NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST BOARD MEETING HELD IN PUBLIC

THURSDAY 14TH MAY 2026, 10.00AM, BOARDROOM, LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P46/26	Welcome and Apologies for Absence – **Kenny Laing**	Janet Dawson	**Note**	
2	1002	P47/26	Declarations of Interests – and changes to be notified	Janet Dawson	**Note**	
3	1003	P48/26	Minutes of the Previous Meeting held on 12th March 2026	Janet Dawson	**Note**	**Enc. 1**
4	1005	P49/26	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	**Note**	**Enc. 2**
ADVISE						
5	1010	P50/26	Patient Story – **CASTT Service (WITHELD)**	Zoe Grant	**Advise**	**Verbal**
6	1012	P51/26	REACH Recognition Individual Award – Specialist Directorate - **Lucy McFadyen – Ward Manager Darwin Centre**	Dr Buki Adeyemo	**Advise**	**Verbal**
7	1020	P52/26	Chief Executives Report	Dr Buki Adeyemo	**Advise**	**Enc. 3**
8	1030	P53/26	Chairs Report	Janet Dawson	**Advise**	**Verbal**
9	1040	P54/26	Questions from Members of the Public	Janet Dawson	**Advise**	**Enc. 4**
ALERT						
APPROVE						

ASSURE						
10	1045	P55/26	Board Assurance Framework Dashboard (BAF) 2026/27	Nicola Griffiths	**Assurance**	**Enc. 5**
11	1050	P56/26	Improving Quality and Performance Report (IQPR) Month 12	Eric Gardiner	**Assurance**	**Enc. 6**
12	1055	P57/26	Finance Report Month 12	Eric Gardiner	**Assurance**	**Enc. 7**
143	1105	P58/26	Finance and Resource Committee Assurance Reports from the meetings held on the 2nd April 2026 and the 7th May 2026	Russell Andrews	**Assurance**	**Enc. 8a and 8b**
10-minute Break						
14	1125	P59/26	Quality Committee Assurance Reports from the meetings held on 2nd April 2026 and the 7th May 2026	Pauline Walsh	**Assurance**	**Enc. 9a and 9b**
15	1135	P60/26	Audit Committee Assurance Report from the meeting held on 8th May 2026	Prem Gabbi	**Assurance**	**Enc. 10**
16	1145	P61/26	People, Culture and Development Committee Assurance Report from the Business Meeting held on 11th May 2026	Martin Evans	**Assurance**	**Enc. 11**
17	1155	P62/26	Veterans Aware / Veterans Covenant Annual Update	Ben Richards	**Assurance**	**Enc. 12**
18	1200	P63/26	Any Other Business	Janet Dawson	**Note**	**Verbal**

19	1205	P64/26	Meeting Self-Assessment	Janet Dawson	**Discussion**	**Verbal**
CONSENT ITEMS						
20	1210	P65/26	Self-Certification G6 and FT4 2025/26	Nicola Griffiths	**Information**	**Enc. 13**
21	1210	P66/26	Board Cycle of Business 2026/27	Nicola Griffiths	**Information**	**Enc. 14**
22	1210	P67/26	Trust Board Attendance Report	Janet Dawson	**Information**	**Enc. 15**

Date and Time of Next Meeting
9th July 2026 at 10.00am, Boardroom
Lawton House and via MS Teams

Appendix 1

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.

Appendix 2 - BAF Risks 2026/27

No	Strategic Priority	Theme / Risk Type	Exec Lead	Risk Title
1	Prevention	Reputational	Chief Strategy Officer	There is a risk that the Trust may be unable to fulfil the role of delivering the NHS 10 Year Plan due to ineffective strategic relationships with partner organisations. As a consequence, we may fail to deliver against the Trusts strategic priorities that require system and cluster collaboration.
2	Access	Quality	Chief Medical Officer	There is a risk that if the Trust's capacity, productivity and pathways do not keep pace with increasing and changing demand for mental health services, we may be unable to consistently meet the needs of our population, resulting in inequitable access, variable experience, reduced responsiveness and increased safety risks across our services.
3	Access	People	Chief People Officer	There is a risk that we will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors. As a consequence, we will not be able to support our people to continue to deliver outstanding, compassionate care.
4	Access	Financial	Chief Operating Officer	There is a risk of non-delivery of our financial plans and/or an impact on service quality due to the level of transformation required, with the consequence being an effect on clinical outcomes and/or the Trust's financial viability.
5	Growth	Financial	Chief Finance Officer	There is a risk to the Trust's long term financial sustainability due to failure to deliver recurrent cash releasing savings, and higher than planned bank and agency expenditure. As a consequence, this could lead to a financial deficit, reduced liquidity, a lack of investment in service delivery which would potentially impact the future viability of the Trust.

6	Growth	Digital	Chief Strategy Officer	There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.
7	Access	Quality	Chief Operating Officer	There is a risk of non-delivery of effective neurodiversity care pathways (including Autism and ADHD) due to the disparity between funded activity and levels of demand, with the consequence being an impact on clinical outcomes and patient experience including long waiting times
8	Prevention	Regulatory	Chief Nursing Officer	There is a risk that the Trust may fail to meet legal and regulatory requirements due to the evolving regulatory and statutory landscape, the consequence is legal and regulatory action, deterioration in ratings, and loss of public and stakeholder confidence.

PUBLIC TRUST BOARD

Minutes of the Public Section of the North Staffordshire Combined Healthcare NHS Trust Board meeting held on Thursday 12th March 2026 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
Lisa Dodds	LD	Deputy Chief Finance Officer
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 Director (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 Griffiths	NG	Deputy Director of Governance / Board Secretary
Joe McCrea	JM	Associate Director of Communications
Jenny Harvey	JH	Staff Side Representative
Lisa Wilkinson	LW	Corporate Governance Manager (Minutes)

Meeting commenced at 10.00am

22/26	**APOLOGIES FOR ABSENCE** Sherrine Khan - Senior Peer Support Worker Eric Gardiner - Chief Finance Officer / Deputy Chief Executive Nicola Bullen - NExT Director Programme Members of the public online were welcomed to the meeting.	
23/26	**DECLARATIONS OF INTEREST RELATING TO AGENDA** No declarations were made ***Noted***	
24/25	**MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 15TH JANUARY 2026** Prem Gabbi noted two typographical errors within the draft minutes. It was agreed that the minutes would be amended to reflect these corrections. Subject to these changes being made, the minutes were approved as a true and accurate record. ***Approved/Received***	

<table>
<tr><td>25/26</td><td>ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 15TH JANUARY 2026

09/26 – QUESTIONS FROM MEMBERS OF THE PUBLIC
Ben Richards agreed to reach out to Healthwatch to seek feedback and assurance that the 'no wrong door' policy was being effectively implemented across services. 12.03.26 – Action Complete. Contact has been made with Healthwatch who are also undertaking some planned public engagement sessions over the coming months. The COO has arranged to meet with the new manager for Healthwatch once these have been completed.

Received</td><td></td></tr>
<tr><td>26/26</td><td>PATIENT STORY – RICHARDS STORY
Kenny Laing, Chief Nursing Officer, presented the patient story.

Richard, now a long-standing member of staff, reflected on his experience of using mental health services around 30 years ago, describing the challenges he faced, the support he received, and the impact this had on his recovery journey. He highlighted the pivotal role of compassionate nursing, therapeutic support and understanding personal history in shaping behaviour and wellbeing. His experience inspired him to pursue a career in mental health.

The Board viewed a video of Richard's story and expressed thanks to Richard for his openness and courage in sharing his lived experience.

Board members reflected on the importance of engaging parents/carers appropriately, including during assessments and treatment, while balancing patient choice and legal considerations around competence and confidentiality. Kenny Laing outlined the Trust's holistic approach and the skills required to navigate these boundaries.

Members of the Board emphasised the enduring impact of seemingly small but meaningful interactions with staff and the importance of continuity, connection and sensitive discharge planning. Examples were shared of good and poor practice nationally, underlining the value of staff training and support.

The Board noted changes in practice since Richard's experience, acknowledging improvements in risk assessment, crisis support, and pathways into community and crisis services. The importance of early, transparent conversations about treatment duration and recovery expectations was highlighted.

The Board discussed opportunities to strengthen community understanding of mental health, recognising signs of distress, and supporting people who may not be formally identified as carers.

The Board welcomed the contribution of lived experience roles and reflected on how staff with personal experience were supported across the organisation. ACTION: Further consideration of support and supervision arrangements for staff with lived experience to be explored through People, Culture and Development Committee (PCDC).</td><td>

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	The ease of locating individuals via social media was noted, and the Board discussed ensuring staff were supported to navigate these risks appropriately. Joe McCrea confirmed that the social media policy included guidance on identifying risks and advised the policy would be reviewed and strengthened if necessary. Overall, the Board recognised the story as a powerful reminder of the importance of relationships, compassion, continuity of care and the progress made in mental health services over the last three decades. Members expressed appreciation for the learning generated and the value of lived experience in shaping service improvement. **Noted**	
27/26	**REACH RECOGNITION TEAM AWARD – Mental Health Law Team** Dr Buki Adeyemo, Chief Executive Officer introduced the award. The Board received the REACH Team Award nomination for the Mental Health Law Team, recognised for their pivotal role in ensuring safe, lawful and efficient application of the Mental Health Act (MHA) and Mental Capacity Act (MCA). The team provides expert guidance to staff, manages tribunals and hospital hearings, liaises with external partners, and safeguards patient rights. It was noted that their work reflected the Trust's Proud to CARE values, consistently managing complex and sensitive cases with professionalism and compassion. Key achievements included introducing eMHA to improve administrative and clinical efficiency and strengthening tribunal and hearing processes. Outcomes included positive feedback from clinicians, strong responsiveness, and preventing unlawful detentions through timely compliance. The Board congratulated the team on their award. ***Received***	
28/26	**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: **National Context:** Dr Buki Adeyemo drew attention to the CQC report and its relevance for Combined. **Veterans Aware** The Trust continues to progress strongly toward gold re-accreditation, with ongoing work to improve identification, support for veterans and armed forces families, community engagement, and staff support. A full annual update will be presented to Board in May. Board members were asked to support external engagement and advocacy to strengthen the Trust's gold accreditation application.	

	Mental Health Nurses Day Activity and engagement were noted positively. **PLACE Results** It was noted that the Trust had again achieved exceptionally high scores in the annual Patient-Led Assessment of the Care Environment, with seven of eight domains above the mental health trust benchmark, and 99% scores for 'Dementia-Friendly Environment' and 'Cleanliness', reflecting consistently strong performance. **Equalities and Inequalities** The Board discussed racial inequality data, noting that whist the Trust did not display significant disproportionality at Trust level, continued focus was required. Further embedding of equalities data, including intersectionality, into Committee reporting and quality cycles was supported. The role of Patient and Carer Race Equality Framework (PCREF) and improvements in data quality were emphasised. **ACTION: Embed regular reporting and discussion of inequality data, including intersectionality, as a standing agenda item in the Quality Committee's business cycle.** **Community Grants & Impact** Board members welcomed the positive outcomes from Primary Care Support England (PCSE) grant allocations and requested continued evaluation of their impact on communities, with a final impact report to be produced at programme end. **Work with Hard-to-Reach Communities** Insights were shared on engaging communities less likely to access services, including using community events as opportunities for connection and mental health awareness. ***Noted***	**KL/NG**
29/26	**CHAIRS REPORT** Janet Dawson, Chair, provided a verbal update. Janet Dawson highlighted the successful celebration event of Project Chrysalis, noting the positive impact of the newly transformed, safe and welcoming environments created through the programme. Appreciation was expressed to all staff and partners involved, with a request to ensure all contributors received appropriate acknowledgment packs. The Chair reflected on recent Board-to-Team visits, including the Parent and Baby Unit, where feedback from service users and staff emphasised strong local leadership, effective multi-agency working and the positive impact of the service environment. The Chair noted that some teams continued to raise recurring issues and suggested periodic reporting back to Board on resolution of actions. The Board discussed strengthening communication back to teams where actions could not be progressed, ensuring clarity and feedback loops. Members also noted the value of thematic review of Board-to-Team issues to identify trends in safety, training, infrastructure and governance.	

	Updates were provided on further Chrysalis developments, including reductions in safety incidents linked to improved environments and fixtures. The Board also noted recent external commissioning of parent-support films by the Family Hub team, supported by Communications and Finance. ***Noted***	
30/26	**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. There were no questions from the public ***Noted***	
31/26	**TERRORISM (PROTECTION OF PREMISES) ACT 2025 (MARTYNS LAW) APPOINTMENT OF SENIOR INDIVIDUAL (DSI) AND IMPLEMENTATION PLAN** Ben Richards, Chief Operating Officer, presented the report. Ben Richards outlined the Trust's duties under the Terrorism (Protection of Premises) Act 2025 ("Martyn's Law") noting that the statutory Code of Practice was still awaited, yet several duties were already in force and required organisational preparedness. The Board noted Harplands Hospital met the criteria for the enhanced duty tier; Keele-based services would align with Keele University arrangements. Public-facing events may also fall within scope and would require specific risk assessments. Much of the required activity aligned with existing Emergency Preparedness, Resilience and Response (EPRR) arrangements, meaning only limited changes were anticipated. The Trust already undertakes multi-agency exercises through the Local Resilience Forum (LRF). National training materials were published this week, and the Trust will integrate these as guidance becomes available. Cyber-related risks would only fall under Martyn's Law where they directly affected physical protection or site lockdown procedures. No significant additional resource impact was currently expected, though this would continue to be reviewed as the statutory guidance is issued. Ben Richards confirmed ongoing engagement with system partners and LRF colleagues to ensure alignment and shared learning. Planned security enhancements at Harplands were already in progress and would contribute to compliance. The Board approved the Chief Operating Officer as the Trust's Designated Senior Individual (DSI) as required by the Act. The Board agreed that ongoing assurance and oversight would be managed via the Quality Committee. ***Approved / Received***	

32/26	**BOARD ASSURANCE FRAMEWORK (BAF) QUARTER 3 2025/26** Nicola Griffiths, Deputy Director of Governance, presented the report. The Board noted that five risks remained stable this quarter, with one risk score reduced following approval by the Quality Committee. Updates to the BAF now include risk appetite statements and tolerance levels, reflecting the development work undertaken over the past year. The Board discussed alignment between BAF risks and high-level Trust and operational risks (15+), supporting improved assurance and informed review. Detailed discussion took place around Risk 3 (People) and Risk 6 (Digital & Data Transformation), including recruitment, workforce sustainability, digital delivery challenges, and the impact of external factors. Members noted that while progress was evident, particularly around workforce, external influences continued to affect risk trajectories. The Board welcomed improvements to data presentation, including tolerance lines, and supported further development of the new BAF for 2026/27, including a move away from fixed target scores toward tolerance-based monitoring. It was noted that some risks may require a longer-term approach aligned to medium and long-term planning cycles. ***Approved / Received***	
33/26	**BOARD POLICIES FOR APPROVAL** Nicola Griffiths, Deputy Director of Governance, presented the report. Nicola Griffiths advised a recent review of Board-level and Committee-level policy approvals had been undertaken in line with NHS England guidance, NHS Providers advice and the Code of Governance. The review confirmed that Boards retained flexibility in determining which policies they wish to approve directly and which could be delegated to Committees under the Scheme of Delegation. The Board currently receives a small number of policies and following review, it was proposed that five policies continued to be reserved for Board approval, Health & Safety, EPRR, Scheme of Delegation, Standing Orders, and Standing Financial Instructions. The Board discussed the balance between Board and Committee responsibilities, noting that Committees (as sub-groups of the Board) undertook detailed scrutiny, with escalation to Board by exception. Some policies (e.g. those negotiated through Joint Negotiating and Consultation Committee (JNCC) followed specific development routes but were supported by Chief Officer attendance. In exceptional cases, such as matters involving vicarious liability or significant organisational impact, Board-level approval may still be required. Quality of reporting at Committee level should allow Board members to identify when escalation is appropriate. The Board agreed the proposed approach and noted that arrangements would continue to be reviewed to ensure they remained proportionate and effective. ***Approved / Received***	

34/26	**IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 10** Lisa Dodds, Deputy Chief Finance Officer, presented the Month 10 IQPR report. Lisa Dodds reported a positive performance overall, with only one operational standard (CYP four-week wait) marginally below target. Workforce metrics such as clinical supervision and appraisal rates remained below target, and access waiting times had improved despite increased demand. Lisa Dodds and Ben Richards discussed ongoing challenges with clinically ready-for-discharge patients, particularly in older adults, and efforts to improve bed flow through engagement with local authorities. Adjustments to length-of-stay metrics were planned to provide a more holistic view. The Board discussed concerns about clinical supervision, which had prompted a multidisciplinary review led by heads of professions. Frieza Mahmood noted that findings from this review were being integrated into improvement plans. The Trust's data quality maturity index remained high. Ben Richards described ongoing action plans to address out-of-area placements and other operational challenges, including upcoming events with system partners to identify further improvements. ***Received***	
36/26	**FINANCE REPORT MONTH 10** Lisa Dodds, Deputy Chief Finance Officer presented the report. Lisa Dodds reported a year-to-date surplus of £942k and a forecasted year-end surplus of £1.75m. However, she highlighted that the underlying financial position remained a deficit of £955k, primarily due to non-recurrent benefits used to achieve the surplus. Frieza Mahmood inquired about the impact of the wider system deficit. Lisa Dodds clarified that the system was working towards break-even, with no expectation for the Trust to contribute to other organisations' deficits. The Trust was expected to deliver its own surplus. Lisa Dodds explained that capital underspend was due to lower-than-anticipated costs for maintenance schemes, with flexibility to defer spending into the next financial year. Surplus funds could be used for future patient care improvements. . Cost Improvement Programme (CIP) was reported to be on track, with 96% of schemes implemented. Agency spend was in line with plan, but bank expenditure is over plan. Lisa Dodds reported that these factors were being monitored as part of ongoing financial management. ***Received***	
36/26	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 5th FEBRUARY 2026 AND 5TH MARCH 2026**	

	Russell Andrews, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: **5 February 2026** The report was taken as read. **5 March 2026** The Chair reflected on the developing use of assurance levels, noting their increasing value as a tool for identifying areas requiring deeper scrutiny. Items with lower assurance levels, such as Orbis and Project Chrysalis, typically received the most discussion due to the complexity of underlying issues. **Orbis (EPR Programme)** Go-live will not take place in June. The Committee agreed this was the right decision and provided Level 3 assurance. There were no immediate dependencies impacting other digital or operational programmes at this stage. **Finance (Month 10)** The Committee discussed the Month 10 position (as presented earlier in the Board meeting) and provided Level 7 assurance, noting the Trust's expected year-end surplus and continued strong financial management. **Cost Improvement Programme (CIP)** It was reported that CIP delivery remained on track and received a strong level of assurance. **Business Opportunities** Although one bid was unsuccessful, three further opportunities were in development, indicating a more consistent pipeline than in previous years. Level 5 assurance was provided. **Digital Funding Opportunities** Members discussed potential system-wide digital investment routes. Russell Andrews advised updates would be fed back to the Committee following ICB-level engagement and national programme discussions. ***Received***	
P37/26	**QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 5TH FEBRUARY 2026 AND 5TH MARCH 2026** Pauline Walsh, Non-Executive Director / Committee Chair, presented the reports. **5 February 2026** A Community Deep Dive was undertaken focusing on people with severe mental illness. The Committee received strong assurance on current systems and risk management, while noting areas for further development and long-term planning. The Committee reviewed the IQPR update, recognising progress and actions underway. Assurance levels were reviewed, the Clinical Audit report was increased from Level 3 to Level 4 due to improved performance.	

	The Committee approved the risk register and policy report. **5 March 2026** The Committee received a positive follow-up report on the Darwin Centre, demonstrating significant improvements in environment, safety, reduction in seclusion and long-term segregation, strengthened MDT working, and progress toward national accreditation. Assurance reports were reviewed, with updated levels: Safeguarding – Level 6 PSIRF – Level 5 Clinical Effectiveness – Level 6 The Committee approved the risk register and policy extensions. Members discussed the Intellectual Property Policy, noting it may be better aligned to another Committee given future organisational ambitions (e.g. training arms, centres of excellence). A review of Committee placement is underway. ***Received***	
P38/26	**AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 28TH JANUARY 2026** Prem Gabbi, Non-Executive Director / Committee Chair, presented the report and highlighted the following: **Accounting Timetable** The Committee noted the new accounting timetable, which would come into effect before the end of the calendar year. **Internal Audit Programme** Internal Audit confirmed that they remained on track to complete the annual programme, despite a large volume of work within the final period. The Committee received assurance that the programme would be delivered in full. **Internal Controls – Audit Report** A positive Internal Audit report was received relating to internal controls within the finance function. Six recommendations were made: 3 low and 3 medium. Many actions had already been completed, and the Committee agreed this demonstrated strong performance from the Finance Team. **Committee Chair Assurance Presentations** This meeting marked the first time another Committee Chair attended to provide direct assurance to the Audit Committee on how their Committee discharged its duties. The approach worked well as a cross-check and oversight mechanism. A template has been developed for use when the remaining two Committee Chairs attend the Audit Committee in due course. The Committee acknowledged this was a "trial and learn" process but agreed it added value and strengthened assurance.	

	Clinical Coding Audit The Committee received the external clinical coding audit undertaken by a third-party specialist. Assurance was significantly strengthened, with primary coding accuracy at 100%. The Committee agreed this represented a high level of assurance regarding patient care coding quality. **Assurance Levels and Approval Decisions** A broader discussion took place on the relationship between levels of assurance and Committee approval of items. Prem Gabbi reflected on scenarios where an item may hold a Level 3 (limited) assurance but still required Committee approval, questioning whether this alignment was appropriate. Pauline Walsh noted a similar issue in the Quality Committee regarding policy approvals. The level of assurance relates to the framework or overall system, not necessarily the individual policy being approved. Committees may therefore approve a policy even when the wider framework still needed improvement. Nicola Griffiths highlighted that every Committee had debated this issue recently. Assurance reflects clarity of understanding of the issues and risks not only high performance. A paper presenting challenges transparently may still provide high assurance if the Committee was confident in the mitigation and governance in place. The Committee agreed further refinement of assurance level definitions may be required. ***Received***	
P39/26	**PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 2ND MARCH 2026** Martin Evans, Non-Executive Director / Committee Chair, presented the report and highlighted the following: **Staff Story** A positive staff story was shared regarding the work led by Sarah, Ward Manager on Ward 6, on embedding "All Being Us" principles within her team. The Committee commended the leadership demonstrated and agreed to review associated workforce measures to triangulate the positive narrative with supporting data. An action was agreed to explore whether additional support could be offered to the ward to sustain and replicate this good practice. **Freedom to Speak up Policy** The Committee held an extensive discussion on the Equality Impact Assessment (EIA) accompanying the revised Freedom to Speak Up Policy. The Committee noted that the EIA recorded "no impact" across all categories, which was inconsistent with known disparities in speaking-up behaviour across staff groups. The Committee therefore did not approve the policy and requested that the EIA be fully reviewed to ensure it meaningfully reflected the impact on different staff groups and appropriately considered implementation issues. It was agreed that this example would be used to reinforce expectations for higher-quality EIAs across all Trust policies. It was agreed a further update would return to the next meeting. **Workforce Summary Report** Level 7 assurance was provided. The Committee welcomed the clear focus within the report and requested exploration of a more progressive approach	

	to managing sickness absence. This was being taken forward at chief officer level, with an update to return to a future meeting. **Quarter 3 Reports** Level 6 assurance was received. The Chair reflected that the Freedom to Speak Up Quarter 3 Report was of sufficient strategic importance that the Board should receive full visibility of it going forward, in addition to Committee assurance. **Inclusion and Belonging Annual Report** Level 6 assurance was received. The Committee noted areas requiring further action, which have been captured within the work plan. **Communications and Engagement Operational Plan – Quarter 3** Level 7 assurance was received. **Pay Gap Report** Level 6 assurance was received. The Committee noted a continued reduction in the gender pay gap (positive progress); that global majority staff, on average, earnt more than white colleagues due to a higher proportion in senior roles; further work required to understand and address disparities relating to disability. The report was approved, with actions to be monitored via the Committee. The Committee also approved three policies, reviewed the associated risks, and confirmed Level 6 assurance for the risk discussion. Dr Buki Adeyemo, highlighted the importance of ensuring staff were fully aware of wellbeing spaces, including the “U2 Matter” room. She emphasised the need for continued, proactive communication so staff felt enabled to use available facilities. Frieza Mahmood, reflected that operational pressures could deter staff from leaving ward areas, even for short periods, and agreed that clearer communication and expectations would be beneficial. Kenny Laing confirmed upcoming work to standardise expectations for staff access to break rooms. This will include assessing facilities across wards and establishing a Trust-wide standard. ***Received***	
P40/26	**CHARITABLE FUNDS COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 2ND MARCH 2026** Martin Evans, Non-Executive Director / Committee Vice Chair, presented the report. **Grant Funding Update** Elizabeth Mellor reported a positive outcome to the Trust’s application to NHS Charities Together Workforce Development Programme. A total of 109 applications were submitted nationally, with 39 organisations successful. The Trust was awarded the full £50,000 allocation. The Committee expressed its delight and thanked all those involved in preparing the application, noting the positive impact this funding would have on staff.	

	Charitable Expenditure The Committee approved the ward request for a “Magic Table”, noting the benefits demonstrated on other wards where similar equipment had already been introduced. ***Received***	
41/26	**ANY OTHER BUSINESS** There were no items of other business. Janet Dawson noted that Nicola Bullen, who had been serving as a Non-Executive Director, officially left the Board today. The Board recorded its thanks and appreciation for Nicola’s contribution during her time with the Trust. Members wished her well and expressed hope that their paths may cross again within the NHS in future. ***Noted***	
42/26	**MEETING SELF ASSESSMENT** Frieza Mahmood observed that the meeting had benefited from a high level of constructive discussion and challenge, noting that this was both healthy and welcome. ***Noted***	
43/26	**BOARD MEMBERS DECLARATIONS OF INTEREST REGISTER** Circulated for information only	
44/26	**MEDIUM TERM PLANNING FINAL SUBMISSION 2026/27** Circulated for information only	
45/26	**TRUST BOARD ATTENDANCE REPORT** Circulated for information only.	
	DATE AND TIME OF NEXT MEETING Thursday 14th May 2026 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12:36pm

Signed: ______________________________ Date:
Chair

Board Action Monitoring Schedule

Trust Board - Action monitoring schedule - (Public)						
No.	**Meeting Date**	**Minute No**	**Action Description**	**Responsible Officer**	**Target Date**	**Progress / Comment**
1	12th March 2026	26/26	**PATIENT STORY - RICHARDS STORY** Further consideration of support and supervision arrangements for staff with lived experience to be explored through People, Culture and Development Committee (PCDC).	Martin Evans / Frieza Mahmood	14th May 2026	This is being picked up as part of the revised PCDC sub committee structure and specifically the New Workforce Development and Transformation Committee which replaces SEAL and has a remit for professional supervision and practice support needs
2	12th March 2026	28/26	**CHIEF EXECUTIVES REPORT - Equalities and Inequalities** Embed regular reporting and discussion of inequality data, including intersectionality, as a standing agenda item in the Quality Committee's business cycle.	Kenny Laing / Nicola Griffiths	14th May 2026	Dr Dennis Okolo will pick up this action and discuss with Pauline Walsh - action wil be closed once built into the Quality Committee process.

Enclosure No: 3

CEO BOARD REPORT – MAY 2026

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

Report to:	Public Trust Board
Date of Meeting:	14 May 2026

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

Aligned to Board Assurance Framework Risk:	Reputational - The Trust may be unable to fulfil the role of delivering the NHS 10 Year Plan due to ineffective strategic relationships with partner organisations.
7 Levels of Assurance:	This paper is for information only
Approval / Review:	Execs
Strategic Priorities:	Prevention – We will continue to grow high quality, integrated services delivered by an innovative and sustainable workforce.
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	Includes developments at a system level

Recommendation / Required Action:	To receive the report for information
Executive Summary:	The Report updates the Board on strategic activity undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest. These include: • Minimum standards for keyworking services for autistic children and young people and children and young people with a learning disability • Mental Health Act 2025 - Section 51 implemented • Dragon Square Short Breaks Rated Good by Ofsted • Combined highlighted as a National Exemplar by the NHS GIRFT (Getting it Right First Time) programme • Combined launches RiTA Risk Management Training • Real Talk Real Change • Engagement@Combined 2026 – our biggest event yet • Lincoln Gombedza, Practice Education Facilitator and Registered Learning Disability Nurse, wins Bronze Nurse of the Year Award • Global Recycling Day at Combined Healthcare • Everyone Health Staffordshire wins HSJ Award for Severe Mental Illness (SMI) Healthy Lifestyle Service

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	07/05/2026

Chief Executive's Report to the Trust Board
May 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 NATIONAL CONTEXT AND UPDATES

Minimum standards for keyworking services for autistic children and young people and children and young people with a learning disability

In April, NHS England published the minimum standards for keyworking services for autistic children and young people and children and young people with a learning disability.

The standards support integrated care boards (ICBs), which commission autism and learning disability keyworkers. Children and young people with a learning disability and/or who are autistic with the most complex needs now receive support from a designated keyworker, following commitment in the NHS Long Term Plan. The minimum standards have been developed from a national evaluation of keyworking.

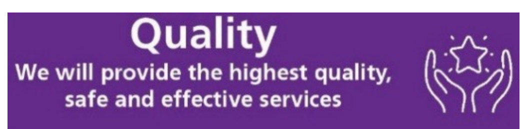
Combined Healthcare was one of the first sites to introduce the Key Working Service, as part of the work we have done across the system we have worked hard to ensure across our ICS that we are aligned,

Mental Health Act 2025 - Section 51 implemented

Section 51 of the Mental Health Act 2025, which addresses a gap in the application of the Human Rights Act to some mental health patients, came into effect in April. Section 51 strengthens patient safeguards by ensuring that private, independent, and voluntary care providers are bound by the same human rights duties as public providers. This change is part of wider reform designed to improve patient care and oversight in private settings.

3.0 OUR TRUST

3.1



Dragon Square Short Breaks Rated Good by Ofsted

We are delighted that Dragon Square Short Breaks has been rated Good overall following an Ofsted inspection on 10–11 March 2026. This continues the service's strong track record, with a Good rating at every inspection since 2021.

Inspectors praised the high-quality, individualised care provided, highlighting the welcoming and nurturing staff team, strong relationships with children and families, and engaging activities that support children's confidence, learning and independence. Safeguarding arrangements were also judged to be Good, with staff demonstrating a clear focus on children's safety, dignity and wellbeing.

A huge thank you to Emma and the entire Dragon Square team for their dedication and commitment. This is a fantastic achievement and real credit to everyone involved. Well done, Dragon Square!

Combined highlighted as a National Exemplar by the NHS GIRFT (Getting it Right First Time) programme

Getting It Right First Time is a clinically led national programme, consisting of a review and implementation team, designed to improve clinical care in the NHS. Through innovative use of data to reduce unwarranted variations in the way services are delivered, and by sharing best practice, GIRFT identifies changes that will help improve care and patient outcomes.

The deep-dive review focused on the trust's high performance regarding access and wait times. The analysis of NHS England Mental Health Services Dataset (MHSDS), placed Combined in the top five Children and Young People's Mental Health (CYPMH) providers for measures relating to average time to first and second meaningful help

The data revealed that Combined experiences some of the highest demand in the country, with accepted referral rates approaching 90 per 1,000 children (roughly 9% of the local youth population). Despite this overwhelming volume, which has seen a threefold increase since the COVID-19 pandemic—the trust consistently reports some of the shortest wait times in England. The average time from an accepted referral to a "First Help" contact is just 18 days, placing Combined firmly in the top performing decile nationally.

The GIRFT team will document Combined's model of integrating informatics with clinical operations (specifically the Performance Clinics and Job Planning matrix) as an area of outstanding national practice. This will be published in the upcoming national dynamic toolkits for other trusts to emulate.

Combined launches RiTA Risk Management Training

A new suite of risk management training films and a brand new Risk Training App – designed and built entirely in-house by the Trust's Governance and Communications teams – are now available for all Combined staff.

Featuring RiTA – Combined's Risk Training Avatar – RiTA Risk Management is a suite of bitesize training films and a simple, easy-to-use app designed to help staff understand and apply risk management in their day-to-day work.

The training content can be viewed via our YouTube channel at https://www.youtube.com/playlist?list=PLuLnRckD7bTdXF9vqy7Go2CekRSmzcTV9

A link to download and install the App is available to all Combined staff.

Real Talk Real Change

The trust has launched its major new engagement and listening programme – Real Talk Real Change. This programme is designed to support meaningful conversations that lead to change. Engaging with colleagues through meaningful, regular conversations is essential for us to continue to be outstanding in all that we do and how we do it.

When we take time to talk, listen and genuinely connect, we build a workplace where everyone feels valued, respected and able to be their best. Our people's insights, ideas and experiences are what drive real change. By engaging openly and honestly, we can remove barriers, celebrate our successes and co-create solutions that improve the services for our patients and service users.

In a time when NHS pressures are higher than ever, staying connected through meaningful conversations is more important than ever in protecting our wellbeing whilst delivering exceptional care.

Our Real Talk, Real Change conversations reiterate our commitment to ensuring colleague voice is at the heart of our decision making and how we intend to work together. They have been developed to allow a broad range of opportunities for colleagues to engage, reflecting our inclusive approach. Every voice strengthens our culture; every conversation deepens our understanding and together we create an environment where we can all thrive.

Outstanding care begins with outstanding colleagues – and that starts with listening to them.

Engagement@Combined 2026 – our biggest event yet

Stakeholders from across Staffordshire and Stoke-on-Trent came together for a fabulous Engagement@Combined event.

This was our third year hosting our stakeholder, service user and carer event, and it has truly gone from strength to strength.

This is down to commitment and dedication from our staff, service users and stakeholder organisations, and we would like to extend a huge thank you to everyone for showing up and participating in this engagement event. The power, energy, and 'can-do' attitude in the room were both heart-warming and encouraging, highlighting the strength of what we offer to our community members with mental health, learning disability and neurodiverse needs.

Many of the attendees commented on the momentum we have built together, and we are keen to keep this moving forward. We are committed to exploring how we can sustain these partnerships and make the most of the unique assets, experiences, and resources that everyone brings. Our ambition is to work in genuine partnerships, helping to reach communities that may currently feel out of reach, and collaborating in ways that are meaningful, balanced, and mutually beneficial for everyone involved in delivering or receiving services.

You can watch a highlight film from the day by clicking here.

Lincoln Gombedza, Practice Education Facilitator and Registered Learning Disability Nurse, wins Bronze Nurse of the Year Award

We are delighted that Lincoln Gombedza, Practice Education Facilitator and Registered Learning Disability Nurse at Combined Healthcare, has received the Bronze Nurse of the Year Award at the British Journal of Nursing Awards 2026.

This award is presented to those who have made an outstanding achievement in nursing this year. This national recognition reflects Lincoln's leadership, innovation, and contribution to nursing practice, education, and digital development.

We are proud to see his achievements recognised through this extremely well-deserved award.

4.3

Global Recycling Day at Combined Healthcare

On Wednesday 18 March, Combined Healthcare marked Global Recycling Day. There was much to celebrate, as colleagues from the Trust and our recycling partner, Biffa, promoted the fantastic achievements made across the organisation since the implementation of single stream recycling.

Since December 2024, the Trust has worked alongside Biffa to roll out single stream recycling across all sites, moving away from general waste and mixed recycling only, to the separate disposal and recycling of general waste, food, glass, cardboard and paper, plastic, and cans. The implementation of the single stream recycling programme across the Trust has already reduced general waste generation by a staggering 25%, and increased recycling across the board – with a 12% increase on food waste separation at source.

The Trust implemented this new recycling programme in time for the introduction of the Simpler Recycling Legislation and momentum has continued during the first year of the programme – with staff from the Trust's estates team and those involved in the Sustainability programme educating colleagues on the importance of recycling and splitting waste types.
Colleagues from the Trust and Biffa are committed to working in partnership to continue to reduce the Trust's general waste production and increase recycling where possible.

Everyone Health Staffordshire wins HSJ Award for Severe Mental Illness (SMI) Healthy Lifestyle Service

Our partners at Everyone Health Staffordshire recently received the HSJ Award for Best Provider of Mental Health Services, for the SMI Healthy Lifestyle Services delivered across South Staffordshire in partnership with local organisations including Combined Healthcare.

The SMI Healthy Lifestyle Service provides people with serious mental illness with advice and support around exercise, weight management and healthy eating, to help them make sustainable lifestyle improvements.

Everyone Health reports that the service is delivering outcomes including:

• improved physical health indicators and healthier lifestyle behaviours
• increased confidence, motivation, and self-management skills
• reduced social isolation through stronger peer and community connections
• improved mental wellbeing and engagement with ongoing support

This is linked to our SMI Pathway and support is offered via Everyone Health Staffordshire which offers specific targeted physical health interventions, our teams are able to refer patients into this service and is linked strategically with the SMI Physical Health Pathways
.
A huge well done to everyone involved in this fantastic project – both our Combined colleagues and those from our partner organisations and Everyone Health Staffordshire.

5.0 CONCLUSION

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

Enclosure No: 4

ASK THE BOARD – MAY 2026

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

Report to:	Public Trust Board
Date of Meeting:	14 May 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 - If the Trust's capacity, productivity and pathways do not keep pace with increasing and changing demand for mental health services, we may be unable to consistently meet the needs of our population.
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 continue to grow high quality, integrated services delivered by an innovative and sustainable workforce.
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	

Recommendation / Required Action:	The Trust Board receive a question from a member of the public and provide a response during Public Trust Board meeting.
Executive Summary:	The following question has been submitted by a member of the public since the previous Public Trust Board meeting. A response will be provided by a Board member during this meeting. **Question**: With pending changes to the Local Government structure in Stoke-on-Trent and Staffordshire. What is the Boards view on the Provision of health services that are commissioned currently by the Local Authorities, should they instead be commissioned by the local ICB. I am especially concerned about the provision of substance misuse services and sexual health services – ***Member of the Public***

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	08/05/2026

Enclosure No: 5

Trust Board, Board Assurance Framework (BAF) 2026/27

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

Report to:	Public Trust Board
Date of Meeting:	14 May 2026

Presented by:	Nicky Griffiths Deputy Director Governance / Trust Board Secretary
Prepared by:	Jayne Mottram Risk Manager
Executive Lead:	Buki Adeyemo-Chief Executive Officer

Aligned to Board Assurance Framework Risk:	This report contains the proposed BAF risks for 2026/27
7 Levels of Assurance:	This paper is for information only
Approval / Review:	Board Seminar Session 12.2.26 Executive Team Meeting 10.3.26 Risk Review Group 7.4.26 Finance & Resource Committee 7.5.26 Quality Committee 7.5.26 Audit Committee 8.5.26 People, Culture & development Committee 11.5.26
Strategic Priorities:	The Trust BAF describes any identified risks to the delivery of the Trust Strategy – and its key priorities.
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	N/A
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.

ICS Alignment / Implications:	NSCHT continues to offer support to the development of the ICS BAF which informs the strategic priorities and risks for the System. Trust Secretary continues to meet with System partners as regards the System BAF on a quarterly basis via the ICB Risk and Governance Meeting.
Recommendation / Required Action:	Trust Board to receive the proposed BAF Dashboard 26/27 for assurance.
Executive Summary:	The Board of each public sector organisation should actively seek to recognise risks and direct the response to these risks. It is for each Accounting Officer, supported by the Board, to decide how. The Board and Accounting Officer should be supported in advising on and scrutinising the management of key risks and the operation of efficient and effective internal controls. The Board, in setting strategy and policy, should use horizon scanning and scenario planning collectively and collaboratively to identify and consider the nature of emerging risks, threats and trends. The Board has an inherent role in protecting and assuring the public, which includes taking cost-effective action to reduce risk to a tolerable level and providing accurate and timely information about risks to the public. It has a responsibility to determine and continuously assess the nature and extent of the principal risks that the organisation is willing to take to achieve its objectives. (The Orange Book. Management of Risk- Principles and Concepts 2023.) The NSCHT BAF Dashboard 26/27 has been engaged upon at various points including: Board seminar session in February 2026. Executive Team meeting in March 2026. Individual 1-1's with Chief Officers and Deputies. Risk Review Group April 2026. **Proposed BAF Risks 2026/27.** (Appendix 1) 1) Strategic Direction / Partnerships 2) Quality and Safety 3) People 4) Financial Plans 5) Financial Sustainability 6) Digital 7) Neurodiversity Care Pathways (new) 8) Regulatory and Statutory (new) **Next Steps.** • Q1 reporting from July 2026

VERSION CONTROL:

Version	Report to	Date Reported
Version 1	Board Seminar Session	12.2.26
Version 1	Executive Team Meeting	10.3.26
Version 2	Risk Review Group Meeting	7.4.26
Version 2	Finance & Resource Committee	7.5.26
Version 2	Quality Committee	7.5.26
Version 2	Audit Committee	8.5.26
Version 2	People, Culture & Development Committee	11.5.26
Version 2	Trust Board	14.5.26

Appendix 1

BOARD ASSURANCE FRAMEWORK 2026-2027

OVERARCHING TRUST RISK APPETITE STATEMENT:

North Staffordshire Combined Healthcare NHS Trust maintains a balanced and purposeful risk appetite, recognising that achieving high quality, innovative and sustainable services requires a willingness to take measured risks where there is clear benefit to patients, staff and the wider population. The Trust is open to managed risk-taking in areas that drive improvement, digital transformation, service redesign, and long term financial sustainability—provided strong governance, controls, and oversight are in place. We remain cautious where risks could compromise safety, regulatory compliance, information governance, or the quality of patient care, and we adopt a minimal appetite for any risk that could impact the safety, dignity or experience of service users. Overall, the Trust seeks to make informed, evidence based decisions, balancing innovation with responsibility to ensure safe, compassionate, efficient and financially sustainable care.

Strategic Priorities

1. **PREVENTION - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care.**
2. **ACCESS - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access them.**
3. **GROWTH - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce.**

Risk No.	Strategic Priority	Theme/Risk Type	Executive Lead	Risk Title	Proposed Gross Score	Risk Appetite Level e.g. SEEK	Risk Appetite Tolerance Level	Risk Appetite Statement
1	Prevention	Reputational	Chief Strategy Officer	There is a risk that the Trust may be unable to fulfil the role of delivering the NHS 10 Year Plan due to ineffective strategic relationships with partner organisations. As a consequence, we may fail to deliver against the Trusts strategic priorities that require system and cluster collaboration.	Impact 4 (*Major*) X Likelihood 5 (*Almost Certain*) = **20**	SEEK	15-20	We are willing to take decisions that may attract scrutiny in order to promote innovation and new ideas where the potential benefits to our local population outweigh the associated risks. We actively encourage calculated reputational risk to drive improvements in patient outcomes, organisational effectiveness, and stakeholder value.
2	Access	Quality	Chief Medical Officer	There is a risk that if the Trust's capacity, productivity and pathways do not keep pace with increasing and changing demand for mental health services, we may be unable to consistently meet the needs of our population, resulting in inequitable access, variable experience, reduced responsiveness and increased safety risks across our services.	Impact 5 (*Catastrophic*) X Likelihood 3 (*Possible*) **= 15**	OPEN	12-20	We are open to taking managed risks in pursuit of improved clinical outcomes, innovation and service quality. We recognise that transformation and improvement may involve uncertainty, but we are committed to ensuring that such risks are carefully assessed, monitored, and aligned with our quality improvement goals. We will not compromise on safety, but we will support innovation that enhances care.
3	Access	People	Chief People Officer	There is a risk that we will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors. As a consequence, we will not be able to support our people to continue to deliver outstanding, compassionate care.	Impact 4 (*Major*) X Likelihood 3 (*Likely*) = **12**	OPEN	12-20	We have an open appetite for people-related risks where they support workforce development, leadership innovation, and cultural transformation. We encourage new approaches to recruitment, retention, and staff wellbeing, recognising that some initiatives may carry uncertainty. We are committed to creating a supportive and inclusive environment and will invest in change that strengthens our workforce and organisational culture.
4	Access	Financial	Chief Operating Officer	There is a risk of non-delivery of our financial plans and/or an impact on service quality due to the level of transformation required, with the consequence being an effect on clinical outcomes and/or the Trust's financial viability.	Impact 5 (Catastrophic) X Likelihood 4 (*Likely*) = **20**	OPEN	12-20	We recognise the importance of Value for Money, and that price is not the overriding factor. We are open to accepting some financial risk as long as the appropriate controls are in place, and where the potential benefits for the population outweighs the inherent risks.
5	Growth	Financial	Chief Finance Officer	There is a risk to the Trust's long term financial sustainability due to failure to deliver recurrent cash releasing savings, and higher than planned bank and agency expenditure. As a consequence, this could lead to a financial deficit, reduced liquidity, a lack of investment in service delivery which would potentially impact the future viability of the Trust.	Impact 5 (*Catastrophic*) x Likelihood 3 (*Possible*) = **15**	OPEN	12-20	We recognise the importance of Value for Money, and that price is not the overriding factor. We are open to accepting some financial risk as long as the appropriate controls are in place, and where the potential benefits for the population outweighs the inherent risks.
6	Growth	Digital	Chief Strategy Officer	There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.	Impact 4 (*Major*) x Likelihood 4 (Likely) = **16**	OPEN	12-20	We are willing to take calculated digital risks to pursue innovation, improve patient care, or enhance operational efficiency. This includes adopting new technologies or digital processes that may involve short-term disruption but offer significant long-term benefits for patients, staff, and the organisation.
7	Access	Quality	Chief Operating Officer	There is a risk of non-delivery of effective neurodiversity care pathways (including Autism and ADHD) due to the disparity between funded activity and levels of demand, with the consequence being an impact on clinical outcomes and patient experience including long waiting times	Impact 4 (*Major*) X Likelihood 5 (*Almost Certain*) = **20**	OPEN	12-20	We are open to taking managed risks in pursuit of improved clinical outcomes, innovation and service quality. We recognise that transformation and improvement may involve uncertainty, but we are committed to ensuring that such risks are carefully assessed, monitored, and aligned with our quality improvement goals. We will not compromise on safety, but we will support innovation that enhances care.
8	Prevention	Regulatory	Chief Nursing Officer	There is a risk that the Trust may fail to meet legal and regulatory requirements due to the evolving regulatory and statutory landscape, the consequence is legal and regulatory action, deterioration in ratings, and loss of public and stakeholder confidence.	Impact 5 *(Catastrophic)* X Likelihood 3 (*Possible*) **= 15**	Cautious	5-10	We are prepared to accept the possibility of limited regulatory challenge or moderate observations arising from our actions, provided these are informed by prior examples of successful practice elsewhere and are essential to achieving safe and effective patient care. Decisions will be taken cautiously, with a focus on learning from comparable situations and mitigating potential impact wherever possible.

Enclosure No: 6

IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) M12 2025/26

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

Report to:	Public Trust Board
Date of Meeting:	14 May 2026

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

Aligned to Board Assurance Framework Risk:	Quality - If the Trust's capacity, productivity and pathways do not keep pace with increasing and changing demand for mental health services, we may be unable to consistently meet the needs of our population.
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
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:	The Finance & Resource Committee is asked to note the contents of the report.
Executive Summary:	This report presents key performance highlights, areas of exception, and progress against the long-term plan and national mental health priorities against operational planning forecasts. There are three special cause variations (orange variation flags) – signifying concern. 1. Early Intervention-a maximum of 2 week waits for Referral to Treatment 2. Talking Therapies for Anxiety and depression: Reliable Recovery 3. Sickness Absence 4. Appraisal There are six special cause variations (blue variation flags) – signifying improvement. 1. Referral to Assessment within 4 weeks 2. CAMHS compliance within 4 week waits (referral to assessment) 3. CAMHS compliance within 18 week waits (referral to treatment) 4. Care Plan Compliance 5. Risk Assessment Compliance 6. Staff Turnover 7. Statutory and Mandatory Training **Performance Highlights – M12** • **Referral to assessment (RTA)** exceeds standard at **95.6%.** PIPs remain in place for community, and specialist directorates. • **Referral to treatment (RTT)** continues to exceed standard at **96.1%**, demonstrating sustained delivery. • **CAMHS compliance within 18 week waits (RTT)** has reduced to **92.8%,** compared to 95.5% **i**n M11. • **Mental Health Liaison Service** continues to perform well, with 4 and 24-hour response times meeting the 95% standard. • **CYP Eating Disorders-referral to assessment within 1 week,** is **100%,** 4 weeks is **98.1%.** • **Early Intervention in Psychosis (EIP)** performance for 2-week waits has seen a slight improvement to **64.3%** and continues to show as a special cause variation but is meeting the required standard. • **Follow up after discharge** remains consistent with **98.1%** of patients receiving follow up within both **48 hours** and **7 days**. • **Talking therapies** achieved both national clinical outcome standards; **reliable recovery 50.7%** and **reliable improvement 71.5%.** Reliable recovery is showing as a special cause of variation as performance has dropped below the lower control limit but is meeting the required standard. • **Care plan compliance** reduced slightly to **95.9%** when

compared to 96.2% in M11. A PIP remains in place in the Specialist directorate.
- **Risk assessment compliance** remains consistent at **95.8%.**
- **Length of stay** (average and median) for older adults remains within national benchmark ranges.
- **Emergency readmission rate** within 30 days have maintained **2.5%** performance.
- **No complaints** breached the 40-day response target.
- **Friends and family test** recommended rate continues to perform at **83.0%,** above standard.
- **Vacancy rate** remains consistent at **2.7%**.
- **Staff turnover** remains consistent at **7.3%**.
- **Statutory and Mandatory Training** performance remains unchanged at **91%**.
- **Data Quality Maturity Index (DQMI) performance** remains consistent at **98.8%** in December 2025.

Performance Exceptions – M12
- **CAMHS referral to assessment (RTA)** compliance within 4-weeks achieved **94.2%,** remaining below standard.
- **MH Liaison 1 hour response** achieved **92.5%**, below standard.
- **Average Length of Stay for Adults** has increased to **62.6 days**, exceeding the 40-day standard.
- **Sickness absence** decreased to **6.04%** above the **<4.95% threshold**. A special cause variation remains in place. PIPs are in place for acute, specialist and primary care directorates.
- **Clinical supervision** continues to reduce to **74.0%,** down from 81% during M11.
- **Appraisal** compliance remains static at **83%**. A special cause variation remains in place.

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

M12 performance against the forecasts submitted to the ICB and NHSE for 2025/26. To note:

- **Out of Area Placements (OOA)** – There were **27 reportable inappropriate OOA placements**, of which 21 were due to adult acute bed availability pressures and 6 were attributable to PICU bed availability.

  This reflects the pressure across the system and on the acute and urgent care directorate (AUCD). The adult acute bed base is currently reduced, with 93 beds operational as a result of Project Chrysalis. This represents the lowest level of available bed stock since September 2020. Further capacity constraints are being driven by delays in discharge. In M12, **18.8% of**

occupied bed days (OBDs) were attributable to patients who were CRFD but remained within inpatient services. As a result, inpatient wards are operating at capacity. To mitigate avoidable admissions, the Home Treatment Team has significantly increased activity, caseload size, and clinical risk management.
An OOA PIP was initiated in M04 for AUCD and Community directorates.

- **Inpatient Stays** – Included within the national operational priorities for the 2025/26 financial year, with the objective of improving patient flow across mental health crisis and acute pathways and reducing average length of stay (LoS) within adult acute beds. Performance is measured on a 3-month rolling basis and covers 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 M12, achieving **49** against the **plan of 39**.

- **Perinatal Access –** The perinatal access metric has met standard in M12, achieving **854** against the **plan of 608**.

- **CYP in contact –** This metric has met standard in M11 achieving **9,489** against the **plan of 7,955**.

- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has not met standard in M11, achieving **872** against a **plan of 1,015**. 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 unlikely to meet this year's plan with the existing workforce available and prescribed caseload sizes.

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

VERSION CONTROL:

Version	Report to	Date Reported
V1 26.27	Finance & Resource Committee	30.04.2026
V1 26.27	Public Trust Board	08.05.2026

Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M12 (March 2026)

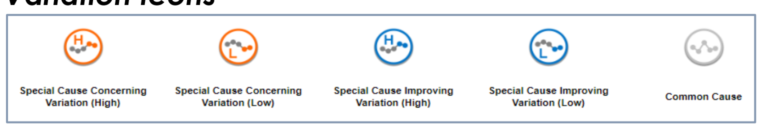
Contents

Core Indicators-Monthly and Balanced Scorecard
Operational Planning Forecasts and Performance
Core Indicators-13-month trend
Performance Improvement Plans (PIPs)
Core Indicators – SPC Trend

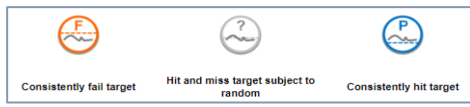
Using Statistical Process Control (SPC)

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

Variation Icons



Assurance Icons



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

1. Early Intervention – a maximum of 2 week waits for referral to treatment
2. Talking Therapies for Anxiety and Depression: Reliable Recovery
3. Sickness Absence
4. Appraisal

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

1. Referral to Assessment within 4 weeks
2. CAMHS compliance within 4 week waits (Referral to Assessment)
3. CAMHS compliance within 18 week waits (Referral to Treatment)
4. Care Plan Compliance
5. Risk Assessment Compliance
6. Staff Turnover
7. Statutory and Mandatory Training

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

1. Referral to Assessment within 4 weeks – Community and Specialist Services directorates
2. Sickness Absence – Acute and Urgent Care, Primary Care and Specialist Services directorates
3. Care Plan Compliance – Specialist directorate
4. 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**
SPC Variations signifying concern	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	64.3%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	50.7%
RAG Rated Standards	12 met, 2 unmet		
Highlights	Referral to Assessment within 4 weeks	95.0%	95.6%
	Referral to Treatment within 18 weeks	92.0%	96.1%
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	92.8%
	MH Liaison 4 Hour Response (Urgent)	95.0%	95.8%
	MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	96.5%
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	100.0%
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	98.1%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	64.3%
	48 Hour Follow Up	95.0%	98.1%
	7 Day Follow Up (All Patients)	95.0%	98.1%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	50.7%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	67.0%	71.5%
Exceptions	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	94.2%
	MH Liaison 1 Hour Response (Emergency)	95.0%	92.5%

Community & Quality			
	Metric	**Standard**	**Performance**
RAG Rated Standards	2 met, 0 unmet		
Highlights	Care Plan Compliance	95.0%	95.9%
	Risk Assessment Compliance	95.0%	95.8%

Performance Improvement Plans (PIPs)			
Directorate	**Metric**	**Standard**	**Performance**
Specialist Services	Referral to Assessment within 4 weeks	95.0%	83.8%
	Sickness Absence (in-month)	<4.95%	4.76%
	Care Plan Compliance	95.0%	94.0%
Primary Care	Sickness Absence (in-month)	<4.95%	4.56%

Inpatient & Quality			
	Metric	**Standard**	**Performance**
RAG Rated Standards	4 met, 1 unmet		
Highlights	Median Length of Stay - Adult	42.4	20.5
	Average Length of Stay - Older Adult	90	59.0
	Median Length of Stay - Older Adult	83.8	51.0
	Emergency Readmissions rate (30 days)	<7.5%	2.5%
Exceptions	Average Length of Stay - Adult	40	62.6

Organisational Health & Workforce			
	Metric	**Standard**	**Performance**
SPC Variations signifying concern	Sickness Absence	<4.95%	6.04%
	Appraisal	85.0%	83.0%
RAG Rated Standards	5 met, 3 unmet		
Highlights	Complaints Open Beyond Agreed Timescale	0	0
	Friends and Family Test - Recommended	80.0%	83.0%
	Vacancy Rate	<10.0%	2.7%
	Staff Turnover	<10.0%	7.3%
	Statutory & Mandatory Training	85.0%	91.0%
Exceptions	Sickness Absence	<4.95%	6.04%
	Clinical Supervision	85.0%	74.0%
	Appraisal	85.0%	83.0%

Performance Improvement Plans (PIPs)			
Directorate	**Metric**	**Standard**	**Performance**
AUCD	Sickness Absence (in-month)	<4.95%	6.44%
Community	Referral to Assessment within 4 weeks-CYP	95.0%	96.2%
	Referral to Assessment within 4 weeks-Adult	95.0%	94.2%
AUCD and Community	Number of inappropriate OOAs during month	2	23
	Number of inappropriate OOAs at EOM (national measure)	2	27

Core Indicators-Monthly

	Indicator	Target	Jan-26	Feb-26	Mar-26	Assurance	Variation
Access & Wait Times	Referral to Assessment within 4 weeks	95.0%	95.8%	94.9%	95.6%		
	Referral to Treatment within 18 weeks	92.0%	96.8%	96.4%	96.1%		
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	94.8%	93.4%	94.2%		
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	94.9%	95.5%	92.8%		
	MH Liaison 1 Hour Response (Emergency)	95.0%	95.9%	95.7%	92.5%		
	MH Liaison 4 Hour Response (Urgent)	95.0%	95.3%	96.2%	95.8%		
	MH Liaison 24 Hour Response (Urgent from General Hospital	95.0%	96.9%	96.2%	96.5%		
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	N/A	N/A	100.0%		
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	N/A	N/A	98.1%		
	Early Intervention - A Maximum of 2 Week Waits for Referral to	60.0%	100.0%	61.1%	64.3%		
	48 Hour Follow Up	95.0%	98.0%	97.6%	98.1%		
	7 Day Follow Up (All Patients)	95.0%	100.0%	97.6%	98.1%		
	Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	49.6%	49.8%	50.7%		
	Talking Therapies for Anxiety and Depression: Reliable	67.0%	72.8%	74.6%	71.5%		

Inpatient & Quality	Indicator	Target	Jan-26	Feb-26	Mar-26	Assurance	Variation
	Average Length of Stay - Adult	40	32.5	36.6	62.6		
	Median Length of Stay - Adult	42.4	15.9	25.9	20.5		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	16.1%	25.8%	25.0%		
	Average Length of Stay - Older Adult	90	55.3	47.4	59.0		
	Median Length of Stay - Older Adult	83.8	48.0	33.0	51.0		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	20.0%	14.3%	18.2%		
	Emergency Readmissions rate (30 days)	<7.5%	0.9%	1.8%	2.5%		
	Clinically Ready for Discharge (CRFD)	No Target	19.4%	23.5%	18.8%		

Community &	Indicator	Target	Jan-26	Feb-26	Mar-26	Assurance	Variation
	Care Plan Compliance	95.0%	96.2%	96.2%	95.9%		
	Risk Assessment Compliance	95.0%	96.5%	95.6%	95.8%		

Organisational Health

Indicator	Target	Jan-26	Feb-26	Mar-26	Assurance	Variation
Complaints Open Beyond Agreed Timescale	0	0	0	0		
Friends and Family Test - Recommended	80.0%	89.0%	92.0%	83.0%		
Safe Staffing	95%-105%	109.6%	104.4%	105.2%		
Vacancy Rate	<10.0%	2.9%	2.2%	2.7%		
Staff Turnover	<10.0%	7.4%	7.7%	7.3%		
Sickness Absence	<4.95%	6.08%	6.13%	6.04%		
Clinical Supervision	85.0%	84.0%	81.0%	74.0%		
Appraisal	85.0%	82.0%	82.0%	83.0%		
Statutory & Mandatory Training	85.0%	91.0%	91.0%	91.0%		

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	17	11	19	11	19	9	7	17	17	21	19	32	27
			Variance	-15	-9	-17	-9	-17	-7	-5	-15	-15	-19	-17	-30	-25
			Kidsgrove Placements				5	3	3	10	7	2	11	3	1	3

	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	8,333	8,407	8,338	9,483	9,693	9,263	8,019	6,967	7,646	7,967	8,350	7,548	8,320
			Variance	-338	-412	-343	-1,488	-1,698	-1,268	-24	1,028	349	28	-355	447	-325
			Nationally Published	8,337	8,405	8,340	9,505	9,695	9,265	8,020	6,965	7,645	7,965	8,350	7,550	
	Number of discharges in the RP		*Plan*	205	205	205	205	205	205	205	205	205	205	205	205	205
			Actual	178	202	188	181	171	182	186	178	175	167	172	167	171
			Variance	27	3	17	24	34	23	19	27	30	38	33	38	34
			Nationally Published	178	200	190	180	170	180	185	180	175	165	170	165	
	Mean Length of stay for discharges in the RP		*Plan*	39	39	39	39	39	39	39	39	39	39	39	39	39
			Actual	47	42	44	53	57	51	43	39	44	48	49	46	49
			Variance	-8	-3	-5	-14	-18	-12	-4	0	-5	-9	-10	-7	-10
			Nationally Published	47	42	44	53	57	51	43	39	44	48	49	45	

**Out of Area Placements had 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	774	682	701	722	746	747	770	803	812	795	822	836	854
			Variance	166	74	93	114	138	139	162	195	204	187	214	228	246
			Nationally Published	749	660	680	700	725	725	745	775	780	795	820	835	

	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	8,959	8,515	8,489	8,605	8,706	8,713	8,897	9,073	9,163	9,164	9,286	9,409	9,489
			Variance	1,004	560	534	650	751	758	942	1,118	1,208	1,209	1,331	1,454	1,534
			Nationally Published	8,923	8,520	8,505	8,620	8,715	8,725	8,910	9,090	9,175	9,180	9,300	9,410	

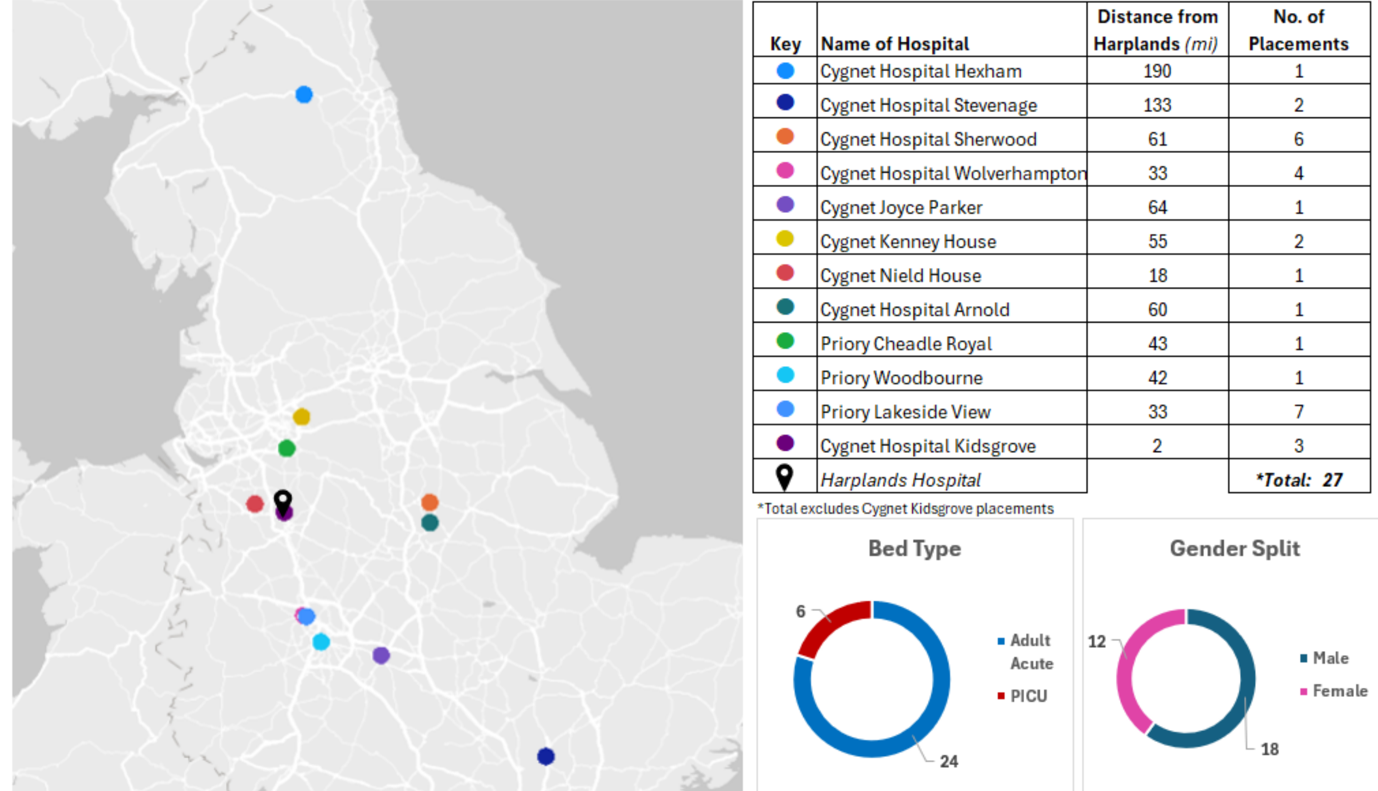
	Individual Placement Support Access	Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5	Number of referrals that accessed Individual Placement Support (IPS) in the reporting period	12-month rolling	*ICB Plan*	913	820	827	846	865	883	902	921	940	958	977	996	1,015
			ICB Actual	813	784	776	782	750	773	800	811	832	853	851	870	872
			Variance	-100	-36	-51	-64	-115	-110	-102	-110	-108	-105	-126	-126	-143
			NSCHT Actual	382	389	388	382	364	365	377	372	380	395	392	390	386
			MPFT Actual	431	395	388	400	386	408	423	439	452	458	459	480	486
			ICB Nationally Published	816	785	780	790	760	780	815	820	835	860	870	885	
			NSCHT Nationally Published	381	390	390	380	365	365	375	370	380	395	390	390	

**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 (OOA) Placements** – At the end of M12, there were 27 reportable inappropriate OOA placements, of which 21 were due to adult acute bed availability pressures and 6 were attributable to PICU bed availability.
  This reflects the pressure across the system and on the AUCD. The adult acute bed base is currently reduced, with 93 beds operational as a result of Project Chrysalis. This represents the lowest level of available bed stock since September 2020. Further capacity constraints are being driven by delays in discharge. In M12, 18.8% of occupied bed days (OBDs) were attributable to patients who were clinically ready for discharge (CRFD) but remained within inpatient services. As a result, inpatient wards are operating at capacity. To mitigate avoidable admissions, the Home Treatment Team has significantly increased activity, caseload size, and clinical risk management.
  In response to these challenges, an OOA Performance Improvement Plan (PIP) was initiated in M04, encompassing both the A&UC and Community directorates.

- A dedicated OOA Standing Operating Procedure (SOP) is in place, providing assurance around staff roles, responsibilities, and clinical oversight for patients placed OOA. A&UC 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. The Discharge Pathway Team maintains frequent contact with provider placements throughout the week to support timely discharge planning. Where involved, community teams remain actively engaged in the patient's care journey during the OOA placement to maintain continuity of care. The Trust places patients only with providers rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC) and seeks to minimise distance from home wherever possible.
  **The below information also shows appropriate placements at Cygnet Hospital Kidsgrove.*

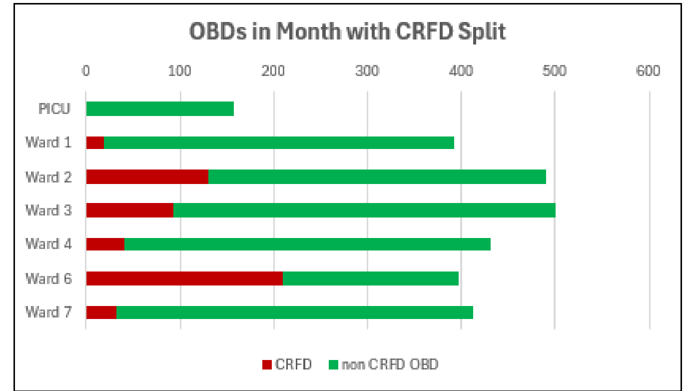


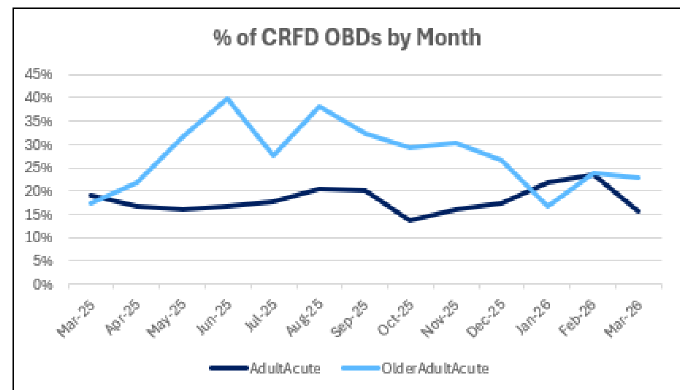
Key	Name of Hospital	Distance from Harplands *(mi)*	No. of Placements
●	Cygnet Hospital Hexham	190	1
●	Cygnet Hospital Stevenage	133	2
●	Cygnet Hospital Sherwood	61	6
●	Cygnet Hospital Wolverhampton	33	4
●	Cygnet Joyce Parker	64	1
●	Cygnet Kenney House	55	2
●	Cygnet Nield House	18	1
●	Cygnet Hospital Arnold	60	1
●	Priory Cheadle Royal	43	1
●	Priory Woodbourne	42	1
●	Priory Lakeside View	33	7
●	Cygnet Hospital Kidsgrove	2	3
📍	*Harplands Hospital*		***Total: 27***

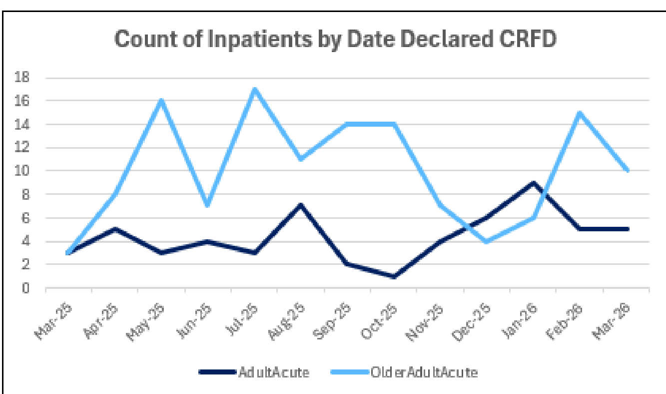
*Total excludes Cygnet Kidsgrove placements

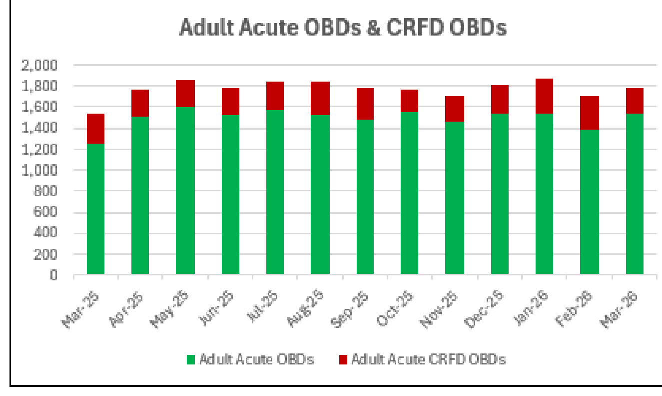
Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 – Supporting Information: Clinically Ready for Discharge (CRFD)

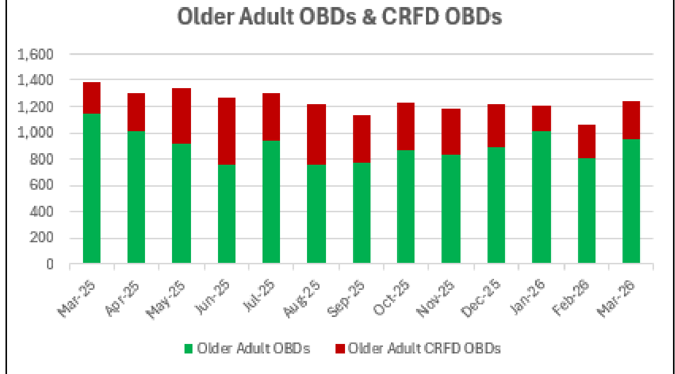
One of the most significant contributors to increased average length of stay (LoS), and one which is often outside of the Trust's direct control, relates to patients who are CRFD. Stoke-on-Trent City Council has been working collaboratively with the Trust to reduce the historically high number of Stoke-based CRFD patients. This is a positive development; however, ongoing market pressures remain. These include limited availability of residential and nursing home placements within Stoke-on-Trent, alongside constraints in accessing funding to support community-based care packages. These issues have been escalated to the ICB.

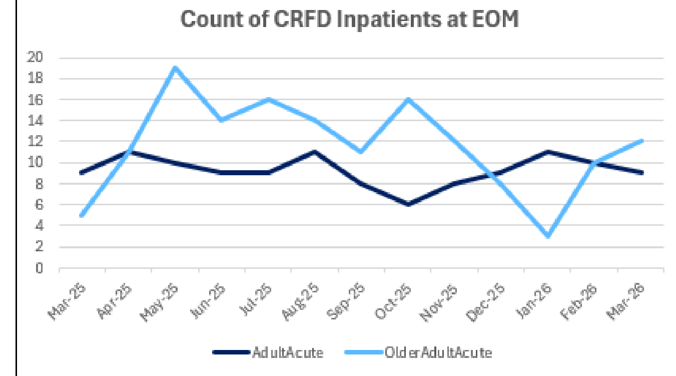












Long Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2025/26 (2 of 2)

- **Inpatient Stays** – Included within the national operational priorities for the 2025/26 financial year, with the objective of improving patient flow across mental health crisis and acute pathways and reducing average length of stay (LoS) within adult acute beds. Performance is measured on a 3-month rolling basis and covers 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 M12, achieving 49 against the plan of 39.

- **Perinatal Access –** The perinatal access metric has met standard in M12, achieving 854 against the plan of 608.

- **CYP Access –** This metric has met standard in M12, achieving 9,489 against the plan of 7,955.

- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has not met standard in M12, achieving 872 against a plan of 1,015. 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 unlikely 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	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Referral to Assessment within 4 weeks	95.0%	93.1%	94.2%	94.7%	93.5%	93.3%	92.4%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%
Referral to Treatment within 18 weeks	92.0%	95.6%	95.9%	96.1%	95.4%	95.9%	96.1%	96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%
CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	85.7%	91.1%	90.9%	92.0%	91.1%	78.2%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%
CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	86.6%	87.6%	91.8%	85.9%	92.8%	88.6%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%
MH Liaison 1 Hour Response (Emergency)	95.0%	90.0%	95.7%	95.7%	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%
MH Liaison 4 Hour Response (Urgent)	95.0%	94.0%	95.4%	97.6%	93.8%	96.0%	95.5%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%
MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	98.2%	95.2%	95.9%	96.0%	96.4%	96.5%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	72.7%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	100.0%	N/A	N/A	97.3%	N/A	N/A	100.0%	N/A	N/A	98.0%	N/A	N/A	98.1%
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	92.0%	100.0%	100.0%	95.0%	94.7%	75.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%
48 Hour Follow Up	95.0%	98.1%	90.9%	95.6%	96.4%	100.0%	100.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%
7 Day Follow Up (All Patients)	95.0%	100.0%	94.5%	100.0%	96.4%	100.0%	100.0%	100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%
Emergency Readmissions rate (30 days)	<7.5%	3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%
Care Plan Compliance	95.0%	94.6%	94.6%	94.5%	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%
Risk Assessment Compliance	95.0%	95.3%	95.2%	95.8%	96.0%	95.7%	96.2%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%
Complaints Open Beyond Agreed Timescale	0	4	3	2	5	1	1	0	0	0	0	0	0	0
Friends and Family Test - Recommended	80.0%	100.0%	57.0%	72.0%	81.5%	86.4%	82.5%	87.6%	76.0%	88.0%	81.0%	89.0%	92.0%	83.0%
Safe Staffing	95%-105%	107.8%	106.7%	107.3%	107.4%	103.9%	103.8%	102.8%	102.5%	106.1%	107.1%	109.6%	104.4%	105.2%
Sickness Absence	<4.95%	6.39%	6.39%	6.35%	6.33%	6.27%	6.25%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.04%

Core Indicators – 13 Month Trend (2 of 2)

Name	Target	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Talking Therapies for Anxiety and Depression: Reliable Recovery	48.0%	51.6%	50.5%	50.2%	51.6%	53.7%	51.9%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%
Talking Therapies for Anxiety and Depression: Reliable Improvement	67.0%	73.2%	74.1%	70.1%	73.9%	77.4%	73.2%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%
Average Length of Stay - Adult	40	27.5	40.9	34.0	62.3	49.3	26.6	37.0	34.7	45.0	43.7	32.5	36.6	62.6
Median Length of Stay - Adult	42.4	16.1	10.0	25.0	19.9	22.9	17.2	14.6	26.9	27.4	18.9	15.9	25.9	20.5
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	14.0%	20.0%	20.7%	16.7%	22.2%	12.8%	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%
Average Length of Stay - Older Adult	90	58.9	41.2	80.9	70.2	55.7	55.3	46.4	47.2	58.5	60.1	55.3	47.4	59.0
Median Length of Stay - Older Adult	83.8	43.0	32.5	48.0	58.0	41.0	32.5	35.5	35.0	45.5	37.5	48.0	33.0	51.0
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	17.0%	10.0%	38.1%	21.1%	30.4%	18.2%	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%
Clinically Ready for Discharge (CRFD)	No Target	18.3%	19.2%	23.3%	27.2%	22.2%	28.5%	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%
Vacancy Rate	<10.0%	7.5%	8.3%	8.3%	8.2%	8.0%	7.6%	5.1%	3.3%	3.0%	3.3%	2.9%	2.2%	2.7%
Staff Turnover	<10.0%	9.5%	9.8%	9.7%	8.9%	8.9%	8.5%	8.1%	7.3%	7.3%	7.4%	7.4%	7.7%	7.3%
Clinical Supervision	85.0%	79.0%	81.0%	83.0%	80.0%	79.0%	81.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%
Appraisal	85.0%	86.0%	85.0%	84.0%	83.0%	81.0%	84.0%	78.0%	79.0%	83.0%	83.0%	82.0%	82.0%	83.0%
Statutory & Mandatory Training	85.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%
DQMI	95.0%	98.4%	98.6%	98.4%	98.5%	98.4%	98.5%	98.6%	98.5%	98.7%	98.8%	N/A	N/A	N/A

In M12 there are 34 metrics monitored; 23 have achieved the required standard and 6 have not achieved the required standard. 3 metrics have no target and are being monitored. 1 metric has a threshold and is being monitored. 1 metric is provided by NHS England with the current month not yet published.

Performance Improvement Plans (PIPs)

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

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

PIPs currently in place:

Metric	Directorate	Status
Referral to Assessment within 4 weeks	**Specialist Services**	The Specialist Directorate voluntarily implemented a PIP in M06 (2024/25) to address underperformance against the 4-week RTA standard, which has persisted since April 2024. The initial target date for achieving compliance was August 2025; this was subsequently extended to January 2026 and is now forecast for November 2026. Trajectory milestones were originally set in M06 (Sept-Jan 2024/25) and have been reset on several occasions to reflect delivery challenges: M11 (Feb–Jun 2025/26), M04 (Aug–Jan 2025/26), and most recently M10 (Jan–Nov 2026/27). Performance in M12 stands at 83.8%, which is below both the planned trajectory of 85.0% and the required standard. Updated actions have been provided in M12.
	Community-CYP	A PIP was requested in M01 (2024/25). The original aim for achieving the required standard was March 2026; this was subsequently brought forward to September 2025 and is currently forecast for April 2026. CYP performance in M12 is 96.2%, exceeding the trajectory of 87.0% and meeting the required standard. Trajectory milestones were initially set in M01 (Apr 2024–Apr 2025) and have been reset to reflect revised planning assumptions: M02 (May–Sep 2025), M04 (2025/26), with trajectory revised from 95% to 85% and M05 (Aug–Apr 2026). Updated actions have been provided in M12.
	Community-Adult	A PIP was requested in M01 (2024/25). The original target date for achieving the required standard was May 2025; this was subsequently revised to August 2025 and is now forecast for January 2026. Adult performance in M12 is 94.2%, exceeding the trajectory of 94.0% but remaining below the required standard.

Metric	Directorate	Status
		Trajectory milestones were initially set in M10 2024/25 (May–Aug 2025) and have since been reset in M06 2025/26 (Sep–Jan 2025/26) and again in M10 2025/26. Updated actions have been provided in M12.
Sickness Absence (In-month)	**Acute & Urgent Care**	A PIP was requested in M05 (2024/25), with supporting actions provided in M07. Trajectories were initially set in November 2024 and subsequently revised in January and March 2025, with the aim of reducing the sickness absence rate to the 4-year average position of 6.9% by March 2026; however, this remains above the required standard of <4.95%. The in-month sickness absence is 6.44% during M12 which is exceeding the 6.80% planned trajectory but remains above the required standard. Updated actions have been provided in M12.
	Primary Care	A PIP was requested in M10 (2024/25). The PIP trajectory was updated in M01 (2025/26) 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 (2025/26) covering the period April 2025 to March 2026. The Primary Care directorate aimed for the standard to be met in December 2025. The in-month sickness absence is 4.56% during M12 which is exceeding the 4.95% planned trajectory and is meeting the required standard. Updated actions have been provided in M12.
	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. The in-month sickness absence is 4.76% during M12 which is exceeding the 6.93% planned trajectory and is meeting the required standard. Updated actions have been provided in M12.
Care Plan Compliance	**Specialist Services**	A PIP was issued in M01 (2025/26). The original aim was for the standard to be met by October 2025 this has been extended to January 2026.

Metric	Directorate	Status
		Performance during M12 is 94.0% which is not meeting the 95.0% planned trajectory or required standard. Trajectory milestones were initially set in M01 (Apr–Jun 2025/26) and have been reset to reflect revised planning assumptions: M03 (Apr–May 2025/26) and M04 (Sept–Jan 2025/26). Updated actions have been provided in M12.
Out of Area Placement (OOAs)	**Acute and Urgent Care and Community**	A PIP was requested in M04 (2025/26). Performance during M12, is measured by the number of inappropriate OOAs during month and the number of inappropriate OOAs at EOM (national measure) which were 23 and 27 respectively. Updated actions have been provided in M12.

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

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

13 Month Trend

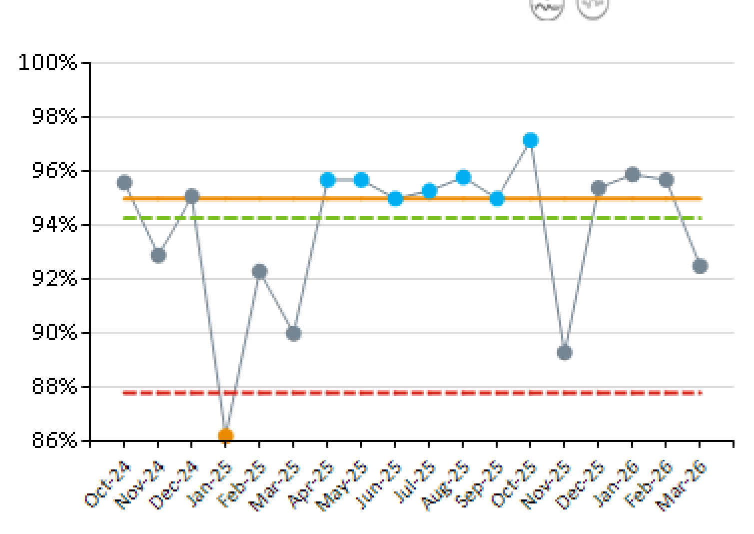
85.7%	91.1%	90.9%	92.0%	91.1%	78.2%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Performance is at **94.2% in M12**. The variation is showing improvement.

Current performance: Community-96.2%, Specialist Services-N/A Acute and Urgent Care-92.9%.

A PIP is in place for Community directorate.

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



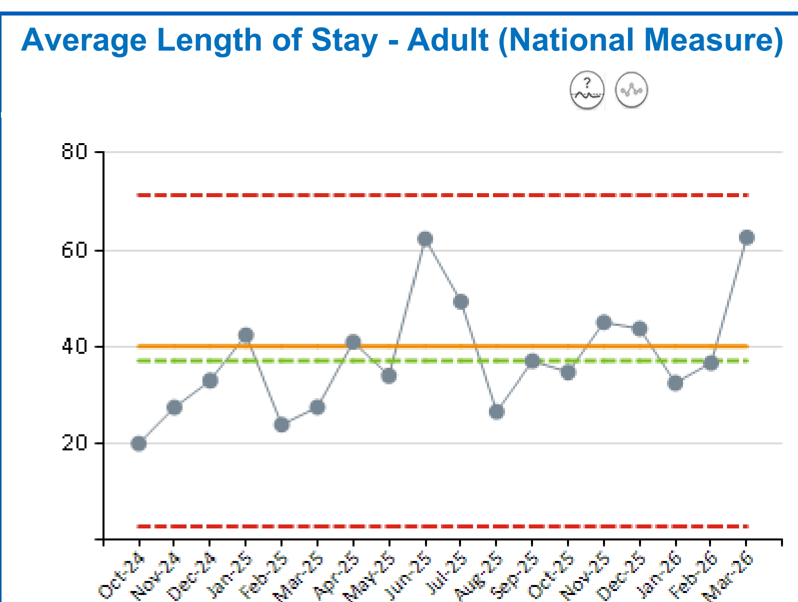
13 Month Trend

90.0%	95.7%	95.7%	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Performance is at **92.5% in M12**. The variation is showing common cause.

In M12, the service faced the highest level of demand seen in the past two years, coinciding with a significant IT outage that persisted for several days. Emergency priority accounted for the majority of referrals.

Average Length of Stay - Adult (National Measure)



13 Month Trend

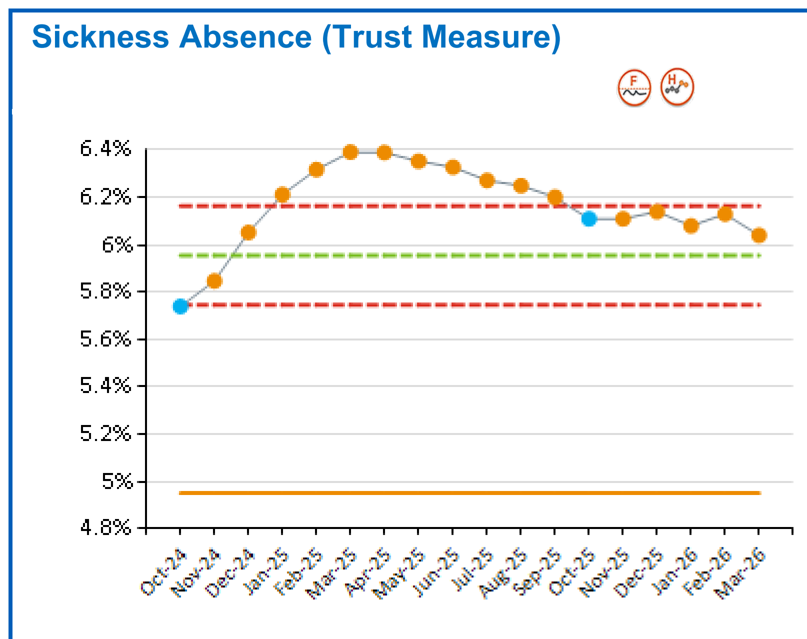
27.5	40.9	34.0	62.3	49.3	26.6	37.0	34.7	45.0	43.7	32.5	36.6	62.6
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Performance is at **62.6 in M12**. The variation is showing common cause.

In M12, Adult Acute recorded seven long length-of-stay discharges (90+ days). The two longest stays were 545 and 337 days respectively, with CRFD days accounting for over 75% of each spell. Despite these outliers, the median length of stay for the month was 20.5 days.

ORGANISATIONAL HEALTH AND WORKFORCE

Sickness Absence (Trust Measure)



13 Month Trend

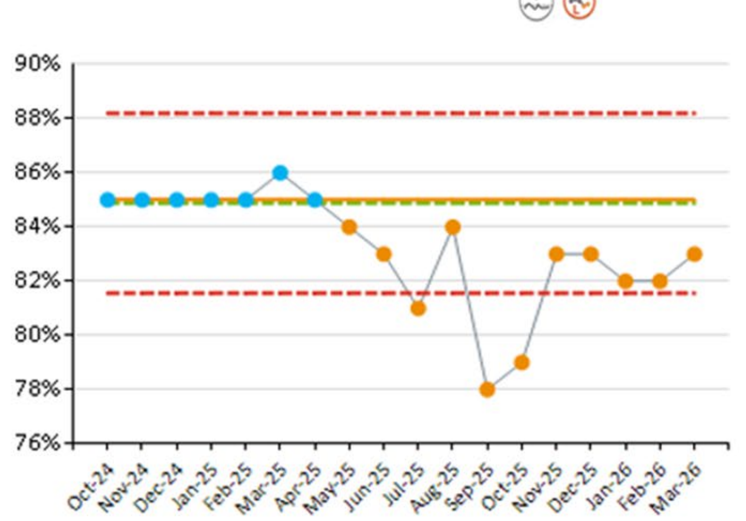
6.39%	6.39%	6.35%	6.33%	6.27%	6.25%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.04%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Performance is at **6.04% in M12**. The variation is showing concern.

Current performance 12-month rolling sickness absence: Community-5.93%, Specialist Services-6.93%, Acute and Urgent Care-7.57%, Primary Care-6.28%, Corporate-2.74%.

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

Appraisal (Trust Measure)



13 Month Trend

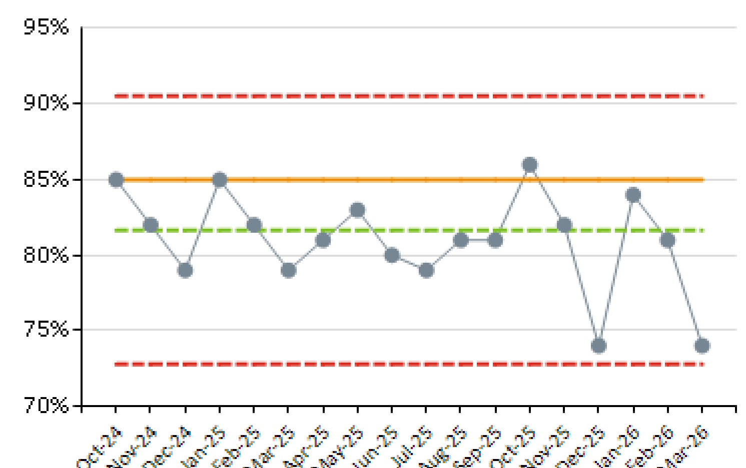
86.0%	85.0%	84.0%	83.0%	81.0%	84.0%	78.0%	79.0%	83.0%	83.0%	82.0%	82.0%	83.0%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Performance is at **83.0% in M12**. The variation is showing concern.

Current performance: Community-89.0%, Specialist Services-88.0%, Acute and Urgent Care-78.0%, Primary Care-79.0%, Corporate-78.0%.

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. These measures are expected to continue to improve compliance.

Clinical Supervision (Trust Measure)



13 Month Trend

79.0%	81.0%	83.0%	80.0%	79.0%	81.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

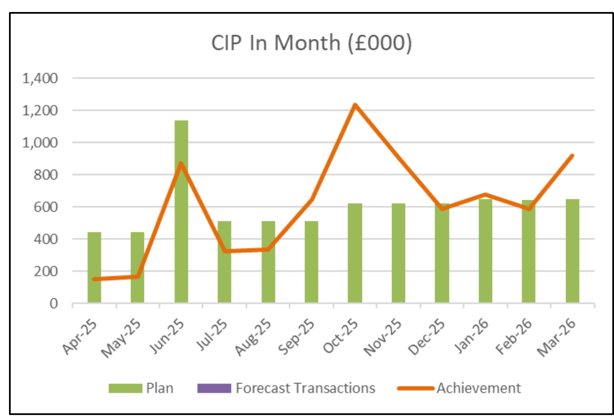
Performance is at **74.0% in M12**. The variation is showing common cause.

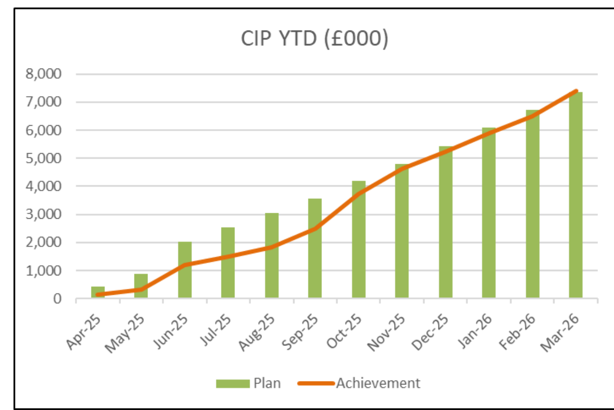
Current performance: Community-70.0%, Specialist Services-80.0%, Acute and Urgent Care-69.0%, Primary Care-79.0%, Corporate-67.0%.

Fortnightly reports identifying non-compliance rates, including named individuals and their line managers, are distributed to Associate Directors and line managers for action. The LMS Clinical Supervision Record has been updated and is fully functional. Staff are now required to access their account and identify ‘Yes’ on the record which will update their record and reset their compliance to be completed in 2 months. Clinical supervision action plan is in development following survey report – this will include education on the importance of Clinical Supervision, guidance and training for supervisors and supervisees, socialisation on the Clinical Supervision Policy. Task and Finish Group to commence May 2026.

Financial Performance

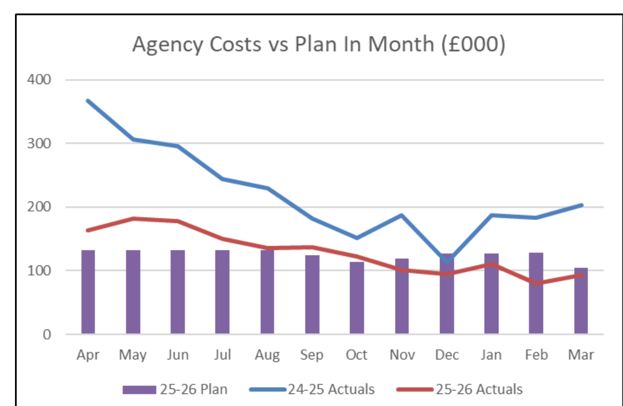
CIP Delivery v Plan

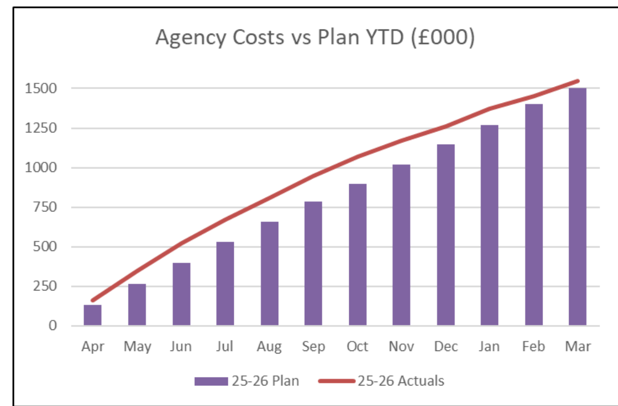




The CIP graphs show full achievement against the £7.4m plan.

Agency Cost v Plan (40% reduction)

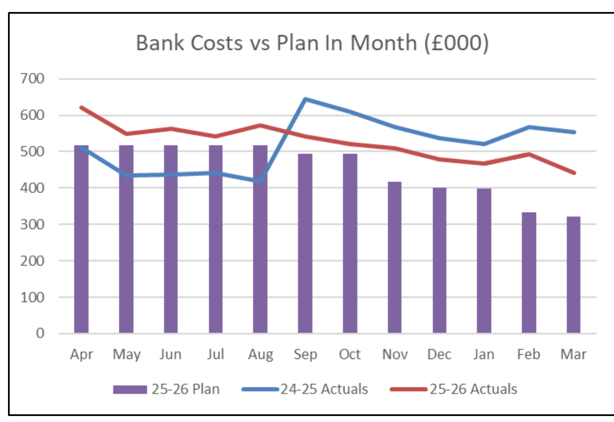


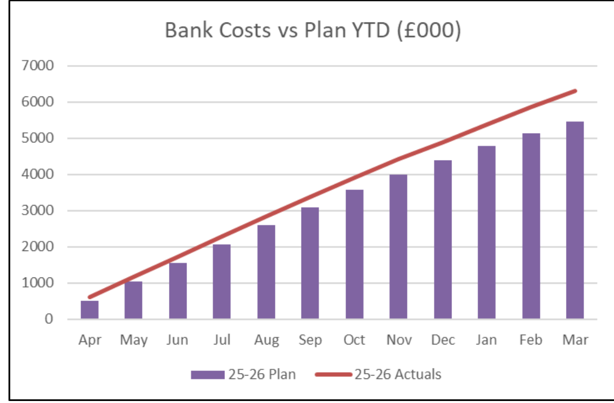


The agency graphs show actual costs against a £1.5m plan.

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

Bank Cost v Plan (10% reduction)





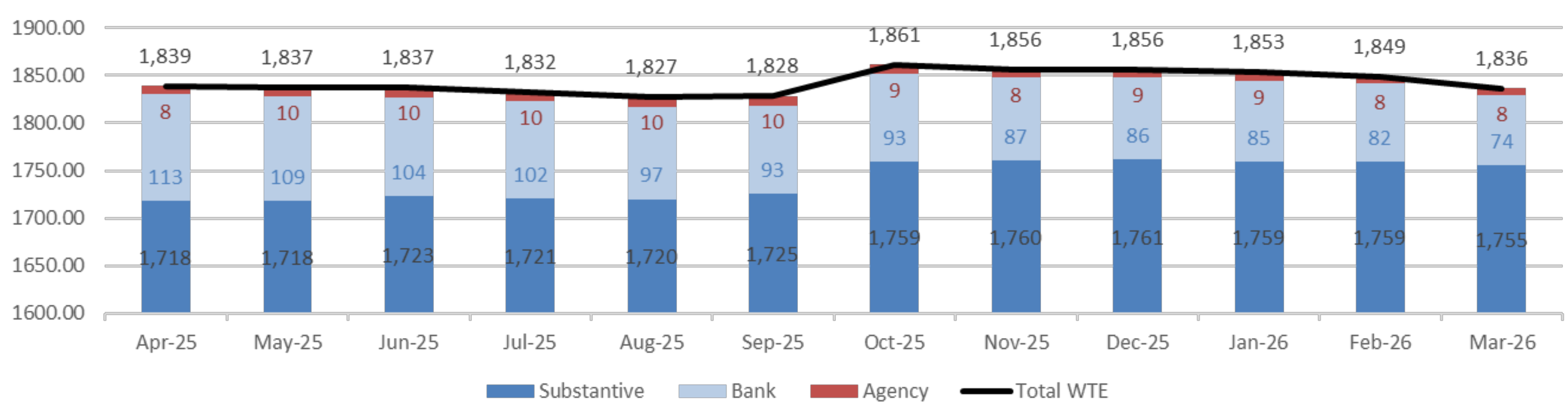
The bank graphs show actual costs against a £5.4m plan.

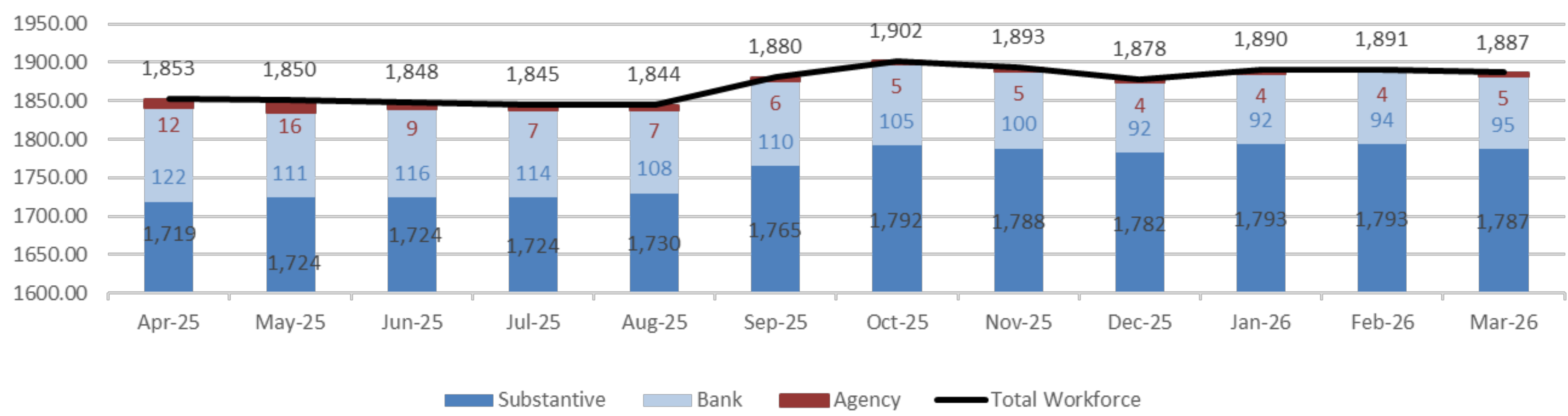
The Trust outturn shows total bank costs of £6.3m, with £3.2m Acute, £2.3m Specialist, £0.5m Community and £0.3m Corporate.

Workforce Plan (1 of 3)

Mar-26 NSCHT	WTE Plan	WTE Actual	WTE Variance From Plan		Spend Plan	Spend Actual	Spend Variance From Plan		WTE TO PLAN	£ TO PLAN	Misalignment of plans
	WTE	WTE	WTE	%	£'000	£'000	£'000	%			
Total	**1,836**	**1,887**	**50**	**+3%**	**£109,129**	**£108,548**	**-£581**	**-1%**	▲	▼	!
Substantive	**1,755**	**1,787**	**32**	**+2%**	**£102,172**	**£100,700**	**-£1,472**	**-1%**	▲	▼	!
Medical and Dental	58	59	1	+1%	£10,811	£11,103	£292	+3%	▲	▲	
Registered nursing, midwifery and health visiting staf	579	562	-17	-3%	£31,305	£32,433	£1,128	+4%	▼	▲	!
Registered scientific, therapeutic and technical staff	305	304	-1	-0%	£21,288	£20,207	-£1,081	-5%	▼	▼	
Support to clinical staff	474	519	45	+10%	£19,978	£18,821	-£1,157	-6%	▲	▼	!
Total NHS infrastructure support	336	340	4	+1%	£18,790	£18,136	-£654	-3%	▲	▼	!
Any other staff	3	3	0	0%	£0	£0	£0		▼	▼	
Bank	**74**	**95**	**21**	**+28%**	**£5,453**	**£6,301**	**£848**	**+16%**	▲	▲	
Medical and Dental	1	4	3	+276%	£1,381	£1,154	-£227	-16%	▲	▼	!
Registered nursing, midwifery and health visiting staf	13	27	14	+108%	£3,822	£1,626	-£2,196	-57%	▲	▼	!
Registered scientific, therapeutic and technical staff	1	2	1	+127%	£3	£210	£207	+6891%	▲	▲	
Support to clinical staff	58	58	1	+1%	£187	£3,088	£2,901	+1551%	▲	▲	
Total NHS infrastructure support	1	3	2	+193%	£60	£224	£164	+273%	▲	▲	
Any other staff	0	0	0		£0	£0	£0		▼	▼	
Agency	**8**	**5**	**-3**	**-36%**	**£1,504**	**£1,547**	**£43**	**+3%**	▼	▲	!
Medical and Dental	5	3	-2	-37%	£1,384	£1,393	£9	+1%	▼	▲	!
Registered nursing, midwifery and health visiting staf	3	1	-1	-55%	£120	£125	£5	+4%	▼	▲	!
Registered scientific, therapeutic and technical staff	0	1	1		£0	£9	£9		▲	▲	
Support to clinical staff	0		0		£0	£20	£20		▼	▲	!
Total NHS infrastructure support	0		0		£0	£0	£0		▼	▼	
Any other staff	0		0		£0	£0	£0		▼	▼	

Workforce Plan (2 of 3)

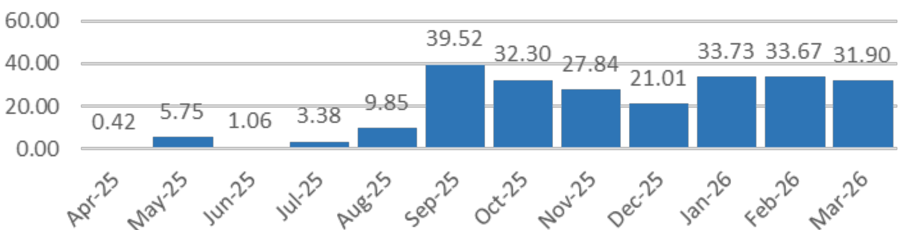


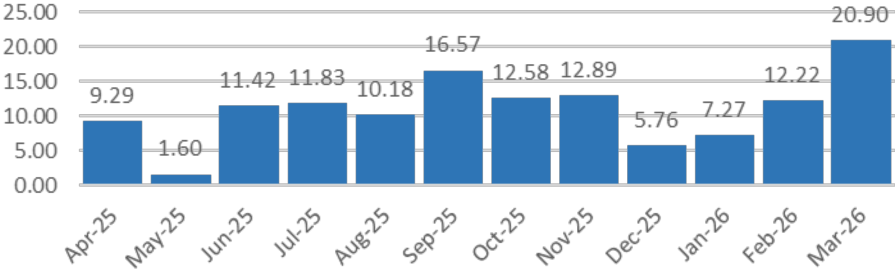


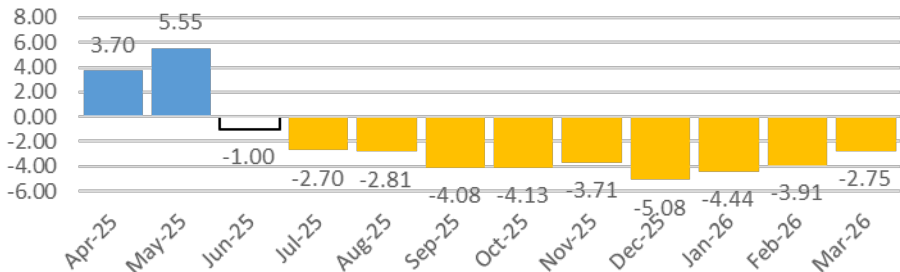
The workforce plan that was submitted in comparison to the actual or forecasted position for the same period.

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

Workforce Plan (3 of 3)







At M12 the Trust is 50wte over the forecast total workforce. This consists of the substantive growth being 32wte over plan and Temp Staffing cover being 18wte over plan.

The main reason for temporary staffing cover in M12 continues to be due high acuity.

The vacancy rate over the financial year so far has seen a decrease, from 7.5% reported in March 25 to 2.8% in M12. This has been as a result of successful recruitment campaigns and a reduction in the budgeted establishment over the same period.

As referenced above, the Trust has seen a 4.5% growth in its substantive workforce (restricted to teams included in the plan) with the biggest relative growth being reflected in Primary Care (Talking Therapies) and Specialist Services (across all service lines).

In terms of staff groups (also restricted to teams included in the plan) Add Prof and Tech have seen the largest relative growth (12.8%). Due to the annual programme of recruiting NQNs, Nursing and Midwifery have seen the largest WTE growth (36.5wte), this accounts for 48% of all substantive growth seen in the financial year.

In the workforce plan, there were teams which had planned growth. These were aligned to additional funding received in 2024/25 but not recruited to. These outstanding vacancies were carried over into 2025/26 and accounted for 47wte. Of these developments, we have seen an indicative growth of 31wte through a combination of internal and external recruitment. Of the 49wte NQNs that were forecasted, we have seen a net growth of 37wte.

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).

Performance during M12 is 96.2%, which is exceeding the planned trajectory and meeting the required standard.

The original target date for meeting the standard was March 2026. This was subsequently revised to September 2025 and has since been further revised to April 2026.

Trajectory adjustments: Set in M01 (Apr-Apr 2024/25). Reset in M02 (May-Sept 2025/26). M04 (2025/26 figures changed from 95% to 85%). Reset in M05 (Aug-Sep 2026).

Updated actions have been provided for M12.

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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	60.2%	77.2%	79.4%	81.4%	75.6%	67.9%	71.9%	88.4%	97.3%	86.1%	93.7%	95.1%	96.2%
Trajectory	70.0%	80.0%	70.0%	80.0%	85.0%	90.0%	70.0%	75.0%	78.0%	80.0%	83.0%	85.0%	87.0%

Actions:

- Tunstall CAMHS 8am-8pm pilot. The extended hours pilot (8am-8pm, Monday-Friday) for Tunstall CAMHS remains scheduled to begin January 2026 for an initial 6-month period. Staff engagement sessions have been completed, with strong interest and positive feedback regarding the new hours. Pilot preparations progressing as planned. An assistant psychologist has been allocated to lead the evaluation, and DNA rates are being closely monitored as part of the pilot metrics. Remains on-going initial feedback from CYP, families and staff is positive. Some early DNA trajectory figures show a decline but need more data required. **M12 progress update:** *ongoing.*
- Effective management of absences. Ongoing adherence to the supporting attendance at work Policy continues across teams. Monthly HR sickness reports are being reviews by service managers to ensure timely action and oversight. In-month sickness continues to be robustly monitored. **M12 progress update**: *Sickness Surgeries to be increased to monthly with all team leads, service manager & senior service manager. Attendance management training compliance to be reviewed with the expectation that all team leads and deputies have attended.*
- Waiting Time Management. Weekly review meetings with the service manager and team leads have been initiated to focus on waiting time performance. This action follows a recent decline in proactive management and associated performance dips**.** Meetings are ongoing which supports timely intervention. CYP RTA performance achieved and with all above actions continuing. Teams are confident that this can be maintained. **M12 progress update**: *on-going.*

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

Community directorate

Feb-26

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	439	23	7	7	476	92.2%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	27	1	0	2	30	90.0%
North Stoke CAMHS	41	1	1	0	43	95.3%
South Stoke CAMHS	48	1	0	0	49	98.0%
CAMHS Total	116	3	1	2	122	95.1%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	10	1	0	1	12	83.3%
North Stoke CAMHS	7	0	0	1	8	87.5%
South Stoke CAMHS	3	0	0	0	3	100.0%
CAMHS Total	20	1	0	2	23	87.0%

Mar-26

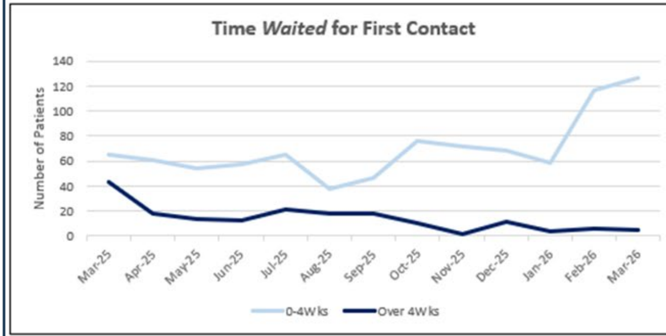
RTA Waited

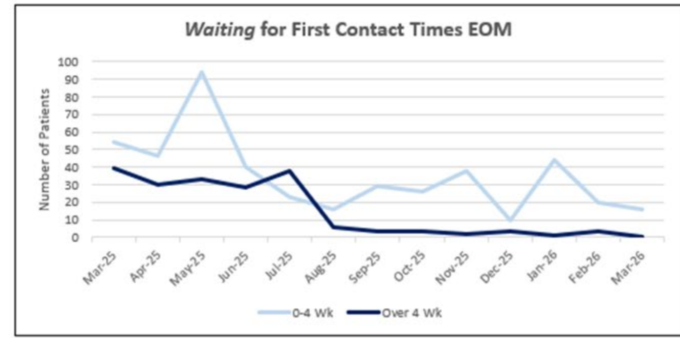
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	490	22	5	4	521	94.0%

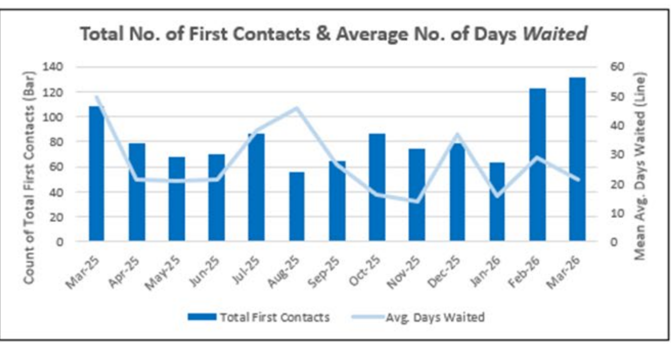
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	31	1	0	2	34	91.2%
North Stoke CAMHS	32	0	0	1	33	97.0%
South Stoke CAMHS	63	1	0	0	64	98.4%
CAMHS Total	126	2	0	3	131	96.2%

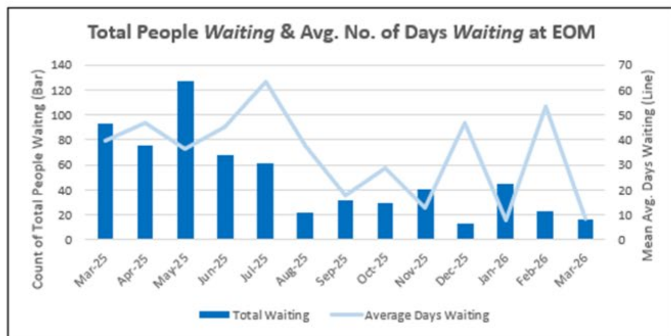
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	3	0	0	0	3	100.0%
North Stoke CAMHS	5	0	0	0	5	100.0%
South Stoke CAMHS	8	0	0	0	8	100.0%
CAMHS Total	16	0	0	0	16	100.0%









- The Community directorate's RTA performance demonstrates an increase of 1.8% when comparing M11 to M12, RTA performance against standard is below target by 1%.
- Core CAMHS CMHTs RTA performance has improved in M12 and has achieved standard with 96.2%.
- The number of CYP awaiting completion of an RTA is at its second lowest level in the past 13 months, with all current waits remaining within the 4-week standard.

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

Community directorate

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

Performance during M12 is 94.2% which is exceeding the planned trajectory but is not meeting the required standard.

The aim is for the standard to be met in May 2025; this has been revised to August 2025, January 2026 and currently April 2026.

Trajectory adjustments: Set M10 2024/25 (May-Aug 2025). Reset in M06 (Sep-Jan 2025/26). Reset in M11 (Feb-Apr 2026).

Updated actions have been provided for M12.

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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%	91.6%	92.1%	88.2%	82.5%	78.8%	93.2%	92.5%	95.0%	96.1%	93.9%	92.6%	94.2%
Trajectory	93.0%	94.0%	92.0%	93.0%	94.0%	95.0%	85.0%	87.0%	90.0%	92.0%	95.0%	93.0%	94.0%

Actions:

- Demand and Capacity Across CMHTs. The senior service manager will be liaising with the performance team to undertake a full demand and capacity review across all CMHT's to ensure resources are deployed effectively in line with variation in local need. meeting scheduled for the end of February 2026. **M12 progress update:** *Data currently being reviewed. Caseload Management tool to be scoped and discussed with a proposed standard tool to be rolled out across the Directorate.*

- Effective management of absences. Team leader absences continue to place operational pressure across several teams. Clinical leads and deputy team leads are providing interim support, with absence management continuing in line with policy. Team leads are working closely with service managers to ensure equitable allocation of work across senior colleagues who are in post. Clinical Lead at Sutherland & Greenfields now returned. Interim Team lead allocated to Lymebrook who is reviewing caseloads with all individuals. **M12 progress update:** *Sickness Surgeries to be increased to monthly with all team leads, service manager & senior service manager. Attendance management training compliance to be reviewed with the expectation that all team leads and deputies have attended.*

- Review of CMHTs structures and resource management. Sutherland Centre-the single assessment framework (SFA) waitlist remains at approximately 12 weeks having been stable for the last few months. Clinical lead actively allocating cases and ensuring patient contact every 2 weeks. Lymebrook-SAF waiting remains at approximately 22 weeks. A caseload review is underway. Newly qualified nurses (NQNs) are expected to support demand when they commence in January 2025. **M12 progress update:** *Action now embedded and can be closed as business as usual.*
- Lymebrook caseload and SAF waitlist undergoing a review to ensure timely allocation of key worker. **M12 progress update** – *caseload reviewed and all reviewed or allocated.*
- Directorate to explore re-deployment of Key workers from across the Directorate to support Lymebrook key worker capacity due. **M12 progress update** – *3 x staff members re-deployed to Lymebrook to support demand.*

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

Community directorate

Feb-26

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	439	23	7	7	476	92.2%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	11	0	0	0	11	100.0%
City CMHT - Sutherland	25	1	0	0	26	96.2%
County CMHT Moorlands	30	0	1	1	32	93.8%
County CMHT Newcastle	34	1	2	2	39	87.2%
CMHT Total	**100**	**2**	**3**	**3**	**108**	**92.6%**

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	15	2	1	0	18	83.3%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	5	2	0	0	7	71.4%
CMHT Total	**27**	**4**	**1**	**0**	**32**	**84.4%**

Mar-26

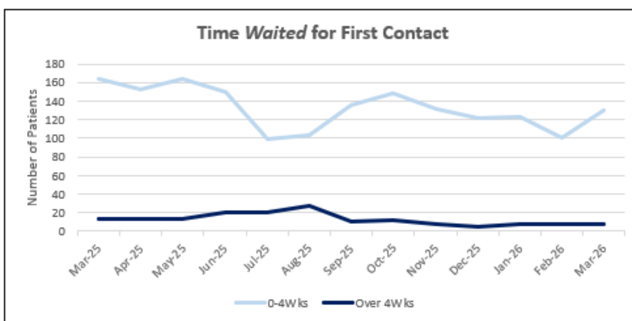
RTA Waited

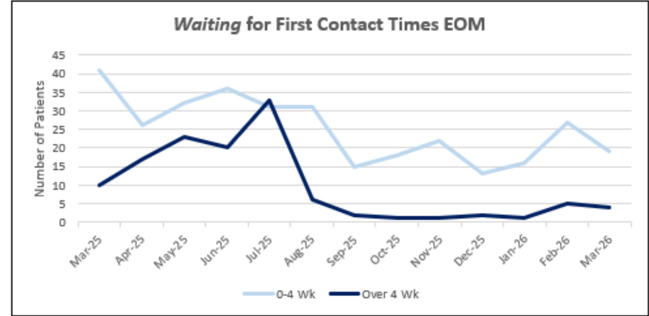
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	490	22	5	4	521	94.0%

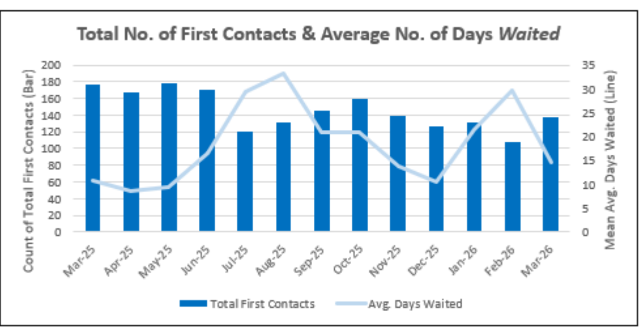
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	19	0	1	0	20	95.0%
City CMHT - Sutherland	23	3	0	1	27	85.2%
County CMHT Moorlands	31	0	0	0	31	100.0%
County CMHT Newcastle	57	2	1	0	60	95.0%
CMHT Total	**130**	**5**	**2**	**1**	**138**	**94.2%**

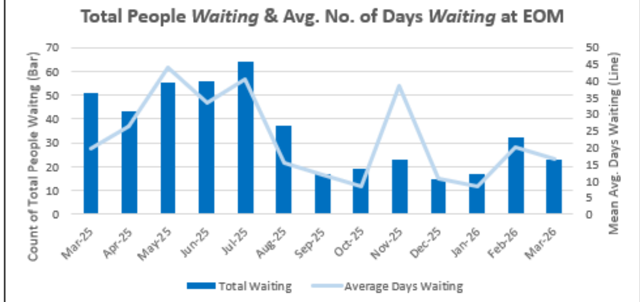
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	10	1	0	0	11	90.9%
City CMHT - Sutherland	8	2	0	0	10	80.0%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	1	1	0	0	2	50.0%
CMHT Total	**19**	**4**	**0**	**0**	**23**	**82.6%**





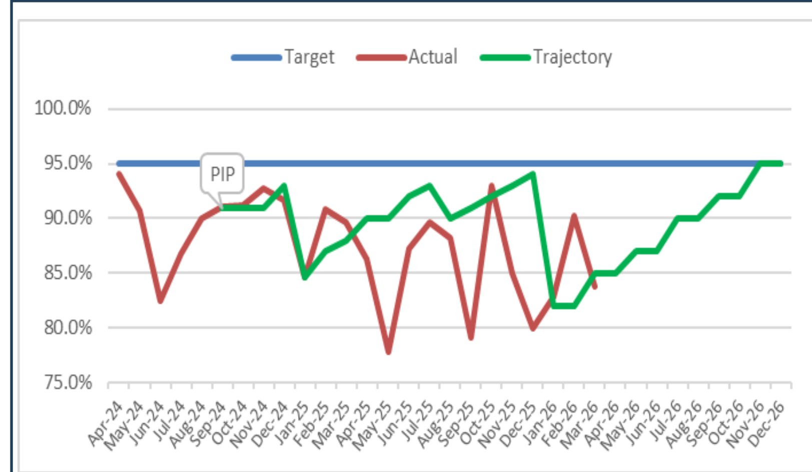




- Adult CMHT services are a main driver for the directorates RTA performance, making up 26.5% of the total RTAs completed in M12.
- RTA performance for Adult CMHTs is slightly below standard in M12, achieving 94.2% against a target of 95%.

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

Specialist Services directorate



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

Performance during M12 is 83.8% which is not meeting the planned trajectory or required standard.

The original aim was for the standard to be achieved by August 2025 this has been extended to January 2026 and is currently November 2026.

Trajectory adjustments; Set M06 (Sept-Jan 2024/25). Reset in M11 (Feb-Jun 25/26). Reset in M04 (Jul-Jan 2025/26). Reset in M10 (Jan-Nov 2026/27).

Updated actions have been provided in M12.

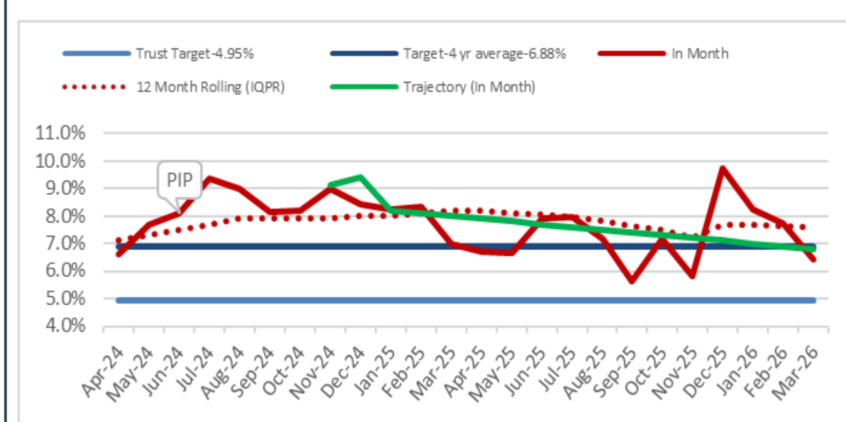
	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	89.7%	86.3%	77.8%	87.3%	89.7%	88.2%	79.2%	93.0%	85.0%	80.0%	82.8%	90.2%	83.8%
Trajectory	88.0%	90.0%	90.0%	92.0%	93.0%	90.0%	91.0%	92.0%	93.0%	94.0%	82.0%	82.0%	85.0%

Actions:

- **M12 progress update:** *Weekly RTA meetings and performance clinics well established. Process is now in place and considered business as usual (BAU). Ongoing issues remain, primarily related to capacity in some areas and factors outside the directorate's control (e.g. patients transferred from other services).*
- **M12 Progress Update:** *Implementation of shadow reporting to separate ASD and ADHD contacts would help reduce breaches out of the directorates control is currently being considered. Performance team is working to publish this in M12 (Outcome to be confirmed).*
- **M12 Progress Update:** *M12 has been impacted by staff capacity, AD requested plans from each service impacted by staff sickness/vacancies to review options for M01.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care directorate



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

The in-month sickness absence is 6.44% during M12, which is exceeding the 6.80% planned trajectory, but is not meeting the required standard.

Updated actions have been provided in M12.

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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	6.99%	6.69%	6.64%	7.89%	7.96%	7.15%	5.64%	7.18%	5.81%	9.73%	8.24%	7.72%	6.44%
12 Month Rolling (IQPR)	8.17%	8.18%	8.09%	8.07%	7.95%	7.80%	7.61%	7.50%	7.23%	7.66%	7.66%	7.63%	7.57%
Trajectory (In Month)	8.00%	7.90%	7.80%	7.70%	7.60%	7.50%	7.40%	7.30%	7.20%	7.10%	7.00%	6.90%	6.80%

M12 progress update:

- In month below trajectory and 4yr average of 6.9% at 6.44%.
- Rolling 12 month reduced from previous 4 months.
- Vacancy rate below Trust target for 9 consecutive months and Turnover rate below Trust target for 10 consecutive months.

Ongoing Actions:

Workforce clinics: Matrons and Service Managers continue attending clinics to monitor sickness absence. Reviews occur from team to Directorate level. **M12 progress update:** *action completed now business as usual.*

Leadership Development Programme: Programme now delivered as face-to-face HR surgeries. Well, attended by various leaders, with positive feedback. **M12 progress update:** *To continue with this provision with ongoing evaluation.*

Wellbeing Champions: Reviewing current numbers and continuing to promote roles across all teams**. M12 progress update:** *To monitor and review as part of the Health, Safety and Wellbeing Group.*

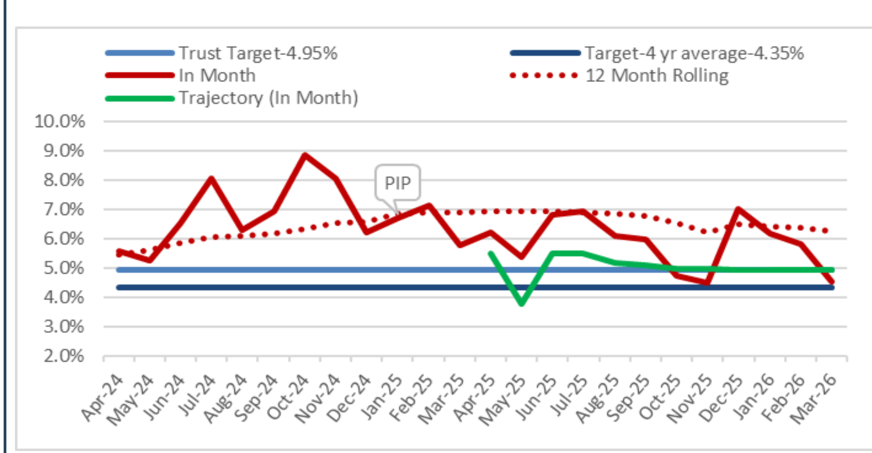
Staff Survey Plan: 2025/26 implementation plan in progress. **M12 progress update:** *All Service lines have identified their three focus areas which are updated monthly. Actions are aligned to the People Promise and responses from the 2025 staff survey are being collated to update the plan. 2025 results have indicated an improvement in all areas of the People Promise from 2024 and further work will continue.*

Targeted support - Psychological and musculoskeletal (MSK) programmes. **M12 progress update:** *A pilot of psychological and MSK support programme is planned across the directorate. The psychological support programme is scheduled to commence on ward 3. MSK clinics remain pending, with Sarah Mountford leading on this.*

Vacancy and turnover reduction: Recruitment and retention plan delivering results. **M12 progress update:** *Ongoing improvement across the directorate with vacancy rate below target for nine consecutive months, and turnover below target for ten consecutive months.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Primary Care directorate



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

The in-month sickness absence is 4.56% during M12 which is exceeding the 4.95% planned trajectory and is meeting the required standard.

Updated actions have been provided in M12.

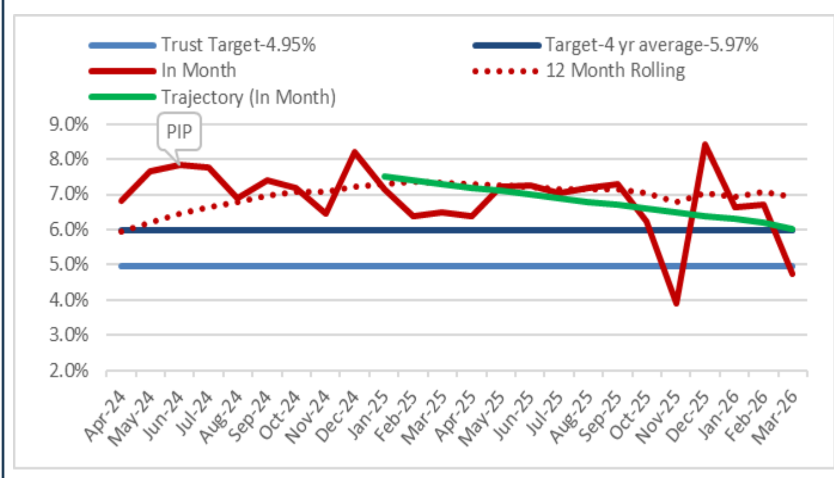
	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%
In Month	5.79%	6.22%	5.37%	6.81%	6.95%	6.11%	6.00%	4.75%	4.52%	7.01%	6.19%	5.84%	4.56%
12 Month Rolling	6.89%	6.94%	6.93%	6.96%	6.89%	6.86%	6.78%	6.53%	6.24%	6.49%	6.42%	6.39%	6.28%
Trajectory (In Month)		5.50%	3.80%	5.50%	5.50%	5.20%	5.10%	5.00%	5.00%	4.95%	4.95%	4.95%	4.95%

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**. M12 progress update***: Actions from the staff survey / people plan work continues to be implemented within talking therapies stoke. Initial analysis of latest staff survey results underway and development of results data to be shared with the teams.*
- Supporting attendance at work clinics held with all line managers. **M12 progress update:** *AD and PBP reviewing different sickness reporting data which allows focus and support on areas with the highest and longest areas of sickness in order to provide focussed sickness clinics. Further stage 3 processes underway to support attendance at work discussions.*

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.

The in-month sickness absence is 4.76% during M12 which is exceeding the 6.00% planned trajectory and is meeting the required standard.

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 M12.

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
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	6.48%	6.38%	7.21%	7.26%	7.03%	7.17%	7.29%	6.24%	3.92%	8.42%	6.65%	6.71%	4.76%
12 Month Rolling	7.33%	7.30%	7.26%	7.22%	7.15%	7.15%	7.14%	7.02%	6.79%	7.03%	6.94%	7.08%	6.93%
Trajectory (In Month)	7.30%	7.20%	7.10%	7.00%	6.90%	6.80%	6.70%	6.60%	6.50%	6.40%	6.30%	6.20%	6.00%

Actions:

Trust People Plan highlights sickness as a targeted objective.

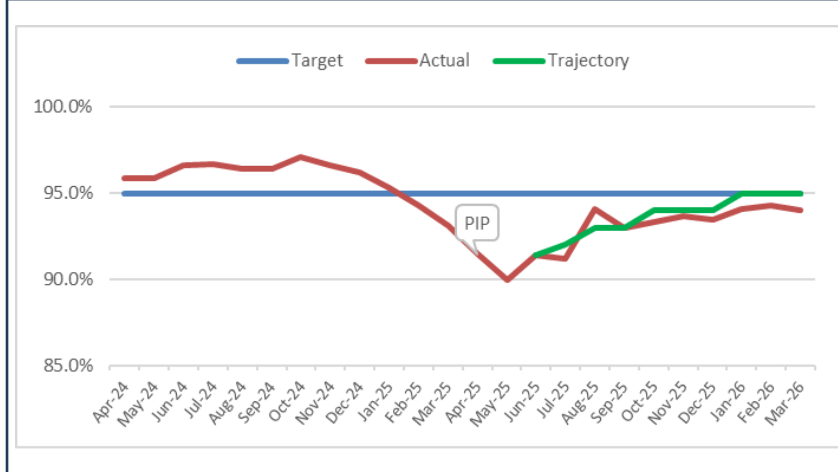
Redesign of directorate performance meetings will bring all teams in scope and will have sickness as a topic for discussion.

M12 Progress Update*:*

- *Second round of new sickness surgeries now taken place, all cases for all areas reviewed. Focus on repeated stage 2 cases, frequent flyers and long-term Sickness. These will continue monthly chaired by AD with People's team support.*
- *The directorate senior leaders have completed a team-level stress risk assessment with support from the health and safety advisor. This will be cascaded across all teams over the next three months to identify and assess common themes. All team managers now completed this in M12, this will then be cascaded to understand directorate themes.*
- *Staff survey results presented to team managers during away day on 11th March. People's team have started to meet with all services to review areas for improvement with easy read graphics to share with wider teams.*
- *AD/CDs to meet with all team managers on the 27th April to review actions of 11th March away day, staff survey and stress risk assessment.*

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services directorate



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

Performance during M12 is 94.0% which is not meeting the planned trajectory or required standard.

The original aim was for the standard to be achieved by October 2025 this has been revised to January 2026.

Trajectory adjustments; Set in M01 (Apr-Jun 2025/26). Reset in M03 (Apr-May 2025). Reset in M04 (Sept-Jan 2025/26).

Updated actions have been provided in M12.

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	93.1%	91.5%	90.0%	91.4%	91.2%	94.1%	93.0%	93.3%	93.7%	93.5%	94.1%	94.3%	94.0%
Trajectory				91.4%	92.0%	93.0%	93.0%	94.0%	94.0%	94.0%	95.0%	95.0%	95.0%

Actions:

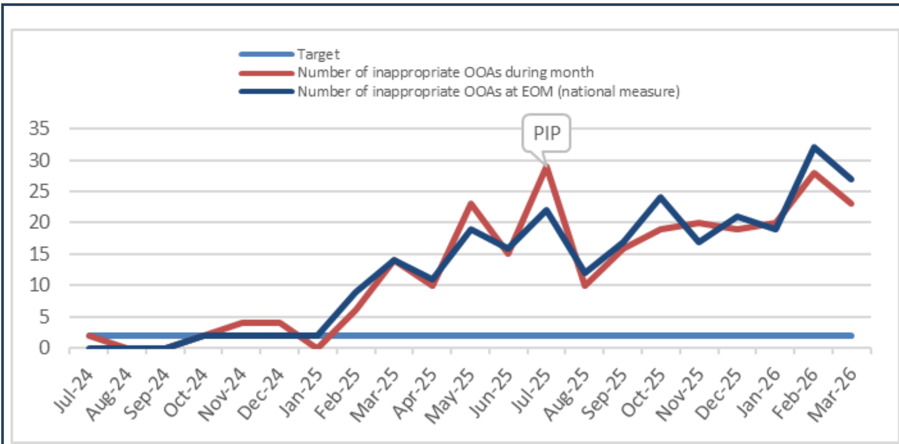
- LD services-promote wider engagement and prioritise attendance at performance clinics.
- Neuropsychiatry & Psychology-review triage process in light of care plan changes; potential to triage patients differently. Additional support planned for transition to new care planning pathway.

M12 progress update:

- *An in-scope service's reviewed by the directorate and agreed to not request further exclusions.*
- *Agreed to request that admin or practitioner's transfer information in care plan letter to the plan and next steps in Lorenzo.*
- *Medics will be supported to ensure clinical notes made during dictation are documented in the plan/next steps rather than requiring a separate letter. The CDs have 1:1 sessions booked in with medics and secretaries to ensure full understanding of the revised processes and requirements. This is ongoing.*

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

Acute and Urgent Care and Community directorates



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

M12 performance is number of inappropriate OOAs during month is 23, number of inappropriate OOAs at EOM (national measure) is 27.

Updated actions have been provided in M12.

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Target	2	2	2	2	2	2	2	2	2	2	2	2	2
Number of inappropriate OOAs during month	14	10	23	15	29	10	16	19	20	19	20	28	23
Number of inappropriate OOAs at EOM (national measure)	14	11	19	16	22	12	17	24	17	21	19	32	27

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

AUCD M12 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 has increased to 12 across the month.
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, CMHTs 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, and all actions cross-directorate are overseen and reviewed.

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. **M12 progress update:** *Average median LoS remains below national target. LoS for OOA placements is also monitored and remains below national average. LoS for those discharged in month also appears to be reducing month on month. The mean average LoS for M12 is above the target, however this is due to 2 long stay patients being discharged which increases the LoS.*

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. **M12 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 sitting outside of CRHTT (appropriate place not yet determined) This action is underway between CRHTT and CMHTs and Primary Care.*

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. **M12 progress update**: *Progressing by Nursing & Quality – no updates as of yet.*

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. **M12 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. **M12 progress update: action completed**. *OOA & CRFD Deliver Group feeds into the strategic OOA Oversight meeting which 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**. M12 progress update: Action complete** *AUCD will continue to provide monthly detailed reports internally and an appropriate overview to the ICB to demonstrate recovery.*

Risk Management : ensure risks linked to OOA placements and bed pressures are recorded on the Trust Risk Register for visibility and timely mitigation. **M12 progress update***:* completed.

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

Community actions:

Senior service manager to liaise with performance to review demand and capacity across all CMHTs to ensure resources are appropriately allocated to meet differing demands within each CMHTS. **M12 progress update:** *Capacity to meet demand across all CMHTS reviewed and resources re-allocated. Remains under constant review by service manager. Action to be closed as now business as usual.*

Ongoing management of absences in line with policy. Team leader absences continue to present operational challenges, with clinical leads and deputy team leads providing cover. Team leads to work with service managers to ensure equitable allocation of work across senior team colleagues. Interim Team lead allocated to Lymebrook who is reviewing individual capacity to ensure timely allocation of key workers. **M12 progress update:** *complete and can now be closed as business as usual.*

Review of all individual caseloads at Lymebrook. On-going and service manager supporting with ward & OOA reviews daily updates provided to the Teams channel and oversight to ensure attendance from CMHTs. **M12 progress update:** *complete and can now be closed as business as usual.*

Effective management of leadership absences and cover to ensure reviews are covered and there are no delays impacting OOA from absences. Ongoing adherence to the supporting attendance at work Policy continues across to ensure timely action and oversight. **M12 progress update:** *Sickness Surgeries to be increased to monthly with all team leads, service manager & senior service manager. Attendance management training compliance to be reviewed with the expectation that all team leads and deputies have attended.*

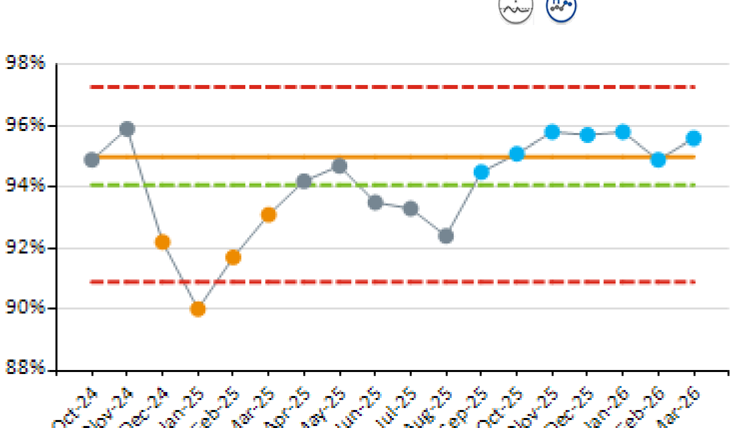
M12 New action – Deteriorating patient/admission checklist devised and to be piloted across Adult CMHTs and EIT to strengthen evidence that all options have been explored within the Community prior to requesting an admission and or MHA Assessment.

M12 New action – Deteriorating patient dashboard to be explored for SMI service users. Meeting arranged with performance, AD, service manager and TMO for 27.04.26.

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

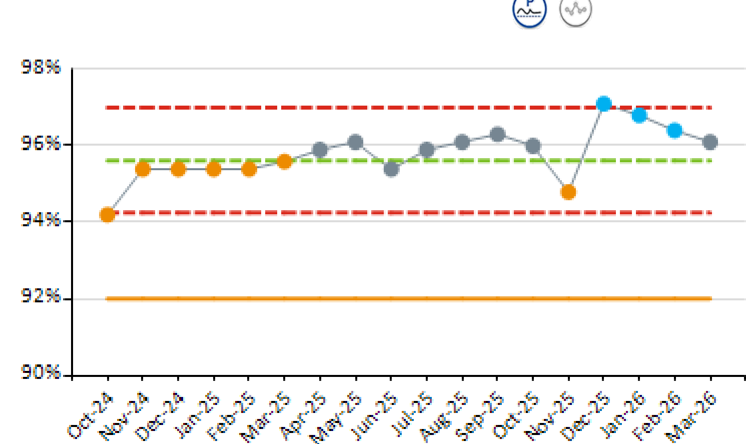
Referral to Assessment within 4 weeks (Trust Measure)



13 Month Trend

93.1%	94.2%	94.7%	93.5%	93.3%	92.4%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

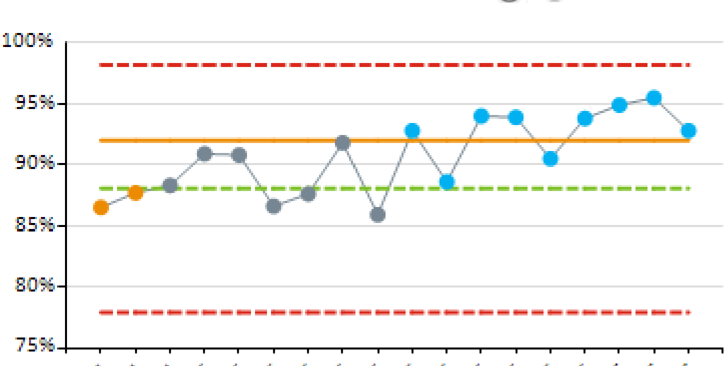
Referral to Treatment within 18 weeks (Trust Measure)



13 Month Trend

95.6%	95.9%	96.1%	95.4%	95.9%	96.1%	96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

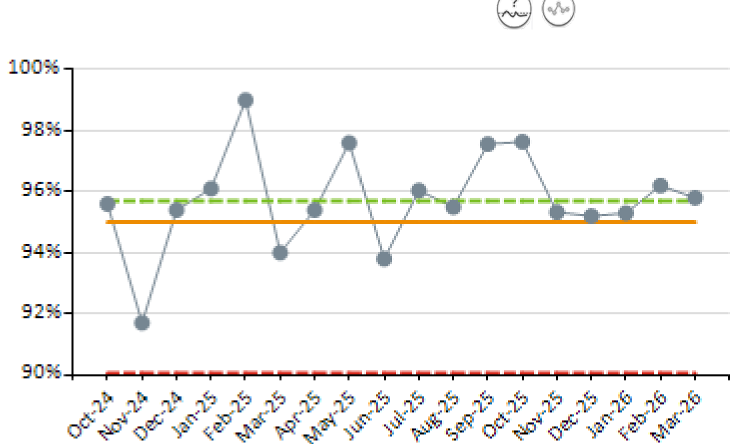
CAMHS Compliance within 18 week waits (Referral to Treatment) (Trust Measure)



13 Month Trend

86.6%	87.6%	91.8%	85.9%	92.8%	88.6%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

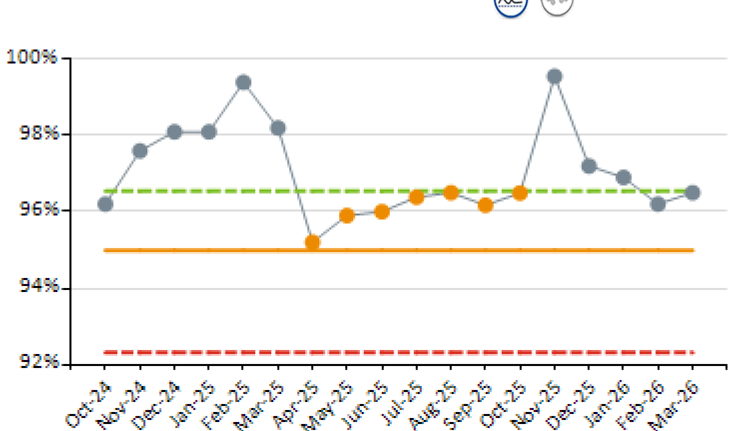
MH Liaison 4 Hour Response (Urgent) (Trust Measure)



13 Month Trend

94.0%	95.4%	97.6%	93.8%	96.0%	95.5%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

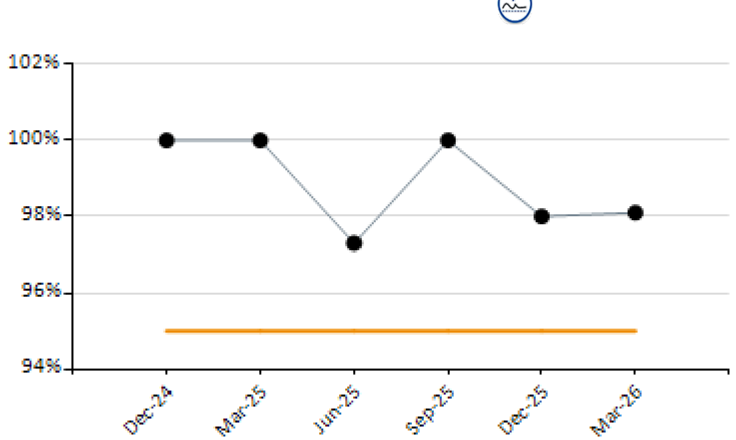
MH Liaison 24 Hour Response (Urgent from General Hospital Ward) (Trust Measure)



13 Month Trend

98.2%	95.2%	95.9%	96.0%	96.4%	96.5%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

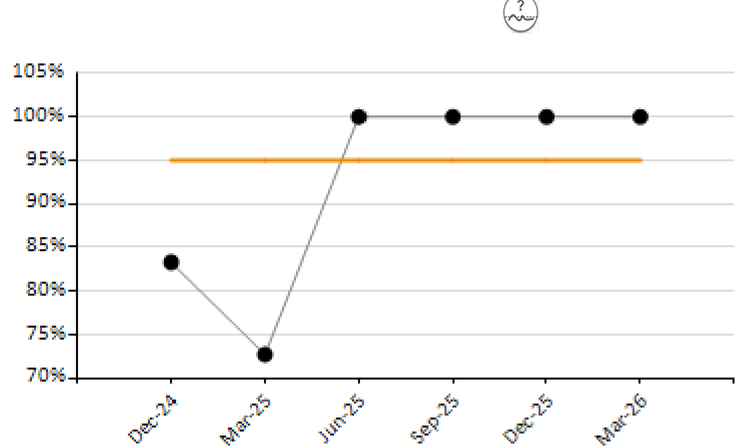
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks (National Measure)



13 Month Trend

100.0%	97.3%	100.0%	98.0%	98.1%
Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26

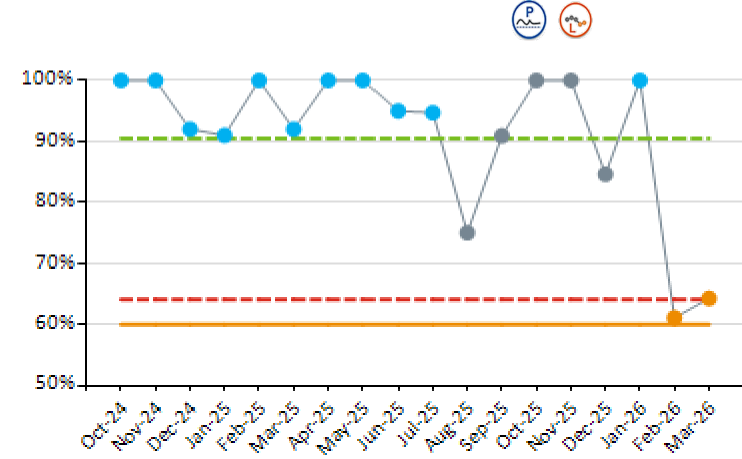
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week (National Measure)



13 Month Trend

72.7%	100.0%	100.0%	100.0%	100.0%
Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26

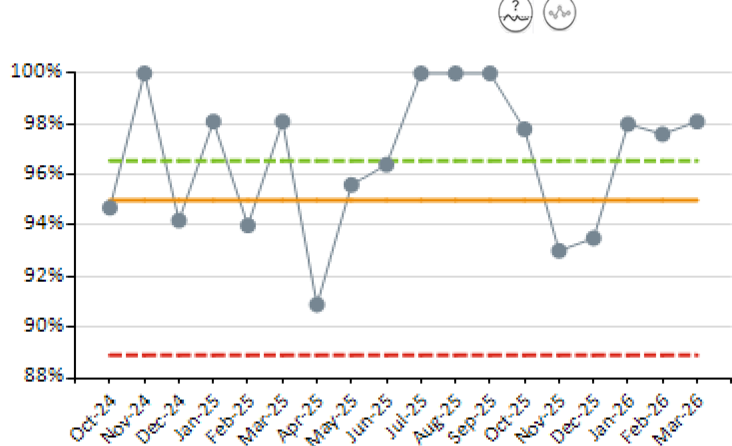
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment (National Measure)



13 Month Trend

92.0%	100.0%	100.0%	95.0%	94.7%	75.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

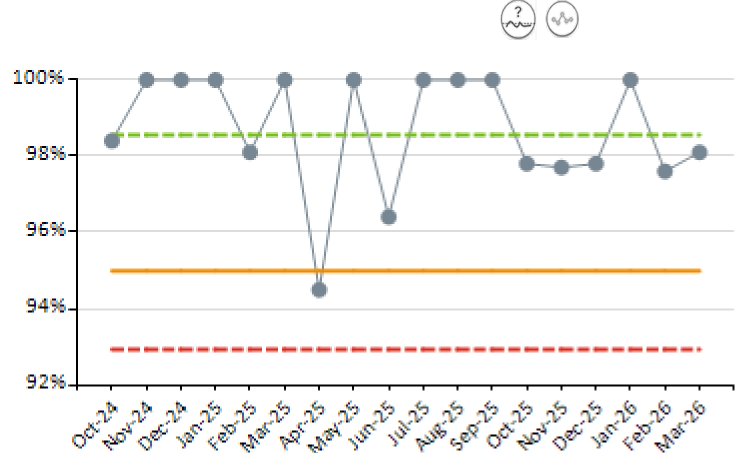
48 Hour Follow Up (Trust Measure)



13 Month Trend

98.1%	90.9%	95.6%	96.4%	100.0%	100.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

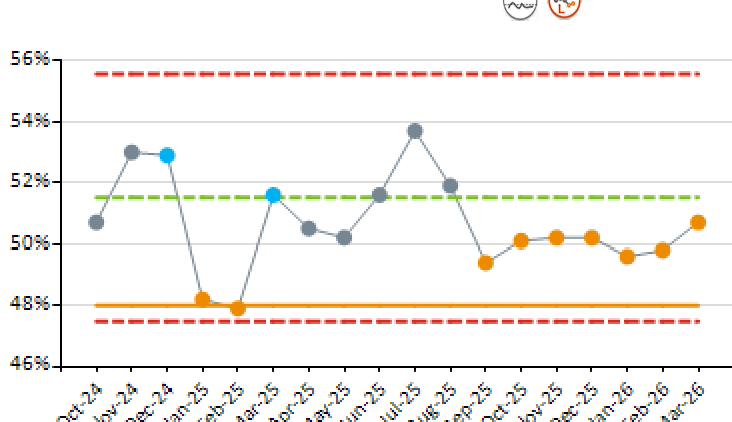
7 Day Follow Up (All Patients) (Trust Measure)



13 Month Trend

100.0%	94.5%	100.0%	96.4%	100.0%	100.0%	100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

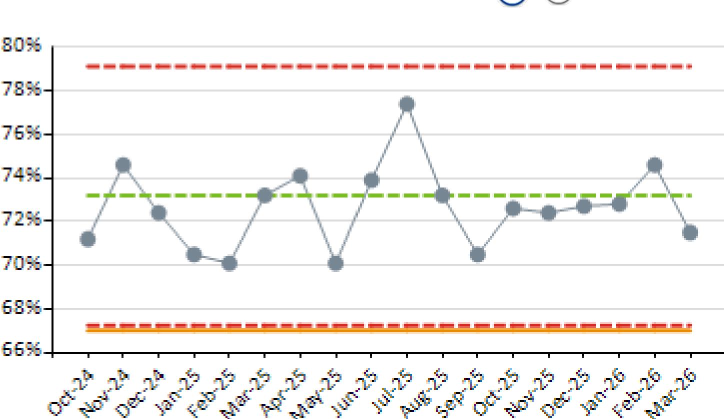
Talking Therapies for Anxiety and Depression: Reliable Recovery (National Measure)



13 Month Trend

51.6%	50.5%	50.2%	51.6%	53.7%	51.9%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

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

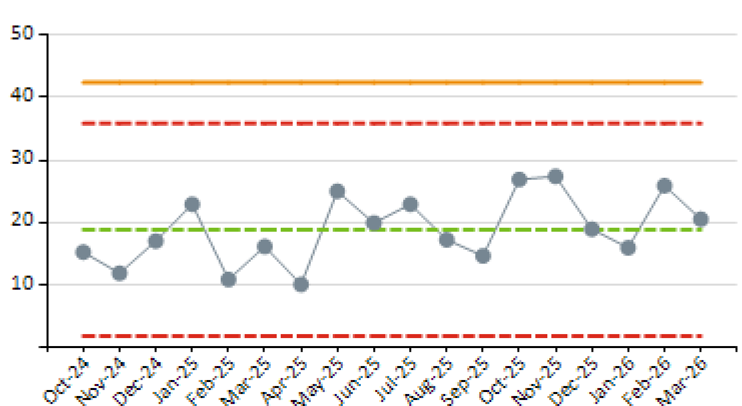


13 Month Trend

73.2%	74.1%	70.1%	73.9%	77.4%	73.2%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Core Indicators – SPC Trend (Inpatient and Quality)

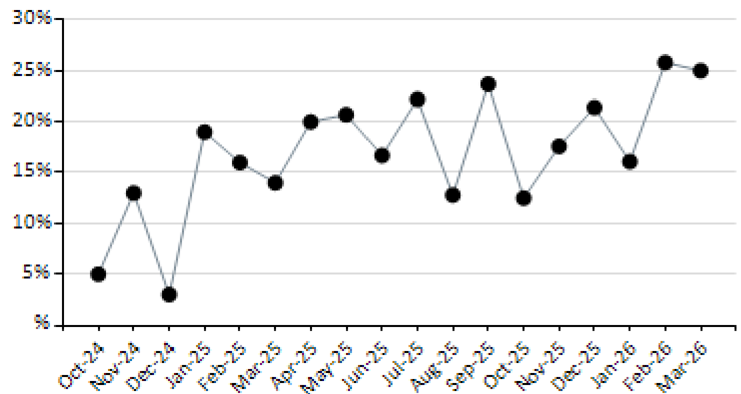
Median Length of Stay - Adult (National Measure)



13 Month Trend

16.1	10.0	25.0	19.9	22.9	17.2	14.6	26.9	27.4	18.9	15.9	25.9	20.5
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

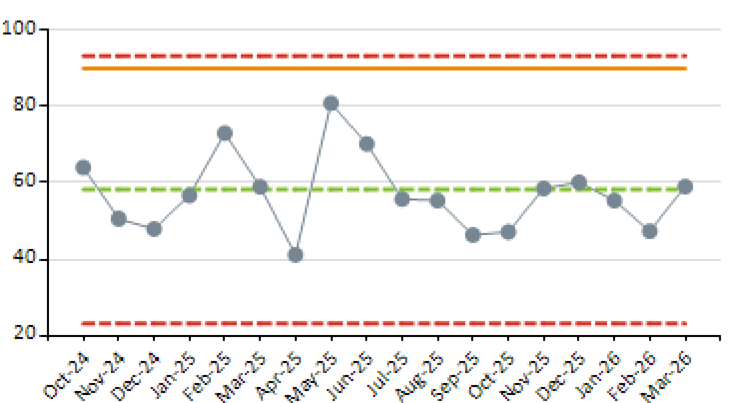
Adult Acute LoS-Over 60 days as a % of all discharges (National Measure)



13 Month Trend

14.0%	20.0%	20.7%	16.7%	22.2%	12.8%	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

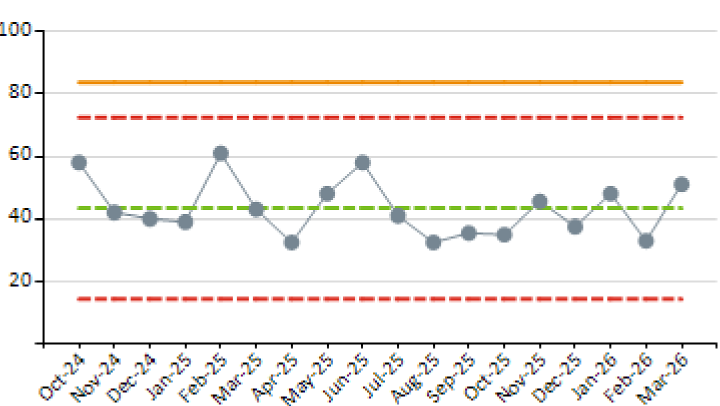
Average Length of Stay - Older Adult (National Measure)



13 Month Trend

58.9	41.2	80.9	70.2	55.7	55.3	46.4	47.2	58.5	60.1	55.3	47.4	59.0
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

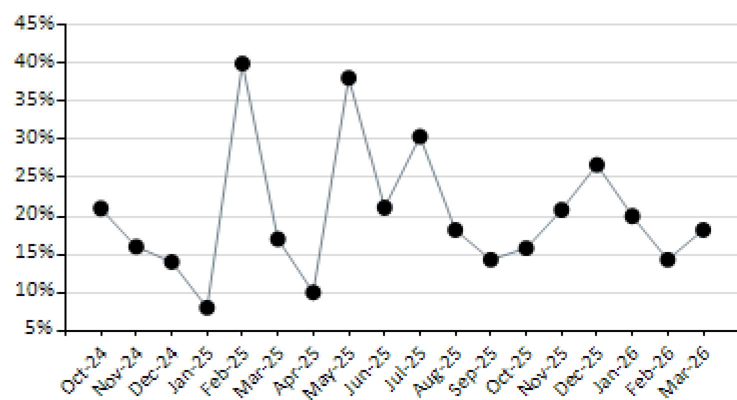
Median Length of Stay - Older Adult (National Measure)



13 Month Trend

43.0	32.5	48.0	58.0	41.0	32.5	35.5	35.0	45.5	37.5	48.0	33.0	51.0
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

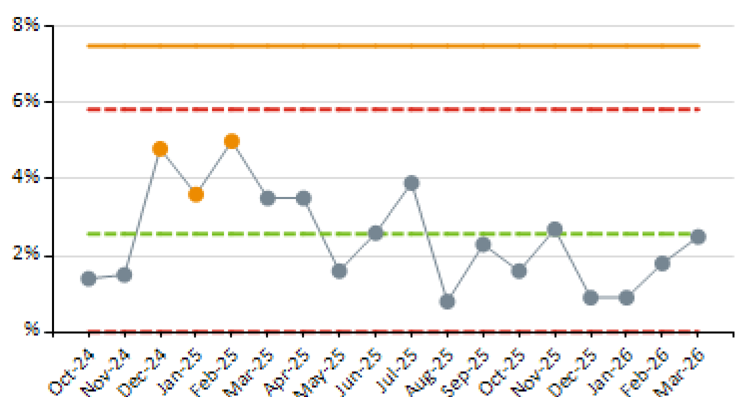
Older Adult Acute LoS-Over 90 days as a % of all discharges (National Measure)



13 Month Trend

17.0%	10.0%	38.1%	21.1%	30.4%	18.2%	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

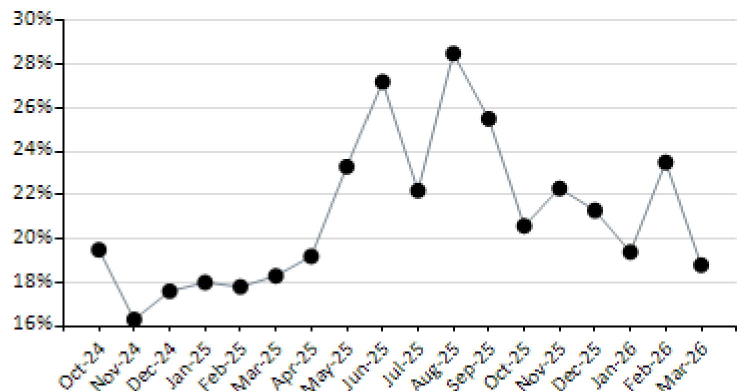
Emergency Readmissions rate (30 days) (Trust Measure)



13 Month Trend

3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Clinically Ready for Discharge (CRFD) (Trust Measure)

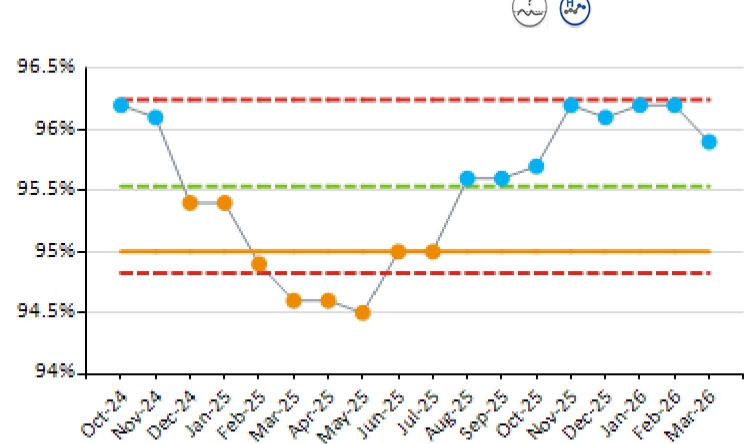


13 Month Trend

18.3%	19.2%	23.3%	27.2%	22.2%	28.5%	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Core Indicators – SPC Trend (Community and Quality)

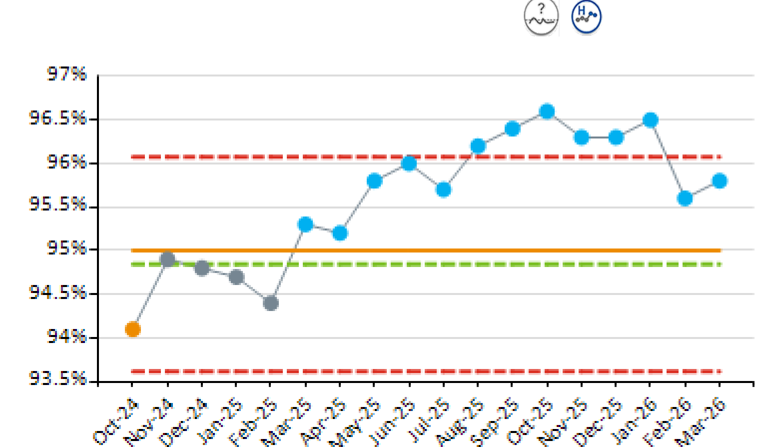
Care Plan Compliance (Trust Measure)



13 Month Trend

94.6%	94.6%	94.5%	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Risk Assessment Compliance (Trust Measure)



13 Month Trend

95.3%	95.2%	95.8%	96.0%	95.7%	96.2%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

Enclosure No: 7

FINANCE POSITION MONTH 12

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

Report to:	Public Trust Board
Date of Meeting:	14 May 2026

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

Aligned to Board Assurance Framework Risk:	Financial - There is a risk to the Trust's long term financial sustainability due to failure to deliver recurrent cash releasing savings, and higher than planned bank and agency expenditure.
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:	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.

<table>
<tr><td>Recommendation / Required Action:</td><td>Receive the Month 12 position noting:

The year-to-date surplus of £3,421k against a planned breakeven position, giving a favourable variance of £3,421k.
The underlying financial position (ULP) of £955k deficit.
Agency expenditure of £1,546k against a plan of £1,504k, resulting in an adverse variance of £42k.
Bank expenditure of £6,301k against a plan of £5,453k, giving an adverse variance of £848k.
The Trust has fully achieved the £7.4m CIP target.
The Trust has spent £4,556k on capital, which is £72k behind plan.
The cash position of the Trust on 31st March with a balance of £33.4m.
</td></tr>
<tr><td>Executive Summary:</td><td>The Adjusted Financial Performance in month is a surplus of £2,191k against a planned surplus of £77k giving a favourable variance of £2,114k. The year to date position is a surplus of £3,421k against a planned breakeven position, giving a favourable variance of £3,421k.

The Trust is reporting an underlying financial position (ULP) of £955k 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 12 the Trust is reporting full delivery of the £7.4m target.

In month agency expenditure was £93k against a plan of £106k representing a favourable variance of £13k against the 40% agency expenditure reduction from 2024/25.

In month bank expenditure was £441k against a plan of £352k representing an adverse variance of £89k against the 10% bank expenditure reduction from 2024/25.

The Trust's capital expenditure year to date was £4,679k against a plan of £4,628k giving an adverse variance of £51k due to backlog maintenance and NHS Notify.

In month, 95.7% based on the number of invoices and 96.3% 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 31st March is £33.4m.</td></tr>
</table>

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	21/04/2026
2	Finance & Resource Committee	21/04/2026
3	Public Trust Board	08.05.2026

TRUST BOARD – 14th May 2026
Finance Position Month 12

This report summarises the Trust's financial position as of 31st March 2026.

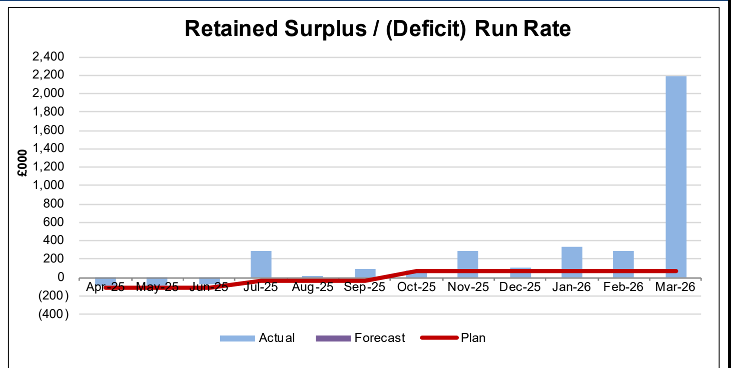
Key financial performance metrics are included for the following:

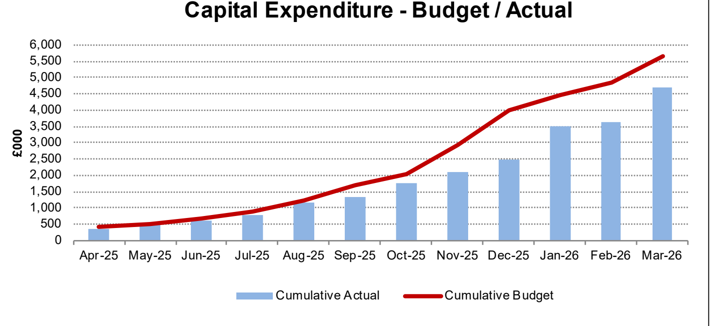
- Income & expenditure position.
- Underlying position.
- Agency expenditure.
- Bank expenditure.
- CIP delivery.
- Capital Expenditure.
- Statement of Financial Position.
- Better Payment Practice Code.

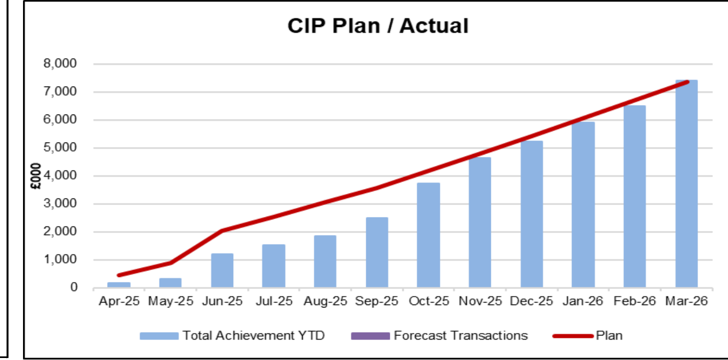
Financial Overview as at 31 March 2026

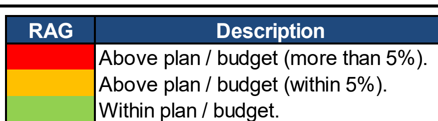
Key Metrics

£000	M10	M11	M12	YTD	Average	RAG
Variance to Plan						
In month financial position	257	222	2,114	3,421	285	
YTD financial position	1,086	1,309	3,421	3,421	285	Green
Run Rates (Actuals)						
Income	15,117	15,062	23,598	187,880	15,657	Green
Pay	(8,968)	(9,215)	(15,988)	(115,790)	(9,649)	Red
Non-pay	(5,520)	(5,260)	(5,228)	(66,734)	(5,561)	Green
Finance & Other Non Operating Costs	(256)	(255)	(279)	(3,075)	(256)	Amber
Agency (Actuals)	(111)	(80)	(93)	(1,546)	(129)	Red
Agency Variance To Plan	**(1)**	**27**	**13**	**(42)**	**(4)**	Red
Medical Agency	(14)	22	20	(9)	(1)	Red
Nurse Agency	8	5	(2)	(5)	(0)	Red
Other Agency	5	0	(5)	(29)	(2)	Red
Non Clinical Agency	0	0	0	0	0	Green
Bank (Actuals)	(468)	(492)	(441)	(6,301)	(525)	Red
Bank Variance To Plan	**(117)**	**(142)**	**(89)**	**(848)**	**(71)**	Red
Medical Bank	5	(18)	(9)	227	19	Green
Nurse Bank	113	110	60	2,196	183	Green
Other Clinical Bank	(225)	(222)	(118)	(3,108)	(259)	Red
Non Clinical Bank	(9)	(12)	(22)	(164)	(14)	Red
CIP (Variance)	28	(51)	273	42	4	Green
Cash balance	31,414	34,555	33,439	33,439	33,267	Green
Capital expenditure (Variance)	(846)	32	(741)	72	6	Red
BPPC						
Number	95.6%	95.6%	95.7%	95.0%	95.0%	Green
Value	98.9%	98.7%	96.3%	97.8%	97.9%	Green









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

Finance Position

Income & Expenditure Position

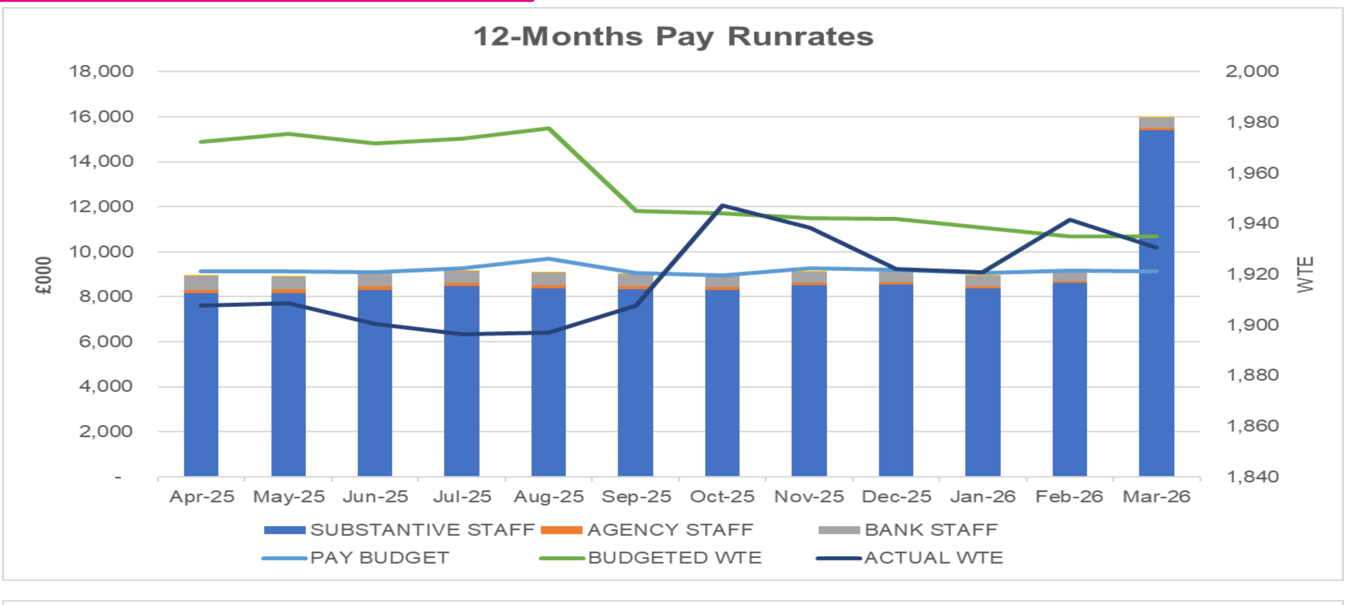
High Level Analysis	Annual Plan £000	In Month Budget £000	In Month Actuals £000	Variance £000	Year to Date Budget £000	Year to Date Actuals £000	Variance £000
Income from Patient Care Activities	160,534	13,757	21,714	7,957	162,789	169,144	6,355
Income from Other Operating Activities	15,692	1,409	1,884	475	17,588	18,735	1,148
Income	**176,226**	**15,166**	**23,598**	**8,432**	**180,377**	**187,879**	**7,502**
Pay Costs	(105,754)	(9,142)	(15,988)	(6,846)	(110,194)	(115,790)	(5,596)
Non Pay Costs	(66,956)	(5,665)	(5,228)	437	(66,737)	(66,735)	2
Operating Expenditure	**(172,710)**	**(14,807)**	**(21,216)**	**(6,409)**	**(176,931)**	**(182,525)**	**(5,594)**
EBITDA	**3,516**	**359**	**2,382**	**2,023**	**3,446**	**5,354**	**1,908**
Finance & Other Non Operating Costs	(3,040)	(247)	(279)	(32)	(2,970)	(3,075)	(105)
Retained Surplus / (Deficit)	**476**	**112**	**2,103**	**1,991**	**476**	**2,279**	**1,803**
Add Back Impairments	0	0	131	131	0	1,663	1,663
Surplus/(deficit) before impairments	**476**	**112**	**2,234**	**2,122**	**476**	**3,942**	**3,466**
Technical Adjustments	(476)	(35)	(43)	(8)	(476)	(521)	(45)
Adjusted Financial Performance	**0**	**77**	**2,191**	**2,114**	**0**	**3,421**	**3,421**

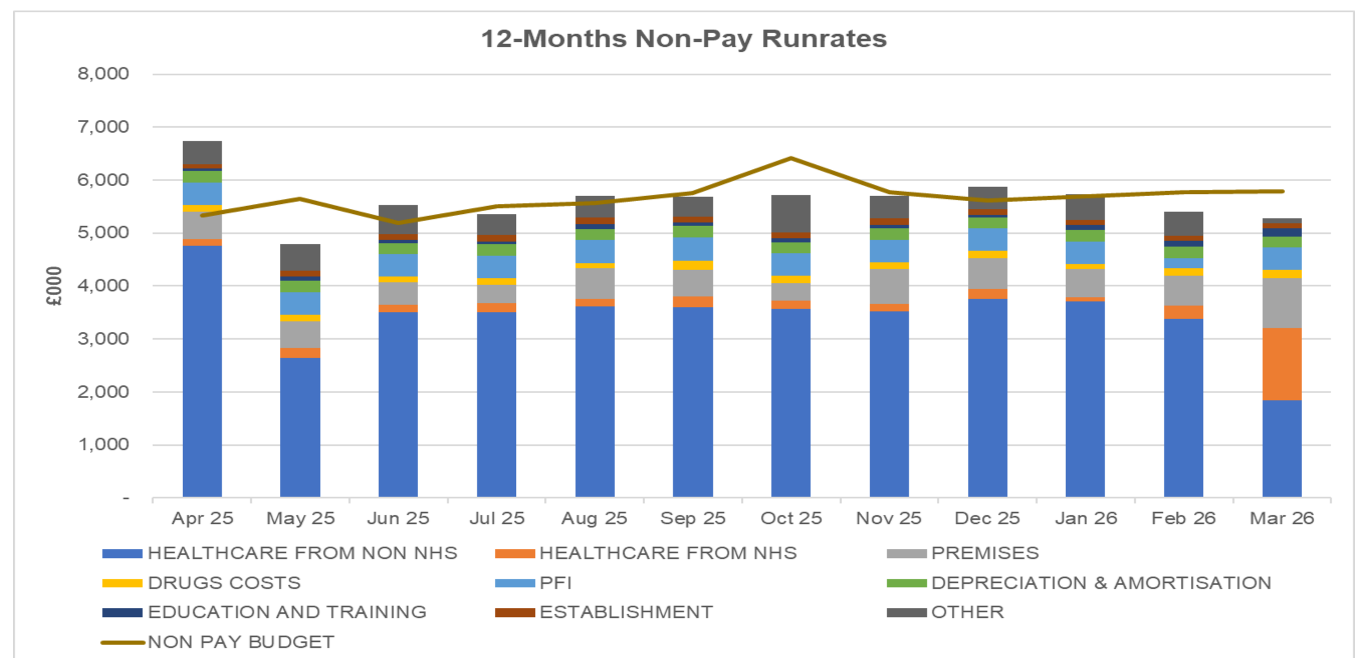
Note: The Adjusted Financial Performance removes the impact of donated asset additions and depreciation and impairments and adjusts for the impact of the PFI revenue costs under IFRS16 compared to on a UK GAAP basis. EBITDA is Earnings Before Interest, Taxes, Depreciation, and Amortisation. It is a non-GAAP metric that provides a measure of core business profitability.

- In month surplus of £2,191k against a planned surplus of £77k giving a favourable variance of £2,114k. The higher surplus results from additional income related to Deficit Support Funding (DSF), which was not allocated to other Systems as they were not achieving their position but instead distributed to those that are breaking even and performing in line with plan, totalling £1,638k.
- Year to date position is a surplus of £3,421k against a forecast of £1,750k. The main driver of the year-to-date favourable variance is vacancy slippage particularly in the Community, Education and Estates teams offset with by high patient transport costs and additional income relating to unearned DSF.
- Income is shown as overperforming due to the employers NHSE pension contribution received in month 12 of £6,827k and DSF of £1,638k. Excluding this funding income has under performed due to lower than planned patient placement income (£2,395k - offset with decreased non pay expenditure), partly offset by increased education and training income.
- Pay includes the additional employers pension cost in line with the NHSE pension funding of £6.827k year. Excluding this the year-to-date position is a favourable variance of £1,231k due to vacancy slippage.
- Non-pay has an adverse variance due to impairments totalling £1,663k, high premises costs and high patient transport costs (£513k year to date) due to a significant increase in out of area patients, partly offset by an underspend on patient placements (£3,734k - offset with decreased patient placements income).
- Finance and other non-operating costs have an adverse variance of £105k due to reduced bank interest following interest rate reductions.

Finance Position

Expenditure Run Rates





Finance Position

Underlying Position (ULP)

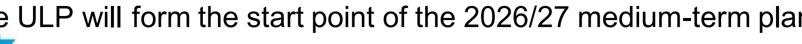
Heading	Income £000	Employee Expenses £000	Operating expenses £000	Non Operating Items £000	Adjusted Position £000
2025/26 Forecast	187,880	(115,790)	(69,143)	474	**3,421**
Forecast non-recurring efficiencies	(200)	(927)	(261)	0	**(1,387)**
Forecast deficit support funding	(1,638)	0	0	0	**(1,638)**
FYE of forecast recurring efficiencies - cash releasing	0	304	109	0	**412**
FYE of forecast recurring efficiencies - non-cash releasing	0	0	0	0	**0**
FYE of forecast investments	0	0	0	0	**0**
Gains and losses and donations	0	0	9	114	**123**
Non-Recurring Redundancy costs	0	96	96	0	**192**
Non-Recurring Cost of Change (Excluding redundancy)	0	0	0	0	**0**
Full year effect of service developments	0	0	(111)	0	**(111)**
Non-recurrent investments	(886)	766	120	0	**0**
Non Recurent Income and Provision Release	(781)	0	(1,186)	0	**(1,967)**
NHSE Pension Contribution 9.4%	(6,827)	6,827	0	0	**0**
2025/26 Underlying Position	**177,548**	**(108,724)**	**(70,367)**	**588**	**(955)**

- 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:
  - Non recurrent Income and provisions release
  - Non recurrent redundancy costs
  - Delayed recruitment
  - Non recurrent efficiencies
  - Full year effect of recurring efficiencies
  - Disposal loss
  - Full year effect of service developments.

- After adjusting for the items outlined above, the Trust's **underlying financial position is a £955k deficit**, which remains unchanged from the position reported at Month 10.

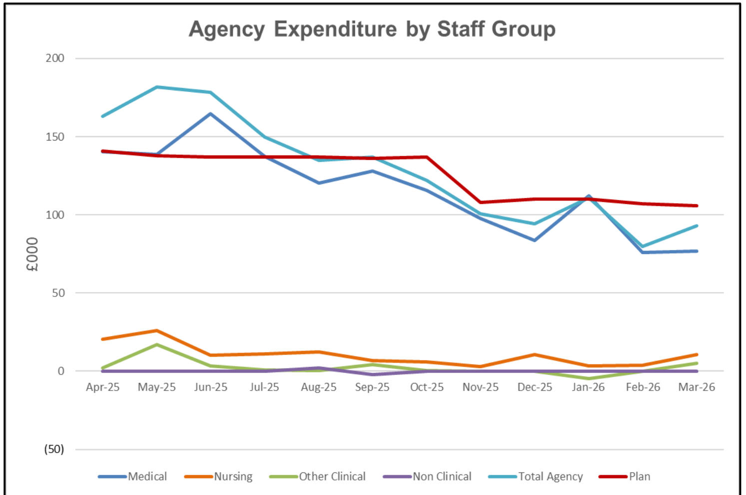
- The ULP will form the start point of the 2026/27 medium-term plan.

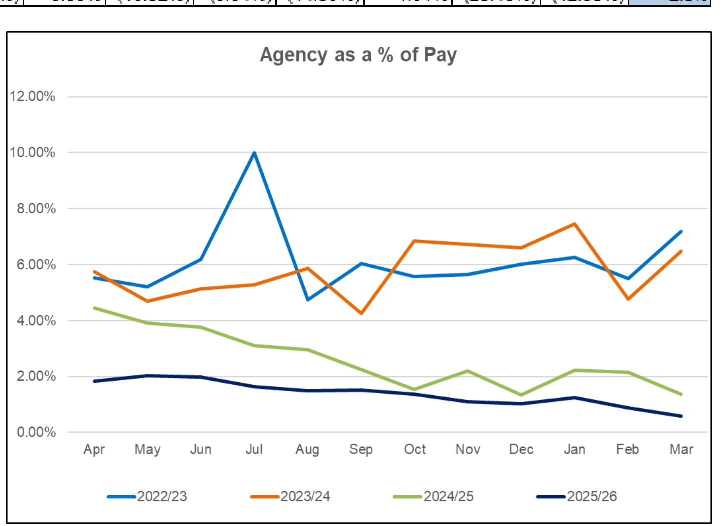


Agency Expenditure

Agency Expenditure	Actual												Total
	Apr-25 £000	May-25 £000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	Oct-25 £000	Nov-25 £000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical	**(141)**	**(139)**	**(165)**	**(138)**	**(120)**	**(128)**	**(116)**	**(98)**	**(84)**	**(112)**	**(76)**	**(77)**	**(1,393)**
Community	(96)	(95)	(112)	(105)	(81)	(87)	(99)	(77)	(74)	(93)	(64)	(68)	**(1,051)**
Specialist Care	(17)	(19)	(26)	(20)	(22)	(1)	0	0	0	0	0	0	**(105)**
Primary Care	(28)	(24)	(27)	(12)	(18)	(36)	(17)	(21)	(10)	(19)	(12)	(9)	**(232)**
Central Services	0	0	0	0	0	(5)	0	0	0	0	0	0	**(5)**
Nursing	**(20)**	**(26)**	**(10)**	**(11)**	**(12)**	**(7)**	**(6)**	**(3)**	**(10)**	**(4)**	**(4)**	**(11)**	**(125)**
Acute Services & Urgent Care	(2)	(10)	(3)	(5)	(6)	0	(0)	(0)	(3)	(3)	(1)	(8)	**(43)**
Primary Care	(5)	1	(5)	(4)	(5)	(4)	(4)	(2)	(2)	(0)	1	(1)	**(29)**
Community	0	0	0	0	(0)	0	0	0	0	0	0	0	**(0)**
Specialist Care	(13)	(17)	(2)	(3)	(1)	(3)	(2)	(1)	(5)	(0)	(4)	(1)	**(53)**
Finance Performance & Estates	0	0	0	0	0	0	0	0	0	0	0	(0)	**(0)**
Other Clinical	**(2)**	**(17)**	**(3)**	**(1)**	**(0)**	**(4)**	**(0)**	**0**	**0**	**5**	**0**	**(5)**	**(29)**
Acute Services & Urgent Care	(1)	(0)	0	0	(0)	(1)	0	0	0	0	0	0	**(3)**
Specialist Care	(1)	(12)	(8)	(1)	0	(3)	(0)	0	0	0	0	(5)	**(31)**
Primary Care	0	(5)	5	0	0	0	0	0	0	5	0	0	**5**
Non Clinical	**0**	**0**	**0**	**0**	**(2)**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
People & OD	0	0	0	0	(2)	2	0	0	0	0	0	0	**0**
Total Agency	**(163)**	**(182)**	**(178)**	**(150)**	**(135)**	**(137)**	**(122)**	**(101)**	**(94)**	**(111)**	**(80)**	**(93)**	**(1,546)**
Agency as a % of Pay	1.82%	2.04%	1.97%	1.63%	1.48%	1.51%	1.36%	1.10%	1.03%	1.24%	0.87%	0.58%	**1.34%**
Plan	(141)	(138)	(137)	(137)	(137)	(136)	(137)	(108)	(110)	(110)	(107)	(106)	**(1,504)**
Variance to Plan (Overspend) / Underspend	(22)	(44)	(41)	(13)	2	(1)	15	7	16	(1)	27	13	**(42)**
Agency Variance as a % of Plan	15.74%	31.84%	30.17%	9.37%	(1.45%)	0.60%	(10.82%)	(6.64%)	(14.39%)	1.01%	(25.46%)	(12.35%)	**2.8%**

- Planned agency expenditure for 2025/26 is £1,504k this represents a mandated 40% reduction of 2024/25 expenditure levels.
- In month expenditure is £93k against planned expenditure of £106k representing a favourable variance of £13k.
- 2025/26 expenditure is £1,546k against planned expenditure of £1,504k representing an adverse variance of £42k.
- 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. However, expenditure is now demonstrating a downward trajectory as the Directorates' measures to reduce reliance on agency staffing take effect.





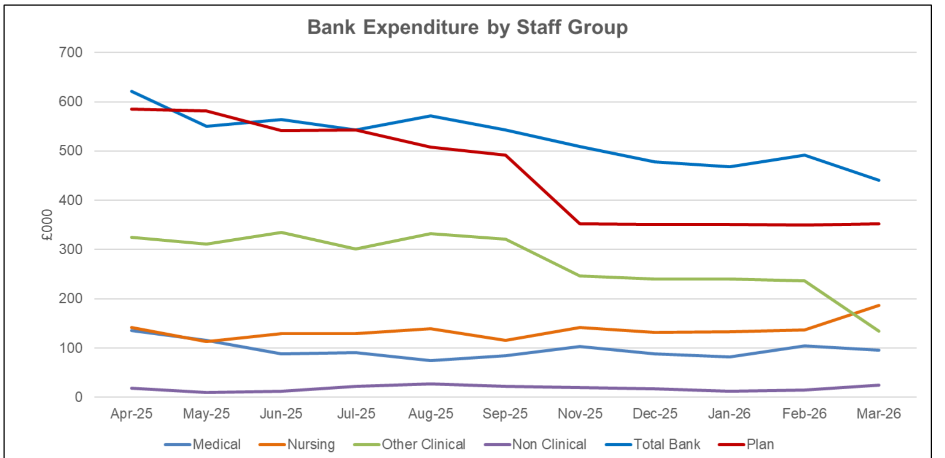
PROUD TO CARE

Finance Position

Bank Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Bank Expenditure	Actual												Total
	Apr-25 £000	May-25 £000	Jun-25 £000	Jul-25 £000	Aug-25 £000	Sep-25 £000	Oct-25 £000	Nov-25 £000	Dec-25 £000	Jan-26 £000	Feb-26 £000	Mar-26 £000	
Medical	**(136)**	**(115)**	**(88)**	**(90)**	**(74)**	**(84)**	**(93)**	**(103)**	**(88)**	**(82)**	**(105)**	**(96)**	**(1,154)**
Acute Services & Urgent Care	(18)	(24)	(24)	(23)	(23)	(17)	(26)	(26)	(18)	(17)	(25)	(27)	**(266)**
Community	(64)	(38)	(29)	(17)	(31)	(28)	(31)	(32)	(28)	(8)	(28)	(22)	**(357)**
Specialist Care	(54)	(54)	(35)	(50)	(12)	(39)	(35)	(44)	(42)	(43)	(47)	(48)	**(503)**
Medical & Clinical Effectiveness	0	0	0	0	0	0	0	0	0	(15)	(5)	(8)	**(28)**
Central Services	0	0	0	0	(9)	0	0	0	0	0	0	9	**0**
Nursing	**(142)**	**(114)**	**(129)**	**(129)**	**(140)**	**(115)**	**(129)**	**(142)**	**(132)**	**(133)**	**(136)**	**(186)**	**(1,626)**
Acute Services & Urgent Care	(101)	(88)	(82)	(72)	(81)	(70)	(88)	(89)	(86)	(90)	(93)	(139)	**(1,079)**
Community	(4)	(4)	(14)	(8)	(9)	(9)	(13)	(13)	(10)	(5)	(4)	(1)	**(95)**
Quality & Nursing	(1)	0	0	(0)	(1)	(0)	0	0	0	(0)	(2)	1	**(4)**
People & OD	(2)	(3)	(0)	(3)	(2)	(1)	(2)	(4)	(4)	(2)	(2)	1	**(25)**
Primary Care	(1)	(2)	(2)	(3)	(1)	(1)	(1)	(1)	(1)	(2)	(1)	(1)	**(17)**
Specialist Care	(32)	(16)	(31)	(43)	(41)	(33)	(24)	(35)	(29)	(34)	(34)	(47)	**(401)**
Central Services	0	0	0	0	(5)	0	0	0	0	0	0	(1)	**(5)**
Other Clinical	**(325)**	**(311)**	**(335)**	**(301)**	**(332)**	**(321)**	**(275)**	**(246)**	**(241)**	**(240)**	**(236)**	**(134)**	**(3,298)**
Acute Services & Urgent Care	(200)	(186)	(174)	(169)	(175)	(171)	(156)	(153)	(138)	(101)	(125)	(73)	**(1,821)**
Community	0	0	(0)	(0)	(0)	(0)	(2)	(1)	0	0	0	(0)	**(4)**
Quality & Nursing	0	(0)	0	0	(0)	0	0	0	0	0	0	0	**(0)**
MACE	(5)	(3)	(4)	(3)	(7)	(5)	(2)	(3)	(7)	(6)	(2)	(2)	**(47)**
Operations	(3)	(3)	(3)	(2)	(4)	(3)	(4)	(4)	(2)	(2)	(1)	1	**(31)**
People & OD	(6)	(3)	(2)	(3)	(5)	(8)	(3)	(1)	(2)	(4)	(3)	(3)	**(44)**
Specialist Care	(111)	(114)	(151)	(123)	(129)	(134)	(107)	(84)	(91)	(127)	(106)	(69)	**(1,345)**
Primary Care	(1)	(1)	(1)	(1)	(0)	(1)	(2)	(0)	0	0	0	1	**(6)**
Central Services	0	0	0	0	(12)	0	0	0	0	0	0	12	**0**
Non Clinical	**(18)**	**(10)**	**(12)**	**(22)**	**(27)**	**(22)**	**(24)**	**(19)**	**(18)**	**(12)**	**(15)**	**(25)**	**(224)**
Acute Services & Urgent Care	(1)	(0)	(0)	(1)	(0)	(1)	(2)	(1)	(2)	(1)	(0)	(1)	**(12)**
MACE	(0)	(0)	(1)	(0)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(7)**
Quality & Nursing	(5)	(3)	(3)	(3)	(4)	(4)	(4)	(4)	(5)	(2)	(5)	(6)	**(48)**
People & OD	(8)	(3)	(7)	(15)	(19)	(13)	(10)	(10)	(5)	(4)	(4)	(2)	**(99)**
Primary Care	(2)	(2)	(0)	(2)	(2)	(3)	(1)	(3)	(3)	(3)	(1)	(2)	**(23)**
Central Services	0	0	0	0	(1)	0	0	0	0	0	0	1	**0**
Specialist Care	(1)	(1)	(1)	(0)	(1)	(1)	(7)	(1)	(3)	(1)	(2)	(14)	**(35)**
Total Bank	**(622)**	**(550)**	**(564)**	**(542)**	**(572)**	**(542)**	**(520)**	**(510)**	**(478)**	**(468)**	**(492)**	**(441)**	**(6,301)**
Bank as a % of Pay	6.93%	6.16%	6.22%	5.90%	6.27%	5.99%	5.79%	5.57%	5.22%	5.21%	5.34%	2.76%	**5.44%**
Plan	(585)	(581)	(542)	(543)	(508)	(492)	(446)	(352)	(351)	(351)	(350)	(352)	**(5,453)**
Variance to Plan (Overspend) / Underspend	(37)	31	(22)	0.716	(64)	(50)	(74)	(158)	(127)	(117)	(142)	(89)	**(848)**
Bank Variance as a % of Plan	6.24%	(5.36%)	4.02%	(0.13%)	12.61%	10.25%	16.67%	44.82%	36.23%	33.21%	40.61%	25.22%	**15.5%**



- Planned bank expenditure for 2025/26 is £5,453k this represents a mandated 10% reduction of 2024/25 expenditure levels.
- In month expenditure is £441k against planned expenditure of £352k representing an adverse variance of £89k.
- 2025/26 expenditure is £6,301k against planned expenditure of £5,453k representing an adverse variance of £848k.
- 75% of expenditure relates to nursing (qualified and unqualified) representing an adverse variance to plan of £699k.
- 18% of expenditure relates to medical staffing with a favourable variance to plan of £227k.
- 3% of expenditure relates to other clinical staffing with an unfavourable variance to plan of £213k.
- 4% of expenditure relates to non-clinical staffing with an unfavourable variance to plan of £164k.

Finance Position

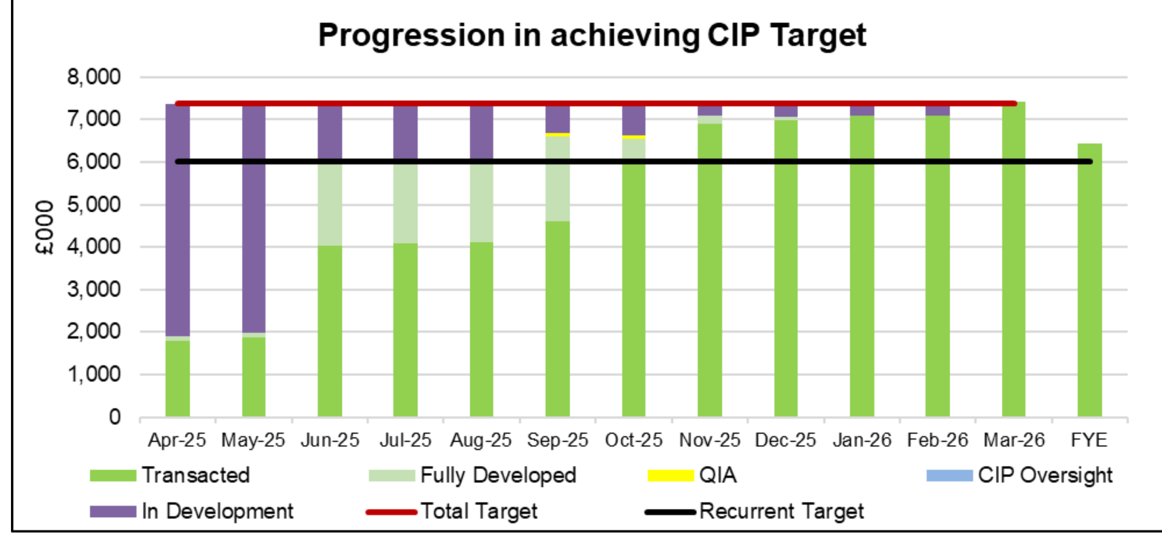
CIP Delivery

2025/26 Efficiency Identified Schemes	Target £000	YTD 2025/26 Plan £000	YTD 2025/26 Actual £000	YTD 2025/26 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	360	308	(52)	*360*	*308*	*(52)*	*360*	*366*	*6*
Community	2,045	2,045	2,958	913	*2,045*	*2,059*	*14*	*2,045*	*2,215*	*169*
Specialist	644	644	464	(180)	*644*	*464*	*(180)*	*644*	*563*	*(82)*
Primary Care	19	19	60	40	*19*	*60*	*40*	*19*	*60*	*40*
Clinical Total	**3,069**	**3,069**	**3,789**	**720**	***3,069***	***2,891***	***(178)***	***3,069***	***3,203***	***134***
Corporate										
CEO	42	42	17	(25)	*42*	*4*	*(38)*	*42*	*4*	*(38)*
Q&N	300	300	95	(204)	*300*	*95*	*(204)*	*300*	*163*	*(137)*
S&D	364	364	113	(250)	*364*	*70*	*(293)*	*364*	*82*	*(282)*
Finance	93	93	45	(48)	*93*	*45*	*(48)*	*93*	*60*	*(33)*
Performance	32	32	0	(32)	*32*	*0*	*(32)*	*32*	*0*	*(32)*
Estates	56	56	11	(45)	*56*	*4*	*(52)*	*56*	*6*	*(50)*
MACE	104	104	2	(102)	*104*	*2*	*(102)*	*104*	*2*	*(102)*
Operational	1	1	1	(0)	*1*	*1*	*(0)*	*1*	*1*	*(0)*
People	174	174	13	(162)	*174*	*13*	*(162)*	*174*	*14*	*(160)*
Corporate Total	**1,166**	**1,166**	**297**	**(869)**	***1,166***	***234***	***(932)***	***1,166***	***331***	***(835)***
Trustwide	**1,532**	**1,532**	**1,723**	**191**	***167***	***1,297***	***1,130***	***167***	***1,300***	***1,133***
Productivity	**1,600**	**1,600**	**1,600**	**0**	***1,600***	***1,600***	***0***	***1,600***	***1,600***	***0***
Total Trust CIP	**7,367**	**7,367**	**7,409**	**42**	**6,002**	**6,022**	**20**	**6,002**	**6,434**	**432**

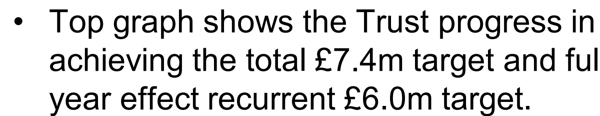
- The efficiency target is £7.4m (reflecting 5.4% of the Trust total cost base excluding TCP & Complex Care) and includes £1.6m recurrent productivity target.
- Of the £7.4m target, £6.0m is recurrent and £1.4m non-recurrent.
- At Month 12 the Trust has fully achieved the £7.4m CIP target.

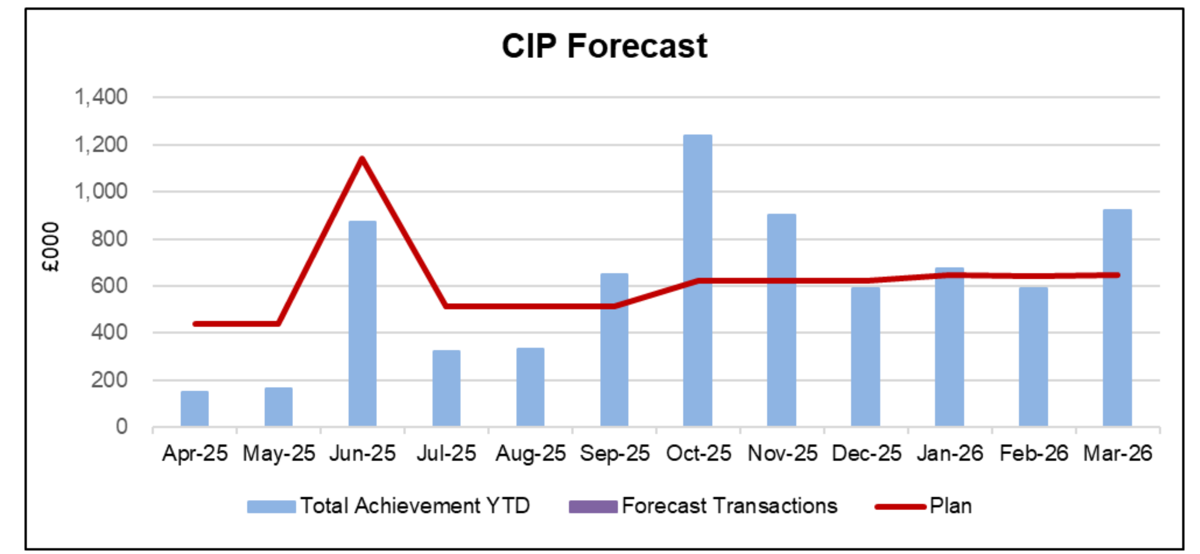
Finance Position

CIP Delivery



- 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.



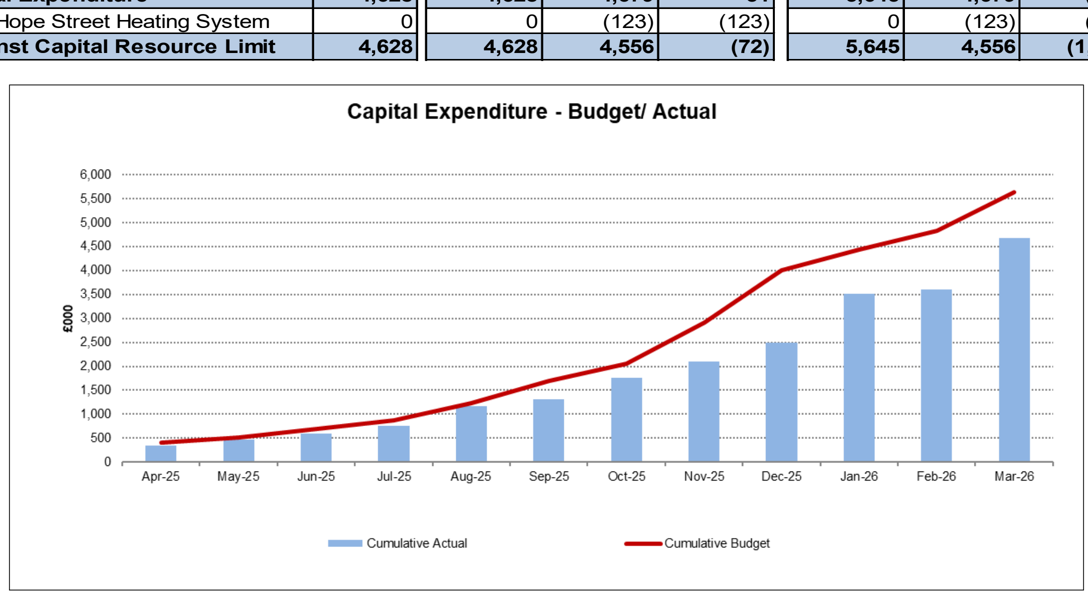


Capital Expenditure

North Staffordshire Combined Healthcare NHS Trust

Capital Expenditure	Annual Plan £000	Outturn Against Plan: Plan £000	Outturn Against Plan: Forecast £000	Outturn Against Plan: Variance £000	Outturn Against Budget: Capital Budget £000	Outturn Against Budget: Forecast £000	Outturn Against Budget: Variance £000
Operational Schemes	**786**	**786**	**147**	**(639)**	**786**	**147**	**(639)**
IFRS16 Leases	199	199	14	(185)	199	14	(185)
Medical Equipment	30	30	17	(13)	30	17	(13)
Estates Fleet	120	120	116	(4)	120	116	(4)
Energy Efficiency	75	75	0	(75)	75	0	(75)
Capital freedom & flexibilities	362	362	0	(362)	362	0	(362)
Digital	**429**	**429**	**537**	**108**	**429**	**537**	**108**
IT Digital Replacement	239	239	496	257	239	496	257
Capitalised Salaries - IT Device Replacement	40	40	41	1	40	41	1
Digital Innovations	50	50	0	(50)	50	0	(50)
Digital Infrastructure	100	100	0	(100)	100	0	(100)
Strategic Schemes	**1,943**	**1,943**	**141**	**(1,802)**	**143**	**141**	**(2)**
Dormitory Conversion Trust funded	1,943	1,943	141	(1,802)	143	141	(2)
Contingency/Reactive Schemes	**0**	**0**	**79**	**79**	**0**	**79**	**79**
PICU Air conditioning	0	0	24	24	0	24	24
Ashcombe Restructure	0	0	0	0	0	0	0
Crisis Centre Doors	0	0	23	23	0	23	23
Contingency	0	0	32	32	0	32	32
Total Trust Funded Capital Expenditure	**3,158**	**3,158**	**903**	**(2,255)**	**1,358**	**903**	**(455)**
NHS Notify	0	0	115	115	227	115	(112)
Backlog Maintenance	470	470	860	390	1,260	860	(400)
Frontline Digitisation Programme PDC Funded	1,000	1,000	1,000	0	1,000	1,000	0
Dormitory Conversion PDC Funded	0	0	1,800	1,800	1,800	1,800	0
Total Gross Capital Expenditure	**4,628**	**4,628**	**4,679**	**51**	**5,645**	**4,679**	**(966)**
Capital disposals - Hope Street Heating System	0	0	(123)	(123)	0	(123)	(123)
Total Charge against Capital Resource Limit	**4,628**	**4,628**	**4,556**	**(72)**	**5,645**	**4,556**	**(1,089)**

- 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 12 is £4,556k, £72k below plan. This includes £123k relating to the disposal of the Hope Street heating system.
- Gross Capital Expenditure against budget is £966k below budget mainly due to underspends on backlog maintenance, IFRS16 leases, NHS Notify and freedom and flexibilities funding.



Statement of Financial Position

SOFP	M10 £000	M11 £000	M12 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	19,686	19,648	19,639
Property, Plant and Equipment	17,156	17,155	17,274
Right of Use Assets	2,648	2,612	2,730
Intangible Assets	1,405	1,362	1,935
NCA Trade and Other Receivables	549	543	549
Total Non-Current Assets	**41,445**	**41,321**	**42,127**
Current Assets			
Inventories	100	109	86
Trade and Other Receivables	7,385	6,831	7,975
Cash and Cash Equivalents	31,415	34,556	33,439
Total Current Assets	**38,900**	**41,497**	**41,500**
Current Liabilities			
Trade and Other Payables	(21,564)	(22,467)	(20,556)
Provisions	(1,966)	(1,966)	(1,945)
Borrowings	(3,072)	(3,072)	(3,199)
Total Current Liabilities	**(26,602)**	**(27,505)**	**(25,700)**
Net Current Assets / (Liabilities)	**12,298**	**13,992**	**15,800**
Total Assets less Current Liabilities	**53,743**	**55,313**	**57,927**
Non Current Liabilities			
Provisions	(850)	(805)	(977)
Borrowings	(15,415)	(15,228)	(14,888)
Total Non-Current Liabilities	**(16,265)**	**(16,033)**	**(15,865)**
Total Assets Employed	**37,478**	**39,280**	**42,062**
Financed by Taxpayers' Equity			
Public Dividend Capital	25,783	27,253	27,850
Retained Earnings reserve	4,728	5,060	7,187
Revaluation Reserve	6,967	6,967	7,025
Total Taxpayers' Equity	**37,478**	**39,280**	**42,062**

Current receivables are £7,975k of which:

- £1,860k is based on accruals (not yet invoiced).
- £3,743k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,685k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.
- Local Authority and Non-NHS invoices overdue by 91+ days are included in the bad debt provision.

Current Liabilities are £25,700k of which:

- Trade and Other payables remain high at £20,556k because of deferred income, patient placement invoices and accruals.

Liquidity ratio:

- A good liquidity ratio should be above 1.0.
- The Trust current ratio is 1.6 showing the Trust can cover its current debt obligation.

Finance Position

Better Payment Practice Code

Better Payment Practice Code	In Month			YTD Total		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices						
Total Paid	116	1,277	1,393	435	11,537	11,972
Total Paid within Target	113	1,220	1,333	425	10,951	11,376
% Number of Invoices Paid	97.41%	95.54%	95.69%	97.70%	94.92%	95.02%
% Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
RAG Rating (Variance to Target)	**2.41%**	**0.54%**	**0.69%**	**2.70%**	**(0.08%)**	**0.02%**
Value of Invoices						
Total Value Paid (£000s)	1,565	9,609	11,174	8,129	99,886	108,015
Total Value Paid within Target (£000s)	1,436	9,327	10,763	7,611	98,052	105,663
% Value of Invoices Paid	91.76%	97.07%	96.32%	93.63%	98.16%	97.82%
% Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
RAG Rating (Variance to Target)	**(3.24%)**	**2.07%**	**1.32%**	**(1.37%)**	**3.16%**	**2.82%**

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 12, the Trust has achieved the 95% target on both the value of invoices paid and the number of invoices paid, both at 96% paid within 30 days.
- During 2025/26 the Trust has achieved the 95% target on both number and the value of invoices paid at 97.82% on value and 95.02% on the number. However, the Trust fell slightly below the target on the number of non-NHS invoices paid within target at 94.92% and on the value of NHS invoices paid at 93.63%.
- The Finance team will continue to monitor and target those areas that are not promptly authorising invoices.

The Trust Board are asked to receive the M12 position noting:

- The full year surplus of £3,421k against a plan of breakeven, giving a favourable variance of £3,421k.
- The underlying financial position (ULP) of £955k deficit.
- Agency expenditure of £1,546k against a plan of £1,504k, resulting in an adverse variance of £42k.
- Bank expenditure of £6,301k against a plan of £5,453k, giving an adverse variance of £848k.
- The Trust's full achievement of the Trust £7.4m CIP target.
- The Trust has spent £4,556k on capital, which is £72k below plan.
- The cash position of the Trust on 31st March with a balance of £33.4m.

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 2nd April 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 an update on the Orbis digital programme. The overall programme remains as 'red' with two further workstream escalated from 'amber' to red'. The supplier has confirmed the summer go-live date is no longer achievable with limited progress since the last month despite best efforts. The gap analysis work is continuing and is expected to be complete in the next month. As the delay continues the impact on wider digital interdependences becomes more significant and therefore formal escalations are now commencing with NHSE.

Members held detailed discussions on the significant challenges of the project with regards to timescales, risks, patient safety and support/capacity required.

Level of assurance 2 agreed.

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 M11
Committee received the report. Overall positive performance across the majority indicators with some challenges on the national metrics in particular out-of-area placements and clinical ready for discharge. It was noted that additional metrics being added to the National Oversight Framework next year. Discussions took place on the increase in out of area placements and specific dip in a service area.

Level of assurance 6 was challenged and reduced to 5 on the basis of PIP performance and performance on the national metrics.

Finance Position M11
Key messages highlighted included a year-to-date surplus which is better than plan. Agency costs were lower than plan in month; however, bank costs were above the required target in month. CIP delivery is slightly behind plan noting that the Trust is forecasting full achievement of the £7.4m, 96% of which has been transacted to month 11. Capital expenditure is lower than planned year-to-date and is expecting to be slightly under the month 8 forecast.

Level of assurance 7 was agreed.

ICS Finance Update M11
At month 11 the System reported a year-to-date deficit of £4.9m, £1.8m favourable to plan. The net risk is £1.1m.

No level of assurance provided. Paper for information.

Cost Improvement Programme
Key messages highlighted included progress made at Month 11 and the focus on 2026/27 CIP delivery.

Level of assurance 4 was challenged and increased to 5 due to the 2025/26 level of performance.

Service Line Reporting Q3
The Committee received an overview of the Q3 Service Line Reporting. The report shows a deep dive into ADHD services looking at clinical variation and how that is driving costs. A service has been identified to come to a future F&R Committee to show how they have used SLR data to affect change and patient outcomes. Discussions took place on the governance route of the data prior to F&R Committee. The Trust hosted a team from NHSE to review productivity in mental health and how our interventions are counted for productivity.

Level of assurance 6 was agreed.

Estates Update
Committee received the report with highlights on backlog maintenance and Estates Safety capital schemes. Discussions took place on fire doors and water temperature issues.

Level of assurance 4 agreed.

Business Development Opportunities
Committee received the report detailing 2 potential business development opportunities for the Trust, noted that one opportunity was not being pursued and a bid previously submitted has been

unsuccessful. A recent opportunity to bid for Lead Provider for the West Midlands Provider Collaborative has arisen.

Level of assurance 5 agreed. Committee challenged that the paper is just provided for information and does not require a level of assurance.

F&R Effectiveness Review
The effectiveness review confirmed that the Committee continues to demonstrate strong governance, effective scrutiny, and a maturing assurance culture. Year on year progress was highlighted along with identified strengths and areas for improvement.

Level of assurance 6 agreed.

APPROVE:

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

Heading:

Risk Register

There were no new risks, no score changes and no closures to be approved. It was noted that 4 risks had their achievement dates amended.

Paper for information – no assurance level.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 7th May 2026 at 10am via MS Teams.

Committee Chair: Pauline Walsh, Vice Chair of the Finance & Resource Committee.

REPORT END

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 7th May 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:
Digital Quarterly Update

Orbis gap analysis was presented to the Programme Board which established a clear baseline of programme readiness. It identified a significant number of unsolved issues including critical gaps which would prevent a safe go-live. Formal escalation has been made to NHSE to secure additional support with commercial contract elements. Discussions took place on when the Trust will be able to set a date for go-live.

Discussions and concerns were raised whether the arrangement with the HIS was a Partnership arrangement given there were changes the Trust was not sighted on during the Partnership Board. The CSO will start attending this Board meeting.

IQPR M12

Committee raised concerns on the plans and actions being taken by the Local Authority on clinically ready for discharge. The Trust has escalated concerns to NHSE.

ADVISE:

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

Heading:

Cost Improvement Programme
Acknowledgement of the 2025/26 position and the continued work on the development of 2026/27 CIP schemes noting the Trust is behind NHSE's expectations for this point in the year.

Level of assurance 3 agreed.

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:

Digital Quarterly Update

The Committee received an update on digital transformation and operational digital services during for quarter 4. NHS app technical integration has been completed now awaiting third party testing. HIS performance significantly reduced during the last quarter with mitigations in place to address this. Discussions took place performance management on the contract, the potential impact on the frontline staff and patients and a requirement for a review of the services.

Discussion took place strategic alignment with the Trust's needs and other organisations both locally and regional. Discussions also took place on digital funding opportunities and digital maturity assessment priority areas for improvement.

Level of assurance 2 agreed.

IQPR M12

Committee received the report. Positive year for access and waiting times with huge improvements in referral to assessment and referral to treatment. NHSE and GRIFT have approached us to understand how we have achieved these improvements. There has been a reduced the number of PIPs and improvements in quality indicators during the year. Challenges continue with out of area placements although admitted 25% less patients in March compared to February. Clinically ready for discharge patients in out of areas beds has increased during March.

Discussions took place on the increased length of stay in month 12 due to discharging several patients with a length of stay over 90 days. Some of these patients were also impacted by clinically ready for discharge delays.

Level of assurance 6 agreed.

Finance Position M12

Committee noted the year end surplus above the planned breakeven position. Agency costs were slightly over plan with bank costs significantly over plan due to acuity and sickness. CIP was delivered in full. Capital expenditure was slightly lower than plan.

Level of assurance 7 agreed.

ICS Finance Update M12

At month 12 the System reported a final position of £6.6m surplus (due to additional deficit support funding), against a breakeven plan.

No level of assurance provided. Paper for information.

Estates and Capital Report

Committee received the report. Backlog maintenance and Estates Safety capital schemes were all complete. Project Horizon and Project Elevate are on track with expected start dates in Q2. Updates were provided on water temperature issues with a remediation programme, mechanical ventilation and fire safety.

Level of assurance 4 agreed.

Strategic Partnership Plan
Committee received the report detailing the progress in implementing the partnership plan, challenges and next steps. Gaps with system working and slow pace was highlighted. Challenges around data sharing were discussed and the positive impact on neighbourhoods.

Level of assurance 5 agreed.

TMO Assurance Q4
The report provided assurance on the delivery, governance and oversight of the transformation portfolio. It was acknowledged that Project Chrysalis has concluded. Committee endorsed the portfolio approach and the assurance provided from the spotlight reports.

Level of assurance 7 agreed.

Sustainability Assurance Q4
The report provided assurance on the delivery for Q4 and year 1 of the 3-year Green Plan. Healthy position for the Trust with most of the objective either on track or complete.

Level of assurance 6 was challenged given the strong position. Agreed a revised assurance level 7.

APPROVE:

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

Heading:

Deep Dive Risk Report

There were no new risks, no score changes and no closures to be approved. It was noted that 1 risk had its achievement date amended.

Paper for information – no assurance level.

F&R Board Assurance Framework
The Board Assurance Framework for 2026/27 was approved.

Paper for information – no assurance level.

Terms of Reference
The updated Terms of Reference to explicitly reference the role of the Risk Review Group was approved.

Level of assurance 7 agreed.

Payroll Service Contract Award

The appointment of a payroll service provider was approved following discussions on the level of risk and value for money.

Level of assurance 6 agreed.

Secure Patient Transport Tender
The Committee approved awarding the secure patient transport contract following clarification that the contact is cost and volume.

Level of assurance 6 agreed.

National Cost Collection
Committee approved the costing plan aligns with the requirements set out in the Approved Costing Guidance.

Level of assurance 6 agreed.

Business Development Opportunities
Committee approved the development of two opportunities which will be discussed further in private Board.

Level of assurance 5 agreed.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 4th June 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 2 April 2026

Introduction:

This assurance report to the Trust Board is produced following the latest Quality Committee. The meeting was held virtually on 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
Plans are in place for the long bank holiday weekend and the resident Doctors industrial action next week. Increased demand seen this week with the mental health liaison service, this will be monitored.

System discharge 2 assess community flow is satisfactory, however ward 4 has impacted due to concerns with water safety and bed closures, this has now been resolved with mitigations put into place.

A simulation event has taken place with NSCHT colleagues in relation to evacuating the Harplands.

OOA placements
The committee held discussion around the existing and ongoing challenges. An update was offered around the deep dive review with senior leaders across the Trust, a summery update of the outcomes linked to this will be brought back to the committee.

The committee requested an overview of the national picture in relation to Out of Area Bed use for other organisations.

End of March position was 25 patients Out of Area. A more detailed update will be delivered to the committee in June 2026.

ADVISE:

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

CQC Update
The committee were updated about the draft CQC framework. This is out for consultation, and a response is being prepared.

IQPR
A discussion around the IPQR took place, with confirmation that the reporting and monitoring of the sickness Improvement Plans and assurance will be reviewed and revised, as such assurance level was reviewed and revised from assurance level 6 to assurance level 5.

ASSURE:

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

Specialist - Deep Dive:
The committee received a spotlight review of all the services offered via the Specialist Directorate – key highlights were the successful transformation of the Darwin Centre and the planned improvements and funding for A&T. The challenge is the inability to maximise on this specialism offered with ward 5 due to barriers in contractual ability to offer out of area placements.

Safer Staffing – February 2026
Overall Fill Rate – 104.4%
Registered Nurse Fill Rate – 95.7%
Level 7 assurance amended to level 6; although there is assurance around safe staffing, there are additional efforts required to sustain this with the over recruitment of nurses and additional HCSW to fill the registered nurse gaps.

Veterans Annual Report
Annual report presented and was well received by the committee.
Assurance level was amended from a 6 to 7 based on the progress and sustained achievements throughout the year.

Committee Effectiveness
The chair presented the review paper with some discussion around the findings. Recommendations will be addressed to improve future committees.

PCREF Inequalities data
The committee received an update regarding the work underway and progress with race inequalities data through the lens of restrictive practices and interventions, the committee can expect to see a regular PCREF report in Q1.

Orbis Update
The Committee received an update regarding the delay within the programmed work for Orbis to go live. This will no longer take place as planned in June and work is underway to review the complexities and barriers to aid progression going forward. The committee were assured that the decision to delay was to ensure patient safety and quality.

APPROVE:

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

Risk Register

- No new risks
- No closures
- One score change - Risk 1112 – Proposing score change from 15 to 10, reducing the likelihood from 3 (Possible) to 2 (Unlikely). There is a request for this to come back to committee with the proposed new risk for the Darwin Centre to ensure that the board has adequate oversight of the risks associated with the Darwin Centre.

- Risk 2170 – The committee supported an amendment to the achievement date from 31.3.26 to 30.9.26, due to delays in the costings for the estate work what is required.

Policy Report

4.01 Safeguarding Children and Young People Policy – Approved.
Level 3 assurance of the report confirmed.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 7 May 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 7 May 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

ALERT:

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

System Update

The ICS winter review took place on 6/5/26; mental health was commended for how well they supported the UEC plan last year.

The Trust have received updates regarding people in post within the ICS as it progresses through its restructure process.

OOA placements

Out of Area placements remains a challenge, with continued high numbers of Clinically Ready For Discharge patients.

Internal reviews and actions continue to be progressed with a key focus on reducing admissions into inpatient facilities and strengthening pathways. There will be a broader overview presented to next month's committee

ADVISE:

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

CQC Update

Acting Chief Nurse gave an overview of the unannounced CQC review which took place in Older Persons Community services during w/c 4/5/26;
Key highlights;

- Majority of teams are highly motivated with high morale and effective MDT team working
- Culturally sensitive clinic and approach to the needs of Asians adults

- Effective partnership working and transitions of care
- Care records and care plans comprehensive and evidence of patient / carer involvement
- Stable workforce and minimal use of temporary staff

Areas for improvement

- Supervision recording
- Broadening models of care

It is likely that the Trust will receive increased CQC inspections over the next few months.

Question for Board - The quality committee would like to have more discussion regarding the developments underway for supervision recording and monitoring.

IQPR

Discussion regarding the metrics and monitoring with assurance provided regarding statistical trend v's standards met.

Discussion also took place regarding sickness and absence trends within the Acute and Urgent Directorate; it was noted that a sickness absence rate for 24/7 services will appear to be higher than those in 9-5 services; this is being reviewed further to consider improved ways to display the metric.

It was also noted that the Trust has been recognised in the GIRFT report as an 'exemplar site' for successfully managing to implement rigorous performance management without sacrificing clinical goodwill.

Recommendation for Board – could consideration be given to a deep dive into sickness challenges within Acute and Urgent care and which committee will oversee this.

Real Talk, real change

Deputy People Officer presented the programme, key focus is engagement, conversations throughout the organisation to support insights around learning, challenges and co-creating solutions to challenges within the Trust. This is intended to become our 'routine' approach to engagement, the approach is evidence based and will support us to adapt to the needs of the Trust in a more fluid and organic way with the voice of staff at the heart of this.

Next steps – the outputs from initial conversations will help to shape our behaviours framework and leadership priorities, before moving into Cycle 2.

The Quality Committee recommend that peer approach is also considered within this programme to support all front-line staff to feel empowered to engage.

ASSURE:

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

Safer Staffing –March 2026
Assurance level 6 confirmed – awaiting improved assurance regarding the impacts of staffing on patient experience.

Committee Effectiveness
Assurance level 3 – due to the number of audits withdrawn and requirements for improvements around re-audit processes which would strengthen the assurance going forward.

PCREF Inequalities data
Assurance level 3 confirmed.

Clinical audit programme Q4 2026/27
Assurance level 3 confirmed, with progress being made and noted. The committee are hopeful that the level of assurance will increase in future reports.

Mental Health Act Compliance action plan Q4 2025/26
Assurance level 5 confirmed – improved picture, more assurance re completion of actions is required in a few areas which will be updated in the next report.

Quality Assurance Group Q4 2025/26
Assurance level 6 confirmed.

Clinical Effectiveness Group Q4 2025/26
Assurance level 5 confirmed.

QIA of CIPs Q4 2025/26
Assurance level 6 confirmed

APPROVE:

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

Terms of Reference – Quality Committee

The addition to the Terms of Reference to specifically reference the alignment with the Trusts Risk Review Group was approved by the group.

Risk Register

- **Risk 1957** – increased to 20 from 16 due to the number & consistency of out of area patients
- **Risk 1875** – score reduction from 12 to 9 with a reduction in the likelihood due to the seasonal reduction in weather alerts
- **Risk 2132** – score increase from 8 to 12 due to likelihood increase based on new dates being issued by the BMA

Policy Report

- 1.89 Safeguarding Adults at Risk Policy
- 3.45 Temporary Staffing Policy

Both above policy amendments were approved.

Committee recommendation – to increase the policy assurance from 3 to 7 and for there to be further discussion regarding levels of assurance for reports that have monthly / quarterly and annual iterations.

Board Assurance Framework Q4 2025/26

Score reduction approval confirmed by the committee for risk 2 – from score 15 to 10; actions completed and likelihood reduced.

Board Assurance Framework 2026/27

An overview of the paper with a note that an amendment to the dashboard will be made, with Q1 reporting in July 2026. There was an acknowledgement of the Trust maturing in this space when compared to previous years BAF.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 4 June 2026 at 2pm via MS Teams.
Committee Chair: Pauline Walsh, Chair of the Quality Committee.
REPORT END

Trust Board Assurance Report
From the Audit Committee Meeting
Held on 8th May 2026

Introduction:

This assurance report to the Trust Board is produced following the latest Audit 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 Audit Committee performance indicators and the Audit Committee Objectives.

Purpose of the Report (Executive Summary):

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

ALERT:

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

Heading:

ADVISE:

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

Heading:

Internal Audit Progress Report and Q4 Reporting. Signs of improvement but some evidence of actions being deferred in certain areas.
Internal Audit – time given re; timeframes for responses/feedback.
NSCHT-timeframes agreed with managers so defaulting on own timescales.
Action – to include trackers being seen in assurance committees for oversight/ monitoring- quartley.

Seek confirmation from the Board for delegated responsibility to Audit Committee to approve the Annual Accounts / Report.

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:

Risk Deep Dive Trust and Operational Risks 15+
Board Assurance Framework 2026/27
Annual Accounts (Draft) L7
Internal Audit Progress Report April 26 (MIAA)
NSCH Quarter 4 Follow-up report 26/27 (MIAA)
Head of Internal Audit (MIAA)
Anti-Fraud Annual Report 2025/26 (MIAA)
External Audit Plan (GT)
Audit Committee Annual Report L6
Business of other Committees – Quality L6
NSCH Internal Audit Charter 26/27(MIAA)

APPROVE:

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

Heading:

Policy Report- L3 increased to L7.
Terms of Reference- L7
Q4 Finance Report. Good work noted on PO's. L6
Anti-Fraud Plan 2026/2027 (MIAA)
NSCH Internal Audit Plan 26/27 (MIAA)
Board Assurance Framework Dashboard 2026/27
Committee Effectiveness Evaluation L6
Going Concern L7

Next Steps (including timeframes):

The next Audit Committee meeting will be held on: 12h June 2026 at 13:00pm via MS Teams.

Committee Chair: Prem Gabbi, Chair of the Audit Committee.

REPORT END

Trust Board Assurance Report from the People, Culture and Development Committee Business meeting held on 11th May 2026

Introduction:

This assurance report is produced following the latest PCDC, which was held on Microsoft Teams and was quorate.

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 welcomed a staff story from the ENRICH staff network chair, who shared consistent themes in experiences from colleagues from a global majority heritage. Although two positive personal work experiences were shared, through the discussion the Committee heard examples of discrimination against colleagues and lack of opportunities for career progression; with additional barriers for colleagues wishing to transition from a non-registered to registered professional roles. The discussions reinforced the Committee's collective acknowledgement that there is much more work to do in supporting global majority colleagues. as detailed within one of the three People priorities, namely 'Combined CARE Culture'. Key objectives and actions to mitigate these experiences are contained within the People Plan and will continue to be overseen by the Committee.

- Proposed sickness targets- As part of the sickness improvement plan update, the committee were provided an overview of ongoing work to refine the Trust's sickness targets. To enable directorates to deliver reductions in sickness absence, directorate level targets are being proposed for 2026/27. The targets have been developed using a combination of stretch, 12 month rolling average performance and peer ranges. The committee debated the merits and potential risks of introducing different target levels for each directorate and acknowledged that the proposed targets were evidence based. Accepting that engagement was still ongoing with each of the Directorates, following a good discussion, the Committee were supportive of the proposed way forward and were assured that they will be able to monitor progress and impact through future reporting to committee. The proposed targets are:
  - Trust wide: 5.4%
  - Acute and Urgent Care: 6.6%
  - Specialist: 6.3%
  - Primary Care: 5.7%
  - Community: 5.0%
  - Corporate: 2.2%

Assurance Level 5 agreed.

- The staff engagement strategy – Real Talk, Real Change – was presented to the Committee. This strategy, developed with staff and adopting the Healthcare Improvement Framework for Improving Joy in Work, reinforces and puts into action the Trust's commitment to ensuring colleague voice is at the heart of our decision making and how we intend to work together. The committee discussed, in particular, the role required from Board members; to visibly lead and participate in meaningful conversations with colleagues, ensuring psychological safety and authentic listening across the Trust. The Board is responsible for assuring that colleague feedback directly informs strategy and culture; with clear evidence of 'listening in action'. Through Board to team visits and governance oversight, Real Talk Real Change will ensure that Board engagement is continuous and enables a culture led by the Trust values whilst creating inclusive environments for colleagues and patients. The committee recognised the role that PCDC has in overseeing assurance of the 'so what' delivery as part of the 'Combined CARE Culture' priority within the People Plan.

Assurance Level 6 agreed.

- The Committee were provided an update of the management of change process that had commenced in the People, Organisational Development and Communications Directorate, and acknowledged the impact this may have on the directorates ability to adapt to emerging priorities, and therefore the importance of maintaining alignment to the People Plan three 'big moves', with the deliverables summarised below:
  - **Workforce Optimisation:** reduce sickness absence, increase e-rostering and ESR utilisation and utilisation of business intelligence reporting to enable evidence-based decision making.
  - **Workforce Transformation:** implement a Trust wide approach to service level workforce planning and align the people function to enable delivery of the People Plan.
  - **Combined CARE Culture:** evaluate and reset people manager expectations through an updated behavioural framework and leadership development provision. Utilise a cultural barometer to triangulate information to understand 'at risk' services / teams.

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

The Committee received an update on the sickness absence improvement plan, which included a comparison to other Trusts within the System and a detailed breakdown for each Directorate. The report highlighted that 48% of sickness is attributable to a stress, anxiety or depression cause. Members reflected that as a mental health trust, leading on interventions to reduce this related absence should be in the core business of the organisation. The current interventions include:

- Access to Occupational Health.
- Intranet Wellbeing Portal.
- Staff Support and Counselling.
- 24/7 Employee Assistance Provision.

Addition support is being deployed to teams experiencing higher than average levels of absence related to stress, anxiety or depression to pilot working in small teams to co-design actions and monitor improvement after six months. The sickness improvement plan also describes actions for a trauma informed approach for managers. The Committee will receive an update on progress in future reporting.
Assurance Level 5 agreed.

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:

- Month 12 Workforce Summary Update (including Sickness Improvement, Employee Relations case work and People Plan updates) – Assurance Level 5 agreed

- Residents Doctors Improving Working Lives Ten Point Action Plan – Committee noted that all actions are either on track or complete and that the Trust has been scored at 86% by the National team following completion of the 10 Point Plan baseline survey against a target of 95%. Of note, national compliance average is currently 68% and regional compliance 72%. Assurance Level 7 agreed

- Committee Effectiveness Report – the Committee agreed that the evidence provided demonstrated that PCDC is operating effectively and that actions taken in response to the 2024/25 review have been successfully embedded. The committee has a focused programme of targeted improvements and is well positioned to further enhance oversight of workforce, people and culture during 2026/27. Assurance Level 6 agreed

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

The Committee approved the following:

- Terms of Reference for the Committee – Assurance Level 7.
- Risk Report Deep Dive.
- Board Assurance Framework 2025/26 Quarter 4.
- Board Assurance Framework 2026/27

Next Steps (including timeframes):

The next PCDC focus meeting will be held on: 1st June 2026.

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

REPORT END

Enclosure No: 12

VETERAN AWARE ANNUAL REPORT

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

Report to:	Public Trust Board
Date of Meeting:	14 May 2026

Presented by:	Ben Richards, Chief Operating Officer
Prepared by:	Rachael Birks, Deputy Chief Operating Officer
Executive Lead:	Ben Richards, Chief Operating Officer

Aligned to Board Assurance Framework Risk:	People - There is a risk that we will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Quality Committee
Strategic Priorities:	Access - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	None
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	This paper aligns to ICB strategic focus on integrating health and care services to improve population health and tackling health inequalities.

Recommendation / Required Action:	The annual report is provided to support assurance against the manifesto requirements for the Veterans Covenant Healthcare Alliance (VCHA) accreditation.
Executive Summary:	This is our third annual report for the Veteran Aware work we carry out on behalf of the Trust, as the Veteran Aware Group. The report provides a summary of activities, achievements, and challenges over the past year against the manifesto standards and aspirations for 2026/27. North Staffordshire Combined Healthcare Trust (NSCHT) has held the Veteran Aware accreditation since February 2023 and all organisations are required to gain re-accreditation every three years. During 2025/26 the Veteran Aware Group have worked hard on ensuring that we meet the manifesto requirements of the re-accreditation and are able to support this with evidence.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	24.03.2026
V1	Quality Committee	02.04.2026
V3	Public Trust Board	08.05.2026

Veteran Aware – Year Four Annual Report

<table>
<tr><td>Name of organisation</td><td colspan="2">North Staffordshire Combined Healthcare NHS Trust</td></tr>
<tr><td>Type of organisation</td><td colspan="2">NHS provider of mental health, learning disability and substance misuse services in the West Midlands</td></tr>
<tr><td>Region</td><td colspan="2">West Midlands</td></tr>
<tr><td>Executive Lead – name and role</td><td colspan="2">Ben Richards, Chief Operating Officer</td></tr>
<tr><td>Name and role of Clinical Champion</td><td>Jason Snape, Consultant Nurse
Liz Viggers, Senior Practice Nurse Lead</td><td>Jason.Snape@combined.nhs.uk

Liz.Viggers@stoke.nhs.uk</td></tr>
<tr><td>Name and role of Management Champion</td><td>Ben Richards, Chief Operating Officer</td><td>Ben.Richards@combined.nhs.uk</td></tr>
<tr><td>Additional Champion/s
E.g., Core committee, functional appointments, Trust and/or department ambassadors
(Link to Charter)</td><td>Project Group members:
Rachael Birks
Laura Reynolds
Victoria Boswell
Jo Copeland
Rachel Wooliscroft
Jayne Simner
Molly Mansfield</td><td></td></tr>
</table>

Governance arrangements
The Veteran Aware Group leads on operationalising the Veteran Aware Plan, this is led by the Deputy Chief Operating Officer and includes membership across clinical and corporate services ensuring a range of representation from across the Trust. There is a monthly meeting schedule which oversees and co-ordinates all aspects of the Veteran Aware programme. Quarterly highlight reports are provided to the Veteran Aware Board and this is led by our lead executive for our Veteran Aware Programme, Chief Operating Officer Ben Richards. The project plan and actions from the group are informed by, and aligned to, the manifesto requirements for the Veterans Covenant Healthcare Alliance (VCHA) accreditation.

1.Introduction

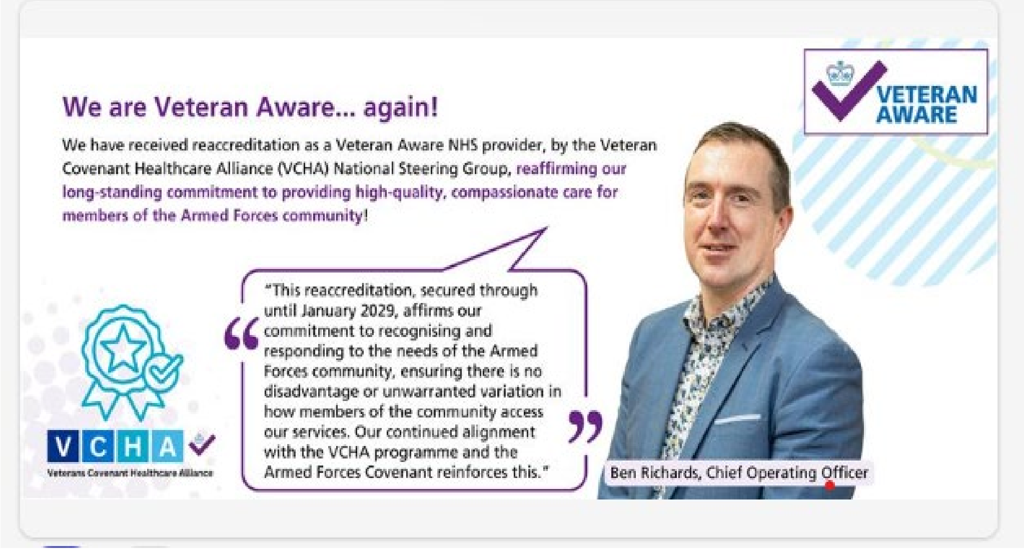
This report provides a summary of activities, achievements, and challenges over the past year and aspirations for 2026/27.

North Staffordshire Combined Healthcare Trust (NSCHT) has held the Veteran Aware accreditation since February 2023 and all organisations are required to gain re-accreditation every three years. During 2025/26 the Veteran Aware Group have worked hard on ensuring that we meet the manifesto requirements of the re-accreditation and are able to support this with evidence.

Manifesto Requirements

1. The Trust understands and is compliant with the Armed Forces Covenant
2. The Trust has a clearly designated Veterans' Champion Dyad
3. The Trust identifies Veterans and armed forces community status patients to ensure they receive appropriate care
4. Staff at the Trust are trained and educated in the needs of veterans and the armed forces community
5. The Trust has established links to appropriate nearby veteran and armed forces community services
6. The Trust will refer veterans and armed forces community to other services as appropriate
7. The Trust raises awareness of veterans and armed forces community
8. The Trust supports the UK Armed Forces as an employer

We are proud to report that our reaccreditation application and supporting evidence has been reviewed and we have again been awarded Veteran Aware accreditation status.



2. Key Highlights of 2025/2026

Manifesto Standard 3 requires organisations to ensure that veteran status is identified to ensure that they received appropriate care.

The 'Armed Forces status' for patients is recorded and managed via the 'Associated Status' Care Activity on the Trusts electronic patient record system. Staff are requested to record this information when known, this flows through to the patient indicators table in MHSDS.

The Trust provides the veterans field in the MHSDS submission. In the latest published MHSDS DQMI (Data Quality Maturity Index) score, the Trust performance was positive:

NSCHT score	81.4%
National average score	32.4%

The identification of 'armed forces status' has improved year on year within the Trust. Additionally, best practice is informed through posts on the Digital Channel and reminders during system updates. The landing page within the patient record system was recently changed to the General Details/Summary page, making it easier for staff to review and update patient demographics, including Veteran Status.

Manifesto Standard 4 requires organisations to ensure that staff are trained and educated in the needs of veterans.

The Trust continues to offer 3 courses on our Learning Management System (LMS) that are a mandatory training requirement for all our employees to support and educate staff on the needs of the Armed Forces Community. These are: The Armed Forces Covenant and the needs of service families; Health and Social Care Access for Veterans' Families and Mental Health Problems in Veterans.

We are working with the National Team to move to the new training provided by the VCHA and this will be supported as we move to our new learning platform. This will both bring the training to be more up to date but also the new training course takes less time overall than the existing three courses therefore reducing the training burden on our staff.

Building on our success of the clinical training model co-developed and delivered by our Consultant Nurse Jason Snape (Veteran Clinical Champion) and Veteran Peer Support Worker, there is work underway to develop an online briefing session (approximately one hour) for front-line clinical staff. This session will provide practical guidance and reinforce the organisation's commitment to improving veteran-sensitive care.

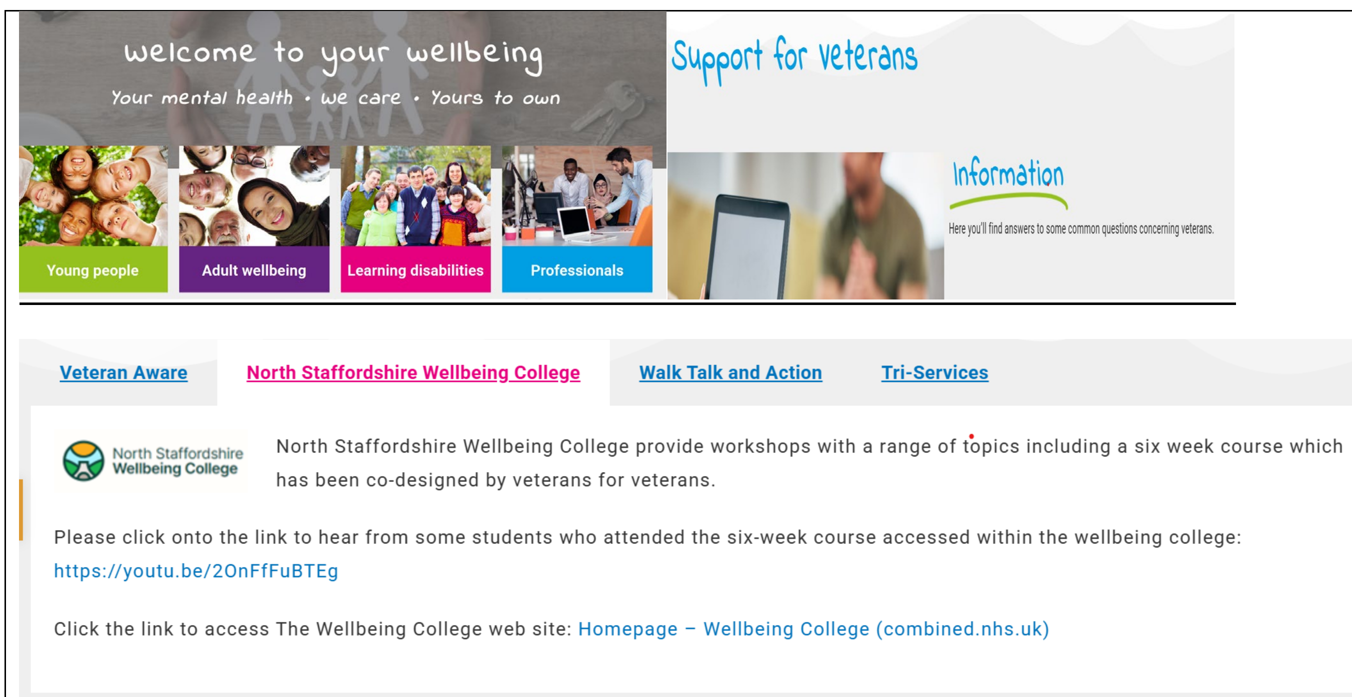
Two members of Trust staff and one volunteer veteran, with lived experience of mental health difficulties, completed the four-day training course with Help for Heroes (H4H) and are now badged by H4H. The veterans champion training was delivered by the UHNM Armed Forces Champion via Microsoft Teams. The principle was to gain greater insight on veterans and how, as an organization, NSCHT could promote veterans' champions. The training was considered to be informative and insightful.
The aims and objectives of the training included:

- Identify Armed Forces champions.
- Background on the needs of the Armed Forces community.
- Raise awareness of Armed Forces veterans.
- Understanding needs and health issues for veterans.
- How to support Armed Forces community.
- Understand requirements of Armed Forces covenant.
- Referral pathways for veterans.
- Linking with charities.

Manifesto Standard 5 the organisation will refer veterans to other services as appropriate

<u>Wellbeing Portal</u>

Rachel Wooliscroft, Community Engagement Co-ordinator and Veteran Group Member has worked with local veterans groups to develop our Wellbeing Portal Page specifically for veterans and this was launched during 2025.



Manifesto 6: The Trust has established links to appropriate nearby veteran and armed forces community services

We continue to build strong links and relationships with wider VCSE partners to support Veterans including Walk Talk Action.

Our Veteran moving forward course delivered by the Wellbeing College continues

Manifesto 7: The Trust raises awareness of veterans and armed forces community

Liz Mellor, Chief Strategy Officer, proudly represented the trust at Stoke-on-Trent City Council's Remembrance Sunday service on Sunday 9 November 2025, laying a wreath at the Stoke Cenotaph to honour those who served and sacrificed.

We also supported internal communication to our staff regarding Armistice Day and invited our staff and our partners from the Sea Cadets and Walk Talk Action to our service held at the Harplands Hospital.

We were also proud of our teams who joined in with the best dressed ward competition

Best-dressed ward – Remembrance Day competition

The Armed Forces champion team are holding a 'Best-dressed ward' competition in honour of Remembrance Day.

You can submit your photos and information on the form here. The deadline in 11am on Tuesday 11 November.

With the winners Ward 6 being crowned by Teri Bryce, from the Walk Talk Action.

Partnerships

Stoke Sea Cadets: the Veteran Aware Group continue to work with the Stoke Sea Cadets and we continue to meet and build this relationship to understand how we can further support the young people who are part of this.

Walk Talk Action: Rachel Wooliscroft and Jayne Simner (Veterans Group) continue to work closely with Walk Talk Action and we also had there support as part of our Remembrance Service

3.Future Plans

Priorities for 2026/27 include:

- To apply for gold award accreditation of the Defence Employer Recognition scheme
- To continue to build our relationships with our partners Stoke Sea cadets and Walk Talk Action
- To capture armed forces community status as part of the formal complaints process
- To build/explore a health and wellbeing offer to veterans, reservists and other members of the armed forces community in our workforce
- To build upon our Reserve and Cadet support activities via Stoke Sea Cadets partnership
- As part of a wider workstream further develop our understanding of the Veteran and Reserve workforce within the organisation, building on the work already undertaken to date.

Enclosure No: 13

NHS Provider Licence Self Certification 2025/26

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

Report to:	Public Trust Board
Date of Meeting:	21 May 2026

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

Aligned to Board Assurance Framework Risk:	Regulatory - The Trust may fail to meet legal and regulatory requirements due to the evolving regulatory and statutory landscape, the consequence is legal and regulatory action, deterioration in ratings, and loss of public and stakeholder confidence.
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:	Choose an item.
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 supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	For Information- NHSE no longer require Trusts to submit this information but advise that Providers may wish to hold same locally for reference/ provide on request.
Executive Summary:	**G6 (All licensed NHS providers – baseline governance assurance)** Following a review undertaken for the purpose of paragraph 2(b) of licence condition G6 of the NHS Provider Licence, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all reasonable and proportionate steps necessary to comply with the conditions of its licence and all applicable requirements under the NHS Acts. The Directors confirm that the Licensee has had due regard to the principles and values set out in the NHS Constitution for England. This assurance is based on the operation of established governance, risk management, and internal control systems, supported by regular Board reporting and oversight. **Key focus of G6:** Compliance with licence conditions Compliance with NHS law and duties “Due regard” to NHS Constitution Basic governance assurance statement **FT4 (NHS Foundation Trusts only – enhanced governance & financial assurance)** Following a review undertaken for the purposes of Condition FT4 of the NHS Provider Licence, the Directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee has maintained and applied effective systems of governance, risk management, and internal control to ensure compliance with the conditions of its licence and all applicable statutory requirements. The Board confirms that these arrangements support effective organisational leadership, sound financial management, efficient use of resources, and the ongoing financial sustainability of the organisation. The Directors are satisfied that appropriate systems are in place to ensure compliance with relevant NHS legislation and regulatory requirements, and that governance arrangements meet the expectations placed upon NHS foundation trusts.

	This assurance is informed by Board reporting, internal and external audit, and ongoing monitoring of risk, performance, quality, and financial position. **Key focus of FT4:** Everything in G6 plus a stronger emphasis on: Financial sustainability / going concern Efficiency and resource use Strength of internal controls Foundation trust governance expectations Broader assurance scope (not just compliance)

VERSION CONTROL:

Version	Report to	Date Reported
V1	Board	6 5 2026

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

North Staffordshire Combined Healthcare NHS Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7" Financial Year to which self-certification relates | 2025 2026 | Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | Confirmed | OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | | Please Respond

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. | | Please Respond

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. | | Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Janet Dawson	**Name**	Dr Buki Adeyemo
Capacity	Chair	**Capacity**	CEO
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

North Staffordshire Combined Healthcare NHS Trust	*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2025-2026

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust confirms that it applies principles, systems, and standards of corporate governance consistent with the requirements of the NHS Provider Licence. Its governance arrangements are designed to ensure effective oversight, accountability, and compliance with all relevant licence conditions. The Board operates with a clear structure of reserved matters, supported by committees with defined terms of reference, enabling robust scrutiny of quality, financial performance, and risk. Systems of internal control and risk management are in place and are regularly reviewed to ensure their effectiveness. The Trust maintains policies and procedures that promote transparency, integrity, and regulatory compliance, and it ensures that appropriate skills, experience, and independence are represented at Board level. These arrangements are kept under continuous review to ensure they remain appropriate for the delivery of NHS-funded healthcare services and consistent with the expectations of the NHS regulatory framework.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board confirms that it has due regard to guidance on good corporate governance issued by NHS England. The Board ensures that such guidance is considered in the development, implementation, and ongoing review of the Licensee's governance framework. Relevant updates and publications are regularly monitored and, where applicable, incorporated into Board policies, procedures, and committee structures. The Board also undertakes periodic reviews of its effectiveness and governance arrangements to ensure continued alignment with national guidance and best practice for NHS-funded healthcare providers.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board is satisfied that it has established and maintains effective governance arrangements in line with the expectations of the NHS Provider Licence. (a) The Board operates through a well-defined structure, supported by committees with formally approved terms of reference, enabling effective oversight of quality, finance, risk, and performance. (b) There are clearly defined roles and responsibilities for the Board, its Committees, and staff, supported by documented schemes of delegation and standing orders, which ensure appropriate levels of authority, accountability, and decision-making. (c) The Trust maintains clear reporting lines and accountability frameworks throughout the organisation, ensuring that information flows effectively from operational to Board level, and that responsibilities are understood at all levels. These arrangements are subject to regular review to ensure they remain effective, proportionate, and aligned with regulatory
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	(a) The Trust operates established performance management and efficiency frameworks to ensure services are delivered economically, efficiently, and effectively, with regular monitoring of key performance indicators and benchmarking where appropriate. (b) The Board receives timely, relevant, and structured information to enable effective scrutiny and oversight of operations, supported by a committee structure that provides detailed review of quality, finance, and risk. (c) Systems and processes are in place to ensure compliance with all applicable healthcare standards, including those set by the Care Quality Commission, the Secretary of State, NHS England (including its role as the NHS Commissioning Board), and relevant professional regulators. (d) The Trust maintains effective financial governance arrangements, including budgeting, forecasting, and internal control systems, to support sound financial decision-making and ensure ongoing viability as a going concern. (e) There are established processes to ensure that accurate, comprehensive, and timely information is generated and disseminated to the Board and its committees to support informed decision-making. (f) A comprehensive risk management framework is in place to identify, assess, and manage material risks to compliance with licence conditions, including the use of risk registers and forward planning processes. (g) The Trust prepares and monitors delivery of business plans, with regular reporting to the Board on progress and performance, supported by internal assurance and, where appropriate, external review. (h) Systems and controls are in place to ensure compliance with all applicable legal and regulatory requirements, with oversight provided through governance, risk, and compliance functions. These systems and processes are subject to ongoing review to ensure they remain effective, proportionate, and aligned with regulatory expectations and best practice.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	(a) The Board maintains sufficient capability and expertise to provide effective organisational leadership on quality of care, including appropriately qualified and experienced executive and non-executive directors, supported by clinical leadership at Board level. (b) Quality of care is embedded within the Board's planning and decision-making processes, with all significant decisions informed by timely and appropriate consideration of quality, safety, and patient outcomes. (c) The Trust has established systems for the collection of accurate, comprehensive, timely, and up-to-date information on quality of care, including clinical outcomes, patient safety indicators, and patient experience data. (d) The Board receives regular, structured reports on quality of care and uses this information to inform its oversight and decision-making, ensuring that quality remains a central focus of governance. (e) The Trust actively engages with patients, staff, and other stakeholders on quality of care, including through feedback mechanisms, surveys, and forums, and takes account of these views in shaping and improving services. (f) There are clear lines of accountability for quality of care throughout the organisation, supported by robust systems for identifying, escalating, and resolving quality issues, including escalation to the Board where appropriate.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board and its committees are composed of individuals with the requisite balance of skills, knowledge, and experience, including clinical, financial, operational, and governance expertise. Appointments are made through robust recruitment and selection processes, with ongoing development and appraisal to ensure continued effectiveness. Across the organisation, workforce planning processes are in place to ensure that staffing levels and competencies are sufficient to support safe, effective, and compliant service delivery. This includes appropriate oversight of senior leadership roles reporting to the Board, as well as systems for recruitment, training, professional development, and performance management.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature ____________________ **Signature** ____________________

Name ____________________ **Name** ____________________

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Financial Year to which self-certification relates Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Enclosure No: 13

TRUST BOARD COMMITTEE CYCLE OF BUSINESS

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

Report to:	Public Trust Board
Date of Meeting:	14 May 2026

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

Aligned to Board Assurance Framework Risk:	Quality & Safety - There is a risk that the Trust fails to deliver timely, safe and effective care for people who use our services, due to increasing demand, increasing needs and a failure to evidence interventions with support recovery.
7 Levels of Assurance:	Level 7 - Evidence of delivery of the majority or all 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:	Trust Board
Strategic Priorities:	Growth - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	N/A
Recommendation / Required Action:	Trust Board to receive for information the Cycle of Business for 2026.27.

Executive Summary:	The Board considered proposed refinements to the Trust Board Cycle of Business (COB) to ensure appropriate coverage of statutory, strategic and assurance responsibilities. Subject to the amendments below, the Board approved the COB for 2026/27. The revised COB strengthens governance oversight through the inclusion of additional key assurance areas, including Health and Safety, Safeguarding, and Infection Prevention and Control. Clarification has also been provided on reporting routes for Emergency Preparedness, Resilience and Response (EPRR), and Quad A reporting, with further refinement agreed to ensure items are considered at the appropriate level (Board or Committee) and to reduce duplication. The Board welcomed the strengthened focus on strategic oversight, including the regular inclusion of strategic planning, partnerships and operational planning updates, with an expectation these are considered on a more routine (e.g. quarterly) basis. The inclusion of research activity within the COB was also supported. The Board confirmed governance arrangements relating to statutory reporting, including that the Annual Report will be formally adopted at the Annual General Meeting, and that responsibility for detailed scrutiny of the Annual Report and Annual Accounts remains delegated to the Audit Committee. Overall, the updated COB provides a more structured, proportionate and assurance-focused framework, supporting the Board to discharge its statutory duties while maintaining appropriate focus on strategic priorities.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	31/03/26
V2	Public Trust Board	08/05/26

Trust Board

2026/27 BUSINESS CYCLE

****Public Boards are highlighted in grey****

KEY TO RAG STATUS	
Paper not received	(red)
Paper rescheduled for future meeting	(amber)
Paper taken to meeting as scheduled	(green)

Title Paper	Executive Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Trust Board	BAF Link
		09-Apr	14-May	11-Jun	09-Jul	10-Sep	08-Oct	12-Nov	14-Jan	11-Feb	11-Mar		
		Private	Public	Private	Public	Public	Private	Public	Public	Private	Public		
STANDING ITEMS													
Attendance Report	Chair	x	x	x	x	x	x	x	x	x	x	COB	
Chairs Report	Chairman	x	x	x	x	x	x	x	x	x	x	COB	
Chief Executive's Report	Chief Executive	x	x	x	x	x	x	x	x	x	x	COB	
Patient Story	Chief Nursing Officer		x		x	x		x	x		x	COB	
REACH Recognition Individual Award	Corporate Governance Manager		x			x			x			COB	
REACH Recognition Team Award	Corporate Governance Manager				x			x			x	COB	
QUALITY COMMITTEE													
Safer Staffing Review Annual (To approve establishment uplift when required)	Chief Nursing Officer							x				Stat	
EPRR Plan / Policy	Chief Operating Officer				x							Stat	
Health, Safety and Security Annual Report	Chief Nursing Officer				x								
(DIPC) Infection, Prevention and Control Annual Report	Chief Nursing Officer				x								
Quality Committee Assurance Report (Quad A)	Chief Nursing Officer / Chief Medical Officer		x		x	x		x	x		x	Stat	
Quality Committee Review of TOR (via Quad A)	Chief Nursing Officer / Chief Medical Officer								X			COB	
Quality Account (as required)	Chief Nursing Officer and Chief Medical Officer			Final								Stat	
Occupational Health and Safety Policy	Chief Nursing Officer											COB	
Research Activity Framework	Chief Medical Officer											Stat	
Safeguarding Children and Adult Annual Report	Chief Nursing Officer				x								

Title Paper	Executive Lead	Apr	May	Jun	Jul	Sep	Oct	Nov	Jan	Feb	Mar	Trust Board	BAF Link
		09-Apr	14-May	11-Jun	09-Jul	10-Sep	08-Oct	12-Nov	14-Jan	11-Feb	11-Mar		
Winter Plan	Chief Operating Officer					x						Stat	
PEOPLE COMMITTEE													
People, Culture and Development Committee Assurance Report (Quad A)	Chief People Officer				x	x		x	x			Stat	
Being Open Annual Report (incl. Freedom To Speak Up)	Chief Executive Officer		x									Stat	
Medical Revalidation Annual Organisational (AOA) - Consent Item	Chief Medical Officer					x						Stat	
People and Culture Committee Annual Review of ToR (via Quad A)	Chief People Officer								X			COB	
Staff Survey Results	Chief People Officer				x							Stat	
Veterans Aware / Veterans Covenant Annual Update	Chief Operating Officer										x	Stat	
WRES and WDES and Equality and Diversity Annual Report	Chief People Officer					x						Stat	
CHARITABLE FUNDS COMMITTEE													
Charitable Funds Assurance Report (Quad A)	Chief Strategy Officer			x		x			x		x	Stat	
Charitable Funds TOR (via Quad A)	Chief Strategy Officer								x		x	COB	
FINANCE COMMITTEE													
Finance Report	Chief Finance Officer	x	x	x	x	x	x	x	x	x	x	Stat	
Finance & Resources Assurance Report (Quad A)	Chief Finance Officer	x	x	x	x	x	x	x	x	x	x	COB	
F&R ToR (via Quad A)	Chair of Committee								x			COB	
IQPR Report	Chief Finance Officer		x		x	x		x	x		x	Stat	
National Planning Guidance	Chief Strategy Officer								x			COB	
Strategic Planning (Quarterly)	Chief Strategy Officer				x		x		x			COB	
REMUNERATION COMMITTEE													
Remuneration Committee Assurance Report (Quad A) Private Board only	Deputy Director of Governance			x		x		x		x		Stat	
AUDIT COMMITTEE													
Annual Statement of Purpose (As required)	Deputy Director of Governance										x	Stat	

Title Paper	Executive Lead	Apr 09-Apr	May 14-May	Jun 11-Jun	Jul 09-Jul	Sep 10-Sep	Oct 08-Oct	Nov 12-Nov	Jan 14-Jan	Feb 11-Feb	Mar 11-Mar	Trust Board	BAF Link
Audit Committee Assurance Report (Quad A)	Deputy Director of Governance			x		x		x		x		COB	
Audit Committee TOR (via Quad A)	Deputy Director of Governance								x			COB	
Declaration of Interests- Board Members	Deputy Director of Governance									x		COB	
Fit and Proper Persons Test	Deputy Director of Governance			x	x (consent)							Stat	
Gifts and Hospitality / Sponsorship Annual	Deputy Director of Governance		x									COB	
Risk Management Strategy & Policy (3 yearly)	Deputy Director of Governance				x							Stat	
Self Certification G6 & FT4 (for info)	Deputy Director of Governance		x									Stat	
Standing Financial Instructions (Annually)	Chief Finance Officer							x					
Standing Orders Policy (Annually)	Chief Finance Officer							x				Stat	
GOVERNANCE													
Board to Team Annual Report	Deputy Director of Governance		Annual / Q4			Q1		Q2			Q3	COB	
Board & Committee meeting dates	Deputy Director of Governance							x				COB	
Board Assurance Framework Dashboard only (Public) Q1, Q2, Q3, Q4 Annual - Private consent	Deputy Director of Governance / Trust Board Secretary		x (Q4) Annual		Annual	x (Q1)		x (Q2)			x Q3	Stat	
Board review of its Cycle of Business	Deputy Director of Governance										x	Stat	
Committee Effectiveness Review	Deputy Director of Governance			x	x							Stat	
Register of Sealed Documents	Deputy Director of Governance									x		COB	
Review Policies to be approved by the Board	Deputy Director of Governance										x		
Provider Collaborative Annual Self Assessment	Deputy Director of Governance						x					COB	
Scheme of Delegation (Annually)	Deputy Director of Governance											COB	
Well Led Progress Update (Private Board)	Deputy Director of Governance		x					x				COB	
AD HOC													
Business Cases (As required)												Stat	

Trust Board 2026/27 Attendance

	9th Apr 26 Private	14th May 26 Public / Private	11th June 26 Private	9th July 26 Public / Private	10th Sept 26 Public / Private	8th Oct 26 Private	12th Nov 26 Public / Private	14th Jan 27 Public / Private	11th Feb 27 Private	11th Mar 27 Public / Private
Non-Executives										
Janet Dawson, Chair	√									
Russell Andrews, Non-Executive / Vice Chair	x									
Pauline Walsh, Non-Executive / Senior Independent Director	√									
Martin Evans, Non-Executive	√									
Prem Gabbi, Non-Executive Director	√									
Jennie Koo, Non-Executive Director	√									
Dr Roger Banks, Associate Non-Executive Director	√									
Katie Laverty, Associate Non-Executive Director	√									
Executive Members										
Dr Buki Adeyemo, Chief Executive Officer	√									
Eric Gardiner, Chief finance Officer / Deputy Chief Executive Officer	√									
Kenny Laing, Chief Nursing Officer / Deputy Chief Executive Officer	√									
Dr Dennis Okolo, Chief Medical Officer	√									
Elizabeth Mellor, Chief Strategy Officer	√									
Ben Richards, Chief Operating Officer	√									
Frieza Mahmood, Chief People Officer	X									
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										
Lisa Wilkinson, Corporate Governance Manager (Minutes)	√									