NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST
BOARD MEETING HELD IN PUBLIC
THURSDAY 12TH NOVEMBER 2026, 10.00AM, BOARDROOM, LAWTON HOUSE AND VIA MS TEAMS

ITEM	TIMING	REF	TITLE	LEAD	ACTION	ENC
1	1000	P125/26	Welcome and Apologies for Absence – **Jennie Koo**	Janet Dawson	**Note**	
2	1002	P126/26	Declarations of Interests – and changes to be notified	Janet Dawson	**Note**	
3	1003	P127/26	Minutes of the Previous Meeting held on 10th September 2026	Janet Dawson	**Note**	**Enc. 1**
4	1005	P128/26	• Action Monitoring Schedule • Matters arising not covered by the rest of the Agenda	Janet Dawson	**Note**	**Enc. 2**
ADVISE						
5	1010	P129/26	Patient Story – Sally's Story	Kenny Laing	**Advise**	**Verbal**
6	1025	P130/26	REACH Recognition Team Award – **Primary Care – Keele GP Practice Team**	Dr Buki Adeyemo	**Advise**	**Verbal**
7	1030	P131/26	Chief Executives Report	Dr Buki Adeyemo	**Advise**	**Enc. 3**
8	1040	P132/26	Chairs Report	Janet Dawson	**Advise**	**Verbal**
9	1045	P133/26	Questions from Members of the Public	Janet Dawson	**Advise**	**Verbal**
ALERT						
APPROVE						

10	1050	P134/26	Board Assurance Framework Dashboard Q2	Nicola Griffiths	**Approve**	**Enc. 4**
11	1100	P135/26	Policy Report	Nicola Griffiths	**Approve**	**Enc. 5**
12	1105	P136/26	Board / Committee Dates 2027/28	Nicola Griffiths	**Approve**	**Enc. 6**
10-minute Break						
ASSURE						
13	1120	P137/26	Being Open Annual Report (including Freedom to Speak Up)	Kenny Laing	**Assurance**	**Enc. 7**
14	1130	P138/26	Board To Team Q2 Report 2026/27	Nicola Griffiths	**Assurance**	**Enc. 8**
15	1135	P139/26	Improving Quality and Performance Report (IQPR) Month 6	Eric Gardiner	**Assurance**	**Enc. 9**
16	1145	P140/26	Finance Report Month 6	Eric Gardiner	**Assurance**	**Enc. 10**
17	1150	P141/26	Finance and Resource Committee Assurance Reports from the meetings held on the 5th November 2026	Russell Andrews	**Assurance**	**Enc. 11**
18	1200	P142/26	Quality Committee Assurance Reports from the meetings held on the 1st October 2026 and the 5th November 2026	Pauline Walsh	**Assurance**	**Enc. 12a & 12b**
19	1210	P143/26	Audit Committee Assurance Report from the meeting held on 30th October 2026	Prem Gabbi	**Assurance**	**Enc. 13**
20	1215	P144/26	People, Culture and Development Committee Assurance Report from	Martin Evans	**Assurance**	**Enc. 14**

			the meeting held on 2nd November 2026			
21	1220	P145/26	Charitable Funds Committee Assurance Report from the meeting held on 7th September 2026	Russell Andrews	**Assurance**	**Enc. 15**
22	1225	P146/26	Any Other Business	Janet Dawson	**Note**	**Verbal**
23	1230	P147/26	Meeting Self-Assessment	Janet Dawson	**Discussion**	**Verbal**
CONSENT ITEMS						
24	1230	P148/26	Trust Board Attendance Report	Janet Dawson	**Information**	**Enc. 16**

Date and Time of Next Meeting
14th January 2027 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 10th September 2026
At 10:00am in the Boardroom, Lawton House and via MS Teams

Present		
Janet Dawson	JD	Chair
Russell Andrews	RA	Vice Chair / Non-Executive Director
Dr Buki Adeyemo	BA	Chief Executive Officer
Eric Gardiner	EG	Chief Finance Officer / Deputy Chief Executive
Kenny Laing	KL	Chief Nursing Officer / Deputy Chief Executive
Dr Dennis Okolo	DO	Chief Medical Officer
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
Katie Laverty	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 10.00am

100/26	**APOLOGIES FOR ABSENCE** Sherrine Khan - Senior Peer Support Worker Ben Richards – Chief Operating Officer Martin Evans - Non-Executive Director	
101/26	**DECLARATIONS OF INTEREST RELATING TO AGENDA** No declarations were made. ***Noted***	
102/25	**MINUTES OF THE LAST PUBLIC BOARD MEETING HELD ON – 9TH JULY 2026** It was noted within the title of Section 92/26 Charitable was misspelt Following the above amendment the minutes were received as a true and accurate record of the meeting. ***Approved/Received***	
103/26	**ACTION MONITORING SCHEDULE FROM THE MEETING HELD ON 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. *10.09.26 – Nicola Griffiths advised this has had been discussed at the Risk Review Group also noting the movement in committees from approval to assurance for policies and recent changes to policies reserved for the board and advised changes would be made to the Risk Policy which would come back to Board for approval.* **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.** *10.09.26 – This will be addressed in future reports.* **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.** *10.09.26 - This will be addressed in future reports.* **85/26 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT** **Review whether EPRR reporting is being considered by the most appropriate Committee.** *10.09.26 - 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.* **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.** *10.09.26 - Complete* **(2) Zoe Grant agreed to review the Lived Experience Shadow Board further as part of the ongoing development of the governance arrangements.** *10.09.26 - This is due to return to Exec's in September 2026* **(3) Review and strengthen the narrative supporting the ligature risk assessment and associated risk rating.** *10.09.26 - Nicola Griffiths confirmed this had been discussed at the Risk Review Group and she was looking at establishing some principles around risk that would come through the next round of Committees.* ***Received***	
104/26	**PATIENT STORY – SIMONS STORY** Kenny Laing, Chief Nursing Officer presented the Patient Story. Simon explained that he had been receiving support since 2005 after a period of psychosis involving paranoia and unusual perceptions. The early intervention team provided a diagnosis, regular contact and structure, which helped him understand that others had similar experiences and reduced his sense of isolation. Simon said that a later period of counselling was followed by detention under the Mental Health Act, which he felt was unnecessary and stressful. He	

	believed decisions were influenced by inaccurate notes and that he had not been sufficiently involved in the process, although one staff member, Nigel, listened to his perspective rather than relying solely on existing records. Simon described using counselling, self-directed learning in psychology, philosophy and spirituality, and preparation for employment to support his recovery. After initially being unsuccessful, he secured a Peer Support Worker role with the early intervention team and continued in that role for approximately five years. The Board highlighted active listening as a key lesson for the Quality Committee and asked whether an independent advocate or family member could have helped Simon during detention. Simon confirmed that advocacy would have been useful; the discussion noted that independent mental health advocacy was now expected when someone was detained, and Janet Dawson asked Dr Dennis Okolo to assure that this requirement was consistently met. The Board discussed developing a consistent approach to advance decisions so that people could record their wishes before a future mental health crisis. Simon was invited to consider helping to co-produce the approach, particularly to ensure that people who may later feel disempowered had their preferences available to decision-makers. The Board thanked Simon for sharing his story. **Noted**	
105/26	**REACH RECOGNITION INDIVIDUAL AWARD – Dave Norcup -** Head of Information and Data Quality. Dr Buki Adeyemo, Chief Executive Officer, introduced the award, which was presented to Dave Norcup, Head of Information and Data Quality, in recognition of his exceptional leadership in transforming data into practical intelligence to support service performance and strengthen patient care. The Board heard that Dave led the team responsible for the Trust's Performance Management Framework and for providing assurance on the accuracy, quality and integrity of organisational data. His contributions included developing predictive intelligence relating to the NHS Oversight Framework ahead of national reporting, enabling services to identify emerging risks, opportunities and performance trends and take earlier action. Dave was also recognised for making complex information clear and accessible, connecting data intelligence with patient care and service delivery, and supporting the Trust's understanding of health inequalities through the inclusion of protected characteristics within performance reporting. This enabled services to identify variation in access, experience, service use and outcomes and to target improvement activity appropriately. Dave thanked Vicky for the nomination and colleagues for their comments. He said he was honoured to receive the award and proud to support work across the Trust and wider local system to improve patient care and experience.	

	The Board congratulated Dave and formally recorded its appreciation for his contribution. ***Received***	
106/26	**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, Chief Executive Officer, presented the report, which was taken as read, and highlighted that the meeting coincided with World Suicide Prevention Day. The Board recognised suicide prevention as a shared responsibility and noted that effective risk assessment should not be treated as a predictive or tick-box exercise, but should be supported by attention to individuals' circumstances and timely, compassionate intervention. The Board discussed the baseline and proposed stretch targets relating to mental health attendances and waits within Emergency Departments. It was noted that the national priorities sought to build on existing achievements, with particular focus on 12-hour waits and accurate differentiation between attendances relating primarily to mental health needs and those where physical healthcare was also required. The Board emphasised that terminology and operational approaches must not imply that people with mental illness were less entitled to physical healthcare. Work continued with University Hospitals of North Midlands NHS Trust and system partners to ensure care reflected individuals' mental and physical health needs. Clarification was requested regarding the baseline, scope and accuracy of the reported target to reduce out-of-area activity by 95% by March 2027. **ACTION: Dr Buki Adeyemo to confirm the baseline, scope and accuracy of the reported 95% reduction target for out-of-area activity by March 2027.** The Board also considered the Trust's involvement in the development of Mental Health Emergency Departments. The Trust's existing 24-hour, seven-day, all-age Crisis Care Centre and established pathways with the Emergency Department would inform work with University Hospitals of North Midlands NHS Trust and system partners to determine the most appropriate local model. The Board noted the importance of ensuring that improvements in digital services did not disadvantage people who were unable or did not wish to use digital channels. Digital access would remain one option within a wider approach, with usage monitored and alternative methods of access and communication maintained and promoted. ***Noted***	**BA**
107/26	**CHAIRS REPORT** Janet Dawson, Chair, provided a verbal update. Janet Dawson, Chair, provided a verbal update and highlighted the relationship between organisational culture and safe care. Drawing on learning from recent reports concerning maternity services, the Board noted	

	the wider importance of leadership, active listening and understanding the experiences of staff, patients and service users. The reports demonstrated the risk of significant concerns not reaching Boards because of blockages in the flow of information. The Board considered whether Committees received sufficient assurance and whether reports enabled members to identify emerging themes and draw meaningful conclusions. Members emphasised the importance of triangulating information from different sources, understanding the reasons for lower levels of assurance and remaining professionally curious, including where information appeared reassuring. The Chair reported positively on a recent visit to the Crisis Care Centre and commended a member of nursing staff for providing an informative account of the service and its pathways. His work to promote greater understanding of mental health within the Muslim community was also recognised. The Chair welcomed improvements to the organisation of Board-to-Team visits and thanked staff for their openness. Particular recognition was given to David, Tobacco Dependency Adviser, for his work supporting patients, service users and staff to stop smoking. The Board agreed that further consideration should be given to how Committees identify, explore and challenge cultural issues. Trade union representatives could provide an additional source of intelligence regarding staff experience and organisational culture. An appropriate opportunity would be included in the Board Development Programme for trade union colleagues to share relevant themes confidentially. The Board sought an update on the involvement of people with lived experience and Service User Council representatives in Trust governance meetings. A paper would be considered by the Chief Officer Team before being presented to the Board. **ACTION: Kenny Laing to review the latest paper on the involvement of people with lived experience and Service User Council representatives, submit it to the Chief Officer Team and present it to a future Board meeting.** **ACTION: Nicola Griffiths to arrange a Board Development discussion on culture, assurance, triangulation and staff experience, including a confidential contribution from trade union representatives.** The Chair recorded the Board's thanks to Roger Banks, former Associate Non-Executive Director, for his valuable challenge and perspective, particularly in relation to learning disability, autism and inclusion. ***Noted***	**KL** **NG**
108/26	**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. ***Noted***	

109/26	**WINTER PLAN** Rachael Birks, Acting Chief Operating Officer presented the plan. The plan set out the arrangements for maintaining safe, effective and resilient services during anticipated winter pressures. The plan identified the principal risks and mitigations and was aligned with the relevant Board assurance statements. The Board noted that daily system calls continued and that recent Emergency Department cases had informed discussions with the Integrated Care Board regarding escalation arrangements and joint working across system partners. The Board emphasised that people with mental health diagnoses must continue to receive appropriate physical healthcare. Work was progressing with acute and system partners to determine the role of a future Mental Health Emergency Department, taking account of the Trust's existing 24-hour, seven-day, all-age Crisis Care Centre and established pathways between Emergency Departments and crisis services. In addition to routine monitoring of liaison and crisis activity, the Trust would monitor referral volumes and response times throughout the winter period. The Board noted that pressures within acute services could increase demand on mental health liaison teams. Members emphasised that winter mitigations should consider the impact on staff, including sickness absence and additional pressures over the Christmas period, as well as service capacity. The Board approved the Winter Plan, subject to final sign-off by Janet Dawson and Dr Buki Adeyemo. ***Approved / Received***	
110/26	**LORD MANN REVIEW BOARD BRIEFING** Frieza Mahmood, Chief People Officer presented the report. The Board received a regarding the Trust's response to the recommendations arising from the national Lord Mann Review into anti-Semitism, racism and discrimination within the NHS. Frieza Mahmood highlighted the requirement from NHS England for organisations to reaffirm their commitment to tackling racism and religious hatred, including consideration of the NHS Race and Health Observatory's Anti-Racism Principles. The Board was advised that the Trust and Integrated Care System had already established a strong foundation in this area through longstanding anti-racism and anti-religious hatred commitments and that existing arrangements were considered aligned with the review's expectations. Clarification was sought regarding references within the action plan to matters being "under review". The Board was advised that this related primarily to the monitoring and implementation framework rather than the Trust's commitment to the principles themselves. Ongoing national developments and definitions would continue to be monitored to ensure compliance with emerging guidance.	

	Board members noted that further contextual information and examples of how related issues were managed within the Trust would have strengthened the report. Assurance was provided that relevant workforce metrics, including protected characteristic data and speaking-up information, were routinely reviewed through established governance arrangements, with no current concerns identified in relation to Anti-Semitism or racism. The Board approved the proposed approach and endorsed the recommendations contained within the report. ***Approved / Received***	
111/26	**SAFE STAFFING 6 MONTHLY REVIEW** Kenny Laing, Chief Nursing Officer / Deputy Chief Executive Officer presented the report. The review covered inpatient nursing establishments and found sufficient staffing plans with one formal exception. Average occupancy was 98.5%, while care hours per patient day averaged 12.78 and benchmarked favourably against comparable organisations. Registered-nurse recruitment had improved and vacancies had reduced, but sickness absence remained high in inpatient areas. This continued to drive reliance on bank staff, which had reduced but remained above plan. The report identified improving use of the E-roster system, reducing sickness absence, improving supervision and reviewing observation practice as priorities. These actions would be overseen through the relevant executive and quality governance arrangements. A temporary night-shift nursing-establishment uplift at Dragon Square respite service had already been approved while a fuller establishment review was undertaken. Ward 3 was also subject to further work because of a challenging period and patient mix, and Ward 5 was identified for review because its establishment appeared high relative to potential patient need. Board members distinguished technical staffing safety from broader workforce resilience, citing persistent bank use, violence and aggression, sickness and possible burnout indicators. The Board agreed that these issues should be explored further, including in Private Board, and that future papers should clearly state what decision had already been taken by Chief Officers or Committees and what action was required from the Board. ***Received***	
112/26	**SAFEGUARDING CHILDREN AND ADULTS ANNUAL REPORT 2025/26** Kenny Laing, Chief Operating Officer / Deputy Chief Executive Officer presented the report. The report covered adult and children's safeguarding duties under relevant statutory guidance. Increased referrals and safeguarding concerns were presented as evidence that clinical teams were identifying and acting on risks affecting adults and children.	

	Level 3 safeguarding children compliance ended the year at 84% against an 85% contractual ICB target. The position had fluctuated during the year, and the safeguarding lead confirmed that corrective work had commenced and was on track. Bank and agency staff were subject to the same safeguarding-training requirements as permanent staff. A training matrix determined the level required for each role, and agencies must provide evidence of compliance as part of the contracting process. The safeguarding team managed thousands of information-sharing checks with partner agencies, and this activity continued to grow. The report therefore identified the need to monitor team capacity while progressing the year's improvement actions. When asked why the mandatory Level 3 target was only 85%, the response was that it was a contractual minimum applied across the ICB rather than the Trust's desired end state. The stated aim remained to achieve full compliance among staff expected to undertake the training. ***Received***	
113/26	**BOARD TO TEAM QUARTER 1 REPORT 2025/26** Nicola Griffiths, Deputy Director of Governance, presented the report. The Board noted the significant review and redevelopment undertaken to strengthen the programme, including improvements to programme design, feedback collection, Directorate action planning and oversight through Chief Officer meetings. Quarter 1 had focused on process review and stabilisation, with more comprehensive reporting and assurance anticipated in Quarter 2. The Board welcomed the increased structure and governance but emphasised the importance of ensuring that intelligence gathered through visits was analysed, acted upon and fed back to staff. Members noted that failure to communicate actions or explain why matters could not be resolved could undermine confidence in the programme. Recurring themes across visits should also be identified and considered as potential indicators of wider organisational or cultural issues. Greater engagement with Clinical Directors and Associate Directors had strengthened Directorate ownership of actions and responses. The Board agreed that continued monitoring was required to ensure that teams experienced tangible outcomes from the issues raised during visits. ***Received***	
114/26	**BOARD ASSURANCE FRAMEWORK (BAF) DASHBOARD QUARTER 1** Nicola Griffiths, Deputy Director of Governance / Trust Board Secretary presented the report. The Board received the Board Assurance Framework (BAF) report and noted that the BAF had been reviewed through Committees, with oversight provided through the relevant committee structures for each principal risk. Nicola Griffiths highlighted that regular monthly reviews of all BAF risks had been undertaken. The Board noted that one BAF risk, BAF Risk 8, remained	

	outside its agreed tolerance level. Assurance was provided that a review of the risk and associated mitigating actions was being undertaken with the intention of strengthening controls and bringing the risk back within tolerance where possible. Members noted that the position provided a useful opportunity to test and apply the Board's developing approach to risk tolerance and to consider how both Committees and the Board should respond when risks fall outside agreed parameters. ***Approved / Received***	
115/26	**WRES AND WDES ANNUAL REPORT 2025/26** Frieza Mahmood, Chief People Officer presented the reports. The Board received the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Report. The Board noted improvements in workforce representation across the equality standards, while recognising that disparities in treatment and outcomes remained in some areas and required continued focus. Assurance was received that a comprehensive improvement plan, revised operating model and supporting governance arrangements were in place to address outstanding issues and support further progress. Members sought clarification regarding an apparent discrepancy in the version control record. The Board emphasised that future reports should accurately and clearly record their governance and approval route. In view of the statutory reporting requirements and external submission deadlines, the Board approved the reports, noting the need to strengthen governance tracking and version control. ***Approved / Received***	
116/26	**IMPROVING QUALITY PERFORMANCE REPORT (IQPR) MONTH 4 2026/27** Eric Gardiner, Chief Finance Officer / Deputy Chief Executive Officer presented the report. The Board received the Month 6 Improving Quality and Performance Report and noted continued strong performance across a number of key indicators, including referral to assessment, Early Intervention in Psychosis and post-discharge follow-up. Positive performance was also noted across a range of workforce, quality and access measures. Exceptions requiring continued focus included: • sickness absence, which had increased to 6.64%, against the Trust threshold of less than 5.40%, with Performance Improvement Plans in place within relevant services; • clinical supervision compliance at 84% and appraisal compliance at 82%, both below the 85% standard; • CAMHS referral to treatment within 18 weeks, which had reduced to 91.3%;	

	• Children and Young People waits exceeding 104 weeks, with 883 waits against a planned level of 446, with enhanced reporting introduced to support targeted management of long waits; and • inappropriate out-of-area placements, which had increased slightly to 13 at month end. The Board noted the actions being taken in response to these areas and the continued monitoring through the appropriate governance arrangements. The Board received the Month 6 IQPR, noting the areas of positive performance and the exceptions requiring continued focus. ***Received***	
117/26	**FINANCE REPORT MONTH 4 2026/27** Eric Gardiner, Chief Finance Officer / Deputy Chief Executive Officer, presented the report. The Trust remained on plan with no significant immediate financial risks. Eric Gardiner advised best and worst case scenarios were being developed for the following month, and the recent performance review with NHS England was expected to serve as the mid-year review, avoiding a separate meeting. Although confidence remained that Trust targets would be met, Eric Gardiner noted that deficits at other organisations in the Midlands could create wider system pressure. The Board recognised that regional financial problems could affect the Trust even if its own position remained on track. ***Received***	
118/26	**FINANCE AND RESOURCE COMMITTEE ASSURANCE REPORTS FROM MEETINGS HELD ON 6th AUGUST 2026 AND 3rd SEPTEMBER 2026.** Russell Andrews, Committee Chair /Non-Executive Director presented the reports. The August report was taken as read, and the following matters from the September meeting were highlighted. The Committee received an update on the Orbis programme. A comprehensive options appraisal would be presented to the Senior Leadership Team and the Committee in October or November 2026 to support decisions on the programme's future direction and implementation. An associated review had been commissioned through MIAA and was expected to align with the options appraisal process. Although this was not an internal audit, Audit Committee members could request sight of the findings if required. The Committee reviewed the Trust's financial position and Cost Improvement Programme. Assurance was received that a robust delivery plan was in place, with planning for the next financial year already under way. In view of the increased confidence and assurance received, the Committee agreed to discontinue the separate monthly Cost Improvement Programme report and incorporate oversight within routine finance reporting.	

	The Committee noted significant improvement in water temperature compliance across the estate, with one isolated area remaining subject to operational issues. The Committee also endorsed the introduction of a fire safety action tracker to support continued oversight of outstanding actions. The Medium-Term Financial Plan update was approved. The Committee also noted the longer-term financial implications of moving away from block contract arrangements as an emerging issue requiring further strategic consideration. ***Received***	
P119/26	**QUALITY COMMITTEE ASSURANCE REPORT FROM MEETING HELD ON THE 6th AUGUST 2026 AND 3rd SEPTEMBER 2026** Pauline Walsh, Committee Chair / Non-Executive Director presented the reports. The Committee had approved a number of policies and reviewed the assurance ratings assigned to reports, amending these where appropriate. Further consideration would be given to how changes to assurance ratings were tracked and reported to the Board. The Board noted positive feedback from recent Care Quality Commission visits to Older People's Services and the Community Learning Disability Service, which had subsequently been confirmed in writing. The Committee had reviewed performance against the one-hour liaison response standard. A detailed review was under way to better understand the factors affecting performance, including pressures within the wider urgent care system. The Committee welcomed the introduction of Directorate Spotlight reports, with Acute Services providing the first formal presentation. The format provided valuable insight into directorate achievements, challenges and priorities and would continue across other service areas. The Committee also considered out-of-area placements and welcomed the inclusion of a case study alongside the performance data. Future reports would include further information on the experiences of affected families. In relation to restrictive practices, additional clarity was requested on how proportionality was assessed and the impact of interventions across protected characteristic groups. The Board noted that increasing demand for Autism and ADHD services remained a significant system-wide challenge, with demand continuing to exceed available capacity. Partnership work and improvement actions were under way, although longer-term solutions would require wider system action and investment. Positive progress was also noted in relation to clinically ready discharges, supported by strengthened partnership working with local authorities and the integration of social work support. ***Received***	

P120/26	**AUDIT COMMITTEE ASSURANCE REPORT FROM THE MEETING HELD ON THE 31st JULY 2026** Prem Gabbi, Non-Executive Director / Committee Chair, presented the report and highlighted the following: The Audit Committee agreed cyber security would be added to the Audit Committee's cycle of business so that the Committee could provide direct assurance to the Board. This separated the topic from its previous position within digital and finance reporting and reflected the continuing external threat. Prem Gabbi advised where internal audit recommendations were more than six months overdue, Chief Officers would be invited to Audit Committee to provide ownership and progress updates. The aim was to prevent actions being repeatedly extended, including actions that remained open for more than 12 months. A question about whether teams could extend audit deadlines led to clarification that deadlines were set by responsible teams but extensions must be controlled and owned by Chief Officers. The established process requires Chief Officers to review progress and approve or challenge extensions rather than allowing teams to move deadlines informally. The Committee discussed an unauthorised lease entered into without adequate understanding of the required process. The Finance Team were asked to review preventive controls so that individuals could not create organisational liabilities without the appropriate approval. The Committee also questioned how the Trust verified that staff had received and seen policy changes. It was noted that the Governance Team were asked to consider a feedback mechanism that demonstrated not only that a policy was issued but that relevant staff were made aware of it. ***Received***	
121/26	**ANY OTHER BUSINESS** There were no items of other business. ***Noted***	
122/26	**MEETING SELF ASSESSMENT** The Board undertook a self-assessment of the meeting and welcomed feedback from attendees observing as part of their induction programme. Attendees reported that the meeting had provided valuable insight into the role and breadth of the Board's work. They commented positively on the Board's culture, its focus on Trust values and the prominence given to patient care, staff experience and issues escalated through the Trust's governance arrangements. The patient story was highlighted as particularly impactful in demonstrating the difference Trust services made to individuals and communities. While acknowledging the volume and complexity of the information considered, attendees welcomed the opportunity to develop their	

	understanding of Board business and expressed interest in observing future meetings. Board members welcomed the feedback and reflected positively on the focus throughout the meeting on organisational culture, patient voice and lived experience. The Board also recognised the importance of constructive challenge in supporting effective governance and decision-making. ***Noted***	
123/26	**Policy Report - Business Continuity Management System Policy and Incident Response Plan** Circulated for information only	
124/26	**TRUST BOARD ATTENDANCE REPORT** Circulated for information only.	
	DATE AND TIME OF NEXT MEETING Thursday 12th November 2026 at 10.00am Boardroom, Lawton House and via MS Teams	

The meeting closed at 12:30pm

Signed: _____ Date: 17th September 2026
Chair

Board Action Monitoring Schedule

Trust Board - Action monitoring schedule - (Public)

No.	Meeting Date	Minute No	Action Description	Responsible Officer	Target Date	Progress / Comment
1	10th September 2026	106/26	**CEO REPORT** Clarification was requested regarding the baseline, scope and accuracy of the reported target to reduce out-of-area activity by 95% by March 2027. Dr Buki Adeyemo to confirm the baseline, scope and accuracy of the reported 95% reduction target for out-of-area activity by March 2027.	Dr Buki Adeyemo	12th November 2026	the trajectory we advised the ICB (operational planning) for Mar 27 was a target of 14 OOA based on bed capacity/previous bed demand. I am aware following this we advised NHSE that we continue to work on a target of zero for Mar 27 however I do not believe we can agree a trajectory of zero by Mar 27 with the current work underway even though we have seen a reduction, on average since the beginning of the year we have a requirement for 11 OOA beds at any one time. A review is currently under way of the OOA actions/oversight and a paper is due to be reseptned to SLT meeting in November.
2	10th September 2026	107/26	**CHAIRS REPORT** 1. Kenny Laing to review the latest paper on the involvement of people with lived experience and Service User Council representatives, submit it to the Chief Officer Team and present it to a future Board meeting. 2. Nicola Griffiths to arrange a Board Development discussion on culture, assurance, triangulation and staff experience, including a confidential contribution from trade union representatives.	Kenny Laing Nicola Griffiths	14th January 2027 12th November 2026	The proposed model for a lived experience advisory group was approved by Chief Officers meeting in October 2026. The board will receive an update on progress in January 2027. . Complete- Discussed with CPO and culture session identified for BOD in January 2027

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 3

CEO BOARD REPORT – NOVEMBER 2026

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

Presented by:	Dr Buki Adeyemo, Chief Executive Officer
Prepared by:	Vicky Self, Deputy Chief People 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: • Independent Review into Mental Health Conditions, ADHD and Autism • Mental Health Personalised Care Framework • Employment Support Expanded to Support Mental Health Recovery • World Mental Health Day 2026 • Community Support for Combined Charity • National Recognition for Learning Disability Services

VERSION CONTROL:

Version	Report to	Date Reported
V1	Public Trust Board	06/11/2026

Chief Executive's Report to the Trust Board
November 2026

1.0 PURPOSE

This report provides an overview of significant strategic, operational and external developments since the previous meeting of the Board. It highlights key national policy and regulatory updates affecting the Trust, together with notable organisational achievements, service developments and partnership activity. The report is intended to support Board oversight, assurance and understanding of the wider context within which the Trust continues to deliver its strategic objectives.

2.0 NATIONAL CONTEXT AND UPDATES

2.1 Independent Review into Mental Health Conditions, ADHD and Autism

In October 2026, the Department of Health and Social Care published the final report of the Independent Review into Mental Health Conditions, ADHD and Autism. The review identifies increasing population need, growing demand for services and continued challenges around access, waiting times and inequalities.

The review reinforces many of the challenges already being experienced across NSCHT services, including increasing demand, rising complexity of need, pressures relating to ADHD and autism pathways and the importance of earlier intervention. The recommendations are likely to influence future commissioning intentions, service specifications and performance expectations. For NSCHT, this presents an opportunity to demonstrate leadership in integrated mental health and neurodevelopmental pathways whilst ensuring service models remain aligned to anticipated national policy direction. The findings also strengthen the case for continued investment in workforce capacity, community based provision and partnership working across health, local authority and voluntary sector organisations.

2.2 Mental Health Personalised Care Framework

In October 2026, NHS England updated the Mental Health Personalised Care Framework, setting out expectations for secondary and community mental health providers. The framework reinforces requirements around personalised care planning, named care coordinators, co-production, therapeutic relationships and ensuring people have greater choice and control over their care.

The updated framework aligns closely with the Trust's commitment to co-production, recovery focused practice and patient centred care. However, it is also likely to increase focus from regulators and commissioners on demonstrating evidence of personalised care planning, care coordination and meaningful patient involvement. The framework provides an opportunity for NSCHT to build on existing strengths while identifying areas where assurance, staff development or service redesign may be required to meet evolving national expectations.

3.0 OUR TRUST

3.1 Employment Support Expanded to Support Mental Health Recovery

NSCHT, working in partnership with Midlands Partnership University NHS Foundation Trust, has expanded its Step On Individual Placement and Support service to reach more people across Staffordshire and Stoke-on-Trent.

The service, previously available to individuals receiving specialist secondary mental health services, has now expanded into primary care settings, enabling Employment Specialists to work alongside Mental Health Practitioners within GP practices. This development increases access to practical employment support and strengthens the Trust's commitment to recovery-focused care.

This development directly supports the Trust's ambition to improve outcomes beyond traditional healthcare measures. Employment is a recognised determinant of health and wellbeing, and expanding access to employment support within primary care settings enables the Trust to intervene earlier and support individuals to achieve sustainable recovery. It also strengthens partnerships across the health system and demonstrates delivery of prevention, recovery and population health objectives.

3.2 World Mental Health Day 2026

The Trust marked World Mental Health Day 2026 through a dedicated event at Harplands Hospital, aligned to the national theme of "Lived Experiences Heard: Real Voices, Real Change".

The event celebrated the contribution of people with lived experience in shaping services and improving care. Activities included service user stories, peer support engagement, staff wellbeing initiatives and fundraising activities for Combined Charity. The event reinforced the Trust's commitment to co-production and recovery-focused practice.

The event demonstrates the Trust's commitment to ensuring lived experience remains central to service design and delivery. By creating opportunities for patients, carers and staff to influence improvements, the Trust continues to strengthen its culture of co-production and engagement.

3.3 Community Support for Combined Charity

Combined Charity received a £10,000 donation following the annual ST9 Ball, an event attended by more than 400 local people which raised over £30,000 for charitable causes.

The additional funding provides opportunities to enhance patient, carer and staff experiences through projects that may not otherwise be possible through NHS funding alone. It also strengthens community relationships and reinforces the Trust's role as an anchor institution within the local area.

3.4 National Recognition for Learning Disability Services

The Trust has received national recognition after winning the Learning Disabilities Nursing Award at the Nursing Times Awards 2026, recognising its innovative work to develop the future learning disability nursing workforce through its T Level placement programme.

The Trust was recognised for its innovative T Level placement programme, which is helping to develop the future registered learning disability nursing workforce by providing young people with practical experience across a range of learning disability services.

The initiative, delivered in partnership with local colleges, promotes learning disability nursing as a career, increases awareness of the needs of people with learning disabilities and equips future healthcare professionals with the skills to deliver inclusive, person centred care. The awards panel commended the project as an innovative approach to attracting young people into the profession and strengthening the future workforce.

This national award provides external validation of the Trust's commitment to innovation, workforce development and improving outcomes for people with learning disabilities. The recognition strengthens NSCHT's reputation locally and nationally, supports recruitment and retention efforts, and demonstrates the Trust's contribution to addressing future workforce supply challenges.

4.0 CONCLUSION

The Trust continues to operate within a dynamic national and local environment. Through the commitment of our colleagues, volunteers and partners, we remain focused on delivering our strategic priorities, responding to emerging opportunities and challenges and ensuring that high quality care and positive outcomes remain at the centre of everything we do.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 4

Trust Board - Board Assurance Framework Quarter 2 Report

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

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. 2 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 Q2 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. **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 Q2 by DDoM **resulting in no impact on the residual score**. The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open. **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 Q2 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. **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).
BAF Updated in Q2 and approved by Interim Acting COO.
Proposing a score reduction from Residual Score 20 to 15, reducing the likelihood from 4 (*Likely*) to 3 (*Possible*).
Rationale - CIP PIDS have been completed to meet the Trust overall target. However, caution remains on some of the high-risk schemes which we are being overseen and monitored. Discussion in F&R Committee that this will be reviewed monthly via the Finance Report, CIP reporting paper has been stood down. Planning for 27/28 has commenced in September 2026.
The risk is within the agreed tolerance level of 12 – 20 with a risk appetite of Open.
ACTION – Trust Board to approve.

This was approved at the Risk Review Group on the 6.10.26 and Quality Committee on the 5.11.26.

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 Q2 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.

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 Q2 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.

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 Q2 and approved by Interim Acting 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 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).
BAF Updated in Q2 and approved by DCNO in CNO absence.
Proposing a score reduction from Residual Score 15 to 10, reducing the likelihood from 3 (*Possible*) to 2 (*Unlikely*).
Rationale - We have had 3 successful CQC core service inspections, two of these have formally been rated as "Good" in every domain and overall, one we are waiting a report but early indication from feedback is positive, also the Trusts performance throughout clinical Directorates remains strong.
If approved to a score of 10, the risk will then be within the agreed tolerance level of 5 – 10 with a risk appetite of Cautious.
ACTION – Trust Board to approve.

This was approved at the Risk Review Group on the 6.10.26 and Quality Committee on the 5.11.26.

Summary of other BAF related activities during quarter 2.

- Updated the risk management policy to provide clarity on the risk approval process relating to the Risk Review Group and Committees.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Risk Review Group	6.10.26
V2	Audit Committee	30.10.26
V2	People, Culture & Development Committee	2.11.26
V2	Finance & Resource Committee	5.11.26
V2	Quality Committee	5.11.26
V3	Trust Board	12.11.26

PREVENTION

ACCESS

GROWTH

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	Residual Risk Score Q2	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	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	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 (*Possible*) = **12**	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	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.	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	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	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	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	10	⇩	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.

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 5

POLICY REPORT– NOVEMBER 2026

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

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

Aligned to Board Assurance Framework Risk:	Regulatory - The Trust may fail to meet legal and regulatory requirements due to the evolving regulatory and statutory landscape, the consequence is legal and regulatory action, deterioration in ratings, and loss of public and stakeholder confidence.
7 Levels of Assurance:	Level 7 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months
Approval / Review:	Senior Leadership Team
Strategic Priorities:	Prevention – We will continue to grow high quality, integrated services delivered by an innovative and sustainable workforce.
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	The Board are asked to approve the following policies.
Executive Summary:	Request is made to approve the following policies as detailed within the report: Approve for 3 years: • 4.18a Risk Policy • 4.02 Standards of Business Conduct Policy Approve for 1 year • 2.03 Standing Financial Instructions • 4.04 Standing Orders Policy • 4.06 Scheme of Delegation Policy

VERSION CONTROL:

Version	Report to	Date Reported
V1	Senior Leadership Team	21/10/2026
V1	Audit Committee	30/10/2026
V1	Public Trust Board	02/11/2026

Report for Trust Board – November 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
4.02 Standards of Business Conduct Policy	The Policy describes the broad framework of arrangements for the management of standards of business conduct and the outlines the conduct expected of all Trust employees.	Corporate Governance Manager	Chief Executive Officer	Existing	Policy Governance Group – September 26	Audit Committee	30.10.26	Approve for 3 years
	Changes to policy: Full review of policy. Introduction of SBC4 Conference Speaker Declaration of Interests Form to establish a consistent process for the advance declaration, assessment and management of actual, potential or perceived conflicts of interest involving speakers at Trust conferences, educational events and training activities. Updated references to the September 2024 NHS England conflicts of interest guidance, NHS Provider Trust Code of Governance. Updated the NHS Constitution for England reference to the August 2023 version. Replaced outdated NHS Improvement terminology. Replaced NHS Protect with the NHS Counter Fraud Authority. Updated the Data Protection Act 1998 reference to the UK GDPR and Data Protection Act 2018. Corrected the title of the Economic Crime and Corporate Transparency Act 2023.							
4.18a Risk Policy	This policy sets out the delivery of effective risk management within a clear infrastructure, systems, and processes.	Deputy Director of Governance	Chief Executive Officer	Existing	Policy Governance Group – October 2026	Audit Committee	30.04.29	Approve for 3 years
	Changes to policy: This policy has been revised to reflect updated Trust governance structures and has been benchmarked against good practice in other NHS Trusts.							

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
4.06 Scheme of Reservation and Delegation	The purpose of this document is to set out those powers reserved to the Trust Board.	Deputy Chief Finance Officer	Chief Finance Officer	Existing	Policy Governance Group – October 26	Audit Committee	31.10.26	Approve for 1 year
	Changes to policy: Addition new subsection 2.9 Public Safety, Protective Security and Martyn's Law Compliance. SFI.4.1 Strengthened Audit Committee responsibilities. New Entries under Accountable Officer duties reflecting statutory requirement to designate a senior individual in organisations. Update to Risk Review Section – linking Martyn's Law into BAF and risk escalation pathways.							
2.03 Standing Financial Instructions	The purpose of this document is to set out the financial responsibilities, policies and procedures to be adopted by the Trust and to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.	Deputy Chief Finance Officer	Chief Finance Officer	Existing	Policy Governance Group - October 2026	Audit Committee	30.10.26	Approve for 1 year
	Changes to Policy: Comprehensive review and update of Standing Financial Instructions to reflect current legislation, NHS governance requirements and procurement regulations. Key changes include: update to Procurement Act 2023 and Procurement Regulations 2024 requirements; inclusion of Economic Crime and Corporate Transparency Act 2023 (Failure to Prevent Fraud); replacement of NHS Litigation Authority references with NHS Resolution; update to UK. GDPR and Data Protection Act 2018; revision of NHS service agreements and contracting arrangements; strengthening of Audit Committee and Internal Audit provisions; update to information governance and digital responsibilities; revision of capital approval arrangements; introduction of social value and inclusive procurement requirements; update to NHS Counter Fraud Authority and security management provisions; refresh of external references and legislative guidance.							

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
4.04 Standing Orders Policy	The Standing Orders form a central part of North Staffordshire Combined Healthcare's Governance together with documents such as the Standing Financial Instructions and the Scheme of Delegation, they fulfil the dual role of protecting the Trust's interests and protecting officers from possible accusation that they have acted less than properly (provided that officers have followed the correct procedures outlined in the relevant document).	Corporate Governance Manager	Chief Executive Officer	Existing	Policy Governance Group – October 2026	Audit Committee	31.10.26	Approve for 1 year
	Changes to policy: A targeted update was required to correct legislative terminology, refine the procurement provisions, update external guidance references, align the document with the latest Standards of Business Conduct Policy, Standing Financial Instructions and Scheme of Delegation, and clarify that final approval rests with the Trust Board. The fundamental structure of the Standing Orders does not require wholesale revision.							

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 6

COMMITTEE / BOARD DATES 2027/28

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

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

Aligned to Board Assurance Framework Risk:	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:	Choose an item.
Approval / Review:	Execs
Strategic Priorities:	Growth - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	N/A

Recommendation / Required Action:	The Board is asked to approve meeting, Committee and Board dates for 2027/28
Executive Summary:	Attached are the Committee / Board dates for 2027/28 for information Noting: • All dates are based on Day 10 reporting • The Committee chart accommodates where there are public bank holidays • Finance and Resource Committee and Quality Committee Face to face meetings have been arranged for June and November • SLTD and Risk Meetings 7th December 2027 are face to face. Items to consider: • Performance Paper Deadline 17th May 2027 is also Day 10 and Performance Meeting is the following day not leaving much time for data validation alternatively Performance could be moved to the Thursday that week. It cannot be pushed forward a week as there are not enough Tuesdays left to then hold an SLT within that month. • People, Culture and Development Focus Meetings moved forward a week in April, June 2027 and January 2028 due to bank holidays no impact on Trust Board as Quad A's not required for Focus meetings.

VERSION CONTROL:

Version	Report to	Date Reported
V1	Execs	22/10/2026
V1	Public Trust Board	02/11/2026

Committee Chart 2027-2028 – Version 1 (Based on Day 10 Reporting)

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W
Jan 27					1 **BH**	2	3	4 PCDC Bus	5 Execs TBPM SLTD / Risk PD	6	7 F&R QC	8 TB/ REMCO/ BOD Exec PD	9	10	11	12 SLTD Risk Execs P	13	14 TB REMCO SEM	15 **Day 10** Perf PD	16	17	18	19 Perf SLT PD	20	21	22 Exec / AC PD	23	24	25 PCDC PD	26 SLT Exec P	27	28 F&R / QC PD	29 TB PM PD AC	30	31			
Feb								1 PCDC Focus	2 Execs TBPM SLTD/ Risk PD	3	4 F&R QC	5 TB/ BOD / Exec PD	6	7	8	9 SLTD Risk Execs P	10	11 PR TB BOD	12 **Day 10** Perf PD	13	14	15	16 Perf SLT PD	17	18	19 Exec PD	20	21	22 PCDC / CFC PD	23 SLT Execs P	24	25 F&R / QC PD	26 TB PM PD	27	28			
March								1 PCDC Bus CFC	2 Execs TBPM SLTD / Risk PD	3	4 F&R QC	5 TB / BOD Exec PD	6	7	8	9 SLTD Risk Execs P	10	11 TB SEM	12 **Day 10** Perf PD	13	14	15	16 Perf SLT PD	17	18	19 Exec PD	20	21	22	23 SLT Execs P	24	25 F&R / QC / TBPM PD	26 **BH**	27	28	29 **BH**	30 Execs TBPM SLTD / Risk / PCDC PD	31
April				1 F&R QC	2 TB/ BOD/ Exec PD	3	4	5 PCDC Focus	6 SLTD Risk Execs P	7	8 PR TB BOD	9	10	11	12	13 Execs Dev Day	14 **Day 10**	15	16 Perf PD	17	18	19	20 Perf SLT PD	21	22	23 Exec PD	24	25	26	27 SLT Execs P	28	29 F&R / QC PD	30 TB PM / AC PD					
May						1	2	3 **BH**	4 Execs TBPM SLTD / Risk / PCDC PD	5	6 F&R QC	7 AC TB / REMCO / Exec PD	8	9	10 PCDC Bus	11 SLTD Risk Execs P	12	13 TB REMCO SEM	14	15	16	17 **Day 10** Perf PD	18 Perf SLT PD	19	20	21 Exec PD	22	23	24	25 SLT Execs P	26	27 F&R / QC PD	28 TB PM / AC / PCDC PD	29	30	31 **BH**		
June		1 Execs TBPM SLTD / Risk PD	2	3 F&R F2F QC F2F	4 TB / BOD / Exec PD AC	5	6	7 PCDC Focus CFC	8 SLTD Risk Execs P	9	10 PR TB BOD	11	12	13	14 **Day 10**	15 Execs Dev Day	16	17	18 Perf PD	19	20	21	22 Perf SLT PD	23	24	25 Exec PD	26	27	28 PCDC PD	29 SLT Execs P	30						
July				1 F&R QC PD	2 TBPM PD	3	4	5 PCDC Bus	6 Execs TBPM SLTD / Risk PD	7	8 F&R QC	9 TB / Exec PD / REMCO PD	10	11	12	13 SLTD Risk Execs P	14 **Day 10**	15 TB SEM REMCO	16 Perf PD	17	18	19	20 Perf SLT PD	21	22	23 Exec PD	24	25	26 PCDC PD	27 SLT Execs P	28	29 F&R / QC PD	30 AC	31			
Aug							1	2 PCDC Focus	3 Execs TBPM SLTD / Risk PD	4	5 F&R QC	6 Exec PD	7	8	9	10 SLTD Risk Execs P	11	12 BOD Full Day	13 **Day 10** Perf PD	14	15	16	17 Perf SLT PD	18	19	20 Exec PD	21	22	23	24 SLT Execs P	25	26 F&R / QC PD	27 TB PM / Exec PD	28	29	30 **BH**	31 Execs TBPM SLTD/ Risk/ PCDC	

Committee Chart 2027-2028 – Version 1 (Based on Day 10 Reporting)

																																							/ CFC PD	
Sept			1	2 F&R QC	3 TB / REM CO / Exec PD	4	5	6 PCDC Bus CFC	7 SLTD Risk Execs P	8	9 TB AGM REM CO SEM	10	11	12	13	**14 Day 10** Exec Dev Day	15	16	17 Perf PD	18	19	20	21 Perf SLT PD	22	23	24 Exec PD	25	26	27 PCDC PD	28 SLT Execs P	29	30 F&R / QC PD	TB PM/ Exec PD						
Oct					1	2	3	4 PCDC Focus	5 Execs TBPM SLTD / Risk PD	6	7 F&R QC	8 TB / BOD / Exec PD	9	10	11	12 SLTD Risk Execs P	13	**14 Day 10** PR TB BOD	15 Perf PD	16	17	18	19 Perf SLT PD	20	21	22 Exec / AC PD	23	24	25 PCDC PD	26 SLT Exec P	27	28 F&R / QC PD	29 TB PM PD AC	30	31				
Nov	1 PC DC Bus	2 Execs TBPM SLTD / Risk PD	3	4 F&R F2F QC F2F	5 TB Exec PD	6	7	8	9 SLTD Risk Execs P	10	11 TB SEM	**12 Day 10** Perf PD	13	14	15	16 Perf SLT PD	17	18	19 Exec PD	20	21	22 PCDC / CFC PD	23 SLT Exec P	24	25 F&R / QC PD	26 TBPM / Exec PD	27	28	29 PCDC Focus CFC	30 Execs TBPM SLTD / Risk PD									
Dec			1	2 F&R QC	3 BOD / Exec PD	4	5	6	7 SLTD F2F Risk F2F Execs P	8	9 BOD Full Day	1 F0	11	12	13	**14 Day 10** Exec Dev Day	15	16	17 Perf PD	18	19	**20**	**21** Perf SLT PD	22	23	**24** Exec PD	25	26	**27 BH**	**28 BH**	29 SLT Exec P PCC PD	**30** F&R / QC PD	**31** TB PM / Exec PS PD						
Jan 28						1	2	**3 BH**	4 Execs TBPM SLTD / Risk / PCDC PD	5	6 F&R QC	7 TB / REM CO / Exec PD	8	9	10 PCD C Bus	11 SLTD Risk Execs P	12	13 TB REM CO SEM	14	15	16	**17 Day 10** Perf PD	18 Perf SLT PD	19	20	21 Ex / AC PD	22	23	24 PCDC PD	25 SLT Execs P	26	27 F&R / QC PD	28 TB PM / Exec PS PD AC	29	30	31				
Feb		1	2	3	4	5	6	7 PCDC Focus	8 Execs TBPM SLTD / Risk PD	9	10 F&R QC	11 TB / BOD / Exec PD	12	13	**14 Day 10**	15 SLTD Risk Execs P	16	17 PR TB BOD	18 Perf PD	19	20	21	22 Perf SLT PD	23	24	25	26	27	28 PCDC / CFC PD	29 SLT Execs P									
March			1	2 F&R / QC PD	3 TBPM / Execs PD	4	5	6 PCDC Bus CFC	7 Execs TBPM SLTD / Risk PD	8	9 F&R QC	10 TB / Exec PD	11	12	13	**14 Day 10** SLTD Risk Execs P	15	16 TB SEM	17 Perf PD	18	19	20	21 Perf SLT PD	22	23	24 Exec PD	25	26	27 PCDC PD	28 SLT Execs P	29	30 F&R / QC PD	31 TB PM / Exec PS PD						

Committee Chart 2027-2028 – Version 1 (Based on Day 10 Reporting)

Key:

TB	**P**ublic and Private Trust Board Meeting	
TBPM	Trust Board Pre-Meet	
PRTB	Private Trust Board only	
SEM	Board Development Seminars	
BOD	Board Development Full Session	
REMCO	Remuneration Committee	
AC	Audit Committee	
PCDC	People Culture and Development Committee	
QC	Quality Committee	
CFC	Charitable Funds Committee	
F&R	Finance and Resource Committee	
SLT	Senior Leadership Team Meeting	
Execs	Executive Team Meeting (papered / no papers)	
Exec Dev	Executive Team Development	
SLTD	Senior Leadership Team Development Meeting	
Perf	Performance	
Risk	Risk Meeting	
PD	Paper Deadlines	
AGM	Annual General Meeting	

Empty boxes shaded in light blue are Bank Holidays
****Days of the month in red are Staffordshire School Holidays****

Enclosure No: 7

Annual Being Open Report – 2025/2026

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

Presented by:	Kenny Laing – Chief Nursing Officer
Prepared by:	Marie Barley – FTSU Guardian and Being Open Lead
Executive Lead:	Kenny Laing – Chief Nursing Officer

Aligned to Board Assurance Framework Risk:	People - We will be unable to recruit, develop and retain an engaged, diverse and effective workforce which meets the needs of our local population and our people, due to the impact of financial challenges and external factors.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	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 PSED G3: Foster good relations between people who have a protected characteristic and those who do not.
ICS Alignment / Implications:	FTSU approaches are consistent with peer FTSU regional Guardians within the ICS

Recommendation / Required Action:	It is recommended that the committee: • Receive the report for information. • Support the proposed next steps. • Receive an update quarterly report.
Executive Summary:	This report shares the annual activity for the three main raising concern platforms provided by the Trust: Dear Buki, Freedom To Speak Up and Resolution of Grievance and Dispute. It identifies key themes and Trust actions for supporting the themes arising, offering assurance governance and senior level consideration. **Dear Buki** During 2025/26 the Trust received a **total of 72 Dear Buki submissions**. This is a decrease of 9 communications when compared to the number of communications (81) received during 2024/25. Thematic analysis is included in the body of the report. Out of the 72 submissions: • 50 communications were raised anonymously • 22 communications were person identifiable **Freedom To Speak Up.** FTSU received a **total of 93 concerns during 2025/26**. This platform continues to show an increase in use year-on-year. Thematic analysis, directorate where concerns have been raised are included in the body of the report. **Staffing Groups Raising Concerns** Concerns during 2025 were mainly raised from the additional clinical services staffing group with use predominantly from the British white staffing group 73% which represents the largest demographic of the Trusts workforce. FTSU was also used by the following staffing groups; 21% Black African, 4% Asian and 2% unknown, due to the concerns being raised completely anonymously and our people reporting they would prefer not to share their ethnicity. **Resolution of Grievance and Dispute** During 2025/26 the Trust received **a total of 17 grievance cases with 9 cases carried forward from the previous tax year**. This is an increase in the number of cases when compared to 2024 data, where there were 18 grievance cases and 3 cases carried forward from the previous tax year. Case detail and position to date of each case are included in the main body of the report. **Summary** Themes of the concerns arising during 2025/26 have and continue to mainly show subject variance between Dear Buki and FTSU.

	There are emerging themes and patterns of concern that have been raised through Dear Buki and FTSU. These relate to cultural and behavioural issues and leadership, which are having a detrimental impact on team psychological safety. This is further supported through the alignment of some of the issues raised through the Trusts Resolution and Grievance Dispute process. The data in this report confirms and supports identification of need for further exploration into these themes specifically. Further support actions are identified as a need around teamwork and supporting appropriate communication. The Trust has supported a further year for the delivery of the Affina team journey piece, meaning a second cohort of teams can be supported through this programme, supporting team effectiveness and communication. The data also identifies a need for the Trust to deliver and embed specific support around inclusion and belonging, aiming to improve culture, and working experiences for its people. The Trust continues to progress and deliver on actions through the outcomes and recommendations from the three external pieces of work which were commissioned in 2025, to support the inclusion agenda, through quarterly steering group meetings to review and report progress against actions. The executive led Big Conversation piece, is due to be launched at the end of Apri 2026, with a series of successions delivered from May onwards. The aim of this is to engage with our people, asking what is needed to improve working experience. This piece may identify some of the specifics needed around some of these issues reported. There is a clear need for the continuation of each of its speaking platforms with year-on-year increased activity through the FTSU platform and an increase in the number of Grievance cases this year. These options offer our people a safe space to choose informal or formal processes to be heard, for issues to be reviewed and explored and for people to feel supported with appropriate outcomes from sharing their voice.

VERSION CONTROL:

Version	Report to	Date Reported
1	PCDC	29.10.26
2	Public Trust Board	06.11.26

North Staffs Combined Annual Being Open Report (including quarter 4)
1st April 2025 31st March 2026

1.0 Introduction

North Staffordshire Combined strives to provide an open and inclusive culture for its workforce, recognising the importance of the wellbeing of our people, which ultimately leads to better patient care.

To support this culture, the Trust provides different options of choice for our people to raise concerns, including raising matters either with their line manager or senior managers or with the Patient Safety Team. If staff feel unable to raise matters via their immediate local level routes, other options are available for raising concerns both internally and externally. All options are promoted on the Trust Intranet.

The two main internal raising concern platforms for the Trust beyond local level are:

- Dear Buki
- Freedom To speak Up (FTSU)

Staff also have the option of raising concerns via a formal route:

- Resolution of Grievance and Dispute Process

The aim of these routes is to provide our people with space to help them feel safe to raise concerns or issues, that impact on either the safety or wellbeing of themselves, patients or others, when staff are exposed to any negative working experience.

The Dear Buki and Freedom to Speak Up options, mainly continue to be used differently by our people, with Dear Buki used to raise issues that could potentially impact on many such as a directorate or for Trust wide issues. FTSU is used for personal, more one to one specific concerns, or for teams who have a consistent concern. FTSU is also used when people have either attempted to raise concerns with their immediate management team and have felt unheard or unsupported, or where they have felt unsafe for whatever reason, to raise a concern at local level.

As a Trust, our responsibility remains to ensure that any concerns raised, are taken seriously, escalated, investigated appropriately, and supported with actions to achieve outcome, with updates on progress provided to those individuals raising the concern.

The Dear Buki platform, shares responses to the concerns raised, using the Trust intranet page, with many of the responses publicly accessible to all. Where person identifiable concerns have been raised, responses are sent back to the originator and are not publicly published.

The Trust also promotes additional and alternative services along with contact details, where subject dependant concerns can be raised, providing our people with a range of options and choice. These alternative details are promoted on the FTSU Trust intranet pages and are promoted by the FTSU Guardian at any engagement opportunity.

On a regular basis, the FTSU Guardian engages with our people at:

- Monthly Corporate Induction
- Junior Doctor Induction sessions
- Preceptorship programme sessions
- Student engagement sessions
- Directorates or team development days when relevant
- Through Staff Survey engagement work
- Through FTSU champions team engagement sessions or where any further appropriate opportunities arise.

2.0 Report Purpose

This report shares the annual activity for the three main raising concern platforms provided by the Trust: Dear Buki, Freedom To Speak Up and Resolution of Grievance and Dispute. It identifies key themes and Trust actions for supporting the themes arising, offering assurance governance and senior level consideration.

3.0 Key Recommendations to Consider

It is recommended that the committees:

- Receive the report for governance assurance purposes.
- Support the next steps proposed.
- Receive quarterly update reports.

4.0 Background

The Dear Buki website, originally launched in February 2015, has subsequently been used for each Chief Executive appointed to the Trust. The website provides our people with an additional mechanism to raise concerns, issues, or queries either anonymously or identifiably, by choice. Dear Buki communications are received by the Trust's Chief Executive and are shared with the FTSU Guardian and the Communications team. Members of the executive team support specific related responses within their portfolio of expertise. The Clinical Directorates, Heads of Directorates or other key stakeholders may be advised of any Dear Buki's which concern their respective Directorates; and may be requested to contribute towards supporting a response. All responses are approved by the Chief Executive before being published.

4.1 Dear Buki (DB) Summary of Activity

All activity for Dear Buki communications is reviewed and categorised on a quarterly basis by themes. The themes align with those recommended by the National Guardians Office, offering the Trust consistency with the FTSU raising concerns platform. These themes are:

- Policy & procedure
- Patient Quality & Safety

- Worker Safety/wellbeing
- Line Manager issues
- Bullying & Harassment
- Professional Development
- Equipment & Maintenance
- Senior Management Issues
- Work Demands
- Inappropriate Attitude & Behaviours
- Staffing Levels
- Other

During 2025/26 the Trust received a total of **72 Dear Buki submissions**. This is a decrease of 9 communications when compared to the number of communications (81) received during 2024/25. Out of the 72 submissions:

- 50 communications were raised anonymously
- 22 communications were person identifiable

The annual Dear Buki communications for 2025/26 presented below in Figure 1. share which directorate he communications were received from.

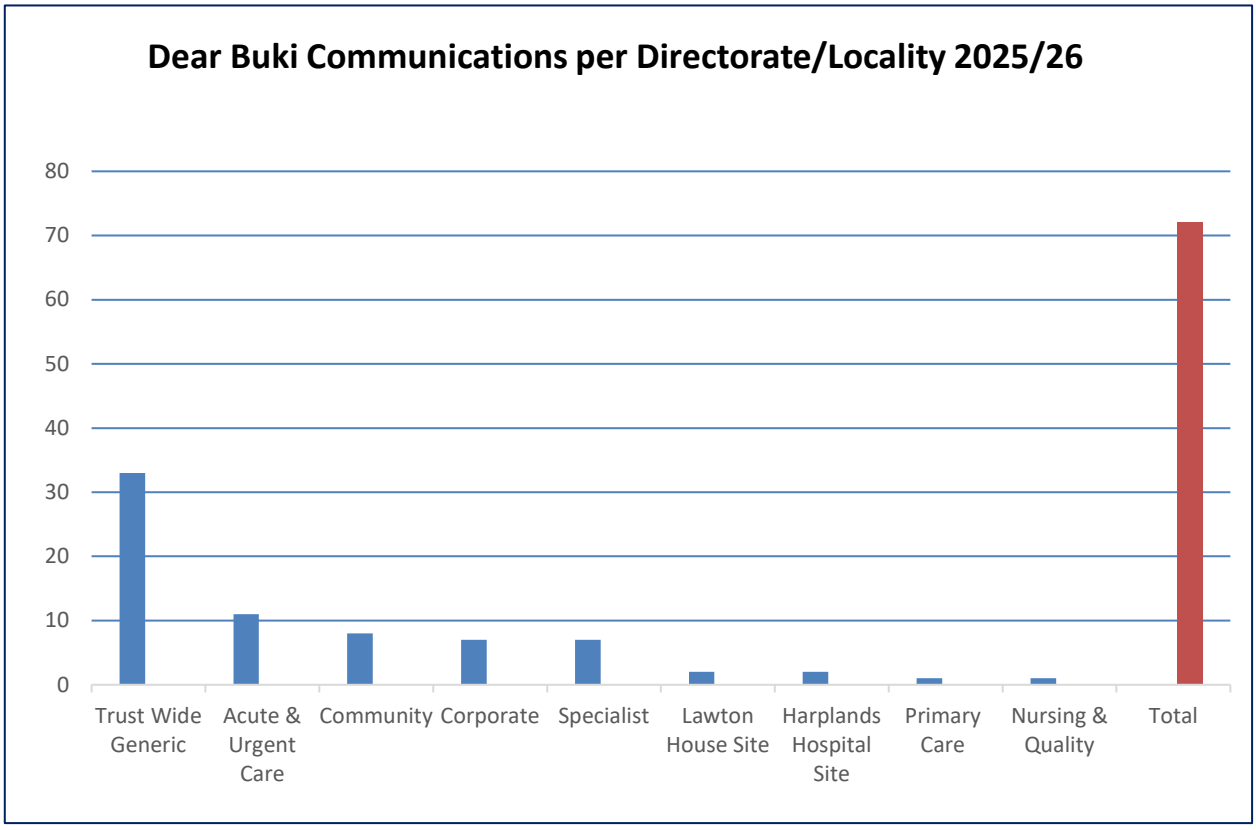


Figure 1. Annual Dear Buki Communications per locality (2025/2026)

4.2 Dear Buki Submissions

A summary of all Dear Buki communications received during 2025/26 are presented in themes in Table 1 below.

Table 1 – Summary of Dear Buki Communications 2025/26

Patient Quality & Safety	
Quarter 1	**1 Communication**
	• Request for Trust clarification why one service area can work against the Trusts no smoking policy when it comes to supporting patient care.
Quarter 2	**2 Communications**
	• Concerns regarding all incident forms being sent to the IPC team when they are not related to infection prevention, therefore impacting on patient privacy. A request was made for incidents that flag up a need for IPC involvement only to be sent directly to the IPC team. • Concerns raised from a ward accepting unsuitable patients for the discharge to assess pathway, with re-admission of a patient within 72 hours to Royal Stoke, due to being physically unstable. A request was made for a member of staff to support track and triage assessments due to compassion fatigue and burn out for staff.
Quarter 3	**2 Communications**
	• Concerns about inappropriately qualified and experienced staff diagnosing patients and no suitably qualified clinicians attending MDT meetings. A request for this to be investigated. • Concerns raised about the Trust sending patients to the Royal Stoke for IV fluids and antibiotics due to dehydration, when the Trust has qualified Doctors and nursing staff that could manage this and prevent patients having to sit in ambulances for hours, when they are often agitated. Request for Combined qualified clinical staff to support this patient need internally.
Quarter 4	**6 Communications**
	• Concern around the Trust being able to access the Electronic Prescriptions facility due to excessive time and efforts spent by staff ensuring that paper prescriptions are delivered to patients, when systems exist for prescriptions to be sent directly to pharmacy. • Reports of an unsafe process and lack of system resulting in a family being locked into the building at end of day. Concerns around and poor leadership and communication with a blame culture within the service and the building not properly managed. No staff are aware of the alarm process and reports of no senior leadership accountability. A request was made for the senior leaders to take responsibility, providing effective local inductions and safety briefings, with clear processes around building use and locking up. • Concern regarding the use and management of seclusion particularly with patients with LD needs. A few suggestions were made for a review and improvements to support this concern. • Concern with regards to the Trusts paper free initiative. Reports with a high proportion of staff unable to access Lorenzo and patients needing enhanced observations. Documentation is not accurately recorded or there is a lack of documented care with patient fluid and

Quarter 4	diet intake, impacting on patient safety. Reports of registered nursing staff updating patient records up to 12 hours later, due to having no capacity and HCSW's having no access to Lorenzo. HCSW's are unaware of what care has been provided and what patients have consumed. • Concerns about the new observation sheets for patients, with staff reporting the question "are they physically well?" is impossible to answer., based on a few seconds of looking at a patient and communicating with them. Concerns that there is no way of being certain that someone is definitely well as patient could look fine one minute and be having a cardiac event in the next. Staff feel this question is to place blame on someone should any incident occur. A request to return to using paper forms • Request for a chair to be removed from the Hope Centre due to contamination. Facilities and Estates have been informed but at present the chair has not been removed and it poses an IPC hazard and potentially puts other patients at risk
Total of 11 Communications	
Worker Safety/Wellbeing	
Quarter 1	**5 Communications** • Reported on-going uncivil behavioural issues from some senior leaders. • Poor interview experience with unprofessional behaviour demonstrated. Request to ensure the recruitment process is fair with staff feeling valued and respected for both their skill and experience. • Excessive temperatures in staff offices at the Harplands Hospital with no air conditioning. Concerns around the inconsistency of this due to other rooms i.e. Keele Hub, the Tribunal room and the command-and-control room having air conditioning, but staff are unable to use these rooms during hot weather conditions. • Request for the Trust to offer wellbeing incentives which are consistent to other organisations. Example used - the application of an annual leave purchase scheme, offering flexi time working to all staff to support and accrue additional leave to support staff wellbeing/work-life balance. • Staff in-patients burn out, with frustration and feelings of being de-valued with no clear progression pathway for Band 5 Staff nurses. Concerns around the minimal pay difference between Band 5 registered nurses and unqualified staff and inconsistencies with roles and responsibilities for band 6 inpatient staff when compared to other service areas such as CRHTT and CMHTs who are reported to have significantly lower workload and different work pressures.
	3 Communications • Concern regarding the lack of accessibility for the musculoskeletal health service for staff. This was advertised as being available with no clear way to access it.

Quarter 2	• Query relating to the trust process for reinstating staff who retire and return to band 6 or 7 posts, with reports of an impact on career development for band 5 nurses. Request to prioritise substantive band 5 nursing staff who wish to progress in their career. • Concerns about staff cover from a specific inpatient area to support cover on other inpatient wards, with no reciprocation when needed. A request was made for acute staff to rotate in services, so they feel comfortable supporting all inpatient services.
Quarter 3	**4 Communications** • Concern regarding the persistent and high-pitched ringing of the fire alarm located in the main office of one of the Trust buildings. Reports of malfunctioning and weekly testing which is creating a disruptive and uncomfortable working environment and impacting on staff wellbeing and health issues. • Concerns with the lack of bank shifts available which is impacting on staff wellbeing. • Concerns with the lack of ability to adjust the temperature of in-patient areas, which is creating unpleasant working environments for staff. • Concern and disappointment shared regarding the decision to close the Staff Psychological Wellbeing Hub; due to the positive impact it has made through supporting staff wellbeing to stay in work and reduce sickness absence. Request to review funding to see if this service could be maintained as a wellbeing benefit for staff.
Quarter 4	**Nil Communications**
Total of 12 Communications	
Senior Management Issues	
Quarter 1	**Nil Communications**
Quarter 2	**1 Communication** • Concerns around a specific service senior leadership team, including lack of visibility, communication, meaningful engagement and decisions communicated electronically. This has been reported to be impacting on staff feeling trusted and creating low staff morale. A request was made for meaningful and urgent intervention to address these issues.
Quarter 3	**4 Communications** • Concerns around lack of consistent and visible leadership, with inconsistent communication and reported behavioural issues within a directorate. • Concerns around senior leader behavioural issues that are affecting the wider team within a directorate. • Reports around the lack of accountability from the senior leadership team, following a facilitated engagement event with a team, leaving staff feeling unheard by their leadership

	team and concerns around the safety of the building the team work from. • Concern around the growing perception of one of the Trusts directorates focus, recognition and actions being limited to the nursing role only, leaving other professions feeling undervalued and marginalised. Request for a more inclusive and collaborative approach that acknowledges the contributions of the whole workforce.
Quarter 4	**2 Communications** • Concerns about reported poor leadership and lack of effectiveness and delivery from a specific service leader • Concern around lack of senior leader visibility and poor communication leaving teams feeling unheard and devalued. Request for planned team visits convenient to suit service need for staff to feel heard and engaged with the senior leaders.
Total of 7 Communications	
Line Management Issues	
	Nil Communications
Quarter 2	**Nil Communications**
Quarter 3	**1 Communication** • Concerns around a line manager targeting a member of staff, leaving staff member feeling constantly blamed.
Quarter 4	**6 Communications** • Concern around ongoing poor communication in relation to MARS application being unsuccessful and a request for a copy of the application. • Concern around a service being without a full leadership team for numerous months impacting on the current leader's wellbeing and having an impact on service safety. Reports of no senior management support with unreasonable pressures on existing leader. • Concerns around poor / awful communication and support for the team on the return of a team lead, with the team feeling anxious and having received no communication about this. Formal concerns have been previously raised but staff report they were unheard, leaving the staff worried. A team survey was completed last year, but this was never discussed and concerns raised within the team were not addressed. This has had an impact on team morale. A request for improved senior leader communication with the team and issues to be addressed. • Reported historic issues of poor management within a service. A request made for the service to revisit the feedback provided from an internal survey that was completed and to support the clinical lead in maintaining the progress that has been made within the service. • Concerns raised about a poorly managed and poorly communicated MOC process, with a request for the management of change process

	to be paused, giving time to listen and engage and collaboratively review alternative options with the leaders and teams affected. • Concern around a job vacancy not being recruited into correctly, with some vacancies not going out to advert and therefore not giving anyone else the opportunity to apply. Reports of staff being promoted beyond one pay band and queries around some medical secretary banding in specific services. Request for all vacancies to be advertised internally and externally offering fair opportunity for all.
Total of 7 Communications	
Inappropriate Attitudes & Behaviours	
	2 Communications
	• Concerns raised about senior leader behaviours during attendance and when delivering a talk at a Trust event. • Concerns raised from staff in a service area, leaving other staff feeling the behaviours to be malicious and vindictive and impacting on staff mental wellbeing
Quarter 2	**1 Communication**
	• Reports of inappropriate use of social media posts by a member of staff was made.
Quarter 3	**Nil Communications**
Quarter 4	**Nil Communications**
Total of 3 Communications	
Other	
Quarter 1	**5 Communications**
	• Request to re-instate the use of Trust credit cards for small purchases to prevent delays through using the Trust ordering process which requires approval and therefore adds delays. • Request for fair cost savings across the Trust, including Trust Board lunches and team development days. • Request for the Trust to design a system for staff to access and see an overview of bookings for their areas of work, to prevent other staff using a room that has already been booked out. • Request for the Trust to ensure all religious holidays are promoted equally. Religious events such as Eid, Ramadan, Diwali etc. are promoted and celebrated but there was no promotion for Easter as one of the most important events in the Christian calendar.
Quarter 2	**3 Communications**
	• Issues were raised about the Trust's decision on the use of colour printing, as this has been reported to impact on several patient and clinical activities, including notice board displays, posters and clinical colour coding for patients. • Concerns were raised about a large tree that has been cut down next to the Lawton House car park and the Trust's contradiction to the Green NHS agenda.

Quarter 3	**6 Communications** • Concern around the lack of hot desks at the Harplands site with an unclear booking system. • Concerns with a negative staff experience from a team when asking for clarification around uploading car insurance details. • Concerns with all mandatory training moving to the Trentham Lakes site making this difficult for staff who need to use public transport. • Concerns with specific staff consistently parking in short stay or disabled spaces, impacting on staff who deliver home visits and carry heavy or bulky equipment to and from the Harplands site. A request for this to be monitored with warning notices issued. • Query around staff using own vehicle when supporting the mobility of patients and having no blue badge but needing to park in disabled spaces as they support patients. Concern around staff being issued a warning through the Trust decision to monitor car parking. • Concerns raised about staff Christmas cards and its impact on sustainability and cost.
Quarter 4	**8 Communications** • Concern and seeking clarification in relation to inconsistency and fairness of leave arrangements across services. • Concerns around the Trusts smokefree agenda and tobacco dependence treatment with a reported lack of dedicated leadership and resources for tobacco dependence treatment, leading to no clear guidance, strategic direction, or accountability, which has led to inconsistent engagement across teams. Request made for this to be reviewed. • Concerns about quality Trust provision for hot desks at the Harplands site, with reported overall experiences of inconsistency and poorly supported lack of equipment or faulty equipment. Request to introduce clear ownership and standards for hot-desking spaces, including responsibility for maintaining equipment and ensuring rooms are consistently and fully set up • Concern with bank employee removed from the MS 365 subscription. Request for this to be to re-instated to help access to information. • Query around High Potential Scheme application and request for clarification around what quality the scheme provides to improve patient care and the whole workforce.

	• Concern that certain staff members are not completing their full allocated working hours. Suggestion made for a clocking in device and management to monitor this more closely. • Concern raised about the cost-of-living crisis and petrol prices with staff members concerned the mileage allowance received does not cover the cost of the miles needed to deliver the service. Request for mileage allowance to be increased. • Queries around plans for the Trust and in particular the Harplands site regards to smoking? Repots of patients and visitors smoking around the main doors, meaning staff, patients and visitors having to walk-through second-hand smoke and impact on staff health. Query also around patients on the acute wards being allowed to vape on the wards.
Total of 22 Communications	
Staffing Levels	
Quarter 1	**Nil Communications**
Quarter 2	**1 Communication**
	• Concern about a reduction in bank shifts and the Trust's employment of NQN's. Action reported as impacting on bank shift availability, leaving bank workers feeling undervalued with personal financial implications.
Quarter 3	**Nil communications**
Quarter 4	**Nil communications**
Total of 1 communication	
Policy & Procedure	
Quarter 1	**2 Communications**
	• Request for all staff to be treated equally with shift allocations in a service area.
Quarter 2	**2 Communications**
	• Weekly fire alarm and pit testing reported to be distracting and distressing to staff members who are observing distressed patients, due to the level of noise. Request made to work with Serco to find ways to test the alarms without alarms having to be set off for sustained periods of time. • Clarity requested around the type and frequency of supervisions needed for clinical members of staff.
Quarter 3	**2 Communications**
	• Trust incident reporting forms described as complex and time-consuming, making reporting difficult. A request was made for the simplified forms. • Concerns reported about the process used for MARS with a request for all applications to be reviewed by the panel for fairness.
Quarter 4	**Nil communications**
Total of 6 communication	
Equipment & Maintenance	
	2 Communications

Quarter 1	• Request for an inpatient area water fountain to work. Concerns about the cost to the Trust using plastic water bottles and its impact on sustainability
Quarter 2	**1 Communication** • Concerns about the responsiveness of the maintenance and support in place with reports of unacceptable delays in resolving the lack of television access on a ward
Quarter 3	**Nil Communications**
Quarter 4	**Nil Communications**
Total of 3 Communication	

Figure 2. below, presents the annual Dear Buki activity themed information above, for 2025/26 presented collectively for ease of viewing.

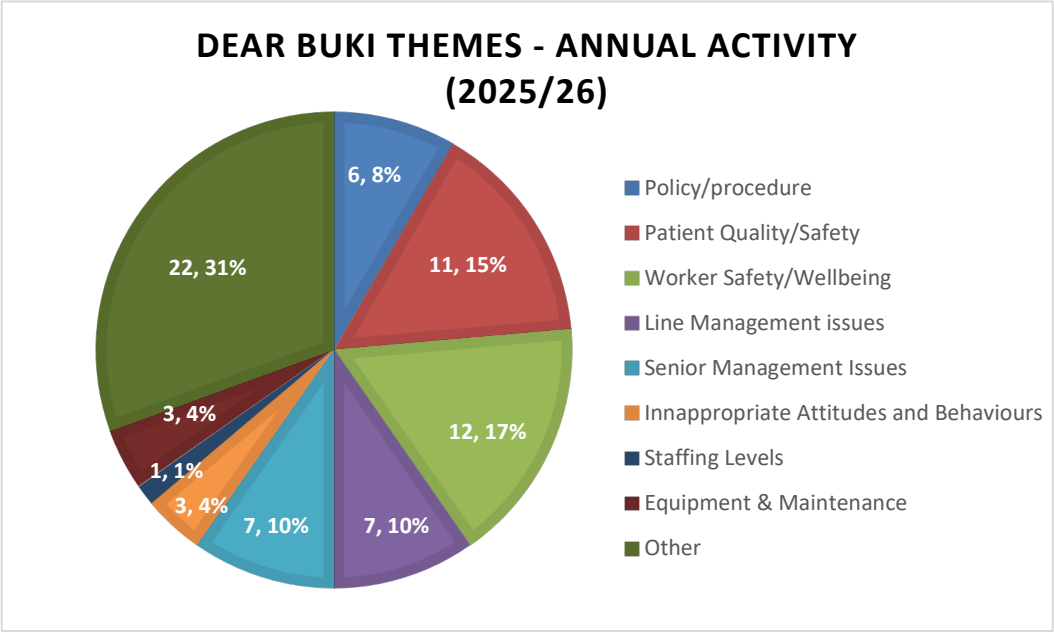


Figure 2. Dear Buki Themes – Annual Activity 2025/26

To ensure the Trust continues to support its open culture, annual Dear Buki activity can be accessed through the Trust intranet for all non-identifiable communications. Any person identifiable Dear Buki communications are responded to direct to the originator. Links to the information are provided below:

Dear Buki – January–June 2025 - CAT
Dear Buki – July–December 2025 - CAT
Dear Buki – January - June 2026 - CAT

5.0 Freedom to Speak Up Background

Following The publication of the Francis Report in 2016, all NHS organisations were required to recruit a Freedom to Speak Up Guardian (FTSU) by 1st October 2016. This remains a mandated post for all NHS organisations.

The purpose of FTSU is to work alongside senior leaders and local leadership teams, to support a more open and transparent place of work and approach with communication and behaviours, where colleagues are actively encouraged, enabled and supported to speak up freely and safely whilst feeling heard and supported.

Freedom To Speak Up concerns remain confidential between the individual raising the concern and the FTSU Guardian, except for FTSU champions, should an individual choose to reach out to a champion for initial engagement to discuss their concern.

Through feedback, staff engagement sessions; and taking the Trusts National Staff Survey scores for raising concerns into consideration, our Trusts FTSU process widened its approach, with the aim of further supporting people to feel safe in raising concerns and supporting the Trusts inclusion and belonging agenda. This is a bespoke localised approach compared to practices of FTSU Guardian within the Midlands regional network group. Our approach extends an offer for FTSU Champions to hear concerns, should anyone feel more comfortable with their concern initially being supported by a champion. The champion may also be invited to the meeting with the FTSU Guardian, by request, offering individuals further wellbeing support.

All concerns raised through FTSU are assessed and escalated to an appropriate senior level, where requested. Exceptions to this will be for safeguarding concerns or patient or staff safety issues, which will automatically be escalated, with this communicated to the individual of concern. To ensure our people feel empowered and own their concern, the FTSU Guardian discusses the escalation options available and agrees, together with the person raising the concern, what actions of support will be taken. Feedback to the individual is shared with progress and updates as their concern is explored for resolution.

FTSU also introduced another approach for our people to raise concerns completely anonymously. This has been in place as an alternative option, for the last 2 years and although throughout 2025/26 this approach use has been minimal, it remains as an increased option of safety. Using this route, however, does come with advice and a caveat. The anonymous process does share with our people, that if they choose to use this approach, the concern will still be taken seriously and escalated, but no progress or outcome can be shared with the individual raising the concern, due to the choice of anonymity. All FTSU approaches continue to be promoted regularly through induction sessions and through any promotional opportunities undertaken by the FTSU Guardian or the champions at local level.

FTSU contracting forms part of the initial concern meetings, to ensure an individual is clear on what information is logged and how information is shared. The FTSU process is also discussed to support individuals' clarity on expectations.

5.1 FTSU Signposting

With all concerns raised, whether a concern is closed or still in progress, the FTSU Guardian will signpost our people to wellbeing services and/or the staff counselling support service, where this is felt to be appropriate.

The Trusts additional diversity and inclusion library of resources which was built through consultation with the Inclusion council group, providing additional learning and awareness for our people, beyond learning at mandatory level, is also discussed where needed and subject dependant, with a link forwarded to those who share any inclusion or belonging concerns. Additional, learning is encouraged as part of their personal development around inclusion.

5.2 Staff Survey Results – Having a Voice that Counts

National Staff Survey results provide FTSU, other raising concern platforms and leaders, with data about how safe our people feel to share their voice either at either local level, through staff network groups, staff wellbeing groups or through the Trust raising concern routes.

Our results show an overall improvement in score of 0.7% for the People Promise '*We each have a voice that counts',* when compared to the scores from 2024. More granular data however, identifies a need for further improvement.

Figure 3 below presents our National Staff Survey results for 2025, compared to the last 4 years of data around our people feeling safe to speak up.

Picker

North Staffordshire Combined Healthcare NHS Trust
NSS25 RAG report - RAG Table Report
Breakdown: Picker Average & Historic Comp
Suppression Threshold: 10

Set RAG % point difference: 3

Key:
100.0%
>3 ppt above
<3 ppt below
In between

Comparator Information			Picker Average 2025	Organisation 2025	Organisation 2024	Organisation 2023	Organisation 2022	Organisation 2021
Section	Q	Description	n = 57783	n = 1297	n = 1223	n = 1225	n = 1227	n = 1055
YOUR ORGANISATION	q25e	Feel safe to speak up about anything that concerns me in this organisation	63.9%	69.0%	68.3%	71.8%	71.1%	71.2%
	q25f	Feel organisation would address any concerns I raised	51.6%	59.9%	60.0%	61.7%	60.5%	63.7%

Figure 3 – Staff Survey Results 2021 - 2025 – Raising Concerns

Results remain relatively stable over the last 4 years with an overall 2.2% difference in sore over this time period. There has however been a slight improvement of 0.7% with our people feeling safe to raise concern. The data also shows a 3.8% decline since 2021 results, for people feeling confident the organisation would address their concerns. This indicates a need for leaders to be demonstrating more compassionate listening with their teams and providing regular spaces for staff to engage visibly with their leadership team, to build relationships and raise any concerns directly if felt appropriate, with leaders feeding back and providing resolution in a timely manner.

Trust results for our people feeling safe to raise concerns around unsafe clinical practices has also declined by 7% since 2021, as shown in Figure 4 below. There is a further decline in

score of 5.2% when compared to scores in 2021, for our people feeling confident that the organisation would address any concerns they raise around unsafe clinical practices.

Picker

North Staffordshire Combined Healthcare NHS Trust
NSS25 RAG report - RAG Table Report
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In between

Comparator Information			Picker Average 2025	Organisation 2025	Organisation 2024	Organisation 2023	Organisation 2022	Organisation 2021
Section	Q	Description	n = 57783	n = 1297	n = 1223	n = 1225	n = 1227	n = 1055
	q20a	Would feel secure raising concerns about unsafe clinical practice	74.2%	77.0%	78.5%	79.4%	80.3%	84.0%
	q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	58.8%	64.6%	66.1%	67.1%	67.3%	69.8%

Figure 4 – Staff Survey Results 2021 - 2025 – Unsafe Clinical Practice Concerns

Further exploration will be needed to determine any additional Trust Wide actions that may support our people to raise concerns and feel confident their concerns will be addressed by the organisation for both clinical and non-clinical issues.

All the Trust raising concerns staff survey scores do, however, remain higher than the comparator group scores for the mental health and learning disability group.

There are also additional Trust Staff Survey scores in other areas, which align to the annual activity concerns raised in this paper. These themes are around culture, behaviour and leadership, with all areas showing a need for improvement. These areas also show a decline in score and further support a need for wellbeing and psychologically safety for our people to be able to speak up, share their voice safely; and feel heard.

Figure 5 below identifies some of the additional key areas which contribute towards workforce wellbeing and safety to speak up.

Picker

North Staffordshire Combined Healthcare NHS Trust
NSS25 RAG report - RAG Table Report
Breakdown: Picker Average & Historic Comp
Suppression Threshold: 10

Set RAG % point difference: 3

100.0%
>3 ppt above
<3 ppt below
In between

Comparator Information			Picker Average 2025	Organisation 2025	Organisation 2024	Organisation 2023	Organisation 2022	Organisation 2021
Section	Q	Description	n = 57783	n = 1297	n = 1223	n = 1225	n = 1227	n = 1055
	q18	Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	72.3%	75.6%	75.6%	76.0%	76.3%	*
	q19a	Staff involved in an error/near miss/incident treated fairly	59.3%	67.1%	67.8%	66.1%	65.8%	*
	q19b	Encouraged to report errors/near misses/incidents	88.5%	89.6%	90.1%	89.6%	88.9%	*
	q19c	Organisation ensure errors/near misses/incidents do not repeat	68.9%	73.3%	77.2%	76.2%	74.9%	*
	q19d	Feedback given on changes made following errors/near misses/incidents	63.0%	65.3%	66.8%	68.0%	68.7%	*
YOUR PERSONAL DEVELOPMENT	q24f	Able to access clinical supervision opportunities	76.5%	79.4%	82.9%	*	*	*

Picker

North Staffordshire Combined Healthcare NHS Trust
NSS25 RAG report - RAG Table Report
Breakdown: Picker Average & Historic Comp
Suppression Threshold: 10

Set RAG % point difference: 3

Key:
100.0%
>3 ppt above
<3 ppt below
In between

			Comparator Information	Picker Average 2025	Organisation 2025	Organisation 2024	Organisation 2023	Organisation 2022	Organisation 2021
Section	Q	Description		n = 57783	n = 1297	n = 1223	n = 1225	n = 1227	n = 1055
YOUR TEAM	q7a	Team members have a set of shared objectives		76.4%	79.8%	80.2%	79.2%	81.3%	80.8%
	q7d	Team members understand each other's roles		70.3%	70.2%	70.0%	74.3%	73.4%	75.6%
	q7e	Enjoy working with colleagues in team		83.2%	83.7%	85.5%	86.1%	86.1%	88.1%
	q7f	Team has enough freedom in how to do its work		60.4%	67.9%	68.2%	70.5%	67.9%	70.7%
	q7g	Team deals with disagreements constructively		60.2%	61.6%	62.0%	65.8%	64.3%	67.1%
YOUR MANAGERS	q9g	Immediate manager listens to challenges I face		79.3%	79.7%	79.0%	79.5%	78.0%	79.5%
	q9h	Immediate manager cares about my concerns		77.9%	79.6%	78.4%	79.3%	77.0%	79.4%
	q9i	Immediate manager helps me with problems I face		74.4%	76.6%	76.0%	76.7%	74.9%	77.4%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public		84.9%	79.9%	81.0%	78.8%	78.0%	79.1%
	q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public		75.5%	74.6%	76.7%	74.8%	73.2%	70.9%
	q14c	Not experienced harassment, bullying or abuse from other colleagues		85.5%	86.4%	86.7%	86.8%	87.0%	89.1%
	q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public		90.0%	91.2%	91.8%	93.6%	93.7%	94.2%

Figure 5 – Staff Survey Results 2025 – Culture, Behaviour and Leadership

Our Staff Survey results indicate a need for all the above areas to be further explored at Trust wide level, to discuss any additional actions of support that can be implemented to support improvement. The above data has been shared with the subject leads by the Trusts Engagement Lead, with a request to review the data and discuss future actions for further development.

5.3 FTSU Summary of Annual Activity

Freedom To Speak Up uses headline themes as recommended by the National Guardians Office as detailed below:

- Policy & procedure
- Worker Safety/wellbeing
- Line Manager issues
- Bullying & Harassment
- Professional Development
- Equipment & Maintenance
- Patient Quality & Safety
- Senior Management Issues
- Work Demands
- Inappropriate Attitude & Behaviours
- Staffing Levels
- Other

FTSU received a total of **93 concerns during 2025/26**. This platform continues to show an increase in use year-on-year as shown in Figure 6 below.

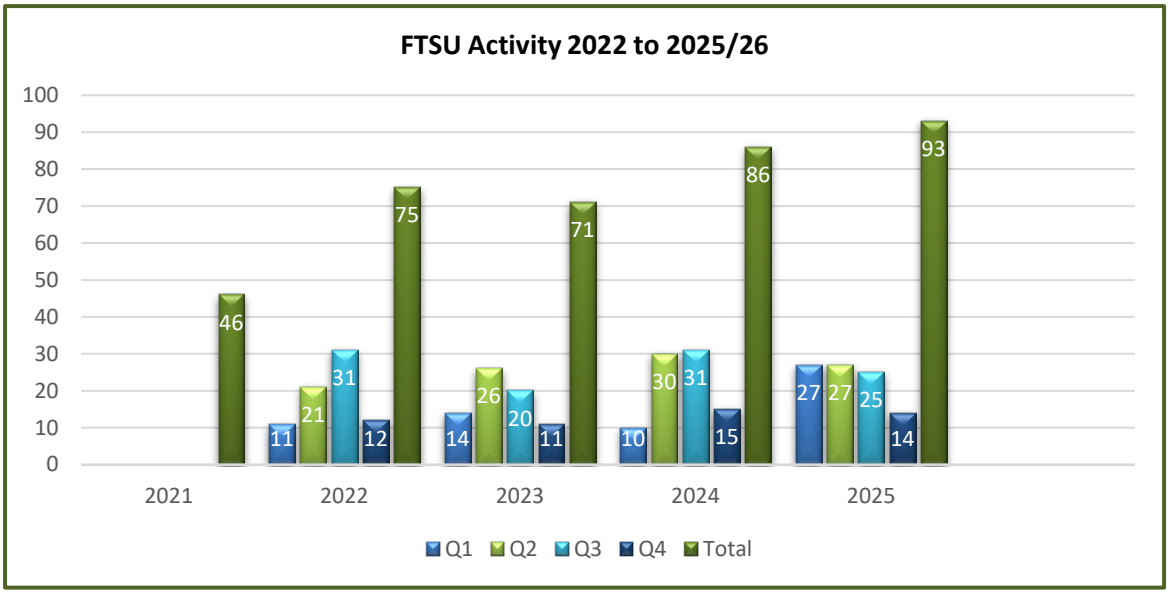


Figure 6. Annual Freedom To Speak Up Activity 2021 - 2025/26

Freedom To Speak Up (FTSU) offers our people a choice in how they raise a concern, using 3 different ways.

Openly Staff consent to their identity being shared with the FTSU Guardian, any leader/s through escalation and team members for their concern to be discussed and supported.

Confidentially Staff consent to their identity being shared with the FTSU Guardian only and the senior leader/s the concern is escalated to, for support.

Anonymously Staff share their identity with the FTSU Guardian only and their concern is escalated to senior leader level, with their identity protected

or

Staff choose to remain completely anonymous even to the FTSU Guardian and concerns are raised generically to senior level, but no outcome can be provided to those using this approach.

Table 2 below shares how each of the 93 FTSU concerns were raised during 2025/26

Table 2 – FTSU Concern Types 2025/26

Type of Concern Raised 2025/26	No.
Concerns received confidentially but requested to be anonymous through escalation	23
Concerns received confidentially and escalated confidentially	49
Concerns received openly and escalated openly	10
Concerns received anonymously with no identification to the Gurdian	5
Concerns received confidentially with no escalation	6
Total Number Concerns	**93**

A breakdown of location for each of the 93 FTSU concerns raised during 2025/26 is presented in Table 3 below.

Table 3 – FTSU Locations

FTSU Location of Concerns Raised 2025/26	
Directorate	**Number of Concerns Raised**
Community Directorate	18 concerns
Acute & Urgent Care Directorate	31 concerns
Specialist	14 concerns
Corporate and Estates	18 concerns
Primary Care	12 concerns
TOTAL	**93 concerns**

Figure 7 below identifies the high-level themes and sub themes for each of the concerns raised during 2025/26.

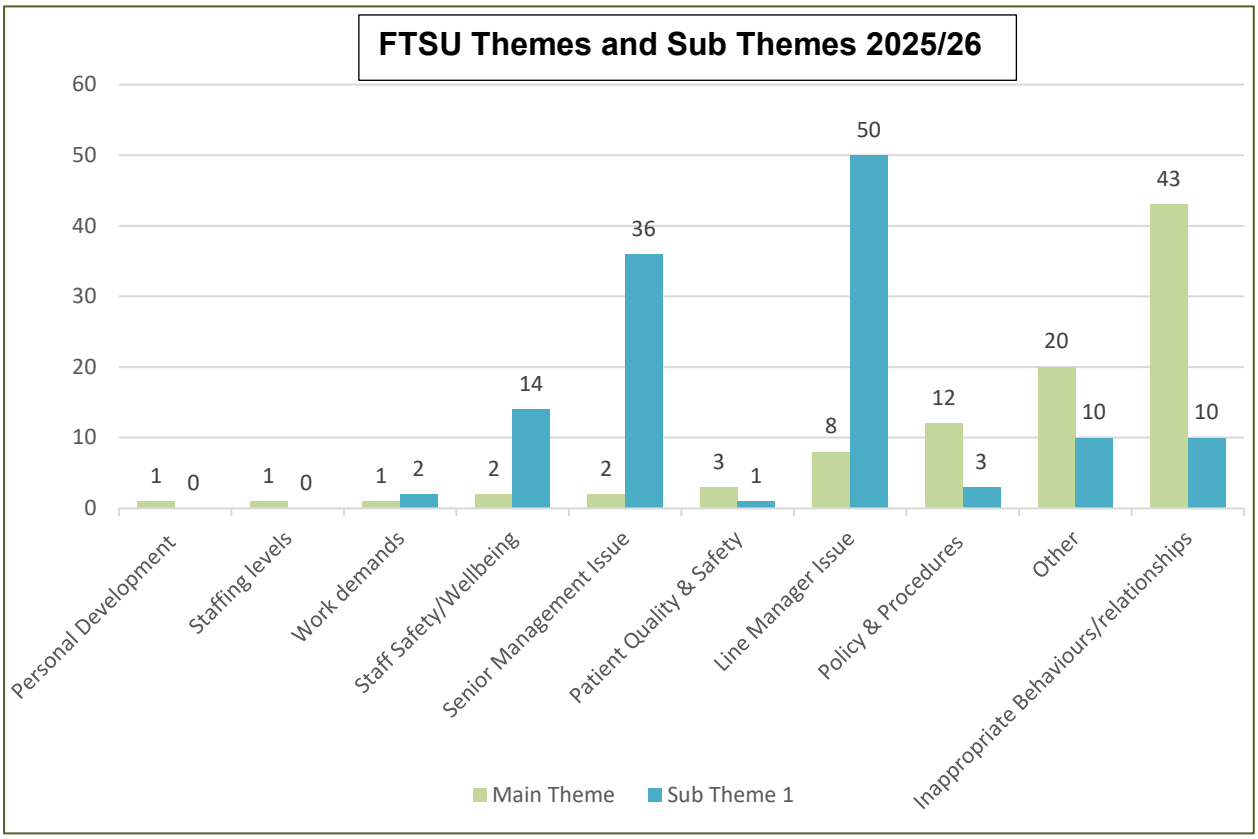


Figure 7. Freedom To Speak Up Annual Themes 2025/26

5.4 Staffing Groups Raising Concerns

All staffing groups are aligned to the NGO recommendations and are shown in figure 8 below.

Concerns during 2025 were mainly raised from the additional clinical services staffing group as indicated below.

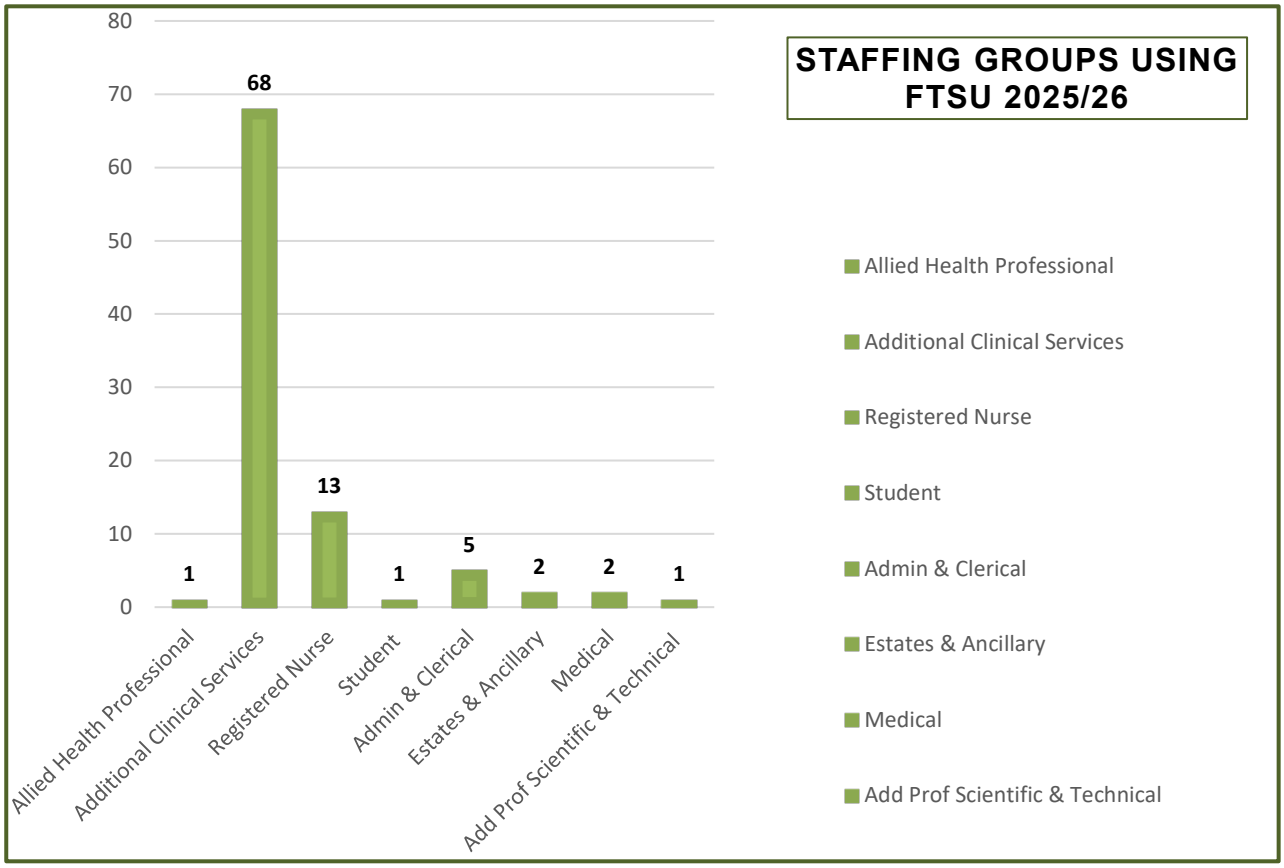


Figure 8. Staffing Groups Using FTSU 2025/26

5.5 Ethnicity of Staffing Groups Raising Concerns

FTSU was predominantly used by the British white staffing group (73%) which represents the largest demographic of the Trusts workforce, with 21% of concerns raised from the Black African staffing group and 4% from the Asian staffing group. Some ethnicities (2%) are unknown due to the concerns being raised completely anonymously and our people reporting they would prefer not to share their ethnicity.

Figure 9 below illustrates the breakdown of staffing demographics who used the FTSU platform during 2025/26.

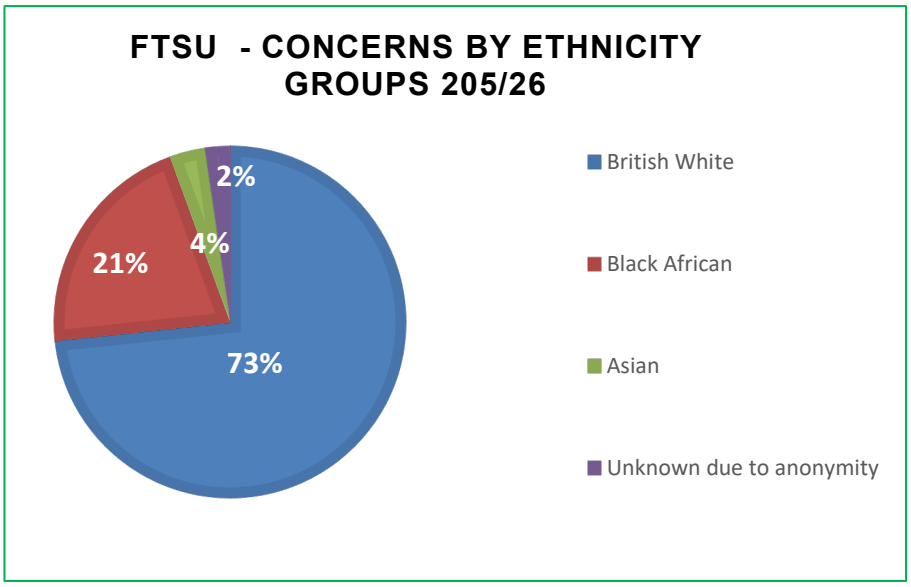


Figure 9. FTSU Concerns by Ethnicity 2025/6

5.6 FTSU Outcomes

Concerns raised through FTSU are escalated and supported using different approaches, subject dependant. The table below shares the position to date or the outcome for each concern raised during 2025/26:

Concern Position / Outcomes	Number
Number of concerns closed and supported at local senior management level	79 concerns
Number of concerns open and being supported	14 concerns

6.0 FTSU Champions

The Trust presently has 34 champions who work across all Directorates of the Trust, with an additional staff member who has expressed interest, who is due to be trained in April 2026. Numbers of champions will always fluctuate in the Trust pending a variety of reasons, including capacity. Champions, wherever possible, have been conscientiously recruited to ensure the Trust provides diversity, recruiting people who deliver services from a broad range of roles and levels of seniority in different directorates. The aim of this is to ensure we provide our people with choice of who they would like to share their concern with.

During Q3 FTSU mapped out the position of champions per directorate, reviewing against any identified protected characteristic. The purpose of this was to create further engagement with the staff network groups and directorate senior leaders, with the potential of recruiting additional champions in targeted areas during 2026 where needed, to provide more balance.

Table 4 below provides a breakdown of the Trusts FTSU champions per directorate, identifying champions who have an identified protected characteristic. Champions do however, in most cases support our workforce beyond their own immediate directorate.

Table 4 – FTSU Champion Numbers & Protected Characteristics

Quarter 3 Freedom To Speak Up Champions					
Directorate	**Total No. Champions**	**Neuro Diverse**	**Global Majority Heritage**	**LGBT+**	**Disability**
Acute and Urgent Care	12	1	4	1	Nil
Specialist	5	Nil	Nil	Nil	Nil
Community	4	Nil	Nil	1	2
Primary Care	5	Nil	1	Nil	Nil
Corporate Directorate	8		3	Nil	2
Total No. Champions with known, identified protected characteristics	**34**	**1**	**8**	**2**	**4**

The role of the FTSU champions was further supported this year through:

- Delivery of a champion development session during quarter 3. This offered champions time to reflect, collaboratively work with the Gurdian and each other through case scenarios, gain understanding of the importance of contracting and refresh on the FTSU process.
- Champions were encouraged to attend the Anti-Racist toolkit lunch and learn sessions for further development.
- Provision of a champion training session for newly recruited champions.

7.0 Proactive Engagement

During 2025/26 several proactive engagement sessions and actions were implemented, to continue to raise the profile of FTSU:

- Promotion and engagement at:
- Monthly corporate induction sessions throughout 2025/26.
- All Junior Doctor Induction sessions.
- Student recruitment sessions.
- All new preceptee programmes.
- Directorate and/or local team engagement sessions.
- Attendance and active contribution and actions as part of the Integrated learning review steering group meetings with monthly reporting against progress.
- Development of a new FTSU process (in consultation stage).
- Development of a 2-year best practise Being Open plan – with FTSU exec lead for approval.
- Black History month attendance and delivery.

- Attendance at regional FTSU Guardian network meetings and other communication channels when appropriate.
- FTSU activity quarterly submissions to the NGO.
- FTSU Guardian refresher training successfully completed.
- FTSU Guardian quarterly visual presence in targeted services.
- Intense support with a team including supporting the development of a team action plan and delivery of team engagement sessions (on-going).
- Speak up week promotions during October 2025 with champion support through a range of promotional activities.
- Charing and supporting champions at FTSU champion meetings.
- Recruitment of new FTSU champions and training - now totalling 34 champions.
- Delivery of champion development session.

7.0 FTSU Next Steps

FTSU continues to be an essential and integral platform to support the Trust Being Open culture and supporting our people's voices when they either feel unsafe to raise an issue direct or at local level or they feel unheard.

The next steps for FTSU during 2026 are:

- Primarily continue to support the workforce with feeling heard and escalating concerns to senior levels on their behalf and as agreed, ensuring feedback is provided to staff to close any communication loop with an outcome shared.
- Providing quarterly update submissions to the National Guardians Office on the Trusts FTSU activity or to NHS England once the NGO closes in June 2026.
- Attendance at regional guardian network meetings and other communication channels as appropriate.
- Regular FTSU promotion at all Trust induction sessions.
- Attendance and support at the Trusts Black History month event.
- Finalise the 2-year Being Open Best Practise plan with the FTSU executive lead supporting.
- FTSU executive lead completion of the NGO reflective tool and discuss with senior leaders as appropriate, reviewing any additional actions needed in the above plan.
- Support FTSU exec lead with a Trust Board Being Open session.
- Continued attendance at the Anti-racist lunch and learn sessions.
- Ensure the FTSU process is uploaded to the FTSU Trust intranet page post consultation period completion.
- Continued attendance, actions and reporting as part of the Integrated Learning Review steering group.
- Continue to build working relationships with quarterly visits and visibility to targeted Trust services.
- Review staff survey data and work with the directorates to review any additional speaking up opportunities at local level.
- Continue to work with staff network leads sharing any new updates when needed.

- Meet with staff side to review concerns and triangulate information and support for our people when needed.
- Encourage champions to actively engage with the upcoming Trusts Big Conversations piece, due to be launched at the end of Apri 2026.
- Welcome and promote newly recruited champions through Newsround and creation of a champion podcast working with the communications team.
- Work with FTSU champions to plan speak up week 2026.
- Continue to update the Trust intranet with newly recruited FTSU champion contact details when needed.
- Chair FTSU Champion meetings and provide ongoing supervision to champions as needed.
- Provide Directorates with FTSU newsletters as and when new information comes to fruition.
- Continue to look for opportunities to promote FTSU Trust Wide.

8.0 Resolution of Grievance and Dispute Background

A grievance may arise when a member of staff or group of staff wishes to resolve a complaint about their working arrangements, which may include:

- Duties
- Working Conditions
- Working Practices
- Conditions of Employment
- Working Procedures

It is clearly in the interests of the Trust and its leaders to resolve problems before they develop into major difficulties/disputes. This procedure provides an appropriate mechanism for individual employees or groups of employees to resolve their complaint, which they may have been unable to resolve through informal means.

All grievance matters are handled in accordance with the Trust's procedure and reviewed, investigated and action taken where required. The Trust's People Advisory team continue to support individuals to resolve grievance matters informally wherever possible.

The Resolution of Grievance and Disputes procedure provides clear informal and formal processes through its policy, for Trust colleagues to raise serious concerns regarding their working arrangements. Should any concerns relate to a matter which may not be able to be resolved informally, this formal process remains available.

In quarter 4, the Trust received 5 new grievance cases and carried forward 6 cases from the previous month.

During 2025/26 the Trust received a total of 17 grievance cases with 9 cases carried forward from the previous tax year. This is an increase in the number of cases when compared to 2024 data, where there were 18 grievance cases and 3 cases carried forward from the previous tax year.

Grievance cases were received from the following directorates: -

- Acute & Urgent Care Directorate 9 grievances
- Community Directorate 9 grievances
- Primary Care Directorate 4 grievances
- Specialist Directorate 3 grievances
- Corporate Directorate 1 grievance

Table 5 below provides an overview and the progress to date for each concern raised through the Resolution of Grievance and Dispute process.

Summary of Resolution of Grievance and Dispute Activity and Outcome to Date 2025/26

Grievance Type	Stage of Concern	Outcome
Poor interpersonal relationship	Closed	
Non receipt of pay post-employment	Closed	
Lack of confidential space	Closed	Confirmed not to proceed with grievance
Lack of JD, H&S concerns	Closed	
Manager overstepping in providing additional info in reference	Closed	
Bullying and discrimination - lack of communication, and empathy	Closed	
Various concerns raised	Closed	
Racially motivated actions	Closed	
Various actions	Closed	
Health and reasonable adjustments unsupported	Closed	
Pay - concerned initially placed on wrong pay point	Closed	
Failure to apply just culture principles	Closed	Reopened but now closed
Safety concerns / health and wellbeing	Closed	
Raising via B&H Policy	Closed	
Query reasonable adjustment provision re. hours	Closed	
Behaviour	Closed	
Concerns around issues raised - cultural angle	Closed	
Lack of professional Trust & HCPC standards: Confidentiality & Trust; Respect & Professionalism; Partnership & Team Accountability; Public Trust & Bullying	Closed	
Professional Boundaries/not wanting friendship	Closed	

B&H and with-holding of sick pay following absence	Closed	
Management of sickness	Closed	
Bullying & Harassment - claims re Line Manager	Open	
Bullying & Harassment - claims re Line Manager	Open	
Service Leads conduct in a meeting to address issues raised about staff member	Open	
Banding review issues and management issues	Open	
Banding review issues and management issues	Open	

9.0 Summary and Outcome

The Trust raising concern platforms continue to provide a source of information to support the Trust Board to connect to current frontline issues or concerns from its workforce. The data and activity provide useful insight and opportunity to review and determine any future focused actions to support positive working experiences.

Themes of the concerns arising during 2025/26 have and continue to mainly show subject variance between Dear Buki and FTSU, with staff using the two main platforms differently. Dear Buki was mainly used, for Trust wide queries, suggestions, or requests. FTSU was used for more personal, one-to-one concerns or to share team concerns, with requests for support and escalation from the FTSU Guardian.

There are emerging themes and patterns of concern that have been raised through Dear Buki and FTSU. These relate to cultural and behavioural issues and leadership, which are having a detrimental impact on team psychological safety. This is further supported through the alignment of some of the issues raised through the Trusts Resolution and Grievance Dispute process. The data in this report confirms and supports identification of need for further exploration into these themes specifically.

Subject leads received 2025 staff survey data relating to their subject lead areas, with a request to review and identify any further supportive Trust actions. This is in the process of being determined.

Further support actions are identified as a need around teamwork and supporting appropriate communication. The Trust has supported a further year for the delivery of the Affina team journey piece, meaning a second cohort of teams can be supported through this programme during 2026 to support team effectiveness and communication.

The data also identifies a need for the Trust to deliver and embed specific support around inclusion and belonging, aiming to improve culture, and working experiences for its people.

The Trust continues to progress and deliver on actions through the outcomes and recommendations from the three external pieces of work which were commissioned in 2025, to support the inclusion agenda. A steering group meets quarterly to report on progress against actions.

The Trusts Big Conversation piece, which will be executive led, is due to be launched at the end of Apri 2026, with a series of successions delivered from May onwards. The aim of this is to engage with our people, asking what is needed to improve working experience. This piece may identify some of the specifics needed around some of these issues reported, if staff feel safe enough to raise their concern with this engagement approach.

There is a clear need for the continuation of each of its speaking platforms with year-on-year increased activity through the FTSU platform and an increase in the number of Grievance cases this year.

These options offer our people a safe space to choose informal or formal processes to be heard, for issues to be reviewed and explored and for people to feel supported with appropriate outcomes from sharing their voice.

10.0 Recommendations

The Trust's Committees are asked to receive this report for assurance and to support the ongoing work to support our being open culture with civility and compassion at its forefront.

Marie Barley
Freedom To Speak Up Guardian and Being Open Lead

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 8

Board to Team (B2T) Programme – Quarterly Report (Q2 2026/27)

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

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 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	SLT
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:	• For assurance to the Board

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 2, a total of 12 Board to Team visits were completed, representing a slight increase compared with Quarter 1, during which 9 visits were undertaken. Although there has been a slight improvement in the number of Board to Team visits completed, overall activity remains lower than anticipated due to the ongoing impact of Executive Team absence and annual leave during the summer holiday period, both of which have affected programme coordination and scheduling. Despite these challenges, the Board to Team visit programme has continued to make progress, demonstrating a sustained commitment to staff engagement, visibility and maintaining meaningful connections between Board members and teams across the Trust.

Visit Activity.

Overview

Measure	Q2 Position
Total visits completed	12
Face-to-face visits	9
Virtual visits (Microsoft Teams)	3
Clinical team visits	8
Corporate team visits	4

Of the twenty visits completed:

- **75% (9)** were undertaken face-to-face.
- **25% (3)** were conducted virtually using Microsoft Teams.
- **67% (8)** involved clinical services.
- **33% (4)** 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.

Oversight and monitoring of the B2T action log is via the Trust's monthly Performance meeting.

Clinical and Associate Directors monitor delivery against actions via the Performance Meeting and within their own Directorate meetings.

Chief Officers are responsible for the oversight and delivery of corporate actions within their portfolio.

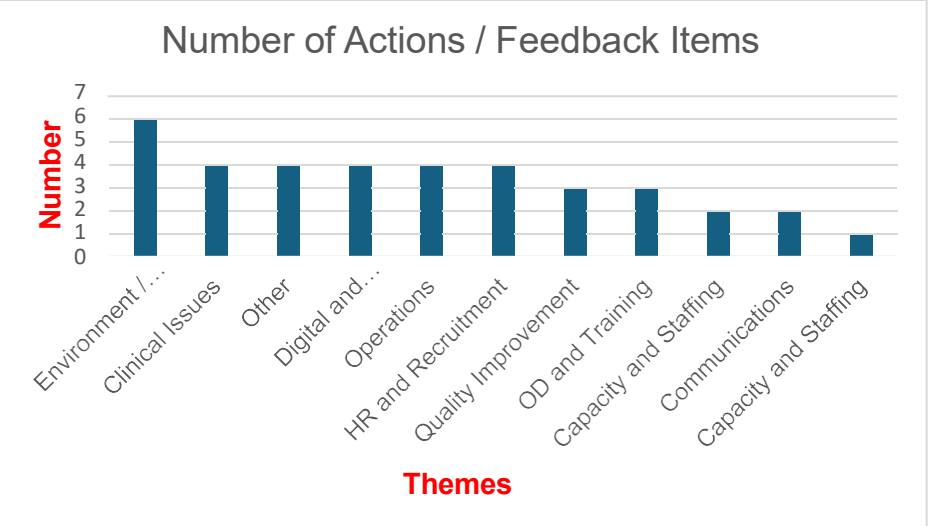
Q2 2026/27 Actions.

12 visits generated **37 actions** in total, The majority of actions remain on track for delivery, two actions from Q2 have already been completed and 5 are under review as they are either longer-term pieces of work or can be completed in month. Continued focus is required to address any actions from Q1 to bring them to satisfactory resolution.

Themes Identified.

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

Theme	Number of Actions / Feedback Items
Environment / Estates	6
Clinical Issues	4
Other	4
Digital and Equipment	4
Operations	4
HR and Recruitment	4
Quality Improvement	3
OD and Training	3
Capacity and Staffing	2
Communications	2
Capacity and Staffing	1



Thematic Analysis.

Environment and Estates

Environment and Estates was the most frequently identified theme, accounting for 6 actions and feedback items. Feedback primarily related to the physical environment, facilities, and estate-related matters affecting both staff and service users. Issues raised included improvements to patient facilities, environmental maintenance, and the suitability of accommodation to support safe and effective service delivery.

Clinical Issues

Clinical issues accounted for 4 actions and feedback items. Feedback focused on patient safety, care pathways and operational processes. Key themes included safe patient handovers by gatekeepers, clarifying the role of the Home Treatment Early Facilitated Discharge Team, improving Ward 2 key management arrangements, and seeking clarity on proposals to support high-risk patients who are not currently engaged with services.

Other

A total of 4 actions and feedback items fell within the Other category. These covered a range of topics that did not sit within the established thematic areas but nonetheless provided valuable insight into service delivery and staff experience. Key topics included promoting awareness of ECT and reducing stigma; updates on the beeper system to support lone working and high-risk visits; strengthening care coordination arrangements for high-risk SMI patients; reviewing Primary Care Services governance to identify opportunities for centralisation; and increasing support from subject matter experts to enhance content development and workforce planning

Digital and Equipment

Digital and Equipment also generated 4 actions and feedback items. Teams identified opportunities to improve access to technology, enhance digital

solutions, and maximise the use of available systems and equipment to support more efficient ways of working, including the use of Copilot.

Operations and Service Changes
Operational matters accounted for 4 actions and feedback items. Feedback focused on service processes, operational effectiveness, and opportunities to improve the coordination and delivery of services across teams.

HR and Recruitment
A further 4 actions and feedback items related to HR and recruitment. Discussions highlighted workforce challenges and opportunities to strengthen workforce sustainability, including sickness management, appraisals, training and development, and support available to ward managers.

Quality Improvement
Quality Improvement generated 3 actions and feedback items. These focused on developing and promoting Quality Improvement initiatives, sharing good practice, and supporting organisational learning and continuous service improvement.

OD and Training
There were 3 actions and feedback items relating to Organisational Development and Training. Feedback identified opportunities to support staff development, enhance learning opportunities and strengthen awareness of available training resources.

Capacity and Staffing
Capacity and Staffing accounted for 2 actions and feedback items. Discussions focused on workforce resilience, staffing levels, retention, and the provision of appropriate resources to support frontline services and improve patient experience.

Communications
Communications generated 2 actions and feedback items. Feedback highlighted opportunities to strengthen communication and information sharing processes, including communication relating to ward relocations and organisational changes.

Capacity and Staffing
Feedback highlighted workforce capacity and service provision challenges. A key action identified was to review the psychology provision for Ward 2 to ensure parity with other wards and confirm that the service is meeting the needs of patients effectively.

Risks and Challenges.

The principal challenge during Q2 was reduced programme capacity arising from:

- Absence within the Executive Team.
- Annual leave during the summer holiday period.

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 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.

During Quarter 2, the Board to Team programme continued to provide valuable opportunities for engagement between Board members and teams across the Trust. A total of 12 visits were completed, generating 37 actions and a wide range of feedback aimed at improving services, staff experience, and organisational learning. Despite the ongoing challenges visit activity increased compared with Quarter 1, demonstrating continued progress in programme delivery.

Priority areas for Quarter 3 will be:

- Increasing visit activity and maintaining planned programme levels.
- Monitoring delivery of the 35 open actions from Quarter 1 and Quarter 2.
- Continuing to identify, share and act upon learning themes emerging from visits.
- Maintaining alignment with the Board to Team principles of listening, learning, engagement and continuous improvement.

Overall position: The programme remains effective in generating organisational insight, strengthening engagement between the Board and

	frontline teams, and identifying opportunities for continuous improvement across the Trust.

VERSION CONTROL:

Version	Report to	Date Reported
V1	SLT	27th October 2026
V2	Board	12th November 2026

SOP / Guidance Number:		Title: STANDARD OPERATING PROCEDURE (SOP) - Board to Team (B2T) Visits	
Effective Date: **Review Date:**	**July 2024** **July 2029**	**Revision Date:**	**July 2026**
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.

START

END

01 Programme

Design the visit programme

02 Confirm

(team, Chief Officer and NED availability; agree date, format and stakeholder communication)

03 Prepare

Templates, documents, staff brief

04 Visit

Board to Team engagement

05 Act

Log, allocate, deliver actions

06 Report

Performance, quarterly SLT, annually to Board

Loop back: reporting informs the future visit programme

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.

01 **ADMIN:** Develop visit programme

02 **ADMIN:** Contact team to confirm availability and operational constraints

03 **ADMIN:** Agree visit format (in-person / virtual)

04 **ADMIN + BOARD:** Schedule visit date

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.

05 **ADMIN:**
Issue feedback template & documentation

06 **TEAM:**
Brief staff and prepare for visit

07 **BOARD + TEAM:**
Conduct Board to Team Visit

08 **BOARD (CHIEF OFFICER):**
Complete feedback report (within 7 days)

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.

09 **ADMIN:** Receive report

10 **ADMIN:** Log actions and distribute report

11 **GOVERNANCE:** Allocate actions to owners

12 **ACTION OWNERS:** Deliver actions and provide 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.

PHASE 4

Monitor progress and report learning back

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

13 **GOVERNANCE:** Monitor progress

14 **GOVERNANCE:** Review at Performance Meeting

15 **GOVERNANCE:** Produce quarterly SLT report

16 **GOVERNANCE:** Produce annual thematic report

17 **LOOP BACK:** Use themes to inform the future visit programme

Quarterly SLT report

Regular visibility of progress, risks, and action status.

Annual thematic report

Aggregated learning that shapes the next programme cycle.

Learning loop: monitor → review → report → refine future visits

Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 9

IMPROVING QUALITY AND PERFORMANCE REPORT (IQPR) M06 2026/27

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

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

Aligned to Board Assurance Framework Risk:	Quality - If the Trust's capacity, productivity and pathways do not keep pace with increasing and changing demand for mental health services, we may be unable to consistently meet the needs of our population.
7 Levels of Assurance:	Level 6 - Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Approval / Review:	Execs
Strategic Priorities:	Access - We will ensure that everybody who needs our services will be able to choose the way, the time, and the place in which they access
Key Enablers:	Quality - We will provide the highest quality, safe and effective services
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper supports wider EDI impacts in a positive matter.
ICS Alignment / Implications:	The IQPR Board report is provided to the ICB as part of our contractual reporting requirements in 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 is one special cause variation (orange variation flag) – signifying concern. 1. Sickness Absence There are five 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. Staff Turnover 5. Statutory and Mandatory Training **Performance Highlights – M06** • **Referral to assessment within 4 weeks** is **95.9%** in M06 compared to 97.5% in M05. • **Referral to treatment (RTT) within 18 weeks** is **96.3%** in M06 compared to 97.4% in M05. • **CAMHS referral to assessment within 4 weeks** compliance remains at **96.4%.** • The **Mental Health Liaison Service has achieved** all three of the required 95% standards. • **Early Intervention in Psychosis (EIP)** 2-week wait has achieved **100%** compliance for the second consecutive month. • **Follow up after discharge within 48 hours and 7 days** achieved **100%** performance. • **Talking therapies for anxiety and depression reliable recovery,** achieved **53.4%** in M06 compared to 54.6% in M05, and **76% for Reliable Improvement** in M06 compared to 71.1% in M05. • **Length of stay** measures for adult and older adults remained well within national benchmark ranges. • **Emergency Readmissions** within 30 days were **2.6%** in M06. • **Care plan compliance** improved to **97%** in M06 from 96.4% in M05**.** • **Risk assessment compliance** improved slightly to **96.2%** in M06 from 96.1% M05. • There were **no reported breaches** to the **40-day complaints response time** during the reporting period.

- **Friends and family test** recommended rate dipped to **80%** in M06.
- The **vacancy rate** reduced to **6.3%** in M06 compared to 6.6% in M05.
- **Staff turnover** reduced to **8.3%** in M06 compared to 8.5% in M05.
- **Statutory and mandatory training** is **92%** in M06 compared to 93% in M05.
- **Data Quality Maturity Index (DQMI)** performance has improved further to **99.2%** in the latest nationally published data.

Performance Exceptions – M06

- **CAMHS referral to treatment within 18 weeks** has dipped to **91.3%** in M06 from 93.4% in M05.
- **Clinical Supervision** reduced to **84%** in M06 from 85% in M05, below the 85% standard.
- **Appraisal compliance** has dipped to **82%** in M06 from 86% in M05, below the 85% standard.
- **Sickness absence** increased further to **6.64%** in M06 from 6.50% in M05, exceeding the organisational threshold of **<5.40%.** PIPs remain in place within both Acute & Urgent Care and Specialist Services directorates.

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

M06 performance against the forecasts submitted to the ICB and NHSE for 2026/27. To note:

- **Out of Area Placements (OAP)** – There were **13 reportable inappropriate OAPs at month end** an increase from 12 in the previous month.
- **Length of Stay** remained better than plan for both Adult Acute **(32.9 days** versus **45.1 days)** and Older Adult services **(51.5 days** versus **58.6 days).**
- **Perinatal Access –** significantly exceeded plan, achieving **893** against a **target of 640.**
- **Children and Young People (CYP) Access** – Performance exceeded plan, with **9,238** accessing services against a **plan of 7,815.**
- **Individual Placement Support (IPS) Access** achieved **1,027** against a **plan of 870**.
- **Mental Health Support Team (MHST) Access** exceeded plan, achieving **917** against a **target of 728**.
- **CYP Waits Over 104 Weeks** remained above target, with **883** waits, compared with a planned level of **446.** New reporting

	arrangements have been implemented to support targeted management of 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	21.10.26
1.0	Public Trust Board	06.11.26

NHS
North Staffordshire
Combined Healthcare
NHS Trust

Improving Quality and Performance Report (IQPR)

Trust Report

Reporting Period: M06 (September 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

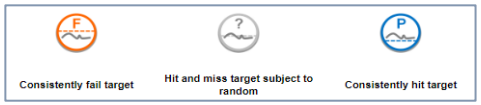
Using Statistical Process Control (SPC)

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

1. Sickness Absence

There are five 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. Staff Turnover
5. Statutory and Mandatory Training

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

1. Referral to Assessment within 4 weeks – Community and Specialist Services directorates
2. Referral to Treatment within 18 weeks – Specialist Services directorate
3. Sickness Absence – Acute and Urgent Care and Specialist Services directorates
4. Care Plan Compliance – Specialist Services directorate
5. Risk Assessment - Specialist Services directorate
6. Out of Area Placements – Acute and Urgent Care and Community directorates
7. Talking Therapies for Anxiety and Depression (90 days wait in treatment) – Primary Care directorate
8. MH Liaison 1-hour response (Emergency) – Acute and Urgent Care

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	13 met, 1 unmet		
Highlights	Referral to Assessment within 4 weeks	95.0%	95.9%
	Referral to Treatment within 18 weeks	92.0%	96.3%
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	96.4%
	MH Liaison 1 Hour Response (Emergency)	95.0%	95.9%
	MH Liaison 4 Hour Response (Urgent)	95.0%	98.1%
	MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	96.6%
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	100.0%
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	100.0%
	Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	100.0%
	48 Hour Follow Up	95.0%	100.0%
	7 Day Follow Up (All Patients)	95.0%	100.0%
	Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	53.4%
	Talking Therapies for Anxiety and Depression: Reliable Improvement	69.0%	76.0%
Exceptions	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	91.3%

Community & Quality			
	Metric	**Standard**	**Performance**
RAG Rated Standards	2 met, 0 unmet		
Highlights	Care Plan Compliance	95.0%	97.0%
	Risk Assessment Compliance	95.0%	96.2%

Performance Improvement Plans (PIPs)			
Directorate	**Metric**	**Standard**	**Performance**
Specialist Services	Referral to Assessment within 4 weeks	95.0%	81.8%
	Referral to Treatment within 18 weeks	92.0%	94.3%
	Sickness Absence (in-month)	<6.30%	7.93%
	Care Plan Compliance	95.0%	95.6%
	Risk Assessment Compliance	95.0%	94.8%

Inpatient & Quality			
	Metric	**Standard**	**Performance**
RAG Rated Standards	5 met, 0 unmet		
Highlights	Average Length of Stay - Adult	40	38.3
	Median Length of Stay - Adult	42.4	22.4
	Average Length of Stay - Older Adult	90	59.9
	Median Length of Stay - Older Adult	83.8	40.1
	Emergency Readmissions rate (30 days)	<7.5%	2.6%

Organisational Health & Workforce			
	Metric	**Standard**	**Performance**
SPC Variations signifying concern	Sickness Absence	<5.40%	6.64%
RAG Rated Standards	5 met, 3 unmet		
Highlights	Complaints Open Beyond Agreed Timescale	0	0
	Friends and Family Test - Recommended	80.0%	80.0%
	Vacancy Rate	<10.0%	6.3%
	Staff Turnover	<10.0%	8.3%
	Statutory & Mandatory Training	85.0%	92.0%
Exceptions	Sickness Absence	<5.40%	6.64%
	Clinical Supervision	85.0%	84.0%
	Appraisal	85.0%	82.0%

Performance Improvement Plans (PIPs)			
Directorate	**Metric**	**Standard**	**Performance**
AUCD	Sickness Absence (in-month)	<6.60%	9.95%
	MH Liaison 1 Hour Response (Emergency)	95.0%	95.9%
Primary Care	Talking Therapies for Anxiety and Depression (90 days wait in treatment)	10.0%	17.0%
Community	Referral to Assessment within 4 weeks-Adult	95.0%	92.9%
AUCD and Community	Number of inappropriate OAPs during month	2	14
	Number of inappropriate OAPs at EOM (national measure)	2	13

Core Indicators – Monthly

	Indicator	Target	Jul-26	Aug-26	Sep-26	Assurance	Variation
Access & Wait Times	Referral to Assessment within 4 weeks	95.0%	96.9%	97.5%	95.9%		
	Referral to Treatment within 18 weeks	92.0%	96.3%	97.4%	96.3%		
	CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	94.6%	96.4%	96.4%		
	CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	93.4%	98.3%	91.3%		
	MH Liaison 1 Hour Response (Emergency)	95.0%	92.3%	91.0%	95.9%		
	MH Liaison 4 Hour Response (Urgent)	95.0%	96.9%	93.1%	98.1%		
	MH Liaison 24 Hour Response (Urgent from General Hospital	95.0%	96.7%	96.7%	96.6%		
	CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	N/A	N/A	100.0%		
	CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	N/A	N/A	100.0%		
	Early Intervention - A Maximum of 2 Week Waits for Referral to	60.0%	85.7%	100.0%	100.0%		
	48 Hour Follow Up	95.0%	95.6%	94.6%	100.0%		
	7 Day Follow Up (All Patients)	95.0%	100.0%	97.3%	100.0%		
	Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	53.3%	54.6%	53.4%		
	Talking Therapies for Anxiety and Depression: Reliable	69.0%	74.4%	71.1%	76.0%		

	Indicator	Target	Jul-26	Aug-26	Sep-26	Assurance	Variation
Inpatient & Quality	Average Length of Stay - Adult	40	29.6	29.2	38.3		
	Median Length of Stay - Adult	42.4	16.7	18.9	22.4		
	Adult Acute LoS-Over 60 days as a % of all discharges	No Target	20.7%	11.1%	22.2%		
	Average Length of Stay - Older Adult	90	52.4	41.2	59.9		
	Median Length of Stay - Older Adult	83.8	40.7	36.1	40.1		
	Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	13.0%	0.0%	20.0%		
	Emergency Readmissions rate (30 days)	<7.5%	2.3%	0.0%	2.6%		
	Clinically Ready for Discharge (CRFD)	No Target	17.3%	14.6%	13.3%		

	Indicator	Target	Jul-26	Aug-26	Sep-26	Assurance	Variation
Community &	Care Plan Compliance	95.0%	96.4%	96.4%	97.0%		
	Risk Assessment Compliance	95.0%	96.0%	96.1%	96.2%		

	Indicator	Target	Jul-26	Aug-26	Sep-26	Assurance	Variation
Organisational Health	Complaints Open Beyond Agreed Timescale	0	1	0	0		
	Friends and Family Test - Recommended	80.0%	85.0%	93.0%	80.0%		
	Safe Staffing	95%-105%	102.1%	98.9%	101.3%		
	Vacancy Rate	<10.0%	6.5%	6.6%	6.3%		
	Staff Turnover	<10.0%	7.9%	8.5%	8.3%		
	Sickness Absence	<5.40%	6.33%	6.50%	6.64%		
	Clinical Supervision	85.0%	88.0%	85.0%	84.0%		
	Appraisal	85.0%	86.0%	86.0%	82.0%		
	Statutory & Mandatory Training	85.0%	92.0%	93.0%	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	11	24	3	5	9	12	13						
			Variance	6	-7	14	12	7	4	3						
			Kidsgrove Placements	1	*3*	*1*	*0*	*1*	*1*	*2*						

	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	3,896	5,050	5,379	3,901	3,347	2,670	3,027						
			Variance	-1,526	-380	-51	-1,524	-2,073	-2,745	-2,383						
			Nationally Published	4,069	5,050	5,380	3,900	3,345	2,670							
	Number of discharges in the RP		Plan	120	120	120	120	120	120	120	120	120	120	120	120	120
			Actual	115	116	130	133	118	100	93						
			Variance	-5	-4	10	13	-2	-20	-27						
			Nationally Published	119	115	130	135	115	100							
	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	33.8	43.5	41.4	29.3	28.6	26.9	32.9						
			Variance	11.4	-1.8	-3.9	-15.9	-16.6	-18.2	-12.2						
			Nationally Published	34	44	41	29	29	27							

	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	3,473	3,496	3,473	3,440	3,443	3,377	3,611						
			Variance	-344	-329	-349	-379	-373	-436	-199						
			Nationally Published	3,446	3,495	3,475	3,440	3,445	3,375							
	Number of discharges in the RP		Plan	65	65	65	65	65	65	65	65	65	65	65	65	65
			Actual	69	68	66	69	69	71	71						
			Variance	4	3	1	4	4	6	6						
			Nationally Published	68	65	65	70	70	70							
	Mean Length of stay for discharges in the RP		Plan (YTD Avg)	58.7	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	50.8	52.2	52.6	49.9	50.6	48.2	51.5						
			Variance	-7.9	-6.6	-6.2	-8.9	-8.1	-10.5	-7.1						
			Nationally Published	51	52	53	50	51	48							

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	9,362	9,513	9,443	9,427	9,316	9,234	9,238						
			Variance	1,562	1,728	1,652	1,630	1,513	1,425	1,423						
			Nationally Published	9,381	9,515	9,450	9,440	9,290	9,210							

	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	862	835	840	864	880	872	883						
			Variance	283	211	204	200	285	358	437						
			Nationally Published	921	915	905	925	935	925							

	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	939	983	966	967	907	893	917						
			Variance	226	285	262	257	191	171	189						
			Nationally Published	944	985	965	970	905	895							

	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	878	871	882	872	866	885	893						
			Variance	238	231	242	232	226	245	253						
			Nationally Published	874	870	880	870	865	885							

	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	964	899	929	961	972	997	1,027						
			Variance	139	109	129	151	142	147	157						
			NSCHT Actual	440	409	410	420	441	471	489						
			MPFT Actual	524	490	519	541	531	526	538						
			ICB Nationally Published	964	915	945	955	990	1,015							
			NSCHT Nationally Published	430	410	410	420	440	470							

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 M06, there were 13 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 M06, 6 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 M06 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.

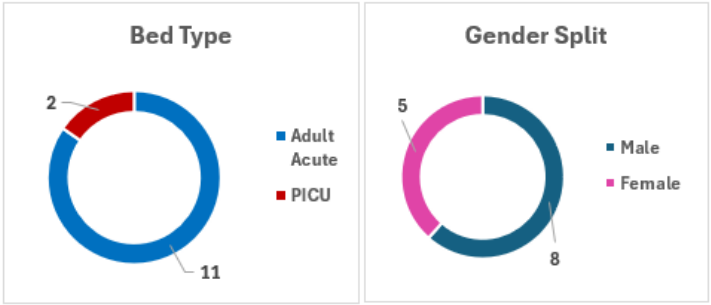
A resolute OAPs Standing Operating Procedure (SOP) is in place, providing assurance around staff roles, responsibilities, and clinical oversight for patients placed out of area (OAP). The Trust places patients only with providers rated 'Good' or 'Outstanding' by the Care Quality Commission (CQC) and 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
	Cygnet Hospital Bury	60	2
	Cygnet Hospital Godden Green	198	1
	Cygnet Hospital Hexham	188	1
	Cygnet Hospital Sherwood	61	2
	Cygnet Hospital Wyke	85	2
	Priory Hospital Arnold	61	1
	Priory Hospital East Midlands	60	1
	Priory Hospital Middleton	165	1
	Priory Lakeside View	33	2
			Total: 13
	Harplands Hospital		
	Cygnet Kidsgrove	*9*	*2*

*Total excludes Cygnet Kidsgrove placements



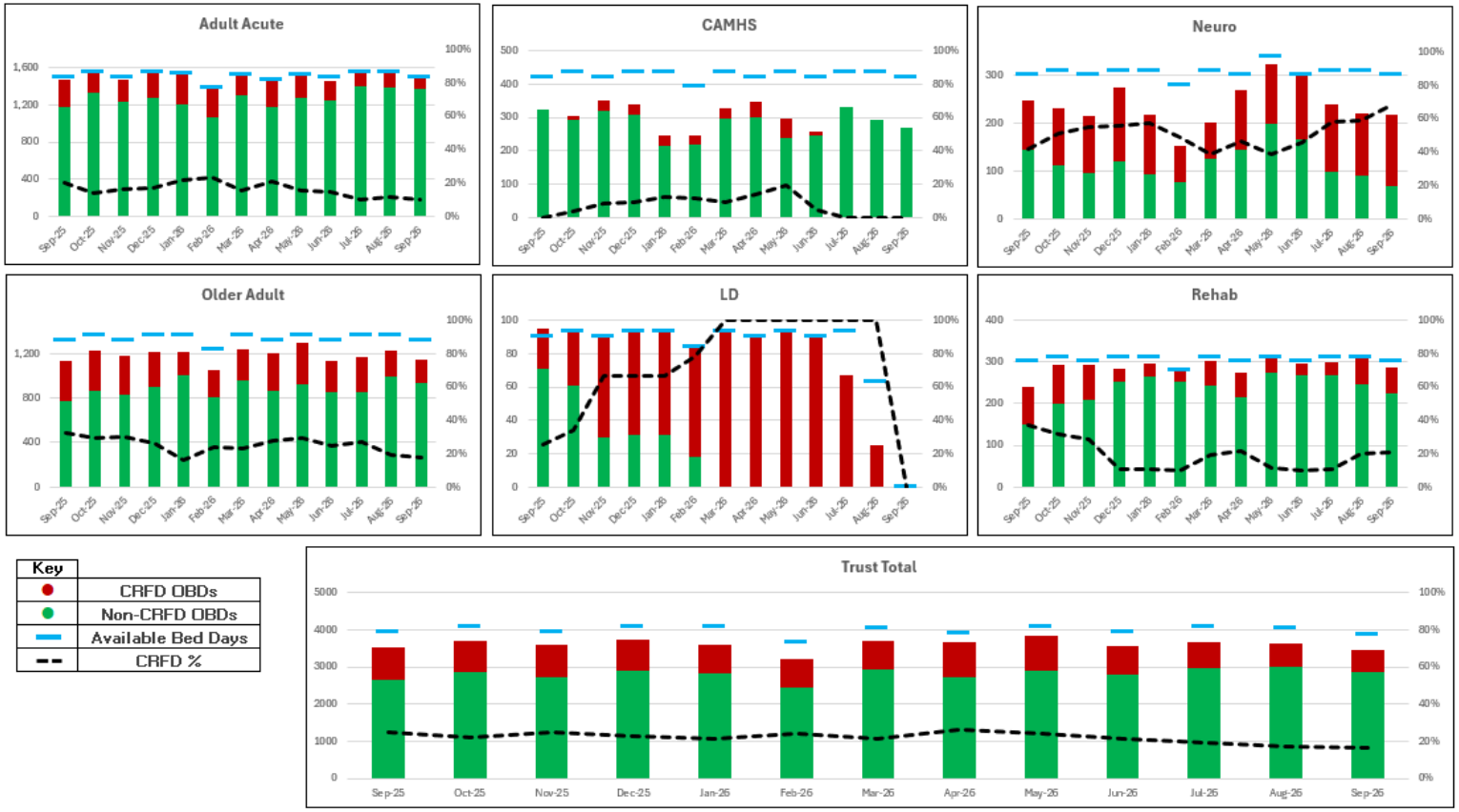
Whilst early improvements in oversight and process are evident, performance continues to be constrained by structural pressures including reduced bed stock and system delays in discharge. Actions remain focused on delivering sustainable improvements in flow and reducing reliance on OAPs over the medium 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 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 M06, achieving 32.9 against the plan of 45.1 for adult acute, and 51.5 against the plan of 58.6 for older adult.

- **Perinatal Access –** The perinatal access metric has met standard in M06, achieving 893 against the plan of 640.

- **CYP Access –** This metric has met standard in M06, achieving 9,238 against the plan of 7,815.

- **Individual Placement Support (IPS) Access** – The Integrated Care Board (ICB) performance plan has met standard in M06, achieving 1,027 against a plan of 870.

- **MHST Access –** This metric has met standard in M06, achieving 917 against the plan of 728.

- **CYP Waits Over 104 Weeks –** This metric has not met standard in M06. There were 883 waits over 104 weeks against a plan of 446. 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. Additional resource is dedicated to clear the backlog, and a process is in place to ensure that there are no further waits occurring over 104 weeks. Weekly monitoring will ensure there is a rapid downward trend to ensure that the waits are eradicated by year end.

Core Indicators – 13 Month Trend (1 of 2)

Name	Target	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
Referral to Assessment within 4 weeks	95.0%	94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%	94.1%	96.5%	96.1%	96.9%	97.5%	95.9%
Referral to Treatment within 18 weeks	92.0%	96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%	96.6%	94.8%	95.4%	96.3%	97.4%	96.3%
CAMHS Compliance within 4 week waits (Referral to Assessment)	95.0%	90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%	94.7%	95.2%	95.3%	94.6%	96.4%	96.4%
CAMHS Compliance within 18 week waits (Referral to Treatment)	92.0%	94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%	93.5%	90.6%	89.6%	93.4%	98.3%	91.3%
MH Liaison 1 Hour Response (Emergency)	95.0%	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%	93.7%	92.3%	91.0%	95.9%
MH Liaison 4 Hour Response (Urgent)	95.0%	97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%	96.6%	98.0%	97.5%	96.9%	93.1%	98.1%
MH Liaison 24 Hour Response (Urgent from General Hospital Ward)	95.0%	96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%	97.9%	96.9%	95.9%	96.7%	96.7%	96.6%
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week	95.0%	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%	N/A	N/A	100.0%
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks	95.0%	100.0%	N/A	N/A	98.0%	N/A	N/A	98.1%	N/A	N/A	100.0%	N/A	N/A	100.0%
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment	60.0%	90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%	83.3%	87.5%	100.0%	85.7%	100.0%	100.0%
48 Hour Follow Up	95.0%	100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%	94.7%	100.0%	96.6%	95.6%	94.6%	100.0%
7 Day Follow Up (All Patients)	95.0%	100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%	98.2%	100.0%	100.0%	100.0%	97.3%	100.0%
Emergency Readmissions rate (30 days)	<7.5%	2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%	5.8%	1.4%	0.7%	2.3%	0.0%	2.6%
Care Plan Compliance	95.0%	95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%	96.0%	96.3%	96.6%	96.4%	96.4%	97.0%
Risk Assessment Compliance	95.0%	96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%	95.5%	96.2%	96.4%	96.0%	96.1%	96.2%
Complaints Open Beyond Agreed Timescale	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Friends and Family Test - Recommended	80.0%	87.6%	76.0%	88.0%	81.0%	89.0%	92.0%	83.0%	86.0%	83.0%	83.0%	85.0%	93.0%	80.0%
Safe Staffing	95%-105%	102.8%	102.5%	106.1%	107.1%	109.6%	104.4%	105.2%	106.0%	105.6%	105.1%	102.1%	98.9%	101.3%
Sickness Absence	<5.40%	6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.14%	6.16%	6.21%	6.23%	6.33%	6.50%	6.64%

Core Indicators – 13 Month Trend (2 of 2)

Name	Target	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
Talking Therapies for Anxiety and Depression: Reliable Recovery	51.0%	49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%	54.4%	50.7%	52.1%	53.3%	54.6%	53.4%
Talking Therapies for Anxiety and Depression: Reliable Improvement	69.0%	70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%	76.5%	73.7%	74.0%	74.4%	71.1%	76.0%
Average Length of Stay - Adult	40	37.0	34.7	45.0	43.7	32.5	36.6	62.6	31.3	32.6	23.9	29.6	29.2	38.3
Median Length of Stay - Adult	42.4	14.6	26.9	27.4	18.9	15.9	25.9	20.5	13.9	12.9	12.2	16.7	18.9	22.4
Adult Acute LoS-Over 60 days as a % of all discharges	No Target	23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%	15.6%	13.3%	9.3%	20.7%	11.1%	22.2%
Average Length of Stay - Older Adult	90	46.4	47.2	58.5	60.1	55.3	47.4	59.0	50.1	48.5	50.5	52.4	41.2	59.9
Median Length of Stay - Older Adult	83.8	35.5	35.0	45.5	37.5	48.0	33.0	51.0	44.6	39.2	42.0	40.7	36.1	40.1
Older Adult Acute LoS-Over 90 days as a % of all discharges	No Target	14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%	12.5%	10.0%	16.0%	13.0%	0.0%	20.0%
Clinically Ready for Discharge (CRFD)	No Target	25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%	23.9%	21.8%	19.0%	17.3%	14.6%	13.3%
Vacancy Rate	<10.0%	5.1%	3.3%	3.0%	3.3%	2.9%	2.2%	2.7%	5.9%	6.0%	6.4%	6.5%	6.6%	6.3%
Staff Turnover	<10.0%	8.1%	7.3%	7.3%	7.4%	7.4%	7.7%	7.5%	7.3%	7.5%	8.2%	7.9%	8.5%	8.3%
Clinical Supervision	85.0%	81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%	78.0%	81.0%	89.0%	88.0%	85.0%	84.0%
Appraisal	85.0%	78.0%	79.0%	83.0%	83.0%	82.0%	82.0%	83.0%	81.0%	81.0%	86.0%	86.0%	86.0%	82.0%
Statutory & Mandatory Training	85.0%	90.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%	92.0%	93.0%	92.0%
DQMI	95.0%	98.6%	98.5%	98.7%	98.8%	98.3%	98.4%	98.5%	98.7%	99.1%	99.2%	N/A	N/A	N/A

In M06 there are 34 metrics monitored; 25 have achieved the required standard and 4 have not achieved the required standard. 3 metrics have no target and are being monitored. 1 metric has a threshold and is being monitored. 1 metric is provided by NHS England with the current month not yet published.

Performance Improvement Plans (PIPs)

Performance 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 M06 is 81.8%, which has not met the planned trajectory (92.0%) or the required standard. Updated actions have been provided in M06.
	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 M06 is 92.9% and has not met the 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 in M05 and M06. Updated actions have been provided in M06.
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.

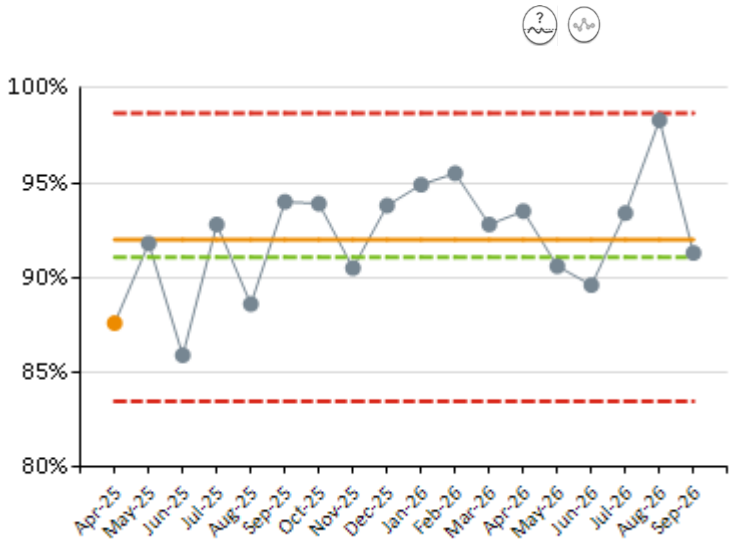
Metric	Directorate	Status
		Rolling 12-month sickness absence at M06 is 8.83%, with in-month absence at 9.95%. The trajectory and required standard have not been achieved. Trajectories have been provided in M04 (Apr-Oct 2026). Updated actions have been provided in M06.
	Specialist Services	A PIP was 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 M06 is 7.10%, with in-month absence at 7.93%. The trajectory and required standard have not been achieved. Trajectory milestones were initially set in M01 (Apr-Sept 2026/27) and have since been reset in M05 (Sept-Feb 2027). September's trajectory has been revised from 5.80% to 6.30% to reflect the increased target. Updated actions have been provided in M06.
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, September 2026 and is currently forecast for December 2026. Performance during M06 is 95.6%, which is exceeding the planned trajectory and has met the required standard. Trajectory milestones were initially set in M01 (Apr–Jun 2025/26) and have been reset to reflect revised planning assumptions: M03 (Apr–May 2025/26) and M04 (Sept–Jan 2025/26) and M01 (Apr-Jun 2026/27). Updated actions have been provided in M06.
Out of Area Placement (OAPs)	Acute and Urgent Care and Community	A PIP was requested in M04 (2025/26). Performance during M06 is measured by the number of inappropriate OAPs during month and the number of inappropriate OAPs at EOM (national measure) which were 14 and 13, respectively. Updated actions have been provided in M06.

Metric	Directorate	Status
Referral to Treatment within 18 weeks	**Specialist Services**	A PIP was requested in M04 (2026/27). The aim is for the standard to be achieved by November 2026. Performance during M06 is 94.3% and has exceeded the planned trajectory and required standard for the third consecutive month. As a result the PIP is closed. Trajectory milestones have been set in M04 (Jul-Nov 2026). Updated actions have been provided in M06.
Risk Assessment	**Specialist Services**	A PIP was requested in M05 (2026/27). The aim is for the standard to be achieved by December 2026. Performance during M06 is 94.8% which has met the planned trajectory but is below the required standard. Trajectory milestones have been set in M05 (Sept-Feb 2027). Updated actions have been provided in M06.
Talking Therapies for Anxiety and Depression (90 days wait in treatment)	**Primary Care**	A PIP was requested in M05 (2026/27). Performance during M06 is 17.0% which has not met the required standard. Trajectory milestones have been updated. Updated actions have been provided in M06.
Mental Health Liaison 1-hour response (Emergency)	**Acute and Urgent Care**	A PIP was requested in M06 (2026/27). Performance during M06 is 95.9% and is meeting the required standard. Trajectory milestones have been requested. Updated actions have been provided in M06.

Core Indicators – SPC Trend (Exceptions in Month)

ACCESS AND WAIT TIMES

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



13 Month Trend

94.0%	93.9%	90.5%	93.8%	94.9%	95.5%	92.8%	93.5%	90.6%	89.6%	93.4%	98.3%	91.3%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Performance is at **91.3% in M06**. The variation is showing common cause.

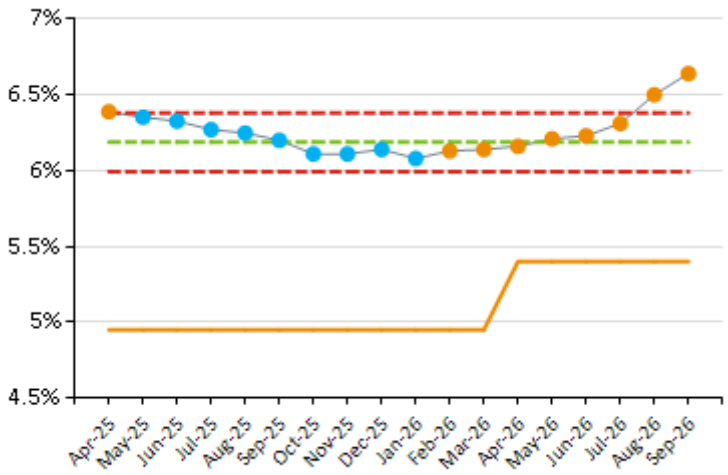
Current performance:

Community	92.8%
Specialist Services	N/A
Acute and Urgent Care	77.8%

In M06, 8 breaches were reported against the **CAMHS RTT** metric.

All other breaches were associated with extended waits within the Autism Assessment Service.

Sickness Absence (Trust Measure)



	Target	Actual	Variance
Trust	**5.40%**	**6.64%**	**-1.24%**
Community	5.70%	6.24%	-0.54%
Specialist Services	6.30%	7.10%	-0.80%
Acute and Urgent Care	6.60%	8.83%	-2.23%
Primary Care	5.70%	5.96%	-0.26%
Corporate	2.20%	4.10%	-1.90%

13 Month Trend

6.20%	6.11%	6.11%	6.14%	6.08%	6.13%	6.14%	6.16%	6.21%	6.23%	6.31%	6.50%	6.64%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Performance is at **6.64% in M06**. The variation is showing concern.

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

Sickness absence remains a significant workforce challenge and continues to be a key focus within the Trust's People Plan, reflecting its impact on workforce capacity, productivity, staff wellbeing, temporary staffing utilisation, and service delivery. As such, a monthly report is presented to People, Culture & Development Committee monthly for assurance. The next update is due November 2026.

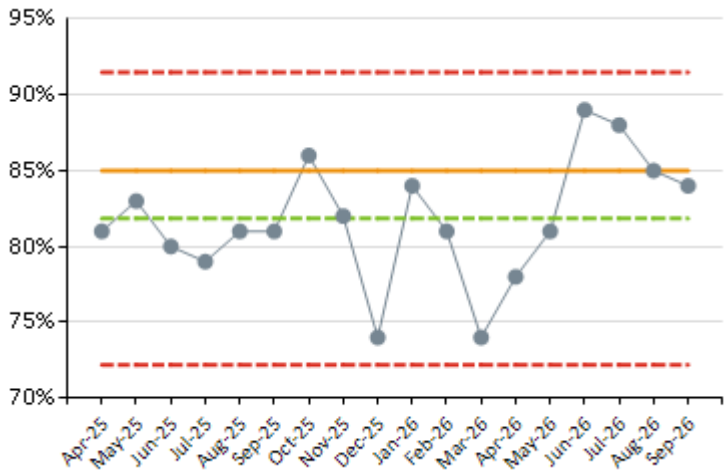
The majority of the plan's 38 actions have now reached either substantial progress or completion, with improvements including enhanced sickness clinics, directorate-specific action plans and targets, improved data analysis, strengthened occupational health oversight and greater focus on performance management. The focus now moves to translating Trust-wide actions into localised directorate plans.

Benchmarking across other NHS trusts demonstrates that reductions in sickness absence have been driven by focusing attention on confirm and challenge sessions and consistent set of data reporting, which is now being progressed as a comparison for NSCHT.

The trend continues that sickness absence is not evenly distributed across the organisation, with a small number of services accounting for a disproportionate level of absence and associated temporary staffing usage. Targeted interventions continue to focus on these hotspot areas, particularly within Acute and Urgent Care and Specialist Services, where enhanced management oversight, long-term absence reviews, wellbeing support, and attendance management actions remain in place. Mental health-related absence continues to represent the largest cause of sickness absence, accounting for over half of all absence episodes, and wellbeing interventions remain focused on prevention, early intervention, and psychological support. Business cases are in development for enhanced health and wellbeing provision and MSK staff fast track pathway.

A key theme emerging from discussions was the importance of consistent attendance management practice across the organisation. Further work is underway to strengthen manager capability, confidence and accountability through training, coaching, and improved performance monitoring, alongside ensuring a balanced approach that combines compassionate leadership with timely and effective management action.

Clinical Supervision (Trust Measure)



13 Month Trend

81.0%	86.0%	82.0%	74.0%	84.0%	81.0%	74.0%	78.0%	81.0%	89.0%	88.0%	85.0%	84.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Performance is at **84.0% in M06**. The variation is showing common cause.

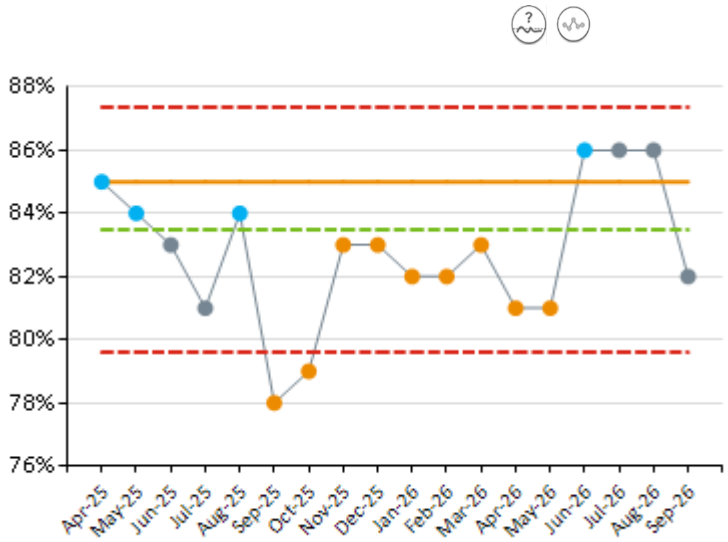
Current performance:

Community	87.0%
Specialist Services	86.0%
Acute and Urgent Care	79.0%
Primary Care	83.0%
Corporate	85.0%

Fortnightly reports identifying non-compliance rates, including named individuals and their line managers, are distributed to associate directors and line managers for action. The transfer to ESR/OLM in October has been communicated Trust-wide. Clinical Supervision recording will remain the same within OLM.

A clinical supervision action plan has been completed following the survey report. Task and finish group commenced focusing on education and communication to raise skills and awareness. A Trust-wide screen saver highlighting requirements remains active.

Appraisal (Trust Measure)



13 Month Trend

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

Performance is at **82.0% in M06**. The variation is showing common cause.

Current performance:

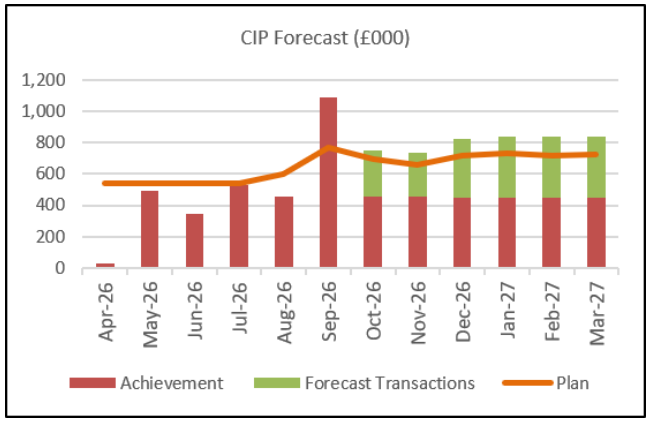
Community	83.0%
Specialist Services	87.0%
Acute and Urgent Care	78.0%
Primary Care	85.0%
Corporate	77.0%

Reports identifying non-compliance rates and the names of those non-compliant and their line managers are sent to the associate directors and line managers fortnightly for action.

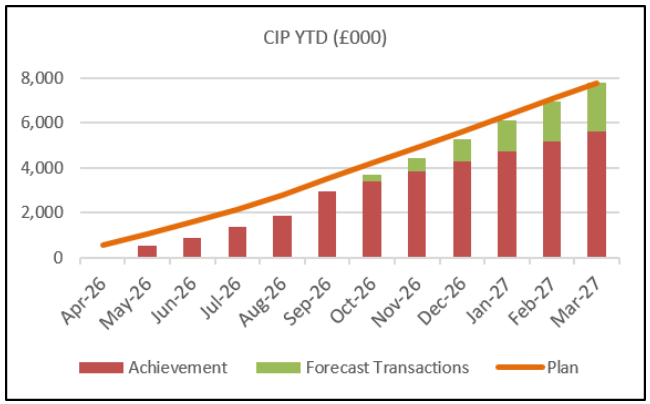
Guidance advising managers on action to undertake to address appraisal inaccuracies on LMS has been put in place. Data cleanse has been completed in readiness for transfer to ESR/OLM in October 2026.

Financial Performance

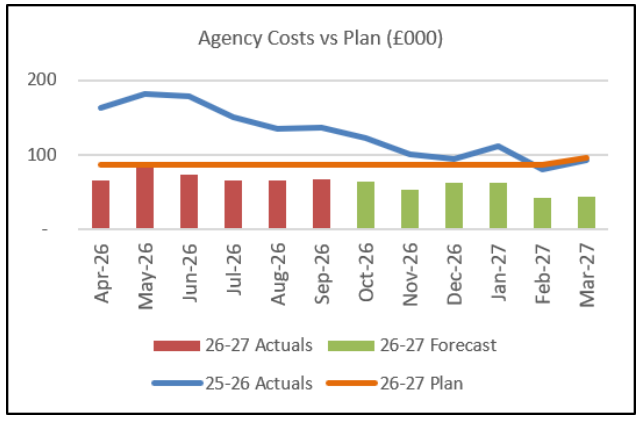
CIP Delivery v Plan



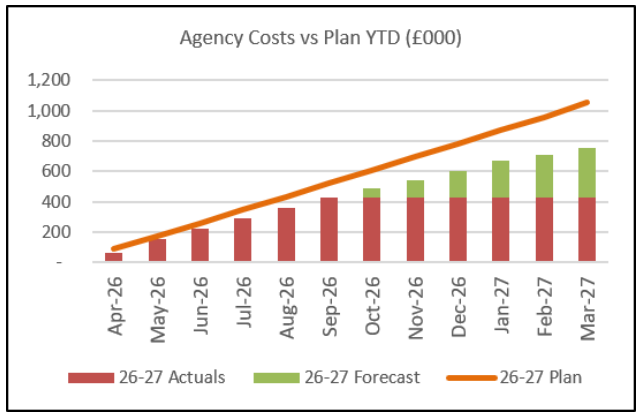
The CIP graph shows current achievement and forecast transactions against the £7.8m plan. The Trust is forecasting full achievement of £7.8m target.



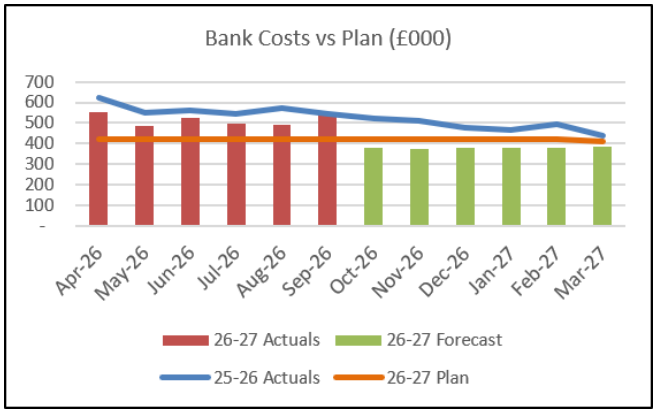
Agency Cost v Plan (40% reduction)



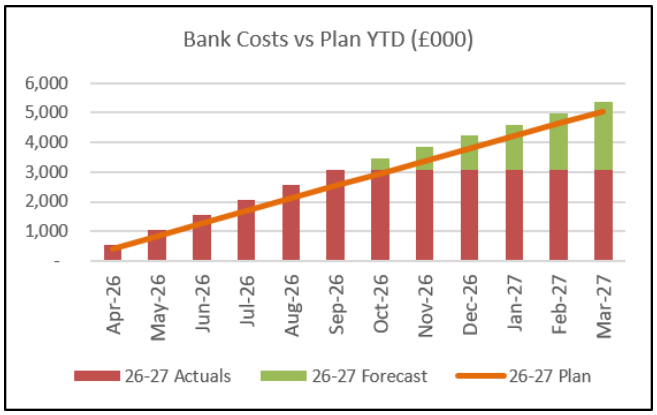
The agency graph shows actual and forecast costs against a £1.1m plan. The Trust is forecasting £0.8m total costs at M06.



Bank Cost v Plan (10% reduction)



The bank graph shows actual and forecast costs against a £5.0m plan. The Trust is forecasting total costs of £5.4m at M06.

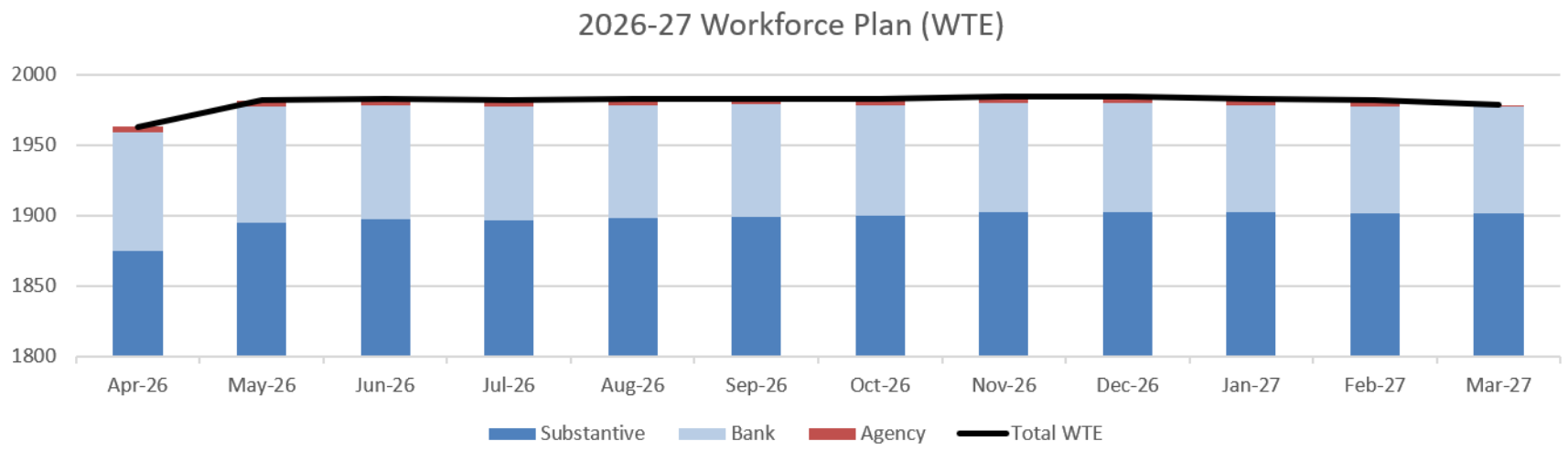


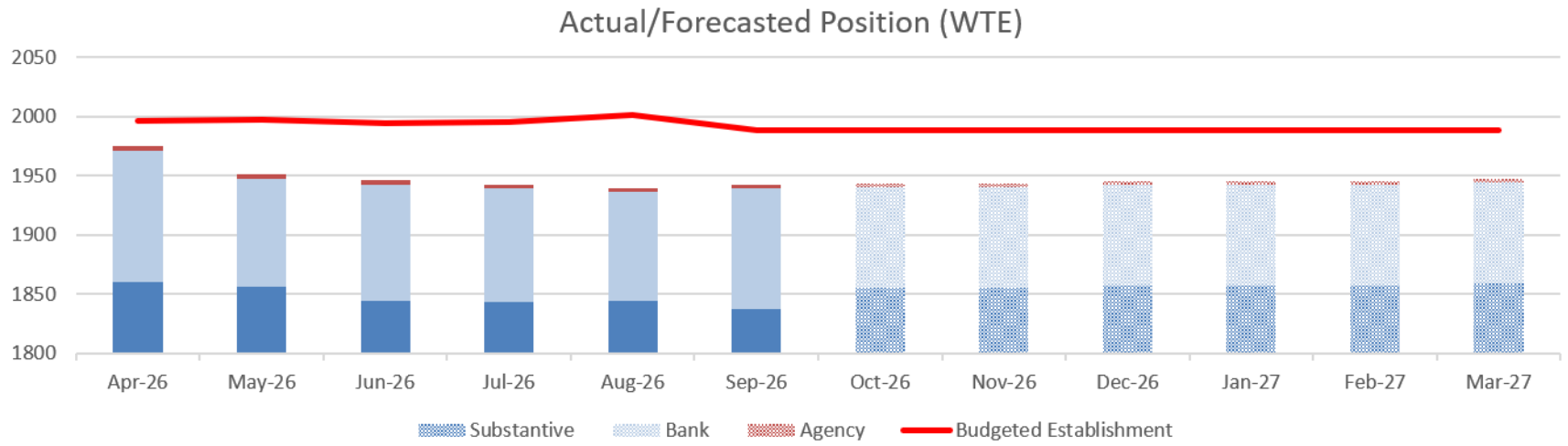
Workforce Plan (1 of 3)

Sep-26	WTE				Spend			
	Plan	Actual	Variance From Plan		Plan	Actual	Variance From Plan	
NSCHT	WTE	WTE	WTE	%	£'000	£'000	£'000	%
Total	**1,982.0**	**1,941.9**	**-40.1**	**-2.0%**	**£55,839.4**	**57,065.0**	**+£1,226**	**+2.2%**
Substantive	**1,897.8**	**1,837.4**	**-60.4**	**-3.2%**	**£52,791.4**	**£53,550.0**	**+£759**	**+1.4%**
Medical and Dental	73.5	71.3	-2.3	-3.1%	£5,843.9	£5,885.0	+£41	+0.7%
Registered nursing, midwifery and health visiting staf	618.2	567.7	-50.6	-8.2%	£17,678.6	£17,037.0	-£642	-3.6%
Registered scientific, therapeutic and technical staff	310.8	310.8	-0.1	-0.0%	£11,394.1	£10,753.0	-£641	-5.6%
Support to clinical staff	510.9	530.2	+19.3	+3.8%	£8,614.4	£9,369.0	+£755	+8.8%
Total NHS infrastructure support	382.7	354.5	-28.2	-7.4%	£9,260.4	£10,506.0	+£1,246	+13.5%
Any other staff	1.6	3.0	+1.4	+86.1%	£0.0	£0.0	£0	
Bank	**79.9**	**101.5**	**+21.6**	**+27.0%**	**£2,526.0**	**£3,089.0**	**+£563**	**+22.3%**
Medical and Dental	1.3	4.8	+3.5	+279.7%	£600.0	£636.0	+£36	+6.0%
Registered nursing, midwifery and health visiting staf	24.4	25.7	+1.3	+5.2%	£570.0	£845.0	+£275	+48.2%
Registered scientific, therapeutic and technical staff	0.7	2.4	+1.7	+239.0%	£72.0	£95.0	+£23	+31.9%
Support to clinical staff	53.1	66.8	+13.6	+25.7%	£1,200.0	£1,440.0	+£240	+20.0%
Total NHS infrastructure support	0.5	2.0	+1.5	+318.7%	£84.0	£73.0	-£11	-13.1%
Any other staff	0.0	0.0	0.0		£0.0	£0.0	£0	
Agency	**4.30**	**2.99**	**-1.3**	**-30.4%**	**£522.00**	**£426.00**	**-£96**	**-18.4%**
Medical and Dental	4.30	2.72	-1.6	-36.7%	£504.0	£393.0	-£111	-22.0%
Registered nursing, midwifery and health visiting staf	0.00	0.27	+0.3		£18.0	£33.0	+£15	+83.3%
Registered scientific, therapeutic and technical staff	0.00	0.00	0.0		£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 M06.
- 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.

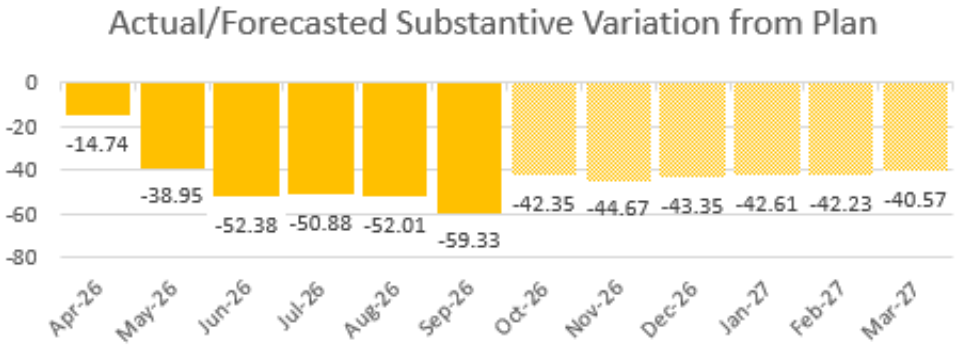
Workforce Plan (2 of 3)

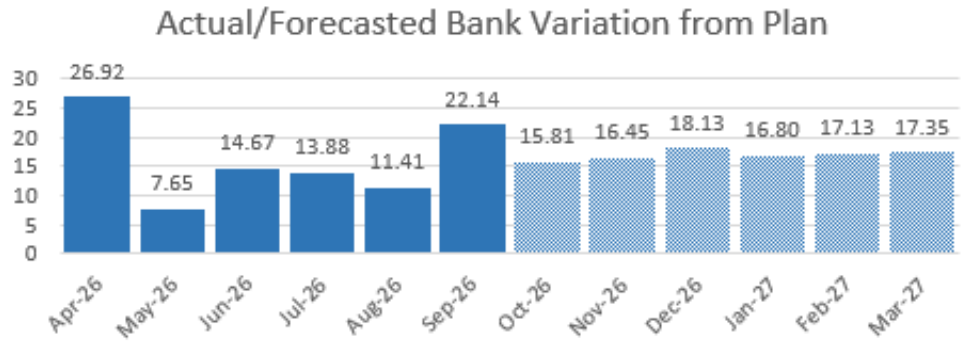


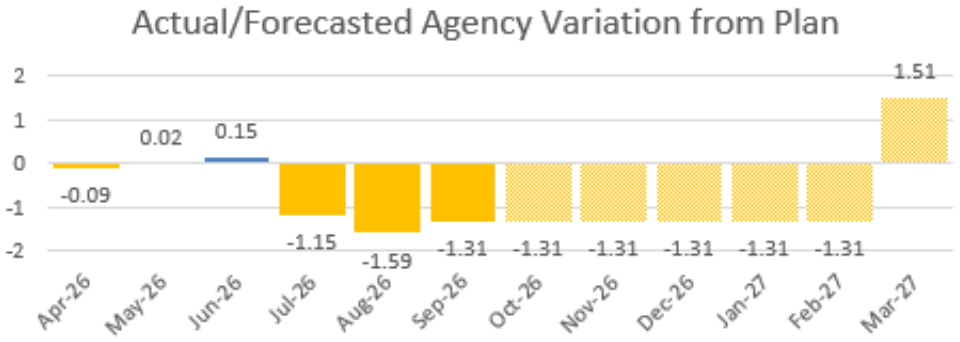


This shows the Workforce Plan that was submitted in comparison to the actual or forecast position for the same period.
The forecast position is based on information that is available from ESR, TRAC and Optima E-rostering. Also included in this year's forecasting is the over/under plan WTE to date.
The forecasted months up until the end of 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)







M06 actual vs plan - As at M06 for 2026-27 the Trust is 40wte below what was forecasted for the total workforce. This consists of the substantive whole time equivalent (WTE) being 59wte under plan and Temp Staffing cover being 21wte over plan.

Included in the 26/27 Workforce Plan, workforce growth was identified for the below services;
Primary Care/Ascend – 0.5wte
Primary Care/CIC – 10wte
Community MH/IPS – 4.6wte – 3.6wte growth by M6
Specialist Services/Forensic Liaison Partnership – 5.1wte – 1wte growth by M06
It is anticipated that this growth will be fulfilled through internal and external recruitment

Temp Staffing

- Bank usage across the Trust accounts for 5.5% of the total workforce wte and Agency usage accounts for 0.2% of the total workforce wte.
- Of the temp staffing usage for September captured within the Optima E-Rostering system, 95% of this was for the 24/7 services. Each of the services have a dedicated headspace of 25.6% in the establishment figures to account for staff absence before needing to bring in additional hours or temp staffing

Trust Vacancy Position

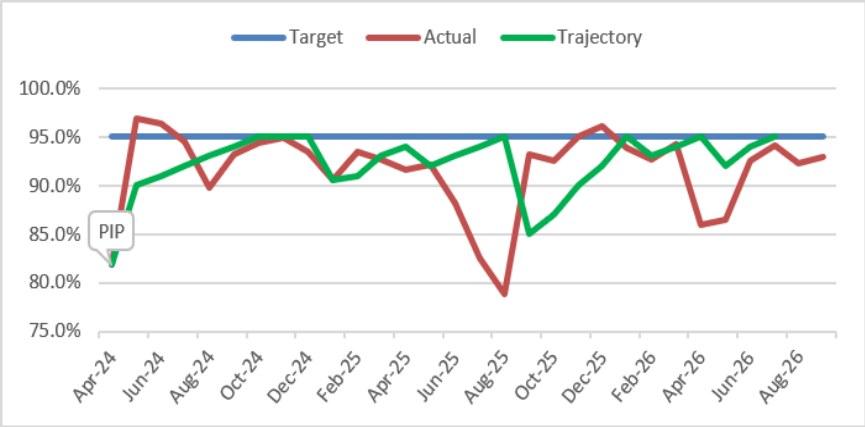
- The vacancy rate for M06 is reported at 6.3%. This is a minor improvement from the reported position for M05 (6.6%)

Forecasted position - The forecasted variation included here 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 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, April and is currently forecast for July 2026.

Performance during M06 is 92.9%, remaining below the required standard and trajectory.

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 in M05 and M06.

Updated actions have been provided in M06.

	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%
Actual	93.2%	92.5%	95.0%	96.1%	93.9%	92.6%	94.2%	86.0%	86.5%	92.5%	94.1%	92.2%	92.9%
Trajectory	85.0%	87.0%	90.0%	92.0%	95.0%	93.0%	94.0%	95.0%	92.0%	94.0%	95.0%		

M06 progress update:

The waiting list for initial assessments continues to be actively monitored across all CMHTs to support timely access and effective utilisation of resources. All CMHTs, except for Sutherland, are currently achieving the 4-week target for initial assessments. Sutherland continues to experience challenges due to sustained sickness absence within the assessment team; however, overall performance has improved, and the number of breaches remains low. Patients who exceeded the 4-week target had been offered appointments within four weeks but did not attend (DNA), meaning delays were not attributable to service capacity.

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.

M06 update: *Workforce mapping has now been completed by the Quality Improvement Lead Nurse and Service Manager, providing a baseline understanding of staffing resource, skill mix, and variation across teams. This information supports the next phase of the demand and capacity review, enabling a more detailed assessment of activity, demand and workforce deployment to ensure resources are aligned effectively to local population 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.

M06 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.

M06 update: *The SAF waiting list continues to be actively monitored to support timely allocation and effective utilisation of resources. Lymebrook has sustained no waiting list for SAF appointments, and performance across the service line has continued to improve. Sutherland's waiting list has reduced further and is now operating well below the 18-week target for SAF assessments. The focused actions implemented to improve oversight of demand, resource allocation and service flow have resulted in sustained improvements in waiting times across the pathway.*

Performance Improvement Plan: Referral to Assessment within 4 weeks – Adult CMHTs (Trust indicator) (2 of 2)

Community directorate

Aug-26

RTA Waited

Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	463	11	3	6	483	95.9%

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	16	1	1	1	19	84.2%
City CMHT - Sutherland	55	4	0	0	59	93.2%
County CMHT Moorlands	36	0	1	3	40	90.0%
County CMHT Newcastle	46	0	0	2	48	95.8%
CMHT Total	153	5	2	6	166	92.2%

RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	13	0	0	0	13	100.0%
City CMHT - Sutherland	14	0	0	0	14	100.0%
County CMHT Moorlands	0	0	0	0	0	
County CMHT Newcastle	2	0	0	0	2	100.0%
CMHT Total	29	0	0	0	29	100.0%

Sep-26

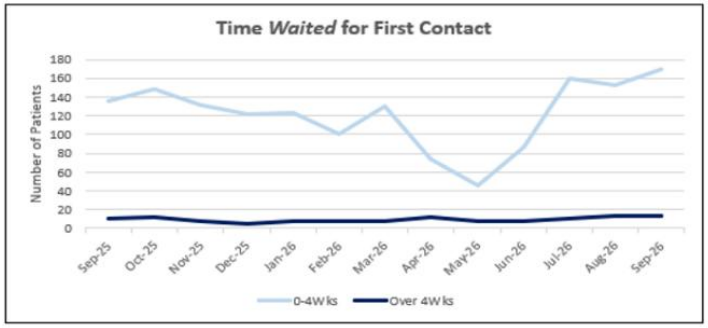
RTA Waited

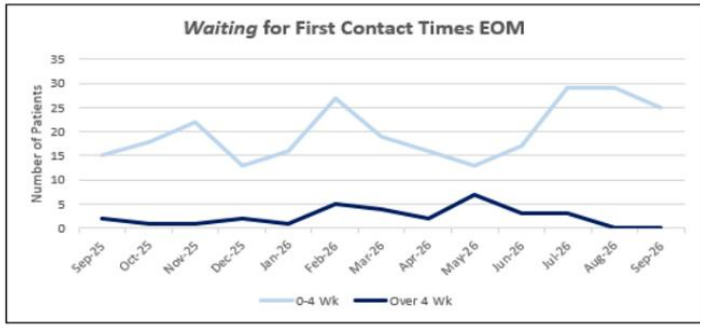
Directorate	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
Community	439	19	2	3	463	94.8%

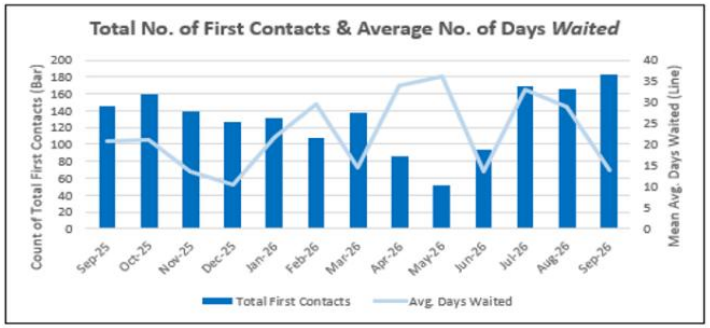
Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	23	1	0	1	25	92.0%
City CMHT - Sutherland	44	9	0	1	54	81.5%
County CMHT Moorlands	32	0	0	0	32	100.0%
County CMHT Newcastle	71	1	0	0	72	98.6%
CMHT Total	170	11	0	2	183	92.9%

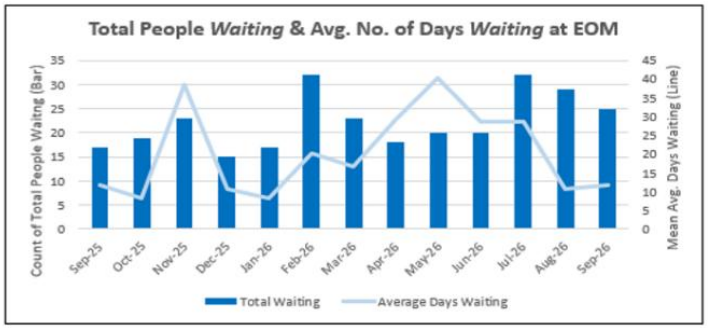
RTA Waiting

Service	0-4Wks	5-18Wks	19-52Wks	52+Wks	Total	4Wk %
City CMHT - Greenfields	9	0	0	0	9	100.0%
City CMHT - Sutherland	13	0	0	0	13	100.0%
County CMHT Moorlands	1	0	0	0	1	100.0%
County CMHT Newcastle	2	0	0	0	2	100.0%
CMHT Total	25	0	0	0	25	100.0%





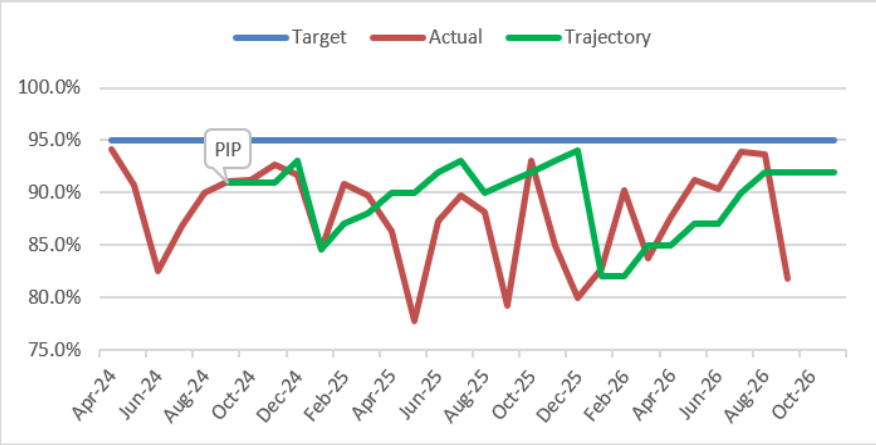




- Adult CMHTs remain a significant driver of directorate RTA performance, contributing 39.5% of all RTAs completed in M06. The service delivered its highest monthly number of RTAs completed in the last 13 months reported.
- RTA performance for Adult CMHTs is below standard in M06, achieving 92.9% against a target of 95%.

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

Specialist Services directorate



A voluntary PIP was implemented 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 aiming to achieve target in March 2027.

Performance during M06 is 81.8% which is considerably below the required standard and trajectory.

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

Updated actions have been provided in M06.

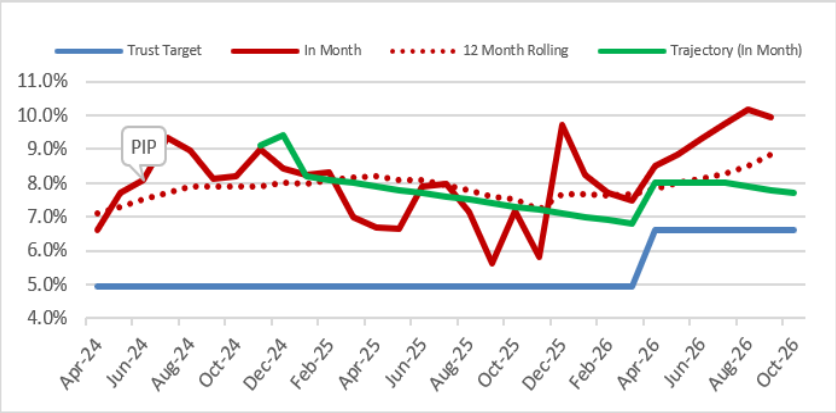
	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Actual	79.2%	93.0%	85.0%	80.0%	82.8%	90.2%	83.8%	87.7%	91.2%	90.3%	93.9%	93.6%	81.8%						
Trajectory	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%	92.0%	92.0%	93.0%	94.0%	95.0%

Actions M06:

- Weekly RTA / RTT 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).
- **Neuropsychology Community:** New process remains in situ however due to two vacancies (in a team of 4) since August this is now having an impact on the capacity within the team. Both vacant posts are recruited to so we should see an improved position within 3 months.
- Directorate has engaged with community directorate regarding their processes. Some are already in place, but the directorate needs to consider how this is implemented in teams struggling with compliance.
- **Physical Health**: Although the waiting lists are closed, a small number of patients remaining on the RTA list have been assessed this month by the remaining two clinicians, causing these to flag. The team are currently operating with 29.6% establishment filled and have a 70.4% vacancy rate. Interviews planned w/c 12/10/26.

Performance Improvement Plan: Sickness Absence (Trust indicator)

Acute and Urgent Care directorate



A PIP was requested 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 M06 is 8.83%, with in-month absence at 9.95%. Both measures remain above the required standard and trajectory. Please note the figures from July to September 2026 cannot be confirmed.

Trajectories were initially set in November 2024 and subsequently revised in January and March 2025, with the objective of reducing the sickness absence rate to the 4-year average of 6.9% by March 2026. Revised trajectories have been provided in M04 (Apr-Oct 2026).

Updated actions have been provided in M06.

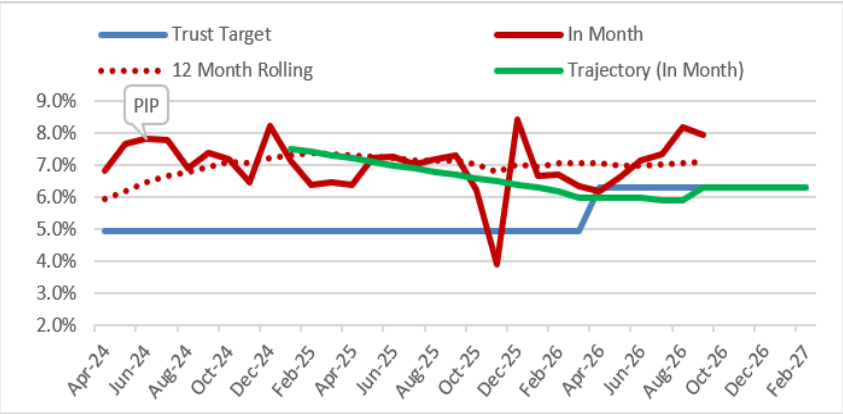
	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Trust Target	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	4.95%	6.60%	6.60%	6.60%	6.60%	6.60%	6.60%	6.60%
In Month	5.64%	7.18%	5.81%	9.73%	8.24%	7.72%	7.46%	8.52%	8.85%	9.29%	9.77%	10.16%	9.95%	
12 Month Rolling	7.61%	7.50%	7.23%	7.66%	7.66%	7.63%	7.66%	7.81%	8.01%	8.13%	8.28%	8.52%	8.83%	
Trajectory (In Month)	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%

M06 progress update:

- Each service line now has its own sickness absence PIP.
- Following a series of structured engagement sessions with ward managers and team leaders across the Directorate, significant themes have emerged regarding the factors contributing to sickness absence, wellbeing, retention and workforce sustainability. These discussions have provided valuable frontline insight into the challenges experienced by teams and have identified a number of organisational, operational and workforce-related factors that require further consideration.
- As a result, the Directorate has commenced a comprehensive refresh of the Sickness Absence Improvement Plan to ensure actions are evidence-based, aligned to staff feedback and focused on addressing the underlying drivers of absence rather than solely the management of absence episodes. The refreshed plan will incorporate findings from staff engagement activity, workforce data, sickness trends and discussions with workforce and HR colleagues.
- The revised action plan is currently being developed and will include clear priorities, measurable outcomes and defined accountability arrangements. It is anticipated that this refreshed approach will provide a more targeted and sustainable framework for reducing sickness absence, supporting staff wellbeing and strengthening attendance management across the Directorate.

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. The current PIP trajectory aims for performance to be at 6.30% by September 2026.

Rolling 12-month sickness absence at M06 is 7.10%, with in-month absence at 7.93%, remaining below the required standard and trajectory. Please note that figures from July to September 2026 cannot be confirmed.

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) and M05 (Sep-Feb 2027) to reflect the increased target.

Updated actions have been provided in M06.

	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	Jan-27	Feb-27
Trust Target	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%	6.30%	6.30%	6.30%	6.30%	6.30%
In Month	7.29%	6.24%	3.92%	8.42%	6.65%	6.71%	6.36%	6.17%	6.61%	7.15%	7.34%	8.16%	7.93%					
12 Month Rolling	7.14%	7.02%	6.79%	7.03%	6.94%	7.08%	7.07%	7.05%	6.99%	6.98%	7.01%	7.07%	7.10%					
Trajectory (In Month)	6.70%	6.60%	6.50%	6.40%	6.30%	6.20%	6.00%	6.00%	6.00%	6.00%	5.90%	5.90%	6.30%	6.30%	6.30%	6.30%	6.30%	6.30%

(September trajectory updated from 5.80% to 6.30%)

Actions M06:
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.

M06 Progress Update:

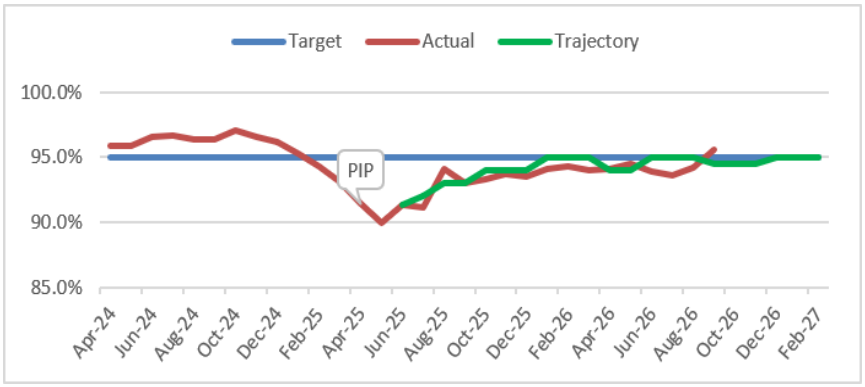
Enhanced Sickness Governance
Monthly sickness surgeries will continue, chaired by the Associate Director and supported by the people team. Focus is placed on; all cases across services being reviewed and continual monitoring of repeat stage 2 cases, frequent absence patterns, and long-term sickness cases.

- Ongoing reviews of all stage 2's with progression to stage 3 being supported where appropriate.
- Third Senior Service Manager is being supported to learn / shadow stage 3 process to support this.
- Reiteration that stage 2 extensions need to be approved by service manager has been completed this month and requires further embedding until this become business as usual - will be monitored via sickness surgeries.
- One informal action plan implemented where it has been identified that a team lead was not adhering to the Supporting Attendance at Work Policy in relation to staff support, return to work discussions and stage process opportunities had been missed.

Further Update: The directorate has 3 x stage 3 meetings booked in M07.

Performance Improvement Plan: Care Plan Compliance (Trust indicator)

Specialist Services directorate



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

Performance at M06 is 95.6%, achieving the required standard for the first time in over 18 months.

The original aim was for the standard to be achieved by October 2025 this has been extended to January 2026, June 2026, Sept 2026 and is currently forecast for December 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) and currently in M05 (Sept-Feb 2027).

Updated actions have been provided in M06.

	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	Jan-27	Feb-27
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%	95.0%
Actual	93.0%	93.3%	93.7%	93.5%	94.1%	94.3%	94.0%	94.1%	94.5%	93.9%	93.6%	94.2%	95.6%					
Trajectory	93.0%	94.0%	94.0%	94.0%	95.0%	95.0%	95.0%	94.0%	94.0%	95.0%	95.0%	95.0%	94.5%	94.5%	94.5%	95.0%	95.0%	95.0%

September trajectory has been updated from 95% to 94.5%

Actions M06:

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.

M05 progress update:

Clinical Documentation Improvements: Work is underway to streamline documentation process for medical staff:

- Clini*cal 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: Neuropsychiatry & Psychology

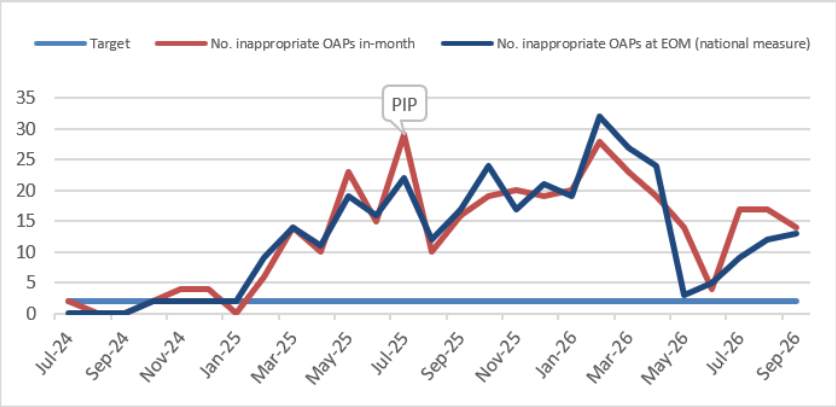
- Complete the review of neuropsychiatry and psychology triage processes and implement any agreed amendments.
- Continue 1:1 engagement to embed new documentation standards.
- Address compliance gaps through robust supervision and performance management.

Actions M06:

Physical Health Psychology Services: *Review all cases non-compliant with care planning & review against caseloads, vacancies, sickness etc to establish causes/ themes.*

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

Acute and Urgent Care and Community directorates



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

Performance during M06 is measured by the number of inappropriate OAPs during the month and the number of inappropriate OAPs at EOM (national measure) which were 14 and 13, respectively.

Updated actions have been provided in M06.

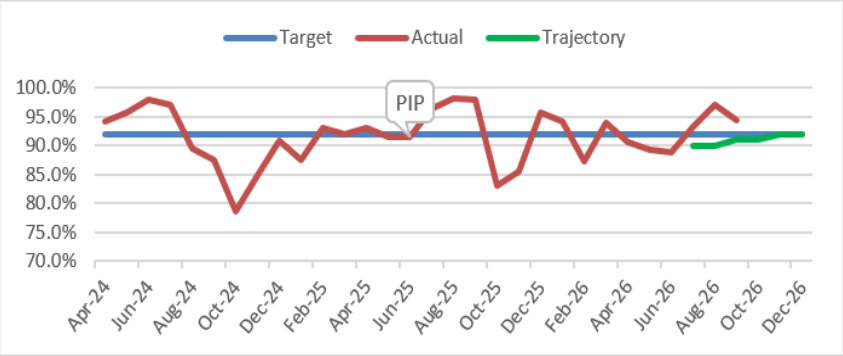
	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Target	2	2	2	2	2	2	2	2	2	2	2	2	2
No. inappropriate OAPs in-month	16	19	20	19	20	28	23	19	14	4	17	17	14
No. inappropriate OAPs at EOM (national measure)	17	24	17	21	19	32	27	24	3	5	9	12	13

M06 progress update:

- The ACUD and Community Directorates continue to deliver the Performance Improvement Plan, which remains subject to ongoing oversight through
- daily bed flow meetings, weekly multi-agency escalation meetings and regular reporting through Trust governance processes.
- During M06, work has continued to focus on reducing inappropriate Out of Area Placements through strengthened bed management, discharge optimisation and admission avoidance initiatives. The Clinical Bed Manager continues to provide enhanced operational oversight of capacity, patient flow and repatriation arrangements, supporting a more proactive approach to managing pressures across inpatient and crisis pathways.
- Progress has continued in the development of the revised CRFD policy and implementation of Multi-Agency Discharge Event (MADE) principles to improve escalation and resolution of discharge barriers. The review of the CRHTT operating model has progressed, with further work underway to protect crisis response capacity and improve alternatives to admission. Work also continues to strengthen reporting arrangements and data insight to better understand the drivers of OAP use and support targeted improvement activity.
- The Trust remains focused on reducing reliance on inappropriate OAP placements through improved flow, timely discharge, strengthened crisis alternatives and enhanced system working with ICB and Local Authority partners.
- The lack of a crisis alternative provision continues to impact admission avoidance. The 24-72hr referral workload being completed by CRHTT continues to impact on OOA due to reduced capacity for an increased HTT function.
- Community services have continued to focus on admission avoidance, timely assessment, proactive care coordination and effective discharge planning to support patient flow across the acute and community mental health system. Community teams continue to work collaboratively with inpatient services, the ICB and Local Authority partners to reduce delays and ensure patients receive care in the most appropriate setting.
- Work has progressed on the development of a Deteriorating Patient Dashboard, which is intended to strengthen oversight of patients whose mental health needs may be escalating within community services. The dashboard will support the earlier identification of deteriorating patients, facilitate proactive intervention and enable services to prioritise support for individuals at greatest risk of admission. This work forms part of the wider approach to reducing avoidable admissions and supporting people to remain safely within community-based services wherever possible.
- Community teams continue to contribute to system-wide initiatives to improve patient flow, reduce delayed discharges and minimise reliance on inappropriate Out of Area Placements. Focus remains on strengthening community alternatives, improving coordination across pathways and ensuring patients receive timely, effective care as close to home as possible.

Performance Improvement Plan: Referral to Treatment within 18 Weeks (Trust indicator)

Specialist Services directorate



A PIP was requested in M04 (2026/27).

Performance in M06 is 94.3% and has met the planned trajectory and required standard for the third consecutive month.

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 M06.

	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%
Actual	98.0%	83.1%	85.5%	95.7%	94.2%	87.2%	94.0%	90.7%	89.2%	88.9%	93.3%	97.1%	94.3%			
Trajectory											90.0%	90.0%	91.0%	91.0%	92.0%	92.0%

M06 Action (Ongoing):

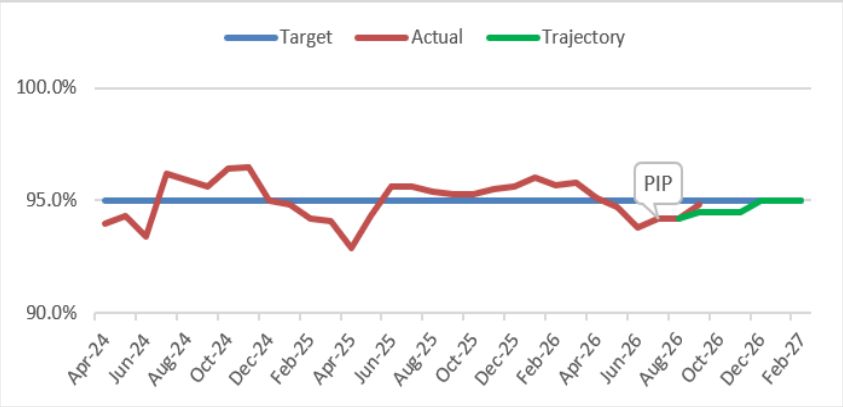
RTT and RTA Tuesday meetings to be chaired by Associate Director going forward to fully assess the challenges and support needed for consistency.

M06 Update:
Directorate has met with the community directorate to share learning of successful improvement.

M06 Update: The PIP is closed due to 3 months compliance.

Performance Improvement Plan: Risk Assessment (Trust indicator)

Specialist Services directorate



A PIP was requested in M05 (2026/27).

Performance in M06 improved to 94.8% and continues to demonstrate sustained improvement. While performance remains marginally below the required standard, the overall trajectory is positive, and the directorate remains on track to achieve compliance by December.

The aim is for the standard to be achieved by December 2026.

Trajectory milestone has been set in M05 (Sept-Feb 2027).

Updated actions have been provided in M06.

	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	Jan-27	Feb-27
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%	95.0%
Actual	95.3%	95.3%	95.5%	95.6%	96.0%	95.7%	95.8%	95.1%	94.7%	93.8%	94.2%	94.2%	94.8%					
Trajectory												94.2%	94.5%	94.5%	94.5%	95.0%	95.0%	95.0%

Actions M06:

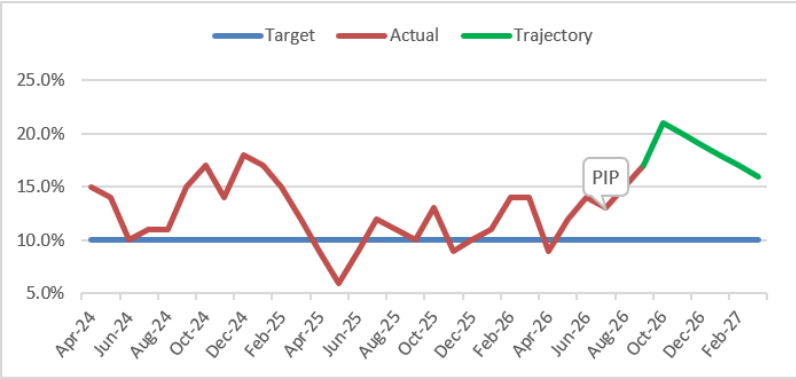
CLDT non-compliant practitioners have been identified and action taken. Targeted actions are being addressed through supervision to improve adherence and consistency, plan being monitored by the deputy team lead.

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.

Cancer Psychology: non-compliant practitioners have been identified, and informal action plan is in place to support a sustained improvement. Performance Improvement Plan: Talking Therapies for Anxiety and Depression (90 days wait in treatment - National indicator).

Performance Improvement Plan: Talking Therapies for Anxiety and Depression 90 Day Waits in Treatment (National Indicator)

Primary Care directorate



A PIP was requested in M05 (2026/27).

Performance during M06 is 17.0% and has not met the required standard.

The aim is for the standard to be achieved by September 2027.

Trajectory milestones have been set in M06 (Sept-2026-Sep 2027).

Updated actions have been provided in M06.

	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	Jan-27	Feb-27	Mar-27
Target	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Actual	10.0%	13.0%	9.0%	10.0%	11.0%	14.0%	14.0%	9.0%	12.0%	14.0%	13.0%	15.0%	17.0%						
Trajectory													17.0%	21.0%	20.0%	19.0%	18.0%	17.0%	16.0%

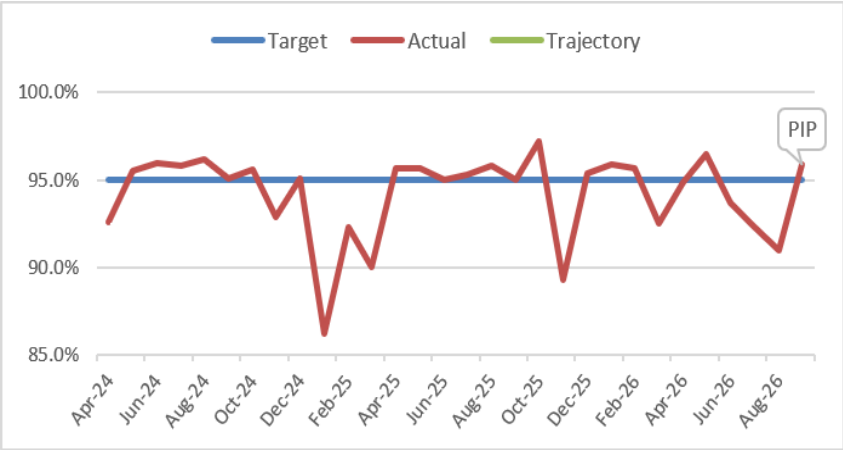
M06 Actions:

The team continue to review the utilisation of the 100 slots provided by Stoke Talking Therapies, recognising that waits for step 2 services remain very low across Stoke and North Staffs teams. The slots have now been converted into 30 step 3 treatment slots for North Staffs. Any remaining slots have been given back to Stoke to support their assessment waits, recognising that teams are also supporting Ascend assessments.

The teams are booking into the treatment slots from September, concentrating on the longest waits first. Positive impact is noted in terms of the longest waits although the percentage for longest waits continues increase as clients are added to the waiting list.

Performance Improvement Plan: MH Liaison 1-hour response (Trust indicator)

Acute and Urgent Care directorate



A PIP was requested in M06 (2026/27).

Performance during M06 is 95.9% and is meeting the required standard.

Trajectory milestones have been requested.

Updated actions have been provided in M06.

	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%
Actual	95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%	93.7%	92.3%	91.0%	95.9%
Trajectory													

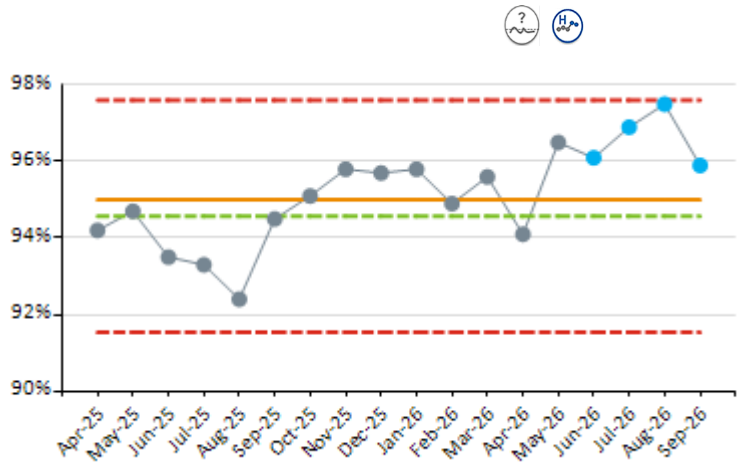
M06 Actions:

- Complete detailed analysis of all breaches during July-Sept 2026, including breach numbers, day/time, referral priority, response/ allocation delay, staffing level, assessment duration, ED factors and recording delay (deadline 31.10.2026).
- Clarify and reinforce prioritisation of emergency referrals for the internal standard: a documented MHLT response within 1 hour. Monitor face-to-face contacts within 1 hour separately for the national NOF measure.
- Complete referral demand and capacity review, mapping hourly/day-of-week demand against rostered clinical capacity; identify peak periods and agree roster changes (deadline 31.12.2026).
- Evaluate twilight shift using referral and breach data; confirm whether current hours/days match peak demand and implement agreed changes (deadline 30.11.2026).
- Complete review of flexible working arrangements against service demand, make recommendations and implement agreed roster changes. (deadline 30.11.2026).
- Introduce daily review of every 1-hour breach, with cause coded, immediate recovery action recorded and repeat themes escalated to directorate leadership team.
- Undertake monthly audit of documentation and time recording, checking referral received, response and face to face timestamps and correcting process gaps.
- Develop and implement a demand/capacity escalation process with defined triggers and actions for periods when referrals exceed available staffing (deadline 31.01.2027).
- Agree joint MHLT/ED review of breach themes and patient-flow constraints, with named actions for factors requiring cross-service resolution (first review by 30.11.2026).
- Review actual performance against recovery trajectory at Directorate Performance Meeting and escalate variance or failure to improve, including workforce mitigation where indicated.

Core Indicators – SPC Trend (Achieved in Month)

Core Indicators – SPC Trend (Access and Waiting Times)

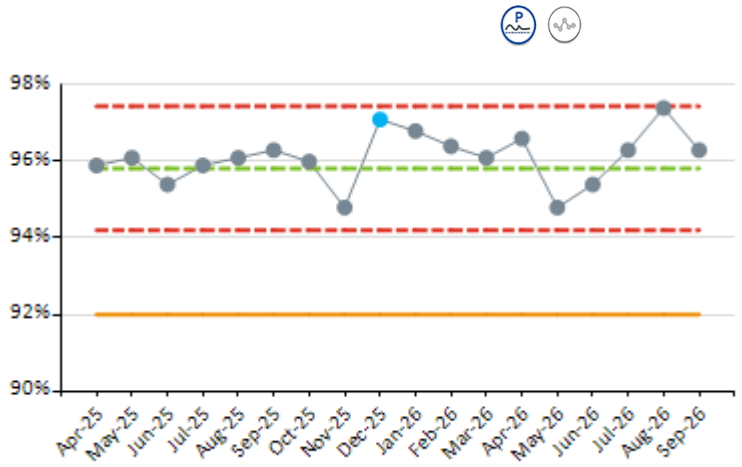
Referral to Assessment within 4 weeks (Trust Measure)



13 Month Trend

94.5%	95.1%	95.8%	95.7%	95.8%	94.9%	95.6%	94.1%	96.5%	96.1%	96.9%	97.5%	95.9%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

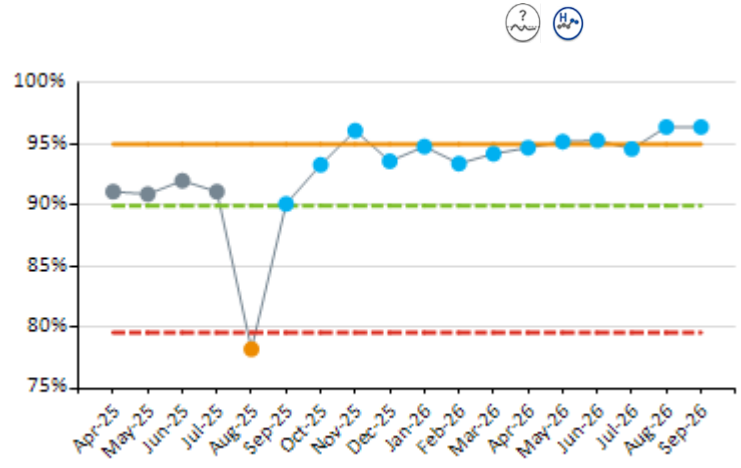
Referral to Treatment within 18 weeks (Trust Measure)



13 Month Trend

96.3%	96.0%	94.8%	97.1%	96.8%	96.4%	96.1%	96.6%	94.8%	95.4%	96.3%	97.4%	96.3%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

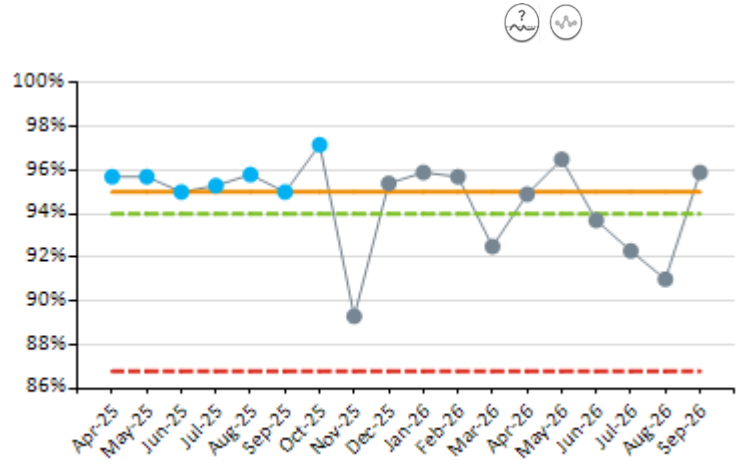
CAMHS Compliance within 4 week waits (Referral to Assessment) (Trust Measure)



13 Month Trend

90.1%	93.3%	96.1%	93.6%	94.8%	93.4%	94.2%	94.7%	95.2%	95.3%	94.6%	96.4%	96.4%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

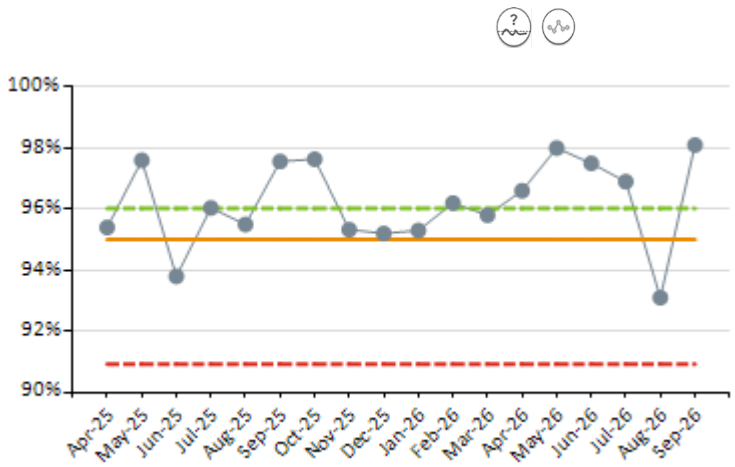
MH Liaison 1 Hour Response (Emergency) (Trust Measure)



13 Month Trend

95.0%	97.2%	89.3%	95.4%	95.9%	95.7%	92.5%	94.9%	96.5%	93.7%	92.3%	91.0%	95.9%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

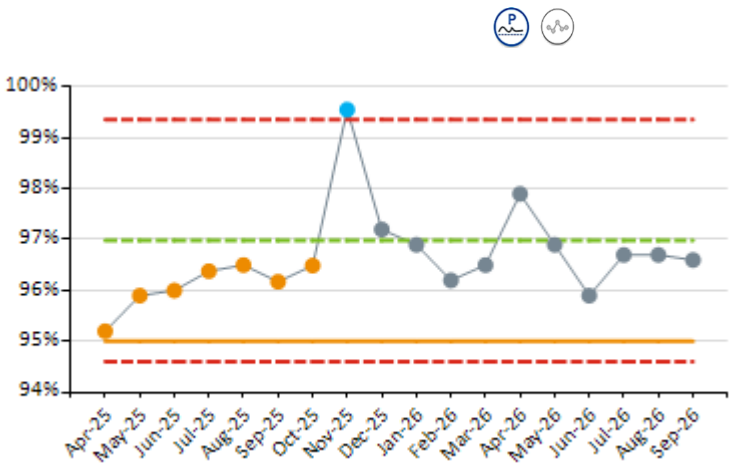
MH Liaison 4 Hour Response (Urgent) (Trust Measure)



13 Month Trend

97.6%	97.6%	95.3%	95.2%	95.3%	96.2%	95.8%	96.6%	98.0%	97.5%	96.9%	93.1%	98.1%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

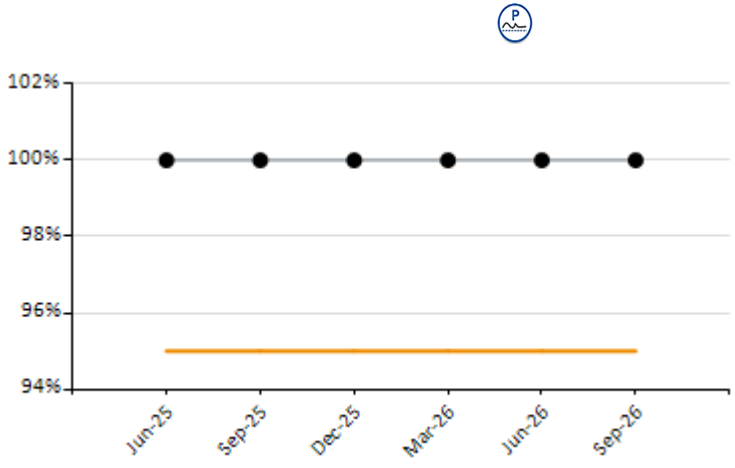
MH Liaison 24 Hour Response (Urgent from General Hospital Ward) (Trust Measure)



13 Month Trend

96.2%	96.5%	99.6%	97.2%	96.9%	96.2%	96.5%	97.9%	96.9%	95.9%	96.7%	96.7%	96.6%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

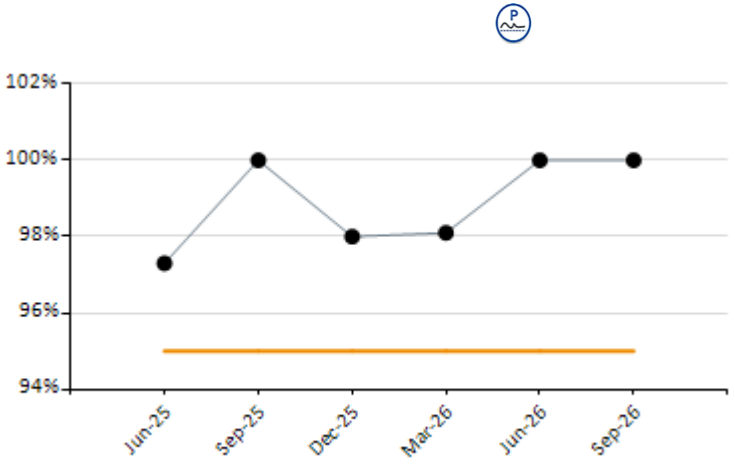
CYP: Eating Disorders - Referral to Assessment (Urgent) 1 Week (National Measure)



13 Month Trend

100.0%	100.0%	100.0%	100.0%	100.0%
Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27

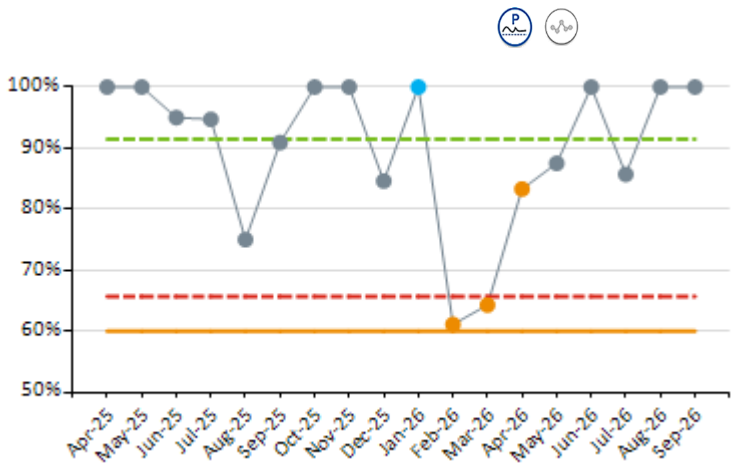
CYP: Eating Disorders - Referral to Assessment (Routine) 4 Weeks (National Measure)



13 Month Trend

100.0%	98.0%	98.1%	100.0%	100.0%
Q2 25/26	Q3 25/26	Q4 25/26	Q1 26/27	Q2 26/27

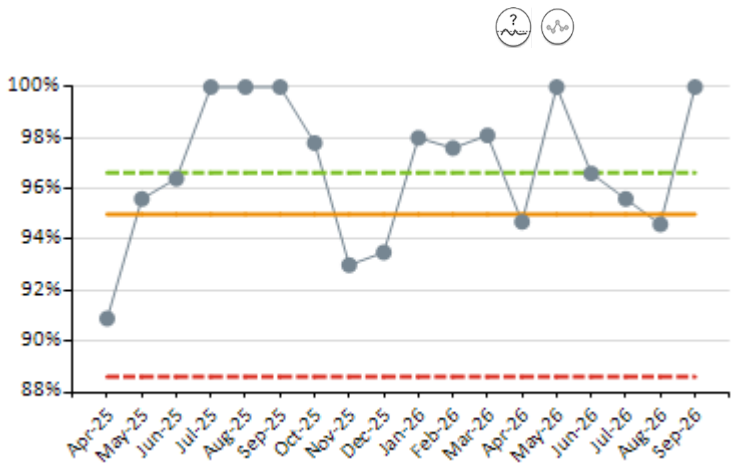
Early Intervention - A Maximum of 2 Week Waits for Referral to Treatment (National Measure)



13 Month Trend

90.9%	100.0%	100.0%	84.6%	100.0%	61.1%	64.3%	83.3%	87.5%	100.0%	85.7%	100.0%	100.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

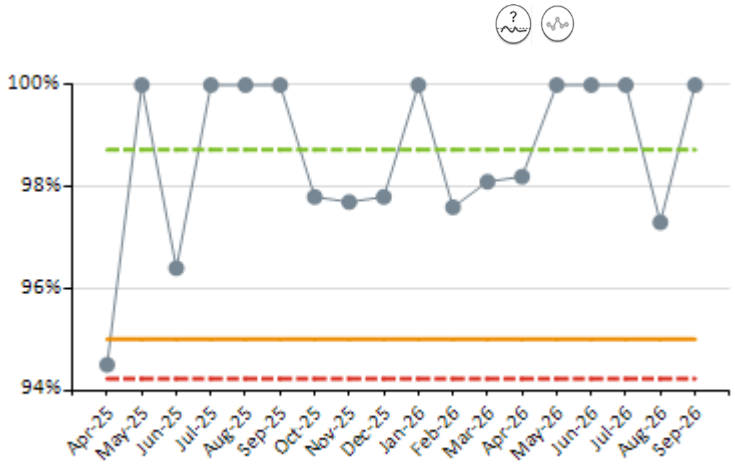
48 Hour Follow Up (Trust Measure)



13 Month Trend

100.0%	97.8%	93.0%	93.5%	98.0%	97.6%	98.1%	94.7%	100.0%	96.6%	95.6%	94.6%	100.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

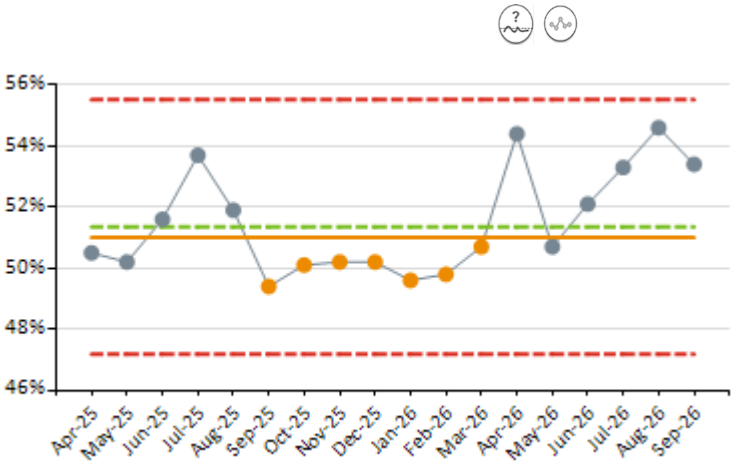
7 Day Follow Up (All Patients) (Trust Measure)



13 Month Trend

100.0%	97.8%	97.7%	97.8%	100.0%	97.6%	98.1%	98.2%	100.0%	100.0%	100.0%	97.3%	100.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

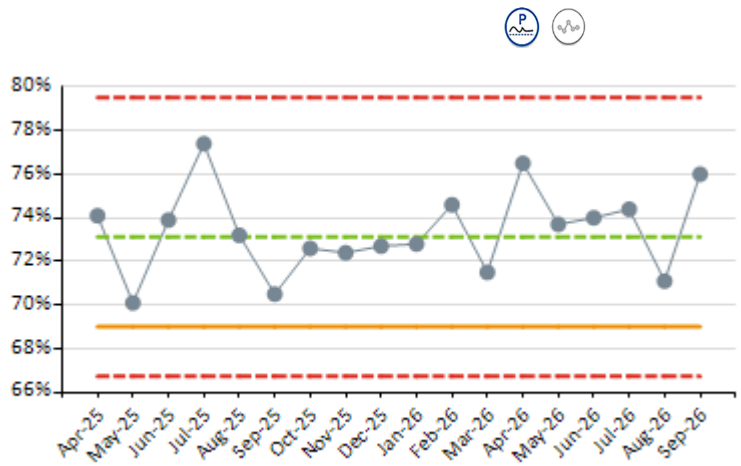
Talking Therapies for Anxiety and Depression: Reliable Recovery (National Measure)



13 Month Trend

49.4%	50.1%	50.2%	50.2%	49.6%	49.8%	50.7%	54.4%	50.7%	52.1%	53.3%	54.6%	53.4%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

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

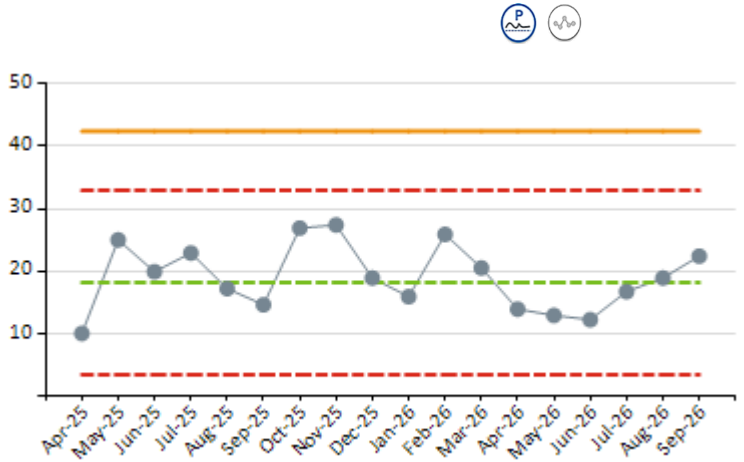


13 Month Trend

70.5%	72.6%	72.4%	72.7%	72.8%	74.6%	71.5%	76.5%	73.7%	74.0%	74.4%	71.1%	76.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Core Indicators – SPC Trend (Inpatient and Quality)

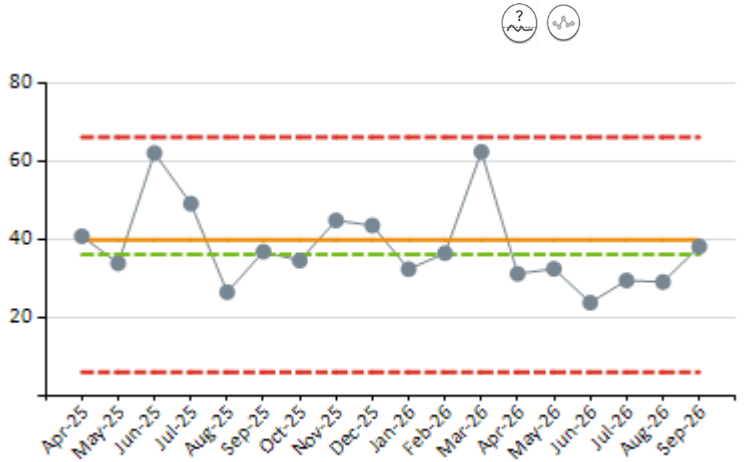
Median Length of Stay - Adult (National Measure)



13 Month Trend

14.6	26.9	27.4	18.9	15.9	25.9	20.5	13.9	12.9	12.2	16.7	18.9	22.4
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

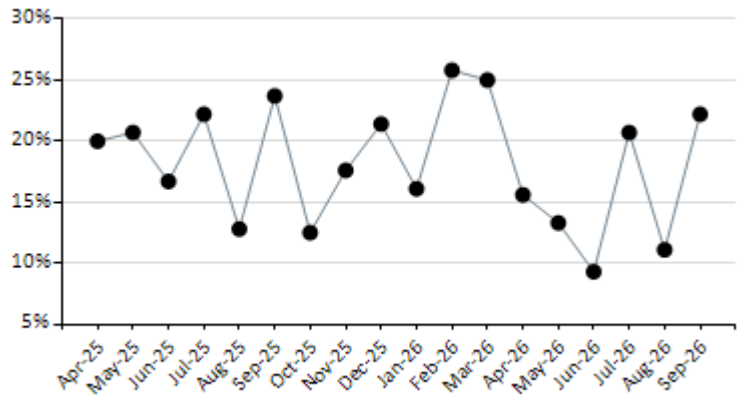
Average Length of Stay - Adult (National Measure)



13 Month Trend

37.0	34.7	45.0	43.7	32.5	36.6	62.6	31.3	32.6	23.9	29.6	29.2	38.3
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

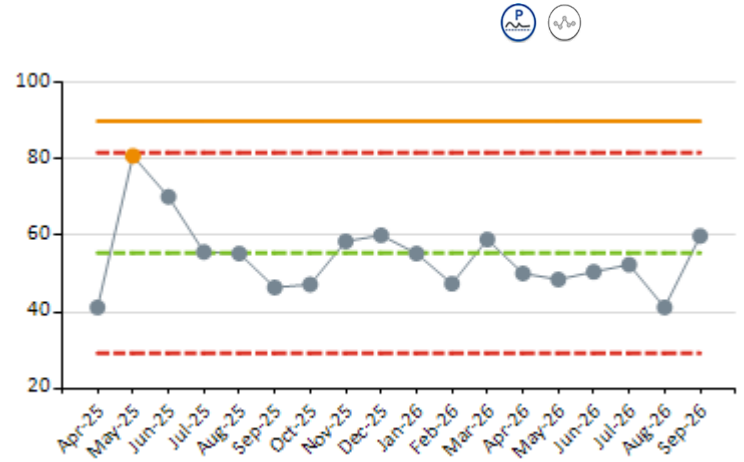
Adult Acute LoS-Over 60 days as a % of all discharges (National Measure)



13 Month Trend

23.7%	12.5%	17.6%	21.4%	16.1%	25.8%	25.0%	15.6%	13.3%	9.3%	20.7%	11.1%	22.2%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

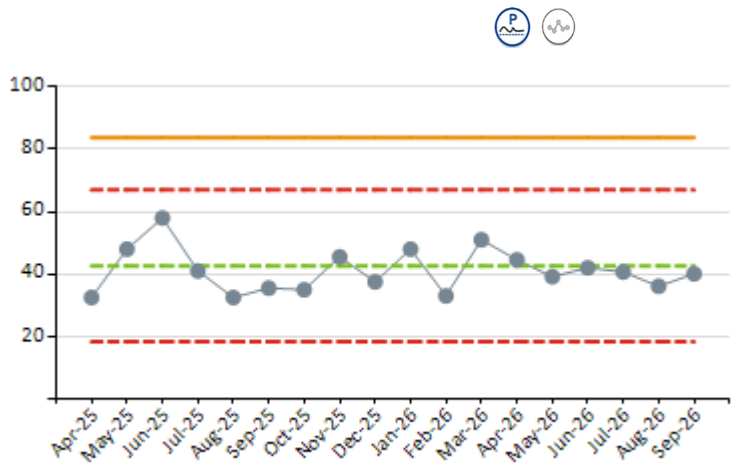
Average Length of Stay - Older Adult (National Measure)



13 Month Trend

46.4	47.2	58.5	60.1	55.3	47.4	59.0	50.1	48.5	50.5	52.4	41.2	59.9
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

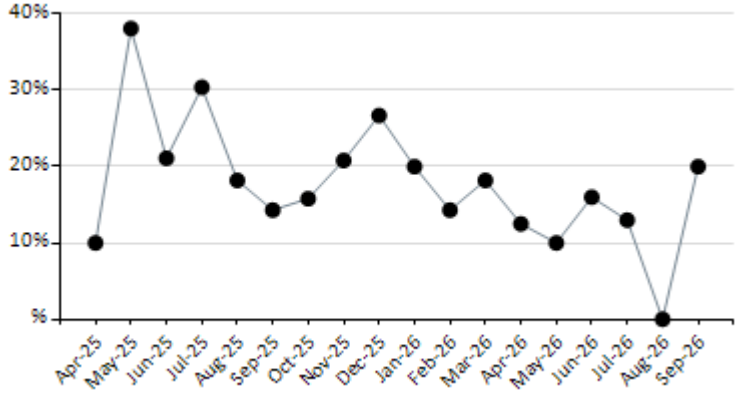
Median Length of Stay - Older Adult (National Measure)



13 Month Trend

35.5	35.0	45.5	37.5	48.0	33.0	51.0	44.6	39.2	42.0	40.7	36.1	40.1
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

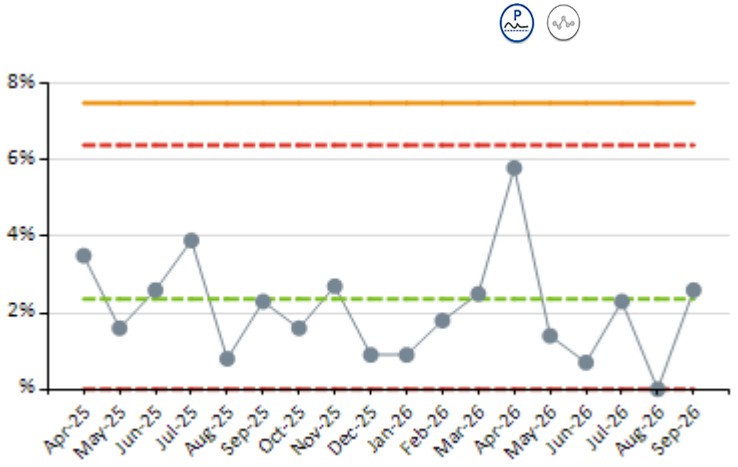
Older Adult Acute LoS-Over 90 days as a % of all discharges (National Measure)



13 Month Trend

14.3%	15.8%	20.8%	26.7%	20.0%	14.3%	18.2%	12.5%	10.0%	16.0%	13.0%	0.0%	20.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

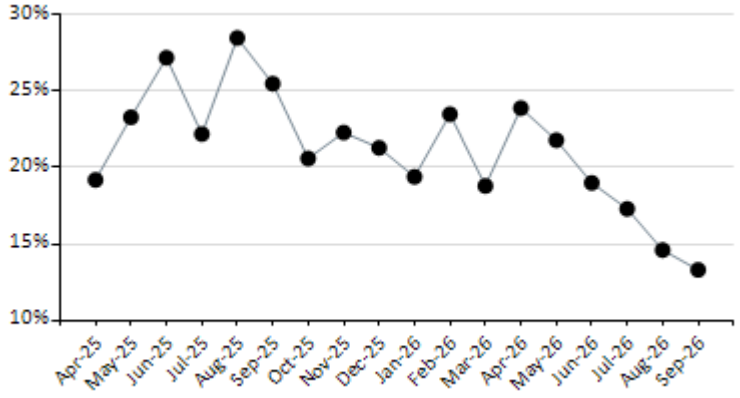
Emergency Readmissions rate (30 days) (Trust Measure)



13 Month Trend

2.3%	1.6%	2.7%	0.9%	0.9%	1.8%	2.5%	5.8%	1.4%	0.7%	2.3%	0.0%	2.6%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Clinically Ready for Discharge (CRFD) (Trust Measure)

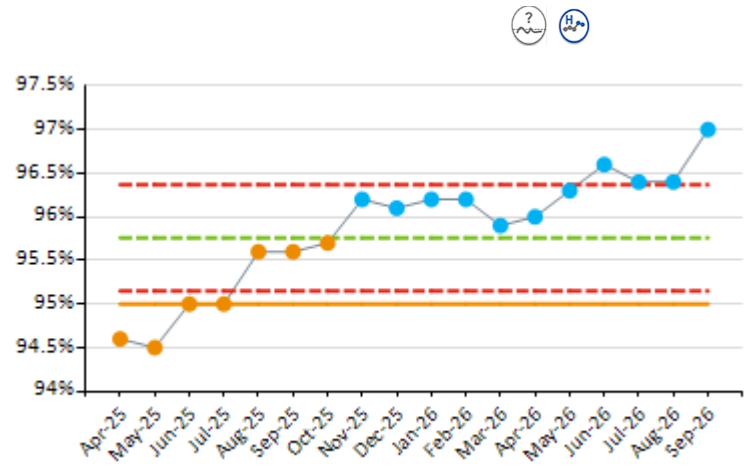


13 Month Trend

25.5%	20.6%	22.3%	21.3%	19.4%	23.5%	18.8%	23.9%	21.8%	19.0%	17.3%	14.6%	13.3%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Core Indicators – SPC Trend (Community and Quality)

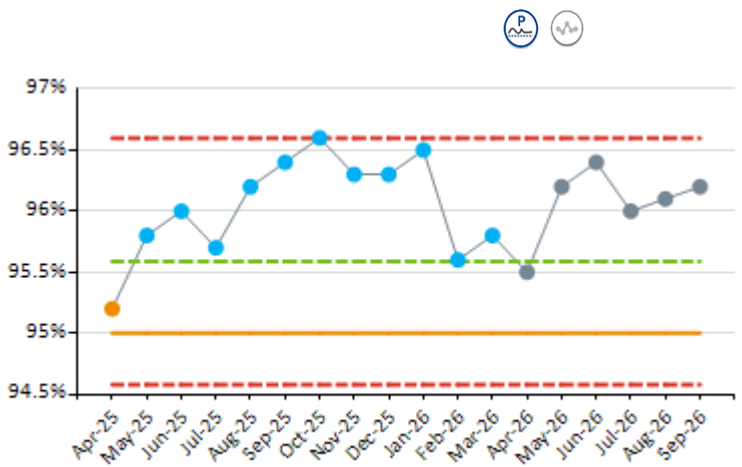
Care Plan Compliance (Trust Measure)



13 Month Trend

95.6%	95.7%	96.2%	96.1%	96.2%	96.2%	95.9%	96.0%	96.3%	96.6%	96.4%	96.4%	97.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Risk Assessment Compliance (Trust Measure)

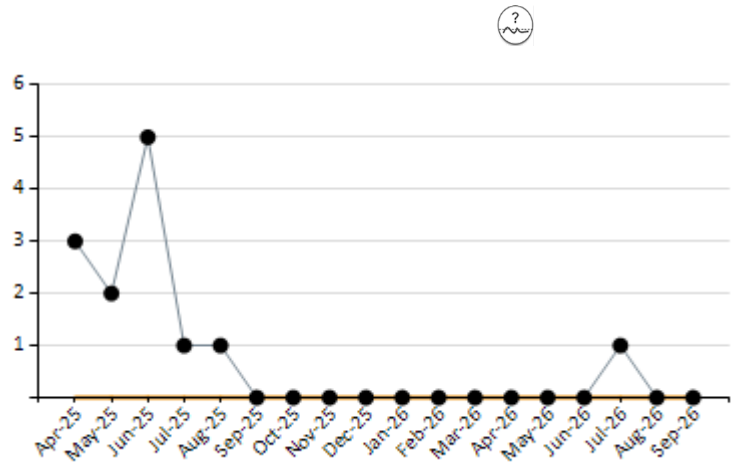


13 Month Trend

96.4%	96.6%	96.3%	96.3%	96.5%	95.6%	95.8%	95.5%	96.2%	96.4%	96.0%	96.1%	96.2%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

Core Indicators – SPC Trend (Organisational Health)

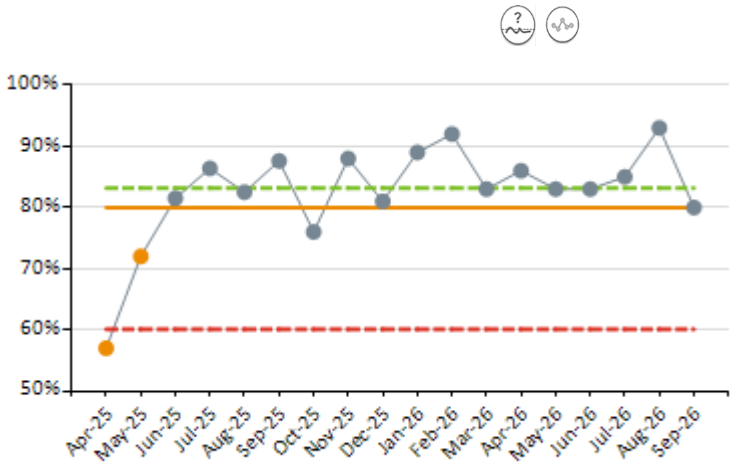
Complaints Open Beyond Agreed Timescale (Trust Measure)



13 Month Trend

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

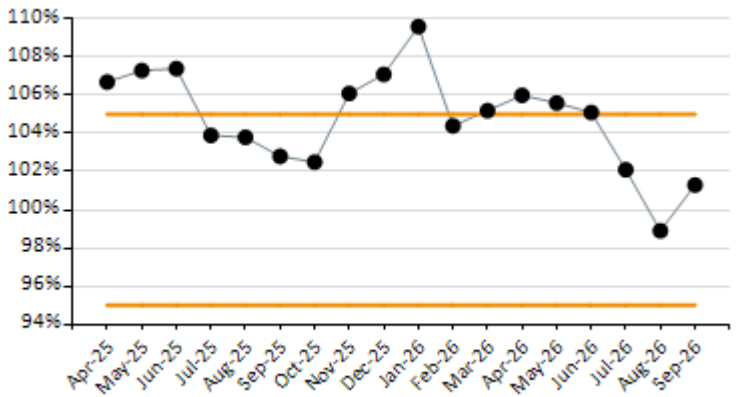
Friends and Family Test - Recommended (Trust Measure)



13 Month Trend

87.6%	76.0%	88.0%	81.0%	89.0%	92.0%	83.0%	86.0%	83.0%	83.0%	85.0%	93.0%	80.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

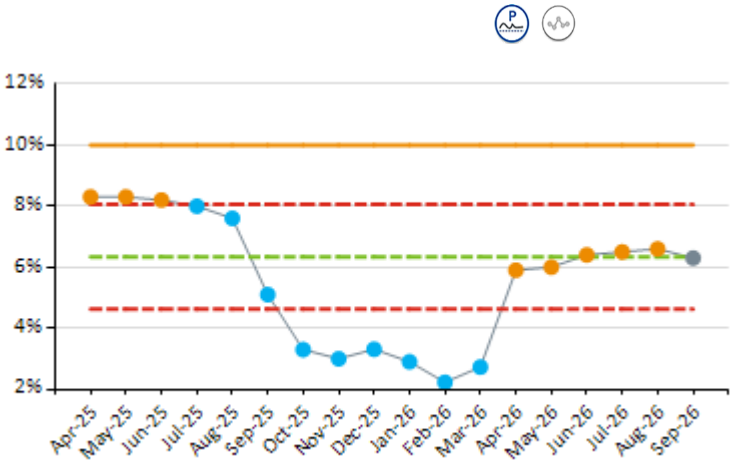
Safe Staffing (National Measure)



13 Month Trend

102.8%	102.5%	106.1%	107.1%	109.6%	104.4%	105.2%	106.0%	105.6%	105.1%	102.1%	98.9%	101.3%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

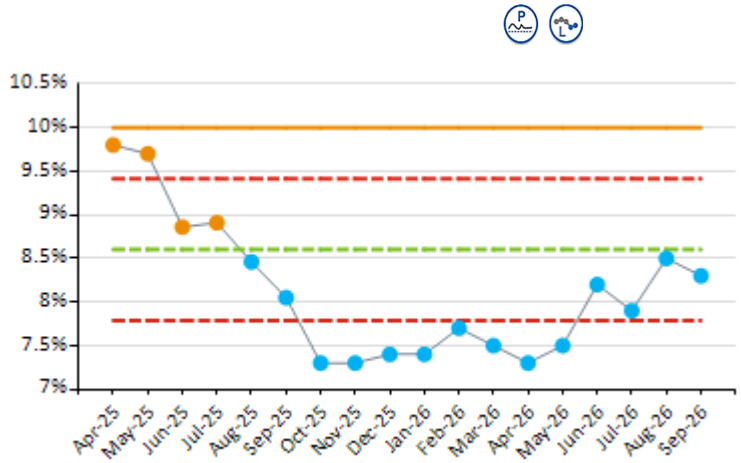
Vacancy Rate (Trust Measure)



13 Month Trend

5.1%	3.3%	3.0%	3.3%	2.9%	2.2%	2.7%	5.9%	6.0%	6.4%	6.5%	6.6%	6.3%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

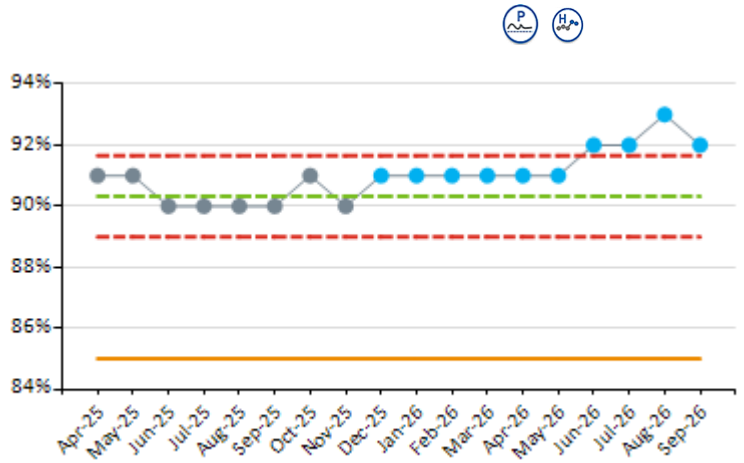
Staff Turnover (Trust Measure)



13 Month Trend

8.1%	7.3%	7.3%	7.4%	7.4%	7.7%	7.5%	7.3%	7.5%	8.2%	7.9%	8.5%	8.3%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

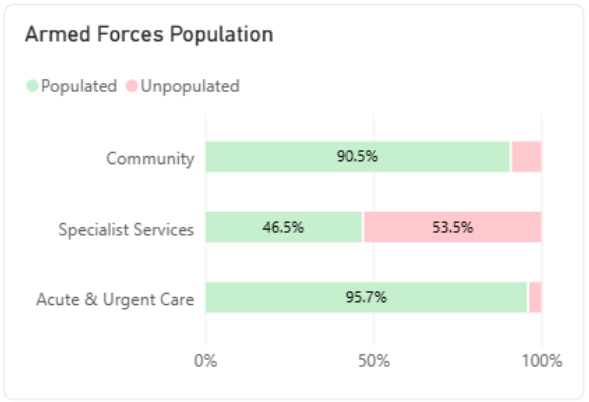
Statutory & Mandatory Training (Trust Measure)

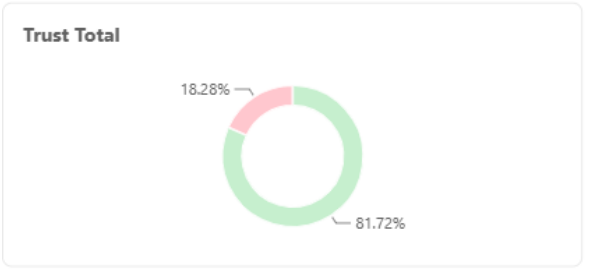


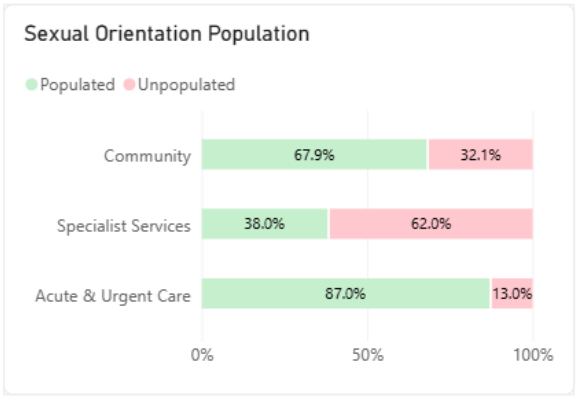
13 Month Trend

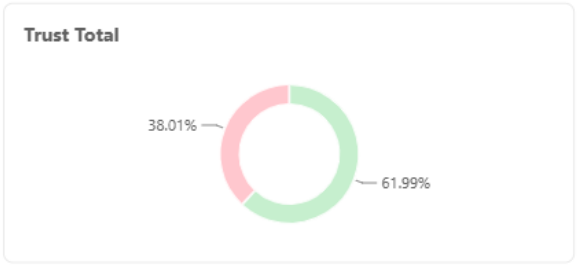
90.0%	91.0%	90.0%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%	92.0%	93.0%	92.0%
Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep

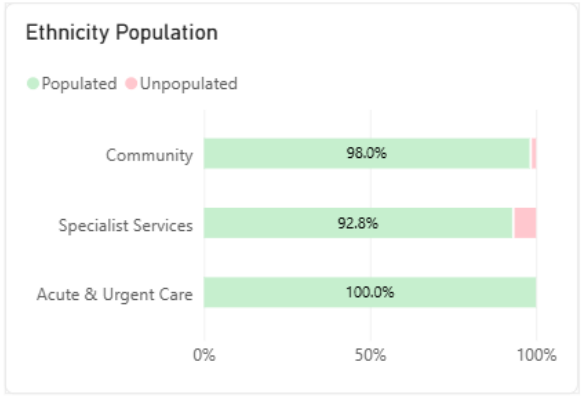
Data Quality Master – Patient Demographic Information

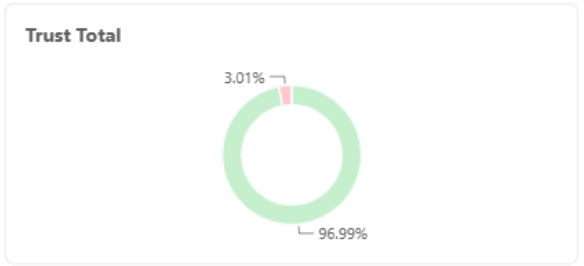


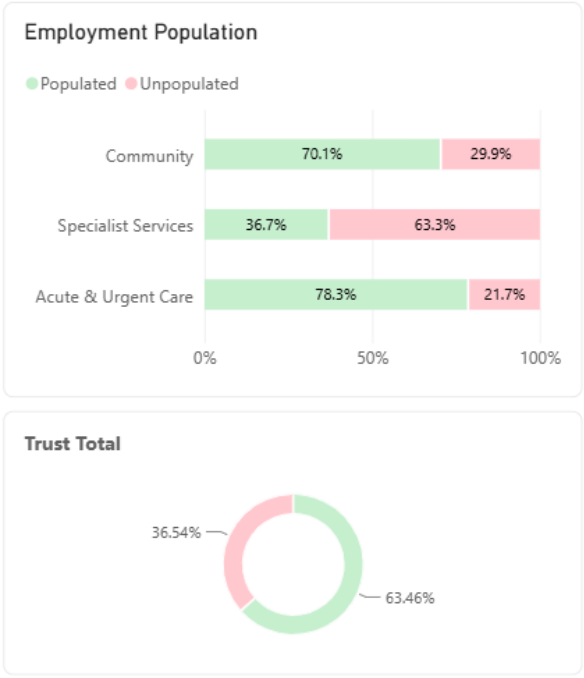


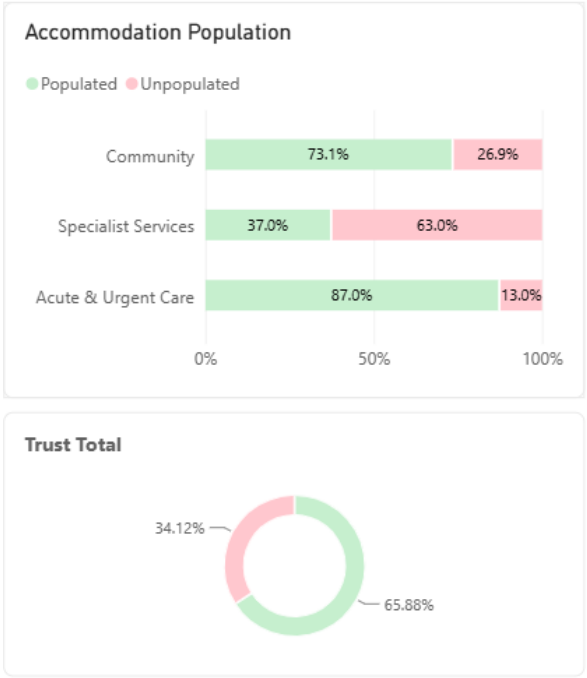












Keele University Teaching Trust

NHS North Staffordshire Combined Healthcare NHS Trust

Enclosure No: 10

FINANCE POSITION MONTH 6

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

Report to:	Public Trust Board
Date of Meeting:	12 November 2026

Presented by:	Eric Gardiner – Chief Finance Officer
Prepared by:	Michelle Wild – Financial Controller Rachel Heath – Project Accountant Lisa Dodds – Deputy 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:	SLT
Strategic Priorities:	Growth - We will continue to grow high-quality, integrated services delivered by an innovative and sustainable workforce
Key Enablers:	Sustainability - We will increase our efficiency and effectiveness through sustainable development
Sustainability:	Share learning and best practice
Resource Implications:	No
Diversity & Inclusion Implications:	This paper has neither a positive or negative impact on EDI.
ICS Alignment / Implications:	N/A.

Recommendation / Required Action:	Receive the Month 6 financial position noting: • A year to date deficit of £224k against a planned deficit of £247k, resulting in a favourable variance of £23k. • An underlying financial position (ULP) deficit of £783k. • Agency expenditure of £426k, against planned expenditure of £522k, resulting in a favourable variance of £96k. • Bank expenditure of £3,089k against planned expenditure of £2,526k, resulting in an adverse variance of £563k. • Year to date CIP delivery of £2,941k against a plan of £3,533k, resulting in an adverse variance of £592k. • Capital expenditure of £225k which is £1,726k behind plan. • A cash balance of £40,220k on 30th September 2026.
Executive Summary:	The purpose of the paper is to update the Committee/Board on the monthly financial position. This includes the in month revenue and capital expenditure, bank and agency expenditure including the historic trends and forecast. The paper also includes the balance sheet and forecast year-end position, including a range or forecast scenarios. The Adjusted Financial Performance in month shows a surplus of £74k, against a planned surplus of £141k, resulting in an adverse variance of £67k. The year-to-date position remains broadly in line with plan with a deficit of £224k against a planned deficit of £247k, resulting in a favourable variance of £23k. The Trust is reporting an underlying financial position (ULP) deficit of £783k, reflecting current efficiency assumptions. The Trust has a recurrent CIP target of £6.3m, a non-recurrent target of £1.5m. At Month 6 the Trust is forecasting full delivery of the £7.8m CIP target. Of this, £5.6m is implemented and £2.2m is fully developed. However, 11% of the CIP target remains classified as high risk. In month agency expenditure was £68k against planned expenditure of £87k, resulting in a favourable variance of £19k against the 32% agency expenditure reduction from 2025/26. In month bank expenditure was £535k against planned expenditure of £421k, resulting in an adverse variance of £114k against the 20% bank expenditure reduction from 2025/26. The Trust's capital expenditure year to date was £225k which is £1,726k behind plan. The Trust is forecasting to spend to plan. The cash position of the Trust on 30th September 2026 is £40,220k.

	Key Messages: • Financial position is on plan. • Bank expenditure is over plan by £563k. • 11% (£0.9m) of the CIP target is classified as high risk.

VERSION CONTROL:

Version	Report to	Date Reported
1	SLT	20/10/2026
1	Finance & Resource Committee	30/10/2026
1	Public Trust Board	06/11/2026

North Staffordshire Combined Healthcare NHS Trust

PUBLIC TRUST BOARD – 12th November 2026 Finance Position Month 6

Finance Position

Introduction

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

Finance Position

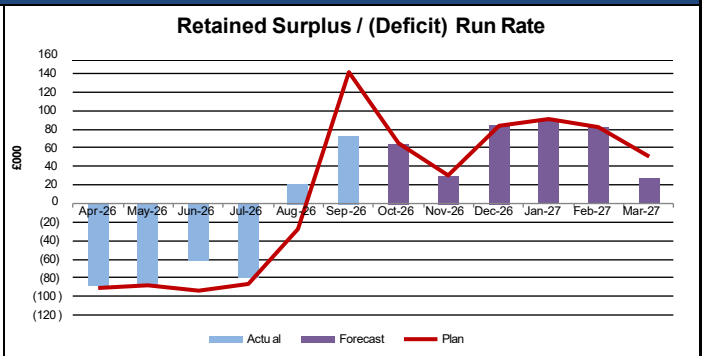
Executive Summary

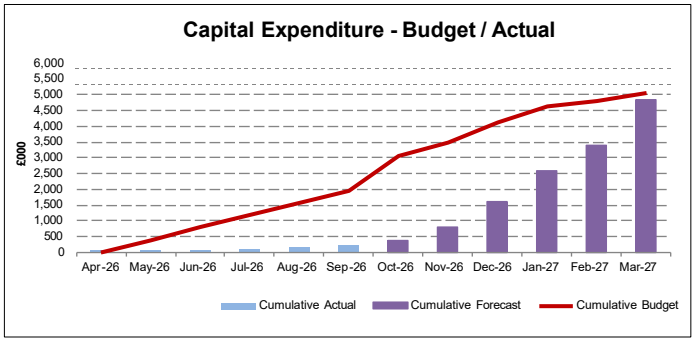
North Staffordshire Combined Healthcare NHS Trust

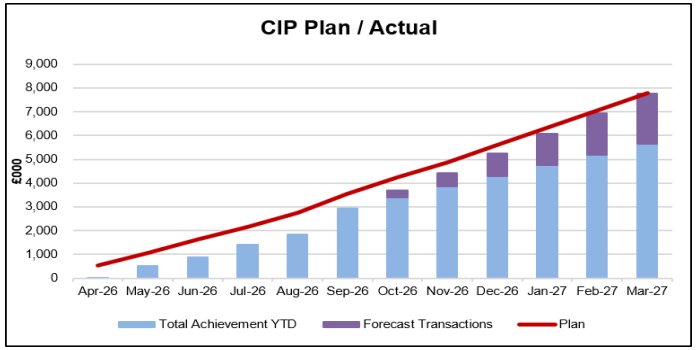
Financial Overview as at 30th September 2026

Key Metrics

£000	M4	M5	M6	YTD	Average	Forecast	FOT RAG
Variance to Plan							
In month financial position	7	48	(67)	23	4		
YTD financial position	42	91	23	23	32	(0)	
Run Rates (Actuals)							
Income	15,005	15,381	15,643	91,569	15,262	183,733	
Pay	(9,453)	(9,502)	(9,598)	(57,012)	(9,502)	(114,285)	
Non-pay	(5,342)	(5,556)	(5,678)	(32,978)	(5,496)	(65,689)	
Finance & Other Non Operating	(244)	(255)	(247)	(1,526)	(254)	(3,077)	
Agency (Actuals)	(66)	(66)	(68)	(426)	(71)	(755)	
Agency Variance To Plan	**21**	**21**	**19**	**96**	**16**	**298**	
Medical Agency	26	23	22	111	19	322	
Nurse Agency	(5)	(1)	(3)	(15)	(2)	(2)	
Other Agency	0	0	0	0	0	(22)	
Non Clinical Agency	0	0	0	0	0	0	
Bank (Actuals)	(499)	(492)	(535)	(3,089)	(515)	(5,370)	
Bank Variance To Plan	**(78)**	**(71)**	**(114)**	**(563)**	**(94)**	**(326)**	
Medical Bank	(11)	(12)	(1)	(36)	(6)	104	
Nurse Bank	(33)	(41)	(52)	(275)	(46)	(205)	
Other Clinical Bank	(37)	(17)	(63)	(263)	(44)	(258)	
Non Clinical Bank	3	(0)	3	11	2	33	
CIP (Variance)	(13)	(145)	317	(592)	(99)	0	
Cash balance	40,726	41,142	40,220	41,142	40,128	30,677	
Capital expenditure (Variance)	372	310	313	1,726	288	(0)	
BPPC							
Number	94.9%	91.7%	92.7%	94.0%	94.6%		
Value	98.1%	96.6%	86.4%	95.5%	96.3%		







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

Finance Position

Income & Expenditure Position

NHS North Staffordshire Combined Healthcare NHS Trust

High Level Analysis	Annual Plan £000	In Month Budget £000	In Month Actuals £000	Variance £000	Year to Date Budget £000	Year to Date Actuals £000	Variance £000	Forecast Budget £000	Forecast Actuals £000	Variance £000
Income from Patient Care Activities	163,888	14,934	14,201	(732)	83,934	82,850	(1,084)	167,891	165,960	(1,931)
Income from Other Operating Activities	16,049	1,484	1,442	(42)	8,611	8,719	108	17,003	17,773	770
Income	**179,937**	**16,417**	**15,643**	**(775)**	**92,545**	**91,569**	**(976)**	**184,894**	**183,733**	**(1,161)**
Pay Costs	(111,104)	(9,716)	(9,598)	118	(57,864)	(57,012)	852	(114,692)	(114,285)	407
Non Pay Costs	(64,860)	(6,243)	(5,678)	564	(33,011)	(32,979)	32	(66,228)	(65,689)	540
Operating Expenditure	**(175,964)**	**(15,958)**	**(15,276)**	**682**	**(90,875)**	**(89,991)**	**884**	**(180,920)**	**(179,973)**	**947**
EBITDA	**3,973**	**459**	**367**	**(93)**	**1,670**	**1,578**	**(92)**	**3,973**	**3,759**	**(214)**
Finance & Other Non Operating Costs	(3,207)	(267)	(247)	20	(1,604)	(1,526)	77	(3,207)	(3,077)	130
Retained Surplus / (Deficit)	**766**	**192**	**119**	**(73)**	**66**	**51**	**(15)**	**766**	**683**	**(83)**
Add Back Impairments	0	0	0	0	0	0	0	0	0	0
Surplus/(deficit) before impairments	**766**	**192**	**119**	**(73)**	**66**	**51**	**(15)**	**766**	**683**	**(83)**
Technical Adjustments	(612)	(51)	(46)	5	(313)	(275)	38	(612)	(529)	83
Adjusted Financial Performance	**154**	**141**	**74**	**(67)**	**(247)**	**(224)**	**23**	**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.

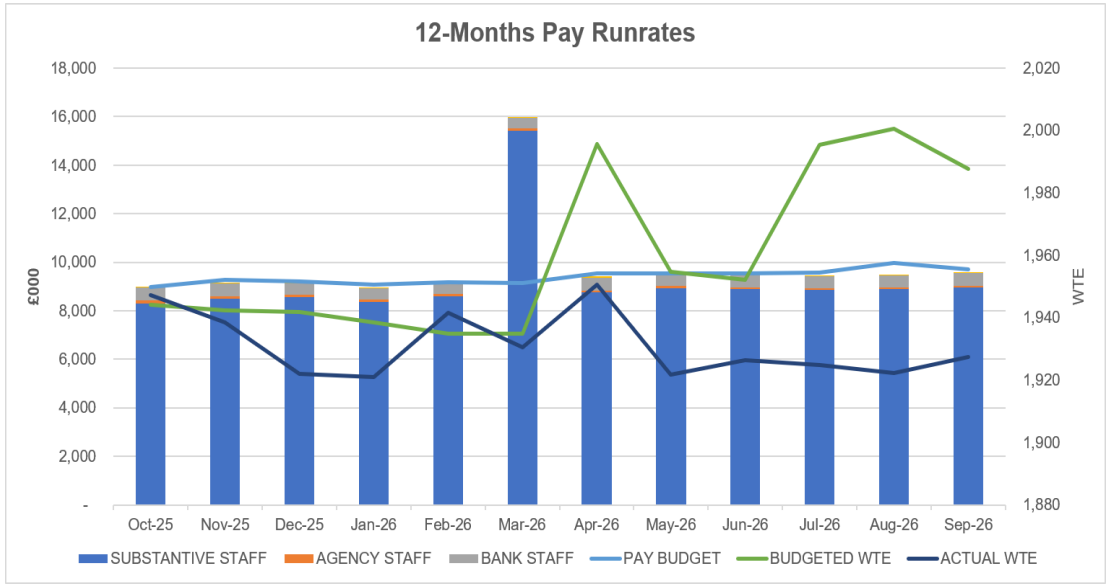
- The in-month position shows a surplus of £74k, against a planned surplus of £141k, resulting in an adverse variance of £67k. This is due the cost of corporate redundancies in month partially offset by non-recurrent mitigations.
- The year-to-date position is a deficit of £224k against a planned deficit of £247k, resulting in a favourable variance of £23k. The main driver of the underspend is additional bank interest due to a higher than planned bank balance.
- The Trust is forecasting to deliver its planned surplus of £154k at year end.
- Income is reporting an adverse variance year to date, driven by reduced patient placements income with an adverse variance year-to-date of £211k (offset with an equal reduction in patient placement expenditure) and Bridge and Beyond income with a year-to-date variance of £856k (partly matched by a non pay underspend).
- Pay expenditure is reporting a favourable variance year to date, primarily attributable to vacancy slippage.
- Non pay expenditure is reporting a small favourable variance year to date primarily due to reduced patient placements costs (offset by an equal reduction in income) and Bridge and Beyond non pay costs with a favourable variance of £502k).

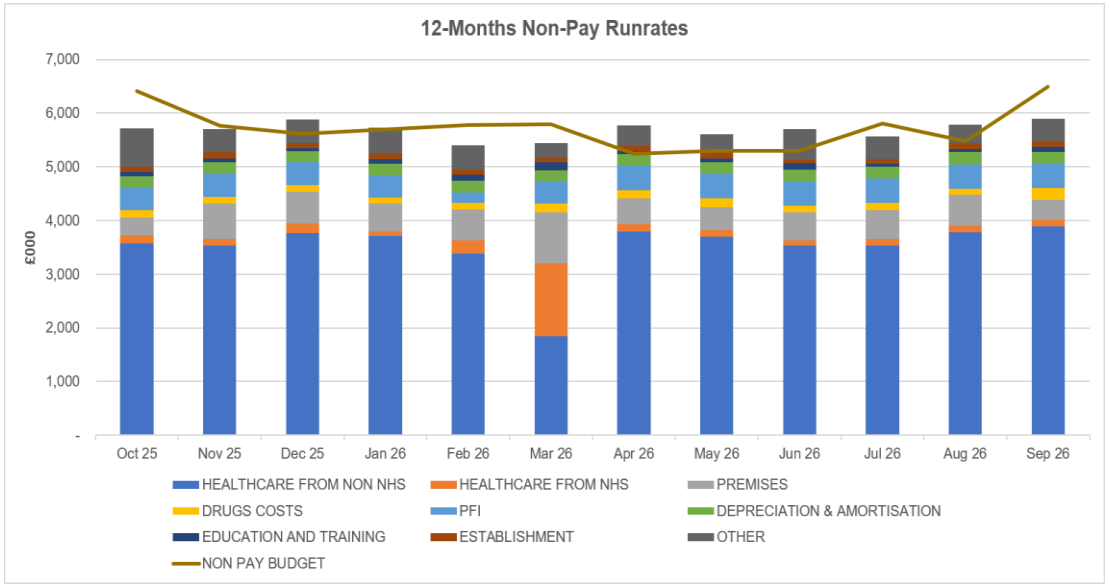
PROUD TO CARE

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Finance Position

Expenditure Run Rates





- Budgeted WTE has decreased by 12.80 wte in September due to A & T staff being deployed to other areas.
- Actual WTE has remained fairly consistent from August to September.
- Substantive staffing costs have increased by £50k in September 2026 mainly due an agreed exit package.
- Agency expenditure has remained at the same level in September, and bank expenditure has increased by £43k due to increases in Short Breaks and Community Rehab.
- Non pay budget increased in September by £1,015k as a result of Bridge and Beyond (offset by income) and the transaction of CIP schemes.
- Non pay expenditure increased by £113k in September, mainly due to an increase in TCP placement costs.

Finance Position

Forecast

North Staffordshire Combined Healthcare NHS Trust

Mitigations	Best £000	Base £000	Worse £000
Unmitigated Forecast Surplus / (Deficit)	944	944	944
Modifications to staffing projections	87	(479)	(911)
HR Provision	0	(198)	(50)
Release of balance sheet flexibilities	237	0	0
PFI	250	0	0
Potential gain share WMPC	1,384	0	0
Toucan mobilisation	0	0	(168)
Asset write off (Orbis)	0	0	(937)
Deferred Income	0	(113)	(49)
Mitigated Surplus / (Deficit)	**2,902**	**154**	**(1,171)**

- The Trust's month 6 forecast submission to NHSE reflects a surplus of £154k, in line with the agreed plan.
- The current underlying forecast indicates an unmitigated surplus of £944k. However, there are several emerging risks which are likely to impact the position including modifications to staffing projections and HR provisions. Delivery of planned year-end position will continue to be closely monitored throughout the year.
- The best-case forecast indicates the Trust could deliver a potential surplus of £2,902k. This includes no further workforce growth beyond the month 6 position, the release of further balance sheet opportunities, a PFI settlement and a potential gain share benefit with WMPC.
- The worse case forecast indicates the Trust would be in a deficit totalling £1,171k. This includes lower staff turnover rates, no release of balance sheet flexibilities, no PFI settlement, Toucan mobilisation costs with no funding and an asset write off.

PROUD TO CARE

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Finance Position

Underlying Position (ULP)

North Staffordshire Combined Healthcare NHS Trust

Heading	Income	Employee Expenses	Operating Expenses	Non Operating Items	Adjusted Position
	£000	£000	£000	£000	£000
2026/27 Forecast	183,732	(114,554)	(68,098)	(926)	**154**
Forecast non-recurring efficiencies	0	(1,989)	(1,496)	0	**(3,486)**
FYE of forecast recurring efficiencies	0	783	762	0	**1,546**
Gains and losses and donations	0	0	9	12	**21**
Non-Recurring Redundancy costs	0	269	0	0	**269**
Non-Recurring Service Delivery - Forensic Liaison Partnership	(279)	279	0	0	**0**
Non-Recurring Service Delivery - Bridge and Beyond	(247)	243	4	0	**0**
Transformation Reserve	0	665	48	0	**713**
2026/27 Underlying Position	**183,206**	**(114,304)**	**(68,771)**	**(914)**	**(783)**

- 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 £783k deficit**.

- The underlying financial position is predicated on the full year delivery of recurring efficiencies as set out in the submitted plan. The current shortfall against the full year recurring efficiency target is £1.5m.

PROUD TO CARE

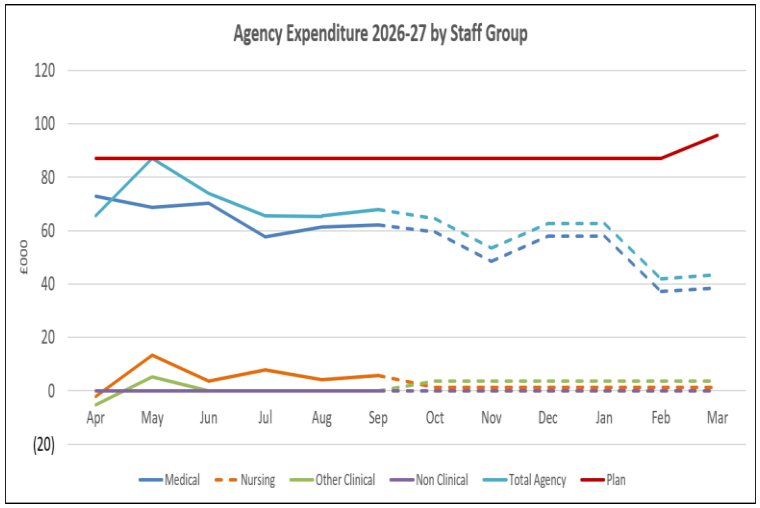
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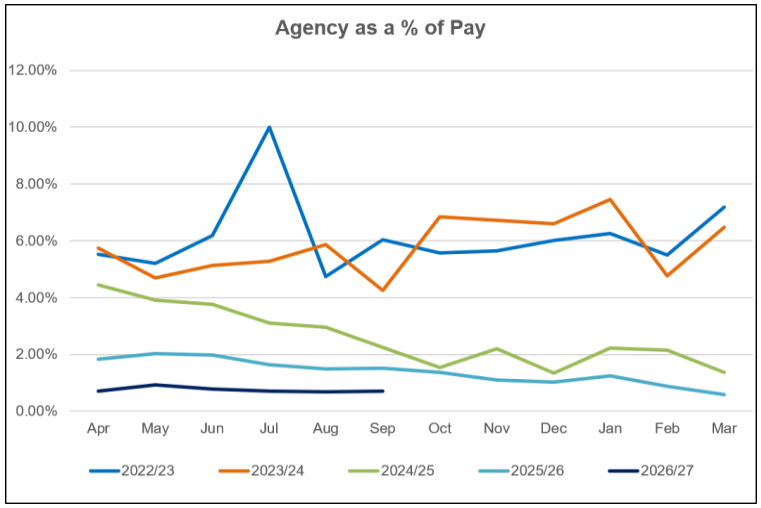
Finance Position

Agency Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

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)**	**(61)**	**(62)**	**(393)**	**(60)**	**(49)**	**(58)**	**(58)**	**(37)**	**(39)**	**(693)**
Community	(65)	(64)	(63)	(46)	(48)	(57)	**(343)**	(51)	(40)	(49)	(49)	(29)	(30)	**(591)**
Primary Care	(8)	(5)	(7)	(12)	(13)	(6)	**(50)**	(9)	(9)	(9)	(9)	(9)	(9)	**(102)**
Nursing	**2**	**(13)**	**(4)**	**(8)**	**(4)**	**(6)**	**(33)**	**(1)**	**(1)**	**(1)**	**(1)**	**(1)**	**(1)**	**(40)**
Acute Services & Urgent Care	(1)	(3)	0	0	(2)	(1)	**(7)**	(1)	(1)	(1)	(1)	(1)	(1)	**(14)**
Specialist Care	3	(10)	(4)	(8)	(2)	(5)	**(26)**	0	0	0	0	0	0	**(26)**
Other Clinical	**5**	**(5)**	**0**	**0**	**0**	**0**	**0**	**(4)**	**(4)**	**(4)**	**(4)**	**(4)**	**(4)**	**(22)**
Primary Care	0	0	0	0	0	0	**0**	(4)	(4)	(4)	(4)	(4)	(4)	**(22)**
Total Agency	**(66)**	**(87)**	**(74)**	**(66)**	**(66)**	**(68)**	**(426)**	**(64)**	**(53)**	**(63)**	**(63)**	**(42)**	**(43)**	**(755)**
Agency as a % of Pay	0.70%	0.91%	0.78%	0.69%	0.69%	0.71%	**0.75%**	0.69%	0.57%	0.66%	0.65%	0.44%	0.44%	**0.66%**
Plan	(87)	(87)	(87)	(87)	(87)	(87)	**(522)**	(87)	(87)	(87)	(87)	(87)	(96)	**(1,053)**
Variance to Plan (Overspend) / Underspend	21	(0)	13	21	21	19	**96**	23	34	24	24	45	52	**298**
Agency Variance as a % of Plan	(24.62%)	0.18%	(15.00%)	(24.59%)	(24.69%)	(22.03%)	**(18.46%)**	(25.90%)	(38.62%)	(27.86%)	(27.86%)	(51.64%)	(54.65%)	**(28.3%)**





- Planned agency expenditure for 2026/27 is £1,053k this represents a 32% reduction of 2025/26 expenditure levels.
- The in-month expenditure is £68k, against planned expenditure of £87k, resulting in a favourable variance of £19k.
- The year-to-date expenditure is £426k against planned expenditure of £522k, resulting in a favourable variance of £96k.
- Forecast agency expenditure is £755k against a plan of £1,053k resulting in a favourable variance of £298k.
- 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.

PROUD TO CARE

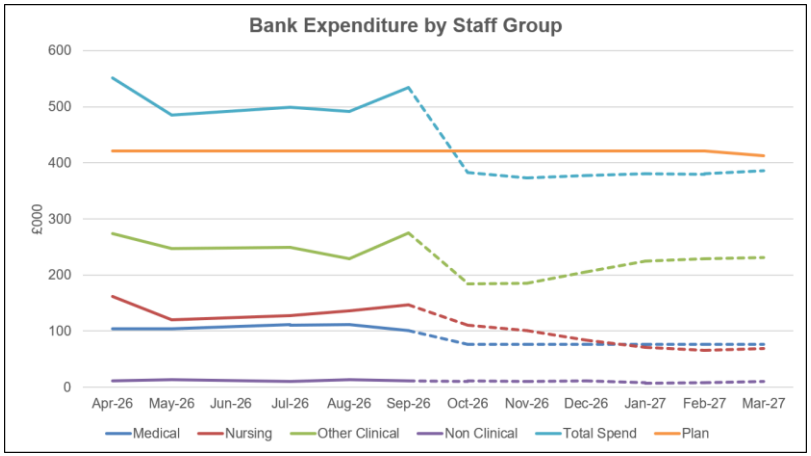
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Finance Position

Bank Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Bank Expenditure	Actual						YTD	Forecast						Total
	Apr-26 £000	May-26 £000	Jun-26 £000	Jul-26 £000	Aug-26 £000	Sep-26 £000	£000	Oct-26 £000	Nov-26 £000	Dec-26 £000	Jan-27 £000	Feb-27 £000	Mar-27 £000	
Medical	**(104)**	**(104)**	**(104)**	**(111)**	**(112)**	**(101)**	**(636)**	**(76)**	**(76)**	**(76)**	**(76)**	**(76)**	**(76)**	**(1,094)**
Acute Services & Urgent Care	(29)	(26)	13	(55)	(33)	(21)	**(150)**	(26)	(26)	(26)	(26)	(26)	(26)	**(306)**
Community	(30)	(26)	(24)	(30)	(31)	(27)	**(167)**	(28)	(28)	(28)	(28)	(28)	(28)	**(335)**
Specialist Care	(44)	(43)	(79)	(22)	(42)	(40)	**(271)**	(14)	(14)	(14)	(14)	(14)	(14)	**(357)**
Medical & Clinical Effectiveness	(1)	(9)	(13)	(5)	(6)	(13)	**(48)**	(8)	(8)	(8)	(8)	(8)	(8)	**(95)**
Nursing	**(162)**	**(121)**	**(151)**	**(128)**	**(136)**	**(147)**	**(845)**	**(110)**	**(101)**	**(84)**	**(71)**	**(66)**	**(69)**	**(1,348)**
Acute Services & Urgent Care	(114)	(92)	(102)	(84)	(92)	(97)	**(582)**	(85)	(84)	(68)	(58)	(53)	(53)	**(980)**
Community	(5)	(4)	(4)	(3)	(5)	(8)	**(29)**	(8)	0	0	0	0	(3)	**(39)**
Quality & Nursing	(0)	(0)	(0)	0	(0)	(0)	**(2)**	(0)	0	0	(0)	(0)	(0)	**(4)**
People & OD	(4)	4	(1)	(0)	(1)	0	**(2)**	0	0	0	0	0	0	**(2)**
Primary Care	(2)	(2)	(2)	(2)	(1)	(3)	**(13)**	(2)	(2)	(2)	(2)	(2)	(2)	**(23)**
Specialist Care	(37)	(25)	(41)	(39)	(37)	(38)	**(217)**	(16)	(16)	(15)	(12)	(12)	(12)	**(300)**
Other Clinical	**(273)**	**(247)**	**(261)**	**(249)**	**(229)**	**(275)**	**(1,535)**	**(185)**	**(185)**	**(206)**	**(225)**	**(229)**	**(231)**	**(2,795)**
Acute Services & Urgent Care	(157)	(144)	(137)	(133)	(115)	(166)	**(851)**	(112)	(111)	(111)	(111)	(111)	(111)	**(1,516)**
Community	0	(0)	(1)	(0)	0	(1)	**(2)**	(0)	0	0	0	0	0	**(2)**
MACE	(1)	(4)	(1)	(2)	(1)	(5)	**(13)**	(1)	(1)	(4)	(4)	(1)	(3)	**(26)**
Operations	(1)	(3)	0	0	0	0	**(4)**	0	0	0	0	0	0	**(4)**
People & OD	(5)	(2)	(3)	(2)	(3)	(3)	**(17)**	(6)	(5)	(5)	(5)	(5)	(5)	**(47)**
Specialist Care	(109)	(94)	(121)	(113)	(110)	(101)	**(648)**	(66)	(69)	(66)	(66)	(63)	(63)	**(1,039)**
Primary Care	(1)	0	0	0	0	0	**(1)**	0	0	0	0	0	0	**(1)**
Central Services	0	0	0	0	0	0	**0**	0	0	(20)	(40)	(50)	(50)	**(160)**
Non Clinical	**(12)**	**(14)**	**(12)**	**(11)**	**(14)**	**(11)**	**(73)**	**(11)**	**(11)**	**(11)**	**(9)**	**(9)**	**(10)**	**(133)**
Acute Services & Urgent Care	(1)	(1)	(0)	(0)	(0)	(2)	**(5)**	(2)	(2)	(2)	(2)	(2)	(2)	**(16)**
MACE	(0)	(0)	0	0	0	0	**(1)**	(1)	(1)	(1)	(1)	(1)	(1)	**(5)**
Quality & Nursing	(5)	(5)	(4)	(6)	(7)	(5)	**(31)**	(4)	(4)	(4)	(2)	(2)	(2)	**(47)**
People & OD	(1)	(1)	(2)	(1)	(2)	(1)	**(8)**	(2)	(2)	(2)	(2)	(2)	(2)	**(21)**
Primary Care	(3)	(3)	(3)	(1)	(2)	(1)	**(13)**	(1)	(1)	(2)	(1)	(1)	(2)	**(20)**
Finance, Performance & Estates	0	0	(0)	0	(0)	0	**(0)**	0	0	0	0	0	0	**(0)**
Specialist Care	(2)	(3)	(2)	(3)	(3)	(1)	**(14)**	(2)	(2)	(2)	(2)	(2)	(2)	**(26)**
Total Bank	**(551)**	**(485)**	**(528)**	**(499)**	**(492)**	**(535)**	**(3,089)**	**(383)**	**(373)**	**(377)**	**(381)**	**(380)**	**(386)**	**(5,370)**
Bank as a % of Pay	5.86%	5.09%	5.54%	5.28%	5.17%	5.57%	**5.42%**	4.10%	3.99%	3.98%	3.95%	3.94%	3.94%	**4.70%**
Plan	(421)	(421)	(421)	(421)	(421)	(421)	**(2,526)**	(421)	(421)	(421)	(421)	(421)	(413)	**(5,044)**
Variance to Plan (Overspend) / Underspen	(130)	(64)	(107)	(78)	(71)	(114)	**(563)**	38	48	44	40	41	27	**(326)**
Bank Variance as a % of Plan	30.86%	15.16%	25.33%	18.63%	16.76%	27.01%	**22.29%**	(9.09%)	(11.31%)	(10.39%)	(9.47%)	(9.66%)	(6.48%)	**6.5%**



- Planned bank expenditure for 2026/27 is £5,044k this represents a 20% reduction of 2025/26 expenditure levels.
- The in-month expenditure is **£535k** against planned expenditure of £421k, resulting in an **adverse variance of £114k**.
- The year-to-date expenditure is £3,089k against planned expenditure of £2,526k, resulting in an **adverse variance of £563k**.
- Internal forecasts indicate a year-end adverse variance of £326k, which remains after accounting for savings associated with the A&T closure.
- Significant and sustained intervention is required to reduce bank expenditure across the Trust, otherwise the Trust will be seen as an outlier across the Region. The high bank expenditure has negatively impacted the NOF score in Q1.
- 47% of expenditure relates to unqualified nursing representing an adverse variance of £240k.
- 27% of expenditure relates to qualified nursing representing an adverse variance to plan of £275k.

Finance Position

CIP Delivery

NHS North Staffordshire Combined Healthcare NHS Trust

Efficiency Identified Schemes	Target £000	YTD 2026/27 Plan £000	YTD 2026/27 Actual £000	YTD 2026/27 Variance £000	Forecast 2026/27 Plan £000	Forecast 2026/27 Actual £000	Forecast 2026/27 Variance £000	*Of which is Recurrent Plan £000*	*Of which is Recurrent Actual £000*	*Of which is Recurrent Variance £000*	*Recurrent Full Year Effect Plan £000*	*Recurrent Full Year Effect Actual £000*	*Recurrent Full Year Effect Variance £000*
Clinical													
Acute	526	234	62	(172)	526	451	(75)	*526*	*159*	*(367)*	*526*	*216*	*(310)*
Community	1,834	816	372	(445)	1,834	544	(1,290)	*1,834*	*273*	*(1,561)*	*1,834*	*593*	*(1,241)*
Specialist	759	338	180	(158)	759	825	66	*759*	*253*	*(506)*	*759*	*303*	*(456)*
Primary Care	85	38	27	(11)	85	105	21	*85*	*71*	*(14)*	*85*	*80*	*(5)*
Clinical Total	**3,203**	**1,426**	**640**	**(786)**	**3,203**	**1,925**	**(1,278)**	***3,203***	***756***	***(2,448)***	***3,203***	***1,191***	***(2,012)***
Corporate													
CEO	57	25	29	3	57	57	(0)	*57*	*47*	*(10)*	*57*	*48*	*(9)*
Q&N	253	113	103	(10)	253	257	5	*253*	*257*	*5*	*253*	*330*	*77*
S&D	300	134	101	(32)	300	261	(39)	*300*	*155*	*(145)*	*300*	*200*	*(99)*
Finance	145	65	233	168	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	79	179	100	178	274	96	*178*	*128*	*(50)*	*178*	*167*	*(11)*
MACE	141	63	199	136	141	409	268	*141*	*83*	*(58)*	*141*	*95*	*(46)*
Operational	(0)	0	0	0	(0)	0	0	*(0)*	*0*	*0*	*(0)*	*0*	*0*
People	143	64	4	(59)	143	144	0	*143*	*144*	*0*	*143*	*287*	*144*
Corporate Total	**1,368**	**579**	**885**	**306**	**1,368**	**1,797**	**429**	***1,368***	***964***	***(404)***	***1,368***	***1,277***	***(90)***
Trustwide	**2,056**	**915**	**804**	**(111)**	**2,056**	**2,904**	**849**	***616***	***1,421***	***805***	***616***	***1,680***	***1,064***
Productivity	**1,149**	**612**	**612**	**0**	**1,149**	**1,149**	**0**	***1,149***	***1,149***	***0***	***1,149***	***1,149***	***0***
Total Trust CIP	**7,775**	**3,533**	**2,941**	**(592)**	**7,775**	**7,775**	**(0)**	**6,335**	**4,289**	**(2,046)**	**6,335**	**5,297**	**(1,038)**

- The efficiency target is £7.8m (reflecting 5.4% of the Trust total cost base excluding TCP & Complex Care) and includes £1.3m recurrent productivity target.
- Of the £7.8m target, £6.3m is recurrent and £1.5m non-recurrent.
- At month 6 the Trust is forecasting full delivery of the £7.8m CIP target. Of this, £5.6m is implemented and £2.2m is fully developed.

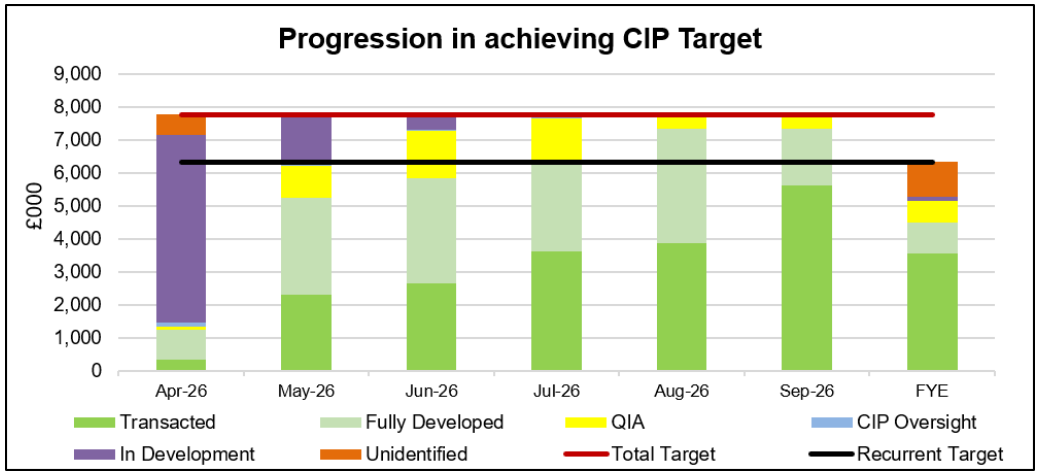
PROUD TO CARE

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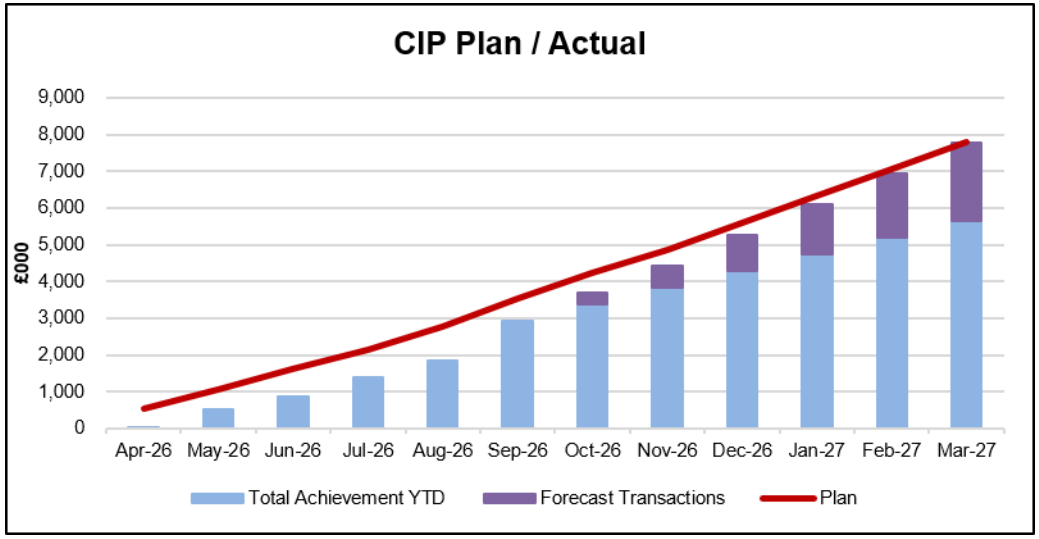
Finance Position

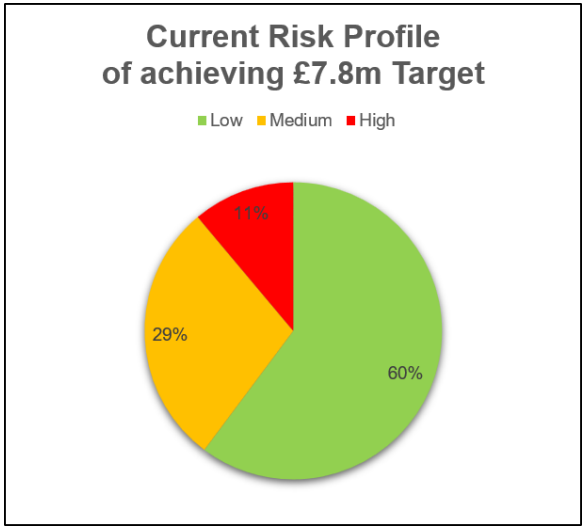
CIP Delivery

North Staffordshire Combined Healthcare NHS Trust



- Top graph shows the Trust progress in achieving the total £7.8m 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.





PROUD TO CARE

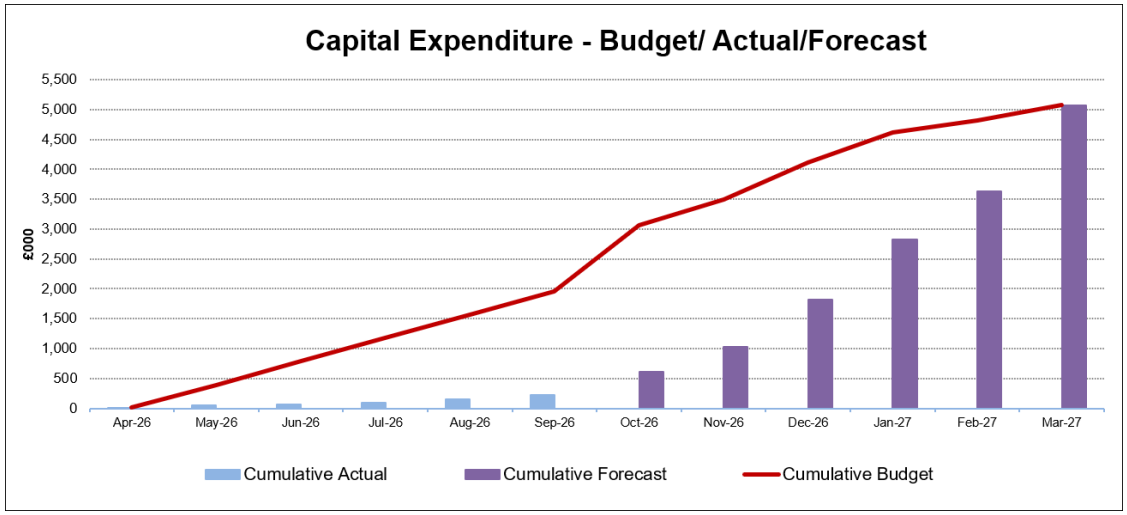
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Finance Position

Capital Expenditure

NHS North Staffordshire Combined Healthcare NHS Trust

Capital Expenditure	Annual Plan £000	Year to Date Against Plan: Plan £000	Year to Date Against Plan: Actual £000	Year to Date Against Plan: Variance £000	Forecast Outturn Against Plan: Plan £000	Forecast Outturn Against Plan: Forecast £000	Forecast Outturn Against Plan: Variance £000	Forecast Outturn Against Budget: Capital Budget £000	Forecast Outturn Against Budget: Forecast £000	Forecast Outturn Against Budget: Variance £000
Operational Schemes	**919**	**0**	**0**	**0**	**919**	**823**	**(96)**	**992**	**823**	**(169)**
Ligature Risks - planned	175	0	0	0	175	172	(3)	175	172	(3)
Ashcombe Restructure	234	0	0	0	234	179	(55)	216	179	(37)
Security	176	0	0	0	176	154	(22)	389	154	(235)
Freedom & Flexibilities	334	0	0	0	334	0	(334)	0	0	0
Solar PV Scheme		0	0	0	0	106	106	0	106	106
Backlog maintenance - boilers	0	0	0	0	0	145	145	145	145	0
Portable Devices	0	0	0	0	0	67	67	67	67	0
Digital	**713**	**19**	**20**	**1**	**713**	**713**	**0**	**713**	**713**	**0**
Capitalised Salaries - Device Replacement	40	19	20	1	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	0	(500)	500	0	(500)
IT - Device Replacement		0	0	0	0	500	500	0	500	500
Digital Infrastructure	115	0	0	0	115	115	0	115	115	0
Strategic Schemes	**3,070**	**1,905**	**186**	**(1,719)**	**3,070**	**3,248**	**178**	**3,080**	**3,248**	**169**
Strategic Schemes - EMU Expansion	1,034	645	56	(589)	1,034	1,202	168	1,034	1,202	168
Strategic Schemes - A & T Refurbishment	1,936	1,210	67	(1,143)	1,936	1,936	0	1,936	1,936	1
Capitalised Salaries - Projects	100	50	63	13	100	110	10	110	110	0
Other Schemes	**200**	**27**	**188**	**161**	**200**	**287**	**87**	**287**	**287**	**0**
IFRS16 Leases	200	27	226	199	200	287	87	287	287	0
Contingency	0	0	(37)	(37)	0	0	0	0	0	0
Total Trust Funded Capital Expenditure	**4,902**	**1,951**	**395**	**(1,556)**	**4,902**	**5,071**	**169**	**5,071**	**5,071**	**0**
Backlog Maintenance	147	0	(0)	(0)	147	147	0	147	147	0
GB Energy Solar Scheme	0	0	0	0	0	22	22	22	22	0
Total Gross Capital Expenditure	**5,049**	**1,951**	**394**	**(1,557)**	**5,049**	**5,240**	**191**	**5,240**	**5,240**	**0**
Lease de-recogniton	0	0	(169)	(169)	0	(169)	(169)	(169)	(169)	(0)
Total Gross Capital Expenditure	**5,049**	**1,951**	**225**	**(1,726)**	**5,049**	**5,071**	**22**	**5,071**	**5,071**	**(0)**



- The Trust's annual capital plan is £5,049k, including £147k of PDC funding.
- The Trust has been notified of additional PDC funding of £22k relating to GB energy solar schemes, increasing the capital budget to £5,071k.
- Year to date net capital expenditure is £225k, giving a favourable variance to plan of £1,726k, mainly due to slippage on the EMU and A & T Schemes.
- Forecast net capital expenditure for the year is £5,071k, £22k above plan as a result of additional PDC funding, but in line with the capital budget of £5,071k.

Finance Position

Statement of Financial Position

NHS North Staffordshire Combined Healthcare NHS Trust

SOFP	M4 £000	M5 £000	M6 £000
Non-Current Assets			
Property, Plant and Equipment - PFI	19,505	19,474	19,556
Property, Plant and Equipment	16,952	16,863	16,713
Right of Use Assets	2,571	2,573	2,541
Intangible Assets	1,741	1,696	1,651
NCA Trade and Other Receivables	525	519	513
Total Non-Current Assets	**41,295**	**41,126**	**40,974**
Current Assets			
Inventories	82	78	87
Trade and Other Receivables	8,344	7,737	7,393
Cash and Cash Equivalents	40,726	41,142	40,220
Total Current Assets	**49,151**	**48,957**	**47,700**
Current Liabilities			
Trade and Other Payables	(27,929)	(27,654)	(26,489)
Provisions	(2,054)	(1,994)	(1,994)
Borrowings	(3,199)	(3,199)	(3,199)
Total Current Liabilities	**(33,182)**	**(32,847)**	**(31,682)**
Net Current Assets / (Liabilities)	**15,970**	**16,110**	**16,018**
Total Assets less Current Liabilities	**57,264**	**57,235**	**56,992**
Non Current Liabilities			
Provisions	(1,101)	(1,097)	(964)
Borrowings	(14,235)	(14,144)	(13,915)
Total Non-Current Liabilities	**(15,337)**	**(15,241)**	**(14,878)**
Total Assets Employed	**41,928**	**41,994**	**42,114**
Financed by Taxpayers' Equity			
Public Dividend Capital	27,850	27,850	27,850
Retained Earnings reserve	7,053	7,119	7,239
Revaluation Reserve	7,025	7,025	7,025
Total Taxpayers' Equity	**41,928**	**41,994**	**42,114**

Current receivables are £7,393k of which:

- £4,097k is based on accruals (not yet invoiced).
- £3,296k is trade receivables, based on invoices raised and awaiting payment of invoice (£1,661k within terms).
- Invoices overdue by more than 31 days are subject to routine credit control processes.
- Local Authority and Non-NHS invoices overdue by 91+ days are included in the bad debt provision.

Current liabilities are £31,682k including trade payables of £26,489k of which:

- £20,875k is based on accruals (not yet invoiced).
- £5,614k is trade payables, based on invoices received (£3,082k within terms). This is a decrease of £1,166k compared to month 5 of which
- mainly relates to a reduction in accruals relating to TCP and Project 86.
- 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.

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Finance Position

Better Payment Practice Code

NHS North Staffordshire Combined Healthcare NHS Trust

	In Month			YTD Total		
Better Payment Practice Code	**NHS**	**Non-NHS**	**Total**	**NHS**	**Non-NHS**	**Total**
Number of Invoices						
Total Paid	34	950	984	188	5,275	5,463
Total Paid within Target	34	878	912	187	4,947	5,134
% Number of Invoices Paid	100.0%	92.4%	92.7%	99.5%	93.8%	94.0%
% Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
RAG Rating (Variance to Target)	**5.0%**	**(2.6%)**	**(2.3%)**	**4.5%**	**(1.2%)**	**(1.0%)**
Value of Invoices						
Total Value Paid (£000s)	716	9,397	10,113	3,118	47,956	51,074
Total Value Paid within Target (£000s)	716	8,025	8,741	3,118	45,682	48,800
% Value of Invoices Paid	100.0%	85.4%	86.4%	100.0%	95.3%	95.5%
% Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
RAG Rating (Variance to Target)	**5.0%**	**(9.6%)**	**(8.6%)**	**5.0%**	**0.3%**	**0.5%**

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 6, the Trust did not achieve the BPPC target for both the value and number of invoices paid within 30 days, with performance at 86.4% for the value of invoices paid and 92.7% for the number of invoices paid. The main drivers behind the invoices that missed target were the late authorisation of 46 TCP invoices with a total value of £896k, and 2 digital invoices with a total value of £462k.

- Year to date the Trust has achieved the BPPC target for the value of invoices paid within 30 days, with performance at 95.5% but is missing target for the number paid at 94.0%.

- The Finance Team will continue to monitor performance and work with operational areas to improve the timely authorisation of invoices where required and to ensure any disputed or queried invoices are clearly noted.

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Finance Position Summary

North Staffordshire Combined Healthcare NHS Trust

The Board are asked to receive the month 6 financial position noting:

- A year-to-date deficit of £224k against a planned deficit of £247k, resulting in a favourable variance of £23k.
- An underlying financial position (ULP) deficit of £783k.
- Agency expenditure of £426k against a plan of £522k, resulting in a favourable variance of £96k.
- Bank expenditure of £3,089k against a plan of £2,526k, resulting in an adverse variance of £563k.
- Year to date CIP delivery of £2,941k against a plan of £3,533k, resulting in an adverse variance of £592k.
- Capital expenditure of £225k, against a plan of £1,951k, resulting in a favourable variance of £1,726k.
- A cash balance of £40,220k on 30th September 2026.

Trust Board Assurance Report
From the Finance & Resource Committee Meeting
Held on 5th November 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 Update
The Committee received an update on the current status of the Trust's Electronic Patient Record (EPR) programme and noted that a report had been submitted to the Senior Leadership Team (SLT) setting out the proposed future direction and next steps.

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
The Committee noted three new risks, one risk score amendment and two risk closures during the reporting period. New risks were recorded relating to fire incidents, data protection associated with AI-enabled solutions, and DSPT cyber assurance. The Committee also noted the closure of the fire safety incidents risk, which has been superseded by a new risk, and welcomed the closure of the

domestic hot water temperature risk. In addition, the Committee noted a reduction in the payroll function risk.

Assurance was sought on the mitigating actions for the fire risk.

Level of assurance 6 agreed.

IQPR M06
The Committee noted continued strong and stable organisational performance, with sickness absence remaining an area of focus. Performance against national standards remains on track in most areas; however, reducing out-of-area placements (OAPs) and CYP 104-week waits continue to be key priorities. A change control paper is scheduled for consideration by the SLT in November.

The Committee discussed the duration for which PIPs remain active and considered whether the level of detail provided remained proportionate. The Committee also discussed the volume of information reported through the IQPR. The Committee noted that eliminating CYP 104-week waits by March 2027 remains a priority and received assurance regarding a revised and refreshed approach to reducing out-of-area placements in line with best practice.

Level of assurance 6 agreed.

Finance Position M06
The Committee noted that the Trust remains on plan overall, although bank staffing expenditure continues to be significantly above plan. Year-to-date CIP delivery is behind target; however, the full programme remains forecast to be delivered by year-end, with 11% of schemes currently rated as high risk. The Committee asked who is leading on CIP within the Executive Leadership Team. The Committee also noted the requirement to submit 2027/28 forecast scenarios to NHSE in the following week.

The Committee discussed the delivery of two major capital projects, which are currently behind plan. Further discussion focused on bank staffing overspends, including the actions being taken and accountability for delivery. The Committee also reviewed BPPC performance and progress against improvement actions.

Level of assurance 5 agreed.

Estates and Capital Report
The Committee received an update on progress against the Trust's capital programme, including Project Horizon (EMU additional six beds) and Project Elevate (A&T refurbishment). Initial cost estimates have been developed and are currently subject to value engineering review. The Committee also noted progress on fire remedial works and welcomed the closure of the domestic hot water temperature risk.

Committee discussed the fire safety visit from Staffordshire Fire and Rescue that is due to take place.

Level of assurance 5 agreed.

2025/26 Premises Assurance Model Summary Report
The Committee noted that the Trust achieved 67% compliance against the Premises Assurance Model self-assessment framework, which reviews the safety, suitability, effectiveness and governance of estates and facilities. Key areas of non-compliance relate to Hard FM technical assurance, asset

information, specialist governance arrangements, selected policies and sustainability. An improvement plan is in place to achieve compliance by March 2027. No submission to NHSE is required.

Level of assurance 5 agreed.

Digital Quarterly Assurance Report
The Committee received the quarterly Digital Report and noted positive assurance regarding core system stability, information governance and cyber security. Areas receiving limited assurance included the EPR, helpdesk performance and Information Governance capacity.

The Committee discussed the continued increase in Subject Access Requests (SARs) and the impact this is having on the capacity and resilience of the Information Governance team.

Level of assurance 4 agreed.

Sustainability Report Q2
The Committee noted progress across the Trust's sustainability programme and received updates on key areas of activity. Progress in the development and implementation of the Travel Plan was highlighted.

The Committee also discussed the sustainability-related risks and controls reflected within the Board Assurance Framework (BAF).

F&R request delegated authority from the Trust Board on 12th November 2026 to approve the Trust's Strategic Travel Plan (2027-30) at Finance & Resources Committee on 3rd December 2026.

Level of assurance 6 agreed.

Strategic Partnership Plan Q2
The Committee noted quarterly progress in delivering the Trust's strategic programmes, including the successful award of the West Midlands Tier 4 CAMHS (Toucan) Lead Provider Contract and continued development of the Neighbourhood Mental Health Centre model. The Committee also noted ongoing engagement in community, place-based and partnership initiatives.

The Committee welcomed the Trust's active involvement in both regional partnerships and local initiatives and sought assurance regarding stakeholder engagement and for the Neighbourhood Mental Health Centre programme.

Level of assurance 5 agreed.

TMO Assurance Report Q2
The Committee received the report and noted the success of the Toucan tender and project management of capital projects. Delivery remains on track across key programmes, supported by focused spotlight reports providing assurance on progress, risks and delivery milestones.
Level of assurance 6 agreed.

Business Opportunities
The Committee received the report outlining the success of the Toucan tender and an opportunity with the ICB for investment into frailty.

Level of assurance 7 agreed.

Policy Report
Committee noted SLTs approval of the Patients Property and Cash Handling policy.

Level of assurance 7 agreed.

APPROVE:

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

Heading:

Board Assurance Framework Q2
There were no score changes to the three BAF risks that fall under F&R's remit.

Next Steps (including timeframes):

The next Finance & Resource Committee meeting will be held on: 3rd December 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 1st October 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 Trust performance and risks in relation to key Quality performance indicators and 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.

There were no alert items.

ADVISE:

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

System Update

The wider health and social care system is beginning to experience winter pressures, driven by demand in the urgent care system and local increase in respiratory illness, including increased rates of infection in our services, particularly Flu and Covid-19. The Trust has contributed to quality review with system partners at the UHNM during the week of the committee and there was a discussion in how the Trust supports as a key system partner.

CQC Update

The Trust are yet to receive the draft report for Older Persons Inpatient CQC report. The CQC have been approached to enquire when this can be expected.

CQC Inspection Report

The committee received CQC reports for Older Person's Communality Mental Health Service and Keele GP Practice. Both were positive reports – both services were rated Good in all CQC domains, and Good overall, with some outstanding practice noted in both reports. No regulatory breaches or enforcement notices received

Keele practice:

- Overall CQC Rating: Good across all five domains (Safe, Effective, Caring, Responsive and Well-led).
- Outstanding Prevention & Population Health Impact
- Innovative work tackling health inequalities, fuel poverty and wider determinants of health.
- Outstanding Partnership Working & Integrated Care
- Outstanding Leadership Culture
- High Patient Satisfaction
- Strong Clinical Governance & Safety
- Reducing Health Inequalities
- Innovation & Service Improvement
- Strong Workforce Culture
- Positive Representation of NSCHT Primary Care

Older Persons Community

- Outstanding patient and carer feedback
- Strong person-centred care
- Excellent standards of safety and clinical practice
- Nationally recognised Memory Service
- Innovation recognised by CQC
- Strong commitment to equality and inclusion
- Excellent partnership working
- Strong assurance on quality and safety

Noting the suggested improvement actions remain under way the assurance level of the report has been advised to reduce from level 7 to level 6.

ASSURE:

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

Out of Area update M05

12 reportable out of area placements at the end of September 2026. Three of these patients are Clinically Ready for Discharge (CRFD). The committee discussed the report in detail and noted the actions which remain underway and their associated progress.

Level 4 assurance was accepted, noting that ongoing challenges and required engagement which require ICB support and resourcing.

Directorate Spotlight – Primary Care

A summary of the report was presented to the committee. Discussion took place, noting positive work across the directorate in relation to improvement and change.

There was a discussion regarding the growing demand and the need to ensure robust clinical triage. The directorate confirmed that they are being responsive to the demand and are currently piloting an approach where senior clinicians have continuous remote oversight on a day-to-day basis.

There was discussion about the use of AI and how this could better assist freeing clinical experts to provide direct care and intervention, ensuring that key decision-making stays within the control of clinical experts.

Discussions took place in relation to recording outcomes from ARRS practitioners and the impact they are having, which would assist further progression into the development of neighbourhood models.

Safe Staffing Monthly Report – August 2026

The report was received for assurance, with the overall fill rate for staffing in August being 98.9%; clinical areas which showed staffing fill rate variance were discussed. Clarification was provided regarding the introduction of dragon square respite service staffing metrics. The committee noted the inpatient sickness absence figures remain high and have requested that the People committee (PCDC) continue to seek assurance in relation to staff wellbeing and sickness absence challenges. The committee supported the report having level 6 assurance.

Health and Safety Report – 2026/27 – Quarter 1

The committee received this report for assurance. Violence and aggression remain our highest incident type with 249 incidents in April, 184 incidents in May and 158 incidents in June. One patient was noted to have caused a significant number of the V&A incidents, a deep dive review of the care provided is underway for learning purposes.

The committee were updated about the work underway in relation to reducing violence and aggression towards staff and a more detailed overview will be shared with the committee in November 2026. Trust board is requested to note that this work has commenced. Hate crime is an increasing trend which will be incorporated in the work referenced above.

A total of 8 RIDDOR-reportable incidents were recorded between April and June 2026, comprising 7 over-7-day absences and 1 specified injury.

The committee requested that the People committee (PCDC) continue to seek assurance in relation to the work to reduce incidents and harm to staff that Violence and Aggression causes.

Level 5 assurance was accepted.

Risk Review report

2 closures and a score reduction were approved in SLT.
Assurance level of 5 was accepted due to the gross and residual in some risks remaining the same.

IQPR M05 2026/27

The committee discussed the challenges related to the Trusts 104-week CAMHS wait. The committee were updated on the work underway by the community directorate; a key challenge relates to historical waits as opposed to current.

A presentation was shared with the committee in relation to a review undertaken with our local Healthwatch. The presentation provided assurance regarding the work and improvements underway to improve parents and children's experience of Autism and AHDH assessment and diagnosis services. This work is expected to improve the 104 week waits and forms part of our improvement plan.

There was a query regarding how the directorate remain in contact with individuals who have waited the longest; an exercise was conducted to contact all individuals on ADHD adult and children's pathways. There are plans to do the same for people requiring ASD services.

Policy Report

Assurance level 6 was accepted and assurance also taken

Any other Business

No items.

Meeting Self- Assessment

Robust and helpful contributions and discussions.

APPROVE:

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

No items to approve.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on 5 November 2026 at 2pm Lawton House

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

REPORT END

Trust Board Assurance Report from the Quality Committee meeting held on 5 November 2026

Introduction:

This assurance report to the Trust Board has been produced following the latest Quality Committee. The meeting was held in person and was quorate. Governance of the Committee focuses on achievements against Trust vision, strategic objectives, Trust performance against key Quality performance indicators and 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 Urgent Care system pressures remain a challenge; winter pressures are being felt with UHNM having had some significant operational pressures in the last month; we continue to contribute routinely via our Acute and Urgent Care teams. No significant impacts for the Trust currently.
The Committee were also notified of the Consultant Doctors strike between 25th – 27th November 2026, the Trust have 19 doctors who could potentially strike, but this impact is not yet fully known, planning to manage and mitigate risk is underway.

ADVISE:

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

CQC Update

The Older Person's Inpatient Wards draft inspection report remains outstanding, but we do expect to receive this imminently.
The Trust have our regular engagement meeting with CQC relations team on Friday 6th November 2026.
The Trust has commissioned Quality Governance Solutions (QGS) to support the Trust to prepare for a CQC Well-Led inspection and they were present in Quality Committee to observe the effectiveness of the Committee.

Progress update on the Nottingham Inquiry action plan

There was a presentation from the community directorate in relation to progress made in response to the above. The committee has an overview of the Psychosis Risk Index (PRI) which is a risk and early deterioration recognition dashboard for patients with psychosis and relevant risk factors. The aim of the PRI is to provide a 'birds eye' view of community caseloads and enable those patients with increasing

needs to be identified early, be reviewed and appropriate interventions to be provided early to prevent deterioration sooner.
The committee discussed the progress in depth and agreed the need for dashboards to utilised dynamically and consideration about how this will be operationalised. There were also discussions regarding the focus being on interventions associated with patients whose deteriorating mental health requires intervention to reduce the risk of violence and aggression.

The Intensive Outreach Team skill mix has been improved to provide enhanced multi professional oversight.
The service has seen an increase in referrals; there are ongoing challenge identified due to no additional investment.

There was agreement that the fundamental principles regarding person centred care, with good risk formulation, ongoing monitoring and engagement with patients and their families must remain priority.

ASSURE:

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

Risk Register Deep Dive
The committee were appraised of the risk score amendments and risk closures which were approved at the Risk Review Group. Assurance Level 6 Assurance accepted.

Out of Area update M06
End of month position for out of area patients is 16, with live position on the day of committee as 6 patients.
There remains a sustained challenge. The positive impact of Ward 5 pathway for acute patients was noted but recognised that this alone would not support a sustained improvement and reduction.
An acute pathway improvement review with be taken forward with a key focus on;

- Deterioration
- Crisis management
- Inpatient flow
- Discharge

A paper detailing this will be forwarded to Committee in due course.
Assurance level 4 was accepted by the Committee.

IQPR M06

The committee noted overall positive performance across many indicators; however sickness absence remains and the potential resulting impact on quality of care remains a key concern. The committee asked for an update from People Committee regarding workforce issues which may be impacting on Staff absence.

An overview of the Performance Improvement Plan's and their progress was given to the Committee.

The positive performance regarding care plan and risk assessment was acknowledged, this being a key indicator of quality.

A concern was raised regarding the distance some of the patients travelling out of area, with some up to 200 miles away, the likelihood of which will reduce as OOA plan reduces those OOA.
The committee acknowledged the importance of focusing on the impact on patients and staff of the IPQR data findings.

Policy Report
Level 7 assurance of the policy report was proposed due to a robust framework now in place to manage policy review and approval.

Mental Health Act Compliance Action Plan Report Q2
Progress and improvement within the compliance areas was recognised and assurance level 6 approved.

Quality Assurance Group Report Q2
An overview of CQC activity, internal quality assurance visits and improved MHA compliance recognised.
Assurance level 6 was approved.

Quality Impact Assessment of Cost Improvement Programmes
The committee received assurance in relation to Quality Impact Assessment of the Trust Cost Improvement Programme (CIP). Assurance level 7 was accepted by the Committee.

Safer Staffing Monthly Assurance report
The committee received the report for assurance. There was a discussion regarding bank staff capability; wrong grade type and also having improved oversight of the reasons that staff are not able to take breaks.
Assurance level 6 was approved.

Associate Hospital Managers Annual Report
It was agreed that this report was an assurance item and therefore the Committee agreed an Assurance level of 6.

CONSENT ITEM;

NCISH report was provided for information. A brief overview was offered advising that the findings are in the main reflective of the local picture.

APPROVE:

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

The committee approved the following Papers:

Clinical Audit Progress Report Q2
Approval was given by the Committee and areas of good practice was acknowledged.

Board Assurance Framework Q2
Approval given for the Q2 BAF Risk 4 to be reduced from a score of 20 to 15 (reduction in likelihood from Likely to Possible) report and acknowledgement that QIA paper also supports this.

BAF risk 8 score reduction from 15 to 10 (reduction in likelihood from Possible to Unlikely) was approved.

Next Steps (including timeframes):

The next Quality Committee meeting will be held on 3 December 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 30th October 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

ALERT:

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

Heading:

- **E – Rostering - Final Report.** (MIAA) - action agreed to take back to MIAA for further work and report to PCDC and Quality Committee's in December.
- **Internal Audit Progress Report** (MIAA) -Audit Recommendations- Ownership of actions, process vs culture.
- **Quarterly Finance Report** - £141k (7%) of paid invoices requiring a purchase order had orders that were retrospectively raised for the period 1st July to 30th September 2026. Noting a decline in retrospective purchase order performance, Committee agreed the following action; Deep dive requested to better understand root causes, with a report back to next Audit Committee.
- **Policy Report -** assurance sought around the effectiveness of the current approach to cascading Policy updates/changes to front line teams. How effective is our current communication approach more generally and what assurance do we have that key messages are reaching all staff groups?

ADVISE:

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

Heading: N/A

ASSURE:

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

Heading:

Quarterly Finance Report – Received for assurance- Level 6 agreed- noting alert identified above.

Internal Audit Progress Report and Quarter 2 Follow-up Report (MIAA) Received for assurance- Level 6 agreed - noting alert identified above.

Anti-Fraud Progress Report - Received for assurance- Level 6 agreed. Conversation held regarding; Just Culture approach and Disciplinary processes and affirmation on our key position statement that 'Fraud is Fraud'. Russell Andrews NED to take conversation over to the People Committee 2nd November 2026.

External Audit Review of Effectiveness – Report received for assurance- Level 7 agreed. Committee noted that Helen Lillington will replace Laurelin Griffiths as the Engagement Lead from Grant Thornton.

Counter Fraud Effectiveness Review - Report received for assurance- Level 7 agreed.

Policy Report - Report received for assurance- Level 7 agreed noting alert identified above.

Board Assurance Framework - Quarter 2 Report - Received for assurance- Level 6 agreed. Discussion held around plans for BAF 26/27 and consideration to Board level Cyber Risk.

Trust/Operational Risks 15+ - Received for assurance - Level 6 agreed. Committee noted inclusion of the revised Fire Risk 2279 approved by Risk Review Group in October 2026.

Data Security and Protection Toolkit (DSPT) Submission 2025/26 - Report received for assurance- Level 5 agreed. Discussion held as regards reporting cycles for DSPT and cyber security informed by MIAA from a benchmarking perspective. Agreed changes to the Audit Committee CoB included Annual IG/Cyber Report to Committee - scheduled January 2027 and bi-annual report; DSPT Progress Update.

Any Other Business - 1 item of AOB raised by Russell Andrews NED – for an NSCHT internal discussion outside of Committee on Audit Recommendation oversight and culture. See Alert section.

Meeting Self-Assessment - Chair, CFO and Deputy Director of Governance noted future developments to committee agenda and CoB that would further enhance subsequent Committee meetings.

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

Heading:
N/A

Next Steps (including timeframes):

The next Audit Committee meeting will be held on: 29th January 2027 at 10:00m via MS Teams.

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

REPORT END

Trust Board Assurance Report from the People, Culture and Development Committee Business meeting held on 2nd November 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

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

- Sickness absence - The Committee reviewed progress against the Sickness Absence Improvement Plan and recognised that, whilst improvement actions continue, sickness absence remains one of the most significant workforce priorities for the Trust. Members discussed the challenge of securing sustainable improvement and noted that success is dependent upon addressing underlying workforce challenges such as capacity alongside ensuring consistent operational ownership. Addressing management capability and capacity challenges will also be key to providing additional assurance on directorate level accountability. Further work and assurance is required on the actions in place to address these key areas and the effectiveness of the oversight processes in place to ensure the delivery of improvements. Level 5 assurance received on progress of actions in current plan but recognised the need for greater assurance on more strategic areas highlighted above.
- Trust People Plan - The Committee reviewed progress against delivery of the Trust People Plan. It was noted that although progress has been made, several areas have not progressed in line with the target dates that had been agreed. The challenge of delivering an ambitious programme of workforce transformation against a backdrop of significant organisational change, team absences and financial pressures was acknowledged and the committee reflected on the related risk recorded in the risk register. Members agreed on the need to maintain pace of delivery whilst embedding benefits and ensuring workforce priorities remain aligned to Trust objectives. The committee requested that a review be carried out and new, achievable target dates for completion to be provided. Level 4 assurance.

The Committee requests that Trust Board reflects on the two workforce challenges that continue to dominate Committee discussions that require the whole Trust's involvement and commitment to delivering:

1. Sustainable improvement in sickness absence.
2. Delivering the People Plan and associated workforce transformation programme.

The Committee recognises these issues are closely linked and will require continued Board visibility, executive leadership and operational ownership to achieve the intended benefits.

- System Collaboration - Although some progress is being made, the Committee discussed and wish to bring to the Boards attention the current challenges of developing meaningful collaboration and joint working across the wider system in relation to integrated workforce delivery models without the required system level joint overview and collective ownership through a coordinated approach.

- Being Open Annual Report - The Committee received, discussed and support approval of the report by the Board.

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

- Staff Story - Through the staff story, the Committee heard how a long serving colleague, who has significant care responsibilities outside of work, was able to remain in work through the use of flexible and supportive employment arrangements. Members reflected on the positive impact that compassionate leadership, flexibility and individualised support can have on retaining experienced staff, maintaining valuable organisational knowledge and improving colleague experience. The discussion reinforced the importance of compassionate leadership and the value of creating employment practices that recognise the complex caring responsibilities colleagues may have outside of work whilst supporting the wider social care system.
- Q1 Health and Safety Report - The Committee reviewed the report – Level 5 Assurance. The committee acknowledged that violence and aggression continues to represent the most significant health and safety risk to staff, accounting for 591 incidents during Q1 2026/27 and 88% of all reported health and safety incidents. The committee discussed the details and learning around a large number of the incidents that related to one patient. The committee has requested further details of preventative and supportive actions that the Trust has in place in relation to violence and aggression against staff.
- Next PCDC Focus session - Members agreed to focus on deeper scrutiny of complex workforce priorities; particularly sickness absence governance, workforce productivity and delivery of strategic People Plan objectives in particular our cultural improvement priorities.
- The Committee received an update regarding emerging national guidance following the Supreme Court definition of sex ruling and subsequent NHS guidance. A multidisciplinary working group has been established to review implications for Trust policies and will provide a further update to a future Committee meeting.
- National Award - The Committee noted national recognition through the Nursing Times Award for the Trust's T-Level and widening participation work, supporting future workforce supply and the Trust's ambitions as an anchor institution.

ASSURE: This section provides assurance of the quality of service and activity delivered under the PCDC's remit and programmes of work.

The Committee received assurance on the following:

- Workforce Metrics - The Committee was assured that robust workforce data, benchmarking and trend analysis continue to support oversight of key workforce indicators; enabling targeted action in areas of concern including sickness absence, vacancies, turnover and Trust performance. Level 5 assurance.
- People Team Management of Change - Assurance was received regarding ongoing workforce support during the People Team Management of Change implementation, with appropriate arrangements in place to support colleagues through transition and minimise impacts on service delivery.
- Quarter Two Being Open Report - The Committee reviewed the report, including the number of contacts, key themes and related actions. The Committee were assured that arrangements to support speaking up, organisational learning and psychological safety remain effective. Level 6 assurance.
- Guardian of Safe Working Quarter 2 report – no exception reports relating to additional hours worked and no identified vacancies during rotation. Level 6 assurance
- CQC Inspection Findings Report – Older Persons CMHT and Keele Practice – referral from Q&S Committee. The committee reviewed the people related areas for improvement and were assured on the measures in place to address them. Level 6 assurance.

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

The Committee received a deep dive on all People open risks and approved the changes to the workforce risks. Level 6 assurance.

The Committee approved the following policies: Level 7 assurance.

- Compassionate and Special Leave
- Menopause and Hormone Related Policy

The next PCDC business meeting will be held on: 4th January 2027

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

REPORT END

Trust Board Assurance Report from the Charitable Funds Committee meeting held on 7 September 2026

Introduction:

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

Purpose of the Report (Executive Summary):

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

ALERT:

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

Charity Operating Model and Sustainability: The Committee reviewed progress against the charity development plan and discussed the future operating model for the charity. The Committee acknowledged the significant progress made over the last two years in establishing the charity's profile, governance arrangements and grant-making activity and noted the importance of establishing a sustainable recharge model to ensure that charitable activities are self-financing. A proposal for evidence-based and proportionate cost-based recharge options will be prepared for the next Committee meeting.

Delegated Limits Review: The Committee reviewed delegated expenditure limits and agreed that the current arrangements should remain in place whilst wider discussions continue through the Trust's Scheme of Delegation and Standing Financial Instructions review.

ADVISE:

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

Inactive Funds Rationalisation: Following approval of the approach at the previous meeting, responses have now been received from all 19 inactive fund holders. Eight fund holders have confirmed expenditure plans, three require further discussion with wider teams, and eight funds with a combined balance of approximately £5,000 are proposed for amalgamation into the General Fund. A final deadline will be established to conclude the exercise and ensure inactive funds are utilised effectively for charitable purposes.

Charity Development and Impact Reporting: The Committee reviewed progress against the charity development programme. Significant investments including Ward 5 Garden, Roundwell Place Eco-Therapy Garden and Workforce Wellbeing initiatives remain in delivery and longer-term benefits are still emerging. Work is underway to strengthen impact reporting, including the development of patient stories and evidence of outcomes from charitable investments. The Committee supported continuation of the charity's grant-focused operating model aligned to Trust strategic priorities.

ASSURE:

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

Finance: The Committee noted a charitable funds balance of approximately £435k as at 31 July 2026. During the quarter the charity received income of £49k and incurred expenditure of £32k, resulting in a net inflow of £17k. The Committee also noted receipt of a restricted legacy of £56k and an unrestricted legacy of £19k during the reporting period.

Fund Governance and Stewardship: Assurance was provided regarding the management of restricted and unrestricted funds, including ongoing work to rationalise inactive funds and review legacy expenditure. The Committee was satisfied that appropriate governance arrangements remain in place to ensure charitable resources are applied in accordance with donor intentions and charitable objectives.

APPROVE:

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

Cycle Storage Facility: Approved charitable funding of approximately £18,435 towards the development of cycle storage facilities at the Harplands site. The proposal was supported on the basis that it represents an enhancement to the staff and patient environment and facilities, promotes wellbeing and sustainable travel, and aligns with the charity's objectives.

Inactive Funds Rationalisation: Approved progression of the next phase of inactive fund rationalisation, including the proposed amalgamation of qualifying inactive unrestricted funds into the General Fund following completion of final engagement with fund holders.

Next Steps (including timeframes):

The next Charitable Funds Committee meeting will be held on: 30th November 2026 at 2pm Via MS Teams.

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

REPORT END

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
Non-Executives						
Janet Dawson, Chair	√	√	√			
Russell Andrews, Non-Executive / Vice Chair	√	√	√			
Pauline Walsh, Non-Executive / Senior Independent Director	√	√	√			
Martin Evans, Non-Executive	√	X	X			
Prem Gabbi, Non-Executive Director	√	√	√			
Jennie Koo, Non-Executive Director	√	√	√			
Dr Roger Banks, Associate Non-Executive Director	√	√	√			
Katie Laverty, Associate Non-Executive Director	√	√	√			
Executive Members						
Dr Buki Adeyemo, Chief Executive Officer	√	√	√			
Eric Gardiner, Chief finance Officer / Deputy Chief Executive Officer	√	√	√			
Kenny Laing, Chief Nursing Officer / Deputy Chief Executive Officer	X	X	√			
Dr Dennis Okolo, Chief Medical Officer	√	√	√			
Elizabeth Mellor, Chief Strategy Officer	√	√	√			
Ben Richards, Chief Operating Officer	X	X	X			
Frieza Mahmood, Chief People Officer	√	√	√			
Zoe Grant, Acting Chief Nursing Officer	√	√	X			
Rachael Birks, Acting Chief Operating Officer	√	√	√			
In Attendance						
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	X			
Lisa Wilkinson, Corporate Governance Manager (Minutes)	√	√	√			