NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 15TH JANUARY 2026, 10.00AM, BOARDROOM, LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P01/26	Welcome and Apologies for Absence	Janet Dawson	**Note**	
2	1002	P02/26	Declarations of Interests – and changes to be notified	Janet Dawson	**Note**	
3	1003	P03/26	Minutes of the Previous Meeting held on 13th November 2025	Janet Dawson	**Note**	**Enc. 1**
4	1005	P04/26	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	**Note**	**Enc. 2**
ADVISE						
5	1010	P05/26	Patient Story – **Diverse Minds Group**	Kenny Laing	**Advise**	**Verbal**
6	1025	P06/26	REACH Recognition Individual Award – Community Directorate - **Deb Boughey Young Adult Pathways & SEND Lead and Interim Service Manager**	Dr Buki Adeyemo	**Advise**	**Verbal**
7	1030	P07/26	Chief Executives Report	Dr Buki Adeyemo	**Advise**	**Enc. 3**
8	1045	P08/26	Chairs Report	Janet Dawson	**Advise**	**Verbal**
9	1055	P09/26	Questions from Members of the Public	Janet Dawson	**Advise**	**Enc. 4**
ALERT						

10-minute Break						
APPROVE						
10	1115	P10/26	Annual Safer Staffing Report	Kenny Laing	**Approval**	**Enc. 5**
11	1120	P11/26	Ward 5 Garden Business Case	Elizabeth Mellor	**Approval**	**Enc. 6**
ASSURE						
12	1130	P12/26	Improving Quality and Performance Report (IQPR) Month 8	Eric Gardiner	**Assurance**	**Enc. 7**
13	1135	P13/26	Finance Report Month 8	Eric Gardiner	**Assurance**	**Enc. 8**
14	1145	P14/26	Finance and Resource Committee Assurance Reports from the meetings held on the 4th December 2025 and the 8th January 2026	Russell Andrews	**Assurance**	**Enc. 9a and 9b**
15	1200	P15/26	Quality Committee Assurance Reports from the meetings held on 4th December 2025 and the 8th January 2026	Pauline Walsh	**Assurance**	**Enc. 10a and 10b**
16	1210	P16/26	People, Culture and Development Committee Assurance Report from the Business Meeting held on 5th January 2026	Martin Evans	**Information**	**Enc. 11**
17	1215	P17/26	Charitable Funds Committee Assurance Report from the meeting held on 1st December 2025	Russell Andrews	**Assurance**	**Enc. 12**
CONSENT ITEMS						
18	1220	P18/26	Seven Levels of Assurance	Nicola Griffiths	**Information**	**Enc. 13**

19	1220	P19/26	Any Other Business	Janet Dawson	**Note**	**Verbal**
20	1225	P20/26	Meeting Self-Assessment	Janet Dawson	**Discussion**	**Verbal**
21	1230	P21/26	Trust Board Attendance Report	Janet Dawson	**Information**	**Enc. 14**

Date and Time of Next Meeting
12th March 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 13th November 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
Ben Richards	BR	Chief Operating Officer
Elizabeth Mellor	EM	Chief Strategy Officer
Frieza Mahmood	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
Dr Roger Banks	RB	Associate Non-Executive Director
Katie Laverty	KLa	Associate Non-Executive Director
In Attendance		
Nicola Bullen	NB	NExT Director Programme
Nicola Griffiths	NG	Deputy Director of Governance / Board Secretary
Joe McCrea	JM	Associate Director of Communications
Jenny Harvey	JH	Staff Side Representative
Sherrine Khan	SK	Senior Peer Support Worker
Lisa Wilkinson	LW	Corporate Governance Manager (Minutes)
Public Attendance		
No public attendance		
REACH Team Award – Complex Care Mental Health Team (Project 86)		
Emilie Shirley – Medical Secretary Kate Devlin - Consultant Clinical Psychologist Matilda Nortu – Unit Manager		

Meeting commenced at 10.00am

146/25	**APOLOGIES FOR ABSENCE** No apologies were received.	
147/25	**DECLARATIONS OF INTEREST RELATING TO AGENDA** There were no declarations of interest. ***Noted***	
148/25	**MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 11TH SEPTEMBER 2025**	

	Date of Next Meeting was noted as 13th September 2025 as opposed to 13th November 2025. Minutes approved subject to above amendment. ***Approved/Received***	
149/25	**ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 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.** *13.11.25 – 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.** *13.11.25 – BAF Risk 1 now under the Strategic Priority of Prevention* **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.** *13.11.25 – Agreed to remove from Trust Board in October and discuss at Corporate Trustees Meeting in January 2026.* ***Received***	
150/25	**PATIENT STORY – KEITHS STORY – WARD 7** Kenny Laing, Chief Nursing Officer presented the patient story. Keith described his experience as a carer for Lynn, detailing the difficulties in obtaining appropriate mental health support, initial misdiagnoses, and the emotional toll of the process. He recounted the eventual intervention by the crisis team and outreach nurses, which provided significant relief and support for both himself and Lynn. Jackie, Staff Liaison on Ward 7 and Keith discussed the ongoing support provided on the ward, the positive and welcoming environment, and the importance of staff engagement in both patient and carer wellbeing. Keith emphasised the value of activities such as walks in the garden and the inclusive atmosphere fostered by staff. Keith addressed the stigma associated with mental health facilities, sharing how his perceptions changed after experiencing the care at the Harplands Hospital. He advocated for greater public understanding and challenged misconceptions about mental health hospitals. Keith and Board members reflected on missed opportunities for earlier intervention by primary care providers, noting that earlier recognition and referral could have prevented deterioration. The discussion highlighted the need for improved training and awareness among GPs regarding mental health issues.	

	Board members discussed the importance of learning from patient stories to improve interfaces with GP surgeries, enhance early detection, and support system-wide improvements. They acknowledged ongoing work and the need for further efforts to prevent crisis situations. Dr Buki Adeyemo highlighted outreach as the essential link between community and inpatient services, particularly for older adults, and stressed the importance of maintaining this connection during organisational changes. Sherrine Khan reflected on the perceived separation between community and inpatient teams, advocating for a unified Trust identity and shared values. The discussion included personal experiences of transitioning between service areas and the need to break down rigid boundaries. Joe McCrea described ongoing initiatives such as virtual walkthroughs and the publication of patient stories to improve public understanding of services. Plans were outlined to enhance the accessibility of information and address common knowledge gaps about available support. The Board thanked Keith for sharing his story. The patient story will be made available on the Trust's public website. **Noted**	
151/25	**REACH RECOGNITION TEAM AWARD – Specialist Service – Complex Care Mental Health (Project 86)** Dr Buki Adeyemo, Chief Executive Officer introduced the award. The Complex Care Team, in collaboration with the Local Authority, facilitated timely discharge and repatriation for individuals with complex mental health needs, successfully placing nine patients in appropriate settings since January. The team was commended for their resilience, professionalism, and positive impact on service morale for which the Board expressed their appreciation. The Board congratulated the team on their award. ***Received***	
152/25	**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: **NHS Providers Conference** The Secretary of State spoke to Chief Executive Officers (CEOs) and Chairs extending his thanks and acknowledged the challenges the Trusts and Integrated Care Boards (ICBs) had been facing and publicly talked about his regret at the pace at which the changes had been made without the support that was necessary. Prem Gabbi noted the rise in racist incidents in staff and asked what we were doing as a Trust to look after our staff. Frieza Mahmood advised bespoke guidance titled 'supporting staff during challenging times' had been developed, addressing health, support, and organisational commitments to staff experiencing anxiety or incidents related to societal tensions.	

	Positive feedback was received for staff events aimed at discussing the impact of external events, with a focus on balancing diverse viewpoints and fostering a sense of belonging through refreshed people priorities. Frieza Mahmood reported increased concerns regarding social media usage and political activities but noted no direct rise in violence or assaults. Adjustments were made to support staff, particularly regarding travel and working hours, and vigilance was maintained in response to regional trends. The organisation signed up to recent NHS England guidance on racism and anti-Semitism, with plans to roll out these standards system-wide in collaboration with the ICB. The Board discussed the new NHS England (NHSE) Restrictive Practice Guidance, Kenny Laing provided assurance the Trust was in keeping with that guidance. The new guidance broadens the definition of restrictive practices to include continuous observation and denial of access, prompting the organisation to adapt internal processes for capturing and reporting these practices. Dr Roger Banks shared insights from the EU-funded Quality Rights Initiative, which evaluates restrictive interventions across several countries and offers toolkits for assessment and cultural change. **Industrial Action** Ben Richards provided an update regarding preparations and procedures in response to upcoming industrial action and reported that the Trust had activated its standard procedures, which had been well-tested due to previous instances of industrial action. The Incident Management Group (IMG) was stood up to oversee the Trust's response and supplementary calls and arrangements had been confirmed, with Directors allocating funded cover for 30 hours to ensure operational resilience. Ben Richards reported that appropriate provision had been made for all required returns to NHS England and confirmed the Trust was prioritising the maintenance of as much activity as possible during the period of industrial action. The only significant change being that resident doctors would not be present, but all other services would continue as normal. Ben Richards confirmed the Trust would conduct its usual post-action review processes, including both "hot" and "cold" debriefs, to capture learning and identify opportunities for improvement and the situation would be continually monitored. ***Received***	
153/25	**CHAIRS REPORT** Janet Dawson, Chair presented the report. **Darwin Centre Visit** The Chair highlighted the positive atmosphere and strong leadership at the Darwin Centre and commended staff for their exceptional work and the	

	quality of mental health care provided. The Chair emphasised pride in the Trust's approach to mental health treatment and the dedication of staff. **Acknowledgement** The Chair expressed gratitude to David Pearson on his retirement after over 50 years of service in the NHS and recognised his significant contributions to mental health services and wished both David and his wife a long, healthy, and happy retirement. **Staff Survey** The Chair encouraged all staff to complete the staff survey noting the current completion rate was approximately 48%, the aim being to increase participation to ensure a representative view of staff experiences. **Vaccinations** Staff were urged to take advantage of vaccination opportunities. The Chair raised concern with regards to the low uptake among health providers across the NHS. **Schools & Youth Engagement** The Board discussed the desire to revive school engagement projects (previous pilot included six schools; currently only St James's High School remains active) and emphasised collaboration between the NHS and Education System to support young people. Elizabeth Mellor highlighted existing youth council work in other organisations. Sherrina Khan advocated for full Council membership and school involvement. **ACTION: An action was agreed to explore opportunities to support Elevate with recruiting young people.** Russell Andrews supported reviving school projects and linking them to Council. Ben Richards suggested leveraging engagement work done with children and young people through the Centre for Mental Health portfolio. ***Noted***	**EM**
154/25	**QUESTIONS FROM MEMBERS OF THE PUBLIC** The Trust continues to encourage the use of Ask the Board Online as part of its ongoing commitment to openness, transparency and innovation. **Question 1:** I am a clinical pharmacist working in Primary Care and running Depression Clinics. For some patients I am finding a barrier to accessing a diagnosis where I suspect an underlying pathology or comorbidity where depression is a feature rather than the condition itself and appropriate treatment, mainly Treatment Resistant Depression. There are medications I would like to give my patients, but they are Amber on the local formulary and therefore cannot be prescribed in Primary Care. The only option therefore is to refer into secondary to access the correct pharmacological treatment (or assessment to see if the diagnosis is depression), unfortunately some of these cases are being declined and referred for Talking Therapy. So my comment is, how can we overcome the gap between the limitations of what we are permitted to treat according to our local drug formulary and sometimes expertise and not seemingly meeting the threshold criteria for referral into secondary care who are the ones permitted to prescribe the	

	medication? **Clinical Pharmacist - Hanley Bucknall and Bentilee Primary Care Network (PCN)** **Response**: Dr Dennis Okolo explained that treatment-resistant depression requires specialist care, with mental health practitioners and nurses available in most PCNs, but complex cases are referred to secondary care. The organisation contributes to the local formulary via the Medication Optimisation Committee and supports changes as needed, with the Chief Pharmacist tasked to liaise with counterparts for improved coordination. **Question 2:** Ben Richards advised a question had been received from a patient and he assured the Board that contact had been made with the patient regarding their care pathway the details of which could not be discussed publicly. ***Noted***	
155/25	**BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 2** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the framework. Nicola Griffiths advised all risks had been updated with actions and mitigations, with a specific debate at the Finance and Resource Committee regarding a proposed score change for risk one, which was not supported pending further work. Board members debated whether the assurance level should be five or six, ultimately agreeing on six based on the clarity and quality of evidence, and the constructive nature of the discussion. Plans were outlined to shift from target scores to risk tolerance scores in reporting, with support from MIAA and contributions from Governance. ***Approved***	
156/25	**BOARD AND COMMITTEE DATES 2026/27** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the dates. The Board were in agreement with dates for 2026/27. **ACTION: Following discussion, it was agreed that the January 2026 Remuneration Committee date be reviewed to ensure Non-Executive availability.** ***Approved***	**LW**
157/25	**POLICY REPORT** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the report. Nicola Griffiths outlined ongoing work to review and update organisational policies, highlighting areas needing improvement and the importance of timely reviews. Nicola Griffiths highlighted the Scheme of Delegation had been approved at Audit Committee and had been brought to Board for approval.	

	The Chair confirmed willingness to approve the policy paper based on Audit Committee recommendations. Dr Dennis Okolo raised concerns about the clarity of assurance when reviewing policies in isolation, prompting suggestions for enhanced executive summaries. The Board noted the value of a rolling plan and comprehensive policy cycle overview, suggesting that the Board would benefit from visibility of the policy refresh cycle and assurance status across Committees. **ACTION: It was agreed the report would be shared with the Board in January 2026.** ***Approved***	**NG**
158/25	**RESEARCH AND DEVELOPMENT (R&D) ANNUAL REPORT** Dr Dennis Okolo, Chief Medical Officer presented the report. Dr Dennis Okolo summarised the R&D team's activities, including over-target recruitment, collaboration with the Regional SSHERPa Group, and the launch of research sponsorship, noting ongoing evaluation of Dragon's Den funded projects. Pauline Walsh queried the Research Nurse role and the activities of academic staff, Dr Dennis Okolo clarified the traditional nature of the Research Nurse post, the early stage of sponsorship activities, and the use of regional GCP training. Prem Gabbi questioned the demonstrable outcomes and value for money of research investments; Dr Dennis Okolo advised that while some impact was hard to quantify, efforts were underway to tighten reporting, especially for doctorate-related research. Martin Evans raised concerns about the report's focus on research over innovation, prompting Dr Dennis Okolo to commit to enhancing the emphasis on innovation and streamlining the interface between research, quality improvement, and audit. **ACTION: The Board discussed the need for a clearer organisational research ambition, suggesting a future board session to define strategic priorities and ensure alignment between research, innovation, and service transformation. Nicola Griffiths to add to Board Development Programme 2026/27. Dr Dennis Okolo to lead future Board session.** Self-assessment level of assurance approved at three. ***Received***	**NG / DO**
159/25	**IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 6** Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the IQPR Month 6 report.	

	Eric Gardiner reported reductions in vacancy rates and sickness absence, attributing improvements to new nursing recruits and ongoing retention efforts, while noting persistent challenges in appraisal completion and system-related recording issues. **ACTION: Martin Evans discussed the need for deeper understanding of Performance Improvement Plans (PIPs), suggesting a Private Board discussion to clarify the journey and effectiveness of PIPs, and highlighting the importance of connecting actions to outcomes. Nicola Griffiths to carry forward to a future Private Board session. Eric Gardiner to deliver agenda item.** The Board acknowledged ongoing manual validation work to address system inefficiencies in recording appraisals and clinical supervision, with efforts to improve data quality and triangulate performance metrics. The Board debated the role of bank staff, distinguishing between different types of bank workers and emphasising the need for nuanced understanding of flexible staffing as an efficiency measure rather than waste. ***Received***	**NG / EG**
160/25	**FINANCE REPORT MONTH 6** Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the report. Eric Gardiner reported a small surplus ahead of plan, outlined forecast scenarios, and highlighted recent successes in securing estate safety and backlog maintenance funding, with expectations for continued positive performance. Eric Gardiner summarised Committee discussions on financial planning, assurance frameworks, and the importance of challenging sub-assurance scores, with attention turning to future tender opportunities and business development. The Board discussed trends in agency and bank staff usage, noting the need for sustained reductions and the importance of flexible staffing to meet fluctuating care needs efficiently. There was further discussion regarding distinction between bank staff and agency workers and agreement these should not be conflated in workforce planning or reporting. Key points highlighted were: - Bank staff are classed as workers for the Trust, not employees, and therefore do not have full statutory employment rights. Agency workers are employed by external agencies. - Many bank staff choose this arrangement for flexibility or additional income and often work regularly on the same wards, maintaining continuity of care. Agency workers typically lack this integration. - While the Trust aims to maximise substantive staffing, bank staff provide valuable flexibility and surge capacity. Reducing bank staff should not be treated as equivalent to reducing agency usage. - Metrics for bank and agency staff should be reported separately to ensure clarity and avoid misleading conclusions.	

	The Board acknowledged the need for a nuanced approach when considering targets and workforce planning. The Board approved the level of assurance at 6. ***Received***	
161/25	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 2ND OCTOBER AND 6TH NOVEMBER 2025** Russell Andrews, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: **2nd October 2025** The report was taken as read **6th November 2025** Level of assurance score 6. **System Finance:** Position slightly ahead of plan regarding deficit. Discussion took place at Committee with regards to on Improving Quality and Performance Report (IQPR) metrics and Performance Improvement Plans (PIPS) a follow-up session was requested for deeper review. Three finance papers were received: Financial Planning, Key Lines of Enquiry (KLOE) Assurance Framework, and Strengthening Financial Management Toolkit. A good level of assurance was noted, though some scoring was queried for debate. **Business Opportunities:** The Committee discussed the successful inclusion on Staffordshire Connects work tender framework following significant effort by the team with attention now turning to Stoke City Council tender. **Orbis and Lorenzo Systems:** Committee reviewed interdependencies and clarified understanding of system relationships. **Approvals**: Risk register, partnership items, policy reports, and two business cases were approved (which will be discussed further within a Private Board session). **ACTION: 2025 Staffordshire Connect to Work Tender outcome acknowledged as positive but not outstanding; Committee agreed to aim for improvement and avoid complacency.** ***Received***	**EM**
P162/25	**QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 2ND OCTOBER AND 6TH NOVEMBER 2025** Pauline Walsh, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: **2nd October 2025 and 6th November 2025**	

	Pauline Walsh advised she would discuss the papers together. Level of assurance score 6. **System Pressures and Out-of-Area Placements:** Pauline Walsh reported ongoing concerns regarding wait times and out-of-area placements, including clinically ready-for-discharge patients remaining in placements. Assurance was provided that individuals were supported and managed by the Trust, though additional workload and complexity acknowledged. **Deep Dives:** Primary Care Integration: Positive feedback from GP practices received on benefits of being part of the Trust, including improved mental health awareness and support. Legal Services: Comprehensive review of services including coronial, tribunal, and hospital manager support. Assurance was noted on recent improvements and format changes following feedback. **Assurance Reporting:** The Committee received updates regarding Safe Staffing, Electronic Patient Records (EPR), Clinical Audit (Q2), Clinical Effectiveness (Q2), Mental Health Compliance Action Plan, and Ligature Annual Report. **Ligature Risk Management**: The annual review highlighted ligature risk as one of the highest Trust risks. Significant investment over recent years has reduced anchor points and related incidents. It was agreed continued focus was required on clinical practice and individual risk assessments. The Committee supported recommendations for further capital investment. **Physical Health Monitoring for SMI Patients:** The Committee agreed to undertake a deep dive into management of physical health for patients with severe mental illness, in response to national concerns. The Committee noted development of an intensive outreach team despite lack of specific commissioning. **Policy Approvals:** A number of policies were approved during both meetings. The Committee provided good assurance on key areas, with recognition of ongoing challenges and commitment to further oversight. ***Received***	
P163/25	**PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM MEETINGS HELD ON THE 29TH SEPTEMBER AND 10TH NOVEMBER 2025** Martin Evans, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: **29th September 2025 – Focus Meeting and 10th November 2025 – Business Meeting** Level of Assurance: November meeting assessed at Level 5. **People Plan Refresh:**	

	The Committee approved a refreshed People Plan, recognising significant changes within the NHS since the original five-year plan was launched. The revised plan focuses on three priority areas Workforce Optimisation, Workforce Transformation, Combined Care Culture. Clear deliverables and timelines have been set for the next 12 months, with consultation across the organisation and executive teams. **System Collaboration Challenges** Concerns were raised regarding the impact of system-level decisions on the Trust, including termination of the staff psychological well-being hub contract and delays in Oliver McGowan training. Risks have been escalated, and mitigation plans are being developed internally. **Performance and Appraisals** A detailed review was undertaken of appraisal compliance. Current performance improving, with figures now at approximately 81–82%. Actions in place to address recording challenges and trajectory to be monitored at future meetings. **Freedom to Speak Up and Culture Initiatives** Assurance was received on ongoing work to strengthen staff voice and cultural development. No significant concerns were reported. **Risk Management** Residual risk was increased regarding Oliver McGowan training; update to be provided at next meeting on plans to reduce this risk. **Resident Doctor 10-Point Action Plan** The Committee noted progress on actions to improve the experience of resident doctors. The plan will continue to be monitored through Committee, with consideration of future reporting to Trust Board. **System-Level Escalation** The Committee expressed concern over reduced investment in collaborative programmes such as the High Potential Scheme and Psychological Well-being Hub, despite strong national recognition. Issues have been escalated to the Integrated Care System (ICS) People Board, governance and risk-sharing arrangements are under review. **Approvals** Assurance Framework (no amendments) Refreshed People Plan ***Received***	
P164/25	**AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 31ST OCTOBER 2025** Prem Gabbi, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Level of Assurance amended to Level 4. **Data Integrity and System Use** The Committee raised concerns regarding data integrity across multiple systems and manual processes, emphasising the need for 100% accuracy	

	to support decision-making. Recommended review by People, Culture and Development Committee. **Internal Audit Reviews** Overall assurance from internal audits was positive, with most areas rated green. **Data Security and Protection Toolkit** The Committee expressed concern over performance and delays in completing actions and agreed prioritisation of outstanding actions were required to address organisational risk. **Transforming Care Programme (TCP)** Internal audit provided good assurance. Improvements noted since the Trust assumed responsibility from the Integrated Care Board (ICB). Further discussion acknowledged potential for future growth and evolving clinical outcome measures. **Policy Status and Compliance** The Committee reviewed policy compliance and noted that most areas were green, with one requiring modification to reflect new fraud legislation. Assurance was provided that policy updates occurred in real time when national guidance changes. Scheme of Delegation policy was approved by the Committee. **Financial Write-Off** The Committee approved write-off of £125,000 relating to late deployment of infrastructure under a lease arrangement. The Committee queried delays in identification and rationale for initial expenditure. **Fraud Legislation** The Committee noted new requirements for policies to reference updated fraud legislation. Assurance was provided that changes would be incorporated. Cyber security remains a priority given recent national incidents. Concerns escalated regarding system-level governance and risk-sharing arrangements. ***Received***	
165/25	**PROVIDER CAPABILITY ANNUAL SELF ASSESSMENT** Circulated for information Dr Buki Adeyemo highlighted concerns regarding the timing of a recent request for additional information, noting that an email was sent with a deadline of less than 24 hours. This was contrary to previous indications of the time required to prepare and involved requests for evidence on four or five specific areas. Despite the short notice, the Executive Team worked collaboratively and was able to respond adequately and provide the necessary evidence. ***Received***	

166/25	**ANY OTHER BUSINESS** There were no items of other business. ***Noted***	
167/25	**MEETING SELF ASSESSMENT** The Board acknowledged that the patient voice was heard during the meeting, enabling consideration of improvements. Dr Buki Adeyemo emphasised the importance of maintaining ambition for continuous improvement and focusing on the "what next" in future discussions. Discussion highlighted challenges in assigning assurance levels to Committee reports versus individual papers. Kenny Laing noted the need for clarity on whether scores represent cumulative or median values. Janet Dawson suggested including assurance levels for key areas within Committee reports rather than applying a single score to large reports. Executive summaries may not be required for Committee reports, reducing duplication and improving clarity. Work will continue to refine the approach to assurance reporting, ensuring clarity and relevance for Board oversight.	
168/25	**TRUST BOARD ATTENDANCE REPORT** Circulated for information only.	
	DATE AND TIME OF NEXT MEETING Thursday 15th January 2026 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12:30pm

Signed:  Date: 22nd December 2025
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	13th November 2025	153/25	**CHAIRS REPORT - Schools & Youth Engagement** An action was agreed to explore opportunities to support Elevate with recruiting young people.	Elizabeth Mellor	15th January 2026	Elizabeth Mellor has made contact with Sabrina (Participation Worker) to encourage engagement with MPFT, SCC and SoTCC Participation Lead and explore opportunities to work on widening participation across the ICS CYP Forums – COMPLETE
2	13th November 2025	156/25	**BOARD AND COMMITTEE DATES 2026/27** Following discussion, it was agreed that the January 2026 Remuneration Committee date be reviewed to ensure Non-Executive availability.	Lisa Wilkinson	15th January 2026	Following a review of the cycle of business and agenda items for the meeting the decision was made to cancel the meeting.
3	13th November 2025	157/25	**POLICY REPORT** It was agreed the report would be shared with the Board in January 2026.	Nicola Griffiths	15th January 2026	Agenda Item
4	13th November 2025	158/25	**RESEARCH AND DEVELOPMENT (R&D) ANNUAL REPORT** The Board discussed the need for a clearer organisational research ambition, suggesting a future board session to define strategic priorities and ensure alignment between research, innovation, and service transformation. Nicola Griffiths to add to Board Development Programme 2026/27. Dr Dennis Okolo to lead future Board session.	Nicola Griffiths / Dr Dennis Okolo	15th January 2026	Added to Board Development Programme 2026/27.
5	13th November 2025	159/25	**IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 6** Martin Evans discussed the need for deeper understanding of Performance Improvement Programmes (PIPs), suggesting a Private Board discussion to clarify the journey and effectiveness of PIPs, and highlighting the importance of connecting actions to outcomes. Nicola Griffiths to carry forward to a future Private Board session. Eric Gardiner to deliver agenda item.	Nicola Griffiths / Eric Gardiner	15th January 2026	Following discussion agreed briefing to be delivered at Finance and Resource Committee by Eric Gardiner.
6	13th November 2025	161/25	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 2ND OCTOBER AND 6TH NOVEMBER 2025** 2025 Staffordshire Connect to Work Tender outcome acknowledged as positive but not outstanding; Committee agreed to aim for improvement and avoid complacency.	Elizabeth Mellor	15th January 2026	Elizabeth Mellor to feedback to the team and ensure all learning is informing new business development opportunities.

Chief Executive's Report to the Trust Board
January 2026

1.0 PURPOSE OF THE REPORT

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

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

People with Learning Disabilities and Autism in Staffordshire and Stoke-on-Trent star in new NHS vaccine films.

Local people with learning disabilities and autism are working with the NHS in Staffordshire and Stoke-on-Trent to boost confidence and encourage more people to get vaccinated through three informative films.

The first film follows a patient with learning disabilities and their carer as they visit their GP practice for a vaccination, showing what to expect on the day and helping to ease any worries. In the second video, local people with learning disabilities put their questions directly to a public health consultant, who tackles common myths, checks the facts and discusses their own concerns about vaccines. The third video shares the same key information in an accessible Easy Read format.

The videos are now available on the Staffordshire and Stoke-on-Trent ICS YouTube channel.

3.0 OUR TRUST

3.1

North Staffordshire Combined Healthcare NHS Trust again ranked number one 'Non-Acute' NHS 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 for the second quarter in a row. The ranking was published as part of the latest quarterly update of the new NHS National Oversight Framework (NOF), which assesses NHS Trust's across England against a range of agreed metrics.

High-performingTrust's 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.

Cost Improvement and Efficiency

At month 8, the Trust is forecasting full achievement of its £7.4m CIP target, with a total of £6.9m fully achieved/transacted, £0.2m fully developed and £0.3m opportunities identified. The Trust is also forecasting full achievement of the additional 3% increase in productivity ask from NHSE.

During December there have been six Project Initiation Documents (PIDs) approved and implemented, across a range of areas. Our internal auditors MIAA facilitated a targeted session with the SLTD on 9th December, featuring three breakout discussions that generated ideas and highlighted improvement opportunities.

Following the SLTD session and December operational plan submissions, the CIP meeting on 12 January will review schemes proposed in operational plans, assess the viability of 14 schemes deferred previously and explore potential new ideas.

The Trust continues to use a variety of external and internal sources, including the NHSE Model Hospital and NOF Framework, NHS Benchmarking Network and Service Line Reporting to explore areas for further improvement regarding productivity and efficiency.

Out of Area Performance

Ongoing reliance on Out of Area (OOA) mental health placements reflects sustained pressures on local bed capacity following dormitory eradication and rising demand in line with national trends. This continues to impact continuity of care, discharge planning, and patient experience, while increasing system inefficiencies and costs. The Trust remains committed to meeting NHS England's requirement to eliminate inappropriate OOA placements by 2026, except in exceptional circumstances.

A recovery plan is in place to optimise bed management and strengthen system-wide coordination. Key actions include daily bed flow meetings, embedded Red-to-Green processes and enhanced multi-agency oversight through a Strategic Oversight Group. Community teams are actively engaged in discharge planning, repatriation and crisis prevention, supported by real-time communication and a new Standard Operating Procedure for OOA management.

Progress is monitored through executive reporting and risk governance processes to ensure accountability and alignment with national targets. More detailed information in relation to OOA can be found within the IQPR and Quality Committee Quad A Report.

Combined Healthcare showcases Trust's pioneering use of virtual reality in Parliament

Dr Becky Chubb, Consultant Psychiatrist and Deputy Clinical Director, and Joe McCrea, Associate Director of Communications, appeared before the Science, Innovation and Technology Committee in Parliament in December. Together, they showcased two examples of innovation delivered by North Staffordshire Combined Healthcare NHS Trust – combining clinical science with the latest developments in innovation and technology.

The two projects showcased at the Committee sit within the Trust's Combined Virtual Reality (CVR) programme: virtual reality delirium training and virtual reality service walkthroughs. Virtual reality delirium training was created to mark World Delirium Awareness Day 2022. The training is a film created for frontline staff such as those in A&E and on acute wards who may care for people with dementia but are not dementia specialists. Virtual walkthroughs were created to reduce the anxiety that patients and families can feel before attending a

mental health hospital, due to negative stereotypes far from the reality of modern, compassionate care environments.

Virtual reality delirium training can be found on the Trust YouTube channel, while virtual walkthroughs can be accessed through the Trust website.

3.2

Combined Healthcare celebrates excellence and achievement with the REACH Awards 2025

The Trust's annual REACH (Recognising Excellence and Achievement at Combined Healthcare) Awards 2025 took place on 13 November to celebrate Combined's staff, service user representatives and carers, and recognise their achievements over the last year.

The awards recognise outstanding achievements in the following categories: Diversity and Inclusion Award, Leading with Compassion Award, Learner of the Year Award, Lived Experience Shining Star Award, Partnership Award, Proud to CARE Award, Research and Innovation Award, Rising Star Award, Service User and Carer Council Award, Team of the Year Award, Unsung Hero Award, and Chair's Award.

Highlights from this year's ceremony are now available on the Trust website and YouTube channel.

3.3

Combined Healthcare colleagues spotlight dementia care services in Stoke-on-Trent

Combined Healthcare colleagues helped to spotlight Stoke-on-Trent's pioneering dementia care services, as the city received a special visit from representatives from Baroness Casey's Independent Commission on Adult Social Care in November.

Colleagues from the Trust joined representatives from Alzheimer's Society and Dougie Mac, at a special event led by Stoke-on-Trent City Council, to share information on a range of new services the organisations are delivering in partnership to support people with dementia in Stoke-on-Trent.

Dr Rebecca Chubb, Consultant Psychiatrist at North Staffordshire Combined Healthcare NHS Trust, showcased the Trust's dementia partnership working and pathways during the visit, which took place at Stoke-on-Trent City Council's Marrow House, in Longton – the home of the Trust's Eaves Memory Clinic.

4.0 Conclusion

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

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 4

ASK THE BOARD QUESTIONS

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

Report to:	Public Trust Board
Date of Meeting:	15 January 2026

Presented by:	Janet Dawson, Chair
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 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:	N/A
Strategic Priorities:	Prevention - 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:	The Trust Board receive questions from members of the public and provide a response to questions during Public Trust Board meeting.
Executive Summary:	The following questions have been submitted by members of the public since the previous Public Trust Board meeting. Responses will be provided by board members during this meeting

	1. Avoidant/Restrictive Food Intake Disorder (ARFID) is an eating disorder which, according to Beat, can present on its own or can co-occur with other conditions such as, but not limited to, autism and ADHD. We have heard that ARFID referrals to specialist eating disorder services were rejected due to the service not providing ARFID-related treatment. What is the correct pathway for individuals to receive support with and treatment for ARFID, whether or not the individual does or does not have another condition present? – ***Healthwatch, Stoke-on-Trent*** 2. I've read the current advice about Mounjaro on the ICB website I understand that patients mustn't speak to their GP about the drug and that the patients will be assessed independently. How will this process work? Will GPs be asked to identify suitable patients and send their details to Combine Healthcare. Patients can access Mounjaro from online sources and therefore a two-tier system has developed, those who can pay get Mounjaro. I understand that a rationing process must operate within the NHS but someone must have authorised the release of this drug to private providers. Was this done by the MHRA? – ***Member of the Public***

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	09.01.26

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 5

Safer Staffing Annual Report 2024-2025

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

Report to:	Public Trust Board
Date of Meeting:	15 January 2026

Presented by:	Kenny Laing – Chief Nursing Officer
Prepared by:	Zoe Grant – Deputy Chief Nursing Officer
Executive Lead:	Kenny Laing – Chief Nursing Officer

Aligned to Board Assurance Framework Risk:	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 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:	SLT
Strategic Priorities:	Prevention - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
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 has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A
Recommendation / Required Action:	The Board is asked to: • Receive the report • Be assured that safe staffing levels have been maintained in inpatient areas.

Executive Summary:	**Introduction** • Since 2014, Trusts in England have been required to monitor nurse staffing levels to ensure safety. • The National Quality Board (NQB) and NHS Improvement have set expectations and guidelines for safe staffing. • Purpose of the Report • The Annual report provides safer staffing data for all inpatient wards for the period of 2024/25. The report provides a summary of the safe staffing deep dive meetings which took place with each ward team and highlights the MHOST safer staffing findings • This Annual review updates the progress made since the six-monthly review, reported in January 2025. • It includes recommendations for 2024/25 based on findings from individual ward reviews. **Key Recommendations for 2025/26:** 1) For the Senior Leadership Team to note the request to adjust Ward 1's staffing establishment budget as per MHOST findings and feedback during the safer staffing review meetings. 2) It is recommended that Summersview safer staffing establishment is reconfigured utilising existing staffing resources to enable them to creation of two full Band 3 posts. 3) To support workforce development and Grow our Own model, the Trust should consider implementing a flexible staffing and funding model that enables the release of staff for training through strategic use of internal bank staff, rotational roles, and co-investment in backfill. This approach will maximise the impact of NHSE-funded development pathways such as Trainee Nursing Associates and MSc Nursing, while mitigating operational pressures on clinical teams. 4) To address the limited pipeline of Learning Disability nurses, it is recommended that we continue to strengthen collaboration with regional universities to develop more accessible placement opportunities and explore options for local delivery of Learning Disability Nurse training. This will support long-term workforce sustainability and improve recruitment into substantive posts within the Trust. 5) It is recommended that the implementation of the Enhanced Therapeutic Observation and Care (ETOC) framework is monitored via the safer staffing Bi-monthly meeting and that data highlighting the

	demand for enhanced care (e.g. 1:1 observations); workforce deployment and utilisation in relation to enhanced care and the impact on temporary staffing usage is routinely reported to the meeting. 6) It is recommended that the Bi-monthly safer staffing group receive regular updates around Culture of Care which specific relate to staffing issues, developments and educational needs. 7) Inpatient optimisation work is routinely reported via the bi-monthly safer staffing meeting, with data demonstrating key impacts of rostering efficiencies and improvements. **Recommendations for Committee** Approval; To support recommendations for staffing amendments in ward 1 and Summersview for onward approval at Trust Board. Assurance of Safe Staffing: Confirm that safe staffing levels have been maintained in inpatient areas.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	Sept 2025
V2	Quality Committee	Oct 2025
V2	Public Trust Board	15th January 2026

Annual Safer Staffing Establishment Review

2024/2025

1. Introduction

Since 2014 all Trust's in England have been required to monitor nurse staffing within in-patient wards to ensure that safe staffing levels are maintained. This monitoring comprises of monthly reporting to the Board and NHS England and an annual strategic staffing review; followed 6 months later by a comprehensive review focused on safer staffing establishments within the inpatient wards.

National Quality Board (NQB, July 2016) published *"supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe, sustainable and productive staffing".* This document provided an updated set of expectations for nurse staffing levels, to help NHS provider boards make local decisions that will support the delivery of high-quality care for patients within the available staffing resource.

In addition, NHS Improvement, (October 2018) published "*Developing workforce safeguards - Supporting providers to deliver high quality - care through safe and effective staffing".* This document strengthens requirements relating to governance and accountability in relation to Safer Staffing. Both this NHSI report and the NQB mental health resource (2018) inform Trust safer staffing practice and reviews moving forward. This document offered organisations best practice advice in effective staff deployment and workforce planning, relating to redesigning roles and responding to unplanned changes in workforce as well as helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually.

In line with the NQB requirements, a 6 monthly safe staffing review of staffing levels in inpatient areas was completed with the results reported via the 6-monthly Staffing review report to Quality Committee and Trust Board in January 2025. This report follows on with the Annual review of safer staffing and updates against the key recommendations made in January's report.

2. Executive Summary:

The annual safer staffing review discussions for this period were held throughout November and December 2024 (findings reflected in the six-monthly review report in January 2025) and also June and July 2025. The Deputy Chief Nurse and temporary staffing lead met with all ward managers individually, with Quality Lead Nurse / Matrons and also supported by finance and People directorate colleagues.

This annual review of safer staffing examines current staffing levels, providing data for the 2024/25 financial year and summarises the findings of the deep dive reviews conducted throughout November and December 2024 and June and July 2025, these include reviews of each teams MDT, skill mix, staff development and roster management.

The report also provides updates against the recommendations made in six-monthly safer staffing report for 2024.

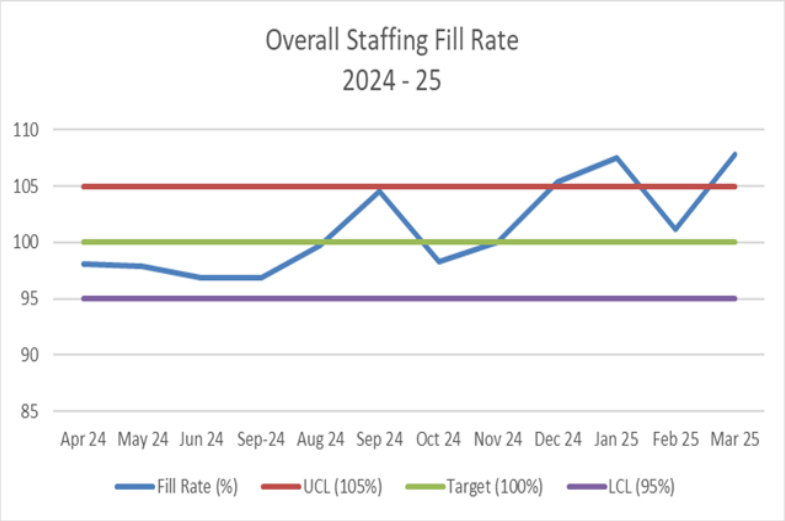
The report outlines recommendations going forward into 2025/26 related to the key findings and themes from the individual ward safer staffing establishment reviews.

In addition to the wider organisational recommendations, each ward have their own specific recommendations based on their own areas for improvement.

All recommendations will be reported via the Trusts Safer Staffing meeting where actions will be agreed, and improvements will be monitored.

2.1. Overview of Key Safer Staffing Metrics for Inpatient Wards:

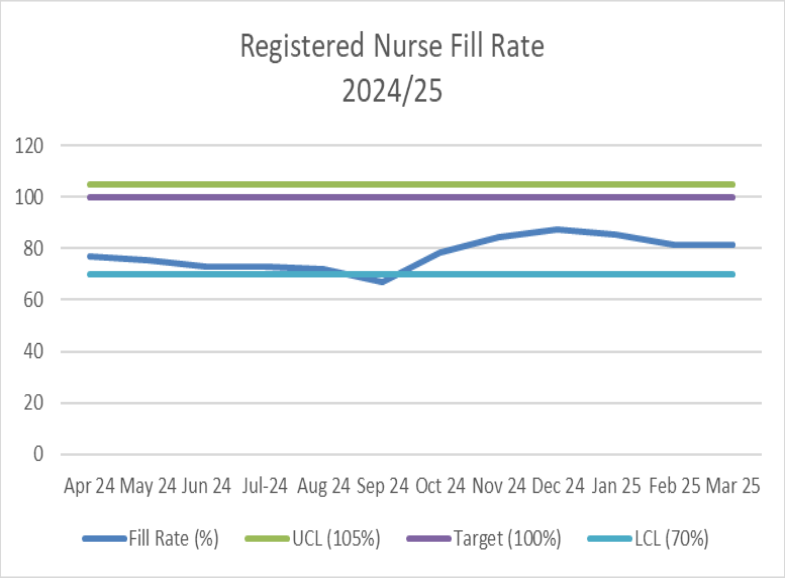
2.1.1. Overall Fill Rate



This graph shows an increasing overall staffing fill rate for the Inpatient Wards.

The average fill rate for 2024-25 was 101.2%

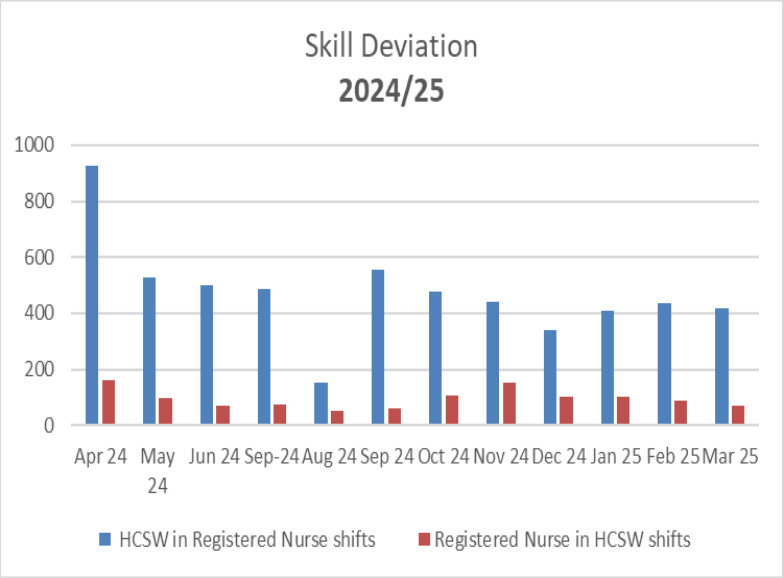
2.1.2. Registered Nurse Fill Rate



This graph shows an increase in registered nurse fill rate for the Inpatient Wards in October 24, this relates to the intake of Newly Registered Nurses which has been sustained.

The average fill rate for 2024-25 was 78%

2.1.3. Skill Deviation in Shifts

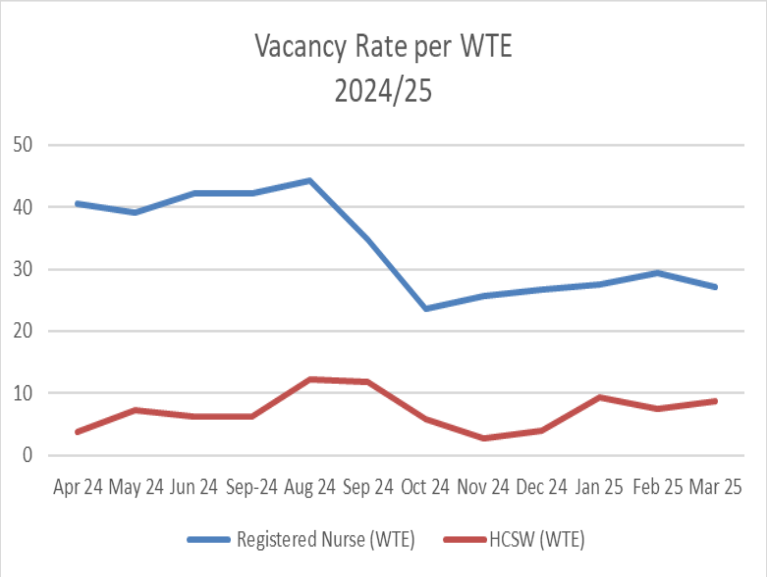


This graph shows the number of shifts which have been filled by the wrong grade type compared to what grade was required for the shift.

The average number of Registered nurse shifts filled by HCSW for 2024-25 was **872** shifts

Compared with an average of **94** shifts filled by Registered Nurses where a HCSW was required

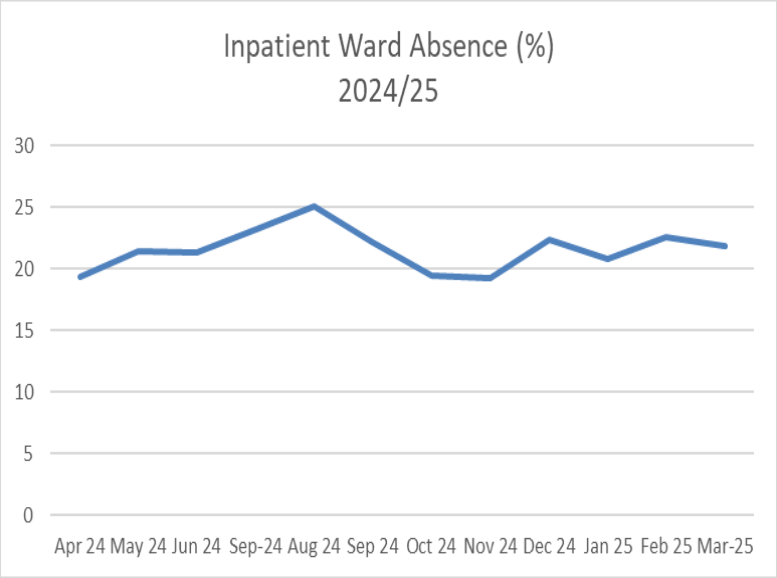
2.1.4. Vacancy Rate



This graph shows a decrease in registered nurse vacancies; this relates to the newly registered nurse intake in Oct 24 & March 25.

The average vacancy rate for 2024-25:
Registered Nurses – 33.6WTE
HCSW's - 7.1WTE

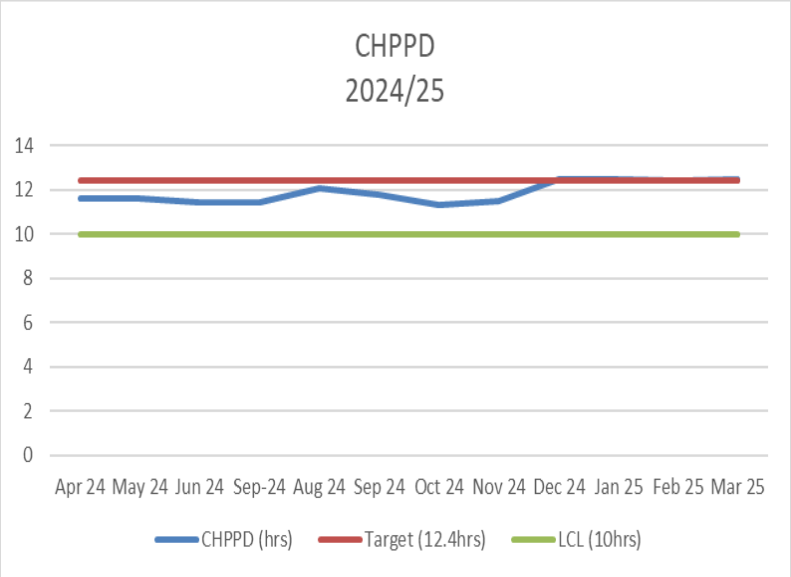
2.1.5. Sickness & Absence Rate



This graph shows that sickness and absences within the inpatient wards have predominantly remained above 20%.

The average sickness & absence for 2024-25 was 21.5%

2.1.6. Care Hours Per Patient Per Day (CHPPD)

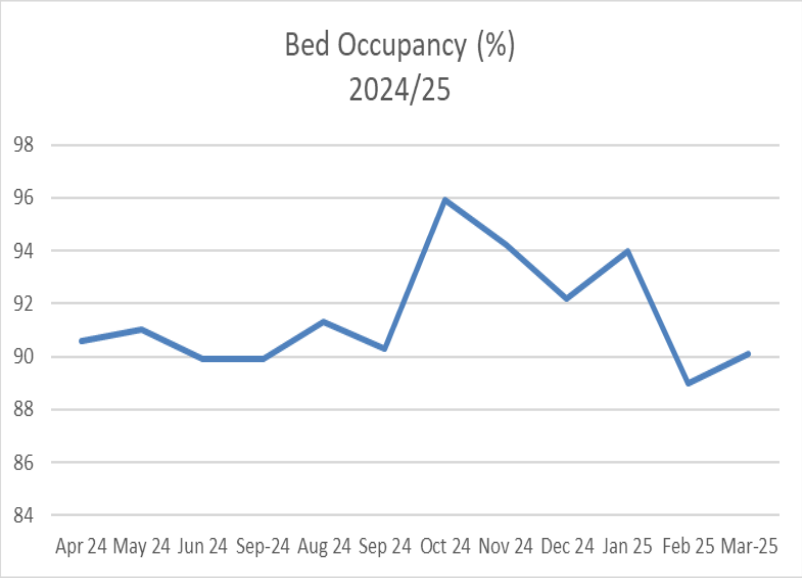


This graph shows the average CHPPD within the inpatient wards.

The average CHPPD for 2024-25 was 12.2hrs.

This benchmarks the Trust nationally as above average and can be linked to higher acuity & Observation levels, complex needs of patients and demonstrates proactive staff management.

2.1.7. Occupancy Levels

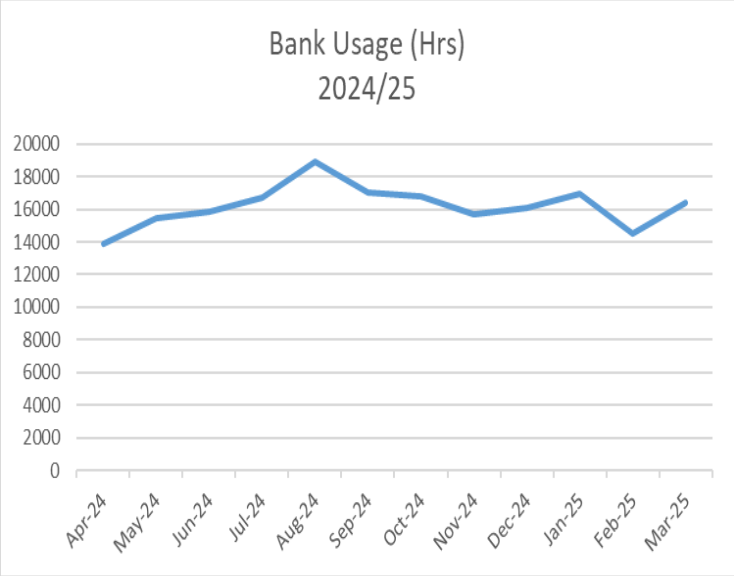


This graph shows the Bed occupancy levels throughout 2024/25.

It highlights a significantly challenging period between Sept – Jan 25 which correlates with the project chrysalis work but also challenges around delayed discharges within the wards.

The average bed occupancy for 2024/25 was 91.5%

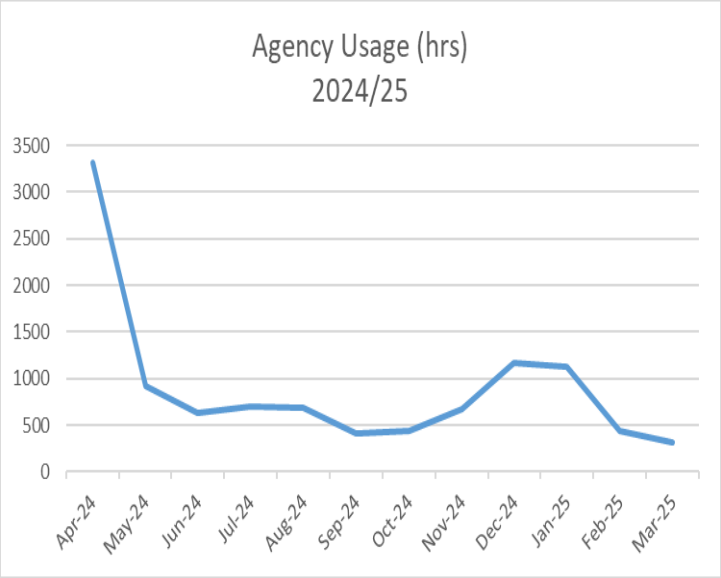
2.1.8. Temporary Staffing - Bank Usage (hrs)



This graph shows the inpatient ward Nurse & HCSW bank utilisation in hrs 2024/25.

Over the annual period this equates to 24.28 WTE Registered Nurses & 52.12 WTE HCSW's routinely working in the inpatient Wards.

2.1.9. Temporary Staffing – Agency Usage (hrs)



This graph shows the inpatient wards Nurse & HCSW agency utilisation in hrs 2024/25.

Over the annual period this equates to 3.39 WTE Registered Nurses & 0.94 WTE HCSW's routinely working in the inpatient wards.

2.2. Key Recommendations to Consider:

For Trusts Senior Leadership Team and Board to be sighted of the Safer Staffing establishment review findings and recommendations:

Recommendation's

1) For the Senior Leadership Team to support the recommendation to adjust Ward 1's staffing establishment budget as per MHOST findings and feedback during the safer staffing review meetings (see section 6.5.1 for more details and costings).

2) It is recommended that Edward Myers Unit (EMU) staffing establishment is uplifted in line with the proposal that the Directorate leadership team will be proposing as part of the EMU expansion paper which will be reported through Trust governance imminently (see section 6.5.2 for more details from the safer staffing deep dive review).

3) To support workforce development and Grow our Own model, the Trust should consider implementing a flexible staffing and funding model that enables the release of staff for training through strategic use of internal bank staff, rotational roles, and co-investment in backfill. This approach will maximise the impact of NHSE-funded development pathways such as Trainee Nursing Associates and MSc Nursing, while mitigating operational pressures on clinical teams.

4) To address the limited pipeline of Learning Disability nurses, it is recommended that we continue to strengthen collaboration with regional universities to develop more accessible placement opportunities and explore options for local delivery of Learning Disability Nurse training. This will support long-term workforce sustainability and improve recruitment into substantive posts within the Trust.

5) It is recommended that the implementation of the Enhanced Therapeutic Observation and Care (ETOC) framework is monitored via the safer staffing Bi-monthly meeting and that data

highlighting the demand for enhanced care (e.g. 1:1 observations); workforce deployment and utilisation and to report the impact that enhanced care needs has on temporary staffing usage.

6) It is recommended that the Bi-monthly safer staffing group receive regular updates around Culture of Care which specifically relate to staffing issues, developments and educational needs.

7) Inpatient optimisation work is routinely reported via the bi-monthly safer staffing meeting, with data demonstrating key impacts of rostering efficiencies and improvements.

Please note – there are additional action points highlighted in appendix 1 which will be carried forward into the Bi-Monthly Safer Staffing meeting for further discussions and alignment to other Trust programmes of work.

3. Summary:

3.1 Progress since previous annual review

A comprehensive six-monthly review report was presented to the Trust Board in January 2025. All recommendations relating to the safer staffing reviews continue to be progressed and monitored through the Safer Staffing Group.

We continue to explore how to maximise on pathways into nursing, innovative recruitment and retention initiatives supported by ward and corporate teams, however, this is proving to be a challenge. We continue to receive NHSE funding to support with the development of staff into roles such as Trainee Nurse Associates and the MSc Nursing pathways, but funding does not support the back fill of staff which is a challenge for directorates due to maintaining safer staffing numbers and cost efficiencies.

We also have an emerging challenge in relation to the lack of local provision for Learning Disability Nurse Training, we are working closely with Derby & Wolverhampton universities to encourage students into placements here at Combined, however due to geographical location, minimal Learning Disability students have come to NSCHT for placements. This has a direct effect in the number of Learning Disability nurses applying for substantive nurse posts within the Trust. This remains an ongoing area of focus.

Rather more positively we are seeing an ongoing growth of newly registered nurses wanting to work in the Trust, we have received an encouraging number of applications and are expecting to recruit 54wte Newly Registered Nurses in October 25. In addition to attracting newly registered nurses, there continues to be a focus on registered nurse retention which has improved during 2024-25.

Despite the challenges, safe staffing has been maintained with the overall priority being the delivery of excellent patient care.

Progress and achievements during 2024-25 include:

- 68 BSc newly qualified mental health nurses commenced training in September 24 from two universities, plus 33 MSc mental health and 2 learning disability nurses.

- We have two Nursing Associates that have started their top up course to BSc Nursing, one is within the adult field (September 24) and one within the mental health field (March 25).

- Since March 24, 9 staff have completed the BSc apprenticeship programme, 4 Nursing Associates have completed the Registered Nurse Degree Apprenticeship top up programme and 14 have completed the Nursing Associate course, all except one have been employed with the Trust.

- We now have 22 Registered Professional Nurse Advocates (PNA's), with an additional 4 due who qualified in August 25, and 5 due to commence training in September 25, they will qualify in January 26.

- Our Preceptorship programmes evaluation has concluded. As a result, from September 25 the following changes will be implemented:

    - all sessions are delivered face to face.
    - Interview preparation sessions will be delivered as part of preceptorship.
    - The study days have been flipped to promote full attendance for the day: Action Learning sets and PNA restorative supervision will be delivered in the morning and theory in the afternoon.
    - Peer support sessions have been strengthened, giving more structure and time for reflection and completion of reflections.

- In November 2024 a 12-month recruitment plan was agreed across directorates to improve consistency in recruitment, clearer communication for the students and Trust staff and is now a centralised process, allowing the Practice Education Team to engage with students throughout their training, interview process, through to employment and the preceptorship programme.

- 6 apprenticeship nurses registered in April 24, 5 of these took up posts with the Trust. A further 4 registered in for October 24; 2 of these took up a post with the Trust. We have 8 apprenticeship nurses who 8 remain in training due to register in October 25.

- Sustained improvements in the compliance of Safecare utilisation within the Inpatient wards.

- RAID training refreshers for existing staff and RAID training for new staff continues to be funded through the education budget for PICU, Ward1,2,3 Darwin and A&T. Ward 4,5,6,7 & Summers view have been offered positive behavioural support training, which has been implemented and funded through Culture of care work stream. This training has contributed to an annual reduction in restrictive practices throughout all Inpatient areas.

- We have seen an annual reduction in restrictive practices throughout all Inpatient areas. Overall, the Trust has observed a reduction in the use of restrictive practices in 2023/24 compared to 2022/23. Specifically, the use of restraint decreased from 958 instances in 2022/23 to 788 in 2023/24. Similarly, the use of rapid tranquilisation dropped from 413 instances in 2022/23 to 215 in 2023/24.

- A pilot and evaluation of self-rostering within 2 inpatient wards was concluded. There was no significant positive impact from the pilots and both wards are now moving into auto rostering, which is recommended as the preferred, more reliable and efficient form of rostering by the E-Roster providers.

- The Culture of Care (CofC) standards continue to be further embedded in Quality Improvement initiatives within Inpatient settings. They bring together the Quality Improvement and Reducing Restrictive Practice with co-production.

- Team Recovery Implementation Plans (TRIP) framework continues to be used to co-produce where we are and where we want to be, this will deliver 2-3 larger QI projects per team and small QI quick wins.

- Year 2 culture of care will continue with TRIP as one of the workstreams, alongside Reasonable Adjustments, Therapeutic engagement and 'things to do' and Trauma informed care, which will support the development, implementation and training in enhanced therapeutic care.

- Co-produced care planning steering and task and finish groups were set up, in year 1 of culture of care, this workstream is coming to an end, seeing the implementation of co-produced care planning in our inpatient wards, reducing duplication for patients and staff, meaningful care plans and releasing time to care. This includes renewed SOPs to help improve practice, creation of a digital clinical dashboard and a strengthened clinical supervision tool which is now available in digital format.

- Our dedicated Safer Staffing leads, and ward managers have received updated and improved training around effective and efficient rostering and there has been a dedicated workshop to focus on effective rostering, aligned to high quality care and safe staffing.

- An Inpatient staffing optimisation group was formed in April 2025 with representatives from operational directorates, finance, people directorate and nursing & quality leads. There are several programmes of work focused on compliance with effective rostering, management of ward staffing budgets and reducing bank and agency usage all with dedicated TMO involvement and support.

4. Safe Staffing Review / Team Level Data

4.1 Evidence-based workforce planning and professional judgement

The NQB and NHSE/I expect Trusts to use evidence-based tools and also professional judgement to review and determine staffing levels. Ward and Senior Managers have supported the improvements around ensuing compliance with the completion of the SafeCare tool rolled out via E-rostering. This incorporates the Hurst Tool and comprises of a census 3 times per day in relation to patient dependency and acuity. Results are provided in a calculation identifying the staffing levels required to support patients on a shift-by-shift basis. The results for each ward can be viewed in section 6 of this report.

The Quality Improvement Lead Nurse / Matrons meet daily with their respective ward managers to review staffing in line with the acuity data within SafeCare, allowing for better informed decision making around staff redeployment.

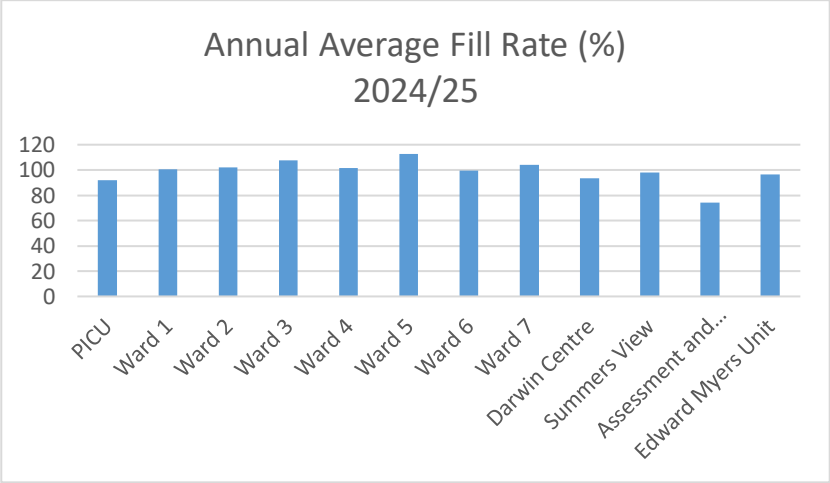
This current staffing review has been undertaken using the Telford Model of professional judgement triangulated with several quantitative measures including rosters, bank use, incident reporting, care hours per patient day (CHPPD), alongside the safecare data being interpreted within the evidence based Mental Health Optimal Staffing Tool (MHOST).

The Royal College of Nursing (RCN, 2010) recommends a registered to non-registered nurse ratio of 60:40, alternatively the Safe Staffing Alliance (2013), a group of senior nurses, believes Registered Nurse-to-patient levels should never fall below 1:8 during the day. As in previous reviews, most recommendations made within this review continue to be based on a 50:50 RN to HCSW split in wards which meets the required 1:8 RN to patient ratio on days.

The Deputy Chief Nurse held staffing review meetings with Ward Managers with input from Quality Improvement Lead Nurse (Matron) or service manager and the Trusts e-roster manager, alongside finance and people directorate representatives in each of the Trusts Inpatient wards.

4.2 Inpatient Ward Staffing levels performance 1st April 2024 to 31st March 2025
The following is an overview of the key staffing metrics per inpatient ward.

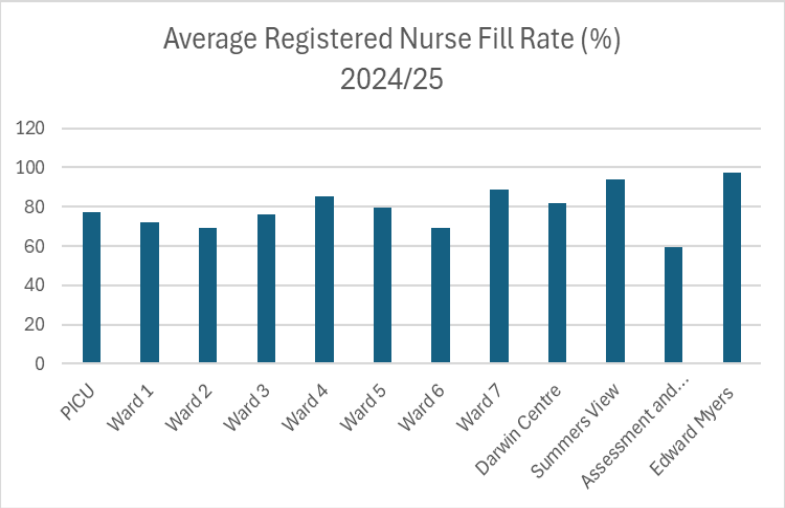
4.2.1. Overall average staffing fill rate



This graph shows each Inpatient Wards average overall staffing fill rate for 2024/25

A&T shows the lowest fill rate, this is associated with periods of low occupancy throughout the year.

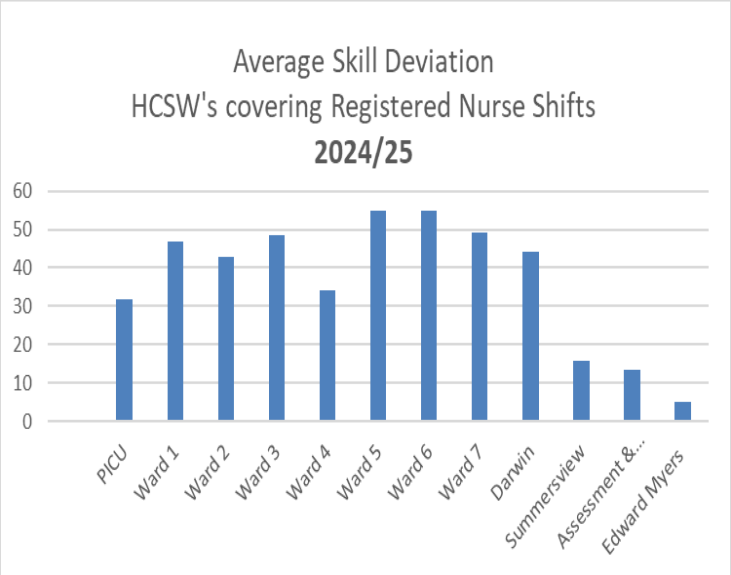
4.2.2. Registered Nurse average fill rate



This graph shows each Inpatient Wards average overall staffing fill rate for 2024/25

A&T shows the lowest fill rate; this is associated with high level vacancies, however mitigated with periods of low occupancy throughout the year.

4.2.3.a. Average Skill Deviation on Shift

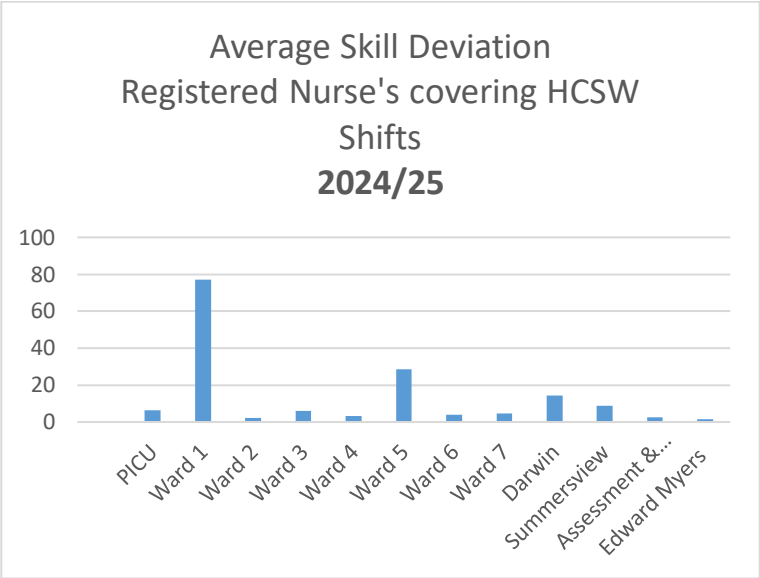


This shows the average number of a Registered Nurse shift has been filled with a HCSW.

This highlights ongoing challenge around Registered Nurse availability, alongside effective roster management.

Wards 5,6,7 filled more Registered Nurse shifts with HCSW's than any of the other wards

4.2.3.b. Average Skill Deviation on Shift

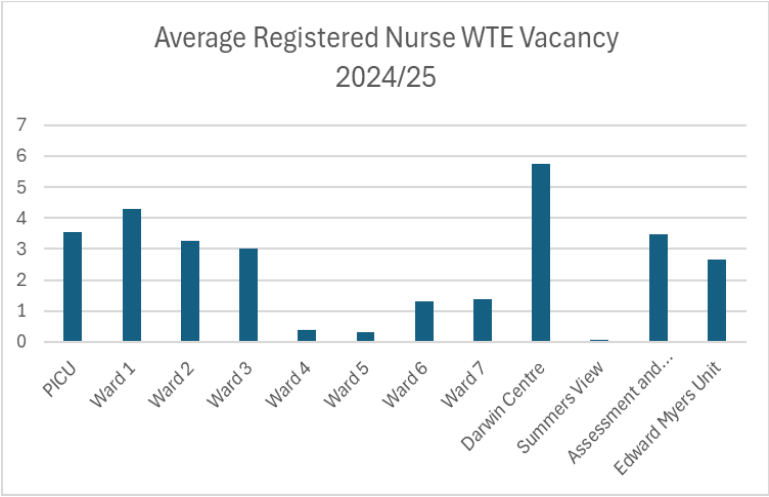


This shows the average number of a Registered Nurses covering HCSW shifts.

This graph shows that this happens less frequently, this is positive in terms of budget management.

Wards 1 & 5 have covered the most HCSW shifts with Registered Nurses.

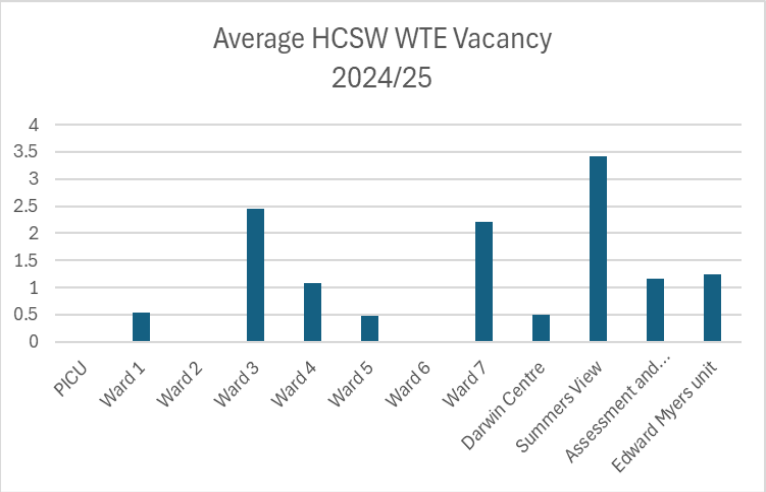
4.2.4.a. Average Registered Nurse vacancy rate



This graph shows each Inpatient Wards average Registered Nurse WTE Vacancy for 2024/25

Darwin & A&T had the highest number of vacancies whilst ward 4,5 and Summers views had the greatest stability.

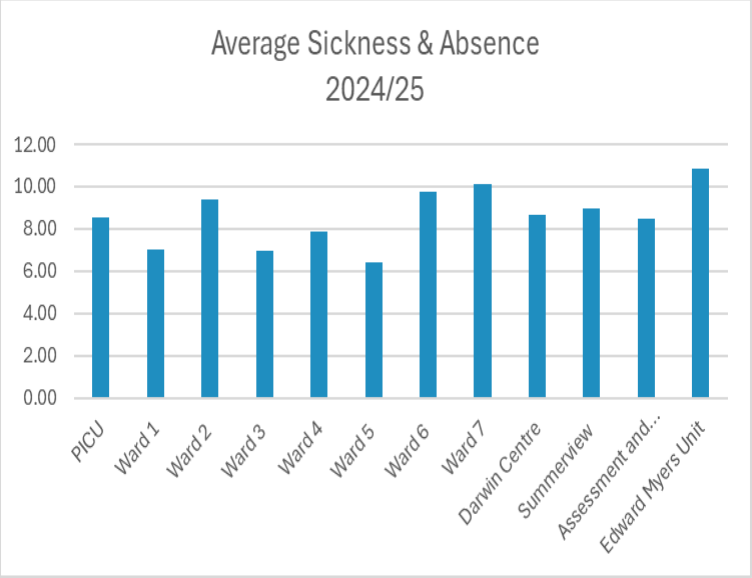
4.2.4.b. Average HCSW vacancy rate



This graph shows each Inpatient Wards average HCSW WTE Vacancy for 2024/25

Summers view had the highest number of vacancies whilst ward 2,6 and PICU had no HCSW vacancies throughout the year.

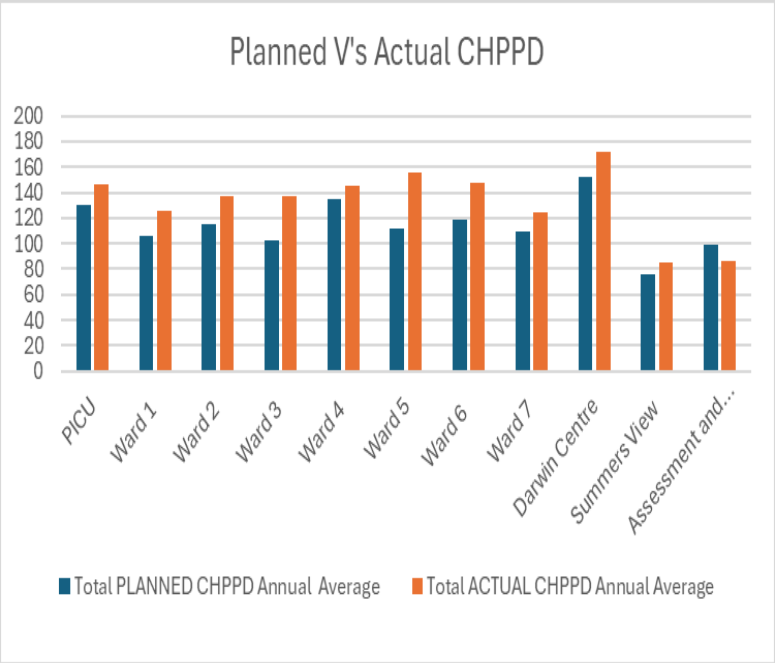
4.2.5. Average sickness and absence rate



This graph shows each Inpatient Wards average (FTE days lost per month) sickness & absence during 2024/25

Edward Myers, wards 6 & 7 had the highest number of absences, whilst ward 1,3 & 5 had the lowest.

4.2.6. Average CHPPD: Required V's Actual



This chart shows the planned v's actual care hours per patient per day for the 12-month period from 1st Apr 24 to 31st March 25.

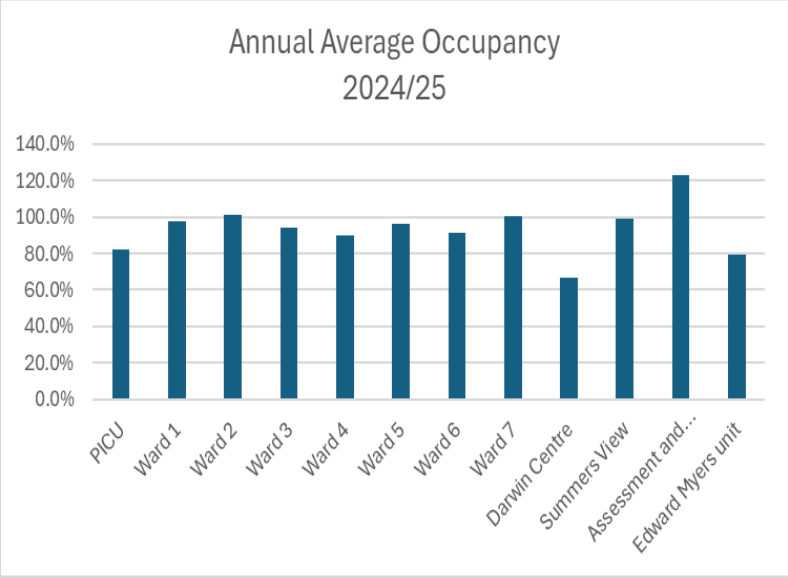
Of note:

8 teams delivered substantially more hours than planned, in all cases, this is due to a mix of:

- Increased demand / acuity
- Unplanned absence
- Increased use of bank / temporary staffing
- Ineffective roster management in some areas

A&T delivered fewer care hours than planned, this relates to the low occupancy / reduced demand within the ward.

4.2.7. Average Occupancy

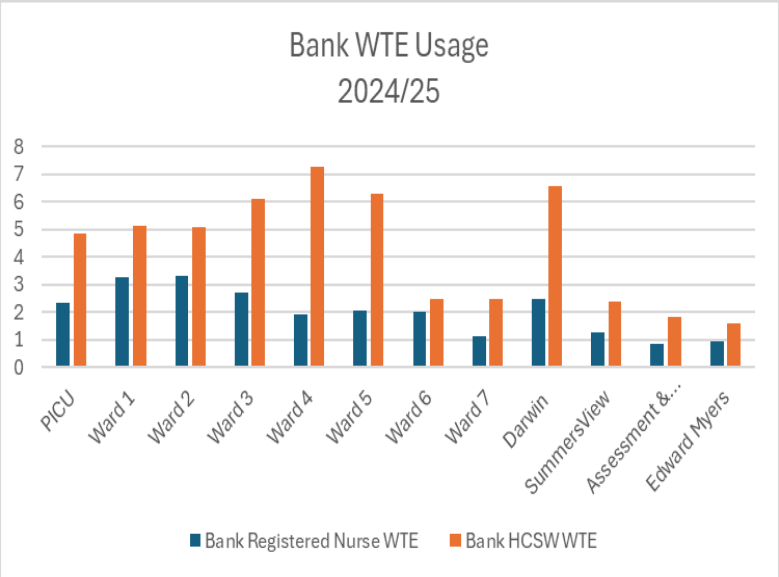


This graph shows each Inpatient Wards average bed occupancy for 2024/25

A&T occupancy increased from 1 patient to 2 inpatients, the manner in which available beds were reported changed during this year, so this average is less reliable than the other wards.

Wards 1,2,3,5,7 & summers views had a sustained period of high occupancy throughout the year.

4.2.8. Bank Usage Per WTE



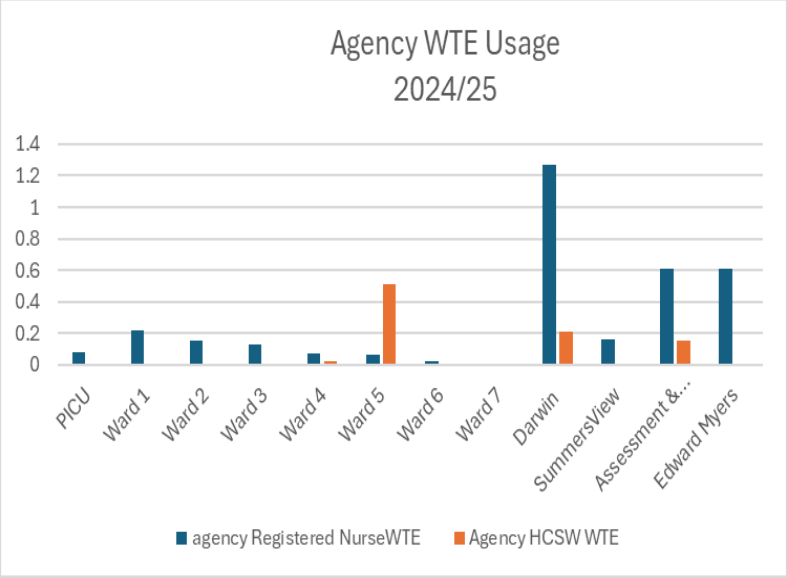
This graph shows each Inpatient Wards Bank WTE Usage

Bank HCSW WTE is consistently higher than RN WTE across all wards.

Ward 4 recorded the highest Bank HCSW WTE, followed by Darwin and Ward 5.

Ward 2 and Ward 1 had the highest Bank RN WTEs

4.2.9. Agency Usage Per WTE



This graph shows each Inpatient Wards Agency WTE Usage

This shows minimal reliance on agency staffing. Agency Registered Nurse WTE generally higher than HCSW WTE.

Darwin are the highest Agency RN usage (1.27WTE).
Ward 5 the highest usage of Agency HCSW (0.51WTE).

5. Progress of Recommendations from the 6-month Safer Staffing Review (reported in January 25)

The overall progress from the recommendations are summarised below. Progress against the unachieved areas will continue to be monitored via the safer staffing meeting. The areas where further work is needed are outlined in the table below:

1	To conduct a collective review of each inpatient wards multi-disciplinary team infrastructure with a view of ensuring consistency, alignment to the needs of the patients and the most efficient use of finance and resource whilst maintaining high quality of care.	This work is underway within the Inpatient staffing optimisation programme of work.
2	To ensure that Trainee Nurse Associate roles are routinely available for staff looking to become a registered Nurse.	We have 2 x Nursing Associates who are currently on the Degree top up programme and 4 x Nursing Associates have completed this year. There are 14 Trainee Nursing Associates who have completed their training this year with the recommendation that they have 12months experience working in this role before they top up.
3	To further strengthen the Enhanced Clinical Practitioner, offer, to enable band 5 nurses to commence the programme and on completion of the programme to move into a band 6 role as an Enhanced Clinical Practitioner within their specialist field (i.e. acute inpatient nurse, older person inpatient nurse).	A business case to support the funding and banding uplift was presented to Trust's executive team, this was not approved due to the financial challenges experienced within the Trust. This will be revisited as part of wider workforce planning programmes of work.
4	To review the process for delivering mandatory training within the inpatient wards which supports effective roster management, whilst ensuring staff are fully compliant with training requirements. Consideration to be given to re-introducing the block week mandatory training which ward managers would all be favourable of.	This was explored and discussed and whilst it remains a favourable suggestion, it is not considered a priority currently due to mandatory training compliance being relatively stable.
5	To ensure that each ward manager has adequate oversight and input into the training needs analysis process, with consideration being given to complementary therapy training for registered and non-registered staff and brief therapeutic interventions for registered nurses.	The TNA requests have been supported via the Culture of Care programmes of work and funding secured for a range of therapeutic training from Inpatient staff; this includes complementary training packages, due to commence in Oct & Nov 25.

6	Each ward to receive a deep dive roster review, taking into account effective rostering and cost pressure reductions with actions for improvement being agreed between the E-rostering team lead and the ward managers.	This is now a rolling programme of work led by the Trusts Temporary Staffing and E-Rostering Team. With oversight at the Staffing Optimisation Group.
7	Prior to the review, each ward manager must ensure that registered nurses are proportionately covering both day shifts and night shifts, with a minimum of two registered nurses per night shift.	The fill rate for two registered nurses on night shifts has improved and remains improved due to retention of Nurses and ongoing intakes of Newly Registered Nurses.
8	Each ward to ensure that all they are fully compliant with the budgeted establishment, ensuring that there are no HCSW's or Registered Nurses undertaking additional roles within the wards in a supernumerary capacity.	This work is underway within the Inpatient staffing optimisation programme of work.
9	To ensure that the roles and responsibilities of Registered General nurses are clearly defined, and this is reflected within their Job descriptions and within their scope of practice.	There is a national programme of work reviewing all nurse job descriptions, this is being led by the Trusts Head of Nursing with direct support from People Directorate. The Job descriptions for Registered General Nurses will be reviewed within this programme of work.
10	To ensure that Rosters clearly highlight RMNs and RGN's per shift, with the RGN being the 3rd registered nurse on duty with 2 RMN's during the day shifts	This is not achievable within the current Roster platform and has been escalated to the platform provider for their review and consideration.
11	All wards to ensure there is a weekly programme of activities and meaningful interventions available throughout the week for patients, any cancellations need to be reported through to the Deputy Chief Nurse on a Monthly basis.	The CoC therapeutic interventions work stream is supporting the development of skills/ interventions and are developing models of care that are reflective of interventions offered. Registered staff will be trained in: Brief CBT, DBT, Motivational interviewing and solution focussed therapy, sustainable through TNA. MDT review is promoting therapeutic interventions offer, ensuring consistent delivery, not single point of failure in the coming year. Work remains underway in the EPR system to allow automated reporting around activities and interventions.

12	All patients should have a meaningful intervention plan which is personalised to them based on the activities, therapeutic interventions and their own care and treatment plan which outlines the plan for the week / duration of admission	Quality Assurance reports / audits are expected to be reported via Quality Assurance Group from Quarter 2 2025/26.

6. Summary of annual Safer Staffing Review:

The review has concluded with 7 recommendations, as seen above in section 2 of this report. Recommendations 1 specifically relate to amendments to the staffing establishment within Ward 1. Recommendation 2 relates specifically to a bespoke safer staffing review conducted by Edward Myers Unit (EMU) ward manager, which evidences the need for a staffing establishment uplift also. This section of the report offers an appraisal of the MHOST / Hurst tool findings, alongside the more detailed information and costings related to the recommended staffing establishment amendments.

It is also to note that the Safer Staffing Lead has explored a safer staffing skill mix adjustment within Summersview at the request of the team. It was initially considered to be a cost neutral adjustment by the ward leadership team; however, it transpired that this would incur additional costs which outweigh the need for the skill mix adjustment. It was therefore agreed to review this over the next 6 months and revisit in the 6monthy safer Staffing Review.

6.1 Staffing Establishment MHOST Review:

The safer staffing review meetings consider a wider range of issues which impact on staffing, one element of this involves the use of the Mental Health Optimal Staffing Tool (MHOST). This is a tool which helps to calculate suggested staffing establishments in inpatient wards based on acuity data submitted daily by ward teams into Safecare, which is a platform which rates the dependency scores of individual patients throughout a 24hr period.

Most inpatient wards stated that their existing staffing establishments were in the main, adequate. Ward's 1 and 2 and EMU all stated that they required a staffing uplift. There is an appraisal of this offered below.

Below are the MHOST calculations based on data extracted from the Safecare Hours Per Patient Per Day report (from 1st January 2025– 30th June 2025) and inputted into the MHOST tool;

Acute Inpatient Wards:

Ward	PICU			1			2			3		
Shifts	**E**	**L**	**N**	**E**	**L**	**N**	**E**	**L**	**N**	**E**	**L**	**N**
Existing Establishment	7	7	6	5	5	4	6	6	4	6	6	4
MHOST Suggested Establishment	5.4	5.4	2.4	5.8	5.8	2.8	7	7	4	6	6	6

Older Persons:

Ward	Ward 4			Ward 6			Ward 7		
Shifts	**E**	**L**	**N**	**E**	**L**	**N**	**E**	**L**	**N**
Existing Establishment	7	7	5	7	7	5	6	6	4
MHOST Suggested Establishment	8.2	8.2	5.2	9.6	9.6	6.6	6.3	6.3	3.3

Specialist

Ward	Darwin			Ward 5			A&T			EMU			Summers View		
Shifts	**E**	**L**	**N**	**E**	**L**	**N**	**E**	**L**	**N**	**E**	**L**	**N**	**E**	**L**	**N**
Existing Establishment	8	8	7	6	6	5	6	6	4	4	4	3	5	5	3
MHOST Suggested Establishment	7.1	7.1	4.1	7.4	7.4	4.4	NA			**(above includes IOU staff of 1/1/1)** NA			3.3	3.3	0.3

6.3. Limitations of these findings:

As mentioned above these findings are used to inform safer staffing establishment decisions as part of a wider process which involves discussions with the ward managers and matrons, reviews of roster effectiveness and relevant or adequate skill mix of the staff on the ward, alongside other issues such as environmental considerations. There is also an overriding key component of professional judgement to be considered when making recommendations and decisions about staffing establishments. The MHOST results above do not take these wider components into consideration but can be utilised as a reasonable indicator of predicted staffing establishment requirements.

NB – it is not recommended to reduce any of the wards staffing numbers during a night shift below 4 staff within the majority of our inpatient wards. Safety Interventions which support patients who pose a high risk of violence and / or aggression are utilised frequently in these settings, it is a minimum requirement to have 3 staff members involved in any Safety Intervention of this nature, leaving the 4th member of staff to support the remainder of the ward until additional support can be provided from other areas.

The reliance of the tool is reduced in areas with low bed numbers, such as the PICU, ward 5 where additional weighting must be given to professional judgement.

The acuity scores calculated above do not incorporate additional duties which are carried outside of the those predicted as part of a routine shift, i.e. additional patient escorts, increased admissions or additional patient need such as higher number of patients requiring closer observations.

Furthermore, there is not an evidence-based tool considered suitable for A&T, EMU.

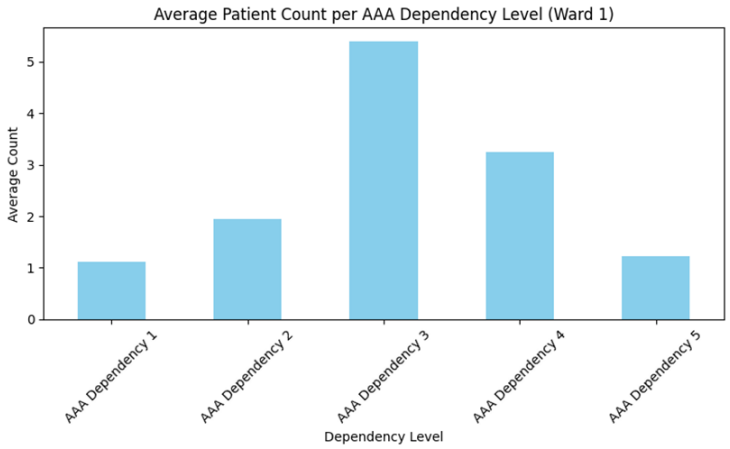
6.4. MHOST Results & recommendations:

The key areas of significance from MHOST review are wards 1, 2, 4, 5 and 6 as the MHOST evidence-based tool suggests that the current staffing establishments need to be uplifted.

The following is an appraisal of these finding for each of the wards noted above, alongside consideration of the safe staffing review meeting and professional judgement.

6.4.1. Ward 1

Ward 1 have routinely increased their staffing levels to 6/6/4 for the duration of the year. Their establishment is currently set to 5/5/4. The graph below shows that the ward tend to have a dependency level of 3 & 4, which you would expect to see in an acute inpatient setting.

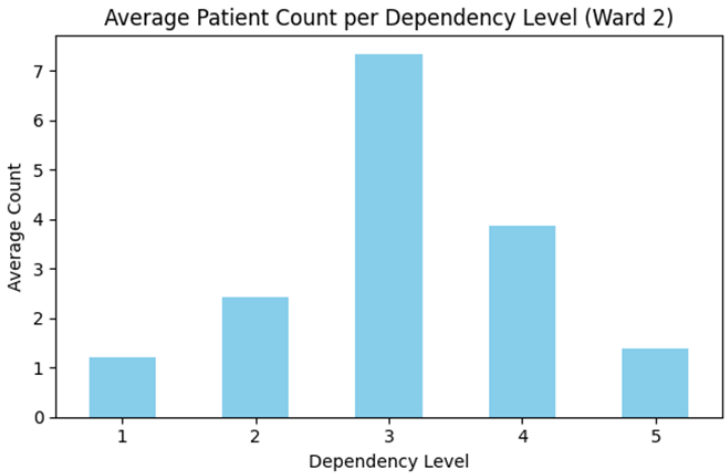


(AAA = Adult Acuity and Dependency Assessment)

Ward 1 routinely has at least one level 5 patient on the ward. Ward 1 has additional environmental security measures when compared to wards 2 and 3 and as such have acted as a 'step down' ward from the PICU unit. This has proven to be helpful as it allows for better flow for patients into the PICU, reducing the need for out of area beds. The MHOST review of the dependency levels for ward 1 would support a staffing uplift, therefore with this and the professional judgement discussions which took the above into account, along with the sustained and prolonged increase of their staffing to 6/6/4 over the previous year; it is recommended that ward 1's safer staffing establishment is uplifted to 6/6/4.

6.4.1 Ward 2

Ward 2 state that they are routinely increasing staffing above their establishment to 7/7/5, the graph below suggests that on average ward 2 had 1 patient dependency level 5 throughout the six-month period on the ward, with most patients being dependency levels 3 & 4, which you would typically expect to see on an acute ward.



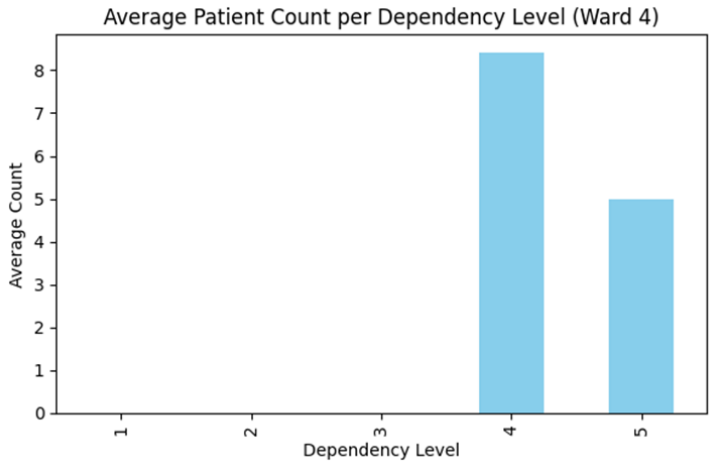
Whilst every acute ward may have a patient with dependency level 5 needs from time to time, this would usually be for short and intermittent periods, due to the Trust having PICU beds on site. It would be expected that dependency level 5 patients are more routinely nursed within the PICU and those patients who benefit from a step down into the acute wards tend to have a reduced dependency level when they do or have the opportunity to step down into ward 1, due to the environment having additional environmental security measures when compared to wards 2 & 3.

The ward leadership rationale for the increased staffing to 7/7/5 indicated that improved shift co-ordination and leadership may mitigate the need for increased staffing, i.e. automatically increasing staffing if they have more than one patient on constant visual observations, allocate staff on shift a duty to 'monitor' the ward entrance / exit door, increase if a patient requires escort to an appointment etc.

It is therefore recommended that before consideration is given to uplift ward 2's staffing establishment that further analysis of patients on ward 2 whose needs may be better met in the PICU or ward 1 is undertaken, alongside reviewing the access into PICU beds for patients from ward 2 who may require this. It is also advised that the team review the allocation of duties to staff during shifts to ensure the most efficient use of the existing staffing resource and a shift by shift basis.

6.4.2. Ward 4

During the staffing review, Ward 4 leadership team confirmed that they believed their existing staffing establishment to be adequate for the needs of their patients. the graph below indicates that the reason for the suggested establishment uplift if due to the high dependency levels of the patients admitted into ward 4, with all patients' dependency levels being 4 or 5.



Ward 4 is a unique ward, catering for the needs of a specific group of patients, which is not typical of that of the generic older person's inpatient ward.

The MHOST tool's calculations for Ward 4's staffing establishment were inputted into the Generic Older persons tool as there is not a dedicated evidence-based tool to support ward 4's model and therefore is a less reliable predictor of staffing.

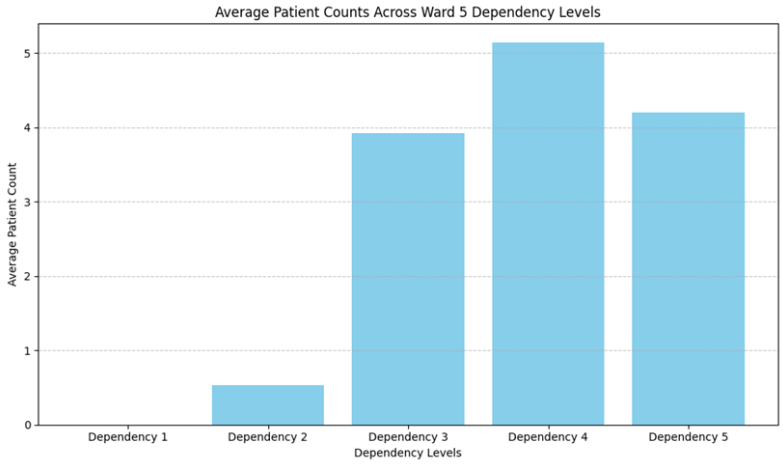
Ward 4 have had high use of bank staff hours, they have had relatively low number of vacancies, with some high levels of sickness and absence which may account for some of the high bank hour usage; however, ward 4 do report needing to occasionally increase their staffing due to specific needs of some patients from time to time.

The ward are keen to engage in the work the Trust intends to roll out in line with Enhanced Therapeutic Observations of Care (ETOC) and are particularly keen to focus on meaningful engagement and occupation of patients from staff within their current recommended staffing budget, alongside the wider MDT with a view of reducing the number and severity of falls within the ward. The ward manager reports positively around staff morale and increased patient activities due to HCSW routinely undertaking these as part of their shift.

The ward leadership team are confident that they can achieve positive results with the existing staffing establishment, it is therefore recommended that the Ward pilot the ETOC approach, monitoring the impact of increased activity and meaningful engagement on patient safety. And in line with professional judgement and noting the reduced reliability of the MHOST tool that the staffing establishment remains as is for this 6 month period and to be re-considered at the next safer staffing deep dive review.

6.4.3. Ward 5

Ward 5 has had a period of high acuity due to the complexity of the Patients admitted into the ward, mainly associated with high levels of support required for patients to tend to their Activities of Daily Living (ADL's), including dressing, feeding, bathing. This is reflected in the high dependency levels in the graph below, on average 9 of an average patient occupancy of 13 were dependency level 4 & 5;



Ward 5 also has the highest bank staff hours, low vacancy and low sickness and absence when compared to the other wards, suggesting that they are frequently requiring additional staff.

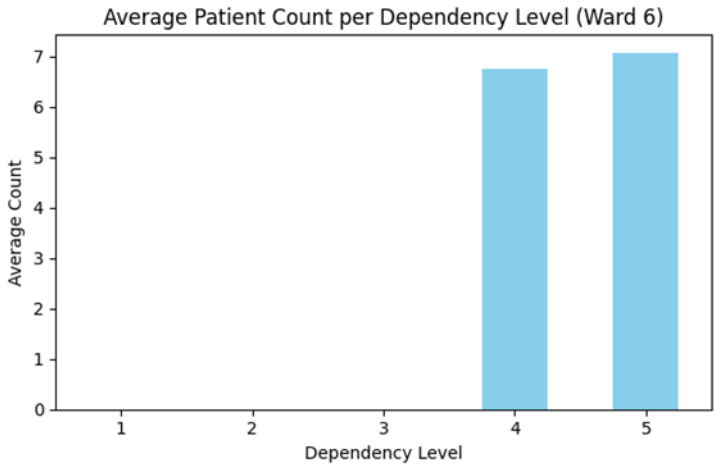
The ward manager reports that the ward staffing establishment is adequate when their occupancy level is around 10 patients, which they try not to exceed, however as over the last 6 month period, according to the patient dependency data, the ward's average occupancy has been 13 patients. If the occupancy was maintained at 10 inpatients, the wards MHOST staffing establishment would match their existing budgeted establishment.

It is therefore recommended that a review of the wards bed number requirements is undertaken prior to any staffing establishment uplifts.

6.4.4. Ward 6

Ward 6 staffing establishment was recently uplifted from 6/6/4 to 7/7/5 in line with the 6 monthly safe staffing reviews for the Trust. The wards leadership team report positively on this. The ward team report an increase in acuity and complexity of patients, particularly those with complex physical health needs and they are also seeing an increase of patients with delirium related symptoms but are managing this within the confines of their existing staffing establishment. Their relatively low usage of bank staff would support this.

The graph below shows that all of ward 6 patients are reported to have dependency levels 4 or 5 with no patients reported as dependency level 1, 2 or 3, which is unusual.



Given the professional judgement of the leadership team and reduced bank usage which supports this, it is recommended that a validation exercise is conducted around how the staff are interpreting and scoring patient dependency before any additional staffing uplift recommendations are made.

6.5. Recommended Safe Staffing establishment amendments & Costings

This section offers an appraisal of the 2 areas which this review supports and recommends for staffing establishment uplifts.

6.5.1. Ward 1

Proposal Summery;

- To increase staff shift numbers from 5/5/4 to 6/6/4 on a permanent basis.
- The increase to the wards budget will be 3.47wte Band 3 staff (£115,567)
- This will allow for 3 registered Nurses and 3 HCSW on the early and late shift.

Rationale

- The team have routinely escalated their staffing levels to 6/6/4 for over a 12month period due to the complexity of needs of the patients.
- The evidence based MHOST review which took place supports this, alongside the detailed deep dive meeting which considered the professional judgement of the team.

Impact

- Workforce Efficiency: reducing reliance on bank and temporary staffing
- Service Quality: Consistency in staff members working in the area which can positively impact on safety, quality and experience of patients.
- Recruitment Strategy: Facilitates a grow your own approach, by recruiting bank staff into substantive posts.

Costings;

Ward 1	Current budget for 5/5/4		Additional budget required to increase rota from 5/5/4 to 6/6/4		Revised Budget for 6/6/4	
	WTE	£	wte	£	WTE	£
Consultant	0.50	134,538			0.50	134,538
Nursing B8a	0.50	40,129			0.50	40,129
Nursing B7	1.00	66,729			1.00	66,729
Nursing B6	3.00	188,674			3.00	188,674
Bursing B5	11.51	595,956			11.51	595,956
Nursing B4	0.60	23,660			0.60	23,660
Nursing B3	11.39	460,162	3.47	115,567	14.86	575,729
OT B5	1.00	39,920			1.00	39,920
Snr Clinical Psychology B8a	0.50	39,546			0.50	39,546
A&C B2	1.00	30,876			1.00	30,876
Ancillary B2	0.97	30,146			0.97	30,146
Activity Worker	1.00	34,051			1.00	34,051
Non Pay	-	27,950			-	27,950
Total	32.97	1,712,337	3.47	115,567	36.44	1,827,904

6.5.2. Edward Myers Unit (EMU)

To uplift EMU staffing establishment to reflect the increased demand and complexity experienced throughout 2024-25. As noted above, there is not a suitable evidence-based tool to support the calculations of staffing requirements within EMU. Therefore, the ward manager has undertaken a bespoke exercise and presented the findings back to the Directorate leads which justifies a staffing establishment increase.

Proposal Summery

The directorate leads have taken this information into account and will be presenting a wider case for EMU which will also reflect the staffing establishment requirements and will provide the relevant costings. The Trust board are asked to note this recommendation for a staffing establishment uplift both in the context of the safer staffing review for 2024-25 and the wider EMU expansion paper which is currently being progressed and will be reported through Trust governance imminently.

Rationale

The Edward Myers Unit currently operates with a total of 14 beds, including 10 detox, 2 ICB, and 2 IOU beds. Despite a staffing establishment of 4/4/3 across shifts, the unit is facing sustained pressure due to increased patient complexity, higher acuity levels, and behavioural challenges. These factors are compounded by long-term sickness, staff vacancies, and the departure of experienced staff, leading to increased reliance on bank and agency cover.

Referral processes have become more demanding, with community services contracting resulting in more complex, out-of-area admissions. This has significantly impacted staff workload, patient care quality, and incident rates. The removal of substances often reveals underlying mental health issues, further straining the unit's capacity.

Impact

Financial constraints mean EMU must be self-funded, yet current income generation is insufficient to support the staffing levels required to maintain safe and effective care. A staffing uplift is necessary to:

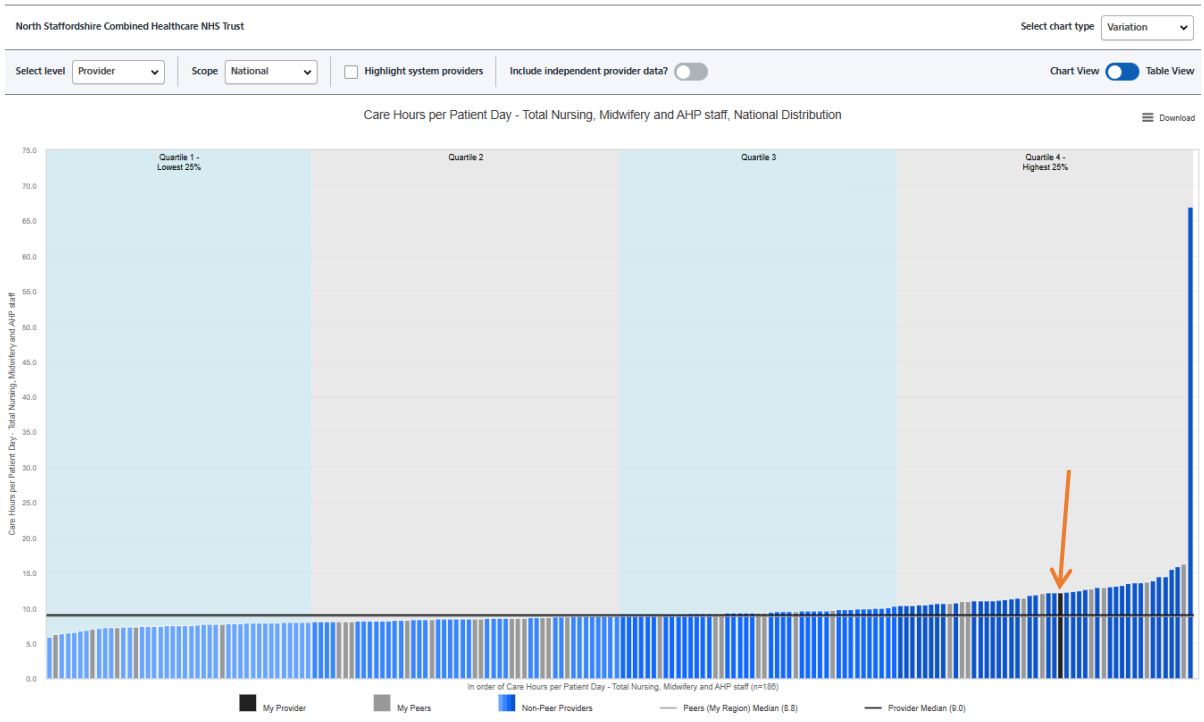
- Ensure safe nurse-to-patient ratios amid rising acuity.
- Reduce reliance on temporary staffing.
- Improve retention through development pathways and leadership roles.
- Support the medical team in managing complex mental health presentations.
- A modest uplift, including an additional qualified staff member per shift and the introduction of a clinical lead role, would provide critical support to the nursing team, enhance patient outcomes, and ensure sustainability of service delivery.

7. Comparing staffing with other Organisations - Care hours per patient day (CHPPD)

The publication of Lord Carter's review, 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted Variations', in February 2016 highlighted the importance of ensuring that efficiency and quality are embedded across the whole NHS health economy.

To mitigate the unwarranted variation of reporting staff distribution, the Care Hours per Patient Day (CHPPD) metric was developed. Since April 2018 all mental health in-patient wards in England have been required to submit data to enable CHPPD to be captured.

The data captured includes planned staffing, actual staffing, and number of beds, clinical speciality and the number of patients at 23:59 each day. This information is then used to determine the CHPPD for each ward. Benchmarking is then available through the Model Hospital for Mental Health Trusts.



The graphic above shows NSCHT national average benchmark position and also shows how we compare to regional peer Trusts.

This shows an improved picture when compared to the previous 6 monthly safer staffing report. We have moved from the 3rd quartile of CHPPD back into the 4th quartile with an average of 12.2 CHPPD.

This is considered a favourable position and shows that staff are delivering a greater number of care hours per patient per day compared to most other organisations. This typically reflects effective staffing resource, allowing staff more time to provide direct patient care, but equally indicates a higher complexity of need for patients. Higher CHPPD is often associated with better patient experience, safety, and clinical outcomes.

8. Extending Safer Staffing to the Community

Currently there is no nationally mandated approach for safe staffing reviews in NHS community mental health and learning disability services.

Building upon the information that we already have worked with our Performance Information Team to review several Community Team metrics including caseload size, vacancy level, absence rate, training and supervision. Since December 2023, the Trust have monitored staffing within the CMHT's.

The metrics are:

- Patient facing workforce – contracted / budgeted / actual
- Sickness & Absence
- Bank & Agency
- Referrals & Caseload
- contacts

These are formally reported via the Trusts safer staffing report; further progress is required to ensure alignment to evidence-based pathway models of care to ensure our workforce is designed to achieve high quality and safe care throughout relevant Trust community services. This will be issued in a separate safer staffing report designed for community services from 24/25 and will be refreshed once national guidance is issued, this was expected early into 2025, but not yet available.

9. Development and Education

Following the statutory and Mandatory review, registered professionals have 38 statutory and mandatory competencies that are required to be completed. 23 of these are monitored through monthly Performance Meetings with Directorate leads alongside Clinical Supervision and Appraisal rates. Throughout 2024/2025 compliance has exceeded the Trust target of 85%.

In addition to mandatory training nurses and AHPs must have access to Continued Professional Development (CPD) to develop knowledge and skills, keeping abreast of evidence-based practice and contemporary practice. However, in the past few years, the Health Education England budget for CPD has fallen by 40% from £205 million to £84 million. The House of Commons Health Committee (2018)

recommended that this funding be re-instated and that it is ring-fenced for nursing and AHP's CPD. As a result, specific CPD funding for nurses and AHP's was agreed for 2024/25, enabling all training requests to date to be approved in the 2024/25 financial year. We have also been awarded for 2025/26. HEE launched the Multi Profession Education and Training Plan 2024 which is an annual plan of investment where we were successful in securing funding for more ACP, ACRC places and psychological therapies training aligned to the Long-Term Plan AMH transformation workstream, specifically targeted towards improving access to NICE approved Psychological Therapies for Severe Mental Health Problems (PT-SMHP).
The Trusts Chief Nursing Officer (CNO) is a strong advocate of higher-level education and increasing the number of graduate professionals within the Trust which is incorporated in the Nursing and AHP Strategies. The resultant CPD funding will support these educational needs enhancing professional roles and capabilities.

The Trust are supporting nurses and AHP's in undertaking the following academic modules/programmes during 2024/25:

- 3 x ACRC Funded Places
- 7 x Advanced Clinical Practitioners
- 1 x Social worker (integrated degree), Level
- 2 x Registered nurse degree (NMC 2018), Level: 6
- Restorative Just Learning Culture Community of Practice Events
- 5 x Suicide Mitigation TTT
- 2 x Principles of physical Assessment
- 1 x Nurse Prescriber

Additionally, our professionals have completed over 100 high level clinical courses in a variety of specialities:

- Compassion and harmful mind
- 4 x Therapeutic skills for clinicians
- 3 x Drawing and talking
- CFT Essentials
- Introduction to Approved Clinician Course
- 4 x The DICES System for Risk Assessment and Management
- NVR Training
- 2 x Practice Educator Social Work
- ERIC Health Bowel and Bladder
- 4 places @ The Children's and Young peoples mental health conference
- Health Assessment in Clinical Practice
- PBS Level 4
- Trauma Informed Care

Further to this, we have invested money in Keele University to improve access to academic CPD opportunities. To ensure fair access to these opportunities Inclusive development and talent management remain embedded within our education and development framework.

The Trust continues to invest in its coaching and quality improvement training opportunities and has joined the West Midlands Coaching Pool and is committed to building quality improvement and coaching skills across our workforce.

We have continued to develop our Suicide Mitigation programme and 82.83% of our clinical staff have now received advanced suicide mitigation training. We now have 15 accredited trainers currently able to deliver the training Trust wide and a planned cohort of 4 in September. This gives the Trust a strengthened position in terms of a standardised approach to suicide prevention with the ability to deliver Suicide Awareness, Suicide Risk Assessment, and Safety Care Planning Trust wide.

10. Preceptorship of Newly Qualified Registered Nurses and AHP's;

Since October 2023, the Trust's new 12-month, semester-based Preceptorship Programme remains fully aligned with NHS England's National Preceptorship Framework and continues to benefit from sustained investment throughout the 2025/26 financial year. This initiative is a cornerstone of our workforce development strategy and is delivering measurable improvements in the following areas:

- Recruitment- improved retention rates with all newly qualified practitioners being offered the preceptorship programme.
- retention- there has been a noticeable improvement in retention of staff
- clinical capability- the preceptorship programme has been largely effective in supporting new practitioners in enhancing their confidence and capability in preparing them for autonomy in their professional roles.
- Protected time- The Trust has implemented protected time for both preceptors and preceptees in line with NHS England's gold standard recommendations (minimum 12 hours annually for preceptors)
- Programme structure- The programme includes structured learning, coaching, peer networking, and regular review meetings, with supernumerary of at least 2 weeks for all new staff

10.1 Strategic Alignment and Future Direction

- The programme is fully compliant with the National Preceptorship Quality Mark and supports the NHS Long Term Workforce Plan's goals for sustainable workforce development.
- Ongoing investment will focus on digital infrastructure, leadership development, and enhanced support for internationally educated staff.
- The Trust is committed to embedding preceptorship as a core retention strategy, not an optional initiative, ensuring consistency and equity across all departments.

Feedback with suggested improvements from all stakeholders is a key component of the programme's success. This enables the Trust to ensure that the programme remains relevant, is more suitable and attractive in line with NHS England expectations. Some of the actions for improvement of the programme include:

The following are some of the additional changes made because of the evaluation feedback:

- Tailored sessions- customisation of sessions to address the unique needs of different practice areas

- Workload management- providing more practical, hands-on learning opportunities
- Interactive sessions- Incorporating interactive elements like group discussions, workshops, and practical exercises to enhance engagement and learning in the taught sessions
- Travel and accessibility- offering a more blended learning approach of learning to reduce travel time and increase accessibility
- Buddy system- implementing a buddy system where preceptees are paired with more experienced practitioners/ colleagues for networking opportunities.

11. E-Rostering

2024/25 has continued to present challenges for the E-Rostering and Temporary Staffing team due to a lack of permanent staffing resources. Despite these obstacles, significant progress has been made in key areas of roster management and optimisation.

11.1 Roster Management & Reviews

Roster reviews have continued across the organisation, with a strong focus on:

- Promoting accurate and efficient rostering
- Emphasising good roster management and housekeeping practices
- Ensuring accurate recording of net hours
- Embedding robust rostering standards across teams

11.2 Auto-Roster & Self-Rostering

The rollout of Auto-Roster is underway, with six areas currently utilising the functionality. The two pilot areas for Self-Rostering have ceased participation due to ineffectiveness. These areas are now transitioning to using Auto-Roster. Ongoing support is being provided to all areas implementing the new system to ensure smooth adoption and compliance.

11.3 SafeCare & Compliance

Weekly SafeCare compliance reports are distributed to Ward Managers, Service Managers, Matrons, QILNs, and Associate Directors. Additionally, monthly oversight reports from RLDatix are being circulated. These reports:

- Benchmark NSCHT against other Trusts using the same system
- Provide detailed analysis across four key domains: Safety, Unavailability, Effectiveness, and Temporary Staffing
- Support has also been provided to the EVO project, with all relevant SafeCare actions completed in alignment with project requirements.

11.4 Roster Optimisation Project

The Roster Optimisation Project, which is a workstream within the Inpatient Optimisation programme of work, has commenced and is already demonstrating benefits. Increased support and scrutiny have identified inefficiencies, such as the overuse of management days by Deputy Ward Managers. Addressing these issues is expected to reduce reliance on temporary staffing and associated costs.

11.5 Data Integrity & Payroll Alignment

The monthly Gateway process (synchronisation between ESR and Optima) and ongoing annual leave accrual management have contributed to a reduction in payroll errors. However, further work is required to fully cleanse and maintain accurate data.

11.6 Policy & Governance

The Roster Policy has undergone a full review and awaiting review by the Policy Governance Group (PGG) and Policy Working Group (PWG) before final approval.

11.7 Reporting & Analytics

There has been a significant increase in reporting capabilities and data analysis, including:

- Monthly NHSi data submissions
- SafeCare analysis
- Break compliance monitoring
- Activity worker fill rate
- Bank and agency usage trends
- Daily allocation reports
- Weekly assignment counts

11.8 Establishment Review Support

Data and attendance have been consistently provided to support establishment reviews across the Trust.

11.9 System Upgrades, Training, and Workforce Data Management

Testing and release of system upgrades have been successfully completed, alongside the development of new Standard Operating Procedures (SOPs) and user guides. These materials are designed to support changes and ensure there is no disruption to end users.

11.10 Training & Engagement

- Face-to-face group training sessions have been delivered across departments.
- Ad hoc training and support continue to be provided on request.
- Targeted training for Finance teams has been delivered to improve understanding of the rostering system and to support more collaborative, joined-up working.

11.11 Data Accuracy & Workforce Maintenance

- Budgets, pay rates, and establishments have been reviewed and updated within the system.
- The Bank Holiday sickness process continues to be enforced, ensuring that annual leave entitlement is adjusted appropriately for staff reporting sick on bank holidays.
- A monthly review of Bank-only workers is conducted, with inactive workers (those who have not worked within the last six months) being removed to maintain data accuracy and compliance.
- The continued rollout of Loop is underway, with full implementation on track and the planned phase-out of Employee Online (EOL) by December 2025. Loop is designed to enhance user experience and provide greater functionality by enabling improved viewing and booking of bank shifts, roster visibility for substantive staff and improved messaging functionality to support timely and direct communication with bank workers
- The transition to Loop represents a significant improvement in the way staff interact with rostering systems, supporting better engagement, improved shift fill rates, and streamlined communication with the temporary workforce.

11.12 Ongoing Support

Continued operational support is provided via the Temporary Staffing / E-rostering inbox. Between 1 January and 31 July 2025, the inbox received a total of 18,968 emails, reflecting the high volume of enquiries and requests managed by this service. The inbox is responsible for actioning requests relating to:

- The creation and maintenance of personal work patterns
- The onboarding and rostering of new starters
- Amendments and updates to existing rosters

12. Temporary Staffing

Over 2024/25, there has been a significant shift in the temporary staffing landscape, particularly within the NHS, driven by decisive action from the Department of Health and Social Care (DHSC) and NHS England to ensure Trusts significantly reduce their reliance on temporary staffing. In response, the Trust has adapted its working practices, working closely with clinical teams and the e-Rostering service. This collaborative approach has led to a substantial reduction in agency usage, although a comparable reduction in bank usage has not yet been achieved.

12.1 Agency

- 73% reduction in nurse & HCSW agency hours used (January–July 2024 compared to January–July 2025)
- All inpatient mental health agency spend has remained within framework and pay cap.
- Supported the Primary Care Directorate to ensure Advanced Nurse Practitioner (ANP) spend is within framework

12.2 Bank

- Despite a continued commitment to reducing bank hours, no significant reduction has been achieved to date
- The complaints management process is being updated to ensure fairness and consistency for the temporary workforce.

- Initiatives to support bank workers into substantive posts include:
  - Advertising Healthcare Support Worker (HCSW) vacancies internally to bank workers first
  - Providing application and recruitment advice to bank workers

- Engagement with bank workers has been strengthened through:
  - Loop communication platform
  - In-person drop-in sessions
  - Dedicated MS Teams sessions for direct access to the team

12.3 Recruitment changes:

- Targeted approach to recruitment substantive HCSW from the staff bank
- Recruitment onto the bank was paused in March 25 and will be revisited in Q3 2025/26.
- We welcomed 15 HCSWs and 11 Nurses to the bank between January–July 2025. This is in addition to the 95 HCSW's and 28 Registered Nurses recruited onto the bank between 1st April 2024 to 30th September 2024.

- All new starters undergo full vetting and training to NHS and Trust standards before commencing work

15. Quality Assurance of Services

15.1 External inspections during 2024/25

The Trust has received an overall rating of 'Outstanding' from the 2018 Care Quality Commission (CQC) inspection and all in-patient units have been rated 'Good' or 'Outstanding' for Caring and Responsive domains. The Trust is fully compliant with the registration requirements of the CQC and continues to maintain the overall "Outstanding" rating.

During 2024/25 the CQC have carried out unannounced MHA visits to Ward 1, 6, 7, Darwin centre and Summersview. All wards received positive feedback and generally good patient experience. Actions in response to these visits are overseen by the Trusts Mental Health Act Law Group. All actions are either progressing well or complete.

In May 2025 the CQC inspected the Trusts Crisis Care Service, this was in response to their commitment to inspect the standards of community mental health services. The have reported an overall rating of Good. The report highlighted the services effective working relationships with the Trust Inpatient Wards.

15.2 Internal Reviews

Internal scrutiny during 2024/25 included the following:

- Daily staffing huddles led by the matrons / QUILNs for their respective ward areas to ensure adequate awareness of staffing escalation processes.
- Monthly safer staffing reporting to Trust Board
- Trust led unannounced assurance visits continue to take place, where staffing and staff wellbeing remain a key focus. Each team have an action plan underway which is monitored by the Trusts Quality Assurance Group. Gemba walks have taken place in all wards to offer additional assurance against improvements made because of the actions taken.

This range of scrutiny provides the Trust Board with assurance that whilst staffing has been challenging patient safety has been prioritised, safe staffing maintained, and quality improvement has been enhanced.

16. Recruitment and Retention

Our workforce priorities focus on ensuring that as a Trust, we attract, develop and retain the best people, to enable the delivery of high quality, safe and effective care. This means that we seek to have a workforce that is diverse and representative of our local communities. We want all people to feel that they belong and are equitably valued and supported.
Our people practices are underpinned by the commitments as set out in the NHS People Plan and aligned in our People Strategy, with a particular focus on being:

- Inclusive and representative; through developing a culture of justice, belonging and inclusivity

- Great place to work; with staff feeling valued and supported
- Supportive of health and wellbeing: with happy, healthy, resilient people
- Supportive of achieving potential & aspirations: by enabling people to achieve their career aspirations
- Focused on good people policies and procedures: by getting the fundamentals right

The Trust's ambition with regard to developing diversity and inclusion is clear to offer outstanding inclusion for all. We are committed to providing excellent employment experiences for those who work within our services and are taking a positive action approach to developing our diverse and representative workforce at every level. This includes specifically encouraging applications from under-represented groups, such as those with black, Asian and minority ethnic heritage, those with disabilities and those who are LGBT+. We have developed our commitment to our Staff Networks and continue to develop the work of these groups as powerful vehicles for positive change through the organisation.

16.1 Leavers

As of 31st March 2025, the Trust's turnover rate was 9.64% (12 month rolling figure). This is below the Trust's 10% KPI turnover rate target. KPI turnover rates have decreased during 2024/2025 from 12.12% to 9.64%.

The Trust's People, Culture & Development Committee (PCDC) continued to receive updates on retention activities throughout the year.

From reviewing the reasons provided by staff who have left the Trust in the last 12 months, the top three reasons given are:

- Work life balance – 23%
- Promotion– 13%
- Retirement – 12%

The reasons for leaving remain broadly the same as for the previous year(s) with retirement being superseded by promotion as a reason for leaving.

We cannot overlook those leaving due to work life balance as this could be an indicator of culture and attitude towards flexible working. We continue to recognise there has been a focus on the promotion of flexible working including the benefits, individual rights balanced against the need to deliver safe and effective clinical services and will continue to monitor this.

We continue to recognise that as a Trust the importance of retaining talent. To support this, we have created and promoted career development opportunities including mentoring and development conversations offers.

During 2034/2025 the Trust continued to work with system partners as part of the Staffordshire and Stoke-on-Trent Integrated Care System Retention Programme (SSOT ICS). The key aim of the project being to improve retention and enable transformation in working practice across the Trust.

During phase 3 of the project the Trust's focus linked to:

- On-boarding & new starter support
- Career development & progression
- Exit data
- Flexible working

Within the Trust and as part of our commitment to reduce attrition and increase greater staff experience, we will review our Combined People Plan (2023 – 2028) to give a greater focus on a few key people initiatives.

The Trust remains committed to improving the experience of our staff. Once again, we will have a focus on the National Staff Survey results expected in March 2026 with Trust and Directorate improvement plans being developed.

17. Summary of Safer Staffing Recommendations for this 2024/25 annual safe staffing review

Recommendation's	
1.	For the Senior Leadership Team to support the recommendation to adjust Ward 1's staffing establishment budget as per MHOST findings and feedback during the safer staffing review meetings (see section 6.5.1 for more details and costings). .
2.	It is recommended that Edward Myers Unit staffing establishment is uplifted from 4/4/3 staff per shift to 5/5/3 staff per shift (see section 6.5.3 for more details and costing)
3.	To support workforce development and Grow our Own model, the Trust should consider implementing a flexible staffing and funding model that enables the release of staff for training through strategic use of internal bank staff, rotational roles, and co-investment in backfill. This approach will maximise the impact of NHSE-funded development pathways such as Trainee Nursing Associates and MSc Nursing, while mitigating operational pressures on clinical teams
4.	To address the limited pipeline of Learning Disability nurses, it is recommended that we continue to strengthen collaboration with regional universities to develop more accessible placement opportunities and explore options for local delivery of Learning Disability Nurse training. This will support long-term workforce sustainability and improve recruitment into substantive posts within the Trust.
5.	It is recommended that the implementation of the Enhanced Therapeutic Observation and Care (ETOC) framework is monitored via the safer staffing Bi-monthly meeting and that data highlighting the demand for enhanced care (e.g. 1:1 observations); workforce deployment and utilisation and to report the impact that enhanced care needs has on temporary staffing usage.
6.	It is recommended that the Bi-monthly safer staffing group receive regular updates around Culture of Care which specifically relate to staffing issues, developments and educational needs.
7.	Inpatient optimisation work is routinely reported via the bi-monthly safer staffing meeting, with data demonstrating key impacts of rostering efficiencies and improvements.

18. Statement for Chief Nursing Officer and Medical Director

In line with NHSI requirements the recommendations included within this report have been agreed by the Chief Nursing Officer and the Medical Director who have confirmed that they are satisfied with the outcome of the review and that staffing is safe, effective and sustainable.

19. Conclusion

In light of the current national shortage of registered nurses and the increasing dependency and acuity of service users it has been challenging to maintain safe staffing levels during 2024/25. However, Quality Improvement Leads (Matrons), Ward Managers and their teams have continued to deliver safe care and also demonstrate areas of notable practice and are commended for their achievement in doing so.

The Board are asked to:

- Receive this report as assurance that the Trust is meetings its accountability to provide safe nursing staffing to inpatient areas.
- Note the continued challenge with training of future Registered Nurses
- Note the planned (and completed) work to be undertaken by the Directorates to support safer staffing levels within the Trust.
- Approve the recommendations detailed in section 17 of this report.

Appendix 1

All safe staffing reviews took place throughout June and July 2025, except for Summersview, which took place in August 2025. Each ward has received AI generated notes from the meeting, outlining the meeting content and each ward has individual actions to take forward and monitored via the Trust Safe staffing group.

Below is a summery of the Key themes and Actions from the meeting which will also be overseen by the Trusts Safer Staffing Group which meets Bi-monthly. These have informed the recommendations highlighted in Section 17 of this report.

Key Themes Across Wards

1. **Staffing Levels & Establishment**

- Project Chrysalis and the eradication of dormitories has led to a reduction in beds across the Harplands site.
- Most wards have required to escalated staffing intermittently throughout the last 12months due to increased patient acuity.
- Auto-rostering improvements have been noted but there is still more that can be done to improve rostering efficiency and effectiveness in all inpatient wards.

Actions:

- Recommend to formally uplift the staffing budget for ward 1.
- Support the cost neutral request for Summerview to adjust the establishment to allow additional HCSW hours and look to recruit peer / expert by experience into the role.
- To conduct the validation process for all wards staffing establishment via MHOST.

- To improve the monitoring of the reasons for and the frequency of staffing escalation requests and improved reporting of patients requiring high levels of observations.
- To Implement a programme of work to ensure that we are compliant with the guidance issued regarding Enhanced Therapeutic Observations of Care (ETOC) which were issued in June 25.

2. Recruitment & Retention

- Delays in recruitment processes were highlighted to be a challenge, especially for Band 5 nurses and support workers.
- There remains a high reliance on bank staff, but significant improvements have been noted in a reduction of agency use.
- There are challenges with international recruitment due to visa and salary thresholds.

Actions:
- Expedite recruitment processes and review HR panel delays.
- Actively encourage bank staff to apply for substantive roles.
- Address visa issues for bank staff transitioning to permanent roles.

3. Training & Development

- Ongoing focus on trauma-informed care training is required for all wards, especially Acute inpatient wards.
- To seek assurance that Bank staff are accessing and up to date with conflict resolution training.
- There is an ongoing need for staff to access training around physical health knowledge and skills, i.e. Diabetes management, NG tube feeding etc.
- Access to nurse training and ongoing development into other nursing roles remains a challenge (e.g. MSc, TNA, ECP, ACP).
- Skill deficits in managing complex patients and using electronic systems.

Actions:
- Scope and deliver bespoke training sessions.
- Develop long-term workforce plans and training pathways.
- Conduct skills reviews and supervision-based development planning.

4. Patient Acuity & Complexity

- There is increased acuity and dependency levels across most wards.
- The acute wards report high observation levels and disruptive behaviours.
- Delays in discharge due to lack of specialist's placements and/or accommodation for people who are ready to leave hospital but would be vulnerable without adequate provision in the community.

Actions:
- Review service specifications to reflect current acuity.

- Continue to escalate discharge delays to senior leadership and ICB and for teams to make links with relevant agencies and partners within the community to help them better understand the needs of the patients ready for discharge and how the Trusts can work collaboratively with them to support patients in the community.
- Explore enhanced therapeutic observations and reduce restrictive practices.

5. Operational Issues.

- Bed availability issues and extended patient stays.
- Lack of supported accommodation and community provision.
- Challenges with managing staff long-term sickness and maternity cover.

Actions:

- Inpatient leads to work with community and crisis care leads to ensure all admission pathways are effective and early intervention for deteriorating patients are available in the community & home treatment services.
- Review sickness management timelines and support structures.
- Investigate supported accommodation gaps with community partners and associated agencies.

6. Therapeutic Engagement & Activities

- Activity worker roles inconsistently filled or repurposed.
- Staff-led activities praised but need structured support and integral to shift management processes aligned to Nurse in Charge
- There is a positive impact of proactive engagement on incident reduction.

Actions:

- Review and optimise shift management to ensure that activities and interventions are delegated to all staff on shift appropriately and in line with their role responsibilities.
- Develop methods to evidence patient participation within activities, meaningful and therapeutic interventions.

7. Staff Wellbeing & Supervision

- There are staff in most areas who are off work due to stress-related sickness, with some being work related.
- Wards are routinely utilising PNAs, psychology support, and mindfulness sessions for staff.
- Need for better occupational health support and advice for managers trying to support staff back into the workplace.

Actions:

- Evaluate effectiveness of occupational health services.
- Enhance communication and implementation of wellbeing initiatives.
- Continue to focus on providing additional supervision and reflective practice opportunities in all wards.

8. Financial Management & Efficiency

- Overspend on temporary staffing.
- Need for accurate coding of bank requests.
- Budget constraints impacting recruitment into training posts.

Actions:

- For individual team managers to analyse and understand their bank and agency spend with projections.
- Cancel unfilled shifts where appropriate and ward managers to ensure they are fully compliant with E-rostering guidelines and Trust policy.
- Review and agree the future and longer-term workforce plans for Trainee Nurse Associates and top-up training opportunities

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 6

Ward 5 Garden Business Case

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

Report to:	Public Trust Board
Date of Meeting:	15 January 2026

Presented by:	Elizabeth Mellor, Chief Strategy Officer
Prepared by:	Laura Smith, Deputy Chief Strategy Officer
Executive Lead:	Elizabeth Mellor, Chief Strategy 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:	Public Trust Board
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:	Funding
Diversity & Inclusion Implications:	This paper supports PSED Duty G2: Advance equal opportunities between people who have a protected characteristic and those who do not.
ICS Alignment / Implications:	Not Applicable
Recommendation / Required Action:	The Board is asked to approve the business case proposing to utilise the Harplands legacy fund to undertake a full redesign of the Ward 5 garden.

Executive Summary:	
	In May 2025 Combined Charity opened round one of the Harplands Grants Programme, seeking applications for grants of varying sizes to be funded via the legacy donation gifted by a former patient in 2024. Ward 5 submitted an initial application to significantly update the garden space. The current garden is not suitable for the needs of ward 5 patients due to uneven services and narrow paths which present a falls risk and cannot be accessed by wheelchair users. An update on this application was provided to Charitable Funds Committee in June 2025 and clarification sought as to whether the required work should be undertaken as part of the Harplands PFI. It was agreed that the Chief Finance Officer would undertake a ward visit to determine suitability. The visit confirmed that to make the garden fit for purpose for the patient cohort a full redesign is required rather than remedial works. As such this falls outside of the PFI contract and can be considered for charitable funds. Two quotes have been sourced via Serco to undertake the proposed works with the lowest quote totalling £102.75k (of which £17.12k is recoverable VAT). An additional quote has been obtained for garden artwork at a cost of £7.44k. The total amount requested from charitable funds is therefore £110.19k, of which £17.12k is recoverable VAT. The current fund balance of the Harplands legacy donation is £268,162. The business case was discussed and supported at Charitable Funds Committee on 1 December 2025. Trust Board is therefore asked to approve this request in accordance with the charitable funds scheme of delegation.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	09.01.26

BUSINESS CASE TEMPLATE Approval for Revenue & Capital Cases	
Scheme Title	Ward 5 Garden Redesign
Directorate	Specialist
Author	Laura Smith, Deputy Chief Strategy Officer Tracey Stevenson, Service Manager Hannah Stone, Ward Manager
Date	17.11.2025
Links to Trust Strategy	The proposal aligns with the Trust's strategic objective of Access in seeking to ensure that Ward 5 patients are provided with access to a high-quality outdoor environment that can provide therapeutic benefit as part their inpatient admission.

1.Executive Summary

In May 2025 Combined Charity opened round one of the Harplands Grants Programme, seeking applications for grants of varying sizes to be funded via the legacy donation gifted by a former patient in 2024. Ward 5 submitted an initial application to significantly update the garden space. The current garden is not suitable for the needs of ward 5 patients due to uneven services and narrow paths which present a falls risk and cannot be accessed by wheelchair users. To make the garden fit for purpose requires a full redesign rather than remedial works and as such this does not fall within the requirements of the current PFI contract for the Harplands site. Charitable funds are therefore requested to deliver this project.

The ward has developed a proposed design, and two quotes have been sourced both via Serco using recognised sub-contractors. A third quote was requested however Serco have been unable to identify a contractor to undertake this. The lowest quote is at total cost of £110.19k including VAT. Specialist advice suggests that any VAT paid (£17.12k) will be recoverable. The current fund balance for the Harplands legacy donation stands at £268k. With cash receipt of the donation in September 2024 there is an onus on the Trust to demonstrate progress in spending these funds. Ward 5 is an appropriate scheme due to the donors' wishes to enhance outdoor environments at Harplands Hospital and the personal connection between the donor and Ward 5, which provided care to her husband.

2.Summary of Proposal

2.1 Introduction

In May 2025 Combined Charity opened round one of the Harplands Grants Programme, seeking applications for grants of varying sizes to be funded via the legacy donation gifted by a former patient in 2024. Ward 5 submitted an initial application to significantly update the garden space. This proposal provides further detail on the application to inform Charitable Funds Committee decision-making.

2.2. Background

Ward 5 of Harplands Hospital is a 10-bedded specialist neuropsychiatry inpatient ward for adults with mental health needs because of neurological disorder or brain injury. The ward provides evidence-based, research-led, person-centred assessment to patients. Ward 5 works in partnership with patients and carers to maximise choice, independence and rehabilitation opportunities.

The ward has a dedicated garden space that is currently underutilised and described as 'unusable' due to uneven services and narrow paving making it difficult for service users with specialist equipment such as wheelchairs to access large areas of the garden. Ward 5 supports patients with various neurological

conditions which impact on mobility, balance and co-ordination. The severity of patient's mobility needs varies with some patients having specialised equipment, such as wheelchairs/ specialist chairs and walking aids such as frames, rollators and crutches. Due to the nature of some of the progressive conditions i.e. Parkinson's disease and Huntington's disease patients continue to mobilise independently, however require a safe environment to aid their independence and minimise risk of falls.

The garden is identified as a risk on the ward risk register and there have been incidents of patients falling in the garden. The present condition of the ward garden is shown in the photos below.






2.3 Rationale for Business Case

Inability to utilise the garden space on ward 5 means that patients and their families cannot currently access the outdoor environment and the range of benefits that this brings, impacting negatively on their overall experience. Where patients do wish to access the garden, this often necessitates 1:1 staffing ratios due to the associated risks, which is not in adherence with least restrictive principles and impacts on staffing resource across the ward.

In contrast to ward 5, many other wards across the hospital have benefited from improvements to their garden areas in recent years, aligned to Project Chrysalis. Images of the ward 7 garden completed in June 2025 are provided for comparison.

The ward 5 application to the Harplands Grants Programme was discussed at Charitable Funds Committee on 2 June 2025. Committee sought clarification on the extent to which proposed works should be undertaken as part of PFI arrangements, noting the safety concerns that were highlighted. This has now been explored and it is considered that a request to charitable funds is appropriate due to the garden requiring a full re-design to fully meet the needs of neuropsychiatry patients, rather than remedial works and like-for-like replacements.

2.4 Options appraisal

The ward's preferred option is to remove the concrete and grass that currently comprise the surface of the garden and resurface the entire area with 'wet pour'. Wet pour is an impact absorbing, soft safety surface that is commonly used for playground surfacing in schools, nurseries and local authority playgrounds. It has been utilised in other wards across the Harplands Hospital, most recently Ward 7 as part of Project Chrysalis improvement works. The surface removes potential trip hazards, reducing the risk of falls but

ensuring a softer surface should a fall occur. A separately marked wet pour path leading around the garden has been included as design feature.

Due to the large surface area the cost of the wet pour is significant, but the material is known for its durability and longevity, typically lasting 15-20 years with proper installation and maintenance. Serco has obtained two separate quotes to undertake the work from approved sub-contractors.

Serco has stated that there are no specific ongoing maintenance costs associated with the wet pour.

In keeping with other wards across the hospital it is proposed to add a range of artwork around the perimeter of the garden and a quote has been obtained to provide this at a total cost of £7437.60 inclusive of VAT.

The existing seating would be removed and replaced with newer seating which is already available within the hospital and therefore at no additional cost.

It is also proposed to retain the existing large wooden planter that was constructed as part of a project with Growth Point and consider creating future garden features through similar projects.

A visual depiction of the proposed design is provided (Enc 1).

3.Recommendation

It is recommended that Charitable Funds Committee support the request to fund a full redesign of the Ward 5 garden at a total cost of: £110.19k (including VAT) to enable the business case to proceed to Trust Board to secure full approval.

4.Benefits Realisation

There are a wide range of benefits that can be realised from delivering the improvements as follows:

Patient Wellbeing

- Mental health support: A safe, welcoming garden offers a therapeutic environment for reflection and relaxation has been proven to have a positive impact in reducing stress, anxiety, and depression.
- Physical recovery: Gentle movement in a garden space can also aid rehabilitation that may be of benefit for some Ward 5 patients.
- Sensory stimulation: For patients with dementia or cognitive impairments, gardens can provide calming sensory experiences that support memory and orientation.

Accessibility and Safety Enhancements

- Inclusive design: Creating a space that is wheelchair-friendly, with clear signage and seating, makes the space usable for all.
- Reduced risk: Good lighting, non-slip surfaces, and secure boundaries help prevent accidents and ensure the safety of vulnerable patients. This includes significantly reducing falls risk and incidents of falls which have occurred in the garden in recent months.

Staff Benefits

- Stress relief: A tranquil outdoor space offers staff a chance to decompress during breaks, which can improve morale and reduce burnout.
- Improved job satisfaction: Access to restorative environments contributes to a more positive workplace culture.

Visitor Experience

- Comfort and privacy: Visitors can use the garden for quiet moments or private conversations away from clinical settings.
- Positive impressions: A well-maintained, accessible garden reflects a caring and holistic approach to healthcare.

Organisational Impact

- Reputation and community engagement: A well-maintained and inclusive garden can be a point of pride and a symbol of compassionate care.
- Sustainability and education: Gardens can be used for environmental education and therapeutic horticulture, with considerate planting helping to improve the biodiversity of the Harplands site in line with the Trust's Green Plan.

5.Planned implementation date

If approved the work would commence at the earliest opportunity depending on the availability of the contractors.

6.Financial Assessment

6.1 Revenue Costs

A summary breakdown of Revenue Costs is shown below.

Non Pay- Charitable Funds Revenue Costs

Summary of Garden Works	£000
Quote MwK121	74.14
Overheads	11.49
Grand Total (excluding VAT)	**85.63**
VAT	17.12
Grand Total (including VAT)	**102.75**

Summary of Courtyard Imagery	£000
Quote 56257/1	6.2
VAT	1.24
Grand Total (including VAT)	**7.44**

Project Total (including VAT)	**110.19**

Following discussions with the Trust's VAT adviser it is anticipated that VAT for the garden works (£17.12k) will be recoverable.

6.3 Funding Source

It is requested that funding for the project is provided from Charitable Funds and specifically from the restricted legacy donation that was gifted to the charity in 2024 for the benefit of Harplands Hospital. The current fund balance is: £268,162.

7.Workforce Impact

Any additional staff required including recruitment plans? Changes to shift or work patterns? If staff displaced or at risk of redundancy please provide details.

Not applicable.

8.Activity Impact

Impact on commissioner activity (increase or decrease) and over what period. Impact on targets or ability or achieve them.

Not applicable.

9.Procurement Impact

Note whether a competitive process was required? If 3 quotes received and lowest accepted? Which national framework was used? If waiver required and why? Please review Standing Financial Instructions and Scheme of Delegation via Policies on CAT to determine procurement route required to follow: https://cat.combined.nhs.uk/policies-procedures-and-resources/

The contractors carrying out the works have been sourced by Serco in accordance with the terms of the associated PFI contract.

10.Informatics Impact

Describe any implications to the trust informatics systems or structures e.g. bespoke systems, SSHIS, impact on trust networks, hardware, software or licensing requirements.

Not applicable.

11.Estates and Facilities Impact

Please describe changes to estate including any impact on leases.

The garden falls within the PFI contract for Harplands Hospital. Quotes have been sourced through Serco who will oversee completion of the works, ensuring compliance with contractual arrangements.

12.Communications

A detailed communication plan will be required at project mobilisation however please provide details of key stakeholders.

The Ward Manager and Service Manager have led the development of this proposal and will work in conjunction with Estates and Facilities teams to ensure that communication around the planned works is carried out as required. The works represent a positive activity and good news story for Combined Charity. This will be shared via the usual Trust communication channels upon completion.

13.Risks and Mitigations

Risk 2164 on the Ward 5 risk register pertains the current state of the garden noting that “There is a risk of patients being at an increased risk of falls in the ward 5 garden due to the current design and inaccessibility to walkways, with the consequence of potential harm to patients with an adverse outcome of reduced outside access for patients.”. Completion of the garden redesign would support closure of this risk. In terms of risks associated with the completion of works, high level risks are identified below. If the use of charitable funds is supported for this project, planning and delivery would be through standard Trust process and procedures in respect of capital work on the Harplands site, with full consideration of risk and appropriate mitigation strategies.

Risk No.	Risk Title	Likelihood (1-5)	Impact (1-5)	Residual Risk Rating	Mitigation	Risk Lead
1	That any change to the garden areas presents a risk of non-compliance	3	3	**9**	The planning and commissioning	Associate Director Estates/He

	with PFI contract, NHS standards, health and safety regulations and IPC policies.				of the garden redevelopment is being undertaken through SERCO. Processes will be followed to ensure compliance	ad of Facilities
2	Disruption to clinical services and care provided on the ward as result of noise, dust and access issues.	3	4	**12**	SERCO will work with the contractor to ensure appropriate Risk Assessment and Method Statements are in place to ensure safety and minimise disruption working in conjunction with the ward manager and other Trust leads as appropriate.	SERCO/ Ward Manager
3	Safety and security may be compromised as construction activity introduces hazards (e.g., tools, machinery, uneven surfaces). Vulnerable patients and visitors may be exposed to risks.	3	4	**12**	As above.	SERCO/ Ward Manager

Risk Matrix

		IMPACT How severe could the outcomes be if the risk event occurred?				
		Negligible/Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
LIKELIHOOD What is the chance of the risk occurring?	Almost Certain - 5	5 Moderate	10 Significant	15 High	20 High	25 High
	Likely – 4	4 Moderate	8 Significant	12 Significant	16 High	20 High
	Possible – 3	3 Low	6 Moderate	9 Significant	12 Significant	15 High
	Unlikely – 2	2 Low	4 Moderate	6 Moderate	8 Significant	10 Significant
	Rare – 1	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

14.CQC Registration Assessment

Is this a CQC regulated activity in line with the statement of purpose? Could this change impact on the Trusts CQC registration requirements?

There is no impact on registration requirements but completion of the works will result in a positive impact in terms of regulatory compliance in ensuring a safe and accessible outdoor space that enhances the quality of patient experience and safety of the physical environment.

Please consider if the following impact assessments are required. You must provide a summary of considerations and an explanation if a full impact assessment has not been completed:

15.Quality Impact Assessment (QIA)

Please complete a QIA and save as appendix 1. The QIA template can be accessed via the Trust templates page on CAT Templates - CAT (combined.nhs.uk)

Provide a summary of the quality impact considerations here (safety, effectiveness and experience). If a QIA is not applicable, please state the reason why.

Not applicable

16.Equality Impact Assessment (EIA)

Please complete a EIA via this link https://cat.combined.nhs.uk/people-and-support/diversity-and-inclusion/equality-impact-assessment/ and save as appendix 2.

Provide a summary of the EIA outcome here. If a EIA is not applicable, please state the reason why.

Not applicable

17.Data Protection Impact Assessment (DPIA)

Please complete a DPIA via this link Information governance guidance - CAT (combined.nhs.uk) and save as appendix 3.

Provide a summary of the DPIA outcome here. If a DPIA is not applicable please state the reason why.

Not applicable

18.Sustainability Impact Assessment (SIA)

A SIA must be completed and saved as appendix 4. The SIA template can be accessed via the Trust templates page on CAT Templates - CAT (combined.nhs.uk)

Provide a summary of the outcome here.

See Enc 5

19.Interdependencies

Please state if this business case has interdependencies with other business cases, CIP schemes, programmes or projects in the Trust.

No interdependencies.

Appendix 1 - Quality Impact Assessment

Appendix 2 - Equality Impact Assessment

Appendix 3 – Data Protection Impact Assessment

Appendix 4 – Sustainability Impact Assessment

Approvals	
Group (as relevant)	**Date**
Execs (Proof of Concept)	
Directorate Management Team	
Senior Leadership Team	
Relevant Committee	
Trust Board	
Please consider any internal approvals that are required before submission to SLT	
Workforce	Deputy Chief People Officer
Infection Prevention and Control	Head of Infection Prevention & Control
Estates & Facilities	Associate Director of Estates
Informatics / Digital	Chief Information Officer
Finance	Assistant Chief Finance Officer
Procurement	Deputy Chief Finance Officer

Sustainability Impact Assessment

Sustainability Impact Assessment
Introduction
This Sustainability Impact Assessment (SIA) is a tool to help teams and individuals consider sustainability and the social value for new business cases. It can also be used to support proposed projects, programmes, and policies. A SIA will help to ensure that any adverse or negative environmental impacts to the organisation are identified and, where possible, mitigated, to ensure that sustainability is considered in all decision making.
Notes on completion and governance
Sustainability Impact Assessments are to be completed alongside all new business cases. In the event that an SIA is not completed prior to business case approval, there will be a requirement for an SIA to be retrospectively completed. Review questions to support with completion can be found on page 3. Please forward completed Sustainability Impact Assessments for those business cases that are approved to the Transformation Management Office TMO-NSCHT@combined.nhs.uk . Completed SIA's will be shared within the Sustainability Steering Group, in alignment with the Trust's sustainability governance structure.

Sustainability Impact Assessment

Responsible Person and Department		Tracey Stevenson, Service Manager and Hannah Stone, Ward Manager				Date: 17th November 2025
Proposed Project		**Ward 5 Garden**				
Image	**Area of Sustainability / Social Value**	**Description of Impact**	**Nature / Degree of Impact**	**Overall Impact***	**How will impact be measured?**	**Actions to mitigate risks and enhance positive outcome**
	Energy	A reduction in energy required to maintain current garden through lawn mowing etc.	Minor as energy usage for this task currently is minimal	+1 Positive	This will form part of overall monitoring of energy usage at Trust site. Impact is too small to be monitored independently.	
	Water	Wet pour surfaces are porous, allowing water to drain through them naturally. This feature reduces stormwater runoff, helps prevent puddling and localized flooding, and allows for groundwater recharge, supporting Sustainable Urban Drainage Systems	There are no specific flooding issues now therefore impact minimal.	+1 Positive	N/A	
	Waste	N/A	N/A	0 Neutral	N/A	
	Capital Projects	This is a capital project involving full garden redesign	The proposal to utilise wet pour throughout the garden limits options to enhance biodiversity however as wet pour is typically created from recycled material and has high durability the sustainability impact is generally considered positive.	+1 Positive	To confirm the nature of the wet pour provided to ensure sustainability is optimised.	
	Travel and Transport	N/A	N/A	0 Neutral	N/A	
	Supply Chain (Inc climate related financial risk)	Contractor to be commissioned to deliver the project	Contractor commissioned by Serco in accordance with current contractual/supply chain arrangements	0 Neutral	N/A	
	Models of Care	Project completion will deliver positive impact on mental wellbeing and enhance delivery of care.	High degree of positive impact in supporting the delivery of care in a therapeutic outdoor	+1 Positive	Patient, family and staff feedback	

Sustainability Impact Assessment

			environment and the range of associated benefits for patient wellbeing and rehabilitation.			
	Adaptation	Impact re. future risk of flooding	Porous surface of new garden design helps to reduce future risks of flooding.	+1 Positive	Monitoring of drainage	
	Workforce	Impact re. workforce wellbeing	Provides a range of benefits for staff including accessible outdoor area for breaks and satisfaction from being able to deliver improved patient care with reduced risks (falls) and least restrictive models.	+1 Positive	Staff feedback	
	Digital Transformation	N/A	N/A	0 Neutral	N/A	
	Nature and Biodiversity	Proposal to remove grassed areas currently within the garden but to retain existing planter and potentially add further.	Minor. Small amount of grass removed however proposal to retain and add to planters will support opportunities to introduce plants that support biodiversity and wildlife e.g. pollinators.	0 Neutral	N/A	Specific consideration of planting schemes within the garden that enhance biodiversity.
	*Jobs: Promote Local Skills and Employment*	Social Value	N/A	0 Neutral		
	*Growth: Supporting Growth of Responsible Regional Business*	Social Value	Procurement will be in accordance with NHS supply chain requirements	0 Neutral		
	*Social: Healthier, Safer and more Resilient Communities*	Social Value	Improving ability for patients to benefit from access to therapeutic outdoor environment as part of their care.	+1 Positive		
	*Environment: Decarbonising and Safeguarding our World*	Social Value	N/A	0 Neutral		
	*Innovation: Promoting Social Innovation*	Social Value	N/A	0 Neutral		
TOTALS				6		

Sustainability Impact Assessment

Review Questions
ENERGY – consider whether the project leads to: • an increase, or decrease, in the amount of electricity or battery usage. • an increase, or decrease, in the amount of heating/hot water required. • an increase, or decrease, in carbon emissions from building energy use.
WATER – consider whether the project leads to: • an increase/decrease in the amount of water used. • an increase/decrease in substances to be disposed of to foul sewer.
WASTE – consider whether the project leads to: • an increase or decrease in the amount of waste generated. • a variation in the type of waste to be disposed of, affecting segregation i.e. more/less hazardous.
CAPITAL PROJECTS – each building or refurbishment work should consider: • energy use, including natural light, ventilation, and renewable energy. • water use, including conservation measures. • use of space as a community resource/social enterprise • enhancing green spaces & biodiversity
TRAVEL & TRANSPORT - consider whether the project leads to an increase or decrease in: • 'care miles' i.e. care closer to home, telemedicine, repeat appointments • access to services for vulnerable or disadvantaged groups • sustainable travel options, i.e. walking, cycling, public transport, electric car.
SUPPLY CHAIN - all procurement related to the project should consider: • whole life costs, i.e. procurement vs. revenue costs (£ and carbon) • supporting local businesses, small businesses, and social organisations • promotion of ethical procurement and labour standards • food/catering from local, seasonal, and sustainable suppliers • social value, i.e. producing a local benefit through employment/training. • wider health impacts, such as antibiotic use, air pollution, modern slavery
MODELS OF CARE - consider the impact the project may have on: • 'Care miles' and delivering care in settings closer to people's homes • promoting prevention, healthy behaviours, mental wellbeing, living independently and self-management • reducing avoidable hospital admissions or admissions to residential care • delivering integrated care, streamlining care pathways
ADAPTATION - consider if the project is impacted by climate change, such as: • hotter, drier summers; milder, wetter winters; increased extreme weather events, including flooding and heatwaves. • support for vulnerable groups, including the elderly, people with long-term health conditions and those with mental health illnesses.
WORKFORCE: Consider whether your project can support social value by: • employment opportunities including disadvantaged groups, i.e. long-term unemployed, people with learning disabilities. • training of existing staff or apprenticeship opportunities • health and wellbeing, flexible hours or childcare / carer support • increasing community resilience & a reduction in social isolation • reduction in health inequalities and access to services • increasing participation of patients, the public and strategic partners
DIGITAL – Consider benefits and risks to digital transformation / digital by choice initiatives; - contributes positively
NATURE AND DIVERSITY – Consider benefits and risks to nature, and biodiversity; - investment into net zero biodiversity

Ward 5 building

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 7

Improving Quality and Performance Report (IQPR) M08 2025/26

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

Report to:	Public Trust Board
Date of Meeting:	15 January 2026

Presented by:	Eric Gardiner, Chief Finance Officer
Prepared by:	Victora 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:	Execs Performance Review meeting – 16 December 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:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	The IQPR Board report is provided to the ICB as part of our contractual reporting requirements in 2025/26 and includes performance against national priorities in advance of the national publication through MHSDS.
Recommendation / Required Action:	Trust Board is asked to note the contents of the report.
Executive Summary:	This report includes key highlights and exceptions and long-term plan and national mental health priorities against operational planning

forecasts.
There is one special cause variations (orange variation flag) – signifying concern.

- Appraisal

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

- Care Plan Compliance
- Risk Assessment Compliance
- Vacancy Rate
- Staff Turnover
- Sickness Absence (unconfirmed as provisional figures)
- Statutory and Mandatory Training

Highlights

- Referral to assessment within 4 weeks continues to improve and remains above standard at 95.8% during M08.
- Referral to treatment within 18 weeks remains above standard at 94.8% during M08.
- CAMHS compliance within 4 weeks has met the required standard in M08 at 96.1% compared to 93.3% in M07.
- MH Liaison 4-hour and 24-hour response are above the 95% standard in M08.
- Early Intervention has achieved 100% during M08.
- 7-day follow up (all patients) has achieved 97.7% in M08.
- Talking Therapies reliable recovery and reliable improvement has achieved the required standard during M08.
- Care Plan compliance has achieved continues to improve at 96.2% during M08.
- Risk Assessment has met the required standard at 96.3% during M08.
- Average Length of Stay – Older Adult has increased to 58.5 days and remains within the <90 days threshold.
- Emergency Readmissions rate (30 days) has increased to 2.7% during M08 compared to 1.6% in M07 but remains well within the <7.5% threshold.
- There are no complaints exceeding the 40-day target response.
- Friends and Family Test has improved to 88% during M08 compared to 76% in M07.
- Vacancy Rate continues to improve to 3% during M08.
- Staff turnover has remained the same during M08 as M07 at 7.3%.
- Statutory and mandatory training has dipped to 90% during M08 but has achieved the required standard.
- DQMI has improved to 98.6% during M08 (latest published report).

Exceptions

- CAMHS compliance within 18 weeks waits (referral to treatment) has not met the required standard in M08 at 90.5% compared to 93.9% during M07.
- MH Liaison 1 hour response has achieved 90.6% during M08.

	• 48-hour follow up has achieved 93% during M08 compared to 97.8% during M07. • Average length of stay-adult has exceeded the <40 days national average at 45 days during M08 compared to 34.7 days during M07. • Provisional sickness absence figures are at 5.87% during M08. • Clinical Supervision has dipped to 82% during M08 compared to 86% during M07 and remains below trust standard. • Appraisal has improved to 83% during M08 compared to 79% during M07. **Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts M08 2025/26** M08 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 M08, all due to the availability of adult acute beds. Additionally, there were 2 local non-NHS bed placements, no longer included in national reporting. • **Inpatient Stays** - this is a 3-month rolling measure of adult acute, older adult acute and psychiatric intensive care unit (PICU) occupied bed days LoS. The average LoS for this metric has not met standard in M08 achieving 44 against the plan of 39. This is due to long LoS discharges in November. • **Perinatal Access –** The perinatal access metric has met standard in M08, achieving 812 against the plan of 608. • **CYP in contact –** This metric has met standard in M08 achieving 9,164 against the plan of 7,955. • **Individual Placement Support (IPS) Access** - the Integrated Care Board (ICB) performance plan has been revised in M08 2025/26 to agree with the IPS fair share values. This metric has not met the revised standard achieving 831 against the revised plan of 867. The report is provided to the Trust Board in addition to the Finance & Resource Committee, Quality Committee and the People, Culture and Development Committee.

VERSION CONTROL:

Version	Report to	Date Reported
V1.0	Public Trust Board	9 January 2026

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M08 (November 2025)

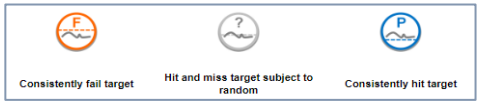
Contents

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

1. Care Plan Compliance
2. Risk Assessment Compliance
3. Vacancy Rate
4. Staff Turnover
5. Sickness Absence (provisional)
6. 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 and Community 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			
	Metric	**Standard**	**Performance**
RAG Rated Standards	9 met, 3 unmet		
Highlights	Referral to Assessment within 4 weeks	95.0%	95.8%
	Referral to Treatment within 18 weeks	92.0%	94.8%
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	96.1%
	MH Liaison 4 Hour Response (Urgent)	95.0%	95.3%
	MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	99.6%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	100.0%
	7 Day Follow Up (All Patients)	95.0%	97.7%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	50.2%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	67.0%	72.4%
Exceptions	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	90.5%
	MH Liaison 1 Hour Response (Emergency)	95.0%	89.3%
	48 Hour Follow Up	95.0%	93.0%

Community & Quality			
	Metric	**Standard**	**Performance**
RAG Rated Standards	2 met, 0 unmet		
Highlights	Care Plan Compliance	95.0%	96.2%
	Risk Assessment Compliance	95.0%	96.3%

Performance Improvement Plans (PIPs)			
Directorate	**Metric**	**Standard**	**Performance**
Specialist Services	Referral to Assessment within 4 weeks	95%	85.0%
	Sickness Absence (in-month)	<4.95%	3.92%
	Care Plan Compliance	95%	93.7%
Nursing and Quality	Complaints Open Beyond Agreed Timescale	0	0
Primary Care	Sickness Absence (in-month)	<4.95%	4.52%

Inpatient & Quality			
	Metric	**Standard**	**Performance**
RAG Rated Standards	2 met, 1 unmet		
Highlights	Average Length of Stay - Older Adult	90	58.5
	Emergency Readmissions rate (30 days)	<7.5%	2.7%
Exceptions	Average Length of Stay - Adult	40	45.0

Organisational Health & Workforce			
	Metric	**Standard**	**Performance**
SPC Variations signifying concern	Appraisal	85.0%	83.0%
RAG Rated Standards	4 met, 4 unmet		
Highlights	Complaints Open Beyond Agreed Timescale	0	0
	Friends and Family Test - Recommended	80.0%	88.0%
	Vacancy Rate	<10%	3.0%
	Staff Turnover	<10%	7.3%
	Statutory & Mandatory Training	85.0%	90.0%
Exceptions	Sickness Absence	<4.95%	5.87%
	Clinical Supervision	85.0%	82.0%
	Appraisal	85.0%	83.0%

Performance Improvement Plans (PIPs)			
Directorate	**Metric**	**Standard**	**Performance**
ACUD	Sickness Absence (in-month)	<4.95%	5.81%
	Clinical Supervision	85%	81.0%
Community	Referral to Assessment within 4 weeks-CYP	95%	97.3%
	Referral to Assessment within 4 weeks-Adult	95%	95.0%
	Clinical Supervision	85%	86.0%
ACUD and Community	Number of inappropriate OOAs during month	2	20
	Number of inappropriate OOAs at EOM (national measure)	2	17

Core Indicators – Monthly

	Indicator	Target	Sep-25	Oct-25	Nov-25	Assurance	Variation
Access & Wait Times	Referral to Assessment within 4 weeks	95.0%	94.5%	95.1%	95.8%		
	Referral to Treatment within 18 weeks	92.0%	96.3%	96.0%	94.8%		
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	90.1%	93.3%	96.1%		
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	94.0%	93.9%	90.5%		
	MH Liaison 1 Hour Response (Emergency)	95.0%	95.0%	97.2%	89.3%		
	MH Liaison 4 Hour Response (Urgent)	95.0%	97.6%	97.6%	95.3%		
	MH Liaison 24 Hour Response (Urgent from General Hospital	95.0%	96.2%	96.5%	99.6%		
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	100.0%	N/A	N/A		
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	100.0%	N/A	N/A		
	Early Intervention - A Maximum of 2 Week Waits for Referral to	60.0%	90.9%	100.0%	100.0%		
	48 Hour Follow Up	95.0%	100.0%	97.8%	93.0%		
	7 Day Follow Up (All Patients)	95.0%	100.0%	97.8%	97.7%		
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	49.4%	50.1%	50.2%		
	Talking Therapies for Anxiety and Depression: Reliable	67.0%	70.5%	72.6%	72.4%		

	Indicator	Target	Sep-25	Oct-25	Nov-25	Assurance	Variation
Inpatient & Quality	Average Length of Stay - Adult	40	37.0	34.7	45.0		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	23.7%	12.5%	17.6%		
	Average Length of Stay - Older Adult	90	46.4	47.2	58.5		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	14.3%	15.8%	20.8%		
	Emergency Readmissions rate (30 days)	<7.5%	2.3%	1.6%	2.7%		
	Clinically Ready for Discharge (CRFD)	No Target	25.5%	20.6%	22.3%		

	Indicator	Target	Sep-25	Oct-25	Nov-25	Assurance	Variation
Community & Quality	Care Plan Compliance	95.0%	95.6%	95.7%	96.2%		
	Risk Assessment Compliance	95.0%	96.4%	96.6%	96.3%		
	Comprehensive Safety Review	No Target	3	1	4		
	Proportionate Reviews	No Target	2	5	5		

	Indicator	Target	Sep-25	Oct-25	Nov-25	Assurance	Variation
Organisational Health	Complaints Open Beyond Agreed Timescale	0	0	0	0		
	Friends and Family Test - Recommended	80.0%	87.6%	76.0%	88.0%		
	Safe Staffing	95%-105%	102.8%	102.5%	106.1%		
	Vacancy Rate	<10%	5.1%	3.3%	3.0%		
	Staff Turnover	<10%	8.1%	7.3%	7.3%		
	Sickness Absence	<4.95%	6.20%	6.11%	5.87%		
	Clinical Supervision	85.0%	81.0%	86.0%	82.0%		
	Appraisal	85.0%	78.0%	79.0%	83.0%		
	Statutory & Mandatory Training	85.0%	90.0%	91.0%	90.0%		

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

	Out of Area Placements	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	14	11	19	11	19	9	7	17	17				
			Variance	-12	-9	-17	-9	-17	-7	-5	-15	-15				
			Kidsgrove Placements				*5*	*3*	*3*	*10*	*7*	*2*				

	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	8,477	8,407	8,338	9,483	9,693	9,263	8,019	6,967	7,646				
			Variance	-482	-412	-343	-1,488	-1,698	-1,268	-24	1,028	349				
			Nationally Published	8,599	8,405	8,340	9,505	9,695	9,265	8,020	6,965					
	Number of discharges in the RP		*Plan*	205	205	205	205	205	205	205	205	205	205	205	205	205
			Actual	183	202	188	181	171	182	186	178	175				
			Variance	22	3	17	24	34	23	19	27	30				
			Nationally Published	184	200	190	180	170	180	185	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	46	42	44	53	57	51	43	39	44				
			Variance	-7	-3	-5	-14	-18	-12	-4	0	-5				
			Nationally Published	47	42	44	53	57	51	43	39					

**Out of Area Placements has been revised in M08 and retrospectively for 2025/26 to exclude placements to Cygnet Kidsgrove*

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

	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	748	682	701	722	746	747	770	803	812				
			Variance	140	74	93	114	138	139	162	195	204				
			Nationally Published	716	660	680	700	725	725	745	775					

	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	8,770	8,515	8,489	8,605	8,706	8,713	8,897	9,073	9,164				
			Variance	815	560	534	650	751	758	942	1,118	1,209				
			Nationally Published	8,726	8,520	8,505	8,620	8,715	8,725	8,910	9,090					

	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 Original Plan*	913	820	827	846	865	883	902	921	940	958	977	996	1,015
			ICB Revised Plan	859	826	832	838	844	850	856	861	867	873	879	885	891
			ICB Actual	788	784	776	782	750	773	800	811	831				
			Variance	-58	-42	-56	-56	-94	-77	-56	-50	-36				
			NSCHT Actual	377	389	388	382	364	365	377	372	380				
			MPFT Actual	411	395	388	400	386	408	423	439	451				
			ICB Nationally Published	790	785	780	790	760	780	815	820					
			NSCHT Nationally Published	376	390	390	380	365	365	375	370					

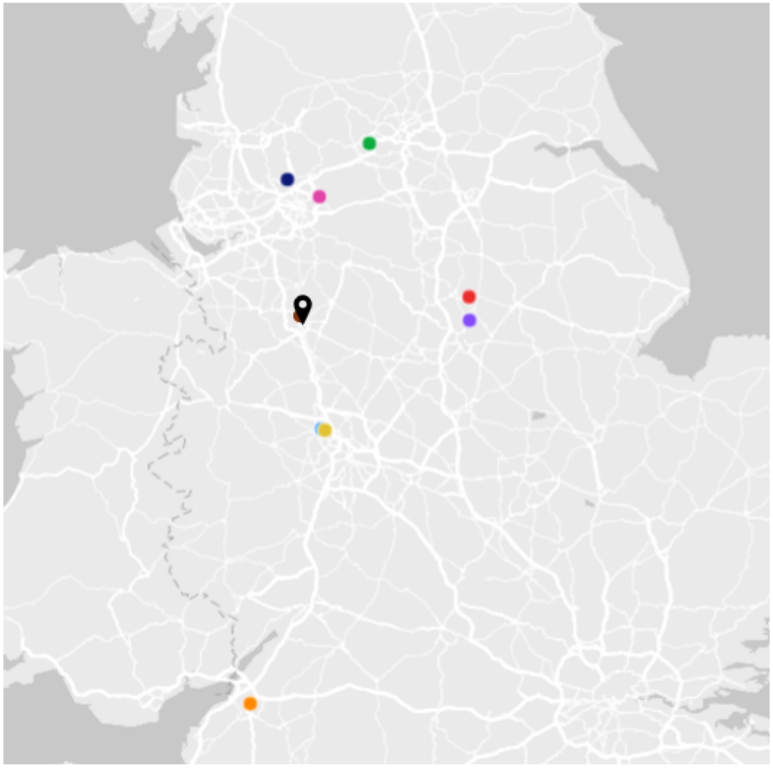
**Nationally published performance has been included where applicable.*

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 M08 - all due to the availability of adult acute beds. Additionally, there were 2 Cygnet Kidsgrove placements, not included in national reporting.

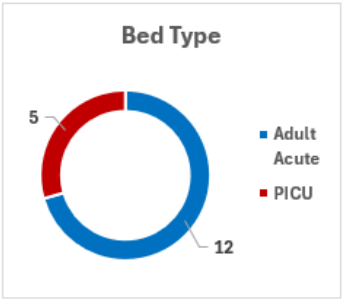
  This reflects the pressure across the system and on the acute and urgent care directorate (ACUD). There is a low number of adult acute beds at the present time due to Project Chrysalis (94 beds). The current bed stock is the lowest since September 2020. There is added pressure due to the number of patients that are clinically ready for discharge (CRFD) but remain within our inpatient services. In M08 15.9% 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.

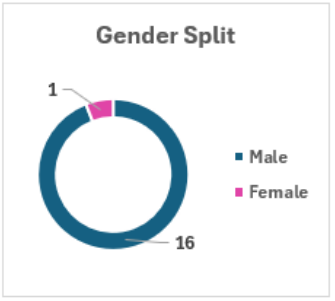
- An OOA standing operating procedure (SOP) provides assurance regarding roles and responsibilities regarding the input and oversight that staff on the wards are providing to patients in OOA beds. ACUC staff attend weekly ward rounds for each OOA patient. In addition, the discharge pathway team remain 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 Hospital Sherwood	61	5
	Cygnet Hospital Wolverhampton	33	1
	Cygnet Hospital Wyke	83	1
	Cygnet Kenney House	55	1
	Cynet Hospital Bury	61	1
	Priory Hospital Arnold	62	1
	Priory Hospital Bristol	124	1
	Priory Lakeside View	33	5
	*Cygnet Kidsgrove	2	5
	Harplands Hospital		***Total: 17***

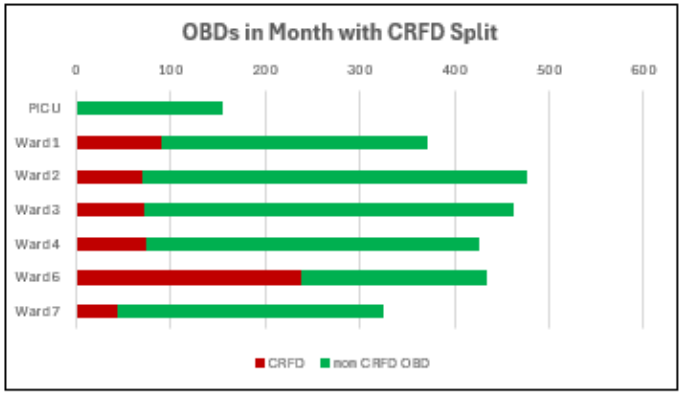
*Total excludes Cygnet Kidsgrove placements

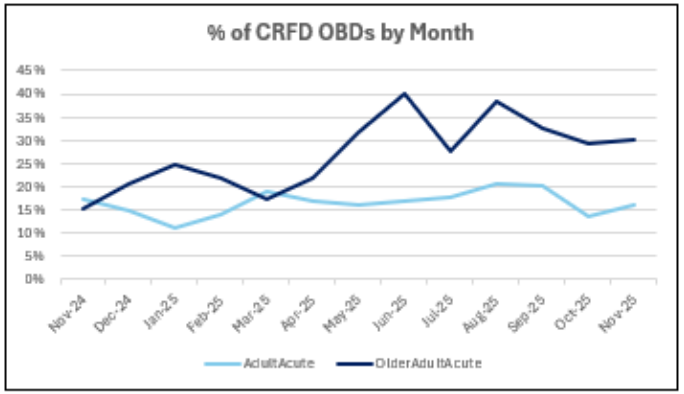


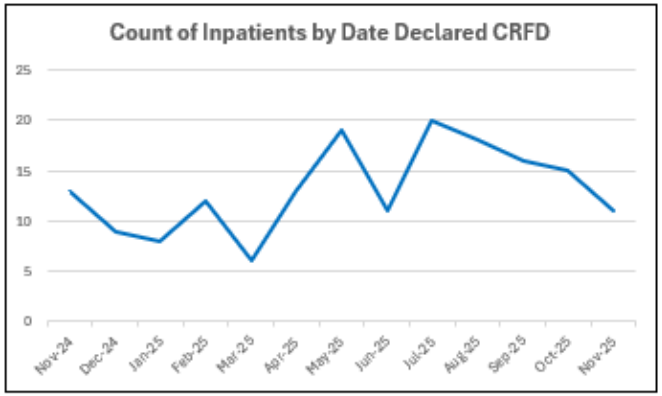


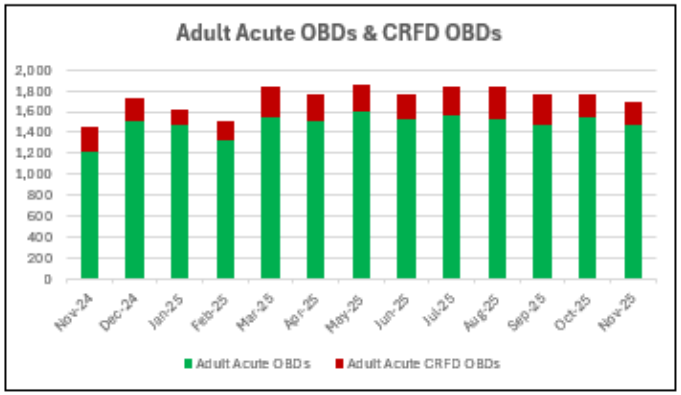
Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 – Supporting Information: Clinically Ready for Discharge (CRFD) (1 of 2)

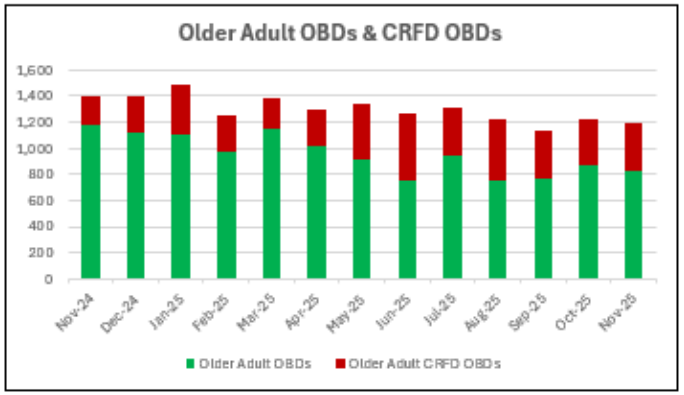
One of the largest contributing factors to average length of stay (LoS), that is often out of our control, is patients who are clinically ready for discharge (CRFD). Stoke-on-Trent City Council have been collaborating with us to reduce the high number of Stoke CRFDs. This is a positive development; however, 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.

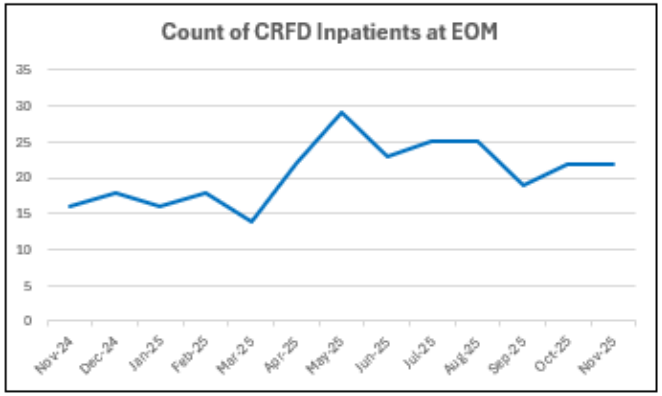












Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (2 of 2)

- **Inpatient Stays** – added to the national operational priorities in financial year 2025/26 with the target of improving patient flow through mental health crisis and acute pathways, reducing average length of stay (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 M08 achieving 44 against the plan of 39. This is due to two long LoS discharges in November.

- **Perinatal Access –** The perinatal access metric has met standard in M08, achieving 812 against the plan of 608.

- **CYP in contact –** This metric has met standard in M08 achieving 9,164 against the plan of 7,955.

- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has been revised in M08 2025/26 to agree with the IPS fair share values. This metric has not met the revised standard achieving 831 against the plan of 867. As performance is under plan, operational management reports have been created by the Performance team in NSCHT and MPFT 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 – 13 Month Trend (1 of 2)

Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Referral to Assessment within 4 weeks	95.0%	95.9%	92.2%	90.0%	91.7%	93.1%	94.2%	94.7%	93.5%	93.3%	92.4%	94.5%	95.1%	95.8%
Referral to Treatment within 18 weeks	92.0%	95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%	95.4%	95.9%	96.1%	96.3%	96.0%	94.8%
CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	92.0%	76.4%	67.3%	76.2%	85.7%	91.1%	90.9%	92.0%	91.1%	78.2%	90.1%	93.3%	96.1%
CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%	85.9%	92.8%	88.6%	94.0%	93.9%	90.5%
MH Liaison 1 Hour Response (Emergency)	95.0%	92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%
MH Liaison 4 Hour Response (Urgent)	95.0%	91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%	93.8%	96.0%	95.5%	97.6%	97.6%	95.3%
MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%	96.0%	96.4%	96.5%	96.2%	96.5%	99.6%
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	N/A	83.3%	N/A	N/A	72.7%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	97.3%	N/A	N/A	100.0%	N/A	N/A
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	100.0%	92.0%	91.0%	100.0%	92.0%	100.0%	100.0%	95.0%	94.7%	75.0%	90.9%	100.0%	100.0%
48 Hour Follow Up	95.0%	100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%	96.4%	100.0%	100.0%	100.0%	97.8%	93.0%
7 Day Follow Up (All Patients)	95.0%	100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%	96.4%	100.0%	100.0%	100.0%	97.8%	97.7%
Emergency Readmissions rate (30 days)	<7.5%	1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%
Care Plan Compliance	95.0%	96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%
Risk Assessment Compliance	95.0%	94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%	96.0%	95.7%	96.2%	96.4%	96.6%	96.3%
Comprehensive Safety Review	No Target	1	5	4	2	3	2	5	6	0	3	3	1	4
Friends and Family Test - Recommended	80.0%	80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%	81.5%	86.4%	82.5%	87.6%	76.0%	88.0%
Safe Staffing	95%-105%	100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%	107.4%	103.9%	103.8%	102.8%	102.5%	106.1%

Core Indicators – 13 Month Trend (2 of 2)

Name	Target	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%	51.6%	53.7%	51.9%	49.4%	50.1%	50.2%
Talking Therapies for Anxiety and Depression: Reliable Improvement	67.0%	74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%	73.9%	77.4%	73.2%	70.5%	72.6%	72.4%
Average Length of Stay - Adult	40	27.5	33.0	42.4	23.9	27.5	40.9	34.0	62.3	49.3	26.6	37.0	34.7	45.0
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%	16.7%	22.2%	12.8%	23.7%	12.5%	17.6%
Average Length of Stay - Older Adult	90	50.6	48.0	56.6	73.0	58.9	41.2	80.9	70.2	55.7	55.3	46.4	47.2	58.5
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%	21.1%	30.4%	18.2%	14.3%	15.8%	20.8%
Clinically Ready for Discharge (CRFD)	No Target	16.3%	17.6%	18.0%	17.8%	18.3%	19.2%	23.3%	27.2%	22.2%	28.5%	25.5%	20.6%	22.3%
Proportionate Reviews	No Target	3	2	4	3	5	2	7	6	9	2	2	5	5
Complaints Open Beyond Agreed Timescale	0	3	2	1	5	4	3	2	5	1	1	0	0	0
Vacancy Rate	<10%	8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%	8.2%	8.0%	7.6%	5.1%	3.3%	3.0%
Staff Turnover	<10%	10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%	8.9%	8.9%	8.5%	8.1%	7.3%	7.3%
Sickness Absence	<4.95%	5.85%	6.05%	6.21%	6.32%	6.39%	6.39%	6.35%	6.33%	6.27%	6.25%	6.20%	6.11%	5.87%
Clinical Supervision	85.0%	82.0%	79.0%	85.0%	82.0%	79.0%	81.0%	83.0%	80.0%	79.0%	81.0%	81.0%	86.0%	82.0%
Appraisal	85.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	84.0%	83.0%	81.0%	84.0%	78.0%	79.0%	83.0%
Statutory & Mandatory Training	85.0%	87.0%	89.0%	89.0%	89.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.0%
DQMI	95.0%	97.2%	98.4%	98.3%	98.3%	98.4%	98.6%	98.4%	98.5%	98.4%	98.5%	98.6%	N/A	N/A

In M08 there are 34 metrics monitored; 18 have achieved the required standard and 7 have not achieved the required standard (to be confirmed due to provisional sickness figures). 5 metrics have no target and are being monitored. 1 metric is being monitored. 2 metrics are reported quarterly. 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:

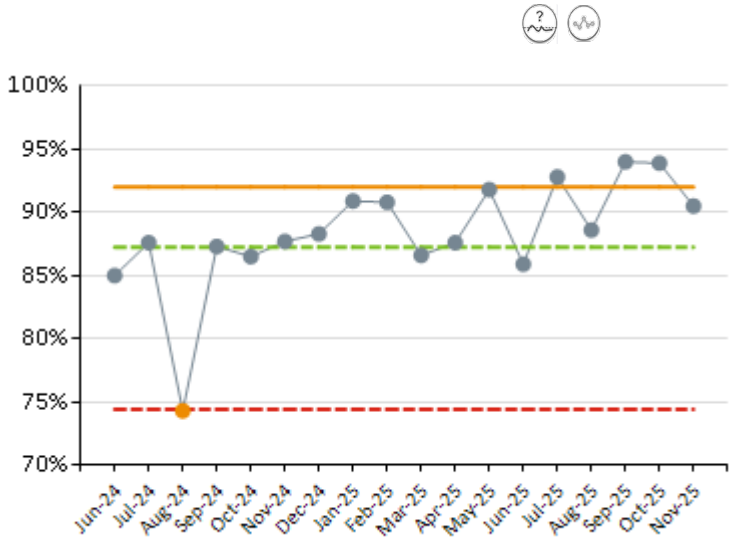
Metric	Directorate	Status
Referral to Assessment within 4 weeks	**Specialist Services**	The Specialist Directorate voluntarily implemented a PIP in M06 (2024/25) for 4-week referral to assessment as performance has been below the required standard since April 2024. Revised trajectories and actions were received in February 2025 and July 2025. The aim was for achievement of the 95.0% standard by August 2025 this has been extended to January 2026. Performance is 85.0% during M08 which is not meeting the 93.0% trajectory or 95.0% required standard. Updated actions have been provided in M08.
	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 97.3% during M08 which is exceeding the 78.0% trajectory and has met the 95.0% required standard for the first time in over 12 months. Updated actions have been provided in M08.
	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 95.0% during M08 which is exceeding the 90.0% trajectory and has met the required 95.0% standard for the first time in over 12 months. Updated actions have been provided in M08.
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
		Provisional sickness absence 12-month rolling period during M08 is 7.23% and 5.81% in-month. The in-month trajectory of 7.20% is being met. The 6.88% 4-year average is being met. The Trust standard of <4.95% is not being met. The 12-month required standard is being met. Updated actions have been provided in M08.
	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. Provisional sickness absence 12-month rolling period during M08 is 6.24% and 4.52% in-month. The in-month trajectory of 5.00% is being met. The 4.35% 4-year average is not being met. The Trust standard of <4.95% is being met. The 12-month required standard is not being met. Updated actions have been provided in M08.
	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. Provisional sickness absence 12-month rolling period during M08 is 6.79% and 3.92% in-month. The in-month trajectory of 6.50% is being met. The 5.97% 4-year average is being met. The Trust standard of <4.95% is being met. The 12-month required standard is not being met. Updated actions have been provided for M08.
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, July 2025 and has been further extended to November 2025. During M08 there are no complaint responses exceeding the 40-day response timescale. Performance is meeting the required trajectory and required standard for the third consecutive month. Updated actions have been provided in M08.
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 M08 is 86.0% and has met the 86.0% planned trajectory and 85.0% required standard for the second consecutive month. Updated actions have been provided in M08.

Metric	Directorate	Status
	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. Trajectories have been extended in M03 for the period covering May 2025 to November 2025. Performance during M08 is 81.0%.and has not met the planned 85.0% trajectory or required standard. Updated actions have been provided in M08.
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 M08 is at 93.7% which is not meeting the 94.0% planned trajectory or 95.0% required standard. Updated actions have been provided in M08.
Out of Area Placement (OOAs)	Acute and Urgent Care and Community	A PIP was requested in M04 (2025/26). Performance during M08 is measured by the number of inappropriate OOAs during month and the number of inappropriate OOAs at EOM (national measure) which were 20 and 17, respectively. Updated actions have been provided in M08.

Core Indicators – SPC Trend (Exceptions in Month)

CAMHS Compliance within 18 week waits (Referral to Treatment) (Trust Measure)



13 Month Trend

87.7%	88.3%	90.9%	90.8%	86.6%	87.6%	91.8%	85.9%	92.8%	88.6%	94.0%	93.9%	90.5%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

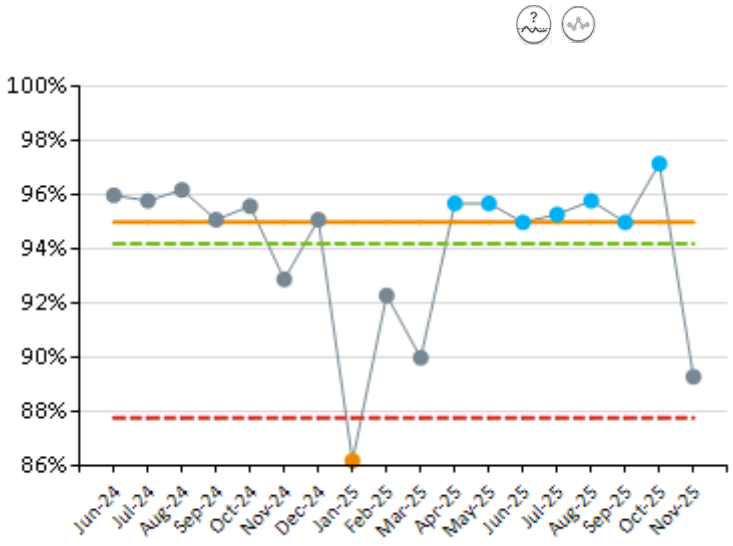
Performance is at **90.5% in M08**. The variation is showing common cause.

Current performance: Community-95.9%, Specialist-N/A, Acute and Urgent Care-50.0%.

A PIP is in place for Community directorate.

Within the Acute and Urgent Care Directorate, 5 out of 10 patients had breached the 18-week referral to treatment metric. All patients that had breached compliance have an autism assessment service referral as part of their patient pathway. If autism assessment service referrals did not impact patient pathway waits, both the Trust and Acute and Urgent Care Directorate positions would be compliant against standard for this metric in M08.

MH Liaison 1 Hour Response (Emergency) (Trust Measure)



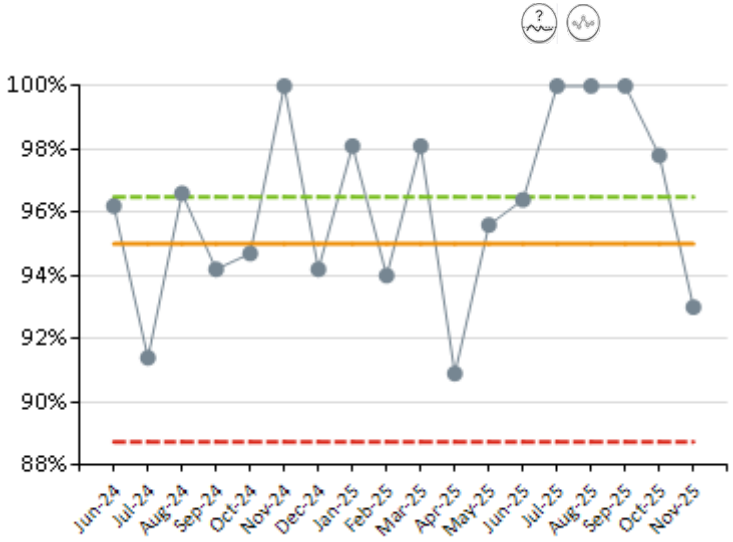
13 Month Trend

92.9%	95.1%	86.2%	92.3%	90.0%	95.7%	95.7%	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Performance is at **89.3% in M08**. The variation is showing common cause.

Due to late notice staff sickness, the MHLT service implemented its Business Continuity Plan during the nights of the 22nd and 23rd November creating 1-hour breaches. It was not possible to provide cover from crisis care staff at this time due to high demand in this service. This was an exceptional occurrence and although some delays occurred, all patients were seen. However, it has highlighted the need to review business continuity arrangements in this area.

48 Hour Follow Up (Trust Measure)



13 Month Trend

100.0%	94.2%	98.1%	94.0%	98.1%	90.9%	95.6%	96.4%	100.0%	100.0%	100.0%	97.8%	93.0%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Performance is at **93.0% in M08**. The variation is showing common cause.

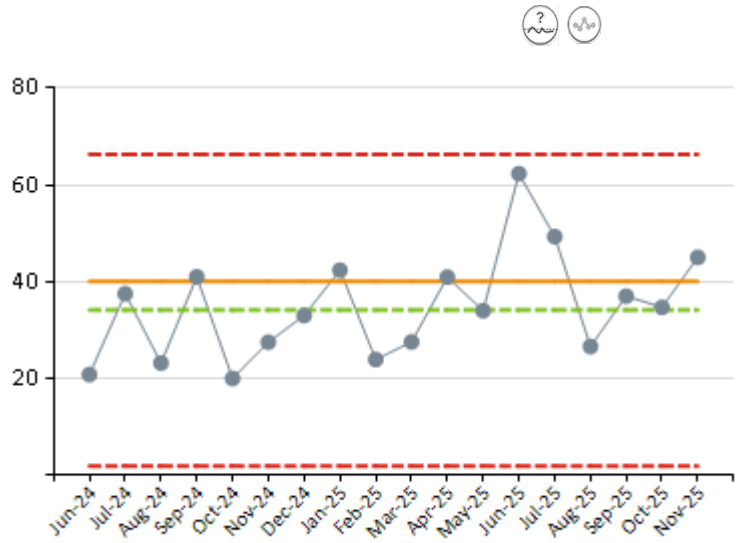
In M08 there were 3 patients that breached the 48-hour follow up metric.

1 breach had been due to a patient not attending the follow up appointment within the 48-hour time frame.

1 breach had been due to a patient being admitted to UHMN from home within 48-hours of discharge subsequently not attending the arranged follow up appointment.

1 breach was associated with late entered data, past the cut-off point for performance figures to be produced and now shows that an attended follow up appointment within 48 hours occurred.

Average Length of Stay - Adult (National Measure)



13 Month Trend

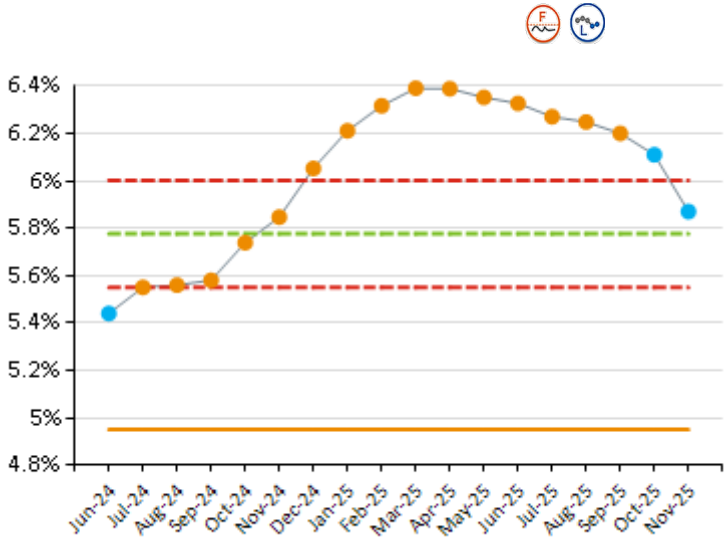
27.5	33.0	42.4	23.9	27.5	40.9	34.0	62.3	49.3	26.6	37.0	34.7	45.0
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Performance is at **45.0 in M08**. The variation is showing common cause.

Adult Acute average LoS had not met standard in M08, achieving an average of 45 days against the standard of 40 days. There were 3 discharges from adult acute wards in M08 that highly impacted this metric, 94, 230 and 349 days were the LOS for these patients.

ORGANISATIONAL HEALTH AND WORKFORCE

Sickness Absence (Trust Measure)



13 Month Trend

5.85%	6.05%	6.21%	6.32%	6.39%	6.39%	6.35%	6.33%	6.27%	6.25%	6.20%	6.11%	5.87%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

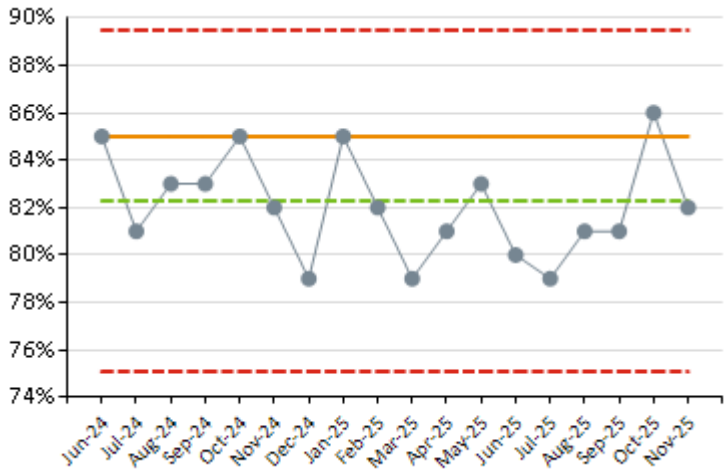
Performance is at **5.87% in M08**. The variation is showing improvement.

Current performance: Community-5.69%, Specialist-6.79%, Acute and Urgent Care-7.23%, Primary Care-6.24%, Corporate-2.82%.

Through the refreshed people plan, sickness absence is a priority within the workforce optimisation big move. To understand the drivers for sickness absence, engagement sessions have commenced, initially within the People team to map actions across a number of dimensions impacting sickness. Focused work from the people business partners has commenced in reviewing triggers and sickness absence reports, with this focus, and support from people managers, realising a small positive reduction in sickness absence when compared to previous months. A detailed improvement plan for each directorate will be developed to support with understanding trajectories for reduction.

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

Clinical Supervision (Trust Measure)



13 Month Trend

82.0%	79.0%	85.0%	82.0%	79.0%	81.0%	83.0%	80.0%	79.0%	81.0%	81.0%	86.0%	82.0%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

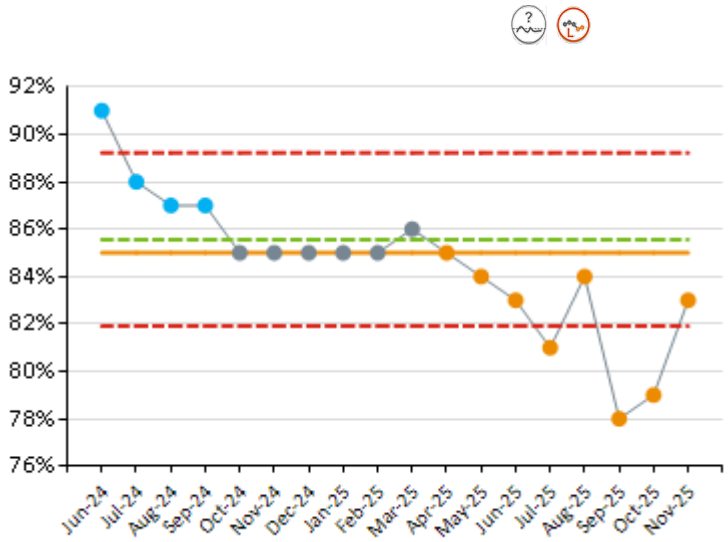
Performance is at **82.0% in M08**. The variation is showing common cause.

Current performance: Community-86.0%, Specialist-85.0%, Acute and Urgent Care-81.0%, Primary Care-80.0%, Corporate-37.0%.

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. A review is taking place of the email list to ensure accuracy. Clinical supervision action plan is in development following survey report. Due to small numbers of people in the corporate directorate requiring supervision, any non-compliance has a big impact on % data. Currently 21 people are non-compliant – raised with responsible deputy directors for awareness and action.

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

Appraisal (Trust Measure)



13 Month Trend

85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	84.0%	83.0%	81.0%	84.0%	78.0%	79.0%	83.0%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

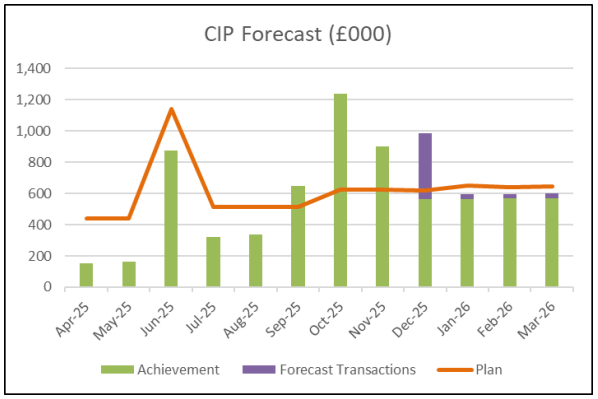
Performance is at **83.0% in M08**. The variation is showing concern.

Current performance: Community-92.0%, Specialist-81.0%, Acute and Urgent Care-80.0%, Primary Care-79.0%, Corporate-79.0%.

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 advising managers on action to undertake to address appraisal inaccuracies on LMS has been in place since September, which has resulted in an improving picture in October and November. These measures are expected to continue to improve compliance.

Financial Performance

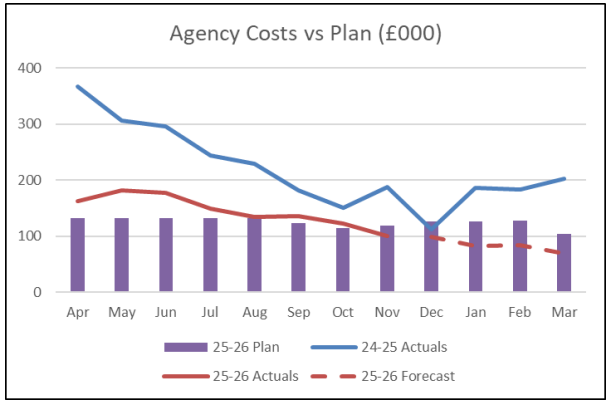
CIP Delivery v Plan



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

The Trust is forecasting full achievement of the plan, with current achievement (transacted) £6.9m, fully developed £0.2m and opportunities identified £0.3m.

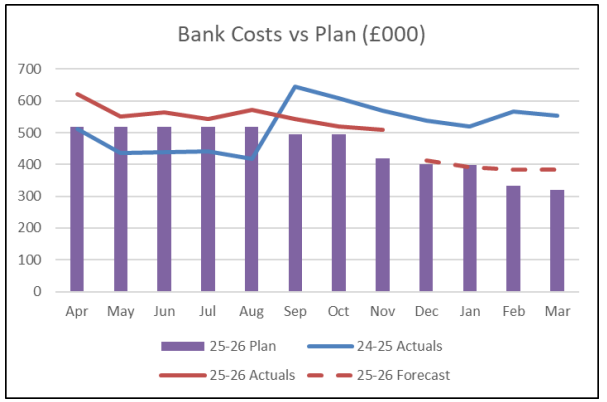
Agency Cost v Plan (40% reduction)



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

The Trust is forecasting total agency costs of £1.5m, with £1.0m Community, £0.3m Primary Care and £0.2m Specialist.

Bank Cost v Plan (10% reduction)



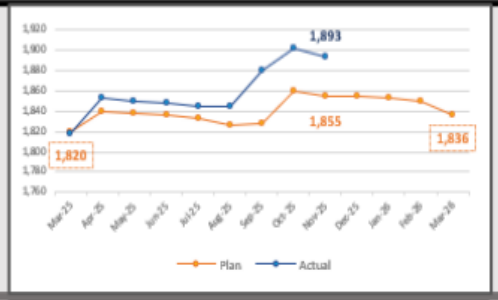
The bank graph shows forecast against a £5.4m plan.

The Trust is forecasting total bank costs of £6.0m, with £3.1m Acute, £2.0m Specialist, £0.5m Community and £0.3m Corporate.

Workforce Plan (1 of 2)

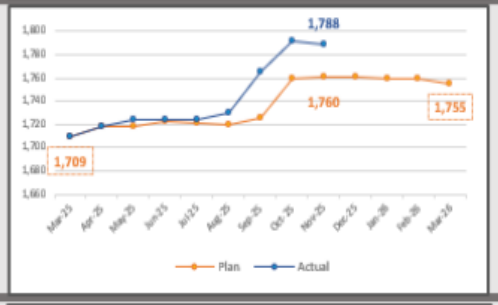
NSCHT

Overall Workforce



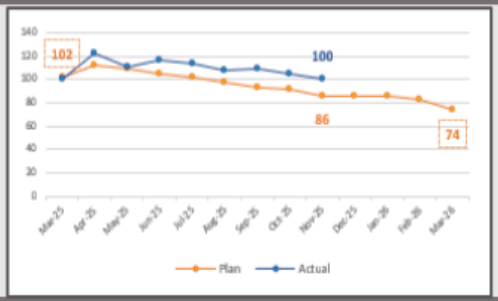
Overall Workforce	Nov-25 WTE	Position to Plan	In Month Change	YTD Change	YTD Spend to Plan (£'000)	Vacancies		Actual to Establishment
Registered Nursing & Midwifery	601	+3	+6	+49	-£1,171	15	2.6%	+12
Registered Scientific, Therapeutic and Technical staff	305	-0	-0	+12	-£705	23	7.1%	-22
Support to Clinical Staff	572	+36	-12	+20	+£1,452	17	3.3%	+46
Infrastructure Support	343	-3	-2	-9	-£396	24	6.6%	-21
Medical and Dental	68	+2	-1	+4	+£150	9	13.6%	-1
Total Workforce	**1,893**	**+38**	**-9**	**+76**	**-£626**	**89**	**4.7%**	**+16**

Substantive Workforce



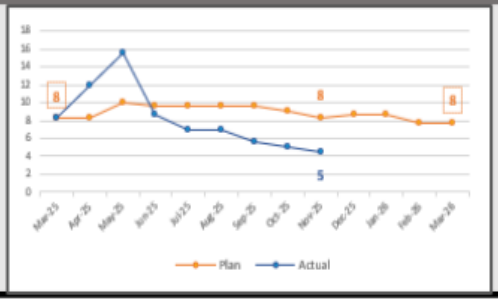
Substantive Workforce	Nov-25 WTE	Position to Plan	In Month Change	YTD Change	YTD Spend to Plan (£'000)
Registered Nursing & Midwifery	573	-6	+4	+46	+£610
Registered Scientific, Therapeutic and Technical staff	304	-1	+1	+12	-£870
Support to Clinical Staff	508	+37	-5	+23	-£728
Infrastructure Support	340	-5	-2	-8	-£502
Medical and Dental	60	+1	-1	+6	+£350
Total Substantive	**1,788**	**+28**	**-4**	**+79**	**-£1,096**

Bank Workforce



Bank Workforce	Nov-25 WTE	Position to Plan	In Month Change	YTD Change		YTD Spend to Plan (£'000)	YTD WTE Utilisation	FYTD WTE utilisation & Spend (£,000) compared to corresponding period 2024-2025			
Registered Nursing & Midwifery	28	+12	+2	+4	15%	-£1,799	196	+16	+9%	+£135	+15%
Registered Scientific, Therapeutic and Technical staff	2	+0	-1	+0	15%	+£156	23	+5	+26%	+£45	+40%
Support to Clinical Staff	64	-1	-7	-3	-4%	+£2,160	604	-31	-5%	+£20	+1%
Infrastructure Support	4	+1	-0	-0	-12%	+£106	27	+5	+22%	+£46	+43%
Medical and Dental	4	+1	+0	-0	-4%	-£251	35	+2	+7%	+£109	+16%
Total Bank	**100**	**+14**	**-5**	**+0**	**0%**	**+£372**	**885**	**-4**	**-0%**	**+£355**	**+9%**

Agency Workforce



Agency Workforce	Nov-25 WTE	Position to Plan	In Month Change	YTD Change		YTD Spend to Plan (£'000)	YTD WTE Utilisation	FYTD WTE utilisation & Spend (£,000) compared to corresponding period 2024-2025			
Registered Nursing & Midwifery	0	-3	-0	-1	-100%	+£18	13	-22	-62%	-£174	-64%
Registered Scientific, Therapeutic and Technical staff	0	0	0	0		+£9	2	+2		+£9	
Support to Clinical Staff	0	0	-0	-0	-100%	+£20	5	-7	-58%	-£81	-80%
Infrastructure Support	0	0	0	0		+£0	1	+1		-£9	-100%
Medical and Dental	5	-1	-0	-2	-32%	+£51	44	-33	-43%	-£540	-34%
Total Agency	**5**	**-4**	**-0**	**-4**	**-45%**	**+£98**	**65**	**-59**	**-48%**	**-£795**	**-40%**

Workforce Plan (2 of 2)

As at M08, overall actual staffing indicates that there is an adverse variance of 38 WTE when compared to plan.

The majority of the adverse WTE variance to plan is within substantive workforce, with an additional 37 WTE ‘support to clinical staff’ being used. Nursing bank staff also had an adverse variance to plan, with 12 WTE additionally used.

Whilst agency usage is small and within the workforce plan, the cost is above the finance plan.

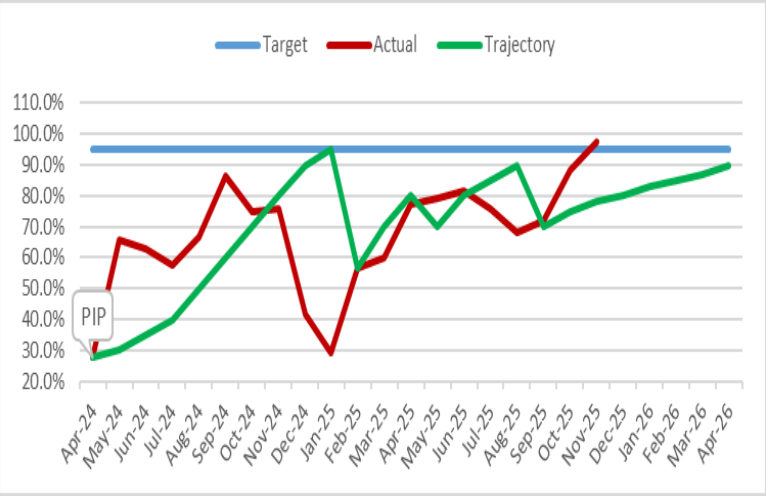
The workforce plan at M08 is using more WTE than planned, however this is being used at a lower cost, resulting in a favourable variance of £626k.

Bank utilisation when comparing M08 2025/26 to M08 2024/25 illustrates an increase in nursing but decrease in support to clinical staff and is generally on track to use the same amount of bank in previous year.

Performance Improvement Plans (PIPs)

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

Community directorate



A PIP was issued in M01 (2024/25).

M08 performance is 97.3% and is exceeding the planned 78.0% trajectory and is meeting the required standard.

The aim is for the standard to be met in March 2026; this was revised to September 2025 and has since been revised to April 2026.

Revised trajectories were provided in M02 for the period May 2025 to September 2025. The trajectory set for July has since changed from 95% to 85.0%. Revised trajectories have been provided in M04 for the period August 2025 to April 2026. Updated actions have been provided for M08.

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-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	75.6%	41.8%	29.2%	56.8%	60.2%	77.2%	79.4%	81.4%	75.6%	67.9%	71.9%	88.4%	97.3%
Trajectory	80.0%	90.0%	95.0%	56.8%	70.0%	80.0%	70.0%	80.0%	85.0%	90.0%	70.0%	75.0%	78.0%

Actions:

- Piloting Tunstall CAMHS working 8-8 Monday to Friday. **M08 progress update:** *Engagement with staff has taken place and there is a keen interest in working 8-8 and this will start in January 2026. This will be for 6 months and if all works well the plan will be to roll out across all Core CAMHS.*
- Continue to offer additional hours to support initial assessments before 9am and after 5pm in the evening. M08 progress update: *Continue to offer additional hours/OT with some uptake to complete initial assessments which could be completed in the evenings and at weekends.*
- Effective management of absences**. M08 progress update**: *Supporting attendance at work Policy is followed. Monthly report is sent from HR to service managers to review. Service Line in month sickness as of 31st November was 1.13%, a further decrease from 1.24%.*
- Contacts to be recorded on Lorenzo in a timely manner. **M08 progress update**: *Teams leads scrutinising weekly unset appointment data and taking appropriate action. Report is then sent to service manager to review.*

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

Community directorate

Oct-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	456	43	3	4	506	90.1%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	25	2	0	0	27	92.6%
North Stoke CAMHS	41	6	1	0	48	85.4%
South Stoke CAMHS	10	1	0	0	11	90.9%
CAMHS Total	**76**	**9**	**1**	**0**	**86**	**88.4%**

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	6	0	0	0	6	100.0%
North Stoke CAMHS	7	1	0	0	8	87.5%
South Stoke CAMHS	13	1	0	1	15	86.7%
CAMHS Total	**26**	**2**	**0**	**1**	**29**	**89.7%**

Nov-25

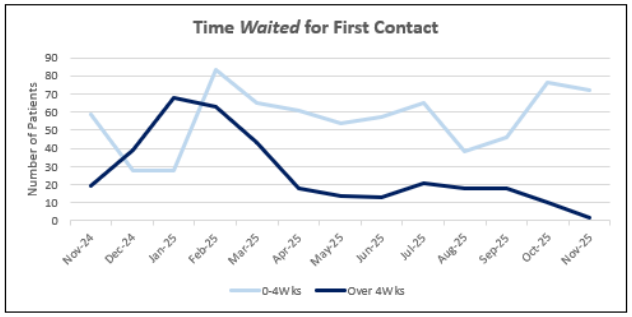
RTA Waited

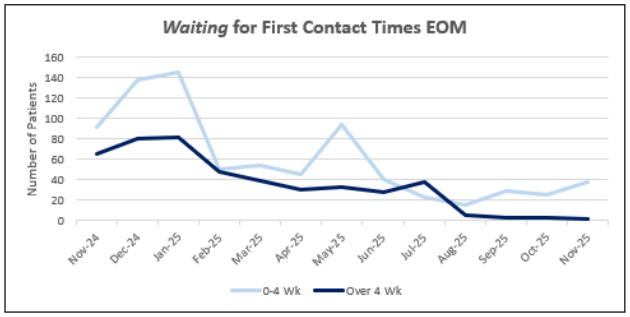
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	484	21	4	3	512	94.5%

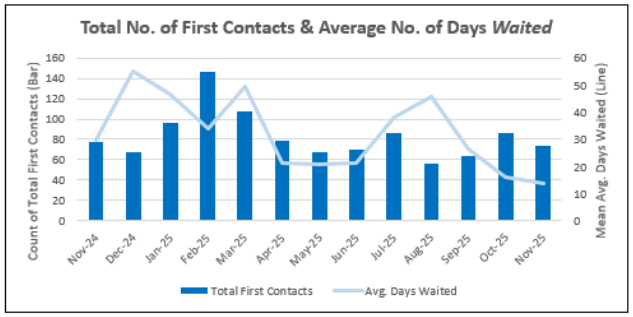
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	26	0	0	0	26	100.0%
North Stoke CAMHS	19	1	0	0	20	95.0%
South Stoke CAMHS	27	1	0	0	28	96.4%
CAMHS Total	**72**	**2**	**0**	**0**	**74**	**97.3%**

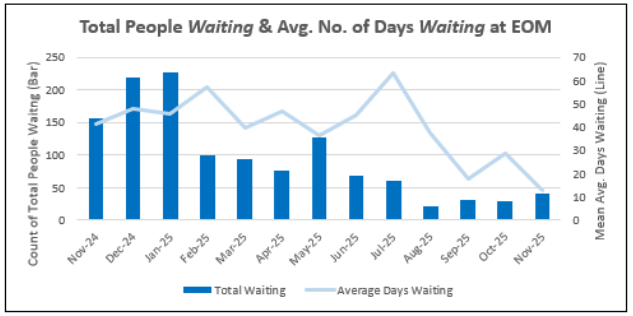
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	8	0	0	0	8	100.0%
North Stoke CAMHS	23	0	1	0	24	95.8%
South Stoke CAMHS	7	1	0	0	8	87.5%
CAMHS Total	**38**	**1**	**1**	**0**	**40**	**95.0%**





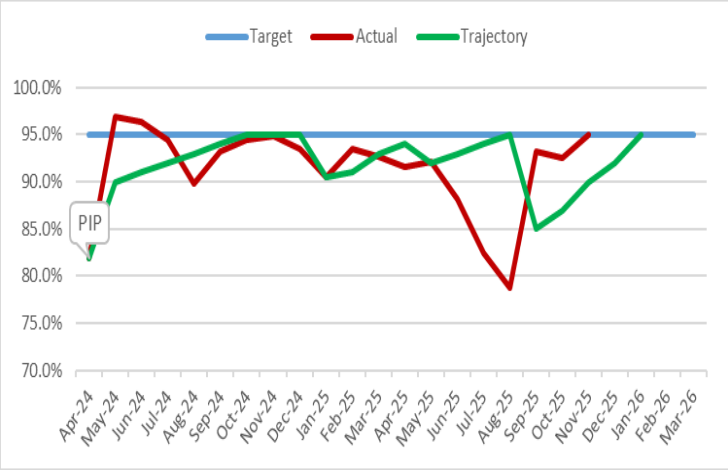




- The Community directorate's referral to assessment (RTA) performance had an increase of 4.4% when comparing M07 to M08, RTA performance against standard is slightly below target by 0.5%.
- Adult and Core CAMHS CMHTs had both met standard in M08 achieving 95% and 97.3%, respectively.
- Core CAMHS CMHTs have significantly improved their RTA performance with the achievement of 97.3% being the highest that we have on record for the service.

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

Community directorate



A PIP was issued in M01 (2024/25).

M08 performance is 95.0% which is exceeding the 90.0% planned trajectory and is meeting the required standard.

The aim is for the standard to be met in May 2025; this has been revised to August 2025 and January 2026. New trajectories have been updated in M01 for the period May 2025 to August 2025. Updated actions have been provided for M08.

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	94.9%	93.5%	90.5%	93.5%	92.7%	91.6%	92.1%	88.2%	82.5%	78.8%	93.2%	92.5%	95.0%
Trajectory	95.0%	95.0%	90.5%	91.0%	93.0%	94.0%	92.0%	93.0%	94.0%	95.0%	85.0%	87.0%	90.0%

Actions:

- Schedule more appointments with GP trainees to complete outstanding Standard Assessment Framework components. **M08 progress update:** *All CMHTs continue to utilise GP trainees as required.*
- Timely on-boarding of Newly Qualified Nurses to enable new starters to support with demand and assessment capacity. **M08 progress update:** *All NQN's now allocated team leads to work with individuals regarding start dates and team induction. NQNs are due to join the Sutherland Centre and Lymebrook from January 2025.*
- Deep dive and review of DNA's and adherence to the DNA Standard Operating Procedure. **M08 progress update:** *Directorate to work with performance team to obtain DNA reports to support this work.*
- Review of adherence to the triage and Initial Assessment pathway at Sutherland Centre. **M08 progress update:** *The triage process continues to have a positive impact, with referrals being reviewed daily, with good attendance from a range of disciplines. The team continue to look at ways to improve this and are looking at ways to improve relationships with GP partners to support their knowledge and improve the quality of referrals. This continues to support improved compliance with the 4WW target.*
- Effective management of absences. **M08 progress update:** *Team leader absences continue to present challenges within the teams, with Clinical Leads and Deputy Team Leads providing cover and support. Absence continues to be managed in accordance with policy across the CMHTs.*
- Review current team structures and manage resources across all CMHT's. **M08 progress update:** *The single assessment framework (SFA) waitlist at the Sutherland Centre remains at approximately 12 weeks having been stable for the last few months, patients are being seen within the 18 weeks RTT target. The Clinical Lead is actively allocating work across the team to manage demand, and contact is made with patients who are on the waitlist every two weeks. At Lymebrook, the SAF waitlist is currently around 22 weeks. The Clinical Lead is actively allocating work across the team to manage demand with reviews of caseload numbers being undertaken. It is hoped that the additional NQNs allocated to LBC will support with demand.*

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

Community directorate

Oct-25

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	456	43	3	4	506	90.1%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	26	2	0	0	28	92.9%
City CMHT - Sutherland	27	3	1	0	31	87.1%
County CMHT Moorlands	32	0	0	0	32	100.0%
County CMHT Newcastle	63	2	1	3	69	91.3%
CMHT Total	**148**	**7**	**2**	**3**	**160**	**92.5%**

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	11	0	0	0	11	100.0%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	0	1	0	0	1	0.0%
CMHT Total	**18**	**1**	**0**	**0**	**19**	**94.7%**

Nov-25

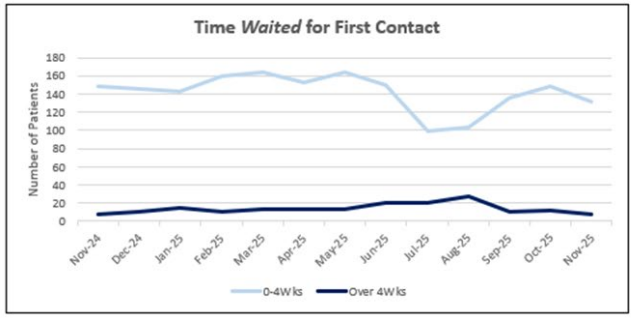
RTA Waited

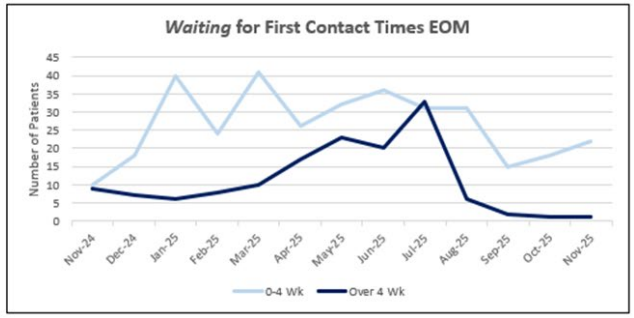
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	484	21	4	3	512	94.5%

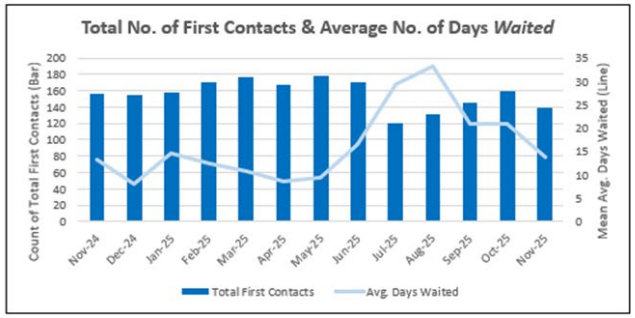
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	16	0	1	0	17	94.1%
City CMHT - Sutherland	40	2	1	0	43	93.0%
County CMHT Moorlands	30	0	0	0	30	100.0%
County CMHT Newcastle	46	1	1	1	49	93.9%
CMHT Total	**132**	**3**	**3**	**1**	**139**	**95.0%**

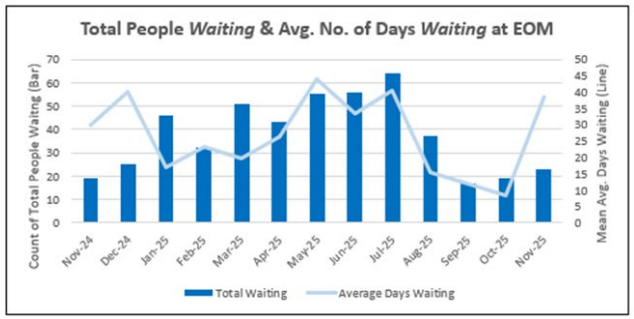
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	12	0	0	0	12	100.0%
City CMHT - Sutherland	8	0	0	1	9	88.9%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	2	0	0	0	2	100.0%
CMHT Total	**22**	**0**	**0**	**1**	**23**	**95.7%**





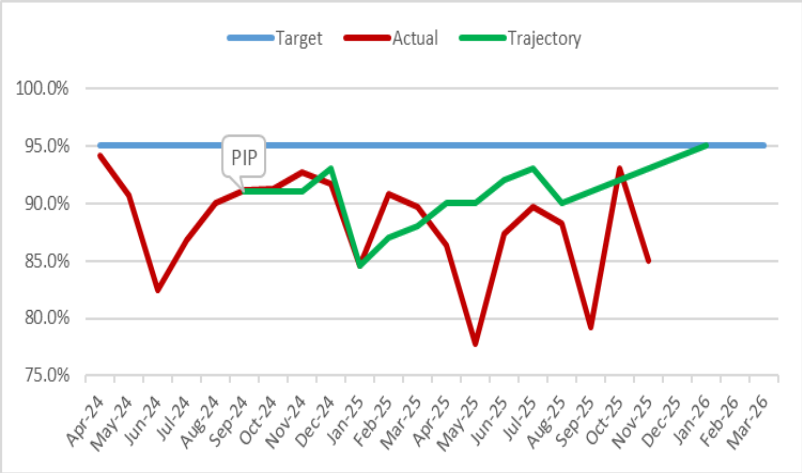




- Adult CMHT services are a main driver for the directorates referral to assessment (RTA) performance, making up 27% of the total RTAs completed in M08.
- RTA performance for Adult CMHTs has met standard in M08, achieving 95% against a target of 95%.

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

Specialist Services directorate



A voluntary PIP was issued in M06 (2024/25).

M08 performance is 85.0%. Performance is not meeting the planned 93.0% trajectory or required standard.

The aim is for the standard to be achieved by August 2025 this has been extended to January 2026. Trajectories have been revised for the period August to January 2026.

Updated actions have been provided in M08.

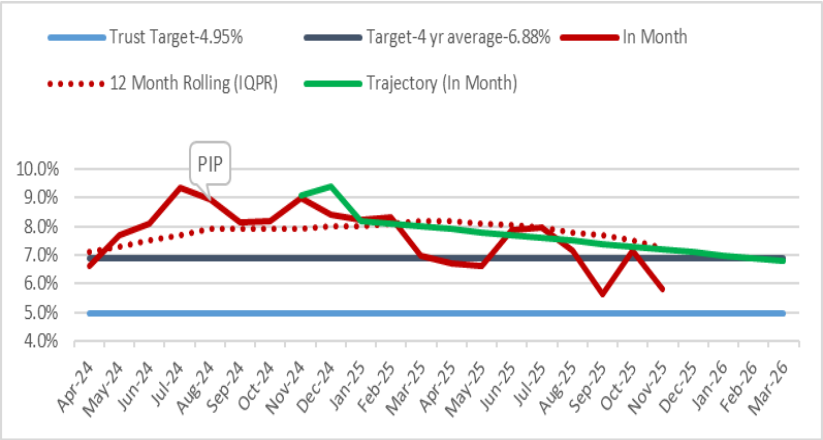
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	92.7%	91.7%	84.6%	90.8%	89.7%	86.3%	77.8%	87.3%	89.7%	88.2%	79.2%	93.0%	85.0%
Trajectory	91.0%	93.0%	84.6%	87.0%	88.0%	90.0%	90.0%	92.0%	93.0%	90.0%	91.0%	92.0%	93.0%

Actions:

- Weekly referral to assessment (RTA) review to be relaunched with new lead. **M08 progress update**: *Weekly meetings and relaunched performance clinics commenced in September, both with an RTA focus due to challenges over the last 18 months. This is in place and as business as usual (BAU) but capacity and issues that are beyond the directorates control i.e. patients that are transferred from other services will remain.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care directorate



A PIP was issued in M03 (2024/25).

Provisional sickness absence figures for M08 are in-month 5.81%, 12-month rolling period is 7.23%.

Performance is meeting the in-month trajectory (7.20%) and 4-year average (6.88%).

The aim is for the 4-year average to be met by March 2026. The focus for this PIP is on the in-month sickness position and trajectory to return to the 4-year average. Updated actions have been provided in M08.

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-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	8.98%	8.41%	8.24%	8.32%	6.99%	6.69%	6.64%	7.89%	7.96%	7.15%	5.64%	7.18%	5.81%
12 Month Rolling (IQPR)	7.90%	8.00%	7.99%	8.09%	8.17%	8.18%	8.09%	8.07%	7.95%	7.80%	7.69%	7.53%	7.23%
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%	7.30%	7.20%

M08 Position:

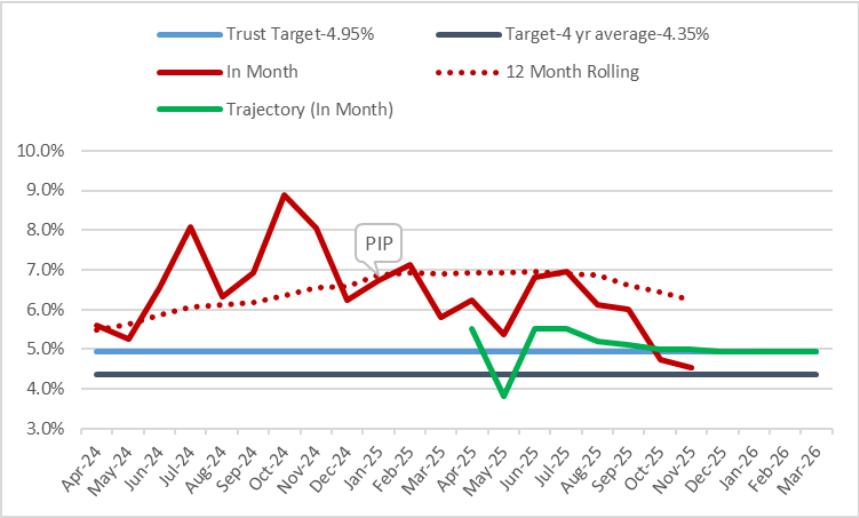
- In-month second lowest in 12 months, below trajectory and 4-year average target.
- Rolling 12 month – lowest recorded in over 12 months, at trajectory.

Actions:

- **Workforce clinics:** Matrons and service managers continue attending clinics to monitor sickness absence. Reviews occur from team to directorate level. **M08 progress update:** *Plan to integrate into business as usual in the new year.*
- **Leadership Development Programme:** Programme now delivered as face-to-face HR surgeries. Well attended by all grade leaders, with positive feedback. **M08 progress update:** *To continue with this provision with ongoing evaluation.*
- **Wellbeing Champions:** Reviewing current numbers and continuing to promote roles across all teams**. M08 progress update:** *To monitor and review as part of the health, safety and wellbeing group.*
- **Staff Survey Plan:** 2025/26 implementation plan in progress. **M08 progress update:** *All service lines have identified their 3 focus areas which are updated monthly. Actions aligned to the people promise.*
- **Targeted support:** Psychological and musculoskeletal (MSK) support programmes to be piloted across the directorate. **M08 progress update:** *Psychological support programme starting with Ward 3.MSK clinics still pending.*
- **Vacancy and turnover reduction:** Recruitment and retention plan delivering results. **M08 progress update:** *Ongoing improvement across the directorate with vacancy rate below target for 5 consecutive months and turnover below target for 6 consecutive months.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Primary Care directorate



A PIP was issued in M10 (2024/25).

Provisional M08 performance is 4.52% in-month and 6.24% within a 12-month rolling period. The focus for this PIP is on the in-month sickness position and trajectory to return to the 4-year average.

The required in-month standard has been met based on the provisional data. The 12-month rolling average has been met. The (5.00%) trajectory has been met. The 4-year average has not been met.

Updated actions have been received in M08.

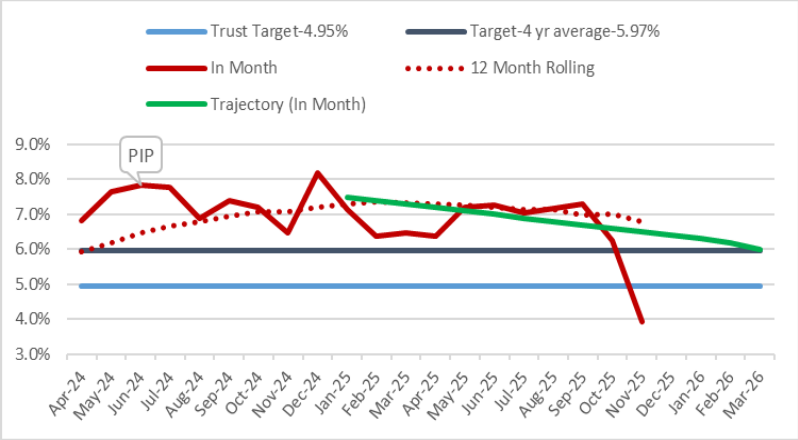
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%
In Month	8.06%	6.24%	6.72%	7.14%	5.79%	6.22%	5.37%	6.81%	6.95%	6.11%	6.00%	4.75%	4.52%
12 Month Rolling	6.54%	6.59%	6.88%	6.92%	6.89%	6.94%	6.93%	6.96%	6.89%	6.86%	6.61%	6.43%	6.24%
Trajectory (In Month)						5.50%	3.80%	5.50%	5.50%	5.20%	5.10%	5.00%	5.00%

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. **M08 progress update***: Actions from the staff survey / people plan work continues to be implemented within talking therapies stoke, focused on the key people promise theme, 'we are safe and healthy.' improving wellness at work, wellbeing and prevention of staff being absent due to anxiety, stress and depression. People business partner (PBP) carried out deep dive analysis of primary care with highest frequent short term sickness absences and open ended / continuous sickness absence - This has confirmed talking therapies (TT) and GP practices as key priority areas and identified interventions, such as OH referrals, in line with supporting attendance at work policy.*
- Supporting attendance at work clinics held with all line managers. **M08 progress update**: *Associate director continues to work closely with the PBP, both continue to attend the clinics; and the service manager has been added too for oversight and leadership. Supporting attendance at work LMS training compliance has been reviewed, and an action assigned to managers to complete this due to low uptake. Staff support and counselling services to carry out stress first aid for GP practices reception staff in January 2026. PBP arranged for sickness episodes and open-ended continuous sickness absence reports to be sent to associate director (AD) monthly to give oversight and to support with holding managers to account at the clinics. PBP drafted a communication (including resources on CAT) regarding wellness at work, wellbeing prevention and sickness absence management outlining managers responsibilities and this will inform a draft agenda for the clinics.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Specialist Services directorate



A PIP was issued in M03 (2024/25). The focus for this PIP is on the in-month sickness position and trajectory to return to the 4-year average.

Provisional M08 in-month performance is 3.92% and 6.79% within a 12-month rolling period. The in-month trajectory (6.50%) is being met. The <4.95% standard is being met.

The current PIP trajectory aims for performance to be at 5.97% by March 2026. The updated trajectory brings the sickness rate back to the 4-year average position of 5.97%, which is higher than the <4.95% required standard. This shows volatility in the in-month position for the directorate.

Updated actions have been provided in M08.

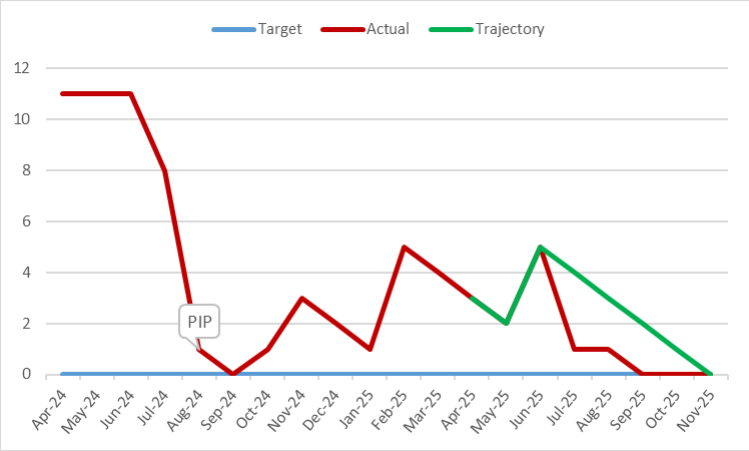
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%	5.97%
In Month	6.46%	8.20%	7.13%	6.37%	6.48%	6.38%	7.21%	7.26%	7.03%	7.17%	7.29%	6.24%	3.92%
12 Month Rolling	7.07%	7.22%	7.30%	7.37%	7.33%	7.30%	7.26%	7.22%	7.15%	7.15%	7.00%	7.01%	6.79%
Trajectory (In Month)			7.50%	7.40%	7.30%	7.20%	7.10%	7.00%	6.90%	6.80%	6.70%	6.60%	6.50%

Actions:

- Trust people plan highlights sickness as a targeted objective. Directorate engagement session with regards sickness completed on 17 November 2025 facilitated by people business partner. **M08 progress update:** *Actions plan being formulated and monitored in directorate quality forum going forward.*
- 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. **M08 progress update:** *Sickness now established 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 and then to July 2025.

During M08 there are no complaints exceeding the 40-day response timescale. Performance has met the planned trajectory and required standard for the third consecutive month.

Updated actions have been received for M08.

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

Update in M08

The team and complaints process is benefiting from having the fixed term position for the Complaints manager filled. New processes are embedded and working well

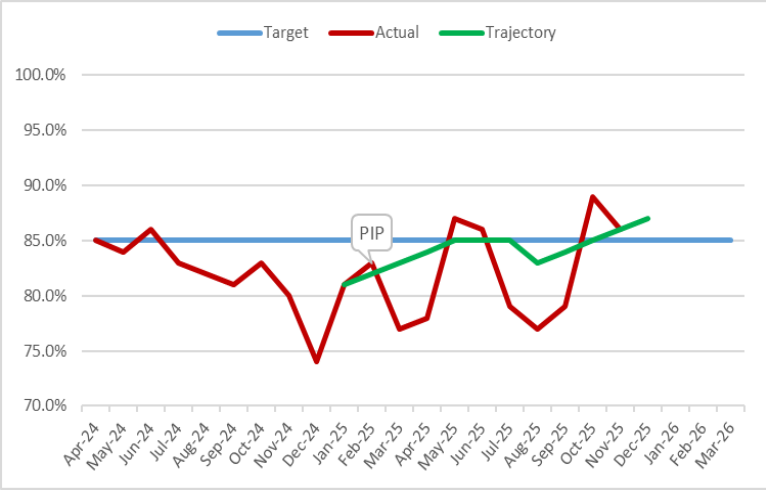
Actions:

These are carried forward in M08:

- 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. **M08 progress update:** monthly QILN and PET interface meeting is going well and supporting early resolution.
- Parallel processes: Recognised the need for 'on hold' when complaints overlap with patient safety incident investigation (PSII), safeguarding, or other processes. **M08 progress update**: Agreed to develop a process to ensure triangulated, consistent responses which will be taken to the clinical safety improvement group (CSIG), where a dashboard linking incidents, complaints, and safeguarding is in development.

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Community directorate



A PIP was issued in M10 (2024/25).

M08 performance is 86.0% and is meeting the planned 85.0% trajectory and required standard.

The aim was for the standard to be met in May 2025; this has been revised to September 2025, October 2025 and December 2025. Trajectories have been extended for the period August to December 2025. Trajectories have been reset in M06 for the period September to December 2025.

Updated actions have been provided for M08.

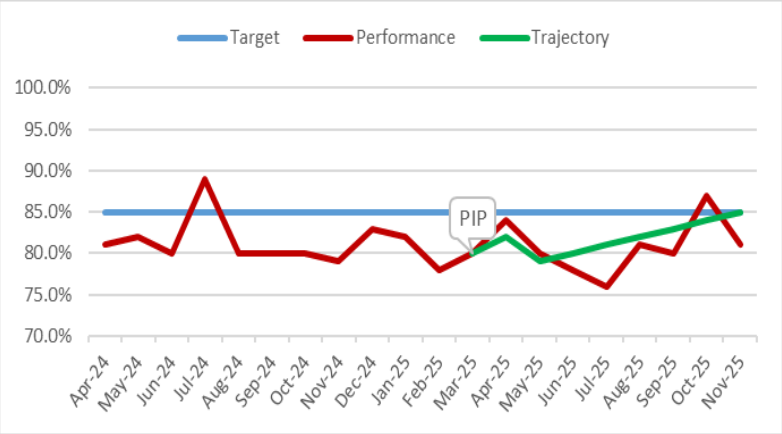
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Actual	80.0%	74.0%	81.0%	83.0%	77.0%	78.0%	87.0%	86.0%	79.0%	77.0%	79.0%	89.0%	86.0%
Trajectory			81.0%	82.0%	83.0%	84.0%	85.0%	85.0%	85.0%	83.0%	84.0%	85.0%	86.0%

Actions:

- Daily review of supervision compliance and reminders sent to staff who are non-compliant. **M08 progress update:** *On-going - e-mails sent to all individuals during November who have consistently shown non-compliance for an eight-week period.*
- Comms related to the changes to the recording requirement circulated across the Directorate. **M08 progress update:** *Supervision report is now a standing agenda item in all monthly service line meetings. Reminders/prompts within service line meetings/senior team catch-ups and 1-1 sessions.*
- Regular data cleansing to ensure accuracy of records complete and accurate. **M08 progress update**: *Data cleanse of the reports sent on a two weekly basis is now business as usual.*

Performance Improvement Plan: Clinical Supervision (Trust indicator)

Acute and Urgent Care directorate



A PIP was issued in M12 (2024/25).

M08 performance is 81.0%, which is not meeting the planned 85.0% trajectory or required standard.

The aim was for the standard to be met in May 2025 this has been extended to November 2025.

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

Updated actions have been provided in M08.

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-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	79.0%	83.0%	82.0%	78.0%	80.0%	84.0%	80.0%	78.0%	76.0%	81.0%	80.0%	87.0%	81.0%
Trajectory					80.0%	82.0%	79.0%	80.0%	81.0%	82.0%	83.0%	84.0%	85.0%

M08 Position:

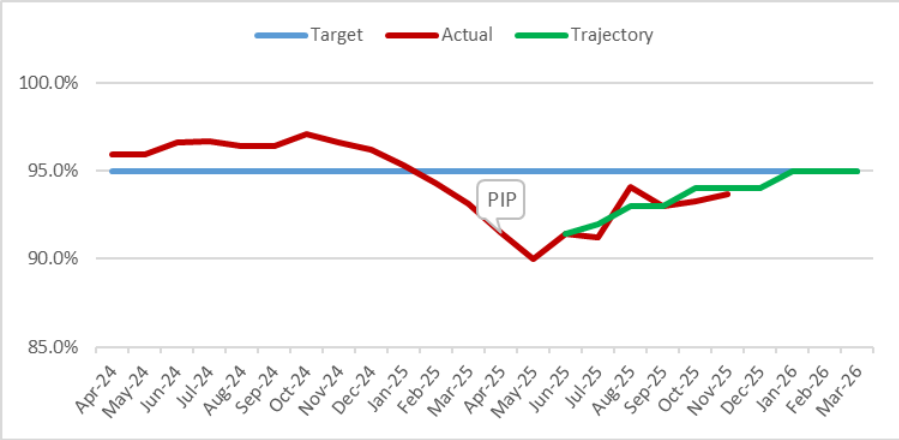
- At the end of the month, compliance stands at 81%, however this fluctuates each day. The number of staff recorded as eligible for supervision is much lower than the headcount. The Learning Management System (LMS) is currently under review. It is important to note that there are known data integrity issues within LMS
- Across the directorate, services remain under significant pressure, with high acuity and demand. Clinical priorities will continue to take precedence.

Actions:

- Ensure LMS staffing lists are accurate and up to date: Senior leadership teams are reviewing their staffing establishments to identify any missing staff names. **M08 Update**: *Data validity and accuracy within the LMS remain a concern. Current reporting reflects a single point in time only. Monitoring continues at team level and through leadership workforce and performance clinics.*
- Maintain oversight of clinical supervision for all staff: Clinical supervision for registered and non-registered continues to be monitored at team level, with escalation to directorate oversight and monthly workforce clinics. **M08 Update:** *Reporting challenges persist due to LMS data integrity issues. Monitoring remains in place through established governance routes.*
- Improve CRHTT supervision compliance: CRHTT is reviewing its supervision structure to ensure full utilisation of team members in delivering effective clinical supervision. **M08 Update:** *Timescales have been extended; however significant improvement being seen.*
- Engage with people and OD on system improvements: Continue collaboration with People and OD to explore options for improving recording and reporting of clinical supervision.

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services directorate



A PIP was issued in M01 (2025/26) and trajectories were set in M03. The aim is for the standard to be achieved by October 2025 this has been extended to January 2026. Trajectories have been reset for the period September to January 2026.

Performance in M08 is 93.7% and is not meeting the planned 94.0% trajectory or required standard.

Updated actions have been provided in M08.

tp	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-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	96.6%	96.2%	95.3%	94.3%	93.1%	91.5%	90.0%	91.4%	91.2%	94.1%	93.0%	93.3%	93.7%
Trajectory								91.4%	92.0%	93.0%	93.0%	94.0%	94.0%

Actions:

- LD services - Wider engagement within teams to be promoted and ensure that attendance at performance clinics is prioritised. **M08 progress update:** *LD teams describe a significant increase in workload and concerns regarding care planning not meeting needs of the service. Meeting with Nursing & Quality Directorate/ Digital taking place (arranged for January) to fully understand the impact of the new expectations as reports are that services workload has significantly increased since new care planning process.*
- Neuropsychiatry & Psychology - Review of triage process in light of the care plan changes as there may be the potential to triage patients differently. Additional support to be offered to the team regarding move to new care planning pathway. **M08 progress update:** *Performance issues continue to be identified within the team and are reviewed in performance clinics. It is noted that this is an ongoing piece of work and will link to action above.*

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

Acute and Urgent Care and Community directorates

A PIP was issued in M04 (2025/26).

M08 performance of the number of inappropriate OOAs during month is 20, number of inappropriate OOAs at EOM (national measure) is 17. Revised figures excluding Cygnet Kidsgrove placements are reported in the IQPR, as these are now deemed to be local and appropriate.

Updated actions have been provided for M08.

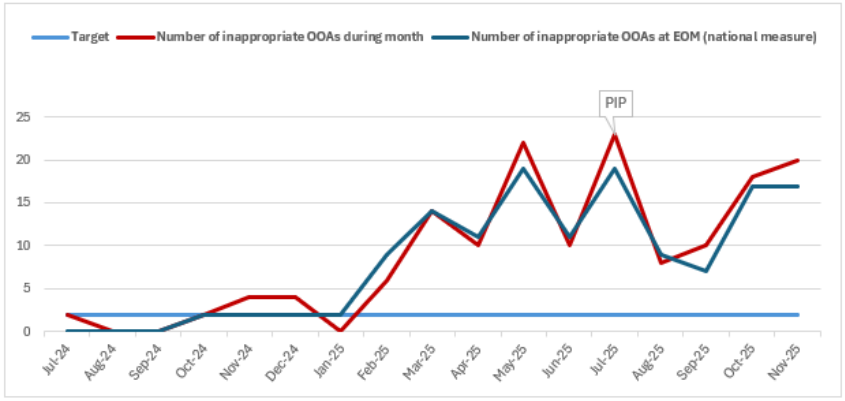
	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Target	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Number of inappropriate OOAs during month	2	0	0	2	4	4	0	6	14	10	23	15	29	10	16	19	25
Number of inappropriate OOAs during month - REVISED	2	0	0	2	4	4	0	6	14	10	22	10	23	8	10	18	20
Cygnet Kidsgrove Placements												*5*	*6*	*2*	*6*	*1*	*5*
Number of inappropriate OOAs at EOM (national measure)	0	0	0	2	2	2	2	9	14	11	19	16	22	12	17	24	19
Number of inappropriate OOAs at EOM (national measure) - REVISED	*0*	*0*	*0*	2	2	2	2	9	14	11	19	11	19	9	7	17	17
Cygnet Kidsgrove Placements												*5*	*3*	*3*	*10*	*7*	*2*

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

AUCD M08 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.

- CRFD for Acute Adults remained at 7 across the month, with 3 currently CRFD in OOA placements.
- Length of Stay (LoS) remains below the national average.
- Reduced in bed stock is a key factor in ongoing evaluations, alongside rising demand at front-door services.



AUCD Ongoing Actions:

- Daily monitoring of OOA provision by AUCD
- Patients reviewed in daily 12:30 bed flow meetings.
- Weekly oversight meetings with ICB, CMHT's and local authorities
- AUCD attend all ward reviews for patients without a CMHT involvement; CMHT attends for their patients
- CMHT attend ward reviews for their patients
- OOA/CRFD Oversight Group established

AUCD actions:

- **Length of Stay** – maintain average length of stay (LoS) for new adult acute admissions at the lower end of our current range (20–30 days) compared to the national average of 40 days. **M08 progress update:** *Average LoS remains below national target. LoS for OOA placements is also monitored and remains below national average.*
- **CRHTT** – assess Crisis Resolution Home Treatment Team's ability to ensure clinically appropriate gatekeeping and determine if additional demand can be absorbed to reduce avoidable admissions and support care closer to home. **M08 progress update:** R*eview completed. The team cannot take on additional capacity as they are required to manage the routine work that needs to be transferred to Community CMHT's when their capacity allows. This action is underway between CRHTT and CMHT's.*
- **Care pathways for admission** – strengthen cross-directorate collaboration to review and streamline admission pathways for new and existing patients. This approach aims to improve efficiency, reduce delays, and ensure timely access to the right care in the right setting. **M08 progress update**: *Progressed by Nursing & Quality.*
- **Weekly multi-agency meetings** – ensure meetings with Rehabilitation Services, the Integrated Care Board (ICB), and Local Authority remain focused and productive, supporting effective decision-making on bed flow, CRFD status, and system pressures. Aim for timely escalation and coordinated action across the pathway. **M08 progress update:** *meetings continue to be effective with broader representation, including housing and other external stakeholders.*
- **Establish review panel** – create and OOA placement review panel to complement weekly acute bed management meetings.to complement the existing weekly acute bed management meetings. **M08 progress update:** *action completed. Oversight meeting commenced which now feeds into the Strategic Transformation Board and Quality Committee.*
- **Comprehensive reporting:** compile and submit a detailed report on OOA progress, challenges, and key metrics to Trust Executives and the Quality Committee**. M08 progress update:** *AUCD will continue to provide monthly detailed reports internally and an appropriate overview to the ICB to demonstrate recovery.*
- **Risk Management: e**nsure risks linked to OOA placements and bed pressures are recorded on the Trust Risk Register for visibility and timely mitigation. **M08 progress update*:*** completed.

  Risk 1957 score = 16 (OOA placement).
  Risk 2126 score = 12 (CRFD).

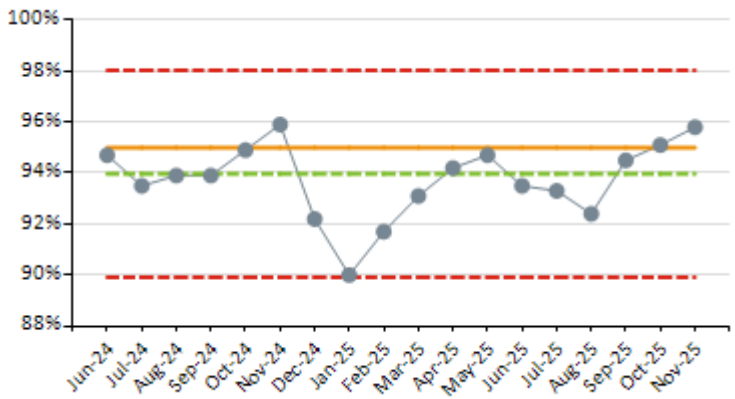
Community actions:

- **Pre-Discharge Engagement**: **M08 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. **M08 progress report:** *Links between CMHTs and the Crisis Resolution and Home Treatment Team (CRHTT) continue to strengthen, with teams attending the weekly urgent care interface to support rapid step-up care in the community. There is on-going work to understand the referrals made to CMHTs from CRHTT that have been declined, with a view to an interface meeting between Team Leads being introduced to further strengthen leadership links across the directorates. Away day took place in November 2025 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. **M08 progress update:** *CMHTs continue to actively work with service users and carers to co-produce robust crisis and contingency plans. Escalating patients to the weekly interface meeting if it is felt support from CRHTT is needed, to reduce the need for inpatient care and OOA beds.*
- **Allocation of Key Workers**: **M08 progress report:** *Key workers are being prioritised for all inpatients to support timely discharge planning, with CMHTs ensuring there is representation from the team at weekly ward reviews to facilitate timely discharge*
- **Identification of Patients for Repatriation: M08 progress report***: CMHTs continue to actively identify patients suitable for repatriation from OOA placements to local beds.*
- **Involvement of CMHTs in the discharge planning process** - CMHTs to work closely with OOAs on a clearly formulated care plan with identified SMART goals to facilitate discharge and reduce length of stay.
- **Review of CMHT involvement in the last 30 days prior to admission** - Address any early intervention gaps prior to admission identified in a review to reduce admissions (January 2026).
- **Review STR pathway** across the community services and urgent care, HTT to ensure the pathway between services offers consistent support for patients. Clarification of the role of the STR role to bolster support for patients to engage with the support available in a community (March 2026)
- **Review of CASTT involvement with Acute & Community patients -** review CAST involvement with patients diagnosed with PD who are admitted to OOA and involve CASTT in discharge planning for patients with a PD diagnosis to prioritise their allocation for appropriate interventions. **M08 progress report:** *CASTT Team Lead post now appointed to who will review input into the Acute Wards. Meeting has taken place with Clinical Director & Service leads to review current clinical model and caseload allocation. Overarching improvement action plan in place.*

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

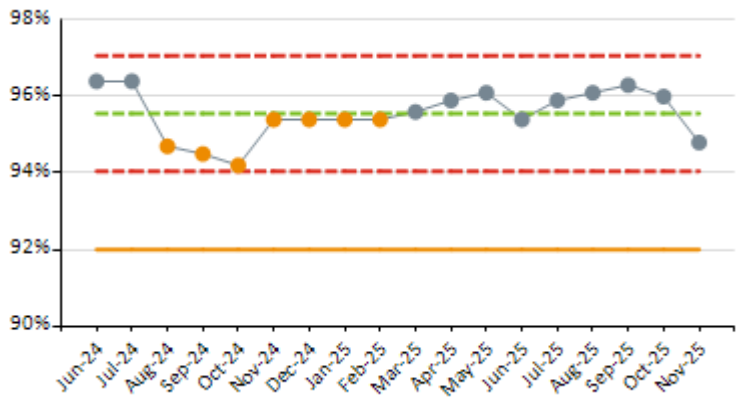
Referral to Assessment within 4 weeks (Trust Measure)



13 Month Trend

95.9%	92.2%	90.0%	91.7%	93.1%	94.2%	94.7%	93.5%	93.3%	92.4%	94.5%	95.1%	95.8%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

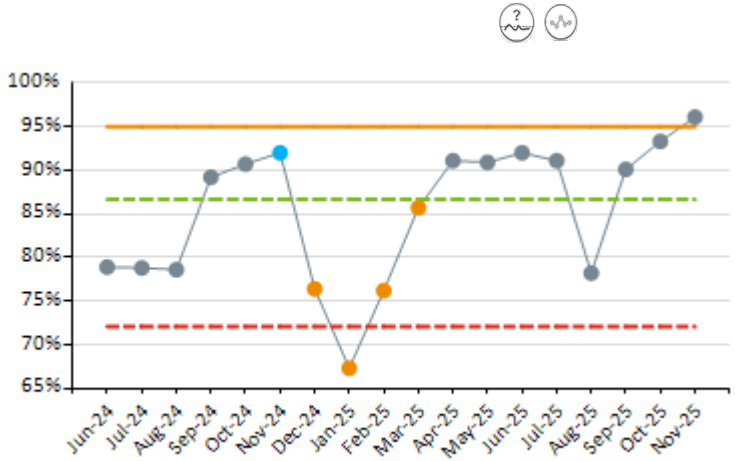
Referral to Treatment within 18 weeks (Trust Measure)



13 Month Trend

95.4%	95.4%	95.4%	95.4%	95.6%	95.9%	96.1%	95.4%	95.9%	96.1%	96.3%	96.0%	94.8%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

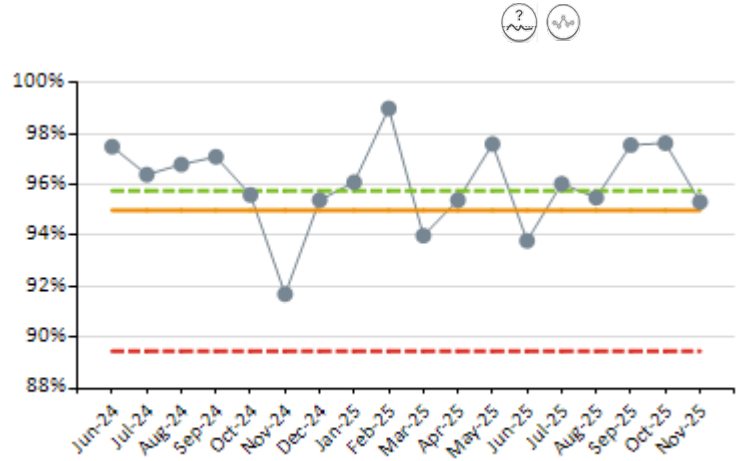
CAMHS Compliance within 4 week waits (Referral to Assessment) (Trust Measure)



13 Month Trend

92.0%	76.4%	67.3%	76.2%	85.7%	91.1%	90.9%	92.0%	91.1%	78.2%	90.1%	93.3%	96.1%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

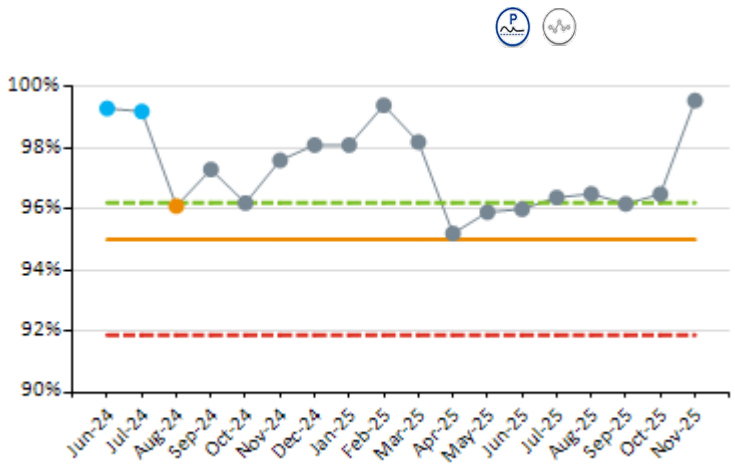
MH Liaison 4 Hour Response (Urgent) (Trust Measure)



13 Month Trend

91.7%	95.4%	96.1%	99.0%	94.0%	95.4%	97.6%	93.8%	96.0%	95.5%	97.6%	97.6%	95.3%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

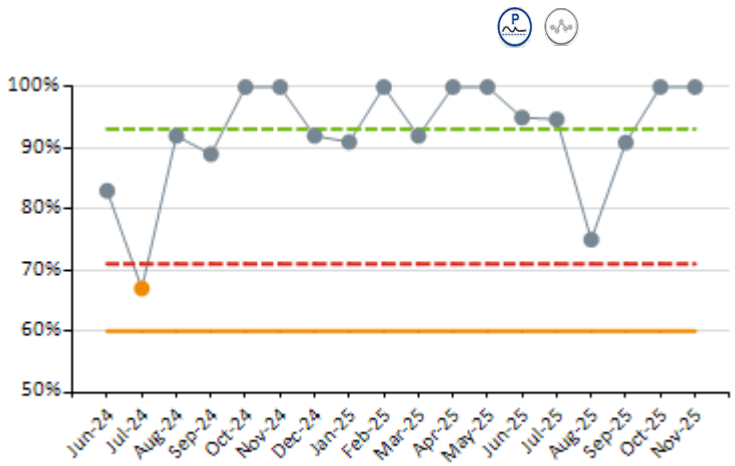
MH Liaison 24 Hour Response (Urgent from General Hospital Ward) (Trust Measure)



13 Month Trend

97.6%	98.1%	98.1%	99.4%	98.2%	95.2%	95.9%	96.0%	96.4%	96.5%	96.2%	96.5%	99.6%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

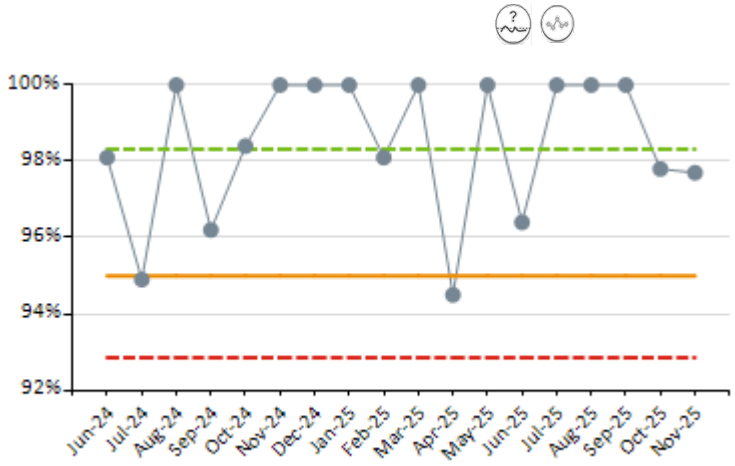
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment (National Measure)



13 Month Trend

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

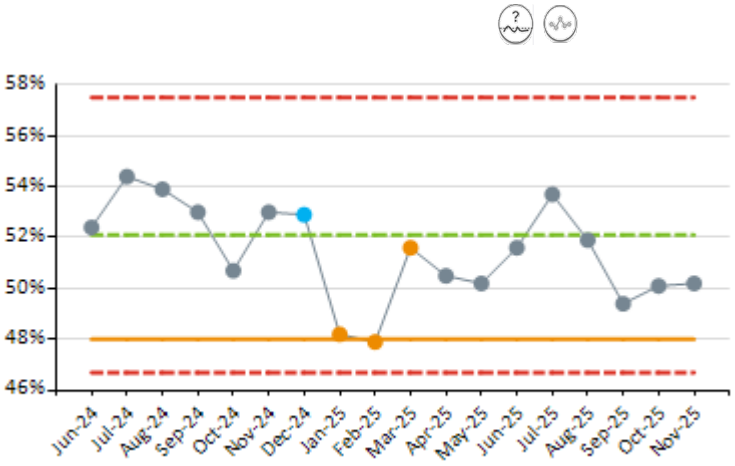
7 Day Follow Up (All Patients) (Trust Measure)



13 Month Trend

100.0%	100.0%	100.0%	98.1%	100.0%	94.5%	100.0%	96.4%	100.0%	100.0%	100.0%	97.8%	97.7%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

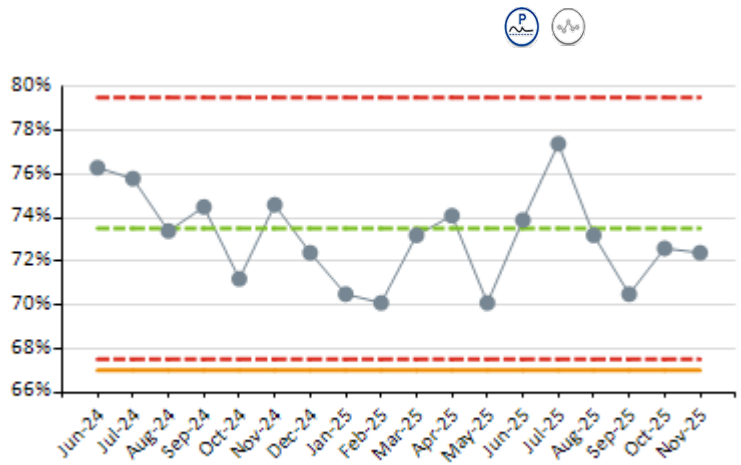
Talking Therapies for Anxiety and Depression: Reliable Recovery (National Measure)



13 Month Trend

53.0%	52.9%	48.2%	47.9%	51.6%	50.5%	50.2%	51.6%	53.7%	51.9%	49.4%	50.1%	50.2%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Talking Therapies for Anxiety and Depression: Reliable Improvement (National Measure)

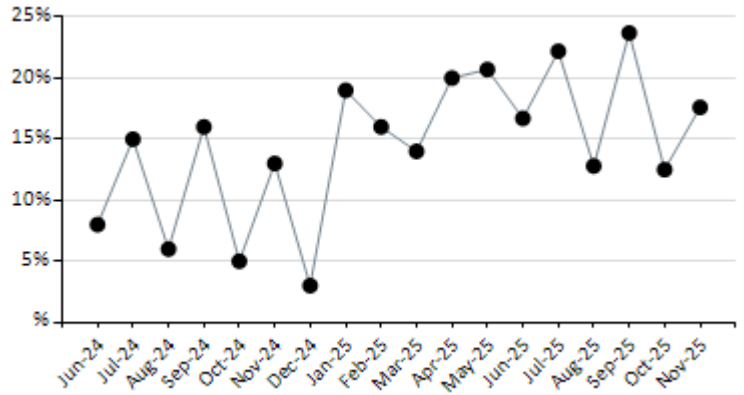


13 Month Trend

74.6%	72.4%	70.5%	70.1%	73.2%	74.1%	70.1%	73.9%	77.4%	73.2%	70.5%	72.6%	72.4%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Core Indicators – SPC Trend (Inpatient and Quality)

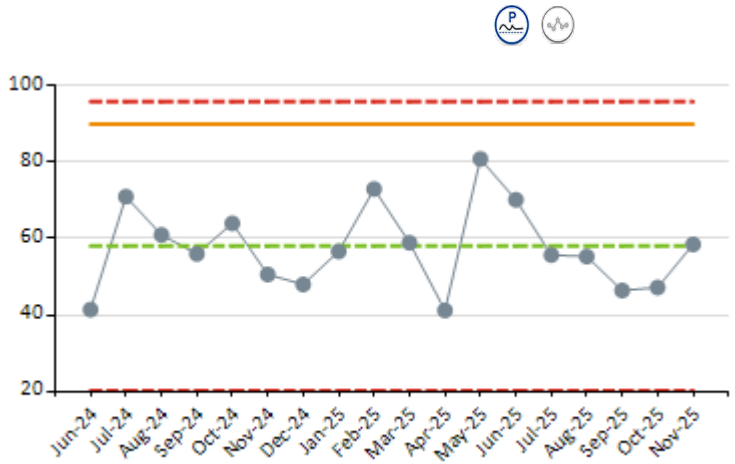
Adult Acute LoS-Over 60 days as a % of all discharges (National Measure)



13 Month Trend

13.0%	3.0%	19.0%	16.0%	14.0%	20.0%	20.7%	16.7%	22.2%	12.8%	23.7%	12.5%	17.6%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

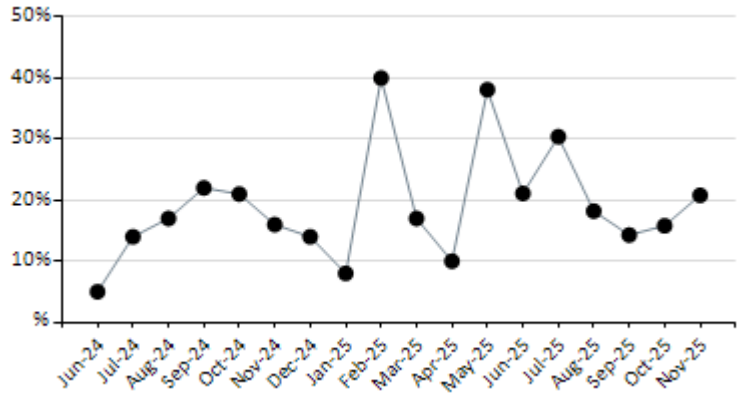
Average Length of Stay - Older Adult (National Measure)



13 Month Trend

50.6	48.0	56.6	73.0	58.9	41.2	80.9	70.2	55.7	55.3	46.4	47.2	58.5
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

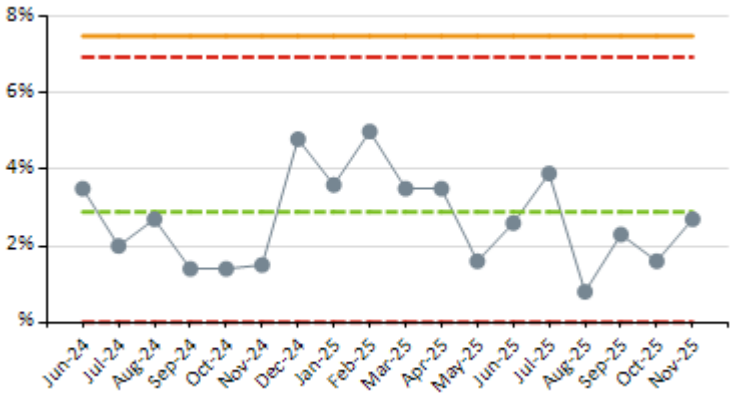
Older Adult Acute LoS-Over 90 days as a % of all discharges (National Measure)



13 Month Trend

16.0%	14.0%	8.0%	40.0%	17.0%	10.0%	38.1%	21.1%	30.4%	18.2%	14.3%	15.8%	20.8%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

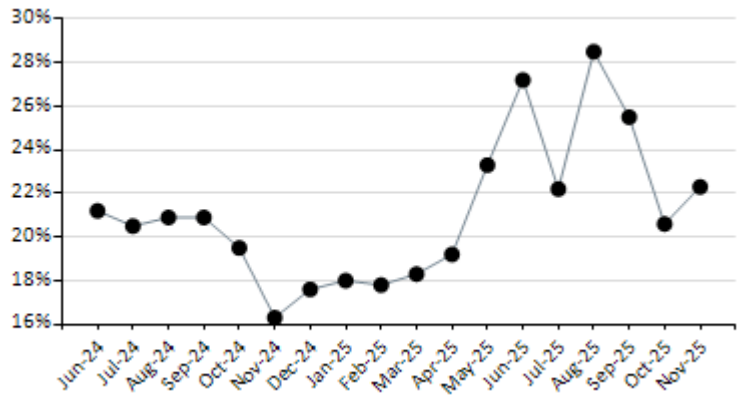
Emergency Readmissions rate (30 days) (Trust Measure)



13 Month Trend

1.5%	4.8%	3.6%	5.0%	3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Clinically Ready for Discharge (CRFD) (Trust Measure)

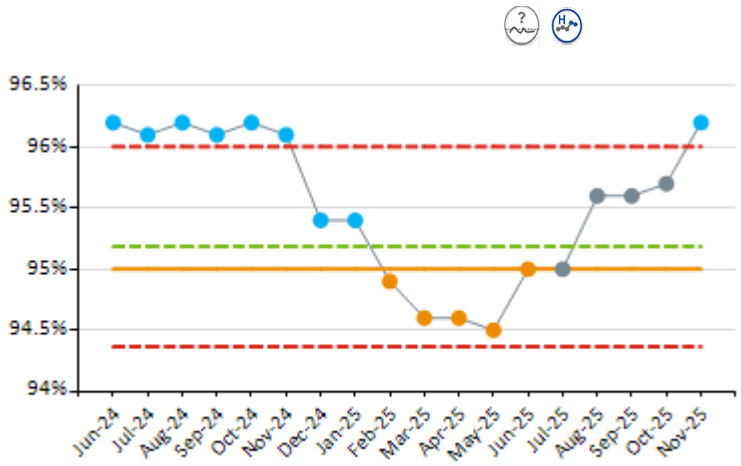


13 Month Trend

16.3%	17.6%	18.0%	17.8%	18.3%	19.2%	23.3%	27.2%	22.2%	28.5%	25.5%	20.6%	22.3%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Core Indicators – SPC Trend (Community and Quality)

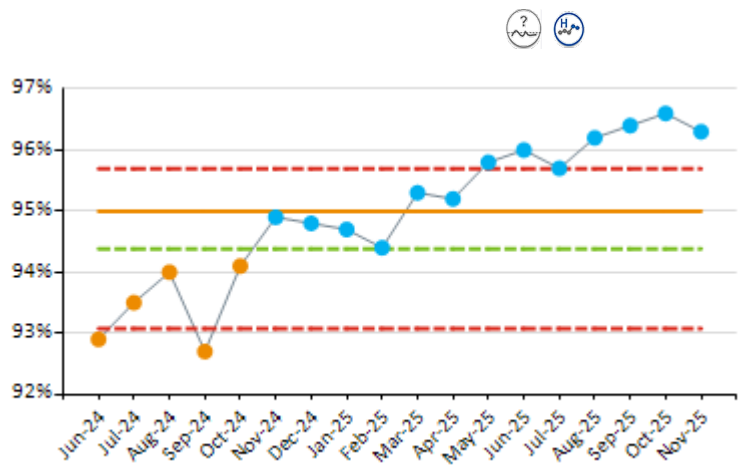
Care Plan Compliance (Trust Measure)



13 Month Trend

96.1%	95.4%	95.4%	94.9%	94.6%	94.6%	94.5%	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

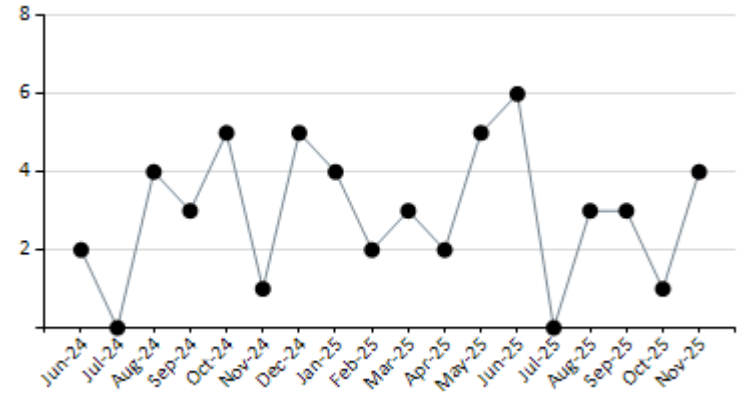
Risk Assessment Compliance (Trust Measure)



13 Month Trend

94.9%	94.8%	94.7%	94.4%	95.3%	95.2%	95.8%	96.0%	95.7%	96.2%	96.4%	96.6%	96.3%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

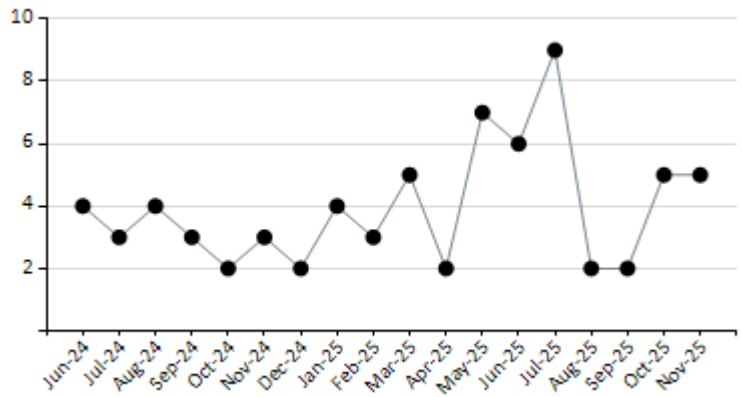
Comprehensive Safety Review (Trust Measure)



13 Month Trend

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

Proportionate Reviews (Trust Measure)

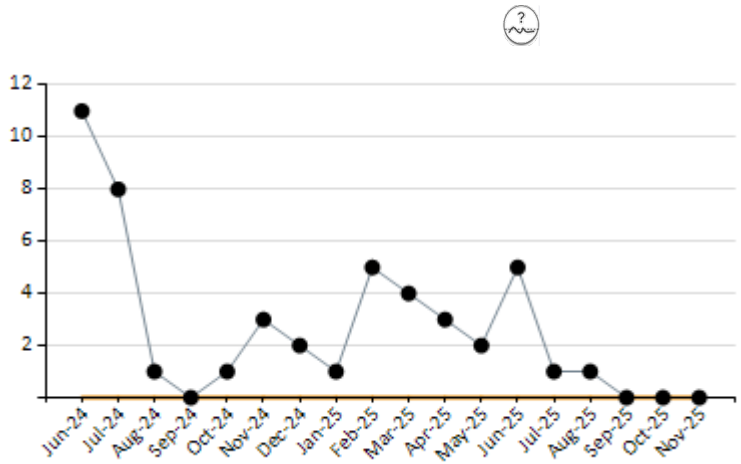


13 Month Trend

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

Core Indicators – SPC Trend (Organisational Health)

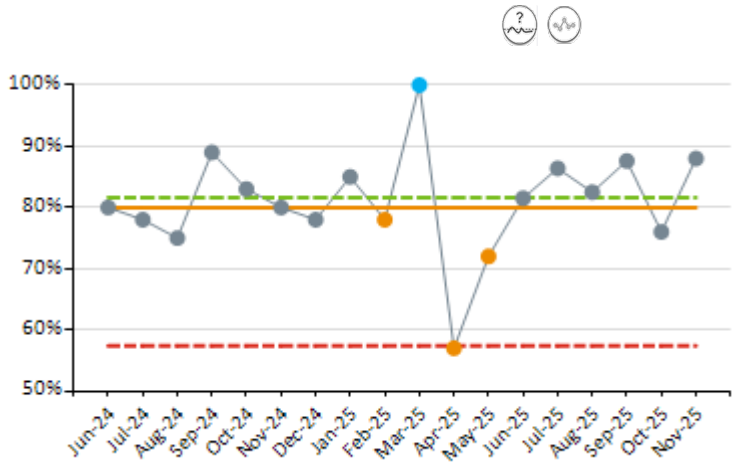
Complaints Open Beyond Agreed Timescale (Trust Measure)



13 Month Trend

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

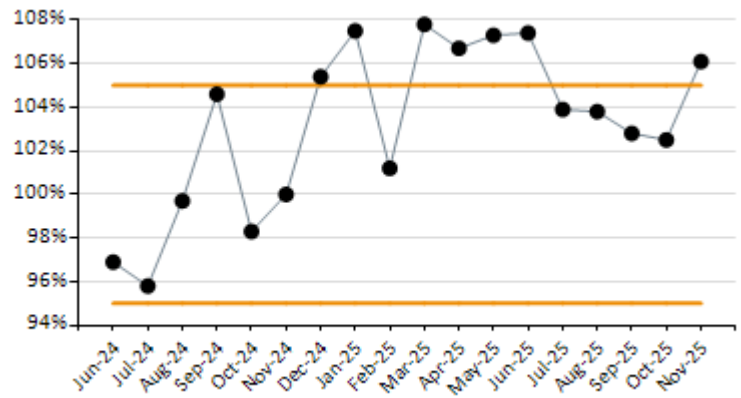
Friends and Family Test - Recommended (Trust Measure)



13 Month Trend

80.0%	78.0%	85.0%	78.0%	100.0%	57.0%	72.0%	81.5%	86.4%	82.5%	87.6%	76.0%	88.0%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Safe Staffing (National Measure)

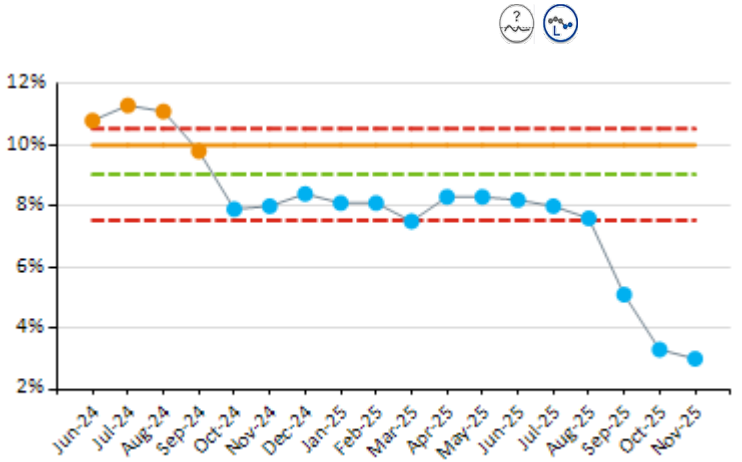


There are 8 inpatient wards whose overall fill rate exceeds target during M08. Further exploration of the following ward staffing fill rate is being explored although it is associated with acuity.
Ward 1-116.9%,
Ward 2-113.7%,
Ward 3-112.9%

13 Month Trend

100.0%	105.4%	107.5%	101.2%	107.8%	106.7%	107.3%	107.4%	103.9%	103.8%	102.8%	102.5%	106.1%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

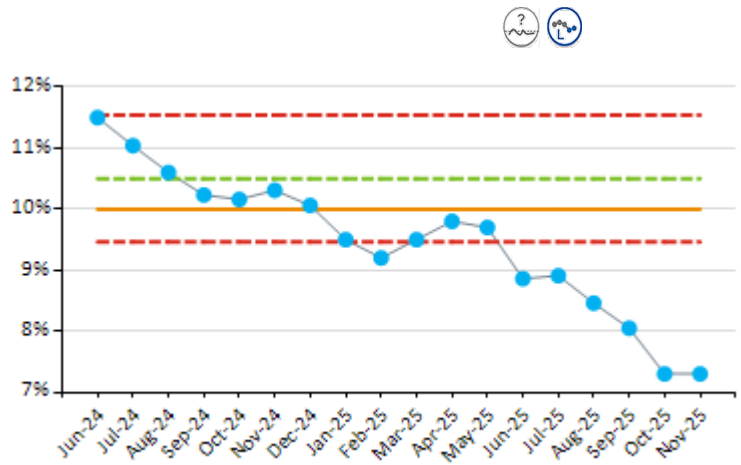
Vacancy Rate (Trust Measure)



13 Month Trend

8.0%	8.4%	8.1%	8.1%	7.5%	8.3%	8.3%	8.2%	8.0%	7.6%	5.1%	3.3%	3.0%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

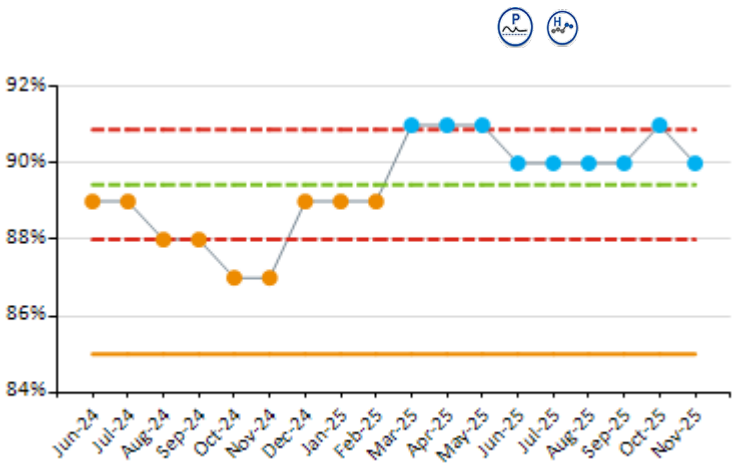
Staff Turnover (Trust Measure)



13 Month Trend

10.3%	10.1%	9.5%	9.2%	9.5%	9.8%	9.7%	8.9%	8.9%	8.5%	8.1%	7.3%	7.3%
Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Statutory & Mandatory Training (Trust Measure)



13 Month Trend

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

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 8

FINANCE POSITION MONTH 8

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

Report to:	Public Trust Board
Date of Meeting:	15 January 2026

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 / Finance and Resource Committee
Strategic Priorities:	Growth - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
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 8 position noting: • The year-to-date surplus of £505k against a planned deficit of £285k, giving a favourable variance of £790k. • The underlying financial position (ULP) of £948k deficit.

	• Agency expenditure of £1,168k against a plan of £1,071k, resulting in an adverse variance of £97k. Medical agency must reduce to get back in line with the plan. • Bank expenditure of £4,422k against a plan of £4,049k, giving an adverse variance of £373k. The Trust is forecasting an adverse variance against planned bank spend of £543k. • The Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £6.9m fully achieved / transacted, £0.2m fully developed and £0.3m opportunities identified. • The Trust has spent £1,977k on capital, which is £944k behind plan. • The cash position of the Trust on 30th November with a balance of £36.3m.
Executive Summary:	The Adjusted Financial Performance in month is a surplus of £286k against a planned surplus of £69k giving a favourable variance of £217k. The year to date position is a surplus of £505k against a planned deficit of £285k giving a favourable variance of £790k. The Trust is forecasting to breakeven at year end. The Trust is reporting an underlying financial position (ULP) of £948k 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 8 the Trust is reporting delivery of £4,632k CIP against a target of £4,809k, an adverse variance of £177k. CIP schemes have been identified for the full target with 93% being implemented, 3% fully developed and 4% are opportunities. In month agency expenditure was £101k against a plan of £108k representing a favourable variance of £7k against the 40% agency expenditure reduction from 2024/25. In month bank expenditure was £510k against a plan of £352k representing an unfavourable variance of £158k against the 10% bank expenditure reduction from 2024/25. The Trust's capital expenditure year to date was £1,977k against a plan of £2,921k giving a favourable variance of £944k. the Trust is forecasting to overspend by £431k against plan due to backlog maintenance. In month, 95.4% based on the number of invoices and 99.0% based on the value of invoices received by the Trust were paid within 30 days against the Better Payment Practice Code target of 95%. The cash position of the Trust on 30th November is £36.3m.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	16/12/2025
1	Finance & Resource Committee	23/12/2025
1	Public Trust Board	08/01/2026

NHS
North Staffordshire
Combined Healthcare
NHS Trust

PUBLIC TRUST BOARD – 15th January 2026 Finance Position Month 8

Finance Position

Introduction

North Staffordshire Combined Healthcare NHS Trust

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

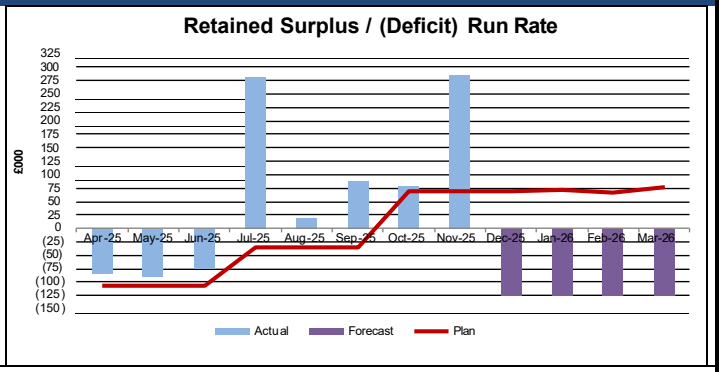
Finance Position Executive Summary

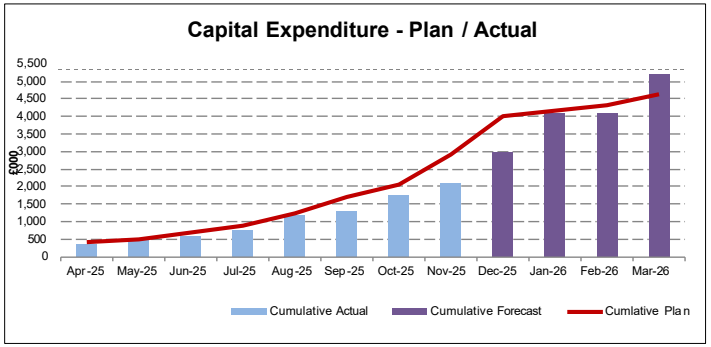
North Staffordshire Combined Healthcare NHS Trust

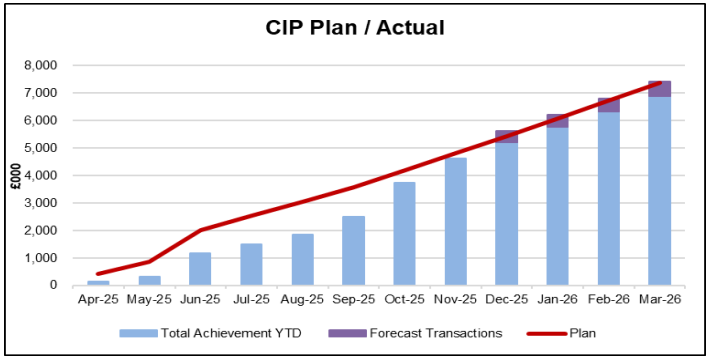
Financial Overview as at 30th November 2025

Key Metrics

£000	M6	M7	M8	YTD	Average	Forecast	RAG
Variance to Plan							
In month financial position	123	9	217	790	99		
YTD financial position	564	573	790	790	99	(0)	
Run Rates (Actuals)							
Income	14,907	14,879	15,228	118,871	14,859	178,730	
Pay	(9,050)	(8,989)	(9,146)	(72,459)	(9,057)	(109,260)	
Non-pay	(5,470)	(5,508)	(7,022)	(45,051)	(5,631)	(67,399)	
Finance & Other Non Operating	(253)	(258)	(271)	(2,038)	(255)	(3,083)	
Agency (Actuals)	(137)	(122)	(101)	(1,168)	(146)	(1,504)	
Agency Variance To Plan	**(1)**	**15**	**7**	**(97)**	**(12)**	**(0)**	
Medical Agency	(1)	12	0	(51)	(6)	16	
Nurse Agency	2	3	7	(18)	(2)	13	
Other Agency	(4)	(0)	0	(28)	(4)	(28)	
Non Clinical Agency	2	0	0	0	0	0	
Bank (Actuals)	(542)	(520)	(510)	(4,422)	(553)	(5,996)	
Bank Variance To Plan	**(50)**	**(74)**	**(74)**	**(215)**	**(31)**	**(543)**	
Medical Bank	48	(6)	(6)	261	33	203	
Nurse Bank	226	212	212	1,907	238	2,439	
Other Clinical Bank	(305)	(260)	(260)	(2,347)	(293)	(3,037)	
Non Clinical Bank	(19)	(21)	(21)	(111)	(14)	(148)	
CIP (Variance)	135	616	279	(177)	(22)	37	
Cash balance	32,833	34,341	36,257	36,257	33,155	34,565	
Capital expenditure (Variance)	325	32	526	943	118	(431)	
BPPC							
Number	97.7%	94.3%	95.4%	94.6%	94.7%		
Value	95.4%	97.0%	99.0%	97.5%	97.6%		







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	13,736	13,433	(303)	108,284	106,775	(1,509)	162,465	160,806	(1,658)
Income from Other Operating Activities	15,692	1,503	1,795	291	11,901	12,095	194	17,580	17,924	344
Income	**176,226**	**15,240**	**15,228**	**(12)**	**120,186**	**118,871**	**(1,315)**	**180,045**	**178,730**	**(1,315)**
Pay Costs	(105,754)	(9,260)	(9,146)	114	(73,613)	(72,459)	1,153	(110,417)	(109,260)	1,157
Non Pay Costs	(66,956)	(5,625)	(7,022)	(1,397)	(44,546)	(45,051)	(505)	(66,182)	(67,399)	(1,217)
Operating Expenditure	**(172,710)**	**(14,884)**	**(16,167)**	**(1,283)**	**(118,159)**	**(117,511)**	**648**	**(176,599)**	**(176,659)**	**(60)**
EBITDA	**3,516**	**355**	**(940)**	**(1,295)**	**2,027**	**1,360**	**(667)**	**3,446**	**2,071**	**(1,375)**
Finance & Other Non Operating Costs	(3,040)	(247)	(271)	(24)	(1,981)	(2,038)	(57)	(2,970)	(3,083)	(113)
Retained Surplus / (Deficit)	**476**	**108**	**(1,210)**	**(1,318)**	**46**	**(678)**	**(724)**	**476**	**(1,011)**	**(1,487)**
Add Back Impairments	0	0	1,531	1,531	0	1,531	1,531	0	1,531	1,531
Surplus/(deficit) before impairments	**476**	**108**	**321**	**213**	**46**	**853**	**807**	**476**	**520**	**44**
Technical Adjustments	(476)	(39)	(35)	4	(331)	(349)	(18)	(476)	(521)	(45)
Adjusted Financial Performance	**0**	**69**	**286**	**217**	**(285)**	**505**	**790**	**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 £286k against a planned surplus of £69k giving a favourable variance of £217k. The main driver of the in month favourable variance is the receipt of income relating to SafeHaven (£152k) and the in-month achievement of CIP.
- Year to date position is a surplus of £505k against a planned deficit of £285k giving a favourable variance of £790k. The main driver of the year to date favourable variance is vacancy slippage particularly in the Community, Education and Estates teams being offset with non pay adverse variances because of unmet CIP and high patient transport costs.
- 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 (£1,255k - 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 the favourable variance on patient placements costs (£1,255k - offset with reduced income). Remaining non pay budgets are an adverse variance due to unmet CIP, high premises costs and high patient transport costs (£328k year to date) due to a significant increase in out of area patients.
- Finance and other non-operating costs have an adverse variance of £57k year to date due to reduced bank interest following the reduction in the interest rate from 7th August.

PROUD TO CARE

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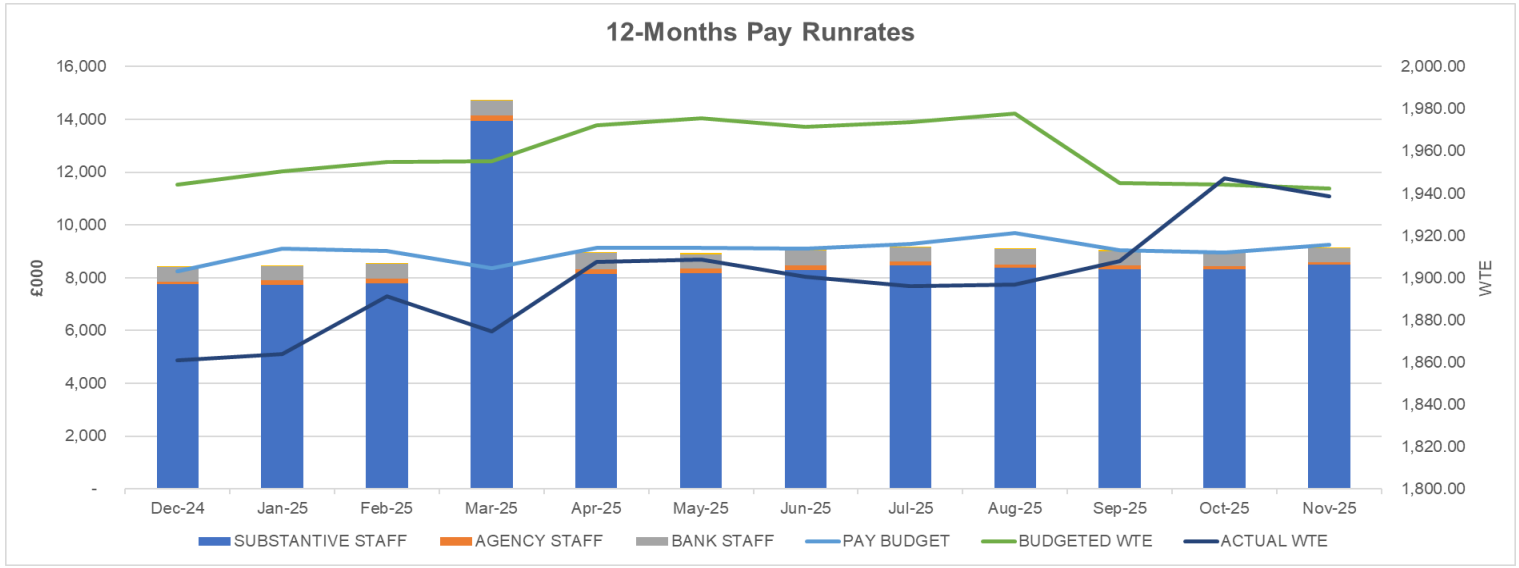
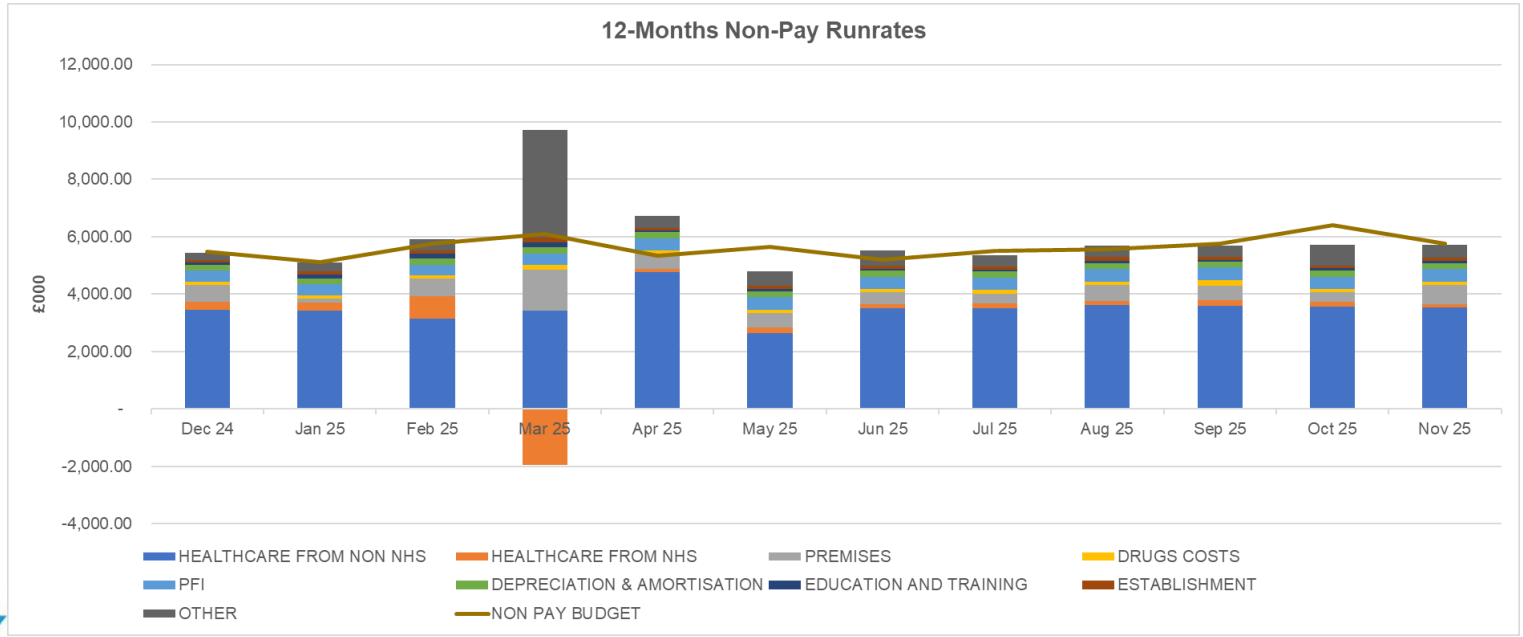
Finance Position

Expenditure Run Rates





Finance Position

Forecast

NHS North Staffordshire Combined Healthcare NHS Trust

Mitigations	Best £000	Likely £000	Base £000	Worse £000
Unmitigated Forecast Surplus / (Deficit)	1,150	1,150	1,150	1,150
Modifications to staffing projections	766	766	0	(249)
HR Provision	(93)	(289)	(289)	(384)
Non-Pay Cost Adjustments	92	(48)	(57)	(327)
Estates Reviews and Assessments	0	(37)	(37)	(37)
Release of balance sheet flexibilities	882	666	122	122
Recovery of bad debt	325	0	0	0
PFI Exit Expenditure	0	(260)	(260)	(260)
Income Provision	0	(37)	(37)	(74)
Deferred Income	0	(378)	(502)	(502)
Mitigated Surplus / (Deficit)	**3,121**	**1,446**	**0**	**(737)**

- 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 £3,121k. This includes no further workforce growth beyond the month 8 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 £737k. This includes lower staff turnover rates, income provisions relating to foundation doctors and HR provisions.
- The likely case forecast indicates the Trust could deliver a potential surplus of £1,446k. This includes no further workforce growth beyond the growth included in the month 8 position, reduced deferred income and the release of further balance sheet opportunities.

PROUD TO CARE

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Finance Position

Underlying Position (ULP)

NHS 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	178,730	(109,260)	(69,848)	378	**0**
Forecast non-recurring efficiencies	(200)	(828)	(337)	0	**(1,365)**
FYE of forecast recurring efficiencies - cash releasing	0	337	82	0	**419**
FYE of forecast recurring efficiencies - non-cash releasing	0	0	0	0	**0**
Gains and losses and donations	0	0	9	114	**123**
Full year effect of service developments	378	(378)	(125)	0	**(125)**
Non-recurrent investments	(886)	766	120	0	**0**
2025/26 Underlying Position	**178,022**	**(109,363)**	**(70,099)**	**492**	**(948)**

- 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 £948k** deficit after adjusting for the items noted above. This represents an improvement compared with Month 7 reflecting the recognition of recurrent efficiencies in Month 8.

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

PROUD TO CARE

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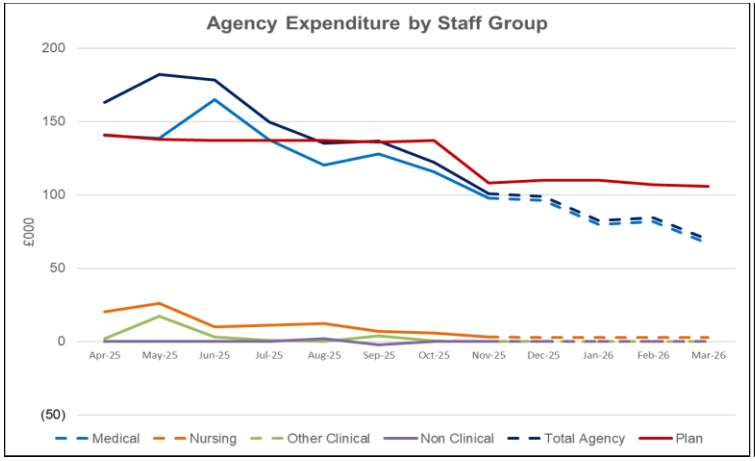
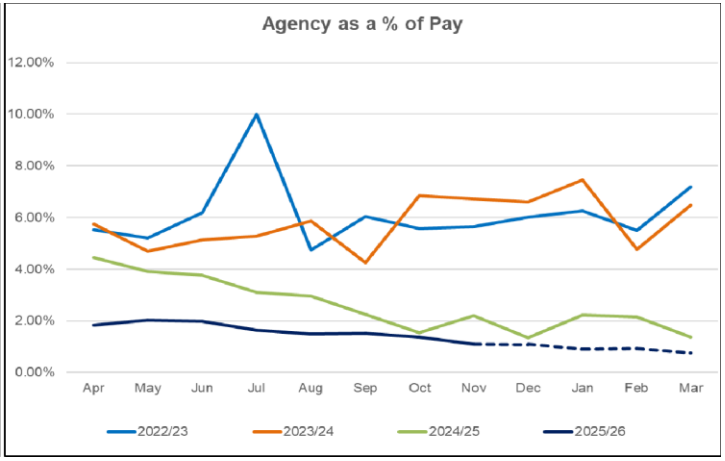
Finance Position

Agency Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Agency Expenditure	Actual								YTD	Forecast				Total
	Apr-25 £000	May-25 £000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	Oct-25 £000	Nov-25 £000	£000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical	**(141)**	**(139)**	**(165)**	**(138)**	**(120)**	**(128)**	**(116)**	**(98)**	**(1,044)**	**(96)**	**(80)**	**(82)**	**(67)**	**(1,368)**
Community	(96)	(95)	(112)	(105)	(81)	(87)	(99)	(77)	**(751)**	(77)	(65)	(62)	(56)	**(1,011)**
Specialist Care	(17)	(19)	(26)	(20)	(22)	(1)	0	0	**(105)**	0	0	0	0	**(105)**
Primary Care	(28)	(24)	(27)	(12)	(18)	(36)	(17)	(21)	**(183)**	(11)	(7)	(12)	(3)	**(216)**
Central Services	0	0	0	0	0	(5)	0	0	**(5)**	(8)	(8)	(8)	(8)	**(36)**
Nursing	**(20)**	**(26)**	**(10)**	**(11)**	**(12)**	**(7)**	**(6)**	**(3)**	**(96)**	**(3)**	**(3)**	**(3)**	**(3)**	**(107)**
Acute Services & Urgent Care	(2)	(10)	(3)	(5)	(6)	0	(0)	(0)	**(27)**	0	0	0	0	**(27)**
Quality & Nursing	0	0	0	0	0	0	0	0	**0**	0	0	0	0	**0**
Primary Care	(5)	1	(5)	(4)	(5)	(4)	(4)	(2)	**(26)**	(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)	(2)	(1)	**(42)**	0	0	0	0	**(42)**
Central Services	0	0	0	0	0	0	0	0	**0**	0	0	0	0	**0**
Other Clinical	**(2)**	**(17)**	**(3)**	**(1)**	**(0)**	**(4)**	**(0)**	**0**	**(28)**	**0**	**0**	**0**	**0**	**(28)**
Acute Services & Urgent Care	(1)	(0)	0	0	(0)	(1)	0	0	**(3)**	0	0	0	0	**(3)**
Quality & Nursing	0	0	0	0	0	0	0	0	**0**	0	0	0	0	**0**
Specialist Care	(1)	(12)	(8)	(1)	0	(3)	(0)	0	**(26)**	0	0	0	0	**(26)**
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**
Quality & Nursing	0	0	0	0	0	0	0	0	**0**	0	0	0	0	**0**
People & OD	0	0	0	0	(2)	2	0	0	**0**	0	0	0	0	**0**
Specialist Care	0	0	0	0	0	0	0	0	**0**	0	0	0	0	**0**
Total Agency	**(163)**	**(182)**	**(178)**	**(150)**	**(135)**	**(137)**	**(122)**	**(101)**	**(1,168)**	**(99)**	**(83)**	**(85)**	**(70)**	**(1,504)**
Agency as a % of Pay	1.82%	2.04%	1.97%	1.63%	1.48%	1.51%	1.36%	1.10%	**1.61%**	1.09%	0.90%	0.92%	0.75%	**1.38%**
Plan	(141)	(138)	(137)	(137)	(137)	(136)	(137)	(108)	**(1,071)**	(110)	(110)	(107)	(106)	**(1,504)**
Variance to Plan (Overspend) / Underspend	(22)	(44)	(41)	(13)	2	(1)	15	7	**(97)**	11	27	22	36	**(0)**
Agency Variance as a % of Plan	15.74%	31.84%	30.17%	9.37%	(1.45%)	0.60%	(10.82%)	(6.64%)	**9.07%**	(10.04%)	(24.97%)	(20.92%)	(34.20%)	**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 £101k against planned expenditure of £108k representing a favourable variance of £7k.
- Year to date expenditure is £1,168k against planned expenditure of £1,071k representing an adverse variance of £97k.
- Forecast agency expenditure is to plan.
- Year to date nursing (qualified and unqualified) and locum spend are the main drivers of the adverse variance.
- Locum utilisation continues to represent the principal driver of agency expenditure year-to-date and within the forecast outturn. However, expenditure is now demonstrating a downward trajectory as the Directorate's measures to reduce reliance on agency staffing take effect.

PROUD TO CARE

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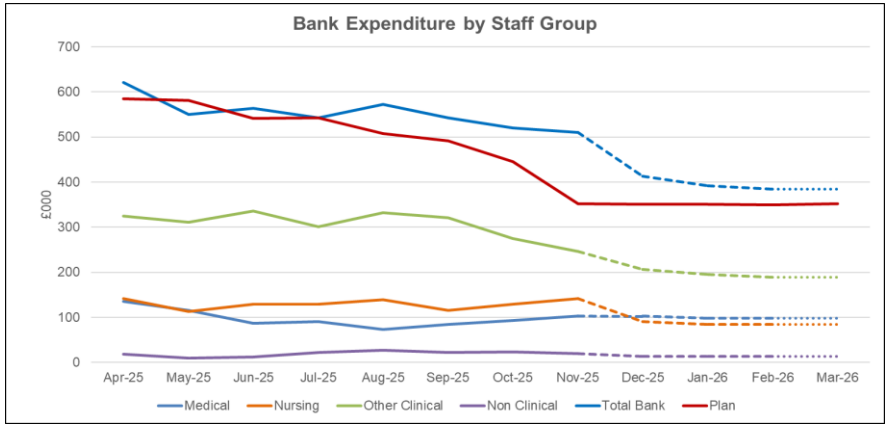
Finance Position

Bank Expenditure

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	Oct-25 £000	Nov-25 £000	£000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical	**(136)**	**(115)**	**(88)**	**(90)**	**(74)**	**(84)**	**(93)**	**(103)**	**(782)**	**(103)**	**(98)**	**(98)**	**(98)**	**(1,178)**
Acute Services & Urgent Care	(18)	(24)	(24)	(23)	(23)	(17)	(26)	(26)	**(180)**	(26)	(26)	(26)	(26)	**(285)**
Community	(64)	(38)	(29)	(17)	(31)	(28)	(31)	(32)	**(271)**	(28)	(28)	(28)	(28)	**(384)**
Specialist Care	(54)	(54)	(35)	(50)	(12)	(39)	(35)	(44)	**(323)**	(48)	(43)	(43)	(43)	**(501)**
Central Services	0	0	0	0	(9)	0	0	0	**(9)**	0	0	0	0	**(9)**
Nursing	**(142)**	**(114)**	**(129)**	**(129)**	**(140)**	**(115)**	**(129)**	**(142)**	**(1,039)**	**(90)**	**(84)**	**(84)**	**(84)**	**(1,383)**
Acute Services & Urgent Care	(101)	(88)	(82)	(72)	(81)	(70)	(88)	(89)	**(671)**	(68)	(68)	(68)	(68)	**(944)**
Community	(4)	(4)	(14)	(8)	(9)	(9)	(13)	(13)	**(74)**	(3)	(3)	(3)	(3)	**(87)**
Quality & Nursing	(1)	0	0	(0)	(1)	(0)	0	0	**(3)**	0	0	0	0	**(3)**
People & OD	(2)	(3)	(0)	(3)	(2)	(1)	(2)	(4)	**(18)**	(2)	(2)	(2)	(2)	**(27)**
Primary Care	(1)	(2)	(2)	(3)	(1)	(1)	(1)	(1)	**(12)**	(1)	(1)	(1)	(1)	**(16)**
Specialist Care	(32)	(16)	(31)	(43)	(41)	(33)	(24)	(35)	**(256)**	(16)	(10)	(10)	(10)	**(301)**
Central Services	0	0	0	0	(5)	0	0	0	**(5)**	0	0	0	0	**(5)**
Other Clinical	**(325)**	**(311)**	**(335)**	**(301)**	**(332)**	**(321)**	**(275)**	**(246)**	**(2,447)**	**(207)**	**(196)**	**(189)**	**(189)**	**(3,227)**
Acute Services & Urgent Care	(200)	(186)	(174)	(169)	(175)	(171)	(156)	(153)	**(1,384)**	(117)	(117)	(117)	(117)	**(1,853)**
Community	0	0	(0)	(0)	(0)	(0)	(2)	(1)	**(4)**	(1)	(1)	(1)	(1)	**(6)**
Quality & Nursing	0	(0)	0	0	(0)	0	0	0	**(0)**	0	0	0	0	**(0)**
MACE	(5)	(3)	(4)	(3)	(7)	(5)	(2)	(3)	**(32)**	(4)	(3)	(3)	(3)	**(45)**
Operations	(3)	(3)	(3)	(2)	(4)	(3)	(4)	(4)	**(26)**	(3)	(3)	(3)	(3)	**(39)**
People & OD	(6)	(3)	(2)	(3)	(5)	(8)	(3)	(1)	**(32)**	(4)	(4)	(4)	(4)	**(49)**
Specialist Care	(111)	(114)	(151)	(123)	(129)	(134)	(107)	(84)	**(951)**	(78)	(68)	(61)	(61)	**(1,217)**
Primary Care	(1)	(1)	(1)	(1)	(0)	(1)	(2)	(0)	**(7)**	0	0	0	0	**(7)**
Central Services	0	0	0	0	(12)	0	0	0	**(12)**	0	0	0	0	**(12)**
Non Clinical	**(18)**	**(10)**	**(12)**	**(22)**	**(27)**	**(22)**	**(24)**	**(19)**	**(154)**	**(14)**	**(14)**	**(14)**	**(14)**	**(208)**
Acute Services & Urgent Care	(1)	(0)	(0)	(1)	(0)	(1)	(2)	(1)	**(7)**	(1)	(1)	(1)	(1)	**(10)**
MACE	(0)	(0)	(1)	(0)	(1)	(1)	(1)	(1)	**(4)**	(1)	(1)	(1)	(1)	**(6)**
Quality & Nursing	(5)	(3)	(3)	(3)	(4)	(4)	(4)	(4)	**(29)**	(3)	(3)	(3)	(3)	**(42)**
People & OD	(8)	(3)	(7)	(15)	(19)	(13)	(10)	(10)	**(84)**	(6)	(6)	(6)	(6)	**(108)**
Primary Care	(2)	(2)	(0)	(2)	(2)	(3)	(1)	(3)	**(15)**	(2)	(2)	(2)	(2)	**(21)**
Central Services	0	0	0	0	(1)	0	0	0	**(1)**	0	0	0	0	**(1)**
Specialist Care	(1)	(1)	(1)	(0)	(1)	(1)	(7)	(1)	**(14)**	(2)	(2)	(2)	(2)	**(21)**
Total Bank	**(622)**	**(550)**	**(564)**	**(542)**	**(572)**	**(542)**	**(520)**	**(510)**	**(4,422)**	**(413)**	**(391)**	**(384)**	**(384)**	**(5,996)**
Bank as a % of Pay	6.93%	6.16%	6.22%	5.90%	6.27%	5.99%	5.79%	5.57%	**6.10%**	4.55%	4.27%	4.16%	4.14%	**5.49%**
Plan	(585)	(581)	(542)	(543)	(508)	(492)	(446)	(352)	**(4,049)**	(351)	(351)	(350)	(352)	**(5,453)**
Variance to Plan (Overspend) / Underspen	(37)	31	(22)	1	(64)	(50)	(74)	(158)	**(373)**	(62)	(40)	(34)	(32)	**(543)**
Bank Variance as a % of Plan	6.24%	(5.36%)	4.02%	(0.13%)	12.61%	10.25%	16.67%	44.82%	**9.21%**	17.76%	11.52%	9.84%	9.22%	**10.0%**



- Planned bank expenditure for 2025/26 is £5,453k this represents a mandated 10% reduction of 2024/25 expenditure levels.
- In month expenditure is £510k against planned expenditure of £352k representing an adverse variance of £158k.
- Year to date expenditure is £4,422k against planned expenditure of £4,049k representing an adverse variance of £373k.
- Forecast bank expenditure is £5,996k, £543k above plan.
- 75% of expenditure to date relates to nursing (qualified and unqualified) representing an adverse variance to plan of £357k. Nursing expenditure is forecast to decline following the induction of newly qualified nurses in October.
- 18% of expenditure to date relates to medical staffing with a favourable variance to plan of £251k.
- The remaining adverse variance to plan is due to therapeutic staff to date totalling £156k, Infrastructure Support £106k and AHPs £4k.

PROUD TO CARE

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Finance Position

CIP Delivery

NHS North Staffordshire Combined Healthcare NHS Trust

2025/26 Efficiency Identified Schemes	Target £000	YTD 2025/26 Plan £000	YTD 2025/26 Actual £000	YTD 2025/26 Variance £000	Total Forecast Plan £000	Total Forecast Actual £000	Total Forecast Variance £000	*Of which is Recurrent Plan £000*	*Of which is Recurrent Actual £000*	*Of which is Recurrent Variance £000*	*Recurrent Full Year Effect Plan £000*	*Recurrent Full Year Effect Actual £000*	*Recurrent Full Year Effect Variance £000*
Clinical													
Acute	360	213	178	(34)	360	308	(52)	*360*	*308*	*(52)*	*360*	*366*	*6*
Community	2,045	1,208	1,960	752	2,045	2,855	810	*2,045*	*2,055*	*10*	*2,045*	*2,182*	*137*
Specialist	644	381	211	(170)	644	433	(212)	*644*	*433*	*(212)*	*644*	*531*	*(113)*
Primary Care	19	12	40	28	19	60	40	*19*	*60*	*40*	*19*	*60*	*40*
Clinical Total	**3,069**	**1,813**	**2,389**	**577**	**3,069**	**3,656**	**587**	***3,069***	***2,856***	***(213)***	***3,069***	***3,139***	***70***
Corporate													
CEO	42	25	11	(14)	42	17	(25)	*42*	*4*	*(38)*	*42*	*4*	*(38)*
Q&N	300	177	57	(120)	300	86	(214)	*300*	*86*	*(214)*	*300*	*89*	*(211)*
S&D	364	215	66	(149)	364	107	(257)	*364*	*64*	*(300)*	*364*	*65*	*(298)*
Finance	93	55	26	(29)	93	45	(48)	*93*	*45*	*(48)*	*93*	*60*	*(33)*
Performance	32	19	0	(19)	32	0	(32)	*32*	*0*	*(32)*	*32*	*0*	*(32)*
Estates	56	33	3	(30)	56	4	(52)	*56*	*4*	*(52)*	*56*	*4*	*(52)*
MACE	104	62	1	(60)	104	2	(102)	*104*	*2*	*(102)*	*104*	*2*	*(102)*
Operational	1	1	0	(0)	1	1	(0)	*1*	*1*	*(0)*	*1*	*1*	*(0)*
People	174	103	8	(94)	174	13	(162)	*174*	*13*	*(162)*	*174*	*14*	*(160)*
Corporate Total	**1,166**	**689**	**173**	**(516)**	**1,166**	**274**	**(892)**	***1,166***	***218***	***(948)***	***1,166***	***239***	***(927)***
Trustwide	**1,532**	**1,244**	**1,003**	**(240)**	**1,532**	**1,874**	**342**	***167***	***1,350***	***1,183***	***167***	***1,480***	***1,313***
Productivity	**1,600**	**1,064**	**1,067**	**3**	**1,600**	**1,600**	**0**	***1,600***	***1,600***	***0***	***1,600***	***1,600***	***0***
Total Trust CIP	**7,367**	**4,809**	**4,632**	**(177)**	**7,367**	**7,404**	**37**	**6,002**	**6,024**	**22**	**6,002**	**6,458**	**456**

- 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 8 the Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £6.9m fully achieved / transacted, £0.2m fully developed and £0.3m opportunities identified.

PROUD TO CARE

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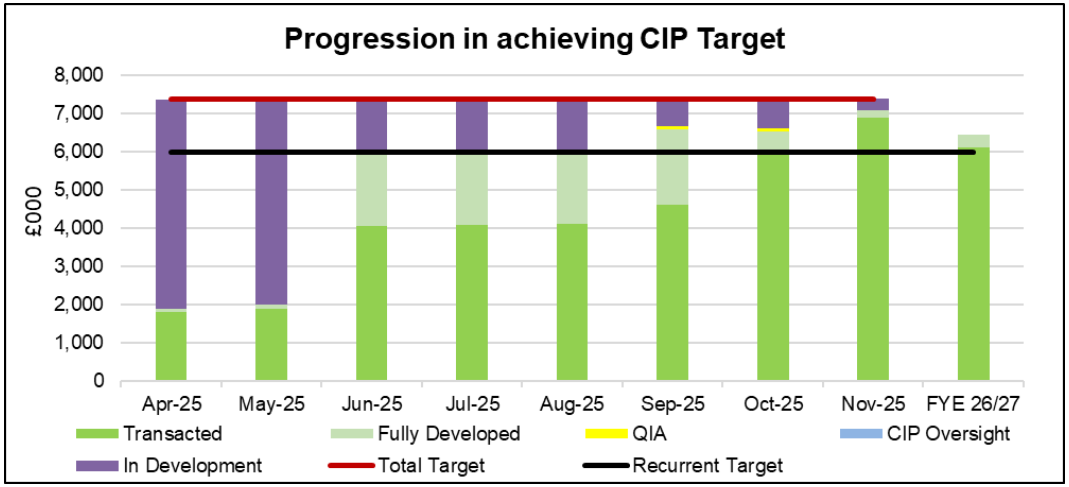
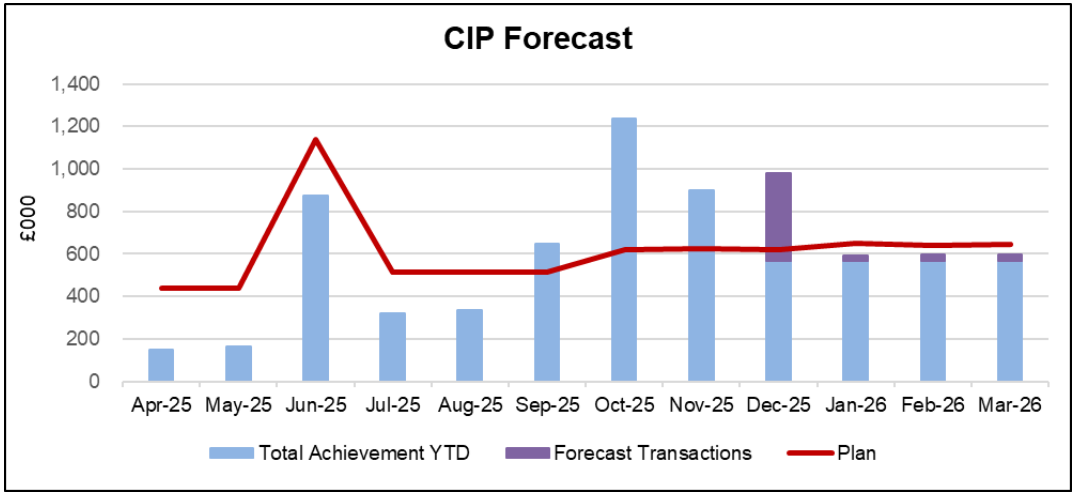
Finance Position

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, 1% medium risk and 95% low risk.

PROUD TO CARE

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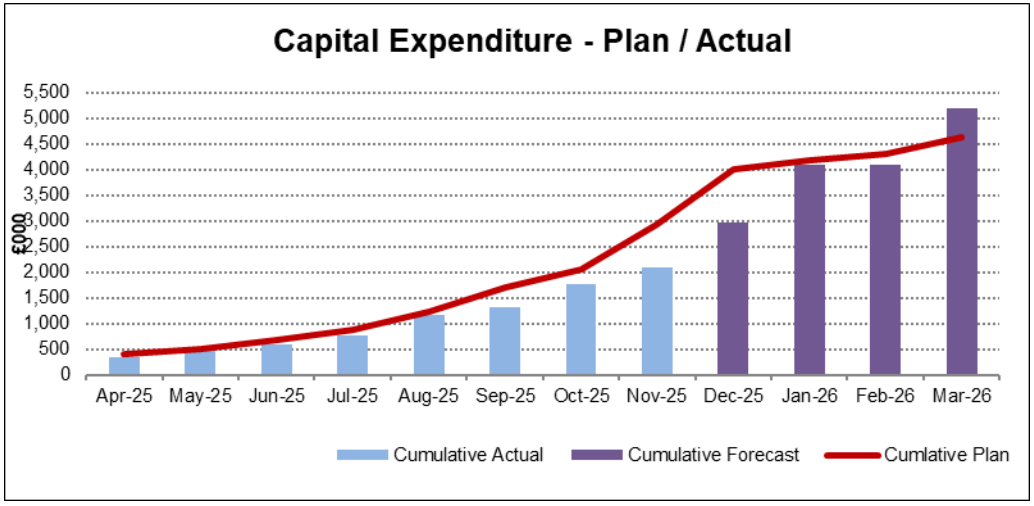
Finance Position

Capital Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Capital Expenditure	Annual Plan £000	Year to Date Against Plan: Plan £000	Year to Date Against Plan: Actual £000	Year to Date Against Plan: Variance £000	Forecast Outturn Against Plan: Plan £000	Forecast Outturn Against Plan: Forecast £000	Forecast Outturn Against Plan: Variance £000	Forecast Outturn Against Budget: Capital Budget £000	Forecast Outturn Against Budget: Forecast £000	Forecast Outturn Against Budget: Variance £000
Operational Schemes	**786**	**318**	**130**	**(188)**	**786**	**334**	**(452)**	**786**	**334**	**(452)**
IFRS16 Leases	199	198	14	(184)	199	188	(11)	199	188	(11)
Medical Equipment	30	0	0	0	30	30	0	30	30	0
Estates Fleet	120	120	116	(4)	120	116	(4)	120	116	(4)
Energy Efficiency	75	0	0	0	75	0	(75)	75	0	(75)
Capital freedom & flexibilities	362	0	0	0	362	0	(362)	362	0	(362)
Digital	**429**	**26**	**27**	**1**	**429**	**543**	**114**	**429**	**543**	**114**
IT Digital Replacement	239	0	0	0	239	503	264	239	503	264
Capitalised Salaries - IT Device Replacement	40	26	27	1	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)
Strategic Schemes	**1,943**	**1,827**	**0**	**(1,827)**	**1,943**	**130**	**(1,813)**	**143**	**130**	**(13)**
Dormitory Conversion Trust funded	1,943	1,827	0	(1,827)	1,943	130	(1,813)	143	130	(13)
Contingency/Reactive Schemes	**0**	**0**	**20**	**20**	**0**	**71**	**71**	**0**	**71**	**71**
PICU Air conditioning	0	0	0	0	0	29	29	0	29	29
Ashcombe Restructure	0	0	0	0	0	20	20	0	20	20
Crisis Centre Doors	0	0	22	22	0	22	22	0	22	22
Contingency	0	0	(3)	(3)	0	0	0	0	0	0
Total Trust Funded Capital Expenditure	**6,316**	**2,171**	**177**	**(1,994)**	**3,158**	**1,078**	**(2,080)**	**1,358**	**1,078**	**(280)**
NHS Notify	0	0	0	0	0	227	227	227	227	0
Backlog Maintenance	470	250	223	(27)	470	1,077	607	1,260	1,077	(183)
Frontline Digitisation Programme PDC Funded	1,000	500	0	(500)	1,000	1,000	0	1,000	1,000	0
Dormitory Conversion PDC Funded	0	0	1,700	1,700	0	1,800	1,800	1,800	1,800	0
Total Gross Capital Expenditure	**7,786**	**2,921**	**2,100**	**(821)**	**4,628**	**5,182**	**554**	**5,645**	**5,182**	**(463)**
Capital disposals - Hope Street Heating System	0	0	(123)	(123)	0	(123)	(123)	0	(123)	(123)
Total Charge against Capital Resource Limit	**7,786**	**2,921**	**1,977**	**(944)**	**4,628**	**5,059**	**431**	**5,645**	**5,059**	**(586)**



- The Trust's annual capital plan is £4,628k. The Trust has secured additional PDC funding of £227k for the NHS Notify scheme and £790k estates safety funding increasing the capital budget to £5,645k.
- The total charge to the Trust's Capital Resource Limit at Month 8 is £1,977k, £944k below plan. This includes £123k relating to the disposal of the Hope Street heating system.
- The favourable variance is due delays in leases renewals, slippage on the frontline digitisation programme and project chrysalis. All are expected to deliver planned levels by the end of the financial year.
- Forecast expenditure is £586k below budget mainly due to forecast underspends on backlog maintenance and freedom and flexibilities funding.

Finance Position

Statement of Financial Position

NHS North Staffordshire Combined Healthcare NHS Trust

SOFP	M6 £000	M7 £000	M8 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	20,698	20,881	19,544
Property, Plant and Equipment	16,094	16,097	16,144
Right of Use Assets	2,804	2,765	2,729
Intangible Assets	1,576	1,534	1,491
NCA Trade and Other Receivables	573	574	561
Total Non-Current Assets	**41,745**	**41,851**	**40,469**
Current Assets			
Inventories	84	94	92
Trade and Other Receivables	6,234	6,088	6,602
Cash and Cash Equivalents	32,833	34,341	36,257
Total Current Assets	**39,151**	**40,523**	**42,951**
Current Liabilities			
Trade and Other Payables	(22,098)	(23,954)	(26,427)
Provisions	(1,622)	(1,622)	(1,966)
Borrowings	(3,072)	(3,072)	(3,072)
Total Current Liabilities	**(26,792)**	**(28,648)**	**(31,465)**
Net Current Assets / (Liabilities)	**12,359**	**11,875**	**11,485**
Total Assets less Current Liabilities	**54,104**	**53,725**	**51,954**
Non Current Liabilities			
Provisions	(1,838)	(1,463)	(1,042)
Borrowings	(16,058)	(15,931)	(15,758)
Total Non-Current Liabilities	**(17,896)**	**(17,394)**	**(16,800)**
Total Assets Employed	**36,208**	**36,331**	**35,154**
Financed by Taxpayers' Equity			
Public Dividend Capital	23,983	23,983	23,983
Retained Earnings reserve	5,213	5,336	4,125
Revaluation Reserve	7,012	7,012	7,045
Total Taxpayers' Equity	**36,208**	**36,331**	**35,154**

Current receivables are £6,602k of which:

- £1,527k is based on accruals (not yet invoiced).
- £5,075k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,486k 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 £31,465k of which:

- Trade and Other payables remain high at £26,427k because of deferred income and patient placement invoices and accruals.

Liquidity ratio:

- A good liquidity ratio should be above 1.0.
- The Trust current ratio is 1.4 showing the Trust can cover its current debt obligation.

PROUD TO CARE

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Finance Position

Better Payment Practice Code

NHS
North Staffordshire Combined Healthcare NHS Trust

Better Payment Practice Code	In Month			YTD Total		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices						
Total Paid	24	928	952	226	7,422	7,648
Total Paid within Target	24	884	908	220	7,017	7,237
% Number of Invoices Paid	100%	95%	95%	97%	95%	95%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**5%**	**0**	**0**	**2%**	**(0%)**	**(0%)**
Value of Invoices						
Total Value Paid (£000s)	471	5,274	5,745	4,759	61,330	66,089
Total Value Paid within Target (£000s)	471	5,215	5,686	4,373	60,088	64,461
% Value of Invoices Paid	100%	99%	99%	92%	98%	98%
% Target	95%	95%	95%	95%	95%	95%
RAG Rating (Variance to Target)	**5%**	**4%**	**4%**	**(3%)**	**3%**	**3%**

The BPPC target is to pay at least 95% of invoices in terms of number and value within 30 days for NHS and Non-NHS suppliers.

- During Month 8, the Trust has achieved the 95% target on both the value of invoices paid at 99% and on the number of invoices paid at 95% paid within 30 days.
- Year to date the Trust has achieved the 95% target on the value of invoices paid at 98% 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

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Finance Position Summary

North Staffordshire Combined Healthcare NHS Trust

The Board are asked to receive the Month 8 position noting:

- The year-to-date surplus of £505k against a planned deficit of £285k, giving a favourable variance of £790k.
- The underlying financial position (ULP) of £948k deficit.
- Agency expenditure of £1,168k against a plan of £1,071k, resulting in an adverse variance of £97k. Medical agency must reduce to get back in line with the plan.
- Bank expenditure of £4,422k against a plan of £4,049k, giving an adverse variance of £373k. The Trust is forecasting an adverse variance against planned bank spend of £543k.
- The Trust is forecasting full achievement of the Trust £7.4m CIP target, with a total of £6.9m fully achieved / transacted, £0.2m fully developed and £0.3m opportunities identified.
- The Trust has spent £1,977k on capital, which is £944k behind plan.
- The cash position of the Trust on 30th November with a balance of £36.3m.

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 4th December 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:

Orbis Update

Committee received the report that raised risks and concerns in relation to the project. Many of the immediate actions highlighted have commenced and there has been a noted improvement in the functionality of Lorenzo since the last system update. There are 5 critical milestones, 2 further updates to Lorenzo in the next 6 months with implementation in 3 stages expecting to go live in summer 2026.

Committee acknowledge their disappointment in the position of the project. Discussions took place on the assurance level Committee can take from this, the escalation processes for deviations from the plan and internal communications plan.

Committee requested a discussion to take place at Quality Committee in the New Year.

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 M7

Committee received the report. Challenges remain with high numbers of out of area placements. Going forward if patients are placed locally, they will be reported as appropriate placements. Clinically ready for discharge patients remain at a consistent level. The Trust also has clinically ready for discharge patients in out of area placements.

Committee noted the overall good performance. Discussions took place on out of area placements and workforce planning and triangulation.

Finance Position M7
Key messages highlighted included a small year-to-date surplus which is better than plan. 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, 81% of which has been transacted to month 7. Capital expenditure is slightly lower than planned year-to-date, forecast to be on plan.

ICS Finance Update M7
At month 7 the System reported a year-to-date deficit of £18.7m, £0.7m favourable to plan. The net risk has reduced to £12.9m. Committee noted that no level assurance was required for this report.

Financial Planning
The report provided Committee with an update on financial planning following the publication of the National Planning Guidance. The initial submission is due on 18th December which will require Board approval.

Cost Improvement Programme
Key messages highlighted included progress made during November and the workshop planned for SLTD in December on CIP with MIAA (Internal Auditors).

Estates Update
Committee received the report with highlights on backlog maintenance and Estates Safety capital schemes. Attentions were drawn to the plans for the Harplands site wide water temperature issues and fire door works at Harplands.

Business Opportunities
Committee received the report highlighting the Trust has submitted a tender for Connect to Work with Stoke-on-Trent City Council.

APPROVE:

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

Heading:

Risk Register
There were no new risks, 1 score change and 1 risk for closure for approval. Score reduction in relation to insufficient capital resource and risk closure for increased costs for Project Chrysalis were approved. 1 risk had a date revision noted.

A&T Business Case
Capital refurbishment for the unit to improve the environment was approved. Approval from Board is required. Committee discussed the current and future need of the unit.

EMU Business Case
Capital expansion for 6 beds for the unit was approved. Approval from Board is required. Committee discussed the commercial angle of the unit and the Trust's commercial strategy. It was noted that the business case has not been to SLT prior to F&R.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 8th January 2026 at 10am via MS Teams.

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

REPORT END

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 8th January 2026

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:

Orbis Update

The Committee received the report outlining the key risks, issues, progress and mitigations in relation to the project. It was noted that relationships with delivery partners have strengthened as a result of the implementation of formal governance arrangements. A clear and agreed timeline is now in place, with system go-live scheduled for summer 2026. A review of risks and issues, together with associated mitigations, has been completed. NHS England will be visiting the Trust in January to support system development and ensure alignment with national standards.

The Committee discussed how the programme had reached a position where governance arrangements were being implemented retrospectively.

In terms of assurance, the Committee noted that progress has been made since the previous meeting; however, there remains a level of risk due to the tight delivery timeframes. The Committee expects to see a rapid improvement in assurance over the coming months against the defined milestones. The Committee challenged the adequacy of the assurance provided through the report, the risk register and the triangulation between these sources. It was noted that key deliverables due by March 2026 will be critical in determining the overall deliverability of the project. The level of assurance was therefore agreed to remain at Level 2. Assurance was provided that the identified actions will be progressed.

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 M8
Committee received the report. Positive performance position with 6 special cause variations signifying improvement. Challenges remain with high numbers of out of area placements. Committee noted the overall good performance. Discussions took place on the challenges on out of area and clinically ready for discharge.

Finance Position M8
Key messages highlighted included a small year-to-date surplus which is better than plan. 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, 93% of which has been transacted to month 8. Capital expenditure is slightly lower than planned year-to-date, forecast to be on plan.

ICS Finance Update M8
At month 8 the System reported a year-to-date deficit of £16.3m, £1.0m favourable to plan. The net risk has reduced to £6.7m.

Financial Planning
The report provided Committee with an update on financial planning following the initial submission on 18th December.

Cost Improvement Programme
Key messages highlighted included progress made during December and planning for 2026/27 CIP delivery including follow up to the CIP workshop at SLTD.

SLR Q2
The Committee received an overview of the Q2 Service Line Reporting. It was noted that NHS England has issued productivity packs, and that the rollout of Service Line Reporting is aligned to the opportunities identified within these packs. The Trust's National Cost Collection Index for 2024/25 was reported as 91, indicating that the Trust's costs are approximately 9% below the national average for comparable activity. The Committee discussed how this information is being used with directorates.

Estates Update
Committee received the report with highlights on backlog maintenance and Estates Safety capital schemes. Updates were given on Project Chrysalis and site wide water balancing.

Business Opportunities
Committee received the report highlighting the Trust has been successful with an Expression of Interest for the Better Care Fund Improvement Support Programme and has submitted a bid with the ICB for Obesity Pathway Innovation Programme Grant.

Strategic Partnership Plan
An update on the Strategic Partnership Plan was presented to Committee noting progress on implementation and areas of challenges.

APPROVE:

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

Heading:

Risk Register
There were no new risks, 1 score change and no risks for closure for approval. Score reduction in relation to the Trust's CIP delivery was approved.

Policy Report
Policy extension for the Subject Access Request Policy was approved for 12 months.

Oliver McGowan Business Case
Revenue business case to deliver the required Oliver McGowan training was approved with the business case going retrospectively to SLT.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 5th February 2026 at 10am via MS Teams.

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

REPORT END

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

Challenges within the system, winter pressures early. High levels of flu and RSV impacting on their flow and therefore ambulance waiting times. The BMA have announced further industrial action for five-days from 17 December.

Out of Area placements (OOA)

We have seen an increase in patients requiring out of area PICU beds but are seeing a reduction in the wider use of OOA Placements with 15 reportable Out of Area placements currently.

There was discussion around what is an inappropriate and appropriate OOA bed based on the national guidance. Based on this guidance and in discussion with ICB colleagues, non NHS providers who fall within the Staffs ICB geographical footprint, which allows local NHS services and family to easily visit patients placed there, such as Cygnet Hospital Kidsgrove, is an appropriate OOA placement. The decision of the committee was that reporting of OOA beds will continue to show all patients placed in beds which are not Trust beds (both appropriate and inappropriate).

4 patients are Clinical Ready for Discharge are in Out of Area beds
5 patients within our own acute wards are clinically ready for discharge and 11 in older persons wards at the Harplands.

Regulation 28 Coroners (Investigations) Regulations 2013 - Prevention of Future Deaths (PFD) Report

The Trust received a prevention of future deaths report, also known as a regulation 28 report or PFD report on 18th November 2025. This is a report was made by the coroner, for the coroner area of Staffordshire and Stoke on Trent in relation to an inquest into the death of a former patient.

The coroner highlighted 2 key areas of concern.

1) Timeliness of follow up appointments in community mental health services following discharge from wards and crisis care services.

We have responded to ensure all patients have an appointment with CMHT within 2 weeks of discharge from these services (in addition to the national standard of 48hr face to face review upon discharge from Inpatient Services)

2) Delays in appointments pending full assessment of patients' needs using the Trust Single Assessment Framework

We are currently reviewing to ensure all individuals waiting for this assessment are in line with national expectations.

We will respond to NHSE by 8th December 2025 and the coroner on 13th January 2026. The Quality Committee will be updated with our response.

ADVISE:

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

CQC Update
There were no additional updates for the committee this month.

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 with a good level of discussion:

There was discussion in relation to all reports received in the committee in relation to the newly introduced assurance levels of the reports.

Safe staffing report October 2025

IQPR M07 2025/26

Co-production, Involvement and Volunteers Report Q2 2025/26

This report was well received with the Committee's request to formally acknowledge the dedication and extent of work being underway to improve experience and wellbeing of our communities. The committee

felt that further work to fully embed recovery and coproduction is required, but acknowledged evidencing impact may be difficult in the short term. The assurance level of this report was advised to be amended from level 3 to level 4 assurance.

Infection, Prevention and Control Report Q2 2025/26

Learning from Experience Report Q2 2025/26

Mortality Surveillance Report Q2 2025/26

Patient Safey Incident Response Framework Report Q2 2025/26

Safeguarding Adult and Children Q2 Report 2025/26

Whilst there as agreement that the report carries a good level of assurance in relation to nearly all areas of practice and compliance was being met at Trust level, the committee felt there remains room for improvement in some directorates in relation to compliance, and therefore the level of assurance is recommended to be reduced from level 7 to level 6.

Restrictive Practice Report Q2 2025/26

A positive example of reducing restrictive practice was noted in the Darwin Centre where there has been a marked reduction in the number of restraints associated with patients requiring Naso-Gastric (NG) feeding. This is because of environmental improvements with the introduction of the peace pod, alongside some changes in practice. The committee recognised this as a positive example of quality improvement.

Quality Impact Assessments (QIA) of Cost Improvement Programme (CIP) Report

Quality Improvement Update

All reports assurance level ratings were confirmed by the committee apart from the two amendments noted above.

APPROVE:

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

Risk Register

9 risks 12 or above
No formal approvals required, no new risks, score changes or closures.
There have been achievement date extensions which the committee considered acceptable.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 7 January 2026 at 2pm via MS teams.

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

REPORT END

Trust Board Assurance Report from the Quality Committee meeting held on 8 January 2026

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
Urgent and Emergency Care remains challenged throughout the county.

Preparing for storm Goretti has been a key focus of concern with business continuity planning actively underway with contingencies in place.

Out of Area placements
21 reportable out of area patients from Acute Inpatient services currently, with additional patients within other local provision. There are 15 Clinically Ready for Discharge.

Actions to address this challenge remain underway and the Trust have reached out to other systems to support patients who are from out of area services and accessing a bed within our local emergency department.

A request was made for a more detailed written report to be presented to the committee next for more detailed discussion.

ADVISE:

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

CQC Update
Nothing Significant to report to this January's committee.

IQPR

The report was received with improvements and progression being noted by the Committee.

The report highlighted that the Mental Health Liaison Service 1hr response was not met due to the service closure for 2 nights due to staff absence and shortage. Business continuity plans are currently being reviewed and an update issued to committee in March 2026.

The 48hr face to face breaches were discussed and explored further, highlighting that there was no harm or risk associated with these delays.

Further enquiry was also made in relation to the Length of Stay metric with a request for further context to be provided in future committees.

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 report was received for assurance with a good level of discussion:

- **Safe staffing report November 2025**

Level 7 Assurance confirmed by the committee

APPROVE:

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

Risk Register
Amendments were approved.

Cycle of Business – Quality Committee
Received and approved

Terms of Reference – Quality Committee
Received and approved

Policy Report – Quality Committee
Level 3 assurance confirmed by the Committee

3 of the 5 polices were approved by the Committee. 2 need additional sign off oversight with the relevant lens of expertise. This highlighted the need to continue to focus on improving the alignment and governance of policy review and sign off. The committee subgroup are under review with view of addressing this challenge.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 5 February 2026 at 2pm In Person.

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

REPORT END

Trust Board Assurance Report from the People, Culture and Development Committee meeting held on 5th January 2026

Introduction:

This assurance report is produced following the latest PCDC, which was held on Microsoft Teams and was quorate. The Committee piloted a refreshed format to the meeting, reflecting the proposed updated annual terms of reference, reducing attendees and reinforcing its purpose as a Board meeting.

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 received high level preliminary results from the 2025 national staff survey. Results indicate that the Trust has maintained its position in the top quartile of results when compared to peers, in addition to an increase in response rates when compared to 2024 results. Focused work on engaging and improving bank experience is evidenced through improved response rates and outcomes. Further results and analysis will be scheduled once the national results have been released post embargoed (TBC March 2026).

- The Committee welcomed a staff story from a Health Care Support Worker who had raised concerns on their working experiences through the Dear Buki route. The story articulated disparity of treatment over a course of years, alongside challenges experienced in their desire to transition their medical qualifications from their home country to pursue a career in medicine and support with gaps in skills across the Trust. The Committee was assured how the early engagement with directorate leadership team resulted in a positive resolution and were further assured on the commitment to developing a localised approach to overseas healthcare qualifications. Learning from this staff experience has been built into the Trust People Plan and the approach of early engagement with directorate leadership will help to inform other mechanisms for colleagues speaking up.

  The Committee were extremely grateful that the member of staff had been prepared to share their experience so openly with the Committee and to the People Directorate and Directorate Leader for the support that they had also provided.

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

- The Committee agreed to undertake a detailed review of its risk register, noting areas of potential duplication, whilst using the opportunity to apply a risk tolerance in line with Board development.
- The Committee reiterated its responsibility in seeking assurance on progress with the Trust's workforce plan in the context of system partners. Detail to explain variance to plan will be captured and reported through to Committee as part of the cycle of business.
- The Committee discussed the Workforce Plan as at month eight 2025/26 and requested further information to enable them to better understand and be more assured on the
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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:

- Progress with the People Plan.
- Sickness improvement plan.
- Workforce metrics as at month eight 2025/26. The Committee acknowledged the very positive performance in the majority of areas including improvements made in a number of areas that have a Performance Improvement Plan in place.
- Staff Survey preliminary results 2025.

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

The Committee welcomed the smaller membership attendance at the meeting and slimmed down agenda which had been developed and implemented through the refresh of the People Plan and Terms of Reference of the Committee.

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

The Committee approved the following:

- Refreshed annual terms of reference.
- Refreshed annual cycle of business.

Next Steps (including timeframes):

The next PCDC meeting will be held on: 2nd February 2026 and will be a focused session.

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

REPORT END

Trust Board Assurance Report from the Charitable Funds Committee meeting held on 1 December 2025

Introduction:

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

Purpose of the Report (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 Charitable Fund Committee's remit and programmes of work.

ALERT:

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

No items to report.

ADVISE:

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

No items to report.

ASSURE:

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

Finance Report and Fund Management:

The quarterly finance report included a reported fund balance of £322,000 as of October, with £21,000 income and £16,000 expenditure, including bank interest and donations. It was noted that a small number of dormant funds had been closed to support administrative efficiency There are now 40 individual funds.

Charity Development Plan:

The quarterly update report presented to Committee provided assurance on the range of activities being taken forward to deliver growth, including grant applications, increased staff engagement, and fundraising events. Committee discussed the two-year development and testing phase that commenced

in September 2025. The Committee requested an overview of Trust resources expended to date. This will be provided at the next meeting in March.

APPROVE:

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

Annual Accounts and Annual Report

The year end charity accounts and annual report were presented to Committee for approval, confirming compliance and readiness for sign-off by Corporate Trustees. The Committee reviewed fund balances (opening £306k, income £35k, expenditure £18k, closing £317k; £268k restricted, £49k unrestricted) and discussed governance requirements, noting that the current approach of an independent examination rather than an audit. It was confirmed that an independent examination is acceptable where the charity income falls below £1m. The accounts and annual report were approved.

Ward 5 Garden Redevelopment – Business Case

The Committee reviewed a business case to redevelop the Ward 5 garden to ensure full accessibility and patient safety. It is proposed to allocate approximately £93,000 from the legacy donation to fund the works. Committee endorsed the business case as an appropriate use of the legacy funding, delivering a much-needed improvement that is outside PFI arrangements and will provide clear benefits for patients and staff. The proposal aligns with the donor's wishes to enhance outdoor facilities at Harplands and maintains the family's connection with Ward 5. As the value exceeds delegated limits, Trust Board approval is required before implementation can proceed.

Staff Lottery Pilot

The Committee considered a proposal to pilot a staff lottery for six months to assess interest and viability as a longer-term form of sustainable income for the charity. Discussion acknowledged the complexities and differing views, including concerns about gambling-related harms. The paper outlined models used by other NHS trusts, including mental health trusts, and the safeguards in place to mitigate risks. The Committee approved the proposal, which will be presented to Corporate Trustees in January for final decision.

NHS Charities Together Workforce Wellbeing Grant

The Committee approved submission of a £50,000 grant application to Round 2 of the NHS Charities Together Workforce Wellbeing Fund. Developed by the People Directorate, the proposal seeks funding to train staff in Emotional Freedom Technique (EFT), an evidence-based self-help strategy for managing stress and anxiety. The training will be delivered at multiple levels to ensure a sustainable model. The application will be submitted by the 22 December 2025 deadline.

Fundraising Policy

The Committee approved a new Fundraising Policy, developed over recent months and tailored to the Combined Charity. The policy draws on best practice from other NHS charities and aligns with the

Fundraising Regulator's updated Code of Practice (effective 1 November 2025). It will be published on CAT and the charity page of the Trust website.

Next Steps (including timeframes):

The next Charitable Funds Committee meeting will be held on: 2 March 2025 at 10am Via MS Teams.

Committee Chair: Russell Andrews, Chair of the Charitable Funds Committee.

REPORT END

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PROUD TO CARE

7 Levels of Assurance

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	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 ie 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

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	Ex-Ord Private 11th Dec 25	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	√	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)													