

NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 10TH SEPTEMBER 2026, 10.00AM, BOARDROOM,
LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P100/26	Welcome and Apologies for Absence – Ben Richards	Janet Dawson	Note	
2	1002	P101/26	Declarations of Interests – and changes to be notified	Janet Dawson	Note	
3	1003	P102/26	Minutes of the Previous Meeting held on 9th July 2026	Janet Dawson	Note	Enc. 1
4	1005	P103/26	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	Note	Enc. 2
ADVISE						
5	1010	P104/26	Patient Story – Simon's Story	Kenny Laing	Advise	Verbal
6	1025	P105/26	REACH Recognition Individual Award – Corporate Services – Dave Norcup - Head of Information and Data Quality	Dr Buki Adeyemo	Advise	Verbal
7	1030	P106/26	Chief Executives Report	Dr Buki Adeyemo	Advise	Enc. 3
8	1040	P107/26	Chairs Report	Janet Dawson	Advise	Enc. 4
9	1045	P108/26	Questions from Members of the Public	Janet Dawson	Advise	Verbal
ALERT						

APPROVE						
10	1055	P109/26	Winter Plan	Rachael Birks	Approve	Enc. 5
11	1100	P110/26	Lord Mann Review Board Briefing	Frieza Mahmood	Approve	Enc. 6
10-minute Break						
ASSURE						
12	1110	P111/26	Safe Staffing 6 Monthly Review	Zoe Grant	Assurance	Enc. 7
13	1115	P112/26	Safeguarding Children and Adult Annual Report 2025/26	Zoe Grant	Assurance	Enc. 8
14	1120	P113/26	Board To Team Q1 Report 2026/27	Nicola Griffiths	Assurance	Enc. 9
15	1125	P114/26	Board Assurance Framework Dashboard Q1	Nicola Griffiths	Assurance	Enc. 10
16	1130	P115/26	WRES and WDES Annual Report	Frieza Mahmood	Assurance	Enc. 11
17	1140	P116/26	Improving Quality and Performance Report (IQPR) Month 4	Eric Gardiner	Assurance	Enc. 12
18	1145	P117/26	Finance Report Month 4	Eric Gardiner	Assurance	Enc. 13
19	1150	P118/26	Finance and Resource Committee Assurance Reports from the meetings held on the 6 th August 2026 and the 3 rd September 2026	Russell Andrews	Assurance	Enc. 14a and 14b
20	1200	P119/26	Quality Committee Assurance Reports from the meetings held on the 6 th August 2026 and the 3 rd September 2026	Pauline Walsh	Assurance	Enc. 15a & 15b

21	1210	P120/26	Audit Committee Assurance Report from the meeting held on 31 st July 2026	Prem Gabbi	Assurance	Enc. 16
22	1215	P121/26	Any Other Business	Janet Dawson	Note	Verbal
23	1220	P122/26	Meeting Self-Assessment	Janet Dawson	Discussion	Verbal
CONSENT ITEMS						
24	1225	P123/26	Policy Report - Business Continuity Management System Policy and Incident Response Plan	Nicola Griffiths	Information	Enc. 17
25	1225	P124/26	Trust Board Attendance Report	Janet Dawson	Information	Enc. 18

Date and Time of Next Meeting
12th November 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 9th July 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	Acting Chief Nursing Officer
Dr Dennis Okolo	DO	Chief Medical Officer
Rachael Birks	RBi	Acting Chief Operating Officer
Elizabeth Mellor	EM	Chief Strategy Officer
Frieza Mahmood	FM	Chief People Officer
Pauline Walsh	PW	Non-Executive Director / Senior Independent Director (SID)
Jennie Koo	JK	Non-Executive Director
Prem Gabbi	PG	Non-Executive Director
Dr Roger Banks	RB	Associate Non-Executive Director
Katie Lavery	KLa	Associate Non-Executive Director
In Attendance		
Nicola Griffiths	NG	Deputy Director of Governance / Board Secretary
Jenny Harvey	JH	Staff Side Representative
Lisa Wilkinson	LW	Corporate Governance Manager (Minutes)

Meeting commenced at 10.15am

73/26	APOLOGIES FOR ABSENCE Sherrine Khan - Senior Peer Support Worker Kenny Laing - Chief Nursing Officer / Deputy Chief Executive Ben Richards – Chief Operating Officer Martin Evans - Non-Executive Director Jenny Harvey - Staff Side Representative	
74/26	DECLARATIONS OF INTEREST RELATING TO AGENDA No declarations were made. <i>Noted</i>	
75/25	MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 14TH MAY 2026 P59/26 - Page 9 Quality Committee Assurance Report from the meeting held on 2 nd April and the 7 th May 2026. 'The Board received feedback from the Quality Committee visit to Older People's Community Services', should read 'The Board received feedback from the Care Quality Commission visit to Older People's Community Services'. Following the above amendment the minutes were received as a true and accurate record of the meeting. <i>Approved/Received</i>	

76/26	ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 14TH MAY 2026 There were no actions recorded during the May Public Board Meeting. Received	
77/26	PATIENT STORY – RICHARDS STORY Zoe Grant, Acting Chief Nursing Officer presented the Patient Story. Zoe Grant presented a patient story detailing Jade's experience of transitioning from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services. Due to technical difficulties, the video could not be played during the meeting; however, an overview of the story was provided to the Board. The story highlighted the positive impact of person-centred care and the support provided throughout Jade's recovery journey. Board members welcomed the positive outcome and reflected on the importance of ensuring service users feel listened to, involved in decisions regarding their care, and supported through key transitions between services. It was noted that a link to the patient story would be added to the Trust website. Noted	
78/26	REACH RECOGNITION TEAM AWARD – Acute & Urgent Care – Ward 4 Dr Buki Adeyemo, Chief Executive Officer introduced the award. Over the past 18 months, the ward has undergone significant positive transformation, creating a more therapeutic, dementia-friendly and engaging environment for patients. There have been some challenging times on Ward 4; however, this has been turned around by the compassionate, caring, and hardworking staff within the Ward. While there has been positive work across the wider Trust, including initiatives such as Culture of Care, Co-produced Care Planning and Project Chrysalis, what truly stands out is the atmosphere on the ward. It feels welcoming and positive, with staff who are happy and genuinely enjoy their work. This has a hugely beneficial impact on patient experience and wellbeing. Ward 4 are continuing to build on their progress by developing more Quality Improvement projects, particularly those focused on enhancing the patient journey between UHNM and Harplands to ensure smoother, more seamless transitions of care. They will continue their Falls Reduction work, which has already had a significant positive impact and promotes safety, independence, and rehabilitation. By maintaining their focus on innovation and patient-centred care, the team is well placed to continue driving improvements and delivering excellent outcomes. The dedication, teamwork, and person-centred approach of the Ward 4 team have led to a dramatic improvement in both service delivery and patient experience, making them highly deserving of recognition. The Board congratulated the team on their ward.	

	Received	
79/26	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: Dr Buki Adeyemo presented the report and drew the Board's attention to the recent Healthwatch Stoke publication relating to Autism and ADHD assessment services. The report highlighted increasing demand for assessments and identified areas where needs were not currently being fully met. The Board was advised that Trust teams had been proactively addressing a number of the issues identified whilst the report was being developed. Although gaps remained, a detailed response and improvement plan would be considered through the Quality Committee before being brought to the Board. During discussion, members reflected on the number of programmes, initiatives and partnerships operating across the system to support children, young people and adults requiring neurodevelopmental services. Assurance was provided that governance arrangements existed at both regional and local level, including through partnership structures and programmes overseeing investment, service development and delivery. Ongoing work to strengthen governance arrangements, particularly in relation to children and young people's services, was also noted. Members emphasised the importance of ensuring patients, families and carers are able to access the right support at the right time and raised concerns that the range of available initiatives could be difficult for service users to navigate. The need for clear signposting and effective communication about available services was highlighted. In response, the Chief Executive advised that the Trust operated a single point of access; however, recognised that pathways did not always work as effectively as intended and that there remained opportunities to learn from patient experience. It was emphasised that partnership working across organisations was essential to improving access and coordination of care. The Board also received an update on the Bridge and Beyond service and its role in supporting children and young people experiencing crisis. Members heard that services should work collaboratively to support individuals and families, rather than expecting them to navigate complex systems independently. Discussion also took place regarding the use of Emotional Freedom Technique (EFT) and broader preventative approaches to wellbeing. The Board was advised that initial feedback on EFT had been positive and that it was viewed as a welcome addition to existing support offer. However, it was recognised that further work was required to strengthen preventative approaches and address wider population health needs. A review of current activity was underway to identify opportunities for further development, with progress and recommendations to be reported through the relevant Committees. Noted	

80/26	CHAIRS REPORT Janet Dawson, Chair, provided a verbal update. The Chair reflected on recent discussions at a Board Development session regarding organisational culture, noting that a poor culture can have a significant impact on both the quality of services provided and the working environment for staff. Janet Dawson highlighted that reports from organisations where staff did not feel able to speak up contained concerning accounts and reiterated the Board's commitment to fostering a positive, open and supportive culture across the Trust. The Chair emphasised that organisational culture remained a key driver of service quality, staff experience and patient outcomes. The Chair also reported on a recent Board-to-Team (B2T) visit to Ward 6, describing it as a very positive experience. Members heard that the Ward provided a welcoming environment and demonstrated strong teamwork, reflecting positively on the service and building on recent positive feedback and inspection findings. The Chair concluded by congratulating Committee Chairs on the quality of committee reporting presented to the Board noting the consistent application of assurance levels across committee reports and commended the clarity, focus and length of the reports, which enabled effective oversight and assurance. The Board acknowledged the significant improvement in the quality and consistency of committee reporting. <i>Noted</i>	
81/26	QUESTIONS FROM MEMBERS OF THE PUBLIC The Trust continues to encourage the use of Ask the Board Online as part of its ongoing commitment to openness, transparency and innovation. There were no questions received from the public. <i>Noted</i>	
82/26	RISK MANAGEMENT POLICY Nicola Griffiths, Deputy Director of Governance, presented the policy. The Board noted the significant progress made in strengthening risk management arrangements over the last three years, including the establishment of the Risk Review Group (RRG), increased organisational understanding of risk management responsibilities, and the alignment of the policy with national guidance and best practice. Members welcomed the improvements made and discussed the Trust's approach to maintaining compliance with evolving national requirements. Assurance was provided that, although policies are approved on a three-year cycle, they are reviewed and updated sooner where changes in legislation, guidance or best practice require this. The Board discussed the relationship between the Board Assurance Framework (BAF) and the Trust Risk Register and agreed that continued work was required to ensure a clear and consistent understanding of how both arrangements support strategic risk oversight.	

	Members also highlighted the importance of ensuring staff understand their responsibilities in relation to risk management. Assurance was provided that supporting training and guidance resources were available to staff through the Learning Management System. The Board recognised the contribution of the Governance Team, particularly Jayne Mottram, Risk Manager, in strengthening the Trust's risk management framework and reporting arrangements. Action: Develop a clear and consistent explanation of the relationship between the Board Assurance Framework and the Trust Risk Register to support Board assurance during a period of significant change. <i>Approved / Received</i>	NG
83/26	HEALTH AND SAFETY ANNUAL REPORT Zoe Grant, Acting Chief Nursing Officer presented the report. Zoe Grant, Acting Chief Nursing Officer, highlighted violence, aggression and hate crime towards staff as key areas of focus. Work is underway to strengthen prevention, reporting and support arrangements, alongside a stronger organisational response to perpetrators of hate crime. Members discussed variations in incident rates across services, including unexpectedly high levels in some areas, and emphasised the importance of understanding contributing factors, including local culture and potential under-reporting. Assurance was provided that incident data was reviewed alongside intelligence from staff support services, Freedom to Speak Up and staff networks to identify barriers to reporting and target improvement activity. The Board welcomed the ongoing work and noted the need for future reports to provide a clearer summary of key issues and actions. ACTION: It was requested that the Equality, Diversity and Inclusion implications and assurance rating within the Executive Summary be reviewed to ensure they accurately reflected the report's content. <i>Received</i>	ZG
84/26	INFECTION, PREVENTION AND CONTROL ANNUAL REPORT (DIPC) Zoe Grant, Acting Chief Nursing Officer presented the report. Pauline Walsh advised that the report had been reviewed in detail by the Quality Committee and members were satisfied that it provided a high level of assurance, reflected in the level 7 assurance rating. ACTION: Members noted that the Equality, Diversity and Inclusion implications within the Executive Summary should be reviewed and updated as appropriate. <i>Received</i>	ZG

85/26	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT Rachael Birks, Acting Chief Operating Officer presented the report. The report outlined the Trust's position against the relevant standards and associated performance measures noting that whilst the report had been considered through the Quality Committee, Business Continuity arrangements were reviewed through the Audit Committee. It was suggested that consideration be given to whether reporting and oversight arrangements should be better aligned. ACTION: Review whether EPRR reporting is being considered by the most appropriate Committee. Prem Gabbi queried the level 7 assurance rating given that formal sign-off had not yet been received. Rachael Birks advised that the assessment reflected the Trust's position against the standards in place during the reporting period, where substantial compliance had been achieved. However, the standards had subsequently changed and the timing of the assessment should be recognised. Members agreed that this should be clearly reflected within the executive summary to provide appropriate context for the assurance rating. Members noted that there were no Equality, Diversity and Inclusion implications arising from the report. Received	RBI
86/26	IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) MONTH 2 2026/27 Eric Gardiner, Chief Finance Officer, presented the report. The report was presented, setting out key performance highlights, areas of exception and progress against Medium Term Plan and national mental health priorities for Month 2. The Board noted positive performance across a number of areas, including Child and Adolescent Mental Health Services (CAMHS) referral to assessment, referral to treatment, Mental Health Liaison response times, Early Intervention in Psychosis (EIP) 2-week waits, discharge follow-up, care plan and risk assessment compliance, complaints response times, Friends and Family Test performance and staff turnover. Members noted areas requiring continued focus, including CAMHS 18-week waits, talking therapies reliable recovery, sickness absence, clinical supervision and appraisal compliance. Sickness absence and appraisal remained subject to special cause variation, with improvement plans requested for appraisals. Performance against operational planning forecasts was noted, with most national priority areas meeting plan. However, Children and Young Persons (CYP) waits over 104 weeks remained below standard, with further work underway through the Performance Team and a new dashboard being developed to support improvement.	

	It was noted that the report had been considered at Finance and Resource Committee, Quality Committee and People, Culture and Development Committee. Received	
87/26	FINANCE REPORT MONTH 2 2026/27 Eric Gardiner, Chief Finance Officer, presented the report. Eric Gardiner advised that the Trust remained on plan overall. Whilst bank expenditure continued to be above planned levels, further work was required to deliver the plan. Members noted that all Cost Improvement Programme (CIP) schemes had been identified, although a financial deficit remained. The Board discussed the increasing challenge of delivering efficiencies whilst maintaining quality and safety. Assurance was provided that all savings proposals were subject to quality impact assessment, with clinical oversight from the Chief Medical Officer and Chief Nursing Officer. Members highlighted the importance of reviewing completed schemes after implementation to ensure anticipated benefits and quality impacts are being realised. A broader discussion took place regarding the sustainability of recurrent efficiency requirements across the NHS. Members acknowledged growing workforce pressures, including sickness absence, appraisal compliance and staff wellbeing, and emphasised the need to balance financial recovery with the delivery of safe, high-quality care. The importance of engaging staff, learning from examples of innovation and transformation, and maintaining open communication regarding financial challenges was recognised. Members also discussed the use of bank staffing and the need to ensure workforce deployment remains aligned to patient demand and safe staffing requirements. Ongoing work to strengthen roster management and workforce planning was noted. The Chair concluded that, whilst efficiency and productivity would remain an ongoing requirement, future financial sustainability would increasingly depend on innovation, transformation and service redesign rather than continued cost reduction alone. Received	
88/26	FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORTS FROM MEETINGS HELD ON 4th JUNE 2026 AND 2nd JULY 2026. Russell Andrews, Committee Chair /Non-Executive Director presented the reports. The report from 4 June 2026 was taken as read. Presenting the report from 2 July 2026, Russell Andrews highlighted Cost Improvement Programme (CIP) delivery and the Orbis programme as key areas of focus for the Committee, noting that considerable assurance-seeking had taken place in both areas. The Committee also reviewed the Trust's financial position and noted that performance remained in line with plan.	

	Members discussed a number of themes arising from the Committee's work, including sickness absence, bank expenditure, workforce pressures and the sustainability of delivering recurrent efficiencies. The importance of balancing financial requirements with staff wellbeing and the delivery of safe, high-quality care was emphasised. Members recognised that whilst opportunities for innovation and transformation remained important, there was growing concern about the cumulative impact of efficiency requirements on staff and services. The Board also discussed organisational communication and the importance of effective escalation processes. Members noted concerns that staff do not always receive timely responses when issues are raised and agreed that consistent acknowledgement, follow-up and feedback were critical to maintaining confidence in organisational processes. The importance of ensuring staff understand how to escalate concerns, and that concerns were acted upon promptly, was highlighted. Members noted the continuing work to strengthen workforce planning, roster management and service transformation, together with opportunities arising from national developments, including potential future changes to payment and tariff arrangements. Received	
P89/26	QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 4th JUNE 2026 AND 2nd JULY 2026 Pauline Walsh, Committee Chair / Non-Executive Director presented the reports. In relation to the June meeting, members noted discussion of the Improving Quality Performance Report, including oversight of supervision, sickness absence and Early Intervention in Psychosis performance, together with a deep dive into Out of Area Placements. Pauline Walsh advised that a number of assurance ratings had been amended by the Committee and queried whether these changes had been reflected within the Board reports. ACTION: Pauline Walsh and Zoe Grant to review and confirm the assurance ratings presented to the Board. It was noted that during the meeting the assurance ratings for the Director of Infection Prevention and Control Annual Report and Safeguarding Annual Report had been amended from level 7 to level 6. The Committee also received an update from the Lived Experience Shadow Board, which prompted a number of questions regarding how lived experience was effectively reflected within Board decision-making. Reporting on the July meeting, Pauline Walsh highlighted the Committee's consideration of the CQC assessment framework pilot. Zoe Grant advised that the pilot presented an opportunity to influence the development of the new inspection approach, which was expected to place greater emphasis on narrative assessment and key lines of enquiry. The Committee also reviewed level 4 incidents, weather alerts, safer staffing and directorate spotlight arrangements, noting that future reporting requirements would be incorporated into the Cycle of Business. The Committee approved revised assurance ratings for the Mortality Report and Health and Safety Annual Report.	PW / ZG

	Members discussed the ongoing work to reduce Out of Area Placements and sought assurance regarding staff involvement in developing solutions. Rachael Birks advised that staff across community, acute, urgent care, rehabilitation and specialist services had been heavily involved in identifying issues and designing improvements, with further engagement planned through joint clinical development sessions. The Board welcomed the collaborative approach being taken. The Board also discussed governance arrangements for the Lived Experience Shadow Board. Janet Dawson welcomed the principle of strengthening the patient voice within organisational decision-making but highlighted the importance of ensuring that participants were not inadvertently placed in a position where they could be perceived as holding statutory Board responsibilities. ACTION: Zoe Grant agreed to review the Lived Experience Shadow Board further as part of the ongoing development of the governance arrangements. Members also discussed the presentation of the ligature risk on the Board Assurance Framework and agreed that the narrative supporting the proposed reduction in risk score required further clarification. ACTION: Review and strengthen the narrative supporting the ligature risk assessment and associated risk rating. <i>Received</i>	ZG NG
P90/26	AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 12th JUNE 2026 Prem Gabbi, Non-Executive Director / Committee Chair, presented the report and highlighted the following: Members noted the update on Declarations and the review of the Central Services Unit undertaken by Deloitte, which identified a single exception that was being addressed through the appropriate processes. The Committee also considered the external audit findings, Annual Report and Accounts, and Letter of Representation. Prem Gabbi advised that Grant Thornton had completed its work and had not identified any significant matters of concern. It was noted that the auditors had not identified any material misstatements within the Annual Accounts, providing a high level of assurance regarding the Trust's financial reporting and governance arrangements. Janet Dawson asked that the Board's gratitude be formally recorded to the Finance Team, Governance Team and all those involved in the preparation of the Annual Report and Accounts, recognising the quality of the work undertaken and the positive external audit outcome achieved. <i>Received</i>	
P91/26	PEOPLE, CULTURE AND DEVELOPMENT COMMITTEE ASSURANCE REPORT FROM THE BUSINESS MEETING HELD ON THE 29th JUNE 2026 Russell Andrews, Non-Executive Director presented the report in the absence of Martin Evans, Non-Executive Director / Committee Chair, and highlighted the following:	

	The Committee reflected on a staff story presented by Dr Jason Lines, which prompted discussion regarding the importance of leadership behaviours, flexibility, engagement and the role of middle leaders in shaping organisational culture. Members noted that the story provided valuable insight into the qualities and support required to enable effective leadership across the organisation. The Committee received early findings from the Real Talk, Real Change programme and noted that the feedback was providing rich intelligence regarding staff experience. In particular, members discussed staff recognition and acknowledged that, whilst a number of formal recognition schemes were in place, the feedback indicated there may be opportunities to strengthen day-to-day recognition and appreciation of staff contributions. Members received updates on the Sickness Improvement Plan and People Plan, both of which remained subject to a level 6 assurance rating. Whilst assurance was provided that the appropriate actions were in place, the Committee recognised that improvements in sickness absence performance had yet to be fully realised and would continue to be monitored closely. The Committee also reviewed mandatory training non-attendance and considered actions to improve compliance. The Health and Safety Annual Report was discussed in detail, with a particular focus on violence and aggression towards staff. The Committee supported the actions being taken and agreed an assurance level of 4 for this area. A broader discussion took place regarding leadership development, staff engagement and organisational culture. Members highlighted the importance of ensuring managers were equipped with the skills, behaviours and support required to lead effectively, recognising the significant influence of local leadership on staff experience. The Board noted ongoing work to align leadership development, staff engagement and cultural improvement initiatives through the People Plan and Real Talk, Real Change programme. <i>Received</i>	
P92/26	CHARITABEL FUNDS COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 1st JUNE 2026. Russell Andrews, Committee Chair / Non-Executive Director presented the report. Russell Andrews highlighted the approval of the revised Terms of Reference, which reflected the delegated authority already contained within the Trust's Scheme of Delegation regarding the approval of charitable expenditure. Members also noted ongoing work to review and rationalise inactive charitable funds, recognising the need to respect the original intentions and restrictions attached to donations whilst ensuring funds are utilised appropriately. The Board discussed the governance arrangements for charitable fund expenditure and received clarification that the Committee's authority is derived from the Scheme of Delegation approved by the Corporate Trustee. Members reflected on the balance between enabling timely decision-making and ensuring appropriate oversight of significant spending decisions. The	

	importance of transparency, fairness and clear principles for the allocation of charitable funds was emphasised. Discussion also focused on the long-term sustainability of the charity and the need to ensure governance arrangements remain appropriate as activity and demand continued to grow. Members noted that charitable funds were intended to be used for the benefit of patients and services, whilst recognising the importance of maintaining confidence that expenditure remained aligned with donor intent and charitable objectives. Nicola Griffiths advised that the Scheme of Delegation was due for review in October 2026 and suggested that any concerns regarding delegated spending limits and governance arrangements could be considered as part of that review before returning to the Board for approval. Members agreed this was an appropriate course of action. Received	
93/26	ANY OTHER BUSINESS There were no items of other business. Noted	
94/26	MEETING SELF ASSESSMENT Members reflected positively on the meeting, noting the quality of discussion across a broad range of agenda items and the clear actions arising from those discussions. Particular reference was made to the focus on organisational culture, which had featured more prominently than in previous meetings and was welcomed as an important area of Board discussion and oversight. Noted	
95/26	QUALITY ACCOUNT Circulated for information only	
96/26	FIT AND PROPER PERSON TEST (FPPT) 2026 SUBMISSION Circulated for information only	
97/26	GIFTS, HOSPITALITY AND SPONSORSHIP ANNUAL REPORT 2025/26 Circulated for information only	
98/26	TRUST BOARD ATTENDANCE REPORT Circulated for information only.	
	DATE AND TIME OF NEXT MEETING Thursday 10th September 2026 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12:30pm



Signed: _____
Chair

Date: 24th July 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>
1	9th July 2026	82/26	RISK MANAGEMENT POLICY Develop a clear and consistent explanation of the relationship between the Board Assurance Framework and the Trust Risk Register to support Board assurance during a period of significant change.	Nicola Griffiths	10th September 2026	Verbal Update to be provided at the meeting.
2	9th July 2026	83/26	HEALTH AND SAFETY ANNUAL REPORT It was requested that the Equality, Diversity and Inclusion implications and assurance rating within the Executive Summary be reviewed to ensure they accurately reflected the report's content.	Zoe Grant	10th September 2026	This will be addressed in future reports.
3	9th July 2026	84/26	INFECTION, PREVENTION AND CONTROL ANNUAL REPORT (DIPC) Members noted that the Equality, Diversity and Inclusion implications within the Executive Summary should be reviewed and updated as appropriate.	Zoe Grant	10th September 2026	This will be addressed in future reports.
4	9th July 2026	85/26	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT Review whether EPRR reporting is being considered by the most appropriate Committee.	Rachael Birks	10th September 2026	EPRR Annual Report has been considered however felt that QC remains the most appropriate committee noting fundamentally this is our ability to maintain services/ensure resilience to clinical delivery during disruption.
5	9th July 2026	89/26	QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 4th JUNE 2026 AND 2nd JULY 2026 (1) Pauline Walsh and Zoe Grant to review and confirm the assurance ratings presented to the Board. (2) Zoe Grant agreed to review the Lived Experience Shadow Board further as part of the ongoing development of the governance arrangements. (3) Review and strengthen the narrative supporting the ligature risk assessment and associated risk rating.	Zoe Grant Zoe Grant Nicola Griffiths	10th September 2026 10th September 2026 10th September 2026	Complete This is due to return to Exec's in September 2026 Verbal update available at the meeting

Enclosure No: 3

CEO BOARD REPORT – SEPTEMBER 2026

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	10 September 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: • New stretch targets for mental healthcare agreed • Plans announced for a new network of community mental health centres and mental health emergency departments • Combined outpatient appointments through the NHS App • Transforming Care Programme transfers to Combined

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	4/9/2026

Chief Executive's Report to the Trust Board September 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

New stretch targets for mental healthcare agreed

Three key stretch targets have been agreed by mental health leaders and NHS England. These targets will be monitored and tracked by Trusts and integrated care boards, and focus on the below three areas:

- A 95% reduction in out-of-area placements by March 2027.
- A reduction in 12-hour breaches for mental health patients in emergency departments.
- An improvement in mental health waiting times for children and young people, with a goal to have 50% seen within four weeks.

Plans announced for a new network of community mental health centres and mental health emergency departments.

Plans have been announced to create a network of 159 community mental health centres and dedicated mental health emergency departments (MHEDs) by 2029.

The aim of the facilities will be to give those experiencing a mental health crisis or significant distress somewhere to go that's designed to provide the support they need.

Included in the plans are 59 new, dedicated MHEDs, on top of the 23 which are already currently operational across the country.

3.0 OUR TRUST

3.1



Combined makes outpatient appointments easier to access through the NHS App

People using the Trust's services can now see their outpatient appointments through the NHS App. The new feature links the Trust's PatientAide portal with the NHS App, helping service users find important information in one simple, familiar place.

All adult service users will receive a text message inviting them to access their Combined Healthcare patient record using their existing NHS App login, this includes quicker access to appointments, letters, care plans, medication and allergy information, and online forms.

The change is designed to enable patients to access their healthcare information in a way that is simpler and easier, helping people to stay empowered and involved when managing their



care. This development represents another significant step in the Trust's commitment to improve digital services, positively impacting the experience of service users who use the technology. It is a simple but exciting step forward, giving people more choice, confidence and control over their care.

3.2



Transforming Care Programme transfers to Combined

The Transforming Care Programme transferred from Midlands and Lancashire Commissioning Support Unit (MLCSU) to Combined in August, following a commissioning decision by NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB).

This change has taken place due to the national closure of commissioning support units, which means alternative arrangements are needed to ensure the continued delivery of the service locally.

The Transforming Care Programme focuses on improving health and care services for people with learning disabilities and autistic people. The program is designed to help individuals live safely and comfortably in their communities rather than in hospitals.

To ensure a seamless transfer with no disruption to people receiving support, the Trust continues to work in partnership with NHS Shropshire, Telford and Wrekin ICB and MLCSU to ensure a smooth transition and maintain strong working relationships with local partners.

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

CHAIRS REPORT – SEPTEMBER 2026

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

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

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:	Choose an item.
Approval / Review:	Choose an item.
Strategic Priorities:	Prevention - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	The report updates the Board on activity undertaken since the last meeting and draws the Board's attention to any other issues of significance or interest.
Executive Summary:	- Board to Team visits - Tobacco Dependency Advisor - A goodbye and thank you to Dr Roger Banks

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	02/09/2026

Ensuring our Culture enables Safe Care

We are all aware of the two recent reports on Maternity Services by Baroness Amos and Donna Ockenden. There have been a series of events where the findings have been considered and there is a Ten-Point Plan that is specific to maternity services but there are other findings that relate to all health providers. Most importantly for us is the key learning around the role of leadership at both board and system level and that culture is not peripheral to patient safety, it is a primary driver of harm. The role of embedded racism in determining the quality of outcomes for some women was also called out. Chairs were challenged to consider these two points:

- As boards, how we know our culture enables learning, accountability and equitable care for every family and staff member?
- What features of the system allowed this to happen, and what stopped the system identifying or intervening sooner?

The review identified the following commonalities in maternity services considered:

- Harm persisted despite risks being repeatedly identified
- Families, frontline staff and junior clinicians recognised problems long before formal governance systems did
- Assurance processes provided confidence, but not necessarily insight
- Organisational reputation and compliance often displaced learning and improvement
- Psychological safety, culture and leadership behaviours proved as important as policies and procedures.

The takeaway was this very sobering question:

Whose concerns are we currently not hearing until they become a serious incident, complaint or external review?

In line with the work we have done in challenging ourselves to bring culture to the centre of our board discussions, I would be grateful if committees could further strengthen and refine the processes we already have in place and the assurance and insights that we are getting with the context of these reviews in mind. As a board we must be seen to be approachable and actively listening to staff and patient concerns and not missing the signs and cues that will help us to know sooner if there are problems.

Visit from Ian Green – System Cluster Chair

At the beginning of August, Buki and I were delighted to welcome Ian to Harplands to show him something of the wide range of services we can offer to those we care for in Stoke on Trent and North Staffordshire. The teams in the Crisis Centre and Wards 4 and 6 were kind enough to show Ian around and talk about their work. As with everyone who visits our services Ian was left with a strong impression of calm and supportive staff and excellent facilities. We are grateful to Ian for finding the time to visit us and to Simon Whitehouse who was able to join us for a conversation about System direction and the ambition for strong partnership working across Shropshire, Telford and Wrekin, Stoke on Trent and North Staffordshire.

Board to Team visits

I am very pleased to see that we now have an improved process for planning and undertaking visits to our various teams by board members and have a plan out to the end of this calendar year to ensure that teams are visited on a regular basis without us getting under their feet. We also have a new report that will allow the board to consider what is working well for people, what they are proud of and what is challenging them. Identifying trends and common issues will lead to more effective issue resolution and provide assurance and insights to the board as mentioned above.

Since May, in the company of executive colleagues, I have had the pleasure of visiting personally the ECT team and the teams in Wards 4 and 6. Other colleagues have similarly visited both service delivery teams and support teams. What always impresses me is the passion we see for great service delivery, care and compassion for those in our care and a strong drive to make the time spent with us homely and welcoming but with a strong drive to get people ready to go to their own home wherever that might be for them. Board to Team visits are a significant part of us understanding the culture of the organisation and the quality of our services. Thank you to every team who has given us time so far and we look forward to more visits for the rest of the year.

It's strange who you meet in the Reception at Harplands



While I was waiting to visit to one of the wards, I met David, Tabacco Dependency Advisor who had a stand supporting those who want to stop smoking tobacco by providing vapes as an alternative. Provided they come from a reliable source, vapes are potentially less harmful than smoking tobacco and David had diverted from his usual role of supporting patients and service

users to supporting staff. This was a one-off offer, but David is happy to provide advice so perhaps a chat with him might help if you are looking to quit.

A goodbye and thank you

In August we said goodbye to Dr Roger Banks who has been an Associate Non-executive Director at the Trust for the past two years. We are most grateful to him for his contribution to Combined bringing his expertise around Learning Disabilities and Autism to our board discussions and to colleagues within the Trust and reminding us that inclusion means no-one is left out. He is unable to be with us today, but I wanted to recognise his contribution in our board in public and for the minutes.

Janet Dawson
Chair
September 2026

Enclosure No: 5

Winter Plan 2026/27

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

Presented by:	Rachael Birks/Interim Chief Operating Officer
Prepared by:	Rachael Birks/Interim Chief Operating Officer
Executive Lead:	Rachael Birks/Interim Chief Operating 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 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Quality Committee
Strategic Priorities:	Access - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	The Trust Winter Plan is aligned with the wider ICS Winter Planning.

Recommendation / Required Action:	Board are asked to approve the Winter Plan.
Executive Summary:	The Winter Plan 2026/27 sets out North Staffordshire Combined Healthcare NHS Trust's approach to maintaining safe, effective and resilient services during the anticipated period of increased operational pressure from November 2026 to March 2027, including the Christmas and New Year period. The plan aligns with the wider Staffordshire and Stoke-on-Trent Integrated Care System winter arrangements and reflects the Trust's role as both a mental health, learning disability, substance misuse and primary care provider and an active system partner in supporting urgent and emergency care flow. The plan has been developed using learning from Winter 2025/26 and is informed by current operational risks, demand and capacity intelligence, workforce resilience considerations, infection prevention and control requirements, and system-wide escalation arrangements. It recognises that while winter pressures affect the whole NHS system, the key risks for the Trust relate to sustained pressure on adult acute, PICU and older persons inpatient capacity; reliance on out of area placements; delays for people clinically ready for discharge; rising crisis and liaison demand; workforce availability; infectious disease outbreaks; adverse weather; estate constraints; and the need for timely support from system partners. A range of mitigations are already in place to support resilience through winter. These include daily operational huddles, active use of SHREWD and OPEL reporting, strengthened bed management and discharge oversight, continued delivery of the Out of Area action plan, enhanced focus on people clinically ready for discharge, maintained crisis access through the Crisis Care Centre and NHS 111 mental health access, festive workforce planning, senior decision-maker rotas, infection prevention and control preparedness, vaccination delivery plans, and established command and control arrangements. The plan also sets out clear escalation routes through internal operational governance, the virtual Incident Control Centre, Executive oversight, system calls, ICS urgent and emergency care governance, and regional escalation where required. These arrangements are designed to ensure that risks are identified early, decisions are made at the right level, and additional support or mutual aid can be mobilised when operational pressure increases. For the Senior Leadership Team, the areas requiring continued focus are delivery of the discharge and out of area placement action plans, maintenance of safe inpatient flow, resilience of crisis and liaison pathways, workforce availability over the festive period, vaccination

uptake, outbreak prevention and response, and escalation of system dependencies that may affect discharge, access and patient experience. Active monitoring of validated performance data, daily operational intelligence and agreed assurance routes will be essential throughout the winter period.

Overall, the Winter Plan provides assurance that the Trust has identified the principal risks associated with winter, has established mitigations and governance arrangements in place, and is prepared to respond dynamically to changing levels of operational pressure. Continued senior leadership oversight will be critical to sustaining safe care, timely access, patient flow, staff resilience and effective partnership working across the winter period.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	25.8.26
2	Quality Committee	3.9.26
3	Public Trust Board	06.09.26

North Staffordshire Combined Healthcare NHS Trust

Winter Plan 2026/27



Reporting period	November 2026 to March 2027, with specific arrangements for Christmas and New Year.
Accountable executive	Chief Operating Officer and Accountable Emergency Officer.
Operational oversight	Clinical Directors and Associate Directors, overseen by the Deputy Chief Operating Officer / Deputy AEO.

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Executive Summary

This Winter Plan sets out North Staffordshire Combined Healthcare NHS Trust's planned response to the anticipated operational pressures for Winter 2026/27, covering November 2026 to March 2027, with specific arrangements for the Christmas and New Year period. It should be read alongside the Staffordshire and Stoke-on-Trent Integrated Care System winter arrangements, recognising the Trust's responsibilities as both a mental health provider and an active system partner.

The plan is informed by learning from Winter 2025/26 and reflects the continuing impact of high service demand, constrained inpatient capacity, increased acuity, discharge delays, workforce resilience pressures and infectious disease risks. While some winter pressures affect all NHS providers, the most material risks for the Trust relate to adult acute, PICU and older persons inpatient flow, out of area placements, people clinically ready for discharge, crisis and liaison demand, and the system dependencies required to sustain safe discharge and community support. Adverse weather impacts also remain a risk but are mitigated by our Adverse Weather Plan.

The Trust enters winter with several established mitigations in place. These include daily operational huddles, SHREWD and OPEL reporting, strengthened discharge oversight, continued delivery of the Out of Area action plan, all-age crisis access through the Crisis Care Centre and NHS 111 mental health access, festive workforce and senior decision-maker rotas, vaccination delivery plans, and infection prevention and control arrangements for flu, COVID-19, norovirus and emerging threats.

The plan also describes the escalation, command and control arrangements that will support timely decision-making throughout winter. The Trust will continue to use the national OPEL framework, SHREWD intelligence, internal huddles and system escalation routes to identify pressure, respond proportionately and mobilise additional support where required. The virtual Incident Control Centre remains available and can transition to physical command arrangements if operational pressure escalates.

Board oversight is required in relation to the highest-risk areas: inpatient capacity and out of area placements; delays for people clinically ready for discharge; crisis, urgent care and Mental Health Liaison Team demand; workforce resilience; infectious disease outbreaks; estate and service continuity risks; and reliance on system partners for flow, discharge and mutual aid. Assurance will be provided through Trust performance reporting, operational governance, Executive oversight, Quality Committee, Board reporting and relevant ICS routes.

Overall, the plan provides the Board with assurance that the Trust has identified the principal winter risks, has established mitigations and escalation routes in place, and will maintain active monitoring throughout the winter period. Continued focus will be required on validated performance data, delivery of agreed discharge and OOA actions, vaccination uptake, workforce resilience, and system partnership support to sustain safe access, patient flow and service continuity.

Introduction

Winter adds significant pressure across all NHS services and the wider population. Last winter within the West Midlands there were sustained pressure across urgent and emergency care pathways, with bed occupancy remaining exceptionally high across much of the region and several organisations frequently operating at, or close to, maximum capacity. Staffordshire and Stoke-on-Trent Integrated Care System are not immune to these challenges and therefore provider winter plans must be developed alongside the ICS Winter Plan. Although these pressures can occur throughout the year, they are more likely to intensify during the winter period.

The key following key pressures remain:

- Increased demand for unscheduled care, including higher Emergency Department (ED) presentations. For Combined, this is most likely to affect the Mental Health Liaison Team at Royal Stoke ED.
- Higher admission rates and longer lengths of stay linked to increased acuity. For Combined, the direct impact on bed capacity is expected to be smaller than for acute partners, although acuity continues to rise and our bed base per 100,000 population remains one of the lowest in the Country.
- More patients awaiting discharge and requiring care packages. For Combined, this is likely to have the greatest impact on older persons inpatient capacity, particularly where external capacity is constrained by D2A prioritisation, outbreaks or service closures. The Trust remains reliant on social care partners.
- Reduced workforce resilience due to festive leave and potential sickness absence, with Combined likely to experience similar pressures to other ICS partners.
- The need to maintain elective programmes while demand and lengths of stay increase. This has limited impact on Combined.
- Requirement to continue to deliver the elective programme at a time when demand and LOS are increasing (e.g., acuity of presentations). This has limited impact on Combined.
- The need for additional health and social care capacity in acute and community settings to respond to increased presentations. For Combined, this is addressed through resources focused on unscheduled care demand.

Learning from past winters at both organisational and as members of the ICS are woven throughout the Winter Plan, however high-level learning from Winter 2025/26 includes:

1. Ongoing requirement to ensure engagement with clinical leads and services regarding winter planning to ensure actions are owned, understood and delivered.
2. Continuing to ensure resources for winter are targeted towards patient flow and alternatives to admission, including oversight and sustainable actions to ensure appropriate levels of discharge including during weekends and public holidays.
3. To ensure IPC arrangements are understood and embedded to further support patient flow and a consistent system wide approach.

4. Ensure all opportunities to improve staff and patient uptake of vaccinations is maximised to support prevention opportunities.
5. To maintain the virtual Incident Control Centre this has proved effective over a number of Winters and throughout the year 2026, this also includes senior representation at the twice daily system calls.

In line with national requirements all providers are to identify a named Executive Sponsor with accountability for winter preparedness, escalation and operational delivery. In line with the previous year this will be Chief Operating Officer who is also the Accountable Emergency Officer (AEO) for the Trust.

1. Key risks requiring Board oversight

It is imperative that organisational boards have oversight of the key risks linked to Winter Plans and are aware of the key mitigations and interventions in situ.

1.1 Key Risks

- Sustained pressure on Adult Acute, PICU and Older Persons inpatient capacity, including high occupancy and reliance on out of area placements.
- Delays for people who are clinically ready for discharge, particularly where onward packages, placements, housing or social care capacity are constrained.
- Increasing demand through the Crisis Care Centre, NHS 111 mental health access, crisis alternatives and Mental Health Liaison Team activity at Royal Stoke.
- Workforce resilience risks arising from sickness, festive leave, bank holiday cover, specialist staffing gaps and potential industrial action if the national position changes.
- Infectious disease and outbreak risk, particularly seasonal influenza, COVID-19 and norovirus, with potential effects on bed availability, staffing and patient flow.
- Estate and service continuity risks, including adverse weather and planned inpatient estate work affecting operational flexibility.
- System dependency risks where mitigations require active support from local authorities, the ICB, UHNM, MPFT, primary care, social care and independent sector providers.

1.2 Key mitigations in place

- Daily operational huddles, SHREWD oversight and OPEL reporting to identify pressure and escalate at pace.
- Virtual Incident Control Centre capability with ability to transition to physical ICC arrangements if required.
- Continued investment into discharge pathway capacity, social work support and out of area reduction actions.
- Maintained all-age crisis access through the Crisis Care Centre, NHS 111 mental health access and text-based access.
- Festive staffing plans and senior decision-maker rotas to support discharge, patient flow and safe care over bank holidays.
- Business-as-usual wellbeing support for our teams and opportunities to stand up specific support where required.
- Vaccination plans for staff and eligible inpatients, including roving clinics and targeted support for hard-to-reach clinical areas.
- IPC preparedness for outbreak management, surveillance, PPE, staff training and microbiology/IPCT advice.

2. Purpose, Scope and Governance

2.1 Purpose and scope

This Plan covers the winter period from November 2026 to March 2027, with a particular focus on the Christmas and New Year period. The plan brings together organisational and system arrangements to maintain safe and effective care, support patient flow, minimise avoidable delays, respond to infectious disease and adverse weather risks, and escalate operational pressures through agreed command arrangements.

Although winter planning is focused on seasonal and festive pressures, many arrangements described in this plan operate throughout the year as part of business-as-usual capacity, flow, resilience and emergency preparedness arrangements.

2.2 Governance and accountabilities

Role / forum	Function
Trust Board	Approval of the Winter Plan and oversight of key risks, mitigations and assurance.
Executive Team	Executive oversight of delivery, risks and escalation.
Chief Operating Officer / Accountable Emergency Officer/Accountable Officer for Winter	Executive accountability for winter planning and oversight, operational resilience and emergency preparedness.
Deputy Chief Operating Officer / Deputy AEO	Operational oversight, coordination and escalation support.
Clinical Directors and Associate Directors	Delivery of directorate plans, capacity, workforce and service-level mitigations.
ICS UEC Board and system calls	System flow, escalation, mutual aid and operational situational awareness.

3. Key Operational Risks Anticipated During Winter 2026/27

The Board Assurance framework risk 2 outlines the risk that ‘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.’ This BAF risk has a current score of 15. The Trust currently has Five high level risks and 2 Operational Risks (15 – 25 scoring) of these three links to risk areas within the Winter Plan.

3.1 Key Operational Risks

The below table outlines key operational risks and the impact if these were not mitigated and the primary mitigations in situ and associated assurance routes.

Risk area	Operational risk	Impact if not mitigated	Primary mitigations	Assurance route
Inpatient capacity and OOA	Adult Acute, PICU and Older Persons occupancy remains high, with limited ability to flex across bed types.	Increased OOA placements, delayed admissions, pressure on MHLT/CCC and reduced patient experience.	OOA action plan, daily bed monitoring, senior huddles, strengthened gatekeeping, investment in Discharge Pathway Team, social work investment and opportunities to further invest in support under the OOA Action Plan.	Performance meetings, OOA Working Group, Executive Team, Quality Committee and Board.
CRFD and discharge delays	People clinically ready for discharge may experience delays due to social care, housing, placements or community capacity.	Longer length of stay, reduced flow, increased OOA risk and poorer outcomes.	Model Discharge Pathway alignment, Integrated Discharge Hub, LA interface meetings, daily CRFD review.	Daily huddles, performance reporting, CRFD monitoring. Performance meetings, OOA Working Group, Executive Team, Quality Committee and Board.
Crisis and liaison demand	CCC and MHLT demand continues to increase, with Royal Stoke ED activity influencing	Longer response times, increased ED waits and higher	24/7 crisis access, NHS 111 mental health access, text-based service, mutual aid between	Trust performance reporting, urgent care governance, system calls.

	MHLT pressure.	admission pressure.	CRHTT and MHLT.	
Workforce resilience	Sickness, festive leave, specialist bank gaps or future industrial action may reduce safe staffing capacity.	Reduced service resilience, fewer discharges, reliance on agency/bank and operational escalation.	Early festive rotas, bank capacity review, senior decision-maker cover, mutual aid MOU, wellbeing support and opportunities to 'stand up' bespoke support.	Directorate oversight, safe staffing processes, daily huddles. Performance reporting.
Infectious disease outbreaks	Flu, COVID-19 and norovirus may affect patients, staff and wards.	Ward closures, staff absence, outbreak controls, reduced flow.	IPC surveillance, outbreak folders, PPE, training, vaccination programme, microbiology advice.	IPCT reporting, CIG, Executive/ICC escalation.
Estate and service continuity	Adverse weather, estate issues and planned works may reduce operational flexibility.	Reduced bed availability, delayed moves, business continuity incidents.	Adverse Weather Plan, business continuity plans, estate escalation and project-specific mitigations.	EPRR governance, ICC, Executive Team.
System dependencies	Flow relies on social care, primary care, acute, community and independent sector capacity.	Delayed discharge, increased ED pressure and reduced system resilience.	UEC Board, system discharge hub, escalation with LAs and ICB, mutual aid arrangements.	ICS governance and twice daily system calls when escalated.

4. Planned Mitigations and Interventions

4.1 Alternatives to admission and front-door resilience

- Maintain the Crisis Care Centre as the first point of contact for many people in or approaching mental health crisis, including NHS 111 mental health access and text-based access.
- Ensure MHLT and Crisis Care Team continue to use the Crisis Care Centre and crisis alternatives to avoid unnecessary ED attendance or admission where safe and clinically appropriate.
- Strengthen gatekeeping to ensure people potentially requiring admission receive robust assessment and least-restrictive intervention (as per the OOA agreed actions).
- Continuing the work between community mental health teams and the acute and urgent care teams to support people whose needs are deteriorating, supported by development of the deteriorating patient dashboard and intervention pro-forma.
- Maintain CYP Intensive Support Hub (ISH), Learning Disability Intensive Support Team (IST) and Key Working Team arrangements to support alternatives to higher-tier admission where appropriate.

The data below have been reviewed and support the above mitigations and interventions.

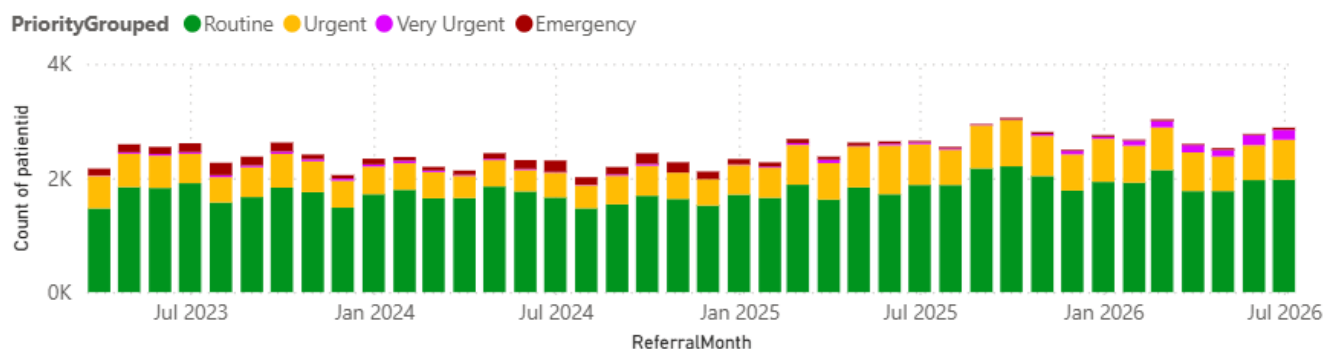
Crisis Care Centre

Referrals to the Crisis Care Centre, based at Harplands Hospital, continue to increase. From December 2025, further data validation has been undertaken with the team to ensure referrals are coded accurately. This has contributed to an increase in the number of patients recorded as very urgent.

Demand within the Crisis Care Centre has continued to grow year on year. A number of service and pathway reviews have taken place to ensure capacity remains aligned to demand. Previous investment was made to support NHS 111 activity, and current capacity is considered sufficient to meet this specific demand through the winter period.

Crisis Centre Referral Referrals by priority:

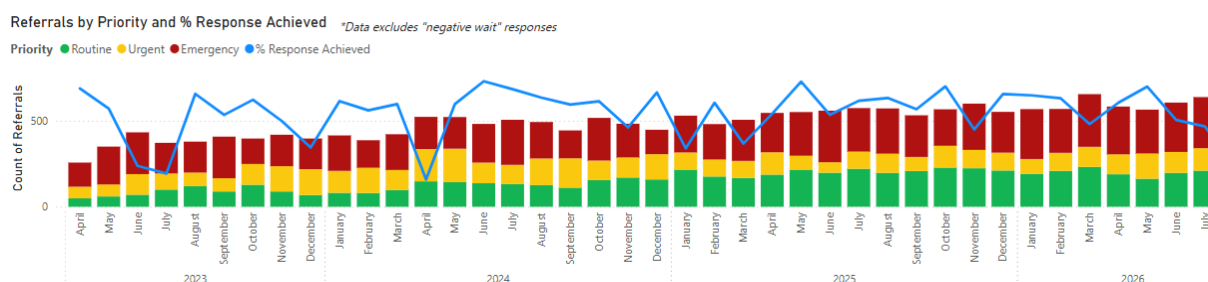
All Referrals by Priority Type



Mental Health Liaison Team

Mental Health Liaison Team referrals have increased year by year. The chart also shows a rise in very urgent cases requiring a one-hour response. However, this should be considered alongside improvements in data validation and recording over the last 12 months. This remains an area for continued monitoring and review.

Mental Health Liaison Team Referrals by priority:



Referrals to the Mental Health Liaison Team (MHLT), co-located with the Emergency Department at Royal Stoke University Hospital, fluctuate but show a sustained increase. This is broadly aligned to overall activity levels within the Emergency Department.

The team provides 24/7 cover, profiled as far as possible against average hourly demand. The Directorate continues to monitor this closely, particularly during winter, when wider ED activity can increase significantly. Current data does not indicate a marked seasonal increase in mental health demand during winter.

Mutual aid arrangements between the Crisis Resolution and Home Treatment Team and MHLT are in place if demand exceeds capacity. Performance against MHLT response standards, including one-hour, four-hour and 24-hour targets, is monitored through the Trust's performance reporting processes.

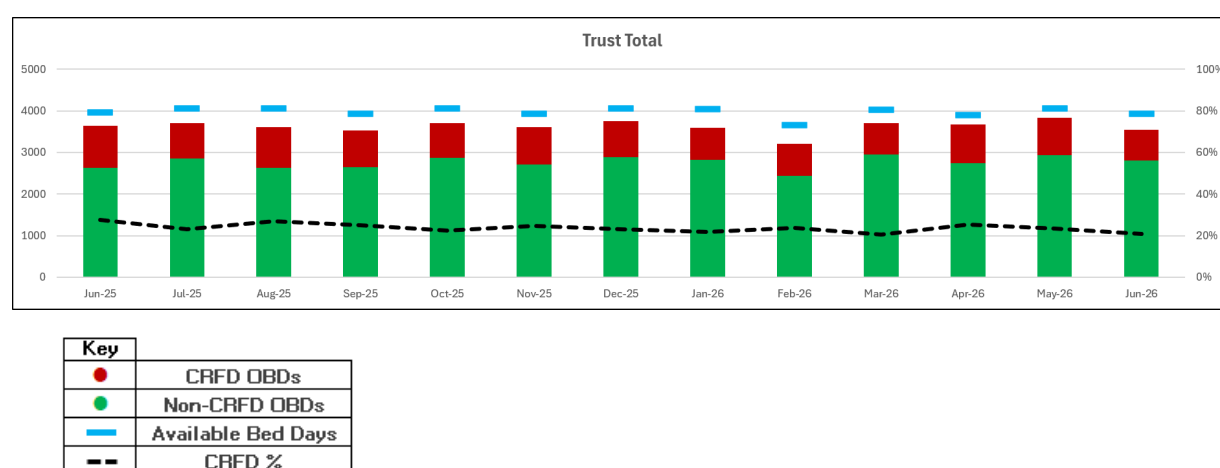
Challenges can arise when Approved Mental Health Practitioner (AMHP) support is required for Mental Health Act assessments. AMHP provision is led by the relevant

local authority, and capacity challenges were highlighted and reviewed through system-wide discussions and agreed actions during last winter.

4.2 Demand and capacity intelligence

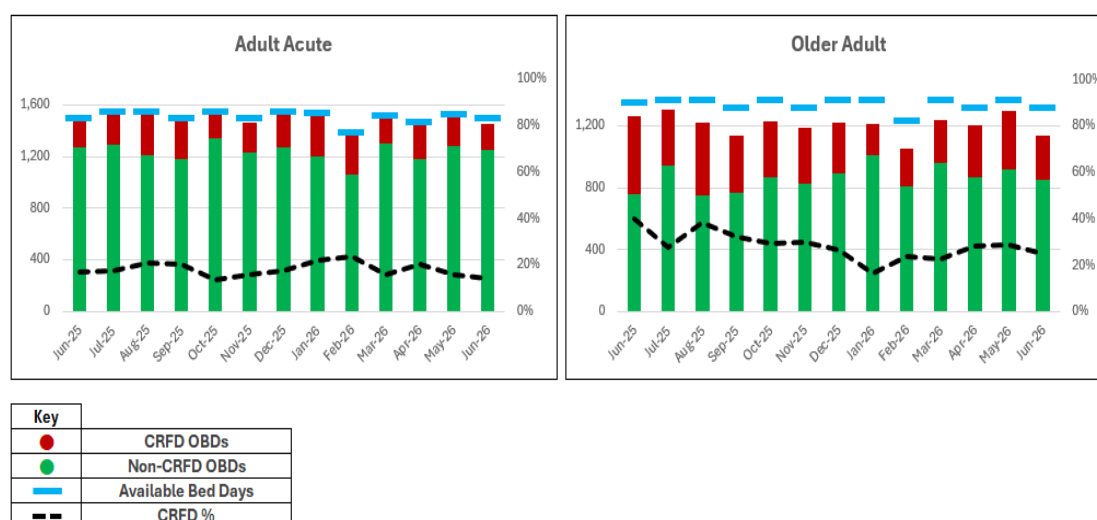
Historic activity, in regard to demand and capacity, has not usually considered utilisation of Out of Area beds notably because this has only become a trend for NSCHT since November 2025. The data below outlines our overall bed occupancy.

Overall Bed Occupancy



Overall bed occupancy across Combined is around 91% over the last 12 months. However, occupancy is higher in Adult Acute beds, including PICU, and Older Persons services. These pressures cannot usually be offset across the wider bed base because of the specific clinical needs and bed types required. Work through the Out of Area Working Group has identified some alternative arrangements, which are closely monitored.

Bed Occupancy Adult Acute (including PICU) and Older Adult



Bed capacity in Adult Acute, PICU and Older Persons services remains constrained and is a key operational and organisational priority as the Trust works to reduce reliance on Out of Area (OOA) placements. Average occupancy in Acute and Urgent Care has been 94.58% over the last 12 months. A detailed action plan is in place to reduce and mitigate OOA bed use, with clear governance and oversight through the relevant committees and Board.

Further opportunities to maintain oversight of demand and capacity include:

- Use SHREWD, OPEL and daily operational reporting (bed board) to identify pressure points and support decision-making.
- Monitor CCC, MHLT, CRFD, bed occupancy, OOA position, staffing, outbreaks and system flow indicators throughout winter.

Primary Care

General practice capacity and demand are monitored on a daily basis, flexing appointments to meet acute and routine needs. Additional GP appointments will be utilised to support acute and routine needs during the anticipated winter demand period, in addition to the continued utilisation of clinical triage to categorize demand into immediate clinical need, 2 – 3 working days and routine requests. The Advanced Clinical Team will be utilised to support this and maximise capacity, including the use of remote clinical management. Service users will be navigated to Pharmacy First where appropriate, as part of clinical triage.

The table below outlines the stratification of the demand coming into Primary Care and how this is managed.

Type of Management	% of requests to be managed in this way each day
Self management or referral to pharmacy first	20%
Manage remotely (no appt follow up)	15%
Red patients	20%
Amber patients	25%
Green + WORK UP	20%

Patients identified as most at risk of admission (4% of total patient list size) will continue to be reviewed across all general practice sites with holistic care assessment and care planning.

5. Escalation, Command and Control

The Trust's Emergency Preparedness, Resilience and Response arrangements provide the framework for winter preparedness, operational resilience and timely escalation. These arrangements are supported by established policies and procedures, including Business Continuity Plans, the Adverse Weather Plan and the Incident Response Guide. Together, these documents set out how the Trust will

identify operational pressure, coordinate its response and align internal command arrangements with wider system escalation routes.

5.1 OPEL Framework

The OPEL framework outlines a number of OPEL levels which are aligned to operational pressures across multiple providers including NHS acute trusts, community providers, mental health providers, NHS 111, integrated care systems (ICSs), and NHS England regional and national teams.

This framework provides the core parameters that each of these types of providers must use to determine their OPEL. Our parameters are updated daily via SHREWD. Below is an example of OPEL Level and typical related trigger, please note this is not the extensive list. See Appendix 1 for the ICB/Partner OPEL Framework.

Level	Typical trigger	Command response	Core actions
OPEL 1 - Business as usual	Demand and staffing manageable within normal operational arrangements.	Service and directorate management.	Routine huddles, daily bed monitoring, BAU performance oversight.
OPEL 2 - Moderate pressure	Emerging pressure in beds, staffing, CRFD, ED liaison demand or outbreaks.	Directorate escalation and senior operational oversight.	Increase huddles, confirm discharges, review staffing, engage system partners via daily system calls.
OPEL 3 - Significant pressure	Sustained high occupancy, delayed admissions, material staffing gaps, outbreak affecting flow or system pressure.	Tactical response led by senior operational leadership.	Twice daily system calls where required, activate recovery actions, review mutual aid, defer non-critical activity if needed.
OPEL 4 - Severe pressure	Severe capacity constraints, unsafe flow, multiple outbreaks, major workforce shortfall or external system super-surge.	Gold/Strategic oversight and ICC activation as required.	Command structure, action log, regional notification, system mutual aid and consideration of major incident criteria.
Major incident / super-surge	Demand exceeds available mitigations or major disruption	Major Incident Plan and ICC arrangements.	Formal command and control, emergency prioritisation, mutual

	affects safe service delivery.		aid, communications and recovery planning.

5.2 SHREWD

SHREWD will be used across the system this winter to support providers and ICS oversight of operational data.

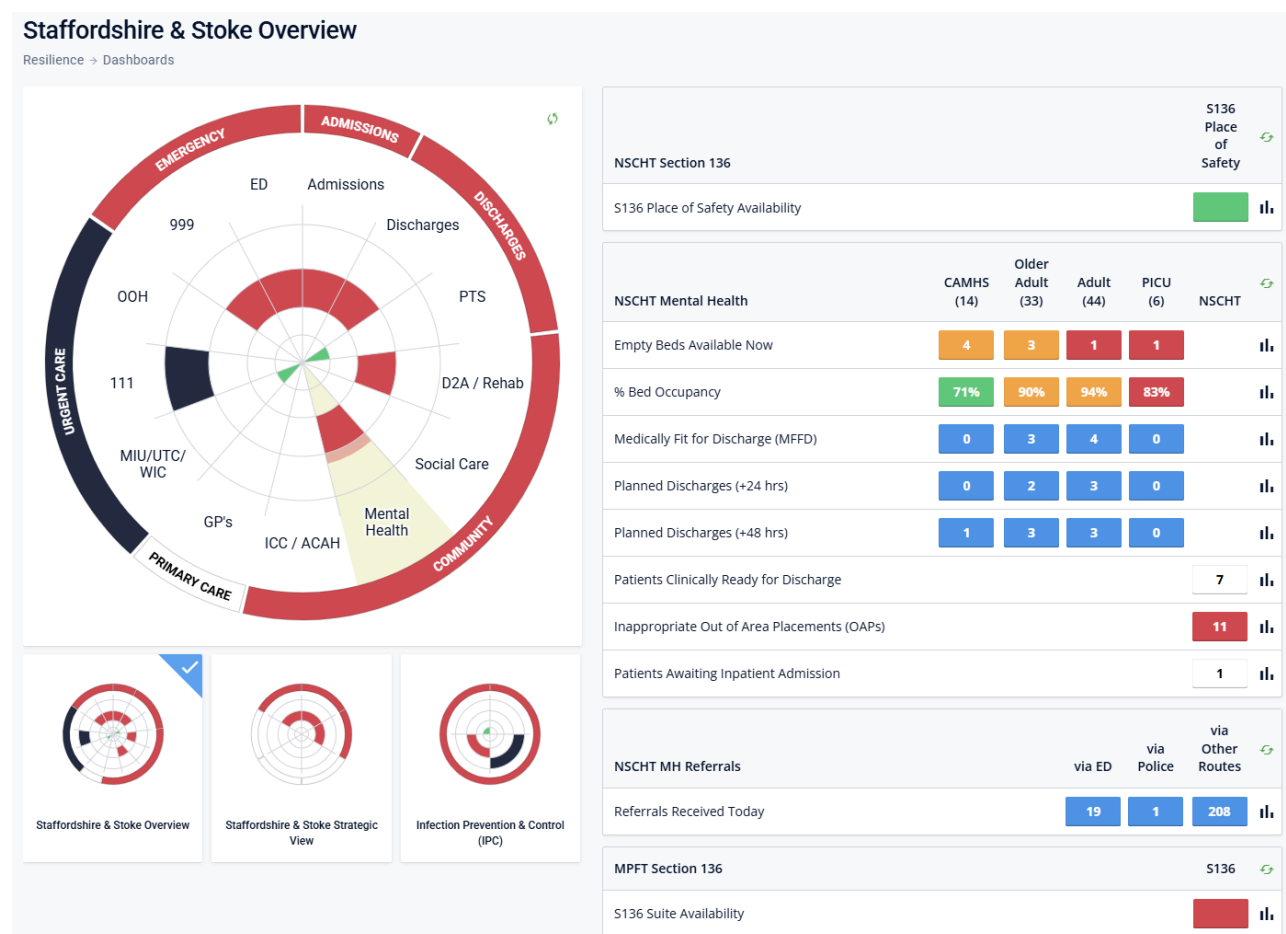
SHREWD presents data in a clear visual format, enabling areas of pressure to be identified quickly. Data is automatically drawn from Combined systems and the Data Warehouse.

The system provides front-line teams and operational leaders with a real-time view of pressure points, with the ability to drill down quickly into the reasons for escalation. This supports timely decision-making and helps teams focus support where it is most needed to improve flow.

Data is captured from providers across the urgent and emergency care pathway, including NHS 111, 999, Emergency Departments, hospital services, community services and third-sector support. This information is accessible to system partners through a web interface and smartphone app.

SHREWD enables relevant Combined staff to view pressures across partner services, including RSUH Emergency Department and MPFT capacity, such as availability of the Place of Safety Suite. The system also generates the Trust's Operational Pressure Escalation Level (OPEL) score, which is reported regionally and nationally. Combined's escalation plans are aligned to the national OPEL framework and have been reviewed and tested through the system-wide winter exercise, Exercise Aegis, in August 2026.

SHREWD Dashboard example:



6. System Flow and Discharge Improvement Actions

6.1 Strategic objective

The principal winter flow objective is to maintain safe access to inpatient care, reduce avoidable delays, actively manage people who are clinically ready for discharge, minimise out of area bed use and strengthen alternatives to admission and early supported discharge.

The table below outlines priorities to support flow and the specific actions, lead and measure of assurance.

Flow priority	Action for winter 2026/27	Lead / partners	Measure of assurance
CRFD reduction	Daily review of people clinically ready for discharge, individual escalation for barriers and weekly review of themes.	Directorates, Discharge Pathway Team, LAs, ICB.	Number of CRFD patients reported via SHREWD/Daily Dashboard, days delayed, reason for delay.

	Weekly ICS meeting to review CRFD with partners.		
Out of area reduction	Deliver OOA action plan, including improved gatekeeping, active repatriation, patient flow huddles and targeted discharge support.	AS&UC, Specialist and Community Directorate, SRO: Deputy Chief Operating Officer	OOA patient numbers reported vis SHREWD, bed days, cost and repatriation.
Integrated Discharge Hub	Continue contribution to Integrated Discharge Hub and Discharge to Assess (D2A) arrangements, including Pathway 2 support.	MHLT, MPFT, UHNM, LAs.	Hub activity, discharge outcomes and delayed discharge reasons. Bed flow and occupancy of ward 4.
Early Facilitated Discharge (EFD)	Optimise discharges earlier in the day and ensure plans are progressed before weekends and bank holidays. Ensure clear plans in situ to support EFD including support via Home Treatment Team.	Ward teams, consultants, ANPs, social care.	Daily discharge numbers, weekend/public holiday discharge position.
Senior clinical decisions	Ensure senior decision-makers are available over festive and escalated periods.	Clinical Directors, ward consultants, nurse in charge, ANPs.	Rota completion and workforce plan element of festive plan both internally and externally
Transport and system barriers	Clarify transport escalation routes and ensure transport barriers are captured in CRFD reporting.	Directorates, transport providers and service line agreement.	Transport delay themes and actions.

6.2 Estate-related flow risks

- Essential work commenced within the Edward Myers Centre in August 2026, Edward Myers moved into the Harplands Hospital and is currently utilising ward 10, also referred to as the decant ward. This move is not utilising commissioned bed

space, but it does mean that opportunities to flex environmental estate are challenged.

- Essential work is also due to commence within the Assessment and Treatment Unit which will mean this is closed until 2027. Operational impacts have been reviewed but there does remain a risk that further admissions may need to be supported in the wider estate.
- 7 beds have been identified during the Summer of 2026 to support the OOA action plan, and these will remain in situ for the duration of Winter 2026/27.

7. Workforce Resilience Arrangements

The following table outlines the workforce resilience arrangements we are aligning to our Winter Plan 2026/27

Workforce requirement	Winter arrangement	Escalation trigger
Festive rotas	All relevant services to agree winter and festive rotas by the end of October 2026.	Rota gaps remain unresolved two weeks before Christmas/New Year.
Senior decision-maker cover	Ensure senior clinical, operational and on-call cover is aligned to discharge and flow requirements.	Senior cover not aligned across inpatient, community and social care interfaces.
Bank and agency resilience	Review bank capacity against likely festive demand and ensure identification of bank staff plans where required.	Bank fill rate insufficient for inpatient specialist areas such as PICU, Adult Acute or Darwin.
Specialist service resilience (CCC/MHLT)	Ensure highly specialist areas have named contingency plans.	Specialist staffing levels fall below agreed safe staffing thresholds.
Staff wellbeing	Support breaks, annual leave planning and visible wellbeing support during winter and bank holidays.	Sickness trends or fatigue indicators increase.
Industrial action	Maintain tested arrangements should industrial action re-emerge.	National or local notice of industrial action or formal ballot outcome.

8. Infection Prevention and Control Preparedness

8.1 Core IPC preparedness

The criteria for identifying an outbreak have not changed, which will include COVID and flu. The IPC team will continue to identify and manage outbreaks with all relevant reporting and support in place as necessary and in line with business-as-usual plans.

The following arrangements will be maintained:

The criteria for identifying an outbreak have not changed, which will include COVID-19, Flu and Norovirus. The IPC will continue to identify and manage outbreaks with all relevant reporting and support in place as necessary and as per our business-as-usual plans.

The following will be maintained:

- Maintain outbreak folders in all wards and clinical areas.
- Prompt identification, isolation and testing of symptomatic patients in line with current guidance.
- Mandatory IPC training and refresher awareness activity ahead of norovirus season.
- Robust ward and clinical area visit plan is in situ by the Infection Prevention and Control Team.
- Central PPE stock arrangements and resilience of FFP3 fit testing via quantitative fit testing arrangements.
- Access to microbiology advice and IPCT support, including out-of-hours routes.
- Holding statements and communications templates for outbreak situations.

The table below outlines infectious disease risk; current actions aligned with plan and escalation considerations.

Infectious disease risk	Preparedness action	Escalation consideration
Norovirus	Surveillance, awareness sessions 4 to 6 weeks before season, outbreak folders and isolation procedures.	Escalate if outbreak affects bed availability, staffing or multiple areas.
Seasonal flu	Vaccination programme, testing/outbreak criteria, antiviral arrangements and UKHSA intelligence updates.	Escalate if outbreak reduces capacity or staffing resilience.
COVID-19	Testing and isolation in line with current guidance, patient vaccination	Escalate if outbreak creates closure risk

	support and mask requirement review.	or material workforce impact.
New/Emerging threats	Maintain awareness of national guidance and local outbreak response routes.	Escalate through IPC, Clinical Effectiveness Group (CEG), EPRR and system routes if threat changes.

9. Vaccination Delivery Plans

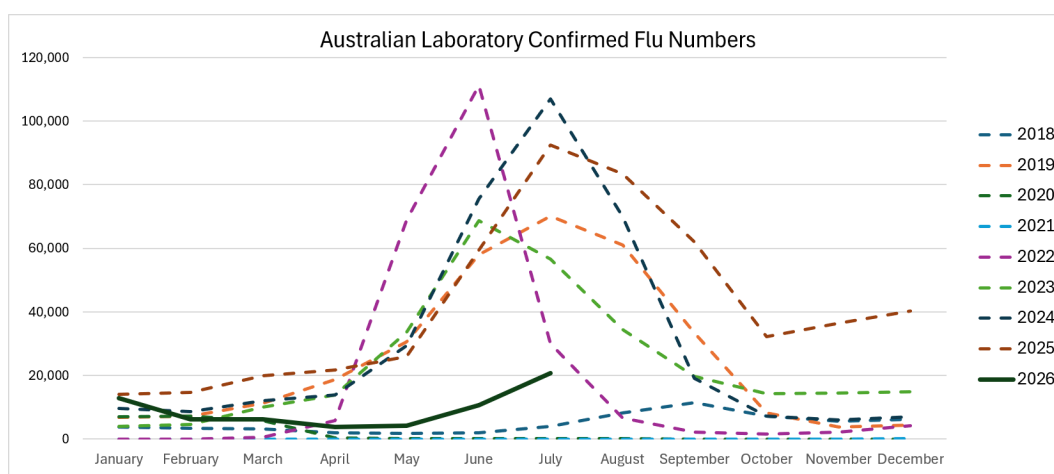
9.1 Winter flu/data analysis

Influenza viruses change each year, and different strains may affect population groups in different ways. The severity of each flu season depends on circulating strains, population susceptibility and changes in the virus.

The Trust has historically achieved good staff and patient flu vaccine uptake, with the programme planned jointly with UHNM as in previous years. Uptake has been lower since COVID-19, partly due to vaccine fatigue. In line with NHS planning guidance, the Trust aims to increase uptake by at least 5% compared with 2025/26.

UKHSA intelligence, informed by Australian surveillance data, suggests the forthcoming UK flu season may follow a similar distribution to last year. This provides a useful indication for planning, recognising the seasonal offset between Australia and the UK.

Current Australian Confirmed Flu Numbers: as of yet confirmed cases remain lower than previous years.



9.2 Vaccination objectives

A number of objectives have been identified to support the Winter vaccination plan:

- ✓ Increase staff flu vaccination uptake by at least 5 percent compared with 2025/26.
- ✓ Provide flu vaccination for eligible inpatients from 1st October 2026, subject to final program confirmation and operational readiness.
- ✓ Use roving clinics and peer vaccinators to support hard-to-reach clinical areas and shift-based teams.
- ✓ Ensure relevant COVID-19 vaccination arrangements for eligible inpatient groups are delivered through the targeted vaccination team where applicable.
- ✓ Submit and analyse vaccine uptake data as required by NHSE and UKHSA.

The table below outlines the current vaccination plan in line with national guidance:

Delivery component	Action	Assurance point
Staff flu programme	Booking system, roving clinics, peer vaccinators and operational performance reporting.	Go-live date (1 st October 2026). Weekly reporting mechanism.
Inpatient flu vaccination	Eligible inpatients to be offered vaccination from October/November subject to supply and clinical suitability.	Eligible patients will be vaccinated via a PSD by trust clinical teams
COVID-19 vaccination	Eligible inpatient cohorts to be supported once national detail is confirmed.	Plan will align to JCVI/NHSE eligibility and Trust process. MPFT targeted vaccination team arrangements
Primary care vaccination	Directorate GP practices to deliver seasonal vaccination clinics and support eligible cohorts.	Delivery will commence from October 2026, weekly reporting mechanism in place and data will be reviewed at UEC Board/oversight group.
Data and reporting	Weekly/regular uptake reporting to operations and vaccination group.	Compliance with NHSE / UKHSA submissions.

10. Mutual Aid and Partnership Interface

Winter requires significant partnership working and reliance on agreed plans and memorandums of understanding (MOU) which have been developed during previous years and reviewed as part of the system winter learning which Combined are an active

partner within. Below are a number of agreed actions we will take to support partnership interface and mutual aid if required.

- Maintain attendance at ICS Urgent and Emergency Care Board and system calls, with COO representation and Deputy COO deputising as required.
- Use system escalation routes for AMHP delays, discharge barriers, social care capacity, D2A and out of area dependencies.
- Apply ICS workforce mutual aid MOU where workforce pressure requires cross-system support.
- Maintain mutual aid between Crisis Resolution and Home Treatment Team and MHLT where surge demand exceeds capacity.
- Use primary care PCN and GP practice mutual aid arrangements where practice teams are affected by outbreak or resilience issues.
- Maintain interfaces with independent sector providers for TCP/Project 86 and ensure contingency plans for provider failure remain current.

11. Triggers for Escalation Under Surge and Super-Surge Conditions

The table below outlines domain examples that may require both organisational and system response and what this may look like from a surge and super surge trigger, however these must also be considered in the round when linked to the OPEL Framework and wider Business Continuity.

Domain	Surge trigger	Super-surge trigger	Required response
Beds / OOA	Adult Acute, PICU or Older Persons occupancy materially above agreed threshold, delayed admissions or rising OOA demand.	No safe local bed options, multiple OOA placements required or inability to admit urgent patients safely.	Tactical/Gold review, OOA action escalation, mutual aid, regional/system notification.
CRFD / discharge	CRFD numbers or delayed days rise above agreed trajectory, discharge barriers not resolving.	Discharge failure materially compromises capacity and OOA/local admission safety.	Daily senior review, LA/ICB escalation, discharge hub prioritisation and recovery plan.
Crisis / MHLT	CCC or MHLT demand exceeds planned capacity, or response standards deteriorate.	Sustained inability to meet urgent response standards or ED/system safety risk.	Activate mutual aid, tactical oversight, system escalation and capacity redeployment.

Workforce	Staffing below planned levels in one or more key services.	Multiple critical services below safe staffing or specialist areas unable to operate safely.	Safe staffing escalation, bank/agency mobilisation, mutual aid and activity prioritisation.
IPC	Single outbreak affects one ward or service, with manageable staffing/capacity impact.	Multiple outbreaks or ward closures materially reduce bed availability or staffing.	IPC escalation, ICC if required, system notification and outbreak communications.
Weather / estate	Adverse weather or estate disruption affects access, staffing or service continuity.	Major estate failure or weather disruption affects multiple critical services.	Business continuity activation, ICC/major incident assessment and recovery response.

12. Specific Festive Period Arrangements

- Proactively discharge patients in the days before Christmas and New Year where clinically appropriate.
- Ensure senior decision-makers from inpatient, community and social care interfaces are rostered across key holiday periods.
- Maintain urgent infrastructure, estates, facilities, SERCO and digital support arrangements.
- Confirm social care support arrangements and integrated urgent care resilience plans.
- Share festive plans internally and with ICS/NHSE regional colleagues as required.
- Complete Primary Care festive access confirmation, including same-day urgent appointments, enhanced access, NHS 111 direct booking, Community Pharmacy and out-of-hours provision.

13. Communications, Information Management and Performance Reporting

13.1 Communications

A wide range of communication activities will be undertaken to provide advice and information to local people across North Staffordshire on how to stay well this winter and highlight the range of services and support available. This will dovetail with arrangements being implemented at system level and between system partners.

This will include but not be limited to:

- ✓ Promote winter and festive service arrangements for the public and staff.

- ✓ Support national winter campaign messages with local information on NHS 111, crisis text, pharmacy, GP access and self-care.
- ✓ Use Trust website, social media, stakeholder newsletter, Newsround, Exec Exchange and Combined Television.
- ✓ Prepare reactive media handling and holding statements for outbreaks, adverse weather or operational escalation.

13.2 Performance reporting

Metric	Purpose	Suggested frequency
OPEL score	Operational pressure and escalation status.	Daily, including weekends.
Bed occupancy and OOA	Capacity and flow assurance.	Daily operational review and oversight Reported daily via SHREWD. Monthly Performance Report.
CRFD and delayed discharge reasons	Discharge improvement and system escalation.	Daily operational review and oversight Reported daily via SHREWD. Monthly Performance Report.
CCC and MHLT demand / response times	Front-door and crisis pathway resilience.	Team level dashboards in situ. Monthly Performance Report.
Staffing levels and sickness	Safe staffing and workforce resilience.	Daily during escalation, routine otherwise.
Vaccination uptake	Prevention and campaign effectiveness.	Weekly during campaign.
Outbreak status	IPC and bed availability impact.	Immediate escalation and regular SITREP.

Appendix 1. Staffordshire and Stoke on Trent ICS OPEL Action Cards

SSOT ICS OPEL Action Card

OPEL 1
Review and assess current OPEL, score and specific contributing parameters. Address any rising pressures by taking a tailored approach to the actions relating to the specific drivers identified within the OPEL parameters
Maintain SHREWD data flows and review of real time information systems supporting system oversight.
Undertake horizon scanning for information sources to identify escalating operational pressure within specific metrics.
Maintain oversight of and compliance with reporting to all NHS England escalation and reporting mechanisms
The system co-ordination centre (SCC) will oversee system-level operations via OPEL monitoring, consistently communicating pressures to local partners and anticipating challenges to foster transparency, collaboration and co-ordinated responses. Provide advance warnings and timely escalation of system pressures. Provide and promote seamless communication channels across the local health economy, bridging communication boundaries between providers to enable agile responses and swift escalation/de-escalation as required.
Maintain agreed information sharing and cascades
Operational management of all UEC pathways across the system with escalation when required
SCC to monitor KPIs and providers to maintain dialogue regarding and challenges
Optimal utilisation of pre hospital pathways
Ensure pathways and services in place to support population health needs
Work to agreed OPEL actions
SCC to assess requirements for system call in line with Operational Pressures Escalation Plan
OPEL 2 (in addition to OPEL 1)
Review the OPEL score for each provider to identify the parameters that are triggering the increase in OPEL.
Work to agreed OPEL Action Cards to support/ensure ongoing flow
Review local policy in collaboration with all providers and formulate a joint plan to stabilise operational pressure and recover or prepare for a further increase in operational pressure.
Assessment of system capacity and demand
ICS communications to support routine messaging
OPEL 3 (in addition to OPEL 2)
SCC to assess and maintain oversight of OPEL scores across the system and escalate to the NHSE regional team in line with the escalation algorithms
Review OPEL drivers and coordination of tactical response
Frequency of and representation at system call in line with System Operational Pressures Escalation Plan
Monitor the effectiveness of actions in stabilising operational pressures, set and monitor recovery objectives, and strengthen communication, alignment and oversight across the system.
Ensure optimal utilisation of all pathways and agree actions for any areas identified as under utilised
SCC to provide updates to executive team and escalate matters requiring strategic support with resolution
Escalation capacity in line with surge plan and local escalation plans
Focussed management of all delays across the system with strategic escalation where tactical response not deescalating
Provide a nominated contact to maintain regular communication with the NHSE regional team, ensuring timely updates around escalation, collaboration and alignment between the local system and regional oversight.
Targeted internal and external communications
Consider targeted OPEL 4 actions in line with Operational Pressures Escalation Plan

OPEL 4 (in addition to OPEL 3)
Escalated system call and stand up of strategic call. Executive team to be fully briefed and coordinate strategic response
Dynamic risk assessments with executive team.
Assessment and management of risk in line with National Quality Board principles
Review and implementation of all OPEL 4 action cards
Agree communication strategy. Ensure clear and consistent communication on position across the system
Provide regular updates to the NHSE regional team in line with the escalation algorithms.
System wide proactive management of staffing levels, deployment of staff to priority areas as appropriate, identify additional workforce where able including release of staff through standing down of non essential activity, consider any additional hours where appropriate
ICB EPRR team to be briefed on position

SSOT Acute OPEL Action Card

OPEL 1	
Ensure data feeds into SHREWD are in place to enable SHREWD calculation. Proactive review of OPEL in line with established battle rhythm with appropriate actions and response where required.	UHNM UHDB
Maintain compliance with regional and national reporting mechanisms and escalation thresholds that have been agreed with the SCC and other providers. Report current position, challenges and agreed actions to ensure support during periods of rising pressure and to maintain oversight in preparedness for any escalation.	UHNM UHDB
Emergency department (ED) and Site Operational teams to monitor the effectiveness of ambulance handovers and critical patient assessments, re allocating staffing where required to respond to clinical need and surges in demand and ensuring standard operating process	UHNM UHDB
Site teams and ED Clinical and Operational teams to assess ED processes in line with KPIs and patient safety and coordinate appropriate response to maintain ED flow.	UHNM UHDB
Site teams and ED Clinical and Operational teams to assess waiting times for all pathways and escalate as per internal process to maintain safe and efficient patient flow within the ED. Proactively monitor through site operational meetings.	UHNM UHDB
Maintain referrals to specialities, assessments and transfers in line with agreed pathways and timescales and adherence to Internal Professional Standards.	UHNM UHDB
Ensure consistent and optimal utilisation of discharge areas and agreed processes for confirmed discharges.	UHNM UHDB IDH
Highlight any deficits to discharge against demand to relevant teams	UHNM UHDB IDH
Proactive discharge planning 7 days a week	UHNM UHDB IDH
NEPTS to keep SCC informed of any challenges with KPIs, increases in bookings, potential delays	NEPTS
Proactive front door streaming including redirection where appropriate.	UHNM UHDB
Assess and optimise utilisation of pre hospital alternative pathways	WMAS ICC CRIS
Ensure optimal utilisation of virtual ward capacity	ACAH
Critical Care and Site operations team to continuously oversee the critical care status (CritCon) and ensure patients are stepped down from critical care within agreed timescales	UHNM UHDB
Engagement with ambulance, acute trusts and SCC to support plans for ambulance-to-hospital handover to ensure efficient and timely transitions from pre-hospital care to hospital services.	UHNM UHDB SCC
Review of repatriation lists to ensure wait times are in line with Midlands' policy and appropriate escalations take place as per policy.	UHNM UHDB
OPEL 2 (in addition to OPEL 1)	
Operational site meetings to assess and agree actions to reduce OPEL and ensure efficient management of resources. Trust wide operational briefings through site team updates. Briefings to Senior Exec Group as per internal process.	UHNM UHDB
ED Based Ambulance personnel to coordinate patient movement, managing hospital turnaround times, and liaise with system partners to address performance and ensure a positive experience for patients and crews.	WMAS UHNM UHDB
ED Duty Manager and Site team to coordinate response to internal flow challenges	UHNM UHDB
Proactive management of Internal Professional Standards for any speciality delays with appropriate escalation.	UHNM UHDB
Proactive management of flow to assessment units/portals and ward once clinically ready to proceed in line with agreed capacity protocols	UHNM UHDB
Highlight any barriers to flow to divisional reps with an expected time for feedback	UHNM UHDB
Proactive discharge planning, management and compliance with agreed discharge processes including optimal utilisation of designated discharge capacity	UHNM UHDB IDH

Proactive management of length of stay and early referral/escalation to external providers at an optimal time	UHNH UHDB IDH UHDB Discharge Team
Proactive management of complex discharge demand	IDH UHDB Discharge Team
Collaborative working with NEPTS PTLO to support prioritisation	IDH NEPTS UHNH UHDB

Continuous monitoring of critical care capacity through site meetings including anticipation of resus demand and step down requirements.	UHNH UHDB
OPEL 3 (in addition to OPEL 2)	
OPEL review and briefings through operational site meetings and system calls.	UHNH UHDB
Increased Care Group/Divisional attendance at site meetings with focus on actions required to respond with Executive team oversight.	UHNH UHDB
SCC to provide updates to executive team and escalate matters requiring strategic support with resolution	SCC
ED based Ambulance personnel and ED clinicians to ensure clinical management and prioritisation for patients awaiting handover in line with agreed policies for rapid handover and minimum care standards.	WMAS UHNH UHDB
Assess and ensure optimal utilisation of non ED pathways	WMAS UHNH UHDB ICC CRIS SCC
Maximise utilisation of UCR 2hour response	WMAS ICC CRIS
Assess and coordinate divert of ambulance activity where appropriate and in line with agreed protocols	WMAS UHNH UHDB SCC
Ensure optimum utilisation of all agreed capacity within ED in line with capacity and escalation protocols	UHNH UHDB
Proactive in-reach and pull/push to assessment units/portals and virtual ward in line with IPS and agreed protocols	UHNH UHDB
Optimise and support all opportunities for admission avoidance	WMAS ICC CRIS UHNH UHDB
Utilisation of HRD to proactively support risk stratification and optimal pathway utilisation	UHNH IDH
Site team to coordinate flow and compliance with agreed timeframes and clinical requirements.	UHNH UHDB
Ensure assessment and implementation as appropriate of agreed capacity plans and protocols including Continuous Flow, TES capacity, Outlying, use of speciality capacity for non speciality patients	UHNH UHDB
Enhanced review and senior clinical support and oversight of afternoon board rounds (with check, chase and challenge), review of criteria to reside and consideration of NEWS2.	UHNH UHDB IDH UHDB Dc
Review of diagnostic waits with consideration of requirement for inpatient investigation	UHNH UHDB
Full IPC review to optimise available capacity	UHNH UHDB
Increased coordination of discharges including allocation of resources to support with discharge medication and additional discharge capacity in line with escalation protocols.	UHNH UHDB IDH UHDB Dc
Escalated management of complex discharge demand	IDH UHDB Discharge Team
Review of patients listed for services to identify opportunities for alternative pathways where capacity available	UHNH UHDB IDH UHDB Dc
Escalation of patients with an extended length of stay and agreed actions to progress discharge plans	UHNH UHDB IDH LA AACC
Liaise with NEPTS Relationship Manager and enhanced coordination of discharge transport, NEPTS to review resource allocation in response to surges in demand. Ensure appropriate use of NEPTS	UHNH UHDB IDH NEPTS
Support with coordination of system actions and response	SCC
Proactively manage critical care capacity in line with agreed protocols	UHNH UHDB

NSCHT will complete review/oversight of MH functions within Acute Trust, including review of number of MH patients in ED/ward based, to support timely review/assessment. MHLT will attend daily ED huddles/review staffing levels.	NSCHT
NSCHT will review MH demand in ED where thresholds met, will consider redeployment from wider MHLT/alternative teams where possible. Deploy 'Attend to Assess' model in ED/Ambulance waits where appropriate.	NSCHT
NSCHT to agree internal communication huddle with MHLT/internal bed flow team throughout agreed timeframe to understand demand/flow in wider services/step down opportunities into CCC	NSCHT
Proactive communication with GPs regarding points of contact for direct access	ICB Primary Care and Comms Team
Targeted Internal and External Comms	UHNM UHDB ICB Comms team

OPEL 4 (in addition to OPEL 3)	
Increased operational meetings and/or tactical coordination in line with Trust protocols with Chief Operating Officer or Nominated Deputy oversight.	UHNM UHDB
Executive team to be fully briefed and coordinate strategic response	UHNM UHDB ICB
Medical Director led response to clinical reviews and risk based discharge planning	UHNM UHDB
DIPC led IPC review	UHNM UHDB
Simple and Timely discharge targets to be agreed by Executive Leadership team	UHNM UHDB
IDH visible presence and support with prioritisation of discharge and tracking of delayed transfers of care with escalation	IDH
Stand down of non-essential services	UHNM UHDB
Clinical prioritisation of elective activity	UHNM UHDB
Stand down of meetings, training and activities not related to clinical and operational response	UHNM UHDB
Deployment of staff to priority areas	UHNM UHDB
SCC support with coordinating repatriations	SCC
Coordination of system strategic and tactical system response including implementation of appropriate actions across multiple agencies	SCC ICB UEC Team
Review of ICS Level 4 Actions and agree implementation of appropriate actions	SCC
Escalation capacity to be open in line with System Surge Plan	UHNM UHDB MPFT ICB

SSOT Mental Health OPEL Action Card

OPEL 1	
Ensure data feeds into SHREWD are in place to enable SHREWD calculation. Associate Director/Deputy COO in NSCHT and Associate Director Urgent Care in MPFT to undertake OPEL assessment by reviewing specific contributing parameters in addition to any other locally agreed parameters with directorate teams. Address any rising pressures by taking a tailored approach to the actions related to the specific drivers identified within the OPEL parameters.	NSCHT MPFT SCC
Monitor demand and capacity through data flows, system calls and system partner input	NSCHT MPFT SCC
Undertake demand and capacity mapping at trust level and escalate to the integrated care board (ICB) where gaps are identified.	NSCHT MPFT
Daily contact with LA partners regarding escalation of CRFD, escalation to the ICB/local authority executives where necessary (locally agreed).	NSCHT MPFT
Maintain compliance with regional and national reporting mechanisms and escalation thresholds that have been agreed with the SCC and other providers. Report current position, challenges and agreed actions to ensure support during periods of rising pressure and to maintain oversight in preparedness for any escalation	NSCHT MPFT
Co-ordinate flow management and review inpatient admissions and discharges in line with baseline activity for bed management. Identify and mitigate any increasing risks that could impact on patient flow, with escalation of barriers to a named individual.	NSCHT MPFT
Directorate discharge lead in NSCHT and Bed Manager in MPFT to co-ordinate and expedite the return of patients in inappropriate out-of-area placements to their local services. Escalate any delays to the SCC	NSCHT MPFT
Review Home Treatment and Crisis teams caseload daily, to assess clinical need for patients to remain on their caseload, and step down or reduce contacts if clinically appropriate, creating capacity within those teams.	NSCHT MPFT
Prioritise community-based care and home treatment team capacity through proactive management of at-risk MH patients at home and facilitating return home for others.	NSCHT MPFT
CRFD/long length of stay meetings to use multi-agency discharge event (MADE) principles; regularly reviewing cases with extended lengths of stay	NSCHT MPFT
Support resolution of escalations relating to MH capacity	NSCHT MPFT
Utilise local escalation protocols for patients waiting to be admitted to MH beds	NSCHT MPFT
Source an out-of-area provider if no local/mutual aid is available and all other options have been exhausted, but with a view to the patient's repatriation as soon as possible.	NSCHT MPFT
OPEL 2 (in addition to OPEL 1)	
Deputy chief operating officer for NSCHT and Operations Director (SSOT Care Group) for MPFT to be briefed and made aware of trust capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources.	NSCHT MPFT
Review the use of leave beds and ensure contingency plans are put in place for their use if clinically agreed, and that these plans are clearly communicated to all those supporting patient flow.	NSCHT MPFT
Maintain weekly bed management meeting	NSCHT MPFT
Review all estimated discharge dates (EDD) that are within the next 72 hours, ensuring all internal and external actions are taken to enable the discharge to proceed.	NSCHT MPFT
Highlight to the ward consultant any newly admitted people who have not had a review within 24 hours of admission and a purpose for admission identified	NSCHT
Inform MH community teams about increasing pressures. Enhance contingency plans to support patients at home, to help prevent hospital admissions and ensure continuous care.	NSCHT MPFT
Utilise Crisis House to step people down from in-patient beds where clinically appropriate	MPFT

OPEL 3 (in addition to OPEL 2)	
Chief operating officer (COO) for NSCHT and Managing Director (SSOT Care Group) for MPFT to be briefed and made aware of trust capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources.	NSCHT MPFT
SCC to provide updates to executive team and escalate matters requiring strategic support with resolution	SCC
Increase frequency of capacity and demand review meetings with senior managers. Focus on expediting discharges, increasing bed capacity and addressing barriers with leadership. Explore options to open more beds to ensure ED and community safety. The COO's deputy for NSCHT and Associate Director Urgent Care for MPFT will attend flow meetings to lead on MH provider objectives. Senior clinicians should provide increased support to wards and be included in early discharge reviews.	NSCHT MPFT
Senior clinicians will support informal admission bed requests, review cases and provide in-reach interventions when needed. They will prioritise the least restrictive alternatives to admission.	NSCHT MPFT
Review options to reopen temporarily closed beds.	NSCHT
Review options to maximise staffing across all appropriate teams by cancelling non-essential training, meetings and activities that impact on clinical staffing levels. Review voluntary review of annual leave, secure temporary staffing, and consider offering voluntarily extra hours, overtime to help patient care needs to be met across inpatient, crisis and community teams.	NSCHT MPFT
Service managers to coordinate review of activity, support prioritisation of workload in line with clinical requirements	NSCHT MPFT
Escalated contact with LA partners regarding escalation of CRFD, escalation to the ICB/local authority executives where necessary (locally agreed).	NSCHT MPFT
OPEL 4 (in addition to OPEL 3)	
Escalate further actions as needed. Maintain review of OPEL to monitor effectiveness of actions on OPEL score.	NSCHT MPFT
Ensure COO in NSCHT and Managing Director (SSOT Care Group) in MPFT is briefed on trust capacity and OPEL position. Focus activities to reduce OPEL and ensure efficient management of resources. Executive clinical leads should maintain a visible presence in high-priority areas.	NSCHT MPFT
ICB Executive team to be fully briefed	SCC
Increase operational bed flow meetings cadence to twice daily, with meetings to be led by the director of nursing and/or medical director or nominated deputies in NSCHT and Operations Director (SSOT Care Group) in MPFT.	NSCHT MPFT
Ensure the presence of key personnel on the hospital site. Members of in reach, hospital discharge teams, bed management and discharge co-ordinators (and relevant managers) should be present on the hospital site to facilitate efficient co-ordination and communication between key personnel, helping to manage patient flow and discharges effectively.	NSCHT MPFT
Implementation of surge plans	NSCHT
Proactively identify discharge opportunities and expedite in-reach processes. Communicate this information to bed capacity teams. Regularly review the list of upcoming discharges from the wards, and strategies to accelerating inreach. This approach aims to enhance patient flow, optimise bed management and make best use of available resources.	NSCHT MPFT
Consider deploying non-clinical staff to alleviate the non-clinical workloads of clinical staff wherever possible, to improve efficiency and allow clinical staff to focus on patient care.	NSCHT MPFT
Cancel non-essential community activity to focus community and crisis resources on admission avoidance where possible.	NSCHT MPFT
Increase the frequency of review of CRfD patients, with review including their EDD, to identify any delays and escalate these to the SCC for system response	NSCHT MPFT

SSOT Community OPEL Action Card

OPEL 1

Maintain established data feeds to enable OPEL calculation through SHREWD. Taking tailored approach to actions relating to specific drivers identified within OPEL parameters.	MPFT ACAH
Review patients daily to identify those that are able to move to a more appropriate place for their onward treatment, and care as per BAU.	MPFT IDH
Discharge to Assess and community teams to maintain dialogue with care transfer hubs, to set dynamic objectives for discharge and to understand the demand for community hospital beds and/or community services to aid flow.	MPFT
Referrals into Community Services to be triaged and processed within agreed timeframes with established processes to identify any capacity and demand gaps.	MPFT ACAH
Monitoring to include capacity and utilisation of virtual wards, intravenous IV pathways, and UCR caseload and response times. Ensure capacity, capability and utilisation of virtual wards are optimised to meet UEC demand.	MPFT ACAH
Optimal utilisation of virtual ward capacity	ACAH UHNM UHDB IDH MPFT
Operational Management of POLR with monitoring through system call	LA SCC
OPEL 2 (in addition to OPEL 1)	
Utilisation of SHREWD and System Calls to monitor OPEL. Associate Director of Urgent Care (MPFT) oversight inc coordination of tactical management to reduce OPEL and ensure efficient management of resources.	MPFT ACAH SCC
Ensure dynamic approach to managing capacity and demand requirements for community services to ensure that resources are fully utilised, enhancing patient flow and providing timely care for those in need.	MPFT ACAH
All Community services to deploy proactive reviews of discharge plans, with discharge waits to be escalated through local governance and escalation processes.	MPFT ACAH LA AACC
Establish and maintain daily reporting across the system. This reporting should detail the current status, identify challenges and outline agreed actions, to ensure transparency, facilitate problem-solving, and promote coordinated efforts to improve patient care and resource management.	MPFT ACAH LA AACC
Ensure virtual wards link with ICC for Urgent Care, Same Day Emergency Care (SDEC), UCR, 999, 111, care homes, and consider in-reach initiatives in both ED and inpatient wards to identify patients who could benefit from virtual ward care.	ACAH MPFT
Increase the frequency of ward rounds and in-reach activities to identify patients across community pathways who can be discharged to maintain flow.	MPFT ACAH UHDB
Highlight and escalate any capacity issues and blockages to ensure timely resolution and improve patient flow using established pathways to escalate to system partners in Social Care and All Age Continuing Care. System partners to also pro-actively provide updates.	MPFT LA AACC
Once funding agreements in place, identify any providers who would agree to new costings in order to transfer funding and release D2A funding	MPFT AACC LA
Proactive management and support for Self Funding with appropriate escalation as per agreed processes	MPFT LA UHDB
Proactive implementation of Choice Policy	MPFT LA UHDB
Clinical and Operational Management oversight of virtual ward, ICC and UCR utilisation and response with information provided through system call.	AACC MPFT WMAS
Operational management of patients with an extended length of stay and agreed actions to progress discharge plans	MPFT UHDB LA AACC
Conduct manual ring-around of providers to collate capacity information and motivate offers	LA AACC
Senior brokers/team manager review cases and escalate any family choice/unclear need issues as required	LA AACC
Brokers and Commissioners to review unmet need and engage with market to identify additional capacity where possible	LA

OPEL 3 (in addition to OPEL 2)

Associate Director of Urgent Care (MPFT) to provide leadership and oversee tactical response to reduce OPEL and ensure efficient management of resources and to keep Managing Director briefed as appropriate.	MPFT
Senior leadership team oversight	AACC
Verify the status of all community bedded and non-bedded capacity, ensuring that all beds are operational. Develop and maintain a comprehensive plan to facilitate early patient transfers.	MPFT
Facilitate the review of and system discussion and enactment of predetermined plans to procure additional capacity.	MPFT SCC
Ensure all partners from whom referrals are accepted are aware of heightened pressure and request that they prioritise any referrals appropriately, seek guidance for using alternative pathways. Utilise SCC and System call to agree actions.	MPFT SCC
Acute providers in collaboration with community services to review patients listed for services to establish any change in need and appropriate alternative pathways	UHNM UHDB IDH MPFT
Focused review of all delays with required escalations. Consideration of ad hoc escalation meetings where limited resolution or ongoing delays	MPFT LA AACC
Head of service overview of delays in each pathway, same day funding consideration	Stoke on Trent LA
Lead Commissioner and Assistant Director oversight of escalations and review of pending cases and escalation of unresolved high cost funding issues	Staffordshire LA
Utilisation of off framework home care (beyond normal 90% target) where available	Staffordshire LA
Extend geographical boundaries beyond usual parameters to support discharge	AACC
Escalation of cases to Director of Nursing All Age Continuing Care to support with decision making	AACC
Enhanced review of patient profiles and system support to identify solutions to progress discharge	MPFT ICB LA UHDB UHNM
Senior support with management of Choice Policy where required.	MPFT LA AACC
Community pathways to conduct additional ward rounds or enhanced patient reviews and rigorously review admission and treatment thresholds, to identify and create capacity wherever feasible.	MPFT ACAH UHDB
Increased monitoring of virtual ward, ICC and UCR utilisation and response.	AACC MPFT WMAS
Proactive management of available resources to respond to priority areas including review of clinical and non clinical activity to ensure optimal clinical response	MPFT ACAH AACC LA
Escalation of patients with an extended length of stay and agreed actions to progress discharge plans	MPFT UHDB LA AACC
Targeted Internal and External Comms	MPFT ACAH ICB Comms team
OPEL 4 (in addition to OPEL 3)	
Associate Director of Urgent Care to brief Managing Director on OPEL position and facilitate strategic response.	MPFT
Executive team to be fully briefed and support with coordinated strategic response	ICB
Clinical Director led response	ACAH
SCC to coordinate system response including effective utilisation of System Call and consideration of Strategic Call.	SCC
Senior management and oversight of case progression	AACC LA
Support POLR movement where greater flexibility on times of calls is required	LA
Stand up of enhanced brokerage where demand dictates	LA
Proactive management of staffing levels, senior managers to support any redeployment of staff to priority areas as appropriate, identify additional workforce where able including release of staff through standing down of non essential activity, consider any additional hours where appropriate	MPFT ACAH LA AACC ICB

Appendix 2: Equality and Health Inequalities Impact

NSCHT - Quality Impact Assessment (QIA) & Equality Health Impact Assessment (EHIA) tool (informed by National Quality Board)

DOCUMENT 1:

- Summary of proposal – Front Sheet
- Summary of Initial assessment and screening tool
- QIA review - STAGE ONE - initial assessment & screening

	Summary of proposal				
Directorate:	Trust Wide			QIA ID:	
Lead completing QIA:	Deputy Chief Operating Officer			QIA version:	1
Executive lead and/or project sponsor:	Chief Operating Officer	Accountable clinical Director:	NA	Date:	16.8.26

Proposal name:	The Winter Plan 2026/27		
Proposal overview:	Proposal Overview: The Winter Plan 2026/27 outlines the Trust's arrangements to maintain safe, effective and equitable services during periods of increased seasonal demand. The plan includes operational escalation arrangements, discharge improvement actions, workforce resilience measures, infection prevention and control arrangements, vaccination programmes, crisis pathway resilience and system-wide partnership working.		
Clinical Director approval:	Name - NA NA Date - NA		
Area(s) affected (for example, service, provider, system):	Trust-wide inpatient, community, crisis, urgent care, liaison and primary care services.	Stakeholders identified as affected by the proposal:	Service users Carers and families Trust staff Local Authorities Primary Care University Hospitals of North Midlands Midlands Partnership Foundation Trust Integrated Care Board

			Voluntary and Community Sector Partners
Engagement work completed for the proposal to date (including engagement with stakeholders):	Development informed by winter learning from 2025/26, directorate operational review, system winter planning arrangements and ICS planning requirements	Engagement work planned for the proposal:	Engagement regarding the Winter Plan with Operational and Tactical Response Leads, wider clinical directorate socialization of the Winter Plan and the ICS Winter Plan.
Funding arrangements and financial implications for proposal:	Delivery through existing operational resources and approved winter, discharge and OOA programmes. Any additional investment subject to normal governance processes.		
Any known gaps in available evidence and plans to address them:	Final occupancy and activity trajectories for Winter 2026/27 remain subject to seasonal variation. Ongoing monitoring through SHREWD, OPEL and performance reporting mitigates this risk.		
Any QI or EHI Mitigations to be put into place?	Please record NA if appropriate		
What will the QI & / or EHI measures be for this proposal and how frequently will they be monitored?	Impact measures: • Bed occupancy • Out of Area placements • CRFD numbers • MHLT response times • Crisis Care Centre activity • OPEL status • Staff sickness absence • Vaccination uptake • Outbreak incident Monitored daily and/or via monthly performance metrics		
Identified Lead for Impact Measure Monitoring	Rachael Birks Interim Chief Operating Officer/AEO		

Summary of Initial assessment and screening tool											
NB - This document needs to be approved before moving to the next stage of your proposal by the Chief Nursing Officer, Chief Medical Officer OR Deputy Chief Nurse											
Summary (completion by project /programme proposal team)									Screening Decision Completed by proposal leads Clinical Director		
NQB domain (QIA)	Impact			Initial assessment			Revised assessment			Sufficient evidence provided? Y/N	Recommendation
	Positive	Neutral	Negative	Consequence	Likelihood	Risk score	Consequence	Likelihood	Risk score		
Patient safety	X									Winter arrangements strengthen surveillance, escalation, IPC, discharge oversight and staffing resilience.	
Clinical effectiveness	X									Supports timely access, flow management, crisis alternatives and discharge pathways.	
Experience	X									Improved crisis access, NHS 111 mental health access, text services and discharge planning	
Well led	X									Clear governance, escalation, command structures and executive accountability	

Sustainable	X									Supports capacity management, reduction of OOA placements and system resilience.	
Equitable	X									Focus on access, crisis alternatives, discharge support and reduction of inequalities associated with delayed care.	
Protected characteristics (EHIA)	Impact			Initial assessment			Revised assessment			Sufficient evidence provided? Y/N	Recommendation
	Positive	Neutral	Negative	Consequence	Likelihood	Risk score	Consequence	Likelihood	Risk score		
Age	X									Older people are likely to benefit from strengthened discharge arrangements, flow improvements, vaccination programmes and outbreak management. Children and young people benefit from continued operation of the Intensive Support Hub and crisis support services. Winter pressures may disproportionately affect older people if discharge pathways	

									become constrained. Mitigation Daily discharge review. Integrated discharge hub arrangements. Vaccination programme. Escalation of delays affecting older adults. KPI Delayed discharge rates. Bed occupancy. Vaccination uptake	
Disability	X								People with mental illness, learning disabilities and long-term conditions benefit from continued crisis support, alternatives to admission and intensive support services. Risks may arise if service pressures reduce responsiveness during peak demand periods. Mitigation Maintain crisis alternatives. Monitor access and response times. Escalation processes for capacity pressures. KPI Crisis response standards.	

									Waiting times. OOA placement numbers.	
Gender reassignment		X							No evidence that the Winter Plan directly disadvantages individuals undergoing gender reassignment. Mitigation Continue person-centred care. Ensure equitable access during periods of escalation. KPI Complaints and patient experience data	
Marriage or civil partnership		X							No differential impact identified	
Pregnancy and maternity	X								Pregnant women accessing mental health services benefit from maintenance of crisis pathways, liaison services and infection prevention arrangements. Mitigation Maintain safe access routes. Individual care planning during periods of pressure. KPI Access and patient feedback	

Race	X									Maintaining access to crisis support, NHS 111 mental health services and community pathways will support equitable access during winter periods. Potential risk exists if communication approaches do not meet diverse community needs. Mitigation Accessible communication. Interpretation services maintained. Monitor patient experience and access data. KPI Patient feedback. Complaints. Access metrics.	
Religion and belief		X								No specific adverse impacts identified. Mitigation Continue to meet religious and cultural needs within inpatient and community settings.	
Sex		X								No differential impact anticipated. Mitigation Monitor service access and experience data	

Sexual Orientation										No adverse impacts identified. Mitigation Continue inclusive and equitable access arrangements	

QIA review - STAGE ONE - initial assessment & screening											
QIA & EHIA Decision is full QIA & / or EHIA required (i.e. proceed to stage 2)	Stage 1 – QIA Initial decision										
	CNO / CMO OR DCNO										
	No Rationale: Overall Assessment: Positive The Winter Plan supports reduction of health inequalities by: • Maintaining all-age crisis access. • Supporting NHS 111 Mental Health access. • Providing alternatives to admission. • Improving discharge processes. • Reducing Out of Area placement reliance. • Supporting access to vaccinations. • Maintaining services throughout periods of increased demand. Potential inequalities may occur if system discharge capacity becomes constrained, particularly affecting older people, people with severe mental illness, those requiring social care packages and people with complex needs. Key Mitigations • Daily operational oversight. • SHREWD monitoring. • OPEL escalation. • Integrated Discharge Hub. • OOA Action Plan. • System escalation with Local Authorities and ICB. Overall QEIA Conclusion The Winter Plan 2026/27 is assessed as having an overall positive impact on quality, equality and health inequalities, through strengthening access, patient flow, service resilience, discharge arrangements, infection prevention and crisis response. No significant adverse equality impacts have been identified. Ongoing monitoring through winter governance arrangements will ensure any emerging impacts on protected groups are identified and addressed promptly.										

	Overall Quality Assessment: Improves Quality Recommendation: Approved to proceed with routine monitoring through existing winter governance and performance reporting arrangements
Date of review:	
Signature	

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	OTHER - Please write below
If Other, write Provider/Trust Name:	North Staffordshire Combined healthcare Trust
Contact details (email, phone number):	Rachael.birks@combined.nhs.uk
Date:	01/07/2026

Please complete these sections					
Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes		
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes		
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes		
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Completed on 18th August (System STW/SSOT) Regional led exercise	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Interim Chief operating Officer (AEO)	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes		

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

			Please complete these sections		
Section B: 26/27 Winter Plan checklist			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes		
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes		
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes		
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes		
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes		
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: •coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Model Discharge Pathways are acute focused however from a MH perspective the Getting It Right First Time Clinical Operational standards Adult Acute Mental Hea	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes		
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	NSCHT have been involved in the preparatory work within the ICS. MH pathways have been reviewed and are aligned.	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	As above	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Monitored closely at operational level and is apt of our performance and safer staffing controls.	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes		
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	NA	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Agreed response times for our MHED presentations and for those within the deep bed base within the acute trust	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	NA	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	NA	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	NA	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes		
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	MH Discharge/GIRFT Principles	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	NA to a MH/LD Trust	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	IPC lead has been involved in the development of the plan and part of the winter learning	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes		
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes		
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes		
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes		
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Tested as part of the ICS winter exercise	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes		
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes		
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes		
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes		
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Clear Buisness Continuity Plans in site which have been tested.	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes		

	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.	Yes	Agreed ICS wide SOP for Place of Safety, worked closely with Acute provider to ensure pathways are insitu to move patients to CCC.

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: North Staffordshire Combined Healthcare Trust

Provider CEO name: Buki Adeyemo

Date reviewed:

Provider Chair name: Janet Dawson

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Rachael Birks Interim Chief Operating Officer/Accountable Emergency Officer

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Confirmed

Please confirm date reviewed

BAS Self-Assessment Dashboard

Trust		
Overall Assessment Rating: 5 - Full assurance		
Section B		Rating
	Prevention	5 - Full assurance
	Flow, occupancy and discharge	5 - Full assurance
	Capacity and community	5 - Full assurance
	UEC Flow	5 - Full assurance
	Infection Prevention and Control (IPC)	5 - Full assurance
	Leadership and operational grip	5 - Full assurance
	Specific actions for Mental Health Trusts	5 - Full assurance

Enclosure No: 6

LORD MANN BOARD BRIEFING

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

Presented by:	Frieza Mahmood, Chief People Officer
Prepared by:	Lincoln Gombedza, Inclusion and Belonging Lead.
Executive Lead:	Frieza Mahmood, Chief People 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 4 - Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Approval / Review:	People, Culture and Development 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 PSED Duty G1: Put an end to unlawful behaviour including discrimination, harassment and victimisation.
ICS Alignment / Implications:	Aligned to the joint ICS Anti-Racism and Anti-Religious Hatred Statement issued by Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB, and signed by the Chief People

	Officer as SRO for Inclusion and Belonging across SSOT. Implementation supports system-wide inclusion, belonging and workforce equality priorities and a consistent ICS response to the Lord Mann Review.
Recommendation / Required Action:	The Board is asked to: • Note the publication of the Lord Mann Review and the NHS England response. • Reaffirm the Trust's commitment to combating racism and all forms of religious hatred, including antisemitism and Islamophobia. • Endorse the existing ICS Anti-Racism and Anti-Religious Hatred Statement as the foundation for local implementation. • Approve adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles. • Approve the proposed embedding approach through existing organisational development, inclusion, workforce and governance arrangements, with implementation and assurance reported through the Inclusion Council and the People, Culture and Development Committee. • Agree that the Trust will continue to review its position regarding the Lord Mann Review recommendations and implementation guidance as national expectations evolve.
Executive Summary:	This paper updates the Board on the Trust's progress against the actions required following the Lord Mann Review. It seeks approval to adopt the NHS Race and Health Observatory Seven Anti-Racism Principles, endorse the existing ICS Anti-Racism and Anti-Religious Hatred Statement as the foundation for local implementation, and embed the agreed approach within policy, workforce practice and governance. The Lord Mann Review identifies persistent racism in healthcare, including antisemitism and Islamophobia, and calls for clearer standards and stronger accountability. In response, NHS England requires organisations to take immediate action on racism, discrimination and inequality; sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles; and confirm by 31 July 2026 whether they have adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility. Trust progress against the immediate actions is set out at Appendix 1. The proposed embedding approach will be delivered through existing organisational development,

inclusion, workforce and governance arrangements, with oversight through the Inclusion Council and the People, Culture and Development Committee.

The Trust's position, published jointly across the ICS in 2024, is to consider the IHRA working definition alongside other recognised definitions and guidance on a case-by-case basis, while maintaining a clear commitment to challenge antisemitism and all other forms of racism wherever they occur. This supports a consistent whole-organisation approach and reflects expert advice that implementation should avoid creating a perceived hierarchy of discrimination. Mandatory EDHR training compliance is 95% as at July 2026. The Trust will implement the new NHS faith co-created bitesize module and Board anti-racism training when these become available.

Subject to Board approval, the Trust will adopt the Seven Anti-Racism Principles, confirm its position to NHS England, embed the agreed requirements within existing policies, leadership development and workforce processes, and strengthen reporting on staff experience of discrimination. Delivery and assurance will be overseen through the Inclusion Council and the People, Culture and Development Committee, using existing resources.

VERSION CONTROL:

Version	Report to	Date Reported
V1	People, Culture and Development Committee	July 2026
V1	Public Trust Board	September 2026

Lord Mann Review Board Briefing

1. Purpose

To advise the Board on the Trusts progress against the required actions set out in the Mann review; inform of the requirement/seek approval to adopt national anti-racism principles and definitions; and confirm the Trust's approach to embedding these within policy, practice and governance.

2. Executive Summary

NHS England requires all organisations to:

- Strengthen action on racism, discrimination and inequality by carrying out a series of immediate actions
- Sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles
- Adopt the IHRA definition of antisemitism and UK Government definition of anti-Muslim hostility

This paper recommends that the Trust:

- Formally adopts the NHS Race and Health Observatory Seven Anti-Racism Principles
- Reaffirms its opposition to antisemitism, Islamophobia and all forms of racism and religious hatred
- Considers the IHRA definition of antisemitism alongside other recognised definitions and guidance where appropriate, on a case-by-case basis
- Embeds these principles within existing policies, leadership development, workforce processes and organisational culture initiatives
- Strengthens reporting, data use and oversight of staff experience

This will ensure compliance with national requirements, provide clarity on unacceptable behaviours, and support a more inclusive environment.

3. Background

The Lord Mann Review identifies persistent racism in healthcare, including antisemitism and Islamophobia and calls for clearer standards and stronger accountability.

In response, NHS England requires organisations to:

- Adopt anti-racism principles

- Strengthen violence prevention and data use
- Implement NHS Staff Standards
- Ensure completion of EDHR training and new learning modules
- Undertake Board-level anti-racism training
- Improve engagement with staff, patients and communities
- Strengthen Board oversight of staff experience data

In addition, Trusts are asked to confirm by Friday 31 July 2026, if they have adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility

4. Current local Position

4.1 Immediate actions Trusts are being asked to carry out

The Trusts progress against the required actions set out in the Mann review can be found at Appendix 1.

4.2 Adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility

The Trust's approach has been to consider the IHRA working definition of antisemitism alongside other recognised definitions and guidance where appropriate, on a case-by-case basis, whilst maintaining a clear commitment to challenge antisemitism and all other forms of racism wherever they occur. This position was published last year by Staffordshire and Stoke on Trent (SSOT) ICB and Shropshire Telford Wrekin (STW) ICB, in a joint statement signed by our Chief People Officer Frieza Mahmood, SRO for Inclusion and belonging across SSOT and Mish Irvine, Chief of Staff, SSOT & STW ICB Cluster.

Statement:

“ICS Anti-Racism and Anti-Religious Hatred Statement:

Standing together against racism, antisemitism, Islamophobia and other hatred

Across our two Integrated Care Systems in Shropshire, Telford and Wrekin, and Staffordshire and Stoke-on-Trent, we are united in our commitment to creating safe, inclusive and respectful environments for all. We are clear and unequivocal in our stance: **racism, antisemitism, Islamophobia and all forms of religious and racial hatred have no place in our workplaces, our services or the communities we serve.**

We are committed to becoming actively anti-racist organisations. This means not only standing against racism in all its forms, but taking deliberate and sustained action to identify, challenge and dismantle the structures, behaviours and inequalities that allow it to persist. We recognise that racism is experienced in both overt and

subtle ways, and we expect all colleagues to role-model inclusive, compassionate behaviours and to speak up when discrimination occurs.

We also stand firmly against religious hatred in all its forms. Antisemitism, Islamophobia and hostility towards people of all faiths and beliefs are unacceptable and will not be tolerated. Everyone - patients, service users, staff and communities - has the right to feel safe, respected and valued, regardless of their background, identity or beliefs.

We are clear that statements alone do not create change. Real change requires consistent, visible action. Across our systems, we are committed to embedding anti-racist principles into our leadership, policies, workforce practices and service delivery. This includes listening to lived experiences, addressing inequalities, holding ourselves to account, and taking meaningful steps to build a culture of belonging for all.

Creating inclusive environments is a shared responsibility. We encourage all colleagues to seek support and to speak up if they experience or witness racism or religious discrimination. If you witness or experience racial or religious abuse, please report it through your organisation's established processes so that appropriate action can be taken. Support and advice are available through:

- People/HR Teams
- Equality, Diversity and Inclusion specialists
- Freedom to Speak Up Guardians and Champions
- Staff Network leads and representatives
- Staff Support and Counselling Services

Together, **through our actions as well as our words**, we will continue to build a culture where everyone feels safe, valued and that they truly belong. By standing together, we send a clear and collective message: **hatred and discrimination will not be tolerated, and inclusion, compassion and respect will always define who we are.**

END

This statement has since been used to confirm our position in a recent FOI request and included the following header: "Following the NHS England adoption of the IHRA working definition of antisemitism, North Staffordshire Combined Healthcare NHS Trust, together with our integrated care system partners across Staffordshire and Stoke on Trent, have issued the following statement confirming that we are opposed to antisemitism, taking into account the IHRA definition alongside other definitions, on a case by case basis if required. The Trust continually reviews its position and is currently considering our response to the Lord Mann Review."

5. National Position from EDI Experts

EDI Advocates (e.g., Roger Kline's, BMJ) have argued that whilst antisemitism is real and serious and must be tackled robustly, there is a risk that implementation of the Mann Review recommendations in their current form, could unintentionally create a perceived hierarchy of discrimination if antisemitism is addressed separately from wider anti-racism work. All agree that implementation should ensure that all racism is scrutinised and addressed through consistent principles and processes, that the

IHRA definition should be used carefully given debate about its application in some contexts and that action be embedded within broader anti-racist structures rather than creating parallel approaches.

6. Embedding Approach

Implementation will be delivered through existing systems as set out in Appendix 2 with Board oversight and assurance strengthened through regular reporting on staff experience of discrimination, tracking of improvement actions, and oversight via Inclusion Council and the People, Culture and Development Committee.

7. Risks and Mitigation

Risk	Mitigation
Perception that the Trust is creating a hierarchy of racism or prioritising one form of discrimination over others	Maintain a whole-organisation anti-racist approach which explicitly addresses all forms of racism and religious hatred, including antisemitism and Islamophobia, using consistent principles, governance and reporting arrangements.
Perception of symbolic compliance without cultural change	Clear implementation plan with tangible actions and reporting
Staff misunderstanding or concern regarding definitions	Clear communications emphasising behavioural expectations and organisational values
Inconsistent application across services or managers	Standardised policy wording and strengthened training
Reputational risk if not implemented effectively	Board oversight and alignment with NHSE expectations

8. Financial Implications

Delivery will be through existing resources by embedding within current policies, training programmes and governance processes. No additional financial investment is required at this stage.

9. Recommendations

The Board is asked to:

- Note the publication of the Lord Mann Review and NHS England response.
- Reaffirm the Trust's commitment to combating racism and all forms of religious hatred including antisemitism and Islamophobia.
- Endorse the Trust's existing ICS Anti-Racism and Anti-Religious Hatred Statement as the foundation for local implementation.
- Approve adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles.

- Approve the proposed embedding approach through existing organisational development, inclusion, workforce and governance arrangements.
- Agree that the Trust will continue to review its position regarding the Mann Review recommendations and implementation guidance as national expectations evolve.

Appendix 1

Trust progress against Lord Mann Review / NHSE immediate actions

1. Chief Executive statement

North Staffordshire Combined Healthcare NHS Trust welcomes the publication of the Lord Mann Review and fully supports its aim to tackle antisemitism and all forms of racism within the NHS. As a mental health trust, we recognise our responsibility to ensure that our services and workplaces are safe, compassionate and inclusive for all patients, communities and colleagues.

This response sets out how the Trust is meeting the expectations outlined by NHS England, how anti-racism is embedded within leadership and governance and where we are strengthening our approach further.

2. Formal confirmations and NHS England requirements

The table below confirms the Trust's position against the requirements set out by NHS England.

NHS England requirement	Status	Evidence / notes
Adoption of IHRA definition of antisemitism	Under review	Anti-racist and anti-discriminatory statement published 2024
Adoption of Government definition of anti-Muslim hostility	Under review	Anti-racist and anti-discriminatory statement published 2024
Sign-up to NHS Race & Health Observatory Seven Anti-Racism Principles	Under Review	Anti-racist and anti-discriminatory statement published 2024
Preparation for forthcoming NHS Staff Standards	In progress	Aligned through People & OD planning
Implementation of Violence Prevention & Reduction Standard	In progress	Embedded within workforce and safety governance
Mandatory EDHR training completion	Yes	95% current compliance (July 2026)
Board agreement to undertake new NHS anti-racism training	In progress	To be scheduled once training released

3. Governance, leadership and accountability

How we ensure our Board and its relevant committees fully understand our staff survey data on the experience of racism in our organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

The Trust uses a combination of NHS Staff Survey data, workforce equality data, employee relations information, Freedom to Speak Up intelligence and violence and aggression reporting to understand staff experience of inclusion, discrimination and racism.

Strong emphasis is placed on understanding lived experience and organisational culture, using staff stories and workforce data as a diagnostic and improvement tool rather than solely for assurance reporting. Increased use of Freedom to Speak Up and alternative confidential reporting routes, including higher reporting from colleagues from under-represented groups, is interpreted as a positive indicator of growing trust and psychological safety rather than an increase in tolerance of poor behaviour. This work is supported by an expanded network of trained FTSU Champions. Where data indicates potential inequity, the Trust has undertaken internal reviews and developed targeted action plans, reflecting a preventative, improvement-focused approach aligned with the Macpherson principle.

We have a strong emphasis across the Board membership that our committees are our Board - sitting in Committee. The People, Culture and Development Committee (PCDC), provide a regular assurance report to the Board, keeping the Board informed of key issues/information and challenges that arise from the Committee agenda. A structured assurance report allows the Committee to provide information and assurance under the headings of 'Alert, Approve, Assure and Advise'. Where reports are provided to Committee or Board for assurance, the author will give a level of assurance from 1-7 based on our current agreed model. Level 7 is the highest level of assurance – indicating there is evidence of delivery of the majority of all agreed actions and clear evidence of achievement of desired outcomes over a defined 3 month time period. Governance and leadership of Inclusion and Belonging at North Staffordshire Combined Healthcare NHS Trust (NSCHT) are well established and embedded within these existing Board and executive structures. Inclusion and Belonging is overseen by the Trust Board and driven through a clear executive sponsorship model, ensuring accountability and visible leadership.

The Trust Inclusion Council, chaired by the Chief Executive and deputised by the Chief People Officer, provides the primary forum for oversight of workforce and service-user inclusion. Membership includes executive leaders, senior managers, staff-side representation and Staff Network Leads, ensuring that lived experience directly informs decision-making. Formal assurance is provided through PCDC, which reviews Inclusion and Belonging performance, approves key reports and monitors delivery against statutory frameworks including WRES, WDES, EDS, pay gap reporting and PCREF.

Executive leadership is strengthened through named Executive Sponsors for staff networks, including race inclusion, LGBT+, disability and long-term conditions.

The Trust's governance arrangements are designed to enable timely action, learning and prevention, rather than reliance on escalation to regulators, supporting an organisation wide approach centred on responsive leadership, accountability and creating a psychologically safe culture.

4. Workforce insight and staff experience

Implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups (to be monitored via the NHS Oversight Framework)

The Trust has established a focused programme of work to reduce physical violence and aggression towards staff, aligned to the Violence Prevention and Reduction Standard. A multi-disciplinary group has undertaken a detailed review of incident data to identify areas of highest risk, including the analysis of physical violence incidents, repeat perpetrators, staff injury profiles, staff absence, patient demographics, and circumstances surrounding incidents. This analysis has been used to identify two pilot inpatient areas where targeted improvement activity will be undertaken.

Improvement work is being delivered through co-produced Quality Improvement projects with staff, supported by enhanced data capture and learning processes. Actions include the introduction of SWARM huddles following incidents of physical harm to facilitate rapid learning and prevention, further analysis of affected staff and patient groups to target interventions, and the reintroduction of a modified Safewards approach aligned to the Trust's Culture of Care programme. Baseline measures are being established using incident and staff survey data to enable monitoring of impact and support continuous improvement. This work will provide assurance that violence and aggression data is being systematically used to identify affected groups and drive targeted action to improve staff safety and experience.

In addition, People Culture and Development Committee have requested a health and safety report to be submitted to understand the impact of violence and aggression on staff and will ensure this is also reported by ethnicity.

How we will implement the newly published NHS Staff Standards

The Trust Organisational Development Framework provides an integrated approach to organisational development, inclusion and workforce experience, aligning the Trust's leadership, team, talent, wellbeing, safety and staff experience priorities within a single organisational improvement framework. This will create the mechanism through which the Trust will implement the NHS Staff Standards, embedding the principles within leadership practice, team effectiveness,

organisational culture and workforce experience rather than through separate workstreams.

5. Training and capability

All staff are required to complete mandatory Equality, Diversity and Human Rights training. Training is aligned with wider capability-building approaches and inclusive leadership development and learning, reinforcing leadership confidence, consistent decision-making and effective responses to incidents of racism and discrimination. The Trust is preparing to implement the new NHS faith co-created anti-racism training module and ensure senior leaders participate in additional development when available.

How we will ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.

All staff are required to complete the mandatory Equality, Diversity and Human Rights (EDHR) training module, which includes content on antisemitism and Islamophobia and has been in place since March 2025. Current compliance across the Trust is 95%. Staff who have not completed the updated EDHR module will be required to complete the new Bite Size Faith module when it becomes available, in line with national requirements. The Trust Inclusion and Belonging Lead will advise the Trust on implementation requirements through the Strategic Education, Apprenticeship and Learning (SEAL) Group, including identifying the relevant staff cohorts and supporting deployment through the Trust's learning management system. This training is aligned to the Trust's wider approach to capability building, inclusive leadership development and organisational learning, strengthening leadership confidence, consistent decision-making, and effective responses to incidents of racism, discrimination, antisemitism and Islamophobia.

How we will ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).

Once the NHS bitesize module co-created with faith leaders becomes available, the Trust will review the national implementation requirements through the Strategic Education, Apprenticeship and Learning (SEAL) Group and work with the Trust Inclusion and Belonging Lead to identify the staff cohorts required to complete the module, taking account of any national exemptions for staff who have completed EDHR training within the previous six months. The module will then be incorporated into the Trust's mandatory learning programme and made available through the Learning Platform, with completion monitored through existing learning compliance reporting arrangements with progress overseen through established workforce governance processes.

How we will ensure Board agreement to undertake new anti-racism training when it becomes available.

In line with the expectations set out in NHSE 6 High Impact Actions, the Trust has deliberately framed anti-racism and inclusion as a core leadership and cultural responsibility rather than a compliance exercise. Board and executive leadership focus on early intervention, consistent decision-making and visible ownership, recognising the role of employers as the first line of defence when racism occurs in the workplace.

This approach is reflected in executive-level Inclusion and Belonging objectives, Board Development Conversations focused on race inclusion and progression and ongoing work to support leaders to act confidently and consistently.

The current Board Development Programme for 26/27 will include the new anti-racism training for Boards when this becomes available.

6. Engagement and communication

How we ensure colleagues, staff representatives, patients and communities are aware of our actions through internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally

The Trust published its Anti-racism Statement in 2024 making it clear that racism, including antisemitism and anti-Muslim hostility, is unacceptable and will not be normalised as part of working in the NHS. As a mental health trust, NSCHT recognises the particular risk of colleagues experiencing racism, abuse or discrimination from patients or members of the public and is explicit in its role as an employer in protecting and supporting staff.

We are committed to ensuring that staff who experience racism are supported, protected and treated with dignity and respect. Support arrangements to ensure staff safety emphasise fairness, timeliness and trust, with clear routes for reporting, investigation and follow-up through.

This includes access to a number of avenues to speak up including:

- Freedom to Speak Up Guardian/Champions
- 'Dear Buki' provides our staff with an additional mechanism to raise concerns with our CEO in an anonymous way
- HR support and clear management guidance for responding to incidents
- Violence prevention and reduction processes, with violence and aggression data reviewed alongside workforce equality information

Hate crime reporting and restorative approaches are used to support staff and inform preventative action, ensuring learning is embedded and organisational responses are consistent, compassionate and proportionate.

Across the Trust, cultural change is reinforced through active engagement with staff networks, trade union partners, patients and communities, ensuring expectations around behaviour, respect and inclusion are clearly understood and consistently communicated.

Staff networks play a key role in shaping policy, supporting organisational learning, raising concerns and strengthening trust and shared ownership of the inclusion and belonging agenda.

This work aligns with the Trust's wider operational and delivery priorities, including the Combined Team Journey, which emphasises compassionate leadership, psychological safety and continuous improvement as enablers of high-quality care.

By embedding inclusion and anti-racism within these core frameworks, the Trust supports a proactive and preventative culture helping us to move beyond reactive compliance.

7. Conclusion

The Trust recognises that the Lord Mann Review represents a critical moment for action and a clear expectation of cultural and organisational transformation. Our focus is on embedding consistent leadership, trusted processes and preventative approaches that reduce the likelihood of harm, strengthen staff confidence and reinforce our values in everyday practice.

This work is integral to how we lead, support our workforce and deliver mental health services. By aligning Inclusion and Belonging priorities with our wider operational and quality improvement ambitions, the Trust is committed to sustained, meaningful change that supports both staff experience and patient confidence.

North Staffordshire Combined Healthcare NHS Trust is committed to tackling all forms of racism, including antisemitism and will continue to strengthen its approach in line with NHS England expectations and the recommendations of the Lord Mann Review.

Enclosure No: 7

Safer Staffing 6 Monthly Review – 2026

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

Report to:	Public Trust Board
Date of Meeting:	10 September 2026

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:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Quality Committee
Strategic Priorities:	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:	Staffing
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:	Set out clearly the action or decision required i.e. funding or resource approval.
Executive Summary:	Executive Summary: The six-monthly Safer Staffing Review provides assurance that inpatient services across the Trust continue to operate safely, supported by established governance arrangements, staffing escalation processes and regular workforce reviews. No inpatient area was identified as unsafe during the review period. Key Messages • Staffing reviews were undertaken across all inpatient wards during January to February 2026, incorporating workforce metrics, patient acuity, quality indicators, occupancy levels and professional judgement. • Patient demand and complexity continue to increase, driven by higher levels of physical health needs, neurodevelopmental presentations, violence and aggression, enhanced observation requirements and delayed discharge pathways. • Average inpatient occupancy remained extremely high at 98.5%, with average Care Hours Per Patient Day (CHPPD) of 12.78 hours, reflecting increasing patient acuity and dependency. • Registered Nurse recruitment has improved, reducing vacancies to 11.98 WTE, although many inpatient areas continue to have a relatively inexperienced workforce profile and ongoing reliance on bank staff. • Sickness absence remains a significant challenge at 21.3%, impacting workforce resilience and increasing temporary staffing requirements. • Agency usage has reduced significantly, demonstrating improved workforce stability and retention. Key Areas of Focus The review highlighted continued progress in: • Embedding Enhanced Therapeutic Observation and Care (ETOC) standards. • Improved utilisation of SafeCare to support evidence-based staffing decisions. • Reduced dependency on agency staffing. • Improved retention of Registered Nurses. • Enhanced understanding of patient acuity and workforce demand. • Principal Risks Requiring Ongoing Oversight • High sickness absence. • Workforce inexperience and the need for continued support,

supervision and development.

- Delayed discharges impacting flow, capacity and staffing demand.
- Reliance on bank staffing.
- High occupancy and increasing patient complexity.
- Violence and aggression within some acute services.
- Continued improvement required in roster management and staffing deployment.

Decisions Required

1. Dragon Square Respite Service

The review identified patient safety, resilience and medication governance risks associated with the current overnight staffing model of one Registered Nurse and one Healthcare Support Worker. Increasing complexity of service users and OFSTED concerns regarding controlled drug administration support the need for an additional Registered Nurse overnight.

Recommendation (Preferred Option):

Approve an uplift from 1 RN to 2 RNs on every night shift.

Additional requirement of 2.34 WTE Band 5 Registered Nurses.

Recurrent cost pressure of approximately £144k per annum.

Commission a wider workforce and roster redesign review to identify potential efficiencies and mitigate future costs.

2. Ward 3 Deep Dive Review

Ward 3 continues to experience sustained operational pressures relating to high occupancy, increasing patient acuity, violence and aggression incidents, delayed discharges and staff wellbeing concerns. However, the review found no evidence that the ward is operating unsafely.

Recommendation: Approve a programme of targeted improvement actions rather than a staffing establishment increase.

Update – This report has been reviewed at SLT on 25th August 2026; both recommendations were accepted, however due to the ongoing need to extend the review of Dragon Square service provision and demand, it was proposed that the uplift of 2.34WTE band 5 Registered Nurses was on a fixed term basis for 6 months to allow for the review to take place and additional recommendations to be considered.

Committee Recommendation

The Committee is asked to:

- Note the assurance that inpatient services continue to operate safely despite increasing acuity and workforce pressures.

- Endorse the proposed overnight Registered Nurse establishment increase for Dragon Square Respite Service – noting SLT proposal that this is secured on a fixed term basis for 6months initially.
- Endorse the recommended improvement programme arising from the Ward 3 safer staffing deep-dive review.
- Receive assurance that ongoing safer staffing risks will continue to be monitored through established governance and review arrangements.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	25.08.2026
V2	Quality Committee	02.09.2026
V2	Public Trust Board	04.09.2026

1. Introduction:

Since 2014, all NHS Trusts in England have been required to monitor nurse staffing levels within inpatient wards to ensure safe staffing is maintained. This monitoring includes monthly reporting to the Trust Board and NHS England, alongside an annual strategic staffing review. A further comprehensive review is undertaken six months later, focusing specifically on safer staffing establishments across inpatient wards.

National guidance on safer staffing has evolved from the National Quality Board's 2016 framework and subsequent 2018 workforce safeguard guidance, which established expectations for safe, effective staffing and strengthened governance and accountability.

More recently, NHS England has embedded safer staffing within a broader quality and workforce framework, emphasising the triangulation of data (including workforce metrics, patient acuity, quality indicators and staff experience) to support evidence-based decision-making. This approach is aligned with the NHS Long Term Workforce Plan (2023), which promotes a sustainable, multi-professional model focused on workforce supply, retention, productivity and new ways of working.

These principles continue to underpin the Trust's safer staffing processes, ensuring staffing decisions are responsive to patient need and support the delivery of high-quality, sustainable care.

This report presents the 6 monthly review of safer staffing levels across inpatient wards. Findings are informed by staffing deep-dive reviews undertaken within each ward area completed in January/February 2026.

2. Purpose of the Report (Executive Summary):

The 6 monthly safer staffing review discussions for this period were held throughout January/February 2026. The Deputy Chief Nurse met with all ward managers individually, with Quality Lead Nurse / Matrons and also supported by Finance and People Directorate colleagues.

This report is intended to provide assurance regarding the outcome of the safer staffing review's and seek endorsement of staffing establishment recommendations for onward submission to Trust Board.

FOR APPROVAL - In response to the safe staffing reviews this report is also seeking approval for;

- A staffing establishment uplift for Dragon Square Respite Service
- The recommendations associated to the safer staffing deep dive review into ward 3 to be approved

3. Executive Summary

This safer staffing review demonstrates that the Trusts inpatient wards continue to operate safely, supported by established workforce governance, escalation processes and regular establishment reviews.

Whilst increasing patient acuity, sickness absence and workforce experience profiles continue to present challenges, no service was identified as unsafe during the review period.

SLT and Quality Committee are asked to endorse two staffing recommendations for onward approval by Trust Board:

- Dragon Square registered Nurse night establishment uplift.
- Ward 3 deep-dive review recommendations.

4. Key Safer Staffing Metrics for Inpatient Wards:

This review was completed between January and February 2026 and incorporated:

- Workforce metrics.
- Vacancy information.
- Fill rates.
- Sickness absence.
- CHPPD.
- Occupancy.
- Temporary staffing utilisation.
- Patient acuity.
- Professional judgement.
- Quality outcomes

Organisation-Wide Position

Indicator	2025-26 Overall average	Trend
Overall Fill Rate	105.7%	Increasing
RN Fill Rate	92%	Improving
RN Vacancy Position	11.98 WTE	Improving
Sickness and Absence	21.3%	Higher than desired
Agency Usage	195hrs	Improving
Bank Usage	16110hrs	Higher than desired

Detailed ward-level safer staffing review findings is provided in Appendix 1.

5. Key Workforce Themes

- Registered nurse vacancy levels have reduced significantly following successful recruitment campaigns.
- Most Inpatient wards continue to have high proportions of newly qualified staff.
- Sickness absence continues to impact workforce resilience.

- Roster management processes continue to require improvements to ensure they are managed effectively and efficiently.

6. Acuity, Demand and Capacity

6.1. Patient Complexity

Reviews consistently identified increasing complexity of patient need across inpatient services including:

- Physical healthcare requirements.
- Neurodevelopmental presentations.
- Enhanced therapeutic observation requirements.
- Violence and aggression management.
- Delayed discharge pathways.

6.2. Care Hours Per Patient Per Day (CHPPD)

The average CHPPD was **12.78hrs** during the reporting period.

This reflects the increasing complexity of patient need across inpatient services and supports the continued requirement for robust staffing establishments.

6.3. Inpatient Occupancy levels

Occupancy remained consistently high throughout the year, creating additional pressure when combined with delayed discharge pathways and increasing acuity levels, with an average of **98.5%** occupancy throughout 2025-26. The staffing levels were increased in response to this increased demand.

7. Triangulation with Quality Indicators

The safer staffing review considered quality indicators alongside workforce metrics.

Overall findings indicate:

- No service determined unsafe during review, with patient safety incident profile remaining predominantly stable.
- There is a sustained reduced in agency dependency.
- Improved workforce stability, with retention of registered nurses improving.
- There is greater compliance with SafeCare inputting, which gives indication of staffing need according to the ward acuity.

8. Improvement Focus during 2026

8.1. Enhanced Therapeutic Observation and Care (ETOC) has been a key area of focus.

The implementation of the principals and standards, alongside the progression to electronic recording of ETOC has continued throughout 2025/26, the key benefit of this focus is to further support and improve;

- Trauma-informed practice.
- Improved therapeutic engagement.
- Reduction in restrictive interventions.
- A better understanding of enhanced care requirements and demand within each inpatient ward.

8.2. SafeCare Optimisation

Throughout 2025/26 we have seen a marked and sustained improvement with the compliance of SafeCare tool to inform safer staffing demand and decisions, recording and monitoring SafeCare within inpatient teams this is intended to support operational day to day staffing decisions and allow;

- A measure of wards acuity.
- Day to day workforce planning
- Day to day staffing deployment and distribution
- Helps to inform longer term staffing establishment review decision-making.

9. Themes from Deep Dive reviews

The principal themes requiring ongoing oversight which were identified through the review are:

Theme	Oversight
Workforce inexperience	Preceptorship, supervision, Band 6 development
Delayed discharges	Red to Green, dedicated MDT Support and System partnership working
Bank workforce reliance	Recruitment and retention initiatives, roster effectiveness oversight and monitoring & ongoing acuity reviews

10. Service Exceptions – Summary of Key Recommendations

The Trusts Senior Leadership Team and Board are requested to consider the Safer Staffing establishment review findings and to approve the recommendations made for Dragon Square Respite Service and Ward 3, Harplands;

10.1. Dragon Square

10.1.1 Issue:

The review identified resilience concerns overnight and recommends an increase from one to two Registered Nurses on night duty. The current model is one Registered Nurse overnight.

The review identified an increasing complexity of service users whose needs require additional nursing staff skills across the duration of the 24hr period. There are also an increasing number of children attending the service who need the support of more than one staff member to tend to their day-to-day care needs.

A recent OFSTED inspection has also identified concerns associated with the administration of controlled medications during the night shift, which require 2 registered nurses to administer and witness in order to comply with the Trusts policy for the Safe administration of Controlled Drugs.

10.1.2 Review findings

The staffing review concluded that the current nursing establishment during the night shifts no longer adequately reflects service demand and does require an uplift of one extra registered nurse per night. The current overnight staffing model consists of 1 Registered Nurse and 1 Healthcare Support Worker. The review recommends increasing this to 2 Registered Nurses and 1 Healthcare Support Worker per night shift. Professional judgement and review of incidents/escalations support additional Registered Nurse capacity.

Failure to increase overnight Registered Nurse capacity presents ongoing risks to patient safety, medication governance, regulatory compliance and service resilience, with continued reliance on staffing escalation processes to safely manage demand.

Whilst the service requested an increase in late-shift staffing, the review did not identify sufficient evidence to support an establishment increase at this stage. The review did indicate roster inefficiencies resulting in additional cost pressures (section 10.1.6 gives more detail regarding the costs) which is associated with the complexity of the service offer and differing staffing requirements during term time, weekends and school holidays. Several operational recommendations have therefore been made to optimise existing staffing resources before further consideration is given to additional investment:

- Conduct a full workforce and roster redesign review
- to review and reconsider the allocations of the children attending the service to ensure that the acuity needs of children are balanced and in line with existing staffing establishment for the day shifts.
- To review existing staffing shift patterns and the number of staff within the unit when the children are at school
- To review the wider MDT infrastructure and working hours to ensure the MDT input is maximised across both the early and late shift when children are in the unit.

Dragon Square operates a unique model compared with other inpatient services within the Trust, providing respite care during term time, weekends and school holidays. During school terms, children attend school during the day, resulting in staffing requirements that differ from a traditional inpatient model and creating opportunities to review workforce deployment and roster efficiency.

10.1.3 Recommendation for approval

Approve an increase in overnight Registered Nurse staffing from 1 RN to 2 RNs per night shift, requiring an additional 2.34 WTE Band 5 establishment at a recurrent cost of £144k per annum.

10.1.4 Intended Impact

- Improved resilience.

- Reduced staffing escalation requirement.
- Improved clinical oversight and safety overnight, including compliance with controlled medications.
- Promotes and improves regulatory compliance.

10.1.5 Costings:

WTE Calculation	
Hours	10
No Days	7
Total Hours	70
WTE	1.87
Headroom (25.6%)	0.48
Total WTE	2.34
Costing	
	£
Midpoint B5	44,006
Unsocial Enhancement	17,531
Cost per WTE	61,537
Total Cost	144,275

10.1.6 Cost Pressure Considerations;

It is recognised that this recommendation poses a significant cost pressure to the team / service. In addition, this review has identified further cost pressure challenges due to the way rosters are operationalised due to the service running school term time hours, weekends and throughout school holidays, resulting in a residual cost pressure of £81k (1.82 WTE), comprising £57k (1.19 WTE) Band 5 and £24k (0.63 WTE) Band 3.

This £81k pressure could be mitigated by reducing the term-time early shift hours from 2 RNs to 1 RN on site for the duration of the full early shift and removing the HCSW 7am to 11am split shift, adjusting the start and finish times of night shifts and staggering start times of the late shifts. However, even with these changes, a cost pressure of £144k would remain for the additional RN required on nights. This would require a Management of Change process and consideration of annualised hours contracts.

Therefore, to ensure that this uplift can be operationalised in the most efficient and effective way, SLT and Quality Committee are requested to agree one of the following options for onward approval at Trust Board;

Option 1 – Accept the cost pressure with the proposal that this is raised as a cost pressure through the 27/28 budget setting process.

Option 2 To tolerate the recurrent £144k cost pressure associated with the additional 2.34 WTE Band 5 establishment required to support two Registered Nurses on every night shift, whilst the service undertakes a full options appraisal for the effective management of the roster noting the differing staffing requirements during term time, weekends and school holidays, where management of change and annualised staffing model will be fully considered.

Option 3 (preferred) – Approve the immediate addition of 1.0 WTE Registered Nurse to each night shift (2.34 WTE Band 5; £144k recurrent cost pressure) to address the patient safety, governance and regulatory risks identified by the review.

Simultaneously commission a full workforce and roster redesign review, including consideration of annualised hours, revised shift patterns and management of change processes, to ensure the wider staffing model is configured as efficiently and effectively as possible for term-time, weekend and school holiday activity.

Any efficiencies identified through this review should be used to offset the recurrent cost pressure where possible, with any remaining pressure being considered as part of the 2027/28 budget-setting process.

This report was presented to SLT on 25th August 2026, SLT made a proposal to support option 3, however on a fixed term basis for 6 months to allow for a wider review of Dragon Square provision and demand. Quality Committee are requested to endorse Option 3, in line with SLT recommendation of an initial 6month fixed term uplift, as the preferred recommendation for onward approval by the Trust Board.

10.2. Ward 3

Issue:

The safer staffing deep-dive review identified sustained operational pressures within Ward 3 associated with increasing patient acuity, high levels of behavioural disturbance, violence and aggression incidents, workforce pressures and delayed discharge pathways. These factors have resulted in increased staffing escalation requirements. The team have raised concerns regarding the sustainability of the current staffing model over the longer term.

Review Findings

The review considered staffing metrics, incident data, occupancy, workforce indicators, patient acuity and professional judgement. Findings identified:

There was a sustained level of high occupancy with frequent staffing escalations required to maintain safe care delivery. There were ongoing concerns around delayed discharge pathways contributing to inpatient flow and the high occupancy levels and minimal use of home treatment team to support early facilitated discharge.

Patient safety incidents identified a theme of behavioural disturbance, violence and aggression, self-harm and absconding. The largest incident categories included disruptive behaviour, ligature incidents and patient-to-staff assaults. Whilst incident levels remain high, the review recognised that this reflects the complexity of the patient cohort and a positive reporting culture. No immediate patient safety concerns were identified that would indicate the service is operating unsafely.

There is regular high use of Enhanced Therapeutic Observation and Care (ETOC) and restrictive interventions to support management of patient within the ward setting. Whilst patient acuity was recognised as a significant contributor, the patient safety incident profile demonstrated recurrent escalation to crisis point, with associated use of restrictive

interventions. This suggests that greater emphasis on proactive clinical leadership, therapeutic engagement, trauma-informed care planning and increased workforce support and supervision may reduce reliance on containment-based interventions.

There was evidence of increasing emotional and psychological demands on the workforce, including concerns relating to staff wellbeing, resilience and burnout. Whilst patient acuity remains a significant contributing factor, the review identified opportunities to further develop proactive models of care that support earlier recognition of deterioration, strengthened multidisciplinary and proactive care planning and to ensure that the wider MDT members are routinely visible and proactive in the relevant ward-based engagement with all patients. This is intended to reduce the frequency of crisis management interventions and reduce reliance on escalated staffing requests.

Recommendation

The safer staffing review recommends a programme of targeted improvement rather than an immediate establishment increase, including:

- Strengthening proactive approaches to recognising and responding to patient distress through enhanced multidisciplinary safety planning and de-escalation interventions.
- Further development of trauma-informed and personalised care planning to support earlier intervention and reduce escalation events.
- Re-introduce the structured 72hr crisis admission pathway.
- Review of access to psychological support for both patients and staff to improve wellbeing and resilience.
- Continued focus on reducing restrictive practice through implementation of ETOC principles and alternative therapeutic interventions.
- Ongoing monitoring through the safer staffing governance framework, including review of violence and aggression trends, staffing escalation data, workforce wellbeing indicators and SafeCare acuity information.

Intended Impact

- Improved management of patient acuity and behavioural risk.
- Reduction in violence, aggression and self-harm related incidents through earlier intervention.
- Improved staff wellbeing, resilience and retention.
- Reduced reliance on restrictive interventions and staffing escalations.
- Strengthened assurance regarding the sustainability of safe care delivery within Ward 3.

SLT have supported these recommendations. Quality Committee are requested to endorse these recommendations for onward oversight through the Trust's safer staffing governance arrangements.

11. Areas Requiring Ongoing Monitoring

- Staff sickness absence remains unchanged, with continued impact on increased use of temporary staffing.
- Workforce Skill and experience profile continued focus on retaining registered nurses, whilst ensuring newly registered nurses have adequate support and supervision.
- Embedding enhanced therapeutic observations of care to ensure that day to day care is therapeutic, meaningful and the least restrictive.
- Continue to monitor violence and aggression incidents in acute & older persons, with thematic reviews and learning to support a sustained reduction.
- Ongoing focus and support in relation to delayed discharges and home treatment to support early facilitated discharge with a view of reducing high occupancy rates which are impacting on increased staffing use.
- A dedicated focus on the utilisation of SafeCare to manage the flow of staff throughout the inpatient wards on a shift-by-shift basis, to reduce reliance on temporary staffing.
- To strengthen controls around the E-Roster management and staffing escalation process to ensure that staffing management is both effective and efficient, actively seeking to reduce reliance on temporary staffing.

12. Conclusion

The six-monthly Safer Staffing Review provides assurance that inpatient services continue to operate safely, supported by established workforce governance arrangements, staffing escalation processes and regular establishment reviews. Whilst increasing patient acuity, workforce pressures, sickness absence and delayed discharge pathways continue to create operational challenges, no service was identified to be unsafe during the review period.

The review has, however, identified two areas requiring Board approval to ensure staffing establishments remain aligned to service demand and patient need. These are:

- 1) Approval of an increase in the Dragon Square night nursing establishment from one Registered Nurse to two Registered Nurses to improve resilience, strengthen medication safety and support regulatory compliance.
- 2) Approval of the recommendations arising from the Ward 3 safer staffing deep-dive review, including the implementation of targeted actions to strengthen workforce resilience, therapeutic engagement, multidisciplinary review processes and proactive approaches to managing patient acuity and behavioural risk.

13. Recommendation

Quality committee and Trust Board is requested to:

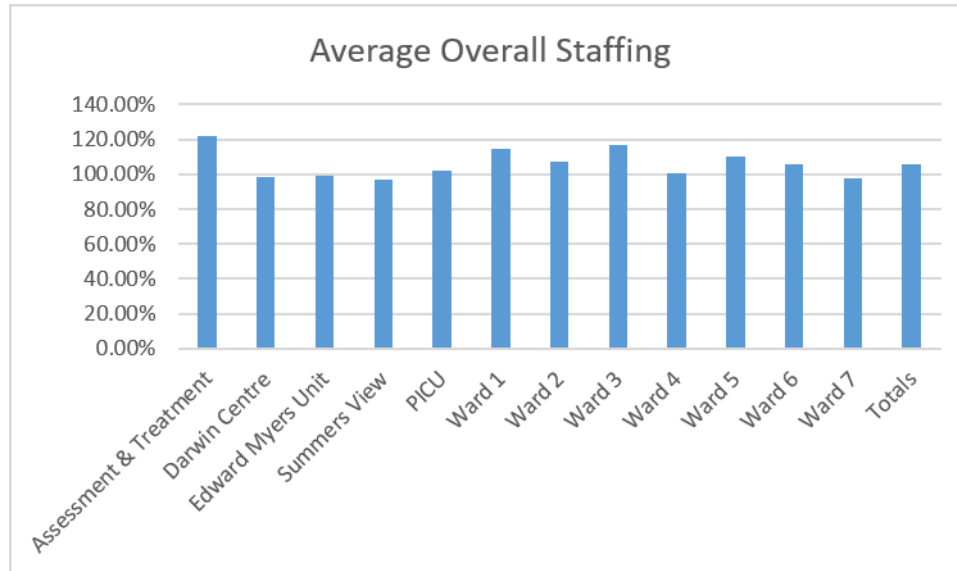
- Approve the immediate addition of 1.0 WTE Registered Nurse to each night shift (2.34 WTE Band 5; £144k recurrent cost pressure) on a fixed term basis for 6months to address the patient safety, governance and regulatory risks identified by the review.
- Simultaneously commission a full workforce and roster redesign review of Dragon Square.
- Approve the recommendations arising from the Ward 3 safer staffing deep-dive review.

- Receive assurance that safer staffing levels across inpatient services continue to be monitored through the Trust's established governance and review processes.

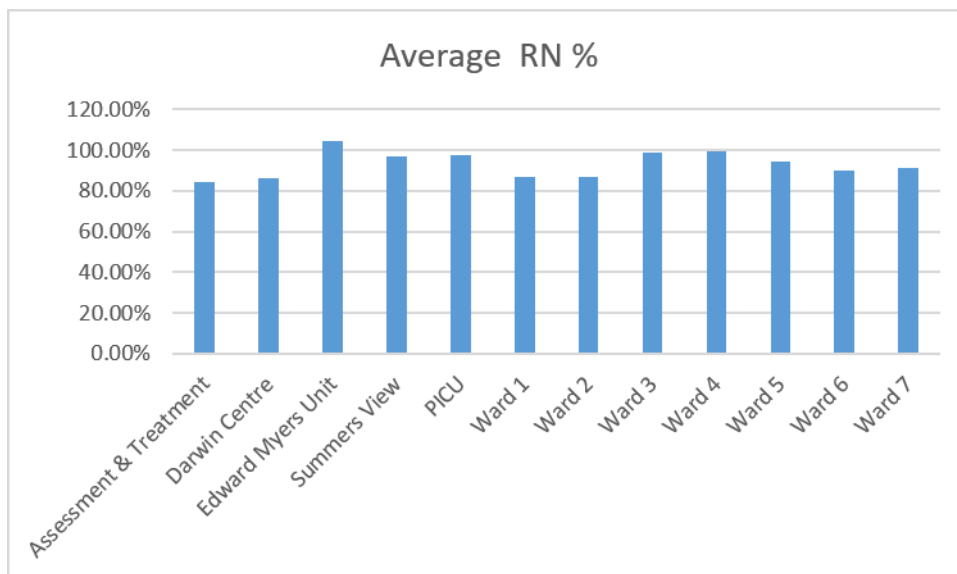
Appendix 1

Detailed ward-level safer staffing review data for 2025/26:

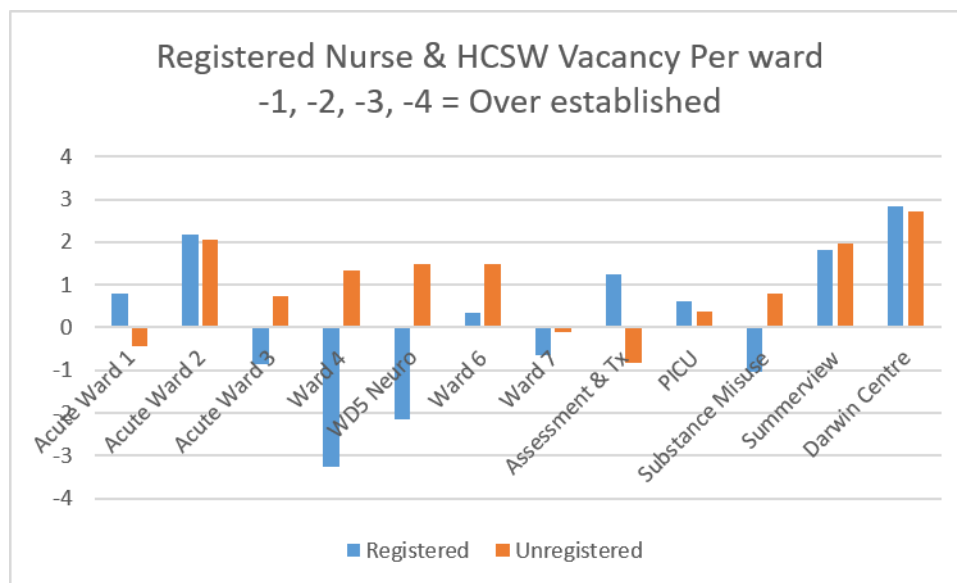
Average Ward by ward Fill Rate:



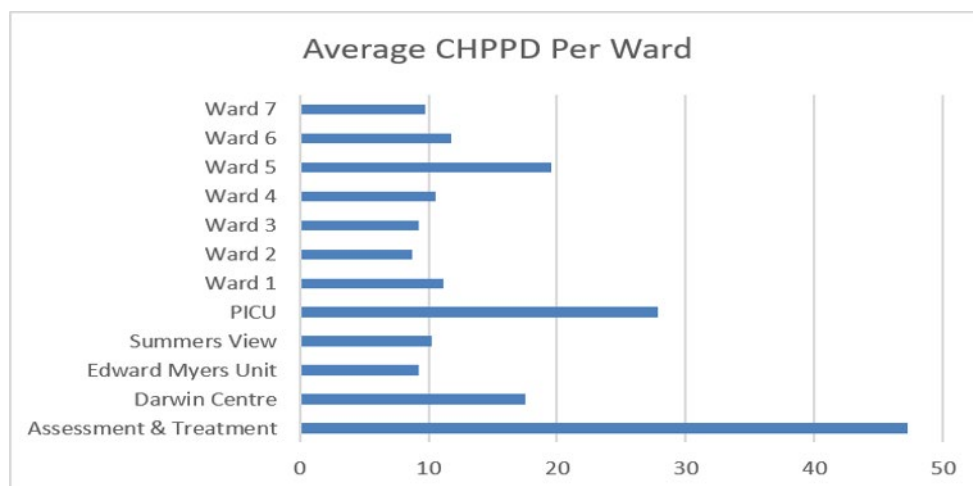
Average Ward by Ward Registered Nurse Fill Rate:



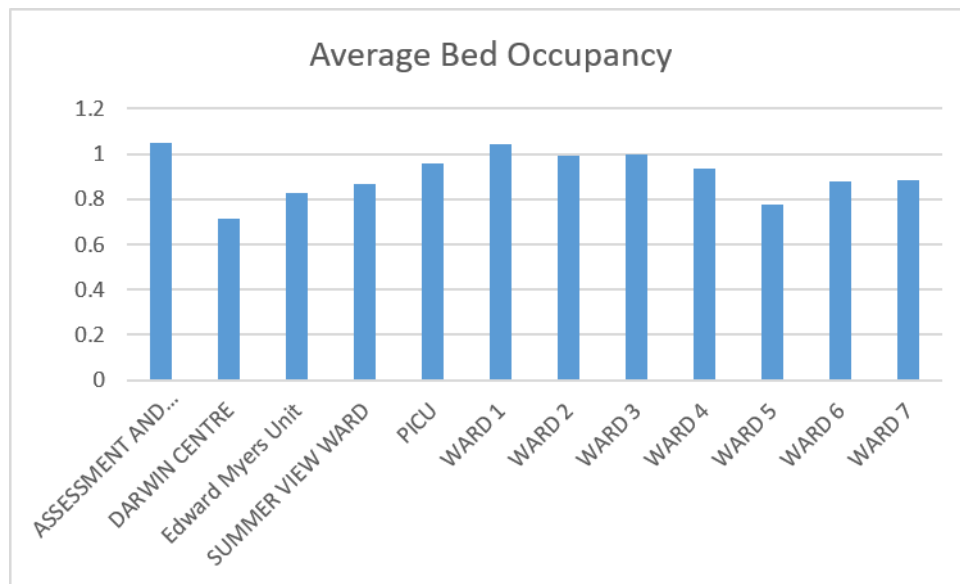
Average Ward by Ward Vacancy Rate:



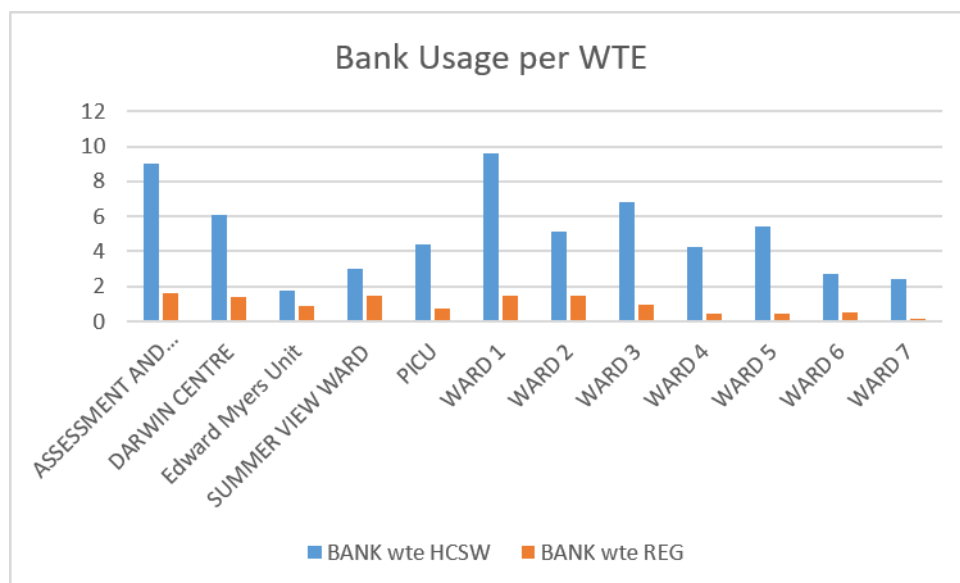
Average Ward by Ward Care Hours Per Patient Per Day (CHPPD):



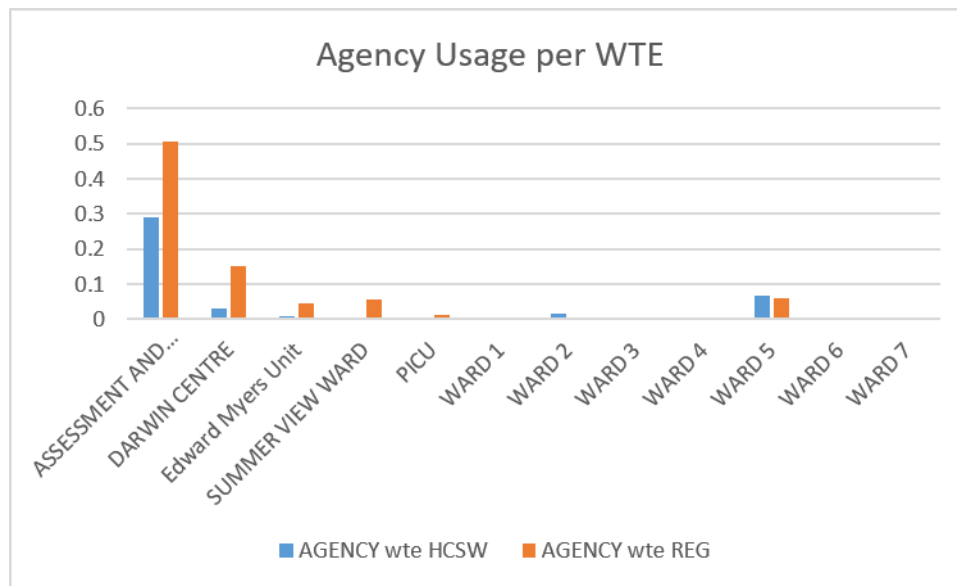
Average Ward by Ward Occupancy Rate:



Average Ward by Ward Bank Usage;



Average Ward by Ward Agency Usage



Appendix 2.

Establishment Review outcomes / team level headlines;

Ward	Review headlines
Assessment & Treatment	- The planned service closure was creating uncertainty, workforce instability, and financial pressure - LD nurse vacancies and reliance on future recruitment pipeline - Leadership capacity gaps (there were periods through the year limited ward manager cover, this is now addressed) - Environmental limitations impacting therapeutic activity
Darwin	- Vacancies and lack of experienced Band 6/7 nurses, with reliance on NQNs - Increasing patient complexity (autism, ARFID) without sufficient specialist MDT support; there have been improvements with access to more specialist support. - High bank use and sustainability concerns - Issues with documentation quality and incident management capability.
Edward Myers	- A robust staffing establishment review was conducted by the ward manager in 2025 – evidencing the need for increase in nursing establishment. - This is being taken forward in the wider programme of work regarding the expansion of EMU.
Summersview	- High sickness absence and staff burnout, impacting resilience - Predominantly junior workforce with limited experience - Environmental restrictions reducing therapeutic space and increasing risk - Dependence on future consultant recruitment to support service development
PICU	- High acuity requiring frequent staffing escalation and MDT flexibility - Workforce largely inexperienced with retention challenges - Capacity pressures and occasional out-of-area placements - Complexity around long-term segregation and restrictive practice governance
Ward 1	- Increasing patient acuity and physical health complexity - Workforce vacancies and skill mix challenges; reliance on newly registered staff. - Delayed discharges and limited specialist placements
Ward 2	- Improving position but still gaps in Band 5 and HCSW workforce - Inexperienced workforce requiring increased supervision - Medical staffing gaps driving financial overspend – this has now been addressed. - Discharge delays impacting flow and capacity
Ward 3	Sustained high occupancy and staffing escalation rates

	• Rising violence, aggression, and complexity of presentations need to check out • Significant staff burnout and absence of psychology support • Delayed discharges contributing to ongoing pressure
Ward 4	• Generally stable and well-managed workforce model • Loss of activity worker roles has created an opportunity to upskill HCSW's and integrating therapeutic activities into their role – impacting positively in morale. • Gaps in medical cover and reduced ANP capacity. • Delays in essential equipment (e.g. bed sensors)
Ward 5	• Increasing acuity despite reduced bed numbers, requiring sustained staffing levels • Complex neuro and physical health needs • Discharge delays and pathway challenges • Environmental and accreditation limitations affecting service development
Ward 6	• Rising frailty, falls, and physical health complexity • Frequent staffing escalation to maintain safety • Concerns around inappropriate admissions and weak community pathways • Limited experienced workforce and governance gaps for physical health
Ward 7	• Focus on aligning staffing establishment with actual acuity demand • Data quality and consistency issues impacting decision-making • Variable bank staff familiarity and induction compliance
Dragon Square	Dragon Square is not routinely monitored in line with safer staffing; this is a respite facility as opposed to an inpatient ward. However, a deep dive staffing review was requested and supported in May 2026 due to challenges associated with staffing fill rate and medications management for children during night shifts.

Enclosure No: 8

Safeguarding Annual Report

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

Presented by:	Zoe Grant / Deputy Chief Nursing Officer
Prepared by:	Maegan Hepher-Williams / Head of Safeguarding
Executive Lead:	Kenny Laing / Chief Nursing Officer

Aligned to Board Assurance Framework Risk:	Quality & Safety - There is a risk that the Trust fails to deliver timely, safe and effective care for people who use our services, due to increasing demand, increasing needs and a failure to evidence interventions with support recovery.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Quality Committee
Strategic Priorities:	Prevention - We will commit to investing in providing high-quality preventative services that reduce the need for secondary care
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	None
Recommendation / Required Action:	For information/assurance

Executive Summary:

This report provides assurance that the Trust continues to meet its statutory safeguarding responsibilities for children, young people and adults.

The Trust remains actively engaged in safeguarding partnerships across Staffordshire and Stoke-on-Trent, contributing to multi-agency reviews, audits, MARAC processes, Prevent arrangements and safeguarding boards.

Key Areas of Assurance

- Adult safeguarding referrals increased by 32% during 2025/26 (268 referrals), reflecting improved staff awareness, confidence and reporting of safeguarding concerns. Child safeguarding referrals remained stable at 221 referrals.
- The Safeguarding Team managed significant information-sharing activity, completing 5,484 safeguarding checks across 1,191 requests from partner agencies.
- Safeguarding supervision, advice and support activity continued to increase across services, particularly within inpatient settings following the introduction of ward-based safeguarding sessions.
- Training compliance remains strong overall, with Trust compliance at 93% for Level 1/2 safeguarding, 88% for Level 3 Adult Safeguarding and 84% for Level 3 Children's Safeguarding.
- Prevent training compliance remains above target overall at 89%.

Notable Achievements

- Increased visibility and accessibility of the Safeguarding Team through enhanced ward engagement and supervision.
- Improved safeguarding incident reporting functionality through collaboration with the Patient Safety Team.
- Continued development of domestic abuse and sexual safety initiatives, including support for the Domestic Abuse and Sexual Violence Charter and implementation of the NHS England Sexual Safety Charter.
- Strengthened safeguarding training competencies and partnership working across the health and care system.

Areas for Focus

- Continued growth in safeguarding activity and complexity of cases.
- Level 3 Children's Safeguarding training compliance remains just below the Trust target.
- Data quality issues relating to recording of ethnicity within safeguarding referrals.
- Ongoing focus required to support delivery of the Sexual Safety Charter and domestic abuse agenda.

Priorities for 2026/27

- Increase safeguarding engagement and supervision within community services.
- Improve compliance with mandatory safeguarding training.
- Refresh the safeguarding audit programme.
- Strengthen domestic abuse and sexual safety arrangements.
- Improve safeguarding data collection and reporting through new systems.
- Develop and implement a Trust-wide Safeguarding Strategy aligned to local and national priorities.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	21.08.2026
V2	Quality Committee	28.08.2026
V2	Public Trust Board	04.09.2026

Safeguarding Annual Report 2025 to 2026

Introduction

North Staffordshire Combined Healthcare NHS Trust (NSCHT) is a leading provider of mental health, social care, learning disability and substance misuse services in the West Midlands.

We provide services to people with a wide range of mental health and learning disability needs in the community as well as in an inpatient setting. We also provide specialist mental health services such as child and adolescent mental health services (CAMHS), psychological therapies, plus a range of clinical and non-clinical services to support University Hospitals of North Midlands NHS Trust (UHNH).

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.

This report will provide a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to safeguarding by promoting the welfare of children, young people, adults and their families or carers who come into contact with our services.

Safeguarding Adults

North Staffordshire Combined Healthcare NHS Trust is committed to ensuring that all adults who come into contact with our services are protected and safeguarded from abuse. We work within the legal framework of the Care Act (2014) which came into force in April 2015 and enshrined the safeguarding of adults with care and support needs, at risk of abuse or neglect, in law.

All staff have a duty of care in relation to safeguarding adults at risk of harm and abuse and to ensure that any concerns raised are appropriately responded to.

Safeguarding Children

The majority of parents manage their mental health and parenting responsibilities well and care for their children appropriately, however, some parents may need extra help and support, particularly at times when a parent's difficulties may become harder to manage, or at times of transition in children's lives.

We have a duty to make sure that all children are safe and well cared for, either when the child is a service user or where their parent/carer, or another person in the child's family or network, is a service user.

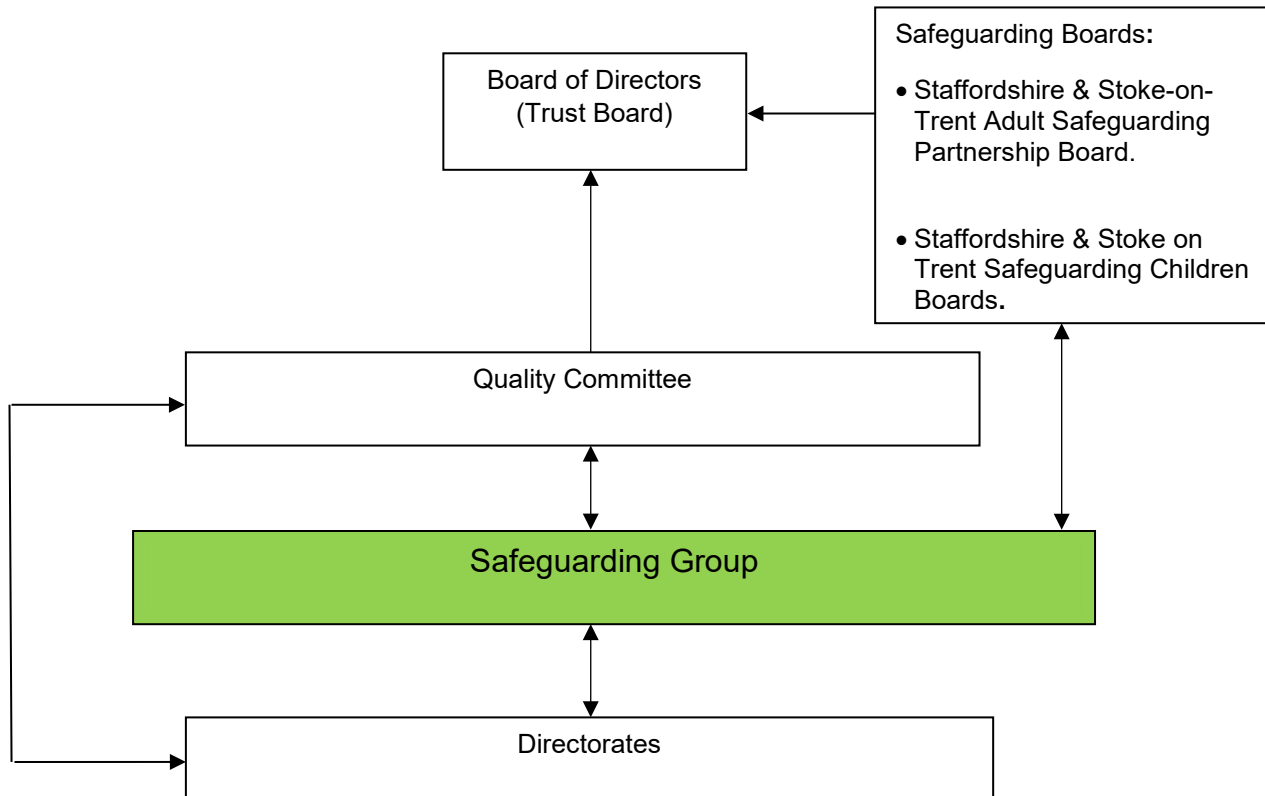
North Staffordshire Combined Healthcare NHS Trust is committed to ensuring the safety of all children who come into contact with our services, either directly or through parents/guardians. We work within the legal framework of the Children Act (2004) and Working Together to Safeguard Children (2018).

Purpose of the Report (Executive Summary)

This report provides assurance that the Trust is meeting its safeguarding roles and duties, that are laid out in the NHS England 'Accountability and Assurance Framework, 2015' outlining the safeguarding work

within the Trust for the period of 1 April 2025 to 31 March 2026. The report will evidence how we are making a positive difference and highlighting any challenges, whilst providing assurance of compliance to the Trust Board and partners.

Accountability Framework



Quality Committee

The Trust's Assurance Framework includes reports from the Executive Safeguarding Lead to the Quality Committee. Guidance documents, any new or updated policies, receive agreement and approval via this committee prior to submission to the Trust Board.

NSCHT Safeguarding Group

The Trust Safeguarding Group meets quarterly and provides an opportunity for representatives from key teams across the service to discuss issues, report progress and provide assurances against documented action plans and audit. Attendance includes: Chief Nursing Officer (Chair), Deputy Chief Nursing Officer, Safeguarding Team, Quality Leads and safeguarding representatives from the Integrated Care Board.

Executive Lead: Chief Nursing Officer

The Chief Nursing Officer is the Executive Nominated Lead for Safeguarding. The Executive Safeguarding Lead reports directly to the Chief Executive and the Trust Board and represents the Trust on the Staffordshire & Stoke-on-Trent Adult Safeguarding Partnership Board.

Safeguarding Team

The Safeguarding Team develops and monitors safeguarding policies, processes and procedures to provide assurance to the Trust Board that there are effective safeguarding arrangements in place. The Safeguarding Team is responsible for safeguarding surveillance across the organisation to identify trends, themes and any areas of concern. This function is carried out by supporting staff in clinical practice and

through the delivery of mandatory training and supervision. A key role of the team is to engage with partner agencies via the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board, the Child Safeguarding Health Forum (chaired by the Integrated Care Board (ICB)) and represent the Trust at the Stoke-on-Trent and Staffordshire Safeguarding Children Boards subgroups to continuously improve safeguarding policy and practice across Staffordshire and Stoke-on-Trent. The Head of Safeguarding also represents the Trust at the Domestic Abuse and ICB and subgroups.

The Safeguarding Team includes a Head of Safeguarding (Named Nurse), Named Doctor, Senior Safeguarding Practitioner, Safeguarding Practitioner, Safeguarding Team Coordinator and two Safeguarding Administration Assistants.

All NSCHT Staff

The Trust embraces the belief that “safeguarding is everyone’s responsibility” and that effective safeguarding practice depends upon the collective contribution of all staff, patients, relatives and carers. Policies and procedures are accessible to staff electronically on the Trust intranet and are reviewed in line with the Trust schedule or as a result of significant legislative changes. Staff complete mandatory internal safeguarding training in relation to both child and adult safeguarding with level 1 and 2 adult and child safeguarding training delivered as eLearning.

Safeguarding supervision is available to all members of staff both on an individual basis and as a team.

Partnership Working

Safeguarding Adults

NSCHT are active members of Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB). SSASPB co-ordinates its work via the following groups of which NSCHT participate:

- Partnership Board with an Independent Chair and Board level representation from statutory agencies.
- Executive Sub-Group.
- Subgroups: Audit & Assurance, Safeguarding Adult Review, Practitioners Forum, Prevention & Engagement and Policies & Procedures (virtual).

The SSASPB brings together lead officers from all agencies concerned with the wellbeing and safeguarding of adults. As part of this multi-agency working policies and procedures are developed to protect adults from abuse; training is provided and assurances sought from partner agencies regarding the quality of safeguarding activity both within organisations and across the wider community.

The SSASPB also lead on Safeguarding Adult Reviews (SAR) and engage the appropriate partners to complete this important work. Regular audits are completed which are led by the SSASPB to assure itself that partnership working and safeguarding frameworks are effective and help adults to achieve positive and meaningful outcomes.

The statutory partners involved are Staffordshire County Council, Stoke-on-Trent City Council, Integrated Care Board, Staffordshire Police and Staffordshire Fire & Rescue Service.

SSASPB Approved Strategic Priorities

The following are the agreed strategic priorities for 2025-2028

- Promote equality
- Amplify the voice of communities, especially those hard to hear groups.

NSCHT remains committed to partnership working through active participation in the various subgroups affiliated with the Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board and sharing of both learning lessons and examples of good practice.

The Safeguarding Team have successfully worked alongside the SSASPB to support the delivery of training.

Practitioner's Forum

The Safeguarding Team and representatives from other agencies work collaboratively to facilitate a Practitioner's Forum in response to themes identified in learning reviews on behalf of the Staffordshire and Stoke-on-Trent Safeguarding Adult Board. This year the Practitioners Forums were held on:

- 7 July 2025, Staffordshire and Stoke on Trent Safeguarding Adult Board: Adult Safeguarding Procedures
This session included latest updates to procedures within Self Neglect, Safeguarding Plans, Closure of the Safeguarding Process, Appeals and Complaints, People in Position of Trust (PiPoT).
- 20 November 2025, Learning from Domestic Abuse Related Death Review (DHR22)
The session focussed on lessons learned and recommendations made in the DHR report around domestic abuse in older people.

Adult Safeguarding Week

As part of the Health Safeguarding Provider Collaborative, NSCHT supported Adult Safeguarding Week: 17 - 21 November 2025.



The poster is titled "Adult Safeguarding Week" and "Monday 17th to Friday 21st November 2025". It features logos for North Staffordshire Combined Healthcare NHS Trust, Staffordshire and Stoke-on-Trent Integrated Care Board, and Midlands Partnership NHS Foundation Trust. The text describes a week of 30-minute lunchtime virtual learning sessions. The schedule is as follows:

Day	Topic	Time	Facilitators	Join Link
Monday 17 th	Good Practice in Safeguarding Adults	13:00 - 13:30	Meagan Hepher-Williams and Sarah Whenmouth	Join the meeting now
Tuesday 18 th	Informal Carers	13:00 - 13:30	Kathy Felton and Wendy Timmerman	Join the meeting now
Wednesday 19 th	Self-Neglect and Adult Safeguarding	13:00 - 13:30	Mark Thomas and Chris Frost	Join the meeting now
Thursday 20 th	Safeguarding and Information Sharing	13:00 - 13:30	Katie Sales	Join the meeting now
Friday 21 st	Organisational Abuse	13:00 - 13:30	Laura Collins, Caroline Phakathi and Amanda Atherton	Join the meeting now

****Please note you can only attend the training by joining from your NHS email address***

The Safeguarding Teams within the Health sector across the local area worked together to provide a week of events to promote current key issues within adult safeguarding practice. These 30-minute lunchtime

sessions were delivered over MS Teams and were well attended healthcare staff from a range of disciplines working within NSCHT, MPFT, UHNM and the ICB.

Maegan Hepher-Williams joint facilitated a session on Good Practice in Safeguarding Adults and Laura Collins joint facilitated a session on Organisational Abuse.

Staffordshire and Stoke-on-Trent Safeguarding Adult Board also hosted a range of events which NSCHT staff were able to book onto, this included:

- **Introduction to SSASPB and Safeguarding Adult Reviews (SARs)**
An overview of SSASPB strategic priorities, SAR process and expectations. There were two sessions aimed at frontline practitioners and team managers and also voluntary and community sector staff.
- **Domestic Abuse in Older Adults – Learning from Tragedy to Improve Practice**
This session was aimed at anyone working with adults.
- **The National SAB Business Managers network (NSBM)** hosted various events during the week, which were available to all. This included sessions on the links between the Department of Work and Pensions and Adult Safeguarding, Safeguarding Adults: Person Centred Planning and Homelessness and Hoarding Awareness sessions.
- **The Ann Craft Trust** national charity also provided sessions nationally, this included sessions on sexuality & relationships in the lives of adults with a learning disability, and understanding and preventing forced marriage.

Safeguarding Children

NSCHT are active members of both the Staffordshire and Stoke-on-Trent Safeguarding Children's Boards sub-groups. The Executive Director of Nursing and Quality for the ICB represented Health at board level during 2025-2026. NSCHT remains committed to active involvement in safeguarding children and young people as part of the new structure moving forwards.

The Trust continues to be part of the Health Forum which is facilitated by the Safeguarding Provider Collaborative and provides an opportunity for all local Health providers to escalate concerns and receive feedback from the partnership group. As part of the development of the collaborative there are regular huddle meetings chaired by the Designated Safeguarding Nurses for Children and Adults from the ICB.

Stoke on Trent Safeguarding Children Board-Strategic Priorities 2025-2028

- Strategic Priorities
Lead and Embed Effective Partnership Arrangements to Safeguard Children
Develop and implement a Quality Assurance and Scrutiny Framework
- Practice Priorities
Child Exploitation
Neglect (Graded Care Profile 2)
Safeguarding young children aged 0-2
- Assurance Priorities
Missing Children
Serious Youth Violence
Child Mental Health

Staffordshire Safeguarding Children Board Strategic Priorities 2025-2028

- Effective integrated front door
- Inter-familial child sexual abuse

Child Safeguarding Week, 16 June – 20 June 2025

Child Safeguarding Week
Monday 16th June – Friday 20th June 2025

The Safeguarding Teams from MPFT, NSCHT and UHNM have worked together to organise a [week long](#) event to promote current key messages in Child Safeguarding Practice. We will be hosting [60 minute](#) virtual learning sessions at lunch time each day for the duration of this week and it would be great to see as many NHS staff from MPFT, NSCHT and UHNM as well as our partner health services in Telford and Shropshire to join us to hear key messages and participate in these interactive sessions. The sessions will be held daily from 12:30 – 13:30, and will consider the following topics, just click on the session to join via Microsoft Teams.

Domestic Abuse and Children
16th June 12:30 – 13:30 with Katie Harris and Amanda Atherton [Join the meeting now](#)

Tackling Youth Trends, Misogyny & Violence in the Digital Age
17th June 12:30 – 13:30 with Nicola Forster [Join the meeting now](#)

Elective Home Educated versus Missing
18th June 12:30 – 13:30 with Helen Kyle [Join the meeting now](#)

Mental Health with a focus on LGBTQ in healthcare
19th June 12:30 – 13:30 with Ben Richards [Join the meeting now](#)

Child Sexual Exploitation
20th June 13:30 – 13:30 with Julie Turner, Heather Bratt-Rose and Cara Owen [Join the meeting now](#)

***NOTE THESE SESSIONS ARE PROVIDED FOR NHS STAFF ONLY AND ARE NOT RECORDED.
PLEASE JOIN FROM A RECOGNISED NHS EMAIL ADDRESS***

The safeguarding teams from North Staffordshire Combined Healthcare NHS Trust, Midlands Partnership University NHS Foundation Trust and University Hospitals of North Midlands NHS Trust worked together to organise a weeklong event to promote current key messages in child safeguarding practice.

NSCHT provided a session on mental health with a focus on LGBTQ in healthcare and was facilitated by Chief Operating Officer Ben Richards.

Professional Boundaries

The Trust Safeguarding Team worked collaboratively with the Head of Nursing and Professional Practice Professional Boundaries framework, which aims to provide clear guidance for Trust staff on maintaining professional relationships with service users with a focus on the delivery of person-centred care while maintaining professional boundaries, ensuring that care remains focused on the needs of the individual and safeguarding both staff and service users.

A number of resources have been developed including presentations, briefings and bespoke sessions delivered to newly qualified practitioners in Preceptorship sessions. All resources can be found on the Trust intranet.

Information Sharing

The Safeguarding Team complete lateral checks requested by Adults and Children's Social Care Safeguarding Teams as part of Adult Safeguarding Section 42 Enquiries, Child and Families Assessments, Child in Need (Section 17 of the Children's Act), Child Protection (Section 47 of the Children's Act) processes. This is a significant piece of work which must be completed within an appropriate timescale to allow agencies to make decisions within their own frameworks.

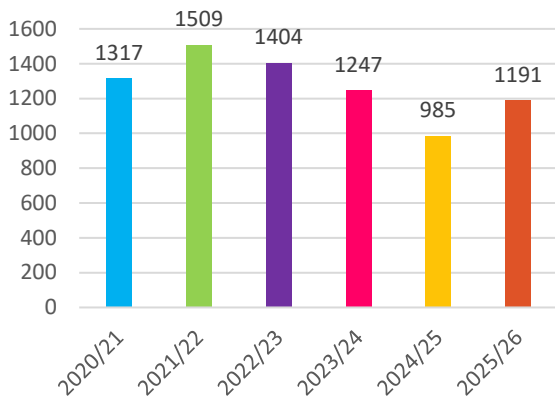
From 1 April 2025 to 31 March 2026 there were:

1191 requests received from Adult and Children's Social Care Safeguarding Teams.

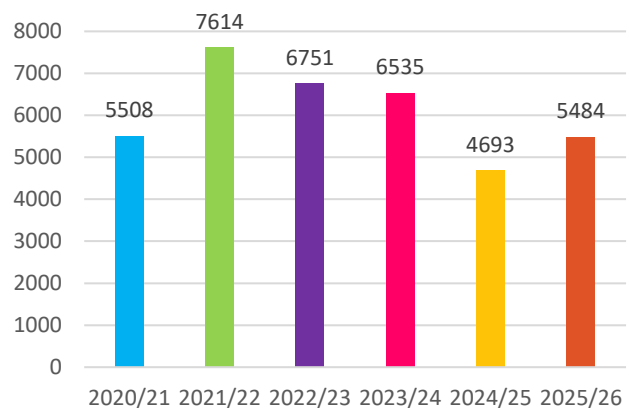
1852 Individuals requested within xx requests.

5484 lateral checks carried out across all Trust systems.

Requests Received



Total Lateral Checks



Audit and Assurance

Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board

The Audit and Assurance Subgroup of the Staffordshire and Stoke on Trent Adult Safeguarding Board (SSASPB) is responsible for monitoring and evaluating the effectiveness and quality of the activities performed by all Board partners through audits. Recurring Safeguarding Adult Review (SAR) themes include mental capacity assessments, professional curiosity, self-neglect and multi-agency information sharing.

Tier 3 – Multi-Agency Case File Audit

Family Concerns Audit

This audit considered nine adults living in a variety of settings where concerns had been raised by family members about abuse, neglect and the quality of care. The audit was completed as part of recommendations made by the author of the Clive Treacey Safeguarding Adult Review to seek assurance from partner organisations through regular audits surrounding the quality of care being delivered to adults in care settings.

Stoke-on-Trent Children's Safeguarding Partnership

Multi-Agency Audits

- Child Sexual Abuse
- Private Fostering
- Multi Agency Planning
- Neglect
- Domestic Abuse including MARAC
- Parental Mental Health & Substance Misuse

The above themes were explored by looking at a series of case file audits for children and young people. The audits were focused on the voice of the child, assessments, planning, intervention, and the impact of the overall work with the child and their family. Multi-agency learning from these audits will be fed back to practitioners and teams, and back to the Quality and Assurance Subgroup to identify how improvements can be achieved.

Staffordshire Safeguarding Children's Partnership

Multi-Agency Audit

- Interfamilial Child Sexual Abuse (IFSA)
- Child Exploitation

The audits focused on the voice of the child, information sharing and decision making, assessment and safety planning, and management oversight/supervision. Both audits highlighted examples of strong practice, including child-centred responses following disclosures, positive school involvement, growing specialist support services and strong commitment from partners to learn and improve outcomes for children. Interfamilial Child Sexual Abuse was completed in July 2025 as part of a mock Joint Targeted Area Inspection (JTAI) to test the process.

Performance

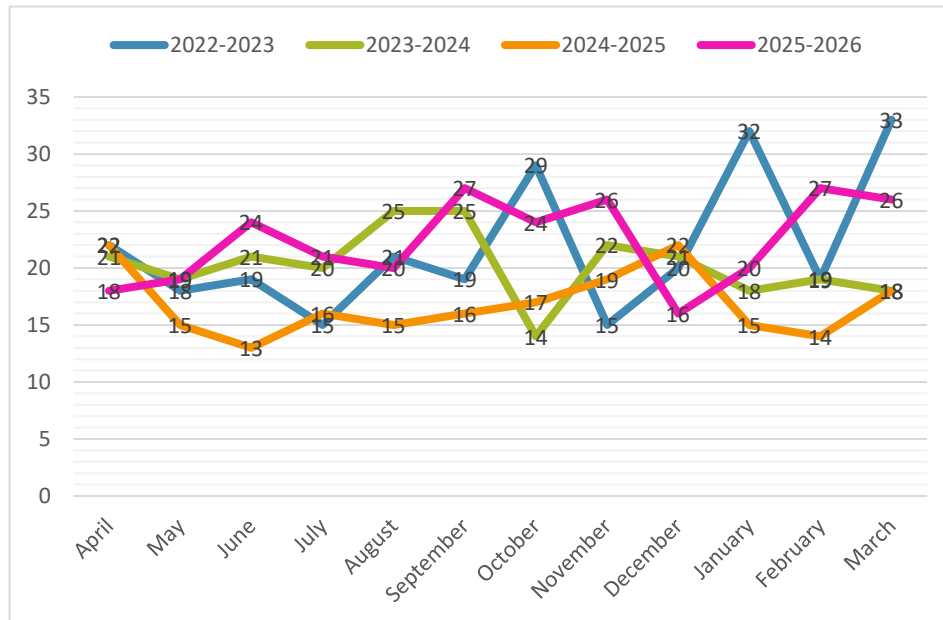
NSCHT Incident Reporting and Safeguarding

Safeguarding Adults

The graph below shows the total number of adult safeguarding referrals which were raised by Trust staff over the previous four years. An adult safeguarding referral is not required for every safeguarding incident.

In some cases, concerns may already be under investigation or may be more appropriately managed through a review of an existing safeguarding plan. The Trust Safeguarding Team monitors all safeguarding incidents and referrals to identify any trends and themes.

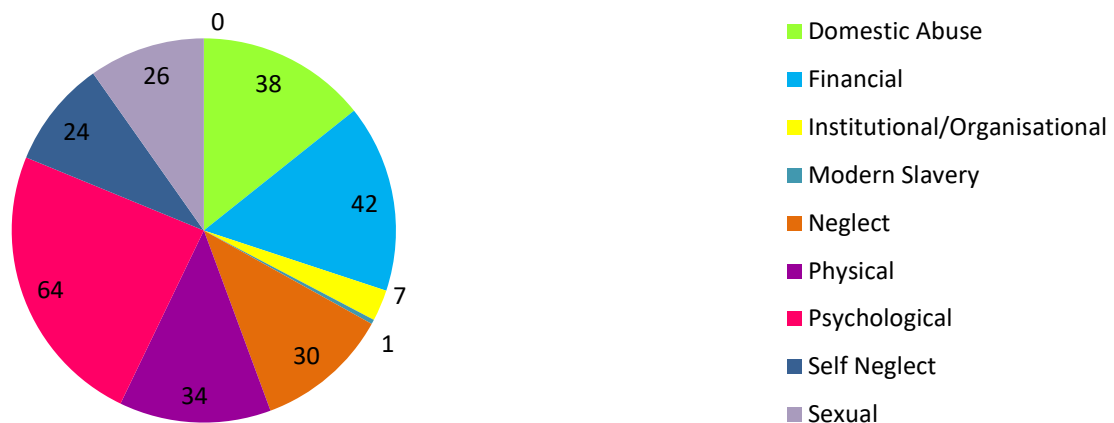
Total Number of Adult Referrals during 2025-2026: 268



There was a 32% increase in adult safeguarding referrals in the year 2025/2026 compared to the previous year. This may be due to a number of factors including increased awareness amongst staff, improved access to training/learning events and supervision, higher levels of public awareness and family reporting.

All referrals are reviewed on a weekly basis through the Weekly Incident Review Group (WIRG) which is attended by the Trust Safeguarding Team. This meeting provides centralised oversight of all incidents forms raised by services across the Trust which ensures that any incidents which may need additional actions are considered. This includes identifying any incidents which may require a safeguarding response or action.

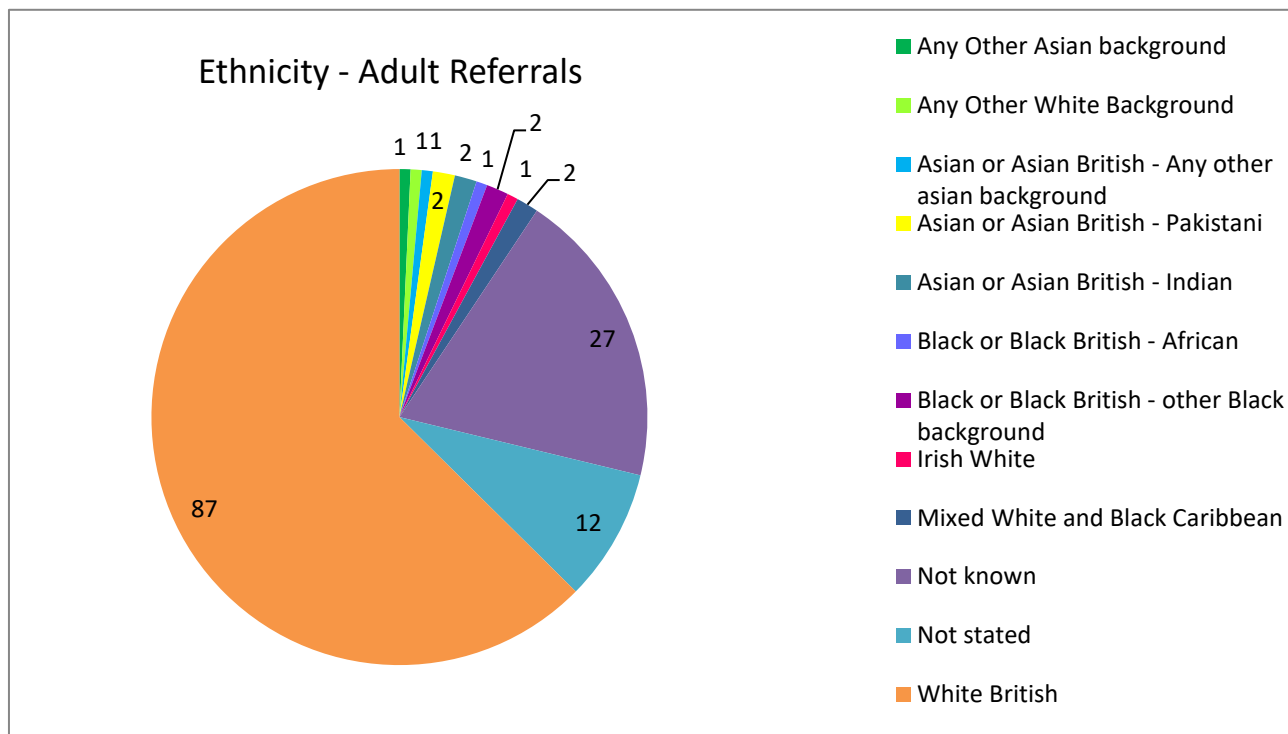
Types of Abuse Reported - Adult Referrals



During 2025/2026 psychological abuse was the most common category reported, followed by physical, financial and domestic abuse. This is in keeping with data across other Local Authorities in England and demonstrates that Trust staff are skilled at identifying all categories of abuse.

Psychological abuse is frequently recorded alongside other categories of abuse such as domestic, financial and neglect.

Patient Ethnicity for Adult Safeguarding Referrals:



'Not known' is where the person making the referral indicated 'not known' to the question on the form. 'Not stated' is where the question was left blank on the form.

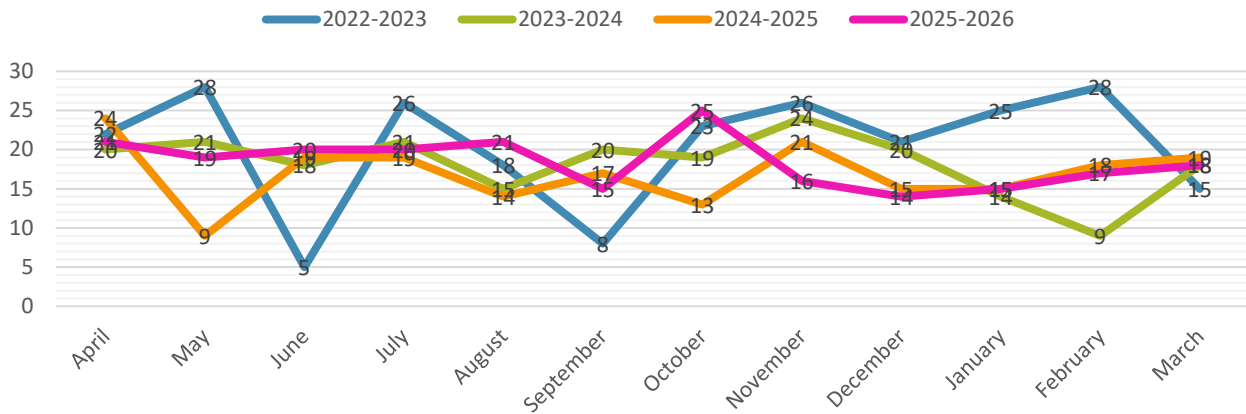
North Staffordshire Census, 2021 shows that the ethnicity data for the local population within Newcastle and Moorlands is less than 2% for Black Minority and Ethnic groups (BME) and 16.5% in Stoke-on-Trent. Trust safeguarding referrals highlights gaps in data reported around ethnicity despite this being a mandated field. This could be due to staff not asking the question or the adult declining to answer.

Safeguarding Children

The graph below shows the total number of child safeguarding referrals which were made by Trust staff over the last four years:

Number of Child Protection Referrals 2025 – 2026: 221

Safeguarding Children Referrals



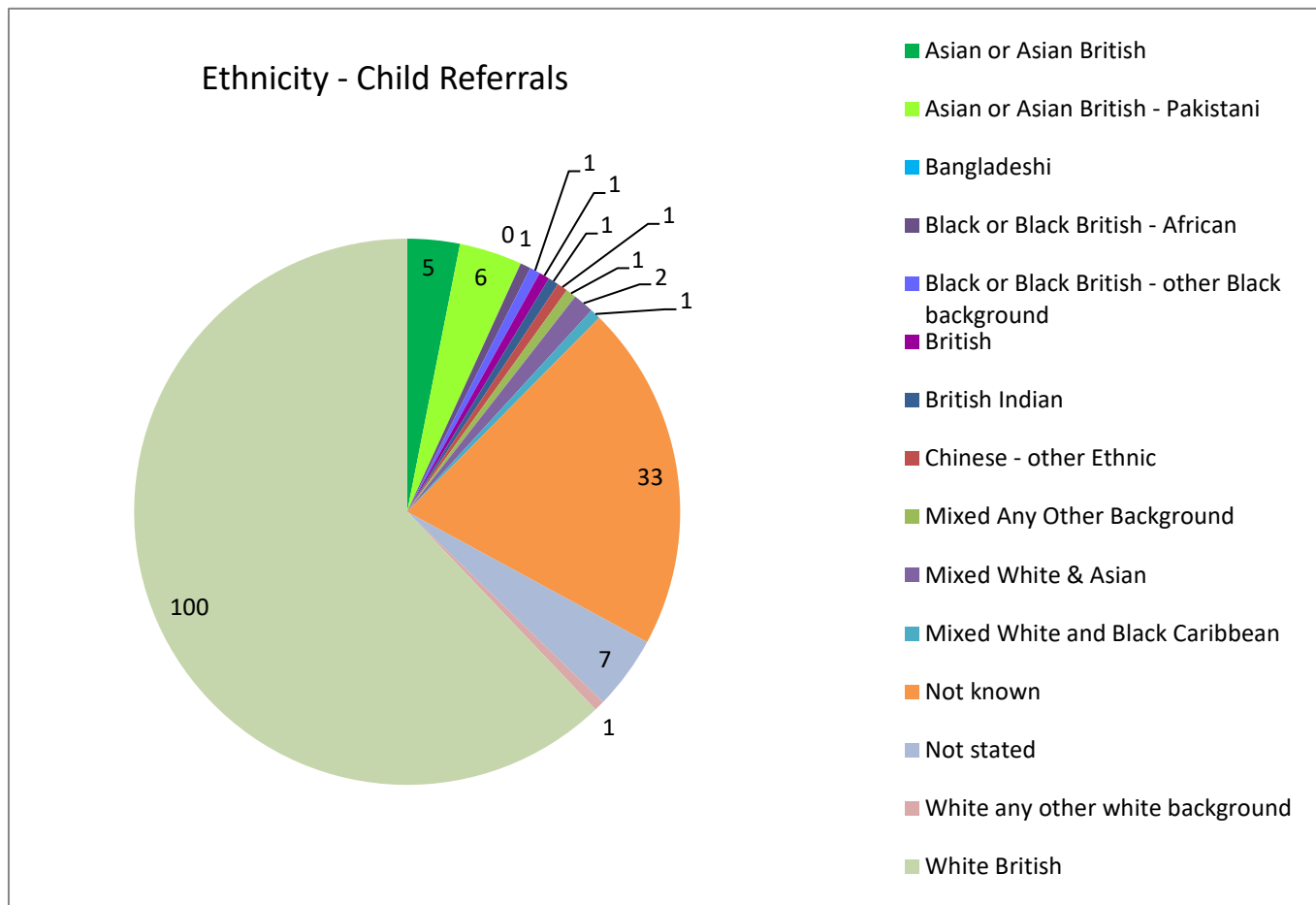
Types of Abuse Reported - Child Referrals



National and local data reflects that 'neglect' is the most common category of abuse is neglect, with emotional abuse following closely.

This may be due to NSCHT staff seeing the emotional impact that parental mental health, domestic abuse, parental conflict and parent-child relationship difficulties has on children in their assessments and formulations of children referred to our service. Social Care assessments may later identify wider patterns of unmet need and chronic care deficits that are categorised as neglect.

Patient Ethnicity for Child Safeguarding Referrals



There are many referrals with unknown information in relation to the ethnicity of children. Learning from statutory reviews indicates that this may be due to practitioners not asking the question, recording systems allow practitioners to proceed with completing demographic information, and general lacking understanding of why this information is relevant and important.

Integrated Front Doors

Throughout 2025 and 2026, there have been several changes to the way that statutory partners respond to and manage referrals made to their respective services which has meant that the MASH has evolved into an Integrated Front Door arrangement. Both Stoke on Trent and Staffordshire children's services are now operated through an Integrated Front Door model which provides a single access point for referrals and incorporates wider early intervention and prevention services rather than focussing only on safeguarding. The IFD approach supports consistent threshold decision making, better information sharing and streamlined management of referrals which allows for more efficient responses.

All referrals to children's services are now made using an online portal, except for when complex and urgent concerns arise and telephone referrals are required.

Training

Mandatory Safeguarding Training

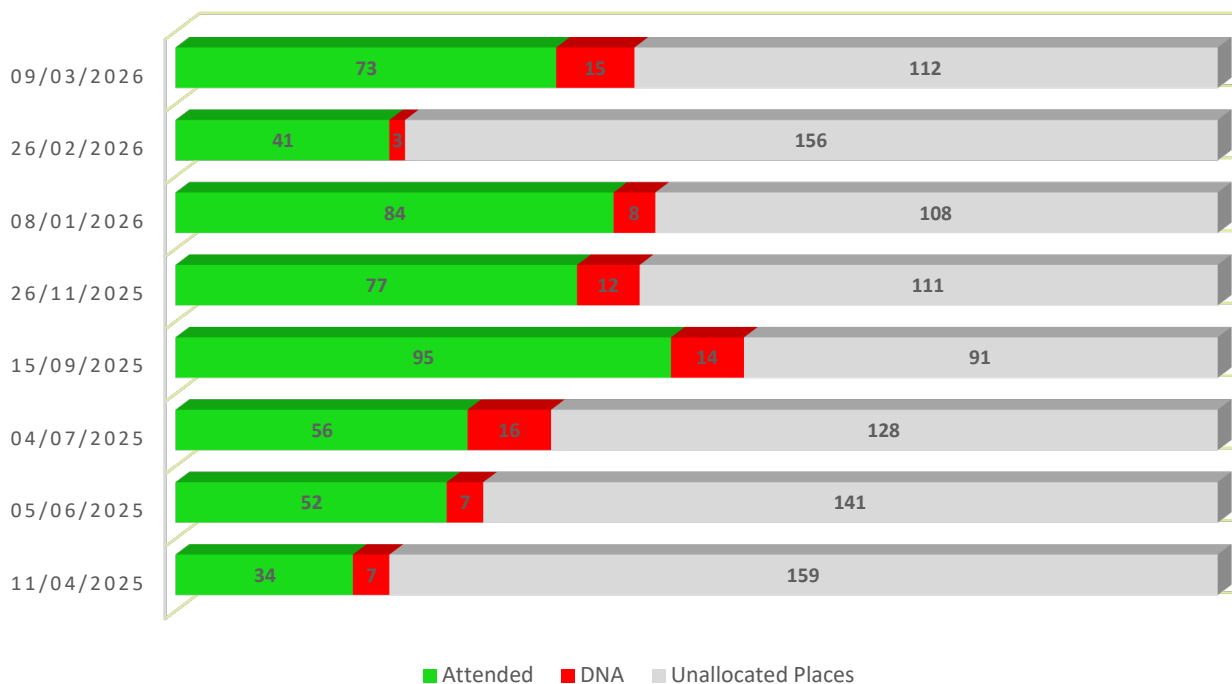
Safeguarding training for both adults and children is mandatory for all Trust staff to ensure that they are equipped with the essential knowledge and skills to recognise and report abuse. Training is provided in accordance with the Intercollegiate Document; Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Intercollegiate Document (2019) which provides clarity on the levels of training required, by role, within health services.

Level 1 and 2 training is a joint adult and child safeguarding package which is delivered via eLearning. This is a live package that is periodically reviewed and updated to reflect legislation, national and local guidance, best practice and learning opportunities identified from both external and internal audit.

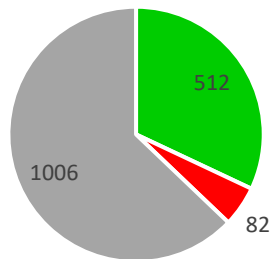
During 2025 – 2026 there were 8 training sessions held for L3 Safeguarding Children Training which is delivered virtually via Microsoft Teams on bi-monthly basis and capacity for each session is 200.

Two bespoke sessions were completed for the medics in 2025 due to increasing difficulty attending the organised sessions throughout the year because of clinical commitments. A total of 512 staff (not including the bespoke sessions) received L3 Safeguarding Children training over the year.

L3 SAFEGUARDING CHILDREN TRAINING

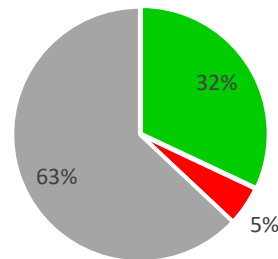


Number of Places: 2025/2026



■ Attended ■ DNA ■ Unallocated Places

Percentage of Places: 2025/2026



■ Attended ■ DNA ■ Unallocated Places

There was a total of 1006 surplus places available to staff during 2025/2026 (63%).

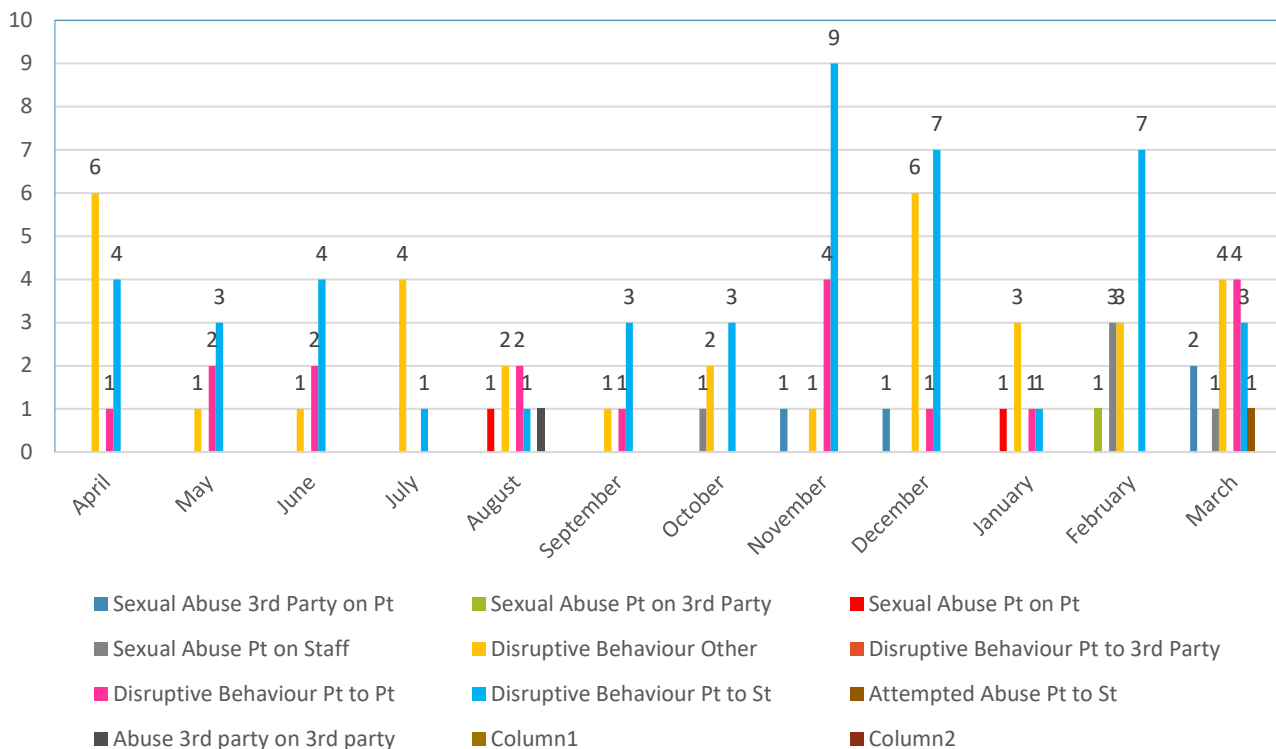
The table below outlines the training figures for mandatory safeguarding training by Directorate as at year end 2025/2026. Each Directorate is responsible for supporting their staff to attend mandatory training and report monthly on mandatory training compliance to the Senior Leadership Team. The target for all Safeguarding training is 85%.

Directorate	L1/2 Safeguarding Training	L3 Safeguarding Children Training	L3 Adult Safeguarding Training
Acute Services and Urgent Care	93%	85%	89%
Specialist Services	96%	88%	93%
Community Directorate	94%	83%	85%
Corporate (Medics)	91%	82%	87%
Primary Care Directorate	90%	86%	94%
Bank Staff	87%	N/A	N/A
Trust Compliance Target	85%	85%	85%
Trust Overall Compliance	93%	84%	88%

Sexual Safety

The Head of Safeguarding is the Sexual Safety Lead for the Trust and has oversight on reporting of Trust incidents involving patients and staff.

Trust Wide Incidents 2025 - 2026



These incidents are available on a weekly incident report and are raised for discussion at the monthly Clinical Safety Improvement Group (CSIG). They are also included in Quarterly Trust Safeguarding Group reports. During 1 April 2025 to 31 March 2026 there were 112 recorded sexual safety incidents. A large proportion of incidents are linked to disinhibition associated with deteriorated mental health towards staff and/or other patients.

NHS England Sexual Safety Charter

The Trust signed up to the commitment of Sexual Safety Charter in November 2023 and as signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.

10. We will capture and share data on prevalence and staff experience transparently.

This piece of work is being led by the People Team with support from the Trust Safeguarding Team as the Sexual Safety Lead, and the Reducing Restrictive Practice Lead who has been very involved in the development of the principles associated with the charter. We have task and finish groups with a range of Trust representatives to ensure we are working towards and achieving a safe workplace for our staff.

In 2025/2026 a Sexual Safety Working Group was set up and Chaired by the ICB People Team. A Sexual Safety training package was designed collaboratively by local Health partners, and there is now Sexual Safety eLearning on LMS. A number of 'bitesize' sessions were also organised and hosted virtually by the ICB, and discussion have been completed about developing a Podcast focussing on staff wellbeing.

Policies

The Safeguarding Team ensure that safeguarding policies reflect current practice within a legislative framework. The following policies are reviewed on a three yearly cycle:

- Children Visiting Mental Health Hospitals Policy (4.22)
- Domestic Abuse Policy (1.75)
- Manage Visits to Trust Premises by Celebrities/VIPs or Other Famous People (4.44)
- Managing Safeguarding Allegations Against Staff Policy (1.70)
- Prevent Policy (4.43)
- Safeguarding Adults at Risk Policy (1.89)
- Safeguarding Children & Young People Policy (4.01)
- Sexual Safety and Responding to Sexual Violence Policy (1.87)
- Staff Domestic Abuse Policy (1.75a)

PREVENT

Prevent is one of the four strands of the Governments Counter Terrorism Strategy called Contest. Prevent gained a statutory footing in July 2015 giving staff a legal duty to report any concerns. The Safeguarding Team are active members of monthly Channel meetings for both Staffordshire and Stoke-on-Trent, the West Midlands Regional Prevent Forum and the Stoke-on-Trent Prevent Board. The Designated Adult Safeguarding Nurse from the Integrated Care Board attends Prevent Board.

Channel is an early intervention multi-agency process designed to safeguard children and adults who may be vulnerable to being drawn into violent extremist or terrorist behaviour. Channel works in a similar way to existing safeguarding partnerships aimed at protecting people vulnerable to exploitation.

Prevent/WRAP Training

Prevent training was developed to increase staff awareness of radicalisation and extremism, and what to do if they have concerns that service users or colleagues are expressing extreme ideologies associated with political or religious views. WRAP is 'Workshop to Raise Awareness of Prevent' and Prevent training is an eLearning package developed by the Home Office which is completed on the Trust Learning Management System (LMS). The Prevent/WRAP training aims to give professionals the skills to identify individuals who show signs of vulnerability, identify what they are vulnerable to, and support those individuals so that they do not become exploited by people or groups supporting violent extremism or acts of terrorism.

The training looks at the background of crime, social processes, the history of terrorism, susceptibility, narratives used by radical groups or individuals and recognising, understanding and referring vulnerable people. During 2018-2019 the WRAP/Prevent training moved from once only to three yearly in line with the NHS England Guidance for Mental Health Services in Exercising Duties to Safeguard People from the Risk of Radicalisation (2017). This transition has now been completed with overall Trust compliance rates remaining above the target of 85% at 94% at year end. This is demonstrated in the table below.

Breakdown of Directorate Prevent Training Compliance (as at 31 March 2026):

Directorate	% Compliance
Acute Services and Urgent Care	90%
Specialist Services	92%
Community	87%
Corporate	95%
Primary Care	84%
Bank	84%
Trust Compliance Target	85%
Trust Total	89%

Below Thresholds Pilot

North Staffordshire Combined Healthcare is a committed and core partner organisation to all work completed as part of the Prevent and Channel agenda. Many referrals to Prevent are assessed by Counter Terrorism Police (CTP) as not meeting the Prevent threshold but identify safeguarding or public protection risks that require support. Recently published Prevent statistics highlight that 65% of Prevent referrals do not progress beyond initial CTP assessment and are signposted to other services.

Stoke on Trent was selected as one of ten local authorities across England to take part in the 6-month Home Office pilot testing whether there should be a formal multi agency oversight process for these 'below threshold' cases where individuals display an interest in serious or mass violence. The pilot was active across the local authorities between March 2025 – February 2026 and the learning was consolidated by the Home Office Homeland Security Analysis and Insight (HSAI) who published a report July 2026 which looked at data across all ten local authorities. The report revealed that the referrals typically related to young males with a range of vulnerabilities including ASD and/or ADHD, low mood, anxiety and depression, social isolation and early trauma. 70% of the cohort were under the age of 18.

Recommendations included the need for a clear audit trail of handover cases from Prevent to other mainstream services, further work being needed around onward referral decisions by multi-agency partners and greater assurance that partners are assuming responsibility of the identified public protection and non-counter terrorism risks.

Domestic Abuse

NSCHT remains committed to improving outcomes for individuals experiencing domestic abuse and supporting perpetrators in accessing treatment and support to address their offending behavior. Domestic abuse is now a category of abuse under the Care Act (2014), and this enables adults at risk of domestic abuse with care and support needs to be supported under adult safeguarding procedures. This definition also includes control and coercion, so called honor-based violence and female genital mutilation.

This is particularly pertinent for the Trust as a provider of mental health and learning disability services as it provides a framework for supporting individuals within services who experience domestic abuse and are unable to protect themselves because of their care and support needs. This is in addition to established criminal justice routes.

The Trust Safeguarding Team worked collaboratively with domestic abuse services to develop mental health and domestic abuse support service leaflet highlighting pathways of support.

Domestic Abuse Policy

All NHS Trusts are required to have a Domestic Abuse Policy. NHS organisations are working towards the recommendations of the Ending Violence Towards Women and Girls Strategy (Home Office, 2016) and consider NICE guidance such as Quality Standard 116 - Domestic Violence and Abuse and Public Health Guideline 50 - Domestic Violence and Abuse: Multi-Agency Working (2014). The Trust has a Domestic Abuse Policy (1.75) and provides stand-alone domestic abuse training as well as incorporating domestic abuse as a 'golden thread' throughout both child and adult safeguarding training packages.

Staff Domestic Abuse Policy

Domestic abuse can have a profound impact on the health, wellbeing, safety and work performance of employees. There is significant national guidance that strongly supports Health organisations should have domestic abuse policy specifically for staff. As a responsible employer and safeguarding organisation, the Trust is committed to providing a safe, supportive and confidential environment for staff affected by domestic abuse. A standalone Staff Domestic Abuse Policy (1.75a) ensures a consistent organisational response, supports early intervention, promotes staff wellbeing and safety, and enables the organisation to meet its legal, safeguarding and duty of care responsibilities.

Domestic Abuse Training

NICE Guidance 50 - Domestic Violence and Abuse: Multi Agency Working, and NICE Quality Standard 116 - Domestic Violence and Abuse set out clear responsibilities for Mental Health Trusts in terms of recognising and responding to domestic abuse. In order to assure that staff are appropriately trained the Safeguarding Team developed a Level 3 eLearning training package for all staff which went live on LMS mid-late 2022, and Trust compliance has remained consistently high and never dropped below 95% throughout 2025/2026. Domestic abuse is a thread throughout Child and Adult Level 3 training sessions.

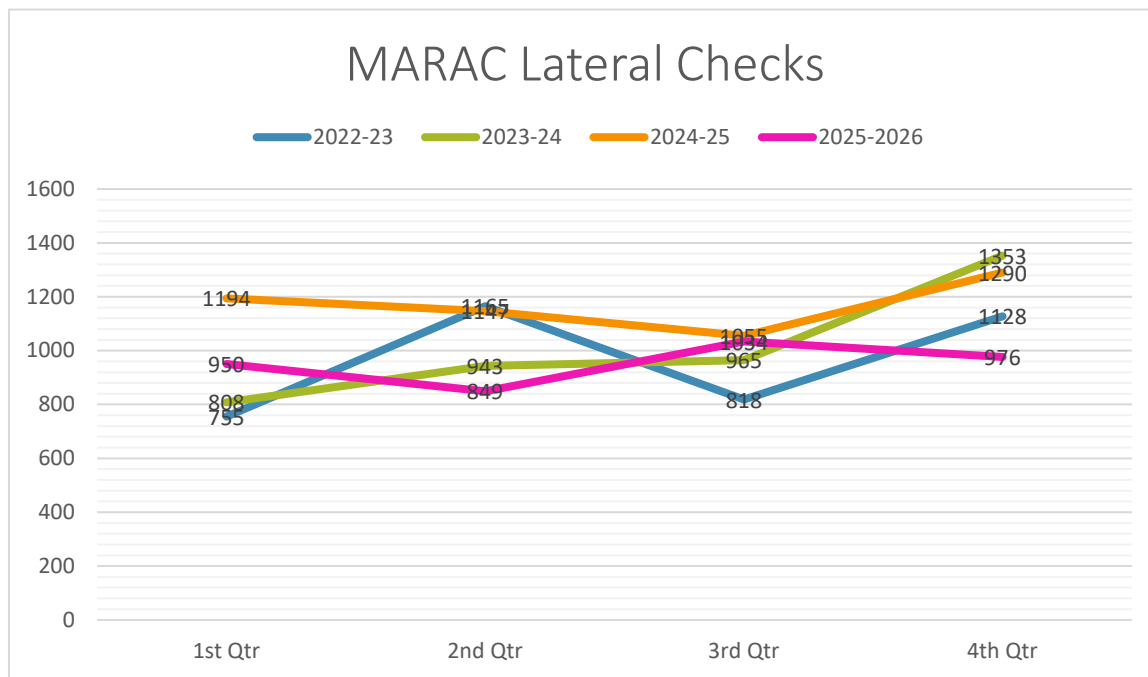
Multi Agency Risk Assessment Conferences (MARAC) Engagement

MARAC is a multi-agency response to individuals and their families experiencing domestic abuse. Locally Multi Agency Risk Assessment Conferences are held every week in four localities including Moorlands, Newcastle, Stoke North and Stoke South. Each MARAC has anywhere between 4-12 cases per meeting and includes checks needed for the perpetrator, victim and any children involved (see data below). The Trust Safeguarding Team processes MARAC invitations on behalf of NSCHT to ensure that frontline practitioners are made aware of relevant referrals so that they can attend or provide a written report. Due to the frequency and short timeframe from receiving invites to the actual MARAC meeting this creates a difficulty for staff to make arrangements to attend, therefore the Trust Safeguarding Team provides information on anyone who has accessed support from NSCHT, whether this is historic or current.

A good practice guide of what happens at the meeting and what is expected of staff attending a MARAC was developed for Trust staff and is sent by email to anyone requesting further information about the meeting and what information to share. In addition to this, individual support and supervision is provided by the Safeguarding Team.

In Stoke-on-Trent and North Staffordshire there has been increasing recognition of the overlap between domestic abuse, MARAC cases, mental health, and suicide risk, and suicide prevention has become a significant part of multi-agency risk management. NSCHT has been a core partner in discussions with other statutory and voluntary partners within Staffordshire and Stoke-on-Trent partnerships to strengthen links between domestic abuse services, safeguarding, mental health providers, and suicide prevention initiatives.

The graph below shows the number of lateral checks undertaken by the Safeguarding Team for MARAC purposes:



During 2025/26 the Safeguarding Team completed 3809 individual lateral checks for the purpose of MARAC which represents a decrease compared to the number of checks last year.

MARAC have strengthened their quality assurance processes over the past 12 months, and all MARAC referrals are now managed by the local Harm Reductions Hubs rather than through the MASH. This enables local Police to have improved local knowledge of local community risk factors, earlier identification of high-risk cases and better engagement with local communities. It may also be due to a reduction in the number of repeat referrals and the development of other risk management processes such as daily risk meetings.

Case Reviews

Learning from all types of case review is shared in a variety of ways; it is discussed at quarterly safeguarding meetings which includes directorate representation, incorporated into mandatory safeguarding training, safeguarding supervision and through the Trust Learning Lessons Forum.

Safeguarding Adult Reviews

SAR's are undertaken when an adult dies or experiences significant harm and it is believed that agencies could have worked together more effectively to support the adult.

The Trust received 10 requests for scopes for a SAR, of which 5 met threshold during 2025/2026 relating to a service user of NSCHT.

Domestic Abuse Related Death Reviews (DARDR)

Domestic Abuse Related Death Reviews (DARDRs) are undertaken when a person over 16 dies because of suspected violence or abuse, the alleged perpetrator was part of their household or was in an intimate relationship with them.

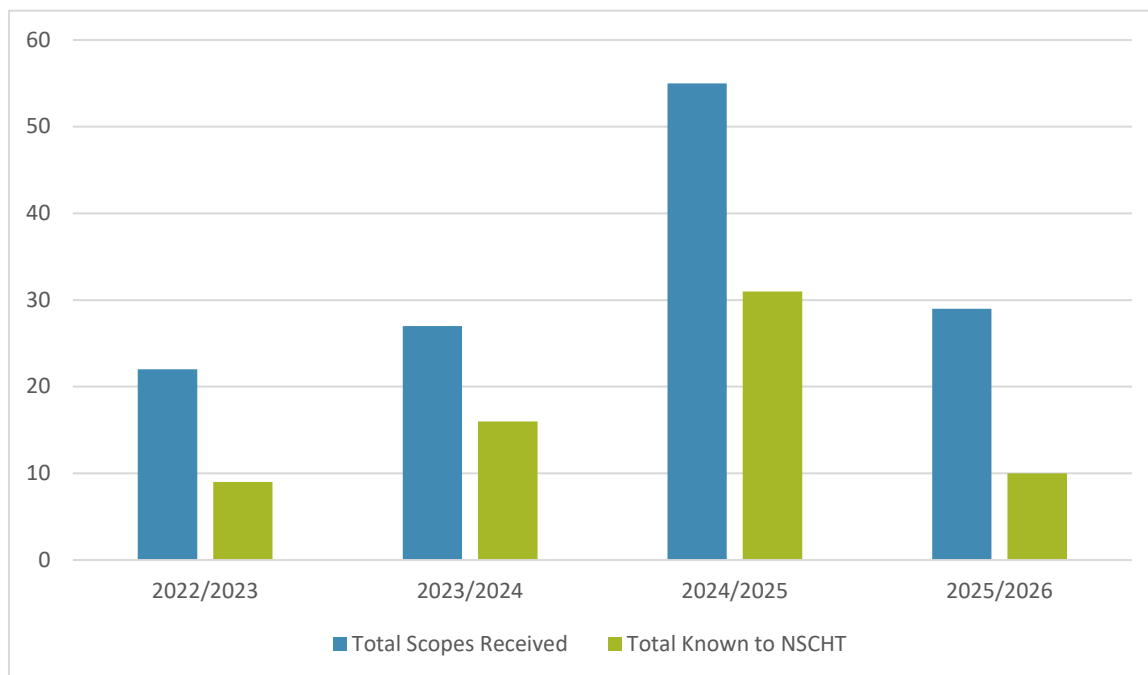
The Trust received 12 requests for scope for DARDR during 2025/2026.

Child Safeguarding Practice Review

Child Safeguarding Practice Reviews (CSPR) are a statutory process undertaken when a child dies or experiences significant harm and abuse or neglect is suspected. The aim of these reviews is to identify learning and areas of improvement in order to improve services for children and young people and prevent future deaths or incidents of serious harm.

The Trust received 5 requests for scope for CSPR during 2025/2026.

Scope request for review of the last four years



Over the previous three years, the Safeguarding Team experienced a significant increase in the number of scopes received. This appears to have stabilised again over the past 12 months.

When individuals are known to us, we contribute meaningfully through the development of chronologies, individual management reports, participation in multi-agency meetings, and the formulation of action plans.

Our work extends beyond case management; we ensure that insights and learning are brought back into the Trust. This is achieved through targeted training, reflective supervision, learning lessons, and the implementation of changes to policies and procedures.

Safeguarding Supervision

Safeguarding Supervision Strategy

A Trust wide safeguarding supervision strategy is in place which identifies four levels of safeguarding supervision available to any staff working with adults or children:

Level 1

Staff can access safeguarding support and advice from their peers and line managers.

Level 2

Safeguarding support and advice is available from the clinical practitioners in the Trust Safeguarding Team via telephone or face to face contact.

Level 3

Staff can access planned or ad hoc face to face individual supervision from the Trust Safeguarding Team on MS Teams or in person.

Level 4

Teams can access planned face to face group supervision from the Trust Safeguarding Team.

Level 5

Supervision for the Named Nurse/Head of Safeguarding is accessed from the Integrated Care Board Designated Nurse for Safeguarding Adults and Designated Nurse for Safeguarding Children, and the Named Doctor accesses regular supervision from the Designated Doctor.

Staff are made aware of the opportunity to seek safeguarding supervision during NSCHT safeguarding training, through the NSCHT Supervision Policy and information provided for staff on the Trust intranet safeguarding page. Practitioners are also offered supervision when invited to a Child Protection Conference, a MARAC or when involved in any other statutory safeguarding process such as a DHR or MALR.

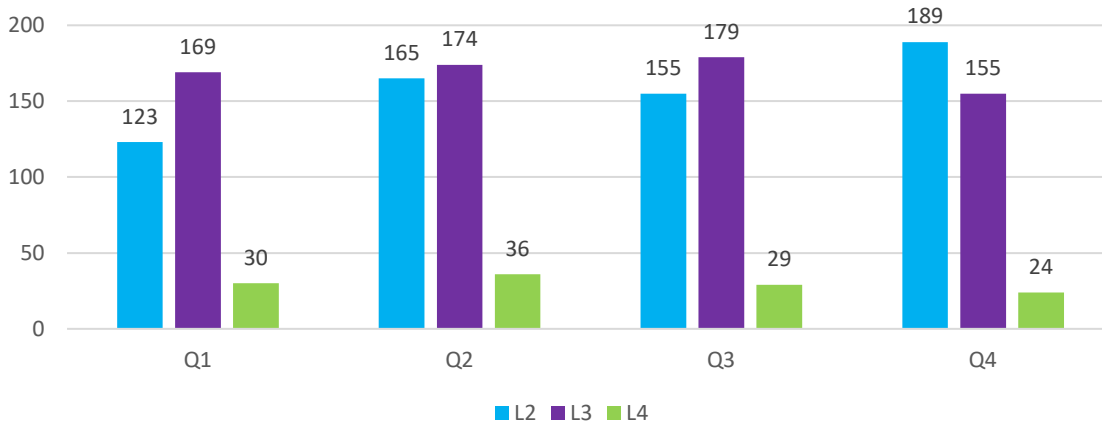
Safeguarding Supervision Sessions

The Safeguarding Team also offer case specific supervision with teams; this has included the opportunity to have multi-agency safeguarding supervision/discussion of specific cases.

The Head of Safeguarding, Named Doctor and Senior Safeguarding Nurse provide safeguarding advice on an individual basis.

The Head of Safeguarding/Named Nurse received supervision from the Integrated Care Board Designated Lead for Safeguarding Adults and Designated Nurse for Safeguarding Children, and the Named Doctor had access to supervision from the Integrated Care Board Designated Doctor during 2025/2026.

Supervision Contacts



Local Authority Designated Officer (LADO)

A referral is made to LADO when someone, in the course of their work, has allegedly harmed a child or behaved in a way which may deem them inappropriate to work with children. Referrals are received by the Local Authority who investigate concerns under the Children Act 1989. The Head of Safeguarding and Named Doctor are the named officers for Trust LADO referrals.

The Trust Safeguarding Team completed 3 referrals to LADO in 2025/2026.

DASM (Designated Adult Safeguarding Manager)

A referral to the DASM (Designated Adult Safeguarding Manager) should be made when there are concerns that a Person in a Position of Trust (PiPoT) may pose a risk to an adult with care and support needs. The concern does not need to be proven before a referral is made. The purpose is to ensure that risk is assessed and managed appropriately. The Head of Safeguarding is the named officer for Trust DASM referrals.

The Trust Safeguarding Team completed 7 referrals to DASM in 2025/2026.

Examples of Good Practice

The Safeguarding Team regularly share examples of good practice at the Safeguarding Group Meeting. This information is shared and disseminated to teams via Quality Leads feedback at Directorate meetings. Some examples which have been shared during 2025/2026 are below:

Case 1: PICU

The Safeguarding Team provided dedicated support to a member of staff on the PICU following an allegation that was subsequently found to be unfounded. Throughout the process, the team ensured that the staff member felt listened to, supported, and reassured.

Positive progress was also identified in referral practices within the ward. Staff are now making safeguarding referrals directly, demonstrating increased confidence and awareness of safeguarding responsibilities, whereas referrals had previously been made predominantly by managers. This improvement has been strongly supported by the new Ward Manager, who actively encourages staff to engage with the Safeguarding Team and seek advice or make referrals when concerns arise.

In addition, the Safeguarding Team continues to strengthen its visibility and accessibility through monthly drop-in sessions on the ward. These sessions provide staff with opportunities to seek guidance, discuss concerns, and receive ongoing support, helping to foster a proactive safeguarding culture across the service.

Case 2: ISH Team

The ISH Team demonstrated good safeguarding practice by identifying and escalating concerns following three significant suicide attempts involving pupils from the same school. Through effective information sharing and professional curiosity, the team recognised a potential emerging pattern and sought to understand the wider contextual factors contributing to risk.

The ISH Team highlighted that bullying was a common theme across all three cases and engaged with the Mental Health Support Team based within the school to gather further information. This collaborative approach confirmed that bullying had been identified as an ongoing concern and highlighted the impact this was having on the wellbeing of young people.

Recognising the potential safeguarding implications, the ISH Team ensured that concerns were shared with the Safeguarding Team, enabling timely liaison with the Local Authority Safeguarding Education Lead. This resulted in the concerns being considered at a wider system level and further enquiries being undertaken.

The case exemplified strong multi-agency working, effective escalation of concerns, and a commitment to identifying emerging themes that may place children and young people at risk. The information gathered also contributed to wider strategic discussions with partners involved in suicide prevention, mental health support within schools, and thematic reviews of child suicides, ensuring that learning from individual cases informed broader safeguarding and preventative activity.

This case demonstrates the value of professional curiosity, partnership working, and early information sharing in identifying and responding to risks affecting vulnerable children and young people.

Case 3: Greenfields Centre

The Greenfields Centre demonstrated outstanding person-centred and collaborative practice in the care of a patient with a long history of complex mental health needs and significant risks. Following the patient's tragic death by suicide, a Comprehensive Safety Review was undertaken to examine the care and support provided.

The review found no additional learning for the service and highlighted extensive evidence of proactive, coordinated, and compassionate care throughout the patient's involvement with services. Staff consistently demonstrated a commitment to understanding and managing the individual's complex needs, with careful consideration given to safeguarding concerns, risk assessment, and risk mitigation for both the patient and those around her.

The review recognised the creativity and determination shown by professionals in identifying solutions to meet the patient's needs. Services worked collaboratively across organisational boundaries to ensure

timely access to support, including inpatient admissions when required. Care planning was structured, responsive, and centred on the individual's circumstances, with clear communication and coordination between teams.

Particular strengths identified included the effective partnership working between the Greenfields Centre, inpatient services, Mental Health Liaison services, and the patient's key worker. This collaborative approach ensured continuity of care and demonstrated a shared commitment to achieving the best possible outcomes for the patient.

The case was recognised as an example of excellent practice, evidencing high-quality multidisciplinary working, robust risk management, and truly person-centred care. The learning from this review has been proposed for inclusion in wider Learning Lessons sessions to share examples of effective practice and promote learning across services.

Case 4: Sutherland Centre

The Sutherland Centre demonstrated excellent safeguarding practice through the vigilance, persistence, and advocacy of a member of nursing staff who identified a significant legal and safeguarding gap affecting a vulnerable young person with a highly complex history.

Following the young person's transition to adulthood at age 18, the nurse recognised that the existing Deprivation of Liberty Safeguards (DoLS) arrangements, which had been in place under children's legislation, were no longer valid. Despite this, the individual continued to be subject to substantial restrictions, including a 3:1 staffing arrangement and limited privacy within the community. The nurse identified that these restrictions were no longer underpinned by an appropriate legal framework, creating a potential safeguarding concern.

Recognising the seriousness of the situation, the nurse took proactive steps to escalate the matter and advocate for the young person's rights and welfare. This was particularly challenging due to the complexity of the case, involving out-of-area commissioning arrangements, social care responsibilities held by another local authority, and multiple agencies across different geographical areas.

Despite initial difficulties in gaining recognition of the concerns, the nurse remained committed to ensuring that the issue received appropriate attention. A safeguarding referral was submitted and, with support from safeguarding colleagues, the concerns were successfully progressed. This led to formal recognition of the risks and the initiation of an application to the Court of Protection to ensure appropriate legal oversight of the care arrangements.

This case highlights the importance of professional curiosity, persistence, and effective safeguarding advocacy during the transition from children's to adult services. It demonstrates how staff at the Sutherland Centre remained focused on the rights, safety, and wellbeing of the individual, ensuring that complex legal and safeguarding issues were identified and addressed appropriately. The case also reinforces the need for careful planning and oversight when young people with significant care needs move into adulthood, recognising that risks do not cease at the point of transition and that robust safeguarding arrangements must remain in place.

Case 5: Children's Eating Disorders Team

The Children's Eating Disorders Team demonstrated excellent safeguarding practice through their proactive escalation of concerns for a young person whose physical health had deteriorated to the point that urgent hospital admission was required.

Despite significant concerns already having been raised by University Hospitals of North Midlands (UHNM), there appeared to be delays in achieving the necessary response. Clinical professionals highlighted the seriousness of the situation, with clear medical advice indicating that the young person was at risk of significant harm without immediate intervention.

Recognising the urgency of the case, the Children's Eating Disorders Team sought support from the Safeguarding Team to ensure that the concerns were appropriately escalated. At the time, challenges within local systems meant that the matter required escalation to senior leaders within the local authority to secure a timely response. The team remained focused on advocating for the young person's safety and ensuring that the level of risk was clearly understood by decision-makers.

Working collaboratively with safeguarding colleagues and acute hospital staff, the concerns were successfully escalated, resulting in appropriate action being taken. The young person was subsequently admitted to hospital, ensuring they received the urgent care and treatment required.

This case highlights the commitment, perseverance, and professional advocacy demonstrated by the Children's Eating Disorders Team and their partner agencies. It also reflects the strength of partnership working between community, hospital, and safeguarding services in responding to high-risk situations. Through effective escalation and a shared focus on the young person's welfare, professionals were able to overcome barriers and ensure that appropriate protective action was taken at a critical time.

The case is an example of safeguarding professionals working collaboratively to champion the needs of a vulnerable young person, ensuring that clinical concerns were heard, acted upon, and translated into effective intervention.

Case 6: Ward 3

Ward 3 demonstrated strong safeguarding practice by identifying and escalating concerns regarding the potential impact of a patient's psychosis on her young children. Staff submitted multiple safeguarding referrals and continued to advocate for the children's welfare despite initial decisions by the local authority not to undertake an assessment.

Through professional curiosity, persistence, and effective escalation, ward staff ensured that the risks remained under review, leading to the local authority reconsidering its position and offering an assessment. The team also worked proactively with the children's father to increase awareness of potential risks and support safeguarding measures within the family.

This case highlights Ward 3's commitment to safeguarding, effective escalation of concerns, and a child-centred approach to care.

Case 7: Daily Briefing Meeting

The Daily Brief Meeting is a daily multi-agency forum that brings together key partners, including Police, Children's Social Care, Youth Justice Services, Catch22 Exploitation Service, Drug and Alcohol Services, and the Trust's Safeguarding Team. Established in response to concerns relating to child exploitation across Stoke-on-Trent, the meeting provides an opportunity to share information, identify risks, and coordinate timely safeguarding interventions for vulnerable children and young people.

A recent example of good practice involved a 12-year-old child who had been reported to the Intensive Support Hub (ISH) as missing overnight. Recognising the potential risks, ISH advised the child's mother to contact the Police and shared the information through the Daily Brief process. This enabled partner agencies to respond quickly, exchange relevant information regarding the child's mental health and vulnerabilities, and support coordinated safety planning. By the time of the meeting, partner agencies had already gathered updates and agreed ongoing actions to safeguard the child.

This case demonstrates the value of the Daily Brief Meeting in facilitating timely information sharing, effective multi-agency collaboration, and a coordinated response to children at risk. The process continues to strengthen partnership working and improve outcomes for vulnerable children and young people across the locality.

Achievements and Priorities

Key Achievements

- During 2025/26, the Safeguarding Team has continued to strengthen safeguarding practice across the Trust through increased staff engagement, partnership working, and service development. Key achievements include:
- Safeguarding supervision and support have continued to improve across Trust services. Increased engagement has been particularly evident within inpatient wards following the introduction of face-to-face ward-based safeguarding sessions. These sessions have enhanced the visibility and accessibility of the Safeguarding Team and have been accompanied by a noticeable increase in requests for safeguarding advice and individual supervision from ward staff.
- Collaborative work with the Patient Safety Team has resulted in improvements to the reporting functionality within Ulysses, supporting more efficient data collection, improved reporting accuracy, and enhanced oversight of safeguarding activity.
- The Trust has continued to promote awareness of domestic abuse through its established Domestic Abuse Champions Network and ongoing work towards the Domestic Abuse and Sexual Violence (DASV) Charter. Several champions have received enhanced training delivered by New Era, strengthening the Trust's capacity to identify and respond to domestic abuse concerns. Regular joint working with New Era has also supported the management of complex cases and strengthened partnership arrangements.
- The Safeguarding Team worked in collaboration with the Learning and Development Team to review safeguarding training competencies across all staff groups, ensuring that training requirements remain appropriate to individual roles and responsibilities and supporting the achievement of compliance targets.

Key Priorities

As part of the Safeguarding Team's commitment to continual improvement, the following priorities have been identified for 2026/27:

- Further increase engagement with community teams through the development of safeguarding drop-in sessions, providing greater access to advice, support, and supervision.
- Improve safeguarding training compliance within corporate services through targeted engagement and monitoring.
- Review and refresh the Safeguarding Audit Plan for 2026/27 to ensure alignment with emerging risks, organisational priorities, and national safeguarding requirements.
- Continue to strengthen the Trust's response to domestic abuse through partnership working with New Era, including the delivery of training sessions focused on coercive and controlling behaviour and non-fatal strangulation.
- Enhance frontline staff engagement through the development of new communication and feedback mechanisms, including safeguarding surveys and a quarterly safeguarding newsletter.
- Implement safeguarding activity reporting through the new Lorenzo suite of forms, improving the capture, analysis, and reporting of safeguarding data across the Trust.
- Develop and implement a Trust Safeguarding Strategy that reflects local safeguarding partnership priorities, national safeguarding guidance, and the Trust's strategic objectives, providing a clear framework for safeguarding activity across all services.

Conclusion

During 2025/26, North Staffordshire Combined Healthcare NHS Trust has continued to demonstrate a strong commitment to safeguarding children, young people and adults at risk. The Trust has maintained robust safeguarding arrangements, providing assurance that statutory responsibilities and national safeguarding requirements are being met through effective governance, partnership working, training, supervision, audit activity, and frontline practice.

Throughout the year, the Safeguarding Team has worked closely with internal services and external partners across Staffordshire and Stoke-on-Trent to promote a culture where safeguarding is recognised as everyone's responsibility. Active participation in safeguarding partnerships, reviews, audits, MARAC processes, Prevent arrangements and multi-agency forums has strengthened information sharing, improved joint working and supported better outcomes for vulnerable individuals and families.

The report evidences increasing safeguarding activity across the Trust, including a rise in adult safeguarding referrals, significant volumes of safeguarding information-sharing requests, continued engagement in statutory review processes, and growing demand for safeguarding advice and supervision. While this reflects increasing complexity and demand within safeguarding services, it also demonstrates improved staff awareness, confidence and willingness to identify, report and respond to safeguarding concerns.

Safeguarding training compliance has remained strong overall, with the majority of directorates achieving or exceeding Trust targets. The continued development of safeguarding education, supervision and specialist support has enabled staff to respond effectively to complex safeguarding issues, including domestic abuse, exploitation, self-neglect, sexual safety concerns, professional boundaries and transition-related safeguarding risks.

Looking ahead to 2026/27, the Trust remains committed to strengthening safeguarding practice through greater engagement with community services, enhanced communication with frontline staff, continued development of safeguarding training and supervision, improved data collection and reporting systems, and the implementation of a Trust-wide Safeguarding Strategy aligned to local and national priorities. Particular focus will be given to domestic abuse, safeguarding assurance, staff engagement, and ensuring safeguarding remains integral to all aspects of care delivery

Enclosure No: 9

Board to Team (B2T) Programme – Quarterly Report (Q1 2026/27)

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

Presented by:	Nicky Griffiths Deputy Director of Governance- Trust Board Secretary
Prepared by:	Rania Mosedale – Corporate Governance Administrator
Executive Lead:	Dr Buki Adeyemo- Chief Executive Officer

Aligned to Board Assurance Framework Risk:	Risk 8 - 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.
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:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	Funding A number of identified Board to Team actions may require additional resource/funding.
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	N/A

**Recommendation /
Required Action:**

Board to receive for assurance.

Executive Summary:

The Board to Team (B2T) Programme continues to support meaningful engagement between Board members and teams across the Trust, providing opportunities to listen, learn, recognise good practice and identify areas for improvement in line with the B2T Principles and Standard Operating Procedure.

During Quarter 1, a total of 9 Board to Team visits were completed. This represents a lower than usual level of activity when compared with the established programme. The reduction was primarily attributable to sickness absence within the Corporate Governance Team and organisational restructuring and role changes impacting programme coordination.

Despite reduced activity, visits were delivered across a range of clinical and corporate services, generating valuable feedback, learning opportunities and actions for improvement.

Visit Activity

Overview

Measure	Q1 Position
Total visits completed	9
Face-to-face visits	6
Virtual visits (Microsoft Teams)	3
Clinical team visits	6
Corporate team visits	3

Of the nine visits completed:

- **67% (6)** were undertaken face-to-face.
- **33% (3)** were conducted virtually using Microsoft Teams.
- **67% (6)** involved clinical services.
- **33% (3)** involved corporate services.

The balance of visits reflects the programme's commitment to engaging with both frontline and corporate teams whilst maintaining accessibility and flexibility through the use of virtual engagement where appropriate.

Action Monitoring

The B2T process places emphasis on ensuring actions arising from visits are clearly assigned, monitored and progressed through to completion.

Outstanding Actions from 2025/26

A total of **7 actions** remain open from the previous financial year 4 of which are overdue and 3 are on track. 1 action is carried over from Q3 2025/26, and 6 are from Q4.

Q1 2026/27 Actions

Q1 visits generated **20 actions** in total. The majority of actions remain on track for delivery, three actions from Q1 have already been completed. Continued focus is required to address the three overdue Q1 actions and the four overdue actions carried forward from 2025/26.

Themes Identified

Several recurring themes emerged from discussions and feedback during Quarter 1 visits.

Theme	Number of Actions / Feedback Items
Clinical Issues	3
Other	4
Environment / Estates	3
Quality Improvement	3
Digital and Equipment	2
Capacity and Staffing	2
Communications	1
Health and Wellbeing	1
HR and Recruitment	1

Clinical Issues

Clinical issues were one of the most frequently reported operational themes, accounting for 3 actions and feedback items. Feedback highlighted matters directly affecting service delivery and patient care, reinforcing the value of Board engagement in understanding frontline challenges, this includes issues such as role clarity in teams and engagement in changes in services.

Other

The largest number of actions and feedback items fell within the Other category (4 items). These issues covered a range of matters that did not sit neatly within the defined thematic categories but nevertheless provided valuable insight into service delivery, operational processes and opportunities for improvement. Matters included stigma associated with ECT treatment and facilitating attending Exec Exchange sessions.

Environment and Estates

Issues relating to the physical working environment and estate infrastructure also accounted for 3 actions and feedback items. These included concerns affecting staff experience, the suitability of facilities and aspects of the environment impacting service functionality, such as grab

rails for patients and room booking.

Quality Improvement

A further 3 actions and feedback items related to quality improvement. These centred on identifying and progressing Quality Improvement (QI) activities within teams, as well as promoting and publishing examples of good practice to support organisational learning and service development.

Digital and Equipment

2 actions and feedback items related to digital systems and equipment. Teams identified opportunities to improve access to technology, equipment availability and digital solutions to support more efficient working practices such as utilising Copilot.

Capacity and Staffing

2 actions and feedback items related to capacity and staffing. Feedback focused on workforce sustainability and support for frontline teams, including consideration of staff retention strategies and the allocation of an Activity Worker to acute wards to enhance patient experience and support ward-based activities.

Communications

1 action or feedback item related to communications. This reflected an opportunity to strengthen information sharing, engagement or communication processes to support service effectiveness. This action relates to ward relocation with in Harplands hospital.

Health and Wellbeing

1 action or feedback item focused on staff health and wellbeing. Positive discussions regarding workforce wellbeing were noted, alongside opportunities to further develop initiatives that support staff health and engagement.

HR and Recruitment

1 action or feedback item related to HR and recruitment. Feedback highlighted recruitment-related challenges and opportunities to strengthen workforce sustainability. Areas of focus to include Sickness, appraisals, training, development support to ward manager etc.

Risks and Challenges

The principal challenge during Q1 was reduced programme capacity arising from:

- Sickness absence within the Corporate Governance Team.
- Organisational restructuring and role changes affecting programme administration and coordination.

These factors led to lower visit completion rates than typically expected within the quarterly programme.

The Governance Team is continuing to stabilise arrangements and support delivery of future visits in accordance with the Board to Team Standard Operating Procedure, please see **Appendix 1**.

To support the continued development of the Board to Team programme, the Governance Team has designed and implemented a comprehensive, easy-to-follow process flowchart which clearly maps the entire Board to Team visit cycle, from initial programme planning through to action monitoring and reporting. The flowchart provides a structured, step-by-step framework that defines responsibilities, key milestones and expected timescales for each stage of the process. Please see **Appendix 2**.

Conclusion

While Quarter 1 activity was below expected levels, the programme continued to provide valuable engagement between Board members and services across the Trust. Nine visits were completed, generating meaningful feedback and 20 actions aimed at improving services, staff experience and organisational learning.

Priority areas for Quarter 2 will be:

1. Increasing visit activity and returning to planned programme levels.
2. Monitoring delivery of the 17 open Q1 actions.
3. Reducing the number of overdue actions from both Q1 and previous financial years.
4. Continuing to identify and share learning themes across the organisation.
5. Maintaining alignment with the B2T principles of listening, learning, engagement and continuous improvement.

Overall position: The programme remains effective in generating organisational insight and improvement opportunities, with recovery of visit activity and action completion being key priorities for Quarter 2.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	21 st July 2026
V1	Public Trust Board	4 th September 2026

SOP / Guidance Number:		Title: STANDARD OPERATING PROCEDURE (SOP) - Board to Team (B2T) Visits	
Effective Date:	July 2024	Revision Date:	July 2026
Review Date:	July 2029		
Supersedes:	Version 3.0 supersedes Version 2.0		
Author:	Corporate Governance Manager		
Agreed by:		Date:	
Approved by:		Date:	
		Date:	

1. Introduction

This Standard Operating Procedure (SOP) sets out the process for planning, undertaking and following up Board to Team (B2T) visits across the Trust. It establishes a consistent, transparent and principles-led approach aligned to organisational governance expectations. The process is designed to ensure that Board engagement is coordinated and minimally disruptive, whilst maximising organisational learning, insight and connection between the Board and frontline services.

2. Purpose

Board to Team visits provide an opportunity for Board members to engage directly with frontline teams to listen and learn from service delivery, recognise good practice, identify opportunities for improvement, and strengthen relationships between Board members and operational staff.

3. Scope

This SOP applies to the below staff involved in Board to Team visits.

- Chief Officers
- Non-Executive Directors
- Corporate Governance (Administrator function)
- Service / Team Leads and operational staff

4. Principles

All Board to Team visits will be undertaken in accordance with the agreed principles. Engagement will remain supportive and non-assurance based, with visits not intended to function as inspection. Conversations will be open, safe and non-judgemental, enabling staff to engage confidently. Visits will be coordinated to minimise disruption to services, and all feedback and actions arising will be progressed in a timely manner to ensure value is realised from the process.

5. Roles and Responsibilities

5.1 Administrator (Corporate Governance)

Corporate Governance will coordinate the overall Board to Team visit programme, including scheduling, preparation of documentation, receipt and distribution of feedback reports, maintenance of action logs, and production of routine reporting.

5.2 The Executive Assistant

The Executive Assistant will provide oversight of the programme, supporting effective coordination through access to Chief Officer diaries and ensuring alignment with organisational scheduling and governance priorities.

5.3 Chief Officers and Non-Executives

Chief Officers and Non-Executive Directors will participate in visits in line with the agreed programme, facilitate open and constructive discussions with teams, and adopt a “going to Gemba” approach to observe, ask and understand service delivery. The Chief Officer acting as Executive Lead will be responsible for completing the visit feedback report within seven days.

5.4 Team / Service Manager

Service and Team Managers will coordinate team participation, ensure staff are appropriately informed and supported to engage in the visit, and act as the host for the visit on the day.

6. Operational Process

6.1 Planning and Scheduling

Corporate Governance will coordinate the Board to Team visit programme, identifying services and initiating scheduling in collaboration with team leads. In doing so, relevant operational information will be captured to support effective planning, including the manager name, main contact, preferred and unavailable days, and any known constraints such as periods where visits should be avoided. This information will inform the design of the programme and support scheduling that minimises disruption to service delivery.

Scheduling will follow a structured and sequential approach. Initial availability will be confirmed with the service or team, followed by alignment with Chief Officer availability, and subsequently Non-Executive Director availability. A final visit date will be agreed once alignment across all parties has been achieved.

Once confirmed, the visit will be formally communicated via email, copying the relevant Clinical Director, Associate Director and Service Manager to ensure organisational visibility and alignment. The visit will be scheduled via the Chief Officer Executive Assistant diary to ensure appropriate coordination, and calendar invitations will be issued in line with agreed organisational conventions, including the use of colour coding where applicable.

6.2 Pre-Visit Preparation

Following confirmation of the visit date, Corporate Governance will issue the relevant documentation, including the feedback template. The team will be contacted to reconfirm arrangements and ensure that staff are appropriately briefed on the purpose and format of the

visit. Board members will review the agreed approach in advance, ensuring alignment with the Board to Team principles.

6.3 Conducting the Visit

All visits will be undertaken in line with the Board to Team principles, ensuring that the approach remains supportive, non-assurance based and focused on learning, engagement and improvement. Board members will meet with the team lead and staff, and the visit will be conducted in an open and non-judgemental manner, with emphasis on listening and understanding, identifying good practice, and exploring opportunities for improvement.

6.4 Post-Visit Reporting

Following the visit, the Chief Officer acting as Executive Lead will complete the feedback report within seven days. The report will include agreed actions, named owners and defined timescales. Upon completion, the report will be returned to Corporate Governance for formal receipt, recording and onward distribution to relevant stakeholders.

6.5 Action Tracking and Follow-Up

Actions arising from Board to Team visits will be logged and monitored by Corporate Governance, with each action assigned a clearly identified owner and tracked through to completion. Reports will be distributed to relevant stakeholders, and progress will be reviewed through the Executive Performance Meeting to ensure appropriate oversight and delivery.

6.6 Reporting and Assurance

Governance arrangements will ensure that progress and learning from Board to Team visits are routinely reported. This will include quarterly summary reporting to the Senior Leadership Team, alongside ongoing oversight through Executive Performance structures, and the production of an annual thematic report capturing key learning and organisational impact.

6.7 Cancellations and Rescheduling

Where a Chief Officer is unable to attend a scheduled Board to Team visit, responsibility for identifying a suitable replacement will sit with the Chief Officer and their Executive Assistant. This will typically be facilitated through direct communication with Chief Officer colleagues, including the use of established communication channels such as messaging groups or the daily Chief Officer meeting, to ensure an appropriate replacement is identified in a timely manner.

Where a Non-Executive Director becomes unavailable, Corporate Governance will support the identification of a replacement by contacting other Non-Executive Directors through appropriate communication methods to maintain the integrity of the visit programme.

In all circumstances where a visit is cancelled or requires rescheduling, Corporate Governance will cancel the existing diary invitation and formally notify the relevant team, Non-Executive Director and Chief Officer. Arrangements will then be made to reschedule the visit at the earliest available opportunity, maintaining alignment with the agreed scheduling process.

All cancellations will be recorded, including the reason for cancellation, to support oversight of the programme and inform ongoing monitoring and improvement.”

7. Monitoring and Effectiveness

The effectiveness of the Board to Team programme will be assessed through consideration of visit completion rates, timeliness of feedback reporting, delivery of actions, and the extent to which thematic learning contributes to service improvement and organisational development.

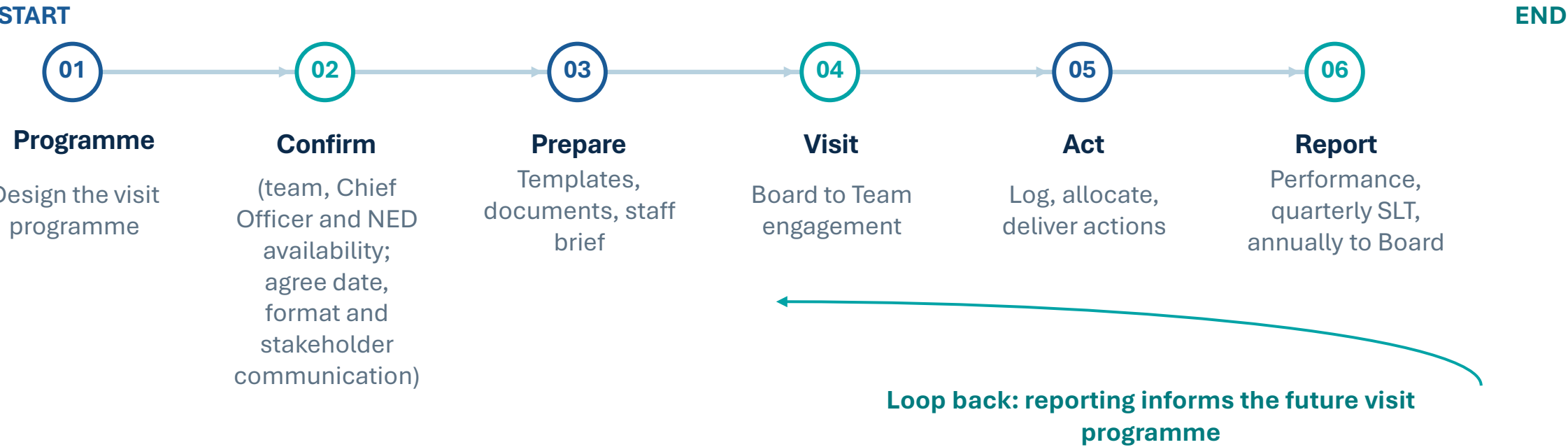
8. Continuous Improvement

Learning arising from Board to Team visits will inform organisational priorities and contribute to improvement planning. Feedback will be shared with teams to support local learning, and insights generated through reporting will be used to inform the design of future visit programmes, ensuring a continuous cycle of evaluation, learning and improvement.

OVERVIEW

Board to Team Visit cycle

A clean end-to-end timeline from programme design through action monitoring and reporting.



ADMIN / EXECUTIVE ASSISTANT

Programme coordination, scheduling and rescheduling (incl. diary coordination), documents, report receipt and distribution

TEAM

Staff briefing and Board to Team Visit participation

BOARD / EXEC LEAD

Visit participation and feedback report completed within 7 days

GOVERNANCE

Action allocation, progress monitoring, EPM and formal reporting

PHASE 1

Plan and schedule the visit

Administrative coordination creates the confirmed visit window and format and includes management of changes to availability, cancellations and rescheduling of visits.



Key handoff

A confirmed date and agreed visit format unlock the documentation and staff briefing steps.

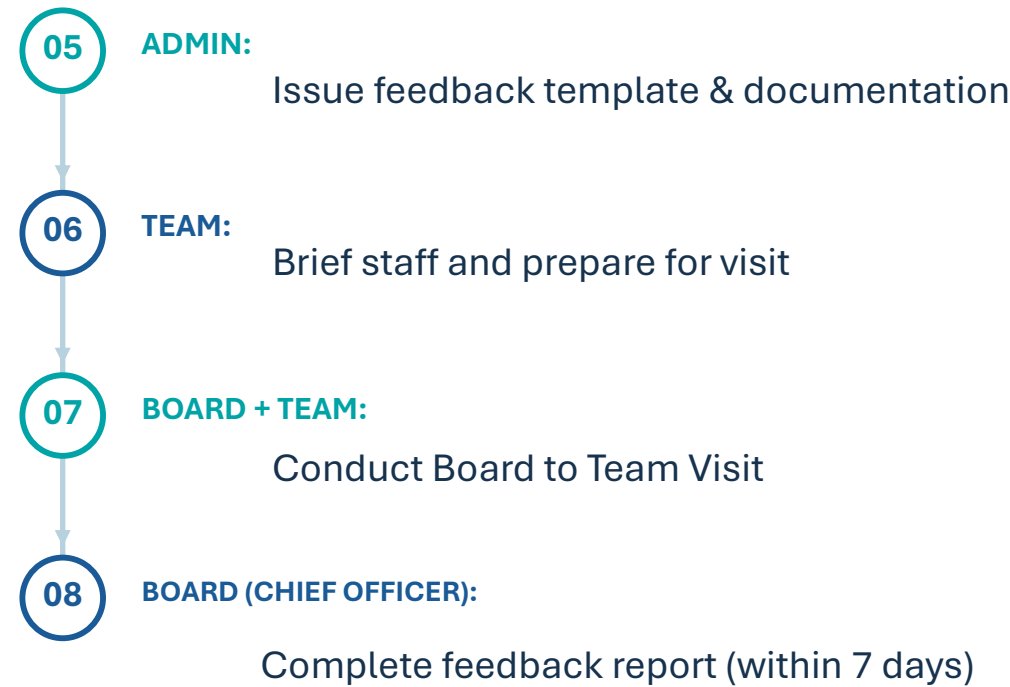
Output

Visit programme, confirmed team availability, agreed format, and scheduled date.

PHASE 2

Prepare, conduct, and capture feedback

The team prepares for the visit; the Board and Team complete the engagement; feedback is recorded promptly.



7-day feedback standard

The Chief Officer completes the feedback report within seven days so actions can be logged while the visit is current.

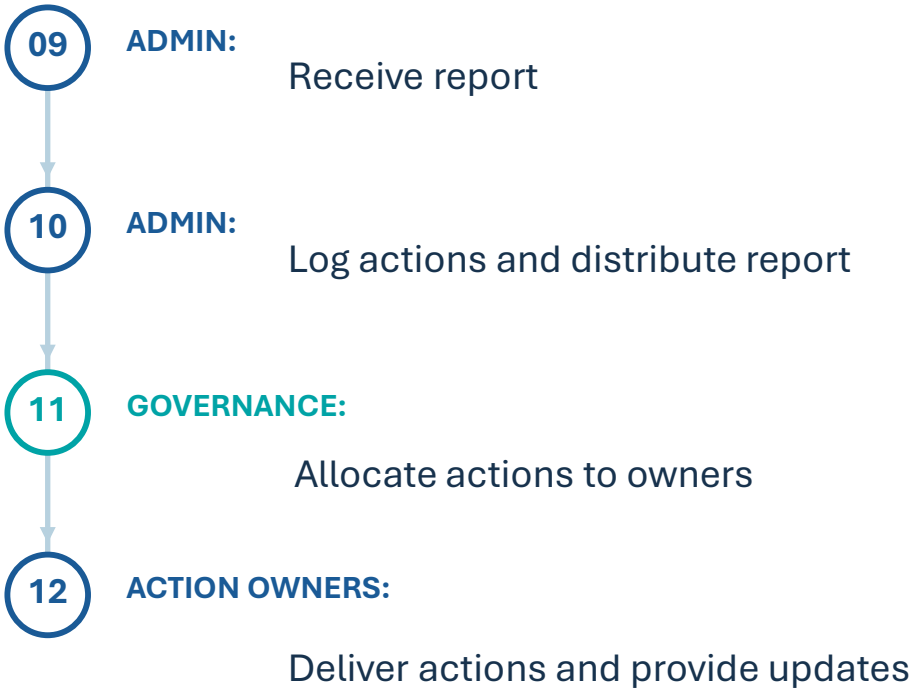
Core visit materials

- Feedback template
- Supporting documentation
- Staff briefing inputs

PHASE 3

Distribute the report and move into action

Administration turns feedback into an action log; governance allocates ownership and action owners deliver updates.



Control point

Each action should have a named owner, expected update route, and visible status before monitoring begins.

Output

Distributed report, action log, assigned owners, and regular delivery updates.

Monitor progress and report learning back

Governance review closes the loop by converting action progress into quarterly and annual learning.



Enclosure No: 10

Trust Board - Board Assurance Framework Quarter 1 Report

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

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

Aligned to Board Assurance Framework Risk:	This report details progress against all risks identified within the Board Assurance Framework.
7 Levels of Assurance:	N/A
Approval / Review:	BAF risks are approved by the relevant Committees and Trust Board.
Strategic Priorities:	Prevention – Risk 1 & Risk 8 Access – Risk 2, Risk 3, Risk 4, & Risk 7 Growth – Risk 5 & Risk 6
Key Enablers:	The Trust key enablers are aligned to individual BAF risks.
Sustainability:	Share learning and best practice
Resource Implications:	Any staffing and/or funding implications, where applicable, are noted within the Board Assurance Framework document.
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	ICS Governance Group stood down for 26/27.
Recommendation / Required Action:	The paper is the Board Assurance Framework (BAF) Qtr. 1 update for the Trust Board approval.

Risk 1 - 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.

Reporting through to Finance & Resource Committee.

Chief Officer Lead - Chief Strategy Officer (CSO).

Residual score 20.

BAF Updated in Q1 and approved by CSO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 15 – 20 with a risk appetite of Seek.

This was approved at the Risk Review Group on the 7.7.26 and Finance & Resource Committee on the 6.8.26.

Risk 2 - 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.

Reporting through to Quality Committee.

Chief Officer Lead - Chief Medical Officer (CMO).

Residual score 15.

BAF Updated in Q1 and approved by CMO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.

This was approved at the Risk Review Group on the 7.7.26 and Quality Committee on the 6.8.26.

Risk 3 - There is a risk that we will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors. As a consequence, we will not be able to support our people to continue to deliver outstanding, compassionate care.

Reporting through to People, Culture & Development Committee.

Chief Officer Lead - Chief People Officer (CPO).

Residual score 12.

BAF Updated in Q1 and approved by CPO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.

Linked Trust Level Risks

High level risk affecting BAF risk 3, includes risk 1856 (Trust risk), as noted in the Q1 report.

This was approved at the Risk Review Group on the 7.7.26. People, Culture & Development Committee is on the 7.9.26 to approve the risk with a verbal update to be provided at Trust Board to confirm the outcome.

Risk 4 - There is a risk of non-delivery of our financial plans and/or an impact on service quality due to the level of transformation required, with the consequence being an effect on clinical outcomes and/or the Trust's financial viability.

Reporting through to Quality Committee.

Chief Officer Lead - Chief Operating Officer (COO).

Residual score 20.

BAF Updated in Q1 and approved by Interim COO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.

This was approved at the Risk Review Group on the 7.7.26 and Quality Committee on the 6.8.26.

Risk 5 - 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.

Reporting through to Finance & Resource Committee.

Chief Officer Lead - Chief Finance Officer (CFO).

Residual score 15.

BAF Updated in Q1 and approved by CFO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.

This was approved at the Risk Review Group on the 7.7.26 and Finance & Committee on the 6.8.26.

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

Reporting through to Finance & Resource Committee.

Chief Officer Lead - Chief Strategy Officer (CSO).

Residual score 16.

BAF Updated in Q1 and approved by CSO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.

Linked Trust Level Risks

High level risk affecting BAF risk 6, includes risk 2031 (Trust risk), as noted in the Q1 report.

This was approved at the Risk Review Group on the 7.7.26 and Finance & Resource Committee on the 6.8.26.

Risk 7 - 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.

Reporting through to Quality Committee.

Chief Officer Lead - Chief Operating Officer (COO).

Residual score 20.

BAF Updated in Q1 and approved by Interim COO **resulting in no impact on residual score.**

The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.

Risk discussed within the RRG meeting July 2026 and it was agreed that the Interim COO will progress mitigating action 3 and clarify internally how this risk is being taken forward with the ICB/NHSE Region, noting current data suggests significant demand which cannot be met by current capacity. This action may not mitigate the risk if further investment to support demand cannot be agreed.

Linked Trust Level Risks

High level risk affecting BAF risk 7, includes risk 1880 (Trust risk) and 1919 (Trust risk), as noted in the Q1 report.

This was approved at the Risk Review Group on the 7.7.26 and Quality Committee on the 6.8.26.

Risk 8 - 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.

Reporting through to Quality Committee.

Chief Officer Lead - Chief Nursing Officer (CNO).

Residual score 15.

BAF Updated in Q1 and approved by Interim CNO **resulting in no impact on residual score.**

The risk does not sit within the agreed tolerance level of 5 – 10 with a risk appetite of Cautious.

Risk discussed within the RRG meeting July 2026 and it was agreed that the Interim CNO will review and update mitigating actions for Q2 to enhance the narrative around actions that sit within NSCHT control.

Linked Trust Level Risks

High level risk affecting BAF risk 8, includes risk 1945 (Trust risk), as noted in the Q1 report.

This was approved at the Risk Review Group on the 7.7.26 and Quality Committee on the 6.8.26.

Summary of other BAF related activities during quarter 1.

- Risk titles have all been approved by the Executive team.
- All mitigations actions have been updated and refreshed.
- In line with Executive direction, the dashboard now applies a RAG rating to the quarterly residual score to indicate whether it falls below, within, or above the agreed risk appetite tolerance level.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Risk Review Group	7.7.26
V1	Audit Committee	31.7.26
V1	Finance & Resource Committee	6.8.26
V1	Quality Committee	6.8.26
V1	People, Culture & Development Committee	7.9.26
V1	Trust Board	10.9.26



PREVENTION



ACCESS



GROWTH



NHS
North Staffordshire
Combined Healthcare
NHS Trust

Board Assurance Framework 2026/27

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

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

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

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



BOARD ASSURANCE FRAMEWORK 2026-2027

OVERARCHING TRUST RISK APPETITE STATEMENT:

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

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

Risk No.	Strategic Priority	Title	Theme/Risk Type	Risk Description	Executive Lead	Gross Score	Residual Risk Score Q1	Risk Movement from Previous Quarter	Risk Appetite Tolerance Level	Risk Appetite Level	Risk Appetite Statements	Lead Committee
1	Prevention	Strategic Direction & Partnerships	Reputational	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.	Chief Strategy Officer	Impact 4 (Major) X Likelihood 5 (Almost Certain) = 20	20	↔	15-20	Seek	We are willing to take decisions that may attract scrutiny in order to promote innovation and new ideas where the potential benefits to our local population outweigh the associated risks. We actively encourage calculated reputational risk to drive improvements in patient outcomes, organisational effectiveness, and stakeholder value.	Finance & Resource
2	Access	Quality & Safety	Quality	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.	Chief Medical Officer	Impact 5 (Catastrophic) X Likelihood 3 (Possible) = 15	15	↔	12-20	Open	We are open to taking managed risks in pursuit of improved clinical outcomes, innovation and service quality. We recognise that transformation and improvement may involve uncertainty, but we are committed to ensuring that such risks are carefully assessed, monitored, and aligned with our quality improvement goals. We will not compromise on safety, but we will support innovation that enhances care.	Quality
3	Access	People	People	There is a risk that we will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors. As a consequence, we will not be able to support our people to continue to deliver outstanding, compassionate care.	Chief People Officer	Impact 4 (Major) X Likelihood 3 (Likely) = 12	12	↔	12-20	Open	We have an open appetite for people-related risks where they support workforce development, leadership innovation, and cultural transformation. We encourage new approaches to recruitment, retention, and staff wellbeing, recognising that some initiatives may carry uncertainty. We are committed to creating a supportive and inclusive environment and will invest in change that strengthens our workforce and organisational culture.	People, Culture and Development
4	Access	Performance	Financial	There is a risk of non-delivery of our financial plans and/or an impact on service quality due to the level of transformation required, with the consequence being an effect on clinical outcomes and/or the Trust's financial viability.	Chief Operating Officer	Impact 5 (Catastrophic) X Likelihood 4 (Likely) = 20	20	↔	12-20	Open	We recognise the importance of Value for Money, and that price is not the overriding factor. We are open to accepting some financial risk as long as the appropriate controls are in place, and where the potential benefits for the population outweighs the inherent risks.	Quality
5	Growth	Financial Sustainability	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. 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.	Chief Finance Officer	Impact 5 (Catastrophic) X Likelihood 3 (Possible) = 15	15	↔	12-20	Open	We recognise the importance of Value for Money, and that price is not the overriding factor. We are open to accepting some financial risk as long as the appropriate controls are in place, and where the potential benefits for the population outweighs the inherent risks.	Finance & Resource
6	Growth	Digital	Digital	There is a risk that the Trust may not fully deliver the digital and data transformation ambitions due to financial constraints and variation in national and local practice. This could lead to concerns in delivering of existing digital maturity and security resulting in poor data quality, operation inefficiencies or compromised care.	Chief Strategy Officer	Impact 4 (Major) X Likelihood 4 (Likely) = 16	16	↔	12-20	Open	We are willing to take calculated digital risks to pursue innovation, improve patient care, or enhance operational efficiency. This includes adopting new technologies or digital processes that may involve short-term disruption but offer significant long-term benefits for patients, staff, and the organisation.	Finance & Resource
7	Access	Quality	Quality	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.	Chief Operating Officer	Impact 4 (Major) X Likelihood 5 (Almost Certain) = 20	20	↔	12-20	Open	We are open to taking managed risks in pursuit of improved clinical outcomes, innovation and service quality. We recognise that transformation and improvement may involve uncertainty, but we are committed to ensuring that such risks are carefully assessed, monitored, and aligned with our quality improvement goals. We will not compromise on safety, but we will support innovation that enhances care.	Quality
8	Prevention	Regulatory	Regulatory	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.	Chief Nursing Officer	Impact 5 (Catastrophic) X Likelihood 3 (Possible) = 15	15	↔	5-10	Cautious	We are prepared to accept the possibility of limited regulatory challenge or moderate observations arising from our actions, provided these are informed by prior examples of successful practice elsewhere and are essential to achieving safe and effective patient care. Decisions will be taken cautiously, with a focus on learning from comparable situations and mitigating potential impact wherever possible.	Quality

Quarterly Residual Risk RAG Rating Key Against Tolerance Levels

RAG Rating Criteria Key	Rating
Below Tolerance Level	BLUE
Within Tolerance Level	GREEN
Above Tolerance Level	RED

* Target achievement date for all BAF risks is the 31st March 27, with a year end position within the agreed tolerance level.

Enclosure No: 11

WRES WDES REPORTS 2026

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

Presented by:	Frieza Mahmood / Chief People Officer
Prepared by:	Janice Ogonji / Inclusion and Belonging Lead
Executive Lead:	Frieza Mahmood / Chief People Officer

Aligned to Board Assurance Framework Risk:	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 4 - Evidence of a number of agreed actions being delivered, 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:	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:	The reports align with NHS England WRES and WDES requirements, the NHS EDI Improvement Plan, the NHS Long Term Workforce Plan, the NHS 10 Year Health Plan ambitions and the Trust's Combined People Plan and Inclusion and Belonging Strategic Plan. The work also supports

	system priorities around workforce inclusion, retention, leadership accountability, reducing inequalities and creating compassionate, safe and inclusive workplaces.
Recommendation / Required Action:	• Note the findings of the 2026 WRES and WDES reports and the progress made in workforce and Board representation. • Recognise the areas of continued inequality, particularly recruitment outcomes, bullying, harassment, abuse, discrimination, reasonable adjustments, career progression and staff experience. • Support delivery of the 2026/27 WRES and WDES action plans and seek assurance that progress is monitored through agreed governance routes. • Champion inclusive leadership and ensure WRES and WDES improvement activity remains embedded within workforce planning, organisational development and service delivery.
Executive Summary:	The paper presents the Trust's 2026 Workforce Race Equality Standard and Workforce Disability Equality Standard reports and associated 2026/27 action plans. The reports show continued progress in workforce representation, with Global Majority representation increasing to 15.51% and disability disclosure increasing to 11.43%, both the highest levels recorded by the Trust. Board diversity also remains positive, with Global Majority Board representation at 35.71% and disability representation at 14.29%. Progress is not consistent across all indicators. WRES findings highlight deterioration in recruitment outcomes, with White applicants 1.62 times more likely to be appointed from shortlisting than Global Majority applicants, and continued disparities in harassment, bullying and abuse. WDES findings show improvement in recruitment and capability measures, but disabled staff continue to report poorer day-to-day experiences, including higher levels of bullying, harassment and abuse, lower confidence in career progression, higher presenteeism, reduced feeling valued and a decline in reported reasonable adjustments. 3 key takeaways are: 1. The issue is now about experience, not just representation. Both WRES and WDES show that the Trust is becoming more representative, but this has not yet translated into consistently fair experiences for Global Majority and disabled staff. 2. People processes need tighter scrutiny and action. Recruitment, progression, employee relations, capability, disciplinary processes and reasonable adjustments remain key areas where disparities can emerge, so the focus needs to be on using data earlier and more consistently to prevent inequalities becoming embedded. 3. Culture change needs to be more targeted and evidence-led. The reports point to persistent issues around bullying, harassment, abuse, discrimination, presenteeism and feeling valued. Improvement will depend on targeted local action, stronger

	manager capability, staff voice and clear accountability through governance. The 2026/27 priorities focus on debiasing people processes, strengthening high-visibility anti-racist and anti-discriminatory work, reducing workforce and health inequalities, and educating for inclusion. Delivery will be monitored through People governance, workforce equality reporting, the Inclusion Council, staff networks, the Integrated Learning Review and relevant action plan milestones. Committee assurance should focus on whether actions are targeted, owned and measurable enough to deliver improvement in staff experience, not just compliance with annual reporting.

VERSION CONTROL:

Version	Report to	Date Reported
	JNCC	08/07/2026
	SLT	25/08/2026
	PCDC	04/09/2026
	Public Trust Board	04/09/2026

NSCHT Workforce Disability Equality Standard (WDES) Trust Report 2026 & Action Plan for 2026/27



Author: Janice Ogonji, NHS SCW CSU WRES and WDES Consultant

Lead Director: Frieza Mahmood, Chief People Officer

Date: 30 June 2026

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Executive summary

This is the Trust's eighth annual Workforce Disability Equality Standard (WDES) Report, published in line with NHS Standard Contract requirements and national benchmarking. The report provides an assessment of the experiences of disabled staff, including those with long-term conditions and neurodivergent colleagues, across the ten WDES indicators. It highlights areas of progress, identifies ongoing inequalities and sets out priorities for improvement during 2026/27.

Aims of this Report

- Assess the Trust's performance against the ten WDES indicators.
- Understand the experiences of disabled staff and identify areas of inequality.
- Benchmark performance against national NHS data where available.
- Demonstrate progress made during the 2025/26 reporting period, referred to as 2026.
- Inform targeted actions to improve disability inclusion, staff experience and organisational culture.

Highlights

- Disability representation increased to 11.43%, the highest level recorded by the Trust to date.
- Recruitment outcomes improved, with disabled applicants more likely to be appointed following shortlisting than non-disabled applicants.
- The capability process measure improved for a second consecutive year.
- Reporting of bullying, harassment and abuse improved among disabled staff in 2026, although disabled staff remained less likely to report incidents than non-disabled staff.
- Board disability representation decreased slightly during 2026 but remained above the national benchmark.
- The Trust continued to outperform national benchmarks across several WDES indicators, including reasonable adjustments, staff engagement and feeling valued at work.

Challenges and risks

- Disabled staff continued to report higher levels of bullying, harassment and abuse from patients, managers and colleagues than non-disabled staff.
- Confidence in equal opportunities for career progression remained lower among disabled staff than non-disabled staff.
- Presenteeism increased and remained significantly higher among disabled staff.
- Fewer disabled staff reported receiving the reasonable adjustments they need.
- Staff engagement and feeling valued at work declined during the reporting period.
- Disability representation at senior leadership levels remained lower than within the wider workforce.
- Board disability representation decreased slightly during 2026 but remained above the national benchmark.

Opportunities

During 2026/27, the Trust will focus on improving the experience of disabled staff by strengthening workplace adjustments, reducing bullying, harassment and discrimination, improving access to career development and progression opportunities, and addressing health and wellbeing inequalities. The Trust will continue to work closely with the Combined Ability Network (CAN), staff networks, Freedom to Speak Up and the Reasonable Adjustments Working Group to ensure staff voice informs improvement activity. Targeted action will also be taken to improve disability representation at senior levels, strengthen inclusive leadership and create an environment where disabled staff feel supported, valued and able to thrive.

NSCHT Workforce Disability Equality Standard (WDES) Report 2026

1.0 Introduction

The Workforce Disability Equality Standard (WDES) has been a mandatory requirement under the NHS Standard Contract since 2019. It supports the Trust's commitment to creating an inclusive workplace where disabled staff are valued, supported and able to thrive, in line with our Combined People Plan 2023–28, Inclusion and Belonging Strategic Plan 2024–28 and the NHS England EDI Improvement Plan.

WDES provides a nationally recognised framework for measuring disability inclusion across ten indicators and enables the Trust to benchmark performance, identify inequalities and target improvement activity where needed. This report presents the Trust's eighth annual WDES submission and associated action plan. It will be published on the Trust's website and shared with NHS England and local commissioners as part of our commitment to transparency, accountability and continuous improvement.

1.1 NSCHT WDES 2026 Key Highlights

The results present a mixed picture, with continued improvements in workforce representation but deterioration across several staff experience indicators.

1. Workforce disability representation continued to increase, with the highest level of disability disclosure recorded by the Trust to date.
2. Recruitment outcomes improved, with disabled applicants experiencing more favourable appointment outcomes than non-disabled applicants.
3. The capability process indicator improved, although disabled staff remain disproportionately more likely to enter formal capability procedures.
4. Bullying, harassment and abuse from patients, relatives and the public increased for disabled staff and remained higher than for staff without a disability or long-term condition.
5. Bullying, harassment and abuse from managers increased, widening the disparity between disabled and non-disabled staff.
6. Reporting of bullying, harassment and abuse improved among disabled staff in 2026, with the gap between disabled and non-disabled staff narrowing.
7. The proportion of disabled staff reporting that reasonable adjustments had been made fell, although performance remained above the national average.
8. Disabled staff were more likely to report presenteeism and less likely to feel valued at work than staff without a disability or long-term condition.
9. Staff engagement among disabled staff declined slightly during the reporting period.
10. Board disability representation decreased slightly during 2026 but remained above the national benchmark.

1.2 What have we been doing to advance the WDES over the past 12 months?

1. Progressed accessibility improvements through partnership with AccessAble, including accessibility audits and the development of site accessibility guides.
2. Published disability pay gap data for the second consecutive year, increasing transparency and understanding of workforce inequalities.
3. Coproduced Reasonable Adjustments Policy and Access to Work Guidance to strengthen support for disabled staff and improve consistency of workplace adjustments.
4. Refreshed the Inclusion Council to strengthen leadership accountability, governance and oversight of inclusion priorities.
5. Continued to support staff networks in influencing policy, co-designing solutions and shaping organisational priorities.

6. Delivered leadership development opportunities to support inclusive leadership and career progression.
7. Delivered staff engagement initiatives, including "You Said, We Did" activity and staff network events to improve staff voice and responsiveness.
8. Developed the Inclusion Photo Campaign, increasing visibility and representation of disabled colleagues across the Trust.
9. Promoted disability inclusion through Disability History Month and wider awareness activities, helping to raise awareness and encourage positive conversations about disability and inclusion.
10. Strengthened wider inclusion infrastructure through OD and Inclusion Team activity, including regular updates to the EDI Dashboard, support for staff networks, delivery of statutory inclusion reporting and provision of diversity, inclusion and belonging learning resources covering allyship, belonging, civility and cultural awareness.
11. Maintained a shared inclusion calendar and awareness programme, supporting visibility of disability, neurodiversity and wider inclusion themes across the Trust and helping to embed disability inclusion within the broader Inclusion and Belonging programme.

1.3 Our priorities

Our WDES priorities for action for 2026-27 are summarised as below:

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

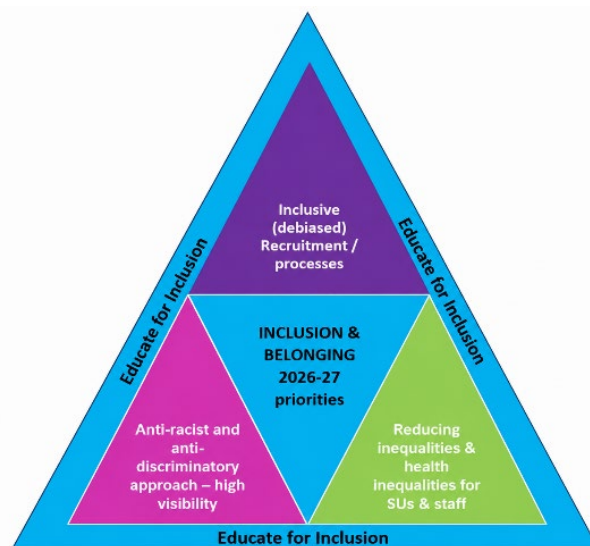


Figure 1: Trust Inclusion and Belonging Priorities, 2026/27.

2.0 Trust summary performance over time against the 10 WDES Indicators

Indicators	Years							2026
	2019	2020	2021	2022	2023	2024	2025	
1.Workforce disability profile	2.50%	4.30%	6.60%	6.10%	7.60%	8.70%	10.16%	11.43% ↑
National	3.10%	3.40%	3.70%	4.20%	4.90%	5.70%	6.70%	Not avail.
2. Recruitment measure	1.9	1.06	0.85	1.01	0.94	0.98	1.3	0.9 ↓
National	1.18	1.2	1.2	1.11	1.09	0.99	0.95	Not avail.
3.Capability process measure	n/a	0	0	0	2.96	11.26	6.94	4.12 ↓
National	n/a	1.53	1.94	2.01	2.17	2.04	Not avail.	Not avail.
4a. HBA from patients / public	35.60%	34.98%	31.9	34.86%	34.46%	32.49%	27.88%	28.00% ↓
No LTC or illness	26.50%	28.62%	26.08%	26.69%	23.56%	21.92%	21.09%	23.51%
4b. HBA from Managers	8.80%	10.40%	9.57	10.68%	12.18%	11.87%	7.95%	10.02% ↓
No LTC or illness	6.70%	9.40%	7.50%	4.40%	5.29%	4.93%	6.82%	5.64%
4c. HBA from staff /colleague	14%	15.42%	16.09	15.96%	21.08%	19.40%	16.88%	16.63% ↑
No LTC or illness	9.40%	10.40%	7.30%	8.80%	9.80%	10.33%	11.54%	11.45%
4d: Reporting of HBA	67.70%	59.74%	64.52	57.27%	66.03%	65.03%	60.45%	65.82% ↓
No LTC or illness	61.40%	60.90%	66.00%	67.30%	68.10%	71.50%	73.11%	71.82%
5. Equal opportunities for career progression	Due to a change in NHS Staff Survey question wording in 2025, WDES Indicator 5 results are not directly comparable with previous years. 2026 should be treated as a new baseline.							54.85% ↓
No LTC or illness								67.75%
6. Presenteeism	15.20%	14.80%	16.20%	17.90%	20.60%	16.60%	15.41%	15.85% ↓
No LTC or illness	13.10%	14.30%	15.50%	13.50%	11.60%	11.54%	11.18%	7.69%
7.Valued at work	37.80%	41.20%	50.40%	52.80%	49.60%	50.88%	53.45%	50.82% ↓
No LTC or illness	48.50%	52.90%	59.30%	61.20%	57.50%	59.88%	60.05%	63.32%
8. Reasonable adjustments	The wording of this Staff Survey question changed in 2022, so results cannot be directly compared with earlier years				86.20%	83.04%	82.74%	79.05% ↓
National					78.76%	79.32%	79.60%	75.30%
9. Staff engagement scores	6.8	7.01	7.2	7.06	7.13	7.08	7.16	7.07 ↓
No LTC or illness	7.1	7.26	7.48	7.49	7.55	7.46	7.37	7.48
National	6.7	6.71	6.85	6.74	6.74	6.82	6.74	6.45
10. Board members representation	0.00%	7.70%	14.30%	20.00%	23.10%	14.29%	15.38%	14.29% ↓
National	2.00%	3.00%	3.70%	4.60%	5.70%	6.50%	7.30%	Not avail.

Table 1: WDES indicator trends for NSCHT between 2019 and 2026. The National 2026 WDES data will be published in 2027 and is therefore unavailable for comparison.

The 2026 WDES results show a mixed picture. The Trust continues to make progress in workforce representation and recruitment, with disability disclosure increasing to its highest level to date and recruitment outcomes becoming more equitable for disabled applicants.

However, several staff experience indicators deteriorated during the year. Disabled staff reported higher levels of bullying, harassment and abuse from patients, managers and colleagues than staff without a disability or long-term condition. Confidence in reporting concerns declined, while fewer disabled staff reported receiving the reasonable adjustments they needed.

Disabled staff were also more likely to experience presenteeism, less likely to feel valued at work and reported lower levels of staff engagement than colleagues without a disability or long-term condition. Board representation of disabled people also decreased slightly during the reporting period.

Overall, the data suggests that while progress continues in representation and access to employment, further work is needed to improve the day-to-day experiences of disabled staff and ensure they feel supported, included and able to thrive at work.

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

2.1. Strategic alignment with organisational and national frameworks

This mapping shows that disability equality is central to the Trust's wider workforce strategy, not a standalone compliance exercise. WDES supports the Trust to improve recruitment, retention, workplace adjustments, staff wellbeing, leadership accountability and staff experience. It also provides clear evidence for Board assurance by linking local disability inclusion work to national NHS priorities and the Trust's People priorities.

Strategic priority	Alignment with WDES priorities
NHS Long Term Workforce Plan	Priority 1 supports fair recruitment, retention, career progression and workplace adjustments for disabled staff. Priority 3 supports improved wellbeing and retention by addressing workforce inequalities. Priority 4 develops inclusive leadership and workforce capability to support a diverse workforce.
NHS 10 Year Health Plan ambitions	Priorities 2 and 3 support the ambition to reduce inequalities and improve wellbeing by creating a more inclusive workplace and addressing the poorer experiences often reported by disabled staff. Priority 1 helps ensure the NHS attracts and retains skilled staff through fair and accessible employment practices.
NHS England EDI Improvement Plan	All four priorities align strongly with the EDI Improvement Plan through their focus on reducing discrimination, improving staff experience, strengthening leadership accountability, improving workplace adjustments, addressing inequalities and embedding inclusion within organisational culture and decision-making.
Our People 'Big Moves'	1. Workforce Optimisation: Priority 1 improves recruitment, retention, career development, workplace adjustments and workforce effectiveness. 2. Workforce Transformation: Priorities 1 and 3 use workforce data, staff experience and organisational learning to address inequalities and inform workforce planning. 3. Our Combined CARE Culture: Priorities 2 and 4 support inclusive leadership, anti-discriminatory practice, staff wellbeing, psychological safety and a culture where disabled staff can thrive.
Combined People Plan 2023–28	1. Inclusive and Representative: WDES supports increased disability representation, improved disclosure rates and reducing inequalities experienced by disabled staff. 2. Great Place to Work: WDES supports improvements in staff experience, workplace adjustments, wellbeing, psychological safety and creating an environment where disabled staff feel valued and included. 3. Health and Wellbeing: WDES directly contributes to improving the health, wellbeing and working lives of disabled staff by addressing presenteeism, workplace barriers and access to support. 4. Achieve Potential and Aspirations: WDES supports equitable access to career development, progression opportunities, leadership development and talent management for disabled staff. 5. Outstanding Systems and Processes: WDES helps strengthen organisational processes through improved accessibility, reasonable adjustments, inclusive workforce policies and evidence-based decision-making using workforce equality data.

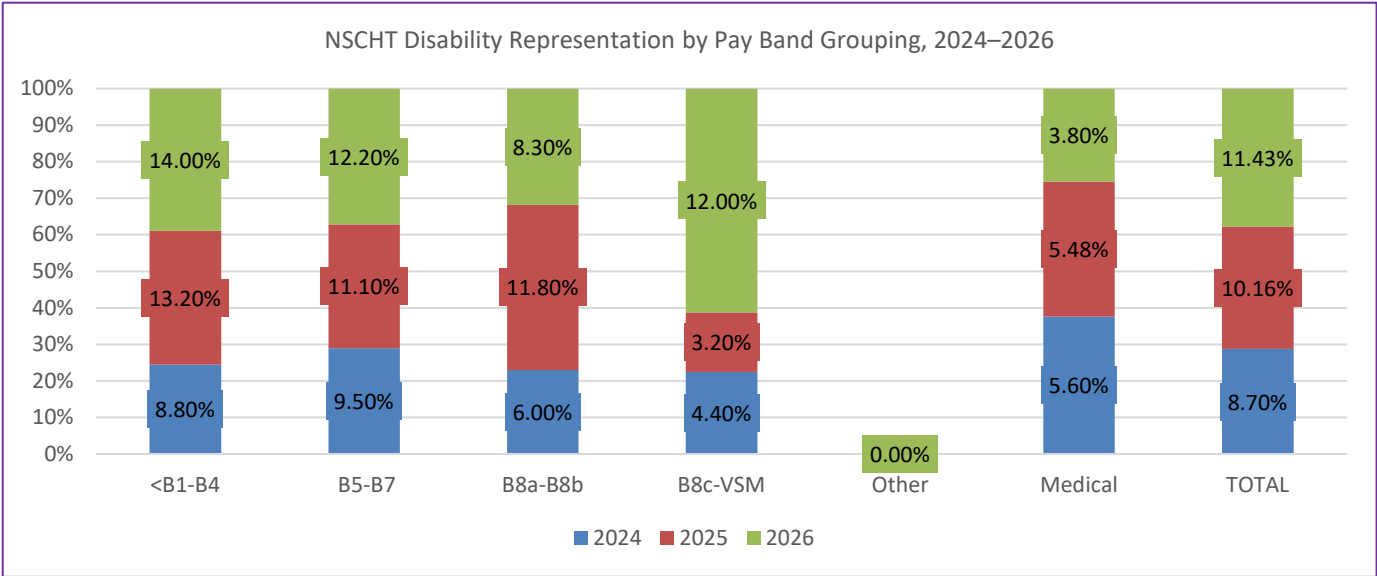
3.0 Trust Performance Breakdown by the 10 WDES Indicators

Indicator 1: Workforce disability profile (Improved)

Disability representation within the Trust continued to improve in 2026, increasing from 10.16% in 2025 to 11.43%, the highest level reported by the Trust to date. This suggests growing confidence in disability disclosure and a workforce that is becoming increasingly representative of people with disabilities, neurodiversity and long-term health conditions.

Representation increased within the non-clinical workforce, rising from 13.2% to 14.0%, while the clinical workforce remained stable at 11.1%. The medical and dental workforce saw a small increase from 3.2% to 3.8%, although this remains significantly lower than the Trust average and may indicate continued under-disclosure or barriers to disclosure within this staff group.

Analysis by pay band shows that disabled staff are represented across all levels of the organisation but are concentrated within lower and middle bands. Within the clinical workforce, disability representation was 12.4% in Bands 1–4, 11.1% in Bands 5–7 but reduced to 6.5% in Bands 8a and above. A similar pattern is seen within the non-clinical workforce, where representation was 14.0% in Bands 1–4, 12.1% in Bands 5–7, and 4.8% in Bands 8a and above, with no disabled staff recorded at VSM level.



The key message from this indicator is that while disability representation continues to strengthen across the Trust, disabled staff remain less visible within senior leadership and management roles. Improving disability disclosure, understanding barriers to progression and ensuring equitable access to development opportunities will be important if the Trust is to achieve a more representative leadership profile in future years.

Figure 2:proportion of staff declaring a disability or long-term condition across workforce pay band groupings between 2024 and 2026

Indicator 2: Recruitment measure (Improved)

The Trust's recruitment measure improved from 1.30 in 2025 to 0.90 in 2026, moving beyond parity (1.0) and indicating that disabled applicants were slightly more likely to be appointed from shortlisting than non-disabled applicants. This compares favourably with the last available national benchmark of 0.95.

Disabled applicants represented 9.9% of applications (346), increasing to 14.7% of shortlisted candidates (130) and 15.5% of appointments (51). In contrast, non-disabled applicants accounted for 87.3% of applications, 82.5% of shortlisted candidates and 78.5% of appointments. This suggests recruitment outcomes became more equitable during 2026, with disabled candidates increasingly represented at each stage of the recruitment process. However, the number of disabled applicants reduced from 450 in 2025 to 346 in 2026, indicating that while appointment outcomes improved, further work is needed to attract more disabled applicants into the recruitment pipeline.

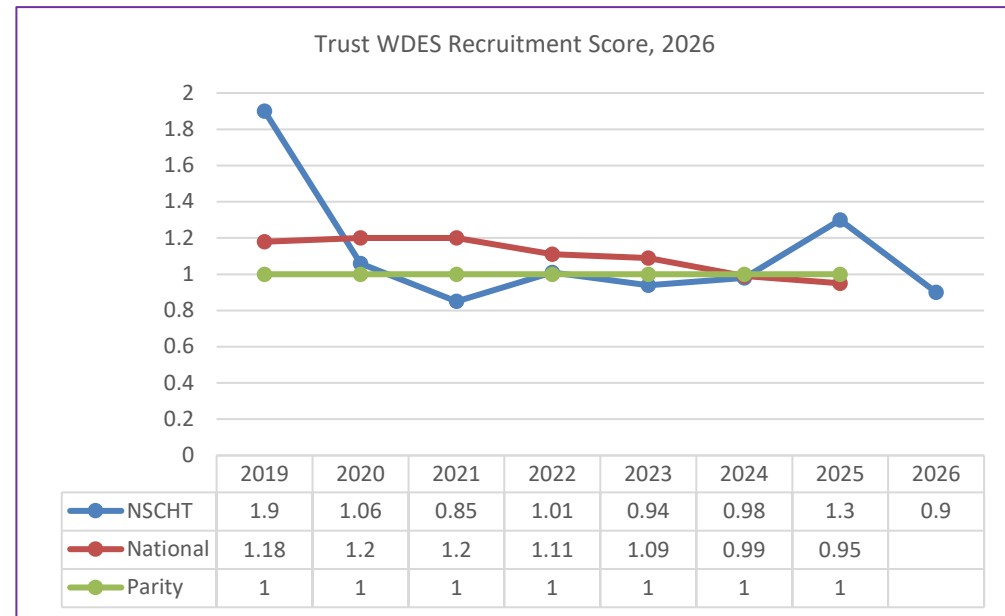


Figure 3: WDES recruitment scores 2019 – 2026 (Trust scores compared with national average).

2025	Applications	Shortlisted	Appointed	2026	Applications	Shortlisted	Appointed
Disabled	450 (7.92%)	196 (9.4%)	55 (9.13%)	Disabled	346 (9.95%)	130 (14.66%)	51 (15.45%)
Non-Disabled	5136 (90.47%)	1829 (88.2%)	505 (83.9%)	Non-Disabled	3037(87.30%)	732 (82.53%)	259 (78.48%)
Unknown	91 (1.60%)	49 (2.3%)	42 (7%)	Unknown	96 (2.76%)	25 (2.82%)	20 (6.06%)
Total	5677 (100%)	2074 (100%)	602 (100%)	Total	3479 (100%)	887 (100%)	330 (100%)

Table 2: Disability through the Trust Recruitment and Selection process comparing 2025 and 2026.

Indicator 3: Capability process measure (Improved)

The Trust's capability process measure improved from 6.94 in 2025 to 4.12 in 2026, indicating a reduction in the disparity between disabled and non-disabled staff entering a formal capability process. While this is a positive improvement, disabled staff remained over four times more likely to enter a capability process than non-disabled colleagues. The measure was 0 between 2019 and 2022, increased to 2.96 in 2023, peaked at 11.26 in 2024, before reducing over the last two years. This volatility reflects the very small number of capability cases occurring each year, where the inclusion or exclusion of a small number of staff can have a significant impact on the overall score.

NHS England no longer publishes a national comparator for this indicator because capability cases are typically low in number across NHS organisations and the resulting rates can fluctuate significantly from year to year, making meaningful comparison between organisations of different sizes difficult.

The overall direction of travel is positive, with the measure reducing for a second consecutive year. However, the continued disparity suggests that further work is needed to understand whether workplace barriers, support arrangements, reasonable adjustments or management practices may be contributing to disabled staff being disproportionately represented within formal capability processes.

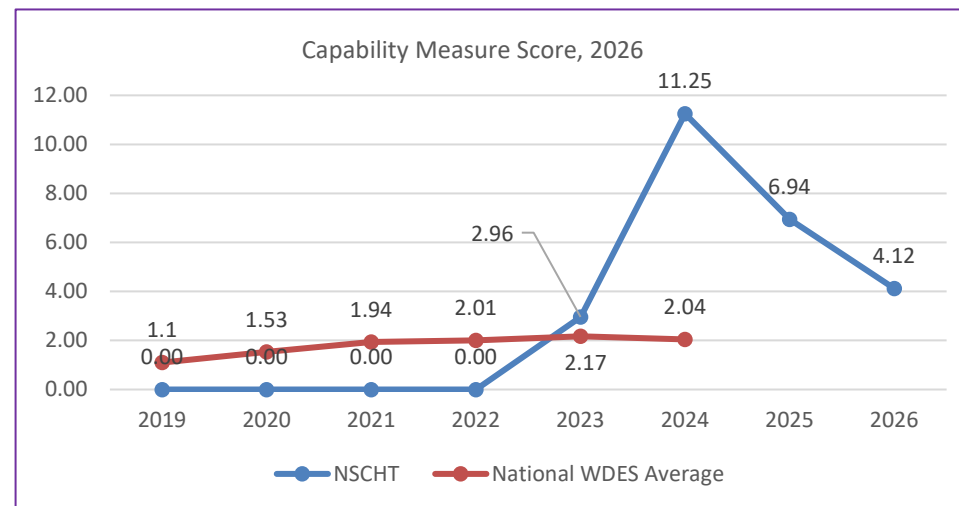


Figure 4: Relative likelihood of disabled staff entering a formal capability process compared with non-disabled staff between 2019 and 2026

Indicator 4a: Harassment bullying and abuse (HBA) - Service users and the public (Worsened very slightly)

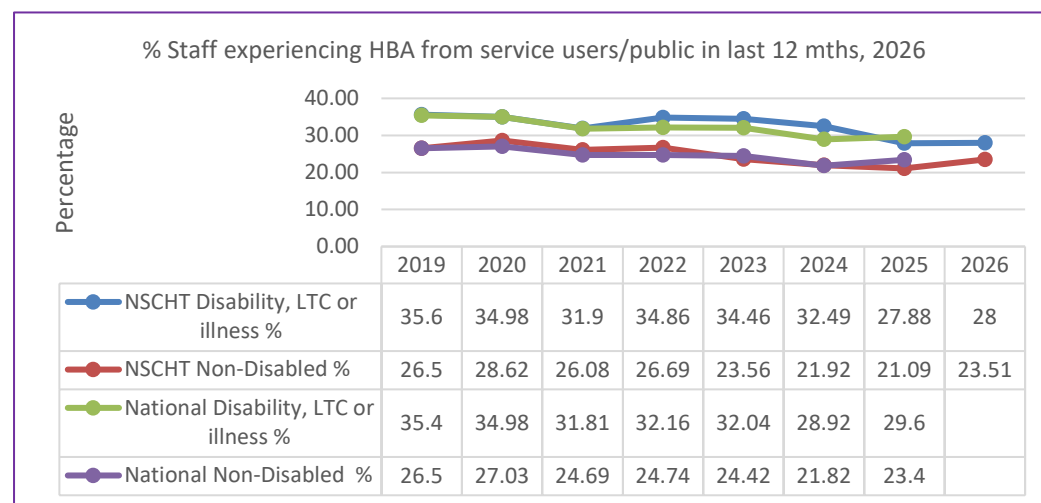


Figure 5: Percentage of staff experiencing HBA from patients, relatives and the public, 2019–2026

28.0% of disabled staff reported experiencing bullying, harassment or abuse (HBA) from patients, relatives or the public, compared with 23.5% of non-disabled staff. While the gap narrowed slightly compared with previous years, disabled staff continued to report poorer experiences than their non-disabled colleagues.

Our results remained broadly unchanged from 27.9% in 2025 to 28.0% in 2026, following a longer-term reduction from 35.6% in 2019. The 2026 result compares favourably with the latest available national figure for disabled staff (29.6% in 2025), suggesting that disabled staff at the Trust experience slightly lower levels of abuse from patients and the public than the national average. Although the overall level of reported abuse has reduced over time, closing the gap between disabled and non-disabled staff remains an important area of focus for the Trust.

Indicator 4b: Harassment, bullying & abuse - Manager (Worsened)

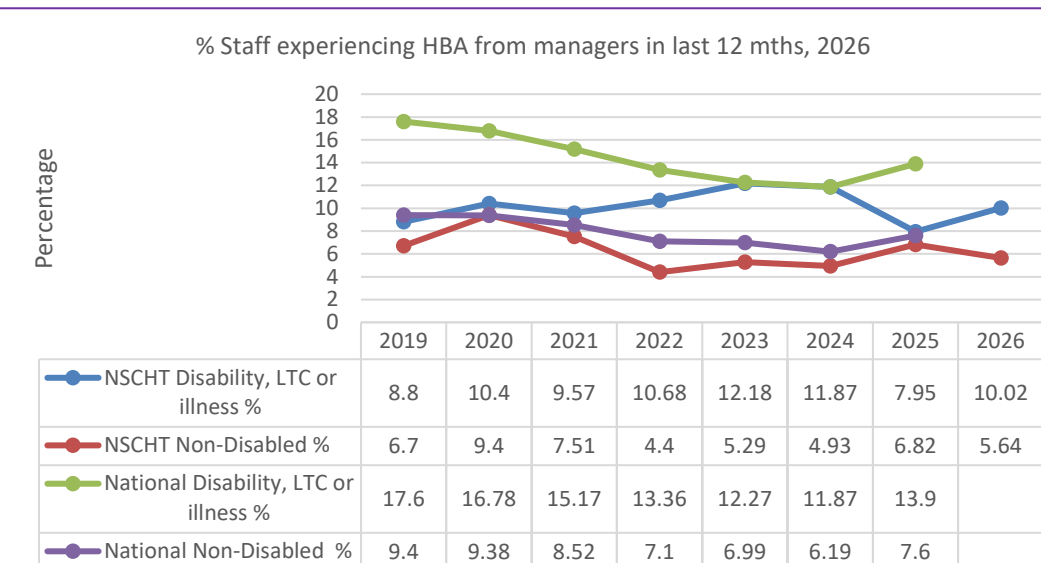


Figure 6: Staff Experiencing Bullying, Harassment or Abuse from Managers, 2019–2026

In 2026, 10.02% of disabled staff reported experiencing bullying, harassment or abuse from managers, compared with 5.64% of non-disabled staff. This indicator worsened from 7.95% in 2025, increasing by 2.07 percentage points and widening the gap between disabled and non-disabled staff from 1.13 to 4.38 percentage points.

Although the Trust remains below the latest national benchmark for disabled staff (13.9%), the longer-term trend has deteriorated, increasing from 8.8% in 2019 to 10.02% in 2026. This suggests disabled staff continue to experience poorer interactions with managers than their non-disabled colleagues, making this an important area for improvement.

Indicator 4c: Harassment, bullying and abuse – Colleagues (Improved slightly)

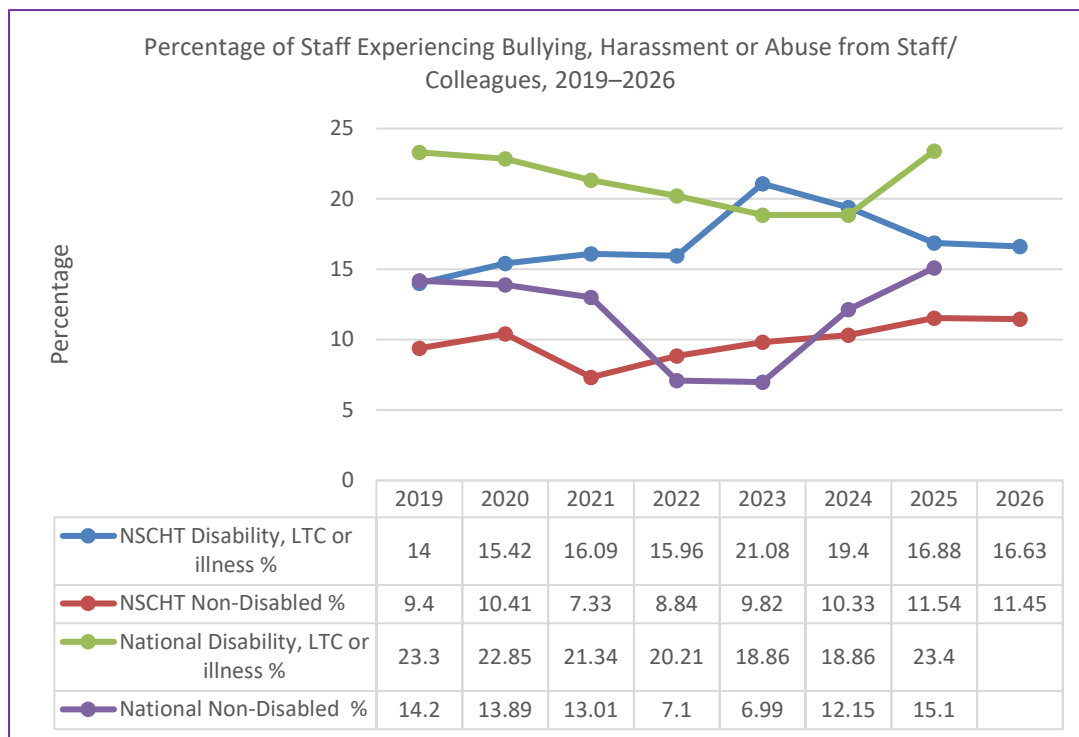


Figure 7: Percentage of disabled and non-disabled staff experiencing bullying, harassment or abuse from colleagues, 2019–2026

In 2026, 16.63% of disabled staff reported experiencing bullying, harassment or abuse from colleagues, compared with 11.45% of non-disabled staff. Disabled staff therefore remained significantly more likely to experience negative behaviours from colleagues. This indicator improved slightly, reducing from 16.88% in 2025 to 16.63%, although the disparity between disabled and non-disabled staff remained substantial at 5.18 percentage points. The Trust's result for disabled staff was also considerably better than the latest available national benchmark (23.4% in 2025). Looking at the longer-term trend, reported experiences increased from 14.0% in 2019 to a peak of 21.08% in 2023, before reducing over the last three years. While this suggests some improvement, almost one in six disabled staff continue to experience bullying, harassment or abuse from colleagues. Overall, this indicator has improved slightly year-on-year, but the persistent gap between disabled and non-disabled staff indicates that further work is needed to create a consistently inclusive and respectful workplace culture.

Indicator 4d: Harassment, bullying & abuse - Reporting (Improved)

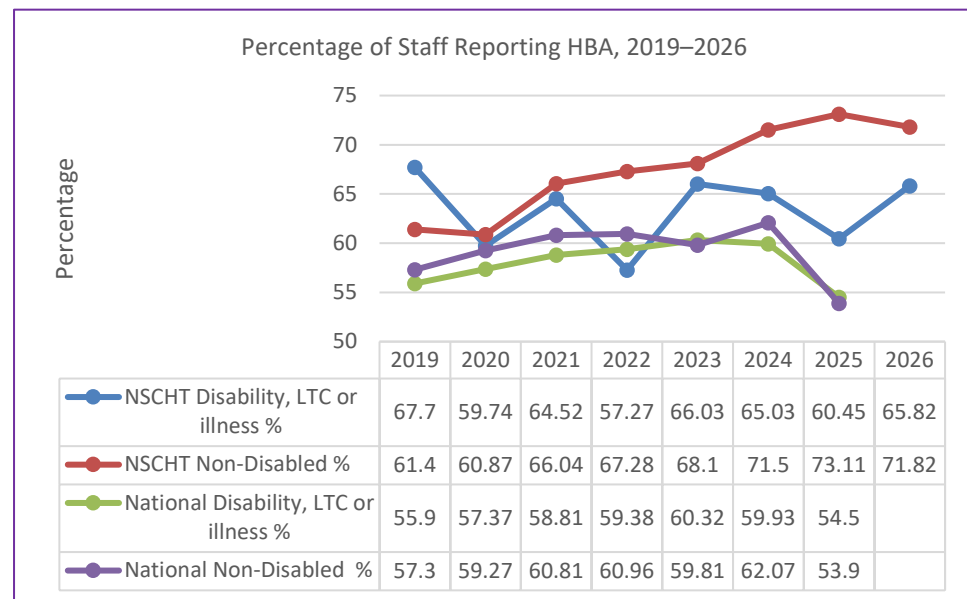
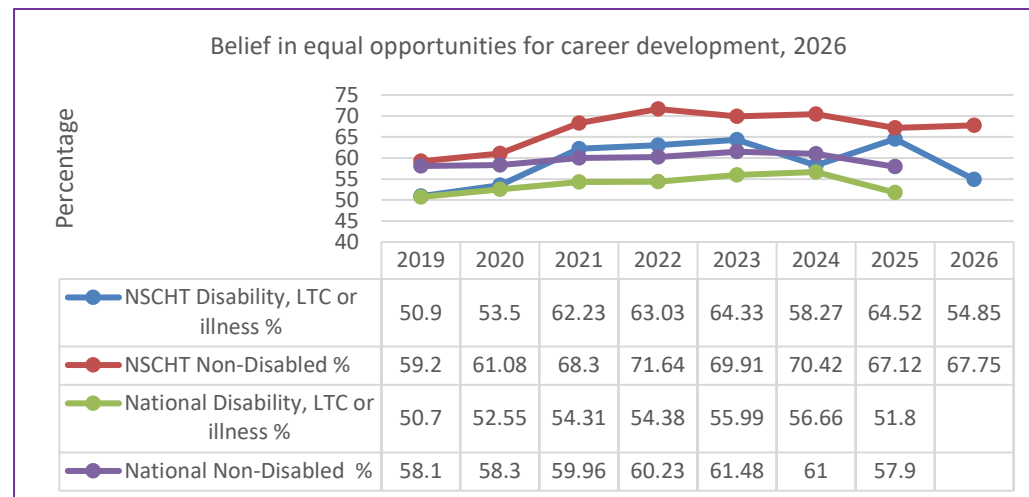


Figure 8: Proportion of disabled and non-disabled staff who reported HBA after experiencing it

In 2026, 65.82% of disabled staff who experienced bullying, harassment or abuse reported it. This represents an improvement from 60.45% in 2025 and is the second highest result recorded by the Trust since 2019. Despite this improvement, disabled staff remained less likely to report incidents than non-disabled staff (71.82%). However, the gap reduced from 12.66 percentage points in 2025 to 6.0 percentage points in 2026, indicating growing confidence among disabled staff to raise concerns.

The increase in reporting may reflect greater awareness of reporting routes, improved visibility of Freedom to Speak Up and staff support mechanisms, and increased confidence that concerns will be taken seriously. While higher reporting rates can initially suggest more incidents are being raised, they are generally viewed as a positive indicator of a more open and psychologically safe culture where staff feel able to speak up. This provides the Trust with better intelligence to identify issues, target interventions and improve staff experience.

Indicator 5: Belief that organisation provides equal opportunities for career progression (Worsened)



In 2026, 54.85% of disabled staff believed the Trust provides equal opportunities for career progression and promotion, compared with 67.75% of non-disabled staff. This represents a gap of 12.9%. Due to changes in the NHS Staff Survey question wording in 2025, 2026 should be treated as a new baseline and cannot be directly compared with previous years. However, the 2026 result remains above the latest available national benchmark for disabled staff (52.0% in 2025).

The data suggests that while a majority of disabled staff believe opportunities are fair, disabled staff remain significantly less positive than non-disabled colleagues about career progression within the Trust.

Figure 9: Percentage of Staff Believing the Trust Provides Equal Opportunities for Career Progression and Promotion

Indicator 6: Presenteeism (Worsened slightly)

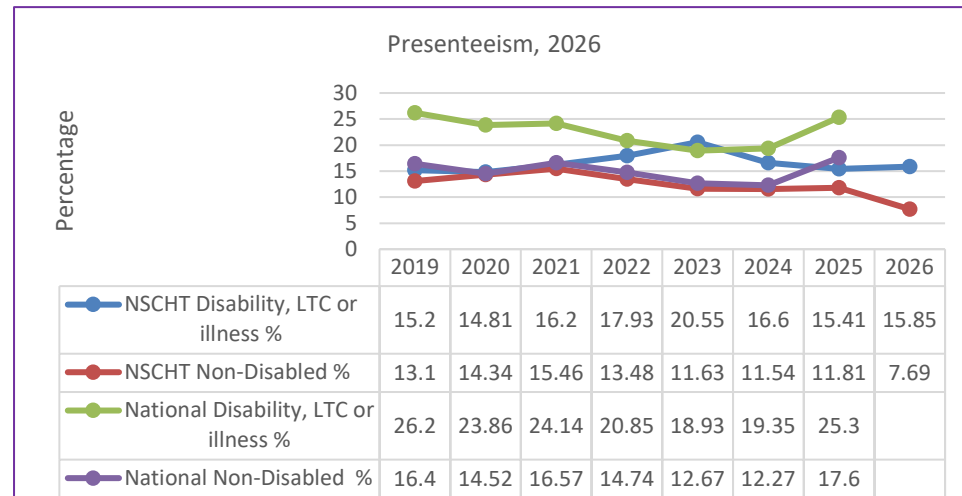


Figure 10: % of Disabled and non-disabled staff reporting pressure to attend work when unwell

In 2026, 15.85% of disabled staff reported feeling pressure to attend work when unwell, compared with 7.69% of non-disabled staff. This represents a gap of 8.16 percentage points, meaning disabled staff were more than twice as likely to experience presenteeism. This indicator worsened slightly in 2026, increasing from 15.41% in 2025 to 15.85%. However, the Trust's result remained substantially better than the latest national benchmark for disabled staff (25.3% in 2025).

Overall, while levels of presenteeism among disabled staff remain lower than the national average, the persistent and widening gap between disabled and non-disabled staff suggests further work is needed to support staff wellbeing and reduce pressure to attend work when unwell.

Indicator 7: Feeling valued (Worsened)

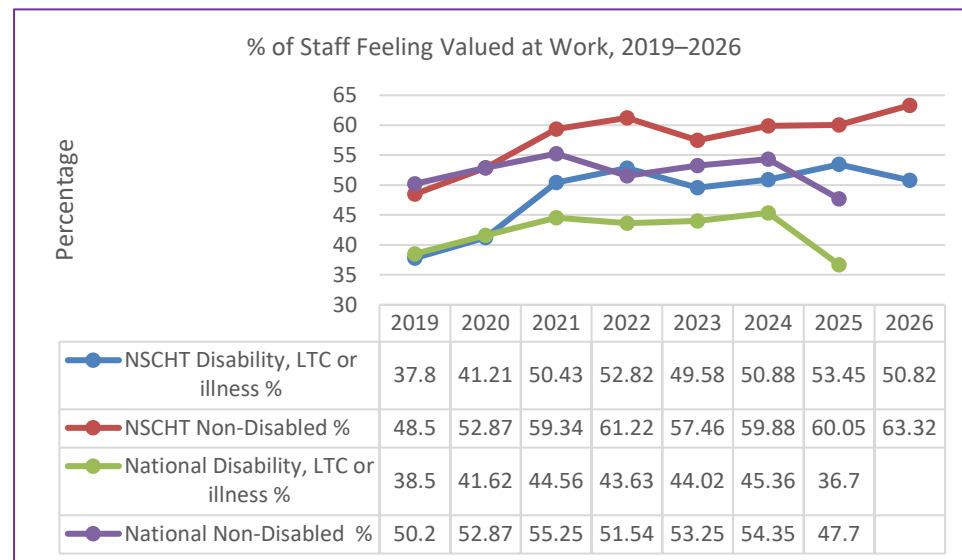


Figure 81: % of disabled and non-disabled staff who feel valued at work

In 2026, 50.82% of disabled staff reported feeling valued at work, compared with 63.32% of non-disabled staff, a gap of 12.5 percentage points. This indicator worsened in 2026, falling from 53.45% in 2025 to 50.82%. While the Trust's result remains considerably above the latest national benchmark for disabled staff (36.7% in 2025), the gap between disabled and non-disabled staff widened slightly.

Overall, although disabled staff report feeling more valued than the national average, only around half feel valued by their organisation, highlighting an ongoing inequality in staff experience and a continued need to strengthen inclusion, recognition and belonging.

Indicator 8: Employer has made reasonable adjustments (Worsened)

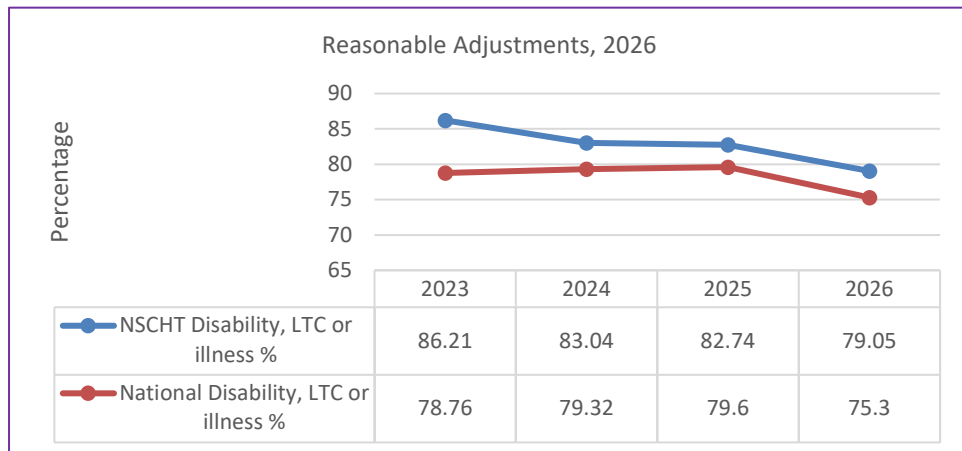


Figure 12: Compares the percentage of disabled staff reporting that the Trust made the reasonable adjustments needed for them to carry out their work against the national benchmark

In 2026, 79.05% of disabled staff reported that the Trust had made the reasonable adjustments they needed to carry out their work. This represents a decline from 82.74% in 2025 and continues the downward trend from 86.21% in 2023. Despite this deterioration, the Trust remained above the latest national benchmark of 75.3%, indicating that disabled staff are still more likely to receive the adjustments they need than the national average.

This suggests that although most disabled staff continue to receive appropriate support, fewer are reporting that their adjustment needs are being fully met. Given the importance of reasonable adjustments in enabling staff to remain well, productive and included at work, this remains a key area of focus. With funding for the Differently Abled Buddy Scheme ending in 2024, the CAN Staff Network has taken on elements of the scheme and continues to provide peer support where requested.

Alongside this, the network is working with the Trust and the Reasonable Adjustments Working Group to review the workplace adjustments processes to improve timeliness, consistency and staff experience, helping disabled colleagues feel supported, valued and able to reach their full potential.

Indicator 9a: Staff engagement (Worsened slightly)

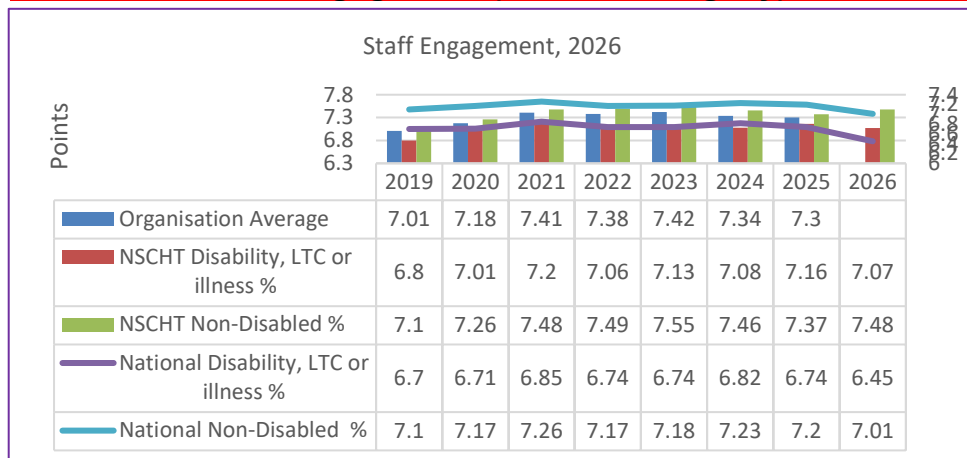


Figure 9: Compares staff engagement scores for disabled and non-disabled staff against Trust and national averages

In 2026, the staff engagement score for disabled staff was 7.07, compared with 7.48 for non-disabled staff and 7.30 for the Trust overall. This represents a slight decline from 7.16 in 2025, while the gap between disabled and non-disabled staff increased from 0.21 to 0.41 points.

Although engagement among disabled staff remains above the national benchmark (6.45), disabled staff continue to report a less positive experience than their non-disabled colleagues.

Staff engagement is included within WDES because it reflects how connected, valued and involved staff feel within their organisation. Higher engagement is associated with improved wellbeing, retention and organisational performance.

Indicator 9b: Measures to hear disabled staff voice

The Trust has continued to strengthen engagement with differently abled colleagues through a range of staff voice and co-production mechanisms during 2026. Central to this has been the Combined Ability Network (CAN), which provides a forum for disabled staff, staff with long-term conditions and neurodivergent colleagues to share experiences, influence decision-making and help shape organisational priorities.

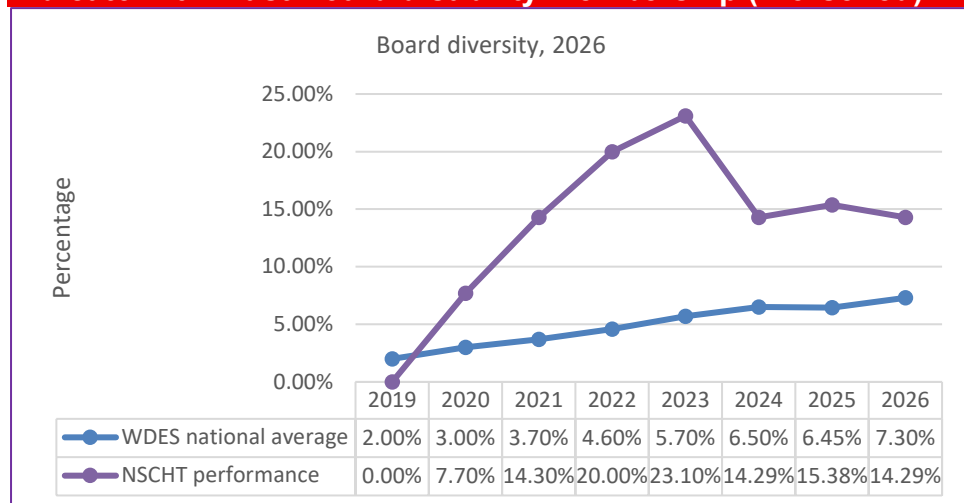
The CAN Network meets regularly and maintains an active Teams community to support ongoing engagement and peer support. The CAN Lead sits on both the Trust Inclusion Council, chaired by the Chief Executive, and the Reasonable Adjustments Working Group, ensuring that the views and experiences of disabled staff directly inform organisational decision-making and improvements to workplace support.

During 2026, (through the CAN Network) disabled staff contributed to the Integrated Learning Review, helped shape the draft Reasonable Adjustments Policy and Access to Work Guidance, and continued to influence Inclusion and Belonging priorities through staff network engagement and consultation activity. The CAN Network also continued to support the Differently Abled Buddy Scheme following the end of external funding, providing peer support where requested.

Additional opportunities for staff voice were provided through staff network events, the Staff Survey "You Said, We Did" programme, the Inclusion Council refresh, and the Inclusion Photo Campaign, which increased the visibility and representation of disabled colleagues across the Trust. These initiatives have helped strengthen engagement, improve understanding of staff experience and ensure that disabled staff voices continue to influence organisational improvement.

In addition, OD and Inclusion Team activity during 2025/26 supported the growth and influence of staff networks, regular updates to the EDI Dashboard and wider learning resources on allyship, belonging, civility and cultural awareness. This has helped strengthen the infrastructure through which disabled staff voice is heard, monitored and translated into organisational priorities.

Indicator 10: Trust Board disability membership (Worsened)



In 2026, 14.29% (2 of 14) Board members identified as disabled, compared with the national benchmark of 7.3%. Both disabled Board members were Voting and Non-Executive Directors, while no Executive Directors declared a disability. Although this represents a slight decrease from 15.38% in 2025, the Trust continues to perform significantly above the national average.

The Board disability profile is broadly reflective of the wider workforce. Disabled staff represent 11.43% of the overall workforce compared with 14.29% of Board members, a positive difference of 2.86 percentage points. Similarly, disabled staff account for 14.29% of Voting Board members. However, the data should be interpreted with caution due to the small size of the Board. With only 14 Board members, changes in the disability status

or membership of one individual can have a significant impact on the reported percentage from year to year.

Figure 104: Board Disability Representation Compared with National WDES Average, 2019–2026

4.0 Priorities, supporting actions and milestones for 2026/27

The table below sets out the Trust's WDES priorities for 2026/27 and shows how each priority will be taken forward. These priorities are based on, and aligned to, the Trust's broader Inclusion and Belonging Strategic Plan priorities for 2024–2028, ensuring that WDES activity supports the organisation's wider inclusion, belonging and equality objectives.

WDES priority	Supporting actions	Milestones / evidence of progress
1. Debiasing people processes	• Embed the Inclusive Recruitment Toolkit • Band 8a+ recruitment and progression review. • Review recruitment, capability, disciplinary and workplace adjustments processes through a disability inclusion lens. • Coaching, mentoring and leadership development opportunities for under-represented staff.	• Toolkit launched and uptake reviewed. • Band 8a+ findings and actions agreed. • Process improvements implemented and monitored. • Disability pay gap actions reported through governance.
2. High-visibility anti-discriminatory approach	• Anti-discrimination and anti-abuse campaigns and communications. • Staff Survey "You Said, We Did" activity. • Freedom to Speak Up learning. • CAN staff network engagement. • Inclusion Council oversight	• Campaigns delivered and reviewed. • HBA themes analysed and actions agreed. • Staff voice informs improvement activity. • Progress reported through governance and inclusion routes.
3. Reducing inequalities and health inequalities for our differently abled workforce.	• WDES, Staff Survey and EDI Dashboard analysis. • Health and wellbeing reviews. • AccessAble audits and accessibility guides. • Reasonable Adjustments Policy, Access to Work Guidance and Reasonable Adjustments Working Group. • Reasonable Adjustment Digital Flag implementation.	• Disability inequality hotspots identified and monitored. • Accessibility improvements implemented. • Workplace adjustment processes reviewed and improved. • Disability representation and wellbeing indicators monitored.
4. Educating for Inclusion	• Inclusive leadership and management development. • Disability and neurodiversity awareness activity. • Disability History Month and inclusion events. • Allyship, belonging and civility resources.	• Leadership learning offer updated and delivered. • Leadership Academy inclusion sessions completed. • Leadership and management programme participation monitored. • Inclusion learning evaluated and embedded within leadership development programmes.

	• Leadership and management development programmes.	• Disability and neurodiversity awareness activity delivered and reviewed.

5.0 Conclusions and Recommendations

The 2026 WDES results present a mixed picture. The Trust has continued to make progress in improving disability representation and recruitment outcomes, with disability disclosure reaching its highest level to date. Reporting of bullying, harassment and abuse by disabled staff also improved, although disabled staff remained less likely to report incidents than non-disabled staff. Board disability representation decreased slightly during 2026 but remained above the national benchmark. Performance also remains above national benchmarks across several indicators. However, disabled staff continue to report poorer workplace experiences than non-disabled colleagues. Bullying, harassment and abuse, career progression, presenteeism, feeling valued, staff engagement and access to reasonable adjustments all remain areas of inequality. While some indicators have improved, the overall findings suggest that improvements in representation have not yet translated into consistently equitable experiences across the organisation. The Trust's focus during 2026/27 must therefore move beyond representation alone and place greater emphasis on improving the day-to-day experience of disabled staff, ensuring they feel supported, included, valued and able to thrive.

The wider OD and Inclusion Team programme provides important supporting evidence for continued progress, including delivery of statutory inclusion reporting, EDI Dashboard updates, staff network support, learning resources and awareness activity. These activities strengthen accountability, improve visibility of disabled staff experience and support the Trust to embed disability inclusion within its broader Inclusion and Belonging priorities.

What we need in 2026-27

- Improve the timeliness, consistency and effectiveness of workplace adjustments.
- Reduce bullying, harassment and abuse experienced by disabled staff.
- Improve disabled staff experiences of career development and progression.
- Address the causes of higher levels of presenteeism among disabled staff.
- Increase disability representation within senior leadership and management roles.
- Strengthen inclusive leadership capability and management practice.
- Continue to improve staff engagement, belonging and feeling valued.
- Use staff voice, lived experience and workforce data to drive targeted improvement.

Recommendations

- Support delivery of the 2026/27 WDES Action Plan, ensuring disability equality remains a strategic organisational priority.
- Strengthen accountability for improving disabled staff experience, particularly in relation to HBA, staff engagement and feeling valued.
- Improve the timeliness, consistency and effectiveness of workplace adjustments, informed by feedback from disabled staff and the Reasonable Adjustments Working Group.

- Increase disability representation within leadership and management roles by promoting equitable access to development, talent management and career progression opportunities.
- Embed inclusive leadership and management practice across the organisation, ensuring managers are equipped to support disabled staff effectively and create psychologically safe working environments.
- Use workforce equality data, staff survey findings and staff voice mechanisms to identify inequalities, monitor progress and target improvement activity.
- Continue to engage with the CAN Network, staff networks and lived experience groups to ensure the voices of disabled staff inform organisational decision-making and service improvement.

APPENDIX 1: Aligned to NSCHT People Priority Areas and the NHS 10 Year Plan

Our WDES Priorities	Key 2026 Achievements	NHS 10 Year Health Plan Alignment	Our People Big Move Alignment
1. Further extend our work to debias employee relations and talent management processes to ensure differently abled staff have equitable access to development and advancement	• Staff and leadership development programmes • Learning and development opportunities • Inclusive recruitment practices • Revised Reasonable Adjustments Policy and Access to Work Guidance • Disability Pay Gap reporting (second year)	Supports delivery of a modern NHS workforce by improving fairness, retention, career progression and workforce productivity.	Workforce Optimisation through fair recruitment, progression and retention. Workforce Transformation through improved workforce processes and data-driven improvement.
2. Understand, engage, develop and progress differently abled talent at every level to achieve a more equitable workforce profile	• Workforce disability disclosure increased to 11.43% • Coaching, mentoring and leadership development • CAN Network engagement and peer support • Inclusion Council refresh • Inclusive recruitment activity	Supports attracting, developing and retaining a diverse workforce that reflects the communities served.	Workforce Optimisation through talent development and retention. Our Combined CARE Culture through inclusion and representation.
3. End disproportionate harassment, bullying and abuse against our differently abled workforce	• Integrated Learning Review • Staff Survey "You Said, We Did" • Staff network engagement and co-production • Inclusion Council oversight • Inclusive leadership awareness activity • Disability History Month and wider inclusion campaigns	Supports creating safe, compassionate workplaces where staff can thrive and deliver high-quality care.	Our Combined CARE Culture through psychological safety, inclusion and belonging. Workforce Transformation through organisational learning and culture change.
4. Deliver actions through the Disability Inclusion Project Group and related improvement programmes	• Reasonable Adjustments Working Group • Progress on Reasonable Adjustments Policy • Access to Work Guidance • Accessibility improvement programme with AccessAble • CAN Network involvement in improvement activity	Supports removing barriers to employment and creating accessible workplaces.	Workforce Transformation through system improvement and accessibility. Workforce Optimisation through improved workplace support.
5. Make EDI and disability inclusion everyone's business and embed sustainable change	• Inclusion Council refresh • People Plan refresh • Leadership podcasts and awareness activity • Disability History Month and inclusion events • Staff network influence on organisational priorities • Inclusion Photo Campaign	Supports creating inclusive organisational cultures and improving staff experience across the NHS.	Our Combined CARE Culture through leadership accountability, visibility and inclusion. Workforce Transformation through embedding inclusion within everyday practice.
6. Close the gap between disability disclosure in ESR and NHS Staff Survey data	• Continued promotion of disability inclusion and visibility • CAN Network engagement activity • Inclusion Photo Campaign featuring disabled colleagues • Accessibility audits and accessibility guides • Staff voice and lived experience initiatives	Supports better workforce data quality and understanding of workforce needs to inform planning and support.	Workforce Transformation through improved workforce intelligence. Workforce Optimisation through better understanding of workforce needs and barriers.

APPENDIX 2 - Inclusion and Belonging Action Plan 2026/27

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

Action	Links to Equality Objectives 24–28	Links to 2026/27 EDI Goals	Must / Should / Could	Action Lead	RAG rating (as at June 2026)
Deliver key milestones to implement, ensure and embed an effectively debiased inclusive recruitment process change programme					
1.1 Develop Inclusive Recruitment Toolkit and Inclusive Recruitment Development package utilising theory / approach of No More Tick-Boxes' and 'If Your Face Fits' (Kline, 2023). 1.1.1 Audit Toolkit use across all recruitment panels by service, role type and band, and report whether Global Majority and disabled applicant outcomes have improved.	4	1	Must	Recruitment Lead	Oct 2026
1.2 Undertake analysis of applications-shortlisting/interview-appointment for posts at band 8A and above to better understand the issues / reasons behind lack of diversity in appointments at this level, and implement action based on findings. 1.2.1 Complete Band 8A+ recruitment analysis by ethnicity, disability, gender and LGB+ status at shortlisting, interview and appointment, with actions for each identified disparity.	4	1	Should	People Team	Dec 2026
1.3 Respond effectively to feedback from staff about experiences of recruitment process from a protected characteristics perspective. 1.3.1 Collect candidate and recruiting manager feedback on fairness, accessibility, adjustments and inclusion, and report themes quarterly through the HR / EDI Dashboard.	4	1	Should	HR Lead	Oct 2026
1.4 Develop a plan to roll out Inclusive Recruitment development, considering the needs of both new recruiting managers and existing recruiting managers.	4	1	Should	Recruitment Lead	Dec 2026

1.4.1 Prioritise rollout to services with poorer recruitment equity indicators, lower senior representation or repeated recruitment feedback, and require completion before managers chair panels.					
Reducing inequalities and health inequalities for our service users and staff					
2.1 All services to undertake a review of service user access analysed with a race lens in 2026/27 and present findings to Directorate committee. Three services to do deeper review via EDS framework – see 2.5 below. 2.1.1 Each Directorate to complete one service-user access review using race and disability data, agree two local actions, and report progress through Directorate governance.	2 & 3	2	Should	All Service Leaders	Mar 2027
2.2 Equitable access to health and wellbeing offers for all staff. Review take-up by colleagues with diverse characteristics. 2.2.1 Analyse health and wellbeing offer take-up by ethnicity, disability, staff group, band and service, and agree targeted actions for any under-represented groups.	2	2	Should	Health and Wellbeing Lead	Dec 2026
2.3 Implement new guidance on recording gender codes in Electronic Patient Record (Lorenzo) and in Electronic Staff Record when available. When in place, analyse the data and identify next steps. 2.3.1 Deliver guidance for staff recording demographic information in Lorenzo and ESR, and complete one data quality review with improvement actions.	1	2	Must	Performance Lead / Head of Clinical Systems	Dec 2026
2.4 Launch and embed new guidance and approach to RADF (Reasonable Adjustment Digital Flag), as mandated through ISN re-recording disability / accessible information needs in Electronic Patient Record. 2.4.1 Implement RADF guidance with a named operational owner, track adoption across services, and escalate barriers through governance.	1	2	Must	TBC	Dec 2026
2.5 Three services to be reviewed and rated under the EDS framework for 2026/27, including detailed review of access, experience, safe from harm and outcomes. 2.5.1 Select three EDS review services using WRES/WDES risk indicators, complete ratings, and agree improvement plans for access, experience, safety and outcomes.	1	2	Must	Identified Service Managers / Inclusion and Belonging Lead	Mar 2027

2.6 Review business case for AccessAble and make decision on potential extension for years 4 and 5. If approved, commission inclusion of Keele Medical Practice and consider inclusion of Lawton House into surveyed premises. 2.6.1 Complete the AccessAble surveys and re-surveys.	4	2	Should	Inclusion and Belonging Lead	Nov 2026
2.7 Support inclusive talent management and career development / progression for all through promotion of career development workshops and career conversations. This offer to be specifically targeted to staff with diverse characteristics, with a focus on race and disability, and encouraging take-up of coaching and mentoring by colleagues with diverse characteristics. 2.7.1 Monitor career workshop, mentoring and coaching participation by ethnicity, disability, band and service, and agree actions where take-up is low.	4	1 & 2	Should	OD Talent Lead	Mar 2027
2.8 All executive directors to agree and deliver against personal and Directorate EDI objectives in 2025–26. 2.8.1 Each Executive Director to set one measurable Directorate EDI objective linked to WRES/WDES disparities and report progress quarterly.	1–4	1–4	Must	CEO/ Execs	Oct 2026
2.9 ~~Introduce and~~ Embed an HR / EDI dashboard for all services and Directorates, with monthly, quarterly and annual monitoring and RAG rating of good / poor performance. The dashboard should support identification of issues, ownership, prioritisation of action and progress monitoring in each service, including workforce ethnicity, LGB+ and disability profile, senior leadership representation, diversity in shortlisted candidates, WRES / WDES and LGBT+ recruitment scores by service, and bullying and harassment rates from line managers and colleagues. 2.9.1 From Q3 2026/27, use the HR / EDI Dashboard quarterly to identify each Directorate's top three inequality risks, assign owners and track actions to closure.	2 & 3	2 & 3	Should	CIO with Inclusion and Belonging Lead	Ongoing
2.10 Publish and monitor annual Ethnicity, Disability and Gender Pay Gap reports, with data to end March 2026 and targeted action plans to address findings.	1	2	Must	Inclusion and Belonging Lead	Ongoing

2.10.1 Publish Ethnicity, Disability and Gender Pay Gap reports with separate action plans linked to recruitment, progression, development and retention.					
3. To progress our high-visibility anti-racist and anti-discriminatory approach, delivering against tangible key milestones including:					
3.1 Development and delivery of a targeted high-profile and impactful communications plan around anti-racist and anti-discriminatory approach, including refreshed posters and promotional campaign. To include anti-abuse messaging in conjunction with Craig Stone work. 3.1.1 Deliver a campaign on racism, disability discrimination, HBA and reporting routes, and evaluate reach and engagement by staff group.	4	1–4	Should	Comms Team with Inclusion and Belonging Lead	Mar 2027
3.2 Share outcomes and take meaningful action from learning emerging from staff speaking up reviews, including FTSU and Dear Buki. 3.2.1 Triangulate FTSU, Dear Buki, Integrated Learning Review and WRES/WDES themes quarterly, publish learning themes, and assign owners for agreed actions.	4	2 & 3	Must	AD OD	Mar 2027
3.3 Review application of Trust Disciplinary Procedure and Trust Supporting Staff to Improve Performance Procedure through case review, taking a critical race and disability perspective. Propose and implement changes to debias process based on findings. 3.3.1 Complete quarterly equality reviews of disciplinary, capability and performance cases by ethnicity, disability, band, staff group and service.	4	1 & 3	Should	People Ops Lead / People Ops Team	Mar 2027
3.4 Begin work to review and debias access to Flexible Working and Flexible Retirement with an EDI lens. 3.4.1 Review flexible working and retirement requests, approvals and refusals by ethnicity, disability, gender, band and service, and address identified barriers.	4	1 & 3	Should	People Ops Lead	Mar 2027
3.5 Review Workplace Adjustments and Access to Work process to eliminate delays and barriers to support for differently abled colleagues. Ensure all job applicants are aware of the Trust's approach to supporting differently abled colleagues and workplace adjustments. Share guidance and raise awareness of the 'This is Me' Health Passport. Consider implementing a timeframe for all	4	3	Could	People Ops Lead and HRBPs	Jan 2027

new staff to discuss the 'This is Me' Health Passport with their line manager within an agreed number of weeks of commencing work. 3.5.1 Implement a reasonable adjustments standard with target response times, escalation routes and a follow-up check to confirm effectiveness.					
3.6 Continue to embed EDI as everyone's responsibility, core to Trust and NHS values. 3.6.1 Include WRES/WDES data in team conversations and leadership reviews, with managers agreeing one local action where disparities are identified.	4	1–4	Should	Inclusion and Belonging Lead	Mar 2027
3.7 Continue to encourage and support a culture of inclusion, openness, authenticity and psychological safety at work through development of the Trust as a great place to work for all and celebration of diverse talent. 3.7.1 From Q3 2026/27, identify teams with higher HBA, discrimination, presenteeism or lower feeling-valued scores, and provide targeted culture improvement support.	4	3	Should	OD & Inclusion Team	Ongoing
3.8 People Ops Team to proactively seek to review protected characteristics at the outset of all employee relations processes and gain agreement for these to be updated where applicable. 3.8.1 Add mandatory equality prompts at the start and closure of each employee relations case to check protected characteristics, adjustments and support needs.	2	1 & 3	Should	People Ops Lead / People Ops Team	Jan 2027
Educate for Inclusion					
4.1 Shift focus away from positive action development programmes and towards ensuring equitable access / positive skew for take-up of development and leadership development opportunities for diverse talent. Development programmes should focus on creating an inclusive working environment, educating the wider workforce for deeper understanding of inclusion and the lived experience of minoritised groups. All Trust leadership offers should include a core inclusion component geared to the audience level of responsibility.	4	1–4	Should	OD & Inclusion Team / Service Managers	Ongoing

4.1.1 From Q3 2026/27, include inclusive recruitment, reasonable adjustments, anti-racism, disability inclusion and psychological safety in all relevant leadership offers.					
4.2 Programme of education around responding effectively to incidents of abuse, discrimination and incivility, understanding race and racism, including the need for active bystander / upstander response and the mechanisms available for reporting and addressing such behaviours. 4.2.1 Develop scenario-based learning on racism, disability discrimination, HBA, incivility, reasonable adjustments and speaking up, using WRES/WDES themes.	4	1–4	Could	TBC	TBC
4.3 Deliver an Executive development session on learning from NHS discrimination cases and setting EDI objectives. 4.3.1 Include 2026 WRES/WDES findings in the Executive development session and agree Directorate-level actions for priority disparities.	3–4	1–4	Should	AD OD & Inclusion and Belonging Lead	Feb 2027
4.4 Trust Leadership Academy inclusion-themed session. 4.4.1 Use Leadership Academy sessions to build capability in interpreting WRES/WDES data and converting insight into measurable local action.	3–4	1–4	Should	TBC	Ongoing
4.5 Programme of activities to celebrate and educate around inclusion, following the national / international awareness calendar, and linking to Newsround, Exec Exchange, Combined TV, podcasts, Inclusion School, Trust / system conferences and other communications opportunities.	3–4	1–4	Should	Staff Network Leads with Inclusion and Belonging Lead	Ongoing
Race Inclusion:					
18 July – 17 August 2026					
September 2026					
October 2026					
1–7 February 2027					
Disability Inclusion:					
12 Nov – 18 Dec 2026					
16–22 March 2027					

LGBT+ Inclusion:						
February 2027	LGBT+ History Month					
June 2026	Pride Month					
Gender Equality:						
8 March 2027	International Women's Day					
4.5.1 From Q3 2026/27, link each inclusion awareness campaign to one practical improvement ask, such as disclosure, adjustments, reporting or staff network engagement.						
4.6 Build on investment in established programmes, including the HPMA Anti-Racist Leadership Programme, WRES Champions and Reciprocal Mentoring. This may involve enlisting these individuals to support the design and delivery of planned interventions. 4.6.1 Establish a delivery group with WRES Champions, Reciprocal Mentoring alumni, staff network representatives and disabled staff voices to co-design interventions.		1–4	1–4	Could	TBC	Mar 2027

Inclusion and Belonging Objectives 24-28 and EDI Goals 2026-27

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

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

1. Deliver overall continuous improvement in our actual and benchmarked performance on our Equality, Diversity and Inclusion Core Annual Responsibilities (see the action plan above) to become and sustain our position as one of the best NHS employers in relation to a range of workforce race, disability, LGBT+ and gender inclusion measures, supported by an effective accountability and monitoring framework for leaders at service level and above.
2. Make demonstrable progress in significantly reducing health inequalities for our local population, including removing barriers to equitable access, experience and outcomes through all our services and demonstrating improved health outcomes, as measured by a range of patient/service user metrics.

Advance our position as a leading inclusive organisation by improving service user and staff experience and outcomes on a wide range of inclusion measures, including across key protected characteristics groups.

4. Deliver on our ambition to truly become an inclusive, anti-racist and anti-discriminatory organisation by 2028.

Our Inclusion and Belonging Priorities for 2026-27

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

NSCHT Workforce Race Equality Standard (WRES) Report

Trust Report 2026 & Action Plan for 2026-27



Author: Janice Ogonji, NHS SCW CSU WRES and WDES Consultant

Lead Director: Frieza Mahmood, Chief People Officer

Date: 30 June 2026

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Executive summary

This report presents North Staffordshire Combined Healthcare NHS Trust's WRES submission for the 2026 reporting year, covering 1 April 2025 to 31 March 2026. It summarises workforce representation, recruitment, employee relations, training access, career progression, staff experience and Board representation, and identifies priorities for improvement in 2026/27.

Highlights

The 2026 results show progress in workforce and leadership diversity. Global Majority representation increased to 15.51%, the highest level recorded by the Trust and above the local population of 11.17%. Board representation increased to 35.71%, staff perceptions of equal opportunities improved, access to non-mandatory training remained broadly equitable, and reported discrimination from managers, team leaders or colleagues reduced significantly.

Challenges and Risks

Progress is not consistent across all indicators. Recruitment outcomes worsened, with White applicants 1.62 times more likely to be appointed from shortlisting than Global Majority applicants. Global Majority staff continued to report higher levels of harassment, bullying and abuse from patients, relatives, the public and colleagues. The disciplinary indicator also worsened, although this is based on a small number of cases and should be interpreted with caution.

Opportunities

The Trust's priority for 2026/27 is to move from improved representation to more equitable experiences and outcomes. Key opportunities include embedding the Inclusive Recruitment Toolkit, strengthening recruitment monitoring, improving senior progression through succession planning and targeted development, continuing anti-racism and Integrated Learning Review actions, and using WRES data, staff survey insight, case reviews and staff voice to target interventions and strengthen accountability.

NSCHT Workforce Race Equality Standard (WRES) Report 2026

1.0 Introduction

The Workforce Race Equality Standard (WRES) is a mandatory annual requirement under the NHS Standard Contract. The Trust is accountable to NHS England, the Care Quality Commission (CQC) and the Staffordshire and Stoke-on-Trent Integrated Care Board (ICB) for demonstrating progress in reducing race inequalities and improving workforce equality.

Introduced by NHS England in 2015, WRES provides a nationally recognised framework for measuring race equality across NHS organisations. The indicators assess workforce representation, employment processes and staff experience, enabling organisations to identify inequalities, benchmark performance and target improvement activity where disparities exist.

The Trust remains committed to creating an inclusive workplace where everyone feels valued, respected and able to reach their potential. This commitment is reflected within our Combined People Plan, Inclusion and Belonging Strategic Plan and wider organisational approach to equality, diversity and inclusion. This report represents the Trust's eleventh annual WRES submission and presents performance against the WRES indicators for the period 1 April 2025 to 31 March 2026. It includes analysis of workforce representation, recruitment, disciplinary processes, training access, career progression, staff experience and Board representation, together with the actions that will support continued improvement during 2026/27.

1.1. NSCHT WRES 2026¹ Key Highlights

1. Workforce diversity continued to increase, with the highest level of Global Majority² representation recorded by the Trust to date.
2. Representation improved across clinical, non-clinical and senior leadership roles, including continued progress in Board diversity.
3. Confidence in equal opportunities for career progression improved among Global Majority staff and remained above the national average.
4. Access to non-mandatory training and development opportunities remained equitable and continued to compare favourably with national performance.
5. Recruitment outcomes became less equitable, with a widening disparity in appointment rates between White and Global Majority applicants.
6. Global Majority staff continued to report higher levels of harassment, bullying and abuse from both patients and colleagues than White staff.
7. Reported experiences of discrimination reduced significantly during the reporting period, although disparities remain.
8. The disciplinary indicator increased during 2026; however, this measure is based on a very small number of cases and should be interpreted with caution.

Overall, the findings demonstrate continued progress in workforce representation and leadership diversity, while highlighting the need for continued focus on staff experience, recruitment equity and workplace culture.

^[1] The reporting period for WRES runs from 1 April 2025 to 31 March 2026 and will be referred to as the 2026 reporting year. In relation to Staff Survey-derived measures, these relate to the NHS Staff Survey from the previous year.

² Terminology note: This report uses "Global Majority" to describe staff from ethnically diverse backgrounds; however, the national WRES indicator terminology refers to "BME".

1.2 What have we been doing to advance the WRES over the past 12 months?

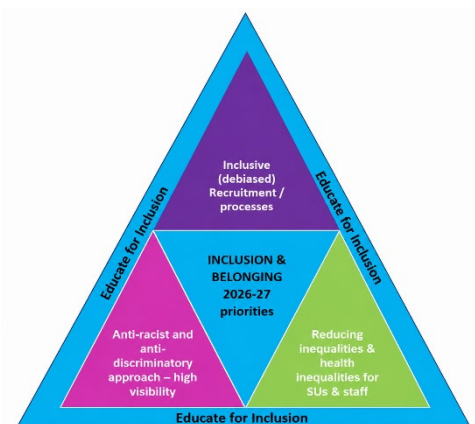
1. The Integrated Learning Review (ILR) programme began in 2024 and has progressed as a combined response to the Learning Review, Invited Review and Workforce Race Equality Reports. Its main areas of focus are inclusive recruitment, leadership values and behaviours, bank and substantive staff equity, career development for Global Majority staff, and Freedom to Speak Up/staff voice. These have agreed deliverables, KPIs, leads and completion dates monitored through the Integrated Learning Reviews Project Group and supporting project plans.
2. Increased Global Majority representation across the workforce, maintaining a workforce profile that exceeds the local population benchmark.
3. Continued to promote inclusive recruitment practices and monitor recruitment outcomes through workforce equality reporting to support fair and equitable access to employment opportunities.
4. Expanded access to coaching, mentoring and leadership development opportunities to support career progression, talent development and future leadership diversity.
5. Refreshed the Inclusion Council to strengthen leadership accountability, staff engagement and oversight of equality, diversity and inclusion priorities.
6. Delivered inclusive leadership development and awareness initiatives, including staff-led learning opportunities focused on inclusion, belonging and allyship.
7. Staff networks continued to influence policy, organisational priorities and improvement activity, ensuring staff voice remained central to decision-making and change.
8. Published ethnicity pay gap data for the second consecutive year, strengthening transparency and understanding of workforce inequalities.
9. Strengthened engagement with local communities through recruitment fairs, cultural events and stakeholder engagement activity to support inclusive recruitment and workforce representation.
10. Continued to embed lived experience into workforce and service development, ensuring diverse perspectives informed organisational improvement.
11. Developed additional support arrangements for internationally recruited colleagues and their families in response to changes in national immigration policy.
12. Promoted inclusion and belonging through key cultural and awareness events, including Race Equality Week, Black History Month, South Asian Heritage Month, Diwali, Ramadan and Eid.
13. Contributed to system-wide race equality activity through the ICS WRES Champions Collaborative, ICS Anti-Racist Toolkit and Lunch & Learn programme, shared inclusion calendar and ICS Race Celebration Event in October 2025.

Some of this work is continuing in the 2026/27 reporting period.

1.3 Our priorities

Our WRES priorities for action for 2026-27 are summarised as below:

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



development and career progression for diverse candidates. To include a focus on educating about our anti-racism approach and responding effectively to incidents of abuse, discrimination and incivility.

2.0 Trust performance over time against the 9 WRES Indicators

Indicators	Years							2026
	2019	2020	2021	2022	2023	2024	2025	
1. Workforce ethnicity profile	6.30%	7.60%	8.20%	9.10%	9.85%	11.11%	13.21%	15.51% ↑
National	19.90%	21.10%	22.40%	24.20%	26.40%	28.60%	30.70%	Not avail.
2. Recruitment measure	2.07	1.89	1.3	1.27	1.14	1.21	1.23	1.62 ↓
National	1.46	1.61	1.61	1.53	1.59	1.62	1.77	Not avail.
3. Disciplinary measure	0.88	1.39	4.35	0.00	0.00	1.83	0.41	5.38 ↓
National	1.22	1.16	1.14	1.14	1.03	1.09	1.11	Not avail.
4. Training measure	0.68	0.78	0.67	0.47	0.83	1.00	0.78	0.83 ↓
National	1.15	1.14	1.14	1.12	1.12	1.06	1.02	Not avail.
5. HBA from patients / public	54.50%	42.00%	27.30%	30.10%	40.50%	30.21%	39.47%	40.99% ↓
White	27.40%	29.88%	27.60%	29.00%	26.00%	24.60%	21.75%	21.38% ↑
6. HBA from staff	21.20%	24.50%	16.70%	23.30%	22.10%	20.83%	23.01%	24.53% ↓
White	14.70%	17.10%	15.40%	13.60%	16.90%	16.13%	16.22%	15.93% ↑
7. Belief in Equal Opportunities	30.30%	40.82%	53.60%	61.60%	67.40%	62.77%	51.75%	59.12% ↑
White	58.70%	60.97%	67.90%	70.00%	68.20%	67.33%	68.03%	64.11% ↓
8. Discrimination at work	3.30%	12.77%	12.50%	14.90%	12.80%	15.96%	19.47%	11.46% ↑
White	4.70%	4.79%	4.30%	3.60%	5.20%	4.76%	5.77%	5.44% ↑
9. Board Membership	14.30%	23.10%	21.40%	20.00%	14.30%	21.43%	30.77%	35.71% ↑
National	8.40%	10.00%	12.60%	14.00%	15.60%	16.50%	17.30%	Not avail.

The data presents a mixed picture of progress and continuing challenge. Positive improvements are evident in workforce diversity, Board representation, perceptions of equal opportunity, and reductions in reported discrimination. However, disparities remain evident across recruitment outcomes, workplace experience, harassment, and disciplinary processes.

Key	
NSCHT	Improved ↑
National	Declined ↓
NSCHT White	Declined ↓

Table 1: WRES indicator trends for NSCHT between 2019 and 2026

2.1 Strategic alignment with organisational and national frameworks

This mapping demonstrates that the Trust's WRES priorities are embedded within wider organisational and NHS workforce objectives, rather than operating as standalone equality initiatives. It provides a clear link between race equality, workforce transformation, staff experience and organisational performance.

Aligning WRES priorities with the [NHS Long Term Workforce Plan](#), [NHS 10 Year Health Plan](#), [NHS England's EDI Improvement Plan](#) and the Trust's People Strategy strengthens accountability, supports targeted improvement and ensures race equality remains central to workforce planning and decision-making. Ultimately, improving race equality is essential to creating fairer recruitment and progression processes, reducing inequalities in staff experience, strengthening inclusive leadership and building a diverse workforce that can meet the needs of our communities.

Strategic Priority	Alignment with our WRES Priorities
NHS Long Term Workforce Plan	Supports Priority 1 (Debiasing People Processes) through fair recruitment, progression and talent management, Priority 3 (Reducing Workforce Inequalities) through improved staff experience and retention, and Priority 4 (Educating for Inclusion) through leadership development and inclusive workforce practices.
NHS 10 Year Health Plan Ambitions	Supports the development of a representative, inclusive and sustainable workforce capable of delivering community-focused, preventative and person-centred care. WRES priorities contribute to reducing inequalities, improving staff experience and strengthening organisational culture.
NHS England EDI Improvement Plan	Directly aligns with all four WRES priorities through its focus on inclusive recruitment, leadership accountability, reducing discrimination, improving staff experience, addressing workforce inequalities and embedding EDI within organisational decision-making.
Our People 'Big Moves'	1. Workforce Optimisation: Priority 1 supports fair recruitment, retention, progression and workforce effectiveness. 2. Workforce Transformation: Priorities 1 and 3 support workforce planning, organisational learning and reducing workforce inequalities through the Integrated Learning Review and workforce intelligence. 3. Our Combined CARE Culture: Priorities 2 and 4 support anti-discriminatory practice, inclusive leadership, staff voice, belonging and a positive workplace culture.
Combined People Plan 2023–28	1. Inclusive and Representative: Priorities 1 and 3 improve workforce diversity and reduce inequalities. 2. Great Place to Work: Priority 2 supports staff experience, belonging and psychological safety. 3. Achieve Potential and Aspirations: Priorities 1 and 4 support career progression, leadership development and equitable access to opportunities. 4. Outstanding Systems and Processes: Priority 1 focuses on reducing bias within workforce processes and decision-making.

3.0 Trust performance breakdown by the 9 WRES indicators

Indicator 1: Workforce ethnicity profile (Improved)

The workforce remains predominantly White British, with 1,686 staff (81.0%) identifying within this ethnic group. The largest Global Majority groups are Black or Black British African (143 staff, 6.9%), Asian or Asian British Indian (48 staff, 2.3%), and Asian or Asian British Pakistani (33 staff, 1.6%). This range of diversity accounts for approximately 15.5% of the workforce, indicating a reasonable level of ethnic diversity compared with many NHS organisations, although representation is concentrated within a relatively small number of ethnic groups.

Several ethnic groups have very small numbers of staff, with many categories containing fewer than 10 individuals. This suggests that while the workforce includes a broad range of ethnic backgrounds, representation for some communities remains limited. The 20 staff recorded as "Not Known" (1.0%) also indicate a small opportunity to improve workforce data completeness.

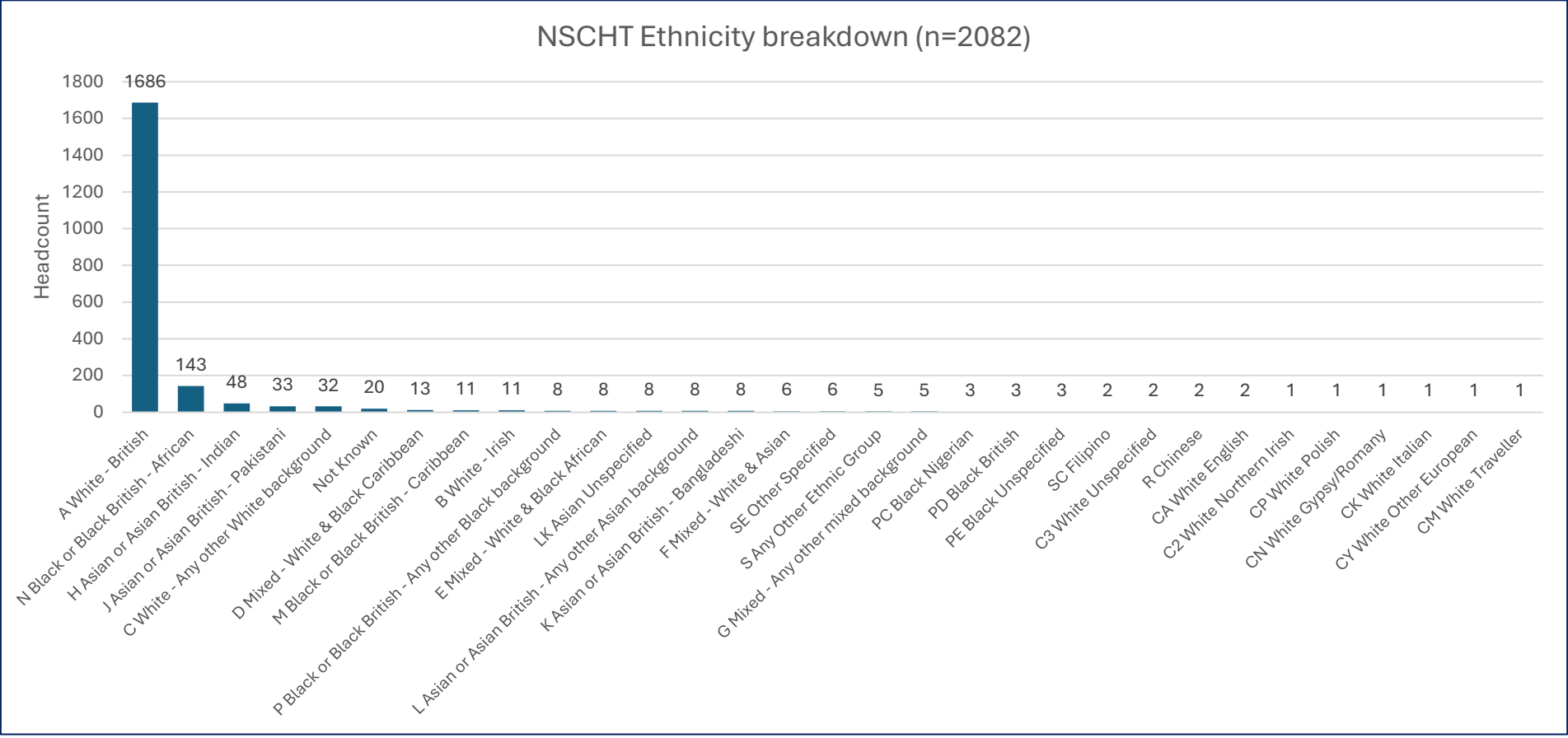


Figure 2: Total Headcount

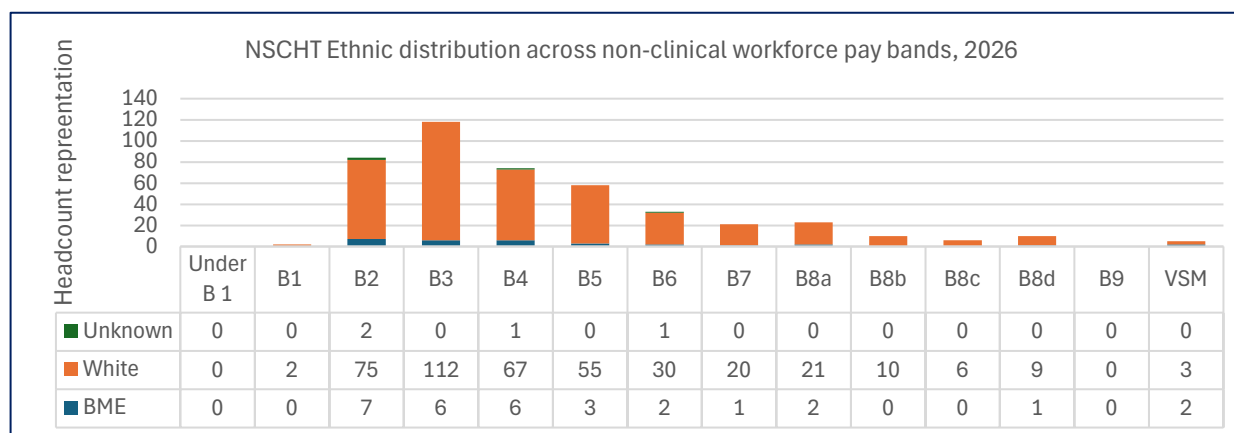
3.1 Progress in workforce representation in clinical and non-clinical roles

Workforce Measure - Ethnic Diversity (GMH)	2025	2026	Progress
Overall Trust Workforce	13.21%	15.51%	+2.30%
...Medical & Dental Workforce	60.27%	64.56%	+4.29%
...Overall Workforce excl. Medical & Dental	11.43%	13.58%	+2.15%
...Non-Clinical Workforce	6.09%	6.76%	+0.67%
...Clinical Workforce excl. Medical & Dental	13.11%	15.52%	+2.41%

Global Majority representation increased from 13.21% in 2025 to 15.51% in 2026, the highest level recorded by the Trust. Diversity also increased across all workforce groups, including Medical and Dental staff (60.27% to 64.56%), the clinical workforce excluding Medical and Dental staff (13.11% to 15.52%), and the non-clinical workforce (6.09% to 6.76%).

The Medical and Dental workforce has a significant impact on the Trust's overall diversity profile because 64.56% of staff in this group identify as Global Majority heritage, compared with 13.58% across the workforce excluding Medical and Dental staff. As a result, the overall Trust figure (15.51%) is higher than the diversity rate for the wider workforce (13.58%).

Table 2: Representation of Global Majority Staff



This distribution is reflected across the non-clinical pay bands, where Global Majority representation remains relatively low at all levels. Most Global Majority staff are concentrated within Bands 2 to 4, with 7 staff at Band 2, 6 at Band 3 and 6 at Band 4. Representation reduces further through the middle grades, with only 3 staff at Band 5, 2 at Band 6, 1 at Band 7, and 2 at Band 8a.

Figure 3: Trust Non-Clinical Staff as at 31 March 2026, based on ESR data.

At the most senior non-clinical levels, representation remains limited, with no Global Majority staff at Bands 8b, 8c or Band 9, and 2 staff at VSM level. While there is evidence of representation across a range of grades, the data highlights that ethnic diversity remains concentrated in lower and middle bands, with under-representation persisting in senior non-clinical leadership and management roles. This suggests that continued focus is needed on progression, talent management and succession planning to improve representation at senior levels.

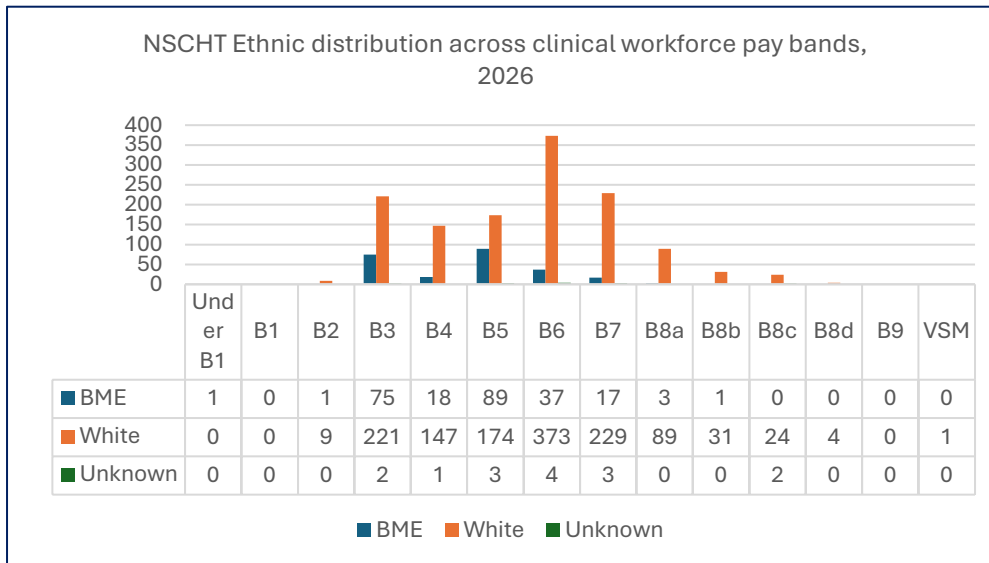


Figure 4: Trust Clinical Staff as at 31 March 2026, based on ESR data.

In contrast to the non-clinical workforce, Global Majority representation is more visible across the clinical workforce and is present throughout much of the career pathway. The highest numbers are seen in Bands 3 and 5. Representation is also evident at Bands 4, 6 and 7, indicating greater diversity across frontline and registered clinical roles. However, representation declines at senior clinical grades. There are only 3 Global Majority staff at Band 8a, 1 at Band 8b, and no Global Majority staff at Bands 8c, 8d, Band 9 or VSM level. While the clinical workforce demonstrates stronger ethnic diversity than the non-clinical workforce overall, the data suggests that progression into the most senior clinical leadership positions remains limited. This mirrors the pattern seen in non-clinical roles and highlights the importance of continued focus on talent management, succession planning and leadership development to improve representation at senior levels.

3.2 Trust Bank Ethnicity Profile

The Trust's bank workforce is considerably more ethnically diverse than the substantive workforce. Of the 245-bank staff, 117 (47.8%) identify as Global Majority heritage, compared with 326 of 2,094 substantive staff (15.6%). White staff account for 49.8% of the bank workforce compared with 83.5% of the substantive workforce. This may reflect different recruitment pathways, workforce supply patterns, flexibility preferences, or barriers to substantive employment.

This difference is largely driven by the composition of the clinical workforce. Within the bank workforce, Global Majority staff represent:

- 69 of 133 (51.9%) Additional Clinical Services staff.
- 28 of 36 (77.8%) Medical and Dental staff.
- 13 of 47 (27.7%) Registered Nursing and Midwifery staff.

In contrast, within the substantive workforce, Global Majority representation is:

- 109 of 557 (19.6%) Additional Clinical Services staff.
- 51 of 79 (64.6%) Medical and Dental staff.
- 95 of 637 (14.9%) Registered Nursing and Midwifery staff.

The most notable difference is within Additional Clinical Services, where over half of bank staff are from Global Majority backgrounds compared with around one fifth of substantive staff. This suggests the Trust relies disproportionately on Global Majority staff within its temporary workforce. The findings highlight an opportunity to better understand the transition between bank and substantive roles and whether there are opportunities to convert more ethnically diverse bank staff into permanent employment, particularly in clinical roles where representation is strongest.

3.3 WRES Aspirational Target

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

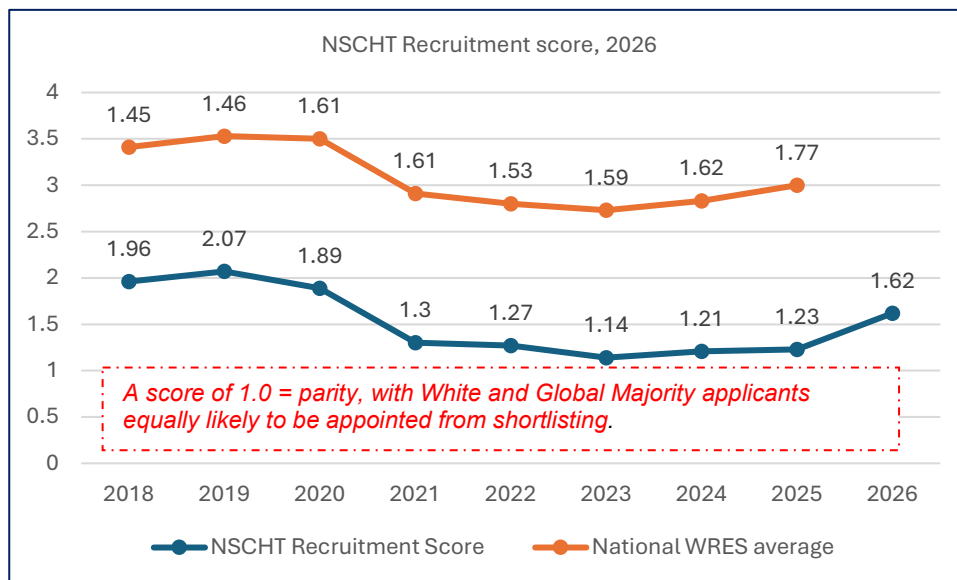
In 2025, we updated our Trust's 2028 Aspirational Target using the latest data from the 2021 Census, which shows that 11.17% of our local population is from ethnically diverse backgrounds. The revised target is shown in Table 3.

Existing Profile: Trust Band 8a-8d establishment as at 31.03.26				Aspirational profile in non-clinical roles (by 2028); based on local population rate of 11.17%: Planned Equitable Distribution in 2028				
Banding / Equivalent	Global Majority	White	Total		Global Majority	White	Total	No. of ethnically diverse appointments needed to be equitable
Band 8A	2	21	23		3	23	26	+1 Global Majority Heritage colleague (2025: +1)
Band 8B	0	10	10		1	8	9	+1 Global Majority Heritage colleague (2025: +1)
Band 8C	0	6	6		1	5	6	+1 Global Majority Heritage colleague (2025: +1)
Band 8D	1	9	10		1	7	8	Aspiration met
TOTAL	3	46	49		6	44	50	+3 Global Majority Heritage 8A-D colleagues (+4) required

Table 3: Trust 2026 Workforce Profile compared to Aspirational Target Workforce Profile (by 2028)

Representation at senior non-clinical grades remains below the level expected based on the local population. Achieving the 2028 aspirational profile would require three additional Global Majority appointments across Bands 8a to 8c, providing a realistic and measurable target for improving leadership diversity.

Indicator 2: Recruitment measure (Worsened)



The Trust's recruitment indicator improved from 2.07 in 2019 to 1.14 in 2023, indicating a reduction in recruitment disparities. However, performance has deteriorated since then, increasing to 1.62 in 2026, up from 1.23 in 2025.

This means White applicants were 1.62 times more likely to be appointed from shortlisting than Global Majority applicants. Although the Trust remains below the latest national average of 1.77 (2025), the widening gap represents a significant setback in recruitment equity.

As shown in Table 4, the diversity of the applicant pool is not reflected in appointment outcomes. While Global Majority candidates account for almost half of all applications, they represent fewer than one in five appointments, indicating a significant disparity in recruitment outcomes.

Figure 1: Trust Recruitment Measure trend from 2018 to 2026. National WRES Average for 2025 has not been published yet.

The recruitment data shows:

Headcount and Percentages				Headcount and Percentages			
2025	Application	Shortlisted	Appointed	2026	Application	Shortlisted	Appointed
Global Majority Heritage	3255 (57.33%)	464 (36.73%)	158 (35.1%)	Global Majority Heritage	1702 (48.9%)	247 (27.8%)	61 (19.1%)
Not disclosed	77 (1.3%)	17 (1.3%)	14 (2.80%)	Not disclosed	64 (1.8%)	17 (1.9%)	10 (3.1%)
White	2345 (41.30%)	782 (62%)	327 (65.53%)	White	1713 (49.2%)	623 (70.2%)	249 (77.8%)
Total	5677 (100%)	1263 (100%)	499	Total	3479 (100%)	887 (100%)	320 (100%)

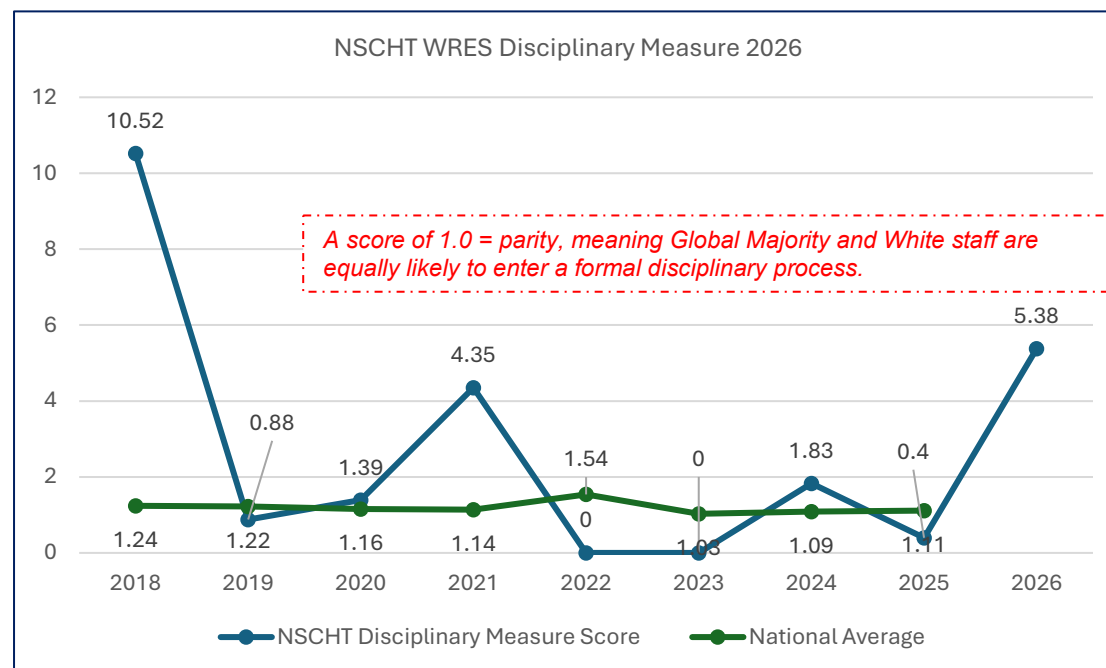
Table 4: Trust 2025 and 2026 appointment rates for different ethnicities.

applicants were substantially more likely to progress through the recruitment process and be appointed than applicants from Global Majority backgrounds.

- Global Majority applicants represented 48.9% of all applications, almost equal to White applicants (49.2%). However, their representation fell to 27.8% of shortlisted candidates and 19.1% of appointments.
- White applicants accounted for 49.2% of applications but increased to 70.2% of shortlisted candidates and 77.8% of appointments.

This pattern is consistent with the WRES recruitment indicator of 1.62, showing that White

Indicator 3: Disciplinary measure (Worsened)



The Trust's disciplinary indicator increased from 0.41 in 2025 to 5.38 in 2026, indicating that Global Majority staff were over five times more likely than White staff to enter a formal disciplinary process during the reporting period. This represents the highest score recorded since 2021 and suggests a significant disparity in outcomes.

However, this indicator should be interpreted with caution. The measure is based on a very small number of disciplinary cases, meaning that a small change in the number of cases involving either staff group can result in large year-on-year fluctuations. This volatility is reflected in the Trust's historical data, where scores have ranged from 0.00 to 10.52 over the reporting period. Because of these limitations, the indicator is less useful for assessing long-term trends in smaller organisations and should be considered alongside qualitative information, case reviews, and broader workforce data rather than in isolation.

Figure 6: WRES Disciplinary Measure, year-on-year performance. National average for 2026 was not available at the time of reporting.

It is also important to note that **NHS England no longer publishes a national disciplinary benchmark for this indicator**. This reflects concerns that the measure can be difficult to compare reliably across NHS organisations of different sizes, particularly where disciplinary case numbers are low and subject to significant annual variation.

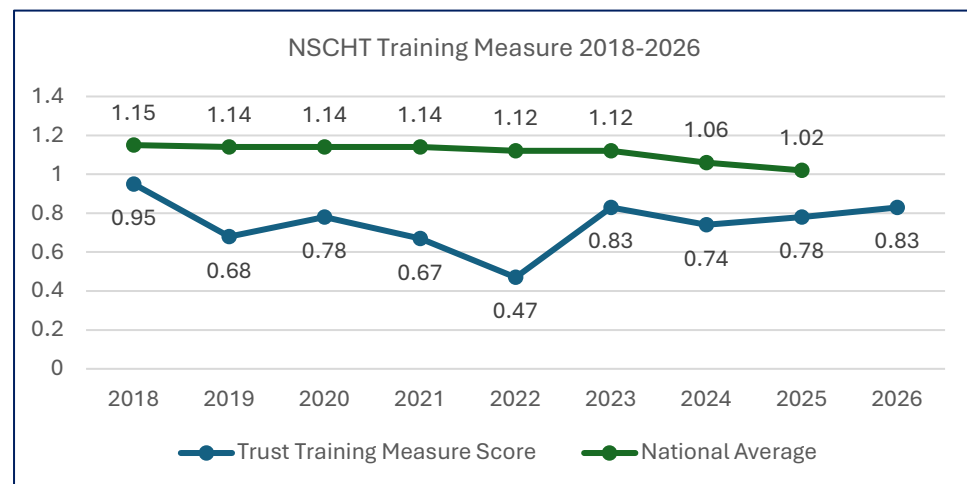
Formal disciplinary cases decreased from 17 in 2025 to 6 in 2026. However, cases involving Global Majority staff increased from 1 to 3, while cases involving White staff fell from 16 to 3. As a result, Global Majority staff accounted for 50.0% of disciplinary cases in 2026, compared with 5.9% in 2025. Given the very small number of cases, these figures should be interpreted with caution, as a change of one or two cases can significantly affect the overall indicator.

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

Table 5: Trust Disciplinary cases by ethnicity 2025 & 2026

	Disciplinary cases	
	2025	2026
Global Majority Heritage	1	3
White	16	3
Ethnicity not known	1	0
TOTAL CASES	17	6

Indicator 4: Training measure (Improved)

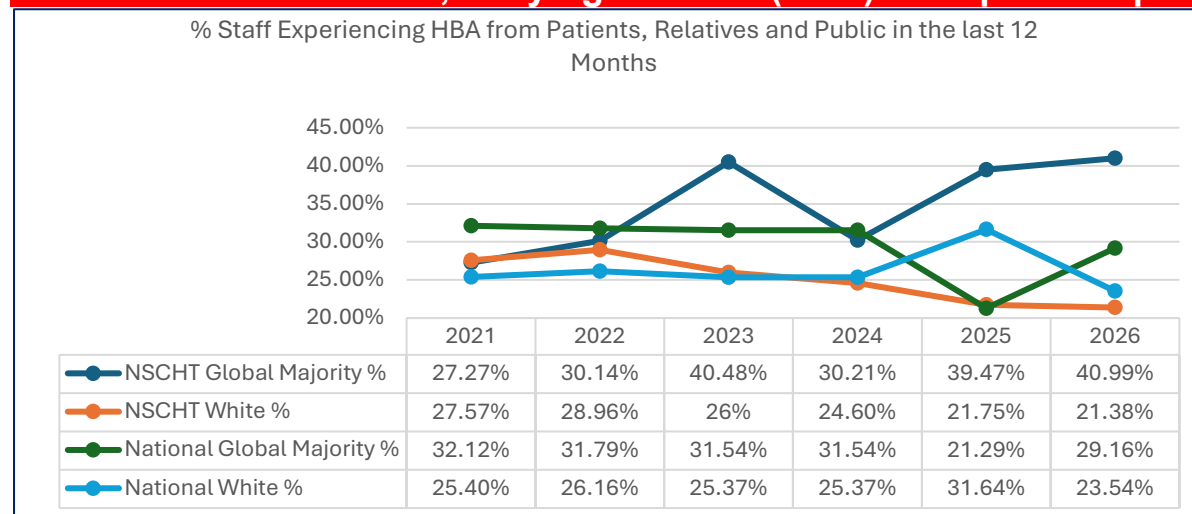


This measures the relative likelihood of White staff compared with Global Majority staff accessing non-mandatory training and continuing professional development (CPD). A score of 1.0 means both groups are equally likely to access training opportunities.

The Trust's score increased from 0.78 in 2025 to 0.83 in 2026, continuing the improvement seen since the low point of 0.47 in 2022. The score remains below 1.0, indicating that Global Majority staff continue to report slightly greater access to non-mandatory training and CPD than White staff. The Trust has consistently performed better than the national average throughout the reporting period. This suggests that access to training and development opportunities is generally equitable and may be more favourable for Global Majority staff than is seen nationally.

Figure 7: WRES Training Measure, year-on-year performance. National average for 2026 was not available at the time of reporting.

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

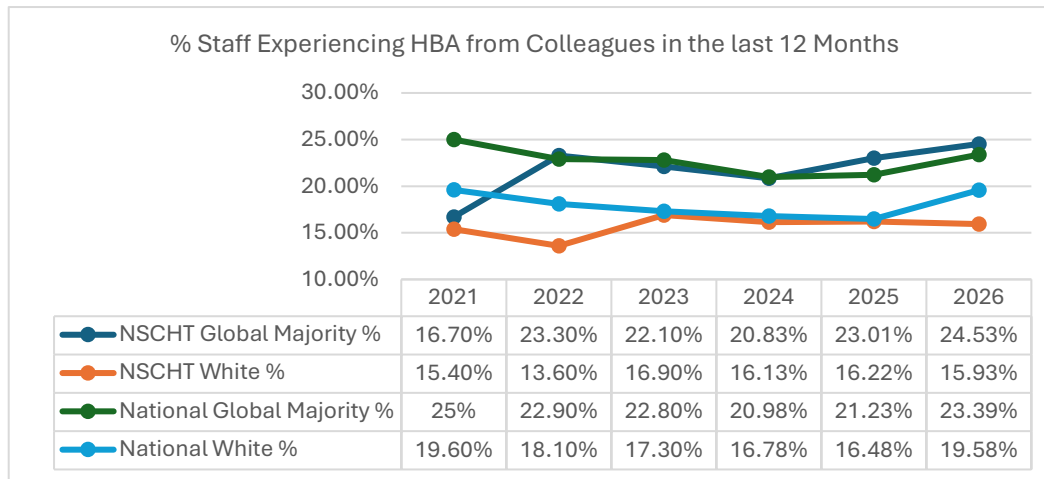


In 2026, 40.99% of Global Majority staff reported experiencing harassment, bullying or abuse (HBA) from patients, relatives or the public, compared with 21.38% of White staff, a gap of 19.61%. The rate for Global Majority staff increased slightly from 39.47% in 2025, while the rate for White staff remained broadly unchanged (21.75% to 21.38%).

The Trust also performs worse than the national average, where 29.16% of Global Majority staff and 23.54% of White staff reported experiencing HBA in 2026. Global Majority staff at the Trust are therefore almost twice as likely as White staff to experience HBA from patients, relatives and the public, with the disparity remaining significantly higher than the national position.

Figure 2: WRES HBA from patients/public Measure, year-on-year performance, Staff Survey 2025.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (Worsened)

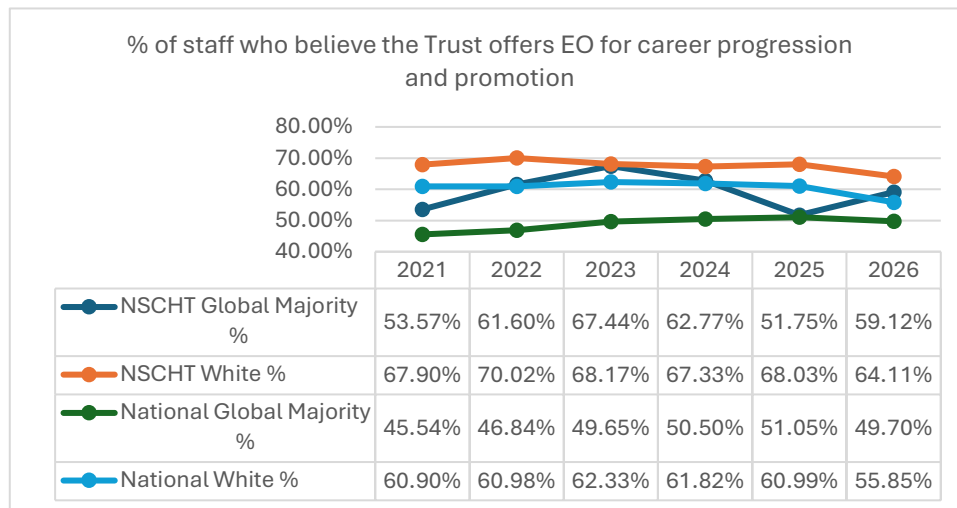


In 2026, 24.53% of Global Majority staff reported experiencing harassment, bullying or abuse (HBA) from colleagues, compared with 15.93% of White staff, a gap of 8.60%. This represents an increase for Global Majority staff from 23.01% in 2025, while the rate for White staff remained relatively stable (16.22% to 15.93%).

The Trust's result for Global Majority staff is also slightly higher than the national average of 23.39%, while the rate for White staff is lower than the national average of 19.58%. As a result, Global Majority staff are approximately 1.5 times more likely than White staff to experience HBA from colleagues, demonstrating a persistent inequality in workplace experience that remains greater than the national position.

Figure 9: WRES HBA from staff Measure, year-on-year performance, Staff Survey 2025.

Indicator 7 - Belief in equal opportunities for career progression (Improved)

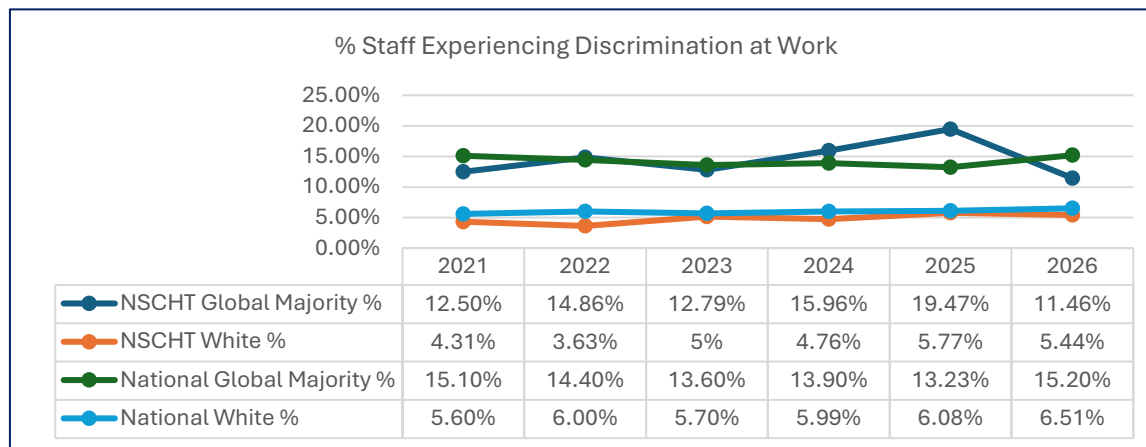


In 2026, 59.12% of Global Majority staff believed the Trust provides equal opportunities for career progression and promotion, compared with 64.11% of White staff, a gap of 4.99 percentage points. This represents a notable improvement from 51.75% in 2025 and continues the overall upward trend since 2021, when the figure stood at 53.57%. Despite this progress, Global Majority staff remain less likely than White staff to perceive opportunities for progression as equitable.

The Trust continues to perform above the national average, where 49.70% of Global Majority staff and 55.85% of White staff reported believing there were equal opportunities for career progression. This suggests that actions to improve inclusive career development are having a positive impact. However, the remaining disparity demonstrates that further work is needed to ensure all staff have equal confidence in progression and promotion opportunities.

Figure 10: WRES Equal Opportunities Measure, year-on-year performance, Staff Survey 2025

Indicator 8 - Staff experiencing discrimination from other staff (Improved)



In 2026, 11.46% of Global Majority staff reported experiencing discrimination at work from a manager, team leader or colleagues, compared with 5.44% of White staff, a gap of 6.02 percentage points. This represents a significant improvement from 2025, when 19.47% of Global Majority staff reported discrimination, although they remain more than twice as likely as White staff to experience discrimination at work.

The Trust performs better than the national average, with 11.46% of Global Majority staff reporting discrimination compared with 15.20% nationally. White staff also reported lower levels of discrimination than the national average

(5.44% compared with 6.51% nationally). Overall, the data show a marked improvement in staff experience during 2026. However, the continued disparity between Global Majority and White staff indicates that reducing discrimination and creating a consistently inclusive working environment remains a key priority.

Indicator 9: Trust BME Board membership (Improved)

Indicator 9: Trust Board Representation	Global Majority	White	Global Majority	White
	Headcount		%	%
Total board members	5	9	35.71%	64.29%
of which : Voting members	3	4	42.86%	57.14%
: Non-Voting Board members	2	5	28.57%	71.43%
of which: Exec Board members	2	5	28.57%	71.43%
Non-Executive	3	4	42.86%	57.14%

Table 6: Global Majority Board Membership at NSCHT, 31 March 2026.

From 2016 to 2026, Global Majority representation on the Board increased from 7.7% to 35.71%, an overall rise of 28.01 %, demonstrating substantial progress in board diversity over the decade. While representation declined from 23.1% in 2020 to 14.3% in 2023, it subsequently recovered strongly, reaching 30.77% in 2025 and 35.71% in 2026. In 2025, Board representation was approximately 13.6 % higher than the national WRES average (30.77% vs 17.2%).

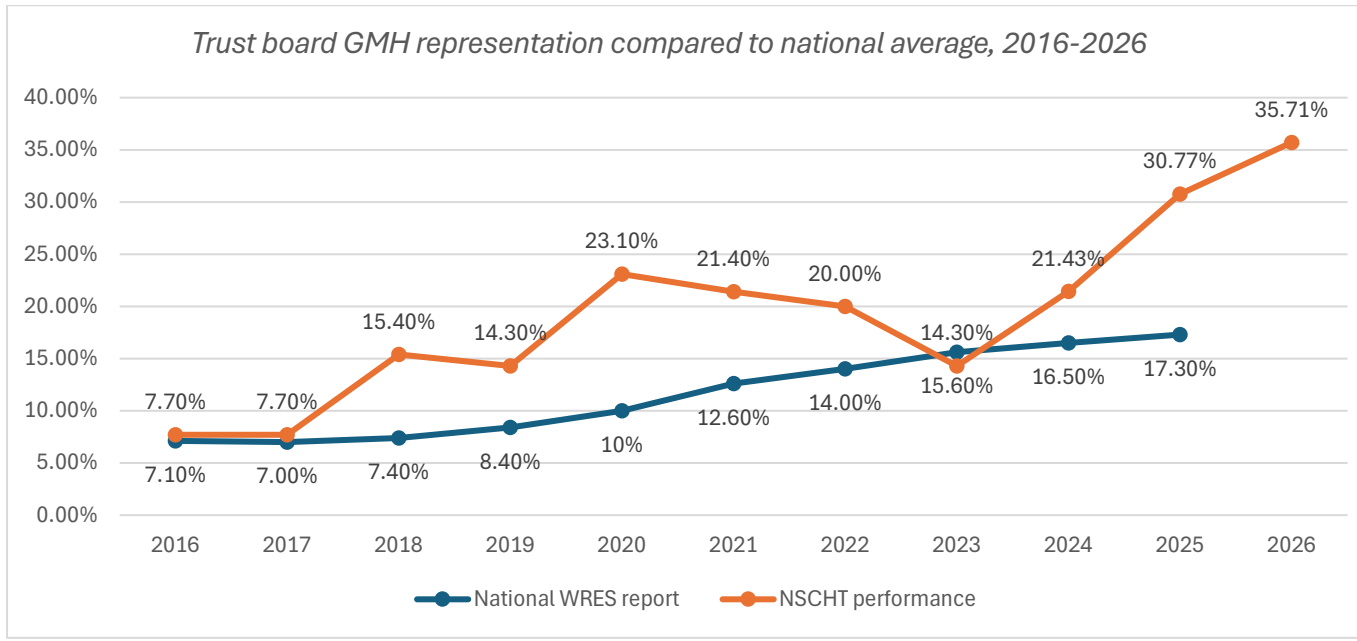


Figure 12: Trust board Global Majority representation compared to national average, 2016-2026 (National WRES data for 2026 was not available at the time of reporting)

4.0 Priorities, supporting actions and milestones for 2026/27

The table below sets out the Trust's WRES priorities for 2026/27 and shows how each priority will be taken forward. These priorities are based on, and aligned to, the Trust's broader Inclusion and Belonging Strategic Plan priorities for 2024–2028, ensuring that WRES activity supports the organisation's wider inclusion, belonging and equality objectives.

Priority	Supporting actions	Milestones / evidence of progress
1. Debiasing people processes	• Embed inclusive recruitment practice and the Inclusive Recruitment Toolkit. • Review recruitment, progression, employee relations and reasonable adjustment processes through a race equity lens.	• Recruitment outcomes reviewed by ethnicity and reported through governance. • Improvement actions agreed and monitored through WRES and ILR routes. • Inclusive recruitment and progression actions reflected in the ILR project plan.
2. High-visibility anti-racist and anti-discriminatory approach	• Use WRES, Staff Survey, FTSU and ENRICH staff network insight to identify priority issues. • Co-design local responses with staff voice representatives. • Continue anti-racism, anti-discrimination and staff voice activity.	• Hotspot analysis completed for discrimination, bullying and harassment themes. • Local response plans agreed for priority areas. • Progress reported through ILR, WRES and People governance routes.
3. Reducing workforce and health inequalities	• Use workforce equality data to target action on representation, development, progression and staff experience. • Review support for internationally recruited staff and Global Majority colleagues. • Strengthen monitoring of bank and substantive staff equity through ILR workstreams.	• EDI dashboard and ethnicity pay gap findings reviewed and translated into actions. • Bank and substantive staff equity actions tracked through ILR project plans. • Progress evidenced through agreed KPIs and reporting dates.
4. Educating for Inclusion	• Align inclusive leadership, anti-racism and upstander education with ILR findings, MALD standards and the Mann Review. • Embed inclusion and belonging principles within leadership and management programmes. • Equip managers to respond to discrimination, inequity, bullying, harassment and incivility.	• Leadership learning offer updated to reflect ILR, MALD and Mann Review requirements. • Relevant learning sessions delivered and evaluated. • Training uptake and impact reviewed through OD, ILR and WRES reporting.

5.0 Conclusions

The 2026 WRES results demonstrate continued progress in increasing ethnic diversity across the Trust. Global Majority representation has reached its highest level to date at 15.51%, exceeding the local population benchmark, while Board diversity has increased significantly over recent years. Staff perceptions of equal opportunities for career progression have also improved and remain above the national average. These achievements indicate that efforts to improve representation, leadership diversity and inclusive career development are having a positive impact. The Trust is increasingly reflective of the communities it serves and continues to make progress against national NHS workforce equality objectives.

However, the data also highlights a number of persistent inequalities. Recruitment outcomes deteriorated during 2026, with White applicants 1.62 times more likely to be appointed from shortlisting than Global Majority applicants. Global Majority staff remain more likely to experience harassment, bullying and abuse from patients, relatives, the public and colleagues, and continue to report higher levels of discrimination than White staff, despite significant improvement during the reporting period. The disciplinary indicator also showed a marked increase. Although this measure is based on a very small number of cases and should be interpreted cautiously, it reinforces the importance of ongoing scrutiny of workforce processes and outcomes.

Taken together, the findings suggest that the Trust's challenge is no longer primarily one of representation. The key priority is ensuring that increased diversity is matched by equitable experiences, opportunities and outcomes throughout employment. This requires a sustained focus on workplace culture, inclusive leadership, recruitment, progression and staff voice.

5.1 Recommendations

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

- Note the findings of the 2026 WRES report and the progress made in improving workforce and leadership diversity.
- Recognise the areas of continued concern, particularly disparities in recruitment outcomes and the experiences of bullying, harassment, abuse and discrimination reported by Global Majority staff.
- Support the delivery of the 2026/27 WRES priorities, with a focus on improving recruitment equity, career progression, staff experience and leadership accountability.
- Seek assurance that actions are in place to address identified inequalities and progress is monitored through regular workforce equality reporting.
- Champion inclusive leadership and organisational culture, ensuring equality, diversity and inclusion remain integral to workforce planning, decision-making and service delivery.
- Support ongoing engagement with networks and representatives to ensure improvement activity is informed by staff experience and lived reality.
- Monitor progress against agreed actions and outcomes through the People and Culture Development Committee, ensuring accountability for delivering measurable improvements in workforce equality.

APPENDIX 1: Progress Report: WRES Action Plan 2026/27 aligned to NSCHT People Priority Areas and the NHS 10 Year Plan

This mapping demonstrates that race equality is embedded within the Trust's wider workforce and organisational priorities rather than being a standalone initiative. The Trust's WRES programme supports delivery of the People Big Moves by improving recruitment, career progression, staff experience, leadership and organisational culture, while also contributing to NHS priorities around workforce sustainability, retention, inclusion and reducing inequalities. Aligning WRES activity with these strategic objectives strengthens accountability, helps target improvement efforts more effectively and ensures race equality remains central to building a diverse, inclusive and high-performing workforce.

Our WRES Priorities	Progress and achievements in 2025/26	People Big Move Alignment	NHS 10 Year Health Plan Alignment
1. Debiasing people processes	• Inclusive Recruitment Toolkit and Development Programme • Review of Band 8A+ progression barriers • Inclusive recruitment monitoring and workforce equality reporting • Leadership development opportunities e.g. Leadership Academy, Anti-Racist Leadership Toolkit and Lunch & Learn sessions, The Launchpad Programme • Publication of ethnicity pay gap data • Review of workforce processes through the ILR	Workforce Optimisation: Improves recruitment, retention, progression and workforce effectiveness through fairer people processes.	Neighbourhood Health Service & Workforce Reform: Supports a skilled, representative workforce and fair access to career opportunities.
2. High visibility anti-discriminatory approach	• Anti-Racism Toolkit and monthly learning sessions • Integrated Learning Review Working Group • Inclusion Council refresh • Staff networks influencing policy and improvement activity • Cultural awareness events and campaigns • Support for internationally recruited colleagues • System wide - ICS WRES Champions Collaborative, ICS Anti-Racist Toolkit and shared race inclusion events.	Our Combined CARE Culture: Strengthens organisational culture, leadership accountability, belonging and psychological safety.	From Treatment to Prevention: Promotes healthier workplaces, reduces discrimination and improves staff wellbeing and retention.
3. Reducing workforce and health inequalities	• Workforce equality dashboard monitoring • Ethnicity pay gap reporting • Support for internationally recruited staff • Community engagement and recruitment fairs • Increased Global Majority representation across the workforce • Embedding lived experience into workforce development	Workforce Transformation: Uses workforce intelligence and population insight to inform workforce planning and organisational development.	Reducing Health Inequalities: Supports fair employment opportunities and addresses inequalities experienced by underserved groups.
4. Educating for inclusion	• Anti-racism education programme • Inclusive leadership development • Reciprocal mentoring, coaching and mentoring opportunities • Leadership podcasts and inclusion learning events • Race Equality Week, Black History Month, South Asian Heritage Month, Ramadan, Eid and Diwali activities • Leadership and management capability development	Our Combined CARE Culture: Develops inclusive leadership behaviours and creates an environment where diverse staff can thrive.	Workforce Culture and Leadership: Supports compassionate leadership, inclusion, staff engagement and retention.

APPENDIX 2: Inclusion and Belonging Action Plan 2026/27

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

Action	Links to Equality Objectives 24–28	Links to 26/27 EDI Goals	Must / Should / Could	Action Lead	RAG rating (as at 06.26)
Deliver key milestones to implement, ensure and embed an effectively debiased inclusive recruitment process change programme					
1.1 Develop Inclusive Recruitment Toolkit and Inclusive Recruitment Development package utilising theory / approach of 'No More Tick-Boxes' and 'If Your Face Fits' (Kline, 2023). 1.1.1 Audit Toolkit use across all recruitment panels by service, role type and band, and report whether Global Majority and disabled applicant outcomes have improved.	4	1	Must	Recruitment Lead	Oct 2026
1.2 Undertake analysis of applications-shortlisting/interview-appointment for posts at band 8A and above to better understand the issues / reasons behind lack of diversity in appointments at this level, and implement action based on findings. 1.2.1 Complete Band 8A+ recruitment analysis by ethnicity, disability, gender and LGB+ status at shortlisting, interview and appointment, with actions for each identified disparity.	4	1	Should	People Team	Dec 2026
1.3 Respond effectively to feedback from staff about experiences of recruitment process from a protected characteristics perspective. 1.3.1 Collect candidate and recruiting manager feedback on fairness, accessibility, adjustments and inclusion, and report themes quarterly through the HR / EDI Dashboard.	4	1	Should	HR Lead	Oct 2026
1.4 Develop a plan to roll out Inclusive Recruitment development, considering the needs of both new recruiting managers and existing recruiting managers.	4	1	Should	Recruitment Lead	Dec 2026

1.4.1 Prioritise rollout to services with poorer recruitment equity indicators, lower senior representation or repeated recruitment feedback, and require completion before managers chair panels.					
Reducing inequalities and health inequalities for our service users and staff					
2.1 All services to undertake a review of service user access analysed with a race lens in 2026/27 and present findings to Directorate committee. Three services to do deeper review via EDS framework – see 2.5 below. 2.1.1 Each Directorate to complete one service-user access review using race and disability data, agree two local actions, and report progress through Directorate governance.	2 & 3	2	Should	All Service Leaders	Mar 2027
2.2 Equitable access to health and wellbeing offers for all staff. Review take-up by colleagues with diverse characteristics. 2.2.1 Analyse health and wellbeing offer take-up by ethnicity, disability, staff group, band and service, and agree targeted actions for any under-represented groups.	2	2	Should	Health and Wellbeing Lead	Dec 2026
2.3 Implement new guidance on recording gender codes in Electronic Patient Record (Lorenzo) and in Electronic Staff Record when available. When in place, analyse the data and identify next steps. 2.3.1 Deliver guidance for staff recording demographic information in Lorenzo and ESR, and complete one data quality review with improvement actions.	1	2	Must	Performance Lead / Head of Clinical Systems	Dec 2026
2.4 Launch and embed new guidance and approach to RADF (Reasonable Adjustment Digital Flag), as mandated through ISN re-recording disability / accessible information needs in Electronic Patient Record. 2.4.1 Implement RADF guidance with a named operational owner, track adoption across services, and escalate barriers through governance.	1	2	Must	TBC	Dec 2026
2.5 Three services to be reviewed and rated under the EDS framework for 2026/27, including detailed review of access, experience, safe from harm and outcomes. 2.5.1 Select three EDS review services using WRES/WDES risk indicators, complete ratings, and agree improvement plans for access, experience, safety and outcomes.	1	2	Must	Identified Service Managers / Inclusion and Belonging Lead	Mar 2027

2.6 Review business case for AccessAble and make decision on potential extension for years 4 and 5. If approved, commission inclusion of Keele Medical Practice and consider inclusion of Lawton House into surveyed premises. 2.6.1 Complete the AccessAble surveys and re-surveys.	4	2	Should	Inclusion and Belonging Lead	Nov 2026
2.7 Support inclusive talent management and career development / progression for all through promotion of career development workshops and career conversations. This offer to be specifically targeted to staff with diverse characteristics, with a focus on race and disability, and encouraging take-up of coaching and mentoring by colleagues with diverse characteristics. 2.7.1 Monitor career workshop, mentoring and coaching participation by ethnicity, disability, band and service, and agree actions where take-up is low.	4	1 & 2	Should	OD Talent Lead	Mar 2027
2.8 All executive directors to agree and deliver against personal and Directorate EDI objectives in 2026–27. 2.8.1 Each Executive Director to set one measurable Directorate EDI objective linked to WRES/WDES disparities and report progress quarterly.	1–4	1–4	Must	CEO/ Execs	Oct 2026
2.9 ~~Introduce and~~ Embed an HR / EDI dashboard for all services and Directorates, with monthly, quarterly and annual monitoring and RAG rating of good / poor performance. The dashboard should support identification of issues, ownership, prioritisation of action and progress monitoring in each service, including workforce ethnicity, LGB+ and disability profile, senior leadership representation, diversity in shortlisted candidates, WRES / WDES and LGBT+ recruitment scores by service, and bullying and harassment rates from line managers and colleagues. 2.9.1 From Q3 2026/27, use the HR / EDI Dashboard quarterly to identify each Directorate's top three inequality risks, assign owners and track actions to closure.	2 & 3	2 & 3	Should	CIO with Inclusion and Belonging Lead	Ongoing
2.10 Publish and monitor annual Ethnicity, Disability and Gender Pay Gap reports, with data to end March 2026 and targeted action plans to address findings.	1	2	Must	Inclusion and Belonging Lead	Ongoing

2.10.1 Publish Ethnicity, Disability and Gender Pay Gap reports with separate action plans linked to recruitment, progression, development and retention.					
3. To progress our high-visibility anti-racist and anti-discriminatory approach, delivering against tangible key milestones including:					
3.1 Development and delivery of a targeted high-profile and impactful communications plan around anti-racist and anti-discriminatory approach, including refreshed posters and promotional campaign. To include anti-abuse messaging in conjunction with Craig Stone work. 3.1.1 Deliver a campaign on racism, disability discrimination, HBA and reporting routes, and evaluate reach and engagement by staff group.	4	1–4	Should	Comms Team with Inclusion and Belonging Lead	Mar 2027
3.2 Share outcomes and take meaningful action from learning emerging from staff speaking up reviews, including FTSU and Dear Buki. 3.2.1 Triangulate FTSU, Dear Buki, Integrated Learning Review and WRES/WDES themes quarterly, publish learning themes, and assign owners for agreed actions.	4	2 & 3	Must	AD OD	Mar 2027
3.3 Review application of Trust Disciplinary Procedure and Trust Supporting Staff to Improve Performance Procedure through case review, taking a critical race and disability perspective. Propose and implement changes to debias process based on findings. 3.3.1 Complete quarterly equality reviews of disciplinary, capability and performance cases by ethnicity, disability, band, staff group and service.	4	1 & 3	Should	People Ops Lead / People Ops Team	Mar 2027
3.4 Begin work to review and debias access to Flexible Working and Flexible Retirement with an EDI lens. 3.4.1 Review flexible working and retirement requests, approvals and refusals by ethnicity, disability, gender, band and service, and address identified barriers.	4	1 & 3	Should	People Ops Lead	Mar 2027
3.5 Review Workplace Adjustments and Access to Work process to eliminate delays and barriers to support for differently abled colleagues. Ensure all job applicants are aware of the Trust's approach to supporting differently abled colleagues and workplace adjustments. Share guidance and raise awareness of the 'This is Me' Health Passport. Consider implementing a timeframe for all	4	3	Could	People Ops Lead and HRBPs	Jan 2027

new staff to discuss the 'This is Me' Health Passport with their line manager within an agreed number of weeks of commencing work. 3.5.1 Implement a reasonable adjustments standard with target response times, escalation routes and a follow-up check to confirm effectiveness.					
3.6 Continue to embed EDI as everyone's responsibility, core to Trust and NHS values. 3.6.1 Include WRES/WDES data in team conversations and leadership reviews, with managers agreeing one local action where disparities are identified.	4	1–4	Should	Inclusion and Belonging Lead	Mar 2027
3.7 Continue to encourage and support a culture of inclusion, openness, authenticity and psychological safety at work through development of the Trust as a great place to work for all and celebration of diverse talent. 3.7.1 From Q3 2026/27, identify teams with higher HBA, discrimination, presenteeism or lower feeling-valued scores, and provide targeted culture improvement support.	4	3	Should	OD & Inclusion Team	Ongoing
3.8 People Ops Team to proactively seek to review protected characteristics at the outset of all employee relations processes and gain agreement for these to be updated where applicable. 3.8.1 Add mandatory equality prompts at the start and closure of each employee relations case to check protected characteristics, adjustments and support needs.	2	1 & 3	Should	People Ops Lead / People Ops Team	Jan 2027
Educate for Inclusion					
4.1 Shift focus away from positive action development programmes and towards ensuring equitable access / positive skew for take-up of development and leadership development opportunities for diverse talent. Development programmes should focus on creating an inclusive working environment, educating the wider workforce for deeper understanding of inclusion and the lived experience of minoritised groups. All Trust leadership offers should include a core inclusion component geared to the audience level of responsibility.	4	1–4	Should	OD & Inclusion Team / Service Managers	Ongoing

4.1.1 From Q3 2026/27, include inclusive recruitment, reasonable adjustments, anti-racism, disability inclusion and psychological safety in all relevant leadership offers.					
4.2 Programme of education around responding effectively to incidents of abuse, discrimination and incivility, understanding race and racism, including the need for active bystander / upstander response and the mechanisms available for reporting and addressing such behaviours. 4.2.1 Develop scenario-based learning on racism, disability discrimination, HBA, incivility, reasonable adjustments and speaking up, using WRES/WDES themes.	4	1–4	Could	TBC	TBC
4.3 Deliver an Executive development session on learning from NHS discrimination cases and setting EDI objectives. 4.3.1 Include 2026 WRES/WDES findings in the Executive development session and agree Directorate-level actions for priority disparities.	3–4	1–4	Should	AD OD & Inclusion and Belonging Lead	Feb 2027
4.4 Trust Leadership Academy inclusion-themed session. 4.4.1 Use Leadership Academy sessions to build capability in interpreting WRES/WDES data and converting insight into measurable local action.	3–4	1–4	Should	TBC	Ongoing
4.5 Programme of activities to celebrate and educate around inclusion, following the national / international awareness calendar, and linking to Newsround, Exec Exchange, Combined TV, podcasts, Inclusion School, Trust / system conferences and other communications opportunities.	3–4	1–4	Should	Staff Network Leads with Inclusion and Belonging Lead	Ongoing
Race Inclusion:					
18 July – 17 August 2026					
September 2026					
October 2026					
1–7 February 2027					
Disability Inclusion:					
12 Nov – 18 Dec 2026					
16 -22 Mar/April 2026 & 2027					
LGBT+ Inclusion:					

February 2027	LGBT+ History Month					
June 2026	Pride Month					
Gender Equality:						
8 March 2027	International Women's Day					
4.5.1 From Q3 2026/27, link each inclusion awareness campaign to one practical improvement ask, such as disclosure, adjustments, reporting or staff network engagement.						
4.6 Build on investment in established programmes, including the HPMA Anti-Racist Leadership Programme, WRES Champions and Reciprocal Mentoring. This may involve enlisting these individuals to support the design and delivery of planned interventions. 4.6.1 Establish a delivery group with WRES Champions, Reciprocal Mentoring alumni, staff network representatives and disabled staff voices to co-design interventions.		1–4	1–4	Could	TBC	Mar 2027

Equality Objectives 2026-28 and EDI Goals 2026-27

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

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

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

Our Inclusion and Belonging Priorities for 2026/27

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

Enclosure No: 12

IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) M04 2026/27

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	10 September 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 and areas of exception, and progress of medium-term plan national priorities activity against operational planning forecasts. There are two special cause variations (orange variation flag) – signifying concern. 1. Sickness Absence 2. Vacancy Rate There are eight special cause variations (blue variation flags) – signifying improvement. 1. Referral to Assessment within 4 weeks 2. CAMHS compliance within 4 week waits (referral to assessment) 3. Care Plan Compliance 4. Risk Assessment Compliance 5. Friends and Family Test-Recommended 6. Staff Turnover 7. Clinical Supervision 8. Statutory and Mandatory Training Performance Highlights – M04 • Referral to assessment within 4 weeks remained stable at 96.9% in M04, an improvement from 96.1% in M03. • Referral to treatment (RTT) within 18 weeks continued to exceed the required standard, improving to 96.3% from 95.4% in the previous month. • CAMHS referral to treatment within 18 weeks showed notable improvement, increasing to 93.4%, compared to 89.6% in M03. • Mental Health Liaison Service continued to perform well, with both 4-hour and 24-hour response times consistently achieving the required 95% standard. • Early Intervention in Psychosis (EIP) 2-week wait performance declined to 85.7% in M04, from 100% in M03. • Follow up after discharge met the required standards, achieving 95.6% within 48 hours and 100% within 7 days. • Talking therapies for anxiety and depression achieved 53.3% reliable recovery, and 74.4% reliable improvement during M04. • Care plan compliance reduced slightly to 96.4%. While a performance improvement plan (PIP) remains in place within the specialist services directorate, overall performance continues to strengthen. • Risk assessment compliance also saw a small reduction to

96.0%, compared with 96.4% in M03, but remains above the required standard.

- **Length of stay** measures, including both average and median, for adults and older adults, remained well within national benchmark ranges.
- **Emergency Readmission rate** within 30 days increased to **2.3%** in M04, compared to 0.7% in M03.
- **Friends and family test** recommendation rate achieved **85.0%**, exceeding the required standard.
- The **vacancy rate** increased slightly to **6.5%** in M04 but remains within the agreed tolerance threshold.
- **Staff turnover** has improved, reducing to **7.9%** from 8.1% in M03.
- **Clinical Supervision** reduced marginally to **88.0%** from 89.0% in M03, although performance has shown improvement during the previous two months.
- **Appraisal** compliance remained unchanged at **86.0%**.
- **Statutory and mandatory training** remains unchanged at **92%**.
- **Data Quality Maturity Index (DQMI) performance** remained exceptionally strong at **98.7%** during April 2026, demonstrating continued high standards of data quality, completeness, and reporting accuracy.

Performance Exceptions – M04

- **CAMHS referral to assessment (RTA)** compliance within four weeks reduced marginally to **94.6%** from 95.3% in M03. compliance.
- **MH Liaison 1 hour response rate** reduced **92.3%** in M04, falling below the required standard. The service continues to perform well against both the 4-hour and 24-hour response target.
- The organisation breached the 40-day **complaints** response time during the reporting period. This related to a complex care quality commission (CQC) complaint that required an extensive review process. This additional scrutiny extended the timescales required to provide a comprehensive response.
- **Sickness absence** increased slightly to **6.27%**, exceeding the revised organisational target of **<5.40% threshold**. PIPs remain in place within both the Acute & Urgent Care and Specialist Services directorates. Targeted workforce interventions continue to focus on improving attendance, supporting staff wellbeing, and reducing sickness absence across the organisation.

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

M04 performance against the forecasts submitted to the ICB and NHSE for 2026/27. To note:

- **Out of Area Placements (OAP)** – There were **9 reportable inappropriate OAPs** at month end.
- **Length of Stay** – Performance is measured on a three-month rolling basis. Adult Acute: **28.6 days** against a plan of **45.2 days** and Older Adult: **50.6 days** against a plan of **58.7 days**.
- **Perinatal Access** – The service exceeded plan, achieving **866** against the plan of **640**.
- **Children and Young People (CYP) Access** – Performance exceeded plan, with **9,316** children and young people accessing services against a target of **7,803**.
- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) plan was achieved, with **968** accessing IPS services against a target of **830**.
- **MHST Access** – Performance exceeded plan, achieving **907** against a target of **716**.
- **CYP Waits Over 104 Weeks** – This metric has not met standard in M04. There were **880 waits over 104 weeks**, compared with a target of **595**. A new dashboard has been developed and demonstrated to services highlighting those patients waiting longer than 52 weeks to strengthen oversight and reduce long waits.

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
1.0	Finance and Resource Committee	27.08.26
1.0	Public Trust Board	28/08/26



Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M04 (July 2026)



Contents

Core Indicators – Monthly and Balanced Scorecard

Operational Planning Forecasts and Performance

Core Indicators – 13-month trend

Performance Improvement Plans (PIPs)

Core Indicators – SPC Trend

Using Statistical Process Control (SPC)

An SPC chart is a time series with three reference lines, the mean, upper and lower control limits. The limits help to understand 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. Vacancy Rate

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

1. Referral to Assessment within 4 weeks
2. CAMHS compliance within 4 week waits (Referral to Assessment)
3. Care Plan Compliance
4. Risk Assessment Compliance
5. Friends and Family Test-Recommended
6. Staff Turnover
7. Clinical Supervision
8. 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 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.

Balanced Scorecard

Access & Waiting Times			
	Metric	Standard	Performance
RAG Rated Standards	10 met, 2 unmet		
Highlights	Referral to Assessment within 4 weeks	95.0%	96.9%
	Referral to Treatment within 18 weeks	92.0%	96.3%
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	93.4%
	MH Liaison 4 Hour Response (Urgent)	95.0%	96.9%
	MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	96.7%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	85.7%
	48 Hour Follow Up	95.0%	95.6%
	7 Day Follow Up (All Patients)	95.0%	100.0%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	53.3%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	69.0%	74.4%
Exceptions	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	94.6%
	MH Liaison 1 Hour Response (Emergency)	95.0%	92.3%

Community & Quality			
	Metric	Standard	Performance
RAG Rated Standards	2 met, 0 unmet		
Highlights	Care Plan Compliance	95.0%	96.4%
	Risk Assessment Compliance	95.0%	96.0%

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
Specialist Services	Referral to Assessment within 4 weeks	95.0%	93.9%
	Referral to Treatment within 18 weeks	92.0%	93.3%
	Sickness Absence (in-month)	<6.30%	6.66%
	Care Plan Compliance	95.0%	93.6%

Inpatient & Quality			
	Metric	Standard	Performance
RAG Rated Standards	5 met, 0 unmet		
Highlights	Average Length of Stay - Adult	40	29.6
	Median Length of Stay - Adult	42.4	16.7
	Average Length of Stay - Older Adult	90	52.4
	Median Length of Stay - Older Adult	83.8	40.7
	Emergency Readmissions rate (30 days)	<7.5%	2.3%

Organisational Health & Workforce			
	Metric	Standard	Performance
SPC Variations signifying concern	Vacancy Rate	<10.0%	6.5%
	Sickness Absence	<5.40%	6.27%
RAG Rated Standards	6 met, 1 unmet		
Highlights	Friends and Family Test - Recommended	80.0%	85.0%
	Vacancy Rate	<10.0%	6.5%
	Staff Turnover	<10.0%	7.9%
	Clinical Supervision	85.0%	88.0%
	Appraisal	85.0%	86.0%
	Statutory & Mandatory Training	85.0%	92.0%
Exceptions	Complaints Open Beyond Agreed Timescale	0	1
	Sickness Absence	<5.40%	6.27%

Performance Improvement Plans (PIPs)			
Directorate	Metric	Standard	Performance
AUCD	Sickness Absence (in-month)	<6.60%	9.70%
Community	Referral to Assessment within 4 weeks-Adult	95.0%	94.1%
AUCD and Community	Number of inappropriate OAPs during month	2	17
	Number of inappropriate OAPs at EOM (national measure)	2	9

Core Indicators – Monthly

Access & Wait Times	Indicator	Target	May-26	Jun-26	Jul-26	Assurance	Variation
	Referral to Assessment within 4 weeks	95.0%	96.5%	96.1%	96.9%		
	Referral to Treatment within 18 weeks	92.0%	94.8%	95.4%	96.3%		
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	95.2%	95.3%	94.6%		
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	90.6%	89.6%	93.4%		
	MH Liaison 1 Hour Response (Emergency)	95.0%	96.5%	93.7%	92.3%		
	MH Liaison 4 Hour Response (Urgent)	95.0%	98.0%	97.5%	96.9%		
	MH Liaison 24 Hour Response (Urgent from General Hospital)	95.0%	96.9%	95.9%	96.7%		
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	N/A	100.0%	N/A		
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	N/A	100.0%	N/A		
	Early Intervention - A Maximum of 2 Week Waits for Referral to	60.0%	87.5%	100.0%	85.7%		
	48 Hour Follow Up	95.0%	100.0%	96.6%	95.6%		
	7 Day Follow Up (All Patients)	95.0%	100.0%	100.0%	100.0%		
	Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	50.7%	52.1%	53.3%		
	Talking Therapies for Anxiety and Depression: Reliable	69.0%	73.7%	74.0%	74.4%		

Inpatient & Quality	Indicator	Target	May-26	Jun-26	Jul-26	Assurance	Variation
	Median Length of Stay - Adult	42.4	12.9	12.2	16.7		
	Average Length of Stay - Adult	40	32.6	23.9	29.6		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	13.3%	9.3%	20.7%		
	Median Length of Stay - Older Adult	83.8	39.2	42.0	40.7		
	Average Length of Stay - Older Adult	90	48.5	50.5	52.4		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	10.0%	16.0%	13.0%		
	Emergency Readmissions rate (30 days)	<7.5%	1.4%	0.7%	2.3%		
	Clinically Ready for Discharge (CRFD)	No Target	21.8%	19.0%	17.3%		

Community &	Indicator	Target	May-26	Jun-26	Jul-26	Assurance	Variation
	Care Plan Compliance	95.0%	96.3%	96.6%	96.4%		
	Risk Assessment Compliance	95.0%	96.2%	96.4%	96.0%		

Organisational Health	Indicator	Target	May-26	Jun-26	Jul-26	Assurance	Variation
	Complaints Open Beyond Agreed Timescale	0	0	0	1		
	Friends and Family Test - Recommended	80.0%	83.0%	83.0%	85.0%		
	Safe Staffing	95%-105%	105.6%	105.1%	102.1%		
	Vacancy Rate	<10.0%	6.0%	6.4%	6.5%		
	Staff Turnover	<10.0%	7.5%	8.2%	7.9%		
	Sickness Absence	<5.40%	6.21%	6.23%	6.27%		
	Clinical Supervision	85.0%	81.0%	89.0%	88.0%		
	Appraisal	85.0%	81.0%	86.0%	86.0%		
	Statutory & Mandatory Training	85.0%	91.0%	92.0%	92.0%		

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	10	24	3	5	9								
			Variance	7	-7	14	12	7								
			Kidsgrove Placements	1	3	1	0	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	4,419	5,050	5,379	3,901	3,347									
			Variance	-1,007	-380	-51	-1,524	-2,073									
			Nationally Published	5,215	5,050	5,380											
	Number of discharges in the RP		Plan	120	120	120	120	120	120	120	120	120	120	120	120	120	120
			Actual	124	116	130	133	118									
			Variance	4	-4	10	13	-2									
			Nationally Published	123	115	130											
	Mean Length of stay for discharges in the RP		Plan (YTD Avg)	45.2	45.3	45.3	45.2	45.2	45.1	45.1	45.0	45.0	45.0	44.9	44.9	44.8	
			Actual	35.7	43.5	41.4	29.3	28.6									
			Variance	9.5	-1.8	-3.9	-15.9	-16.6									
			Nationally Published	43	44	41											

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	3,463	3,496	3,473	3,440	3,443									
			Variance	-358	-329	-349	-379	-373									
			Nationally Published	3,485	3,495	3,475											
	Number of discharges in the RP		Plan	65	65	65	65	65	65	65	65	65	65	65	65	65	65
			Actual	68	68	66	69	69									
			Variance	3	3	1	4	4									
			Nationally Published	65	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	51.3	52.2	52.6	49.9	50.6									
			Variance	-7.5	-6.6	-6.2	-8.9	-8.1									
			Nationally Published	53	52	53											

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	9,425	9,513	9,443	9,427	9,316								
			Variance	1,631	1,728	1,652	1,630	1,513								
			Nationally Published	9,483	9,515	9,450										

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	855	835	840	864	880								
			Variance	225	211	204	200	285								
			Nationally Published	910	915	905										

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	956	983	966	967	907								
			Variance	249	285	262	257	191								
			Nationally Published	975	985	965										

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	873	871	882	872	866								
			Variance	233	231	242	232	226								
			Nationally Published	875	870	880										

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	939	898	928	960	968								
			Variance	131	108	128	150	138								
			NSCHT Actual	420	409	410	420	441								
			MPFT Actual	519	489	518	540	527								
			ICB Nationally Published	930	915	945										
			NSCHT Nationally Published	410	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. At the end of M04, there were 9 reportable inappropriate OAPs attributable to adult acute bed capacity constraints and flow issues.

In response to these challenges, an OAPs Performance Improvement Plan (PIP) was initiated in M04 (2025/26), 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 and 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. At the end of M04, 5 patients who were clinically ready for discharge (CRFD) remained within adult acute 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 M04 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.

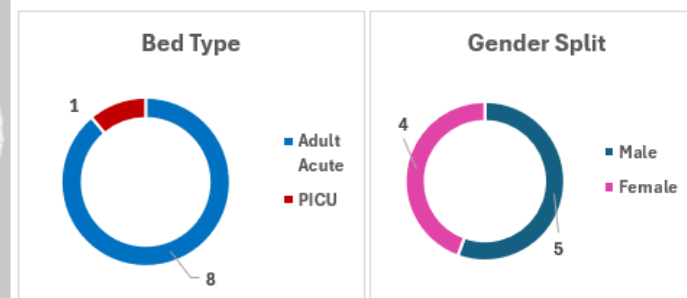
A resolute OAPs Standing Operating Procedure (SOP) is in place, providing assurance around staff roles, responsibilities, and clinical oversight for patients placed out of area (OAP). The Trust places patients only with providers rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC) and 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
●	Priory Hospital Bristol	125	1
●	Cygnet Nield House	18	1
●	Cygnet Hospital Hexham	188	1
●	Priory Hospital East Midlands	60	1
●	Cygnet Hospital Sherwood	61	2
●	Cygnet Hospital Wolverhampton	33	1
●	Priory Lakeside View	32	2
●	Cygnet Hospital Kidsgrove	1	1
●	Harplands Hospital		*Total: 9

*Total excludes Cygnet Kidsgrove placements



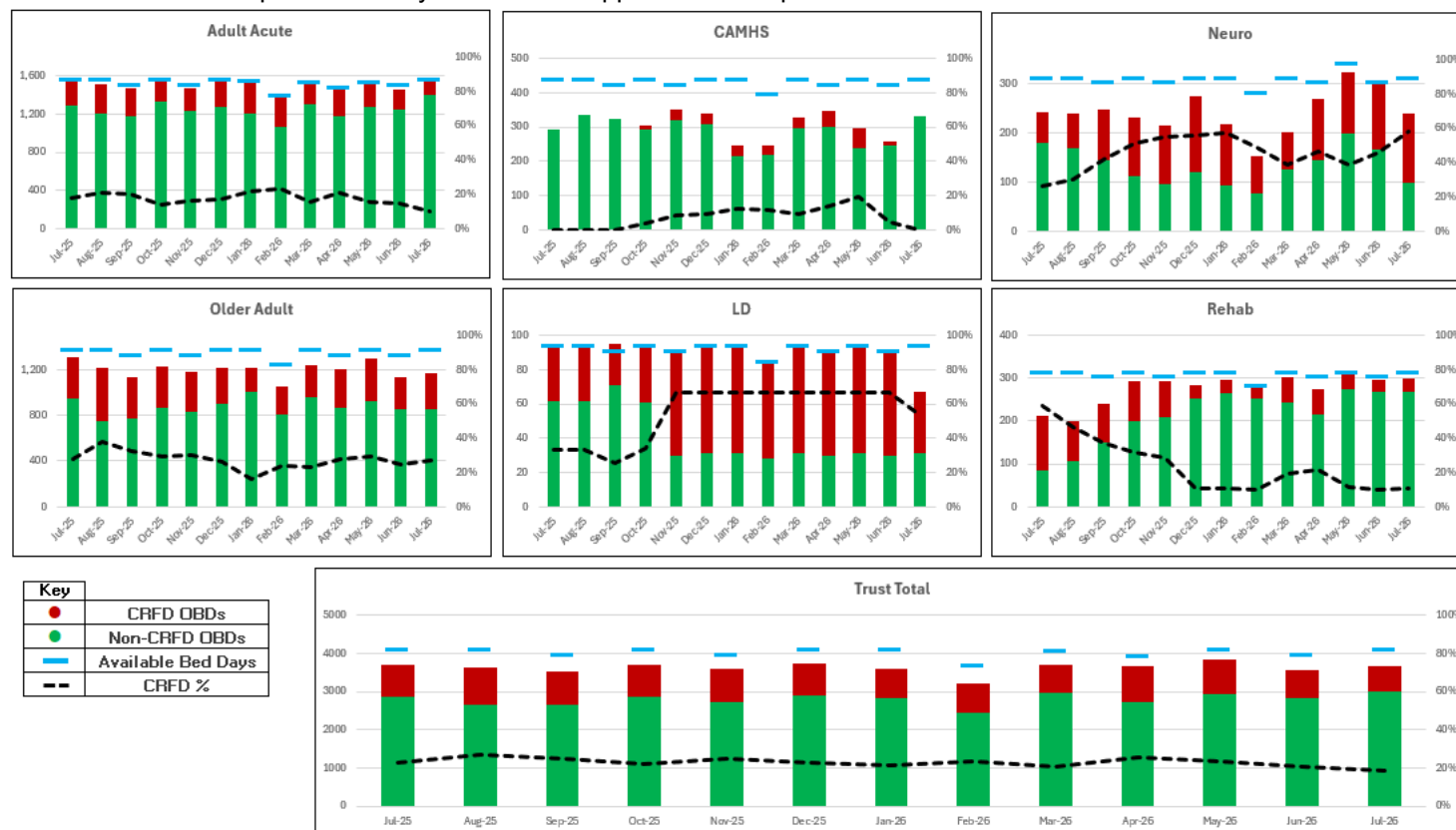
Whilst early improvements in oversight and process are evident, performance continues to be constrained by structural pressures including reduced bed stock and system delays in discharge. Actions remain focused on delivering sustainable improvements in flow and reducing reliance on OAPs over the medium 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 out of area as 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 M04, achieving 28.6 against the plan of 45.2 for adult acute, and 50.6 against the plan of 58.7 for older adult.
- **Perinatal Access** – The perinatal access metric has met standard in M04, achieving 866 against the plan of 640.
- **CYP Access** – This metric has met standard in M04, achieving 9,316 against the plan of 7,803.
- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has met standard in M04, achieving 968 against a plan of 830.
- **MHST Access** – This metric has met standard in M04, achieving 907 against the plan of 716.
- **CYP Waits Over 104 Weeks** – This metric has not met standard in M04. There were 880 waits over 104 weeks against a plan of 595. 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 has been demonstrated to services that have patients waiting longer than 52 weeks.

Core Indicators – 13 Month Trend (1 of 2)

Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Referral to Assessment within 4 weeks	95.0%	93.3%	92.4%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%	94.1%	96.5%	96.1%	96.9%
Referral to Treatment within 18 weeks	92.0%	95.9%	96.1%	96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%	96.6%	94.8%	95.4%	96.3%
CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	91.1%	78.2%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%	94.7%	95.2%	95.3%	94.6%
CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	92.8%	88.6%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%	93.5%	90.6%	89.6%	93.4%
MH Liaison 1 Hour Response (Emergency)	95.0%	95.3%	95.8%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%	93.7%	92.3%
MH Liaison 4 Hour Response (Urgent)	95.0%	96.0%	95.5%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%	96.6%	98.0%	97.5%	96.9%
MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	96.4%	96.5%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%	97.9%	96.9%	95.9%	96.7%
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	N/A	N/A	100.0%	N/A	N/A	98.0%	N/A	N/A	98.1%	N/A	N/A	100.0%	N/A
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	94.7%	75.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%	83.3%	87.5%	100.0%	85.7%
48 Hour Follow Up	95.0%	100.0%	100.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%	94.7%	100.0%	96.6%	95.6%
7 Day Follow Up (All Patients)	95.0%	100.0%	100.0%	100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%	98.2%	100.0%	100.0%	100.0%
Emergency Readmissions rate (30 days)	<7.5%	3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%	5.8%	1.4%	0.7%	2.3%
Care Plan Compliance	95.0%	95.0%	95.6%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%	96.0%	96.3%	96.6%	96.4%
Risk Assessment Compliance	95.0%	95.7%	96.2%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%	95.5%	96.2%	96.4%	96.0%
Complaints Open Beyond Agreed Timescale	0	1	1	0	0	0	0	0	0	0	0	0	0	1
Friends and Family Test - Recommended	80.0%	86.4%	82.5%	87.6%	76.0%	88.0%	81.0%	89.0%	92.0%	83.0%	86.0%	83.0%	83.0%	85.0%
Safe Staffing	95%-105%	103.9%	103.8%	102.8%	102.5%	106.1%	107.1%	109.6%	104.4%	105.2%	106.0%	105.6%	105.1%	102.1%
Sickness Absence	<5.40%	6.27%	6.25%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.14%	6.16%	6.21%	6.23%	6.27%

Core Indicators – 13 Month Trend (2 of 2)

Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	53.7%	51.9%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%	54.4%	50.7%	52.1%	53.3%
Talking Therapies for Anxiety and Depression: Reliable Improvement	69.0%	77.4%	73.2%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%	76.5%	73.7%	74.0%	74.4%
Average Length of Stay - Adult	40	49.3	26.6	37.0	34.7	45.0	43.7	32.5	36.6	62.6	31.3	32.6	23.9	29.6
Median Length of Stay - Adult	42.4	22.9	17.2	14.6	26.9	27.4	18.9	15.9	25.9	20.5	13.9	12.9	12.2	16.7
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	22.2%	12.8%	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%	15.6%	13.3%	9.3%	20.7%
Average Length of Stay - Older Adult	90	55.7	55.3	46.4	47.2	58.5	60.1	55.3	47.4	59.0	50.1	48.5	50.5	52.4
Median Length of Stay - Older Adult	83.8	41.0	32.5	35.5	35.0	45.5	37.5	48.0	33.0	51.0	44.6	39.2	42.0	40.7
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	30.4%	18.2%	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%	12.5%	10.0%	16.0%	13.0%
Clinically Ready for Discharge (CRFD)	No Target	22.2%	28.5%	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%	23.9%	21.8%	19.0%	17.3%
Vacancy Rate	<10.0%	8.0%	7.6%	5.1%	3.3%	3.0%	3.3%	2.9%	2.2%	2.7%	5.9%	6.0%	6.4%	6.5%
Staff Turnover	<10.0%	8.9%	8.5%	8.1%	7.3%	7.3%	7.4%	7.4%	7.7%	7.5%	7.3%	7.5%	8.2%	7.9%
Clinical Supervision	85.0%	79.0%	81.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%	78.0%	81.0%	89.0%	88.0%
Appraisal	85.0%	81.0%	84.0%	78.0%	79.0%	83.0%	83.0%	82.0%	82.0%	83.0%	81.0%	81.0%	86.0%	86.0%
Statutory & Mandatory Training	85.0%	90.0%	90.0%	90.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%	92.0%
DQMI	95.0%	98.4%	98.5%	98.6%	98.5%	98.7%	98.8%	98.3%	98.4%	98.5%	98.7%	N/A	N/A	N/A

In M04 there are 34 metrics monitored; 23 have achieved the required standard and 4 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 M04 is 93.9%, which is above the planned trajectory of 90.0% and below the required standard. Updated actions have been provided in M04.
	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 M04 is 94.1% and despite recent recovery, performance has not met the planned trajectory or required standard. 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 M11 (Feb-Apr 2026), and most recently M01 (Apr-Jul 2026). Revised trajectories have been requested, Updated actions have been provided in M04.
Sickness Absence (In-month)	Acute and Urgent Care	A PIP was requested in M05 (2024/25), with supporting actions subsequently provided in M07. Sickness absence trajectories were initially established in November 2024 and revised in January and March 2025, with the objective of reducing the sickness absence rate to the four-year average of 6.9% by March 2026. For 2026/27, a new rolling 12-month target of 6.60% has been implemented.

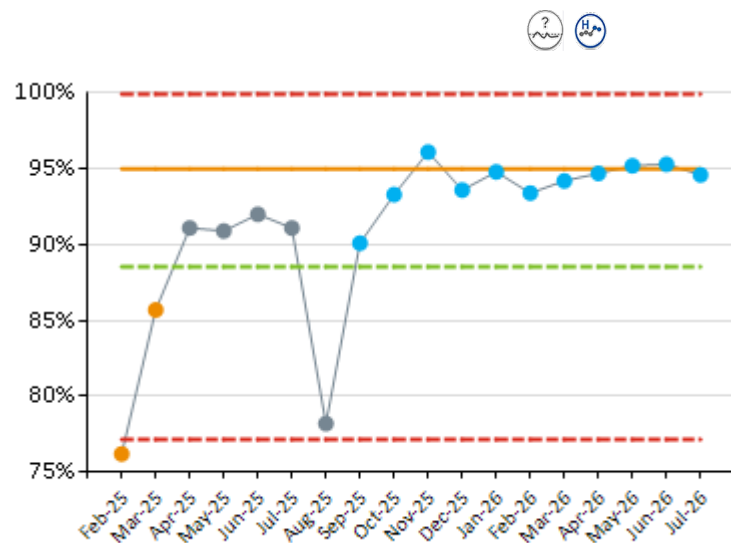
Metric	Directorate	Status
		Rolling 12-month sickness absence at M04 is 8.27%, with in-month absence at 9.70%. Both measures remain above the required target. May and June figures have been updated. Trajectories have been provided in M04 (Apr-Oct 2026). Updated actions have been provided in M04.
	Specialist 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). For 2026/27, a new rolling 12-month target of 6.30% has been implemented. Rolling 12-month sickness absence at M04 is 6.95%, with in-month absence at 6.66%. Both measures remain above the required target. April to June figures have been updated. The current PIP trajectory aims for performance to be at 5.80% by September 2026. Updated actions have been provided in M04.
Care Plan Compliance	Specialist Services	A PIP was requested in M01 (2025/26). The original aim was for the standard to be achieved by October 2025 this has been extended to January 2026, June 2026 and is currently forecast for September 2026. Performance during M04 is 93.6%, which is below the planned trajectory of 95.0% and 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 M04.
Out of Area Placement (OAPs)	Acute and Urgent Care and Community	A PIP was requested in M04 (2025/26). Performance during M04 is measured by the number of inappropriate OAPs during month and the number of inappropriate OAPs at EOM (national measure) which were 17 and 9, respectively. Updated actions have been provided in M04.

Metric	Directorate	Status
Referral to Treatment within 18 weeks	Specialist Services	A PIP was requested in M04 (2026/27). Performance during M04 is 93.3% and is achieving the required standard. Trajectories milestones have been set in M04 (Apr-Nov 2026/27). The aim is for the standard to be achieved by November 2026. Trajectory milestones were set in M04 (Jul-Nov 2026). Updated actions have been provided in M04.
Risk Assessment	Specialist Services	A new PIP will be requested in M05.
Talking Therapies for Anxiety and Depression (90 days wait in treatment)	Primary Care	A new PIP will be requested in M05.

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

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



13 Month Trend

91.1%	78.2%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%	94.7%	95.2%	95.3%	94.6%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Performance is at **94.6% in M04**. The variation is showing improvement.

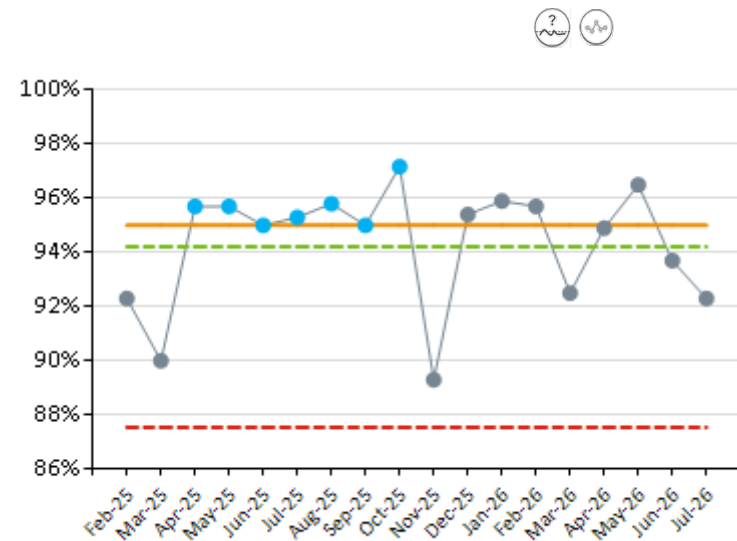
Current performance

Community	93.9%
Specialist Services	N/A
Acute and Urgent Care	96.2%

In **M04**, there were **10 breaches** reported against **CAMHS RTA metric**.

Of these, only **3 breaches** can be attributed to long waits in **neurodevelopmental services**. The remaining **7 breaches** related to waits within **community services**, comprising 5 breaches in North Staffs CAMHS, 1 breach in South Stoke CAMHS, and 1 breach within the Single Point of Access team.

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



13 Month Trend

95.3%	95.8%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%	93.7%	92.3%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

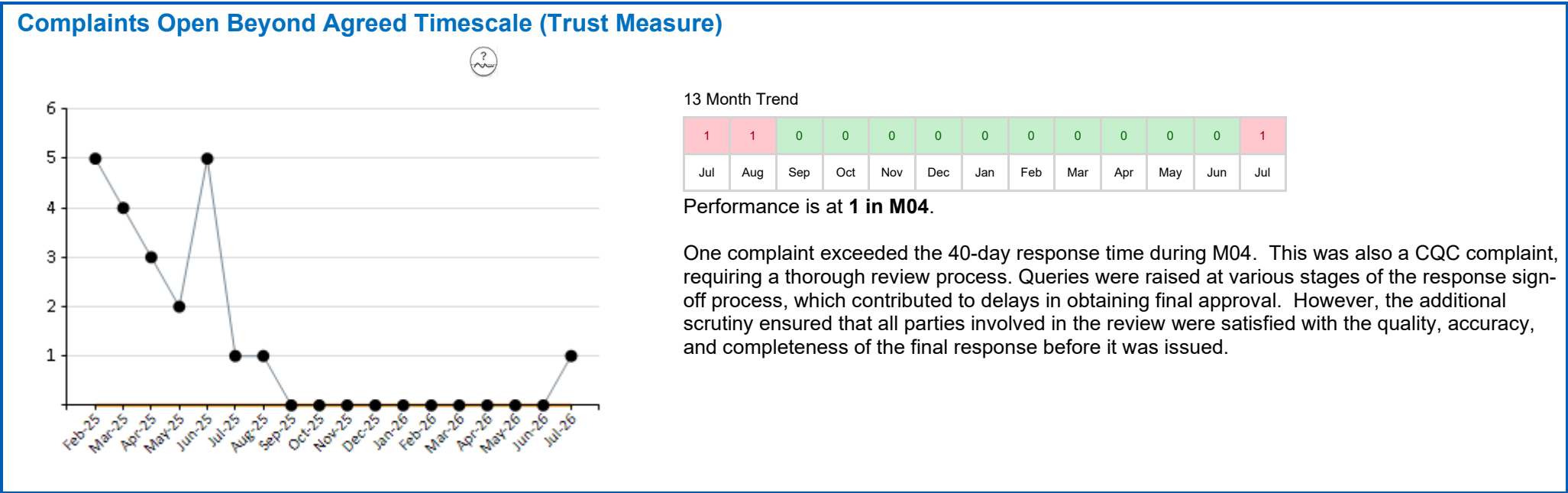
Performance is at **92.3% in M04**. The variation is showing common cause.

In M04, 23 breaches were reported against the **MH Liaison 1 hour response** metric.

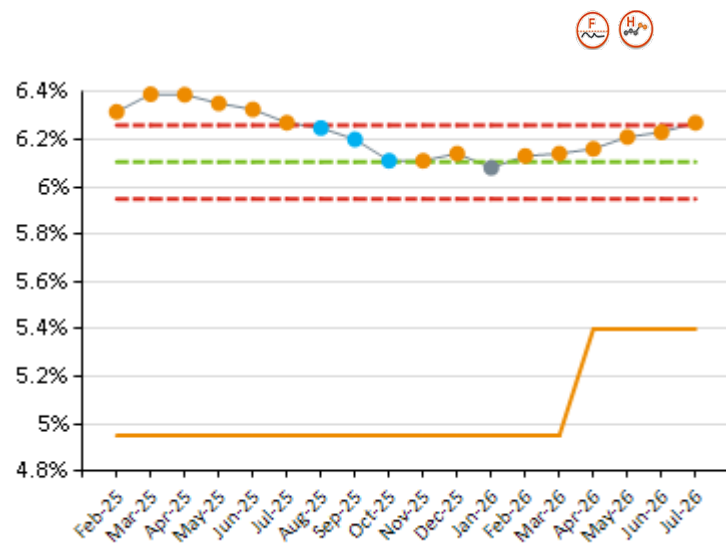
Workforce pressures persisted during M04, with a combination of long-term absences and vacant posts significantly affecting service capacity and contributing to challenges in meeting response time expectations.

Alongside workforce constraints, the service encountered sustained periods of **heightened demand**, especially overnight, which placed additional pressure on an already reduced workforce and **affected responsiveness**.

The service continues to monitor performance closely and is taking steps to mitigate the impact of staffing shortages wherever possible.



Sickness Absence (Trust Measure)



The previous single Trust-wide sickness absence target (<4.95%) has been replaced with **directorate specific targets** to better reflect service-specific challenges, benchmarking data, and workforce context.

Sickness KPI Targets

Trust	Acute and Urgent Care	Community Mental Health	Corporate Services	Primary Care	Specialist Services
5.40%	6.60%	5.70%	2.20%	5.70%	6.30%

13 Month Trend

6.27%	6.25%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.14%	6.16%	6.21%	6.23%	6.27%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Performance is at **6.27% in M04**. The variation is showing common cause.

Current performance:

Community	6.07%
Specialist Services	6.95%
Acute and Urgent Care	8.27%
Primary Care	5.64%
Corporate	3.35%

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

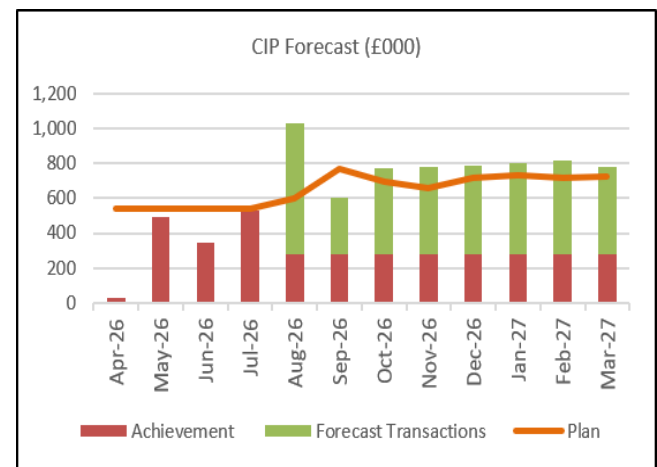
Sickness absence variation to target has continued to be shown as a signifying concern in M04.

Primary Care are the only directorates who are currently achieving the revised in month sickness target. The aim of the directorate level targets is to offer a stretch whilst recognising the differing circumstances that may contribute to sickness, for example, environmental factors.

Stress, anxiety or depression accounts for the largest proportion of absence. A sickness absence improvement plan has been developed, is reported, and monitored monthly through People, Culture and Development Committee to ensure all interventions and actions are aligned with supporting preventative and corrective actions.

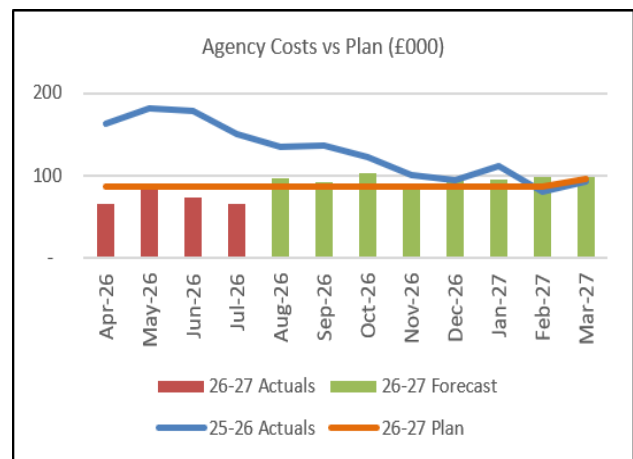
Financial Performance

CIP Delivery v Plan



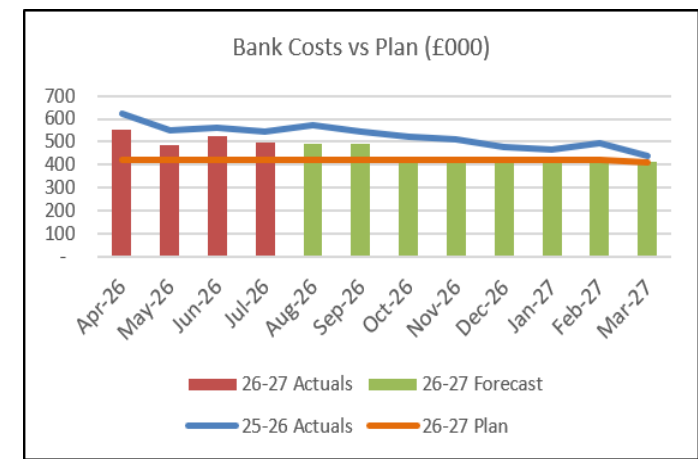
The CIP graph shows current achievement and forecast transactions against the £7.8m plan. The Trust is forecasting full achievement of £7.8m target.

Agency Cost v Plan (40% reduction)

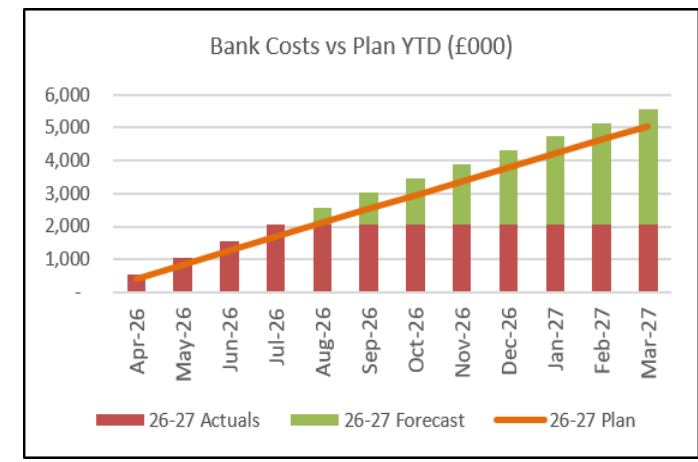
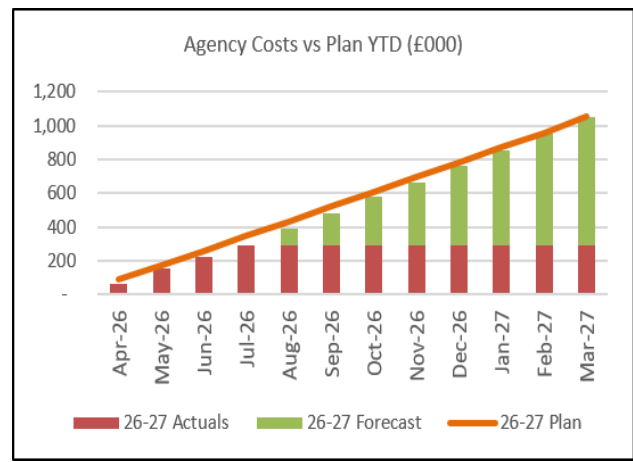
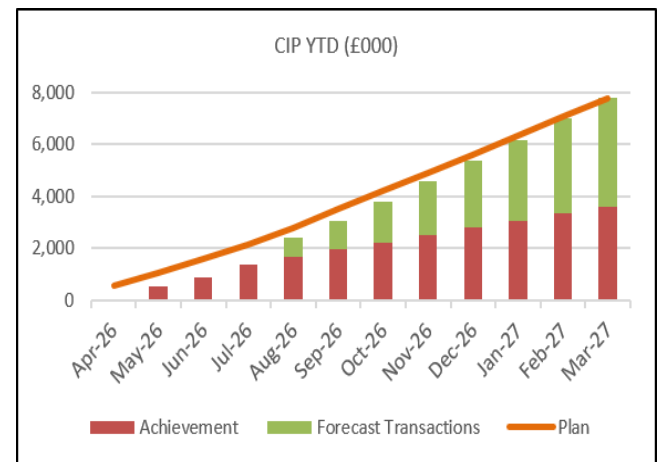


The agency graph shows actual and forecast costs against a £1.1m plan. The Trust is forecasting £1.1m total costs at Month 4.

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 4 total costs of £5.6m.

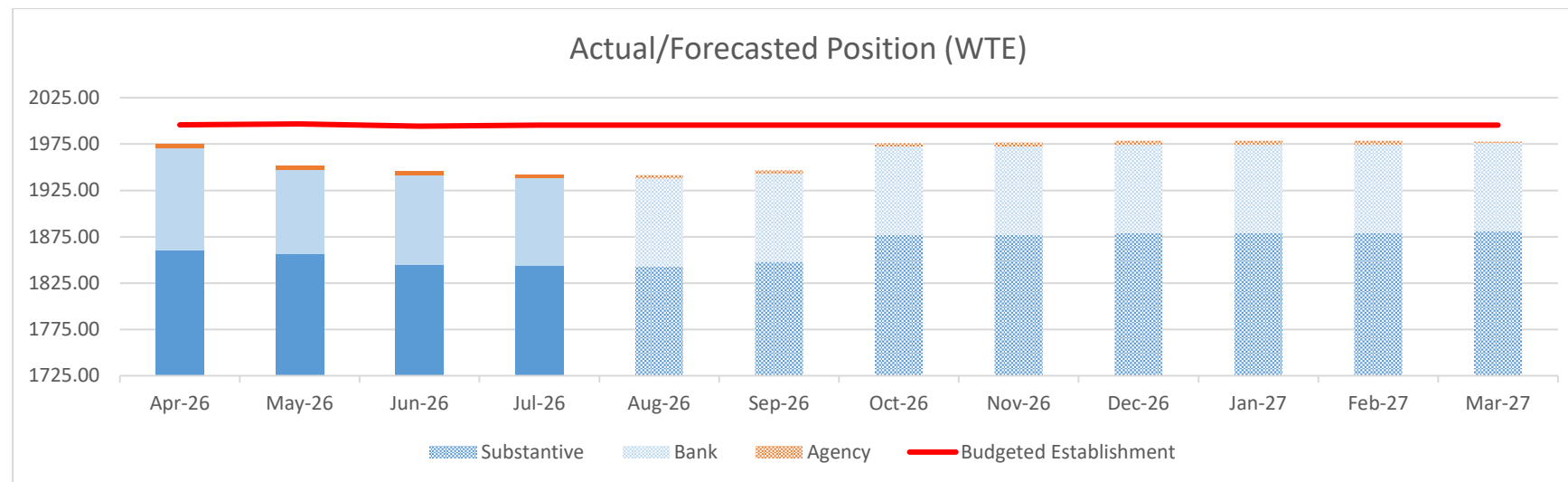
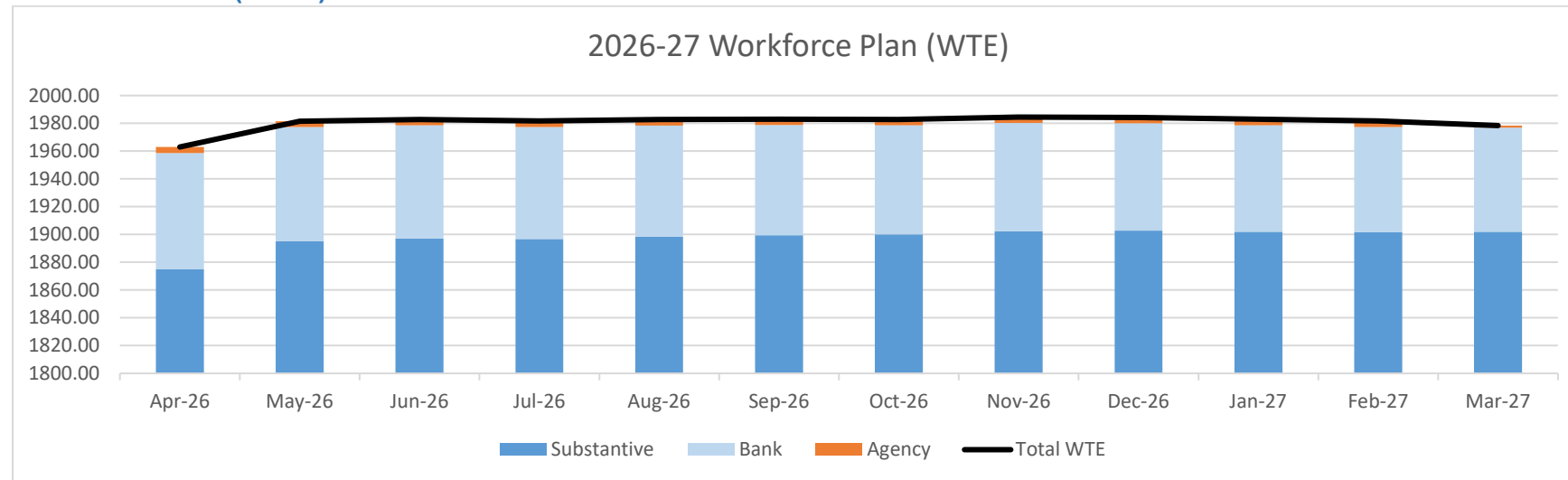


Workforce Plan (1 of 3)

Jul-26 NSCHT	WTE				Spend			
	Plan	Actual	Variance From Plan		Plan	Actual	Variance From Plan	
	WTE	WTE	WTE	%	£'000	£'000	£'000	%
Total	1,980.1	1,941.9	-38.2	-1.9%	£37,226.3	37,768.0	+£542	+1.5%
Substantive	1,894.5	1,843.6	-50.9	-2.7%	£35,194.3	£35,413.0	+£219	+0.6%
Medical and Dental	72.5	68.6	-4.0	-5.5%	£3,895.6	£3,902.0	+£6	+0.2%
Registered nursing, midwifery and health visiting staff	617.8	571.8	-46.0	-7.4%	£11,786.0	£11,387.0	-£399	-3.4%
Registered scientific, therapeutic and technical staff	310.4	306.4	-4.0	-1.3%	£7,596.4	£7,156.0	-£440	-5.8%
Support to clinical staff	508.2	535.0	+26.8	+5.3%	£5,743.0	£6,241.0	+£498	+8.7%
Total NHS infrastructure support	383.9	358.4	-25.5	-6.6%	£6,173.3	£6,727.0	+£554	+9.0%
Any other staff	1.6	3.4	+1.8	+111.5%	£0.0	£0.0	£0	
Bank	81.3	95.2	+13.9	+17.1%	£1,684.0	£2,063.0	+£379	+22.5%
Medical and Dental	1.3	4.5	+3.2	+250.6%	£400.0	£423.0	+£23	+5.8%
Registered nursing, midwifery and health visiting staff	24.8	24.8	+0.0	+0.1%	£380.0	£561.0	+£181	+47.6%
Registered scientific, therapeutic and technical staff	0.7	1.8	+1.1	+152.3%	£48.0	£57.0	+£9	+18.8%
Support to clinical staff	54.0	62.7	+8.6	+15.9%	£800.0	£974.0	+£174	+21.8%
Total NHS infrastructure support	0.5	1.4	+1.0	+204.9%	£56.0	£48.0	-£8	-14.3%
Any other staff	0.0	0.0	0.0		£0.0	£0.0	£0	
Agency	4.30	3.15	-1.2	-26.7%	£348.00	£292.00	-£56	-16.1%
Medical and Dental	4.30	2.33	-2.0	-45.8%	£336.0	£269.0	-£67	-19.9%
Registered nursing, midwifery and health visiting staff	0.00	0.33	+0.3		£12.0	£23.0	+£11	+91.7%
Registered scientific, therapeutic and technical staff	0.00	0.49	+0.5		£0.0	£0.0	£0	
Support to clinical staff	0.00	0.00	0.0		£0.0	£0.0	£0	
Total NHS infrastructure support	0.00	0.00	0.0		£0.0	£0.0	£0	
Any other staff	0.00	0.00	0.0		£0.0	£0.0	£0	

- The table above is a comparison between the plan and actual position for WTE/Spend during M03.
- 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.

Workforce Plan (2 of 3)



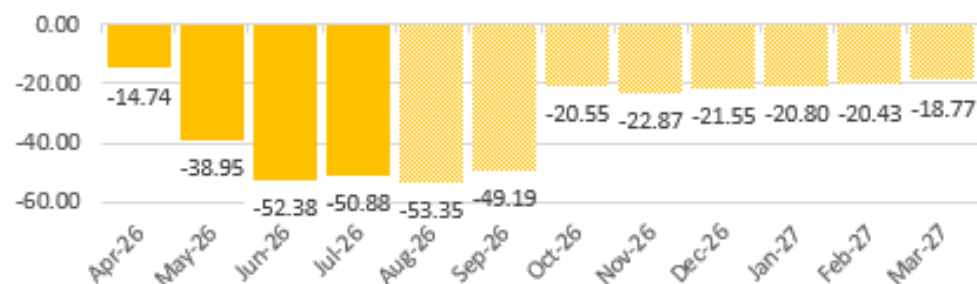
This shows the Workforce Plan that was submitted in comparison to the actual or forecasted position for the same period.

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.

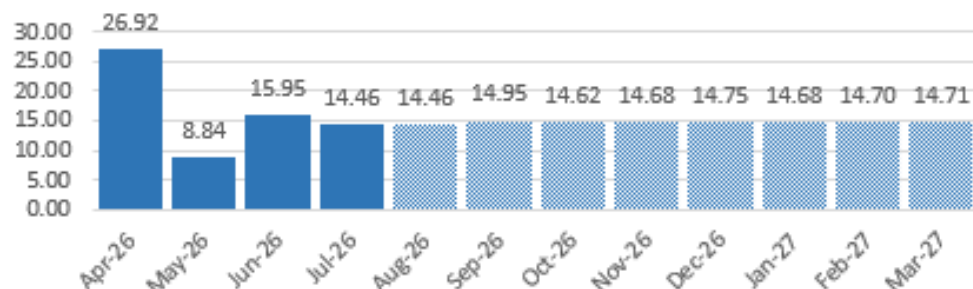
The forecasted months up to September reflect a more dynamic position as further access to system information enables this. Indicative in year changes that are known have been included into the forecasted year ahead.

Workforce Plan (3 of 3)

Actual/Forecasted Substantive Variation from Plan



Actual/Forecasted Bank Variation from Plan



Actual/Forecasted Agency Variation from Plan



M04 actual vs plan - As at M04 for 2026/27 the Trust is 38wte below what was forecasted for the total workforce. This consists of the substantive whole time equivalent (WTE) being 51wte under plan and Temp Staffing cover being 13wte 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 – 3.8wte growth by M04

Specialist Services/Forensic Liaison Partnership – 5.1wte – 1wte growth by M04

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

Temporary Staffing

- Bank usage across the Trust accounts for 5.2% of the total workforce wte and Agency usage accounts for 0.2% of the total workforce wte.
- Of the temporary staffing usage for July captured within the Optima E-Rostering system, 97% of this was for the 24/7 services. Each of the services have a dedicated headspace of 24% in the establishment figures to account for staff absence before needing to bring in additional hours or temp staffing.

Trust Vacancy Position

- The vacancy rate for M04 is reported at 6.5%. This is a minor increase from the reported position for M03 (6.4%).

Forecasted position - The forecasted variation is based on the current variation from plan and has been mitigated by indicative changes that could 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 – Adult CMHTs (Trust indicator) (1 of 2)

Community directorate



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

Performance during M04 is 94.1% and despite recent recovery, performance has not met the planned trajectory or required standard.

The original target date for achieving the required standard was May 2025; this was subsequently revised to August 2025, January 2026, April and is currently 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). Revised trajectories have been requested.

Updated actions have been provided for M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-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	82.5%	78.8%	93.2%	92.5%	95.0%	96.1%	93.9%	92.6%	94.2%	86.0%	86.5%	92.5%	94.1%
Trajectory	94.0%	95.0%	85.0%	87.0%	90.0%	92.0%	95.0%	93.0%	94.0%	95.0%	92.0%	94.0%	95.0%

Actions M04:

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.

M04 update: Work is on-going commenced between the Quality Improvement Lead Nurse and Service Manager to map the current CMHT workforce across the service line. This baseline exercise will support the planned demand and capacity review and help identify opportunities to align resources more effectively with variations in local demand and need.

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.

M04 update: Monthly sickness surgeries continue across all teams. Absence management remains under regular review, with managers continuing to provide support and implement appropriate interventions to minimise the impact on service delivery.

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.

M04 update: The SAF waiting list continues to be actively monitored across all CMHTs to support timely allocation and effective use of available resources. Lymebrook continues to make significant progress in reducing both SAF waiting times and initial assessment waits, reflecting the impact of recent caseload management and capacity initiatives. At Sutherland, a number of targeted measures have been implemented to manage demand and improve access, including the utilisation of bank hours over a four-week period to support achievement of the Referral to Assessment 4-week standard, additional hours for part-time staff to increase SAF completion capacity, and a full review of patients awaiting SAF allocation. These actions have improved oversight of demand, supported service flow, and contributed to reductions in waiting times across the pathway.

Re-deployment – Re-deployment and temporary resource allocation from Ashcombe Centre and Lymebrook to support increased pressures due to absences at Greenfields.

Performance Improvement Plan: Referral to Assessment within 4 weeks – Adult CMHTs (Trust indicator) (2 of 2)

Community directorate

Jun-26

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	337	13	3	4	357	94.4%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	13	0	0	0	13	100.0%
City CMHT - Sutherland	22	5	0	1	28	78.6%
County CMHT Moorlands	15	0	0	0	15	100.0%
County CMHT Newcastle	36	1	0	0	37	97.3%
CMHT Total	86	6	0	1	93	92.5%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	7	0	1	0	8	87.5%
City CMHT - Sutherland	10	2	0	0	12	83.3%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	0	0	0	0	0	
CMHT Total	17	2	1	0	20	85.0%

Jul-26

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	553	17	7	8	585	94.5%

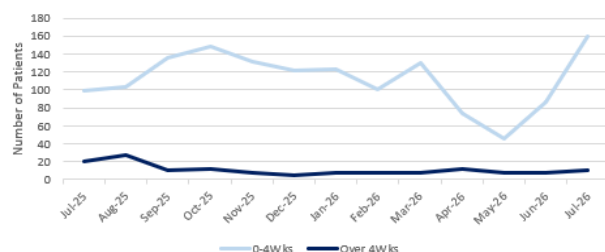
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	18	0	1	1	20	90.0%
City CMHT - Sutherland	44	1	0	1	46	95.7%
County CMHT Moorlands	32	0	1	2	35	91.4%
County CMHT Newcastle	65	1	0	2	68	95.6%
CMHT Total	159	2	2	6	169	94.1%

RTA Waiting

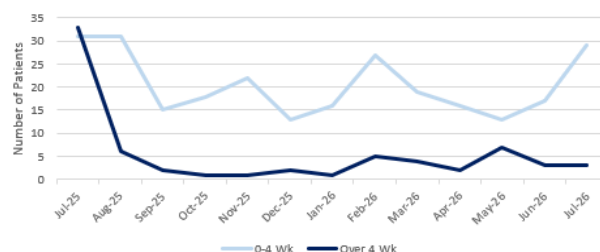
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	13	0	0	1	14	92.9%
City CMHT - Sutherland	15	2	0	0	17	88.2%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	1	0	0	0	1	100.0%
CMHT Total	29	2	0	1	32	90.6%

- Adult CMHTs remain a significant driver of directorate RTA performance, contributing 28.9% of all RTAs completed in M04. The service delivered its highest monthly number of RTAs completed in the last 13 months.
- RTA performance for Adult CMHTs is slightly below standard in M04, achieving 94.1% against a target of 95%.

Time Waited for First Contact



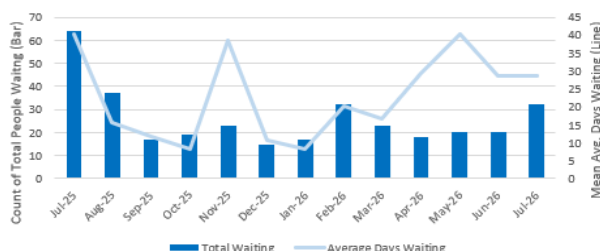
Waiting for First Contact Times EOM



Total No. of First Contacts & Average No. of Days Waited

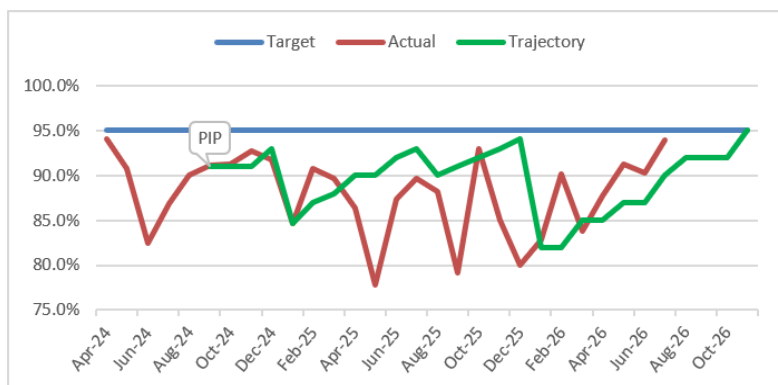


Total People Waiting & Avg. No. of Days Waiting at EOM



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 M04 is 93.9% which has exceeded the planned trajectory but did not meet the required standard.

The original aim was for the standard to be achieved by August 2025; this has been extended to January 2026 and is currently 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 M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-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%	95.0%	95.0%	95.0%	95.0%
Actual	89.7%	88.2%	79.2%	93.0%	85.0%	80.0%	82.8%	90.2%	83.8%	87.7%	91.2%	90.3%	93.9%				
Trajectory	93.0%	90.0%	91.0%	92.0%	93.0%	94.0%	82.0%	82.0%	85.0%	85.0%	87.0%	87.0%	90.0%	92.0%	92.0%	92.0%	95.0%

Actions M04:

Weekly referral to assessment (RTA) review to be relaunched with AD chairing, RTT to also be monitored.

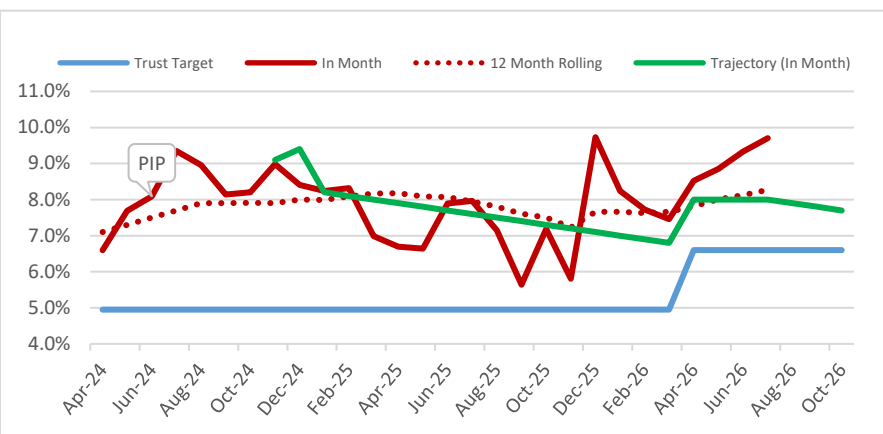
M04 progress update: Weekly RTA meetings and performance clinics are now well established. The process is embedded and operating as business as usual (BAU). Ongoing challenges remain, primarily linked to capacity constraints in certain areas and external factors outside of the Directorate's control (e.g. patients transferred from other services, although the shadow reporting is making it easier to differentiate).

M04 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%]).

M04 progress update: Recovery plans are now in place and performing above trajectory since April 2026. **Neuropsychology** has implemented a new assessment process which has supported a vast improvement in long standing waits.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care directorate



A PIP was issued in M03 (2024/25). For 2026/27, a new rolling 12-month target of 6.60% has been implemented.

Rolling 12-month sickness absence at M04 is 8.27%, with in-month absence at 9.70%. Both measures remain above the required target. May and June figures have been updated.

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%. Revised trajectories have been set in M04 (Apr-Oct 2026).

Updated actions have been provided in M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Trust Target	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	6.60%	6.60%	6.60%	6.60%	6.60%	6.60%	6.60%
In Month	7.96%	7.15%	5.64%	7.18%	5.81%	9.73%	8.24%	7.72%	7.46%	8.52%	8.85%	9.33%	9.70%			
12 Month Rolling	7.95%	7.80%	7.61%	7.50%	7.23%	7.66%	7.66%	7.63%	7.66%	7.81%	8.01%	8.12%	8.27%			
Trajectory (In Month)	7.60%	7.50%	7.40%	7.30%	7.20%	7.10%	7.00%	6.90%	6.80%	8.00%	8.00%	8.00%	8.00%	7.90%	7.80%	7.70%

M04 progress update:

The current plan requires review, alongside the Trust Sickness Improvement Plan, as it does not adequately address the root causes of sickness absence and includes actions that are unlikely to be achievable or deliver the required outcomes. A revised approach should focus on understanding the key drivers of absence and implementing targeted, measurable actions with demonstrable impact. AD will discuss further with DCOP.

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.

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.

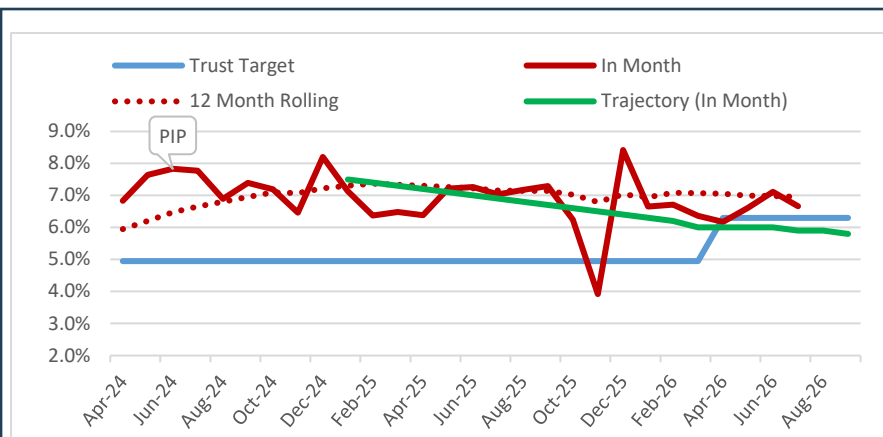
Directorate leads to review current barriers and inconsistencies in sickness absence management, working with HR to standardise process and strengthen compliance.

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)

Specialist Services directorate



A PIP was issued in M03 (2024/25). For 2026/27, a new rolling 12-month target of 6.30% has been implemented.

Rolling 12-month sickness absence at M04 is 6.95%, with in-month absence at 6.66%. Both measures remain above the required target. April to June figures have been updated.

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

Updated actions have been provided in M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Trust Target	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	6.30%	6.30%	6.30%	6.30%	6.30%	6.30%
In Month	7.03%	7.17%	7.29%	6.24%	3.92%	8.42%	6.65%	6.71%	6.36%	6.17%	6.61%	7.11%	6.66%		
12 Month Rolling	7.15%	7.15%	7.14%	7.02%	6.79%	7.03%	6.94%	7.08%	7.07%	7.05%	6.99%	6.98%	6.95%		
Trajectory (In Month)	6.90%	6.80%	6.70%	6.60%	6.50%	6.40%	6.30%	6.20%	6.00%	6.00%	6.00%	6.00%	5.90%	5.90%	5.80%

Actions M04:

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.

M04 Progress Update:

Enhanced Sickness Governance

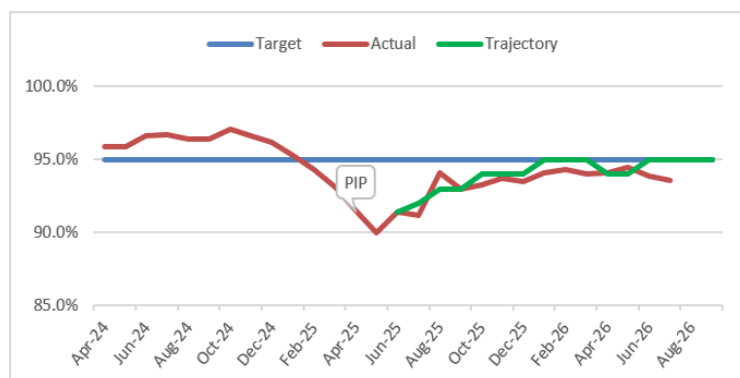
Monthly sickness surgeries will continue, chaired by the Associate Director and supported by the people team. Focus is placed on; all cases across services are reviewed and continual monitoring of repeat stage 2 cases, frequent absence patterns, and long-term sickness cases.

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.

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services directorate



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

Performance at M04 is 93.6%. Performance has not met the planned trajectory or required standard.

The original aim was for the standard to be achieved by October 2025 this has been extended to January 2026, June 2026 and is currently forecast for September 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 M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-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%	95.0%	95.0%
Actual	91.2%	94.1%	93.0%	93.3%	93.7%	93.5%	94.1%	94.3%	94.0%	94.1%	94.5%	93.9%	93.6%		
Trajectory	92.0%	93.0%	93.0%	94.0%	94.0%	94.0%	95.0%	95.0%	95.0%	94.0%	94.0%	95.0%	95.0%	95.0%	95.0%

Actions M04:

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.

M04 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. An action plan is in place and being monitored.

This programme of engagement is currently ongoing.

Compliance and Caseload Oversight (Neuropsychiatry)

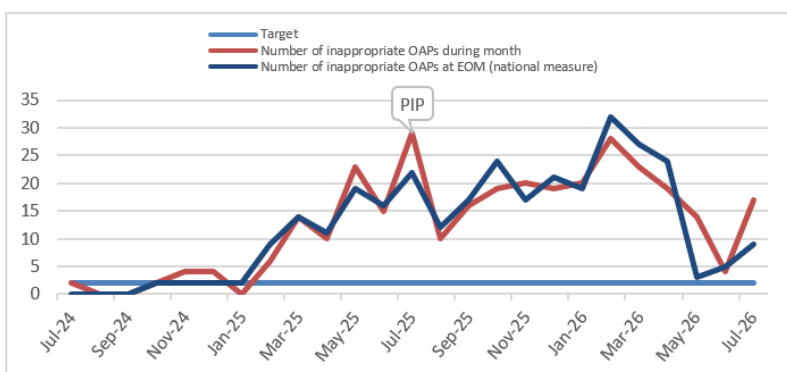
- Neuropsychiatry services - non-compliant practitioners have been identified and action taken. Targeted actions are being addressed through structured caseload supervision to improve adherence and consistency. An action plan is in place and being monitored by the SLT and will form part of the informal performance management stage.

Next Steps

- 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) (1 of 2)

Acute and Urgent Care and Community directorates



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

M04 performance shows that there were 17 inappropriate OAPs recorded during the month, with the EOM position at 9 inappropriate OAPs (national measure). A significant increase compared to M03.

Updated actions have been provided in M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Target	2	2	2	2	2	2	2	2	2	2	2	2	2
Number of inappropriate OAPs during month	29	10	16	19	20	19	20	28	23	19	14	4	17
Number of inappropriate OAPs at EOM (national measure)	22	12	17	24	17	21	19	32	27	24	3	5	9

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

A Performance Improvement Plan (PIP) remains in place to address the number of inappropriate Out of Area (OAP) placements. In M04, there were 17 inappropriate OAPs during the month and 9 inappropriate OAPs on the last day of the month, primarily attributable to adult acute bed capacity constraints, flow issues, and social care delays, noting 3 remain CRFD.

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 OAP 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 OAP 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 OAP 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.

The volume of 24–72 routine referrals continues to increase month on month reaching over 900 in M4.

Performance Improvement Plan: Out of Area Placement (National indicator) (2 of 2)

Acute and Urgent Care and Community directorates

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.

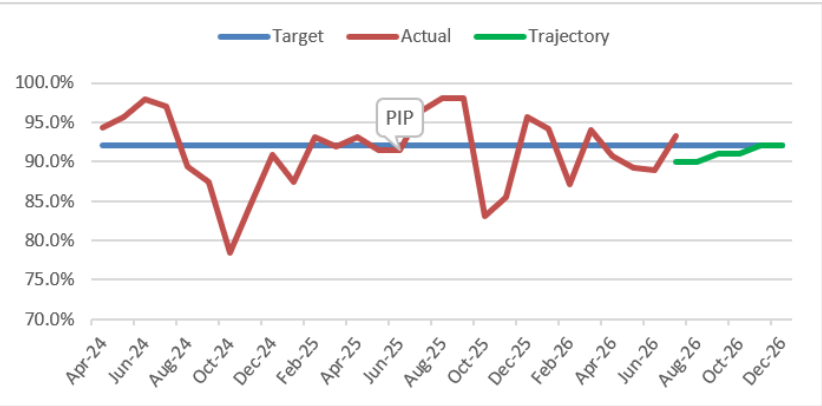
Enhanced Data and Reporting

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

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

M04 update: *The Performance Improvement Plan remains in place, with daily bed flow meetings and weekly system oversight meetings continuing to provide robust management of bed capacity and patient flow. The Clinical Bed Manager remains in post and is supporting proactive capacity management across the pathway. Work to optimise bed utilisation, strengthen discharge processes, and reduce inappropriate OAP placements continues, with no significant change to the actions reported in M03.*

Performance Improvement Plan: Referral to Treatment within 18 Weeks (Trust indicator)
Specialist Services directorate



A PIP was issued in M04 (2026/27).

Performance in M04 is 93.3% and is achieving the required standard.

The aim is for the standard to be achieved by November 2026.

Trajectories have been set in M04 (Jul-Nov 2026).

Updated actions have been provided in M04.

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Actual	96.4%	98.1%	98.0%	83.1%	85.5%	95.7%	94.2%	87.2%	94.0%	90.7%	89.2%	88.9%	93.3%					
Trajectory													90.0%	90.0%	91.0%	91.0%	92.0%	92.0%

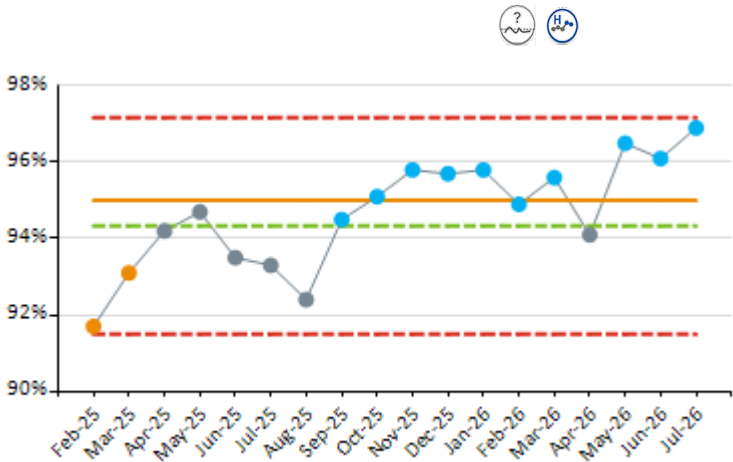
Action M04:

New PIP for M04. RTT and RTA Tuesday meetings to be chaired by AD going forward to fully assess the challenges and support needed for consistency.

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

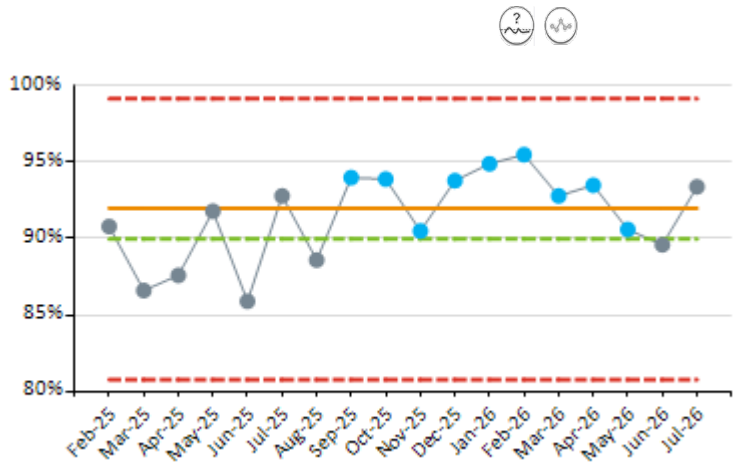
Referral to Assessment within 4 weeks (Trust Measure)



13 Month Trend

93.3%	92.4%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%	94.1%	96.5%	96.1%	96.9%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

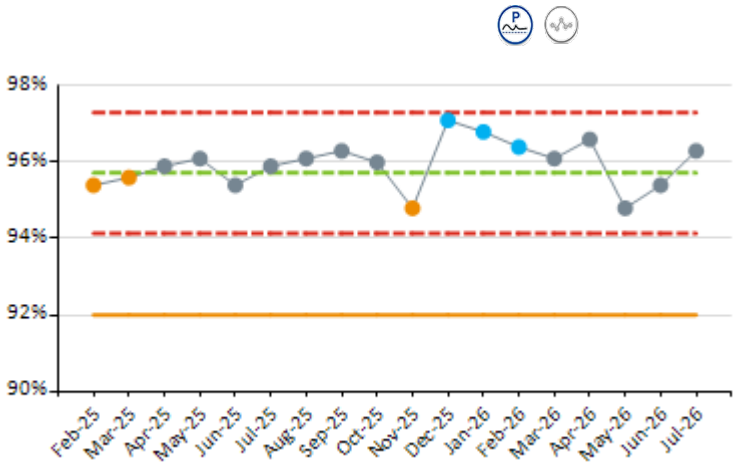
CAMHS Compliance within 18 week waits (Referral to Treatment) (Trust Measure)



13 Month Trend

92.8%	88.6%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%	93.5%	90.6%	89.6%	93.4%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

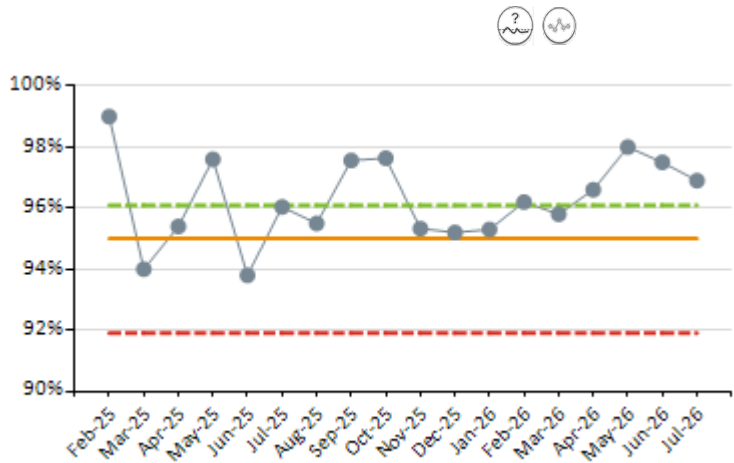
Referral to Treatment within 18 weeks (Trust Measure)



13 Month Trend

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

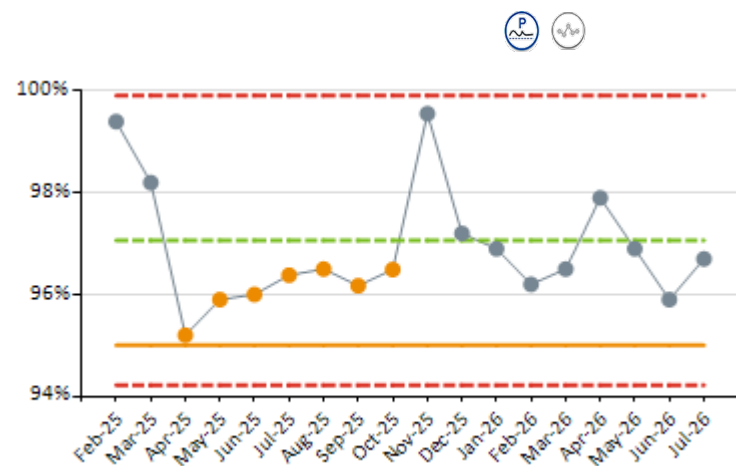
MH Liaison 4 Hour Response (Urgent) (Trust Measure)



13 Month Trend

96.0%	95.5%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%	96.6%	98.0%	97.5%	96.9%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

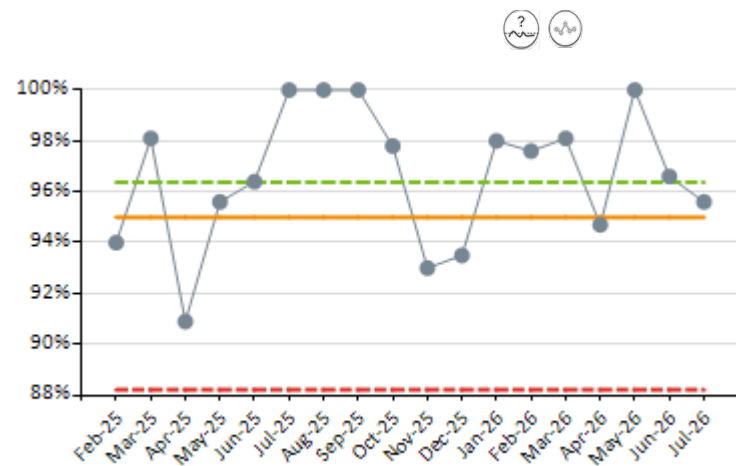
MH Liaison 24 Hour Response (Urgent from General Hospital Ward) (Trust Measure)



13 Month Trend

96.4%	96.5%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%	97.9%	96.9%	95.9%	96.7%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

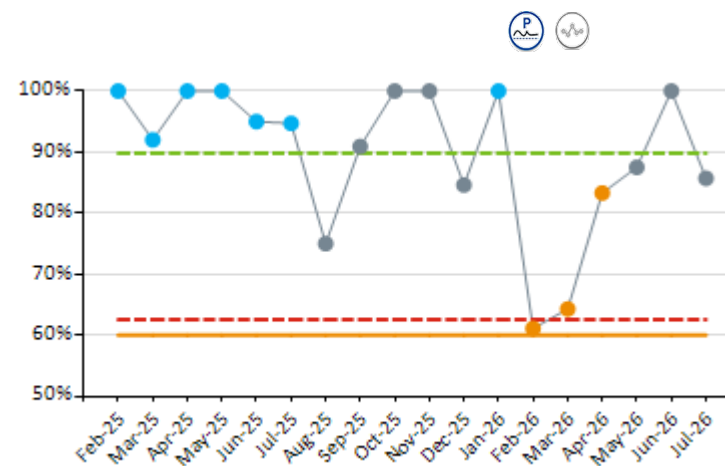
48 Hour Follow Up (Trust Measure)



13 Month Trend

100.0%	100.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%	94.7%	100.0%	96.6%	95.6%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

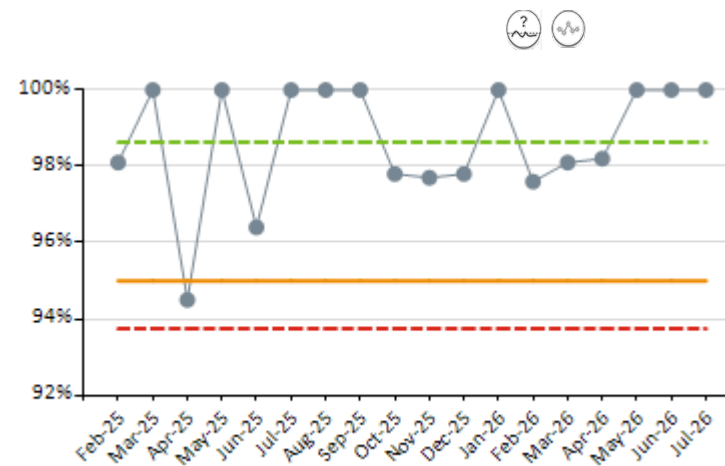
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment (National Measure)



13 Month Trend

94.7%	75.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%	83.3%	87.5%	100.0%	85.7%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

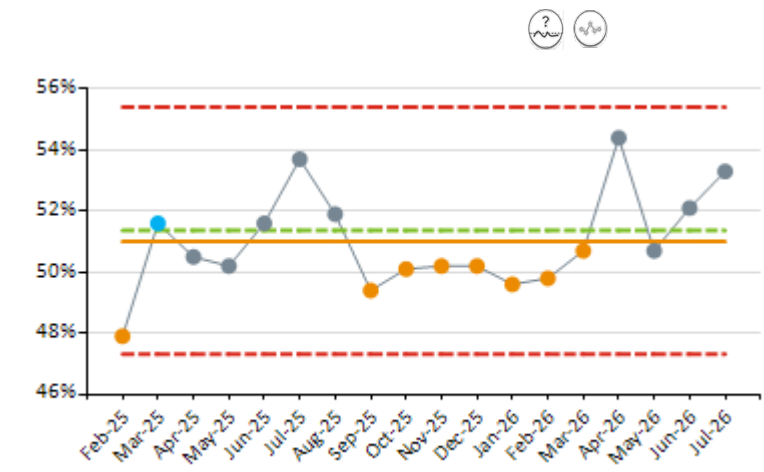
7 Day Follow Up (All Patients) (Trust Measure)



13 Month Trend

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

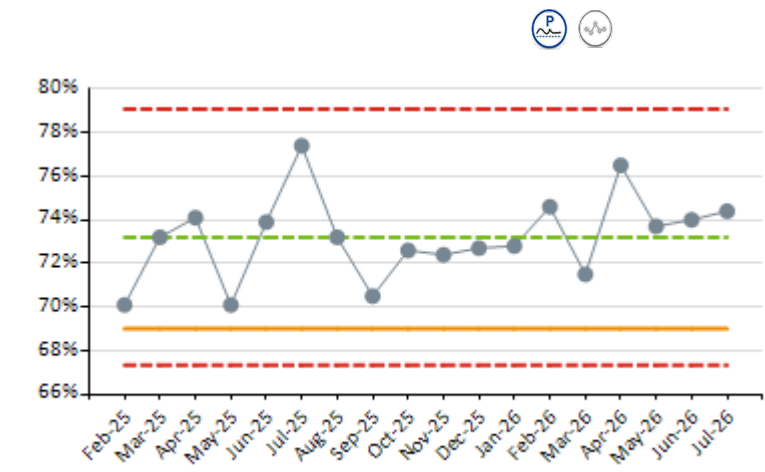
Talking Therapies for Anxiety and Depression: Reliable Recovery (National Measure)



13 Month Trend

53.7%	51.9%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%	54.4%	50.7%	52.1%	53.3%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

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

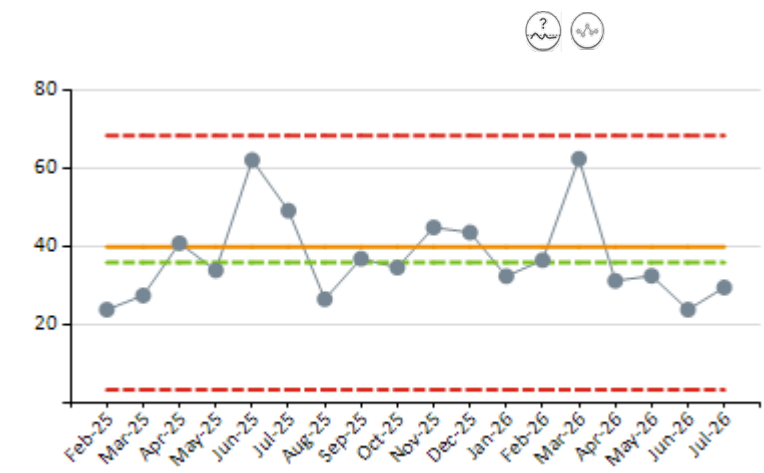


13 Month Trend

77.4%	73.2%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%	76.5%	73.7%	74.0%	74.4%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Core Indicators – SPC Trend (Inpatient and Quality)

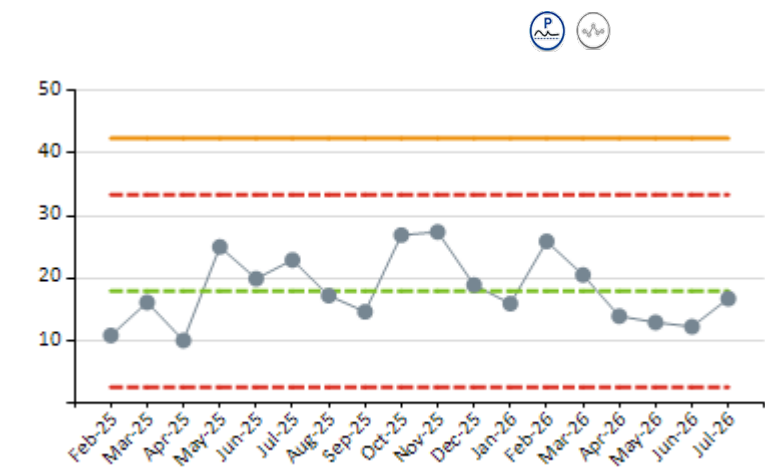
Average Length of Stay - Adult (National Measure)



13 Month Trend

49.3	26.6	37.0	34.7	45.0	43.7	32.5	36.6	62.6	31.3	32.6	23.9	29.6
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

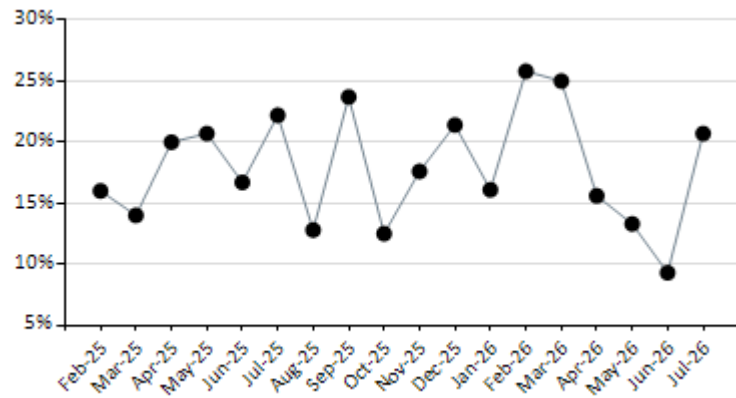
Median Length of Stay - Adult (National Measure)



13 Month Trend

22.9	17.2	14.6	26.9	27.4	18.9	15.9	25.9	20.5	13.9	12.9	12.2	16.7
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

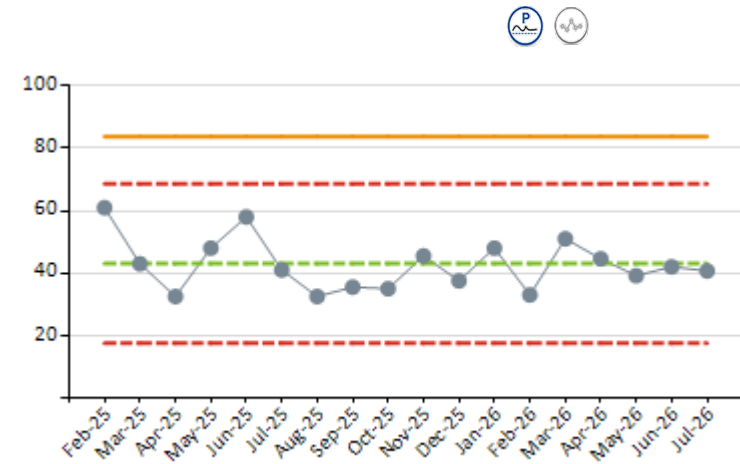
Adult Acute LoS-Over 60 days as a % of all discharges (National Measure)



13 Month Trend

22.2%	12.8%	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%	15.6%	13.3%	9.3%	20.7%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

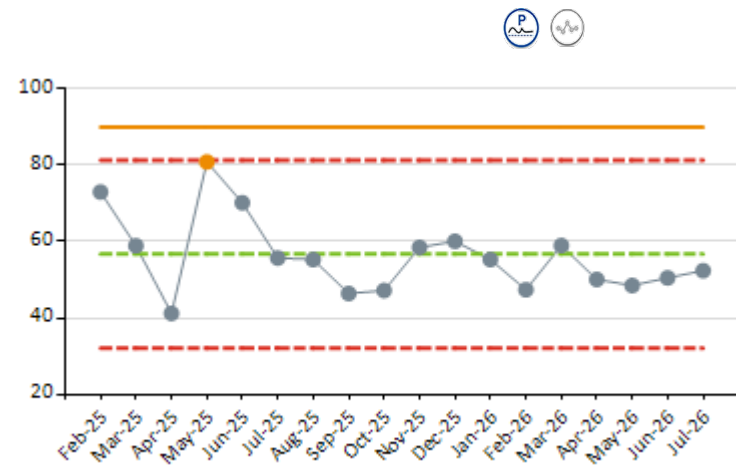
Median Length of Stay - Older Adult (National Measure)



13 Month Trend

41.0	32.5	35.5	35.0	45.5	37.5	48.0	33.0	51.0	44.6	39.2	42.0	40.7
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

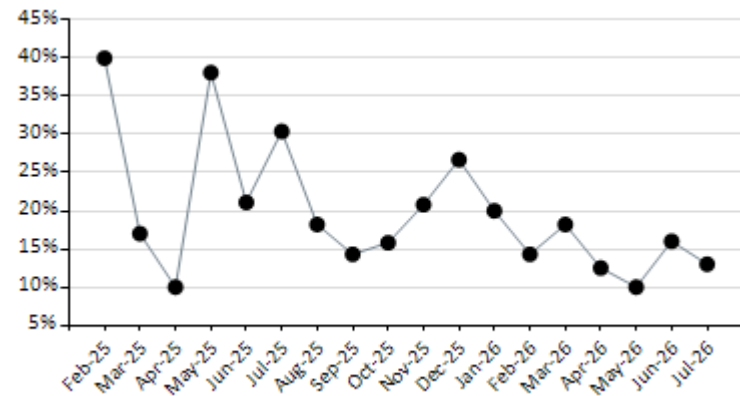
Average Length of Stay - Older Adult (National Measure)



13 Month Trend

55.7	55.3	46.4	47.2	58.5	60.1	55.3	47.4	59.0	50.1	48.5	50.5	52.4
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

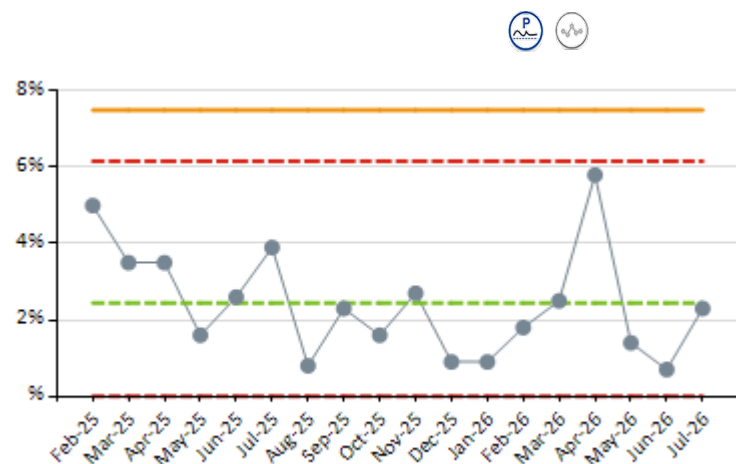
Older Adult Acute LoS-Over 90 days as a % of all discharges (National Measure)



13 Month Trend

30.4%	18.2%	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%	12.5%	10.0%	16.0%	13.0%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

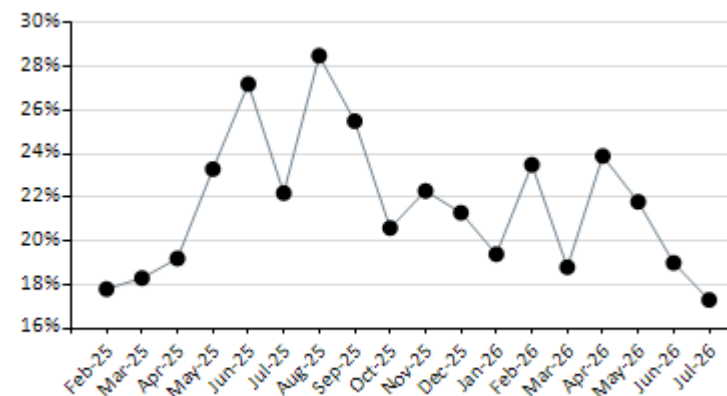
Emergency Readmissions rate (30 days) (Trust Measure)



13 Month Trend

3.9%	0.8%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%	5.8%	1.4%	0.7%	2.3%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Clinically Ready for Discharge (CRFD) (Trust Measure)

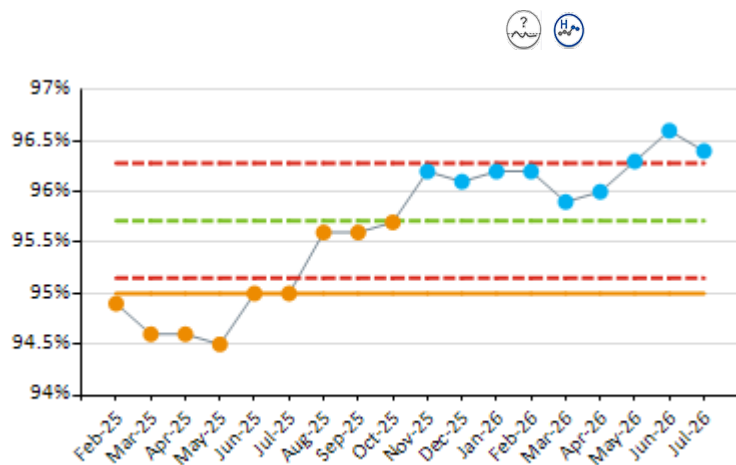


13 Month Trend

22.2%	28.5%	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%	23.9%	21.8%	19.0%	17.3%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Core Indicators – SPC Trend (Community and Quality)

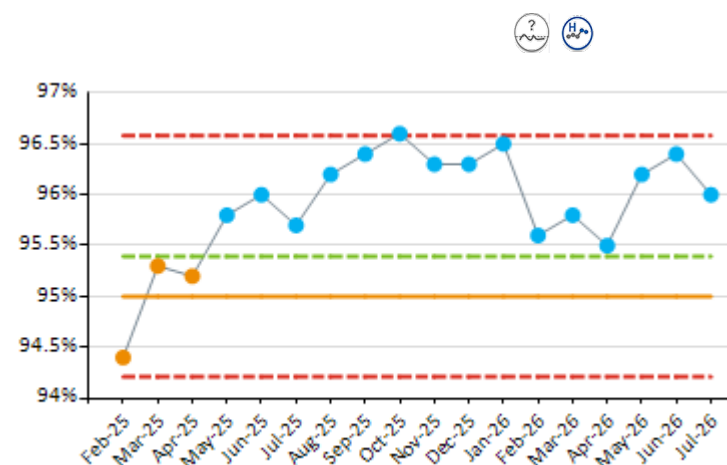
Care Plan Compliance (Trust Measure)



13 Month Trend

95.0%	95.6%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%	96.0%	96.3%	96.6%	96.4%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Risk Assessment Compliance (Trust Measure)

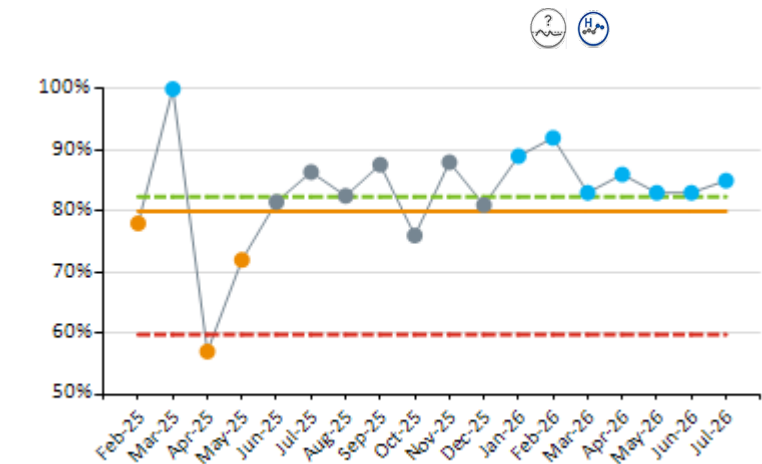


13 Month Trend

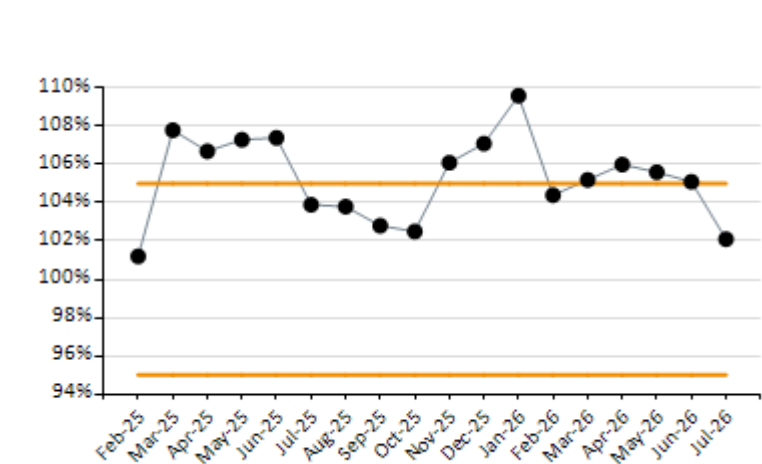
95.7%	96.2%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%	95.5%	96.2%	96.4%	96.0%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Core Indicators – SPC Trend (Organisational Health)

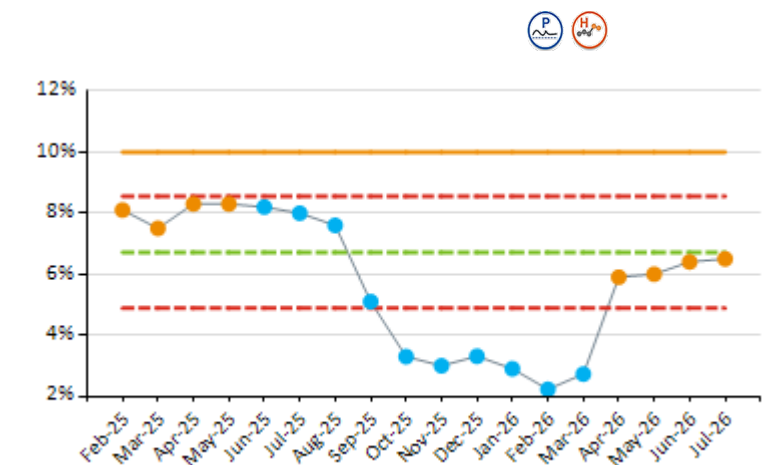
Friends and Family Test - Recommended (Trust Measure)



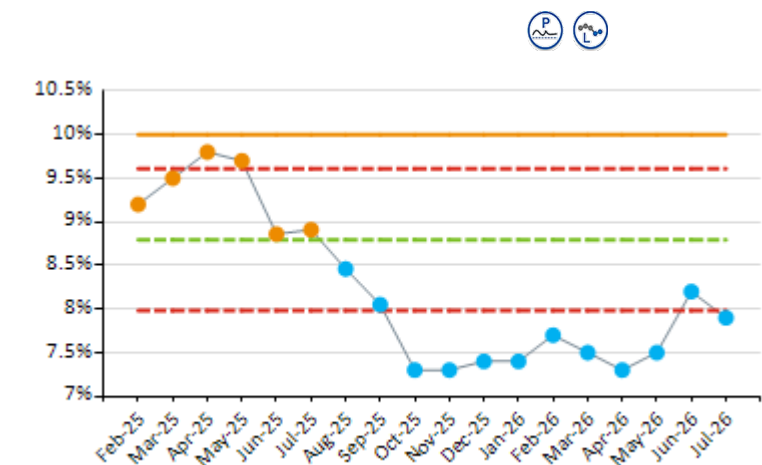
Safe Staffing (National Measure)



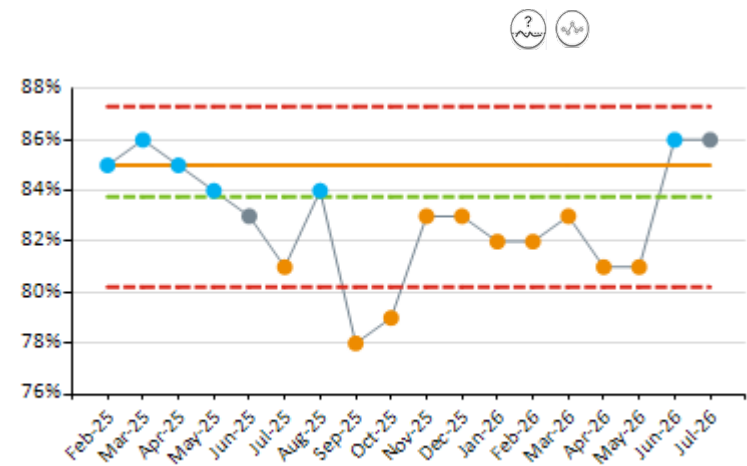
Vacancy Rate (Trust Measure)



Staff Turnover (Trust Measure)



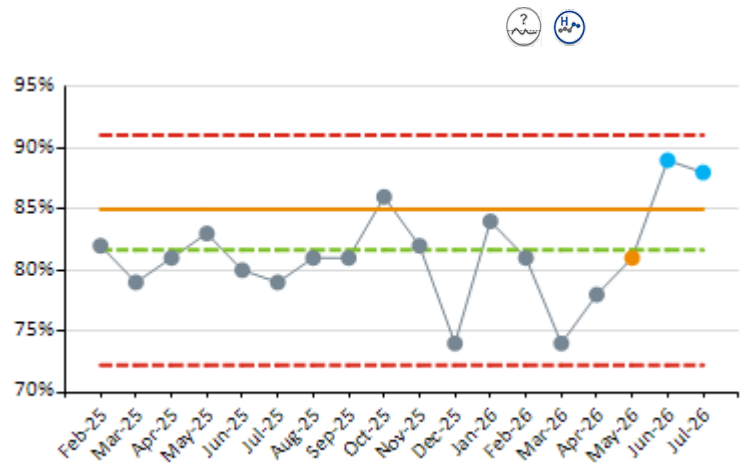
Appraisal (Trust Measure)



13 Month Trend

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

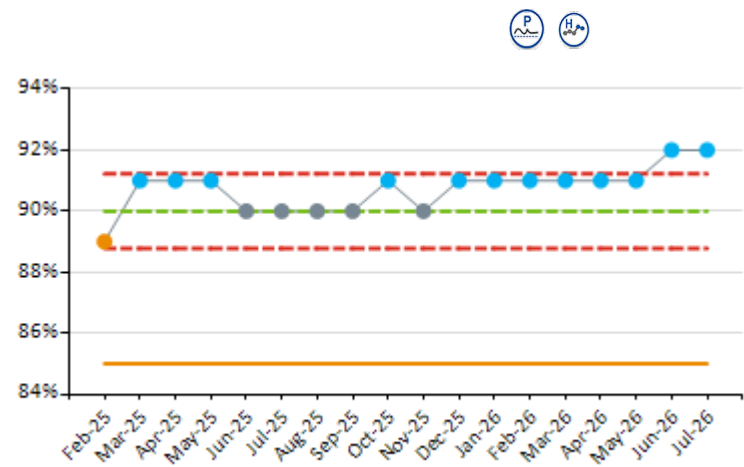
Clinical Supervision (Trust Measure)



13 Month Trend

79.0%	81.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%	78.0%	81.0%	89.0%	88.0%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul

Statutory & Mandatory Training (Trust Measure)



13 Month Trend

90.0%	90.0%	90.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%	92.0%
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	

Enclosure No: 13

FINANCE POSITION MONTH 4

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

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

Aligned to Board Assurance Framework Risk:	Financial - 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:	Finance and Resource Committee
Strategic Priorities:	Growth - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A.

Recommendation / Required Action:	Receive the Month 4 financial position noting: • A year to date deficit of £319k against a planned deficit of £361k, resulting in a favourable variance of £42k. • An underlying financial position (ULP) deficit of £280k. • Agency expenditure of £292k, against planned expenditure of £348k, resulting in a favourable variance of £56k. • Bank expenditure of £2,063k against planned expenditure of £1,684k, resulting in an adverse variance of £379k. • Year to date CIP delivery of £1,396k against a plan of £2,160k, resulting in an adverse variance of £764k. • Capital expenditure of £89k which is £1,092k behind plan. • A cash balance of £40.7m on 31st July 2026.
Executive Summary:	The Adjusted Financial Performance in month shows a deficit of £80k, against a planned deficit of £87k, resulting in a favourable variance of £7k. The year-to-date position remains in line with plan with a deficit of £319k against a planned deficit of £361k, resulting in a favourable variance of £42k. The Trust is reporting an underlying financial position (ULP) deficit of £280k, reflecting current efficiency assumptions. The Trust has a recurrent CIP target of £6.3m, a non-recurrent target of £1.5m. At Month 4 the Trust is forecasting full delivery of the £7.8m CIP target. Of this, £3.6m is implemented and £4.2m is fully developed. However, 15% of the CIP target remains classified as high risk. In month agency expenditure was £66k against planned expenditure of £87k, resulting in a favourable variance of £21k against the 32% agency expenditure reduction from 2025/26. In month bank expenditure was £499k against planned expenditure of £421k, resulting in an adverse variance of £78k against the 20% bank expenditure reduction from 2025/26. The Trust's capital expenditure year to date was £89k which is £1,092k behind plan. The Trust is forecasting to spend to plan. In month, the Trust achieved the Better Payment Practice Code target of 95% for value of invoices paid within 30 days, with performance at 97.6% but only achieved 92.8% of the number invoices paid within 30 days. The cash position of the Trust on 31st July 2026 is £40.7m.

Key Messages:

- Financial position is on plan.
- Bank expenditure is over plan by £379k.
- 15% (£1.2m) of the CIP target is classified as high risk.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	18/08/2026
2	F&R	21/08/2026
2	Public Trust Board	02/09/2026



TRUST BOARD – 10th September 2026

Finance Position Month 4

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

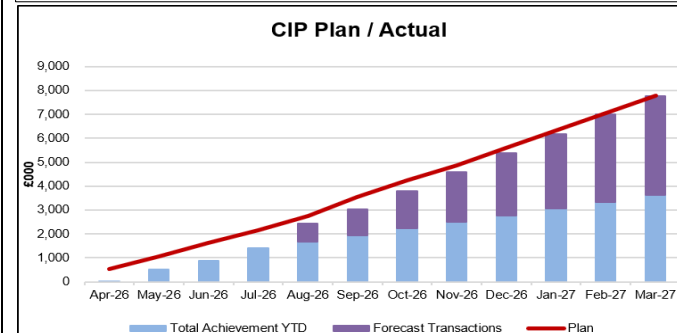
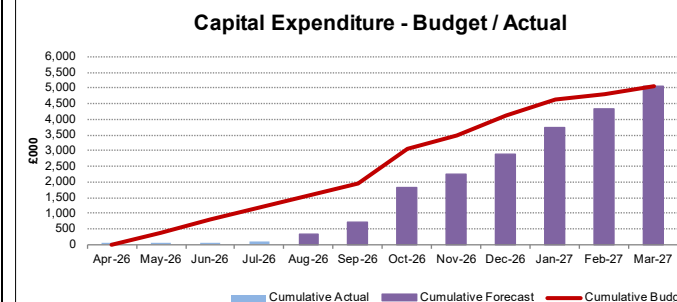
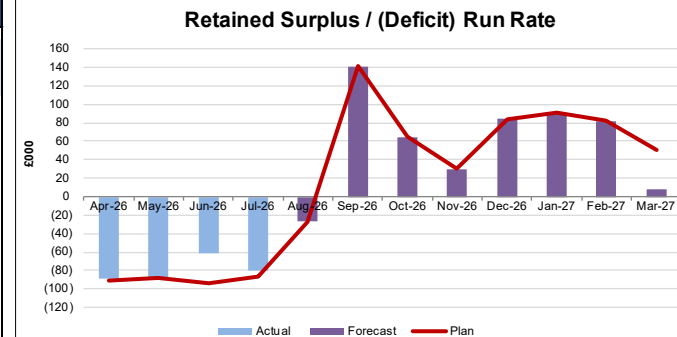
Key financial performance metrics are included for the following:

- 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 July 2026

Key Metrics								
£000	M1	M2	M3	M4	YTD	Average	Forecast	FOT RAG
Variance to Plan								
In month financial position	2	(0)	33	7	42	10		
YTD financial position	2	1	35	42	42	20	(0)	
Run Rates (Actuals)								
Income	15,183	15,128	15,230	15,005	60,545	15,136	182,285	
Pay	(9,407)	(9,533)	(9,519)	(9,453)	(37,912)	(9,478)	(114,064)	
Non-pay	(5,550)	(5,378)	(5,474)	(5,342)	(21,744)	(5,436)	(64,402)	
Finance & Other Non Operating	(269)	(259)	(252)	(244)	(1,024)	(256)	(3,127)	
Agency (Actuals)								
	(66)	(87)	(74)	(66)	(292)	(73)	(1,053)	
Agency Variance To Plan								
	21	(0)	13	21	56	14	0	
Medical Agency	11	15	14	26	67	17	2	
Nurse Agency	5	(10)	(1)	(5)	(11)	(3)	(2)	
Other Agency	5	(5)	0	0	0	0	0	
Non Clinical Agency	0	0	0	0	0	0	0	
Bank (Actuals)								
	(551)	(485)	(528)	(499)	(2,063)	(516)	(5,567)	
Bank Variance To Plan								
	(130)	(64)	(107)	(78)	(379)	(95)	(522)	
Medical Bank	(4)	(4)	(4)	(11)	(23)	(6)	222	
Nurse Bank	(67)	(26)	(56)	(33)	(181)	(45)	(295)	
Other Clinical Bank	(61)	(35)	(49)	(37)	(183)	(46)	(495)	
Non Clinical Bank	2	0	2	3	8	2	46	
CIP (Variance)	(512)	(43)	(196)	(13)	(764)	(191)	0	
Cash balance	36,928	40,778	40,973	40,726	40,726	39,851	30,075	
Capital expenditure (Variance)	0	343	389	361	1,093	273	(0)	
BPPC								
Number	95.6%	96.6%	96.1%	94.9%	94.9%	95.8%		
Value	98.7%	99.8%	98.2%	98.1%	98.1%	98.7%		



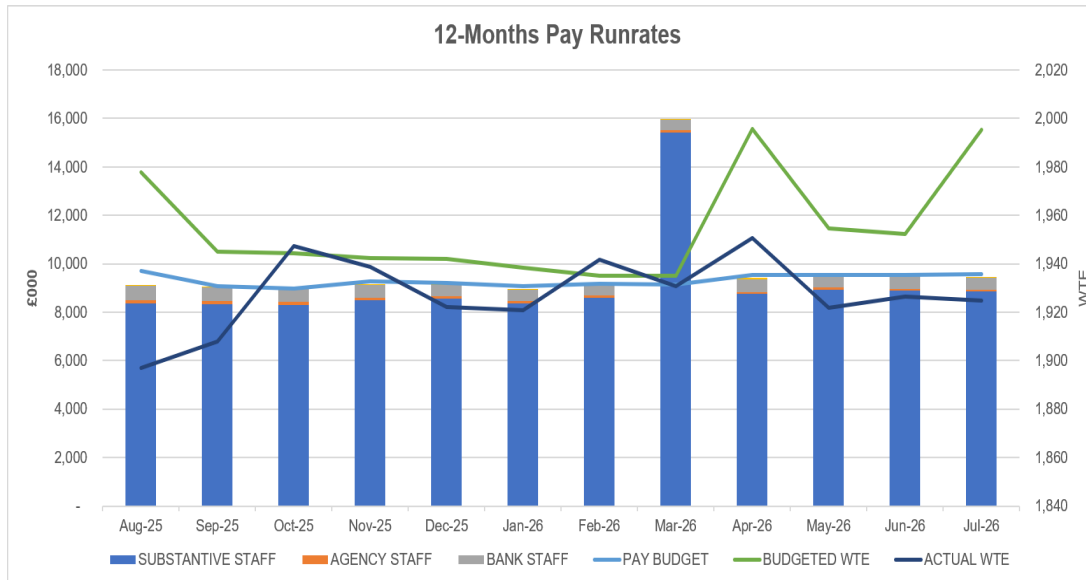
RAG	Description
	Above plan / budget (more than 5%).
	Above plan / budget (within 5%).
	Within plan / budget.



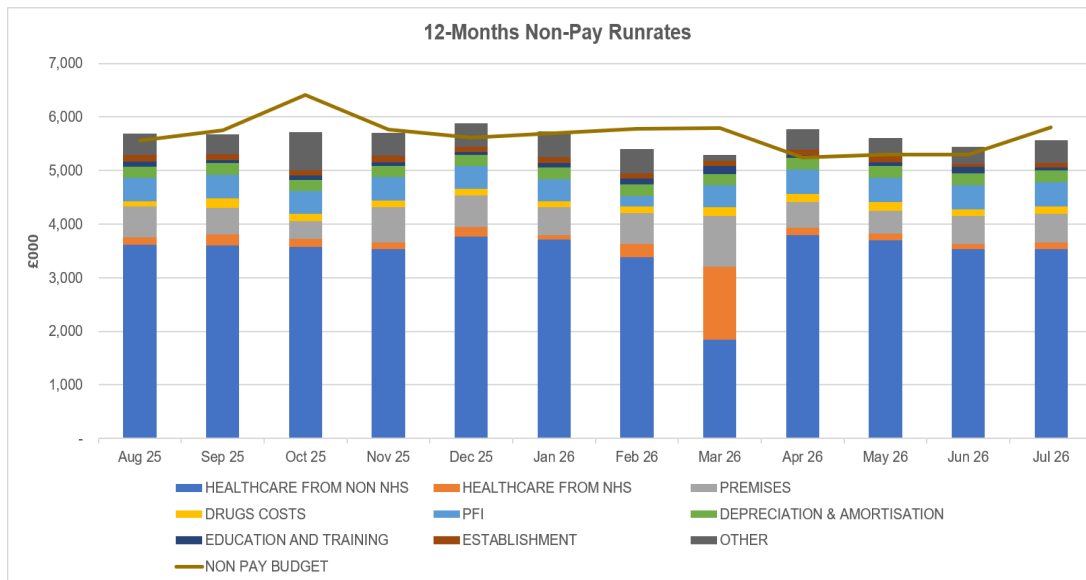
High Level Analysis	Annual Plan £000	In Month Budget £000	In Month Actuals £000	Variance £000	Year to Date Budget £000	Year to Date Actuals £000	Variance £000	Forecast Budget £000	Forecast Actuals £000	Variance £000
Income from Patient Care Activities	163,888	13,716	13,571	(145)	54,732	54,746	14	164,223	164,864	641
Income from Other Operating Activities	16,049	1,599	1,434	(165)	5,712	5,800	87	16,953	17,421	469
Income	179,937	15,315	15,005	(310)	60,444	60,545	101	181,175	182,285	1,110
Pay Costs	(111,104)	(9,566)	(9,453)	113	(38,164)	(37,912)	252	(111,894)	(114,064)	(2,170)
Non Pay Costs	(64,860)	(5,518)	(5,342)	175	(21,363)	(21,745)	(382)	(65,876)	(64,402)	1,474
Operating Expenditure	(175,964)	(15,084)	(14,795)	289	(59,527)	(59,656)	(130)	(177,770)	(178,466)	(696)
EBITDA	3,973	231	210	(21)	917	889	(28)	3,405	3,819	414
Finance & Other Non Operating Costs	(3,207)	(267)	(244)	23	(1,069)	(1,024)	46	(3,207)	(3,127)	81
Retained Surplus / (Deficit)	766	(36)	(34)	2	(152)	(135)	17	198	693	495
Add Back Impairments	0	0	0	0	0	0	0	0	0	0
Surplus/(deficit) before impairments	766	(36)	(34)	2	(152)	(135)	17	198	693	495
Technical Adjustments	(612)	(51)	(47)	5	(209)	(185)	24	(44)	(538)	(495)
Adjusted Financial Performance	154	(87)	(80)	7	(361)	(319)	42	154	154	(0)

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 £80k, against a planned deficit of £87k, resulting in a favourable variance of £7k.
- The year-to-date position is a deficit of £319k against a planned deficit of £361k, resulting in a favourable variance of £42k.
- The Trust is forecasting to deliver its planned surplus of £154k at year end.
- Income is reporting a favourable variance year to date, primarily driven by additional ICB income relating to the CUF uplift and education and training income is exceeding plan.
- 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 primarily due to unmet cost improvements and patient transport costs, partly offset by reduced patient placements costs (offset by an equal reduction in income).



- Budgeted WTE has increased by 43 wte in July.
- Actual WTE has remained constant throughout June and July.
- Substantive staffing costs remained stable in July 2026.
- Both bank and agency expenditure decreased in July 2026.



- Non-pay budget increased from June to July by £500k as a result of CIP and bad debt releases being transacted in previous months.
- Non-pay expenditure increased by £125k from June to July, mainly due to non pay including a credit for the reduction in the bad debt provision as a result of the Section 75 settlement agreement.

Mitigations	Forecast £000
Unmitigated Forecast Surplus / (Deficit)	(459)
HR Provision	(261)
Release of Balance Sheet Flexibilities	697
PFI Unavailability	375
Modifications to staffing projections	(198)
Mitigated Surplus / (Deficit)	154

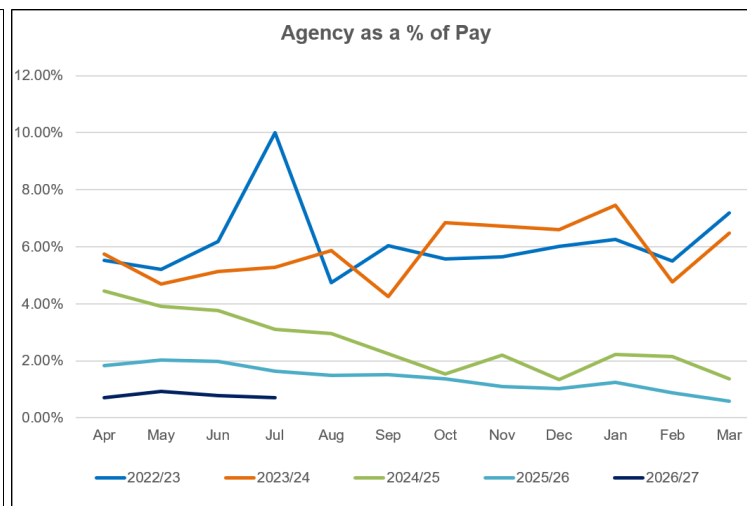
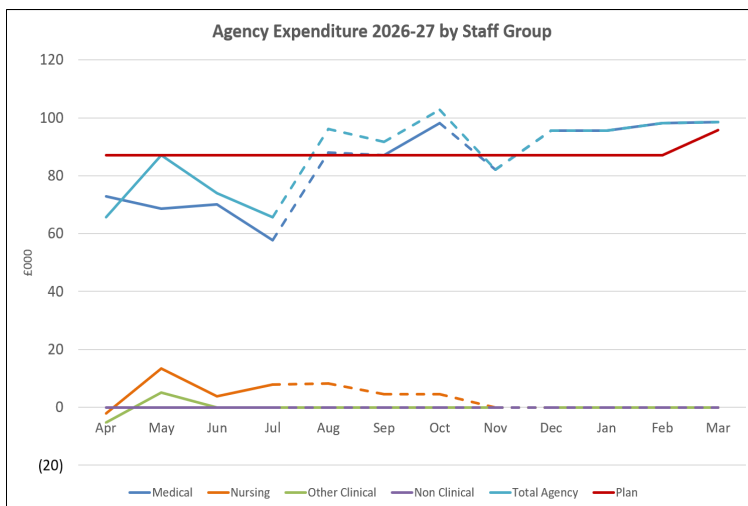
- The Trust's month 4 forecast submission to NHSE reflects a surplus of £154k, in line with the agreed plan.
- However, the current underlying forecast indicates an unmitigated deficit of £0.5m (this is a £65k improvement on the month 3 position). As a result, the submitted position is dependent upon 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, release of balance sheet flexibilities, PFI unavailability and modifications to staffing projections. 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	182,285	(114,064)	(67,092)	(975)	154
Forecast non-recurring efficiencies	0	(1,855)	(1,496)	0	(3,352)
Forecast deficit support funding	0	0	0	0	0
FYE of forecast recurring efficiencies	0	1,679	233	0	1,912
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	261	0	261
Non-Recurring Cost of Change (Excluding redundancy)	0	0	0	0	0
Non-Recurring Service Delivery - Bridge and Beyond	(311)	310	1	0	0
Non-Recurring Service Delivery - Reach Out	(300)	300	0	0	0
Transformation Reserve	0	665	80	0	745
2026/27 Underlying Position	181,674	(112,965)	(68,005)	(984)	(280)

- 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 £280k deficit.**

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)	(70)	(58)	(269)	(88)	(87)	(98)	(82)	(96)	(96)	(98)	(99)	(1,013)
Community	(65)	(64)	(63)	(46)	(238)	(54)	(53)	(64)	(48)	(62)	(62)	(64)	(65)	(710)
Primary Care	(8)	(5)	(7)	(12)	(32)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(9)	(100)
Central Services	0	0	0	0	0	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(25)	(203)
Nursing	2	(13)	(4)	(8)	(23)	(8)	(5)	(5)	0	0	0	0	0	(40)
Acute Services & Urgent Care	(1)	(3)	0	0	(4)	0	0	0	0	0	0	0	0	(4)
Specialist Care	3	(10)	(4)	(8)	(19)	(8)	(5)	(5)	0	0	0	0	0	(36)
Other Clinical	5	(5)	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
Total Agency	(66)	(87)	(74)	(66)	(292)	(96)	(92)	(103)	(82)	(96)	(96)	(98)	(99)	(1,053)
Agency as a % of Pay	0.70%	0.91%	0.78%	0.69%	0.77%	1.03%	0.95%	1.10%	0.87%	1.01%	1.01%	1.03%	0.99%	0.92%
Plan	(87)	(87)	(87)	(87)	(348)	(87)	(87)	(87)	(87)	(87)	(87)	(87)	(96)	(1,053)
Variance to Plan (Overspend) / Underspend	21	(0)	13	21	56	(9)	(5)	(16)	5	(9)	(9)	(11)	(3)	0
Agency Variance as a % of Plan	(24.62%)	0.18%	(15.00%)	(24.59%)	(16.01%)	10.57%	5.31%	18.14%	(5.66%)	9.80%	9.80%	12.94%	2.84%	(0.0%)

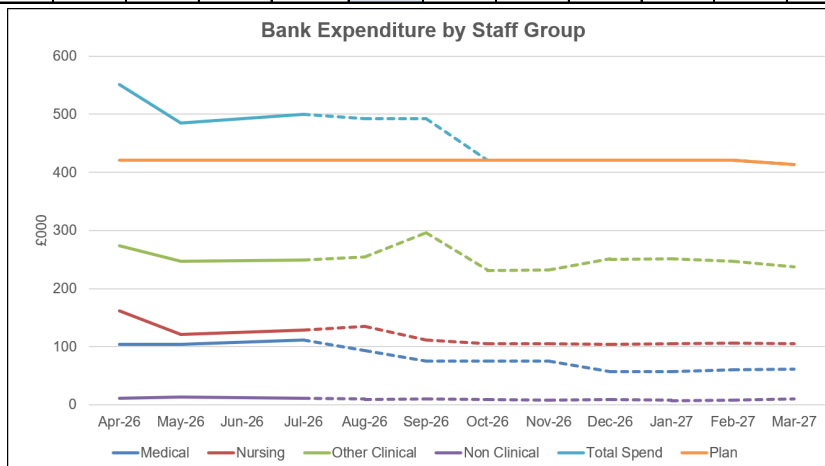
- Planned agency expenditure for 2026/27 is £1,053k this represents a 32% reduction of 2025/26 expenditure levels.
- The in-month expenditure is £66k, against planned expenditure of £87k, resulting in a favourable variance of £21k.
- The year-to-date expenditure is £292k against planned expenditure of £348k, resulting in a favourable variance of £56k.
- 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

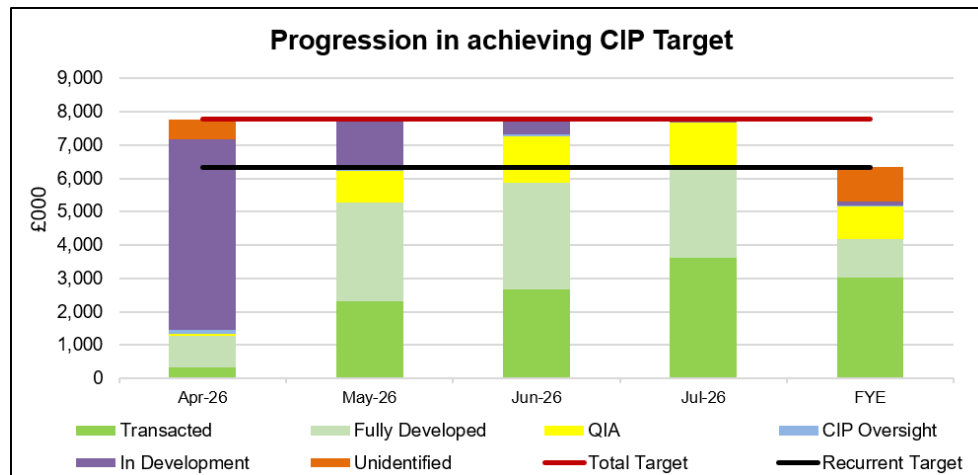
Bank Expenditure	Actual				YTD £000	Forecast									Total
	Apr-26 £000	May-26 £000	Jun-26 £000	Jul-26 £000		Aug-26 £000	Sep-26 £000	Oct-26 £000	Nov-26 £000	Dec-26 £000	Jan-27 £000	Feb-27 £000	Mar-27 £000		
Medical	(104)	(104)	(104)	(111)	(423)	(93)	(75)	(75)	(75)	(57)	(57)	(60)	(62)	(976)	
Acute Services & Urgent Care	(29)	(26)	13	(55)	(96)	(14)	(29)	(29)	(29)	(29)	(29)	(29)	(29)	(311)	
Community	(30)	(26)	(24)	(30)	(110)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(26)	(319)	
Specialist Care	(44)	(43)	(79)	(22)	(188)	(47)	(18)	(18)	(18)	0	0	0	0	(290)	
Medical & Clinical Effectiveness	(1)	(9)	(13)	(5)	(28)	(6)	(2)	(2)	(2)	(2)	(2)	(5)	(7)	(55)	
Nursing	(162)	(121)	(151)	(128)	(561)	(135)	(111)	(105)	(105)	(104)	(105)	(106)	(105)	(1,438)	
Acute Services & Urgent Care	(114)	(92)	(102)	(84)	(393)	(93)	(88)	(84)	(84)	(84)	(84)	(84)	(84)	(1,078)	
Community	(5)	(4)	(4)	(3)	(16)	(3)	(3)	(1)	(1)	(1)	(1)	(1)	(1)	(30)	
Quality & Nursing	(0)	(0)	(0)	0	(1)	(0)	(0)	0	0	0	(0)	(2)	(0)	(5)	
People & OD	(4)	4	(1)	(0)	(2)	0	0	0	0	0	0	0	0	(2)	
Primary Care	(2)	(2)	(2)	(2)	(8)	(2)	(3)	(3)	(3)	(2)	(2)	(2)	(2)	(25)	
Specialist Care	(37)	(25)	(41)	(39)	(142)	(37)	(17)	(17)	(17)	(17)	(17)	(17)	(17)	(299)	
Other Clinical	(273)	(247)	(261)	(249)	(1,031)	(254)	(296)	(232)	(232)	(251)	(252)	(247)	(237)	(3,032)	
Acute Services & Urgent Care	(157)	(144)	(137)	(133)	(570)	(138)	(138)	(138)	(129)	(129)	(114)	(114)	(114)	(1,585)	
Community	0	(0)	(1)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(3)	
MACE	(1)	(4)	(1)	(2)	(8)	(5)	(4)	(1)	(1)	(4)	(4)	(1)	(3)	(29)	
Operations	(1)	(3)	0	0	(4)	0	0	0	0	0	0	0	0	(4)	
People & OD	(5)	(2)	(3)	(2)	(11)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(50)	
Specialist Care	(109)	(94)	(121)	(113)	(436)	(106)	(63)	(65)	(65)	(65)	(65)	(65)	(65)	(993)	
Primary Care	(1)	0	0	0	(1)	0	0	0	0	0	0	0	0	(1)	
Central Services	0	0	0	0	0	0	(86)	(23)	(33)	(48)	(64)	(62)	(51)	(367)	
Non Clinical	(12)	(14)	(12)	(11)	(48)	(10)	(10)	(9)	(9)	(9)	(8)	(8)	(10)	(120)	
Acute Services & Urgent Care	(1)	(1)	(0)	(0)	(2)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(7)	
MACE	(0)	(0)	0	0	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(6)	
Quality & Nursing	(5)	(5)	(4)	(6)	(19)	(4)	(4)	(3)	(2)	(2)	(2)	(2)	(2)	(37)	
People & OD	(1)	(1)	(2)	(1)	(5)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(22)	
Primary Care	(3)	(3)	(3)	(1)	(10)	(1)	(1)	(1)	(1)	(2)	(1)	(1)	(2)	(19)	
Specialist Care	(2)	(3)	(2)	(3)	(10)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(29)	
Total Bank	(551)	(485)	(528)	(499)	(2,063)	(493)	(493)	(421)	(421)	(421)	(421)	(421)	(413)	(5,567)	
Bank as a % of Pay	5.86%	5.09%	5.54%	5.28%	5.44%	5.30%	5.10%	4.51%	4.47%	4.44%	4.44%	4.43%	4.15%	4.88%	
Plan	(421)	(421)	(421)	(421)	(1,684)	(421)	(421)	(421)	(421)	(421)	(421)	(421)	(413)	(5,044)	
Variance to Plan (Overspend) / Underspend	(130)	(64)	(107)	(78)	(379)	(72)	(72)	0	0	0	0	0	0	(523)	
Bank Variance as a % of Plan	30.86%	15.16%	25.33%	18.63%	22.49%	17.07%	17.07%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	10.4%	



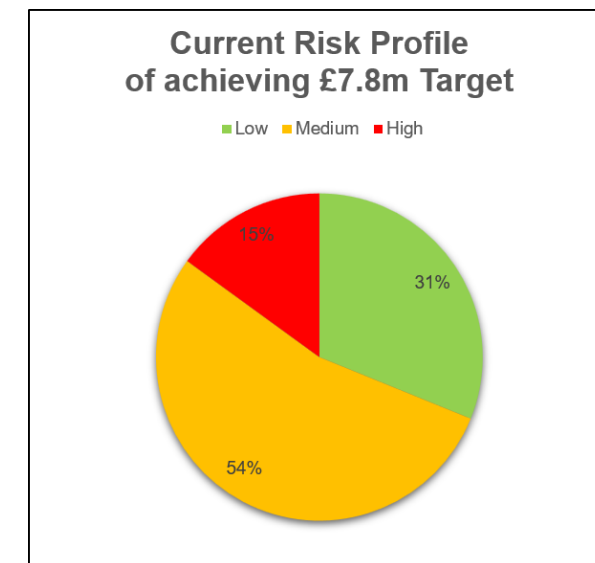
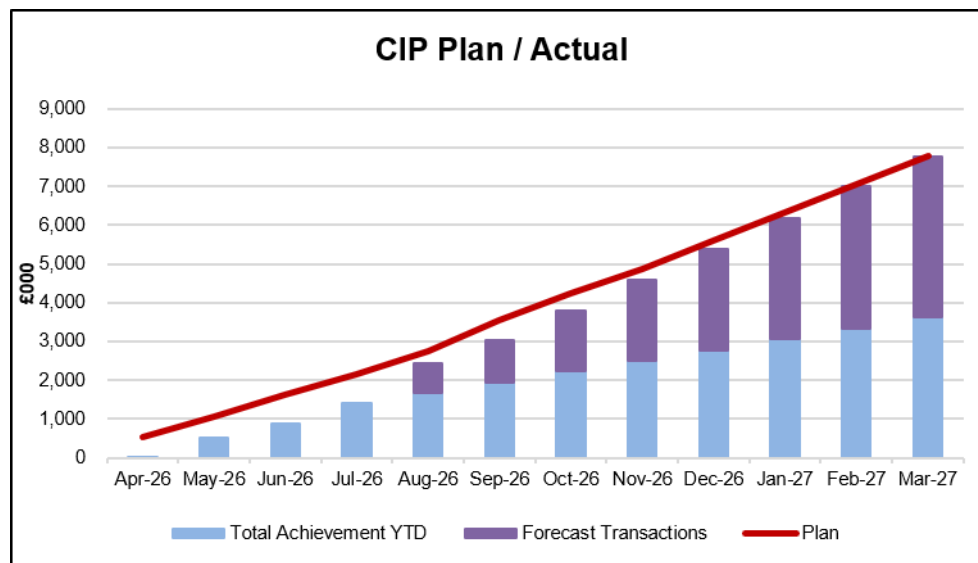
- Planned bank expenditure for 2026/27 is £5,044k this represents a 20% reduction of 2025/26 expenditure levels.
- The in-month expenditure is £499k against planned expenditure of £421k, resulting in an adverse variance of £78k.
- The year-to-date expenditure is £2,063k against planned expenditure of £1,684k, resulting in an adverse variance of £379k.
- Internal forecasts indicate an adverse variance of £523k, which remains after accounting for savings associated with the A&T closure.
- 47% of expenditure relates to unqualified nursing representing an adverse variance of £174k
- 27% of expenditure relates to qualified nursing representing an adverse variance to plan of £181k.
- 21% of expenditure relates to medical staffing representing an adverse variance to plan of £23k.
- 3% of expenditure relates to other clinical staffing representing an adverse variance to plan of £9k.
- 2% of expenditure relates to non-clinical staffing representing a favourable variance to plan of £8k.

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	140	14	(127)	526	460	(66)	526	159	(367)	526	216	(310)
Community	1,834	489	138	(351)	1,834	632	(1,202)	1,834	418	(1,416)	1,834	699	(1,135)
Specialist	759	202	100	(102)	759	846	87	759	253	(506)	759	303	(456)
Primary Care	85	23	4	(19)	85	102	18	85	71	(14)	85	80	(5)
Clinical Total	3,203	854	256	(599)	3,203	2,041	(1,162)	3,203	901	(2,302)	3,203	1,296	(1,907)
Corporate													
CEO	57	15	8	(7)	57	47	(10)	57	37	(20)	57	48	(9)
Q&N	253	67	2	(65)	253	57	(195)	253	57	(195)	253	130	(123)
S&D	300	80	56	(24)	300	268	(31)	300	162	(137)	300	121	(179)
Finance	145	39	225	187	145	245	100	145	0	(145)	145	0	(145)
Performance	150	38	38	0	150	150	(0)	150	150	(0)	150	150	(0)
Estates	178	47	34	(14)	178	127	(52)	178	127	(52)	178	166	(13)
MACE	141	38	17	(21)	141	63	(78)	141	43	(98)	141	55	(86)
Operational	(0)	0	0	0	(0)	0	0	(0)	0	0	(0)	0	0
People	143	38	0	(38)	143	144	0	143	144	0	143	287	144
Corporate Total	1,368	362	379	17	1,368	1,101	(267)	1,368	720	(648)	1,368	956	(412)
Trustwide	2,056	548	365	(183)	2,056	3,484	1,428	616	1,661	1,045	616	1,920	1,304
Productivity	1,149	395	395	0	1,149	1,149	0	1,149	1,149	0	1,149	1,149	0
Total Trust CIP	7,775	2,160	1,396	(764)	7,775	7,775	(0)	6,335	4,431	(1,905)	6,335	5,321	(1,014)

- 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 M04 the Trust is forecasting full delivery of the £7.8m CIP target. Of this, £3.6m is implemented and £4.2m is fully developed.

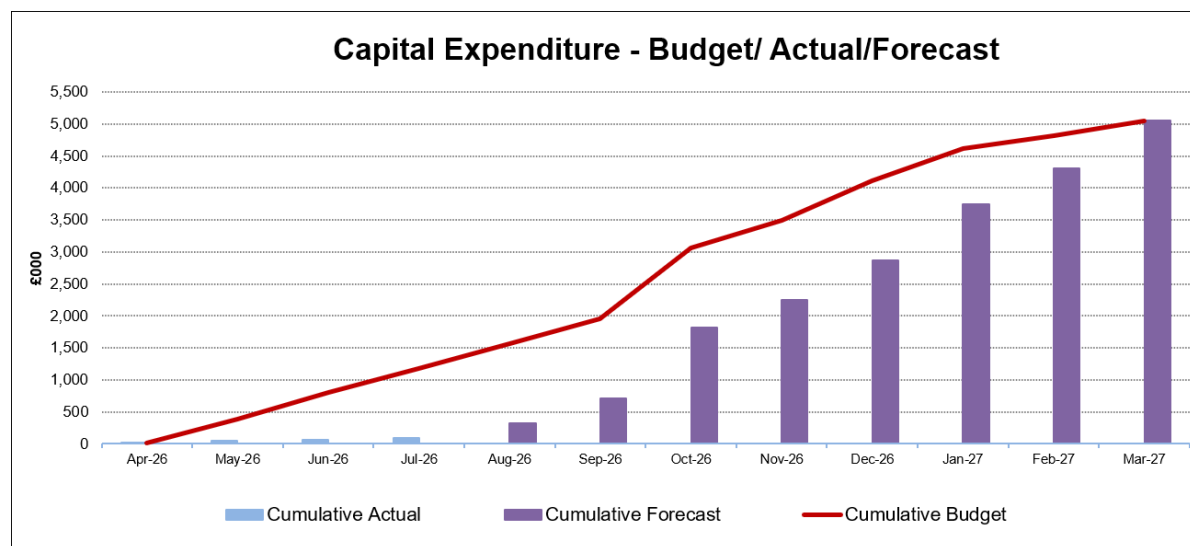


- Top graph shows the Trust progress in achieving the total £7.8m target and full year effect recurrent £6.3m target.
- Bottom left graph shows the cumulative phasing of the £7.8m target against the amount that has been achieved year to date and forecast.
- Bottom right pie chart shows the current risk level.



Capital Expenditure	Annual Plan £000	Year to Date Against Plan			Forecast Outturn Against Plan			Forecast Outturn Against Budget		
		Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000	Capital Budget £000	Forecast £000	Variance £000
Operational Schemes	919	0	0	0	919	919	0	919	919	0
Ligature Risks - planned	175	0	0	0	175	175	0	175	175	0
Ashcombe Restructure	234	0	0	0	234	234	0	234	234	0
Security	176	0	0	0	176	176	0	176	176	0
Freedom & Flexibilities	334	0	0	0	334	334	0	334	334	0
Digital	713	13	10	(3)	713	713	0	713	713	0
Capitalised Salaries - Device Replacement	40	13	10	(3)	40	40	0	40	40	0
Digital Solution CRHTT	58	0	0	0	58	58	0	58	58	0
Frontline Digitisation Programme	500	0	0	0	500	500	0	500	500	0
Digital Infrastructure	115	0	0	0	115	115	0	115	115	0
Strategic Schemes	3,070	1,146	103	(1,043)	3,070	3,070	0	3,070	3,070	0
Strategic Schemes - EMU Expansion	1,034	387	21	(366)	1,034	1,034	0	1,034	1,034	0
Strategic Schemes - A & T Refurbishment	1,936	726	42	(684)	1,936	1,936	0	1,936	1,936	0
Capitalised Salaries - Projects	100	33	40	7	100	100	0	100	100	0
Other Schemes	200	22	(35)	(57)	200	200	0	200	200	0
IFRS16 Leases	200	22	3	(19)	200	200	0	200	200	0
Contingency	0	0	(37)	(37)	0	0	0	0	0	0
Total Trust Funded Capital Expenditure	4,902	1,181	79	(1,102)	4,902	4,902	0	4,902	4,902	0
Backlog Maintenance	147	0	10	10	147	147	0	147	147	0
Total Gross Capital Expenditure	5,049	1,181	89	(1,092)	5,049	5,049	0	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 £89k, giving a favourable variance to plan of £1,092k, 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	M2 £000	M3 £000	M4 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	19,582	19,543	19,505
Property, Plant and Equipment	17,111	17,027	16,952
Right of Use Assets	2,650	2,611	2,571
Intangible Assets	1,836	1,786	1,741
NCA Trade and Other Receivables	537	531	525
Total Non-Current Assets	41,715	41,498	41,295
Current Assets			
Inventories	63	104	82
Trade and Other Receivables	6,139	6,558	8,344
Cash and Cash Equivalents	40,778	40,972	40,726
Total Current Assets	46,979	47,635	49,151
Current Liabilities			
Trade and Other Payables	(25,995)	(26,464)	(27,929)
Provisions	(1,794)	(2,054)	(2,054)
Borrowings	(3,199)	(3,199)	(3,199)
Total Current Liabilities	(30,988)	(31,717)	(33,182)
Net Current Assets / (Liabilities)	15,991	15,917	15,970
Total Assets less Current Liabilities	57,706	57,416	57,264
Non Current Liabilities			
Provisions	(1,109)	(1,110)	(1,101)
Borrowings	(14,621)	(14,345)	(14,235)
Total Non-Current Liabilities	(15,730)	(15,455)	(15,337)
Total Assets Employed	41,977	41,961	41,928
Financed by Taxpayers' Equity			
Public Dividend Capital	27,850	27,850	27,850
Retained Earnings reserve	7,101	7,086	7,053
Revaluation Reserve	7,025	7,025	7,025
Total Taxpayers' Equity	41,977	41,961	41,928

Current receivables are £8,344k of which:

- £4,517k is based on accruals (not yet invoiced). This has increased £831k since month 3 due prior year TCP credits accrued in month 3.
- £3,827k is trade receivables; based on invoices raised and awaiting payment of invoice (£1,624k within terms). This is an increase of £955K compared to month 3 due to month 4 invoices to MPFT for Talking Therapies, Health and Justice and Lawton House occupancy and month 4 P2P invoice to UHNM outstanding at 31st July.
- 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 £33,182k including Trade payables of £27,929k of which:

- £21,477k is based on accruals (not yet invoiced).
- £6,452k is trade payables, based on invoices received (£3,523k within terms). This is an increase of £934k compared to month 3 of which mainly relates to TCP invoices (£649k) and Dedalus service charges from May 2026 to November 2026 (£462k).
- Trade and Other payables remain high 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	40	957	997	132	3,441	3,573
Total Paid within Target	40	885	925	131	3,260	3,391
% Number of Invoices Paid	100.0%	92.5%	92.8%	99.2%	94.7%	94.9%
% Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
RAG Rating (Variance to Target)	5.0%	(2.5%)	(2.2%)	4.2%	(0.3%)	(0.1%)
Value of Invoices						
Total Value Paid (£000s)	451	7,763	8,214	1,688	30,833	32,521
Total Value Paid within Target (£000s)	451	7,568	8,019	1,688	30,209	31,897
% Value of Invoices Paid	100.0%	97.5%	97.6%	100.0%	98.0%	98.1%
% Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
RAG Rating (Variance to Target)	5.0%	2.5%	2.6%	5.0%	3.0%	3.1%

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 4, the Trust achieved the BPPC target for value of invoices paid within 30 days, with performance at 97.6% but did not achieve the target for the number of invoices paid at 92.8%.
- Year to date the Trust has achieved the BPPC target for the value of invoices paid within 30 days, with performance at 98.1% but is narrowly missing target for the number paid at 94.9%.
- The Finance Team will continue to monitor performance and work with operational areas to improve the timely authorisation of invoices where required.

The Trust Board are asked to receive the month 4 financial position noting:

- A year-to-date deficit of £319k against a planned deficit of £361k, resulting in a favourable variance of £42k.
- An underlying financial position (ULP) deficit of £280k.
- Agency expenditure of £292k against a plan of £348k, resulting in a favourable variance of £56k.
- Bank expenditure of £2,063k against a plan of £1,684k, resulting in an adverse variance of £379k.
- Year to date CIP delivery of £1,396k against a plan of £2,160k, resulting in an adverse variance of £764k.
- Capital expenditure of £89k, against a plan of £1,181k, resulting in a favourable variance of £1,092k.
- A cash balance of £40.7m on 31st July 2026.



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

ADVISE:

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

Heading:

Finance Position M03

The Committee noted that bank staffing costs are forecast to exceed the planned budget and agreed that this represents a financial pressure requiring immediate management action. It was noted that a task and finish group has been established to review roster optimisation, reduce reliance on bank staffing, and identify mitigating actions to bring expenditure back in line with plan.

CIP Report

The Committee noted that the full CIP target is supported by schemes that have been confirmed as either fully developed or implemented, representing a significant improvement. As a result, weekly reporting is no longer required. However, delivery risk remains, particularly where individual schemes may be delayed or fail to achieve their planned savings trajectory. It was noted that the Trust is required to submit its 2027/28 CIP position by the end of August.

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 M03

The Committee noted the overall strong and stable performance, with exceptions relating to CAMHS RTT performance, the liaison one-hour response standard, and sickness absence. It was noted that performance against national targets remains on track, with the exception of out-of-area placements and CYP 104-week waits.

The Committee welcomed the sustained positive performance and noted that sickness absence is being reviewed through PCDC, while CYP 104-week waits and the liaison one-hour response standard will be monitored through Quality Committee.

The Committee requested a review to quantify the impact of the preventative work being undertaken within the community. The Committee also requested that a case study on out-of-area placements and patients who are clinically ready for discharge be presented to a future meeting of the Quality Committee.

Level of assurance 6 agreed.

Finance Position M03

Committee noted the Trust is on plan whilst bank usage continues to be significantly over plan. 18% of the overall CIP programme is classified as high risk. Committee discussed rostering optimisation and the impact on bank.

Level of assurance 5 agreed.

Estates and Capital Report

The Committee received the report and noted the progress made on Project Horizon (EMU additional six beds) and Project Elevate (A&T refurbishment). It was also noted that the water quality issues on Ward 4 have been resolved and that the fire door remedial programme is 97% complete.

The Committee discussed the financial implications of Project Horizon, noting that the estimated costs for the scheme exceed the approved budget, and sought assurance regarding the management of the associated financial pressure.

Level of assurance 5 agreed.

Fire Safety Report

The Committee received the report and noted the fire safety risks identified at Harplands. It was noted that two high-risk issues relate to fire warden training and access and egress within the roof voids. These risks will be addressed as part of the planned air handling unit works. The Committee challenged the proposed target dates and sought assurance regarding the delivery of the actions identified. It was confirmed that progress against the action plan will be monitored through the monthly Estates report. The Committee also discussed how the identified risks align with, and are reflected within, the Trust's risk register.

Level of assurance 5 was challenged and agreed this should be a level 4.

Digital Quarterly Assurance Report

Committee noted we were successful with national funding and digital plan delivery working with the cluster around digital solutions and alignment across organisations.

Level of assurance 4 agreed.

Strategic Partnership Plan

Committee noted the quarterly progress on the implementation of the plan including the continued changes in the ICB, the reorganisation for Local Government and the Trust's progress on Neighbourhood Mental Health Centre.

Level of assurance 5 agreed.

Sustainability Assurance Report Q1

The Committee noted positive progress across the areas of focus and updates provided on current activity.

Level of assurance 6 agreed.

Transformation Assurance Report Q1

The Committee received the report and noted that the report has been revised to reflect the portfolio model. The Committee welcomed the progress made and acknowledged the work undertaken to implement the new approach.

Level of assurance 5 agreed.

Audit Tracker Follow Up Q1

Committee noted the audit recommendations that had been implemented and the outstanding recommendations relating to the Cyber Assessment Framework.

Level of assurance 6 agreed.

APPROVE:

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

Heading:

Risk Register

There were no new risks identified, no score changes and no closures. Committee approved two risks that have amendment of an achievement date and the transfer of a risk from an operational risk to a Trust level risk. Discussions took place on the risk transfer relating to primary care activity and the impact on income.

Board Assurance Framework Q1

There were no score changes to the three BAF risks that fall under F&R's remit.

Policy Report

The business continuity policy was approved for 3 years.

Ashtenne Units Lease Renewal

Lease relating to units 1, 2, 5-6, 20-23 with a 5-year contract term backdated to February 2023 at a total value of £400k was approved.

Lease relating to units 3, 4 and 24 with a 5-year contract term backdated to February 2023 at a total value of £198k was approved.

Summerview Ensuite Upgrade

Business case for capital expenditure for £453k over a 4-year period was approved funded from PDC from the Estates Safety Fund.

Business Opportunities

The Committee endorsed the Trust's continued progression of the tender response. Discussions took place on the high-level finance details that are available and potential risks.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 3rd September 2026 at 10am in Lawton House.

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

REPORT END

Trust Board Assurance Report From the Finance & Resource Committee Meeting Held on 3rd September 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:

ADVISE:

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

Heading:

Orbis Board

The Orbis programme remains rated red (RAG), with no agreed go-live date due to a fourth delay in the delivery of the required data migration functionality. While a third of the identified gaps have now been resolved, significant concerns remain regarding several outstanding major gaps. Escalation to NHSE has resulted in senior-level recognition of the issues and challenges associated with Orbis. A comprehensive options appraisal will be presented to SLT and F&R in October and November.

Discussions were held regarding the controls currently in place, and the Committee welcomed the inclusion of associated risks within the options appraisal. The Committee also welcomed the review to be undertaken by Internal Audit.

ASSURE:

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

Heading:

Risk Register

There are no new risks, no score changes and no closures. It was noted that one risk had an achievement date amended. Committee discussed the escalated risk relating to the reduction in patient numbers in GP practices.

Level of assurance 6 agreed.

IQPR M04

The Committee noted the overall strong and stable performance, with exceptions relating to sickness absence and vacancy rates. It was noted that performance against national targets remains on track, with the exception of out-of-area placements and CYP 104-week waits.

The Committee discussed the fluctuation in the 1-hour Mental Health Liaison response times, alongside the increasing demand for services and workforce capacity challenges. National targets for the Early Intervention in Psychosis two-week wait standard and emergency readmissions have been achieved. The implementation of the new CYP dashboard for managing 104-week waits is having a positive impact on caseload management. Clinical teams are confident that the number of 104-week waits will be reduced to zero by the end of the year. Reducing sickness absence remains a key area of focus for PCDC. Positive improvements were also noted within CRFD.

Level of assurance 6 agreed.

Finance Position M04

Committee noted the Trust is on plan whilst bank usage continues to be significantly over plan. 15% of the overall CIP programme is classified as high risk.

Level of assurance 5 agreed.

CIP Report

The Committee noted that the full CIP target is supported by schemes that have been confirmed as either fully developed or implemented. However, delivery risk remains, particularly where individual schemes may be delayed or fail to achieve their planned savings trajectory. CIP planning for 2027/28 is commencing. Committee agreed to stand down the monthly CIP report and will capture updates through the monthly finance report.

Level of assurance 5 agreed.

Estates and Capital Report

The Committee received the report and noted the progress made on Project Horizon (EMU additional six beds) and Project Elevate (A&T refurbishment). Both projects are expected to be fully costed by early October, with a proposed start date of 2 November and completion by the end of March. The final version of the Letter of Indemnity for the EMU works is awaited. Site-wide security capital works have commenced, and plans are in place to issue tenders during September for the Summerview ensuite refurbishment and Dragon Square boiler replacement projects.

The Committee also noted that the water quality improvement works are scheduled for completion in September, which should enable the associated risks to be closed. The fire door remedial programme is now 97% complete.

The Committee acknowledged the progress made in addressing water temperature issues. Discussions also took place regarding the Fire Safety Action Tracker and the ongoing management of fire safety actions.

Level of assurance 5 agreed.

Business Opportunities

The Committee received the report and noted the submission of a tender response and the successful transfer of Shropshire, Telford and Wrekin Transforming Care Programme from Midlands and Lancashire CSU.

Level of assurance 6 agreed.

APPROVE:

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

Heading:

Medium Term Financial Plan Update

An updated Medium Term Financial Plans was presented to Committee which included the aim to have all efficiencies identified and approved by 31st December 2026. Broad efficiency themes have been identified. Risks were also highlighted regarding the deconstruction of the block contract which may impact the financial position of the Trust from 2027/28.

The Committee discussed the required reduction in bank staffing expenditure and the funding implications of the proposed left shift of services, which is currently supporting Urgent and Emergency Care (UEC). Ongoing financial pressures relating to neighbourhood funding were also highlighted. Further discussion took place regarding the impact of the deconstruction programme and its associated implications.

Committee approved the paper.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 1st October 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 6 August 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

ALERT:

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

System Update

The system remains pressured, with ongoing challenges due to demand in emergency departments. There is also an increase in Crisis Care presentations which is under review.

ADVISE:

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

CQC Update

- The Trust has received the Older Persons community report with an overall rating of Good.
- The Older persons Inpatient ward was inspected in July, and we are awaiting this report, the informal feedback was very positive.
- Keele Surgery was also inspected in July, the Trust has received the report, and this is currently ongoing a factual accuracy check

Healthwatch report – Children and Young People, Autism and ADHD

The report generated robust discussion, acknowledging the Trusts responsibilities and actions taken and wider system pathways, the work of Health watch is welcomed and we continue to remain committed and engaged in working with Health watch. An update regarding the progress of the actions will come back to the Quality Committee.

ASSURE:

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

IQPR M03 2026/27

Sickness is the key cause for concern in month 3. The performance improvements plans are being reviewed for month 4.

CYP performance plan has been closed with the target being met for the 3rd consecutive month. This closure has an unintended consequence of losing focus on delays in neurodevelopmental services; the performance team have this in hand.

The committee acknowledged the improvements to the Trusts supervision compliance – Directorates are more confident that this challenge was a recording challenge as the efforts targeted to assist the current compliance improvement has been around encouraging and reminding staff how to record their supervision once received, they continue to maintain a focus on this.

A discussion took place regarding the challenge regarding the CAMHS 18-week wait; the Directorate lead advised the committee that this will be improved with recruitment into posts currently underway.

One hour liaison in Acute and Urgent Care is currently undergoing a deep dive review.

Level 6 assurance was confirmed.

Directorate Spotlight – Acute

This first report of this style within Quality Committee was well received, both from a content, format and succinct perspective.

The report generated good discussion, particularly around improvement and learning in response to patient safety incidents and work underway to support and help to improve to staff wellbeing.

Level 6 assurance was reduced to level 5 based on the challenges within the service and the ongoing improvement work.

Safe Staffing Report June 2026

Safer Staffing fill-rate for June was 105.6%

Discussion took place regarding areas with over established staffing; this does not always match the acuity and therefore more robust management of rosters and staffing escalation approvals is required.

Level 6 assurance accepted.

Quality Assurance Group Report Q1

The report was received and level 6 assurance accepted.

Quality Impact Assessment of Cost Improvement Programmes Q1

None of the transacted PIDs required QIA for this quarter.

Level 7 assurance was accepted.

Clinical Audit Progress Report and Programme Q1

Level 5 assurance was accepted.

Mental Health Act Compliance Action Plan Report Q1

Level 5 assurance was accepted noting improvements required around MHA compliance.

Internal Audit Recommendation Tracker

The report was welcomed by the committee and Chief Officers will update progress going forward.,
Level 6 assurance was downgraded to level 5 by the committee.

Any Other Business

The Out of Area report paper was discussion, this will include a patient case study within the next report.

Meeting Self-Assessment

Well engaged and good discussions.

APPROVE:

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

The committee approved the following Papers:

Risk Review Report

- No new risks, no score changes and no closure requests for this month's report.
- The committee discussed progress of risk mitigations and discussion took place about risk score reductions and what needs to happen for the risk to be reduced (i.e. after a sustained period of stability or as soon as the mitigation is fully implemented).
- The committee discussed risk 1609 in a little more detail with a view of the risk tolerance and appetite being reviewed as opposed to mitigations which are unlikely to reduce the risk currently.

Board Assurance Framework Q1

Risk 8 was discussed; this is being reviewed due to being outside of the Trusts current tolerance.

Policy Report

- All policies were approved.
- One extension was confirmed for 1.62 Physical Health Policy

The committee acknowledged the extensive work which helped to inform the Enhanced Therapeutic Observations of Care Policy which was a co-produced policy and has undergone pilot tests prior to finalising the policy.

Work is also underway to review how staff are informed about policy implementation, updates and changes.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on 3 September 2026 at 2pm Board Room, Lawton House
Committee Chair: Pauline Walsh, Chair of the Quality Committee.

REPORT END

Trust Board Assurance Report from the Quality Committee meeting held on 3 September 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

ALERT:

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

System Update

The system update was supported by an overview of the winter plan which was an agenda item. System and national planning are underway.

ADVISE:

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

CQC Update

The Older Persons Community Report and the Keele Practice report have now been published, they will be brought back to the next Committee.

The Trust continues to await the Inpatient Older Persons report.

Out of Area update M04

9 reportable out of areas patients at the end of month 4, 17 patients throughout the month had been discharged or repatriated back to the Trust. The report highlighted a case study to help to give context to the impact of out of area placements on patients and their families and how this was mitigated by NSCHT by remaining robustly engaged in ensuring contact was sustained around discharge planning and transition support for the patient. It was noted that the number of patients Clinically Ready For Discharge (CRFD) is currently with 5 patients CRFD at end of Month 04.

ASSURE:

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

Risk Review Report

Report accepted. No new risks, no closures. Level 6 assurance confirmed.

Learning from Deaths Report Q1

The report has replaced the PSIRF report to focus ore centrally around learning from deaths. This new report was well received offering a collective overview of deaths and therefore presenting opportunities in future reporting to offer more collective assurance around learning. Assurance 5 confirmed

Restrictive Practice Report Q1

The report was well received with the detailed analysis welcomed. A good discussion regarding so key areas with future reports requested to consider analysis regarding patient demographics in prone and restraint occurring 30minutes or more, alongside more clarity regarding the rationale for assessments regarding proportionality of incidents in relation to protected characteristics. Assurance 5 confirmed.

Clinical Effectiveness Report

The report was well received with a detailed account of the work overseen by CEG. Assurance score amended from level 5 to 6.

Pharmacy Annual Report 2025/26

The report was well received; The assurance was considered robust and score amended to level 6.

Infection Prevention and Control Q1

Assurance level 7 reduced to level 6 due to a downward trend in IPC audit compliance.

Policy Report

Committee noted the 4 approved policies, alongside extension approval for Dress policy. Level 6 assurance confirmed.

IPQR

Committee noted an increase in vacancy rate. Sickness remains a variation of concern with a 6th consecutive increase in sickness rate and noted that a deep dive paper will be presented through to PCDC next month. The detail regarding progress against PIPs was presented to the Committee,

including a thorough discussion regarding the Mental health Liaison 1-hour waits – further work is underway with UHNM regarding their referral process.

Learning from Experience Q1 & Annual

Both reports received with level of assurance accepted.

Safeguarding Children and Adult Report Q1

Assurance level 6 reduced to level 5 due to non-compliance with level 3 children's safeguarding training in two of the clinical directorates.

Safer Staffing Bi-Annual Report

Level 6 assurance received and SLT recommendations acknowledged and supported by the committee. A discussion was held regarding ward 5's establishment and any consideration to reduce this based on consistently low occupancy – a deep dive review is underway.

Safer Staffing Monthly Assurance Report

Level 6 assurance supported.

Briefing Paper Gap Analysis

In response to a parliamentary letter outlining the need for all Trusts to remain competitive in NHS research, a plan of response was presented to the Committee, The paper was received; areas for improvement acknowledged and level 4 assurance accepted.

APPROVE:

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

The committee approved the following Papers:

Pharmacy & Medicines Optimisation Service Delivery Plan 2026-2030

The plan was well received. The committee advised the amendment of the assurance noting this is an approval report.

Winter Plan

The plan is built around learning from last and previous years and describes escalation processes noting our key issues being around patient flow, workforce resilience and Clinical Ready for Discharge patients which tends to spike during winter months - Received and approved. Assurance removed noting this is a plan for approval.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on 1 October 2026 at 2pm via MS Teams

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

REPORT END

Trust Board Assurance Report From the Audit Committee Meeting Held on 31st July 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.

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:

Cyber Security- Committee noted the letter received from NHSE regarding '*Board and Executive assurance; Cyber Security Risk*' (Tom Wechsler- Head of Cyber Security NHSE).

The Committee also noted the guidance provided from *HFMA – NHS Audit Committee Handbook (2024)* which is designed to help NHS governing bodies and audit committees to review and continually re-assess their system of governance to ensure that it remains effective and 'fit for purpose'.

The Committee took assurance that to date, updates on Cyber Security have been provided under the 'Digital' report, currently sitting within F&R. However, going forwards it is agreed that Cyber Security, as a distinct item for the Audit Committee, will be added to the Audit Committee cycle of business.

Action. Cyber Security to be added as a distinct item to the Audit Committee CoB.

MIAA Internal Audit Recommendations- Discussion held re; Teams/Managers seeking extensions to deadline dates and a small number of actions remaining past their due date. Assurance was sought as regards oversight by Chief Officers (CO) and recommendation made by Committee that CO's be required to attend future Audit Committee meetings to provide assurance where recommendations are outstanding for more than 6 months within their portfolios.

ADVISE:

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

Heading:

External Audit – Grant Thornton – provided a verbal update on the 2025/26 financial statements, annual report and audit work and confirmed that all actions are closed out and have been concluded as planned.

ASSURE:

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

Trust and Operational Risks 15+- Assurance sought as to whether current actions are sufficiently mitigating risks and impacting residual scores. The Committee sought assurance on how mitigating actions are/are not impacting scores as it was noted that there are a number of high-level risks whereby the gross and residual scores are the same, which may suggest that the mitigating actions are not positively impacting scores. Level 6 agreed.

Board Assurance Framework Q1- Committee noted the work to be undertaken against BAF Risk 8 to bring score within tolerance level in quarter 2. Level 6 agreed.

Being Open Report Q1 2026/27- Committee received the report and suggested that the report may be further enhanced by the inclusion of Real Talk/Real Change and Staff Survey feedback. Level 6 agreed.

Business from the People, Culture and Development Committee- The Committee thanked Martin Evans, Chair PCDC, for a helpful and informative report. The Committee had a healthy discussion about the challenges facing the Trust i.e. sickness absence, rostering, bank usage etc. whilst acknowledging the renewed focus on the People Plan (and main priorities identified) and the work being done across the organisation in this space. Level 5 agreed.

Freedom of Information Six-Monthly Report Q3/Q4 2025/26- Committee received the report and noted the increasing demand for FOI requests and teams' resilience to provide responses within the 20-day deadline. Nicky Griffiths provided further verbal assurance to Committee as regards future plans to use AI and digital innovation to support FOI processes going forwards. Level 5 agreed.

Counter Fraud Progress Report/ Annual Self-Assessment against NHS CFA Standards- Committee received both reports and took assurance on same provided by MIAA and the Trust.

Annual Clinical Audit Programme- Committee received the report and noted progress made in Quarter 1 against the programme. Level 5 agreed.

Breach of Standing Financial Instructions- Committee received the report and sought assurance as regards procurement processes. CFO to take forward a discussion with procurement and consider the introduction of KPIs within current SLA.

APPROVE:

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

Heading:

Policy Report – Policy report approved by Committee who sought further assurance on how changes to the Standards of Business Conduct Policy changes align to the Trust's Disciplinary Policy and how policy changes are communicated to staff across the organisation.

Quarterly Finance Report, including Losses and Waiver- Committee received the report and sought assurance on items including bad debt and procurements issues. The Report was approved following discussion.

Any Other Business- None

Meeting Self-Assessment- Chair sought feedback on meeting and reviewed cycle of business ahead of next Audit Committee meeting in October.

Next Steps (including timeframes):

The next Audit Committee meeting will be held on: 30th October 2026 at 10:00 via MS Teams.

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

REPORT END

Enclosure No: 17

POLICY REPORT – AUGUST 2026

Report provided for:				Report to:	Public Trust Board
Approve	☐	Alert	☐	Date of Meeting:	10 September 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:	Board to receive the report for information.
Executive Summary:	Request was made to approve the following policies as detailed within the report at the August Private Trust Board. Policies required approval in August to support the Trust's Core Standards submission. Approve for 1 year: • 6.00 Incident Response Plan • 4.45 Business Continuity Policy

VERSION CONTROL:

Version	Report to	Date Reported
V1	Senior Leadership Team	20/07/2026
V2	Quality Committee	31/07/2026
V3	Finance and Resource Committee	31/07/2026
V4	Private Trust Board	07/08/2026
V4	Public Trust Board	20/08/2026

Report for Extra-ordinary Private Trust Board – 13th August 2026

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

Name of Policy	Purpose of Policy	Policy Author / Head of Service Lead	Director Lead	New or Existing Policy	Policy Reviewed at:	Committee Approval	Policy Due For Review Date	Recommendations
6.00 Incident Response Plan	Plan to support incident response command and control aligned to National/provider responsibilities	EPRR CSU Embedded Officer	Chief Operating Officer	Existing	Policy Governance Group – July 26	Quality Committee	31.05.26	Approve for 1 year
	Changes to plan: Updated Critical Service List. This plan is approved on annual basis.							
4.45 Business Continuity Policy	The Policy provides advise on Business Continuity Management	EPRR Embedded Officer	Chief Operating Officer	Existing	Policy Governance Group – July 26	Finance and Resource Committee	31.10.26	Approve for 1 year
	Changes to policy: Minor refresh. Change to logo/updated critical services list aligned to current services. To be submitted to Board in August for compliance purposes. The policy is approved on an annual basis.							

Trust Board 2026/27 Attendance

	14th May 26 Public	9th July 26 Public	10th Sept 26 Public	12th Nov 26 Public	14th Jan 27 Public	11th Mar 27 Public
<u>Non-Executives</u>						
Janet Dawson, Chair	✓	✓				
Russell Andrews, Non-Executive / Vice Chair	✓	✓				
Pauline Walsh, Non-Executive / Senior Independent Director	✓	✓				
Martin Evans, Non-Executive	✓	x				
Prem Gabbi, Non-Executive Director	✓	✓				
Jennie Koo, Non-Executive Director	✓	✓				
Dr Roger Banks, Associate Non-Executive Director	✓	✓				
Katie Laverty, Associate Non-Executive Director	✓	✓				
<u>Executive Members</u>						
Dr Buki Adeyemo, Chief Executive Officer	✓	✓				
Eric Gardiner, Chief finance Officer / Deputy Chief Executive Officer	✓	✓				
Kenny Laing, Chief Nursing Officer / Deputy Chief Executive Officer	x	x				
Dr Dennis Okolo, Chief Medical Officer	✓	✓				
Elizabeth Mellor, Chief Strategy Officer	✓	✓				
Ben Richards, Chief Operating Officer	x	x				
Frieza Mahmood, Chief People Officer	✓	✓				
Zoe Grant, Acting Chief Nursing Officer	✓	✓				
Rachael Birks, Acting Chief Operating Officer	✓	✓				
<u>In Attendance</u>						
Jenny Harvey, Union Representative	✓	x				
Joe McCrea, Associate Director of Communications	✓					
Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary	✓	✓				
Sherrine Khan, Peer Support Worker	x	x				
Lisa Wilkinson, Corporate Governance Manager (Minutes)	✓	✓				