NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 13TH NOVEMBER 2025, 10.00AM, BOARDROOM, LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P146/25	Welcome and Apologies for Absence	Janet Dawson	**Note**	
2	1002	P147/25	Declarations of Interests – and changes to be notified	Janet Dawson	**Note**	
3	1003	P148/25	Minutes of the Previous Meeting held on 11th September 2025	Janet Dawson	**Note**	**Enc. 1**
4	1005	P149/25	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	**Note**	**Enc. 2**
ADVISE						
5	1007	P150/25	Patient Story – **Keiths Story – Ward 7**	Kenny Laing	**Advise**	**Verbal**
6	1015	P151/25	REACH Recognition Team Award – **Specialist Service – Complex Care Mental Health (Project 86)**	Dr Buki Adeyemo	**Advise**	**Verbal**
7	1020	P152/25	Chief Executives Report	Dr Buki Adeyemo	**Advise**	**Enc. 3 – To Follow**
8	1030	P153/25	Chairs Report	Janet Dawson	**Advise**	**Enc. 4**
9	1035	P154/25	Questions from Members of the Public	Janet Dawson	**Advise**	**Verbal**
ALERT						
10-minute Break						

APPROVE						
10	1050	P155/25	Board Assurance Framework (BAF) Quarter 2	Nicola Griffiths	**Approval**	**Enc. 5**
11	1055	P156/25	Board and Committee Dates 2026/27	Nicola Griffiths	**Approval**	**Enc. 6**
12	1100	P157/25	Policy Report	Nicola Griffiths	**Approval**	**Enc. 7**
ASSURE						
13	1105	P158/25	Research and Development Annual Report	Dr Dennis Okolo	**Assurance**	**Enc. 8**
14	1110	P159/25	Improving Quality and Performance Report (IQPR) Month 6	Eric Gardiner	**Assurance**	**Enc. 9**
15	1115	P160/25	Finance Report Month 6	Eric Gardiner	**Assurance**	**Enc. 10**
16	1120	P161/25	Finance and Resource Committee Assurance Reports from the meetings held on the 2nd October 2025 and the 6th November 2025	Russell Andrews	**Assurance**	**Enc. 11a and 11b**
17	1130	P162/25	Quality Committee Assurance Reports from the meetings held on 2nd October and the 6th November 2025	Pauline Walsh	**Assurance**	**Enc. 12a and 12b**
18	1140	P163/25	People, Culture and Development Committee Assurance Report from the Focus Meeting held on 29th September 2025 and the Business Meeting held on 10th November 2025	Martin Evans	**Information**	**Enc. 13a and 13b – To Follow**

19	1150	P164/25	Audit Committee Assurance Report from the meeting held on 31st October 2025	Prem Gabbi	**Assurance**	**Enc. 14**
CONSENT ITEMS						
20	1155	P165/25	Provider Capability Annual Self-Assessment	Nicola Griffiths	**Information**	**Enc. 15**
21	1155	P166/25	Any Other Business	Janet Dawson	**Note**	**Verbal**
22	1158	P167/25	Meeting Self-Assessment	Janet Dawson	**Note**	**Verbal**
23	1200	P168/25	Trust Board Attendance Report	Janet Dawson	**Information**	**Enc. 16**

Date and Time of Next Meeting
15th January 2026 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 11th September 2025
At 10:00am in the Boardroom, Lawton House and via MS Teams

Present		
Janet Dawson	JD	Chair
Russell Andrews	RA	Vice Chair / Non-Executive Director
Dr Buki Adeyemo	BA	Chief Executive Officer
Eric Gardiner	EG	Chief Finance Officer / Deputy Chief Executive
Kenny Laing	KL	Chief Nursing Officer / Deputy Chief Executive
Dr Dennis Okolo	DO	Chief Medical Officer
Frieza Mahmood (from 10.30am)	FM	Chief People Officer
Pauline Walsh	PW	Non-Executive Director / Senior Independent Advisor (SID)
Jennie Koo	JK	Non-Executive Director
Martin Evans	ME	Non-Executive Director
Prem Gabbi	PG	Non-Executive Director
Katie Laverty	KLa	Associate Non-Executive Director
Rachael Birks	RB	Deputy Chief Operating Officer
Laura Smith	LS	Deputy Chief Strategy 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
Tracey Cooper	TC	Executive Assistant (Minutes)
Public Attendance		
Mark Axcell	MA	Staffordshire and Stoke-on-Trent Integrated Care System Provider Collaborative Interim Managing Director
REACH Individual Award – Primary Care		
Rachel Hughes, Senior Directorate Business Administrator		

Meeting commenced at 10.00am

121/25	**APOLOGIES FOR ABSENCE** Elizabeth Mellor, Chief Strategy Officer Dr Roger Banks, Associate Non-Executive Director Nicola Bullen, NExT Director Programme Ben Richards, Chief Operating Officer Sherrine Khan, Senior Peer Support Worker	
122/25	**DECLARATIONS OF INTEREST RELATING TO AGENDA** There were no declarations of interest. ***Noted***	

123/25	**MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 10TH JULY 2025** Minutes were approved as a true and accurate record ***Approved/Received***	
124/25	**ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 10TH JULY 2025** **96/25 – Patient Story - Kenny Laing talked about All Age Access and challenges highlighted in the patient story advising that the Trust had practitioners with knowledge across all age ranges but acknowledged that 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. Kenny Laing to arrange.** *11.09.25 – 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.* **104/25 – Mortality Surveillance Annual Report 2024/25 and Quarter 4 Report 2024/25. 25(1) Correct the date and spelling errors in the Mortality Surveillance Report and ensure it reflects the current year.** *11.09.25 – Actioned.* **(2) Consider implementing an external review process for the Mortality Surveillance Report to ensure objectivity and accuracy.** *11.09.25 - This has been considered and discussed at Quality Committee (QC), a review of the presentation of the Mortality Surveillance process with additional information of staff involved will be included to contextualise reports and objectivity - to go to Quality Committee.* **(3) Clarify the purpose and requirements of the Mortality Surveillance Report, including its mandated aspects and the objectives it aims to achieve.** *11.09.25 - The Mortality Surveillance Report which reviews all mortality within NHS organisations is a national requirement. The report is based on national guidance; – The Royal College toolkit' and these reviews serve as opportunities for learning and improvement of care within the Trust.* **(4) Review the process of report writing to ensure that all reports acknowledge and refer to the relevant BAF risks, providing context and assurance.** *11.09.25 - 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.* **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.***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.* ***Received***	

125/25	**PATIENT STORY** On this occasion the patient story was heard in private at the Service User's request. **Noted**	
126/25	**REACH RECOGNITION INDIVIDUAL AWARD – Primary Care - Rachel Hughes, Senior Directorate Business Administrator** Dr Buki Adeyemo, Chief Executive Officer introduced the award. Dr Buki Adeyemo advised that Rachel provided senior administrative support to the Directorate leadership team and across several services, including General Practices, Talking Therapies, Mental Health Additional Roles Reimbursement Scheme (ARRS) and the Severe Mental Illness (SMI) Physical Heath Check team. Rachel was described as a hardworking and dedicated member of the Directorate team demonstrating dedication and passion for service delivery, with a positive and cheerful attitude. Dr Buki Adeyemo advised that Rachel's compassion could be clearly demonstrated as a core value in everything that Rachel did. Service users and team members are all recognised and considered in every part of Rachel's work. This is particularly demonstrated for new members of staff who often have limited experience within general practice settings. Rachel will check in on individuals, offer mentorship and peer support and guidance whilst they settle in. The Board congratulated Rachel on her award. ***Received***	
127/25	**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 highlighted the CQC 'Good' rating for the Crisis Care Centre and praised collaborative work with the Local Authority and Integrated Care Board (ICB) on early years behavioural stress, led by Elizabeth Mellor. Prem Gabbi queried funding for the Green Plan; Eric Gardiner noted there was no confirmed funding, though capital bids were invited. Laura Smith added that NHS Green Community applications were ongoing. Martin Evans welcomed the innovation updates, particularly the 360 Walk Through's and the Peace Pod at the Darwin Centre and asked how impact was being captured. Dr Buki Adeyemo confirmed data was being collected for potential publication. Joe McCrea shared examples of virtual walkthroughs, including a service user film for Project Chrysalis and Ward 4. Pauline Walsh asked about the epilepsy model; Dr Buki Adeyemo shared early evaluation insights from a Child and Adolescent Mental Health Service (CAMHS) team visit. Nicola Griffiths outlined the Provider Capability Assessment under the new NHS Oversight Framework. A self-assessment plan is in development and	

	will be brought to the Board in October. The Chair noted the scale of the work and the Trust's alignment with the process. ***Received***	
128/25	**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. No further update. ***Received***	
129/25	**CHAIRS REPORT** Janet Dawson, Chair presented the report. The Chair congratulated the Trust on being ranked number one in the NHS England National Mental Health and Community Provider Hospital Trust's League Table, with System partner MPUFT ranked second. While it is positive to be at the top, the Chair emphasised the importance of recognising the strong performance across Staffordshire. The Chair reflected on a visit to the Talking Therapies Team in Stoke in July, where she received a warm welcome and an informative update on the range of services offered. The team's person-centred approach and accessible pathways were commended. A photo of the team will feature in the upcoming Board report. The Chair encouraged colleagues to connect with the team, noting their enthusiasm and openness in sharing their work. On diversity and inclusion, the Chair reaffirmed that the organisation welcomed all individuals equally, regardless of background or place of birth. Assurance was given that the organisation did not align with exclusionary attitudes and remained committed to inclusivity. Jenny Harvey welcomed this stance, highlighting the NHS's vital role in civil society. She emphasised the importance of maintaining an anti-racist approach, recognising that societal attitudes could impact both staff wellbeing and patient mental health. She called for continued vigilance in promoting inclusive values within the workplace. ***Noted***	
P130/25	**BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 1** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the framework. It was noted that the Trust had six BAF risks, the paper outlined progress through Committees. The BAF continues to evolve with constructive discussion and challenge. A Board Development session, led by Internal Audit, explored overarching and individual risk appetite statements, which will inform Quarter 2 reporting. Dr Buki Adeyemo noted a typo in BAF Risk 1; Nicola Griffiths confirmed this would be corrected. Russell noted that some risks may increase considering risk appetite, reflecting a shift in thinking.	**NG**

	Kenny Laing raised the absence of a prevention focused BAF risk. Nicola Griffiths confirmed this was being considered, with further work planned and Board Development sessions scheduled for October and November. Nicola Griffiths welcomed this suggestion and proposed exploring how BAF Risk 1 could be developed within that context and committed to reviewing it further. ***Received***	**NG**
131/25	**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***	
132/25	**HEALTH AND SAFETY ANNUAL REPORT 2024/25** Kenny Laing, Chief Nursing Officer / Deputy Chief Executive presented the report and highlighted the following: Safety incident reporting remains low, with 18 incidents recorded to date, mainly involving slips, trips, falls, and sharps. The Health and Safety Group has requested further assurance work, including walkarounds and staff engagement, though no evidence of underreporting has been found. Additional training for line managers is underway and executive colleagues have completed health and safety training. Physical assaults remain the highest risk, though a reduction has been seen over the past three years following focused work. Improvements in hate crime recording now allow for deeper analysis. Frieza Mahmood welcomed the report and noted the decline in incidents, highlighting Ward 5 as an area for further review and suggesting better restraint and manual handling practices. Clarification was also sought on how psychological harm is assessed in incident reports, with potential links to sickness absence data for future discussion. The Board discussed staff safety, incident reporting and wellbeing. KL confirmed that corporate support is deployed where increased harm is identified and both physical and psychological harm are considered in governance processes. PW commended the proactive approach to validating incident data. ME and People Culture & Development Committee (PCDC) are exploring further staff support in high-risk areas, linking incident data to sickness absence. Benchmarking with other Trusts was encouraged to assess reporting levels and KL confirmed comparative data is available. PG raised the importance of psychological safety in reporting and triangulating harm data, which KL confirmed is being collected. PG also flagged a potential date error and the need to capture near-miss incidents more effectively. JH shared staff concerns about normalised violence and long-term psychological harm, welcoming trauma-informed support initiatives. FM highlighted the development of an integrated workforce report to support assurance and targeted interventions. The Chair welcomed the discussion	

	and emphasised the importance of near miss reporting as a sign of a healthy safety culture. ***Received***	
133/25	**QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 7TH AUGUST AND 4TH SEPTEMBER 2025** Pauline Walsh, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: **7th August 2025** Both reports related to BAF Risk 2, including a Deep Dive from the Acute and Urgent Care Directorate on out-of-area placements. Current challenges and actions to reduce future need were outlined and welcomed. Clarification was provided on reporting figures, noting monthly data reflects a single day snapshot. No action was required regarding industrial action. Verbal CQC feedback confirmed a 'Good' rating for the Crisis Care Centre. The Board approved the Risk Register, Board Assurance Framework, and associated policies. **4th September 2025** The Quality Committee discussed system pressures linked to discharge delays for clinically ready patients, contributing to out-of-area bed use. One ward had temporarily closed due to a COVID-19 outbreak but has since reopened. A patient story and quality improvement update were shared. The Board was assured by standard reports, including mortality surveillance, and approved the Winter Plan and Risk Register changes. ME raised concerns about discharge delays, with KL leading work to coordinate efforts across services and partners. RB noted collaboration with Stoke Local Authority as part of winter surge planning, highlighting the complexity of patient flow and the need for tailored approaches in mental health. KL emphasised the quality risks of delayed discharge and the importance of system-wide enablers. The Chair acknowledged the challenges and confirmed the issue remains significant across the NHS. ***Received***	
134/25	**IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 4** Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the IQPR Month 4 report. Eric Gardiner presented the report, highlighting improvements in crisis care data recording and ongoing concerns around sickness absence, which continued to impact overall performance ratings. Appraisal and supervision remained below target, with system limitations affecting reporting accuracy. Complaints were largely resolved, with only one complex case outstanding. Out-of-area placements were reduced to eight, with further improvement expected. System issues were discussed, with a transition to a new platform underway to address current data and process challenges. A detailed review of sickness absence has been commissioned, with a management plan to be presented to the Performance Meeting.	

	Concerns were raised about appraisal reporting and its impact on CQC ratings and frustrations were expressed over shifting Performance Improvement Plans (PIP) deadlines. Eric Gardiner acknowledged staffing constraints as a key barrier to meeting targets. Rachael Birks added that workforce pressures continued to disrupt progress, with temporary improvements often followed by setbacks. Dr Buki Adeyemo highlighted national recognition of the Trust's progress despite pressures and referenced a 900% increase in Children's and Young Persons Services (CYP) demand since 2019. She confirmed Ben Richards would attend the Stoke Health and Wellbeing Board to represent these issues. The Chair supported maintaining visibility on unmet targets and questioned the relevance of some benchmarks in the current climate. Frieza Mahmood raised concerns about the evidence base behind some PIPs and stressed the need for realistic, justified plans. Prem Gabbi emphasised the moral responsibility to support those waiting for services and called for clearer assurance. Jenny Harvey shared staff concerns about normalised violence and long-term psychological harm, welcoming trauma-informed support. The Chair concluded by reaffirming the importance of maintaining focus on these issues. ***Received***	
135/25	**PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 1ST SEPTEMBER 2025** Russell Andrews, Non-Executive Director presented the report highlighting the following: Russell Andrews reminded the Committee of the BAF risk concerning recruitment, retention, and workforce diversity, noting its relevance throughout the meeting. He highlighted the staff story of Beth Griffiths as an example of Trust values and suggested wider sharing. Key topics included ongoing concerns around sickness and wellbeing, high levels of complex employee relations activity, appraisal and workforce planning and inclusive recruitment. Minor amendments to risk scores and titles were approved. Joe McCrea confirmed Beth's story was publicly available via the Trust's YouTube channel. The Chair requested clearer data context in future reports to avoid misleading percentage figures. Frieza Mahmood explained rising casework was due to longer resolution times and outlined process improvements underway. Kenny Laing raised risks linked to national nursing job profile reviews, with potential pay discrepancies. The Chair sought assurance on equal pay compliance and Frieza Mahmood confirmed this was now a national priority. ***Received***	
136/25	**WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORTS** Frieza Mahmood, Chief People Officer presented the reports. The Board received the reports, which had been reviewed through governance. Frieza Mahmood highlighted progress on racial inclusion,	

	recruitment fairness, disciplinary equity, and disability representation. Challenges remain around perceptions of harassment and discrimination, with targeted actions underway. Board members welcomed the reports and raised areas for further focus, including nursing career progression, diversity data interpretation and staff engagement. A development session will be held to strengthen leadership accountability and tailor improvement plans. The Chair praised the organisation's commitment to diversity and high performance, noting the importance of embedding these values across all levels. ***Received***	
137/25	**FINANCE REPORT MONTH 4** Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the report. Eric Gardiner provided an update on the Month 4 financial position, reporting a monthly surplus of £281K and a year-to-date surplus of £34K, placing the Trust slightly ahead of plan. Bank and agency usage had reduced but remained above target. Cost Improvement Programme (CIP) had plateaued, though recent engagement with directorates was expected to improve delivery. Capital funding remained uncertain, with support from the Integrated Care Provider (ICP) and a final bid of £1.6M for Project Crystal was pending Health and Safety Executive (HSE) approval. The Trust's estate was reported to be in good condition, supported by ongoing investment. Frieza Mahmood raised concerns about staffing morale and potential winter pressures, particularly in treatment centres. Eric Gardiner noted that acuity levels were consistently high year-round and staffing was currently above establishment, managed at risk to maintain service levels. The Chair and Kenny Laing supported the use of Bank workforce as a flexible, cost-effective staffing model. Frieza Mahmood highlighted rising demand, including a 77% increase in crisis care and suggested reviewing activity assumptions. Kenny Laing confirmed staffing levels were regularly reviewed and aligned with current demand, ensuring safe and efficient workforce planning. ***Received***	
138/25	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 7TH AUGUST AND 4TH SEPTEMBER 2025** Russell Andrews, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: **7th August 2025** No update provided. **4th September 2025** Russell Andrews provided an overview of key items from the meeting highlighting improvements in Children and Young Person's (CYP) 18-week referrals and ongoing monitoring of discharge trajectories. Financially, the Trust remained in a strong position with a small year-end surplus expected.	

	Cost Improvement Programme (CIP) progress was slowed slightly but remained robust, with improved reporting distinguishing between general and transformational schemes. System finance showed a net risk of nearly £60m. Updates were provided on Project Chrysalis and PFI contract management, with PFI remaining a regular Board item. Russell Andrews confirmed the Trust would bid for all lots in the Connect to Work tender, supported by dedicated working groups. A deep dive on financial metrics was held following the Committee Effectiveness Review and was praised for its clarity. ***Received***	
139/25	**CHARITABLE FUNDS COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 1ST SEPTEMBER 2025** Russell Andrews, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Russell Andrews updated the Committee on the charity's financial position, noting it remained strong, supported by a legacy donation linked to Harplands Hospital. He proposed exploring a staff lottery to create a regular income stream and move the charity toward financial sustainability. The proposal will be raised at the next Private Board meeting to gauge Trustee views, considering sensitivities around gambling. Fundraising activities were noted, including a 28-mile sponsored walk and a charity golf day. Progress was reported on the Harplands grant, with three items approved to move forward. Frieza Mahmood queried community involvement in events; Russell Andrews confirmed engagement was planned once staff support was established. ***Received***	**RA**
140/25	**WINTER PLAN 2025 AND BOARD ASSURANCE STATEMENT (BAS)** Rachael Birks, Deputy Chief Operating Officer presented the report. The Board was asked to approve the Winter Plan and assurance submission to NHS England (NHSE). It was noted that the Trust had participated in a system-wide winter planning exercise, with further learning to be incorporated following regional engagement. No updates were required regarding industrial action. Prem Gabbi queried differences from last year's plan; Rachael Birks confirmed improvements in sickness and wellbeing management, mutual aid, and workforce data tools. Martin Evans raised the need for stronger focus on community-based care; Rachal Birks confirmed this was in place through liaison and community teams. The Board discussed flu vaccination targets, with assurance provided on promotion efforts. Pauline Walsh confirmed equality impacts for learning disability and autism had been considered in planning. The Winter Plan and assurance submission were approved. ***Approved / Received***	

P141/25	**AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 25TH JULY 2025** Prem Gabbi, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Counter Fraud Progress Report - A new offence was introduced last week. The Internal Audit Team will carry out a gap analysis and deliver webinars to support understanding and compliance. An increase in FoI requests was noted during Quarter 3 and Quarter 4. Dr Buki Adeyemo was informed that delays were occurring due to requests being passed between teams. A review of the process will be undertaken to prevent future issues. Updates were received from internal audit, external audit and counter fraud teams. There were no matters to report to the Board, and all areas were progressing well. The write-off of small-value bad debts was approved. Primary Care Bank Accounts were discussed, Eric Gardiner confirmed that work had commenced. Whist there was no current risk, it was noted that consolidating the funds into a single account would be preferable. The deadline for the Data Protection and Security toolkit had been extended due to changes in the Cyber Assessment Framework. The toolkit will be rewritten to reflect the new guidelines. Eric Gardiner reported that debts were being actively pursued with Local Authorities. ***Received***	
142/25	**BOARD TO TEAM ANNUAL REPORT 2024/25** Circulated for information	
143/25	**MEDICAL REVALIDATION ANNUAL ORGANISATIONAL AUDIT (AOA)** Circulated for information	
144/25	**ANY OTHER BUSINESS** There were no items of other business. ***Noted***	
145/25	**MEETING SELF ASSESSMENT** Members found the meeting good, with a lot going on. The Chair thanked all for their attendance.	
	DATE AND TIME OF NEXT MEETING Thursday 13th September 2025 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12:30pm

Signed: _____ Date_____
Chair

Board Action Monitoring Schedule

Trust Board - Action monitoring schedule - (Public)

No.	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
1	11th September 2025	130/25	BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 1 (1) Dr Buki Adeyemo noted a typo in BAF Risk 1; Nicola Griffiths confirmed this would be corrected.	Nicola Griffiths	13th November 2025	Completed
			(2) Kenny Laing raised the absence of a prevention focused BAF risk. Nicola Griffiths confirmed this was being considered, with further work planned and Board Development sessions scheduled for October and November. Nicola Griffiths welcomed this suggestion and proposed exploring how BAF Risk 1 could be developed within that context and committed to reviewing it further.	Nicola Griffiths	13th November 2025	BAF Risk 1 now under the Strategic Priority of Prevention
2	11th September 2025	139/25	CHARITABLE FUNDS COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 1ST SEPTEMBER 2025 (1) Russell Andrews proposed exploring a staff lottery to create a regular income stream and move the charity toward financial sustainability. The proposal will be raised at the next Private Board meeting to gauge trustee views, considering sensitivities around gambling.	Russell Andrews	9th October 2025	Agreed to remove from Trust Board in October and discuss at Charity Committee in January 2026.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 3

CEO BOARD REPORT – NOVEMBER 2025

Report provided for:			
Approve	☐	Alert	☐
Assure	☐	Advise	☒

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

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

Aligned to Board Assurance Framework Risk:	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.
7 Levels of Assurance:	Level 7 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Approval / Review:	Execs
Strategic Priorities:	Prevention - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	Includes developments at a system level
Recommendation / Required Action:	For information
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: • Resident doctors in England set to strike in November • Rise in racist abuse reported by ethnic minority nursing staff • NHS England publishes resource to reduce restrictive practices in mental health services • Emergency Planning Exercise - Pegasus • New Chief Executive Officer appointed to ICB Cluster between Staffordshire and Stoke-on-Trent, and Shropshire, Telford and Wrekin Integrated Care Boards • New text services offer 24/7 mental health support via text message across Staffordshire and Stoke-on-Trent • North Staffordshire Combined Healthcare NHS Trust rated the number one non-acute Trust in England • Combined Healthcare publishes its Annual Report and Accounts 2024/25 • Annual General Meeting 2025 • Combined colleagues mark autumn events and awareness days • Celebrating Black History Month • Trust sees results from new recycling programme

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	07.11.25

Chief Executive's Report to the Trust Board
November 2025

1.0 PURPOSE OF THE REPORT

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

2.0 NATIONAL CONTEXT AND UPDATES

Resident doctors in England set to strike in November

The British Medical Association (BMA) resident doctors committee England has announced doctors will stage full walk-out action from 7am on 14 November 2025.

The announcement comes after resident doctors' leaders met health secretary Wes Streeting on 13 October, to discuss a plan for jobs and pay restoration.

The Trust has stood up its Incident Management processes as per its Emergency Planning, Resilience and Response (EPRR) policy. Directorates are managing the impact 'in hours' with support from other staff groups and 'out of hours' cover has been centrally sourced.

At the time of writing all out of hours shifts have been covered with appropriate medical cover in place. The only expected activity impact within the Trust is in relation to outpatient clinics provided directly by resident doctors, where impacted patients will be clinically prioritised as required.

Rise in racist abuse reported by ethnic minority nursing staff

Analysis from The Royal College of Nursing (RCN) shows the number of reports by nurses of racist incidents at work has risen by 55% in the last three years.

These reports include experiences of incidents with both colleagues, and patients and their relatives.

NHS England publishes resource to reduce restrictive practices in mental health services

The resource is designed to help mental health inpatient services identify and reduce eight types of restrictive practices that can cause harm to patients. The resource defines restrictive practices as interventions limiting movement, liberty or independence, including physical restraint, surveillance, blanket restrictions, and cultural restraint.

Using this resource, providers of NHS commissioned services are asked to report restrictive practices more comprehensively in line with the requirements set out in the Use of Force Act, 2018, and ensure staff feel supported and trained to recognise and report appropriately.

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

Emergency Planning Exercise - Pegasus

The Trust has participated in all three parts of Exercise Pegasus, a Tier 1 emergency planning exercise (defined as a national-level exercise involving ministerial participation and Cabinet Office Briefing Rooms [COBR] activation) throughout September and November 2025.

Its key purpose was to simulate a realistic pandemic scenario and is the first of its kind in nearly a decade. Operational, Emergency Planning and Infection Prevention and Control teams took part alongside multiagency partners from within Staffordshire and Stoke on Trent and national teams from UKHSA, Cabinet Office and others.

New Chief Executive Officer appointed to ICB Cluster between Staffordshire and Stoke-on-Trent, and Shropshire, Telford and Wrekin Integrated Care Boards

Simon Whitehouse has been confirmed as the Chief Executive Officer of the Integrated Care Board (ICB) Cluster for NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin.

Simon currently serves as Chief Executive Officer for NHS Shropshire, Telford and Wrekin, and has over 30 years of experience in the NHS, including expertise in clinical practice, as a physiotherapist, and senior leadership roles.

Under the new ICB cluster, both ICBs will remain separate statutory organisations initially, but will increasingly operate with a single management team.

New text services offer 24/7 mental health support via text message across Staffordshire and Stoke-on-Trent

Free text messaging services are now offering 24/7 mental health support for all adults and young people across Staffordshire and Stoke-on-Trent.

The text services are delivered by North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Midlands Partnership University NHS Foundation Trust (MPFT), commissioned by Staffordshire and Stoke-on-Trent Integrated Care Board (ICB).

North Staffordshire Combined Healthcare NHS Trust's service covers the North Staffordshire and Stoke-on-Trent area. The service is tailored to mental health support, ensuring that the support provided is appropriate, understanding, and compassionate.

4.0 OUR TRUST

4.1

North Staffordshire Combined Healthcare NHS Trust rated the number one non-acute Trust in England

North Staffordshire Combined Healthcare NHS Trust has been ranked the number one 'Non-Acute' NHS Trust in England by NHS England and the Department of Health.

The ranking was published in September as part of the new NHS National Oversight Framework (NOF), which assesses NHS trusts across England against a range of agreed metrics. The Framework is designed to drive improvement, highlight excellence, and ensure greater transparency for patients and the public.

High-performing trusts such as Combined Healthcare may also benefit from greater autonomy – including the ability to reinvest surplus budgets directly into frontline services and improvements. NHS England has launched an interactive public dashboard that provides clear league tables and overall performance ratings for every trust in the country.

Combined Healthcare publishes its Annual Report and Accounts 2024/25

The Trust published its Annual Report and Accounts for 2024/25 in September. The Annual Report gives details of the performance and achievements of the Trust during the financial year to 31 March 2025.

Annual General Meeting 2025

The Annual General Meeting for North Staffordshire Combined Healthcare NHS Trust took place on Thursday 10 September. The agenda for the AGM covered a range of topics including a review of the year, quality review of the year, finance and performance review of the year, annual report and accounts 2024/25, and questions from members of the public.

4.2

People
We will attract, develop and retain the best people

Combined colleagues mark autumn events and awareness days

Throughout October, colleagues across the Trust have been marking several awareness days and events.

Speak up Week has seen the Trust's Freedom to Speak Up (FTSU) Guardian and FTSU Champions highlight the Trust's FTSU process and raise awareness about the importance of speaking up. World Mental Health Day encouraged us all to take a moment to remind ourselves of the importance of investing in our mental health, while colleagues took on a special 28-mile sponsored walk across North Staffordshire and Stoke-on-Trent, in aid of Combined Charity.

Colleagues across the Trust also joined thousands of people across the UK for Show Racism the Red Card's 'Wear Red Day' — a national day of action to show solidarity and stand up to racism. While World Menopause Month has provided the opportunity for us all to educate ourselves on the impact of menopause, as themes have been shared in the Trust's weekly communications around support for staying well during menopause.

Finally, it has been wonderful to see colleagues across the Trust come together to celebrate Diwali – the Festival of Lights. It's fantastic to see colleagues take the opportunity to learn more about the traditions and meanings of Diwali, and continue to build an inclusive workplace where everyone feels seen, valued and supported.

Celebrating Black History Month

The month of October was truly a special one as we joined thousands across the country to celebrate Black History Month.

Here at Combined Healthcare, we encouraged participation from members and non-members of the Equality Network for Race, Inclusion and Cultural Heritage (ENRICH), inviting colleagues to share inspiring written reflections through Newsround each week throughout the month. These stories offered thoughtful insights and reflections that encouraged open conversations across our organisation.

We also enjoyed a vibrant tasting event that celebrated culture and community, before rounding off the month with a finale celebration filled with pride, inspiration and togetherness. Each activity reflected the creativity, connection and shared values that define us as a Trust. A heartfelt thank you to the executive team, ENRICH leadership, and to all participants, contributors and attendees who helped make this year's celebrations such a success. Your enthusiasm and engagement brought Black History Month to life across our organisation.

4.3

Trust sees results from new recycling programme

Over the last six months, a segregated recycling programme has been rolled out across Combined Healthcare. Since the introduction of the programme, the amount of general waste generated by the Trust has been reduced by over four tonnes since January 2025. This has saved over 61.8 tonnes of carbon emissions by diverting waste going to landfill.

The trust's waste partner, Biffa, shared some facts highlighting recycling statistics for the period January to September 2025 including:

- the amount of card and paper recycled at the trust helped to save 185 trees and 273,225 litres of water.
- 78.4 tonnes of general waste has been diverted from landfill and reused - saving over 44,308kgs of carbon emissions.
- 6.5 tonnes of plastic has been recycled through the scheme - saving the equivalent of 154,762 two-litre bottles (or 541,667 carrier bags) from being produced.

These results are a tangible demonstration of the hard work of our Trust teams and colleagues across all of our sites. This is also credit to colleagues in our facilities team, who worked in close partnership with our teams and colleagues at Serco to ensure the success of the roll out.

5.0 CONCLUSION

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

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 4

CHAIRS REPORT – NOVEMBER 2025

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	02 September 2025

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

Aligned to Board Assurance Framework Risk:	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, increasing needs and a failure to evidence interventions with support recovery.
7 Levels of Assurance:	N/A
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
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
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: - Sir Julian Hartley steps down as Chief Executive of Care Quality Commission (CQC) - Matthew Taylor, Chief Executive of NHS Confederation to step down in April - New Chair appointed to ICB Cluster between Staffordshire and Stoke-on-Trent, and Shropshire, Telford and Wrekin Integrated Care Boards

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	07.11.25

Chair's Report November 2025

People

Sir Julian Hartley steps down as Chief Executive of CQC

Sir Julian Hartley stepped down as Chief Executive of the Care Quality Commission (CQC) in October, with Dr Arun Chopra, Chief Inspector of Mental Health, assuming the role of Interim Chief Executive until a permanent successor is appointed.

Matthew Taylor, Chief Executive of NHS Confederation to step down in April

The Chief Executive of the NHS Confederation, Matthew Taylor, has announced that he will stand down from the role in April 2026. Matthew has led the NHS Confederation since June 2021.

New Chair appointed to ICB Cluster between Staffordshire and Stoke-on-Trent, and Shropshire, Telford and Wrekin Integrated Care Boards

Ian Green OBE has been confirmed as the Chair of the newly formed cluster between NHS Staffordshire and Stoke-on-Trent and NHS Shropshire, Telford and Wrekin Integrated Care Boards (ICBs).

Ian has previously held Non-Executive Director posts within the NHS, including Chair of Salisbury NHS Foundation Trust, Non-Executive Director of the South-Central Ambulance Trust Board and, more recently, Chair of NHS Shropshire, Telford and Wrekin. We very much look forward to working with Ian as the two Systems are brought together under his leadership.

We would like to express our thanks to **David Pearson** as he steps down from his role as ICB Chair and from the NHS after a lifetime of service to the people of Staffordshire and Stoke on Trent. David has been an enthusiastic supporter of Combined, and we are grateful for his kindness and help over the years. We wish him a happy and healthy retirement.

Chair

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 5

Board Assurance Framework Quarter 2 Report

Report provided for:			
Approve	☒	Alert	☐
Assure	☐	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Nicola Griffiths, Deputy Director of Governance/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.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	BAF risks are approved by the relevant Committees and Trust Board.
Strategic Priorities:	Prevention – Risk 1 Access – Risk 2, Risk 3, & Risk 4 Growth – Risk 5 & Risk 6
Key Enablers:	The Trust key enablers are aligned to individual BAF risks.
Sustainability:	Share learning and best practice
Resource Implications:	Any staffing and/or funding implications, where applicable, are noted within the Board Assurance Framework
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	NSCHT continues to support the development of the ICS BAF and informs the strategic priorities and risks for the System.
Recommendation / Required Action:	Approval for the Quarter 2 BAF report.

Executive Summary:	The paper is the Board Assurance Framework (BAF) Qtr. 2 update for the Trust Board approval. **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. 2 and approved by CSO. It was agreed in Board on the 5.9.25 that BAF risk one would be reassigned to Strategic Priority - Prevention. Residual Score 16, proposing a score reduction at Finance & Resource Committee on the 6th November to a revised residual score of 12, reducing the likelihood from 4 (Likely) to 3 (Possible). **Rationale** - The Trust is now actively engaged in system projects that align to the delivery of the 10 Year Plan, including Neighbourhood Health and the requirements are being mapped and addressed as part of the required response to the new NHSE Planning Framework. Evidence from Qtr. 2 that is provided in the mitigating action updates demonstrates strengthened partnership working, which reduces both likelihood and potential impact of the risk. In particular, the North Stoke Ageing Well project and the Youth Community Grants. The score reduction was supported by the Risk Review Group on the 7th October. **The score reduction *was not approved* by the Finance & Resource Committee on the 6th November. Committee noted the Provider Collaborative (identified in gaps and challenges) is not currently progressing effectively and is of concern.** **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 based 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. 2 and approved by CMO and CNO **resulting in no impact on residual score change.**

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. 2 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. 2 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. 2 and approved by CFO **resulting in no impact on residual score**.

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. 2 and approved by CSO **resulting in no impact on residual score change.**

	Summary of other BAF related activities during Qtr. 2. • In line with an Internal Audit recommendation and following a facilitated Board Development session with MIAA in August 2025, a risk appetite level has been added to the dashboard for each risk. • Themes now added to the BAF dashboard against agreed risk titles. **Next Steps** • MIAA reviewing suggested risk appetite statements, further work to be completed on risk tolerance and national examples of good practice to be provided. • Tolerance scores to be added to the Dashboard for Qtr. 3. • To discuss with MIAA a SLTD session in the new year to apply risk appetite and tolerance scores to Operational and Trust level risks.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Risk Review Group	7.10.2025
V1	Finance and Quality Committee	6.11.2025
V1	People, Culture and Development Committee	10.11.2025

PREVENTION

ACCESS

GROWTH

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.

COMPASSIONATE APPROACHABLE RESPONSIBLE EXCELLENT PROUD TO CARE

SUSTAINABILITY QUALITY PARTNERSHIPS PEOPLE

safe • personalised • accessible • recovery focused spar

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

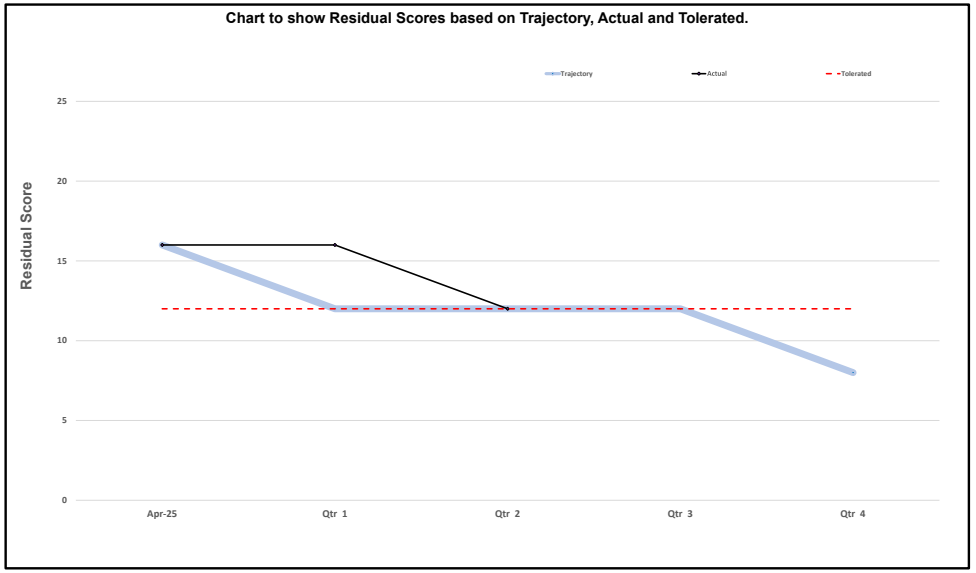
Risk No.	Strategic Priority	Title	Theme/Risk Type	Risk Description	Executive Lead	Gross Score	Residual Risk Score Qtr. 1	Residual Risk Score Qtr. 2	Risk Movement from Previous Qtr.	Target Score	Tolerance Level	Target Achievement Date	Lead Committee	Risk Appetite Level
1	Prevention	Strategic Direction & Partnerships	Reputational	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	12	↓	8	TBC	31st March 2026	Finance & Resource	**Seek** - Strategic Direction. **Cautious/Open** for partnerships (higher tolerance for Strategic Direction, lower tolerance for Partnerships).
2	Access	Quality & Safety	Quality	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	15	⟷	10	TBC	31st March 2026	Quality	**Seek** Patient Safety. **Open** for Quality and Innovation.
3	Access	People	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	16	⟷	12	TBC	31st March 2026	People, Culture and Development	**Open**
4	Access	Performance	Financial	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	16	⟷	12	TBC	31st March 2026	Quality	**Open**
5	Growth	Financial Sustainability	Financial	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	10	⟷	5	TBC	31st March 2026	Finance & Resource	**Open**
6	Growth	Digital	Reputational	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	16	⟷	12	TBC	31st March 2026	Finance & Resource	**Seek**

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 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 operative 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**	**Seek - Strategic Direction** **Cautious / Open - Partnerships**
Executive Lead	**Chief Strategy Officer**	**Strategic Priority**	**Prevention**
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**			**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 16 to 12 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	The Trust is now actively engaged in system projects that align to the delivery of the 10 Year Plan, including Neighbourhood Health and the requirements are being mapped and addressed as part of the required response to the new NHSE Planning Framework. Evidence from Qtr. 2 that is provided in the mitigating action updates demonstrates strengthened partnership working, which reduces both likelihood and potential impact of the risk. In particular, the North Stoke Ageing Well project and the Youth Community Grants. Proposing score change from 16 to 12 reducing the likelihood from 4 (Likely) to 3 (Possible). 7.10.25 - The Risk Review Group are in support of the score reduction. 6.11.25 - Finance & Resource Committee has not approved the score reduction. Committee noted the Provider Collaborative (identified in gaps and challenges) is not currently progressing effectively and is of concern.
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.
		On Target for Delivery	**Qtr. 2** 10 Year Plan was published during Qtr. 2 and discussed in various forums. The new NHSE planning framework was also published during Qtr. 2 with a requirement for providers to submit a five year integrated delivery plan alongside a one year operational plan. The requirements have been discussed with SLT, F&R and Board. A core planning group has been mobilised to coordinate the development and delivery of planning requirements.	**Qtr. 2.** There is still varying understanding of the neighbourhood health agenda and a need to develop and embed this across Trust.	**Qtr. 2** An SLTD session is scheduled for October with an expectation that key messages are cascaded. As part of strategic and operational planning broader staff engagement will also be facilitate with methodology still to be agreed.
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).
		On Target for Delivery	**Qtr. 2** The Trust participated in a system-wide bid to become an early implementer site for Neighbourhood Health pilots, focusing on the North Stoke Frailty Project. Although the bid was unsuccessful, the Trust remains actively involved in shaping the model. The Primary Care Steering Group has been reconvened to support delivery of the neighbourhood health agenda, with pilot opportunities currently being scoped and engagement underway with other mental health trusts to learn from their Integrated Neighbourhood Team pilots.	**Qtr. 2** Progress within the Provider Collaborative has been slower than anticipated due to factors outside of the control of the Trust. Existing system governance around Neighbourhood Health has been reviewed in Qtr. 2 with a number of meetings cancelled.	**Qtr. 2** A new system governance and meeting structure for Neighbourhood Health has now been agreed with system meetings due to resume in October.

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 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 amends 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.
		On Target for Delivery	**Qtr. 2.** Progress made during Qtr. 2 on a number of strategic developments with partners that support the 'left shift' objectives of the 10 Year Plan. This includes community grants supporting 15 VCSE organisations to embed mental health support within youth provision, the out of area (OOA) recovery plan which has mobilised an effective partnership response to reduce adult OOA placements, productive conversations with recovery service providers around improved models of joint working, participation in the steering group driving the North Stoke Ageing Well project which is still progressing despite not being selected as an early implementer site for neighbourhood health.	**Qtr. 2.** SLTD session on partnership plan was rescheduled from September to October to align with a face-to-face meeting and wider planning discussion. This has delayed wider implementation but will commence from October with monitoring through Finance and Resource Committee.	**Qtr. 2** SLTD session to take place in October following which the plan will be formalised and move into active implementation and monitoring.

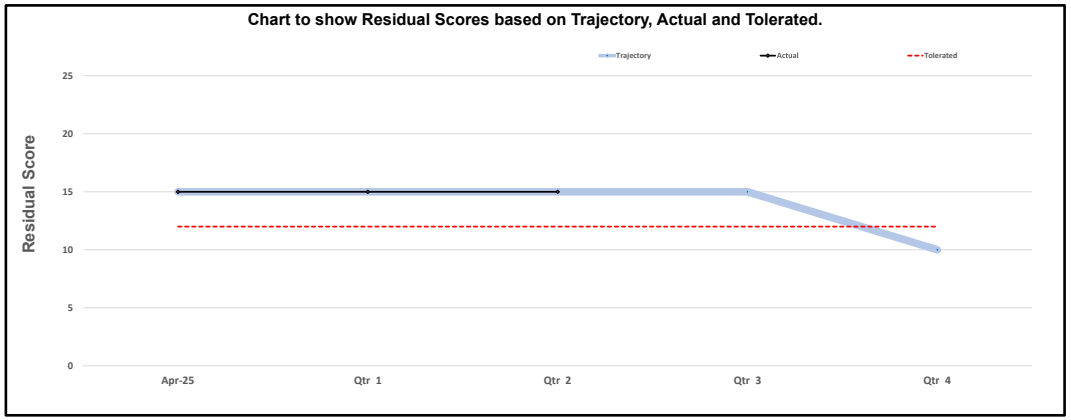
Action Reference	Evidence to Provide Assurance (Narrative)	Level of Assurance	Frequency of Assurance	Qtr.1 Delivered	Qtr.2 Delivered	Qtr.3 Delivered	Qtr.4 Delivered
Action 1	10 Year Plan scheduled as part of SLT(Business & Development) Cycle of Business.	Level 1	Six Monthly	N/A it is expected that the 10 Year Plan will be published during Q2	To be covered at SLTD on 7th October		
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	Yes updates continue through ICB governance		
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 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**	**Seek - Patient Safety** **Open - Quality & Innovation.**
Executive Lead	**Chief Medical Officer and Chief 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 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	No change in score. Actions are still on target for completion but are still being worked through.
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.
		On Target for Delivery	**Qtr. 2** The draft plan is currently with the Chief Nursing Officer for comment, once approved a paper will be produced for Senior Leadership Team - estimated completion October 2**5.**	**Qtr. 2** None to date.	**Qtr. 2** 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.**
		On Target for Delivery	**Qtr. 2** Final Crisis Care CQC report gives an overall rating of Good. The Trust's self assessments against CQC standards is due to be reported to Quality Committee in Qtr. 3.	**Qtr. 2** Service areas completing the self assessments in a timely manor.	**Qtr. 2** Ongoing collaboration with service leads and updates regarding service challenges to be discussed at Quality Assurance Group.

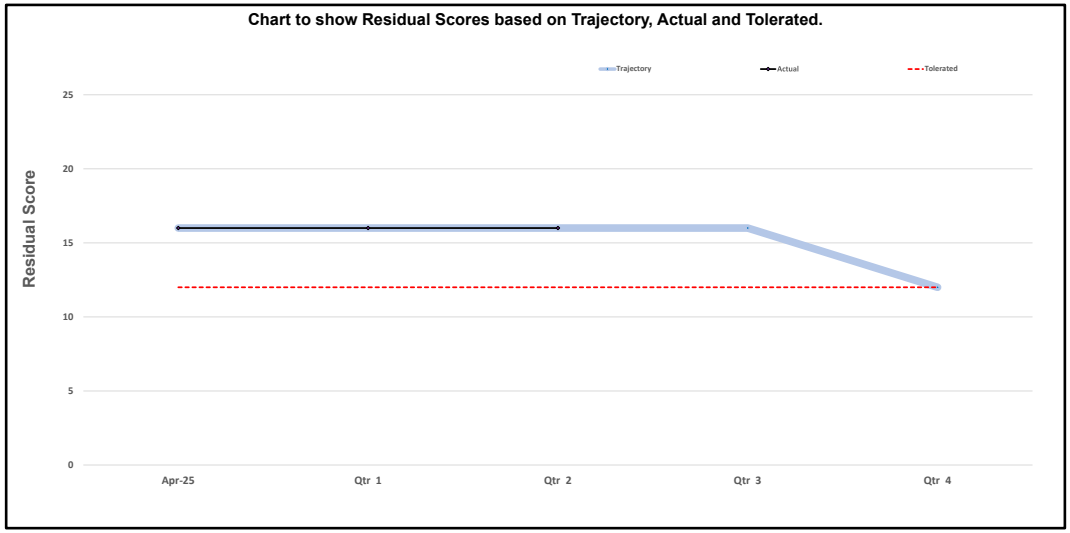
Mitigation Actions	Target Date	Quarterly Progress RAG Rating	What's Going Well	What are the Current Challenges/ Gaps In Assurance	Action Plan To Address Current Challenges/Gaps/Timeline
Action 3 For Health Inequalities data to be visible within the Trusts Governance structure in a manner which ensures 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 Senior Leadership Team.	**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).
		On Target for Delivery	**Qtr. 2** Terms of Reference reviewed at the PCREF steering group on the 27th June, comments have been actioned and due to go to the next PCREF meeting in Qtr. 3. Health Equity Framework has been produced.	**Qtr. 2** To agree the main area of focus of the year relating to the Health Equity Framework. Embed EDI patient data into all relevant Quality Committee Reports.	**Qtr. 2** Chief Medical Officer to take the Health Equity Framework through to Execs and Senior Leadership Team by the end of Qtr. 3 To mirror the principles taken forward in the reducing practice report - to be completed by Qtr. 3

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 5 Year Plan will be implemented by Qtr. 3.	Level 2	From Qtr. 3.	N/A	N/A		
Action 2	Retain overall CQC outstanding rating with assurance reports and progress against self assessments being reported through Quality Committee	Level 2	Quarterly	Delivered	Delivered		
Action 3	Health inequalities data is Integral to Trusts Performance and Quality Committee reporting.	Level 2	From Qtr. 4 - Report(s) will be quarterly	N/A	N/A	N/A	

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 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**	**Open**
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 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	The score is remaining the same because the projects are in the initial early stages, but are on target for delivery by March 26.
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.
		On Target for Delivery	**Qtr. 2** The Trust have placed all of the newly qualified band 5 nurses (56 WTE), including those recruited above the establishment into substantive roles. A detailed update was provided at the PCDC business meeting on the 1.9.25, which provided an account of all of the Trusts widening participation activity over the last 12 months and reported on progress against the Trust's Inclusion ambitions, which focus on delivery against local population demographics to demonstrate how the Trust are delivering against representative workforce ambitions. A Trust wide approach to diversifying our recruitment process was presented and approved at PCDC on the 1.9.25, with the intention of improving the representation of Global Majority candidates through the recruitment process.	**Qtr. 2** The Trust do not currently have enough voices which represent the diverse needs of our community shaping our offer to address our current and emerging needs. Due to the financial scrutiny on pay spend and vacancy controls, the opportunity to explore different ways of doing things is becoming diminished, particularly due to consistent reduction in Trust's turnover levels.	**Qtr. 2** Work is being undertaken to align our Widening Participation Approach with our Community Engagement Coordinator role and explore the role of Service User and Carer Council, and to identify new voices/groups from the community. The Trust has reviewed it's risk appetite and confirmed that it is OPEN to some workforce risk where this drives delivery of workforce, optimisation and transformation objectives. This month, on the 2.9.25, the Mutually Agreed Resignation Scheme (MARS) was open to staff to apply to leave their role in exchange for a voluntary severance payment, which will create organisational redesign opportunities that will support innovation.

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 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.
		On Target for Delivery	**Qtr. 2** New staff supervision policy is in situ and embedded in practice. Staff supervision survey has been delivered and a report is drafted with recommendations for future practice, this will be taken to PCDDC on the 3.11.25. Stress policy currently under review and significant redevelopment which includes risk assessments, this is due be ratified in November 25. Health and Wellbeing offers are shared with Directorate Associate Directors (AD's) to support their performance improvement programmes for sickness absence. Current data from Staffs Support and Counselling Service is shared monthly with AD's to give an enhanced understanding of their Directorate needs.	**Qtr. 2** Learning Management System (LMS) has issues which is effecting confidence in reporting of compliance figures. Sickness absence levels and clinical supervision compliance levels are remaining off track and are relatively static over the last quarter.	**Qtr. 2** A Commitment has been provided by the Executive Team to the Chief People Officer to transition to Electronic Staff Records (ESR) as the single recording system. The effect of this will be greater oversight and management of issues relating to data integrity and compliance rates. Next steps in Qtr. 3, a paper and project plan developed to move from LMS to ESR. A final demonstration of ESR capabilities is due in September 25, and the Trust project group is determined to ensure scale, spread and ease of transfer, which will be operational by March 26. A detailed review has taken place of sickness absence of levels and cases over the last 12 months, alongside internal audit findings, which have formed the basis of a draft sickness improvement plan that will be shared with PCDC business meeting on the 3.11.25. Each Directorate area which is above target has a Performance improvement plan (PIP), which is being regularly monitored for progress in performance meetings.
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.
		On Target for Delivery	**Qtr. 2** The Trust are currently aligning the draft strategy with community demographics, which will then inform objectives and outcome measures to review actions against progress. Currently, links are being developed into the local population to ensure voice and engagement to shape our Trust's participation agenda. This links to the programmed work being undertaken to align our Widening Participation approach with our Community Engagement Coordinator role and explore the role of Service User and Carer Council, and to identify new voices/groups from the community. The Strategy is planned to go to the next PCDC business meeting on the 3.11.25.	**Qtr. 2** Due to the financial scrutiny on pay spend and vacancy controls the opportunity to explore different ways of doing things is becoming diminished particularly due to consistent reduction in Trust's turnover levels. There is currently a lot of political and social debate and challenge regarding access to opportunities for particular communities being deemed to be at odds with other communities. Views or requirements are proving challenging to navigate and are at risk of impacting on moral and motivation for key staff and communities.	**Qtr. 2** The Trust has reviewed its risk appetite and confirmed that it is OPEN to some workforce risk where this drives delivery of workforce optimisation and transformation objectives. This month, on the 2.9.25 the Mutually Agreed Resignation Scheme (MARS) was open to staff to apply to leave their role in exchange for a voluntary severance payment, which will create organisational redesign opportunities that will support innovation. Further engagement work will take place internally and in the wider communities to open up discussion.

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	Delivered - Excellent feedback given from the Chair on progress and the quality of the report		
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	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	Delivered		

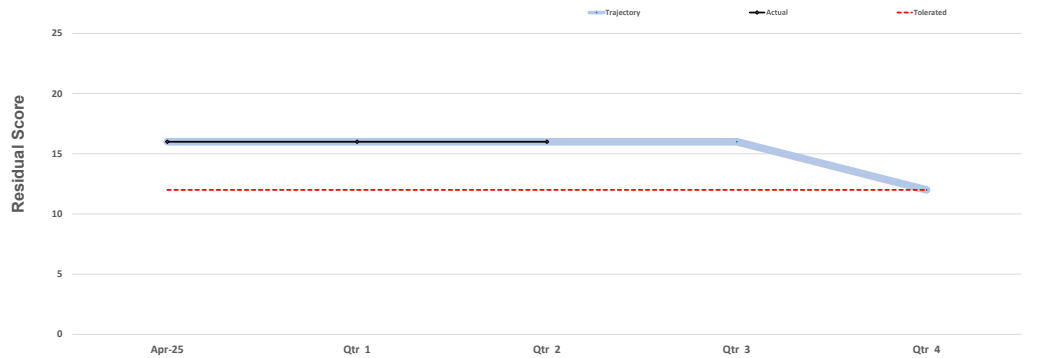
BAF Risk 4	**There is a risk of non-delivery of our financial plans and/or an impact on service quality due to the level of transformation required, with the consequence being an effect on clinical outcomes and/or the Trust's financial viability.**
Risk Context	The level of transformation required across 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**	**Open**
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 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 Qtr. 2.
Qtr. 2	No score change in Qtr. 2. Achieved CIP of £4,677m with a gap of £1.040 remaining, review underway regarding implementation of the agreed CIP by finance and some non-recurrent mitigation in place. Further PIDS being approved in Q3 and planning session for 26/27 planned for end of Q3.
Qtr. 3	
Qtr. 4	

Chart to show Residual Scores based on Trajectory, Actual and Tolerated.



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.
		Risk to Delivery, Plan in Place	**Qtr. 2** Unidentified CIP in one operational directorate, unidentified CIP from some Corporate areas. Weekly CIP meetings continue to track progress as does reporting to and monitoring by Finance and Resources Committee.	**Qtr. 2** Opportunities identified have not given full year effect or have not hit the projected target. Some CIP schemes require longer pieces of work noting the scale of transformation. Some schemes have required modification (or have been rejected) as a result of the QIA process.	**Qtr. 2** Deficit currently identified within Specialist CIP target may be met by overperformance in bank reduction in AS&UC (Finance currently reviewing). No further update on Corporate Reductions and their impact on CIP (national expectation), noting MARS has only launched in September.
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.
		On Target for Delivery	**Qtr. 2** Refresh of the QIA process has been completed and is out for consultation. Deep dive review to take place at next CIP meeting. The Quarterly Update to Quality Committee has provided assurance as to existing schemes.	**Qtr. 2** Review of QIA process underway so that there is clarity on the process once CIP transacted, however in general process is working well.	**Qtr. 2** Deep dive will take place at the next CIP meeting: 15/9/25 to ensure BAU review is in situ.
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.
		On Target for Delivery	**Qtr. 2** No issues arising from a KPI perspective specifically relating to transformation, nor any initial concerns raised through QIA monitoring.	**Qtr. 2** Some schemes have evolved/changed noting clinical input or QIA process.	**Qtr. 2** Continue to monitor throughout the year.

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	Delivered - Risk to delivery noting the deficit outlined		
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	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	Complete - no concerns created in relation to CIP		

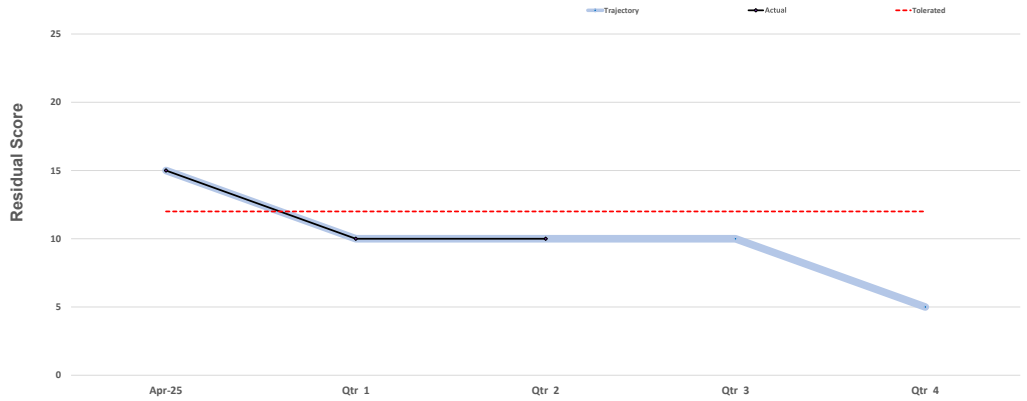
BAF Risk 5	**There is a risk to the Trust's long term financial sustainability due to failure to deliver the recurrent savings programme, and higher than planned bank and agency expenditure. As a consequence, this could lead to a financial deficit, reduced liquidity, a lack of investment in service delivery and potentially impact the future viability of the Trust.**
Risk 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**	**Open**
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 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 Qtr. 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. 7.8.25 - Finance & Resource Committee approved the score reduction.
Qtr. 2	No score change in Qtr. 2. The Trust continue to perform better than plan, however there is still risks around CIP deliverability.
Qtr. 3	
Qtr. 4	

Chart to show Residual Scores based on Trajectory, Actual and Tolerated.



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 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.
		On Target for Delivery	**Qtr. 2** At M5 (latest information) the Trust was £440K better than plan and is expected to be better than plan by the end of Qtr. 2.	**Qtr. 2** At M5 - Agency costs have a negative variance of £118k compared to plan. At M5 - Bank also has a negative variance of £91k compared to plan.	**Qtr. 2** Monthly medical task and finishing groups are starting to address agency locum expenditure. The M5 forecast currently suggests that the year end position will be a negative variance of £24K. There are fortnightly roster optimisation working group meetings to address roster inefficiencies, with the aim to reduce bank expenditure. This is in addition to recruiting 54 newly qualified nurses in October which will be over the budgeted establishment, the consequence of which will reduce the bank expenditure.

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 2 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.
		Risk to Delivery, Plan in Place	**Qtr. 2** Capital expenditure in line with plan with a slight underspend. Project plan on schedule to complete in December 2025. The Trust has submitted a bid for additional capital funding for Out of Area Mental Health, with the outcome expected by the end of September 2025.	**Qtr. 2** All System capital allocations have not been confirmed, which leaves 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. 2** Gain clarity from System partners in Qtr. 2 on the capital allocations and the Trust's share of the System allocation to fund Chrysalis. All system partners are refreshing forecasts as at M6 to inform a realistic position against capital allocations, which will enable the Trust to understand any risks. Confirm the revenue consequences with PFI Partners.
Action 3 Continuation of the Trust wide 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.
		Risk to Delivery, Plan in Place	**Qtr. 2** Weekly CIP oversight groups and weekly reporting to NHSE taking place with progress being made most weeks. Monthly reporting to F&R Committee commenced. Schemes have been identified for the Trust's total CIP value. In the process of arranging for MIAA to deliver a CIP workshop to identify CIP schemes for 2026/2027.	**Qtr. 2** Progress has stalled and slowed during Qtr. 2, and implementation plans are not progressing as quickly as required. The delivery of the identified schemes is still to be validated.	**Qtr. 2** Discussions take place at the weekly CIP oversight group, challenging the Directorates on the implementation and delivery of the schemes.

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	Delivered		
Relates to all above actions.	Monthly reports to Senior Leadership Team, Finance and Resource Committee and Board.	Level 2	Monthly	Delivered	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.	N/A Qtr. 3 Internal Audit and Qtr. 1 26/27 External Audit		

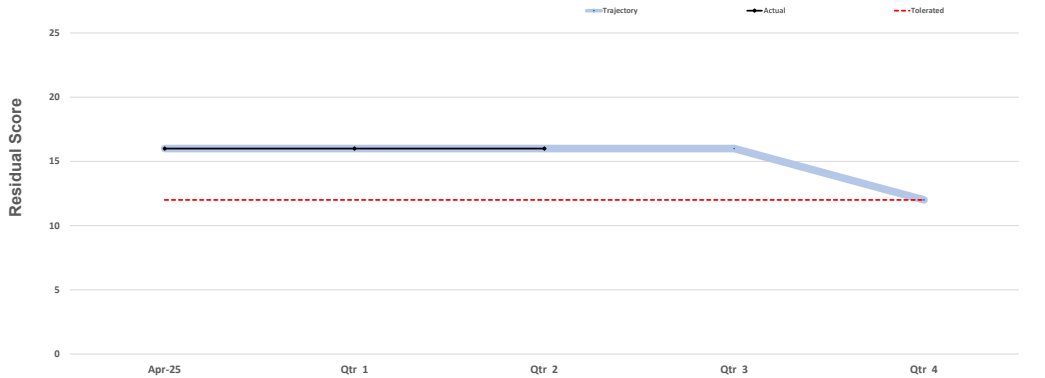
BAF Risk 6	**There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.**
Risk 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**	**Seek**
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 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 score change. Initial actions initiated and actions will start to be completed in later quarters.
Qtr. 2	No score change. There remains a significant number of actions outstanding for completion in later quarters.
Qtr. 3	
Qtr. 4	

Chart to show Residual Scores based on Trajectory, Actual and Tolerated.



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.
		Risk to Delivery, Plan in Place	**Qtr. 2** Building on the progress made in Qtr. 1, the Trust has continued to advance its digital transformation agenda. The implementation timeline for the Orbis EPR solution has been extended from November 2025 to Summer 2026, allowing additional time for product development and ensuring the solution is robust and fit for purpose. This adjustment reflects the complexity of the programme and the need to accommodate evolving requirements. Additionally the Trust has been successful in an application for funding from NHSE for the integration of PatientAide with the NHS Notify service to improve the flow of information to service users. The review of the Wellbeing Portal remains ongoing under the Digital Cost Improvement Programme (CIP), with a focus on assessing current usage and identifying opportunities to enhance productivity and quality outcomes for operational teams. Meanwhile, the productivity benefits associated with the text messaging reminder service are being progressed through the wider CIP programme, with operational management leads overseeing the integration of these improvements into service delivery.	**Qtr. 2** The challenges outlined in Qtr. 1 remain largely unchanged, with funding limitations and resource constraints continuing to impact delivery assurance across the digital transformation programme. While the extension of the Orbis EPR implementation timeline provides an opportunity to address some of these risks, it also reflects the scale and complexity of the programme and the need for sustained investment. In addition, ongoing stability issues with the legacy Lorenzo EPR system have emerged as a significant concern, requiring increased resource allocation from both the Trust and Dedalus to maintain operational continuity and mitigate disruption. These issues place further pressure on internal teams and reinforce the need for strengthened technical support, clearer prioritisation, and enhanced programme governance to ensure delivery confidence and minimise risk to frontline services.	**Qtr. 2** In response to ongoing delivery challenges and resource constraints, digital workstreams have been further prioritised to concentrate efforts on the Orbis EPR Programme, the Digital Cost Improvement Programme (CIP), and broader productivity opportunities in collaboration with operational teams. Additional focus has also been directed toward the resolution of stability issues affecting the Lorenzo EPR system, with dedicated problem management activities now underway. These targeted actions are being delivered alongside core business-as-usual operations, both within the Trust and through continued engagement with system partners. This approach aims to maximise available capacity, maintain service continuity, and ensure that critical digital initiatives remain on track despite limited investment flexibility.

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 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.
		On Target for Delivery	**Qtr. 2** The Trust BI strategy was reviewed and redrafted to more closely align with the Trust strategy and the newly released NHS long term plan. The new strategy was approved by SLT in July 25. 1. The procedure dashboard is in use and the Digital team have been rolling out training to inform staff of the change in process. 2. An inpatient dashboard is in development in Power BI to replace an existing SSRS dashboard, to be shared at the ACUC directorate meeting in Q3. 3. An inpatient co produced care planning dashboard is in place, and a community care planning dashboard was released in Q2, which includes activity for LD, CYP and Specialist directorate. 4. A general Trust activity dashboard is in development, to be iterated internally within the Performance team before being discussed in key areas. Current version was demonstrated at the Qtr. 2 medical away day in September, and was well received. 5. Dashboards that reflect national priorities that support the Oversight Framework are in development, with a view to releasing for consumption in Qtr. 3.	**Qtr. 2** 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. The ongoing ORBIS migration/integration is a potential barrier to progress, with a final end state in terms of data recording still being unclear. The cost of Power BI licenses prohibited the widespread rollout of Power BI, and funding for trust wide licensing was still in discussion. In Qtr. 1, an agreement was made with MPFT to share Power BI licenses, to be underpinned with an MOU. This will remove a key barrier to moving towards PBI becoming the primary reporting tool for the Trust.	**Qtr. 2** Issues emerging from the ORBIS migration are being addressed through the project governance process, and escalating through the Trust risk management process where appropriate. The project completion date has been pushed back to mid 2026, which has mitigated some concerns around the workload being place upon the Performance team. Engagement with services is intended to surface reporting needs, which will shape the general activity dashboards, with a view to signposting staff to self service reports, reducing the burden on the Performance team.
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&SHIS 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.
		Risk to Delivery, Plan in Place	**Qtr. 2** The Trust continues to strengthen its cybersecurity and digital resilience posture. The Digital Team remains actively engaged with the EPRR group, supporting the integration of cyber preparedness into emergency planning. A regional NHS Cyber Exercise is currently being scheduled, with participation from EPRR representatives to test response capabilities and enhance system-wide coordination. In parallel, the Staffordshire ICS Cyber Security Strategy has been published, providing a strategic framework for collaborative action across the system. The Trust's own Cyber Security Plan is now in its final stages of review and is being prepared for submission to the Data Protection Steering Group, ensuring alignment with national standards and local priorities.	**Qtr. 2** The Trust continues to face challenges in fully assuring its cybersecurity posture, particularly in meeting the evolving requirements of the new Cyber Assurance Framework aligned with the Data Security and Protection Toolkit (DSPT). While collaborative work is ongoing with system partners through the Staffordshire and Shropshire Health Informatics Service (SSHIS) Security Operations Centre, significant internal effort is still required to address the expanded scope of the 2024/25 DSPT. Resource limitations persist, and the complexity of the new framework has placed additional pressure on internal teams, highlighting the need for strengthened capacity and clearer prioritisation. Although progress is being made, a substantial volume of work remains to ensure full compliance and to deliver against the Trust's DSPT action plan within the required timeframe.	**Qtr. 2** Following the submission of the 2024/25 DSPT in June and the completion of the MIAA audit, the Trust has developed a targeted action plan which has supported the attainment of the "Approaching Standard" rating for the DSPT from NHS England. The plan addresses all key objectives outlined in the Cyber Assurance Framework and reflects a structured approach to strengthening compliance and resilience. However, delivery risks remain due to ongoing capacity constraints and limited access to specialist expertise. While the action plan provides a clear roadmap, successful implementation will depend on sustained internal engagement, prioritisation of critical tasks, and continued collaboration with SSHIS to leverage shared resources and technical support.

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	Delivered		
Action 2	Data Quality Audit - Finance and Resource Committee	Level 3	Quarterly	24/25 Report Delivered.	Delivered		
Action 3	Data Protection and Security Tool Kit Audit - Finance and Resource Committee	Level 3	Annually	24/25 Report Delivered.	Action Plan due Q3		

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

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

Assurance Level

KEY

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

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

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 6

PROPOSED COMMITTEE /BOARD DATES 2026/27

Report provided for:			
Approve	☒	Alert	☐
Assure	☐	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Nicola Griffiths, Deputy Director of Governance
Prepared by:	Lisa Wilkinson, Corporate Governance Manager
Executive Lead:	Dr Buki Adeyemo, Chief Executive Officer

Aligned to Board Assurance Framework Risk:	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, increasing needs and a failure to evidence interventions with support recovery.
7 Levels of Assurance:	Level 7 - Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Approval / Review:	Execs
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A
Recommendation / Required Action:	Trust Board are asked to review the document, consider the recommendations and approve the dates.

Executive Summary:	Attached are the proposed Committee / Board dates for 2026/27 for approval. Notes for discussion: • All dates are based on Day 10 reporting • Committee dates have been compared with dates across the system, i.e. UHNM and MPUFT. • The Committee chart accommodates where there are public bank holidays Board are asked to review the document consider the notes for discussion and approve the recommended dates in Appendix 1.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Execs	27.10.25
V2	Public Trust Board	03.11.25

Committee Chart 2026-2027 – Version 2 (Based on Day 10 Reporting)

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W
Jan 26				1	2 TBPM PD	3	4	5 PCDC Bus REMCO PD	6 Execs TBPM SLTD / Risk PD	7	8 F&R QC	9 TB/ Corp Tr / Exec PD	10	11	12 REMCO	13 SLTD Risk Execs P	14	15 Day 10 TB SEM Corp Tr	16 Perf PD	17	18	19	20 Perf SLT PD	21 AC PD	22	23 Exec PD	24	25	26 PCDC PD	27 SLT Execs P	28 AC	29 F&R / QC PD	30	31					
Feb					TBPM PD		1	2 PCDC Ex F	3 Execs TBPM SLTD / Risk PD	4	5 F&R QC	6 BOD / Exec / TB PD	7	8	9	10 SLTD Risk Execs P	11	12 PR TB BOD	13 Day 10 Perf PD	14	15	16	17 Perf SLT PD	18	19	20 Exec PD	21	22	23 PCDC / CFC PD	24 SLT Execs P	25	26 F&R / QC PD	27						
March					TBPM PD		1	2 PCDC Bus CFC	3 Execs TBPM SLTD / Risk PD	4	5 F&R QC	6 TB / Exec PD	7	8		10 SLTD Risk Execs P	11	12 TB SEM	13 Day 10 Perf PD	14	15	16	17 Perf SLT PD	18	19	20 Exec PD	21	22	23 PCDC PD	24 SLT Execs P	25	26 F&R / QC PD	27 TBPM PD	28	29	30 PCDC Ex F	31 Execs TBPM SLTD / Risk PD			
April			1	2 F&R QC TB / BOD / Exec PD	3	4	5	6	7 SLTD Risk Execs P	8	9 PR TB BOD	10	11	12	13	14 Execs Dev	15	16 Day 10	17 Perf PD	18	19	20	21 Perf SLT PD	22	23	24 Exec PD	25	26	27	28 SLT Execs P	29	30 F&R / QC PD							
May					1 TBPM / AC PD	2	3	4	5 Execs TBPM SLTD / /PCDC / Risk / PD	6	7 F&R QC	8 AC TB / REM CO / Exec PD	9	10	11 PCDC Bus	12 SLTD Risk Execs P	13	14 TB REM CO SEM	15 Day 10 Perf PD	16	17	18	19 Perf SLT PD	20	21	22 Exec PD	23	24	25	26 SLT Execs P PCDC / CFC PD	27	28 F&R / QC PD	29 TBPM PD	30	31					
June								1 PCDC Bus CFC	2 Execs TBPM SLTD/ Risk PD	3	4 F&R QC	5 TB / BOD / Exec PD	6	7	8	9 SLTD Risk Execs P	10	11 PR TB BOD	12 Day 10 Perf PD	13	14	15	16 Perf SLT PD	17	18	19 Exec PD	20	21	22 PCDC PD	23 SLT Exec P	24	25 F&R / QC PD	26 TBPM PD	27	28	29 PCDC Ex F	30 Execs TBPM SLTD / Risk PD			
July			1	2 F&R QC	3 TB / Exec PD	4	5	6	7 SLTD Risk Execs P	8	9 TB SEM	10	11	12	13	14 Day 10 Execs Dev	15	16	17 Perf PD	18	19	20	21 Perf SLT PD	22	23	24 Exec / AC PD	25	26	27 PCDC PD	28 SLT Exec P	29	30 F&R / QC PD	31 TBPM PD AC						
Aug						1	2	3 PCDC Bus	4 Execs TBPM	5	6 F&R	7 Exec PD	8	9	10	11 SLTD Risk	12	13 BOD Full Day	14 Day 10	15	16	17	18 Perf	19	20	21 Exec PD	22	23	24 PCDC PD	25 SLT Exec P	26	27 F&R / QC PD	28 TBPM PD	29	30	31			

Committee Chart 2026-2027 – Version 2 (Based on Day 10 Reporting)

									SLTD / Risk PD		QC					Execs P			Perf PD				SLT PD						PCDC PD								
Sept		1 Execs TBPM SLTD / Risk / PCDC /CFC PD	2	3 F&R QC	4 TB / REMCO/ Exec PD	5	6	7 PCDC Ex Foc CFC	8 SLTD Risk Execs P	9	10 TB REM CO SEM	11 Perf PD	12	13	14 Day 10	15 Perf SLT PD	16	17	18 Exec PD	19	20	21 PC DC PD	22 SLT Exec P	23	24 F&R / QC PD	25 TBPM PD	26	27	28 PCDC Bus	29 Execs TBPM SLTD / Risk PD	30							
Oct				1 F&R QC	2 TB / BOD / Exec PD	3	4	5	6 SLTD Risk Execs P	7	8 PR TB BOD	9	10	11	12	13 Exec Dev	14 Day 10	15	16 Perf PD	17	18	19	20 Perf SLT PD	21	22	23 Exec / AC PD	24	25	26 PCDC PD	27 SLT Exec P	28	29 F&R / QC PD	30 TBPM PD AC	30	31			
Nov							1	2 PCDC Ex Foc	3 Execs TBPM SLTD / Risk PD	4	5 F&R QC	6 TB / Exec PD	7	8	9	10 SLTD Risk Execs P	11	12 TB SEM	13 Day 10 Perf PD	14	15	16	17 Perf SLT PD	18	19	20 Exec PD	21	22	23 PCDC / CFC PD	24 SLT Exec P	25	26 F&R / QC PD	27 TBPM PD	28	29	30 PCDC Bus CFC		
Dec		1 Execs TBPM SLTD / Risk PD	2	3 F&R QC	4 BOD / Exec PD	5	6	7	8 SLTD Risk Execs P	9	10 BOD Full Day	11	12	13	14 Day 10	15 Exec Dev	16	17	18 Perf PD	19	20	21	22 Perf SLT PD	23	24 Exec PD	25	26	27	28	29 Virt SLT Exec P PCDC PD	30	31 F&R / QC PD	TBPM PD				
Jan 27					1	2	3	4 PCDC Ex Foc	5 Execs TBPM SLTD / Risk PD	6	7 F&R QC	8 TB / REM CO / Exec PD	9	10	11	12 SLTD Risk Execs P	13	14 TB REM CO SEM	15 Day 10 Perf PD	16	17	18	19 Perf SLT PD	20 AC PD	21	22 Exec / AC PD	23	24	25 PCDC PD	26 SLT Exec P	27	28 F&R / QC PD	29 TBPM PD AC	30	31			
Feb								1 PCDC Bus	2 Execs TBPM SLTD / Risk PD	3	4 F&R QC	5 TB / BOD / Exec PD	6	7	8	9 SLTD Risk Execs P	10	11 PR TB BOD	12 Day 10 Perf PD	13	14	15	16 Perf SLT PD	17	18	19 Exec PD	20	21	22 PCDC / CFC PD	23 SLT Execs P	24	25 F&R / QC PD	26 TBPM PD	27	28			
March								1 PCDC Ex Foc CFC	2 Execs TBPM SLTD / Risk PD	3	4 F&R QC	5 TB / Exec PD	6	7	8	9 SLTD Risk Execs P	10	11 TB SEM	12 Day 10 Perf PD	13	14	15	16 Perf SLT PD	17	18	19 Exec PD	20	21	22 PCDC PD	23 SLT Execs P	24	25 F&R / QC / TBPM PD	26	27	28	29	30	31

Committee Chart 2026-2027 – Version 2 (Based on Day 10 Reporting)

Key:

TB	**P**ublic and Private Trust Board Meeting
TBPM	Trust Board Pre-Meet
PRTB	Private Trust Board only
SEM	Board Development Seminars
BOD	Board Development Full Session
REMCO	Remuneration Committee
AC	Audit Committee
PCDC	People Culture and Development Committee
QC	Quality Committee
CFC	Charitable Funds Committee
F&R	Finance and Resource Committee
SLT	Senior Leadership Team Meeting
Execs	Executive Team Meeting (papered / no papers)
Exec Dev	Executive Team Development
SLTD	Senior Leadership Development Meeting
Perf	Performance
Risk	Risk Meeting
PD	Paper Deadlines

Empty boxes shaded in light blue are Bank Holidays
****Days of the month in red are Staffordshire School Holidays****

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 7

POLICY REPORT – NOVEMBER 2025

Report provided for:			
Approve	☒	Alert	☐
Assure	☐	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary
Prepared by:	Lisa Wilkinson, Corporate Governance Manager
Executive Lead:	Dr Buki Adeyemo, Chief Executive Officer

Aligned to Board Assurance Framework Risk:	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, increasing needs and a failure to evidence interventions with support recovery.
7 Levels of Assurance:	Level 3 - Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Approval / Review:	Audit Committee
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
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A
Recommendation / Required Action:	Trust Board are asked to ratify the policy that has been approved at Audit Committee.
Executive Summary:	Request is made to **ratify** the following policy for 1 year:

	4.06 Scheme of Delegation A copy of the policy is available upon request.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Senior Leadership Team Meeting	22.10.25
V1	Audit Committee	23.10.25
V1	Public Trust Board	07.11.25

Report for Trust Board – November 2025

Should you have any comments please save the document having tracked your changes and return to the author and the Corporate Governance Manager.

Name of Policy	Purpose of Policy	Policy Author / Head of Service Lead	Director Lead	New or Existing Policy	Policy Reviewed at:	Committee Approval	Review Date	Recommendations
4.06 Scheme of Delegation	The policy sets out those powers reserved to the Trust Board, generally matters for which it is held accountable to the Secretary of State, together with those powers delegated to the appropriate level for the detailed application of Trust policies and procedures.	Assistant Chief Finance Officer	Chief Finance Officer	Existing	Governance and Finance Team	Audit Committee	31.10.25	Approve for 1 year
	Changes to policy: Job title updates. Policy to be ratified at Trust Board upon approval.							

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 8

RESEARCH, EVALUATION AND INNOVATION ANNUAL REPORT

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Dr Dennis Okolo / Chief Medical Officer
Prepared by:	Corrina Bentley / Acting R&D Lead
Executive Lead:	Dr Dennis Okolo / Chief Medical Officer

Aligned to Board Assurance Framework Risk:	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.
7 Levels of Assurance:	Level 3 - Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Approval / Review:	SLT, Quality Committee
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	The Trust is a key partner of Staffordshire and Stoke on Trent, Shropshire, Telford and Wrekin Health Economy Research Partnership (SSHERPa) and continues to support collaborative and joint working objectives through this network.
Recommendation / Required Action:	Trust Board is asked to receive this report and note progress against the R&D Roadmap, recruitment figures, development of relationships with local and regional partners, and other key achievements in

	research, evaluation and innovation during 2024/25.
Executive Summary:	This report is shared in order to highlight progress made during 2024/25 against the R&D Roadmap, research recruitment, engagement with research, and other achievements in relation to research, evaluation and innovation. Key highlights are: • Changes to R&D establishment, including the creation of a new Research Portfolio Manager role (0.4WTE) and the confirmation of the Project Support Manager's role as substantive. • Continued support for two clinical academic posts (0.2WTE), plus an additional post supported by the postholder's Directorate. • Continued development of NIHR capacity and capability through links with the Staffordshire and Stoke on Trent, Shropshire, Telford and Wrekin Health Economy Research Partnership (SSHERPa) and local partners, including a joint Research Nurse post hosted by MPFT. • Developing relationships with vertically integrated primary care practices and community lounges. • Supporting regional partnerships, including the successful bid to establish one of the UK's new NIHR Commercial Research Delivery Centres. • Sustained increase in recruitment to research studies with 215 participants recruited in 2024-25. • A spotlight on the Social Cognition and Functioning and Alzheimer's Dementia (SOCIAL) study, for which the local Principal Investigator was Jessica Corden, and for which we successfully recruited in excess of target. • Further development of our research sponsorship programme, in preparation for launch in 2025-26, including the delivery of a Chief Investigator development training programme. • Journal articles and other publications produced by Trust staff. • A spotlight on the Community Mental Health Framework Transformation Review, an evaluation supported by the R&D Team. • The 2024 joint Research, Innovation, Quality Improvement and Clinical Audit event "Motivating Combined", which took place on 16 October 2024 and was very well received. • Six projects supported through the Trust's Dragons' Den programme. • A spotlight on "Enabling Family Carers to Safely and Proactively Support Those Who Can Show Behaviours of Concern at Home", a project supported through the Trust's Dragons Den programme led by Jessica Lister. A review of progress against 2024/25 objectives is provided alongside objective setting for 2025/6, with a focus on rollout of the new Research Sponsorship programme, review and reinvigoration of the R&D

	Roadmap (including an exploration of challenges such as the reliance on annually allocated RRDN funding), further work to embed research into our vertically integrated primary care practices, consolidating relationships with local and regional partners, and working with the Trust pharmacy to support them to become “research ready”. This report was previously received by Senior Leadership Team on 28 October 2025 Please find link to report below: Research and Development Annual Report

VERSION CONTROL:

Version	Report to	Date Reported
1	Senior Leadership Team, Quality Committee	
2	Public Trust Board	03.11.25

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 9

Improving Quality and Performance Report (IQPR) M06 2025/26

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

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

Aligned to Board Assurance Framework Risk:	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.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Performance Review meeting – 21 October 2025
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:	Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	The IQPR is provided to the ICS on a monthly basis to provide assurance on Trust performance against key national priorities as part of the ICS contract reporting requirements.
Recommendation / Required Action:	The Trust Board is asked to note the contents of the report.
Executive Summary:	This report summarises the key highlights and exceptions in the M06 IQPR, and performance for the national mental health priorities against

operational planning forecasts.

There is one special cause variation (orange variation flags) – signifying concern.

- Appraisal

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

- CYP Eating Disorders-Referral to Assessment (Urgent) 1 Week
- CYP Eating Disorders-Referral to Assessment (Routine) 4 Weeks
- Vacancy Rate
- Staff Turnover
- Sickness Absence
- Statutory and Mandatory Training

Highlights

- Referral to treatment within 18 weeks remains above standard at 96.3% and continues to improve from 96.1% in M05.
- CAMHS compliance within 18 weeks has met the required standard in M06 at 94.0% from 88.6% in M05.
- CYP Eating Disorders-Referral to Assessment 1 week and 4 weeks has achieved 100% throughout Quarter 2.
- Early Intervention has achieved 90.2% during M06.
- Talking Therapies reliable recovery and reliable improvement has achieved the required standard during M06.
- 48-hour and 7-day follow up metrics achieved 100% in M06.
- Care plan compliance has achieved the 95% standard in M06 for the fourth consecutive month.
- Risk Assessment compliance has improved to 96.4% in M06 compared to 96.2% in M05.
- Average Length of Stay for older adults is well within the 90-day standard at 46 days during M06. Adult length of stay is 37 days in M06.
- There are no complaints exceeding the 40-day response time in M06.
- Friends and family recommended rate continues to improve to 87.6% during M06.
- Vacancy rate continues to improve to 5.1% during M06 compared to 7.6% during M05.
- Staff turnover has improved in M06 at 8.1% compared to 8.5% during M05.
- Statutory and mandatory training remains static at 90% in M06.
- DQMI has improved to 98.5% during M03 (latest published

data).

- Sickness absence (12 month) has improved to 6.14% in M06 from 6.25% in M06.

Exceptions

- Referral to Assessment within 4 weeks performance has improved to 94.5% during M06, compared 92.4% in M05, but remains below Trust standard.
- Clinical Supervision remains static at 81.0% during M06 and remains below trust standard.
- Appraisal has fallen to 78.0% during M06, which is the lowest recorded rate in over 4 years. It was 84% in M05.

Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts M06 2025/26

M06 performance against the forecasts submitted to the ICB and NHSE for 2025/26. To note:

- **Out of Area Placements -** There were 17 reportable out of area placements at the end of M06, all due to the availability of adult acute beds.

- **Inpatient Stays -** The average length of stay (LoS) for this metric has not met standard in M06 achieving 43 against the plan of 39. This is due to long LoS discharges in the previous months.

- **Perinatal Access -** The perinatal access metric has met standard in M06, achieving 770 against the plan of 608.

- **CYP in contact -** This metric has met standard in M06 achieving 8,897 against the plan of 7,955.

- **Individual Placement Support Access -** This metric is set against the Integrated Care Board (ICB) performance plan, achieving 760 against a plan of 883 in M06. As performance is under plan, operational management reports have been created by the Performance team in NSCHT to help drive improvement in activity. However, there are workforce issues and NHSE and the ICB are aware that the team is unable to meet this year's plan with existing workforce available and prescribed caseload sizes.

The report is provided to Quality Committee and People, Culture and Development Committee in addition to Finance and Resource Committee.

VERSION CONTROL:

Version	Report to	Date Reported
V1.0	Finance & Resource Committee	27 October 2025
V2.0	Public Trust Board	6th November 2025

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M06 (September 2025)

Contents

Using Statistical Process Control (SPC)

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

Variation Icons

Assurance Icons

There is one special cause variation (orange variation flags) – signifying concern.

1. Appraisal

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

1. Risk Assessment Compliance
2. Vacancy Rate
3. Staff Turnover
4. Sickness Absence
5. Statutory and Mandatory Training

There are six 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 and Primary Care directorates
3. Complaints - Nursing and Quality directorate
4. Clinical Supervision - Acute and Urgent Care, Community and Specialist Services directorates
5. Care Plan Compliance - Specialist directorate
6. Out of Area Placements – Acute and Urgent Care and Community directorates

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	12 met, 2 unmet		
Highlights	Referral to Treatment within 18 weeks	92%	96.3%
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92%	94.0%
	CYP Eating Disorders-Referral to Assessment (Urgent) 1 Week	95%	100.0%
	CYP Eating Disorders-Referral to Assessment (Routine) 4 Weeks	95%	100.0%
	MH Liaison 1 hour response (Emergency)	95%	95.0%
	MH Liaison 4 hour response (Urgent)	95%	97.6%
	MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	96.2%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60%	90.9%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48%	49.4%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	67%	70.5%
	48 Hour Follow Up	95%	100.0%
	7 day follow up (All Patients)	95%	100.0%
Exceptions	Referral to Assessment within 4 weeks	95%	94.5%
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95%	90.1%

Community & Quality			
SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	2 Met, 0 unmet		
Highlights	Care Plan Compliance	95%	95.6%
	Risk Assessment Compliance	95%	96.4%
Exceptions	There are no exceptions to report		

Inpatient & Quality			
SPC variations signifying concern	Metric	Standard	Performance
RAG rated standards	3 met, 0 unmet		
Highlights	Average Length of Stay - Older Adult	90	46
	Emergency Readmissions rate (30 days)	<7.5%	2.3%
	Average Length of Stay - Adult	40	37
Exceptions	There are no exceptions to report		

Organisational Health & Workforce			
SPC variations signifying concern	Metric	Standard	Performance
	Appraisal	85%	78.0%
RAG rated standards	6 met, 3 unmet		
Highlights	Complaints Open Beyond Agreed Timescale	0	0
	Friends and Family Test	80%	87.6%
	Vacancy Rate	<10%	5.1%
	Staff Turnover	<10%	8.1%
	Statutory and Mandatory Training	85%	90.0%
	DQMI	95%	98.5%
Exceptions	Sickness Absence (12-month)	<4.95%	6.14%
	Clinical Supervision	85%	81.0%
	Appraisal	85%	78.0%
	Safe Staffing	95%-105%	102.8%

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
ACUD directorate	Sickness Absence (in-month)	<4.95%	5.96%
	Clinical Supervision	85%	80.0%
Community directorate	Referral to Assessment within 4 weeks-CYP	95%	71.9%
	Referral to Assessment within 4 weeks-Adult	95%	93.2%
	Clinical Supervision	85%	79.0%
ACUD and Community	Number of inappropriate OOAs during month	2	16
ACUD and Community	Number of inappropriate OOAs at EOM (national measure)	2	17

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
Specialist Services directorate	Referral to Assessment within 4 weeks	95%	79.2%
	Sickness Absence (in-month)	<4.95%	7.29%
	Care Plan Compliance	95%	93.0%
	Clinical Supervision	85%	85.0%
Nursing and Quality directorate	Complaints Open Beyond Agreed Timescale	0	0
Primary Care directorate	Sickness Absence (in-month)	<4.95%	6.00%

Core Indicators – Monthly

Domain	Indicator	Target	Jul-25	Aug-25	Sep-25	Assurance	Variation
Access & Wait Times	Referral to Assessment within 4 weeks	95%	93.3%	92.4%	94.5%		
	Referral to Treatment within 18 weeks	92%	95.9%	96.1%	96.3%		
	CAMHS Compliance within 4 Week Waits (RTA)	95%	91.1%	78.2%	90.1%		
	CAMHS Compliance within 18 Week Waits (RTT)	92%	92.8%	88.6%	94.0%		
	CYP Eating Disorders-1 Week (Urgent)	95%	N/A	N/A	100.0%	Run chart	Run chart
	CYP Eating Disorders-4 Weeks (Routine)	95%	N/A	N/A	100.0%	Run chart	Run chart
	MH Liaison 1-hour response (Emergency)	95%	95.3%	95.8%	95.0%		
	MH Liaison 4-hour response ((Urgent)	95%	96.0%	95.5%	97.6%		
	MH Liaison 24-hour response (Urgent from General Hospital Ward)	95%	96.4%	96.5%	96.2%		
	Early Intervention-A maximum of 2 Week Waits for Referral to Treatment	60%	94.7%	75.0%	90.9%		
	48 Hour Follow Up	95%	100.0%	100.0%	100.0%		
	7 Day Follow Up (All Patients)	95%	100.0%	100.0%	100.0%		
	Talking Therapies for Anxiety and Depression Reliable Recovery Rate	48%	53.7%	51.9%	49.4%	Run chart	Run chart
	Talking Therapies for Anxiety and Depression Reliable Improvement	67%	77.4%	73.2%	70.5%	Run chart	Run chart

Domain	Indicator	Target	Jul-25	Aug-25	Sep-25	Assurance	Variation
Inpatient & Quality	Average Length of Stay - Adult	40	49	27	37		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	22.2%	12.8%	23.7%	Run chart	Run chart
	Average Length of Stay - Older Adults	90	56	55	46		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	30.4%	18.2%	14.3%	Run chart	Run chart
	Emergency Readmissions rate (30 days)	7.5%	3.9%	0.8%	2.3%		
	Clinically Ready for Discharge (CRFD)	No Target	22.2%	28.5%	25.5%	Run chart	Run chart

Domain	Indicator	Target	Jul-25	Aug-25	Sep-25	Assurance	Variation
Community & Quality	Care Plan Compliance	95%	95.0%	95.6%	95.6%		
	Risk Assessment Compliance	95%	95.7%	96.2%	96.4%		
	Comprehensive Safety Review	No Target	0	3	3	Run chart	Run chart
	Proportionate Reviews	No Target	9	2	2	Run chart	Run chart

Domain	Indicator	Target	Jul-25	Aug-25	Sep-25	Assurance	Variation
Organisational Health & Workforce	Complaints Open Beyond Agreed Timescale	0	1	1	0	Run chart	Run chart
	Friends and Family Test-Recommended	80%	86.4%	82.5%	87.6%		
	Safe Staffing	95%-105%	103.9%	103.8%	102.8%	Run chart	Run chart
	Vacancy Rate	<10%	8.0%	7.6%	5.1%		
	Staff Turnover	<10%	8.9%	8.5%	8.1%		
	Sickness Absence	<4.95%	6.27%	6.25%	6.14%		
	Clinical Supervision	85%	79.0%	81.0%	81.0%		
	Appraisal	85%	81.0%	84.0%	78.0%		
	Statutory and Mandatory Training	85%	90.0%	90.0%	90.0%		

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

	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	16	11	19	16	22	12	17						
			Variance	-14	-9	-17	-14	-20	-10	-15						

	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	8,867	8,407	8,338	9,483	9,693	9,263	8,019						
			Variance	-872	-412	-343	-1,488	-1,698	-1,268	-24						
			Nationally Published	9,042	8,405	8,340	9,505	9,695	9,265							
	Number of discharges in the RP		*Plan*	205	205	205	205	205	205	205	205	205	205	205	205	205
			Actual	185	202	188	181	171	182	186						
			Variance	20	3	17	24	34	23	19						
			Nationally Published	184	200	190	180	170	180							
	Mean Length of stay for discharges in the RP		*Plan*	39	39	39	39	39	39	39	39	39	39	39	39	39
			Actual	48	42	44	53	57	51	43						
			Variance	-9	-3	-5	-14	-18	-12	-4						
			Nationally Published	49	42	44	53	57	51							

	Perinatal access	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
3	Number of people accessing specialist community PMH and MMHS services in the RP	12-month rolling	*Plan*	608	608	608	608	608	608	608	608	608	608	608	608	608
			Actual	728	682	701	722	746	747	770						
			Variance	120	74	93	114	138	139	162						
			Nationally Published	698	660	680	700	725	725							

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

	CYP Access	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	12-month rolling	*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	8,654	8,515	8,489	8,605	8,706	8,713	8,897						
			Variance	699	560	534	650	751	758	942						
			Nationally Published	8,617	8,520	8,505	8,620	8,715	8,725							

	Individual Placement Support Access	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5	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
			NSCHT Actual	371	389	388	382	364	365	337						
			MPFT Actual	400	395	388	400	386	408	423						
			ICB Actual	771	784	776	782	750	773	760						
			Variance	-86	-36	-51	-64	-115	-110	-142						
			ICB Nationally Published	779	785	780	790	760	780							
			NSCHT Nationally Published	378	390	390	380	365	365							

**Nationally published performance has been included where applicable.*

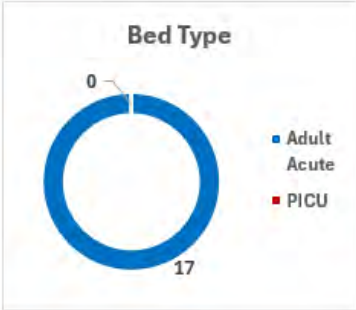
Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (1 of 3)

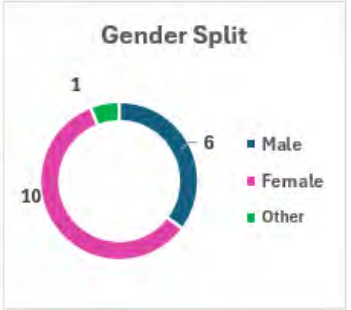
- **Out of Area Placements (OOA)** – There were 17 reportable out of area placements at the end of M06 - all due to the availability of adult acute beds.

  This reflects the pressure across the system and on the acute and urgent care directorate (ACUD). There is a low number of adult acute beds at the present time due to Project Chrysalis (89 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 M06, 20.1% 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 was initiated in M04 for ACUD 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.

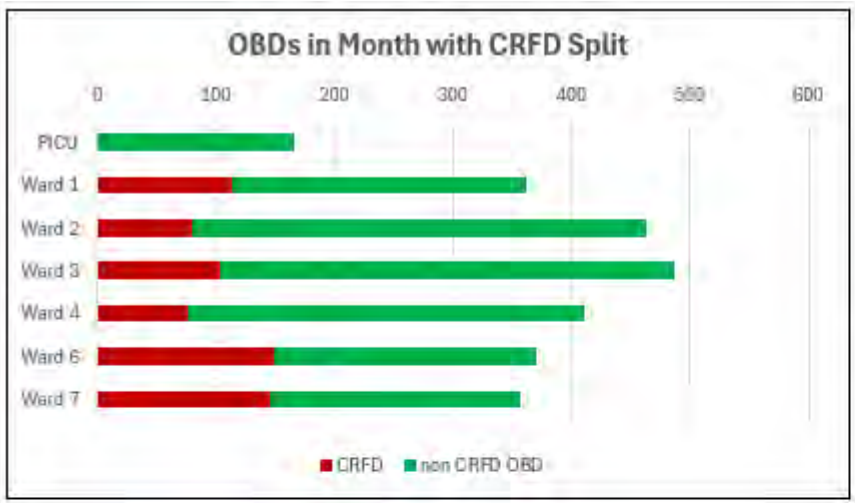
Key	Name of Hospital	Distance from Harplands *(mi)*	No. of Placements
	Cygnet Acer	65	1
	Cygnet Hospital Kidsgrove	9	10
	Cygnet Sherwood	61	1
	Priory Arnold	61	4
	Priory Nottingham	56	1
	Harplands Hospital		***Total: 17***

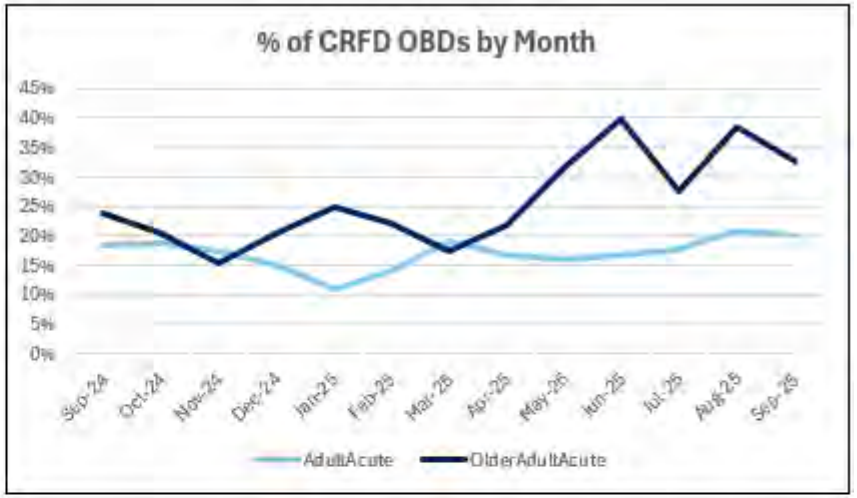


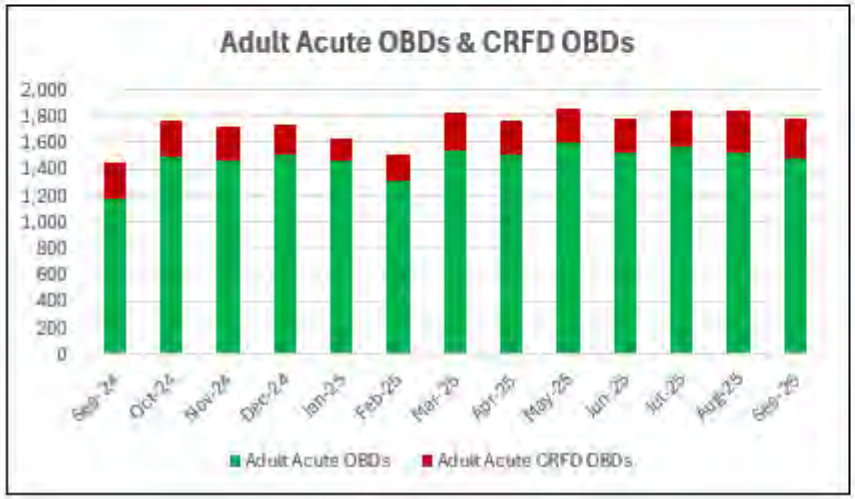


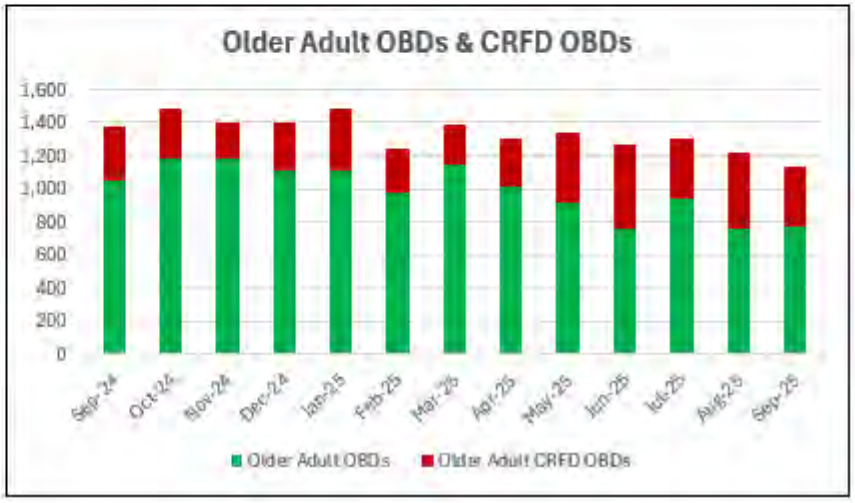
Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 – Supporting Information: Clinically Ready for Discharge (CRFD) (2 of 3)

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-on-Trent City Council have been collaborating with us to reduce the high number of Stoke CRFDs. This is a positive development; however, there remain market pressures due to the lack of availability of residential and nursing home placements in Stoke and access to funding to support care packages in the community and this has been escalated to the ICB.









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 M06 achieving 43 from 51 in M05, against the plan of 39. This is due to long LoS discharges in the previous months.

- **Perinatal Access –** The perinatal access metric has met standard in M06, achieving 770 against the plan of 608.

- **CYP in contact –** This metric has met standard in M06 achieving 8,897 against the plan of 7,955.

- **Individual Placement Support (IPS) Access** – This metric is set against the Integrated Care Board (ICB) performance plan, achieving 760 against a plan of 883 in M06. As performance is under plan, operational management reports have been created by the Performance team in NSCHT to help drive improvement in activity. However, there are workforce issues and NHSE and the ICB are aware that the team is unable to meet this year's plan with the existing workforce available and prescribed caseload sizes.

Core Indicators – Trends

Indicator	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-26	Aug-25	Sep-25
Referral to Assessment within 4 weeks	95%	93.9%	94.9%	95.9%	92.2%	90.0%	91.7%	93.1%	94.2%	94.7%	93.5%	93.3%	92.4%	94.5%
Referral to Treatment within 18 weeks	92%	94.5%	94.2%	95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%	95.4%	95.9%	96.1%	96.3%
CAMHS Compliance within 4 Week Waits	95%	89.2%	90.7%	92.0%	76.4%	67.3%	76.2%	85.7%	91.1%	90.9%	92.0%	91.1%	78.2%	90.1%
CAMHS Compliance within 18 Week Waits	92%	87.3%	86.5%	87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%	85.9%	92.8%	88.6%	94.0%
MH Liaison 1 Hour response (Emergency)	95%	95.1%	95.6%	92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%	95.0%	95.3%	95.8%	95.0%
MH Liaison 4 hour response (Urgent)	95%	97.1%	95.6%	91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%	93.8%	96.0%	95.5%	97.6%
MH Liaison 24 hour response (Urgent from General Hospital Ward)	95%	97.3%	96.2%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%	96.0%	96.4%	96.5%	96.2%
CYP Eating Disorders-1 Week (Urgent)	95%	100.0%	N/A	N/A	83.3%	N/A	N/A	72.7%	N/A	N/A	100.0%	N/A	N/A	100.0%
CYP Eating disorders-4 Weeks (Routine)	95%	90.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	97.3%	N/A	N/A	100.0%
Early Intervention-A maximum of 2 Week Waits for Referral to Treatment	60%	89.0%	100.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%	95.0%	94.7%	75.0%	90.9%
48 Hour Follow Up	95%	94.2%	94.7%	100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%	96.4%	100.0%	100.0%	100.0%
7 Day Follow Up (All Patients)	95%	96.2%	98.4%	100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%	96.4%	100.0%	100.0%	100.0%
Talking Therapies for Anxiety and Depression Reliable Recovery Rate	48%	53.0%	50.7%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%	51.6%	53.7%	51.9%	49.4%
Talking Therapies for Anxiety and Depression Reliable Improvement	67%	74.5%	71.2%	74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%	73.9%	77.4%	73.2%	70.5%
Average Length of Stay - Adult	40	41	20	28	33	42	24	28	41	34	62	49	27	37
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	16.0%	5.0%	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%	16.7%	22.2%	12.8%	23.7%
Average Length of Stay - Older Adults	90	56	64	51	48	57	75	59	41	81	70	56	55	46
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	22.0%	21.0%	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%	21.1%	30.4%	18.2%	14.3%
Emergency Readmissions rate (30 days)	<7.5%	1.4%	1.4%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%
Clinically Ready for Discharge (CRFD)	No Target	20.9%	19.5%	16.3%	17.6%	18.0%	17.8%	18.3%	19.2%	23.3%	27.2%	22.2%	28.5%	25.5%
Care Plan Compliance	95%	96.1%	96.2%	96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%	95.0%	95.0%	95.6%	95.6%
Risk Assessment Compliance	95%	92.7%	94.1%	94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%	96.0%	95.7%	96.2%	96.4%
Comprehensive Safety Review	No Target	3	5	1	5	4	2	3	2	5	6	0	3	3
Proportionate Reviews	No Target	3	2	3	2	4	3	5	2	7	6	9	2	2
Complaints Open Beyond Agreed Timescale	0	0	1	3	2	1	5	4	3	2	5	1	1	0
Friends and Family Test-Recommended	80%	89.0%	83.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%	81.5%	86.4%	82.5%	87.6%
Safe Staffing	95%-105%	104.6%	98.3%	100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%	107.4%	103.9%	103.8%	102.8%
Vacancy Rate	<10%	9.8%	7.9%	8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%	8.2%	8.0%	7.6%	5.1%
Staff Turnover	<10%	10.2%	10.2%	10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%	8.9%	8.9%	8.5%	8.1%
Sickness Absence	<4.95%	5.58%	5.74%	5.85%	6.05%	6.21%	6.32%	6.39%	6.39%	6.35%	6.33%	6.27%	6.25%	6.14%
Clinical Supervision	85%	83.0%	85.0%	82.0%	79.0%	85.0%	82.0%	79.0%	81.0%	83.0%	80.0%	79.0%	81.0%	81.0%
Appraisal	85%	87.0%	87.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	84.0%	83.0%	81.0%	84.0%	78.0%
Statutory and Mandatory Training	85%	88.0%	87.0%	87.0%	89.0%	89.0%	89.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%
DQMI	95%	97.2%	97.5%	97.2%	98.4%	98.3%	98.3%	98.4%	98.6%	98.4%	98.5%	N/A	N/A	N/A

In M06 there are 34 metrics monitored; 22 have achieved the required standard (see achieved in month) and 5 have not achieved the required standard (see exceptions in month). 5 metrics have no target and are being monitored. 1 metric is being monitored. 1 metric is provided by NHS England with the current month not yet published.

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 July 2025. The aim is for achievement of the 95.0% standard by August 2025 this has been extended to January 2026. Performance is 79.2% during M06 which is not meeting the 91.0% trajectory or 95.0% required standard. Updated actions have been provided in M06.
	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, July 2025, September 2025 and beyond April 2026. Trajectories were set in April 2024 and have been revised in May 2025 for the period covering May to September 2025. Trajectories have been revised in July 2025 covering the period August to April 2026. CYP performance is 71.9% during M06 which is meeting the 70.0% planned trajectory but not the 95.0% required standard. Updated actions have been provided in M06.
	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 93.2% during M06. Although performance is not meeting the 95.0% required standard, the planned 85% trajectory has been exceeded and there has been a significant improvement when compared to last month (78.8%) performance. Updated actions have been provided in M06.
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.

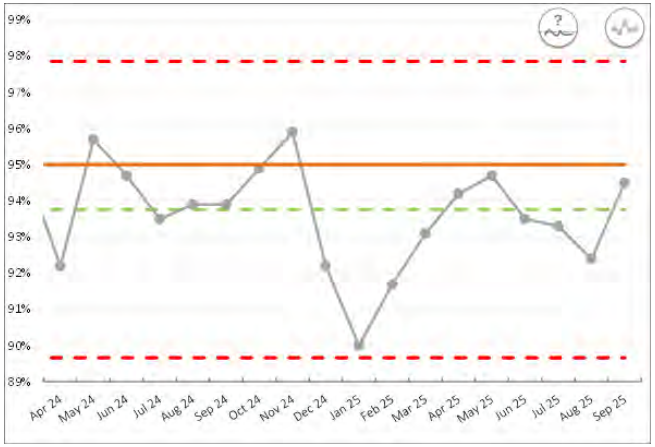
Metric	Directorate	Status
		Sickness absence 12-month rolling period during M06 is 7.69% and 5.96% in-month. The in-month trajectory of 7.4% is being met. The 6.9% 4-year average is being met. The Trust standard of <4.95% is not being met. The 12-month required standard is not being met.
	Primary Care	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 M06 is 6.61% and 6.00% in-month. The in-month trajectory of 5.1% is not being met. The 4.4% 4-year average is not being met. The Trust standard of <4.95% is not being met. The 12-month required standard is not being met. Updated actions have been provided in M06.
	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 M06 is 7.00% and 7.29% in-month. The in-month trajectory of 6.7% is not being met. The 6.0% 4-year average is not being met. The Trust standard of <4.95% is not being met. The 12-month required standard is not being met. Updated actions have been provided for M06.
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 M06 there are no complaint responses exceeding the 40-day response timescale. Performance is meeting the required trajectory and required standard. Updated actions have been provided in M06.
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 and further extended to December 2025, revised in M06 to October 2025. Trajectories were set in February 2025 and have been updated for August and September. Trajectories were updated in July covering the period August to December 2025. Trajectories have been updated in M06 covering the period September to December 2025. Performance during M06 is 79.0% and has not met the 84.0% planned trajectory or the 85.0% required standard. Updated actions have been provided in M06.
	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 M06 is 80.0%.and is not meeting the planned 83.0% trajectory or 85.0% required standard.

Metric	Directorate	Status
		Updated actions have been provided in M06.
	Specialist Services	A PIP was requested in M04 (2025/26). Trajectories have been set for the period July to October 2025. Specialist directorate aims for the standard to be met by October 2025. Performance during M06 is 85.0% which has met the 85.0% required standard for the second consecutive month. Updated actions have been provided in M06.
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 and this has been extended to January 2026. 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. Trajectories have been reset in July covering the period August to January 2026. Performance during M06 is at 93.0% and is meeting the 93.0% planned trajectory and not meeting the 95.0% required standard. Updated actions have been provided in M06.
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 M06 is £87k total agency against £80k target. Updated actions have been provided in M06. It was agreed at M06 Performance Review meeting to close the PIP.
Out of Area Placement (OOAs)	Acute and Urgent Care and Community	A PIP was requested in M04 (2025/26). Performance during M06 is measured by the number of inappropriate OOAs during month and the number of inappropriate OOAs at EOM (national measure) which were 16 and 17, respectively. There were 17 reportable OOAs at the end of M06. Updated actions have been provided in M06.

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

Referral to Assessment within 4 weeks (Trust indicator)

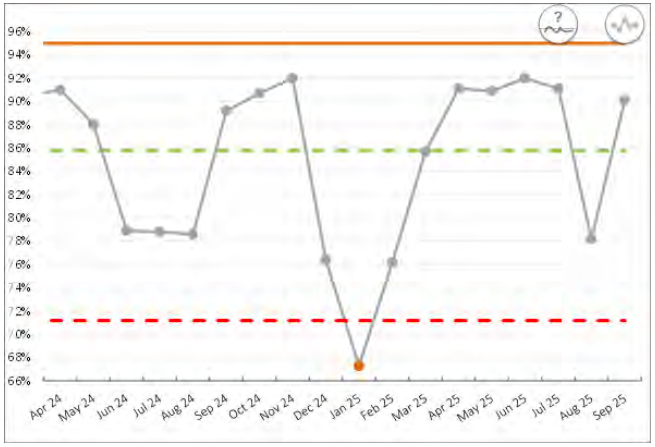


Performance is at **94.5%** in M06. The variation is showing as common cause.

Current Performance: Community-89.6%, Specialist-79.2%, Acute and Urgent Care-97.8%.

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

CAMHS Compliance within 4 weeks Waits (Trust indicator)



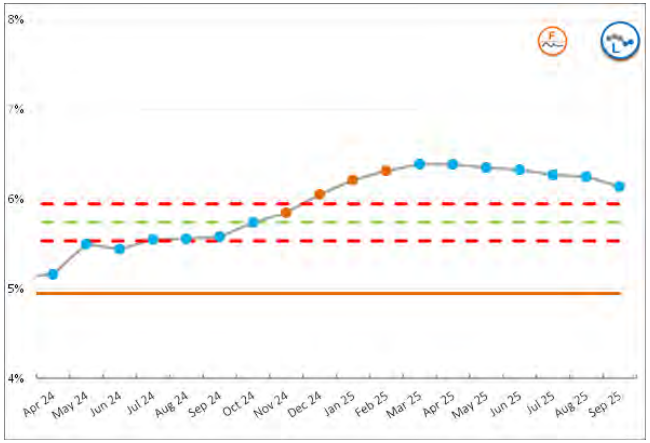
Performance is at **90.1%** in M06. The variation is showing as common cause.

Current performance: Community-71.9%, Specialist-N/A, Acute and Urgent Care-97.5%.

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

A PIP is in place for Community directorate.

Sickness Absence (Trust indicator)



Sickness absence performance is at **6.14%** in M06. A special cause variation of improvement remains in place.

Current performance: Community-5.78%, Specialist-7.00%, Acute and Urgent Care-7.69%, Primary Care-6.61%, Corporate-3.24%.

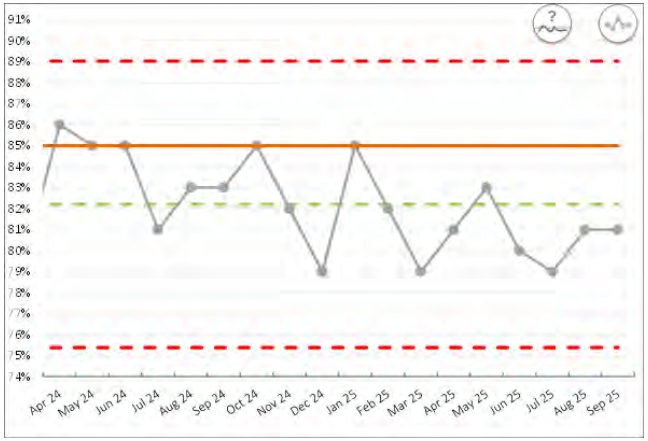
Reducing sickness absence is a core priority for the Trust and features as a key programme of work in the refreshed People Plan presented at PCDC Committee in September. Approval will enable agility in the people operating model to deploy specific support to lead improvements.

Enabling resolution of long-term sickness remains a focus, including a case-by-case review. Work continues to progress with benchmarking the Trust's policy for managing sickness to ensure process aligns to service needs whilst maintaining individual support for the impacted member of staff.

Within directorates, clinics and support for individual cases continues to be offered to ensure consistency in application of the policy.

PIPs remain in place for Acute and Urgent Care, Specialist Services and Primary Care directorates.

Clinical Supervision (Trust indicator)



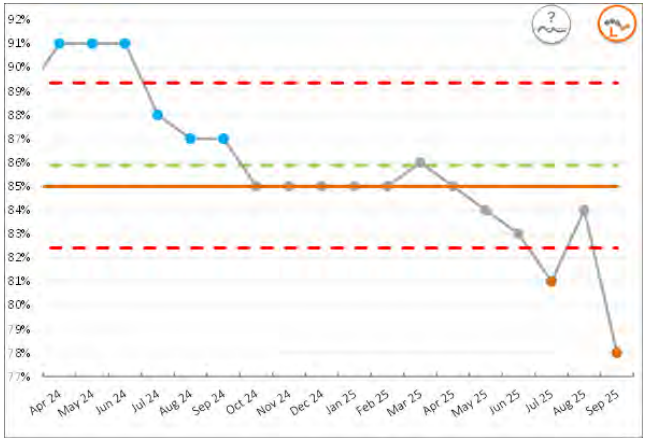
Performance is at **81.0%** in M06. The variation is showing as common cause.

Current performance: Community-79.0%, Specialist-85.0%, Acute and Urgent Care-80.0%, Primary Care-85.0%, Corporate-57.0%.

Reports identifying non-compliance rates and names of those non-compliant and their line managers are sent to the associate directors and line managers fortnightly for action. Clinical Supervision survey report was completed in September. Early insight into the survey results indicate that a high number of staff are reporting that clinical supervision is of good quality when they receive it. Action plan to be developed for approval at the Strategic Education, Apprenticeship and Learning group in December 2025.

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

Appraisal (Trust indicator)



Performance is at **78.0%** in M06. The variation is showing a special cause variation of concern, as performance is operating outside of the lower control limit.

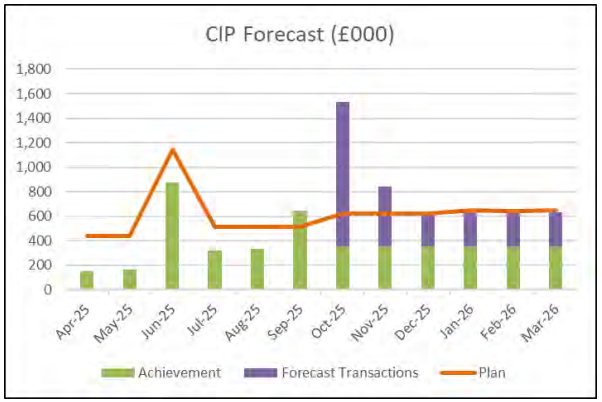
Current performance: Community-78.0%, Specialist-74.0%, Acute and Urgent Care-82.0%, Primary Care-81.0%, Corporate-57.0%.

Reports identifying non-compliance rates and the names of those non-compliant and their line managers are sent to the associate directors and line managers fortnightly for action. Guidance now includes actions to be undertaken by managers to address non-compliance and issues with due dates.

This advises staff that the annual appraisal window is open for 90 days: 30 days before the due date and 60 days after. Once the 60 days has passed the LMS automatically resets to the following year when it is next due, however the account remains non-compliant as no appraisal has taken place. Staff have been reminded to check the last appraisal date column – and if an appraisal has not taken place within a 12 month period, to complete the appraisal using the 'interim appraisal' and inform the educationhelpdesk@combined.nhs.uk advising the new date to be used as an annual appraisal. These measures are expected to improve compliance.

Financial Performance

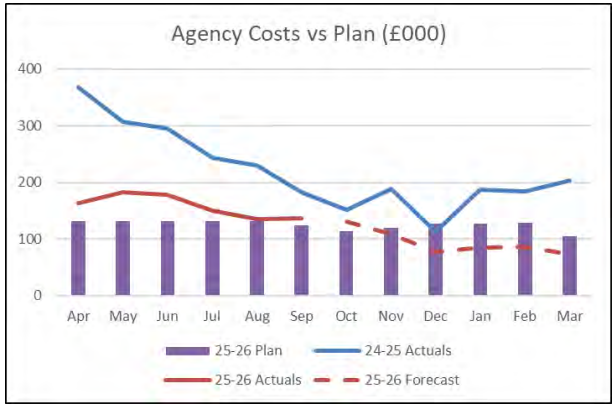
CIP Delivery v Plan



The CIP graph shows forecast against a £7.4m plan.

The Trust is forecasting full achievement of the plan, with current achievement (transacted) £4.6m, fully developed £2.1m, plans in progress £0.4m and opportunities identified £0.3m.

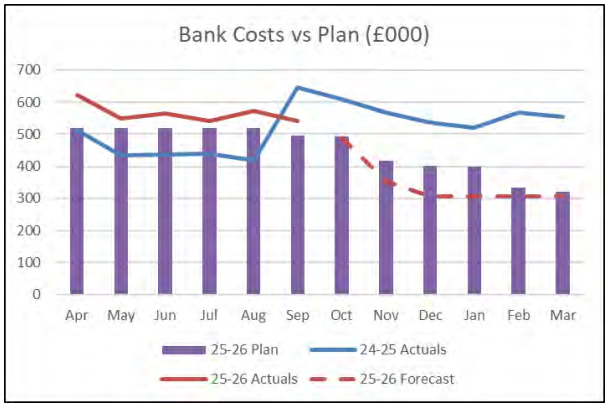
Agency Cost v Plan (40% reduction)



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

The Trust is forecasting total agency costs of £1.5m, with £1.0m Community, £0.2m Primary Care, £0.2m Specialist and £0.1m Trust wide.

Bank Cost v Plan (10% reduction)

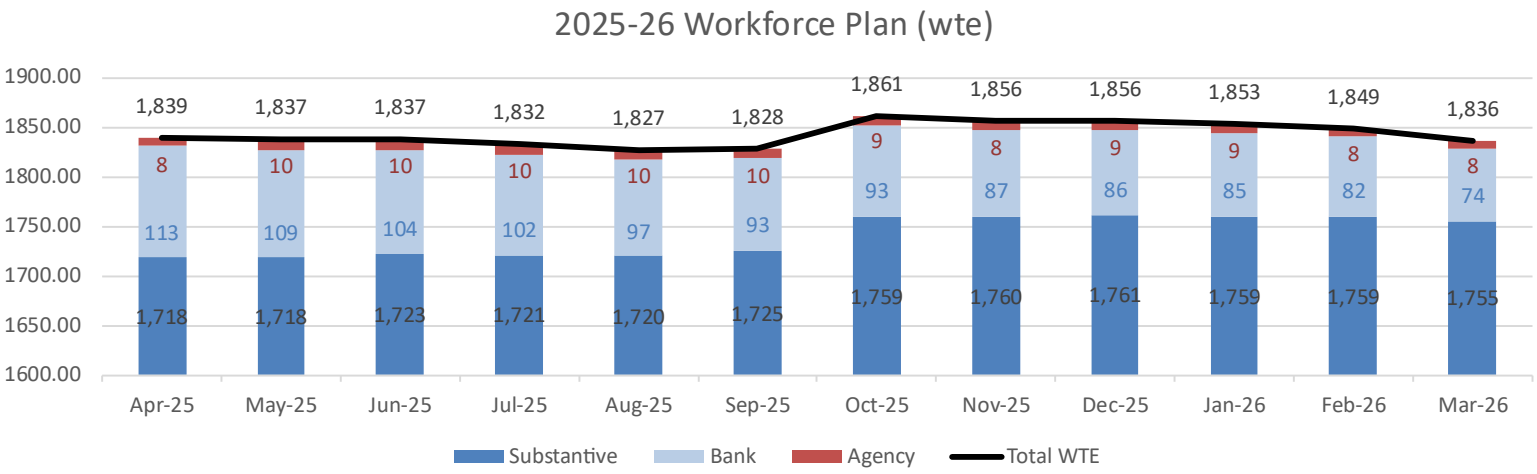


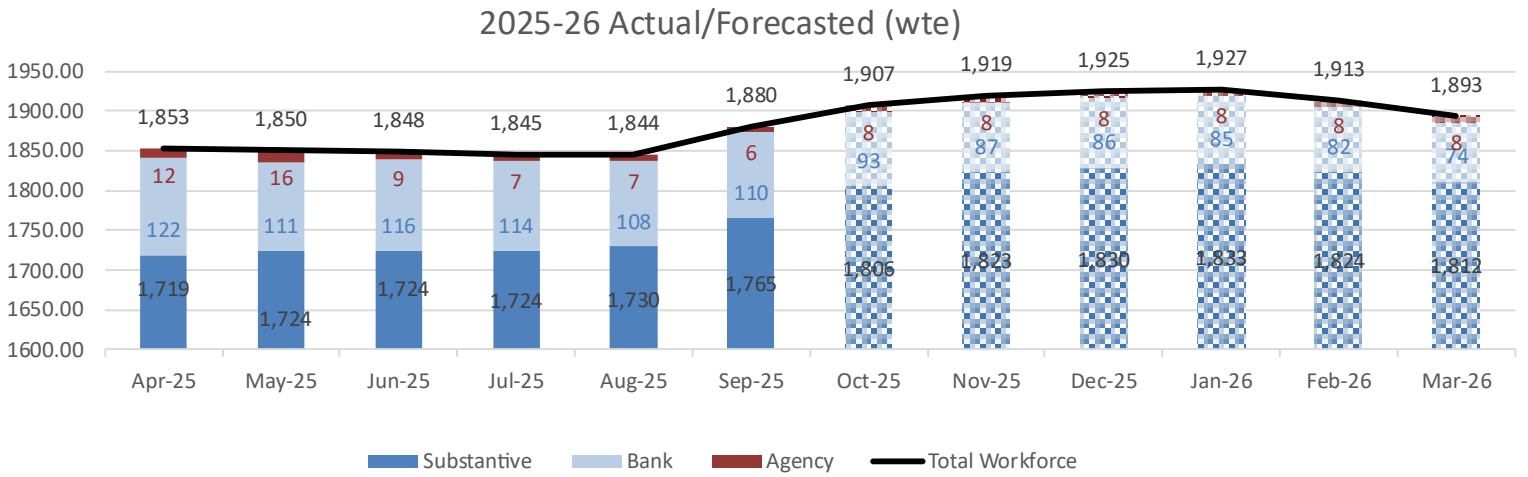
The bank graph shows forecast against a £5.4m plan.

The Trust is forecasting total bank costs of £5.4m, with £2.5m Acute, £1.9m Specialist, £0.5m Community, £0.2m Trust wide & £0.3m Corporate.

Workforce Actual vs Plan

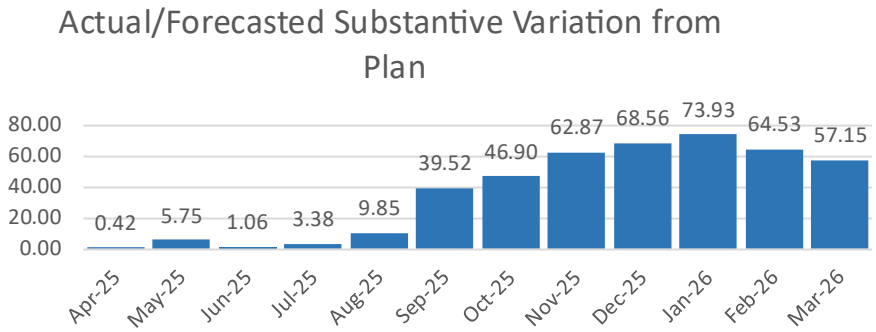
Sep-25	WTE				Spend						
	Plan	Actual	Variance From Plan		Plan	Actual	Variance From Plan				
NSCHT	WTE	WTE	WTE	%	£'000	£'000	£'000	%	WTE TO PLAN	£ TO PLAN	Misalignment of plans
Total	**1,828.3**	**1,880.3**	**+52.0**	**+2.8%**	**£54,742.0**	**54,122.0**	**-£620**	**-1.1%**	▲	▼	!
Substantive	**1,725.5**	**1,765.0**	**+39.5**	**+2.3%**	**£50,665.0**	**£49,782.0**	**-£883**	**-1.7%**	▲	▼	!
Medical and Dental	54.9	60.6	+5.7	+10.3%	£5,171.0	£5,516.0	+£345	+6.7%	▲	▲	
Registered nursing, midwifery and health visiting staf	529.9	551.0	+21.1	+4.0%	£15,408.0	£15,681.0	+£273	+1.8%	▲	▲	
Registered scientific, therapeutic and technical staff	304.5	299.7	-4.9	-1.6%	£10,613.0	£9,903.0	-£710	-6.7%	▼	▼	
Support to clinical staff	484.4	507.2	+22.8	+4.7%	£9,964.0	£9,393.0	-£571	-5.7%	▲	▼	!
Total NHS infrastructure support	348.3	343.2	-5.1	-1.5%	£9,509.0	£9,289.0	-£220	-2.3%	▼	▼	
Any other staff	3.4	3.4	0.0	0.0%	£0.0	£0.0	£0		▼	▼	
Bank	**93.1**	**109.7**	**+16.6**	**+17.8%**	**£3,251.0**	**£3,393.0**	**+£142**	**+4.4%**	▲	▲	
Medical and Dental	4.3	2.8	-1.5	-34.6%	£859.0	£587.0	-£272	-31.7%	▼	▼	
Registered nursing, midwifery and health visiting staf	20.3	21.5	+1.2	+5.9%	£2,251.0	£768.0	-£1,483	-65.9%	▲	▼	!
Registered scientific, therapeutic and technical staff	1.3	3.9	+2.6	+205.0%	£1.0	£131.0	+£130	########	▲	▲	
Support to clinical staff	64.9	77.6	+12.7	+19.6%	£98.0	£1,796.0	+£1,698	+1732.7%	▲	▲	
Total NHS infrastructure support	2.3	3.9	+1.6	+67.7%	£42.0	£111.0	+£69	+164.3%	▲	▲	
Any other staff	0.0	0.0	0.0		£0.0	£0.0	£0		▼	▼	
Agency	**9.7**	**5.6**	**-4.1**	**-42.0%**	**£826.00**	**£947.00**	**+£121**	**+14.6%**	▼	▲	!
Medical and Dental	6.6	4.2	-2.5	-37.2%	£767.00	£830.0	+£63	+8.2%	▼	▲	!
Registered nursing, midwifery and health visiting staf	2.8	0.5	-2.3	-82.5%	£59.00	£87.0	+£28	+47.5%	▼	▲	!
Registered scientific, therapeutic and technical staff	0.0	0.0	0.0		£0.00	£9.0	+£9		▼	▲	!
Support to clinical staff	0.3	1.0	+0.7	+206.3%	£0.00	£19.0	+£19		▲	▲	
Total NHS infrastructure support	0.0	0.0	0.0		£0.00	£2.0	+£2		▼	▲	!
Any other staff	0.0	0.0	0.0		£0.00	£0.0	£0		▼	▼	

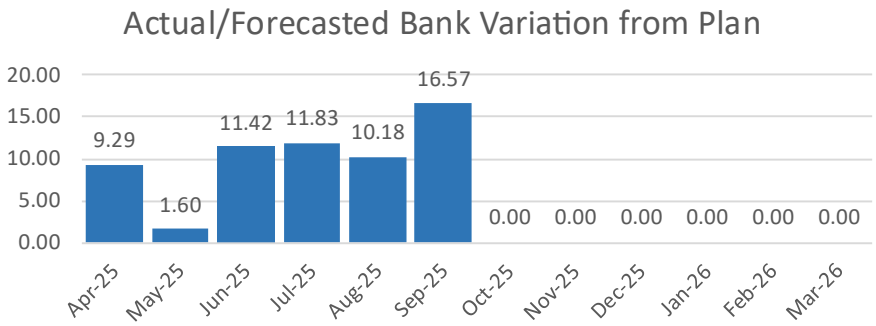


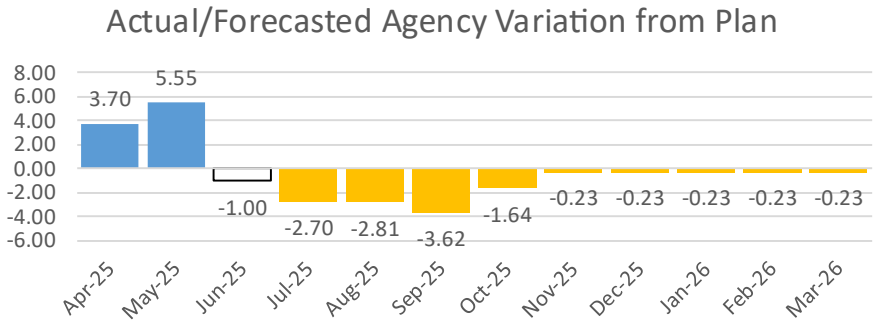


Workforce Plan submitted in comparison to the actual or forecasted position for the same period.

The forecasted position is based on information that is available from ESR, TRAC and Optima E-rostering and in line with the submission requirements. The GP surgeries have been excluded







As at M06 the Trust is 52wte over its total workforce plan. This consists of the substantive growth being 39.5 wte over plan and Temp Staffing cover being 12.5wte over plan.

Substantive growth for M06 includes 11 NQNs which will mitigate M07's expected growth. However, it is worth noting that 54 NQNS will be joining the Trust in this cohort whereas the plan only accounted for 49. Mid year analysis shows that of the 46wte growth that was originally forecasted, there has been an actual growth of 56wte by the end of M06.

Top reasons for temporary staffing cover for M06 are reported as a result of levels of establishment shortfall, high acuity and vacancies. The forecasted position will continue to be over plan for all but agency usage (based on current trends). There will be the substantive variation peak in January with the impact of the NQNs joining the Trust in September/October and new services being staffed within Specialist Services.

A mitigating factor that is not yet known is the outcome of the Mutually Agreed Resignation Scheme. This might impact the variation slightly as, at the point of submitting the plan, any known savings were applied for the year end position and not the end of Q3, as may be the case.

The position put forward in this forecast is based on current usage with a mitigation in place for the over-establishment of Band 5 Registered Nurses (circa 25wte).
There is no bank variation forecasted against the plan submitted. With the mitigation of the NQNs referenced above (Band 5 RNs), the plan is more achievable than it would have been without the over-establishment. This element will continue to be closely monitored.

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, July 2025, September 2025 and has since been revised to April 2026.

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%. Revised trajectories have been provided in M04 for the period August to April 2026. The trajectory is not anticipated to be met until after April 2026.

CYP performance is 71.9**%** during M06 which is above the planned trajectory but below the required 95.0% standard.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-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	86.3%	74.7%	75.6%	41.8%	29.2%	56.8%	60.2%	77.2%	79.4%	81.4%	75.6%	67.9%	71.9%
Trajectory	60.0%	70.0%	80.0%	90.0%	95.0%	56.8%	70.0%	80.0%	70.0%	80.0%	85.0%	90.0%	70.0%

The above table RAG rating measures actual performance against Trust target

New actions in M06

- Deep dive and review of process and standard operating procedure (SOP) for cancellation of appointments by service user/family (Dec 2025).
- Deep dive and review of did not attends (DNA) and adherence to the DNA SOP. **M06 progress update:** *Directorate to work with performance team to obtain DNA reports to support this work.*

Actions:

- Contacts to be recorded on Lorenzo in a timely manner. **M06 progress update:** *Team leads scrutinising weekly unset appointment data and taking appropriate action. Report provided to service managers for review.*
- Transfer all ADHD referrals to neurodevelopmental service line to a stand-alone team. Ensure effective caseload management for core CAMHS and clear distinguished reporting to understand demand for core CAMHS. **M06 progress update:** A*ll referrals are entered onto Lorenzo for ADHD team, ready to move over to the neurodevelopmental service line. All relevant staff identified to move over to the ADHD team and plans finalised. The service is ready to be mobilised the first week in November.*
- All teams to mirror North Staffs working by completing more ADHD digital contacts**. M06 progress update:** *All teams are doing this now. 50% increase in number of ADHD triage capacity by completing via telephone rather than face-face.*

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

Community directorate

Aug-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	321	57	7	4	389	82.5%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	18	3	0	1	22	81.8%
North Stoke CAMHS	15	2	0	1	18	83.3%
South Stoke CAMHS	5	10	1	0	16	31.3%
CAMHS Total	**38**	**15**	**1**	**2**	**56**	**67.9%**

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	8	0	0	0	8	100.0%
North Stoke CAMHS	5	0	2	0	7	71.4%
South Stoke CAMHS	3	4	0	0	7	42.9%
CAMHS Total	**16**	**4**	**2**	**0**	**22**	**72.7%**

Sep-25

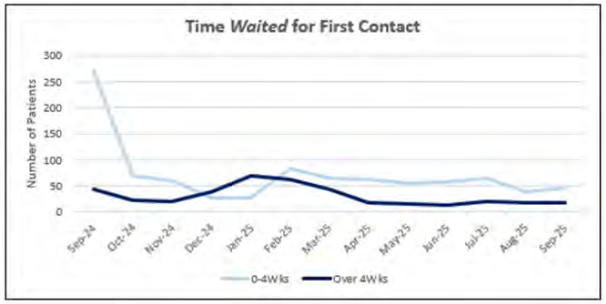
RTA Waited

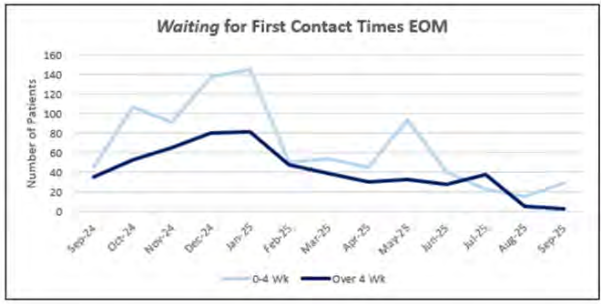
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	432	38	7	5	482	89.6%

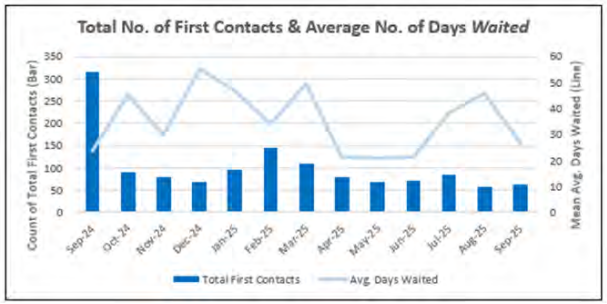
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	22	9	0	0	31	71.0%
North Stoke CAMHS	11	4	2	0	17	64.7%
South Stoke CAMHS	13	3	0	0	16	81.3%
CAMHS Total	**46**	**16**	**2**	**0**	**64**	**71.9%**

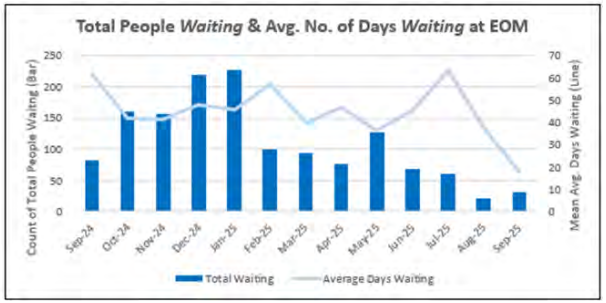
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	20	0	0	0	20	100.0%
North Stoke CAMHS	8	1	1	0	10	80.0%
South Stoke CAMHS	1	1	0	0	2	50.0%
CAMHS Total	**29**	**2**	**1**	**0**	**32**	**90.6%**









- The Community directorate's RTA performance had a significant increase of 7.1% when comparing M05 to M06, RTA performance against standard is however underperforming by 5.4%.
- Core CAMHs CMHTs have improved their RTA performance in M06 which is showing a 4.0% increase when compared to M05.
- The number of patients waiting for RTA to be completed is the lowest seen over the last 13 months, further improvements in RTA performance in M07 is expected when also considering that the number of open referrals has remained unusually low at the end of M06.

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 and 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%. Trajectories were updated for the period May to August 2025. Trajectories have been updated covering the period September to January 2026.

Adult performance is 93.2% during M06. Although performance is not meeting the 95.0% required standard, the planned 85% trajectory has been exceeded and there has been a significant improvement when compared to last month (78.8%) performance.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-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	93.2%	94.4%	94.9%	93.5%	90.5%	93.5%	92.7%	91.6%	92.1%	88.2%	82.5%	78.8%	93.2%
Trajectory	94.0%	95.0%	95.0%	95.0%	90.5%	91.0%	93.0%	94.0%	92.0%	93.0%	94.0%	95.0%	85.0%

The above table RAG rating measures actual performance against Trust target

New actions in M06

- Schedule more appointments with GP trainees to complete outstanding Standard Assessment Framework components (Dec 2025).
- Timely on-boarding of newly qualified nurses (NQNs) to enable new starters to support with demand and assessment capacity. **M06 progress update:** All NQN's now allocated team leads to work with individuals regarding start dates and team induction.
- Deep dive and review of did not attends (DNAs) and adherence to the DNA standard operating procedure (Dec 2025).

Actions:

- The Sutherland Centre to complete an initial assessment week in September. **M06 progress update:** *No patients have breached the 4-week wait (4ww) since 03/10/25 and all patients are currently being offered an assessment within two weeks of referral. The additional assessments within September have cleared the backlog of assessments. Referral to assessment (RTA) is monitored daily by clinical leads and a plan is in place with the wider team to offer capacity should additional assessment appointments be required.*
- Review of adherence to the triage and Initial Assessment pathway at Sutherland Centre. **M06 progress update:** *The triage process continues to have a positive impact, with referrals being reviewed daily. This proactive approach enables quicker identification of clear care plans, which in turn supports improved compliance with the 4WW target.*
- Review current team structures and manage resources across all CMHTs. **M06 progress update:** *The Single Assessment Framework (SAF) waitlist at Sutherland remains at approximately 12 weeks. The clinical lead is actively allocating work across the team to manage demand. At Lymebrook, the SAF waitlist is currently around 17 weeks. The clinical lead is actively allocating work across the team.*
- Pro-active and timely recruitment. **M06 progress update:** *Ongoing – vacancies continue to progress through TRAC. Greenfields has had several new starters last month who are currently settling into the team. Lymebrook* have recruited to receptionist post and duty post. OT interviews were unsuccessful so will be advertised again. Band 8b Clinical Psychologist (21.5 hours) post to be created and advertised using existing psychology budget from vacancy. Ashcombe have recruited to a Band 6 social worker post.

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

Community directorate

Aug-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	321	57	7	4	389	82.5%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	18	3	2	0	23	78.3%
City CMHT - Sutherland	19	14	3	0	36	52.8%
County CMHT Moorlands	20	1	0	1	22	90.9%
County CMHT Newcastle	47	2	1	1	51	92.2%
CMHT Total	**104**	**20**	**6**	**2**	**132**	**78.8%**

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	13	0	0	0	13	100.0%
City CMHT - Sutherland	14	5	0	0	19	73.7%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	4	1	0	0	5	80.0%
CMHT Total	**31**	**6**	**0**	**0**	**37**	**83.8%**

Sep-25

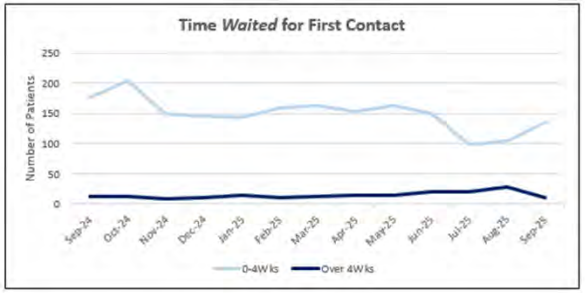
RTA Waited

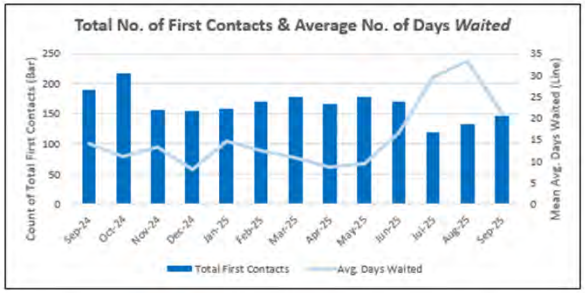
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	432	38	7	5	482	89.6%

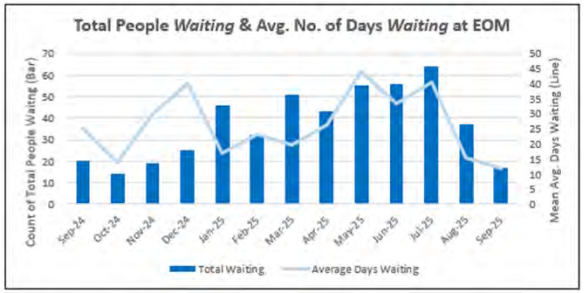
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	30	0	0	2	32	93.8%
City CMHT - Sutherland	26	4	0	0	30	86.7%
County CMHT Moorlands	36	0	1	1	38	94.7%
County CMHT Newcastle	44	1	1	0	46	95.7%
CMHT Total	**136**	**5**	**2**	**3**	**146**	**93.2%**

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	7	0	0	0	7	100.0%
City CMHT - Sutherland	5	0	0	0	5	100.0%
County CMHT Moorlands	1	0	0	0	1	100.0%
County CMHT Newcastle	2	2	0	0	4	50.0%
CMHT Total	**15**	**2**	**0**	**0**	**17**	**88.2%**



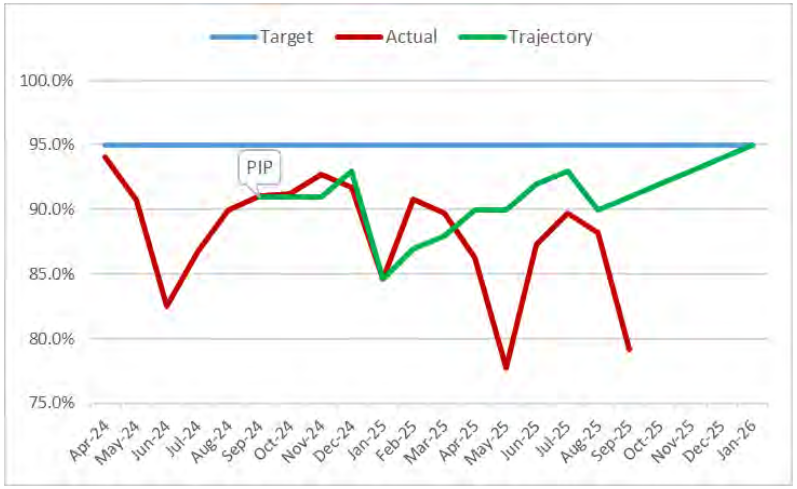




- Adult CMHT services are a main driver for the directorates RTA performance, making up 30% of the total RTAs completed in M05.
- RTA performance for Adult CMHTs has significantly improved in M06, achieving 93.2% against a target of 95.0%
- The number of patients waiting for an RTA to be completed and the proportion of these patients that have been waiting inside 4 weeks has also improved when comparing M06 to M05.

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 79.2**%** during M06 which is not meeting the 91.0% trajectory or 95.0% required standard.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-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	91.1%	91.2%	92.7%	91.7%	84.6%	90.8%	89.7%	86.3%	77.8%	87.3%	89.7%	88.2%	79.2%
Trajectory	91.0%	91.0%	91.0%	93.0%	84.6%	87.0%	88.0%	90.0%	90.0%	92.0%	93.0%	90.0%	91.0%

The above table RAG rating measures actual performance against Trust target

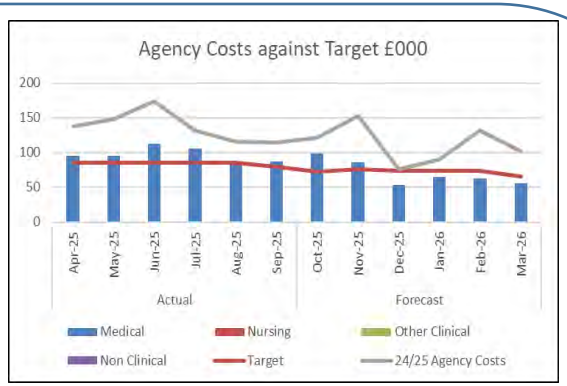
Actions:

- Weekly referral to assessment (RTA) review to be relaunched with new lead**. M06 progress update:** *Weekly meetings commenced week commencing 15.09.25 and relaunched performance clinics begin 29.09.25 both with an RTA focus due to challenges over the last 18 months. There are issues that are beyond the directorates control i.e. patients that are transferred from other services that will remain.*

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	81	87	99	86	53	65	62	56	576	997
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	81	87	99	86	53	65	62	56	576	997
Target	86	86	86	86	86	80	73	76	74	74	74	66	508	944
Over / (under) Target	10	10	27	20	(5)	7	26	10	(20)	(9)	(12)	(10)	68	53
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
-

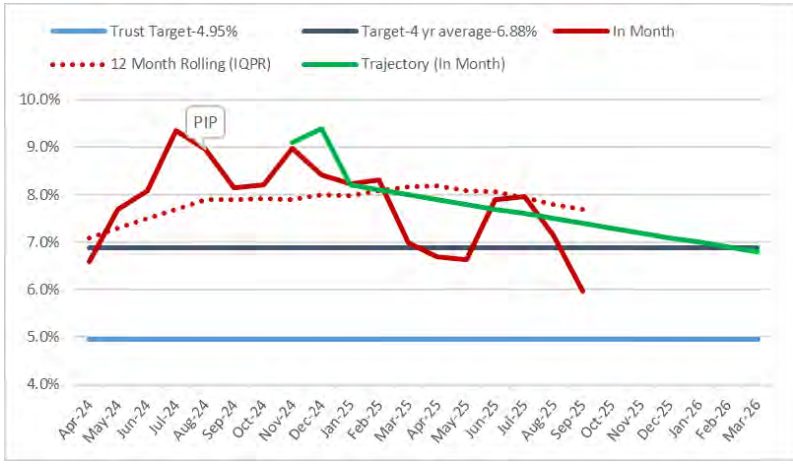
A PIP was requested in M01 (2025/26) and was stood down in M02. The PIP was reinstated in M03. Performance in M06 is £87k total agency against £80k target. Updated actions have been provided in M06. It was agreed at the Performance Review meeting in M06 that the PIP will be closed.

Actions:

- Older Adult- Trust locum in place whilst we appoint substantively. **M06 progress update***: Locum will be interviewed in December of the substantive post.*
- EIT/EMU joint post. **M06 progress update:** *Panel date deferred until April 2026.*
- Sutherland & Lymebrook. **M06 progress update:** *Interviews scheduled for the Sutherland post in December.*
- Eating Disorders**. M06 progress update:** *Still awaiting JD from Royal College – to be re-submitted using the new process. Clinical Director to have conversations with Locum who may be interested in part of the post.*
- Greenfields/ ADHD. **M06 progress update:** *Locum will continue to cover part-time vacancy and Directorate will pursue the potential to work with Rehab.*
- Eating Disorders**. M06 progress update:** *Still awaiting JD from Royal College – to be re-submitted using the new process. Clinical Director to have conversations with Locum who may be interested in part of the post.*
- Stoke Memory Clinic. **M06 progress update:** *JD approved and will be advertised.*
- CAMHS - North Stoke Consultant**. M06 progress update:** *Recruited and postholder commenced in September.*

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 M06 is 7.69% and 5.96% in-month. The in-month trajectory of 7.4% is being met. The 6.9% 4-year average is being met. The Trust standard of <4.95% is not being met. The 12-month required standard is not being met.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%	6.88%
In Month	8.14%	8.20%	8.98%	8.41%	8.24%	8.32%	6.99%	6.69%	6.64%	7.89%	7.96%	7.15%	5.96%
12 Month Rolling (IQPR)	7.90%	7.91%	7.90%	8.00%	7.99%	8.09%	8.17%	8.18%	8.09%	8.07%	7.95%	7.80%	7.69%
Trajectory (In Month)			9.10%	9.40%	8.20%	8.10%	8.00%	7.90%	7.80%	7.70%	7.60%	7.50%	7.40%

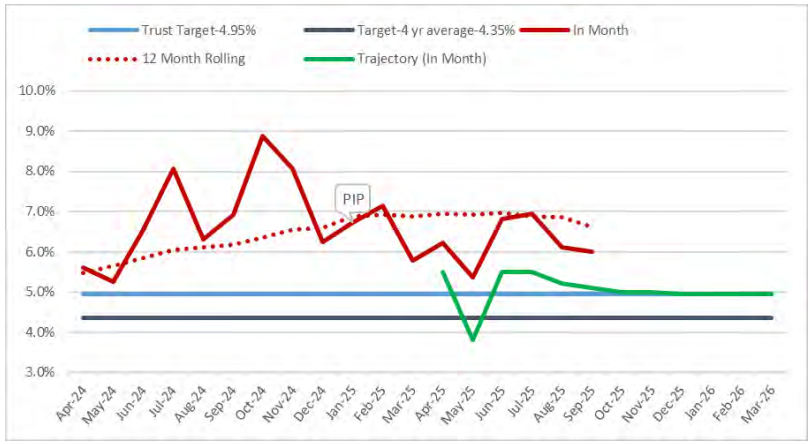
The above table RAG rating measures in-month performance against Trust target

Actions:

- Workforce clinics within the Directorate. **M06 progress update**: *Performance/workforce clinics continue to be held within the directorate – with activity being reviewed from team level through to service line and leadership oversight.*
- Leadership *Development Programme*. **M06 progress update**: *This programme is now running as HR surgeries, which are held on wards or appropriate office space, face to face. These are well attended by leaders across all areas, including senior managers. Positive feedback received from Wards 1,2,3,4, and 6, CRHTT, HVU and PICU. People Ops information is shared with managers.*
- Associate director is looking at specific and targeted programmes of support in relation to musculoskeletal (MSK) and psychological support. **M06 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 has met with Chief People Officer to discuss further opportunities and currently reviewing data into current provisions available to staff to explore any further opportunities to support 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. **M06 progress update**: *Ongoing improvement across the directorate with vacancy rate below target for 2 consecutive months.*
- 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. **M06 progress update**: *Ongoing improvement across the directorate with vacancy rate below target for 3 consecutive months.*

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 M06 is 6.61% and 6.00% in-month. The in-month trajectory of 5.1% 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 provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%
In Month	6.93%	8.88%	8.06%	6.24%	6.72%	7.14%	5.79%	6.22%	5.37%	6.81%	6.95%	6.11%	6.00%
12 Month Rolling	6.17%	6.35%	6.54%	6.59%	6.88%	6.92%	6.89%	6.94%	6.93%	6.96%	6.89%	6.86%	6.61%
Trajectory (In Month)								5.50%	3.80%	5.50%	5.50%	5.20%	5.10%

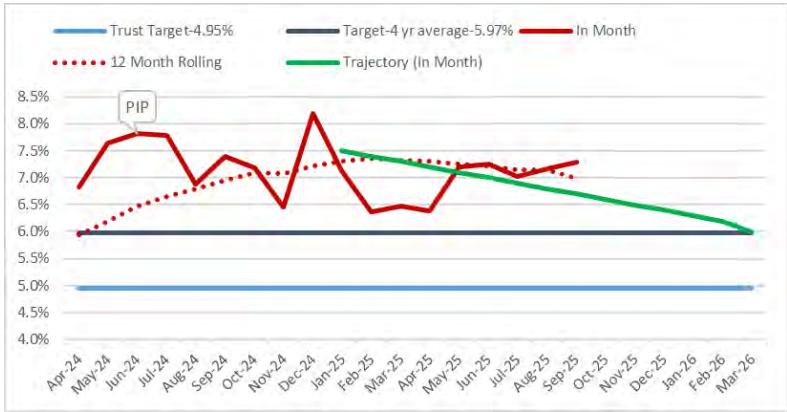
The above table RAG rating measures in-month performance against Trust target

Actions:

- Staff survey review with identified actions from this focussing on specific team with highest levels of variance in comparison to trust averages. This is to work with teams to identify key trends from the survey and actions to support the team. **M06 progress update***: Focussed workshop booked for beginning of October with opportunity for feedback from the team.*
- Supporting attendance at work clinics held with all line managers. **M06 progress update:** *Supporting attendance at work clinics continue with review of stages for team members, including reasonable adjustments. Some long term identified sickness identified which has been discussed with Line Manager and People Ops team as part of clinics.*

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 M06 is 7.00% and 7.29% in-month. The in-month trajectory of 6.7% for M06 is not being met. The 6.0% 4-year average is not being met. The Trust standard of <4.95% target is not being met. The 12-month required standard is not being met.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%
In Month	7.39%	7.19%	6.46%	8.20%	7.13%	6.37%	6.48%	6.38%	7.21%	7.26%	7.03%	7.17%	7.29%
12 Month Rolling	6.95%	7.09%	7.07%	7.22%	7.30%	7.37%	7.33%	7.30%	7.26%	7.22%	7.15%	7.15%	7.00%
Trajectory (In Month)					7.50%	7.40%	7.30%	7.20%	7.10%	7.00%	6.90%	6.80%	6.70%

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. **M06 progress update:** *Wellbeing calendars are distributed to the directorate, Trust wellbeing training/planning attended by the directorate, wellbeing portal information well shared and known within the directorate. Wellbeing supervisions are incorporated into managerial supervision throughout the directorate.*
- 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. **M06 progress update:** *Sickness is now incorporated into performance clinics for an extra layer of support and scrutiny.*

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 M06 there are no complaints exceeding the 40-day response timescale. Performance is meeting the required trajectory and required standard.

Updated actions have been provided in M06.

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

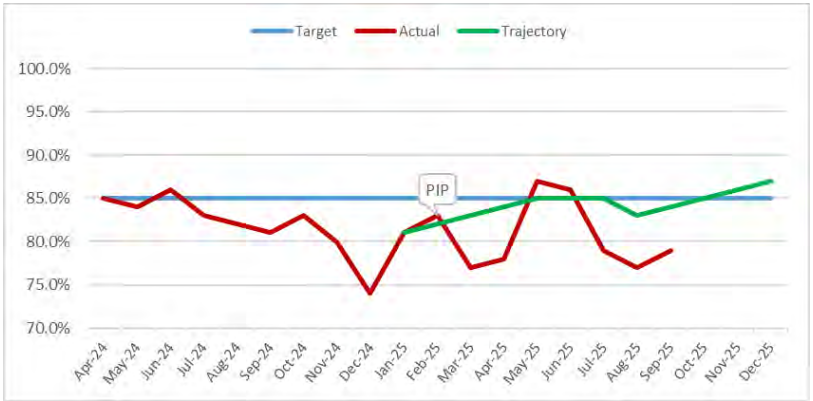
The above table RAG rating measures actual performance against Trust target

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. **M06 progress update**: monthly QILN and PET interface meeting is going well and supporting early resolution.
- 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.
- The team has appointed to the fixed term post of complaints manager and will be commencing in M06.

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 revised to September 2025; this has since been revised to December 2025; this has since been revised to October 2025.

Trajectories were set in February 2025 covering the period January to July, these have been extended to September 2025. Trajectories have been extended for the period August to December 2025. Trajectories have been updated in M06 until December 2025.

Performance during M06 is 79.0% and is not meeting the 84.0% planned trajectory or 85.0% required standard.

Updated actions have been provided in M06.

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

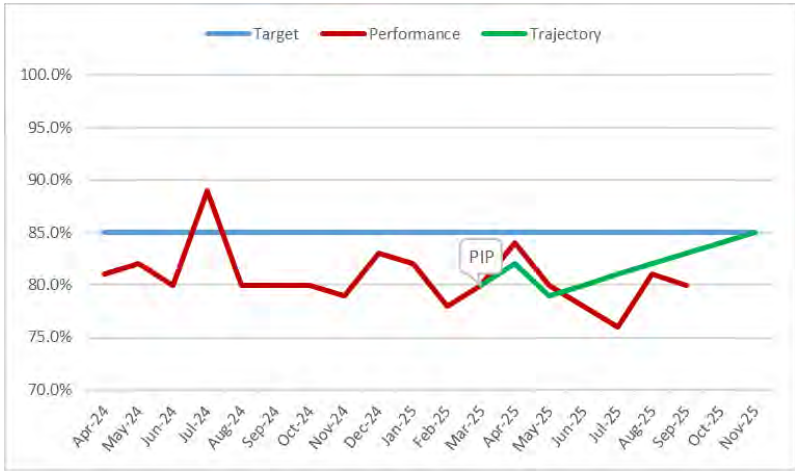
The above table RAG rating measures actual performance against Trust target

Actions:

- Comms related to the changes to the recording requirement circulated across the Directorate. **M06 progress update:** *Reminders/prompts within service ling meetings/senior team catch-ups and 1-1 sessions.*
- Productive time management and booking of supervision with supervisors to achieve performance target and ensure staff are receiving regular supervision sessions. **M06 progress update:** *Weekly reports continue to be supplied to all team leads on supervision status for their respective areas*.
- Regular data cleansing to ensure accuracy of records complete and accurate. **M06 progress update**: *Adult CMHT Team Leads will ensure supervision is completed and recorded within appropriate time frames.*
- Recording of supervision on LMS to prevent any delay in recording. **M06 progress update**: *Team leads asked to ensure supervision in logged prior to leaving the session to avoid delays.*
- Associate director to contact staff who remain non-compliant for a period of two months. **M06 progress update**: *In the last month, the Associate Director has sent individual e-mails to six staff members who have had continuous non-compliance for two months. This has resulted in supervision being recorded that has taken place or booked where it has not taken place.*

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%. The trajectories have been revised for the period May to November 2025.

Performance during M06 is 83.0**%,** which is not meeting the 83.0% planned trajectory or 85.0% required standard.

Updated actions have been provided in M06.

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

The above table RAG rating measures actual performance against Trust target

M06 Position:

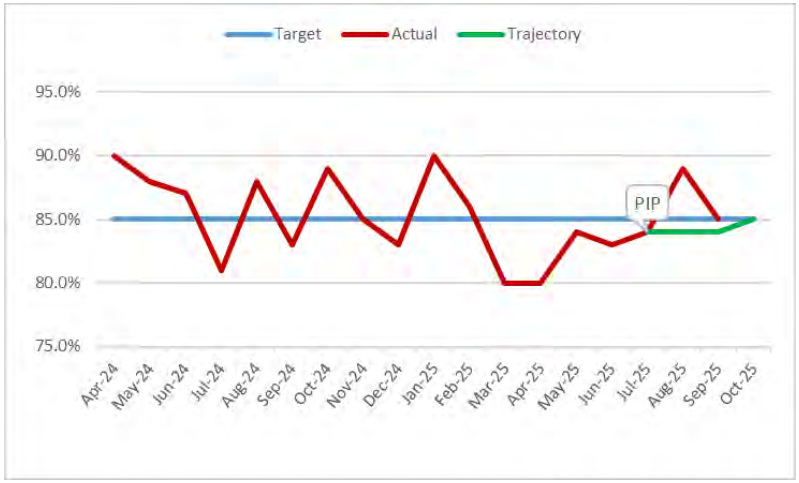
- High acuity, high demand and extremely stretched services across the whole Directorate. Clinical needs will take priority.
- A review of the staffing lists held on learning management system (LMS) compared to electronic staff records (ESR) continues to be reviewed due to inaccuracies.
- A review of the current supervision structure in teams completed. Areas for improvement have been identified and incorporated into actions below.

Actions:

- Ensure the staffing lists within LMS are accurate and up to date. **M06 progress update:** *Senior leadership team to review current list to identify missing eligible staff names.*
- 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. **M06 progress update:** *The validity and accuracy of the data regarding LMS remains a concern. 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. **M06 progress update:** *CRHTT currently has its own PIP to deliver against. Timescale extended due to sickness within the leadership team and ongoing increase in demand, however a there has been significant improvement for the team now at 85%.*
- Professional Nurse Advocate (PNA) support for CRHTT. PNA support is currently provided to the inpatient areas, and the benefits should also apply to Crisis Care Service Line. **M06 progress update:** *Commenced in September 2025 - first session on 29/09/25.*

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Specialist Services directorate



A PIP was requested in M04 (2025/26). M12 (2024/25). The aim is for the standard to be achieved by October 2025. Trajectories have been set for the period August to October 2025.

Performance during M06 is 85.0**%** and has met the required 85.0% standard for the second consecutive month.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-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%	89.0%	85.0%	83.0%	90.0%	86.0%	80.0%	80.0%	84.0%	83.0%	84.0%	89.0%	85.0%
Trajectory											84.0%	84.0%	84.0%

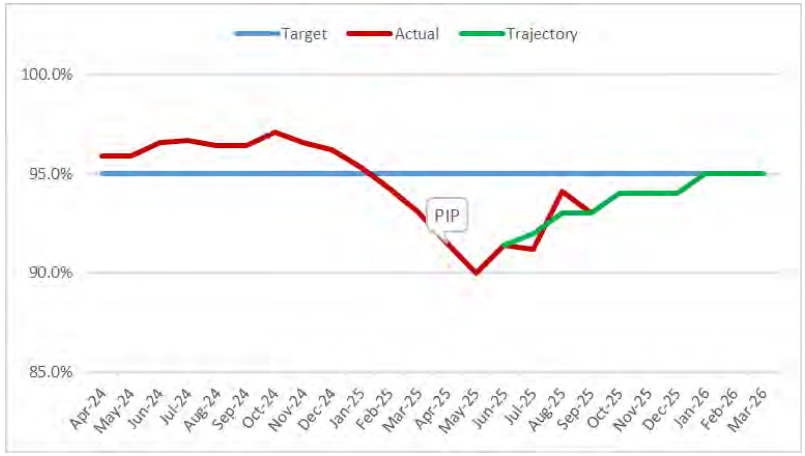
The above table RAG rating measures actual performance against Trust target

Actions:

- Ensure reports are reflective of staff absences before they impact on compliance. **M06 progress update:** *QILN monitors weekly on a Monday.*
- Review supervision structures within teams **M06 progress update:** *Completed in most areas, assurance still being sought for some areas.*
- Weekly supervision monitoring to identify individuals due to expire and proactively prompt. Improving overall compliance. **M06 progress update:** *QILN monitors weekly on a Monday. Complete.*
- Pick up supervision stats within the performance clinics to ensure team leads are monitoring and proactively working on supervision monitoring and to give a regular opportunity for them to raise challenges and for senior management to support finding solutions. **M06 progress update:** *Supervision is now further scrutinised in performance clinics.*

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. Trajectories have been reset for the period September to January 2026.

The aim was to achieve the required standard by October 2025 this has been extended to January 2026.

Performance during M06 is at 93.0% and is meeting the 93.0% planned trajectory but is not meeting the 95.0% required standard.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-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	96.4%	97.1%	96.6%	96.2%	95.3%	94.3%	93.1%	91.5%	90.0%	91.4%	91.2%	94.1%	93.0%
Trajectory										91.4%	92.0%	93.0%	93.0%

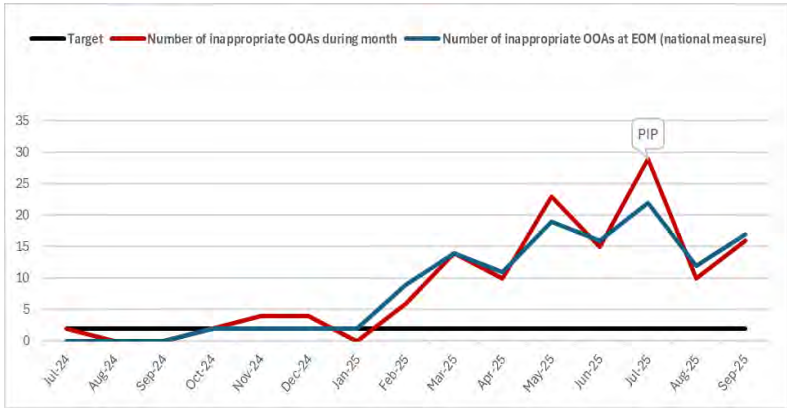
The above table RAG rating measures actual performance against Trust target

Actions:

- Review to be completed for each service area to establish the progress of care planning changes to provide a clear understanding of where each service is in the transition over to the new care plan and how this impacting on performance reporting and on patient care. **M06 progress update:** *Expectations known.*
- LD services - Wider engagement within teams to be promoted and ensure that attendance at performance clinics is prioritised. **M06 progress update:** *Performance clinics now established, team managers know expectations as do service managers. Care planning is scrutinised during clinics.*
- Neuropsychiatry & Psychology - Review of triage process considering the care plan changes there may be the potential to triage patients differently. Additional support to be offered to the team regarding move to new care planning pathway. **M06 progress update**: *Performance issue identified within the team are being managed through weekly supervisions prior to formalising performance process.*

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 M06 is number of inappropriate OOAs during month is 16, number of inappropriate OOAs at EOM (national measure) is 17. The context is that 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.

Updated actions have been provided in M06.

	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Target	2	2	2	2	2	2	2	2	2	2	2	2	2
Number of inappropriate OOAs during month	0	2	4	4	0	6	14	10	23	15	29	10	16
Number of inappropriate OOAs at EOM (national measure)	0	2	2	2	2	9	14	11	19	16	22	12	17

Optimising bed management and improving patient flow to reduce Out of Area Placements (OOA)

Acute and Urgent Care directorate (AUCD) M06 progress update:

AUCD continue to deliver on all agreed actions and maintain a rigorous review of the data to understand and evaluate current bed demand.

- Clinically ready for discharge (CRFD) for acute adults is at its lowest level in a considerable period.
- Length of Stay (LoS) remains significantly below the national average.
- The reduction in bed stock remains a key factor in ongoing evaluations of system performance and capacity, noting the monthly increase in demand to front door services.

AUCD Ongoing actions:

- Daily monitoring of OOA provision by AUCD
- Patients discussed as part of the daily bed flow 12:30 meeting.
- Patients discussed at weekly oversight meeting (attended by ICB, CMHTs and local authorities)
- AUCD attend all ward reviews for patients without a CMHT
- CMHT attend ward reviews for their patients
- OOA/CRFD Oversight Group has been established–first meeting to be held on 19/09/25
- This PIP also acts as the recovery plan with the aim to reach zero OOA beds as outlined in the planning guidance by 2027/28.

- **Length of Stay**-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). **M06 progress update:** *LoS remains below national target and OOA LoS for patients repatriated and discharged is also monitored and reported upon each month.*
- **CRHTT**-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. **M06 progress update:** *This will not be possible due to the required change in service delivery against response to patients in MH crisis requiring a F2F contact within 24 hours*.
- **CRFDs-**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. **M06 progress update**: *Continues to be monitored and reported against-a recent harm review undertaken by the AUCD provides further recommendations noting the impact on OOA beds.*
- **Care pathways for admission**-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. **M06 progress update**: *Progressed by nursing and quality.*
- Explore the establishment of an out of area placement review panel to complement the existing weekly acute bed management meetings. **M06 progress update:** *First meeting has taken place–this will feed into the strategic transformation group.*

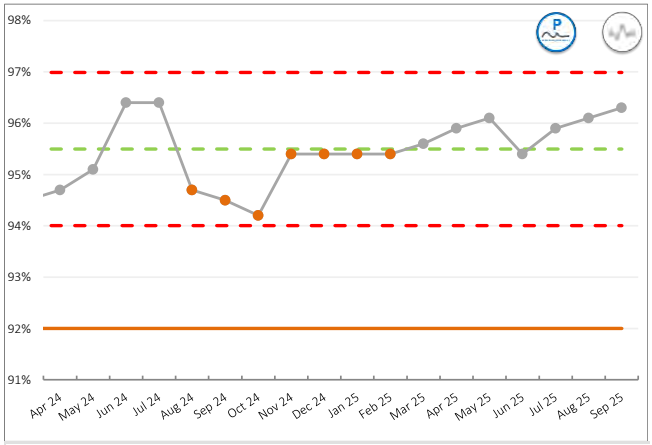
Actions: Community

- **Pre-Discharge Engagement**: **M06 progress report:** *CMHTs continue to engage with service users prior to discharge through ward visits and participation in MDTs. Service manager and senior service manager now attend the daily bed management meeting which has improved communication between the teams.*
- **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. **M06 progress report:** *There is an away day planned for November 2025 between urgent care and community directorates to strengthen the pathways between the services.*
- **Enhanced crisis planning**: CMHTs are working with service users and carers to develop robust, co-produced crisis and contingency plans. **M06 progress update:** *CMHTs continue to actively work with service users and carers to co-produce robust crisis and contingency plans and escalate patients to the weekly interface meeting if it is felt support from CRHTT is required.*

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

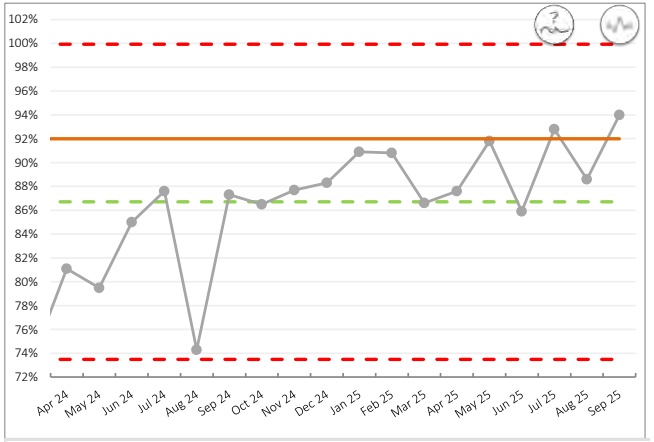
Referral to Treatment 18 Weeks (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
94.2%	95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%	95.4%	95.9%	96.1%	96.3%

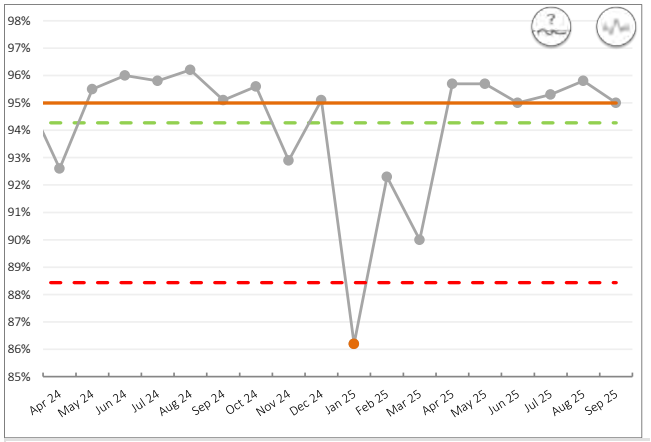
CAMHS Compliance within 18 week waits (RTT)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
86.5%	87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%	85.9%	92.8%	88.6%	94.0%

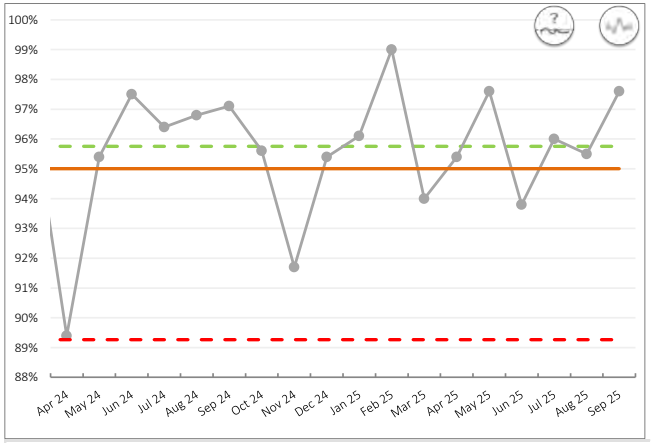
MHLT 1-hour (Emergency) (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.6%	92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%	95.0%	95.3%	95.8%	95.0%

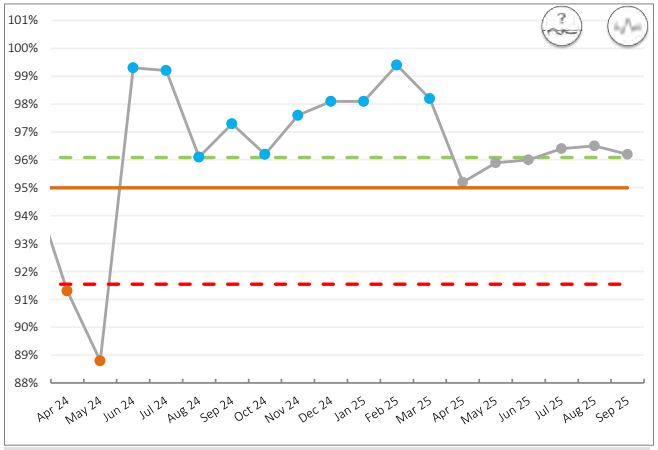
MHLT 4-hour (Urgent) (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
95.6%	91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%	93.8%	96.0%	95.5%	97.6%

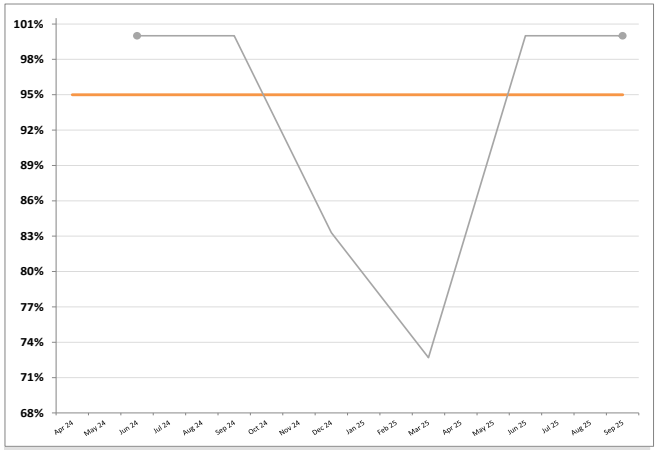
MHLT 24-hours (Routine) (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
96.2%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%	96.0%	96.4%	96.5%	96.2%

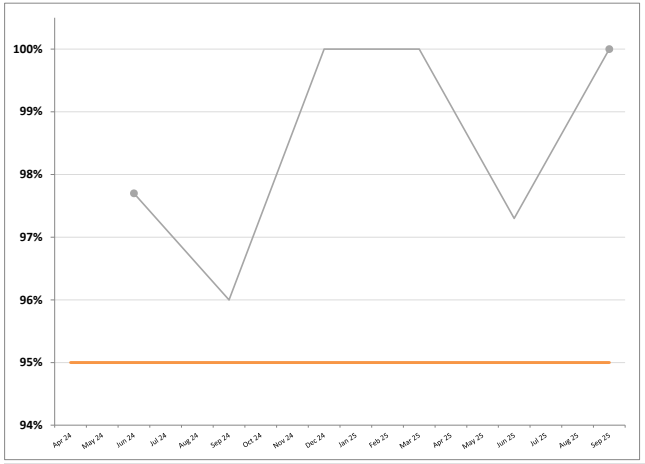
CYP EDS RTA (Urgent) 1 Week (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
		83.3%			72.7%			100.0%			100.0%

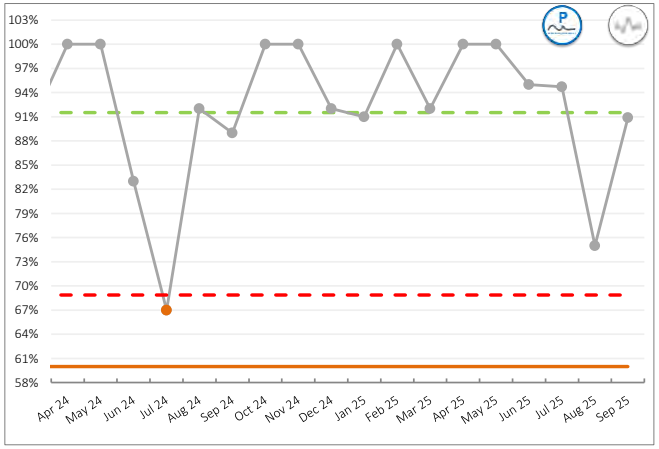
CYP EDS RTA (Routine) 4 Weeks (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
		100.0%			100.0%			97.3%			100.0%

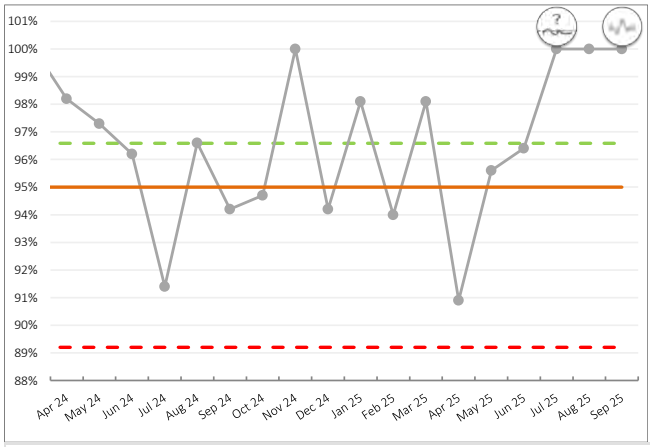
Early Intervention (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
100.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%	95.0%	94.7%	75.0%	90.9%

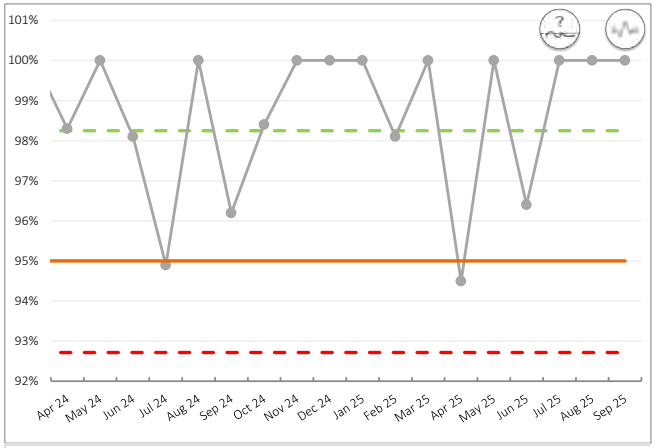
48 Hour follow up (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
94.7%	100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%	96.4%	100.0%	100.0%	100.0%

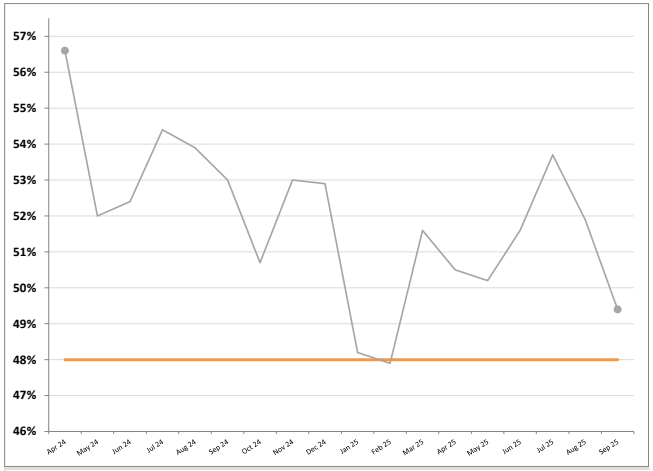
7 day follow up (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
98.4%	100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%	96.4%	100.0%	100.0%	100.0%

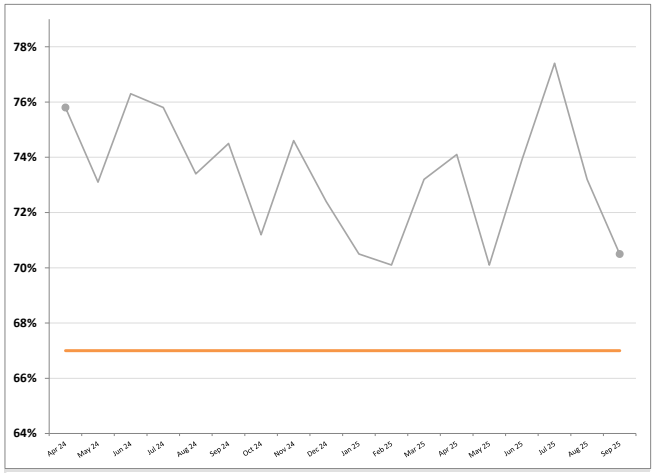
Talking Therapies: Reliable Recovery (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
50.7%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%	51.6%	53.7%	51.9%	49.4%

Talking Therapies: Reliable Improvement (National indicator)

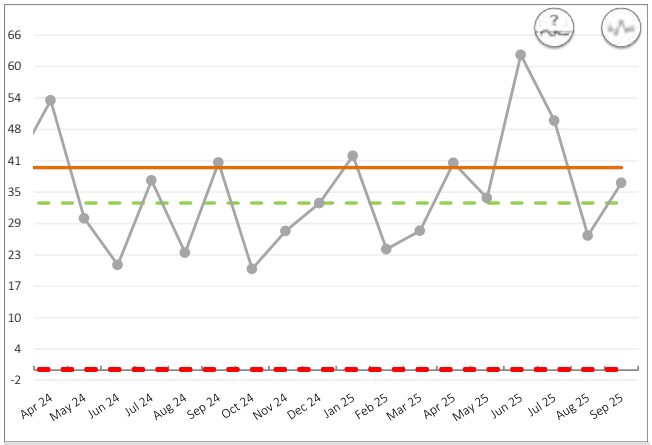


12 Month Trend

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

Core Indicators – SPC Trend (Inpatient and Quality)

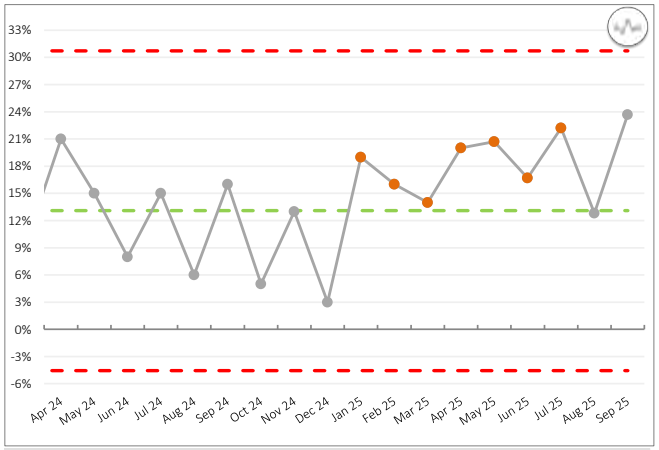
Average Length of Stay-Adult (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
20	28	33	42	24	28	41	34	62	49	27	37

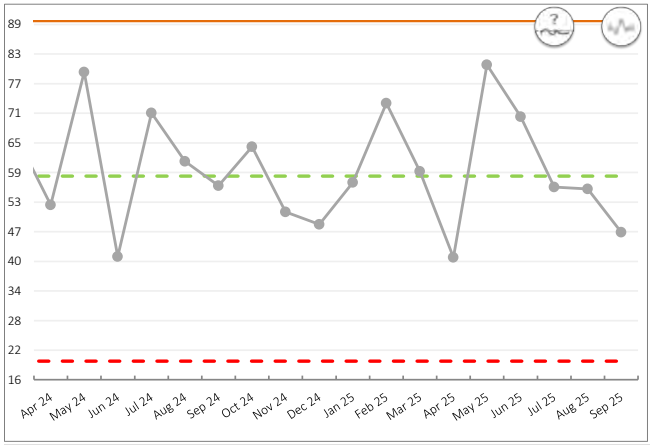
Adult Acute LoS-Over 60 days (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
5.0%	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%	16.7%	22.2%	12.8%	23.7%

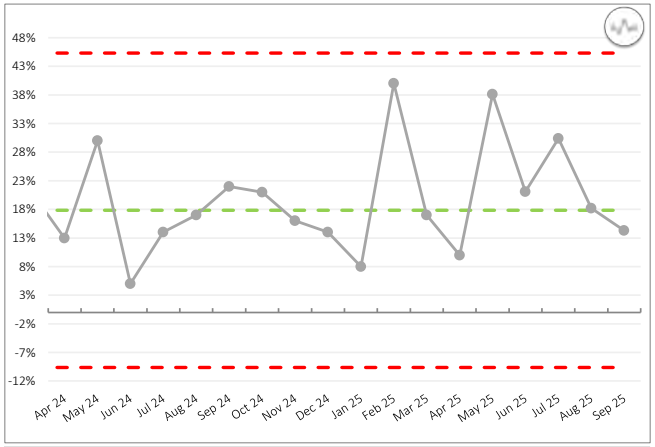
Average Length of Stay-Older Adult (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
64	51	48	57	73	59	41	81	70	56	55	46

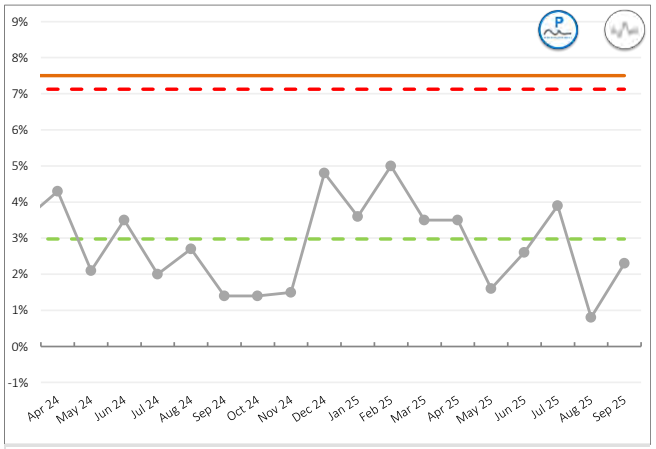
Older Adult Acute LoS-Over 90 days (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
21.0%	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%	21.1%	30.4%	18.2%	14.3%

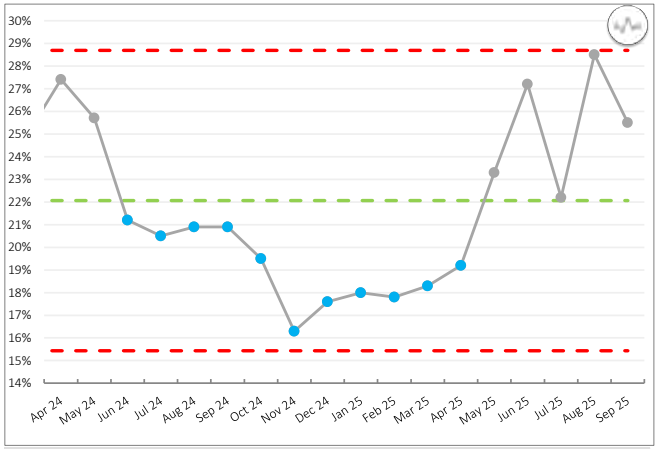
Emergency Readmissions (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
1.4%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%

Clinically Ready for Discharge (Trust indicator)

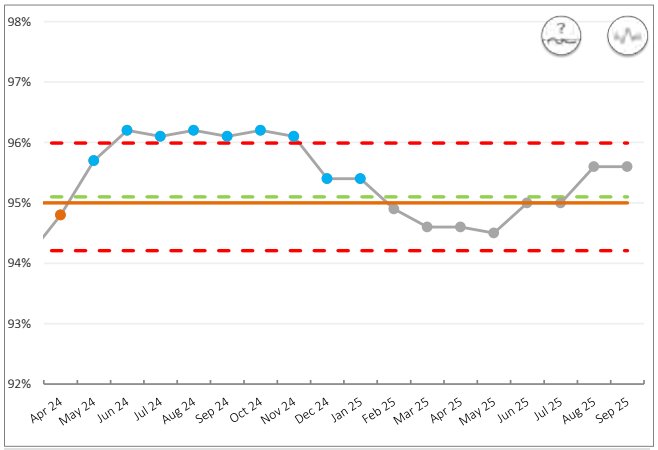


12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
19.5%	16.3%	17.6%	18.0%	17.8%	18.3%	19.2%	23.3%	27.2%	22.2%	28.5%	25.5%

Core Indicators – SPC Trend (Community and Quality)

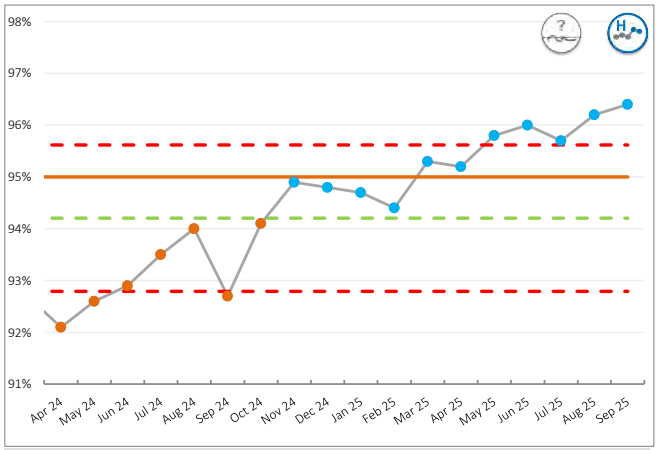
Care Plan Compliance (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
96.2%	96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%	95.0%	95.0%	95.6%	95.6%

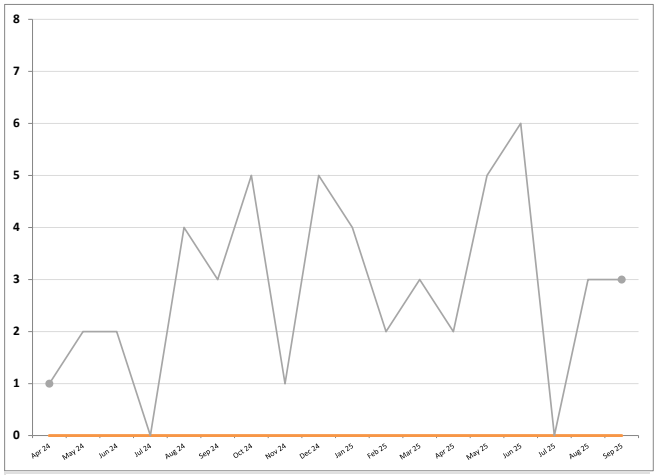
Risk Assessment Compliance (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
94.1%	94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%	96.0%	95.7%	96.2%	96.4%

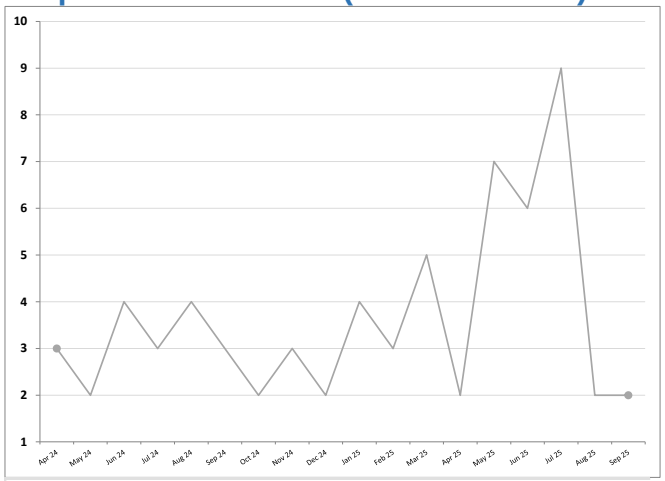
Comprehensive Safety Review (Trust indicator)



12 Month Trend

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

Proportionate Review (Trust indicator)

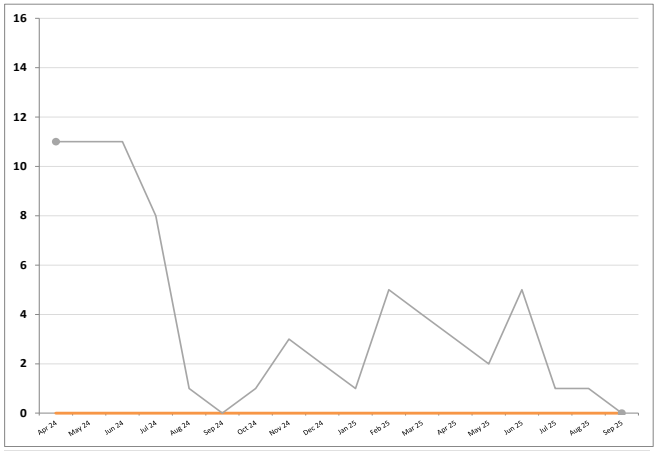


12 Month Trend

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

Core Indicators – SPC Trend (Organisational Health)

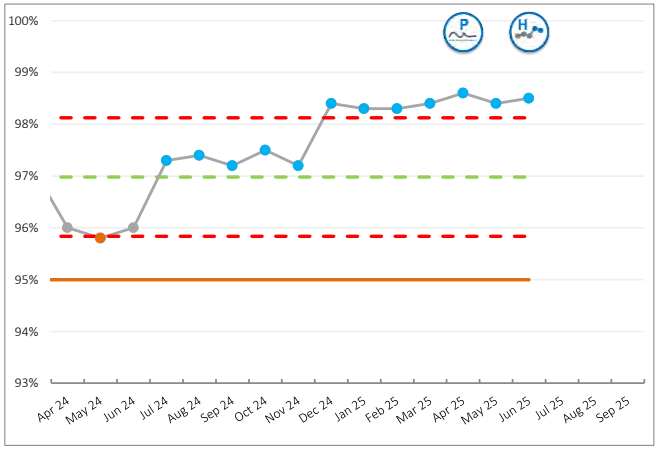
Complaints Open Beyond Agreed Timescale (Trust indicator)



12 Month Trend

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

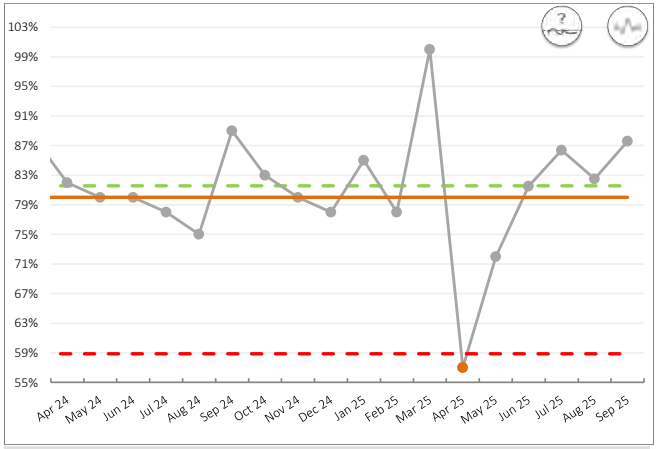
DQMI (National indicator)



12 Month Trend

97.5%	97.2%	98.4%	98.3%	98.3%	98.4%	98.6%	98.4%	98.5%			
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

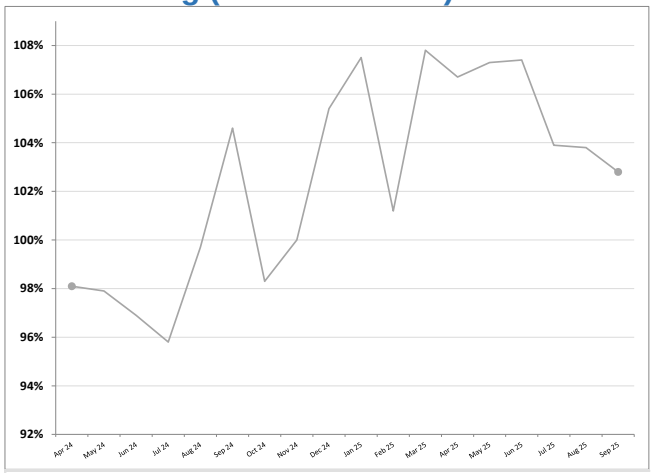
Friends and Family Test (National indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
83.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%	81.5%	86.4%	82.5%	87.6%

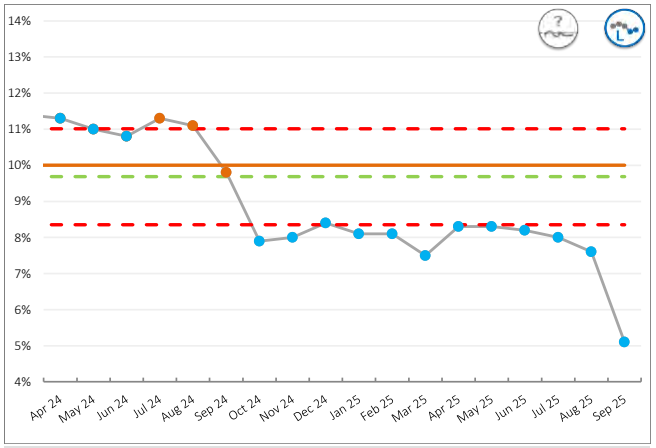
Safe Staffing (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
98.3%	100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%	107.4%	103.9%	103.8%	102.8%

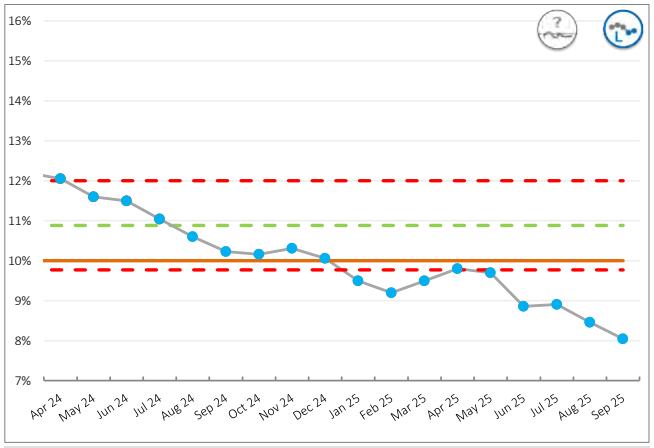
Vacancy Rate (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
7.9%	8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%	8.2%	8.0%	7.6%	5.1%

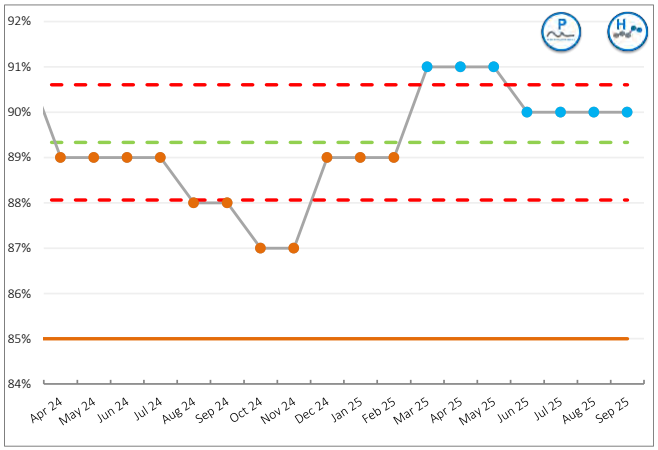
Staff Turnover (Trust indicator)



12 Month Trend

Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
10.2%	10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%	8.9%	8.9%	8.5%	8.1%

Statutory and Mandatory Training (Trust indicator)



12 Month Trend

87.0%	87.0%	89.0%	89.0%	89.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 10

Finance Position Month 6

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Eric Gardiner – Chief Finance Officer
Prepared by:	Michelle Wild – Financial Controller Rachel Heath – Project Accountant Michelle Geddes – Assistant Chief Finance Officer
Executive Lead:	Eric Gardiner – Chief Finance Officer

Aligned to Board Assurance Framework Risk:	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
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	SLT
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	Part of the aggregate ICS reported financial position.

Recommendation / Required Action:	Receive the Month 6 position noting: • The year-to-date surplus of £141k against a planned deficit of £423k, giving a favourable variance of £564k. • The underlying financial position (ULP) of £1.29m deficit. • Agency expenditure of £945k against a plan of £826k, resulting in an adverse variance of £119k. Medical agency must reduce in order to get back in line with the plan. • Bank expenditure of £3,392k against a plan of £3,251k, giving a negative variance of £141k. 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 £4.6m fully achieved / transacted, £2.1m fully developed, £0.4m plans in progress and £0.3m opportunities identified. • The Trust has spent £1,317k on capital, which is £385k behind plan. • The cash position of the Trust on 30th September with a balance of £32.8m.
Executive Summary:	The Adjusted Financial Performance in month surplus of £88k against a planned deficit of £35k giving a favourable variance of £123k. The year-to-date position is a surplus of £141k against a planned deficit of £423k giving a favourable variance of £564k. The Trust is forecasting to breakeven at year end. The Trust is reporting an underlying financial position (ULP) of £1.29m deficit and the ULP will form the start point of the 2026/27 medium-term plan. The Trust has a recurrent CIP target of £6.0m, a non-recurrent target of £1.4m. At Month 6 the Trust is reporting delivery of £2,492k CIP against a target of £3,564k, an adverse variance of £1,072k. CIP schemes have been identified for the full target with 62% being implemented, 28% fully developed, 5% have plans in progress and 4% are opportunities. In month agency expenditure was £137k against a plan of £136k representing an unfavourable variance of £1k against the 40% agency expenditure reduction from 2024/25. In month bank expenditure was £542k against a plan of £492k representing an unfavourable variance of £50k against the 10% bank expenditure reduction from 2024/25. The Trust's capital expenditure year to date was £1,317k against a plan of £1,702k giving a favourable variance of £385k. the Trust is forecasting to underspend by £273k against plan due to the delays in the frontline digitalisation scheme offset with spend relating to NHS Notify.

	In month, 97.7% based on the number of invoices and 95.4% based on the value of invoices received by the Trust were paid within 30 days against the Better Payment Practice Code target of 95%. Please note in month the value of NHS invoices paid within 30 days was well below target at 68% this was due to authorisation delays of one invoice (£335k) relating to TCP / P86. With prompt payment of invoices for the remainder of the year, the Trust will be able to achieve the target of 95%. The cash position of the Trust on 30th September is £32.8m.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	21/10/2025
2	Finance & Resource Committee	21/10/2025
3	Public Trust Board	06/11/2025

NHS
North Staffordshire
Combined Healthcare
NHS Trust

PUBLIC TRUST BOARD – 13th November 2025
Finance Position Month 6

Finance Position

Introduction

This report summarises the Trust's financial position as of 30th September 2025.

Key financial performance metrics are included for the following:

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

Finance Position

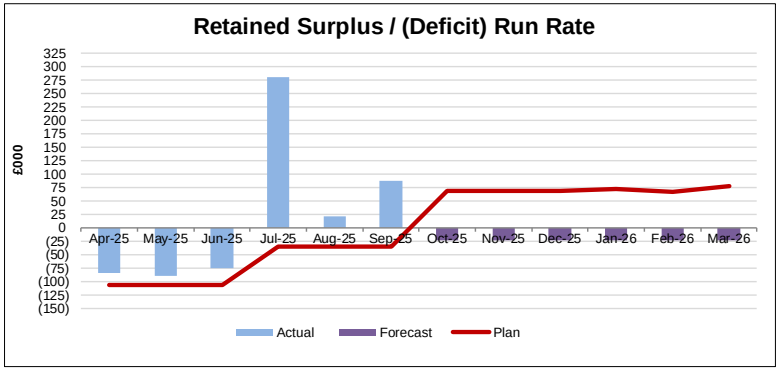
Executive Summary

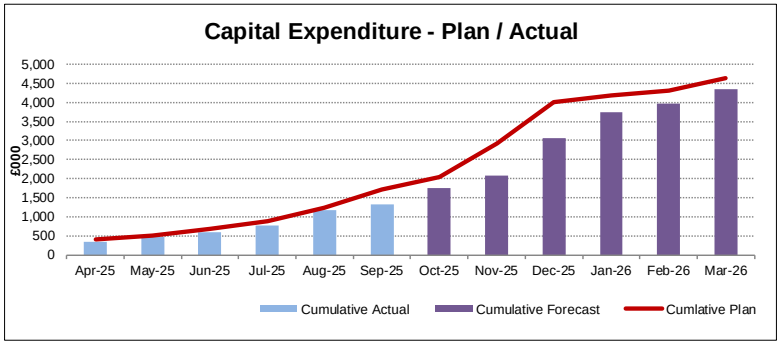
NHS North Staffordshire Combined Healthcare NHS Trust

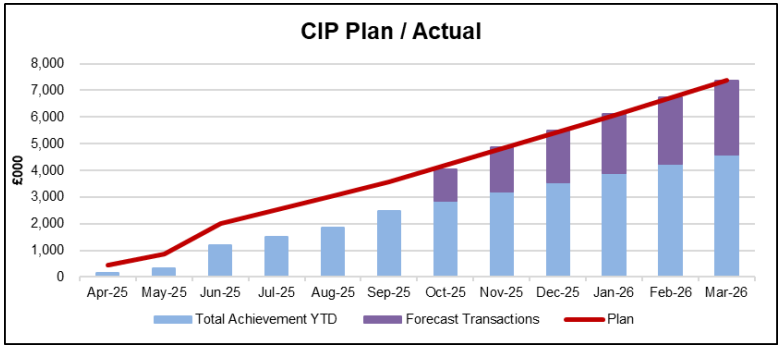
Financial Overview as at 30th September 2025

Key Metrics

£000	M4	M5	M6	YTD	Average	Forecast	RAG
Variance to Plan							
In month financial position	316	55	123	564	94		
YTD financial position	385	440	564	564	94	(0)	
Run Rates (Actuals)							
Income	14,908	14,939	14,907	88,764	14,794	178,837	
Pay	(9,187)	(9,121)	(9,050)	(54,324)	(9,054)	(109,702)	
Non-pay	(5,144)	(5,483)	(5,470)	(32,521)	(5,420)	(65,458)	
Finance & Other Non Operating Costs	(252)	(270)	(253)	(1,509)	(252)	(3,168)	
Agency (Actuals)	(150)	(135)	(137)	(945)	(158)	(1,504)	
Agency Variance To Plan	**(13)**	**2**	**(1)**	**(119)**	**(20)**	**0**	
Medical Agency	(10)	8	(1)	(63)	(11)	12	
Nurse Agency	(2)	(3)	2	(28)	(5)	16	
Other Agency	(1)	(0)	(4)	(28)	(5)	(28)	
Non Clinical Agency	0	(2)	2	0	0	0	
Bank (Actuals)	(542)	(571)	(542)	(3,392)	(565)	(5,453)	
Bank Variance To Plan	**1**	**(64)**	**(50)**	**(141)**	**(23)**	**(0)**	
Medical Bank	56	71	48	272	45	330	
Nurse Bank	244	201	226	1,483	247	2,432	
Other Clinical Bank	(284)	(317)	(305)	(1,827)	(305)	(2,626)	
Non Clinical Bank	(15)	(20)	(19)	(69)	(11)	(137)	
CIP (Variance)	(192)	(180)	135	(1,072)	(179)	0	
Cash balance	31,103	35,925	32,832	32,832	32,439	30,236	
Capital expenditure (Variance)	10	(51)	325	385	64	273	
BPPC							
Number	90.4%	94.8%	97.7%	94.6%	93.9%		
Value	96.8%	96.6%	95.4%	97.5%	98.3%		







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

Finance Position

Income & Expenditure Position

NHS North Staffordshire Combined Healthcare NHS Trust

High Level Analysis	Annual Plan £000	In Month Budget £000	In Month Actuals £000	Variance £000	Year to Date Budget £000	Year to Date Actuals £000	Variance £000	Forecast Budget £000	Forecast Actuals £000	Variance £000
Income from Patient Care Activities	160,534	13,504	13,470	(34)	80,946	80,019	(927)	161,955	161,018	(936)
Income from Other Operating Activities	15,692	1,456	1,437	(19)	8,819	8,745	(74)	17,284	17,819	535
Income	**176,226**	**14,960**	**14,907**	**(53)**	**89,764**	**88,764**	**(1,000)**	**179,238**	**178,837**	**(401)**
Pay Costs	(105,754)	(9,089)	(9,050)	39	(55,560)	(54,324)	1,236	(109,987)	(109,702)	285
Non Pay Costs	(66,956)	(5,617)	(5,470)	146	(32,887)	(32,521)	366	(65,806)	(65,457)	349
Operating Expenditure	**(172,710)**	**(14,706)**	**(14,520)**	**185**	**(88,447)**	**(86,846)**	**1,602**	**(175,793)**	**(175,159)**	**633**
EBITDA	**3,516**	**254**	**386**	**132**	**1,317**	**1,919**	**602**	**3,446**	**3,678**	**232**
Finance & Other Non Operating Costs	(3,040)	(247)	(253)	(6)	(1,487)	(1,509)	(22)	(2,970)	(3,168)	(198)
Retained Surplus / (Deficit)	**476**	**7**	**133**	**126**	**(170)**	**409**	**579**	**476**	**510**	**34**
Technical Adjustments	(476)	(42)	(45)	(3)	(253)	(269)	(16)	(476)	(510)	(34)
Adjusted Financial Performance	**0**	**(35)**	**88**	**123**	**(423)**	**141**	**564**	**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. EBITDA is Earnings Before Interest, Taxes, Depreciation, and Amortisation. It is a non-GAAP metric that provides a measure of core business profitability.

- In month surplus of £88k against a planned deficit of £35k giving a favourable variance of £123k. The favourable variance in month is driven by pay underspends due to vacancies and favourable variances relating to education and training income.
- Year to date position is a surplus of £141k against a planned deficit of £423k giving a favourable variance of £564k.
- The Trust is forecasting to at least breakeven at year end.
- Income year to date is under performing due to lower than planned patient placement income (£859k - offset with decreased non pay expenditure) and service development slippage, partly offset by increased education and training income.
- Pay year to date is favourable due to vacancy slippage particularly in the Community, Education and Estates teams.
- Non-pay year to date has a favourable variance however this is due to reduced patient placements costs (£859k - offset with reduced income). Remaining non pay budgets have an adverse variance overall due to unmet CIP and high patient transport costs (£262k year to date) due to a significant increase in out of area patients.
- Finance and other non-operating costs have an adverse variance of £22k year to date due to reduced bank interest following the reduction in the interest rate from 7th August.

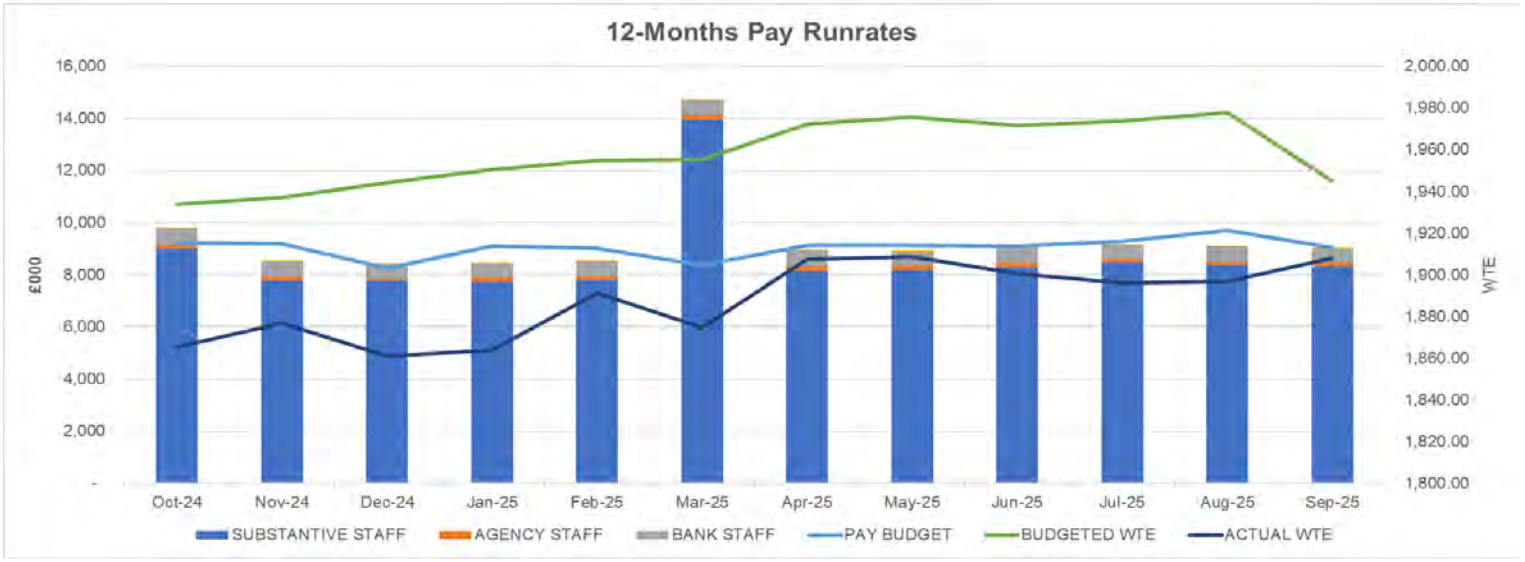
PROUD TO CARE

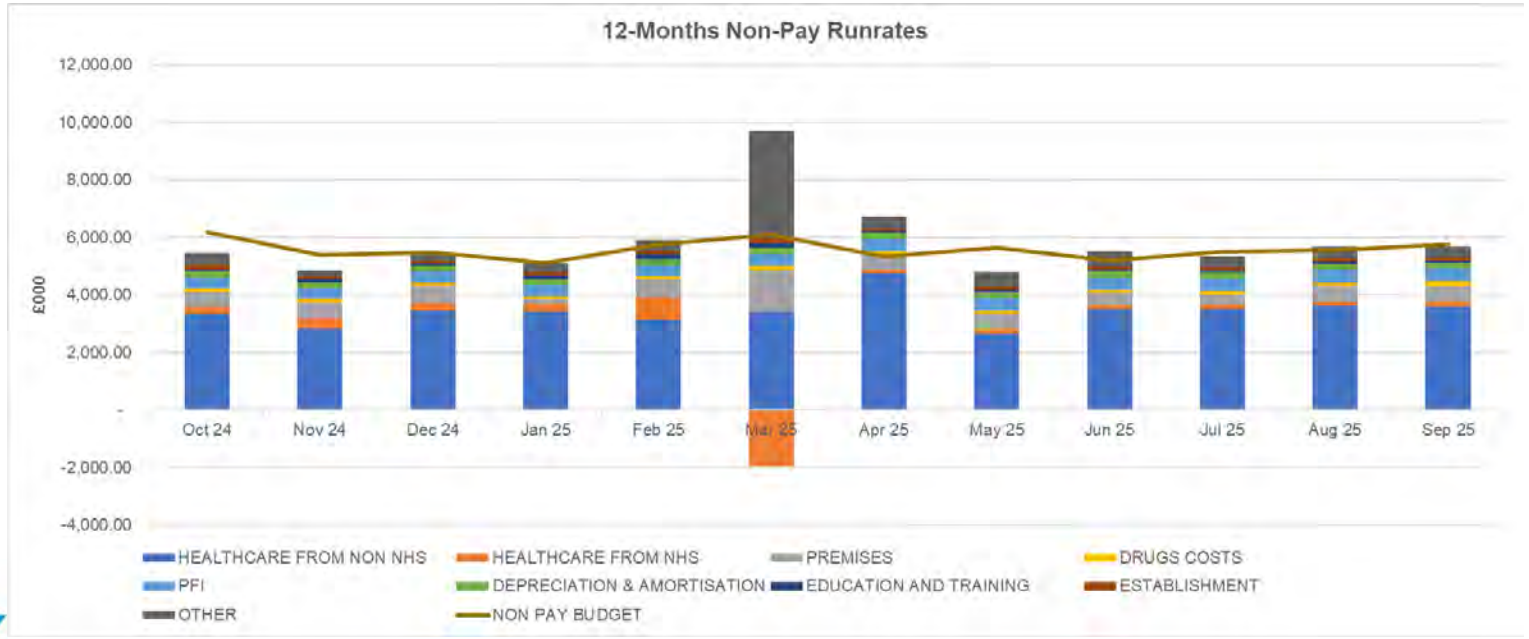
spar

Finance Position

Expenditure Run Rates

NHS
North Staffordshire Combined Healthcare NHS Trust





PROUD TO CARE

spar

Finance Position

Forecast

North Staffordshire Combined Healthcare NHS Trust

Mitigations	Best £000	Likely £000	Base £000	Worse £000
Unmitigated Forecast Surplus / (Deficit)	976	976	976	976
Modifications to staffing projections	811	811	0	(662)
HR Provision	100	(255)	(425)	(425)
Non-Pay Cost Adjustments	242	(84)	(89)	(358)
Estates Reviews and Assessments	(59)	(69)	(20)	(69)
Release of balance sheet flexibilities	811	595	307	0
Recovery of bad debt	424	0	0	0
Non delivery of cash releasing CIP	0	(200)	0	(817)
Enabling costs for CIP	0	0	0	(450)
Deferred Income	0	(378)	(749)	(749)
Mitigated Surplus / (Deficit)	**3,304**	**1,395**	**0**	**(2,554)**

- The Trust is forecasting to breakeven at year end which includes HR provisions, ICB income deferral and release of balance sheet flexibilities.
- The best-case forecast indicates the Trust could deliver a potential surplus of £3,304k. This includes no further workforce growth beyond the month 6 position, the release of further balance sheet opportunities, recovery of bad debt with the Local Authorities and reduced non pay.
- The worse-case forecast indicates the Trust would be in a deficit of £2,554k. This includes lower staff turnover rates, the non-delivery of cash releasing CIP and enabling cost for CIP.
- The likely case forecast indicates the Trust could deliver a potential surplus of £1,395k. This includes no further workforce growth beyond the growth included in the month 6 position, the release of further balance sheet opportunities, HR provisions and the non-delivery of cash releasing CIP.

PROUD TO CARE

spar

Finance Position

Underlying Position (ULP)

North Staffordshire Combined Healthcare NHS Trust

Heading	Income £000	Employee Expenses £000	Operating expenses £000	Non Operating Items £000	Adjusted Position £000
2025/26 Forecast	178,838	(109,701)	(67,979)	(1,158)	**0**
Forecast non-recurring efficiencies	(200)	(828)	(782)	0	**(1,810)**
Forecast deficit support funding	0	0	0	0	**0**
FYE of forecast recurring efficiencies - cash releasing	0	429	91	0	**519**
FYE of forecast recurring efficiencies - non-cash releasing	0	0	0	0	**0**
FYE of forecast investments	0	0	0	0	**0**
Gains and losses and donations	0	0	9	116	**125**
Non-Recurring Redundancy costs	0	0	0	0	**0**
Non-Recurring Cost of Change (Excluding redundancy)	0	0	0	0	**0**
Full year effect of service developments	378	0	(502)	0	**(124)**
Non-recurrent investments	(866)	866	0	0	**0**
2025/26 Underlying Position	**178,150**	**(109,234)**	**(69,163)**	**(1,042)**	**(1,290)**

- The underlying financial position (ULP) represents the true, sustainable, recurring financial position of the Trust after removing non-recurrent items.

- The Trust's current break-even forecast includes several non-recurrent and timing-based items:
  - Delayed recruitment
  - Non recurrent efficiencies
  - Full year effect of recurring efficiencies
  - Disposal loss
  - Full year effect of service developments.

- The Trust is reporting an **underlying financial position (ULP) of £1.29m** deficit after adjusting for the above items.

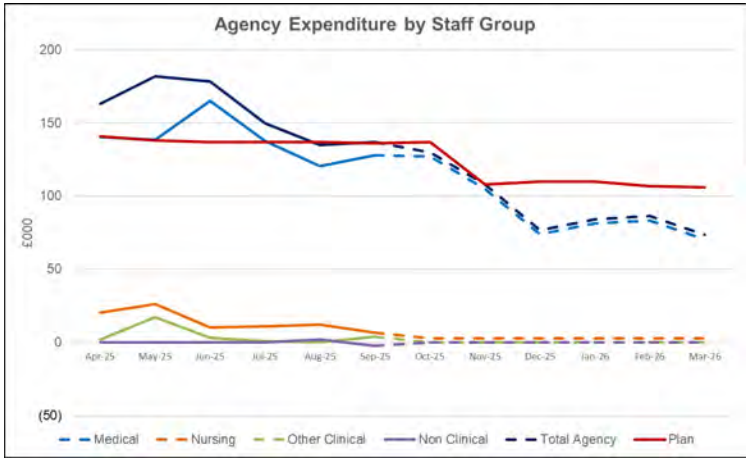
- The ULP will form the start point of the 2026/27 medium-term plan.

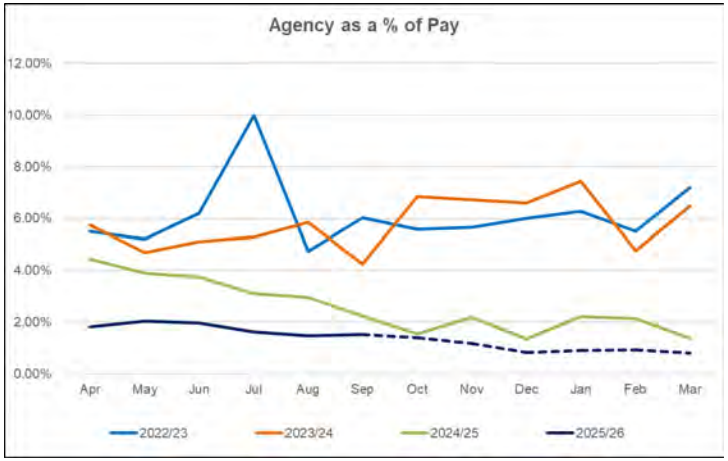
Finance Position

Agency Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Agency 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	**(141)**	**(139)**	**(165)**	**(138)**	**(120)**	**(128)**	**(830)**	**(127)**	**(105)**	**(74)**	**(81)**	**(84)**	**(71)**	**(1,372)**
Community	(96)	(95)	(112)	(105)	(81)	(87)	**(576)**	(99)	(86)	(53)	(65)	(62)	(56)	**(997)**
Specialist Care	(17)	(19)	(26)	(20)	(22)	(1)	**(105)**	0	0	0	0	0	0	**(105)**
Primary Care	(28)	(24)	(27)	(12)	(18)	(36)	**(145)**	(19)	(9)	(11)	(7)	(12)	(3)	**(206)**
Central Services	0	0	0	0	0	(5)	**(5)**	(10)	(10)	(10)	(10)	(10)	(12)	**(64)**
Nursing	**(20)**	**(26)**	**(10)**	**(11)**	**(12)**	**(7)**	**(87)**	**(3)**	**(3)**	**(3)**	**(3)**	**(3)**	**(3)**	**(104)**
Acute Services & Urgent Care	(2)	(10)	(3)	(5)	(6)	0	**(26)**	0	0	0	0	0	0	**(26)**
Primary Care	(5)	1	(5)	(4)	(5)	(4)	**(21)**	(3)	(3)	(3)	(3)	(3)	(3)	**(38)**
Community	0	0	0	0	(0)	0	**(0)**	0	0	0	0	0	0	**(0)**
Specialist Care	(13)	(17)	(2)	(3)	(1)	(3)	**(40)**	0	0	0	0	0	0	**(40)**
Other Clinical	**(2)**	**(17)**	**(3)**	**(1)**	**(0)**	**(4)**	**(28)**	**0**	**0**	**0**	**0**	**0**	**0**	**(28)**
Acute Services & Urgent Care	(1)	(0)	0	0	(0)	(1)	**(3)**	0	0	0	0	0	0	**(3)**
Specialist Care	(1)	(12)	(8)	(1)	0	(3)	**(25)**	0	0	0	0	0	0	**(25)**
Primary Care	0	(5)	5	0	0	0	**0**	0	0	0	0	0	0	**0**
Non Clinical	**0**	**0**	**0**	**0**	**(2)**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
People & OD	0	0	0	0	(2)	2	**0**	0	0	0	0	0	0	**0**
Total Agency	**(163)**	**(182)**	**(178)**	**(150)**	**(135)**	**(137)**	**(945)**	**(130)**	**(108)**	**(77)**	**(84)**	**(86)**	**(73)**	**(1,504)**
Agency as a % of Pay	1.82%	2.04%	1.97%	1.63%	1.48%	1.51%	**1.74%**	1.41%	1.18%	0.84%	0.91%	0.93%	0.79%	**1.37%**
Plan	(141)	(138)	(137)	(137)	(137)	(136)	**(826)**	(137)	(108)	(110)	(110)	(107)	(106)	**(1,504)**
Variance to Plan (Overspend) / Underspend	(22)	(44)	(41)	(13)	2	(1)	**(119)**	7	0	33	26	21	33	**0**
Agency Variance as a % of Plan	15.74%	31.84%	30.17%	9.37%	(1.45%)	0.60%	**14.42%**	(5.13%)	(0.13%)	(30.22%)	(23.40%)	(19.31%)	(30.68%)	**(0.0%)**





- Planned agency expenditure for 2025/26 is £1,504k this represents a mandated 40% reduction of 2024/25 expenditure levels.
- In month expenditure is £137k against planned expenditure of £136k representing an adverse variance of £1k.
- Year to date expenditure is £945k against planned expenditure of £826k representing an adverse variance of £119k.
- 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.

PROUD TO CARE

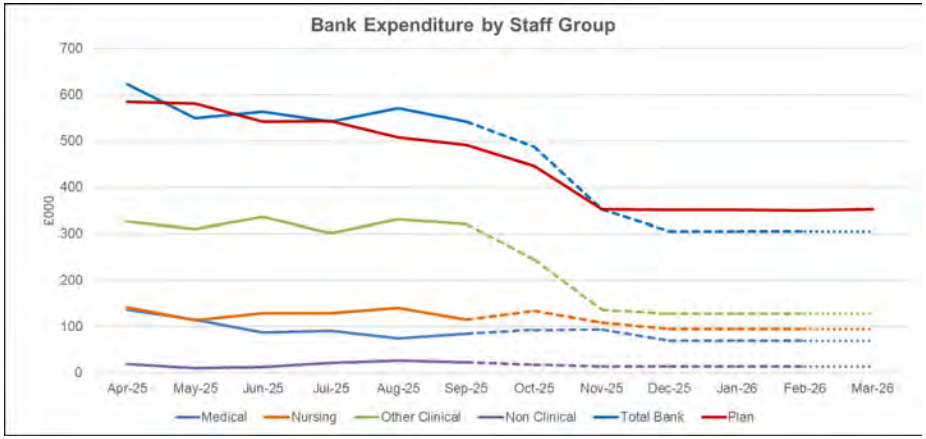
spar

Finance Position

Bank Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Bank Expenditure	Actual						YTD	Forecast						Total
	Apr-25 £000	May-25 £000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	£000	Oct-25 £000	Nov-25 £000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical	**(136)**	**(115)**	**(88)**	**(90)**	**(74)**	**(84)**	**(587)**	**(93)**	**(94)**	**(69)**	**(69)**	**(69)**	**(69)**	**(1,051)**
Acute Services & Urgent Care	(18)	(24)	(24)	(23)	(23)	(17)	**(128)**	(23)	(23)	(23)	(23)	(23)	(23)	**(264)**
Community	(64)	(38)	(29)	(17)	(31)	(28)	**(207)**	(28)	(28)	(28)	(28)	(28)	(28)	**(377)**
Specialist Care	(54)	(54)	(35)	(50)	(12)	(39)	**(243)**	(42)	(43)	(19)	(19)	(19)	(19)	**(402)**
Central Services	0	0	0	0	(9)	0	**(9)**	0	0	0	0	0	0	**(9)**
Nursing	**(142)**	**(114)**	**(129)**	**(129)**	**(140)**	**(115)**	**(768)**	**(133)**	**(108)**	**(95)**	**(95)**	**(95)**	**(95)**	**(1,390)**
Acute Services & Urgent Care	(101)	(88)	(82)	(72)	(81)	(70)	**(494)**	(58)	(42)	(34)	(34)	(34)	(34)	**(730)**
Community	(4)	(4)	(14)	(8)	(9)	(9)	**(49)**	(8)	(8)	(8)	(8)	(8)	(8)	**(95)**
Quality & Nursing	(1)	0	0	(0)	(1)	(0)	**(3)**	0	0	0	0	0	0	**(3)**
People & OD	(2)	(3)	(0)	(3)	(2)	(1)	**(11)**	(1)	(1)	(2)	(2)	(2)	(2)	**(22)**
Primary Care	(1)	(2)	(2)	(3)	(1)	(1)	**(9)**	(1)	(1)	(1)	(1)	(1)	(1)	**(16)**
Specialist Care	(32)	(16)	(31)	(43)	(41)	(33)	**(197)**	(27)	(18)	(12)	(12)	(12)	(12)	**(290)**
Central Services	0	0	0	0	(5)	0	**(5)**	(39)	(39)	(38)	(38)	(38)	(38)	**(235)**
Other Clinical	**(326)**	**(311)**	**(335)**	**(301)**	**(331)**	**(321)**	**(1,926)**	**(244)**	**(137)**	**(127)**	**(127)**	**(127)**	**(127)**	**(2,816)**
Acute Services & Urgent Care	(200)	(186)	(174)	(169)	(175)	(171)	**(1,075)**	(135)	(55)	(55)	(55)	(55)	(55)	**(1,487)**
Community	0	0	(0)	(0)	(0)	(0)	**(1)**	0	0	0	0	0	0	**(1)**
Quality & Nursing	0	(0)	0	0	(0)	0	**(0)**	0	0	0	0	0	0	**(0)**
MACE	(5)	(3)	(4)	(3)	(7)	(5)	**(27)**	(3)	(3)	(3)	(3)	(3)	(3)	**(45)**
Operations	(3)	(3)	(3)	(2)	(4)	(3)	**(18)**	(3)	(3)	(3)	(3)	(3)	(3)	**(37)**
People & OD	(6)	(3)	(2)	(3)	(5)	(8)	**(28)**	(4)	(4)	(4)	(4)	(4)	(4)	**(52)**
Specialist Care	(111)	(114)	(151)	(123)	(129)	(134)	**(761)**	(98)	(70)	(62)	(62)	(62)	(62)	**(1,175)**
Primary Care	(1)	(1)	(1)	(1)	(0)	(1)	**(5)**	(1)	(1)	0	0	0	0	**(7)**
Central Services	(1)	0	0	0	(11)	0	**(12)**	0	0	0	0	0	0	**(12)**
Non Clinical	**(18)**	**(10)**	**(12)**	**(22)**	**(27)**	**(22)**	**(111)**	**(17)**	**(14)**	**(14)**	**(14)**	**(14)**	**(14)**	**(197)**
Acute Services & Urgent Care	(1)	(0)	(0)	(1)	(0)	(1)	**(5)**	(1)	(1)	(1)	(1)	(1)	(1)	**(13)**
MACE	(0)	(0)	(1)	(0)	(1)	(1)	**(3)**	(1)	(1)	(1)	(1)	(1)	(1)	**(7)**
Quality & Nursing	(5)	(3)	(3)	(3)	(4)	(4)	**(21)**	(3)	(3)	(3)	(3)	(3)	(3)	**(40)**
People & OD	(8)	(3)	(7)	(15)	(19)	(13)	**(64)**	(10)	(6)	(6)	(6)	(6)	(6)	**(104)**
Primary Care	(2)	(2)	(0)	(2)	(2)	(3)	**(11)**	(2)	(2)	(2)	(2)	(2)	(2)	**(20)**
Central Services	0	0	0	0	(1)	0	**(1)**	0	0	0	0	0	0	**(1)**
Specialist Care	(1)	(1)	(1)	(0)	(1)	(1)	**(6)**	(1)	(1)	(1)	(1)	(1)	(1)	**(12)**
Total Bank	**(622)**	**(550)**	**(564)**	**(542)**	**(571)**	**(542)**	**(3,392)**	**(488)**	**(353)**	**(305)**	**(305)**	**(305)**	**(305)**	**(5,453)**
Bank as a % of Pay	6.94%	6.16%	6.22%	5.90%	6.26%	5.99%	**6.24%**	5.28%	3.85%	3.32%	3.29%	3.30%	3.30%	**4.97%**
Plan	(585)	(581)	(542)	(543)	(508)	(492)	**(3,251)**	(446)	(352)	(351)	(351)	(350)	(352)	**(5,453)**
Variance to Plan (Overspend) / Underspend	(37)	31	(22)	1	(63)	(50)	**(141)**	(42)	(1)	46	46	45	47	**(0)**
Bank Variance as a % of Plan	6.37%	(5.36%)	4.02%	(0.13%)	12.46%	10.25%	**4.34%**	9.39%	0.18%	(13.04%)	(13.04%)	(12.79%)	(13.29%)	**0.0%**



- 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 £492k representing an adverse variance of £50k.
- Year to date expenditure is £3,392k against planned expenditure of £3,251k representing an adverse variance of £141k.
- Forecast bank expenditure is to plan.
- 75% of expenditure to date relates to nursing (qualified and unqualified) representing an adverse variance to plan of £212k. Nursing expenditure is forecast to decline following the induction of newly qualified nurses in October.
- 17% of expenditure to date relates to medical staffing with a favourable variance to plan of £272k.
- The remaining adverse variance to plan is due to therapeutic staff to date totalling £130k, Infrastructure Support £69k and AHPs £3k.

PROUD TO CARE

spar

Finance Position

CIP Delivery

North Staffordshire Combined Healthcare NHS Trust

2025/26 Efficiency Identified Schemes	Target £000	YTD 2025/26 Plan £000	YTD 2025/26 Actual £000	YTD 2025/26 Variance £000	Total Forecast Plan £000	Total Forecast Actual £000	Total Forecast Variance £000	*Of which is Recurrent Plan £000*	*Of which is Recurrent Actual £000*	*Of which is Recurrent Variance £000*	*Recurrent Full Year Effect Plan £000*	*Recurrent Full Year Effect Actual £000*	*Recurrent Full Year Effect Variance £000*
Clinical													
Acute	360	142	110	(31)	360	261	(99)	*360*	*261*	*(99)*	*360*	*319*	*(41)*
Community	2,045	806	1,296	490	2,045	2,783	738	*2,045*	*1,983*	*(62)*	*2,045*	*2,210*	*165*
Specialist	644	254	107	(147)	644	380	(264)	*644*	*380*	*(264)*	*644*	*474*	*(171)*
Primary Care	19	8	5	(2)	19	11	(9)	*19*	*11*	*(9)*	*19*	*11*	*(9)*
Clinical Total	**3,069**	**1,209**	**1,519**	**310**	**3,069**	**3,435**	**366**	***3,069***	***2,635***	***(434)***	***3,069***	***3,013***	***(56)***
Corporate													
CEO	42	16	7	(9)	42	15	(27)	*42*	*2*	*(40)*	*42*	*2*	*(40)*
Q&N	300	118	32	(86)	300	68	(232)	*300*	*68*	*(232)*	*300*	*70*	*(230)*
S&D	364	143	15	(128)	364	30	(333)	*364*	*2*	*(361)*	*364*	*4*	*(360)*
Finance	93	37	9	(28)	93	66	(27)	*93*	*66*	*(27)*	*93*	*77*	*(16)*
Performance	32	13	0	(13)	32	0	(32)	*32*	*0*	*(32)*	*32*	*0*	*(32)*
Estates	56	22	0	(22)	56	0	(56)	*56*	*0*	*(56)*	*56*	*0*	*(56)*
MACE	104	41	0	(41)	104	0	(104)	*104*	*0*	*(104)*	*104*	*0*	*(104)*
Operational	1	0	0	(0)	1	1	(0)	*1*	*1*	*(0)*	*1*	*1*	*(0)*
People	174	69	5	(63)	174	11	(164)	*174*	*11*	*(164)*	*174*	*12*	*(162)*
Corporate Total	**1,166**	**459**	**69**	**(390)**	**1,166**	**190**	**(977)**	***1,166***	***149***	***(1,018)***	***1,166***	***166***	***(1,001)***
Trustwide	**1,532**	**1,098**	**104**	**(994)**	**1,532**	**2,143**	**611**	***167***	***1,174***	***1,007***	***167***	***1,298***	***1,131***
Productivity	**1,600**	**798**	**800**	**2**	**1,600**	**1,600**	**0**	***1,600***	***1,600***	***0***	***1,600***	***1,600***	***0***
Total Trust CIP	**7,367**	**3,564**	**2,492**	**(1,072)**	**7,367**	**7,367**	**0**	**6,002**	**5,557**	**(445)**	**6,002**	**6,077**	**75**

- 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 6 the Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £4.6m fully achieved / transacted, £2.1m fully developed, £0.4m plans in progress and £0.3m opportunities identified.

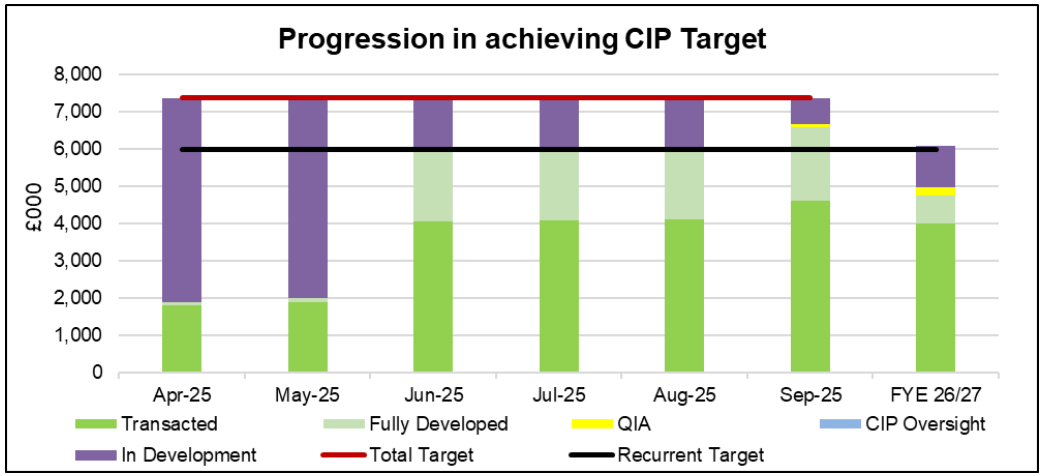
PROUD TO CARE

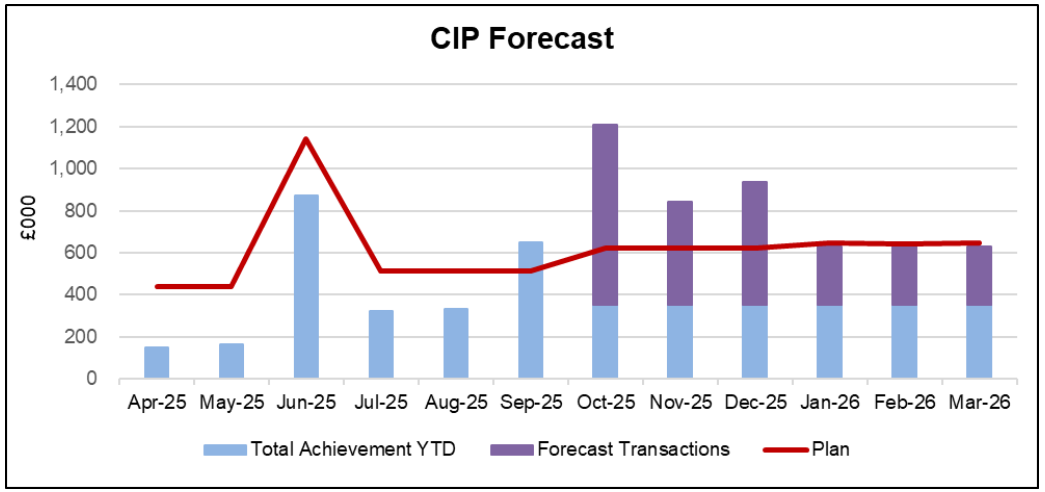
spar

Finance Position

CIP Delivery

North Staffordshire Combined Healthcare NHS Trust





- Top graph shows the Trust progress in achieving the total £7.4m target and full year effect recurrent £6.0m target.
- Bottom graph shows the total monthly phasing of the £7.4m target against the amount that has been achieved year to date and forecast.
- Pie chart shows currently 4% of schemes are considered high risk, 7% medium risk and 89% low risk.

PROUD TO CARE

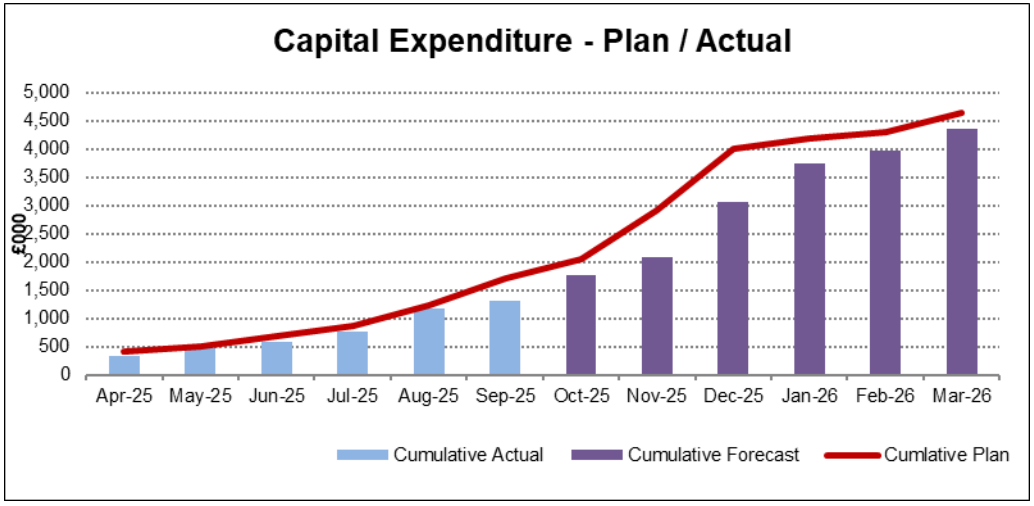
spar

Finance Position

Capital Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Capital Expenditure	Annual Plan £000	Year to Date Against Plan			Forecast Outturn Against Plan			Forecast Outturn Against Budget		
		Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000	Capital Budget £000	Forecast £000	Variance £000
Operational Schemes	**786**	**318**	**16**	**(302)**	**786**	**692**	**(94)**	**786**	**692**	**(94)**
IFRS16 Leases	199	198	16	(182)	199	188	(11)	199	188	(11)
Medical Equipment	30	0	0	0	30	30	0	30	30	0
Estates Fleet	120	120	0	(120)	120	120	0	120	120	0
Energy Efficiency	75	0	0	0	75	75	0	75	75	0
Capital freedom & flexibilities	362	0	0	0	362	279	(83)	362	279	(83)
Digital	**429**	**20**	**20**	**(0)**	**429**	**667**	**238**	**656**	**667**	**11**
IT Digital Replacement	239	0	0	0	239	400	161	239	400	161
Capitalised Salaries - IT Device Replacement	40	20	20	(0)	40	40	0	40	40	0
Digital Innovations	50	0	0	0	50	0	(50)	50	0	(50)
Digital Infrastructure	100	0	0	0	100	0	(100)	100	0	(100)
NHS Notify	0	0	0	0	0	227	227	227	227	0
Strategic Schemes	**1,943**	**1,364**	**1,264**	**(100)**	**1,943**	**1,896**	**(47)**	**1,943**	**1,896**	**(47)**
Dormitory Conversion Trust funded	1,943	1,364	1,264	(100)	1,943	1,896	(47)	1,943	1,896	(47)
Contingency/Reactive Schemes	**0**	**0**	**18**	**18**	**0**	**86**	**86**	**0**	**86**	**86**
PICU Air conditioning	0	0	0	0	0	29	29	0	29	29
Ashtenne Relocation	0	0	0	0	0	37	37	0	37	37
Crisis Centre Doors	0	0	20	20	0	20	20	0	20	20
Contingency	0	0	(3)	(3)	0	0	0	0	0	0
Total Trust Funded Capital Expenditure	**3,158**	**1,702**	**1,317**	**(385)**	**3,158**	**3,341**	**183**	**3,385**	**3,341**	**(44)**
Backlog Maintenance	470	0	0	0	470	514	44	470	514	44
Frontline Digitisation Programme PDC Funded	1,000	0	0	0	1,000	500	(500)	1,000	500	(500)
Total Gross Capital Expenditure	**4,628**	**1,702**	**1,317**	**(385)**	**4,628**	**4,355**	**(273)**	**4,855**	**4,355**	**(500)**
Total Charge against Capital Resource Limit	**4,628**	**1,702**	**1,317**	**(385)**	**4,628**	**4,355**	**(273)**	**4,855**	**4,355**	**(500)**



- The Trust's annual capital plan is £4,628k. The Trust has been successful securing additional PDC funding of £227k for the NHS Notify scheme, increasing the capital budget to £4,855k.
- The Trust's year to date gross capital expenditure is £1,317k against planned expenditure of £1,702k representing a favourable variance of £385k.
- The favourable variance is due to timing in relation to the delay in the estates fleet scheme and leases. Both are expected to deliver planned levels by the end of the financial year.
- Forecast expenditure is £273k below plan, £500k below budget due to slippage on the frontline digitisation programme.
- The total charge to the Trust's Capital Resource Limit at Month 6 is £1,317k, £385k below plan.

PROUD TO CARE

spar

Finance Position

Statement of Financial Position

North Staffordshire Combined Healthcare NHS Trust

SOFP	M4 £000	M5 £000	M6 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	20,255	20,612	20,698
Property, Plant and Equipment	16,265	16,180	16,094
Right of Use Assets	2,858	2,821	2,804
Intangible Assets	1,662	1,619	1,576
NCA Trade and Other Receivables	585	579	573
Total Non-Current Assets	**41,625**	**41,811**	**41,745**
Current Assets			
Inventories	79	78	84
Trade and Other Receivables	8,989	6,146	6,234
Cash and Cash Equivalents	31,104	35,926	32,833
Total Current Assets	**40,172**	**42,149**	**39,151**
Current Liabilities			
Trade and Other Payables	(23,111)	(25,089)	(22,098)
Provisions	(1,622)	(1,622)	(1,622)
Borrowings	(3,072)	(3,072)	(3,072)
Total Current Liabilities	**(27,805)**	**(29,783)**	**(26,792)**
Net Current Assets / (Liabilities)	**12,368**	**12,367**	**12,359**
Total Assets less Current Liabilities	**53,993**	**54,178**	**54,104**
Non Current Liabilities			
Provisions	(1,543)	(1,838)	(1,838)
Borrowings	(16,440)	(16,265)	(16,058)
Total Non-Current Liabilities	**(17,983)**	**(18,103)**	**(17,896)**
Total Assets Employed	**36,010**	**36,075**	**36,208**
Financed by Taxpayers' Equity			
Public Dividend Capital	23,983	23,983	23,983
Retained Earnings reserve	5,015	5,080	5,213
Revaluation Reserve	7,012	7,012	7,012
Total Taxpayers' Equity	**36,010**	**36,075**	**36,208**

Current receivables are £6,234k of which:

- £2,215k is based on accruals (not yet invoiced).
- £4,019k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,423k 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 £29,792k of which:

- Trade and Other payables remain high at £22,098k because of deferred income and patient placement invoices and accruals.

Liquidity ratio:

- A good liquidity ratio should be above 1.0.
- The Trust current ratio is 1.5 showing the Trust can cover its current debt obligation.

PROUD TO CARE

spar

Finance Position

Better Payment Practice Code

NHS
North Staffordshire Combined Healthcare NHS Trust

Better Payment Practice Code	In Month			YTD Total		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices						
Total Paid	40	972	1,012	176	5,470	5,646
Total Paid within Target	38	951	989	170	5,169	5,339
% Number of Invoices Paid	95%	98%	98%	97%	94%	95%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**0%**	**3%**	**3%**	**2%**	**(1%)**	**(0%)**
Value of Invoices						
Total Value Paid (£000s)	1,122	10,087	11,209	3,798	47,780	51,578
Total Value Paid within Target (£000s)	763	9,932	10,695	3,412	46,861	50,273
% Value of Invoices Paid	68%	98%	95%	90%	98%	97%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**(27%)**	**3%**	**0%**	**(5%)**	**3%**	**2%**

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 6, the Trust has achieved the 95% target on both the value of invoices paid at 95% and the number of invoices paid at 98% of invoices paid within 30 days. NHS invoices paid during month 6 did miss the target on the value of invoices paid due to one invoice from Coventry and Warwickshire Partnership NHS Trust with a value of £335k being authorised later than 30 days.

- Year to date the Trust has achieved the 95% target on the value of invoices paid at 97% but is currently slightly below target on the number of invoiced paid within 30 days at 94.6%. 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.

PROUD TO CARE

spar

Finance Position Summary

North Staffordshire Combined Healthcare NHS Trust

Trust Board are asked to receive the Month 6 position noting:

- The year-to-date surplus of £141k against a planned deficit of £423k, giving a favourable variance of £564k.
- Agency expenditure of £945k against a plan of £826k, resulting in an adverse variance of £119k. Medical agency must reduce in order to get back in line with the plan.
- Bank expenditure of £3,392k against a plan of £3,251k, giving an adverse variance of £141k. 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 £4.6m fully achieved / transacted, £2.1m fully developed £0.4m plans in progress and £0.3m opportunities identified.
- The Trust has spent £1,317k on capital, which is £385k behind plan.
- The cash position of the Trust on 30th September with a balance of £32.8m.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 11a

F&R Committee Assurance Report

Report provided for:			
Approve	☐	Alert	☐
Assure	☐	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Martin Evans, Non-Executive Director (Vice Chair of F&R Committee)
Prepared by:	Lisa Dodds, Deputy Chief Finance Officer
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk:	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
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions with clear evidence of the achievement of desired outcomes.
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
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
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 2nd October 2025.

	Updates were received relating to: • M5 Trust Performance (IQPR) • Risk Register • M5 Finance Position • M5 ICS Finance • Cost Improvement Programme • Quarter 1 2025/26 SLR Report • Estates and Capital • Business Opportunities • Digital Quarterly update • Orbis updates *To note, although a level 6 assurance has been given for this report, further work will be done on the Digital report to provide Committee with a higher level of assurance in future.*

VERSION CONTROL:

Version	Report to	Date Reported
1	Private Trust Board	02/10/2025
1	Public Trust Board	03/11/2025

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 2nd October 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:

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 M5
Committee received the report highlights included improvements in clinical ready for discharge, reduction in out of area placements and improvements average length of stay. Challenges on sickness levels, appraisals and Performance Improvement Plans were presented. Discussions took place on referral to assessment performance. Committee took assurance on the out of area placements reductions.

Finance Position M5
Key messages highlighted included a small year-to-date surplus which is better than plan at this point in the year. Agency costs were within target for the first time this year, however bank costs were above the required target in month. 61% of CIP schemes have been transacted in month 5 against the annual target. Capital expenditure is slightly lower than planned year-to-date, forecast to be on plan. Discussions took place on bank and agency expenditure forecast.

ICS Finance Update M5
At month 5 the System reported a year-to-date deficit of £20.5m, £0.5m favourable to plan. The net risk has reduced to £25.5m. Concerns were raised about the System's ability to mitigate the risks and what impact that would have on NSCHT as well as concerns on the winter plan modelling. If the System deviate from plan this will put the deficit support funding at risk.

Cost Improvement Programme
Key messages highlighted included progress made during September and recognition that ICB weekly reporting has ceased. Discussions took place on a specific scheme and the CIP Framework. Committee acknowledge the assurance they took on progress.

Service Line Reporting Q1
Highlights include the rebasing of block contract income against service lines, the top 10 and bottom 10 contributing services and productivity metrics. Explanations were provided on the interpretation of the data on specific elements of the report. Committee queried how this information was being used across the Trust and from a F&R perspective what Committee can expected to see from the use of the data.

Estates Update
Committee received the report with highlights on backlog maintenance, Project Chrysalis running to timescales, the pipework in EMU, fire safety compliance and water temperature compliance. Discussions took place on site wide balancing for water temperature compliance.

Business Opportunities
Committee received the report highlighting the Trust was successful in securing funding for supporting children and young people with behaviours of distress project. Connect to Work tender with Staffordshire County Council has been submitted. Discussions took place on timescales for the Connect to Work tender.

Digital Quarterly Assurance Update
First quarterly assurance report provided to Committee. Highlights included updates on Strategic Digital Plan progress, the Trust's positive digital maturity position, CIP digital schemes, and digital

initiatives and innovations. Discussion took place on the Strategic Digital Plan for increasing performance and reducing costs. Challenges were raised on the assurance provided by the report for the risks raised.

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 engagement from teams to recruit Agents of Change.

APPROVE:

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

Heading:

Risk Register
There were no new risks, no closures and no score changes for approval. 1 risk have had date revision.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 6th November 2025 at 10am via MS Teams.

Committee Chair: Martin Evans, Vice Chair of the Finance & Resource Committee.

REPORT END

Enclosure No: 11b

F&R Committee Assurance Report

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Russell Andrews, Chair of F&R Committee & NED
Prepared by:	Lisa Dodds, Deputy Chief Finance Officer
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk:	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
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
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
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
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 6th November 2025.

	Updates were received relating to: • Risk Register Q2 Deep Dive • Board Assurance Framework Q2 • Policy Report • Digital Replacement Programme Capital Business Case • Microsoft Licensing • M6 Trust Performance (IQPR) • M6 Finance Position • M6 ICS Finance • Financial Planning • Underlying Position KLOE Assurance Framework • Strengthening Financial Management Toolkits • Cost Improvement Programme • Estates and Capital • Business Opportunities • Transformation Management Assurance Report Q2 • Sustainability Assurance Report Q2 • Orbis updates

VERSION CONTROL:

Version	Report to	Date Reported
1	Public Trust Board	06/11/2025

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 6th November 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:

No areas to highlight

ADVISE:

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

Heading:

ICS Finance Update M6
At month 6 the System reported a year-to-date deficit of £21.2m, £0.7m favourable to plan. The net risk has reduced to £24.7m. Committee noted the overall improvement in the ICS position over recent months.

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 M6
Committee received the report. Discussions took place on the challenges on appraisals in particular corporate team – this issue was referred to PCDC. Workforce plan variance was also referred to PCDC.

National priorities performance out of area placements was slightly higher than the previous month and there was a reduction in month for clinically ready for discharge. There are also clinically ready for discharge patients in out of area placements which the Trust is work to address.

Finance Position M6
Key messages highlighted included a small year-to-date surplus which is better than plan at this point in the year. Agency costs were in line with plan in month; however, bank costs were above the required target in month. CIP delivery is behind plan noting that the Trust is forecasting full achievement of the £7.4m, 62% of which has already been transacted to month 6. Capital expenditure is slightly lower than planned year-to-date, forecast to be on plan.

Financial Planning
The report highlighted the requirement for a 3-year revenue plan with multiyear efficiency requirements as well has a 3% contingency reserve for one-time investments and service transformation. The reported noted that the Trust has a current underlying deficit which would be the start point for planning.

Underlying Position KLOE Assurance Framework
The assurance framework was presented to provide assurance on that the underlying position is based on the technical guidance issued by NHSE.

Strengthening Financial Management Toolkits
The Trust has completed NHSE grip and control checklist for 2025/26 and the Well-Led Finance Self-Assessment 2025/26 as best practice. Discussions took place on the scrutiny and process the self-assessment went through.

Cost Improvement Programme
Key messages highlighted included progress made during October and acknowledgment of the audit recommendations. Discussions took place on whether particular Directorates had more challenges to deliver CIP than others.

Estates Update
Committee received the report with highlights on capital funding allocations for Freedoms & Flexibilities and Estates Safety. Discussions took place on site wide water quality issues and the appointment of a specialist report to provide recommendations - this will delay the handover of phase 5 of Chrysalis.

Business Opportunities
Committee received the report highlighting the Trust was successful with the Connect to Work tender with Staffordshire County Council to get on the framework and the documents have been published for the tender with Stoke City Council. ICB have confirmed they are supportive of the CYP MDT neighbourhood pilot.

Transformation Management Assurance Report Q2
The report was presented to Committee highlighting current projects.

Sustainability Assurance Report Q2
The report highlighted the progress on the Green Plan and the detailed action plan required.

Orbis Update
Committee received the report updating that service pack 5 has gone live so have seen improvements with the Lorenzo LBM issues. Further updates to Lorenzo will need to be implemented and sustained before Orbis can be implemented. Formally written to the supplier driven from the monthly Orbis Board.

APPROVE:

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

Heading:

Risk Register – Q2 Deep Dive
There were no new risks, no closures and 2 score changes for approval. Score reductions in relation to the Green Plan deliverability and Clinical Transformation Lead for the Green Plan were approved. 2 risks had date revisions were noted.

Board Assurance Framework Q2
Proposed score reduction to BAF risk 1 (delivery of the 10-year plan) was NOT approved by Committee, further evidence required. Challenges were raised on the neighbourhood health maturity. Risk 5 (financial sustainability) and risk 6 (digital and data transformation) were received.

Policy Report
Approval given for Lift Safety Policy and Door Access Policy for 3 years.

Digital Replacement Programme Capital Business Case
Capital purchase of end user devices was approved subject to capital funding availability. Approval from Board is required.

Microsoft Licensing
Approved option 3 which uses enhanced role profiling to enable the Trust to manage license requirements within current budgets with minimal levels of risk to clinical safety and business continuity. Approval from Board is required.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 4th December 2025 at 10am via MS Teams.

Committee Chair: Russell Andrews, Chair of the Finance & Resource Committee.

REPORT END

Enclosure No: 12a

Quality Committee Assurance Report –October 2025

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

Report to:	Public Trust Board
Date of Meeting:	13th November 2025

Presented by:	Pauline Walsh, Chair/Non-Executive Director – Quality Committee
Prepared by:	Zoe Grant, Deputy Chief Nursing Officer Helen Sweeney, Deputy Director of MACE and Medicines
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 2nd October 2025.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	03/10/25
V2	Public Trust Board	03/11/25

Trust Board Assurance Report from the Quality Committee meeting held on 2 October 2025

Introduction:

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

Deep Dive – Primary Care

The Committee received a deep dive presentation from the Clinical Director and Associate Director of Operations (Primary Care Directorate), in relation to General Practice. The deep dive looked at access into Primary care, the benefits and advantages which our services have with the earlier adoption of the Patches online system, our integrated model of General Practice. There was also discussion regarding the benefits and challenges of the new contracting arrangements, including the requirement for online appointment availability within General Practice.

The committee were also assured to hear the benefits that Primary Care services have experienced by being integrated with a Mental Health and Learning Disability Trust.

System Update

The Chief Nursing Officer gave an update regarding the rise in COVID community transmissions, the Trust have experienced this rise, with 2 ward outbreaks currently.

The Flu Vaccine programme is now live in the Trust, our vaccination target for staff is 55%.

Patients Inappropriately Placed Out of Area

The Committee were advised that there are currently 17 patients receiving Acute Care and Treatment in Out of Area beda. An update regarding the oversight, re-patriation back to services and monitoring safety of these patients was provided to the committee.

ADVISE:

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

CQC Update
The Trust received a copy of the Unannounced Mental Health Act report for Ward 3, following the CQC inspection in August 2025. There are a few actions for improvement, which the team have already started to address; a formal action plan will be presented back to the CQC on 3 October 2025.

NCISH Report
Quality Committee have requested a further update regarding the Trusts position in relation to the findings of this report and the associated work plan.

Pharmacy report
The committee were updated in relation to the preparedness of Trust and prescribing pharmacists in 2026. Additional assurance was requested in relation to the monitoring of patients following the administration of Rapid Tranquilisation medication.

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 August 2025 –
Report received for assurance the overall staffing fill rate was 103.8%. The committee were assured that the Trust's Staffing levels are adequate and safe.

Safe staffing Annual report 2024/25

The annual report was received by the Committee and recommendations noted. Of these, there were 2 recommendations for changes in establishment uplift, these were Ward 1 and the Edward Myers Unit

IQPR M05 2025/26
There was a discussion noting the reduction in the Trust's waiting times and assurance sought regarding the mitigation in place to reduce harm for people whilst they are waiting.

The committee also noted the removal of FFT Performance Improvement plan due to a sustained period of positive performance.

APPROVE:

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

Risk Register – Deep dive
Risk 1139 approved to close

Ligature Risk Deep Dive

The Quality Committee will receive the annual ligature at the next Committee; this is likely to provoke a more thorough review of risk at team level.

Policies

The Committee approved the following polices**.**

Approved for 3 years

4.33 Policy for the use of clinical photography and conventional or digital video recording
3.45 Temporary Staffing Policy and Bank and Agency Guidance Notes
3.47 Electronic Rostering Policy
4.43 Prevent Policy
R07 Guidelines for when police use incapacitant spray or taser on Trust premises
1.74 Clinical Environment Policy (Inclusive of Environmental Ligature Risk Assessment)

Approved for extension for 12 months

5.41 Lone Worker Policy
4.39 Clinical Audit Policy
1,70 Managing Allegations of Abuse

Approved for 1 year

Business Continuity Management System Policy

The committee requested additional assurance regarding the risk appraisal approach when requesting extensions to policies.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 5 November 2025 at 2pm via MS teams.

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

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 12b

Quality Committee Assurance Report – November 2025

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

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

Aligned to Board Assurance Framework Risk:	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, increasing needs and a failure to evidence interventions with support recovery.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Quality Committee
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:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	Not applicable
Recommendation / Required Action:	For assurance
Executive Summary:	*The attached assurance report describes the business and outputs from the meeting of the Quality Committee on 6 November 2025.*

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	07.11.25

Trust Board Assurance Report from the Quality Committee meeting held on 6 November 2025

Introduction:

This assurance report to the Trust Board is produced following the latest Quality Committee. The meeting was held 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 system / UHNM are seeing the impact of winter pressures earlier this year.

Out of Area placements
There remain ongoing challenges with out of area placements, with an additional concern that we now have patients in out of areas beds who are also clinically ready for discharge.

ADVISE:

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

CQC Update
The committee were updated that the Trust received notification that there will be further changes to the personal from CQC who will be working with us. We are awaiting the opportunity to meet with these individuals.

There was a discussion held regarding the way the Trust supports Seriously Mentally Ill patients who present with risks of harm – The committee have requested a deep dive session into this in the coming months.

ASSURE:

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

Deep Dive – Legal Services presentation by Legal Services Manager

The committee received a presentation into the work overseen by our legal service manager, we received an overview of the key areas of focus and detail around the MH Law, Legal affairs and the coroner's office.

There was a good level of assurance offered regarding the hospital managers processes and improvements being made, such as updated report templates.

The committee were also updated regarding some of the potential pending impacts of the new Mental Health Law bill and amendments and when we may expect to hear more updates of this.

The following reports were received for assurance with a good level of discussion:

- **Safe staffing report September 2025**
- **IQPR M06 2025/26**
- **Clinical Audit Q2 2025/26**
- **Clinical Effectiveness Report Q2 2025/26**
- **Mental Health Compliance Action Plan Q2 2025/26**
- **Ligature Annual Report 2025**
  There was discussion around two keep factors of environmental design, management and oversight of this and the clinical risk implications of patients who pose a risk of harm by ligature, noting that the risk of harm by anchored and non-anchored ligatures both need to be proactively managed. The report made recommendations for capital investment which the committee supported.
- **Quality Assurance Group Q2 2025/26**
- **Research and Development Annual report**

APPROVE:

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

Risk Register – Deep dive - approved

Board Assurance Framework Q2 – approved

Policies

Approved for 3 years

Consultant Pay Progression Policy
5.31 Water Systems Management Policy
5.06 Waste Management Policy

5.27 Electrical Safety Policy

The two policies below have been removed from this committee for approval and will be re-issued to the next:

1.83 Safer Staffing Policy
1.0 Complementary Therapies

Approved for extension for 12 months
MHA20 Procedural Guidance for Independent Mental Health Advocate Service Policy Test
MHA24 Receipt and Scrutiny of Applications for Detention Policy
MHA26 Voting Rights for Mental Health Patients' Policy
MHA27 Non-Medical Approved Clinician Policy
MHA28 Covert Administration of Medicines Policy

1.28 Non-Acute Delays Protocol – committee agreed to the removal of this policy.

Next Steps (including timeframes):

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

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

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 13a

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

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

Report to:	Public Trust Board
Date of Meeting:	13th November 2025

Presented by:	Martin Evans, Chair, People, Culture & Development Committee
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 updates in the form of Alert, Advise, Assure and Approve.

VERSION CONTROL:

Version	Report to	Date Reported
1.0	Private Trust Board	30.09.2025
1.0	Public Trust Board	03.11.2025

Trust Board Assurance Report from the People, Culture and Development Committee Focus meeting held on 29th September 2025

Introduction:

This assurance report is produced following the latest PCDC, which was a Focus meeting held in person for a duration of three hours. The purpose of the session was to facilitate a focused discussion on the Trust's People Plan. Whilst some governance items were presented for assurance, most of the session was spent reflecting on progression of the plan to date, and the needs and priorities required in the Trust's People Plan moving forward.

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.

Members and attendees were invited to contribute to the focused session, bringing their expertise and welcoming a challenging lens to contribute and design a refreshed People Plan and resulting priorities ('People Big Moves').

The session outlined through a combination of presentations and group discussion:

- Understanding the national and local context for rationale for change.
- Learning from the achievements of the existing People Plan.
- Acknowledging that the current Plan has too many areas of priority making it unachievable to deliver and measure
- Exploring the value of identifying three 'Big Moves' that form priorities within a refreshed People Plan.
- Creating a 12-month operational plan to enable some sharp focus, and the ability to reflect some external uncertainty and increase agility to accommodate further demand moving forward.
- Approach to developing measurements of success to monitor impact.
- Commitment to next steps; including developing the people operating model, people action plan and KPIs.
- Reflecting on how the Committee needs to operate to support and influence delivery whilst seeking assurance as Board in the Committee – changes required to the ToR, membership and focus of meeting.

The three Big Moves agreed by the committee were the following:

1. Workforce Optimisation: improving efficiency and effectiveness of our people through reduced sickness absence, effective recruitment, vacancy control and productivity.
2. Workforce Transformation: organisational design and workforce planning to align to the Trust's strategic priorities and future models of care. Agility to respond to a changing commissioning context, enabled through a People function that is high performing.
3. Our Combined CARE Culture: leveraging our intelligence to in-reach our 'at risk' services with a comprehensive organisational development offer to reduce the risk of formal escalation of issues. Demonstrating our values in action; expecting leaders to support with managing their team and offering interventions to reflect the diversity of challenges for our people.

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

Through the focused and facilitated discussion, members and attendees were able to contribute to activities that would form part of the People Plan. This included mapping each activity on an impact / effort matrix that allowed the Committee to understand timescales in relation to anticipated delivery.

A reflection on how people priorities have evolved resulted in a discussion on what workstreams may need to close or merge into another priority to ensure the 'Big Moves' align with organisational objectives.

Understanding the governance and structures to seek assurance on the delivery of the 'Big Moves' was discussed, with an acknowledgement that whilst we aim to be outstanding in our people approach, there are implications that may need to be surfaced, for example, changes to people team roles or capacity to accommodate future requests that fall outside of the priorities. A review of our structures that report into the Committee was supported.

ASSURE: This section provides assurance of the quality of service and activity delivered under the PCDC's remit and programmes of work.

The committee received the PCDC risks and acknowledged that there were no new risks, no score changes and no closures.

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

The following policies were approved:

Recruitment & Selection Policy

Temporary Staffing Policy and Procedure

Non-NHS-Terms-and-Conditions-Remuneration-Policy

The Committee approved the approach to refreshing the People Plan, including the three 'Big Moves'. The Committee agreed the next steps and timescale for receiving updates on actions relating to the People Plan.

Next Steps (including timeframes):

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

Committee Chair: Martin Evans, Chair of the People, Culture & Development Committee

REPORT END

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 13b

PEOPLE, CULTURE & DEVELOPMENT COMMITTEE ASSURANCE REPORT

Report provided for:			
Approve	☐	Alert	☐
Assure	☐	Advise	☒

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Martin Evans, Non-Executive Director and Chair, People, Culture & Development Committee
Prepared by:	Victoria Self, Deputy Chief People Officer
Executive Lead:	Frieza Mahmood, Chief People Officer

Aligned to Board Assurance Framework Risk:	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.
7 Levels of Assurance:	Level 3 - Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Approval / Review:	Trust Board
Strategic Priorities:	Prevention - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	Funding
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	The work of the Committee and our local refreshed People Plan continue to align with both the ICB, and national People Plan requirements. However, a lack of mutual support for a collaborative approach to funding for the Staff Psychological Wellbeing Hub and Oliver McGowan training will adversely impact on our offer to staff.

Recommendation / Required Action:	The Board is asked to approve/extend the policies detailed in the Quad A report and be assured that the Committee is proactively monitoring the refreshed aspects of the Trust's People Plan.
Executive Summary:	The Quad A report provides assurance from the People, Culture & Development Committee to Trust Board on updates in the form of Alert, Advise, Assure and Approve.

VERSION CONTROL:

Version	Report to	Date Reported
1.0	Public Trust Board	13.11.2025

Trust Board Assurance Report from the People, Culture and Development Committee meeting held on 10th November 2025

Introduction:

This assurance report is produced following the latest PCDC, which was held on Microsoft Teams and was quorate. The Committee focused on seeking assurance on key metrics that demonstrate compliance with workforce indicators and staff experience.

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.

- The Committee shared concerns with the ICS decision to terminate the contract for the staff psychological wellbeing hub. Whilst members were alerted to the redundancy risk, the detrimental impact on colleagues was noted, particularly in the context of high levels of sickness absence. The Committee welcomed further exploration on how to mobilise a local service, utilising the skills of the colleagues at risk and providing sustainable support.

- Post submission of papers for Committee, the BMA announced industrial action for resident doctor's 14th to 19th November. Assurance that plans are in place to mitigate risks was provided. Further discussion noted the risk of national negotiations for Agenda for Change annual pay award; reflecting that this is likely to be prolonged and more difficult when compared to previous years.

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

- Reflecting on the reports and discussions during the Committee, members highlighted the detrimental impact on wider collaborative working through some decisions being made at ICS level; for example, unwillingness to collaborate on Oliver McGowan training, lack of senior commitment across organisations to identify funding to support the High Potential development Scheme and the decision to close the staff psychological wellbeing hub. Two of these programmes have held a strong reputation nationally.

- These examples result in a reduced level of confidence when seeking to collaborate in future arrangements / partnerships.

- A detailed discussions was held in relation to low performance on appraisals with some assurance provided that work is progressing in the following areas to improve compliance:

  - Hierarchy set up within LMS to be reviewed to ensure teams receive accurate compliance reports.
  - People Business Partners working with directorates to assign target dates for completion, that in turn, create an accurate trajectory for achieving compliance.

- Local engagement across directorates to validate current level of compliance and capture where appraisals have not been recorded as completed.

An update on progress will be received at the next Committee.

ASSURE: This section provides assurance of the quality of service and activity delivered under the PCDC's remit and programmes of work.

The Committee received assurance via detailed reports on the following priorities:

- Workforce metrics as at month six 2025/26.
- Initial engagement for co-development of sickness improvement plans.
- Workforce plan as at month six 2025/26.
- 12-month vacancy review deep dive.
- Student placement experience.
- Freedom to speak up Q2 report.

The Committee welcome continued updates on these priorities as work progresses.

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

The Committee approved the following:

- The Board Assurance Framework – no amendments were made.
- An increase in the residual risk for 1856 in relation to Oliver McGowan mandatory training, with assurance that mitigations are in progress including exploration of business case.
- The terms of reference for the Professional Leads Advisory Group.
- The refreshed People Plan to replace the current 5-year plan. The Committee will receive a future update that describes the achievements from the previous plan and an outline of the activities that have stopped before socialising through a communications plan.
- The following policies:

  - Learning and Development Policy
  - Mandatory Education Policy
  - Mobile Phone Policy
  - Induction Policy
  - Appraisal Policy
  - Compassionate and Special Leave Policy
  - Disciplinary Policy

Next Steps (including timeframes):

The next PCDC business meeting will be held on: 5th January 2026.

Committee Chair: Martin Evans, Chair of the People, Culture & Development Committee.

REPORT END

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Our Combined People Plan 2026

Our 12 month plan to enabling our people to be outstanding

PROUD TO CARE

spar

Introduction

When we launched the Combined People Plan in 2023, we said it was one of the most important documents in the Trust; and the progress since has proven that true.

Thanks to your hard work, we've delivered nationally leading NHS Staff Survey results, reduced bank and agency spend and kept our services strong, even in tough times. But a great plan doesn't sit on a shelf. It grows with us.

As the NHS continues to change, it's the right time at the halfway point of our 2023 to 2028 Plan to pause, reflect and refresh. We're looking at what's working, what needs to evolve and what we can stop to make space for what matters most.

What hasn't changed – and never will – is our commitment to you. We're here to support and grow with every person who chooses to be part of our Combined family. We hope this refreshed People Plan feels meaningful to you, and we're excited to continue building something special together; always aiming to be outstanding in all we do and how we do it.

Dr Buki Adeyemo
Chief Executive

Frieza Mahmood
Chief People Officer

New challenges, new contexts, new opportunities

NHS
North Staffordshire Combined Healthcare NHS Trust

Anyone who's worked in the NHS knows one thing: change is constant. Since launching the Combined People Plan in 2023, we've seen that play out both across the NHS and in the communities we serve. The illustration below highlights some of the key changes.

10 Year Health Plan

How we need to make three 'big shifts' on how the NHS works:

- Hospital to community: so that more care is available on people's doorsteps and in their homes
- Analogue to digital: new technology to liberate staff from admin and allow people to manage their care as easily as they bank or shop online
- Sickness to prevention: to reach patients earlier and make the healthy choice the easy choice.

Continue to be Outstanding

- Continue to demonstrate our high performance through NHS oversight framework.
- Deliver financial balance.
- Commitment to deepen partnerships with voluntary organisations and NHS provider collaboratives.

Working @ Combined

- Changes in People leadership team provides opportunity for refresh whilst reflecting the external context and becoming a modern, enabling People function.
- Staff Survey feedback indicates that we need to address behavioural and cultural issues, whilst improving team effectiveness.
- Embedding opportunities for service transformation, such as Culture of Care and financial sustainability including vacancy control processes.
- Socio-economic changes for our colleagues, both personally and professionally.

PROUD TO CARE

spar

Streamlining through Learning

With everything we've learned so far, and all the developments happening around us, it's become clear that we need to focus our efforts. The original plan was ambitious, and rightly so. But to make the biggest impact moving forward, we'll be streamlining the workstreams and prioritising the areas where we can deliver the most value based on what we have heard from our colleagues.

This doesn't mean stepping away from our original goals or the direction we set out on. Far from it. We're building on solid foundations and a strong track record of success. Our refreshed approach has been developed through extensive stakeholder engagement and determined that the People Plan should:

1. Focus on fewer objectives and workstreams to maximise impact.
2. Clear, measurable metrics that will describe impact of our actions.
3. Actions aligned to operational and clinical priorities.
4. Short term actions to reflect the changing national landscape.

Our People Vision

NHS
North Staffordshire
Combined Healthcare
NHS Trust

We will be an organisation where people thrive; a place where compassion leads, innovation drives us, and we all feel seen and included. Together, we will grow a culture that is truly outstanding in all we do and how we do it – empowering our colleagues to deliver exceptional care, shape transformative change and make North Staffordshire a centre of excellence in mental health and learning disability services.

Our People Three 'Big Moves'

NHS
North Staffordshire Combined Healthcare NHS Trust

Workforce Optimisation: improving efficiency and effectiveness of our people through reduced sickness absence, effective recruitment, vacancy control and productivity.

Workforce Transformation: organisational design and workforce planning to align to the Trust's strategic priorities and future models of care. Agility to respond to a changing commissioning context, enabled through a People function that is high performing.

Our Combined CARE Culture: leveraging our intelligence to in-reach our 'at risk' services with a comprehensive organisational development offer to reduce the risk of formal escalation of issues. Demonstrating our values in action; expecting leaders to support with managing their team and offering interventions to reflect the diversity of challenges for our people; with a high performing, modern People function as an enabler.

PROUD TO CARE

spar

Workforce Optimisation

Improving efficiency and effectiveness of our people through reduced sickness absence, effective recruitment, vacancy control and productivity.

Objective	Action Steps	Responsible Officer	Resources	Completion Date
Implement business intelligence across directorates and align with performance data warehouse for triangulated position.	1. Review workforce information dashboards. 2. Explore integrating workforce information into performance data warehouse. 3. Consider ICS opportunities to collaborate on data triangulation.	People Team	• Performance team capacity.	January 2026
Reduce sickness absence levels to achieve local directorate targets by December 2026.	1. Update sickness absence policy in line with national benchmarking. 2. Create a sickness improvement plan for each directorate that includes trajectory return to work dates and planned resolution for each absence or trend. 3. Evaluate occupational health contract and ensure interventions aligned to need of directorates. 4. Review wellbeing provision to align to themes of sickness absence, including fast track of clinical services (e.g. MSK).	People Team Associate Directors People Managers	• Training sessions • People capacity • Access to health and wellbeing provision. • Partnership across NHS services.	February 2026 November 2025 December 2025 January 2026
Increase current level of attainment for e-rostering, e-job planning and ESR with implementation by December 2026.	1. Develop business case for utilisation of ESR, aligned with further roll out of e-rostering. 2. Scope employee relations electronic system to embed a performance approach to managing caseloads (i.e. delivery against timescales for both HR and Investigating Officers). 3. Use the latest submission of current levels of attainment for e-job planning and e-rostering to identify gaps and develop actions to progress.	Workforce Information Team Nursing Team Medical Staffing People Team	• Project management resource to lead implementation. • Funding for additional rostering licenses.	December 2025 November 2025 February 2026
Performance against workforce metrics will be compliant with local directorate targets (e.g. appraisal, mandatory training, turnover).	1. Define key metrics for the seven stages of the employee life cycle and evaluate performance to date to identify areas for improvement. 2. Implementation of new learning management system (ESR) that will provide confidence in data integrity of workforce metrics. 3. Alignment with NHS Leadership & Management framework to reinforce people management responsibilities. 4. Review core policies to ensure alignment with national benchmarking and organisational priorities.	People Team Education Team People Managers	• Project management for system implementation. • Training sessions.	March 2026 April 2026 June 2026 March 2026

Workforce Transformation

Organisational design and workforce planning to align to the Trust's strategic priorities and future models of care. Agility to respond to a changing commissioning context, enabled through a People function that is high performing.

Objective	Action Steps	Responsible Officer	Resources	Completion Date
Implement a Trust wide approach to service workforce planning, with assurance that plans are in development by December 2026.	1. Utilise evidence-based learning to co-develop a workforce planning approach that incorporates organisational design and development for service redesign. 2. Create a Trust 'shadow plan' for monitoring completion and that aligns to the workforce plan submission for the system.	People Team Strategy Team Finance Team	• Access to national benchmarking. • Senior leadership engagement.	March 2026 September 2026
Lead the collaboration with partners for the corporate services review, specifically within the people function by December 2026.	1. Review the people operating model within Combined and seek assurance on its optimisation against local and national benchmarking. 2. Explore income generating opportunities to position Combined as the leader in people services. 3. Contribute to the partnership for corporate services review, with a risk appetite for leading on the change.	People Team Finance Team	• Access to national benchmarking. • Costing model. • Digital support.	November 2025 January 2025 Dependent on system timescales.
Align the people function to enable delivery of the People Plan by December 2026.	1. Utilise national benchmarking to complete a comparison against current operating model. 2. Integrate learning from national people operating model programme to develop local model. 3. Create annual work programme to provide assurance with people plan delivery.	People Team	• Access to national benchmarking. • CIPD.	November 2025 December 2025

Our Combined CARE Culture

Leveraging our intelligence to in-reach our 'at risk' services with a comprehensive organisational development offer to reduce the risk of formal escalation of issues. Demonstrating our values in action; expecting leaders to support with managing their team and offering interventions to reflect the diversity of challenges for our people; with a high performing, modern People function as an enabler.

Objective	Action Steps	Responsible Officer	Resources	Completion Date
Cultural barometer will be in operation by April 2026 that enables the Trust to understand 'at risk' services and deploy cultural interventions.	1. Design dashboard with support from BI team. 2. Embed dashboard within performance management governance.	People Team BI Team Governance Team	• Access to examples of best practice. • Collaboration at ICS level.	December 2025 January 2026
By April 2026, the OD, inclusion and health & wellbeing provision will be evaluated and realigned to meet the growing needs of clinical and corporate directorates.	1. Complete baseline assessment of current provision and alignment to organisational objectives and risks. 2. Utilise best practice to refine provision.	OD, Inclusion, HWB Team	• Access to national benchmarking. • Senior leadership engagement.	January 2026 March 2026
By June 2026, a refreshed behavioural framework will be co-produced that describes how we demonstrate our values in action. This will inform a common language for our just, learning civility and respect principles.	1. Design a train the trainer approach to ensure co-production is led by local teams and managers. 2. Functionality to collate feedback and identify themes. 3. Design feedback into behavioural framework. 4. Map through into policy expectations.	People Managers People Team Communications Team	• Toolkit for people managers. • Communications resources for presentation across Trust.	December 2025 February 2026 June 2026 June 2026
We will evaluate and reset leadership expectations to seek assurance that our colleagues experience a high-class relationship by May 2026.	1. Refresh training needs analysis to ascertain essential learning for leaders. 2. Evaluate current leadership development offer. 3. Communications reset with people leaders to outline expectations of role, updating People Team infrastructure to enable.	Associate Directors People Managers People Team	• Existing learning offers. • Feedback from user experience.	December 2025 February 2026 March 2026
We will implement recommendations from our learning reviews to improve the cultural experience of our colleagues. Work will continue during 2026.	1. Through the Learning Review Group, implement the action plan. 2. Board development session to progress priority areas. 3. Complete 'temperature check' to receive assurance on progress.	Senior leadership team People Team	• Learning Reviews.	December 2026 November 2025 May 2026

What will be different?

By December 2026, our actions will have resulted in…

NHS
North Staffordshire Combined Healthcare NHS Trust

Workforce Optimisation

Enhanced workforce transparency and efficiency by optimising the use of e-rostering, e-job planning and ESR. Our focus will enable a directorates to achieve their locally determined sickness compliance, directly increasing operational capacity. Additionally, we will achieve full compliance with key workforce metrics, including appraisals, mandatory training, vacancy rates and staff turnover.

Workforce Transformation

We will implement a Trust wide, service-led approach to workforce planning, supported by a clear trajectory for delivery. We will lead collaborative efforts across partner organisations as part of the corporate services review and ensure our People Team meets both national benchmarking standards and the expectations of our internal stakeholders. This will ensure Combined has a blueprint for future sustainability and aligned to new models of care.

Our Combined CARE Culture

By leveraging our integrated dashboard to triangulate key workforce data, we will deliver targeted interventions through a comprehensive organisational development, health and wellbeing, and inclusion offer – focusing support where it is most needed. Our leaders will model clear, measurable expectations aligned to our behavioural framework. We will create a culture where global majority colleagues feel heard, supported and empowered; informed by the actions from our learning reviews. As a result, we expect to see sustained improvements in staff experience, reflected in consistently high levels of engagement in the 2025 National Staff Survey.

PROUD TO CARE

spar

Key Performance Indicators

The following metrics will be monitored to seek assurance that we are making the intended impact:

Workforce Optimisation

1. Reduction in sickness absence.
2. Time to hire.
3. Vacancy rate.
4. Turnover rate.
5. Mandatory training completion.
6. Appraisal completion.
7. Attainment level of systems, including ESR manager self service and e-rostering.

Workforce Transformation

1. Workforce plan for each directorate.
2. Customer satisfaction metrics for People team.

Our Combined CARE Culture

1. Leadership assessment (self and 360 feedback).
2. Annual staff survey and quarterly PULSE check.
3. Number of Freedom to Speak Up concerns.
4. Number of formal employee relations cases.
5. Improvement in experience of our global majority colleagues.

How to find out more…

If you would like to learn more about our People Plan and how it relates to you and your team, please speak with your line manager, connect with your People Business Partner or reach out directly to the People Team.

Together we can bring this strategy to life and enable our Combined family to be outstanding in all we do and how we do it.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 14

Audit Committee Quad A Assurance Report for Audit Committee 31 10 2025

Report provided for:			
Approve	☐	Alert	☐
Assure	☒	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Prem Gabbi- Non-Executive Director
Prepared by:	Nicky Griffiths- Deputy Director Governance
Executive Lead:	Eric Gardiner, Chief Finance Officer

Aligned to Board Assurance Framework Risk:	Quad A reports from Committee's cover all aspects of Committee business and consider all the risks within the Board Assurance Framework.
7 Levels of Assurance:	Level 7 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Approval / Review:	Audit Committee
Strategic Priorities:	Quad A reports from Committee's cover all aspects of Committee business which are aligned to all of the Trust's strategic priorities.
Key Enablers:	Quality - We will provide the highest quality, safe and effective services.
Sustainability:	Share learning and best practice.
Resource Implications:	A number of items contained within the Audit Committee Quad A report may have staffing and / or financial resource implications.
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	Committee Chairs are linked in with System work across key priority areas- Finance and Resource, Audit, Quality and People.
Recommendation / Required Action:	Report for assurance and to alert the Board to any matters arising from Committee.
Executive Summary:	Please find attached the Quad A Report for Audit Committee held on 31 10 2025

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Board	31 10 2025

spar

PROUD TO CARE

Trust Board Assurance Report.
Audit Committee Meeting
31st October 2025 via MS Teams.

Introduction: This assurance report follows the latest Audit Committee meeting held on the 31st October 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 against the four categories of Alert, Assure, Advise and Approve. Each category provides assurance on the quality of service and activity delivered under the Audit Committee's remit and programmes of work.

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

Heading:

- No items

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

Heading:

- No Items

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** presented to the Committee by MIAA. Several reviews have been finalised:
  • *Sickness Absence* – Limited Assurance MIAA have identified high risk control design and operating effectiveness issues which put the achievement of system objectives at risk. Further medium risk issues have also been identified for management attention to improve system design and their operation.
  • *Fit and Poper Person Test* – Substantial Assurance MIAA review found that there was a good system of internal control in place, with medium and low risk recommendations raised regarding operational effectiveness issues related to audit trails for recruitment checks, ESR update, enhancement of Board updates and annual checks/self-attestation completion.
  • *Cost Improvement Programme* – Substantial Assurance The review found that there was generally a good system of internal control in place designed to meet the system objectives, with medium and low risk issues to improve post scheme evaluation control and operational effectiveness of the tracker, training and scheme audit trails.
  • *Risk Appetite Workshop* (Board) - Completed
  • *Data Protection & Security Toolkit (24/25)* - Overall Assurance Rating – High Risk / Veracity of the organisation's self-assessment - Medium Confidence. Data Security and Protection

Toolkit review is now aligned to the National Cyber Security Centre's Cyber Assessment Framework. 12 of 47 outcomes were reviewed (8 mandated, 4 chosen by the trust/auditors). The Trust met the minimum required profile for 8, but 4 required further work, resulting in a high-risk assurance level. Key gaps: supply chain controls, identity/access management, major incident/response plans, and stored data protection. It was noted the need for more clarity on HIS responsibilities and suggested better triangulation of evidence in future years.

- **Internal Audit Follow up Report** presented to the Committee by MIAA. Out of 18 recommendations, 11 were fully completed and 7 were partially implemented. The partially implemented recommendations were: 1 data quality recommendation had a further update after the report and may be closed pending review. 6 recommendations remain partially implemented: 3 related to medical job planning (with a revised completion date at the end of January) and 3 related to the patient safety and incident response framework (with a revised completion date at the end of December). No high-level recommendations are outstanding.
- **Audit Recommendations** presented to the Committee by Lisa Dodds. The Committee acknowledged the update, noted the good progress and did not raise further questions or concerns.
- **Internal Audit TCP Operational Process Review** presented to Committee by Eric Gardiner. The TCP review was initiated in response to late challenges from the ICB. The review took longer than expected due to issues on both sides and a meeting with MIAA is planned to discuss lessons learned. The review found the quality of care for patients was very good, with no concerns from a quality perspective, which was the main priority for the Trust. The Chair agreed the overall picture is positive, with process weaknesses being addressed and the Trust's achievements are not to be overlooked.
- **Counter Fraud Progress Reports** presented to the Committee by MIAA. All components were scored green in the May self-assessment against government and counter fraud standards, except for component 3, which was marked amber due to the introduction of new fraud defence legislation. This amber rating is for internal tracking only until further work is completed. Members welcomed the comprehensive update, noting the positive green ratings and the value of national context.
- **External Audit update** presented to Committee by Grant Thornton.
- **External Audit Effectiveness Review** presented to the Committee by Lisa Dodds. This was the first time the Committee had formally reviewed external audit effectiveness. Similar reviews for internal audit and counter fraud are planned in the business cycle. The relationship with Grant Thornton is very positive, with strong challenge and collaboration and no significant issues.
- **Board Assurance Framework** presented to the Committee by Nicky Griffiths. Responsible Chief Officers and Deputies had updated all risks. Out of 6 risks, 5 had no score changes, while BAF Risk 1 was pending approval at the Finance and Resource Committee for a proposed score reduction. The Chair emphasised the importance to review high-level risks and ensure they are the right ones.
- **Data Protection Security Toolkit** presented to the Committee by Dave Hewitt. Discussion held about the volume of outstanding actions and the Trust's capacity to deliver and the need for Executive/SLT-level oversight and support noting the importance of understanding which actions are critical risks versus administrative/documentation tasks and the need for clear escalation if resources are insufficient. The Chair questioned the RAG ratings and prioritisation in the action plan, noting some actions should be quickly resolvable, while others are more substantial. Committee requested future updates distinguish between high-impact risks and administrative tasks and clarify the impact of delayed actions. DH agreed to refine the action plan accordingly.

- **Mobile Phone Overage Charge** presented to the Committee by Dave Hewitt. There was a significant incident involving unplanned, unbudgeted mobile phone overage charges totalling approximately £20k, resulting from excessive data usage by a few individuals. The Trust uses a central data pool contract, which is more cost-effective than individual contracts but does not allow for individual usage caps. Additional controls are being considered to monitor and manage data usage, with the goal of reducing the number of phones by the end of December. These controls can be adjusted monthly to balance cost and oversight.
- **Risk Deep Dive Trust and Operational Risks 15+** presented to the Committee by Nicky Griffiths. Members felt the risks aligned with those reviewed in other Committees and that the process of cross-committee review is functioning as intended. RA noted that the Committee's role is to take an overview, while detailed scrutiny occurs in the relevant sub-committees. He expressed confidence that the high-level risks presented are appropriate and familiar from his work in other Committees.

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

- **Policy Report** presented to the Committee by Nicky Griffiths. Committee approved 3 policies for 3 years- Freedom of Information Act and the Environmental Information Regulations Policy, Local Counter Fraud and Bribery Policy, the Policy for the Development of Trust wide procedural/approved documents. 3 further policies were approved for the period of 1 year including Scheme of Delegation, Standing Financial Instructions and Standing Orders. The report also included a full policy status report for all policies held within the Trust relating to Audit Committee.
- **Q2 Finance Report, including losses and waivers** presented to the Committee by Lisa Dodds. The report was approved and covered losses and special payments, waivers over £15k, patient placements outside of the DPS, purchase order compliance and payables and receivables for Q2 (July to September 2025).
  A formal write off of £125k relating to the boilers and heating system installed at Hope Street, a leased premises which the Trust no longer occupies since November 2024, was approved.

Next Steps (including timeframes):

The next Audit Committee meeting will be held on 28th January 2026 via MS Teams.

Committee Chair: Prem Gabbi Chair of the Audit Committee. **REPORT END**

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 15

Provider Capability Assessment NSCHT submission October 2025.

Report provided for:			
Approve	☐	Alert	☐
Assure	☐	Advise	☐

Report to:	Public Trust Board
Date of Meeting:	13 November 2025

Presented by:	Nicky Griffiths Deputy Director of Governance
Prepared by:	Nicky Griffiths Deputy Director of Governance
Executive Lead:	Dr Buki Adeyemo- Chief Executive Officer

Aligned to Board Assurance Framework Risk:	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.
7 Levels of Assurance:	Level 7 - Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Approval / Review:	Execs
Strategic Priorities:	Growth - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	NHSE will reach out to ICB's as part of the triangulation process seeking local intelligence (by exception) in deciding Provider Capability ratings. ICB's self-assessment will commence from 2026/27- against specific ICB related metrics.
Recommendation / Required Action:	Approval required from the Board for the NSCHT Provider Capability submission (appendix 1) to the regional/national team by 22nd October 2025.

Executive Summary:	The NHS oversight framework 2025/26 (NOF) set out how NHSE would use Provider Capability Assessments to determine their improvement response, enabling them to understand how capable an organisation is of improving without additional support. The focus on Provider Boards' awareness of the challenges facing their organisations and what is needed to address them, is intended to promote Board self-awareness as well as transparency with oversight teams, providing a framework for their engagement with Providers. The capability self-assessment guidance confirms that Boards will self-assess annually against the six oversight domains set out in The Insightful Provider Board. The self-assessment should be submitted to the regional NHSE oversight team along with supporting evidence. The self-assessment should highlight any areas of concern, the reasons why and planned for actions to address same. **The self-assessment statements and certification submission.** The six domains are set out, alongside self-assessment criteria and non-exhaustive examples of indicative evidence that the Board might require to assure itself of compliance. Trusts are expected to use their own approaches to gain assurance in each of the areas. **The domains are:** **Strategy, leadership and planning** **Quality of care** **People and culture** **Access and delivery of services** **Productivity and value for money** **Financial performance and oversight**. The submission requires Boards to highlight any areas where they do not meet the criteria, explain why and set out remedial action underway or to be taken. Trusts will self-rate their compliance on the submission as either -Complaint (full), Partial, None. **Inability to make a positive self-assessment**. The Board may not be able to make a positive self-assessment either because it considers the risks in a specific area are too great or its organisation is already manifestly failing in a specific area (for example, delivering on access targets). In these situations – and in line with the 'no surprises' ethos – in the self-assessment Board's should provide: • the reasons why a positive self-assessment cannot be made against specific criteria and the extent to which these have been outside the trust's control to address (for example, industrial action, system-wide factors)

- how long the reasons have persisted.
- a summary of any mitigating actions the trust has taken or is taking.
- if not already shared with oversight teams, a high-level description of trust plans to address the issue, how long this is likely to take and KPIs or other information the Trust will use to assess progress.

Oversight teams will use this information to form their view of the overall capability of the Trust and tailor their oversight relationship with it.

Material in-year changes

In addition to the annual self-assessment, if the Board becomes aware in-year of a significant change to its ability to meet any of the self-assessment criteria – for example, an external report reveals material quality risks or an unforeseen cost will affect its financial performance – it should inform the oversight team along with the actions it is taking to address the issue. Such in-year changes will likely inform the ongoing regulatory relationship with the NHS England region.

The NHS Provider Trust Capability Rating.

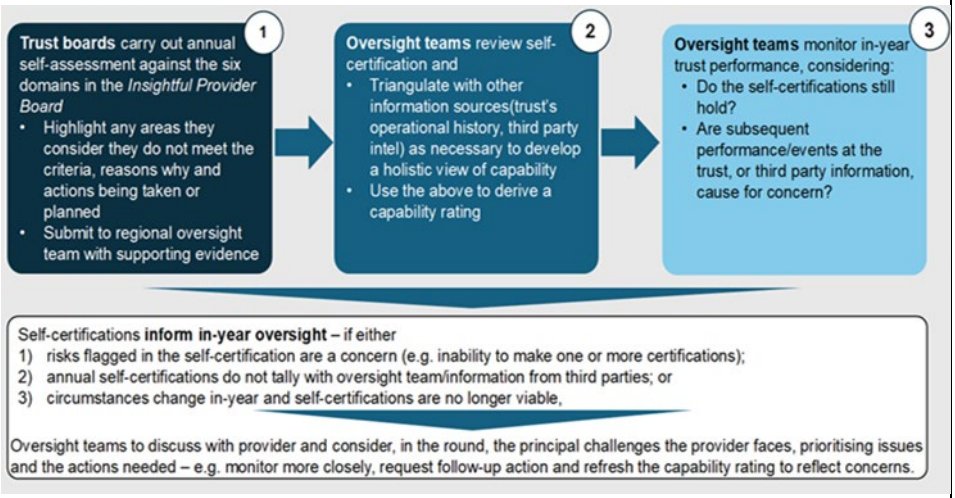
NHSE will triangulate the Board self-assessment with third party information to determine which of four capability ratings to allocate: green, green-amber, amber-red, or red. Green denotes high confidence in management. Amber-red and red ratings indicate possible and likely breaches of the provider licence, respectively.

Third parties whose input may be considered include Care Quality Commission (overall rating and specifically well-led); integrated care board(s); trust staff, patients and the public; coroners; professional regulators; and local authorities.

Regional oversight teams will review the Trust's submitted self-assessment and consider the statements and evidence. Using a range of considerations, including the historical track record of the Trust, its recent regulatory history and any relevant third-party information, the oversight team will decide the Trust's capability rating and share this with it, including the rationale for the rating.

Rating	Indicative Criteria
Green High confidence in management	No concerns evident from the self-assessment or subsequent performance No concerns arising from third-party information. High confidence in the Trust's ability to deliver on its priorities based on track record over past 12–24 months
Green / Amber Some concerns or areas that need addressing	After discussion with the Trust, some concerns emerging across more than one domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS. Trust has prepared plan(s) to address any problems with associated timeframe for delivery. Historical issues/track record mean NHS England does not (yet) have full confidence in the Board
Red Significant concerns arising from poor delivery, governance and other issues	Material or long-running concerns at the organisation that management has been unable to grip. NHS Trust in breach of licence or likely to be.

Figure 1- Figure 1 below sets out the self-assessment process which will take a number of stages across the year:



Summary.

Following a presentation by NHSE the Board needs to focus on-

- Does the Board understand the issues facing it and have a credible plan- with partners – to address same?
- Will they deliver?
- Ratings will be formed from a holistic viewpoint linked to self-assessment, triangulation of data and intelligence from other sources and linked to the provider licence performance (or breaches noted in same).
- Ratings will be published in Nov/Dec aligned to NOF Q2 segmentation. However resourcing capability in NHSE may delay this.
- The scope is intentionally broad and submission simplistic. Boards however will need to deeply understand their position and if required provide evidence against their statements.
- There will be an emphasis on NHSE regional Directors to 'stand by' the submission made by Providers.
- From Q4, early Q1 2026 this will move into the regular cadence of reporting i.e. Audit, AGS etc...
- Initial focus will be on Providers in NOF 4

Timescales.

The timescales for this during 2025 are for Boards to do the self-assessment within eight weeks of when they receive the guidance. They should then submit the required declaration submission form to the regional team by 22nd October 2025, which then has four weeks to review and triangulate with information from a variety of other sources, before coming to a view about a capability rating. These will be discussed with Provider Boards and Trust's allocated to the Provider

	Improvement Programme (PIP) will be told in December.

Date	
9th September	**Named Chief Officer takes lead for narrative submission for each domain (related to portfolio).**
10th September	**Share agreed approach across the wider Board membership**
23rd September	**Draft submission to Execs for approval for Board**
9th October	**Approval of submission requested at Private Trust Board**
22nd October	**Submit approved self-assessment to NHSE regional team with copy of Board papers confirming same.**
November	**NHSE will review submission and rate providers.**
December	**All ratings to go NHSE Board for approval.**
Q3/Q4	**Shared learning/ Cold debrief.**

VERSION CONTROL:

Version	Report to	Date Reported
V1	Execs	10th September 2025 23rd September 2025
V1	Private Board	9th October 2025
V1	Public Trust Board	3rd November 2025

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	The Trust has an embedded Strategy 2023-2028 with 3 clear organisational priorites of prevention, access and growth, these are relevant and aligned to the 10 Year Plan. Delivery against the strategy is measured by 12 KPI's, these are reviewed through Trust and system planning cycles. A number of strategic plans are in place to deliver against the strategy and the 10 year plan. Engagement has commenced to produce a refreshed strategy by 2027. All Board roles are filled and there are currently no vacancies. Board members receive training, support and development with all appraisals being up to date. The Trust is an active member of various national, regional and system forums including the ICS Provider Collaborative, with members of the Board leading various programmes of work to improve outcomes for staff, patients and the wider communities.
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	We have systems and processes to measure quality across the domains of safety, effectiveness and experience and these are reported as part of the performance framework. Reporting is reviewed as part of executive performance meetings and senior leadership team. Risks in relation to the quality of care are recorded and managed as part of the risk framework and escalated for review by the Risk Review Group and subsequently at Quality Committee. Assurance as to the quality-of-service delivery is provided via the Quality Committee to the Trust Board. The Trust has quality assurance and quality improvement embedded into its management models and can demonstrate improvement in quality as a result of these approaches. The Board and Quality Committee uses a range of qualitative and quantitative measures to triangulate data in relation to quality matters. This includes benchmark data, regular visits to clinical areas and stories from patients, carers and staff members to further understanding. Data and analysis in relation to the variation in quality experienced by different communities is incorporated into reporting and actions are agreed to address patterns in inequality. The Trust has mechanisms to measure patient experience including FFT, surveys and complaints. The Trust routinely involves people with lived experience in its service design, delivery and governance processes.
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	The appropriate structures, processes and practice support arrangements are in place to provide assurance that the Trust is utilising staff feedback effectively to enhance quality of care provision. The Trust manages its available capacity well and systematically meets developmental requirements. Staff are empowered to raise concerns through a range of mechanisms that are monitored on a regular basis. The outcome of these processes informs improvements where necessary. The expected cuts to training and CPD funding as a result of national ongoing efficiency expectations are a potential constraint to the Trusts future performance.
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	The Trust is meeting the waiting time standards outlined within the 2025/26 planning guidance and has processes and governance in place to continue to monitor and assure this throughout the year. Outside of the planning guidance standards the Trust does have concerns in relation to the delivery of Autism and ADHD services due to significant increases in activity. Internal process design has produced some additional capacity through efficiencies and there was a small investment in 23/24. The Trust is working with commissioners and other ICS partners in relation to these services to develop a sustainable way forward. The Trust uses population health measures to track disparity in service provision and as part of its planning approach for service development. The VCSE sector and other partners are key aspects of the delivery of a range of Trust services.
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	The Board regularly uses various benchmarking reports such as the Model Hospital, national clinical benchmarking returns, corporate benchmarking and produces SLR reports on a quarterly basis to monitor progress.
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	The Trust does have robust financial governance in place evidenced by numerous internal audit reports providing significant assurances. These arrangements have been through the I&I process as part of the ICS and financial governance and are considered to be strong. The annual external audit has not reported any material issues and the Trust prides itself on producing a high quality error free set of accounts. The Trust has very good data quality with a current DQMI score of over 98%. There have been no contract disputes over the last 12 months. All CIP schemes are subject to a Quality Impact Assessment which is signed off by the CNO and the CMO and schemes are reviewed on an annual basis to ensure there is no detrimental impact to patient care and that they are delivered as planned. The Trust has significantly reduced its agency usage over recent years and is on track to reduce agency costs by 40% in 2025/26 and bank costs by 10%. The Trust pro-actively works with system partners to reduce the system deficit and ensures its plans align to the wider system.
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Name

Date

Trust Board 2025/26 Attendance

	10th Apr 25 Private	8th May 25 Public / Private	12th June 25 Private	10th July 25 Public / Private	Ex -Ord Private 14th Aug 25	11th Sept 25 Public / Private	9th Oct 25 Private	13th Nov 25 Public / Private	Dec no meeting	15th Jan 26 Public / Private	12th Feb 26 Private	12th Mar 26 Public / Private
Non-Executives												
Janet Dawson, Chair	x	√	x	√	√	√	√					
Russell Andrews, Non-Executive / Vice Chair	√	√	√	√	√	√	√					
Pauline Walsh, Non-Executive / Senior Independent Director	x	√	√	√	√	√	√					
Martin Evans, Non-Executive	√	√	√	√	√	√	√					
Prem Gabbi, Non-Executive Director	√	√	√	√	√	√	√					
Jennie Koo, Non-Executive Director	√	x	√	√	√	√	√					
Dr Roger Banks, Associate Non-Executive Director	√	x	√	√	√	X	X					
Katie Laverty, Associate Non-Executive Director	√	√	√	√	X	√	X					
Nicola Bullen, (NExT Director Programme)	√	x	√	√	X	x	√					
Executive Members												
Dr Buki Adeyemo, Chief Executive Officer	x	√	x	√	√	√	√					
Eric Gardiner, Chief finance Officer / Deputy Chief Executive Officer	x	√	√	√	√	√	√					
Kenny Laing, Chief Nursing Officer / Deputy Chief Executive Officer	√	√	√	√	X	√	√					
Dr Dennis Okolo, Chief Medical Officer	√	√	√	X	√	√	√					
Elizabeth Mellor, Chief Strategy Officer	√	√	√	√	√	x	√					
Ben Richards, Chief Operating Officer	x	√	√	√	√	x	√					
Kerry Smith, Interim Chief People Officer	√	√	√									
Frieza Mahmood, Chief People Officer			√	√	√	√	√					
Dr Ravi Belgamwar, Deputy Chief Medical Officer				√								
Zoe Grant, Deputy Chief Nursing Officer	√				√							
Rachael Birks, Deputy Chief Operating Officer	√					√						
Lisa Dodds, Deputy Chief Finance Officer	√											
In Attendance												
Jenny Harvey, Union Representative	√	√		√		√						
Joe McCrea, Associate Director of Communications	√	√		√		√						
Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary	√	√	√	√	√	√	√					
Sherrine Khan, Peer Support Worker	√	x		√		x						
Lisa Wilkinson, Corporate Governance Manager (Minutes)	√	√	√	√	√	x	√					
Tracey Cooper, Executive PA (Minutes)						√						
Mandy Brown, Senior Executive PA (Minutes)												