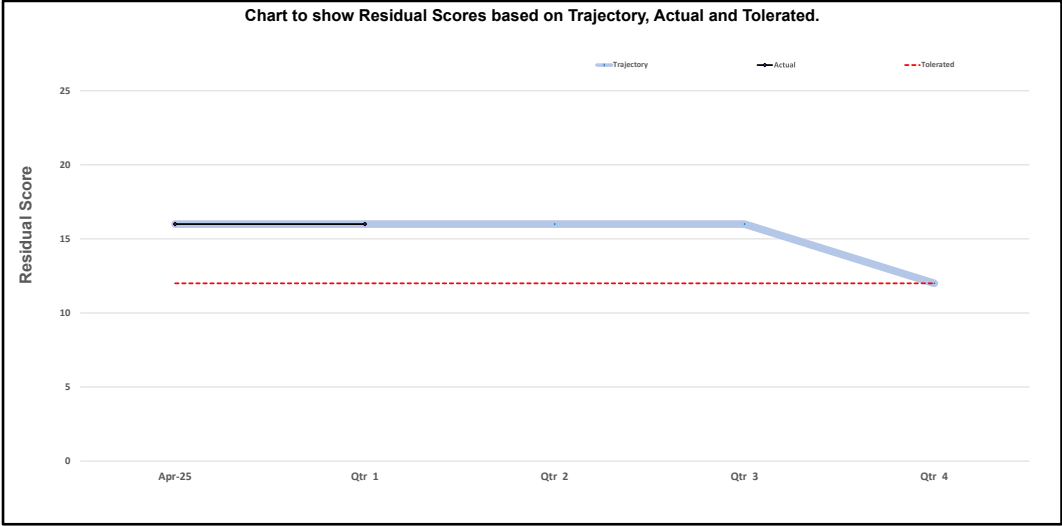
Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps in Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 1 The Trust will launch a 5 year Quality Plan in quarter 2. The plan will relay our intentions to ensure we are delivering inclusive care and treatment throughout our diverse communities.	31st January 2026	On Target for Delivery	Qtr.1 Consulted with staff and stakeholders and patient and carers representatives to co produce our Quality priorities.	Qtr.1 None to date.	Qtr. 1. None to date.
Action 2 To further embed Quality Assurance Framework with a key focus on more core services achieving CQC outstanding rating at the next Trust CQC well led inspection.	31st March 2026	On Target for Delivery	Qtr.1 Unannounced MH CQC visits to 2 inpatient wards with positive reports and unannounced CQC inspection to Crisis Care, awaiting draft report but no immediate patient safety identified.	Qtr.1	Qtr. 1.
Action 3 For Health Inequalities data to be visible within the Trusts Governance structure in a manner which ensures the data is driving service level improvements around equitable access, experience and outcomes for people requiring our Trusts services and ensures the workforce are adequately equipped to deliver these improvements.	31st March 2026	On Target for Delivery	Qtr.1 PCREF Steering group Implemented. Refreshed EDI Plan received by SLT.	Qtr.1 Need to agree how the Health Inequalities data is going to be embedded within the Trusts Governance structure and accessible at service line level.	Qtr. 1. PCREF Steering group Term of Reference to be agreed at next meeting (27th June).

Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
Action 1	Quality Plan will be implemented	Level 2	Quarterly				
Action 2	Retain Overall CQC outstanding rating	Level 3	Quarterly				
Action 3	Health inequalities data is Integral to Trusts Performance reporting.	Level 2	Quarterly				

BAF Risk 3	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.				
Risk Appetite Statement	TBC				
Risk Context	There is a national workforce shortage for hard to fill roles in key specialist areas from a representative population as a result of the impact of fewer people entering formal training and an increase in retirement numbers due to the workforce population ageing. Workforce supply is also affected by the NHS struggling to compete in a competitive employment market. The impact of sustained operational pressures is also increasing burnout of the workforce and resulting in difficulty in accommodating release for training/development to support people aspirations which is exacerbated by the scale of the financial challenges we are facing. This has a negative effect on staff morale and our ability to deliver high quality care.				
SPAR	Safe		Risk Appetite	TBC	
Executive Lead	Chief People Officer		Strategic Priority	Access	
Committee	People, Culture & Development Committee				

	Residual Risk Score				
Gross Score	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16				Impact 4 x Likelihood 3 = 12
Arrows Indicate Score Movement	↔				31st March 2026

Quarter	Rationale for Score Change/ Score Remaining the Same.
Qtr. 1	The score is remaining the same on the basis that there are a number of work programmes in development or early stages of implementation which will not have been fully delivered by the time of the review period. However plans are in place with sufficient confidence about the likelihood of these delivering in line with expectations.
Qtr. 2	
Qtr. 3	
Qtr. 4	

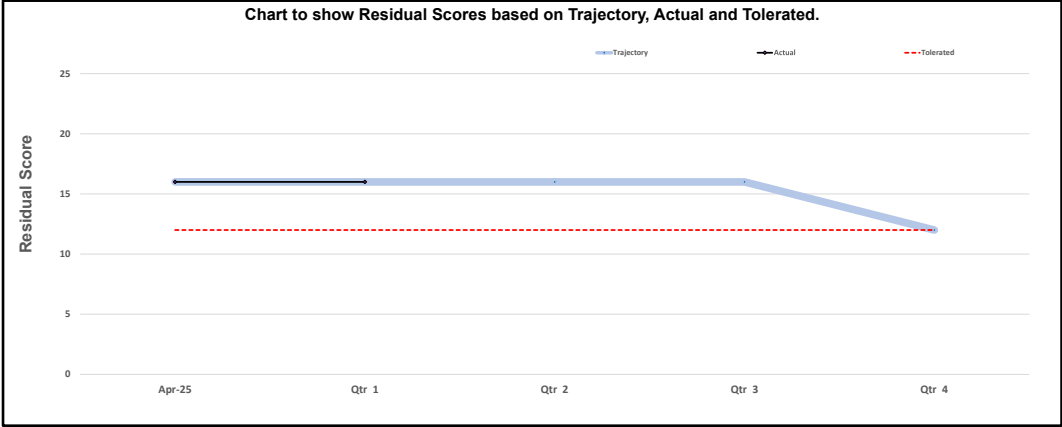


Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps in Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 1 Targeting substantive recruitment opportunities to our own trainees and bank workers to support internal talent management and progression - measured by placement feedback, succession plans and where possible recorded numbers of staff progressing to permanent roles. Reviewing our advertising campaigns and utilising a variety of different events and other mediums to engage with potential applicants.	31st March 2026	On Target for Delivery	Qtr.1 Offered bank staff and trainees permanent working opportunities as they arise.	Qtr.1 Challenges with some bank staff preferring the flexibility that temporary work offers in relation to working hours. Reduced pastoral and professional support due to the impact of operational pressures which means some workers who may not possess all the experience necessary are being discounted for roles.	Qtr. 1. Encourage flexibility on shift patterns for bank staff transferring to our substantive employment by reviewing working hours expectations and full employment benefits. review support structure in place for practice and professional development to include exposure/buddying opportunities.
Action 2 Focus on clinical supervision to support practice, health and wellbeing and professional development. Evidenced by LMS records and validated by the staff survey results. Review of skill mix to ensure safer staffing levels and support health and wellbeing. Monitored through safer staffing report, the stress risk assessment process and a reduction in reported sickness absence for Stress, Anxiety and Depression.	31st March 2026	On Target for Delivery	Qtr.1 Emphasised the importance of clinical supervision on screensavers and in executive exchange. Regular review and reporting on numbers/compliance in performance oversight meetings.	Qtr.1 Impact of sickness absence on effectiveness of clinical supervision and capacity to support reviews. Operational pressures also impacting on documentation to LMS.	Qtr. 1. Performance Improvement Plans in place for reducing sickness absence and prioritisation given to bank back fill for key risk areas.
Action 3 Development of a widening participation and access approach that is tailored to the needs of our local population, reduces barriers to entry and improving workforce representation.	31st March 2026	On Target for Delivery	Qtr.1 Draft widening participation and access strategy has been produced. The approach is building on existing strengths, previous successes and relationships with an aligned programme of activity identified within it.	Qtr.1 Further analysis is required to ensure the focus and resources are targeted appropriately with clear outcome measures.	Qtr. 1. A deeper review of local demographic needs and partnership opportunities with other organisations in the system and outside of it particularly in the third sector are being actively reviewed.

Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
Action 1	Recruitment metrics and progress on resourcing strategy regularly presented to PCDC on a bi-monthly basis.	Level 2	Monthly	Delivered			
Action 2	Performance reviews conducted by the executive team with directorate leadership teams focusing on clinical supervision on a monthly basis. This is also reflected in the IQPR which is reviewed by Board on a monthly basis and shared with PCDC regularly.	Level 2	Monthly	Delivered			
Action 3	The widening participation and access strategy will be reviewed by PCDC and the SLT. The aligned outcome measures will also be incorporated into the reporting for SEAL and reviewed by PCDC	Level 2	Monthly	Delivered			

BAF Risk 4	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.				
Risk Appetite Statement	TBC				
Risk Context	The level of transformation required across operational services is ambitious when noting the requirement to meet the financial target of £7.36M during 25/26. The programmes of work are being developed to ensure alignment with strategic priorities, consideration of interdependencies, and effective risk management. This needs to be balanced with the Trust's target to deliver sustainable efficiencies while maintaining quality of care.				
SPAR	Safe		Risk Appetite	TBC	
Executive Lead	Chief Operating Officer		Strategic Priority	Access	
Committee	Quality Committee				

	Residual Risk Score				
Gross Score	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16				Impact 4 x Likelihood 3 = 12
Arrows Indicate Score Movement	↔				31st March 2026
Quarter	Rationale for Score Change/ Score Remaining the Same.				
Qtr. 1	No change to residual score - actions underway. Forward look - if all PIDs completed as per deadline then potential to reduce to 12 in Q2.				
Qtr. 2					
Qtr. 3					
Qtr. 4					



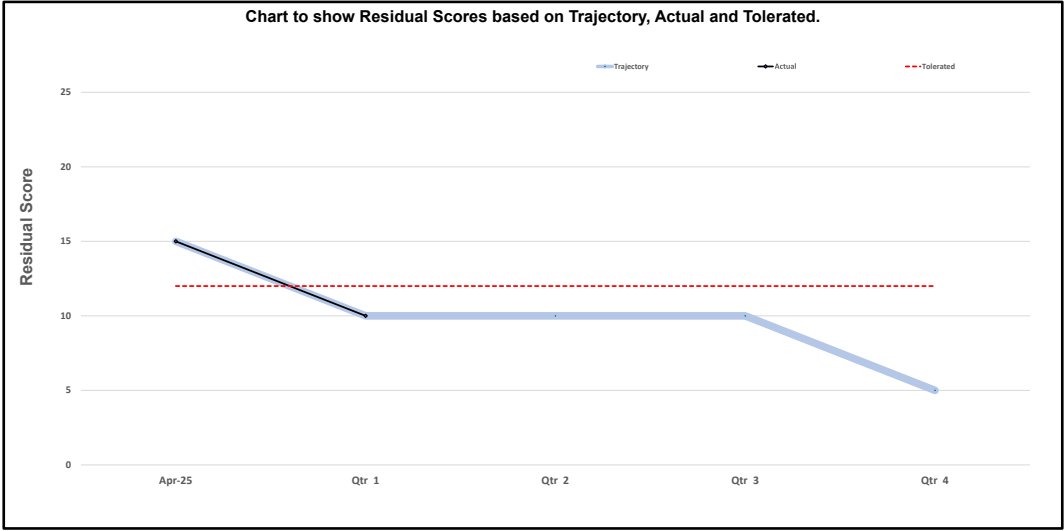
Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps in Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 1 Achievement of service (clinical and corporate) and cross cutting CIP (Cost Improvement Programme) targets with recurrent savings delivery in year.	31st March 2026	On Target for Delivery	Qtr.1 Weekly CIP meetings to review/scrutinise progress, development of PIDS with a target of 23/6/25 for completion. CE2m of schemes fully implemented and transacted within the ledger. Reporting no unidentified schemes to ICB via weekly monitoring.	Qtr.1 Opportunities for transformation in some areas noting the capital constraints. Challenge between available operational capacity to deliver clinical pressures vs transformational requirements. Awaiting feedback from NHSE on Corporate Savings Plan.	Qtr. 1. Weekly CIP meetings to review/scrutinise progress, support from TMO and subject experts to aid delivery. Additional work being undertaken within Specialist in relation to CIP. CIP process reviewed to ensure continued suitability for use.
Action 2 Regular Quality Impact Monitoring (minimum quarterly) to ensure there is no negative impact on service quality as a result of cost improvement schemes.	31st March 2026	On Target for Delivery	Qtr.1 QIA (Quality Impact Assessment) process in situ and reviewed in weekly CIP meeting. Process reviewed by DCNO to ensure quality impacts are identified and mitigations in place if required.	Qtr.1 Further work required to support ongoing review within BAU once transaction completed.	Qtr. 1. DCNO exploring where any potential impact is already being monitored by another route (e.g. Trust Performance process) how this can be utilised to reduce duplication.
Action 3 Maintaining/improving key performance indicators, and as required undertaking specific scrutiny on areas of transformation where these are of concern / significant interest.	31st March 2026	On Target for Delivery	Qtr.1 No specific issues identified within Performance data relating to any areas where transformation has occurred, nor any initial concerns raised through QIA monitoring.	Qtr.1 Some schemes have not been implemented or are early in implementation, this will require further monitoring as the year progresses.	Qtr. 1. Continue to monitor throughout future quarters.

Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
Action 1	CIP Oversight Group: Weekly oversight group to review current proposals/PIDS, monthly paper to F&R Committee. Weekly enhanced reporting by all ICB partners to ICB and NHS England.	Level 2 & Level 3	Monthly	Delivered			
Action 2	QIA Process: this will support initial oversight/scrutiny of any transformational plans. Work underway to support BAU review post implementation. Monthly paper to QC	Level 1	Monthly	Complete - no concerns created in relation to CIP			
Action 3	Performance monitoring against key performance indicators/operational priorities	Level 3	Monthly	Complete - no concerns created in relation to CIP			

BAF Risk 5	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. As a consequence, 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.				
Risk Appetite Statement	TBC				
Risk Context	Achieving financial balance is our statutory financial duty, for which the Trust has a very strong track record. 2025/26 is known to be a challenging financial year with less resource being available than required by the NHS. NSCHT is as well placed as other Trusts to deal with these challenges having planned for a challenging year and has set a recurrent CIP of 3.2 % (excluding TCP & P86) and a non-recurrent CIP of 1% to achieve financial balance.				
SPAR	Safe		Risk Appetite	TBC	
Executive Lead	Chief Finance Officer		Strategic Priority	Growth	
Committee	Finance & Resource Committee				

	Residual Risk Score				
Gross Score	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Impact 5 x Likelihood 3 = 15	Impact 5 x Likelihood 2 = 10				Impact 5 x Likelihood 1 = 5
Arrows Indicate Score Movement	↓				31st March 2026

Quarter	Rationale for Score Change/ Score Remaining the Same.
Qtr. 1	Based on a review of quarter 1 financial position performing better than plan taking into account the pay underspend and slippage on developments. 8.7.25 - Risk Review Group approved the score reduction. 7.8.258 - Finance & Resource Committee approved the score reduction.
Qtr. 2	
Qtr. 3	
Qtr. 4	



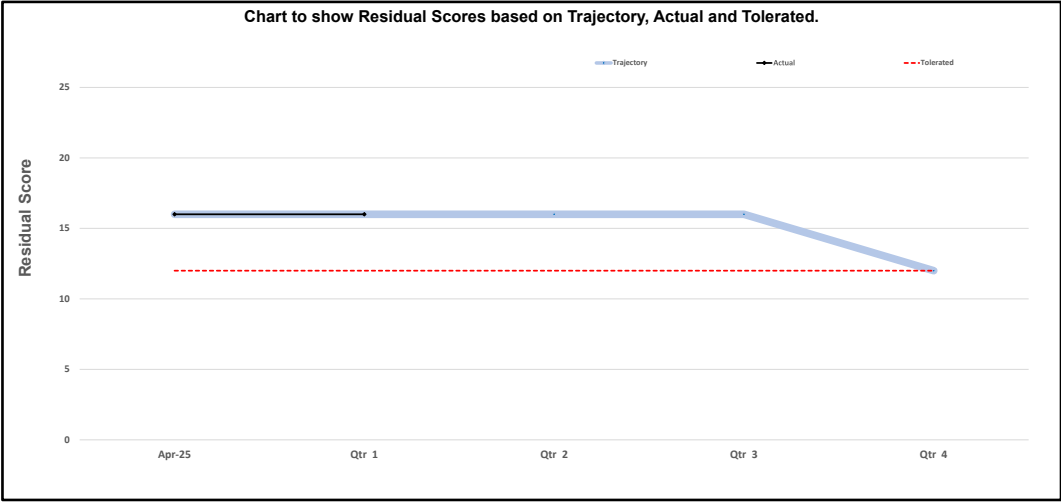
Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps In Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 1 Delivery of CIP - SMART action will be developed in Qtr. 2.	31st March 2026				
Action 2 Weekly Financial Control and Recovery Group meetings are held to approve recruitment and establishment changes, as well as to review and oversee bank and agency usage in areas of concern. Additionally, monthly monitoring of the finance position and bank and agency usage is conducted to support effective planning and targeting.	31st March 2026	On Target for Delivery	Qtr.1 At M2 the Trust was £39k better than plan and is expected to be better than plan by the end of Q1.	Qtr.1 Agency is above target by £66k and bank is above target by £5k.	Qtr. 1 Initial M2 forecasts have been produced to be confirmed with the Directorates. Follow up review with FCRG to take place in M3 with action plans required if forecast to be away from plan.
Action 3 Continue to work with System partners to identify capital funding allocations for the remainder of Project Chrysalis. Achieve formal confirmation of all capital funding for 25/26 by Q2. Work with PFI partners to confirm and challenge revenue consequences of Project Chrysalis by Q2. .	31st December 2025	Risk to Delivery, Plan in Place	Qtr.1 Capital expenditure in line with plan. Project plan on schedule to complete in December 2025.	Qtr.1 All System capital allocations have not been confirmed which leave uncertainty around the funding source for Project Chrysalis. Revenue costs for Chrysalis have been provided by the PFI partners. Work is now in progress to confirm and challenge the costs.	Qtr. 1 Gain clarity from System partners in Q2 of the capital allocations and the Trust's share of the System allocation to fund Chrysalis. Confirm the revenue consequences with PFI Partners.
Action 4 Continuation of the Trustwide CIP Oversight Group that includes scheme risk reviews, delivery status and escalation process. All schemes to have PIDS in place (fully developed) by the end of Q1 with month reporting to F&R Committee. All schemes to be implemented by Q3.	31st December 2025	Risk to Delivery, Plan in Place	Qtr.1 Weekly CIP oversight groups and weekly reporting to NHSE taking place with progress being made most weeks. Monthly reporting to F&R Committee commenced.	Qtr.1 Unlikely to have all CIP schemes fully developed by the end of Q1.	Qtr. 1 Recovery actions and mitigations for all 'opportunity' schemes by Q2.

Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
Relates to all above actions.	Monthly review of the financial position with oversight by the senior finance team, including the CFO .	Level 1	Monthly	Delivered			
Relates to all above actions.	Monthly reports to Senior Leadership Team, Finance and Resource Committee and Board.	Level 2	Monthly	Delivered			
Relates to all above actions.	Annual review of financial controls by internal audit in Q3. Annual external audit of accounts in Q1 of the following year	Level 3	Annually	Qtr. 1 - Delivered 24/25. 25/26 - Planned May 26.			

BAF Risk 6	There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.				
Risk Appetite Statement	TBC				
Risk Context	This risk is particularly significant in light of the 2025/26 NHS England priorities and operational planning guidance, which call for improved access, increased productivity, and system reform within existing financial constraints. The guidance highlights the critical role of digital maturity, data-driven decision-making, and cyber resilience in enabling integrated care and operational efficiency. Failure to address these digital infrastructure challenges may limit the Trust's ability to meet national expectations, innovate effectively, and maintain regulatory and reputational standing. Given the Trust's integral role within the wider Integrated Care System (ICS), mitigating this risk is essential not only for local service delivery but also for supporting system-wide digital ambitions. Due to the broad and complex nature of this risk, a multi-year approach will be required, underpinned by the phased delivery of the Trust's Digital Plan. It is also recognised that several influencing factors lie beyond the Trust's direct control, including national, regional, and system-level developments.				
SPAR	Safe		Risk Appetite	TBC	
Executive Lead	Chief Strategy Officer		Strategic Priority	Growth	
Committee	Finance & Resource Committee				

	Residual Risk Score				
Gross Score	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Target Score / Achievement Date
Impact 4 x Likelihood 4 = 16	Impact 4 x Likelihood 4 = 16				Impact 4 x Likelihood 3 = 12
Arrows Indicate Score Movement	↔				31st March 2026

Quarter	Rationale for Score Change/ Score Remaining the Same.
Qtr. 1	Initial actions initiated and actions will start to be completed in later quarters.
Qtr. 2	
Qtr. 3	
Qtr. 4	



Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps In Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 1 To address outdated digital infrastructure and low adoption of digital tools, the Trust will launch a digital transformation programme focused on upgrading legacy Electronic Patient Records (EPR) systems with modern, interoperable platforms and investing in technologies like virtual consultations and remote monitoring to enhance patient access and efficiency.	31st March 2026	Risk to Delivery, Plan in Place	Qtr.1 During Quarter 1, the Trust advanced the digital transformation agenda through three key initiatives: the development of the Orbis EPR system commenced in partnership with Dedalus; a review of the wellbeing portal, Patient Aide and text messaging reminder services were undertaken as part of the digital cost improvement programme; and clinical leadership capacity was strengthened with the appointment of a Clinical Digital Lead, supporting the Chief Clinical Information Officer to ensure effective clinical engagement and governance.	Qtr.1 While the digital transformation programme continues to progress, several challenges remain that impact delivery assurance. Funding constraints persist, limiting the Trust's ability to scale delivery capacity and accelerate progress across key digital initiatives. There are also ongoing gaps in specialist digital and clinical informatics expertise, which present risks to programme implementation, adoption, and long-term sustainability. Although recruitment of Agents of Change Experts (ACEs) is underway to address some of these gaps, broader clinical engagement remains critical to successful delivery. These issues are further compounded by operational pressures that constrain the availability of internal subject matter experts and frontline staff. To mitigate these risks, there is a clear need for strengthened programme assurance, prioritisation of resources, and targeted investment to support delivery and realise the intended benefits.	Qtr. 1. Given the current funding challenges the opportunity to invest further in digital is limited at this time and the focus needs to be on maintaining current services and looking for opportunities to deliver productivity improvements. To address current delivery and assurance gaps within existing resource constraints, the Trust is reprioritising digital workstreams to focus on high-impact, lower-resource initiatives, investigating opportunities to leverage internal expertise through time-limited secondments and rotational roles to strengthen capacity, and enhancing collaboration with system partners to share tools, knowledge, and best practices, thereby maximising value without additional financial investment.
Action 2 To improve data quality, reporting consistency, and clinical intelligence use, the Trust will implement a data quality and governance programme featuring automated validation tools, real-time analytics dashboards, and a Centralised Data Management Solution to support safe, data-driven care. This will be supported by a revised business intelligence strategy, mandatory training tailored to mental health pathways, increased clinical engagement, and key milestones such as the relaunch of the Business Intelligence (BI) portal, rollout of high-value dashboards, and completion of the Halo extract process.	31st March 2026	On Target for Delivery	Qtr. 1 During Quarter 1, the Business Intelligence (BI) Strategy was presented to SLT with a request to align it to the NHS 10 Year Plan and 25/26 Trust Strategy. It will return to SLT in Quarter 2 as a final document with a 1 year Plan. The Trust has reviewed the content of the BI Portal, validated data and made changes to make the reports more user friendly to increase clinical engagement, with a view to relaunch the Portal in Q2 to empower users and advance self-serve reporting. Development of high value dashboards is progressing: 1. Procedure coding - dashboard has been developed to support the move to new coding procedure on Lorenzo EPR system with training provided to staff to support the change. 2. Inpatient care - reviewed current reporting offer and arranged engagement session with ACUC senior team in July to agree specification of new inpatient dashboard aligned to new operational planning priorities and Trust requirements. 3. Community care planning - 5 dashboards in development with aim to have them finalised by end of Q1. Daily bed report has been updated in June and exploring high frequency reporting in support of the management of crisis services. Engagement with operational directorates commenced with professional support provided to ACUC data lead.	Qtr.1 While the BI Strategy aims have been agreed and automation of operational performance reports is progressing, some challenges remain that impact delivery assurance. Funding constraints persist, limiting the Trust's ability to flow all system data through the data warehouse that would enable the development of powerful reports integrating activity, workforce and quality data. This would support Trust efforts to identify opportunities for efficiency and productivity. There are also ongoing gaps in operational data and informatics expertise, which present risks to BI implementation and utilisation. To mitigate these risks, there is a need for prioritisation of resources, and targeted investment to support delivery and realise the intended benefits of the BI Strategy and Data Warehouse, and to further support operational directorates to develop informatics expertise through the establishment of a network of clinical service data leads/ power users. .	Qtr. 1. To address current delivery and assurance gaps within existing resource constraints, the opportunity to implement the BI Strategy aims is limited, and the focus is on further developing self serve reporting and automation to support efficiency and opportunities to deliver productivity improvements. The Trust is prioritising the delivery of high-impact, lower-resource initiatives to deliver national planning priorities, productivity improvements and supporting operational services with their delivery challenges. This involves enhancing engagement and support with operational directorates to maintain good data quality and high levels of performance. Wider networks are to be created of data lead/ power users to focus on current data quality issues and increase knowledge of reports that can be used for validation. This links with the BI strategy aims of engaging and empowering staff across the Trust. The Trust will continue to enhance collaboration with system partners to share tools, knowledge, and best practices, thereby maximising value without additional financial investment.
Action 3 To strengthen resilience against cyber threats, the Trust will implement an enhanced cybersecurity programme featuring advanced technologies to proactively detect and prevent attacks. This will be supported by staff training, phishing simulations, and improved business continuity and disaster recovery capabilities through upgraded backups and cloud-based recovery solutions.	31st March 2026	On Target for Delivery	Qtr.1 As part of the 2024/2025 Data Security and Protection Toolkit requirements, the Trust has strengthened its cybersecurity posture through the deployment of advanced monitoring and intrusion detection at the network edge via the S&SHS Security Operations Centre, completed a successful phishing simulation and maintained regular cyber and data protection communications, and conducted a disaster recovery test while actively contributing to the Trust's EPRR group to ensure digital resilience is embedded in service continuity planning.	Qtr.1 The Trust continues to face several challenges in fully assuring cybersecurity and digital resilience posture. Key gaps include limited internal resource capacity to sustain and scale security operations, reliance on external support for key functions, and delayed progress in implementing some advanced security tools due to funding constraints. Competing digital priorities and the need to balance operational pressures with ongoing cyber preparedness have further stretched available resources. Additionally, while progress has been made in awareness and training, ensuring consistent engagement and coverage across all staff groups remains a challenge	Qtr. 1. Given the current funding challenges the opportunity to invest further in data protection and cyber security is limited and the focus needs to be on maintaining current services and looking for opportunities to deliver productivity improvements. To address current assurance gaps without requiring additional funding, the Trust will maximise the value of existing cybersecurity tools and contractual services, enhance cross-functional collaboration by leveraging internal resources and appointing local cyber champions to drive awareness and resilience, and embed cyber risk and digital continuity planning into established governance structures to strengthen oversight and assurance within existing operational arrangements.

Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
All Actions	Digital update to Finance and Resource Committee.	Level 2	Quarterly	Delivered			
Action 2	Data Quality Audit - Finance and Resource Committee	Level 3	Quarterly	24/25 Report Delivered.			
Action 3	Data Protection and Security Tool Kit Audit - Finance and Resource Committee	Level 3	Annually	24/25 Report Delivered.			

Appendix Page

RAG Rating Key

RAG Rating Criteria Key	Rating
Complete With Assurance	BLUE
On Target For Delivery	GREEN
Risk To Delivery, Plan In Place	AMBER
Not Deliverable By Target Date	RED

Assurance Level

KEY	
Level 1	Self Assurance
Level 2	Internal Oversight
Level 3	External/Independent

Scoring Matrix

		Likelihood				
		Rare	Unlikely	Possible	Likely	Almost Certain
Impact	Rating	1	2	3	4	5
Negligible/ Insignificant	1	1	2	3	4	5
Minor	2	2	4	6	8	10
Moderate	3	3	6	9	12	15
Major	4	4	8	12	16	20
Catastrophic	5	5	10	15	20	25

Internal Audit Assurances	External Audit Assurances
Level 1 Heatmaps (part of Quality Assurance) Quality Walk Arouns ISM/CSM Self Assessments Team Level audits LEVEL 2 Quality Assurance Visits PIPS Board to Ward visits Corporate Performance Report/Dashboard Internal Performance Reportable Issues Alert Practice Improvement & Lessons Learnt Report Being Open Report (complaints) Comprehensive Safety Report Strategy Implemented Plan Realised Clinical Audit Performance Scrutiny	Level 3 Internal Audit (linked to annual plan) National Patient Satisfaction Surveys (F & F Test) Healthwatch Reports Independent Reviews (e.g. Ombudsman Reports) External Visits/Inspection Reports MHSD Submissions HSJ Awards CQC Inspections External Audit (e.g. Annual Governance Statement / Statement of Financial Control) NHS Benchmarking Club Quality Account INSIGHT NHSI Oversight AQUA NHS Operating Framework (NOF) - Provides externally generated report on the performance of the Trust against 18 Mental Health Metrics Accreditation National Audits CQUINS NHS Oversight Segmentation level Clinical Audit, CQUINS.

Enclosure No: 7

Health and Safety Annual report 2024/25

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	4 September 2025
Discussion	☐	Approval	☐		

Presented by:	Kenny Laing, Chief Nursing Officer
Prepared by:	Adrian Greensill, Health and Safety Advisor
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:	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:	Demonstrate where we are aligning our Strategy to the ICS
Recommendation / Required Action	The Trust are asked to accept the findings of this report as assurance into our health and safety management processes
Executive Summary	The report focuses on the key areas of activity associated with health and safety for our work force. From reporting of incidents as they occur, to violence and aggression faced, training, RIDDOR reportable incidents as well as blood borne virus exposure (BBVE) incidents.

It focuses on the data primarily for the period 2024/25, with some elements of longitudinal reporting to help provide context to a preceding time period to support analysis.

There was only 18 reports that fit into the categories defined as related to health and safety for the period of 2024/25, it is unclear at this stage whether this is an accurate picture as there has been a potential reduced knowledge deficit by managers which is to be addressed by the upcoming reformatted health and safety training for managers and there has been separate training secured for the executive board members to support there knowledge and roles and responsibilities. 2024/25 was the lowest reporting period fin the last 7 years and we need to do further analysis of this to understand this concern.

There has been a reduction in the impact of harm following the incidents of violence and aggression for staff

VERSION CONTROL:

Version	Report to	Date Reported
1	Quality Committee	23/07/25
2	Public Trust Board	01/09/25

1. Introduction

North Staffordshire Combined Healthcare NHS Trust was created under a statute provision, and as such legal accountability for health and safety passed to the board of North Staffordshire Combined Healthcare NHS Trust. The ultimate responsibility for health and safety management throughout North Staffordshire Combined Healthcare NHS Trust is vested in the Board of Directors and Chief Executive Officer (CEO). The board delegates executive lead responsibility of health and safety (including patient safety) to the Executive Director of Nursing & Quality.

2. Purpose

The purpose of this Annual Report is to provide details of the current management arrangements in place for health and safety and to give assurances that the Trust is meeting its statutory requirements for health and safety. The report summarises key areas associated with good practice and successful health and safety management for the period 1st April 2024 – 31st March 2025.

3. Structures

In accordance with the requirements set out in section 2(7) of the Health and Safety at Work Act 1974, the Board of Directors of North Staffordshire Combined Healthcare NHS Trust has established a Health, Safety and Well-being (HSWB) group which is a sub-group reporting to the Quality Committee. The HSWB group thus aligns with the Trust's organisational and governance structures and framework; there is no requirement for this function to report directly into the Trust board.

The Health, Safety and Well-being Group meets quarterly and focuses on significant health and safety issues and seeking wider assurances around health and safety management issues. All actions generated from the group are monitored to ensure timely completion and compliance. Where required issues will be escalated through the governance structures and in line with the Trusts risk management procedures.

4. Competent Advice

The Management of Health and Safety at Work Regulations 1999 requires employers to appoint one or more competent persons to assist in health and safety management. North Staffordshire Combined Healthcare NHS Trust has a designated Health and Safety Advisor post within the Patient Organisational Safety Team. The Health and Safety Advisor is formally designated as North Staffordshire Combined Healthcare NHS Trust "Competent Person".

5. Policy

All organisations employing five or more people must have a written Health and Safety Policy. The policy should cover all aspects of the organisation and be of an appropriate length and relevance to the activities and size of the organisation.

North Staffordshire Combined Healthcare NHS Trust has an approved Health and Safety Policy, which has been produced and revised in accordance with the general requirements of Section 2(3) of the Health & Safety at Work Act 1974. The Policy provides guidance to Directors, Managers, Supervisors and Employees on the arrangements and procedures for managing Health & Safety throughout the Trust. The Policy contains details of roles and responsibilities for the management and planning of Health and Safety throughout the Trust and is supported by a suite of specific policies related to Health and Safety.

6. Reporting

The Ulysses Reporting and Risk Management System is used in the Trust to manage incident reporting, including accident reports, complaints and risk registers.

The incident reporting module is used to report and record adverse events, incidents and near misses. It is also used to report on performance in terms of overall levels of reporting, the quality and accuracy of incident reporting. Staff are required as part of their roles to report all incidents or near misses via the online incident reporting module within Ulysses.

There were 18 incidents reported that were categorised as staff health and safety incidents. These incidents in the majority relate to staff accidents such as slips trips and falls, contact with sharps and collision with objects, however they also include:

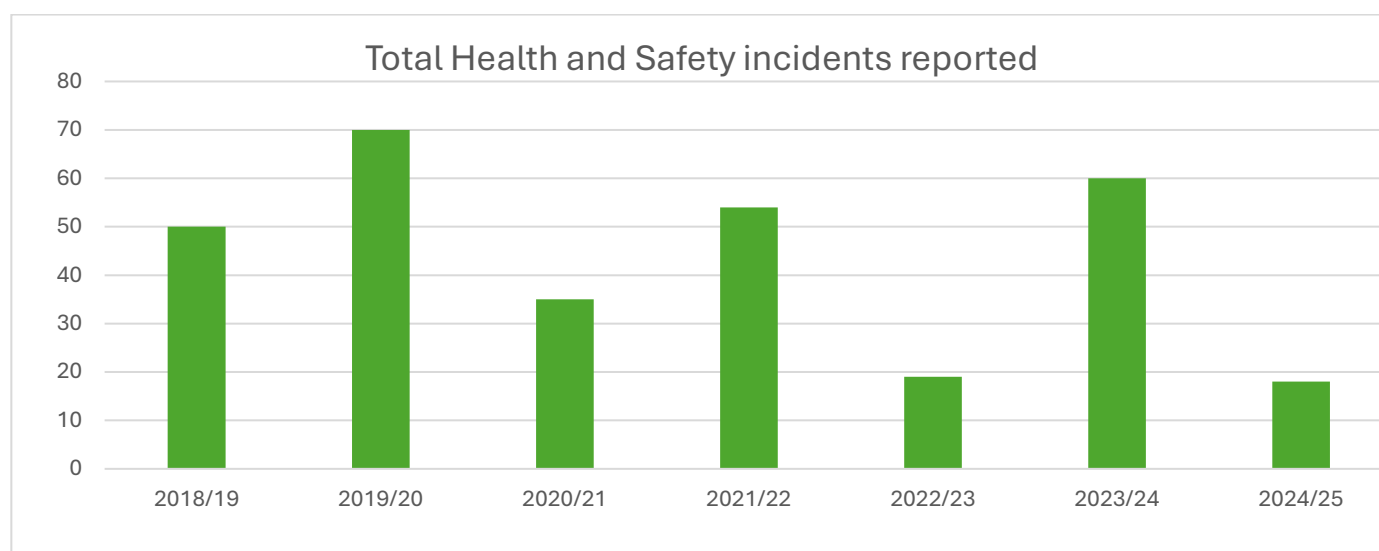
- Burns And Scalds (Staff)
- Exposure to Hazardous substance (Staff)
- Fit Or Faint - Staff
- Manual Handling - Staff Injury
- Restraint Related Injury
- Injured by animal

This figure does not include violent incidents which are covered separately in the report. The 18 reported health and safety incidents is a decrease over previous years. The below table provides year on year totals for health and safety incidents since 2018/19.

Table 1 Health and safety incidents reported annually since 2018

Year	Total Health and Safety incidents reported
2018/19	50
2019/20	70
2020/21	35
2021/22	54
2022/23	19
2023/24	60
2024/25	18

Graph 1 Annual number of incident reported



In 2023/2024 there were 10 incidents reported as Medical emergencies, 10 incidents of collision with a moving object and 12 slips trips and falls contributed to the higher number of accidents reported in 2023/24, compared to the low numbers reported in 2022/23 and 2024/25. This provides an accident rate per 100,000 of approximately 1000, the national average all industries as estimated by the HSE to be 1890 per 100,000 employees. Consideration has

been given as to whether we have an issue with under reporting of Health & Safety staff related incidents. Following a quality assurance project issues were highlighted around the time needed to complete a Ulysses report, lack of appreciation of its importance, lack of effective investigation into incidents. The health and safety managers training which is being rolled out over the next year includes information on effective reporting and investigation of accidents and the importance of accident and near miss reporting.

Table 2 Violence and aggression statistics

Physical assault resulting in an injury 2024-2025

		2024 Qtr2	2024 Qtr3	2024 Qtr4	2025 Qtr1	
Violence/Assault	Physical - Assault (Injury) St On Pt			1		1
	Physical - Assault (Injury) Pt On St	43	48	53	55	199
	Physical - Assault (Injury) Pt On Pt	9	3	8	6	26
	Physical - Assault (Injury) Pt On 3rd Party	1			3	4
	Physical - Assault (Injury) 3rd Party On Pt	3	2		2	7
	Physical - Assault (Injury) 3rd Party On 3rd Party	1				1
Violence/Assault Total		57	53	62	66	238

Table 3 Level of harm for Physical assaults

Level of harm	
1 - No Harm	34
2 - Minor	198
3 - Moderate	6
Grand Total	238

Although listed as assault with injury 34 of these incidents were regarded as causing no harm, i.e. the level of injury was insignificant in the opinion of the reporter. 26 of which were Patient to staff assaults.

Table 4 Physical Assaults resulting in injury last three years

		2022-23	2023-24	2024-25	
Violence/Assault	Physical - Assault (Injury) 3rd Party On 3rd Party	1	4	1	6
	Physical - Assault (Injury) 3rd Party On Pt	6	6	7	19
	Physical - Assault (Injury) 3rd Party On St		2		2
	Physical - Assault (Injury) Pt On 3rd Party	13	19	4	36
	Physical - Assault (Injury) Pt On Pt	37	29	26	92
	Physical - Assault (Injury) Pt On St	285	266	199	750

	Physical - Assault (Injury) St On 3rd Party		1		1
	Physical - Assault (Injury) St On Pt			1	1
Violence/Assault Total		342	327	238	907

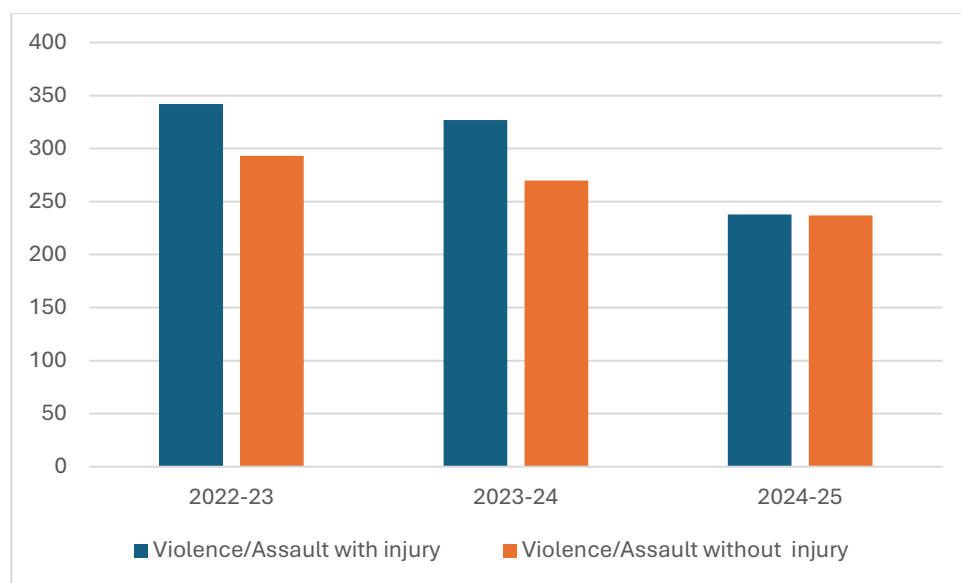
Since 2022/23 there has been a drop in patient to staff assaults resulting in an injury of approximately 32% likewise the has been a drop in patient to patient incidents of 30%

Table 5 Physical Assaults resulting in no injury

Violence/Assault No Injury	2024 Qtr2	2024 Qtr3	2024 Qtr4	2025 Qtr1	
Physical - Assault (No Injury) St On Pt			1		1
Physical - Assault (No Injury) Pt On St	38	53	57	44	192
Physical - Assault (No Injury) Pt On Pt	8	7	11	11	37
Physical - Assault (No Injury) Pt On 3rd Party	2				2
Physical - Assault (No Injury) 3rd Party On St	2				2
Physical - Assault (No Injury) 3rd Party On Pt	1	1			2
Physical - Assault (No Injury) 3rd Party On 3rd Pa		1			1
Violence/Assault Total	51	62	69	55	237

There were an additional 234 incidents reported as attempted assaults, 201 of which were recorded as Patient to staff incidents.

Graph 2 Violence and assault incidents last three years



Over the last three years there has been a consistent fall in both the numbers of incidents resulting in injury and incidents without injury

Table 6 Spitting incidents reported 2024-25

		2024 Qtr2	2024 Qtr3	2024 Qtr4	2025 Qtr1	
Violence/Assault	Spitting - Pt On Staff	2	7	2	6	17
	Spitting - Pt On Pt	1	1			2
	Spitting - Pt On 3rd Party				1	1
Violence/Assault Total		3	8	2	7	20

Table 7 Spitting incidents reported last 3 years

		2022- 23	2023- 24	2024- 25	
Violence/Assault	Spitting - Pt On 3rd Party		1	1	2
	Spitting - Pt On Pt	2	2	2	6
	Spitting - Pt On Staff	43	9	17	69
Violence/Assault Total		45	12	20	77

Table 8 Self-Harm incidents 2024-25

		2024 Qtr2	2024 Qtr3	2024 Qtr4	2025 Qtr1	
Self Harm	Self-Harm - Suffocation		1	1	1	3
	Self-Harm - Self-Induced Vomiting				2	2
	Self-Harm - Overdose	87	90	63	83	323
	Self-Harm - Ligature	139	40	110	51	340
	Self-Harm - Jump From Height	3	2	2		7
	Self-Harm - Ingestion	7	2	8	7	24
	Self-Harm - Ideation	19	23	22	24	88
	Self-Harm - Hitting Self	7	2	9	3	21
	Self-Harm - Head Banging	20	9	28	29	86
	Self-Harm - Drowning		1		1	2
	Self-Harm - Cuts	59	35	52	48	194
	Self-Harm - Burn	2		3	2	7
	Self-Harm - Biting	1	1			2
Self Harm Total		344	206	298	251	1099

Table 9 Actual Impact of self-Harm incidents (ligature)

Level of Harm	
1 - No Harm	312
2 - Minor	26
3 - Moderate	2
Grand Total	340

Table 10 Incidents of Self Harm by location

Location	1 - No Harm	2 - Minor	3 - Moderate	Grand Total
Ashcombe CHMT	1			1
Crisis Resolution Home Treatment Team	1			1
Darwin Centre	198	20		218
IAPT (Newcastle)		1		1
IAPT Stoke (Healthy Minds)	1		1	2
North Stoke CAMHS	2	1		3
Older Persons CMHT - City		1		1
PICU	7			7
Place Of Safety (Crisis Care Centre)	14	1		15
South Stoke CAMHS	1	1		2
Sutherland CMHT			1	1
Ward 2	1			1
Ward 3	82	1		83
Ward 6	3			3
Ward 7	1			1
Grand Total	312	26	2	340

Hate crime

Hate crimes are now recorded as a separate incident type giving a breakdown of the type of hate crime this allows us to understand the level and nature of hate crime that staff are exposed to. Additional support has been sought to provide a method for staff to obtain support following hate crime even if they feel they are unable to report this through the formal process. This service is provided by uniting Staffordshire against Hate who are a charity engaged by Staffordshire police to support victims.

[Uniting Staffordshire Against Hate](#) (USAH) is a dedicated specialist support service for individuals and communities affected by hate crime in Stoke on Trent and Staffordshire. They provide emotional support, practical assistance, and information, advice and guidance to help victims cope and recover after a hate crime or incident

Table 11 Hate crimes reported Via Ulysses 2025

Cause Group	Cause 1	2024 Q2	2024 Q3	2024 Q4	2025 Q1	Grand Total
Hate Crime	Hate Crime - Disability - Pt To Pt				2	2
	Hate Crime - Disability - Pt To St			1		1
	Hate Crime - Race - 3rd Party To 3rd Party				1	1
	Hate Crime - Race - 3rd Party To Pt		1			1
	Hate Crime - Race - 3rd Party To St	1				1
	Hate Crime - Race - Pt To 3rd Party			1	5	6
	Hate Crime - Race - Pt To Pt	2	1	4	7	14
	Hate Crime - Race - Pt To St	9	25	42	37	113

Hate Crime - Sexual Orientation - Pt To St			2		2
Hate Crime - Transgender Identity - Pt To Pt	1				1
Hate Crime - Transgender Identity - Pt To St			2		2
Hate Crime Total	13	27	52	52	144

The increase in numbers of reported Hate crimes within the trust reflects the work done to highlight the new reporting categories since April 2024.

- 92% of all hate crimes reported occurred at the Harplands hospital
- 82% of all hate crimes reported where patient to staff incidents
- 94% of all hate crimes reported related to race (79% directed toward staff)
- 24 of all incidents were identified as causing Harm

Table 12 Verbal Abuse incident 2024-2025

	Incident type	2024 Qtr2	2024 Qtr3	2024 Qtr4	2025 Qtr1	
Violence/Assault	Verbal - Disruptive Behaviour - Pt To Pt	2	2	1		5
	Verbal - Abuse Pt On St	20	23	37	29	109
	Verbal - Abuse Pt On Pt	3	4	6	8	21
	Verbal - Abuse Pt On 3rd Party	3	1	3		7
	Verbal - Abuse 3rd Party On St	5	9	6	2	22
	Verbal - Abuse 3rd Party On Pt	1	1		1	3
	Verbal - Abuse 3rd Party On 3rd Party	0	1	0	0	1
	Racial - Abuse Pt On St	2	3	6	0	11
	Racial - Abuse Pt On Pt	1	0	0	0	1
	Racial - Abuse Pt On 3rd Party	1	0	0	0	1
Violence/Assault Total		38	44	59	40	181

Over the last year there have been 181 incident recorded as verbal abuse

- 12 incidents were reported as racial abuse but not identified as hate crimes.
- 60 % of reported incidents were patient to staff incidents

RIDDOR reportable

The Trust is fully aware of its statutory duties under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). There have been 6 incidents reported relating to accidents during the period covered in this report that met the criteria set out under RIDDOR.

Table 13 RIDDOR reportable incidents

Date	Area	Category	Detail
11/09/2024	Ward 5	Physical assault	Patient came out of his bedroom and assaulted member of staff by kicking and hitting out, as she put her hands up to defend herself the kick made contact with both of her hands. She has sustained a break to one finger on her left hand, and a break and ligament damage to a finger on her right hand. As a result of this incident, she will be absent from work for at least four weeks.
23/09/2024	Ward 5	Physical Assault	A patient was in distress and the injured party tried to intervene and reassure the patient where an injury occurred following assault.
18/11/2024	Ward 5	Lifting and handling	The injured party was assisting a patient to reposition in bed. Whilst lifting the patient the member of staff strained their back

27/11/2024	Ward 5	Physical assault	Patient was agitated and requesting a cigarette the patient had been asked to return to there room so they could be showered to remove medical cream that had been previously applied. when returning to his room the patient unexpectedly assaulted the member of staff and verbally abused staff members
13/01/2025	PICU	7-day Absence	Member of staff received injuries whilst restraining a patient in PICU
13/01/2024	PICU	7-day Absence	Member of staff was injured whilst moving a patient to seclusion

Hope centre

Following several incidents at the hope centre involving staff being concerned about members of the public behaviour in the surrounding area, several actions were undertaken to improve staff safety. Including: -

- Review of risk assessments
- Liaison with Staffordshire police to review the local incidents and identify any lines of investigation
- Review of CCTV coverage for the site
- Removal of staff from site during a period of civil disorder in the local area
- Staffordshire police have additionally planned a wider operation in the area for August 2025 targeting anti social behaviour
- Staff have been encouraged to report all incidents that they observe in the area so that a clear picture of incidents can be established

Fire safety

Fire safety reports will be completed by the fire safety officer in a separate report

Blood Bourn Virus exposure incidents (BBVE)

Table 14 Incidents classed as BBVE 2024-2025

	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
Abrasion	1	2	1	1	5
Spitting	1	2	0	7	10
Cut	6	3	0	1	10
Total	18	21	24	29	92

Work has continued over the last year to improve the response to BBV incidents with The IPC, Health and Safety and the occupational health provider triangulating data to ensure that cases are followed up and that the BBVE protocol is followed following incidents. The cross-referencing process has allowed the team to identify occasions that protocols have not been followed. On these occasions advice and guidance has been provided to managers and team members to ensure that in future protocols are followed.

Training Compliance

All staff working within the trust complete basic level 1 training on Health and Safety. DSE training and manual handling on line.

We have successfully completed a new training module for health and safety training for managers, which comes on the successful procurement of health and safety training for executives.

Below is an overview of trust record of training compliance for 2024/25,

Table 15 Training completion rates

Course	Compliance – Q1 2024/25	Compliance – Q2 2024/25	Compliance – Q3 2024/25	Compliance – Q4 2024/25	Annual Variation		
					→	↗	↘
CBRNE	100%	100%	100%	100%	→		
Conflict resolution (Full)	83.40%	83.85%	87.98%	86.62%		↗	
Conflict resolution (Refresher)	93.20%	93.03%	92.60%	91.21%			↘
DSE	90.60%	90.76%	93.03%	92.92%		↗	
Duty of Candour	95.50%	94.92%	96.16%	95.02%			↘
Fire prevention and safety - community	83.80%	87.11%	89.67%	88.02%		↗	
Fire prevention and safety - inpatient	71.60%	75.48%	78.44%	77.59%		↗	
Fire prevention and safety - non clinical	91.70%	92.03%	93.19%	98.51%		↗	
Health and Safety	95.50%	94.05%	95.26%	94.70%			↘
IPC	95.80%	94.71%	96.76%	95.80%	→		
IPC level 2	85.10%	87.79%	92.01%	86.43%		↗	
Patient safety syllabus level 1	89.20%	89.45%	93.44%	92.79%		↗	
Patient safety syllabus level 2	81.20%	76.47%	79.53%	80.79%			↘
Safer people handling	74.10%	71.88%	79.73%	79.89%		↗	
Suicide awareness level 1	98.30%	97.97%	98.31%	98.05%			↘
Suicide mitigation	79.10%	80.02%	79.86%	82.16%		↗	

Training Plan

Training has now been planned for 2025 with directors now attending the Director training provided by Astuti's training, this is a one-day training course accredited by the institute of occupational safety and health.

Management of Health and Safety training has now been planned for 2025-2026 with a pilot course running 02 July 2025 the target audience for the training is any manager who is required to manage staff or safety issues within the trust.

Further courses have been planned for

- 30th July 2025
- 10th September 2025
- 26th November 2025

- 7th January 2026
- 11th February 2026

Additional courses will be planned for 2026 and 2027 as part of a rolling programme. The current online mandatory health and safety will continue to be available for all trust employees.

Medical devices

The main area of focus for last year was to continue to reconcile the asset register with our colleagues at the clinical technology department at UHNM as well as to streamline the ordering process of our resus trolley equipment.

We have progressed well with the asset register and we regularly meet with our clinical technology colleagues to support the ongoing procurement, authorisation for use and servicing schedule and this is to encompass all teams within the Trust for 2025/26.

The policy for medical devices has also been reviewed and updated to reflect these subtle operational processes.

The resus trolley has also been embedded in a sustainability project too with the projected financial savings as noted below.

Item	Order No	Delivery Pack	Cost per Pack	Cost per item
Pen Torch	FFE 1552	Pack of 6	£1.99	£0.33
Guedel airway size 2 (Green)	FDB 316	Pack of 10	£2.15	£0.22
Guedel airway size 3 (Orange/Yellow)	FDB 317	Pack of 10	£2.15	£0.22
Guedel airway size 4 (Red)	FDB 318	Pack of 10	£2.28	£0.23
Magills forceps	FIC 8816	Pack of 20	£88.03	£4.40
Suction yankauer	FWP85001	Pack of 50	£25.42	£0.51
Suction tubing	FWP425	Pack of 1	£1.01	£1.01
Suction liner bag	FDR570	Pack of 1	£3.60	£3.60
Non rebreathe mask	FDE 1081	Pack of 50	£49.04	£0.98
Ambi bag	FDE 378	Pack of 25	£133.25	£5.33
Venflon grey	FSP 5004	Pack of 50	£27.50	£0.55
Venflon blue	FSP 5001	Pack of 50	£27.50	£0.55
Venflon pink	FSP 5002	Pack of 50	£27.50	£0.55
Venflon green	FSP 5003	Pack of 50	£27.50	£0.55
IV Giving Set	FBO85003	Pack of 50	£98.76	£1.98
Bag valve mask	FDE379	Pack of 1	£5.34	£5.34
Pocket mask	FDE 1161	Pack of 20	£39.24	£1.96
Defib UniPads	FDJ85180	Pack of 1	£180.00	£180.00
Defib Battery	FDJ 2956	Pack of 1	£150.00	£150.00
Glucometer	HHH85196	Pack of 1	£25.39	£25.39
Glucometer fluid N	HHH85202	Pack of 1	£18.90	£18.90
Glucometer fluids H	HHH85203	Pack of 1	£18.90	£18.90
Test Strips for Glucometer	HHD85009	Pack of 50	£16.14	£0.32
Cost per Trolley			£971.59	£421.31
Additional items needed				£4.40
Total Cost per Trolley (3 yearly)				£425.71

14 Trolleys in the Trust			£13,602.26	£5,959.94
Saving per Trolley				£587.87

Enclosure No: 8a

Quality Committee Assurance Report – August 2025

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11th September 2025
Discussion	☐	Approval	☐		

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 7 August 2025.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	01/09/25

Trust Board Assurance Report from the Quality Committee meeting held on 7 August 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Quality Committee. The meeting was held face to face 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.

- **Deep Dive – Acute and Urgent Care Directorate - Out of Area Placements (OOA) presentation**

A presentation was delivered to the Committee describing the current challenges associated with the increased number of Out of Area placements for patients requiring an inpatient bed.

The presentation outlined the next steps in relation to fully scoping and understanding the route causes; the work is underway with collaboration from Acute & Urgent Care teams, including inpatient wards, crisis care pathways and community Directorate.

- **System Update**

The committee received an update regarding the Trusts response to the industrial action. There were no challenges, and all plans were executed well.

ADVISE:

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

- **CQC Update**

There have been two Unannounced Mental Health Act visits since the last Quality committee, one was in ward 5 and one in ward 3. Both have received verbal feedback and awaiting the formal reports. Positive feedback received for each ward and actions underway to address some initial learning. The formal report findings will be shared with the Committee once we have received them.

We have successfully submitted a factual accuracy response to the CQC in relation to the Crisis Care Inspection and are awaiting the formal publication of the report.

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 June 2025**

Report received for assurance the overall staffing fill rate was 107.4% and were assured that the Trust's Staffing levels are adequate and safe.

- **Safe staffing Community report June 2025**

The report was received and assurance around overall staffing in the community obtained.

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

- Safeguarding Children and Adult Annual Report 2024/25
- Quality Assurance Report Q1 2025/26
- Clinical Audit Report Q1 2025/26
- Mental Health Act Compliance Action Plan Q1 2025/26
- Clinical Effectiveness Report Q1 2025/26
- CIP related Quality Impact Assessment Q1 2025/26
- IQPR

APPROVE:

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

- **Board Assurance Framework Q1 2025/26**

The amendments recommended within the BAF were discussed and supported by the Committee.

- **Risk Register**

The report was accepted with a good level of discussion.

- **Policies**

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

1. 5.42 Display Screen Equipment Policy
2. 5.11 Security Management Policy
3. 5.41 Lone Worker Policy
4. 1.80 Resuscitation Policy
5. R08 Search Policy
6. 1.84 Care Management Policy
7. 1.64 Effective Care Planning

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 4 September 2025 at 2pm via MS teams.

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

REPORT END

Enclosure No: 8b

Quality Committee Assurance Report –September 2025

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 September 2025
Discussion	☐	Approval	☐		

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 4 September 2025.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	05.09.25

Trust Board Assurance Report from the Quality Committee meeting held on 4 September 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Quality Committee. The meeting was held remotely via MS 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.

- **System Update**

The committee were updated to highlight the ongoing challenges of patients within our wards who are Clinically Ready for Discharge (CRFD) and are awaiting placement/ assessments and cannot be discharged. This is having a detrimental impact on the number of patients who are currently receiving care in Out of Areas beds.

During August there was one inpatient ward closed due to a COVID outbreak. The ward is now open with minimal impact on health and wellbeing of people with COVID and service delivery.

ADVISE:

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

- **Patient Story – presentation**

The story generated a good level of discussion; key themes discussed was the importance of strong therapeutic relationship building, improved co-produced discharge planning and access / re-access to services.

- **Quality Improvement Update – presentation**

The presentation regarding our ongoing approach to Continual Quality Improvement was well received by the committee.

- **Independent Investigation outcomes from NICHE report**

The report, actions and progress were received by the committee and will be monitored by the quality committee.

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 July 2025**

Report received for assurance the overall staffing fill rate was 103.9% 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

- **Safeguarding Children and Adult Q1 2025/26**
- **Infection, Prevention and Control Q1 2025/26**
- **Co-production Involvement and Volunteer Report Q1 2025/26**
- **Restrictive Practice Report Q1 2025/26**
- **Health and Safety Annual Report 2024/25**
- **Learning from Experience Annual Report 2024/25**
- **Learning from Experience Report Q1 2025/26**
- **PSIRF Report Q1 2025/26**
- **PSIRF Annual Report 2024/25**
- **Statement of Purpose**

The following reports generated further detail worthy of note:

- **Mortality Surveillance Report Q1 2025/26**

The committee discussed a question which was raised at Trust Board in July 2025 and a suggestion as to whether an external review of Mortality Surveillance decisions would be helpful. The Chief Medical Officer advised that a benchmarking exercise with other Providers has been undertaken and confirmed that no other providers use external reviewers for this process. Additionally, assurance was provided in relation to the multi-disciplinary nature, skill and independence of the review panel. The committee agreed that this would not add any qualitative value. Action was agreed to provide additional detail and clarity regarding our internal review process and decision-making in future reporting.

- **IQPR M4 2025/26**

The committee noted areas of improvement and sought assurance on the impact where performance was not being achieved.

The committee discussed the Performance Improvement Plans (PIP'S) where achieving target has been challenging in some areas, in particular the 4 week wait and supervision. It was agreed for Quality Committee to receive assurance regarding the measures in place to minimise the impact of harm on patients who are waiting and to also seek assurance regarding levels of harm in the event of the target not being achieved.

APPROVE:

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

- **Board Assurance Statement – Winter Plan 2025/26**

Approval was given by the committee.

- **Risk Register**

The committee approved the following:

- Risk 1277 – requested for due date amendment
- Risk 2132 – to retain risk score at 8
- Risk 944 – Score increase from 9 to 12.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 2 October 2025 at 2pm via MS teams.

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

REPORT END

Enclosure No: 9

IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) M04 2025/26

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

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	Trust 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. • Sickness Absence • Appraisal There are 5 special cause variations (blue variation flags) – signifying improvement. • Early Intervention - a maximum of 2 week waits for Referral to Treatment • Risk Assessment Compliance • Staff Turnover • Vacancy Rate • Complaints Open Beyond Agreed Timescale Highlights Overall, there are more highlights to report than exceptions during M04. • Referral to treatment within 18 weeks remains above standard at 95.9% and continues to improve. • Compliance within CYP 18 weeks referral to treatment (RTT) has significantly improved to 92.8% in M04 compared to 85.9% in M03, previous achievement of the target was in January 2024. • Mental Health Liaison responses are all above the 95% standard in M04. • 48-hour and 7-day follow up metrics achieved 100% in M04. • Care plan compliance has achieved the 95% in M04 for the second consecutive month, which is encouraging during the transition period to the new co-produced care plans. • Risk Assessment compliance has dipped slightly to 95.7% in M04 compared to 96.0% in M03, still meeting the required standard. • Average length of stay for older adults is within the 90-day threshold at 56 days in M04. • Friends and Family Test recommended rate has improved to 86.4% during M04, meeting the 80% standard for the second month. • The number of outstanding complaint responses has improved in M04 to one, compared to five in M03. • Staff turnover has remained static at 8.9% during M04 and is within the <10.0% threshold. • The vacancy rate has improved to 8.0% during M04 and is within the <10.0% threshold. • Statutory and mandatory training has remained static at 90% in M04 and is meeting the required standard.

- DQMI rate has continued to improve to 98.6% in M04 (latest published national position).

Exceptions

- Referral to Assessment within 4 weeks performance has declined to 93.3% in M04 compared to 93.5% in M03, below trust standard.
- CYP 4-week referral to assessment standard has declined to 91.1% in M04 compared to 92.0% in M03, below trust standard.
- Both appraisal and clinical supervision performance have further declined during M04 (81.0% and 79.0% respectively) and are not meeting the required 85% standard.
- Average length of stay-adults has exceeded the 40 days threshold at 49 days during M04, this is due to clinically ready for discharge (CRFD) patient's subsequent discharge in month. Work is ongoing with Stoke Local Authority to further reduce Stoke CRFDs.
- There have been 9 proportionate reviews undertaken in M04, a gradual increase from 2 in April 2025.

Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts M04 2025/26

M04 performance against the forecasts submitted to the ICB and NHSE for 2025/26.

In M04, nationally published performance has been included where applicable. To note:

- **Out of Area Placements**-There were 22 reportable out of area placements at the end of M04, 21 due to the availability of adult acute beds and 1 due to the availability of psychiatric intensive care unit (PICU) beds.
- **Inpatient Stays**-The average length of stay (LoS) has not met plan in M04 achieving 57 against the plan of 39.2 patients.
- **Perinatal Access**-The perinatal access metric has met standard in M04, achieving 746 against the plan of 608.
- **CYP in contact**-This metric has met standard in M04 achieving 8,706 against the plan of 7,955.
- **Individual Placement Support Access**-This metric is set against the Integrated Care Board (ICB) performance plan. The Trust is working towards collecting Midlands Partnership University NHS Foundation Trust (MPFT) performance so that we can report against the system plan.

VERSION CONTROL:

Version	Report to	Date Reported
1.0	Finance & Resource Committee	26.08.25
1.0	Public Trust Board	04.09.25



Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M04 (July 2025)



Contents

Core Indicators-Monthly and Balanced Scorecard
Operational Planning Forecasts and Performance
Core Indicators-12-month trend!
Performance Improvement Plans (PIPs)
Core Indicators – SPC Trend

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. **Vacancy Rate**
5. **Complaints Open Beyond Agreed Timescale**

There are 7 metrics with Performance Improvement Plans (PIPs) in place for:

1. Referral to Assessment within 4 weeks - Specialist Services and Community directorates
2. Sickness Absence – Acute and Urgent Care, Specialist Services, Community Primary Care directorates
3. Complaints - Nursing and Quality directorate
4. Friends and Family Test - Nursing and Quality directorate
5. Clinical Supervision - Acute and Urgent Care and Community directorates
6. Care Plan Compliance - Specialist directorate
7. Out of Area Placement – Acute and Urgent Care and Community

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	10 met, 2 unmet, 2 N/A		
Highlights	Referral to Treatment within 18 weeks	92%	95.9%
	CYP Eating Disorders-Referral to Assessment (Urgent) 1 Week	95%	N/A
	CYP Eating Disorders-Referral to Assessment (Routine) 4 Weeks	95%	N/A
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92%	92.8%
	MH Liaison 1 hour response (Emergency)	95%	95.3%
	MH Liaison 4 hour response (Urgent)	95%	96.0%
	MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	96.4%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60%	94.7%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48%	53.7%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	67%	77.4%
Exceptions	48 Hour Follow Up	95%	100.0%
	7 day follow up (All Patients)	95%	100.0%
	Referral to Assessment within 4 weeks	95%	93.3%
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95%	91.1%

Community & Quality			
SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	2 Met, 0 unmet		
Highlights	Care Plan Compliance	95%	95.0%
	Risk Assessment Compliance	95%	95.7%

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
Acute and Urgent Care directorate	Sickness Absence (in-month)	<4.95%	7.6%
	Clinical Supervision	85%	76.0%
Community directorate	Referral to Assessment within 4 weeks-CYP	95%	75.6%
	Referral to Assessment within 4 weeks-Adult	95%	82.5%
	Clinical Supervision	85%	79.0%
	Sickness Absence (in-month)	<4.95%	4.7%
Acute and Urgent Care and Community	Out of Area Placement-count of referrals in month	No Target	29

Inpatient & Quality			
SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	2 met, 1 unmet		
Highlights	Average Length of Stay - Older Adult	90	56
	Emergency Readmissions rate (30 days)	<7.5%	3.9%
Exceptions	Average Length of Stay - Adult	40	49

Organisational Health & Workforce			
SPC variations signifying concern	Metric	Standard	Performance
	Appraisal	85%	81.0%
	Sickness Absence (12-month)	<4.95	6.2%
RAG rated standards	5 met, 4 unmet		
Highlights	Vacancy Rate	<10%	8.0%
	Staff Turnover	<10%	8.9%
	Statutory and Mandatory Training	85%	90.0%
	DQMI	95%	98.6%
	Friends and Family Test	80%	86.4%
Exceptions	Sickness Absence (12-month)	<4.95%	6.2%
	Clinical Supervision	85%	79.0%
	Appraisal	85%	81.0%
	Complaints Open Beyond Agreed Timescale	0	1
	Safe Staffing	95%-105%	103.9%

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
Specialist Services directorate	Referral to Assessment within 4 weeks	95%	89.7%
	Sickness Absence (in-month)	<4.95%	7.2%
	Care Plan Compliance	95%	91.2%
	Clinical Supervision	85%	84.0%
Nursing and Quality directorate	Complaints Open Beyond Agreed Timescale	0	1
	Friends and Family Test	80%	86.4%
Primary Care directorate	Sickness Absence (in-month)	<4.95%	6.6%

Core Indicators – Monthly

Domain	Indicator	Target	May-25	Jun-25	Jul-25	Assurance	Variation
Access & Wait Times	Referral to Assessment within 4 weeks	95%	94.7%	93.5%	93.3%		
	Referral to Treatment within 18 weeks	92%	96.1%	95.4%	95.9%		
	CAMHS Compliance within 4 Week Waits (RTA)	95%	90.9%	92.0%	91.1%		
	CAMHS Compliance within 18 Week Waits (RTT)	92%	91.8%	85.9%	92.8%		
	CYP Eating Disorders-1 Week (Urgent)	95%	N/A	100.0%	N/A	Run chart	Run chart
	CYP Eating Disorders-4 Weeks (Routine)	95%	N/A	97.3%	N/A	Run chart	Run chart
	MH Liaison 1 hour response (Emergency)	95%	95.7%	95.0%	95.3%		
	MH Liaison 4 hour response ((Urgent)	95%	97.6%	93.8%	96.0%		
	MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	95.9%	96.0%	96.4%		
	Early Intervention-A maximum of 2 Week Waits for Referral to Treatment	60%	100.0%	95.0%	94.7%		
	48 Hour Follow Up	95%	95.6%	96.4%	100.0%		
	7 Day Follow Up (All Patients)	95%	100.0%	96.4%	100.0%		
	Talking Therapies for Anxiety and Depression Reliable Recovery Rate	48%	50.2%	51.6%	53.7%	Run chart	Run chart
	Talking Therapies for Anxiety and Depression Reliable Improvement	67%	70.1%	73.9%	77.4%	Run chart	Run chart

Domain	Indicator	Target	May-25	Jun-25	Jul-25	Assurance	Variation
Inpatient & Quality	Average Length of Stay - Adult	40	34	62	49		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	20.7%	16.7%	22.2%	Run chart	Run chart
	Average Length of Stay - Older Adults	90	81	70	56		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	38.1%	21.1%	30.4%	Run chart	Run chart
	Emergency Readmissions rate (30 days)	7.5%	1.6%	2.6%	3.9%		
	Clinically Ready for Discharge (CRFD)	No Target	23.3%	27.2%	22.2%	Run chart	Run chart

Domain	Indicator	Target	May-25	Jun-25	Jul-25	Assurance	Variation
Community & Quality	Care Plan Compliance	95%	94.5%	95.0%	95.0%		
	Risk Assessment Compliance	95%	95.8%	96.0%	95.7%		
	Comprehensive Safety Review	No Target	5	6	0	Run chart	Run chart
	Proportionate Reviews	No Target	7	6	9	Run chart	Run chart

Domain	Indicator	Target	May-25	Jun-25	Jul-25	Assurance	Variation
Organisational Health & Workforce	Complaints Open Beyond Agreed Timescale	0	2	5	1		
	Friends and Family Test-Recommended	80%	72.0%	81.5%	86.4%		
	Safe Staffing	95%-105%	107.3%	107.4%	103.9%	Run chart	Run chart
	Vacancy Rate	<10%	8.3%	8.2%	8.0%		
	Staff Turnover	<10%	9.7%	8.9%	8.9%		
	Sickness Absence	<4.95%	6.3%	6.2%	6.2%		
	Clinical Supervision	85%	83.0%	80.0%	79.0%		
	Appraisal	85%	84.0%	83.0%	81.0%		
	Statutory and Mandatory Training	85%	91.0%	90.0%	90.0%		

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 RP	Plan	2	2	2	2	2	2	2	2	2	2	2	2	2
			Actual	17	11	19	16	22								
			Variance	-15	-9	-17	-14	-20								

Inpatient Stays (people aged 18 and over from adult acute, older adult acute and PICU beds)		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2	Total bed days for discharges in the RP	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	
			Actual	8,980	8,407	8,338	9,483	9,693									
			Variance	-985	-412	-343	-1,488	-1,698									
			Nationally Published	8,373	8,405	8,340											
	Number of discharges in the RP		Plan	205	205	205	205	205	205	205	205	205	205	205	205	205	205
			Actual	186	202	188	181	171									
			Variance	20	3	17	24	34									
			Nationally Published	195	200	190											
	Mean Length of stay for discharges in the RP		Plan	39	39	39	39	39	39	39	39	39	39	39	39	39	39
			Actual	49	42	44	53	57									
			Variance	-10	-3	-5	-14	-18									
			Nationally Published	43	42	44											

Perinatal access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	Number of people accessing specialist community PMH and MMHS services in the RP	12-month rolling	Plan	608	608	608	608	608	608	608	608	608	608	608	608	608
			Actual	713	682	701	722	746								
			Variance	105	74	93	114	138								
			Nationally Published	670	660	680										

CYP Access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	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	8,579	8,515	8,489	8,605	8,706								
			Variance	624	560	534	650	751								
			Nationally Published	8,513	8,520	8,505										

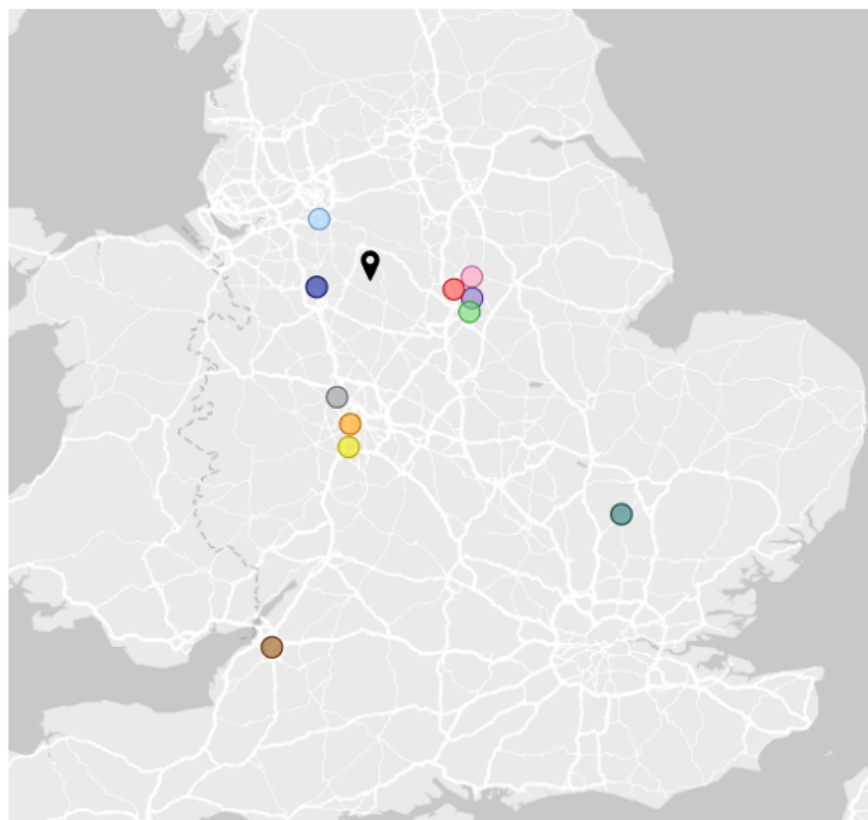
Individual Placement Support Access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
3	Number of referrals that accessed Individual Placement Support (IPS) in the reporting period	12-month rolling	ICB Plan	913	820	827	846	865	883	902	921	940	958	977	996	1,015
			ICB Actual													
			Variance													
			NSCHT Actual	381	389	388	382	364								
			ICB Nationally Published	783	785	780										
			NSCHT Nationally Published	390	390	390										

*In M04, nationally published performance has been included where applicable.

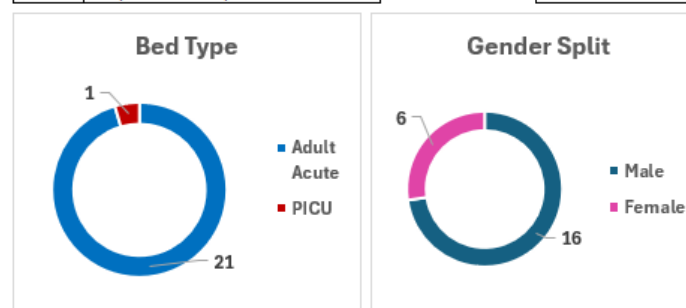
Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (1 of 3)

- Out of Area Placements (OOA)** – There were 22 reportable out of area placements at the end of M04, 21 due to the availability of adult acute beds and 1 due to the availability of psychiatric intensive care unit (PICU) beds.
- This reflects the pressure across the system and on the acute and urgent care directorate (ACUC). There is a low number of adult acute beds at the present time due to project chrysalis (94 beds). The current bed stock is the lowest since September 2020. There is added pressure due to the number of patients that are clinically ready for discharge (CRFD) but remain within our inpatient services. In M04, 22.2% of occupied bed days (OBDs) relate to patients that are CRFD. The wards are operating to capacity, and the home treatment team has increased activity, caseload, and level of risk to avoid admissions.

An OOA PIP has been initiated in M04 for ACUC and Community Directorates.
- An OOA standing operating procedure (SOP) provides assurance regarding roles and responsibilities regarding the 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, the discharge pathway team remain in frequent contact with the placements throughout the week. Where community teams are involved, they too engage in the patients journey whilst OOA. The Trust only places patients in hospitals with care quality commission (CQC) rating good/outstanding and ensure the minimum distance from home.

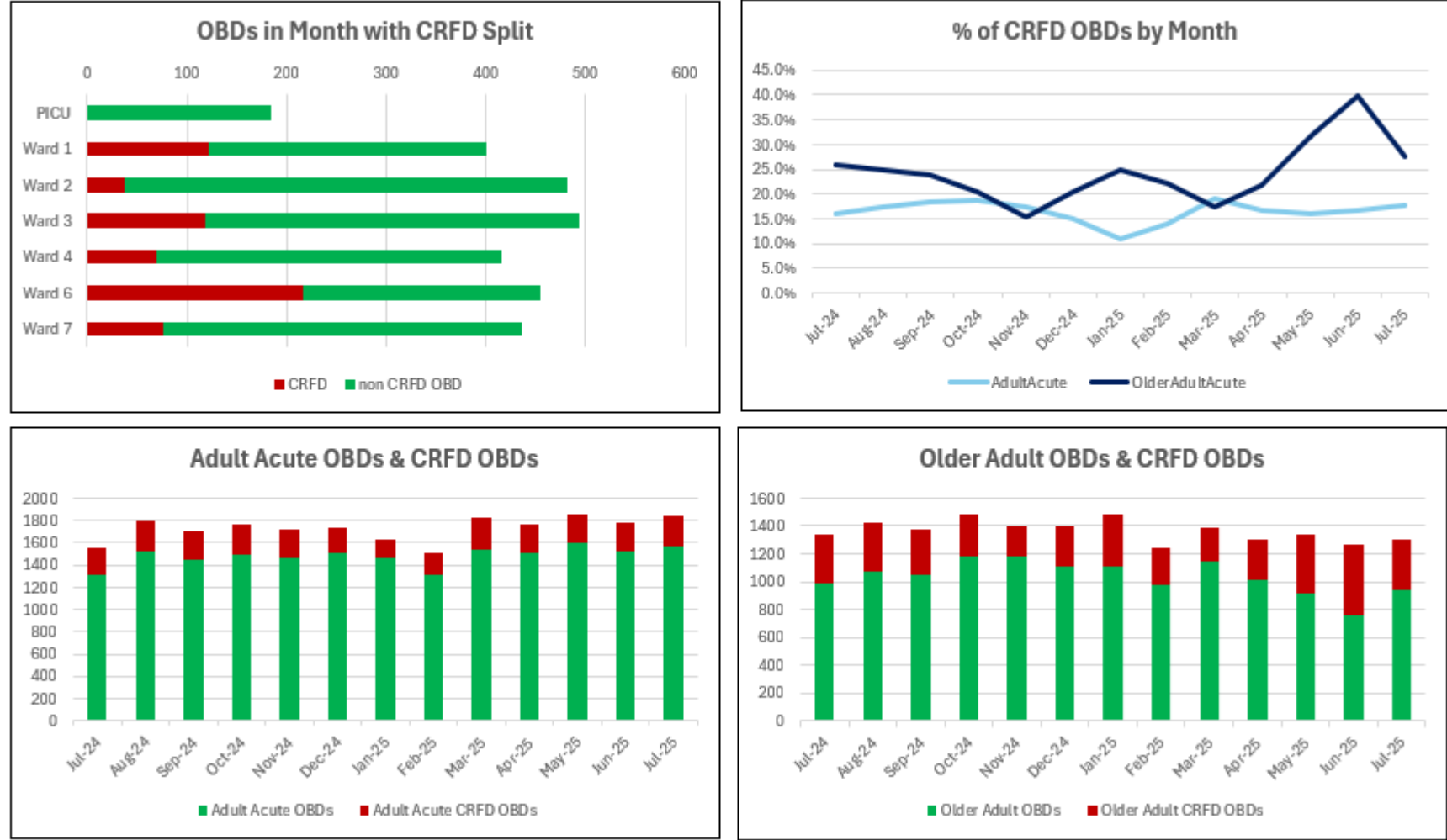


Key	Name of Hospital	Distance from Harlands (mi)	No. of Placements
●	Cygnets Kidsgrove	9	3
●	Cygnets Oldbury	41	1
●	Cygnets Sherwood	61	4
●	Cygnets Wolverhampton	32	2
●	Cygnets Wyke	85	1
●	Priory Arnold	61	4
●	Priory Barnt Green	52	1
●	Priory Bristol	124	1
●	Priory East Midlands	56	1
●	Priory Kneeworth	139	2
●	Priory Nottingham	56	2
📍	Harlands Hospital		Total: 22



Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 – Supporting Information: Clinically Ready for Discharge (CRFD) (2 of 3)

One of the largest contributing factors to average length of stay (LoS), that is often out of our control, is patients who are clinically ready for discharge (CRFD). Stoke local authority have been collaborating with us to reduce Stoke CRFDs in June and July. This is a positive development; however, it impacted on length of stay measures as more patients with a longer length of stay were discharged.



Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (3 of 3)

- **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 (LoS) in adult acute beds. This is a 3-month rolling measure of adult acute, older adult acute and psychiatric intensive care unit (PICU) occupied bed days (OBDs), discharges and LoS. The average LoS for this metric has not met standard in M04 achieving 57 against the plan of 39.
- **Perinatal Access** – The perinatal access metric has met standard in M04, achieving 746 against the plan of 608.
- **CYP in contact** – This metric has met standard in M04 achieving 8,706 against the plan of 7,955.
- **Individual Placement Support (IPS) Access** – This metric is set against the Integrated Care Board (ICB) performance plan. As we hold the IPS contract, the Trust is seeking Midlands Partnership University NHS Foundation Trust's (MPFT) local performance data so that we can report against the system plan. Within the nationally published data, we can obtain ICB and provider level totals. However, as MPFT IPS services cover more than one ICB, their total provider data would not support us to accurately reflect our contact levels. As performance is under plan, operational management reports have been created by the Performance team in NSCHT to help drive improvement in activity.

Core Indicators – Trends

Indicator	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-26
Referral to Assessment within 4 weeks	95%	94.7%	93.5%	93.9%	93.9%	94.9%	95.9%	92.2%	90.0%	91.7%	93.1%	94.2%	94.7%	93.5%	93.3%
Referral to Treatment within 18 weeks	92%	96.4%	96.4%	94.7%	94.5%	94.2%	95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%	95.4%	95.9%
CAMHS Compliance within 4 Week Waits	95%	78.9%	78.8%	78.6%	89.2%	90.7%	92.0%	76.4%	67.3%	76.2%	85.7%	91.1%	90.9%	92.0%	91.1%
CAMHS Compliance within 18 Week Waits	92%	85.0%	87.6%	74.3%	87.3%	86.5%	87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%	85.9%	92.8%
MH Liaison 1 Hour response (Emergency)	95%	96.0%	95.8%	96.2%	95.1%	95.6%	92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%	95.0%	95.3%
MH Liaison 4 hour response (Urgent)	95%	97.5%	96.4%	96.8%	97.1%	95.6%	91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%	93.8%	96.0%
MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	99.3%	99.2%	96.1%	97.3%	96.2%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%	96.0%	96.4%
CYP Eating Disorders-1 Week (Urgent)	95%	100.0%	N/A	N/A	100.0%	N/A	N/A	83.3%	N/A	N/A	72.7%	N/A	N/A	100.0%	N/A
CYP Eating disorders-4 Weeks (Routine)	95%	97.7%	N/A	N/A	90.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	97.3%	N/A
Early Intervention-A maximum of 2 Week Waits for Referral to Treatment	60%	83.0%	67.0%	92.0%	89.0%	100.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%	95.0%	94.7%
48 Hour Follow Up	95%	96.2%	91.4%	96.6%	94.2%	94.7%	100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%	96.4%	100.0%
7 Day Follow Up (All Patients)	95%	98.1%	94.9%	100.0%	96.2%	98.4%	100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%	96.4%	100.0%
Talking Therapies for Anxiety and Depression Reliable Recovery Rate	48%	52.4%	54.4%	53.9%	53.0%	50.7%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%	51.6%	53.7%
Talking Therapies for Anxiety and Depression Reliable Improvement	67%	76.3%	75.8%	73.4%	74.5%	71.2%	74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%	73.9%	77.4%
Average Length of Stay - Adult	40	21	38	23	41	20	28	33	42	24	28	41	34	62	49
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	8.0%	15.0%	6.0%	16.0%	5.0%	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%	16.7%	22.2%
Average Length of Stay - Older Adults	90	41	71	61	56	64	51	48	57	75	59	41	81	70	56
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	5.0%	14.0%	17.0%	22.0%	21.0%	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%	21.1%	30.4%
Emergency Readmissions rate (30 days)	<7.5%	3.5%	2.0%	2.7%	1.4%	1.4%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%	2.6%	3.9%
Clinically Ready for Discharge (CRFD)	No Target	21.2%	20.5%	20.9%	20.9%	19.5%	16.3%	17.6%	18.0%	17.8%	18.3%	19.2%	23.3%	27.2%	22.2%
Care Plan Compliance	95%	96.2%	96.1%	96.2%	96.1%	96.2%	96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%	95.0%	95.0%
Risk Assessment Compliance	95%	92.9%	93.5%	94.0%	92.7%	94.1%	94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%	96.0%	95.7%
Comprehensive Safety Review	No Target	2	0	4	3	5	1	5	4	2	3	2	5	6	0
Proportionate Reviews	No Target	4	3	4	3	2	3	2	4	3	5	2	7	6	9
Complaints Open Beyond Agreed Timescale	0	11	8	1	0	1	3	2	1	5	4	3	2	5	1
Friends and Family Test-Recommended	80%	80.0%	78.0%	75.0%	89.0%	83.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%	81.5%	86.4%
Safe Staffing	95%-105%	96.9%	95.8%	99.7%	104.6%	98.3%	100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%	107.4%	103.9%
Vacancy Rate	<10%	10.8%	11.3%	11.1%	9.8%	7.9%	8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%	8.2%	8.0%
Staff Turnover	<10%	11.5%	11.0%	10.6%	10.2%	10.2%	10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%	8.9%	8.9%
Sickness Absence	<4.95%	5.4%	5.6%	5.6%	5.6%	5.7%	5.8%	6.0%	6.1%	6.2%	6.4%	6.4%	6.3%	6.2%	6.2%
Clinical Supervision	85%	85.0%	81.0%	83.0%	83.0%	85.0%	82.0%	79.0%	85.0%	82.0%	79.0%	81.0%	83.0%	80.0%	79.0%
Appraisal	85%	91.0%	88.0%	87.0%	87.0%	87.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	84.0%	83.0%	81.0%
Statutory and Mandatory Training	85%	89.0%	89.0%	88.0%	88.0%	87.0%	87.0%	89.0%	89.0%	89.0%	91.0%	91.0%	91.0%	90.0%	90.0%
DQMI	95%	96.0%	97.3%	97.4%	97.2%	97.5%	97.2%	98.4%	98.3%	98.3%	98.4%	98.6%	N/A	N/A	N/A

In M04 there are 34 metrics monitored; 18 have achieved the required standard (see achieved in month) and 7 have not achieved the required standard (see exceptions in month). 5 metrics have no target and are being monitored. 1 metric is provided by NHS England with the current month not yet published. 2 metrics are not applicable as reported quarterly. 1 metric is being monitored.

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 89.7% during M04 which is not meeting the 93.0% trajectory or 95.0% required standard. Updated actions have been received in M04.
	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 75.6% during M04 which is not meeting the 85.0% planned trajectory or the 95.0% required standard. Updated actions have been received in M04.
	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 have been reset in M03 covering August to January 2026. Adult performance is 82.5% during M04 which is not meeting the 94.0% planned trajectory or the 95.0% required standard. Updated actions have been received in M04.
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 M04 is 7.9% and 7.6% in-month. The in-month trajectory of 7.6% in M04 is being met. The 6.9% 4-year average is not being met. The in-month <4.95% target is not being met. Updated actions have been received in M04.

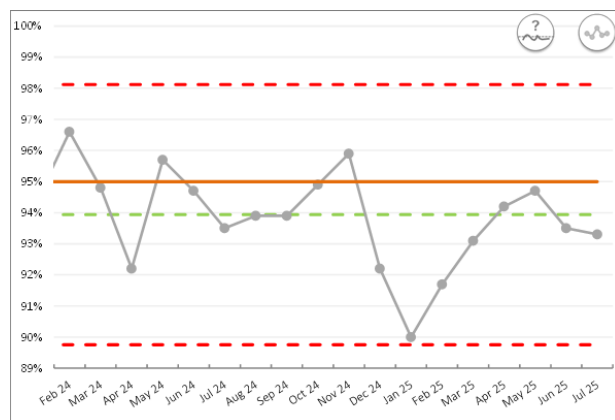
Metric	Directorate	Status
	Primary Care	A PIP was requested in M10 (2024/25). The PIP trajectory was updated in M01 to bring sickness rate back to the 4-year average position of 4.4% which is within the <4.95% required standard. Trajectories have been set in M02 covering the period April 2025 to March 2026. The Primary Care directorate aims for the standard to be met in December 2025. Sickness absence 12-month rolling period during M04 is 6.8% and 6.6% in-month. The in-month trajectory of 5.5% in M04 is not being met. The 4.4% 4-year average is not being met. The in-month <4.95% target has not been met. Updated actions have been received in M04.
	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 M04 is 5.6% and 4.7% in month. The in-month trajectory of 5.0% in M04 is being met. The 3.9% 4-year average is not being met. The in-month <4.95% target has been met for the third consecutive month. The 12-month rolling standard is not being met. Updated actions have been received for M04. <i>Decision made at Performance review meeting to close PIP in M04 as the standard has been achieved for the third consecutive month.</i>
	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 M04 is 7.2% and 7.2% in-month. The in-month trajectory of 6.9% for M04 is not 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 M04.
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. This has further been extended to November 2025. During M04 there is one complaint exceeding the 40-day response timescale. Performance is meeting the required trajectory but not the required standard. Updated actions have been received in M04.
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, and reset in M03. The aim is for the standard to be met in July 2025 and continue for the following 3 months. Performance for the recommended rate during M04 is 86.4% and has met the required standard for the second consecutive month. The data has not been validated during M04. Updated actions have been received in M04.

Metric	Directorate	Status
Clinical Supervision	Community	A PIP was issued in M10 (2024/25). Community directorate aims to achieve the 85.0% standard by May 2025; this has been extended to July 2025. Trajectories were set in February 2025 and have been updated for August and September. Performance during M04 is 79.0% and has not met the 85.0% planned trajectory or the 85.0% required standard. Updated actions have been received in M04.
	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, extended to November 2025. M02 (May) trajectory has been revised from 85.0% to 79.0%. Trajectories have been extended in M03 for the period covering May 2025 to November 2025. Performance during M04 is 76.0%.and is not meeting the planned 81.0% trajectory or 85.0% required standard. Updated actions have been received in M04.
	Specialist Services	A PIP was requested in M04 (2025/26). Performance during M04 is 84.0% and is not meeting the 85.0% required standard. Updated actions and trajectories have been received in M04.
Care Plan Compliance	Specialist Services	A PIP was issued in M01 (2025/26). Specialist directorate aims for the standard to be met by October 2025. Trajectories have been reset in M03 and reported in M04 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. Trajectories have been set in M04 covering the period June to October 2025. Performance in M04 is at 91.2% and is not meeting the 92.0% planned trajectory or the 95.0% required standard. Updated actions have been received in M04.
Agency and Bank Spend	Community	A PIP was requested in M01 (2025/26) and was stood down in M02. The PIP was reinstated in M03. Performance in M04 is £86k total agency against £95k target. Updated actions have been received in M04.
Out of Area Placement (OOAs)	Acute and Urgent Care and Community	A PIP was requested in M04 (2025/26). Performance in M04 is 22 OOAs at end of month (national measure) and 29 count of OOAs in total in M04. Actions have been received in M04.

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

Referral to Assessment within 4 weeks (Trust indicator)

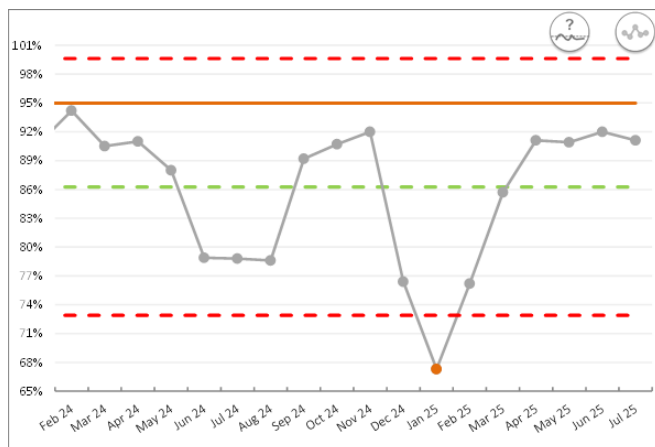


Performance is at **93.3%** in M04. The variation is showing as common cause.

Current Performance: Community-84.2%, Specialist-89.7%, Acute and Urgent Care-97.6%.

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

CAMHS Compliance within 4 weeks Waits (Trust indicator)



Performance is at **91.1%** in M04. The variation is showing as common cause.

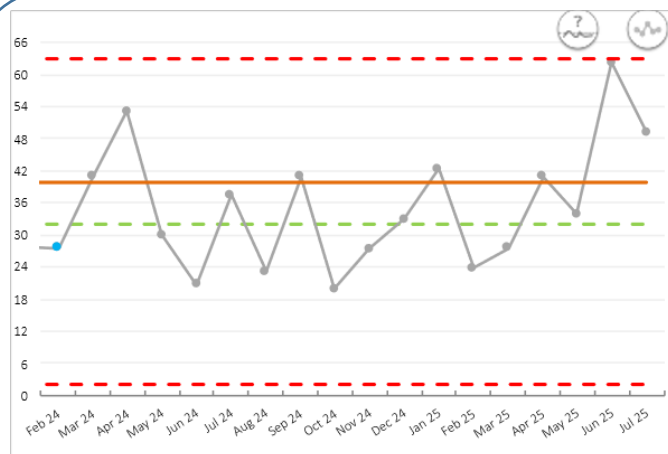
Current performance: Community-75.6%, Specialist-100.0%, Acute and Urgent Care-96.6%.

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

A PIP is in place for Community directorate.

INPATIENT AND QUALITY

Length of Stay-Adult (Trust indicator)

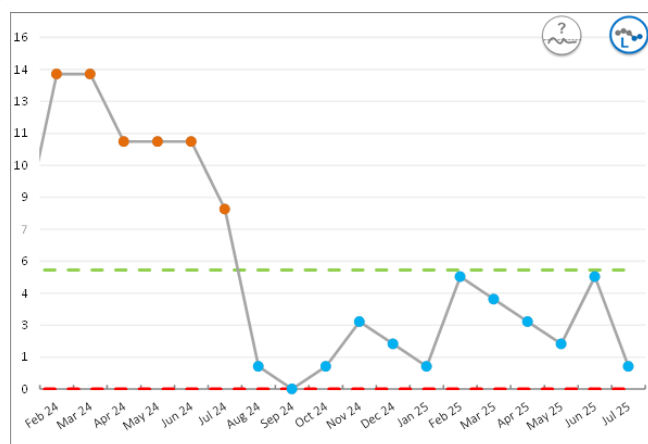


Performance is **49 days** during M04. The variation is showing as common cause.

Average LoS remains elevated this month due to progress discharging long LoS inpatients. There were 6 discharges from Adult Acute wards with a LoS of over 90 days. The Median position for M04 was 20 days.

ORGANISATIONAL HEALTH AND WORKFORCE

Complaints (Trust indicator)

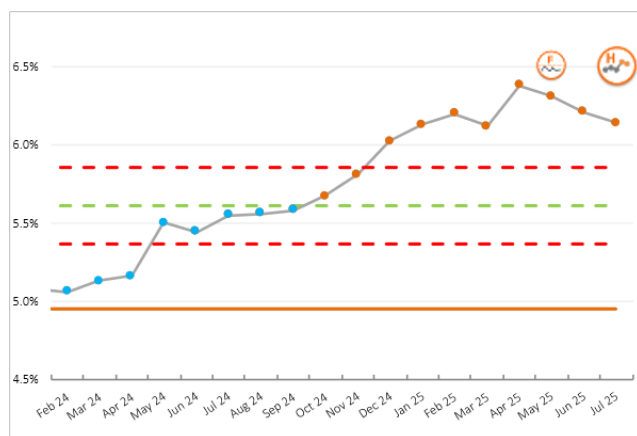


There is **one** complaint exceeding the 40-day response timescale. The variation is showing as a special cause of improvement.

The one reported overdue complaint in M04 has been a particularly complex one as the response requires legal support. There has been a meeting arranged with the family and they are aware of the extended timescales and reasons for resolution of the complaint.

PIP is in place for Nursing and Quality directorate.

Sickness Absence (Trust indicator)



Sickness absence performance is at **6.2%** in M04. A special cause variation of concern remains in place as performance has been operating outside of the upper control limit for the eighth consecutive month.

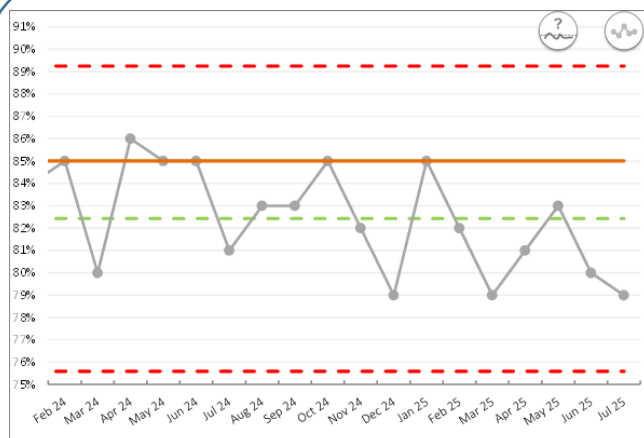
Current performance: Community-5.6%, Specialist-7.2%, Acute and Urgent Care-7.9%, Primary Care-6.8%, Corporate-3.5%.

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 for Acute and Urgent Care, Specialist Services, Community, and Primary Care directorates.

Clinical Supervision (Trust indicator)



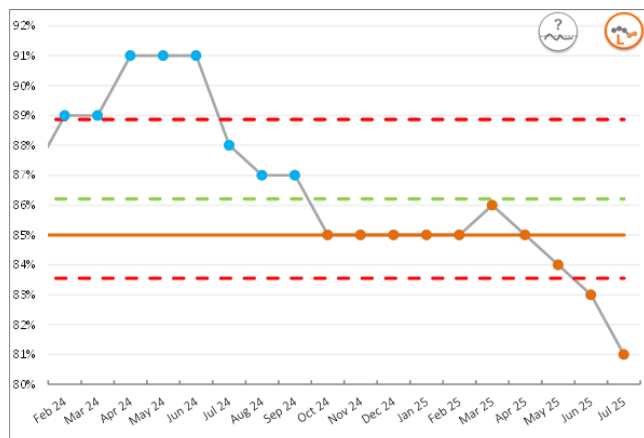
Performance is at **79.0%** in M04. The variation is showing as common cause.

Current performance: Community-79.0%, Specialist-84.0%, Acute and Urgent Care-76.0%, Primary Care-81.0%, Corporate-50.0%.

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. Learning management system (LMS) module has been reviewed and amended to new policy. Survey has concluded to ascertain any issues re: policy, quality, recording and reporting, to make recommendations and take action as required. Survey report due September with actions to be taken as required. Screensaver agreed to highlight Supervision needs and recording.

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

Appraisal (Trust indicator)



Performance is at **81.0%** in M04. The variation is showing a special cause variation of concern, as performance is operating outside of the lower control limit.

Current performance: Community-82.0%, Specialist-82.0%, Acute and Urgent Care-79.0%, Primary Care-79.0%, Corporate-80.0%.

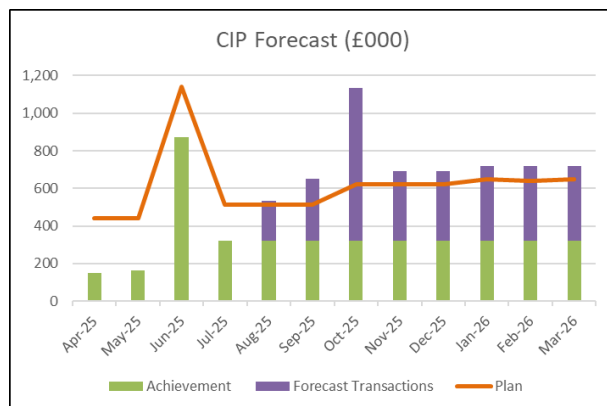
Reports identifying non-compliance rates, names of those non-compliant and their line managers are sent to the associate directors and line managers fortnightly for action. Learning management system (LMS) currently under review to develop a new appraisal module for 2026-27 and to improve recording and reporting capabilities. LMS to undertake a review and data cleanse during September focussing on specifically on appraisal to understand and respond to any issues specifically relating to the module.

The known issues with the LMS system in respect of accurate recording of appraisal dates due are recognised to be impacting on IQPR and PIP performance.

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

Financial Performance

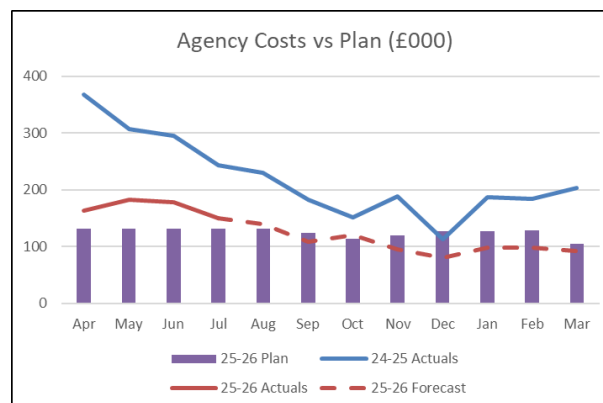
CIP Delivery v Plan



The cost improvement programme (CIP) graph above shows forecast against a £7.4m plan.

The trust is forecasting full achievement of the plan, with current achievement (transacted) £4.1m, fully developed £2.1m, plans in progress £0.6m and opportunities identified £0.6m.

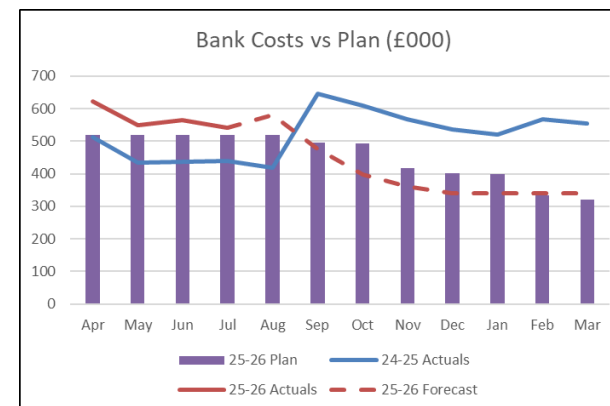
Agency Cost v Plan (40% reduction)



The agency graph above shows forecast against a £1.5m plan.

The Trust is forecasting total agency costs of £1.5m, with £1.2m Community, £0.2m Primary Care, £0.2m Specialist & (£0.1m) Central Services.

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 £5.4m, with £2.6m Acute, £1.9m Specialist, £0.4m Community, £0.3m Central Services and £0.2m Corporate.

- Agency year to date expenditure is £523k against planned expenditure of £416k representing an adverse variance of £107k. Medical spend of £444k and Qualified Nursing of £57k are the main drivers of the adverse variance. Medical costs are made up of £303k Community, £79k Primary Care and £62k Specialist.
- Bank year to date expenditure is £1,735k against planned expenditure of £1,708k representing an adverse variance of £27k. 74% of expenditure to date relates to nursing (qualified and unqualified) representing an unfavourable variance to plan (£46k). 20% of expenditure to date relates to medical staffing with a favourable variance to plan (£97k). The remaining unfavourable variance to plan is due to therapeutic staff to date.

Workforce Actual vs Plan

Jul-25	Plan	Actual	Variance From Plan		
	WTE	WTE	WTE	%	Supporting Information for variance to plan (WIE and details of additional business cases, non-delivery of CIPs etc)
Total	1,832.4	1,844.9	12.5	+0.7%	
Substantive	1,720.8	1,724.2	3.4	+0.2%	68.98 WIE has not been included in the data set as this relates to services not included within our 2025-26 workforce plan (Holmcroft , Keele and Moorcroft Surgeries)
Medical and Dental	53.9	51.9	-2.0	-3.7%	
Registered nursing, midwifery and health visiting staff	527.7	530.7	3.0	+0.6%	
Registered scientific, therapeutic and technical staff	303.3	290.8	-12.5	-4.1%	
Support to clinical staff	481.2	504.6	23.4	+4.9%	
Total NHS infrastructure support	351.3	342.8	-8.5	-2.4%	
Any other staff	3.4	3.4	0.0	0.0%	
Bank	101.8	113.6	11.8	+11.6%	2.73 WIE has not been included in the data set as this relates to services not included within our 2025-26 workforce plan (Holmcroft , Keele and Moorcroft Surgeries)
Medical and Dental	5.0	4.9	-0.1	-2.7%	
Registered nursing, midwifery and health visiting staff	22.0	25.0	3.0	+13.7%	
Registered scientific, therapeutic and technical staff	1.3	2.7	1.4	+112.7%	
Support to clinical staff	70.2	77.1	6.9	+9.9%	
Total NHS infrastructure support	3.3	3.9	0.6	+17.8%	
Any other staff	0.0	0.0	0.0		
Agency	9.7	7.0	-2.7	-27.8%	0.47 WIE not included in the registered Nursing staff group as this relates to services not included within our 2025-26 workforce plan (Holmcroft , Keele and Moorcroft Surgeries)
Medical and Dental	6.6	5.6	-1.1	-16.4%	
Registered nursing, midwifery and health visiting staff	2.8	1.3	-1.5	-53.5%	
Registered scientific, therapeutic and technical staff	0.0	0.2	0.2		
Support to clinical staff	0.3	0.0	-0.3	-100.0%	
Total NHS infrastructure support	0.0	0.0	0.0		
Any other staff	0.0	0.0	0.0		
Vacancies		154.0			The Vacancy detail is not related to the Workforce Plan but an additional element that is reported to our system colleagues. Shared here for information purposes only
Medical and Dental		14.7			
Registered nursing, midwifery and health visiting staff		62.0			
Registered scientific, therapeutic and technical staff		32.4			
Support to clinical staff		16.6			
Total NHS infrastructure support		27.2			
Any other staff		1.1			
Workforce Metrics					
Sickness absence rate % (12 month rolling)	5.8%	6.1%	0.4%		
Turnover rate % (12 month rolling)	9.7%	8.9%	-0.8%		

Performance Improvement Plans (PIPs)

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

Community directorate



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. The trajectory set for M04 has since changed from 95% to 85%.

CYP performance is **75.6%** during M04 which is below the planned trajectory and the required 95.0% standard.

Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	57.6%	66.7%	86.3%	74.7%	75.6%	41.8%	29.2%	56.8%	60.2%	77.2%	79.4%	81.4%	75.6%
Trajectory	40.0%	50.0%	60.0%	70.0%	80.0%	90.0%	95.0%	56.8%	70.0%	80.0%	70.0%	80.0%	85.0%

The above table RAG rating measures actual performance against Trust target

Actions:

- Review admin support for education, health, and care plan (EHCP) processes due to the capacity to support triage and impacting on 4 week waits. **M04 progress update:** meeting arranged with child and adolescent mental health services (CAMHS) administration lead and special educational needs and disabilities (SEND) lead to discuss alternatives.
- Transfer all attention deficit hyperactivity disorder (ADHD) referrals to neurodevelopmental service line to a stand-alone team. **M04 progress update:** all referrals are on Lorenzo for ADHD ready to move over to the neurodevelopmental service line. Early engagement with staff commenced and expressions of interest from some staff who are interested in moving to the new ADHD service. Most posts are covered and a management of change (MoC) process may not be required. People directorate continue to support.
- Review of assessment and treatment pathways, increase assessment and caseload capacity through timely throughput and effective discharge planning. **M04 progress update:** five clinical pathways now in place. Standard Assessment Framework (SAF) model has been agreed and will provide six sessions prior to moving to the appropriate clinical treatment pathway. This is still in pilot stage in North Stoke with a review in September. Materials for the SAF sessions in development to align with the getting help/more help of the Thrive model. Pilot was reviewed in July 2025 and felt further data is required to understand the impact.

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

Community directorate

Jun-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	400	53	8	2	463	86.4%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	32	2	1	0	35	91.4%
North Stoke CAMHS	16	4	0	0	20	80.0%
South Stoke CAMHS	9	5	1	0	15	60.0%
CAMHS Total	57	11	2	0	70	81.4%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	5	0	0	0	5	100.0%
North Stoke CAMHS	14	13	1	0	28	86.9%
South Stoke CAMHS	21	6	8	0	35	8.3%
CAMHS Total	40	19	9	0	68	74.0%

Jul-25

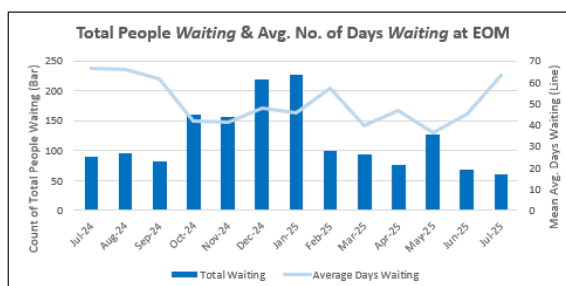
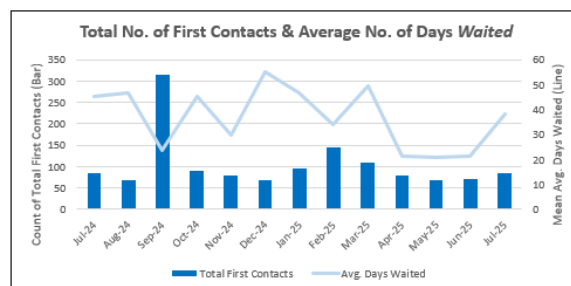
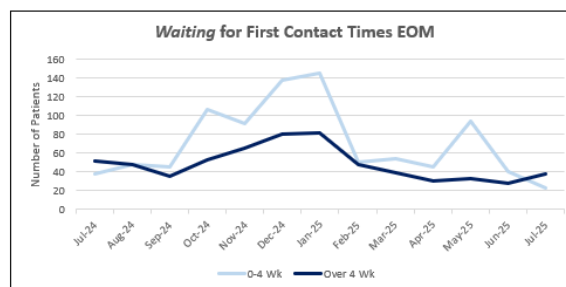
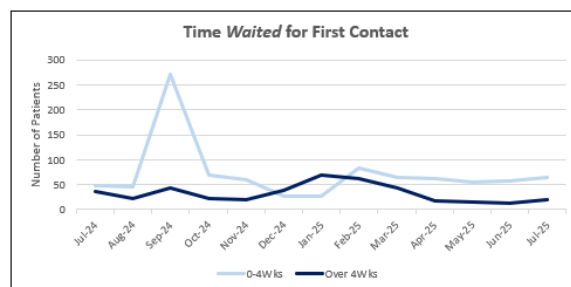
RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	426	68	4	8	506	84.2%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	29	2	0	2	33	87.9%
North Stoke CAMHS	31	10	0	1	42	73.8%
South Stoke CAMHS	5	5	1	0	11	45.5%
CAMHS Total	65	17	1	3	86	75.6%

RTA Waiting

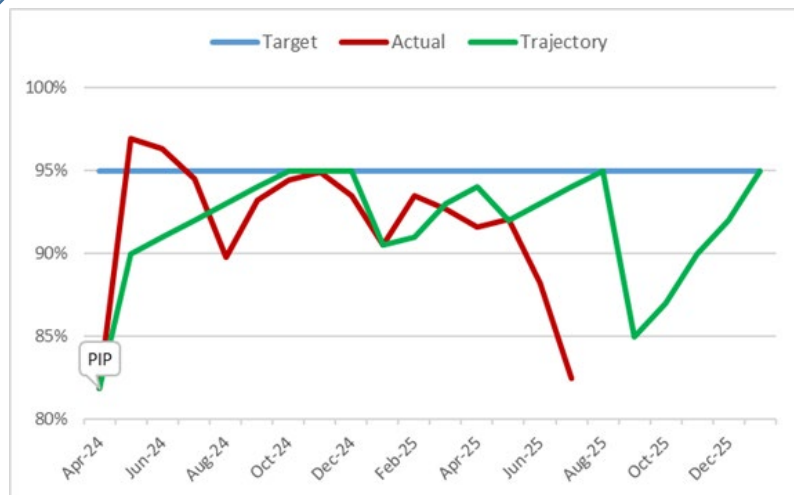
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	5	0	1	0	6	83.3%
North Stoke CAMHS	11	9	1	0	21	52.4%
South Stoke CAMHS	7	17	10	0	34	20.6%
CAMHS Total	23	26	12	0	61	37.7%



- The Community directorate has seen a decrease of 2.2% in referral to assessment (RTA) performance when comparing M03 to M04, underperforming against standard by 10.8%.
- At the end of M04, the number of patients waiting for assessment in core CAMHS community mental health teams (CMHTs) are the lowest seen over the last 13 months.
- Improvement in M05 is not predicted due to 62.3% of the patients waiting already surpassing the 4-week wait target.

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

Community directorate



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, August 2025, January 2026. 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%. New trajectories have been updated for the period May to August 2025.

Adult performance is **82.5%** during M04 which is not meeting the 94.0% trajectory or the 95.0% required standard. Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	94.5%	89.8%	93.2%	94.4%	94.9%	93.5%	90.5%	93.5%	92.7%	91.6%	92.1%	88.2%	82.5%
Trajectory	92.0%	93.0%	94.0%	95.0%	95.0%	95.0%	90.5%	91.0%	93.0%	94.0%	92.0%	93.0%	94.0%

The above table RAG rating measures actual performance against Trust target

Actions:

- Review of adherence to the triage and initial assessment (IA) pathway at Sutherland Centre (July 2025). **M04 progress update:** Recent changes to the triage process have had a positive impact, with consistent daily attendance supporting a more robust and efficient approach. Referrals are now being triaged more promptly, ensuring timely access to care. All accepted referrals undergo an initial assessment and are reviewed within the multidisciplinary team (MDT) meeting prior to progressing to further intervention.
- Effective management of absences. **M04 progress update:** The clinical lead has delegated duties and responsibilities to the deputy team lead, promoting greater consistency and accountability across the team.
- Effective review of data. **M04 progress update:** Ongoing review of data, with those at risk of breaching being identified. The Sutherland Centre are looking to complete an initial assessment week in September 2025. Whilst the number of initial assessments completed has increased, due to the backlog, there continues to be a number of 4 week wait breaches.
- Offer additional hours paid or time off in lieu (toil) using vacancy underspend to support initial assessments and triage before 9am and after 5pm. **M04 progress update:** Overtime has been approved until the end of August 2025 to support with assessments. Staff are completing these, however there has been reduced uptake due to Summer annual leave.
- Review current team structures and manage resources across all community mental health teams (CMHT's). **M04 progress update:** Ongoing. Standard assessment framework (SAF) wait list is currently averaging around 14 weeks. Staff member has recently transferred to the Sutherland Centre (TSC) from Greenfield Centre (GFC) which has helped with capacity.

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

Community directorate

Jun-25

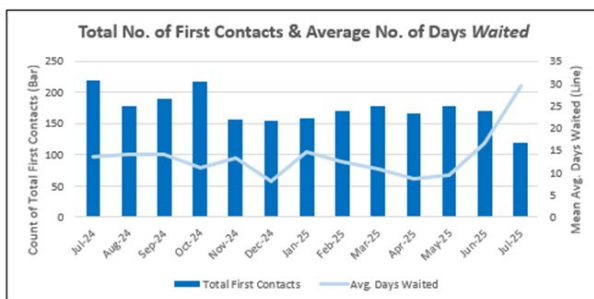
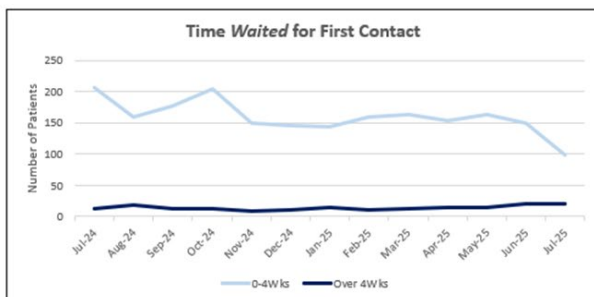
RTA Waited

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	66	1	1	0	68	97.1%
City CMHT - Sutherland	17	12	1	1	31	54.8%
County CMHT Moorlands	22	0	0	0	22	100.0%
County CMHT Newcastle	45	2	2	0	49	91.8%
CMHT Total	150	15	4	1	170	88.2%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	2	0	0	0	2	100.0%
City CMHT - Sutherland	31	18	1	0	50	62.0%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	3	1	0	0	4	75.0%
CMHT Total	36	19	1	0	56	64.3%



Jul-25

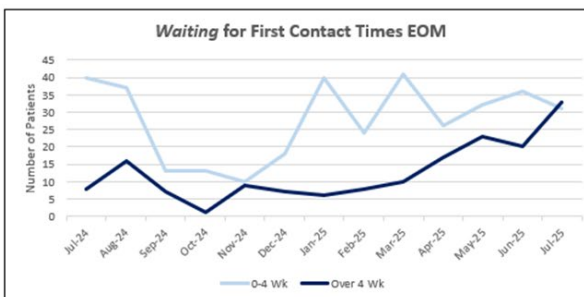
RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	426	68	4	8	506	84.2%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	24	0	0	0	24	100.0%
City CMHT - Sutherland	6	13	1	0	20	30.0%
County CMHT Moorlands	30	0	0	3	33	90.9%
County CMHT Newcastle	39	3	0	1	43	90.7%
CMHT Total	99	16	1	4	120	82.5%

RTA Waiting

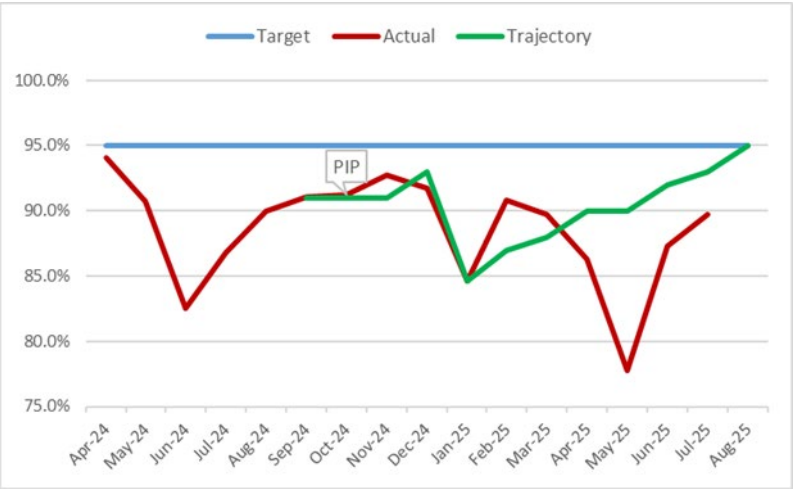
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	9	1	0	0	10	90.0%
City CMHT - Sutherland	18	26	4	0	48	37.5%
County CMHT Moorlands	1	1	0	0	2	50.0%
County CMHT Newcastle	3	1	0	0	4	75.0%
CMHT Total	31	29	4	0	64	48.4%



- Adult community mental health team (CMHT) services are a main driver for the directorates referral to assessment (RTA) performance, making up 23.7% of the total RTAs completed in M04.
- RTA performance for Adult CMHTs has not met standard in M04, achieving 82.5% against a target of 95%.
- In M04, the number of RTAs completed by Adult CMHTS is the lowest seen over the last 13 months.
- The number of patients waiting for an RTA to be completed is the highest over the last 13 months showing a negative correlation relationship with RTAs completed.
- The number of patients that have been waiting over 4 weeks for an RTA within Adult CMHTs has, for the first time in the last 13 months, surpassed the number of patients that have been waiting within 4 weeks.

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

Specialist Services directorate



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 have since been revised for the period August to January 2026. The aim was for achievement of the 95.0% standard by August 2025. This has been extended to January 2026.

Performance is at **89.7%** during M04 which is not meeting the 93.0% trajectory or 95.0% required standard. However, performance is improving.

Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
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%
86.8%	90.0%	91.1%	91.2%	92.7%	91.7%	84.6%	90.8%	89.7%	86.3%	77.8%	87.3%	89.7%
		91.0%	91.0%	91.0%	93.0%	84.6%	87.0%	88.0%	90.0%	90.0%	92.0%	93.0%

The above table RAG rating measures actual performance against Trust target

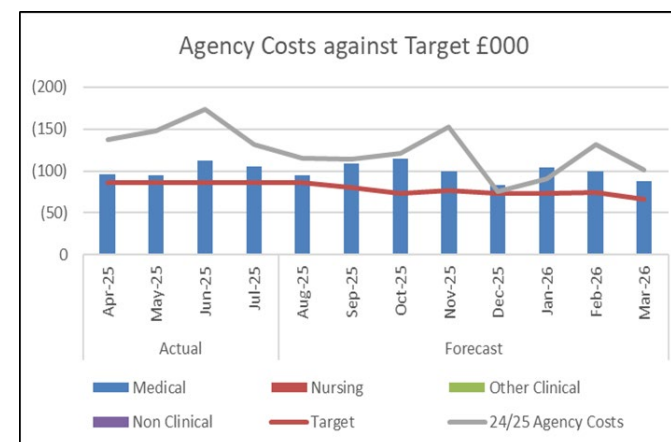
Actions:

- Tuesday meetings held with team managers using the trust’s current waiters report to provide live monitoring of any breaches. **M04 progress update:** weekly meetings to focus on referral to assessment (RTA) relaunched led by service manager.
- Review capacity concerns in children and young people learning disabilities (CYP LD) 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 non-medical prescribing (NMP) training has impacted on wait times **M04 progress update:** no back fill options available. Performance has improved indicating capacity challenges are being well managed.

Performance Improvement Plan: Agency and Bank Spend

Community directorate

COMMUNITY	Actual				Forecast										
Agency £000	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Total	
Medical	96	95	112	105	95	109	115	99	83	104	99	88	408	1,200	
Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other Clinical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Non Clinical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Agency	96	95	112	105	95	109	115	99	83	104	99	88	408	1,200	
Target	86	86	86	86	86	80	73	76	74	74	74	66	342	944	
Over / (under) Target	10	10	27	20	9	29	42	23	9	30	25	22	66	255	
24/25 Agency Costs	137	148	174	132	115	114	121	153	76	90	131	102		1,494	



The Agency target has changed from a maximum of 3.2% of the total pay bill across 2024/25 to 2 metrics in 2025/26

- 40% agency reduction from the 2024/25 M8 forecast outturn position.
- 10% bank reduction from the 2024/25 M8 forecast outturn position

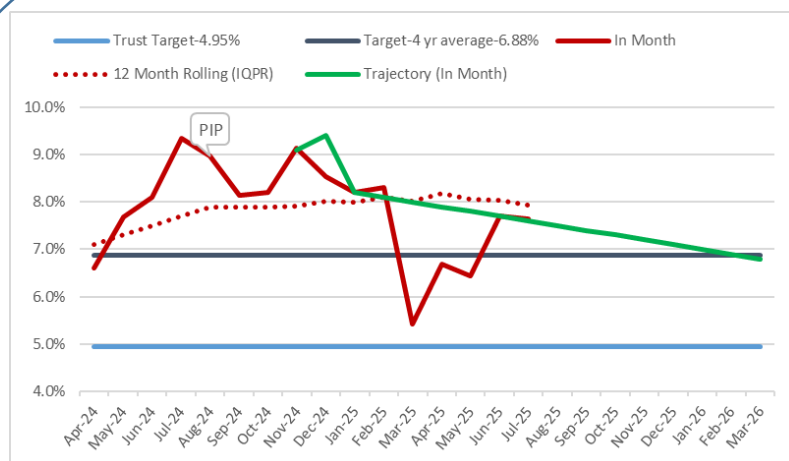
A PIP was requested in M01 (2025/26) and was stood down in M02. The PIP was reinstated in M03. Performance in M04 is £86k total agency against £95k target. Updated actions have been received in M04.

Actions:

- Greenfields/attention deficit hyperactivity disorder (ADHD). **M04 progress update:** Currently have 3x trust consultants supporting with ADHD assessments. There is a need to understand the demand and once there is a stable picture a job description will be developed to merge the post with Greenfields.
- Sutherland, Lymebrook and Stoke memory assessment consultant posts. **M04 progress update:** Posts progressed through TRAC online recruitment programme and British Medical Journal (BMJ).
- Child and adolescent mental health services (CAMHS) North Stoke consultant. **M04 progress update:** Post holder to commence in September 25.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care directorate



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 M04 is 7.9% and 7.6% in-month. The in-month trajectory of 7.6% in M04 is being met. The 6.9% 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. The 4-year (6.88%) average is not being met.

Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	9.4%	9.0%	8.1%	8.2%	9.1%	8.5%	8.2%	8.3%	5.4%	6.7%	6.4%	7.7%	7.6%
12 Month Rolling (IQPR)	7.7%	7.9%	7.9%	7.9%	7.9%	8.0%	8.0%	8.1%	8.0%	8.2%	8.1%	8.0%	7.9%
Trajectory (In Month)					9.1%	9.4%	8.2%	8.1%	8.0%	7.9%	7.8%	7.7%	7.6%

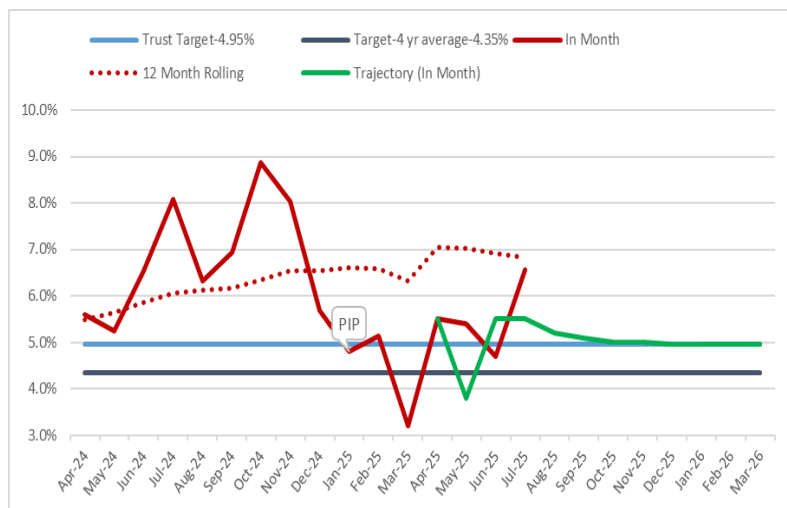
The above table RAG rating measures in-month performance against Trust target

Actions:

- 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. **M04 progress update:** the directorate has access to a workforce dashboard which all leaders can view. They can only accurately review and report data from two months prior because our workforce reporting date is later than that of other systems. Also awaiting benchmarking data for a comparison with similar trusts.
- To encourage more staff to become wellbeing champions across the directorate. **M04 progress update:** currently have 5 members of staff who have received the wellbeing ambassadors induction across the directorate, with a further 3 awaiting attendance.
- The associate director is looking at specific and targeted programmes of support in relation to musculoskeletal (MSK) and psychological support for the workforce. **M04 progress update:** Psychology sessions are offered to teams on a regular basis throughout the month. The MSK staff clinic pilot will be commencing shortly – targeting a couple of areas in the first instance.
- Associate director to monitor the progress of the staff survey implementation plan for 22024-25. **M04 progress update:** The time between completion of the survey to the release of the results is quite significant and does not allow for time to demonstrate any progression before staff are asked to complete the next survey. ACUC continues to deliver against the people promise, setting actions that are more achievable and meaningful to staff.
- Associate director to 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. **M04 progress update:** Ongoing improvement across the directorate with vacancy rate below target for the first time. The percentage of true vacancies whereby candidates not yet interviewed or recruited remains below the 10% target and has done for some time. Recruitment processes are delayed due to the additional scrutiny and monitoring required through establishment control panels.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Primary Care directorate



A PIP was requested in M10 (2024/25). The PIP trajectory was 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 and Primary Care directorate aims for the standard to be met in December 2025.

Sickness absence 12-month rolling period during M04 is 6.8% and 6.6% in-month. The in-month trajectory of 5.5% in M04 is not being met. The 4.4% 4-year average is not being met. The in-month <4.95% target is not being met. The 12-month standard is not being met.

Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	8.1%	6.3%	6.9%	8.9%	8.0%	5.7%	4.8%	5.1%	3.2%	5.5%	5.4%	4.7%	6.6%
12 Month Rolling	6.1%	6.1%	6.2%	6.4%	6.5%	6.5%	6.6%	6.6%	6.3%	7.1%	7.0%	6.9%	6.8%
Trajectory (In Month)										5.5%	3.8%	5.5%	5.5%

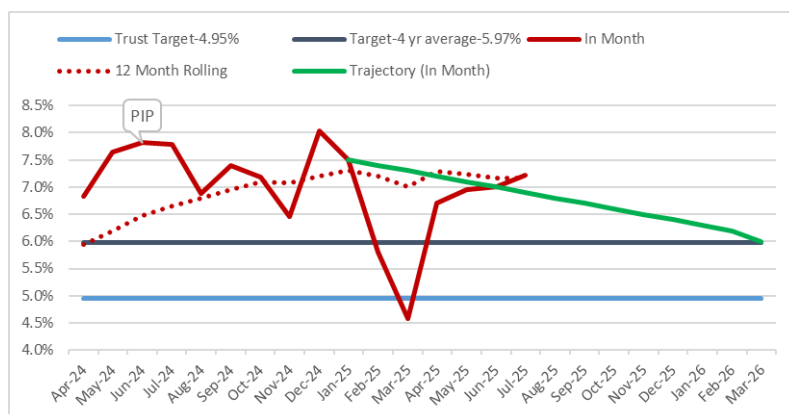
The above table RAG rating measures in-month performance against Trust target

Actions:

- Review staff survey results identifying key actions, focussing on specific teams with the highest levels of variation compared to trust averages. This is to collaborate with teams to identify key trends from the survey and actions to support the team. **M04 progress update:** dates booked with talking therapies (TT) team for focussed workshop and opportunity for feedback from the team.
- Supporting attendance at work clinics held with all line managers. **M04 progress update:** supporting attendance at work clinics continue with review of stages for team members, including reasonable adjustments.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Specialist Services directorate



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 M04 is 7.2% and 7.2% in-month. The in-month trajectory of 6.9% for M04 is not 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 M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	7.8%	6.9%	7.4%	7.2%	6.5%	8.0%	7.5%	5.8%	4.6%	6.7%	7.0%	7.0%	7.2%
12 Month Rolling	6.7%	6.8%	7.0%	7.1%	7.1%	7.2%	7.3%	7.2%	7.0%	7.3%	7.2%	7.2%	7.2%
Trajectory (In Month)							7.5%	7.4%	7.3%	7.2%	7.1%	7.0%	6.9%

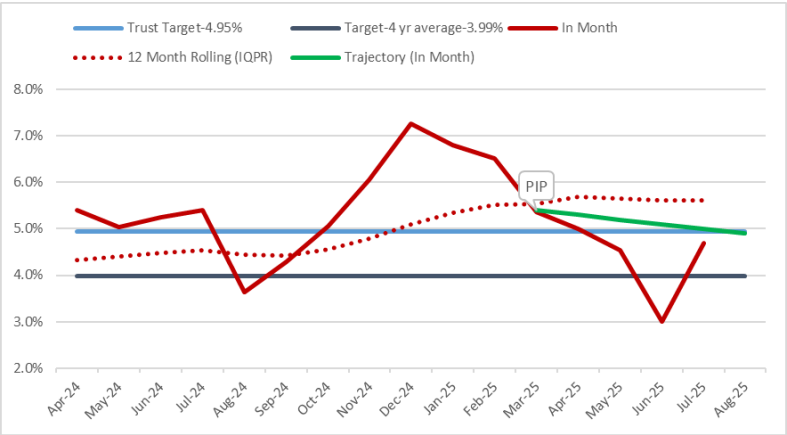
The above table RAG rating measures in-month performance against Trust target

Actions:

- Wellbeing schedule for 2025-26 to be developed and embedded ahead of new financial year. Staff wellbeing initiatives can help to reduce sickness episodes and improve morale and culture. **M04 progress update:** Action plan to be formulated.
- Redesign of directorate performance meetings will bring all teams in scope and will have sickness as a topic for discussion. This will reduce the need for duplication of the sickness surgeries and will give the team leads the opportunity to raise challenges and seek support. **M04 progress update:** Meeting booked for senior directorate team regarding the format of the new performance clinics to ensure all areas are captured and that we have whole directorate engagement.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Community directorate



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 M04 is 5.6% and 4.7% in month. The in-month trajectory of 5.0% in M04 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 rolling standard is not being met. The required standards have been met for the third consecutive month. Agreed at M04 Performance Review to close PIP as performance has been met for three consecutive months.

Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	5.4%	3.6%	4.3%	5.1%	6.1%	7.3%	6.8%	6.5%	5.4%	5.0%	4.5%	3.0%	4.7%
12 Month Rolling (IQPR)	4.5%	4.5%	4.4%	4.6%	4.8%	5.1%	5.3%	5.5%	5.5%	5.7%	5.7%	5.6%	5.6%
Trajectory (In Month)									5.4%	5.3%	5.2%	5.1%	5.0%

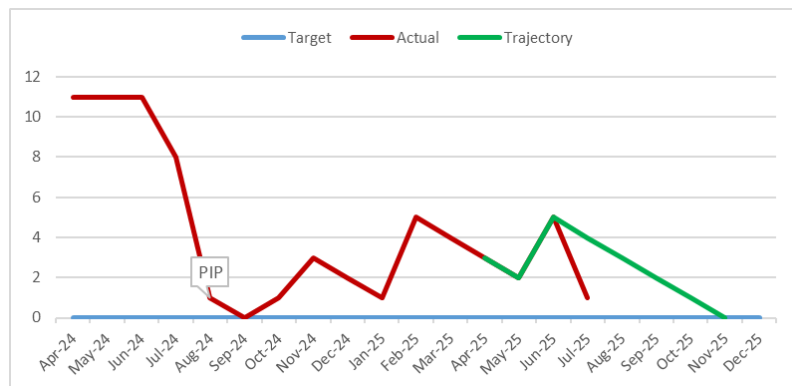
The above table RAG rating measures in-month performance against Trust target

Actions:

- Commenced workforce clinics for top 3 areas of high sickness. These are held with the service manager and 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. **M04 progress update:** Workforce clinics taking place with top 3 areas of sickness with HR, team leads and service managers.
- To ensure compliance with policy and this is managed in accordance with the supporting attendance at work. **M04 progress update:** 2 weekly catch-up with HR team to review absences.
- Well-being activities and team away days will be promoted and encouraged across the directorate.

Performance Improvement Plan: Complaints (Trust indicator)

Nursing and Quality directorate



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, then to July 2025, this has since been extended to November 2025.

During M04 there is **one** complaint exceeding the 40-day response timescale. Performance is meeting the required trajectory but not the required standard.

Updated actions have been received in M04.

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

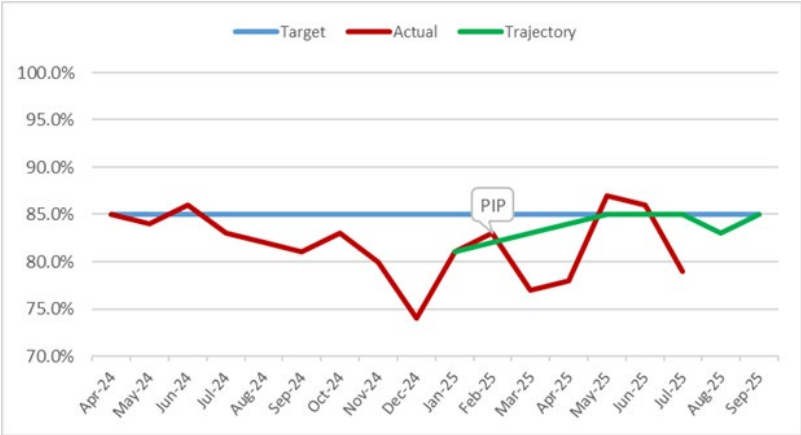
The above table RAG rating measures actual performance against Trust target

Actions:

- Accurate dates: Patient experience team (PET) / Quality Improvement Lead Nurse (QILN) monthly meeting reinforced ensuring consistent start/stop dates, especially for straightforward local resolution cases (often process or waiting-time related). Clock starts only when no local resolution opportunity exists.
- Backdating closures: For overdue complaints, stop clocks were backdated to the point the process was exhausted.
- Local resolution closures: Case has been resolved locally where the complainant did not respond, recognising that some complainants are satisfied without confirming, though PET seeks confirmation where possible.
- 'On hold' status: Clarified in PET/QILN meeting that when two directorates respond, only one associate director approval is required before submission to chief nursing officer (CNO).
- Parallel processes: Recognised the need for 'on hold' when complaints overlap with patient safety incident investigation (PSII), safeguarding, or other processes. Agreed to develop a process to ensure triangulated, consistent responses which will be taken to the clinical safety improvement group (CSIG), where a dashboard linking incidents, complaints, and safeguarding is in development.

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Community directorate



A PIP was issued in M10 (2024/25). Community Directorate aims to achieve the 85% standard by May 2025 this has been extended to September 2025. Trajectories were set in February 2025 covering the period January to July, these have been extended to September 2025.

Performance during M04 is at **79.0%** and is not meeting the planned 85.0% trajectory or 85.0% required standard.

Updated actions have been received in M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	83.0%	82.0%	81.0%	83.0%	80.0%	74.0%	81.0%	83.0%	77.0%	78.0%	87.0%	86.0%	79.0%
Trajectory							81.0%	82.0%	83.0%	84.0%	85.0%	85.0%	85.0%

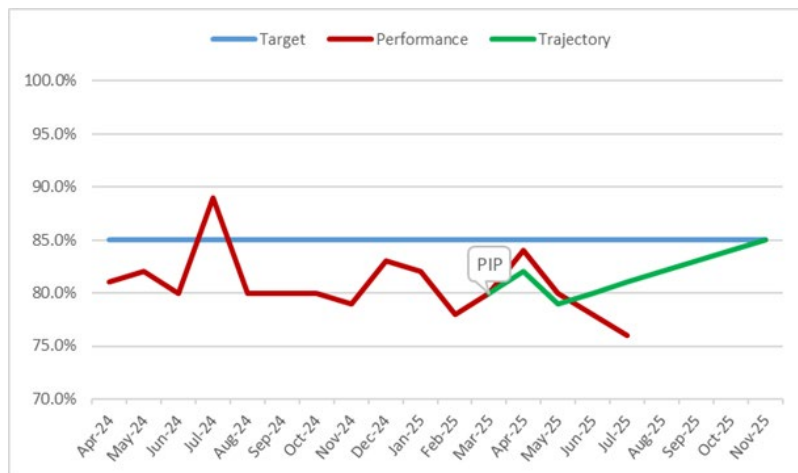
The above table RAG rating measures actual performance against Trust target

Actions:

- Weekly reports continue to be supplied to all team leads on supervision status for their respective areas.
- Productive time management and booking of supervision with supervisors to achieve performance target and ensure staff are receiving regular supervision sessions. **M04 progress update:** weekly status reports continue to be supplied to all team leads.
- Regular data cleansing to ensure accuracy of records complete and accurate. **M04 progress update:** Adult community mental health teams (CMHT's) team leads will ensure supervision is completed and recorded within appropriate time frames.

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Acute and Urgent Care directorate



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, this has been extended to November 2025. M02 trajectory has been revised from 85.0% to 79.0%.

Performance during M04 is **76.0%**, which is not meeting the 81.0% planned trajectory or 85.0% required standard.

Updated actions have not been received in M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	89.0%	80.0%	80.0%	80.0%	79.0%	83.0%	82.0%	78.0%	80.0%	84.0%	80.0%	78.0%	76.0%
Trajectory									80.0%	82.0%	79.0%	80.0%	81.0%

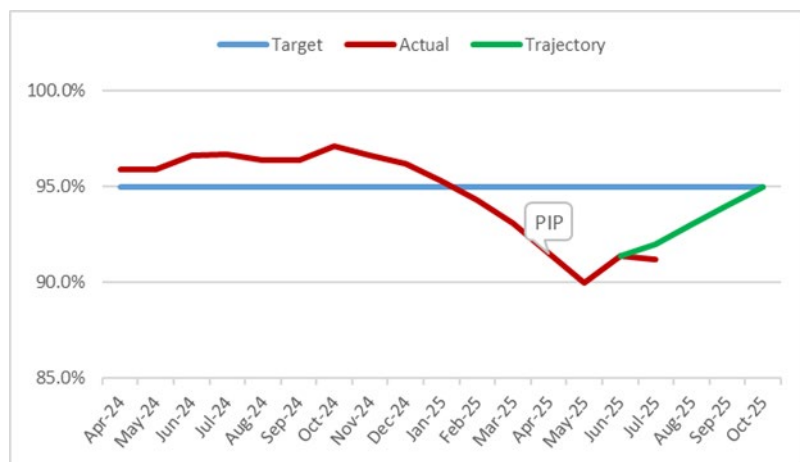
The above table RAG rating measures actual performance against Trust target

Actions:

- To 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. **M04 progress update:** The validity and accuracy of the data regarding learning management system (LMS) remains a concern. Reporting is currently only at one moment in time and ACUC are unable to pull reports. Continues to be monitored at team level through to leadership workforce and performance monitoring clinics.
- To ensure crisis resolution and home treatment review their current supervision structure and 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. **M04 progress update:** timescale extended due to sickness within the leadership team and ongoing increase in demand, however a PIP for the team has now been issued.
- For the associate director to establish contact with staff who remain non-compliant for 2 consecutive months. **M04 progress update:** Reporting is currently only at one moment in time and we are unable to extract reports. Associate director to discuss further with people directorate as there is no capacity within the existing workforce team to collate the data for consecutive months.
- Discussion to be held with a view to removing the 'written copy mandated question' as part of the recording of clinical supervision. Associate director to pick up with people, nursing, and quality. **M04 progress update:** completed.

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services directorate



A PIP was issued in M01 (2025/26). Trajectories have been set in M03 with the aim to achieve the required standard by October 2025.

Performance during M04 is at **91.2%** and is not meeting the 92.0% planned trajectory or 95.0% required standard.

Updated actions have not been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-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	96.7%	96.4%	96.4%	97.1%	96.6%	96.2%	95.3%	94.3%	93.1%	91.5%	90.0%	91.4%	91.2%
Trajectory												91.4%	92.0%

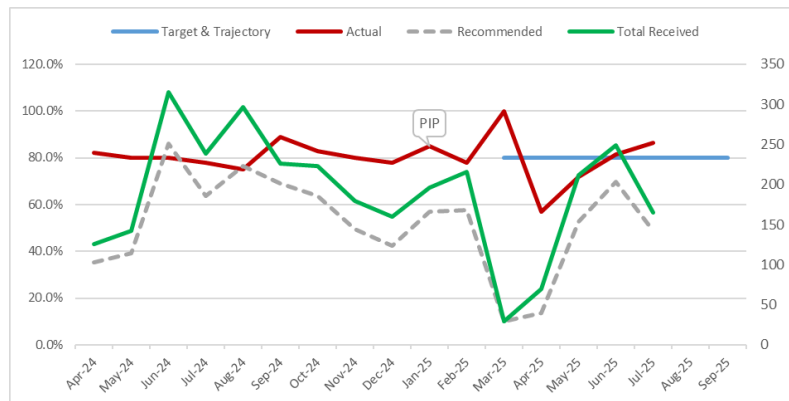
The above table RAG rating measures actual performance against Trust target

Actions:

- Review to be completed for each service area to establish transition progress to the new care plan and how this is impacting on performance reporting and on patient care. **M04 progress update:** Services reviewed and are at various stages of and confidence in implementation.
- Learning disabilities (LD) services - wider engagement with teams to be promoted and ensure attendance at performance clinics is prioritised. **M04 progress update:** New service manager to commence in community teams in M05. New performances clinics to be launched in September 2025 with a wider scope of team leads included.
- Neuropsychiatry and psychology - review of triage process in light of the care plan changes there may be potential to triage patients differently. Additional support to be offered to the team regarding move to new care planning pathway. **M04 progress update:** Review of triage processes. Additional support from senior management during transition to new care planning process.

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

Nursing and Quality directorate



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 M04 is **86.4%** and is meeting the 80.0% required standard. There have been 165 friends and family responses received, of which 142 have provided feedback on their experience of our service as being very good or good.

Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Target & Trajectory									80.0%	80.0%	80.0%	80.0%	80.0%
Actual	78.0%	75.0%	89.0%	83.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%	81.5%	86.4%
Recommended	186	223	201	186	144	124	166	168	29	40	154	203	142
Total Received	238	297	226	223	179	160	196	216	29	70	212	249	165

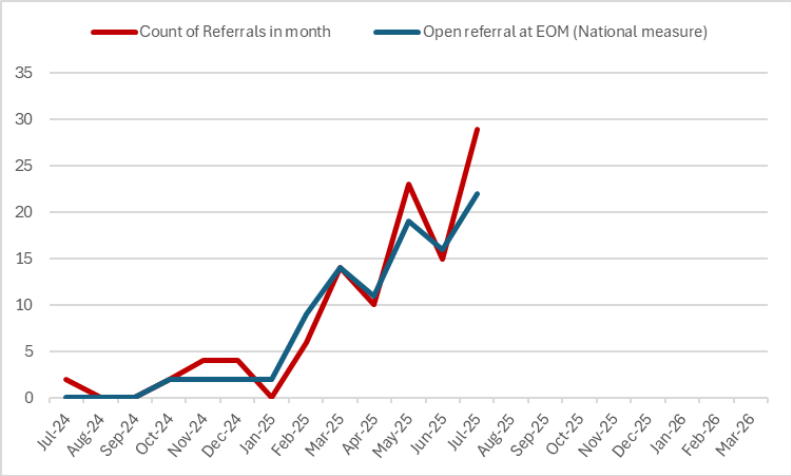
The above table RAG rating measures actual performance against Trust target

Actions:

- Ensure all feedback cards and posters are visibly displayed in clinical areas, near the exits. Increase response rate from cards, website, and quick response (QR) code via raising awareness to directorate leads, (change from smart survey to Microsoft forms). Reports to directorates showing their response rates. **M04 progress update:** due to absence in the team, support is being provided by a volunteer for this ongoing action.
- Review inclusion/exclusion criteria, against the NHSE friends and family test (FFT) standards. This may impact on our position going forward and the below actions in the new proposal. **M04 progress update:** exclusion criteria: all emergency portals e.g. crisis care centre (CCC) and child and adolescent mental health services (CAMHs). Inclusion criteria for texting: those discharged from the trust. Inclusion criteria for all other forms of FFT, anyone that completes it, regardless of specified timeframe.
- Develop a standard operating procedure (SOP) that includes general practitioner (GP) process for FFT, as these differ from the rest of the organisation (June 2025). **M04 progress update:** SOP has been finalised. Action closed.

Performance Improvement Plan: Out of Area Placement (National indicator)

Acute and Urgent Care and Community directorates



A PIP has been requested in M04 (2025/26).

Performance during M04 is 29 OOAs in month and 22 OOAs at end of month (national measure).

Updated actions have been received for M04.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Count of Referrals in month	2	0	0	2	4	4	0	6	14	10	23	15	29
Open referral at EOM (National measure)	0	0	0	2	2	2	2	9	14	11	19	16	22

Actions: Acute & Urgent Care-

Optimising bed management and improving patient flow

- To maintain the average length of stay (LoS) for new patients in adult acute beds at the lower end of our current range (20–30 days). **M04 progress update:** length of stay (LoS) for out of area (OOA) placements is also being monitored ensuring these are also below national average.
- Embed the red to green system as a core component of the daily bed flow and management process. **M04 progress update:** embedded and effective
- Ensure daily bed flow meetings are attended by professionals representing all stages of the patient pathway to support coordinated decision making and timely transitions. **M04 progress update:** Embedded and effective—these take place at 12.30 each day.

Actions: Acute & Urgent Care-

- Undertake a comprehensive review of the crisis resolution home treatment team's capacity to ensure gatekeeping decisions are clinically appropriate and effective. Assess whether the team can safely absorb additional demand to reduce avoidable admissions and support care closer to home.
- Continue to monitor the clinically ready for discharge (CRFD) position regularly, recognising its influence on local bed availability and overall patient flow. Use this data to identify barriers to discharge and inform targeted interventions to release bed capacity. **M04 progress update:** embedded with reviews throughout each week. Appropriate escalations made through to the integrate care board (ICB) either through the daily system calls when appropriate or directly to the mental health portfolio lead.
- Promote effective and timely cross directorate working to review and streamline care pathways for both new and existing patients who may require admission. This collaborative approach will support improved efficiency, reduce delays, and ensure patients receive the right care in the right setting at the right time. **M04 progress update:** first meeting took place 25 July 2025. Additional roles reimbursement scheme (ARRS), Talking Therapies, community mental health teams (CMHT) representation, Acute & Urgent Care, – processes, pathways and gaps identified.
- Explore the establishment of an out of area placement review panel to complement the existing weekly acute bed management meetings. This panel would provide additional oversight and scrutiny of OOA placement decisions, ensuring they are clinically justified, time-limited, and aligned with national reduction targets.

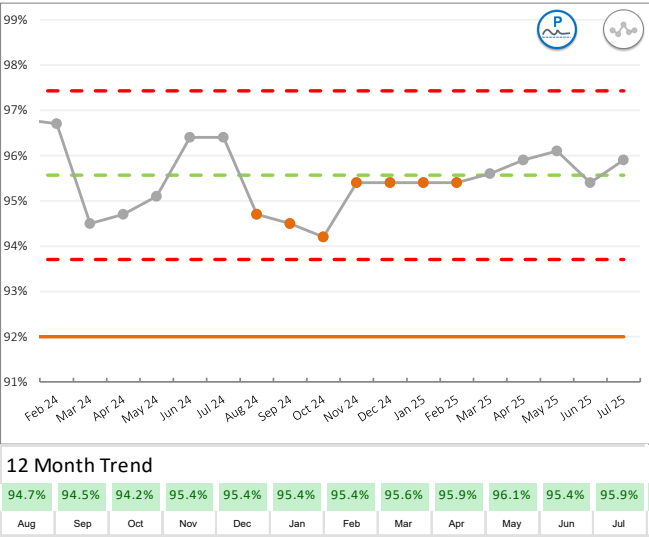
Actions: Community-

- **Pre-discharge engagement:** CMHTs start community engagement before discharge (ward visits where appropriate, attendance at multidisciplinary team (MDTs) to ensure continuity of care.
- **Step-Up to CRHTT:** CMHTs working to strengthen links with crisis resolution and home treatment team (CRHTT) to offer rapid step-up care in the community. Attending urgent care interface weekly.
- **Enhanced crisis planning:** CMHTs are working with service users and carers to develop robust, co-produced crisis and contingency plans.
- **Allocation of key workers:** Prioritise allocation of key workers for inpatients to avoid delays in discharge planning.
- **Identification of patients for repatriation:** CMHTs are supporting to identify patients for repatriation to local beds.

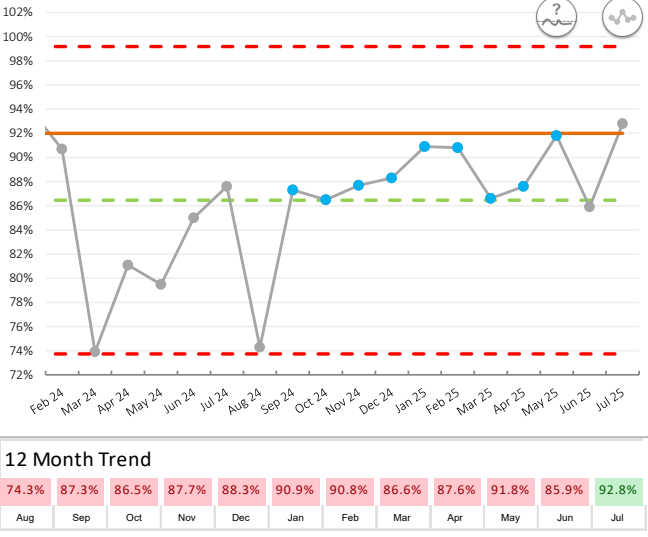
Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

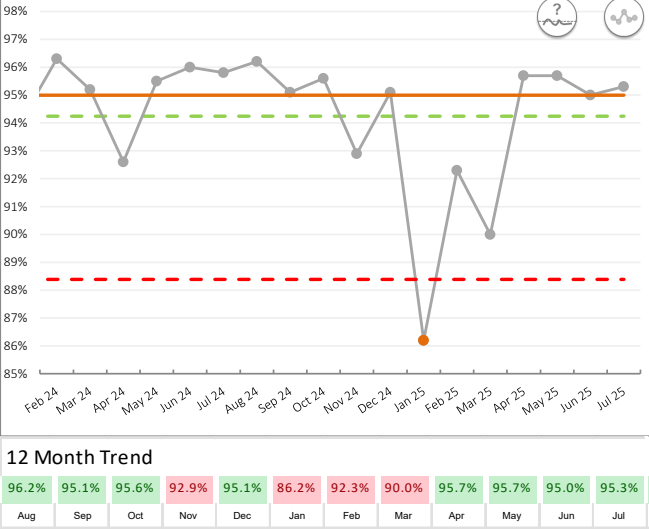
Referral to Treatment 18 Weeks (Trust indicator)



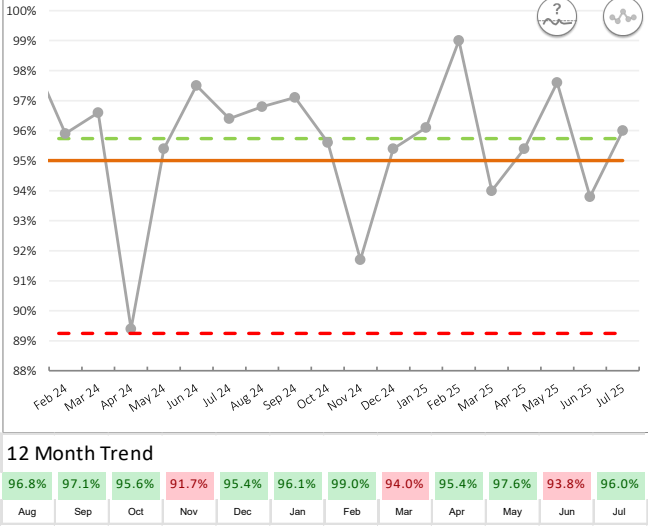
CAMHS 18 week wait Referral to Treatment (Trust indicator)



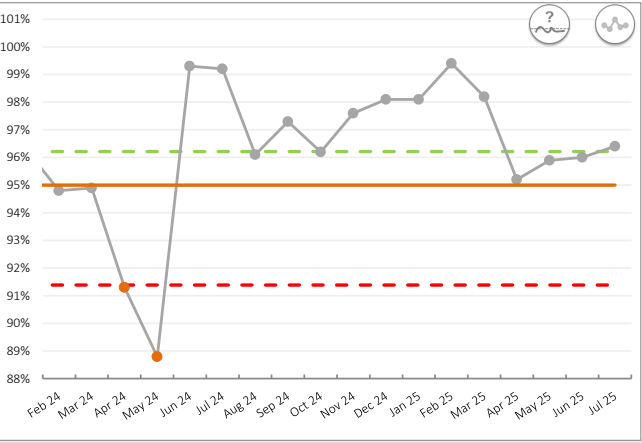
MHLT 1 hour (Emergency) (Trust indicator)



MHLT 4 hour (Urgent) (Trust indicator)



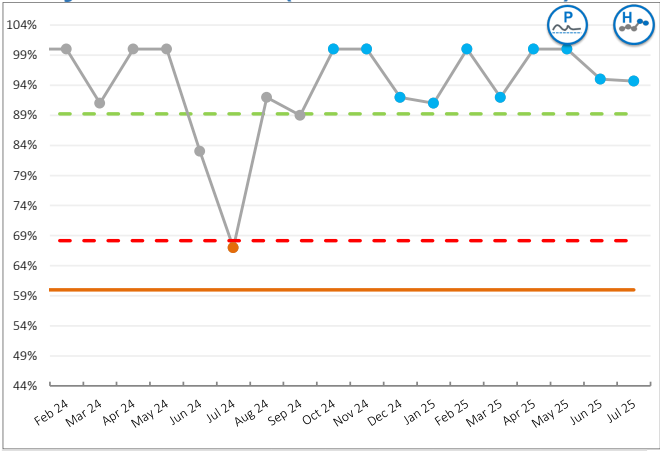
MHLT 24 hours (Routine) (Trust indicator)



12 Month Trend

96.1%	97.3%	96.2%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%	96.0%	96.4%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

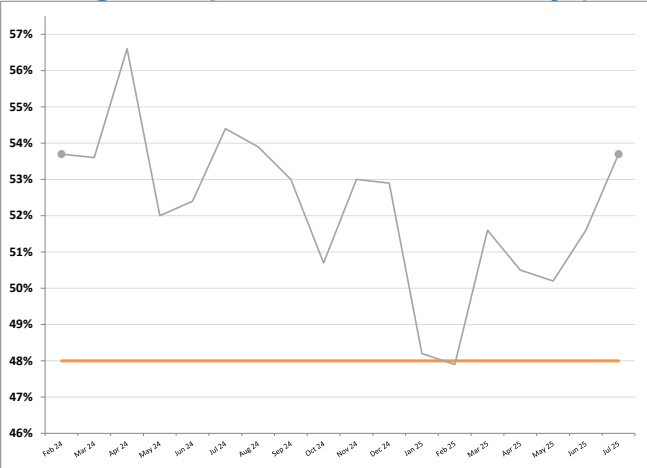
Early Intervention (National indicator)



12 Month Trend

92.0%	89.0%	100.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%	95.0%	94.7%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

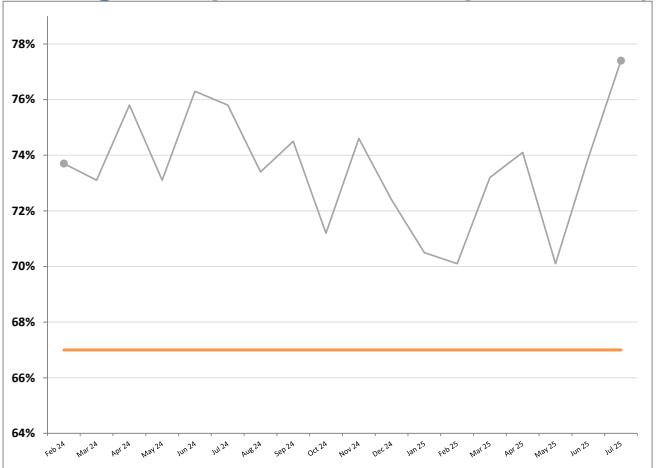
Talking Therapies: Reliable Recovery (National indicator)



12 Month Trend

53.9%	53.0%	50.7%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%	51.6%	53.7%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

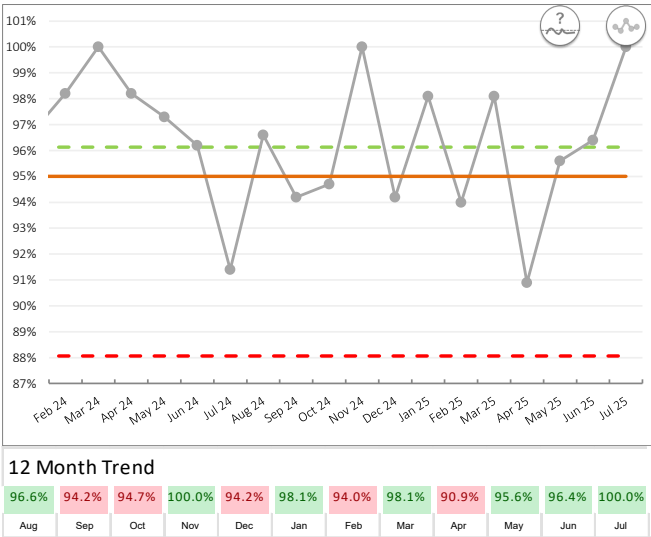
Talking Therapies: Reliable Improvement (National indicator)



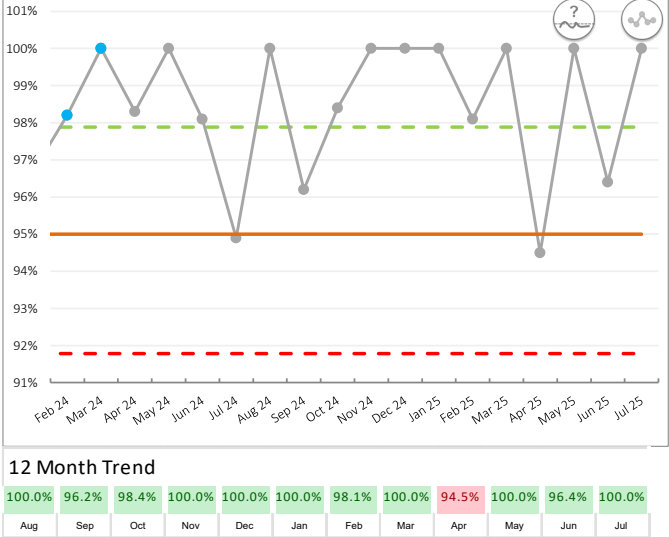
12 Month Trend

73.4%	74.5%	71.2%	74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%	73.9%	77.4%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

48 Hour follow up (Trust indicator)

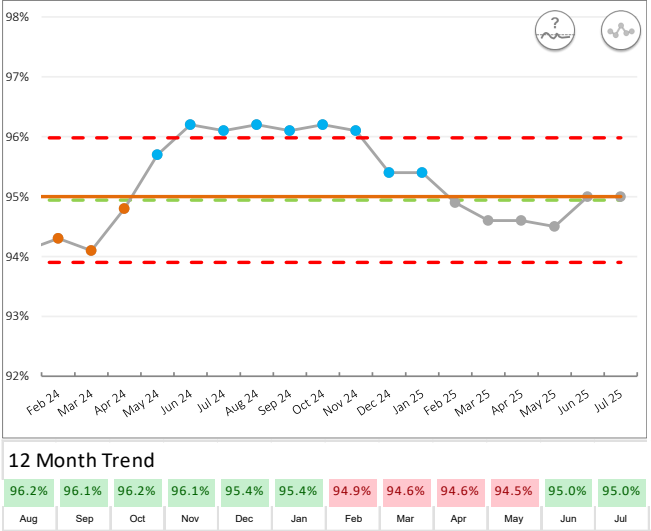


7 day follow up (Trust indicator)

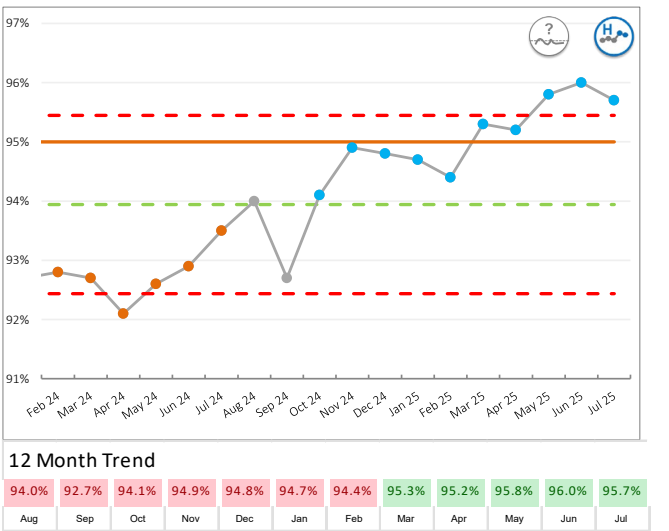


Core Indicators – SPC Trend (Community and Quality)

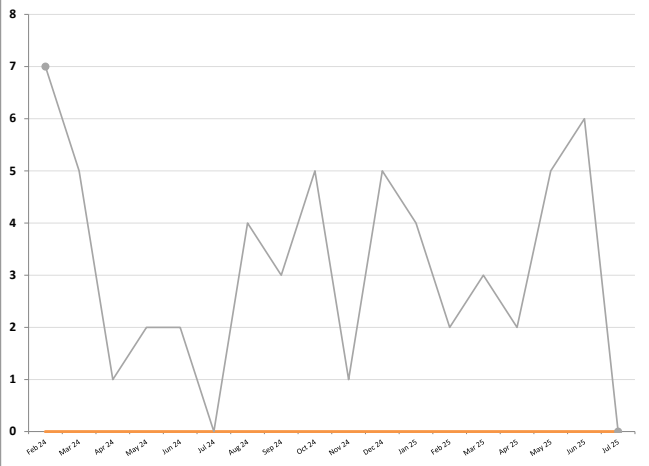
Care Plan Compliance (Trust indicator)



Risk Assessment Compliance (Trust indicator)



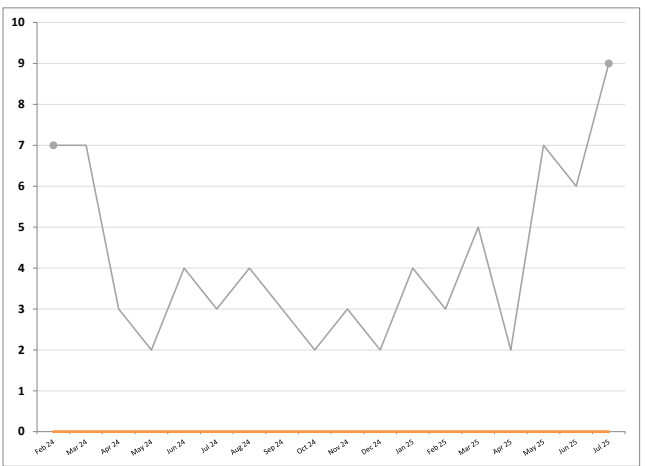
Comprehensive Safety Review (Trust indicator)



12 Month Trend

4	3	5	1	5	4	2	3	2	5	6	0
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Proportionate Review (Trust indicator)

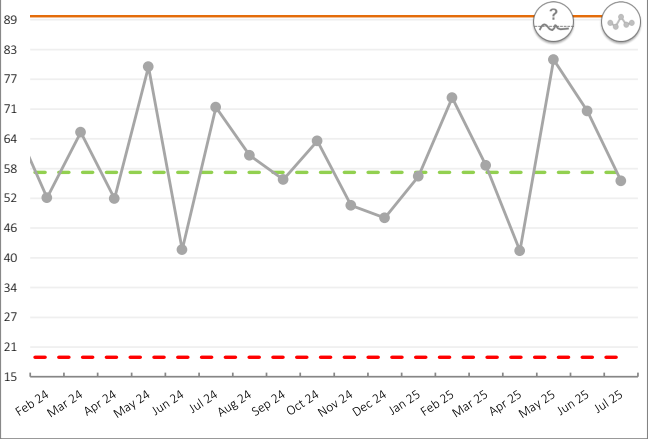


12 Month Trend

4	3	2	3	2	4	3	5	2	7	6	9
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Core Indicators – SPC Trend (Inpatient and Quality)

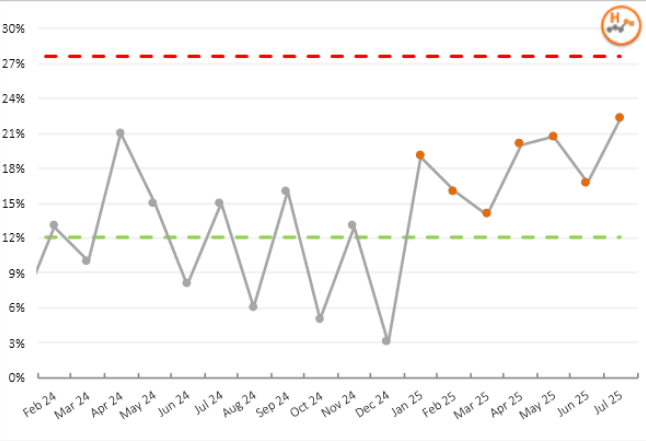
Average Length of Stay-Older Adult (Trust indicator)



12 Month Trend

61	56	64	51	48	57	73	59	41	81	70	56
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

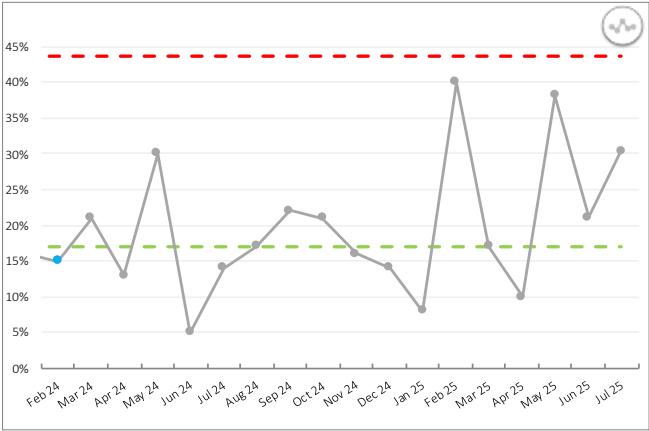
Adult Acute LoS-Over 60 days (National indicator)



12 Month Trend

6.0%	16.0%	5.0%	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%	16.7%	22.2%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

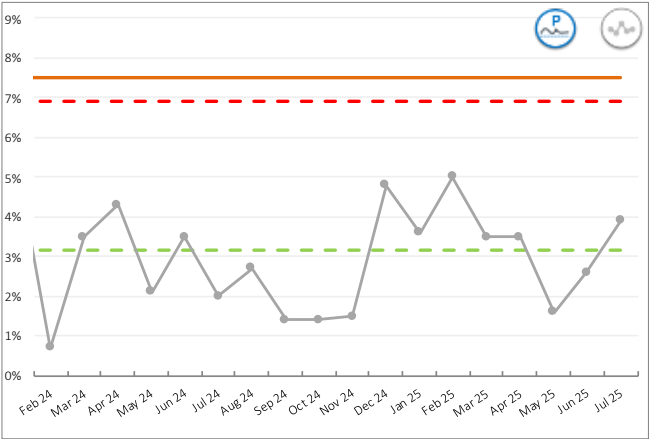
Older Adult Acute LoS-Over 90 days (National indicator)



12 Month Trend

17.0%	22.0%	21.0%	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%	21.1%	30.4%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

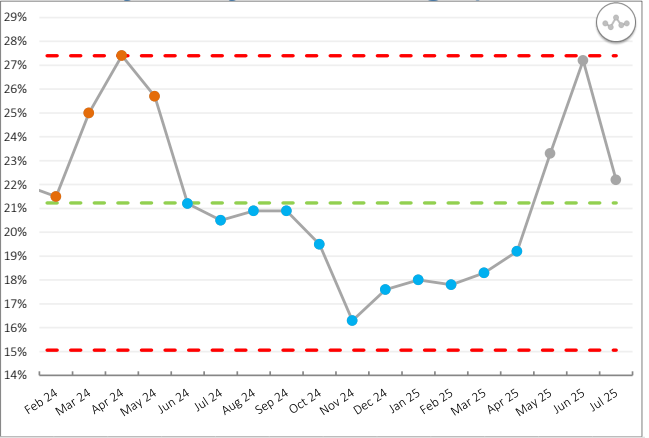
Emergency Readmissions (Trust indicator)



12 Month Trend

2.7%	1.4%	1.4%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%	2.6%	3.9%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Clinically Ready for Discharge (Trust indicator)

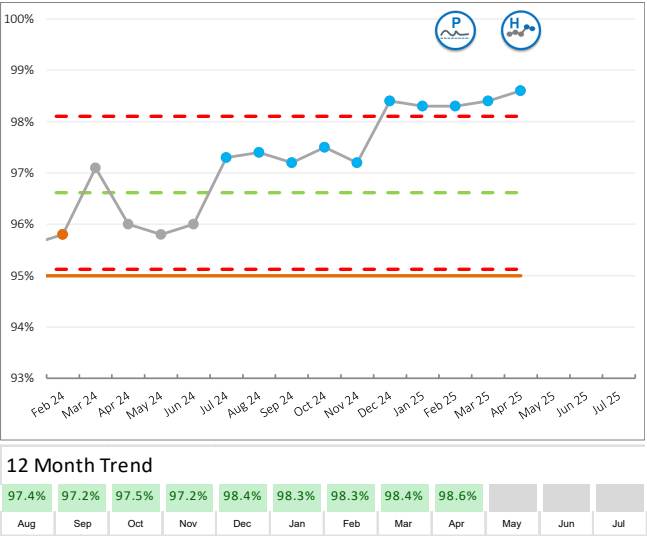


12 Month Trend

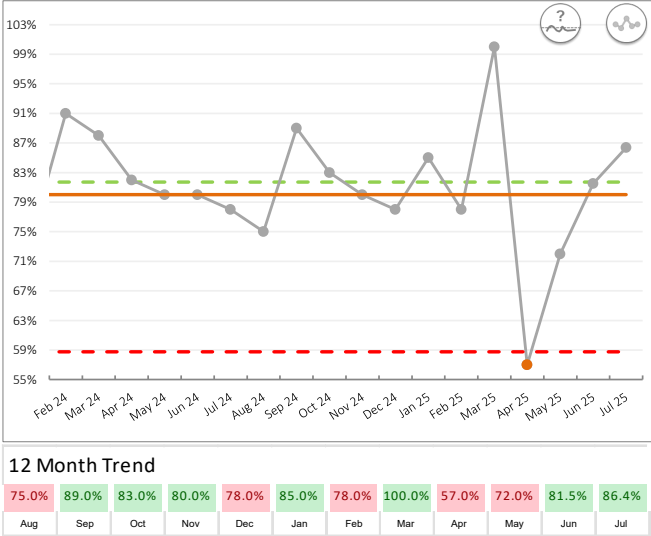
20.9%	20.9%	19.5%	16.3%	17.6%	18.0%	17.8%	18.3%	19.2%	23.3%	27.2%	22.2%
Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Core Indicators – SPC Trend (Organisational Health)

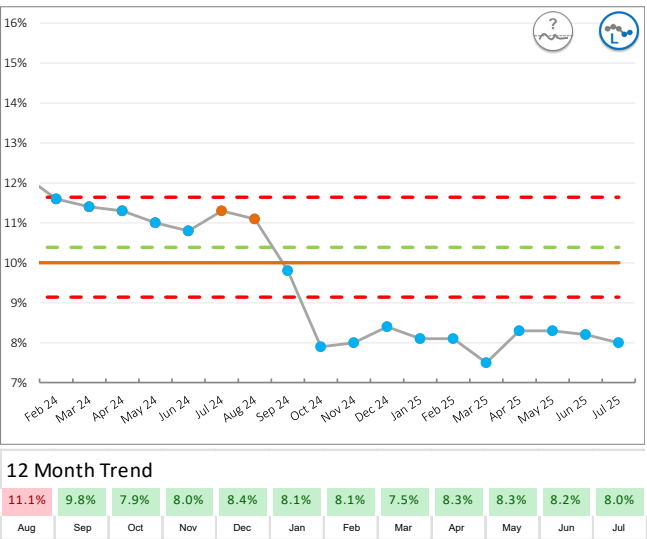
DQMI (National indicator)



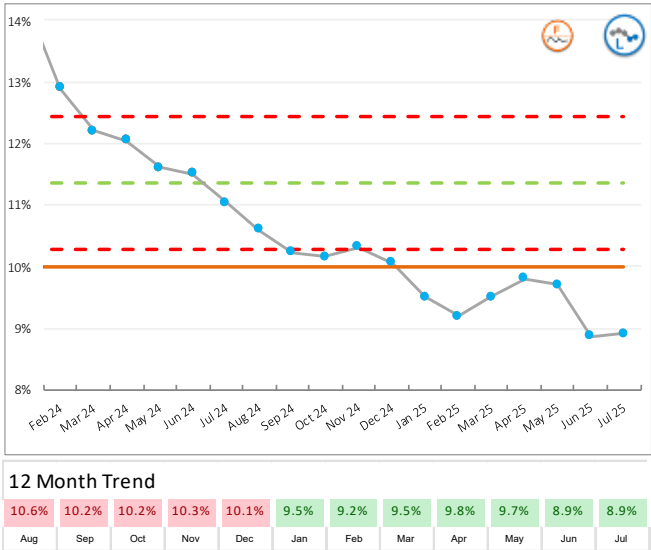
Friends and Family Test (National indicator)



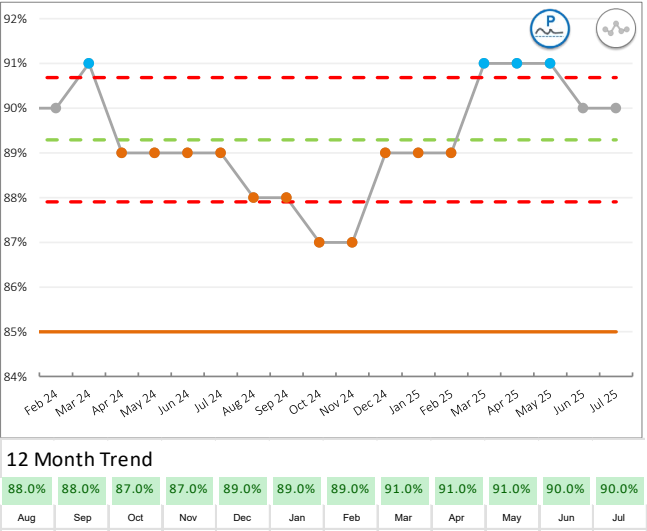
Vacancy Rate (Trust indicator)



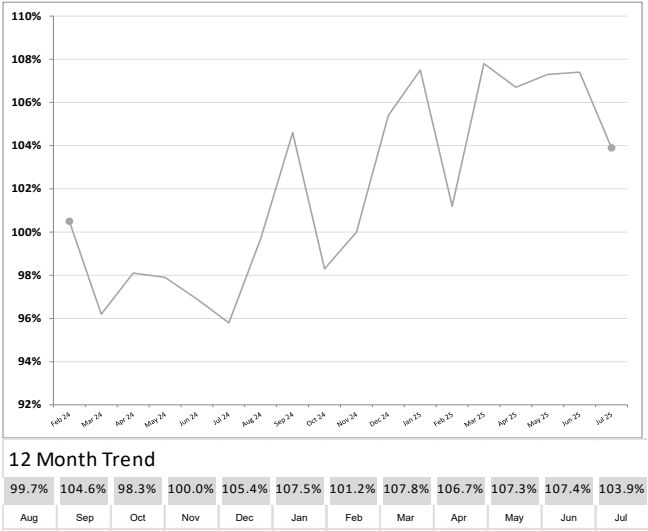
Staff Turnover (Trust indicator)



Statutory and Mandatory Training (Trust indicator)



Safe Staffing (Trust indicator)



Enclosure No: 10

TRUST BOARD ASSURANCE REPORT FROM THE PEOPLE, CULTURE & DEVELOPMENT COMMITTEE

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

Presented by:	Russell Andrews, Committee Chair / Non-Executive Director
Prepared by:	Vicky Self, 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 in line with our Inclusion work programme.
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	11.09.2025

Trust Board Assurance Report from the People, Culture and Development Committee meeting held on 1st September 2025

Introduction:

This assurance report is produced following the latest PCDC, which was held on Microsoft Teams and was quorate for the first 90 minutes (of 180 minutes) of the meeting, and no approvals were required after this point. 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: The video story was presented as winner of Chairs award at REACH 2024. The story illustrated the engaging leadership approach that led to improved outcomes for the service. The discussion recognised the value of prioritising wellbeing and connection within the team. The Committee concluded that this approach to leadership should be harnessed across the Trust which will be a primary focus in the refresh of our people priorities.

Performance:

- **Sickness and Wellbeing** – Despite small incremental improvements in absence levels over recent months compliance against the Trust's 12m rolling sickness absence target of 4.95% has not been achieved since June 2023 with a reported in month sickness absence rate for July '25 standing at 6.24% in contrast to 5.30% in the previous year. There has been an increase in the number of calendar days lost to sickness absence of 28.72% on the previous reporting year, with an estimated cost of over £4m (excluding on-costs and backfill). The split of Long Term (LTSA) and Short Term (STSA) is 70/30% (respectively). Mental Wellbeing related sickness absence continues to be the highest reason for sickness absence within the Trust. The Trust's Health and wellbeing offer, current sickness management strategy and policy will be reviewed with a detailed rectification plan coming to PCDC for assurance.
- **Employee Relations** Formal ER Activity continues to remain high and complex in nature which is impacting timescales for Policy development. However, all policies remain legally compliant. A renewed focus on more effective restorative people management approaches is expected to mitigate issues in this area by improving capacity, timescales and outcomes.
- **Appraisal** and clinical supervision performance have further declined during M04 (81.0% and 79.0% respectively) and are not meeting the required 85% standard. There are a number of issues linked to the use of the LMS system which are impacting on timeliness of recording and will be rectified through the move to ESR as a central system for recording. Nonetheless there continues to be a focus by managers supported by the people team on ensuring completion along with quality of appraisal and supervision.

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

The Committee is asked to note the updates provided and seek further clarification where required.

Horizon scan: key activity in relation to the Chief People Officer portfolio was presented, with discussion in relation to the potential risk from the national job profile review (nursing and midwifery band 4 to band 8a), the impact of change in organisational structure for Occupational Health provider Optima and a planned deep dive session for the 29th September PCDC to review progress and next steps for the Trust's People Plan.

Being open report: a summary of raising concerns activity during quarter one 2025/26 identified key priority areas for organisational development work to support improving relationships between colleagues.

Inclusive Recruitment: an update on the process for embedding inclusive recruitment; leading to a Committee discussion on moving from process to culture change with inclusive actions.

Widening Participation and apprenticeships: update on the status, recent activity and future plans for widening participation, including the nationally led work around T Levels.

Health and wellbeing report: Outlining delivery against the health and wellbeing plan and planned response to funding challenges.

Achievements with embedding a just and learning culture: Noting the key achievement and next steps.

Progress with the Affina OD programme: Noting the key dates for implementation and discussion in relation to sustainability.

People Operations Annual Report: In line with national trends, employee relations (ER) activity has increased significantly across case types in 2024/2025. Compared to the previous year we have seen:

- A 28% rise in disciplinary fact-finds
- A 52% increase in formal disciplinary cases
- A 28% rise in grievances
- A 50% increase in safeguarding incident meetings (People/Safeguarding teams)
- A 100% increase in employment tribunal cases

This upward trajectory reflects a broader shift in the ER landscape. A review of People Team priorities, working practices and the target operating model for the team will support management of these issues.

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 and were assured on the process of management.

Performance:

- Improvements in Staff turnover are maintained at 8.9% during M04 meeting the <10.0% threshold.
- The vacancy rate has improved in M04 to 8.0% and is within the <10.0% threshold.

- Statutory and mandatory training has remained static at 90% in M04 but is meeting the standard.
- Time to hire for Q1 is at 57.2 working days, which is an increase of 1.4 days from Q4. However, performance remains within our target KPI of 60 working days.

Communications Delivery Plan Update – Quarter 1: Updates received under consent item for assurance/information.

- **WRES report:** Updates received under consent item for assurance/information. Noting improvements in improving workforce diversity, advancing fairer recruitment and reducing disparities in disciplinary outcomes. Priorities for the future include addressing underrepresentation in access to wellbeing support, sustaining leadership development, delivering on pay gap and recruitment action plans.
- **WDES report:** Updates received under consent item for assurance/information. Noting improvements in disability inclusion, with workforce representation reaching its highest level, board diversity improving and disabled staff reporting better perceptions of equal opportunities and feeling valued. Capability cases also fell, and harassment, bullying and abuse (HBA) scores showed improvement. Priorities for the future include addressing recruitment equity and staff experience of HBA.

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

BAF/ PCDC Risk: The PCDC risks were reviewed. The Committee approved the following changes to risks:

Amended the title of risk number 900 along with the target completion date to align with programme of work.

Risk 900 – title amended.

Risk 12 – title amended and score reduced.

Risk 2055 – achievement date amended.

Risk 1948 was recommended to change the impact score, but the Committee agreed to explore this further.

Policies: No policies were submitted for approval, review or extension.

Next Steps (including timeframes):

The next PCDC business meeting will be held on: 3rd November 2025.

Committee Chair: Russel Andrews, Vice Chair of the People, Culture & Development Committee

REPORT END

Enclosure No: 11a

Workforce Race Equality Standard (WRES) Final Submission

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

Presented by:	Frieza Mahmood, Chief People Officer
Prepared by:	Janice Ogonji, Inclusion and Belonging Lead
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:	N/A
Diversity & Inclusion Implications	The 2025 WRES report supports compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED) and offers evidence to inform the Trust's wider EDI strategy on race inclusion.
ICS Alignment / Implications:	The Trust's progress in workforce diversity, fairer recruitment, reduced disciplinary disparities, and above-average board representation supports ICS priorities on equality and inclusion. However, ongoing challenges with harassment, discrimination, and inconsistent perceptions of career progression show that cultural improvements are not yet embedded. Continued ICS-wide collaboration, shared learning, and targeted interventions will be vital to sustain progress and close remaining gaps.

Recommendation / Required Action	1. Acknowledge the findings as a key driver for the Trust's Inclusion and Belonging Action Plan, ensuring alignment with wider ICS priorities. 2. Support sustained cultural change by strengthening anti-harassment measures and embedding cultural competence across the organisation. 3. Promote equitable career pathways by connecting Trust talent development initiatives with ICS-wide leadership programmes. 4. Leverage the diversity of the Trust Board to champion and share best practice on equality and inclusion across the ICS.
Executive Summary	This report provides assurance on the Trust's performance against the NHS WRES indicators for 2025 (covering 1 April 2024 – 31 March 2025). It outlines key findings, areas of improvement and concern, and the actions required to meet statutory duties under the Equality Act 2010. In 2025, the Trust made notable progress in improving workforce diversity, advancing fairer recruitment, and reducing disparities in disciplinary outcomes. Some actions could not be completed due to capacity constraints and have been carried forward into the 2025/26 plan, which is aligned with ICS priorities and delivery capability. Overall, the Trust is embedding anti-racist practice, strengthening accountability and transparency, and supporting the development of Global Majority staff. Priorities going forward include addressing underrepresentation in access to wellbeing support, sustaining leadership development, and delivering on pay gap and recruitment action plans. What's Improved: • Workforce Diversity: 13.21% global majority staff in 2025, up from 11.11% in 2024, exceeding local population benchmark of 11.2%. • Disciplinary: Likelihood of Global Majority staff entering disciplinary action fell to 0.41 in 2025, down from 1.83 in 2024, and from 10.52 in 2018. This is based on a very small data set. • Training Access: Training access ratio slightly increased to 0.79 in 2025 from 0.74 in 2024. • Board Representation: 30.77% of board members were from Global Majority backgrounds in 2025, up from 14.3% in 2024, exceeding the national NHS average of 16.5%. Deterioration in Performance: • Recruitment: White-to-Global Majority recruitment ratio increased slightly to 1.23 in 2025 from 1.21 in 2024, showing a small widening after earlier improvements. This means

white applicants are more likely to be recruited than global majority applicants.

- Harassment from Patients/Public: Reports increased to 39.5% in 2025 from 30.21% in 2024 for Global Majority staff; White staff reports rose slightly to 21.75% from 24.6% in 2024.
- Harassment from Staff: Global Majority staff reports rose to 23.01% in 2025 from 20.83% in 2024; White staff remained steady at 16.22% in 2025 vs 16.13% in 2024.
- Career Progression: 68% of Global Majority staff felt progression opportunities were equal in 2025, up slightly from 67.33% in 2024; White staff dropped to 52% in 2025 from 62.77% in 2024.
- Discrimination: Reports rose in 2025 to 19.47% from 12.8% in 2024 for Global Majority staff, and to 5.8% from 5.2% for White staff.

Progress on WRES in 2025

The Trust has advanced race inclusion through a wide range of actions, including embedding accountability for EDI within executive leadership, publishing the first Ethnicity Pay Gap report with an action plan, and strengthening workforce development through positive action, mentoring and system-wide anti-racist leadership programmes. Recruitment processes are being reviewed to tackle bias, while the ENRICH network and Inclusion Trailblazer project continue to influence change. Staff wellbeing support remains strong but shows underrepresentation of minority groups, highlighting a need to address barriers. Awareness has been raised through cultural events, the launch of resources such as the Anti-Racism Toolkit, and initiatives like “See Me First” badges.

Overall, progress is evident in building an inclusive culture, increasing transparency, and supporting Global Majority colleagues, with future focus on addressing access gaps, sustaining leadership development and delivering on pay gap and recruitment commitments.

WRES Priorities for Action for 2025–26:

The WRES action plan is part of the Trust four-year Inclusion and Belonging Strategy (2024–2028) aligned with the Trust’s Equality Objectives for the same period. Key priorities include debiasing people processes especially recruitment, talent management and performance management with a focus on race inclusion. An ongoing two-year programme is supporting embedding a just and inclusive culture, alongside reforms to recruitment and leadership development aimed at tackling bullying and harassment. The Trust also plans to improve the timeliness and effectiveness of workplace adjustments. Progress is monitored and reported annually.

Next steps

1. Deliver the 25/26 action plan with a focus on embedding cultural change, strengthening career progression, and leveraging

	diverse leadership. 2. Integrate key WRES actions into existing EDI and workforce plans to track progress efficiently and avoid duplication. 3. Use existing communication channels to promote awareness of workplace adjustments and inclusive behaviours. 4. Engage the ENRICH Staff Network to capture global majority staff feedback and feed insights into workforce and EDI planning. 5. Monitor progress through the EDI workforce dashboard and quarterly reporting, sharing best practice across the ICS to support system-wide improvement.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	26.8.25
V1	PCDC	01.09.25
V1	Public Trust Board	01.09.25

Workforce Race Equality Standard (WRES)

Trust Report 2025 & Action Plan for 2025-26



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Date: 8 August 2025

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WRES KEY FINDINGS

REPRESENTATION

GMH staff hit a record 13.21%, above local rates — but mostly in medical roles (60.27%). Non-clinical sits at 6.1%, nursing stalls beyond Band 5.



RECRUITMENT

GMH applicants drop from shortlist to hire; White colleagues are more likely to be appointed



PROGRESSION

GMH staff confidence in promotion fairness down, 17% gap vs White colleagues — biggest yet.



DISCRIMINATION

1 in 5 GMH staff face discrimination — 6% above national average, gap with White staff widens.



GMH – Global Majority Heritage

Executive summary

This tenth annual Trust WRES Report and associated action plan is produced in compliance with the NHS Standard Contract, for publication and national benchmarking. Overall, the Trust has seen a continued general improvement annually in our WRES indicators on an annual basis since the WRES was introduced. However, this year we see indications of a slowing rate of progress and decline in some key measures.

What's Improved:

Improved on 4 measures, including:

- ✓ Overall Global Majority workforce representation
- ✓ Disciplinary measure
- ✓ Accessing non-mandatory training and CPD
- ✓ Trust Board Global Majority representation

What's Worse:

Worse on 5 measures, including:

- ! Recruitment score
- ! Harassment, bullying or abuse (HBA) by patients/public
- ! Harassment, bullying and abuse from staff
- ! Belief in equal opportunities for career progression
- ! Discrimination at work from a manager/team leader or other colleagues

Key Messages

1. Global Majority representation in the workforce has increased showing progress from last year.
2. Board diversity has risen though this may be affected by a small overall board size.
3. Access to development opportunities has declined, with belief in fair progression falling along with confidence in equal opportunities for progression.
4. Reports of bullying, harassment, and discrimination from patients, staff, and managers have increased.
5. Fewer Global Majority colleagues are accessing non-mandatory training.

What we've done in 2025 (1 April 2024 to 31 March 2025)

Inclusion and Belonging remains a key area of focus as we continue to strengthen our culture of inclusion across the Trust by:

1. Continuing to remove bias from recruitment and selection processes.
2. Embedding our Anti-Racism approach across the organisation and systemwide.
3. Working to prevent and respond to racial violence, aggression and harassment against staff.
4. Strengthening accountability for EDI and race inclusion across all roles, with a focus on leadership responsibility.

What we'll do in 2025-26 (1 April 2025 to 31 March 2026)

In 2025-26, we will deepen our anti-racism and inclusion work by embedding it into daily practice, strengthening leadership accountability, and improving recruitment fairness. We will also centre staff voices and use data more effectively to drive action and respond consistently to racial violence and harassment.

NSCHT Workforce Race Equality Standard (WRES) Report 2025

1.0 Introduction

The Workforce Race Equality Standard (WRES) is a mandatory annual requirement under the NHS Standard Contract. We are accountable to NHS England, the Care Quality Commission (CQC) and our local Integrated Care Board (ICB) for meeting this obligation.

WRES helps us drive forward our ambition to create an inclusive workplace, as outlined in our Combined People Plan 2023-28 and our Inclusion and Belonging Strategic Plan 2024-28. It also supports our commitment to The RACE Code and allows us to track and benchmark our race inclusion performance against other NHS organisations nationally.

This report presents our Trust's tenth annual WRES performance, along with our action plan. It will be published on our website, shared with NHS England and our ICB commissioners, and may be reviewed during any CQC inspections. Our performance across the nine WRES indicators is shown through charts, tables, and narrative. We've included summary data on the ethnicity of our medical and bank staff for internal monitoring purposes.

1.1. Trust WRES 2025¹ summary performance

Findings suggest an overall positive trajectory in ethnic inclusion at the Trust, though peer relationships and reporting confidence need continued attention.

Some key highlights show:

1. Ethnic minority staff made up 13.21% of the workforce in 2025 (11.42% excluding medical staff). Board diversity also improved, rising to 30.77% from 21.43% in 2024.
2. Global majority applicants were 23% (approx.) up from 21% the year before.
3. Global majority staff facing disciplinary action dropped significantly, from 83% in 2024 to 41% in 2025, though this is based on a small data set.
4. Access to non-mandatory training improved for global majority staff in 2025.
5. Harassment and discrimination against global majority staff increased, with patient/public harassment rising to 39.47% and reported discrimination reaching 19.47%, over three times higher than for White staff. Confidence in equal opportunities among global majority staff also dropped to 51.75%.

¹ The reporting period for WRES runs from 1 April 2024 to 31 March 2025 and will be referred to as the 2025 reporting year. In relation to Staff Survey derived measure these relate to NHS Staff Survey from the previous year.

1.2 What we have been doing

Advancing race diversity and inclusion remained a key priority for the Trust throughout 2025 in alignment with the Combined People Plan 2023-28 and Inclusion and Belonging Strategic Plan 2024–28, which placed inclusivity and representation at its core.

Key achievements during 2025 included:

1. The Trust took a brave step in reviewing racial bias in recruitment after staff raised concerns. The reviews confirmed inequitable practices and validated staff experiences. Key recommendations were made to improve fairness, training and accountability. A co-produced action plan is now in place.
2. We developed more inclusive recruitment practices, informed by Roger Kline's work and lessons from NHS discrimination cases.
3. We launched our Anti-Racism Statement with ICS partners and began taking action, including setting EDI objectives for our executive team. Together, we are now developing an anti-racism toolkit for use across our system.
4. We strengthened our approach to preventing and responding to racial violence and harmful behaviours through our Just, Fair and Restorative Culture programme.
5. We supported leaders to take greater ownership of their EDI data and made race inclusion a shared responsibility.

This work is continuing in 2025-26 reporting period. Further progress on this year's actions is outlined in Section 4.0 and Appendix 1.

1.3 Our priorities

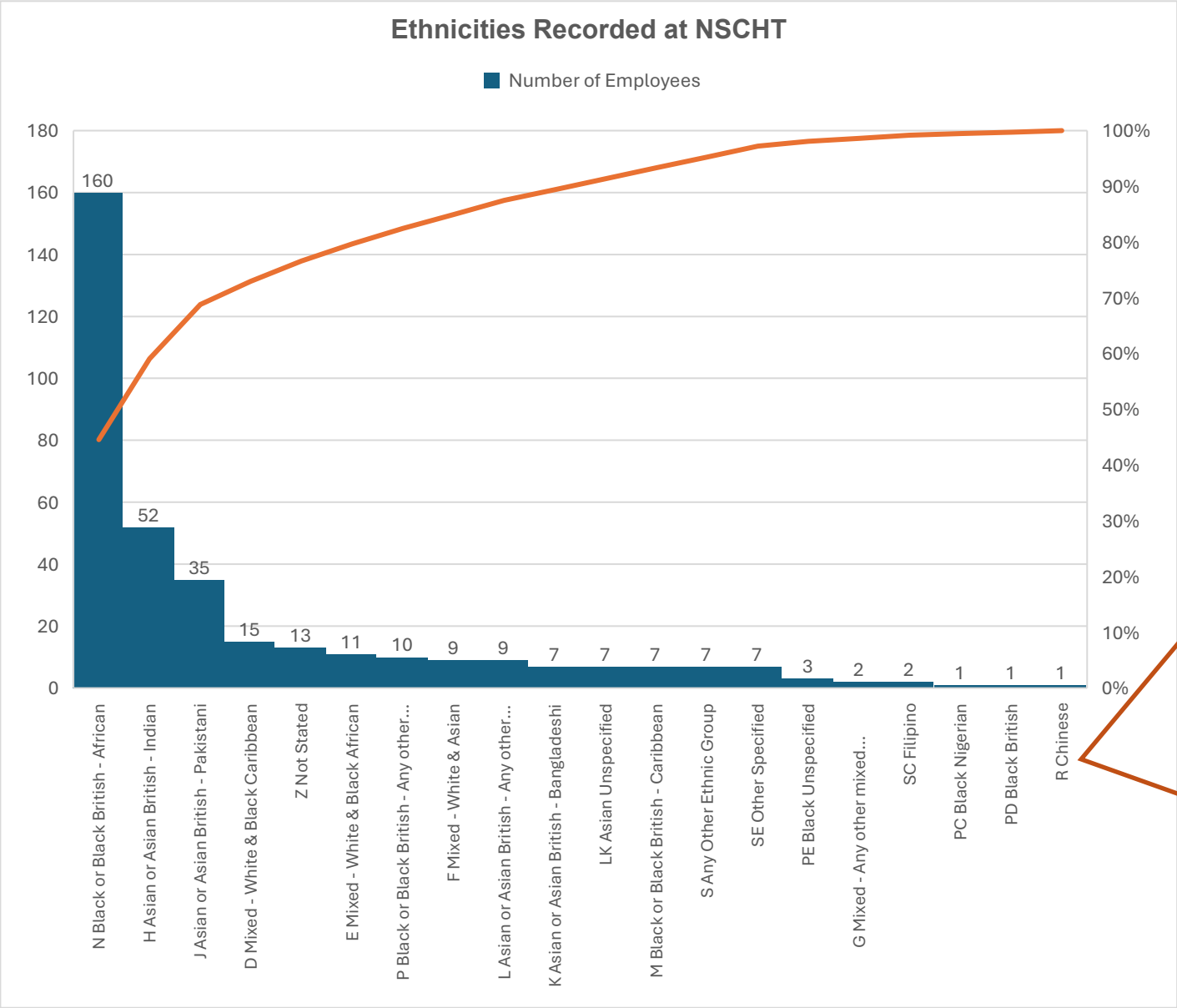
Our WRES priorities for action for 2025-26 are summarised as below:

1. Debiasing of our people processes, especially retention, recruitment and selection, career development and progression, disciplinary and capability processes and our workplace / reasonable adjustments approach.
2. 'High visibility' focus around an anti-discriminatory approach, creating a great place to work for all.
3. Reducing inequalities and health inequalities in the Global Majority workforce.
4. Educating for Inclusion – focus change away from positive action development programmes ('deficit model') towards programmes for the wider workforce, ensuring an environment in which diverse colleagues can thrive. Ensuring equitable or positive action access to development and career progression for diverse candidates. To include a focus on educating about our anti-racism approach and responding effectively to incidents of abuse, discrimination and incivility.



Figure 1: Trust Inclusion and Belonging Priorities, 2025-26.

1.4 Recognising diverse ethnic identities



The term "**Global Majority**" refers to a broad and diverse group, not a single, uniform identity. This includes a wide range of cultures, national and continental backgrounds. It's also recognised that some international ethnic identities aren't included in the ESR coding system, which means some colleagues are unable to record their specific ethnic background.

The graph below shows the wide range of ethnic identities self-reported by Trust staff in ESR. The largest group is Black / Black British – African, followed by Asian Indian, Pakistani and other Asian backgrounds. Most of our race inclusion plans will support the entire Global Majority workforce. Where the data highlights specific challenges for certain groups, we will aim to develop targeted actions to address those needs and work towards more equitable outcomes.

Trust Global Majority Ethnicities represented (headcount and percentage) as at 31.3.25 (source: ESR data).

2.0 Trust summary performance over time against the 9 WRES Indicators

Indicators	Years						
	2019	2020	2021	2022	2023	2024	2025
1. Workforce ethnicity profile	6.30%	7.60%	8.20%	9.10%	9.85%	11.11%	13.21% 
National	19.90%	21.10%	22.40%	24.20%	26.40%	28.60%	Not avail.
2. Recruitment measure	2.07	1.89	1.3	1.27	1.14	1.21	1.23 
National	1.46	1.61	1.61	1.53	1.59	1.62	Not avail.
3. Disciplinary measure	0.88	1.39	4.35	0.00	0.00	1.83	0.41 
National	1.22	1.16	1.14	1.14	1.03	1.09	Not avail.
4. Training measure	0.68	0.78	0.67	0.47	0.83	1.00	0.78 
National	1.15	1.14	1.14	1.12	1.12	1.06	Not avail.
5. HBA from patients / public	54.50%	42.00%	27.30%	30.10%	40.50%	30.21%	39.47% 
White	27.40%	29.88%	27.60%	29.00%	26.00%	24.60%	21.75%
6. HBA from staff	21.20%	24.50%	16.70%	23.30%	22.10%	20.83%	23.01% 
White	14.70%	17.10%	15.40%	13.60%	16.90%	16.13%	16.22%
7. Belief in Equal Opportunities	30.30%	40.82%	53.60%	61.60%	67.40%	62.77%	51.75% 
White	58.70%	60.97%	67.90%	70.00%	68.20%	67.33%	68.03%
8. Discrimination at work	3.30%	12.77%	12.50%	14.90%	12.80%	15.96%	19.47% 
White	4.70%	4.79%	4.30%	3.60%	5.20%	4.76%	5.77%
9. Board Membership	14.30%	23.10%	21.40%	20.00%	14.30%	21.43%	30.77% 
National	8.40%	10.00%	12.60%	14.00%	15.60%	16.50%	Not avail.

2025 data is considered against the **local Global Majority Heritage population figure of 11.17%** (based on the 2021 Census), to highlight how well the Trust reflects the diversity of the community it serves.

Key	
NSCHT	Improved 
National	Declined 
NSCHT White	

Table 1: Trust 2025 Performance against the 9 WRES Indicators, 2018-2025

2.1. National WRES results up to 2024 for comparison

The table below is taken from the most recent [NHS England » Workforce Race Equality Standard: 2024 data analysis report for NHS trusts](#)² (Page 6, NHS England, published 25th June 2025), depicting average national performance annually since 2016. This provides information on the direction of travel nationally, for comparison against Trust performance. Generally, Trust performance (see section above) is in line with the national trend over time.

WRES indicator			2016	2017	2018	2019	Year 2020	2021	2022	2023	2024	Trend	
1	Percentage of BME staff	Overall*	17.7%	18.1%	19.1%	19.9%	21.1%	22.4%	24.2%	26.4%	28.6%		● Overa ● VSM
		VSM*	5.4%	5.3%	6.9%	7.6%	7.9%	9.2%	10.3%	11.2%	12.7%		
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.57	1.6	1.45	1.46	1.61	1.61	1.53	1.59	1.62		
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.56	1.37	1.24	1.22	1.16	1.14	1.14	1.03	1.09		
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.11	1.22	1.15	1.15	1.14	1.14	1.12	1.12	1.06		
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	29.1%	28.4%	28.5%	29.7%	30.3%	28.9%	29.2%	30.4%	27.8%		● BME ● White
		White	28.1%	27.5%	27.7%	27.8%	27.9%	25.9%	27.0%	26.8%	24.1%		
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	27.0%	26.0%	27.9%	29.3%	28.4%	28.8%	27.6%	27.7%	24.9%		● BME ● White
		White	24.0%	23.0%	23.4%	24.4%	23.6%	23.2%	22.5%	22.0%	20.7%		
7	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion **	BME			47.5%	44.6%	45.6%	44.0%	44.4%	46.4%	48.8%		● White ● BME
		White			61.1%	59.0%	59.7%	59.6%	58.7%	59.1%	59.4%		
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.0%	14.5%	15.0%	15.3%	14.5%	16.7%	17.0%	16.6%	15.5%		● BME ● White
		White	6.1%	6.1%	6.6%	6.4%	6.0%	6.2%	6.8%	6.7%	6.7%		
9	BME board membership		7.1%	7.0%	7.4%	8.4%	10.0%	12.6%	14.0%	15.6%	16.5%		

* Data source: 2016-2017 - NHS workforce statistics website; 2018-2024 - SDCS/DCF data collection

** The way that indicator 7 is calculated has been changed for the NHS Staff Survey conducted in November and December 2021 and reported from 2022 onwards. Historic figures have been recalculated back to 2017 (2018 reporting year). (Previously, the figure was derived by dividing the number of “yes”

6

Table 2: NHS Average National Performance of WRES Indicators starting from 2016.

² The 2025 WRES national data, covering 1 April 2024 to 31 March 2025, has not yet been published and is therefore not available for benchmarking.

3.0 Trust performance breakdown by the 9 WRES indicators

Indicator 1: Workforce ethnicity profile

We aim to reflect our Global Majority heritage workforce across all staff groups and bands both clinical and non-clinical excluding medical staff. Currently **13.21%** of our overall workforce (excluding bank staff) identify as having Global Majority heritage. This is our highest rate to date and an increase from 11.11% in 2024. It also exceeds the local Global Majority population, which stands at 11.17% according to the 2021 Census.

Medical staff continue to be significantly over-represented, with 60.27% identifying as Global Majority heritage (slightly down from 61.11% in 2024). This group has a major impact on our overall diversity figures. When we **exclude medical staff, the Trust's ethnic diversity rate drops to 11.42%** still a notable rise from 9.25% in 2024.

However, ethnic diversity is still lacking in some areas, particularly within non-clinical roles. An exception is band 5 nursing, where representation is stronger. Overall, our non-clinical workforce continues to lag behind in Global Majority representation.

- ✓ Trust **Non-Clinical** Ethnic Diverse Workforce: 6.1% (significantly up from 4.5% in 2024)
- ✓ Trust **Clinical** (Medical Excluded) Ethnic Diverse Workforce: 13.1% (up from 12.09% in 2024)
- ✓ Trust **Overall** Workforce (excluding medical): 11.42% (up from 9.5% in 2024)

Ethnic diversity in our **non-clinical workforce** remains low across nearly all levels, with the exception of Bands 6, 8d and Board roles. The lack of progress in improving Global Majority heritage representation in these areas remains a key priority for action. A similar pattern exists within **our clinical workforce**. Bands 3 and 5, mainly nursing roles, show better representation, but this may be linked to lower rates of career progression for Global Majority staff beyond Band 5 when compared to their white colleagues.

Table 3 shows that the Trust continues to under-represent Global Majority heritage staff across most staff clusters, except for medical roles. Workforce ethnicity data as of 31 March 2025 is detailed in the table and charts below.

Band/group	2024			2025		
	Global Majority	White	Unknown	Global Majority	White	Unknown
band <1-4	9.87%	89.47%	0.66%	12.6%	86.72%	0.67%
band 5-7	9.68%	89.33%	0.99%	11.72%	86.94%	1.34%
band 8a-9	3.74%	96.26%	0%	5.025%	94.97%	0%
Medical	61.11%	37.50%	1.39%	60.27%	38.36%	1.37%
TOTAL (Exc. Medical)	9.5%	88.11%	0.78%	13.21%	87.65%	0.93%

- Data in the table shows our **best yet ethnic diverse representation** (13.21%). Progress recorded in increasing diversity in all cluster groups.
- This is **slightly higher than the local population rate of 11.17%** (from 2021 census) as at 31.3.25.
- A key challenge continues to be the under-representation across most staff groups and pay bands. See details in Chart 1-3 below.

Table 3: Global Majority heritage workforce yearly comparison based on cluster bands.

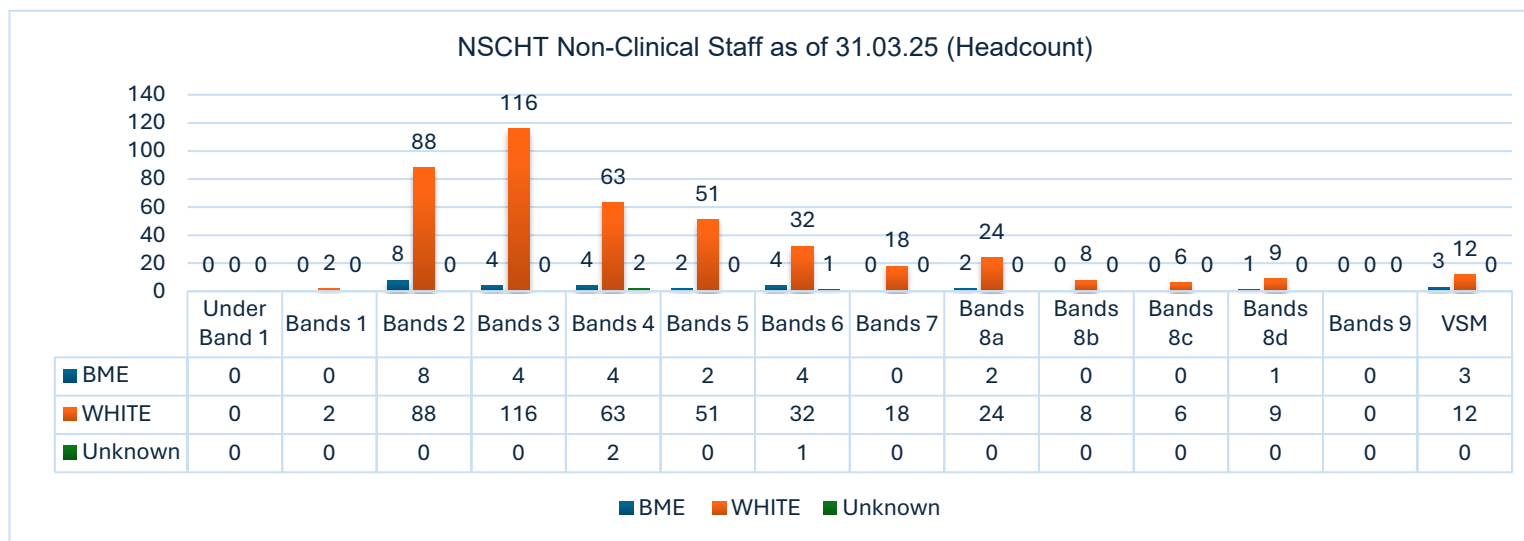


Chart 1: Trust Non-Clinical Staff as of 31st March 2025, based on ESR Data.

- **Non-clinical workforce** shows much lower representation of Global Majority staff compared to the local population (11.17%)
- Global Majority staff are present in small numbers at B2–6.
- Some representation at B8a, 8d and VSM.
- No representation at B7, B8b–c, B9, and 8d. Overall, diversity within the workforce decreases sharply at senior levels, highlighting ongoing challenges in progression and leadership

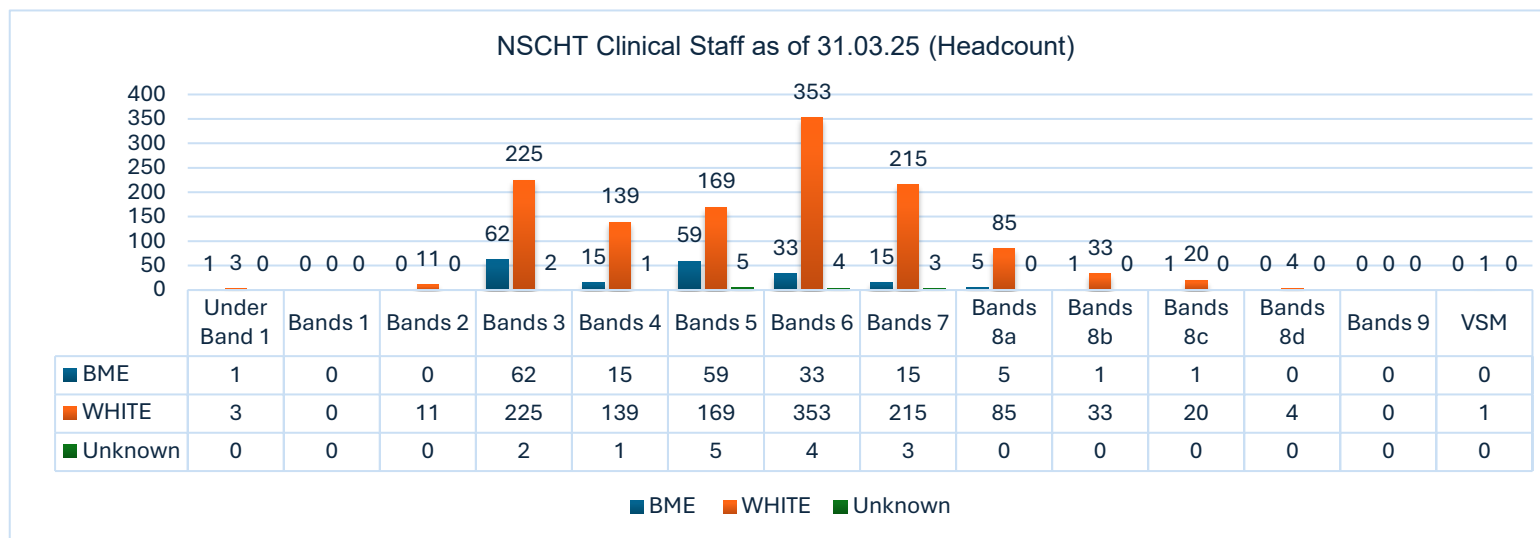
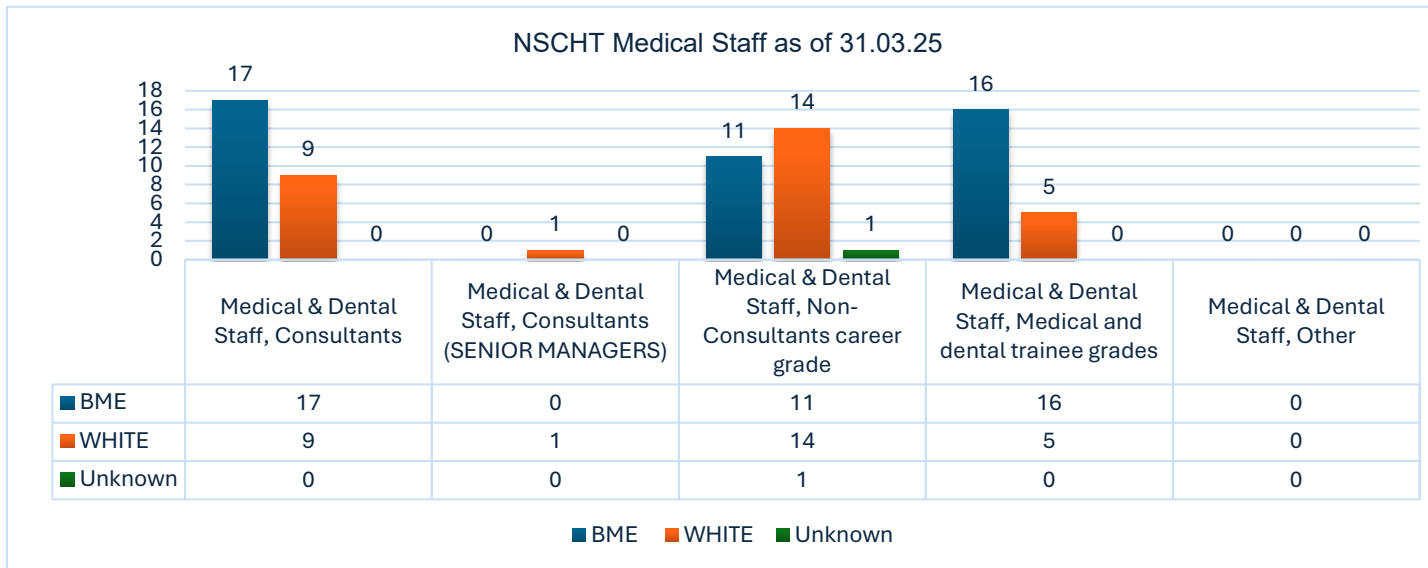


Chart 2: Trust Clinical Staff as of 31st March 2025, based on ESR Data.

- Global Majority **clinical staff** are represented across several bands, with the largest numbers at B3 (62 staff) and B5 (59 staff). (but remains below the local Global Majority Heritage population at 11.17%).
- Some presence at B6–7 and limited representation at B8a–8c, there is no representation at B8d, 9, or VSM.
- This shows that although Global Majority staff are entering clinical roles, progression into senior and leadership positions remains limited, leaving the workforce profile less diverse than the local community it serves.



- Global Majority medical staff are strongly represented across most groups, with numbers well above the local Global Majority Heritage population benchmark of 11.17%.
- Global Majority staff make up the majority of consultants (17 compared with 9 White) and trainees (16 compared with 5 White) and are well represented among non-consultant career grades (11 compared with 14 White).
- There is a gap at consultant senior manager level, where there is no representation.

Chart 3: Trust Medical Staff as of 31st March 2025, based on ESR Data.

Trust Bank Ethnicity Profile

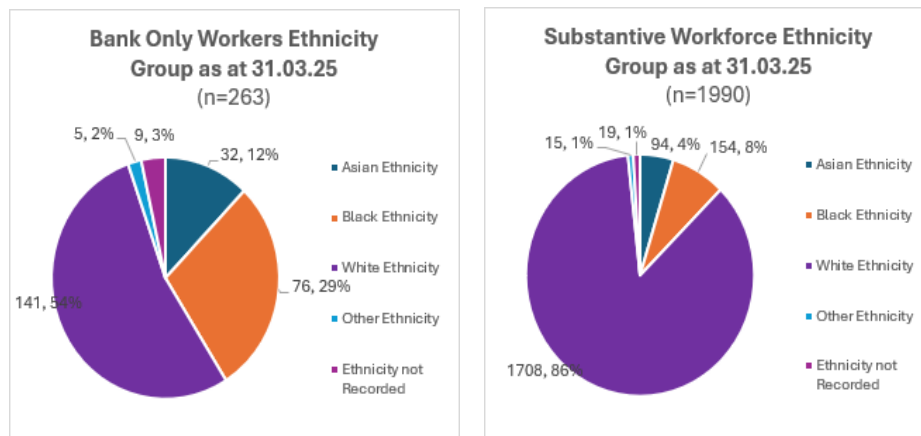


Chart 4a: Bank only workers ethnicity

Chart 4b Substantive workforce ethnicity as of 31st March 2025 (ESR Data).

In 2025, the bank workforce shows a more diverse profile compared to 2024. Staff from a global majority background (all non-White ethnicities) make up 42.97% of the bank workforce in 2025, a significant increase from 29.14% in 2024. Within this, Black staff represent the largest global majority group at 28.90%, followed by Asian staff at 12.17%, and other ethnicity at 1.90%. White staff account for just over half of the workforce at 53.61%.

Nationally, Global Majority staff represent 28.6% of the NHS workforce. This disparity raises important questions about the underlying factors influencing the preference for bank roles among Global Majority Heritage staff. It prompts further exploration into whether flexibility, perceived inclusivity, reduced exposure to workplace discrimination, or barriers to progression in substantive roles contribute to this trend. Understanding these motivations could help the Trust identify and replicate inclusive practices from bank staffing within permanent recruitment and retention strategies.

3.1. WRES Aspirational Target

Workers from Global Majority Heritage backgrounds remain significantly under-represented in senior non-clinical roles across the NHS (excluding clinical and medical positions). The WRES Aspirational Target aims to improve representation at Band 8A and above by 2028.

This year, we updated our Trust's 2028 Aspirational Target using the latest data from the 2021 Census, which shows that 11.17% of our local population is from ethnically diverse backgrounds. The revised target is shown in Table 4.

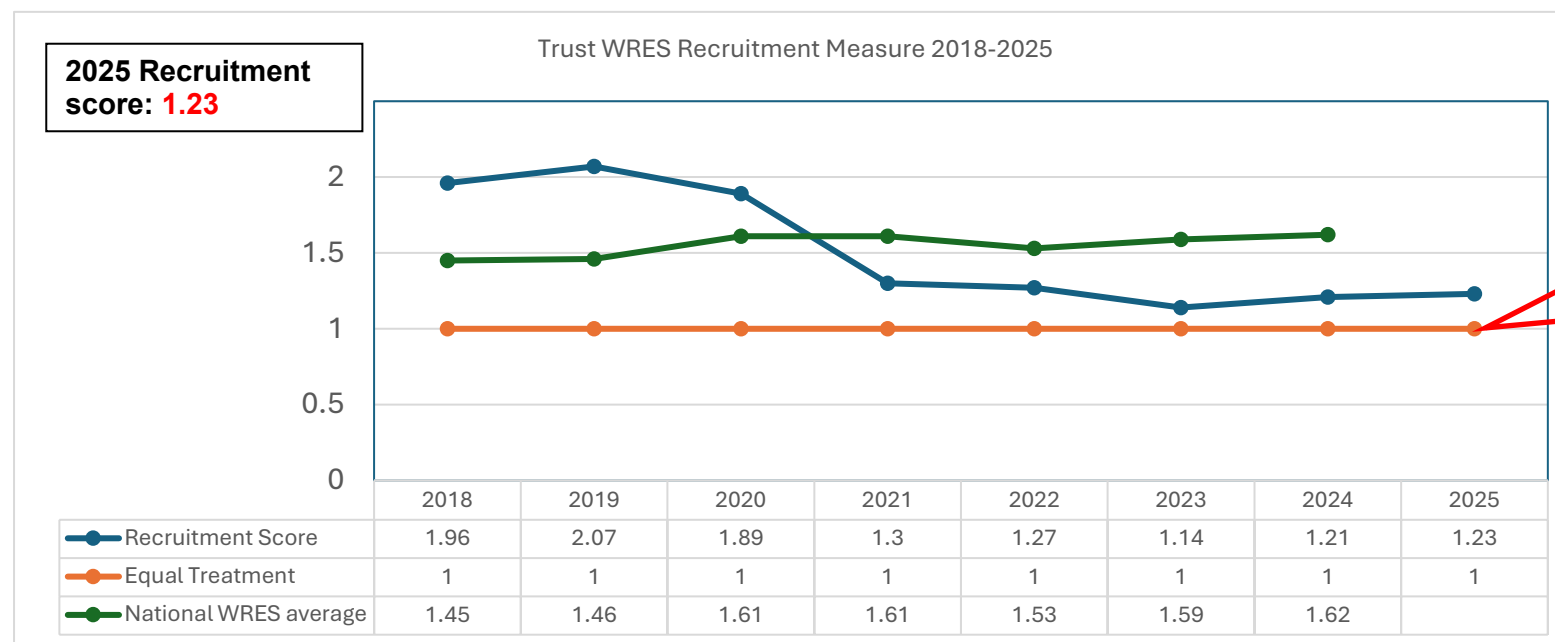
Existing Profile: Trust Band 8a-8d establishment as at 31.03.25					Aspirational profile in non-clinical roles (by 2028); based on local population rate of 11.17%: Planned Equitable Distribution in 2028				
Banding / Equivalent	Global Majority	White	Total		Global Majority	White	Total		No. of ethnic diverse appointments needed to be equitable
Bd 8A	2	24	26		3	23	26		+1 Global Majority Heritage colleague (2025: +1)
Bd 8B	0	8	8		1	8	9		+1 Global Majority Heritage colleague (2025: +1)
Bd 8C	0	6	6		1	5	6		+1 Global Majority Heritage colleague (2025: +1)
Bd 8D	1	9	10		1	7	8		+1 Global Majority Heritage colleague (2025: +1)
TOTAL	3	47	50		6	44	50		+4 Global Majority Heritage 8A-D colleagues (+4) required

Table 4: Trust 2025 Workforce Profile compared to Aspirational Target Workforce Profile (by 2028)

To meet our WRES Aspirational Targets by 2028, the Trust needs to appoint/convert four more individuals from Global Majority Heritage backgrounds into Band 8 (A–D) roles, based on current staffing levels (see Table 5 above).

To support this goal, we will focus on developing and progressing our existing Global Majority Heritage staff, alongside external recruitment. Our aim is to build a strong and diverse pipeline of internal candidates, ensuring we are always 'spoiled for choice' when filling senior roles.

Indicator 2: Recruitment measure



WORSE than 2024:

Our recruitment score for 2025 has slightly declined but still outperforms the national average. We remain focused on bringing it below 1.00 and sustaining that improvement.

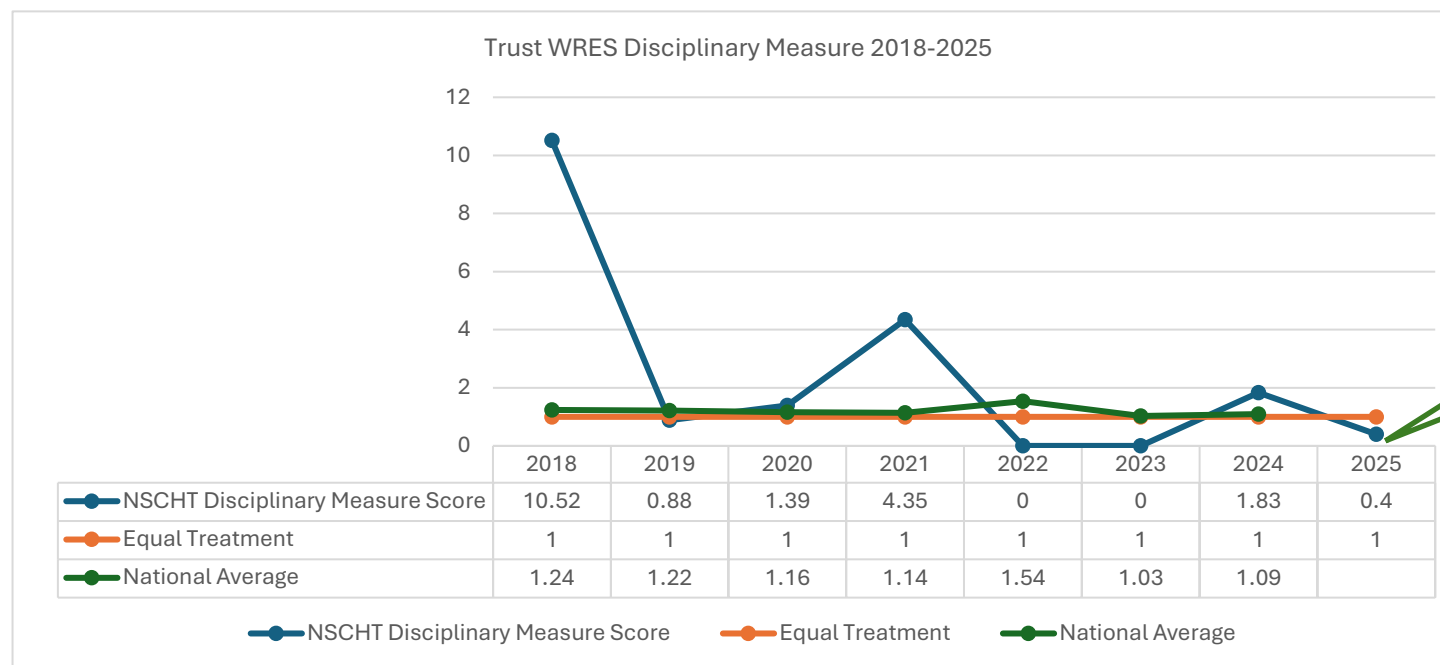
Chart 5: Trust Recruitment Measure trend from 2018 to 2025. National WRES Average not for 2025 has not been published yet.

Headcount and Percentages				Headcount and Percentages			
2024	Application	Shortlisted	Appointed	2025	Application	Shortlisted	Appointed
Global Majority Heritage	3843 (55.7%)	612 (29.5%)	149 (24.8%)	Global Majority Heritage	3255 (57.33%)	464 (36.73%)	158 (35.1%)
Not disclosed	124 (1.8%)	40 (1.9%)	34 (5.7%)	Not disclosed	77 (1.3%)	17 (1.3%)	14 (2.80%)
White	2931 (42.5%)	1422 (68.6%)	418 (69.6%)	White	2345 (41.30)	782 (62%)	327 (65.53%)
Total	6898 (100%)	2074 (100%)	601 (100%)	Total	5677 (100%)	1263 (100%)	499

The score is calculated from shortlisted and appointed data from recruitment and selection in 2025. It is noted that there is a significant reduction in the proportion of Global Majority applicants at application-to-shortlisting stage, with a much further reduction at interview-to-appointment stage, with a corresponding increase in the proportion of White candidates, in terms of percentages.

Table 5: Trust 2024 and 2025 appointment rates for different ethnicities.

Indicator 3: Disciplinary measure



MUCH BETTER than 2024:

Our score *has improved significantly in 2025* and stands at 0.41. It must be noted that this relates to just 1 disciplinary case involving a Global Majority Heritage colleague.

	Disciplinary cases	
	2024	2025
Global Majority Heritage	3	1
White	13	16
Ethnicity not known	0	1
TOTAL CASES	16	17

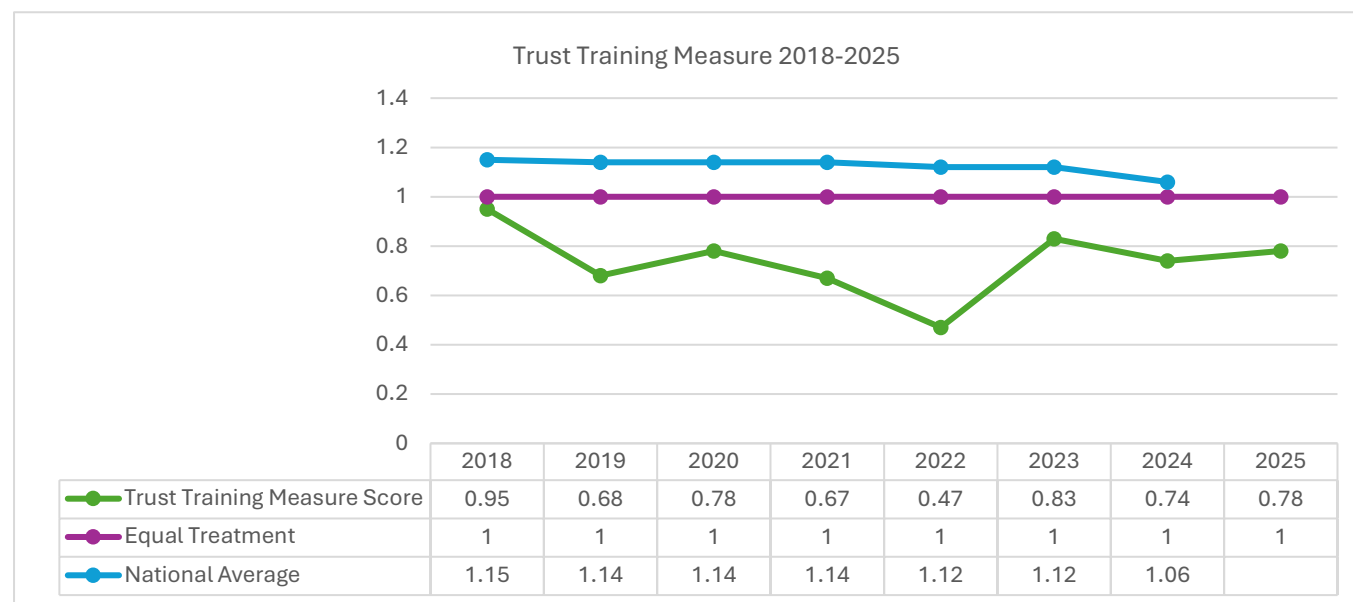
Chart 6: WRES Disciplinary Measure, year-on-year performance, Staff Survey 2024, National Average for 2025 not available yet.

Table 6: Trust Disciplinary cases by ethnicity 2024 & 2025

In 2025, there was one disciplinary case involving a Global Majority colleague, compared to 16 White colleagues. This reflects underrepresentation, with a score of 0.40. Small case numbers and a limited ethnically diverse workforce mean the measure can fluctuate significantly year to year.

We've continued to embed our Just and Fair Culture, focusing on civility and respect, supported by our investigation's checklist. This helps ensure disciplinary investigations are only used when necessary and are carried out with the right level of rigour to reduce or remove potential bias.

Indicator 4: Training measure



This indicator measures the proportion of Global Majority colleagues taking part in **at least one piece of non-mandatory development**, compared to White colleagues.

The Trust's training measure has traditionally favoured Global Majority colleagues and 2025 is no exception, with a score of 0.78. This continues to be largely influenced by the medical workforce, where 60.27% of staff identify as Global Majority. Since medical staff routinely complete non-mandatory CPD (Continuing Professional Development), their high representation skews the overall score.

However, this training measure is relatively limited - it doesn't account for the type, level, or duration of development accessed. A more detailed analysis may reveal further

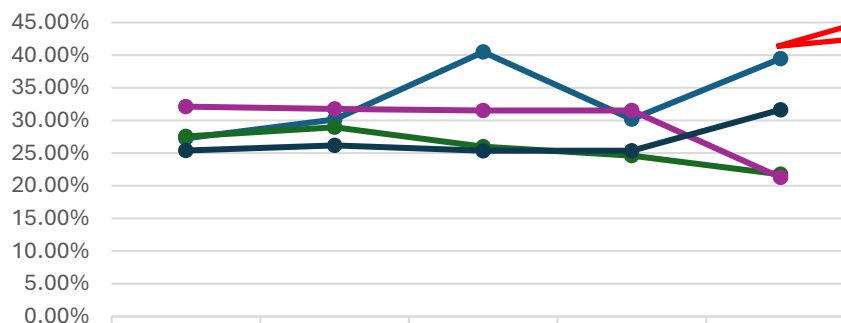
Chart 7: WRES Training Measure, year-on-year performance (National Average for 2025 not available yet)

inequalities in access to meaningful development for Global Majority staff.

Previously, the Trust offered positive action programmes such as Stepping Up, New Futures, Aspirant Leaders and Developing You: Developing Me. These were paused in 2025. Going forward and subject to funding and capacity, the focus will shift to creating an environment where Global Majority colleagues have equal access to all development opportunities. The impact of this new approach will be tracked through future training scores.

Indicator 5: Harassment, bullying & abuse (HBA) from patients/public

% of Staff Experiencing HBA from Patients, Relatives and Public in the last 12 Months (2021-2025)



WORSENE from 2024 position.

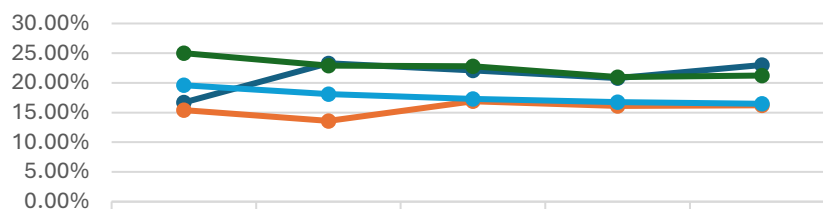
- Also, worse than national average rate for Global Majority Heritage staff.
- Worse than the Trust and national rates for White staff.

This year, our WRES score for HBA from patients and the public (2024 Staff Survey data) increased from 30.21% to 39.47%. This position is also worse than average (31.64%) for Global Majority colleagues nationally. It remains higher than the Trust (and national mental health) rate of HBA from patients and the public towards White colleagues (by nearly 18%). It is also concerning that the size of the gap between Global Majority and White experience on this measure has increased considerably from the previous year, when the difference was 5.61%. It is noted that this gap varied considerably over the years, ranging from just 0.3% in 2021 to the 14.4% gap in 2023.

Chart 8a: WRES HBA from patients/public Measure, year-on-year performance, Staff Survey 2024.

Indicator 6: Harassment, bullying and abuse from staff

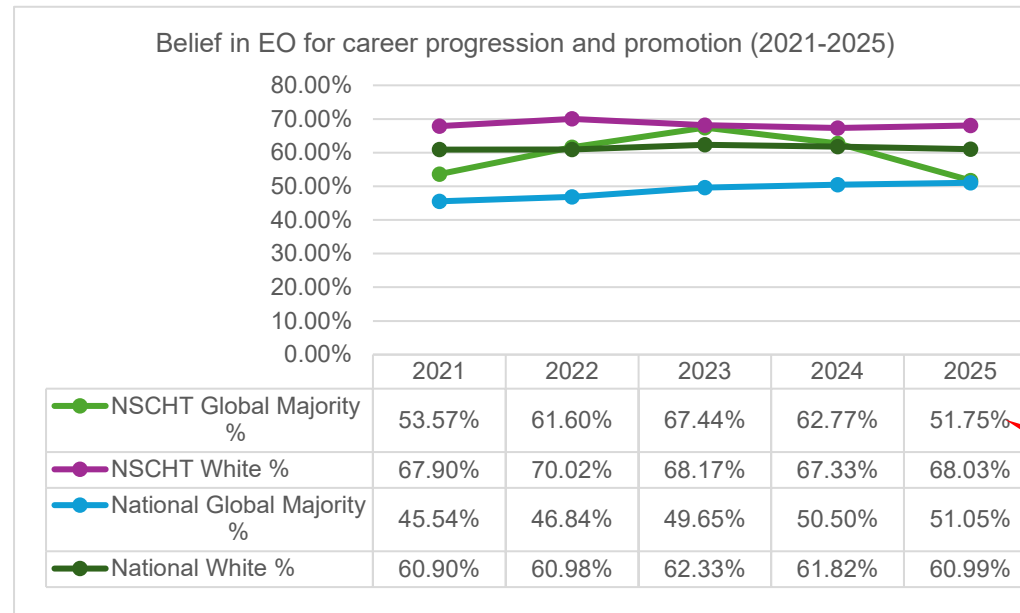
% of Staff Experiencing HBA from other Staff in the last 12 Months (2021-2025)



According to the 2024 Staff Survey, reports of HBA among staff fell slightly for the second year in a row — down by 2.18%. However, the gap between the experiences of White staff and Global Majority colleagues remains largely unchanged, with a difference of nearly 7%. Our figures have generally mirrored the national rate for Global Majority staff over the past five years, apart from 2021 (based on the 2020 survey), which showed an unusually low rate and appears to be an outlier. Despite the small decline, nearly 1 in 4 ethnically diverse staff continue to report HBA from colleagues. This remains unacceptable. We are committed to preventing these behaviours, responding more effectively when they occur and ensuring staff feel safe and supported to report them so they can be properly addressed

Chart 8b: WRES HBA from staff Measure, year-on-year performance, Staff Survey 2024.

Indicator 7 - Belief in equal opportunities for career progression



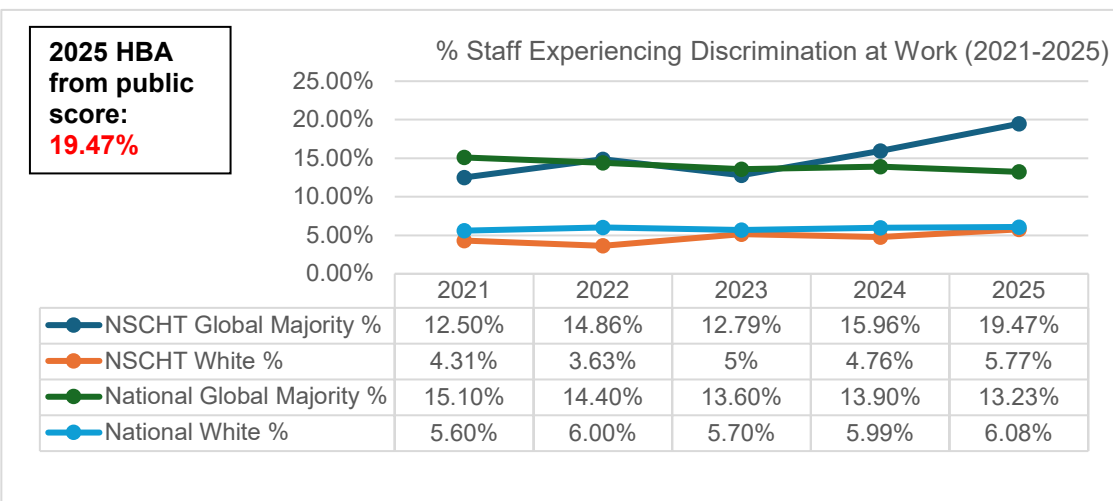
There has been a drop in our 2025 score for Belief in Equal Opportunities (EO) (from the 2024 survey), with a significant increase in the gap between Global Majority and White colleagues. After a smaller 5% gap in 2024, the 2025 data show this has widened to nearly 17% - one of the largest differences we've seen in recent years. Despite this, the Trust's score for Global Majority colleagues is still 0.70 percentage points higher than the national average. We are committed to improving this outcome through our inclusive recruitment change programme and by visibly reinforcing our commitment to race equality across all areas of employment.

Position has WORSENEd for the first time since 2021.

- Score worse for Trust Global Majority colleagues than White colleagues.
- Remains almost equal to national average for Global Majority.

Chart 9: WRES Equal Opportunities Measure, year-on-year performance, Staff Survey 2024.

Indicator 8 - Staff experiencing discrimination from other staff



Nearly 20% of Global Majority colleagues reported experiencing discrimination at work — the highest rate in the past five years. This figure is 6% above the national average for Global Majority staff, and the gap between their experiences and those of White colleagues has widened to 13.7%. This is a serious concern. As part of our anti-racism approach, we will ensure all teams and leaders are equipped and expected to identify and challenge bias and discrimination wherever it occurs. While any colleague is experiencing discrimination, we cannot truly deliver on our commitment to be a great place to work, or on our vision of inclusion and belonging for all our people.

Chart 10: WRES Discrimination Measure, year-on-year performance, Staff Survey 2024

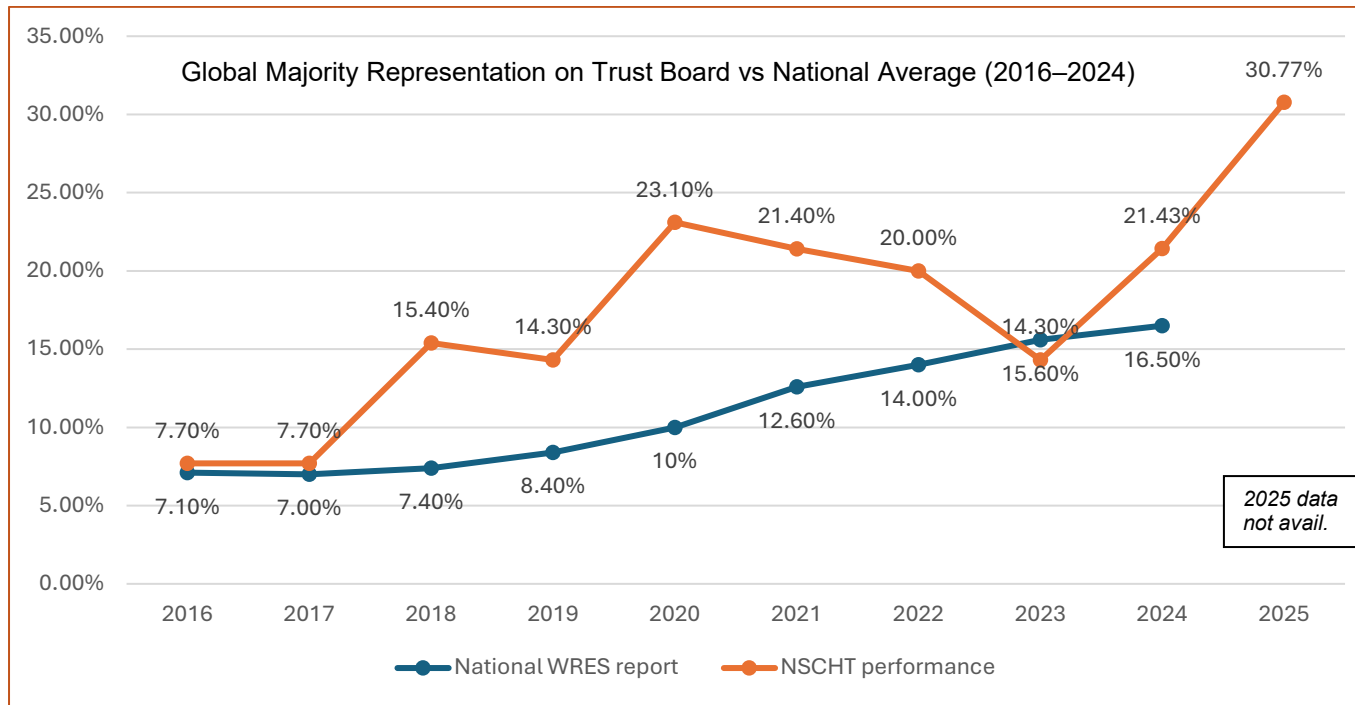
Indicator 9: Trust BME Board membership

2025	Global Majority	White	Global Majority	White
	Headcount		%	%
Executive Directors	4	9	30.77%	69.23%
.. Of which: Voting members	4	7	30.77%	53.85%
Non-Executive	2	4	15.38%	30.77%
Total board members	4	9	30.77%	69.23%

Global Majority Heritage board headcount has INCREASED to 4 (from 3) members.

- This is made up of 2 Executive and (for the first time) 2 non-executive members.
- All 4 Global Majority Heritage Board Members have voting rights.
- Our overall position of 30.77% Global Majority Heritage Board Members and 69.23% Global Majority Heritage Executive members is highly favourable, far exceeding ethnic diversity in both our local workforce and population and the latest published national rates.

Table 7: Global Majority Board Membership at NSCHT, 31.3.25



The Trust is proud to have strong Global Majority representation at Board level, exceeding our local population rate of 11.17%. Currently, 30.77% of our Board (four members) are from ethnically diverse backgrounds. We are also one of the few Trusts nationally with both a Black CEO and a Black Medical Director. For the first time, we now also have Global Majority representation among our non-executive directors. Throughout 2025, our Board has continued to show strong leadership and commitment to inclusion, both locally and nationally. In 2024, our executive team took part in inclusion-focused development and have committed to delivering meaningful inclusion objectives within their Directorates.

Chart 11: Trust board Global Majority representation compared to national average, 2016-2024 (2025 national data not available yet)

4.0. What have Combined been doing to advance the WRES over the past 12-18 months?

Inclusion and belonging remain at the heart of our People strategy at Combined. We've continued refining our approach to ensure everyone in our workforce feels included, valued, supported and genuinely cared for. Our Combined People Plan continues to guide and measure our progress, particularly around improving inclusion and race equity.

Key areas of focus include:

- Celebrating and recognising diversity.
- Building a culture of justice, belonging and inclusivity.
- Reflecting the diversity of our communities at all levels of the organisation.

Activities to advance race inclusion through this period included:

- Advancing our **#InclusiveHR change** programme with the People Directorate, aiming to lead by example on equality.
- Strengthening the impact of our **ENRICH Staff Network** on Trust activities and decision-making.
- The Inclusion Trailblazers Project was delivered in 2024, aimed at removing barriers and promoting equity by using lived experience to rethink and debias processes. While no new actions were undertaken in 2025, staff continue to benefit from the outcomes of the project and next steps will be agreed going forward in alignment with wider inclusion work underway to deliver on our Trust Inclusion and Belonging Strategy.
- The Recruitment Team, in collaboration with the OD and Inclusion Team, is enhancing Values-Based Recruitment by reviewing assessment materials and ensuring interview and selection processes are consistent and anti-discriminatory. This work involves external experts and the Inclusive Recruitment Network Group, with early drafts already in progress.
- The Trust continues to prioritise **staff wellbeing** by offering a wide range of support services and resources. Staff have access to platforms like Optima for confidential self-referrals and manager referrals, as well as the Learning Management System (LMS) for professional development. Centralised tools such as the Combined Access Tool and Health & Wellbeing pages provide easy access to counselling and tailored team sessions. Support materials are regularly shared via email and updates are communicated through monthly newsletters and Newsround. However, usage data shows that 77% of users are White (English/European), with only 8% from minority ethnic groups and 15% with no recorded ethnicity, indicating potential underrepresentation and data gaps. This highlights the need to explore barriers to access and improve inclusivity for ethnic minority staff.
- Delivered the Trust's first **Ethnicity Pay Gap report**, including analysis at service and Directorate levels and development of an action plan.
- We listened and responded to the concerns of our global majority workforce and ENRICH members following the civil unrest of August 2024. A dedicated listening session was held with ENRICH members, manager and staff guidance has been developed and issued, and a One Combined / Parade of Flags video created and launched on the Trust YouTube page.
- All **executive directors committed to delivering against one or more EDI objectives for their Directorates** in 2025 (race inclusion and career progression for our Global Majority workforce identified as key priority).
- **Staff development** focused on promoting equity and inclusion, with positive action taken to prioritise Combined Connects and Foundations in Leadership and Management (FLM) nominations from underrepresented groups, such as those from global majority heritage, LGBTQ+, disabled, or neurodiverse backgrounds. Staff were signposted to key Trust and system-wide development opportunities through targeted



communications via Staff Networks. Delegates from positive action programmes like New Futures and Stepping Up were offered further CPD through alumni events. A career development workshop and 1:1 sessions were delivered for the ENRICH network.

- A new **Board Development Conversations** process and framework was introduced, embedding inclusion as a priority.
- Coaching and mentoring were further promoted within the Staff Networks, with improved access to mentors with lived experience. A ward-based stretch opportunity pilot was trialled, with plans to relaunch in 2025/26. In addition, a new Career Development CAT page and handbook were launched and promoted through Staff Network events.
- Launching systemwide **race inclusion programmes** such as HPMA Anti-Racist Leadership Programme (attended by HR teams across the ICS), WRES Champions and Reciprocal Mentoring programmes to develop participants skillset in leading elements of anti-racism culture change
- The Anti-Racist Leadership Toolkit was co-developed with system partners to support leadership development. We also delivered a Leadership Academy aimed at 'Accelerating Our Inclusive Leadership Culture' We also continue to deliver the "Developing Inclusive Cultures" modules for both FLM and Combined Connects Leadership programmes. We continue to learn from evidence-based and best practice approaches to leadership and inclusion. As part of this commitment, the Trust welcomed Professor Michael West to deliver a session at the recent conference on Compassionate and Inclusive Leadership. His insights reinforced the importance of embedding compassion at all levels of leadership and highlighted how inclusive practices can positively impact staff wellbeing, engagement, and organisational culture.
- 79 '**See me First**' badges have been distributed to staff since the inception of the scheme in October 2023.
- Introduced and continue to embed our **HR / EDI dashboard** for all services and directorates to support accountability for positive change in each service.
- **Raising awareness through our annual inclusion calendar and celebrating key EDI events** within the Trust and across the system, including Race Equality Week, South Asian Heritage Month, Black History Month, Diwali, Ramadan and Eid to promote inclusion and awareness across our organisation.
- In response to Health and Safety Executive (HSE) guidance, the Trust **reviewed policies, procedures and incident data on workplace violence, aggression and injuries**. A separate reporting category for hate crime was introduced, alongside a restorative post-incident response in line with just culture principles. Staff are now supported to report hate crime to the police and access victim support, while warning letters have been issued to offenders to highlight the harm caused. The Trust has also formed links with Uniting Staffordshire Against Hate to provide additional specialist support for staff.
- We are acting on recommendations from recent **Learning Reviews** to embed inclusive practices. Key areas include inclusive recruitment, addressing inequities for bank staff, reviewing Freedom to Speak Up (FTSU) practices and supporting career development for global majority colleagues.
- An **Anti-racism toolkit** was developed as an educational resource for individuals to build their capability on race and anti-racism practices (videos, personal stories, links to speakers, documents to support different learning styles). In 2025-26 the toolkit will be launched to bring it to life.
- A System Sexual Safety session was held in October 2024 and attended by several staff members. While the primary focus was on sexual safety, the session on 'Being an Upstander and Active Bystander' was noted for its relevance and applicability to other forms of incivility and discrimination.

Further detail on our WRES action plan 2025-26 is available in Appendix 1. For more on our wider Inclusion programme, see our *Inclusion and Belonging Annual Report 2025* on the Trust's website (to be published in Q3).

5.0 WRES action planned for 2025-26

Our focus in 2025-26 will be concentrating on four key areas of focus which allow us to maximise the measurable impact of change interventions action as well as working to ensure the sustainability of these outcomes, summarised as below [for full detail, see Appendix 2].

1. Delivering key milestones to implement, ensure and embed an effectively debiased inclusive recruitment process change programme, including to:

- Continue Trust-wide rollout and embedding of the Inclusive Recruitment Toolkit and Development Programme.
- Complete and act on the review of Band 8A+ roles to identify barriers to progression for global majority staff.
- Use staff feedback to improve recruitment processes from a race equity and inclusion perspective.

2. Reducing racial inequalities and health inequalities for our workforce, including:

- Use insights from the embedded HR/EDI Dashboard to drive local accountability and action.
- Promote equitable access to non-mandatory training, addressing the re-emerging gap.
- Ensure wellbeing services are inclusive and accessible to all staff groups.
- Use findings from the Ethnicity Pay Gap Report to shape targeted interventions at service and Directorate levels.

3. Progressing our high-visibility anti-racist and anti-discriminatory approach, delivering against tangible key milestones

- Sustain a high-profile anti-racist communications campaign, reinforcing expectations and accountability.
- Continue to de-bias disciplinary, performance, flexible working and retirement processes, using a race equity lens.
- Maintain the practice of reviewing and updating protected characteristics at the start of employee relations cases.
- Respond to increased reports of harassment (patients and staff) with clear prevention and response measures.
- Actively engage the ENRICH Network in co-developing anti-discrimination efforts.

4. Educating for Inclusion: advancing a supporting programme of education to underlie our work in priorities 1, 2 and 3 above:

- Deliver leadership educational intervention that deepens understanding of race, racism and inclusive practice.
- Provide practical training on responding to discrimination, abuse and incivility.
- Expand the Leadership Academy's race inclusion offers, with clear outcomes linked to WRES priorities.
- Continue a programme of events and learning to celebrate and educate around key race-themed dates.
- Build on our investment in HPMA Anti-Racist Leadership Programme, WRES Champions and Reciprocal Mentoring by involving participants in leading elements of anti-racism culture change.

6.0 Conclusions and Recommendations

The 2025 WRES data highlights persistent racial disparities across several key areas of the workforce experience. While there are some areas of progress such as improved board diversity and a reduction in the disciplinary gap, concerning trends remain. Global majority staff continue to face disproportionate levels of harassment, reduced access to training, lower confidence in equal opportunities and significantly higher rates of perceived discrimination compared to White colleagues.

The widening gap in training access and declining confidence in fairness point to a need for stronger accountability and cultural change at every level. The overall picture shows that while structural tools and processes (such as inclusive recruitment resources, dashboards and pay gap analysis) have been introduced, greater focus is now required on embedding these into everyday practice and leadership accountability to ensure we not only maintain progress but continue to improve.

What we need in 2025-26

In 2025–26, we need to shift from implementation to meaningful impact. This means embedding inclusive recruitment practices across all services, ensuring equitable access to development and progression and holding leaders visibly accountable for race equity outcomes. We must act on insights from our Ethnicity Pay Gap Report and workforce dashboard, close gaps in training access and tackle the root causes of harassment and discrimination. Strong leadership, clear expectations and continued engagement with our ENRICH Network will be critical to creating a safer, fairer and more inclusive workplace for all.

Recommendations

Board members, Senior Leadership Team (SLT) and members of the People and Culture Development (PCD) Committee are asked to:

1. Note the progress made and areas where performance has declined in our 2025 WRES outcomes, particularly around staff experience and access to development.
2. Approve the 2025 WRES Report and the 2025–26 WRES Action Plan for publication and implementation.
3. Acknowledge that personal and team-level actions are expected as part of the plan and commit to delivering these within their own areas of responsibility.
4. Continue to act as visible and active ambassadors for race inclusion, championing a Trust-wide culture that is inclusive, anti-racist, and accountable.
5. Take personal responsibility for improving their own awareness and understanding of race equity issues, including by seeking support, training, or guidance where needed.
6. Use the HR/EDI Dashboard and Ethnicity Pay Gap insights to challenge disparities and support targeted actions within their services or directorates.
7. Engage with staff networks, including the ENRICH Network, to better understand lived experiences and co-create solutions that drive lasting change.

END

APPENDIX 1: Progress Report: WRES Action Plan 2024

WRES Priority Areas	Train	Retain	Reform
1. Debias employee relations and talent management processes	✓ Leadership education on race and racism (ongoing). ✓ Leadership Academy on race inclusion. ✓ HPMA Anti-Racist Leadership Programme and WRES Champions. ✓ People Team development day focused on equality impact assessments and a team-wide Privilege Walk session. ✓ Career development workshops and 1:1 sessions are offered through the OD CAT pages, though uptake was minimal (ongoing)	✓ Debaised Disciplinary and Improving Performance processes (ongoing). ✓ Review protected characteristics in Employee Relations (ER) cases (ongoing). ✓ Fair access to flexible working and retirement (ongoing). ✓ Learning Review actions focused on fair recruitment, bank staff equity, FTSU, and career growth for global majority staff (ongoing).	✓ Recruitment, OD, and Inclusion teams are enhancing Values-Based Recruitment assessment and selection materials. ✓ External expert engaged to review interview and selection practices for consistency and anti-discrimination. ✓ Inclusive Recruitment Network Group and Recruitment Managers involved, with initial drafts produced.
2. Engage, develop and progress ethnic diverse talent	✓ Career development workshops and conversations for Global Majority colleagues (ongoing). ✓ Inclusive Recruitment Toolkit and Development Programme (rolled over to 25/26). ✓ Coaching and Mentoring Platform(ongoing)	✓ Equitable access to health and wellbeing offers (ongoing). ✓ HR/EDI Dashboard embedded for monitoring workforce demographics (ongoing). ✓ Ethnicity Pay Gap Report analysis to inform retention strategies (ongoing).	✓ Talent management and progression reforms supported by Executive-led EDI objectives. ✓ Ethnicity Pay Gap Report to inform systemic changes.
3. End violence, aggression, harassment and abuse	✓ Race-themed inclusion calendar activities (ongoing). ✓ In response to rising reports of HBA from the public on wards, some sites developed posters. (ongoing – centrally coordinated inclusion photo campaign supported by Comms to streamline messaging).	✓ Targeted communications on anti-racist practice (ongoing). ✓ Strengthening staff support mechanisms via ENRICH Network (ongoing).	✓ Project group actions to address bullying and abuse. ✓ Policy reform is shaped through the ENRICH Network, with leads on the Partnership Working Group and input from staff survey and WRES results to drive changes, including tackling harassment and abuse (ongoing).
4. Make EDI and race inclusion everyone's business	✓ EDI development across levels to embed inclusive culture e.g. training, awareness activities (ongoing). ✓ Participation of leaders in anti-racism education and mentoring programmes.	✓ Directorates were tasked with setting EDI objectives. ✓ Embed inclusive practice across all teams (ongoing).	✓ HR/EDI Dashboard embedded to support accountability. ✓ Culture change through anti-racist leadership at all levels (Ongoing). ✓ Launched PCREF with a new Steering Group, embedding it into the Health Equity Framework (ongoing).
5. Close the gap in ethnicity declaration	✓ Staff education on importance of self-declaration and how data informs inclusion work.	✓ Use dashboard insights to engage services with low declaration rates.	✓ Targeted action plans to close ethnicity declaration gaps in services (ongoing)

APPENDIX 2 - Inclusion And Belonging Action Plan 2025-26

The WRES action plan is part of the Trusts wider 4 year Inclusion and Belonging Strategic plan (2024–2028) aligned with the Trust’s Equality Objectives. Progress is monitored and reported annually. The plan is ambitious and will be supported by a refresh of the People Plan and root cause analysis to identify where best to focus our efforts for the greatest impact.

Action	Links to Equality Objectives 24-28	Links to 25-26 EDI Goals	Must / Should / Could	Action Lead	RAG rating (as at 08.25)
1. Deliver key milestones to implement, ensure and embed an effectively debiased inclusive recruitment process change programme					
1.1 Develop Inclusive Recruitment Toolkit and Inclusive Recruitment Development package utilising theory / approach of No More Tick-Boxes’ and ‘If Your Face Fits’ (Kline, 2023).	4	1	Must	Ami Stonier	Oct 2025
1.2 Undertake analysis of applications-shortlisting/interview-appointment for posts at band 8A and above to better understand the issues / reasons behind lack of diversity in appointments at this level, and implement action based on findings.	4	1	Should	People Team	Dec 2025
1.3 Respond effectively to feedback from staff about experiences of recruitment process from a protected characteristics perspective.	4	1	Should	Rachel Birks	Oct 2025
1.4 Develop a plan to roll-out of Inclusive Recruitment development (considering the needs of both new recruiting managers and existing recruiting managers)	4	1	Should	Ami Stonier	Dec 2025
2. Reducing inequalities and health inequalities for our service users and staff					
2.1 All services to undertake a review of service user ACCESS analysed with a race lens in 2025-26 and present findings to Directorate committee (3 services to do deeper review via EDS framework – see 2.5 below)	2 & 3	2	Should	All Service Leaders	March 2026
2.2 Equitable access to health and wellbeing offers for all staff (our workforce as a microcosm of our local population). Review take-up by diverse characteristics colleagues.	2	2	Should	Dawn Ainsworth	Dec 2025
2.3 Implement new guidance on recording gender codes in Electronic Patient Record (Lorenzo) and in Electronic Staff Record when available. 2.4 When in place, action needed to analyse the data and identify next steps.	1	2	Must	Vicky Boswell / Lauren Cartwright	Dec 2025

2.4 Launch and embed new guidance and approach to RADF (Reasonable Adjustment Digital Flag) as mandated through ISN re-recording disability/ accessible information needs in Electronic Patient Record.	1	2	Must	TBC	Dec 2025
2.5 Three services to be reviewed and rated under the EDS framework for 2025-26 (detailed review of Access, Experience, Safe from Harm, Outcomes).	1	2	Must	Identified Service Mgrs / Janice Ogonji	March 2026
2.6 Review business case for AccessAble and make decision on potential extension for years 4 and 5 (if approved, commission inclusion of Keele Medical Practice and consider inclusion of Lawton House into surveyed premises).	4	2	Should	Janice Ogonji	Nov 2025
2.7 Support inclusive talent management and career development / progression for all , through promotion of our career development workshops and career conversations - see Career devt link . This offer to be specifically targeted to staff with diverse characteristics (focus on race and disability. Encouraging take-up of coaching and mentoring by diverse characteristics colleagues).	4	1 & 2	Should	Jody Nicholls	Mar 2026
2.8 All executive directors to agree and deliver against personal and Directorate EDI objectives in 2025-26.	1-4	1 - 4	Must	Buki Adeyemo/ Execs	Oct 2025
2.9 Introduce and embed an HR / EDI Dashboard for all services and Directorates Monthly, Quarterly and Annual Monitoring and RAG rating of good / poor performance of (minimum by Dec 24), supporting identification of issues, ownership, prioritisation of action and progress monitoring of action in each service: • Workforce ethnicity, LGB+ and disability profile • Snr leadership representation. (Band 8A,8C upwards) – ethnicity, disability, LGB+, & gender • Diversity in shortlisted candidates (Global Majority / Differently Abled / LGB+ candidates) • WRES / WDES and LGB+ Recruitment score by service (x2 annually TBC) • Bullying & Harassment (NSS) rates from line mgrs/colleagues.	2 & 3	2 & 3	Should	Dave Hewitt, CIO with Janice Ogonji	Phase thru' 25-26

2.10 Publish and monitor annual Ethnicity, Disability and Gender Pay Gap reports (data to end March 2025), with targeted action plans to address findings	1	2	Must	Janice Ogonji	Dec 2025
3. To progress our high-visibility anti-racist and anti-discriminatory approach, delivering against tangible key milestones including:-					
3.1 Development and delivery of a targeted high-profile and impactful communications plan around anti-racist and anti-discriminatory approach (including refreshed posters & promotional campaign). To include anti-abuse message in conjunction with Craig Stone work.	4	1-4	Should	Comms team with Janice Ogonji	March 2026
3.2 Share outcomes and taking meaningful action from learning emerging from staff speaking up reviews , including FTSU, Dear Buki etc.	4	2 & 3	Must	Pauline Grant	March 2026
3.3 Review application of Trust Disciplinary Procedure and Trust Supporting Staff to Improve Performance Procedure through case review, taking a critical race and disability perspective. Propose and implement changes to debias process based on findings.	4	1 & 3	Should	Laura Reynolds / People Ops Team	March 2026
3.4 Begin work to review and debias access to Flexible Working and Flexible Retirement with an EDI lens.	4	1 & 3	Should	Laura Reynolds/ People Ops Team	March 2026
3.5 Review Workplace Adjustments and Access to Work process to eliminate delays and barriers to support for differently abled colleagues i. Ensure all job applicants are aware of the Trust's approach to supporting differently abled colleagues and workplace adjustments. ii. Share guidance and awareness raising around 'This is Me' Health Passport. Consider implementing a timeframe whereby all new staff have a discussion with their line manager about the 'This is Me' health passport within x weeks of commencing work.	4	3	Could	Laura Reynolds, Laura Ross & Laura Reynolds	Jan 2026
3.6 Continue to embed EDI as everyone's responsibility , core to Trust & NHS Values.	4	1-4	Should	Janice Ogonji	March 2026
3.7 Continue to encourage and support culture of inclusion, openness, authenticity and psychological safety at work through development of the Trust as a great place to work for all & celebration of diverse talent	4	3	Should	OD & Inclusion Team	Ongoing

3.8 People Ops Team to proactively seek to review protected characteristics at the outset of all employee relations processes and to gain agreement for these to be updated where applicable.	2	1 & 3	Should	Laura Reynolds, People Ops Team	Jan 2026												
4. Educate for Inclusion																	
4.1 Shift of focus away from positive action development programmes, & towards:- i. Ensuring equitable access / positive skew for take-up of development and leadership development opportunities for diverse talent ii. Development programmes focussed on creating an inclusive working environment , ie educating wider workforce for deeper understanding of inclusion and the reality of experience for minoritised groups iii. All trust leadership offers to include core inclusion component geared to audience level of responsibility	4	1-4	should	OD & Inclusion Team / service managers	Ongoing												
4.2 Programme of education around responding effectively to incidents of abuse, discrimination, incivility, understanding race & racism , including the need for active bystander/upstander response and the mechanisms available for reporting and addressing such behaviours.	4	1-4	Could	TBC													
4.3 Deliver an Executive development session on the learning from NHS discrimination cases and setting EDI objectives	3, 4	1-4	Should	Pauline Grant & Janice Ogonji	Feb 2026												
4.4 Trust Leadership Academy inclusion-themed session	3, 4	1-4	Should		Ongoing												
4.5 Programme of activities to celebrate and educate around inclusion, following national/international awareness calendar , particularly (link to Newsround, Exec Exchange, Combined TV, podcasts, Inclusion School, Trust/system conferences and other comms opportunities): <table><tr><td colspan="2">Race Inclusion:</td></tr><tr><td>18 Jul -17 Aug 2025:</td><td>South Asian Heritage Month</td></tr><tr><td>September</td><td>East and South Asian Heritage Month</td></tr><tr><td>October</td><td>Black History Month</td></tr><tr><td>3-9 February 2026</td><td>Race Equality Week</td></tr><tr><td colspan="2">Disability Inclusion:</td></tr></table>	Race Inclusion:		18 Jul -17 Aug 2025:	South Asian Heritage Month	September	East and South Asian Heritage Month	October	Black History Month	3-9 February 2026	Race Equality Week	Disability Inclusion:		3, 4	1-4	Should	Staff Network Leads with Janice Ogonji	Ongoing
Race Inclusion:																	
18 Jul -17 Aug 2025:	South Asian Heritage Month																
September	East and South Asian Heritage Month																
October	Black History Month																
3-9 February 2026	Race Equality Week																
Disability Inclusion:																	

14 Nov – 20 Dec	Disability History Month					
17 -23 Mar/April	Neurodiversity Celebration Wk/Awareness Mth					
LGBT+ Inclusion:						
February	LGTB+ History Month					
June	Pride Month					
Gender Equality:						
8 March	International Women's Day					
4.6 Build on investment in established programmes (HPMA Anti-Racist Leadership Programme, WRES Champions, Reciprocal Mentoring, etc). This might involve enlisting these individuals to support design and delivery of planned interventions.		1-4	1-4	Could	TBC	Mar 26

Equality Objectives 2025-28 and EDI Goals 2025-26

The numbers in columns 2 and 3 in the table above relate to the below.

Our Inclusion and Belonging Strategic Plan Equality Objective Priorities 25-28

1. Deliver overall continuous improvement in our actual and benchmarked performance on our Equality, Diversity and Inclusion Core Annual Responsibilities (see Appendix 2) to become and sustain our position as one of the best NHS employers in relation to a range of workforce race, disability, LGBT+ and gender inclusion measures, supported by an effective accountability and monitoring framework for leaders at service level and above.
2. Make demonstrable progress in significantly reducing health inequalities for our local population, including removing barriers to equitable access, experience and outcomes through all our services and demonstrating improved health outcomes, as measured by a range of patient/service user metrics.
3. Advance our position as a leading inclusive organisation by improving service user and staff experience and outcomes on a wide range of inclusion measures, including across key protected characteristics groups.
4. Deliver on our ambition to truly become an inclusive, anti-racist and anti-discriminatory organisation by 2028.

Our Inclusion and Belonging Priorities for 2026-27

1. Debiasing our Trust recruitment processes - leading to greater representation and parity and more inclusive talent management.
2. Reducing health inequalities for our service users and staff - leading to measurable reduction in gaps in access (focus on access in year 1, experience yr 2, outcomes yr 3).
3. 'High visibility' focus around anti-discriminatory approach.
4. Educating for inclusion.

←--- Educate for Inclusion ---→

Enclosure No: 11b

Workforce Disability Equality Standard (WDES) Final Submission

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11th September 2025
Discussion	☐	Approval	☐		

Presented by:	Frieza Mahmood, Chief People Officer
Prepared by:	Janice Ogonji, Inclusion and Belonging Lead
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:	N/A
Diversity & Inclusion Implications	The 2025 WDES report supports compliance with the Equality Act 2010 and the Public Sector Equality Duty (PSED) and offers evidence to inform the Trust's wider EDI strategy on disability and neurodiversity inclusion.
ICS Alignment / Implications:	The Trust's 2025 disability workforce data shows strong alignment with ICS priorities on equality, diversity, and inclusion, with record levels of disability declaration, improved feelings of value at work, and consistently high rates of reasonable adjustments. However, challenges remain in recruitment parity and declining incident reporting, indicating the need for sustained cultural change. Continued ICS-wide collaboration, shared learning, and targeted interventions will be key to

	embedding progress and addressing remaining disparities.
Recommendation / Required Action	1. Recognise that findings will inform the Trust's Inclusion and Belonging Action Plan delivery and ICS alignment. 2. Improve recruitment to achieve parity and fairness for disabled staff. 3. Embed cultural change by addressing harassment, promoting respect, and encouraging confident incident reporting. 4. Maintain strong performance in reasonable adjustments and board diversity, sharing best practice across the ICS.
Executive Summary	This report provides assurance on the Trust's performance against the NHS WDES indicators for 2025 (period covering 1 April 2024 – 31 March 2025), measuring progress towards our disability equality and inclusion objectives. WDES data is drawn from NHS workforce records (ESR and HR systems) and the annual NHS Staff Survey and is reported nationally by NHS England each year. Key highlights In 2025, the Trust saw strong progress in disability inclusion, with workforce representation reaching its best level yet, board diversity improving, and disabled staff reporting better perceptions of equal opportunities and feeling valued. Capability cases also fell, and harassment, bullying and abuse (HBA) scores showed improvement. However, recruitment equity worsened, and fewer staff reported HBA compared to the previous year. Other measures, such as engagement, workplace adjustments, and presenteeism, showed only marginal change. Overall, while representation and perceptions have improved, further focus is needed on recruitment fairness, reporting confidence and sustaining access to adjustments. What's Improved: • Further improvement in workforce disability representation again to best yet rate (10.16%, against a national average of 5.7% in 2024). • Our capability measure score has improved, falling from 11.25 in 2024 to 6.9 in 2025. However, this is based on a small data set, which can lead to noticeable year-on-year fluctuations and may not reflect broader trends. • Perceptions of equal opportunities for career development and progression increased from 58.3% (in 2024) to 64.5% for disabled staff. • Perceptions of feeling valued by disabled staff marginally improved (up 3% to 53.5%). • Improved HBA scores from patients / public (27.88% compared to 32.49% in 2024); managers (7.95% compared to 11.87% in 2024) and (3) staff (16.88% compared to 19.40% in 2024). • Representation of Board members with disabilities or long-term conditions increased to 23.1% in 2025 from 14.29% in 2024. As

this is based on a small data set, the figures may be subject to noticeable variation year on year.

Deterioration in Performance:

- Recruitment measure 1.3 (1.00 = equity) a decline from 0.98 in 2024.
- Reporting of HBA fell from 65.03% in 2024 to 60.45% in 2025.

No / Marginal Change:

- Fewer staff with disabilities reported presenteeism (reduced to 15.41% from 16.6% in 2024).
- Staff engagement score for differently abled staff was 7.16 (7.08 in 2024).
- The proportion of disabled staff who felt they had received the reasonable adjustments needed to carry out their work fell slightly to 82% in 2025, compared with 83% in 2024.

Progress on WDES in 2025

Combined has continued to strengthen its inclusive culture through targeted recruitment reforms, inclusive leadership development, and improved accessibility. In 2025, it advanced inclusion for differently abled staff through a wide range of initiatives. Recruitment practices were reviewed with external input to ensure fairness and consistency, supported by inclusive leadership training and mentoring opportunities for underrepresented groups. A new course, Feedback through the Lens of Inclusion, promoted inclusive communication across all characteristics.

Practical support included ward-based stretch opportunities, the Career Development CAT page, an Inclusion & Belonging hub, and resources such as Lexxic, TextHelp and free webinars. Although funding for the Differently Abled Buddy Scheme ended in 2024, the Combined Ability Network continued providing support and delivered a successful Disability Conference with regional partners.

Other measures included embedding inclusion in Board development, updating leadership programmes, conducting AccessAble audits across Trust sites, and launching a new Flexible Working toolkit. Health, wellbeing and workplace adjustments were built into appraisals, and staff engagement in initiatives such as the System Sexual Safety session highlighted the wider importance of being an upstander against discrimination.

It is noted that not all actions from the 2024 action plan have been delivered due to limited resources and capacity. These outstanding actions have been rolled over into the 25-26 plan (covering 1 April 2025 – 31 March 2026), which remains aligned to ICS priorities.

WDES Priorities for Action for 2025–26:

The WDES action plan is a part of the Trusts 4 year Inclusion and

Belonging Strategy (2024–2028) aligned with the Trust’s Equality Objectives for the same period. Key priorities include debiasing people processes, especially recruitment, talent management and performance management with a focus on disability inclusion. An ongoing two-year programme is supporting embedding a just and inclusive culture, alongside reforms to recruitment and leadership development aimed at tackling bullying and harassment. The Trust also plans to improve the timeliness and effectiveness of workplace adjustments. Progress is monitored and reported annually.

Next Steps

1. Deliver the 25-26 action plan, prioritising parity in recruitment, reducing capability disparities, and strengthening cultural change.
2. Address harassment through targeted interventions, improved respect in the workplace, and rebuilding trust in reporting processes.
3. Sustain high performance in reasonable adjustments and leverage inclusive leadership to drive system-wide improvement.
4. Monitor progress quarterly, ensuring efficient use of resources and ongoing ICS alignment.

VERSION CONTROL:

Version	Report to	Date Reported
1.0	SLT	26.08.25
1.0	PCDC	01.09.25
1.0	Public Trust Board	01.09.25

Workforce Disability Equality Standard (WDES)

Trust Report 2025 & Action Plan for 2025-26



Author: Janice Ogonji inclusion & Belonging Lead

Lead Director: Frieza Mahmood, Chief People Officer

Date: 8 August 2025

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APPENDIX 2 - Inclusion And Belonging Action Plan 2025-26

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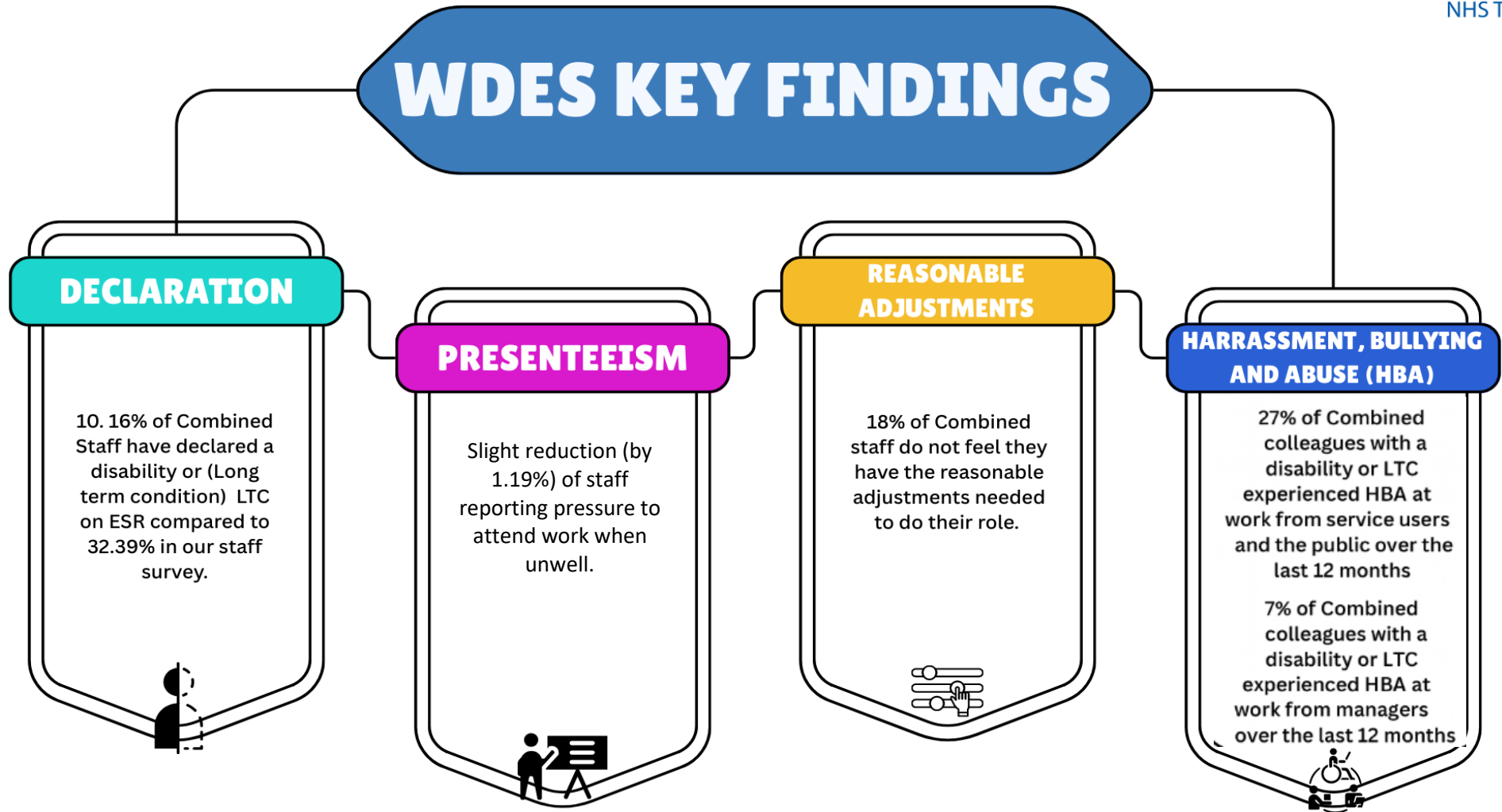


Figure 1: WDES 2025 key findings summary

Executive Summary

This is the Trust's seventh annual **Workforce Disability Equality Standard (WDES)** Report, published in line with NHS Standard Contract requirements and national benchmarking.

Overall Performance

Progress in WDES metrics has slowed this year, with most indicators remaining stable. However, the Trust continues to perform strongly overall at the time of writing this report we are awaiting the national rank position however given our performance expect this to remain high.

Areas of Improvement

- ✓ Increased disability **representation** in the workforce.
- ✓ Reduction in **presenteeism** (staff attending work while unwell).
- ✓ Improved reporting of **fair treatment** in capability processes.
- ✓ Better perceptions of **equal opportunities** for career progression.
- ✓ **Board representation**.

Areas of Concern

- ! **Recruitment** indicates a move away from parity, with non-disabled applicants now more likely to be appointed than their disabled peers.
- ! **Capability** remains a key issue. Although only a few disciplinary cases involve disabled staff (three per year), they continue to impact the score significantly and reflect ongoing challenges.
- ! Disabled staff continue to report **poorer experiences** than non-disabled colleagues, especially around **harassment, bullying and abuse (HBA), career progression and feeling valued**.

These insights underscore the need for renewed focus on inclusion and better support for our differently abled workforce.

Key Actions in 2025 (covering 1 April 2024 to 31 March 2025)

- **Refocused Inclusion and Belonging approach** as part of our strategic plan.
- Continued work on **debiasing people processes**, particularly recruitment and selection to better support neurodiverse individuals.
- Introduced an **accessibility toolbar** on internal and external sites to support a range of disabilities.
- Developed and shared **resources for line managers and staff** around workplace adjustments.
- Strengthened the **Combined Ability Network**, expanding its role and impact.
- Promoted shared responsibility for **EDI and race inclusion**, including encouraging leaders to engage with their EDI data.

Priorities for the period 2025–26 (covering 1 April 2025 to 31 March 2026)

- Continue debiasing work, with a focus on **disability-inclusive recruitment and inclusive talent management**.
- Improve processes for ensuring **timely access to workplace adjustments** for differently abled colleagues.

These efforts will support our goal of creating a more inclusive, equitable and supportive workplace for all.

NSCHT Workforce Disability Equality Standard (WDES) Report 2025

1.0 Introduction

The Workforce Disability Equality Standard (WDES) is mandated annually as part of the NHS Standard Contract since 2019, feeding into NHS England, the Care Quality Commission (CQC) and our local commissioners monitoring processes. The WDES supports us to develop our Trust ambition to provide **outstanding inclusion** for all of our workforce as set out in our [Combined People Plan 2023-28](#) and [Inclusion and Belonging Strategic Plan 2024-28](#) and in line with the national [NHS EDI Improvement Plan](#). This provides a national benchmarking of our performance on disability inclusion (as measured by the 10 indicators of the WDES).

This report contains the Trust's seventh annual WDES performance and our associated action plan. This will be published on our website and shared with NHS England and our local commissioners.

1.1 Trust WDES 2025¹ Performance Overview

While two measures have seen note-worthy continued improvement in 2025, overall the Trust has seen some slowing of pace in progress with its WDES data. A few measures have held their position or changed minimally. This is perhaps to be expected given the significant year-on-year progress made since the WDES was introduced to achieving a rank position of 7th nationally (Top 4%) for overall 2024 WDES performance, at the time of writing the report we are still awaiting the national ranking.

What's Improved:

- ✓ Further improvement in workforce disability representation again to best yet rate (10.16%, against a national average of 5.7% in 2024).
- ✓ Our capability measure score has improved, falling from 11.25 in 2024 to 6.9 in 2025. However, this is based on a small data set, which can lead to noticeable year-on-year fluctuations and may not reflect broader trends.
- ✓ Perceptions of equal opportunities for career development and progression increased from 58.3% (in 2024) to 64.5% for disabled staff
- ✓ Perceptions of feeling valued by disabled staff marginally improved (up 3% to 53.5%).
- ✓ Improved HBA scores from (1) patients / public; (2) managers and staff.
- ✓ Representation of Board members with disabilities or long-term conditions increased to 23.1% in 2025 from 14.29% in 2024. As this is based on a small data set, the figures may be subject to noticeable variation year on year.

What's Worse:

- ! Recruitment measure 1.3 (1.00 = equity) a decline from 0.98 in 2024.
- ! Reporting of HBA fell from 65.03% in 2024 to 60.45% in 2025.

No / Marginal Change:

- Fewer staff with disabilities reported presenteeism (reduced to 15.41% from 16.6% in 2024).
- Staff engagement for differently abled staff was 7.16 (7.08 in 2024).
- The proportion of disabled staff who felt they had received the reasonable adjustments needed to carry out their work fell slightly to 82% in 2025, compared with 83% in 2024.

¹ The reporting period for this WDES report runs from 1 April 2024 to 31 March 2025 and will be referred to as 2025.

Key Messages

1. The Trust has seen strong progress in disability inclusion, with record-high workforce representation (10.16%), improved perceptions of career progression (up to 64.5%), reduced presenteeism, and a rise in board-level representation of disabled members.
2. While improvements are evident, challenges remain particularly in recruitment equity, where the score declined to 1.3, and access to workplace adjustments, which saw a slight drop. Some areas, such as staff engagement and experiences of harassment, showed minimal change.

2.0 Trust summary performance over time against the 10 WDES Indicators

	Years						
Indicators	2019	2020	2021	2022	2023	2024	2025
1.Workforce disability profile	2.50%	4.30%	6.60%	6.10%	7.60%	8.70%	10.16% ↑
National	3.10%	3.40%	3.70%	4.20%	4.90%	5.70%	Not avail.
2. Recruitment measure	1.9	1.06	0.85	1.01	0.94	0.98	1.3 ↓
National	1.18	1.2	1.2	1.11	1.09	0.99	Not avail.
3.Capability process measure	n/a	0	0	0	2.96	11.26	6.94 ↑
National	n/a	1.53	1.94	2.01	2.17	2.04	Not avail.
4a. HBA from patients / public	35.60%	34.98%	31.9	34.86%	34.46%	32.49%	27.88% ↑
No LTC or illness	26.50%	28.62%	26.08%	26.69%	23.56%	21.92%	21.09%
4b. HBA from Managers	8.80%	10.40%	9.57	10.68%	12.18%	11.87%	7.95% ↑
No LTC or illness	6.70%	9.40%	7.50%	4.40%	5.29%	4.93%	6.82%
4c. HBA from staff	14%	15.42%	16.09	15.96%	21.08%	19.40%	16.88 ↑
No LTC or illness	9.40%	10.40%	7.30%	8.80%	9.80%	10.33%	11.54%
4d: Reporting of HBA	67.70%	59.74%	64.52	57.27%	66.03%	65.03%	60.45% ↓
No LTC or illness	61.40%	60.90%	66.00%	67.30%	68.10%	71.50%	73.11%
5. Equal opportunities for career progression	50.90%	53.50%	62.23%	63.03%	64.33%	58.27%	64.52% ↑
No LTC or illness	59.20%	61.10%	68.30%	71.60%	69.90%	70.42%	67.12%
6. Presenteeism	15.20%	14.80%	16.20%	17.90%	20.60%	16.60%	15.41% ↑
No LTC or illness	13.10%	14.30%	15.50%	13.50%	11.60%	11.54%	11.18%
7.Valued at work	37.80%	41.20%	50.40%	52.80%	49.60%	50.88%	53.45% ↑
No LTC or illness	48.50%	52.90%	59.30%	61.20%	57.50%	59.88%	60.05%
8. Reasonable adjustments	The wording of this Staff Survey question changed in 2022, so results cannot be directly compared with earlier years				86.20%	83.04%	82.74% ↓
National					78.76%	79.32%	79.60%
9. Staff engagement scores	6.8	7.01	7.2	7.06	7.13	7.08	7.16 ↑
No LTC or illness	6.8	7.01	7.2	7.06	7.13	7.08	7.16
National	6.7	6.71	6.85	6.74	6.74	6.82	6.74
10. Board members representation	0.00%	7.70%	14.30%	20.00%	23.10%	14.29%	15.38 ↑
National	2.00%	3.00%	3.70%	4.60%	5.70%	6.50%	Not avail.

Key			
National		Improved	↑
No Long Term Condition or illness		Declined	↓
NSCHT			

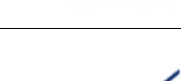
2.1. National WDES results up to 2024 for comparison

The table below is taken from the most recent [NHS England » Workforce Disability Equality Standard: 2024 data analysis report for NHS trusts](#)² (Page 8 & 9, NHS England, published 25th June 2025), depicting average national performance annually since 2016. This provides information on the direction of travel nationally, for comparison against Trust performance. Generally, Trust performance (see section above) is in line with the national trend over time.

WDES metrics based on workforce headcounts		Reporting year						Trend
		2019	2020	2021	2022	2023	2024	
1	Percentage of staff declaring a disability	3.1%	3.5%	3.7%	4.2%	4.9%	5.7%	
	Percentage of staff whose disability status is unknown	25.4%	23.1%	21.3%	19.1%	16.6%	14.3%	
2	Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.18	1.20	1.11	1.09	0.99	0.98	
3	Relative likelihood of disabled staff entering the formal capability proceedings (excluding ill-health) compared to non-disabled staff	1.08	1.53	1.94	2.01	2.17	2.04	
10	Disability representation on the executive board	2.0%	3.0%	3.7%	4.6%	5.7%	6.5%	

WDES metrics based on the NHS Staff Survey			NHS Staff Survey year					Trend
			2019	2020	2021	2022	2023	
4a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Disabled	34.0%	31.6%	33.0%	33.1%	30.0%	
		Non-disabled	27.1%	25.2%	25.8%	25.9%	23.3%	
4b	Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	Disabled	18.5%	18.6%	17.2%	16.4%	14.6%	
		Non-disabled	10.8%	10.7%	9.8%	9.4%	8.2%	
4c		Disabled	26.4%	25.7%	25.3%	25.0%	23.8%	

² The 2025 WDES national data, covering 1 April 2024 to 31 March 2025, has not yet been published and is therefore not available for benchmarking.

	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Non-disabled	17.2%	16.8%	16.6%	16.6%	15.4%	
4d	Percentage of staff who indicated that they or a colleague reported the last incident	Disabled	49.6%	49.6%	49.7%	51.0%	52.5%	
		Non-disabled	48.4%	48.0%	48.3%	49.1%	51.4%	
5	Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	Disabled	51.9%	51.5%	51.0%	51.7%	52.2%	
		Non-disabled	58.0%	57.6%	57.0%	57.5%	58.1%	
6	Percentage of staff who felt pressure from their manager to come to work despite not feeling well enough to perform their duties	Disabled	30.7%	31.3%	30.2%	28.0%	26.6%	
		Non-disabled	21.1%	23.0%	22.2%	20.1%	18.5%	
7	Percentage of staff who were satisfied with the extent to which their organisation values their work	Disabled	39.0%	39.2%	34.7%	34.7%	36.9%	
		Non-disabled	50.3%	50.5%	44.6%	44.6%	47.8%	
8	Percentage of disabled staff whose employer had made reasonable adjustments to enable them to carry out their work*					73.4%	74.5%	
9	Staff engagement score	Disabled	6.6	6.7	6.5	6.4	6.5	
		Non-disabled	7.1	7.1	7.0	6.9	7.0	

— Disabled — Non-disabled

3.0 Trust Performance Breakdown by the 10 WDES Indicators

Indicator 1: Workforce profile: Trust Workforce Disability Profile

Our aim at Combined is to be equally representative of our overall workforce reporting disabilities through all bands (clinical and non-clinical), and to have a culture in which all workers feel valued and where colleagues with health conditions, neurodiversity and disability ('differently abled') feel comfortable and supported in sharing this information. The Trust's overall disabled workforce (bank excluded) has increased to 10.16% in 2025. It is anticipated that this will continue to be in line with the top 10% of trusts nationally on this measure (as in 2023, when we were ranked 19th nationally).

The national 2024 WDES disability declaration rate was 5.7%. The Trust's rate was higher at 8.7% in 2024, rising further to 10.16% in 2025. National 2025 data has not yet been published and is therefore unavailable for comparison. It is noted however, this falls significantly short of the self-reported (anonymous) NHS Staff Survey results suggesting 32.39% of Trust staff have a long-term health condition, are neurodiverse or have a disability.

Table 1 below provides a breakdown of our Trust Disability data for 2025 by WDES 'Cluster', compared to the 2024 results (whole workforce, excluding bank only workers). The shows that we are more representative of disability in the lower 2 clusters (bands 5-7, and particularly bands 1-4) than in higher banded clusters and medical roles.

- **Whole Trust Workforce** Disability (excluding bank): **10.16%** (**up** from 8.7% in 2024)
- Trust **Non-Clinical** Disabled Workforce: **12%** (**up** from 9.5% in 2024)
- Trust **Clinical** Disabled Workforce (excluding medical): **9.8%** (**up** from 8.5% in 2024)
- Trust **Medical Workforce**: **5.6%** (remain the same at 5.6% in 2024)

Cluster / Grouping	2023			2024			2025		
	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown	Disabled	Non-disabled	Unknown
1: <B1-B4	8.5%	73.6%	17.9%	8.8%	77.4%	13.8%	11.45%	78.03%	10.52%
2: B5-B7	7.8%	83.6%	8.6%	9.5%	83.7%	6.8%	10.26%	84.56%	5.18%
3. B8a-B8b	5.2%	80.7%	14.1%	6.0%	85.9%	8.1%	8.22%	85.46%	6.32%
4:B8c-VSM	4.4%	84.4%	11.1%	4.4%	91.1%	4.4%	3.50%	93.00%	3.50%
Other	4.5%	95.5%	0.0%	0.0%	0.0%	0.0%	0.00%	0.00%	0.00%
Medical	4.4%	75.0%	20.6%	5.6%	80.6%	13.9%	5.48%	83.56%	10.96%
TOTAL	7.6%	79.3%	13.0%	8.7%	81.4%	9.9%	10.16%	82.23%	7.61%

IMPROVED: The data shows steady progress in disability declaration.

- Records of "unknown" fell from 13.0% to 7.61%, reflecting better data quality.
- The percentage of non-disabled staff has stayed broadly consistent.
- Gains were made in B1–7 with representation up around 10–11%. B8a–8b have also risen to 8.22%, though this remains lower than the overall workforce.
- At senior levels (B8c–VSM), representation has slightly declined from 4.4% to 3.5%, and among medical a slight decrease from 5.6% to 5.48% (both below the organisational average).

Table 1: Whole Workforce WDES Summary data 2025 – by WDES 'cluster' (Green shows improvement vs red showing decline)

Indicator 2: Recruitment: relative likelihood of disabled applicants being appointed from shortlisting across all posts

Between 2024 and 2025, NSCHT’s WDES recruitment score increased from 0.98 to 1.3. In this metric, a score of 1.0 represents parity, where disabled and non-disabled applicants are equally likely to be appointed from shortlisting. In 2024, NSCHT was just below parity, suggesting a slightly more favourable outcome for disabled applicants. However, the increase to 1.3 in 2025 indicates a shift away from parity, with non-disabled applicants becoming more likely to be appointed. In contrast, the national average improved slightly from 0.99 to 1.0, reaching parity. This shift highlights an area of focus for the Trust to ensure recruitment practices remain equitable for disabled applicants. A more complete analysis of our recruitment activities (including applications stage) is included below:

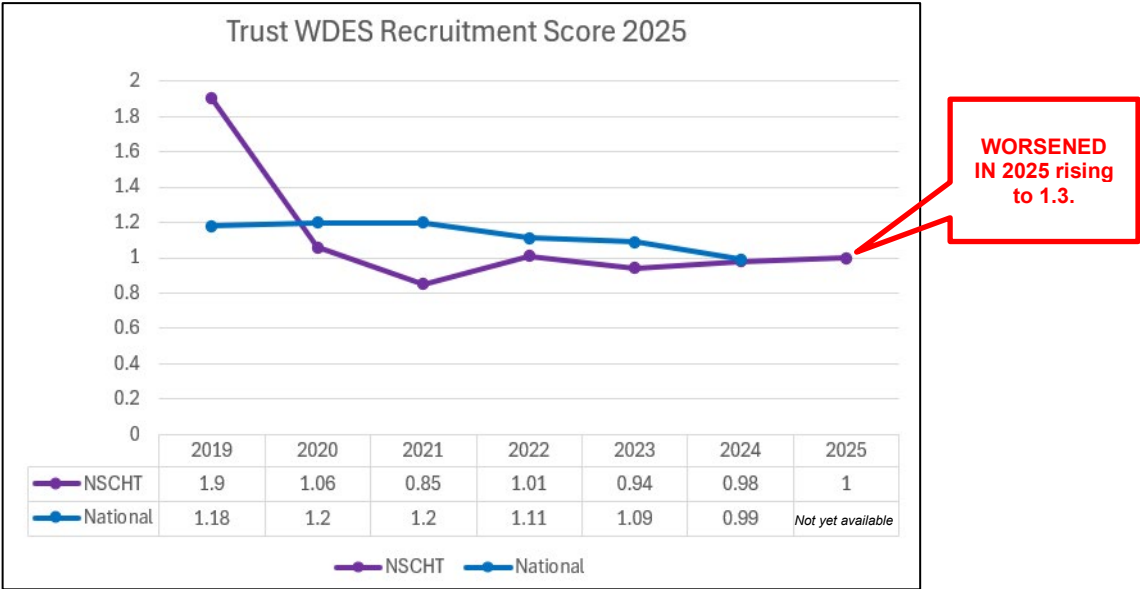


Chart 1: WDES recruitment scores 2019 – 2024 (Trust scores compared with national average).

2024	Applications	Shortlisted	Appointed	2025	Applications	Shortlisted	Appointed
Disabled	469 (6.8%)	196 (9.5%)	55 (9.2%)	Disabled	450 (7.92%)	196 (9.4%)	55 (9.13%)
Non-Disabled	6305 (91.4%)	1829 (88.2%)	504 (83.9%)	Non-Disabled	5136 (90.47%)	1829 (88.2%)	505 (83.9%)
Unknown	124 (1.8%)	49 (2.4%)	42 (7.0%)	Unknown	91 (1.60%)	49 (2.3%)	42 (7%)
Total	6898 (100%)	2074 (100%)	601 (100%)	Total	5677 (100%)	2074 (100%)	602 (100%)

Table 2: Disability through the Trust R&S Process comparing 2024 and 2025.

Indicator 3: Capability Process Measure: Relative likelihood of disabled staff entering the formal capability process

The capability measure remains a key area of concern for the Trust and requires continued improvement. For the first four years of WDES reporting, there were no capability cases involving staff with recorded disabilities, resulting in a score of zero. However, this changed in 2023, with 3 cases leading to a score of 2.96 - affected by the relatively small number of staff declaring a disability. In 2024, the number of cases rose sharply to 11.26, making it an extreme outlier. In 2025, the score reduced to 6.9, which, while an improvement, still indicates the need for focused action. As noted, this measure may be skewed by the Trust’s small size, low number of capability cases and few staff declaring disabilities. Nonetheless, the Trust will undertake to review our Improving Performance process with an inclusion lens and specifically, a differently abled focus.

The People Operational Team are actively reviewing and updating equality data in ESR, with consent, for staff involved in disciplinary,

Capability cases				
	2023	2024	2025	2 year rolling average (for WDES calculation)
Disabled	2	3	3.5	3.25
Non-Disabled	3	3	3	3
Unknown	0	0	0	0
Total	5	6	6.5	6.25

Table 3: Trust Formal Capability Procedure Cases 2022-2025.

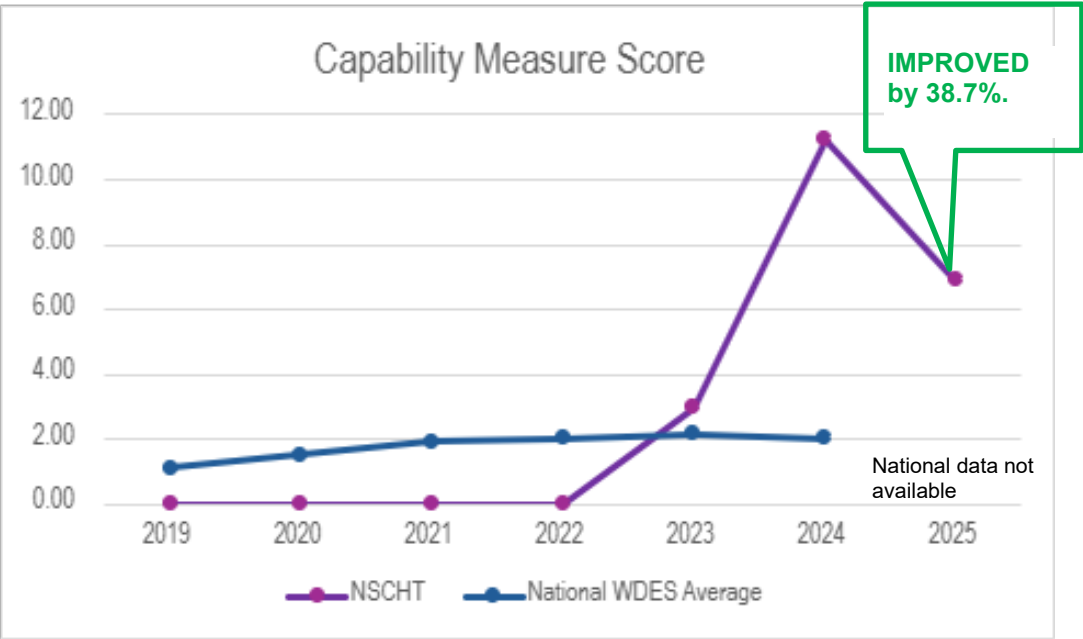


Chart 2: Trust Capability measure score 2019-25.

performance, sickness, or other employee relations processes. The Trust is also engaging with peer organisations to identify and adopt best practices in managing performance for staff with disabilities and neurodivergence. Going forward, all new cases will be closely monitored and assessed through the lens of a Just, Fair and Restorative Culture before any formal capability action is taken.

As bank workers are not substantive employees, they are not subject to the formal disciplinary policy. However, there were 5 bank worker cases reviewed in line with just culture / principles of disciplinary policy.

Indicator 4a: Harassment Bullying and Abuse (HBA): Service Users and the Public

BETTER than 2024

HBA decreased for staff with disabilities but remained higher than the national average and unchanged for those without disabilities.

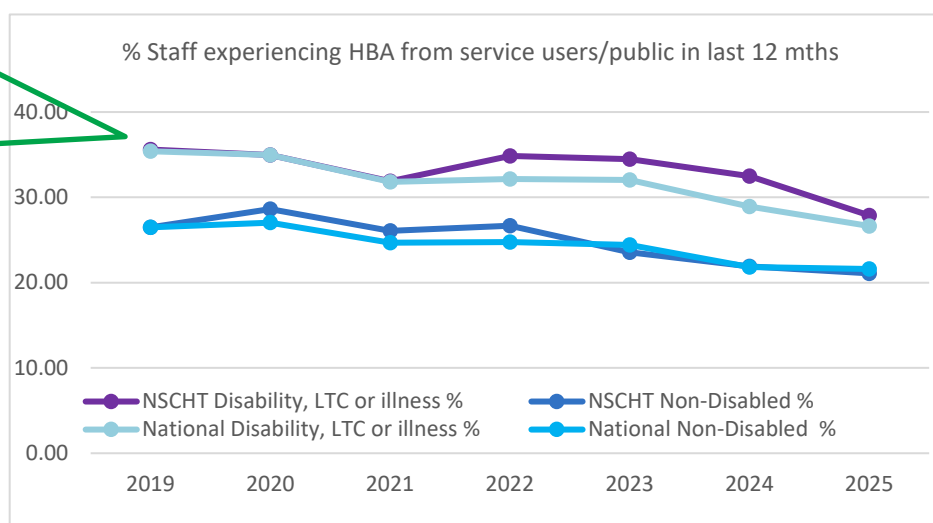


Chart 3: HBA by service users and the public in last 12 months (Trust results, 2024 Staff Survey).

The 2025 WDES (based on the 2024 Staff Survey) shows a 5% improvement in reports of HBA from service users, relatives, and the public among disabled staff. However, the rate for non-disabled staff remained unchanged, with a 6-point gap still present. Despite the improvement, it's concerning that one in four disabled colleagues continue to report experiencing HBA, compared to just over one in five non-disabled staff.

The Trust remains committed to addressing this issue, encouraging all staff to report incidents and continuing efforts through the Just, Fair and Restorative Culture programme to reduce and eliminate violence and abuse in the workplace.

	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	35.6	34.98	31.9	34.86	34.46	32.49	27.88
NSCHT Non-Disabled %	26.5	28.62	26.08	26.69	23.56	21.92	21.09
National Disability, LTC or illness %	35.4	34.98	31.81	32.16	32.04	28.92	26.64
National Non-Disabled %	26.5	27.03	24.69	24.74	24.42	21.82	21.6

Table 4: Percentage of staff experiencing HBA from service users/public 2019-2025.

Indicator 4b: Harassment, Bullying & Abuse: Manager

There was a marginal improvement in the percentage of staff with and without disabilities reporting HBA from Trust managers. Almost 8% of differently abled colleagues (1 in 13) reported HBA from a Trust manager, compared to 6.82% (1 in 15) of non-disabled Trust colleagues.

Whilst the score for differently abled colleagues was lower than the average this year, it is clear unacceptable that so many staff with disabilities should feel they experience HBA from those in positions of responsibility. We continue to work to reduce and eliminate all forms of harassment, bullying and abuse, particularly those emerging from members of the Trust's own workforce / team or managers.

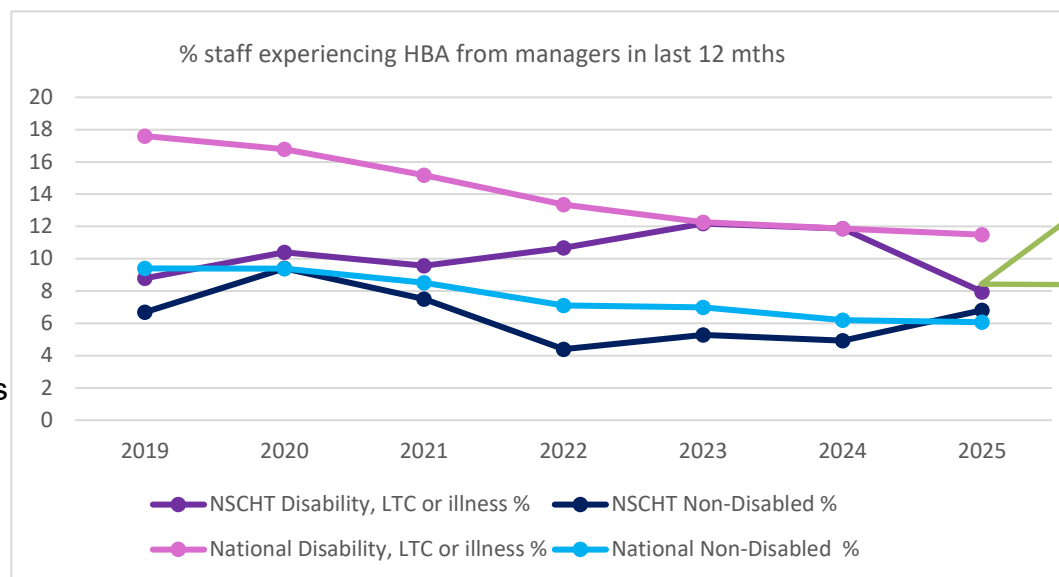


Chart 4: HBA by managers in last 12 months (Trust results, 2024 staff survey).

Improvement in reports of HBA from managers among disabled staff, while rates slightly increased for non-disabled staff. Encouragingly, the rate for disabled staff remains below the national average.

	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	8.8	10.4	9.57	10.68	12.18	11.87	7.95
NSCHT Non-Disabled %	6.7	9.4	7.51	4.4	5.29	4.93	6.82
National Disability, LTC or illness %	17.6	16.78	15.17	13.36	12.27	11.87	11.49
National Non-Disabled %	9.4	9.38	8.52	7.1	6.99	6.19	6.07

Table 5: Percentage of staff experiencing HBA from managers 2019-2025.

Indicator 4c: Harassment, Bullying & Abuse: Staff

There was a slight improvement in HBA reported by staff with disabilities in the 2025 WDES (2024 staff survey).

Almost one in 6 Trust staff with disabilities reported experiencing harassment, bullying or abuse from their colleagues, compared to just above 1 in 10 for non-disabled staff. Despite being highly unsatisfactory, the Trust's score on this measure was equal to the national average.

Preventing and responding better to all forms of bullying and abuse will continue to be a key focus within our anti-discriminatory approach.

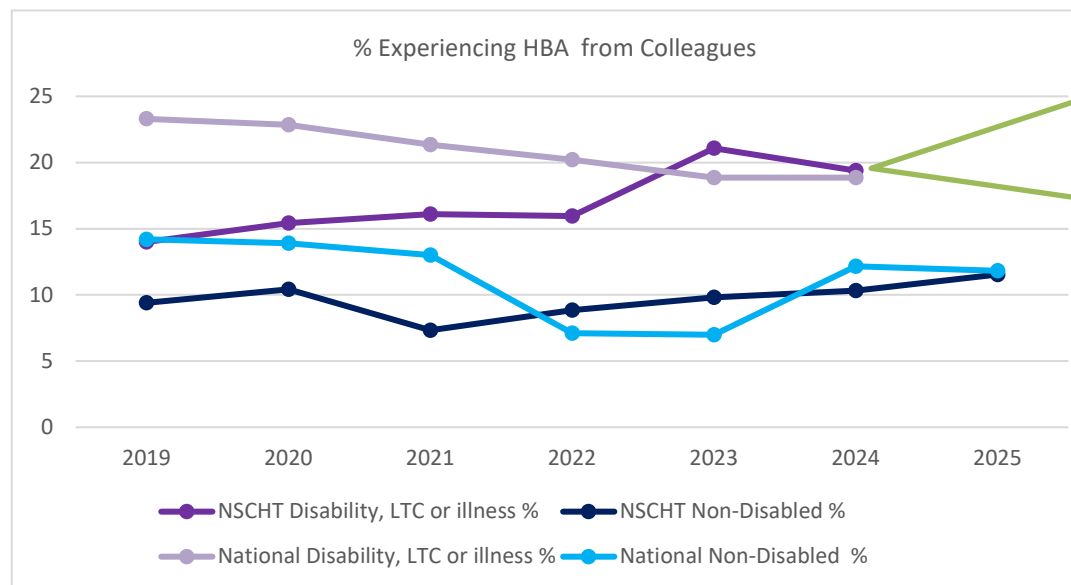


Chart 5 HBA by colleagues in last 12 months (Trust results, 2024 staff survey).

	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	14.00	15.42	16.09	15.96	21.08	19.40	16.88
NSCHT Non-Disabled %	9.40	10.41	7.33	8.84	9.82	10.33	11.54
National Disability, LTC or illness %	23.30	22.85	21.34	20.21	18.86	18.86	17.96
National Non-Disabled %	14.20	13.89	13.01	7.10	6.99	12.15	11.81
NSCHT Disability, LTC or illness responses	172	201	230	282	351	397	391
NSCHT Non-disabled responses	595	567	682	747	845	813	806

Table 6: Percentage of staff experiencing HBA from colleagues 2019-2025.

Indicator 4d: Harassment, Bullying & Abuse: Reporting

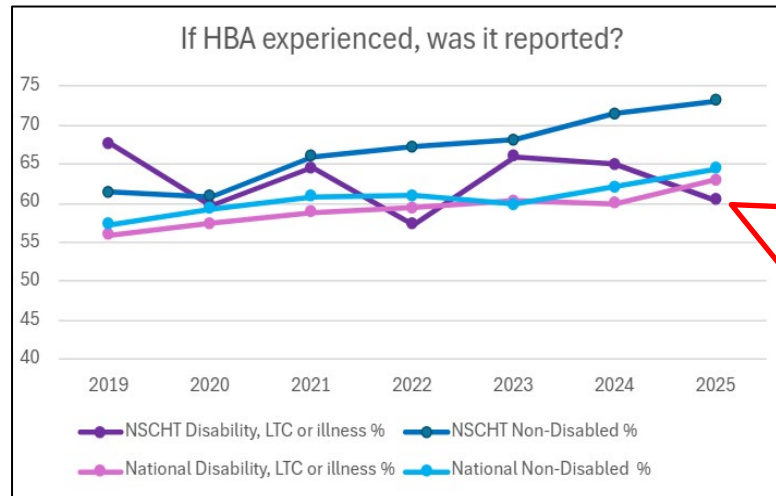


Chart 6: Staff Reporting HBA in last 12 months, (Trust results, 2024 staff survey).

HBA creates a harmful work environment that can impact staff wellbeing, hinder performance, and compromise the quality and safety of care. It also makes recruitment and retention more difficult, increasing pressure on an already stretched workforce.

The Trust continues to report higher-than-average rates of HBA incident reporting, with around two-thirds of affected staff in both groups choosing to report. While reporting among non-disabled colleagues improved in 2025, the rate for disabled staff declined from 65.03% in 2024 to 60.45% in 2025. The Trust remains committed to supporting all staff in reporting abuse and taking meaningful action in response to every report received.

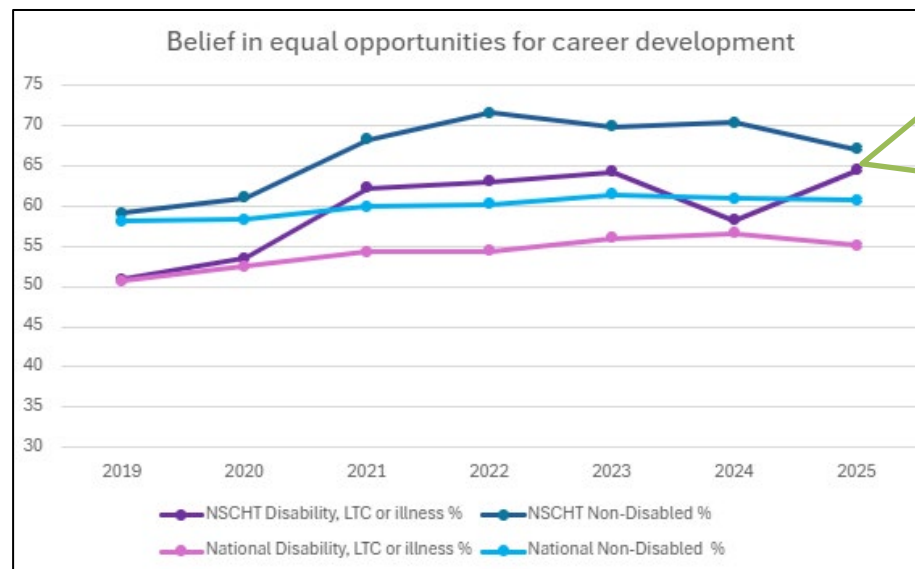
	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	67.70	59.74	64.52	57.27	66.03	65.03	60.45
NSCHT Non-Disabled %	61.40	60.87	66.04	67.28	68.10	71.50	73.11
National Disability, LTC or illness %	55.90	57.37	58.81	59.38	60.32	59.93	62.98
National Non-Disabled %	57.30	59.27	60.81	60.96	59.81	62.07	64.40
NSCHT Disability, LTC or illness responses	62	77	93	110	156	163	134
NSCHT Non-disabled responses	171	184	212	217	210	214	212

Table 7: Percentage of staff reporting HBA 2019-2025.

Indicator 5: Belief that organisation provides equal opportunities for career progression & promotion

Results show improvement from 58.27% in 2024 to 64.52% in 2025. This upward shift of over six percentage points suggests growing confidence among staff in the fairness of career opportunities. While positive progress is evident, the figures also highlight that more than a third of staff remain unconvinced, indicating continued work is needed to further strengthen equity and transparency in promotion pathways.

One of our Trust inclusion and belonging strategic priorities for 2025-26 is to focus on more equitable and inclusive talent management and career progression for our diverse talent.



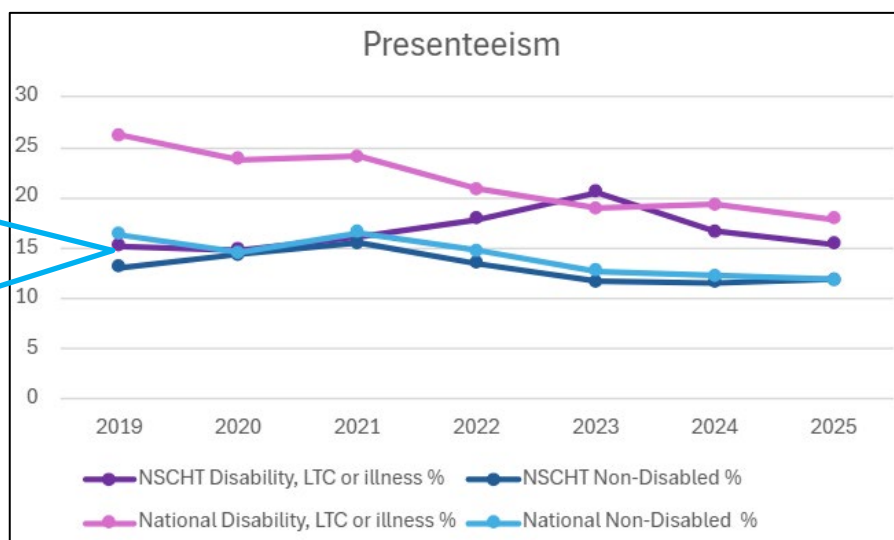
There was a **6.25% IMPROVEMENT** in disabled staff's perceptions of equal career progression opportunities, while non-disabled staff saw a 3.3% decline. Scores for both groups remain above the national average, though only slightly so for disabled staff.

Chart 7: Belief in equal opportunities for career development & progression (Trust results, 2024 staff survey).

	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	50.90	53.50	62.23	63.03	64.33	58.27	64.52
NSCHT Non-Disabled %	59.20	61.08	68.30	71.64	69.91	70.42	67.12
National Disability, LTC or illness %	50.70	52.55	54.31	54.38	55.99	56.66	55.13
National Non-Disabled %	58.10	58.30	59.96	60.23	61.48	61.00	60.75
NSCHT Disability, LTC or illness responses	175	200	233	284	365	393	389
NSCHT Non-disabled responses	598	573	694	751	845	808	806

Table 8: Percentage of experiencing belief in equal opportunities for career development & 2019-2025.

Indicator 6: Presenteeism (pressure to attend work despite not feeling well enough)



There was a 1.19% reduction in disabled staff reporting feeling pressure to work while unwell, marking a positive shift. Although this remains a better-than-average result nationally, a 3.6% gap still exists between disabled and non-disabled staff, with more disabled colleagues reporting presenteeism.

Working while unwell can impact the quality and safety of care, increase the risk of errors, and contribute to staff burnout and turnover. The Trust remains committed to reducing presenteeism through the continued delivery of the 'Health and Wellbeing' strand of Our Combined People Plan.

Chart 8: Presenteeism: Staff feeling pressure to attend when unwell (Trust results, 2024 staff survey).

	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	15.20	14.81	16.20	17.93	20.55	16.60	15.41
NSCHT Non-Disabled %	13.10	14.34	15.46	13.48	11.63	11.54	11.81
National Disability, LTC or illness %	26.20	23.86	24.14	20.85	18.93	19.35	17.91
National Non-Disabled %	16.40	14.52	16.57	14.74	12.67	12.27	11.86
NSCHT Disability, LTC or illness responses	125	135	142	184	253	265	279
NSCHT non-disabled responses	290	265	278	319	387	364	364

Table 9: Percentage of staff feeling pressure to attend when unwell (2019 – 2025).

Indicator 7: Feeling Valued

Feeling valued is vital to delivering high-quality care, promoting teamwork, and supporting staff wellbeing. It's encouraging that Trust scores in this area remain significantly above the national average for both disabled and non-disabled staff.

Among disabled staff, the percentage feeling valued rose from 50.88% in 2024 to 53.45% in 2025. For non-disabled staff, the rate increased slightly from 59.88% to 60.05% over the same period.

The Trust remains committed to ensuring all colleagues particularly those with disabilities feel supported, recognised and rewarded, as part of creating a 'Great Place to Work' through Strand 2 of Our Combined People Plan.

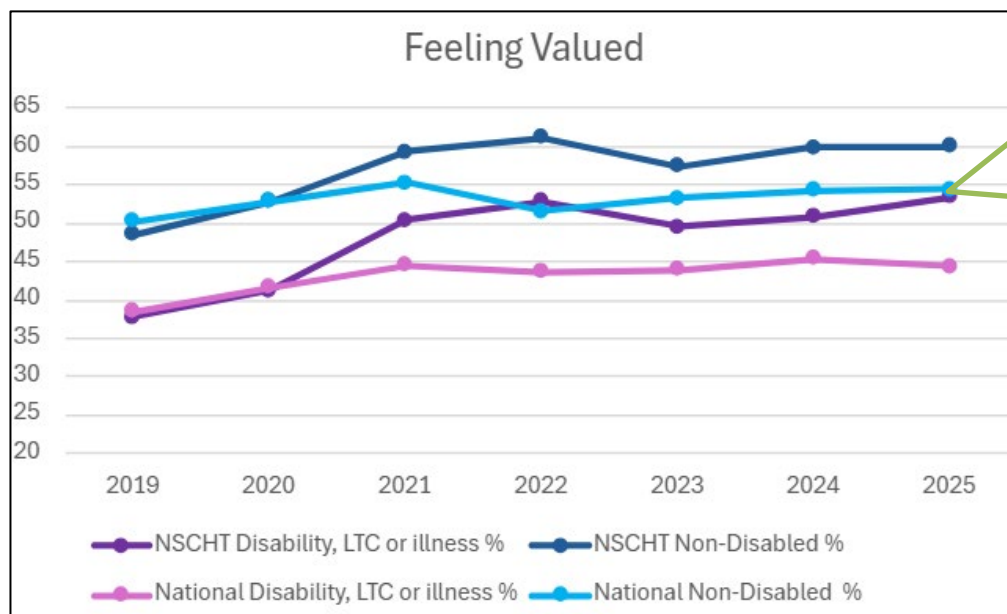


Chart 9 Feeling valued (Trust results, 2024 staff survey).

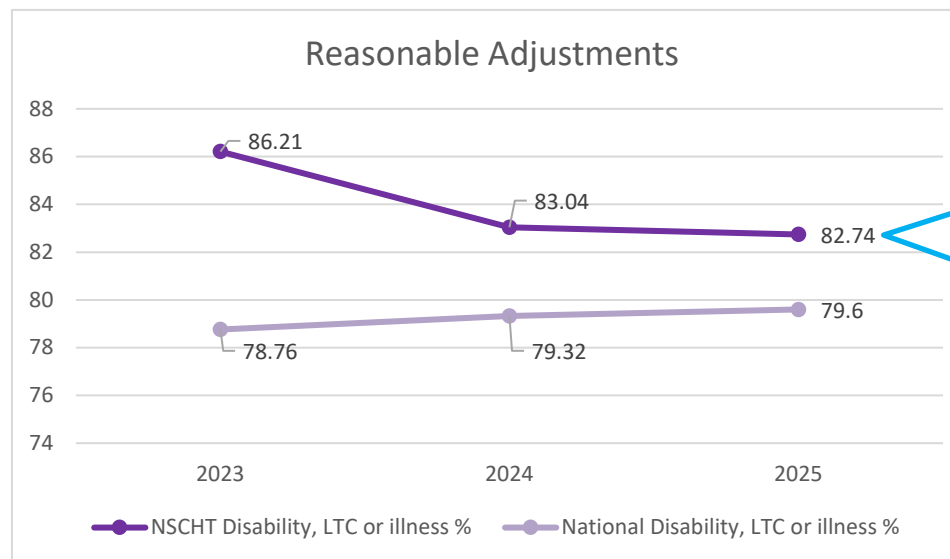
	2019	2020	2021	2022	2023	2024	2025
NSCHT Disability, LTC or illness %	37.80	41.21	50.43	52.82	49.58	50.88	53.45
NSCHT Non-Disabled %	48.50	52.87	59.34	61.22	57.46	59.88	60.05
National Disability, LTC or illness %	38.50	41.62	44.56	43.63	44.02	45.36	44.33
National Non-Disabled %	50.20	52.87	55.25	51.54	53.25	54.35	54.37
NSCHT Disability, LTC or illness responses	172	199	234	284	353	397	391
NSCHT Non-disabled responses	596	575	696	752	851	810	806

Table 10: Percentage of staff feeling pressure to attend when unwell (2019 – 2025).

Indicator 8: Differently Abled staff saying employer has made reasonable adjustment(s) to enable them to carry out role

Providing reasonable adjustments is key to creating an inclusive workplace where staff with disabilities can thrive, feel supported and perform effectively. These adjustments can range from simple, low-cost changes to more complex solutions, often supported by Access to Work funding. The Trust continues to perform above the national average in providing reasonable adjustments. However, this year the gap has narrowed due to a slight decline in Trust performance and an improvement nationally.

With funding for the Differently Abled Buddy Scheme ending in 2024, the CAN Staff Network has taken on some elements of the scheme and continues to buddy up members where support is requested. Alongside this, the network is working with the organisation to review our workplace adjustments process to ensure timely support for all staff, helping them feel valued and able to reach their full potential.



SLIGHT IMPROVEMENT:
82% of differently abled colleagues have reasonable adjustments in place – **better than average.**

Chart 10: Differently Abled colleagues reporting reasonable adjustments (Trust results, 2024 staff survey).

	2023	2024	2025
NSCHT Disability, LTC or illness %	86.21	83.04	82.74
National Disability, LTC or illness %	78.76	79.32	79.60
NSCHT Disability, LTC or illness responses	203	224	226

Table 11: Percentage of staff feeling pressure to attend when unwell (2019 – 2025).

Indicator 9a: Staff Engagement

Staff engagement at the Trust has remained strong, consistently ranking in the top 5% nationally, with scores around 7.3–7.4 over the past four years. While engagement among disabled staff has remained slightly lower than their non-disabled colleagues, it is encouraging to see improvement in 2025, returning to 2023 levels after a slight dip.

Improving engagement for disabled staff presents a valuable opportunity to boost overall staff satisfaction and positively impact service user experience. The Trust will continue to strengthen engagement through Our Combined People Plan, with a focus on supporting disabled colleagues via the Combined Ability Network and by reviewing access to workplace adjustments in 2025–26.

Remained STABLE but still better than average.

Engagement scores for disabled and non-disabled staff - but fell for both groups
Trust disabled staff engagement remains lower than non-disabled.

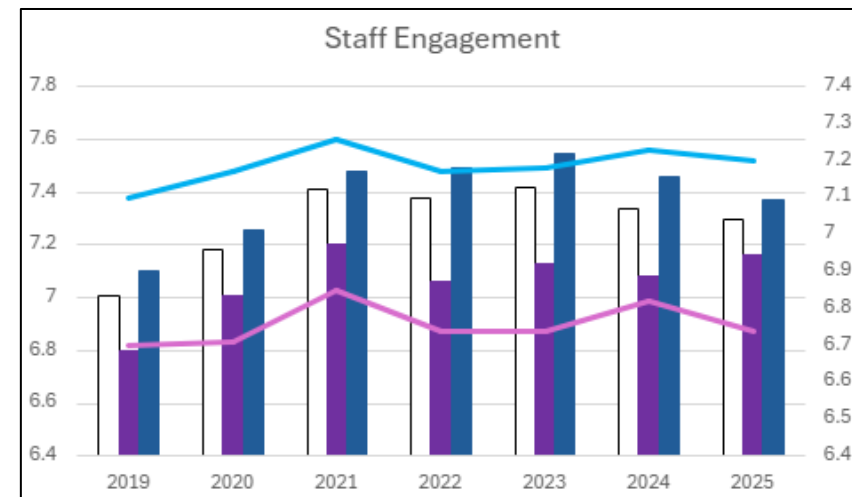


Chart 11: Staff Engagement score (Trust results, 2024 staff survey).

	2019	2020	2021	2022	2023	2024	2025
Organisation Average	7.01	7.18	7.41	7.38	7.42	7.34	7.3
NSCHT Disability, LTC or illness %	6.8	7.01	7.2	7.06	7.13	7.08	7.16
NSCHT Non-Disabled %	7.1	7.26	7.48	7.49	7.55	7.46	7.37
National Disability, LTC or illness %	6.7	6.71	6.85	6.74	6.74	6.82	6.74
National Non-Disabled %	7.1	7.17	7.26	7.17	7.18	7.23	7.2
NSCHT Disability, LTC or illness responses	175	203	234	285	356	398	391
NSCHT non-disabled responses	602	577	698	757	857	815	814

Table 12: Percentage of staff feeling engaged at work (2019 – 2025).

Indicator 9b: Disabled Voices: Measures to hear Disabled Staff Voice

The Trust has continued to work to listen to and engage with differently abled colleagues in a variety of ways through 2025 and beyond. Key to this have been our Combined Ability Staff Network (CAN) and our Differently Abled Buddy Scheme is now operated through the CAN network with the support of trained buddies, enabling the scheme to continue despite a lack of funding.

The CAN network meets at least every two months and maintains an active Teams chat for ongoing member engagement. The CAN Lead sits on the Trust Inclusion Council, chaired by the CEO and supported by the CPO. CAN members are regularly consulted on initiatives to support differently abled colleagues and to provide a disability perspective on broader Trust developments.

Indicator 10: Trust Board Membership

The Trust is proud to have a diverse Trust Board (including ethnicity and LGBT+). It is pleasing to see that 2 of our executive team (both voting members) have declared that they have a disability or long-term condition. No non-executive directors have declared a disability, long term health condition or neurodiversity.

The reduction in the number of board members declaring disability means that, whilst board representation exceeds our overall Trust rate (10.16%) it now falls well below the rate stated in our latest NHS Staff Survey (32.39%) for members of the workforce having a long-term health condition.

2025	Non-Disabled headcount	Disabled headcount	Non-Disabled %	Disabled %
Executive Directors	5	2	71.43%	28.6%
.. Of which: Voting members	10	2	83.33%	16.67%
Non-Executive	6	0	100%	0.0%
..Of which: Voting members	5	0	100%	0.0%
Total board members	11	2	84.6%	15.38%

Table 13: Trust Board Disability Profile 2025.

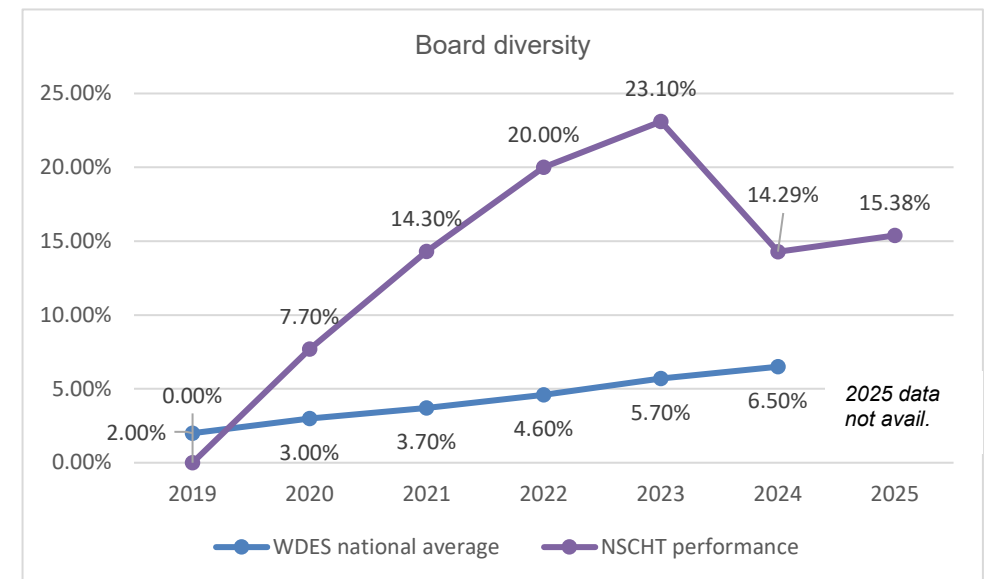


Chart 12: Trust Board Membership Disability, 2019-25.

4.0 What have Combined been doing to advance the WDES over the past 12-18 months?

Inclusion and belonging remain at the heart of the Trust's People approach. The strategy continues to evolve to ensure all staff feel valued, supported, and part of an inclusive workplace. The goal is to foster a culture where every colleague feels they belong and can thrive. Progress is guided by the Combined People Plan, with a strong focus on improving inclusion for all, particularly disabled staff.

Key areas of work include:

- Celebrating & recognising diversity
- Developing a culture of justice, belonging & inclusivity
- Being representative of our diverse communities at every level

Initiatives to advance differently abled inclusion through 2025 included:

- The Recruitment Team, in collaboration with the OD and Inclusion Team, is enhancing Values-Based Recruitment by reviewing assessment materials and ensuring interview and selection processes are consistent and anti-discriminatory. This work involves external experts and the Inclusive Recruitment Network Group, with early drafts already in progress.
- A new course, "Feedback through the Lens of Inclusion", was launched to support inclusive communication, promote psychological safety and value diverse perspectives. While the course focused on inclusion through a race lens, feedback from participants indicated the learning provided a broader approach, focusing on delivering feedback through an inclusive lens across all characteristics.
- The Trust prioritised inclusion and belonging through targeted leadership development, including support for underrepresented groups via Combined Connects, Foundations in Leadership and Management (FLM) and Continual Professional Development (CPD) for alumni of positive action programmes. The Board Development Conversations process now includes inclusion as a key priority and access to coaching and mentoring has been expanded with mentees now having the option to have a mentor with relevant lived experience.
- Other initiatives include a pilot of ward-based stretch opportunities, launch of the Career Development CAT page and Inclusion & Belonging learning hub, and updates to leadership programmes to embed inclusive recruitment and awareness training.
- To support awareness and accessibility, staff are encouraged to use Lexxic resources, TextHelp and access free webinars. Although funding for the Differently Abled Buddy Scheme ended in 2024, the Combined Ability Network continues to offer buddying and other forms of support into 2025.
- The Combined Ability Staff Network has continued to grow in influence, contributing meaningfully to Trust decisions. A key moment this year was the successful Disability Conference, held in collaboration with regional NHS partners, which featured a [story](#) from the Trust's first wheelchair-using colleague and fostered shared learning across the system.
- The Inclusion Trailblazers Project drove further changes to remove equity barriers. While it was mainly focused on supporting anti-racism, it also addressed broader elements of inclusion.
- AccessAble audits of all Trust sites improved accessibility.
- In October 2024, updates to the Flexible Working Policy introduced a new staff toolkit with guidance on conversations with managers, tips for working flexibly, and other key considerations.



Figure 2: Combined People Plan 2023-28 at a glance summary.

- Health, wellbeing and workplace adjustments also remain central to appraisals and supported discussions, helping staff feel heard and enabled for providing advice on having conversations with your manager and things to think about.
- The System Sexual Safety session held in October 2024 was attended by several staff members. While the primary focus was on sexual safety, the session on being an Upstander and Active Bystander was noted for its relevance and applicability to other forms of incivility and discrimination.
- In response to Health and Safety Executive (HSE) guidance, the Trust reviewed policies, procedures and incident data on workplace violence, aggression and injuries. A separate reporting category for hate crime was introduced, alongside a restorative post-incident response in line with just culture principles. Staff are now supported to report hate crime to the police and access victim support, while warning letters have been issued to offenders to highlight the harm caused. The Trust has also formed links with Uniting Staffordshire Against Hate to provide additional specialist support for staff.

4.1 Priorities for Action 2025-26

Looking ahead, the Trust plans to collaborate with ICS partners to offer the Calibre Programme, a leadership development course for disabled staff. Advancing equity and inclusion remains a key priority. In 2024 we launched our [Inclusion and Belonging Strategic Plan \(2024–28\)](#), strengthening our inclusive culture. In 2025–26, we will focus on debiasing people processes, with particular attention to disability-inclusive recruitment, talent management and performance management. Key initiatives include a two-year programme to embed a just and inclusive culture, continued reform of recruitment and talent processes and sustained leadership development to tackle bullying and harassment. We will also review and improve how we support timely, effective workplace adjustments. Further details are available in our WDES Action Plan (Appendix 1) and the Inclusion and Belonging Annual Report 2025 on the Trust's website ((to be published in Q3).

The WDES 2025-26 action plan includes several long-term and ongoing priorities focused on culture change, inclusive practices and structural improvements. We will additionally review and improve our process for supporting differently abled colleagues to access appropriate and effective workplace adjustments in a timely manner.

Our WDES priorities for action for 2025-26 are summarised as below:

1. **Debiasing of our people processes**, especially recruitment and selection and career development, disciplinary and capability processes and our workplace / reasonable adjustments approach, to ensure that we recruit, retain and progress our differently abled workforce talent.
2. 'High visibility' focus around **anti-discriminatory approach**, creating a **great place to work** for all and closing the gap in experience between those with and without disabilities, neurodiversity and/or long term conditions.
3. **Reducing inequalities and health inequalities** for our differently abled workforce.
4. **Educating for Inclusion** – developing through education an environment in which diverse colleagues can thrive. Ensuring equitable or positive action access to development and career progression for diverse candidates.



Figure 3: Trust Inclusion and Belonging Priorities, 2025-26

5.0 WDES Action Planned for 2025-26

Our focus in 2025-26 will be concentrating on four key areas of focus which allow us to maximise the measurable impact of change interventions action as well as working to ensure the sustainability of these outcomes, summarised as below [for full detail, see Appendix 2].

1. Delivering key milestones to implement, ensure and embed an effectively debiased inclusive recruitment process change programme, including to:

- Continue Trust-wide rollout and embedding of the Inclusive Recruitment Toolkit and Development Programme.
- Complete and act on the review of Band 8A+ roles to identify barriers to progression.
- Use staff feedback to improve recruitment processes from a disability/neurodiversity perspective.

2. Reducing inequalities and health inequalities for our differently abled workforce, including to:

- Use insights from the embedded HR/EDI Dashboard to drive local accountability and action.
- Promote equitable access to non-mandatory training, addressing the re-emerging gap.
- Ensure wellbeing services are inclusive and accessible to all staff groups.
- Use findings from the Disability Pay Gap Report to shape targeted interventions at service and Directorate levels.

3. Progressing our high-visibility anti-discriminatory approach, delivering against tangible key milestones including to:

- Sustain a targeted high-profile and impactful communications plan around anti-discriminatory practise.
- Continue to de-bias disciplinary, performance, flexible working and retirement processes using a critical disability lens.
- Maintain the practice of reviewing and updating protected characteristics at the start of employee relations cases.
- Respond to increased reports of harassment (patients and staff) with clear prevention and response measures.
- Consult, listen and respond effectively to the voice of our Combined Ability Network on a wide range of workforce matters.

4. Educating for Inclusion: advancing a supporting programme of education to underlie our work in priorities 1, 2 and 3 above:

- Deliver leadership educational intervention that deepens understanding of disability and neurodiversity inclusion and workplace adjustments.
- Provide practical training on responding to discrimination, abuse and incivility.
- Education-based activities to celebrate disability, health and neurodiversity-themed dates in the inclusion calendar.

6.0 Conclusions and Recommendations

The Trust has made meaningful progress in several key areas of the Workforce Disability Equality Standard (WDES), including improved workforce representation of disabled staff, higher perceptions of feeling valued, and increased access to reasonable adjustments—consistently performing above national averages. Staff engagement scores remain strong and stable, and disabled colleagues continue to report better-than-average experiences across many indicators.

However, some areas show signs of concern or slowing progress. These include a decline in the reporting of harassment, bullying, and abuse (HBA) by disabled staff, a widening gap in recruitment equity, and inconsistent perceptions of career progression. Capability scores—while improved—remain high due to the small number of cases and require ongoing attention. The gap between disabled and non-disabled staff persists across multiple indicators, including feeling valued, presenteeism, and experiences of HBA from managers and colleagues.

What we need in 2025-26

We need the **commitment and action of all our leaders** in 2025 to rooting out the causes of unfair differences in the quality of the employment experiences between our differently abled workforce and those without health conditions, disability or neurodiversity.

We ask all leaders to **prioritise work on improving inclusion, debiasing processes and actively becoming anti-discriminatory** as a key means of jointly improving retention, engagement and performance, offering a great place to work for all, and at the same time improving the quality and safety of our service user experiences and outcomes.

Recommendations

Board members, Senior Leadership Team (SLT) and members of the People and Culture Development (PCD) Committee are asked to:

1. Note the progress made and areas where performance has declined in our 2024–25 WRES outcomes, particularly around staff experience and access to development.
2. Approve the 2025 WDES Report and the 2025–26 WDES Action Plan for publication and implementation.
3. Acknowledge that personal and team-level actions are expected as part of the plan and commit to delivering these within their own areas of responsibility.
4. Continue to act as active ambassadors of disability inclusion, championing an inclusive and anti-discriminatory culture and take action to root out the causes of bias reflected in the WDES outcomes from our Trust processes
5. Take individual personal responsibility for updating personal awareness and deeper understanding on race inclusion, seeking help where required
6. Use the HR/EDI Dashboard and Disability Pay Gap insights to challenge disparities and support targeted actions within their services or directorates.
7. Engage with staff networks, including the CAN Network, to better understand lived experiences and co-create solutions that drive lasting change.

END

APPENDIX 1: Progress Report: WDES Action Plan 2024

WDES Priority Areas	Train	Retain	Reform
1. To further extend our work to debias our employee relations and talent management processes to achieve a position where differently abled workers are as likely to access development and advancement as their non-disabled counterparts	✓ Ongoing leadership development and education in support of our culture of inclusion.	✓ Debaised Disciplinary and Improving Performance processes (ongoing). ✓ Reviewed protected characteristics in Employee Relations (ER) cases (ongoing). ✓ Fair access to flexible working and retirement (ongoing).	✓ Recruitment, OD and Inclusion teams are enhancing Values-Based Recruitment assessment and selection materials (ongoing). ✓ External expert engaged to review interview and selection practices for consistency and anti-discrimination. ✓ Inclusive Recruitment Network Group and Recruitment Managers involved, with initial drafts produced.
2. Seek opportunities to understand, engage, develop and progress our differently abled talent at every level (including bank workers) to achieve an equitable workforce profile across levels and staff groups by 2025-26.	✓ Career development workshops and conversations for differently abled colleagues (ongoing). ✓ Inclusive Recruitment Toolkit and Development Programme (ongoing).	✓ Equitable access to health and wellbeing offers (ongoing). ✓ HR/EDI Dashboard for monitoring workforce demographics (ongoing). ✓ Disability Pay Gap Report analysis to inform retention strategies (ongoing).	✓ Talent management and progression reforms supported by Executive-led EDI objectives (ongoing). ✓ Disability Pay Gap Report to inform systemic changes (ongoing).
3. End disproportionate harassment, bullying and abuse against our differently abled workforce 4. Project group action delivered through 2024 and ongoing	✓ Disability-themed inclusion calendar activities (ongoing)	✓ Targeted communications on neurodiversity and disability inclusion (ongoing). ✓ Staff support mechanisms have been strengthened through CAN, with ongoing work to provide peer support, buddying, and tailored guidance to staff who need it (ongoing). ✓ Enhanced our Flexible Working offer with specific focus on staff in minoritised groups, linking with Health Passport.	✓ Project Working Group was formed to address bullying and abuse (ongoing). ✓ Policy reform based on staff voice via CAN Network (ongoing).
5. Make EDI and disability inclusion everyone's business – and make it demonstrable and sustainable – work in progress with more to do in 2025	✓ EDI development across levels to embed inclusive culture (ongoing). ✓ Participation of leaders in inclusion education programmes (This has been partly achieved through training sessions linked to awareness days)	✓ Directorates to set EDI objectives. ✓ Embed inclusive practice across all teams (ongoing).	✓ HR/EDI Dashboard embedded to support accountability (ongoing) ✓ Culture change through inclusive leadership at all levels (ongoing).
6. Directorates and services to work to close the gap between declared disability in ESR and the rate suggested by the NHS Staff Survey	✓ Staff education on importance of self-declaration and how data informs inclusion work.	✓ Use dashboard insights to engage services with low declaration rates.	✓ Targeted action plans to close disability declaration gaps in services (ongoing).

APPENDIX 2 - Inclusion And Belonging Action Plan 2025-26

The WDES action plan is part of the Trusts wider 4 year Inclusion and Belonging Strategic plan (2024–2028) aligned with the Trust's Equality Objectives for the same period. Progress is monitored and reported annually.

Action	Links to Equality Objectives 24-28	Links to 25-26 EDI Goals	Must / Should / Could	Action Lead	RAG rating (as at 08.25)
1. Deliver key milestones to implement, ensure and embed an effectively debiased inclusive recruitment process change programme					
1.1 Develop Inclusive Recruitment Toolkit and Inclusive Recruitment Development package utilising theory / approach of No More Tick-Boxes' and 'If Your Face Fits' (Kline, 2023).	4	1	Must	Ami Stonier	Oct 2025
1.2 Undertake analysis of applications-shortlisting/interview-appointment for posts at band 8A and above to better understand the issues / reasons behind lack of diversity in appointments at this level, and implement action based on findings.	4	1	Should	People Team	Dec 2025
1.3 Respond effectively to feedback from staff about experiences of recruitment process from a protected characteristics perspective.	4	1	Should	Rachel Birks	Oct 2025
1.4 Develop a plan to roll-out of Inclusive Recruitment development (considering the needs of both new recruiting managers and existing recruiting managers).	4	1	Should	Ami Stonier	Dec 2025
2. Reducing inequalities and health inequalities for our service users and staff					
2.1 All services to undertake a review of service user ACCESS analysed with a race lens in 2025-26 and present findings to Directorate committee (3 services to do deeper review via EDS framework – see 2.5 below).	2 & 3	2	Should	All Service Leaders	March 2026
2.2 Equitable access to health and wellbeing offers for all staff (our workforce as a microcosm of our local population). Review take-up by diverse characteristics colleagues.	2	2	Should	Dawn Ainsworth	Dec 2025
2.3 Implement new guidance on recording gender codes in Electronic Patient Record (Lorenzo) and in Electronic Staff Record when available. When in place, action needed to analyse the data and identify next steps.	1	2	Must	Vicky Boswell / Lauren Cartwright	Dec 2025
2.4 Launch and embed new guidance and approach to RADF (Reasonable Adjustment Digital Flag) as mandated through ISN re-recording disability/ accessible information needs in Electronic Patient Record.	1	2	Must	TBC	Dec 2025

2.5 Three services to be reviewed and rated under the EDS framework for 2025-26 (detailed review of Access, Experience, Safe from Harm, Outcomes).	1	2	Must	Identified Service Mgrs / Janice Ogonji	March 2026
2.6 Review business case for AccessAble and make decision on potential extension for years 4 and 5 (if approved, commission inclusion of Keele Medical Practice and consider inclusion of Lawton House into surveyed premises).	4	2	Should	Janice Ogonji	Nov 2025
2.7 Support inclusive talent management and career development / progression for all , through promotion of our career development workshops and career conversations - see Career devt link . This offer to be specifically targeted to staff with diverse characteristics (focus on race and disability. Encouraging take-up of coaching and mentoring by diverse characteristics colleagues.	4	1 & 2	Should	Jody Nicholls	Mar 2026
2.8 All executive directors to agree and deliver against personal and Directorate EDI objectives in 2025-26.	1-4	1 - 4	Must	Buki Adeyemo / Execs	Oct 2025
2.9 Introduce and embed an HR / EDI Dashboard for all services and Directorates Monthly, Quarterly and Annual Monitoring and RAG rating of good / poor performance of (minimum by Dec 24), supporting identification of issues, ownership, prioritisation of action and progress monitoring of action in each service:- • Workforce ethnicity, LGB+ and disability profile. • Snr leadership representation. (Band 8A,8C upwards) – ethnicity, disability, LGB+, & gender. • Diversity in shortlisted candidates (Global Majority / Differently Abled / LGB+ candidates). • WRES / WDES and LGB+ Recruitment score by service (x2 annually TBC) • Bullying & Harassment (NSS) rates from line mgrs/colleagues.	2 & 3	2 & 3	Should	Dave Hewitt, CIO with Janice Ogonji	Phase thru' 25-26
2.10 Publish and monitor annual Ethnicity, Disability and Gender Pay Gap reports (data to end March 2025), with targeted action plans to address findings.	1	2	Must	Janice Ogonji	March 2026

3. To progress our high-visibility anti-racist and anti-discriminatory approach, delivering against tangible key milestones including:-

3.1 Development and delivery of a targeted high-profile and impactful communications plan around anti-racist and anti-discriminatory approach (including refreshed posters & promotional campaign). To include anti-abuse message in conjunction with work underway in this area.	4	1-4	Should	Comms team with Janice Ogonji	March 2026
3.2 Share outcomes and taking meaningful action from learning emerging from staff speaking up reviews , including FTSU, Dear Buki etc.	4	2 & 3	Must	Pauline Grant	March 2026
3.3 Review application of Trust Disciplinary Procedure and Trust Supporting Staff to Improve Performance Procedure through case review, taking a critical race and disability perspective. Propose and implement changes to debias process based on findings.	4	1 & 3	Should	Laura Reynolds / People Ops Team	March 2026
3.4 Begin work to review and debias access to Flexible Working and Flexible Retirement with an EDI lens.	4	1 & 3	Should	Laura Reynolds/ People Ops Team	March 2026
3.5 Review Workplace Adjustments and Access to Work process to eliminate delays and barriers to support for differently abled colleagues. i. Ensure all job applicants are aware of the Trust's approach to supporting differently abled colleagues and workplace adjustments. ii. Share guidance and awareness raising around 'This is Me' Health Passport. Consider implementing a timeframe whereby all new staff have a discussion with their line manager about the 'This is Me' health passport within x weeks of commencing work.	4	3	Could	Laura Reynolds Laura Ross & Laura Reynolds	Jan 2026
3.6 Continue to embed EDI as everyone's responsibility , core to Trust & NHS Values.	4	1-4	Should	Janice Ogonji	Ongoing
3.7 Continue to encourage and support culture of inclusion, openness, authenticity and psychological safety at work through development of the Trust as a great place to work for all & celebration of diverse talent.	4	3	Should	OD & Inclusion Team	Ongoing
3.8 People Ops Team to proactively seek to review protected characteristics at the outset of all employee relations processes and to gain agreement for these to be updated where applicable.	2	1 & 3	Should	Laura Reynolds, People Ops Team	From Sept 2025

4. Educate for Inclusion

4.1 Shift of focus away from positive action development programmes, & towards:- i. Ensuring equitable access / positive skew for take-up of development and leadership development opportunities for diverse talent ii. Development programmes focussed on creating an inclusive working environment , ie educating wider workforce for deeper understanding of inclusion and the reality of experience for minoritised groups iii. All trust leadership offers to include core inclusion component geared to audience level of responsibility	4	1-4	Should	OD & Inclusion Team / service managers	Ongoing																								
4.2 Programme of education around responding effectively to incidents of abuse, discrimination, incivility, understanding disability , including the need for active bystander/upstander response and the mechanisms available for reporting and addressing such behaviours.	4	1-4	Could	TBC																									
4.3 Deliver an Executive development session on the learning from NHS discrimination cases and setting EDI objectives.	3, 4	1-4	Should	Pauline Grant & Janice Ogonji	Feb 2026																								
4.4 Trust Leadership Academy inclusion-themed session	3, 4	1-4	Should		Ongoing																								
4.5 Programme of activities to celebrate and educate around inclusion, following national/international awareness calendar , particularly (link to Newsround, Exec Exchange, Combined TV, podcasts, Inclusion School, Trust/system conferences and other comms opportunities): <table><tr><td colspan="2">Race Inclusion:</td></tr><tr><td>18 Jul -17 Aug 2025:</td><td>South Asian Heritage Month</td></tr><tr><td>September</td><td>East and South Asian Heritage Month</td></tr><tr><td>October</td><td>Black History Month</td></tr><tr><td>3-9 February 2026</td><td>Race Equality Week</td></tr><tr><td colspan="2">Disability Inclusion:</td></tr><tr><td>14 Nov – 20 Dec</td><td>Disability History Month</td></tr><tr><td>17 -23 Mar/April</td><td>Neurodiversity Celebration Wk/Awareness Mth</td></tr><tr><td colspan="2">LGBT+ Inclusion:</td></tr><tr><td>February</td><td>LGTB+ History Month</td></tr><tr><td>June</td><td>Pride Month</td></tr><tr><td colspan="2">Gender Equality:</td></tr></table>	Race Inclusion:		18 Jul -17 Aug 2025:	South Asian Heritage Month	September	East and South Asian Heritage Month	October	Black History Month	3-9 February 2026	Race Equality Week	Disability Inclusion:		14 Nov – 20 Dec	Disability History Month	17 -23 Mar/April	Neurodiversity Celebration Wk/Awareness Mth	LGBT+ Inclusion:		February	LGTB+ History Month	June	Pride Month	Gender Equality:		3, 4	1-4	Should	Staff Network Leads with EDI Lead	Ongoing Phase through 2025-26
Race Inclusion:																													
18 Jul -17 Aug 2025:	South Asian Heritage Month																												
September	East and South Asian Heritage Month																												
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LGBT+ Inclusion:																													
February	LGTB+ History Month																												
June	Pride Month																												
Gender Equality:																													

8 March	International Women's Day						
4.6 Build on investment in established programmes (HPMA Anti-Racist Leadership Programme, WRES Champions, Reciprocal Mentoring, etc). This might involve enlisting these individuals to support design and delivery of planned interventions.			1-4	1-4	Could	TBC	Mar 2026

Equality Objectives 24-28 and EDI Goals 25-26

The numbers in columns 2 and 3 in the table above relate to the below.

Our Inclusion and Belonging Strategic Plan Equality Objective Priorities 24-28

1. Deliver overall continuous improvement in our actual and benchmarked performance on our Equality, Diversity and Inclusion Core Annual Responsibilities (see Appendix 2) to become and sustain our position as one of the best NHS employers in relation to a range of workforce race, disability, LGBT+ and gender inclusion measures, supported by an effective accountability and monitoring framework for leaders at service level and above.
2. Make demonstrable progress in significantly reducing health inequalities for our local population, including removing barriers to equitable access, experience and outcomes through all our services and demonstrating improved health outcomes, as measured by a range of patient/service user metrics.
Advance our position as a leading inclusive organisation by improving service user and staff experience and outcomes on a wide range of inclusion measures, including across key protected characteristics groups.
4. Deliver on our ambition to truly become an inclusive, anti-racist and anti-discriminatory organisation by 2028.

Our Inclusion and Belonging Priorities for 2025-26

1. Debiasing our Trust recruitment processes - leading to greater representation and parity and more inclusive talent management
2. Reducing health inequalities for our service users and staff - leading to measurable reduction in gaps in access (focus on access in year 1, experience yr 2, outcomes yr 3)
3. 'High visibility' focus around anti-discriminatory approach
4. Educating for inclusion

↑ ---- Educate for Inclusion ---- ↓

Enclosure No: 12

Finance Position Month 4

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

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 5 Financial Sustainability.
Approval / Review:	SLT / F&R
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 4 position noting: - The year-to-date surplus of £32k against a plan of £353k, giving a favourable variance of £385k. - Agency expenditure of £673k against a plan of £553k, resulting in a negative variance of £120k. Medical agency must reduce in order to reduce costs and get back on plan. - Bank expenditure of £2,277k against a plan of £2,251k, giving a negative variance of £26k. All areas of bank usage must reduce in order to get back in line with the plan. - The Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £4.1m fully achieved / transacted,

	£2.1m fully developed, £0.6m plans in progress and £0.6m opportunities identified. - The Trust has spent £763k on capital, which is £111k behind. - The cash position of the Trust on 30th June with a balance of £31.1m.
Executive Summary	The Adjusted Financial Performance in month surplus of £281k against a planned deficit of £35k giving a positive variance of £316k. The year-to-date position is a surplus of £32k against a planned deficit of £353k giving a positive variance of £385k. The Trust has a recurrent CIP target of £6.0m, a non-recurrent target of £1.4m. At Month 4 the Trust is reporting delivery of £1,510k CIP against a target of £2,537k, an adverse variance of £1,027k. CIP schemes have been identified for the full target with 60% being implemented, 26% are fully developed, 10% have plans in progress and 4% are opportunities. In month agency expenditure was £150k against a plan of £137k representing an adverse variance of £13k against the 40% agency expenditure reduction from 2024/25. In month bank expenditure was £542k against a plan of £543k representing a positive variance of £1k against the 10% bank expenditure reduction from 2024/25. The Trust's capital expenditure year to date was £763k against a plan of £874k giving a positive variance of £111k. In month, 90% based on the number of invoices and 97% 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	18/08/2025
1	F&R	19/08/2025
1	Public Trust Board	05/09/2025



PUBLIC TRUST BOARD – 11th September 2025

Finance Position Month 4

This report summarises the Trust's financial position as of 31st July 2025.

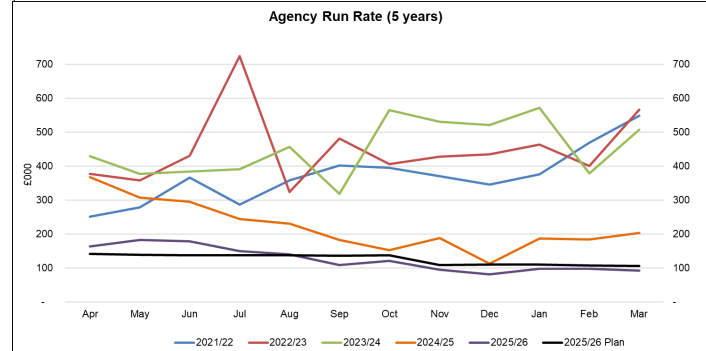
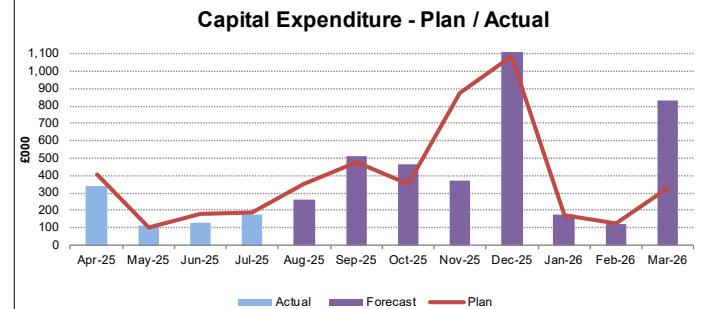
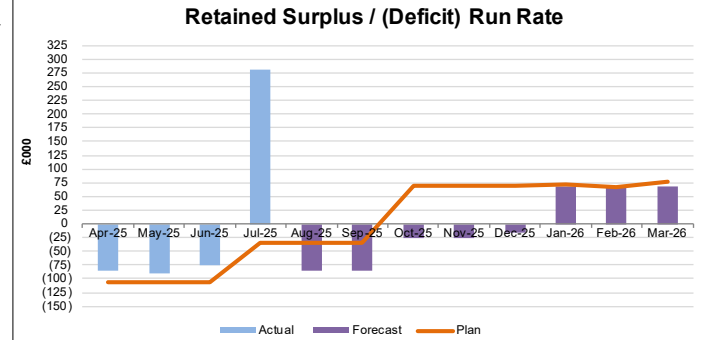
Key financial performance metrics are included for the following:

- Income & expenditure position.
- Forecast.
- Agency expenditure.
- Bank expenditure.
- CIP delivery.
- Capital Expenditure.
- Statement of Financial Position.
- Better Payment Practice Code.



Financial Overview as at 31st July 2025

Key Metrics							
£000	M1	M2	M3	M4	YTD	Average Forecast	RAG
Variance to Plan							
In month financial position	22	17	30	316	385	96	
YTD financial position	22	39	69	385	385	96	(0)
Run Rates (Actuals)							
Income	15,694	13,709	14,608	14,908	58,919	14,730	178,815
Pay	(8,970)	(8,929)	(9,069)	(9,187)	(36,154)	(9,039)	(109,049)
Non-pay	(6,522)	(4,585)	(5,317)	(5,144)	(21,568)	(5,392)	(66,051)
Finance & Other Non Operating	(242)	(239)	(253)	(252)	(986)	(247)	(3,203)
Agency (Actuals)							
	(163)	(182)	(178)	(150)	(673)	(168)	(1,504)
Agency Variance To Plan							
	(22)	(44)	(41)	(13)	(120)	(30)	0
Medical Agency	(13)	(11)	(37)	(10)	(70)	(17)	17
Nurse Agency	(7)	(16)	(1)	(2)	(27)	(7)	13
Other Agency	(2)	(17)	(3)	(1)	(24)	(6)	(30)
Non Clinical Agency	0	0	0	0	0	0	0
Bank (Actuals)							
	(622)	(550)	(564)	(542)	(2,277)	(569)	(5,453)
Bank Variance To Plan							
	(37)	31	(22)	1	(26)	(7)	(0)
Medical Bank	9	31	57	56	153	38	232
Nurse Bank	270	297	244	244	1,055	264	2,685
Other Clinical Bank	(308)	(294)	(318)	(284)	(1,205)	(301)	(2,843)
Non Clinical Bank	(7)	(3)	(5)	(15)	(30)	(7)	(74)
CIP (Variance)	(291)	(276)	(268)	(192)	(1,027)	(257)	(0)
Cash balance	31,734	31,725	31,316	31,104	31,104	31,470	29,424
Capital expenditure (Variance)	67	(17)	51	10	111	28	0
BPPC							
Number	96.5%	95.6%	93.0%	90.4%	93.7%	93.9%	
Value	99.5%	99.5%	97.4%	96.8%	98.3%	98.3%	



RAG	Description
Red	Above plan / budget (more than 5%).
Yellow	Above plan / budget (within 5%).
Green	Within plan / budget.



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	13,424	13,353	(70)	53,669	53,073	(595)	161,092	161,308	217
Income from Other Operating Activities	15,692	1,491	1,555	64	5,700	5,846	145	16,755	17,506	751
Income	176,226	14,915	14,908	(6)	59,369	58,919	(450)	177,847	178,815	968
Pay Costs	(105,754)	(9,289)	(9,187)	103	(36,752)	(36,154)	598	(109,366)	(109,049)	317
Non Pay Costs	(66,956)	(5,363)	(5,144)	219	(21,800)	(21,568)	232	(65,011)	(66,051)	(1,040)
Finance & Other Non Operating Costs	(3,040)	(255)	(252)	3	(1,001)	(986)	15	(2,994)	(3,203)	(210)
Expenditure	(175,750)	(14,908)	(14,583)	325	(59,553)	(58,708)	845	(177,371)	(178,304)	(933)
Retained Surplus / (Deficit)	476	7	326	319	(184)	211	395	476	511	35
Technical Adjustments	(476)	(42)	(45)	(3)	(169)	(179)	(10)	(476)	(511)	(35)
Adjusted Financial Performance	0	(35)	281	316	(353)	32	385	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 surplus of £281k against a planned deficit of £35k giving a positive variance of £316k. The positive variance in month is driven by non-recurrent release of rates accrual and a VAT review.
- Year to date position is a surplus of £32k against a planned deficit of £353k giving a positive variance of £385k.
- The Trust is forecasting to breakeven at year end.
- Income year to date is under performing due to lower than planned patient placement income (£578k - offset with decreased non pay expenditure) and service development slippage, partly offset by increased education and training income.
- Pay year to date is underspent due to vacancy slippage particularly in the Community teams.
- Non-pay year to date has a positive variance however this is due to reduced patient placements costs (£578k - offset with reduced income). Remaining non pay budgets have a negative variance overall due to unmet CIP and high patient transport costs due to a significant increase in out of area patients (£185k year to date).
- Finance & other non-operating costs are slightly underspent due to reduced depreciation.



Mitigations	Best £000	Base £000	Worse £000
Unmitigated Forecast	(217)	(217)	(217)
Changes in recruitment assumptions	1,333		(550)
Additional Chrysalis expenditure		(150)	
Release of balance sheet flexibilities	667	367	
Recovery of bad debt	898		
Non deliver of cash releasing CIP			(817)
Enabling costs for CIP			(450)
Potential gain share WMPC	1,000		
Adjusted Financial Performance	3,681	(0)	(2,034)

The Trust is forecasting to breakeven at year end which includes additional Project Chrysalis expenditure and the release of some balance sheet flexibilities.

The best-case forecast indicates the Trust could deliver a potential surplus of £3,681k. This includes no further workforce growth beyond the month 4 position, the release of further balance sheet opportunities, recovery of bad debt with the Local Authorities and a potential (unconfirmed) gain share with WMPC.

The worse-case forecast indicates the Trust be in a deficit of £2,034k. This includes lower staff turnover rates, the non-delivery of cash releasing CIP and enabling cost for CIP.

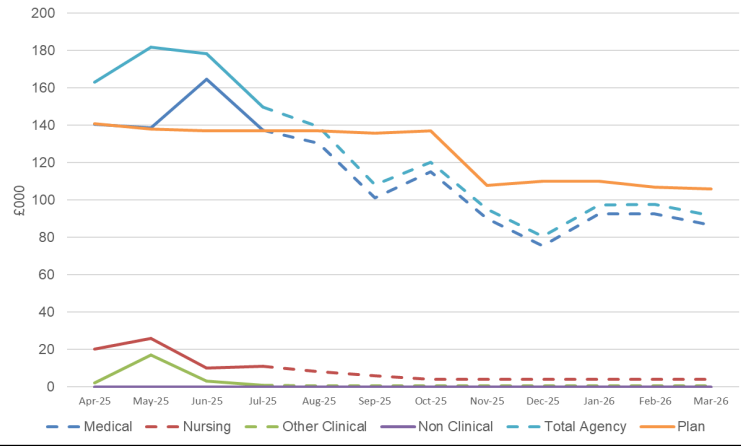
Finance Position

Agency Expenditure

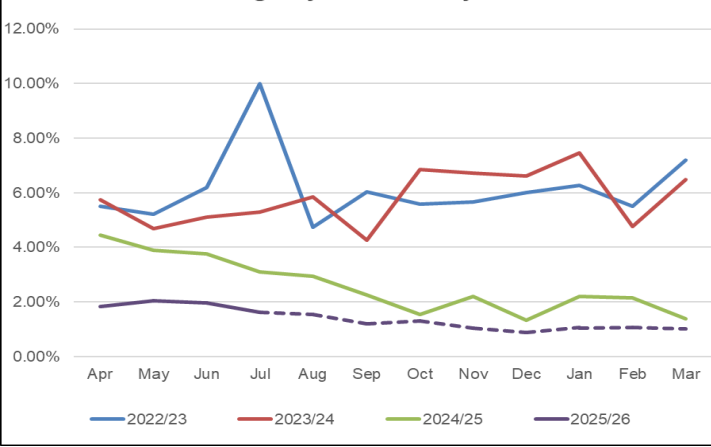
- Planned agency expenditure for 2025/26 is £1,504k this represents a mandated 40% reduction of 2024/25 expenditure levels.
- In month expenditure is £150k against planned expenditure of £137k representing an adverse variance of £13k.
- Year to date expenditure is £673k against planned expenditure of £553k representing an adverse variance of £120k.
- Forecast agency expenditure is to plan.
- Year to date nursing (qualified and unqualified) and locum 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.

Agency Expenditure	Actual					Forecast									Total
	Apr-25 £000	May-25 £000	Jun-25 £000	Jul-25 £000	YTD £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	(141)	(139)	(165)	(138)	(582)	(130)	(101)	(115)	(90)	(76)	(93)	(93)	(87)	(1,367)	
Community	(96)	(95)	(112)	(105)	(408)	(95)	(109)	(115)	(99)	(83)	(104)	(99)	(88)	(1,200)	
Specialist Care	(17)	(19)	(26)	(20)	(82)	(22)	0	0	0	0	0	0	0	(104)	
Primary Care	(28)	(24)	(27)	(12)	(91)	(32)	(10)	(18)	(9)	(10)	(6)	(11)	(17)	(205)	
Central Services	0	0	0	0	0	18	18	18	18	18	18	18	18	142	
Nursing	(20)	(26)	(10)	(11)	(68)	(8)	(6)	(4)	(4)	(4)	(4)	(4)	(4)	(107)	
Acute Services & Urgent Care	(2)	(10)	(3)	(5)	(20)	(4)	(2)	0	0	0	0	0	0	(26)	
Quality & Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Primary Care	(5)	1	(5)	(4)	(12)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(34)	
Specialist Care	(13)	(17)	(2)	(3)	(36)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(46)	
Central Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other Clinical	(2)	(17)	(3)	(1)	(24)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(30)	
Acute Services & Urgent Care	(1)	(0)	0	0	(2)	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)	(8)	(1)	(22)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(28)	
Primary Care	0	(5)	5	0	0	0	0	0	0	0	0	0	0	0	
Non Clinical	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	
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)	(178)	(150)	(673)	(139)	(108)	(120)	(95)	(81)	(98)	(98)	(92)	(1,504)	
Agency as a % of Pay	1.82%	2.04%	1.97%	1.63%	2.50%	1.55%	1.20%	1.31%	1.04%	0.87%	1.07%	1.07%	1.01%	1.38%	
Plan	(141)	(138)	(137)	(137)	(553)	(137)	(136)	(137)	(108)	(110)	(110)	(107)	(106)	(1,504)	
Variance to Plan (Overspend) / Underspend	(22)	(44)	(41)	(13)	(120)	(2)	28	17	13	29	12	9	14	0	
Agency Variance as a % of Plan	15.74%	31.84%	30.17%	9.37%	21.75%	1.75%	(20.36%)	(12.30%)	(11.83%)	(26.76%)	(11.30%)	(8.76%)	(13.48%)	(0.01%)	

Agency Expenditure by Staff Group



Agency as a % of Pay

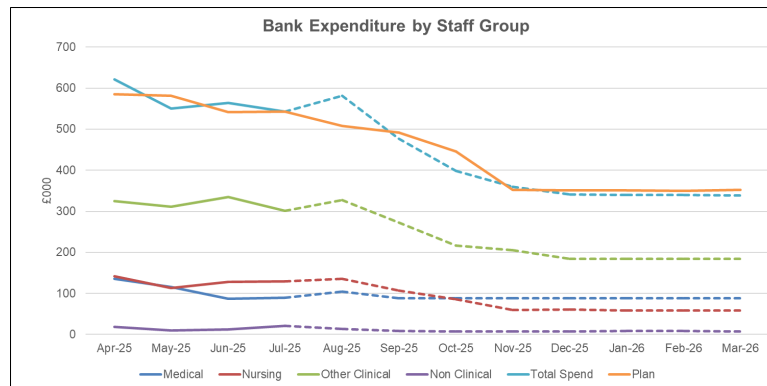


Finance Position

Bank Expenditure

Bank Expenditure	Actual				YTD £000	Forecast									Total
	Apr-25 £000	May-25 £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	(136)	(115)	(88)	(90)	(429)	(105)	(88)	(88)	(88)	(88)	(88)	(88)	(88)	(88)	(1,149)
Acute Services & Urgent Care	(18)	(24)	(24)	(23)	(88)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(24)	(279)
Community	(64)	(38)	(29)	(17)	(148)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(350)
Specialist Care	(54)	(54)	(35)	(50)	(193)	(36)	(35)	(35)	(35)	(35)	(35)	(35)	(35)	(35)	(471)
Central Services	0	0	0	0	0	(20)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(49)
Nursing	(142)	(114)	(129)	(129)	(514)	(135)	(107)	(86)	(59)	(61)	(59)	(59)	(59)	(59)	(1,137)
Acute Services & Urgent Care	(101)	(88)	(82)	(72)	(343)	(79)	(74)	(53)	(35)	(35)	(33)	(33)	(33)	(33)	(719)
Community	(4)	(4)	(14)	(8)	(30)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(69)
Quality & Nursing	(1)	0	0	(0)	(2)	(1)	(1)	0	0	0	0	0	0	0	(4)
People & OD	(2)	(3)	(0)	(3)	(9)	(1)	(1)	(1)	(1)	(2)	(2)	(2)	(2)	(2)	(19)
Primary Care	(1)	(2)	(2)	(3)	(7)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(15)
Specialist Care	(32)	(16)	(31)	(43)	(122)	(24)	(21)	(21)	(13)	(13)	(13)	(13)	(13)	(13)	(251)
Central Services	0	0	0	0	0	(25)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(59)
Other Clinical	(325)	(311)	(335)	(301)	(1,273)	(328)	(273)	(217)	(205)	(184)	(184)	(184)	(184)	(184)	(3,033)
Acute Services & Urgent Care	(200)	(186)	(174)	(169)	(729)	(141)	(141)	(105)	(93)	(87)	(87)	(87)	(87)	(87)	(1,557)
Community	0	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	(0)
MACE	(5)	(3)	(4)	(3)	(15)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(52)
Operations	(3)	(3)	(3)	(2)	(12)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(31)
People & OD	(6)	(3)	(2)	(3)	(14)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(42)
Specialist Care	(111)	(114)	(151)	(123)	(498)	(110)	(107)	(88)	(88)	(74)	(74)	(74)	(74)	(74)	(1,187)
Primary Care	(1)	(1)	(1)	(1)	(4)	(1)	(1)	(1)	(1)	0	0	0	0	0	(9)
Central Services	0	0	0	0	0	(64)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(154)
Non Clinical	(18)	(10)	(12)	(22)	(62)	(13)	(8)	(8)	(8)	(8)	(9)	(9)	(8)	(8)	(134)
Acute Services & Urgent Care	(1)	(0)	(0)	(1)	(3)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(6)
Chief Executive Office	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MACE	(0)	(0)	(1)	(0)	(2)	(0)	(0)	0	0	0	0	0	0	0	(3)
Quality & Nursing	(5)	(3)	(3)	(3)	(14)	(3)	0	0	0	0	(1)	(1)	0	0	(19)
Strategy & Development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
People & OD	(8)	(3)	(7)	(15)	(33)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(78)
Primary Care	(2)	(2)	(0)	(2)	(6)	0	0	0	0	0	0	0	0	0	(6)
Rechargeables	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Central Services	0	0	0	0	0	(3)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(7)
Specialist Care	(1)	(1)	(1)	(0)	(4)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(14)
Total Bank	(622)	(550)	(564)	(542)	(2,277)	(581)	(476)	(398)	(360)	(341)	(340)	(340)	(339)	(339)	(5,453)
Bank as a % of Pay	6.93%	6.16%	6.22%	5.90%	8.45%	6.47%	5.27%	4.34%	3.93%	3.69%	3.74%	3.74%	3.72%	3.72%	5.00%
Plan	(585)	(581)	(542)	(543)	(2,251)	(508)	(492)	(446)	(352)	(351)	(351)	(350)	(352)	(352)	(5,453)
Variance to Plan (Overspend) / Underspend	(37)	31	(22)	1	(26)	(73)	16	48	(8)	10	11	10	13	13	0
Bank Variance as a % of Plan	6.24%	(5.36%)	4.02%	(0.13%)	1.18%	14.45%	(3.17%)	(10.73%)	2.25%	(2.89%)	(3.11%)	(2.83%)	(3.73%)	(3.73%)	0.01%

- Planned bank expenditure for 2025/26 is £5,453k this represents a mandated 10% reduction of 2024/25 expenditure levels.
- In month expenditure is £542k against planned expenditure of £543k representing a favourable variance of £1k.
- Year to date expenditure is £2,277k against planned expenditure of £2,251k representing an adverse variance of £26k.
- Forecast bank expenditure is to plan.
- 75% of expenditure to date relates to nursing (qualified and unqualified) representing an unfavourable variance to plan (£68k).
- 19% of expenditure to date relates to medical staffing with a favourable variance to plan (£150k).
- The remaining unfavourable variance to plan is due to therapeutic staff to date totalling £78k.

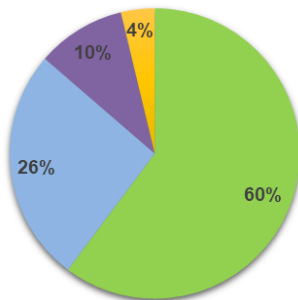


2025/26 Efficiency Identified Schemes	Target £000	YTD 2025/26			Total Forecast			Of which is Recurrent		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Clinical										
Acute	360	89	66	(23)	360	507	147	360	507	147
Community	2,045	504	730	227	2,045	2,936	891	2,045	2,136	91
Specialist	644	159	71	(87)	644	478	(166)	644	478	(166)
Primary Care	19	5	0	(5)	19	8	(11)	19	8	(11)
Clinical Total	3,069	756	868	112	3,069	3,930	861	3,069	3,130	61
Corporate										
CEO	42	10	5	(5)	42	15	(27)	42	2	(40)
Q&N	300	74	22	(52)	300	68	(232)	300	68	(232)
S&D	364	90	10	(79)	364	155	(208)	364	127	(236)
Finance	93	23	2	(21)	93	66	(27)	93	66	(27)
Performance	32	8	0	(8)	32	0	(32)	32	0	(32)
Estates	56	14	0	(14)	56	150	94	56	150	94
MACE	104	26	0	(26)	104	0	(104)	104	0	(104)
Operational	1	0	0	(0)	1	1	(0)	1	1	(0)
People	174	43	4	(39)	174	11	(164)	174	11	(164)
Corporate Total	1,166	287	43	(245)	1,166	465	(702)	1,166	424	(743)
Trustwide	1,532	962	67	(895)	1,532	1,373	(159)	167	849	682
Productivity	1,600	532	533	1	1,600	1,600	0	1,600	1,600	0
Total Trust CIP	7,367	2,537	1,510	(1,027)	7,367	7,367	0	6,002	6,002	0
Total Efficiency identified	7,367	2,537	1,510	(1,027)	7,367	7,367	0	6,002	6,002	0
Total Efficiency unidentified						(0)	(0)		(0)	(0)
Total Trust Efficiency YTD & Forecast		2,537	1,510	(1,027)	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 4 the Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £4.1m fully achieved / transacted, £2.1m fully developed, £0.6m plans in progress and £0.6m opportunities identified.

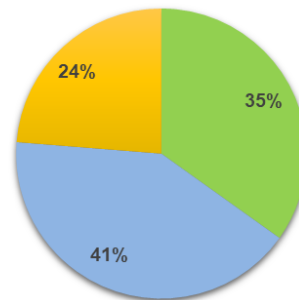
Recurrent Schemes as % of £6m target

Implemented Fully Developed Plans in Progress
Opportunity Unidentified



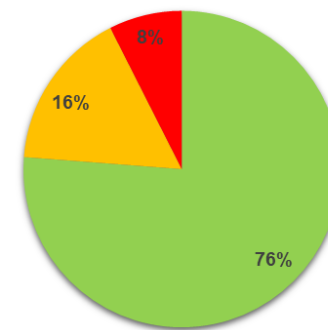
Non Recurrent Schemes as % of £1.4m target

Implemented Fully Developed Plans in Progress
Opportunity Unidentified

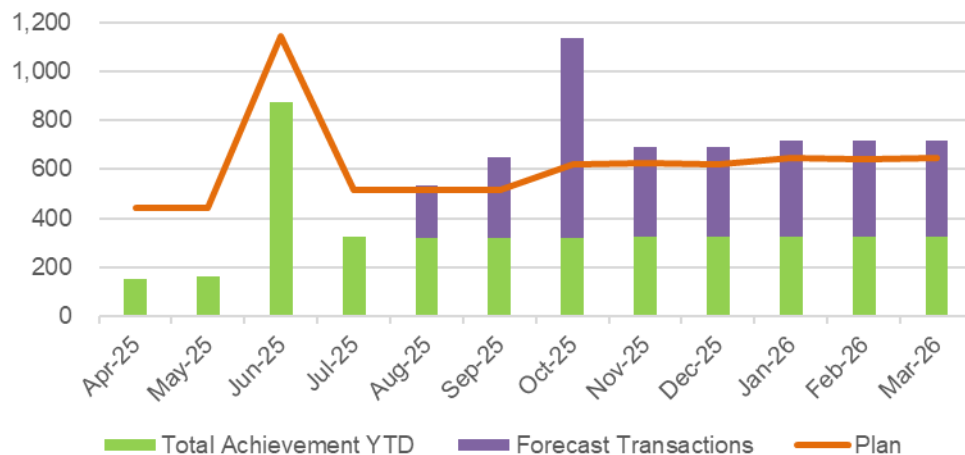


Current Risk Profile of achieving £7.4m Target

Low Medium High



CIP Forecast (£000)

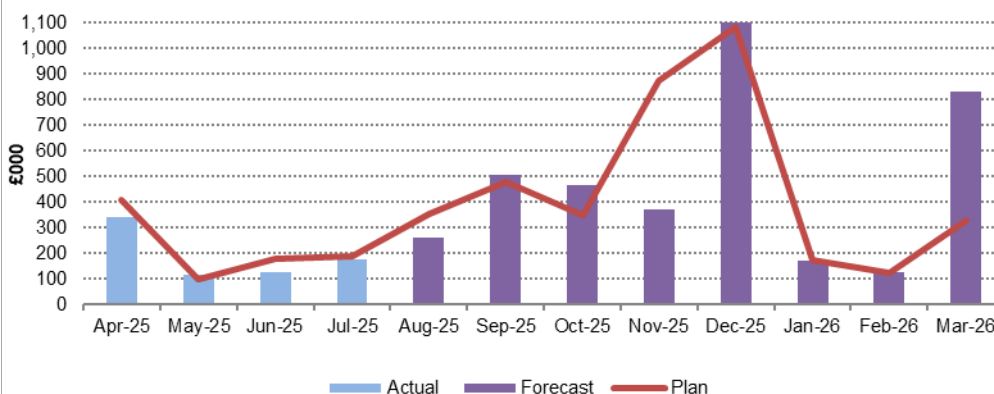


- 60% of the recurrent target has been implemented (transacted) and 26% fully developed.
- 10% of the recurrent target are plans in progress and 4% opportunities identified.
- 35% of the non-recurrent target has been implemented (transacted) and 41% fully developed.
- 24% of the non-recurrent target are opportunities identified.
- Currently 8% of schemes are considered high risk, 16% medium risk and 76% low risk.

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	786	30	(3)	(33)	786	786	0
IFRS16 Leases	199	30	(3)	(33)	199	199	0
Medical Equipment	30	0	0	0	30	30	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	429	13	13	0	429	429	0
IT Digital Replacement	239	0	0	0	239	239	0
Capitalised Salaries - IT Device Replacement	40	13	13	0	40	40	0
Digital Innovations	50	0	0	0	50	50	0
Digital Infrastructure	100	0	0	0	100	100	0
Strategic Schemes	1,943	831	755	(76)	1,943	1,943	0
Dormitory Conversion Trust funded	1,943	831	755	(76)	1,943	1,943	0
Contingency/Reactive Schemes	0	0	(3)	(3)	0	0	0
Contingency	0	0	(3)	(3)	0	0	0
Total Trust Funded Capital Expenditure	3,158	874	763	(111)	3,158	3,158	0
Backlog Maintenance	470	0	0	0	470	470	0
Frontline Digitisation Programme PDC Funded	1,000	0	0	0	1,000	1,000	0
Total Gross Capital Expenditure	4,628	874	763	(111)	4,628	4,628	0
Total Charge against Capital Resource Limit	4,628	874	763	(111)	4,628	4,628	0

- The Trust's annual capital plan is £4,628k.
- The Trust's year to date gross capital expenditure is £763k against planned expenditure of £874k representing a favourable variance of £111k.
- The favourable variance is due to timing in relation to the eradication of dormitories at the Harplands and leases. Both are expected to deliver planned 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 4 is £763k, £111k below plan.

Capital Expenditure - Plan / Actual



SOFP	M2 £000	M3 £000	M4 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	20,040	20,123	20,255
Property, Plant and Equipment	16,402	16,351	16,265
Right of Use Assets	2,933	2,894	2,858
Intangible Assets	1,747	1,705	1,662
NCA Trade and Other Receivables	597	591	585
Total Non-Current Assets	41,720	41,664	41,625
Current Assets			
Inventories	81	83	79
Trade and Other Receivables	5,847	8,346	8,989
Cash and Cash Equivalents	31,726	31,316	31,104
Total Current Assets	37,653	39,745	40,172
Current Liabilities			
Trade and Other Payables	(20,864)	(22,895)	(23,111)
Provisions	(1,622)	(1,622)	(1,622)
Borrowings	(3,072)	(3,072)	(3,072)
Total Current Liabilities	(25,558)	(27,589)	(27,805)
Net Current Assets / (Liabilities)	12,096	12,156	12,368
Total Assets less Current Liabilities	53,816	53,820	53,993
Non Current Liabilities			
Provisions	(1,341)	(1,515)	(1,543)
Borrowings	(16,795)	(16,621)	(16,440)
Total Non-Current Liabilities	(18,135)	(18,136)	(17,983)
Total Assets Employed	35,680	35,684	36,010
Financed by Taxpayers' Equity			
Public Dividend Capital	23,983	23,983	23,983
Retained Earnings reserve	4,720	4,689	5,015
Revaluation Reserve	6,977	7,012	7,012
Total Taxpayers' Equity	35,680	35,684	36,010

Current receivables are £8,989k of which:

- £5,007k is based on accruals (not yet invoiced).
- £3,983k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,517k 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 £27,805k of which:

- Trade and Other payables remain high at £23,111k 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 1.4 showing the Trust can cover its current debt obligation.



Better Payment Practice Code	In Month			YTD Total		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices						
Total Paid	31	1,052	1,083	99	3,670	3,769
Total Paid within Target	29	950	979	96	3,434	3,530
% Number of Invoices Paid	94%	90%	90%	97%	94%	94%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	(1%)	(5%)	(5%)	2%	(1%)	(1%)
Value of Invoices						
Total Value Paid (£000s)	342	7,147	7,489	2,071	31,890	33,961
Total Value Paid within Target (£000s)	335	6,912	7,247	2,062	31,327	33,389
% Value of Invoices Paid	98%	97%	97%	100%	98%	98%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	3%	2%	2%	5%	3%	3%

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 4, the Trust has achieved the 95% target on the value of invoices paid at 97% but has missed the target on the number of invoices paid at 90% of invoices paid within 30 days. The main driver of this under achievement was relating to invoices from Exclusive Travel.
- Year to date the Trust has achieved the 95% target on the value of invoices paid at 98% but is currently below target on the number of invoiced paid within 30 days at 94%. With prompt payment of invoices for the remainder of the year, the Trust will be able to achieve the target of 95%.
- The finance team will continue to monitor and target those areas that are not promptly authorising invoices.



The Public Trust Board are asked to receive the Month 4 position noting:

- The year-to-date surplus of £32k against a planned deficit of £353k, giving a favourable variance of £385k.
- Agency expenditure of £673k against a plan of £553k, resulting in a negative variance of £120k. Medical agency must reduce in order to reduce costs and get back on plan.
- Bank expenditure of £2,277k against a plan of £2,251k, giving a negative variance of £26k. All areas of bank usage must reduce in order to get back in line with the plan.
- The Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £4.1m fully achieved / transacted, £2.1m fully developed, £0.6m plans in progress and £0.6m opportunities identified.
- The Trust has spent £763k on capital, which is £111k behind plan.
- The cash position of the Trust on 31st July with a balance of £31.1m.



Enclosure No: 13a

Finance & Resource Committee Assurance Report

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	14 th August 2025
Discussion	☐	Approval	☐		

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 7 th August 2025.

	Updates were received relating to: • M3 Trust Performance • Business Intelligence Strategy • Risk Register • Board Assurance Framework Q1 • M3 Finance Position • M3 ICS Finance • Cost Improvement Programme • Estates and Capital • ERIC Submission • Business Opportunities • TMO Assurance Report Q1 • Sustainability Assurance Report Q1 • Orbis updates • Business case Darwin MDT

VERSION CONTROL:

Version	Report to	Date Reported
1	Public Trust Board	07/08/2025

Trust Board Assurance Report From the Finance & Resource Committee Meeting Held on 7th August 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:

ADVISE:

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

Heading:

The CFO advised Committee the System could be at risk of losing the deficit support funding in Q3 depending on the financial position.

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 M3**

Committee received the report with highlights on national priorities including length of stay, clinical ready for discharge and out of area placements. Discussions took place on out of area patients, clinical ready for discharge and the workforce plan.

Finance Position M3

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. 54% of CIP schemes have been transacted in Month 3 against the annual target. Capital expenditure is lower than planned year-to-date, forecast to be on plan.

ICS Finance Update M3

At Month 3 the System reported a year-to-date deficit of £17.9m, £0.3m favourable to plan. The net risk has reduced to £59.6m.

Cost Improvement Programme

Key messages highlighted included in month progress on CIP deliverability. Discussion took place on highlighting innovative schemes and the use of the EVO Framework.

Estates Update

Committee received the report with highlights on fire doors door and boiler replacements, the final stage of Project Chrysalis and fire safety action plans. Discussions took place EV chargers. Acknowledgement was made on the performance of PPM.

ERIC Submission

The report highlighted the significant movements between the reporting years from 2023/24 to 2024/25.

Business Opportunities

Committee received the report highlighting the Connect to Work tender documents have not yet been released.

TMO Assurance Report Q1

The report was presented to Committee highlighting current projects.

Sustainability Assurance Report Q1

The report highlighted the progress on the Green Plan and the detailed action plan required.

Orbis Update

Committee received the report highlighting the changes to the timescales to Summer 2026. An update was provided on the delivery plan and risks to the project. Discussions took place on the impact of the revised timescales.

APPROVE:

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

Heading:

Business Intelligence Strategy

Vision for how data is shared across the Trust including automated reporting and dashboard reporting. The ambition of the Strategy was acknowledged and encouraged, noting the deliverability of the Strategy. The Strategy was approved.

Risk Register

Deep dive report for Committee covering all risks. There were 3 new risks (on Lorenzo data loss, the Green Plan delayed national guidance and the Green Plan leadership), 2 score changes (on CIP and Orbis delays) and no closures for approval. 3 risks have had date revisions. All risks were approved.

Board Assurance Framework Q1

BAF risk 1, 5 and 6 relate to F&R. Score reduction was approved for risk 5 on the financial position.

Business Case Darwin MDT

External funding from West Midlands Provider Collaborative (TOUCAN). The business case was approved.

Business Opportunities

Two Patient Engagement Portal capital funding were retrospectively approved.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 4th September 2025 at 10am via MS Teams.

Committee Chair: Russell Andrews, Chair of the Finance & Resource Committee.

REPORT END

Enclosure No: 13b

F&R Committee Assurance Report

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

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 5 Financial Sustainability
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 4 th September 2025.

Updates were received relating to:

- M4 Trust Performance
- Risk Register
- F&R Terms of Reference
- M4 Finance Position
- M4 ICS Finance
- Cost Improvement Programme
- Estates and Capital
- Business Opportunities
- Orbis updates
- NHSE Planning Framework 2026/27 – 2030/31

VERSION CONTROL:

Version	Report to	Date Reported
1	Public Trust Board	04/09/2025

Trust Board Assurance Report From the Finance & Resource Committee Meeting Held on 4th September 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 four categories of Alert, Advise, Assure and Approve. 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:

ADVISE:

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

Heading:

The COO advised that there are currently 12 OOA patients which is an improvement on previous months.

The CFO advised that the deficit support funding for the system could be withdrawn for Q3 based on the risk of the System financial performance. The contract with the ICB has not been signed due to not receiving the final version. Also to note the ICB contracts have not been signed by any System providers.

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 M4

Committee received the report with highlights on CYP 18-week RTT, appraisals and clinical supervision performance, PIP performance, national priorities out of area placements and average length of stay. Discussions took place on clinically ready for discharge and escalation processes between Local Authorities and the performance of the PIPs including trajectories.

F&R Terms of Reference

Terms of reference deferred for approval to the following month.

Finance Position M4

Key messages highlighted included a small year-to-date surplus which is better than plan at this point in the year. Bank and agency costs in month were both above the required reductions. 60% of CIP schemes have been transacted in month 4 against the annual target. Capital expenditure is slightly lower than planned year-to-date, forecast to be on plan. Discussions took place on agency expenditure and corporate reductions monitoring.

ICS Finance Update M4

At month 4 the System reported a year-to-date deficit of £19.5m, £0.4m favourable to plan. The net risk has reduced to £59.7m.

Cost Improvement Programme

Key messages highlighted included in month progress on CIP deliverability. Committee welcomed the CIP audit commencement.

Estates Update

Committee received the report with highlights on backlog maintenance, Project Chrysalis, the pipework in EMU, fire safety action plans and water temperature compliance. Acknowledgement was made on the performance of PPM. Discussions took place on EMU and PFI contractual performance.

Business Opportunities

Committee received the report highlighting the Connect to Work tender documents with Staffordshire County Council are now live. The Trust was successful with the capital bid to NHSE for Notify.

Orbis Update

Committee received the report updating on the delivery plan and risks to the project. An update was also received on the Lorenzo (LBM) issues. Discussions took place on contract management with the supplier.

NHSE Planning Framework 2026/27 – 2030/31

The Committee received an update on the requirements of the new planning framework published in August and the indicative governance plan to support submission. Planning guidance and templates expected to be issued in October. Discussions took place on how Board assurance would be given.

APPROVE:

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

Heading:

Risk Register

There was 1 new risk on the loss of the Payroll function, 1 closure on Performance team capacity and no score changes for approval. 2 risks have had date revisions and 1 title change to a risk. All risks were approved.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 2nd October 2025 at 10am via MS Teams.

Committee Chair: Russell Andrews, Chair of the Finance & Resource Committee.

REPORT END

Enclosure No: 14

CHARITABLE FUNDS COMMITTEE BOARD ASSURANCE REPORT

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

Presented by:	Russell Andrews, Non-Executive Director
Prepared by:	Laura Smith, Deputy Chief Strategy Officer
Executive Lead:	Elizabeth Mellor, Chief Strategy 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:	Charitable Funds Committee
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Partnerships - We will actively promote partnership and integrated models of working
Sustainability:	Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent
Resource Implications:	NSCHT officer time is provided to support the development of the Charity. An exercise is being undertaken to accurately quantify time spent on Charitable Funds activities to ensure that appropriate recharging arrangements are in place.
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 the report for information and assurance.

Executive Summary	This report provides an overview of the Charitable Funds Committee meeting held on Monday 1 September 2025. The Committee attendance was confirmed as quorate. The Committee reviewed financial performance as of 31 July 2025, noting a closing balance of £312k. A staff lottery was discussed as a potential sustainable income stream, with soft market testing proposed to assess staff interest. It was agreed to seek Trustees' views on gambling-related concerns before progressing. Fundraising activities continue to expand, with recent events including the NHS Big Tea and upcoming campaigns such as Move for Mental Health and a Combined Charity Golf Day. The Committee approved governance routes for three NHS Charities Together grant applications totalling £225k. Assurance was provided on the Charity Development Plan, including sustainable income initiatives and a new risk register, with all risks scoring nine or below. Planned next steps include submission of grant applications, launching a charity impact video, delivering the Golf Day, promoting World Mental Health Day activities, and finalising the Fundraising Policy in line with the Fundraising Regulator's updated Code of Practice.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	02.09.25

Trust Board Assurance Report from the Charitable Funds Committee meeting held on 1 September 2025

Introduction:

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

Purpose of the Report

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 Charitable Fund 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.

Finance and Fundholder Balances

A summary of draft charitable fund balances as of 31 July 2025 was presented. The opening balance on 1 April 2025 was £317k, with income of £7k and expenditure of £12k to date, resulting in a net outflow of £5k and a closing balance of £312k. The Committee also reviewed the 47 individual fund balances and endorsed a proposal to streamline the approach by closing dormant funds where appropriate.

Staff Lottery

To support the development of sustainable funding for the charity, a staff lottery has been explored. This included engagement with other NHS charities—particularly mental health trusts—to understand delivery models and potential implications. The viability of a lottery would depend on sufficient staff interest and engagement. The Committee discussed a proposal to conduct soft market testing to gauge this interest. While Trustees have previously expressed concerns about links to gambling, it was noted that society lotteries carry minimal risk of gambling-related harm and are widely adopted across NHS charities. The Committee agreed that Trustee views should be formally sought before proceeding further.

ADVISE:

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

Fundraising:

The charity's fundraising programme continues to grow, aligned with key calendar events. In July, various teams celebrated the NHS Big Tea to mark the NHS' birthday. In September, the charity will launch its *Move for Mental Health* campaign, promoting the benefits of physical activity in the lead-up to World Mental Health Day on 10th October. A 28-mile sponsored walk across Trust sites is planned for the day itself. Planning is also underway for the Combined Charity Golf Day in support of Neuropsychiatry services. Service users are receiving free coaching from Trentham Park Golf Club in preparation for the event.

Grant making:

The second round of the Harplands Grants Programme was delivered over the summer to support fair distribution of the 2024 legacy donation. Two further small grants were awarded, and scoping is

underway for a Ward 4 request to install televisions in patient bedrooms. Following a Round 1 application from Ward 5, a business case is being developed to secure significant investment in enhancing the garden space for neuropsychiatry patients. This proposal is expected to be presented to the Charitable Funds Committee in December for approval.

ASSURE:

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

Charity Development Plan:

The quarterly update report presented to Committee provided assurance on the range of activities being taken forward to deliver growth. This included consideration of sustainable income streams through mechanisms such as Run for Charity and a staff lottery. A risk register has now been established specific to the charity and Committee noted the three current risks with residual scores all nine or below.

APPROVE:

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

External grant applications:

The committee approved governance routes for three NHS Charities Together grant applications:

- £25k to the *Greener Communities Fund* to enhance a designated green space for patients and staff (due 8 September).
- £150k to the *Innovation Challenge Fund* to support children and young people awaiting CAMHS access (due 30 September).
- £50k to *Round 2 of the Workforce Wellbeing Fund*, launching later this year.

Next Steps:

Activity to be completed in the next quarter includes:

- Submission of NHS Charities Together grant applications.
- Launch of Combined Charity impact video.
- Deliver in partnership with Hugh James Solicitors Combined Charity Golf Day in October.
- Combined Charity Golf Day.
- Promotion and fundraising associated with World Mental Health Day.
- Finalise the Fundraising Policy to reflect the requirements of the new Fundraising Code of Practice.

The next Charitable Funds Committee meeting will be held on 1 December 2025 at 2pm Via MS Teams.

Committee Chair: Russell Andrews, Chair of the Charitable Funds Committee.

REPORT END

Enclosure No: 15

WINTER PLAN 2025/26

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☐	Date of Meeting:	11 September 2025
Discussion	☐	Approval	☒		

Presented by:	Rachael Birks, Deputy Chief Operating Officer
Prepared by:	Ben Richards, Chief Operating Officer and Accountable Emergency Officer
Executive Lead:	Ben Richards, Chief Operating Officer and Accountable Emergency Officer

Aligned to Board Assurance Framework Risk	Risk 4 The Trust fails to meet the health needs of our local communities, particularly those with health inequalities resulting in worse outcomes for our most vulnerable patients
Approval / Review:	SLT
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:	Partnerships - We will actively promote partnership and integrated models of working
Sustainability:	Share learning and best practice
Resource Implications:	Yes
Funding Source:	
Diversity & Inclusion Implications	The Winter Plan impacts on the population of North Staffordshire and Stoke on Trent and our workforce. A full EQIA has been completed as part of the process of development and the PSED has been given due consideration.
ICS Alignment / Implications:	The Trust Winter Plan is aligned with the wider ICS Winter Planning.
Recommendation / Required Action	1. Trust Board is asked to approve the Winter Plan for 2025/26 2. Trust Board is asked to approve the assurance submission for NHSE.

Executive Summary

It is the joint responsibility of the ICS and the Trust as a statutory entity to ensure that robust arrangements are in place for the winter, including the festive period. This is essential in order to ensure that our patients receive the best possible care and inappropriate deterioration is avoided. Responsibility for delivering the winter arrangements sits with the Executive and operational leads and is overseen by the Chief Operating Officer who also acts as the Trusts Accountable Emergency Officer.

The Winter Plan 2025-26 has been developed with appropriate input from and engagement with all system partners in line with both previous practice and in line with NHSE requirements. . As with previous years it is largely reflective of last year's plan which following a review was felt to be effective but contains some new actions as a result of a change in circumstances (e.g. Project Chrysalis and Out of Area demands) or where specific investment has been made (e.g NHS111).

At the moment we are not currently facing regular industrial action and therefore it does not feature in this year's plan, however should this situation change we have tried and tested planning arrangements to mitigate any risks when this occurs, and these processes would be implemented if required and complement the actions within this winter plan. It is also recognised that the mandate for resident doctors action remains valid until January 2026 at the current time.

The Winter Plan sets out in summary:

- Actions to maintain and strengthen capacity within Acute and Urgent Care, Specialist Services and Primary Care.
- A balanced approach to admissions and discharges, with the aim of reducing avoidable delays, maintaining services and delivering appropriate waiting times
- Minimizing the impact and number of Out of Area Placements
- An increase in social care capacity to support discharges from hospital
- Plans for an effective 'flu programme
- Arrangements to ensure staff capacity is in place over the festive period.

In addition to planning for the pressures of winter, the health and social care partners also work with the local population to promote initiatives that reduce ill health and ensure that individuals know the best place to seek health advice and treatment

This year NHSE are requesting that Trusts complete a Board Assurance Statement to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair – the Trust's suggested submission is enclosed.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT Business	26 August 2025
2	Quality Committee	4 September 2025

Staffordshire Prepared



North Staffordshire
Combined Healthcare
NHS Trust

North Staffordshire Combined Healthcare Winter Plan

2025-26



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Executive Summary

Pressures on NHS services exist all year round and all parts of the health and social care system are experiencing demand growth on year-on-year basis, however we also recognise that on many parts of the health and social care system these can become even more acute throughout the winter period. The Staffordshire and Stoke on Trent Integrated Care System (SSOT ICS) has traditionally had particular challenges in this regard and therefore the system collaborates on a series of actions, the majority of which (the system actions) are outlined within the ICS Winter Plan which will progress through Trust Governance processes later in the year.

The plan also refers to specific actions that are required in the winter period to ensure that the care of people is not affected by the additional public holidays over the festive period and to ensure that we are well prepared for the 'flu virus, COVID, norovirus and mpox. Out with this plan the Trust will also be participating in national planning and exercising in relation to pandemic response.

It is the joint responsibility of the ICS and the Trust as a statutory entity to ensure that robust arrangements are in place for the winter, including the festive period. This is essential in order to ensure that our patients receive the best possible care and inappropriate deterioration is avoided. Responsibility for delivering the winter arrangements sits with the Executive and operational leads and is overseen by the Chief Operating Officer who also acts as the Trusts Accountable Emergency Officer.

The Winter Plan 2025-26 has been developed with appropriate input from and engagement with all system partners in line with both previous practice and in line with NHSE requirements. . As with previous years it is largely reflective of last year's plan which following a review was felt to be effective but contains some new actions as a result of a change in circumstances (e.g. Project Chrysalis and Out of Area demands) or where specific investment has been made (e.g NHS111).

At the moment we are not currently facing regular industrial action and therefore it does not feature in this year's plan, however should this situation change we have tried and tested planning arrangements to mitigate any risks when this occurs, and these processes would be implemented if required and complement the actions within this winter plan. It is also recognised that the mandate for resident doctors action remains valid until January 2026 at the current time.

The Winter Plan sets out in summary:

- Actions to maintain and strengthen capacity within Acute and Urgent Care, Specialist Services and Primary Care.
- A balanced approach to admissions and discharges, with the aim of reducing avoidable delays, maintaining services and delivering appropriate waiting times
- Minimizing the impact and number of Out of Area Placements
- An increase in social care capacity to support discharges from hospital
- Plans for an effective 'flu programme
- Arrangements to ensure staff capacity is in place over the festive period.

In addition to planning for the pressures of winter, the health and social care partners also work with the local population to promote initiatives that reduce ill health and ensure that individuals know the best place to seek health advice and treatment.

Communications activities are and will continue to be undertaken locally and these are linked to the national NHS Winter campaign. This will cover a wide range of issues and the Trust will not only focus on Mental Health needs but also wider health issues including local pharmacy services, GP opening times and self-care for common winter ailments such as colds and coughs.

Ben Richards, Chief Operating Officer and Accountable Emergency Officer



Summary of Key Actions for Winter 2025-26

Discharges	Identifying priority patients for discharge Working with LA partners to minimize the number of patients delayed whilst considered Clinically Ready for Discharge (CRFD) Continuation of two social worker posts in conjunction with Stoke on Trent City Council to support with discharge (learning from winter 2024-25) Continue to develop our engagement with the system Discharge Hub. Additional resources within the Discharge Pathway Team
Community Care Services	Festive arrangements for Primary Care Services e.g., repeat prescriptions Enhanced duty provision within the Mental Health Liaison Team ensuring consistent seven day provision.
Winter Contingency Arrangements	Winter Contingency arrangements for additional community hospital and intermediate care capacity Adverse weather procedures
Workforce	Winter staffing plans across health and social care for winter and for the festive period, including out of hours rotas to support escalation arrangements.
Coordinating Capacity and Flow	Enhanced existing huddles and system wide meetings for the winter period including Strategic (GOLD) system calls when necessary. Virtual ICC arrangements with the ability to transition to a physical ICC arrangement if required.
'Flu Vaccination	Staff and patient vaccination plan in place
Adverse Weather	Enhanced arrangements for accessing 4x4 vehicles for staff and patient transport, including those owned by staff.

1.0 Introduction

1.1 Background

Service arrangements for all year-round capacity and flow management are being augmented to deal with the additional pressures placed on services during the winter period. It is important however to recognize that the ability to expand mental health and learning disability and autism capacity above and beyond what we have already committed to in light of recent investments within North Staffordshire remains limited due to wider capacity and market forces outside of the Trusts control.

During the winter period, a number of pressures will be prevalent which will have an impact on the Staffordshire and Stoke on Trent Integrated Care System to manage demand and capacity, although these pressures can also be experienced at other times of the year. These include:

- Increased demand for unscheduled care, including increased ED presentations- *for Combined this is most likely to impact on our MH Liaison Team within the Royal Stoke ED*
- Higher rate of admissions to hospital, and higher lengths of stay due to increases in acuity – *for Combined this is may have a small direct impact on our bed base but is not a substantial impact compared with acute partners. We are seeing a continued general increase in acuity but this is not specifically as a result of winter pressures. However we must also consider the impact of the reduced bed base following the completion of Project Chrysalis.*
- More patients waiting to be discharged from hospital and requiring subsequent care packages to support discharge – *for Combined this impact is lost likely to be most significant in our older persons inpatient capacity, although we have an excellent record in relation to the Clinically Ready for Discharge (CRFD) standard we are aware that delays increase due to capacity being prioritized for Discharge to Assess (D2A) capacity for acute and community partners and also where external services are impacted by outbreaks and other closures/limitations on capacity. Where possible we have made internal investments to limit the impact of this, but ultimately remain reliant on social care partners for their response..*
- Decreased workforce resilience (festive holidays and sickness absence) – *Combined is likely to be impacted in a similar way to all ICS partners*
- Requirement to continue to deliver the elective programme at a time when demand and LOS is increasing (e.g., acuity of presentations) – *limited impact on Combined*
- Need to provide additional health and social care capacity in acute hospital and community settings to respond reliably and consistently to increased presentations at e.g., ED and in Acute Assessment Units – *for Combined this is covered off using resources for the increased demand for unscheduled care*

This year there is not an annual 'Winter letter' from NHS England in the usual fashion, however guidance has been issued and an assurance checklist is accompanying this plan when presented to Trust Board for final approval in September.. As with previous years there is a focus on ensuring emergency care flow with an emphasis on the acute trusts. There are two mental health specific items this year which relate to the continued accessibility of crisis line services (provided within Combined by the Crisis Care Centre) and crisis plans for high volume patients. Both of these aspects are covered within the responses outlined within this plan. The wider actions for all NHS providers are also covered off by the detail within this plan, save for:

- *The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.*
- *Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.*

The Trust has considered the impact of 'winter' on its overarching delivery of activity including that non related to urgent and emergency care delivery, however the phrasing of these specific points within the assurance statement means that they are not directly relevant to Combined as a provider. They have therefore been marked as not applicable.

1.2 Purpose and Scope

This Plan focuses on the period from November 2025 to March 2026 highlighting in particular, arrangements for the festive holiday periods in December and January. However, it should also be noted that many of the arrangements described in this plan to deal with peaks in demand and associated capacity are applicable all year round, which are the focus of the clinical directorates and both the Chief Operating Officer and the Deputy Chief Operating Officer.

As with previous years this plan represents a whole organisation approach and builds upon local service and directorate contingency plans and ensuring formal links with the plans of key stakeholders including the directions set out by the ICB, Stoke on Trent City Council, Staffordshire County Council, and external service providers (including Serco).

1.3 Governance

This Plan takes account of the national guidance and has been developed with the support of managers and clinicians from within the organisation. Although formal accountability for the plan sits with the Chief Operating Officer, as the actions form within their scope of responsibility and also within their role as the organisations Accountable Emergency Officer, day to day operational delivery of the plan sits with the Clinical Directors and Associate Directors of the clinical directorates, overseen by the Deputy

Chief Operating Officer (who also acts as the Deputy Accountable Emergency Officer if required).

These arrangements, alongside progress made with delivering the areas of change and improvement are summarised in this plan. The arrangements will be monitored throughout the winter period, in order to respond in a timely way to variations as necessary. Escalation arrangements are in place, with daily or more frequent teleconferences scheduled as appropriate.

1.4 Main Areas

The majority areas included in this plan mirror those of previous years and are described in detail in the following sections:

- Lessons Learned from last year
- Analysis of Activity, Capacity and Demand
- Improving Service Delivery - Initiatives in Place and Actions for 2025-26
- Managing the Impact of Infectious Diseases
- Resilience
- Communications
- Resources
- Information Management and Performance Reporting

Lessons Learned from 2024-25

1.5 Top Areas for Learning from 2024-25

1. Importance of engaging service and clinical leads at the earliest opportunity in order to ensure that the winter plan and associated actions are owned and delivered, and that clear prioritisation is in place for optimising the use of resources.
2. The additional social care capacity (with Combined funding and Stoke City Council providing the workers) proved invaluable to reducing the time waiting for social care assessment and therefore further delays in relation to Clinically Ready for Discharge patients.
3. A virtual Incident Control Centre (ICC) proved effective in the last two winters and throughout a range of situations through the summer of 2025. As such a virtual ICC has remained 'stood up' on Monday to Friday to continue to coordinate interactions with external bodies including NHSE.
4. Continue to target winter resources towards discharges, including those at weekends and public holidays, with a continued focus on actions to reduce the impact of delayed discharges. In response, the Plan identifies actions to deliver improvements in discharge and the investment in the discharge pathway team

5. Continue to explore every opportunity to increase flu vaccination uptake and ensure that the delivery of vaccination services in Primary Care do not have a negative impact in uptake by adults where eligible.

Many of the processes and activities identified above and, in the sections, below, have been incorporated in all year-round approaches to the management of unscheduled care, with the additional focus during the winter period on increasing capacity, including workforce, the flu programme and raising awareness (being prepared for winter) with patients and the wider public.

1.6 Improving Discharge

- Weekend Discharge target and trajectory agreed with winter plan leads
- Monitoring put in place through the daily bed monitoring report
- Virtual Discharge hub enhanced and focus on delayed discharges, with dedicated senior leadership
- Staffing resilience over Public Holidays implemented
- Monitoring at Performance for patients who are clinically ready for discharge (CRFD)
- Engagement with both Local Authorities (LAs) in relation to patients who are CRFD.
- Continued investment (non recurrent) with Stoke on Trent City Council in two qualified social workers by Combined to support patient assessment and onward discharge from hospital
- Continued engagement with the system Discharge Hub based at UHNM and hosted by MPFT.
- Additional resources within the Discharge Pathway Team

1.7 Demand and Capacity

- Detailed data and analysis of demand and capacity were used to inform the winter plan and agree key actions
- Improved access to real time information for operational leads
- Review of existing data sources and data sets to ensure these continue to provide the information required to plan for winter and to manage activity throughout the winter period

1.8 Escalation Plans

- Internal escalation plans were refreshed during the earlier part of the year and are aligned with the revised NHSE OPEL standards
- All partners clear about their responsibilities

1.9 COVID, Norovirus, mpox and Seasonal Influenza

- Plans agreed for COVID, influenza, mpox and norovirus in acute and community

settings

- Continue to review and revise plans for COVID, influenza, mpox and norovirus to meet requirements from best evidence and intelligence
- Local plans for outbreaks agreed where relevant (e.g., Edwards Myers Unit)

1.10 Vaccination

- National request to increase uptake by a minimum of 5% when compared to last years.
- Agreement renewed with University Hospital of North Midlands (UHNM)
- Vaccination nurses worked in partnership with Occupational Health to offer greater flexibility for staff vaccination
- Vaccination FAQs prepared
- Communications campaign

2 Analysis of Activity, Capacity and Demand

North Staffordshire Combined Healthcare has completed a detailed analysis of activity, capacity and demand across the MHLDA care system in North Staffordshire. This has enabled analysis of the possible impact on care services and identification of options for managing surges in demand across the festive period, and potential increases in activity due to other issues, such as increases in respiratory illness or severe weather. The key findings are summarised below.

2.1 Demographic Change

Staffordshire and Stoke on Trent is seeing shifts in demand due to the changing demographics, which include a growth in the older age groups and increasing numbers of people with co-morbidities. In the main, this is resulting in rising acuity levels across a range of care settings across the whole spectrum of health conditions. In addition, shifts in healthcare activity into community settings, both within physical health and across MHLDA has resulted in the remaining inpatient capacity in all areas being at the higher end of the acuity spectrum.

Within its modelling the Trust has attempted, wherever possible, to also take into account Wider determinants of health in order to recognise the local socioeconomic environment within North Staffordshire and also national drivers such as inflation and the current cost of living challenge.

2.2 Seasonal Variation and Impact of the Festive Break

In order to plan effectively for capacity over the festive and post-festive period it is important to have a good understanding of likely demand. Whilst levels of demand can appear to vary considerably from day to day, the overall pattern of demand is reasonably consistent, with predictable maximum and minimum levels of attendances and admissions.

2.3 Impact of private sector capacity on TCP/Complex Care (Project 86) Capacity

As at the end of Month 4, the Trust (on behalf of Staffordshire wide commissioners) has 28 inpatients within the TCP setting in total, with a further 114 being supported in the community but with additional support to mitigate the risk of placement breakdown.

As these places are within a private sector setting, the placement is subject to market forces, and it is recognised that the risk of provider failure is higher than that of a statutory setting. The Trust continues to see a reduction in the overall number of TCP inpatients, but its success in this area means that we are supporting 12.8% more individuals in the community than at Month 4 24/25.

Within the financial year to date there has been no provider withdrawals (compared to one at the same point last year and the year previous) which have negatively impacted on TCP/P86 capacity. In each case previously the Trust's contingency plans have operated effectively.

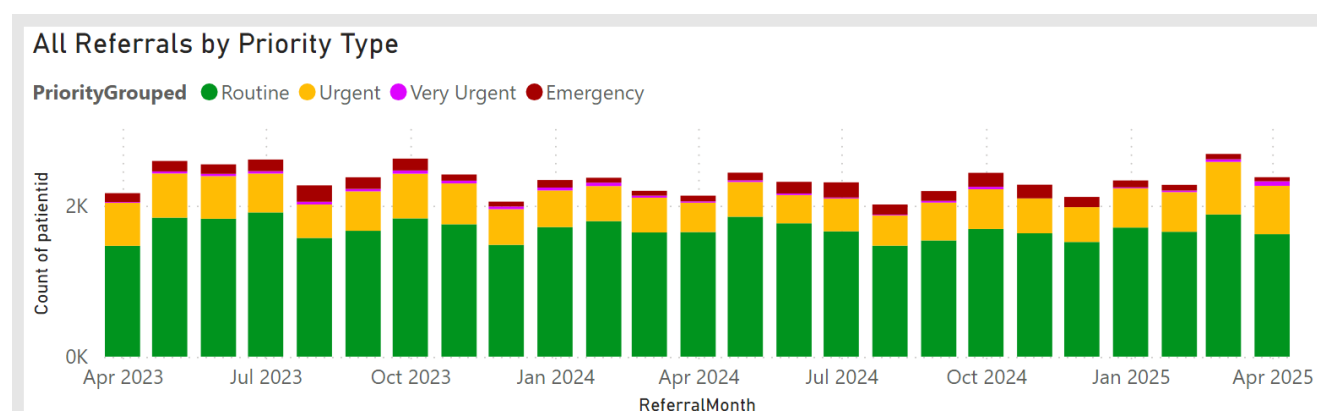
However, when compared to last year there is considerably more displeasure within the market in relation to the annual uplift offered by the Trust which potentially increases the risk that providers may exit the market over the winter period. This rate has been set by the ICB and the Trust is seeking to take a common approach with the ICB for individual requests for increases outside of the initial offer.

In line with the approach adopted in previous years for the purposes of winter planning there is assumed no increase nor decrease of external LDA capacity for these patients, but the contingency measures remain in place if required.

2.4 'Admissions' Data

2.4.1 Crisis Care Centre and Mental Health Liaison Team Contacts

Crisis Care Centre Referrals

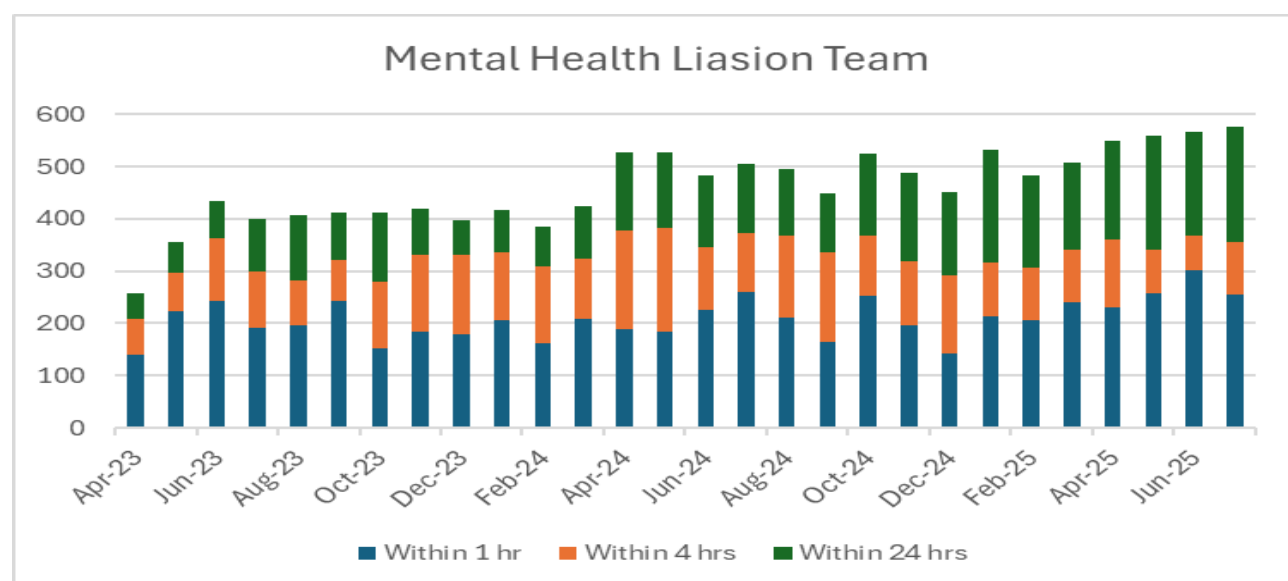


Referrals to the Crisis Care Centre located at Harplands Hospital remain relatively constant.

Given the investment of circa £0.7m made in 24/25 in relation to NHS111 activity capacity within the Crisis Care Centre is expected to sufficiently meet demand through the winter

period (as an additional 9WTE were provided).

Mental Health Liaison Team Referrals



Referrals for the Mental Health Liaison Team (MHLT), co-located with the Emergency Department at the Royal Stoke University Hospital, see an element of fluctuation regularly but have seen a sustained increase, which is in line with general activity levels within the RSUH Emergency Department.

The Team is resourced to provide 24/7 cover which is profiled (as far as is possible) to the average hourly demand, however the Directorate team were already monitoring the increase in activity levels.

Mutual aid provisions within the CRHTT and the MHLT are in place should demand exceed capacity and monitoring of the MHLT targets (1 hour, 4 hour and 24 hour) form part of the Trusts Performance Monitoring regime

Challenges however exist with support from Approved Mental Health Practitioners (AMHPs) which support this team when a patient is detained under the provisions of the Mental Health Act. AMHPs are provided by the relevant LA and the challenges in provision have been highlighted. Delays in an average month are around 60 hours, but this peaked at 140 hours in January 2024 at the height of the last winter period.

Escalation procedures are in place between UHNM, Combined and both Upper Tier Local Authorities in relation to AMHP Delays within the system. Escalations in relation to delays in relation to Out of Area Patients (usually Cheshire) are coordinated by the System Control Centre operated by the ICB.

The MHLT also forms a core part of the Integrated Discharge Hub (IDH) at the Royal Stoke University Hospital with 2WTE roles specifically deployed within that team. The IDH is hosted by MPUFT and brings together NHS and local authority partners to facilitate

discharges out of the acute setting. For this winter Combined's contribution will be in the form of an aligned person to facilitate discharge of patients with an actual or perceived mental health need.

Crisis Care Centre

The first point of contact for many patients in or approaching a degree of crisis in relation to MHLDA is via the Crisis Care Centre based at Harplands Hospital. The All-age Access Team will accept referrals from any source whereby there is concern for an individual's mental health.

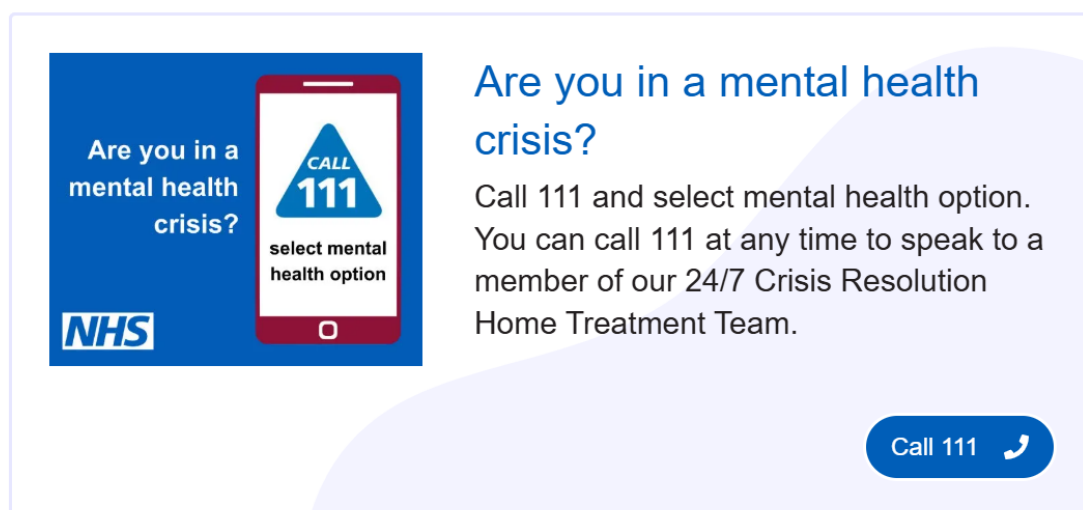
In line with the referral criteria referrals come through three main areas as outlined below, the majority of which come through the access line. Activity on this line is therefore an important element of winter planning for Combined.

Referrals to Crisis Care Centre ([North Staffordshire Combined Healthcare Crisis Care Centre](#))

Self-referral, family, carers should contact the Crisis Care Centre using NHS 111 (option 2) where possible in order to triage and arrange assessment venue and time appropriate to an individual's needs.

Professional referrals, either urgent or routine, should contact the Crisis Care Centre via telephone number 0800 0 328 728 (option 1) with the exception of routine GP referrals that are made via ERS.

Self-presentations are also accepted. A triage assessment will be undertaken in order to determine an individual's needs, whereby a further assessment may be arranged at a venue and time appropriate to an individual's needs.



The graphic is a promotional banner for NHS 111's mental health crisis support. On the left, there is a blue square with the text 'Are you in a mental health crisis?' and the NHS logo. Next to it is a red smartphone icon displaying 'CALL 111' and 'select mental health option'. To the right of the phone, the text reads: 'Are you in a mental health crisis?' followed by 'Call 111 and select mental health option. You can call 111 at any time to speak to a member of our 24/7 Crisis Resolution Home Treatment Team.' At the bottom right, there is a blue button with the text 'Call 111' and a white telephone handset icon.

A new addition to the crisis care service offering for this winter is a text-based option. A major milestone was met recently in the launch of NHS 111's urgent mental health support option, and thanks to national funding we are now introducing locally commissioned mental health text services, fully integrated into our mental health pathways. This will give our communities another discreet, immediate way to reach out

for help – anytime, anywhere.

2.4.2 Clinically Ready for Discharge (CRFD)

Someone is determined to be 'Clinically Ready for Discharge' when the multidisciplinary team (MDT) supporting them conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient setting.

There are three key criteria which need to be met before the MDT can make this decision:

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing the discharge plan
- The MDT must also have involved any services external to the provider in their decision-making where these services will play a key role in the person's ongoing care e.g., social care teams

The national CRFD guidance makes it clear that the criteria of Clinically Ready for Discharge applies equally both to people who are informal and detained under Mental Health Act (MHA). CRFD forms part of the refreshed Trust IQPR and is monitored through the Performance meeting process.

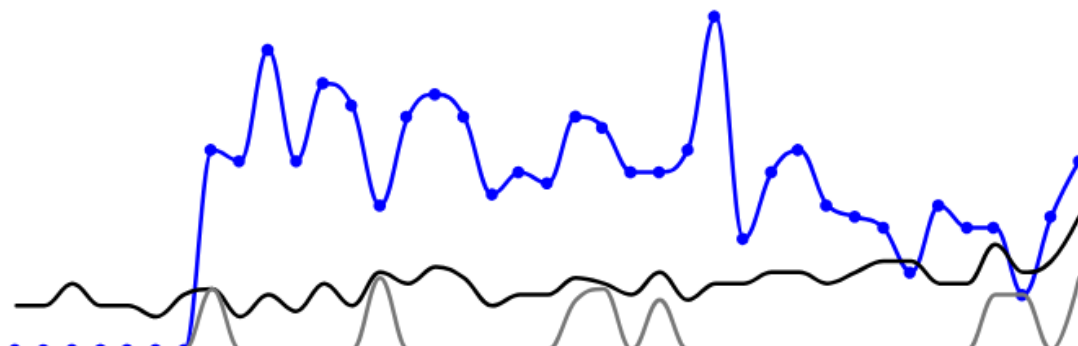
		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
MEASURE																	
CRFD		32	21	26	28	28	27	26	24	27	24	28	20	28	35	28	27
Acute & Urgent Care		25	16	19	20	20	19	18	16	17	16	18	13	23	29	22	23
WARD AREA																	
Adult IP		12	8	9	9	9	10	9	9	7	5	9	9	11	10	9	10
Older Adult		13	8	10	11	11	9	9	7	10	11	9	4	12	19	13	13
Specialist Services		7	5	7	8	8	8	8	8	10	8	10	7	5	6	6	4
WARD AREA																	
CYP		0	0	0	0	2	2	2	0	0	0	0	0	0	0	0	0
LD		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Neuro		4	2	4	5	2	1	1	4	6	4	6	3	2	3	2	2
Rehab		2	2	2	2	3	4	4	3	3	3	3	3	2	2	3	1

In line with other partners and systems nationally discharges are constrained by the availability of a range of community-based options including intermediate care beds, step up: step down, care and care homes as well as care package availability in the community at a person's home.

Following the success of the scheme last winter Combined has again invested on a non recurrent basis with Stoke on Trent City Council to provide 2WTE qualified social workers through to March 26. This will allow speedier assessments for Stoke on Trent residents which form a significant part of the delays being experienced. A bid to the

Stoke on Trent Better Care Fund (BCF) for the £124k recurrent funding has been made, given that mental health services now have parity for access to BCF funding, however all funding within the BCF is committed until September 2026.

Delayed discharges for mental health adult patients



There have been rises in the CRFD experienced by Combined, national benchmarking (NHS Model Mental Health Trust – last data refresh Aug 25) shows that as a Trust (blue line) we experience more delays than our peers (black line)

The national data also shows that we have 100% of the expected internal processes and practices in place to reduce LOS delays that are created internally within the Trust. As a Trust we discharge 85% of patients back to their own homes (compared to 68.6% nationally) which does mitigate, in part, the delays relating to CRFD. The Trust remains in the upper quartile for long lengths of stay.

Management of CRFD is led primarily by the Acute and Urgent Care and Specialist Directorates and forms part of their Business as Usual (BAU) processes and remains an area of focus of the Deputy Chief Operating Officer

2.4.3 Bed Occupancy and Out of Area Patients

Delays in discharges are a major contributor to bed occupancy. Patient flow from the Mental Health Liaison Team, Crisis Care and PICU into downstream wards is dependent on efficient discharging of patients, working towards lowering the average length of stay and reducing the percentage occupancy.

	APR	MAY	JUN	JUL	AUG	
MEASURE						YTD
Bed Occupancy %	87.67	88.09	87.65	87.56	84.9	87.39
LOCALITY						
Acute & Urgent Care	92.45	93.12	93.58	96.4	93.85	93.87

In previous years the Trust has had sufficient bed capacity overall to meet local need, however with changes in demand and changes to bed provision connected to Project Chrysalis our bed

stock entering this winter is constrained. At a macro level our bed capacity appears sufficient, however some of these vacancies do not contribute to the availability of beds for acutely unwell patients. Occupancy within Acute and Urgent Care is running at 93.87% year to date and the Trust has seen a rise in Out of Area patients during this financial year. Following the completion of Project Chrysalis work will commence on the Edward Myers Unit to remove the girpee pipework causing the unit to relocate temporarily to the Ward 10 footprint. The Trust therefore has no additional inpatient estate available to it for any additional capacity over the winter period. The only flex capacity available for us will be the use of OOA beds.

Where a patient requires an OOA bed then the Directorate Standard Operating Procedure will be followed, ensuing that repatriation is timely and the patients care is not negatively impacted.

2.4.4 SHREWD and OPEL

SHREWD is again being used this across the system this winter, and a sample of the reporting that is provided in real time is below.

SHREWD displays data in a way that is simple to understand and visually identifies areas of pressure quickly. Data is automatically fed from Combined systems and the Data Warehouse.

SHREWD enables front line teams and operational leaders to see a real time view of the situation in around three seconds. Users can then 'drill down' into the precise reason for that pressure within a few clicks. This enables users to focus on where support is needed to improve flow.

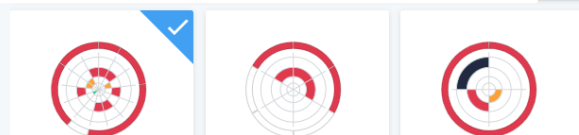
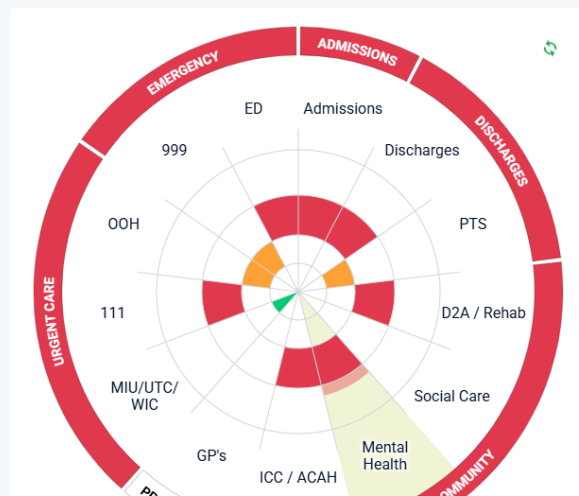
Data is captured from all providers within the urgent and emergency care pathway, from all acute front-line services, such as 111, 999 and A&E, throughout the hospital footprint, and all the way into community services and beyond to third sector support services. The data is then made accessible to all providers in the system via a web interface and smartphone app.

SHREWD offers relevant Combined staff to see the pressures across all other areas, including RSUH ED and pressures being experienced within MPFT, including the availability of their s136 suite. The data is also processed to provide an Operational Pressure Escalation Level (OPEL) score for the Trust which is reported regionally and nationally. Combined's escalation plans are written using the national OPEL framework criteria.

Staffordshire & Stoke Overview

Resilience → Dashboards

Dashboard Actions



stoke-system-dashboard

NSCHT Section 136	S136 Place of Safety
S136 Place of Safety Availability	

NSCHT Mental Health	CAMHS (14)	Older Adult (33)	Adult (44)	PICU (6)
Empty Beds Available Now	4	3	1	1
% Bed Occupancy	71%	90%	100%	83%
Medically Fit for Discharge (MFFD)	0	11	10	0
Planned Discharges (+24 hrs)	0	1	2	0
Planned Discharges (+48 hrs)	2	1	5	0

NSCHT MH Referrals	via ED	via Police	via Other Routes
Referrals Received Today	21	1	204

MPFT Section 136	S136
S136 Suite Availability	

MPFT Mental Health	MOD (6)	Older Adult (26)	Adult (51)	PICU (11)
Empty Beds Available Now	0	0	0	0
% Bed Occupancy	100%	100%	100%	
Delayed Transfers of Care (DToC)	0	2	0	
Planned Discharges (+24 hrs)	0	1	0	
Planned Discharges (+48 hrs)	0	0	0	

Mental Health Framework 24/26	Staffs & Stoke
% Bed Occupancy - Adult	103.57%
% Bed Occupancy - Older Adult	89.09%
% Patients Clinically Ready for Discharge	17.32%
Inappropriate Out of Area Placements (OAPs)	21
% Planned Discharges (Tomorrow)	2.23%
% Achieved Discharges (Yesterday)	0.56%
% Beds Closed to Admission	0%
% Patients Awaiting Inpatient Admission	0.56%

OPEL Status	Whole System	UHNM	RSUH	UHDB	QHB
OPEL Status	3	3	3	2	3
Non-Acute OPEL	Staffs CC - Social Care	SOT CC - Social Care	MPFT - Mental Health	NSCHT - Mental Health	Totally Urgent Care 111
OPEL Status			3	3	

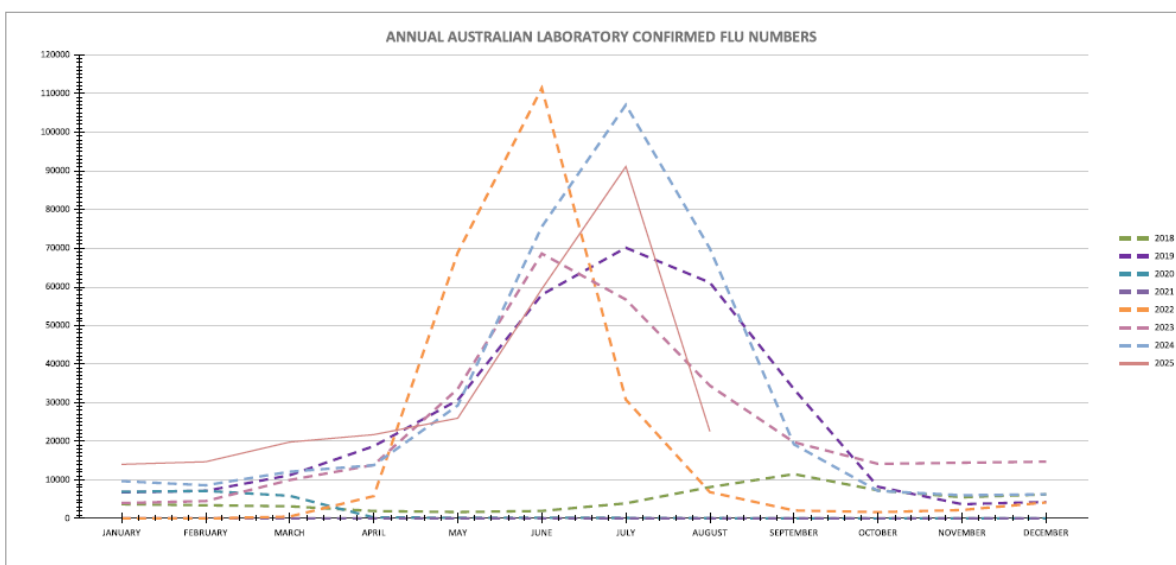
2.4.5 Winter Flu

Each year, the influenza virus changes, and different strains can circulate in the population. Particular subtypes of influenza can affect different groups of the population more than others. Depending on the susceptibility of the population, the subtypes that are circulating and the changes to the virus itself, the influenza season can be very different year to year.

The Trust has historically had a good uptake of the 'flu vaccine and has planned its programme for staff and patient vaccination in conjunction with UHNM, as was the case in recent years. Uptake has been lower post COVID, in part driven by some elements of vaccine 'fatigue'. In line with NHS planning guidance the Trust is seeking an increase of uptake over 2024/25 of 5% at the absolute minimum,

It is important to note that information provided from the UK Health Security Agency, received from their colleagues in the National Notifiable Diseases Surveillance System (NNDSS) within the Australian Government Department of Health and Aged Care shows that the peak of laboratory flu in Australia (which due to seasonal offset usually provides a reasonable indication of the UK profile for the forthcoming winter) shows a similar distribution as seen last year.

The commencement of the 'flu vaccination campaign is constrained by the availability of the vaccine, which does not become available until mid-September at the earliest with vaccination activity planned for October onwards. Recruitment of peer vaccinators is already underway and vaccine orders were placed a number of months ago.



Reference: These statistics are taken from the Aust Government Department of Health, National Notifiable Diseases Surveillance System

2.4.6 Urgent and Emergency Care Board

The Trust remains a key participant in the ICS Urgent and Emergency Care Board and is represented by the Chief Operating Officer with the Deputy Chief Operating Officer also attending and deputizing as required.

The Board meets monthly and is chaired by Dr Diane Adamson (Chief Medical Officer at UHNM) in her role as ICS Portfolio lead for Urgent and Emergency Care with the ICB Chief Delivery Officer acting as the Deputy.

In addition to local partners the meeting is also attended by West Midlands Ambulance Service and a senior member of the NHSE Regional Team.

Improving Service Delivery - Initiatives in Place and Actions for 2025-26

This section of the Combined Winter Plan presents the main focus of planning for peaks in demand and activity, including the winter planning period for this year and also indicates how the relevant points within NHSE letter will be addressed.

The actions for Winter 2025-26 are summarised under the following areas of activity:

- Preventing admissions and supporting discharge
- Specific arrangements for the festive period
- Preventing and responding to surges in demand

As with last winter, in order to learn fully from our experiences this winter, and to prepare for winter 2026-27 which will be upon us before we know it, it is proposed to hold a winter plan debrief session in Quarter 1 2026-27.

2.5 Preventing Admissions and Supporting Discharge

If admission and discharge rates are maintained at normal levels over Christmas and New Year, this reduces the potential for post-festive pressures. These pressures are particularly acute in the first week in January due to the combination of increased emergency demand, external pressures and clearing any post-festive build-up. The main areas that have been identified for improvement are:

- The risk of patients being delayed on their pathway
- Discharges at weekends and bank holidays
- Optimising care in Community and Primary Care Settings
- Safe and effective admission/discharge continues in the lead-up to and over the festive period and also into January

²² The majority of the actions summarised below are reviewed regularly by the senior operational team and at Executive Meetings and SLT Business as required. Some of the metrics also form part of our BAU Performance management processes.

2.5.1 Supporting Discharge

Reducing the numbers of patients delayed in their discharge from hospital and their length of stay in hospital, is a key priority for the Trust, the ICS and nationally. Reducing delays not only helps patients who benefit from getting home or to a more appropriate, more homely setting as soon as possible, it is also essential to maintain flow through the health and social care system.

What we are doing

Improvement Programmes	Continue to maximise the benefits of the EPMA prescribing system in supporting earlier in the day discharges and improving the flow of unscheduled care patients ready for discharge. Improving the spread of discharges across the working day, including more earlier in the day discharges, should improve the ability of pharmacy to dispense discharge prescriptions within the agreed turnaround times.
Coordinating Capacity and Flow	Reinforce clinical decision making and roles, in particular Clinical Directors, ward-based Consultants, Charge Nurses and Advanced Professional Practitioners, and staff (NHS and social care) to ensure patient flow is optimised across extended hours and weekends.
Coordinating Capacity and Flow	Arrangements for accessing social care packages at the weekend are in place in order to improve weekend discharge rates, however it is recognised that priority is given to urgent care patients in the acute setting during this period. We have also made investments into additional social worker capacity from SOT over the winter period.
Coordinating Capacity and Flow	Wards will optimise transfers to social care packages earlier in the day to support flow.
Delays to Discharges	Maintain the excellent work in relation to delays to discharge and aim to eliminate all CRFD delays within the sole control of Combined and work with partners to reduce other CRFD delays to a minimal level.
Coordinating Capacity and Flow	Multiple daily capacity huddles involving senior leaders and the Harplands manager take place, supported by escalation to a daily senior leaders' check in teleconference, from December.

Coordinating Capacity and Flow	Continue with CRFD monitoring for patients within an inpatient setting to identify those who are potentially delayed in accessing the most appropriate place of care and use the results for improvement with health and social care colleagues across the ICS and for patients who need returning to another area, the relevant ICS organisations in that area.
Coordinating Capacity and Flow	Daily huddles are in place to consider the impact of patient needs, staffing needs, bed capacity and safety issues. All wards and departments are represented, including crisis care, corporate nursing and the ICC.

2.5.2 Preventing Admissions

What we are doing

Front Door	Mental Health Liaison Team (MHLT) service supports the Royal Stoke ED and assessment units in order to assess patients with an identified change or new onset mental health challenges and supports those who are suitable, either avoiding admission or enabling early discharge home.
Community Based Care	The High-Volume Users service review patients most at risk of admission, ensuring clear arrangements including the range of community alternatives offered, if admission is required then they will attempt to bypass the ED department to ensure the patient is admitted to the correct location. This is a specific requirement for MH Trusts as part of the assurance process for 2025/26.
Community Based Care	The Learning Disability Intensive Support Team support complex patients in remaining within a community setting, but who still require high levels of complex care, avoiding the need for admission to a high tier bed.
Community Based Care	Fully utilise the NHS111 Mental Health system for North Staffordshire and Stoke on Trent, allowing faster and more direct access to mental health professionals for those in crisis.
Community Based Care	Implement the Crisis Care Text service offer for patients in North Staffordshire and Stoke on Trent, expanding the availability of mental health support to citizens,

2.5.3 Improving Patient Flow

What we are doing

Coordinating Capacity and Flow	Clear escalation plan in place to manage severe capacity pressures, recognising that managing patient safety at times of increased escalation.
Coordinating Capacity and Flow	Standard Operating procedures and criteria are in place for boarding in acute inpatient ward areas.
Coordinating Capacity and Flow	Attendance and escalation to the daily (and twice daily in times of extremis) system escalation calls, providing all partners with direct access to system partners to reduce patient delays.
Clinically Ready for Discharge	Where patients are CRFD there is a protocol in place to allow these to outlie to alternative wards if and when a specific bed type is required for another patient. This limits the impact on the receiving teams and ensures that each of the patients receive the best available care at that time.
Transport	Involvement with both our own PTS provider and the ICS provider (now both provided by E-zec) to ensure timely transfer of patients from the acute setting, between MH settings and discharge out of Combined services. Where clinically required Safe and Secure transport arrangements are in place.
Norovirus	A modified norovirus protocol and robust pathways have been prepared for this winter for testing and for containment measures, any treatment and options for discharge or admission. This has been prepared by the Infection Control Team in conjunction with Microbiology.
Winter Flu	A modified Flu protocol and robust pathways have been prepared for this winter for testing and for follow up treatment if appropriate, discharge or admission. This has been prepared by the Infection Control Team in conjunction with Microbiology.
COVID	A modified COVID protocol and robust pathways have been prepared for this winter for testing and for follow up treatment if appropriate, discharge or admission. This has been prepared by the Infection Control Team in conjunction with Microbiology.
mpox	A mpox protocol for both inpatient and primary care areas has been developed and will be kept under constant review as new guidance is issued.

2.5.4 Primary Care

The service regularly monitors access provision across all Primary Care Directorate practices, adjusting capacity as necessary to meet acute and routine demand. Where possible and appropriate, the service aims to share resources across Directorate practices to support access, and this year we have strengthened business continuity processes through further joint working across the practices.

As part of the Hanley, Bucknall and Bentilee Primary Care Network (PCN), Moorcroft Medical Centre will be providing extended hours appointments on Tuesday evenings to practice and PCN patients. Further extended access appointments will be offered by PCN practices, supported by North Staffordshire GP Federation, to the total PCN patient population, including weekend appointments and appointments outside of core hours. PCN practices also having the ability to manage patients for other PCN practices via mutual aid should a practice team be affected by an outbreak such as COVID.

Patients from Keele Surgery have access to a similar offer from the Newcastle South PCN and Holmcroft Surgery from Stafford Town PCN.

The Primary Care Directorate will continue to promote the use of online consultations as an alternative method of communication and care management. Online consultation volume is regularly monitored by the team and provision of clinical sessions managed to support the review of online consultations. The service also has a suitable level of digital equipment, such as laptops, to support homeworking should this be required during an infection outbreak.

In addition, this year all of the Combined GP practices can utilize PATCHS to provide additional capacity for patient contacts. PATCHS is an online consultation service that allows patients to quickly and easily access GP services online. It allows a range of tasks and issues to be streamed away from GPs and to more appropriate clinical or non-clinical teams. In addition to PATCHS we maintain more 'traditional' routes of patient contact to ensure that those unable or unwilling to use PATCHS have access to primary care services, this is particularly important where the demography may differ, such as at Holmcroft Surgery. The 2025/26 GP contract in England introduces several changes aimed at improving access and modernizing general practice, these changes include allowing patients to book appointments online throughout working hours and requiring practices to make all directly bookable appointments available online

Directorate practices also take part in the winter access scheme provided by commissioners. This scheme includes the review of appointment slot types to ensure accurate recording of appointment data and increased utilisation of the Community Pharmacy Consultation scheme, which is monitored on a regular basis.

The service will be starting its influenza vaccinations in October with large walk in clinics being held over Directorate sites and additional clinics provided as needed. Moorcroft Medical Centre is also expecting to provide COVID vaccination clinics for identified patient cohorts. Directorate sites also have the ability to see patients who are COVID positive with the use of "hot" clinical rooms and a PortaKabin located at Moorcroft Medical Centre.

Specific Arrangements for the Festive Period

We have focused our festive period activity on addressing the issues identified earlier in this plan but recognizing the additional challenges that are placed upon and are faced by services during an extended holiday period. In addition to the measures described in other sections of the plan regarding discharges from hospital, every effort will be made to discharge patients proactively in the days prior to the public holidays at Christmas and New Year.

The Trust has long acknowledged the importance of improving resilience and sustainability of health and social care services over public holiday periods. The Combined Plan recognises these issues, and in particular the need to ensure that there is sufficient staff availability across a wide range of services on and after public holidays, and seeks to provide assurance that staff will be deployed appropriately and that business as usual is maintained as far as practicable, linked to NHS and social care workforce plans and escalation arrangements

The key messages specifically for the holiday period are:

- Ensure sufficient levels and numbers of senior decision makers from all sectors are duty rostered at same time for both inpatient and community teams
- Timely and continuous access to local infrastructure services within hospitals
- Proactive discharge planning before public holidays
- Timely and clear social care support arrangements
- Timely, integrated health and social care urgent care resilience plans (daily staffing meetings, huddles, data, escalation arrangements)
- Support towards staff wellbeing and staff ability to take a rest break over the holiday period

2.6 Workforce Capacity Plans and Rotas for Winter and the Festive Period

It is generally possible to predict levels of festive and post-festive demand based on previous experience, although there are factors such as 'flu prevalence, COVID prevalence etc. which will directly impact. However, it is generally considered possible to plan appropriate staffing levels for the festive period, in addition to ensuring staffing levels are appropriate for the winter period.

Agreeing rotas and staffing levels for health and social care services early increases the time to ensure that allocation of holidays is managed optimally to maintain adequate cover at peak time and also to allow staff to take a break themselves during this festive period. We require workforce capacity plans & rotas for the winter/festive period to be agreed and in place before the end of October 2025 in all relevant departments and it is expected that departments and services will liaise regarding mutual arrangements.

The directorate teams are ensuring that the appropriate levels of staffing are in place across the whole system, for the entire festive period to deliver effective and efficient patient care. There will be an emphasis on ensuring that on all days over the Christmas and New Year fortnight there will be focus and drive on

maximizing the number of discharges on each day and progressing the planned discharges for future days.

As part of the communications package on Winter Planning, staff are being informed of the expectation that robust staff cover must be in place over the festive period for all stages of the patient journey.

At the moment we are not currently facing regular industrial action and therefore it does not feature in this years plan, however should this situation change we have tried and tested planning arrangements to mitigate any risks when this occurs, and these processes would be implemented if required and complement the actions within this winter plan.

What we are doing

Staffing Plans	Each service will have staffing plans in place, including rotas, by the end of October 2025 to ensure appropriate capacity during winter and also over the festive period. This will provide sufficient time for the Steering Group to review staffing across all services and for any concerns to be addressed. Staffing plans for each service must include sufficient service provision in to maintain discharges at a suitable level during the festive period.
Contingency Beds	There are no plans for the creation of additional bed capacity, based on both the ability to staff these and the available inpatient estate. Where contingency capacity is needed it is expected that this can be delivered by changing the case or gender mix of additional capacity and this will be undertaken by clinical teams at an operational level.
Social Care	The ICS has requested that social care services plan their staffing resources during the predicted periods of high demand, alongside the NHS workforce, to meet additional requirements for assessment and social care.
Managing Leave	Ensure health and social care staff annual leave is managed effectively over the festive period to minimise the impact of leave on service capacity. All services must be committed to staffing rotas appropriately to ensure that a shortfall in one area does not impact on the ability of another service to function or impinge on any service's ability to provide appropriate care.
Staffing Levels	Ensure that Estates and Facilities staff, and SERCO, have adequate staffing in place and robust, rehearsed, escalation plans in place to meet demand.
Festive Plan	Review the capacity of the staff bank against the known and likely demands, and recruit additional staff as necessary, to address any gaps, including highly specialist areas such as PICU, EMU and CAMHS.

Industrial Action	At the moment we are not currently facing regular industrial action , however should this situation change we have tried and tested planning arrangements to mitigate any risks when this occurs, and these processes would be implemented if required and complement the actions within this winter plan.

2.7 Preventing and Responding to Surges in Demand

It is possible to identify periods of festive and post-festive demand based on previous experience. It is therefore possible to plan for increased demand for care packages, ambulance transfers, nursing home placements, social work assessments etc. based on historical data and to ensure that services are suitably prepared to provide additional activity in the post-festive surge period and all year round. The majority of this activity sits outside the direct control of Combined however we remain an active member within system planning processes.

2.8 Specific Arrangements for Primary Care

This year, the Christmas and New Year closures form four day and three day blocks, we therefore find us with the same challenging circumstances that we found in. 2022 and 2023. However, in both of those years our plans functioned effectively and therefore their principles remain in place for this year.

Each of our practices participates in appropriate out of hours arrangements funded by the ICB/NHSE. The most significant impact on Combined is therefore likely to be felt within our urgent care services in relation to Mental Health. The impact is therefore covered elsewhere within this plan.

However Primary Care Services remain a critical element in the overall approach to managing winter demand pressures both for physical and mental health services.

Managing the Impact of Infectious Diseases

The impact of influenza, norovirus and COVID all have the potential to have a significant impact on service delivery, in particular through the winter period. The contribution of infection control in maintaining service provision during the winter months is therefore an essential part of any winter planning process.

The following areas describe how we will manage these issues in Combined:

- Managing Norovirus
- Seasonal Flu
- COVID
- mpox (previously known as monkeypox)

2.9 Managing Norovirus

Combined has extensive infection control arrangements in place, which are part of an ongoing review process to ensure that they remain fit for purpose. It is recognised that ward closures would have a major impact across the service.

A range of well-tested actions are already in place, including:

- All patients with symptoms of diarrhoea and vomiting are isolated promptly and reviewed by the Infection Prevention & Control Team
- A Pathway for Enteric Illness including Clostridium Difficile is available to ensure all patients with symptoms of diarrhoea and vomiting are managed appropriately
- There is a robust ward / clinical area visit programme for the Infection Prevention & Control Team (IPCT) to ensure that the IPCT are available for all staff
- Outbreak folders are in place in all wards providing Infection Control Information relating to outbreaks including norovirus
- Infection control training is mandatory for all staff and compliance remains consistently high
- Information providing useful Infection Control Information is provided on the intranet to all staff
- An on-call doctor (microbiologist) is available 24/7 for IPCT advice
- Systems in place for a holding statement/advice for a norovirus outbreak
- Closely monitored hand hygiene measures are in place for all visitors to wards and clinical areas

What we are doing

Surveillance	As part of the annual norovirus campaign, close monitoring of national norovirus surveillance rates will ensure Combined will have timely notice of the start of the norovirus season.
Staff Awareness	Norovirus awareness sessions to all ward staff will commence 4-6 weeks prior to the anticipated season start.
Festive Plan	Cover for the new year bank holiday by IPCT staff (via the on-call microbiologist) will ensure the necessary support to ward staff in the event of an outbreak.

2.10 Seasonal Flu

In Combined, we will continue to review our Pandemic Influenza planning processes in conjunction with our ICS partners. As a provider we have traditionally performed well in relation to 'flu vaccination uptake for our inpatients and for our staff overall.

Staff Immunisation Programme

- The vaccination clinics booking system will go live in October
- The Trust will work in partnership to support UHNM to deliver the vaccination programme and deliver to UHNM and Combined staff members
- Data will be available to give an overview of % uptake for COVID and Flu. Information will be disseminated across operations to drive performance uptake across clinical services
- Roving clinics will be deployed in hard-to-reach clinical areas
- Vulnerable in-patients will be supported by MPUFT team coming on site to deliver vaccines to appropriately identified patients in October and November
- 31 • The vaccination group will continue to meet regularly to support UHNM and have the trust overview

Diagnosing Flu and Managing Patients

The criteria for identifying an outbreak have not changed which will include COVID and Flu. The IPC will continue to identify and manage outbreaks with all relevant reporting and support in place as necessary

What we are doing

Flu Testing	The criteria for identifying an outbreak have not changed which will include COVID and Flu.
Flu Testing	The IPC will continue to identify and manage outbreaks with all relevant reporting and support in place as necessary
Vaccination Programme	Implement Seasonal Flu Vaccination Programme for all identified groups.
Vaccination Programme	All GPs within the Combined 'family' will continue to deliver the Seasonal flu program to over 50s, those in 'at risk' groups and pre-school children.
Vaccination Programme	The Trust has agreed the SLA with UHNM for this year's staff vaccination programme
Vaccination Programme	The Immunisation Team will be available to provide targeted vaccination sessions to Care Homes or other high-risk settings if required.
Vaccination Programme	Encourage at risk individuals and unpaid carers to be vaccinated for Flu.
Vaccination Programme	Provide a roving vaccination programme for staff in addition to fixed and open sessions in a variety of locations.
Vaccine Uptake	Aim for at least 75% of Combined staff to be vaccinated for Flu.
Vaccine Uptake	Ensure timely submission and analysis of relevant vaccine uptake data as required by NHSE / UKHSA
Antivirals	Antiviral prescribing will be recommended on advice from Chief Medical Officer.
Intelligence	UKHSA weekly updates will be widely circulated within Combined once they commence

2.11 COVID

COVID has had a significant impact on all health and social care providers, Indeed on society as a whole, over the past few years. It is clear that COVID has not 'gone away' and there remains a risk that there will be another wave surge resulting in system fragility and potentially impacting on patient safety and delivery of restoration and recovery trajectories.

As with norovirus and 'flu, COVID is no longer a new threat and therefore a range of well-tested actions are already in place, including:

- All patients with symptoms of COVID are isolated promptly and tested appropriately
- A clinical pathway is in place, which also includes admission and discharge testing requirements.
- There is a robust ward / clinical area visit programme for the Infection Prevention & Control Team (IPCT) to ensure that the IPCT are available for all staff
- Infection control training is mandatory for all staff and compliance remains consistently high
- Information providing useful Infection Control Information is provided on the intranet to all staff
- The IPCT is available for advice
- Systems in place for a holding statement/advice for a COVID outbreak
- Closely monitored hand hygiene measures are in place for all visitors to wards and clinical areas
- Mask requirement will be constantly reviewed within clinical areas

For the upcoming autumn 2025 COVID-19 vaccination program, NHS staff will **not** be eligible for the national vaccination program, according to the Joint Committee on Vaccination and Immunisation (JCVI). This decision follows a review indicating limited benefit of vaccination for this group in terms of infection and transmission reduction. The focus of the autumn program will be on individuals at higher risk of severe disease.

2.11 mpox

Following the declaration by the World Health Organization of an outbreak and rapid spread of a new strain of mpox in some African countries as a Public Health Emergency of International Concern (PHEIC), Combined Healthcare, along with all other NHS bodies needs to ensure appropriate measures are in place to manage cases and reduce the risk of spread should cases be identified in the United Kingdom.

The risk to our population is currently low. However, planning is under way to prepare for any cases that we might see within the Trust either as an inpatient or within our primary care services. This includes ensuring clinicians are aware and able to recognise cases promptly, that testing is available, and that protocols are put in place for the safe clinical care of people who have the infection and for the prevention of onward transmission.

The Trust has two procedures agreed and in place in relation to both of these scenarios and will develop these further as additional national guidance is published.

Although not a winter issue per se, given the timescales involved there is a risk that any spread is likely to progress over the winter period, hence its consideration as part of winter planning.

What we are doing

COVID Testing	Continue to test symptomatic patients and staff, admissions and discharges in line with current NHSE guidance, as advised by CPAG
Vaccination Programme	Implement COVID Booster Vaccination Programme for all identified patient groups once detail is provided
Vaccination Programme	The Trust has agreed the SLA with UHNM for this year's staff vaccination programme
Vaccination Programme	The Immunisation Team will be available to provide targeted vaccination sessions to Care Homes or other high-risk settings if required.
Vaccination Programme	Provide a roving vaccination programme for staff in addition to fixed and open sessions in a variety of locations.
Vaccine Uptake	Ensure timely submission and analysis of relevant vaccine uptake data as required by NHE / UKHSA
Intelligence	UKHSA weekly updates are widely circulated within Combined

Resilience

North Staffordshire Combined Healthcare NHS Trust, Staffordshire and Stoke on Trent ICS and our Multi-Agency Resilience Partners have a range of plans in place for dealing with major incidents, severe weather, surges in demand and subsequent impact on capacity throughout the system. The following plans and processes are in existence for dealing with major disruption to service provision:

- Trust Major Incident Plan
- Severe Weather Activation, Response and Recovery Framework
- Site and service level Business Continuity arrangements
- Trust Pandemic Influenza Plan

These plans include details of critical service provision, staff, equipment and services that can be temporarily suspended to allow resources to be targeted to essential areas.

We also have a number of multiagency continuity plans in existence with our Staffordshire Local Resilience Partners (LRP) including:

- Response and Escalation Plans (Contingency, Severe Weather etc.)
- Pandemic Influenza Response Arrangements
- Third Sector - Single Point of Contact via local authorities
- Major Incident Control Centre (MACC) facilities if required

The plans, activation, response and recovery arrangements are reviewed and exercised on a regular basis including debrief reports following incidents and lessons identified are incorporated.

We will also deliver targeted training to groups such as community-based staff and participate in multiagency exercises to test business continuity and response arrangements.

The ICS continues to model the impact on capacity and flow throughout the whole system and identify solutions to address surge and capacity issues on a multi-agency basis.

The Trust participated in the Regional Winter Planning Stress Test Exercise led by NHS England in Birmingham on Wednesday 17 September. This provides an opportunity for systems and organisations to stress test their plans against winter scenarios to maximize reliance.

In addition the Trust is participating in Exercise PEGASUS, a Tier 1 (national) pandemic response exercise led by Department of Health and Social Care (DHSC) which aims to assess the UK's preparedness, capability and response strategies in relation to a novel infectious disease pandemic. The exercise follows on from Exercise TANGRA (Midlands-based health-focussed pandemic exercise) and Exercise SOLARIS (Staffordshire Local Resilience Forum (LRF) exercise), and will focus on the initial stages of a pandemic.

The national exercise will run across three weeks (one each in Sep, Oct and Nov).

Communications

The Key communications aims are to:

- Ensure the general public are aware of local health service arrangements and throughout the winter period, including the festive public holidays, and know where to turn to for health service information and advice
- Ensure national winter campaigns, key messages and services (including NHS 111 and the new crisis text service) are promoted effectively across North Staffordshire and supported by relevant local information and advice
- Ensure staff are informed about preparations for winter including arrangements for staff flu and COVID vaccinations, local service arrangements and advice for patients
- Effectively manage the response to increased media interest over the winter period and provide reassurance that appropriate plans and contingency arrangements are in place to manage demand throughout the winter period

2.12 Key Actions

A wide range of communication activities will be undertaken to provide advice and information to local people across North Staffordshire on how to stay well this winter and highlight the range of services and support available. This will include:

A wide range of communication activities will be undertaken to provide advice and information to local people across North Staffordshire on how to stay well this winter and highlight the range of services and support available.

This will dovetail with arrangements being implemented at system level and between system partners' comms teams and will include:

- Adapting national campaign materials, building on local messaging
- Signposting on home page of websites across Staffordshire and Stoke-on-Trent
- Repeated on pages related to urgent and emergency care on local NHS websites
- Social media campaign (building on the toolkit issued to all members of the Staffordshire and Stoke-on-Trent ICS)
- Partnership media releases

Specifically, within Combined Healthcare, we will use the following Trust channels and tools:

- social media accounts - Facebook, LinkedIn, YouTube
- Trust website
- email newsletter to stakeholders and staff
- Newsround and Exec Exchange
- specific 'help us help you' video
- Combined Television (CTV) - onsite, online and on demand

Information Management and Performance Reporting

High quality management information is a core part of winter planning to ensure effective analysis, provide the ability to monitor winter capacity, identify and predict activity pressures and manage overall performance. Performance Management is also a critical component of the Winter Plan in order to ensure that efforts are targeted effectively and that the intended outcomes are achieved.

What we are doing

National Reporting	Monitor winter activity in order to demonstrate data collection and analysis is in line with national requirements.
Delayed Discharges	Continue to review and improve delayed discharge reporting to ensure that this supports daily decision-making including information on the reasons for the delay.
SHREWD	SHREWD is used on the system calls to ensure that all system partners have a real time and accurate joint understanding of the pressures facing individual system partners, and of the system overall.
OPEL	Daily submissions (including weekends) are submitted via the ICS System Control Centre to regional and national teams at NHSE.

Equality and Health Inequalities Impact Assessment (EHIA)

1. Main potential positive or adverse impact of the proposal for protected characteristic groups summarised

Please briefly summarise the main potential impact (positive or negative) on people with the nine protected characteristics (as listed below). Please state **N/A** if your proposal will not impact adversely or positively on the protected characteristic groups listed below. Please note that these groups may also experience health inequalities.

Protected characteristic groups	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Age: older people; middle years; early years; children and young people.	• Risk profiles vary with age. • Service provision in some areas is age specific (eg CAMHS, older adult psychiatry)	Reducing Adverse Impacts: Decisions are made on a case- by-case basis following clinician-patient discussion.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	Services are provided to meet the needs of the population	Reducing Adverse Impacts: Decisions are made on a case- by-case basis following clinician-patient discussion. Active management of length of stay to reduce the number of patients out of area. Increasing Positive Impacts: Service provision is established to meet the needs of individuals with mental health conditions and increase access.

Gender Reassignment and/or people who identify as Transgender	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated with gender reassignment and/or people who identify as transgender from the implementation of this plan.	
Marriage & Civil Partnership: people married or in a civil partnership.	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated with marital status from the implementation of this plan.	
Pregnancy and Maternity: women before and after childbirth and who are breastfeeding.	While data is unavailable with respect to this characteristic, we expect that there are no adverse impacts associated with pregnancy or maternity status arising from the implementation of this plan.	

Race and ethnicity²	For several reasons, some conditions are more common or serious within certain ethnic groups For example black men are statistically more likely to be detained under the Mental Health Act.	Reducing Adverse Impacts: Monitoring of demographic data within the Trust to identify trends and any services within the Trust where clinical practice may not be in line with expectation.
Religion and belief: people with different religions/faiths or beliefs, or none.	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated with religion and belief from the implementation of this plan	

Sex: men; women	Men are more likely to be detained under the provisions of the Mental Health Act than women. This means that they are more likely to be subject to an Out of Area bed if capacity is constrained.	Reducing Adverse Impacts: • The OOA SOP ensures that any OOA placements are managed effectively.
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated on people by sexual orientation from the implementation of this plan	

2. Main potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). Please state **N/A** if your proposal will not impact on patients who experience health inequalities.

Groups who face health inequalities ⁴	Summary explanation of the main potential positive or adverse impact of your proposal	Main recommendation from your proposal to reduce any key identified adverse impact or to increase the identified positive impact
Looked after children and young people	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated on looked after children and young people from the implementation of this plan.	
Carers of patients: unpaid, family members.	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact associated on carers of patients from the implementation of this plan.	
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on homeless people from the implementation of this plan.	Reducing Adverse Impacts: • Access to access to healthcare, for vulnerable groups, is a wider, recognised problem which various initiatives are attempting to address. This is a complex issue where individual circumstances may play a significant role, and the appropriate treatment may depend on information obtainable only in the clinician-patient interaction.

People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on people involved in the criminal justice system from the implementation of this plan.	
People with addictions and/or substance misuse issues	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on people with addictions and/or substance abuse issues from the implementation of this plan.	
People or families on a low income		
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	There is no routinely collected data by intervention on people with poor literacy or health literacy issues, so we cannot definitively assess if there will be any direct adverse or positive impacts on this population. While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on people with addictions and/or substance abuse issues from the implementation of this plan.	

People living in deprived areas	Maintaining access to appropriate services should have a positive impact on those impacted by deprivation	
People living in remote, rural and island locations	Maintaining access to appropriate services should have a positive impact on remote and rural services.	
Refugees, asylum seekers or those experiencing modern slavery	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on refugees, asylum seekers or those experiencing modern slavery from the implementation of this plan.	
Other groups experiencing health inequalities (please describe)	While data is unavailable with respect to this characteristic, we do not expect there to be any adverse impact on other groups experiencing health inequalities from the implementation of this plan.	

3. Engagement and consultation

a. Have any key engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	No	Do Not Know

b. If yes, please briefly list up the top 3 most important engagement or consultation activities undertaken, the main findings and when the engagement and consultative activities were undertaken.

4. What key sources of evidence have informed your impact assessment and are there key gaps in the evidence?

Evidence Type	Key sources of available evidence	Key gaps in evidence
Published evidence	• NHS England Winter Guidance • NHSE OPEL Framework • SHREWD • Peer-reviewed published clinical literature	• N/A.

Evidence Type	Key sources of available evidence	Key gaps in evidence
Consultation and involvement findings	Engagement with partners	N/A.
Research	Bespoke data analysis	N/A.
Participant or expert knowledge For example, expertise within the team or expertise drawn on external to your team	- IPC - ICS UEC Team - AEO/Deputy AEO - CCU	N/A.

5. Is your assessment that your proposal will support compliance with the Public Sector Equality Duty? Please add an x to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			X
The proposal may support?	x	x	
Uncertain whether the proposal will support?			

6. Is your assessment that your proposal will support reducing health inequalities faced by patients? Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?	X	X
The proposal may support?		
Uncertain if the proposal will support?		

7. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	N/A	
2	N/A	
3	N/A	

8. Summary assessment of this EHIA findings

In summary, the Winter Plan aims to ensure that our services operate effectively during the winter period by maintaining access to services at times of potential increased demand.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.



Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust





Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025**.

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Plan approved at Trust Board at the September meeting
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Considered as part of the plan development
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The Trust has also engaged with the wider SSOT system plan
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	COO/AEO attending the Midlands regional exercise – however this is planned for the 17/09/25
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	COO/AEO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Not applicable	These specific measurements are not relevant to NSCHT. Plans however do assure delivery of BAU activity across MHLDA services.

Provider:	North Staffordshire Combined Healthcare NHS Trust

Provider CEO name	Date	Provider Chair name	Date
Dr Buki Adeyemo	11.9.25	Janet Dawson	11.9.25

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Modelling forms a core part of the Trust Winter Plan. Demand modelling has been undertaken system wide as part of the MH Inpatient Transformation Workstream.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Not applicable	These specific measurements are not relevant to NSCHT. Plans however do assure delivery of BAU activity across MHLDA services.
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	

7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	The Trust has escalation plans which allow the outlying of patients on different wards, however the MHA provisions for detention do not allow flexibility to cohort/board patients in the same manner as acute providers.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Surge plans in place for all Crisis Care Centre services (MHLT, Crisis Line, CRHTT, HVU, NHS111 (voice and text)) In addition there is a mutual aid protocol in place with MPFT in relation to s136 capacity and acute beds.
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Coordination is undertaken by the High Volume Users team.

Enclosure No: 16

Audit Committee Assurance Report

Report provided for:				Report to:	Public Trust Board
Information	☐	Assurance	☒	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

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 25th July 2025. Updates were received relating to: Other items received were:

	• Counter Fraud Progress Report • Freedom of Information Q3/Q4 • Freedom to Speak Up • Internal Audit Progress Report • Counter Fraud Progress Report • External Audit Update • Quarterly Finance Report • Progress Report: Audit Recommendations

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	29.08.2025

**Trust Board Assurance Report.
Audit Committee Meeting
25th July 2025 via MS Teams.**

Introduction: This assurance report follows the latest extraordinary Audit Committee meeting held on the 25th July 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:

- Counter Fraud Progress Report - A new offence will come into effect on the 1st September 2025, making organisations criminally liable if an associated person commits fraud for their benefit—unless reasonable fraud prevention measures are in place. Examples to illustrate the nature of the offence, include false accounting: concealing losses to present a healthier financial position and fraud by false representation. MIAA will conduct a gap analysis for each organisation to assess the current control environment and the potential impact of the new requirements. In addition, a series of Webinars will be delivered for both Executive and Non-Executive Leaders.

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

Heading:

- Freedom of Information Q3/Q4 – A 10% increase was noted compared to the same period in the 2023/24 financial year. The total number of FOI requests received by the Trust in 2024/25 was 444, marking a 9% increase year-on-year. Q3: 98% of requests were responded to within the statutory 20 working days. Q4: 95% compliance. Delays were primarily due to interdepartmental response times and the complexity of certain requests. The FOI team is currently mapping the FOI request timeline to identify potential bottlenecks, particularly around inter-team handovers. They are piloting the use of NHSFOI Advisor on Copilot to enhance FOI handling through AI. The Trust participated in the Information Commissioner's Office (ICO) FOI Compliance Project, receiving positive feedback and best practice commendations.
- Freedom to Speak Up - There was an increase in Dear Buki submissions of 22 from the previous year, with 56 submitted anonymously. 86 Freedom to Speak Up cases were recorded—an increase of 15 year-on-year. Committee Chair questioned the value of presenting the report to the Finance and Resource Committee in the same format as to the People Committee. Suggestion this be raised at a broader point about when and how often Committee Chairs should be invited to attend other Committees. If Committee Chairs are only invited annually then a six-monthly attendance pattern might be a more effective approach.

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

Heading:

- Internal Audit Progress Report was presented to the Committee by MIAA.
- Counter Fraud Progress Report - the self-assessment against the National Counter Fraud, Bribery, and Corruption Standards has been submitted. The Trust received an overall green rating, including green across all 12 components.
- External Audit Update was presented to Committee by Grant Thornton

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

- Quarterly Finance Report. Bad Debt Write-Offs approval was requested for the formal write-off of 17 bad debts, totalling £1,995 which date back to 2023, the outstanding debts generally relate to small-value payments. The Committee discussed challenges experienced when dealing with Primary Care bank accounts, noting that the process was often complex and full of unexpected issues. As a result of these ongoing difficulties this matter will be added to the organisation's Risk Register.
- Progress Report: Audit Recommendations. Data Protection and Security Toolkit – as a result of the transition to the new CATH-aligned framework, the new standards do not directly align with earlier Audit actions. Four actions remain unresolved due to challenges in mapping them directly to the new framework. A new audit has recently been completed and is currently being finalised. In response, a comprehensive Action Plan is being developed.

Next Steps (including timeframes):

The next Audit Committee meeting will be held on 31st October 2025 via MS Teams.

Committee Chair: Prem Gabbi Chair of the Audit Committee. **REPORT END**

Enclosure No: 17

Board to Team Visits Annual Report 2024/25

Report provided for:				Report to:	Public Trust Board
Information	☒	Assurance	☐	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

Presented by:	Nicky Griffiths Deputy Director Governance
Prepared by:	Nicky Griffiths Deputy Director Governance
Executive Lead:	Dr Buki Adeyemo Chief Executive 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:	SLT
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:	Yes
Funding Source:	Several actions arising from Board to Team visits may require additional investment- including financial resource. Many items however are picked up through the Trust's ongoing commitment to quality improvement and continuous learning.
Diversity & Inclusion Implications	Actions identified through visits may support the development of and or support D&I related issues.
ICS Alignment / Implications:	The Trust's commitment to Board to Team visits is aligned to the Trusts vision and values and is aligned to the wider Strategy of the ICS.
Recommendation / Required Action	The report comes to Board for information.
Executive Summary	This report covers the Board to Team Programme between 1st April 2024 and 31st March 2025. During this timeframe 46 visits were undertaken into the Community Directorate (17), Specialist Directorate (9), Acute & Urgent Care (5), Corporate Directorate (12) and Primary Care (2). (Please see Table 1).

The Executive Team visited 58% of the Trust teams in this period.
There was a total of 78 actions, 62 of which were completed with 16 being carried over to the next cycle.
The average time to complete an action was 60.6 days.

The top 3 themes from the year were

- **Environment / Estates** with 13 actions identified,
- **Digital & Equipment** with 12 actions identified
- **Operations / Service Change** with 10 actions identified.

Table 1.

Total Actions: (open & complete)	
Agile Working	3
Business Opportunities	3
Capacity / Staffing	8
Clinical	7
Communication	6
Covid	0
Digital & Equipment	12
Digital Prescribing	0
Environment / Estates	13
Financial	0
Health & Wellbeing	0
HR & Recruitment	6
Leadership	3
OD & training	3
Operations / Service Change	10
Other	3
Service Users & Carers	1
Total Actions 2024/25:	78

Challenges.

- Previously the absence of a tracker has not allowed for the Trust to robustly monitor actions arising from Board to Team visits.
- Actions logs had been seen in several Trust meetings which has been confusing and didn't allow for teams to have clarity on where actions would be progressed and monitored.
- Co-ordination of diaries/availability across the Executive, Non-executive and Teams.

Achievements.

During the year the Governance Team has worked on developing several areas within the Board to Team process.

- A Board to Team SOP has been established to define and describe the process and expectation of individuals and teams. This was done in conjunction with the Trust's Quality Improvement Team so visits are 'quality led'.
- A new pre-visit questionnaire has been introduced to encourage teams to think about things they would like to highlight and to encourage teams to showcase any Quality Improvement work they have been undertaking.
- An updated feedback form for Execs to complete has been introduced to ensure that actions are clearly identified and allows for a theme to be allocated to allow for the analysis and tracking of common areas from across the Trust.
- Regular updates to the action tracker now allow for data to be extracted from the actions and to provide timely reports to the Directorates directly and through the Trust's Executive Performance Meetings (Clinical and Corporate).

Next steps

- Establish a 6–12-month cycle to try to better plan for and enable more visits throughout the year.
- To embed Board to Team into the Corporate and Clinical Performance Meetings.
- Improve feedback to teams following their visit.
- Develop survey for team to complete about the Board to Team process.
- Quality Assurance Heatmaps now included in Pre -Visit Information pack.
- Board to Team Annual Report included in the new Cycles of Business 2025/26 to allow for timely end of year reporting.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	26 th August 2025
V1	PCDC	1 st September 2025
V1	Public Trust Board	11 th September 2025

Enclosure No: 18

Designated Body Annual Board Report and Statement of Compliance (Annual Organisation Audit for Medical Appraisal and Revalidation) 2023-24

Report provided for:				Report to:	Public Trust Board
Information	☒	Assurance	☐	Date of Meeting:	11 th September 2025
Discussion	☐	Approval	☐		

Presented by:	Dr Dennis Okolo, Chief Medical Officer
Prepared by:	Robert Walley, Medical Staffing Lead
Executive Lead:	Dr Dennis Okolo, Chief Medical 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:	Execs
Strategic Priorities:	Prevention - To will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
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	No implications
ICS Alignment / Implications:	Demonstrate where we are aligning our Strategy to the ICS
Recommendation / Required Action	The board members are asked to: 1) Note the compliance rates of medical appraisal and revalidation 2) Be assured that the Trust policies and procedures continue to support appraisers and appraisees to undertake meaningful, timely appraisal and revalidations 3) Note there are no required actions to be taken forward

Executive Summary

This report offers assurance that the Trust are fully compliant with the regulations and commitment to continual quality improvement in the delivery of professional standards.

In 2023/24, the Trust achieved an appraisal compliance rate of 30 out of 34 for Consultants, Staff Grades and Specialty Doctors, with a prescribed GMC connection to our Trust. The remaining 4 appraisals were unable to be completed during the appraisal period due to long term absence.

All medical staff remained revalidated, with 5 out of 5 Doctors being revalidated with a positive recommendation to the GMC.

The SARD Appraisal and Revalidation software continues to help facilitate an effective process for appraisers and appraisees. A concerted effort from the CMO, Clinical Directors, Appraisers, as well as improved engagement from appraisees, has helped to achieve the high rates.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	26.08.25
2	Public Trust Board	01.09.25

Annex A

Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

The Annual Organisational Audit offers reassurance that the Trust is managing the Revalidation of its medical staff effectively. In 2023/24, as summarised in this report, all required medical revalidation recommendations were positive, and on time.

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board of: North Staffordshire Combined Healthcare NHS Trust

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes

Action from last year:	n/a
Comments:	Dr Dennis Okolo is the Substantive Chief Medical Officer and Responsible Officer for the Trust.
Action for next year:	n/a

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	n/a
Comments:	n/a
Action for next year:	n/a

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	n/a
Comments:	Licenses are monitored on a daily basis via GMC Connect and SARD
Action for next year:	n/a

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes

Action from last year:	n/a
Comments:	Medical Appraisal Policy in place and reviewed regularly.
Action for next year	n/a

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	n/a
Comments:	JLNC updates and approves the Medical Appraisal Policy
Action for next year:	n/a

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	n/a
Comments:	Medical agencies continue to ensure registration is up to date. Only Framework compliant agencies are used.
Action for next year	n/a

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	n/a
Comments:	Processes are in place to ensure the above.
Action for next year:	n/a

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	n/a
Action from last year:	n/a
Comments:	n/a
Action for next year:	n/a

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes

Action from last year:	n/a
Comments:	The Medical Appraisal policy is ratified by board and JLNC.
Action for next year:	n/a

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	n/a
Comments:	The Trust has sufficient appraisers, and continues to support other Consultants to become new appraisers.
Action for next year:	n/a

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	n/a
Action from last year:	n/a

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	n/a
Action for next year:	n/a

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	n/a
Comments:	Annual internal quality assurance processes take place and are included in annual updates to the board
Action for next year:	n/a

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	n/a
Comments:	Recommendations have been processed in accordance with GMC requirements
Action for next year:	n/a

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the

doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	n/a
Comments:	Recommendations have been processed in accordance with GMC requirements
Action for next year:	n/a

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	n/a
Comments:	Doctors have a direct link to the Clinical Directors with processes in place to escalate should an issue be identified that requires it
Action for next year:	n/a

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes

Action from last year:	n/a
Comments:	The governance process runs through the Directorate with monthly performance reviews to identify any conduct or performance issues
Action for next year:	n/a

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	n/a
Comments:	Relevant links and templates are provided within the SARD Appraisal and Revalidation system, for appraisers and appraisees.
Action for next year:	n/a

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	n/a
Comments:	Yes, through the Remediation Policy.

Action for next year:	n/a

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	n/a
Comments:	Yes, via the Remediation Policy, and workforce metrics.
Action for next year:	n/a

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	n/a
Comments:	Yes, via the Alert Notices
Action for next year:	n/a

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	n/a
Comments:	Yes, through the Remediation Policy
Action for next year:	n/a

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	n/a
Comments:	Yes, Trust representatives attend external updates regularly. Regular independent audits also take place to ensure policies and procedures are up to date.
Action for next year:	n/a

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	n/a
Comments:	n/a
Action for next year:	n/a

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	n/a
Comments:	NHS standard ID checks take place for all staff. Locum doctors are booked via TWS III Framework, ensuring NHS standard ID checks are undertaken.
Action for next year:	n/a

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes

Action from last year:	n/a
Comments:	There is a well-established CPD and reflective Away days for doctors within the organisation where excellence is promoted and discussed.
Action for next year:	n/a

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	n/a
Comments:	This is re-enforced through the Trust values, and policies
Action for next year:	n/a

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	n/a

Comments:	The Trust supports and encourages openness from employees through various programmes, including Freedom to Speak Up, and Lessons Learned
Action for next year:	n/a

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	n/a
Comments:	Yes, via the Remediation Policy
Action for next year:	n/a

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	n/a
Comments:	This is assessed when required.
Action for next year:	n/a

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	n/a
Comments:	The RO regularly attends network events and engagement with other ROs
Action for next year:	n/a

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	38
Total number of appraisals completed	34
Total number of appraisals approved missed	4
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	5
Total number of late recommendations	0
Total number of positive recommendations	5
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	
Total number of trained case managers	
Total number of concerns received by the Responsible Officer ²	0
Total number of concerns processes completed	n/a
Longest duration of concerns process of those open on 31 March (working days)	n/a
Median duration of concerns processes closed (working days) ³	n/a
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	n/a
Total number of new doctors joining the organisation	2
Total number of new employment checks completed before commencement of employment	2
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
No actions
Actions still outstanding
No actions
Current issues
No issues currently. The appraisal process is working well via SARD, for both appraisers and appraisees.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
None identified.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The number of appraisals completed in a timely manner, within the reporting period, has improved. The only incomplete/missed appraisals are due to long term absence.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of the designated body:	North Staffordshire Combined Healthcare NHS Trust

Name:	Dr Olubukola Adeyemo
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Robert Walley, Medical Staffing Lead
Email address:	Robert.walley@combined.nhs.uk