

NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 9TH JULY 2026, 10.00AM, BOARDROOM,
LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P73/26	Welcome and Apologies for Absence – Kenny Laing, Ben Richards, Martin Evans	Janet Dawson	Note	
2	1002	P74/26	Declarations of Interests – and changes to be notified	Janet Dawson	Note	
3	1003	P75/26	Minutes of the Previous Meeting held on 14th May 2026	Janet Dawson	Note	Enc. 1
4	1005	P76/26	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	Note	Enc. 2
ADVISE						
5	1010	P77/26	Patient Story – Jades Story	Zoe Grant	Advise	Verbal
6	1025	P78/26	REACH Recognition Team Award – Acute & Urgent Care – Ward 4	Dr Buki Adeyemo	Advise	Verbal
7	1030	P79/26	Chief Executives Report	Dr Buki Adeyemo	Advise	Enc. 3
8	1040	P80/26	Chairs Report	Janet Dawson	Advise	Verbal
9	1045	P81/26	Questions from Members of the Public	Janet Dawson	Advise	Verbal
ALERT						
10-minute Break						

APPROVE						
10	1100	P82/26	Risk Management Policy	Nicola Griffiths	Approve	Enc. 4
ASSURE						
11	1105	P83/26	Health and Safety Annual Report	Zoe Grant	Assurance	Enc. 5
12	1110	P84/26	Infection Prevention and Control Annual Report	Zoe Grant	Assurance	Enc. 6
13	1115	P85/26	EPPR Annual Report	Rachael Birks	Assurance	Enc. 7
14	1120	P86/26	Improving Quality and Performance Report (IQPR) Month 2	Eric Gardiner	Assurance	Enc. 8
15	1125	P87/26	Finance Report Month 2	Eric Gardiner	Assurance	Enc. 9
16	1135	P88/26	Finance and Resource Committee Assurance Reports from the meetings held on the 2 nd April 2026 and the 7 th May 2026	Russell Andrews	Assurance	Enc. 10a and 10b
17	1145	P89/26	Quality Committee Assurance Reports from the meetings held on the 4 th June 2026 and 2 nd July 2026	Pauline Walsh	Assurance	Enc. 11a & 11b
18	1155	P90/26	Audit Committee Assurance Report from the meeting held on 12 th June 2026	Prem Gabbi	Assurance	Enc. 12
19	1200	P91/26	People, Culture and Development Committee Assurance Report from the Business Meeting held on 29 th June 2026	Martin Evans	Assurance	Enc. 13
20	1205	P92/26	Charitable Funds Assurance Report from	Russell Andrews	Assurance	Enc. 14

			the meeting held on 1 st June 2026			
21	1220	P93/26	Any Other Business	Janet Dawson	Note	Verbal
22	1225	P94/26	Meeting Self- Assessment	Janet Dawson	Discussion	Verbal
CONSENT ITEMS						
23	1230	P95/26	Quality Account	Zoe Grant	Information	Enc. 15
24	1230	P96/26	Fit and Proper Persons Test (FPPT) 2026 Submission	Nicola Griffiths	Information	Enc. 16
25	1230	P97/26	Committee Effectiveness Report 2025/26	Nicola Griffiths	Information	Enc. 17
26	1230	P98/26	Gifts, Hospitality and Sponsorship Annual Report 2025/26	Nicola Griffiths	Information	Enc. 18
27	1230	P99/26	Trust Board Attendance Report	Janet Dawson	Information	Enc. 19

Date and Time of Next Meeting
10th September 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 14th May 2026 At 10:15am in the Boardroom, Lawton House and via MS Teams

Present		
Janet Dawson	JD	Chair
Russell Andrews	RA	Vice Chair / Non-Executive Director
Dr Buki Adeyemo	BA	Chief Executive Officer
Eric Gardiner	EG	Chief Finance Officer / Deputy Chief Executive
Zoe Grant	ZG	Deputy Chief Nursing Officer
Dr Dennis Okolo	DO	Chief Medical Officer
Rachael Birks	RBi	Deputy Chief Operating Officer
Elizabeth Mellor	EM	Chief Strategy Officer
Frieza Mahmood [arrived 10.35am]	FM	Chief People Officer
Pauline Walsh	PW	Non-Executive Director / Senior Independent Director (SID)
Jennie Koo [arrived 10.29am]	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)
Lucy Fadyen	LF	Ward Manger, Darwin Centre
Dr Haya Nadir	HN	Consultant Psychiatrist
Dr Rajyal Enugula	RE	Consultant Psychiatrist

Meeting commenced at 10.15am

46/26	APOLOGIES FOR ABSENCE Sherrine Khan - Senior Peer Support Worker Kenny Laing - Chief Nursing Officer / Deputy Chief Executive Ben Richards – Chief Operating Officer	
47/26	DECLARATIONS OF INTEREST RELATING TO AGENDA No declarations were made. <i>Noted</i>	
48/25	MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 12TH MARCH 2026 The minutes were reviewed and approved as a true and accurate record, subject to a minor amendment regarding clarification of the CQC report referenced in section 26/28.	

	Approved/Received	
49/26	ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 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). 14.05.26 – <i>This is being picked up as part of the revised PCDC subcommittee structure and specifically the New Workforce Development and Transformation Committee which replaces SEAL and has a remit for professional supervision and practice support needs</i> 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. 14.05.26 - <i>Dr Dennis Okolo will pick up this action and discuss with Pauline Walsh - action will be closed once built into the Quality Committee process.</i> Received	
50/26	PATIENT STORY – RICHARDS STORY Zoe Grant, Deputy Chief Nursing Officer advised. The Interim Chief Nursing Officer advised that a planned patient story would not be presented following a request from the patient's family following bereavement. The Board extended its condolences and noted that the story may be shared at a future meeting. Noted	
51/26	REACH RECOGNITION INDIVIDUAL AWARD – Lucy Fadyen – Ward Manager – Darwin Centre Dr Buki Adeyemo, Chief Executive Officer introduced the award. The Board was advised that Lucy joined the Darwin Team 12 months prior at a pivotal time. Since her appointment, she had demonstrated exemplary leadership, bringing significant experience, professional insight and a calm, consistent approach which had provided reassurance to both staff and partners. The Darwin Centre is a 14-bed General Adolescent Unit supporting children and young people with complex mental health needs requiring inpatient care across the region, including those with eating disorders. The Board noted the complexity of the service and the requirement for strong, multidisciplinary leadership. Lucy's contribution was recognised as highly impactful, both in stabilising the service and establishing firm foundations for continued improvement.	

	Her leadership was noted to strongly reflect the Trust's CARE values and the Board further noted Lucy's work in progressing Autism Accreditation for the service and her ongoing focus on strengthening the multidisciplinary team and partnership working to support future growth and investment. In receiving the award, Lucy expressed her appreciation for the recognition and acknowledged the collective effort of the team, noting that whilst progress had been made, there remained further work to continue improving the service. The Board congratulated Lucy on her award and commended the significant contribution she has made to the Darwin Centre. Received	
52/26	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: The Board noted the positive Ofsted outcome for Dragon Square and the associated performance ratings, alongside wider updates relating to Children and Young People's community services. The Chief Executive also highlighted recent engagement activity, including visits to Older People's Community Services and ongoing support for international nursing colleagues. Discussion focused on the continued development of the "Real Talk, Real Change" initiative. Non-Executive Directors emphasised the significance of the programme as a key cultural driver for the organisation and welcomed its visibility at Board level, noting its potential to support meaningful organisational improvement through staff engagement. The Chief Executive reflected positively on early implementation, highlighting the value of real-time staff feedback mechanisms and the inclusive approach being taken. It was noted that the initiative supports both validation of current practice and identification of opportunities for improvement. Board members welcomed the breadth of positive activity outlined within the report and emphasised the importance of recognising and promoting good practice more consistently across the organisation. The Board discussed forthcoming changes to the Mental Health Act and received assurance that preparatory work has been undertaken. It was recognised that whilst the Trust was well positioned for implementation, further clarity was dependent on the publication of the accompanying Code of Practice. The Board also acknowledged wider system engagement activity to consider the implications of legislative changes, particularly in relation to individuals with learning disabilities and autism and noted the complexity of future arrangements. Members highlighted the importance of strengthening the systematic sharing of innovation and best practice across the Trust and more broadly, recognising this as an area for further cultural development. Noted	
53/26	CHAIRS REPORT	

	Janet Dawson, Chair, provided a verbal update. The Chair provided a verbal update and began by sharing thanks received from Nicola Bullen, acknowledging the value of the experience and the openness, support and leadership demonstrated by Board members during her time with the Trust. The Chair reflected on a recent visit to Ward 7, noting the strong team culture, continuity of staff and positive working environment. It was highlighted that staff retention, alongside examples of colleagues returning to the organisation following training, was indicative of a supportive culture and a positive staff experience. The Chair took the opportunity to reflect more broadly on organisational culture, emphasising the importance of maintaining a safe, inclusive and respectful environment for all staff. This was considered particularly important in the context of wider societal challenges, including increasing division and discrimination, which may impact staff wellbeing, particularly for those working within community settings. The Board discussed the need to ensure that the Trust continued to provide an environment where individuals felt safe, valued and able to contribute, regardless of personal background or external influences. The Chair emphasised the importance of actively promoting inclusion and ensuring that discriminatory behaviours, including antisemitism and all forms of racism, were clearly challenged. Frieza Mahmood provided assurance regarding ongoing system-wide work to promote inclusion and belonging, including the development of guidance and resources on tackling discrimination and supporting staff. It was noted that this work was being progressed collaboratively across the Integrated Care System, with strong engagement from staff and partners, including well-attended learning sessions and continued dialogue to inform future development. Jenny Harvey welcomed the discussion, highlighting the impact that wider societal issues can have on staff wellbeing and reinforcing the importance of continued investment in equality, diversity and inclusion initiatives. The Board acknowledged the importance of sustained focus in this area and the need to ensure that this work remains a priority. The Board recognised that cultural leadership and visible commitment from senior leaders was essential to fostering an inclusive environment and supporting staff to raise concerns and feel heard. The alignment of this work with the 'Real Talk, Real Change' programme was noted as a key enabler in strengthening staff voice and engagement. <i>Noted</i>	
54/26	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. One question was received from a member of the public. The Board noted the response provided, including clarification that services referenced were commissioned externally and no changes were proposed.	

	Noted	
55/26	BOARD ASSURANCE FRAMEWORK (BAF) 2026/27 Nicola Griffiths, Deputy Director of Governance, presented the report. The Board noted that the framework had been subject to extensive development, including engagement sessions, committee review and recent Board development discussions. It was highlighted that the BAF reflected the Board's agreed strategic priorities and provided a structured approach to identifying and managing principal risks. The Board noted the significant progress made in the maturity of the framework, with members reflecting that the current iteration demonstrated a clear improvement compared to previous years. The inclusion of defined risk appetite and tolerance levels were welcomed as supporting more informed and consistent decision-making. Members discussed the importance of maintaining an appropriate balance between clarity and flexibility within the framework. It was noted that the BAF should remain sufficiently dynamic to respond to emerging national and local developments, whilst avoiding unnecessary expansion or complexity. The approach of iteratively updating and refining existing risks, rather than continually adding new risks, was supported. The Board was assured that quarterly review processes, including engagement with Executive leads, provided an opportunity to assess emerging risks, review mitigating actions and identify gaps in assurance. It was noted that this approach enabled the framework to remain responsive to the evolving external environment. Further discussion emphasised the importance of collective ownership of the BAF across the Board, with members recognising that it should be actively used as a tool to support governance and decision-making, rather than being viewed as solely a governance function. The Executive team confirmed that the BAF was embedded within routine governance processes and subject to regular review, with continued opportunities for further development identified. The Board approved the Board Assurance Framework for 2026/27 and noted the assurance provided. Approved / Received	
56/26	IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 12 Eric Gardiner, Chief Finance Officer / Deputy Chief Executive, presented the Month 12 IQPR report. The Board noted that reducing out of area placements remained a priority with continued focus on improving patient flow and reducing delays for those clinically ready for discharge. Linked to this, the Board discussed system	

	pressures impacting length of stay, noting a slight increase in recent months alongside a reduction in median length of stay. Progress in reducing sickness absence was noted, with levels showing a continued, albeit gradual, improvement. The Board acknowledged this as a positive trajectory, whilst recognising that sustained focus was required to maintain and accelerate improvement. Updates were also provided in relation to service performance, including improvements in Children and Young People's access targets, with reported progress towards achieving four-week referral to assessment standards. It was noted that continued improvement may support removal from national performance oversight processes. The Board discussed sickness absence in more detail, particularly within acute and urgent care services. It was noted that this area was subject to ongoing review through the People, Culture and Development Committee, supported by a targeted improvement plan informed by service-level data and operational insight. The Board acknowledged the complexity of factors contributing to sickness absence, including service demand, workforce pressures and reliance on additional staff hours to maintain service delivery. Members emphasised the importance of a coordinated, cross-committee approach in addressing these issues, ensuring that workforce, quality and operational risks were considered holistically. Assurance was provided that detailed oversight arrangements were in place, with further work underway to develop preventative approaches to staff health and wellbeing. The Board reflected on the value of committee escalation routes, noting that issues identified within Finance and Resource Committee, including out of area placements and discharge delays, were appropriately referred to Quality Committee for further scrutiny and action. A discussion was held regarding appraisal compliance, with clarification provided that performance was measured across the full appraisal cycle rather than at a fixed point in time. It was noted that whilst improvements were expected in upcoming reports, achieving full compliance remained an ongoing challenge, influenced in part by recording and system constraints. The Board emphasised the importance of avoiding duplication of reporting and ensuring that Board discussions add value alongside committee-level scrutiny. Received	
57/26	FINANCE REPORT MONTH 12 Eric Gardiner, Chief Finance Officer / Deputy Chief Executive Officer presented the Month 12 Finance Report, noting that the reported position remained subject to external audit. The Board welcomed the reported year-end surplus of £3.4m, noting that this included £1.6m additional system funding linked to delivery against financial targets. It was highlighted that the surplus position enabled strategic reinvestment through the Trust's capital programme, providing tangible benefit for future service development.	

	The Board noted that agency expenditure was broadly in line with plan; however, a variance against the bank workforce plan was reported, with an overspend of approximately £0.9m. It was acknowledged that further work was required to reduce reliance on bank staffing in line with national expectations, although it was noted that expenditure trends had improved across the year, providing a more favourable position going forward. A detailed discussion was held regarding the complexities associated with bank, agency and overtime expenditure. Members recognised that these workforce models were not directly comparable and were influenced by factors including service demand, workforce availability, staff preference and contractual arrangements. It was acknowledged that bank staffing played an important role in supporting flexible workforce deployment and maintaining service continuity, particularly where traditional employment models may not meet staff needs. The Board noted the importance of balancing financial efficiency with workforce sustainability and staff experience, including consideration of opportunities to transition bank staff into substantive roles where appropriate. It was also recognised that workforce planning decisions should take into account equality considerations and employment conditions. Frieza Mahmood highlighted that the current position presented an opportunity to consider broader workforce models and risk appetite in relation to flexibility, noting that reducing reliance on bank staffing requires alternative approaches to workforce deployment and planning. The Board sought clarification regarding the use of additional system funding, noting that funding received was required to be reflected in the year-end financial position and supported overall organisational financial delivery, rather than being directly allocated to in-year expenditure. The Chair formally recorded the Board's thanks to Eric Gardiner and the Finance Team for the delivery of a strong financial performance, recognising the challenges associated with achieving a surplus position whilst maintaining operational services. <i>Received</i>	
58/26	FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON 2ND APRIL 2026 AND 7TH MAY 2026 Russell Andrews, Non-Executive Director / Committee Chair, presented the reports and highlighted the following: The Board noted that the April report had been taken as read. In relation to the May meeting, the Committee Chair highlighted key areas of discussion and assurance. The Board received an update on the Trust's digital programme, noting progress towards implementation alongside ongoing challenges. In particular, concerns were raised regarding the performance of the IT support service provider, with a deterioration in response rates attributed to workforce issues. It was noted that the Trust was actively engaging with the provider at partnership level, with representation to ensure appropriate contractual scrutiny and improvement actions.	

	The Committee scrutinised the Month 12 IQPR and financial year-end position and the Board noted the positive financial performance reported. The Board also received an update on Estates, specifically in relation to water temperature management at the Harplands. It was recognised that whilst a definitive resolution had not yet been achieved, there were early indications of improvement, providing a degree of assurance following a sustained period of limited progress. The Board noted that the Strategic Partnership Plan continued to present challenges, particularly in relation to alignment with external partners. It was highlighted that this was now reflected within the Board Assurance Framework risk register, reinforcing the importance of ongoing monitoring and engagement. The Committee confirmed that two items had been recommended for Board approval which would be discussed during Private Board relating to the secure patient transport tender and the payroll services contract. The Board discussed progress in relation to digital system development, noting that whilst improvements had been observed, further work was required to ensure readiness for implementation. Members also discussed the Cost Improvement Programme (CIP) for 2026/27, noting that whilst good progress had been made, there remained a gap to target which was being actively addressed through established planning processes. The Board acknowledged that the Trust's robust and detailed approach to financial planning, whilst sometimes extending timelines, provided greater assurance over deliverability. The importance of ensuring visibility of progress and assurance at Committee and Board level was highlighted, with members noting the value of continued monitoring and reporting to support informed decision-making. Received	
P59/26	QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 2ND APRIL 2026 AND 7TH MAY 2026 Pauline Walsh, Non-Executive Director / Committee Chair, presented the reports. In relation to the April meeting, the Board noted discussion regarding benchmarking of key quality indicators to support understanding of the Trust's position relative to peers. The Committee also received deep dive presentations from the Specialist Directorate, including Neuropsychiatry, which were considered helpful in providing insight into service performance, challenges and opportunities for development. It was noted that further consideration was required in relation to service capacity and potential for growth, including addressing barriers to increased activity. The Board noted that the Neuropsychiatry Service was a highly specialised offering, with opportunities for expansion subject to workforce and commissioning arrangements. In relation to the May meeting, the Committee highlighted continued focus on out of area placements. The Board noted that a detailed review was	

	planned to provide a clearer trajectory for improvement, including understanding the Trust's position within the national context and identifying actions to reduce reliance on placements. The Board received feedback from the Quality Committee visit to Older People's Community Services, noting identified strengths alongside areas for improvement, including consistency of supervision recording and the development of models of care. The importance of strengthening assurance relating to supervision was discussed, including distinguishing between delivery of supervision and the ability to demonstrate and evidence it effectively. Members discussed sickness absence within Acute and Urgent Care Directorate, noting alignment with discussions held at Board and through other Committees. It was recognised that this remained an area requiring ongoing focus and coordinated oversight. The Committee also received a presentation on the "Real Talk, Real Change" initiative and noted its strong potential to support cultural change. Opportunities to further strengthen engagement, including peer-to-peer approaches, were highlighted as part of ongoing development. The Board noted that the Quality Committee had approved updates to Terms of Reference and considered policy approvals, with discussion highlighting the need for consistent approaches to assessing levels of assurance. It was recognised that assurance should relate to the specific item presented, rather than the broader context of organisational compliance, and that further clarity across Committees would support consistency in approach. The Board acknowledged that there has been variability in how assurance levels had historically been applied and supported further reflection to ensure a more consistent and shared understanding across all Committees. A focused discussion was held regarding out of area placements, with members emphasising the importance of maintaining a patient-centred perspective. It was recognised that whilst benchmarking was useful, the primary focus must remain on improving outcomes for individuals and reducing placements wherever possible. The Board reinforced expectations for a comprehensive and outcome-focused improvement plan, including clear trajectories for reduction. Members were assured that Committee discussions maintained a strong focus on individual patient impact, with regular review of cases and actions to support safe and timely discharge. <i>Received</i>	
P60/26	AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 8TH MAY 2026 Prem Gabbi, Non-Executive Director / Committee Chair, presented the report and highlighted the following: The Board noted improvements in the management and oversight of internal audit actions. It was highlighted that enhanced governance arrangements were being implemented to strengthen accountability, including increased ownership of actions at Committee level and more regular monitoring of	

	progress. The Board supported the approach of embedding oversight within relevant Committees to ensure timely delivery and to reduce reliance on retrospective assurance. The Board considered and approved the request to delegate authority to the Audit Committee to approve the Annual Report and Accounts, noting the timing of the Committee meeting scheduled following the Board. The Committee reported a positive position in relation to internal audit and counter fraud activity. The Board noted that year-end reports indicated a good level of assurance across key control areas, with no significant issues identified. The Head of Internal Audit opinion was noted as providing a satisfactory level of assurance, reflecting strong progress whilst recognising that further actions remain in train. The Board welcomed the continued development of assurance processes, including increased engagement between Committees. It was noted that the Audit Committee had received a presentation from the Quality Committee Chair, providing assurance regarding governance arrangements for quality and safety, which was positively received. The Board noted progress against the external audit plan and year-end processes, including confirmation of the going concern assessment and financial statements. It was recognised that the Committee had also reviewed its own effectiveness and was satisfied with the level of assurance being provided. Discussion was held regarding the consistency of assurance levels applied to policy approvals. Members noted that variation in approach had historically existed and agreed the importance of ensuring that assurance ratings reflect the specific item under consideration, rather than the broader organisational context. The Board supported further work to promote a consistent approach across Committees. The Board discussed the importance of strengthening visibility and ownership of audit actions, including ensuring that action deadlines are appropriately set and monitored by the responsible Committees. It was emphasised that proactive management of actions was essential to avoid delays and ensure continuous improvement. The Board also reflected on the relationship between Audit Committee oversight and the Board Assurance Framework, noting the importance of ensuring clear alignment between assurance activities, risk management and committee responsibilities. <i>Approved / Received</i>	
P61/26	PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 11TH May 2026 Martin Evans, Non-Executive Director / Committee Chair, presented the report and highlighted the following: The Board noted a staff story presented by the Chair of the Enrich Staff Network, which provided valuable insight into staff experience, including both positive aspects and ongoing challenges relating to discrimination in the workplace. The discussion reinforced that, whilst progress had been	

made, there remained further work to do to address discrimination experienced by staff from patients, the public and colleagues. The Board was assured that this is reflected within the People Plan, with continued oversight by the Committee.

The Board received an update on sickness absence and the associated improvement plan. It was noted that a revised approach was being taken, including the introduction of directorate level targets informed by underlying data and operational context. Members acknowledged both the opportunities and risks associated with this approach and were assured that it was evidence-based and subject to ongoing engagement with Directorates, with progress to be monitored through the Committee.

The Board noted that progress continued towards the overall sickness reduction ambition, with the introduction of more realistic improvement trajectories supporting increased engagement and ownership at service level. It was recognised that sickness absence remained significantly influenced by workforce pressures, with approximately 48% of absence attributed to stress, anxiety and depression. The Board emphasised the importance of strengthening preventative approaches to staff wellbeing and agreed that further work is required in this area.

The Board discussed the continued development of the “Real Talk, Real Change” initiative, recognising its potential to support cultural transformation through strengthened staff voice and engagement. Members highlighted the importance of Board and senior leadership visibility, and the need to ensure that feedback is translated into clear and demonstrable actions.

The Board noted the impact of organisational change within Corporate Services and the need to maintain focus on key strategic priorities. It was reiterated that the Committee had agreed a clear set of priority areas within the People Plan and that effort should remain focused on these core objectives.

The Board received assurance regarding progress against the NHS Improving Working Lives 10-point action plan, noting that the Trust was performing strongly compared to national benchmarks, with delivery currently at 86% against a target of 95%.

A detailed discussion was held regarding equality, diversity and inclusion, including the continued prevalence of discrimination experienced by staff with certain protected characteristics. The Board recognised the importance of maintaining a clear organisational stance on unacceptable behaviours and strengthening support mechanisms for staff. It was also noted that further consideration was required regarding workforce development and progression opportunities for internationally recruited staff and those working in non-substantive roles.

The Board reflected on the need to shift from reactive to preventative approaches in supporting staff wellbeing, with members emphasising the importance of early identification of risk factors and proactive intervention. The introduction of additional approaches, including enhanced engagement, data-driven insight and targeted support, was noted as a positive step.

	The Board also discussed the importance of maintaining openness and psychological safety within the organisation, ensuring that staff felt able to raise concerns and that feedback mechanisms were inclusive and effective. Received	
P62/26	VETERANS AWARE / VETERANS COVENANT ANNUAL UPDATE Rachael Birks, Acting Chief Operating Officer presented the report. The Board noted that the Trust had successfully achieved reaccreditation, in line with the four-year review cycle, reflecting continued commitment to supporting veterans and their families. The report also outlined a forward plan of activity for 2026/27 to further develop and strengthen this work. Members welcomed the continued progress and recognised the importance of maintaining focus on the needs of veterans within service delivery. It was suggested that future reporting could include patient stories or case examples to demonstrate the impact of the Trust's work in this area and to highlight positive outcomes for veterans accessing services. Received	
63/26	ANY OTHER BUSINESS There were no items of other business. Noted	
64/26	MEETING SELF ASSESSMENT The Board reflected on the effectiveness of the meeting, noting that the session had commenced later than planned, which impacted the available time. Members identified opportunities to strengthen future meetings, including ensuring clarity regarding assurance ratings presented within Board papers and maintaining focus on the purpose and value of discussion. The Board welcomed the breadth of perspectives shared during the meeting and noted the value of discussion in supporting collective learning and understanding across the Board. Noted	
65/26	SELF CERTIFICATION G6 AND FT4 2025/26 Circulated for information only	
66/26	BOARD CYCLE OF BUSINESS 2026/27 Circulated for information only	
67/26	TRUST BOARD ATTENDANCE REPORT Circulated for information only.	
	DATE AND TIME OF NEXT MEETING Thursday 9th July 2026 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12:15pm



Signed: _____
Chair

Date: 12th June 2026

Board Action Monitoring Schedule

Trust Board - Action monitoring schedule - (Public)						
<u>No.</u>	<u>Meeting Date</u>	<u>Minute No</u>	<u>Action Description</u>	<u>Responsible Officer</u>	<u>Target Date</u>	<u>Progress / Comment</u>
			There were no actions recorded during the May Public Board Meeting			

Enclosure No: 3

CEO BOARD REPORT – JULY 2026

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☐	Advise	☒		
Information	☐				

Presented by:	Dr Buki Adeyemo, Chief Executive Officer
Prepared by:	Sarah Smith, Communications 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 commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	People - We will attract, develop and retain the best people
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper 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: • Cross-government Mental Health Strategy launched • RCN finds half a million children attended A&E in mental health crisis • Trust projects shortlisted for Nursing Times Awards • Oliver McGowan Training Recruitment Day • Combined unveils latest digital learning film – FRED explains the Cost Improvement Programme • Combined awarded £49,998 to deliver vital wellbeing support to colleagues • Bridge and Beyond: new collaborative service set to launch this Autumn

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	02/07/2026

Chief Executive's Report to the Trust Board July 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

Cross-government Mental Health Strategy launched

The government is developing a 10-year, cross-government Mental Health Strategy for England, with a call for evidence launched during Mental Health Week in May.

This seeks evidence and examples of good practice across themes including community-based mental health care, cross-sector partnership working, support for people with severe mental illness, digital and AI-enabled services, prevention and early intervention, and reducing inequalities in mental health outcomes. The Trust is actively developing a response which will be submitted in advance of the deadline in July.

RCN finds half a million children attended A&E in mental health crisis

Research carried out by the Royal College of Nursing (RCN) has shown that half a million children have presented to NHS emergency departments in a mental health crisis since 2019, with waits as long as 3 days before being transferred to a mental health unit.

The research also found that waits of 12 hours or more for children in a mental health crisis more than tripled during the same period in NHS trusts in England.

We welcome the RCN's recent analysis highlighting the significant number of children and young people presenting to emergency departments in mental health crisis, alongside the concerning increase in prolonged waits for appropriate care. The findings that many children are waiting extended periods, including up to three days, in A&E environments are deeply concerning and reflect pressures that are being experienced across the system nationally.

We recognise and share the RCN's view that emergency departments are not therapeutic environments for children in acute psychological distress, and that prolonged stays in such settings risk compounding distress and trauma.

In response to these challenges, services across Combined Healthcare are working in partnership with system colleagues, to develop and implement trauma-informed alternatives to A&E attendance, with a clear emphasis on early intervention, crisis prevention, and coordinated multi-agency support.

Our Mental Health Liaison Service is an all-age service and has proactive pathways to support and clear links with our wider services and the Local Authority.

Our Children and Young People Intensive Support Hub (ISH) has been established to:

- Provide rapid, flexible, and intensive community-based support to children and young people at risk of escalation to crisis.



- Reduce avoidable A&E attendances by offering timely intervention in more appropriate environments.
- Deliver trauma-informed, relational care, recognising the impact of distress and adversity on presentation.
- Enable step-up and step-down pathways, supporting safer transitions and reducing reliance on inpatient admission.

This model reflects the direction of travel advocated by the RCN, ensuring that children receive care in environments designed to meet their needs, rather than defaulting to emergency departments.

Recognising that a subset of children and young people experience recurrent crisis and system escalation, we have also developed, through extensive system engagement and co-production, our Children and Young People (CYP) Complex Situations pathway, designed to strengthen system responses for those with the most complex needs.

Core aims:

- Reduce repeated crisis presentations, including A&E attendances.
- Provide coordinated, multi-agency care across health, social care, and education.
- Move away from fragmented responses towards consistent, relationship-based support.
- Prevent escalation to restrictive environments, including inpatient admission and extended A&E stays.
- Embed trauma-informed, formulation-led approaches that support sustainable outcomes.

This pathway focuses on individuals at highest risk of system breakdown, ensuring earlier identification, shared accountability, and timely, coordinated decision-making.

We fully support the RCN's call for:

- Expansion of specialist crisis alternatives to A&E.
- Strengthened early intervention and prevention models.
- Greater focus on the wider determinants of children's mental health.

Our local transformation programme reflects these priorities, with ongoing work to:

- Expand community-based crisis support capacity.
- Strengthen integrated pathways across partners.
- Improve flow and access to appropriate care settings.
- Embed trauma-informed practice across all services.

The RCN's findings provide an important national perspective on the challenges facing children and young people in mental health crisis. Within our system, we are actively addressing these challenges through the development of innovative, integrated, and trauma-informed models of care, designed to reduce reliance on emergency departments and improve outcomes for children, young people, and their families/caregivers.

We remain committed to working collaboratively with partners, including the RCN, to ensure that children in crisis receive timely, appropriate, and compassionate care in environments that support recovery rather than exacerbate distress.



3.0 OUR TRUST

3.1



Trust projects shortlisted for Nursing Times Awards

I'm pleased to announce that two individual projects within our learning disability services have been shortlisted for the Nursing Times Awards in the learning disability nursing category.

The 'supporting families who manage risky behaviours at home' project focuses on supporting families caring for loved ones whose behaviours can be challenging at home. Staff worked with families to help to reduce risk, increase family confidence, prevent crisis and family breakdown, and reduce the need for urgent or emergency services.

This initiative delivers clear value by improving safety, wellbeing and quality of life for children with learning disabilities and their families, while enhancing service effectiveness.

The second project focuses on sustaining the future registered nurse learning disabilities workforce by developing placements for T-Level Health students from two local colleges. Placements were across five different learning disability services, including children's services, adult services, short breaks, and community teams. The programme aimed to raise awareness of learning disability nursing as a career and improve understanding of the needs of people with learning disabilities when accessing mainstream services.

To see both projects recognised is incredibly exciting, both showcase the difference that learning disability nursing can make to individuals, families, and future generations of healthcare professionals.

Oliver McGowan Training Recruitment Day

On Thursday 4 June 2026 Combined Healthcare hosted an Oliver McGowan Training Recruitment Day.

All colleagues at Combined Healthcare are required to complete the Oliver McGowan Mandatory Training on Learning Disability and Autism. To help facilitate the sessions, the Trust is looking to employ more experts with lived experience of autism or learning disability, to support this essential training as co-facilitators.

In recognition of the importance and quality of this training, the Trust has approved a local business case to establish and sustain an in-house delivery model. This approach ensures consistent access to suitably skilled co-facilitators, strengthens the authenticity of lived experience within the training and supports timely, high-quality delivery aligned to local workforce needs.

Each training session requires a trio of facilitators – Lead Trainer, Co-Trainer with lived experience of a learning disability and Co-Trainer with lived experience of autism. To support with the recruitment of experts with lived experience, the Oliver McGowan Training Recruitment Day was organised to share information about the training and its importance with those who may be interested in getting involved. A number of teams from across the Trust, and our partner organisations, supported with the running of the day – including the Oliver McGowan team, the Trust's recruitment team, the Combined Ability Network, Staffordshire Wellbeing College and the Citizens Advice Bureau.



The day was a success, and a number of co-facilitators have now been recruited to support the training. We look forward to welcoming them to the Trust and are extremely grateful for their support with this important training programme.

Combined unveils latest digital learning film – FRED explains the Cost Improvement Programme

The latest digital learning film from Combined Healthcare features Digital Trainer FRED (Finance and Resources Expert in Delivery) explaining the principles and practice lying behind our Cost Improvement Programme (CIP).

The new film is the latest stage in the Trust's harnessing of artificial intelligence (AI) to transform learning and training, with AI tools embedded in Adobe Creative Cloud used to develop the digital environment in which FRED is presented. This builds on a history of digital experimentation, including the launch of the NHS's first frontline podcast 'NHS Combinations' in 2019, followed in 2022 by the creation of the Trust's digital TV platform 'CTV' and pioneering use of virtual reality 'CVR' to deliver immersive empathy-based training.

You can watch 'FRED explains the Cost Improvement Programme' via the Trust's YouTube channel.



3.2

Combined awarded £49,998 to deliver vital wellbeing support to colleagues

As NHS staff across the country continue to work under intense pressure, Combined Healthcare will be able to provide crucial support to help improve the wellbeing of local NHS staff, both now and in the future, thanks to a £49,998 grant from NHS Charities Together and NHS England.

The grant has been awarded as part of an £11 million programme – which includes a £5 million contribution from NHS England – and is one of 61 ambitious projects across England to receive funding from the programme since its launch in 2024.

Through this funding, Combined will deliver and embed Emotional Freedom Techniques (EFT) within the Trust, developing a resilient model to support EFT into the future. This will allow the Trust to complete a programme to deliver a resilient and sustainable EFT programme to benefit our people.

This approach is particularly important for the Trust as it directly supports the delivery of our People Plan; where fostering a positive, inclusive culture is a key priority through high levels of staff experience, by prioritising colleague health and wellbeing. This investment is a key intervention to empower colleagues with the tools to support feelings of overwhelm in the moment. In turn, this contributes to improved staff wellbeing, supports a more engaged and resilient workforce; and plays an important role in reducing sickness absence and ensuring long-term sustainability of our services. A small group of colleagues have received the training, and a project plan has been developed to extend implementation.



3.3

**Bridge and Beyond: new collaborative service set to launch this Autumn**

Bridge and Beyond, a new and innovative, multi-disciplinary team supporting children and young people (CYP) across Staffordshire and Stoke-on-Trent, led by North Staffordshire Combined Healthcare NHS Trust and in partnership with Midlands Partnership University NHS Foundation Trust (MPFT), Stoke-on-Trent Council and Staffordshire County Council will be launched in the autumn.

Bridge and Beyond is the new service designed to support children, young people and families, aged 13-18, who have significant and varied needs, across Stoke-on-Trent and Staffordshire. By bringing together expertise from health, social care, education and partner agencies, the service will help to manage escalating risks, coordinate support, and provide specialist intervention before situations escalate further. The team will focus on improving outcomes for children and young people who may be experiencing significant emotional, behavioural, social or placement-related challenges. Through collaborative working, shared decision-making and a trauma-informed approach, Bridge and Beyond aims to increase stability, strengthen support networks, reduce the need for emergency placements and hospital admissions, and help children and young people achieve positive long-term outcomes.

Through a belief in a vision that collaboration would make a real difference to local CYP, Combined Healthcare was delighted to secure the investment for this new service from Toucan (West Midlands CAMHS Provider Collaborative). Being in a position to launch this service with partners is really going to make a difference to CYP who need this support.

4.0 CONCLUSION

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



Enclosure No: 4

POLICY REPORT – JULY 2026

Report provided for:				Report to:	Public Trust Board
Approve	☒	Alert	☐	Date of Meeting:	09 July 2026
Assure	☐	Advise	☐		
Information	☐				

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

Aligned to Board Assurance Framework Risk:	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:	
Approval / Review:	Senior Leadership Team
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 supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	The Board is requested to approve the revised Risk Policy for implementation and adoption across the Trust for a period of three years
Executive Summary:	The Board is asked to approve the revised policy for a further three-year period. The policy has been comprehensively updated to reflect the Trust's current governance framework, strategic priorities and the NHS England Risk Management Framework (2025), and has been benchmarked against good practice across NHS organisations. The revised policy provides a clear and consistent framework for the identification, assessment, escalation, monitoring and management of risks across the Trust. It strengthens governance arrangements by clarifying risk ownership and accountability, defining escalation thresholds, aligning risks to the Board Assurance Framework (BAF), Trust, Directorate and Team Risk Registers, and embedding the NHS England Three Lines Model of assurance. The policy supports compliance with CQC Regulation 17 (Good Governance), NHS provider licence requirements, and national risk management expectations. It promotes a proactive risk management culture, ensuring that risks are managed effectively to support the delivery of the Trust's strategic priorities of Prevention, Access and Growth and its SPAR quality priorities. There are no financial implications arising from the policy, no specific training requirements beyond existing risk management awareness arrangements, and the Equality Impact Assessment identified no adverse impact on protected groups.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Senior Leadership Team	28/04/2026
V2	Audit Committee	08/05/2026
V2	Public Trust Board	03/07/2026

Document level: Trust wide _____
 Code: 4.18a _____
 Issue number: 3 _____

Risk Policy

Lead executive	Chief Executive
Authors details	Deputy Director of Governance

Type of document	Policy
Target audience	All Trust Staff
Document purpose	This policy sets out the delivery of effective risk management within a clear infrastructure, systems, and processes.

Approving meeting		Meeting date	
Implementation date		Review date	

Trust documents to be read in conjunction with	
5.01	Incident Reporting Policy

Document change history		Version	Date
What is different?	This policy has been revised to reflect updated Trust governance structures and has been benchmarked against good practice in other NHS Trusts.		
Appendices / electronic forms	Appendix 1 – General Risk Assessment Form.		
What is the impact of change?	Improved clarity and consistency of risk governance arrangements.		

Training requirements	There are no specific training requirements for this document.
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Document consultation	
Directorates	N/A
Corporate services	N/A
External agencies	N/A

Financial resource implications	No
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Sustainability	1. Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent ☐ 2. Build a network of climate and sustainability champions across Staffordshire and Stoke on Trent ☐ 3. Share learning and best practice ☒
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External references
1.

Monitoring compliance with the processes outlined within this document	This policy will be updated by the Associate Director of Governance on expiry and submitted to SLT for sign off and Audit Committee for approval.
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– Age (e.g. consider impact on younger people/ older people)	No	
– Disability (remember to consider physical, mental and sensory impairments)	No	
– Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– Pregnancy and maternity, including adoption (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not)	No	
– Marriage and/or Civil Partnership (including heterosexual and same sex marriage)	No	

– Religion and/or Belief (includes those with religion and /or belief and those with none) – Other equality groups? (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
Enter details here if applicable		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Enter details here if applicable		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A	
Enter details here if applicable		
Does this document affect one or more group(s) less or more favorably than another (see list)?		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.		
For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There is no specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There is specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required- contact the Education and Widening Participation Manager who will support submission for approval to the Strategic Education, Apprenticeship and Learning (SEAL) group)	

Staff Group	✓ if appropriate and define professional group if not all	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Rotational Doctor				
Doctor				
Inpatient Registered Professionals				
Inpatient Non-registered professionals				
Community Registered Professionals				
Community Non Registered professionals				
Clinical Psychologist				
Pharmacist				
Registered Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy
i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed
by

Date

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1. Introduction

Trust Overview

North Staffordshire Combined Healthcare NHS Trust (the Trust') is committed to improving the mental health and wellbeing of the local population. The Trust's five-year Strategy 2023-2028 outlines its ambitions for the next five years, which include continuously improving services with co-production, recovery, and partnerships at the heart of how it works.

The Trust's Strategy further sets out three overarching Strategic Priorities — *Prevention, Access and Growth*. These priorities shape how the organisation plans and delivers services, ensuring that risks are managed in a way that supports early intervention, timely and equitable access to care, and the sustainable development of services for the future. They provide the strategic context within which this Risk Management Policy operates.

SPAR Quality Priorities

The SPAR Quality Priorities provide an important context for how the Trust approaches quality, safety and risk across all services.

- S** - Our services will be consistently **Safe**
- P** - Our care will be **Personalised** to the individual needs of our service users
- A** - Our processes and structures will guarantee **Access** to services for our service users and their carers
- R** - Our focus will be on the **Recovery** needs of those with mental illness

Key Enablers

1. Quality

Supporting personalised, safe and effective care.

This focuses on:

- driving continuous quality improvement
- ensuring safe clinical practice
- embedding learning cultures
- meeting regulatory and assurance requirements

2. People

Developing, supporting and retaining the Trust's workforce, ensuring that:

- the Trust remains a great place to work
- leadership capability is strengthened
- staff wellbeing, training and development are prioritised

3. Partnerships

Recognising the importance of collaboration and working across:

- local system partners
- primary care
- social care
- voluntary and community groups
- digital and academic partners

This supports integrated care and system-wide delivery.

4. Sustainability

Ensuring the Trust can deliver sustainable, future-proof services by:

- reducing the Trust's carbon footprint
- progressing toward the NHS Net Zero agenda
- using resources efficiently
- embedding environmental sustainability into service planning
- our direction of travel is to ensure that transformation enables change at scale and delivers improved outcomes and demonstrable returns on investment

Risk influences every aspect of the Trust's day-to-day operations, and the delivery of high-quality care relies on the effective identification, assessment, management and minimisation of risks. The Trust adopts an integrated and organisation-wide approach to risk management that is embedded within its performance management, strategic planning and business decision-making processes.

This document sets out the Trust's risk management procedures and guidance. Together, these provide a coherent and consistent approach to managing risk across all services and corporate functions, ensuring that risks are understood, appropriately escalated, and used to inform assurance, governance and improvement activities.

This Policy is aligned to the NHS England Risk Management Framework (2025), including updated requirements for risk escalation, governance, risk appetite and the Three Lines Model.

2. Purpose & Aim

North Staffordshire Combined Healthcare Trust (NSCHT) is committed to establishing an effective and pro-active approach to managing all risks which may impact on its ability to deliver its statutory responsibilities and the achievement of its objectives and values. This policy sets out the processes and responsibilities for risk management within the Trust.

The Trust is committed to aligning risk management with its strategic objectives, business plans, and day-to-day operational management systems.

The objective of the Risk Management Policy is to promote an integrated and consistent approach across all parts of the Trust. The policy applies to staff at all levels. Staff are expected to ensure that risk management is a fundamental part of their approach to clinical and corporate governance which will in

turn contribute to improved, safe and high-quality service provision. The Trust promotes a Being Open Culture with Freedom To Speak Up. Risk Management is a central element of the Trust's quality, governance, and performance processes.

The Trust recognises that risk management is essential for identifying and managing risks that threaten its ability to achieve its strategic objectives. It is also clear that understanding and responding to risk, both clinical and non-clinical, is essential in achieving the Trusts SPAR quality priorities – to provide services that are Safe, Personalised, Accessible and Recovery-Focused.

This Policy supports compliance with CQC Regulation 17 (Good Governance), ensuring the Trust maintains effective systems and processes for identifying, assessing, monitoring and managing risks.

The Trust acknowledges that taking well-managed risks is essential to improving health outcomes and enabling innovation, while recognising that a completely risk-free environment is neither possible nor desirable. The Trust therefore adopts an overarching Risk Appetite Statement which guides decision-making, ensuring that risks are understood, proportionately managed and aligned to the Trust's strategic priorities.

Risk management includes identifying and assessing risks and responding to them (treat, tolerate, terminate, transfer). The Trust's risk appetite sets out the level of risk it is willing to seek or accept in delivering its objectives. This is agreed by the Trust Board and is documented within the Board Assurance Framework.

All staff have a responsibility for identifying and minimising risk. This will be achieved within a culture of honesty, openness, and proactivity, where risks, system variability, and incidents are quickly identified and addressed.

3. Scope

This Policy applies to all members of staff throughout the Trust, including those working under a contract of service, volunteers, students, contractors, temporary staff and agency workers.

The Trust Board is assured through the work of the Audit Committee that it reflects currently available information, guidance and legislation governing the NHS, with the Committee providing independent oversight and scrutiny of the Trust's governance, internal control and risk management arrangements. Through regular review of compliance, external audit findings, internal audit reports, the Audit Committee ensures that the Trust's approach to risk remains robust, up-to-date and aligned to statutory and regulatory requirements.

This Policy establishes the arrangements that enable the Trust to:

- Actively identify uncertainties, so that threats can be mitigated and opportunities utilised
- Develop and maintain a mature, risk-aware and safety-focused culture across the organisation
- Ensure a consistent and integrated approach to risk management in everyday practice, embracing both clinical and corporate risks

- Ensure that risk management processes are applied across all relevant Trust activities, including (but not limited to) clinical care, operations, digital, estates, workforce, finance and strategic planning
- Maintain effective systems and structures for identifying, assessing, escalating, monitoring and recording risks via the Board Assurance Framework (BAF), Trust, Charitable Fund risks and Operational risks
- Use multi-source intelligence, including incidents, system variability, complaints, audits, claims, inspections and external recommendations (e.g., HM Coroner, CQC) - to improve quality and support organisational learning
- Provide assurance to the Board and senior leaders that risks are being effectively identified, managed and mitigated
- Demonstrate compliance with regulatory frameworks, including NHS England, the Care Quality Commission (CQC) and the Health & Safety Executive (HSE)
- Utilise Internal Audit effectively to provide independent assurance regarding the effectiveness of risk controls
- Maintain the Trust Risk Register, ensuring that risks and actions are regularly reported to the Risk Review Group (RRG), Committees of the Board, and the Trust Board in line with their Terms of Reference

4. Definitions

The following definitions are used throughout this policy.

Risk - the combination of the likelihood that an event will occur and the impact or consequences if it does occur. These consequences may be negative (threats) or positive (opportunities), and the level of risk increases as either likelihood or impact increases.

Risk Management - a process that helps the Trust understand, evaluate and take action on all risks, with the aim of increasing the probability of success and reducing the likelihood of failure to the benefit of patients, staff and the public.

Threat - a risk that may hinder the achievement of objectives

Opportunity - a risk that may help the achievement of objectives

Risk Appetite - the amount and type of risk the Trust is willing to pursue or tolerate in achieving its strategic objectives

Risk Tolerance - the specific threshold levels of risk beyond which the Trust is not prepared to operate

Board Assurance Framework (BAF) - details the procedures and actions the Trust has identified for risk management against key strategic objectives

Trust Risks - a risk with implications beyond a single team or directorate, including operational, clinical, financial, digital, workforce or strategic issues. Trust-level risks may be high, moderate or low in score and are recorded on the Trust Risk Register when they require oversight at Trust level. They do not sit within the Board Assurance Framework

Operational Risks - all risks associated with clinical and corporate, operational and administrative procedures related to service provision

Charitable Funds Risk - a charitable funds risk is the risk that events or decisions could adversely affect the proper stewardship, governance, compliance, or reputation of the Trust in its role as corporate trustee of charitable funds, or its ability to achieve the charity's objectives

Project Risks - a risk that may affect the delivery of a project's intended objectives

Risk Title – the risk title should describe the risk, the cause (due to), and the consequence. Clear risk articulation is essential for ensuring the risk is understood and correctly managed

Gross Risk Score – the initial score upon identification of the risk

Residual Risk Score – the current score upon application of controls

Target Risk Score – a reducing score to be achieved over an agreed period of time as further controls/mitigations are implemented until the risk can be eliminated or tolerated

Risk Treatment – a process to modify risk (4 T's Tolerate, Treat, Transfer, Terminate)

SMART Actions – where possible actions should be:-

- Specific
- Measurable
- Assignable
- Realistic
- Time bound.

Accepted Risks - the Trust accepts where further mitigation is not possible or feasible

Issue - an issue is a problem, event or situation that has already occurred and is currently affecting services, performance or delivery. Unlike a risk, which is a potential future event, an issue requires immediate action, management or resolution

Assurance – evidence that controls are in place and operating effectively to manage risks

Risk Owner – is the individual accountable person for ensuring a risk is managed, monitored and reviewed

5. Risk Appetite and Risk Tolerance

This section outlines how the Trust defines and applies its approach to risk appetite and risk tolerance.

Risk appetite represents the amount and type of risk the Trust is prepared to pursue or retain in achieving its strategic objectives.

The Trust Board reviews and approves a Risk Appetite Statement annually. This statement informs decision-making, the evaluation of strategic risks on the BAF, and the categorisation of risks into defined risk-type domains.

Risk tolerance is the acceptable level of residual risk. The Trust sets its tolerance threshold based on the level of risk it is prepared to accept, using tolerance categories such as None, Minimal, Cautious, Open, Seek and Significant.

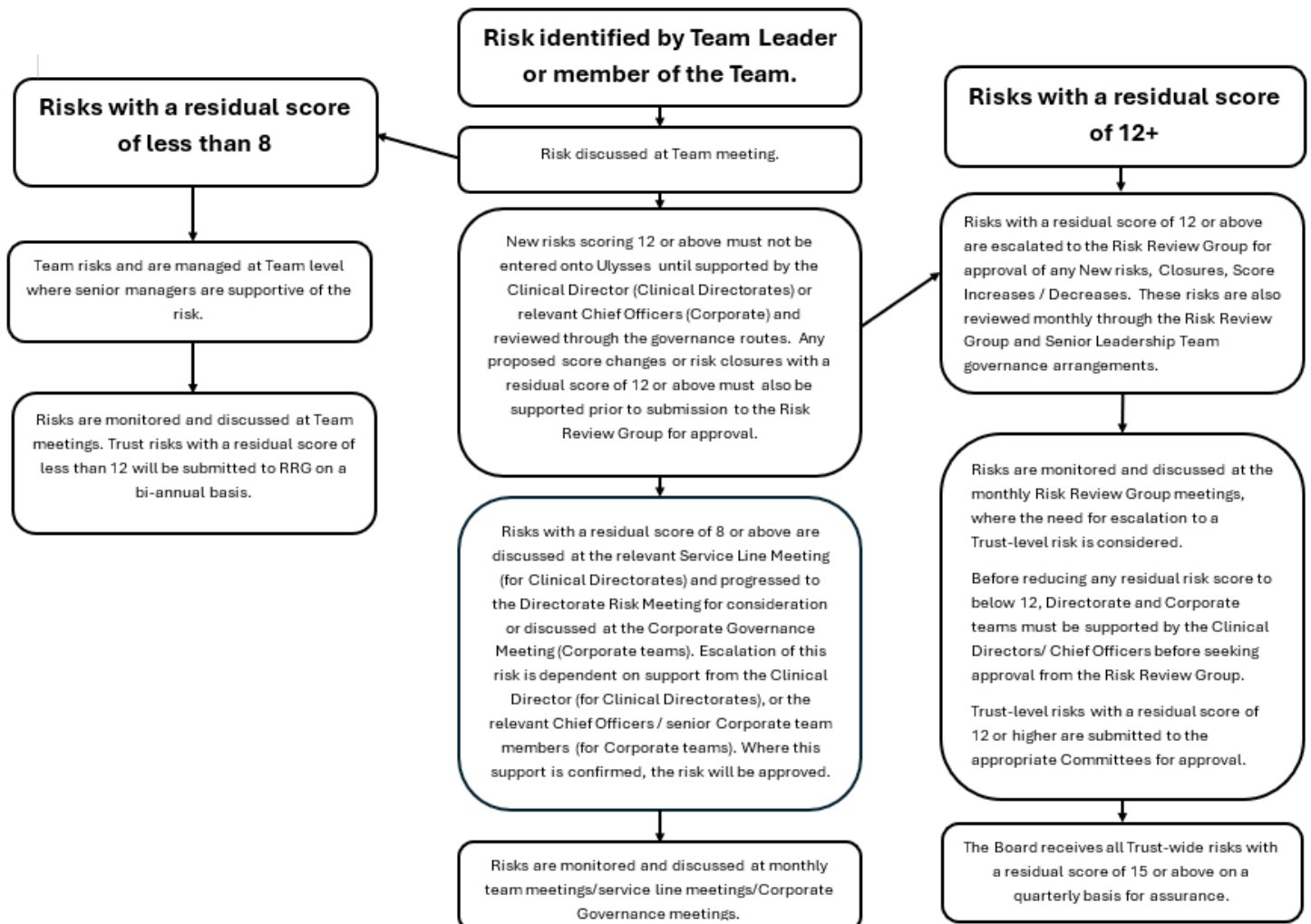
6. Risk Management Framework

The Trust has an established Risk Management Framework that provides a clear structure for identifying, assessing, escalating and managing risks across all levels of the organisation. The Framework ensures that risk information flows effectively from teams and directorates through the corporate governance system to the Trust Board.

The Trust has four risk levels within the management framework:

- 1 Board Assurance Framework (BAF)
- 2 Trust Risk Register
- 3 Directorate Risk Register
- 4 Team Risk Register

The risk management process that is in place for identification, recording, review and escalation is summarised in the flowchart below: -



The Three Lines Model

In line with NHS England's Risk Management Framework, the Trust adopts the Three Lines Model, which provides a clear structure for accountability and assurance across operational management, oversight functions and independent review.

First Line – Operational Management

The first line consists of all clinical, operational and corporate teams, including:

- Team Managers
- Directorate leadership
- Staff delivering care and support services

Responsibilities include:

- Identifying and assessing risks
- Implementing and monitoring local controls
- Maintaining Team and Directorate Risk Registers
- Escalating risks that exceed local control or tolerance

Second Line – Oversight and Governance

The second line provides organisational oversight, coordination and challenge through:

- Risk Review Group (RRG)
- Quality Committee
- Finance & Resources Committee
- People, Culture & Development Committee
- Charitable Funds Committee
- Remuneration Committee
- Audit Committee

Responsibilities include:

- Reviewing risks escalated from Directorates and overseeing Trust level and strategic risks
- Providing challenge and assurance on controls and mitigations
- Monitoring risk trends and organisational exposure
- Ensuring compliance with policy, process and regulatory standards

Third Line – Independent Assurance

The third line provides independent scrutiny and validation through:

- Internal Audit
- External Audit
- CQC and other regulators
- Independent reviews and inspections
- These bodies assess whether the risk-management processes and controls are effective, reliable and applied consistently across the Trust.

Governance Structure

Risk management is embedded within the Trust's governance structure, enabling clear lines of accountability and escalation:

Team → Directorate → Risk Review Group (RRG) → Committees → Trust Board.

Risk information flows upward through monthly reviews and formal reporting, ensuring that Trust risks, significant operational risks and emerging concerns are visible at the appropriate level. Decisions and assurance are fed back through the structure to support risk de-escalation.

Committees provide assurance across the following areas:

- Quality
- Finance, estates and resources and charitable funds
- Workforce, organisational development and senior staff remuneration

The Trust Board receives assurance through:

- Quarterly BAF reports
- Monthly Audit Committee updates via the QUADA Assurance Report
- Annual Governance Statement (AGS)
- Internal and External Audit findings reporting through Committees and into the Board via the QUADA Assurance Report

7. Risk Identification

The Trust adopts both proactive and reactive approaches to identifying, understanding and anticipating risks.

Proactive Identification

The Trust proactively identifies risk using a wide range of internal and external intelligence, including but not limited to:

- Audit outcomes and assurance reports
- Patient and staff surveys
- External enquiries and best-practice guidance
- CQC intelligence, regulatory findings and quality reviews
- NHS Oversight Framework Metrics
- Trust-wide benchmarked performance indicators (e.g., Model Hospital)
- Horizon scanning of local socio-economic changes, national policy changes and international public-health intelligence

This intelligence helps the Trust anticipate and respond to changes in the risk environment before they materialise.

Reactive Identification

Risks may also be identified through routine operational oversight and learning, including:

- Routine discussions within Teams and Directorates
- Monitoring of incidents, complaints, near misses and learning reviews
- Findings from Serious Incident (SI) investigations
- Internal audit, external audit and regulatory inspections
- Performance data, safety dashboards and trend analysis
- Quality Improvement discussions and governance meetings
- Issues arising from service transformation, business planning or system change
- Concerns raised through Freedom to Speak Up
- Feedback during multidisciplinary meetings and clinical forums
- Identification of compliance gaps with the Health & Social Care Act 2008 (Regulated Activities Regulations)

Risk identification begins with asking:

- What can go wrong?
- How could it happen?
- What would the effect be?

Strategic BAF Level Risk Identification

Strategic risk identification follows the Trust's annual planning cycle:

- The Board refreshes strategic objectives annually
- Strategic risks threatening delivery of strategic objectives are added to the BAF
- Each BAF risk is assigned to a Lead Chief Officer
- BAF risks are reviewed quarterly by the Board, with quarterly oversight through the RRG and Committees.

This ensures that BAF risks directly link to the Trust's Strategic Priorities: Prevention, Access and Growth.

Project Risks

Project risks are managed through project-level governance arrangements, with oversight provided via Portfolio Steering Group meetings with Chief Officer leadership. Project-specific risks are documented through project documentation. Where a project risk escalates to have wider operational or strategic impact, it will be considered through these governance routes and, where required, formally recorded on Ulysses as an Operational or Trust-level risk, with escalation to the Risk Review Group (RRG).

Recording Risks in Ulysses

All operational and Trust-level risks are recorded in the Ulysses Risk Management System and are managed by an identified Risk Owner. Strategic risks included in the Board Assurance Framework (BAF) are recorded separately and managed in line with the Trust's BAF process, while project risks are managed as described above.

All recorded risk titles must undergo a minimum annual review, with the review date documented in the Ulysses review section.

The Trust's Risk Register provides a single, consistent mechanism for identifying scoring, managing and escalating risks across all areas of the organisation.

This enables the Trust to:

- Identify and manage risks consistently across all services, in line with NHS requirements for systematic risk identification and escalation.

- Aggregate risk information to establish the Trust's overall risk exposure and highlight areas requiring additional control or monitoring.
- Support evidence-based decision-making on prioritisation, resource allocation and risk-reduction activity.

The Trust is committed to maintaining compliance with the *Health and Social Care Act 2008 (Regulated Activities) Regulations* and associated Fundamental Standards. Any essential quality or safety standards assessed as having a residual risk score of 12 or above will be considered for escalation to the Trust Risk Register. These risks will be submitted to RRG for monthly review to ensure appropriate mitigation and oversight.

8. Risk Assessment & Measurement

When the risks have been identified, each one will be analysed to assess the likelihood of it recurring, how often it is likely to occur and what the likely impact would be. Consideration of the controls in place for that risk and more importantly the adequacy and effectiveness of those controls will form part of the assessment. The culmination of this process is the prioritisation of the identified risks, within the Trust's Risk Registers, to create a manageable programme of risk targets.

The risk assessment process is based upon the following key definitions (see Appendix 1 – General Risk Assessment Form if required).

Risk Area/Hazard - An event which has the potential to inflict damage, loss or harm.

- Risk - the combination of the probability of an event and its consequence (Likelihood and Impact). Consequences can be positive or negative or a deviation from the expected outcome
- Loss - The consequent damage, loss or harm

The process of risk assessment is based on the key stages set out below:

Risk Identification:

- What can go wrong?
- How could it happen?
- What would the effect be?

Risk Analysis:

- How often is it likely to occur?
- What would the impact be?
- What are the potential operational, clinical, financial or reputational consequences?

Risk Control:

- How can the risks be eliminated?
- How can they be avoided?
- How can they be made less likely or reduce the impact?

Some risk assessments are legally required under various legislation, such as health and safety and food hygiene. Risk assessments should identify the significant risks arising out of the tasks/activities undertaken within the organisation and assess their potential too, for example:

- Cause injury or ill health to people

- Reduce quality of care/services
- Result in civil claims/litigation
- Result in enforcement action e.g., Health & Safety Executive (HSE)
- Cause damage to the environment
- Cause damage or loss to property
- Result in operational delays
- Result in loss of reputation
- Result in financial loss

Risk scores determine the level at which a risk is managed, reviewed and escalated.

Risk Assessment/Scoring

Risk is the combination of the probability of an event and its consequence (likelihood and impact). Consequences can range from positive to negative.

When scoring the level of risk you should consider the following two factors: -

- Likelihood
- Impact

Each risk should be given a gross, residual and target score

Gross Risk Score – the initial score upon identification of the risk.

Residual Risk Score – the current score upon application of controls/mitigations

Target Risk Score – a reducing score to be achieved over an agreed period as further controls/mitigations are implemented until the risk can be eliminated or tolerated.

Risks must be scored using the 5 x 5 scoring matrix as set out below (Using the guidance provided to determine impact and likelihood).

The impact score may vary across the gross, residual and target assessments. Gross impact reflects the inherent severity of the risk before any controls are applied. Residual impact reflects the severity after current controls, assurance and operating conditions are considered. Target impact represents the expected severity once planned mitigations or service improvements are fully implemented. Impact can change at each stage because new information, changes in service delivery, strengthened or weakened controls, or external factors may increase or reduce the potential consequence of the risk. Impact should therefore be reviewed and updated at each scoring stage to ensure it remains accurate and evidence based

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

This process will then generate scores for each identified risk; they will then be categorised as follows: -

Residual Risk Rating	Risk Priority	Reporting Level	Action
1-3	Low	Team	• Risks will be considered at team level and recorded on the Team Risk Register. • Risks will be owned by Team Manager/Leader who will work with the team to determine and implement mitigating actions. • Risk will be a standing agenda item at team meetings, where the Manager will share the team's risk register and hold discussion under the key headings of Existing, New, Escalated/De-escalated, and Closed risks. • The risk will be reviewed and updated on Ulysses in accordance with the review frequency determined for the risk, which may be less frequently than monthly based on the nature of the risk and the lower risk score. • Review frequency – recommended at least annually unless the nature of the risk determines otherwise.

4-6	Moderate	Team	• Risks will be considered at team level and recorded on the Team Risk Register. • Risks will be owned by Team Manager/Leader who will work with the team to determine and implement mitigating actions. • Risk will be a standing agenda item at team meetings where the Manager will share the teams risk register and hold discussion under the key headings of Existing, New, Escalated and Closed risks. The risk will be reviewed and updated on Ulysses in accordance with the review frequency determined for the risk, which may be less frequently than monthly based on the nature of the risk and the lower risk score. • Review frequency – recommended at least 6 monthly as a minimum unless the nature of the risk determines otherwise.
8-10	Significant	Directorate	• Risks will be considered at team level and recorded on the Directorate Risk Register. • Risks will be owned by the Clinical Director (unless a more appropriate person is identified) and reviewed during monthly Directorate meetings where key members of the Directorate are present. • Directorate Risk Leads will update risks on the Ulysses Risk Management System. • Review frequency – recommended monthly as a minimum unless the nature of the risk determines otherwise.
12	Significant	Directorate/ RRG	• Risks will be considered at Directorate level, recorded on the Directorate Risk Register, and owned by the Clinical Director or Chief Officer. • Reviewed monthly by the Directorate and by the RRG. • These risks will also be considered by RRG for escalation to the Trust Risk. • The Risk Manager will update those risks recorded on the Trust Risk Register. • Directorate Risk Leads will update risks retained at Directorate level.

15-25	High	Directorate/ RRG	• Operational risks will be considered at Directorate level, recorded on the Directorate Risk Register and owned by the Clinical Director or relevant Chief Officer. • Reviewed monthly by the Directorate and the RRG, these risks will also be considered by RRG for escalation to the Trust Risk Register. • The Risk Manager will update those risks recorded on the Trust Risk Register. • Directorate Risk leads will update risks retained at Directorate level. • Escalation of a Directorate risk to Trust level will transfer ownership to the relevant Chief Officer. • Trust level risks will be aligned to their relevant Committee and report directly into the Committee for monitoring and decision making.
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RISK ASSESSMENT MATRIX - From the Trust's Risk Management Strategy

Measurement of Likelihood

	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certainly 5
Descriptor					
How often might it/does happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Time-framed descriptors of frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Measurement of Consequence

Domains	Consequence score (severity levels) and examples of descriptors				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Impact on the safety of patients, staff for public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention. Requiring time off work for 3 days. Increase in length of hospital stay by 1–3 days.	Moderate injury requiring professional intervention. Requiring time off work for 4–14 days. Increase in length of hospital stay by 4–15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.	Major injury leading to long-term incapacity/disability. Requiring time off work for 14 days. Increase in length of hospital stay by 15 days. Mismanagement of patient care with long-term effects.	Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.

Consequence score (severity levels) and examples of descriptors					
Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Quality/Complaints/ Audit	Peripheral element of treatment or service sub-optimal. Informal complaint/inquiry	Overall treatment or services sub-optimal. Formal complaint (Stage 1). Local resolution. Single failure to meet internal standards. Minor implications for patient safety if unresolved. Reduced performance rating if unresolved.	Treatment service has significantly reduced effectiveness. Formal complaint (Stage 2). Local resolution (with potential to go to Independent Review). Repeated failure to meet internal standards. Major patient safety implications if findings are not acted upon.	Non-compliance with national standards with significant risk to patients if unresolved. Multiple complaints/Independent Review. Low performance rating. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety if findings not acted upon. Inquest/Ombudsman Inquiry. Gross failure to meet national standards.

Domains	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Human Resources /Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (>1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff. Unsafe staffing level or competence (<1 day). Low staff morale. Poor staff attendance for mandatory/key training.	Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory/key training.	Non-delivery of key objective/service due to lack of staff. On-going unsafe staffing levels or competence. Loss of several key staff. No staff attending mandatory training /key training on an on-going basis.

Consequence score (severity levels) and examples of descriptors					
Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Statutory Duty/ Inspections	No minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance rating if unresolved.	Single breach in statutory duty. Challenging external recommendations on Improvement Notice.	Enforcement action Multiple breaches in statutory duty. Improvement Notices. Low performance rating. Critical report.	Multiple breaches in statutory duty. Prosecution. Complete systems change required. Zero performance rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours. Potential for public concern.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage - long-term reduction in public confidence.	National media coverage with (>3 days) service well below reasonable public expectation.	National media coverage with (>3 days) service well below reasonable public expectation. MP concerned (questions in the House). Total loss of public confidence.

Domains	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Business Objectives/ Projects	Insignificant cost increase/schedule slippage	>5% over project budget. Schedule slippage.	5%-10% over project budget. Schedule slippage.	Non-compliance with national 10%-25% over project budget. Schedule slippage. Key objectives not met.	Incident leading >25% over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss. Risk of claim remote.	Loss of 0.1%-0.25% of budget. Claim less than £10,000.	Loss of 0.25%-0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective/losses of 0.5%-1% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective/loss of >1% of budget. Failure to meet specification/slippage. Loss of contract/ payment by results. Claim(s) >£1 million)
Service Business interruption environmental impact	Loss/interruption of <1 hour. Minimal or no impact on the environment.	Loss/interruption of >8 hours. Minor impact on environment.	Loss/interruption of >1 day. Moderate impact on environment.	Loss/interruption of >1 week. Major impact on environment.	Permanent loss of service for facility. Catastrophic impact on environment.

9. Risk Evaluation

Risk evaluation takes place once a risk has been reviewed to determine whether the residual level of risk is acceptable or whether further action or escalation is required. Evaluation considers whether the mitigating actions in place are effective and whether the current level of exposure indicates the need for additional mitigation. Risks assessed as requiring further attention should be reviewed through the appropriate governance routes.

Risk evaluation also includes re-examining risks dynamically when new information becomes available, circumstances change, or planned actions are completed. Where this results in a change to the residual score, the risk must be escalated or de-escalated through the relevant governance process, and the decision recorded and updated in Ulysses.

10. Risk Treatment

In planning the response or 'treatment' of an identified risk, the following principles should be considered:

- Balancing relative risks: where the management of one risk adversely affects the management of another or increases its rating, a decision will be needed on whether to proceed with planned controls, based on the significance of each risk
- Avoiding the creation of new risks: establishing controls or mitigations for one risk may inadvertently create additional risks; proposed measures should therefore be assessed for unintended consequences
- Ensuring mitigation is proportionate: controls must be proportionate to the level and significance of the risk, taking account of time, effort and resources.
- Monitoring changes in risk ratings: ratings and controls must be reviewed regularly. Although priority is influenced by risk level, attention should not focus solely on high and extreme risks
- Aligning risk management with policies and procedures: treatment should be consistent with relevant Trust requirements
- Understanding impact vs likelihood: the impact of a risk occurring will generally remain the same; treatment usually aims to reduce the likelihood of risk materialising

The aim of risk treatment is to reduce the residual risk toward the agreed target risk score.

11. Levels and Escalation/De-Escalation

Board Assurance Framework (BAF)

BAF risks represent the Trust's principal strategic risks that have the potential to impact delivery of the Trust's strategic objectives. These risks are recorded on the BAF and are owned by a Chief Officer, reflecting the need for strategic oversight, assurance and alignment to organisational priorities. BAF risks are reviewed through the Trust's corporate governance structure and monitored via formal reporting arrangements to the relevant Committees, the Risk Review Group and the Board. Their impact extends across multiple services or functions, meaning they require Trust-wide coordination to ensure effective controls, robust assurance and timely mitigation.

The BAF is maintained as a standalone document outside of the Trust's Ulysses Risk Management System, reflecting its role in capturing strategic risks rather than Trust or Operational risks.

The Trust Risk Registers are held on the Ulysses Risk Management system to improve clarity of reporting, linking and monitoring of risks, evidencing mitigations and enabling accurate, clear reports to be extracted as required.

Trust Risks / Trust Risk Register

Trust-level risks are those that have an impact beyond a single team or directorate and require coordination, oversight and action at an organisation-wide level. These risks are entered onto the Trust Risk Register and assigned to a Chief Officer as the designated risk owner, reflecting the need for organisation-wide controls, resources and assurance. Trust-level risks are reviewed through the Trust's corporate governance structure and monitored via established reporting arrangements, including the Risk Review Group, relevant Committees and the Board. Their impact extends across multiple services or functions, meaning they cannot be managed solely at operational level and therefore require Trust-wide collaboration to ensure appropriate mitigation and assurance are in place. Trust-level risks may also have a residual score below 12, as classification is based on their strategic and organisational impact rather than the numerical score alone. Where a risk is classified as Trust level but has a residual score below 12, it must still be presented to the relevant governance meeting for approval before being included on the Trust Risk Register.

Directorate Risk Register – Residual Score above 8.

Risks with a residual score of 8 and above will be escalated to Directorate level for review and approved at the monthly Directorate risk review meeting. These risks may still be managed within the Directorate where their impact is limited to a single team or service, and they do not meet the criteria for a Trust-level risk. Risks scoring 12 or above must be escalated for further consideration; however, they will only be classified as Trust-level if their impact is organisation-wide, strategic, or requires oversight through a Trust Committee. Where a risk scores 12 or above but its impact remains confined to a single team or Directorate, it will be recorded and managed as a Directorate-level risk under the oversight of the Clinical Director. Where a risk's residual score increases to 12, it must be presented to the Risk Review Group (RRG) for approval before any

change in risk level or escalation is applied. Any risk with a residual score of 12 or above must be approved by the Clinical Director (for Clinical Directorates) or by the relevant Chief Officer (for Corporate Directorates) before being proposed for discussion/approval at the monthly RRG. The designated risk owner must be the Clinical Director or Chief Officer as appropriate.

Team Level – Residual score below 8.

Team risks with a residual score below 8 remain at team level for ongoing management and review. These risks are owned by the Team Manager, who is responsible for ensuring that appropriate controls, actions and monitoring arrangements are in place. Team-level risks are discussed as part of routine monthly team meetings, with progress reviewed in line with the agreed review date. Where the nature or severity of the risk changes, the Team Manager must reassess the risk and, where appropriate, escalate it for consideration at Directorate level.

Corporate Teams

May hold risks at Team, Directorate or Trust level depending on the scope and organisational impact of the risk. Risks that relate solely to the work of an individual corporate team will be managed at Team level by the relevant Corporate Manager. Where a corporate risk reaches a residual score of 8 or above, it will be escalated for review and oversight within the relevant corporate Directorate and governance oversight group. If a corporate risk has a residual score of 12 or above but its impact is confined to a single team or Directorate, it will remain classified and managed as a Directorate-level risk; however, ownership must be assigned to the relevant Chief Officer to ensure appropriate Chief Officer oversight. All corporate risks with a residual score of 12 or above must be reviewed and approved by the appropriate Chief Officer prior to being presented for discussion and validation at the Risk Review Group (RRG) monthly meeting. Corporate risks that have organisation-wide or strategic impact, or relate to statutory or regulatory requirements, will be escalated to the Trust Risk Register and owned by a Chief Officer. This approach ensures that risks arising within corporate services follow the same escalation and assurance processes as clinical and operational risks and are managed consistently at the appropriate level within the Trust's governance framework.

12. Risk Monitoring & Review

Risks must be dynamically monitored, because risks change constantly, effective control can only be achieved when risk information, associated controls and assurance evidence are kept current.

Review Frequency

Strategic (BAF) Risks – Quarterly Review

Strategic risks recorded on the BAF are reviewed and updated on a quarterly basis through the Trust's established corporate governance process, with oversight by Chief Officers, Committees and the Board.

Monthly Review – High/Significant/ Moderate Risks

All risks with a residual score of 8 or above must be reviewed at least monthly by the Risk Owner, or sooner where required (e.g., when new information emerges, the score changes, or existing controls are found to be ineffective). These risks must also be discussed through the appropriate governance routes, including Directorate Service Line meetings, Directorate Risk meetings, relevant Corporate Governance monthly meetings, and—for risks scoring 12 or above—the Risk Review Group (RRG) and the appropriate Committees, depending on the nature and classification of the risk. Review frequencies represent a minimum requirement and may be increased where necessary but must not be extended beyond the recommended timeframe.

Following each review, the risk record must be updated on the Ulysses Risk Management System to reflect any changes in score, controls or actions.

Team Level Risks (Below 8)

All risks with a residual score below 8 must be reviewed in line with the policy, which outlines the suggested review timeframes in Section 8: Risk Assessment and Measurement. A review must take place earlier where circumstances change, new evidence emerges, or where an emerging issue indicates a potential increase in severity or likelihood.

13.Training Resources

All staff receive risk management awareness training as part of the Trust Induction Programme.

Board members and Senior Managers will receive periodic risk management training as part of the Trusts Board Development Programme.

The Risk Manager works with Clinical Directors, Associate Directors, Quality Improvement Leads, Service Managers, Ward Managers/Deputies, Team Leaders and Directorate Risk Leads to provide guidance and support.

The Trust also provides a Risk Avatar (*RiTA*) e-learning module, available on CAT, which covers the basics of risk management.

The Risk Manager offers group and one-to-one training sessions for Managers as required, covering:

- the risk management process, including identification, assessment, escalation and review
- the practical use of the Ulysses Risk Management System for recording, updating and managing risks

The Risk Manager and Directorate Risk Leads provide ongoing advice and support to staff involved in risk management. A dedicated Risk Management page on CAT contains useful information, guidance documents, templates and key contact details.

14. Roles & Responsibilities

The Trust has six Committees that report to the Board: Charitable Funds, Finance & Resources, People, Culture & Development, Quality, Audit, and Remuneration. Each Committee operates under an agreed set of Terms of Reference, which are reviewed annually. Responsibilities for risk management are defined within the Terms of Reference of each Committee and its respective sub-committees.

Trust Board

The Trust has an established Board and Committee Governance Framework that supports the implementation of this Risk Management Policy. This infrastructure enables effective escalation, scrutiny and assurance across all levels of the organisation.

The Deputy Director of Governance is accountable for delivering the Risk Management Framework and ensuring that risk management processes provide the Board with adequate and appropriate information and assurance on risks that may threaten the Trust's strategic objectives.

The Trust Board is required to approve the annual NHS Provider self-certification (G6) confirming that the Trust's risk management systems are effective and fit for purpose. G6 is one of the general conditions that NHS providers (e.g. NHS trusts and foundation trusts) must comply with. In simple terms, it requires that a provider:

Has robust systems and processes in place to:

- identify risks of non-compliance
- prevent those risks happening

Takes all reasonable precautions to comply with:

- the provider licence
- NHS legislation (e.g. NHS Acts)

Has robust systems and processes in place to:

- identify risks of non-compliance
- prevent those risks happening

Takes all reasonable precautions to comply with:

- the provider licence
- NHS legislation (e.g. NHS Acts)

The Board have taken “**all such precautions as were necessary**” to comply with licence conditions and legal requirements.

This includes assurance that:

- Risk management systems are effective
- Compliance monitoring is in place
- Governance structures support legal and regulatory compliance

The Trust Board will:

- Receive the Risk Policy (3 yearly)
- Receive quarterly BAF reports summarising strategic risks, controls and assurances
- Receive monthly updates from the Audit Committee via the QUADA Assurance Report
- Receive assurance through the Annual Governance Statement (AGS), included within the Annual Report and Accounts, confirming the effectiveness of internal control and risk systems via the Audit Committee QUADA Assurance Report

Audit Committee

The Audit Committee will seek assurance on behalf of the Board that the Trust has an effective system of internal control, integrated governance and risk management across all clinical and non-clinical areas.

The Audit Committee will:

- Receive annually from Internal Audit, assurance on the effectiveness of risk management systems
- Seek additional assurance from External Audit where required
- Review the adequacy of controls for all key risks including quality, finance, workforce and business development

The Quality Committee will:

- Focus on risks threatening delivery of the Trust’s quality objectives
- Oversee patient safety, clinical effectiveness, patient experience and statutory compliance
- Scrutinise mitigation plans

The Finance & Resources Committee will:

- Focus on risks that threaten delivery of the Trust's finance and resources objectives.
- Oversee financial performance, resource allocation and compliance with governance requirements.
- Scrutinise mitigation plans.

The People Culture and Development Committee will:

- Focus on risks relating to workforce, culture and organisational development
- Oversee workforce planning, leadership development, staff experience and regulatory compliance.
- Scrutinise mitigation plans

Remuneration Committee will:

- Focus on risks relating to workforce and pay systems compliant with national guidance, manage risks associated with Very Senior Manager (VSM) pay and retention
- Ensures compliance with Fit and proper Person's requirements
- Scrutinise mitigation plans

Charitable Funds Committee will:

- Focus on risks relating to protecting the Charities assets and reputation why ensuring compliance with legal and regulatory standards
- Risk Management in this context aims to support the Charities strategic goals by systematically identifying, assessing and mitigating risks related to its activities
- Scrutinise mitigation plans

Each Committee receives a risk report detailing the risks linked to their respective Committee with a residual score of 12 and above. Proposed score changes, new risks and risk closures are first reviewed and approved through the Risk Review Group (RRG), before being escalated to the respective Committee for oversight and ratification.

Each Committee should review their associated risks scoring less than 12 on a bi-annual basis.

Risk Review Group (RRG)

The RRG meets monthly and comprise the Trust Chief Officers, Clinical Directors, the Deputy Director of Governance and other members as specified within its Terms of Reference. This senior membership ensures that risk is considered at the highest level of the organisation. The RRG reviews and approves risks where the residual score is 12 or above, after which the relevant Trust-level risks are submitted to the appropriate Committees for final approval and oversight.

The RRG also receives a bi-annual report of all risks with a residual score below 12, to provide assurance that these risks continue to be managed appropriately

Chief Executive

The Chief Executive will:

- As Accountable Officer for the Trust, be ultimately accountable for all risks in the Trust
- Delegated responsibility from the Board as the Trust lead on the overall system of Risk Management
- Provide the Audit Committee and Trust Board with the necessary assurance that supports the Annual Governance Statement

Chief Officers

The Chief Officers will:

- Identify and measure risks that threaten delivery of the Trust's strategic and annual objectives
- Monitor and review processes for effective Trust-wide risk management
- Take overall responsibility for Trust-level risks and ensure risk treatment plans are in place
- Keep the Senior Leadership Team and Trust Board fully informed of all Trust risks
- Ensure each Chief Officer formally reviews the risks they own
- Ensure risk treatment plans are timely, proportionate and effective
- Be accountable for the performance of Corporate Teams risk management within their designated portfolio

Clinical Directors

These officers will:

- Actively manage all Directorate risks (clinical, financial, operational, workforce, digital, estates, corporate)
- Nominate a Directorate Risk Lead
- Ensure annual review of all Directorate risk assessments, including ligature assessments where applicable
- Ensure risk assessments and treatment plans are implemented in a timely manner

- Ensure all identified risks are entered into the Directorate Risk Register with treatment plans
- Maintain monthly Directorate risk reviews and ensure risks align with the Trust Risk Register
- Ensure risk is a standing agenda item at Directorate and team meetings
- Develop and implement robust monitoring arrangements for the Directorate through the formal monthly review of Directorate risks at the Directorate
- Risk Meetings, with agreed actions / reviews added directly into the risk management system (Ulysses)
- Ensure that Risk is a standing agenda item at Directorate, Service Lines and Team Meetings, recorded in accordance with audit requirements under the headings: Existing, New, Escalated/De-escalated and Closed
- Ensure that risks managed at team level are escalated to the Directorate where appropriate
- Ensure alignment between the Directorate Risk Register and the Trust Risk Register, consistent with Trust-wide governance and escalation processes

Deputy Director of Governance

The Deputy Director of Governance will:

- Act as the Trust's Risk Management Policy Lead, ensuring the policy remains current and compliant
- Lead and maintain the Board Assurance Framework (BAF)
- Maintain responsibility for the development, review and publication of the Trust's Risk Management Policy
- Manage the Trust Risk Register, ensuring appropriate control and quality assurance of its contents
- Co-ordinate all aspects of the Trust's risk-management arrangements and produce the Trust-wide Risk Report
- Co-ordinate formal reporting to the Trust Board's sub-committees (Audit Committee, Quality Committee, Finance & Resources Committee, People, Culture & Development Committee, Charitable Funds Committee and Remuneration Committee).
- Ensure that staff have access to appropriate advice, support and guidance in applying the risk-management process.

Risk Manager

The Risk Manager will:

- Support the Deputy Director of Governance in strengthening and embedding effective risk-management practices across the Trust.
- Work with Clinical Directors, Associate Directors and Directorate Managers to support the review, monitoring and escalation of Directorate risks, ensuring that Trust policy and procedures are consistently followed.
- Support the Chief Officers with reviewing, updating and validating Trust-level risks.

- Lead on the review and update of the Risk Management Policy as required.

All Staff

All Staff will:

- Every member of staff has a responsibility to understand and apply the Trust's Risk Management Policy. Staff must have an awareness of risks and the processes for identifying, recording, reviewing, and escalating risks. Through regular team discussions, staff should understand the risks on their team's Risk Register and be aware of the key risks affecting their Directorate
- All incidents should be reported and managed in line with the Trust's Incident Reporting process
- Promote a fair, open, non-blame culture for risk reporting
- Ensure effective implementation of risk processes and policies
- Support staff in applying the risk-management procedure
- Raise awareness of risk management within their areas of responsibility
- Understand and apply the Trust's Risk Management Policy
- Identify, record, review and escalate risks through local processes
- Participate in required Health & Safety and risk-management training
- Report incidents, near misses and risks promptly
- Take reasonable steps to reduce risks and stop unsafe practice
- Own risks until resolved or formally handed over

15. Review & Evaluation of the Policy

Compliance with this policy will be monitored through the roles and responsibilities sections as outlined above and via the monthly Trust Risk Review Group. Where compliance is deemed to be insufficient and the assurance provided is limited, an action plan will be developed to address the gaps. Progress against the action plan will be monitored via the Risk Review Group.

This Risk Management Policy will be reviewed every 3 years or earlier considering new national guidance/other significant changes.

16. Assurance

The Trust obtains assurance on the effectiveness of its risk management arrangements through a combination of internal and external oversight mechanisms. Assurance is gained through the operation of the Trust's governance structure, with risk oversight, monitoring and review undertaken at multiple levels.

The Trust's RRG provides routine oversight of Trust-wide and Directorate risks, ensuring that escalation, de-escalation and mitigation processes are applied consistently.

17. Appendix

General Risk Assessment

Appendix 1

The purpose of the risk assessment is to identify hazards/concerns and to implement measures to control the risk. This form should be used where there is no specific legislative guidance or risk assessment methodology available and as such it is used for 'general' or 'non-specialist' risk assessment.

The Management of Health and Safety at Work Regulations 1999 requires every employer to make a suitable and sufficient assessment of: -

- *the risks to the health and safety of employees to which they are exposed whilst they are at work*
- *the risks to the health and safety of persons not in his employment arising out of, or in connection with the conduct by him of this undertaking*

Work activity/process/concern being identified			
Reason for assessment: (e.g. mandatory/ periodic review/ adverse incident / complaint / concern raised)			
Department/Ward/Area:		Name(s) of Manager	
Site:			
Directorate:			
Date of Assessment		Date of first Review	Review Frequency
<u>Undertaking the risk assessment:</u>		<u>Identify hazards</u> <u>Decide who might be harmed and how</u> Are they at risk? <u>Consider the risks</u> Are the precautions already taken adequate to deal with the risks? <u>Record your finding</u> <u>Regularly review the assessment.</u> If any significant changes take place, make ensure existing precautions and management arrangements are still adequate to deal with the risks	
Using the Trust's Risk Matrix what is the level of risk			
Risk score without current control (Gross risk)		Risk score with current control (Residual risk)	
Target risk score		Is this risk to be entered on the Risk Register held on Ulysses?	

Name of Assessor	Signature	Date
-------------------------	------------------	-------------

Note: the Line Manager should sign below to show that the assessment is a correct and reasonable reflection of the hazards and of the control measures and actions required		
Line Manager`s Name	Line Manager`s Signature	Date

What are the hazards	Who might be harmed	What control measures are currently in place	
What further actions are necessary to control the risk?	Action by who?	Action by when?	Date completed

Risk Assessment Review

Your risk assessment should be reviewed:

- Following an accident/incident
- If the assessment may no longer be valid
- If changes to the process have occurred
- At intervals dictated by the initial assessment
- If concerns are raised

Have there been any major changes affecting hazards and risks? If Yes , complete a new risk assessment .		Yes/No	
Name of person completing review			
Review Date	Outstanding actions	Action by who	Date completed

Note: The Line Manager should sign below to show that the assessment is a correct and a reasonable reflection of the review of hazards and of the control measures and actions required

Line Manager's Name	Line Manager's Signature	Date

Enclosure No: 5

Health and Safety annual report

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	10 July 2026
Assure	☒	Advise	☐		
Information	☐				

Presented by:	Zoe Grant, Acting Chief Nursing Officer
Prepared by:	Adrian Greensill Health and Safety Advisor
Executive Lead:	Zoe Grant, Acting Chief Nursing 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 3 - Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Approval / Review:	SLT
Strategic Priorities:	Prevention - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	Demonstrate where we are aligning our Strategy to the ICS

Recommendation / Required Action:	To receive for assurance and information.
Executive Summary:	Executive Summary This report provides the Health, Safety & Wellbeing Group (HSWG) with an overview of Trust health and safety performance for 2025–2026, in line with statutory obligations under the Health and Safety at Work etc. Act 1974. It summarises incident reporting trends, violence and aggression (V&A), injury outcomes, hate crime incidents, Right Care Right Person interface issues, potential blood-borne virus exposure (BBVE), and audit activity, highlighting key risks, learning, and assurance. A total of 2,008 health and safety and physical assault incidents were reported during the year. Violence and aggression incidents accounted for the majority of reports, with quarterly totals ranging from 390 to 613 incidents. Other incident categories, including manual handling, sharps injuries, slips, trips and falls, and vehicle incidents, remained comparatively low and stable. Violence and Aggression Analysis demonstrates an upward trend in V&A incidents over the final two quarters, following a sustained period of reduction. November 2025 and February 2026 recorded particularly high levels of reporting, with February 2026 the highest single month. Importantly, the increase in incident volume is driven by a small number of acutely unwell patients, particularly within high-acuity inpatient settings. The ten patients with the highest incident frequency consistently accounted for a disproportionate share of incidents. Incidents were predominantly concentrated within acute inpatient services, with PICU, Assessment & Treatment, and general adult wards accounting for approximately 60% of all V&A incidents. PICU alone contributed 349 incidents (21%), reflecting the complexity and acuity of patient presentations. Community and specialist teams reported comparatively low volumes, with monthly variation suggesting episodic pressure rather than a Trust-wide escalation of risk. Harm and Injury Outcomes Despite increased incident volumes, the harm profile remains stable and predominantly low. Approximately 80% of incidents resulted in no harm, with a further ~19% resulting in minor injury. Moderate and severe injuries remain rare. Injury rates have remained consistent across all four quarters

(18–21%), providing assurance that increased reporting has not translated into increased severity of harm.

High-volume areas, including PICU, demonstrated comparatively low injury rates, suggesting effective risk management, staff competence, and de-escalation practices. Conversely, some lower-volume areas recorded higher injury rates, indicating the need for targeted review of local controls, staffing, training, and environmental factors, rather than organisation-wide interventions.

Hate Crime

A total of 119 V&A incidents were recorded as hate crime, representing a small proportion of overall reporting. Incidents were concentrated within high-acuity inpatient areas, particularly PICU and neurological wards. The predominant category was race-related abuse from patients towards staff, accounting for the majority of reports. Quarterly trends mirrored overall V&A activity and are likely reflective of periods of heightened clinical acuity. There is no evidence of systemic or organisational issues, but the data reinforces the importance of continued staff support, clear reporting pathways, and zero-tolerance messaging within high-risk environments.

Right Care Right Person (Police Interface)

A small number of incidents (n=12) were reported relating to lack of police response, with half involving risk to self and/or others. While volumes are low, the nature of these incidents presents potential high-impact safety risks. Themes relate primarily to communication and response-time challenges, rather than refusal of support, and will continue to be addressed through established multi-agency escalation and partnership arrangements.

Blood-Borne Virus Exposure (BBVE)

A total of 112 potential BBVE incidents were identified across the year, with 29 incidents in the final quarter following data cleansing. Review identified gaps between advice given to staff and subsequent contact with Occupational Health, with six cases lacking evidence of follow-up. A new post-incident BBV questionnaire has been introduced on Ulysses, and further work is required to strengthen data quality, staff compliance with the BBV pathway, and assurance around post-incident management.

Assurance and Forward Actions

Overall, the report provides assurance that the Trust has effective systems for incident reporting, investigation, and learning, with no evidence of widespread or uncontrolled risk. Key priorities moving forward include:

- Continued monitoring and targeted management of violence and aggression linked to high-acuity patients
- Focused review of areas with higher injury rates despite lower incident volumes
- Strengthening BBVE pathway compliance and data integrity
- Delivery of the Health and Safety Audit Programme, including ligature risk assessment refresh and expanded drop-in audits across wards and community sites

The HSWG is asked to note and accept this report for the current period and year, taking assurance from the findings and supporting the recommended areas of focus.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Health Safety and Wellbeing Committee	27/04/2026
V2	Quality Committee	25/06/2026
V2	Public Trust Board	03/07/2026

Annual Health & Safety Report – 2025 -26

1. Introduction

Ensuring the health, safety and wellbeing of all staff, patients, visitors and other stakeholders remains a statutory obligation under the Health and Safety at Work etc. Act 1974, and is integral to the Trust's commitment to safe, high-quality care.

The Trust is required to systematically identify, assess and control risks arising from its activities. This includes the effective management of risks to patient safety, staff, members of the public, and Trust assets.

In discharging these responsibilities, the Trust must demonstrate full compliance with relevant statutory requirements and the standards set by the Health and Safety Executive (HSE) and other regulatory bodies. Robust governance arrangements and ongoing performance monitoring are essential to provide assurance to the Board that these duties are being met.

2. Scope

This report provides the Health, Safety and Wellbeing Group (HSWG) with a comprehensive overview of health and safety performance for the current reporting period and year to date. It is intended to support governance, oversight and assurance processes by:

- Presenting an analysis of reported health and safety incidents
- Identifying key trends, emerging risks and areas of concern
- Highlighting organisational learning and improvement actions
- Providing updates on policy and procedural developments
- Summarising findings from quarterly health and safety audits
- Reporting on any regulatory or enforcement actions

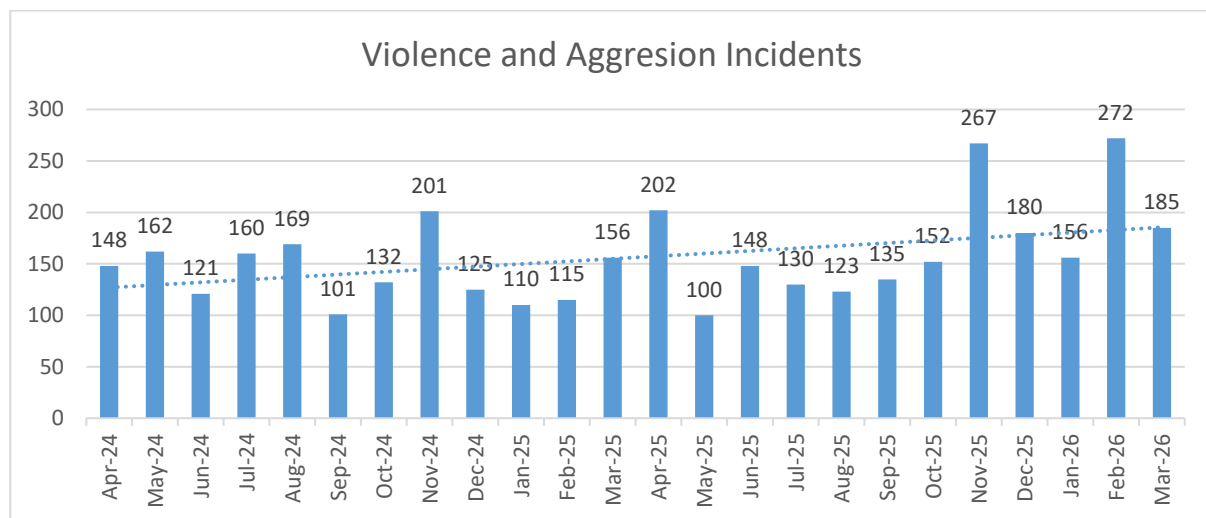
The Health, Safety and Wellbeing Group is requested to review the content of this report, note the key issues identified, and provide assurance to the Board regarding the effectiveness of health and safety management arrangements across the Trust.

3. Incident Analysis

Table 1 Incidents by type

	Q1 2025/ 2026	Q2 2025/ 2026	Q3 2025/ 2026	Q4 2025/ 2026
Manual Handling	1	3	3	2
Other Accident (Patient)	20	13	9	10
Other Incident (Staff)	0	3	4	3
Sharps/Needlestick/ (Patients)	0	1	0	3
Sharps/Needle stick (Staff)	0	2	2	2
Slip, Trip And Falls - Visitor	0	2	1	1
Slips, Trips And Falls - Patient	114	128	134	128
Slips, Trips And Falls - Staff	0	0	6	1
Vehicle incident	1	1	2	1
Violence/Assault	450	391	613	555
Grand Total	587	541	797	701

Graph 1 incidents of violence and aggression by month



Violence and Aggression Incident Analysis

Analysis of violence and aggression (V&A) incident reporting demonstrates an upward trend over the most recent two quarters, following a sustained reduction over the preceding four quarters. This represents a notable change in trajectory and warrants continued monitoring (see Graph 1).

November 2025 and February 2026 recorded particularly elevated levels of reported incidents, with February 2026 representing the highest number of incidents within the reporting period.

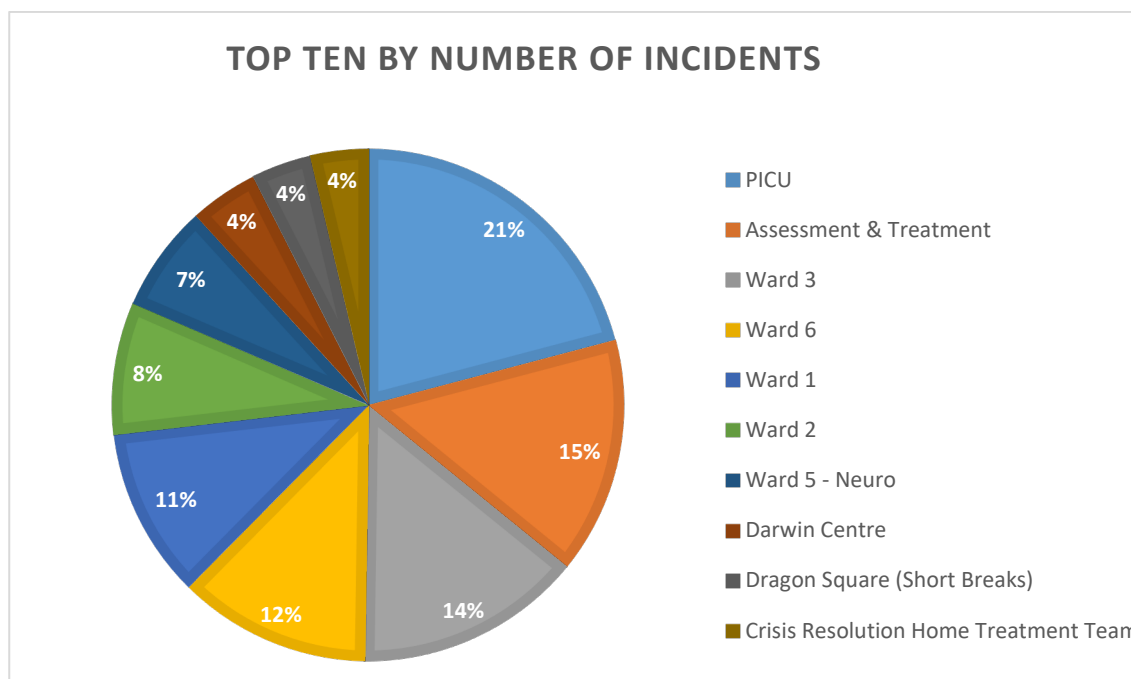
In February 2026, a total of 272 violence and aggression incidents were reported. The ten patients with the highest incident frequency accounted for 128 incidents (47%), indicating a significant concentration of incidents within a small cohort.

Conversely, May 2025 recorded the lowest number of reported incidents (100). Despite the overall reduction in incident volume, the ten patients with the highest incident frequency were responsible for 57 incidents (57%), demonstrating a continued disproportionate contribution from a limited number of individuals.

Further investigation suggests that the recent increase in reported incidents is primarily driven by a small number of acutely unwell patients, particularly within high-acuity settings. For example, during Q4 2026, one patient within the Psychiatric Intensive Care Unit (PICU) accounted for 62 incidents (37%) of the 168 V&A incidents reported on PICU during the quarter. Additionally, in March 2026, a single patient accounted for 24 incidents (43%) of the 55 V&A incidents reported on PICU during that month.

Overall, the data indicates that violence and aggression incidents remain concentrated within a small cohort of high-risk patients, irrespective of overall reporting volume. This pattern reinforces the need for enhanced patient-specific risk assessments, dynamic management and de-escalation plans, multidisciplinary oversight, and targeted interventions to mitigate risk, support staff safety, and reduce repeat incidents.

Graph 2 Top 10 locations by number of incidents reported



This pie chart shows the top ten locations by number of reported violence and aggression incidents for the reporting period. Each segment represents the proportion of total V&A incidents attributable to each location.

Key points from the chart:

- PICU accounts for the largest share of incidents (21%),
- Assessment & Treatment areas account for 15%, making this the second highest location.
- Ward 3 (14%) and Ward 6 (12%).
- Ward 1 (11%) and Ward 2 (8%) show moderate but still significant incident volumes.
- Lower proportions are seen in:
 - Ward 5 – Neuro (7%)
 - Darwin Centre (4%)
 - Dragon Square – Short Breaks (4%)
 - Crisis Resolution Home Treatment Team (4%)

Table 2 Violence and Aggression Incidents by location

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
PICU	53	5	19	22	14	10	14	78	39	12	28	55	349
Assessment & Treatment	25	13	9	20	5	21	49	40	32	15	7	14	250
Ward 3	22	14	22	11	22	10	18	35	5	31	31	19	240
Ward 6	21	4	20	11	10	32	15	14	16	39	5	16	203
Ward 1	4	1	4	1	14	11	12	29	18	10	9	67	180
Ward 2	20	2	16	19	6	6	11	14	20	16	4	5	139
Ward 5 - Neuro	15	22	4	4	7	4	5	8	13	18	6	7	113
Darwin Centre	4	1		1	7	5	5	10	13	9	4	13	72
Dragon Square (Short Breaks)	4	5	4	3	7	5	2	3	3	3	6	18	63
Crisis Resolution Home Treatment Team	6	3	7	2	3	4	5	7	5	5	8	6	61
Ward 4	10	3	7	5	7	2	3	2	7	2		1	49
Substance Misuse Inpatient (EMU)	4	2	8	8	5	4	2	8	2	1			44
Summers View	1	7	9	4	2		3	3	2	6	4	3	44
Hilda Johnson House	2	2	11	7	3	5	2	1		1	1	2	37
Ward 7	1	2		1	1		1	6	2	3	3		20
Patient Experience Team						2				5	4	3	14
Greenfields CMHT		2	1	1	1	2	1	1	1	2			12
Intensive Support Team (IST)		1		1	1	2		2			3	2	12
Sutherland CMHT	1	3			2	1		2		1	1		11
Mental Health Liaison Team	3		2			1		2	1			1	10
Place Of Safety (Crisis Care Centre)	1	1	2		1	2	1			2			10
Stoke Talking Therapies (IAPT)			1	1			1	2		2		2	9
Early Intervention		2				1		2	1	1			7

Harplands Main Reception	1			1			1			1		3	7
Lymebrook CMHT	1	1				1	1		1	1		1	7
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Site Managers (Crisis Care Centre)	2					4						1	7
ARRS MH Team		1		1		1	1						4
Health & Justice				1						1	1		3
North Stoke CAMHS					1			1			1		3
Children's LD (Community LDIs)				1					1				2
Community City And County LD Team (Broom Street)									1		1		2
Holmcroft Surgery						1			1				2
Intensive Outreach Team			1		1								2
Moorcroft Medical Practice	1						1						2
NStaffs Memory Service				2									2
Parent And Baby						1			1				2
South Stoke CAMHS					1							1	2
Adult ADHD Team		1											1
Criminal Justice Team	1												1
CYP Eating Disorders Team				1									1
Discharge Pathway Team					1								1
Keele Practice							1						1
Moss Green Surgery		1											1

Multiple Disadvantage Team				1									1
Neuro Community								1					1
North Staffs CAMHS								1					1
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
Older Persons CMHT - City		1											1
Older Persons Outreach							1						1
Patient & Organisational Safety Team												1	1
Totals	203	100	147	130	122	138	156	272	185	187	127	241	2008

Analysis of reported violence and aggression incidents by location indicates a clear concentration within acute inpatient settings, most notably within Psychiatric Intensive Care Units (PICU), Assessment and Treatment (Specialist) services, and general adult inpatient wards.

PICU recorded the highest number of incidents during the reporting period (349 incidents), which is consistent with the higher acuity, complexity, and risk profile associated with patients managed within these environments.

Collectively, the five highest-reporting inpatient areas account for approximately 60% of all incidents, demonstrating a significant clustering of risk within a relatively small number of clinical settings. In contrast, community and specialist services report comparatively low incident volumes, reflecting differing care environments, patient cohorts, and risk exposure.

Trend analysis shows monthly variation characterised by episodic peaks, which appear to correlate with periods of heightened clinical acuity and service pressure, rather than indicating a sustained or systemic increase across all services.

This pattern suggests that incident frequency is dynamic and influenced by operational and clinical factors, reinforcing the need for targeted risk management, workforce support, and responsive mitigation strategies within high-risk inpatient areas.

Table 3 Health and Safety / Physical Assault incidents outcomes

	Qtr1 2025- 2026	Qtr2 2025- 2026	Qtr3 2025- 2026	Qtr4- 2025- 2026	Total
1 - No Harm	368	308	488	447	1611
2 - Minor	77	74	120	103	374
3 - Moderate	4	5	5	3	17
4 - Major/Severe	1	1			2
6 - Near Miss		2		2	4
Total	450	390	613	555	2008
Injury Rate %	18.2%	20.5%	20.3%	18.5%	

Table 4 Injury rate by location

Location	Injury rate %
Assessment and Treatment	35.5%
PICU	11.1%
Ward 1	13.1%
Ward 2	12.2%
Ward 3	7.1%
Ward 4	28%
Ward 5	12.3%
Ward 6	30%
Ward 7	30%
Dragon Sq	52%
Summer View	18%

Despite an increase in reported violence and aggression incidents, the overall harm profile remains stable and predominantly low. Approximately 80% of incidents resulted in no harm, with around one in five resulting in minor injury. Moderate and severe injuries remain rare. Injury rates have remained consistent across all four quarters. High-acuity inpatient areas such as PICU account for a significant proportion of incident volume but demonstrate comparatively low injury rates, indicating effective risk management and staff response. Conversely, some lower-volume areas demonstrate higher injury rates, suggesting the need for targeted review of local controls, staffing, and environmental factors

Table 5 Hate crime incidents reported

Hate Crime Incidents Reported	No of incidents
Qtr1 2024 -2025	14
Qtr2 2024 -2025	28
Qtr3 2024 -2025	52
Qtr4 2024 -2025	52
Qtr. 1 2025-2026	23
Qtr. 2 2025-2026	26
Qtr. 3 2025-2026	36
Qtr. 4 2025-2026	32

Between January and March 2026, around 38 hate-crime-related incidents were reported across mental health inpatient settings, mainly at Harplands Hospital, Summers View, and Assessment & Treatment units. The vast majority involved racial abuse, most commonly patients directing racist language at staff, with some patient-to-patient incidents. Most incidents caused no physical harm, but many involved explicit racial slurs, gestures, and repeated behaviour, posing significant psychological impact. A small number required short-duration restraint due to escalation or safety risks.

Table 6 Hate crime by location

	Qtr1 2025- 2026	Qtr2 2025- 2026	Qtr3 2025- 2026	Qtr4 2025- 2026	Total
Assessment & Treatment	4	2	4	3	13
Crisis Resolution Home Treatment Team			1		1
Darwin Centre			1		1
Hilda Johnson House		3			3
Moorcroft Medical Practice		2			2
PICU	6	5	12	8	31
Substance Misuse Inpatient (EMU)	2	1			3
Summers View			1	2	3
Ward 1	4	2	4	5	15
Ward 2		1	3		4
Ward 3	4	5	2	6	17
Ward 5 - Neuro	3	6	8	8	25
Ward 6	1				1
Grand Total	24	27	36	32	119

Table 7 Hate Crime by type

Description – Hate crime	Incidents
Disability - Pt to Pt	1
Race - 3rd Party to St	1
Race - Pt to Pt	5
Race - Pt to St	105
Religion - Pt To 3rd Party	1
Sexual Orientation - Pt to Pt	1
Sexual Orientation - Pt to St	3
Transgender Identity - Pt to St	2
Grand Total	119

During 2025–2026, a total of 119 violence and aggression incidents were recorded as hate crimes, representing a small proportion of overall incident reporting. Incidents were primarily concentrated within high-acuity inpatient settings, particularly PICU and neurological wards. The predominant category was race-related abuse directed from patients towards staff, accounting for the majority of reports. The quarterly pattern mirrors trends in overall violence and aggression incidents and is likely reflective of periods of increased patient acuity. There is no evidence of widespread or systemic issues; however, the data reinforces the importance of continued staff support, clear reporting pathways, and targeted interventions within high-risk environments.

Table 8 Right care right person

Incident type	Incidents
Lack Of Police Response - AWOL	2
Lack Of Police Response - Communication Issues	2
Lack Of Police Response - Missing Person	1
Lack Of Police Response - Other	1
Lack Of Police Response - Risk To Self/others	6
Total	12

A small number of incidents (n=12) were reported in relation to lack of police response during the reporting period. Half of these incidents related to situations involving risk to self and/or others. While the overall volume remains low, the nature of these incidents highlights the importance of timely multi-agency response during high-risk scenarios. The themes identified primarily relate to communication and response-time challenges rather than refusal of support and will be reviewed through existing partnership and escalation mechanisms. Bi monthly meeting will continue to take place between the local policing team and the post team to review and identify any improvement opportunities. The senior service manager for acute services additionally attends the police led right care right person quarterly multi-disciplinary review meeting which looks at the learning from serious incidents across the north midlands area.

Table 9 Number of Potential BBVE incidents

	Q1 2025-2026	Q2 2025-2026	Q3 2025-2026	Q4 2025-2026	Total
Bite	4	1	4	2	11
Scratch	12	7	20	15	54
Needlestick	1	1	3	2	7
Abrasion	2	3	4	6	15
Spitting	6	6	1	2	15
Cut	2	2	4	2	10
Total	27	20	36	29	112

Sharps, inoculation injuries, and potential BBV exposure (BBVE) incidents are reported via the Ulysses Incident Management System and reviewed by the Trust's Health and Safety Advisor and the IPC (Infection Prevention and Control) team. Managers follow up on incidents with IPC support to ensure the BBV pathway and policy are followed appropriately.

Monthly meetings between Occupational Health, Infection control and Health and safety continued Quarterly with anomalies in data challenged. In total, following review and data cleansing in the final quarter of the year there were 29 potential blood borne virus exposure (BBVE) incidents.

- 20 of these incidents should have been referred to occupational health referred to Occupational Health
- 1 incident has no record of BBV protocol being followed
- 19 of the incidents staff advised to contact occupational health
- Six of these incidents have no record with occupational health of any contact being made
- Two needle stick injuries were reported both had appropriate after incident actions
- The after incident BBV questionnaire has now been introduced on Ulysses

One incident from dec 2025 fell into the Q4 reporting period

Emerging issues

Incident reports indicate that staff are being advised to follow the BBV protocol however this is not reflected in the data held by Occupational health with staff choosing not to contact Occupational health for an assessment (six identified cases) in the final quarter.

It is additionally clear that further work needs to be completed on the use of the BBV questionnaire on Ulysses as the completed questionnaires do not reflect the after-incident information provided by the line manager. Temporarily the Infection control team have resumed contacting managers following incidents to identify any inconsistencies in reporting. This will be further reviewed at the next BBV review meeting with occupational Health

4. Health and Safety Audit Schedule

Health and Safety Audits will continue with the focus of Q1 2026 being on a refresh of the Ligature Risk assessment. Documentation on CAT has now been updated and will be reviewed in Q 2 2026.

2026-2027 will additionally have a focus on drop in Audits for wards and community sites.

5. Training Compliance

Below is an overview of Trust training compliance records, which have been collated from April 2024 onwards

Table 10 – Training compliance

Training	Q1	Q2	Q3	Q4	
CBRNE	100%	100%	100%	100%	→
Conflict Res Full	88.73%	88.03%	88.10%	88.73%	↗
Conflict Res Refresher	92.28%	92.83%	91.74%	92%	↗
DSE	93.12%	82.94%	86.82%	86.50%	↘
Duty of Candour	95.65%	94.86%	96.42%	96.86%	↗
Fire Prevention and Safety – e-Learning community 2 yearly	95.50%	95.50%	95.36%	95.42%	↗
Fire Prevention and Safety Inpt e-Learning year 2+3	81.28%	80.81%	82.52%	82.04%	↘
Fire Prevention and Safety- e-learning nonclinical	97.99%	96.48%	94.95%	91.60%	↘
Health and Safety	94.27%	94.57%	94.03%	94.40%	↗
IPC	95.36%	95.68%	96.12%	96.50%	↗
IPC Level 2	82.24%	86.28%	88.67%	86.69%	↗
Patient Safety Syllabus 1	92.70%	93.50%	91.67%	94.25%	↗
Patient Safety Syllabus2	80.00%	81.18%	80.98%	83.59%	↗
Safer People Handling	83.03%	81.41%	83.83%	83.14%	↘
Suicide Awareness 1	98.36%	98.79%	Not reported	96.53%	
Suicide Mitigation	83.86%	85.30%	79.18%	82.87%	↗

6 Outbreak management support

The health and safety advisor and patient and organisation team will continue to provide support to all required actions and work in relation to supporting our response to outbreak management in conjunction with our IPC and clinical colleagues.

Outbreak management is managed via the IPC team and proportionate reviews of these sit within the outbreak management meeting.

7. RIDDOR

The Trust is fully aware of, and compliant with, its statutory duties under the **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)**. All incidents meeting the reporting threshold are reviewed and submitted to the Health and Safety Executive (HSE) within the required timescales.

Table 11 RIDDOR incidents

Date	Area	Category	Detail
16/04/2025	Assessment and Treatment	7-day absence	Whilst preparing patient for discharge the patient became distressed, assaulting staff and attempting to self-harm whilst attempting to assist the patient the member of staff was injured
15/05/2025	Darwin	7-day absence	Injury initially reported as a hand injury, however injured party then reported sick absence related to an existing back injury. Injured party has now reported that the existing back injury has been exacerbated by this incident causing the sick absence
20/05/2025	Assessment and Treatment	7-day absence	Injured party was bitten on the thumb causing nerve damage
14/07/2025	A&T	7-day absence	Assault by Patient and trapped against door and chair causing injury
24/07/2025	EMU	7-day absence	Back injury sustained whilst manual handling
03/08/2025	A&T	7-day absence	Fall whilst manual handling resulting in a broken elbow
09/09/2025	Ward 6	7-day absence	Member of staff assaulted by patient resulting in head injury
09/11/2025	Darwin	7-day absence	Staff assaulted
09/11/2025	Darwin	7-day absence	Back injury sustained whilst administering safety holds
27/11/2025	A & T	7-day absence	Staff member injured following an assault
22/06/2025	Summers view	7-day absence	Sick absence following an assault identified late by a review of sick absence when staff identified link of sick absence to the incident
07/12/2025	Ward 5	7-day absence	Report returned by RIDDOR as not reportable
14/12/2025	A & T	7-day absence	Member of staff assaulted by patient resulting in an arm injury
14/12/2025	A & T	7-day absence	Staff member assaulted by patient whilst applying safety holds
20/01/2026	A & T	7-day absence	Staff member struck knee against a piece of furniture whilst dealing with a distressed patient

15/01/2026	Ward 5 Nero	7-day absence	Patient pressed staff members stomach exacerbating an existing condition
16/01/2026	Ward 5	7-day absence	Muscle strain in upper body whilst administering care to a disruptive patient

Summary / assurance statement (optional but recommended)

A total of **17 incidents** met the RIDDOR reporting threshold during the reporting period. The majority relate to **patient-related violence and aggression or manual handling activities**, consistent with wider incident trends. One incident was subsequently deemed **not RIDDOR-reportable by the HSE** following review. Ongoing learning from these incidents continues to inform risk assessments, training, and local control measures to reduce recurrence.

8. FFP3 fit mask training

The PortaCount face fit testing equipment has now been delivered, and a “train the trainer” session has been scheduled for mid-June.

Following completion of this training, a face fit testing programme will be implemented across the Trust. This programme will take advantage of the reduced testing time per staff member afforded by the PortaCount equipment, enabling a more efficient and sustainable approach to Respiratory Protective Equipment (RPE) assurance.

This enhanced approach will support improved compliance, increase testing capacity, and ensure that staff are appropriately protected through effective and timely fit testing processes.

9. HSE Enforcement

The trust has received no enforcement action from the HSE in 2025-2026 the trust continues to work towards improving systems following the letter sent to all NHS trusts and board chief executives in march 2023 highlighting a number of areas of concern in relation to violence and aggression (VA) against staff and Muscular Skeletal Disorders (MSD) This followed three years of inspections of NHS sites.

10. Central Alerting System

Open alerts

Table 9 – CAS reported alerts detail

The issue with the decontamination wipe has also been highlighted with our IPC colleagues as well and a request has been made to review areas and stocks of these and a differing code has been provided to ensure compliance with our cleaning standards

Action – to complete an ad hoc visit to team areas to provide assurance to this measure and instruction that has been posed to all and report back to the Health, Safety and Well-Being group

Reference	Alert Title	Originated by	Issue Date	Status	Response	Deadline
NatPSA/2025/002/uk HSA	Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia Spp:meas...	National patient alert UKHSA	26-Jun-2025	Issues	Acknowledged	29 August 2025
CEM/CMO/2025/001	Influenza season 2024/25 ending the prescribing and supply of antiviral medicines in primary care	CMO messaging	15 May 2025	issued	Response not required	
NatPSA/2025/005/NH SPS	Harm from delayed administration of rasburicase for tumour lysis syndrome	National Patient Safety Alert - NHS England Patient Safety	09-Sep-25	Issued	Assessed - not relevant to organisation's services	09-Mar-26
NatPSA/2025/004/MV A	Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment	National Patient Safety Alert - DHSC	29-Jul-25	Issued	Action Completed	15-Aug-25
CHT/2025/001	Update from the CAS Helpdesk: National Supply Disruption Response (NSDR) now accredited to issue Nat ...	CAS Helpdesk Team	07-Jul-25	Issued	Response Not Required	
NatPSA/2025/003/DH SC	Shortage of bumetanide 1mg tablets	National Patient Safety Alert - DHSC	03-Jul-25	Issued	Action Completed	11-Jul-25
NatPSA/2025/008/NHSP S	Risk associated with adult breathing circuits lacking a	National Patient Safety Alert - NHS England	11-Dec-25	Issued	Acknowledged	12-Jun-26

	patent exhalation route	Patient Safety				
NatPSA/2025/007/DHSC	Supply of Licensed and Unlicensed Epidural Infusion Bags	National Patient Safety Alert - DHSC	02-Dec-25	Issued	Assessed - not relevant to organisation's services	12-Dec-25
NatPSA/2025/006/NHSP S	Harm from incorrect recording of a penicillin allergy as a penicillamine allergy	National Patient Safety Alert - NHS England Patient Safety	20-Nov-25	Issued	Assessed - relevant to organisation's services	20-Nov-26
CEM/CMO/2025/002	Influenza season 2025/26: early season activity and implications for clinical practice	CMO Messaging	05-Nov-25	Issued	Response Not Required	

NatPSA/2026/002/MHRA	Recall of Quetiapine Oral Suspension (unlicensed medicine), manufactured by Eaststone Limited due to a potential for overdosing	National Patient Safety Alert - MHRA	29/01/2026	Issued	Assessed - not relevant to organisation's services	05/02/2026
NatPSA/2026/001/DHSC	Steriflex No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags	National Patient Safety Alert - DHSC	14/01/2026	Issued	Assessed - not relevant to organisation's services	06/02/2026
DMRC- 37923982	Medicine recall: CLASS 2 MEDICINES RECALL, EL(26)A/01 Paliperidone Mercury Pharma 50 mg prolonged-release suspension for injection in pre-filled syringe Action within 48 hours	Defective Medicines Report Centre	20/01/2026	Issued	Actioned within the 48 hrs from the issue date	22/01/2026

11. Medical Devices

The Trust continues to work closely with clinical teams to ensure access to fit for purpose medical equipment, with the equipment replacement and procurement programme being updated in response to clinical need. All newly purchased equipment undergoes formal acceptance testing by Clinical Technology and is recorded on the asset register to support ongoing safety assurance, maintenance, and lifecycle monitoring. Regular meetings are held with the Finance team to review the current financial position, plan for the upcoming financial year, and agree priorities for the replacement and renewal of clinical equipment, informed by the established asset register. A comprehensive review of asset registers has been completed by the Patient Safety Team, in collaboration with Clinical Technology colleagues at UHNM. This has improved visibility of equipment across all service areas and supports informed decision making regarding the planned lifecycle replacement of approved and registered assets. Work is ongoing to explore procurement options for bed and chair sensor devices, recognising their role in reducing restrictive practices and supporting falls prevention. This has been escalated as a priority Through the physical health group following the cessation of trading by the current chair sensor manufacturer, requiring identification of suitable alternative suppliers to maintain service continuity. PortaCount devices have now been received, supporting respiratory protective equipment testing and providing assurance in relation to staff safety.

12. Rough Sleeping and Site Security Improvements

Incidents of rough sleeping continue to be reported to Staffordshire Police across the site. In response, a business case has been developed to enhance building security.

The proposed measures include:

- Removal of climbing and unauthorised access points to building roofs
- Improved CCTV coverage across the site
- A comprehensive review and update of site signage, which is currently outdated

These improvements will not only address the immediate risks associated with unauthorised access and occupation but will also initiate the process of bringing the Trust into alignment with *Martyn's Law*, strengthening its counter-terrorism preparedness and protective security arrangements.

Summary Conclusion

Overall, the Trust continues to demonstrate a robust and compliant approach to health and safety management, with effective governance arrangements in place to support safe care delivery and staff wellbeing.

While overall incident activity fluctuated across the year, the data highlights that violence and aggression (V&A) remain the most significant risk, accounting for the highest proportion of incidents and showing an upward trend in the latter part of the reporting period. Notably, these incidents are largely concentrated within a small cohort of high-acuity patients and specific inpatient settings (particularly PICU and specialist wards), rather than representing a widespread systemic issue.

Encouragingly, despite increased reporting levels, the overall harm profile remains stable and low, with approximately 80% of incidents resulting in no harm and only a small proportion leading to moderate or severe injury. This indicates that existing risk management processes, staff training, and response measures are largely effective in mitigating harm and protecting both patients and staff.

The report also highlights a number of emerging themes requiring continued focus, including:

- The need for targeted, patient-specific interventions to manage repeated V&A incidents
- Variation in injury rates across locations, suggesting opportunities to strengthen local controls in some areas
- Inconsistent adherence to BBV follow-up processes, particularly staff engagement with occupational health
- Ongoing multi-agency working challenges, including a small number of police response issues

In addition, training compliance remains generally strong, regulatory requirements (including RIDDOR) are being met, and there has been no HSE enforcement action, providing further assurance regarding organisational compliance.

In conclusion, the Trust is meeting its statutory health and safety obligations and maintaining effective systems of assurance. However, continued targeted action is required within high-risk inpatient environments, particularly in relation to violence and aggression, to further reduce incident frequency, improve staff safety, and strengthen consistency of practice across all services.

Enclosure No: 6

Infection Prevention and Control Annual Report 2025/26

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☒	Advise	☐		
Information	☐				

Presented by:	Zoe Grant Acting Chief Nursing Officer
Prepared by:	Clare Williams Head of Infection Prevention and Control
Executive Lead:	Zoe Grant Acting Chief Nursing 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:	SLT
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 has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	Demonstrate where we are aligning our Strategy to the ICS

Recommendation / Required Action:	Board are asked to receive the Infection Prevention and Control Annual Report 2025/26. Report is for information and assurance
Executive Summary:	The purpose and content of this annual report is to inform the Trust Board of the Infection Prevention and Control Team (IPCT) activities during the period of 01 April 2024 to 31 March 2025. The annual DIPC report is aligned to the ten compliance criteria as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated July 2022). The compliance framework is used by the Care Quality Commission to assess a registered provider on how they comply with Cleanliness and Infection Prevention & Control requirements as detailed in the legislation. (Table 1 of main report). The highlights are as follows: - • Receive and Acknowledge the Report • The Board and IPCG are recommended to formally receive the annual report as assurance of the Trust's ongoing IPC activity and compliance for 2025/26. • The Trust continues to comply with the Health and Social Care Act 2008 (revised 2022) Code of Practice on the Prevention and Control of Infections. (appendix 1) • Strong performance in key Healthcare-associated infections (HCAIs), zero MRSA bacteraemia maintained with no Trust-attributable C. difficile cases, this is down from 4 cases from the previous year. • 1 case of GNBSI / MSSA bacteraemia linked to a cannula related infection, resulting in review of the standard operating procedure and ANTT training. • Mandatory IPC training compliance remains strong overall with level 1 remaining high at 96% with IPC level 2 (clinical staff) showing an improving trend at 87% • Completion of all inpatient and community IPC environmental audits completed, with the majority of areas scoring between 93% and 100%. Overall, Trust compliance for 2025/26 is 94.7%; an improvement of 1.3% on last year's performance. • Significant reduction in COVID-19 outbreaks (66.6%) and Covid-19 hospital-onset cases • Blood borne virus exposure incidents increased from 77 in the previous year to 114 in 2025/26, The majority of incidents related to scratches and bites, alongside an increase in needlestick injuries. These were due to user error and the wrong procurement of needles. • The Trust performed second highest within the ICB for staff seasonal influenza vaccination programme, achieving the 5%

	improvement on the previous year's data with 899 (53.3%) of NSCHT staff receiving their flu vaccine. MPFT vaccination team supported the delivery of two on-site Covid-19 vaccination for patients
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VERSION CONTROL:

Version	Report to	Date Reported
V1.0	Infection Prevention and Control Group	13.04.2026
V1.0	SLT	21/06/2026
V1.0	Quality Committee	02/07/2026
V1.0	Public Trust Board	09/07/2026

DIPC Annual Report 2025/26

Foreword by Director of Infection Prevention and Control (DIPC)

This Annual report covers the period 1st April 2025 to 31st March 2026 and has been written in line with the ten Criterion as outlined within the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022) for the purpose of this report, this will be referred to as 'the Act'

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

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

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

Kenny Laing

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

Introduction:

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

This report provides patients, service users, the public, staff, the Trust Board and Governors with an overview of the infection prevention and control (IPC) of the work undertaken between 1 April 2025 and 31 March 2026. It outlines the activities completed to meet the statutory requirements of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, referred to in this report as “the Act”. It also provides assurance regarding the control measures in place within NSCHT and the Trust’s compliance with the Act.

High standards of IPC are essential to preventing infection across all healthcare settings. Effective IPC is underpinned by the fundamentals of care, strong leadership and evidence-based clinical practice, helping to reduce infection risks, prevent healthcare-associated infections, minimise antimicrobial resistance and maintain high standards of cleanliness across Trust premises. As clinical practice continues to evolve, new IPC challenges emerge, and these have been kept under review throughout the reporting period.

The IPC team has continued to work collaboratively with directorates and corporate teams to prevent avoidable infections and minimise the risk of resistant organisms across the healthcare economy. The Trust’s Chief Nursing Officer is the designated Director of Infection Prevention and Control (DIPC), and in accordance with the Code of Practice, the DIPC is required to produce an annual report.

Purpose of the Report (Executive Summary):

The Trust has a statutory responsibility to comply with the Health and Social Care Act 2008 and the Code of Practice on the prevention and control of infections and related guidance (revised 2022). NSCHT remains committed to maintaining a robust IPC function that supports the delivery of high-quality care and protects the health of patients, service users, staff and visitors. Appendix 2 details the completed IPC annual audit plan and provides evidence of compliance with the Act.

NSCHT continues to participate in the mandatory surveillance of MRSA bacteraemia, MSSA bacteraemia, E. coli bacteraemia and Clostridioides difficile infection through the UK Health Security Agency (UKHSA) Healthcare Associated Infections Data Capture System (HCAI DCS). Mandatory reporting of P. aeruginosa and Klebsiella species also continues.

Incidents and outbreaks were managed throughout 2025/26 as they occurred. The management of Covid-19, influenza and seasonal outbreaks remains a key priority for the Trust, and local policies and procedures are reviewed and updated annually in line with national guidance.

The annual DIPC report is aligned to the ten compliance criteria set out in the Act. This framework is used by the Care Quality Commission to assess how registered providers comply with cleanliness and infection prevention and control requirements. While some responses relate to more than one criterion, information has been presented under the most relevant criterion to avoid duplication.

The ten Criterion outlined in the code are:

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

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

Key Recommendations and achievements to Consider:

- Receive and Acknowledge the Report
- The Board and IPCG are recommended to formally receive the annual report as assurance of the Trust's ongoing IPC activity and compliance for 2025/26.
- The Trust continues to comply with the Health and Social Care Act 2008 (revised 2022) Code of Practice on the Prevention and Control of Infections. (appendix 1)

- Strong performance in key Healthcare-associated infections (HCAIs), zero MRSA bacteraemia maintained with no Trust-attributable C. difficile cases, this is down from 4 cases from the previous year.
- 1 case of GNBSI / MSSA bacteraemia linked to a cannula related infection, resulting in review of the standard operating procedure and ANTT training.
- Mandatory IPC training compliance remains strong overall with level 1 remaining high at 96% with IPC level 2 (clinical staff) showing an improving trend at 87%
- Completion of all inpatient and community IPC environmental audits completed, with the majority of areas scoring between 93% and 100%. Overall, Trust compliance for 2025/26 is 94.7%; an improvement of 1.3% on last year's performance.
- Significant reduction in COVID-19 outbreaks (66.6%) and Covid-19 hospital-onset cases
- Ongoing involvement and support to external services e.g. Occupational Health provision
- The Trust performed second highest within the ICB for staff seasonal influenza vaccination programme, achieving the 5% improvement on the previous year's data with 899 (53.3%) of NSCHT staff receiving their flu vaccine.
- MPFT vaccination team supported the delivery of two on-site Covid-19 vaccination for patients
- Providing a response to and supporting the Trusts regulatory and mandatory requirements i.e. CQC and NHSE.

Infection Prevention and Control Team Structure 2025/26 (Criteria 1)

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

The purpose of the IPCG is to gain assurance that the Trust is fulfilling national and local infection prevention and control requirements. Performance on the number and status of specific reportable and non-reportable Healthcare Associated Infections (HCAI) in the Trust is reported to the IPCG on a quarterly basis. The IPCT produces quarterly assurance reports, all quarterly IPCG meetings were held with minutes and actions recorded. Membership of the IPCG includes the DIPC, IPC Team, Estates, Facilities, directorate/corporate leads and matrons. Other representatives may attend as a one-off according to the agenda. Directorate updates are also provided and after IPCG approval, these reports are presented to the Quality and Safety Committee and Trust Board. External stakeholders such as our local Integrated Care Board (ICB) also receive these reports.

The specialist IPC Team provides a wide variety of support and advice to all Trust staff, wards and departments in relation to infection prevention and control matters and liaise regularly with information on alert organisms, offering advice and reassurance when required. Supporting clinicians, AD's, QI Matrons

and ward managers who have responsibility for the operational delivery of IPC, clinical governance and risk management. The team continues to support frontline staff and prioritise urgent IPC issues during winter pressures and the ongoing response to outbreak management.

The remit of the team includes:

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

Water Safety Group (Criteria 1)

The Water Safety Group (WSG), chaired by the DIPC/Deputy DIPC which reports into the IPCG via Estates and Facilities. The WSG follows and implements the standards and guidance set out in Health Technical Memorandum (HTM) 04-01, Safe Water in Healthcare Premises. The HTM 04-01 gives guidance on the legal requirements, design applications, maintenance and operation of hot and cold-water supply, storage and distribution systems in all types of healthcare premises. A Water Safety Plan is in place, which provides detail on how the risks from microbiological and scalding hazards associated with the supply and use of water are assessed, managed and controlled, and is owned and managed by the WSG.

Following the completion of the annual water safety audit by the Trust's appointed Water Authorising Engineer on 25 September 2025. A formal review of the WSG structure, terms of reference and roles and responsibilities was completed. 8 staff have now completed the responsible persons training with a further 14 staff completing the City and Guilds training for departmental managers. The WSG meets quarterly and reports into the IPC Group. During this reporting period all quarterly meetings took place with 14 extraordinary WSG meetings been held in response to adverse water sample results and the ongoing support required in relation to Project Chrysalis and the site wide monitoring of the flow and return water temperatures in accordance with HTM 04-01.

Water Risk Assessments are monitored by the WSG and, as of 31 March 2026, all Water Risk Assessments were in date. On completion of Water Risk Assessments, any actions are added to the Trust's Water Safety

Action Plan. Remedial works are prioritised and monitored by the designated Responsible Person in the Estates Team and the WSG.

Cleaning and Environmental Standards (Criteria 2)

The Trust is now working to the National Standards of Healthcare Cleanliness 2021 and delivering services in accordance with Functional Risk (FR) category and corresponding target audit score FR2 in all our inpatient units. This being a commitment to achieve a score of 95% or above monthly. During 2025/2026 we achieved an average score of 96.36% for inpatients areas.

In our community clinical premises, we are working to Functional Risk (FR) category score FR3. With a target commitment to achieve a score of 90% or above and audited on a bi-monthly basis to comply with the new standards. During 2025/26 we achieved an average score of 94.76% in these areas.

On the 23 February 2026, our cleanliness scores were validated by Hotel Services manager from Derbyshire NHS foundation Trust, feedback received to the Trust indicated that both Harplands Hospital, and the Darwin Centre were cleaned to a high standard, and they confirmed that the 5 star cleanliness rating (as defined by the National Standards of Healthcare Cleanliness 2025) are correct and appropriate.

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

Patient Led Assessment Care Environment (PLACE) 2025

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

Table 2: PLACE scores 2025

PLACE 2025	Cleanliness %	Food and Hydration			Privacy, Dignity and Well Being %	Condition, Appearance and Maintenance %	Dementia %	Disability %
		Food %	Organisation Food %	Ward Food %				
Harplands Hospital	98.92	95.92	91.32	98.35	98.05	95.41	99.19	97.46
Dragon Square	100	N/A	N/A	N/A	100	100	N/A	100
A&T Unit	97.86	92.07	90.43	94.29	95.12	98.81	N/A	90.38
Darwin Centre	100	94.88	89.54	100	97.56	100	N/A	92.31
Hilda Johnson House (Sutherland)	100	N/A	N/A	N/A	91.89	100	N/A	91.67
Summers View (Greenfields)	100	N/A	N/A	N/A	94.74	98.75	N/A	91.67
NSCHT Organisation score	99.13	95.66	91.10	98.34	97.47	96.52	99.19	96.23
National Mental Health and LD average scores	98.82	93.15	90.60	95.34	96.36	97.37	93.29	91.97
National (mean) average score –all site types	98.55	92.13	92.79	92.30	89.37	97.00	85.68	87.12

Waste Management including Sharps

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

Monitoring and audit of the policy:

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

Laundry

A high-quality linen hire service is provided to the Trust by Elis. This service has recently been tendered and are currently in the standstill period. We are looking forward to working with the new provider to embrace the opportunity to work with our new contract to review our stock levels and work with the clinical teams to

provide an efficient and effective service. This contract is managed and monitored by the Trust Facilities team.

Nutrition

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

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

Food Safety audits/inspections

Efficient and accurate record keeping is completed by Support Services and SERCO teams to demonstrate both food safety and successful application of food safety management and provide evidence for due diligence to prove that all reasonable and satisfactory precautions have been taken.

Compliance against our managing food safety documentation is checked on a quarterly basis by the Support Services and SERCO supervisors/managers.

These audits are unannounced and identify compliance with: -

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

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

Food wastage has reduced significantly over the last twelve months within all categories of food wastage. These figures are reported at the Trust Sustainability group meeting.

External Food Safety Inspections

All premises are registered with the Food Standards Agency and inspected by Environmental Health Officer (EHO), except for Hilda Johnson House, who due to the change of use of premise, are no longer registered but are monitored by the Facilities team to ensure Food safety and hygiene standards are maintained. All premises inspected by EHO in 2025/26 have retained 5-star rating.

Refurbishment Projects - Infection Prevention and Control in the Built Environment

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

Antimicrobial Stewardship (Criteria 3)

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

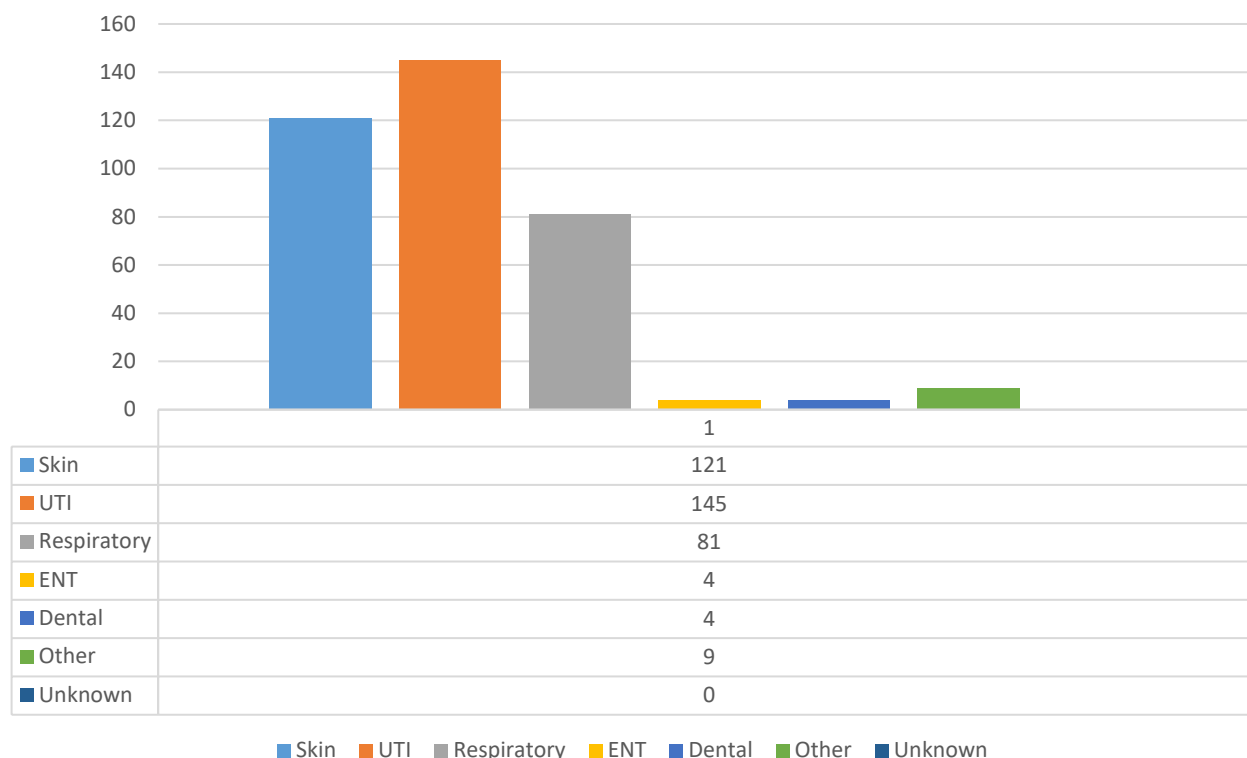
Monthly audits are completed to monitor antimicrobial prescribing with the aim to improve patient care by identification and challenge of prescriptions which do not follow local guidelines.

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

Table 3: Antibiotic use by ward, by indication 2025/26

Infection	PICU	1	2	3	4	5	6	7	A&T	EDMY	SV	Darwin	Total
Skin	5	11	13	9	39	3	11	16	1	6	1	6	121
UTI	4	11	9	23	30	6	29	28	1	4	0	0	145
Respiratory	8	2	1	7	40	4	9	8	0	2	0	0	81
ENT	0	4	0	0	0	0	0	0	0	0	0	0	4
Dental	2	0	0	0	0	0	0	0	1	0	1	0	4
Other	2	1	0	1	1	0	1	1	0	0	2	0	9
Unknown	0	0	0	0	0	0	0	0	0	0	0	0	2
Total	21	29	23	40	110	13	50	53	3	12	4	6	364

Chart 1 Number of Antibiotics Used by indication 2025-2026



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

There is a separate Local Health Economy Infection Prevention & Control and Antimicrobial Group, which is chaired by the Consultant Microbiologist from University Hospital North Midlands (UHNM) with representation from pharmacy and IPC. On review of the annual work plan, these areas are sitting amber as the ICB system establishes a new lead.

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

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

Communication Programme

The IPC Team and communications team, work together to:

- Promote IPC events.
- Communicate campaigns to inform staff, patients and visitors around Influenza, seasonal winter infections e.g. Norovirus

- Update the Trust website and intranet.
- Support the preparation of media statements during outbreaks if required.
- Support the annual flu vaccination campaign
- Support the COVID vaccination programme
- Support communication of COVID-19 and other infection related information and guidance
- Awareness campaigns
- Dedicated IPC noticeboard in main Harplands reception

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

The IPC team have followed national guidance in relation to information relating to visitor information and signage relating to respiratory symptoms. There is also information for these infections and general IPC information available on the internet. The IPC team have worked with Primary Care teams to offer advice for patients regarding M-Pox, Hantavirus and other High Consequence Infectious Disease (HCID) in line with the Trust Emergency Preparedness, Resilience and Response planning.

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

The Trust had a low incidence of reportable healthcare associated infections during 2025/26. There are currently no national or local trajectories assigned to NSCHT. However, this does not diminish the Trust's responsibility in preventing HCAIs. Investigations are undertaken in alignment with local and national guidance. Reports are escalated by exception and shared with external partners on request. Learning is cascaded to all relevant stakeholders to prevent future occurrences.

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

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

- MRSA
- MSSA
- *C. difficile*
- Gram-negative bloodstream infections (*Escherichia coli*, *Klebsiella spp*, *Pseudomonas aeruginosa*)

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

Clostridium Difficile Infection (CDI)

Clostridium Difficile (*C. difficile*) is an anaerobic spore-forming Gram-positive rod which can cause antibiotic-

associated diarrhea and, less commonly, a severe and life-threatening disease, pseudo-membranous colitis. NSCHT is compliant with the Department of Health (DOH) and UK Health Security Agency (UKHSA) testing guidance for CDI.

At the end of the reporting period, there were no cases of *Clostridioides difficile* infection (CDI) attributed to the Trust, demonstrating a sustained improvement compared to 2024/25, where four cases were identified. This reflects the continued effectiveness of antimicrobial stewardship, environmental cleaning, and early identification and management of diarrheal illness.

Gram Negative Blood Stream Infections (GNBSI)

Gram-negative bloodstream infections remain a key national priority due to their association with avoidable healthcare harm. The Trust continues to work collaboratively with system partners across the local health economy to reduce GNBSI incidence, recognising that many community-onset cases are linked to previous healthcare interventions.

During 2025/26, one GNBSI case was attributed to the Trust and classified as hospital-onset healthcare-associated (HOHA). Review of this case identified a peripheral cannula site infection as the likely source. An After-Action Review highlighted several key learning points, including:

- Improvements required in clinical documentation
- Enhanced skin preparation prior to device insertion
- Strengthened monitoring and review of invasive devices

In response, targeted actions were implemented, including revision of the relevant Standard Operating Procedure (SOP), delivery of additional training in Aseptic Non-Touch Technique (ANTT), and the introduction of 2% chlorhexidine gluconate in 70% alcohol for skin preparation, in line with NICE guidance.

MSSA Bacteraemia

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

One case of Methicillin-Susceptible *Staphylococcus aureus* (MSSA) bacteraemia was reported during the year and attributed to the Trust as a hospital-onset healthcare-associated (HOHA) infection. This case was linked to the same patient identified in the GNBSI incident, with a common source of infection relating to a cannula site.

MRSA Bacteraemia

Methicillin-Resistant Staphylococcus aureus (MRSA) is a serious bloodstream infection caused by an

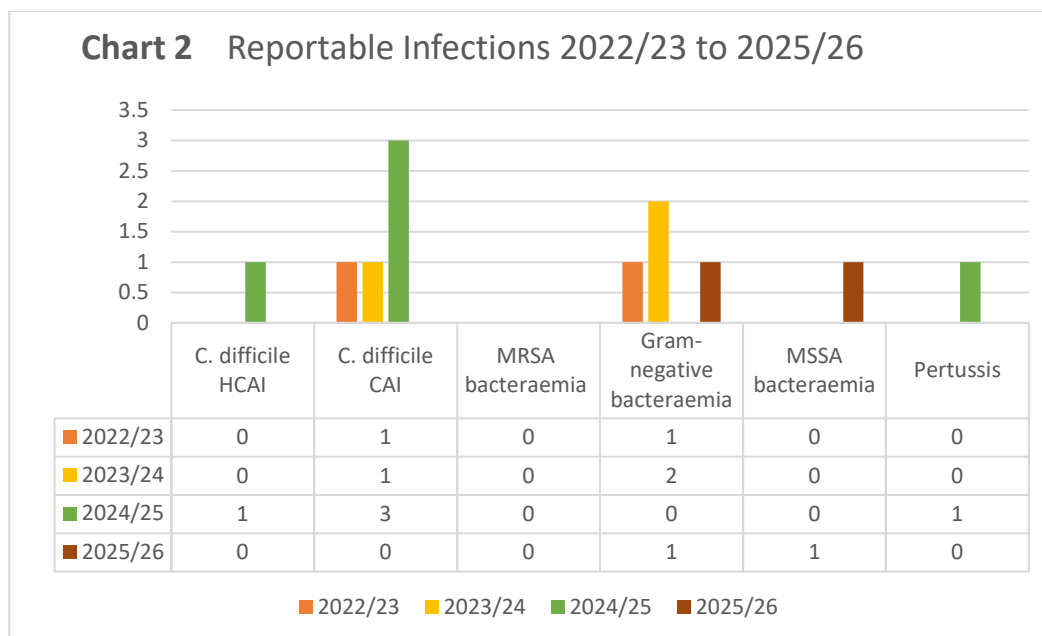
antibiotic-resistant bacterium.

There were no cases of MRSA bacteraemia attributed to the Trust during 2025/26. This continues a sustained period of zero attributable cases, demonstrating effective adherence to screening, decolonisation, and infection prevention practices.

Trend Overview of Reportable Infections

Analysis of reportable infections over the past four years (chart 2) demonstrates consistently low numbers across all categories, with:

- No MRSA bacteraemia cases reported
- Minimal incidence of GNBSI, with only four cases over the four-year period
- A reduction in CDI cases, with no Trust-attributable cases in the current year
- Isolated cases of MSSA bacteraemia and pertussis



MRSA Acquisitions

Methicillin-resistant *Staphylococcus aureus* (MRSA) colonisation remains a recognised risk within healthcare settings, with up to 30% of the population carrying *Staphylococcus aureus* asymptomatically on the skin or in the nasal passages. As part of national guidance, the Trust continues to undertake targeted MRSA screening for all eligible inpatient admissions, with the aim of reducing colonisation burden and preventing subsequent infection and transmission.

During 2025/26, a total of 14 MRSA acquisitions were identified, of which 8 were classified as healthcare-associated (HCAI). This represents a slight increase compared to 2024/25, where 12 acquisitions were reported, including 7 HCAI cases. The upward trend is more notable when compared to 2023/24, when only 3 HCAI cases were recorded.

Analysis indicates that the increase in HCAI MRSA colonisation is associated with reduced compliance with admission screening, including patient refusal in some cases. This highlights the ongoing challenge of ensuring consistent screening uptake and the importance of patient engagement in infection prevention measures.

In response, the Trust continues to strengthen screening processes, reinforce staff adherence to national guidance, and promote patient education to improve compliance. These measures are supported by robust surveillance and timely intervention to minimise the risk of progression from colonisation to infection and to reduce onward transmission.

Covid-19 2025/26

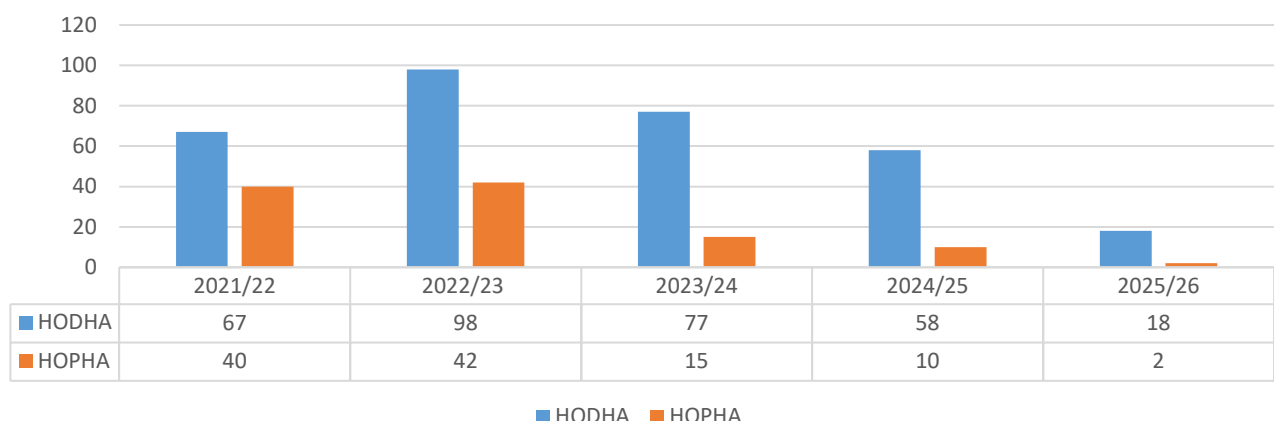
During 2025/26, the Trust reported a total of 20 hospital-onset COVID-19 cases, comprising 18 Hospital Onset Definite Healthcare Associated (HODHA) cases and 2 Hospital Onset Probable Healthcare Associated (HOPHA) cases. HODHA cases are defined as those where the first positive specimen is identified 15 or more days following admission, while HOPHA cases are those with a first positive result between 8 and 14 days post-admission.

Trend analysis over the past five years (Chart 3) demonstrates a sustained and significant reduction in hospital-onset COVID-19 cases across the Trust. HODHA cases have decreased from a peak of 98 in 2022/23 to 18 in 2025/26, while HOPHA cases have reduced from 42 to 2 over the same period. This indicates continued improvement in infection prevention and control measures and reduced transmission within inpatient settings.

It is recognised that a proportion of cases, particularly within mental health services, are associated with patients returning from periods of home leave as part of their therapeutic recovery. Whilst these cases are likely to have been acquired in the community, national surveillance definitions require them to be reported as hospital-onset due to the patient's admission status at the time of diagnosis.

The marked reduction in reported cases is likely multifactorial. Contributing factors include changes to testing protocols, with testing now primarily focused on symptomatic individuals, and environmental improvements such as the transition from dormitory-style accommodation to single rooms with en-suite facilities. These measures have strengthened the Trust's ability to prevent and control transmission within care settings

Chart 3 Number of Covid-19 HODHA and HOPHA 2021/22 to 2025/26



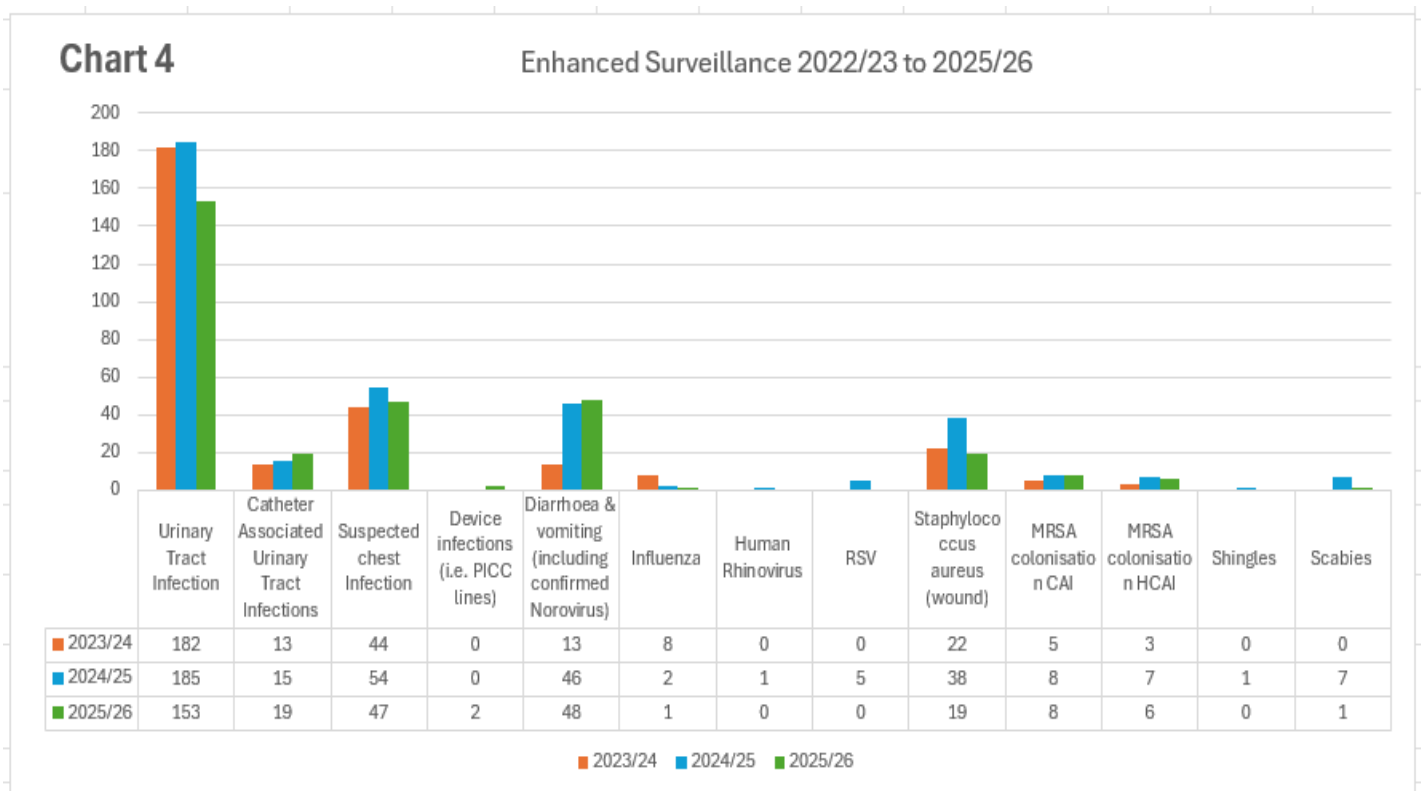
Extended Surveillance

As part of the Trust's ongoing surveillance programme, inpatient care settings submit weekly updates capturing all suspected infections managed within the organisation. Chart 4 summarises the distribution of cases recorded across the Trust during the reporting period.

A total of 172 urine specimens were analysed. Of these, 76 yielded sensitive organisms, 89 demonstrated mixed growth, and 8 identified resistant organisms, specifically ESBL-producing *E. coli*.

During the reporting period, there was a reduction in the number of reported chest infections. This is likely attributable to a decrease in respiratory outbreaks during this reporting period. In contrast, reflecting increased community prevalence of norovirus, there was a rise in cases of diarrhoea and vomiting (D&V).

Where an infection prevention and control (IPC) risk was identified, appropriate transmission-based precautions were implemented, including enhanced environmental cleaning. Antimicrobial therapy was reviewed and managed in line with established antimicrobial prescribing guidance.



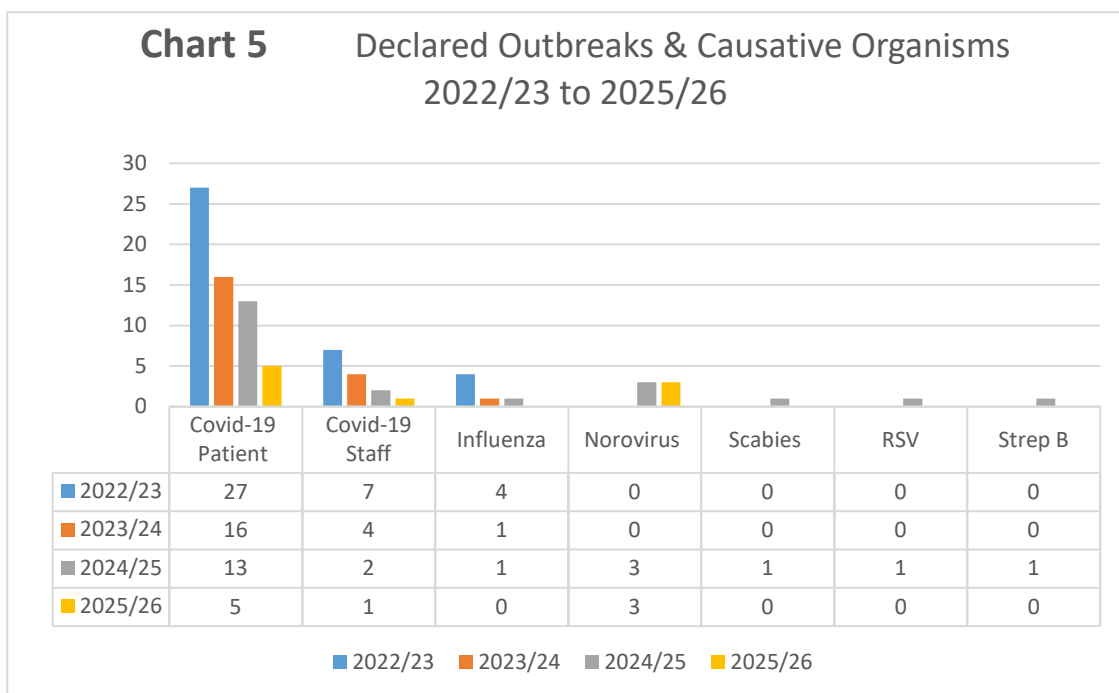
Outbreak Activity and Trends

During 2025/26, the Trust managed 9 declared outbreaks across inpatient and staff settings. 5 COVID-19 inpatient outbreaks, 1 COVID-19 staff-only outbreak, 3 Norovirus outbreaks. It is to note there were no outbreaks of influenza, scabies, RSV, or Group B Streptococcus reported during the year.

Compared to previous years, this represents a significant reduction in overall outbreak activity, particularly in relation to COVID-19, indicating improved resilience and effectiveness of infection prevention and control measures across the organisation. (Chart 5)

Three Norovirus outbreaks were reported during the year, with Norovirus G2 identified as the causative organism. These outbreaks lasted an average of 10 days and affected 26 patients and 10 staff members. Epidemiological investigation identified links to community leave and inter-provider patient transfers, emphasising the ongoing risk at the interface between healthcare settings. Control measures included ward closures to non-essential admissions and transfers, enhanced environmental cleaning, and strict isolation precautions.

Managing outbreaks within mental health inpatient settings continues to present specific challenges. In particular, supporting patient adherence to isolation measures can be difficult due to the nature of mental health conditions, which may increase the risk of transmission within ward environments.



Training and Education (Criteria 6)

The IPC Team are committed to ensure Trust staff are trained in appropriate IPC practices and support a range of education and training activity. Staff undertake IPC e-learning modules on LMS for mandatory training. All IPC related training is underpinned by national guidance and Trust policy and procedures and provides NHSE the required assurance that staff are up to date with their mandatory training and are responsive to outbreak management. The overall annual trust compliance as of the 31 March 2026 for Level 1 was 96.92% - this is slight increase from 96.25% from the previous year. Level 2 mandatory training for clinical staff was 86.46%.

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

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

In addition, the team have also offered:

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

Isolation Facilities (Criteria 7)

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

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

Laboratory Support (Criteria 8)

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

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

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

Policies / SOPs are reviewed and updated to reflect any changing national or local guidelines or legislation as required. To support the overarching IPC policy, during 2025/26, 3 standard operating procedures / policies have been produced/updated and can be found on the Trusts CAT page.

These consist of:

- IPC 11-EMU Peripheral Intravenous (IV) Cannulation (Adult)
- Pandemic Influenza Management Plan
- 1.83 Pressure Ulcer Prevention and Management

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

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

Staff Health and Wellbeing (Criteria 10)

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

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

Flu Programme

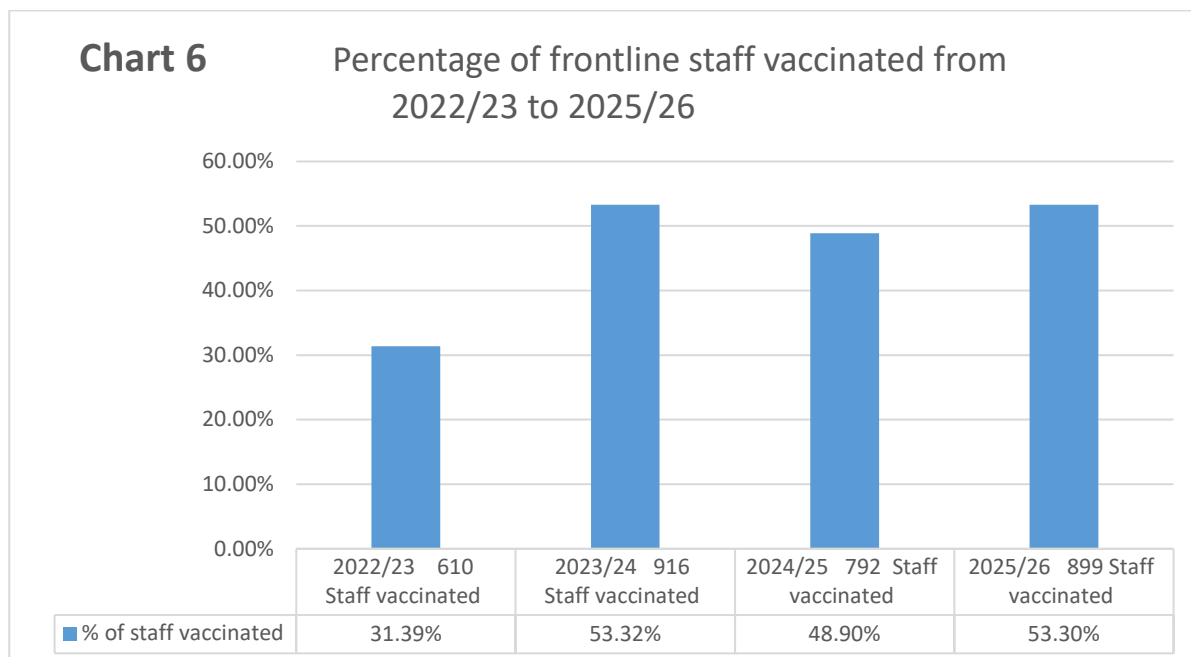
The Trust has a responsibility to offer the seasonal influenza vaccine to 100% of frontline healthcare staff in order to protect vulnerable patients, staff members and visitors and support the resilience of the health and care system by reducing the number of Influenza infections amongst frontline healthcare staff, the campaign continues to promote the importance of staff being vaccinated annually against influenza, The Trust commenced its planning of the annual influenza vaccination campaign in March 2025.

For 2025-26 the flu campaign was facilitated in-house and compliance included in IPC reporting. Although there is no CQUIN set for this year campaign, NHS England has requested that all Trusts aim for a 5% improvement on their previous year's performance. All frontline health care workers, including both clinical and non-clinical staff who have contact with patients, will be offered the influenza vaccine to protect themselves and those they care for as part of winter planning.

The below chart shows the progress for 2025/26 influenza campaign and key highlights.

- 25 peer vaccinators were recruited compared to 30 on the previous year's data. Peer vaccinators attended flu vaccination training (or for those who had undertaken the training previously on-line e-learning modules were undertaken). On completion of training all peer vaccinators completed individual competency assessments to enable them to assist the infection prevention and control team in administering staff flu vaccinations safely.

- Monthly seasonal flu planning meetings commenced in March 2025 to complete all the necessary actions to ensure the vaccine were made available from 20 September 2025 through to the end of February 2026, taking into consideration lessons learned from the previous year's campaign.
- Non-mandatory threshold for 65-75% of front-line healthcare workers to be vaccinated during 2025/26 campaign.
- 1 on site Covid-19 vaccination sessions were held for staff and patients, this service is provided by the targeted vaccination team from MPFT.
- 5% improvement target achieved on last year's performance set by NHS England



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

Sharps and inoculation injuries are reported via the Ulysses Incident management system and reviewed by the Trust's Health and Safety advisor. Organisation wide Learning form part of the incident review. A report is submitted quarterly to the IPCG. Blood borne virus exposure (BBVE) incidents have increased from the previous year's data, from 77 to 114, with a peak in quarter 3 and consistently high levels in quarter 4, indicating a rising exposure risk across services. The majority of incidents relate scratches and bites, alongside an increase in needlestick injuries. While robust reporting and review systems are in place, gaps were identified in compliance with post-exposure management, specifically inconsistent referral and engagement with Occupational Health. Actions have been implemented to strengthen assurance, including reinforcing the BBV pathway, improving Occupational Health referral and tracking processes, enhancing data quality through the introduction of a BBV questionnaire, and targeting reduction of preventable incidents through focused training, safer working practices, and improved oversight.

Table 4: Total Number of Inoculations Injuries

	Q1 2025-2026	Q2 2025-2026	Q3 2025-2026	Q4 2025-2026	Total
Bite	4	1	6	2	13
Scratch	12	7	20	15	54
Needlestick	1	1	3	2	7
Abrasion	2	3	4	6	15
Spitting	6	6	1	2	15
Cut	2	2	4	2	10
Total	27	20	38	29	114

Recommendations and IPCT Aims 2026/27

The IPC Team have continued to provide a responsive service for the prevention of infections across all services provided by NSCHT. The intention for 2026/27 is to provide a proactive and equitable IPC service across all Trust services.

The focus and IPC priorities for 2026/27 will be to:

- Reduce healthcare associated infections through strengthened surveillance, early identification, and timely intervention.
- Improve antimicrobial stewardship to optimise prescribing and minimise antimicrobial resistance.
- Strengthen compliance with IPC policies and post-exposure pathways, including Occupational Health follow-up.
- Reduce avoidable harm by targeting BBV exposures, device-related infections, and high-risk clinical practices.
- Maintain high standards of environmental cleanliness and embed IPC requirements in estate refurbishment and design.
- Enhance workforce capability through improved IPC training, education, and accountability.
- Strengthen screening, surveillance, and risk assessment processes for alert organisms and vulnerable patients.
- Improve outbreak preparedness and response, particularly for respiratory and seasonal infections.
- Enhance system-wide working across the health economy to reduce infection risks across care pathways.
- Support staff health and wellbeing through vaccination programmes, occupational health provision, and exposure risk reduction.

Summary:

Throughout the period of this report, the Infection Prevention and Control Team and extended workforce of the organisation have continued to be responsive to the infection prevention and control challenges. The IPC Team has continued to deliver the Trust IPC agenda, ensuring all staff in the Trust are aware of their responsibilities in relation to IPC. This was reflected in the low numbers of reportable infection identified within the Trust during this reporting period. Healthcare associated infections remain a high priority in the Trust for 2026/27.

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

Appendices

Appendix 1 Annual Work Plan 2025/26

Annual Infection Prevention and Control Work Plan 2025-2026

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

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

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

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

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Preparation of a biannual report detailing activities in the previous 6 months, this will be consolidated at year end in the format of a DIPC annual report.	Head of IPC	• Annual DIPC report to Board due in July 2025					Presented at SLT on 24.06.2025 and Quality Committee on the 03.07.2025. COMPLETED Q1
		• Q1 DIPC report due July 2025					COMPLETED Q1
		• Q2 DIPC report due Oct 2025					COMPLETED Q2
		• Q3 DIPC report due Jan 2026					COMPLETED Q3
		• Q4 DIPC report due Apr 2025					COMPLETED Q4
		• Exception reports at the request of the DIPC as required.					COMPLETED

Escalation of emerging issues which may impact on patient safety and quality to Trust board from IPCG	DIPC	Head of IPC to escalate concerns to DIPC in line with local and national issues.					COMPLETED Q4
Continue to develop the IPCT to ensure a Health economy approach to the Infection Control agenda and ensure the team have the appropriate skill mix.	Head of IPC	Identify lead areas of responsibility within the team across the acute and community footprint					COMPLETED Q4
		Support the development of IPC team to ensure they have the knowledge and skills required to deliver the service based on trust requirements					Band 7 - completed QI protected for ANTT. Band 6 – funding granted via TNA for Marian Reed Development Program and BSc degree in Infection Prevention and Control
		Identify development opportunities via 1-1 and appraisal process.					Band 6 and 7 appraisals completed in Q4
Ensure that the Infection Prevention and Control group chaired by the DIPC meets quarterly	DIPC	Papers to be circulated in a timely manner to all members of the group.					COMPLETED Q4
		Actions from IPCG are recorded and monitored					COMPLETED Q4
		ToR are reviewed by the IPCG in 2025/26					ToR reviewed in July 25

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure IPC representation at key trust and partnership meeting	Head of IPC	• Clinical Professional Advisory Group (CPAG)					Meeting stood down
		• Water Safety					17.03.2026 Water Safety Meeting COMPLETED Q4
		• Physical health group					Meeting held bi-monthly. 24.02.2026 – Physical Health Group COMPLETED Q4
		• Antimicrobial stewardship					IPC attended independent prescribing and medicine optimisation meeting 24.03.2026 COMPLETED Q4
		• ICB (formally CCG) Health Economy HCAI group / Health Economy IPC meeting					COMPLETED Q4 – no meeting held
		• Health Care Economy Anti-Microbial Group					COMPLETED Q4 – no meeting held
		• Incident Management Group (IMG)					
		• Clinical Effectiveness Group (CEG)					COMPLETED Q3 – 28.01.26, 25.02.2026 & 25.03.2026

		ICB (formally CCG) /IPC leads Meeting					COMPLETED Q4– weekly meeting attendance throughout Q4
Ensure mandatory reporting of alert organisms	Head of IPC	Outbreaks reported as required.					COMPLETED Q4 – 2 outbreaks declared during Q4
		Influenza reporting					Imms submission sent for March 2026
		Using iportal system to review results which support IPC advice and support to clinical areas on patient management					Plus, statutory alert organism reporting e.g. C. diff. COMPLETED Q3
Monitor and review IC risk register including any infection control related risks added by Directorates.	Head of IPC	Risk register is a standing agenda item at Infection Control Group – quarterly review					Risks are reviewed monthly by the HIPC. COMPLETED Q4
Re-establishment of IPC operational sub-group of IPC Champions	Clinical Specialist Practitioner IPC	To support development of knowledge and skills to enable staff to support within their work area					Increased visibility within clinical areas has been the priority. COMPLETED Q4
Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments

Undertake Post Infection Reviews on MRSA, BSI, CDI and MSSA and other alert organisms in line with NHS England and Trust criteria.	Clinical Specialist Practitioner IPC	• PIR's undertaken with Clinical teams for all acute attributable MRSA and CDi cases					COMPLETED Q4 – no cases identified during Q4
		• Learning from reviews to be fed back into practice and policy as required.					COMPLETED Q4
		• Collaborative working with UKHSA, IPCT to undertake PIR on Community Onset Healthcare Associated (COHA) cases					COMPLETED Q4 – None reported during Q4
		• Full PIR for MSSA cases where risk factors / concerns identified, this includes peripheral inserted lines and urinary catheters					COMPLETED Q4 – None reported during Q4

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Environmental audit programme	Head of IPC	• Identify best practice and/or areas requiring improvement within clinical areas. Develop action plans to address areas of concern					COMPLETED Q4
		• Quality improvement audit tool to review clinical standards and compliance with IC policies. To be fed back to QI leads and ward managers					COMPLETED Q4

		SERCO to complete their monitoring audits submitting scores to Head of Facilities to address any issues, concerns.					COMPLETED Q4
		IPCT to undertake period of increased audits in clinical areas to monitor environment to reduce transmission related to alert organisms e.g. MRSA/C.diff and respiratory illness e.g. COVID/flu. To be fed back to Matron and senior Sister					COMPLETED Q4
		ICT to undertake specific audits including Hand Hygiene and commode audits following cases of CD when required. To be fed back to Matron and Senor Sister.					COMPLETED Q4
		Undertake audits of community-based clinics feeding back to community service leads					Community audits scheduled for Q2, Q3 & Q4 as per annual audit plan
Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments

IPCG provides a forum for Health & Safety, Estates, Facilities, Wards and IPCT to explore collaborative working and information sharing	Clinical Specialist Practitioner, IPCT	Ongoing oversight of IPC related issues pertaining to Estates, Soft FM, Medical Devices and/or cleaning					COMPLETED Q4
		Devolved responsibility from IPCG to operationalise key work streams. IPCT to work with QI Lead Matrons to identify.					COMPLETED Q4
IPCT to advise on new builds and or any changes to existing areas	Head of IPC	Provide IPC and technical advice on building re-configuration of Harplands site wards refurbishments and re-location					COMPLETED Q4
		Provide ad hoc support to estates as required.					COMPLETED Q4
Participate in Cleanliness and Patient led Assessment of the Care Environment (PLACE)	Head of Facilities	Identify and provide leads from IPCT					COMPLETED Q4
		Review/ implement actions through IPCG.					COMPLETED Q4

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

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
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Pharmacist input required to C. difficile and bacteraemia and MSSA post infection review process.	Antimicrobial Pharmacist	• Clinical assessment of antibiotic profile to be undertaken by antimicrobial pharmacist and entered relevant documentation					COMPLETED Q4
		• Antimicrobial ward rounds on newly identified IC patients in particular newly identified patients with CDI					COMPLETED Q4
Antibiotic Stewardship	Antimicrobial Pharmacist	• Actively involved in the AMR programme board for Staffordshire and SOT					COMPLETED Q4
		• Develop local action plan for AMR					COMPLETED Q4
		• Audit Antibiotic compliance and submit quarterly report to IPCG					COMPLETED Q4
Health Economy Antimicrobial meetings	Antimicrobial Pharmacist	• Link in with HE overview of AM use					COMPLETED Q4
		• Identify trends related to AM use in wider HE					COMPLETED Q4
		• Attendance at quarterly HE meetings					COMPLETED Q4
4. Provide suitable accurate information on infections to service users, their visitors, and any person concerned with providing further support or nursing / medical care in a timely fashion.							

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

5. Ensure prompt identification of people who have or are at risk of developing and infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure the correct placement of patients with a known infection	Clinical Specialist Practitioner, IPCT	• Use of Iportal for early identification of patients with existing or new infections to ensure clinical review					COMPLETED Q4
		• Infection control notice board displaying information					COMPLETED Q4
		• Discharge EDNF to include IPC status					COMPLETED Q4
The Trust is a key stakeholder in the Health Economy ECOLI reduction group	Head of IPC	• Peer review of PIR to support a learning outcome and influencing change in practice					COMPLETED Q4
Reduce the risk of avoidable MSSA infections by implementing an RCA process to establish lessons learnt.	Clinical specialist practitioner, IPCT	• Implementation of a mini-PIR process for all cases of trust attributable MSSA with IPCT					COMPLETED Q4
		• Formal PIR on all cases identified as line related to include QI Lead Matron, Ward Manager					COMPLETED Q4
	Clinical specialist	• PIR on all cases attributed to the Trust using the new national objective criteria					COMPLETED Q4

Identify key themes/ lessons learnt from CDI against the new national criteria	practitioner, IPCT	Incident form completed by ward. Learning and actions identified and cascaded to clinical areas, via ward managers.					COMPLETED Q4
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6. Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infections

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

7. Provide and source adequate isolation facilities

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Respond and advise on the management of outbreaks.	Clinical specialist practitioner, IPCT	• Identify risks of patients in side rooms as to who should take priority including opportunities to cohort nurse.					COMPLETED Q4
		• Implement screening process for staff and patients in line with UKHSA directives.					COMPLETED Q4
		• Cascading information from UKHSA ensuring staff understand the changes					COMPLETED Q4
	Head of IPC	• Attend Trust/ directorate meetings to give advice on overall situation as required					COMPLETED Q4
Identify risks around lack of side rooms for isolation	Head of IPC	• Work with project Chrysalis in reviewing plans for refurbishment, to ensure side rooms identified which would support isolation					This project will continue into 25/26.
		• Work with directorates on winter planning/ emergency preparedness to ensure that capacity is included to manage multiple cases of respiratory illnesses.					COMPLETED Q4

8. Secure adequate access to laboratory support as appropriate

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure the lab has current CPA accreditation	DIPC	CPA accreditation in place, review as part of SLA					UHNM as it forms part of their accreditation requirement.
Liaise with UHNM Lab and access consultant Microbiologist if clinically required.	Head of IPC and IPCT	Review alert organisms as required					COMPLETED Q4
		Work with Laboratory staff in use of early identification of specific organisms using PCR machine, prioritising cases as required.					COMPLETED Q4
		Early review of blood cultures relating to MRSA/ MSSA.					COMPLETED Q4

9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure that any policy/ guidance reflect new directives from NHS England/ UKHSA and	Head of IPC	Amend policies/SOPs and guidance and any related documentation in response to legislation or evidence-based changes					COMPLETED Q4

or any regional specialist groups.		Interpret and cascade changes to guidance due to emerging diseases e.g. COVID/Monkeypox. This includes recommendations for the management of patients and the use of PPE ensuring clinical areas are working to the most up to date guidance.					Guidance updated to reflect regional and national related requirements.
		Any existing policies/SOPs due for renewal to be revised in line with new guidance / recommendations, evidence-based practice					Overview of policies renewal dates undertaken through the Policy working group.

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

Plan & Priority Activities	Lead	Deliverables	Q1	Q2	Q3	Q4	Comments
Ensure that the trust has systems and process in place which reduces the risk of transmission of Influenza in line with UKHSA recommendations	Head of IPC	Deliver a robust staff seasonal influenza campaign ensuring accessibility of all trust staff and key partners (SERCO/CDAS) across the organisational footprint and in accordance with the CQUIN					- Vaccination meeting commenced Q2. - No CQUIN in place for flu performance for 2025/26 - NHSE has issued a notice that trusts should increase

								the vaccination uptake by 5% on the previous year's performance
Work plan and IPC Strategy submitted to IPCG for review and sign off								
Q1	15.07.25	Submitted to IPCG and updated by	Head of IPC - CW	Q3	06.01.2025	Submitted to IPCG and updated by	Head of IPC - CW	
Q2	09.10.25	Submitted to IPCG and updated by	Head of IPC - HW	Q4	13.04.2026	Submitted to IPCG and updated by	Head of IPC - CW	

Appendix 2 Annual Audit Plan 2025/26

NSCHT INFECTION PREVENTION AND CONTROL AUDIT PLAN 2025/26

Introduction

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

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

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

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

Once an audit is completed, the score can be used to provide objective data on compliance with infection prevention and control practice and policies within the Trust. This data can then be used to direct the Infection Prevention and Control Annual Programme to meet the needs of the Trust in relation to infection prevention and control.

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

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

Infection Prevention and Control Link Workers/Champions

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

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

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

References

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

Table 1: Audit Schedule

INFECTION PREVENTION & CONTROL AUDIT PROGRAMME 2025/26 AUDITS TO BE COMPLETED LOCALLY	Q 1			Q2			Q3			Q4		
	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026

Hand hygiene Audit ALL In-patient areas - New Tool	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th
Sharps Audit (IPC to complete) ALL In-patient areas		✓			✓			✓			✓	
Hand Hygiene Audit ALL Community Teams and Primary Care	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th	✓ By 15th
Sharps Audit (IPC to complete) Community Teams & Primary WHERE APPLICABLE		✓			✓			✓			✓	
PPE (IPC to complete) ALL in-patient,	✓			✓			✓			✓		
Annual IPC Audit ALL in-patient, out-patient and community & GP teams	✓ Inpatient Services across site- Annual IPC Audit			✓ Primary care – GP - Annual IPC Audit			✓ Community Services			✓ Community Services & follow up audits		
Therapeutic toy audit CAMHS, Dragan, Parent & Baby only	✓			✓			✓			✓		

Table 2: Quarter 1 Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Kitchen	Annual Environmental Audit 2025-26 score
Ward 1	100%	93%	92%	100%	92% ↓	95%
PICU	86% →	94% ↑	92% ↑	86% ↓	92% ↓	90% ↓
Ward 2	87% →	94%	93%	100%	87%	91%

Ward 3	86%	68% ↓	93% ↑	100% →	92% ↓	91% ↓
Ward 4	100% ↑	94% ↑	86% ↑	100% ↑	96% ↑	98% ↑
Ward 5	100%	100% ↑	100% ↑	100% →	100% →	97% →
Ward 6	100%	100% →	86% ↑	100% →	96% →	96% ↑
Ward 7	-----DECANT WARD-----					
A&T	93% →	75% ↓	86% ↓	100% →	88% ↑	90% →
Crisis Care Centre	80% ↑	81% ↑	93% ↑	100% ↑	100% ↑	97% ↑
Summers View	100% →	100%	100% ↑	100% →	96% →	96% ↑
Dragon Square Respite	100% →	86% ↓	78% ↓	100% →	92% ↓	88% ↓
Darwin Centre IP	100% →	81% ↓	86% ↑	100% →	100% →	91% ↓
EMU	93% ↓	94% ↑	93% ↓	100% →	86% ↓	92% ↓
ECT	100%	100% ↑	100% ↑	100%	NA	99% ↑

Quarter one has demonstrated a positive upward trajectory in IPC compliance, with improvements noted across multiple standards. Specifically, 10 standards previously rated as requiring moderate improvement have now shown measurable progress.

Key Findings from In-Patient Audits

Audits conducted during this period identified several areas requiring attention, including:

- Use of temporary closures
- Incorrect assembly of sharps bins
- Use of non-safe sharp devices
- Non-compliance with hand hygiene practices, including:
 - Failure to adhere to “bare below the elbow” policy
 - Presence of nail varnish or false nails
 - Non-submission of monthly hand hygiene audits

Audit Completion and Follow-Up

All IPC audits scheduled for quarter one was completed in accordance with the audit workplan. Each area audited received tailored feedback, and action plans were developed by area leads to address identified issues.

Areas assessed as requiring major or moderate improvement are being actively followed up by the Infection Prevention and Control Team (IPCT) and are under ongoing review by the Infection Prevention and Control Group (IPCG)

Table 3: Quarter 2 Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Waste	Environment	Overall Annual Audit score 2025-26
Moorcroft Medical Centre	NA	93% ↓	71% ↓	87% →	100% →	86% ↑	93% ↑
Holmcroft	NA	100% ↑	100% ↑	100% →	91% ↓	96% ↓	97% ↓
Keele	NA	87% ↑	79% ↑	100% →	100% →	82% ↑	89% ↑
Moss Green		81% ↓	92% →	93% →	100% →	88% →	92% ↓

Quarter two has demonstrated a positive upward trajectory in IPC compliance, with improvements noted across multiple standards. Specifically, 8 standards previously rated as requiring moderate improvement have now shown measurable progress.

Key Findings from Primary Care Audits

- Audits conducted during this period noted an overall improvement in compliance for 2025/26 for both Moorcroft and Keele with a 56% improvement on last year's data for Keele.

Areas requiring attention, include:

- Use of temporary closures on sharp bin
- Incorrect assembly of sharps bins
- Use of non-safe sharp devices
- Alcohol hand gel must be available at the point of care
- Monthly hand hygiene audits must be completed and submitted

Table 4: Quarter 3 Community Services Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Waste	Kitchen	Environment	Overall Annual Audit score 2025-26
Bennett Centre Adult ASD	NA	↑ 100%	67% →	85% ↓	100% →	93% →	↑ 100%	↑ 94%
Bennett Centre Neuro Team	NA	↑ 92%	93% →	100% →	100% →	↑ 100%	↑ 87%	↑ 97%
North Stoke CAHMS	NA	100% →	92% ↑	100% ↑	100% →	93% →	↑ 87%	↑ 93%
The Willows	NA	87% →	92% ↓	100% →	100% →	↑ 100%	89% →	↑ 97%

Table 5: Quarter 4 Community Services Audit Performance

Adult Inpatient Ward / Area	Linen	Hand Hygiene Facilities	Sharps	PPE	Waste	Kitchen	Environment	Overall Annual Audit score 2025-26
Ashcombe	NA	87% ↓	100% →	100% →		100% →	100% ↑	99% →
Bennett Centre: Mother & Baby	100% ↑	100% ↑	67% →	87% ↑	100% ↑	100% ↑	100% ↑	98% ↑
Broom Street	100%	100% →	90% ↓	90% ↓	100% →	96% ↓	78% ↓	94% ↓
Darwin Centre OP/School/Offices	NA	100% →	NA	100% →	100% →	96% ↓	100% →	99% →
Greenfields	NA	94% ↑	93% ↑	87% ↓	100% →	100% →	100% →	98% →
Lymebrook: CMHT / Memory	NA	93% ↓	100% ↑	100% ↑	100% →	100% ↑	100% →	97% ↑

Clinic/Older Adult								
Marrow House	NA	100% →	100%	88% →	100% →	100% →	89% →	98% →
Sutherland	NA	93% ↑	93% →	100% →	100% →	92% ↓	78% ↓	96% ↓
South Stoke CAMHS Blurton HC	NA	81% →	90% ↓	75% →	91% ↓	100% →	78% →	90% ↑
Dragon Square out-patients & LD & CAHMS	NA	100% ↑	93% ↑	100% →		100% →	89% →	98% ↑
Hope Centre (combined result)	NA	94% →	100% ↑	100% →	100% ↑	96% ↑	85% ↑	96% ↑

Quarter three and four has demonstrated a positive upward trajectory in IPC compliance, with improvements noted across multiple standards. Specifically, 5 standards previously rated as requiring moderate improvement have now shown measurable progress. While the majority of services consistently achieve strong audit scores, several IPC concerns with identified across the community:

- Staff readiness and hygiene practices
- Management of consumables (hand gel, PPE)
- Clinical environment maintenance
- Sharps management
- Medicines management (new concern identified in Q4)

Areas where standards were not met managers were notified at the time of audit with any repairs been log via the estate's helpdesk.

Enclosure No: 7

Emergency Preparedness Resilience and Response Annual Report 2025-2026

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☒	Advise	☐		
Information	☐				

Presented by:	Rachael Birks, Deputy Chief Operating Officer
Prepared by:	Emma Beswick, EPRR Lead
Executive Lead:	Ben Richards, Chief Operating Officer and Accountable Emergency 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:	SLT
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:	Reduce the environmental impact of health and social care in Staffordshire and Stoke on Trent
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	Demonstrate where we are aligning our Strategy to the ICS

Recommendation / Required Action:	Agree assurance of the work completed within the EPRR Workstream and against NHS England Emergency Preparedness, Resilience and Response Core Standards.
Executive Summary:	The Trust has completed its 2025/26 self-assessment against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards, covering 58 applicable standards. The overall outcome confirms the Trust is substantially compliant, with this position formally reviewed and validated by the Accountable Emergency Officer, NHS England (NHSE) and the Integrated Care Board (ICB), and subsequently endorsed through the Local Health Resilience Partnership (LHRP) in November 2025. Performance across domains was strong, with full compliance achieved in the majority of standards, including governance, risk assessment, emergency planning, command and control, training, response, communications, cooperation, and CBRN preparedness. Only two areas (Business Continuity-related standards CS49 and CS53) were assessed as partially compliant. The Trust continues to demonstrate a proactive and mature EPRR capability. This is evidenced through: • Comprehensive training and exercising programmes, including multi-agency participation in Exercise RAVEN and internal evacuation and communications exercises. • Ongoing review and strengthening of emergency plans, supported by an active EPRR Working Group. • Strong business continuity arrangements, including organisation-wide awareness initiatives. • Effective incident response, including management of industrial action, with structured lessons learned processes embedded. External assurance also highlighted good practice in business continuity management system (BCMS) monitoring, particularly the use of clear and structured performance indicators. In summary, the Trust is well positioned in terms of EPRR compliance, with robust systems, governance, and partnerships in place. Targeted improvements are underway to address minor gaps. The Trust Board is asked to note the substantial compliance position and take assurance that EPRR arrangements are effective, resourced, and continuously improving.

VERSION CONTROL:

Version	Report to	Date Reported
1.	EPRR Working Group	22.4.26
2.	SLTB	26.5.26
3.	Quality Committee	27.05.26
3.	Public Trust Board	09.07.26

Emergency Planning Resilience and Response (EPRR) Annual Assurance Report

Introduction:

Each NHS Organisation must assess itself on an annual basis against the national core standards for emergency response, resilience and recovery (EPRR).

In the year 2025/26, the number of standards applicable to the Trust was 58 core standards only. There were no deep dive standards to assess against.

As part of the core standards process, the Trust is required to submit a report to the Trust board summarising the current position of emergency preparedness, as outlined in the completed self-assessment for their endorsement.

Purpose of the Report (Executive Summary):

This report aims to provide a high-level summary of the outcome of the Trust's self-assessment for 2025/26 and the work undertaken following the 2025/26 core standards process, in anticipation of the 2026/27 process being initiated in June 2026.

In 2025/26 the Trust undertook a self-assessment against the core standards and provided an overall rating of substantially compliant against the applicable core standards and the deep dive standards. The Trust's Accountable Emergency Officer reviewed the self-assessment and the submission rating, which was reviewed and confirmed by NHS England (NHSE) and the Integrated Care Board (ICB). In November 2025, the Trust was confirmed to be substantially compliant against the National Core Standards for EPRR in the assurance report presented to the Local Health Resilience Partnership (LHRP) by NHSE and the ICB.

Core standards summary 2025/26

Core standards (CS)	Standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	10	10	0	0

Compliance summary 2025/26

The Trust self-assessment indicated partial compliance on two of the core standards. Details of the standards that were self-assessed as partial compliance and the actions taken to improve them to full compliance are outlined in the table below.

Ref	Standard	Action taken	Anticipated rating 2026/27
CS49	Data Protection and Security Toolkit	The Trust is expected to receive an 'approaching standards' result this year. An action plan has been developed and is awaiting sign off by NHSE.	Fully compliant
CS53	Assurance of commissioned providers/suppliers BCPs	As part of the scheduled review of the Trust BCMS policy (July 2026), further explanation of the process of assurance of commissioned providers/suppliers BCPs will be included to strengthen compliance in this area.	Fully compliant

Good practice identified in 25/26 process

NHSE Midlands EPRR developed an 'EPRR Assurance Good Practice Report' following the conclusion of the 25/26 core standards process and one area of good practice was identified within the report for the Trust, which is outlined in the below table.

Ref	Standard	Good practice identified
CS50	BCMS monitoring and evaluation	Annex B of the BCMS Policy contained clearly written Key Performance Indicators with examples of poor, average, good and excellent indicators against each indicator, and clear to understand what needs to be achieved to move up in position.

Background (EPRR activity undertaken and planned by the Trust from 2025/26 to 2026/27):

Training and exercising

The Trust via the EPRR Team has provided multiple training sessions throughout the years 2025/26 and 2026/27, for on-call Strategic (Gold) and Tactical (Silver) Commanders. Further to this all Strategic Commanders within the Trust and Tactical Commanders with Incident Control Centre responsibility have been provided with the opportunity to receive accreditation through Skills for Justice, upon completion of LRF training for their on-call roles.

Trust representatives have participated in the Exercise RAVEN series, which simulate live multi-agency tactical co-ordinating group (TCG) and local health strategic command cell response to a Chemical, Biological, Radiological, Nuclear (CBRN) scenario, facilitated by the Staffordshire Resilience Forum (SRF) throughout 2025/26. Participation consisted of Trust representation at a tactical level to inform both multi-agency and internal learning and testing of plans and arrangements, such as the Incident Response Guide and system level plans.

The Trust has committed to participating in the Exercise RAVEN series for the year 2026/27 of which the scenario is extreme heatwave. This will provide further opportunities to experience multi-agency and health system response to a wide scale incident, to test plans relating to adverse weather, utilities failures and mass casualties.

In addition to this the Trust has participated in and facilitated a number of communications exercises in alignment with the requirements for EPRR testing and exercising. The EPRR Team have also delivered an evacuation command post exercise with representation ranging across the Trust and learning identified to strengthen plans and procedures in this area.

Emergency plans

All emergency plans are required to be reviewed on an annual basis in line with the NHS core standards for EPRR. All plans were reviewed in 25/26 and submitted to NHSE and ICB as part of the core standards process.

The EPRR Working Group established by the Trust has continued to meet to:

- Increase awareness of EPRR across the Trust
- Ensure clarity of plans, arrangements and communications
- Support the Trust to comply with the NHSE EPRR Framework and NHS Core Standards Assurance Process
- Ensure the Trust is prepared to respond to incidents by reviewing and approving plans, policies and arrangements
- Ensure that staff are appropriately trained and exercised to undertake their roles and responsibilities in relation to incident response

In addition to the internal work, the Trust has engaged in a number of workstreams, with multi-agency partners to support the production of collaborative plans and arrangements. Engagement has been achieved via participation in workshops, task and finish groups and multi-agency meetings.

Business continuity

Business continuity plans continue to be reviewed as per their agreed annual cycle. In 25/26 the Trust promoted Business Continuity Awareness Week through screensavers, encouraging all staff to read their business continuity plan and highlighting NHSE led business continuity sessions taking place throughout the week. This process will be repeated in 26/27 due to the positive response from staff and adherence to business continuity standards.

Incidents

The Trust has responded and led an Incident Management Group response in 25/26 to a number of incidents, including industrial action.

Lessons learned

Lessons learned reports have been developed for all incidents that the Trust has responded to and exercises that have been participated in. All recommendations have been logged by the EPRR Team and are being tracked and taken forward as appropriate, this includes wider lessons which have been shared with the Trust through the NHSE regional lessons process.

Summary:

The Trust was confirmed to be substantially compliant against the NHS England national core standards for the year 2025/26, with a number of areas of good practice identified. Action is being undertaken to increase the compliance of the core standards which were self-assessed as partial compliance and these are anticipated to be fully compliant ahead of the 2026/27 core standards submission. EPRR compliance is further demonstrated through the activity undertaken by the Trust throughout 2025/26 and planned for 2026/27.

Ongoing compliance against the core standards will continue through the EPRR work programme for the remainder of 2026/27 and beyond.

Next Steps (including timeframes:

The Trust Board is asked to receive for assurance this report summarising the Trust's position in relation to the completed EPRR self-assessment for 2025/26 and that EPRR activity within the Trust is adequately resourced and committed to.

Enclosure No: 8

IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) M02 2026/27

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☒	Advise	☐		
Information	☐				

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 2026/27 and includes performance against national priorities in advance of the national publication through MHSDS.

Recommendation / Required Action:	The Board is asked to note the contents of the report.
Executive Summary:	This report presents key performance highlights, areas of exception, and progress of medium-term plan national priorities activity against operational planning forecasts. Change Control (Q4 2025/26): • Talking therapies (anxiety and depression) national standards have been updated for 2026/27. There are two special cause variations (orange variation flags) – signifying concern. 1. Sickness Absence 2. Appraisal There are seven special cause variations (blue variation flags) – signifying improvement. 1. CAMHS compliance within 4 week waits (referral to assessment) 2. CAMHS compliance within 18 week waits (referral to treatment) 3. Care Plan Compliance 4. Risk Assessment Compliance 5. Vacancy rate 6. Staff Turnover 7. Statutory and Mandatory Training Performance Highlights – M02 • Referral to assessment within 4 weeks performance improved to 96.5% in M02 (from 94.1% in M01). • Referral to treatment (RTT) continues to exceed the required standard, delivering 94.8%. • CAMHS referral to assessment (RTA) compliance within 4-weeks achieved 95.2% compliance, a notable improvement. • Mental Health Liaison Service continues to perform well, with 1, 4 and 24-hour response times consistently meeting the 95% standard. • Early Intervention in Psychosis (EIP) 2-week wait performance improved to 87.5%, (from 83.3% in M01), returning to common cause variation. • Follow up after discharge within 48 hours and 7 days has been achieved at 100% during M02. • Talking therapies for anxiety and depression achieved the revised 69% reliable improvement standard, delivering 73.7%. • Length of stay both average and median for adults and older adults remains within national benchmark ranges. • Care plan compliance improved to 96.3%, although a performance improvement plan (PIP) remains in place within the specialist services directorate. • Risk assessment compliance has increased to 96.2%,

maintaining compliance with required standard.

- **Emergency Readmission rate** within 30 days has reduced significantly to **1.4%** in M02, returning to common cause variation following a spike to 5.8% in M01.
- **No complaints** breached the 40-day response target, demonstrating effective and timely resolution processes.
- **Friends and family test** recommended rate is **83.0%**, exceeding the required standard.
- Despite the vacancy rate increasing to **6.0%** in M02, performance remains well within the threshold. April 2026 figures have been revised.
- **Staff turnover** remains stable at **7.4%**.
- **Statutory and mandatory training** remains unchanged at **91%** during M02.
- **Data Quality Maturity Index (DQMI) performance** remains consistently high at **98.4%** (February 2026).

Performance Exceptions – M02

- **CAMHS compliance within 18 week waits (RTT)** performance has deteriorated below standard, reducing to **90.6%** in M02, (from 93.5% in M01).
- **Talking therapies for anxiety and depression: reliable recovery** achieved **50.7%** during M02, marginally below the revised 51% target for 2026/27.
- **Sickness absence** has marginally increased to **6.18%**, exceeding the **<4.95% threshold**. A special cause variation remains, with PIPs active across acute and urgent care, specialist services, and primary care directorates. March and April data have been revised, and differential directorate targets have been proposed and will be introduced from M04.
- **Clinical supervision** has improved to **81.0%**, (from 78.0% in M01) but continues to remain below the required standard, indicating ongoing compliance challenges.
- **Appraisal** compliance remains static at **81.0%** with special cause variation persisting due to sustained under performance against target.

Medium Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2026/27

M02 performance against the forecasts submitted to the ICB and NHSE for 2026/27. To note:

- **Out of Area Placements (OOA)** – In M02, there were 3 inappropriate OAPs, primarily attributable to adult acute bed capacity constraints and flow issues (2 were due to adult acute

bed availability pressures and 1 was attributable to PICU bed availability).

- **Length of Stay** – Performance is measured on a 3-month rolling basis. The **average LoS**
- for this metric has met standard in M02, achieving **41.4** against the **plan of 45.3** for adult acute, and **52.6** against the **plan of 58.8** for older adult.
- **Perinatal Access** – The perinatal access metric has met standard in M02, achieving 882 against the plan of 640.
- **CYP Access** – This metric has met standard in M02, achieving 9,443 against the plan of 7,791.
- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has met standard in M02, achieving 927 against a plan of 800.
- **MHST Access** – This metric has met standard in M02, achieving 966 against the plan of 704.
- **CYP Waits Over 104 Weeks** – This metric has not met standard in M02. There were 840 waits over 104 weeks against a plan of 636. The Performance Team is actively working with services to ensure they understand this target and the actions required to improve performance. A new dashboard has been developed and is scheduled for rollout by the end of M02, focusing on services with patients waiting over 104 weeks.

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

VERSION CONTROL:

Version	Report to	Date Reported
V1	Finance and Resource Committee	23/06/26
V1	Public Trust Board	09/07/26



Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M02 (May 2026)



Contents

Change Control

Core Indicators – Monthly and Balanced Scorecard

Operational Planning Forecasts and Performance

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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 the 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 two special cause variations (orange variation flags) – signifying concern.

1. Sickness Absence
2. Appraisal

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

1. CAMHS compliance within 4 week waits (Referral to Assessment)
2. CAMHS compliance within 18 week waits (Referral to Treatment)
3. Care Plan Compliance
4. Risk Assessment Compliance
5. Vacancy Rate
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 Services 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.

Change Control

- **Talking Therapies for Anxiety and Depression**

Updated national performance standards for 2026/27 included in M02:

Metric	Target
RTT (6 weeks)	≥ 75%
RTT (18 weeks)	≥ 95%
Wait ≤90 days for treatment	<10%
Reliable Recovery	≥ 51%
Reliable Improvement	≥ 69%

Balanced Scorecard

Access & Waiting Times			
	Metric	Standard	Performance
RAG Rated Standards	10 met, 2 unmet		
Highlights	Referral to Assessment within 4 weeks	95.0%	96.5%
	Referral to Treatment within 18 weeks	92.0%	94.8%
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	95.2%
	MH Liaison 1 Hour Response (Emergency)	95.0%	96.5%
	MH Liaison 4 Hour Response (Urgent)	95.0%	98.0%
	MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	96.9%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	87.5%
	48 Hour Follow Up	95.0%	100.0%
	7 Day Follow Up (All Patients)	95.0%	100.0%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	69.0%	73.7%
Exceptions	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	90.6%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	50.7%

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

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
Specialist Services	Referral to Assessment within 4 weeks	95.0%	91.2%
	Sickness Absence (in-month)	<4.95%	6.49%
	Care Plan Compliance	95.0%	94.5%
Primary Care	Sickness Absence (in-month)	<4.95%	4.70%

Inpatient & Quality			
	Metric	Standard	Performance
RAG Rated Standards	5 met, 0 unmet		
Highlights	Average Length of Stay - Adult	40	32.6
	Median Length of Stay - Adult	42.4	12.9
	Average Length of Stay - Older Adult	90	48.5
	Median Length of Stay - Older Adult	83.8	39.2
	Emergency Readmissions rate (30 days)	<7.5%	1.4%

Organisational Health & Workforce			
	Metric	Standard	Performance
SPC Variations signifying concern	Sickness Absence	<4.95%	6.18%
	Appraisal	85.0%	81.0%
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%	6.0%
	Staff Turnover	<10.0%	7.4%
	Statutory & Mandatory Training	85.0%	91.0%
Exceptions	Sickness Absence	<4.95%	6.18%
	Clinical Supervision	85.0%	81.0%
	Appraisal	85.0%	81.0%

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
AUCD	Sickness Absence (in-month)	<4.95%	8.92%
Community	Referral to Assessment within 4 weeks-CYP	95.0%	92.3%
	Referral to Assessment within 4 weeks-Adult	95.0%	86.5%
AUCD and Community	Number of inappropriate OAPs during month	2	14
	Number of inappropriate OAPs at EOM (national measure)	2	3

Core Indicators-Monthly

Access & Wait Times	Indicator	Target	Mar-26	Apr-26	May-26	Assurance	Variation
	Referral to Assessment within 4 weeks	95.0%	95.6%	94.1%	96.5%		
	Referral to Treatment within 18 weeks	92.0%	96.1%	96.6%	94.8%		
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	94.2%	94.7%	95.2%		
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	92.8%	93.5%	90.6%		
	MH Liaison 1 Hour Response (Emergency)	95.0%	92.5%	94.9%	96.5%		
	MH Liaison 4 Hour Response (Urgent)	95.0%	95.8%	96.6%	98.0%		
	MH Liaison 24 Hour Response (Urgent from General Hospital)	95.0%	96.5%	97.9%	96.9%		
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	100.0%	N/A	N/A		
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	98.1%	N/A	N/A		
	Early Intervention - A Maximum of 2 Week Waits for Referral to	60.0%	64.3%	83.3%	87.5%		
	48 Hour Follow Up	95.0%	98.1%	94.7%	100.0%		
	7 Day Follow Up (All Patients)	95.0%	98.1%	98.2%	100.0%		
	Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	50.7%	54.4%	50.7%		
	Talking Therapies for Anxiety and Depression: Reliable	69.0%	71.5%	76.5%	73.7%		

Inpatient & Quality	Indicator	Target	Mar-26	Apr-26	May-26	Assurance	Variation
	Median Length of Stay - Adult	42.4	20.5	13.9	12.9		
	Average Length of Stay - Adult	40	62.6	31.3	32.6		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	25.0%	15.6%	13.3%		
	Median Length of Stay - Older Adult	83.8	51.0	44.6	39.2		
	Average Length of Stay - Older Adult	90	59.0	50.1	48.5		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	18.2%	12.5%	10.0%		
	Emergency Readmissions rate (30 days)	<7.5%	2.5%	5.8%	1.4%		
	Clinically Ready for Discharge (CRFD)	No Target	18.8%	23.9%	21.8%		

Community & Quality	Indicator	Target	Mar-26	Apr-26	May-26	Assurance	Variation
	Care Plan Compliance	95.0%	95.9%	96.0%	96.3%		
	Risk Assessment Compliance	95.0%	95.8%	95.5%	96.2%		

Organisational Health	Indicator	Target	Mar-26	Apr-26	May-26	Assurance	Variation
	Complaints Open Beyond Agreed Timescale	0	0	0	0		
	Friends and Family Test - Recommended	80.0%	83.0%	86.0%	83.0%		
	Safe Staffing	95%-105%	105.2%	106.0%	105.6%		
	Vacancy Rate	<10.0%	2.7%	5.9%	6.0%		
	Staff Turnover	<10.0%	7.5%	7.3%	7.4%		
	Sickness Absence	<4.95%	6.14%	6.15%	6.18%		
	Clinical Supervision	85.0%	74.0%	78.0%	81.0%		
	Appraisal	85.0%	83.0%	81.0%	81.0%		
	Statutory & Mandatory Training	85.0%	91.0%	91.0%	91.0%		

Medium Term Plan and National Mental Health Priorities: Operational Planning Forecasts 2026/27 (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	16	17	17	17	16	16	16	15	15	15	14	14	14
			Actual	14	24	3										
			Variance	4	-7	14										
			Kidsgrove Placements	2	3	1										

Inpatient Stays (people aged 18 and over from 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	5,407	5,430	5,430	5,425	5,420	5,415	5,410	5,405	5,400	5,395	5,390	5,385	5,380	
			Actual	5,215	5,050	5,379											
			Variance	-216	-380	-51											
			Nationally Published	5,050	5,050												
	Number of discharges in the RP		Plan	120	120	120	120	120	120	120	120	120	120	120	120	120	120
			Actual	123	116	130											
			Variance	3	-4	10											
			Nationally Published	115	115												
	Mean Length of stay for discharges in the RP		Plan (YTD Avg)	45.3	45.3	45.3	45.2	45.2	45.1	45.1	45.0	45.0	45.0	44.9	44.9	44.8	44.8
			Actual	42.4	43.5	41.4											
			Variance	2.8	-1.8	-3.9											
			Nationally Published	44	44												

Inpatient Stays (people aged 18 and over from Older Adult acute beds)		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
3	Total bed days for discharges in the RP	3-month rolling	Plan	3,808	3,825	3,822	3,819	3,816	3,813	3,810	3,807	3,804	3,801	3,798	3,795	3,791	
			Actual	3,485	3,496	3,473											
			Variance	-339	-329	-349											
			Nationally Published	3,495	3,495												
	Number of discharges in the RP		Plan	65	65	65	65	65	65	65	65	65	65	65	65	65	65
			Actual	67	68	66											
			Variance	2	3	1											
			Nationally Published	65	65												
	Mean Length of stay for discharges in the RP		Plan (YTD Avg)	58.8	58.8	58.8	58.8	58.7	58.7	58.6	58.6	58.5	58.5	58.4	58.4	58.3	
			Actual	52.4	52.2	52.6											
			Variance	-6.4	-6.6	-6.2											
			Nationally Published	52	52												

Medium Term Plan and National Mental Health Priorities: Operational Planning Forecasts 2026/27 (2 of 2)

CYP Access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	12-month rolling	Plan	7,818	7,785	7,791	7,797	7,803	7,809	7,815	7,821	7,827	7,833	7,839	7,845	7,851
			Actual	9,478	9,513	9,443										
			Variance	1,690	1,728	1,652										
			Nationally Published	9,515	9,515											

CYP Waits Over 104 Weeks		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
5	Children and Young People with community mental health related waits - over 104 weeks	12-month rolling	Plan	383	624	636	664	595	514	446	373	306	228	147	66	0
			Actual	838	835	840										
			Variance	208	211	204										
			Nationally Published	915	915											

MHST Access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
6	Access to Mental Health Support Teams in schools and colleges.	12-month rolling	Plan	731	698	704	710	716	722	728	734	740	746	752	758	764
			Actual	975	983	966										
			Variance	274	285	262										
			Nationally Published	985	985											

Perinatal access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
7	Number of people accessing specialist community PMH and MMHS services in the RP	12-month rolling	Plan	640	640	640	640	640	640	640	640	640	640	640	640	640
			Actual	877	871	882										
			Variance	237	231	242										
			Nationally Published	870	870											

Individual Placement Support Access		Plan Basis	Measure	Average	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
8	Number of referrals that accessed Individual Placement Support (IPS) in the reporting period	12-month rolling	ICB Plan	910	790	800	810	830	850	870	900	930	960	1,002	1,054	1,118
			ICB Actual	913	898	927										
			Variance	118	108	127										
			NSCHT Actual	410	409	410										
			MPFT Actual	503	489	517										
			ICB Nationally Published	915	915											
			NSCHT Nationally Published	410	410											

Medium Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2026/27

Out of Area Placements (OAPs) – OAPs remain a key performance challenge and continue to be driven by system-wide pressures, including reduced bed capacity, high levels of acuity, and delays in discharge. In M02, there were 3 inappropriate OAPs, primarily attributable to adult acute bed capacity constraints and flow issues (2 were due to adult acute bed availability pressures and 1 was attributable to PICU bed availability).

In response to these challenges, an OAPs Performance Improvement Plan (PIP) was initiated in M04 (25/26), encompassing both the A&UC and Community directorates.

The adult acute bed base is reduced due to Project Chrysalis, with 50 beds operational, a reduction of 14 beds. This represents the lowest level of available beds since September 2020.

The Acute & Urgent Care Directorate has established a comprehensive and multi-faceted response aligned to national priorities focused on improving patient flow, reducing length of stay, and, in collaboration with the Community Directorate, strengthening community alternatives to admission.

Further capacity constraints are being driven by delays in discharge. In M02, 21.8% 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 with CRFD patients blocking new admissions. The CRHT team is managing a higher caseload and retaining patients for longer periods to help prevent hospital admissions despite an increase in demand.

Overall, delivery against the OAP action plan continues to progress at pace, with a significant proportion of actions either completed or on track for delivery. Actions arising through the daily oversight of the programme are incorporated into the plan to ensure continuous improvement, responsiveness, and the timely identification and resolution of emerging gaps.

Progress in M02 demonstrates a system-wide improvement driven by a range of aligned factors and interventions, indicating strengthened operational grip and programme maturity:

- **System-wide oversight and governance:**

Daily bed flow meetings, weekly multi-agency oversight with ICB and local authority partners, and an established OAPs/CRFD oversight structure are now embedded, ensuring real-time visibility of capacity, demand, and escalation.

- **Improved discharge coordination and flow:**

The implementation of a revised CRFD policy and alignment of discharge coordinators to OAP patients are strengthening escalation processes and improving accountability for timely discharge.

- **Enhanced infrastructure and capacity management:**

The introduction of a Clinical Bed Manager role and continued focus on maximising internal bed utilisation (including Ward 5 capacity and rehabilitation pathways) are supporting more proactive and coordinated bed management.

- **Strengthening community pathways and gatekeeping:**

Work is underway to optimise the Crisis Resolution Home Treatment Team (CRHTT) model, including the completion of a demand and capacity review and development of options to transfer non-crisis work out of the service to protect its gatekeeping function.

- **Reducing inappropriate admissions:**

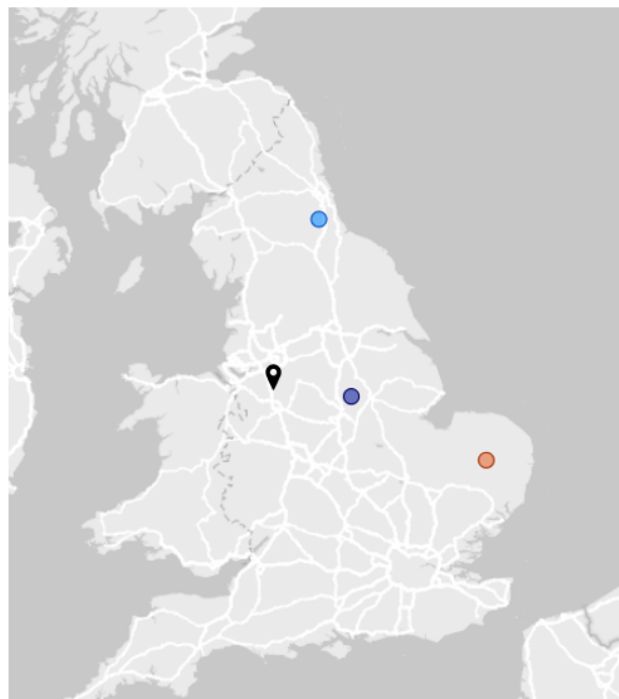
The implementation of deteriorating patient pathways in the Community, strengthened gatekeeping processes, and development of alternative crisis provision are improving the identification and management of patients earlier in the pathway, reducing avoidable admissions.

- **Improved reporting and assurance:**

Development of enhanced reporting dashboards is progressing to support better tracking of OAPs drivers, delays, and outcomes, with routine reporting to the Executive Team and Quality Committee now established.

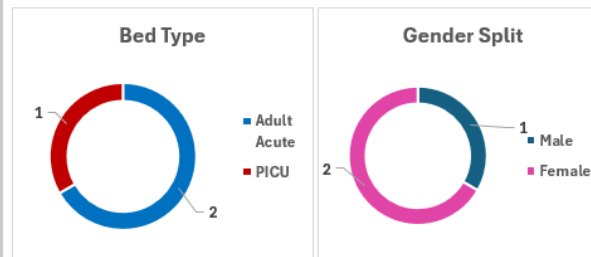
A resolute OAPs Standing Operating Procedure (SOP) is in place, providing assurance around staff roles, responsibilities, and clinical oversight for patients placed out of area (OOA). The Trust places patients only with providers rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC) and seeks to minimise distance from home wherever possible. We recognise that the ICS may place patients in out-of-area beds rated "Requires Improvement."

**The below information highlights the distance from Harplands to OAP admissions and shows appropriate placements at Cygnet Hospital Kidsgrove. As a Trust, we prioritise placements rated "Good" wherever possible. The exception is Cygnet, Kidsgrove which has recently been re-rated as "Requires Improvement"; however, this remains aligned with the ICS position. We are satisfied that robust oversight arrangements are in place, with any concerns addressed promptly. Our proximity to the service further supports regular visits and effective monitoring of patient care.*



Key	Name of Hospital	Distance from Harplands (mi)	No. of Placements
●	Cygnet Appletree	180	1
●	Cygnet Hospital Sherwood	61	1
●	Priory Hospital Norwich	184	1
●	Cygnet Hospital Kidsgrove		1
📍	Harplands Hospital		*Total: 3

*Total excludes Cygnet Kidsgrove placements



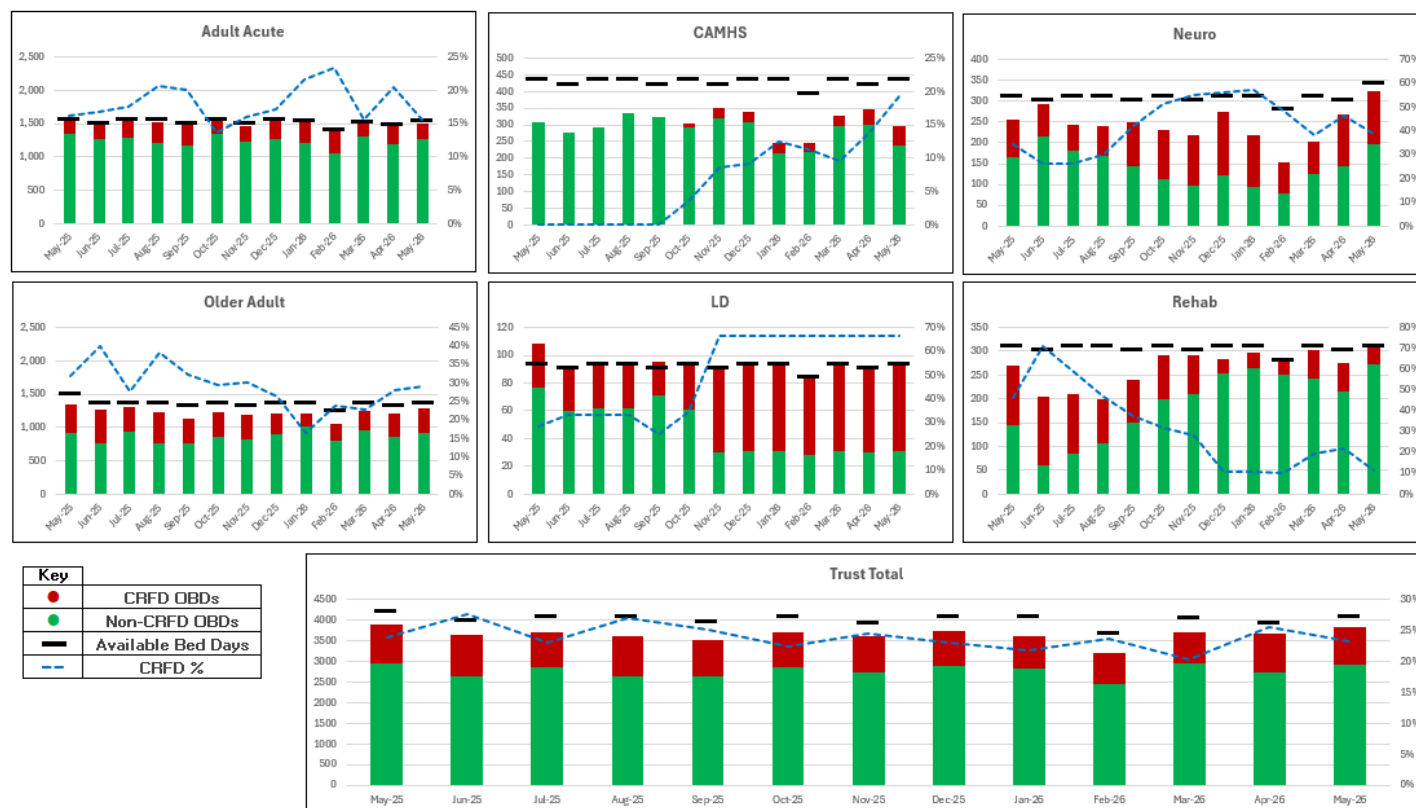
Whilst early improvements in oversight and process are evident, performance continues to be constrained by structural pressures including reduced bed stock and system delays in discharge. Actions remain focused on delivering sustainable improvements in flow and reducing reliance on OAPs over the medium term.

Medium Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2026/27 – 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 clinically ready for discharge (CRFD). Whilst Stoke-on-Trent City Council has been working collaboratively with the Trust to reduce the historically high number of Stoke-based CRFD patients, these continue and remain a significant contributing factor impacting both local and OAP patients.

There remain delays in discharging CRFD patients from both local inpatient beds and OAPs, which is directly impacting patient flow and limiting the availability of beds for new admissions. In addition, complexity of need and placement matching requirements further contribute to delays, particularly for patients placed OOA where repatriation is dependent on suitable local provision becoming available.

These combined factors continue to create blockages within the discharge pathway, increasing LoS for those CRFD, and sustaining reliance on OAPs. The risks associated with this have been escalated system-wide, with ongoing engagement with the ICB and local authority partners to identify sustainable solutions. It is of concern that the Social Care Act does not require the timely social care support for those patients in acute mental health beds.



Medium Term Plan and National Mental Health Priorities: Performance against Operational Planning Forecasts 2026/27

- **Inpatient Stays** – Included within the national operational priorities for the 2026/27 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 and older adult acute beds. Performance is measured on a 3-month rolling basis and covers adult acute, psychiatric intensive care unit (PICU) and older adult acute occupied bed days (OBDs), discharges, and LoS. The average LoS for this metric has met standard in M02, achieving 41.4 against the plan of 45.3 for adult acute, and 52.6 against the plan of 58.8 for older adult.
- **Perinatal Access** – The perinatal access metric has met standard in M02, achieving 882 against the plan of 640.
- **CYP Access** – This metric has met standard in M02, achieving 9,443 against the plan of 7,791.
- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has met standard in M02, achieving 927 against a plan of 800.
- **MHST Access** – This metric has met standard in M02, achieving 966 against the plan of 704.
- **CYP Waits Over 104 Weeks** – This metric has not met standard in M02. There were 840 waits over 104 weeks against a plan of 636. The Performance Team is actively working with services to ensure they understand this target and the actions required to improve performance. A new dashboard has been developed and is scheduled for rollout by the end of M02, focusing on services with patients waiting over 104 weeks.

Core Indicators – 13 Month Trend (1 of 2)

Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Referral to Assessment within 4 weeks	95.0%	94.7%	93.5%	93.3%	92.4%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%	94.1%	96.5%
Referral to Treatment within 18 weeks	92.0%	96.1%	95.4%	95.9%	96.1%	96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%	96.6%	94.8%
CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	90.9%	92.0%	91.1%	78.2%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%	94.7%	95.2%
CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	91.8%	85.9%	92.8%	88.6%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%	93.5%	90.6%
MH Liaison 1 Hour Response (Emergency)	95.0%	95.7%	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%
MH Liaison 4 Hour Response (Urgent)	95.0%	97.6%	93.8%	96.0%	95.5%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%	96.6%	98.0%
MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	95.9%	96.0%	96.4%	96.5%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%	97.9%	96.9%
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	N/A	97.3%	N/A	N/A	100.0%	N/A	N/A	98.0%	N/A	N/A	98.1%	N/A	N/A
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	100.0%	95.0%	94.7%	75.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%	83.3%	87.5%
48 Hour Follow Up	95.0%	95.6%	96.4%	100.0%	100.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%	94.7%	100.0%
7 Day Follow Up (All Patients)	95.0%	100.0%	96.4%	100.0%	100.0%	100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%	98.2%	100.0%
Emergency Readmissions rate (30 days)	<7.5%	1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%	5.8%	1.4%
Care Plan Compliance	95.0%	94.5%	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%	96.0%	96.3%
Risk Assessment Compliance	95.0%	95.8%	96.0%	95.7%	96.2%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%	95.5%	96.2%
Complaints Open Beyond Agreed Timescale	0	2	5	1	1	0	0	0	0	0	0	0	0	0
Friends and Family Test - Recommended	80.0%	72.0%	81.5%	86.4%	82.5%	87.6%	76.0%	88.0%	81.0%	89.0%	92.0%	83.0%	86.0%	83.0%
Safe Staffing	95%-105%	107.3%	107.4%	103.9%	103.8%	102.8%	102.5%	106.1%	107.1%	109.6%	104.4%	105.2%	106.0%	105.6%
Sickness Absence	<4.95%	6.35%	6.33%	6.27%	6.25%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.14%	6.15%	6.18%

Core Indicators – 13 Month Trend (2 of 2)

Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	50.2%	51.6%	53.7%	51.9%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%	54.4%	50.7%
Talking Therapies for Anxiety and Depression: Reliable Improvement	69.0%	70.1%	73.9%	77.4%	73.2%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%	76.5%	73.7%
Median Length of Stay - Adult	42.4	25.0	19.9	22.9	17.2	14.6	26.9	27.4	18.9	15.9	25.9	20.5	13.9	12.9
Average Length of Stay - Adult	40	34.0	62.3	49.3	26.6	37.0	34.7	45.0	43.7	32.5	36.6	62.6	31.3	32.6
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	20.7%	16.7%	22.2%	12.8%	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%	15.6%	13.3%
Median Length of Stay - Older Adult	83.8	48.0	58.0	41.0	32.5	35.5	35.0	45.5	37.5	48.0	33.0	51.0	44.6	39.2
Average Length of Stay - Older Adult	90	80.9	70.2	55.7	55.3	46.4	47.2	58.5	60.1	55.3	47.4	59.0	50.1	48.5
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	38.1%	21.1%	30.4%	18.2%	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%	12.5%	10.0%
Clinically Ready for Discharge (CRFD)	No Target	23.3%	27.2%	22.2%	28.5%	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%	23.9%	21.8%
Vacancy Rate	<10.0%	8.3%	8.2%	8.0%	7.6%	5.1%	3.3%	3.0%	3.3%	2.9%	2.2%	2.7%	5.9%	6.0%
Staff Turnover	<10.0%	9.7%	8.9%	8.9%	8.5%	8.1%	7.3%	7.3%	7.4%	7.4%	7.7%	7.5%	7.3%	7.4%
Clinical Supervision	85.0%	83.0%	80.0%	79.0%	81.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%	78.0%	81.0%
Appraisal	85.0%	84.0%	83.0%	81.0%	84.0%	78.0%	79.0%	83.0%	83.0%	82.0%	82.0%	83.0%	81.0%	81.0%
Statutory & Mandatory Training	85.0%	91.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%
DQMI	95.0%	98.4%	98.5%	98.4%	98.5%	98.6%	98.5%	98.7%	98.8%	98.3%	98.4%	N/A	N/A	N/A

In M02 there are 34 metrics monitored; 22 have achieved the required standard and 5 have not achieved the required standard. 3 metrics have no target and are being monitored. 2 metrics are reported quarterly. 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 Improvement 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 currently forecast for November 2026. Trajectory milestones were originally set in M06 (Sept-Jan 2024/25) and have been reset to reflect delivery challenges: M11 (Feb-Jun 2025/26), M04 (Aug-Jan 2025/26), and most recently M10 (Jan-Nov 2026/27). Performance in M02 is 91.2%, which is above the planned trajectory of 85.0% and below the required standard. Updated actions have been provided in M02.
	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, expected to achieve standard in April 2026, and is currently forecast for July 2026. CYP performance in M02 is 92.3%, which is below the planned trajectory of 94.0% and does not meet 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 2025/26), M04 (2025/26), with trajectory revised from 95% to 85% and M05 (Aug-Apr 2026), M01 (Apr-Jul 2026). Updated actions have been provided in M02.
	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, January 2026 and is now forecast for July 2026. Adult performance in M02 is 86.5%, which is below the planned trajectory of 92.0% and does not meet the required standard.

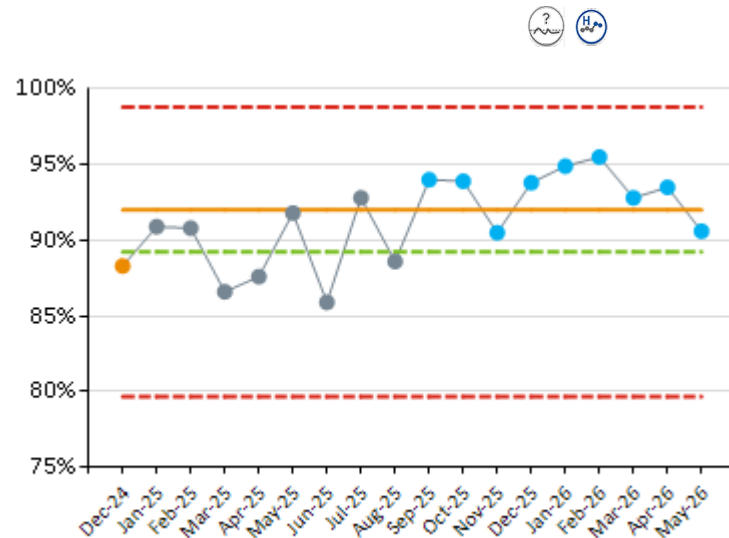
Metric	Directorate	Status
		Trajectory milestones were initially set in M10 2024/25 (May–Aug 2025) and have since been reset in M06 2025/26 (Sep–Jan 2025/26) and again in M10 2025/26, and most recently M01 (Apr-Jul 2026). Updated actions have been provided in M02.
Sickness Absence (In-month)	Acute & 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%. In-month sickness absence for M02 is 8.92%, which is higher than the required standard, indicating performance below expectation. Updated trajectories will be provided when the new directorate sickness targets are agreed.. Updated actions have been provided in M02.
	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 4.35% which is within the <4.95% required standard. Trajectories have been set in M02 (Apr-Mar 2025/26) and revised in M01 (Apr-Jun 2026/27). The Primary Care directorate aimed for the standard to be met in December 2025 and this has been revised to June 2026. The in-month sickness absence for M02 is 4.70%, which is below the 5.80% planned trajectory and required standard, indicating performance above expectation. The Trust standard has been met for the third consecutive month, allowing the performance improvement plan to be closed. Updated actions have been provided in M02.
	Specialist Services	A PIP was requested in M03 (2024/25). The trajectories were set in February 2025 to return the sickness absence rate to the 4-year average position of 5.97% by end of March 2026, which exceeds the <4.95% required standard and subsequently revised in M01 (Apr-Sep 2026/27). In-month sickness absence for M02 is 6.49%, which is higher than the planned trajectory of 6.00% and required standard, indicating performance below expectation. Updated actions have been provided in M02.

Metric	Directorate	Status
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 was revised to January 2026 and is now forecast for June 2026. Performance during M02 is 94.5%, exceeding the planned trajectory of 94.0% and slightly below the 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) and M01 (Apr-Jun 2026/27). Updated actions have been provided in M02.
Out of Area Placement (OAPs)	Acute and Urgent Care and Community	A PIP was requested in M04 (2025/26). Performance during M02 is measured by the number of inappropriate OAPs during month and the number of inappropriate OAPs at EOM (national measure) which were 14 and 3, respectively. Updated actions have been provided in M02.

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

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



13 Month Trend

91.8%	85.9%	92.8%	88.6%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%	93.5%	90.6%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Performance is at **90.6% in M02**. The variation is showing improvement.

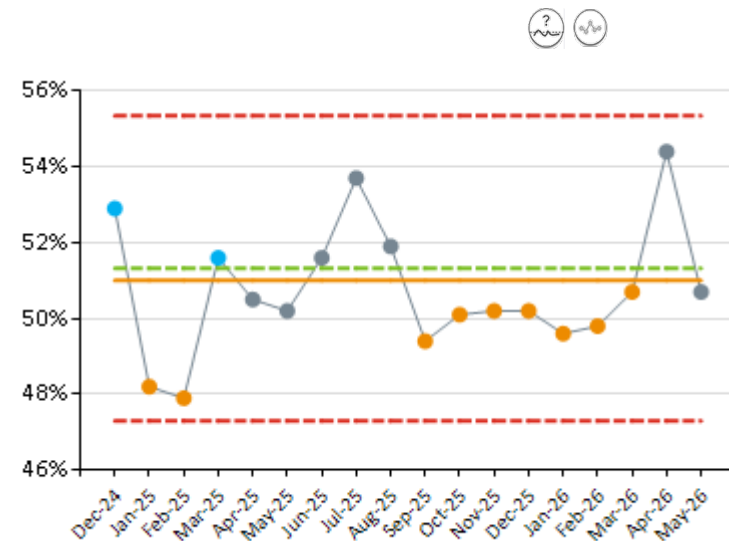
Current performance: Community-96.3%, Specialist Services-N/A, Acute and Urgent Care-2.2%.

In M02, 11 breaches were reported against the **CAMHS RTT** metric.

At the point of breach, no patients had an open mental health service exceeding a duration of 18 weeks.

All breaches were associated with extended waits within Neurodevelopmental services. Of these, 9 referrals were allocated to ASD services and 2 to ADHD services.

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



13 Month Trend

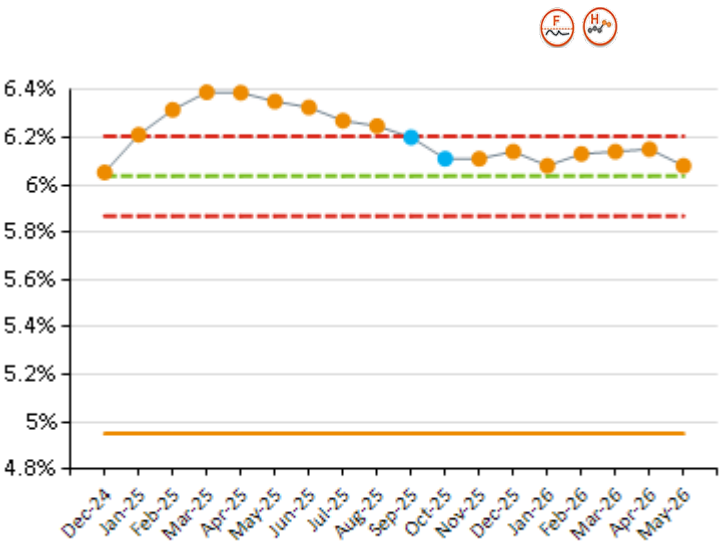
50.2%	51.6%	53.7%	51.9%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%	54.4%	50.7%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Performance is at **50.7% in M02**. The variation is showing common cause.

The 2026/27 national performance standard has been updated to 51%.

ORGANISATIONAL HEALTH AND WORKFORCE

Sickness Absence (Trust Measure)



13 Month Trend

6.35%	6.33%	6.27%	6.25%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.14%	6.15%	6.08%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Performance is **6.08%** in **M02**, with variation indicating concern.

Community	6.05%
Specialist Services	6.98%
Acute and Urgent Care	8.00%
Primary Care	6.02%
Corporate	2.89%

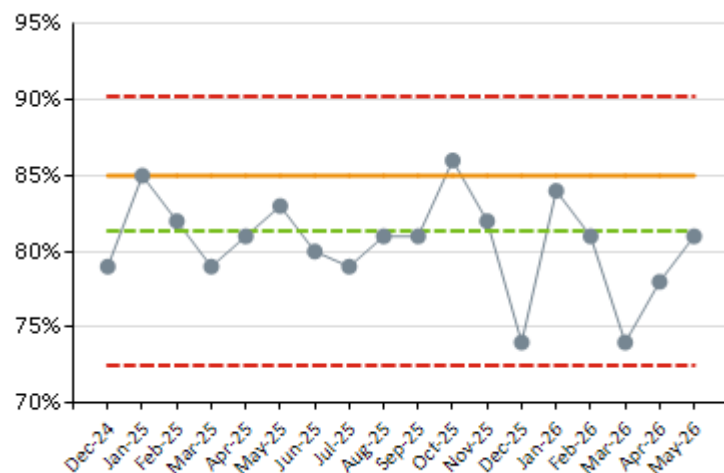
A PIP is in place for Acute and Urgent Care, Specialist Services and Primary Care directorates. Primary Care performance improvement plan is to be closed.

Whilst the variation to target is showing concern, the Trust has delivered a reduction in sickness absence in M02. Partnership with the people team and directorate leadership teams to develop plans for return to work whilst holding accountability with managers has commenced. PCDC received a detailed update on the trends with sickness absence data; alongside suggested local directorate targets based on actual performance and peer benchmarking. The aim will be to use the targets as a framework for co-producing interventions and a trajectory for delivery in 2026/27. Following support from People, Culture & Development Committee and Senior Leadership Team, localised directorate targets have been proposed and follow up actions involve socialising in detail with directorates to seek assurance that a trajectory of delivery will be achievable. The aim is to introduce these into the M04 IQPR.

Stress, anxiety or depression accounts for the largest proportion of absence. Interventions to support preventative and corrective action are in place including Health & Wellbeing actions: EFT wellbeing project, Menopause action plan and Stress reduction pilot, policy development, and attendance clinics.

Whilst sickness absence is above target, recognition of the improved compliance has been acknowledged by NHS England Midlands, and representatives from the Trust were invited to share best practice at a recent regional summit.

Clinical Supervision (Trust Measure)



13 Month Trend

83.0%	80.0%	79.0%	81.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%	78.0%	81.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

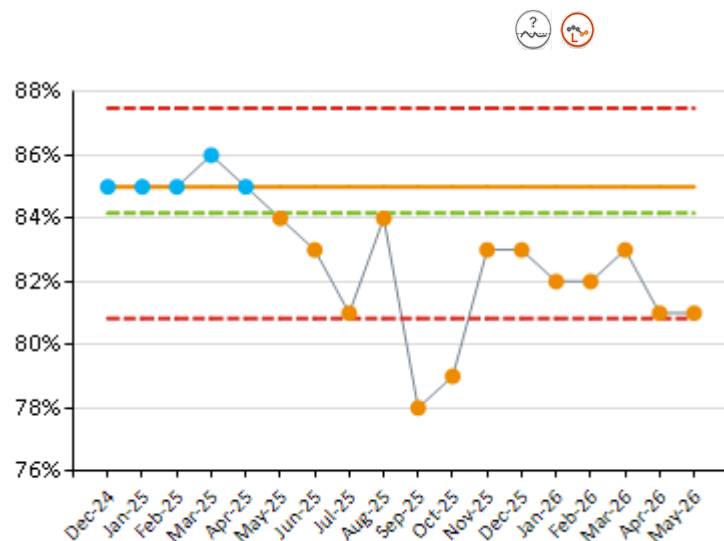
Performance is at **81.0% in M02**. The variation is showing common cause.

Current performance: Community-78.0%, Specialist Services-83.0%, Acute and Urgent Care-82.0%, Primary Care-87.0%, Corporate-79.0%.

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 completed following survey report. Task and finish group commenced focusing on education and communication to raise skills and awareness Trust wide. Screen saver highlighting requirements is active.

Appraisal (Trust Measure)



13 Month Trend

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

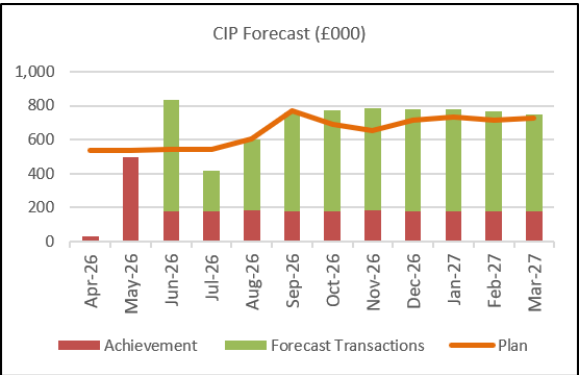
Performance is at **81.0% in M02**. The variation is showing concern.

Current performance: Community-83.0%, Specialist Services-86.0%, Acute and Urgent Care-77.0%, Primary Care-76.0%, Corporate-80.0%.

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 put in place since September 2026. Data cleanse will be undertaken in M03. These measures are expected to improve compliance.

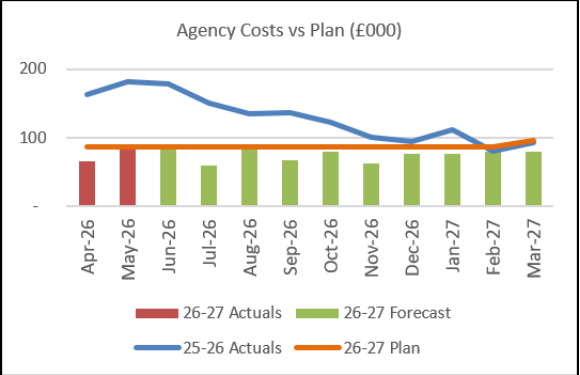
Financial Performance

CIP Delivery v Plan



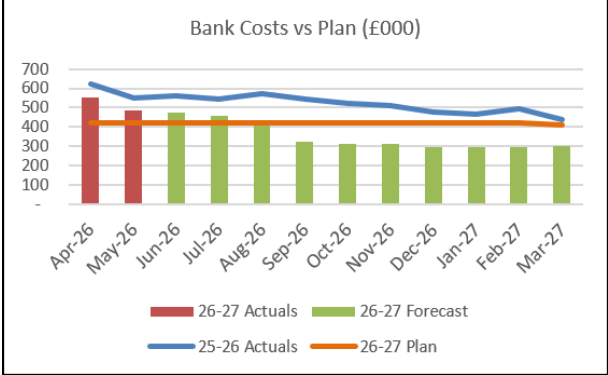
The CIP graph shows current achievement and forecast transactions against the £7.8m plan. The Trust is forecasting full achievement of £7.8m target.

Agency Cost v Plan (40% reduction)

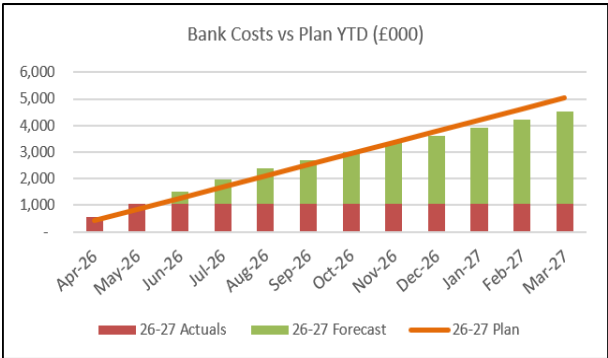
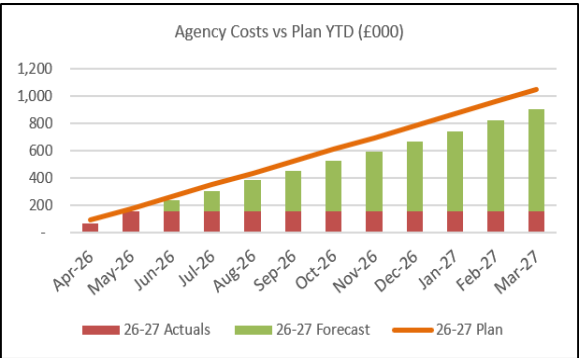
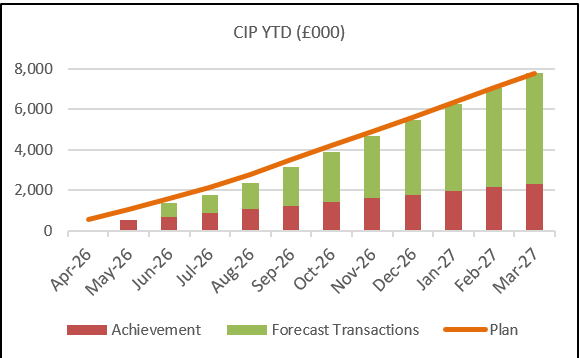


The agency graph shows actual and forecast costs against a £1.1m plan. The Trust is forecasting £0.9m total costs at Month 2.

Bank Cost v Plan (10% reduction)



The bank graph shows actual and forecast costs against a £5.0m plan. The Trust is forecasting at Month 2 total costs of £4.5m.



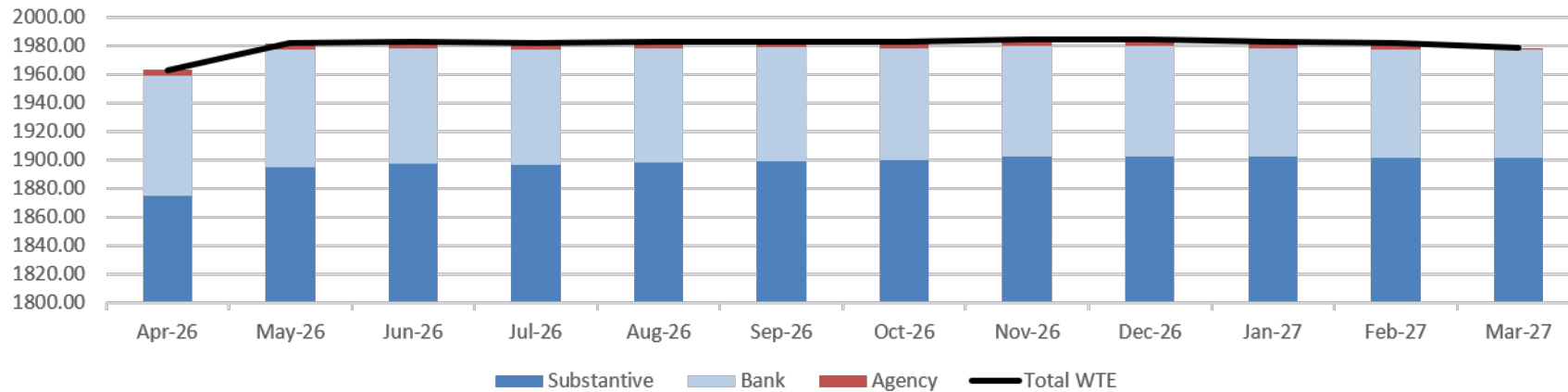
Workforce Plan (1 of 3)

May-26 NSCHT	WTE				Spend				WTE TO PLAN	£ TO PLAN
	Plan	Actual	Variance From Plan		Plan	Actual	Variance From Plan			
	WTE	WTE	WTE	%	£'000	£'000	£'000	%		
Total	1,982.8	1,951.5	-31.3	-1.6%	£9,238.0	18,868.0	+£9,630	+104.2%	▼	▲
Substantive	1,895.2	1,856.2	-38.9	-2.1%	£8,730.0	£17,680.0	+£8,950	+102.5%	▼	▲
Medical and Dental	72.5	69.5	-3.0	-4.2%	£962.0	£1,934.0	+£972	+101.0%	▼	▲
Registered nursing, midwifery and health visiting staff	617.8	575.6	-42.2	-6.8%	£2,930.0	£5,850.0	+£2,920	+99.7%	▼	▲
Registered scientific, therapeutic and technical staff	309.2	306.0	-3.2	-1.0%	£1,880.0	£3,553.0	+£1,673	+89.0%	▼	▲
Support to clinical staff	507.2	540.8	+33.6	+6.6%	£1,419.0	£3,194.0	+£1,775	+125.1%	▲	▲
Total NHS infrastructure support	386.9	360.9	-25.9	-6.7%	£1,539.0	£3,149.0	+£1,610	+104.6%	▼	▲
Any other staff	1.6	3.4	+1.8	+111.5%	£0.0	£0.0	£0		▲	▼
Bank	83.3	90.9	+7.7	+9.2%	£421.0	£1,036.0	+£615	+146.1%	▲	▲
Medical and Dental	1.3	4.5	+3.2	+251.8%	£100.0	£208.0	+£108	+108.0%	▲	▲
Registered nursing, midwifery and health visiting staff	25.2	23.8	-1.5	-5.9%	£95.0	£283.0	+£188	+197.9%	▼	▲
Registered scientific, therapeutic and technical staff	0.7	1.6	+0.9	+128.1%	£12.0	£32.0	+£20	+166.7%	▲	▲
Support to clinical staff	55.0	58.7	+3.8	+6.8%	£200.0	£488.0	+£288	+144.0%	▲	▲
Total NHS infrastructure support	1.1	2.3	+1.2	+115.8%	£14.0	£25.0	+£11	+78.6%	▲	▲
Any other staff	0.0	0.0	0.0		£0.0	£0.0	£0		▼	▼
Agency	4.30	4.32	+0.0	+0.5%	£87.00	£152.00	+£65	+74.7%	▲	▲
Medical and Dental	4.30	3.01	-1.3	-30.0%	£84.00	£141.0	+£57	+67.9%	▼	▲
Registered nursing, midwifery and health visiting staff	0.00	0.76	+0.8		£3.00	£11.0	+£8	+266.7%	▲	▲
Registered scientific, therapeutic and technical staff	0.00	0.55	+0.6		£0.00	£0.0	£0		▲	▼
Support to clinical staff	0.00	0.00	0.0		£0.00	£0.0	£0		▼	▼
Total NHS infrastructure support	0.00	0.00	0.0		£0.00	£0.0	£0		▼	▼
Any other staff	0.00	0.00	0.0		£0.00	£0.0	£0		▼	▼

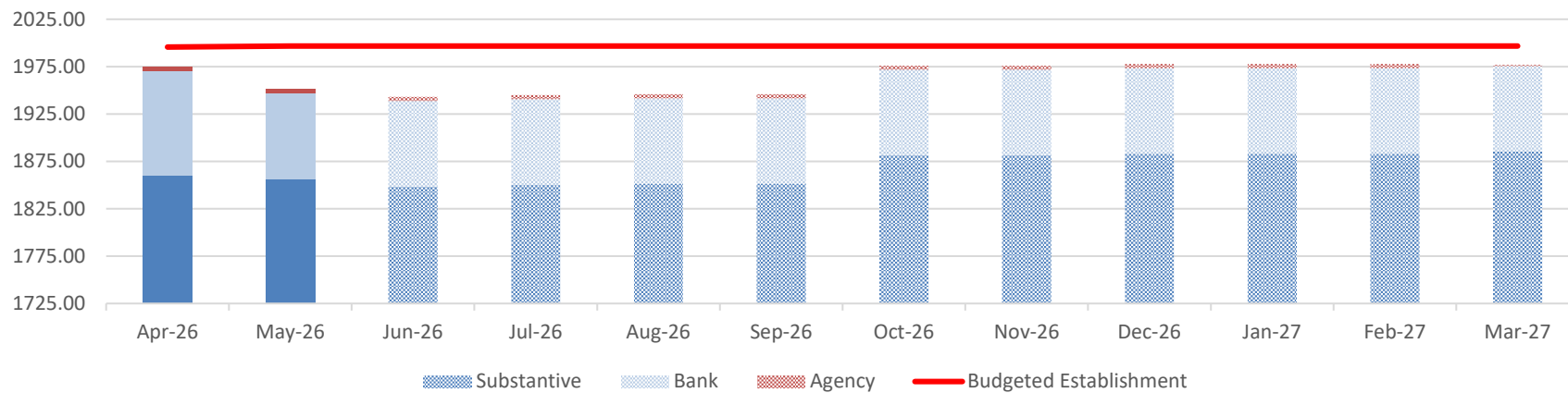
- The table above is a comparison between the plan for WTE/Spend for M02 and the actual position.
- Since the workforce plan was submitted earlier this year, there has been a national coding update which means that certain roles that previously fell under NHS Infrastructure, now fall under the Support to Clinical Staff. This has generated the over/under plan variation as above.

Workforce Plan (2 of 3)

2026-27 Workforce Plan (WTE)

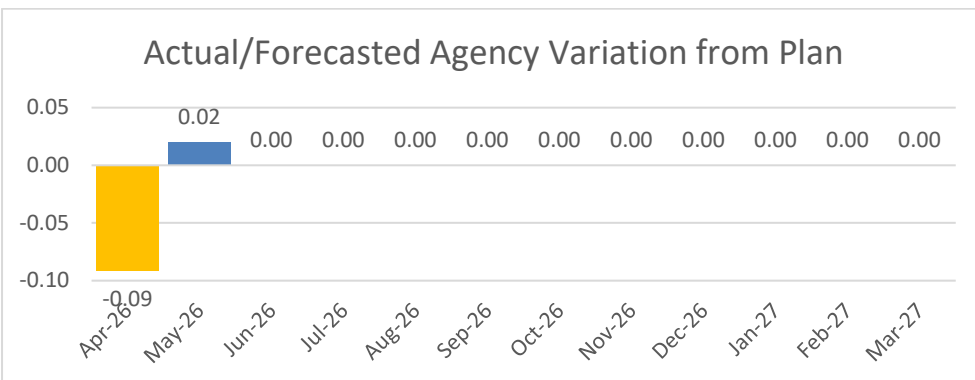
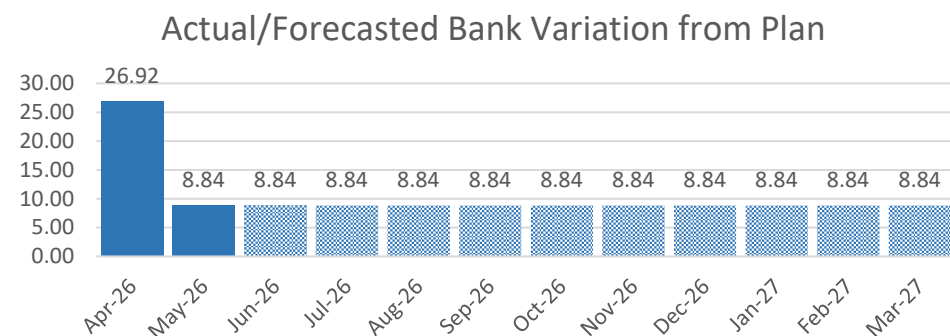
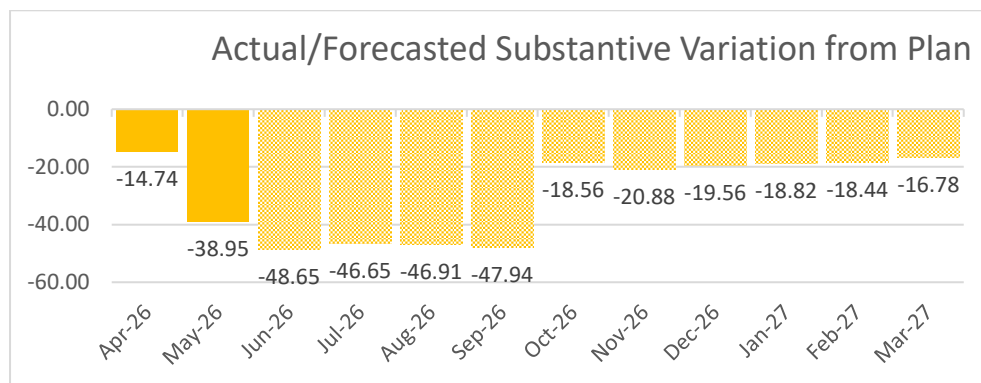


Actual/Forecasted Position (WTE)



This shows 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. Also included in this year's forecasting is the over/under plan wte to date.

Workforce Plan (3 of 3)



M02 actual vs plan - As at M02 for 2026-27, the Trust is **20wte** below what was forecasted for the total workforce. This consists of the substantive whole time equivalent (WTE) being **39wte** under plan and Temp Staffing cover being 9wte over plan.

Included in the 2026/27 Workforce Plan, workforce growth was identified for the below services;

Primary Care/Ascend – 0.5wte

Primary Care/CIC – 10wte

Community MH/IPS – 4.6wte – 1wte growth by M02

Specialist Services/Forensic Liaison Partnership – 5.1wte – 1wte growth by M02.

It is anticipated that this growth will be fulfilled through internal and external recruitment.

Temp Staffing - 66% of all Bank usage included in M02 reporting was for “Establishment Shortfall” as recorded in Optima. This reporting reason includes all staff absences except for annual leave and where there has bank usage for this reason.

Trust Vacancy Position - The vacancy rate for M02 is 6%. This is a slight increase from M02 and is due to a small increase in the budgeted establishment and a reduction in the staff in post wte.

Forecasted position - The forecasted variation included here is based on the current variation from plan and has been mitigated by indicative changes that may take place over the financial year that were not included in the original plan submission.

The indicative figures referenced here and in the previous workforce forecast are not yet confirmed but come from workforce planning conversations with clinical and specialty leads.

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 M02 is 92.3% and is not exceeding the planned trajectory of 94.0% nor meeting the required standard.

The original aim for achieving the required standard was March 2026, this was subsequently brought forward to September 2025, expecting to achieve standard in April 2026, and is currently forecast for July 2026.

Trajectory milestones were initially set in M01 (Apr-Apr 2024/25) and have been reset to reflect revised planning assumptions, M02 (May-Sept 2025/26). M04 (2025/26 with trajectory revised from 95% to 85%) and M05 (Aug-Apr 2026), and M01 (Apr-Jul 2026/27).

Updated actions have been provided for M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	79.4%	81.4%	75.6%	67.9%	71.9%	88.4%	97.3%	86.1%	93.7%	95.1%	96.2%	93.8%	92.3%
Trajectory	70.0%	80.0%	85.0%	90.0%	70.0%	75.0%	78.0%	80.0%	83.0%	85.0%	87.0%	90.0%	94.0%

Actions in M02:

The extended hours pilot (8am–8pm, Monday–Friday) at Tunstall CAMHS is now concluding, with engagement sessions completed across the wider Core CAMHS teams. During the pilot, services operated Monday–Thursday before transitioning to a full Monday–Friday offer. All three Core CAMHS teams are now preparing to move to 8am–8pm working from mid-July, with rotas currently being finalised. The pilot has demonstrated a positive impact, particularly in reducing DNA rates, which continue to be closely monitored by Team Leads, with monthly highlight reports submitted to the Service Manager for inclusion in the risk register. Feedback from children, young people and families has been positive, alongside improvements in room utilisation at Tunstall, and similar benefits are anticipated across other teams as the model is rolled out.

Teams continue to maintain adherence to the **Supporting Attendance at Work Policy**, with a clear focus on effective absence management. Monthly HR sickness reports are reviewed by Service Managers to ensure appropriate oversight and timely action, while in-month sickness is monitored by Team Leads, the Service Manager and Senior Service Manager through regular sickness surgeries. Early findings from these reviews highlight the need for more robust application of Stage 1, 2 and 3 processes. Attendance management training compliance will be reviewed, with the expectation that all Team Leads and Deputies have completed this, and compliance will continue to be monitored until fully achieved.

To address recent challenges in waiting time performance, weekly review meetings between the Service Manager and Team Leads have been introduced. These meetings focus on strengthening proactive management and responding to recent performance dips, supporting timely intervention and oversight. It is noted that all recorded breaches in Month 02 were linked to the ASD pathway apart from one that needed a full notes review by one of our consultants.

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

Community directorate

Core CAMHS

Apr-26

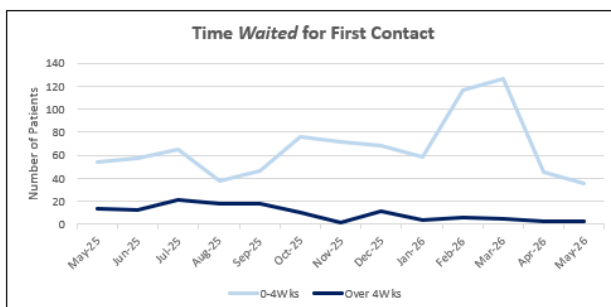
RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	318	38	4	6	366	86.9%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	15	0	0	2	17	88.2%
North Stoke CAMHS	14	1	0	0	15	93.3%
South Stoke CAMHS	16	0	0	0	16	100.0%
CAMHS Total	45	1	0	2	48	93.8%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	10	1	0	0	11	90.9%
North Stoke CAMHS	0	0	0	0	0	
South Stoke CAMHS	8	0	0	0	8	100.0%
CAMHS Total	18	1	0	0	19	94.7%



May-26

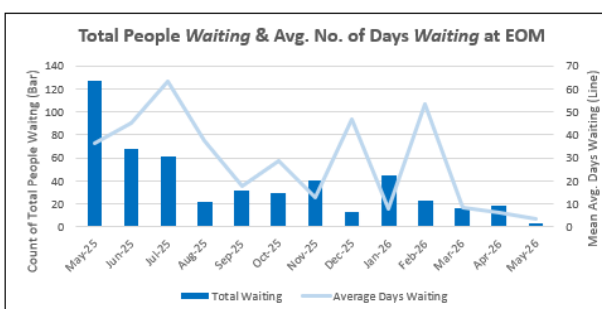
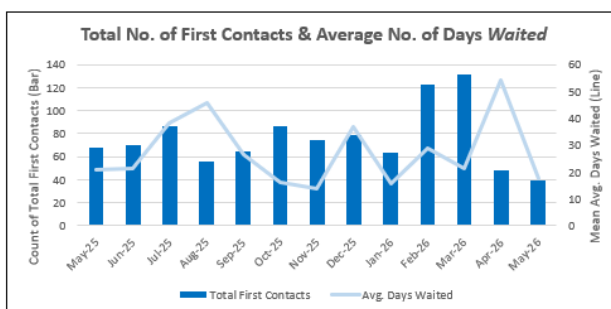
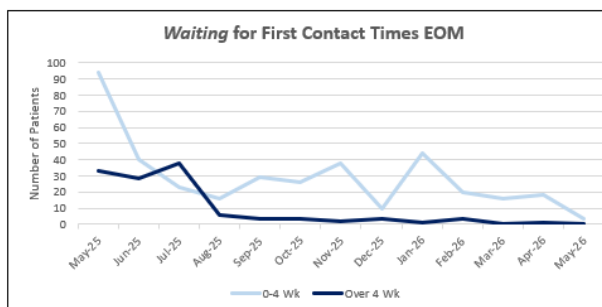
RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	290	13	2	5	310	93.5%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	15	3	0	0	18	83.3%
North Stoke CAMHS	7	0	0	0	7	100.0%
South Stoke CAMHS	14	0	0	0	14	100.0%
CAMHS Total	36	3	0	0	39	92.3%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
North Staffs CAMHS	0	0	0	0	0	
North Stoke CAMHS	1	0	0	0	1	100.0%
South Stoke CAMHS	2	0	0	0	2	100.0%
CAMHS Total	3	0	0	0	3	100.0%



- The Community directorate's RTA performance increased by 6.6% between M01 and M02. RTA performance in M02 is 1.5% below standard.
- RTA performance for Core CAMHS CMHTs is below standard in M02, achieving 92.3% against a target of 95%.

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 M02 is 86.5% which is below the planned trajectory of 92.0% and is currently not meeting the required standard. Performance has declined significantly compared with the prior 7 months.

The original target date for achieving the required standard was May 2025; this was subsequently revised to August 2025, January 2026 and is now forecast for July 2026.

Trajectory adjustments: Set M10 2024/25 (May-Aug 2025). Reset in M06 (Sep-Jan 2025/26). Reset in M11 (Feb-Apr 2026). Reset in M01 (May-Jul 2026/27).

Updated actions have been provided for M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	92.1%	88.2%	82.5%	78.8%	93.2%	92.5%	95.0%	96.1%	93.9%	92.6%	94.2%	86.0%	86.5%
Trajectory	92.0%	93.0%	94.0%	95.0%	85.0%	87.0%	90.0%	92.0%	95.0%	93.0%	94.0%	95.0%	92.0%

Actions:

Demand and Capacity Across CMHTs. The senior service manager will be consulting with the performance team to undertake a full demand and capacity review across all CMHTs to ensure resources are deployed effectively in line with variation in local need.

M02 update: Data review is ongoing. Work to scope a caseload management tool continues, with the intention of implementing a standardised approach across the Directorate.

Team leader absences have previously placed operational pressure across several teams. All team leads and clinical leads have now returned from sick leave, and substantive leadership arrangements are in place across CMHTs. Absence management continues in line with policy, with team leads working closely with service managers to ensure equitable allocation of work across senior colleagues who are in post.

M02 update: Monthly sickness surgeries continue to be embedded across all teams, supporting proactive attendance management, early intervention, and improved workforce stability. Compliance with attendance management training for Team Leads and Deputies continues to be monitored.

Review of CMHTs structures and resource management. The Single Assessment Framework (SAF) waiting list remains under active review across CMHTs to ensure timely allocation and effective use of available resources. **M02 update:** Caseload reviews with Band 6 practitioners at Lymebrook have now been completed. Across Lymebrook and all depot areas, non-complex caseloads have been reallocated to Band 5 staff, with only complex patients remaining with Band 6 practitioners. This is expected to create additional capacity within the workforce to increase SAF allocation and improve overall flow through the system. Further work to review job plans and maximise capacity for SAF activity will continue, alongside ongoing monitoring of waiting times, caseload saturation, and workforce availability.

Actions:

Review of CMHTs structures and resource management. The Single Assessment Framework (SAF) waiting list remains under active review across CMHTs to ensure timely allocation and effective use of available resources. **M02 update (contd):** *Challenges within CMHTs currently remain most notable at the Sutherland site. These are primarily linked to staff sickness, vacancies, and the impact of newly appointed staff who are still completing inductions and therefore not yet contributing fully to assessment activity. As a result, overall assessment throughput has been temporarily reduced. Despite these pressures, the team is actively working towards achievement of the RTA target, supported by the appointment of a substantive Team Leader. In addition, Pathway Leads are now in post, which is expected to drive improved efficiency, oversight, and consistency across the service line.*

The Directorate has explored the **redeployment of Key Workers** from across the Directorate to support capacity pressures at Lymebrook. **M02 update:** *Three redeployed staff members remain in post and are continuing to provide additional Key Worker capacity to support demand and improve timeliness of allocation. This action remains under review to ensure sustained impact.*

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

Community directorate

Apr-26

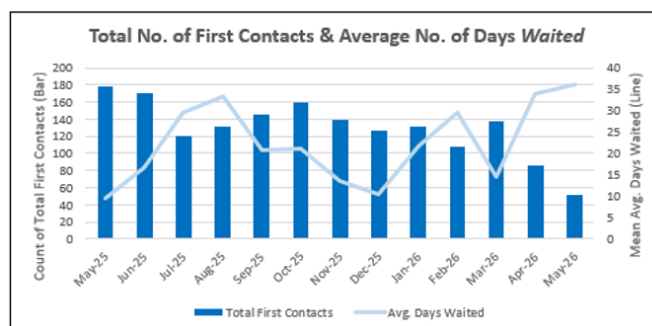
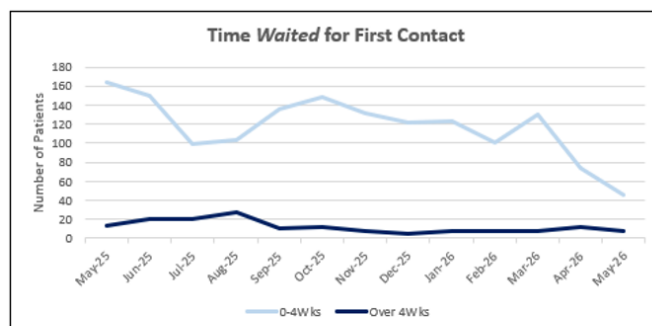
RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	318	38	4	6	366	86.9%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	20	1	0	0	21	95.2%
City CMHT - Sutherland	13	6	1	1	21	61.9%
County CMHT Moorlands	13	0	0	0	13	100.0%
County CMHT Newcastle	28	1	1	1	31	90.3%
CMHT Total	74	8	2	2	86	86.0%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	1	0	0	0	1	100.0%
City CMHT - Sutherland	14	1	1	0	16	87.5%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	1	0	0	0	1	100.0%
CMHT Total	16	1	1	0	18	88.9%



May-26

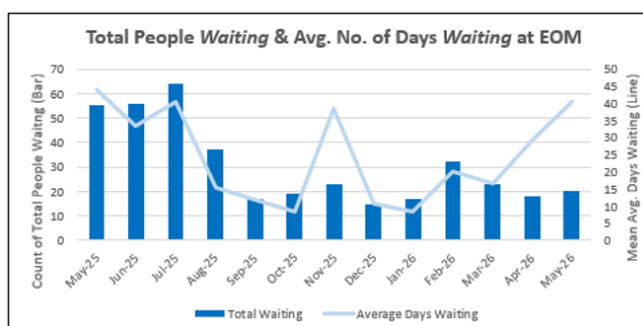
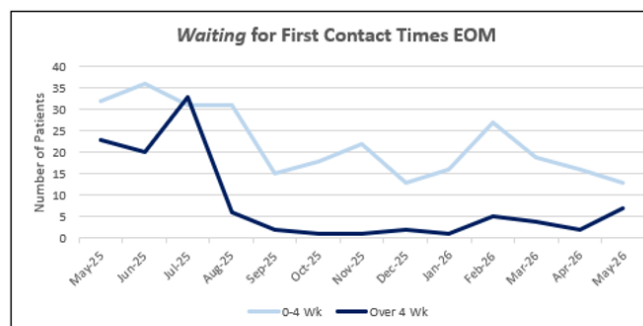
RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	290	13	2	5	310	93.5%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	12	1	0	1	14	85.7%
City CMHT - Sutherland	15	3	1	0	19	78.9%
County CMHT Moorlands	13	0	0	1	14	92.9%
County CMHT Newcastle	5	0	0	0	5	100.0%
CMHT Total	45	4	1	2	52	86.5%

RTA Waiting

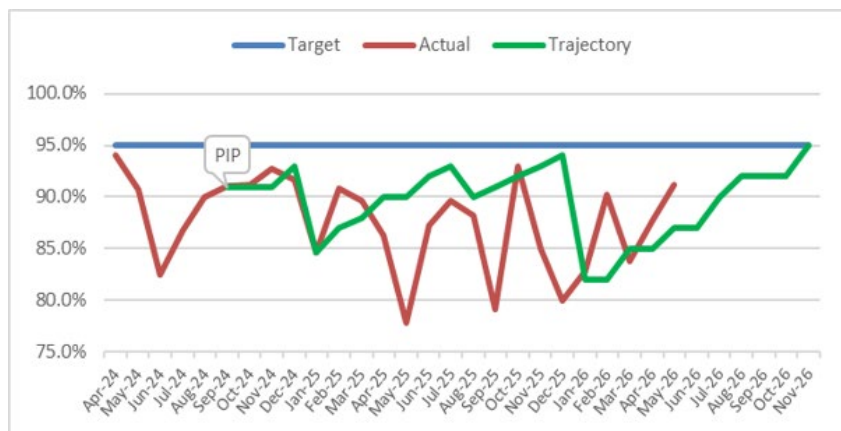
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	1	0	0	0	1	100.0%
City CMHT - Sutherland	12	5	0	1	18	66.7%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	0	1	0	0	1	0.0%
CMHT Total	13	6	0	1	20	65.0%



- Adult CMHT services are a main driver for the directorates RTA performance, making up 16.8% of the total RTAs completed in M02.
- RTA performance for Adult CMHTs is below standard in M02, achieving 86.5% 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) to address underperformance against the 4-week RTA standard, which has persisted since April 2024.

Performance during M02 is 91.2% which is above the planned trajectory of 87.0% but is not meeting the required standard.

The initial target date for achieving compliance was August 2025; this was subsequently extended to January 2026 and is currently forecast for 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 M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	77.8%	87.3%	89.7%	88.2%	79.2%	93.0%	85.0%	80.0%	82.8%	90.2%	83.8%	87.7%	91.2%
Trajectory	90.0%	92.0%	93.0%	90.0%	91.0%	92.0%	93.0%	94.0%	82.0%	82.0%	85.0%	85.0%	87.0%

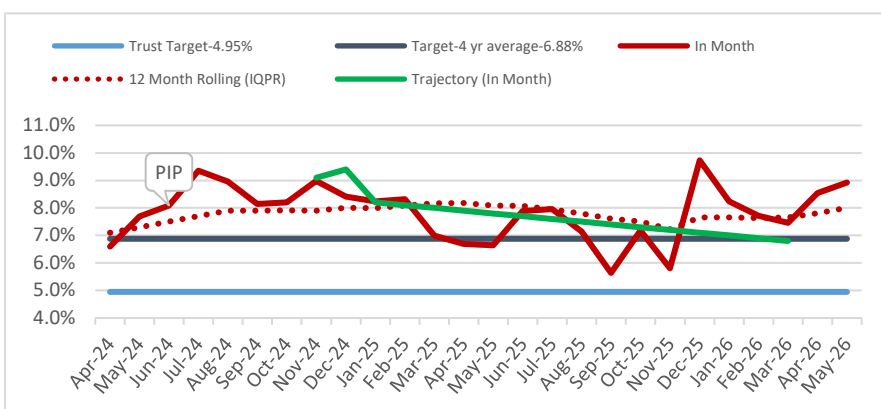
Actions:

Weekly referral to assessment (RTA) review to be relaunched with new lead.

- M02 progress update:** *Weekly RTA meetings and performance clinics are now well established. The process is embedded and operating as business as usual (BAU). Ongoing challenges remain, primarily linked to capacity constraints in certain areas and external factors outside of the Directorate's control (e.g. patients transferred from other services, although the shadow reporting is making it easier to differentiate).*
- M02 Progress Update:** *The introduction of shadow reporting to separate ASD and ADHD contacts would help reduce breaches outside of the Directorates control. Shadow reporting evident within this report. [CYP LD is a clear example of the difference this makes from 75% to 100%].*
- M02 Progress Update:** *M02 has been impacted by workforce capacity. The Associate Director has requested recovery plans from services affected by sickness absence and vacancies to identify mitigating action. **Neuropsychology** has implemented a new assessment process. Improvement will be fully evident by Month 04 due to long standing waits being cleared by this point.*

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care directorate



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

Sickness absence figures for M02 are in-month 8.92%, 12-month rolling period is 8.00%. Performance has not met the 4-year average (6.88%).

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

Updated actions have been provided in M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	6.64%	7.89%	7.96%	7.15%	5.64%	7.18%	5.81%	9.73%	8.24%	7.72%	7.46%	8.54%	8.92%
12 Month Rolling (IQPR)	8.09%	8.07%	7.95%	7.80%	7.61%	7.50%	7.23%	7.66%	7.66%	7.63%	7.66%	7.81%	8.00%
Trajectory (In Month)	7.80%	7.70%	7.60%	7.50%	7.40%	7.30%	7.20%	7.10%	7.00%	6.90%	6.80%		

M02 progress update:

Review of previous actions and next steps:

Over the last 12 months, workforce and wellbeing initiatives have become embedded across the Directorate. Workforce and HR surgeries were established across the Directorate. However, this now requires a review due to the ongoing challenges for the whole workforce; increased risk of burnout, continued 100% occupancy, increased acuity, and leaders unable to meet their managerial responsibilities due to capacity.

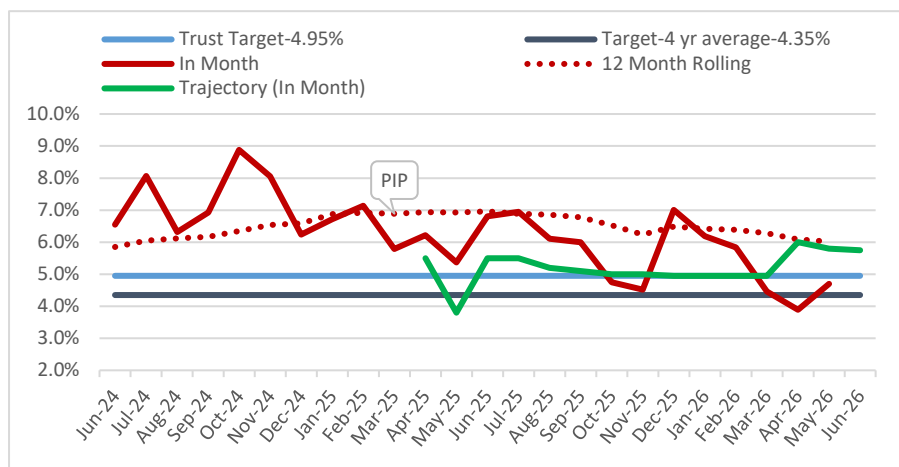
Wellbeing champions continue to be recruited and the staff survey actions for 2025/26 are being reviewed with new actions being added for 2026/27, noting the improved results against all domains of the People Promise. Targeted psychological and MSK support is being piloted, and recruitment and retention have strengthened over the last 12 months, with vacancy and turnover rates consistently below target for over 12 months.

M02 Actions:

- AUCD Associate Director is continuing to facilitate structured engagement sessions with team leads and ward managers to understand key drivers of sickness absence and co-develop practical, frontline solutions, with actions being undertaken in response to these discussions.
- Directorate leads to review current barriers and inconsistencies in sickness absence management, working with HR to standardise process and strengthen compliance.
- An assessment of workforce wellbeing and potential burnout across the Directorate to inform targeted preventative interventions is ongoing.
- AUCD Associate Director to explore any potential digital solutions that could improve efficiency and strengthen the management and monitoring of sickness absence across the Directorate – remains ongoing.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Primary Care directorate



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

Sickness absence figures for M02 are in-month 4.70%, 12-month rolling period is 6.02%.

Based on the in-month position, the Trust standard has been achieved for three consecutive months and the PIP is to be closed.

The PIP trajectory was updated in M01 (2025/26) to bring sickness rate back to the 4-year average position of 4.35% which is within the <4.95% required standard. Trajectories have been set in M02 (Apr-Mar 2025/26) and revised in M01 (Apr-Jun 2026/27). The Primary Care directorate aimed for the standard to be met in December 2025.

Updated actions have been provided in M02.

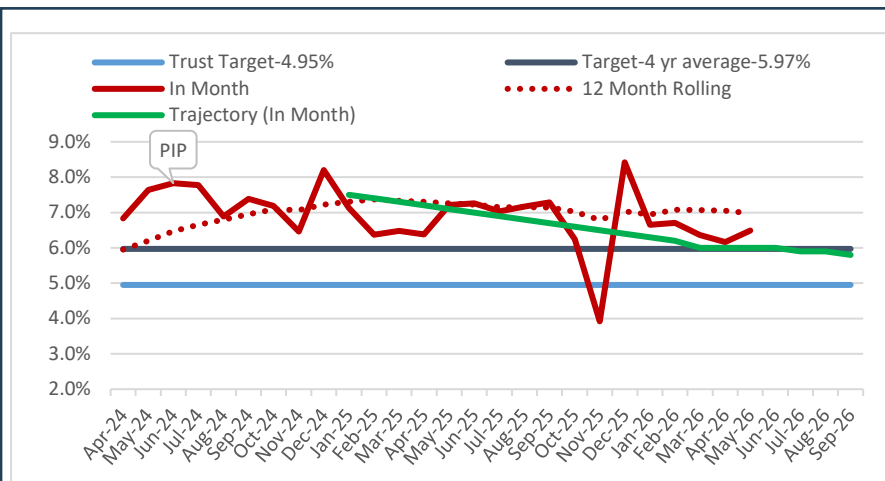
	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Trust Target-4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%
Target-4 yr average-4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%	4.35%
In Month	5.37%	6.81%	6.95%	6.11%	6.00%	4.75%	4.52%	7.01%	6.19%	5.84%	4.46%	3.89%	4.70%
12 Month Rolling	6.93%	6.96%	6.89%	6.86%	6.78%	6.53%	6.24%	6.49%	6.42%	6.39%	6.28%	6.09%	6.02%
Trajectory (In Month)	3.80%	5.50%	5.50%	5.20%	5.10%	5.00%	5.00%	4.95%	4.95%	4.95%	4.95%	6.00%	5.80%

Actions:

- Staff survey review with identified actions from this focussing on specific team with highest levels of variance in comparison to trust averages. This will enable the Associate Director to support teams to identify key trends from the survey and actions to support the team. **M02 progress update:** Task group has met and developed action plan following review of survey results. Communications are being developed to share results with the teams.
- Supporting attendance at work clinics held with all line managers. **M02 progress update:** Associate Director and People Business Partner continue to review reporting data focussing on highest and longest areas of sickness. This is having a positive impact on the 12-month rolling position.

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.

Sickness absence figures for M02 are in-month 6.49%, 12-month rolling period is 6.98%. Performance has not met the 4-year average (5.97%).

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 and subsequently revised in M01 (Apr-Sep 2026/27).

Updated actions have been provided in M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	7.21%	7.26%	7.03%	7.17%	7.29%	6.24%	3.92%	8.42%	6.65%	6.71%	6.36%	6.16%	6.49%
12 Month Rolling	7.26%	7.22%	7.15%	7.15%	7.14%	7.02%	6.79%	7.03%	6.94%	7.08%	7.07%	7.05%	6.98%
Trajectory (In Month)	7.10%	7.00%	6.90%	6.80%	6.70%	6.60%	6.50%	6.40%	6.30%	6.20%	6.00%	6.00%	6.00%

Actions:

The Trust People Plan identifies sickness reduction as a key priority. To support this, directorate performance meetings are being redesigned to ensure all teams are in scope, with sickness absence established as a standing agenda item to strengthen oversight and accountability.

M02 Progress Update:

Enhanced Sickness Governance

Monthly sickness surgeries will continue, chaired by the Associate Director and supported by the people team. Focus is placed on; all cases across services are reviewed and continual monitoring of repeat stage 2 cases, frequent absence patterns, and long-term sickness cases.

Stress Risk Assessment Rollout

The Directorate senior leaders have completed team-level stress risk assessment with support from the Health and Safety Advisor. All team managers have completed assessment in M12. Over the next three months, this will be cascaded across all teams and outputs will be consolidated to identify common themes and inform Directorate-wide actions.

Staff Survey Follow-up

The people team has begun engagement sessions with all services to review staff survey findings. Insights are being shared through accessible, easy-read visuals. Focus is on identifying tangible improvement actions to for teams.

Wellbeing Strategy

As part of the Trust wellbeing strategy, Specialist Services have identified community learning disability team (CLDT) for participation in a stress reduction pilot. CLDT have been prioritised due to higher levels of stress-related sickness absence. An initial engagement meeting took place on 13 May with the Associate Director and wellbeing leads.

Next Steps

Continue with monthly sickness surgeries with strengthened focus on repeat and complex cases.

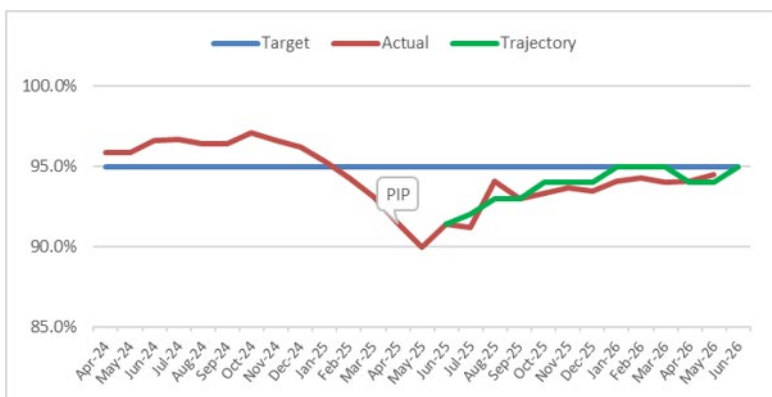
Complete full rollout and thematic analysis of stress risk assessments.

Translate staff survey insights into targeted improvement actions.

Progress and evaluate the CLDT stress reduction pilot for potential wider roll-out.

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services directorate



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

Performance in M02 is 94.5%. Performance has met the planned trajectory but did not meet the required standard.

The original aim was for the standard to be achieved by October 2025 this has been revised to January 2026 and is currently forecast for June 2026. Trajectory adjustments: Set in M01 (Apr-Jun 2025/26) and have been reset to reflect revised planning assumptions in M03 (Apr-May 2025), M04 (Sept-Jan 2025/26) and M01 (Apr-Jun 2026/27).

Updated actions have been provided in M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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	90.0%	91.4%	91.2%	94.1%	93.0%	93.3%	93.7%	93.5%	94.1%	94.3%	94.0%	94.1%	94.5%
Trajectory		91.4%	92.0%	93.0%	93.0%	94.0%	94.0%	94.0%	95.0%	95.0%	95.0%	94.0%	94.0%

Actions:

- Neuropsychiatry & Psychology
Review and optimise the triage process in line with revised care planning pathways, with additional support in place to enable effective transition. Prioritised consistent engagement at the Performance Clinics.

M02 progress update:

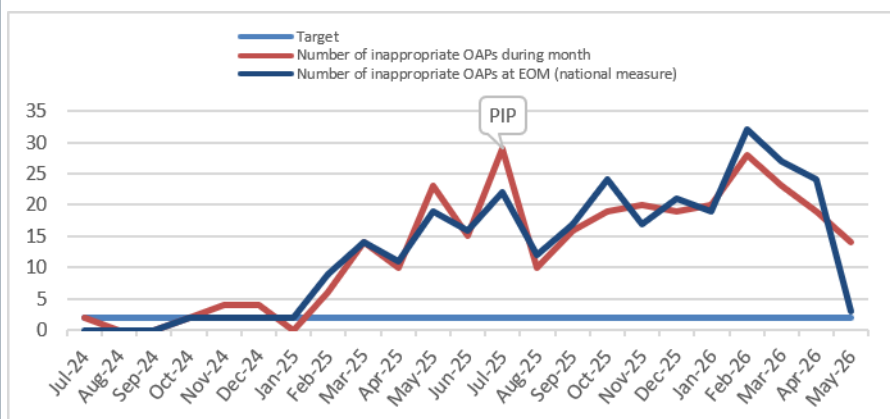
- Clinical Documentation Improvements**
Work is underway to streamliner documentation process for medical staff:
 - Clinical notes produced during dictation will be incorporated directly into care plans and next steps, reducing on the reliance on separate correspondence.
 - Clinical Directors have initiated 1:1 sessions with medics and administrative staff to ensure a clear understanding of the revised processes and expectations. This programme of engagement is currently ongoing.
- Compliance and Caseload Oversight (Neuropsychiatry)**
Neuropsychiatry services continue to face challenges with process compliance.
 - The team manager is actively identifying non-compliant practitioners.
 - Targeted actions are being addressed through structured caseload supervision to improve adherence and consistency.

Next Steps

- Strengthen attendance engagement at Neuro Performance Clinics, with clearer expectations and monitoring.
- Complete the review of neuropsychiatry and psychology triage processes and implement any agreed amendments.
- Continue 1:1 engagement to embed new documentation standards.
- Address compliance gaps through robust supervision and performance management.

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

Acute and Urgent Care and Community directorates



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

M02 performance shows that there were 14 inappropriate OAPs recorded during the month, with the EOM position at 3 inappropriate OAPs (national measure).

Updated actions have been provided in M02.

	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Target	2	2	2	2	2	2	2	2	2	2	2	2	2
Number of inappropriate OAPs during month	23	15	29	10	16	19	20	19	20	28	23	19	14
Number of inappropriate OAPs at EOM (national measure)	19	16	22	12	17	24	17	21	19	32	27	24	3

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

A Performance Improvement Plan (PIP) remains in place to address the number of inappropriate Out of Area (OOA) placements. In M02, there were 3 inappropriate OAPs, primarily attributable to adult acute bed capacity constraints and flow issues (2 were due to adult acute bed availability pressures and 1 was attributable to PICU bed availability).

The ACUD and Community Directorates continues to deliver against a comprehensive action plan, with demonstrable progress across key areas:

Strengthened Operational Oversight

Daily monitoring of OOA placements and bed capacity is embedded through structured bed flow meetings, ensuring senior clinical and operational oversight of all admissions and discharges.

A weekly multi-agency meeting structure, including ICB and local authority partners, is established to support system-wide escalation and decision-making.

Improved Patient Flow and Discharge Management

A revised CRFD policy is in development to strengthen escalation processes and improve consistency in managing delayed discharges.

Discharge coordination for OOA patients has been aligned to improve oversight, coordination, and timeliness of repatriation.

Increased Internal Capacity and Bed Management

A Clinical Bed Manager has been recruited and is now in post, improving visibility and proactive management of capacity across the pathway.

Work to maximise existing bed capacity, including utilisation of additional ward capacity and optimisation of rehabilitation pathways is supporting reductions in avoidable OOA use. This post is already demonstrating its effectiveness and improvement in flow across the system.

Increased Internal Capacity and Bed Management

A Clinical Bed Manager has been recruited and is now in post, improving visibility and proactive management of capacity across the pathway.

Work to maximise existing bed capacity, including utilisation of additional ward capacity and optimisation of rehabilitation pathways is supporting reductions in avoidable OOA use. This post is already demonstrating its effectiveness and improvement in flow across the system.

Optimisation of Crisis Pathways

A review of the CRHTT capacity and model is underway, which has already highlighted the impact of non-crisis demand on service effectiveness.

An options appraisal has been developed to rebalance the 24–72-hour response function and protect core crisis response capacity, awaiting further guidance from Execs.

Development of Alternative and Preventative Pathways

Work is progressing to develop crisis alternative provision and strengthen the deteriorating patient pathway, supporting earlier intervention, and reducing avoidable admissions.

Improved gatekeeping processes and use of admission checklists are being embedded to ensure all alternatives to admission are considered.

Enhanced Data and Reporting

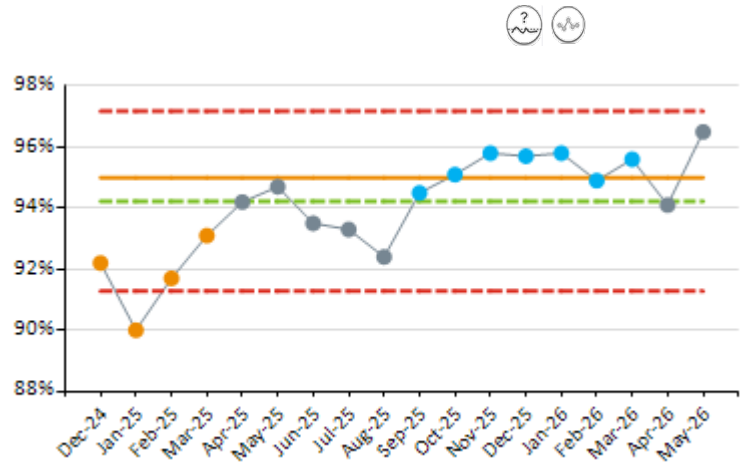
Work is underway to strengthen data collection, develop reporting dashboards, and improve insight into drivers of OOA placements and delays.

Regular reporting to Chief Officers and Quality Committee provides increased assurance and oversight of progress and risks.

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

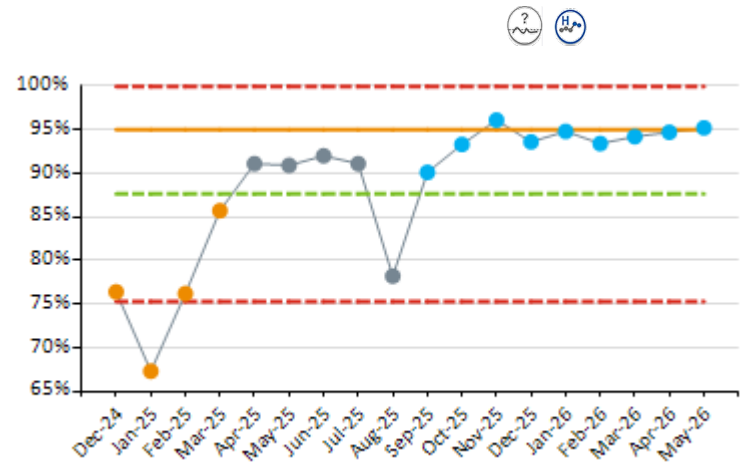
Referral to Assessment within 4 weeks (Trust Measure)



13 Month Trend

94.7%	93.5%	93.3%	92.4%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%	94.1%	96.5%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

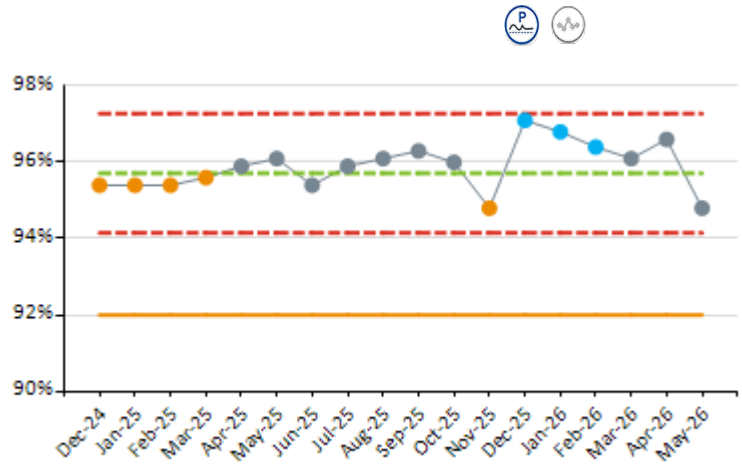
CAMHS Compliance within 4 week waits (Referral to Assessment) (Trust Measure)



13 Month Trend

90.9%	92.0%	91.1%	78.2%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%	94.7%	95.2%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

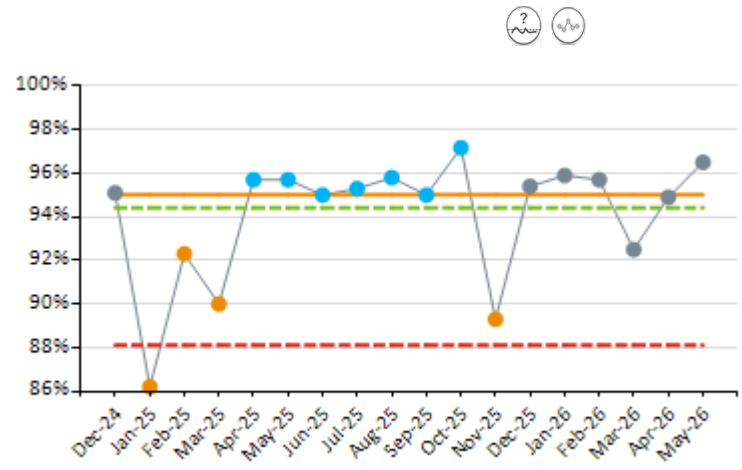
Referral to Treatment within 18 weeks (Trust Measure)



13 Month Trend

96.1%	95.4%	95.9%	96.1%	96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%	96.6%	94.8%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

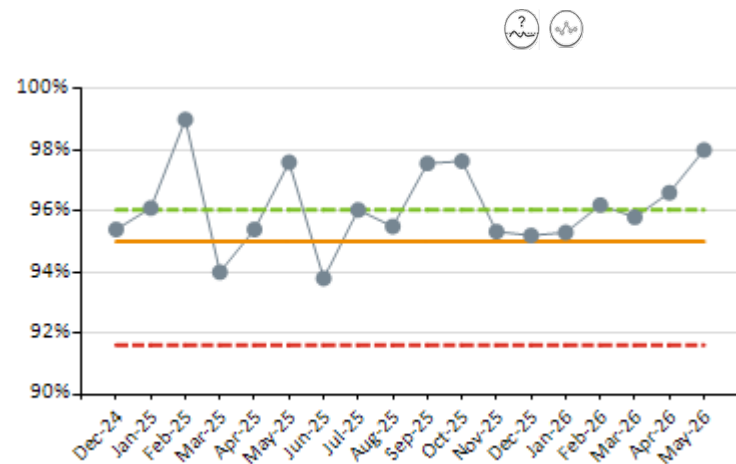
MH Liaison 1 Hour Response (Emergency) (Trust Measure)



13 Month Trend

95.7%	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

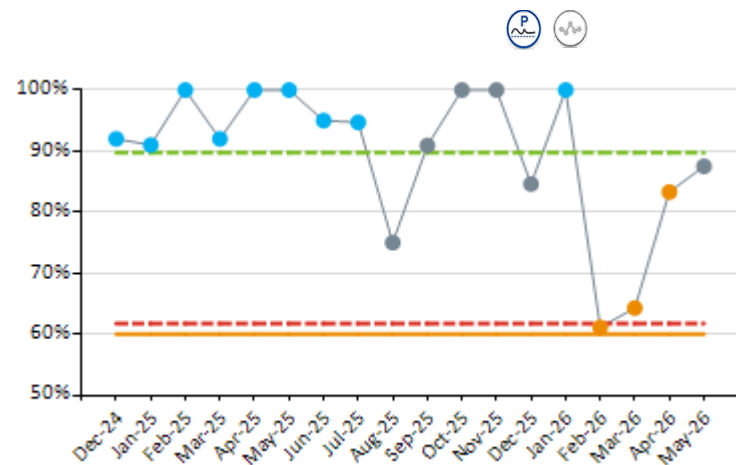
MH Liaison 4 Hour Response (Urgent) (Trust Measure)



13 Month Trend

97.6%	93.8%	96.0%	95.5%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%	96.6%	98.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

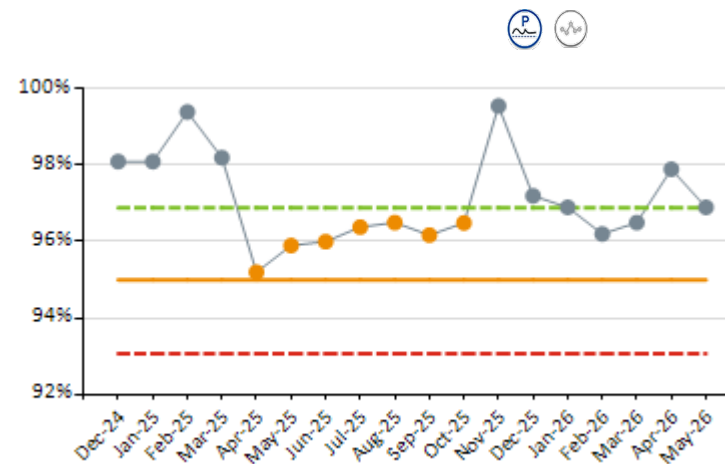
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment (National Measure)



13 Month Trend

100.0%	95.0%	94.7%	75.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%	83.3%	87.5%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

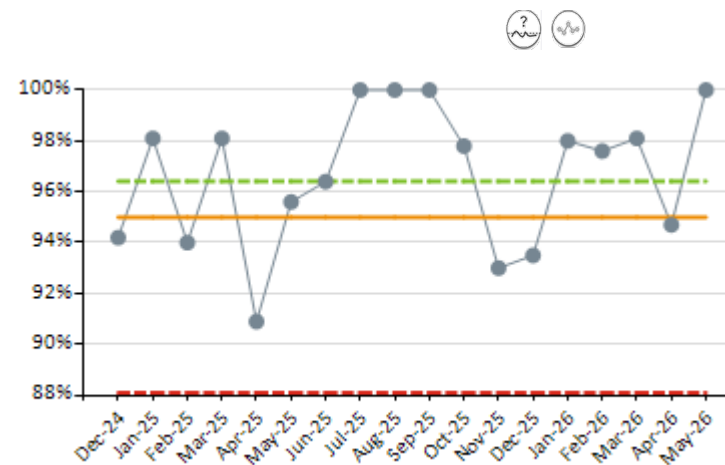
MH Liaison 24 Hour Response (Urgent from General Hospital Ward) (Trust Measure)



13 Month Trend

95.9%	96.0%	96.4%	96.5%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%	97.9%	96.9%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

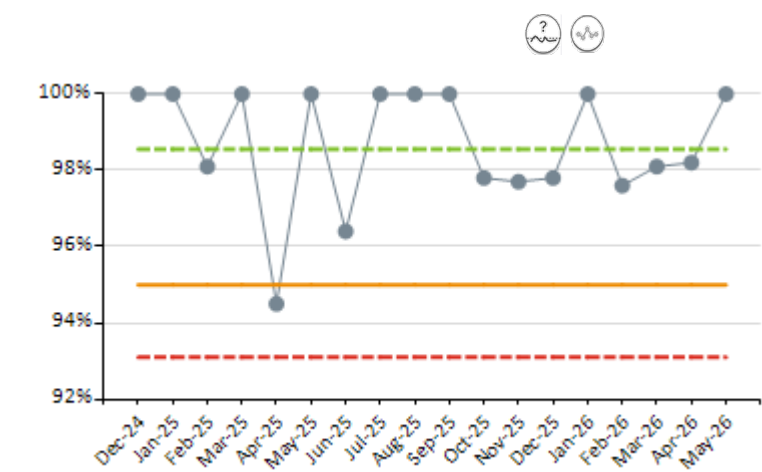
48 Hour Follow Up (Trust Measure)



13 Month Trend

95.6%	96.4%	100.0%	100.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%	94.7%	100.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

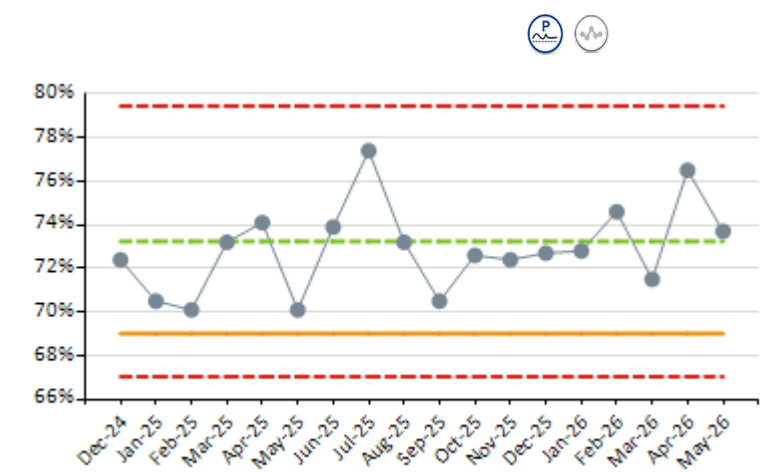
7 Day Follow Up (All Patients) (Trust Measure)



13 Month Trend

100.0%	96.4%	100.0%	100.0%	100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%	98.2%	100.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

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

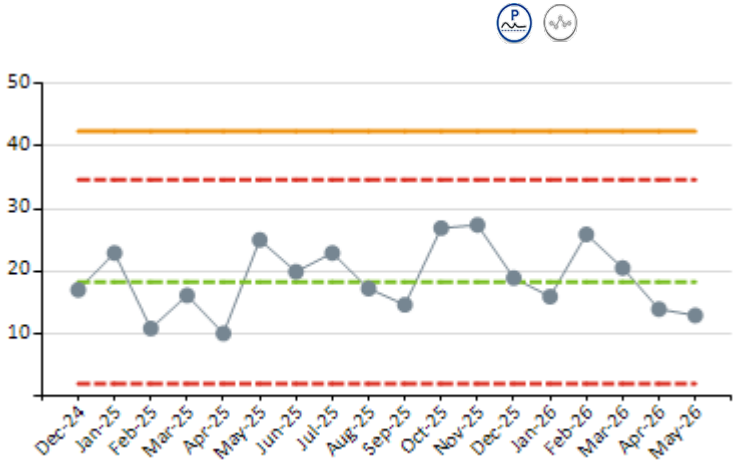


13 Month Trend

70.1%	73.9%	77.4%	73.2%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%	76.5%	73.7%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Core Indicators – SPC Trend (Inpatient and Quality)

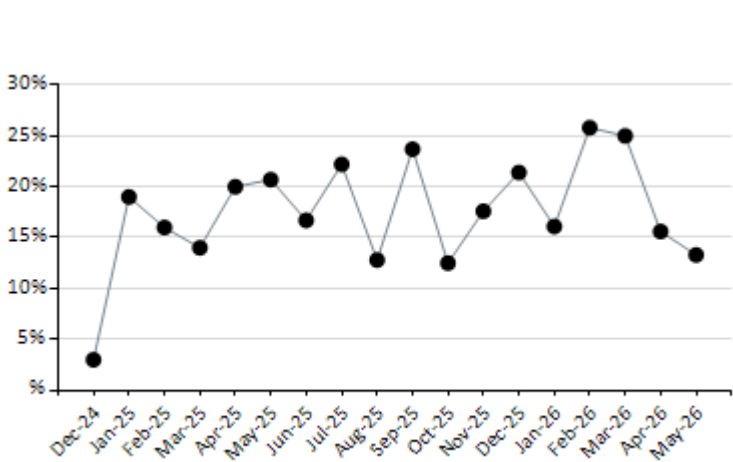
Median Length of Stay - Adult (National Measure)



13 Month Trend

25.0	19.9	22.9	17.2	14.6	26.9	27.4	18.9	15.9	25.9	20.5	13.9	12.9
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

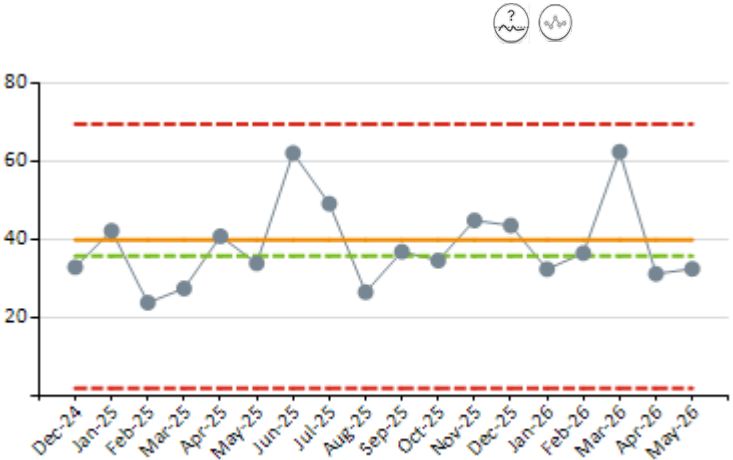
Adult Acute LoS-Over 60 days as a % of all discharges (National Measure)



13 Month Trend

20.7%	16.7%	22.2%	12.8%	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%	15.6%	13.3%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

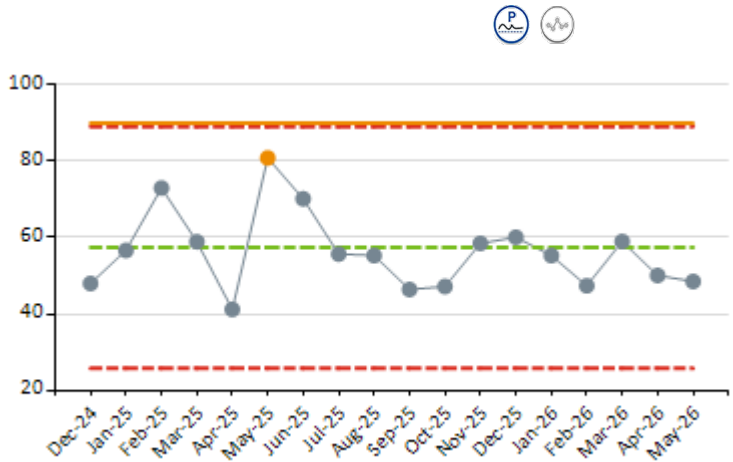
Average Length of Stay - Adult (National Measure)



13 Month Trend

34.0	62.3	49.3	26.6	37.0	34.7	45.0	43.7	32.5	36.6	62.6	31.3	32.6
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

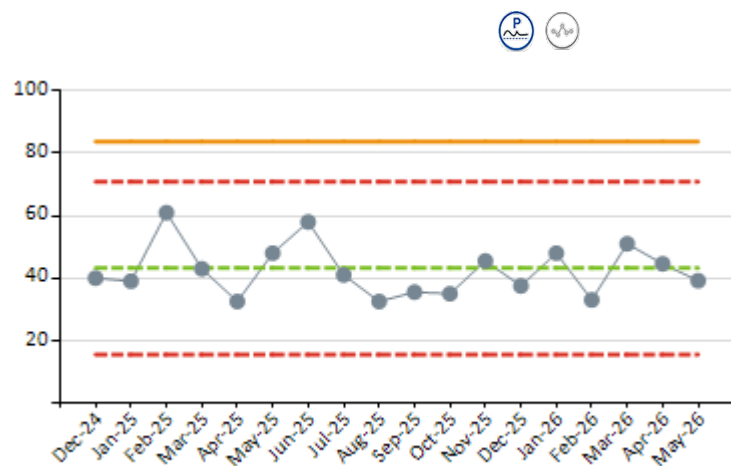
Average Length of Stay - Older Adult (National Measure)



13 Month Trend

80.9	70.2	55.7	55.3	46.4	47.2	58.5	60.1	55.3	47.4	59.0	50.1	48.5
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

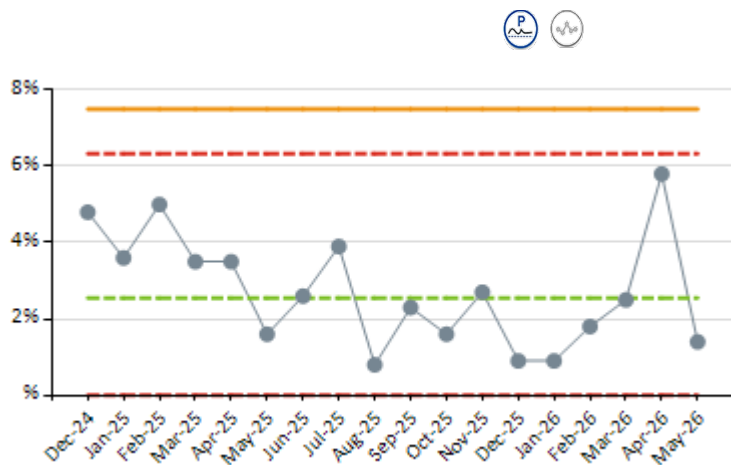
Median Length of Stay - Older Adult (National Measure)



13 Month Trend

48.0	58.0	41.0	32.5	35.5	35.0	45.5	37.5	48.0	33.0	51.0	44.6	39.2
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

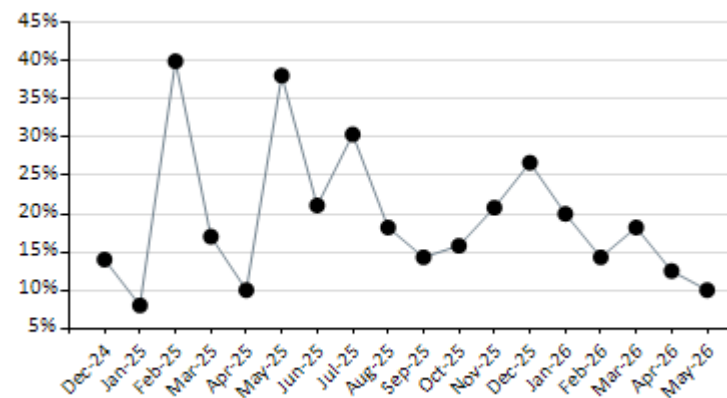
Emergency Readmissions rate (30 days) (Trust Measure)



13 Month Trend

1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%	5.8%	1.4%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

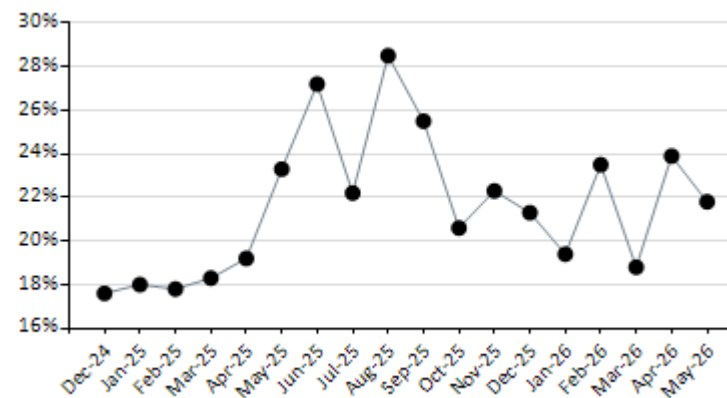
Older Adult Acute LoS-Over 90 days as a % of all discharges (National Measure)



13 Month Trend

38.1%	21.1%	30.4%	18.2%	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%	12.5%	10.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Clinically Ready for Discharge (CRFD) (Trust Measure)

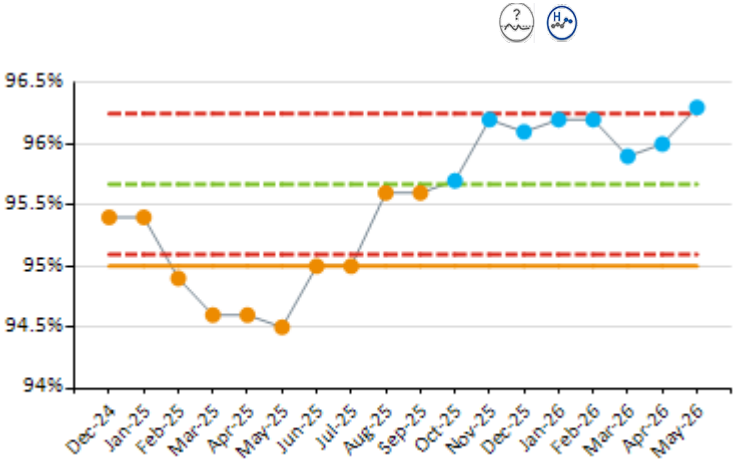


13 Month Trend

23.3%	27.2%	22.2%	28.5%	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%	23.9%	21.8%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Core Indicators – SPC Trend (Community and Quality)

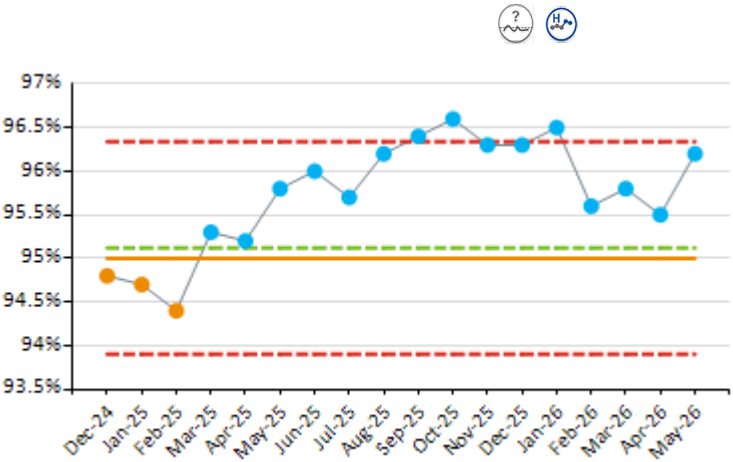
Care Plan Compliance (Trust Measure)



13 Month Trend

94.5%	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%	96.0%	96.3%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Risk Assessment Compliance (Trust Measure)

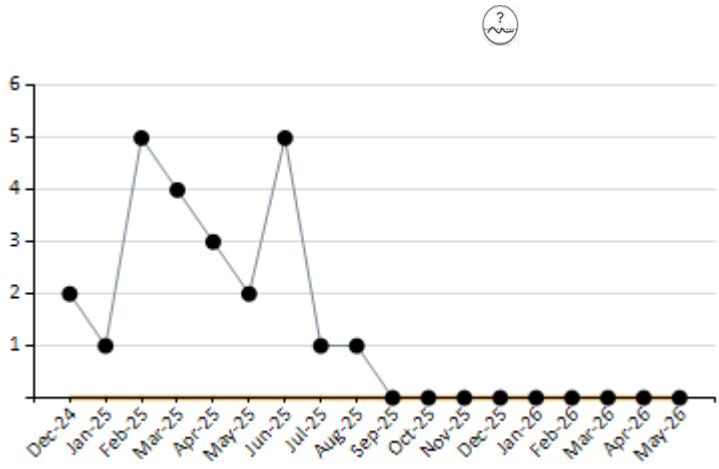


13 Month Trend

95.8%	96.0%	95.7%	96.2%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%	95.5%	96.2%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Core Indicators – SPC Trend (Organisational Health)

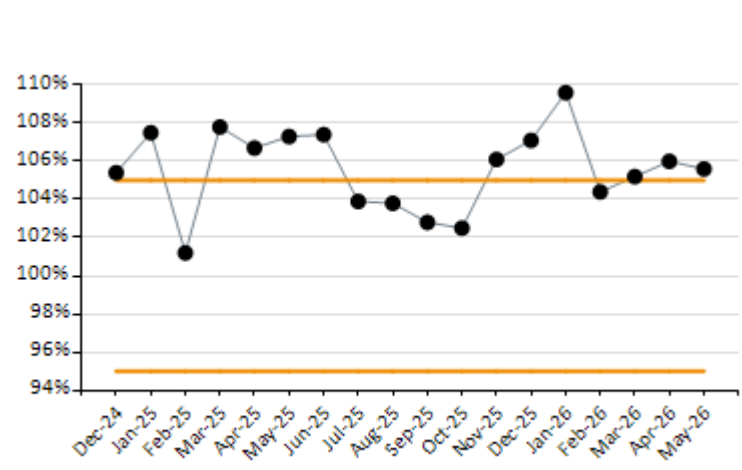
Complaints Open Beyond Agreed Timescale (Trust Measure)



13 Month Trend

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

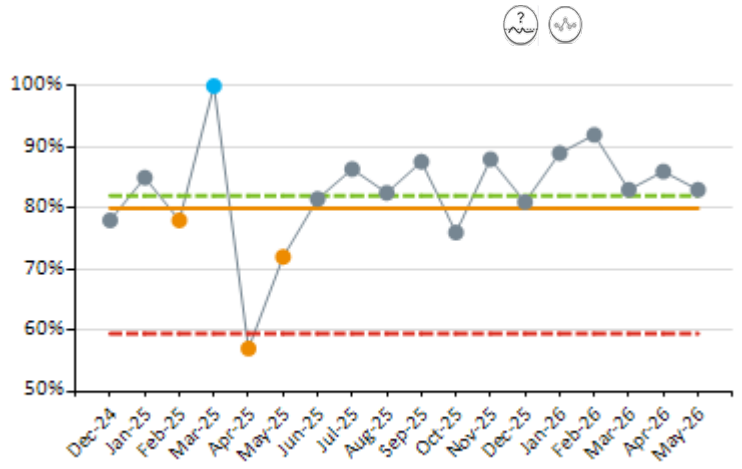
Safe Staffing (National Measure)



13 Month Trend

107.3%	107.4%	103.9%	103.8%	102.8%	102.5%	106.1%	107.1%	109.6%	104.4%	105.2%	106.0%	105.6%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

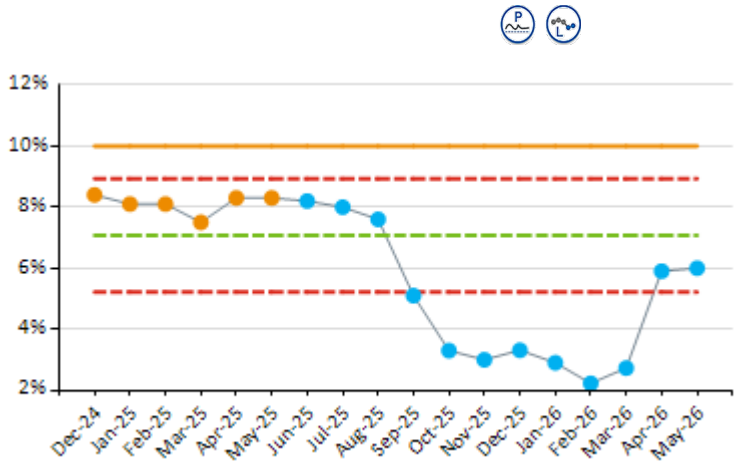
Friends and Family Test - Recommended (Trust Measure)



13 Month Trend

72.0%	81.5%	86.4%	82.5%	87.6%	76.0%	88.0%	81.0%	89.0%	92.0%	83.0%	86.0%	83.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

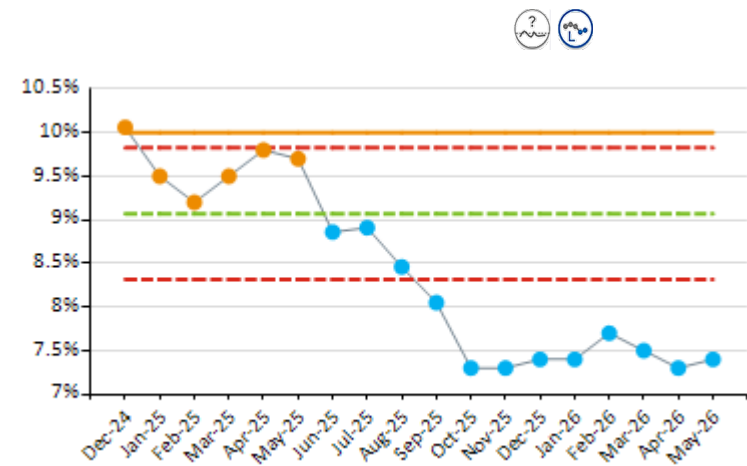
Vacancy Rate (Trust Measure)



13 Month Trend

8.3%	8.2%	8.0%	7.6%	5.1%	3.3%	3.0%	3.3%	2.9%	2.2%	2.7%	5.9%	6.0%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

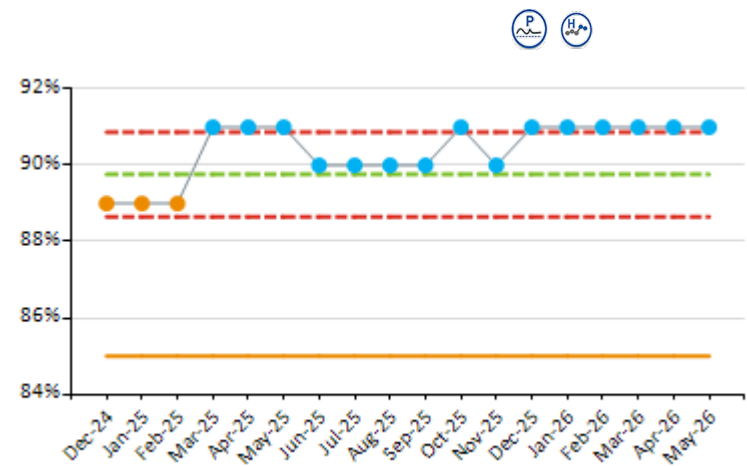
Staff Turnover (Trust Measure)



13 Month Trend

9.7%	8.9%	8.9%	8.5%	8.1%	7.3%	7.3%	7.4%	7.4%	7.7%	7.5%	7.3%	7.4%
May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May

Statutory & Mandatory Training (Trust Measure)



13 Month Trend

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

Enclosure No: 9

FINANCE POSITION MONTH 2

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☒	Advise	☐		
Information	☐				

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 5 - Evidence of delivery of the majority of agreed actions, with little or no evidence of the achievement of desired outcomes.
Approval / Review:	SLT
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:	N/A.

Recommendation / Required Action:	Receive the Month 2 financial position noting: • A year-to-date deficit of £178k against a planned deficit of £179k, resulting in a favourable variance of £1k. • An underlying financial position (ULP) deficit of £292k. • Agency expenditure of £153k, against planned expenditure of £174k, resulting in a favourable variance of £21k. • Bank expenditure of £1,036k against planned expenditure of £842k, resulting in an adverse variance of £194k. • Year to date CIP delivery of £521k against a plan of £1,078k, resulting in an adverse variance of £555k. • Capital expenditure of £50k which is £343k behind plan. • A cash balance of £40.8m on 31st May 2026.
Executive Summary:	The Adjusted Financial Performance in month shows a deficit of £88k, which is in line with the planned deficit of £88k. The year-to-date position remains in line with plan with a deficit of £178k against a planned deficit of £179k, resulting in a favourable variance of £1k. The Trust is reporting an underlying financial position (ULP) deficit of £292k, reflecting current efficiency assumptions. The Trust has a recurrent CIP target of £6.3m, a non-recurrent target of £1.5m. At Month 2 the Trust is forecasting full delivery of the £7.8m CIP target. Of this, £6.6m is implemented or fully developed and £0.2m relates to plans in progress. However, £1.0m remains classified as opportunities representing a significant delivery risk against the overall programme. In month agency expenditure was £87k in line with plan against the 32% agency expenditure reduction from 2025/26. In month bank expenditure was £485k against a plan of £421k representing an adverse variance of £64k against the 20% bank expenditure reduction from 2025/26. The Trust's capital expenditure year to date was £50k which is £343k behind plan. The Trust is forecasting to spend to plan. In month, the Trust achieved the Better Payment Practice Code target of 95% for both the number and value of invoices paid within 30 days, with performance at 96.6% by number and 99.8% by value. The cash position of the Trust on 31st May 2026 is £40.8m. <u>Key Messages:</u> • Financial position is on plan. • Bank expenditure is over plan by £194k. • £1.0m of CIP remains classified as opportunities and therefore is classified as high risk.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	15/06/2026
1	F&R	22/06/2026
1	Public Trust Board	09/07/2026



PUBLIC TRUST BOARD – 9th July 2026

Finance Position Month 2

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

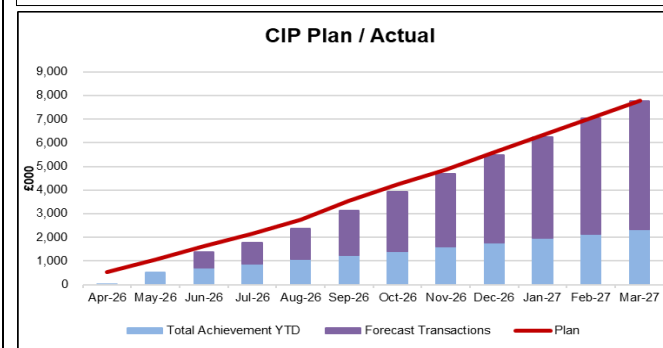
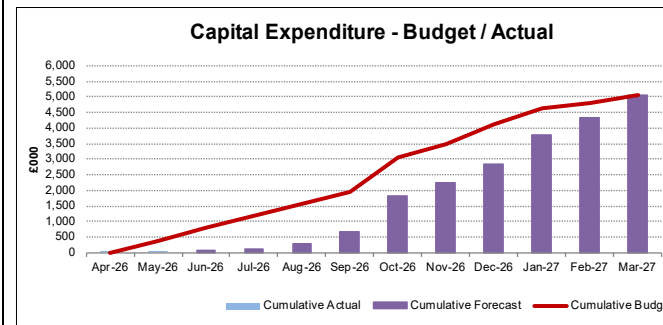
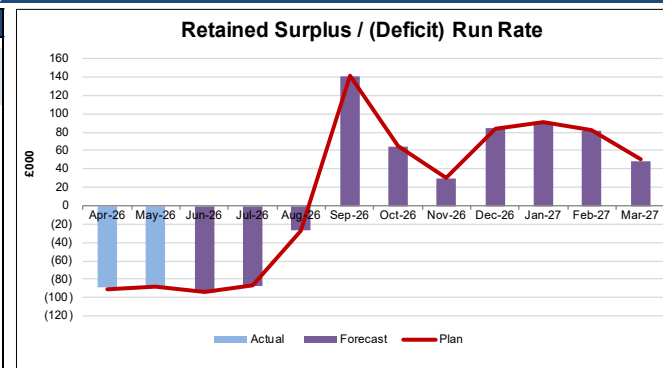
Key financial performance metrics are included for the following:

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



Financial Overview as at 31st May 2026

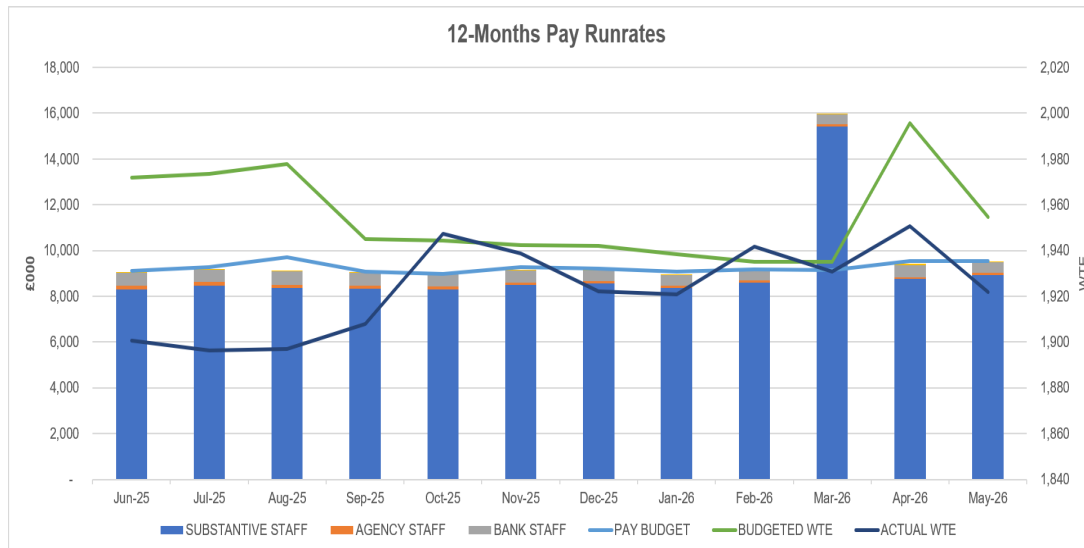
Key Metrics								
£000	M11	M12	M1	M2	YTD	Average	Target	YTD RAG
Variance to Plan								
In month financial position	222	2,114	2	(0)	1	1	0	
YTD financial position	1,309	3,421	2	1	1	1	0	
Run Rates (Actuals)								
Income	15,062	23,598	15,183	15,128	30,310	15,155	30,041	
Pay	(9,215)	(15,988)	(9,407)	(9,533)	(18,940)	(9,470)	(19,067)	
Non-pay	(5,260)	(5,228)	(5,550)	(5,378)	(10,928)	(5,464)	(10,514)	
Finance & Other Non Operating	(255)	(279)	(269)	(259)	(527)	(264)	(535)	
Agency (Actuals)	(80)	(93)	(66)	(87)	(153)	(76)	(174)	
Agency Variance To Plan	27	13	21	(0)	21	11	0	
Medical Agency	22	20	11	15	27	13	0	
Nurse Agency	5	(2)	5	(10)	(5)	(3)	0	
Other Agency	0	(5)	5	(5)	0	0	0	
Non Clinical Agency	0	0	0	0	0	0	0	
Bank (Actuals)	(492)	(441)	(551)	(485)	(1,036)	(518)	(842)	
Bank Variance To Plan	(142)	(89)	(130)	(64)	(194)	(97)	0	
Medical Bank	(18)	(9)	(4)	(4)	(8)	(4)	0	
Nurse Bank	110	60	(67)	(26)	(93)	(46)	0	
Other Clinical Bank	(222)	(118)	(61)	(35)	(96)	(48)	0	
Non Clinical Bank	(12)	(22)	2	0	3	1	0	
CIP (Variance)	(51)	273	(512)	(43)	(555)	(278)	0	
Cash balance	34,555	33,439	36,928	40,778	40,778	38,853	34,596	
Capital expenditure (Variance)	(32)	741	0	343	343	171	0	
BPPC								
Number	95.6%	95.7%	95.6%	96.6%	96.1%	96.1%	95%	
Value	98.7%	96.3%	98.7%	99.8%	99.2%	99.3%	95%	



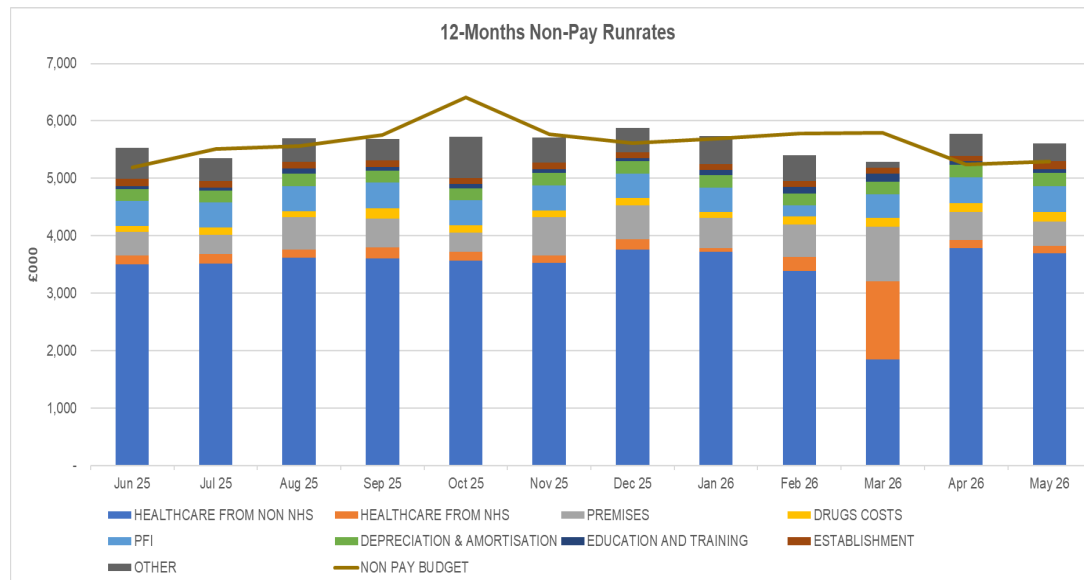
High Level Analysis	Annual Plan £000	In Month Budget £000	In Month Actuals £000	Variance £000	Year to Date Budget £000	Year to Date Actuals £000	Variance £000
Income from Patient Care Activities	163,888	13,669	13,730	61	27,333	27,500	167
Income from Other Operating Activities	16,049	1,369	1,398	29	2,708	2,810	102
Income	179,937	15,038	15,128	90	30,041	30,310	269
Pay Costs	(111,104)	(9,542)	(9,533)	9	(19,067)	(18,940)	127
Non Pay Costs	(64,860)	(5,265)	(5,378)	(113)	(10,514)	(10,929)	(415)
Operating Expenditure	(175,964)	(14,807)	(14,911)	(105)	(29,581)	(29,869)	(288)
EBITDA	3,973	231	217	(15)	461	442	(19)
Finance & Other Non Operating Costs	(3,207)	(267)	(259)	8	(535)	(527)	7
Retained Surplus / (Deficit)	766	(36)	(42)	(6)	(74)	(86)	(12)
Add Back Impairments	0	0	0	0	0	0	0
Surplus/(deficit) before impairments	766	(36)	(42)	(6)	(74)	(86)	(12)
Technical Adjustments	(612)	(52)	(46)	6	(105)	(92)	13
Adjusted Financial Performance	154	(88)	(88)	0	(179)	(178)	1

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.

- The in-month position shows a deficit of £88k, which is in line with the planned deficit of £88k.
- The year-to-date position is a deficit of £178k against a planned deficit of £179k, resulting in a favourable variance of £1k.
- Income is reporting a favourable variance year to date, primarily driven by additional ICB income relating to the CUF uplift.
- Pay expenditure is reporting a favourable variance year-to-date, primarily attributable to vacancy slippage.
- Non-pay expenditure is reporting an adverse variance year-to-date due to unmet CIP delivery, increased premises costs relating to THL delay costs, and increased services received costs relating to secure patient transport.



- March 26 substantive pay includes £6.8m NHSE pension contribution.
- April 26 Budgeted WTE does not include reduced establishment relating to the target vacancy factor, this is included in May 26.
- Actual WTE has reduced in May 26 due to reduction in bank workers in the main relating to nursing and support to nursing.



- The purchase of healthcare from NHS bodies is high in March 26 due to coding corrections from the purchase of healthcare from Non NHS bodies.
- Premises costs in March 26 includes a provision to repay Microsoft licences VAT of £348k.

Mitigations	Forecast £000
Unmitigated Forecast Surplus / (Deficit)	(1,140)
HR Provision	(400)
Release of Balance Sheet Flexibilities	652
PFI Unavailability	500
Delivery of Cash Releasing CIP	308
Modifications to staffing projections	234
Mitigated Surplus / (Deficit)	154

- The Trust's Month 2 forecast submission to NHSE reflects a surplus of £154k, in line with the agreed plan.
- However, the current underlying forecast indicates an unmitigated deficit of £1.1m. As a result, the submitted position is dependent upon the successful delivery of identified mitigations and financial flexibilities. Whilst these actions are being actively progressed, a residual delivery risk remains and will continue to be closely monitored through the year.
- The mitigated forecast includes HR provisions, the release of balance sheet flexibilities, delivery of cash releasing Cost Improvement Programmes (CIPs), and anticipated benefits from PFI unavailability deductions. Delivery of these mitigations will be critical to achieving the planned year-end position and will continue to be closely monitored through the year.

Heading	Income £000	Employee Expenses £000	Operating Expenses £000	Non Operating Items £000	Adjusted Position £000
2026/27 Forecast	180,769	(111,936)	(67,552)	(1,127)	154
Forecast non-recurring efficiencies	0	(1,786)	(1,434)	0	(3,220)
Forecast deficit support funding	0	0	0	0	0
FYE of forecast recurring efficiencies	20	1,010	750	0	1,780
FYE of forecast investments	0	0	0	0	0
Gains and losses and donations	0	0	9	(9)	0
Non-Recurring Redundancy costs	0	0	0	0	0
Non-Recurring Cost of Change (Excluding redundancy)	0	0	0	0	0
Transformation Reserve	0	994	0	0	994
2026/27 Underlying Position	180,789	(111,718)	(68,227)	(1,136)	(292)

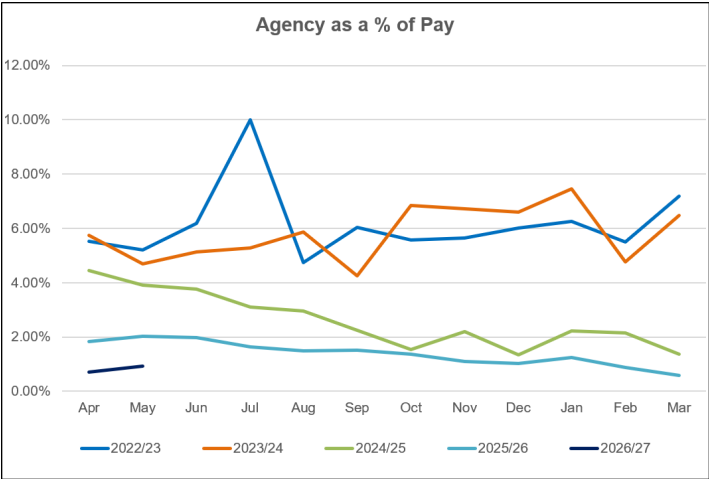
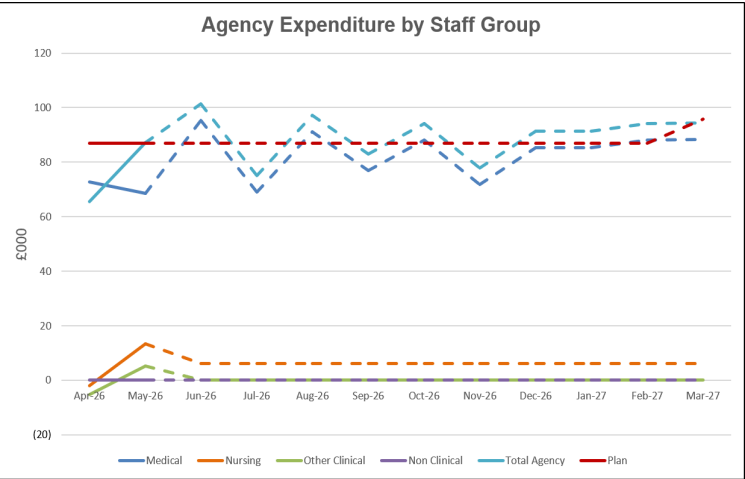
- The underlying financial position (ULP) represents the true, sustainable, recurring financial position of the Trust after removing non-recurrent items.
- The Trust's current surplus forecast includes:
 - Non recurrent efficiencies
 - Full year effect of recurring efficiencies
 - Non recurrent transformation reserve expenditure
- After adjusting for the items outlined above, the Trust's **underlying financial position is a £292k deficit.**

Finance Position

Agency Expenditure

Agency Expenditure	Actual		YTD £000	Forecast										Total £000
	Apr-26 £000	May-26 £000		Jun-26 £000	Jul-26 £000	Aug-26 £000	Sep-26 £000	Oct-26 £000	Nov-26 £000	Dec-26 £000	Jan-27 £000	Feb-27 £000	Mar-27 £000	
Medical	(73)	(69)	(141)	(95)	(69)	(91)	(77)	(88)	(72)	(85)	(85)	(88)	(88)	(981)
Community	(65)	(64)	(129)	(72)	(45)	(67)	(53)	(64)	(48)	(62)	(62)	(64)	(65)	(731)
Specialist Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary Care	(8)	(5)	(12)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(98)
Central Services	0	0	0	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(15)	(151)
Nursing	2	(13)	(11)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(6)	(72)
Acute Services & Urgent Care	(1)	(3)	(4)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(14)
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	3	(10)	(7)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(58)
Finance Performance & Estates	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Clinical	5	(5)	0	0	0	0	0	0	0	0	0	0	0	0
Acute Services & Urgent Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	5	(5)	0	0	0	0	0	0	0	0	0	0	0	0
Primary Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Clinical	0	0	0	0	0	0	0	0	0	0	0	0	0	0
People & OD	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Agency	(66)	(87)	(153)	(101)	(75)	(97)	(83)	(94)	(78)	(91)	(91)	(94)	(94)	(1,053)
Agency as a % of Pay	0.70%	0.91%	0.81%	1.08%	0.79%	1.02%	0.88%	0.99%	0.82%	0.96%	0.96%	0.99%	0.99%	0.92%
Plan	(87)	(87)	(174)	(87)	(87)	(87)	(87)	(87)	(87)	(87)	(87)	(87)	(96)	(1,053)
Variance to Plan (Overspend) / Underspend	21	(0)	21	(14)	12	(10)	4	(7)	9	(4)	(4)	(7)	1	0
Agency Variance as a % of Plan	(24.62%)	0.18%	(12.22%)	16.52%	(13.79%)	11.64%	(4.60%)	8.22%	(10.38%)	5.09%	5.09%	8.22%	(1.44%)	(0.0%)

- Planned agency expenditure for 2026/27 is £1,053k this represents a 32% reduction of 2025/26 expenditure levels.
- The in-month expenditure is £87k, in line with the planned expenditure of £87k, resulting in a variance of £0k.
- The year-to-date expenditure is £153k against planned expenditure of £174k, resulting in a favourable variance of £21k.



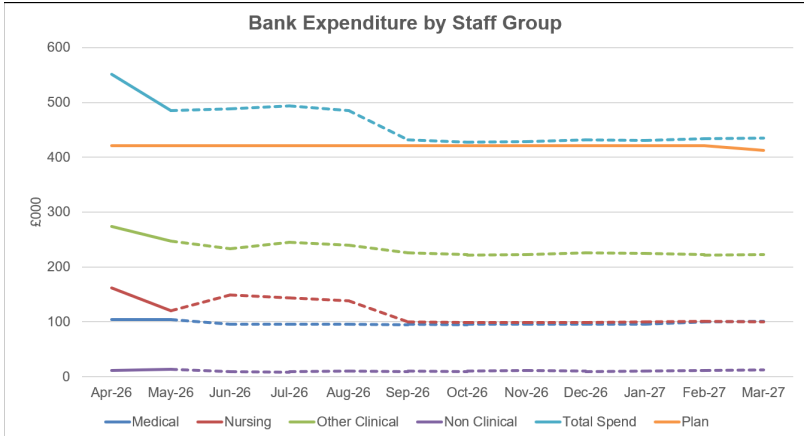
- Forecast agency expenditure is to plan.
- Locum utilisation continues to be the principal driver of agency expenditure, particularly within the Community Directorate, and there are no immediate plans to reduce this spend.

Finance Position

Bank Expenditure

Bank Expenditure	Actual		YTD £000	Projections										Total
	Apr-26 £000	May-26 £000		Jun-26 £000	Jul-26 £000	Aug-26 £000	Sep-26 £000	Oct-26 £000	Nov-26 £000	Dec-26 £000	Jan-27 £000	Feb-27 £000	Mar-27 £000	
Medical	(104)	(104)	(208)	(96)	(96)	(96)	(96)	(96)	(96)	(96)	(96)	(99)	(101)	(1,175)
Acute Services & Urgent Care	(29)	(26)	(55)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(317)
Community	(30)	(26)	(56)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(317)
Specialist Care	(44)	(43)	(87)	(42)	(42)	(42)	(25)	(18)	(18)	0	0	0	0	(274)
Medical & Clinical Effectiveness	(1)	(9)	(10)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(5)	(7)	(36)
Central Services	0	0	0	0	0	0	(16)	(23)	(23)	(42)	(42)	(42)	(42)	(230)
Nursing	(162)	(121)	(283)	(149)	(143)	(139)	(100)	(99)	(99)	(99)	(100)	(101)	(100)	(1,412)
Acute Services & Urgent Care	(114)	(92)	(206)	(105)	(100)	(95)	(75)	(71)	(71)	(71)	(71)	(71)	(71)	(1,008)
Community	(5)	(4)	(9)	(5)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(47)
Quality & Nursing	(0)	(0)	(1)	0	0	(0)	(0)	0	0	0	0	(2)	(0)	(4)
People & OD	(4)	4	(0)	0	0	0	0	0	0	0	0	0	0	(0)
Primary Care	(2)	(2)	(5)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(22)
Specialist Care	(37)	(25)	(62)	(39)	(37)	(37)	(18)	(18)	(18)	(18)	(18)	(18)	(18)	(303)
Central Services	0	0	0	1	(1)	(1)	(1)	(4)	(4)	(4)	(4)	(4)	(4)	(28)
Other Clinical	(273)	(247)	(520)	(234)	(244)	(239)	(225)	(222)	(222)	(226)	(225)	(222)	(222)	(2,803)
Acute Services & Urgent Care	(157)	(144)	(301)	(131)	(118)	(113)	(111)	(111)	(111)	(111)	(111)	(111)	(111)	(1,436)
Community	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(4)
Quality & Nursing	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MACE	(1)	(4)	(5)	(2)	(1)	(5)	(4)	(1)	(1)	(4)	(4)	(1)	(3)	(31)
Operations	(1)	(3)	(4)	0	0	0	0	0	0	0	0	0	0	(4)
People & OD	(5)	(2)	(7)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(47)
Specialist Care	(109)	(94)	(203)	(101)	(98)	(95)	(53)	(53)	(53)	(53)	(53)	(53)	(52)	(867)
Primary Care	(1)	0	(1)	0	0	0	0	0	0	0	0	0	0	(1)
Central Services	0	0	0	5	(23)	(23)	(53)	(53)	(53)	(53)	(53)	(53)	(53)	(413)
Non Clinical	(12)	(14)	(25)	(10)	(10)	(11)	(10)	(10)	(11)	(10)	(10)	(11)	(12)	(130)
Acute Services & Urgent Care	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(9)
MACE	(0)	(0)	(1)	(1)	(0)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(7)
Quality & Nursing	(5)	(5)	(9)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(53)
People & OD	(1)	(1)	(3)	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(8)
Primary Care	(3)	(3)	(6)	(1)	(1)	(1)	(1)	(1)	(2)	(1)	(1)	(2)	(2)	(18)
Central Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Specialist Care	(2)	(3)	(5)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(35)
Total Bank	(551)	(485)	(1,036)	(488)	(493)	(485)	(431)	(428)	(428)	(431)	(431)	(434)	(435)	(5,520)
Bank as a % of Pay	5.86%	5.09%	5.47%	5.20%	5.22%	5.10%	4.55%	4.49%	4.49%	4.52%	4.52%	4.55%	4.56%	4.84%
Plan	(421)	(421)	(842)	(421)	(421)	(421)	(421)	(421)	(421)	(421)	(421)	(421)	(413)	(5,044)
Variance to Plan (Overspend) / Underspend	(130)	(64)	(194)	(67)	(72.324)	(64)	(10)	(7)	(7)	(10)	(10)	(13)	(22)	(476)
Bank Variance as a % of Plan	30.86%	15.16%	23.01%	15.92%	17.18%	15.12%	2.46%	1.57%	1.71%	2.43%	2.42%	3.12%	5.32%	9.4%

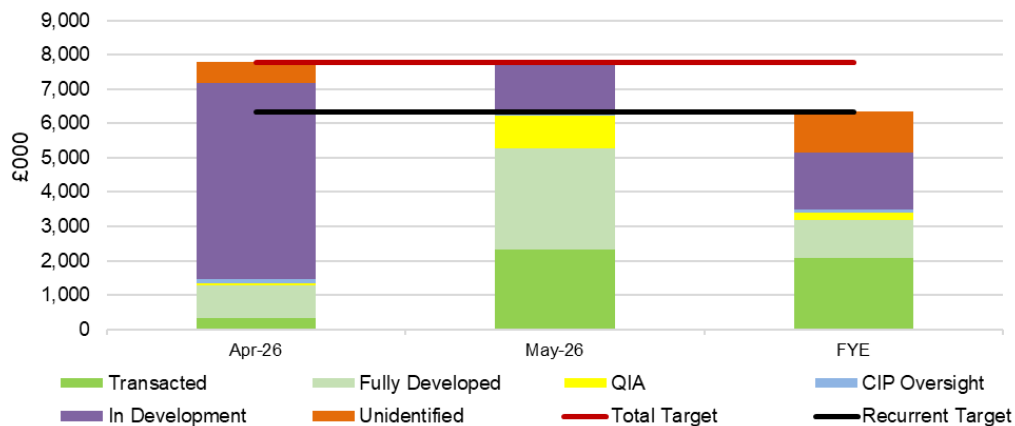
- Planned bank expenditure for 2026/27 is £5,044k this represents a 20% reduction of 2025/26 expenditure levels.
- The in-month expenditure is £485k against planned expenditure of £421k, resulting in an adverse variance of £64k.
- The year-to-date expenditure is £1,036k against planned expenditure of £842k, resulting in an adverse variance of £194k.
- Initial internal forecasts indicate an adverse variance of £476k, which remains after accounting for savings associated with the A&T closure.
- 74% of expenditure relates to nursing (qualified and unqualified) representing an adverse variance to plan of £180k.
- 20% of expenditure relates to medical staffing representing an adverse variance to plan of £8k.
- 3% of expenditure relates to other clinical staffing representing an adverse variance to plan of £8k.
- 2% of expenditure relates to non-clinical staffing representing a favourable variance to plan of £3k.



Efficiency Identified Schemes	Target £000	YTD 2026/27			Forecast 2026/27			Of which is Recurrent			Recurrent Full Year Effect		
		Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Clinical													
Acute	526	70	0	(70)	526	429	(97)	526	128	(398)	526	203	(323)
Community	1,834	244	25	(219)	1,834	170	(1,664)	1,834	170	(1,664)	1,834	170	(1,664)
Specialist	759	101	89	(12)	759	839	80	759	245	(513)	759	315	(443)
Primary Care	85	11	0	(11)	85	62	(22)	85	62	(22)	85	71	(14)
Clinical Total	3,203	426	114	(312)	3,203	1,501	(1,702)	3,203	606	(2,597)	3,203	759	(2,444)
Corporate													
CEO	57	8	0	(8)	57	23	(34)	57	23	(34)	57	34	(23)
Q&N	253	34	0	(34)	253	49	(204)	253	49	(204)	253	117	(136)
S&D	300	40	22	(18)	300	271	(29)	300	199	(101)	300	236	(64)
Finance	145	19	81	62	145	233	88	145	30	(115)	145	30	(115)
Performance	150	25	25	0	150	150	(0)	150	150	(0)	150	150	(0)
Estates	178	24	14	(10)	178	217	38	178	217	38	178	217	38
MACE	141	19	5	(14)	141	43	(98)	141	43	(98)	141	55	(86)
Operational	(0)	0	0	0	(0)	0	0	(0)	0	0	(0)	0	0
People	143	19	0	(19)	143	144	0	143	144	0	143	287	144
Corporate Total	1,368	187	147	(40)	1,368	1,129	(239)	1,368	854	(514)	1,368	1,126	(242)
Trustwide	2,056	274	70	(204)	2,056	3,996	1,941	616	1,946	1,331	616	2,107	1,491
Productivity	1,149	191	192	1	1,149	1,149	0	1,149	1,149	0	1,149	1,149	0
Total Trust CIP	7,775	1,078	523	(555)	7,775	7,775	(1)	6,335	4,555	(1,780)	6,335	5,140	(1,195)

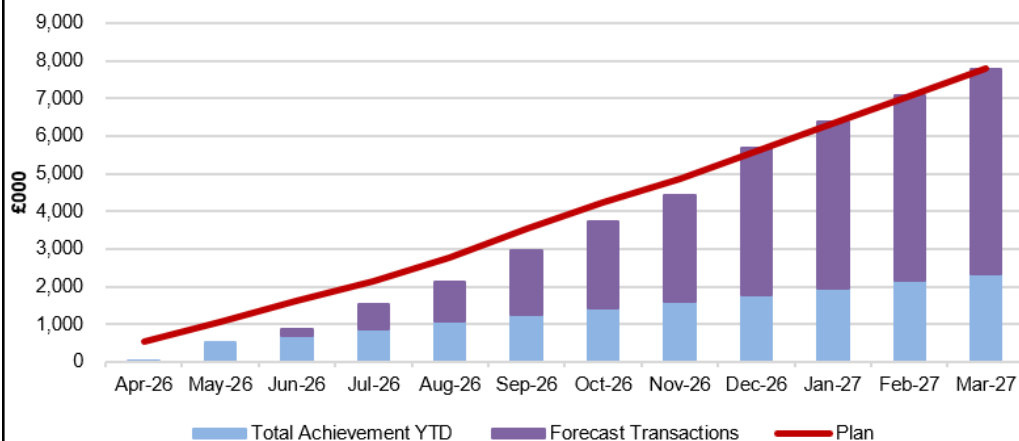
- The efficiency target is £7.8m (reflecting 5.4% of the Trust total cost base excluding TCP & Complex Care) and includes £1.3m recurrent productivity target.
- Of the £7.8m target, £6.3m is recurrent and £1.5m non-recurrent.
- At Month 2 the Trust is forecasting full delivery of the £7.8m CIP target. Of this, £6.6m is implemented or fully developed and £0.2m relates to plans in progress. However, £1.0m remains classified as opportunities representing a significant delivery risk against the overall programme.

Progression in achieving CIP Target

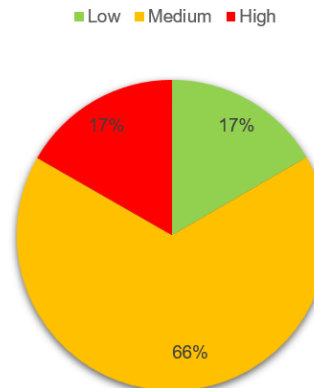


- Top graph shows the Trust progress in achieving the total £7.4m target and full year effect recurrent £6.0m target.
- Bottom left graph shows the cumulative phasing of the £7.4m target against the amount that has been achieved year to date and forecast.
- Bottom right pie chart shows the current risk level.

CIP YTD Plan / Actual

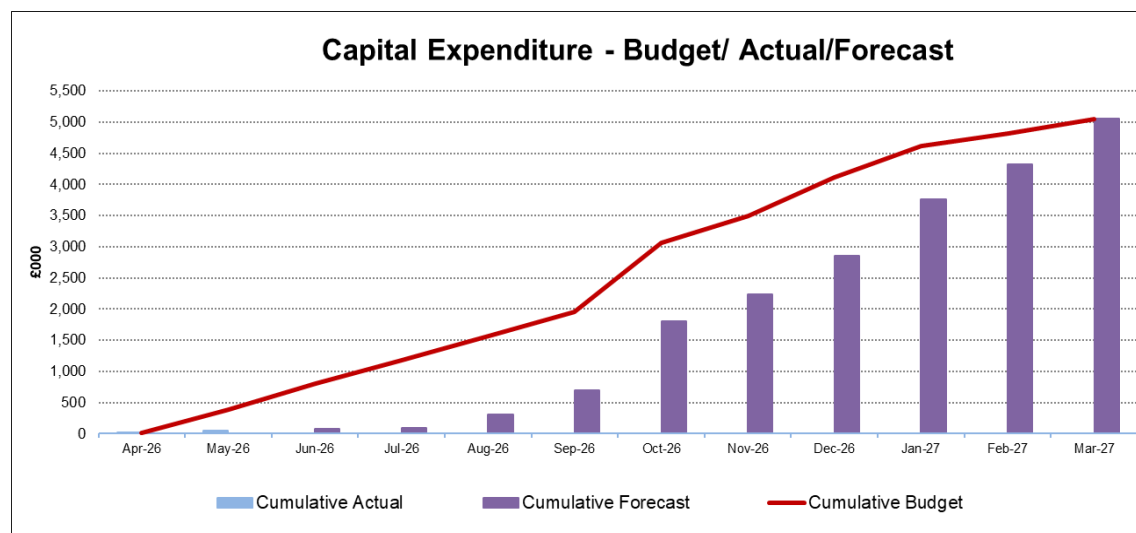


Current Risk Profile of achieving £7.8m Target



Capital Expenditure	Annual Plan £000	Year to Date Against Plan			Forecast Outturn Against Plan		
		Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Operational Schemes	919	0	0	0	919	919	0
Ligature Risks - planned	175	0	0	0	175	175	0
Ashcombe Restructure	234	0	0	0	234	234	0
Security	176	0	0	0	176	176	0
Freedom & Flexibilities	334	0	0	0	334	334	0
Digital	713	6	7	1	713	713	0
Capitalised Salaries - Device Replacement	40	6	7	1	40	40	0
Digital Solution CRHTT	58	0	0	0	58	58	0
Frontline Digitisation Programme	500		0		500	500	0
Digital Infrastructure	115	0	0	0	115	115	0
Strategic Schemes	3,070	387	84	(303)	3,070	3,070	0
Strategic Schemes - EMU Expansion	1,034	129	20	(109)	1,034	1,034	0
Strategic Schemes - A & T Refurbishment	1,936	242	46	(196)	1,936	1,936	0
Capitalised Salaries - Projects	100	16	18	2	100	100	0
Other Schemes	200	0	1	1	200	200	0
IFRS16 Leases	200	0	0	0	200	200	0
Contingency	0	0	1	1	0	0	0
Total Trust Funded Capital Expenditure	4,902	393	91	(302)	4,902	4,902	0
Backlog Maintenance	147	0	(41)	(41)	147	147	0
Total Gross Capital Expenditure	5,049	393	50	(343)	5,049	5,049	0

- The Trust's annual capital plan is £5,049k, including £147k of PDC funding.
- Year to date gross capital expenditure is £50k, giving a favourable variance to plan of £343k, mainly due to slippage on the EMU and A & T Schemes.
- Forecast gross capital expenditure for the year is £5,049k against plan, and is also in line with the approved capital programme.



SOFP	M12 £000	M1 £000	M2 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	19,639	19,606	19,582
Property, Plant and Equipment	17,274	17,182	17,111
Right of Use Assets	2,730	2,689	2,650
Intangible Assets	1,935	1,886	1,836
NCA Trade and Other Receivables	549	543	537
Total Non-Current Assets	42,127	41,906	41,715
Current Assets			
Inventories	86	88	63
Trade and Other Receivables	7,975	9,979	6,139
Cash and Cash Equivalents	33,439	36,928	40,778
Total Current Assets	41,500	46,994	46,979
Current Liabilities			
Trade and Other Payables	(20,556)	(26,023)	(25,995)
Provisions	(1,945)	(1,794)	(1,794)
Borrowings	(3,199)	(3,199)	(3,199)
Total Current Liabilities	(25,700)	(31,016)	(30,988)
Net Current Assets / (Liabilities)	15,800	15,979	15,991
Total Assets less Current Liabilities	57,927	57,884	57,706
Non Current Liabilities			
Provisions	(977)	(1,110)	(1,109)
Borrowings	(14,888)	(14,755)	(14,621)
Total Non-Current Liabilities	(15,865)	(15,865)	(15,730)
Total Assets Employed	42,062	42,020	41,977
Financed by Taxpayers' Equity			
Public Dividend Capital	27,850	27,850	27,850
Retained Earnings reserve	7,187	7,145	7,101
Revaluation Reserve	7,025	7,025	7,025
Total Taxpayers' Equity	42,062	42,020	41,977

Current receivables are £6,139k of which:

- £3,275k is based on accruals (not yet invoiced).
- £2,863k is trade receivables; based on invoices raised and awaiting payment of invoice (£6,139k 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 £30,988k of which:

- Trade and Other payables remain high at £25,995k 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 1.5 showing the Trust can cover its current debt obligation.

Better Payment Practice Code	In Month			YTD Total		
	NHS	Non-NHS	Total	NHS	Non-NHS	Total
Number of Invoices						
Total Paid	24	718	742	68	1,544	1,612
Total Paid within Target	24	693	717	68	1,481	1,549
% Number of Invoices Paid	100.0%	96.5%	96.6%	100.0%	95.9%	96.1%
% Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
RAG Rating (Variance to Target)	5.0%	1.5%	1.6%	5.0%	0.9%	1.1%
Value of Invoices						
Total Value Paid (£000s)	493	6,876	7,369	812	15,060	15,872
Total Value Paid within Target (£000s)	493	6,864	7,357	812	14,936	15,748
% Value of Invoices Paid	100.0%	99.8%	99.8%	100.0%	99.2%	99.2%
% Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
RAG Rating (Variance to Target)	5.0%	4.8%	4.8%	5.0%	4.2%	4.2%

The Better Payment Practice Code (BPPC) target is to pay at least 95% of invoices, by both number and value, within 30 days for NHS and non-NHS suppliers.

- During month 2, the Trust achieved the BPPC target for both the number and value of invoices paid within 30 days, with performance at 96.6% by number and 99.8% by value.
- Year to date the Trust has achieved the BPPC target for both number and value of invoices paid within 30 days, with performance at 96.1% by number and 99.2% by value.
- The Finance Team will continue to monitor performance and work with operational areas to improve the timely authorisation of invoices where required.



The Board are asked to receive the Month 2 financial position noting:

- A year-to-date deficit of £178k against a planned deficit of £179k, resulting in a favourable variance of £1k.
- An underlying financial position (ULP) deficit of £292k.
- Agency expenditure of £153k against a plan of £174k, resulting in a favourable variance of £21k.
- Bank expenditure of £1,036k against a plan of £842k, resulting in an adverse variance of £194k.
- Year to date CIP delivery of £523k against a plan of £1,078k, resulting in an adverse variance of £555k.
- Capital expenditure of £50k, against a plan of £393k, resulting in a favourable variance of £343k.
- A cash balance of £40.8m on 31st May 2026.



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

Cost Improvement Programme

An update on the development of 2026/27 CIP schemes was provided noting the Trust is behind NHSE's expectations for this point in the year. The end of May trajectory was not achieved and consequently the Trust has been asked to submit an approved timetable setting out how full scheme development will be secured. The current position on 4th June is 85% of schemes are fully developed or implemented.

Bank expenditure remains high and is an area of focus alongside roster optimisation. Work is being undertaken across the clinical and corporate directorates to address this and reduce costs.

Level of assurance 4 agreed, although there were discussions whether the assurance could be level 5.

Orbis Update

The Committee received an update on the implementation of Orbis. The gap analysis has been completed, and progress is being made in addressing the issues identified, with target completion dates now assigned to each action. The Trust continues to engage with NHSE regarding the escalation that has been raised and is in discussion about establishing a contract change notice linked to the outcomes of the gap analysis.

The Committee sought assurance on whether confidence in the programme had improved. The CSO and CIO confirmed that they were confident in the progress being made and the actions underway to address outstanding issues. The Committee noted the positive progress achieved to date.

Level of assurance 2 agreed.

ADVISE:

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

Heading:

Business Opportunities

Lead Provider for West Midlands Tier 4 Child and Adolescent Mental Health Services, NHS England tender expected to launch week commencing 1st June 2026.

Following the Digital Board Development session in May, the Trust has continued its collaboration with NHS Alliance to refresh the Digital Strategic Plan. The plan will set out the Trust's vision for using digital technology to support staff and improve patient care. Stakeholder engagement is ongoing, with a first draft expected to be produced in the autumn.

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:

Finance Position M1

Committee noted the Trust is on plan. Bank is significantly over plan due to acuity and sickness. 29% of the overall CIP programme is unidentified or opportunity and therefore is classified as high risk. Committee challenged on the bank the high levels of bank expenditure and the plans to address this. Members discuss the cross overs with other committees and the escalations required for PCDC and Quality Committee.

Level of assurance 5 agreed.

IQPR M1

The Committee received the report and noted exceptions relating to four-week referral-to-assessment performance, and demand for Early Intervention services continues to increase beyond available capacity. An increase in the emergency admission rate was also reported, with some data quality issues identified. Positive progress was noted across several performance improvement plans, including reductions in sickness absence. National priority access standards were achieved, while 104-week waits remained above trajectory at month 1, with plans in place to reduce these to zero by year-end. Out-of-area placements were reported at 24 for month 1, with the Committee noting the significant improvement in the current position.

The Committee discussed the factors contributing to the reduction in out-of-area placements (OOA) and the initiatives supporting the NHS priority of shifting care from hospital to community settings. Clinically ready for discharge was also discussed, and ongoing work with the ICS and the Local Authority. The trajectory for eliminating 104-week waits was challenged; however, assurance was provided that, despite being off plan at month 1, the Trust remains confident that the year-end target will be achieved.

Level of assurance 6 agreed.

Estates and Capital Report

Committee received the report. Project Horizon and Project Elevate are on track with expected start dates in Q2. EMU contractual issues are being worked through with THL. Following an onsite review with Staffordshire Police, security upgrades are required, a business case will follow for this. A remedial programme has been agreed with TLH in relation to water issues at Harplands due to complete on 7th July. Technical designs continue to progress for ventilation with an expectation at that the works will take 8-10 weeks per unit. Fire safety remedial works are well underway; however, a fire specialist report noted several areas below standard.

The Committee discussed whether any actual security incidents had occurred and received an update on progress in mitigating the identified fire safety risks.

Level of assurance 4 was challenged and was agreed that the assurance level should be level 5.

APPROVE:

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

Heading:

Risk Register

There were no new risks identified. One risk score was increased in relation to the delivery of the Trust's CIP programme, and one risk concerning system instability and data loss in Lorenzo was closed. Both the score increase and the risk closure were approved.

Business Opportunities

The Committee retrospectively endorsed the submission of a bid to NHSE for capital funding to support the further development of PatientAide, as well as the submission of the Trust's priorities as part of the SSOT/STW cluster's expression of interest for the NHSE Digital Frontline Productivity Programme.

STW TCP Phase 1 Business Case

Phase 1 of the STW TCP business case was approved, enabling the transfer of STW TCP operational staff from MLCSU under TUPE arrangements.

Mental Health Support Team Wave 16 Funding Rollout

Committee approved the mobilisation and utilisation of Wave 16 funding to expand MHST provision across Staffordshire Moorlands, enabling full school coverage in line with national expectations. Committee challenged the benefits realisation of the previous roll outs.

Conversations took place on prevention and the F&R role in seeking assurance on this.

Policy Report

The Committee approved 4 IG policies for 3 years.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 2nd July 2026 at 10am via MS Teams.

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

REPORT END

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

Cost Improvement Programme

An update on the development of 2026/27 CIP schemes was provided noting the Trust has not achieved the NHSE development requirements by the end of June. The shortfall against the fully developed requirement reduced from 20% at the end of May to 7%, £0.5m gap. The current position on 2nd July is a shortfall of 5% or £0.4m.

Level of assurance 4 agreed.

Orbis Update

The Committee received an update on the implementation of Orbis, noting that a revised go-live date has yet to be agreed. Members received assurance on progress in addressing system gaps and noted ongoing engagement with NHSE and the development of a draft contract change notice currently with the supplier's legal team. The Committee noted some service areas may have issues affecting access to data for improvement projects and received assurance that teams should be able to input and access the required data, this will be followed up outside Committee.

Level of assurance 4 agreed.

ADVISE:

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

Heading:

Business Opportunities

Committee received assurance on two live tender opportunities that are currently active for the Trust. Committee were cited on the SLA recently agreed with UHNM to deliver provide psychological leadership and staff support within maternity services at Royal Stoke.

Level of assurance 5 agreed.

Finance Position M02

Bank staffing costs are forecast to overspend against plan. This variance should be treated as a financial pressure requiring immediate management action, with strengthened controls, review of reliance on bank staffing, and mitigation measures to reduce expenditure and bring costs back in line with plan.

IQPR M02

Sickness absence levels remain higher than plan and are creating additional operational and financial pressure. This trend should be monitored closely, with actions required to understand underlying causes and implement appropriate mitigation to reduce impact on staffing capacity and reliance on additional cover.

Estates and Capital Report

A further update on fire safety will be presented to a future meeting to provide additional assurance on progress, the management of identified risks, and the delivery of agreed actions.

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 M02

The Committee noted the revised Talking Therapies trajectory for 2026/27 and considered exceptions relating to CAMHS RTT performance and sickness absence. Members welcomed continued improvement in out of area placements and received assurance that the Trust remains confident of achieving the year end Talking Therapies target.

Level of assurance 6 agreed.

Finance Position M02

Committee noted the Trust is on plan. Bank usage is significantly over plan due to acuity and sickness. 13% of the overall CIP programme is classified as opportunity and is high risk. Committee discussed bank usage and further discussions to take place regarding safer staffing.

Level of assurance 5 agreed.

Service Line Reporting Q4 2025/26

The Committee received assurance on trends in unit costs across inpatient, community and outpatient services, noting the introduction of national benchmarking to support service reviews and productivity. Members noted plans to showcase use of the information at the next meeting. Members also noted the proposed 2027/28 payment mechanism changes relating to the deconstruction of the block exercise.

Level of assurance 6 agreed.

Estates and Capital Report

The Committee received the report. Updates were received on the Trust's estates and capital programme, noting slippage in dates within Project Horizon and Project Elevate. The Committee was assured that targeted actions are in place to address ongoing risks relating to Harplands Hospital water quality and fire safety. The Committee noted improvements in water safety and requested a separate paper on fire safety to provide additional assurance.

Level of assurance 5 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 identified, no score changes and no closures. Two risks were approved for the amendment of achievement dates.

Committee discussed progress around Harplands fire safety including the findings of the independent specialist. An update was provided on ventilation works, with commencement scheduled for August. Members also discussed the importance of setting realistic target dates for the completion of the remaining works and monitoring progress against those milestones.

Site Security Business Case

The Committee approved the business case (option 4) for a targeted programme of security improvements at Harplands Hospital, including £389k capital investment and associated revenue funding. The Committee was assured that the scheme provides a proportionate, evidence-based approach to addressing key site security risks and will strengthen patient and staff safety, organisational resilience, and emergency preparedness.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 6th August 2026 at 10am via MS Teams.

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

REPORT END

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

Update received, nothing significant to report from this month's Committee.

ADVISE:

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

CQC Update

Update received, nothing new to report / update.

Trust still awaiting the CQC report from the Older Adults Community review in April 2026.

IQPR

There were 3 key areas of discussion regarding this months IQPR;

- **Supervision** – The committee received an overview of the work underway in services regarding the importance of recording and documenting Supervision. Primary Care Directorate highlighted an area of good practice with other directorates encouraged to focus their attention in ensuring that supervision records are retained at service level and therefore readily available should they be required for regulatory assurance. It was also acknowledged that the medium to longer-term work remains underway to move to ESR which will further support assurance regarding the recording of compliance and retaining documented evidence.
- **Sickness** – The ongoing focus and work underway in Directorates was discussed and acknowledged. The sickness improvement trajectory will also be triangulated with PCDC

- **Early intervention Team performance** – A potential deterioration in the performance trajectory for Early Intervention services was highlighted and discussed, the Directorate updated the Committee regarding the key areas of focus and activity underway to mitigate this.

ASSURE:

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

OOA placements;

The Committee received a detailed presentation which gave an overview of;

- OOA bed reduction trajectory aligned to key improvement focused activities
- Improvements underway in relation to
 - Early Facilitated Discharge
 - Gatekeeping assessments
 - Deteriorating patient monitoring in community services
- Ongoing challenges associated with system wide issues; i.e. Clinically Ready for Discharge and interface with local authority provisions and requirements.

There was good discussion regarding processes in place to ensure that the quality of patient care for patient in Out of Area Placement is under constant review and surveillance. This will be monitored via the monthly reporting which will go to both Quality and Finance and Resource Committees.

The committee were assured that the action underway are having an impact in the reduction of out of area placements being used and were pleased to hear that on the day of the Committee there were only 2 reportable inappropriate out of area placements.

Safer Staffing –April 2026

There was a robust discussion regarding safer staffing v's rostering efficiencies. Deep dive review into ward 3 acuity will form part of the establishment reviews which will be reported to the committee via the 6monthly safer staffing report. The committee were assured that staffing level's were safe during April.

Infection Prevention and Control Quarter 4 Report

The committee noted challenges in the compliance to some areas of the IPC audits and therefore reduced the level of assurance from 7 to Level 6.

Restrictive Practice Quarter 4 Report

Safeguarding Adult and Children Quarter 4 Report

The safeguarding Q4 report level of assurance was reduced from level 7 to 6 due to ongoing challenge with Safeguarding children training compliance.

The increase in allegation against staff was also noted by the committee and acknowledgement given to the work underway regarding professional standards and expectations which is underway.

Learning from Experience Quarter 4 Report

There remains an ongoing concern regarding the high level of falls within the Inpatient areas, mainly the Older Persons Wards, this remains a focused area for the falls prevention group who continue to look for areas of improvement in response to identified themes.

Mortality Surveillance Quarter 4 Report - nothing of concerns for this Q4 report

PSIRF Quarter 4 Report

The committee welcomed the structure of this Q4 report and welcomed the proposed changes for Q1 which will have more emphasis on learning from patient deaths.

EPRR Annual Report

The committee held a discussed assurance about the level 7 assurance, noting gaps in assurance for a small number of actions. However, based on there being significant assurance in the main and acknowledgment of how well the Trust performs when compared to other areas in the west midlands, it was agreed to remain at level 7.

Lived Experience Shadow Board (LESB) Proof of Concept

The committee welcomed this proof of concept and fully support progression into a full business case.

There was discussion held regarding

- how this will be operationalised,
- easily accessible papers,
- timings of feedback from shadow board to influence board
- Shadow Board engagement in committee's

These considerations will be taken forward into the coproduced programme of work where Executive and Non-Executive involvement will key to the success of the board.

APPROVE:

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

The committee approved the following Papers:

- Risk Register
- Policy Report
- Community Mental Health Survey Report & Plan
- Baseline Clinical Audit and Evaluation Programme 2026/27
- Quality account

Next Steps (including timeframes):

The next Quality Committee meeting will be held on: 2 July 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 2 July 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

System in critical level 4 incident at the beginning of this week; NSCHT have however continued as business as usual but proactively support flow out of emergency portals for mental health patients. This was stood down on 1st July 2026.

We are anticipating weather alerts of increased heat which could potentially impact on Emergency Departments. A similar impact is being monitored for patients with SMI and increased needs associated with warmer weather.

ADVISE:

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

CQC Update

The CQC arrived unannounced to the Older Persons Inpatient Wards on 30th June 2026. This is in the form of a 3-day core service inspection into wards 4,6 & 7. This will be rated under the current Single Assessment Framework; however, the Trust have also consented to be part of the pilot for the draft new framework which was launched in June 2026. The committee were updated regarding the positive energy and positive informal feedback thus far during the inspection.

IQPR M2 2026/27

The committee requested more assurance regarding the performance around managing sickness, the committee were advised that over a long trajectory period there is evidence to support that sickness improvement is being achieved. The effectiveness of the PIP process was discussed; the committee were advised that there is evidence that PIPs are closed and do deliver intended outcomes.

Directorate Spotlight

The paper and proposal was well received; going forward each directorate will present a Spotlight Review twice annually.

This will be a brief, structured paper submitted in advance with Committee papers. Directorate teams will identify key issues for discussion, enabling focused and meaningful dialogue rather than report-driven presentations.

Update on Quality Improvement Showcase Event

The chair and Acting CNO updated the committee regarding the event which took place earlier in June. 4 teams showcased their quality improvement initiative. This is the first time the programme was done with teams as opposed to individuals and proved to be a success, it is intended that this approach will help to further embed continuous quality improvements throughout teams and services.

Insights into challenges regarding data access have been followed up with consideration of this informing the ongoing work with Orbis. It was also recognised how staff continue to go the extra mile to ensure patients have a seamless experience even when met with commissioning challenges.

ASSURE:

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

OOA placements;

End of May the Trust reported 3 inappropriate out of area patient. Through June there was 1 reported, up to the end of June when we had 5.

A deep dive review into inappropriate OOA admissions have been validated as requiring hospital admission in accordance with their needs, with evidence that early intervention and gatekeeping were integral to the process leading to admission, offering assurance that processes in place are effective.

Safer Staffing –May 2026

Good discussion re safer staffing assurance v's operational management of increased staffing / bank. The committee were assured that staffing is safe but agreed that articulating the dependency and acuity of patients more robustly will help to triangulate whether we have the most efficient use of staffing. The robust use of SafeCare operationally on a day-to-day basis was highlighted as a requirement and the work underway regarding the electronic recording of Enhanced Therapeutic Observations of Care (ETOC) is intended to support better understanding of the acuity needs of the wards and will be incorporated into future reports once the data has been validated.

Infection, Prevention and Control Annual Report

The report and level 7 assurance were accepted as robust. The committee were also alerted to the high regard for the IPC team from system and UHNM colleagues for their proactiveness and high standards in relation to IPC compliance.

Health and Safety and Security Annual Report

There was good discussion regarding the assurance of the report; level 3 was originally given noting the work underway to reduce the harm experienced from violence and aggression to staff. The committee were assured that there was a clear plan and work underway in this space and therefore assurance level 4 was agreed.

Mortality Surveillance Annual Report

The report was well received, and the committee welcomed the plan to bring future reports together into one 'Learning from Deaths' report.

Discussion regarding assurance level 3, it was noted that there was one quarter where mortality surveillance review was cancelled, however mitigation was put in place and there was no re-occurrence, therefore agreement to revise this to assurance level 4.

Suicide Prevention Annual Report

The committee received an overview of Suicide Prevention activity with useful recommendations working with partners outside of the Organisation.

APPROVE:

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

The committee approved the following Papers:

Risk Register

The Trust Ligature risk score from 15 to 10 approved on basis that the Darwin risk is visible at risk level 15 and adequately monitored.

Risk 944 score change from 6 to 12 approved, noting the seasonality and concerns around global warming

Policy Report

The following policies were approved for 3 years;

1. 5.44 Medical Gases Policy
2. MHA20 Mental Health Act – Policy guidance for Independent Mental Health Act Advocacy
3. 1.06 Transition of Adult patients to Older People's services Trust-wide policy
4. MHA18 Deprivation of Liberty Safeguards Policy (the guidance issued to the organisation will be addendum to the policy in light of the Cheshire West ruling)
5. MHA16 Mental Capacity Act Policy MHA18 Deprivation of Liberty Safeguards Policy
6. MHA26 Voting Rights for Mental Health Patients Policy

The following policy was agreed for 12 months;

7. 7.07 Records Management Policy – 12 months

Next Steps (including timeframes):

The next Quality Committee meeting will be held on 6 August 2026 at 2pm via MS Teams.

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

REPORT END

Trust Board QUAD A Assurance Report From the Audit Committee Meeting Held on 12th June 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 Audit Committee's remit and programmes of work.

ALERT:

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

Heading:

ADVISE:

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

Heading:

Fit and Proper Persons Test

Committee received the report for information only.

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:

Declarations of interest- Level 6

Committee were informed that the Trust had reached a 98% compliance rate at year end and not 100% due to a declaration being made on the Board Member Register in January and not the AFC 8c and above register running April- April taken from a report provided by ESR. During this period a member of staff moved from AFC to VSM for an interim period. Learning going forwards is that for next year the Board Member declarations and annual AFC 8c and above declarations will be done collectively in January. Level 6 agreed.

CSU Service Auditor Report- Level 7

During the audit, there were 34 controls tested, 28 of which related to payroll. Of the 28 payroll related control tests, there was one relevant exception noted relating to payroll overpayments being accurately calculated and recorded to enable recovery.

Deloitte's opinion is the CSU's activities, and the control objectives have been suitably designed to provide reasonable assurances and operated effectively for the 12-month period of 1st April 2025 to 31st March 2026.

Auditor's Annual Report 2025/26- Grant Thornton

External Audit is required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to as Value for Money).

The National Audit Office re Code of Audit Practice requires assessment against three areas:

- Financial sustainability
- Governance
- Improving economy, efficiency and effectiveness.

No significant matters/issues were found.

Audit Findings Report 2025/26- Grant Thornton

External Audit has not identified any material adjustments to the financial statements which impact on the Trust's reported Comprehensive Income figure. It is anticipated that the audit report opinion will be unmodified.

APPROVE:

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

Heading:

Annual Accounts

No adjusted or unadjusted material misstatements have been identified in the accounts during the audit.

The Annual Report and Accounts were amended to reflect misclassification and disclosure changes identified by the auditors. One proposed change relating to Note 3.2 (Income from patient care activities by source) has not been made because it is not material enough to affect the financial statements. However, the organisation plans to update its source mapping from the 2026/27 financial year to align with the auditors' recommendation.

Annual Report

Committee approved the Trust Annual Report 2025/26 noting the Directors signatures and financial accounts are to be added following approval at Committee, plus auditor's report and certificate. Further amendments were agreed to be added to the final version including

- Typo on a Director Biography
- Further work on design to refine the BAF table.
- Updates from finance team following advise and feedback from Grant Thornton
- Assure the correct use of NHS logos throughout is in keeping with national standards for same- (Design element.)

Letter of Representation

Approved by Committee and will be signed in conjunction with accounts. Level 7 assurance.

Next Steps (including timeframes):

The next Audit Committee meeting will be held on: 31st July 2026 at 10:00m 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 29th June 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 received a staff story that highlighted the importance of flexibility in career development, alongside the significant but often under recognised leadership potential within the workforce, for example, clinicians transitioning to operational management. Members noted a disconnect between the complex decision making staff undertake in their clinical roles and their confidence to step into leadership positions, indicating missed opportunities to support development across all bands. The discussion drew out themes relating to the need for stronger supervision, appraisal and development conversations; as well as a shift towards a flatter, more inclusive leadership culture that enables staff to contribute more fully. The Committee reflected on the role of the manager in improving staff experience and culture; and will feature as a future focussed Committee.
 - Ongoing clinical supervision concerns regarding inconsistent compliance and quality were discussed, with agreement this may require an increased risk rating and greater visibility on the risk register.
 - Despite improvements, statutory and mandatory training compliance remains a concern, particularly in high-pressure services; and in light of upcoming national changes to competency-based assurance models led through the updated framework in development by NHS England.
 - Feedback from the Real Talk, Real Change sessions were presented to Committee, and highlighted recurring themes:
 - Culture & leadership: Expectations for kinder, more professional behaviours, with stronger leadership accountability.
 - Recognition & feedback: Limited appreciation; small, positive actions seen as high impact.
 - Communication: Need for clearer, more transparent and consistent messaging, especially during change.
 - Workload pressures: High demand and limited capacity affecting quality and wellbeing.
 - Efficiency: Too many meetings and processes; desire to streamline bureaucracy.
 - Roles & development: Lack of clarity in roles, role creep and unclear career pathways.
 - Wellbeing: Closely linked to workload and culture; desire to improve team connection and morale.
 - Engagement in change: Strong appetite for involvement, co-production, and visible feedback loops.
- Cycle two of engagement commences in July 2026, with a targeted approach for facilitated conversations within existing directorate meetings.

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

- The Committee triangulated the assurance reports to identify area of focus as part of ongoing programmes of work, aligned with the People Plan:
 - Deep dive into rostering and training attendance to better understand and address DNAs, particularly in high-pressure services.
 - Enhance management capability and support, including structured onboarding and peer networks.
 - Embed a culture of daily recognition, ensuring appreciation is consistently demonstrated at all management levels, not just through formal schemes.

- Strengthen zero-tolerance approach to violence and discrimination, with clearer linkage to EDI impacts and support mechanisms for affected staff.

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:

- Positive trajectory in workforce metrics; including improved compliance rates and reductions in sickness absence, with national recognition from NHS England for improvement work. Assurance level 6.
- Sickness improvement plan delivering sustained progress, supported by directorate level KPIs and targeted interventions. Assurance level 6.
- Training attendance improving, with reductions in DNAs and cancellations, alongside strengthened enforcement approaches (particularly for bank staff), however still remains a live risk. Assurance level 3.
- People Plan delivery on track, with continued focus on cultural transformation and workforce optimisation. Assurance level 6.
- Health and safety actions in place, including quality improvement initiatives and relaunch of zero-tolerance messaging. Assurance level 3.

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

The Committee approved the following:

- Risk Report Deep Dive.

Next Steps (including timeframes):

The next PCDC focus meeting will be held on: 3rd August 2026

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

REPORT END

Trust Board Assurance Report from the Charitable Funds Committee meeting held on 1 June 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

ALERT:

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

Financial Sustainability Risk: The Committee continues to monitor its principal risk relating to the long-term financial sustainability of the charity. Work is underway to develop an evaluation of charitable funds activity over the last two years and options appraisal for potential future operating models. This will be considered at the next Committee meeting in September.

Terms of Reference: An updated Terms of Reference was discussed including revisions to approved expenditure levels to align with the Trust scheme of delegation as follows:

Fund	General Fund	Specific Fund
Fund holders	None	£2,000
Chief Strategy Officer or Chief Finance Officer	£10,000	£10,000
Charitable Funds Committee	Unlimited	Unlimited

This marks a change from the previous authorisation limits whereby any expenditure exceeding £50,000 required approval from Trust Board.

ADVISE:

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

Charity Development and Fundraising Activity: Updates included exploration of pro-bono management consultancy from the Cranfield Trust to support with the future options appraisal and strategy for the charity. The development of a National Lottery Reaching Communities bid was also discussed to build on the children and young people's community grants programme that has been delivered by the Community Directorate.

Inactive Funds Rationalisation: The Committee agreed a structured approach to write to fund holders to request spending plans and merge inactive unrestricted funds into the general fund where appropriate. Inactive funds are those that have not generated any income or committed expenditure for 2 years or more.

ASSURE:

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

Finance: The Committee noted a fund balance of £343k at 31 March 2026 increasing to £385k at 30 April 2026, income of £53k and expenditure of £27k. Most funds remain restricted and inactive funds have been identified for action.

NHS Charities Together Grants: Assurance was provided on delivery of the Greener Communities and Workforce Wellbeing projects, including governance and reporting arrangements. Both projects remain on track with good engagement from Trust staff and wider partners to support their delivery.

APPROVE:

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

Terms of Reference: Approved, including alignment with the Scheme of Delegation and strengthened clarity of governance arrangements, subject to confirmation by Trust Board.

Approach to Inactive Funds: Approved approach to engagement with fund holders and potential consolidation of unrestricted funds.

Next Steps (including timeframes):

The next Charitable Funds Committee meeting will be held on: 7 September 2026 at 2pm Via MS Teams.

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

REPORT END

Enclosure No: 15

QUALITY ACCOUNT

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☐	Advise	☐		
Information	☒				

Presented by:	Zoe Grant – Acting Chief Nursing Officer
Prepared by:	Zoe Grant – Acting Chief Nursing Officer
Executive Lead:	Zoe Grant – Acting Chief Nursing 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:	Not applicable for approval
Approval / Review:	Quality Committee
Strategic Priorities:	Choose an item. The Quality Account is aligned to all Strategic Priorities
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:	None identified

Recommendation / Required Action:	The Board is asked to note the content and narrative within this Quality Account and to note levels of assurance in relation to this. Quality Committee has approved having designated responsibility for approval on behalf of the Trust Board.
Executive Summary:	The Trust Quality Account is an annually mandated report, it is a look back on performance from the previous year, describing what the Trust has done well, and where improvement is required and also describing areas that have been identified as priorities for improvement. This version of the account is to provide initial overview of the narrative content being proposed for final submission and publication on 30th June 2026 (as per National requirement). The Quality account runs from 1st April 2025 to 31st March 2026, all relevant Trust information and data is now updated in this draft version of the Quality account. This document reflects the feedback from our stakeholder engagement session. The account has been shared with Commissioners, Health Watch and the Local Authorities Overview & Scrutiny Committee's for their review and feedback.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Quality Committee	28.05.26
V1	Public Trust Board	09/07/26

Outstanding

Our quality journey continues

NHS

North Staffordshire
Combined Healthcare
NHS Trust



Quality Account
2025/26

Quality matters

North Staffordshire Combined Healthcare NHS Trust is a leading provider of inpatient and community mental health, learning disability, substance misuse and primary care services in the West Midlands.

We were particularly proud in November 2025 to be officially ranked as the number one 'Non-Acute' NHS Trust in England in the new NHS Oversight Framework.

This was the latest step in our continuing journey of improvement and achievement and positive proof that our determination to deliver our vision – **to be Outstanding – in ALL we do and HOW we do it** – burns as strong and as bright as ever.

We are proud to be an outstanding Trust, but we constantly make clear – to our leaders, our people, our service users and stakeholders – that we are never complacent and that our journey of improvement always continues to deliver our vision.



And at the heart of that vision is our commitment to the pursuit and promotion of the highest quality possible in our services, our processes and the care we provide.

Put simply, we know that quality really matters.

What is the Quality Account?

Quality accounts, also known as quality reports, are produced annually to provide information and assurance for service users, families, carers, the public and commissioners, to demonstrate that the Trust reports on quality and shows improvements in the services we deliver.

Quality accounts look back on performance from the previous year, describing what the Trust has done well, and where improvement is required. They also look forward, describing areas that have been identified as priorities for improvement resulting from patient and public consultation.

We hope that you find this Quality Account, covering the financial year 1 April 2025 to 31 March 2026, helpful in enlightening you about our work and priorities to date, to improve services over the coming year.

We also look forward to your feedback, which will assist us in improving the content and format of future quality accounts. Feedback can be given via our Trust website combined.nhs.uk.

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Part one – Quality statement

Outstanding quality at a glance

Our journey continues – to drive quality and be Outstanding in ALL we do and HOW we do it. Here are some of the highlights of how we're doing.

CareQuality Commission

Outstanding

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Outstanding
Well-led	Good

Proud to be outstanding, but never complacent.



Officially ranked as the number one 'Non-Acute' NHS Trust in England in the new NHS Oversight Framework.

Strong results for staff involvement and all NHS People Promise themes in the NHS Staff Survey.



27th consecutive year of achieving financial surplus – making us one of the top financial performers in the region.



Praised by service users for our partnership with them in making appointments and deciding our quality priorities – including our biggest ever Engagement@Combined event.

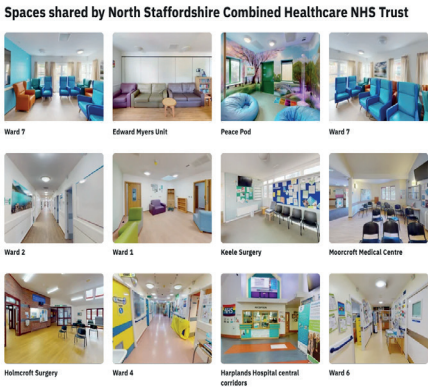
Sustaining improvement

CareQuality Commission

A series of case studies showing how trusts have achieved significant improvements in their ratings - and how they have since sustained those improvements or improved further.

Praised by the CQC for our ability to sustain improvement – year after year – following receiving an outstanding rating.

Proud of our record in innovation in research, digital and communications - including virtual walkthroughs of all our services



Our long-term Trust Strategy 2023-2028 driving forward improvement and transformation, underpinned by three strategic priorities – Prevention, Access, Growth.





Children and Young People services exceeding national targets in-line with 100% coverage by 2029

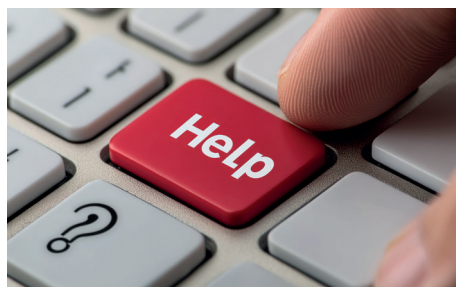


New Forensic Liaison Partnership service enhancing the way patients from Stoke-on-Trent transition from secure inpatient settings into community mental health services

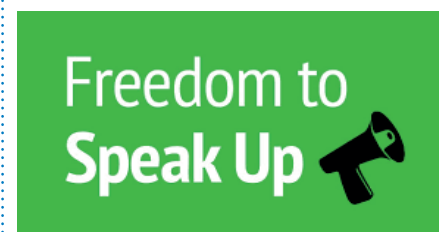
New patient wellbeing initiative exploring a variety of therapeutic activities, including recent autism informed engagement approaches.



Holmcroft Surgery awarded a 'Good' rating by CQC across all domains, with no regulatory breaches identified.



New Ascend Recovery Service offering evidence-based, psychological treatment and support to anyone aged 16+ experiencing trauma symptoms as a result of sexual assault or abuse



One of the strongest Freedom to Speak Up infrastructures in the NHS with every directorate and staff network represented with a champion.

24/7 mental health support for all adults and young people in North Staffordshire and Stoke-on-Trent by text, including new free text messaging service.



Every ward set up with a dedicated project group to deliver Culture of Care in their area.





57% increase in active students using our Wellbeing and Recovery College and rising expressions of interest to enrol



New 'What to Expect' service information videos delivered in partnership with our Service User and Carer Council

Inpatient services fully transitioned to co-produced care planning.



NHS 111 mental health option supporting people experiencing mental health crisis.



Proud to be part of community lounges held in community settings to give support with food, debt, housing, mental health and other social adversities.



Peer Support workers expanded significantly, strengthening our foundations of 'lived experience'

Strong results in the PLACE (Patient Led Assessment of the Care Environment) annual assessments



'Time to Shine' guide produced to support our frontline teams to prepare for inspections and showcase their quality and innovation.





Sensory packs co-developed for wards to support trauma-informed, neuro-inclusive therapeutic environments



New Community Meetings Standard Operating Procedure introduced, cofacilitated by someone with lived experience

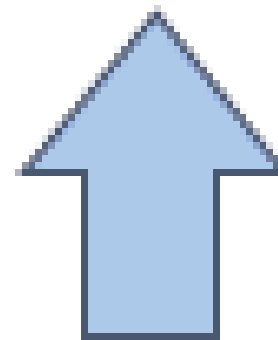
Elevate youth council rebranded and expanded to strengthen youth voice across health and social care.



Volunteer interest remaining consistently high with 30–32 expressions of interest each quarter and 10 new applications progressed

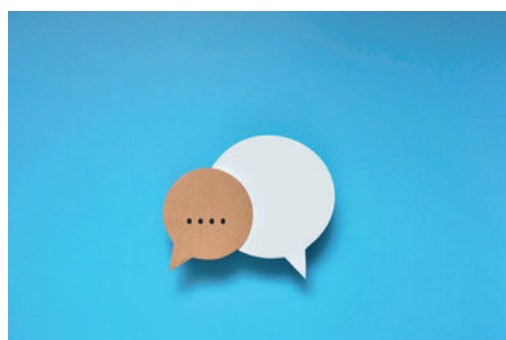


Hub-and-spoke engagement model progressed with three CMHTs establishing regular service-user forums feeding insights into SUCC



Talk and Change Group playing pivotal role in shaping LD service improvements, ward documentation and co-producing the care planning frameworks

Recovery Conversations and TRIP plans rolled out Trust-wide across inpatient wards..



1,933 compliments either directly to an individual team or via the FFT responses.



Our commitment to quality

Overview from our Chair and Chief Executive

Welcome to our Quality Account for 2025/26.

It is now more than seven years since the CQC awarded the Trust its overall ‘Outstanding’ rating—the highest recognition available.

At the time, we were clear that we would not become complacent, and that our improvement journey would continue. Our ambition was, and remains, to be ‘Outstanding in ALL we do and HOW we do it’, strengthening integration with our partners and deepening engagement with staff, service users, families and communities.

Quality sits at the centre of that ambition—whether we are delivering services and outcomes, communicating and engaging with the public, undertaking research, driving innovation, or providing the support and corporate functions that enable our teams to do their best work.

Against a backdrop of significant financial pressure, it can be easy to assume that quality is only achievable through increased spend. Our experience shows the opposite can be true: when we focus on doing the right things, in the right way, quality and cost-effectiveness can reinforce one another.

This is especially evident when peer support and lived experience shape how we design, deliver and improve care. We have seen this in practical, meaningful improvements—such as new sensory packs codeveloped for wards to support trauma-informed, neuro-inclusive therapeutic environments, and our new ‘What to Expect’ service information videos produced in partnership with our Service User and Carer Council.

In essence, quality is everyone’s business—and everyone should feel the benefit. This Quality Account shows how our drive for sustained improvement and innovation continues to be a defining feature of life at Combined.

None of this is possible without our commitment to delivering outstanding services that keep people safe and reflect our promise to be personalised, accessible and recovery focused.

One example of this progress is our new Ascend Recovery Service, providing evidence-based psychological treatment and support to anyone aged 16+ experiencing trauma symptoms following sexual assault or abuse.

We also launched a new Forensic Liaison Partnership service, strengthening how patients in Stoke-on-Trent move from secure inpatient settings into community mental health services.

Together, these examples reflect the determination and creativity of our people at Combined to keep innovating, improving and delivering better outcomes for the individuals and communities we are privileged to serve.

We hope you find this year’s Quality Account informative and inspiring, and that it brings to life the many ways quality continues to shape everything we do.



Dr Buki Adeyemo
Chief Executive



Janet Dawson
Chair

About us

North Staffordshire Combined Healthcare NHS Trust is a statutory body which came into existence on 1 April 1994 under The North Staffordshire Combined Healthcare National Health Service Trust (Establishment) Order 1993.

We provide inpatient and community mental health, learning disability, substance misuse and primary care services to people predominantly living in the city of Stoke-on-Trent and in North Staffordshire. The Trust runs a number of GP surgeries and is one of seven providers of mental health, social care and learning disability services in the West Midlands.

We currently work from hospital, general practice and community-based premises, operating from approximately 30 sites to approximately 464,000 people of all ages and diverse backgrounds in our core area of Stoke-on-Trent and across North Staffordshire. Our main site is Harplands Hospital which opened in 2001 and provides the setting for most of our inpatient units.

A number of our teams provide services across Staffordshire, the West Midlands and beyond.

We provide services to people with a wide range of mental health, substance misuse and learning disability and/or autism needs. Sometimes our service users need to spend time in hospital, but much more often we can provide care in community settings and in people's own home.

We also provide specialist mental health services such as child and adolescent mental health services (CAMHS), substance misuse services and psychological therapies, plus a range of clinical and non-clinical services to support University Hospitals of North Midlands NHS Trust (UHNM).

The Trust has a range of formal and informal mechanisms in place to facilitate effective working with key partners across the local economy. These include participation in partnership boards which bring together health, social care, independent and voluntary sector organisations in the city of Stoke-on-Trent and the county of Staffordshire.

We look to involve our service users in everything we do, from providing feedback about the services we provide, to helping shape our priorities, to helping us find the right people to work for and with us. This work is co-ordinated by our Service User and Carer Council.



Visit by Baroness Merron to Combined

Our vision and values

The Trust’s core purpose is to improve the mental health and wellbeing of our local population, some 464,000 people living across North Staffordshire and Stoke-on-Trent. We strive to be recognised as a centre of excellence in both integrated and specialist care, bringing innovative solutions to the services we deliver and the strategies we develop, embedding a culture of continuous learning across our organisation, and supporting and inspiring others.

This is reflected in our vision, values and objectives. These guide not only how we deliver our services on a day-to-day basis, but also how we support and develop our people and our own organisation, how we manage and develop our partnerships and relationships with our service users, carers and families, as well as our external stakeholders across the local health and care economy.

Our vision and values

Our vision is

'To be Outstanding' – in ALL we do and HOW we do it

Our SPAR quality priorities

Our vision is underpinned by our SPAR quality priorities – developed with service users, carers and staff, forming the framework for our annual improvement programme – to provide services that are **safe**, **personalised**, **accessible** and **recovery-focused**. These guide all we do and are the benchmark against which we judge how we perform.



Our Proud to CARE values

In delivering those services, as well as in all of our working relationships with service users, carers, families, stakeholders and each other, we are guided by our Proud to CARE values – to be **compassionate**, **approachable**, **responsible** and **excellent**.



Our Trust Strategy

In 2023, we unveiled our five-year Trust Strategy, 'The future of North Staffordshire NHS Trust 2023-2028'.

This outlined our ambitions over the five years of the strategy in addressing how we respond to the evolving wellbeing needs of our local population and changes in our NHS and government landscapes.

The strategy sets out our sustained commitment to continuously improve services with co-production, recovery and partnerships at the heart of how we work, ensuring national requirements and local priorities are taken into account.

Our values and quality priorities shaped our three strategic priorities and are underpinned by four key enablers, which act as the pillar of why, how and what we do.

The strategy also set out our measures by which we would demonstrate the impact of our plans.

We are an organisation that lives by our values. We recognise this is an ambitious strategy in which we will focus on preventing people becoming more unwell, provide timely and easy access to care and maintain and develop high quality, outstanding services.

Over the five years of the strategy, we will invest and develop our people so the Trust becomes an organisation of excellence, delivering this change through our strategic and operational plans.

Enablers					
Strategic Priorities		Quality	People	Partnerships	Sustainability
	Prevention	Reduce suicide rates year on year by 2028	Improve staff health year on year	Embed Mental Health service within NHS 111	By 2024 we will have supported 35% of service users into employment
	Access	Improve access by co-producing new services with our communities	Ensure our Trust is the best place to work in the NHS	Expand our primary care offer	Develop digital access to all our services by 2028
	Growth	Reduce waiting times for services	Increase our workforce by developing our services	Increase the number of services delivered in collaboration with partners by 50%	Deliver a 50% Carbon Net Zero reduction by 2028



Services covered by this Quality Account

This Quality Account covers the period 1 April 2025 to 31 March 2026. Over this period, our services have been delivered from within a locality structure with an associate director and cinical director formally responsible for each of the directorates. These are supported across the Trust by our corporate services.

Our Organisational Structure



Chief Executive - Dr Buki Adeyemo				
Chief Medical Officer - Dr Dennis Okolo		Chief Finance Officer/Deputy Chief Executive - Eric Gardiner		Chief Nursing Officer/Deputy Chief Executive - Kenny Laing
Chief Strategy Officer - Liz Mellor		Chief People Officer - Frieza Mahmood		Chief Operating Officer - Ben Richards
Community	Specialist Services	Acute Services and Urgent Care	Primary Care	Corporate Services
Clinical Director Associate Director Senior Service Manager	Clinical Director Associate Director Senior Service Manager	Clinical Director Associate Director Senior Service Manager	Clinical Director Associate Director Clinical Lead	Exec PAs Governance Digital / IT Strategy and Partnerships Transformation Management Office Estates Finance Performance Communications Education and Training Medical Staffing Organisational Development People Operations Recruitment Staff Counselling Temporary staffing MACE Mental Health Law Team Pharmacy Psychology Research and Development Facilities Infection Prevention and Control North Staffordshire Wellbeing College Patient Experience Team Patient Safety Quality Improvement Safeguarding Volunteers
Adult CMHT ASD Assessment ASD School Age CAMHS CAMHS Eating Disorders Care Home Liaison / Physio Community Assessment Stabilisation Treatment County Older Person's Mental Health Team Criminal Justice Team Dementia Primary Care Early Intervention in Psychosis Looked After Children Yellow House Memory Services Mental Health Support Teams Mental Health Youth Offending Team Multiple Disadvantaged Team Older Person's Mental Health Team Outreach Team Older People Parent and Baby Specialist Adult Eating Disorders SMI Physical Health Team Step On Vascular Wellbeing	Assessment and Treatment CAMHS Intensive Support Hub Children's Community LD Team Children's Short Breaks (Dragon Square) Community and Hospital Alcohol Community Learning Disabilities Team Community Rehab Team Darwin Centre Healthcare Facilitation Hilda Johnson House Intensive Support Team IOU (Adult / Substance Misuse) Neuro Community Services Out of Area / Resettlement Team Substance Misuse Inpatients (Edward Myers Unit) Transforming Care Partnership Team Ward 5 Neuropsychiatry	All-Age Access Team Community (Street) Triage ECT Team High Volume Users Home Treatment Team (Adult) Mental Health Liaison Team Psychiatric Intensive Care Unit Place of Safety Ward 1 – Acute Admission (mixed) Ward 2 – Acute Admission (male) Ward 3 – Acute Admission (female) Ward 4 – Discharge to Assess Ward 6 – Older People's Complex Care Ward 7 – Acute Admission (Older People)	ARRS Mental Health Direct Enhanced Services Education Locally Enhanced Services Primary Care Development Primary Care Networks Primary/General Medical Services Talking Therapies	

How to find out more about our services

In December 2024, the Trust released the new version of its public website, including introducing a new and improved suite of user-friendly service pages.

Almost 70 teams across the Trust’s portfolio of mental health, learning disabilities, substance misuse and primary care services are listed in the comprehensive new section of the website, improving functionality and usability.

Each page now provides key core information such as contact details, location and what the service offers. Users will also find additional updates from the services including testimonials, videos, podcasts and virtual tours of the building.

The layout has been standardised and teams and services can be searched for by name or alphabet, making it easier than ever for the user to find what they are looking for.

The pages have been built with accessibility in mind and have been carefully considered to ensure that information is clear, easy to understand and easy to find.

This complete library of patient-facing services can also be translated into over 130 languages with the click of a button.

The launch assists the Trust to further improve how it delivers its key requirements to be responsive, accessible and to deliver high-quality services to its users.

The pages will continue to be developed as the Trust builds on its offering to users, providing detailed and easy-to-use resources about its services.

You can see the new service section of the website at combined.nhs.uk/services.

You can access our complete library of patient stories, including those for Ward 6 show in the picture opposite on our YouTube channel at youtube.com/playlist?list=PLuLnRckD7bTep22NYgl_CfuY3WE2dxLaL.

Ward 6

Details

Phone Number

01782 441706

Service Hours

24 hours a day, 7 days a week

Out of Hours Contact Number

N/A

About the service

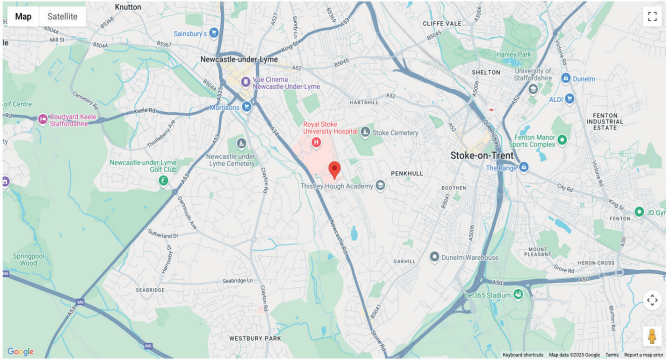
Ward 6 is a 15-bedded mixed-sex ward for older people aged 65 and above who suffer with a functional or organic mental health problem that causes complex multiple care issues.

The team provides specialist person-centred assessment, treatment and management of complex factors for the older person with a diagnosis of dementia or suspected dementia. The team aims to understand the root cause/contributory factors to the behaviour to enable the delivery of effective interventions that minimise the frequency and intensity of the behaviour and maximise the person's functioning, autonomy, independence and wellbeing.

Assessment and treatment is provided by medical staff, mental health nurses, healthcare support workers, advanced nurse practitioners, occupational therapists, physiotherapist, psychologists and diversional therapists.

Location

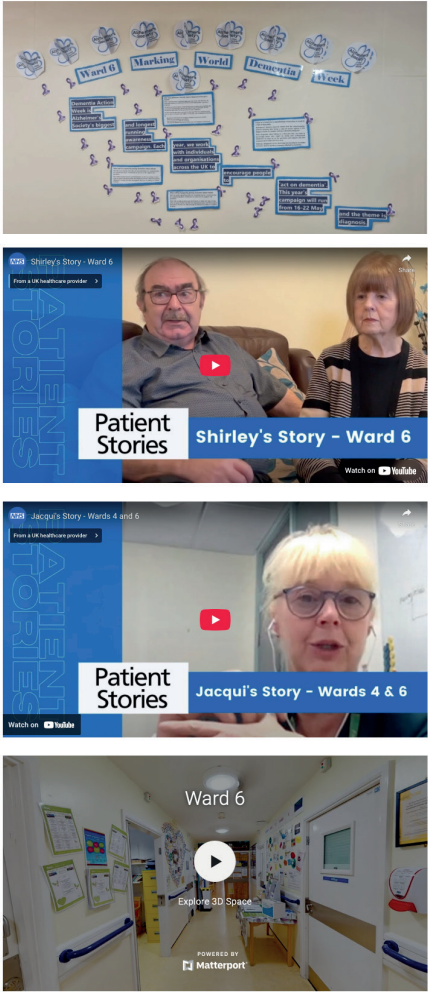
Harplands Hospital, Hilton Road, Harplefield, Stoke-on-Trent ST4 6TH



Ward 6 - Harplands Hospital Accessible



Gallery



Outstanding – Our quality journey continues – Quality Account 2025/26 13

Directorate key achievements 2025/26

Our directorates are shaped to provide secondary mental health, substance misuse and learning disability care and treatment. We also provide primary care services for parts of the communities we serve.

The following overview describes the services within each of the directorates, alongside details of their achievements throughout 2025/26. It also provides patient and carer feedback which has been obtained from within the directorates to bring our service users and carers voice into this year's Quality Account.

Our directorates' key focus throughout 2025/26 has remained focused on delivering successful improvement after attaining an 'outstanding' CQC rating.

Community Directorate

Children's Mental Health Services (CAMHS)

Throughout 2025-26 the CAMHS services have grown the offer from Mental Health Support Teams in Schools, exceeding national targets. This aligns to the national expectation of 100% coverage by 2029 and shows the commitment to improve the emotional wellbeing of our young people.

The service has improved integration with the Local Authority (especially within Children in Care) improving transitions from health teams to social care ensuring safe and effective handover and improved outcomes for the Children and Young People.

Throughout the year the CAMHS teams have focused on embedding the following improved pathways: Trauma, Self-Harm, Attachment, Anxiety, Depression, Post Traumatic Stress Disorder, Trauma Informed Care and Disordered Eating.



As part of the community Mental Health transformation programme the Trust entered the fifth and final grant round in May 2025. The aim to provide accessible mental health and wellbeing support in local communities, delivered in a safe, youth friendly environment, with a primary focus on early intervention and prevention of mental health difficulties. Out of 29 total applications, 15 projects were awarded funding covering a diverse range of organisations and activities across North Staffordshire and Stoke-on-Trent, ranging from creative arts, boxing, and specialist bereavement support.

Service User feedback on CAMHS

"I wanted to say a huge thank you. You gave us the support we needed to stay strong at times when it felt horrendous for us all, and you reassured us that things could improve for the family if we continued our support and in implementing your advice> we will never forget that"

Older Adults Community Services

In 2025-26 our Memory services for older adults achieved the Memory Services National Accreditation, a quality improvement programme led by Royal College of Psychiatrists and focused on improving care for people undergoing assessment, diagnosis and treatment for dementia.

Our Deputy Clinical Director attended the Select Committee at Westminster evidencing National recognition for the virtual reality delirium training and also the virtual reality service walkthroughs.

The Memory Services have also developed a new outpatient model moving towards neighbourhoods, this ensures service users have maximums choice of location for appointments that is convenient to them and their needs. It also maximises on clinical effectiveness, allowing for additional appointments to be offered.

Service User feedback for
Memory Service

“Just want to say a huge thank you to you all for the great care you give to Mum and the excellent way you communicate with me, It makes such a huge difference to both of us. Love to you all”) came from, what was keeping them from working towards recovery and what we can do together to support their on-going journey.

During 2025-26 the service has reconfigured the operational structure, which ensures a more efficient and higher quality service for all those accessing Older Adult Teams.

The Care Home Liaison service have developed a new referral and triage system which offers a more effective access process ensuring timely and rapid response to those most urgently requiring support. This has been met favourably by those care homes accessing the service.

Adult Community Mental Health Services

The services have focused on embedding a newly introduced Standardised Assessment Framework (SAF) across all four Community Mental Health Teams (CMHTs). The framework allows for a consistent approach to assessment for Service Users across Stoke and North Staffordshire.

The services have improved their performance in the areas of Referral to Assessment, Referral to Treatment, Risk Assessment and Care Planning compliance demonstrating the Directorates dedication to improve services for the benefit of service users.

Service User
feedback
Greenfields

“In my time seeing Shaun for therapy CBT and EMDR I have been so satisfied with both therapies. I found Shaun to be a very efficient therapist, and he has helped me enormously. He has given me tools to take away with me so that I can carry on working on myself in the future. I would certainly recommend Shaun for both therapies. Shaun throughout has been supportive, consistent and patient”

The service has also implemented two new clinical pathways across all core team and plan to implement a third.

The Trauma Pathway – This is a clinical pathway focused on supporting people with a history of complex trauma. The pathway has core elements including Trauma Stabilisation Group and 1:1 Trauma therapy, with additional opportunity for individualised interventions bespoke to the needs of the service user.

Anxiety and Depression Pathway – this is known as a 'Non-Serious Mental Illness (SMI) Pathway' focused on supporting individuals with Coping Skills and Emotional regulation. This goal-based pathway is designed to support people to better regulate their emotions to help them to be in better control of their own wellbeing.

Development of the SMI Pathway remains underway and will be mobilised in 2026.

Elements of the Pathway including Mood on Track (for Bipolar Affective Disorder). The medication elements of this pathway are already established across all four CMHTs.

The services have also received investment for additional training for Multi-Disciplinary Staff members to offer additional skills to deliver on all aspects of the pathways.

Other Adult Community Services

Throughout 2025 – 26 the Community Directorate have received investment to Grow the Step On services, allowing for more people with mental health difficulties to access support to find and maintain meaningful employment.

The Community Assessment Stabilisation and Treatment Team (CASTT) continues to support adults with severe personality difficulties and high-risk behaviours; acknowledging the vital care and support that carers offer and provide informal emotional support and practical help.

The Trust's Reconnect service offer has extended into an additional 4 prisons demonstrating a dedication to growth and commitment to this service user group.

Service user feedback on CASTT

"You have made such a difference in my life, stopped me in my tracks at the point I needed to be stopped. I really feel like I have changed for the better, in all aspects of life"

Neurodevelopmental and Ageless Services

CYP ADHD service is now a functional stand-alone team and separate from CAMHS to allow for dedicated and bespoke focus for children with ADHD needs, the plans for 2026-27 is to further develop the service into an ageless Neurodevelopmental Service in line with NHSE aspirations.

Specialist services

The Specialist Directorate provides a diverse range of services with pathways of community services operating across localities and inpatient units for substance misuse, learning disability, neuropsychiatry and CAMHS as well as a short breaks respite bed service for children with complex needs.

The Community Mental Health Rehab Team

This newly established team offers support focused on keeping people in their existing accommodation or helping people transition to community from hospital placements working closely with the Complex Care Mental Health Team and Early Intervention Team. This pathway supports people returning to the locality from out-of-area inpatient units. The rehab team works seamlessly with the Complex Care Mental Health Team with a joint multi-disciplinary team approach which now includes specialist psychology input.

Hilda Johnson House

This service continues to provide safe, supported accommodation for adults with mental health needs. Our interventions are delivered in a variety of community-based settings, and are designed to promote wellbeing, independence, and recovery. The service supports adults to develop and maintain their independence and overall wellbeing, enabling them to live confidently within their own accommodation in the local community. (add service user feedback)

Summers View Rehabilitation Inpatient Service

Continues to be a CQC outstanding rated service. Summersview provides comprehensive and holistic assessment with a key aim to make effective use of partnership resources to identify the most appropriate accommodation solutions that meet each person's needs as they transition through their mental health recovery.

Throughout 2025-26 the service has continued to support timely and effective repatriation of individuals placed out of area; this supports the service's long-term goal of developing local resources that prevent the need for service users to move away from their own community.

Forensic Liaison Partnership

This is a newly funded service launched in April 2026; the service is designed to enhance the way patients from Stoke-on-Trent transition from secure forensic inpatient settings into community mental health services, ensuring that transfers are timely, well-coordinated, clinically appropriate and recovery focused.

Complex Care Team

Throughout 2025/26 the Complex Care Mental Health Team has repatriated 9 more people from out-of-area placements into local settings such as their own family home, supported accommodation and residential and nursing care.

Since the Trust took over management of the Complex Care Mental Health Team in April 2021, the caseload has reduced from 86 to 30 by the end of 2025/26 — a reduction of 65.1%. This has enabled more people to be supported in local, more appropriate, and least restrictive environments.

Inpatient Neuropsychiatry Service

This service is one of only four such services in the UK. It provides treatment to patients with an acquired or progressive neurological condition that impacts on their physical and mental health, cognition and behaviour. The service completes the pathway offer from community services, outpatient clinics and inpatient care. As part of neuropsychiatry outpatients, they assess and treat patients with younger onset dementia and make differential diagnoses.

Specialist psychology services

Throughout 2025-26 the service has continued to manage a range of specialist psychology services to other healthcare providers. Providing highly specialist psychological expertise to both inpatient and outpatient acute tertiary services as core members of the multi-disciplinary teams. This includes spinal injuries, inpatient and community stroke, acute rehabilitation and trauma, neuro-oncology, neurology, neuropsychiatry, cancer, critical care, bariatric services, pain, general physical health, paediatric oncology, cystic fibrosis, diabetes and paediatric psychology.

Throughout 2025-26 the Physical health psychology service focused on rebranding and promoting their services to other health professionals to help ensure that all people with long term health conditions, pain and cancer who are eligible for psychological support are aware and referred into the service.

Assessment and Treatment Unit

This service is led by a Positive Behavioural Support (PBS) model of care and incorporates trauma-informed approaches to promote rehabilitation, emotional wellbeing, and the reduction of restrictive practices. The inpatient service works closely with the Intensive Support Team and Community Learning Disability Team to ensure a seamless transition and continuity of care.

CQC feedback on Assessment and Treatment Unit

The service underwent a CQC Mental Health Act Inspection in February 2026, the feedback was;

“All carers interviewed spoke positively about the ward and staff. They told us that their relatives had made good progress and continued to do so.”

“Care plans are patient centred and took account of patients’ views and preferences.”

“All the patients on the ward were treated as individuals and with respect”.

The CQC feedback recognised a proactive and dynamic approach to risk management, particularly in relation to a complex patient whose care has been guided using the HOPE(S) model. This work has supported a sustained reduction in restrictive practices and a structured pathway towards ending long-term segregation, with the CQC acknowledging that the restrictions in place were proportionate and clinically justified.

In addition, current inpatients and their families are actively engaged in the Cecilia Project, contributing to the review and development of the Community Treatment Review process, further demonstrating our commitment to co-production and person-centred care.

Community Learning Disability Team

Our community teams bring together community learning disability nurses, psychiatrists, occupational therapists, physiotherapists, speech and language therapists, clinical psychologists and other applied psychological therapists. These teams work in partnership with local authorities and other organisations to provide a range of care services and therapies.

Primary Healthcare Facilitation and Acute Liaison Service

This service works closely with local mainstream and specialist health services to reduce the overall health inequalities experienced by people with learning disabilities. The team provides service users, families and carers with access to rapid response, intensive assessment, treatment and support at times of crisis to reduce the need for admission to hospital. The team also supports timely discharges from inpatient services.

The Keyworker Team

This is a newly implemented service which supports patients and their families by navigating their care from health, local authorities and the private sector for patients from the age 0 to 25 with learning disabilities and/ or people with autism who are at risk of placement breakdown or hospital admission.

Feedback on The Specialist Children's Short Break Service

The Specialist Children’s Short Break Service at Dragon Square offers residential short breaks, including day visits, for children and young people between the ages of 4 to 19 years with severe learning disabilities and other complex needs.

The service is registered with Ofsted as a children’s home that can support children with learning disabilities, physical disabilities and sensory impairments and is rated as 'Good' by the CQC.

The service received an OFSTED Inspection in January 2026 and have successfully retained their OFSTED rating of ‘Good’.

The report offers the following feedback;

“Staff are welcoming and nurturing towards children, who receive individualised care from staff who understand their complex care needs and are familiar to them”

“Children respond to interactions with staff with excitement and affection. Staff communicate with children using their preferred method. This helps them to understand children's views, wishes and feelings and informs the care that children receive. Staff encouraged children to make decisions about things that are important to them. This ensures that children feel heard and are valued”

Children's Community Learning Disability Team

The multi-disciplinary team provides specialist assessment and treatment interventions to children with a diagnosed learning disability with associated complex health needs.

The Darwin Centre

The Darwin centre is a 14-bedded inpatient unit, providing specialist mental health services for young people and their families between the age ranges of 12 to 18 years. In 2025 the service proudly opened their new multifunctional enhanced support suite, this is the first of its kind in the UK and was co-designed with the young people accessing the services. The 'Peace Pod' has been widely used by young people; its key benefits have been supporting self regulation and de-escalation during periods of heightened distress, providing a calm, sensory informed environment that enhances emotional safety, reduces the use of restrictive interventions, and empowers young people to use personalised coping strategies co designed with them.

Children and Young People (CYP) Complex situations

In 2026, we launched a new team as part of the CYP Complex Situations Project. This team operates as a Multidisciplinary Team (MDT) supporting Children and Young People (CYP) with complex needs and challenging circumstances. It will focus on those experiencing significant mental health needs and high levels of psychological distress, including children and young people in care, across the Stoke and Staffordshire area.

Key features and desired outcomes of the team –

- MDT Pathway, A coordinated, trauma-informed care model integrating health, social care, and education services.
- Rapid Response Panel: A multi-agency panel convened within 48 hours of a crisis for swift intervention.
- Community-Based Stabilisation: Focus on supporting CYP at home or in local placements to avoid secure or out-of-area placements.
- Education Support: Collaboration with schools to prevent exclusions and maintain engagement.
- Transition Planning: A co-produced exit strategy to ensure sustained support and prevent re-entry into crisis care.

The Edward Myers Unit

This Inpatient unit continues to offer hospital-based drug and alcohol detox and treatment. The unit accepts local and national referrals, often the most complex, and following its recent digital movement and advertising of the unit has seen a recent surge in referrals. The unit now has plans to expand and increase capacity to accommodate the demand beyond its current 14 beds.

The Community Hospital Alcohol Team (CHAT)

Throughout 2025 – 26 the team have continued to support UHNM with patients who require alcohol detoxification, attending emergency portals and daily ward visits to prepare the patient for continuation of their detox while in the community.

The Intensive Support Hub

The Hub directly supports patients in the community, seven days a week. This team supports young people locally at risk of admission to an inpatient bed and where possible reducing the need for admission through a more intensive offer of support.

Acute and Urgent Care

The directorates' key focus throughout 2025/26 has remained focused on delivering successful improvement after attaining an 'outstanding' CQC rating.

Acute Inpatient Wards

The Psychiatric Intensive Care Unit (PICU)

This is a specialised, high-specification service providing intensive nursing support for working-age adults (18–65), both male and female, who are experiencing an acute phase of their illness.

The team delivers care using a trauma informed model, ensuring that each patient is treated individually and receive high quality, intensive nursing support. The PICU has maintained its commitment to the National Association of Psychiatric Intensive Care Units (NAPICU) framework, achieving accreditation since opening in 2019.

A continued focus on reducing restrictive practices has supported the introduction of a less intrusive zonal observation approach.

Service user feedback on PICU

"I had a good time here. Your staff are so kind and have the patience of saints you have a lovely team of help."

"I get treated right. Didn't have to wait very long to see the consultant."

The positive culture within the unit is further strengthened by the ongoing use of the psychological Reinforce, Appropriate, Implode Disruptive (RAID) approach, which has been pivotal in supporting recovery for some of our most acutely unwell patients.

This approach, combined with sustained psychological input, has made a significant contribution to creating a safer and more therapeutic environment that promotes both recovery and overall well-being.

Ward 1

Ward 1 is a mixed-gender acute admissions ward supporting patients aged 18 to 65 and specialising in the treatment of individuals with complex mental health needs. The ward remains focused on delivering high quality, compassionate care that promotes independence and recovery for people experiencing mental health challenges.

As a multi-disciplinary team, Ward 1 uses an evidence-based approach, adopting a holistic view of each patient's needs to guide treatment and support. Alongside nursing and medical care, the psychology team plays a significant role in the care model, offering therapeutic interventions tailored to each patient's psychological needs.

Throughout 2025- 26 Ward 1 has maintained a dedicated focus on ensuring sexual safety and have actively participated in the Sexual

Safety Collaborative led by the Royal College of Psychiatrists (RCP). The ward has also worked closely with the Trust's diversity and inclusion leads to ensure that care for non-binary and transgender patients is inclusive, sensitive, and tailored to their individual needs.

Service User feedback on Ward 1

"I was well understood."

"You help me to recover thanks very much."

"The staff are good people you just have to work with them."

"Whilst being ill the nurses helped me a lot including applying for benefits for me. thank you."

Ward 2

Ward 2 is a dedicated acute ward for males of working age, providing comprehensive assessment and initial treatment for individuals experiencing a range of mental health challenges.

The ward works closely with a variety of other services to ensure continuous support and recovery. With a strong commitment to person centred care, Ward 2 places patients at the centre of everything they do, offering tailored and intuitive interventions that focus on everyone’s unique needs and aspirations

Throughout 2025-26 patients accessing Ward 2 have benefitted from a ward based personal trainer, who delivers exercise and wellbeing initiatives designed to enhance both physical and mental health.

The ward operates within a multi-disciplinary team (MDT) model, ensuring a collaborative and holistic approach to care and treatment. The psychology team plays a vital role within the MDT, providing psychological assessments, therapeutic interventions, and guidance in supporting patients through their mental health challenges.

Service User feedback on Ward 2

"Informative helpful staff doing their best to make my dad comfortable in a stressful environment."

"How well the staff deal with my partner and his mental health."

"Solely due to all the amazing staff members, who do a truly diligent job, with great compassion and care."

"Whilst being ill the nurses helped me a lot including applying for benefits for me. thank you."

Ward 3

Ward 3 is a dedicated female acute ward within the Acute and Urgent Care Directorate, providing compassionate, person centred care for women aged 18 to 65 who are experiencing a broad range of mental health challenges.

The ward is committed to delivering high quality care that not only addresses patients’ immediate mental health needs but also supports their wider wellbeing during times of crisis.

In addition to core mental health interventions, Ward 3 offers access to bespoke women’s health programmes, including tailored support around menopause, recognising the significant impact that hormonal and physiological changes can have on mental health and overall wellbeing.

Service user feedback on Ward 3

"The support from staff was amazing."

"Everything brilliant ☺kind caring staff, very clean, excellent food and choice, big THANKYOU to everyone on ward 3."

"They supported me when I became unwell with my Mental Health and arranged for assessments and support. I had lots of assessments and joined a few groups. Most of the staff were kind and supportive."

"All staff have been caring and supportive during my admission. Activity workers Lewis and Sarah in particular have been crucial to my recovery by enabling me to go to the gym and have that dedicated support for activities. Angela has also been so lovely and kind and always found time for a chat."

Ward 3 has adopted an evidence based self-injury reduction protocol, supported by the psychology team, specifically designed to assist women with emotionally unstable personality disorder. The staff team takes great pride in their holistic, multi agency approach, which brings together a range of services such as psychiatry, psychology, nursing, financial advice, housing support, exercise programmes, and occupational and diversional therapy.

Older Persons Inpatient Wards

Ward 4

Ward 4 is a dual care assessment unit commissioned inpatient ward. The service accepts patients with complex physical health needs and organic illnesses and supports them to reach their maximum potential before identifying the most appropriate discharge destination that best meets the patient's needs. The service supports timely discharge from Royal Stoke University Hospital and admission or transfer avoidance via emergency portals. It operates a multi disciplinary team model with involvement from the mental health liaison team, health and social care, and independent agencies, with other services included as required based on individual needs.

Ward 4 prides itself on its close working relationships with families and carers, ensuring they are kept informed and involved from admission through to discharge. The ward continues to adapt to ensure it offers the same excellent level of care and experience to its patients and their relatives. During 2025-26 the team have reinstated the family group, which provides valuable support for families whose relatives have been admitted to Ward 4.

The team have also improved their activity schedule which is more structured and embedded into the daily routine of the ward. This enhanced programme offers meaningful, therapeutic, and engaging activities tailored to individual capabilities. It has been instrumental in promoting patient recovery, supporting cognitive stimulation, improving mood and confidence, and increasing social interaction across the ward. In addition, Ward 4 has introduced 'mid-week feel good' beauty makeover Wednesdays, offering a wide range of beauty and makeover services for both patients and staff. This initiative focuses on enhancing wellbeing, boosting morale, and improving social engagement.

Service user feedback on Ward 4

To all the staff on Ward 4, just a little thank you for the wonderful care Jean has received whilst staying with you on Ward 4. The family have seen a big change in Jean since being admitted and we feel it is down to the care and attention from all the staff on Ward 4."

"Following her admission to Royal Stoke, my mum was transferred to Ward 4. The ward itself offers a safe, welcoming environment and an impressive range of activities. Yet it is the people who make the real difference. The staff care not only for patients, but also for relatives, who may be struggling to cope with difficult circumstances and changes in their loved ones. As a frequent visitor, I saw first-hand that Ward 4 is a challenging clinical environment requiring immense skill, patience, creativity, and empathy. The team consistently delivers all of these and more. Their ability to work together seamlessly allows them to manage highly complex needs—calmly de-escalating difficult situations with compassion and respect. During what has been one of the most difficult times in my life, knowing my mum was in safe, skilled, and in caring hands was an enormous comfort. The Ward 4 team are not only experts in their field—they are role models for what healthcare should be. Their dedication, humanity, and genuine compassion improve lives every single day, even in the most challenging circumstances. I will be forever grateful for the care they provided to my mum and to me"

Ward 6

Ward 6 is a 15 bedded, mixed inpatient ward for patients with a diagnosis of dementia and associated complex health needs. It provides outstanding care through a person centred, individualised approach. The ward's aim is to make a positive difference to the lives of patients, supporting them to live well with dementia and, where possible, return home, or assisting them and their carers in identifying the most appropriate 24 hour care setting for their ongoing needs.

Over the last 12 months, Ward 6 has continued to implement innovative practices that enhance patient safety and wellbeing. These include:

- The purple wristband initiative – a clear way of identifying patients with a 'Respect' form in place, ensuring that important decisions are upheld appropriately in specific situations.
- Yellow socks – an initiative to easily identify patients at risk of falls
- Sunflower initiative – introduced for patients who wear dentures. A sunflower picture is placed on the wall in their bedroom to alert staff to check bedding and clothing for misplaced dentures, significantly reducing the risk of loss.
- Patient wellbeing initiative – the clinical team is exploring a variety of therapeutic activities, including recent autism informed engagement approaches, all designed to be inclusive and respectful of individual needs.
- Veterans support initiative – the team is raising awareness among families and patients about how support and intervention plans take past trauma into account. This informs nursing and psychological approaches, increasing staff awareness and enhancing their ability to support patients in their recovery. The carer support group has been instrumental in working alongside families to develop and strengthen this initiative

Service user feedback on Ward 6

"The team works hard to include family, friends, carers on the ward. Using their own time too, to ensure success of events on the ward. It's good to enjoy making more happy memories with my husband."

"The facial was so lovely and relaxing and so nice to chat with the therapist which was very therapeutic"

"Our Aunty arrival at Ward 6 was a bit sudden and we were all saddened that she'd had to leave home but all the staff on Ward 6 helped her settle so quickly and it was a huge reassurance to us. Thank you."

"Nothing but positives to say about Ward 6."

Ward 6 also offers a dedicated health and beauty experience through its own on ward salon. This space provides patients with opportunities for pampering and relaxation in a calm, familiar environment that supports dignity and wellbeing. Staff delivering these services have received suitable training to ensure treatments are safe, personalised, and appropriate for individuals living with dementia and complex health needs. The salon has become a valued feature of the ward, helping to enhance confidence, promote positive self-esteem, reduce anxiety, and increase social engagement among patients

Ward 7

Ward 7 is a functional unit for elderly patients over the age of 65. The ward provides mixed gender accommodation for short term assessment and treatment, supporting service users either informally or under the Mental Health Act. Patients admitted to the ward receive a comprehensive needs assessment conducted by a multi disciplinary team, ensuring a holistic and person centred approach to recovery.

Both inpatient and community teams work closely together to facilitate safe and timely discharges back into the community.

The carer support worker continues to provide dedicated support to carers, following the triangulation of care ethos. This approach emphasises equal partnership among carers, service users, and professionals to promote safety, aid recovery, and maintain wellbeing. Innovative multi-disciplinary team (MDT) working continues to be a strength within Ward 7, with MDT Screen One enabling the remote attendance of external professionals in ward rounds and reviews.

Ward 7 works in close collaboration with the Outreach Team to identify patients suitable for early facilitated discharge into the community. Throughout 2025-26 Staff from the ward, including healthcare support workers and nurses have spent time shadowing the Outreach Team to gain a better understanding of their services, and Outreach staff have done the same in return. This shared learning has significantly reduced readmissions by helping patients make more effective use of their leave.

As part of the Culture of Care initiative, a quality improvement project has been established to review the team’s operational structure. Its aim is to identify new ways of working that enhance team efficiency and ultimately improve the overall patient experience and journey.

Service user feedback on Ward 7

"Mum and family wish to thank all day and night staff for all their kindness and support with Mum throughout her stay at Harplands. We would like to thank Andrea especially for brightening up Mums stay with your cheerful attitude and caring nature".
"I don't know how the world would manage without the lovely staff on ward 7".

"Ward 7 has given me my life back. thank you".
"Never known staff always very happy and caring, lovely ward to visit my lovely wife"

Ward 7 continues to receive consistently positive feedback from patients and carers. Recently, two patients shared their experiences through the Outreach Team, highlighting the strong and effective collaboration between Outreach and the Ward 7 team, which have been captured in a Patient Story video.

Electroconvulsive Therapy (ECT) Department

The Electroconvulsive Therapy (ECT) Department is staffed by a small team of specialist doctors and nurses, delivering both inpatient and outpatient services twice a week. The team also provides support to medical and nursing students, who frequently offer positive feedback on their learning experience.

The service has a high success rate in treating severe depression, mania, and catatonia. A typical course of ECT may include up to 12 treatments, allowing the team to build positive therapeutic relationships with patients and their families. This is consistently reflected in the excellent feedback received throughout treatment and upon completion.

Service user feedback on ECT

- " "Friendly, helpful staff. clean hospital. "
- "The nurses are all very kind and patient. "
- "Lovely staff so so nice."
- "Staff friendly and helpful. very caring and considerate.")

The team works closely with referring services to ensure a smooth referral and review process, promoting continuity of care at every stage of the patient’s recovery.

The ECT clinic is accredited by the Electroconvulsive Therapy Accreditation Service (ECTAS) every three years, ensuring that high standards of care are maintained and continuously improved. 7 s a functional unit for elderly patients over the age of 65. The war

Urgent and Emergency Mental Health Care

Crisis Care Centre

The Crisis Care Centre, based at Harplands Hospital offers an all-age single point of access to mental health services and providing an immediate response for individuals experiencing a mental health crisis, either by telephone or in person. This ensures that people are signposted to the most appropriate pathway to meet their needs.

The Crisis Resolution Home Treatment Team (CRHTT) is a multi-disciplinary team of mental health professionals providing a 24 hour, seven day a week service as an alternative to psychiatric hospital-based treatment for service users aged 18–65, as well as an all age access service for individuals experiencing an episode of acute mental health crisis. The team also supports earlier discharge from inpatient care and undertakes gatekeeping for acute hospital admissions, ensuring that all admissions are appropriate and that, where possible, admission is avoided.

Service user feedback on Crisis Resolution Home Treatment Team

- "I just wanted to say a big thank you for all of the help that I have received over the past few weeks. I am slowly getting back to my life and attending counselling. The work that you all do is amazing and I am so grateful. "
- "My Clinician was excellent and actually made me aware of an issue that I had not previously thought of which was fundamental in my moving forward."

During 2024/25, the NHS 111 Mental Health option was introduced within the team, offering a 24/7 route for individuals of any age to seek help. This service can be used by someone experiencing a mental health crisis themselves, or by someone concerned about another person. As part of the ongoing improvements in the accessibility of crisis services, the team have introduced the 24/7 Text services during 2025-26 which is now well-embedded within the service.

An interim review completed in 2025 saw CRHTT successfully maintain its accreditation with the Royal College of Psychiatrists Quality network for Crisis resolution and Home Treatment.

In response to feedback from patients and carers, improvements have been made to the reception area within the Crisis Care Centre, with new artwork and the installation of acoustic tiles to reduce noise transmission between rooms, helping to create a calmer and more therapeutic environment.

The Support Time and Recovery (STR) Crisis Café Team Care Centre

This team continues to provide an alternative crisis pathway designed to offer low level support and practical interventions to service users experiencing a self-defined crisis. The team plays a crucial role in offering early help and preventing escalation, ensuring individuals have access to timely emotional support, practical guidance, and a safe, non clinical environment in which to talk through their difficulties.

Alongside offering immediate crisis response, the team also holds an active caseload, enabling them to provide ongoing short term support to people who may require additional follow up, monitoring, or signposting to other relevant services.

In addition to their core role, the STR Crisis Café Team contributes significantly to the Communities Together Lounges initiative. These lounges operate within community-based venues rather than traditional healthcare premises, helping to reduce stigma and encourage individuals to seek support in a more familiar and accessible setting.

Within the Community Lounges, people receive help with a variety of social and practical difficulties, including food availability, debt management, housing issues, mental health concerns, and other social adversities that may be contributing to their crisis.

By offering early intervention, compassionate guidance, and partnership based support, the STR Crisis Café Team and the Communities Together Lounges work collaboratively to prevent deterioration, promote resilience, and help individuals feel supported, connected, and empowered within their local communities.

The High Volumer Users (HVV) Team

The High-Volume Users (HVV) Team works holistically with service users who frequently attend accident and emergency (A&E). The primary goal of the team is to identify the reasons behind repeated A&E attendances and to reduce or prevent avoidable presentations by supporting service users to engage with the most appropriate primary care and community services.

Service user feedback on the High Volume Users Team

If the team were medicine, everyone would be well. "

"Can't fault at all, they have been brilliant so thank you".

"Very pleased with the help"

Throughout 2025/26, the team further developed and expanded its existing role, continuing to work closely with A&E and the University Hospitals of North Midlands (UHNM) wards to strengthen discharge planning processes. This has included ongoing community-based support for service users following discharge, helping to minimise reattendance and/or readmission. These practices are now fully embedded into day-to-day operations and continue to demonstrate positive impact.

As a result of their consistent in reach work, the team has effectively strengthened the link between acute hospital services and community-based support. This enhanced continuity of care has contributed to improved outcomes for service users, ensuring that their needs are met across both clinical and social domains.

The HVU Team continues to support service users in reducing avoidable attendances, and they have received excellent feedback from those they work with. Service users regularly highlight the compassion, responsiveness, and effectiveness of the support offered.

The Mental Health Liaison Team (MHLT)

This is part of the crisis care service line and aims to provide a timely, comprehensive, and multidisciplinary assessment service to people presenting with urgent mental health problems within the emergency portals and inpatient settings at the acute hospitals operated by the University Hospitals of North Midlands NHS Trust (UHNM).

In addition to delivering direct clinical assessment, the team aims to increase the detection, recognition, and early treatment of impaired mental wellbeing and mental disorder.

A core objective of the service is to work collaboratively with the acute trust to develop joint care pathways for patients with mental illness. These shared pathways support a consistent, integrated approach across services and help ensure that individuals receive coordinated care regardless of the setting in which they first present.

Throughout the year, the team has faced increased challenges due to a significant increase in referrals across all age ranges. This rise in activity has been further compounded by the introduction of a new way of working in line with the updated National Institute for Health and Care Excellence (NICE) guidelines relating to self-harm presentations. Implementing these new guidelines has required extensive adaptation and enhanced clinical responsiveness, with the team continuing to deliver high quality and timely assessments despite increased demand.

The team has achieved Psychiatric Liaison Accreditation Network (PLAN) accreditation through the Royal College of Psychiatrists. This accreditation confirms that the team is meeting recognised standards for delivering safe, effective, and sustainable patient care, in line with other accredited services across England and Wales.

Service user feedback on the Mental Health Liaison Team

" Very friendly service. Also extremely friendly understand conversation were taken into account.. "

"Very caring and I got to speak freely and they were understanding"

"Well informed throughout the process, good communication, easy to understand"

"Staff member did everything she could for me, full of praise"

"Caring and understanding, actually got us the help we needed, sincerely thank you"

"More support than expected, lovely, helpful people, thank you"

Carer feedback

"A heartfelt thank you for looking after us in our most difficult time! How you were with *****, we'll never forget. "

"You supported my dad in AED when he was referred to MHLT. The nurse assessing him was compassionate and kind towards my father and your input really put him at ease'

The team has continued to maintain the ‘attend to assess’ approach, which has significantly strengthened the relationship between MHLT and UHNM. This model has enabled patients to be seen within one hour in A&E, within four hours in emergency portals, and within 24 hours on the wards. This timely response supports patient flow across the system and ensures individuals receive prompt assessment and appropriate care planning.

Primary Care Services

The directorate has continued to develop primary care physical and mental health services, working in partnership across teams, including integrated general practice teams, talking therapies, primary care networks (PCNs), Serious Mental Illness (SMI) Physical Health Check Team and Additional Roles Reimbursement Scheme (ARRS) mental health teams, supporting integrated and community-based care. Following the integration of Keele Practice, the directorate has worked with Keele University to review the physical and primary care mental health offer available to students, promoting groups such as Managing Your Own Wellbeing facilitated by the ARRS mental health team and promoting general practice services across the campus. In partnership with Keele University, improvements have been made to the practice building and surrounding areas. The directorate has continued to develop cross site functionality to maximize quality and consistent service provision across different directorate teams.

The General Practice Service Team

This team provides a responsive approach, monitoring access and patient satisfaction. The practices have continued to develop a digital offer for patients to reduce telephone demand and provide a convenient alternative, whilst ensuring that patients care is safely and appropriately navigated. Patchs digital software has become embedded into the general practice service offer and in preparation for national changes to provide an “all day” online consultation service.

The Holmcroft General Practice Team

This team was inspected by the Care Quality Commission in October 2024, which was the first inspection since the integration of the practice. Holmcroft received an overall rating of “good” with “good” achieved in all domains.

Working with our voluntary sector partner

The Primary Care service has continued to work with voluntary partners and Beat the Cold initiative. Moorcroft Team reached out to 81 people from identified patient groups during the December to February period to provide support and energy advice. As part of the Keep Warm Keep Well project, 36 patients were referred for a heating grant and 32 referrals for water tariff support and an approximate £17,000 in tariff support savings. The Trust achieving highly commended for Driving Change Through Data and Analytics award as part of the Keep Warm Keep Well project.

The ARRS mental health team

This team have continued to work closely with their respective PCNs, developing networking opportunities and working with local practices in partnership, rolling out the Managing Your Own Wellbeing groups across Stoke on Trent and North Staffordshire. The ARRS mental health team have attended a number of PCN and community events to promote primary care mental health and the services available. This included a men’s event at Newcastle South PCN where men’s physical and mental health were promoted and was well received by the local population.

The ARRS Mental Health Team continue to develop the children and young people’s service, supporting Moorcroft and Keele’s patient population under the age of 25 years. The service supports patients with potential eating disorder, self-harm or post-COVID mental health needs.

North Staffordshire and Stoke-on-Trent NHS Talking Therapies Team

This team continues to provide assessment and psychological therapies as first choice interventions for depression and anxiety. The service is achieving above national targets for rates of reliable recovery and reliable improvement. The team lead and support on a number of projects to promote Talking Therapies services and the support available, including long term condition management, menopause, university students, men’s health, equality, diversion and inclusion.

As part of the Talking Therapies team, the Ascend Recovery Service has been established in partnership with MPFT, to provide offer evidence-based, psychological treatment and support to anyone aged 16+ who might be experiencing trauma symptoms because of sexual assault or abuse.

What the Care Quality Commission said about the Trust

The Trust continues to maintain its overall Outstanding rating from the Care Quality Commission (CQC), held since 2019, reflecting our sustained commitment to safe, effective and compassionate care. The Trust remains fully compliant with all CQC registration requirements under the Health and Social Care Act 2008, with no enforcement action taken during 2025/26 and no conditions placed on its registration. We remain one of the few mental health providers nationally to retain an Outstanding rating for both Caring and Responsive services.



North Staffordshire Combined Healthcare NHS Trust

Last rated
1 June 2020

Overall rating

Inadequate

Requires improvement

Good

Outstanding

Are services

Safe?

Good

Effective?

Good

Caring?

Outstanding

Responsive?

Outstanding

Well-led?

Good

The Care Quality Commission is the independent regulator of health and social care in England. You can read our inspection report at <https://www.cqc.org.uk/provider/RLV>. We would like to hear about your experience of the care you have received, whether good or bad. Call us on 03000 61 61 61, e-mail enquiries@cqc.org.uk, or go to www.cqc.org.uk/share-your-experience-finder

PRIMARY CARE SERVICES

	Safe	Effective	Caring	Responsive	Well-led	Overall
Moorcroft Medical Centre & Moss Green Surgery	Good	Good	Good	Good	Outstanding	Good
Holmcroft Surgery	Good	Good	Good	Good	Good	Good
Keele Practice	Good	Good	Good	Good	Good	Good

In February 2025, the CQC undertook a comprehensive inspection of Holmcroft Surgery, with the final report published in May 2025. The service was awarded a ‘Good’ rating across all domains, with no regulatory breaches identified.

Further focused inspections were undertaken in May 2025 as part of the national mental health inspection programme, reviewing the Trust’s Mental Health Crisis Services and Health-Based Places of Safety. The report, published in August 2025, gave an overall rating of Good, highlighting exemplary staff compassion, strong safeguarding practice, and positive patient involvement. Opportunities for improvement were identified in the consistency and quality of care planning, reflected in the Effective domain rating down from Good to Requires Improvement.

In addition, the CQC undertook unannounced Mental Health Act monitoring visits to Ward 2, Ward 5 and Ward 3. The Trust continues to strengthen its quality and assurance processes in response to the findings, ensuring that learning is shared and improvements are embedded consistently across all inpatient areas. Ongoing Mental Health Act audits are completed to monitor adherence, provide assurance of compliance, and support continuous improvement.



North Staffordshire Combined Healthcare NHS Trust

Last rated
1 June 2020

Overall rating

Inadequate

Requires improvement

Good

Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Community mental health services with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Outstanding	Outstanding	Good	Outstanding
Mental health crisis services and health-based places of safety	Good	Good	Outstanding	Outstanding	Good	Outstanding
Wards for people with a learning disability or autism	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Outstanding	Outstanding	Good	Outstanding
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Substance misuse services	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good

Building capacity and capability

During the past year, our Board membership was refreshed and further enhanced:

- We now produce a Trust Board briefing summary immediately after each open Trust Board meeting. This is circulated to all our staff and stakeholders, so they can easily be kept abreast of latest proceedings.
- Frieza Mahmood was appointed as Chief People Officer from June 2025

The Board has a wide range of experience and skills to provide effective leadership. Our continuous cycle of board development acts as an opportunity for ongoing organisational development and quality improvement.

A core component of the development programme is to ensure that all board members have a focus of continued improvement in order to deliver the highest quality, safe services for our community, within resources available. This includes individual appraisal, personal development, board development schedule, statutory and mandatory training and additional learning development, for example, the Trust's Veteran Aware and Equality, Diversity and Inclusion Training.

Our Open Trust Board proceedings are livestreamed – full papers and recordings of key elements are made available on our website thereafter at combined.nhs.uk/about/our-board/board-meetings/board-meeting-archive the recordings include:

- Chair's Report
- CEO Board Report
- REACH Award
- Patient/Service User Story

In addition, our Ask the Board facility allows anyone to ask a question or make a comment or suggestion ahead of the Board meetings. It is answered live during the meeting.


North Staffordshire
Combined Healthcare
NHS Trust

North Staffordshire Combined Healthcare NHS Trust Board Briefing – March 2026 Board

This briefing aims to keep you informed of the discussions at our Trust Board.

To watch the recording and read the papers, please visit the [Board Meeting page](#) on the Combined Healthcare website.

Please note this briefing does not replace the official Board minutes, which will be published in due course and be available on the website.

Service User Story

This month's Service User Story featured Richard's story, which was shown only during Board proceedings at Richard's request.

REACH Recognition Team Award

This month's REACH Recognition Team Award was presented to the Mental Health Law Team. You can watch the recording of the REACH Award [at this link](#).

Chief Executive's Report

Dr Buki Adeyemo, Chief Executive, presented the report, which is available [at this link](#). Buki wanted to draw the Committee's attention to our continuing support for veterans and high performance in the PLACE assessment (Patient Led Assessments of the Care Environment).

There was particular interest from the Board in how the trust is ensuring equality in access and delivery of its services. There was also a welcome from the Board to the investments made through the community mental health transformation programme and for the message of support for any staff affected by the recent events in the Middle East. You can watch the recording of the CEO Report [at this link](#).

Chair's Report

The Chair's report to the Board is available [at this link](#). Janet wanted to thank everyone involved with the successful conclusion of Project Chrysalis, which had been an excellent example of great partnership working between the contractor, Interclass and the Trust. Janet had enjoyed her Board to Ward visits, in particular a visit to the Parent and Baby Unit.

You can watch the recording of the Chair's report [at this link](#).

Questions from Members of the Public

There were no questions from members of the public. N.B. Anyone can submit a question for consideration and discussion at the Board via the [Ask The Board facility](#) on the Trust website.



Terrorism (Protection of Premises) Act 2025 ("Martyn's Law") - appointment of Designated Senior Individual (DSI) and Implementation plan

Ben Richards, Chief Operating Officer, presented the report. The Board noted this was still work in progress and approved the appointment of Ben Richards, Chief Operating Officer as the Trust's Designated Senior Individual under the Terrorism (Protection of Premises) Act 2025, complimenting his role as the Trust's designated Accountable Emergency Officer.

There was an extended discussion and assurance was received about the nature of the role and how the associated processes and procedures dovetail with existing policies and practice at the Trust.

The Board also approved the delegation from Trust Board to Quality Committee to endorse board compliance ahead of full implementation and to provide the assurance route for the Trust. The full report is available in the [Trust Board bundle](#).

Board Assurance Framework Quarter 3

Nicola Griffiths, Deputy Director of Governance/Board Secretary, presented the report.

In line with an audit recommendation and following a facilitated Board development session with MIAA in August 2025, a risk appetite tolerance upper and lower levels has been added to the dashboard for each risk linked to the tagged risk.

The risk tolerance range has been included which is based on the risk appetite level within each individual risk graph and a proposed risk appetite statement produced which is showing on the risk dashboard.

There was a particular discussion about how the Trust is addressing risks around sickness absence, with a recognition that action is being taken in this regard, notwithstanding the effects of external factors outside the control of the organisation.

The full report is available in the [Trust Board bundle](#).

Listening to our people

Being open raising concerns and Freedom to Speak Up

At Combined, we strive to create an open and inclusive culture for our workforce. Our people are our most valuable resource, so providing safe spaces for them to have their voices heard is critical for supporting their wellbeing, which ultimately leads to better patient care. It is essential therefore, that we ensure any concerns or issues raised by our people, are heard, taken seriously, investigated and supported with actions.

Our primary focus will always be to encourage our people to raise any issues or concerns within their immediate management team or with the patient safety team if it is safety related, but we recognise that in some cases, speaking up using this approach may feel uncomfortable.

We therefore take pride in providing our people with alternative options to be able to share their voice or to raise a concern, using our well-established routes, to ensure people do feel heard, with their concerns explored and supported.

Our alternative speaking up routes available for our people to use freely are:

- Dear Buki
- Freedom To speak Up (FTSU)

The Trust also provides a more formal process, should this be needed, through our Resolution of Grievance and Dispute Process.

The aim of these routes is to provide our people with spaces to help them feel safe to share any issues that impact on the safety or wellbeing of themselves, patients, or others, when staff are exposed to a negative working experience. Our raising concerns routes are promoted through our Trust intranet, with additional and alternative routes for people’s voices to be heard, promoted on our Freedom To Speak Up pages.

Each year, the Trust Board is provided with an annual Being Open Report, which presents the Trust’s combined annual activity for these three main raising concern services, identifying key themes and patterns for assurance and consideration at senior level.

Our Peoples Voices - Annual Activity 2025/26

Every concern, communication received or issue is heard and taken seriously before it is reviewed and categorised into themes. These themes help to provide us with consistency to identify any potential patterns arising as well as invaluable insight to support any further developmental actions that may be needed.

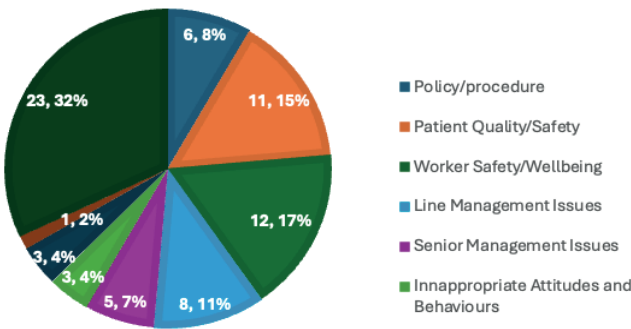
Dear Buki Communications

Dear Buki is an anonymous option for our people to use, through a secure website that enables our people to share their voice about any issue, concern or query they may have about quality, safety, or any other related issue in our Trust. Although this option is anonymous, it can sometimes be difficult to review some of the communications received, without further detail. The website does therefore encourage users to leave their contact email address or contact number, if they feel safe to do so, to enable us to liaise directly if necessary, with an individual, to support cases with more detail.

This year the Trust received a total of 72 Dear Buki communications. An overview of the themes from the issues raised through Dear Buki are provided here.

To ensure Combined continues to support its open and transparent culture, all non-identifiable Dear Buki communications are accessible to our people through the Trust intranet and any person identifiable communications are responded direct to the originator.

DEAR BUKI - ANNUAL ACTIVITY 2025/26



Freedom To Speak Up (FTSU) Concerns

FTSU aims to work alongside senior leaders and local leadership teams to support a more open and transparent place of work and approach with communication and behaviours, where colleagues are actively encouraged, enabled, and supported to speak up freely and safely, while feeling heard and supported.

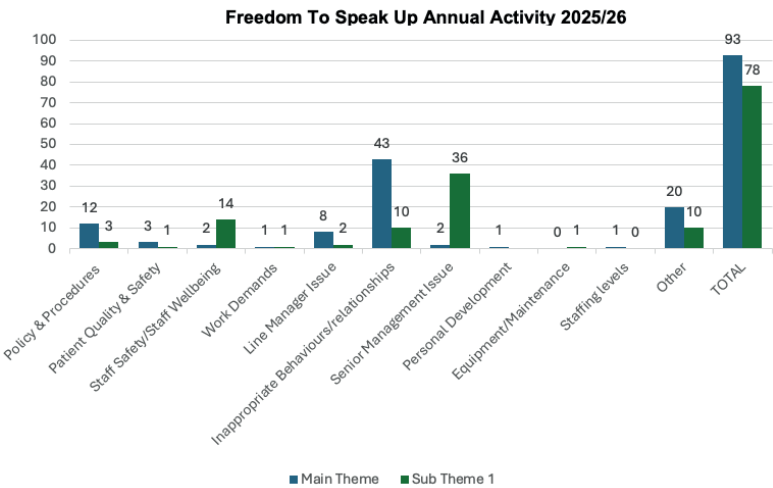
Any FTSU activity remains confidential between the individual raising the concern and the FTSU Guardian, apart from a FTSU champion, if an individual chooses to reach out to a champion for any initial engagement.

Any action to support an individual who has raised a concern will be supported by the Trusts FTSU Guardian, with actions agreed and progressed by the Guardian on behalf of the individual.

Our people have the option to raise a concern in a number of ways through FTSU:

- Openly
- Confidentially
- Anonymously

This year the Trust received 93 FTSU concerns. The figure above shares the themes arising through our people using this route.



Outcomes of FTSU Concerns Raised

Concerns raised through FTSU are escalated and supported using different approaches, depending on their content and sensitivity. The table below shares the position to date or outcome for each concern raised during 2025/26:

Concern Position / Outcomes	Number
Number of concerns supported and closed at local senior management level	79 concerns
Number of concerns open and still in progress	14 concerns

Resolution of Grievance and Disputes

During 2025/26 the Trust received 12 grievance cases.

New grievance cases were received from the following directorates:

- Corporate Directorate: 1 grievance
- Acute and Urgent Care Directorate: 5 grievances
- Specialist Directorate: 1 grievance
- Community Directorate: 5 grievances

The NHS Staff Survey

The National NHS Staff Survey results for 2025 showed that we continue to maintain high levels of performance and engagement through our survey results. Overall, 65.4% of our people shared their feedback and experiences with us, by responding to the survey in Autumn 2025. This was 1.4% higher than the feedback we received during 2024 and 9.4% higher than the average for our comparator group. This is particularly great news for our Trust due to the reported positive upward trend contrast with the national average, which has declined and the reported overall decline in other mental health organisations, making this response rate notable.

We will however still not be complacent. We very much want to hear from as many of our people as we possibly can, so we will be looking at Trust areas where responses were lower than most in our Trust and we will be working with teams to encourage positive change to be effectively and regularly communicated to the whole team throughout the year, sharing how their feedback has influenced such change. As well as this, we will be thinking over the coming year about how we can encourage even more people to share their experiences with us through this metrics, to improve our participation rate further.

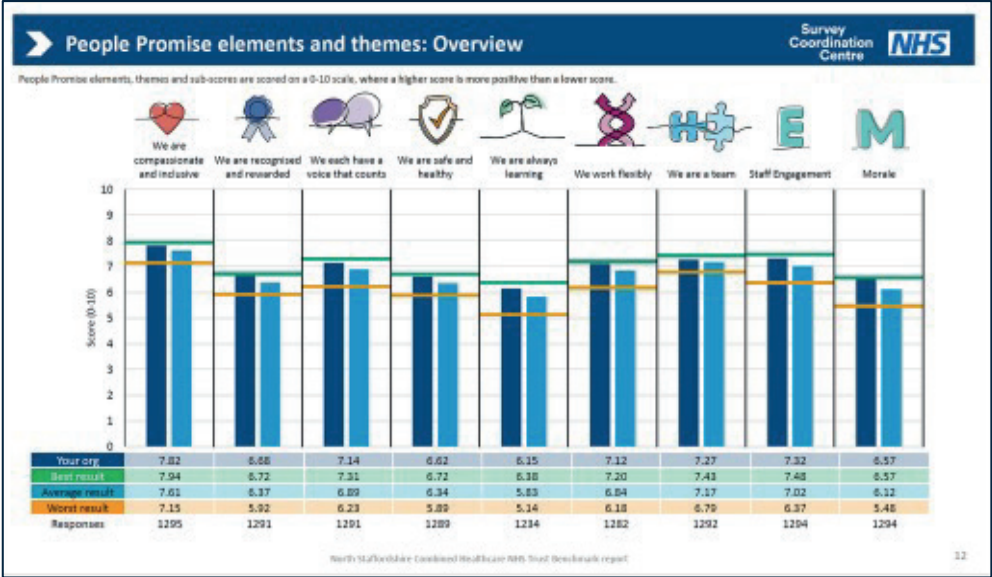
We are delighted that our overall results for all of the NHS People Promise's and the Themes are higher than the average for our comparator group, with two People Promises showing an improved score when compared to our 2024 scores and the remaining promises and theme maintaining their score from last year. This gives us clear indication that there is much we continue to do well.

After another really challenging year for the NHS, we have seen an increase in our scores for 'we are recognised and rewarded', 'we are a team' and 'staff morale' since 2024.

There was also a positive improvement in the number of colleagues reporting they would recommend our Trust as a place to work and that they are unlikely to be leaving the Trust or looking for alternative employment in the next 12 months. Our people also shared they would be happy with the standard of care provided by us if a friend or relative needed treatment and they recognise that our Trust takes positive action to support their health and well-being. Our most improved areas showed a reduction in the number of staff working additional unpaid hours over and above their contracted hours, a reduction on the number of staff coming to work when feeling unwell and a reduction in the number of people experiencing work related stress.

We also recognise from the feedback received, that we need to further support reasonable adjustments for our people to be able to carry out their work, review our safety management to ensure that errors or incidents are not repeated and ensure our colleagues are able to access clinical supervisions and the right learning to continue to develop their career.

We have heard this feedback and will take positive actions of support. We will continue to progress actions that we began during 2024 to help to further develop those areas which included leadership, team working, inclusion and belonging and health and wellbeing and we have heard the feedback from our peoples voices from this year's survey and we will support areas that have been reported that are not so good such as: Workload and wellbeing, Discrimination by ethnicity, sexual orientation and religion, Career progression opportunities, personal development, effectiveness of appraisals and Safety and incident management.



Promoting and celebrating quality

The Quality Assurance Group

The main forum for overseeing quality at an operational level is the Quality Assurance Group (QAG), which reports into the Quality Committee. This was established to ensure continuous improvement in the quality of services provided at Combined. The group reviews governance, performance, and internal control systems to support the delivery of safe, high-quality patient care.

Its membership includes:

- Chief Nursing Officer (Chair)
- Deputy Chief Nursing Officer (Vice Chair)
- Head of Nursing
- Clinical Directors for each directorate
- Quality Assurance and Improvement Manager
- Towards Outstanding Improvement lead
- Recovery and Experience Lead
- Legal Services Manager or Mental Health Law Lead
- Head of Facilities
- Head of IPC
- Head of Estates
- Clinical Audit Manager or Research and Development Lead
- Associate Director of Communications
- Transformation Management Office Representative

Its key objectives are:

- monitor and review: assess the quality of the services we provide
- compliance: ensure compliance with national quality standards and local requirements
- risk management: identify and manage risks associated with the quality of patient care
- quality improvement: oversee the implementation of quality improvement initiatives and action plans

It carries out its function by, amongst other things:

- examining quality and safety reports, audit findings, and performance data
 - monitoring action plans to address identified issues from quality assurance visits, clinical and quality audit findings and progress against self-assessments

- receiving updates and insights into engagement activity with patients, carers and staff – and how this is being used to improve services/care
- ensuring staff training and development needs are identified

The Trust places great importance on promoting and celebrating quality and raising awareness of the importance of quality amongst its frontline staff and teams – as well as supporting, showcasing and rewarding quality improvement initiatives and projects.

The Quality Committee

The Quality Committee is chaired by Professor Pauline Walsh, Senior Independent Director and Non-Executive Director. Kenny Laing is Chief Nursing Officer at North Staffordshire Combined Healthcare NHS Trust and the Executive Lead for Quality, his role is to ensure the Trust effectively trains, develops, and retains nursing, AHP and social work staff to deliver high quality care and treatment to its users.

The Quality Committee is one of six board committees at Combined and plays a crucial role by:

- ensuring that healthcare services provided by the Trust are safe, effective, and centered around the needs of patients
- monitoring clinical quality and safety
- overseeing governance of patient care
- managing risk related to quality of care
- reviewing serious incidents and complaints
- ensuring compliance with regulations
- supporting a culture of quality improvement

The Time to Shine handbook

The Time to Shine handbook has been created to:

- support our frontline people and teams in shining a light on the fantastic care they provide
- support them to feel confident in keeping in line with health and social care regulations
- maintain the expectations set out in our Trust Quality Strategy
- prepare for a CQC inspection

The handbook is designed as a 'checklist' to help everyone to continue to maintain good standards, keeping in line with health and social care regulations. As a result, we will always be prepared for any inspection and we will continue to meet expectations and aspire to exceed them:

- showing how the Trust adapts, learns and continues to make positive progress
- ensuring that the Trust has addressed all the areas where improvements were recommended at previous well-led reviews
- providing evidence of any changes that have made a positive impact on people who use our services and staff working for the Trust

Helping our people to shine isn't just about inspection and regulation – it's also about helping them and their services gain profile and recognition for the fabulous work they do. We have always recognised the value and benefit of highlighting and promoting information and feedback about our services and celebrating the very best that our people and services can be.

We have invested heavily over the years in content, innovations and channels to enable this to happen.

Doing so is a powerful way to support our people, our services, our service users and their families. It also helps us to meet key requirements of the CQC assessment framework.

By completing a self-assessment in the handbook of the use of our communications channels, each of our services can:

- learn more about the channels and innovations available to them and their service
- review existing content to ensure it remains accurate and up to date
- identify where there are currently gaps in information or content
- prioritise and timetable actions to ensure they and their service are reflected across all of the channels available to them



Engagement@Combined

Engagement@Combined is one of the most important stakeholder and service user engagement events we hold each year and a key part of our engagement around our quality priorities.

Engagement, co-production and partnership are all things that are dear to the heart of Combined Healthcare. So we want to ensure that what we do is meeting the needs and preferences of our service users, their families and stakeholders.

This event is an annual opportunity for our Trust to spend time with them – to celebrate what we have achieved together so far, learn from each other and ‘dream big’, so we can together achieve even more.

We do this because we recognise that outstanding, compassionate, high-quality care is not achieved alone. It requires thought, imagination, dedication and determination, and, above all, it requires people and communities engaging – working together, listening and learning from each other, supporting each other and achieving in partnership.

The Engagement@Combined event is an opportunity to look back and celebrate. But also an opportunity to hear from our service users and stakeholders, to look forward and plan for the future. Each year, we hear from a number of initiatives and projects that have truly demonstrated the power of engagement, co-production and partnership with service users and stakeholders.

2026 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 sheer 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 partnership—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](#).

REACH Awards 2025

The annual REACH (Recognising Excellence and Achievement in Combined Healthcare) Awards is Combined Healthcare's staff awards ceremony. Running since 2015, the evening gives us a chance to celebrate Combined staff and teams, as well as volunteers and service user representatives who have made a truly outstanding contribution and gone above and beyond to promote compassion and quality in all we do.

We hosted the 2025 awards on 13 November 2025 at the DoubleTree by Hilton Hotel, Stoke-on-Trent. For those not able to attend in person, the whole event was broadcast live and a catch-up recording can be viewed at: <https://youtube.com/live/QqxePjUwdbY?feature=share>

We were delighted to be presenting REACH in partnership with our main event sponsor, Dedalus.

We were also grateful for award sponsorship from the following organisations:

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

Awards and Winners

Diversity and Inclusion Award – sponsored by Stoke City FC

This award recognises the contribution of staff and volunteers who have made a positive difference in developing greater diversity and inclusion. This might be improving access and experience to services or employment for people in disadvantaged or minority groups, improving quality of life or quality of working life.

- Winner: Sarah Lawton, Ward 6
- Highly Commended: Children's Community Learning Disability Team

Leading with Compassion Award – sponsored by Rowtype Printers Ltd

This award recognises a member of staff who values and develops people, sees them as individuals and encourages working together for better lives through an open and honest approach. It recognises an individual who has demonstrated compassionate leadership with patients, colleagues or their wider team.

- Winner: Dr Jason Lines, Mental Health Liaison Team
- Highly Commended: Dr Hannah Cowan, Older People's Community Mental Health

Learner of the Year Award – sponsored by RLDatix

This award recognises and celebrates our learners and the contribution they make to Combined and its service users. This award is open to students, apprenticeships and anyone studying as part of their role across the Trust.

- Winner: Charis Hancock, Mental Health Liaison Team
- Highly Commended: Ella Baddeley, Mental Health Nursing

Lived Experience Shining Star Award – sponsored by Town Hospitals Ltd

This award recognises an individual who has lived experience of mental distress or who has accessed mental health services and champions recovery values, inspiring hope and supporting others to be the best version of themselves.

- Winner: Michele Nicholson, Peer Support
- Highly Commended: Justyna Novak-Rowcliffe, Peer Support

Partnership Award – sponsored by Interclass

This award showcases how an individual or team can work in partnership to produce results to improve the lives of others. Successful individuals or teams will have broken down professional barriers across the Trust and/or with partner organisations, leading to a positive impact on the experience of service users.

- Winner: Additional Roles Reimbursement Scheme (ARRS) Mental Health Team, Hanley, Bucknall and Bentilee Primary Care Network (PCN)
- Highly Commended: Stoke-on-Trent Youth Collective

Proud to CARE Award – sponsored by Serco

This award recognises someone who exemplifies our Proud to CARE values: compassionate, approachable, responsible and excellent. Staff vote to decide the final winner from a shortlist.

- Winner: Dr Bethan Brace, Greenfields Adult Community Mental Health Team
- Highly Commended: Lisa Nagington, Quality Improvement

Research and Innovation Award – sponsored by Dedalus

This award recognises innovation or achievement in research and development or practice which has a positive impact on mental health care or improves quality or value for money services through innovative approaches.

- Winner: Children's Community Learning Disability Team
- Highly Commended: Enhanced Support Suite Project Team

Rising Star Award – sponsored by Dedalus

This award recognises emerging exceptional leaders who are exceeding expectations and making change happen. The award aims to recognise the influencers of today, and the senior leaders of tomorrow.

- Winner: Boluwatife Adeoye, Organisational Development
- Highly Commended: Molly Mansfield, Communications Team

Service User and Carer Council Award – sponsored by Interclass

This award values individual or teams who stand out from the crowd for being thoughtful, for listening and responding to our service users' needs.

- Winner: Jaime Lowe, Neuropsychiatry
- Highly Commended: Parent Engagement Group in Stoke (PEGiS)

Team of the Year Award – sponsored by Port Vale FC

This award is given to a team which shows, through their actions and approaches, how they work together to improve the lives of others and demonstrate creative approaches to problem solving.

- Winner: Substance Misuse Inpatients Team
- Highly Commended: CAMHS Eating Disorders Team

Unsung Hero Award – sponsored by Unison

This award pays tribute to an individual who has exceeded the expectations of their role with an outstanding attitude and behaviour. Working behind the scenes, or in a supportive role, they have a positive attitude and, through their actions, help to make a difference to others.

- Winner: Dave Norcup, Performance and Business
- Highly Commended (joint winners): Julie Chapman, Mental Health Liaison Team and Jenny Reynolds, Discharge Pathway Lead Management

Chair's Award

Chosen by the Chair from the winners on the night, this award recognises an individual or team who embodies the Trust's values.

- Winner: Dr Jason Lines, Mental Health Liaison Team

Details of the winners of each award, what their nominators said about them, and videos of each ceremony segment can be found at combined.nhs.uk/about/staff-reach-awards/staff-reach-awards-2025.



Part two – Priorities for improvement and statements of assurance

Our progress against strategic priorities

During 2025/26, North Staffordshire Combined Healthcare NHS Trust continued to make strong progress against its three strategic priorities: Prevention, Access, and Growth. This year has been shaped significantly by national change, including the NHS Medium Term Planning Framework and the emerging NHS 10 Year Health Plan, which together emphasise a future NHS built on prevention, neighbourhood models of care, digital innovation and improved productivity.

Against this backdrop, the Trust sustained delivery of high quality, compassionate and personalised care, while also preparing for the substantial transformation required over the coming years.

We continued to respond to rising demand across crisis care, children and young people's services and neurodevelopmental pathways, and worked closely with system partners to improve access, reduce variation and support earlier intervention.



A Transitional Year of Delivery and Preparation

- A major focus of 2025/26 has been the development and submission to NHSE England of our three year Medium Term Plan and accompanying five year Integrated Delivery Plan. This plan sets out how the Trust will transition towards delivery models aligned with national policy direction, including:
- Neighbourhood health and integrated multi-disciplinary teams, enabling care closer to home and earlier intervention.
- Prevention focused models across the life course, with expansion of early intervention, school based prevention, and population health approaches.

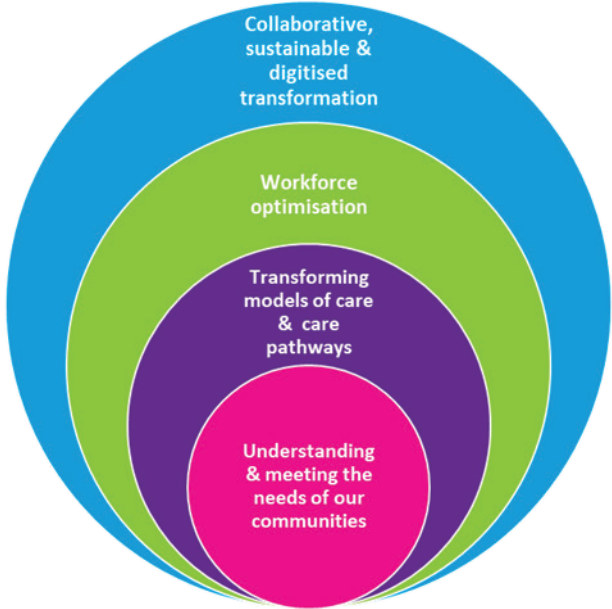
The development of Neighbourhood Mental Health Centres and Mental Health Emergency Departments, delivered through strong system partnership.

- A substantial step forward in the analogue to digital transition, including the upgrade of our Electronic Patient Record to ORBIS U and improved digital access for patients through our patient engagement portal PatientAide.
- Ensuring sustainable, high quality and productive services through new workforce, estates and digital plans.

This work positions the Trust to meet the requirements of future NHS models and helps ensure that our services reflect the needs, aspirations and experiences of our local communities.

Quality Embedded Throughout Our Plans

Quality remains at the heart of everything we do. As part of the Integrated Delivery Plan, our Quality Priorities were mapped directly across the Trust's four emerging transformation portfolios:



This alignment ensures that every major area of change is underpinned by quality, with clear accountability for delivering improvements in safety, experience, access, equity and outcomes.

The transformation portfolios integrate quality impact assessment, clinical leadership and data driven improvement, providing assurance that:

- Quality, safety, experience and equity remain central to service redesign.
- Productivity and efficiency improvements enhance rather than compromise quality.
- Lived experience, co production and recovery focused practice are embedded throughout.
- Workforce, digital and operational changes are aligned with clinical leadership and evidence based best practice.

These arrangements give assurance that, even in a period of substantial transformation, we remain committed to delivering outstanding, inclusive and sustainable care.

Our Key Achievements in 2025/26

Throughout the year, we achieved significant progress across our strategic priorities. Highlights include:

Prevention: We will commit to investing in providing high quality preventative services that reduce the need for secondary care

Strengthening Early Help and Community Prevention

- Expanded Mental Health Support Teams and deepened early intervention work in schools across North Staffordshire and Stoke on Trent.
- Developing new community based prevention initiatives, including enhanced support for young people in complex situations and expanded whole school wellbeing approaches.
- Continued development of social and community models such as Diverse Minds, supporting people with neurodivergence in community settings.
- Successful system leadership and delivery of the Transforming Care Programme (TCP) with Staffordshire and Stoke-on-Trent (SSOT) TCP identified as the third best performing in the country and the best performing in the Midlands.

Improving Physical Health and Reducing Inequalities

- Increased delivery of holistic support for people with mental illness, learning disabilities and autism, including physical health checks, expansion of Talking Therapies including for those with long-term physical health conditions and further growth in our Step-On service supporting access to work.
- Progressed targeted prevention pathways informed by our Health Equity Framework, ensuring needs led support for communities experiencing the greatest inequalities.

Embedding Trauma Informed, Recovery Focused Care

- Continued embedding of trauma informed, compassionate and recovery focused practice across all services, supported by an expansion of lived experience roles in inpatient settings and community co production.

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.

Better Access for Children and Young People

- Redesign of CAMHS pathways to improve flow, ensure clearer access routes and strengthen early intervention, including Expanding our All-Age Neurodevelopmental service line to include children's ADHD supporting better understanding and visibility of demand that can be used to shape service provision going forward.
- Addressed long waits through productivity improvements, pathway redesign and digital opportunities in neurodevelopmental services.

Strengthening Urgent and Crisis Support

- Full integration of NHS 111 and 24/7 crisis text services, providing easier access to support at any time.
- Continued market engagement to support the development of crisis alternatives, including work with VCSE partners to offer community based support options.

Reducing Use of Out of Area Placements

- Implemented a Trust wide programme to reduce inappropriate out of area placements, in collaboration with system partners, supported by strengthened discharge pathways and flow improvement.
- A continued downward trajectory of adults in out of area level 2 mental health rehabilitation settings from a peak of 89 in 2021 to 32 in January 2026.

Expanding Digital Access and Communication

- Prepared for the transition to ORBIS U, our new electronic patient record, which will support safer, more joined up care.
- Expanded digital access for patients through Patient Aide, including further integration with the NHS App and NHS Notify for appointments, letters and results.

Growth: We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce.

Building Neighbourhood and Community-Based Models

- Initiated the development of the first children and young people's neighbourhood multidisciplinary teams through the Primary Care Directorate.
- Commenced initial system discussions and planning around the design and delivery of Neighbourhood Mental Health Centres and Mental Health Emergency Departments, supporting the shift from hospital to community based care.

Strengthening and Supporting Our Workforce

- Improved recruitment, reduced reliance on agency staffing and supported a more stable and sustainable workforce model.
- Strengthened leadership and career pathways aligned with future neighbourhood models and integrated care.

Continued delivery of the Culture of Care programme to enable inclusive, therapeutic and recovery focused inpatient environments.

Digital Growth and Productivity

- Expanded digital tools that support staff productivity, decision making and improved care coordination including the roll-out of co-produced care planning to inpatient settings.
- Strengthened data and business intelligence capability to support real time decision making and operational flow.

Maintaining Financial Stability

- Delivered another year of financial balance, marking 27 years of financial stability for the Trust.
- Developed robust plans for long term productivity, sustainable transformation and digital investment aligned to the national Medium Term Planning Framework.

Looking Ahead

Given the scale of national change, 2025/26 has been a transitional year—for the Trust, the ICS and the wider NHS. The work completed this year provides a clear blueprint for how we will realign our strategic priorities to deliver the expectations of the Medium Term Planning Framework, future strategic commissioning arrangements, and the 10 Year Health Plan.

To ensure ongoing alignment with national, system and population needs, the Trust will undertake a refresh of its strategy and strategic priorities during 2026/27. This refresh will set out the organisation's direction for the next 3–5 years, ensuring our priorities fully reflect neighbourhood-based care, prevention, digital transformation and the needs of the communities we serve.

Throughout this period of transition, our commitment remains unchanged: to deliver safe, compassionate, personalised and recovery focused care. We remain proud of our track record of high quality delivery and financial discipline, and the progress made during 2025/26 provides a strong platform for the next phase of transformation and improvement.

Quality planning, governance and quality improvement

Quality Improvement

At Combined, our shared purpose is to support everyone to improve the care we provide and the way we work, every day. We have focused embedding Continuous Quality Improvement (CQI) into routine practice, enabling the people closest to the work to identify what matters most to them and to make meaningful small changes that enhance patient care and staff experience.

In 2024/25, the NHS IMPACT (Improving Patient Care Together) self-assessment tool was used to review the organisation's Quality Improvement maturity. This has helped us to identify our strengths and opportunities for development as an organisation. NHS IMPACT is based on five key principles considered to be the "DNA" of an improvement culture.

- Building a Shared Purpose and Vision
- Building Improvement Capability
- Developing Leadership Behaviours for Improvement
- Investing in Culture & People
- Embedding into Management Systems and Processes

This created a fresh CQI team driver diagram, here are the highlights of our progress over throughout 2025/26.

Building a Shared Purpose and Vision

The Quality Improvement (QI) Team continues to promote a shared commitment to CQI across the organisation and wider system.

This is demonstrated through ongoing leadership of the ICS CQI Network, supporting system partners to collaborate around common improvement priorities. Strong national connections are maintained through participation in the National Improvers Learning Network. Motivating Combined was our sharing event in 2024. Leading clinicians shared stories about what motivated them and how they motivated their team.

Amy Spruce, at North Stoke Child and Adolescence Mental Health Service shared that her team benefited from taking a Quality Improvement approach to their triage process and reducing unwarranted variation. The triage process has improved, and the Team is keen to sustain this as standard work. The team now believe they can make changes in the way they work developing further plan do study act cycles.

Innovative communication continues to support a shared improvement vision, three episodes of The Quality Show have been delivered via Combined TV, achieving 440 views to date. These episodes showcase improvement activity across the Trust, improving visibility and engagement.

Investing in People and Culture

Quality improvement is more of a philosophy or ethos; the team continue to invest in people and culture. Our inpatient wards who are participating in the Culture of Care programme are actively working with service users to identify areas of improvement using the Team Recovery Implementation Plan (TRIP) in community meetings and collaborating to create and test improvement ideas using PDSA methodology, strengthening co-production and ownership of change.

Ward 2 successfully completed a Culture of Care QI project focused on improving staff knowledge and team cohesion. The project introduced structured teaching sessions, guest speakers and team-building activities, resulting in a measurable improvement in staff knowledge (average scores increasing from 6.25 to 8.61) alongside positive qualitative feedback. These sessions are now embedded as business as usual and the project has been formally closed.

A Community Directorate project undertaken as part of Improvement Leaders training also illustrates CQI, the project aim was to improve the number of staff, patients & carers trained in the Triangle of Care approach, working together to provide holistic care. From a baseline in March 2024 of zero, to 32 by 31st March 2025 which evolved into a further improvement which aimed to improve the number of referrals to North Staffs Carers Association by 100% made by staff for carers, from a baseline of 3, by March 31st, 2024. This CQI project features in the Quality Show on Combined TV sharing the story of how taking a QI approach has enabled the team to include carers in the delivery recovery focused holistic care.

Developing Leadership Behaviours

System leadership continues to be demonstrated through active collaboration with ICS partners and sustained national engagement. The QI Team plays a key role in shaping improvement approaches across the wider health system by sharing learning, influencing practice and modelling collaborative leadership behaviours. Engagement Value and Outcomes was completed throughout 2024, leading combined to be the first trust to be awarded EVO Silver site status.

Three dynamic teams from our Community and Acute Directorates engaged in the Engagement Value Outcome (EVO) Framework, developed by One NHS Finance. This innovative approach focuses on improving value and best quality within the available resources. Clinical teams were supported by Combined Finance and Costings Team, QI Lead and the Transformation Management Office. The benefits of this collaborative working between the EVO leads and clinicians generated insights beyond intended focus opening new areas for interest.

Improvements included:

- Community Eating Disorders Teams (Children and Adults): Delved deep into their patient pathways, focusing on refining recording processes, optimising resource use, and identifying added value across services.
- Adult Community Mental Health Team Text Message Reminder Service: To evidence a reduction in unattended appointments this project aimed to ensure we are always optimising clinical time. With promising results, the trust plans to fully implement use of Lorenzo diaries to expand text reminder services.
- Acute and Urgent Care Directorate: Analysed patient length of stay and acuity measures across wards. This has identified the potential functionality of the Safe care system, with future focus on more informed workforce planning and acuity measurement.
- Lymebrook Adult Community Mental Health Team Triage: The aim of this project was to reduce the referral to triage times within Lymebrook CMHT. Achieved a two-week reduction in triage process times following a QI process to review activity data, achieving next-day triaging.
- The Team also wished to improve the referral to assessment (RTA) time by 70% by to improve patient experience and access to appropriate treatment in a timely manner. Wait times reduced - previous data suggested that the RTA was 166 days which reduced to just over 4 weeks, two service users waited over the referral to assessment, which is due to service users who did not attend their appointments.

Building Improvement Capability and Capacity

The QI Team continues to build improvement capability across clinical and managerial teams, designing and delivering learning opportunities to promote "Improvement Thinking" to understand everyday problems and apply QI methodology. We continue to use the Model for Improvement as our clear and consistent improvement method for the organisation.

The growing culture is reflected in increasing engagement across the organisation, with rising demand for Quality Improvement mentoring and facilitation as colleagues take ownership of improvement in their day-to-day roles.

The team have placed focus upon re-designing learning opportunities and recording training activity utilising LMS. In 2025, thirty-four people undertook QI Quickstart and QI Fundamentals training.

In addition, five people completed our flagship Improvement Leaders Programme becoming QI Leaders with each participant delivering a QI project which was shared at a celebration event. Following a Kirkpatrick-aligned evaluation of the Leaders Programme the team will be testing a new approach by launching the Applying QI programme early 2026. This initiative aligns with Trust priorities and will include clinical staff and people with lived experience ensuring improvement is driven by those closest to care delivery.

In line with the drive to instil the spirit of QI in all that we do, we have now integrated the Fundamentals of QI into our Trust Preceptorship programme, Student and Medical Staff Master classes, Foundations in Leadership and Management, Trust Induction programme and the Connects Leadership programme. This way we reach more of our people.

We have worked with system partners to design and deliver coproduced QI training for patients, families and carers who wish to get involved and developed a new intro to QI video for everyone, this can be seen on the Staffordshire and Stoke-on-Trent ICS website. This year has seen the growth of our Integrated Care System (ICS) QI Network with 565 members. With Shropshire and Telford & Wrekin ICS and system partners we have delivered four Connect, Learn and Share QI Network sessions that also includes how Quality Improvement links to Patient Safety developing our links with Patient Safety colleagues.

Embedding Improvement into Management Systems and Processes

Making continuous quality improvement (CQI) part of everyday management is still a key focus. After reviewing how the previous system was used and listening to staff feedback, the Life QI platform was stopped. Instead, we now use simple Microsoft Teams forms to register and close projects. This helps us keep track of improvement work across the Trust, saves time, and reduces costs. There are currently 30 quality improvement projects registered using this consistent process.

A culture of continuous improvement is now clearly taking hold at Combined. For example, the Infection Prevention and Control Team (IPC) used improvement methods to reduce avoidable bloodstream infections. In the Community Directorate, Community Mental Health Teams have improved attendance and engagement with child protection processes. Both pieces of work achieved their aims.

We will keep linking quality improvement work to assurance processes and staff survey action plans across the Trust. This includes connecting projects to key priorities such as efficiency, capacity, and demand.

Our “what matters to you” approach empowers staff to fix day-to-day problems where they arise. This supports a culture of continuous improvement and helps staff feel more satisfied and supported in their work.

Continuous quality improvement is also built into several priority areas. These include supporting clinical teams involved in the National Audit on Melatonin prescribing, improving ward environments through the Culture of Care programme, and supporting the Crisis Care Service following its CQC inspection.

The Towards Outstanding Regulatory Compliance Lead has strengthened assurance by making sure every core service completed a self-assessment using the CQC Preparedness Tool. Quality improvement methods were then used to identify gaps and move action plans forward following Quality Assurance visits.

We are also working with the Patient Safety Facilitator to apply improvement methods within the Patient Safety Incident Framework. One example of clear impact was shared on The Quality Show: by streamlining how resuscitation trolley equipment is ordered, the team achieved a £7,500 cost saving.

Statement of assurance from the Board

How progress will be measured and monitored

This section assures that we are performing well, as a Trust, against our internal and external (independent assurance) assessment processes, via procedures which measure clinical outcomes including audit, research and development, and participation in national projects and initiatives.

Quality was monitored by our monthly performance meetings, through Board Committees and through the Trust's Integrated Quality Performance Report (IQPR). There is a contract in place to ensure clarity regarding the services commissioned for local people, the expectations of the service provider, and expectations for the quality of services. Compliance with the Health and Social Care Act 2008, and the essential standards of quality and safety

The Trust registered with the Care Quality Commission in 2010, without conditions, to provide a range of regulated activities. We have self-assessed against the outcomes, defined by the regulations, and declared compliance against all, including the NHS Provider License requirements.

Measuring clinical performance

Clinical audit, clinical excellence, and research and innovation, all contribute to measuring effectiveness, (including both clinical outcomes and patient-reported outcomes) safety, and patient experience via quantitative and qualitative information, including reporting on data regarding the impact of services on patients. Our clinical audit programme, detailed below, is developed to reflect these needs, and national priorities. We have continued to evolve our Improving Quality and Performance Report Board Report (IQPR), primarily using statistical process charts to analyse trend data across both clinical and non-clinical performance metrics.

This enables the Trust to demonstrate quality improvement and describe the process changes that have resulted in it. It also enables the early detection of any issues and development of performance improvement plans to rectify them.

National quality improvement projects (service accreditation programmes): managed by the Royal College of Psychiatrists' centre of quality improvement:

Acute and Urgent Directorate (QNPICU and QNWA)

The Psychiatric Intensive Care Unit (PICU) have registered with the Royal College of Psychiatrists' (RCPsych) Quality Network for Psychiatric Intensive Care Units (QNPICU). They have completed their developmental year and will undergo a formal peer review in November 2025.

Ward 1 has completed the developmental year for the Quality Networks and Accreditation (QNWA) scheme and is seeking formal accreditation in October 2025.

Wards 2 and 3 will begin the QNWA developmental year in 2025, with a view to formal accreditation in 2026/27.

Older Adult Wards (AIMS)

Ward 7 is currently accredited under AIMS and is due for review in June 2025, followed by a self-review period from July to October, followed by an accreditation review in November 2025. Ward 6 did not previously meet accreditation standards but are pursuing re-applying to re-start the formal accreditation process in Summer 2025, pending financial considerations.

Crisis services (PLAN and QNCRHTT)

The Mental Health Liaison Team were successfully accredited under the RCPSych Psychiatric Liaison Accreditation Network (PLAN) scheme in July 2024, valid until 11 December 2026. The Crisis Resolution Home Treatment Team (CRHTT) were accredited under The RCPSych Quality Network for Crisis Resolution and Home Treatment Teams (QN CRHTT) in May 2023. CRHTT remains accredited until January 15 2026, following an interim review by the accreditation committee in January 2025.

ECT Service (ECTAS)

The Electroconvulsive Therapy (ECT) Service holds RCPSych Electroconvulsive Therapy Accreditation Service (ECTAS) accreditation, valid until March 2027.

Specialist Directorate

Learning Disability ward (QNLD)

The Assessment and Treatment Team commenced the RCPSych Quality Network for Inpatient Learning Disability Services (QNLD) accreditation process, but this is currently stalled due to environmental requirements.

CAMHS inpatient (QNIC)

The Darwin Centre has had an RCPSych Quality network for inpatient CAMHS (QNIC) peer review completed, with another scheduled for May 2025. Formal accreditation is anticipated in 2025/26, once the multidisciplinary team (MDT) is fully established.

Rehab services (AIMS and QN-Neuro)

Summers View and the Community Rehabilitation Team are pursuing Accreditation for Inpatient Mental Health Services (AIMS) accreditation in 2025/26, pending financial considerations. Ward 5 is in a developmental year with the newly developed Quality Network for Neuropsychiatry Services (QN-Neuro) accreditation for Neuropsychiatry from RCPSych.

Community Directorate

Memory services

The memory services have been successfully reaccredited with the Memory Service Network Accreditation Programme (MSNAP), they will be reviewed again in December 2025.

Parent and Baby Service

The Parent and Baby Service have completed the Perinatal Quality Network (PQN) accreditation process and are currently awaiting panel decision and formal notification.

Carer support

The Trust earned the Triangle of Care Star 1 Accreditation from the Carers Trust in December 2023. The organisation is working towards Star 2, with a panel review in September 2025 and an annual review in March 2026.

Culture of Care Programme

The Culture of Care Programme (CofC) was a national quality improvement initiative led by the Royal College of Psychiatrists (RCPSych), aimed at improving the culture of inpatient mental health wards so they are safe, therapeutic, equitable places to receive care and fulfilling environments in which staff can work. A core principle of the programme is coproduction, ensuring that the voice and experience of people who use services are central to quality improvement activity.

The Trust participated in the programme over a two-year period, initially piloting CofC on Wards 2, 3, 6 and 7, supported by both external and internal quality improvement expertise. Building on learning from the pilot phase, the Trust extended the approach to Wards 1, 4, PICU and Summers View, supported by internal quality improvement coaches, embedding the programme across the inpatient pathway.

Key quality improvements delivered

A series of focused steering groups were established over the programme period to drive sustainable improvements in care quality, including:

- Coproduced care planning
- Embedding coproduction and quality improvement through community meetings (Team Recovery Implementation Plans – TRIP)
 - Reasonable adjustments
 - Therapeutic engagement
 - Trauma-informed care
 - Enhanced therapeutic care

Workforce developments

We developed fixed term lived experience peer roles and a trauma informed care assistant psychology role within our inpatient teams.

Coproduced care planning

Coproduced care planning is now embedded in inpatient practice, supported by changes to the electronic patient record (EPR). A coproduced care planning dashboard has been implemented, enabling monitoring of timeliness and assurance of high-quality, person-centred care planning across inpatient areas.

Community meetings and ward-level quality improvement

Ward-based project teams, comprising ward managers, lived experience partners and quality improvement coaches, redesigned community meetings to place coproduction at their core. This led to tangible ward-level improvements, including accessible information booklets, welcome packs, reading corners, patient goals walls, sensory resources and enhanced therapeutic and engagement activities, directly improving patient experience and participation.

Reasonable adjustments and accessibility

Experts by Experience co-developed easy-read formats of the Team Recovery Implementation Plan and undertook reviews of inpatient environments. Their recommendations informed changes to community meeting templates, environmental improvements and the introduction of sensory resources. Training was delivered to staff on creating accessible information to support equitable care.

Trauma-informed care

Trauma-informed care champions were trained and a steering group established. Coproduced trauma-informed care training, developed and co-delivered by an assistant psychologist and senior peer, has now been delivered to over 80% of inpatient staff, supporting consistent trauma-informed practice across wards.

Enhanced therapeutic care

The Trust reviewed and transformed its approach to enhanced therapeutic care (previously known as observation levels), shifting from task-focused observation to a therapeutic engagement model. This represents a significant cultural change, recognising that observation can be distressing and re-traumatising, and prioritising safety, trust, collaboration and meaningful therapeutic interaction. Practice changes have been embedded within documentation, training and clinical oversight.

Therapeutic engagement and things to do

Staff were trained in therapeutic interventions and complimentary therapy. We have reviewed our therapeutic offer, co-developed more groups, supporting connection and recovery. We have enhanced the way this is recorded and will capture this on a dashboard going forward.

Sustainability and assurance

To ensure changes are sustained, relevant policies and standard operating procedures have been developed or updated, embedding Culture of Care principles into everyday practice. Quality improvement and coproduction boards have been introduced within inpatient areas to support ongoing community meetings and continuous improvement. Work is also underway to enhance dashboards capturing therapeutic engagement and activity, strengthening quality oversight and assurance.

Engagement Value Outcome (EVO)

The Engagement Value Outcome (EVO) Framework, developed by One NHS Finance, supports system level improvement in patient care by enabling evidence driven, value-based decision making at specialty and service level, explicitly aligning quality improvement with cost optimisation.

Over the last 12 months, the framework has been applied across four priority areas, including community service improvements such as the introduction of text message reminders prior to appointments, reductions in referral to assessment waiting times, pathway review of children's eating disorder services, and the exploration of acuity measurement across acute wards. This work enabled transformation across multiple services and resulted in the Trust becoming the first organisation nationally to receive Silver EVO Recognition. EVO has since been embedded within the Trust's quality improvement approach, ensuring a sustained organisational focus on value and outcomes across all improvement activity.

The Trust was also subsequently invited to present its experience at a Healthcare Financial Management Association (HFMA) Midlands conference and to deliver a seminar for aspiring NHS finance leaders. The aim was to share our learning and discuss the benefits of utilising the framework.

Review of services

During the period from 1 April 2025 to the 31 of March 2026, we have reviewed all data available on the quality of care, in all the NHS services we provide. Our main services, as referred to above, are listed in the introductory section of this Quality Account – see 'services covered by this Quality Account' on page 12.

Participation in clinical audit

"Clinical audit is a quality improvement process which seeks to improve patient care and outcomes against specific criteria and the implementation of change. Where indicated, changes are implemented at an individual, team or service level, and further monitoring is used to confirm improvement in healthcare delivery. As such, clinical audit is an essential part of the quality assurance framework and a key element of clinical governance."

In 2025/26, eight national clinical audits, one national confidential inquiry and one national review programme included relevant health services provided by the Trust, where eligible cases were identified, and data collection was in progress.

During the period, we participated in all (100%) of these audits/inquiries /review programmes, for which we were eligible, as follows:

- Learning Disabilities Mortality Review (LeDeR)
- National Audit of Cardiovascular Disease Prevention
- National Audit of Care at the End of Life
- National Audit of Dementia
- National Audit of Eating Disorders
- National Audit of Inpatient Falls (NAIF)
- National Clinical Audit of Psychosis
- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
- National Core Diabetes Audit
- National Obesity Audit
- Prescribing Observatory for Mental Health (POMH) (three topics)

The national clinical audits and national confidential inquiries we participated in, and collected data for the period, are listed below, alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

The national clinical audits and national confidential inquiries we participated in, and collected data for the period, are listed below, alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

Title	Number of cases required to be submitted	Number of cases submitted	Percentage of cases submitted
Learning Disability Mortality Review	All those meeting eligibility criteria (100% return)	21	100%
National Audit of Care at the End of Life	All those meeting eligibility criteria (100% return)	1	100%
National Audit of Inpatient Falls	All those meeting eligibility criteria (100% return)	6	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	All those meeting eligibility criteria (100% return)	15	100%
Use of clozapine (POMH Topic 18c)	No minimum number specified	50	NA
Improving the quality of valproate prescribing in adult mental health services (POMH Topic 20c)	No minimum number specified	67	NA
Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services (POMH Topic 22b)	No minimum number specified	104	NA
National Audit of Dementia	NA - Service mapping exercise only		
National Audit of Eating Disorders	NA – Service mapping exercise and staffing survey only.		
National Audit of Cardiovascular Disease Prevention	NA – Data extracted automatically from the General Practice Extraction Service.		
National Core Diabetes Audit	NA – Data extracted automatically from the General Practice Extraction Service.		
National Obesity Audit	NA – Data extracted automatically from the General Practice Extraction Service		

The reports of five national clinical audits were reviewed by the provider in 2025/26 and Combined Healthcare intends to take the following actions to improve the quality of healthcare provided. Actions are monitored by the Trust's Clinical Effectiveness Group.

National Audit of Inpatient Fallss

Good practice	Key actions
N/A – Data reported nationally at aggregate level. All national recommendations reviewed during action planning and narrative recorded in relation to current processes.	• To communicate to staff clarifying PSIRF guidance and that severe harm should always be attributed to inpatient fall-related hip fractures. • To undertake a Quality Improvement project focused on the assessment and recording of lying and standing blood pressure

POMH Topic 18c: Use of clozapine

Good practice	Key actions
• Significant improvement in assessment of blood pressure and body weight, glycaemic control and plasma lipids. • 96% of patients prescribed clozapine for more than one year had received an annual review.	• To communicate with all Consultants (including locums) that off-label prescribing should form part of all clozapine reviews for discussion with the patient.

POMH Topic 20c: Improving the quality of valproate prescribing in adult mental health services

Good practice	Key actions
• There has been an improvement in compliance with regards to the documentation of target symptoms or behaviours for valproate treatment, annual assessment of the risk-benefit balance, and compliance with the conditions of the Prevent programme, bringing performance above the national average in relation to all these criteria.	• To finalise and implement the clinical protocol for valproate prescribing. • To extend the valproate protocol to the Early Intervention team. • To review and republish the SOP for the safe prescribing of valproate, to include reference to how external prescribing of valproate for non-mental health indications should be recorded.

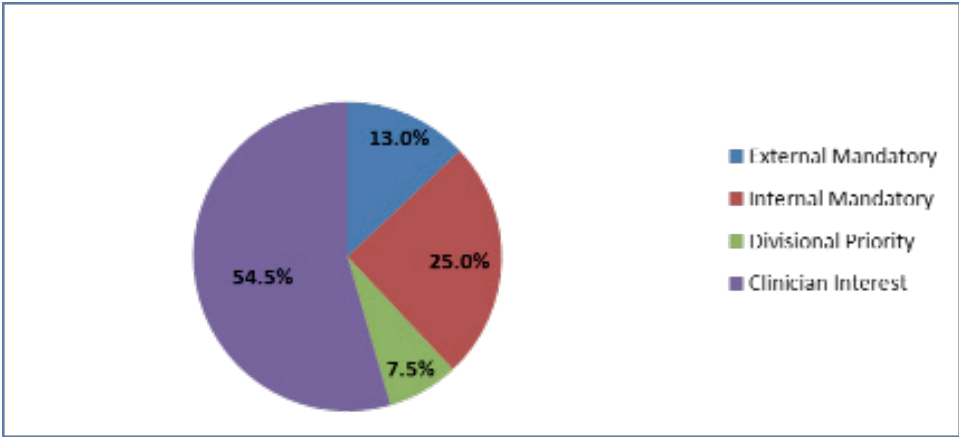
POMH Topic 24a: Opioid medications in mental health services

Good practice	Key actions
• Where opioids were prescribed for pain, this was as part of a pain management plan in 78% cases, significantly above the national average (27%)	• A reminder to be sent to staff regarding the need to discuss and document a pain management plan wherever continuing opioid prescriptions for pain are present. • A reminder to be sent to staff regarding the need to regularly review continuing opioid prescriptions to ensure that the benefits of continued use outweigh the risks. • A reminder to be sent to staff emphasising the need for clear documentation of the rationale when benzodiazepines are prescribed alongside opioid medications.

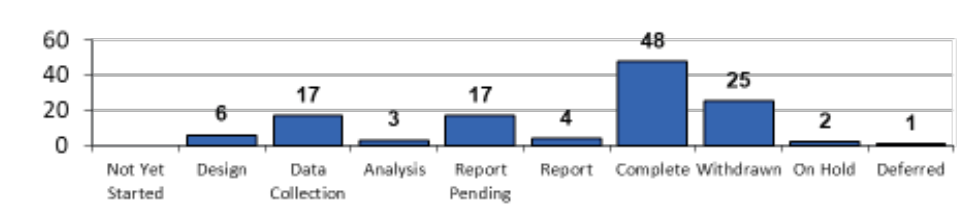
Local clinical audit and evaluation programme 2025/26

External mandatory and internal priority projects were facilitated by the Clinical Audit Team. The programme is split into four priority levels in line with national requirements/standards, including National Institute for Health and Clinical Excellence (NICE) guidance, Prescribing Observatory for Mental Health (POMH) and other national audits and standards produced by the royal colleges.

The chart below reflects the total number of projects identified, split by the four priority areas



The graph below outlines the 123 projects registered on the clinical audit programme for the period, and their status



Of the 95 active projects undertaken by the Clinical Audit Department during 2025/26, 48 (50.5%) were completed. For all clinical audits on the formal programme of work, an action plan to improve the quality of healthcare is developed in conjunction with the project steering group.

The process includes reviewing the findings and devising appropriate actions to reduce any shortfalls identified.

The action plans are agreed with the audit lead and then submitted to the Clinical Effectiveness Group (CEG) for ratification. Once this process is completed, the reports are published and disseminated appropriately for implementation and monitoring.

The reports of 100% of completed local clinical audits and evaluations were reviewed by the provider in 2025/26 and Combined Healthcare intends to take the following actions to improve the quality of healthcare provided:

- Areas for action include but are not limited to:
- Creation of a visual display / infographic of relevant physical health forms on the electronic patient record, to be posted in doctors' rooms.
 - Development of tic management posters in line with local guidelines.
 - Display of an antipsychotic monitoring sheet in all clinic rooms.
 - Education to be provided to staff around prescribing of parenteral thiamine.
 - Encourage outcome measure completion via engagement strategies.
 - Standardisation of completion points for outcome measures for all participants of the coping skills group.
 - Training for ward staff to be provided by the diabetic team.

Once actions have been implemented, a re-audit is undertaken to determine if the actions made have resulted in improvements to the quality of healthcare. Further details are available via the Trust website: combined.nhs.uk/about/quality-and-innovation.

Participation in research, development and innovation

Research and Development – Research, Evidencing Practice, and Innovation

In 2025, we completed our three year research and innovation roadmap, aligned to the Trust strategy and our ambition to inspire research, support evidence based practice, and foster innovation. This final year reflects significant achievements and learning that will shape our next phase.

Research Hosted

Hosted research was supported across our clinical teams, with R&D playing a central part in identifying and determining suitable studies, supporting Principal Investigators (PI), managing setup and delivery, and assuring compliance with sponsor and regulatory approvals. In 2025/26, the Trust hosted 27 research studies, 17 of which were high quality studies adopted onto the National Institute for Health and Care Research (NIHR) portfolio, and recruited 256 participants to those studies, a 43% increase (n=179) from 2024/25. There has been a 17% increase in the number of Principal Investigators (PIs) leading studies at the Trust over the past year, from 12 to 14. In addition 22 staff completed Good Clinical Practice (GCP) training (the agreed international standard for involvement in clinical research), a 16% increase (n=19) from 2024/25.

Research Sponsored

A key achievement for 2025/26 was the development and launch of the Research Sponsorship pathway in April 2025. Over the last year, we have engaged internal and external stakeholders, liaison with key regional partners, and created a robust framework. To date, there are nine potential applications with one pending application – ready to be taken to Stage 2 of the sponsor review.

Research Engagement

In 2025/26, we strengthened research visibility by creating a presence in community lounges, built partnerships with our vertically integrated Primary Care practices, appointed Research Champions, and supported Chief and Principal Investigators to develop their skills.

Research Partnerships

The R&D team continued to collaborate with a wide range of partners, including Keele and Staffordshire Universities, the NIHR Regional Research Delivery Network West Midlands, Midlands Partnership NHS Foundation Trust, the Staffordshire and Stoke-on-Trent / Shropshire / Telford and Wrekin Research Partnership (SSHERPa), and the new Central and North West Midlands Clinical Research Delivery Network. These partnerships support portfolio management, staff development, and opportunities for joint research activity.

Evaluation

R&D continued to lead and support strategic evaluations within the Clinical Audit and Evaluation programme. Clinical Academics enhanced the Trust's evaluation and research output through collaboration, publications, and proposal development. Staff were encouraged to evidence and share their work, resulting in 21 publications this year. Some of these include:

- Lister, J., Ulleri, G., & Kaur, R. (2026, January 26). Down's syndrome guidance: Why learning disability nursing must be at the centre. Learning Disability Today.
- Gaskell, C., Keeling-Ball, C., Furniss, C., & Evans, J. (2025). Practice effects and long delays: A case report exploring a novel approach to detecting accelerated long-term forgetting. Archives of Clinical Neuropsychology, 40(7), 1444–1452.
- Lonsdale, J. (2025). Let's play with EMDR: The fundamentals of EMDR with children, adolescents and teens. EMDR Therapy Quarterly, Spring 2025.

Innovation

Innovation at the Trust is orientated around innovative approaches, and forms one of the three key building blocks to making an organisation Outstanding. During 2025/26 we coordinated key events and initiatives focused on supporting, developing, and showcasing innovation, including:

Dragons' Den 2025

Dragons' Den saw applicants pitch to our fantastic panel. Successful projects included; Reducing MRI anxiety through CBT-based virtual reality exposure therapy; Expanding our behavioural support pathway through bespoke and evidence-based group interventions; Connecting Care – supporting diversity of accessibility information for patients and carers; Flock of Hope - An art installation promoting recovery, unity and sustainability; and Supporting Inpatient Peer Support Workers' meaningful, accessible engagement activities and interventions.

Celebrating Combined 2026

Celebrating Combined was held on the 11th of February 2026 - showcasing how storytelling is strengthening the Trust's culture of clinical audit, quality improvement, innovation, and research. Keynotes demonstrated, Dr Amar Shah (National Clinical Director for Improvement) and Nancy Dixon (Healthcare Quality Improvement Quest), how data and clear communication drive meaningful change, while breakout sessions focused on shared purpose and action planning. The event also highlighted Trust led innovations—from improved neuropsychology documentation and enhanced carer support to Dragons' Den funded wellbeing tools and the new research sponsorship pathway.

Looking forward to 2026/27

2025/26 was an exciting year for research, evidence, and innovation. In 2026/27, we will refresh our Research and Development Roadmap, explore opportunities to recruit additional clinical academics, expand the research portfolio, and pilot our new research sponsorship process. We will also strengthen innovation processes, including developing our approach to Intellectual Property.

Statement from the Care Quality Commission

North Staffordshire Combined Healthcare NHS Trust is required to register with the Care Quality Commission (CQC) (registration number CRT1 – 17707835325), and our CQC-regulated activities include:

Accommodation for persons who require nursing or personal care:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services

Surgical procedures at the following locations:

- Ashcombe Centre
- Bennett Centre
- Blurton CAMHS
- Broom Street
- Darwin Centre
- Dragon Square
- The Greenfields Centre
- Harplands Hospital
- Hilda Johnson House
- Holmcroft Surgery
- Hope Centre
- Keele Practice
- The Lymebrook Centre
- Marrow House
- Moorcroft Medical Centre (Branch surgery – Moss Green)
- Roundwell Place
- Summers View
- Sutherland Centre
- Trust headquarters
- The Willows

Further information regarding our registration and compliance process can be found in the papers to the Trust Board at combined.nhs.uk/about/our-board/board-meetings, on the Trust's public website combined.nhs.uk/about/cqc/ or on the Care Quality Commission's (CQC) website cqc.org.uk.

CQC inspection

North Staffordshire Combined Healthcare NHS Trust received an overall 'outstanding' rating from the CQC in 2019.

This prestigious rating placed us among the top mental health providers in England.

In November 2021, the CQC inspected our primary care services, Moorcroft and Moss Green. The services received an 'outstanding' rating for being well-led. Additionally, they were rated as 'good' within Safe, Effective, Caring and Responsive domains.

There have been no enforcement actions required by the Trust during 2024/2025

CQC Special Reviews and Investigations.

The CQC has not required the Trust to participate in any special reviews nor investigations during 2024/2025.

Statement on data quality

Data Quality Maturity Index (DQMI)

The DQMI is a monthly publication intended to raise the profile and significance of data quality in the NHS by providing trusts with consistent and transparent information about their data quality. NHS providers, and any third-sector organisations providing secondary mental health services are measured against key national data sets to create a composite indicator of data quality at a provider level.

The latest published DQMI score for the Trust stands at 98.7% (November 2025). This position places the Trust as having the joint second highest DQMI score across NHS trusts that submit the mental health services data set. Planned workstreams are in place to seek continuous improvement of data quality through clinical engagement and focused reporting.

NHS number and General Medical Practice Code validity

The Trust submitted records during 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, included in the latest published data (November 2025).

The percentage of records in the published data, including patients' valid NHS number, was:

- 100% for admitted patient care
- 100% for outpatient care

The percentage of records in the published data, including patients' valid General Medical Practice Code, was:

- 100% for admitted patient care
- 100% for outpatient care

N.B. The Trust does not provide accident and emergency care.

Data Security and Protection Toolkit

The Trust measured its performance using the online self-assessment tool declaring compliance with the National Data Guardian's 10 data security standards.

External clinical coding audit

In October 2025 the Trust was subject to the annual external clinical coding audit for 2025/26 by an NHS Digital approved auditor.

The results in the audit report for accuracy regarding clinical coding (diagnosis and treatment) are:

- 100% Primary diagnosis
- 97.5% Secondary diagnosis
- 100% Primary procedures coded
- 100% Secondary procedures coded

The services reviewed in the audit were Adult Mental Health Illness and Old Age Psychiatry.

The Trust achieved Exceeded for the Data Security & Protection Toolkit contributing outcome E4b.

Relevance of data quality

The availability of complete, comprehensive, accurate and timely data is an essential component in the provision of high-quality mental health services and risk management. It is also required to ensure compliance with external regulatory requirements and national and local targets, standards and contractual requirements.

Good data quality is essential to ensuring that, at all times, reliable information is available throughout the Trust to support clinical and/or managerial decisions. Poor data quality can create clinical risk, compromise effective decision-making and impact on the Trust's ability to monitor standards of care and secure income for its services.

Safe and efficient patient care relies on high-quality data, and by taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care.

Data quality metrics

To make our governance process manageable, and monitoring proportionate, appropriate key data quality metrics have been developed and kept under review to support governance arrangements. This is discharged via review of our business processes; identification of critical data flows; analysis (potential and actual) of data quality issues; definition of key data quality performance measures; and agreeing tolerance thresholds (beyond which issues are escalated).

Action to improve data quality

There is a need to create a culture and understanding in staff of the value of capturing high-quality data in real time, to improve patient care. All staff are required to continually record accurate data to ensure and evidence high-quality care to all patients and stakeholders.

Other actions include:

- on-the-job training and induction programmes to ensure that data is entered correctly onto systems, and system champions to support clinicians
- regular audits to check the quality of data to ensure that data is recorded accurately, completely and kept as up to date as possible.

Data Quality Forum – data issue management

The Trust has a clear management structure which clarifies responsibilities and accountabilities for individuals who enter data. This ensures accountability for levels of data quality and accuracy. The Data Quality Forum consists of representatives from corporate services and clinical directorates (data champions who take a leadership role in resolving data integrity issues).

The Forum is responsible for data issue management and the process of reducing and removing barriers that limit the effective use of data within the Trust. This includes identifying data quality issues, approving definitions, establishing quantification of issues, prioritising data quality problems, tracking progress and ultimately resolving data quality issues.

The Forum also guarantees a high standard of data quality within clinical systems across the Trust, and identifies changes needed for systems or processes to deliver improvements in data quality. It also ensures that clinical and non-clinical staff are aware of their responsibilities surrounding excellent data quality standards via continuous communication and promotion of standards.

Data Quality Assurance Framework

The Trust has signed up to, and participates in, the Data Quality Assurance Framework run by NHS Digital. The framework is aimed at provider organisations who, in terms of data quality assurance, wish to expand their existing data quality assurance processes and practices.

It covers five main themes:

- Oversight
- Process
- People
- Systems
- Measures

Looking ahead

Within each theme, objectives are described, benefits associated with it, and current best practice, such as:

1. Having a detailed and comprehensive systems training programme is critical to defining data quality responsibilities and expectations, establishing best practice and gaining user acceptance of the system. Training is used to provide clear understanding of how the system has been configured to deliver best practice, what good data quality looks like and how this directly supports delivery of high-quality patient care. Furthermore, high-quality systems training promotes user confidence, which reduces the risk of data errors.
2. Having a dedicated group within the organisation's governance structure to define and oversee the implementation the data quality strategy and associated data quality policies provides the focus to set and drive the data quality agenda. The Trust's Data Quality Forum meets on a regular basis to ensure our data quality policies and strategy remain relevant and are implemented.
3. Using internal data quality metrics to ensure that acceptable quality thresholds are clear, in place and visible to all. They provide assurance of adherence to national information standards and internal quality standards, thereby offering confidence to data users across both primary and secondary use settings. The Trust manages a suite of internal metrics through the Improving Quality and Performance Report (IQPR) and directorate performance dashboards. This enables improved identification of data quality issues, planning and prioritisation of actions and improvements.

Data Quality Internal Audit

In the Internal Data Quality Audit 2024/25, MIAA undertook a Key Performance Indicator (KPI) Data Quality Review of the risk assessment and care plan metrics to provide assurance that systems and processes are in place to accurately report performance against the Trust's KPIs. They made an overall assessment opinion of substantial assurance with three medium and two low operative effectiveness improvement opportunities.

The report concluded that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

Although the Trust is performing well in terms of ensuring excellent data quality across our systems, there are a number of initiatives underway to maintain and improve performance in the following areas.

Meeting key national performance/ data requirements 2025/26:

- Performance monitoring of NHS Mental Health Operational Planning Priorities, including demonstrating and improving productivity in our services
- Performance monitoring of NHS Mental Health National Metrics
- Embedding Outcome Reporting within services

Our strong partnerships with digital colleagues and closer collaboration with our clinical teams across all areas of the Trust will enable us to continue on our journey towards ensuring outstanding data quality.



Part three – other quality achievements and reporting against Key indicators

Key achievements 2025/26

Key Achievements in Coproduction, Involvement and Lived Experience (2025/26)

1. Year-on-Year Increase in Service User and Carer Engagement & Co-Production

Across Q1–Q3 2025/26 the Trust recorded clear, measurable growth in engagement.

The Wellbeing & Recovery College saw active students rise from 321 in Q4 2025 to 505 by Q3 2025/26, a 57% increase

Expressions of interest to enrol as a wellbeing college student climbed steadily (69 in Q4 2025, 83 in Q1 2025, 60 in Q3)

SUCC engagement remained strong with monthly meetings, contributing to service redesign, care planning, and the new 'What to Expect' service information videos

The Talk & Change Group contributed to LD resources, co-delivered workshops, and directly informed OT assessment tools
Youth voice via Elevate expanded into digital transition tools and supported Families First project.

2. Embedding Cultures, Systems and Processes Supporting Co-Production

The Trust fully transitioned inpatient services to coproduced care planning in November 2025, which included new Electronic patient records forms and documents. This change has released more time to care and ensures care plans and recovery goals are co-produced with patients and families.

A new Community Meetings Standard Operating Procedure was introduced to standardize and ensure weekly co-produced ward conversations happen and are cofacilitated by someone with lived experience. The meeting agenda templates have been designed as Easy Read templates by our learning disability and Autism experts by experience supporting accessibility for all.

Lived-experience staff shaped multiple policies – including Stress at Work, enhanced observations, trauma-informed practice, reasonable adjustments – ensuring meaningful involvement in governance

Peer and volunteer voices were consistently present in PLACE inspections, recruitment panels, and Observe & Act reviews across Harplands wards, ATU, Summers View, Dragon Square, Darwin Centre and Hilda Johnson House.

The Wellbeing & Recovery College team contributed to internal Trust training, including:

- Delivery of Team Recovery Implementation Plans for each ward. We also delivered group-facilitation workshops for inpatient and community staff to support recovery-focused group delivery.
- Reasonable Adjustments training input, offering lived-experience insight around neurodiversity and disability inclusion.
- CAN Disability History Month presentations, including personal reflections on Access to Work and workplace adjustments.
- Contributions to and production of the quarterly Culture of Care Newsletter, supporting shared learning across the Trust.

This positioned the College not only as a service to the public, but as a core internal development resource for workforce culture, compassion, and inclusive practice.

3. Progressing the Recovery-Focused Culture of Care Programme

Recovery Conversations and TRIP plans were rolled out Trust-wide across inpatient wards. As part of the Culture of Care programme, the Wellbeing College team delivered group-facilitation training for staff responsible for leading patient-participation spaces. This included TRiP-aligned facilitation skills, co-production methodology, and frameworks for hosting psychologically safe group conversations. The training increased staff confidence in running structured, recovery-oriented group sessions and ensured consistency across inpatient areas.

Peer Support Workers expanded significantly: one Band 5 Senior Peer Worker recruited, plus six new Band 3 PSWs across four WTE roles, embedding lived-experience input in MDTs and ward activity.

Sensory packs were co-developed for wards to support trauma-informed, neuro-inclusive therapeutic environments.

Trauma-Informed Care training was fully co-developed by lived-experience and clinical staff and delivered Trust-wide from February 2026

Feedback from wards shows improved therapeutic engagement, reduced distress, and clearer recovery-focused pathways.

4. Increasing Partnerships & Lived Experience Workforce Recruitment

Volunteer interest remained consistently high with 30–32 expressions of interest each quarter with 10 new applications progressed.

Active volunteers (including PSPs) supported EMU, wards 1,2,6, Dragon Square, Harplands Garden, Wellbeing College and more.

Peer roles increased toward the 30% expansion target, already achieved in Q3.

Nine new facilitators were trained in Q3 – combining Trust staff and lived-experience students – strengthening coproduced delivery.

Several volunteers transitioned successfully into paid PSW roles, confirming effectiveness of lived-experience pathways.

Partnerships grew significantly across Q1–Q3, with the College actively collaborating with at least nine new partner organisations, bringing the total number of College partner organisations to 50.

New community partner organisations: Support Staffordshire, British Ceramic Biennial, South Stoke Primary Care Network (PCN), Urban Wilderness USAH (Uniting Staffordshire Against Hate), Everyone Health, Royal Literary Fund, RISE, Project 93.

This expansion brought record partner-forum attendance and introduced new creative, heritage workshops, a focus on physical-health, and neurodiversity-themed sessions into the College curriculum.

5. Talk & Change Group – Learning Disability Involvement

This group played a pivotal role in shaping LD service improvements, reviewing police resources, ward documentation, and co-producing the care planning frameworks.

They contributed to the 2024 newsletter, co-delivered Wellbeing College workshops, and advised on redevelopment of the LD Assessment & Treatment Unit.

Group members also supported research projects and represented the Trust at regional awareness and inclusion events.

6. Service User & Carer Council (SUCC)

SUCC maintained consistent involvement by reviewing Trust financial updates, crisis care developments, ASD pathways, and Culture of Care progress.

Members co-produced the new carers leaflet (now published on the Wellbeing Portal) and contributed to Triangle of Care accreditation efforts.

The hub-and-spoke engagement model progressed, with three CMHTs establishing regular service-user forums feeding insights into SUCC.

SUCC members also selected REACH award winners, demonstrating their role in celebrating positive practice across services.

The Trust achieved the Triangle of Care Star 2 accreditation, with SUCC members and carers contributing to the Year 2 community review and action plan submission. Carers also sit on the Triangle of Care Steering Group, where they shape learning-lessons sessions, improvements in confidentiality documentation, and Trust-wide carer-support planning.

7. Elevate – Youth Participation & Co-Production

Elevate strengthened youth voice across health and social care. Contributions included evaluation of assessment processes for the Families First initiative, testing of a new app supporting CAMHS-to-AMHS transitions, and participation in local youth-focused engagement events.

Efforts to increase youth attendance included targeted outreach, sessions with Dragon Square, and partnerships with external providers. Their insight is now shaping new CYP complex-situations projects and Ashcombe Centre redesign.

8. Peer & Lived Experience Network Development

The Peer Support Worker Network grew to include 22 PSWs, 4 MPFT PSWs, 18 Trust staff attendees and volunteer contributors. Regular supervision, training, and shared-learning sessions ensured safe, high-quality practice.

PSWs supported recruitment, policy updates, transformation programmes and regional NHSE initiatives such as Learning in Networks and Out-of-Area Bed workstreams.

Newly recruited Peer Support Workers (PSWs)—including the Band 5 Senior Peer Worker and the six Band 3 PSWs completed a 10 week Peer Support Worker training provided by 'WithYou'.

8 Peer support workers trained to be Domestic Violence Champions for their clinical areas.

Lived experience colleagues made substantial contributions to multiple operational, strategic, and transformational workstreams, including:

- Trauma-Informed Care staff training rollout, developed and co-produced with lived-experience staff, and delivered through structured workshops designed to prevent re-traumatisation and support emotionally safe practice.
- Peer-to-Peer Supervision, delivered by senior peer staff to build reflective practice and ensure safe boundaries.
- Care Planning Transformation – co-developing new EPR templates, minimum standards, and data-capture fields to support Trust-wide adoption of co-produced care plans.
- Length of Stay / Out-of-Area Bed Placement Programme (NHSE LiN) – participating in regional collaboration with MPFT and contributing lived-experience perspective to the development of Carers Corners on inpatient wards and in community.
 - Reasonable Adjustments workstreams across both Culture of Care and TMO, ensuring neuro-inclusive and accessibility-informed approaches for staff and service users.
 - Autism Champions Network re-launch, shaping Trust-wide autism-inclusive practice.

- Trauma-Informed Policy & Enhanced Therapeutic Observations policy, including the redesign of observation practices into therapeutic engagement.
- Lived-experience representatives were integral to recruitment processes throughout the year, participating in interview cycles for roles across multiple directorates. They brought authentic insight into values-based recruitment, helped assess candidates' recovery-focused approaches, and shaped selection decisions. This included PSW, clinical, and administrative posts. Their involvement provided a crucial safeguard for ensuring staff attitudes aligned with compassion, accessibility, and co-production principles. The lived experience input is also provided in the Band 7 and above Assessment Centres redesign.
- The Trust's commitment to embedding lived experience in governance structures was strengthened by appointing a Band 5 Senior Peer Support Worker in Acute & Urgent Care, whose role includes supporting development work linked to the Coproduction & Lived Experience Plan and contributing to higher-level governance forums. This creates a direct line of lived-experience influence on Trust leadership conversations and strategic direction.

These contributions ensured lived-experience thinking influenced policy, training, environmental improvement, governance, and inter-agency systems.

Feedback

"As a result of this session I will look at my life differently, and attempt to make simple changes"

"I will remember that it's ok and valid to feel as I do"

"I've learnt that other people have the same feeling as me as I often feel like I'm the only one. I enjoyed the workshop, found it was delivered well, did not feel uncomfortable"

"I now have a greater understanding of lived experience from someone with this condition" (professional's feedback)

"As a result of this workshop I feel I can give my clients hope" (professional's feedback)

"Amazing that the college has become a thing in this time of depression, anxiety and mental health crisis in this country... Thank you so much for bringing it to Biddulph!" — from Biddulph mental health support group coordinator

Landau Staff Feedback (After a workshop)

"Hi, just wanted to let you know the guys loved the workshop today they haven't stopped talking about it. I would like too personally thank you for the opportunity — keep up the good work. I look forward to seeing you in the future, Many Thanks Andy"

Complaints Overview Year to Date

Overall, we receive a very low number of complaints when compared to NHS benchmarking data. During 2025/26 we have received 67 formal complaints (YTD to Feb 26) compared to 70 in 2024/25. When these are set against the circa 300,000 face to face and telephone clinical patient contacts equates to 0.02% of the clinical activity undertaken. Our continued focus is around early resolution and addressing concerns via PALS and front-line teams where possible.

Over the past year we have strengthened our complaints procedure to provide timely and quality investigations and responses. This has also been confirmed by the removal of the PIP having achieved over 3 months of timely responses to complainants.

Main themes of the 67 received to date

- 19 around Lack of Support/Communication
- 2 around Attitude of Staff Nursing/Medical
- 9 CAMHS with pathway and outcome of assessment

Compliments Overview

During 2025/26 we have received 1933 compliments either directly to an individual team or via the FFT responses.

PALS Overview Year to Date

Main themes of the 258 received to date

- 60 around Lack of Support/Communication
- 13 around Attitude of Staff Nursing/Medical
- 18 around Discharge Decision
- 10 around Medication concerns

FFT Overview Year to Date

Using this important national feedback tool, which supports the fundamental principle that people who use NHS services, should have the opportunity to provide feedback of their experience we have during 2025/26 received to date feedback from 2247 service users, which is in line with responses received during 2024/25. There is a continued high rate of satisfaction with 83% of responses rating the Trust as good or very good, 4% were undecided and 11% who rated the Trust as poor or very poor.

We have continued to utilise new technologies with the text messaging service and MS Forms, alongside the FFT cards, QR codes on all correspondence and on the Trust website.

Rating of the 2247 received to date

- 1561 Very Good
- 318 Good
- 88 Neither Good nor Poor
- 72 Poor
- 188 Very Poor

Overall percentage of Good/Very Good is 83%

Progressing our Patient Carer Race Equality Framework (PCREF)

Over the past 12 to 18 months, progress has been made in strengthening the collection and analysis of data related to health inequalities, ethnicity recording, patient safety incidents and Mental Health Act activity. The work underpins both PCREF implementation and broader regulatory compliance.

Throughout the year we have improved our compliance with recording ethnicity allowing for more accurate data to be collected around;

- Admissions into Hospital
- MHA detentions
- Patient Safety incidents
- Incidents of racial abuse
- Referrals into service

Thus far the data suggests;

- for the area we have slightly less “White” and “Other ethnic groups” admissions as a percentage of the population than the census split suggests, with all other ethnicity’s admissions being slightly higher than the census split. Our current data analysis shows a relatively stable inpatient ethnicity profile.
- When reviewing Mental Health Detentions, the ethnicity breakdown of people detained under the Mental Health Act broadly aligns with the Stoke-on-Trent population ethnicity breakdown.
- Analysis of Patient Safety data shows that most incidents involve patients from the White British ethnicity group, which reflects the local population demographics. Most reported incidents result in no or minor harm
- Ethnicity recording is generally high, although some variation remains across services, including a small proportion recorded as unknown or not stated.

- Incidents of racial abuse mainly occurs within our inpatient setting. We do have processes in place to support individuals who are subject to racial abuse, we also ensure that this is recognised as a hate crime, we still have more to do to reduce the occurrence of this.
- The occurrence of racially motivated incidents is across multiple groups, though most perpetrators are recorded as White British.

In response to the Care Quality Commission published guidance outlining how PCREF implementation will be assessed during inspections. The Trust has completed a self-assessment; throughout 206-27 the following will remain key areas of focus and development;

- Cultural competency and anti-racism training
- Staff awareness and engagement with PCREF
- Improved recording and completeness of ethnicity data
- Further validation of self-assessment findings through inspection and patient feedback

Providing continual support to our staff for continual professional development (CPD)

The learning management system (LMS) supports over 300 courses, covering:

- Statutory and Mandatory
- Staff Counselling and Support
- Health and Wellbeing
- Admin and Corporate
- Information and Bite-size Workshops
- Organisation and Personal Development
- Physical Health Training
- Talent and Leadership
- Quality Improvement
- Digital and Clinical Systems
- Coaching Culture
- Physical Skills

Our CPD outside of our online offer has expanded. Here are some examples of the training and development our staff have attended during 2025/26:

- Funded attendance at numerous conferences – nationally, regionally and locally
- Funded numerous leadership programmes – nationally, regionally and locally
- Non-medical prescribing programmes
- Therapeutic intervention and therapy training and development

- Assessment and Risk Assessment of Children and Adolescents in Crisis
- RAID® (Reinforce Appropriate, Implode Disruptive)
- Institute of Leadership and Management (ILM) coaching
- Motivational interviewing theory and skills
- DBT (Dialectical Behaviour Therapy)
- Trauma-informed care
- Compassion focused therapy
- ACT Skills for children and adolescents
- Stress and anxiety
- Degree / master modules
- Neuropsychiatric Disorder
- Children's bowel and bladder training
- Civility and respect
- Safety pods
- Quality improvement

Patient-Led Assessments of the Care Environment (PLACE) 2025

The Patient-Led Assessment of the Care Environment (PLACE) for Combined Healthcare was completed in line with the target dates set by NHS England. PLACE aims to promote the principles established by the NHS England that focus on areas that matter to patients, families and carers: putting patients first

- active feedback from the public, patients and staff
- adhering to basics of quality care
 - ensuring services are provided in a clean and safe environment that is fit for purpose

PLACE assesses a number of non-clinical aspects of the healthcare premises identified as important by patients and the public:

- Cleanliness
- Food and Hydration
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia: how well the needs of patients are met
- Disability: how well the needs of patients with a disability are met

All assessments were completed in accordance with the PLACE guidelines and with a team of at least 50% representation from NSCHT Service User Care Council (SUCC) or Patient representatives. This year we were fortunate to have four patient assessors who engaged and completed the PLACE assessments in all our premises. Many favourable comments were received on how we had maintained/improved our standards and taken on board previous recommendations to enhance our environment and our service users experience. The management representation included Facilities and Estates

PLACE 2025	Cleanliness	Food and Hydration			Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
		Food	Organisation Food	Ward Food				
	%	%	%	%	%	%	%	%
Harplands Hospital	98.92	95.92	91.32	98.35	98.05	94.51	99.19	97.46
Dragon Square	100	N/A	N/A	N/A	100	100	N/A	100
A&T Unit	100	92.07	90.43	100	95.12	98.81	N/A	90.38
Darwin Centre	100	94.88	89.54	100	97.56	100	N/A	92.31
Hilda Johnson House	100	N/A	N/A	N/A	91.89	100	N/A	91.67
Summers View	100	N/A	N/A	N/A	94.74	98.75	N/A	91.67
NSCHT Organisation score	99.13	95.66	91.10	98.34	97.47	96.52	99.19	96.23
National Mental Health and LD average scores	98.82	93.15	90.60	95.34	96.36	97.37	93.29	91.97
National (mean) average score – all site types 2023	98.55	92.13	92.79	92.30	89.37	97.00	85.68	87.12

Infection prevention and control (IPC)

Infection prevention and control is an essential component of our care. We want our patients to feel they are safe and receiving the best possible healthcare with us. While the risk of an infection is small, continuing to reduce the risk of infections remains of paramount importance. The Trust has a zero tolerance to healthcare-associated infections (HCAI). The Trust demonstrates its commitment to quality improvement in IPC practice for the prevention of HCAI through the annual IPC audit programme and education and training programmes. The following is an outline of the performance in these areas during this reporting period:

- Annual environmental audits have been completed across the organisation. Audits demonstrate the Trust's compliance to the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and related guidance (revised July 2022). Across all 2025/26 inpatient and community audits, most areas score between 93% and 100%. Overall, Trust compliance is 94.7%; an improvement of 1.3% on last year's performance.
- Mandatory training (e-learning) – at the end of quarter 3, the overall Trust IPC training compliance for Level 1 was 96.4%. The Trust total for IPC training compliance for Level 2 mandatory training for clinical staff was 87.83% (excluding bank staff).
- Quarterly IPC Link Worker completed.
- Use of the weekly Newsround as a means of communication to staff.
- Flu vaccination, 52.6% uptake among frontline staff exceeding the 5% improvement required by NHS England for 2025/26 flu campaign
- The eradication of dorm style accommodation has resulted in a reduction of 66.6% of declared outbreaks.

Our Infection Prevention and Control Team uses a surveillance system to monitor and record data on alert organisms and alert conditions found in the patients that we care for. Alert organisms and alert conditions are those that may give rise to outbreaks.

The table below is based on locally produced information in the absence of information available from an independent source. Alert organisms are those bacteria responsible for several difficult-to-treat infections in humans e.g. MRSA, MSSA and E-Coli bacteraemia, Clostridium difficile and COVID-19 diagnosed through laboratory tests.

Preventing outbreaks depends on prompt recognition of one or more infections with alert organisms and instituting special control measures to reduce the risk of spread of the organism.

The below table shows our performance over the last five years.

Year	MRSA Bacteraemia	Gram-negative bacteraemia	MSSA bacteraemia	COVID-19 HCAI
2025/26	0	1	1	18
2024/25	0	0	0	51
2023/24	0	0	0	77
2022/23	0	1	0	140
2021/22	0	0	0	67

Reporting against core indicators

This section describes how we have performed against core indicators required by NHS England, and indicators of interest to key stakeholders. The indicators are grouped, as per the three quality dimensions (patient safety, clinical effectiveness and patient experience).

Each section describes the review area, the metric used to measure performance and our overall performance.

Patient safety incidents

All patient incidents are reported via Ulysses (the Trust's incident reporting system). The NHS-agreed definition for reportable patient safety incidents is as follows:

“A Patient Safety Incident (PSI) is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care.”

All identified patient safety incidents are directly uploaded to the national Learning From Patient Safety Events (LFPSE) platform for oversight from the national team as well as local integrated care boards (ICB)

The reported data is fluid, and can alter over time, therefore the table below represents our position at year end, in relation to the number of patient safety incidents within our incident report system, and the harm impact, in comparison to previous years. All incidents (clinical and non-clinical) are displayed.

Area of performance	Incidents (clinical and non-clinical)		
Impact	2023/24	2024/25	2025/26
General Incidents	5257	5253	6760
Moderate	70	107	164
Major	12	7	21
Catastrophic	71	49	59
Total	5411	5697	7004
Major and Catastrophic incidents as a % of total (i.e. those resulting in severe harm or death)	1.50%	0.98%	1.14%

The above table illustrates a static reporting in the number of incidents reported for the period of 2023/24 to 2025/26 in yearly breakdowns with minimal deviations noted.

All incidents are subject to weekly review and analysis, ensuring issues and/or trends are quickly identified, and actions implemented, enabling improved delivery of care services. When required, in accordance with our Patient Safety Incident Response policy and plan, we would commission a proportionate review to enable that wider learning into patient safety incident to help reduce the likelihood of occurrence.

The table below, relates to the number of patient safety incidents that were reported to the LFPSE and is for the period 1 April 2025 to 31 March 2026 (at present to the end of January 2026)..

Area of performance	Incidents reported to the Learning From Patient Safety Events (LFPSE) platform
Performance	There were 4014 incidents reported to LFPSE, of these the number of incidents resulting in severe harm or death of service users as a percentage of the total was 1.29%

Never events

A never event is a serious, largely preventable, patient safety incident that should not occur if the available, preventable measures have been implemented (for example, an inpatient suicide, using curtain or shower rails). The below table details our performance in 2022/26.

Area of performance	Never events
Performance	There were 0 never events during 2025/26

Patient safety incidents (previously serious incidents):

For this report, we are working towards the framework that has been provided by NHS England in relation to the Patient Safety Incident Response Framework.

The table below illustrates the number and type of proportionate reviews which have been completed since the commencement of PSIRF.

Proportionate review	Q1	Q2	Q3	Q4	Total 2024/25	Q1	Q2	Q3	Q4	Total 2025/26
Rapid Review	11	5	3	2	21	2	6	3	3	14
After Action Review	2	8	9	12	31	13	6	13	12	44
MDT Review	0	0	0	0	0	0	0	1	0	1
Patient Safety Review	0	1	0	0	1	0	0	2	0	2
Comprehensive Safety Review	5	7	11	14	37	14	6	10	10	40
Falls Comprehensive Safety Review	0	0	0	6	6	0	0	0	0	0
Thematic Review	1	0	1	0	2	1	0	0	0	1
Patient Safety Incident Investigation	0	1	0	1	2	1	1	2	2	6
TOTAL	19	22	24	35	100	31	19	31	27	108

In 2024/25 we have:

- Completed a QI project around family engagement in relation to our PSIRF policy and plan and made improvements to family involvement at all proportionate reviews
- Commenced a Trust wide review with the support of the Transformational Management Office (TMO) to ensure that our processes for suicide mitigation are embedded and match national expectations in line with the Staying Safe from Suicide best practice guidance.
- Embedded the Staying Safe from Suicide national training programme onto our learning management platform for staff training.
 - Increased our compliance with our suicide mitigation training to a high of 85% to support the above approaches.
 - Continue to work closely with our Quality Improvement colleagues to ensure that sustainable learning is maintained through our learning from patient safety incidents and projects have been completed to demonstrate this.
 - Continue to collaborate and present learning at the systems bi-annual patient safety learning conference hosted by Staffordshire and Stoke on Trent ICB.
 - Support the Real Time Suspected Suicide Surveillance meeting hosted by Staffordshire Police to share learning, review incident data support wider systems learning.

Learning lessons

During 2025/26, the Trust has continued to strengthen its organisational learning culture through the further development of its Learning Lessons Programme. Monthly Learning Lessons workshops and bulletins have provided a structured, Trust-wide mechanism for sharing insights from contemporary patient safety issues and supporting staff to embed improvements across services.

The workshops, which remain open to all staff, have focused on key areas of risk and opportunity, including reducing medication errors on acute wards; learning from national and local Regulation 28 recommendations; strengthening child protection processes within the Community Directorate; reducing avoidable device-related healthcare-associated infections; and improving how we listen to, respond to and learn from the experiences of patients and families. Together, these sessions have fostered a consistent and inclusive forum for reflection, discussion and shared ownership of safety and quality.

The monthly Learning Lessons bulletins have complemented this work by disseminating broader national and local learning across the organisation. Over the past year, bulletins have highlighted learning from national court rulings, the Nottingham Inquiry, the national Staying Safe from Suicide publications, and key topics such as consent and confidentiality, hydration, and Mental Health Act compliance. This has strengthened the visibility of safety issues, supported staff awareness and helped align local practice with national expectations.

In line with the Patient Safety Incident Response Framework (PSIRF), the Trust has continued to embed a systems-based, learning-focused approach to patient safety. To ensure learning translates into sustainable improvement, the Patient and Organisational Safety Team has continued to bridge the gap between patient safety and quality improvement. Embedding QI approaches to recommendations and action plans has ensured that learning is not only identified but tested, implemented and monitored to create lasting change. This integrated approach has supported a range of quality improvement projects arising from Comprehensive Patient Safety Reviews, including improving safety within community depot clinics, strengthening family-involvement processes, strengthening documentation and decision-making processes, addressing gaps in services for people with co-occurring needs and streamlining patient journeys across the wider system.

Collectively, these achievements demonstrate a mature and forward-looking approach to patient safety. By combining PSIRF principles with structured quality improvement, the Trust continues to strengthen its ability to learn, adapt and deliver safer, more reliable and compassionate care.

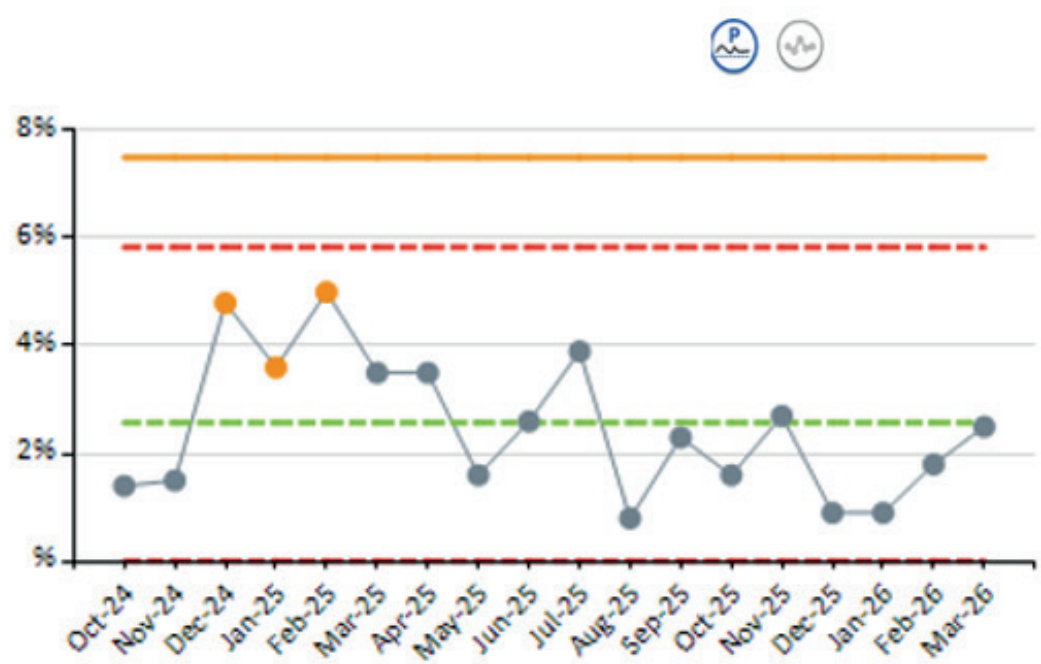
Emergency Readmission rates

This has been a key area of work and focus around embedding our person-centred framework tools in collaboration with service users and carers. The below table show the rate of unplanned readmissions for patients (adults and older adults) within 30 days. The target for this metric is <7.5%.

The readmission rate during 2025/26 was 2.1% against the less than 7.5% standard.

During 2024/25 this was 3.0% and during 2023/24 this was 3.8% and during 2022/23 this was 4.8% and during 2021/22 this was 4.5%.

Emergency Readmissions rate (30 days) (Trust Measure)



13 Month Trend

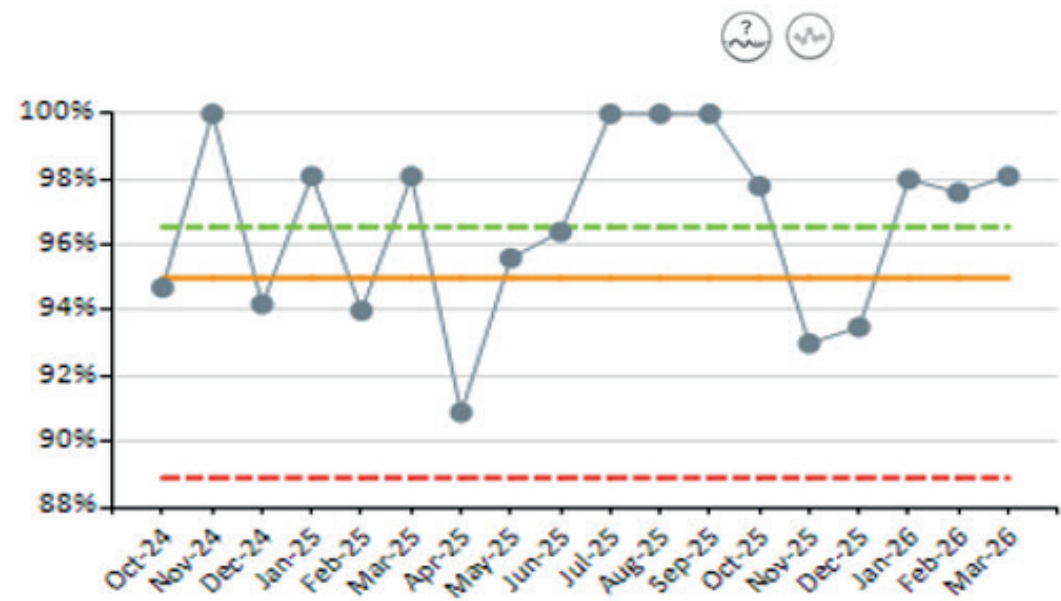
3.5%	3.5%	1.6%	2.6%	3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%
Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

48 hour follow up

The Trust’s performance continues to be positive for 48-hour follow up. During 2025/26 this was 96.7% against a standard of 95.0%.

During 2024/25 this was 96.1% and during 2023/24 this was 95.3% and during 2022/23 this was 94.2% and during 2021/22 this was 94.4%.

48 Hour Follow Up (Trust Measure)



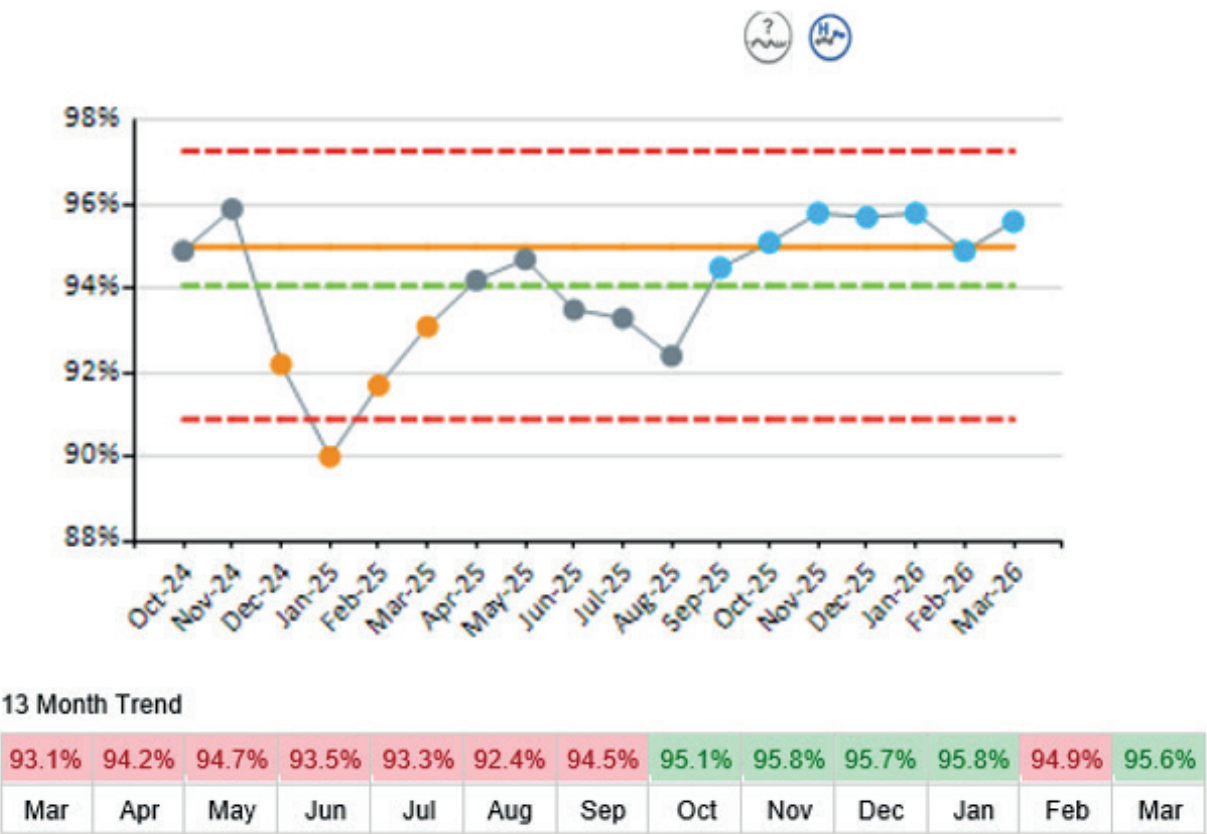
13 Month Trend

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

Referral to assessment within four weeks

The Trust’s performance for referral to assessment within four weeks for 2025/26 was 94.6% against a standard of 95.0%.

During 2024/25 this was 93.5% and during 2023/24 this was 95.0% and during 2022/23 this was 94.9% and during 2021/22 this was 96.6%.

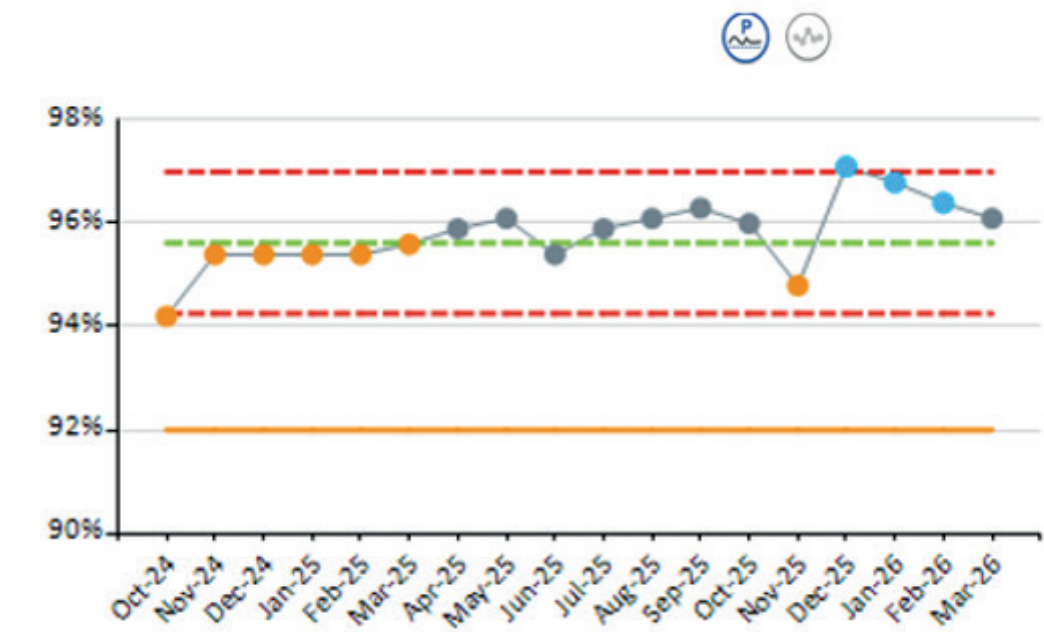


Referral to treatment within 18 weeks

The Trust’s performance for referral to treatment within 18 weeks for 2025/26 was 96.1% against a standard of 92.0%.

During 2024/25 this was 95.3% and during 2023/24 this was 96.4% and during 2022/23 this was 97.2% and during 2021/22 this was 98.0%.

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

Patient experience of community mental health services – the annual mental health community survey

On an annual basis, the CQC commissions a national survey to explore the experiences of people who receive care and treatment from community mental health services, which all mental health trusts participate in. For 2025, the survey was sent to 1,250 people who received care from the Trust between April and May 2025.

Survey response data was analysed by the national survey team and national and Trust-level results were subsequently published by the CQC on its website in March 2026 (<https://www.cqc.org.uk/publications/surveys/community-mental-health-survey>). The national findings showed that experiences of mental health care are improving, but that there are still significant barriers to appropriate care. In particular, crisis care, waiting times, involvement in and planning care, care reviews, provision of psychological therapies, and support with other areas of life were identified as areas for improvement.

At Trust level, the following areas for focus were identified:

- support in other areas of life – finding support for help with money or benefits
- involving family / carers and particularly supporting them when service users have a crisis
- how medications are discussed with service users

The results of the survey are under review by an internal working group, which is in the process of developing a responsive action plan. This will be approved at Trust level in due course and progress monitored via the performance pack.



Part four – Engagement and statements from key partners

Engaging our partners and stakeholders

North Staffordshire Combined Healthcare NHS Trust remains committed to working collaboratively with a range of partners and, as such, has engaged partners in the development and publication of this Quality Account.

We would like to take this opportunity to thank everyone who has worked with us and provided assurance. Their views and comments have helped to shape this Quality Account.

On 25th March 2026, we held our 3rd consecutive annual engagement event with Service users / carers, key partners and stakeholders at Port Vale Football Club. The primary reason for the event was to present our quality headlines for 2025/26 and to seek engagement and feedback which will help to validate or improve the findings. The feedback from the event has also helped us to further shape our quality objectives, going forward into 2026/27. The event was well attended with service user and carer representatives and over 50 different partners who we work in collaboration with to ensure that we can provide high-quality, safe and outstanding care.

Feedback from our Service users, partners and stakeholders helped us to shape this years engagement event with a key focus on the vast range of support offers available to members of our communities in the context of their mental health and wider wellbeing and offering opportunities to explore how services can come together and provide more cohesive care and support offers to our communities. The day ended with collective commitment and pledges; these will further inform our priorities for 2026/27.

Sharing the draft Quality Account

In line with the Department of Health guidance, the draft Quality Account was shared with all our key partners and stakeholders. We gained feedback from those who attended the event and extended the offer of feedback to anyone wishing to contribute but unable to attend the event..

Stakeholder Engagement Event 2026

Engagement@Combined is one of the most important stakeholder and service user engagement events we hold each year and a key part of our engagement around our quality priorities.

For 2026, this included

- Strong partnership engagement and collaboration: The event brought together a wide and diverse range of VCSE organisations, statutory partners and community services, creating a positive environment for collaboration and shared learning. Attendees described a strong energy and shared commitment to improving outcomes for local people.
- Improved awareness of community-based services: Stakeholders reported increased awareness of the breadth of community, voluntary and charitable services available locally, supporting improved referral, signposting and co-production.
- Value of face-to-face networking: Attendees highlighted the importance of face-to-face engagement, putting faces to names and forming personal relationships. The marketplace format and short presentations were effective in building meaningful connections.
- Inclusive and engaging event format: The interactive structure, including marketplace stalls, short presentations and facilitated discussions, was viewed as inclusive, accessible and supportive of open and transparent dialogue.
- Commitment to partnership working and lived experience: Feedback and pledges demonstrated a clear commitment to reducing silo working, strengthening partnership approaches and keeping lived experience at the heart of service development.

We asked for feedback on our key areas of focus going forward into 2026/27, feedback included;

Priority Area: Improving Carer Experience and Involvement

Why this is a priority

Feedback from engagement with carers has highlighted opportunities to strengthen how the Trust identifies, supports and involves carers across the patient pathway. Carers play a critical role in patient safety, recovery and experience; however, some people felt that we could be timelier in the support we offered and more proactive in helping carers to navigate services.

The Trust is therefore committed to improving the visibility, inclusion and support of carers, with a focus on earlier intervention, clearer communication, and stronger partnership working.

What we learned from carers

Our engagement has identified several key themes:

- Many carers do not self-identify, particularly family members, leading to “hidden carers” not receiving support
- Limited recognition of multiple carers involved in a person’s care
- Delayed access to support, often only available at crisis point
- Challenges navigating services with a need for more clear, accessible information
- Use of medical terminology and jargon, creating barriers to involvement
- Improve support at key transition points, especially hospital discharge
- Recognition and support in relation to the impact of caring responsibilities on finances, employment, and wellbeing
- Gaps in out-of-hours support and community-based provision

What we will do improve the experience of our patients and carers in 2026/27

The Trust will focus on the following priorities:

1. Improve identification and inclusion of carers

- Embed processes to identify carers early, including those who may not recognise themselves as carers
- Ensure all carers are recorded and involved, including multiple carers where appropriate
- Introduce consistent use of tools such as “About Me” to support personalised care
- Promote approaches that empower carers to challenge language and request inclusion

2. Enhance access to information and support for patients and carers

- Improve signposting to support, particularly at discharge and prior to crisis
- Ensure communication is clear, jargon-free and accessible

3. Strengthen workforce support for carers

- Provide training opportunities for carers with active encouragement to participate in the Wellbeing college (e.g. practical care skills, system navigation)
- Ensure carers have access to a named contact where possible

4. Deliver more integrated and collaborative care

- Further strengthen multi-disciplinary team working to include carers as partners in care
- Explore more opportunities with other services to work in partnership with patients and carers focusing on improving coordination and reducing duplication

5. Improve community and preventative support

- Expand drop-in opportunities and community-based support (e.g. carer hubs/lounges)
- Increase awareness of available services, events and support

6. Address inequalities and individual needs

- Ensure services are flexible and responsive to individual circumstances
- Recognise and respond to cultural diversity and differing family structures
- Improve access for carers who may face geographical or digital barriers
- To maintain our focus on strengthening co-production and lived experience to further embed the involvement of service users and carers in planning, delivery and evaluation of our services.

7. Use data and insight to drive improvement

- Strengthen data collection on carers' experience, access and outcomes alongside improving feedback from patients.
- Demonstrate where feedback and insight has identified gaps and showcase improvements
- Monitor progress to ensure equitable access to support

8. Develop digital and innovative approaches

- Expand use of digital resources (videos, podcasts, online sessions)
- Ensure digital solutions remain inclusive and accessible

9. Strengthen community and voluntary sector partnerships

- Continue to expand our work with partners to create inclusive volunteering and engagement opportunities
- Continuing to promote and support initiatives that enable people with lived experience to contribute

How we will measure success

Progress will be monitored through:

- Increase in identified and recorded carers
- Improved patient and carer experience and satisfaction feedback
- Increased uptake of additional community support services and resources which are accessible
- Reduced reports of delayed access to support
- Evidence of patient and carer involvement in care planning and decision-making.

Comments from key partners

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Stoke-on-Trent City Council Adults and Neighbourhoods Overview and Scrutiny Committee

Staffordshire County Council Health and Care Overview and Scrutiny Committee

Statement of directors' responsibilities in respect of the Quality Account

The directors are required, under the Health Act 2009, to prepare a Quality Account for each financial year. The Department of Health (DoH) has issued guidance on format and content of annual quality accounts. This guidance incorporates legal requirements in the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce quality accounts if they deliver services under an NHS standard contract, have staff numbers over 50 and NHS income greater than £130k per annum.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- It presents a balanced picture of the Trust's performance over the period covered
- The performance information reported is reliable and accurate
- There are proper internal controls over the collection and reporting of measures of performance included, and that these controls are subject to review; to confirm they are working effectively in practice
- The data underpinning the measures of performance reported is robust and reliable, conforms to specified data quality standards, prescribed definitions and that this is subject to appropriate scrutiny and review
- It has been prepared in accordance with Department of Health guidance

The directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing the Quality Account.

Glossary

A&E – Accident and Emergency	ISH – Intensive Support Hub
ADHD – Attention Deficit Hyperactivity Disorder	IT – Information Technology
ARFID – Avoidant/Restrictive Food Intake Disorder	KPI – Key Performance Indicator
ANTT – Aseptic Non-Touch Technique	LD – Learning Disability
ARRS – Additional Roles Reimbursement Scheme	LFPSE – Learning From Patient Safety Events
ASIST – Advocacy Services in Staffordshire	LMS – Learning Management System
BTEC – Business and Technology Education Council	MACE – Medicine and Clinical Effectiveness
CAMHS – Child and Adolescent Mental Health Services	MDT – Multi-Disciplinary Team
CAN – Combined Ability Network	MPFT – Midlands Partnership University Foundation NHS Trust
CASTT – Community Assessment Stabilisation and Treatment Team	MSNAP – Memory Services National Accreditation Programme
CBT – Cognitive Behavioural Therapy	NHS – National Health Service
CEG – Clinical Effectiveness Group	NICE – National Institute for Health and Clinical Excellence
CHIME – Connectedness, Hope and optimism, Identity, Meaning and Empowerment	NIHR – National Institute for Health and Care Research
CMHT – Community Mental Health Team	NSCHT – North Staffordshire Combined Healthcare NHS Trust
CofC – Culture of Care	PALS – Patient Advice and Liaison Service
CPD – Continuing Professional Development	PCNs – Primary Care Networks
CQC – Care Quality Commission	PCREF – Patient Carer Race Equality Framework
CRDCs – Commercial Research Delivery Centres	PICU – Psychiatric Intensive Care Unit
CRHTT – Crisis Resolution Home Treatment Team	PNA – Professional Nurse Advocate
CTV – Combined Television	POMH – Prescribing Observatory for Mental Health
CYP – Children and Young People	PROM – Patient Reported Outcome Measure
DBT – Dialectical Behaviour Therapy	PRSB – Professional Records Standard Body
DDP – Dyadic Developmental Psychotherapy	PSII – Patient Safety Incident Investigation
DNA – Did Not Attend	PSIRF – Patient Safety Incident Response Framework
DoH – Department of Health	PSP – Patient Safety Partners
ECT – Electroconvulsive Therapy	QI – Quality Improvement
ECTAS – Electroconvulsive Therapy Accreditation Service	R&D – Research and development
EMDR – Eye Movement Desensitization and Reprocessing	REACH – Recognising Excellence and Achievement in Combined Healthcare
ENRICH – Equality Network for Race Inclusion and Cultural Heritage	RCA – Root Cause Analysis
EVO – Engagement Value Outcome	SMI – Serious Mental Illness
FFT – Friends and Family Test	SSHERPa – Staffordshire and Stoke-on-Trent and Shropshire, Telford and Wrekin Health and Care Research Partnership
FTSU – Freedom To Speak Up	STR – Support Time Recovery
GP – General Practitioner	SUCC – Service User and Carer Council
HCAI – Healthcare-Associated Infections	TRIP – Team Recovery Implementation Plan
HVU – High Volume Users	UHNM – University Hospitals of North Midlands NHS Trust
ICS – Integrated Care System	VCSE – Voluntary Community and Social Enterprise
ICB – Integrated Care Board	VR – Virtual Reality
IDH – Integrated Discharge Hub	
ILM – Institute of Leadership and Management	
IMCA – Independent Mental Capacity Advocate	
IMHA – Independent Mental Health Advocacy Service	
ImROC – Implementing Recovery through Organisational Change	
IPC – Infection Prevention and Control	
IPS – Individual Placement Support	
IQPR – Integrated Quality and Performance Report	

The Trust is committed to providing communication and foreign language support for service users and carers who may need it for any reason. This Quality Account can be made available in different languages and formats, including Easy Read. If you would like to receive this document in a different format, please contact the Communications Team at communications@combined.nhs.uk or write to the FREEPOST address below:

Freepost RTCT-YEHA-UTUU
Communications and Membership Team
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Stoke-on-Trent
ST4 8HH

Enclosure No: 16

Fit and Proper Persons Test (FPPT) Annual Submission 2025/26

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☐	Advise	☐		
Information	☒				

Presented by:	Janet Dawson, Chair
Prepared by:	Lisa Wilkinson, Cortpoate Governance Manager
Executive Lead:	

Aligned to Board Assurance Framework Risk:	People - 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:	Choose an item.
Approval / Review:	Audit Committee
Strategic Priorities:	Growth - 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:	N/A

Recommendation / Required Action:	Trust Board is asked to receive this report for approval. The report has been subject to prior review by the members of Audit Committee.
Executive Summary:	This report presents the Trust's annual Fit and Proper Persons Test (FPPT) submission to NHS England for the period 2025/26. The FPPT is a statutory requirement designed to ensure that all Board members meet the necessary standards of competence, integrity, and capability to undertake their roles. During the reporting period, the Trust has undertaken FPPT assessments for all Board members, including Non-Executive Directors and Chief Officers. The submission confirms that all Board members (8 Non-Executive/Chair and 7 Executive Directors) have been assessed and confirmed as fit and proper, with no identified breaches or cases requiring mitigation. The Trust continues to apply the NHS Leadership Competency Framework as part of its assessment process, strengthening the robustness and consistency of evaluations. Formal declarations have been completed in line with the national requirements, including independent confirmation of the Chair's compliance by the Senior Independent Director, and the Chair's confirmation that all Board members meet the FPPT requirements. Overall, the Trust can provide high assurance that robust processes are in place and operating effectively to ensure ongoing compliance with the FPPT framework. There are no outstanding issues or risks requiring escalation, and arrangements are in place to ensure continuous monitoring and re-submission should any changes arise.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Audit Committee Members virtually	03.06.2026
V1	Private Board	05.06.2026
V1	Public Trust Board	09/07/2026

Appendix 5: NHS FPPT submission reporting template

This is a submission form. If anything changes during the year, submit a new form and notify an RD immediately. Do not alter the form.

NAME OF ORGANISATION	TYPE OF ORGANISATION <i>Select organisation</i>		NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:
North Staffordshire Combined Healthcare NHS Trust	X	Trust	Janet Dawson	(2025/26) – Date of Test: May 2026
		Foundation Trust		
		ICB		

Part 1: FPPT outcome for board members including starters and leavers in period

Role**	Total Number Count	Confirmed as fit and proper?			Leavers only	
		Yes	No	How many Boad Members in the 'Yes' column have mitigations in place relating to identified breaches? *	Number of leavers	Number of Board Member References completed and retained
Chair/NED board members	8	x		0	0	
Executive board members	7	x		0		
Partner members (ICBs)						
Total	15					

* See 3.8 'Breaches to core elements of the FPPT (Regulation 5)' in the Framework.

** Do not enter names of board members.

Have you used the Leadership Competency Framework as part of your FPPT assessments for individual board members?	Yes	
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Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
Internal Audit	04.08.25	Overall assurance rating - Substantial	Internal Audit raised 3 medium risk recommendations, which related to ensuring robust audit trails for recruitment checks were retained, regular update and maintenance of the Board member FPPT Checks / Dashboard on ESR and developing a more robust assurance report for Board review on the FPPT compliance checks completed. Two low risk recommendations were raised regarding the audit trails for the annual checks and completion of the self-attestation forms.	All actions were completed within the agreed timeframe October 2025 – 31 st March 2026

Part 3: Declarations

DECLARATION FOR North Staffordshire Combined Healthcare NHS Trust 2025/26				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director / Non-Executive Director	Pauline Walsh	26.05.26	Yes
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:		
	Yes			
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	No	If 'yes', provide detail:		
	N/A			
<i>As Chair of North Staffordshire Combined Healthcare NHS Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.</i>				
Chair signature:				
Date signed:	03.06.26			

For the regional director to complete:	
Name:	
Signature:	
Date:	

Enclosure No: 17

COMMITTEE EFFECTIVENESS REVIEW 2025/26

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	09 July 2026
Assure	☐	Advise	☐		
Information	☒				

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

Aligned to Board Assurance Framework Risk:	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 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
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 has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	Receive the paper for information.
Executive Summary:	This report provides the Trust Board with a consolidated summary of the six Committee Effectiveness Reviews completed for 2025/26, drawing together the key assurance messages, common strengths, recurring development themes, and the principal recommendations agreed at Committee level. All six reports have been considered by the respective Committees and the recommendations have been accepted/approved. Across 2025/26, the Committee effectiveness reviews describe a generally strong and maturing governance environment, with Committees demonstrating effective Charing, constructive challenge, and improving assurance culture. The collective picture is one of Committees functioning well, with development needs focused primarily on refinement and consistency rather than fundamental weaknesses. However, the reviews also identify cross-cutting opportunities to strengthen the Trust-wide assurance framework further, particularly around agenda / cycle-of-business (CoB) discipline, paper quality and timeliness (especially where ad hoc meetings occur), clarity/consistency of assurance reporting, horizon scanning, and the clarity of Committee to Board reporting and interfaces. Recommendation: The Trust Board is asked to: • Receive this briefing summary of Committee Effectiveness Reviews for 2025/26. • Note that the six Committee Effectiveness Reviews have been completed and the recommendations have been accepted/approved at Committee level • Take assurance from the overall positive assurance position described across Committees and note the cross-cutting development themes being progressed through agreed Committee actions.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Private Trust Board	05/06/2026
V1	Public Trust Board	09/07/2026

REPORT TO TRUST BOARD

Committee Effectiveness Reviews –2025/26

Purpose of the Report (Executive Summary)

This briefing provides the Trust Board with a consolidated summary of the six Committee Effectiveness Reviews completed for 2025/26, drawing together the key assurance messages, common strengths, recurring development themes, and the principal recommendations agreed at Committee level.

All six reports have been considered by the respective Committees and the recommendations have been accepted/approved.

Headlines

Across 2025/26, the Committee effectiveness reviews describe a generally strong and maturing governance environment, with Committees demonstrating effective Chairing, constructive challenge, and improving assurance culture. The collective picture is one of Committees functioning well, with development needs focused primarily on refinement and consistency rather than fundamental weaknesses.

However, the reviews also identify cross-cutting opportunities to strengthen the Trust-wide assurance framework further, particularly around agenda / cycle-of-business (CoB) discipline, paper quality and timeliness (especially where ad hoc meetings occur), clarity/consistency of assurance reporting, horizon scanning, and the clarity of Committee to Board reporting and interfaces.

Cross Committee themes

Strengths are:

1. Constructive challenge and positive committee culture

Multiple reviews explicitly describe open, respectful environments where members feel able to contribute, challenge, and express views, supported by effective Chairing.

2. Improving governance maturity and more structured ways of working

Several Committees describe maturing approaches—e.g. improvements in meeting structure and focus (PCDC), strengthened alignment to forward plans/CoB (Quality, Charitable Funds), and continued development of oversight maturity (F&R, Audit).

3. Clear evidence of strong performance in core assurance Committees

The Audit Committee review explicitly concludes it is “functioning strongly and effectively” and recognises it as a credible assurance body.

The Finance & Resource Committee review similarly describes strong performance and maturing oversight with robust, respectful discussion and open challenge.

The Quality Committee review highlights maturing scrutiny across clinical governance and a strengthening challenge culture, with 100% compliance with the one-week circulation standard noted in the data template.

Trust-wide Development Themes

1. CoB/agenda discipline and “slippage” control

The Audit Committee review identifies inconsistent adherence to the cycle of business and recommends stronger tracking for deferred/missed cyclical items.

The F&R Committee review similarly notes that deferred items risk losing visibility and recommends a deferred item tracker and pacing discipline.

The Quality Committee review highlights long agendas and meeting fatigue, recommending stronger agenda discipline and meeting flow controls.

2. Paper quality and consistency (and, in some places, timeliness)

Quality and consistency of papers emerges repeatedly:

- F&R notes ongoing variability in paper quality and recommends a pre-meeting paper quality assurance step.
- PCDC highlights variability in executive summary quality and proposes a light-touch quality check and a pre-circulation assurance step.
- Quality identifies issues with paper length/clarity and consistency of assurance conclusions, recommending report writer training and improved assurance reporting.
- Charitable Funds identifies paper timeliness as requiring improvement and recommends strengthening deadline discipline and pre-circulation review.
- REMCO identifies short-notice papers (especially for ad hoc meetings) and recommends improved notice periods and timeliness.

3. Strengthening “forward look” / horizon scanning

- The Audit review recommends strengthening horizon scanning and future-risk focus.
- F&R recommends a quarterly horizon scanning item on national policy/financial landscape.
- Quality also proposes a standing “hot topics” forward view on emerging quality priorities and national issues.

4. Clarifying interfaces and Board reporting

This theme appears in different ways across Committees:

- Audit recommends clarifying formal interface arrangements with other risk-reviewing committees and system partners.
- Quality recommends strengthening the golden thread between QAG/CEG and the Committee via structured summaries and clearer flow mapping.
- REMCO highlight the need to strengthen clarity of reporting to the Trust Board (recognising confidentiality constraints for REMCO).

Committee-by-Committee: Board-level highlights

Audit Committee (2025/26)

Assurance position: Operating strongly and effectively; credible assurance body with strong Chairing, high expertise, and robust challenge.

Key development themes: strengthen CoB discipline (exception tracker), tighten audit action follow-up/closure, increase horizon scanning, and formalise interfaces with other Committees.

Finance & Resource Committee (2025/26)

Assurance position: Strong performance and maturing oversight; robust yet respectful discussion and increased confidence in challenge, with continuing paper quality variation noted.

Key development themes: strengthen membership finance expertise (training/induction), clarify escalation for PIP underperformance, improve strategic alignment in papers, introduce horizon scanning, and embed paper quality assurance and “deferred item” tracking.

Quality Committee (2025/26)

Assurance position: Maturing scrutiny and strong engagement; strengthening challenge culture; strong paper circulation timeliness (100% within one-week standard) with improvement focus on assurance consistency and agenda manageability.

Key development themes: agenda discipline and breaks (fatigue), improve consistency/quality of assurance reporting, strengthen “golden thread” from QAG/CEG, refine deep dives, enhance operational engagement, and add forward look/hot topics horizon scan.

People, Culture & Development Committee (PCDC) (2025/26)

Assurance position: Clear maturation year-on-year; strong attendance; improved focus and depth through distinct business vs focus meetings (with focus sessions additional to bi-monthly business meetings); constructive challenge culture strengthening.

Key development themes: strengthen alignment to People Plan, improve quality/consistency of executive summaries, enhance risk readiness prior to committee, increase operational/clinical representation, and embed paper quality assurance steps.

Charitable Funds Committee (2025/26)

Assurance position: Positive culture and strong Chairing; constructive and collegiate forum; committee is still maturing strategically and needs stronger strategic objectives and assurance framework as charity activity increases.

Key development themes: articulate annual strategic objectives, clarify assurance role as the charity matures (including whether quarterly remains sufficient), improve paper timeliness and ensure ToR approval/review discipline.

Remuneration Committee (REMCO) (2025/26)

Assurance position: Operating effectively with strong Chairing and engaged membership; positive culture and appropriate challenge; governance maturing with a CoB now in place but ad hoc scheduling and short notice papers remain challenges.

Key development themes: strengthen forward planning of meetings, improve paper timeliness/notice, strengthen structured reporting to the Board (recognising confidentiality), and clarify the scope of matters for committee consideration.

Consolidated Trust-wide Action Themes

The six reviews collectively suggest that the most effective way to manage implementation is via a small number of cross-cutting governance improvements, with committee-specific actions sitting underneath. The themes below are explicitly drawn from the committee recommendations:

1. **Committee workplan discipline and tracking** (CoB exceptions / deferred items / agenda pacing)
2. **Paper quality and assurance consistency** (executive summary quality, clarity of assurance conclusions, pre-circulation checks)
3. **Forward look / horizon scanning** embedded as a routine feature of committee oversight
4. **Assurance (golden thread) and Board reporting clarity** (interfaces, structured summaries from subgroups, proportionate Board reporting where confidentiality applies)
5. **Capability / input strengthening where reviews identify gaps** (e.g., technical expertise, operational/clinical representation, induction/training).

Recommendation:

The Trust Board is asked to:

- Receive this briefing summary of Committee Effectiveness Reviews for 2025/26.
- Note that the six Committee Effectiveness Reviews have been completed and the recommendations have been accepted/approved at Committee level
- Take assurance from the overall positive assurance position described across Committees and note the cross-cutting development themes being progressed through agreed Committee actions.

Surveys and results have not been appended to the report but are available upon request.

Enclosure No: 18

Gifts, Hospitality and Sponsorship / Declarations of Relevant and Material Interests 2025/26

Report provided for:				Report to:		Public Trust Board	
Approve	☐	Alert	☐				
Assure	☐	Advise	☐				
Information	☒						
				Date of Meeting:		09 July 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:	People - 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:	Audit Committee
Strategic Priorities:	Growth - 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 has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	The Board is asked to receive this report for information.
Executive Summary:	During 2025/26, compliance with the declaration of relevant and material interests reached 98% in 2025/26, reflecting strengthened oversight and follow-up arrangements. The minor variance related to one individual who left the organisation prior to submitting a declaration; their most recent declaration was a nil return, providing assurance that no material conflicts were identified. This reflects sustained monitoring, targeted follow-up activity and clear escalation routes, including Chief Officer oversight where required. The approach taken provides assurance that potential risks of non-compliance were proactively identified, escalated and resolved within the year. The Trust's Standards of Business Conduct Policy was updated during the year to reflect the introduction of the Failure to Prevent Fraud offence under the Economic Crime and Transparency Act 2023. This update further strengthens the Trust's governance framework and reinforces expectations around transparency, ethical conduct and the proactive management of conflicts of interest. Review of the Gifts, Hospitality and Sponsorship Register and the Declarations of Interests registers demonstrates that: - Declarations are being actively maintained and updated as circumstances change, evidencing that these operate as live controls rather than a single annual exercise. Where interests are declared, they are predominantly routine and expected in nature (for example, private practice, medico-legal work, professional engagement or secondary employment). - Appropriate contextual information and mitigation is routinely recorded, supporting proportionate and transparent management of any actual or potential conflicts. - No undeclared material conflicts have been identified that would require additional mitigation beyond existing controls. Ongoing education and engagement activity throughout the year has strengthened awareness, improved the quality and timeliness of declarations, and continued to support a positive organisational culture of openness and transparency. Looking forward, further work is underway to strengthen the sustainability of arrangements, including exploration of an electronic declarations solution to enhance monitoring and reporting, and the introduction of a revised declaration form for 2026/27 to improve clarity

and consistency.

Overall, the progress made during 2025/26 provides strong assurance that the Trust's arrangements for managing gifts, hospitality, sponsorship and conflicts of interest are effective, compliant with legislative and regulatory requirements, and continue to mature.

The Audit Committee has received this report for assurance and information.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Senior Leadership Team	14/04/2026
V2	Audit Committee	04/06/2026
V2	Public Trust Board	09/07/2026

Governance Team update regarding Gifts, Hospitality and Sponsorship and Declarations of Interest to the Audit Committee June 2026

Introduction:

This report provides the Audit Committee with assurance on the Trust's arrangements for the declaration and management of gifts, hospitality and sponsorship, and declarations of relevant and material interests. It summarises progress made during the 2025/26 financial year, highlights key developments since the previous report, and outlines actions taken to strengthen compliance, oversight and assurance.

The report is supported by the current Gifts, Hospitality and Sponsorship Register, together with the Declarations of Relevant and Material Interests registers for Band 8c and above staff, Consultants and Other Staff which are provided as appendices for information.

Purpose of the Report (Executive Summary):

The purpose of this report is to provide assurance to the Audit Committee regarding the effectiveness of the Trust's Standards of Business Conduct arrangements and compliance with requirements relating to the declaration and management of interests.

During 2025/26, the Trust achieved 100% compliance with declarations of relevant and material interests for applicable staff groups. This report outlines the actions taken to reach this position, provides assurance on the nature and management of interests declared, and describes further work underway to support sustained compliance and effective monitoring.

The Audit Committee is asked to receive this report for assurance and information.

Background

Gifts, Hospitality and Sponsorship

The Trust's approach to gifts, hospitality and sponsorship is set out within the Standards of Business Conduct Policy (4.02), which is reviewed on a three-yearly cycle and was most recently reviewed in July 2024. The policy reflects legislative requirements, NHS guidance and internal audit recommendations.

Declarations continue to be recorded on a central register maintained by the Governance Team. During 2025/26, the register included declarations associated with professional and sector engagement, such as conferences, awards events and network activity, in addition to occasional patient-offered gifts. Managerial approval is recorded for accepted items, and values are captured where known, with declarations over the £25 threshold appropriately recorded where exact values were not available.

Training relating to gifts, hospitality and sponsorship forms part of the Trust's Conflicts of Interest Training via the Learning Management System. The Governance Team continues to work closely with Communications and Medical Teams to ensure sponsorship linked to Trust-hosted events is identified and recorded. Annual checks of the ABPI Disclosure UK database continue to provide additional assurance.

Standards of Business Conduct Policy Update

During 2025/26, the Standards of Business Conduct Policy was updated to reflect the introduction of the Failure to Prevent Fraud offence under the Economic Crime and Transparency Act 2023. This update strengthens the Trust's governance framework and reinforces expectations around transparency, ethical conduct and proactive identification and management of conflicts of interest.

Declarations of Relevant and Material Interests – Performance and Compliance

Compliance with the declaration of relevant and material interests reached 98% in 2025/26, reflecting strengthened oversight and follow-up arrangements. The minor variance relates to one individual who left the organisation prior to submitting a declaration; their most recent declaration was a nil return, providing assurance that no material conflicts were identified.

Towards the end of the financial year, a small number of outstanding Consultant declarations required formal escalation. These cases were escalated appropriately through Clinical Directors and, where necessary, the Chief Operating Officer and Chief Medical Officer, enabling full compliance to be achieved by year-end. This process provided assurance that potential non-compliance risks were actively identified, escalated and resolved.

Nature of Interests Declared and Assurance from the Registers

Review of the Consultants declarations register for 2025/26 shows a combination of “nothing to declare” submissions alongside a range of declared interests. Where interests are declared, these most commonly relate to private practice activity and medico-legal work undertaken outside NHS contractual hours, statutory assessment remuneration, and directorships or limited company interests. The register also evidences declarations being updated to reflect changes in circumstance, demonstrating that declarations operate as a live control rather than a single annual exercise.

The Band 8c and above declarations register similarly includes a substantial number of “nothing to declare” returns alongside declared interests typically relating to secondary employment or self-employment, professional consultancy activity, governance or voluntary roles, and indirect interests. Where appropriate, declarations include contextual information outlining boundaries and mitigation, such as confirmation that activities are undertaken outside Trust time and without use of Trust premises or resources. This supports assurance that interests are assessed proportionately and transparently.

Although not included within the formal compliance metric, declarations recorded within the Other Staff register provide additional assurance regarding organisational culture. Examples include indirect interests being proactively identified and accompanied by clear mitigation actions to manage any perceived or potential conflict.

Across all registers, no undeclared material conflicts have been identified that would require further mitigation beyond existing controls.

Education, Engagement and Culture

The Governance Team has maintained a strong focus on staff awareness and engagement throughout 2025/26. This has included ongoing communications via posters and Trust Newsround articles, targeted engagement with Consultants and senior staff groups, and reinforcement of declaration requirements through governance and clinical leadership channels.

This activity has contributed to improvements in the timeliness, consistency and quality of declarations and supports continued development of a culture of openness and transparency across the organisation.

The Governance Team also reviewed and considered recommendations from an NHS Counter Fraud Authority Learning Report in August 2025.

Strengthening Systems and Sustainability

Work is underway to explore an in-house electronic declarations solution, known as Fusion, to support improved monitoring and management of declarations. The proposed system would enable enhanced tracking, automated reminders, clearer escalation routes and improved reporting, reducing reliance on manual processes and strengthening assurance, particularly for large and complex staff groups such as Consultants.

In preparation for 2026/27, the Trust has also updated the SBC3 Relevant and Material Interests declaration form to ensure it is clear and self-explanatory. The revised form includes guidance on how to complete the declaration and clearer explanations and examples of the types of interests that are required to be declared. This change is intended to improve consistency, reduce ambiguity, and strengthen the overall quality of declarations submitted.

Together, these developments demonstrate a continued focus on sustainable controls and the ongoing strengthening of the Trust's approach to probity, transparency and effective management of conflicts of interest.

Summary

The Trust has made demonstrable progress during 2025/26 in strengthening governance arrangements relating to gifts, hospitality, sponsorship and declarations of interest. Achievement of 100% compliance for relevant and material interests, supported by clear escalation routes, updated policy alignment with new fraud legislation, strengthened guidance and continued staff education, provides strong assurance to the Audit Committee.

The nature of interests declared, and the mitigations recorded where appropriate, further support assurance that conflicts of interest are being proactively identified and effectively managed.

Recommendation

The Audit Committee is asked to receive this report for assurance and information.



Gifts and Hospitality Register 2025 - 2026

Directorate / Team	Surname	Forename	Date of Offer	Date of Receipt (If applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror Name and Nature of business	Declined or Accepted?	Approved by Manager
Holmcroft Surgery	Hughes	Melissa	01/04/2025	10/04/2025	Restaurant gift voucher offered by patient voucher kindly declined but patient insisted. Patient thanked and voucher handed back but left on the desk. Voucher made out to recipient	£30	Patient Holmcroft Surgery	Accepted	Yes
Trust Board	Gardiner	Eric	14/10/2025	14/10/2025	Dinner provided by the HFMA as a thank you for being on the national MHLDA Steering Group prior to the annual MHLDA conference. I am personally a member of the HFMA and the Trust will spend money with the HFMA on staff development throughout the year.	£32	HFMA	Accepted	Yes
Trust Board	Adeyemo	Buki	25/06/2025	25/06/2025	Overnight accommodation due to my participation as a guest chair at HPN conference session	Not known but will be greater than £25	Healthcare Partnership Network	Accepted	Yes
Trust Board	Adeyemo	Buki	27/03/2025	27/03/2025	NHS Confederation member dinner Due to evening roundtable discussion	Not known but will be greater than £25	NHS Confederation	Accepted	Yes
Trust Board	Adeyemo	Buki	11/06/2025	11/06/2025	Dinner as part of my role as Chair of the Mental Health Network	Not known but will be greater than £25	NHS Confederation	Accepted	Yes
Trust Board	Richards	Ben	07/08/2025	20/11/2025	Free place at the HSJ Awards due to my participation as a judge for the awards process.	Not known but will be greater than £25	HSJ Information Ltd.	Accepted	Yes
Trust Board	Richards	Ben	07/08/2025	15/09/2025	Free place at the HSJ Patient Safety wards due to my participation as a judge for the awards process.	Not known but will be greater than £25	HSJ Information Ltd.	Accepted	Yes
Trust Board	Richards	Ben	10/09/2025	20/09/2025	Attendance at the football match on 20/09 with associated hospitality	Not known (not on general sale) but will be greater than £25	Port Vale Foundation Trust	Accepted	Yes
Community	Poornamodan	Bindu	09/12/2025 & 13/05/2025	09/12/2025 & 13/05/2025	The Flynn pharmaceutical representative provided sandwiches for the prescribing MDT on the above dates and talked to us about their product. They were introducing a new stimulant medication. In December came to provide some more information leaflets	Approx. £15 on each occasion	The Flynn Pharmaceutical	Accepted	Yes
Corporate	Smith	Laura	19/03/2026	19/03/2026	Attendance at Spinal Injuries Association Cornflower Ball at the Emirates Stadium, Old Trafford as a guest of Hugh James Solicitors. Hospitality includes attendance at the ball and overnight accommodation. There is a relationship in place between the Trust and Hugh James via Combined Charity for which Hugh James is a supporter, specifically of the Golf Day in aid of the Trust's neuropsychiatry and neuropsychology services. The hospitality is offered as an opportunity to strengthen the networks and opportunities for the Trust Charity.	£447.10 (Table of 10 is £3450 and accommodation £107.10)	Hugh James Solicitors	Accepted	Yes

Trust Board	Mellor	Elizabeth	20/03/2026	20/03/2026	Attendance at Spinal Injuries Association Cornflower Ball at the Emirates Stadium, Old Trafford as a guest of Hugh James Solicitors. Hospitality includes attendance at the ball and overnight accommodation. There is a relationship in place between the Trust and Hugh James via Combined Charity for which Hugh James is a supporter, specifically of the Golf Day in aid of the Trust's neuropsychiatry and neuropsychology services. The hospitality is offered as an opportunity to strengthen the networks and potential corporate sponsorship for the Trust Charity. The Trust has a long-standing relationship with Huge James who offers advice and support to patients on ward 5. The firm has been approached independently to act as a sponsor of this years REACH awards.	£447.10 (Table of 10 is £3450 and accommodation £107.10)	Hugh James Solicitors	Accepted	Yes
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Corporate Register 2025 - 2026

Directorate / Team	Name	Date of Offer	Date of Receipt (If applicable)	Details of Gift / Hospitality	Estimated Value	Supplier / Offeror Name and Nature of business	Declined or Accepted?	Approved by Manager
Communications	Trust Board	28/11/2025	28/11/2025	REACH Awards 2025 sponsorship £13,000 – Dedalus – main event sponsor £500 – Stoke City FC – Diversity and Inclusion £500 – Rowtype – Leading with Compassion £500 – Serco – Proud to CARE £1,000 – Interclass – Partnership/Service User and Carer Council £500 – Port Vale FC – Team of the Year £250 – Unison – Unsung Hero £500 Town Hospitals – Lived Experience Shining Star £500 RLDatix – Learner of the Year £1,000 – Browne Jacobson – Menu (£3,000 discount) – LED Synergy - discounted price for digital walls – sponsor of pre-dinner drinks	£18,250 plus £3,000 discount		Accepted	Yes

Band 8c and Above Declarations Register 2025 - 2026							
Surname	Name	Current Position	Declared Interest (Name of the organisation and nature of business)	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared	Reviewed
Ault	Claire	Acting Chief Pharmacist	I am employed by Keele University on zero hours contract to review and mark their post graduate mental health pharmacy module.	2025 - Present		27/08/2025	y
Birks	Rachael	Deputy Chief Operating Officer	Nothing to Declare	N/A	N/A	10/04/2025	y
Blaise	Steve	Interim Asst Chief Finance Officer	I work for UHNM 2 days per week in a similar senior finance Manager role	April 2025 - March 2026		01/05/2025	y
Bloor	Rachel	Head of Nursing & Professional Practice	Nil	N/A	N/A	02/06/2025	y
Boardman	James	Consultant Clinical Psychologist and Deputy Clinical Director for the Community Directorate	Nothing to Declare	N/A	N/A	01/05/2025	y
Boswell	Victoria	Associate Director of Performance	Nothing to Declare	N/A	N/A	06/05/2025	y
Brookes	Philip	Senior Practitioner	Providing psychological therapy/consultation to private clients outside of my practice within the NHS. As I am currently full time with the NHS this work would be undertaken outside of working hours such as evenings/weekends.	12/01/2021 - Present		15/04/2025	y
Bullock	Rachel	Clinical Director, Specialist Directorate	Nothing to Declare	N/A	N/A	09/04/2025	y
Cantrell	Donna	Associate Director	Nothing to Declare	N/A	N/A	08/04/2025	y
Carr	Suzanne	ANP/Nurse Consultant	Nothing to Declare	N/A	N/A	24/02/2026	y

Cooke	Gill	Clinical Director Consultant Clinical Neuropsychologist	Nothing to Declare	N/A	N/A	01/05/2025	y
Cowan	Hannah	Consultant Clinical Psychologist	Private Practice - I offer private psychological assessment and therapy to adults in the Cheshire area/online and this takes place outside of my contracted Trust hours. I do not use Trust record forms, nor do I use Trust premises.	Ongoing - Present	DO NOT PUBLISH PERSONAL DETAILS EXTERNALLY	30/04/2025	y
Crowther	Rebecca	Interim Deputy Chief People Officer	Nothing to Declare	N/A	N/A	01/05/2025	y
Devlin	Kate	Consultant Clinical Psychologist	Nothing to Declare	N/A	N/A	16/07/2025	y
Dodds	Lisa	Deputy Chief Finance Officer	Nothing to Declare	N/A	N/A	09/04/2025	y
Ford	Michael	Associate Director	Nothing to declare	N/A	N/A	10/09/2025	y
Gaitley	Josephine	Associate Director	Nothing to Declare	N/A	N/A	09/04/2025	y
Geddes	Michelle	Assistant Chief Finance Officer	Nothing to Declare	01/04/2025 - 31/03/2026		28/08/2025	y
Grant	Zoe	Deputy Chief Nursing Officer	Governor at New Fryers College	March 2024 - Present		23/04/2025	y
Grant	Pauline	Associate Director of Organisational Development	Nothing to Declare	17/06/2025 - Present		17/06/2025	y
Griffiths	Nicola	Deputy Director of Governance	Nothing to Declare	N/A	N/A	09/04/2025	y
Hewitt	David	Chief Digital Information Officer	Nothing to Declare	01/04/2025 - 31/03/2026		08/05/2025	y
Holdcroft	Wesley	Acting Associate Director of Estates	Nothing to Declare	N/A	N/A	14/04/2025	y

Hutton	Rebecca	Consultant Clinical Psychologist	Nothing to Declare	N/A	N/A	21/08/2025	y
Joy-Johnson	Louise	Consultant Clinical Psychologist	I have my own private practice, prior to commencing my role at NSCHT (started role in Jan 2024) where I offer psychological assessments and therapy to private clients. I do not think there is a conflict of interest but declaring this for the avoidance of doubt. My husband (Nathan Joy-Johnson) is the Director of Procurement at UHNM overseeing contracts with NSCHT, this does not & should not impact on my role/clinical work. I do not think there is a conflict of interest but declaring this for the avoidance of doubt.	2019 (prior to starting in my current post) - Current 2015 - Current	I have my own private practice, prior to commencing my role at NSCHT (started role in Jan 2024) where I offer psychological assessments and therapy to private clients. I do not think there is a conflict of interest but declaring this for the avoidance of doubt. My husband (Nathan Joy-Johnson) is the Director of Procurement at UHNM overseeing contracts with NSCHT, this does not & should not impact on my role/clinical work. I do not think there is a conflict of interest but declaring this for the avoidance of doubt.	27/01/2026	y
Khan	Sobia	Consultant Clinical Psychologist	I have a Linked-In profile where I do talk about my work occasionally or promote roles or projects I am directory of 2 companies Utopia Psychological ServicesLtd – based in Newcastle Under Lyme Nurture Journal Ltd	2010 - Present 2020 - Present		02/09/2025	y
Kilanska	Ann	Consultant Clinical Psychologist	In my own time, I work privately as a Consultant Clinical Psychologist. I am registered as a sole trader with HMRC. This work is from my home base in South Staffordshire via video-call. I envisage rarely working with clients from the North Staffs area. I take referrals from online databases, other colleagues in private practice and insurance providers. I explore with referrers their NHS options on initial contact where appropriate. I do not use Trust record forms, nor do I use Trust premises or time to carry out my private practice. I am also working as a Yoga instructor at Chase Leisure Centre and online on a self-employed basis outside of my core working hours.	2016 - Present		28/04/2025	y

King	Lorraine	Consultant Clinical Neuropsychologist	1) I act as co-Patron for Headway, North Staffordshire (Registered Charity No. 1077770). 2) In my own time, I work privately as a Consultant Clinical Neuropsychologist. Neuropsychological assessment, rehabilitation and therapy in ad hoc appointment times, not during my Trust working days (i.e. Mondays, Thursdays, Fridays and weekends) I work with associate colleagues within my newly registered Ltd. Company: NWCPP Neuropsychology Ltd. (North West Clinical Neuropsychology Partnership, http://www.nwcpp.co.uk). We are all registered as separate sole traders/Limited companies with HMRC and share the NWCPP website and branding only, meeting occasionally to discuss and pass over referrals, and for clinical and peer supervision. This work is from my home base in Manchester, and most of my work is in the North-West. I rarely work with clients from the North Staffs area, and if so, would usually be for medicolegal assessment. I am registered with HMRC as a Limited Company, and am VAT registered. I take referrals from case managers, solicitors, self-referrals and occasionally medical consultants for neuropsychological assessment, intervention and rehabilitation work; as well as capacity assessments and medico-legal reports. And I pass referrals onto my associate colleagues and supervise their private practice. This work is undertaken either at my Manchester clinic rooms, from my home address, via video-call, at the clients' home, or at their solicitor's office. I explore with referrers/clients their NHS options for input on initial contact	From 2022 - Present From 2015 - Present		06/05/2025	y
Larvin	Natalie	Clinical Director/Consultant Nurse	Aesthetics Practitioner	01/04/2025 - Present		01/05/2025	y
Lines	Jason	Principle Clinical Psychologist	Other non-financial interests •Ormiston Meridian Academy – Chair of Governors, SEND Governor Financial Interest Private Practice Online Psychotherapy services – CogniWealth Clinical Psychologist, Psychotherapy	Ongoing		27/08/2025	y
Lonsdale	Jennifer	Consultant Clinical Psychologist	Self-employment – I occasionally work on a self-employed basis as a Clinical Psychologist outside of my work for NSCHT	April 2025 - Present		29/04/2025	y

Lunt	Sarah	Head of Psychological Professions	I work as an expert witness for an independent forensic psychology company (Tully Forensic Psychology), taking instruction from solicitors and the court. The work cannot be completed internally through the NHS as all assessments must be completed as an independent expert witness. Referrals all come through solicitors and are made directly to the clinical lead for the company in Nottingham, and not through any direct contact with me either in or out of my NHS post. 2.) I am a licensed tutor for the Association of Psychological Therapies. This is a Leicester based company which uses psychologists nationally to teach psychological therapies, practice and processes across the country/internationally. I use annual leave, weekends or non-working days in order to complete this teaching. N.B. I am also able to teach within my organization on behalf of this company. Where this is the case, I do not receive any additional payment for this and I work my usual NHS hours whilst the organization receives a reduction in the cost of the training. <u>N.B. I am also able to teach within my organisation on behalf of this</u>	Ongoing	1.) All expert witness work takes place in prisons, in solicitor's offices, online or in courts. It is forensic risk assessment and assessment of mental health in relation to alleged offending, independently of the NHS or prison service. I am able to choose how much work I do and when. I complete all of this work and related activity in my own time whilst I am not in my NHS employment. 2.) My role as a licensed tutor takes place in venues across the country or online. The company organize this with sponsors across the country and request my input directly. I use my non-working days, annual leave and evenings and weekends to prepare for and deliver this training.		y
Mason	Heather	Consultant Clinical Psychologist (CASTT)	Indirect interest - I am chair of a local fundraising group for the Christie Charity (reg no 1201654)	01/06/2022 - Present		03/11/2025	y
MacKay	Jessica	Consultant Clinical Psychologist	I have a part-time role in BSMHFT (NHS Trust) working as a Clinical Psychologist.	02/07/2025 - Present	NSCHT are aware of this part time role, it was declared at acceptance of my current part-time role with NSCHT.	20/08/2025	y
McCrea	Joe	Associate Director of Communications	Owner and Director, JB McCrea Ltd. Provider of communications and engagement consultancy services	January 2008 - Present	This company has not provided any services over the past 2 years and is not expected to do for the foreseeable future.	12/06/2025	y
Mercer	Gemma	Consultant Clinical Neuropsychologist	In my own time, I work privately as a Consultant Clinical Neuropsychologist. I work with colleagues who all use the name North West Neurotherapeutics (NWNT - www.nwnt.co.uk). We are all registered as separate limited companies with HMRC and share the NWNT website and branding only, meeting occasionally to discuss and pass over referrals, and for clinical and peer supervision. I take referrals from case managers, solicitors, self-referrals and occasionally medical consultants for neuropsychological assessment, intervention and rehabilitation work; as well as capacity assessments and medico-legal cases. ☐ This work is undertaken either at my clinic rooms in Warrington, from my home address via video-call, at the clients' home, or at their solicitor's office.	2013 - Present	This has been discussed and agreed with my manager I explore with referrers their NHS options on initial contact where appropriate. I do not use Trust premises, materials or time to carry out my private practice.	03/06/2025	y
Miebodei	Douebi	GP	Nothing to Declare	N/A	N/A	01/05/2025	y

Morris	Charlotte	Consultant Clinical Psychologist	Financial – provider of psychological therapy outside of the NHS, taking a small number of referrals from privately funded clients and those funded by insurance companies. Self employed basis and taking referrals from: Bupa, Axa and self-funding clients.	28/05/25 - 28/05/26		28/05/2025	y
Newton	Sarah	Associate Director of Transformation Management Office (TMO)	Nothing to Declare	N/A	N/A	12/04/2026	y
O'Byrne	Evan	GP	Nothing to Declare	N/A	N/A	11/04/2025	y
Ochogwu	Jeremiah	GP	Nothing to Declare	N/A	N/A	29/04/2025	y
O'Reilly	Kelsey	Consultant Clinical Psychologist	Secondary employment – independent psychology practice on NWD from the trust. No conflict of interest – Based in Cheshire, focus primarily on the psychology of breastfeeding, no links to NHS or statutory services.	Ongoing		20/08/2025	y
Owen	Lorna	Consultant Clinical Psychologist	Nothing to Declare	01.04.25 - Present		18/06/2025	y
Oyelade	Bolanle	Salaried GP	Nothing to Declare	N/A	N/A	02/05/2025	y
Platt	Fiona	Associate Director	Nothing to declare in relation to NSCHC. Currently director in a Dairy business but no links to the health service. Name of company Plattfarms Ltd.	01/04/2026 - 31/03/2026		29/10/2025	y
Saravanappa	Tharakeswari	Specialty Doctor	Nothing to Declare	N/A	N/A	14/04/2025	y
Self	Victoria	Deputy Chief People Officer	Nothing to Declare	N/A	N/A	23/12/2025	y
Smith	Laura	Deputy Chief Strategy Officer	Nothing to Declare	N/A	N/A	11/06/2025	y

Srejic	Gabi	Clinical Psychologist	Nothing to Declare	N/A	N/A	29/05/2025	y
Stanyer	Kim	Associate Director	Nothing to Declare	N/A	N/A	03/11/2025	y
Stretton	Rachel	Consultant Clinical Psychologist (Learning Disabilities)	Nothing to Declare	28/04/2025 - Present		30/12/2025	y
Sweeney	Helen	Deputy Director of MACE	Nothing to Declare	N/A	N/A	26/01/2026	y
Tighe	Catherine	Consultant Clinical Psychologist, NSCHT CAMHS	Nothing to Declare	N/A	N/A	10/04/2025	y
Wall	Gemma	Consultant Clinical Neuropsychologist	In my own time, I work privately as a Consultant Clinical Neuropsychologist. I work with colleagues who all use the name North West NeuroTherapeutics (NWNT - http://www.nwnt.co.uk) and North West Neurotherapeutics – Neuropsychology Experts (NWNT-NE) based in Warrington and Bury. I am a limited company my colleagues are separate sole traders and not a company, although we share referrals and peer supervision. We are open to referrals from wider than the North West if appropriate. I take referrals from case managers, solicitors, self-referrals and occasionally medical consultants. I take on assessment, intervention and rehabilitation work; as well as capacity assessments and medico-legal cases. I explore with referrers their NHS options on initial contact where appropriate. During periods of increased activity I pay for assistant support, and any support provided is within the person's own time and not as part of any other paid employment. I have made an explicit arrangement regarding the use of test materials. I do not use Trust record forms. I also provide private neuropsychology input for awake Craniotomy at the Alexandra Hospital, Cheadle, and have put a proposal together on request for Preston Hospital with Mr Ray for private ad hoc awakes.	2016 - Present		09/04/2025	y
Zahid	Sadia	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	15/04/2025	y

Consultants Declarations Register 2025 - 2026

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared	Reviewed
Adeyemo	Buki	Chief Executive Officer	Board of Governors University of Wolverhampton	Non-Financial Professional Interest	2017 - Present		16/05/2025	y
Ahmed	Wigdan	GP	Nothing to Declare	N/A	N/A	N/A	29/04/2025	y
Aiyelabola	Mofolorunso	GP	Nothing to Declare	N/A	N/A	N/A	22/04/2025	y
Alpanseque	Laura	Salaried GP	A&E UHNM- I do locum shifts as an A&E registrar at UHNM mostly, but as well in occasions in other Trusts. I do this ones outside my contractual hours with Keele Practice.	Financial Interest	All year	I make sure I follow recommendations on shift patterns, to ensure good rest, as per GMC and BMA.	15/04/2025	y
Andrew	Gemma	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	28/04/2025	y
Anwar	Saeed	GP	Nothing to Declare	N/A	N/A	N/A	30/04/2025	y
Arnold	Sally	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	03/11/2025	y
Barracough	Laura	Salaried GP	Nothing to Declare	N/A	N/A	N/A	15/04/2025	y
Bashir	Fareed	Locum Consultant psychiatrist	Medicolegal reports non-NHS- Private work outside of NHS contracted hours or time-shifted. Director of limited company for this purpose.	Financial Interest	2004 - Present		09/04/2025	y
Belgamwar	Ravindra	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	14/01/2026	y
Bhardwaj	Bhavana	Locum Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	30/03/2026	y
Carr	Darren	Clinical Director	Director of Dornlie Ltd - Medicolegal report writing business	Financial Interest	2012 - Present		28/05/2025	y
Cawley	Marie	Consultant Psychiatrist	Upcoming private role with PSICON doing ADHD assessments. Due to start March 2nd 2026. Will be a speciality doctor.	Financial Interest	02.03.2025 - Present		19/12/2026	y
Chubb	Becky	Locum Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	09/04/2025	y
Clarson	Samuel	Consultant GP	Nothing to Declare	N/A	N/A	N/A	29/04/2025	y
Ekuri	Raphael	Psychiatry CT3 Resident Doctor	Nothing to Declare	N/A	N/A	N/A	23/03/2026	y

Eligizawy	Fatima	Salaried GP/ Primary Care Clinical Director	GP Training Programme Director for North Staffordshire. No conflict/declaration of interest involved	Non-Financial Professional Interest	26/07/2021 - Present		20/04/2025	y
El-Nimr	George	Consultant Neuropsychiatrist	Educational events that I organise can be sponsored by relevant companies. I don't see private patients but am a director of a limited company through which I do occasional medicolegal work. I am a trustee for the Huntington's Disease Association of England and Wales. I am the Chair of the Faculty of Neuropsychiatry of the Royal College of Psychiatrists. My wife is a local GP.	Financial Interest Non Financial Professional Interest Indirect Interest	Present		06/09/2025	y
Enugula	Rajya	CAMHS Consultant psychiatrist	Nothing to Declare	N/A	N/A	N/A	03/03/2026	y
Fawcett	Steven	GP / Clinical Director	Clinical Director for ICB Clinical Director for Acute Care at Home - UHNM	Financial Interest	Nov 23 - Present Dec 24 - Present		12/06/2025	y
Foster	Michael	CAMHS Inpatient Psychiatry Consultant	Nothing to Declare	N/A	N/A	N/A	01/09/2025	y
Grant	Rachael	GP w ER	I am a director of a corporation. Under this my husband conducts private operations and I do private fostering and medical advisory work. The company is named Elliot Alexander.	Financial Interest	Aug 2020 - Present		27/01/2026	y
Grey	David	GP	Nothing to Declare	N/A	N/A	N/A	09/04/2025	y
Halstead	Simon	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	06/05/2025	y
Hashmi	Akbar	Speciality Doctor	Nothing to Declare	N/A	N/A	N/A	28/05/2025	y
Hassan Randhawa	Bilal	Bank Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	17/02/2026	y
Hawcroft	Victoria	Speciality Doctor	Nothing to Declare	N/A	N/A	N/A	14/04/2025	y
Izediuno	Patrick	Locum Speciality Doctor	Nothing to Declare	N/A	N/A	N/A	31/10/2025	y
Jorsh	Michael	Consultant Liaison Psychiatrist	All previous interests, such as a zero hours contract as an assessor/supervisor for the GMC and occasional medico-legal reports have been terminated. No interests beyond contracted hours	Financial Interest	01/02/2025 - Present		01/05/2025	y
Kaleem	Tabana	GP	Nothing to Declare	N/A	N/A	N/A	12/06/2025	y
Kanessan	Radhika	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	26/03/2026	y

Kumar	Manoj	Consultant Psychiatrist Bank	I held a private practice position at Emotions clinic in Stoke on Trent. It is dormant now and I am not doing any private work at all.	N/A	N/A	No ongoing patient responsibility . No private work outside my NHS role. I hold private indemnity via MPS	25/03/2026	y
Latif	Lubna	CAMHS Consultant Psychiatrist , South stoke	Nothing to Declare	N/A	N/A	N/A	03/03/2026	y
Lodhi	Mohammad	Speciality Doctor	Nothing to Declare	N/A	N/A	N/A	24/03/2026	y
Lyons	Emily	Speciality Doctor	Nothing to Declare	N/A	N/A	N/A	14/04/2025	y
Majeed	Amir	GP	Locum GP (North Staffs Federation)	Financial Interest	01/01/2020 - Present		12/06/2025	y
Mirza	Qasim	Consultant Old Age Psychiatry	Nothing to Declare	N/A	N/A	N/A	02/06/2025	y
Mittal	Raman	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	12/06/2025	y
Mohan	Mohit	Acting Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	25/07/2025	y
Nadir	Haya	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	16/03/2026	y
Parker	Helen	Specialty Doctor in Learning Disability	Nothing to Declare	N/A	N/A	N/A	30/03/2026	y
Poornamodan	Bindu	Consultant Psychiatrist	Sits in the director board of a private company and receives a small dividend. I am one of the directors of Medicas Curas Ltd, a health care company providing anaesthetic care	Financial Interest	April 2018 - Present		26/01/2026	y
Popoola	Oluwafemi	Consultant Psychiatrist	I complete section 12 mental health assessments and I am remunerated for this.	Financial Interest	01/06/2024 - Present		23/12/2025	y
Rahman	Mohammad	Consultant Psychiatrist	Nottingham and Nottinghamshire ICB - Deputy Medical Director - Senior Management Role in Midlands administrative region, which is shared by Combined.	Non-Financial Professional Interest	April 2023	Ongoing	16/02/2026	y
Randhawa	Bilal	Bank Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	24/02/2026	y
Saeed	Uzma	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	29/01/2026	y
Shivamurthy	Sasalu	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	01/05/2025	y
Shridaran	Baskaran	Consultant Psychiatrist	Astro Healthcare Ltd - Providing ad hoc medico legal reports; private consultation. Joint Director / Consultant		Feb 2020 -Present Feb 2022 - Present	In non-NHS times, evenings and weekends, in person and remote	21/08/2025	y
Sivaji	Rajeswari	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	03/05/2025	y

Slahudeen	Siraj	Consultant Psychiatrist	Director of two private Limited Companies- SS Medical Consultancy Ltd and Babs Properties Ltd Private work in my own time- as agreed in the job plan. Undertaken through SS Medical Consultancy Ltd.	Financial Interest	01/09/2018 - Present 26/10/2022 - Present 16/11/2016 - Present 01/08/2022		02/05/2025	y
Stevenson	Laura	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	04/05/2025	y
Udeze	Bernard	Consultant Psychiatrist	Medico-legal work at request of solicitors and private agencies. This service is provided via Lojja Ltd for which I am a Director.	Financial Interest	2021 - Present	Non-contractual work usually ad hoc outside contractual hours.	02/05/2025	y
Waziry	Kamran	Locum Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	21/08/2025	y
Yevtushenko	Boris	Speciality Doctor	Nothing to Declare	N/A	N/A	N/A	28/05/2025	y
Zahid	Sadia	Consultant Psychiatrist	Nothing to Declare	N/A	N/A	N/A	15/04/2025	y

Other Staff below Band 8c

Surname	Forename	Current position (s)	Declared Interest (Name of the organisation and nature of business)	Type of Interest	Date of Interest (From and To)	Action taken to mitigate risk	Date Declared	Reviewed
Brace	Bethan	Speciality Doctor	My husband has commenced a new job working as a functional assess for Capita on behalf of the DWP. He will be covering ST postcodes, and his role is part of the PIP assessment process. His assessment catchment area overlaps with the area covered by Greenfields CMHT.	Indirect Interest	23.02.2026 - Ongoing	My husband has notified his line manager of my job and the area that I cover. We maintain confidentiality in the home and do not discuss patients/clients. Should my husband identify that he is due to assess a patient for whom I have provided supporting evidence, he will escalate this appropriately within his job role. Similarly, if I receive a request for supporting information that is addressed from my husband, I will escalate appropriately and ensure that another appropriate clinician completes this request. The risk of any conflict of interest is minimal due to these measures.	03.03.2026	y
Brookes	Phillip	Senior Practitioner (Stoke Talking Therapies)	Providing psychological therapy/consultation to private clients outside of my practice within the NHS.	Financial Interest	12/01/2021 - Present		15/04/2025	y
Byers	Donna	ANP	Secondary employment outside of NHS - PA in Husbands Company	Financial Interest	April 2025 - Present		01/05/2025	y
Harrison	Diane	Education and OD Project Manager	Secondary employment with Midlands Partnership University Foundation Trust (MPUFT)	Financial Interest	Present		19/05/2025	y
Roberts	John	Digital Clinical Lead Service Manager	Health Service Ombudsman - Subject Matter Expert	Financial Interest	April 2025 - Present	Providing ad hoc advice and review of complaints relating to mental health services on behalf of the Health Service Ombudsman – subject matter expert. Reimbursed via hourly sessional time submitted for work undertaken for the case in question. No conflict of interest work will be undertaken.	02/05/2025	y
Sherratt	Katie	Team Lead -CASTT	Reiki and Crystal healing practitioner. Business name- Alchemy Healing Circles.	Financial Interest	Jan 26 - present	This work does not relate to any Trust business, and it will be completed outside of working hours.	31.12.25	y

Trust Board 2026/27 Attendance

[illegible]