

Our Ref: NG/RM/26001
Date: 27th January 2026

Nicola Griffiths
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
ST4 8HH

Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 2nd January 2026. Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

I am writing to request information under the Freedom of Information Act 2000. The questions for the request can be found in the attached document. The purpose of this request is to support a review of mental health service models and best practices across NHS Trusts.

The information will help inform service improvement initiatives aimed at enhancing care for individuals with complex mental health needs, ensuring consistency, and promoting patient safety.

Please see Appendices 1 and 2 attached.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely



Nicola Griffiths
Deputy Director of Governance

Please provide responses to the following questions, grouped under relevant themes:

A. Service Provision

1. Does your Trust provide Assertive Outreach Teams and Early Intervention services?
Yes
2. If yes, please outline the scope and structure of these services.

Early Intervention has fidelity to the model as laid out in the White Paper and evidenced by the Level 4 NCAP score maintained by the Trust.

The IOT is a bolt-on service made up of Mental Health Nurses, Social Workers, Occupational Therapists and Healthcare Support workers (Psychiatry and Psychology remains with originating CMHT). This team works with those people with a diagnosis of a psychotic illness whom CMHTs are unable to engage or require a period of intensive support to stabilise and re-establish back into the CMHT.

3. How does your Community Mental Health Team (CMHT) deliver an intensive approach for patients requiring higher levels of support?

Increased appointments at locations preferable to the service user are offered, and there is increased engagement with the system around the service user. If this is not effective, a referral is made to IOT or Community Rehab (depending on need) who can offer a more intensive and assertive approach.

4. Please provide details of any specific models or frameworks used.

Key principles of intensive/ assertive outreach used.

B. Care Coordination

5. What criteria does your Trust use to allocate care coordinators to patients? **The Trust no longer have a care co-ordination model in place, except for adult eating disorder and perinatal MH services. The Trust is moving towards the personalised care framework; this will include all specialist MH/ LD services and will mean that every patient will have a named professional.**
6. Are there any prioritisation factors (e.g., risk level, diagnosis, complexity)? **Yes, the named professional is allocated based on the complexity and needs of the patient.**
7. How does your Trust manage the allocation of care coordinators across teams and caseloads? **N/A**

8. What is the average number of cases held by each care coordinator? **There are currently 305 patients with a care coordinator and 22 individual practitioners. This works out to an average of 14 patients each.**
9. Please provide any relevant policy or guidance. **We are currently drafting our new care management policy, that will follow the framework of the personalised care framework.**

C. Risk Management

10. How does your Trust identify patients considered to be at high risk?

Our Trust does not use a risk stratification model when reviewing individual patient risk. Instead, we follow a contemporary, collaborative, and person centred approach to safety. This is supported by our policy, which emphasizes that safety is dynamic and best understood through ongoing relational engagement with the patient. Practitioners undertake a risk/safety assessment, which includes formulation, and then develop a personalized safety plan as part of the care plan. If a patient expresses suicidality, an enhanced safety plan is created that builds on the existing plan. This approach ensures that interventions are tailored to the individual's needs rather than applying a generic set of measures.

11. Please include any tools, assessments, or processes used.

We complete a risk/safety assessment including formulation, followed by a safety plan. Should someone express suicidality, we have a safety plan specifically for this, that builds on from the safety plan, which is part of the care plan.

The Trust policy provides clear guidance on safety assessments, shared formulations, agreed safety actions, dynamic reviews and personalised care plans in a way that is meaningful, accessible, and co-produced with the individual. In line with current NHS policy and national guidance (NICE NG225; NHS England 'Staying Safe from Suicide'), we undertake a comprehensive risk and safety assessment with clinical formulation, co-produced with the individual, leading to a personalised safety plan. If suicidality is disclosed, a dedicated safety plan is created, and suicide 4MH 'Connecting with People' tools are used to establish level of distress and most appropriate support for the individual. Our Trust policy ensures documentation of the shared formulation, agreed safety actions, and safety plan embedded in the care plan, using clear, accessible language and co-production principles from CQC Regulation 9 and NHS England's personalised care standards. All assessments and plans are regularly reviewed and escalated when clinical need increases.

12. What additional provisions or interventions are in place for patients identified as high risk? **This dependent on the needs identified for each individual in line with our personalised approach to care and safety planning; we do not have a generic set of approaches; although care, oversight and support from additional**

services such as Crisis Care/ Inpatient Treatment is a consideration, along with HT or increased appointments/ contacts.

13. In what ways does the provision for high-risk patients differ from your standard CMHT offer? **This dependent on the needs identified for each individual in line with our personalised approach to care and safety planning and is a difficult question to answer as we do not stratify risk in this manner.**

D. Staff Training

14. Does your Trust provide specific training for staff working with complex patients? **Not in relation to this specifically, all staff have received care planning training, to support a person centred approach to planning care. In many of our inpatient areas staff have been trained in RAID by APT services and positive behavioural support.**

15. If yes, please provide a list of available training programs and their content focus.

- **RAID® (Reinforce Appropriate, Implode Disruptive) approach is a positive psychology framework used in mental health and related fields to manage challenging behaviours by focusing on strengthening positive actions (Reinforce Appropriate) and minimizing disruptive ones (Implode Disruptive), rather than punishing them, creating a more supportive, less restrictive environment for both clients and staff. It's a proactive, constructional method that aims to displace problematic behaviours by developing incompatible, positive behaviours, improving overall quality of life, and fostering hope. The 3-day RAID® course is the UK's leading positive psychology approach for tackling disturbed and challenging behaviour at source. It is a comprehensive approach which teaches staff a philosophy and practice not only to deal with disturbed and challenging behaviour when it occurs, but also to prevent it by tackling it at source. The essence of the RAID® approach is to play down disturbed and challenging behaviour as far as safety allows, and to nurture and develop positive behaviour so that it systematically overwhelms and displaces the disturbed and challenging behaviour. Inpatient staff in Acute and Urgent Care settings – child and adult, Specialist Inpatient and Intensive Support Teams.**
- **Positive Behaviour Support (PBS) - Positive Behaviour Support (PBS) is a person-centred, evidence-based framework focused on improving the quality of life for individuals, often those with learning disabilities or autism, by understanding the reasons behind challenging behaviours, teaching new skills, and making environmental changes, rather than just punishing the behaviour itself. It involves understanding triggers, building strengths, promoting inclusion, and creating practical support plans with families and professionals to help individuals live more meaningful lives with greater independence and dignity.**
- **Learning Disability Services: Inpatient and Community - All staff complete a variety of courses aligned to role: Diploma in PBS, Positive Behaviour Support Awareness**
- **Crisis Prevention Institute (CPI) Training – We have in house trainers (CPI Safety Intervention™ Advanced/Advanced & Emergency Training) and all**

in-patient staff complete Safety Intervention Training: Safety Intervention™ Foundation - training incorporates trauma-informed and person-centred approaches. It is recommended for professionals who work in environments that require restrictive or physical intervention techniques. Participants will engage with seven modules and practical skills, including safety intervention & disengagement skills. Two distinct programmes: Verbal Intervention™ is the programme that enables you to teach all the CPI preventative approaches. Safety Intervention™ is the programme that enables you to teach all the CPI preventative interventions plus the disengagements and/or holding skills. Mandatory Training.

- **Suicide Mitigation Training: Suicide Awareness for Professionals, Suicide Response 1 (Risk Assess), Suicide Response 2 (Safety Planning)** - Improve the assessment and documentation of people at risk of suicide and/or self-harm, provides a clear structure for the recording of client information, to ensure excellent governance, providing effective client-centred intervention practices and techniques, ensuring compassionate engagement, tailored triage assessment, appropriate referral and client collaboration, support the development of a common language, promoting a more integrated response across statutory services, third sector providers and communities, minimises the anxiety and emotional labour for staff when addressing the mental health concerns of others. All registered professionals complete this programme. Mandatory Training Inpatient and Community Services.
- **Clinical Risk Assessment and Management – Mandatory Training.** Assessing the clinical risk is particularly important in mental health and learning disability but it is also more sensitive and challenging. Course has been designed to give an introduction to the following topics: Risk in the Context of Mental Health and Learning Disability Services, Risk assessment formulation and management, Approaches to risk management, Decision Making, Effective teamwork and partnerships
- **Transforming Care.....Co-produced care planning - Enhancing our culture of co-produced care planning and the significance of empowering and partnering with our service users to support their recovery.** This training is crucial to understanding the principal values and vision of recovery focussed care planning. "CHIME model" primarily refers to a recovery framework in mental health, CHIME = Connectedness, Hope, Identity, Meaning, and Empowerment, outlining core elements for personal recovery and well-being. All registered professional Inpatient and Community – mandatory training.

E. Compliance and Governance

16. Is your Trust compliant with Care Programme Approach (CPA) timelines? **The Trust is moving away from CPA as per national guidelines.**

17. How do you monitor compliance? **N/A**

18. What actions are taken in cases of non-compliance? **This forms part of Exec and committee oversight/ directorate level into individual caseload supervision.**

19. How does your Trust monitor levels of non-diagnosis, un-outcomed appointments, and completion of risk assessments? **Risk Assessments are supported by the above process. Un-outcomed appts are monitored through data quality/ team level weekly review.**
20. What assurance processes are in place to ensure compliance? **As above**
21. What governance processes oversee the delivery of Assertive Outreach and Intensive Care action plans? **Reviewed internally through steering group, Quality Committee and Trust Board as well as the ICB/ NHSE Regional meetings.**
22. Please include any committees, reporting structures, or performance monitoring mechanisms. **Please see Appendix 2 attached.**

Performance Management Framework

Lead executive	Chief Finance Officer
Author's details	Associate Director of Performance

Type of document	Framework
Target audience	Trust Board and all staff
Document purpose	The objective of this framework is to ensure that information, insight, and intelligence is available which enables the Trust Board and key managers and clinicians to understand, monitor and assess the Trust's quality and performance, enabling appropriate action to be taken when performance against standards deteriorates. The purpose of the Trust's Performance Management Framework is to describe and standardise the processes in the Trust and to ensure appropriate management of its performance against strategic and operational goals. This is in support of the Improving Quality and Performance Report (IQPR) that provides performance assurance to Committee and Board. It sets out the reporting and monitoring arrangements at every level of the organisation as well as the responsibilities and accountabilities of individuals.

Approving meeting	SLT	Meeting date	27 May 2025
Implementation date	1 June 2025	Review date	27 May 2028

Trust documents to be read in conjunction with	
Document Code	Document name
7.13	Data Quality Policy
7.08	Information Governance Policy
7.17	Health Records Standards & Clinical Data Management Policy
7.01	Confidentiality of Patient & Employee Information Policy
	Terms of Reference: Data Quality Forum.
	Terms of Reference: Data Protection Steering Group.
	Terms of Reference: Senior Leadership Team (SLT).

Contents

Performance Management Framework

1. Background
2. Principles of Performance Management
3. Objectives
4. Using Statistical Process Control (SPC)
5. Roles and Responsibilities
6. Performance Management Arrangements
7. Assurance: Trust and Board Structure Performance Monitoring Arrangements
8. Improving Quality and Performance Report (IQPR)
9. Glossary: Index of IQPR Metrics
10. Change Control Process
11. Performance Improvement Plans (PIPs)
12. Directorate Reports: Performance Review
13. Benchmarking

LIST ALL APPENDICES

Appendix 1: Board Reporting Arrangements: Performance and Quality Framework
[IQPR]

Appendix 2: Format for the SPC Charts

Appendix 3: IQPR Glossary summary

Appendix 4: PIP Process and Escalation Flow Chart

Appendix 5: Performance Improvement Plan (PIP) Template

Performance Management Framework

1. Background

The purpose of the Trust's Performance Management Framework is to describe and standardise the processes in the Trust and to ensure appropriate management of its performance against strategic and operational goals.

This is in support of the Improving Quality and Performance Report (IQPR) that provides performance assurance to Committee and Board.

It sets out the reporting and monitoring arrangements at every level of the organisation as well as the responsibilities and accountabilities of individuals.

2. Principles of Performance Management

Performance in the Trust encompasses quality, performance, workforce, and finance. Establishing the performance culture throughout the Trust requires embedding seven principles:

1. Aligning performance to the Trust Strategy.
2. Clear corporate vision and priorities embedded at every level of the Trust.
3. Implementation of Quality Improvement methodology using Statistical Process Charts (SPC). It is a set of statistical methods based on the theory of variation that can be used to make sense of any process or outcome measured over time, usually with the intention of detecting improvement or maintaining a high level of performance.
4. Quantitative national, contractual and Trust stretch targets where appropriate based on measures which link to the real drivers of performance.
5. The right performance tracking through Performance Improvement Plans – open and objective assessment with a focus on insight, actions, and trajectories for improvement.
6. Effective and systematic review meetings that are appropriate at all levels in the organisation.
7. Good performance conversations that are supportive and accountable – problem solving/ looking forward.

3. Objectives

The objective of this framework is to ensure that information, insight, and intelligence is available which enables the Trust Board and other key managers and clinicians to understand, monitor and assess the Trust's quality and performance, enabling appropriate action to be taken when performance against standards deteriorates.

Information must be timely, accurate and complete and follow the principles set out in the Trust's Information Governance and Data Quality Policies.

The Performance Management Framework supports the delivery of the Trust's values and key strategies by delivering the following objectives:

- Provide regular comprehensive reporting focussed on quality improvement (SPC).

- Provide clear lines of responsibility and accountability.
- Provide assurance against the achievement of strategic and business objectives.
- Facilitate the Executive Team's role of ensuring progress and identifying corrective action.
- Inform priorities for management action, developments, and funding.
- Embed strong risk management.
- Ensure sustainability and review annually in line with contractual arrangements and business objectives.
- Improve performance linked to benchmarking or peer comparison.
- Provide input for the appraisal, personal and professional development process, training, and skill development.

4. Using Statistical Process Control (SPC)

Statistical process control (SPC) enables analysis of a process, rather than the relationship between 2 data points as is used in RAG ratings and in-month trends. It is a set of statistical methods based on the theory of variation that can be used to make sense of any process or outcome measured over time, usually with the intention of detecting improvement or maintaining a high level of performance.

SPC charts plot historical data and include a central line for the average of the data, an upper line for the upper control limit, and a lower line for the lower control limit. SPC methodology enables the measurement of change from the mean within and beyond the control limits; this change can be positive or negative.

5. Roles and Responsibilities

Performance management within the Trust is a recognised management function and performance monitoring is the responsibility of the Executive and Senior Leadership Team. Assurance is provided to the Trust Board and sub-committees of the Board on how the Trust manages performance.,

The PMF affirms that Performance is everyone's responsibility in the Trust.

6. Performance Management Arrangements

Service Users

Members of the public are welcome to attend the Trust Board meeting held in public each month. The IQPR is discussed at these meetings and is available via the Trust's website.

All Staff

The Trust has a standardised appraisal framework that links each member of staff's contribution to the strategic and business objectives of the Trust. Every member of staff is responsible for ensuring that they complete their appraisal on an annual basis, understand how their objectives contribute to the goals and objectives of the Trust, and deliver their annual objectives.

Team Managers

Team Managers are responsible for their team's performance and for:

- Ensuring they receive appropriate management information.
- Ensuring the accuracy and timeliness of data inputs and outputs for their Directorate/service in line with Trust policy and guidance.
- Reviewing performance on a daily, weekly, and monthly basis.

- Providing and responding to any information necessary to enable the effective measurement of performance.
- Responding to any areas of underperformance for which they are named.
- Ensuring that action to address underperformance is agreed and taken forward.

Clinical Directors and Associate Directors

All Clinical Directors and Associate Directors are accountable for the performance of their respective Operational Directorates and specifically for:

- Creating a culture of excellence and high-performance expectations within their Directorate.
- Collectively reviewing performance monthly at Directorate Business Meetings. Identifying any inaccuracies in the IQPR and other performance information and highlighting any areas of underperformance which are not identified within the monthly reports as relevant to the Directorate.
- Providing any information necessary to enable the effective measurement of performance.
- Responding to any areas of underperformance at Directorate level.
- Developing and implementing Performance Improvement Plans (PIPs) as necessary and keeping them up to date as appropriate.

Executive Directors

Executive Directors are responsible for corporate Directorate performance, which includes cross-organisational performance. They are responsible for the delivery of the quality improvement and operational performance of those metrics relevant to their portfolios.

All Executive Directors are accountable for:

- Creating a culture of excellence and high-performance expectations within their area of responsibility.
- Collectively reviewing quality improvement and performance.
- Identifying any inaccuracies in the IQPR and highlighting any areas of underperformance which are not identified within the monthly reports.
- Responding to any areas of underperformance for which the Executive Director is named as lead.
- Ensuring that action to address underperformance is agreed and taken forward by the responsible manager.
- Monitoring Performance Improvement Plans where necessary and ensuring they are updated as appropriate.

Chief Executive

The Chief Executive has overall responsibility for ensuring that the Trust has a clearly defined purpose, vision and set of core values which underpin a robust Trust Strategy and Annual Plan that is aligned with the ambitions of service users, staff and key stakeholders. The Chief Executive is responsible for driving outstanding and high-performance expectations, the projection of a strong patient and carer focus and communicating clear and visible values throughout the organisation.

The Chief Executive will ensure that the IQPR is in place and monthly quality, performance, finance, and workforce reports are received and the contents responded to through responsibilities delegated to the Executive Team.

7. Assurance: Trust and Board Structure performance monitoring arrangements

The IQPR is reported monthly to the three sub-committees and Trust Board, with the People Committee receiving a cut of the organisational health metrics only. These arrangements provide robust assurance across the Trust and to commissioners and regulators.

The Trust Board has overall responsibility for performance through the Chair and Chief Executive. Board Committees are responsible for performance through the Chair and lead Non-Executive Director.

Trust Board

The Trust Board has overall responsibility through the Chief Executive and Chair for the implementation of the Performance Management Framework. The Board is required to ensure that the Trust remains compliant with regulatory and mandated requirements, NHSE Long Term Plan objectives, the NHSE Oversight Framework, ICB contractual requirements, and has regard to the NHS Constitution.

The Trust Board provides leadership and direction to the organisation and will receive regular reports assuring them of the quality and performance of services. This Performance Management Framework will form part of the assurance to the Trust Board achieving the performance objectives as detailed in the Board Assurance Framework (BAF).

The Trust Board is required to ensure:

- That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided.
- The collection of accurate, comprehensive, timely and up to date information on quality of care.
- That the Trust actively engages on quality of care with patients, staff and other relevant stakeholders and considers as appropriate, views and information from these sources.
- That there is clear accountability for quality of care throughout the Trust, including but not restricted to, systems and/or processes for escalating and resolving quality issues.

Sub-Committees of the Trust Board

The sub-committees of the Trust Board have delegated responsibility for oversight of key areas. Chaired by non-executive directors of the Board these include:

- Quality Committee (QC) – to provide oversight of the clinical effectiveness, safety and patient experience performance by assuring risks to quality are mitigated.
- Finance and Resource Committee (F&R) – to provide oversight of financial performance and operational standards. F&R forms a view on the combined financial, performance and prospects of the organisation by reviewing the IQPR and the monthly Finance Report.
- People, Culture and Development Committee (PCDC) – the role of the committee is to determine and assure strategy related to the Trust workforce and culture development.

Chief Finance Officer

The Chief Finance Officer has the delegated lead for performance and is therefore responsible for the management and implementation of the performance framework, information management and data quality.

Associate Director of Performance

The Associate Director of Performance is responsible for the development and maintenance of systems to produce accurate and timely internal and external reports from the Trust's information systems and is responsible for the operational implementation of the various processes outlined in this framework.

Performance Team

The Performance team provides the accurate and timely analysis and interpretation of performance data for review and follow up purposes.

The Trust and Board Structure performance monitoring arrangements are set out in Appendix 1.

8. Improving Quality and Performance Report (IQPR)

The Improving Quality and Performance Report (IQPR) underpins the Trust's quality and performance management arrangements; a key driver towards maintaining outstanding services. It provides a single format for Board and Committee reporting and the means to report, monitor, review and improve organisational quality and performance outcomes from 'floor to board.'

The use of SPC charts demonstrates quality improvement and helps to describe the process changes that have resulted in it. At the same time, it recognises that the Trust's national and contractual KPIs are RAG-rated targets that must be achieved and therefore offers a hybrid approach of run charts or SPC charts with an indication of achievement of performance against target as appropriate at Trust and Locality/ Directorate level.

In this way, a single report on high value KPIs can serve both as a quality Improvement and performance tool to support Board, Committee, Performance Review and Directorate performance meetings.

The IQPR provides a high degree of assurance to Trust Committees and the Board on performance against a balanced scorecard of national, contractual and Trust stretch targets and includes:

- Regulatory – NHS Operational Planning priorities and Oversight Framework standards.
- Key ICB contractual metrics.
- Workforce measures.
- Quality targets.
- Operational performance standards.
- Finance metrics.

The content of the IQPR is reviewed annually in line with national and local contract and reporting requirements.

Timescale and process

The timeline for submission of reports and exception and remedial plan submissions is attached as ***Appendix 2.***

IQPR format and methodology

The SPC format optimises the presentation of the charts by providing a clear illustration of the SPC control limits and rule breaches on the charts.

The format for the SPC charts is set out in Appendix 3.

In addition, a summary table of the highlights and exceptions will be summarised in the IQPR (SPC rule breaches or metrics below target level). Tolerances will be red and green (no amber tolerance).

The format for the summary table is attached as Appendix 4.

Reporting to Committee and open and closed Board

The IQPR charts include alignment of metrics to Executive lead and Committee. All metrics are reported to public Board and closed Board on the months where public Board does not meet.

All highlights and exceptions are highlighted in the IQPR and reported to the Finance & Resource and Quality Committees. The People, Culture and Development Committee will receive a summary of the organisational health/workforce metrics only.

9. Glossary: Index of IQPR Metrics

The Glossary template is completed for all IQPR metrics to enable clear visibility of the measure definition, indicator calculation formulae, standard/ target, tolerance and inclusions and exclusions for all metrics. This is supplemented with a schedule showing team level inclusions and exclusions to give greater transparency of reported metrics.

Any future change requests to IQPR metrics will be presented at SLT with a new version of the IQPR Glossary published if changes are approved.

This enables a stable set of high value KPIs to be reported to Board, Committee and Directorate performance review meetings reflecting the Trust's priorities.

The Glossary format is attached as Appendix 3

10. Change Control Process

The Change Control Process will be formalised through a quarterly review of the metrics reported to the Board and the targets and measure definitions. The review and any changes will be directed through and approved by the Senior Leadership Team (SLT).

The Change Control Process will also be enacted in the event of an urgent need to report a new national measure or quality/ performance concerns raised by regulators or commissioners.

This ensures that the Trust accurately reflects activity for all reporting metrics and responds to changes in national and local priorities.

11. Performance Improvement Plans (PIPs)

Performance Improvement Plans (PIPs) provide a more detailed recovery position, including an analysis of performance, focused actions, and an improvement trajectory. These inform performance review by Trust Executive and the exception narrative to be reported in the IQPR to Committee and Board.

Performance Improvement Plans (PIPs) will be completed by any Directorate where performance for the Trust or Directorate falls into any of the categories below.

- Under performance of a RAG rated metric for 3 consecutive months.
- Special cause variation under the SPC methodology indicates consistently poor or worsening positions of performance, typically outside control limits for 3 consecutive months.
- In breach of a national, schedule 4 contractual or internal target for 3 consecutive months.

Agreement to issue a PIP is made at Operational or Corporate Performance Review meeting. It should be noted that this is the default position unless agreed by the Director of Operations who will exercise judgement on when a PIP is required. Alternatively, there may be occasions where Executive concern raises a request for a PIP, or a performance issue is escalated to the Executive team for a detailed discussion and agreed actions.

PIPs are issued to Operational Assistant Directors and Corporate Deputy Directors, Associate Directors or equivalent for completion.

New PIPs will be approved and monitored at Performance Review meetings prior to being reported to Committee and Board. They will be active, updated and reported monthly until the standard has been achieved for 3 consecutive months. This will ensure that actions are embedded and performance levels will be sustained.

Should the trajectory for improvement not be met, this will be escalated to the Executive Team to ensure a confirm and challenge conversation takes place at Performance Review, including an assessment of whether any corporate support is required to support achievement of *the* standard. Following Executive agreement, a new PIP will be issued and the trajectory will be reset, new actions provided and risks mitigated. This will be approved at the subsequent Performance Review meeting prior to being reported to Committee and Board.

***The PIP Process and Escalation template is attached as Appendix 4.
The PIP template is attached as Appendix 5.***

12. Directorate Reports: Performance Review

Performance packs are produced monthly to inform the Directorate Executive Performance Review meetings. These incorporate integrated quality and performance measures: Finance, Workforce, Quality and Operational Performance.

They have been enhanced to provide better visualisation of the most important performance measures and quality indicators. Where there are areas of underperformance, graphs to show performance over time are provided to enable root causes, trends and themes to be more easily identified.

Performance packs are moving to service line reporting to align to clinical directorate management structures and benefit service line meetings. The greater transparency of performance being reported at each service line improves ownership and allows for targeting improvement plans to be set.

Key priorities are reviewed each month to ensure that the most pressing indicators of performance and quality are in focus and Performance Improvement Plans provided by Associate Directors, including issues, actions, and improvement trajectory.

Expectations

- Performance reports are provided 3 days in advance of the Performance Review meeting for review and comment by Directorates.
- Everyone attending the meeting has a responsibility to read papers in advance.
- Directorates and Performance Team will raise any areas of concern regarding performance of services or teams if not highlighted in performance reports.

13. Benchmarking

The Trust uses local and national benchmarking information to add intelligence and insight to its performance management processes, and includes the following areas:

- Cost and price
- Efficiency and productivity
- Quality and safety
- Effectiveness
- Patient experience
- Workforce

The Trust remains a member of the national NHS Mental Health Benchmarking Reference Group.

Benchmarking data will provide a context when there are performance exceptions of the Trust's relative position compared to national performance. It enables the performance of the directorates to be analysed, and they are supported in identifying how improvement in quality, productivity and efficiency can be achieved.

Board Reporting and Monitoring Arrangements: Improving Quality and Performance Report [IQPR]

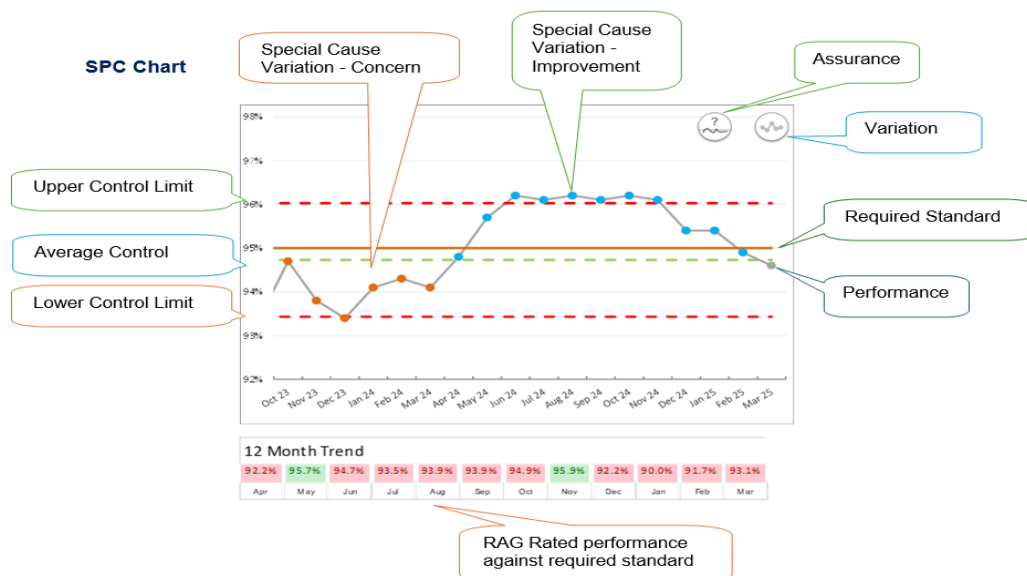
LEVEL 3: DIRECTORATE MONTHLY MEETINGS (DIRECTORATE AND CORPORATE)		
Directorate/ Locality Business meetings	Directorate Senior Management Team HR Business Partner Finance Management Accountant Performance Lead Quality lead	• Directorate level IQPR metrics and Performance packs at ward/ team level • Corporate reports • Activity data • Directorate and Corporate Performance Improvement plans • Risk assessment, mitigation, and escalation. • Other issues by exception
Finance & Resource Committee (F&R) Quality Committee (QC) People, Culture and Development Committee (PCDC)	Board Members and Lead Executives	• IQPR • Presentation on key performance information, including detailed information, actions, and trajectories on any key business KPIs currently at risk or under performance standard. • Scrutiny and assurance regarding risks and adequacy of actions
LEVEL 2a: EXECUTIVE: MONTHLY OPERATIONAL DIRECTORATE PERFORMANCE REVIEW MEETINGS		
Directorate/ Locality Performance review meetings	Executive Team Directorate Clinical Directors & Associate Directors Deputy Director of Governance/ Trust Board Secretary Associate Director of Performance	• Directorate level performance pack incorporating Board metrics and Directorate specific metrics or KPIs. • Performance packs. - detailed Performance Assurance Framework at team/ ward level – quality, operational performance, workforce, and finance • Service Line presentation on Performance Improvement Plans - commentary on actions to meet trajectories for improvement. • Other issues by exception
LEVEL 2b: EXECUTIVE: QUARTERLY CORPORATE SERVICES PERFORMANCE REVIEW MEETINGS		
Corporate services Performance review meetings	Core Executives – CEO and COO Senior Operational Directorate representation – CD/ AD Deputy Director of Governance/ Trust Board Secretary Associate Director of Performance Corporate Management Team as appropriate	• Directorate (Executive portfolio) level performance pack incorporating Board metrics as relevant and Directorate specific metrics or KPIs. • Performance Assurance Framework for Corporate services - quality, operational performance, workforce, and finance • KPIs in support of Trust Strategy • KPIs in support of Operational Directorate plans • Corporate services commentary • Other issues by exception

Appendix 1 (Cont'd)

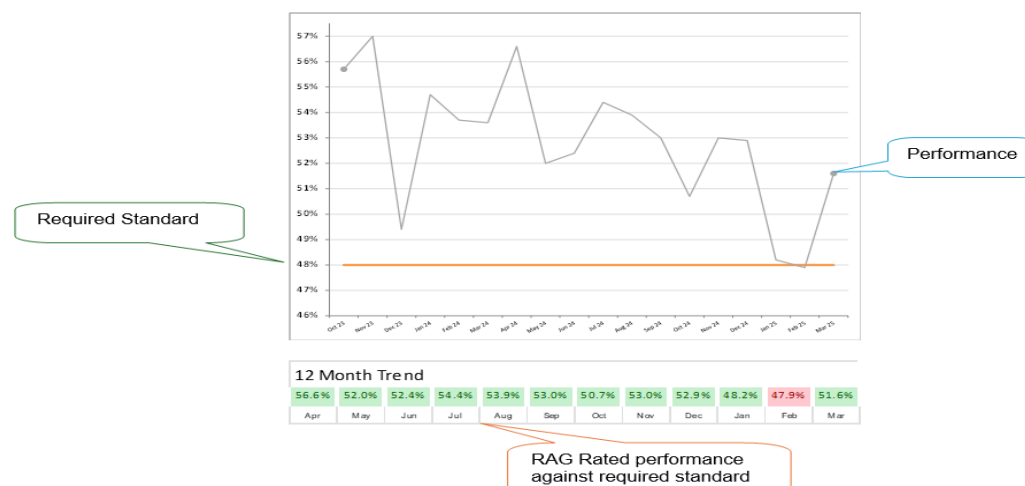
LEVEL 4 SUB DIRECTORATE/ SPECIALITY DEPARTMENT MONTHLY REVIEW MEETINGS (DIRECTORATE AND CORPORATE)		
Sub directorate/ speciality monthly performance review meetings	Directorate/ Corporate Service Manager Other Team Managers/ Service Leads Corporate leads as required	• Key Quality and Performance Indicators combined in a sub directorate/ team assurance framework. • Commentary on actions to meet trajectories for improvement for exceptions. • Risk assessment, mitigation, and escalation. • Other issues by exception
LEVEL 5: INDIVIDUAL		
Individual Performance Management arrangements	Individual and Line Manager	• Individual performance reports • Supervision • Agreed objectives and review of performance • Appraisal documentation. • End of probation review

Appendix 2

Format for SPC Charts



Run chart



Appendix 3

IQPR Glossary

AVERAGE LENGTH OF STAY – OLDER ADULT

Trust indicator –
Monitors a patient's
length of stay in line
with NHS
Benchmarking
definition.

Reducing the length of stay aims to provide patients with a better care experience by ensuring they are discharged from hospital without unnecessary delay.

Using NHS Benchmarking definition, the average length of stay is calculated from discharges during the period but includes the entirety of the patient length of stay, excluding time spent on leave.

Threshold: 87 days (a lower value is better)

Frequency: Monthly

Source of Data: Lorenzo

Expressed as: Integer

Inclusions & Exclusions:

[Appendix A](#) – Teams Included and Excluded

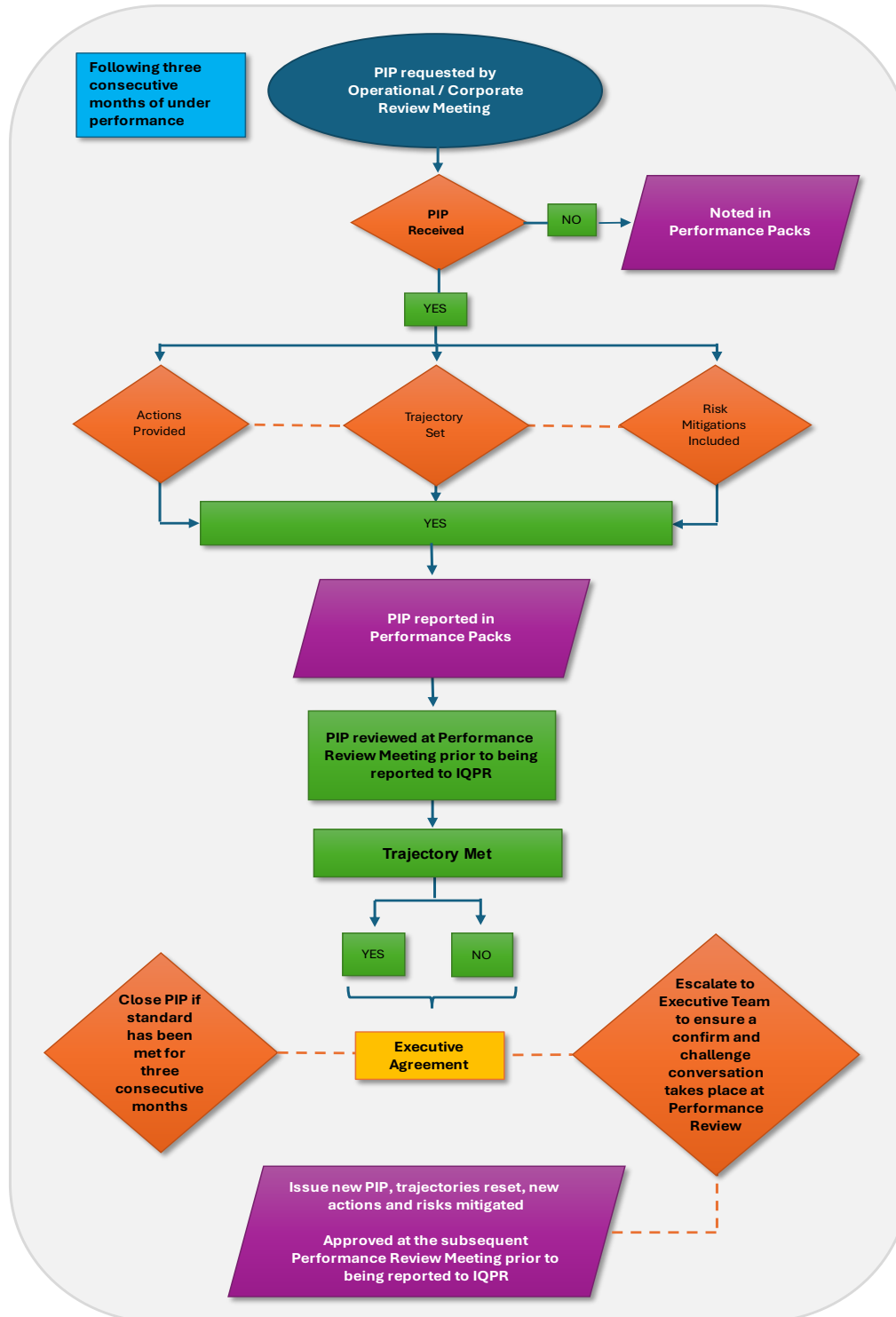
Lead: Chief Operating
Officer

- Team level inclusions and exclusions are included as an appendix to give greater transparency of reported metrics.

Service Line	Team Name	Early Intervention	CYP Ending Discharge	RTA 4 Wks	CAMHS RTA 4 Wks	RTT 18 Wks	CAMHS RTT 18 Wks	Emergency Readmission	IMHLT Response	Access Response	48hr Follow Up	Sore Day Follow Up	Care Plan	Risk Assess	Avg LoS Adult	Avg LoS Older Adult	Clinically Ready for Discharge
LD Inpatient & Community	A&T																
LD Inpatient & Community	OLDT North Staffs																
LD Inpatient & Community	OLDT Stoke																
LD Inpatient & Community	Community LD Children																
LD Inpatient & Community	Children's SBS																
TOP/LD Admission Avoidance	CYP LDKW																
TOP/LD Admission Avoidance	Intensive Support Service																
TOP/LD Admission Avoidance	TOP																
Neuro & Substance Misuse	Bariatric Psychology																
Neuro & Substance Misuse	Cancer Psychology																
Neuro & Substance Misuse	Clinical Health Psychology																
Neuro & Substance Misuse	Clinical Neuropsychology																
Neuro & Substance Misuse	Long COVID																
Neuro & Substance Misuse	Neuro Onc Psych																
Neuro & Substance Misuse	Neurology Psychology																
Neuro & Substance Misuse	Neuropsychiatry																
Neuro & Substance Misuse	Neuropsychology																
Neuro & Substance Misuse	Pain Psychology Services																
Neuro & Substance Misuse	Stroke Psychology																
Neuro & Substance Misuse	V CSE - Catch 22																
Neuro & Substance Misuse	Ward 5																
CYP	CYPISH																
CYP	Darwin																
CYP	Paed Psych																
Complex Care & Rehab	Community Rehab																
Complex Care & Rehab	Complex Care																
Complex Care & Rehab	Hilda Johnson House																
Complex Care & Rehab	Summers View																

PIP Process and Escalation Flow Chart

Performance Improvement Plan (PIP) Process



Appendix 5

Performance Improvement Plan (Template)

Performance Improvement Plan (PIP)				
Reporting Period (Month and Year):		Report Author:		
Locality / Directorate:		Date PIP updated:		
Associate Director:		Version:		

1. Current Performance (to be completed by Performance Team)				
Metric	Target	Latest Actual	Month	Executive Lead

2. Performance Improvement Plan (to be completed by Associate Director)		
Issues		
Description	Impact	Progress Update (completed in subsequent months)

Actions				
Action	Intended / Expected Impact	Directorate Lead	Timescale	Progress Update (completed in subsequent months)

[illegible]